Health Care Transformation Task Force

Partners in Promoting Value

ADVANCING AFFORDABILITY IN VALUE-BASED CARE MODELS

CONTENTS

INTRODUCTION

The high cost of U.S. health care is a huge burden on individuals and families. A recent poll reveals that about half of adults struggle to afford health care costs.[i] The Health Care Transformation Task Force (HCTTF) believes that a truly person-centered health care system is one that makes care affordable to all populations so that health care services can be accessed when needed.

This HCTTF resource addresses the issue of rising health care costs to patients and highlights its impact on access and equity. It presents strategies that health care organizations can implement under value-based care (VBC) arrangements to drive affordable care for patients, increase access to care, and advance equity. In addition to presenting these strategies, the resource highlights efforts by three health care organizations – Elevance Health, MedStar Health, and Sentara Health – to implement these strategies.

VBC seeks to transform the health care system to one that improves quality of care while reducing health care spending. However, cost reduction efforts have primarily focused on reducing total health care system spending – including costs incurred by health insurance companies and health care providers – rather than reducing out-of-pocket (OOP) costs for patients. While reduced system costs can impact patient costs by limiting low-value care and preventing unnecessary hospitalizations, more focused efforts are necessary to reduce OOP costs. To ensure consumer affordability efforts achieve progress, the impact of OOP costs should be included as a key element of VBC model design. The strategies laid out in this resource can help to move the needle in the right direction.

What Are Out-of-Pocket (OOP) Costs?

Out of Pocket (OOP) Costs are defined as the money consumers spend on health-care. Direct OOP costs include copays, coinsurance, and premiums. Indirect OOP costs include transportation, child care, time off work, and other costs required to receive health care services

THE AFFORDABILITY PROBLEM

Nearly 100 million Americans have medical debt totaling about $220 billion. Black and Hispanic adults, women, the uninsured, and those with lower incomes are more likely to go into debt compared to their counterparts.[ii] Nearly 75 percent of adults worry about being able to afford unexpected medical bills or the cost of health care services, and nearly 30 percent of Medicare beneficiaries reported using up all their savings to pay for medical bills or debt.[iii, iv]

Affordability concerns are highest among lower income households and the uninsured, yet they also extend to those with health care coverage. Family premiums have increased 22 percent and deductibles have increased 10 percent over the last five years.[v] Many retirees also struggle to afford their premiums and other OOP costs, which include premiums for supplemental MediGap policies for those with Traditional Medicare.[vi] With the cost of health care growing faster than wages and outpacing inflation, many don't have the liquid assets to meet these rising costs.[vii] In fact, the majority of people in bankruptcy attributed the cause to medical bills or losing work due to illness.[viii] Additionally, the OOP costs for pregnancy and childbirth are high for many with private insurance, with 30 percent of multi-person households and 50 percent of single-person households struggling to cover costs.[ix]

The high cost of care significantly limits access to care for many Americans. Due to the soaring price of health care, one in five adults say they have not filled a prescription, and in the last 12 months, one in four adults have skipped or postponed health care visits.[x] Not surprisingly, skipped or postponed care leads to worsening health problems. These high costs likely factor into the 20 percent of adults who have not sought counseling or therapy for a mental health concern. Those who are able to receive treatment for depression or anxiety had almost double the OOP costs compared to those not treated.[xi] In addition to high direct health care costs, indirect costs like transportation, childcare, and time off work add to the burden of accessing care.

Affordability efforts offer significant opportunities to advance health equity by making health care financially accessible, particularly for marginalized and low-income communities. While not all marginalized people have low-incomes and vice versa, structural oppression and discrimination have limited opportunities for economic growth for racial, ethnic, sexual, and gender minorities. Structural racism in the health care system has also led to significant health inequities which further disenfranchise Black, Indigenous, and People of Color (BIPOC). Affordability efforts seek to reduce the costs of clinical care, as well as expand access to nonclinical services like food, transportation, and housing. While affordability efforts alone cannot overturn underlying causes of systemic racism, they can mitigate the negative impact, especially for low-income and marginalized communities.

AFFORDABILITY IN THE HEALTH CARE LANDSCAPE

The goal of VBC, as reflected in the triple aim, is to improve population health and patient experiences through high quality care while reducing per capita costs. Some initiatives that health care organizations have implemented to achieve these goals include prioritizing disease prevention, strengthening care coordination, investing in primary care, reducing drivers of unnecessary utilization, eliminating low-value care, and integrating behavioral health into primary care. Many of these initiatives have shown some success at achieving the triple aim. While these efforts can reduce duplicative services, slow disease progression, and prevent emergency department (ED) visits, more targeted and direct efforts are needed to reduce OOP costs to relieve the burden on patients.

