DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION

REPORT ON SHARED SAVINGS INCENTIVE PROGRAMS

PREPARED PURSUANT TO PUBLIC CHAPTER 407 OF THE 111TH GENERAL ASSEMBLY

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SHARED SAVINGS INCENTIVE PROGRAMS

Executive Summary

PUBLIC CHAPTER NO.4O7 SENATE BILL NO.5IO.

"56-7-3506. The state insurance committee, created by 8-27-201, shall publish a report no later than January 1, 2020, on examples of shared savings incentive programs that directly incentivize current enrollees and retirees to shop for lower cost care in other states and consider implementation of such a program in this state. The state insurance committee may implement such a program as part of the next open enrollment period if it is believed to be cost effective. The state insurance committee shall share the report in writing to the government operations committees in both the senate and house of representatives."

The Division of Benefits Administration in the Department of Finance and Administration serves as administrative staff to the State Insurance Committee. Benefits Administration prepared this report on behalf of the Committee for their publication and release. The Division conducted primary research with eleven state public sector plan administrators, conducted secondary research through literature review of relevant published articles and case studies, and inventoried legislation passed in other states for this report.

High level findings of this review are outlined below:

- Although price comparison tools are increasingly available, transparency alone does not increase member shopping. Pairing price transparency with incentive programs works better.

- Shared incentive programs have achieved savings that, while modest, are immediate and measurable in the short term. State plan sponsors indicated that they continue to see program growth and feel the effort is worthwhile.

- There is limited rigorous analysis of shopping programs. There are no long-term studies to determine if facilities increase prices on non-shoppable services to make up for revenue reduction on price-sensitive services, or if the low cost selection for the same service would be repeated absent an incentive.

- Incentive shopping participation is not as high as plan sponsors had hoped. Challenges to member engagement include patients' preferences to maintain provider relationships, and thoughts that shopping would ultimately not change their decision.

- Incentive shopping programs require frequent and sustained communication. Health plans and employers that more successfully engage enrollees might find more robust savings.

- Shared savings incentives programs help reinforce the concept of member engagement and educate members about the cost of health care in a way that traditional member cost-sharing (deductibles and co-insurance) does not.

- Price shopping varied by site of care; medical imaging services such as MRI, mammography and CT had highest use.

- Incentive shopping tools have room for improvement. Some provide incomplete information to the consumer, most notably, the absence of meaningful quality information alongside prices.

- Incentive shopping programs may compete with value-based payment strategies, such as incentives for high-value, bundled services, along with efforts to coordinate care. Careful pairing of the strategies may mitigate this concern (i.e., not incenting the same services if both programs are in place).

- Behavioral economics shows that the "carrot" approach of incentive programs is less effective than other programs with a "stick" approach, as individuals are less motivated by a reward and more motivated by a loss.

State Program Research

Benefits Administration contacted eleven states regarding shared savings programs. Based on these preliminary contacts we interviewed, by phone, administrative staff from eight states that had some elements of shared savings programs. Staff submitted questions to these eight states prior to hosting conference calls in order to learn more about their experience with implementing transparency tools and offering incentives to their enrolled members for shopping prior to receiving healthcare services. One state, Arizona, responded through email.

Our research shows that state transparency with shopping incentive programs are relatively new, with New Hampshire and Kentucky having the longest history with an incentive shopping program. Multiple tools have been used by the various states including health insurance carriers' own tools and third party tools like SmartShopper and Health Care Blue Book (HCBB).

Typically, there is a specific list of elective outpatient services that are considered shoppable with imaging and elective surgeries being the most common. The majority of programs offer a flat dollar incentive ranging, on average, from $25 - $500 per service with proof of shopping being a requirement. Seven of the eight states require the use of in-network providers to earn incentives.

For those states that reported shopping behavior, most member usage percentages were in the single digits. There was a significant outlier, however, raising the question about how shopping behavior is measured. States that offer incentives did not indicate that they were

able to measure member behavior change. Therefore, although some states have reported a reduction in costs, actual savings may be overstated.

