COMMONWEALTH of VIRGINIA

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The Honorable S. Chris Jones, Chairman, House Appropriations Committee
The Honorable Thomas K. Norment, Jr., Co-Chairman, Senate Finance Committee
The Honorable Emmett W, Hanger, Jr., Co-Chairman, Senate Finance Committee

Subject: Review of Shared Savings Incentive Programs

The attached report is pursuant to Chapter 836, Item 85.J. of the 2017 Virginia Acts of the General Assembly.

Please contact me if there are any questions.

Sincerely,

Gene Raney
Director, Office of Health Benefits

cc: The Honorable Nancy Rodrigues, Secretary of Administration
Sara R. Wilson, Director, Department of Human Resource Management

VIRGINIA DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

Chapter 836, Item 85.J
Review of Shared Savings Incentive Programs

November 1, 2017

Review of Shared Savings Incentive Programs

Introduction

The Department of Human Resource Management (DHRM) was directed to evaluate the merits of implementing a shared-savings incentive program for state and local government employees and retirees and present its findings in a report to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2017, in response to Chapter 836, Item 85.J, which states:

> *The Department of Human Resource Management shall identify the requirements, costs, and benefits of implementing a shared-savings incentive program for state-employed, public sector or retired enrollees who elect to shop and receive health care services at a lower cost than the average price paid by their carrier for a comparable health care service. Under such a program, the Department shall develop a plan to reimburse the insured for using a lower cost site of service. The cash payment incentive could be calculated as a percentage or as a flat dollar amount, or by some reasonable methodology determined by the Department. The Department shall determine whether to administer the program itself or through a third-party, or to require carriers to offer access to such a program for health care services eligible for shared incentives and estimate the projected fiscal impact of the program. No later than November 1, 2017 the Department shall report to the Chairmen of the House Appropriations and Senate Finance Committees.*

This report document is responsive to this requirement.

During the process, DHRM was assisted by the Acting Director of State Payroll Operations with the Department of Accounts (DOA) and Aon, the State Employee Health Benefits Program's actuary and consultant. The following steps were taken to identify marketplace capabilities and related challenges to requirements contained in the budget item, in addition to familiarity with similar shared savings incentive programs implemented by other large public sector entities.

Marketplace Capabilities

To obtain an understanding of the capabilities that exist in the marketplace, interviews were conducted with Healthcare Blue Book (HCBB) and Vitals, the two leading administrators of shared savings incentive programs (both of which have extensive experience with public sector incentive programs). Information was also gathered from Anthem and Aetna, the claims administrators for the Commonwealth of Virginia's self-insured Employee Health Benefits Plans. An interview was requested with Castlight Health, but Castlight declined the request. DHRM also met with a representative of the Foundation for Government Accountability to discuss its interest in shared savings incentive programs.

- ***Healthcare Blue Book (HCBB)***

  HCBB was interviewed on June 16, 2017, and key findings are provided below.

  - HCBB has developed a simple color-coded system to identify **provider cost rankings**. Quality designations are indicated with Check+ (plus), Check or Check– (minus) iconography.
  - HCBB's primary **source of pricing** is the client's historical claims data. For Anthem plans, they can use the National Blues' price database. All pricing is based upon the allowed amount, which is the amount paid after the claims administrator's contractual rate is applied.
  - Inpatient **quality ratings** are derived from CMS MedPar data. Outcomes are evaluated in four dimensions including mortality, complications, safety and compliance with standard protocols. Outpatient quality measures are challenging to develop since CMS does not release this information. HCBB is seeking development of a specialty physician quality evaluation tool on high volume procedures.
  - **Incentives are paid** as an additional sum into a member's paycheck, or as a cash reward via a separate check. Both would be subject to tax. HCBB does not issue 1099 forms to employees. The health plan will need to arrange for all required tax documents.
  - **Incentives are triggered** based on the cost of the facility used for a procedure, not on the professional provider because differences in cost are primarily driven by facility. Their standard incentive program uses fixed nominal reward amounts (as examples, $50, $100, $250).
  - They have a **customer service team** available to help members, but members can engage electronically to earn rewards.
  - They assert that it is difficult for **claims administrators** to directly administer this type of program because they cannot steer members to specific low-cost entities due to network contracts and anchor hospitals' desire for steerage to their facilities.
  - HCBB would be **paid by the health plan** on a Per Employee Per Month (PEPM) basis and could offer a Return On Investment (ROI) guarantee if the health plan would meet certain requirements, such as managing a specified amount of the communication effort.
  - HCBB has **experience** with administration of public sector employer incentive plans and considers Vitals and Castlight as their primary competition in this arena.

