Issue Brief # 5 – Employer Engagement

The Connecticut State Healthcare Innovation Plan proposes initiatives designed to impact the "supply side" of healthcare (how care is delivered) and the "demand side" of healthcare (how consumers seek care). Employer engagement is fundamental to both. This issue brief explains the proposed approach for engaging employers in primary care payment reform and accelerated adoption of value-based insurance design (VBID).

Background

When we talk about "payers", we often think first of Connecticut's health insurance companies including Aetna, Anthem, Cigna, Connecticare, HealthyConnecticut, and UnitedHealthcare. These companies process and pay claims to reimburse providers for healthcare services. However, in Connecticut, 60-85% of provider reimbursements are actually paid by employers that contract with health insurance companies or other third parties as administrators for self-insured employee benefit plans. These self-insured employers are financially at risk for their employee's healthcare services. Both self-funded employers and fully insured health plans are concerned about the continued increase in health care costs. However, self-funded employers are perhaps more concerned about their employees long term health because employees are more likely to stay with their employer for many years, as compared to their health plan. In addition, employers are concerned about costs associated with employee health such as productivity, absenteeism, and presenteeism related to employee health issues. Therefore employers are important stakeholders in the adoption of value based payment reforms and value based insurance design.

Self-insured employers are seeking to maximize value for their healthcare spending, be it through the way they design employee benefit plans (e.g. VBID), the way they reimburse providers (e.g. value over volume) or the way they impact healthcare costs (e.g. price transparency and price variation analytics). In 2010, large self-insured employers such as Connecticut's GE and Pitney Bowes joined forces with other large self-insured employers to form Catalyst for Payment Reform to change the way they pay for healthcare, holding quarterly meetings with the nation's four largest insurers: Aetna, Cigna, UnitedHealthcare and Wellpoint.[1]

Thus far, discussions of primary care delivery payment innovations and the state's health innovation plan have included (1) advanced or enhanced payments for care coordination (typically PMPM or PMPQ) to practices on the AMH transformation glide path; (2) reimbursements for non-visit based care such as medication therapy management, telemedicine, econsults, email; (3) reimbursements for provider activities such as case conferencing on high risk patients, complex case management; and (4) reimbursements for new services such as health/wellness coaching, and patient navigation.

There is a growing trend for self-insured employers to view these care delivery innovations as high-value and worthy of reimbursement. Employers report that some non-visit based primary care services (e.g. care coordination/management, disease management, and telemedicine) may already be reimbursed through an existing mechanism, a per member fee that is paid by the self-insured employer to the health insurance companies.

[1] Kliff, S. How Fortune 500 companies plan to cut health costs: Act like Medicare, *The Washington Post*, March 27, 2013. http://www.washingtonpost.com/blogs/wonkblog/wp/2013/03/27/how-fortune-500-companies-plan-to-cut-health-costs-act-like-medicare/

VBID is a complement to care delivery payment reforms in that it is a mechanism that aligns the interests of consumers and providers. VBID is an employee benefit plan approach used by small and large, fully- and self-insured innovative employers to lower or eliminate financial barriers to, or introduce rewards for preventive care, medication adherence, chronic disease management, and high-quality provider selection. These employers recognized that simply increasing employee cost share as a way to curb costs had the short-term effect of lowering employee utilization of drugs and services. The long-term consequence was higher aggregate health care costs due to employees forgoing preventive and chronic disease care. Employers use VBIDs to incentivize employees to purchase high-value drugs or services in hope of avoiding more expensive future medical costs such as emergency department visits and hospitalization.[2]

Public and private employers have been implementing VBIDs to alter employee/consumer behavior and change utilization since the early 2000s.[3] Connecticut's Pitney Bowes and Office of the State Comptroller are among early adopters. In other states, health insurance exchanges have implemented or are considering implementing VBIDs. There is no one-size-fits-all VBID design; VBIDs have been designed to focus on particular health services (e.g. cholesterol tests), health conditions (e.g. all employees with diabetes), health condition severity, provider quality (e.g. centers of excellence), and disease management participation.[4]

Table 1 Examples of VBID strategies[5]

Goal	VBID Component
Increase adherence of high-value prescription medications	Eliminate or reduce consumer cost-sharing for chronic disease management (e.g. insulin, statins, anti-hypertensives, asthma inhalers)
Incentivize use of high-value services	Eliminate or reduce consumer cost-sharing for office visits related to diabetes, asthma, COPD, heart disease, hypertension
Improve management of chronic diseases	Reduce or eliminate cost-sharing for key drugs, services, and visits to high-performing providers (e.g. insulin and diabetic retinal exams)
Promote the medical home model	Reduce cost-sharing for office visits at recognized medical homes
Encourage healthy lifestyles	Decrease premium costs for employees that agree to use lifestyle improvement services (e.g. tobacco cessation)
Incentivize shared decision-making for preference-sensitive conditions	Decrease cost-sharing for office visits with providers who utilize shared decision-making