There is a lack of consistency in how states and incentive vendors measure savings. Based on the information provided to Benefits Administration, the savings are frequently calculated as the difference between the more costly provider and the member's chosen low cost provider without taking into consideration if the member would have chosen the low cost provider even if they had they not used the tool. As a comparison, this would be equivalent to assuming every employee health clinic visit was an avoided ER visit when it may have only been an avoided PCP visit.

While state savings did net out incentive payments, it was unclear in some instances if the savings factored in the cost of vendor administration or member outreach. States shared the various activities they employed to raise awareness and engage members. Member engagement requires significant and sustained effort. The two programs in place for the longest time indicated similar savings. Through June, 2018, Kentucky reported approximately $11.3 million in net claims savings over three and a half years with New Hampshire reporting $12 million in net savings over three years.

The lack of insight to savings calculations and low member utilization may limit the ability to achieve a robust return on investment from implementing a shared savings incentive program. States indicated, however, that they continue to see program growth and feel the effort is worthwhile.

Arizona

The Arizona Legislature required the Arizona Benefits Service Division to research whether cost savings could be derived from transparency and provide a report of their findings. The Division issued a Request for Information and received several responses. Based upon those responses the report was provided to the Joint Legislative Budget Committee. A representative of the Arizona Benefits Services Division indicated that the report was not a public document. Based on their analysis of incentive programs, however, they did not implement such a program following their initial review and do not plan to implement in 2020. Arizona is going through a plan redesign and felt the incentive program did not currently fit their plan design.

Florida

In Florida, a 2016 bill required the Agency for Healthcare Administration to "contract with a vendor to provide a consumer-friendly, internet-based platform that allows a consumer to research the cost of healthcare services and procedures and allows for price comparison, ...procured through a competitive procurement process..." as well as the ability to search and shop for surgical bundles. A subsequent 2017 bill required the state to provide shared savings incentives.

http://laws.flrules.org/2017/88; https://m.flsenate.gov/Statutes/110.12303

The Florida Department of Management Services, State Group Insurance Program, which covers approximately 367,000 covered lives, issued a Request for Information in 2017 subsequent to the legislation for both programs. HCBB was determined to be the only viable transparency tool and SurgeryPlus prevailed for surgical bundles.

See website: https://www.mybenefits.myflorida.com/health/shared_savings_program

HCBB administrative fees are a flat Per Employee Per Month (PEPM) and paid through a separate funding authority. HCBB works within the health plan services and is accessed by a computer or a mobile app. All services are searchable and shoppable. However, only certain services are eligible for reward of $25 - $1,300 per service based upon historical Florida claims. Employees can search for rewardable services and results will show cost variances between facilities. For example, an MRI conducted at standalone facility vs. hospital would show a cost variance with a reward. Other outpatient examples include ENT (ear, nose and throat) procedures and colonoscopy procedures as well as inpatient examples such as total knee replacement and other orthopedic procedures.

HCBB uses a formula based upon high and low end prices i.e. "red light, yellow light, green light" to determine whether a member is eligible for a reward. The formula is not an average but a fair price algorithm determined by the number of providers in the area, geographic market, information, and cost. For outpatient procedures, the provider must be designated "green" in the system in order for the member to receive an incentive. Inpatient facilities may be "yellow" overall but must be designated "green" for quality. Quality information is only available for inpatient procedures based upon facility data submitted to CMS. Rewards are not available if out-of-network providers are utilized.

When a member logs into HCBB, their shopping activity is tied to their member ID for the entire family. Claims from the health plan are verified against the member's shopping history to determine eligibility for a reward. HCBB maintains the search history for 12 months to allow time for service utilization and claims processing. HCBB provides a list of individuals and associated reward amounts to the FL Health Plan for payment of rewards. The FL Health Plan pays the reward into the member's choice of health savings account (HSA), flexible spending account (FSA), health reimbursement account (HRA) or other health plan reimbursement. The HRA was competitively bid specifically for this program. Of note, unlike the HSA, HRA funds belong to the employer, not the employee. This means that any unused funds will remain with the plan if the employee leaves employment versus the employee being able to take the funds with them. Due to IRS rules, the options of FSA, HSA, or HRA may be limited to an individual.

From January through October of 2019 Florida estimates rewards at $371,340 for 2,786 procedures, out of 235,102 searches. The net estimated state savings year to date are $1,791,724 as reported by HCBB according to Florida.