- ***Vitals***

  Vitals was interviewed on June 19, 2017 and key findings include:

  - They have **interactive tools** for employees and a **customer service team**. Members can call Vitals to determine where a procedure can be administered to receive an incentive.

  - Vitals has an **existing relationship with Anthem** to receive claim and eligibility data, which is required to administer their *SmartShopper* program.

  - **Claim savings** are determined by subtracting the actual cost from the allowable charge.

  - They can **incorporate wellness programs**, like MyActiveHealth, in their tool.

  - **Incentives are triggered** based on the cost of the facility used for a procedure, not on the professional provider because differences in cost are primarily driven by facility.

  - The **average amount of incentives** paid to participants is $80. Incentives increase in relationship to the cost of the procedure. The most frequent procedures for which incentives are available include lab work, mammograms, MRIs, colonoscopies, CT Scans, hip/knee surgeries and Remicade therapy treatments. If this program is implemented, they predict that the promise of employee incentives will spike claims for colonoscopies and mammograms.

  - Vitals sets the **incentive levels** and does not advocate placing a limit on incentives received during a plan year.

  - Vitals **reaches out to employees** who had qualifying procedures and did not seek information regarding incentives, letting them know that they missed an incentive opportunity and how to qualify in the future.

  - Although incentives are earned strictly on the basis of cost savings, Vitals also provides **quality information** to members. Quality data is obtained from a variety of trusted sources including the Centers for Medicare and Medicaid Services (CMS). The balance of cost and quality is used to guide members to high value or best buy locations for the care they need.

  - Vitals would require the Commonwealth to provide an **incentive working fund** equal to three months of projected incentive payments. COVA will be responsible for funding incentives and will need to replenish the funds on a weekly basis. Most clients choose rewards processed via checks, but Vitals offers a variety of ways to disburse incentives. Vitals indicated payment by separate check (not included in the paycheck) reinforces the value of the program. Although Vitals is able to accommodate having the incentive paid to the employee via paycheck, it does not advocate this approach. However, if requested by the employer, it will support including the incentive in the paycheck and reinforce receipt of the incentive by sending a separate letter to the employee explaining that he or she has earned an incentive that will be included in his or her paycheck, and why.

- Vitals can **issue a Form 1099** to participants who earn greater than $600 in incentives or a letter for those who earn less than $600. Vitals can also provide the payroll system with the amount of incentives so that it can be included in an employee's W-2.

- Vitals can be paid on either a percentage of savings basis or PEPM basis. Under the percentage of savings payment model, Vitals is only paid if savings are achieved. At least one employer has started a relationship with Vitals using one **payment model** and switched to the other when it appeared to be a better deal for the employer. Vitals' pricing to the Commonwealth of Virginia would be the same regardless of whether Virginia contracted directly with Vitals or engaged Vitals as a subcontractor to Anthem.

- **Savings** is defined as the difference in cost between a participant's initially preferred facility/provider and the facility/provider ultimately chosen through the program. Return on investment is measured as the savings minus the administrative fees and reported on a monthly basis.

- Vitals recognizes that there are challenges in **determining savings** for services capitated by Anthem (AIM radiology) but can work with AIM to get usable data.

- Vitals **current clients** include state employee health plans of New Hampshire and Kentucky and 50 municipalities.

- Vitals views HCBB as its **primary competition** in this arena.

➢ ***Aetna***

- Currently Aetna does not have the **capabilities or infrastructure** to administer a shared savings program with internal resources. They are in the early stages of partnering with a transparency incentive vendor that would enable Aetna to provide a shared savings platform to their clients and members. They indicated that these capabilities will not be ready for implementation until mid-2018.

- However, Aetna articulated a willingness to **work with a third party** transparency incentive vendor if the Commonwealth chose to move forward before Aetna would develop their own arrangement. Aetna does not have any plan sponsors that currently work with a third party transparency incentive vendor and, therefore, has no experience with implementation of a shared savings program or integration with such an entity.

- If the Commonwealth were to require Aetna to integrate with a third party vendor, they indicated a $500 per file charge to provide claim information. In addition, Aetna would not release **contracted rate** information to the third party transparency vendor. It was assumed by Aetna that these vendors use historical claims data, obtained from a variety of sources to derive prospective charges.

- Concurrent with establishing a relationship with a third party transparency incentive vendor, Aetna is developing a **transparency tool** which will include a **reward/incentive component**. This capability is expected to be available to Aetna clients by late 2018. This proposed incentive program would be a points-driven model under which members could complete certain actionable items and earn points towards non-cash rewards. Actionable items would include tasks such as using the transparency tool and obtaining services based on specific cost or quality measures.

