Value Based Insurance Design

Connecticut's Experience

January 18, 2017

Early discussions around Accountable Care in CT

- Negotiating performance and outcome measures
- Physician concerns around patient engagement
- Utilizing member-specific data to inform the design process

Discussions at Health Care Cost Containment Committee (HCCCC)

- Physician concerns brought to HCCCC regarding member engagement
- Exploration led to VBID as one way to engage members in their healthcare
- VBID always seen as a complement to Accountable Care Contractors with providers

HOW WE GOT HERE

- **Catalyst:**
  - » $3.8 billion budget deficit in FY 2011
  - » Unions proposed a value-based insurance design to achieve savings and improve the health of their members and their dependents


AMERICA'S OLDEST CONTINUOUSLY PUBLISHED NEWSPAPER

Hartford Courant

FISCAL TROUBLES

$3.8B DEFICIT

What is Value Based Insurance Design (VBID)?

Health plan benefit designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers

Example: plan designs that lower or eliminate the cost of medications to control diabetes to increase adherence and reduce the need for future expensive medical procedures

Data Driven Design

Analysis of State of CT member claims data *(measured against state and national benchmarks)* revealed:

- Underutilization of age-specific preventive screenings
  - *Colorectal screenings*
  - *Physicals*
  - *Cancer screenings*
- Underutilization of PCPs
- Over utilization of specialists

Accountable Care and *Value Based Insurance Design (VBID)*

The State of Connecticut Health enhancement Program (HEP) was a compromise between the employer's proposals to shift costs and the union coalition's proposals to restrain costs by increasing use of services that had "value".

VBID's main premise is to promote value over volume

HEALTH ENHANCEMENT PROGRAM

- **Targets preventive care and chronic disease through:**
  - » Voluntary enrollment for employees
  - » Required age appropriate preventive screenings and care
  - » Lower co-pays for medication/care associated with five chronic diseases and conditions
  - » Chronic disease management education program
- **Lowers costs for participating/compliant employees by:**
  - » Waiving co-pays for preventive care and chronic disease management
  - » Reducing monthly premium share ($100 per month)
  - » Waiving annual deductible ($350 individual, $1,400 family)

CHRONIC DISEASE MANAGEMENT

- Targets five chronic diseases: Asthma, COPD, diabetes, hypertension, hyperlipidimia
- Lower co-pays for medications used for target chronic conditions

	HEP Chronic Condition Drugs	Standard Drugs	
Generic	$0	$5	*All Diabetes drugs have a $0 co-pay
Preferred	$5	$20	
Non-Preferred	$12.50	$35	

- No co-pays for office visits related to chronic conditions
- Chronic Disease Education Program:
  - » Administered by third party vendor with dedicated staff of RNs
  - » Participant engagement monitored
    - Compliance with HEP program contingent upon minimum level of engagement
    - Engaged members eligible for $100 annual bonus payment

2015 HEP Requirements

MORE INFO: www.CTHEP.com | 877.687.1448

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 3 years	Every 2 years	Every year
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT

*Dental cleanings are required for family members who are participating in one of the state dental plans

