

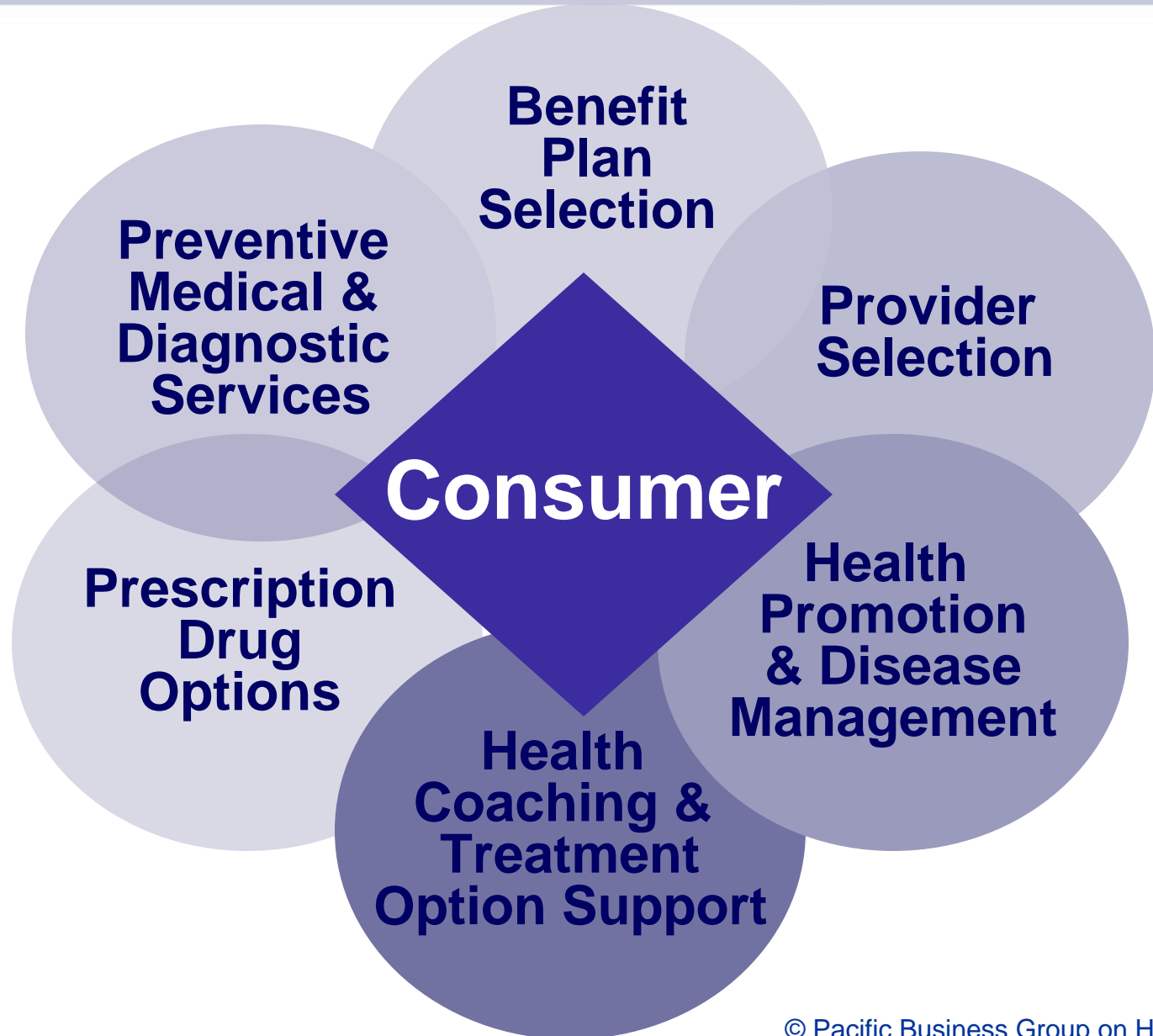
Evidence and Impact of Value-Based Benefit Design

