V-BID X for Employers: A Framework Designed to Promote Employee Access to High-Value Drugs, Services

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Value-based insurance design (V-BID), a health insurance design concept first developed in the 1990s, has been implemented in varying degrees by both commercial and public plans since that time, most notably in the Affordable Care Act (ACA), which called for certain essential health benefits to be offered without co-payment.[1]

Increasingly, employers are emerging as a group of stakeholders with great interest in V-BID, as they recognize their role in shaping how their employees' share of healthcare costs can affect what care they seek—and ensuring that their decisions on benefit design promote not just the cheapest immediate option, but high-value care.

With that in mind, A. Mark Fendrick, MD, director of the Center for Value-Based Insurance Design at the University of Michigan and co-editor-in-chief of *The American Journal of Managed Care*® (*AJMC*®), and Suzanne F. Delbanco, PhD, MPH, executive director of Catalyst for Payment Reform, recently presented a webinar for members of the Northeast Business Group on Health on "V-BID X for Employers." V-BID X is a framework developed by the Michigan center in partnership with public and private stakeholders.[2]

During the webinar, Fendrick said V-BID X was specifically constructed through benefit-design and payment reform to promote high-value services and deter low-value care. "In a cost-neutral V-BID design, they are feasible, they can be done, and there's a large number, almost infinite number, of plausible combinations of services and cost-sharing changes that would allow us to get to cost neutrality as long as you have the courage to go after specific low-value care services or categories of care," he said.

The goal of V-BID X is not to be an academic exercise for employers, Fendrick said, but an actual template for one to look at and understand that it is possible to achieve high-quality care while maintaining the same premiums and deductibles.

"The one thing worse than having a patient have a low-value care service covered is a patient having to pay out-of-pocket fully for a low-value care service.…As we put in benefit designs and, more importantly, payment reforms around these designated low-value care services, they have to be provider liable or patients will end up in that really difficult situation of battling getting a care [service] that might harm them, but [they] have to pay full price for it," Fendrick said.

One feature of V-BID X is a list of high-value services that should be targeted for reduced or eliminated cost sharing, as well as a list of those that are considered low-value services for which employers could offer no coverage.[2]

Of note, some items on the high-value list include glucometers and test strips for people living with diabetes, antipsychotics for those with psychotic disorders, and antiretroviral therapies for those with HIV. These items have been the focus of studies and news reports as patients share the consequences of being denied coverage or asked to ration supplies.[3-5]

As Delbanco has written, V-BID's potential remains unfulfilled. A recent article contributed by Delbanco and colleagues to the website

of *AJMC*® highlights President Donald Trump's June 2019 executive order as well as bipartisan legislation to allow high-deductible health plan health savings accounts to cover services for chronic condition management before they meet the deductible.[6] Fendrick presented data during the webinar that showed the escalation of deductibles over the past decade: Analyses of Kaiser Family Foundation Employer Health Benefit Survey and IBM MarketScan data show that average deductibles were rising each year before the ACA passed in 2010, but increased at a faster pace once the law took effect.

Low-value care is an important contributor to the $375 billion annual tab for out-of-pocket healthcare costs.[7] Fendrick cited examples such as vitamin D screening tests, diagnostic tests before low-risk surgery, and prescribing branded drugs when identical generics are available.

How much low-value care can be eliminated? Some estimates put the percentage of overall waste in the healthcare system at 30%, but Miller et al wrote in 2018 that despite consensus that low-value care exists, precise instruments for measuring it are still being developed.[8]

Employers, however, agree that they cannot sit by and see more and more of their money go toward healthcare with less to show for it. An October 2019 survey by Willis Towers Watson found that healthcare costs were a priority for 93% of employers and that more were interested in value-based designs.[9]

Freeing up money on healthcare within employer budgets is crucial, as US healthcare spending makes up 17.7% of the nation's gross domestic product, amounting to nearly $3.6 trillion, according to 2018 figures.[10] "Price is a very big driver of healthcare costs. Why are prices growing, and why are they such a big driver? It's largely due to the fact that there has been a huge amount of consolidation among healthcare providers," Delbanco said during the webinar.

She said the trend would be acceptable if this spending had some connection to quality, but currently, just 8% of adults 35 years and older have received all recommended high-priority preventive services.[11] "The amount of consolidation that's been happening over the past decade has led to a real imbalance in power in many healthcare marketplaces where providers are really in a position to command whatever prices they like. Again, prices have no correlation to quality of care," Delbanco said.

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