**Or as recommended by your physician

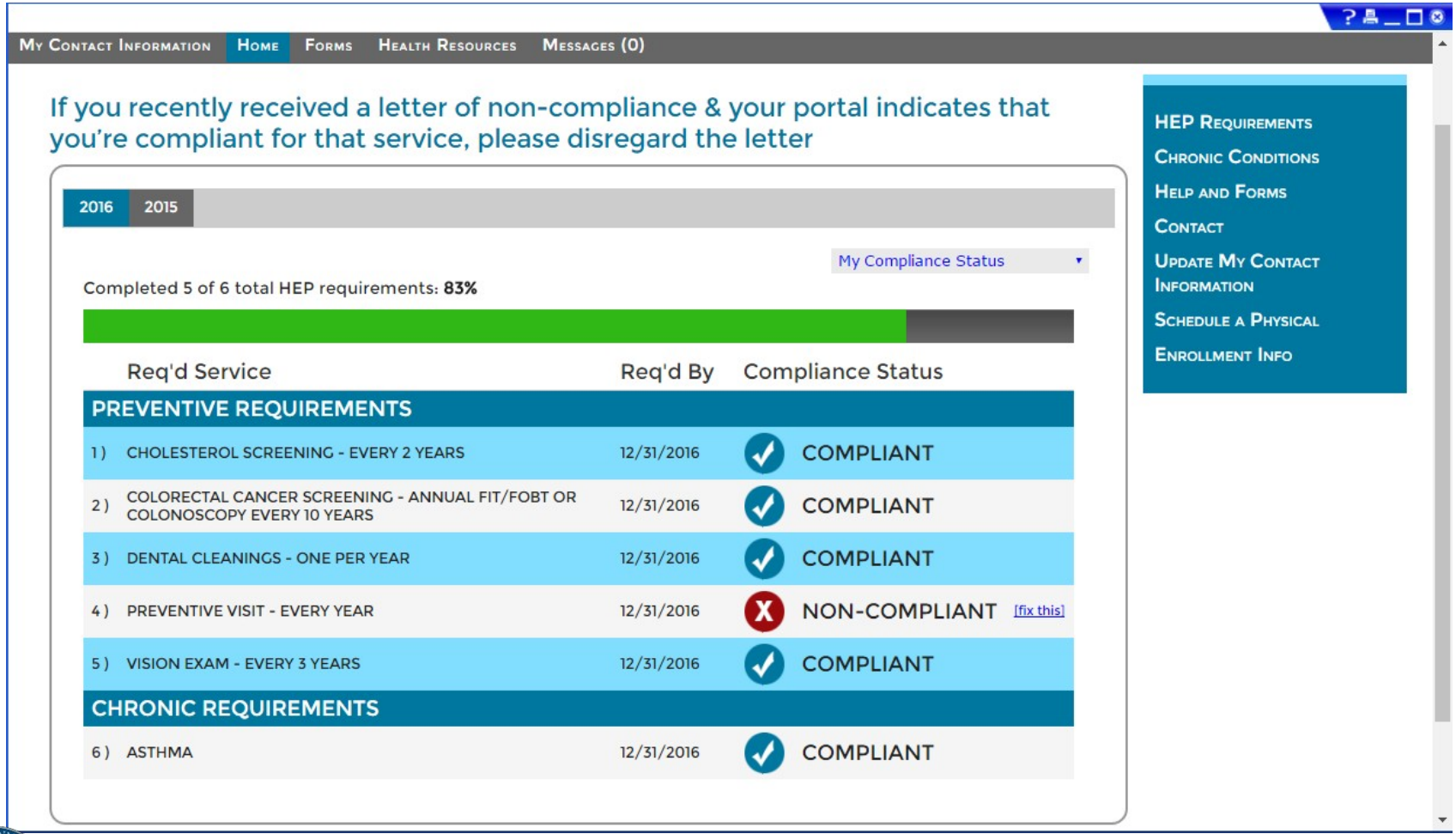
For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant.
As is currently the case under your state health plan, any medical decisions will continue to be made by you and your physician.

Communication is key!

The State of CT issues over 50 communications to HEP members annually, including:

- **Hard copy notices** such as Newsletters, postcards , compliance
  mailing , penalty letters
- **Emails** that include:
  - Reminders on both preventive and chronic care
  - Some specific health screenings or topics, e.g. colonoscopy, dental, diabetes prevention
- Member portal available 24/7 for compliance information and chronic condition education

HEP Member Portal



HEP Compliance Timeline

Jan

Compliance year begins January 1st
Requirement charts are mailed to members

Sep - Dec

Monthly individual compliance reports mailed to members
Compliance year closes December

Apr - Jun

Non-compliance letters sent in April, Compliance review and appeal period through June, Healthcare Cost Containment Cmte. votes to remove non-compliant members, member letters sent

Aug

Additional premiums deducted from paychecks of non-compliant members

HEP IMPLEMENTATION

LESSONS LEARNED:

- **Deadlines spur action**
- **Regular and varied communications a must**
- **Financial penalties work**

HEP IMPACT OSC/HEALTHCORE OBSERVATIONAL CLAIM STUDY

- Compared HEP enrollee outcomes to an in state control group created using propensity score matching using the following factors:
  - » Age
  - » Gender
  - » Comorbidities
  - » Benefit design
- Difference in Difference model – program impact determined by observed differences in changes between base year and study year for study vs. control group (2010 base year, 2012 study year)

OSC/HealthCore. "Evaluating the Impact of the Health Enhancement Plan on Member Outcomes – An observation claim study". Draft study results. June 2015.