Emma Hoo, Director of Value-Based Purchasing
Pacific Business Group on Health

National Pay for Performance Summit
March 10, 2009



A Vision for Value-Based Benefit Design



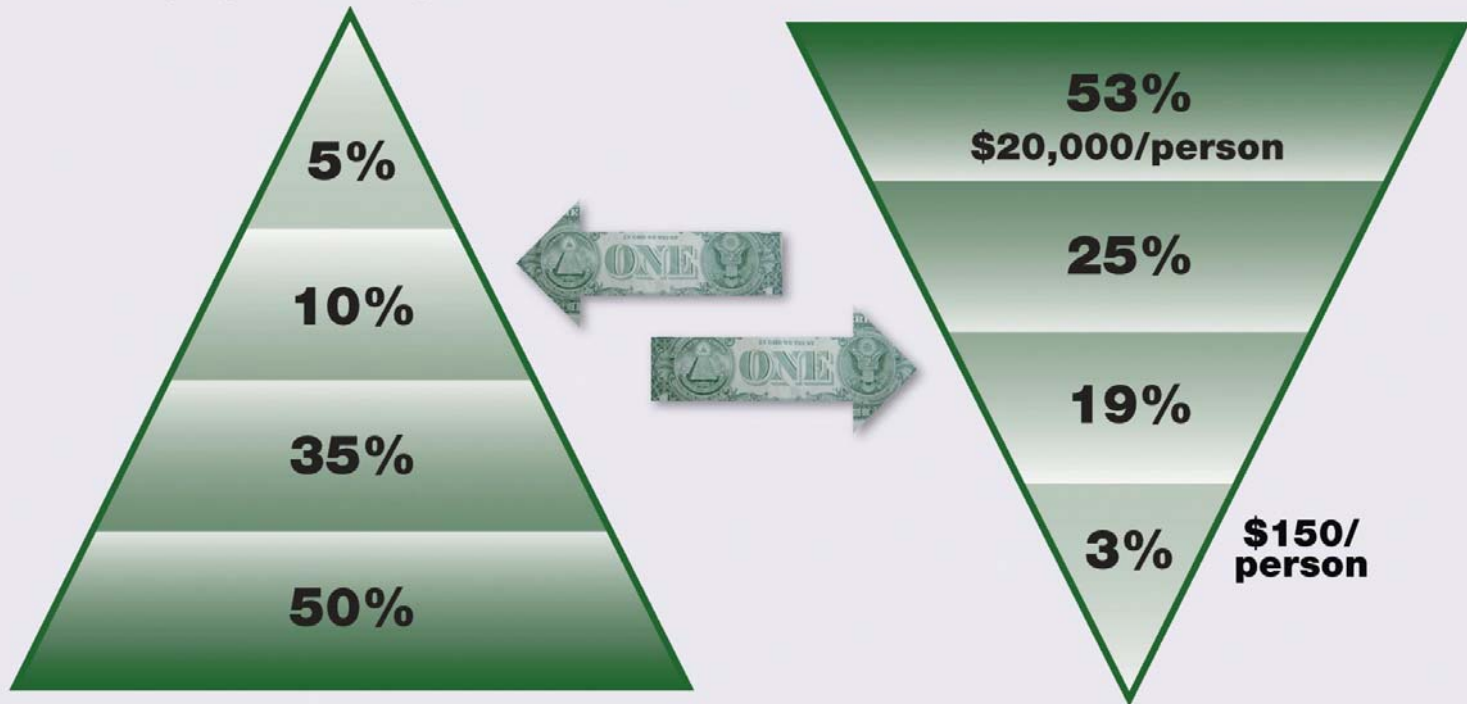


Harnessing the Value of Health Management

15% of People Account for Nearly 78% of Cost

Employees & Dependents

\$\$\$



Adapted from Mercer HR Consulting

% of Employees	5%	10%	35%	50%
% of Claims	53%	25%	19%	3%
Average Claims/Employee	\$20,000	\$5,000	\$1,000	\$150