Several broad trends exacerbate affordability issues. For example, low reimbursement rates make it challenging for providers to continue accepting Medicaid patients, who are disproportionately BIPOC. This leads to reduced access to care, especially for those in rural areas who may struggle to find a nearby alternative. In 2020, hospitals only received 88 cents for every dollar spent on Medicaid patients, resulting in $24.8 billion in underpayments.[xii] Hospitals also report that Medicare rates do not cover the cost of care.[xiii] Low reimbursement rates in combination with high inflation have led payers and providers to see a sharp decline in operating margins. These trends most negatively impact rural and underserved populations.

Subscription-based primary care options such as concierge medicine and direct primary care are on the rise and allow people to pay a flat fee for increased access to more personalized primary care. Concierge medicine is expensive and infeasible for many patients, with membership fees ranging from $1,200 to $10,000 per year.[xiv] While direct primary care is significantly more affordable than concierge medicine, both can exacerbate accessibility and equity concerns. When providers switch to subscription-based primary care and stop accepting insurance, low-income patients and those in rural areas face limited options finding a new provider. Additionally, membership fees are not covered by insurance and require people to purchase health insurance coverage for hospital and specialty care and prescription drugs. Accessibility concerns are also intensified by the national shortage of primary care physicians.

KEY INITIATIVES TARGETING AFFORDABILITY

VBC offers unique opportunities for health care organizations to implement strategies to reduce the burden of high costs on patients. Patients are not only burdened by direct costs, such as co-pays and the costs of services, but also by indirect costs, such as transportation and childcare costs related to receiving health care services. Health-related social needs (HRSNs), such as stable housing and healthy food access, also contribute to a patient's ability to maintain health and access to care but can add to financial burden. While drug costs also have a large impact on patient affordability, they are not reflected in the strategies below because they are beyond the scope of the Task Force.

Figure 1 summarizes efforts that the Task Force has identified to relieve the financial burden on consumers by addressing both direct and indirect costs.

Figure 1: Levers to Address Direct and Indirect Costs

Direct Costs

- Value-based insurance design
- Episode-based cost sharing
- Patient cost sharing waivers
- Administrative burden reduction
- Financial assistance programs
- Price transparency
- Fair co-pay legislation

Indirect Costs

- Supplemental benefits
- Care coordination
- One stop shops
- Technology and data sharing
- Care in the community
- Digital health
- Safe harbor laws
- Food and housing interventions

The following sections expand upon these efforts, which are categorized as payer, provider and policy initiatives. This categorization indicates which stakeholder is primarily responsible for implementing the effort, with an understanding that many of these efforts require collaborative partnerships between payers and providers. The following sections also include case studies from three Task Force members – Elevance Health, MedStar Health, and Sentara Health – that highlight these affordability initiatives in action.

PAYER AFFORDABILITY INITIATIVES

Value-Based Insurance Design

Value-based insurance design (VBID) is an important aspect of benefit design that allows payers to limit patient OOP costs. The main goal of VBID is to encourage the use of high-value services, such as primary care, by reducing cost barriers to those services. VBID also discourages low-value services, such as imaging for low-risk patients prior to surgery, by increasing OOP costs for these services. As an example, payers can use VBID to eliminate copayments for medications that manage chronic diseases like diabetes and asthma, or for preventive services such as cancer screenings and wellness visits. By making high-value care more accessible, VBID can improve patient adherence to high-quality treatments and preventive care, leading to better health outcomes. Reduced cost sharing for high-value services directly reduces the financial burden on individuals and families.

In 2015, the Center for Medicare and Medicaid Innovation (CMMI) announced the Medicare Advantage (MA) VBID Model, which allows MA plans the flexibility to offer cost-sharing reductions and additional non-covered benefits to enrollees with specified conditions. While participation in the model was associated with small but statistically significant increases in premiums, it was also associated with increases in drug adherence and quality measures.[xv] The latest evaluation also found that participants are increasingly using VBID for supplemental benefits such as healthy food, cash rebates, and over-the-counter medical benefits.[xvi]

State and private plans have also successfully implemented VBID. The state of Connecticut's Health Enhancement Program for state employees uses VBID to provide full coverage for preventive care, while increasing cost-sharing for non-emergent ED visits. The evaluation found a 13.5 percent increase in office visits for preventive care in the first year, and a 1.6 percent increase in having an office visit for chronic conditions. Blue Cross and Blue Shield of North Carolina's VBID program eliminated copays for generic medications used for hypertension, diabetes, and congestive heart failure for those in the program, and lowered copays for brand-name medications for all health plan enrollees. While changes in total health expenditures or emergency department utilization were not significant, the evaluation found an increase in medication adherence and a small decrease in inpatient admissions.[xvii]

