ConsumersUnion

POLICY & ACTION FROM CONSUMER REPORTS

Consumer Criteria for Value-Based Insurance Designs

HEALTH POLICY
RECOMMENDATIONS
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SUMMARY

The California Health Benefit Exchange (Covered California) may allow Qualified Health Plans to vary from the standard benefits package that will be offered all enrollees, through value-based insurance design (VBID) options. VBID incorporates financial incentives into health insurance cost-sharing approaches to encourage healthy outcomes. Consumers Union has developed a set of criteria that Covered California and other Exchanges should use to evaluate whether the proposals are in the best interest of consumers.

The California Health Benefit Exchange (Covered California) staff has proposed standardizing benefits and cost-sharing for Qualified Health Plans (QHPs) participating in Covered California. Coupled with the standard package of essential health benefits, this means that only a limited number of benefit designs would be sold in the individual and Covered California's SHOP exchanges, a position strongly supported by consumer advocates to allow for easier comparisons among plans. At the same time, Covered California staff also recommends permitting some QHP product variations to allow for "value-based insurance design" (VBID).[1] VBID builds into insurance products cost-sharing and other financial incentives to promote certain behaviors deemed beneficial.[2] The staff recommendation, endorsed by the Board, asserts that for the first few years, VBIDs permitted by Covered California would be

[1] In this paper, we have chosen to use the term "Value-Based Insurance Design" (VBID), rather sometimes used "Value-Based Benefit Design" (VBBD), to encompass benefit design for both insurance and health plan products and because it is more commonly found in the literature than VBBD.

[2] This paper deals solely with VBID as Consumers Union and much of the literature define it: benefit designs varying *cost-sharing* by and financial "rewards" to consumers, sometimes joined with consumer engagement activities, with a goal of improving health outcomes. Other steps to improve patient health or overall quality aimed at providers, such as pay-for-performance initiatives, and other steps to achieve cost savings and quality improvement through health care delivery reform, such as accountable care organizations, are not the subject of this paper.

"largely positive in nature ('carrots') to incent compliance with beneficial treatment plans." Other than the "carrot" concept, no specific criteria or metrics have been suggested by which to evaluate whether to approve VBID proposals.

While there are sound reasons to pilot a limited number of proven VBIDs that reduce or remove financial barriers for procedures or medications that are aimed at improving the quality of care and promoting better health outcomes, care must be taken to:

- Ensure that these programs are based on rigorous evidence of improved outcomes;
- Avoid risk selection, both among QHPs in Covered California (if some but not all QHPs offer them) and against Covered California, if such designs are not uniformly offered in the market outside Covered California, thereby attracting a less healthy risk mix to Covered California;
- Ensure that these programs provide equal access to enrollees and do not have a discriminatory impact; and
- Balance the likely benefit of VBID measures against undermining the standardization and level playing field approaches otherwise intended by Covered California.

Below, we recommend criteria for evaluating VBID proposals and preconditions to be met before Covered California permits them. In the event that approaches are considered in the future that put financial barriers in place for procedures or medications found to be ineffective ("sticks"), rather than just the removal of financial barriers for promoting certain "good behaviors" ("carrots") that Covered California staff has suggested to date, we recommend that the state proceed with particular caution to evaluate whether those proposals are in the best interest of California consumers.

What is value-based insurance design (VBID)?

Value-based insurance design incorporates financial incentives into health insurance cost-sharing approaches to encourage healthy outcomes.[3] In particular, the idea is to use differences in cost-sharing to steer enrollee behavior toward services that have proven to be more efficacious, toward healthy lifestyles (such as smoking cessation), and/or toward "high value" services[4] (generally those that meet some quality and efficiency performance threshold, usually aimed at systemic cost savings).

