Report on panel about identifying high- and low-value services

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Summary points from panel

- Value of a service depends on who gets it and its price
- Use an open, transparent process to identify high- and low-value services
- Align beneficiary and provider incentives
- Medical management should work in concert with benefit design
- Beneficiaries will be more open to benefit changes if presented with choices

Panelists had a range of perspectives

- Eleven participants included academics, employers, benefit consultants, and representatives from health plans
- Panel included 5 physicians, 1 nurse, 2 pharmacists, and a consumer advocate
- All had experience designing, implementing, or evaluating benefits that take value into account

Panel used multiple approaches to identify service value

- Services that are beneficial or harmful to patients
- Services that are used in ways that support or go beyond clinical evidence
- Services that cost more or less than comparable services
- Services with high marginal cost relative to health benefit gains

Value of a service depends on who gets it and how it is priced

- Importance of targeting incentives to the subpopulation that can most benefit from the service
  - Can cost sharing be based on diagnosis?
  - Implicates both equity issues and technical issues
- Low value may be a function of mispricing
- Benefit design should be aligned with coverage and payment policies

A process to value services should:

- Be open and transparent
- Be based on a set of guiding principles
- Be evidence-based
- Begin with a determination of who will make decisions and what the burden of proof should be
- Set priorities

Align beneficiary and provider incentives

- Provider incentives should reflect the value of services provided to beneficiaries
- Medicare supplemental policies also must be aligned with benefit changes
- Some panelists suggested that private payer incentives should also be aligned
- Medical management should work in concert with benefit design

Panelists suggested different ways to begin a benefit reform process

- Start with services that harm patients, then those that provide little or no benefit
- Start by evaluating services that cost the program the most money
- Start with Part D because beneficiaries are used to tiered copayments
- Focus on tiering efficient, high-quality providers
- Start with new services

The panel discussed “graded benefits”

- Could develop a new Medicare option based on value in addition to the FFS benefit
- Option could apply to new Medicare beneficiaries
- Beneficiaries who chose the graded benefit might have a lower Part B premium and opportunities for lower cost-sharing

Panel said benefit reform is more acceptable if beneficiaries have a choice

- Should enrollment use an opt in or opt out model?
- Should beneficiaries receive penalties for not choosing the new design or rewards for choosing it? A combination?
- Should the choice be annual or one time only?

Beneficiaries and providers must be engaged in the reform process

- Active involvement of stakeholders in process
- Some panelists suggested use of “value” implies lower quality to beneficiaries
- Avoid too much complexity in benefit design
- Education on risk of low-value services

Summary of issues discussed by panel

- Level of value assessment
  - Service
  - Provider
  - Plan
- Design features
  - Beneficiary choice
  - Medical management
  - Penalties and rewards
  - Locus of decision-making (local or national)