Episode-Based Cost Sharing

Episode-based cost sharing is a payment model that allows payers to bundle the costs of an episode of care together, rather than paying for each individual service separately. This method incentivizes providers to deliver efficient and high-quality care across multiple providers within the bundled payment amount. As an example, bundled payments for maternity care may include a set cost for prenatal visits, delivery, and postnatal care, that allow providers to coordinate care, manage costs, and avoid duplicative or low-value services. Patients are responsible for a share of the total cost of the episode, rather than each individual service, which can reduce OOP expenses by avoiding multiple co-pays and deductibles and preventing surprise billing.

Physical therapy (PT) is another good example of an episodic cost. PT can help patients maintain and improve their overall health while preventing injuries and managing existing conditions. PT is often utilized as a cost-effective prevention treatment and alternative to surgery, and when sought out first, can reduce the overall cost of care by 54 percent. Early access to PT can also reduce ED visits by 15 percent.[xviii] However, because PT is considered a specialty service, rather than a primary care service, patients are responsible for more expensive copays. PT generally requires multiple visits per week over an extended period to realize the full benefits of treatment. The associated costs can cause patients to self-ration care. This is an example of a service that could be bundled as an episode of care to reduce OOP costs.

Supplemental Benefits

Supplemental benefits are additional services offered through plans that seek to fill the gaps in traditional medical coverage. For many years, MA plans have offered supplemental benefits to reduce patient cost sharing and offer prescription drug, dental, and vision coverage. More recently, MA plans have expanded these benefits to cover non-medical benefits such as meals, transportation, in-home supports, and rent subsidies.[xix]

The number of MA plans offering supplemental benefits has risen dramatically over the last several years, however, the benefits offered vary widely across plans. Almost every enrollee in a plan with supplemental benefits receives vision, hearing, fitness, and dental services. However, access to services such as over-the-counter medication coverage, remote patient monitoring, meals, transportation, and acupuncture varies widely across plans.

Even greater variation exists in the share of enrollees in a plan offering less common services, such as in-home support, bathroom safety, Medicare Part B rebates, telemonitoring, and caregiver support.[xx] While there is limited publicly available data on utilization and cost of supplemental benefits, one recent analysis found that patients who used supplemental benefits had decreased inpatient admissions and non-emergent ED visits, and increased outpatient visits and preventive screenings.[xxi]

In addition to the opportunity to reduce OOP costs to patients by providing reduced cost sharing and/or extra services, supplemental benefits are an important tool for addressing unmet social needs. One study found that self-reported HRSNs were associated with significantly higher rates of utilization measures including ED stays, hospitalizations, and 30-day readmissions. Beneficiaries with a HRSN had a 53.3 percent higher rate of avoidable hospitalizations compared to beneficiaries without HRSNs, and these increased rates of hospital stays were associated with financial strain and unreliable transportation.[xxii] Since 2020, over 95 percent of plans have offered dental, vision, and hearing services. Increasingly, plans are offering a broader array of supplemental benefits including meals (74%) and transportation (36%).[xxiii] To strengthen the use of supplemental benefits, payers should consider expanding the services covered and sharing best practices on the impact of these services.

Waivers for In-Kind Patient Supports

To encourage providers to participate in alternative payment models (APMs), CMMI waives select regulations to allow providers more flexibility in delivering high-quality patient care. Several CMMI waivers related to patient incentives and expanded benefits directly impact patient affordability. For example, the patient cost-sharing waiver allows providers to reduce or eliminate copays or coinsurance for certain services. Waivers are most effective if they can be targeted to specific populations based on clinical conditions, identified social needs, or insurance status. For example, the chronic disease management reward waiver allows providers to offer patients up to $75 in gift cards per year to encourage participation in chronic disease management programs. Providers are also able to offer in-kind items or services related to the disease management program purpose to promote patient engagement or adherence to clinical regimens.

