The primary goal of value-based insurance design is to encourage consumers to get the right care in the right setting at the right time from the best providers.

Value-based insurance design has the potential to improve patients’ health and lower health care costs. But it must be driven by high-quality clinical evidence and consumer-friendly principles to ensure that patients can get the care they need.

This brief explains value-based insurance design and high-value care, and it outlines the key elements that value-based insurance should include.

**What is high-value health care?**

High-value health care consists of:

- Services and treatments that have been clinically proven to work and that provide patients with a high level of health benefits relative to their cost. Common high-value health care services include drugs that have been proven effective for managing chronic conditions, such as asthma inhalers for asthma and insulin for diabetes.

- Care that is delivered by high-value health care providers. These are providers who consistently follow current clinical guidelines and who are recognized for providing care that is evidence-based, patient-centered, high-quality, and efficient.

High-value care is not necessarily the least expensive care. A more expensive treatment or provider may be of higher value than an alternative if it delivers a greater health benefit or, in the case of a provider, higher-quality care.

The highest-value care consists of services or treatments with high clinical value that are delivered by high-quality providers. But value-based insurance programs can choose to focus on only one of these factors to define what types of high-value care they give consumers incentives to use.

**What is value-based insurance design?**

Value-based insurance design aims to help consumers understand which services or providers offer the best care at the best prices, and it offers financial incentives to consumers to seek high-value care. It can do this by changing the amount of cost-sharing patients pay in one or both of these ways:

- Eliminating or reducing cost-sharing for high-value services or for care from high-value providers. This reduces the financial barriers patients can face when they seek out evidence-based care, making it easier for them to get the right care at the right time.

- Charging patients more for services that are proven to be either ineffective or no more effective than less expensive alternatives, or increasing cost-sharing for care from providers who do not perform well against recognized quality measures. These higher out-of-pocket costs can steer consumers away from less effective services and providers.

Value-based insurance design uses financial incentives to encourage consumers to get treatments that have been proven effective, which can reduce health care costs and improve health outcomes.

Health insurance providers (including employers, state Medicaid programs, and private insurers) must use high-quality clinical evidence and consumer-friendly principles to ensure that patients can get the care they need.
Some health plans use value-based insurance design for all enrollees. Other value-based insurance programs focus on specific groups, such as people with chronic conditions like asthma, diabetes, or heart disease.

A growing body of research supports the effectiveness of value-based insurance design. For example, researchers conducted a study of a program that reduced cost-sharing for drugs and services that were recommended for managing diabetes. The study found that the patients in the program were more likely to take prescribed medications, experienced improved health outcomes, and decreased their risk of hospitalization, all while costs were lowered for patients and the insurance provider.¹

**Key Principles of Consumer-Friendly, Value-Based Insurance Design Programs**

**Relies on High-Quality Clinical Evidence and Evidence-Based Measures of Clinical Effectiveness and Provider Performance**

To determine which services and providers offer the best value, value-based insurance should use high-quality clinical evidence and data on provider performance. Decisions about the value of services or providers should never be based solely on cost.

For example, programs should use peer-reviewed clinical and comparative effectiveness research to decide which services or treatments should have reduced (or increased) cost-sharing. And to determine whether a provider is included in a high-value provider network, programs should assess whether the provider consistently meets or exceeds recognized quality standards.

**Emphasizes Reducing the Cost of High-Value Services**

Reducing or eliminating cost-sharing can make it easier for patients to get the best health care available. Research has identified numerous high-value drugs and services that could be included in a value-based insurance design program. However, programs need to be cautious about charging higher cost-sharing for services that are not as effective, because research to identify these services is more limited.

In many instances, a treatment’s effectiveness depends on the patient population. Programs should increase cost-sharing for a health care service only if a significant body of peer-reviewed research shows that it is harmful, ineffective, or no more effective than a less expensive treatment. In addition, if research has found that a particular treatment is ineffective for only a specific group of patients, insurance providers should not increase cost-sharing for all consumers.

