

2015 Connecticut's Health Enhancement Plan for State Employees UPDATE



Connecticut's Health Enhancement Plan for State Employees: Improving health outcomes and consumer engagement

Connecticut's V-BID plan

At a time when state governments are [under considerable strain](#) to cover the escalating cost of active and retired employee health benefits, many states have sought measures to improve care quality and increase beneficiary accountability as part of a multifaceted approach to reducing health care expenditures.

Faced with a nearly \$4 billion budget gap in fiscal year 2012, members of the State of Connecticut's Governor's Office, Office of the State Comptroller and state employee union coalitions worked together to negotiate and implement an innovative, clinically nuanced **value-based insurance design** (V-BID) plan as a means to control long-term costs.



[V-BID Overview](#)

[V-BID](#) is built on the principle of lowering or removing financial barriers to essential, high-value clinical services by aligning patients' out-of-pocket costs, such as copayments, with the value of services. V-BID products and plans are designed with the tenets of "clinical nuance" in mind. These tenets recognize that 1) medical services differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, as well as when and where the service is provided.

Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent.

Known as the [State of Connecticut Health Enhancement Program](#) (HEP), HEP incorporates [V-BID principles](#) of reduced cost-sharing for high-value clinical services and targeted patient incentives to eliminate barriers to evidence-based care. Specifically, HEP offers reduced monthly premiums and lower cost-sharing if enrollees commit to yearly physicals, age- and gender-appropriate health risk assessments and evidence-based screenings, physical and vision examinations, and free dental cleanings. Enrollees with certain chronic conditions are required to utilize specific guideline-based clinical services and medications, and co-pays are eliminated for those requirements. HEP enrollees also face an additional co-pay for non-emergent use of the emergency room. Those who do not comply with program requirements may be disenrolled from HEP; however, they may re-enroll when those requirements are met. Non-participants and participants who did not comply with program requirements face a \$100 monthly premium surcharge.



[Read Brief](#)

For more comprehensive information about HEP, including initial results, please view the University of Michigan Center for Value-Based Insurance Design [January 2013 issue brief](#).

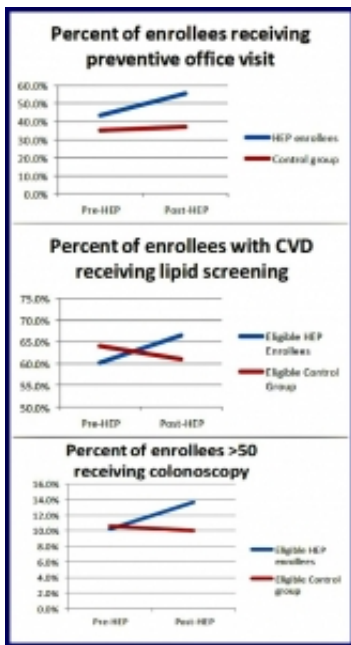
HEP's Initial Effects on Service Utilization

In the HEP program's introductory year, 98 percent of state employees and their dependents enrolled in the program and 98 percent of enrollees met compliance standards required to receive reduced monthly premiums. HEP administrators noted that compliance standards were being phased in (e.g., preventive services with less than annual frequencies, preventive visits for those under age 50), so noncompliance primarily stemmed from failure to receive services expected annually (screenings with annual frequencies for the subset of enrollees targeted for those tests, dental visits, or preventive office visits for those over 50 years of age). Approximately half of the enrollees deemed noncompliant restored their status within several months of facing the \$100 premium surcharge.

To assess HEP's preliminary impact on overall preventive service usage and services targeted for chronic conditions, University of Michigan researchers compared usage changes in the first HEP plan year (July 1, 2011-June 30, 2012) to the prior plan year. To control for underlying trends, the research team compared those changes in utilization to changes over the same time period in a control group of state employee health plan enrollees in four different states without a comparable intervention. These control states were derived from TruvenHealth's MarketScan data base. Analyses were limited to adult enrollees and dependents (age 21 and over), resulting in samples of

about 82,247 in Connecticut and 265,114 in the control states. Demographics were very similar across groups (average age 43.6 years in each group; 57.7% female in Connecticut vs. 54.7% in the control states).