The Centers for Medicare and Medicaid Services (CMS) also work with states to offer Medicaid "1115" waivers, to allow states greater flexibility to test innovative approaches to delivering Medicaid services. Some states use 1115 waivers to directly improve patient affordability. North Carolina's Healthy Opportunities Pilots, for example, assesses Medicaid beneficiaries for HRSNs and connects qualifying beneficiaries to free services and supports related to food, housing, transportation, and interpersonal safety. The program offers benefits such as one-time payments to cover housing security deposits, healthy food boxes or meals, and payment for non-medical transportation.[xxiv] In February 2024, the Biden administration approved eight additional waivers related to addressing HRSNs and included approvals for coverage of up to six months of rent and utilities, and meal support for up to three meals per day.[xxv]

Administrative Burden Reduction

Streamlining administrative processes allows health care providers to reduce their operational expenses, which can then be passed on to patients through lower fees and charges. For example, payers can simplify prior authorization policies, post-claim reviews, denial and appeal processes, credentialing, and utilization management policies to improve efficiency. These changes allow providers more time to focus on patient care. Notably, in 2023, the Task Force released principles for streamlining prior authorization policies in VBC arrangements. Prior authorization often poses challenges to patients in accessing care, causing frustration at best, and leading to adverse health outcomes at worst. The principles seek to improve the prior authorization process for payers and improve access to care for patients.

PROVIDER AFFORDABILITY INITIATIVES

Financial Assistance Programs

Financial assistance programs are designed to help patients manage the cost of medical care and reduce the financial burden on patients. These include charity care programs that provide free or reduced costs to patients who meet income requirements, sliding scale discounts based on income levels, and payment plans that allow patients to spread out the cost of care over time. Some providers also hire patient navigators who assist patients with enrolling in health insurance.

Rochester Regional Health, a nonprofit hospital system in upstate New York, bars aggressive collection activities and instead works directly with patients to settle their debt. When patients are unable to pay their bills, they often risk facing denied care, being chased by debt collectors, legal action, and sinking credit, which can make it harder to rent an apartment or get a car loan.

Medical debt collection also disproportionately impacts BIPOC and individuals with lower incomes and disabilities.[xxvi, xxvii] Instead of reporting people to credit bureaus, Rochester Regional helps to enroll patients in health insurance and connect patients to financial assistance and interest-free payment plans. Rochester Regional's approach doesn't eliminate medical debt, but it has fostered greater trust and collaboration with their patients and allowed them to spend less on pursuing patients who have not paid.[xxviii]

One-Stop Shops

One-stop shops allow patients to access clinical care providers and other services in a single location. Patients can limit transportation costs and save time when they can access their primary care provider and other services like career counseling and support groups in one location. One-stop shops also facilitate more effective communication among providers, helping to expedite internal referrals and access to needed care while limiting duplicative services and unnecessary referrals. By more effectively and holistically managing patients' health, care teams can help prevent costly emergency care for patients.

For example, Oak Street Health is a network of value-based primary care centers that seek to improve accessible high-quality care for seniors. In addition to traditional clinical care, providers at Oak Street Health offer behavioral health care, physical and social activities, nutrition consultations, health education sessions, social services and on-site pharmacies. They also provide on-the-spot referrals to reduce wait times for those in need. This model has led to a 41 percent reduction in patient hospital admissions and a 49 percent reduction in emergency room visits compared to Medicare benchmarks.[xxix]

Additionally, Kaiser Permanente operates an integrated delivery model that utilizes co-located providers, facilities, and services to enable a convenient one-stop shop experience for its members. In addition to primary care services, members can access a broad range of physician specialties (e.g., behavioral health, cardiology, oncology, neurology), imaging, labs, pharmacy, urgent care and other services at the same medical office building. Team-based care among Kaiser Permanente's clinicians and staff enhances communication and care coordination for its members and enables seamless patient referrals across departments, facilitated by advanced medical technology and comprehensive patient data collection including a single medical record platform accessible to all Kaiser Permanente clinicians.

CASE STUDY: Sentara Health

Sentara Health is a not-for-profit health care system and health plan serving Virginia, Florida, and northeastern North Carolina. Sentara's efforts to make the cost of care more affordable include financial assistance and discount programs, school-based telehealth, Community Care Centers, and partnerships to increase access to low-cost services.

Sentara's financial assistance and discount programs aim to strengthen access to care for low-income individuals and families by offering free or reduced cost of care. The financial assistance program waives patient OOP costs for both insured and uninsured individuals whose household income is 300 percent or below the federal poverty limit, with less than $50,000 in available assets. The program provides an 80 percent discount for those between 300 and 400 percent of the federal poverty limit, with less than $500,000 in assets. Sentara's Uninsured Discount Program provides a 50 percent discount for individuals not eligible for the financial assistance program. Sentara employs community health workers (CHWs) who assist patients with applications for financial assistance both at Sentara and other hospital systems if they need to be seen elsewhere.

