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# HEALTH PLAN CAPABILITIES TO SUPPORT VALUE BASED BENEFIT DESIGN

NBCH
National Business Coalition on Health

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# HEALTH PLAN CAPABILITIES TO SUPPORT VALUE BASED BENEFIT DESIGN

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# HEALTH PLAN CAPABILITIES TO SUPPORT VALUE BASED BENEFIT DESIGN

## Executive Summary

Employers are finding the current rate of health care cost increases to be unsustainable.

Between 1999 and 2008, employment-based health insurance premiums increased 120% compared to cumulative inflation of 44% and cumulative wage growth of 29% during the same period.[1] Stated differently, health care premiums increased 2.7 times the rate of inflation and over 4 times that of wage growth. These cost increases are also impacting employees. The average employee contribution to company-provided health insurance has increased more than 120% between 2000 and 2008. Average out-of-pocket costs for deductibles and co-payments for medications and co-insurance for physician and hospital visits rose 115%.[2] In the United States health care spending in 2006 accounted for 15.3% of gross domestic product (GDP), while other industrialized nations spent closer to 10% on health care.[3]

Lifestyle choices and management of chronic conditions have had a major impact on rising health care costs. The incidence and prevalence of chronic conditions, such as heart disease, cancer and diabetes, have risen as a direct result of the increase in obesity.[4] Moreover, research has also identified treatment of chronic conditions as being responsible for as much as 75% of the nation's overall health care spending.[5]

Recognizing the importance of consumer decision-making on health care costs, employers are trying innovative programs to engage their enrollees in making healthy lifestyle and medical care decisions. One such strategy is called Value Based Benefit Design or VBBD, which builds specific consumer incentives into plan design benefits or premium contribution structure to steer consumers to make high value decisions. High value decisions are ones that research has demonstrated to have a direct positive impact on health outcomes. VBBD incentives relate to use of specific medical services or medications, adoption of healthy lifestyles, or use of high performance providers. For example, a VBBD plan design focusing on diabetes might reduce co-payment amounts for diabetes medications and proactively reach out to enroll the person in a disease management program.

To implement a VBBD program, a health plan must have the IT capability to vary plan design elements, including co-payments, co-insurance and deductibles by factors such as medication classification, type of office visit and patient diagnosis. It must also offer well-designed support programs, including disease management, wellness and pharmacy management programs that are essential to creating a successful VBBD initiative.

The National Business Coalition on Health's eValue8 Request for Information (RFI), which collects information on a range of health plan initiatives, includes questions that address specific health plan capabilities required to support a VBBD program. eValue8 transmits the expectation that health plans will have the capacity to offer several different types of incentives, administer tiered network plans, and offer programs that promote wellness and improve the management of existing chronic conditions. In 2008 151 HMO and PPO health plans responded to the eValue8 RFI, and 99 of the responses were validated by local business coalitions. The information in this Guide is based on the 99 validated health plan responses. Responses indicate that many, but not all plans have the capability to effectively support VBBD plans.

Important findings of this report include:

1. **Capability to Offer Incentives.** Approximately 80% of health plans have the capability to offer incentives to manage specific diseases or to promote preventive care for children, adolescents and adults. Diabetes and asthma are the disease-specific conditions most health plans support with incentives. Health plan capabilities to support VBBD incentives for well-child and adolescent visits and preventive care are strong. Few health plans offer incentives for selecting specific acute care services known to be of higher value.
2. **Most Common Incentives.** Out-of-pocket adjustments, such as a reduced or waived co-payment amount, are the most commonly used incentives to manage chronic conditions. Out-of-pocket adjustments and cash or cash equivalent rewards, such as discounted gym memberships, are equally used as incentives to receive preventive services or improve healthy behaviors.
3. **IT Capabilities of National and Regional Plans.** In general, national plans have broader IT and operational capabilities than do regional plans to implement out-of-pocket adjustment and rewards linked to chronic condition management, and prevention services. Both national and regional plans are able to support incentives for wellness programs at comparable levels..

4. **Tiered Provider Networks by National and Regional Plans.** Tiered provider networks that offer consumer incentives to use higher performing providers are becoming more available. Generally, national plans more often created specialty tiered networks and regional plans more often created primary care networks. Both national and regional health plans adjusted co-payments, co-insurance or deductibles more frequently than offering lower premiums as incentives.
5. **Program Support Services.** A large majority of health plans offer some form of program support for VBBD plans, including
    a. Offering incentives for **completing a Personal Health Assessment (PHA)**, and sharing aggregate survey results with the employer;
    b. Using PHA results to **encourage enrollee behavior change** by providing personalized results and making some form of outreach contact with enrollees;
    c. Offering **weight loss support** through reductions in weight loss program costs;
    d. Offering **smoking cessation support** through education and behavioral interventions such as interactive electronic support and stop smoking kits;
    e. Offering **disease management programs** that stratify enrollees by risk and adjust the level of intervention and content of intervention based on enrollee's needs, and
    f. Offering **pharmacy management programs** that identify gaps in compliance, and notify members and providers of the gaps.
    g. Offering **provider and hospital selection support** when tiered networks are a benefit option, and
    h. Offering **treatment choice supports** when incentives around acute episodes of care are offered.

Offering a service or having VBBD capabilities should not be confused with uptake by the plan's customers. eValue8 does not measure uptake. The prevalence of use of financial VBBD elements in particular is known to be considerably lower than the presence of capabilities represented herein. NBCH's *Purchaser Guide to Value Based Benefit Design: Engaging Enrollees in Making Effective Health Care Decisions*, available at www.NBCH.org provides employers detailed information on best practices for implementing VBBD.

# I. THE LANDSCAPE FOR EMPLOYERS

## Introduction

As health care costs continue to rise, purchasers are looking to innovative ways that are based on a solid research foundation to slow those increases. Increasingly purchasers are recognizing the key role that enrollees necessarily play in responding to our health care crisis. Research data has shown that 75% of health care costs are linked to life style choices and to poor management of chronic conditions,[6] both of which require active involvement of enrollees to change. In recognition of these statistics, purchasers are developing incentives to engage their employees, retirees and their dependents in making positive health care decisions. With the support of health plans, a new type of benefit design has emerged and is starting to garner wide attention. The insurance design is called Value Based Benefit Design or VBBD, which incorporates focused consumer incentives into health plan and related benefits to steer consumers to better health and lifestyle decisions. This approach was pioneered by IBM and Pitney Bowes in the mid 1990's and has been steadily adopted by other larger organizations.[7] Health plans, both nationally and regionally, are making these types of incentives available to a wider range of purchasers.

