DRAFT TITLE: Choose Your Own Adventure: Value-Based Insurance Design in Medicare Advantage

WORKING PAPER

LAST UPDATED: JUNE 2019

Executive Summary

In 2018, CMS increased the flexibility of benefit designs in Medicare Advantage by reinterpreting Uniformity Requirement (UR) rules under Medicare Advantage (MA). However, the new, universal flexibilities only apply to Part C benefits and excludes Part D benefits. MA plans that participate in the Medicare Advantage Value-Based Insurance Design (MA-VBID) demonstration project can alter cost-sharing for both chronic disease services and drugs. MA enrollees would be better off if the new, broad flexibilities were extended to Part D benefits, due to the strong evidence that value-based insurance design (VBID) reduces cost-related non-adherence, reduces out of pocket spending for vulnerable seniors, and improves health outcomes. This policy brief compares and contrasts the MA-VBID demo (including January 2019 updates) and the new UR flexibilities. We recommend extending new UR flexibilities to Part D benefits to fully empower MA organizations to improve benefits for their enrollees.

Background on MA-VBID Demonstration

On January 1, 2017, the Center for Medicare and Medicaid Services (CMS) launched the Medicare Advantage Value-Based Insurance Design (MA-VBID) Model Test (the "demo") to assess the utility of structuring consumer cost-sharing and plan elements to encourage the use of high-value clinical services and providers.[1]

In 2017, 7 states were eligible to participate in the VBID demo. The Bipartisan Budget Act of 2018 expanded the VBID demo eligibility; MA plans in all 50 states will be eligible to participate by 2020. Plans must apply to be include in the demo and meet certain criteria, such as years of MA experience.

Through the demo, MA plans can offer varied plan benefit design for enrollees who fall into certain clinical categories, including diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders, dementia, rheumatoid arthritis, and any combination of these categories. Starting in 2019, plans will be able to propose a methodology to CMS to incorporate additional chronic diseases.

The benefit flexibilities in the demo include:

1. Reduced cost-sharing for related health benefits (*e.g.*, eye exam for members with diabetes);
2. Extra supplemental benefits (*e.g.,* telehealth counseling for members with depression);

[1] http://V-BIDcenter.org/initiatives/medicare-and-medicare-advantage/

These flexibilities are permissible when using a high value provider or as a reward for participation in a disease management, wellness, or other program. Importantly, the demo only allows cost-sharing *reductions* and benefit *enhancements* – targeted enrollees can never pay higher cost-sharing or receive fewer benefits than other enrollees as a result of the demo.

An evaluation of the first year of the demo (2017) concluded that 9 MA insurers in 3 states offered 45 V-BID plans.[2] A total of 58,687 beneficiaries participated in the demo. Insurers targeted 4 out of 7 allowed conditions, including COPD, congestive heart failure, diabetes, and hypertension. Among those who offered V-BID plans, 7 out of 9 plans required participation in care management to receive V-BID benefits.

On January 18, 2019, CMS further expanded the MA-VBID demonstration to include more flexibilities for MA plans. The new VBID interventions are:

Table 1: January 2019 MA-VBID expansion details

VBID intervention	**Description**
V-BID by condition *and socioeconomic status, or both*	Non-uniform benefit design to provide reduced cost-sharing or additional supplemental benefits for enrollees based on condition and/or certain socioeconomic (i.e. low-income subsidy eligibility or dual-eligible) status
MA and Part D Rewards and Incentives programs	Plans can implement "meaningful and focused" MA and Part D Rewards and Incentive programs, which include cash-like incentives to influence healthy behaviors.
Telehealth Networks	Increased access to telehealth services by allowing plans to propose using access to telehealth services instead of in-person visits, as long as an in-person option remains, to meet certain requirements for the provider network
Wellness and Health Care Planning	Timely, coordinated approaches to wellness and health care planning, including advance care planning. *This is a requirement component for all BID participating MA plans*.
Medicare Hospice Benefit	More details to come. (Slated to begin in CY 2021).

Source and for more information: https://www.cms.gov/newsroom/fact-sheets/value-based-insurance-design-model-vbid-fact-sheet-cy-2020 (emphasis added)

Uniformity Rule Background

[2] https://innovation.cms.gov/Files/reports/vbid-yr1-evalrpt-fg.pdf

In April 2018, CMS announced a final rule regarding the reinterpretation of the Medicare Advantage (MA) uniformity requirement (UR).[3] The UR originally required that premiums and cost-sharing must be the same across all enrollees in a given MA plan, and therefore traditional V-BID was not permissible: differential cost-sharing based on any distinction between enrollees would violate the UR.