Sentara also partners with TytoCare, a virtual care company, to increase access to primary and urgent virtual care for children in schools. School-based clinics help to limit missed school and work days for children and their parents, travel time to and from an office visit, time spent in waiting rooms, as well as avoidable ED visits. This initiative is especially beneficial in rural or underserved areas where access to care may be more limited. TytoCare reports that 27 percent of parents indicated they would have taken their child to the ED and 45 percent to an urgent care center if it weren't for the school-based telehealth program.[xxx]

Sentara also makes care more accessible by bringing care closer to the communities they serve. Their Community Care Centers are home bases for their mobile vans, which seek to reduce barriers to care such as transportation and time constraints. One of Sentara's Community Care Centers is located directly next door to a food pantry, where they have partnered to provide free groceries to residents. Sentara has embedded clinics within shelters and other places of high needs and has partnered with several community settings to offer free or discounted lab services, health screenings, physicals, and immunizations. Another partnership with a local community pharmacy has led to the provision of basic medications at no cost to the patient, with other medications offered at reduced rates. These efforts align with Sentara's commitment to reach the communities they serve to alleviate burden and costs.

Care Coordination

Care managers collaborate with patient care teams and community providers to coordinate patients' health care journeys. Because care managers collaborate with all members of a patient care team, they can encourage preventive care and early intervention, help patients avoid duplicative care, and manage patient referrals to specialists and other health care services to ensure access to timely and appropriate care. They can also help patients understand and utilize their insurance benefits to cover necessary services and treatments, as well as guide patients to in-network providers to reduce OOP costs.

Providers can implement care management programs to assist patients in managing medical conditions and coordinate care across clinical and non-clinical services. Providers can also partner with local data exchanges to obtain information that helps them more effectively manage patient care. While many providers deliver care coordination services, many payers also offer care coordination. Close coordination is required to ensure patients are not being outreached by multiple care managers, which can cause confusion for patients and further fragment care.

Technology Enablement and Data Sharing

Providers can implement several technologies into their practices to improve patient care. For example, providers can implement admission, discharge, transfer (ADT) alerts into their electronic health records to strengthen patient care management and coordination. ADT feeds notify providers in real time about patient status changes within or between health care facilities. Care management teams can use ADT alerts to follow-up with patients throughout their care journey to manage transitions and prevent gaps in care. Care teams can also use ADT alerts to identify and monitor high-risk patients and target interventions to improve outcomes.

For example, MedStar Health has partnered with the Chesapeake Regional Information System of our Patients (CRISP), a nonprofit regional health information exchange (HIE), to receive alerts when their patients receive care at another health care site or community-based organization. This allows MedStar Health to work with other providers outside of their system to better coordinate their patients' care needs, limit duplicative services and procedures, and reduce readmission rates. While MedStar has not released data on the impact on patient costs, the system calculated a return on investment of more than $2 million.[xxxi]

Providers can also implement remote patient monitoring (RPM), a health care delivery method that monitors patients' health outside of traditional clinical settings. Through RPM, providers can offer patients at-home and wearable devices such as blood glucose and blood pressure monitors, fitness trackers, and pulse oximeters to identify potential health issues sooner than with in-person visits. Early detection and intervention can prevent health complications and hospitalizations, reducing patient travel time and expenses associated with attending in-person visits. This is particularly beneficial for patients in remote or underserved areas, as well as those with mobility issues.

Locating Care in the Community

Providers can deliver care outside of traditional health care settings and closer to the communities they serve to increase accessibility and affordability. For example, mobile health clinics drive to underserved communities, such as rural and low-income areas, to address patient access issues related to distance, transportation issues, or financial constraints. Mobile clinics offer basic primary care and preventive services such as immunizations, screenings, and vaccinations, and help to detect health issues before they become more severe. Providers can also establish clinics in highly frequented locations like grocery stores and retail locations, to increase accessibility for patients. Many clinics in these locations have extended hours of operation to accommodate people outside of typical business hours.

Providers can also employ CHWs to reach underserved populations and those with limited access to traditional health care settings. For instance, the People's Center, a federally qualified health center in Minnesota, employs CHWs to make regular home visits to build trusting relationships with patients and proactively identify health concerns. People's Center CHWs also utilize tools such as in-home blood pressure and blood sugar checks, community wellness classes, and healthy cooking demonstrations to support patients. By visiting patients in their homes, one CHW learned that a patient was experiencing housing insecurity that was causing depression and anxiety. The CHW connected the patient to a case manager, who helped him access rent support programs so he could afford his diabetes and blood pressure medications, as well as better manage his mental health.[xxxii]

CASE STUDY: MedStar Health

MedStar Health is a not-for-profit health care system serving patients in more than 300 care locations across Maryland, Virginia and Washington, D.C. MedStar Health implements several programs aimed at reducing patient costs such as Mobile Health Centers (MHCs), in-home care for frail elders, and comprehensive care for high utilizers of the ED. MedStar Health also utilizes Community Health Advocates to identify and address social needs and partners with community organizations, including Hungry Harvest, Uber Health, and local community organizations to address patients' HRSNs.