Florida staff shared information about their roll-out and communications campaign. The communications campaign to employees was prior to the 2019 Annual Enrollment and included in-person sessions, vendors/benefits fairs, mailers, emails, statewide HR presentations, webinars, and information distributed by the health plan.

Florida's bundled surgery services contract is with SurgeryPlus out of Texas and is a separate network of surgeons, facilities, and anesthesiologists (specifically in the Jacksonville, Orlando, and South Florida areas). Claims are 'bundled' from the group of providers and facilities for particular elective, non-emergent surgeries. Members call SurgeryPlus (there is no portal to search) which has full concierge services and provides 3 in-network doctors from which to choose based on the member's specific surgery and location. The plan pays for travel expenses including travel out of state for these select bundled services. Travel is paid via a pre-loaded debit card which provides benefits for 90 days including pre-op through post-op care. Using SurgeryPlus rewards members from $500 to $6,000 to the health savings or spending account of their choice. There is no double dipping between HCBB and SurgeryPlus for rewards.

Surgery Plus usage has had a low participation rate with approximately 60+ open cases, 17-19 completed surgeries, and 4 planned surgeries.

Kansas

The Kansas legislature proposed a shared savings incentive program which did not pass. The Kansas State Employee Health Plan (KSSEHP), which covers approximately 92,000 lives, chose to voluntarily work with their third party administrator Blue Cross Blue Shield of Kansas (BCBSKS) to subcontract with SmartShopper. KSSEHP launched the SmartShopper program in June of 2018.

SmartShopper worked with BCBSKS and the KSSEHP reviewed historical claims data to identify cost variance. They found that the variance for their costs was primarily in facility costs. Therefore, the list of shoppable items is based upon procedures where members have a choice in the place of service.

http://www.kdheks.gov/hcf/sehp/download/State_of_Kansas_Steps.pdf

Members can earn flat incentive amounts from $25-$500 per service, with no annual maximum. Members earn incentives by registering an account and then going on-line or calling SmartShopper to shop for a service such as a mammogram, colonoscopy, total joint replacement, etc. All network providers are held to basic credentialing standards; however, no additional quality measures are utilized. SmartShopper is reviewing options for adding quality to the tool in the future.

Shopping activity is recorded by SmartShopper and claims information is shared by BCBSKS for SmartShopper to match the claims to the shopping history. SmartShopper mails a check directly to the member if they shop for a service prior to utilization of a low cost in-network provider. No incentives are earned for out-of-network utilization. At the end of the year, SmartShopper sends tax information to each member who earned incentives as no tax is taken out when incentives are awarded.

Kansas reports low shopping activity of less than 1% of eligible members with mammograms as the most frequently shopped service. Savings is calculated by

SmartShopper to be an average of $15,000 - $25,000 a month. SmartShopper administrative fees are paid as a percentage of the program savings.

Kansas reports no member feedback regarding the program. The SmartShopper program is communicated through e-newsletters and home mailers. The most successful communications campaign was held to promote registration on the tool in November of 2018 and yielded approximately 1,000 members registering.

Kentucky

Kentucky's Department of Employee Insurance started with a small transparency program pilot in 2013 with Humana as their third party administrator (TPA). They issued a Request for Proposals in 2014 and Vital (now SmartShopper) won the contract. The program was not only about shopping, sharing incentives, and saving money but also as a way to encourage enrollment into their Consumer Driven Health Plan (CDHP). Members in a CDHP typically experience higher cost sharing on the front end of their care, which increases the importance of being able to shop for care. Currently Anthem is the single TPA administering Kentucky's benefit plans. Initially Anthem voiced some concern with publishing the contracted rates online but has since abandoned those complaints. Kentucky indicated they implemented the program by choice without a legislative requirement, as commercial tools are available for their members.

https://livingwell.ky.gov/Pages/PreventionDiscounts.aspx

SmartShopper calculates the savings through an algorithm of a range of providers and Anthem's provider costs. Members earn incentives by registering an account and then going on-line or calling SmartShopper to shop a service such as a mammogram, colonoscopy, knee surgery, x-ray, etc. The average incentive is $100, ranging from $25 to $500 per service, with no annual maximum. The program focuses on shopping quantity and not quality. SmartShopper is planning to bring HEDIS quality measures into the equation and introduce other tools to incorporate additional quality measures.

