

IMPLEMENTING VALUE BASED INSURANCE DESIGN IN THE MEDICARE ADVANTAGE PROGRAM

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ABOUT VBID HEALTH

Value Based Insurance Design Health specializes in designing and promoting health benefits plans and payment strategies that get more health out of every health care dollar spent. The U.S. spends \$2.6 trillion on health care – everyone agrees we should be getting more “health” out of that investment. VBID Health provides streamlined, Value Based Insurance Design consulting services to facilitate creation and adoption of VBID plans and payment policies that increase patient, employee, and enrollee health. VBID Health assists employers ranging from Fortune 100 companies to City Governments, health insurance plans, and health systems in designing clinically nuanced health care benefits packages. For more information, visit vbidhealth.com

INTRODUCTION

Policymakers are now considering Medicare reform proposals that seek to reduce the Medicare spending trend. Efforts to control Medicare expenditures often focus on decreasing payments for health care plans and providers. Recent proposals focus on increases in the eligibility age, as well as requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests, and prescription drugs. **Efforts to slow the rate of Medicare spending growth need to simultaneously focus on Medicare spending trend and improving health care quality for our nation’s seniors and those with disabilities.** One way to achieve this goal is to transition from the current system that rewards providers based on the volume of services provided to one that rewards based on the value of care provided. Such an approach would balance efforts to reduce Medicare spending while preserving access to high quality care. Therefore, instead of an unwavering focus on *how much* is spent – attention should shift to encompass *how well* we spend our increasingly scarce health care dollars in order to maximize health outcomes produced for the dollar spent.

CREATING VALUE: THE IMPORTANCE OF EMPHASIZING CLINICAL EFFECTIVENESS

Due to misaligned incentives, Medicare beneficiaries receive too little high-value care and too much low-value care. **To efficiently reallocate medical spending and optimize population health, it will be critical to pursue clinically focused strategies that align beneficiary incentives with clinical effectiveness by focusing on the following principles: 1) medical services differ in the benefit provided; and 2) the clinical benefit derived from a specific service depends on the individual patient using it, and the setting where it is provided.** Creating a Medicare program that maximizes health per dollar spent requires policy makers to incorporate these concepts and address the substantial variation in value across health care services and providers.

Identifying High Value Services and Providers

With regard to health care services, it is well known that all health services do not deliver better health. For example, while some services, such as immunizations, cancer screenings, and medications to manage chronic disease are broadly accepted as contributing to high quality care, other services can be harmful or unnecessary because they may be misused or overused. According to the literature, these overused or misused services account for at least 20 percent of health care expenditures¹.

Fortunately, there is a growing movement to both identify and discourage the use of unnecessary services. The American Board of Internal Medicine Foundation, in association with Consumers Union, has launched *Choosing Wisely*², an initiative in which medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, twenty-six medical specialty societies have each identified at least five services within their respective fields that fall into this category while nineteen additional societies are also preparing services lists. Substantial cost savings are available from efforts such as Choosing Wisely. For example, savings of more than \$5 billion were estimated if use of the top five overused clinical services identified by three primary care specialties were used more appropriately³.

With regard to providers, wide variation in practice patterns across geographic areas is not generally associated with better quality. The implications to Medicare of encouraging patients to choose high performing providers based upon the cost and quality of care are substantial. A recent report from The Commonwealth Fund Commission on a High Performance Health Systems estimated that substantial savings would accrue to Medicare over 10 years if we were to “develop a value-based design that encourages beneficiaries to obtain care from high-

¹ Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care. JAMA. 2012; 307(14):1513-1516.

² <http://www.choosingwisely.org/>

³ Kale MS, Bishop TF, Federman AD, Keyhani S. "Top 5" Lists Top \$5 Billion. Arch Intern Med. 12/14/2011. Vol 171. (no 20); 1856-57.

performing care systems.”⁴ Additionally, the June 2011 MedPAC report summarized findings from the coronary artery bypass graft demonstration project, which selected seven sites based on price, quality of care, and geography. The evaluation found that the project generated interest among providers, reduced costs to Medicare and most participants, and increased quality of care⁵. The broader adoption of such an approach is increasingly feasible, as quality metrics and risk-adjustment tools evolve to provide a widely available foundation for identifying high-performing health care providers and care settings that consistently deliver superior quality.