Incentives are not new in the insurance world. Insurers have historically used differential cost-sharing to incentivize patient behavior in an effort to lower costs overall. What VBID does is to strive for better patient outcomes by linking out-of-pocket incentives, rewards, and sometimes consumer engagement requirements to higher quality services. The patient cost-sharing incentive targets a specific clinical benefit of the service (e.g., diagnosis, medication, treatment, or program) based on available scientific evidence.[5] As used in this paper, under Consumers Union's definition of VBID, positive health outcomes must be a primary goal of any VBID proposal.[6]

As illustrated by the examples below, much of today's experience with VBID comes from large employers. In particular, many large employers have focused VBID efforts on cost-sharing reductions for prescription drugs, often targeted at those designed to treat chronic diseases. More recently, proponents of VBID have contemplated hybrid approaches, with cost-sharing incentives for "high value" services and disincentives for "low value" services.

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[3] Value-based insurance design directed at guiding consumer choices differs from "value-based purchasing," an approach that incentivizes plans or providers to improve outcomes and cut costs, such as paying plans or providers based on performance measures. VBID and value-based purchasing can be used in conjunction with each other.

[4] While there is no standard definition of "high value services," they are commonly viewed as affording better health outcomes per dollar spent. This may include the use of certain preventive services, certain prescription drugs, or providers with better outcomes who adhere to evidence-based treatment guidelines. See, e.g., *Value-based Benefit Design: A Purchaser's Guide*, National Business Coalition on Health (January 2009), p. 2.

[5] Fendrick, M., et al., A Benefit-based Copay for Prescription Drugs: Patient Contribution Based on Total Benefits, No Drug Acquisition, *The American Journal of Managed Care*, Volume 7. No. 9, pages 861-867 (September 2001).

[6] Again, other measures aimed at improving health outcomes that do not rely on financial incentives directed at consumers, of course, are worthy of consideration, but simply not applicable under the VBID label.

Carrots v. Sticks

In some instances, the VBID approach incentivizes patient behavior by lowering cost-sharing if patients engage in healthy behavior (the "carrot"). A far reaching example is the ACA ban on cost-sharing for preventive services (e.g., well-child visits, routine immunizations). Other examples come from large purchaser experience, such as removing co-payments for certain prescription medications. For example, a large employer eliminated or lowered cost-sharing for five classes of medications for all enrollees prescribed the medications, regardless of what condition they were being treated for, with zero cost-sharing for generic and a 50% decrease for brand name drugs. A three-year evaluation showed improved medication adherence for those patients using the reduced cost-sharing medications.[7]

In other instances, enrollees were provided incentives, coupled with the requirement to participate in a disease management program. In one study, a large retail employer reduced cost-sharing of certain classes of medications for those with diagnoses of diabetes, asthma, coronary artery disease, or heart failure, conditioned on enrollees participating in a disease management program. Those enrollees who did not participate in the disease management program (either out of choice or life circumstance restrictions) were not eligible for the reduced cost-sharing and their costs for medications remained the same as for all other medications covered by the company. The results indicated that the combination program of disease management and reduced cost-sharing had the potential to improve medication adherence.[8]

Recent VBID approaches use both financial sticks and carrots: plans increase co-payments for services determined to be of "low value" (the "stick") and decrease cost-sharing for "high value" services (the "carrot"). For example, Oregon's Public Employee's Benefit Board created a three-tiered benefit system that included a high value tier with little or no cost-sharing for patients, a standard tier, and then a third low value tier that had a separate deductible, higher out-of-pocket maximums, and higher co-insurance for services the insurer deemed "low value" services.

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[7] Chernew, M., et al., Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment, *Health Affairs*, Volume 27, No. 1, pages 103-112 (2008); See also, Gibson, T, et al., A Value-based Insurance Design Program at a Large Company Boosted Medication Adherence for Employees with Chronic Illnesses, *Health Affairs*, Volume 30, No. 1, pages 109-117 (2011); Choudhry, N., et al., At Pitney Bowes, Value-based Insurance Design Cut Copayments and Increased Drug Adherence, *Health Affairs*, Volume 29, No. 11, pages 1995-2001 (2010).

