

## Value-Based Insurance Design

While traditional health insurance plans generally use patient cost-sharing primarily to control costs, Value-Based Insurance Design (VBID) plans use cost-sharing as a tool to align patient and payer financial incentives around the value of specific health care items and services. Value can be defined as the clinical benefit gained for the money spent, and VBID creates incentives to encourage patients to pursue high-value care and discourage the use of low-value care.

VBID determines coverage and cost-sharing rules (such as co-payments, coinsurance, and deductibles) based on an assessment of the clinical value of individual health care items or services. Specifically, VBID plans are designed in accordance with the tenets of “clinical nuance,” recognizing that medical services may differ in the amount of health produced, and that the clinical benefit derived from a service depends on the person receiving it, as well as when, where, and by whom the service is provided.

### Aligning Incentives to Promote Care

While both payment reform and benefit design may theoretically be working toward the same goal of promoting quality health care, unless those supply side and demand side incentives are intentionally aligned, it can be excessively and unfairly challenging for patients, providers, and payers to achieve their shared goal of quality.

For example, a quality metric for physicians may be the extent to which their patients' blood glucose is within an acceptable range. To help their patients manage uncontrolled blood glucose, physicians may want to refer their patients to a diabetes prevention program (DPP). However, if patients' insurance benefits impose significant cost-sharing for DPP enrollment, patients may not have the financial

means to follow through with their physicians' advice.

Due to these misaligned incentives, the system may face: (a) physicians who cannot meet their quality metrics due to patient non-compliance; (b) patients who forgo high-value care due to financial barriers and subsequently become sicker; (c) employers that lose productivity due to employee illness; and (d) payers that ultimately pay more money to care for sicker patients. Clearly, no one benefits from this approach.

Instead, a health plan incorporating VBID could choose to reduce or eliminate patient cost-sharing for DPPs, reducing the chance that financial barriers will prevent patients from following their physicians' recommendations. Similarly, plans applying VBID to ease the burden of diabetes could choose to reduce patient cost-sharing for evidence-based items and services, such as insulin therapy and vision and foot exams. In this way, VBID plans would align patient, physician, and payer incentives to promote high-value care.

### VBID In Action

Hundreds of private and public payers are implementing VBID programs, including:

- Medicare Advantage (MA): Legislation and regulations have required expansion of the MA VBID model to all 50 states by January 1, 2020 and provided greater flexibility around the MA uniformity requirement to allow for the implementation of VBID principles throughout the MA program.
- TRICARE: Recent legislation commissioned a pilot program to test the feasibility of incorporating VBID into the TRICARE program and further incorporate VBID principles into the TRICARE Pharmacy Benefits Program.

- Connecticut implemented a collectively bargained state-based VBID program for its state employees that applies VBID to prescription drugs and to reduce cost-sharing across the spectrum of care.

## Longstanding AMA Support of VBID

The AMA has long recognized VBID's potential to help contain rising health care costs, and AMA policy supports the use of VBID to promote affordable access to high-value care and reduce utilization of low-value care, across the care continuum. AMA policy supports:

- Flexibility in the design and implementation of VBID programs and provides principles to guide VBID implementation, including:
  - Involving practicing physicians (including relevant specialists) in the development of VBID programs,
  - Using evidence-based data to support targeted benefit design (in developing incentives and disincentives), and
  - Emphasizing the importance of transparency and unrestricted patient choice in care.
- Third-party payers using targeted benefit design. Targeted benefit design can incorporate patient cost-sharing based on clinical value, with consideration given to patient income and other factors known to impact compliance.
- VBID plans designed with clinical nuance and processes to appeal low-value care designations.
- Initiatives that align provider-facing financial incentives (through payment reform) and patient-facing financial incentives (through benefit design reform), to ensure that patient, provider, and payer incentives all promote the same quality care.
- National medical specialty societies identifying high-value services and collaborating with payers to design incentives to encourage use of high-value services.

- Continued implementation of innovative VBID programs in MA plans.
- Legislative and regulatory flexibility to accommodate VBID that allows innovations that expand access to affordable care.

### **Additional Resources:**

- [Value-Based Insurance Design](#)
- [Value of Preventive Services](#)
- [Aligning Clinical and Financial Incentives for High-Value Care](#)