This report highlights data reported by health plans that participate in a national "eValue8 Request for Information" (eValue8) fielded by the National Business Coalition on Health (NCBH) each year in December.

NBCH is a national organization representing local community coalitions that represent local employers and support them in their value based purchasing efforts that range from measuring performance and promoting improved outcomes to direct contracting with providers of health care. eValue8 was created to assist NBCH member coalitions, and the employer-members of coalitions to assess health plan capabilities and performance. eValue8 is also used proactively to encourage plans to adopt innovative or evidence-based programs, such as VBBD. Through eValue8, employers establish expectations and drive continuous improvements in care quality.

In this national snapshot, NBCH uses eValue8 data from health plans to examine the capabilities of plans to implement and support VBBD. It is a companion report to the recently published *Purchaser Guide to Value Based Benefit Design: Engaging Enrollees in Making Effective Health Care Decisions*. The latter report examines the business case for VBBD and then discusses best practices to implement a VBBD program successfully. This report provides employers with information regarding the capabilities of plans to implement and support a VBBD program that incorporates these best practices.

## The 2008 eValue8 RFI

eValue8 is an NBCH tool for member coalitions to access standardized information on health plan performance. eValue8 examines how health plans deploy evidence-based approaches and innovative strategies to promote health and manage disease in the covered population. Through coalitions, employers have access to health plan-specific performance and operational information.

The eValue8 RFI tool is updated annually to examine health plan activities that address national or employer priorities. This report analyzes data that specifically address health plan capabilities to administer plan designs that provide consumer incentives to use high value services – services can be used to advance health status, such as increasing diabetes medication compliance by lowering or waiving co-payments for specific diabetes drugs, or promoting smoking cessation by providing incentives to participate in smoking cessation programs.

The experience of the pioneering employers offering VBBD indicates that a successful VBBD program requires strong consumer engagement support programs, pharmacy management, and chronic disease management. Therefore, this report also presents the data documenting the health plan performance in these essential support areas.

## Notes about eValue8 Data

Response to the eValue8 Request for Information is voluntary. Many health plans respond to the Request for Information at the urging of local business and health coalitions. These coalitions represent local employers who purchase either self-insured products or fully insured health benefit programs. When a responding health plan is located in a community served by a coalition, the coalition engages a trained reviewer to validate the responses to the RFI. The adjusted validated responses drive an automated score. After scoring, local coalitions and their employer members meet with health plan leadership to provide feedback on performance and future year expectations.

151 health plans covering over 100 million people responded to the 2008 eValue8 RFI.[8] Of those plans, 99 operate in regions represented by a local business coalition. It is these 99 validated plans from which data in this report are drawn. This subset of the data is considered "cleaner" for analytic purposes. Fifty-two percent of the 2008 respondents were health maintenance organizations (HMO) and the other forty-eight percent were preferred provider organizations (PPO). Most responding health plans, HMO or PPO, were for-profit organizations (62 percent).

The data produced here was reported to NBCH in response to the 2008 eValue8 RFI. In most instances, the data reported by plans reflect their 2007 program activities. Responding health plans generally offer multiple fully insured and self-insured products. Many of the questions report on plan capability to deliver selected services. It is important to recognize that they are not delivering these services to all customers. Uptake of program innovations is ultimately dependent on the employer's selection of benefit services. This report, therefore, provides information on the percentage of health plans reporting that they are able to provide a particular service or type of benefit design-based incentive. With few exceptions, their answers do not report the extent to which employers have elected to receive those benefits or services.

# II. ABOUT VALUE BASED BENEFIT DESIGN (VBBD)

## Basic Definition

Value-Based Benefit Design is the explicit use of employee rewards and out-of-pocket contributions to create consumer incentives for adoption of one or more of the following:

- use of high value services, including certain prescription drugs and preventive services;
- adoption of healthy lifestyles, such as smoking cessation or increased physical activity, and
- use of high performance providers who adhere to evidence-based treatment guidelines.

Enrollee incentives can include rewards such as vouchers for consumer goods, reduced premium share and/or co-pay levels, and contributions to fund-based plans such as Health Savings Accounts.

VBBD grew out of the recognition that some medical services are of greater value to specific individual enrollees than to others when medical evidence of the effectiveness of a particular treatment and the cost of the treatment are considered.

Recognizing that the value of services varies by individual, the concept of VBBD also introduces a level of complexity that is challenging to administer. Enrollee cost sharing should be based on the value (benefit net of cost) of the service or lifestyle program or provider to the individual enrollee, and should not be the same for all enrollees or be based simply upon the price of the service.[9] Thus the out-of-pocket enrollee contributions and reward structure will vary for medical services, prescription drugs and lifestyle programs based on the evidence of effectiveness for the individual circumstances of each enrollee. This tiering of services, lifestyle programs and providers should direct individuals toward choices that will yield superior benefit relative to other options.

Research has demonstrated that financial incentives can influence health-related behavior,[10] and that the cost of services impacts use of services[11] and compliance rates.[12,13] Therefore, by removing barriers to needed, valuable services, or by providing positive incentives to participate in health promotion programs, VBBD initiatives can optimize the likelihood of patients complying with recommended treatment plans and engaging in healthy behaviors. In turn, healthier people generally have lower health care costs, and there is evidence that patients with specific chronic conditions who maintain their treatment regimens have lower overall health care costs.[14]

## Consumer Engagement Support Services

Implementing a VBBD initiative must also incorporate a range of consumer engagement supports including a purchaser-wide communication strategy and a clinical outreach strategy to targeted enrollees through disease and case management programs and through disease education initiatives. If a VBBD initiative provides incentives to participate in health promotion programs, a wide range of options is needed to meet the needs of all enrollees. A dynamic process of consumer education and engagement focused on specific high value services is an integral component of VBBD implementation. VBBD programming will be less effective if it involves only a static plan design change.

## Importance of VBBD to Employers

By taking actions that will improve the health and productivity of their employees, employers are using their health and welfare programs as something more than a means to attract and retain workers. VBBD provides "an opportunity to fundamentally change the way health benefits are structured, and to reframe the national debate on healthcare to focus on the value of health services – not on cost or quality alone."[15] VBBD principles, therefore, can be used to achieve any cost target more efficiently. By focusing on value, an employer can spend its health care dollar more wisely and can impact employee's health and productivity for the better.

