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V-BID Center brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs

The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the Governor's representatives, and the Connecticut Office of the State Comptroller led to the October 2011 launch of an uncommonly innovative initiative—the Health Enhancement Program (HEP).

Given the new and central role of beneficiary accountability in this novel plan design, preliminary versions were carefully scrutinized and modified. Shortly after union ratification, open enrollment took place in October 2011. As designed and implemented, HEP incorporates clinically-nuanced elements of V-BID, eliminating barriers to specified evidence-based clinical services based on beneficiary demographics and medical history. This brief highlights some of HEP's key features, as well as early results and lessons learned.

The Key Features of HEP

Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this outcome through regular reminders and other forms of consumer outreach. Compliance with requirements is verified through claims data when possible, and written personal attestation when claims-based verification is not possible.

Incentives for Participants. HEP enrollees pay lower premiums and lower out-of-pocket costs at the point of service than beneficiaries who do not elect to participate. Specifically, HEP offers enrollees:

- 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

[a]This applies only to those enrolled in dental coverage. [b]The state's two third party administrators offer disease management services for these conditions.

associated with the management of chronic medical conditions (savings of up to $25 per prescription fill);[c]
- Elimination of copayments for office visits for chronic conditions (savings of $15 per visit); and
- 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.

To encourage prudent resource use, the new health plan imposes a $35 copayment for emergency department visits when there is a "reasonable medical alternative" and the beneficiary is not admitted to the hospital. This new provision applies to HEP members and non-members alike.

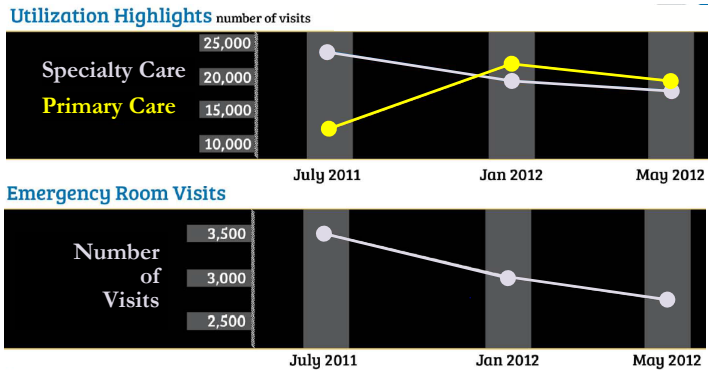
Early Results

Participants Respond to Incentives and Accept Accountability. About 98% of the approximately 54,000 eligible Connecticut state employees and retirees voluntarily enrolled in HEP. These individuals have overwhelmingly complied with program requirements: after 15 months of follow-up, the Office of the Comptroller estimates that more than 99% have met expectations.[i]

Clinically-Nuanced Incentives Increase Evidenced-Based Care and May Promote Favorable Changes in Utilization. *According* to the Connecticut State Comptroller, monthly primary care visits have increased from about 12,000 in July 2011 (prior to HEP launch) to about 21,000 in May 2012 (following HEP launch). Specialty care visits have decreased from about 24,000 in July 2011 to about 19,000 in May 2012. Monthly emergency room visits have fallen from about 3,500 in July 2011 to about 2,700 in May 2012. Adherence to heart disease, blood pressure, cholesterol, and diabetes medication has modestly improved since HEP's launch.[i]

Increases in Health Care Spending May Be Slowing. Medical trend for HEP enrollees decreased from +13% in fiscal year 2011 to +3.8% in fiscal year 2012. The pharmacy trend remained flat, despite increased use of drugs to manage chronic disease.[i]

Formal Evaluation Will Provide More Conclusive Evidence. While encouraging, these preliminary data on utilization and expenditures do not allow for the direct association of HEP implementation with these favorable changes. Even if the trends in use and spending are confirmed, it is impossible to attribute causality without the use of a control population. To address this issue, the V-BID Center, in collaboration with the State of Connecticut, has been awarded support from the Robert Wood Johnson Foundation's State Health Access Reform Evaluation (SHARE) program to rigorously evaluate trends in utilization and expenditures made by HEP enrollees relative to control populations. Results will be available within the next year.



Early Lessons Learned

Stakeholders Can Collaboratively Design and Implement Innovative "Win-Win" Plans, Even Under Difficult Circumstances. The Connecticut experience demonstrates the ability of management and labor to reach consensus on significant changes to "business as usual" in health plan design, even in challenging fiscal environments. The success in launching HEP confirms that management and labor leaders can successfully engage third party administrators, pharmacy benefit managers, and other key stakeholders. Together, vested parties can overcome concerns about perceived intrusiveness, technical challenges, and other potential obstacles.[ii]

Consumers Will Commit to Health-Promoting Activities When Appropriately Incented. HEP has been broadly accepted, with nearly all eligible employees selecting the option.

Incentives Can Change Behavior. In accordance with a substantial body of literature, the new clinically-nuanced incentives appear to have affected use patterns among HEP enrollees. Early (albeit uncontrolled) data demonstrates favorable shifts, with promising implications for long-term health and health care spending.

Innovative Plan Designs are Imperfect, and Flexibility is Critical. Given the rapid timeframe for roll-out, HEP leaders encountered implementation challenges, including clinician availability and establishment of vendor-administered programs. Leaders rapidly addressed these issues.

HEP incorporates clinically-nuanced elements of V-BID, eliminating barriers to evidence-based clinical services based on enrollee demographics and medical history.

Next Steps, Implications, and Concluding Thoughts

Next Steps for Connecticut. Buoyed by early successes, the Connecticut stakeholders are seeking to evolve and expand HEP. Next steps include increasing use of patient-centered medical homes, improving awareness of emergency department alternatives, integrating with providers' electronic health records, and extending HEP to municipal-level employees and dependents under age 26.

Broader Implications. When available, results from the V-BID Center's evaluation of HEP will shed light on the clinical and financial impact of comprehensive, thoughtfully-designed V-BID programs. However, other employers and payers may consider adopting the Connecticut move from "volume to value" in whole or part even before definitive results are available. In light of the promising early findings and the broader evidence for V-BID, there is every reason to suspect that HEP-like approaches will produce dividends in terms of health, satisfaction, productivity, and affordability.

[c] 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.

[i] Kevin Lembo. "Connecticut's Health Enhancement Program." Presentation to the National Academy for State Health Policy 25th Annual Conference (Baltimore, MD). 2012 October 15.

[ii] Chernew ME, Rosen AB, Fendrick AM. Value-Based Insurance Design. Health Affairs. 2007 March 1;26(2):w195–w203.