MedStar Health operates MHCs to increase access to affordable care for those in underserved areas. MHCs offer high-quality care in a patient-centered fashion, removing structural and physical barriers. MHCs also increase access for historically marginalized populations, un- or under-insured patients, or those unable to otherwise reach traditional care settings. MedStar's MHCs offer basic primary care services, urgent care, wellness exams, on-site testing, and health insurance assistance. Currently, one MedStar Health MHC delivers care to underserved areas in south Baltimore City, and one pediatric MHC serves Washington, D.C. MedStar Health has a financial assistance program that offers free or reduced-cost care at the vans for those who qualify. By bringing care directly to the communities they intend to serve, these vans help to limit additional costs that may be associated with needing to receive care in a traditional setting such as transportation costs and extended time off work.

In addition to the MHCs, MedStar Health hosts two programs aimed at reducing unnecessary ED and hospital visits, as well as lowering costs of care. The MedStar Health House Call program offers home-based, holistic, and coordinated primary care for frail elders. Elders with severe chronic illness may struggle to get to the doctor's office, resulting in delayed care and unnecessary utilization. This targeted model increases access and has demonstrated a 20 percent average reduction in total cost of care against the benchmark over the last 10 years. In addition to primary care, the program offers care coordination with specialists and support services, such as home aides and legal assistance. If hospitalization is needed, the care team provides timely post-utilization follow-up visits to address any new and or emerging issues. MedStar Health incorporated this care pathway into several CMMI models in which it participates, including the Independence at Home Demonstration, Primary Care First, and ACO REACH.

MedStar Health has also implemented a program to better manage patients with high ED utilization, who often have multiple health-related social needs such as food insecurity or homelessness. When a patient arrives at the ED for the fourth time in 90 days, this triggers an interdisciplinary team to respond. A Community Health Advocate will first meet with the patient to assess their social needs and underlying drivers of utilization. Next, an interdisciplinary care team led by an ED provider reviews the patient's needs and develops tailored interventions to address these identified needs. Team members and program partners then act on this plan to ensure the patient has the resources and supports in place to avert the need for future ED visits. To date, more than 600 patients have been identified and are engaged in the program.

POLICY AFFORDABILITY INITIATIVES

Price Transparency

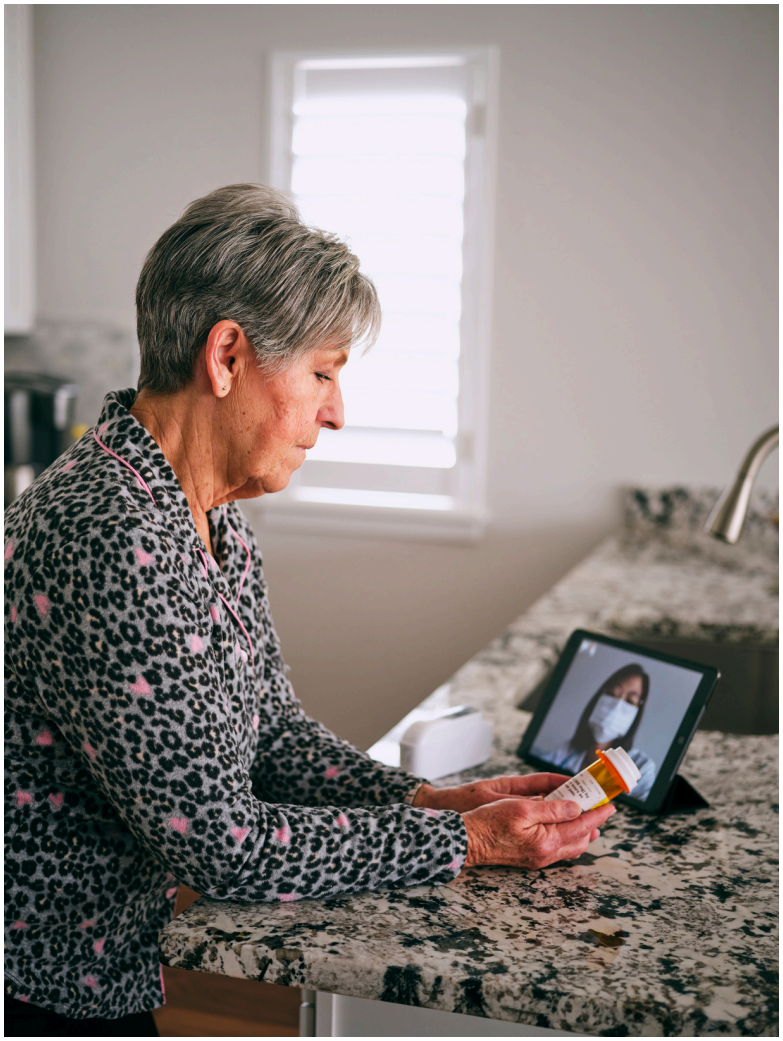
Price transparency efforts aim to help patients shop around for more affordable services by requiring hospitals and insurance companies to publicly report their prices. While these efforts alone can't make care more affordable, they can help patients choose lower cost "shoppable" services, or ones that can be planned for ahead of time. In 2019, the Trump Administration required hospitals and health plans to publicly publish their negotiated prices in a consumer-friendly format, such as a price estimating tool. However, to date, not all hospitals and health insurers have complied with these requirements, and among those who have, the price data has been inconsistent and inaccessible to most consumers. Additionally, because the policies that mandate price transparency feature different ways in which patients can access pricing information, there isn't a single source of truth for patients looking to get consistent and reliable information.[xxxiii]

