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Value-Based Insurance Design Viability in the Illinois Exchange

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I. INTRODUCTION

State health insurance exchanges are a core, yet controversial, element of healthcare reform and have been at the forefront of both political and policy debates since the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010. States that run their own exchanges or partnership exchanges jointly with the federal government have a degree of latitude in the design and implementation of their exchanges.[1] As a result, state exchanges have the opportunity to be test sites for various insurance policy reform efforts.[2]

This article argues that the state of Illinois and Illinois insurance companies should incorporate elements of value-based insurance design (VBID) into the state exchange as well as Medicaid expansion. Part II provides background information on VBID and the potential benefits of its implementation. Part III provides an overview of the state exchange and Medicaid expansion in Illinois. Part IV argues why VBID should be adopted as part of Illinois health reform efforts and Part V outlines possible methods by which this may be accomplished.

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1. STAFF OF H.R. COMM. ON THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY 97TH CONG., REP: FINDINGS OF THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY COMMITTEE 7 (COMM. PRINT 2011), *available at* http://cgfa.ilga.gov/Upload/FindingsOfILLegisHealthInsuranceExchangeStudyCommitteeSB1555.pdf.

2. *See id.* at 17 (describing "the issues regarding the implementation and establishment of a health benefits exchange for the State of Illinois.").

II. VBID AND POTENTIAL BENEFITS OF IMPLEMENTATION

VBID seeks to "align patients' out-of-pocket costs, such as copays and deductibles, with the value of health services" in an effort to improve health outcomes while simultaneously lowering healthcare costs.[3] In a broad sense, VBID aims to increase the usage of "high-value" medications and medical procedures, such as insulin and statins, which provide substantial clinical benefits relative to costs.[4] These efforts often target chronic diseases to reduce the probability of adverse events in the future that are significantly more expensive than the cost of prevention-related services and medications.[5] A simple example to illustrate this concept is when an insurance policy eliminates copayments on a heart medication in order to induce the beneficiary to comply with its treatment program, and therefore avoid a heart attack and a costly trip to the emergency room.[6]

VBID relies on two main principles. The first is that patients should not be discouraged through cost sharing for taking advantage of cost-effective care that can significantly improve their health.[7] The second is that value in health care should be signaled to consumers.[8] For example, non-cost effective care such as name-brand prescription drugs or unnecessary procedures should be eliminated from benefits packages or have increased cost sharing.

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3. *Value-Based Insurance Design can drive innovation in Health Insurance Exchanges*, UNIV. OF MICH. CTR. FOR VALUE-BASED INS. DESIGN 1, *available at* https://www.statereforum.org/system/files/principles_for_vbid_in_exchanges_final.pdf (last visited Sept. 27, 2014) [hereinafter *Value-Based Insurance Design*].

4. Michael E. Chernew et al., *Evidence that Value-Based Insurance can be Effective*, 29 HEALTH AFF. 530, 530 (2010).

5. *Id.* at 531.

6. Niteesh K.Choudhry, et al. *Full Coverage For Preventive Medications After Myocardial Infarction*. 365 NEW ENG. J. MED., 2088, 2096 (2011) (finding that the elimination of copayments for statins, beta-blockers and other common heart medication increased medication adherence and reduced the rates of first major vascular events and total major vascular events or revascularization).

7. Sarah Thomson et al., *Value-Based Cost Sharing in the United States and Elsewhere can Increase Patients' Use of High-Value Goods and Services*, 32 HEALTH AFF. 704, 704 (2013) (cost sharing refers to the share of costs covered under an insurance policy that the patient pays out-of-pocket, including deductibles, coinsurance and copayments).

8. *Id.*

Existing VBID plans have sought to achieve these aims in different ways. One method is to base reduced cost sharing on clinical criteria.[9] Under this approach, patients suffering from specific conditions would be targeted for reduced copayments. [10] For instance, diabetics would receive free secondary prevention treatment such as eye and foot exams.[11] Alternatively, some plans have eliminated copayments on drugs that treat common chronic conditions such as hypertension.[12] Another structure in which VBID may be utilized is through the use of copayment tiers based on value that is similar to copayment tiers that are tied to the cost of prescription drugs (generic, preferred name-brand, name-brand).[13]

While the cost-effectiveness of treatment may be achieved through the implementation of VBID principles, cost savings through VBID are the ultimate goal for employers and insurers.[14] This issue will be further addressed below.

