

THE ESSENTIAL ROLE OF EMPLOYERS IN
ALIGNING PLAN DESIGN & PAYMENT
REFORM TO IMPROVE QUALITY,
ENHANCE EQUITY, AND PROMOTE VALUE

VBIDHEALTH

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About V-BID Health:

Value-Based Insurance Design Health specializes in designing and promoting health benefit plans and payment strategies that get more health out of every healthcare dollar spent. VBID Health provides streamlined, value-based insurance design consulting services to facilitate creation and adoption of VBID plans and payment policies that increase patient, employee, and enrollee health. VBID Health facilitates the [Low-Value Care Task Force](#), comprised of public and private employers, business coalitions, consumer advocates, health plans, and life science companies, all focused on accelerating concerted action to reduce low-value medical care and thereby reduce pressure on payers and consumers. For more information, visit vbidhealth.com.



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EXECUTIVE SUMMARY

Employers and their employees bear a large share of health care spending in the US, which includes the cost associated with inefficiencies in the US health care system. For decades, health plans, often at the behest of employers, have used both payment models and benefit design to influence utilization, prices, and spending. However, little attention has been paid to how the supply-side incentives of payment models interact with the demand-side incentives of benefit design. In isolation, each approach has advantages and pitfalls that are potentially exacerbated or diminished by the effects of the other. When provider and consumer incentives are not aligned, well-intentioned initiatives can create conflicts at the point of care.

Further, potential synergies of coordinating provider and consumer incentives go unrealized. In this paper, we discuss how employers can harmonize clinically driven payment reform and evidence-based benefit design to obtain better clinical outcomes, employee satisfaction, enhanced equity, and improved efficiency from their health care spending. We offer concrete recommendations on how employers and policymakers can better align benefit design to support payment reform efforts.

When provider and consumer incentives are not aligned, well-intentioned initiatives can create conflicts at the point of care.

INTRODUCTION

Health care spending in the United States is the highest in the world, yet outcomes lag most other developed countries. (1) Employers and their employees bear a large share of the financial burden. Over the last ten years, the average premium for employer-sponsored family coverage has increased by 55% to over \$21,000. (2)

Because health care providers are a primary determinant of health care utilization, many believe that high spending stems largely from how we pay providers. Fee-for-service payment encourages excess utilization of care. As a result, many purchasers have developed alternative payment models designed to discourage providers from delivering unnecessary care. These models range from those that reward efficiency within a single episode of care (e.g., bundled payment for childbirth) and care delivered to a designated population over an entire year (e.g., global budget). Because these models may inadvertently discourage delivery of high-value services, they are often coupled with rewards or penalties for performance on clinical quality metrics.

While addressing how, and how much, we pay for medical services is central to reducing spending growth, employers have little direct control over payment rates and models. For example, an insurer cannot practically alter payment patterns for a single employer because the providers with whom the insurer contracts serve patients from multiple employers, making it infeasible to individualize contracts for employers with each provider.

Because employers cannot directly control payment, they preferentially focus efforts on benefit design—which they can more easily control—to reduce spending. Specifically, insurers allow employers, to a degree, to customize the deductible, copayments, co-insurance, and out-of-pocket maximum rates in the plans that they offer to their employees and dependents. Increasingly, employers can also opt for tiered or narrow network plans, where the amount employees or dependents pay at the point of service varies by the provider's network status, though uptake of this approach has been low.

Over time, rising medical spending has led employers to reduce plan generosity. Over the last decade, deductibles in employer-sponsored insurance (ESI) increased by over 100% to an average of \$1,644 for single coverage, and the percentage of beneficiaries covered by large employer plans with annual deductibles exceeding \$1,000 increased from 17% to 54%. (2) Higher patient cost-sharing reduces access to both high and low-value care, worsens health care disparities, and imposes greater financial risk on individual patients, disproportionately affecting low-income populations and those with chronic clinical conditions. (3, 4, 5, 6, 7, 8) Moreover, with commercial insurance costs rising, employers are less able to increase wages and provide other benefits. (9)

With about half of the total US population covered by ESI, (10) employers and their employees play a critical role in determining access to care, improving quality, and controlling health care spending. Yet for more than two decades, payment reform strategies to impact provider incentives and benefit design changes to influence patient behavior have not been well coordinated. (11) Although new quality-driven payment models often explicitly encourage use of high-value care and implicitly discourage use of low-value care, current benefit design strategies,

such as deductibles, are a blunt instrument, in that patients are generally required to pay the same amount out-of-pocket for high- and low-value services. This lack of alignment can create conflicts at the point of care and diminishes the likelihood of success of either strategy.

