

# **Incorporation of Value-Based Insurance Design Principles into the North Carolina State Employee Health Plan**

**Meeting of the Board of Trustees  
January 23, 2015**



# **NCSHP: Mission**

**Improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.**

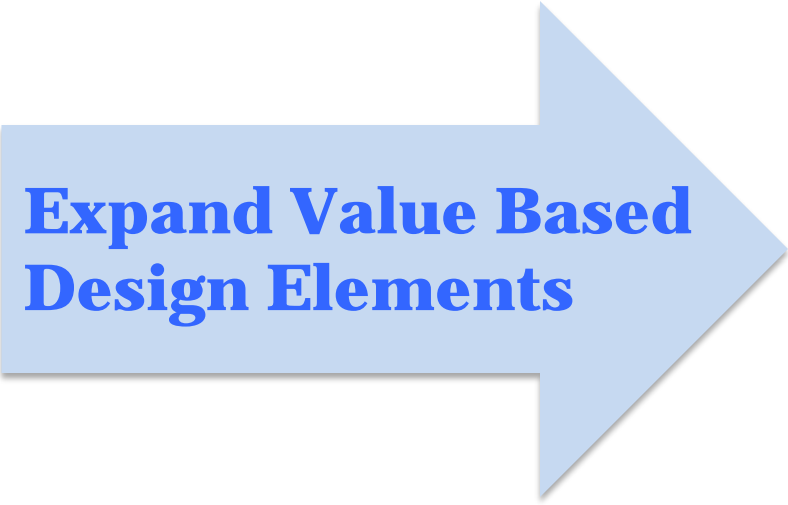


# **NCSHP: Guiding Principles**

- **Improve Affordability**
- **Improve Members' Health**
- **Ensure Access to Quality Care**
- **Incent Member Engagement**
- **Promote Health Literacy**
- **Provide Member Choice**
- **Maintain Financial Stability**

# NCSHP

## Guiding Principles

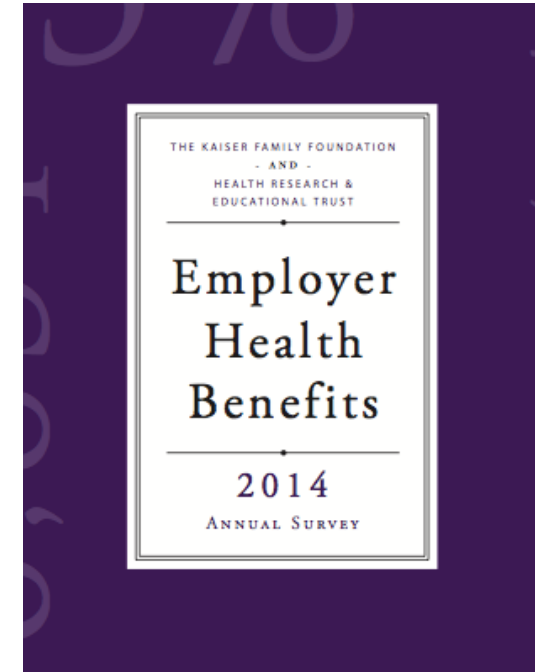


**Expand Value Based  
Design Elements**

- **Improve Affordability**
- **Improve Members' Health**
- **Ensure Access to Quality Care**
- **Incent Member Engagement**
- **Promote Health Literacy**
- **Provide Member Choice**
- **Maintain Financial Stability**

# Motivation for VBID

- **For today, our focus is on costs paid **by the member****
- **Ideally cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **“One-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions**
- **Despite a slowing in cost growth, consumer contributions are rising**



# Costs Still Keep 30% of Americans From Getting Treatment

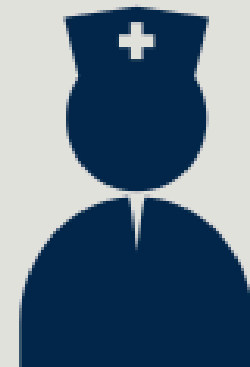
Lower-income and younger adults most likely to have delayed treatment