Shopping activity is recorded by SmartShopper and claim information is shared by Anthem for SmartShopper to match the claims to the shopping history. Shopping must have occurred prior to receiving a service from an in-network low cost provider. No incentives are paid on out-of-network providers. Incentives are paid out in an HRA or as cash in the form of a check. At the end of the year, SmartShopper sends tax information to each member who earned incentives as no tax is taken out when incentives are awarded. Kentucky receives monthly billings on administrative fees, incentive checks, and shopping activities.

Kentucky reports that engagement has been lower than preferred. Out of 266,000 covered individuals or approximately 144,000 households, 18,000 (6.7%) individuals have received an incentive. However, the number of people shopping increases as the program continues. Calculated savings from 2015 through mid-2018 was approximately $13.2M gross or $11.3M in net claims savings with $1.9M in cash incentives to public employees. As an example, incentives have been paid for 1,191 mammograms totaling $26,000 in incentives with a

calculated savings of $3M. According to Kentucky, savings cannot be calculated based upon member behavior change from a high to a low cost provider, only that they shopped and used a low cost provider.

No formal member satisfaction feedback has been obtained but agency leadership indicated that employees seem happy and like the incentives. There has been some negative provider feedback, but some providers have also asked about becoming a lower cost provider.

Maine

Maine's shared savings incentive statute applies to commercial plans in the small group market that are compatible with an HSA. Shoppable services include: physical and occupational therapy services, radiology and imaging services, laboratory services, and infusion therapy services.

http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp

The law has transparency tool provisions that took effect January 1, 2018 and require the Maine Health Data Organization (MHDO) to upgrade its "CompareMaine" website to include all "comparable services" and requires carriers to submit additional data for that purpose. MHDO is a separate state agency, which administers their all-payer (self-funded ERISA plan optional) claims database.

Carriers were required to provide incentives for shopping in 2019. Each carrier's program must run for at least two years. In addition, all plans must reduce cost sharing to the network level if the shopper picked an out-of-network provider that beat the average network price. Carriers have the right to provide their own transparency tools or to refer enrollees to MHDO. One carrier contracts with SmartShopper.

Each carrier is allowed to design its own incentives, subject to approval by the Bureau of Insurance. Gift cards ranging from $5 to $25 are commonly used. One carrier has a $100 cash incentive for patients who get home infusion therapy instead of going to a facility. There is no minimum incentive required by the law and maximum incentives are typical. For example, one carrier imposes an annual aggregate limit of $200. Another carrier limits incentives to one per CPT code per year, with the exception of one code. One carrier provides a $10 gift card (maximum of one per quarter) for doing a search on their website.

Proof of shopping and paying incentives for out-of-network providers is up to the carrier. The Bureau of Insurance does not regulate profiling programs that purport to rate providers by quality but enforces laws that give providers a right to know the basis for any ratings and the right to contest errors.

New Hampshire

The New Hampshire Department of Insurance offers a shopping tool, which is not an incentive program, for all New Hampshire residents.

See website: https://nhhealthcost.nh.gov/

The New Hampshire Department of Administrative Services, Division of Personnel's incentive program is limited to state employees and non-Medicare retirees and their covered dependents on the State of New Hampshire's health benefit plan via a collective bargaining agreement. SmartShopper was obtained through a subcontract with Anthem BCBS of New Hampshire with incentives ranging from $25-$500 per service for outpatient surgeries, labs, imaging, etc. The algorithm for incentive amounts is determined by SmartShopper based on availability of services and variation in cost and provider location. All network providers are held to basic credentialing standards. No additional quality measures are utilized.

(https://das.nh.gov/documents/rmu/benefits/smartshopper-incentive-list.pdf).

The program mails a check directly to the member if they shop for a service prior to utilization of a low cost in-network provider. No incentives are earned for out-of-network utilization. At the end of the year, SmartShopper sends tax information to each member who earned incentives as no tax is taken out when incentives are awarded.

Approximately 51% of eligible members have participated in the program since inception and savings is attributed to the incentive motivation. Agency staff reported average savings of $4.5M per year over the past 3 years with approximately $1M total incentives paid.

