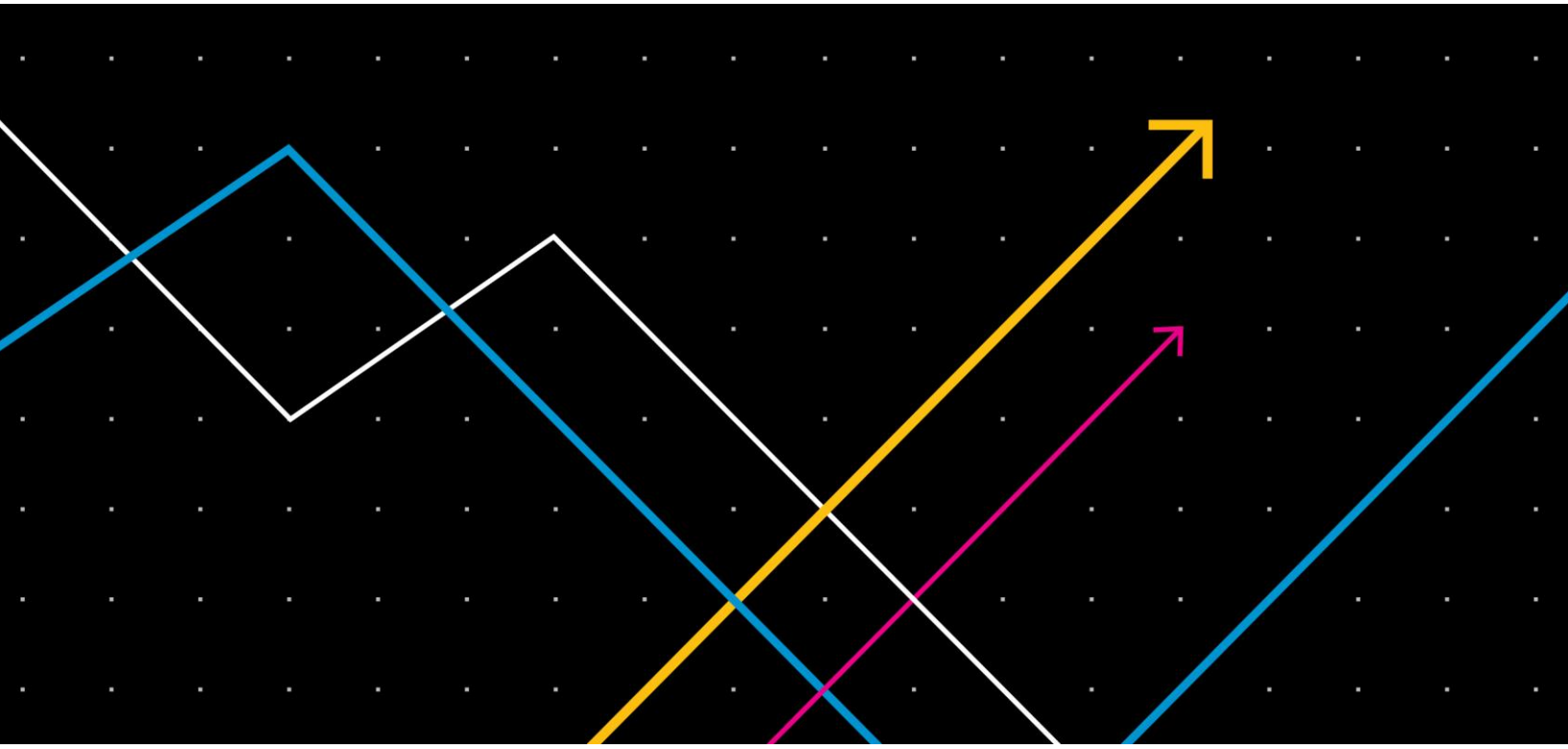

RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Value-Based Insurance Design

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OUR HEALTH CARE SYSTEM NEEDS CPR

CATALYST FOR PAYMENT REFORM

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the seven benefit designs discussed in the report *Benefit Designs: How They Work*. All reports and chapters can be found on our project page: Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care.