In this paper, we discuss how employers can act to harmonize clinically driven payment reform and evidence-based benefit design, and offer concrete recommendations to obtain improved patient-centered outcomes and achieve higher value for their employees and companies.

For more than two decades, payment reform strategies to impact provider incentives and benefit design changes to influence patient behavior have not been well coordinated.

PAYMENT REFORM & BENEFIT DESIGN HAVE BEEN MISALIGNED

For decades, payers such as insurers and employers have implemented both payment models and benefit design to influence utilization, prices, and spending. However, little attention has been paid to how the incentives of 'provider facing' payment models (i.e., the supply side) interact with the incentives of 'consumer facing' benefit design (i.e., the demand side). If supply-side and demand-side incentives are not well aligned, conflicts may arise between providers and patients at the point of care.

For example, increasingly, payment models reward providers for meeting clinical quality targets or penalize them for failing to do so. Many of the commonly used quality targets are highly influenced by patient behavior (e.g., control of hypertension, or eye examinations for individuals with diabetes). Benefit designs that create barriers to the use of clinically indicated care needed to meet such metrics (e.g., high plan deductibles) might directly contribute to lower performance scores, reduced provider payment, and provider frustration, diminishing provider support for quality-driven payment approaches.

Fortunately, employers can play a key role in aligning payment models and benefit design.

Who controls payment?

Insurance carriers and pharmacy benefit managers, not employers, tend to control the details of payment for medical services. This is true for both fully-insured and self-insured employers. Employers can choose which carriers they use for health plan administration, but rarely can they substantially change the amounts or the methods by which they pay contracted providers. Larger employers, or groups of employers, have somewhat more, albeit still limited, control. (12) They may be able to directly contract with providers for certain care episodes to be delivered at a negotiated price, or work closely with third-party companies that do so. They might also elect to directly contract with health systems for population health that would take accountability for the total cost of care delivered. However, even in these scenarios, employers typically have no direct control over provider prices or payment models (e.g., capitation or risk contracts). But they have more flexibility to select (or incent enrollment in) health plans that include specific desired elements such as provider risk-sharing arrangements and meaningful incentives for steerage to high-value providers.

Who controls benefit design?

Typically, employers have more control over benefit design than payment. Self-insured employers can work with their third-party administrators to define deductibles, cost-sharing, and other benefit terms such as contingent coverage (i.e., services that need administrative authorization). Using these tools, they can steer patients to high-value providers and encourage/discourage the use of specific clinical services (e.g., primary care visits, high-cost imaging). Large employers, or groups of employers, have additional options. For example, they can implement value-based insurance design (V-BID) models that lower cost-sharing for select high-value services (13,14) or issue a request for proposal (RFP) asking for reference pricing with appropriate member protection. (15) They can also work directly with providers to identify centers of excellence and incentivize employees to seek care there. While employers may offer several plans with different design features (e.g., deductible sizes or tiered networks) from which to choose, carriers tend to define the specific details. In many cases, benefit consultants and other vendors assist employers in identifying the features of their health care benefit that best meets their clinical and financial needs.

PAYMENT REFORM ADDRESSES SUPPLY-SIDE INCENTIVES

Providers deliver too little high-value care, too much low-value care, and charge high prices

Fee-for-service (FFS) payment does not distinguish high- from low-value care. There are no guardrails to discourage the use of low-value care, and payment for high-value care, including some care coordination, is often insufficient (or less profitable relative to other services). For example, the diabetes prevention program is a public-private effort to prevent type 2 diabetes through cost-effective evidence-based interventions. (16) It is highly effective and is often covered without cost-sharing by public and private insurers. However, its implementation requires services, such as care coordination, that are frequently unpaid or underpaid. This leads to decreased access to, and use of, this valuable program.

The same is often true for the management of substance use disorders that requires the active engagement of community-based organizations instead of repeated stays in rehabilitation facilities. The former are chronically underfunded, while the latter are often overpriced and ineffective.