HEP IMPACT OSC/HEALTHCORE OBSERVATIONAL CLAIM STUDY

Preventive Service	*Program Impact*
Colorectal Cancer Screenings	▲ 8.9%
Cervical Cancer Screenings	▲ 2.4%
Breast Cancer	▲ 8.3%
Cholesterol Screenings	▲ 10.4%
Health Care Utilization	
ER Use	▼ 1.3%
Office Visits	▲ 1.7%
Overall Medical Costs	▼ 3.2%

Increases in screenings and testing for chronic disease but improved lab numbers were not evident (too early?)

OSC/HealthCore. "Evaluating the Impact of the Health Enhancement Plan on Member Outcomes – An observation claim study". Draft study results. June 2015.

CHALLENGES/ LESSONS LEARNED

- Clear and regular communication to participants is key
- Pre-establishing a process for determining and adjusting program requirements, preferably by adopting national standards
- Overcoming challenges posed by compliance monitoring
  - » Establishing a compliance timeline and re-enrollment process
  - » Develop a plan to handle claims lag

NEXT STEPS

HEP gets employees to the doctor's office. Now we must ensure they get efficient and quality care once they get there. To Drive future behavior change we are:

- Promoting new payment arrangements with providers including Accountable Care Organizations with shared savings opportunities
- Direct engagement with physician groups regarding wasteful health care spending using choosing wisely measures
- Educating employees about appropriate care
- Using our experience to broaden the adoption of VBID in employer plans throughout the state via the State Innovation Model

VBID and Connecticut's State Innovation Model (SIM) Initiative

- *Office of the State Comptroller is lead for the SIM VBID Initiative*
- *Convenes VBID Consortium with the SIM Program Management Office*