➢ ***Anthem***

- Anthem indicated that they would not directly administer an incentive fund and would **rely upon a working arrangement with Vitals**. They proposed using a subcontracted arrangement between Anthem and Vitals to administer this shared savings incentive programs for COVA Care and COVA HDHP, the two state employee health plans that they administer.
- Anthem has negotiated a **discounted price** with Vitals for the program. Similar to programs obtained direct from Vitals, it can be priced on a Per Employee Per Month (PEPM) rate or percentage of savings.
- **Pricing** would include program installation, custom communications, engagement strategy, incentive administration and reporting. There would be an additional cost for claims extract files and potential other charges from Anthem to fully integrate with Vitals. Anthem would be billed by Vitals and then Anthem would invoice DHRM. In short, Anthem would act as intermediary in the billing process.
- Anthem indicated that their **existing partnership** with Vitals would ensure:
  - ✓ Provider demographics,
  - ✓ Eligibility,
  - ✓ Cost source (allowable charges),
  - ✓ Ongoing claim file extracts, and
  - ✓ Single sign-on
- Anthem's willingness to share its **contracted allowable charges** is a significant differentiator from Aetna who will not provide negotiated charges to any third party transparency incentive vendor.
- Because of their existing relationship with Vitals, Anthem indicated several **administrative charges** would be mitigated by using Vitals which include data management and building of infrastructure to accommodate a new relationship.

Vitals and Anthem have an agreement which allows the release of negotiated fee levels. The type of data that could be exchanged under a different vendor relationship would need to be determined during implementation.

- Anthem indicated that they could **implement** the shared savings program established through a subcontracted arrangement or from a procurement process. The implementation timeline will vary depending on the vendor selected.

- ***Castlight Health***

  - Castlight Health, another health care transparency company that is developing a relationship with Anthem, was asked to interview regarding the proposed shared savings incentive program. Castlight **declined multiple opportunities** to discuss their capabilities and how they might administer an incentive program. They indicated the proposed program did not fit their business model.

Review of Similar State Programs

DHRM and Aon are aware of two states, Kentucky and New Hampshire, which include shared savings incentive programs as part of their state employee health plans.

- **State of Kentucky**

  On May 25, 2017, an interview was conducted with the **Commissioner of the Kentucky Department of Employee Insurance** to evaluate their experience. The Commonwealth of Kentucky implemented a shared savings program in 2013.

  According to a November 1, 2016, article in the **Wall Street Journal**, Kentucky realized gross saving of $10 million through this program between 2013 and 2015, of which $1.1 million went to employee rewards.

  The Commissioner was asked to **share results**, insight on administration and concerns/challenges, if any. Key findings from that conversation are provided below.

  - The **program** (Smart Shopper) is administered by Vitals, a third party transparency and shared savings incentive program administrator.

  - Similar to Virginia, Kentucky offers both Preferred Provider Organization (PPO) and High Deductible **plans**, which are administered by Anthem.

  - Anthem **provides files** that include the actual negotiated cost for services and claims. These are used by Vitals to pay incentives directly to members.

  - **Incentives are paid** when members choose lower cost options for services and incentive size is tied to the procedure cost and savings potential. At this juncture, there is no provider quality factored into the incentive payment process. Cost is a

more objective metric and thus provides a preferable basis for establishing incentives.

- Colonoscopies and mammograms are the **most incentivized procedures**.
- Vitals is **paid** by Kentucky on a Per Employee Per Month (PEPM) basis.
- **Providers** are aware of the program and have expressed interest in qualifying as lower cost providers.
- Kentucky is **satisfied with the program**, although they are interested in increasing member engagement. They have also encountered some challenges with tax implications for members due to incentive payment. Later in this report it has been confirmed that Vitals can administer tax reporting.

Discussion with an Interested Party

- ***Foundation for Government Accountability***
  DHRM representatives met with a representative of the Foundation for Government Accountability on July 7, 2017, to discuss the foundation's interest in this initiative. This is the group that discussed the concept with the patron.
  - The representative described his **organization** as a think tank that worked with legislators throughout the country to find ways to spur innovation in health care, in part to determine what worked and what did not.
  - He listed the companies that he saw as **key players** in this type of shared savings incentive program; the leading entities were Vitals and HCCB, followed by Castlight.

Analysis

This type of shared savings incentive program **holds great promise**, because it appears to yield savings that are more tangible, measurable, and immediate than longer-term strategies aimed at cost avoidance that is difficult to attribute to a specific program. The shared savings model simply rewards members who choose to receive treatment at facilities that offer quality care at the lower end of the cost scale. In doing so, it instills and reinforces the benefits of participant engagement, a critical tool in holding down future costs, and is the basis for the consumer-driven approach to health care.