ENCOURAGING MEDICARE BENEFICIARIES TO USE HIGH VALUE SERVICES AND PROVIDERS: THE CASE FOR VALUE BASED INSURANCE DESIGN

Transitioning from a volume-driven to value-based delivery system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). For example, cost-sharing for all clinician visits, diagnostic tests, and prescription drugs, is typically implemented in a “one size fits all” way. Under the Medicare program, this is the required approach. A growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care. Peer-reviewed studies reveal that when patients are asked to pay more for high-value cancer screenings⁶ and potentially life-saving drugs⁷, they use significantly less of these services. Conversely, decreases in cost-sharing applied to all services regardless of clinical benefit may lead to overuse or misuse of services that are potentially harmful or provide little clinical value.

⁴ Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System. The Commonwealth Fund Commission on a High Performance Health System. January 2013.

⁵ The Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System (June 2011). Available at: http://www.medpac.gov/documents/Jun11_EntireReport.pdf

⁶ Trivedi AN, Rakowski W, Ayanian JZ. Effect Of Cost Sharing On Screening Mammography In Medicare Health Plans. *New England Journal of Medicine*. 2008;358(4):375–83.

⁷ Goldman D, Joyce G, Zheng Y. Prescription Drug Cost Sharing: Associations With Medication And Medical Utilization And Spending And Health. *Journal of the American Medical Association*. 2007;298(1):61–9.

To encourage consumers to take advantage of high-value services and actively participate in decision making about treatments that are subject to misuse, more than a decade ago private sector purchasers began to implement a concept known as Value Based Insurance Design (VBID)⁸. **The basic VBID premise calls for structuring benefit designs to align with the higher value of evidence-based services and high-performing providers in contrast to low value care.** This alignment can foster better health care delivery at any level of care.

VBID in the Commercial Sector and at the State Level

Many health care organizations and experts agree it makes sense to pursue payment strategies and plan designs focused on promoting clinical effectiveness to maximize value for every health care dollar spent. The commercial sector pioneered the development and implementation of these programs, and promising reports of health improvement and cost savings soon followed. Early VBID programs were employer-driven, with Pitney Bowes receiving considerable attention for their sentinel program. Blue Cross Blue Shield of North Carolina-administered plans eliminated copays for select generic drugs and reduced copays for select brand-name drugs, and saw improved adherence in all drug classes, with the greatest improvement for diabetes control drugs. United and Aetna offer similar programs for the self-insured insurance market, focusing on patients with chronic conditions such as asthma and heart disease. Early results of these condition-specific programs suggest increased adherence to evidence based guidelines, improved clinical outcomes, and decreased disease-specific spending in certain circumstances.

The Oregon Public Employees' Benefit Board introduced VBID elements into their benefit program, by eliminating cost sharing for certain high-value services, such as weight management and tobacco cessation. For other high-value services, such as office visits for chronic disease, the Board reduced cost sharing. Moreover, the Board increased cost sharing for over-used or preference-sensitive services of low-value (with some exceptions, for example,

⁸ www.vbidcenter.org

when care was medically necessary), which resulted in decreased usage of 15-17 percent for targeted procedures.

Similarly, Connecticut State Employees implemented the Health Enhancement Program (HEP) in October 2011. HEP includes robust VBID principles, including that HEP enrollees benefit from cost sharing reductions if they commit to: yearly physicals, age-appropriate screenings and preventive care, two free dental cleanings, and (as appropriate) participation in disease management programs. Additionally, HEP enrollees save \$100 a month on the cost of premiums as compared to enrollees remaining in the traditional preferred provider organization offering. As reported⁹ by the Connecticut State Comptroller, early results show: participants respond to incentives and accept accountability (about 98 percent of the approximately 54,000 eligible Connecticut state employees and retirees voluntarily enrolled in HEP); clinically-focused incentives increase evidenced-based care and may promote favorable changes in utilization that promote enrollee health; and increases in health care spending may be slowing¹⁰.