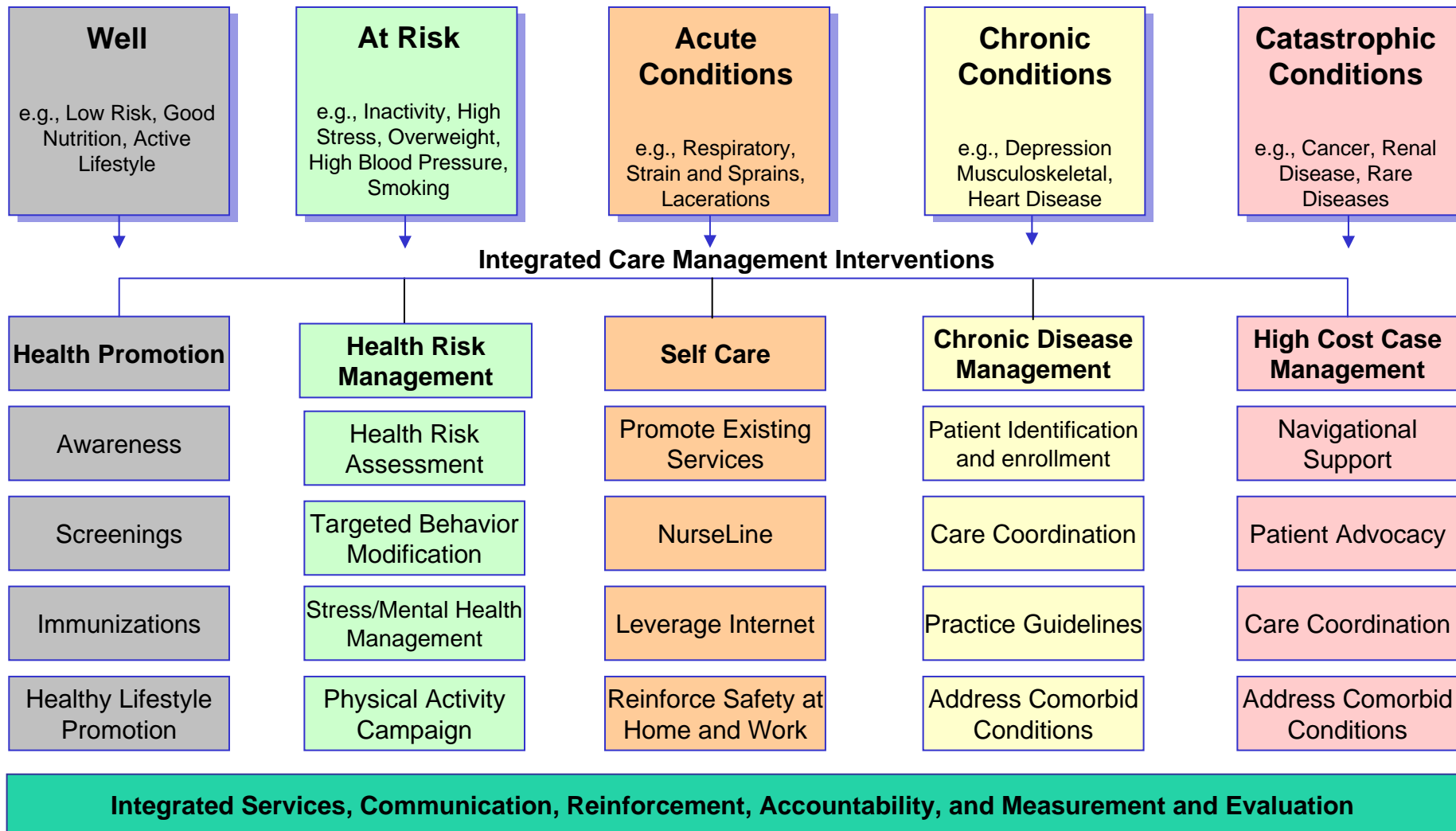


Health Promotion, Risk Reduction and Disease Management Support

- Coverage policy (e.g., nutritional consult with dietician for diabetics)
- Reduced barriers to access to improve adherence (e.g., first dollar coverage or reduced out-of-pocket costs for diagnostic testing, maintenance medication)
- Incentives to obtain care management support and provide self-report information (e.g., rewards for participation)
- Purchaser expectations for plan/vendor performance and services
 - Mechanisms to connect member to care
 - Self-report data merged with claims
 - Availability of personal care tools
 - Customized, personal messaging
- Performance and measurement criteria
 - Member engagement
 - Quality and health status outcomes



