Bending the Curve Through Health Reform Implementation

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ENGELBERG CENTER for
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The Engelberg Center for Health Care Reform is committed to producing innovative solutions that will drive reform of our nation's health care system. The Center's mission is to develop data-driven, practical policy solutions that promote broad access to high-quality, affordable, and innovative care in the United States. The Center conducts research, makes policy recommendations, and facilitates the development of new consensus around key issues and provides technical support to implement and evaluate new solutions in collaboration with a broad range of stakeholders.

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Executive Summary

In September 2009, we released a set of concrete, feasible steps that could achieve the goal of significantly slowing spending growth while improving the quality of care. We stand by these recommendations, but they need to be updated in light of the new Patient Protection and Affordable Care Act (ACA).

Reducing health care spending growth remains an urgent and unresolved issue, especially as the ACA expands insurance coverage to 32 million more Americans. Some of our reform recommendations were addressed completely or partially in ACA, and others were not. While more should be done legislatively, the current reform legislation includes important opportunities that will require decisive steps in regulation and execution to fulfill their potential for curbing spending growth.

Executing these steps will not be automatic or easy. Yet doing so can achieve a health care system based on evidence, meaningful choice, balance between regulation and market forces, and collaboration that will benefit patients and the economy (see Appendix A for a description of these key themes).

We focus on three concrete objectives to be reached within the next five years to achieve savings while improving quality across the health system:

1. Speed payment reforms away from traditional volume-based payment systems so that most health payments in this country align better with quality and efficiency.

2. Implement health insurance exchanges and other insurance reforms in ways that assure most Americans are rewarded with substantial savings when they choose plans that offer higher quality care at lower premiums.

3. Reform coverage so that most Americans can save money and obtain other meaningful benefits when they make decisions that improve their health and reduce costs.

We believe these are feasible objectives with much progress possible even without further legislation (see appendix B for a listing of recommendations). However, additional legislation is still needed to support consumers – including Medicare beneficiaries – in making choices that reduce costs while improving health.

Objectives for Moving Forward Health Reform

OBJECTIVE 1: Speed payment reforms away from traditional volume-based payment systems so that most health payments in this country align better with quality and efficiency.

Our previous report emphasized that reorienting providers' financial incentives and support toward improving value is essential. Medicare fee-for-service (FFS) payments are becoming steadily less generous. Reductions in payment updates for most providers, in addition to lack of funds to provide longer-term updates for physicians, creates rising pressure for policymakers, private payers, and especially health care providers to find better alternatives to current payment models. FFS payments may be the best payment strategy in some circumstances and adjustments to make FFS payments more accurate and efficient can help. But reducing payments for "overpriced" services, combating fraud, and reducing administrative costs are insufficient to solve the fiscal challenges facing the health care system. Moreover, reducing payment and administrative costs will not address other shortcomings of the health care system such as fragmented care, the lack of evidence-based care, and the lack of accountability for improving quality and efficiency in the U.S. health care system.

ACA offers a number of opportunities to develop evidence on alternatives to traditional FFS provider payments to transform our health system. It grants broad new authority to reform Medicare payments, and for Medicare to support private-sector payment reforms. Still, there is high uncertainty as to whether these initiatives will successfully address the issues associated with controlling spending growth and increasing quality; payments are still largely disconnected from quality and the use of unnecessarily costly services. There is also no clear path yet to identify and quickly implement effective combinations of payment reforms or to scale effective reforms quickly. Furthermore, political pressure has repeatedly undone past efforts to reform Medicare provider payments, making it essential to take steps now to build momentum to use these new opportunities effectively.

Specific Recommendations for Bending the Curve

1. Design Medicare payment reform pilots, demonstrations and programs, including accountable care organizations (ACOs), to achieve rapid innovation, synergy, and scalability. The overall aim is to move toward payment for a broader set of services for a patient, with shared savings and losses based on prospective budgets for total spending, partial or full capitation, or bundled payments.