BARRIERS TO VBID IN MEDICARE

While the success of VBID programs is well-established, there are challenges to implementing VBID in the Medicare program. Although the Medicare statute provides for coverage of certain preventive services identified by the U.S. Preventive Services Task Force (USPSTF) with zero cost-sharing, the fee-for-service (FFS) Medicare program allows little flexibility to implement clinically driven benefits. Specifically, program administrators are limited in their ability to lower cost-sharing levels for other services recommended in clinical guidelines. Moreover, the FFS program is unable to use benefit design to encourage patients to use high value providers.

⁹ Kevin Lembo. "Connecticut's Health Enhancement Program." Presentation to the National Academy for State Health Policy 25th Annual Conference (Baltimore, MD). 2012 October 15.

¹⁰ University of Michigan Center for Value-Based Insurance Design. V-BID Center Brief. V-BID in Action: A Profile of Connecticut's Health Enhancement Program. January 2013. Available at: http://www.sph.umich.edu/vbidcenter/publications/pdfs/V-BID%20brief_CT%20HEP%20final.pdf

Within a provider type, Medicare beneficiaries must pay the same regardless of which provider they choose. The FFS program sets prices administratively, using methodologies that do not provide for variation in price to align with variation in value. Yet practice patterns and quality may vary across providers. Unlike in the private sector, the FFS program is unable to incorporate clinically focused benefit design to promote better outcomes and greater efficiency.

In contrast, private health plans participating in Medicare Advantage (MA), have flexibility to use care management techniques to promote evidence-based care, including limited ability to adjust benefit design. The compendium of MA tools includes network formation, provider facing-interventions (e.g., bonuses for quality and high performance), and utilization management programs to identify under-utilization as well as over-utilization. From the consumer engagement perspective, however, MA plans could further enhance their ability to serve beneficiaries if they had greater ability to use benefit design to promote value.

Specifically:

MA plans are not allowed to tailor benefits to specific sub groups of patients who may receive particularly high value from a given service. If MA plans try to encourage the use of a service by lowering copays, they must lower copays for everyone in the plan, even though clinical appropriateness for specific patients may vary widely. For example, it is not clinically appropriate for all Medicare beneficiaries to receive annual eye exams, but it is clinically indicated for all Medicare beneficiaries with a diagnosis of diabetes to receive this service. Although clinical evidence frequently determines treatment recommendations based on specific diagnoses, a plan design that tailors copayments to disease-specific guidelines for recommended services for specific diagnoses is not permitted as it would be considered to violate antidiscrimination rules.

Chronic Special Needs Plans (SNPs) tailor benefits to the needs of individuals with chronic and complex health care needs to increase access and encourage patient engagement with

treatment regimes to improve outcomes. Making these programs and services available to a greater number of Medicare beneficiaries is likely to be beneficial.

MA plans are allowed to create a provider network, but their ability to vary copays within that network is limited. For example, in many markets there are providers that are important members of any network, perhaps because there are few providers of specialized services that patients may need or perhaps because of reputation. Exclusion of such providers completely from the network could be problematic because plans must meet network adequacy requirements and beneficiaries may want access to providers that are well-regarded in their community. Yet it may also be the case that for many services the desired provider practices a very costly style of care that may not significantly improve quality.

In the commercial sector, plans have much more flexibility to place such providers in non-preferred tiers. For example, a Medicare Advantage plan has the flexibility to establish a \$50 copayment for an out of network office visit and a \$25 copayment for an in network office visit, but might also wish to establish a \$0 copayment for an in-network office visit that takes place at a recognized patient-centered medical home that has demonstrated better performance on key quality measures. While CMS permits MA plans to establish differential cost sharing by service category (e.g., inpatient hospital services) and based upon the facility setting (e.g., diagnostic imaging services), as long as certain standards are met, the agency does not permit differential cost sharing based upon the provider group an enrollee selects. **CMS should issue clear guidance that provides greater flexibility for MA plans to establish tiers of cost sharing to encourage beneficiaries to choose high value hospitals and physician providers.** Such a policy would be consistent with other Medicare initiatives, for example, those promoting establishment of patient-centered medical homes and accountable care organizations, that are designed to make the program a leader in delivery system transformation to achieve greater quality and efficiency not only for Medicare beneficiaries but for all consumers.

