Value-Based Insurance Design (V-BID) Policies in State Health Insurance Exchanges

One of the most important tasks before states policymakers today is to build health insurance exchanges that will inform consumers, incentivize healthy behavior, and help balance plan comprehensiveness and affordability. V-BID is one concept that brings all of these goals together. The goal of V-BID is to structure health plan design elements to optimize patient health through increased utilization of evidence-based health care services. In particular, V-BID lowers financial barriers to high-value services and provides disincentives for low-value care. Restructuring health insurance plans to provide patient incentives for evidence-based care can help refocus the health care system on quality outcomes rather than volume, especially if the provider payment system is restructured along similar lines.

As attention turns from the logistics of exchange building to issues of quality and cost, it is important to note that V-BID can add value to exchanges in several ways. First, V-BID encourages smarter healthcare spending in order to provide comprehensive health benefits at lower cost. Second, V-BID promotes access to needed services and higher quality care. Finally, V-BID increases an exchange's capacity to integrate new clinical evidence and standards by providing appropriate incentives.

The IOM Essential Benefits Report on V-BID

In its October 2011 report on the Essential Health Benefits (EHB) package, the Institute of Medicine (IOM) discussed the need to build increased value into health plans offered in the health exchanges, and specifically highlighted the role of V-BID in making that change. The report strongly endorsed the premise, central to V-BID, that clinical nuance should be a significant determinant of the benefits offered in the Health Exchanges, saying, "The committee believes that the EHB package should become more fully evidence-based, specific, and value-based over time."[i] The Committee noted, "Benefit design and its subsequent *administration* can be instrumental in addressing the cost and quality of services and care delivered. Insurers and employers are experimenting with an array of medical management and cost-sharing designs (e.g., value-based insurance design)."[ii] Remarking that benefit design choices could be a positive influence for good clinical care practices, the report also stated, "The committee supports an evidence-based and value-based approach to coverage of health services as desirable to maximize the health gains of such services as well as provide patients with the best choice of safe and effective treatments."[iii]

Principles for applying V-BID in exchanges

States can maximize opportunities for plans to innovate using V-BID to encourage better health and smarter spending using these principles:

- ***Avoid over-prescriptive cost-sharing rules.*** V-BID works by varying cost-sharing based on clinical evidence with regard to a specific clinical service (e.g., mammography), and often directed to a specific patient population (e.g., eye examinations for individuals with diabetes). Therefore, while the desire to set standardized benefits is understandable, setting uniform requirements for co-pays and deductibles can have the unintended effect of prohibiting value-based principles. The potential result of strict cost-sharing requirements without clinical nuance would be underuse of high-value services and overuse of low-value services. Additionally, once set, such rules would be difficult to change, making the timely adoption of best practices based on new clinical evidence less likely. Rather, a rule more protective of patients, such as one recommending that copays be related to clinical value, will allow necessary flexibility and better protect patients from high out of pocket costs for essential medical services.

- ***Maintain flexibility and limit mandates in benefit designs.*** Value-based benefits generally raise the actuarial value of a plan, even though they may reduce health spending in the long run. This is due to the lower up-front cost, which leads to increased use of high-value services. This result—increased short term expenditures and lower long-term aggregate costs—is similar to the actuarial projections for Section 2713 of the Affordable Care Act (ACA), which mandates no patient cost-sharing for high value preventive services such as immunizations, wellness visits, and cancer screenings. Under the ACA, plans in each tier—platinum, gold, silver and bronze—have corresponding limits in actuarial value. Consequently, states should take care when mandating specific benefits and services for plans. Too many prescribed benefits will exclude value-based designs, especially for the bronze and silver plans, which will be sold to the very populations who have the potential to benefit from V-BID the most.[iv]

- ***Quality ratings for health plans should incorporate value-based principles.*** Value-based insurance design improves quality because it encourages patients to seek high-value care, improving health outcomes per dollar spent. The new quality rating tools available in Exchanges should provide consumers with the information needed to allow them to choose plans that include clinically nuanced incentives for high value care. Where appropriate, preference can be given to plans that incorporate value-based designs.

Policy Models

Many states have researched the possible role of V-BID as part of their exchange planning process. For example, the Maryland health benefits exchange bill, passed in 2011, included a mandate for the exchange's Board of Trustees to examine, "the feasibility and desirability of

the Exchange engaging in...value-based insurance design..." An independent report found that Maryland and other states could use of range of policy options to implement V-BID in exchanges, from creating cost-sharing guidelines for high and low-value services (the Oregon model) to encouraging insurers to design their own value-based plans, to incentivizing plans to offer V-BID models through the request for proposal process.[v]

In a July, 2012 draft report on the use of quality-enhancing polices in the California Health Benefits Exchange prepared by Exchange's staff, V-BID was sighted as one of several "strategies to promote quality and better care." The report noted that the exchange could pursue several different policies: "Use value-based benefit design strategies that reduce or waive copayments to improve adherence to chronic care management; Implement wellness and health promotion programs that reward risk reduction; [and] Use incentives and information to promote effective outreach and engagement in self- care and management."[vi] After considering trade-offs among the choice to standardize benefits and cost-sharing (which can facilitate plan comparisons for consumers) or leave those choices open to insurers in order to drive V-BID innovations, the report also recommended that the California Exchange allow innovation in benefit designs that provide rewards for high-value care.

---

[i] Institute of Medicine. Essential Health Benefits: Balancing Coverage and Costs. National Academies of Sciences, 2011: 23.
[ii] Ibid, 59.
[iii] Ibid, 92.
[iv] Chernew ME, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, and Fendrick AM. Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care. J Gen Intern Med 2008 23(8):1131–6
[v] Buttorff C, Tunis S, Weiner J. Improving Value and Investing in Prevention: Encouraging Value-Based Insurance Designs in State Health Benefit Exchnages. Maryland Citizens Health Initiative, November 2011.
[vi] California Health Benefits Exchange. Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability. Discussion Draft—Options and Recommendations. July 2012, p. 153.