Similarly, fee-for-service payment often overcompensates low-value services and can be especially pernicious in encouraging use of services with low resource costs for incremental volume. For instance, imaging and laboratory tests have high fixed costs and low variable costs, so it is not surprising to find rampant overuse of low-value services such as imaging of patients with uncomplicated back injuries and vitamin D testing of low-risk patients in the fee-for-service system.

The recent trend toward consolidation exacerbates the over-utilization issue with high prices. Providers with increased market power demand higher prices without providing commensurately higher quality care. (17) Health care prices across the US are high, rising, and highly variable across markets. While an issue for all services, the problem is especially pronounced for hospital services. (18) Within states, hospital prices for inpatient care commonly vary by more than threefold, and outpatient hospital prices vary even more. (19)

Payment reform can address supply-side problems, but has difficulty addressing misaligned incentives created by benefit designs

Compared to fee-for-service payment, alternative payment models (APMs) that shift financial risk to providers and reward quality can address overuse and underuse. Though often built on a fee-for-service chassis, APMs can incent providers to be more efficient and reward providers for high-value care. (See the glossary in the appendix for more details on specific payment models.)

However, **clinicians enrolled in APMs may have difficulty meeting specific quality targets when their patients are faced with high deductibles and/or other barriers deterring the use of those services.** In such cases—in which patients are financially disincentivized from seeking high-value care—providers sensing a lack of control over patients' use of health care may be unwilling to take on risk. For example, a patient with diabetes may forego routine care management in the form of visits, diagnostic tests, and medications because of a high plan deductible. The patient's provider, who is financially incented to manage the patient's diabetes, may become frustrated by the patient's "lack of compliance", ([20](#)) which may have more to do with the patient's ability to afford the care than their willingness to adhere to provider recommendations.

Conversely, **APMs have difficulty addressing overuse when patient demand contradicts payment incentives.** For example, certain diagnostic imaging services such as CT and MRI scans, while high-value in some circumstances (e.g., to diagnose stroke or symptomatic brain lesions), are low-value for several common clinical conditions (e.g., uncomplicated back injury and headache) for which they may be demanded by patients. The costs of unnecessary care go beyond the price paid for the unneeded service, as their use can lead to costly care cascades. ([21,22](#))

Clinicians enrolled in APMs may have difficulty meeting specific quality targets when their patients are faced with high deductibles and/or other barriers deterring the use of those services.

Some APMs such as global payment contracts can address high prices by encouraging referrals to lower-priced, high-quality providers (when the referring provider is not in the same health care system as the high-priced specialist or hospital). (23) This can lower average prices by both increasing the share of patients receiving treatment at lower-priced providers and forcing providers to accept lower prices lest they lose volume as patients are steered elsewhere. However, the effectiveness of such models is limited by the prevalence of benefit designs that often do not distinguish between high- and low-value providers. Benefit designs that do align patient cost-sharing with provider value, such as tiered provider networks, better align incentives, but the incentives for individuals to use high-value providers must be meaningful enough to compel patients to consider changing their usual source of care.



APMs have difficulty addressing overuse when patient demand contradicts payment incentives.

BENEFIT DESIGN ADDRESSES DEMAND-SIDE INCENTIVES

Patients underutilize high-value care, overutilize low-value care, and are not active health care shoppers

Benefit design strategies that necessitate out-of-pocket payments at the point of care (i.e., deductibles, copayments, and coinsurance) are designed, in part, to discourage overuse by patients. However, since patient out-of-pocket costs are typically set without regard to whether services are high- or low-value, these ‘blunt’ approaches have difficulty addressing overuse of low-value care without inducing underuse of high-value care. High-deductible health plans (HDHPs) are a prime example, reducing health care spending by discouraging access to both low- and high-value care. (4)

Some benefit design strategies (e.g., V-BID) can mitigate the concerns that high cost-sharing discourages use of high-value care by explicitly reducing the cost-sharing on high-value services and increasing cost-sharing on low-value services.