REDUCING BARRIERS TO IMPLEMENTING VBID IN MEDICARE ADVANTAGE

As noted above, Medicare Advantage plans are not permitted the same flexibility that exists in the private market to use VBID strategies. There are several reasons why this is the case. CMS has historically viewed benefit packages that charge different beneficiaries varying amounts for the same service as inconsistent with the “antidiscrimination” provisions in the Social Security Act. This position is in line with the agency’s view of the Medicare entitlement which seems to be that all MA enrollees enrolled in the same plan must have the same access to benefits and in-network providers at the same cost sharing levels even if providing incentives to high quality providers would improve the quality and cost-effectiveness of the program. Finally, providing MA plans with increased flexibility through VBID has often been viewed with skepticism by some who believe organizations would use benefit design to discourage enrollment of beneficiaries with high health care needs.

In fact, Medicare regulations require Medicare Advantage plans to implement utilization review as part of their quality improvement programs. These accepted programs could also be considered “discriminatory” but are accepted as value promotion that encourages high value care and discourages low value care. These programs address under-utilization as well as over-utilization and help to ensure EVERY beneficiary has access to a service if appropriate in the clinical situation. Moreover, the Medicare program is starting to reward high quality care through demonstration programs such as pay-for-performance, provider feedback, and the Affordable Care Act established payment-based incentives for MA plans and other providers that perform well on quality metrics. Additionally, there is growing interest in granting Medicare more flexibility to vary benefits based on value. Finally, Special Needs Plans (SNPs) are allowed to tailor benefit packages to individuals with selected diseases. Medicare does not consider this discrimination, but instead recognizes the flexibility as a way to promote value.

To increase quality and decrease long-term cost growth in the Medicare program, CMS should permit MA plans to vary copayments and coinsurance to incentivize beneficiaries to receive high value services from high value providers and actively engage with their providers in

decision making about care that is low value if misused or overused. This would include reduced cost sharing for evidence-based services (e.g., NCQA HEDIS measures).

CMS should reconsider its antidiscrimination and benefit uniformity policies in light of the agency's goals for improving quality and efficiency throughout the delivery system to contribute to the sustainability of the Medicare program. The agency should update existing guidance to provide greater opportunity for MA plans to have the flexibility to set enrollee cost-sharing based on clinical information such as diagnosis and to create multiple tiers of provider networks that would incentivize beneficiaries to select high performing providers. This increased flexibility would permit MA plans to promote value in clinically appropriate ways that are proven to improve quality. Moreover, CMS through its ongoing review of plan benefit packages can continue to ensure that such benefit designs are not discriminatory and promote value for beneficiaries with complex needs. These changes are necessary to move the Medicare program into the 21st Century by encouraging quality and cost-effectiveness.

CONCLUSION

Although there is urgency to bend the health care cost curve, it is critical for cost containment efforts to go hand in hand with a focus on quality. **Applying clinically focused strategies in benefit design presents an enormous opportunity for the Medicare program.** If such principles of Value Based Insurance Design encourage the utilization of high value providers and services and consultation with providers before receiving services that can be low value if misused or overused, Medicare Advantage plans can improve health and quality, enhance consumer engagement, and reduce costs. Key stakeholders—including a large and growing number of medical professional clinical societies—agree that discouraging providers from misuse or overuse of identified low-value services with the active involvement of consumers in decision making must be part of the strategy. As evidence-driven approaches to identify high- and low-value services and providers are coupled with carefully designed strategies for consumer education and communication, Medicare can become more efficient. Congress and

the Administration can achieve this goal by allowing MA plans to create Value Based Insurance Designs that will better serve beneficiaries in the long run.