Relative to employees and dependents in the control states, Connecticut state employees and dependents experienced significant improvements post-HEP for a variety of standard preventive measures. Receipt of a preventive diagnostic office visit rose by 10.6 percentage points (PPT) and receipt of lipid tests increased (12.7 PPT overall; 16.0 PPT in those over 50 years of age). Similar improvements were seen in age and sex specific services including colonoscopy and fecal occult screening for those above age 50 (4.3 and 3.7 PPT, respectively), mammography for women over age 35 (6.7 PPT) and pap smears (4.3 PPT).



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Service utilization improvements across several targeted chronic condition cohorts were also documented. Among enrollees with diabetes, receipt of one or more office visits (3.2 PPT), lipid tests (6.9 PPT), A1c tests (5.6 PPT) and eye exams (3.3 PPT) all increased. Additionally, there is a higher likelihood among those with congestive heart failure/heart disease, of receiving one or more office visits (2.1 PPT) and lipid screenings (9.4 PPT) after HEP enrollment. Finally, among those with COPD or asthma, the likelihood of receiving one or more office visits increased by 3.3 PPT with participation in HEP.

Summary and Future Directions

Despite a delayed rollout three months into the plan year, and limited enforcement of requirements during the first year, clinically meaningful improvements in utilization of evidence-driven services in the HEP enrolled population were realized. The use of both overall and recommended preventive services in chronic disease cohorts increased after HEP implementation relative to trends observed in a comparison group of employees and dependents of four other state governments. These findings point to the potential of V-BID as a tool for increasing the value of care in state employee populations and other groups, and demonstrate the importance of using multiple kinds of incentives and enrollee-accountability standards. While initial results are promising, further analyses of data for subsequent program years will determine whether these findings persist or even strengthen as the program matures and systematic enfor

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Additionally, as the HEP program matured, compliance standards have become more rigorous. In addition to enforcing requirements for less-than-annual preventive service (e.g., preventive visits for enrollees under age 50 and non-annual screenings), exceptions granted in the plan's first year such as time extensions to receive mandatory services have been phased out, while communication regarding program requirements and compliance status has been enhanced. Even with these adjustments, HEP participation and compliance remains high. In the recently completed annually cycle, 96 percent of enrollees were in compliance. Based on results from prior cycles, the state anticipates that approximately half of those deemed out-of-compliance will restore their status in the program within several months of facing the premium surcharge, suggesting that the reduced premium for HEP enrollees is a significant compliance motivator.

HEP's focus on primary care coupled with member engagement and education aligns with established health care quality initiatives such as patient-centered medical homes (PCMHs) coordinated with Accountable Care Organization (ACO) initiatives. To date, nearly half of HEP members participate in ACO arrangements featuring shared-savings benefits for meeting or exceeding quality metrics.



[Partners for a healthy Connecticut](#)

Increased enrollee participation and engagement may have systemic benefits as well. By expanding enrollee education efforts/provider communication measures exploring appropriate care and increasing enrollee access to quality and cost data, HEP addresses quality measures intended to produce greater health care system cost-and-service delivery transparency. Currently, based on early results, HEP has been expanded to some of the state’s municipal employees through the [Connecticut Partnership Plan](#) with several thousand municipal employees already enrolled, while other municipalities are actively considering adoption. Given these results, HEP may serve as a model program across other employee groups in the future.

In conclusion, responding to a potential insurmountable budget deficit, the State of Connecticut has spearheaded a deliberate attempt to improve enrollee health outcomes using a combination of value-based benefit design concepts and clinically nuanced incentives geared toward reducing unnecessary spending in accordance with clinical guidance and greater attention to both individual and municipal fiscal accountability.