REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-13

Subject: Value-Based Insurance Design

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Referred to: Reference Committee G
(Martin D. Trichtinger, MD, Chair)

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-185.984, which asks that the AMA study value-based insurance design as a modality for enhancing patient care and reducing health care costs. Consistent with the AMA's strategic focus on improving health outcomes and shaping delivery and payment models, the following report describes the concept of value-based insurance design (VBID), summarizes evidence related to the effect of VBID on patient outcomes and health care costs, and proposes a set of principles to guide the implementation of VBID initiatives.

BACKGROUND

Traditional health insurance benefit designs use patient cost-sharing primarily as a way to control health care costs. Insurers can reduce their costs directly by increasing the amount enrollees are required to pay out-of-pocket for each covered service, thus shifting costs from the plan to the covered individuals. Indirectly, cost-sharing arrangements have the potential to lower utilization overall by giving patients "skin in the game," and creating an incentive for them to avoid the unnecessary or wasteful use of covered services. Evidence shows that increasing cost-sharing reduces utilization of both necessary and unnecessary services. As a consequence, traditional cost-sharing designs risk creating financial barriers to care that could compromise patient health and result in higher health care costs in the long run.[1]

VBID uses cost-sharing as a tool to encourage the use of specific health care services based on their "value," which is defined as the clinical benefit gained for the money spent.[2] The primary goal of VBID is not to lower costs. It is a benefit design strategy that is intended to promote the most efficient and effective use of health care services, and generate better health outcomes for the dollars spent. Unlike traditional benefit designs that apply a standard set of cost-sharing requirements to all services and all patients, VBID determines coverage and cost-sharing rules based on an assessment of the clinical value of individual health care treatments or services. A well-designed VBID benefit promotes patient engagement by giving patients an incentive to be responsible health care consumers, while also providing a structure to guide them toward clinically valuable services.[3]

The VBID concept was introduced in 2001 by a team of faculty from the University of Michigan,[4] including A. Mark Fendrick, MD, who serves as director of the University of Michigan's Center for Value Based Insurance Design. The Center, which was established in 2005, is a leader in VBID research, development and advocacy, and its faculty and consultants continue to be actively engaged in shaping and promoting the VBID concept. The Center's comprehensive website,

www.vbidcenter.org, is an excellent resource for historical and current information related to the evolution, implementation, and evaluation of the VBID framework.

Effective VBID implementation depends on the availability of high quality, evidence-based data that demonstrates the impact of clinical services and treatments on patient outcomes. Accordingly, VBID commonly targets medical conditions and treatments with well-established clinical evidence, particularly chronic conditions that can be successfully managed, such as hypertension, asthma, or diabetes.[5] Early plans featuring VBID typically reduced cost-sharing to encourage patients to comply with recommended medication or treatment regimens that can help stabilize chronic conditions and minimize the need for costly medical interventions. Over the past decade, the VBID concept has expanded to include incentives for other types of evidence-based services or wellness activities. For example, the Patient Protection and Affordable Care Act of 2010 invokes the VBID concept in its requirement that health insurance plans cover preventive services rated A or B by the US Preventive Services Task Force with no cost-sharing requirements. Some health plans are also using VBID to drive patient participation in health or disease management programs.

Although VBID has traditionally focused on positive incentives, new models are being considered that employ disincentives to discourage the use of inefficient or unnecessary services. Until recently, efforts to identify "low-value" services have been limited, and a lack of clinical evidence has made it difficult for physicians and patients to incorporate the concept of value when there are alternative treatments from which to choose. However, increasing support for comparative effectiveness research, particularly through the work of the Patient-Centered Outcomes Research Institute (PCORI), will likely result in a growing body of clinical evidence that can help inform decisions about the relative effectiveness and value of specific medical treatments.

In theory, VBID principles could also be applied to encourage patients to seek care from more efficient providers or sites of service. Increasing numbers of health plans are introducing tiered network structures that use reduced cost-sharing or other incentives to encourage patients to use certain providers. AMA policy strongly opposes the use of tiered physician networks that attempt to steer patients toward certain physicians primarily based on cost of care factors (Policies H-450.941 and D-285.972), and the AMA has been working to ensure that third party payers disclose the criteria by which carriers create tiered or restricted networks. As with all forms of VBID, incentives that are intended to shape care delivery decisions must be based on evidence related to quality of care and patient outcomes.