[8] Yoona, A. K, et al., Evaluation of Value-based Insurance Design with a Large Retail Employer, *The American Journal of Managed Care*, Volume 17, No. 10, pages 682-690 (October 2011).

Most evidence to date examines the carrot approach. There is scant evidence for VBID programs that raise cost-sharing in order to reduce the use of lower value services. Researchers have struggled to effectively determine which services should be deemed "low value" in order to institute disincentive cost-sharing.[9] While some argue that cost-sharing formulas should discourage all services that "result in harm," others argue for a broader approach that discourages care that is "too expensive" for the health outcomes associated with the services, without necessarily defining what "too expensive" means.[10] A number of professional societies have recently identified multiple overused, often ineffectual tests and treatments that can cause more harm than benefit.[11] However, they have been careful to urge that their work not be used for benefit design at this point, since most of the items or services identified are appropriate in some circumstances, even if ineffective in many.

[9] Choudhry, N., Rosenthal, M., Milstein, A., Assessing the Evidence for Value-based Insurance Design, *Health Affairs*, Volume 29, No. 11, pages 1988-1994 (2010).
[10] Fendrick, M., Smith, D., & Chernew, M., Applying Value-based Insurance Design to Low-Value Health Services, *Health Affairs*, Volume 29, No. 11, pages 2017-2021 (2010).
[11] "Choosing Wisely" at http://consumerhealthchoices.org/campaigns/choosing-wisely/ Consumer Reports is a partner in the Choosing Wisely Campaign, translating the recommendations into plain language for consumers and promoting them with the public.

Six Proposed Criteria for Evaluating Value-Based Insurance Design Variations in Covered California

Requests for benefit design variations that are based on Value-based Insurance Design (VBID) considerations should be rigorously evaluated by Covered California to ensure that the variations are justified based on sound evidence. To keep the number of variations to a manageable level, Covered California should select the more thoroughly proven interventions over those less studied. Reintroducing variation in cost-sharing itself has a cost – it makes the health plans harder for consumers to compare[12] – and only the most valuable and evidence-based cost-sharing variations should be offered.

The burden of proof should be on the Qualified Health Plan (QHP) requesting the variation.[13] The requesting insurer must:

I. PROVIDE EVIDENCE OF HEALTH IMPROVEMENT UNDER THE VBID

- Demonstrate to Covered California that the **primary goal is to improve the health and well being of a specified sub-population** of enrollees, through the proposed financial incentives. If the insurer cannot demonstrate improved health and well being, the option should not be permitted under VBID. [14] This should be demonstrated using a two-part test:
    - The QHP proposal must demonstrate that there are **proven health benefits** to the VBID proposal **via a publicly available, independent assessment** of the strength of the evidence, with any

[12] L.Quincy. *What's Behind the Door: Consumers' Difficulties. Selecting Health Plans*, Consumers Union (January 2012).
[13] Other authors, as well, urge certain "preconditions" to broad adoption of these new approaches to payment and benefit design. See Lansky, D., Nwachukwu, B., Bozic, K., Using Financial Incentives to Improve Value in Orthopaedics, *Clinical Orthopaedics and Related Research*, Volume 470, No. 4, pages 1032-33 (April 2012).
[14] We recognize and support efforts throughout the health care delivery system to undertake responsible cost-saving measures. This paper is specifically on VBID, which proposes to link quality improvement to cost savings. Efforts that simply look at cost savings, while perhaps meritorious, would not meet the definition of VBID.

contrary studies identified. The relevance of the evidence must be assessed: if it comes from a large employer, can these better outcomes be realized by the Covered California population, given its specific demographic characteristics, rate of churn, etc.?[15] and

- The QHP proposal must show that the **cost-sharing variation has proven successful in directing patients to more healthy behaviors and/or improved clinical outcomes**. It should ensure that cost-sharing does not result in consumer confusion when comparing plans, benefits and the actual variations.