Price transparency tools alone are not sufficient in reducing OOP costs for patients. For example, New Hampshire's price transparency tool was only used by one percent of consumers during its first three years. Research has found that other similar tools have not been associated with high usage or lower spending for those who use the tool. However, studies show that patients' use of low-price facilities increases when price transparency tools are combined with financial incentives, such as reduced OOP costs if a patient chooses care from lower-cost providers.[xxxiv] Additionally, hospitals have decreased their prices by approximately five percent after price transparency regulation took effect.[xxxv] These results show that price transparency tools have the potential to impact patient choices and lower spending, but may require complete data and consistency across tools, greater awareness among consumers, and the pairing of additional incentive structures.

The Task Force envisions additional strategies for enhancing price transparency tools. In addition to cost information, these tools should include quality scores so that patients can select high-quality and cost-effective providers. These tools should also be tiered based on location and specialist, to let the consumer select from high-quality providers in different price ranges. Patients would be able to make more informed decisions if they had access to additional information like the impact of the cost on the patient's deductible, health savings account balances, and financing.

Digital Health Reimbursement

Digital health encompasses virtual visits between patients and providers, as well as virtual messaging platforms and devices that facilitate communication with the health care team outside of visits. Digital health allows patients greater access to care by reducing transportation time and costs. Before the Covid-19 pandemic, digital health was generally limited to patients in rural areas and had low reimbursement rates, restrictions on where each party could be located, and limits on what services were covered. The Covid-19 pandemic prompted Congress and states to temporarily ease restrictions, leading to increased uptake of digital health for Medicare and Medicaid beneficiaries. Commercial health plans also broadened coverage for digital health services, expanding access.



Despite the significant uptake in and demand for digital health, access to it depends on each person's insurance. Digital health is important for improving access to health care for those with challenges accessing care in-person, such as those with disabilities and low-income patients who may struggle with transportation, time off work, and childcare costs. Audio-only digital health services also increase access for those who lack digital access or technical ability to engage in video visits.

CASE STUDY: Elevance Health

Elevance Health's companies serve approximately 115 million consumers. Elevance Health aims to lower member OOP costs through a combination of strategies, including supportive services and benefit designs that prioritize preventive care. Elevance Health utilizes advanced analytics to identify emerging risks for members who may be in need of supportive services, then provides outreach and support based on members' risk level and engagement. Elevance Health offers a range of support services including behavioral health case management, appointment reminders and proactive outreach, care and chronic condition management, wellness programs, and 24/7 nurse lines. This additional support aims to keep individuals engaged and continually connected to care to improve overall health and prevent the need for more costly interventions.