III. LANDSCAPE OF THE ILLINOIS EXCHANGE AND MEDICAID EXPANSION

Illinois currently has a partnership-exchange, referred to as the Illinois Health Benefits Exchange, which is jointly run by the state and federal government.[15] Illinois plans to transition to a fully state-run exchange in 2015.[16] The Illinois Health Benefits Exchange law created the exchange in

9. Niteesh K. Choudhry et al., *Assessing the Evidence for Value-Based Insurance Design*, 29 HEALTH AFF. 1988, 1990 (2010) (noting that clinical criteria may mean a triggering event, for example a patient who has suffered a myocardial infarction).

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.* (describing an insurance plan where copayments for medications used to treat chronic conditions were reduced by 100 percent for generic, 50 percent for preferred name-brand, and 25 percent for name-brand).

14. Chernew et al., *supra* note 4, at 531.

15. *State Marketplace Profiles: Illinois*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/health-reform/state-profile/state-exchange-profiles-illinois (last updated Oct. 15, 2013).

16. *Id.* (positing that state–run exchanges give the state more flexibility and control in deciding what insurers may participate, designing plan benefits, and performing local outreach and promotion).

2011, which functions as a marketplace for individuals and businesses with fewer than fifty employees.[17] One of the hallmarks of the PPACA is that in order for a health insurance plan to be adequate and able to be sold on the exchange it must provide a minimum set of "essential health benefits" that each state may tailor to its specific goals.[18] Illinois chose the BlueCross BlueShield of Illinois BlueAdvantage small group plan as its essential health benefits benchmark.[19]

Health Care Service Corporation, the owner of Blue Cross Blue Shield of Illinois, is the largest health carrier in Illinois and has 49% of the total market share for health insurance, representing the second highest level of market concentration among the ten largest states.[20] As of 2011, it was estimated that 52% of Illinoisans were covered by employer-sponsored insurance, 4% by the individual market, 20% by Medicaid, 12% by Medicare and other public programs, and 12% were uninsured.[21] The most important factors Illinois residents consider in selecting an insurance plan are out-of-pocket costs (copayments, deductibles, and premiums), accessibility of providers in network, and coverage of prescription drugs.[22] The regulatory framework for new insurance carrier entrants into the Illinois health insurance market-

17. Illinois Health Benefits Exchange Law, 215 ILL. COMP. STAT. 122/5-5 (2011).

18. 42 U.S.C. § 18022 ("Essential health benefits" are the federally mandated package of items and services required of insurance plans for minimum coverage and include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).

19. *State Marketplace Profiles: Illinois*, *supra* note 15 (noting that this is a relatively lean plan, covering Illinois-mandated services such as treatment for autism and infertility but imposing, for example, a $1,000 annual limit on chiropractic care as well as offering no coverage for vision or hearing exams for adults).

20. DELOITTE, REVIEW OF THE CURRENT ILLINOIS HEALTH COVERAGE MARKETPLACE: BACKGROUND RESEARCH REPORT 7 (2011), *available at* http://insurance.illinois.gov/hiric/resources/ILBackgrounResearchFinalReport_September2011.pdf (noting that Illinois has a high market concentration for health insurance: the top two carriers in the state have 63% of the total membership).

21. *Id.* at 5.

22. *Id.* at 52.

place presents no unusual barriers to entry when compared to other states.[23]

Presently, Illinois has not determined the structure and organization of its state-run exchange; however, other states follow either the "market organizer" or "market developer" models.[24] Illinois legislators will face a choice whether to be hands-off and let market forces dominate the organization of the insurance plans on the exchange or take a more active role by regulating and developing the various plans.[25] The Illinois Health Benefits Exchange Legislative Study Committee has identified the following goals for the exchange: the exchange should encourage competition among health insurers, seek enhanced value of health insurance products, and encourage insurers to make their best products available.[26] Further, the exchange should strive to gain volume in order to be more attractive to health insurers and encourage competition in order to reduce the demand for government intervention.[27]