The uptake in VBIDs has been gradual. Some barriers to accelerated uptake of VBIDs include the capacity for employers to quantify clinical and economic return on investment, measure outcomes, accurately determine the value of specific services through comparative effectiveness research, and perform actuarial analysis to set copayments.[6] Additionally, employers that offer their employees enrollment choice across multiple health plans may not be able to implement one standard VBID, as each health plan may have unique VBID products and administrative capabilities. This creates an additional layer of employee education and administrative burden on the employer.

Today, healthplans, TPAs, consultants, and coalitions provide assistance to employers looking to design and implement VBIDs. However, there is rarely interaction between employers and the provider community to assist in designing VBIDs to influence employee consumer behaviors to support better health.

[2] Fendrick, Mark, MD. *Value-Based Insurance Design Landscape Digest*, University of Michigan Center for Value-Based Insurance Design, July 2009.
[3] Ibid.
[4] Ibid.
[5] The University of Michigan Center for Value-Based Insurance Design. *The State Innovation Models Initiative: An Opportunity to Align Payer and Consumer Incentives*, May 2013.
[6] Fendrick, Mark, MD. *Value-Based Insurance Design Landscape Digest*, University of Michigan Center for Value-Based Insurance Design, July 2009.

Strategy

Connecticut's Innovation Plan proposes to empower consumers to make healthier lifestyle decisions and engage in effective illness self-management through VBID.[7] The Plan also proposes employer engagement as a catalyst for increasing the number of consumers enrolled in VBID benefit plans.[8] VBID is a feature of SIM test grants in Maine, Oregon, and Arkansas.[9] Our strategy for accomplishing these goals is to bring employers and their advisors together with providers to reaffirm what should be incented by employers, develop a prototype VBID plan design that aligns supply and demand and enables program administration, and provide a mechanism for sharing best practices to accelerate the adoption of VBID plans.

Proposed Approach

I. Ensure self-insured **employer stakeholder representation** on the Practice Transformation Task Force for development of value-based payment methods and on an ad-hoc Quality Council workgroup to provide input to quality measures and common performance scorecard development.

II. Establish a **baseline of business intelligence** regarding (a) self-insured employer reimbursement strategies for care delivery innovations, and (b) use of VBIDs in the state by employers and private exchanges, including: # of employers with a VBID for employees in CT; # of employee-consumers currently enrolled in a VBID; size and composition of employer workforces enrolled in VBIDs; VBID plan designs offered by CT's healthplans, level of employer readiness to implement or expand VBIDs; types of incentives and disincentives currently used in established VBIDs / under consideration; extent to which current VBIDs focus on conditions specified in the SIM: diabetes, obesity, tobacco use, asthma, hypertension, ACSCs; impact of established VBIDs on utilization, costs; and employer reported barriers to VBID implementation. Baseline data collection will be designed, performed, analyzed, synthesized, and reported by the SIM program evaluator.

III. Provide support for an **employer-led consortium** comprised of employers, employer associations, health plans, brokers/consultants, consumers, public and private exchanges, the state insurance department, and primary care and specialty providers to engage in dialogue of both supply (value based payment reform) and demand side (value based insurance design) innovation. The consortium will advise across multiple facets of the proposed approach for employer engagement, including recommendations for developing a self-funded employer template for value based payment contract terms, standard VBID plan options, and implementation tool kit. The consortium will also conduct outreach to other employers, advise on the design and content for the learning collaborative, provide subject matter expertise to the employer learning collaborative, and develop guidance for regulatory considerations (e.g. HSAs, CDPs, filing requirements).The consortium will be supported by the PMO through the procurement of a third party vendor with expertise in employer-centric health system innovations. Employer, provider, broker/consultant and healthplan representatives that concurrently serve on the SIM Steering Committee and SIM Workgroups may assist in the facilitation of the consortium.

[7] *Connecticut Healthcare Innovation Plan*, page 89-90, December 30, 2013.
[8] *Connecticut Healthcare Innovation Plan*, page 101, December 30, 2013.
[9] The University of Michigan Center for Value-Based Insurance Design. *The State Innovation Models Initiative: An Opportunity to Align Payer and Consumer Incentives*, May 2013.

