

Value-based Insurance Design Implementations in the Public Sector

The California Public Employees' Retirement System (CalPERS) staff reviewed a variety of Value-Based Insurance Design (VBID) implementations in other states to determine if these VBID approaches would be suitable for CalPERS' member population. The following sections describe the approaches and preliminary outcomes experienced by some of the states evaluated.

Also included below is a description of the Centers for Medicare and Medicaid (CMS) Medicare Advantage VBID Model. The results from testing these new payment and service delivery models in other states might also prove useful to determine if VBID approaches could be applied to CalPERS Medicare health plans.

Connecticut

In 2011, the State of Connecticut implemented the Health Enhancement Program (HEP), which is a value-based insurance design-inspired health plan for its state employees. HEP enrollees pay lower premiums and lower out-of-pocket costs at the point of service than beneficiaries who do not elect to participate.

Plan incentives and requirements

The program provides a number of requirements and incentives to participate¹²³:

- Exemption from a health insurance premium surcharge imposed on non-enrollees (savings of \$100 per month)
- No deductibles (potential annual savings of \$350 per person, up to \$1,400 per family)
- Reduction or elimination of copayments for medication associated with the management of chronic medical conditions (savings of up to \$25 per prescription fill)
- Copayments for diabetes drugs are waived. Copayments for cholesterol, blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder medications are tiered at \$0 / \$5 / \$12.50 (generic/preferred brand/other brand) versus \$5 / \$10 / \$25 for non-HEP enrollees.
- Elimination of copayments for office visits for chronic conditions (savings of \$15 per visit)
- Incentive payments of \$100 annually if a member with a targeted chronic condition, including his/her dependents, complies with all of the HEP requirements in a given year.
- A \$35 copayment for emergency department visits when there is a reasonable medical alternative and the member is not admitted to the hospital.

Noncompliant members would be given notice to fulfill requirements to improve and those that do not comply would be reviewed by a committee, which also developed an appeals process

Outcomes

In the first year, approximately 98 percent of the 54,000 eligible Connecticut state employees and retirees voluntarily enrolled in HEP. After 15 months of follow-up, the Connecticut Office of the

¹ State of Connecticut Health Enhancement Program.

<http://www.osc.ct.gov/empret/healthin/2011hcplan/HEPprogress/hepindex.htm>

² *Evidence, Examples, and Insight on Value-Based Insurance Design*. University of Michigan V-BID Center Brief. https://www.calpers.ca.gov/docs/board-agendas/201607/full/day2/6.8V-BID-brief_CT-HEP-finalBackgroundInfo2.pdf

³ Patient-Centered Primary Care Collaborative. *Connecticut Health Enhancement Program (HEP): Statewide*. <https://www.pcpcc.org/initiative/connecticut-health-enhancement-program-hep>

Comptroller estimates that more than 99 percent of enrollees had met program expectations by complying with program requirements.

A 2016 study in Health Affairs⁴ found that utilization of preventive services increased substantially in the first year in relation to a comparison group of state government employees located in the eastern United States. This effect in the second year was higher than baseline but moderated possibly due to the nature of certain procedures that are not required annually or program cost-sharing shifts related to Affordable Care Act requirements. There was also a significant decrease in the total number of emergency department visits without a resulting hospital admission in both years. Total spending increased in year one and two compared to the comparison group, but the authors of the research paper suggest that this effect is partially explained by differential rates of price increases between Connecticut and comparison states and they ultimately concluded that the program's impact on costs is inconclusive and requires a longer follow-up period.

Oregon

The Oregon Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board provide health benefits to Oregon state employees and collaborated in 2010 to incorporate VBID strategies in their health program⁵. The plans increase copayments for overused or preference-sensitive services of low relative value and cover preventive and high-value services at low or no cost.

Plan incentives and requirements

Beginning with the 2011 plan year, services were tiered based on their value:

- Tier 1: no or low copays for preventive and high value services, such as:
 - tobacco cessation
 - weight management
 - value medications for chronic conditions (e.g., cardiac, high blood pressure, diabetes and asthma),
 - labs and x-rays
- Tier 2: \$100 co-pays for standard services, such as:
 - advanced imaging
 - sleep studies
 - bunionectomy
- Tier 3: \$500 co-pays for member preference or supply-sensitive and low value services, such as:
 - spinal procedures
 - bariatric surgery
 - shoulder and knee arthroscopy
 - hip and knee replacement

⁴ Hirth, Richard A. *Connecticut's Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence*. Health Affairs 35, no.4 (2016). <http://content.healthaffairs.org/content/35/4/637.full.pdf+html>.

⁵ Kapowich, Joan M. *Oregon's Test Of Value-Based Insurance Design In Coverage For State Workers*. Health Affairs 29, no.11 (2010). <http://content.healthaffairs.org/content/29/11/2028.full.pdf+html>.

These design elements have been refined over the years and now include variation in copay and coinsurance based on the value of a variety of services.⁶ In addition, members must participate in age-appropriate preventative services or participate in a disease management program if they have a chronic disease condition. If members do not participate, they must pay a \$100 per month premium share. New employees who have used tobacco in the 12 months prior to enrollment have higher premium rates and members who use tobacco have \$25 deducted monthly from their paychecks until they quit to offset the known risks for health care costs.

Outcomes

PEBB have reported decreases in obesity and tobacco use, and improved screening of colorectal cancer, cholesterol, blood pressure and diabetes. Additionally, imaging, sleep studies and other low value services decreased.⁷

Medicare Advantage VBID Model

The CMS Center for Medicare and Medicaid Innovation (CMMI) is testing various value-based insurance design strategies for Medicare Advantage plans in 7 states in 2017 (Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee), expanding to three more states in 2018 (Alabama, Michigan, and Texas).⁸

The strategies target populations with chronic conditions such as diabetes, chronic obstructive pulmonary disease, congestive heart failure, past stroke, hypertension, coronary artery disease, mood disorders and, starting in 2018, rheumatoid arthritis and dementia.

Participating plans may select one or more of the following approaches:

- Reduced cost-sharing for high-value services
- Reduced cost-sharing for high-value providers
- Reduced cost-sharing for enrollees participating in disease management or related programs
- Coverage of additional supplemental benefits, such as supplemental tobacco cessation assistance for enrollees with chronic obstructive pulmonary disease

⁶ PEBB Statewide Plan 2016 Benefit Summary.

<https://healthplans.providence.org/~media/Files/Providence%20HP/pdfs/pebb/Documents/2016/benefit%20summary/PEBB%20Statewide.pdf>.

⁷ Oregon Health Leadership Council. *Value-Based Benefits*.

<http://www.orhealthleadershipcouncil.org/value-based-benefits>.

⁸ Medicare Advantage Value-Base Insurance Design Model. <https://innovation.cms.gov/initiatives/VBID>.