Value Based Insurance Design Consortium

Charter

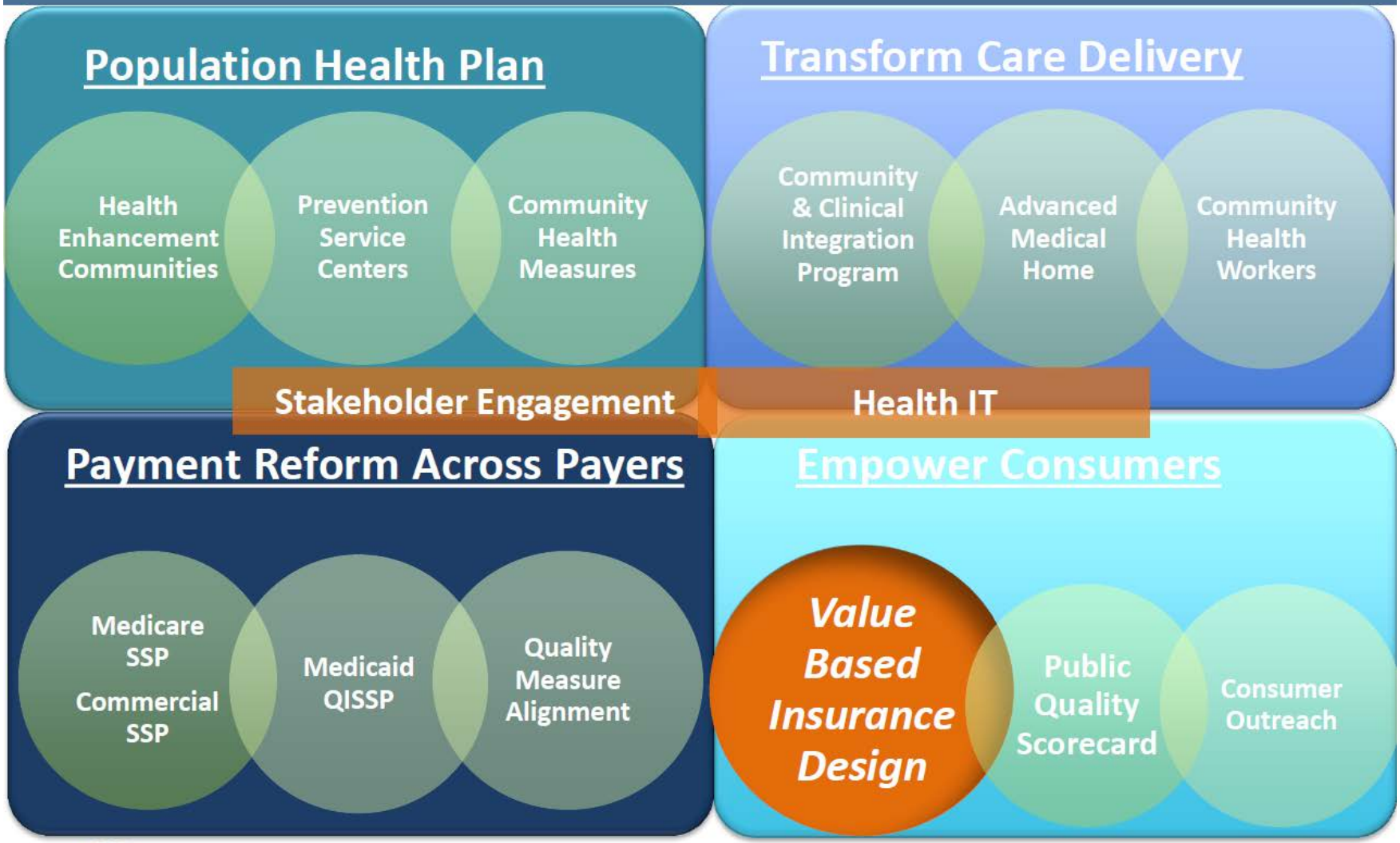
The VBID Consortium is an advisory committee to the Connecticut SIM Program Management Office. The consortium will develop recommendations for the SIM Healthcare Innovation Steering Committee with respect to the promotion and adoption of value based insurance design models for use by self-insured employers, fully insured employers and private and public health insurance exchanges. The Consortium will consist of consumers, providers, CT state agencies, accountable care organizations (ACOs), employers, employer associations and health plans that will work collaboratively to encourage uptake of VBID benefit plans in the state. Specific recommendations and deliverables (outcomes) include: identifying and engaging stakeholders, identifying and assessing successful VBID programs in and out of CT, creating a prototype VBID, and establishing the program design for a VBID learning collaborative.

Key focus of this group:

VBID Initiative Requirements

1. Assess VBID models for CT that include the following features of VBID:
   a) Incentives to engage consumers in high value health care services
   b) Designs to encourage utilization of ACOs, PCMH practices and other providers of high value services
   c) Behavioral economics applications that discourage use of low value services
   d) Designs that encourage consumer engagement in healthier lifestyles (e.g. smoking cessation, diet and exercise)
   e) Patient-centered health behavior incentives to encourage consumers to engage in effective chronic care disease management
2. Create a prototype VBID and advise re:
   a) Developing a template for recommended VBID benefit plan for use by self-insured and fully-insured employers and private and public health insurance exchanges
   b) Providing employer guidance for value-based payment arrangements
   c) Developing a VBID implementation toolkit that provides technical assistance to accelerate employer uptake of VBID
3. Advise on an approach for employer and consumer engagement
4. Develop communications and marketing materials for employers, employees and consumers to promote and facilitate VBID adoption
5. Engage stakeholders for VBID Learning Collaborative and advise on Collaborative goals, format and structure

CT SIM: Main Drivers to achieve aims



Recommended Incentive Mechanisms

Plan Type	Incentive Mechanisms
All plans	o Bonus payment for complying with recommended services o Reduced premium for complying with recommended services
Plans with copayment or coinsurance cost-sharing	o Waived or reduced copayment or coinsurance for recommended services and drugs o Waived or reduced copayment or coinsurance for visit to high value provider
Health Savings Account-eligible High Deductible Health Plan (HSA-HDHP)*	o Contribution to HSA for complying with recommended services or visiting high value provider
Health Reimbursement Account-eligible High Deductible Health Plan (HRA-HDHP)	o Contribution to HRA for recommended services and drugs o Contribution to HRA for visit to high value provider o Exclusion of recommended services and drugs from deductible
All plans	o Financial incentives external to health benefit plan designs, including gift cards, payroll bonuses, and other rewards programs