Targeting Incentives: A Continuum of Health and Disease Management Services





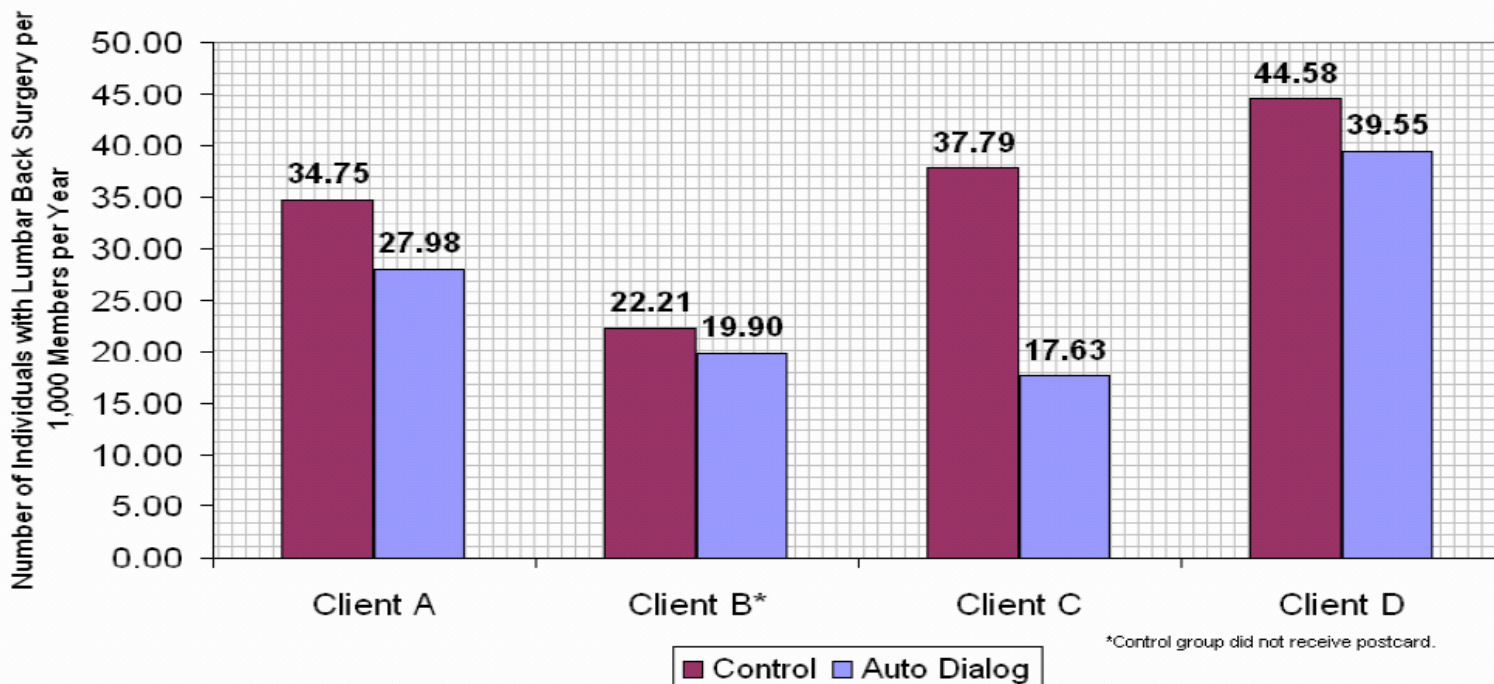
Health Coaching & Treatment Option Support

- Early identification of members
 - Just diagnosed
 - Ongoing illness
 - Personal behavior change
 - Annual budgeting and planning
- Treatment options tailored to individual
 - Preference-sensitive
 - Integrated with benefit design and cost information
- Coordination between medical group/provider and patient
- Coordination between plan and medical group/provider
- Coordination between plan and patient
- Support for risk reduction and self-care
- Performance and measurement criteria
 - Member identification and engagement
 - Quality and health status outcomes



Health Dialog Consumer Support through Interactive Voice Response

Lumbar Back Surgery Rates for Commercial Clients



Overall, the AutoDialog group had 21% lower surgery rates than the control group ($p < .05$) 12 months after outreach.