    - Pilot a range of ACOs in Medicare before 2012, accommodating the diversity of market characteristics across the country; use the new Center for Medicare and Medicaid Innovation (CMMI) as a vehicle for accelerating these pilots.
    - Implement bundled and related payment reforms for hospital, physician, and other clinical services for important episodes that cover enough of the medical costs in aggregate (e.g., chronic conditions as well as hospital-based episodes) to change behaviors across the health system.
    - Promptly introduce downside risk to ACOs, as well as episode and bundled payment pilots, even at early stages of implementation.

2. Coordinate CMMI and other Medicare pilot initiatives to promote collaboration with private and state payers, as well as across federal initiatives.

    - Ensure that the private sector is an active partner in the research and design of payment reforms, building on concepts

that have been proven to work at the state, regional, or federal level. Specifically, Medicare should give preference to multi-payer initiatives to test reforms.
- Clarify regulatory guidance and policies that are essential in a FFS environment but that could stifle public and private sector innovation around value-based payments. Further guidance and opinions may be needed to address potential anti-trust concerns related to provider collaboration, as well as anti-kickback concerns.
- Implement consistent methods to measure improvements in performance across pilots, and across the public and private sectors. Tracking the evolving combinations of payment and other reforms that achieve maximum impact is essential. Trying to evaluate individual payment reforms in isolation, rather than focusing on combinations of reforms that achieve the largest effects, may lead to overly narrow and slow reform, without full understanding of unintended consequences, complementary incentives, and reinforcing organizational and community contexts.

3. Build comparable data collection, aggregation, analytics, and reporting capabilities to more rapidly develop consistent evidence of the impact of reforms on cost and quality. This involves making better use of existing data sources and supporting incremental, progressive improvements in electronic data, instead of waiting for full electronic records.

    - Develop timely and consistent data feeds from Medicare, private payers, and other data sources. This will give providers the information they need to take steps to improve care for beneficiaries, as well as to support better performance measures.
    - Adopt standardized performance metrics by leveraging measures already endorsed as consensus standards (such as through the National Quality Forum). Measures should be both timely enough to enable action by providers and broad-based enough to reflect the experience of the entire U.S. population and the full spectrum of care. Measures should also be outcome oriented and widely available to facilitate knowledge transfer to all populations, communities, and consumers.

4. Strengthen and clarify the authority and capacity of the Independent Payment Advisory Board (IPAB). Doing so will enable the IPAB to effectively apply pressure to transition away from the current FFS payment model.

    - Recruit knowledgeable representatives of the entire health system and other experts, particularly those of provider groups. Attracting the right talent pool will require sensitivity to time commitment and avoidance of overly broad conflict of interest disqualification.
    - Assure IPAB's mandate allows a broad range of payment reforms beyond reductions in payment rates for particular services in achieving its "GDP+1%" goal for per-capita spending growth. In the short term, this should include many reforms considered by the Medicare Payment Advisory Committee (MedPAC) – which are available now and have already been tested by states and the private sector. Doing so could provide a pathway for IPAB to take action before its "due date" of 2014.
    - Empower IPAB with tools (e.g., performance measures and clinical, economic, and actuarial expertise) to identify emerging treatment and payment trends quickly.

These steps focus on using the broad authority in the reform law for Medicare and other public programs to implement effective payment reforms. Additionally, they stress opportunities for

government programs to complement and promote effective private sector reforms. The following objectives provide much stronger accountability and incentives for private payers to implement payment reforms that reduce costs and improve quality as well.

OBJECTIVE 2: Implement health insurance exchanges and other insurance reforms in ways that assure most Americans are rewarded with substantial savings when they choose plans that offer higher quality care at lower premiums.