Such clinically driven designs have been implemented by public and private payers, and V-BID programs have been demonstrated to improve use of evidence-based services, reduce health care disparities, and in certain instances reduce overall health care spending. However, implemented V-BID plans have for the most part been designed to encourage the use of high-value services, and only recently explicitly focused on reducing the use of low-value care. A novel benefit design template, referred to as V-BID X, targets low-value care and increases access to high-value services without increasing premiums or deductibles. (24) The potential value of such a design continues to gain notice as the 2021 HHS Notice of Benefit and Payment Parameters final rule strongly recommended that federally qualified health plans incorporate V-BID X. (25)

A novel benefit design template, referred to as V-BID X, targets low-value care and increases access to high-value services without increasing premiums or deductibles.

Patients' decision-making regarding use and site of services is heavily influenced by their clinicians, and patients tend not to shop for care even when price shopping tools are available. (26,27) For example, patients commonly bypass several lower-priced providers between their homes and their treatment locations. (28) Reference pricing, which provides first-dollar coverage for shoppable services up to a fixed provider price, has had some success in encouraging patient shopping for a defined set of shoppable services and providers, although when resisted or not fully understood by users, reference pricing arrangements can leave patients with large unexpected bills. Despite efforts to enhance transparency and better engage consumers, patients continue to frequently obtain care in unnecessarily high-acuity settings.

Exhibit 1. Schematic: Redesign of payment and benefit to encourage increased health care value and affordability

		Payment (Providers)	Benefit Design (Patients)
High-Value Care	Patient-Driven		Charge little or nothing at point of service
	Provider-Driven	Pay fee-for-service with margin	
Low-Value Care	Patient-Driven		Charge substantial and predictable amount out-of-pocket and at point of service
	Provider-Driven	Bundle or capitate if possible. Negative margin in fee-for-service	

ALIGNING BENEFIT DESIGN AND PAYMENT REFORM

In certain circumstances, employers have started blending benefit design and payment reform. For example, large employers have instituted centers of excellence (COE) and are paying those centers a fixed payment for a case while steering patients through benefit design. This payment can include an evaluation of the patient and the potential for redirecting care to a conservative form of management instead of surgery and can incorporate addressing any complications through a warranty. This payment model encourages the use of higher-value care while simultaneously discouraging the use of low-value care. It also offers higher margins to those providers who can deliver care with the lowest total cost and better outcomes such as fewer complications. Those same employers are creating significant benefit design changes to encourage employees to get care from the COEs. For example, some employers have considered back surgeries ineligible for coverage unless done at a COE, and others reduce cost-sharing and provide more generous benefits for those using COEs.

As currently implemented, payment models and benefit designs lack the needed clinical nuance to substantially improve the value of care. *APMs and benefit design strategies can—and should—complement each other.* Building on prior work in this area, such as Catalyst for Payment Reform’s Employer-Purchaser Action Paper, (29) we offer the following specific recommendations to help employers better align benefit design with payment models (see *Exhibit 1* for a schematic of payment and benefit redesign options and *Exhibit 2* for specific models available to employers).

RECOMMENDATIONS FOR EMPLOYERS

Employer recommendation 1: Keep cost-sharing low for high-value services, especially those services designated as provider performance measures (e.g., eye exams for patients with diabetes).

Low cost-sharing for high-value service encourages employees to use them. Employers can start by keeping cost-sharing low for services that are benchmarked by health plans for provider performance measurement. To achieve this, employers can use value-based insurance designs that selectively waive deductibles and lower co-pays or co-insurance for high-value services.

Employer recommendation 2: Measure and report low-value care and increase cost-sharing for low-value services for which patients have some control.

Overuse of low-value services can be reduced by decreasing reimbursement to providers and increasing patient cost-sharing through benefit design. However, the value of a specific clinical service can vary for different patients. For example, the United States Preventive Services Task Force recommends colorectal screening for average-risk individuals between ages 45 and 75, but discourages its use in those over 85 years of age. This clinical nuance potentially complicates the use of benefit design to reduce low-value care. Employers can advocate for lower reimbursement and increase cost-sharing for services that are almost always low-value (e.g., vitamin D testing of average-risk patients), and task their carriers with quantifying potential low-value services in ways that recognize the nuance in value definitions for future action.

Employer recommendation 3: Hold carriers accountable for procuring high-value services.