To incentivize the use of preventive care, Elevance Health uses VBID to eliminate cost-sharing for members for their first three primary care office visits, virtual visits, and maintenance medications. One study of Elevance Health's commercially-insured members found that this policy resulted in a 13 percent decrease in patient OOP costs for physician visits, compared to a nearly 10 percent increase in OOP costs for the comparison group. VBID also helped reduce outpatient and ED visits for members whose conditions could be treated with a primary care visit, as compared to the comparison group.[xxxvi]

In addition to direct member programming and benefit design, Elevance Health is active in policy advocacy at the federal and state levels to make care more affordable. Elevance Health advocates for the further expansion of protections to more effectively allow providers to practice value-based care and provide more support to members. For example, certain providers and value-based entities are limited in what services and equipment they can provide to patients based on Stark Law and anti-kickback exceptions or lack thereof. Thus, if a primary care provider in a VBE identifies a concerning trend with blood sugar management for a certain group of patients, they are unable to provide blood glucose monitors since they can only be furnished by a physician or employee of a physician or group practice that also furnishes outpatient diabetes self-management training to the patient. This is a limiting factor and could prevent patients from being able to better manage their blood glucose levels, particularly when there are multiple providers who may be caring for the same patient, and multiple provider types who can provide the monitors.

Elevance Health also advocates for site neutral payment policies, which require providers to bill the same amount for services regardless of where they are provided, and for the expansion of telehealth services with no facility fee.

Safe Harbors

In 2020, the Office of Inspector General (OIG) and CMS implemented major changes to the Stark Law and Anti-Kickback Statute regulations, which aim to prevent fraud and abuse among provider organizations. The OIG finalized safe harbors to protect organizations in value contracts engaging in activities that improve care for patients, with greater flexibility for those taking on more risk. The care coordination safe harbor protects nonmonetary payments that further patient care coordination regardless of financial risk. For example, a skilled nursing facility could provide a hospital with staff to assist in coordinating patient care through an inpatient discharge process. Additional safe harbors protect both monetary and nonmonetary payments between value-based enterprises (VBE) and VBE participants with substantial or full risk. Safe harbors can be expanded further for those in VBC arrangements to expand benefits to patients.

Food and Housing Benefits

In 2022, CMS first began incentivizing providers to screen for five core social determinants of health (SDOH) – food insecurity, housing instability, transportation needs, difficulty paying utilities, and interpersonal safety. CMS also recently added SDOH screening and referral to intervention to the 2025 MA Star Ratings, a system that rates the quality of services provided by MA plans. Currently, MA plans have two pathways for providing food and housing-related benefits: (1) special supplemental benefits for the chronically ill (SSBCI), and (2) primarily health-related supplemental benefits. However, federal regulations for MA plans limit their coverage of food and housing for members in need.

A recent Health Affairs article outlines two policy actions that CMS can take to increase the use of food-related benefits, which would also apply to housing-related benefits.[xxxvii] First, CMS could issue guidance providing greater flexibility for MA plans in determining which members qualify as "chronically ill" in order to receive SSBCI. Current guidelines are vague and prevent MA plans from offering SSBCI more broadly because of concerns around noncompliance. Second, CMS could clarify that specific food- and housing-related benefits are primarily health-related. Because nutritious food access and other HRSNs account for up to 50 percent of clinical outcomes, addressing these gaps in care is highly relevant to complex care planning and management. CMS should also clarify what kinds of food and housing interventions qualify as primarily health-related to help plans fully operationalize efforts to address HRSNs.

The MA VBID model also provides an opportunity for MA plans to increase access to food and housing support for patients. Under this model, participating plans can provide patients with various supplemental benefits to address HRSNs including grocery and housing assistance. CMS can expand access to these supplemental benefits to more beneficiaries by implementing successful aspects of the model into the Medicare Shared Savings Program.

Fair Co-Pay Legislation

Patients face high financial burdens for services like PT that require multiple visits a week across several months to improve care outcomes. PT is also classified as specialty care, which triggers costlier copays than primary care visits. In combination with an increased visit frequency, the higher copay can lead patients to skip out on medically necessary care. Under some health plans, PT copays can also exceed the reimbursement amount paid by the plan to the provider. To counter this, the American Physical Therapy Association (APTA) supports fair co-pay legislation that prevents cost-shifting to the patient by removing PT designation as specialists. APTA has developed draft model legislation for others looking to advocate for fair copays as well as a template letter to state legislators.[xxxviii, xxxix]

CONCLUSION

Rising health care costs place undue financial burden on patients, limit access to care, and exacerbate health inequities. The affordability initiatives outlined above can be implemented by health care organizations to reduce both direct and indirect patient costs under VBC arrangements. In addition to presenting existing initiatives, this resource points out areas where policy and operational changes can strengthen and standardize these efforts. Scaling these efforts is necessary for reducing patient costs and driving toward a more person-centered health care system where appropriate care is planned and accessed without impact of patient cost considerations.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.

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