Consortium Points of Discussion

1. Disincentives for Low-Value Services- **not included at this time, in favor of a patient-provider education strategy**

2. Outcomes-based incentives- **included as an option, with the understanding that outcomes can be defined as "improving" or "maintaining" certain health measures**

3. Incentives for High-value providers- **included, with the understanding that "providers" also includes hospitals and advanced networks**

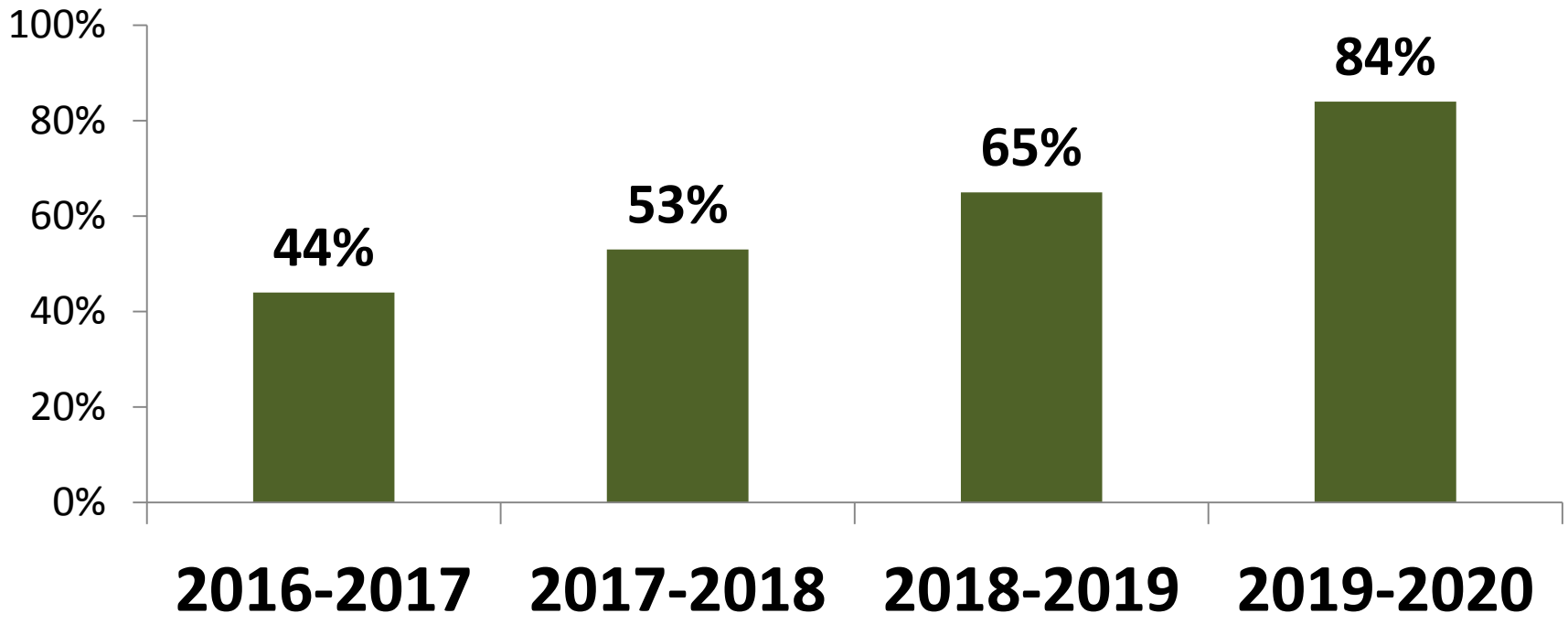
VBID to date:

Published Employer Manuals

- Self-Insured: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2016/11-10/final_self-insured_v-bid_manual.pdf
- Fully Insured: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2016/10-13/v-bid_fully_insured_manual_2_0_9_26_16.pdf

Value Based Insurance Design Goal

<u>Accountability Target</u>: 84% of insured population has a Value-Based Insurance Design Plan by 2020



NOTE: Targets subject to change based on baseline study