The best design of health insurance plans for protecting consumers and promoting better care is still evolving, but is likely to be something other than traditional third-party FFS-based indemnity insurance. To encourage the development and adoption of insurance plans that are more effective at improving care while lowering costs, we recommend the availability of a broad array of health plan products in all insurance markets, and the opportunity for consumers to share in the savings when they choose coverage that leads to lower costs and higher quality.

ACA provides important opportunities to enhance plan competition based on quality and efficiency and avoid adverse risk selection through state exchanges, reinsurance and risk adjustment provisions, and minimum coverage requirements. The flat subsidy for low-income people purchasing coverage from exchanges – which means those choosing a higher-cost plan pay the full additional cost – is particularly important in encouraging value-based decision making.

However, ACA is not clear on whether a broad array of innovative insurance plan designs will be permitted, potentially creating barriers to needed support for changes in the delivery of care. For example, it is unclear that value-based insurance design will be permitted, let alone encouraged. Such lower-cost options will be especially important to achieve the very broad participation needed to keep coverage costs down.

Specific Recommendations for Bending the Curve

1. Set a clear process for promoting vigorous competition among plans in insurance exchanges.
   - Promote a broad range of meaningfully different plan options. Provided actuarial equivalence is met, plans should be able to compete using the innovative benefit designs described more fully under Objective 3 of this report.
   - Create penalties, such as exchange exclusion or marketing restrictions, for plans that underperform on important quality metrics while otherwise promoting year-to-year continuity in available plan offerings.
   - Assure that exchanges provide practical, useful cost, quality, and patient experience information for individuals to compare plans and their associated provider networks, so that people can confidently switch plans for better value.

2. Develop viable alternatives to avoid adverse selection, especially if it is difficult to achieve a strong mandate for individuals to obtain coverage.

   - Balance need for choice with enrollment restrictions that limit rapid movement from less generous to much more generous plans. These could include limiting open enrollment periods, limiting range of switching from plans of lower to plans of higher actuarial value each year, and adding late enrollment penalty and/or restrictions.
   - Monitor effectiveness of the transitional reinsurance program in encouraging competition among insurers for high-risk patients. As needed, secure additional subsidies for high-risk patients, using existing funding augmented or replaced with direct, ongoing funding. Like the exchange subsidies, these subsidies should be fixed prospectively based on health characteristics.

3. Provide comparative monitoring and evaluation of insurance exchanges across states based on their performance related to the minimum functions required under ACA as well as additional functions added by states. These efforts should help ensure that states, which are often resource constrained, have adequate technical assistance to implement and manage the exchanges.

    - Assure regular and consistent performance reporting as a basis for developing better evidence for promoting insurance competition that improves quality and lowers costs.
    - Identify and publicize effective strategies among states for limiting cost growth while achieving high coverage rates and consumer satisfaction, particularly for high-risk and vulnerable patients.

While these recommendations focus on insurance exchanges, the same principles should apply to private insurance and Medicare coverage options discussed below.

OBJECTIVE 3: Reform coverage so that most Americans can save money and obtain other meaningful benefits when they make decisions that improve their health and reduce costs.

Like our recommendations for holding providers and insurers more accountable for high value in health care (Objectives 1 and 2), we recommend that consumers also have stronger incentives and support for making higher-value choices related to their health and health care.

To address this issue, we originally recommended capping income tax exclusions for health insurance to encourage workers to choose more cost-effective coverage. We further proposed expanded competitive bidding in Medicare Advantage (whereby Medicare beneficiaries bear the additional cost of plans with above-average bids), potentially with a transition to include Medicare FFS. Along with coverage in insurance exchanges that involves a fixed subsidy, the vast majority of Americans would be able to keep the savings from choosing less costly coverage.

The excise tax under ACA is an important step in addressing the incentive for carriers and employers to provide high-cost, rich benefit plan options to employees. Nonetheless, a number of political and structural uncertainties could weaken the impact of this provision. In particular, the provision has a high threshold with substantial exceptions and a very late implementation timeline (2018), which provides opportunities for legislation that could lead to further delays or possibly elimination of this provision.

