
VALUE-BASED INSURANCE DESIGN EMPLOYER MANUAL

FULLY-INSURED EMPLOYERS

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INTRODUCTION

VALUE-BASED INSURANCE DESIGN

Value-based insurance design is an innovative insurance strategy that seeks to improve health and control rising health care costs by promoting the use of high value services and providers through consumer incentives. High-value services are those that have a strong evidence-base, enhance clinical outcomes, and increase efficiency. V-BID plans utilize “clinical nuance”, a concept that recognizes that medical services differ in the benefit provided, and that the clinical benefit derived from a specific service depends on the patient using it, as well as when, where, and by whom the service is provided. The aim of V-BID is to increase healthcare quality and use healthcare dollars more effectively by implementing differential cost sharing for consumers to promote use of high value services and providers, and decrease use of low value services.

V-BID has received national attention and has been implemented by several major employers, such as Marriott International, Lowes, and Pitney Bowes, as well as various city and state governments, who have found the plans to be successful in improving health outcomes and providing higher quality, more cost-effective healthcare for their employees.

More recently, the Centers for Medicare & Medicaid Services (CMS) announced an initiative to pilot V-BID in Medicare Advantage plans in seven states, beginning in January 2017. Notably, Connecticut has led the nation in value-based insurance design since its successful 2011 implementation of the Health Enhancement Program (HEP), a V-BID plan offered to state employees that has improved the use of preventive care services and reduced the use of expensive emergency and specialty care among employees. Increasing the number of employers using V-BID strategies in their health plans shows promise for providing more effective and efficient care, and improving the health of Connecticut employees and residents.

The aim of V-BID is to increase healthcare quality and use healthcare dollars more effectively by promoting the use of high value services and high value providers through consumer incentives.

CONNECTICUT SIM V-BID INITIATIVE

As part of its State Innovation Model (SIM) program, the Connecticut SIM Program Management Office (PMO), in partnership with the Connecticut Office of the State Comptroller (OSC), has launched an ambitious V-BID initiative to expand V-BID plan offerings across the state. The aim of the initiative is to significantly increase uptake of V-BID among Connecticut employers by 2020.

To that end, this Employer Manual offers employers a customizable template for creating a Value-Based Insurance Design plan. The template includes a set of recommended core benefits and additional benefit options, as well as guidance for implementing the plan components and justifications for the recommendations. The Manual also provides employers with implementation and communication strategies, best practices from employers currently using V-BID plans, and resources and tools to assist employers with implementation. This initiative has been guided by the V-BID Consortium, an advisory workgroup comprised of various stakeholder groups that provided input on the template and recommendations included in this Manual.

V-BID BENEFITS TO EMPLOYERS

Rising out-of-pocket costs can be a major barrier to accessing healthcare services in Connecticut and nationwide, and most adversely affect those with chronic diseases who require more services. As employees shoulder a greater cost burden for health care services, this can result in reduced use of essential services, decreased employee productivity, and diminished business performance. V-BID plans aim to counteract this trend by changing the health care cost discussion from 'how much' to 'how well'.

When employees utilize high-value services, overall health improves, health disparities decrease, and there are potential cost-savings for both the employer and the employee.

GET MORE FOR YOUR HEALTHCARE DOLLAR

Employers have also felt the burden of increasing health care costs, while not necessarily getting a return on their investment in employees' health. V-BID means spending healthcare dollars more wisely by incentivizing the use of more effective services only for those patients who need them, at the time that they need them.

Employer Spotlight

United Healthcare's "Diabetes Health Plan" eliminated payments for diabetes-related supplies and drugs for employees with diabetes who participated in routine disease maintenance exams. They estimated this resulted in \$2.9 million in savings after 1 year.
- [United HealthCare Study](#), 2013

IMPROVE EMPLOYEES' HEALTH AND PRODUCTIVITY

V-BID can improve health outcomes for employees in a number of ways: encouraging the use of high value providers with a history of good outcomes, reducing cost-sharing on prescriptions for employees struggling to manage their chronic conditions, or helping employees to quit smoking by covering the costs of a Smoking Cessation Program. Improved employee health can ultimately lead to decreased absenteeism and presenteeismⁱ and improved performance for companies.

REDUCE HEALTH CARE COSTS FOR EMPLOYEES

With the increase in High Deductible Health Plans, employees are responsible for paying for most health care services before their deductible is met. While this may increase awareness of health care prices, it may also result in decreased use of essential services and medications that employees have to pay for in full. By using V-BID's targeted cost sharing incentives, employers

can improve chronic disease management and medication adherence, prevent disease-related complications, and provide financial relief to those at greatest risk.

INCREASE EMPLOYEE SATISFACTION

V-BID plans focus on getting patients the most effective care at the right time to improve their health and prevent future health risks and complications. Knowing that their employer is investing in their health helps employees feel supported by company leadership and may increase employee satisfaction. For example, one large employer found that its employees consistently report that the company supports employees' health and well-being and found that this is a top performance driver.

ⁱ Presenteeism refers to working while sick, which can cause productivity loss, poor health, exhaustion, and workplace epidemics.

HOW TO USE THIS MANUAL

This Employer Manual is intended to provide Connecticut employers with the tools, strategies, and guidance necessary to implement the recommended Value-Based Insurance Design (V-BID) template.

The Connecticut State Innovation Model V-BID Initiative recognizes that any change to an employer health plan has to reflect the structure, culture, and goals of that employer, as well as the interests of employees. As such, the template provided in this Manual is designed to be adaptable to different fully-insured employers with different benefit structures.

For help designing your V-BID Plan, check out the V-BID Template Worksheet starting on page 27

V-BID TEMPLATE

This Manual presents a V-BID template for fully-insured employers, designed to specifically address the needs of this employer group. If you are a self-insured employer, please see the Self-Insured Employer Manual.

The V-BID template for fully-insured employers consists of the following three core components:

Core Component 1: <i>Change Cost Sharing for Certain Services</i>	Change Incentives for Specific Services for All Applicable Members, Targeted by Age and Gender
Core Component 2: <i>Change Cost Sharing for Certain Drugs</i>	Change Cost Sharing for Specific Prescription Drugs for All Applicable Members
Core Component 3: <i>Change Cost Sharing for Certain Providers</i>	Change Incentives for Visits to High Value Providers

Each component consists of Recommended Core Benefits, which are recommended for inclusion in a V-BID plan, and some suggested additional benefits that employers and health plans may consider. **It is strongly encouraged that plans consist of the recommended core benefits of all three components of this template.** Employer guidance, justification for the recommendations, and examples of employers currently implementing the component are provided with each core component.