The challenge to purchasers is to a) overcome operational challenges, and b) to pursue the strategy long enough to assess its impact on the organization and its employees and their dependents. One key to overcoming operational challenges is to understand health plan capabilities and know what an employer can reasonably expect.

# III. FINDINGS FROM THE eValue8 SURVEY

This section is divided into two major parts. Part 1 provides information on the plans that report having the capability to provide the necessary consumer engagement support services to make the VBBD plan offering successful. Part 2 examines the capabilities of the plans to support the use of financial incentives to promote use of high value services, efficient providers and key health and wellness programs. Specifically, Part 2 will examine plan capabilities to support:

- incentives for chronic condition management, use of preventive services and selection of effective acute care services, generally and by national and regional plans, and
- tiered provider networks incentives that steer consumers to high performing providers.

In each Part, the eValue8 questions that were used to evaluate the plans' capabilities will be footnoted for the reader's reference.

## PART I: PROGRAM SUPPORTS FOR VBBD PLANS

Purchasers who pioneered VBBD plans quickly realized that the success of their VBBD initiatives required offering a wide variety of programs to educate and engage consumers in better understanding their health risks and to support them in making lifestyle changes to improve their risk profile. This section examines what initiatives plans have in place to support the successful implementation of VBBD.

### Background

Employers offering VBBD plans must understand the health profile of their enrollees. One key way of gathering this type of information is through a Personal Health Assessment (PHA). PHAs are considered important for building an effective wellness program. By having enrollees complete a PHA, health plans are able at an earlier point in time to identify and engage high-risk enrollees in making lifestyle and medical care changes to reduce the risk of future illness. However, PHAs are only one source of information an employer should review in developing an understanding of opportunities to reduce or better manage costs. Other data sources include: enrollment demographics, medical and pharmacy claims data, and information from disease management, Employee Assistance Program (EAP), and disability programs, as well as information regarding worker absence and productivity.

With this information in hand employers will want to examine the following variables:

- the age and sex composition of its work force;
- the disease prevalence and associated costs by diagnosis;
- the per capita use of key high cost services, such as inpatient services and high tech radiology compared to best practices benchmarks;
- the number of people eligible for disease or case management compared to those enrolled;
- the frequency with which the covered population uses preventive services compared to a regional or national benchmark, and
- whether any supply-sensitive procedures or preference-dominated services are being over-used.

This data should be reviewed with the employer's health plan and used as a basis for developing targeted interventions that address to each opportunity identified.

### Personal Health Assessments[16]

eValue8 asks health plans to respond to a range of questions regarding a health plan's capability to obtain a high level of completion of PHAs and to use the information to encourage behavior change. The health plan capabilities are examined in the following sections.

VBBD plans that impact enrollee behavior require robust enrollee support programs, including

- Incentives to assure high Personal Health Assessment participation rates
- Actionable Personal Health Assessment data
- Disease management and pharmacy management programs that support and reinforce VBBD-targeted conditions
- Provider selection support programs that enable enrollees to access detailed clinician- and hospital-specific quality information
- Treatment choice support programs that help patients understand treatment options, associated risks and benefits, and factors to consider in making a treatment decision

## Obtaining High Participation Rates: Use of Incentives and Enrollee Communication

A very high percentage of health plans offer some type of incentive to complete a PHA. Only 17% of the responding plans reported not having any incentives available.

At varying levels health plans also administratively support an employer-sponsored incentive. 87% of health plans either currently communicate the incentive plan to enrollees on behalf of employer, or would do so, if requested and 85% currently fulfills financial incentives based on employer instruction or would do so if requested. Plans may charge an additional fee for these services.

Health plans also use regular enrollee communications to promote PHA completion. The top two communication vehicles that health plans use are targeted mailings or push email (80%), and calls from health coaches or case managers (88%). All health plans communicate through their website or enrollee newsletter with 51% communicating more than 6 times a year.

PHA forms are readily available. 94% of health plans have PHA accessible both online and in print, with 67% having it available in multiple languages.

## Using PHA Results to Encourage Behavior Change

The importance of completing a PHA is to use the information to identify opportunities for healthy behavior changes. eValue8 expects health plans to have administrative processes to convey PHA information to employers and to use PHA data to engage patients in disease management, case management or education.

## Communicating with Purchasers

Having the capability to communicate PHA information to purchasers is strong among health plans. Overwhelmingly plans indicate that they are able to report PHA participation to employer (92%), report aggregate PHA results to employer for purposes of developing wellness programs (89%), and track and report enrollee participation in recommended disease management or wellness program to employer (87%).

Only 42% of respondents reported that they currently track and report outcome metrics (BMI, tobacco cessation) to employers. 47% of plans said that they would not perform this function at all. It is possible that few plans offer this level of support because of privacy concerns.

## Obtaining Enrollee Engagement and Making PHA Information Actionable

Providing feedback to enrollees around the results of their PHA is the first step in obtaining consumer engagement. The three most common ways in which plans provide information regarding individual risk behaviors are the following:

- A personalized PHA report is generated after the PHA is completed that provides enrollee-specific risk modification actions based on responses (99%);
- Case manager or health coach outreach call is triggered based on PHA results (83%);
- Enrollees may update responses and track the changes against earlier responses to obtain feedback on how their behavior changes are impacting their health (81%).
- Ongoing push messaging is sent for self-care based on enrollee's PHA results (79%).

## Offering Interactive Functionality to Increase Engagement

Less available are features that create a more immediately interactive experience to increase engagement, such as

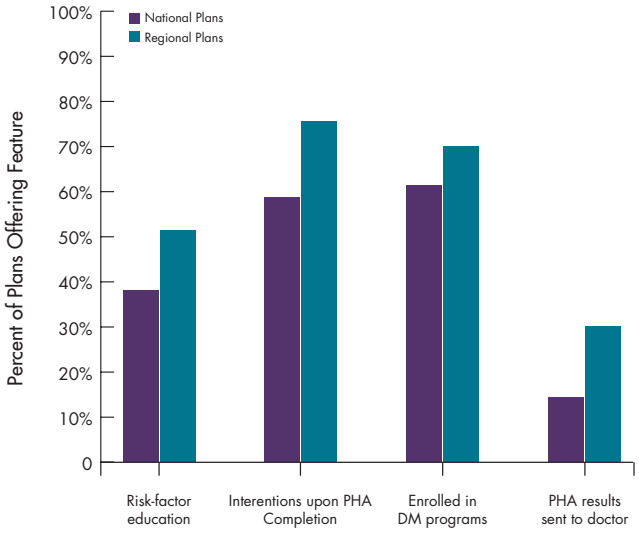
- providing risk-factor education to an enrollee based on the enrollee-specific risk at the point of the enrollee's PHA response;
- directing enrollees to targeted interactive intervention modules for behavior change as soon as the enrollee completes the PHA;
- linking PHA information to other people involved in health care management, such as the person's physician, and
- enrolling eligible enrollees into disease management programs, based on PHA results.