Finally, the improved health insurance environment fostered by the exchange should make Illinois more attractive to employers and the authorizing legislation to create an exchange in Illinois should provide control over plan certification so that plan design on the exchange is not cabined by federal requirements.[28] All of these goals for the Illinois health insurance marketplace have potential ramifications for the introduction of VBID principles into the exchange. Furthermore, the Illinois Department of Insurance has announced that ten insurance carriers have applied to offer 504 new Qualified Health Plans in 2015 that meet the state's essential health benefits

23. *Id.* at 82 (stating that the licensing and HMO approval process is not excessively burdensome, product approval and rate review does not significantly limit the attractiveness of the Illinois marketplace, and that consumer protections, rating and underwriting restrictions are consistent with those in other states).

24. STAFF OF H.R. COMM. ON THE ILLINOIS LEGISLATIVE HEALTH INSURANCE EXCHANGE STUDY, *supra* note 1, at 7-8 (In a market organizer model the exchange would have no role in bargaining with insurers or otherwise attempting to influence the insurance market whereas in a market developer model the exchange would pursue competitive plans, leveraging its power to ensure the "best" deal for consumers).

25. *Id*. at 8.

26. *Id*. at 9-10.

27. *Id*.

28. *Id*.

requirement through the exchange.[29]

Illinois further expanded its Medicaid program to include "PPACA adults" in 2014.[30] Numerous statutory changes made within the past few years affect the Illinois Medicaid program, including legislation requiring that at least half of Medicaid recipients be enrolled in risk-based, coordinated care systems by 2015.[31] Additionally, a number of federal grants were awarded to Illinois to fund efforts to improve the delivery of Medicaid services.[32] Furthermore, in March of 2014 Illinois submitted a Medicaid 1115 waiver request, called *Path to Transformation*, to the Centers for Medicare and Medicaid Services (CMS) for approval.[33] If approved, the 1115 waiver authorizes a demonstration or pilot program for various Medicaid reform initiatives.[34] It may be possible for Illinois to incorporate VBID principles within this framework of reform because such waiver allows the state to receive matching federal funds for spending that is not currently allowed un-

29. Press Release, State of Ill. Dept. of Ins., DOI Announces Ten Issuers Apply to Offer 504 Qualified Health Plans for Year Two of Illinois Health Insurance Marketplace (June 12, 2014), *available at* http://www3.illinois.gov/pressreleases/ShowPressRelease.cfm?SubjectID=2&RecNum=12330 (a Qualified Health Plan is a plan that meets the federally mandated essential health benefits plus any other minimum benefits required by the Illinois exchange).

30. Illinois Medicaid Moving Forward in 2014, MEDICAID.GOV, http://www.medicaid.gov/medicaid-chip-program-information/by-state/illinois.html (last visited Oct. 22, 2014) (describing "PPACA adults" as those low-income, healthy adults who now qualify for Medicaid outside of the traditional categories as a result of the PPACA Medicaid expansion).

31. *Illinois Alliance for Health Innovation Plan*, ALLIANCE FOR HEALTH 1 (Dec. 30, 2013), *available at* http://www2.illinois.gov/gov/healthcarereform/Documents/Alliance/Alliance%20011614.pdf (describing a "risk-based coordinated care system" as an integrated delivery system consisting of a broad network of providers including primary care physicians, behavioral health professionals, and long-term care facilities, amongst others, linked by a redesigned payment structure to support clinical integration between those providers by basing reimbursement on population health).

32. *Id.* (including a $2 million six-month planning grant from the Center for Medicare and Medicaid Innovation intended to help Illinois achieve the "triple aim" of improved health status, improved efficiency of clinical care, and cost reduction of care).

33. *FAQ on 1115 Waiver Application*, ILL. GOVERNOR'S OFFICE OF HEALTH INNOVATION & TRANSFORMATION 1, http://www2.illinois.gov/gov/healthcarereform/Documents/GOHIT/FINAL%20FAQs%20about%20the%201115%20Waiver%20Application.pdf (last visited Sep. 26, 2014).