Member satisfaction is unknown.

Utah

The State of Utah's Public Employees' Benefit and Insurance Program covers 170,000 lives (65,000 employees) and offers coverage to other government entities. The benefit program operates with in-source actuaries, underwriters, and handles all provider contracting. They offer three network options.

Shared savings incentive legislation was passed in 2018.
https://le.utah.gov/~2018/bills/static/HB0019.html

Utah utilizes their own in-house cost comparison tool, which compares price between the provider and/or place of service developed by their actuarial team. In two of their networks Utah negotiates the costs and uses those costs and their historical claims data in their cost comparison tool.
https://www.pehp.org/general/how-to-use-cost-saving-tools

The program incents services based upon the place of service, e.g., office vs. hospital; out-patient vs. in-patient. Examples of services that are shoppable and eligible for incentives are colonoscopy, MRI, CT scan, some elective outpatient surgery procedures, total knee replacement. If a member elects to have their total knee replacement performed at a surgery center vs. hospital the eligible member would call the health plan or service center within 90 days of the procedure or service. If the claim comes through verifying the low-cost facility,

the employee would earn the incentive. The member must call and request their incentive in order to earn it.

Incentives range from $50 to $300 per service with the maximum in a given year of $3,900. The member receives the incentive in their paycheck with FICA withheld. In-patient services at a preferred inpatient hospital are automatically eligible for $500 cash back. A special cash back incentive is offered to members with limited or no access to choice in rural areas and for community hospitals. No incentives are available for using out-of-network providers.

According to Utah, quality measurement capabilities need to improve from process quality metrics (HEDIS) to include care quality metrics (outcomes) in order to share quality data with members. Some quality opportunities include a member survey for six months post-surgery and tracking member claims for the six months following surgery to see if claim patterns change.

Within the first 10 months 10,094 eligible members used the cost comparison tool. Utah paid approximately 932 cash payments so far with the majority attributed to colonoscopies followed by imaging. As the program was just implemented this year, they have not reported savings yet. Utah's goal for their incentive program is to make sure the incentive never costs more than savings. Utah believes the program is the right thing to do, as a third of their members are enrolled in a CDHP.

Utah communicated to members through monthly emails, member meetings, town hall meetings, and posters.

Virginia

According to Virginia, a legislative budget amendment requires a shopping program with shared savings exclusively for the state employee health plan with optional participation for all payers.

https://budget.lis.virginia.gov/amendment/2017/1/HB1500/Introduced/MR/85/1h/

The Commonwealth of Virginia, Department of Human Resource Management, Office of Heath Benefits health plan's third party administrator subcontracted with SmartShopper in October 2018. The cost for the subcontractor is deducted from the savings from shoppable services and procedures defined by the subcontractor which include: diagnostics, x-rays, labs and certain surgeries.

http://www.dhrm.virginia.gov/healthcoverage/healthcoveragesmartshopper

The incentive ranges from $25 to $500 per service with no annual maximum. Incentives are only available for using providers who are in the health plan's PPO network. All network providers are held to basic credentialing standards. No additional quality measures are utilized.

Members can log in to a secure website and choose the type of procedure and location of provider. The search returns a choice of three high value providers and the employee can

choose from those three. Employees can also contact a call center or Personal Assistance Team (PAT) for assistance. The member shops online or with the PAT, schedules the appointment, and has the service completed. The provider files a claim and the claim file is sent to the subcontractor to match against the shopping history. There are no specific timeframes for the length of time allowed between shopping date and the date services are rendered. The State receives a monthly report and the incentive is paid to the member. For active employees, the incentive is included in their paycheck as taxable income with FICA paid on it. Retirees receive a manual check and the State provides 1099s at year end to the retiree.

The program has evolved, and participation continues to grow. Three hundred seventeen individuals, out of 168,996 covered lives, have earned $57,800 in incentives from late 2018 to September 2019. Virginia indicates that it is a "win-win" and there is no loss for participating. They have seen increases in utilization of the tool each month. The claims savings since October 2018 due to the program was quoted as $297,000. Virginia feels the incentives encourage participants to use lower cost providers.