- **A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care and in some cases leads to greater overall costs**
- **Effects worse in low-income individuals and beneficiaries with chronic illness**



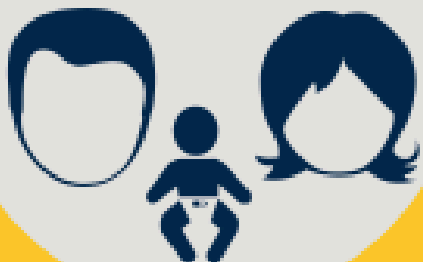
# A New Approach: Clinical Nuance

## 1. Services differ in clinical benefit produced

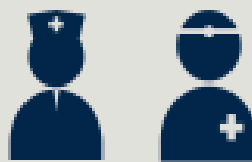


## 2. Clinical benefits from a specific service depend on:

Who  
receives it



Who  
provides it



Where  
it's provided



# 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**
- **Successfully implemented by hundreds of public and private payers**



# Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- Improved adherence
- Lower consumer out-of-pocket costs
- No significant increase in total spending
- Reduction in health care disparities

**EXHIBIT 1**  
Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay descr
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reduc tier 1 and
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated for tier 2 reduc \$1250, tier reduced to 9
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text) Choudhry et al. (Notes 10 and 11 in text)	Statins Clopidogrel	3 tiers 3 tiers	Eliminated for statins Reduced to tier
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsurance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance retail scripts, 7% coinsurance for mail-order prescription
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics Antidiabetics	10-35% coinsurance 10-35% coinsurance	10% coinsurance
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	10% coinsurance with disease management Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1 Eliminated for tier 1,
Blue Cross Blue	Rodin et al. (Note 18)	Antidiabetics,	3 tiers	



# Value-Based Insurance Design

## Broad Multi-Stakeholder Support

- **HHS**
- **CBO**
- **SEIU**
- **MedPAC**
- **Brookings Institution**
- **The Commonwealth Fund**
- **NBCH**
- **PCPCC**
- **PhRMA**
- **AHIP**
- **NBCH**
- **National Governor's Assoc.**
- **Academy of Actuaries**
- **Bipartisan Policy Center**
- **Kaiser Family Foundation**
- **NBGH**
- **National Coalition on Health Care**
- **Urban Institute**
- **RWJF**
- **IOM**
- **US Chamber of Commerce**



# Value-Based Insurance Design Growing Role in State Health Reform

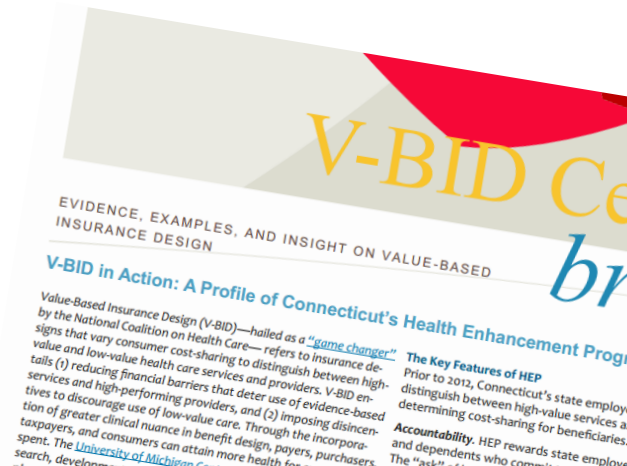
- **State Employees Benefit Plans**

- **Connecticut**
- **Oregon**
- **Virginia**
- **Minnesota**
- **Maine**
- **New York**



# Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums (\$100/month) if they commit to:**
  - **Yearly physicals, age-appropriate screenings/preventive care, free dental cleanings**
  - **If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)**



# **Connecticut State Employees Health Benefit Plan**

## **Positive Year 1 Results**

**Relative to enrollees in state employee health plans in four other states that did not have a comparable intervention, preventive services rose:**

- **receipt of at least one preventive office visit - 11.7%,**
- **colonoscopy - 4.2%**
- **fecal occult screening - 3.6%**
- **mammography - 7.1%**
- **pap smear - 4.9%**
- **lipid screen - 13.2%.**