Core Component 1 of the template includes certain services for which cost sharing may be reduced for all members, and Core Component 2 includes incentives for specific prescription drugs for all applicable members. Core Component 3 recommends providing incentives for visits to high-value providers.

Additional V-BID Options and Supplemental Benefits

To expand on the Recommended Core Benefits, there are suggested additional V-BID options throughout the template. While these additional options are not part of the Recommended Core Benefits, they are valuable programs that health plans and employers may consider when developing their customized V-BID plan. Unlike the Recommended Core Benefits, plans may choose which additional benefits to implement (if any).

Please note: While it is strongly encouraged to implement a plan that contains all Recommended Core Benefits of the template, the V-BID Initiative recognizes that health plans and employers may need to take a more gradual approach, and initially may only be able to implement certain V-BID components and/or benefits due to certain limitations, such as challenges with identifying high value providers. The

key is that employers and health plans begin moving in the direction of incentivizing high-value, evidence-based services and providers.

V-BID IMPLEMENTATION AND COMMUNICATION STRATEGIES

In addition to the template, the V-BID Implementation section of this Manual, starting on page 18, includes step-by-step guidance on how to implement a V-BID plan, and Frequently Asked Questions about V-BID plans to help overcome some common implementation barriers. The Communicating V-BID section, starting on page 22, provides best practices for communicating health plan changes and V-BID benefits to employees, and encourages employers to explore the *Choosing Wisely*[®] campaign along with their V-BID plan to educate consumers on how to talk to their healthcare providers about which services are necessary for their care.

APPENDICES

The Appendices in this Manual provide additional resources for employers and health plans who are designing and implementing V-BID plans, including a toolkit with sample communications and marketing materials for senior leadership and employees, and links to online V-BID resources.

V-BID GUIDING PRINCIPLES

The V-BID guiding principles serve as the foundation from which V-BID plans should be built. The template reflects these principles, and the implementation and communication strategies provide guidance around how to implement a plan design that incorporates these principles. The principles were developed with input from the V-BID Consortium.

1. V-BID options are **clinically nuanced**, i.e. medical services differ in the benefit provided and the clinical benefit derived from a specific service depends on the patient using it, as well as when, where, and by whom the service is provided.
2. V-BID options should be **flexible**, allowing for adoption of select provisions, or all provisions, in order to meet diverse employers' needs and readiness for adoption.
3. V-BID is promoted as part of a comprehensive approach to benefit design that also includes provider-side reforms (e.g. value based payments, alternative payment methodologies, etc.).
4. V-BID options recognize that that all health plans must comply with state and federal regulations, including mental health parity regulations and health plan nondiscrimination laws.
5. V-BID plans are implemented as part of a **consumer-centric approach** that incorporates:
 - a. A collaborative care model focused on quality and accessibility of high value providers, effective patient communication, and shared decision making between the provider and patient;
 - b. Alignment of consumer benefits and incentives with provider incentives;
 - c. Health navigation services and coordination of community services across the care continuum; and
 - d. Consumer engagement strategies that provide patients with resources and education materials on V-BID, *Choosing Wisely*[®] examples of low value services, health monitoring tools, and flexible communication methods.
6. In this initial phase, high-value providers are identified using transparent cost and quality of care metrics.ⁱⁱ Future iterations may measure other dimensions, such as provider accessibility, patient-centeredness, and care collaboration. In identifying high value providers:
 - a. Method is transparent;
 - b. Data are shared with providers;
 - c. Definition of high value includes both cost of care and quality of care;
 - d. Cost should not be determined solely as price, but rather as a reflection of total cost of care (incorporating both price and utilization rates);
 - e. Quality measurement should use validated and accepted measures; and
 - f. Quality measures should address clinical quality and patient experience, as well as other domains that are accepted as valid and important.
7. Various VBID options are offered to accommodate an employer's ability to adopt certain plans based on their current plan design, size, industry type and composition of employee demographic, all of which impact an employer's ability to adopt a VBID plan.
 - a. V-BID options take into account various employer perspectives, including recognizing regulatory barriers for innovative plan design, and how V-BID designs may affect short and long-term cost savings and Return on Investment.
 - b. Examples of V-BID variations may include small group v. large group, self-insured v. fully insured, employers with Health Reimbursement Account or Health Savings Account-eligible High Deductible Health Plans v. traditional cost sharing models.

ⁱⁱ While this initiative does not define the specific metrics that should be used to identify high value providers, the concept of high value provider is being constructed by the Connecticut SIM Steering Committee, including specific criteria for measuring providers. Refer to Online Resources on page 38 for a link to the complete criteria.

V-BID TEMPLATE FOR FULLY-INSURED EMPLOYERS

This template is intended to provide a basic foundation for employers interested in implementing Value-Based Insurance Design that may have limited flexibility or resources to implement a more comprehensive V-BID plan. It includes recommended core benefits (in yellow) to be implemented as part of a V-BID plan, and suggested additional benefits (in grey) that employers may choose to implement with the core elements. Although these are the recommended employer types, any interested employer may use this template.

RECOMMENDED INCENTIVE MECHANISM(S)

Incentive mechanisms refer to the method of changing cost sharing for your employees. This could be through changes in copayments, changes in premium rates, bonus payments, contributions to Health Reimbursement Accounts or Health Savings Accounts, among others. Each employer should choose a method appropriate to the structure of the health plan offered. Below is a table to provide guidance on the mechanisms that work best for different plan types.