II. DEMONSTRATE CONSUMER AND PROVIDER UNDERSTANDING

- Demonstrate that **benefit variations are readily understood by consumers** at the point of plan shopping and that they can correctly gauge the relative generosity of their plan options. That is, can consumers accurately assess the effect of the VBID on cost-sharing limitations, deductibles and co-insurance within each of the metal tiers? This can be demonstrated from prior plan design evaluations or independent, carefully designed consumer testing of the cost-sharing variations demonstrating that consumers understand the VBID. Does the evidence appear to be applicable to the Covered California population, given its language characteristics, health insurance literacy levels, etc.? Covered California should carefully consider whether patient confusion over plan benefits would outweigh the potential for improved health. When there is no evidence of consumer understanding, Covered California should deny the benefit design.
- Require that plans provide a **multi-faceted communication plan** that clearly describes the terms and emphasizes the benefits of the program to enrollees in multiple languages, and to providers.[16] Providers should have a

[15] While generally supportive of the potential of VBID, a guide by the National Business Coalition on Health (NBCH) notes that the "currently available research evidence documenting a positive [short- or long-term] ROI [return on investment] from VBBD initiatives is limited, preliminary and mixed" (citing Hunt S, Maerki S, and Rosenberg W., Assessing Quality-Based Benefit Design, Prepared for the California HealthCare Foundation and Pacific Business Group on Health, April 2006.) Houy, M., *Value-based Benefit Design: A Purchaser's Guide*, National Business Coalition on Health (January 2009), p. 4. The NBCH Guide notes that VBID may not be worthwhile in places with high employee turnover – especially given that high-value services take several years to realize savings. And NBCH states that most experience with VBID is in companies with 10,000 or more employees. With fewer than 5,000 employees, the administrative costs may be too high to realize savings. Id. p. 7.

[16] The communication plan should explicitly include a clinical outreach strategy, a disease education initiative (including health promotion and a wide range of options to meet the needs of all enrollees), educational materials to help educate enrollees prior to initiation of the plan and information regarding the costs and benefits available at the point of decision making. The proposal should show that the plan

key role in implementing VBID and the health plan should produce a detailed communications approach that targets all providers in the plan's network.

- Avoid the term "value-based" in marketing and descriptions of the plan, in order to ensure that it does not confuse or unduly sway consumers; rather, ensure clear, specific descriptions of what the insurance design provides.

III. CONVENE AN ADVISORY COMMITTEE

Convene an advisory committee or stakeholder workgroup that includes consumers and independent practitioners to review the above evidence and advise Covered California on the VBID's likely value and feasibility.

IV. PROVIDE EQUAL ACCESS

- Ensure that the **incentives are applied evenly**, without discrimination, and identify the recourse available to the Exchange and individual enrollees if the proposal results in disparities during implementation. Additionally, the plan should provide assurances that its related data collection complies with the Affordable Care Act (ACA), Americans with Disabilities Act (ADA), HIPAA, the Civil Rights Act, and any other applicable laws.
- When the cost-sharing variation is tied to the use of certain providers, identify whether there is **adequate and meaningful access** to those certain high quality providers (e.g., if designed for heart disease management, is the provider network large enough to support enrollee participation – including a network sufficient to accept new patients, etc.). Further, network adequacy must be demonstrated for all geographies where the VBID is being proposed and include an adequate number of providers who speak in the languages of the targeted patient population, based on state standards such as the list of Medi-Cal Managed Care threshold languages.

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will provide a variety of consumer tools, in multiple languages to ensure understanding by limited English proficient populations, to assist potential consumers in benefiting from the design proposal – medical records access, optional personal health assessments, tools to track compliance, medication support, shared decision making support tools, quality and cost score sheets, community wellness resource lists, links to disease management services, and concise and accessible benefits explanations.