## Availability of Interactive Functionality by National and Regional Plans

When examining the availability of less common PHA functionalities by national and regional plans, more regional plans than national plans generally have these capabilities. Two of the functionalities reported in Figure 1 require sophisticated programming to engage the member in teachable moments either while or immediately after completing the PHA. 52% of regional plans and 37% of national plans provide information about risk factors as soon as they are identified and 74% of regional plans and 57% of national plans direct the member to appropriate interventions immediately upon completion of the PHA. The

third functionality, which allows a plan to enroll a member in a disease management program upon completion of the PHA, is used by 70% of regional plans and 61% of national plans. Few of regional plans (30%) or national plans (14%) have the capability for members to make electronically available the results of the PHA to their personal physician.

### FIGURE 1: LESS COMMON PHA FUNCTIONALITY BY NATIONAL AND REGIONAL PLANS




### Offering Incentives to Take Action

Finally, a large number of health plans are making PHA information actionable through the use of incentives. 84% of health plans tie receipt of an incentive to participation in a disease management or wellness program that was based on PHA results.

## Disease Management Programs[17]

Typically, disease management is a strategy health plans use to reach out proactively to patients with a diagnosed chronic disease. Disease management (DM) is based on the premise that coordinated care with patient involvement results in reduced costs by avoiding use of the emergency department and inpatient services. These programs focus on prevention, patient education and self-management skill development, and use of outpatient care rather than more intensive services.

### Increasing Impact of VBBD

To reinforce a VBBD design, disease management programs can increase the likelihood that the adherence goals of the design will be reached. For example, if diabetes drug compliance has been identified as a problem and the VBBD plan design reduces or waives co-payments for diabetes drugs, the purchaser's disease management program will bring education and coaching to reinforce the financial incentives.

### Availability of Disease Management Programs

The eValue8 responses indicate that disease management has become virtually a standard offering of health plan services for commonly occurring chronic conditions. Several prevalent conditions, such as hypertension and hyperlipidemia, are often managed as co-morbidities, that is, managed only when they are also present with another disease that is being managed. Figure 2 reports by condition the availability of disease management services either plan wide and available to all commercial enrollees or as a condition managed only as a co-morbidity. This chart also shows the percentage of health plans that will make these programs available as an option to purchase.

### FIGURE 2: AVAILABILITY OF DISEASE MANAGEMENT PROGRAMS BY CONDITION

| Condition or Disease | Percent of Plans Offering DM Program | Managed only as a Co-morbidity |
|---|---|---|
| Coronary Artery Disease (CAD) | 86% | N/A |
| Diabetes – adults | 86% | N/A |
| Asthma – pediatric | 83% | 1% |
| Congestive Heart Failure (CHF) | 83% | 1% |
| Asthma – adult | 81% | 1% |
| High Risk Pregnancy | 74% | N/A |
| Diabetes – pediatric | 73% | N/A |
| Chronic Obstructive Pulmonary Disease (COPD) | 70% | 9% |
| Back Pain | 51% | 8% |
| Arthritis | 46% | 18% |
| Cancer | 31% | 27% |
| Hypertension | 24% | 57% |
| Hyperlipidemia | 21% | 55% |
| Migraine Management | 19% | 40% |
| Pain management | 15% | 50% |
| Stroke | 12% | 56% |
| Alzheimer | 7% | 41% |

### Identifying and Engaging Eligible Enrollees

Mechanisms for identifying and stratifying enrollees according to intensity of needs (e.g., predictive model, clinical criteria) permit use of resources and enrollee support that is tailored to the needs of the member.

eValue8 survey results indicate little distinction between health plans in terms of basic DM program elements. Trained case managers hold consultations with patients to ensure they understand how to manage their disease, how to identify signs of problems and are able to engage collaboratively with his or her physician to obtain necessary tests and services. The intensity of interventions (i.e., frequency and duration of calls and number of other contacts through other sources, such as emails) will often vary based on the risk stratification of the enrollee with the highest risk enrollees received the most intense level of intervention.

eValue8 data reveals that there is wide variation in the number and proportion of individuals identified as eligible for and participating in DM programs. Therefore purchasers may want to examine plan strategies for identifying persons with chronic conditions targeted for their VBBD initiative and the approaches used for enrollment. Purchasers will also want to evaluate how quickly and successfully health plans engage those enrollees in the DM program and how engagement is measured.

## Pharmacy Management Programs[18]

Incentivizing enrollees to take maintenance medications through reduced or waived co-payments or co-insurance is one of the most frequently used VBBD plan designs. To increase the success of this type of VBBD plan design, health plans must be able to support VBBD through pharmacy outreach initiatives.

### Role of Health Plans

Health plans are in a unique position to have an active role in monitoring medication compliance because they receive pharmacy data on an almost real time basis from their pharmacy benefit mangers. On the other hand, physicians generally do not know if their patients are taking medications as prescribed unless health plans alert them.

### Reminder Programs

eValue8 specifically asked health plans what types of reminder or alert programs they have for filling maintenance medications for regular retail and mail order. Information about mail order prescriptions is very relevant, since many enrollees will fill maintenance medications through mail order because of ease of use and to save money. As Figure 3 shows, a higher percentage of plans monitor gaps in maintenance medications filled through mail order than through a retail pharmacy. Since the percentage of plans notifying physicians and enrollees of gaps in maintenance medications is relatively low, this is an area that a purchaser interested in implementing a VBBD plan design to encourage medication compliance for chronic conditions should carefully investigate.