Plan Type	Incentive Mechanisms
All plans	<ul style="list-style-type: none"> ○ Bonus payment for complying with recommended services ○ Reduced premium for complying with recommended services
Plans with copayment or coinsurance cost-sharing	<ul style="list-style-type: none"> ○ Waived or reduced copayment or coinsurance for recommended services and drugs ○ Waived or reduced copayment or coinsurance for visit to high value provider
Health Savings Account-eligible High Deductible Health Plan (HSA-HDHP)*	<ul style="list-style-type: none"> ○ Contribution to HSA for complying with recommended services or visiting high value provider
Health Reimbursement Account-eligible High Deductible Health Plan (HRA-HDHP)	<ul style="list-style-type: none"> ○ Contribution to HRA for recommended services and drugs ○ Contribution to HRA for visit to high value provider ○ Exclusion of recommended services and drugs from deductible
All plans ⁱⁱⁱ	<ul style="list-style-type: none"> ○ Financial incentives external to health benefit plan designs, including gift cards, payroll bonuses, and other rewards programs

ⁱⁱⁱ Employers may encounter barriers with integrating incentives or coverage of supplemental benefits as part of health plan benefits. As an alternative, employers may choose to provide incentives outside of the plan design, such as the employer’s benefits department offering gift cards to those who participate in a supplemental benefit program. For example, one large national employer offers \$500 gift cards to employees who participate in a surgical decision support program for eligible surgeries.

RECOMMENDED V-BID STRUCTURES

Incentive Structure

It is recommended that V-BID incentives be based on participation in or compliance with recommended services, such as screenings and disease management programs. However, employers may choose to make incentives for any of the recommended core benefits or additional benefits conditional on achieving certain outcomes. If incentives are outcomes-based, participation should be voluntary, and plans are required to offer an alternative way to earn incentives for members who are unable to meet outcomes requirements.^{iv}

	Participatory	Outcomes-Based
All Members	Incentive for participating in recommended service	Rewards for meeting certain targets, including improving on or maintaining personal targets
Targeted Members	Incentives for participation in chronic disease management program	Rewards for members with certain clinical conditions that meet certain targets

Enrollment Structure

Enrollment in a V-BID plan may be compulsory or voluntary. Employers who choose to make the V-BID plan compulsory can offer the V-BID plan as the only health plan available to employees. Employers who choose to make the V-BID plan voluntary can allow employees to opt-in.

If choosing an opt-in structure, the plan will need an incentive sufficient to encourage high rates of enrollment in the program. If offering an opt-in structure, the plan may require that enrollees comply with recommended services in order to maintain enrollment in the program and V-BID benefits. For example, the Connecticut State Employee Health Enhancement Program offers reduced premiums if employees enroll in the program and comply with the recommended services; employees who do not enroll face a premium penalty.

Implementation Guidance

- *Please note:* When offering V-BID benefits, plans are still required to remain in compliance with federal regulations, including mental health parity regulations and health plan nondiscrimination laws. For more information about federal regulations, refer to the Employer Resources section on page 39 of the Employer Manual.
- **For HSA-HDHPs:* According to IRS guidance, coverage does not include “any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications” until the deductible is met.¹ Employers should consult their legal team and health plan on which preventive services may be excluded from the deductible, and on approaches that incentivize drugs and services based on a

^{iv} This is required by ACA regulations governing wellness programs. For more information, visit <https://www.federalregister.gov/articles/2013/06/03/2013-12916/incentives-for-nondiscriminatory-wellness-programs-in-group-health-plans>

member’s clinical condition. For more information from the V-BID Center on Increasing Flexibility to Expand IRS Safe Harbor Coverage in HSA-High Deductible Health Plans, refer to Online Resources on page 39 of the Employer Manual.

RECOMMENDED V-BID COMPONENT 1: CHANGE INCENTIVES FOR SPECIFIC SERVICES FOR ALL APPLICABLE MEMBERS, TARGETED BY AGE AND GENDER

It is recommended that health plans encourage use of specific high value services for all applicable members. In addition to the services below, all plans are mandated by the ACA to cover additional preventive visits and screenings at no cost to the patient. Refer to the Online Resources for a list of services that are mandated by the ACA on page 39.

	Services	Applicable Members*
Recommended Core Benefit Design	<i>Biometric and Mental Health Screenings</i>	
	Blood Pressure Screening	Applicable members depending on age group and gender
	Cholesterol Screening	Applicable members depending on age group and gender
	Obesity Screening	Applicable members depending on age group and gender
	Depression Screening	Adolescents over 12 years and adults
	Alcohol Screening and Counseling	All adults
	<i>Cancer Screenings</i>	
	Breast Cancer Screening	Women depending on age group
	Cervical Cancer Screening	Women depending on age group
	Colorectal Cancer Screening	Applicable members depending on age group and gender

*For recommendations on appropriate screenings for age groups and genders, as well as recommended frequency of screenings for each group, visit: <http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

Implementation Guidance

- For high value services included in the core benefit design that are already mandated to be covered at no cost to the patient by the ACA, **it is recommended that employers provide an additional incentive for employees who participate in the services recommended for their age group and gender to encourage utilization of high value preventive services.**
- Employers may choose to make these incentives instead based on outcomes achieved on certain biomarkers. However, if an employer chooses an outcomes-based incentive approach, health care laws require that there is an alternative way to earn incentives for members who are unable to reach required targets. The ACA also specifies a maximum payout that is allowed.
- To increase utilization of preventive services, plans may encourage recommended screenings to be part of primary care visits, or may offer these services through on-site or nearby clinics to make them convenient for employees. For the purpose of care coordination, it is encouraged that records of services from on-site or nearby clinics be sent to the patient’s PCP or usual source of care. For plans such as HMOs that require members to have an assigned PCP, encouraging these services through primary care visits will assist with PCP

attribution efforts as well as continuity of care. Refer to the Implementation Strategies section on page 18 of the Employer Manual for various methods for measuring compliance with screenings.

- Fully insured plans may offer reduced cost sharing for certain prescription drugs by including these drugs in a lower tier.

Justification for Recommendation

- This is the most basic plan design to implement – simplicity was emphasized by stakeholders interviewed and Consortium members.
- Recommended preventive services are determined to be evidence-based by the US Preventive Services Task Force and align with the Connecticut SIM Quality Council’s Provisional Measure Set for measuring provider performance. Consortium members agreed that aligning patient incentives with provider incentives was key to this initiative.
- Most employers currently implementing V-BID plans incentivize biometric screenings and certain cancer screenings.
- Evidence from the Connecticut State Employee Health Enhancement Program suggests incentivizing preventive visits/diagnostics increases use of primary care and diagnostic screenings, and decreases use of higher cost services such as specialty care.²
- Consortium members emphasized the importance of behavioral health and substance use screenings for all members as fostering population health.