34. *Id.*

der the Medicaid rules.[35]

IV. VBID SHOULD BE ADOPTED IN ILLINOIS HEALTHCARE REFORM EFFORTS

One significant reason for Illinois and insurance companies within the state to experiment with VBID is that it is particularly well suited to the management of chronic conditions.[36] Chronic diseases like heart disease, cancer, stroke, and diabetes are responsible for seven out of ten deaths every year and account for 75% of healthcare spending in the United States.[37] Around half of all American adults have one or more chronic health conditions and one in four adults have two or more chronic health conditions.[38] Additionally, more than one third of adults were characterized as obese in 2010.[39] Chronic conditions are the "most common, costly, and preventable of all health problems,"[40] and therefore implementing VBID to better manage chronic conditions makes clinical and economic sense.

Behavioral economics research has shown, however, that consumers of health care are not adept at making decisions that pit present expenditures against future catastrophic medical problems.[41] The inability to make efficient health care choices is further exacerbated by the daunting complexity of modern health insurance, where even a simple explanation of benefits contains many terms and policies with which a broad swath of consumers are unfamiliar and have no frame of reference for comparison or understanding. This is deeply problematic because management of chronic condi-

35. *Id.*

36. Chernew et al., *supra* note 4, at 531.

37. *The Affordable Care Act's Prevention and Public Health Fund in Your State*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/healthcare/facts/bystate/publichealth/ppht-map.html (last updated Feb. 14, 2012).

38. *Chronic Disease Prevention and Health Promotion*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/chronicdisease/overview/index.htm (last updated May 9, 2014).

39. *Id.*

40. *Id.*

41. Daniel Young, *Curing What Ails Us: How the Lessons of Behavioral Economics Can Improve Health Care Markets*, 30 YALE L. & POL'Y REV. 461, 469 (2012).

tions falls largely on the choices of patients to seek initial treatment or to comply with their current treatment plans.[42] Behavioral health experts have suggested that simplifying the process of purchasing insurance on state exchanges and offering comprehendible, "apples to apples" comparisons may improve the efficiency of the consumer's health care choices by directing them toward plans with benefits they require.[43] This concept coincides with the "signaling" principle of VBID, which proposes that the value of a treatment should be made apparent to consumers so that they can distinguish high-value from low-value care.[44] An example is the use of reference pricing, where an insurer sets a maximum reimbursement, the reference price, for a cluster of similar drugs and the patient pays the difference if they choose a drug above the reference price.[45] As a result, consumers are steered toward lower cost substitutes. Similarly, if health insurance plans incorporated VBID principles such as providing benefit incentives to individuals to better manage their chronic conditions, it may lead consumers to purchase those plans, resulting not only in improved health outcomes but cost savings as well.[46]

In addition to its promising application for the improved management of costly chronic conditions, Illinois insurance companies should consider VBID because it has been successfully implemented in a number of test settings and shown benefits to insurers in certain circumstances.[47] Test settings for VBID have largely been in the commercial sector, where private insurers such as Blue Cross and Blue Shield, Aetna, and United Healthcare have

42. Chernew et al., *supra* note 5, at 530.
43. Young, *supra* note 41, at 495.
44. Thomson et al., *supra* note 7, at 704.
45. *Id*. at 706.
46. Chernew et al., *supra* note 5, at 531.
47. *See* Michael E. Chernew et al., *Implementing Value Based Insurance Design in the Medicare Advantage Program*, VBID HEALTH 6-7 (May 2013), *available at* http://www.vbidhealth.com/docs/ImplementingVBIDintheMedicareAdvantageProgram_May2013.pdf.

been at the forefront of value-based experimentation.[48] Blue Cross Blue Shield of North Carolina experienced increased adherence to diabetes control medications when it eliminated or reduced copayments for both generic and brand name drugs.[49] Also, United Healthcare and Aetna used condition-specific programs to target patients with chronic conditions and experienced positive results.[50] The Oregon Public Employees' Benefit Board is another example of the successful integration of VBID principles into a benefit program.[51] The Board coupled reduced cost sharing for chronic disease management and preventive services with increased cost sharing for "over-used or preference-sensitive services of low value," and saw more favorable usage rates for the procedures they targeted.[52]

A comprehensive example of an entity successfully utilizing VBID is the Connecticut Health Enhancement Program (HEP) for state employees.[53] Launched in 2011, the HEP "incorporates clinically-nuanced elements of VBID, eliminating barriers to specified evidence-based clinical services based on beneficiary demographics and medical history."[54] The marriage of accountability and incentives for participants has proved promising as monthly primary care visits have increased, specialty care visits have decreased, and monthly emergency room visits have fallen.[55] These results, if repeatable in the Illinois market, offer evidence that VBID can be a viable

48. Thomson et al., *supra* note 7, at 708.

49. Chernew et al., *supra* note 47, at 6.

50. *Id.* at 6 (citing increased adherence to evidence based guidelines, improved clinical outcomes, and decreased disease-specific spending for patients with asthma and heart disease).