Value-Based Insurance Design

Value-based insurance design (V-BID) is built on the principle of lowering or removing financial barriers to essential, high-value clinical services based on the tenets of "clinical nuance." These tenets recognize that (1) medical services differ in the amount of health they produce, and (2) the clinical benefit derived from a specific service depends on the consumer's using it, as well as when and where they receive the service. Therefore, a specific service that is beneficial to a certain population may not be beneficial to all (e.g., a stent would be beneficial for a consumer with a myocardial infarction but could be intrusive and unnecessary for others without a clear clinical indication). V-BID aligns consumers' out-of-pocket costs with services, based on the service's "relative value" for a consumer or population. Therefore, consumers' out-of-pocket costs are lowered for services considered to be clearly beneficial to them, often based on long-established appropriateness standards. In theory, V-BID could also raise consumers' out-of-pocket costs for clinically non-beneficial services, though this is not common; virtually all services that are low value for some patients are high value for others. In addition, claims data or other readily available patient data are rarely adequate for determining whether a service is high value for a particular patient or not.

Generally, V-BID can be used for pharmaceuticals, preventive services (such as screenings, immunizations, and counseling), or services related to particular chronic conditions. The most well-known implementation of V-BID is in Section 2713 of the Affordable Care Act, which eliminates out-of-pocket costs for evidence-based primary preventive services, as determined by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices. Currently, all commercial payers must abide be this rule.

Many experts emphasize designing V-BID around common conditions, particularly because these are high-cost areas with well-established appropriateness standards that define beneficial care and services, though not all health care providers meet these standards. For example, it would be beneficial for a patient with diabetes to receive an annual eye exam, but it would be much less critical for a patient without the condition. In January 2017, the Centers for Medicare & Medicaid Services will implement a V-BID design model test for its Medicare Advantage plans in seven states around seven specific chronic conditions: diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, and mood disorders. The design model will test whether reduced cost-sharing for high-value services and providers can improve health outcomes and lower expenditures for Medicare Advantage enrollees.

The particular financial burden of health care on sick or low-income consumers is well documented. Increasing out-of-pocket costs often prevent consumers from receiving high-value health care services that they need. When patients do not get the care they need, their outcomes may worsen and they may experience higher rates of emergency visits and hospitalization. In some instances, this means higher aggregate medical spending. By taking these financial barriers away, value-based insurance design has successfully reduced health care disparities in many instances.

Both private and public payers have been experimenting with V-BID programs, and some have implemented them widely. For example, the State of Connecticut Health Enhancement Program for state employees reduces monthly premiums and out-of-pocket costs for clinically beneficial, evidence-based care, if enrollees commit to receive yearly physicals, age- and gender-appropriate screenings, and free dental screenings, among other services. Additionally, enrollees with chronic conditions have lower co-pays for specific services and medications.

Key Objectives of Value-Based Insurance Design

A major objective of V-BID is to encourage consumers to receive the medical services they need by reducing financial barriers to receiving them—typically their out-of-pocket costs. The aim is to prevent the adverse health effects that can arise when patients do not get the care they need. In the long term, the objective of V-BID is to improve the health of a population by increasing the rate at which consumers use high-value treatments.

Strengths

- V-BID encourages consumers who refrain from seeking care due to financial barriers to seek beneficial services. This has the potential to improve their health and prevent costly hospitalizations and visits to the emergency department.
- The financial incentives inherent in V-BID (and the education that typically accompanies a V-BID program) can signal to consumers the importance of seeking certain services, particularly for a given condition. Therefore, patients' use of high-value treatments, including those that help them manage or treat their conditions or diseases, may increase and make them healthier in the long term.
- V-BID can target high-value services for specific conditions, enhancing patient outcomes, reducing wasteful spending, and promoting efficient expenditures, potentially aligning patients' needs with providers' initiatives to improve care and make it more affordable.
- V-BID incentives may resonate particularly with patients who have chronic conditions and are well informed about the care they need.

Weaknesses

- Some experts express concern that V-BID, by increasing use of particular health care services, will lead to higher health care costs in the short term. Available evidence suggests that offsets in spending from improved quality may take time to accrue. Thus, V-BID may not save money in the short run unless the program also raises the consumers' share of costs for low value services.