IV. Develop **employer guidance for value based payment arrangements** that can be applied to contract negotiations between self-insured employers and their healthplans. Our goal is to engage employers in proposed care delivery and payment reforms such that the substantial majority of self-funded employers throughout Connecticut adopt such reforms in their benefit administration arrangements with healthplans. Guidance may include promoting the adoption of advanced primary care models such as Connecticut's Advanced Medical Home (AMH), including support for providers that are participating in the SIM Glide Path program; supporting the adoption of associated primary care services and activities through contractual requirements and options for financing such services and activities; utilizing pay for performance strategies for providers that are in the early stages of advancement or which lack sufficient attributed consumers; utilizing shared savings programs or other total cost of care accountable payment methods for providers that have minimally sufficient attributed lives (e.g, 5,000+) and pursuing methods for pooling to achieve such minimum threshold.

V. Develop a **template for a minimum recommended VBID benefit plan** for use by (1) self-insured employers, (2) fully insured employers, and (3) private and public health insurance exchanges, and recommendations for technical assistance to accelerate employer uptake. The employer-led consortium, supported by the PMO procured vendor, will assess VBIDs in the marketplace and create a universal template that aligns with SIM aims for self-insured employers contemplating a VBID for the first time. It is critical that the recommended VBID avoid being overly prescriptive in order for it to be feasible across employers with a variety of benefit plan designs and employee populations. The recommended VBID must also be administratively viable for employers and their contracted healthplans. Due to regulatory requirements and limitations, fully-insured employers will be encouraged to adopt off-the-shelf VBID benefit plan offerings available through their contracted healthplans. The SIM PMO will leverage regulatory authority to eliminate barriers for fully-insured employers to maximize the utility of VBID, such as the use of tiered networks to incent employees to access high quality providers (e.g. AMH, PCMH).

VI. Develop a **VBID implementation tool kit** to provide technical assistance to accelerate employer uptake. The employer-led consortium, in collaboration with the PMO procured vendor, will create a VBID tool kit for corporate/municipal leadership and HR/Benefits decision makers. The tool kit may include: strategies and tactics for assessing the costs and benefits of implementing a VBID and selling the concept to the CFO; guidance on customizing the VBID template for employer cultural context considerations; implementation approaches to engage and educate employees; day-to-day administrative considerations; and ROI /program measurement methods.

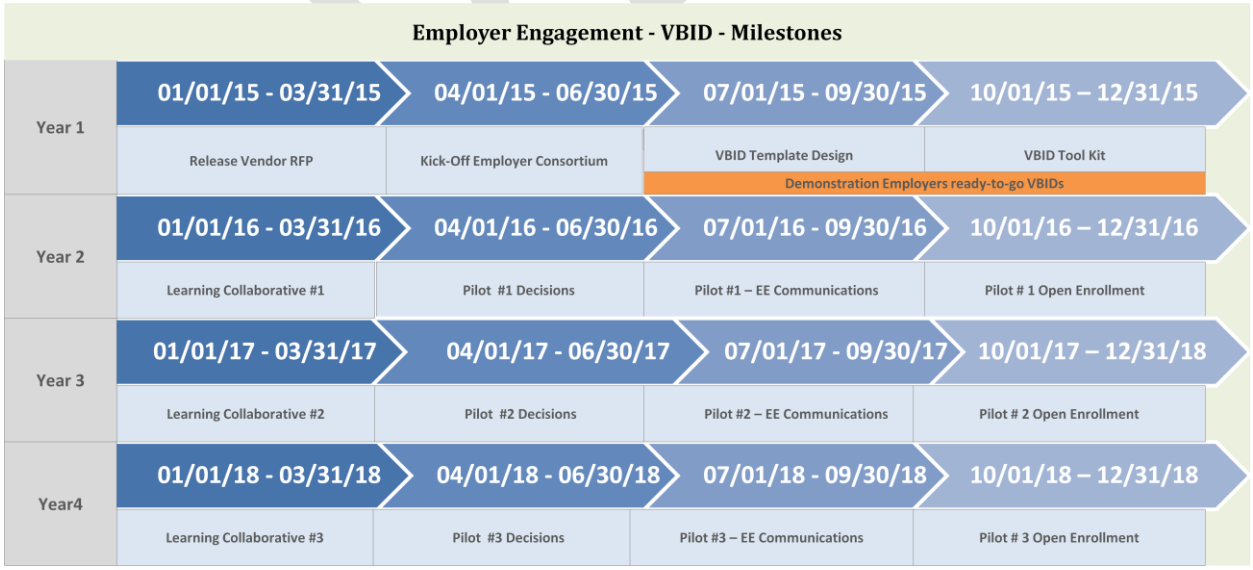
VII. Support the establishment and on-going activities of an **employer-led learning collaborative.** Learning collaborative members may include self- and fully-insured employers of any size, brokers/consultants, health plans, consumers, private and public health insurance exchanges, providers, and the state insurance department. The collaborative will have dual tracks -- one for large, self-insured employers and one for smaller, fully-insured employers – and points of convergence. Employer outreach will be conducted by SIM employer representatives that concurrently serve on the SIM Steering Committee and SIM Workgroups as well as employer associations such as CBIA, CBGH, and NEBGH. Best practices in collaborative learning will be utilized to allow employers that share common goals (i.e. lowering or eliminating their employees' financial barriers to, or introducing rewards for preventive care, medication adherence, chronic disease management, and high-quality provider selection, while decreasing absenteeism) to learn informally from each other. The