The reinterpretation, however, allows for differential cost-sharing based on health status and related services, such as diabetic eye exams for people with diabetes. CMS specifically stated in their final rule: "providing services (or reductions in specific cost-sharing and/or deductibles for services or items) that are tied to health status or disease state in a manner that ensures that *similarly situated* individuals are treated uniformly is consistent with the uniformity requirement in MA regulations."[4] Meaning, cost-sharing can now be altered by disease status, but people within that same disease status ("similarly situated") must be treated equally.

MA plans across the country will now be allowed the flexibility to alter cost-sharing for certain covered services under Part C attached to a diagnosis, paving the way for further incorporation of value-based principles in MA without the need to "apply" for the demo.

In addition to the benefit design flexibility, CMS also expanded the scope of supplemental benefits that MA plans could offer. For the first time, MA plans can cover disease-specific meals, transportation, and some additional preventive services (eg, nicotine replacement therapy). As of December 2018, consultants "identified 102 plans that are set to offer one or more of the *new* supplemental benefits in 2019, representing roughly 3 percent of MA plans nationally."[5]

Under the new UR rule, MA organizations therefore have the flexibility to:

1) reduce cost-sharing, for similarly situated enrollees, for certain benefits related to chronic conditions,
2) lower deductibles for targeted, but similarly situated, enrollees
3) provide new supplemental benefits, related to a chronic condition, for targeted enrollees

The January 2019 demo update elements, highlighted in Table 1, are not included in the UR flexibilities mentioned above, however, most notably the ability for MA plans to alter cost-sharing by socioeconomic status.

Key differences between the demo and uniformity rule changes

Allowable conditions and affected benefits

The demo has specific conditions (outlined in the table above) to which plans can apply varied cost-sharing. These conditions were selected based on their likelihood to be valuable, evidence-based targets. In the MA-VBID demonstration thus far, MA organizations are mostly focusing their V-BID benefit strategies on enrollees with diabetes, congestive heart failure and chronic obstructive pulmonary disease or comorbidities of these conditions. However, plans participating

[3] https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

[4] http://vbidcenter.org/wp-content/uploads/2018/05/HPMS-Memo-Uniformity-Requirements-4-27-18.pdf

[5] https://www.bettermedicarealliance.org/newsroom/bma-blog/uptake-new-medicare-advantage-supplemental-benefits-2019

in the demo can expand the conditions by submitting proposals to CMS, starting in 2019, based on objective criteria that CMS can replicate.

Table 2: Highlighted differences between demo and uniformity rule

	MA-VBID Demo	Uniformity Rule	Key Differences
Cost-sharing changes	Can reduce cost-sharing for disease-related services and drugs, and high-performing providers. In 2020, plans can vary cost-sharing by socioeconomic status (SES) as well. Premiums must be uniform	Plans may reduce or eliminate a deductible, co-pay, or cost sharing for Part C services. "Similarly situated enrollees (that is, all enrollees who meet the identified criteria" must be treated the same. Premiums must be uniform.	Both demo and UR only allow reductions in cost sharing for plan-determined high-value services and providers (neither allow increased cost sharing for low-value services). Only the demo allows for cost-sharing reduction by SES
Conditions affected	Diabetes, congestive heart failure (CHF), COPD, hypertension, coronary artery disease, depression or other mood disorders, rheumatoid arthritis, or a history of stroke. Plans can also submit proposal to CMS to expand the eligible conditions	"CMS [will] permit MA organizations to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria".	UR definition of potential conditions is less explicit, but constrained by ICD-10 codes, whereas demo participants can propose any number of objective criteria to CMS, starting in 2019.
Benefits affected	Can apply to both a plan's Part C benefits and Part D drug benefits, must be related to a specific condition from above.	Cost sharing reductions can only apply to MA benefits directly related to the specific health status of the individual patient and medically related services or high-quality network providers. This also includes reduced cost sharing for participation in disease management programs.	Most significantly, VBID demo allows for plans to alter Part D drug benefits, if applicable, whereas the uniformity rule applies to Part C benefits only.
Plan participation	Legislation expanded participation eligibility to all 50 states in 2020, but MA plans must apply to participate.	Any MA organization could offer a plan, subject to normal approval and auditing.	The demo requires a plan to apply, which can create hurdles.
Marketing, oversight, and evaluation	Includes monitoring to ensure compliance with demonstration rules and CMMI statute, restricts low performing plans from participating, and includes evaluation. Participating plans are not allowed to market cost sharing changes pre-enrollment.	MA organizations that plan to offer a VBID plan are subject to plan review and all normal compliance and auditing. MAOs cannot be restricted from marketing.	The demo has more oversight and evaluation requirements, overall protections higher. MA rules require that plans advertise benefits upfront and marketing will therefore be unrestricted.