FIGURE 3: PERCENTAGE OF HEALTH PLANS PROVIDING REMINDERS TO ENROLLEES AND PHYSICIANS FOR GAPS IN MAINTENANCE MEDICATIONS, ALL DRUG CLASSES

| Interventions | Regular Retail | Mail Order |
|---|---|---|
| Reminders to enrollees for gaps in maintenance medications | 60% | 77% |
| Reminders to prescribing physicians for gaps in maintenance medications | 60% | 65% |
| Alerts to physicians for prescribing gaps based on guidelines | 68% | 69% |
| Outbound call program for enrollees | 39% | 61% |

### Value-based Formulary

eValue8 uses the term "value-based formulary" to define one of the newest developments in pharmacy management. This careful evaluation of the effectiveness and relative importance of drugs within and across drug classes is an emerging focus nationally that disrupts the usual tiered structure of pharmaceutical plan design in favor of the drug's criticality rather than cost alone. When linked to a variable co-pay design, it becomes a VBBD initiative. 46 percent of health plans, the majority of which are national plans, reported having value-based formulary available that is linked to variable co-pays and an additional 9% are piloting it. Another 38% of health plans, the majority of which are national plans, reported either having value based formulary not linked to variable co-pays or having one under development.

## Provider and Hospital Selection Support

For VBBD plan designs that are built on a tiered provider network, giving enrollees tools to research provider background and quality becomes extremely important. This information will assist enrollees in selecting physicians within a high performing tier. eValue8 asks health plans specifically about information available through the online physician directory and what hospital choice tools are available to enrollees.

### Provider-related Quality Information[19]

A variety of quality information is available for health plans to assemble, organize and make available to enrollees. Most fundamentally is the network participation status and tier assignment for providers in tiered networks. NCQA, a non-profit organization that accredits health plans, has disease or condition-specific recognition programs for physicians. By receiving NCQA recognition, a provider has demonstrated that he or she is providing evidence-based care, which means that the provider has achieved a certain threshold of processes and outcomes for the practice caseload with the condition.

Increasingly, states and other governmental organizations are making quality information available, such as mortality or complication rates. Some health plans are also collecting practice information that relates to a provider's use of innovative technology, such as electronic health records (EHRs) and electronic prescribing, both of which can increase the quality and safety of care provided by assuring ready access to current health records and minimizing prescription errors. Patient satisfaction information, collected through patient experience surveys, is another source of quality-related information that health plans can make available to share with enrollees. Finally, many states are making information about disciplinary actions and malpractice history available to the public.

### Availability of Provider-related Quality Information On-line

As Figure 4 shows, over 50% of plans are making evidence-based quality informationavailable on line in searchable form to enrollees

either generally or as part of a tiered network reporting function. Significantly fewer plans make available on line searchable information regarding NCQA Recognition status, a provider's use of newer technology or information on disciplinary actions or malpractice history.

FIGURE 4: PERCENTAGE OF PLANS MAKING QUALITY-RELATED INFORMATION AVAILABLE ON-LINE OR THROUGH CUSTOMER SERVICE

| Available Provider-related Quality Information | Percentage of Plans Making Quality-related Information Available On-line and Searchable |
|---|---|
| High performance network participation/status | 53% |
| NCQA Diabetes Recognition Program | 14% |
| NCQA Recognition for Heart/Stroke | 14% |
| Uses web visits | 5% |
| Uses patient email | 5% |
| Uses electronic prescribing | 4% |
| Patient experience survey data | 5% |
| Uses electronic health records | 4% |
| NCQA Recognition for back pain | 5% |
| Disciplinary actions and malpractice history | 4% |
| Other evidence-based measures of quality | 16% |

### Hospital-related Quality Information

Approximately 31% of the health care dollar goes for hospital care. Health plans are increasingly focusing on steering enrollees to higher performing hospitals by varying co-payments and co-insurance based on the cost and quality performance of hospitals in their networks. Several commercial companies have developed hospital evaluation systems, as have health plans. eValue8 data indicates that 60% of health plans use internal sources to grade hospitals. Web MD Health Services, which acquired Subimo Hospital Advisor in 2006, is the most commonly used commercial product.

### Nature of Hospital-related Quality Information

Almost all of the hospital choice support tools allow enrollees to search by basic descriptive information: hospital name, geographic proximity, condition and procedure. Decision support tools also describe the treatment or condition for which performance is being reported and discloses scoring methods. The most common quality information provided is the level of hospital adherence to Leapfrog safety measures (87%), which are nationally accepted safety procedures hospitals can follow to minimize complications and medical errors. 83% of health plans report complication indicators if they are relevant to the treatment. Less commonly available is information regarding mortality if relevant to the treatment (67%), hospital efficiency rating (59%) and occurrence of never events (11%), which are hospital errors, such as operating on the wrong part of the body, that should never occur.

## Treatment Choice Supports

Although few health plans offer incentives to encourage use of more cost effective treatment options or use of shared decision support technology, it is necessary to provide consumers with treatment support tools when incentives are provided.

### Sources and Functionality of Treatment Choice Support Information

The commercial products most frequently used by health plans offering treatment support services are Healthwise Decision Points, Subimo Healthcare Advisor and WebMD Condition Centers. 42% of health plans offering incentives have developed their own decision support tools.

The most common functionalities included in a health plan's treatment option decision support tool are

- static descriptions of the treatment or condition (98%);
- treatment benefits and risks (95%);
- what decision factors are associated with the condition (94%);
- questions or discussion points to ask providers (89%) and
- information on the likely condition or quality of life if no treatment is provided (83%).

### Availability of Tailored Information and Interactive Sites

Health plans are beginning to provide more options to tailor information and create interactive sites. For example, 63% of the health plan support programs will tailor responses based on a progression of enrollee input regarding such topics as symptoms and concerns; 56% elicit enrollee lifestyle preferences; and 36% allow the user to organize and rank preferences. Very few sites provide cost information. For example, only 35% of health plans report that their sites offer a treatment cost calculator based on paid charges in the local market, and only 12% link cost information to an enrollee's benefit to reflect potential out-of-pocket costs.

- Over 75% of plans are able to adjust co-payment, co-insurance or deductibles to encourage enrollees to seek high value preventive and chronic care services
- Over 75% of plans offer incentives for enrollees to participate in health promotion programs, such as weight loss or smoking cessation
- national plans have greater capabilities to support chronic condition and prevention incentives than do regional plans
- primary care tiered networks are less available than specialty tiered networks
- regional plans are more likely to offer tiered primary care networks and national plans are more likely to offer tiered specialty plans.