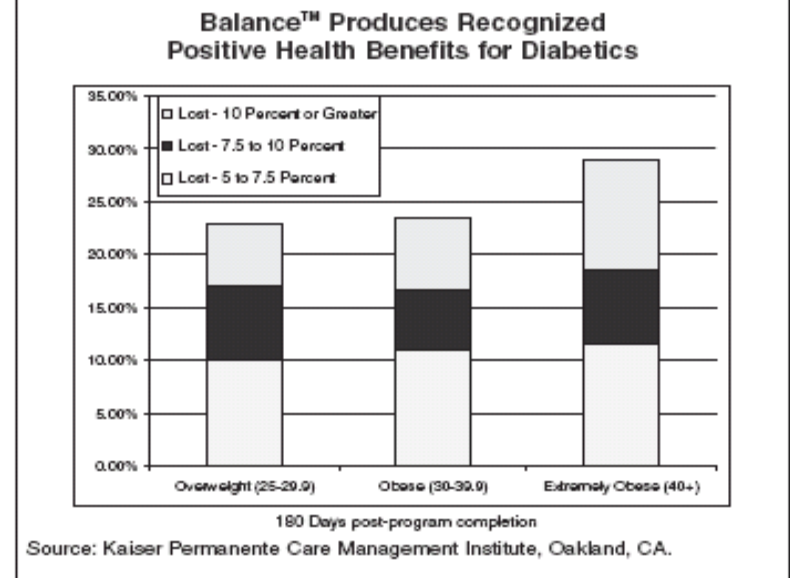
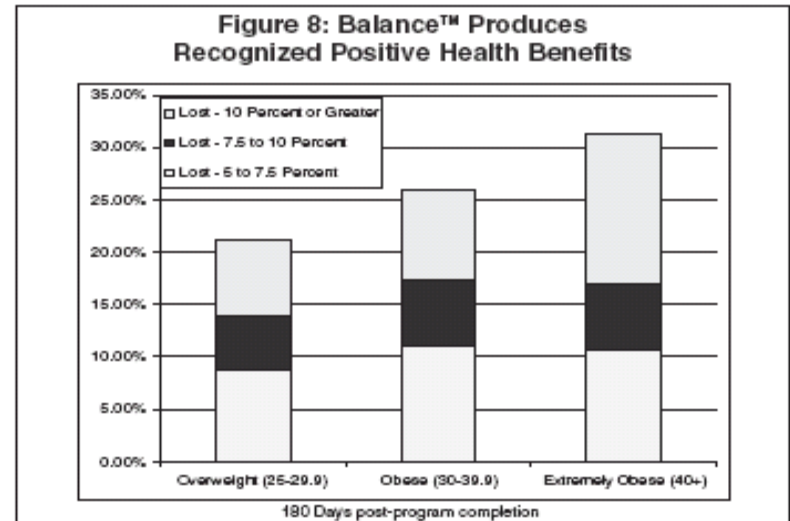
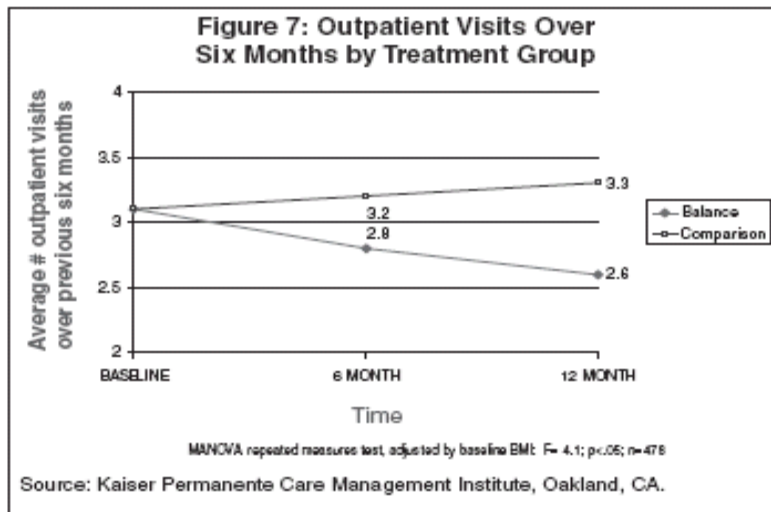
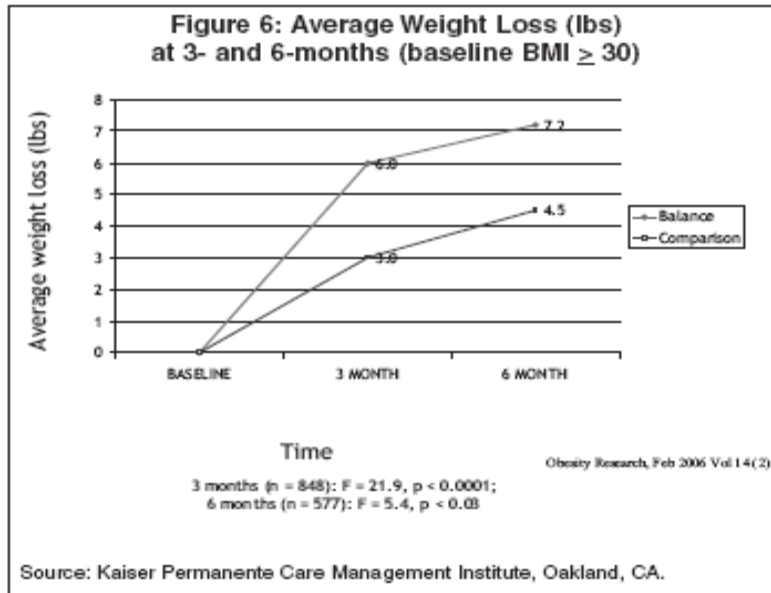
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Harnessing the Value of Behavior Change, Self-Care and Risk Reduction