**Offers a Robust Network of High-Value Providers across Care Specialties and across the Geographic Regions They Serve**

Value-based insurance design programs must have an adequate number of providers who:

» are equipped to meet the cultural and linguistic needs of diverse populations

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¹ Key Principles of Consumer-Friendly, Value-Based Insurance Design Programs

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Value-based insurance design programs must have an adequate number of providers who:

» are equipped to meet the cultural and linguistic needs of diverse populations
» are accessible by public transportation
» offer evening or weekend appointments

This is especially important for consumers with lower incomes, who may rely exclusively on public transportation or have restricted availability during typical workday hours.

**Rewards Providers for Delivering Evidence-Based Care**

Providers do not always recommend care that offers the highest value. This could be because they rely on outdated evidence; have a financial incentive to provide a less effective treatment; or are unfamiliar with new, high-value treatment options.

To address this problem, programs need to educate providers about the clinical evidence supporting their insurance design policies and create financial incentives to encourage providers to deliver high-value care. Financial incentives could include bonus payments for consistently following evidence-based clinical guidelines or increased reimbursements for using high-value treatment options.

** Provides Consumers with Resources That Explain How Value-Based Insurance Works and the Tools They Need to Engage in Health Care Decision Making **

Programs should regularly provide consumers with notices that explain which services the program targets, how the program changes cost-sharing, and when reduced (or increased) cost-sharing applies. Programs that reduce cost-sharing for care from high-value providers should also include information about how the plans determine which providers deliver high-quality care and how consumers can find those providers.

In addition, value-based insurance programs may want to provide consumers with “patient decision aids” to help consumers understand the evidence behind different treatment options. These tools should present easy-to-understand, unbiased, transparent information about the relative effectiveness of different treatment options for a particular health condition, including information about what research was used to justify increasing or decreasing cost-sharing for a certain type of care. Consumers should also be able to find out what their cost-sharing would be for different types of care. Patient decision aids can be written, video, or web-based, and they should be made available in multiple languages.²

**Has an Accessible Exceptions and Appeals Process**

While certain treatments may be the best option for most people, there will always be exceptions. Commonly used high-value services may not work for certain patients, while treatments that provide less clinical benefit (on average) may actually be very effective for those patients. There may also be situations where patients cannot find in-network providers who are easily accessible or who meet their needs, such as the need for interpreter services.

Value-based insurance programs need to have simple processes for granting exceptions to ensure that consumers can get reduced cost-sharing for the care that is most effective for them. Programs also need to have
Evaluates the Program Regularly

Value-based insurance design programs should annually evaluate whether or not they effectively encourage consumers to get the best care available. To do this, programs need to measure how they affect the use of high-value services or providers, adherence to prescribed treatments, and health outcomes. Evaluation should never be based solely on whether health care costs go down.

Programs also need to measure patient experiences, including whether the program hinders access to care and whether consumers can use the exceptions process to get fair prices for the care they need.

Programs should pay particular attention to how value-based insurance affects access to care and health outcomes for lower-income consumers, who will be most sensitive to any increases in cost-sharing and who may also have a harder time finding an accessible, high-value provider. Evaluating programs based on all of these measures will help identify how programs can improve their design and exceptions processes to ensure that all patients can get the right care at the right time.

What are wellness and disease management programs?

Wellness programs and disease management programs provide services like health coaching or nutrition counseling that can help patients make and maintain healthy behavior changes. Some programs require participants to attend a certain number of classes, or to complete a minimum number of approved health activities (including getting recommended health care services, like an annual physical and preventive screenings).
Conclusion

Value-based insurance design programs aim to encourage consumers to choose high-value care. To succeed, these programs need to be based on high-quality clinical evidence, protect access to care, and help consumers understand which health care services and providers offer the best care at the best prices. When built in a consumer-friendly way, value-based insurance design can help consumers take a more active role in their health care decisions and makes it easier for consumers to get the right care at the right time in the right setting from the best provider.

Endnotes