V. IDENTIFY POTENTIAL UNINTENDED CONSEQUENCES

Explicitly **identify any potential "side effects" of the proposed cost-sharing variation**, including its effect on rates overall. This pre-assessment should:

- Explain whether the reduced cost-sharing is expected to "pay for itself" by lowering costs elsewhere (and over what time frame), or if the cost of greater coverage will need to be made up by higher patient cost-sharing elsewhere.[17]
- Describe whether any **costs saved from the variations are reflected in reduced premiums** to the consumer.
- Describe the support the insurer will provide to **help enrollees overcome non-financial barriers to improved adherence**. It should identify how it will provide enhanced access to services for consumers and provide copies of written communications it will give enrollees and providers. For example, such support could include alternatives to face-to-face visits, office hours after work time, e-mail and web access to providers, and options for 24/7 practice.
- Even if the VBID variation has been demonstrated to work well on average, the insurer must **identify any specific sub-populations that might be worse off as a result of the VBID change** or unable to take advantage of lower cost-sharing for some reason.
- Identify a **multi-disciplinary team responsible for assessing the initiative**, including clinicians and social workers or case workers. Tools should be incorporated into the evaluation to ensure "real-time" tracking and assessment of the impact of the effort.

VI. DOCUMENT THE IMPACT AFTER THE VBID INTERVENTION AND TAKE APPROPRIATE CORRECTIVE ACTION, IF NEEDED

Covered California, working with the relevant state regulators and the Department of Health Care Services, should **conduct an ongoing, independent assessment of the impact on enrollees** regarding access to care, utilization rates, experience

[17] Though rewards and cost reduction incentives may seem indisputably positive, a financial incentive to some enrollees will mean a "penalty" for all others whose medical condition or circumstances hinder them from using the service or medication on which the reward or incentive is based. For example, reduced cost-sharing for one medication may be made up by higher cost-sharing for the less preferred medication, resulting in surcharges to those patients who need the alternate medication (e.g. one that is less efficacious for most patients). The evidence suggests that few interventions are a net savings, vaccines being an exception. Lieu, T, et al., Overcoming Economic Barriers to the Optimal Use of Vaccines, *Health Affairs*, Vol. 24, No.3, pages 666– 679 (2005), citing Miller, MA and Hinman, AR, Cost-Benefit and Cost-Effectiveness Analysis of Vaccine Policy, in *Vaccines*, 3d ed., ed. S.A. Plotkin and W.A. Orenstein, pages 1074-1088 (Philadelphia: W.B. Saunders, 1999).

accessing services, financial impact, and impact on the marketplace. This assessment must:

- Identify explicit metrics to **measure health outcomes** and assess whether they are a loose or close proxy for the desired behaviors (compliance, morbidity, cessation of a behavior or activity, rates of incidence – increase or decrease, patient satisfaction, etc.).
- Review and **report on patient impact**, such as access to care, financial implications, and satisfaction. These should be measured overall for the affected patient population, and also for vulnerable sub-populations. An independent expert should report to plan members on increased or decreased costs associated with the benefit design. If costs are decreased or increased, the expert should indicate what financial elements have been affected and who has received any savings or paid more.
- Provide **baseline benchmark data**, including a comparison group so results can be tracked contemporaneously.
- Require Covered California to **report all findings publicly**, including on its website.
- If, over time, robust evidence shows the VBID plan is beneficial, Covered California should **consider requiring *all* plans to address these benefits in subsequent offerings**.
- Closely and frequently **monitor the VBID for selection effects**, working with partner state agencies—the Department of Health Care Services, Department of Managed Health Care, and Department of Insurance— and track closely for adverse selection within sub-populations, among QHPs, and between Covered California and the outside market. In addition, determine whether any such adverse risk selection effects can be and are being addressed by the market's risk adjustment mechanisms.[18] If not, Covered California and the appropriate regulator should remediate the risk selection effects immediately, or through the QHP recertification process.

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[18] Weiner, J.P., et al., Adjusting for Risk Selection in State Health Insurance Exchanges will be Critically Important and Feasible, But Not Easy, *Health Affairs*, Volume 31, No. 2. pp 306–315 (2012).

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