## PART 2: HEALTH PLAN CAPABILITY TO SUPPORT PLAN DESIGN AND OTHER FINANCIAL INCENTIVE STRUCTURES[20]

### Types of Incentives Supported by Health Plans

Health plans were asked to indicate whether they are able to support any of a variety of incentives for enrollees with Asthma, Hypertension, Hyperlipidemia, Diabetes, Depression, or for Well Child and Adolescent Visits, and Preventive Care. The incentives the health plans were asked about are designed to 1) encourage enrollees to better manage their chronic conditions or 2) seek preventive services and pursue healthier lifestyles to prevent future illness or 3) seek high quality, efficient services.

To analyze the variety of incentives health plans are offering, we have categorized them into five categories:

- **Participation Rewards for Members with Chronic Conditions** include cash or cash equivalent rewards for participation in chronic disease management coaching, adherence to chronic disease guidelines and success with specific target goals for chronic disease management.
- **Out-of-Pocket Adjustments for Members with Chronic Conditions** are reductions or waivers of co-payments, co-insurance or deductibles associated with specific services, such as prescriptions for a diabetes drug or office visits for monitoring and treatment of a chronic condition.
- **Participation Rewards for Preventive Services** include cash or cash equivalent rewards for completing a Personal Health Assessment (PHA), participating in a weight loss program, succeeding in a weight loss program, participating in wellness coaching, and succeeding at a wellness goal other than weight loss.
- **Out-of-Pocket Adjustments for Preventive Services** are reductions or waivers of co-payments, co-insurance or deductibles associated with specific prevention services, such as well-child and adolescent visits and annual physicals.
- **Out-of-Pocket Adjustments for Acute Services** are reductions or waivers of co-payments, co-insurance or deductibles for selecting a higher quality, less invasive services, such as an arthroscopic joint procedure rather than surgery; or for using evidence-based shared decision support services before making a treatment decision.

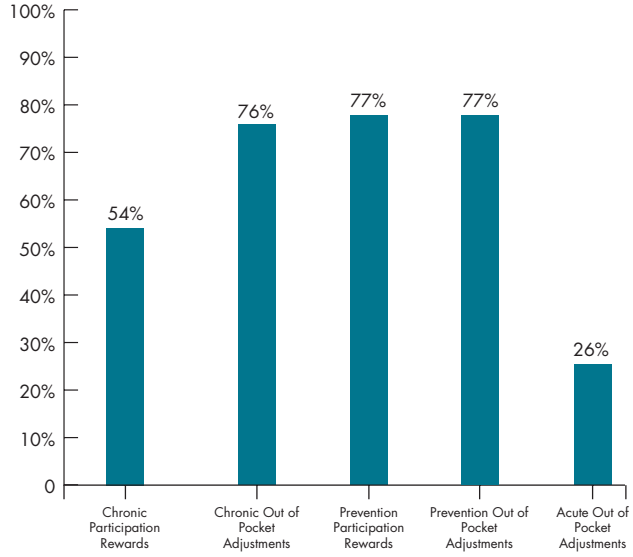
Tiered networks, which provide consumer incentives to select a high value provider, are discussed in a separate section in Part 2.

Because these types of financial incentives are the building blocks of a VBBD plan, a health plan's ability to support these types of incentives is essential to offering a VBBD plan. eValue8 scores health plans based on the their ability to administer this complexity, which at its extreme is like having multiple plan designs within a single plan to accommodate the needs of each enrollee.

### Health Plan Capabilities to Support Incentives for Chronic Conditions, Prevention, and Acute Episodes of Care: All Plans

Figure 5 shows the level of health plan support for incentives for chronic conditions, prevention and acute episodes of care.

FIGURE 5: PERCENTAGE OF HEALTH PLANS WITH THE CAPABILITY TO SUPPORT INCENTIVES BY TYPE OF INCENTIVE




#### Incentives for Chronic Conditions

Out-of-pocket adjustments for essential services to members with chronic conditions, such as reduction or waiver of co-payments/deductibles, are supported by 76% of plans. Participation rewards for this group, such as cash payment for participating in a disease management program, are supported by only 54% of plans. These different levels of support are understandable in light of the current VBBD focus on improving medication compliance for people with chronic conditions. Adjusting out-of-pocket costs, such as reducing a diabetes prescription drug co-payment, offers an incentive directly tied to the desired behavior.

#### Incentives for Prevention Services

Both prevention participation rewards and prevention out-of-pocket adjustments are supported by 77% of health plans. Prevention out-of-pocket adjustments provide incentives for enrollees to receive necessary vaccines and annual physicals. Prevention participation rewards may be used to encourage enrollees to complete Personal Health Assessment forms, which provide key data on enrollee health risks and identify behavioral changes that will prevent future illness.

#### Incentives for High Value Acute Episodes of Care Services

Only 26% of health plans offer out-of-pocket adjustments for selecting higher value acute services or participation in shared decision support leading to acute interventions. This type of

incentive program is relatively rare because there are relatively few procedures for which there is evidence-based support for making the choice that is the "right one" for the patient. This type of program may also require the health plan or employer to identify preferred providers who are best qualified to do the preferred procedure. This added level of complexity may be a barrier to setting up such an incentive program.

## Health Plan Capabilities to Support Incentives for Chronic Conditions, Prevention, and Acute Episodes of Care: Comparisons of National and Regional Plans

### Incentives for Chronic Conditions

Employers will find that national plans have greater capabilities to support incentives for chronic condition initiatives than do regional plans. A significantly greater number of national plans than regional plans are able to support both out-of-pocket adjustments and rewards linked to program participation relating to chronic conditions.

### Incentives for Prevention Services

National plans also have a greater capacity than regional plans to support incentives for prevention programs, but the gap is not as great. eValue8 results also reveal that the capability of regional plans to support incentives for prevention programs is much greater than their capability to support incentives for chronic condition management.

### Incentive for Acute Episodes of Care

Only a small number of national and regional plans support incentives for acute episodes of care. Regional plans are somewhat more likely to have that capability than national plans, although this capability is not widely available. When offered, the most common incentive is a reduction of a co-payment or deductible. The data also suggests that a higher percentage of health plans in the west and mid-west are offering this option.

As shown in Figure 6, a closer look at incentives offered by national and regional plans suggests that national plans generally have more sophisticated IT and operational capabilities to support VBBD. This is evidenced by the fact that incentive administration capabilities of regional plans are more centered around rewards that can be delivered offline and independently of the claims adjudication process.