Sources: Optum White Paper, MedPac comments, VBID Center comments, Federal Register, CMS memo on UR

The new UR does not explicitly outline specific conditions, but instead allows for any chronic condition identified by ICD-10 codes. Despite public comments received after the proposed

changes to the UR, CMS stated they do not have the regulatory authority to specify certain conditions.[6] CMS will allow MA organizations to decide which conditions and services they would like to cover under the UR, given their population, as long as they fit the conditions described by ICD-10 codes. CMS nonetheless encouraged MA organizations in the final rule to consider high priority conditions such as dementia and opioids. In addition, CMS makes clear that social determinants cannot be used as a rationale for altering cost-sharing; however, the guidance would apply to Z-codes which are a special group of codes for reporting factors influencing health status and contact with health services.

In general, the demo may offer opportunities for a broader list of conditions, because the allowable conditions or circumstances for varied cost-sharing are not constrained by ICD-10 codes. In addition, the demo expansion announced in January 2019 would allow flexibilities beyond the UR changes, such as altering cost-sharing by SES.

Disclosures and marketing
The demo does not allow plans to market V-BID benefits before enrollment. The demo also does not allow the disclosure of V-BID benefits to enrollees not eligible. However, in 2019, plans may disclose benefits to the extent permitted for benefits offered under the general flexibility.

Under the UR, CMS would require all MA plans that incorporate a V-BID element to provide full transparency to beneficiaries. This means that regular MA plans market V-BID benefits upfront. In addition, the Evidence of Coverage must include information regarding V-BID benefits. Public comments of the proposed rule indicated a concern about discrimination and adverse selection with the new uniformity rule, especially given the flexibilities to market V-BID benefits. Specifically, a plan could reduce cost-sharing for a lot of conditions and services, but forego doing so for higher cost conditions.[7]

Cost-sharing changes for prescription drugs
Perhaps most notably, the demo allows cost-sharing changes for drug benefits – CMS did not extend their new UR reinterpretation to Part D benefits; their reinterpretation applies only to Part C benefits.[8] Further under the UR, it is also worth noting that CMS will not permit cost-sharing reductions across all benefits for an individual enrollee (eg, means-tested) for either UR flexibilities or the demo; cost-sharing reductions must be for specific services related to a specific diagnosis or health status.

Similar flexibilities for MA-PD are possible
The demo allows qualified and accepted MA plans to modify their Medicare Advantage Part D (MA-PD) prescription drug benefits in addition to supplemental and medical benefits provided under Part C. The final UR expands the scope of supplemental benefits but explicitly covers Part C services only. In comments regarding this rule change, MedPAC noted that the rule change loosely follows their 2013 recommendations on this topic, except for the exclusion of drugs.[9] The implication being that drugs could be considered as well.

---

[6] https://www.federalregister.gov/documents/2017/11/28/2017-25068/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare
[7] http://V-BIDcenter.org/wp-content/uploads/2018/05/HPMS-Memo-Uniformity-Requirements-4-27-18.pdf
[8] Cite the final rule comments page where they say this explicitly
[9] http://www.medpac.gov/docs/default-source/comment-letters/01032018_partc_d_comment_v2_sec.pdf?sfvrsn=0

CMS has yet to make clear why Part D benefits were not included in these new flexibilities. In the final rule, CMS states that plans must continue to follow Part D law and regulations regarding uniformity, despite the rule change for Part C benefits, but there is no obvious legal justification that precludes CMS from making the same reinterpretation for MA-PD plans. It is therefore possible that further rulemaking would allow MA-PD cost-sharing, but this would require a separate rulemaking process or new legislative action.