ADDITIONAL V-BID COMPONENT 1 OPTION: CHANGE INCENTIVES FOR SPECIFIC SUPPLEMENTAL BENEFITS FOR ALL APPLICABLE MEMBERS*

In addition to incentivizing specific high -value services, employers may choose to incentivize certain supplemental benefits for all applicable members providing a bonus payment or incentive for those who participate in the supplemental benefit or program.

	Supplemental Benefits	Applicable members
Suggested Additional Benefits	Treatment decision support/counseling	Members with conditions that have multiple treatment options with differing risks and benefits, e.g. lung cancer, breast cancer, depression, etc.
	Surgical decision support	Members undergoing elective surgeries that have other treatment alternatives, e.g. low back surgery, hysterectomy, hip or knee replacement, bariatric surgery, breast reduction surgery, etc.
	Chronic Disease Management program	Members with chronic diseases, e.g. diabetes, asthma/COPD, hypertension, depression, substance use disorders, congestive heart failure, coronary artery disease, etc.
	Pain Management	Members with chronic pain
	Healthy pregnancy program	Pregnant women
	Smoking Cessation	All members, as applicable
	Complex Case Management	Members with complex conditions, e.g. cancer

*For HSA-HDHPs: Employers should seek legal guidance on plan designs that provide HSA contributions for services related to a member’s clinical condition before implementing these benefits. Employers should seek legal guidance on approaches that incentivize drugs and services based on a member’s clinical condition.

Implementation Guidance

- Connecticut health insurance regulations restrict copayment variation based on intensity of services, a member’s medical condition, or provider specialty (with the exception of office visits for primary care versus specialty care). To avoid offering discriminatory benefits, health plans must make condition management programs available to all members that could benefit from the program.
- Chronic disease management programs and other condition management programs may be offered as a supplemental benefit by the health plan, or as part the existing care management activities. If part of the existing care management, providers and health plans will need to have open communication about how programs are structured, which members are targeted, and which members are participating in these programs.
- Employers may encounter barriers with integrating incentives or coverage of supplemental benefits as part of health plan benefits. As an alternative, employers may choose to provide incentives outside of the plan design, such as the employer’s benefits department offering gift cards to those who participate in a supplemental benefit program. For example, one large national employer offers \$500 gift cards to employees who participate in a surgical decision support program for eligible surgeries.

Examples of Employers Implementing V-BID Component 1

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 1: Change Incentives for Specific Services for All Applicable Members Targeted by Age and Gender	National	Large National Employer	<ul style="list-style-type: none"> ▪ HSA funding for achieving biometric makers within certain range and participating in annual physical exams and cancer screenings 	<ul style="list-style-type: none"> ▪ Over 75% participation ▪ Improvements in biometrics
	Publicly funded Connecticut-based	Connecticut State Employee Health Enhancement Program	<ul style="list-style-type: none"> ▪ Reduces premiums and cost-sharing for enrollees who participate in yearly physicals, age and gender-appropriate health risk assessments and evidence-based screenings, vision exams and dental cleanings 	<ul style="list-style-type: none"> ▪ Primary care visits increased by 75% ▪ Preventive diagnostic visits increased over 10%, and ▪ Specialty visits decreased by 21% in the first year

RECOMMENDED V-BID COMPONENT 2: CHANGE COST SHARING FOR SPECIFIC PRESCRIPTION DRUGS FOR ALL APPLICABLE MEMBERS*

It is recommended that health plans reduce cost sharing of specific high value prescription drugs for all applicable members. This may be done by assigning recommended high value prescription drugs to a lower tier.

	Prescription Drugs	Applicable Members
Recommended Core Benefit Plan Design: Recommend employers choose at least two drug classes	Beta-blockers	All members prescribed drug for any indication
	ACE inhibitors and ARBs	
	Insulins and oral hypoglycemics	
	Long-acting inhalers	
	Inhaled corticosteroids	
	Statins	
	Anti-hypertensives	
	Anti-depressants	
	Smoking cessation drugs	

*For HSA-HDHPs: Although this is a recommended core benefit, IRS guidelines on preventive care services prohibit coverage of “any service or benefit intended to treat an existing illness, injury, or condition, including drugs or medications” until the deductible is met for HSA-HDHP plans. Employers should seek legal guidance on approaches that incentivize drugs or services for clinical conditions.

Implementation Guidance

- Connecticut health insurance regulations restrict copayment variation based on intensity of services, a member’s medical condition, or provider specialty (with the exception of office visits for primary care versus specialty care). However, health plans may choose to reduce cost sharing for prescription drugs by assigning certain high-value drugs, such as diabetes drugs, to lower cost tiers. It is recommended that cost sharing is reduced for generic, preferred brand, and brand name drugs for all targeted drug classes, although these do not need to be in the same tier. For example, cost sharing may be reduced by 75% for generic drugs, 50% for preferred brand, and 25% for brand name drugs.
- Fully-insured employers should work with their health plans on which drug classes can be made part of a lower cost tier. Larger fully-insured employers may have more flexibility to choose plans that reduce cost sharing for drug classes most relevant to their employee population. These lists should be promptly updated to be in accord with FDA approval of new and more effective agents.
- The purpose of this component is to increase medication adherence by reducing financial barriers to effective prescription drugs. As part of V-BID Component 1, plans may also choose to incentivize medication adherence programs.
- Small and fully insured employers may be concerned that making certain drugs part of a lower cost share will attract sicker employees to the plan, resulting in adverse selection. To help attract healthy employees to the plan, components one and three provide incentives to all

members who participate in screenings and visit high value providers. Therefore, it is strongly recommended that employers implement all recommended core benefits of the V-BID Basic Plan if the plan is not compulsory.

Justification for Recommendation

- Evidence from employers such as Pitney Bowes, Marriott International, and Procter & Gamble suggests reducing cost sharing for certain drugs, for all members prescribed these drugs, increases medication adherence and decreases overall medical costs.³ Reducing cost sharing for recommended drugs for all members increases access to drugs for members with conditions for which drugs are evidence-based without needing to identify members with specific conditions.
- Several Connecticut employers and health plans currently offer value based prescription benefit plans, and highly recommend this strategy for other employers.