Prescription Drug Options

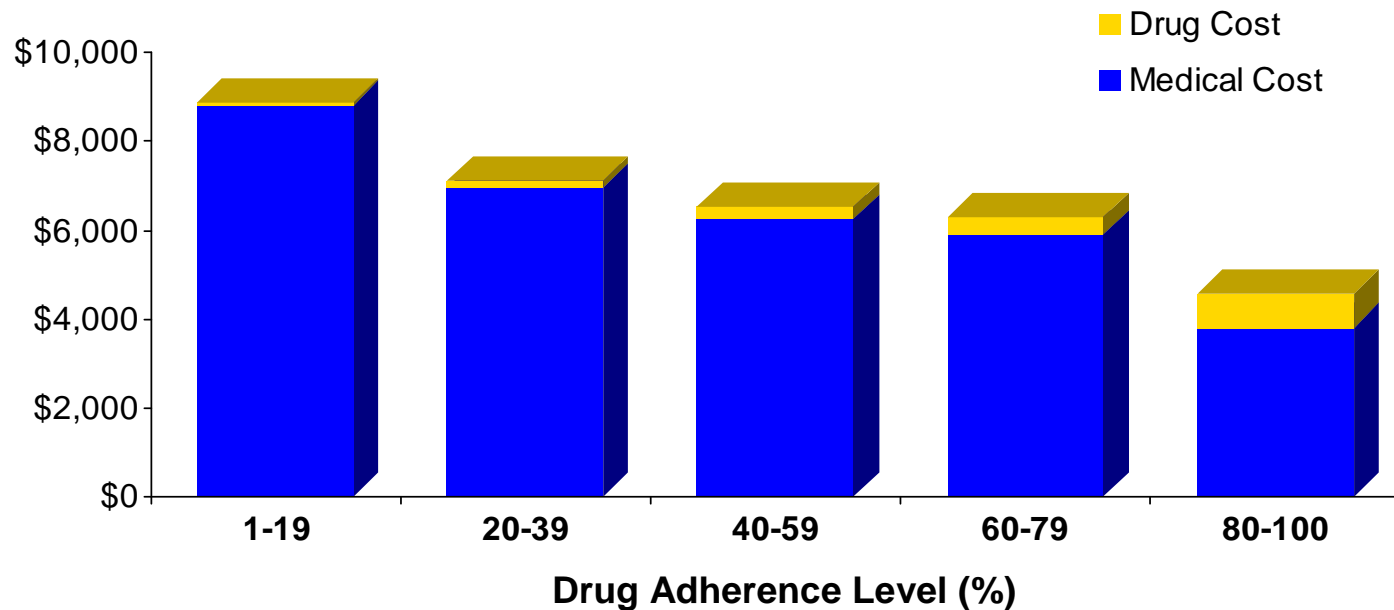
- Assess data
 - Quantify population prevalence of health condition
 - Evaluate level of non-adherence and improvement opportunity
- Incentives for access, adherence or engagement in managing health condition
- Rewards for behavior change
- Coordination with medical benefits
 - Coverage for routine diagnostic services to manage chronic condition
 - Coverage for services that support behavior change (e.g., nutritional counseling for diabetics)
- Performance and measurement criteria
 - Medication adherence and possession rates
 - Utilization changes (e.g., avoided admissions or ER visits)
 - Quality and health status outcomes