learning collaborative may leverage similar learning collaboratives in the New England region to cross-pollinate employer experiences and best practices. Similar to the CMS Comprehensive Primary Care (CPC) initiative's learning collaborative, the employer-led learning collaborative will feature a mix of touch points and venues such as an annual meeting, monthly webinars, and an online resource library to disseminate information and diffuse knowledge as well as provide coaching and technical support to pilot employers. The moderated webinars will feature subject matter experts, and healthplan and physician panels. The employer-led consortium, in collaboration with the PMO and a third party procured vendor with expertise in the learning collaborative approach applied to healthcare innovation settings, will establish and support the learning collaborative.

VIII. Support the establishment and on-going activities of an **employer-led innovation pilot** to design metrics, data collection, and analytics for workforce health outcomes (e.g. employee absenteeism), and develop a mechanism for integrating this measure in quality measures and the common performance scorecard that health plans will use for value based payment of providers.

IX. Timeline and Incentives for VBID Uptake

Typically, an employer will require nine months to a year to implement a VBID plan, and a majority of employers introduce new plans in alignment with calendar year (January 1) open enrollment. During the SIM test grant period there will be an opportunity for a demonstration of early adopters. AccessHealthCT, the state's public insurance exchange, will consider implementing VBID subject to board approval of VBID criteria and design. There will be three waves of self-selected employer VBID pilots during the 4-year test grant period. Employers will be incented to implement pilot VBIDs through no-cost technical assistance available through the employer learning collaborative.



X. Evaluate the impact of employer engagement strategies.

The SIM program evaluator will conduct an annual survey of health plans to assess payment reform and VBID adoption through established tools and survey methods. The VBID learning collaborative will be designed to evaluate uptake or readiness for uptake of VBID. Outcomes to be measured include the rate of readiness,

rate of adoption, # of employers and # of employees enrolled in VBIDs, and an economic analysis of the impact of VBIDs at an aggregate level.

XI. Staffing

Employer Engagement activities will be resourced with a combination of SIM PMO and procured vendor support.

XII. Addendum – VBID in SIM Test Grant States

MAINE

http://www.maine.gov/dhhs/sim/strategies/payment-reform.shtml

"To explore VBID in more detail and assess its potential for increasing healthcare value in Maine, the Maine Health Management Coalition (MHMC) convenes the VBID Workgroup. Facilitated by the MHMC's VBID Manager, the workgroup is charged with examining VBID examples around the country and identifying best practices in a value-based insurance design. They are also responsible for creating a means to rank insurance plans according to adopted VBID metrics, and encouraging Maine businesses to adopt the new benefit model."

OREGON

"In 2010 two Oregon public employee benefit boards implemented value-based insurance design programs for state workers. The plans increase copayments for overused or preference-sensitive services of low relative value, and they cover preventive and high-value services at low or no cost. So far, the results have been promising. This article describes Oregon's recent experience designing and implementing these value-based insurance design programs for state workers."

http://content.healthaffairs.org/content/29/11/2028.full?ijkey=s734bzMjS21yE&keytype=ref&siteid=healthaff

ARKANSAS

"We have a shared goal to fully align payment mechanisms to both physicians and consumers through a combination of network design and benefits. Both private payers and Medicaid are exploring options for value-based insurance designs, where individuals' contributions to their insurance costs are changed to encourage the use of high-value care (e.g., lower co-pays or deductibles for the use of preventative services and medications effective in controlling a given condition) and discourage the use of low-value care (e.g., higher co-pays). Beyond benefit design, across the U.S. there is a growing interest in applying behavior science to health. Examples include the use of public commitments, team- and community-based initiatives and small rewards for reaching health goals or engaging in desired behaviors. These are potential consumer engagement tools for employers, schools, payers, providers, and other stakeholders to apply."

http://www.paymentinitiative.org/referenceMaterials/Documents/SIM%20III.%20%20State%20Innovation%20Plan%202012%2009%2021%20%20FINAL%20-%20TO%20SUBMIT.pdf