Examples of Employers Implementing V-BID Component 2

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 2: Change Cost Sharing for Specific Prescription Drugs for All Applicable Members	National	Marriott International	<ul style="list-style-type: none"> ▪ Decreased copayments for members prescribed medications from five drug classes for all tiers: Statins, inhaled corticosteroids, ACE inhibitors and ARBs, beta-blockers and diabetes medications 	<ul style="list-style-type: none"> ▪ Improved medication adherence in four out of five drug classes ▪ Decreased non-adherence by 7 – 14%
	Connecticut	United Healthcare “Diabetics Health Plan”	<ul style="list-style-type: none"> ▪ Eliminated payments for diabetes-related supplies and Rx drugs for participation in routine disease maintenance exams ▪ Provided free access to online health educators and disease monitoring systems 	<ul style="list-style-type: none"> ▪ After one year of implementation reduced total net cost by 9%, saving about \$3 million

RECOMMENDED V-BID COMPONENT 3: CHANGE INCENTIVES FOR VISITS TO HIGH VALUE PROVIDERS

It is recommended that employers provide incentives for visits to high value providers, such that the measures of “value” are transparent, and are defined by both cost and quality metrics.

	Provider Type
Recommended Core Benefit Plan Design: Employers choose to incentivize visits to at least one of the following provider types	Network of providers who have been identified as high value based on performance on cost and quality metrics
	Providers who are part of an ACO identified as high value based on performance on cost and quality metrics
	Primary care physician or Patient Centered Medical Home that has been identified as high value based on performance on cost and quality metrics

Implementation Guidance

Although each health plan may use different measures and criteria to define “value” for providers, it is recommended the measures used are transparent to providers and consumers, and at a minimum use a validated set of cost and quality metrics. The SIM Quality Council Provisional Measure Set (see Online Resources on page 38) was developed through an intensive stakeholder engagement and public process, and provides a standardized set of validated metrics that health plans may use for identifying high value providers.

For guidance and recommendations on how value should be defined for providers, please see the V-BID Plan Guiding Principles on page 8.

Justification for Recommendation

- Approach aligns consumer incentives with provider incentives, which experts and stakeholders agreed was essential.
- Consortium members emphasized that while important, value cannot be defined solely in terms of cost but should also include quality measures, and that measures need to be transparent. Other dimensions, such as provider accessibility, credentials, etc. should be considered for incorporation into future V-BID templates.
- Quality measures align with the SIM Quality Council initiative, which is developing a Provisional Core Measure set to propose tying provider payment to selected quality metrics.
- According to stakeholders, many health plans in Connecticut have established incentive structures to drive consumers towards high value providers. Stakeholders suggested building/improving upon these models and ensuring transparency in defining value.

- Health plans such as Anthem’s Patient Centered Primary Care Program and Aetna Whole Health - Hartford HealthCare & Value Care Alliance that reduce cost sharing for providers who are being paid for performance have seen success with these programs.⁴

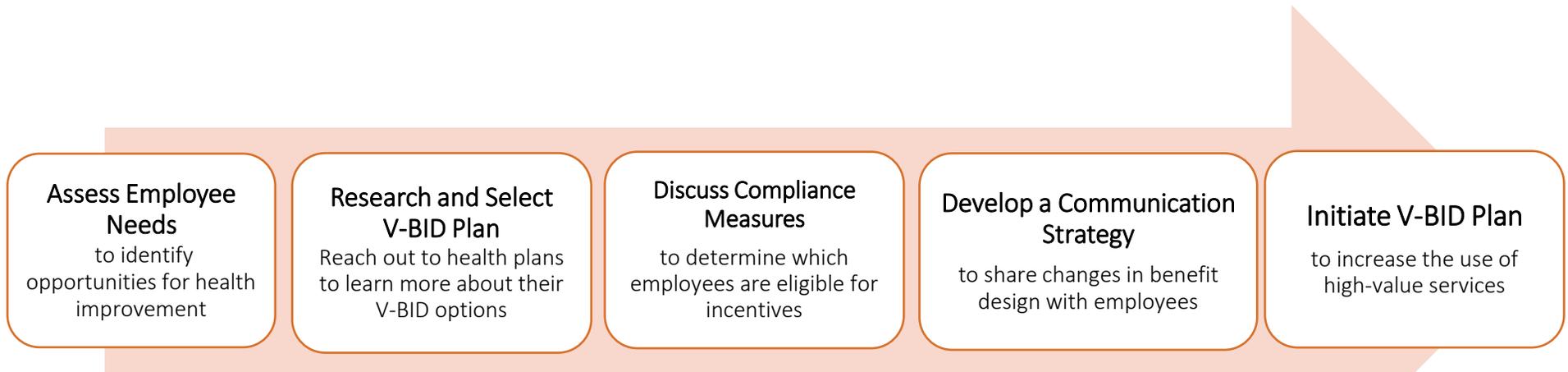
Examples of Employers Implementing V-BID Component 3

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 3: Change Incentives for Visits to High Value Providers	Publicly funded	New York City Employees	<ul style="list-style-type: none"> Will eliminate copayment for primary and specialty care visits at one of 36 sites in which providers are part of specified pay for performance contracts 	<ul style="list-style-type: none"> Program implemented in 2016 – anticipated savings of \$150M
	National - Connecticut based	Pitney Bowes	<ul style="list-style-type: none"> Incentivizes use of high performing physicians through tiered network 	<ul style="list-style-type: none"> Increased cost savings as result of incentive program

IMPLEMENTATION STRATEGIES

Steps for Implementing a V-BID Plan

Below is an outline of steps that fully-insured employers should take to implement a V-BID plan. These were developed based on feedback from employers currently implementing V-BID plans, as well as tools from the V-BID Center and National Business Coalition on Health.



Employer Spotlight

Connecticut's State Employee Health Enhancement Program (HEP) was a voluntary program launched on October 1, 2011, that introduced incentives to align patient costs with the value of care, including the elimination of office visit copayments for chronic conditions and the reduction or elimination of copays for medications associated with the management of chronic conditions, including asthma or COPD, diabetes, heart disease, hypertension, and hyperlipidemia. In its first year, HEP had 98% enrollment and 98% compliance with program requirements. There was also significant improvement in the use of high-value medical services, increasing preventive care office visits by 13.5% in the first year, and increasing the use of preventive screenings, including colonoscopies, mammograms, and lipid screenings.