A number of justifications have been used previously not to change the UR interpretation for Part D benefits, which could inform how to go about new legislation or rulemaking. First, there is a statutory uniform premium requirement for Part D. CMS interprets this statutory requirement that everyone pay the same premium as a requirement that everyone should pay the same cost-sharing.[10] It's possible to claim that in order to meet the intent of the premium uniformity requirement, cost-sharing across all enrollees in a Part D plan must also be the same. However, a similar statute exists for Medicare Advantage, and CMS was still able to issue a new reinterpretation of MA uniformity rules in April.[11] Therefore, the premium uniformity requirement in Part D should not be a barrier to future rulemaking or legislation.

Second, CMS has previously debated whether plans could offer non-uniform negotiated prices for Part D eligible individuals.[12] In 2005, CMS stated "we believe that non-uniform negotiated prices would discourage enrollment by certain Part D eligible individuals" which would be considered discriminatory under the Social Security Act.[13] CMS has used this interpretation since to imply that non-uniform benefits, in general, are prohibited in Part D. Similar to above, CMS decided in April that the application of non-uniformity in Part C would not violate that same principle.

Beyond legal explanations, there are elements of the Part D framework to consider with new rulemaking or legislation. For example, standalone Prescription Drug Plans (PDPs) do not have the medical information necessary to determine whether or not a member fits a clinical category in the same way that CMS approved plans to do so in Part C. In other words, to vary cost-sharing for Part C benefits, CMS requires that similarly situated persons with chronic diseases have the same cost-sharing (so everyone who has diabetes in their plan must have access to the same diabetes-specific cost-sharing). Standalone PDPs would not have the diagnostic information to make that determination; they only know what medications enrollees have, which is not an allowable method of identifying a similarly situated person under the UR reinterpretation. When expanding flexibilities for Part D benefits, this nuance should be considered.

[10] 1860D-13(a)(1)(G) https://www.ssa.gov/OP_Home/ssact/title18/1860D13.htm
[11] Sec on 1854(c) (see here: https://www.ssa.gov/OP_Home/ssact/title18/1854.htm
[12] Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 FR 191801 (Jan. 10, 2014).
[13] 1860D11(e)(2)(D)(i) of the Act

Recommendations

1. Expand similar UR flexibilities currently applicable to Part C to Part D benefits, for integrated MA-PD plans, but not for standalone PDPs.

2. Establish a Medicare Advantage Learning Collaborative to facilitate dialogue around implementing V-BID in Medicare Advantage, the differences between the ongoing demonstration and the new UR flexibilities, and the importance of including Part D for the benefit of patients.

Why is it important to expand new UR flexibilities to MA-PD benefits?

The new UR flexibilities would be stronger and would have improved the well-being of seniors with chronic conditions in Medicare more, had drug cost-sharing been included in the final rule.

In the first year of the demonstration, only 2 MA-VBID plans include changes to drug benefit designs to encourage the use of high-value medications for certain conditions.[14] There is significant evidence to suggest, however, that pharmaceuticals are important to enrollee health and the success of VBID in MA. First, a growing body of published research reveals that increases in out of pocket costs for Medicare enrollees create a significant deterrent to receiving and maintaining essential services such as drug regimens, known as cost-related non-adherence (CRN).[15] CRN impacts the most vulnerable patients the most, including low-income enrollees and those with multiple chronic conditions for which they take multiple drugs.

In addition, a recent systematic review of V-BID demonstrated that V-BID improves medication adherence without an increase in total health care spending.[16] For MA-VBID plans, this is particularly of interest given that budget-neutral increases in high-value medication adherence through Part D benefits could translate into medical savings on Part C benefits for certain conditions, such as congestive heart failure. Furthermore, allowing varied cost-sharing for Part D benefits would immediately align with the administration's goal to reduce out-of-pocket costs for seniors.

Not to mention, inclusion of Part D benefits in the UR flexibilities, in some capacity, would allow for holistic continuity of flexibilities. It may be increasingly confusing to a patient to have certain benefits based on a disease status for certain services, but not for the drugs that commonly go along with treating and maintaining that disease.

[14] https://innovation.cms.gov/Files/reports/vbid-yr1-evalrpt-fg.pdf
[15] http://V-BIDcenter.org/wp-content/uploads/2016/08/MA-White-Paper_final-8-16-16.pdf
[16] http://V-BIDcenter.org/initiatives/medicare-and-medicare-advantage/