VBID EVIDENCE

Available evidence suggests that VBID is an effective way to improve the value of health care (i.e., improving patient care for the same or lower cost), although formal research into the effects of VBID on patient outcomes and health care costs is limited. Also, because VBID is a relatively new concept, research to date is limited to short-term effects, or is based on predictive modeling, and little is known about whether VBID is effective in producing longer term benefits (e.g., lifetime management of chronic conditions, or a reduction in the need for costly medical interventions).

In November 2012, the University of Michigan's VBID Center developed an issue brief that summarized current, peer-reviewed research related to VBID implementation.[6] The issue brief highlighted eight studies, two of which examined VBID designs that incorporated both incentives and disincentives. The research suggests that incentive-based VBID programs (i.e., those that lower cost-sharing to encourage the use of high-value services) can improve quality of care and reduce the use of more expensive acute care services without a significant net increase in health care costs. Data on programs that impose higher cost-sharing for low value services suggests a potential to

reduce wasteful spending, which could contribute to lower cost growth. The following programs were included in the Center's summary:

Pitney Bowes

Pitney Bowes, a Fortune 500 company specializing in communication technology, implemented a VBID program for its 36,000 employees in 2001, and realized significant savings from reduced complications after lowering copayments for treatments for asthma and diabetes.[7] In 2007, the company eliminated copayments for statins for patients with diabetes or a history of vascular disease, and reduced copayments for all patients prescribed clopidogrel. A 2012 study published in the *Journal of the American College of Cardiology* reported that the reduced copayments for these cardiovascular medications resulted in an increase in adherence of 5.9 – 7.1 percentage points, and reduced rates of physician visits, hospitalizations, and emergency department admissions. The results did not indicate significant reductions in major coronary events, likely because of the limited time period evaluated by the study. In the first year of reduced copayments, there was no net increase in total spending; insurer prescription drug spending increased, but patient out-of-pocket spending decreased.[8]

Novartis US Pharmaceuticals

Novartis is a global pharmaceutical company with 13,000 US employees. In January 2005, the company reduced cost-sharing for drugs used to treat asthma, hypertension and diabetes. A 2009 study published in the *American Journal of Pharmacy Benefits* evaluated the changes in resource utilization, health plan costs, and adherence over a three year period following implementation of the new benefit design. Results over the three year period showed a 4 – 9 percentage point increase in medication adherence, and net decreases in disease specific expenditures for the targeted diabetes patients (37%) and targeted asthma patients (2%). In both cases increased prescription drug costs were offset by decreases in other medical services related to these diseases. There was a net increase in disease-specific expenditures for hypertension (9%), as the increased medication costs were not completely offset by decreases in office visits or other related expenditures. The authors note that complications associated with hypertension generally manifest in the long term, so cost savings are less likely to be evident for that cohort.[9]

Oregon Public Employee Benefit Boards

The Oregon Public Employees' Benefit Board and the Educators Benefit Board design and purchase benefits for approximately 235,000 state and university employees and employees of Oregon's public education system. The Boards first incorporated VBID into their plan designs by eliminating cost-sharing for seventeen preventive services, offering full coverage for tobacco and weight management programs, and covering generic drugs for chronic conditions for little or no cost-sharing. In 2010, the Boards decided to adopt a tiered benefit design, which would include increasing cost-sharing amounts for low-value medical services. Under the Boards' design, Tier 1 includes high-value services that have little or no cost sharing (e.g., insulin and diabetic supplies); Tier 2 includes benefits with "standard" cost-sharing requirements (i.e., services that are not explicitly encouraged or discouraged); and Tier 3 includes a separate deductible, higher cost-sharing, and higher out-of-pocket maximums for certain services that may be overused compared with their risks and benefits (e.g., advanced imaging services).[10] Oregon has not published results of its VBID implementation, but shared several positive outcomes with researchers at the University of Michigan's VBID Center. Specifically, the Boards reported a reduction in obesity rates of 4 – 5 percentage points, a reduction in tobacco use of 6.6 percentage points, and 15 – 30

percentage point decreases in select low-value procedures and services.[11] The Boards did not report on costs associated with the program.

AMA POLICY

The VBID concept is consistent with the AMA's commitment to achieving better value for health care spending. Policy H-460.909 defines value as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Policy H-450.938 encourages physicians to work with their patients to make value-based decisions, and to consider the best available evidence at the point of decision-making.

One of the AMA's core strategies to address rising health care costs is to promote value-based decision making at all levels, and the AMA specifically encourages third-party payers to use targeted benefit design. In particular, Policy H-155.960 encourages targeted benefit designs in which patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Policy D-330.928 encourages the Centers for Medicare and Medicaid Services to explore the use of value-based, targeted benefit designs in the Medicare program.

