SHARE Webinar - #SHAREVBID

Innovative Benefit Design for Connecticut State Employees: Findings from a V-BID Evaluation

A. Mark Fendrick - @um_vbid
Richard Hirth
Thomas Woodruff
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Innovative Benefit Design for Connecticut State Employees: Agenda

- Introduction to Value-Based Insurance Design
- Evaluation of the Connecticut Health Enhancement Program for State Employees
- How the Employee V-BID Plan fits into the State of Connecticut health care strategy
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Improving Consumers’ Access to High-Value Health Care
Shifting the discussion from “How much” to “How well”

• Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality

• Regardless of these advances, cost growth is the principle focus of health care reform discussions

• Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care
Improving Consumers’ Access to High-Value Health Care
Role of Consumer Cost-Sharing in Clinical Decisions

• For today’s discussion, our focus is on costs paid by the consumer, not the employer or third party administrator.

• Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services.

• Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions.

• Consumer cost-sharing is rising rapidly.
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

Barbara Fendrick (my mother)
A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and in some cases leads to greater overall costs.

One in four adults with non-group coverage report going without needed care due to cost.
Improving Consumers’ Access to High-Value Health Care Solutions Is Needed to Enhance Efficiency

- Consumers currently do not have the necessary information to make informed health care decisions.
- While important, clinician incentives and providing accurate price and quality data does not ensure appropriate care delivery.
- Additional consumer engagement solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services.
Potential Solution: Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced

Clinical benefits from a specific service depend on:

- Who receives it
- Who provides it
- Where it’s provided
Implementing Clinical Nuance: Value-Based Insurance Design

- Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
  - Reduce or eliminate financial barriers to high-value clinical services and providers

- Successfully implemented by hundreds of public and private payers
Value Based Insurance Design
More than High-Value Prescription Drugs

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- High performing networks
- PCMH
- Hospitals
• Many “supply side” initiatives are restructuring provider incentives to move from volume to value

AJAC. 2014;2(3);10.
• “Supply side” initiatives are restructuring provider incentives to move from volume to value

• Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

• “Supply side” initiatives are restructuring provider incentives to move from volume to value

• Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction

• Adding clinical nuance can improve quality of care, enhance employee experience, and contain cost growth

AJAC. 2014;2(3);10.
Putting Innovation into Action: Create Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- Families USA
- AHIP
- National Governor’s Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA
- AARP

Lewin. JAMA. 2013;310(16):1669-1670
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Does V-BID work??

- Early programs mainly employed “carrots”
  - Reduced cost-sharing for high-value services, mainly pharmaceuticals
  - Lit review concluded that V-BID consistently improved adherence, but most programs did not decrease total medical spending over 1-3 years of follow up (Lee et al., Health Affairs, 2013); other outcomes such as absenteeism not widely studied
• **2 “carrot-based” programs that were bundled with disease management produced savings**
  - Florida Health Care Coalition (Gibson et al., Health Affairs, 2011)
  - Marriott (Chernew et al., 2009)

• **2 recent “carrot & stick” programs are generating savings**
  - Mayo Clinic increased copays for some tests and imaging studies and specialty visits, reducing use
  - Oregon public employees faced higher cost-sharing for targeted over-used or preference sensitive services, reducing utilization
The way forward

• **Research suggests:**
  – Carrots improve quality, often cost neutral, and implementation usually generates little controversy/opposition
  – Bigger impact and potential savings require coupling V-BID with complementary initiatives (e.g., DM, wellness, patient education, P4P, HIT, price transparency) and adding sticks (identifying and raising cost-sharing for low-value services)
Connecticut's Health Enhancement Program (HEP)

- First comprehensive V-BID program for state employees

Why are state employees significant to health policy?
- Large employer
- Dominant employer in some markets
- May apply lessons to other state programs (retirees, Medicaid)
“You never want a crisis to go to waste” – Rahm Emanuel

- CT faced $3.8B budget deficit for FY 2012

- State employees were asked to help address deficit

- Governor’s office and union coalition met throughout 2011
  - Many issues, not just health care
  - Health care discussions focused on creating savings while improving members’ health
  - Led to HEP launching on October 1, 2011
Key Features of HEP

• Incentives
  – Carrots
    • Reduce or eliminate copays for chronic conditions
    • $100 annual incentive if those with chronic conditions comply with all HEP requirements
  – Sticks
    • $35 copay for ER visits when there is a “reasonable medical alternative” and person is not admitted
    • Premiums: $100/mo surcharge on non-enrollees
    • $350 pp deductible (Maximum of $1,400)
Key Features of HEP

• Accountability:
  – Obtain specified age- and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations
  – Undergo dental cleanings
  – Participate in condition-appropriate chronic DM/education services (diabetes, cholesterol, blood pressure, heart disease, asthma and COPD)
  – Resources available to members include web portal, nurses and counselors, risk assessments, chronic care workbooks, personal goal planning
Key Features of HEP

• **Compliance monitoring**
  – Annual evaluation
  – Multiple means of communication
    • Email, mail, telephone, human resources
  – Member access to on-line tracking of compliance status and self-reported scheduled appointments
  – Final non-compliance determination overseen by a labor & management committee
Implementation

• 98% enrollment (far in excess of actuaries’ projections)
  – Non-enrollees from smaller families, older, but had lower baseline health spending
• Compliance has remained over 97%
• Lessons Learned
  – Communication Strategy is Critical to Success
  – Adjustments can be made even in collective bargaining setting
  – For Connecticut, full employees acceptance by 3rd cycle
  – Third party program management very important due to PHI
  – Program can reduce trends immediately by changing utilization
• Claims and enrollment data for CT state employees and post-Sept. 2011 retirees
  – Pre-HEP plan year July 1, 2010-June 30, 2011
  – Post-HEP plan year July 1, 2011-June 30, 2012
  – Post-HEP plan year July 1, 2012-June 30, 2013

• Control group
  – TruvenHealth MarketScan, state employees and dependents from 6 states
Preventive Services

Percent of enrollees receiving preventive office visit

Pre-HEP  Post Year 1  Post Year 2  Post Year 3

- HEP-eligible
- Control group

V-BID
Preventive Services

Percent of enrollees >50 receiving colonoscopy

- HEP-eligible
- Control group

![Graph showing percent of enrollees >50 receiving colonoscopy over time. The graph compares HEP-eligible and control group data across Pre-HEP, Post Year 1, Post Year 2, and Post Year 3.](image-url)
Preventive Services

Percent females >35 receiving mammography

- HEP-eligible
- Control group
Preventive Services

Percent of enrollees with CVD receiving lipid screening

- HEP
- Control

Pre | Post
--- | ---
50.0% | 75.0%
55.0% | 70.0%
60.0% | 65.0%
65.0% | 60.0%
Chronic Conditions

- Compared with controls, in HEP:
  - Diabetics were **3.2 percentage points (ppt)** more likely to have an eye exam post-HEP
  - Diabetics were **5.5 ppt** more likely to have an **A1c test**
  - Heart disease patients were **9.5 ppt** more likely to have a **lipid test**
  - Across chronic conditions, patients were **3.0 ppt** more likely to have an **office visit**
  - Across chronic conditions, there was **no significant difference in ED use**
Preliminary cost results

![Graph 1: Total Spending per enrollee](image)

![Graph 2: Year-to-year percentage change in total spending](image)
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System Delivery Reform and VBID

System Delivery Reform
Value-based Payment

Demand-side Reform
Value-based Insurance Design (VBID)
Using incentives in benefits to encourage employees to be more value-conscious in their health behaviors and treatment choices
University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

vbidcenter@umich.edu