Understanding the Cost Impact of Improved Prescription Drug Adherence

Diabetics who stay on therapy have lower overall healthcare costs¹

The Value of Compliance With Drug Regimens



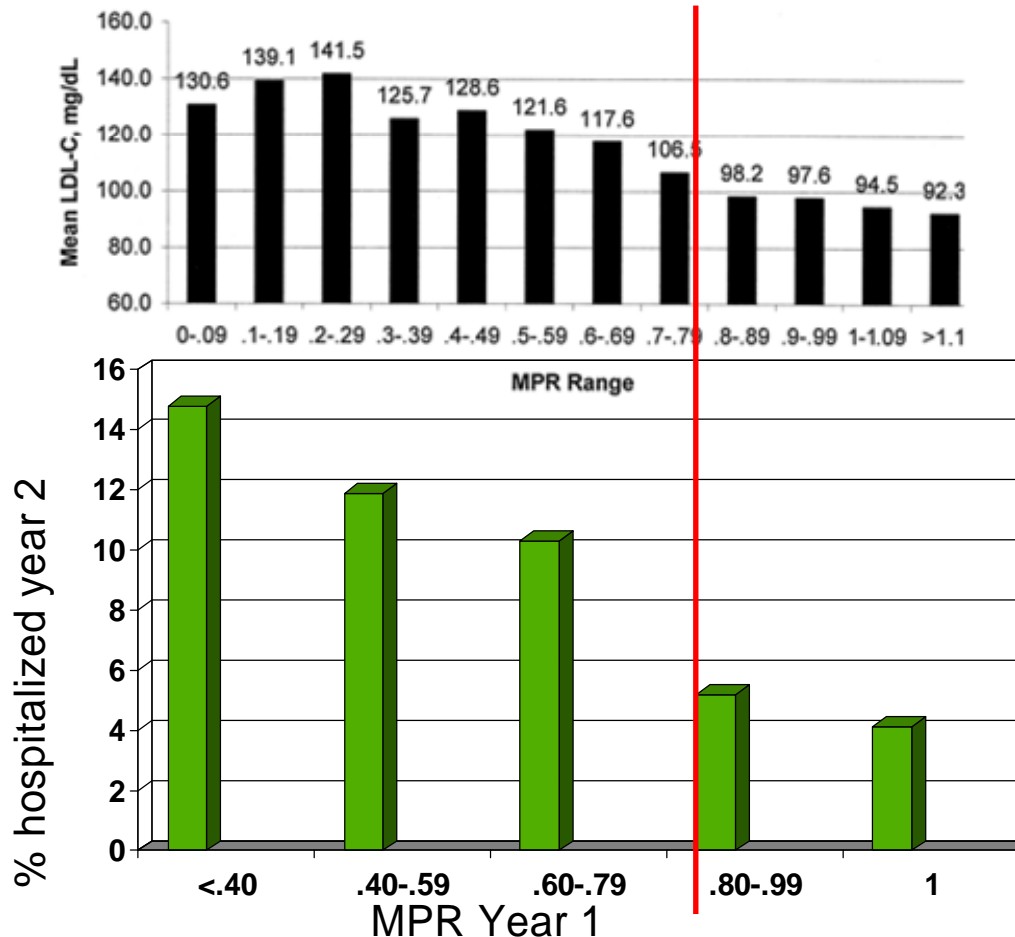
¹Sokol, MC, McGuigan, KA, Verbugge, RR, Epstein, RS. *Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost.* Medical Care 2005; 43: 521-530.

Source: Presented by Jane Barlow, MD at PBGH Pharmacy Symposium, April 2008



Understanding the Cost Impact of Improved Prescription Drug Adherence

Compliance (MPR) Improves Blood Levels And Reduces Hospitalizations^{1 2}



Target compliance MPR \geq 80%

¹Parris ES et al: Adherence to Statin Therapy and LDL Cholesterol Goal Attainment by Patients With Diabetes and Dyslipidemia *Diabetes Care* 28:595-599, 2005

²Lau DT, Nau DP: Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals With Type 2 Diabetes. *Diabetes Care* 27:2149-2153, 2004

Source: Presented by Jane Barlow, MD at PBGH Pharmacy Symposium, April 2008



Preventive Medical and Diagnostic Services

- Prioritize evidence-based clinical preventive services with greatest economic and health value
- Map to population risk profile
- First dollar coverage of preventive services or modest cost-share
- Broad communications
- Personalized messaging and reminders
- Performance and measurement criteria
 - Member identification and engagement
 - Quality and health status outcomes



The Evidence for Preventive Medical and Diagnostic Services

Service	CPB — Maximum Score = 5	CE — Maximum Score = 5	Combined Score CPB and CE — Maximum Score = 10
Aspirin chemoprophylaxis	5	5	10
Childhood immunization series	5	5	10
Tobacco use, screening and brief intervention	5	5	10
Problem drinking, screening and brief counseling	4	4	8
Colorectal cancer screening	4	4	8
Hypertension screening	5	3	8
Influenza immunization	4	4	8
Pneumococcal immunization	3	5	8
Vision screening (adults)	3	5	8
Cervical cancer screening	4	3	7
Cholesterol screening	5	2	7
Breast cancer screening	4	2	6
Calcium chemoprophylaxis	3	3	6
Chlamydia screening	2	4	6
Vision screening (children)	2	4	6
Folic acid chemoprophylaxis	2	3	5
Obesity screening	3	2	5
Depression screening	3	1	4
Hearing screening	2	2	4
Injury prevention, counseling	1	3	4

CPB indicates clinically preventable burden; CE, cost-effectiveness.