- [Connecticut's Value-Based Insurance Plan Increased the Use of Targeted Services and Medication Adherence](#), *Health Affairs* June 2016

ASSESS THE CLINICAL NEEDS OF YOUR EMPLOYEE POPULATION

V-BID plan designs are most effective when targeted towards an employer's specific employee population. Collected data on your employee population is critical to successfully targeting conditions that impact the workforce. Fully-insured employers can collect this information by **asking employees to complete an anonymous survey** about what services or medications they use most frequently, or for which

Get to Know Your Employees!

Biometric screenings and health risk assessments can help you determine which services are most valuable to your employees.

services or medications financial assistance would be the most helpful. Be mindful and respectful of the privacy concerns of your employees, and ensure they understand that the information gathered from these surveys is anonymous, and would only be used to incentivize the use of valuable drugs and services. Many employers currently offer biometric and mental health screenings, which may be an ideal opportunity to distribute these surveys.

Another option for fully-insured employers is to **request summary data from their current health insurance carrier** on clinical conditions that are impacting the employee population. Involving a clinician in this assessment is recommended to identify opportunities for intervention and improvement.

RESEARCH AND SELECT A V-BID PLAN

Some fully-insured employers may have the ability to work directly with their insurance carrier to develop a fully-customized V-BID health plan. These fully-insured employers can discuss the needs of their employees with their carrier, and create an incentive program based on the template on page 9. Insurance companies can provide additional guidance on state and federal regulations, and can provide online tools for record keeping and tracking participation.

In other cases, fully-insured employers may need to shop around for the V-BID product that makes the most sense for their company. The V-BID template included in this manual provides health plans and employers with a recommended core benefits plan design. The goal of this template is to provide recommended V-BID benefits, while allowing for flexibility through additional options that may be incorporated into a plan design. Based on the result of their analyses, employers should choose which V-BID plan offering best meets the needs of their employee population. For example, if a large percentage of employees have diabetes, look for a V-BID product that includes OOP discounts for diabetes medication and supplies. Complete the V-BID Template Worksheet on pg. 28 and use it as a guide to finding the right V-BID plan for your company.

For a list of health plans currently offering V-BID plans, please visit the State Innovation Model website.

DISCUSS COMPLIANCE MEASURES

In order to determine which employees are eligible for incentives, employers need to know which employees participated in the required services or met required targets. Many plans recommend using an automated method instead of self-report, such as healthcare claims analysis. If incentives are based on compliance (or participation), carriers can use claims data to identify which members complied with recommended services and are eligible for incentives. If incentives are based on outcomes, carriers will need to determine a mechanism for the provider to communicate whether targets were achieved, as

Employer Spotlight

By reducing copayments for services relating to diabetes and promoting the use of minimally invasive surgeries through their V-BID initiative, **Hannaford Brother's Company** employees were able to improve their diabetes biometric testing results and shift the standard of care for surgery to minimally invasive procedures.

- [V-BID Landscape Digest](#), V-BID Center 2009

claims data would not contain this information. Tracking compliance with recommended services should be the role of the health insurance carrier. Employers should not have access to their employees' health information in order to protect employee confidentiality. Some employers that make HSA contributions use a third party contractor to track employees' service utilization or outcomes, and then only tell the employer the incentive amount for each employee.

Please note: If services are delivered by a provider other than the members' primary care physician, such as an on-site clinic, records should be sent to the member's usual source of care as soon as possible for care coordination purposes.

Communication is Key!

Plan for at least 5 employee touch points to share upcoming changes to health benefits.

DEVELOP A COMMUNICATIONS STRATEGY

Employee communication, education and engagement are key to the success of any V-BID plan design.⁵ Employers should work with their HR departments to develop a communications strategy before changing plan offerings to a V-BID plan design. Connecticut employers that have implemented V-BID suggest giving employees ample time to understand the plan before implementing it (this may be up to one year), and communicating the plan design to them repeatedly through different communication methods. Employers can ask their carrier for marketing materials for the new plan to be distributed to employees. For more information about communicating plans to employees, see the Communicating Benefits section starting on page 22.

INITIATE A V-BID PLAN

Once the employer has chosen a V-BID plan, they should choose a date for open enrollment that allows ample time to communicate to employees the new plan offering. Once the V-BID plan goes into effect, employers should begin the evaluation process to measure program success and employee satisfaction. To learn how to address common implementation barriers, refer to the Frequently Asked Questions section on page 23 and Overcoming Barriers Appendix on page 31.

Once the plan is fully implemented, it is helpful to assess its impact, if possible. Larger fully-insured companies may be able to determine the impact of the V-BID plan on employee performance, such as reduced absenteeism due to illness and reduced presenteeism, through data collected by their HR departments. To measure the overall effects of V-BID on health care utilization and spending, the health insurance carrier may analyze claims data across the market to determine if members enrolled in V-BID plans have improved health outcomes and changes in utilization and cost trends compared to non V-BID plans. If available, employers can request summary outcomes reports for their product from their carrier.

Best Practices and Lessons Learned

These best practices are based on suggestions from national and Connecticut-based employers currently implementing V-BID plans who participated in individual interviews or an employer focus group.

REQUEST A V-BID PLAN FROM YOUR HEALTH INSURANCE CARRIER

- Insurance carriers are more likely to offer V-BID plans if the market demands it. If your insurance carrier does not offer a V-BID plan, engage with them about the possibility of offering this in the future. If they do offer a V-BID plan, discuss ways in which it can be customized to meet the needs of your employee population.
- For a list of health plans currently offering V-BID plans, visit the State Innovation Model website.

USE INCENTIVE AMOUNTS THAT WILL MOTIVATE EMPLOYEES' BEHAVIOR

- If administering incentives beyond the plan design, such as gift cards or HSA contributions for biometric screenings, incentive amounts need to be appropriate for the company's specific population and significant enough to motivate people to change their behavior. For example, one national employer found a \$500 annual bonus payment for participation in biometric screenings increased their screening rates.
- Employers should work with senior leadership and employee leaders to balance providing incentives that are both significant to employees and cost-effective for the employer.