**Among chronic condition cohorts, use of recommended services rose 3.1-9.5%**

# Current Plan Offerings

- **Enhanced 80/20, 52% of membership,**
- **Traditional 70/30, 45% of membership,**
- **CDHP (with HRA), 3% of membership**



# Guiding Principles

- **Improve Affordability**
- **Improve Members' Health**
- **Ensure Access to Quality Care**
- **Incent Member Engagement**
- **Promote Health Literacy**
- **Provide Member Choice**
- **Maintain Financial Stability**
- **Expand Value Based Design Elements**
- **Plan Differentiation**



# Summary of Recommendations

## Enhanced VBID in CDHP

- **Approve existing VBID elements**
- **Review and endorse incremental VBID elements under consideration**
- **Recommend additional elements that have synergy with other ongoing transformation activities**



# Potential Progression of Value-Based Insurance Design CDHP

## 2016

- Preventive services with no cost-sharing (ACA)
- Premium credits tied to wellness activities
- Incentives to choose PCP
- Steerage to Blue Option high- performing providers
- Deductible-exempt chronic disease medications (standard co-insurance)
- HRA credits for engaging in health management activities
- Select services with \$0 cost-sharing:
  - diabetes, asthma, or hypertension :
    - 2 additional PCP visits
  - diabetes:
    - HbA1c test (2/yr)
    - microalbumin test (1/yr)
    - Certified Diabetes Educator visits
    - Access to Diabetes Primary Prevention program

## 2017

- Enhance existing VBID elements in place and under consideration
- Broaden diabetes health engagement program to include additional metrics (e.g. eye exams)
- Add selected high value services (e.g. diagnostic tests) for clinical conditions in addition to diabetes (e.g. asthma, hyperlipidemia) with similar administrative complexity
  - LDL testing
  - Asthma action plan
- Consider reducing co-insurance levels for high-value drug classes that are deductible-exempt
- Consider cost-sharing reductions for NCQA certified PCMH providers

## 2018

- Optimize member engagement and plan selection based on benefit value
- Align consumer engagement initiatives with payment reform efforts
- Better utilize wellness, satisfaction and claims data to refine plan offerings
- Expand high value service for selected conditions across entire spectrum of care



# **Progression of Value-Based Insurance Design**

## **2016 – Approve Existing VBID elements**

- **Preventive services with no cost-sharing (ACA)**
- **Premium credits tied to wellness activities**
- **Incentives to choose PCP**
- **Steerage to Blue Option high-performing providers**
- **Deductible-exempt chronic disease medications (standard co-insurance)**

# **Progression of Value-Based Insurance Design**

## **2016 – Endorse VBID Elements under Consideration**

- **HRA credits for engaging in health management activities**
- **Select services with \$0 cost-sharing:**
  - **Diabetes, Asthma, or Hypertension:**
    - **2 additional PCP visits**
  - **Diabetes:**
    - **HbA1c test (2/yr)**
    - **Microalbumin test (1/yr)**
    - **Certified Diabetes Educator visits**
    - **Access to Diabetes Primary Prevention Program**



## **VBID Progression: 2017 – Enhance Existing VBID Elements in Place and under Consideration**

- **Consider broadening diabetes health engagement program to include additional services (e.g. eye exams)**
- **Consider adding selected high value services (e.g. diagnostic tests) for clinical conditions in addition to diabetes (e.g. asthma, hyperlipidemia) with similar administrative complexity**
  - **LDL testing**
  - **Asthma action plan**
- **Consider reducing co-insurance levels for high-value drug classes that are deductible-exempt**
- **Consider cost-sharing reductions for NCQA certified PCMH providers**

## **VBID Progression: 2018 – Expand VBID and Align with Broader Health Transformation Initiatives**

- **Consider expand high value services for selected conditions across entire spectrum of care**
- **Better utilize wellness, satisfaction and claims data to refine plan offerings**
- **Optimize member engagement and plan selection based on benefit value**
- **Align consumer engagement initiatives with payment reform efforts**



# Discussion