^aEvaluated in terms of the clinically preventable burden of disease and cost-effectiveness.

Dyann M. Matson Koffman, DrPH, MPH, CHES, Andrew Lanza, MPH, MSW, Kathryn Phillips Campbell, MPH. *A Purchaser's Guide to Clinical Preventive Services: A Tool to Improve Health Care Coverage for Prevention*

http://www.cdc.gov/pcd/issues/2008/apr/07_0220.htm



Incentives Work, *but...*

- Benefit design (consumers) and reimbursement methods (providers) inherently provide incentives
- Incentives interact with one another and drive all stakeholders' behavior
- Key challenges confronted today have to do with alignment of incentives:
 - discourage “bad” and encourage “good” behaviors
 - efficiently target incentives to reward change in behavior while still encouraging those who are already “there”
 - facilitate good doctor-patient relationships without adding excess burdens
 - Consider impact of incentives on *all* stakeholders



A Toolkit for Value-Based Benefit Design

- Develop framework for implementation
- Define benefit actions and opportunity for product types
 - HMO
 - PPO
 - CDHP
 - Self-funded vs. insured
- Estimated short, medium and long-term impact
 - Total claims experience (utilization) in ASO settings
 - Premiums (pmpm) in insured settings
 - Indirect financial benefits
 - Quality of care
- Provide common benefit design language and benefit coverage interpretation



PBGH-Milliman Project (example)

Nature of Incentive/Design	Action(s) Sought and Goal(s)
<p>Preventive medical and diagnostic services</p> <ul style="list-style-type: none"> • Reduced copayment for preventive adult services (well-baby/child preventive visits are already commonly offered with reduced copayments) • Reduced copayment for diagnostic services (e.g., colonoscopy) • Additional categories to be addressed (map to CDC-NBGH preventive guidelines) 	<p>Action: Increase use of EBM-supported preventive care generally; promote screening.</p> <p>Goal: Increase preventive care and early intervention in disease.</p>
<p>Health and disease management</p> <ul style="list-style-type: none"> • Positive incentive (payment of premium or fund HSA) or reduced co-payment (insurance) to participate • Positive incentive (payment of premium or fund HSA) or reduced co-payment (insurance) to complete HRA • Positive incentive to use other online tools or personal health record 	<p>Action: Encourage better compliance with treatment for individuals with chronic illness; may also include incentives to promote engagement in shared decision-making to encourage more preference-sensitive patient decision-making.</p> <p>Goal: reduce morbidity/mortality and costs for chronically ill; increase patient engagement in self-care and adherence.</p> <p>Action: Consumer self-assessment of health status and engagement opportunities.</p> <p>Goals: (1) Encourage better patient engagement in their own care; (2) create data platform to provide data interchange and electronic transmission of patient information to emergency rooms and/or other service sites to avoid unnecessary tests</p>
<p>Treatment option decision support</p> <ul style="list-style-type: none"> • Positive incentive to use treatment decision support • Reduced copayment or coinsurance for services upon completion of decision support/health coach encounter 	<p>Action: Increase selection of lower-cost alternative treatments that are preference-sensitive.</p> <p>Goal: Reduce cost without reducing quality</p>



Challenges: Implementation Issues

- **Conditions to advance purchaser engagement**
 - Creating and communicating the business case
 - Quantifying the value
 - Documenting the evidence
 - Enhancing the availability of performance information
- **Conditions to advance consumer engagement**
 - Price and quality transparency
 - Product choice
 - Communication and health education
 - Consumer decision support infrastructure and services with trusted information
- **Conditions to advance provider engagement**
 - Documenting evidence
 - Demonstrating link to quality improvement
 - Effective engagement by plans and other sponsors



To Learn More...

www.pbgh.org – an overview of PBGH programs and initiatives

<http://blog.pbgh.org> – commentary on health care policy and reform

www.calquality.org – an overview of the California Quality Collaborative (CQC) with resources for providers

www.cchri.org – an overview of the California Cooperative Healthcare Reporting Initiative (CCHRI)

To subscribe to the PBGH E-Letter, go to www.pbgh.org/news/eletters