DISCUSSION

The VBID concept is becoming increasingly relevant as policymakers and others call for reforms that increase the efficiency of the health care system. The imperative to align clinical and financial incentives is a primary driver of delivery and payment reforms that seek to move the health care system away from a primarily fee-for-service system to one in which physicians and other providers are paid for the quality of care delivered. To date, however, little attention has been given to aligning incentives for patients. VBID can help promote alignment of financial and clinical incentives across all segments of the health care system, for all stakeholders.[12]

By emphasizing clinical value over cost, VBID provides a mechanism to steer patients toward effective care, and away from wasteful or ineffective care. Health insurance plans that incorporate VBID elements have the potential to promote patient engagement and responsibility, while simultaneously preserving, or even expanding, patient access to necessary health care services. Even modest differences in cost-sharing under a VBID plan may raise patient awareness about the relative costs and benefits of certain medical procedures, and could stimulate and encourage discussion about how to best use health care resources.

The lack of conclusive evidence about the effects of VBID on patient outcomes and health care costs can be attributed to the fact that VBID as a concept is relatively new. Pitney Bowes, an early adopter of the concept, continues to experiment with VBID elements in its health benefit plan, and consistently reports positive results with respect to both employee health outcomes and plan costs. Other companies that have experimented with the VBID concept report similar results, and appear to embrace VBID as an economically viable and socially responsible approach to managing the health of their insured populations.

Advocates of the VBID concept emphasize the need for flexibility in designing and implementing programs. From a clinical and a financial perspective, VBID's impact depends heavily on implementation details. For example, highly targeted plan designs (e.g., cost-sharing modifications are made for specific individuals with specific conditions) are more difficult for insurers to administer, and require extremely robust data collection and tracking capabilities, but have the

advantage of targeting enrollees who could most benefit from the service. Less targeted plan designs (e.g., no cost-sharing for any preventive service) have fewer administrative requirements, but limit opportunities for specific interventions that could yield demonstrable long-term health benefits. Similarly, the mix of incentives and disincentives included in the plan design is likely to have a significant impact on the relationship between VBID implementation and net health care costs. Plans should be able to design programs consistent with their organizational capabilities and the needs of their insured populations.

As noted, Policy H-155.960 supports the use of incentive-based VBID models, specifically those related to chronic medical conditions. The Council believes that the AMA should also support VBID models that incorporate disincentives to reduce the use of unnecessary or low-value services. All VBID designs should be guided by rigorous, evidence-based data to support a determination of high- or low-clinical value, and the Council is hopeful that through the efforts of PCORI, more data will become available to help guide determinations regarding what services offer the most clinical value. The Council notes that initiatives, such as the American Board of Internal Medicine Foundation's Choosing Wisely campaign (www.choosingwisely.org) and efforts by the AMA-convened Physician Consortium for Performance Improvement to define appropriate use/overuse measures, are already providing resources and opportunities for the medical profession to examine clinical evidence and reach consensus on commonly used tests or procedures whose necessity should be discussed.

Practicing physicians should be actively involved in the development of VBID programs, to ensure plan designs reflect the best clinical evidence, and do not limit patient access to necessary care. The Council is aware that VBID plans represent a more nuanced and complicated benefit structure than most physicians and patients are used to. It is critical that plans that use VBID are transparent about the processes they use to identify high- or low-value treatments, and how those determinations affect coverage and cost-sharing policies. Educational materials should be made available to help physicians and patients understand the incentives and disincentives built into the plan design.

Although VBID can help guide patients to clinically effective care, physicians must be able to exercise their clinical judgment in determining the appropriate care for individual patients. VBID designs should not restrict patient access to necessary care. Plan designs that include disincentives for services designated as low-value must include an appeals process that would enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

Despite the lack of definitive evidence that VBID will consistently result in better health outcomes, lower health care costs, or both, the Council believes that it is important to encourage innovative benefit designs that are consistent with system-wide efforts to improve patient outcomes and population health, and reduce health care costs. The Council will continue to monitor developments in the field of VBID with respect to its impact on patient outcomes and health care costs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-155.960 by addition and deletion as follows:

H-155.960 Strategies to Address Rising Health Care Costs
Our AMA…(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment ~~reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs~~. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance… (Modify Current HOD Policy)

2. That our AMA support flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

    a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

    b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

    c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.

    d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

    e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.

    f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.

    g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

    h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

    i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling

and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (New HOD Policy)

3. That Policy D-185.984 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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[3] Ibid.

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