51. *Id.*

52. *Id.* at 6-7 (including elective surgery for back pain, arthroscopies, and advanced imaging as examples of over-used or preference-sensitive services).

53. *V-Bid in Action: A Profile of Connecticut's Health Enhancement Program*, UNIV. OF MICH. CTR. FOR VALUE-BASED INS. DESIGN, 1 (Jan. 2013), *available at* http://www.shadac.org/files/shadac/publications/V-BID%20brief_CT%20HEP%20final.pdf.

54. *Id.*

55. *Id.* at 2 (reporting that after the implementation of this program monthly primary care visits have increased from about 12,000 to about 21,000, monthly specialty care visits have decreased from about 24,000 to about 19,000 and emergency room visits have fallen from about 3,500 to 2,700).

element of health insurance plans.

Overall, the possibility of VBID to improve clinical outcomes, reducing costs for chronic conditions, and its successful implementation in test settings support the contention that Illinois and insurance companies within the state should incorporate VBID principles through the state Exchange.

V. HOW ELEMENTS OF VBID MAY BE IMPLEMENTED IN ILLINOIS

A confluence of factors support the notion that the best time to implement VBID in the Illinois Health Benefit Exchange is now. A study by Mercer in 2010 showed that 81% of large employers plan to incorporate VBID into their employee benefit plans in the near future.[56] Furthermore, one third of U.S. employers plan to move their workers to a private exchange in the next few years.[57]

The best time to introduce innovation into a system is when it is in flux, as is the current health insurance market in Illinois. From a challenge to the status quo emerges the opportunity for innovation that may not have been previously possible and the potential to benefit payers who take advantage of the changing health insurance structure. As a result of the planned expansion of the Illinois exchange, the state and Illinois insurance companies have a window to apply VBID principles, thereby adding value to the system. For example, incorporating a "signaling" function into the exchange may, through consumer choice, synchronize insurance design and patient needs in a manner impossible before the exchange, creating a more efficient healthcare system. According to the University of Michigan Center for Value-Based Insurance Design (the Center), VBID can add value to state exchanges by "encourag[ing] smarter health care spending in order to provide

56. *Value-Based Insurance Design*, *supra* note 3.

57. Caroline Chen, *Employers Turn to Private Health Exchanges to Cut Costs*, BLOOMBERG (Feb. 19, 2014), http://www.bloomberg.com/news/2014-02-19/employers-turning-to-private-health-exchange-to-cut-costs.html (noting that private exchanges are health insurance marketplaces geared more towards large employers who contract with the insurers on the exchange who then offer a limited range of options to employees).

comprehensive health benefits at lower cost, promot[ing] access to needed services and higher quality of care, and increas[ing] the capacity to integrate new clinical evidence and standards by providing appropriate incentives."[58]

To accomplish these ends, the Center recommends that states like Illinois avoid over-prescriptive cost-sharing rules, maintain flexibility and limit mandates in benefit designs, and ensure that quality ratings for health plans incorporate value-based principles.[59] These principles can be broken down into more concrete suggestions. For example, tying copayments to clinical value will encourage providers to adhere to best practices and promote the use of high value services.[60] Also, because VBID plans tend to increase the use of high-value services due to lower up-front cost, actuarial values may be higher than usual.[61] Therefore, the exchange should be wary of mandating too many benefits in order to prevent "pricing out" VBID plans from the bronze and silver tier due to high actuarial value.[62] Furthermore, the quality rating tools on the exchange website should inform consumers of the potential benefits of VBID plans.[63]

