

Insurance Benefit Design

Background Information Prepared for the Health Care Transformation Task Force by Minnesota Department of Health Staff December 3, 2007

The Transformation Task Force has asked for information about insurance benefit designs that encourage more effective use of health care services. This background paper provides information on two approaches to this issue. The first approach, “value based insurance design,” typically involves lower copayments for drugs and services that are considered to be highly effective. The second approach excludes coverage for services that are considered to be ineffective or of low value compared to other services.

Value-Based Insurance Design

The concept of value-based insurance design is based on the idea that enrollee cost sharing is a relatively blunt tool for controlling health care costs. Research evidence from the 1970s RAND Health Insurance Experiment indicates that higher enrollee cost sharing reduces overall use of services and health care spending, but that people tend to cut back on the use of effective services as well as ineffective ones. Although the RAND study showed that higher cost sharing reduced overall health care spending without significant adverse effects on health for the average person, the study raised concerns about the impact of cost sharing on people with low incomes and in poor health.¹

The goal of value-based insurance design is to remove financial disincentives to the use of services that are clinically valuable (i.e. services whose net clinical benefits exceed their cost) while retaining the features of enrollee cost sharing that deter unnecessary use of services. This is usually achieved by selectively reducing cost sharing for particular services. In some cases, the reduced cost sharing is specifically targeted to patients who will benefit most from the service. Most of the evidence that is available to date on value-based insurance design relates to cost sharing for prescription drugs.

In recent years, several large employers have experimented with value-based design of prescription drug benefits for chronic disease patients. Early research evidence suggests that redesigning benefits in this way may improve health outcomes and cut costs.² Specific examples include the following:

¹ Joseph P. Newhouse, *Free For All? Lessons from the RAND Health Insurance Experiment*, Harvard University Press, 1993.

² M Fendrick and M Chernew, “Value-Based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment,” *American Journal of Managed Care*, December 2006.

- In 2001, Pitney Bowes³ reduced coinsurance for diabetes and asthma maintenance drugs to 10% (compared to 30% and 50% coinsurance in higher tiers). Although the company spent more on these drugs, median total costs for diabetes and asthma patients dropped by 12% and 15% respectively between 2001 and 2003. The cost savings came from reduced use of rescue medications and fewer hospitalizations, office visits, and emergency room visits.
- In 2005, Marriott International reduced copayments for medications designed to better manage chronic conditions.⁴ Copayments were eliminated entirely for generic drugs to treat heart disease, diabetes, and asthma. Although evaluation of this initiative is still ongoing, early results indicate that compared to a control group, patients with reduced cost sharing had significantly better drug adherence. Marriott's overall health care costs did not increase.

There are several potential barriers to more widespread use of value-based insurance design. For example, most of the programs involve increased short-term costs to sponsors (because they are subsidizing lower copayments, and because of increased utilization of the targeted services). Employers may be concerned about their ability to "capture" the savings, due to employee turnover; this is a particular concern if the savings to offset initial costs will take a long time to materialize.

In addition, value-based insurance design is potentially more cost-effective when it is specifically targeted to groups of patients who will benefit most from reduced cost sharing. However, identifying these patients requires sophisticated data collection and analysis that can be administratively burdensome.⁵ This approach is more straightforward for conditions that are easily identified using claims data, such as diabetes. Targeting patients with risk factors such as smoking and obesity is more difficult because this information is not reliably included in claims data. Expanded use of interoperable health information technology could facilitate this process.

Finally, value-based insurance design requires significant research in order to differentiate between high and low value services. For many conditions, this information is simply not available.⁶ However, expanded use of value-based design would probably stimulate more comparative effectiveness research.

The use of value-based insurance design has the potential to complement other policies that the Transformation Task Force is considering. For example, it can be used as a means of creating patient financial incentives for behaviors (such as medication adherence) that will improve health and reduce overall health care spending. It could also

³ Vanessa Fuhrmans, "A Radical Prescription: While Most Companies Look to Slash Health Costs by Shifting More Expenses to Employees, Pitney Bowes Took a Different Tack; The Results Were Surprising," *The Wall Street Journal*, May 10, 2004.