The subcontractor uses their communication campaign to introduce members to the program. Virginia has also communicated the program to its members through their normal communication channels.

West Virginia

West Virginia's Public Employees' Insurance Agency incentive program functioned more like a reference-based price structure, with transparency and an increased risk of balance billing for out-of-state provider utilization, than a shared savings incentive. West Virginia has a state law that allows their plan to set rates for any willing West Virginia provider with no balance billing. If a West Virginia provider accepts the patient, they are agreeing to accept the plan reimbursement rate.

The West Virginia employee health plan implemented their version of an incentive program, by choice, to manage the budget and encourage in-state provider utilization. They implemented HCBB and identified all participating West Virginia providers as green while the rest of the providers are green, yellow, or red. Quality information for inpatient facilities is available in the HCBB tool.

West Virginia reported that with 230,000 covered lives, at best, they had 150 searches per month on HCBB in the first year with little or no financial impact. There were 143 shoppable items (CT, MRI, Dialysis, Ultrasounds, X-rays, etc.) and all were set with West Virginia rates as the maximum allowable charge. There were no incentives to the member for shopping other than avoiding the increased risk of balance billing when using out-of-state providers. The shopping and maximum allowable charge was in place for approximately three years with very little shopping prior to service utilization, which led to member complaints regarding surprise/balance billing due to out of state provider usage.

A teacher strike in 2018 resulted in changes to the plan effective July 1, 2019, addressing, among other issues, complaints about the health plan. As a result, West Virginia reverted to the benefit structure prior to introducing HCBB, thus reducing the risk of balance billing.

Secondary Research Summary

Benefits Administration conducted secondary research through a literature review of relevant published articles and case studies. Only a handful of peer-reviewed journal articles on this topic were identified, primarily through *JAMA* and *Health Affairs*.

In general, the literature indicates that savings have been achieved with incentive programs. However, behavioral economics evidence shows that the "carrot" approach of incentive programs is less effective than other programs with a "stick" approach, as individuals are less motivated by a reward and more motivated by a loss.

Some procedures appear to be more "shoppable" than others, with people being more likely to compare prices for physical therapy, labs, and imaging.

Barriers to shopping still exist for multiple reasons, among which include a desire to maintain existing provider relationships, reluctance to change and engagement challenges.

There is no information on the long-term impact of these programs to determine, for example, if facilities increase prices on non-shoppable services to make up for the reduction in revenue on price-sensitive services, or if the low cost selection for the same service would be repeated absent an incentive.

A summary of the findings from the literature is outlined below.

Savings:

A March 2019 *Health Affairs* study analyzing the impact of a rewards program implemented by 29 employers with more than 269,000 members found in the first twelve months of the program a 2.1% reduction in prices paid for services targeted by the rewards program (Whaley). This resulted in savings of $2.3 million (roughly $8 per person, per year) which represented 0.3% of total medical spending. This same study found that "rewards programs may be less effective in reducing spending" than those with penalties.

New Hampshire and Kentucky have two of the longest running programs. As of 2016, the savings cited over three years for New Hampshire were $12 million with over $1 million paid incentives (Archambault). After approximately three and one half years, Kentucky's program has saved $13.2 million in health care costs with 1.9 million in paid incentives (Rhoads).

Shopping varies by service and is concentrated on a few procedures:

A *Health Affairs* article suggested that price shopping varied by site of care with individuals being more likely to compare costs for physical therapy, labs and imaging services (Mehrotra). Those who received a procedure in an ambulatory surgery center were most likely to have sought information on the cost of care before receiving care.

A separate study also suggested that patients in a rewards program saved the most, and the decrease in the prices was greatest when they shopped for imaging services such as ultrasounds, mammograms and MRIs (Whaley). Engagement in that program was also highest for MRIs and MRIs also showed the greatest decrease in prices. An article on the Kentucky program supported this idea by noting that the top 5 most frequently shopped procedures are mammogram, MRI, colonoscopy, CT scan and ultrasound (Rhoads).

Impediments to shopping:

Research suggests that price transparency laws or offering tools to shop alone does little to significantly increase the number of people who shop for healthcare. According to a *JAMA Forum* article, "A study published in the *American Journal of Managed Care* surveyed more than 140 million health plan members across 31 different commercial plans who had access to price transparency tools. Only 2% used them" (Frakt, Benavidez).