Employers can hold carriers accountable by negotiating actionable performance guarantees to increase high-value care. One option is to demand refunds from carriers if targets for utilization of high-value services are not met. Additionally, employers can provide an advantage in procurement to carriers that make meaningful commitments to high-value care. The Catalyst for Payment Reform's Aligned Sourcing & Contracting toolkit provides editable templates that employers can use to aid in health plan selection. ([30](#))

Employer recommendation 4: Hold carriers accountable for decreasing utilization of low-value services.

Employers can hold carriers accountable by negotiating actionable performance guarantees to decrease low-value care. Employers can demand refunds from carriers if targets for decreased utilization of low-value services are not met. Self-insured employers can also share any savings from reducing low-value care with carriers and providers.

Employer recommendation 5: Contract with carriers or third-party companies to improve patient steerage to high-value providers.

Patient steerage to high-value providers can help patients obtain higher-value care. Employers can choose carriers that offer benefit designs with meaningful incentives for patients to seek care from high-value providers through approaches including tiered or high-performance networks.

Employer recommendation 6: Contract with carriers to move to advanced forms of value-based payment where appropriate.

Moving from fee-for-service to alternative payment models can hold providers accountable for delivering high-value care. Employers can select carriers with robust alternative payment models and nudge carriers to expand such models, and when given the choice, opt to participate in such models. Self-insured employers can also contract with third-party companies that offer alternative payment models for specific conditions, such as bundled payments for knee surgery.

Employer Recommendation 7: Contract with carriers that seek to align fee-for-service reimbursement rates with the value of care delivered.

Fee-for-service will continue to be the payment mechanism for a substantial portion of medical services, and fee-for-service equivalency often forms the basis of alternative payment models. Employers should continue to challenge carriers to negotiate contracts that give fee-for-service rate increases only to high-value services that are underutilized, and to implement fee decreases for low-value services which are overutilized.

PUBLIC POLICY RECOMMENDATIONS

Public policy can help employers coordinate benefit design and payment. We have four public policy recommendations that may help better align payment models with benefit design and potentiate employer actions.

Public policy recommendation 1: Define a set of high-value services for which providers may receive payment bonuses and that may be covered pre-deductible by health plans.

Deductibles have been shown to indiscriminately discourage high- and low-value care, and selectively waiving deductibles for high-value services will increase their utilization. Affordable Care Act Section 2713 requires all health plans to cover certain services—such as wellness check-ups, vaccinations, and certain preventive screenings—without patient cost-sharing. (31,32) But many other high-value services commonly require cost-sharing, such as office visits for chronic disease care. Federal policy changes have recently provided health plans greater flexibility to provide pre-deductible coverage. A 2019 notice from the Internal Revenue Service allows high-deductible health plans to cover certain services used to manage chronic diseases—such as heart disease, asthma, and diabetes—before patients meet their deductible. (33) Increased flexibility to reduce cost-sharing for a broader set of high-value services will encourage their utilization and reduce friction between payment models and benefit design.

Public policy recommendation 2: Implement regulations such as Affordable Care Act Section 4105 that eliminate payment for specific low-value services.

Affordable Care Act Section 4105 authorizes Medicare to eliminate coverage for preventive services that are not clinically indicated to improve health based on recommendations by the United States Preventive Services Task Force (USPSTF). Services receiving a D rating from the USPSTF have been estimated to cost the Medicare program over \$500M annually. (34) Implementing regulations such as this would decrease low-value care.

Public policy recommendation 3: Encourage payers to report the percentage of spending in alternative payment models by model type.

This will help employers select and hold accountable carriers that aim to incentivize high-value care. While measurement is difficult, tools, as well as precedent by payers, do exist. For example, Covered California, California's individual insurance Marketplace, has required health plans to report the percentage of members enrolled in certain alternative payment models. (11) Encouraging reporting of spending by model type will also help move toward transparency, preventing providers and health plans from obscuring the true cost of care through side payments.

Public policy recommendation 4: Re-equilibrate the Medicare RBRVS Fee Schedule to increase payments for underprovided high-value services and lower payments for low-value services.