⁴ Chris Silva, "Marriott Finds Early Success with Value-Driven Health," *Employee Benefit News*, November 10, 2007.

⁵ Fendrick et. al

⁶ Fendrick et. al

be used as a strategy for achieving the Task Force's goals of reducing overweight and obesity, smoking, and other health promotion goals.

Exclusion of Coverage for Less Effective Services

Some payers are attempting to encourage more effective service use by eliminating coverage for services that are deemed to be unnecessary or less effective. The Oregon Health Plan is the most commonly cited example of this approach. In 1989, Oregon sought to expand Medicaid coverage to more people by limiting its benefit package (and therefore reducing the cost per person).⁷ The Oregon Health Plan's Prioritized List of Health Services ranks condition/treatment pairs based on their clinical and cost effectiveness. Services ranked above a specific cutoff point on the list are covered by Medicaid, and services below the cutoff are not.

Originally, Oregon law called for the list (and the cutoff point) to be reevaluated every two years based on available funding. Ultimately, the Center for Medicaid and Medicare Services (CMS) did not allow Oregon to exclude services for its mandatory Medicaid population beyond those excluded based on the original list.⁸ However, Oregon's actuaries estimate that the program is approximately 10% less expensive per member per month as a result of the list.⁹ Additionally, the list has evolved over time in response to changing evidence and public priorities. For example, cochlear implants were moved up on the list and certain guidelines have been added for over-utilized procedures such as back surgery.

In 2006, Oregon revised its ranking methodology to place greater emphasis on preventive services and chronic disease management. The table on page 4 describes the ranking of categories of care on the prioritized list. Within each category of care, priority rankings are established based on the following factors:

- Impact on health life years;
- Impact on suffering;
- Population effects;
- Vulnerability of population affected;
- Tertiary prevention;
- Effectiveness;
- Need for medical services; and
- Net cost

In addition to its prioritized list of services, Oregon has also implemented a ranking system to control pharmaceutical costs in its Medicaid fee-for-service program. In 2001, Oregon began developing an evidence-based process to identify "best in class" drugs in

⁷ "Prioritization of Health Services: A Report to the Governor and the 74th Oregon Legislative Assembly," Oregon Health Services Commission, Office for Oregon Health Policy and Research, 2007

⁸ Oregon did implement a more limited benefit set, called OHP Standard, for its optional Medicaid populations in 2004.

⁹ Office for Oregon Health Policy and Research, 2007

four pharmaceutical classes. Initially, providers were required to prescribe the best in class drugs unless an exception was medically necessary. Researchers have estimated that this policy resulted in immediate prescription drug savings of 9.1% per member per month when it was implemented in 2002. A “soft prior authorization” policy implemented in 2003 was associated with an additional 17.7% savings.¹⁰ Although the number of drug classes has expanded over time, in October 2003 the Oregon Legislature prohibited active enforcement of the best in class drug policy, effectively making compliance voluntary (and resulting in a 5.5% cost increase).

Oregon Prioritized List: Rank Order of Health Care Categories	
1.	Maternity and newborn care: Obstetrical care for pregnancy. Includes prenatal care, delivery services, postpartum care, newborn care
2.	Primary prevention and secondary prevention: Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage.
3.	Chronic disease management: Treatment aimed at prevention exacerbation of an established disease or secondary illness.
4.	Reproductive services (excluding maternity and infertility services)
5.	Comfort care: Palliative care for patients with terminal conditions.
6.	Fatal conditions, where treatment is aimed at disease modification or cure
7.	Nonfatal conditions, where treatment is aimed at disease modification or cure
8.	Self-limiting conditions: Treatment that expedites recovery for conditions that will resolve on their own whether treated or not.
9.	Inconsequential care: Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment.

¹⁰ Daniel M. Hartung et al., “An Evaluation of Oregon’s Evidence-Based Practitioner-Managed Prescription Drug Plan,” *Health Affairs*, September/October 2006.