Offering rewards can increase consumer engagement, as shown in one study where 8.2% of patients eligible for rewards used a price shopping tool compared to 1.4% of those who were not eligible for rewards (Frakt, Benavidez).

There are a myriad of reasons why people do not shop for care. Among the reasons cited in reviewed literature include a desire to maintain current provider relationships, not having considered engaging in the behavior, thoughts that shopping would ultimately not change their decision, thoughts that there is little relationship between the cost and quality of care, a lack of options, and the fact that many people are shielded from high costs due to their benefit design (Mehrotra, Kullgren, Frakt).

The growth in value-based payment models may conflict with shared savings shopping programs. Payment models focused on coordinated care actually discourage shopping as the expectation is that the majority of the healthcare would be provided by a single provider or system (Mehrotra).

Long-term impact:

While some incentive programs have been in place for several years, there is little to no evidence of the impact of incentive programs on long term cost savings or on patient utilization. One article described outcomes that could not be supported yet by evidence. As stated in one article, reduction in utilization "may be due to patients using the price shopping tools, becoming more aware of these out-of-pocket liabilities and deciding to not get care from any provider.

Whether this reduction in care is beneficial or harmful depends on the relative impact on low- or high-value care" (Whaley). The savings estimates for this same study did not include cost of the program and did not extend beyond one year.

One study found a 0.3-percentage-point relative reduction in utilization among patients in receipt of any reward-eligible services but, given the small percentage, it was noted that this needs to be confirmed in future work (Whaley).

See Appendix A for articles, case studies and works reviewed.

Other State Legislation

Benefits Administration found four examples of shared savings incentive legislation enacted in other states: Utah, Florida, Virginia, and Maine. The Virginia and Maine statutes are limited to private insurance carriers and do not apply to their state group insurance programs.

The four enacted statutes are fairly unique in terms of specific program requirements. Florida and Maine specify the services that are eligible for incentives; Utah and Florida are not as specific. Every state lists acceptable modalities for the incentive payments. Maine requires that members choose "high-quality" providers, but no state's statute gives specific quality metrics. Neither does any state clearly require the use of in-network providers, with Maine specifically permitting out-of-network provider use.

Each state but Utah requires the development of an easily accessible transparency tool for members to select a service eligible for incentives, whether that tool is provided by the carriers (Virginia), a separate entity (Florida), or the state itself (Maine).

See Appendix B for Enacted Statutes Reviewed.

Appendix A

Works Reviewed

Archambault, Josh and Horton, Nic. "Right To Shop: The Next Big Thing In Health Care" *Forbes, The Apothecary*, August 5, 2016, https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#4dc548f14f60

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National Conference for State Legislators, "State Actions Related to Transparency and Disclosure of Health and Hospital Charges." http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx

Appendix A

Whaley, Christopher M., et al. "Paying Patients To Switch: Impact Of A Rewards Program On Choice Of Providers, Prices, And Utilization." *HEALTH AFFAIRS*, March 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05068

Whaley, Christopher M., et al. "Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing." *American Journal of Health Economics* Volume 5| Issue 2 |Spring 2019 p.227-249
https://www.mitpressjournals.org/doi/full/10.1162/ajhe_a_00118

Appendix B

Enacted Statutes Reviewed

The following lists Shared Savings Incentive legislation passed in other states. Some other shared savings incentive programs may have been instituted administratively or via other arrangement such as a collective bargaining agreement.

Utah (HB 19 became Chapter 181 of 2018)

- Voluntary for private insurers.
- Mandatory for the state health plan.
- Legislation is broad, just requires the insurer/state health plan to reward, via incentive, members who receive covered services at an amount below the average cost. No consideration of networks in the legislation.
- Incentives may be delivered via premium discount, rebate, reduction of out-of-pocket costs or "other."
- Fiscal Note was neutral.