MAKE SERVICES CONVENIENT FOR EMPLOYEES

- Larger employers may offer certain services on-site, such as biometric screenings and health risk assessments to make them convenient for employees and increase screening rates. Employees should follow up with their usual health care provider to discuss screening outcomes.
- Alternatively, employers may partner with a free-standing clinic near their location(s) to offer specific services, such as a national pharmacy health clinic.
- If services are offered on-site or at nearby clinics, the employer should develop a mechanism to send records of these services to the patient's PCP, with the patient's consent, to ensure care coordination. If an employee was recently screened by their PCP, they should not participate in on-site screenings to avoid duplication of services.

Employer Spotlight

Procter & Gamble's
"Healthy Living Brand"
tiered healthcare services and drugs and eliminated coverage for non-essential drugs; doing so resulted in increased enrollment in disease management programs, improved medication adherence rates among employees and decreased overall medical spending of the company.

- "[V-BID Landscape](#)," V-BID Center
July 2009

INVOLVE SENIOR LEADERSHIP IN PROMOTING V-BID TO EMPLOYEES

- When possible, messaging to employees should come directly from senior leadership to emphasize the company's commitment to employees' health and integrate V-BID into the company culture.
- Company leaders may promote the plan by indicating that they participate in recommended screenings or a disease/condition management program themselves. For a script to promote V-BID plans to senior leadership, refer to the Employer Resources starting on page 36.

COMMUNICATING V-BID BENEFITS TO EMPLOYEES

The following communication strategies are best practices from other employers and current literature.

Best Practices

WHO SHOULD COMMUNICATE

- Communications to employees should come from employers and health insurance carriers. While carriers may communicate about the specific benefits and cost sharing aspects of the plan, employers should communicate to employees about why the company is implementing a V-BID plan and how it will directly benefit them.
- Employer communications should come from both senior management and employee leaders. Messages from senior management demonstrate the initiative's importance to the company, while employee leaders can help build employee buy-in through peer-to-peer learning.

WHAT TO COMMUNICATE

- Educate employees on how their health plan can improve their health, prevent future health issues or complications, reduce their out of pocket spending, provide higher quality services at lower costs, and help them make the best health care decisions for themselves and their families.
- Address employee concerns about employers accessing their health information by highlighting that the employer will not have access to the employees' information and that the company is committed to protecting employee confidentiality.
- Emphasize the company's dedication to meeting its employees' health care needs.

HOW TO COMMUNICATE

- Utilize multiple communication channels and strategies to effectively communicate with a diverse range of employees, such as newsletters, infographics, and brochures. In-person communication through "lunch and learns" or benefits fairs may be particularly effective. Many carriers also offer interactive online tools to help communicate benefits and customize messaging for individual employees.
- Keep materials simple, clear and easy to read. Consider the health literacy of your audience and meet them at their level by incorporating visuals, using direct language, and providing definitions for complex topics and words.

WHEN TO COMMUNICATE

- Set a realistic timeline to develop and roll-out your communications plan. V-BID concepts are novel and could take several months for employees to understand the proposed plan.
- Repeat messaging frequently. This helps employees pay attention to and understand the V-BID concepts, which may at first seem complex.
- Develop an evaluation tool, such as a survey, to monitor employee satisfaction and identify areas for improvement. Evaluation of the communication campaign should be ongoing.

FREQUENTLY ASKED QUESTIONS

WHAT IS CLINICAL NUANCE?

Clinical nuance is the foundation of V-BID. This concept recognizes that medical services differ in the benefit they provide, and that the benefit of a clinical service depends on the patient using it, as well as when, where and by whom the service is provided. V-BID plans utilize “clinical nuance” by providing incentives for specific patient populations, such as those with chronic diseases, for specific services that will provide the highest benefit. In this way, V-BID improves health care quality and spends health care dollars more effectively.

WHAT IS MEANT BY “HIGH-VALUE SERVICES”?

High-value services are those that have a strong evidence-base, enhance clinical outcomes, and increase efficiency. The template in this Manual recommends incentivizing certain “high value services” that have shown evidence of improving health for specific patient groups.

WHAT IS MEANT BY “HIGH-VALUE PROVIDERS”?

For the purposes of this initiative, high value providers are those identified by a health plan as achieving superior performance on certain transparent cost and quality metrics. While this initiative does not define the specific metrics that health plans should use to identify high value providers, the concept of “high value provider” is being constructed by the Connecticut SIM Steering Committee, including specific criteria for measuring providers. Refer to Online Resources on page 38 for a link to the complete criteria under consideration. This initiative recommends the use of this criteria, along with cost metrics, as part of a transparent value measurement method. In addition, the consumer representatives of the V-BID Consortium have defined care collaboration principles that providers should consider when delivering services as part of a V-BID plan. Refer to page 8 for these principles.

HOW DO I KNOW IF MY HEALTH INSURANCE CARRIER OFFERS A V-BID PLAN?

To determine which carriers offer V-BID plans, and what products are currently available, visit the State Innovation Model website. Employers should choose a V-BID plan offering that best meets the needs of their employee population and the employer’s financial situation. Some carriers may allow for some customization of their V-BID product for individual employers, while others may offer one standard product. If the carrier your company wishes to use does not have a V-BID product, discuss the possibility of this offering in the future.

WILL V-BID IMPLEMENTATION INCREASE COSTS TO EMPLOYEES?

No. By reducing cost-sharing or providing financial incentives for specific services and visits to specific providers to employees, V-BID relieves employees of financial burdens that are common barriers to effectively managing chronic conditions or adhering to medication regimens.

HOW DO I EXPLAIN V-BID TO MY EMPLOYEES?

Communication is key to the success of any V-BID plan design. Employers should develop a communication plan to explain, in detail, V-BID benefits to employees before implementation. For more information on communication best practices, refer to page 22 and 23. For sample visual aids and communication and marketing scripts, refer to the Communicating Benefits section starting on page 36.

HOW DO I GET MY EMPLOYEES TO SUPPORT MOVING TO A V-BID PLAN?

Using employee leaders to promote V-BID plans can increase employees' buy-in to the program, as they may be more likely to trust a peer. Some Connecticut employers have suggested that in-person communications, such as lunch and learns, are also highly effective. In addition, while V-BID plans incentivize the use of specific high-value services and providers for specific members, many employers and health plans currently offer incentives for other wellness and health initiatives. Tying V-BID plan designs into a larger employer wellness and/or incentive program is a strategy many employers in Connecticut have found useful for engaging employees in health improvement activities.