Moreover, ACA made little progress in giving Medicare beneficiaries opportunities to save money when choosing coverage and care that costs less while meeting their needs. While the legislation does make significant strides in promoting preventive care and provides some other measures that may improve health decisions such as menu labeling, much more could be done to directly reward consumers and employers for changes in their actions that reduce health care costs.

Specific Recommendations for Bending the Curve

1. Maintain, at a minimum, the current provision on taxing high-premium insurance plans and, ideally, take further legislative action to strengthen this provision. Strengthening this very important tax reform should be considered as part of the upcoming debates on extending the 2001 and 2003 tax cuts and on deficit reduction.

    - Enact legislation to implement the tax earlier – potentially phasing in the tax beginning in 2014 instead of 2018.

- Lower the threshold to encourage more than a small fraction of employers to design – and workers to choose – more cost-effective coverage.
- Increase the breadth of employers affected by reducing the exclusions from the tax, while taking steps to increase risk adjustment and high-risk payments for those with chronic illnesses to more efficiently assist workers and retirees with disabilities and chronic health problems.

2. Reform Medicare FFS benefit design and implement a competitive plan choice process that is consistent with our recommendations on plan choice for insurance exchanges, to promote beneficiary savings from choosing higher-value care.

    - Consider a transition to including Medicare FFS in the bidding system.
    - Allow co-pay reforms in Medicare FFS that parallel the reforms in provider payments, so that Medicare beneficiaries as well as providers can get savings when they use higher-quality, lower-cost care.
    - Increase flexibility for Medicare to alter benefits over time, without reducing actuarial value, based on evidence of better quality and lower costs. Such models should go beyond variations in co-pays and include other incentives for consumers based on their specific needs and conditions. For example, beneficiaries who participate in high-value ACOs or beneficiaries with serious illnesses who choose providers that offer a bundle of services (surgery, chronic disease management) at a lower cost should share in the savings.
    - For Medigap, allow variations in co-pays based on evidence (e.g., allow tiered co-pays for providers and services based on evidence of quality and efficiency), and support a redesign of incentives for Medigap plan choice that reflect their overall Medicare cost impact.

3. Provide clarification or loosen restrictions around ACA reforms, and existing laws and regulations, which may impede health plans from adopting these value-based design options.

    - For exchange-based plans, assure that Medical Loss Ratio (MLR) requirements do not discourage health plans from implementing non-traditional benefit designs and services that encourage and support consumer use of higher-quality, lower-cost care. For example, costs of developing better evidence for services where the risks and benefits for particular patients are unclear, costs of implementing value-based insurance designs, and costs of providing information to patients to support decision-making should be considered "medical" costs under the MLR requirements.

4. Develop and expand demand-side wellness incentives, including premium rebates, to encourage all beneficiaries to undertake measurable health and risk-factor improvements. Doing so includes building incentives with risk adjustment so that all beneficiaries have a meaningful opportunity to participate and save, regardless of health status.

Conclusion

The recently enacted federal health care legislation provides some important new opportunities to bend the curve of health care costs, but implementing the new law will be difficult. But more must be done. This hard work can and must start immediately.

A first step should be to enhance information sharing capabilities, which includes defining specific performance measures to track progress against these reform initiatives across the entire health care system. Doing so will first require the administration and private parties to work together to exchange real-time information to support care and also to enable better measurement of cost and quality of care at the individual-level, empowering specific clinical transformation efforts.

Individual performance should be rolled-up to develop the "big picture" assessment needed to evaluate the overall impact of reforms and their ability to realize savings, enabling more timely and effective course corrections. Steps to achieve this goal can begin over the next three to six months:

- Create an infrastructure for Medicare to provide data feeds to providers, as a basis for identifying opportunities to improve care for specific patients and document progress. Encourage private payers and other data holders to do the same consistently.
- Leverage existing private and public programs to align on consistent metrics, so that summary information on health care performance can be aggregated across all health care programs, even if metrics are not yet tied to payment reforms or other incentives.
- Focus data resources on setting baselines and risk-adjustment procedures correctly, thus ensuring reasonable expectations for driving improvement in performance.