The Medicare fee schedule has long been known to overcompensate procedural and technical services relative to cognitive services, though not all cognitive services are high-value and not all technical services are low-value. Aligning payment with value is complex because the value of a service depends on who receives it. Still, there is room to adjust payments to better align with value. This is important because the Medicare fee schedule is the basis of many other fee schedules, and is often used to determine the value of APM contracts. Fixing long-standing inequities in the Medicare fee schedule can help increase the overall value purchased far beyond that for Medicare beneficiaries alone.

Exhibit 2. Payment and benefit design tools available to employers

Tools	Problem(s) addressed	Incentive strength	Employer control
<u>Payment</u>			
Episode-based payment	Overuse, prices	++	Medium
ACOs	Overuse, underuse, (prices)	++	Low
Capitation	Overuse, prices	+++	Low
<u>Benefit design</u>			
HDHPs	Overuse	+++	High
Reference pricing	Prices	++	Medium
V-BID	Overuse, underuse	++	Medium
Centers of excellence	Prices	+	High
Tiered/narrow networks	Overuse, underuse, (prices)	++	High

Note: Table rating different alternative payment models and benefit design strategies according to: (1) which problem(s) they address, (2) how strong incentives are, and (3) how much employers have control over them. ACOs = Accountable Care Organizations. HDHPs = high-deductible health plans. V-BID = value-based insurance design.

CONCLUSION

Employers have the power of the pen when contracting with carriers. Better alignment of clinically driven payment with evidence-based benefit design can improve quality of care, enhance equity, and promote value.

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GLOSSARY OF PAYMENT MODELS & BENEFIT DESIGN STRATEGIES

1. Payment models

a. Episode-based payment (EBP)

- Instead of paying providers piecemeal for each service delivered, EBP models pay a single bundled price for common care episodes and let providers decide how to most efficiently provide relevant services. They incentivize providers to deliver care more efficiently for a given price, addressing overuse and high prices.

b. Accountable care organizations (ACOs)

- ACOs are groups of physicians and hospitals that have contracted with a payer to be jointly responsible for the quality and cost of care for a population of patients with financial incentives to minimize overuse and underuse and maintain or improve quality.

c. Capitation

- Capitated insurance contracts pay per patient instead of per service. By shifting the financial risk of care onto providers, capitation addresses overuse and high prices. If not accompanied by quality metrics or risk adjustment, capitation can lead to underuse or provider reluctance to care for high-risk patients.

2. Benefit design

a. High-deductible health plans (HDHPs)

- Patients with HDHPs are responsible for their entire medical spending except for preventive care up to the deductible, after which they are responsible only for their co-pay or co-insurance. In theory, this should incentivize patients to shop for lower prices and forego low-value care, thereby reducing overuse. In practice, research has shown that patients forego high- and low-value care about equally, reducing both overuse and *increasing* underuse. This suggests patients are not good at determining which services are beneficial and which are wasteful, even when they face the full price of their care.

GLOSSARY CONT...

- b. Reference pricing (RP)
 - Under RP, care is covered in its entirety without patient cost-sharing up to the reference price, after which patients are responsible for the entire difference between the provider price and the reference price. RP has been shown to steer patients to lower-priced providers and reduce prices for low- and high-priced providers. However, some reference price plans do not have a contracted network of providers, and this can lead to unexpected balance billing for elective procedures that would not be prevented by upcoming “surprise billing” regulations.
- c. Value-based insurance design (V-BID)
 - V-BID aligns patient cost-sharing with the clinical value a service provides. This can mean reducing cost-sharing for high-value services or increasing cost-sharing for low-value services. V-BID has been shown to address underuse and overuse. Since most high-value medical care is cost-effective and not cost-saving, increasing utilization of high-value care leads to improved outcomes but often leads to higher spending.
- d. Centers of Excellence (COEs)
 - COEs are providers that specialize in specific medical conditions and have a proven track record of high-quality, cost-effective care for those conditions. By delivering high-quality care for a competitive price, COEs address the problem of high prices. They may also reduce overuse or underuse for these conditions.
- e. Tiered/narrow networks
 - Tiered networks place providers in different cost-sharing categories (i.e., tiers) based on price or quality. Lower-priced and/or higher-quality providers are in less expensive tiers, making it cheaper for patients to access them. Narrow networks have the same cost-sharing for providers that meet certain price or quality criteria, and exclude those providers from the network that do not. Tiered networks have been shown to influence patient utilization of hospital services.