- While V-BID is meant to reduce financial barriers to care, cost is not always the barrier to patients' seeking the care they need. For example, a person with no financial barriers to care who will not take her medication because she dislikes the side effects may not be any more likely to follow her prescribed regimen with lower out-of-pocket costs.
- Despite the presence of the right incentives, some consumers may still not appreciate the importance of seeking particular services.
- If consumers have a high deductible health plan with an HSA, where the care they seek does not receive first-dollar coverage until the deductible is met, V-BID may have little effect.
- There is concern that the costs of implementing V-BID may be greater than the savings it can produce.

Design Choices to Mitigate Weaknesses

Cost-Sharing

Incentives must be strong enough to encourage consumers to use clinically beneficial services. To strengthen these incentives, implementers can lower the patient's out-of-pocket costs or even provide the patient with a cash bonus, though this practice is rare. In addition, physicians play a vital role in getting their patients to make good health care choices. The American Board of Internal Medicine's Choosing Wisely campaign and the American College of Physicians' High-Value, Cost-Conscious Care initiative are predicated on this idea. Some have discussed structuring V-BID to penalize patients for using low-value services. For example, the Oregon Educators Benefit Board and the Public Employees Benefit Board have structured higher cost-sharing for health services that are recognized as overused and driven by providers' preferences (e.g., surgery for back pain over physical therapy).

Clinical Nuance

V-BID implementers can customize consumer incentives based on a specific type of service or a specific condition, such as diabetes or asthma. Experts contend this approach addresses "clinical nuance" by lowering cost-sharing for services known to improve outcomes for a specific condition. A service that

may be high value for one consumer may be harmful to another; not all health care services affect consumers in the same way.

Availability of Price and Quality Information

Making information about health care prices and quality available to consumers can show them the relative value of particular services and point them toward higher-value options and providers. Additionally, consumer-facing transparency tools can estimate a consumer's out-of-pocket costs for particular procedures; with V-BID, this may help distinguish between those that are clinically beneficial and those that are not.

Compatibility with Other Benefit Designs and Payment Approaches

V-BID could work well with tiered networks. Blue Shield of California implemented a program called Blue Groove, which provided enrollees with V-BID subsidies for receiving care from higher-tier providers. If the consumers received care from lower-tier providers, they would not be eligible for V-BID subsidies. While Blue Groove never took off, this model could be successful if designed simply and comprehensibly.

A key feature of V-BID is that it aligns consumers' incentives with most payment approaches that emphasize value over volume. The provision of incentives prompting compatible behaviors from providers and consumers is an important element of a high-performing delivery system. A scenario that offers a clinician bonus for performing a certain service (e.g., eye examination for a diabetic patient) is less likely to succeed if the patient's benefit design does not generously cover the service (as may be the case in some high deductible health plans).

Fee schedules can be structured so that providers are paid for care that is clinically beneficial for the patient and are not paid for care that is not beneficial. For example, a provider would be paid every time a 50-year-old patient seeks a colonoscopy, but not for a patient without known risk factors who seeks a colonoscopy at the age of 31.

V-BID is compatible with payment reforms that maintain fee schedule payments and are tied to providers' performance on quality measures (particularly pay-for-performance). V-BID encourages

patients to stay healthy or keep themselves from getting sicker, which may result in better patient outcomes. Delivery of these same services by providers may also be used as a process measure in pay-for-performance programs, shared savings, or shared risk payment arrangements. Ensuring that a high proportion of patients get the preventive services they need can make providers eligible for a bonus payment or to share any cost savings they produce.

Focus of Performance Measurement

The same services targeted by V-BID may also be the subjects of provider performance measures. For the most part, these measures would be process measures, verifying that health care providers are following the processes of care suggested in established guidelines. Such measures may help verify that providers are not withholding care, despite the incentives to do so inherent in some provider payment methods that put providers at financial risk for overspending as compared to a budget. Using available outcome measures also would be ideal to determine whether improvements in the process of care lead to better results for patients.

Potential Impact on Provider Prices and Price Increases

V-BID is intended to reduce the barriers, especially economic, that patients perceive to receiving high-value services. It is unclear whether V-BID has any influence on health care prices.

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A technical expert panel advised the project team and reviewed the reports at different stages.

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