Recent reports from the Medicare Trustees, the Congressional Budget Office, the National Commission on Fiscal Responsibility and Reform, and many others confirm that controlling health care spending remains among the top issues to be addressed for ensuring a healthy economic future.

We now have a window of opportunity for true health care reform – a chance not only to build momentum away from current, unsustainable models, but to provide alternative models that will allow both consumers and providers to achieve higher-value health care.

Appendix A. Key Themes for Health Care Reform

Four overarching themes underlie these recommendations:

1. **Improve Performance through Data and Evidence:** Accurate, timely, reliable, consistent and increasingly comprehensive data are essential to provide the evidence on outcomes to improve treatment, coverage and policy decisions. Moreover, facilitating the availability of low-cost or free summary information based on aggregated health data could empower consumers to make more informed decisions while also giving communities and policymakers better tools for applying pressure on health systems to improve performance. Data should reflect privacy and confidentiality protections. In particular, identifiable patient information should generally be shared only for patient care. In addition, information on the performance of providers, plans, and treatments should not involve the use of patient identifiable information.

2. **Provide Flexibility and Meaningful Choice to Identify the Most Effective Reforms:** Consumers, particularly those with costly chronic conditions, urgently need help to make value-based decisions. Unfortunately, much remains to be learned about the best designs for health care and health insurance coverage. To generate this new knowledge, we must promote and test a range of innovative insurance designs that have the potential to improve value-based decision-making. These insurance plans would incorporate flexibility and innovation in payment systems and coverage, with providers and consumers getting the financial benefits of successful approaches, so that successful plans will be chosen and expanded quickly and unsuccessful ones will not persist. This is essential to achieving high-value, low-cost care and financial protection for consumers.

3. **Achieve the Right Balance between Market Forces and Regulation:** Regulation should create the framework for vigorous competition and markets should be evaluated on results – better health outcomes and lower costs, especially for vulnerable patients. Regulation is more likely to succeed in both supporting effective market forces and protecting consumers from market abuses if it adapts to the inevitable changes coming in health care rather than continuing to lock in processes that are out of sync with these changes.

4. **Promote Collaboration across Stakeholders in Reform Initiatives:** Innovation in health care policies for greater efficiency and better care can occur in both the public and private sectors. Creating opportunities to align efforts will be important to promote momentum for effective change, and to minimize burdens and conflicts on providers, payers, employers and patients. However, it will be important to ensure that collaboration does not become collusion for financial gain, but works, instead, to achieve the reform goals of higher quality and better outcomes at lower cost through effective competition.