Within the next year, Illinois will make a decision as to which model of state-run exchange it wants to implement when it fully takes over operation of the exchange from the federal government.[64] This will be an opportune time to open the exchange to plans that incorporate VBID principles and encourage private insurance companies to experiment with value-based policies. Although empirical studies show the efficiency of VBID plans, the

58. *Value-Based Insurance Design*, *supra* note 3.
59. *Id.* at 1-2.
60. *Id.* at 1.
61. *Id.* at 2 (defining the actuarial value of a health insurance plan as the percentage of total average costs for covered benefits that the plan will pay for). *See also*, Actuarial Value, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/actuarial-value/ (last visited Oct. 22, 2014).
62. *Value-Based Insurance Design*, *supra* note 3 (describing "pricing out" as a plan paying for too large a percentage of the covered benefits vis a vis the beneficiary. Actuarial value under PPACA is set at 60% of costs for a bronze plan and 70% for a silver plan.).
63. *Id.*
64. *State Marketplace Profiles: Illinois*, *supra* note 15.

gains may not be visible in the short term and administrative costs can be high, possibly discouraging insurers and employers from utilizing VBID.[65] Additionally, VBID programs may need to be in effect for several years to achieve cost savings and/or specifically target high-risk populations or groups for whom cost is an important aspect of health care consumption.[66] Given this uncertainty, while VBID may pay off for private insurers over time, the profit-seeking nature of the commercial sector may make it more efficacious for Illinois to incorporate VBID into its Medicaid expansion effort.

Currently, the Illinois Alliance for Health, a group composed of health policy makers, health care providers, insurers, payers, public health professionals, small and large businesses, and community development advocates, has received a substantial federal grant to develop an Innovation Plan to improve Medicaid services in Illinois.[67] Two primary components of the plan are "building a Medicaid Innovation Model that has consumer empowerment at its core" and "redefining roles and responsibilities for all providers, plans, and payers."[68] The integration of VBID into Illinois Medicaid reform has the potential to help achieve these goals.

Although Medicaid is not an insurance plan sold on the exchange, the exchange is the point of entry for new Medicaid enrollees.[69] Illinois' 1115 waiver offers the opportunity to use Medicaid as a testing ground for elements of VBID. The waiver would allow Illinois much more latitude in designing its Medicaid benefits.[70] Medicaid offers an interesting alternative to commercial insurers. For instance, Medicaid has a ready-made pool of high-

65. Thomson et al., *supra* note 7, at 709.

66. Matthew L. Maciejewski et al., *Value-Based Insurance Design Program in North Carolina Increased Medication Adherence but was Not Cost Neutral*, 33 HEALTH AFF. 300, 306 (2010).

67. *Illinois Alliance for Health Innovation Plan*, *supra* note 31.

68. *Id.* at 3.

69. *State Marketplace Profiles: Illinois*, *supra* note 15.

70. *FAQ on 1115 Waiver Application*, *supra* note 33, at 1.

risk populations and populations for who cost may limit health care consumption. Furthermore, certain Medicaid beneficiaries may be more likely to remain on Medicaid than employees on private insurance plans who may frequently change jobs and therefore insurance plans.[71] Incorporating VBID into Medicaid expansion would allow the positive effects of VBID to be observed over a longer period of time.

VI. CONCLUSION

As a result of the PPACA, state health insurance exchanges have the opportunity to be test sites for various insurance policy reform efforts. The emphasis VBID places on the increased use of high-value services and medications makes it a policy proposal that has the potential to both lower costs and improve clinical outcomes, particularly in the area of chronic disease management. Therefore, Illinois and insurance companies within the state should incorporate elements of VBID into the state exchange as well as Medicaid expansion. The state and private insurance companies can look to successful VBID-based programs around the country for direction in implementing similar policies in Illinois. Illinois' shift to a state-run exchange allows it greater latitude in promoting VBID principles and in working with insurers to provide plans that incorporate those principles. VBID has strong proponents in the academic and policy arenas in part because it makes so much sense in theory yet has not been widely-enough implemented to come into disfavor. If Illinois adopts VBID in its state exchange either through private insurers or Medicaid expansion, there is not only the possibility that health care costs will fall and clinical outcomes improve, there is the potential for Illinois to emerge as a national leader in health care reform policy.

71. *See* Choudhry et al., *supra* note 9, at 1993.