Furthermore, this type of program is **well-suited for all of the Commonwealth's self-insured plans**.

- Both **COVA HealthAware** and **COVA HDHP** are coinsurance-based plans with relatively high deductibles (COVA HealthAware: $1,500 for single coverage; $3,000 for two or more; COVA HDHP: $1,750 for single coverage; $3,500 for two or more) and

Out-of-Pocket (OOP) maximums (COVA HealthAware: $3,000 for single coverage; $6,000 for two or more; COVA HDHP: $5,000 for single coverage; $10,000 for two or more) when compared to the state's other self-insured plan, COVA Care. These coinsurance plans provide ample incentive for members to take advantage of a shared savings incentive program. Simply put, a member who is responsible for 20% of the cost of a procedure has an obvious reason to keep costs as low possible, and the incentive opportunity further reinforces this.

- By contrast, **COVA Care** is a rich copay-based plan with relatively low deductibles ($300 for single coverage; $600 for two or more) and OOP maximums ($1,500 for single coverage; $3,000 for two or more). Copays range from $25 for a primary care visit to $300 per stay for inpatient hospital services. By themselves, these relatively low OOP expenses provide little reason for the average member to shop for lower cost options. However, providing opportunities for shared savings incentives changes that paradigm as it educates the participant on the actual cost of health care versus just the knowledge of a relatively small out-of-pocket copayment. Also, while a coinsurance model inherently includes an immediate incentive to shop for lower prices, a copay model typically lacks this immediate incentive, and inclusion of this program would address this issue.

The provision of the budget item that requires the **payment of a cash incentive** to employees "who receive health care services at a lower cost *than average price paid by the insurance carrier*" needs further clarification. During interviews with each vendor, it was indicated that the use of an average price approach would be difficult to administer and would neither truly drive appropriate behavior nor maximize cost savings. Vendor comments are summarized below.

- **Vitals** does not advocate setting incentive levels based on a percentage difference in price, because incentives will be greater for participants who initially choose a procedure at or near the highest cost, thus creating the opportunity for employees to inflate their incentive amounts. Also, in some cases, price differences may be driven by location, creating a situation where employees may travel further than necessary for the procedures in order to earn a higher incentive level. Under their system, the greatest incentives are paid to participants who undergo procedures in the most cost-effective settings in their geographical area. For many procedures, participants may receive slightly lower incentives by going to the second less costly setting, and lower incentives still by going to the third least costly setting.

- **HCBB** makes a distinction between fair price and average price. They prefer basing the incentive on a fair price because the average price might not reflect the cost at a specific entity and may overstate the cost of a procedure. As a result, they recommend setting a fixed price for member incentive payment because using average price could produce different incentive levels to be paid. The Commonwealth would need to determine whether the fixed price will be regional or statewide.

- These vendors have **significant expertise** in administering these programs. Both models of incentive payment appear well-reasoned and valid. In order to derive maximum impact

from this program, DHRM recommends allowing the vendor administering the program the leeway to establish incentive levels.

- **Both vendors** advocate sending an incentive check directly to members, because they believe this has a reinforcing effect that encourages the members to continue to be good consumers in order to earn future incentives.

    - **DOA's preference** is for incentive payments to be included with the employees' pay so that taxes would be deducted at that time so that members minimize additional taxes owed at the end of the year. (Incentives for retirees would have to be addressed separately.) The incentives are taxable, and this will better allow the members to understand why taxes were withheld from the incentive payment.

    - A reasonable **compromise** might be for the incentives to be included with the pay, and for the vendor to send letters to members when they earn incentives explaining that they will see the incentive included soon in their pay.

DHRM Recommendation

DHRM believes that a shared savings incentive program would be a **valuable, no-risk tool** for lowering costs without sacrificing quality.

- ***State Self-Insured Health Benefit Plans***. DHRM recommends taking steps to implement this program in the state employee health plan effective July 1, 2018.

- ***Local Health Benefit Plans***. DHRM administers The Local Choice (TLC) Health Benefits Plan, which is available to localities, local school divisions and other political subdivisions throughout Virginia. In Fiscal Year 2019, assuming that minimum required enrollment thresholds are met, DHRM will also implement the COVA Local Health Benefits Plan, which will be available to localities, local school divisions and other political subdivisions in Virginia. For the same reasons that a shared savings incentive program is attractive to the state employee health plan, DHRM believes that this program would be a good fit for both TLC and COVA Local. DHRM recommends implementing this program effective July 1, 2019 in the local health benefit plans, to allow adequate time for a robust initial marketing campaign.