FIGURE 6: PERCENTAGE OF HEALTH PLANS SUPPORTING INCENTIVES FOR CHRONIC CONDITIONS, PREVENTION AND ACUTE EPISODES OF CARE BY NATIONAL VS REGIONAL PLANS

| | Chronic Conditions | |
|---|---|---|
| Incentives | National Plans* | Regional Plans* |
| Out of Pocket Adjustments | 94% | 59% |
| Rewards Linked to Program Participation | 88% | 24% |

| | Prevention | |
|---|---|---|
| Incentives | National Plans* | Regional Plans* |
| Out of Pocket Adjustments | 82% | 72% |
| Rewards Linked to Program Participation | 84% | 70% |

| | Acute Episodes of Care | |
|---|---|---|
| Incentives | National Plans* | Regional Plans* |
| Out of Pocket Adjustments | 20% | 28% |

### Prevention example: Incentives for Weight Loss[21]

eValue8 contains a section specifically targeted at the plan's capabilities to address obesity. Obesity has become an acute problem in the United States, with over 34% of the adult population considered overweight and an additional 32% considered obese.[22] The dramatic rise in the incidence of diabetes is being linked to the increase in the number of overweight Americans. Excess weight is becoming American's number one public health problem. Increasing the number of enrollees who are participating in weight loss programs is important to improving the health status of an employer's covered population.

*Availability of Incentives for Program Participation or Working with Coach.*

Incentives for participating in a weight loss program and for achieving success with weight loss/maintenance are offered by 86% and 70% of all plans, respectively. Fewer plans provide incentives for working with a health coach. Approximately 60% of plans offer incentives for participating in wellness health coaching and for achieving wellness goals other than weight loss.

*Types of Incentives Offered.* As Figures 7 and 8 show, purchasing credits/discounts for consumer goods and offering discounts on health/wellness-related activities are the two most commonly offered incentives for participating in weight loss and wellness health coaching programs. Importantly, health plans are also offering incentives for successes, although incentives for program participation are more prevalent than incentives for achieving

successes. This difference may be due in part to the HIPAA non-discrimination issues that are raised by incentives tied to success, rather than participation.

### FIGURE 7: PERCENTAGE OF HEALTH PLANS OFFERING INCENTIVES FOR WEIGHT LOSS

| Incentives | Incentives to Participate* | Incentives for Success* |
|---|---|---|
| Cash payments (including salary differentials) | 22% | 19% |
| Purchasing credits/discounts for consumer goods | 49% | 41% |
| Discounts on health/wellness-related activities (weight loss programs, health clubs, etc.) | 59% | 42% |
| Health plan premium reduction | 21% | 18% |
| Health plan co-pay/deductible reduction | 22% | 23% |
| Other incentives | 40% | 36% |
| Incentives Not Available | 14% | 30% |

### FIGURE 8: PERCENTAGE OF HEALTH PLANS OFFERING INCENTIVES FOR WELLNESS HEALTH COACHING

| Incentives | Incentives to Participate* | Incentives for Success* |
|---|---|---|
| Cash payments (including salary differentials) | 36% | 33% |
| Purchasing credits/discounts for consumer goods | 41% | 40% |
| Discounts on health/ wellness-related activities (weight loss programs, health clubs, etc.) | 44% | 38% |
| Health plan premium reduction | 35% | 32% |
| Health plan co-pay/deductible reduction | 38% | 37% |
| Other incentives | 29% | 48% |
| Incentives Not Available | 39% | 41% |

** Shaded cells indicate top two incentives for each type of targeted behavior*

*Incentive Offerings by National and Regional Plans.*
When comparing the capacity of national and regional plans to offer the two most common wellness incentives for weight loss activities or participating with wellness coaches, Figure 9 indicates that a greater percentage of national plans than regional plans offer these incentives.

*Incentives for Use of Weight Loss Drugs*[23].
Very few health plans provide incentives for enrollees identified as obese to use weight loss drugs by waiving or reducing co-payment amounts. Only 9% of the health plans routinely reduce or waive co-pays for Xenical or Meridia, two popular weight loss drugs, although nearly 30% of the plans would do so at the purchaser's discretion. Between 61% and 62% of the health plans do not cover either drug.

Even fewer health plans (2%) will cover or reduce co-pays for those weight loss drugs as an incentive to participate in behavioral counseling. Approximately 25% of the health plans will do so at the purchaser's discretion.

Health plans primarily offer discounts to Weight Watchers or for health club membership as incentives to lose weight, neither of which is linked to using weight loss medications.

*Interventions Included in the Weight Management Programs.*[24]
Although few health plans offer incentives to use weight loss drugs, they do offer a range of interventions designed to engage patients in meeting their weight loss goals. As Figure 10 reveals that the most common interventions are web-based information and educational materials. More rare are programs that are more labor intensive, such as obesity centric telephonic coaching or in-person group sessions or classes. Even though obesity is increasingly a problem among children and adolescents, very few health plans have special programming for children or adolescents.

### FIGURE 9: PERCENTAGE OF HEALTH PLANS OFFERING WELLNESS INCENTIVES BY TYPE OF INCENTIVE AND TARGETED BEHAVIOR

| Incentive | Purchasing credits/ discounts for consumer goods | | Discounts on health/wellness-related activities | |
|---|---|---|---|---|
| | National Plans | Regional Plans | National Plans | Regional Plans |
| Participating in weight loss programs | 61% | 37% | 67% | 52% |
| Success in weight loss/ maintenance | 61% | 22% | 61% | 24% |
| Participate in wellness coaching | 57% | 26% | 63% | 26% |

## Tiered Network Plans[25]

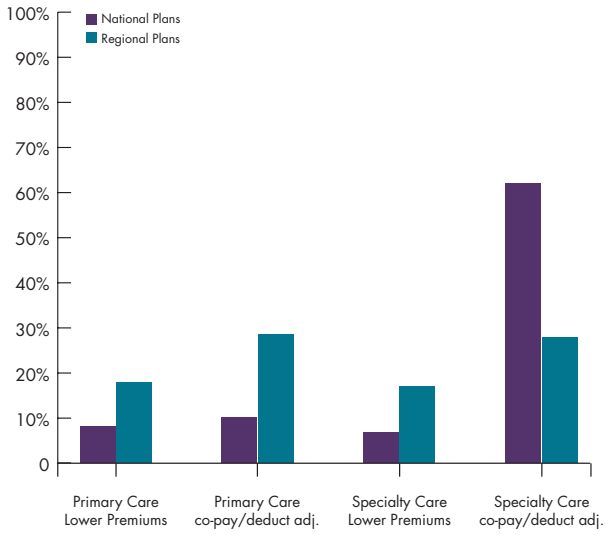
A tiered network VBBD plan is one that evaluates providers based on cost and quality measures, places them in tiers, and encourages consumers through use of financial incentives to use the highest performing providers. Tiered networks can be created for primary care providers, specialty providers and/or hospitals.