Florida (SB7022 became Chapter 88 of 2017)

- Requires the state group insurance program to contract with an entity that "provides comprehensive pricing and inclusive services for surgery and other medical procedures…"
    - This entity must provide education to members, include only high-quality providers, provide assistance to members accessing and coordinating care, and provide cost savings to the state to be shared between members and the state.
        - The savings may be shared via FSA, HSA, or HRA contribution or as "additional health plan reimbursement."
- Requires the state group insurance program to contract with an entity that "provides enrollees with online information on the cost and quality of health care services and providers, allows an enrollee to shop for healthcare services and providers, and rewards the enrollee by shared savings…"
    - This entity's services must be provided via an online platform that allows members to shop between providers in their geographic location based on price and quality of bundled services.
    - Certified bargaining agents are permitted to provide information to employees about the service.
    - Identify the savings realized by the member's shopping and facilitate a shared savings payment to the employee. The state group insurance plan must approve the methodology for determining savings.

- The savings may be shared via FSA, HSA, or HRA contribution or as "additional health plan reimbursement."

Virginia (SB1611 became Chapter 684 of 2019)

- The shared savings legislation specifically includes physical and occupational therapy, radiology and imaging, labs and infusion therapy as "comparable services" (eligible for shared savings incentives). Health insurance carriers have the discretion to add further non-emergency services.
- Bill applies to small group market health benefit plans, state and political subdivisions are exempt from the definition of "health benefit plan."
- All health benefit plans (as defined) must develop a program that pays incentives to members that choose to receive a comparable service from a lower cost provider.
    - Incentives are payable via gift card, cash, or credits towards/reductions of premiums, copayments, or deductibles.
- No apparent requirement for the provider to be in network.
- The [Department of Insurance equivalent] is empowered to review and approve carriers' methodology for determining whether there has been a savings and what incentives are owed. No service under $25 is eligible for an incentive.
    - Carriers must also file their program with the Department prior to every plan year.
- Carriers are responsible for informing members about the program.
- Carriers must report annually on the incentives paid and savings generated by their program to the Department. The Department, also on an annual basis, must aggregate and submit a report to the legislature.
- The bill has a separate section directing all carriers to develop an online transparency tool that members may use to compare estimates of their out-of-pocket costs for a given service between multiple in-network providers.
- The Fiscal Note recognized non-specified costs to the Department that the Department is expected to absorb.

Virginia (2017 Budget Document)

- Item 85.J. of Virginia's 2017 budget legislation required the Department of Human Resource Management to identify the "requirements, costs, and benefits" of implementing a shared-savings incentive program for public sector employees.

Maine (LD 445 became Chapter 232 of 2017)

- The shared savings legislation applies to the small group market and only to plans compatible with an HSA. Health benefit plans (as defined) must develop a program that pays incentives to members that choose to receive a comparable service from a lower cost, but still high-quality, provider.
    - The Maine state employee plan does not fit within the law's small group market applicability, but the plan may participate if it chooses.
    - Incentives are payable via gift card, cash, or credits towards/reductions of premiums, copayments, or deductibles.
- Members, as long as they are not in HMOs, are specifically permitted to go out of network if they can obtain a comparable service from an out-of-network provider at a lower rate than either their carrier's average in-network rate or the average rate found on the Maine Health Data Organization's all payer claims database (APCD). If a member obtains a service that meets these requirements, they may request that their out-of-pocket costs be applied to their deductible and out of pocket maximum.
- "Comparable service" is defined as physical and occupational therapy, radiology and imaging, labs, and infusion therapy. Health insurance carriers have the discretion to add further non-emergency services.
- Incentives must be filed with the Superintendent of Insurance as part of the Summary of Benefits and Coverage.
- The Superintendent of Insurance is responsible for reporting on these programs to the legislature on an annual basis. The Superintendent may request data from the carriers for the purpose of composing the report.
- Carriers are responsible for informing members about the program.
- Healthcare providers are required to provide written notice to patients with private insurance coverage, upon referral of a "comparable service," that the referred service may be obtained by another provider and that the patient should consult their carriers' transparency tools.
- The bill has a separate section directing all carriers to develop an online transparency tool that members may use to compare estimates of their out-of-pocket costs for a comparable service between multiple providers. Carriers may comply with some of this separate section's requirements by directing members towards the Maine Health Data Organization's APCD.
- The Fiscal Note was neutral but indicated that the state group insurance plan may incur some savings if the plan opted to participate.