Appendix B. Administrative versus Legislative Actions

Objective 1: Speed payment reforms away from traditional volume-based payment systems so that most health payments in this country align better with quality and efficiency	
1. Design Medicare payment reform pilots, demonstrations and programs, including accountable care organizations (ACOs), to achieve rapid innovation, synergy, and scalability. The overall aim is to move toward payment for a broader set of services for a patient, with shared savings and losses based on prospective budgets for total spending, partial or full capitation, or bundled payments	
Pilot a range of ACOs in Medicare before 2012, accommodating the diversity of market characteristics across the country; use the new Center for Medicare and Medicaid Innovation (CMMI) as a vehicle for accelerating these pilots	Administrative
Implement bundled and related payment reforms for hospital, physician, and other clinical services for important episodes that cover enough of the medical costs in aggregate (e.g., chronic conditions as well as hospital-based episodes) to change behaviors across the health system	Administrative
Promptly introduce downside risk to ACOs, as well as episode and bundled payment pilots, even at early stages of implementation	Administrative
2. Coordinate CMMI and other Medicare pilot initiatives to promote collaboration with private and state payers, as well as across federal initiatives	
Ensure that the private sector is an active partner in the research and design of payment reforms, building on concepts that have been proven to work at the state, regional, or federal level. Specifically, Medicare should give preference to multi-payer initiatives to test reforms	Administrative
Clarify regulatory guidance and policies that are essential in a FFS environment but that could stifle public and private sector innovation around value-based payments. Further guidance and opinions may be needed to address potential anti-trust concerns related to provider collaboration, as well as anti-kickback concerns	Administrative effort required on part of HHS to build in guidance to pilot participation require/ Legislative work required to clarify existing regulations
Implement consistent methods to measure improvements in performance across pilots, and across the public and private sectors, and track the evolving combinations of payment and other reforms that achieve maximum impact. Trying to evaluate individual payment reforms in isolation, rather than focusing on combinations of reforms that achieve the largest effects, may lead to overly narrow and slow reform, without full understanding of unintended consequences, complementary incentives, and reinforcing organizational and community contexts	Administrative

3. Build comparable data collection, aggregation, analytics, and reporting capabilities to more rapidly develop consistent evidence of the impact of reforms on cost and quality. This involves making better use of existing data sources and supporting incremental, progressive improvements in electronic data, instead of waiting for full electronic records	
Develop timely and consistent data feeds from Medicare, private payers, and other data sources, to give providers the information they need to take steps to improve care for beneficiaries, as well as to support better performance measures	Administrative/ Potential legislative action to ensure appropriate level of data can be shared as needed
Adopt standardized performance metrics by leveraging measures already endorsed as consensus standards (such as through the National Quality Forum). Measures should be both timely enough to enable action by providers and broad-based enough to reflect the experience of the entire U.S. population and the full spectrum of care. Measures should also be outcome oriented and widely available to facilitate knowledge transfer to all populations, communities, and consumers	Administrative
4. Strengthen and clarify the authority and capacity of the Independent Payment Advisory Board (IPAB). Doing so will enable the IPAB to effectively apply pressure to transition away from the current FFS payment model	
Recruit knowledgeable representatives of the entire health system and other experts, particularly those of provider groups. Attracting the right talent pool will require sensitivity to time commitment and avoidance of overly broad conflict of interest disqualification	Administrative
Assure IPAB's mandate allows a broad range of payment reforms beyond reductions in payment rates for particular services in achieving its "GDP+1%" goal for per-capita spending growth. In the short term, this should include many reforms considered by the Medicare Payment Advisory Committee (MedPAC) – which are available now and have already been tested by states and the private sector. Doing so could provide a pathway for IPAB to take action before its "due date" of 2014	Legislative
Empower IPAB with tools (e.g., performance measures and clinical, economic, and actuarial expertise) to identify emerging treatment and payment trends quickly	Legislative effort potentially needed to acquire funds to support such efforts

Objective 2: Implement health insurance exchanges and other insurance reforms in ways that assure most Americans are rewarded with substantial savings when they choose plans that offer higher quality care at lower premiums	
1. Set a clear process for promoting vigorous competition among plans in insurance exchanges	
Promote a broad range of meaningfully different plan options. Provided actuarial equivalence is met, plans should be able to compete using the innovative benefit designs described more fully under Objective 3 of this report	Legislative work needed to clarify regulations to support such plans. Additional language may be needed to encourage such plans
Create penalties, such as exchange exclusion or marketing restrictions, for plans that underperform on important quality metrics while otherwise promoting year-to-year continuity in available plan offerings	Legislative
Assure that exchanges provide practical, useful cost, quality, and patient experience information for individuals to compare plans and their associated provider networks, so that people can confidently switch plans for better value	Administrative work needed to specify measure and ensure effective communication to consumers/ Legislative action may be needed to ensure plan compliance
2. Develop viable alternatives to avoid adverse selection, especially if it is difficult to achieve a strong mandate for individuals to obtain coverage	
Balance need for choice with enrollment restrictions that limit rapid movement from less generous to much more generous plans (e.g., limit open enrollment periods, limit range of switching from plans of lower to plans of higher actuarial value each year, and add late enrollment penalty and/or restrictions)	Legislative
Monitor effectiveness of the transitional reinsurance program in encouraging competition among insurers for high-risk patients and, as needed, secure additional subsidies for high-risk patients, using existing funding augmented or replaced with direct, ongoing funding. Like the exchange subsidies, these subsidies should be fixed prospectively based on health characteristics	Legislative