### Availability of Primary and Secondary Tiered Network Plans

In general, primary care tiered networks are less available than specialty tiered networks. Regional plans are more likely to offer tiered primary care networks and national plans to offer tiered specialty plans. Only 24% of all plans offer a tiered primary care network with 35% of regional plans (verses 12% of national plans) offering tiered primary care networks. 50% of all plans offer tiered specialty care networks with 65% of national plans (verses 35% of regional plans) offering tiered specialty care networks.

As Figure 11 indicates, the most common type of consumer incentive for both tiered primary care and specialty networks are out-of-pocket adjustments, such as reduced or waivers of co-payments, co-insurance or deductibles. Lower premiums are less frequently used as incentives for both primary and specialty networks. This is reasonable, since reduced co-payments or co-insurance amounts are more directly tied to the desired behavior of selecting specific high performing providers at the time services are needed and lower premiums suggest a narrow network, which are only beginning to re-emerge in the aftermath of the sharp decline in HMO popularity.

## FIGURE 11: PERCENTAGE OF HEALTH PLANS OFFERING TIERED NETWORK INCENTIVES BY TYPE OF INCENTIVE




### Employer Considerations

When selecting a tiered network plan that offers differential co-pay, co-insurance or deductible, purchasers should consider whether the cost differentials are significant enough to steer consumer choice. When selecting a plan with a narrow network that offers a lower premium, purchasers must also consider how their enrollees will react to a network that may not include their long-time providers.

## FIGURE 10: MOST COMMON TYPES OF INTERVENTIONS USED IN WEIGHT MANAGEMENT PROGRAMS

| Intervention | Standard Offering | Option to Purchase | Option not Available | Special Programming for children/ adolescents |
|---|---|---|---|---|
| Web & printed educational materials about BMI and importance of maintaining a healthy weight | 94% | 7% | 3% | 31% |
| Discounts for Weight Watchers, fitness center discounts | 86% | 16% | 3% | 5% |
| Online interactive support that might include tools and/or chat sessions | 81% | 5% | 16% | 19% |
| Printed (not online) self-management support tools such as BMI wheels, pedometer or daily food & activity logs | 73% | 22% | 18% | 10% |
| Telephonic coaching that is obesity-centric | 57% | 17% | 32% | 5% |
| In-person group sessions or classes that are obesity centric | 52% | 18% | 30% | 5% |
| Obesity-centric telephonic or in person family counseling to support behavior modification | 39% | 5% | 53% | 12% |
| Pedometer and/or biometric scale or other device for home monitoring and that electronically feeds a PHR or EMR | 20% | 3% | 77% | 0% |

# IV. CONCLUSION

Value-Based Benefit Design changes the basic paradigm upon which benefits are provided to the consumer. Instead of setting uniform co-payment or deductible levels for all services, VBBD bases co-payments and deductibles on the value of the service to the consumer. Higher value services have lower out-of-pocket costs to provide incentives to the consumer to use the high value services. Because value will be different for consumers with different health care or wellness needs, the administration of a VBBD program is substantially more complicated than a standard plan design. The eValue8 tool has a robust question set to examine a health plan's capabilities to offer and support a VBBD program, which this report has highlighted.

Approximately 80% of health plans have the capability to offer incentives to manage specific diseases or to promote preventive care for children, adolescents and adults. Diabetes and asthma are the disease-specific conditions most health plans support with incentives. Health plan capabilities to support VBBD incentives for well-child and adolescent visits and preventive care are also strong. Few health plans offer incentives for selecting specific acute care services known to be of higher value.

Incentives for managing chronic conditions and receiving preventive services are most frequently in the form of reduced or waived co-payments amounts. However, incentives to participate in health promotion and wellness programs are most frequently in the form of purchasing credits/discounts for either consumer goods or wellness-related activities.

National plans have greater capacities than regional plans to support incentives based on waiver or modification of copayments, co-insurance or deductibles, which are operationally complex to implement. Support for incentives to encourage receiving well-child and adolescent visits and preventive services is strong among all plans. Both national and regional plans can support incentives for health promotion and wellness programs at comparable levels.

In general, across all health plans, specialty tiered networks are more available than primary care tiered networks. More regional plans offer tiered primary care networks and more national plans offer tiered specialty networks. The most common type of consumer incentive for both tiered primary care and tiered specialty care networks is differential co-payments.

Both national and regional plans have developed the basic infrastructure to support a VBBD program, including creating actionable PHA information, and offering disease management and pharmacy management programs. Fewer health plans offer provider and hospital selection support, on-line provider quality information or treatment choice support.

As VBBD programs mature, we anticipate that employers will begin applying disincentives selectively for services that are discretionary and of little proven value, such as using an MRI to diagnose back pain. The opportunities to apply VBBD principles will also be expanded as areas of comparative effectiveness research are expanded, enhancing the national dialog on what is quality care. More research is also needed on how to best structure incentives to encourage use of high value services and support healthy lifestyle changes.

VBBD programs are consistent with and reinforce a broader employer strategy to promote employee health as a way to improve productivity and maintain a competitive edge.

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[8] The data presented in this report are from 2008 eValue8, unless otherwise noted. The number of responses to each question varies.

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[16] Information on PHAs is based on plan responses to 1.4.5, 1.6.3, 5.4.1, 5.4.3, 5.4.5, and 5.4.6.

[17] Based on responses to question 6.2.4, 6.3.4, 6.3.6

[18] Based on responses from question 4.3.6, 4.7.2

[19] Based on responses to questions 2.2.1, 2.3.1, 2.3.3, 2.4.3

[20] All information for Part 1 comes from responses to questions 1.6.2 and 1.6.3, unless indicated otherwise.

[21] Information on wellness incentives is based on plan responses to question 1.6.3. Information on plan availability is based on plan responses to question 1.4.5.

[22] Statistics accessed on May 15, 2009 at http://www.cdc.gov/nchs/fastats/overwt.htm

[23] Based on plan responses to question 5.8.8

[24] Based on plan responses question 5.8.5

[25] Information on tiered accounts is based on plan responses to questions 3.6.3, 3.6.6 and 3.6.8, 3.8.2, 3.8.5

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