3. Provide comparative monitoring and evaluation of insurance exchanges across states based on their performance related to the minimum functions required under ACA as well as additional functions added by states. These efforts should help ensure that states, which are often resource constrained, have adequate technical assistance to implement and manage the exchanges	
Assure regular and consistent performance reporting as a basis for developing better evidence for promoting insurance competition that improves quality and lowers costs	Administrative
Identify and publicize effective strategies among states for limiting cost growth while achieving high coverage rates and consumer satisfaction, particularly for high-risk and vulnerable patients	Administrative

Objective 3: Reform coverage so that most Americans can save money and obtain other meaningful benefits when they make decisions that improve their health and reduce costs	
1. Maintain, at a minimum, the current provision on taxing high-premium insurance plans and, ideally, take further legislative action to strengthen this provision. Strengthening this very important tax reform should be considered as part of the upcoming debates on extending the 2001 and 2003 tax cuts and on deficit reduction	
Enact legislation to implement the tax earlier – potentially phasing in the tax beginning in 2014 instead of 2018	Legislative
Lower the threshold to encourage more than a small fraction of employers to design – and workers to choose – more cost-effective coverage	Legislative
Increase the breadth of employers affected by reducing the exclusions from the tax, while taking steps to increase risk adjustment and high-risk payments for those with chronic illnesses to more efficiently assist workers and retirees with disabilities and chronic health problems	Legislative
2. Reform Medicare FFS benefit design and implement a competitive plan choice process that is consistent with our recommendations on plan choice for insurance exchanges, to promote beneficiary savings from choosing higher-value care	
Consider a transition to including Medicare FFS in the bidding system	Legislative
Allow co-pay reforms in Medicare FFS that parallel the reforms in provider payments, so that Medicare beneficiaries as well as providers can get savings when they use higher-quality, lower-cost care	Legislative

Increase flexibility for Medicare to alter benefits over time, without reducing actuarial value, based on evidence of better quality and lower costs. Such models should go beyond variations in co-pays and include other incentives for consumers based on their specific needs and conditions. For example, beneficiaries who participate in high-value ACOs or beneficiaries with serious illnesses who choose providers that offer a bundle of services (surgery, chronic disease management) at a lower cost should share in the savings	Legislative
For Medigap, allow variations in co-pays based on evidence (e.g., allow tiered co-pays for providers and services based on evidence of quality and efficiency), and support a redesign of incentives for Medigap plan choice that reflect their overall Medicare cost impact	Legislative
3. Provide clarification or loosen restrictions around ACA reforms, and existing laws and regulations, which may impede health plans from adopting these value-based design options	
For exchange-based plans, assure that Medical Loss Ratio (MLR) requirements do not discourage health plans from implementing non-traditional benefit designs and services that encourage and support consumer use of higher-quality, lower-cost care. For example, costs of developing better evidence for services where the risks and benefits for particular patients are unclear, costs of implementing value-based insurance designs, and costs of providing information to patients to support decision-making should be considered "medical" costs under the MLR requirements	Administrative
4. Develop and expand demand-side wellness incentives, including premium rebates, to encourage all beneficiaries to undertake measurable health and risk-factor improvements. Doing so includes building incentives with risk adjustment so that all beneficiaries have a meaningful opportunity to participate and save, regardless of health status	

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