HOW DO I ADDRESS EMPLOYEE CONCERNS ABOUT THE COMPANY ACCESSING THEIR HEALTH INFORMATION?

Employers should assure employees that their health information will remain confidential in communications materials about V-BID, and that employers will not have access to employees' health information. Rather, health plans should keep track of employee compliance and conduct health care claims analyses. If an employer is offering HSA contributions or other incentives outside of the insurance design, the employer should work with their health plan to develop a feedback system. Health plans may notify the employer of the incentive amount that is owed to each employee based on their data, but should not tell the employer how the incentives were earned (i.e. the employee's participation in certain programs or outcomes). Additionally, employers can utilize nurse health counselors or coaches to notify members if they qualify for certain incentives based on health status, and to inform their carriers of employees' participation in certain programs.

APPENDICES

Appendix A: Recommendation Development

This Employer Manual is the product of the Value Based Insurance Design Initiative, a joint initiative led by the State Innovation Model (SIM) Program Management Office (PMO) and the Office of the State Comptroller (OSC). The PMO and OSC engaged consultants Freedman HealthCare, LLC, in partnership with Dr. Bruce Landon, and Drs. Mark Fendrick and Michael Chernew of VBID Health, LLC, V-BID's founders and leading experts, to develop a recommended set of core V-BID benefits for integration into employer-sponsored health plans.

The template recommendations, guiding principles and best practices in this Manual were developed through a comprehensive stakeholder engagement process, which consisted of the following activities:

V-BID CONSORTIUM

The initiative was advised by a Value Based Insurance Design Consortium, which served as a workgroup to provide input on recommendations for the V-BID templates and guiding principles, and to provide feedback on all initiative materials, including this Manual. The group met seven times between February and June 2016, including four webinar meetings and three in-person meetings. Consortium members include the following representatives, who were appointed by the Connecticut SIM Steering Committee:

- 1 representative from the Department of Insurance
- 1 representative from the Health Insurance Exchange, Access Health CT
- 5 provider representatives
- 5 health plan representatives
- 5 employer representatives
- 5 consumer advocates
- 3 employer association representatives

EXECUTIVE COMMITTEE

Each stakeholder group (providers, health plans, employers and consumers) appointed one member from the Consortium to be on the V-BID Consortium Executive Committee, which met in advance of the Consortium meetings to vet meeting agendas and materials and provide feedback to the project team. The Executive Committee met three times between February and June.

DESIGN WORKGROUPS

In addition to full Consortium meetings, members volunteered to join two design session work groups:

Template Design Workgroup: This workgroup met twice to discuss the recommendations and formats for the V-BID templates and to discuss the guiding principles.

Learning Collaborative Workgroup: This workgroup met twice to discuss the structure of the Learning Collaborative, recruitment strategies, and the kickoff meeting.

STAKEHOLDER INTERVIEWS

Freedman HealthCare and the Connecticut project team conducted individual interviews with six of Connecticut's major health plans to learn about the benefits they are currently offering in both the self-insured and fully-insured markets, and what insurance benefits employers are demanding. In addition, the V-BID Initiative interviewed the three employer associations and three national employers (two of

which are based in Connecticut) currently implementing V-BID about their plans, successes and challenges, and lessons learned. Results of this outreach were summarized in a Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis of employer uptake of V-BID in Connecticut.

EMPLOYER SURVEY AND FOCUS GROUP

The V-BID initiative also developed and distributed a qualitative survey for employers in Connecticut to learn more about what V-BID and other innovative strategies employers in the state are currently implementing, how they communicate benefits to employees, and what insurance designs they would be interested in implementing in the future. To discuss the results of the survey, the V-BID initiative engaged several innovative employers throughout the state in an employer focus group. The employers generously shared success stories and best practices from their own experiences implementing V-BID and other innovative benefits.

Appendix B: V-BID Template Worksheet

V-BID RECOMMENDED CORE BENEFITS FOR FULLY-INSURED EMPLOYERS

To qualify as a V-BID Basic plan, employers must implement all three Components.

Core Component 1: Change Incentives for Specific Services for All Applicable Members

V-BID Basic	Recommended Core Benefits	Incentive	Amount
<p>Component 1 Change Incentives for Specific Services for All Applicable Members</p>	<ul style="list-style-type: none"> ✓ Blood pressure screening for applicable members depending on age group and gender ✓ Cholesterol screening for applicable members depending on age group and gender ✓ Obesity screening for applicable members depending on age group and gender ✓ Depression screening for adolescents over 12 years and adults ✓ Alcohol screening and counseling for all adults ✓ Breast cancer screening for women depending on age group ✓ Cervical cancer screening for women depending on age group ✓ Colorectal cancer screening for applicable members depending on age group and gender 	<p>I will provide employees that use any of these services with a:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	<p>\$ _____</p>

Core Component 2: Change Cost Sharing for Specific Drugs for All Applicable Members

V-BID Basic		Recommended Core Benefits	Incentive	Amount
Component 2 Change Cost Sharing for Specific Drugs for All Applicable Members	Choose at least two:	<input type="checkbox"/> Beta-blockers	I will provide employees that use any of these drugs with a: <ul style="list-style-type: none"> <input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Reduced Copayment <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	\$ _____
		<input type="checkbox"/> ACE inhibitors and ARBs		
		<input type="checkbox"/> Insulins and oral hypoglycemic		
		<input type="checkbox"/> Long-acting inhaler		
		<input type="checkbox"/> Inhaled corticosteroids		
		<input type="checkbox"/> Statins		
		<input type="checkbox"/> Anti-hypertensives		
		<input type="checkbox"/> Anti-depressants		
		<input type="checkbox"/> Smoking cessation drugs		

Core Component 3: Change Incentives for Visits to High Value Providers

V-BID Basic		Recommended Core Benefits	Incentive	Amount
Component 3: Change Incentives for Visits to High Value Providers	Choose at least one:	<input type="checkbox"/> Network of providers who have been identified as high value based on performance on cost and quality metrics	I will provide employees that visit any of these providers with a: <ul style="list-style-type: none"> <input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Reduced Copayment <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	\$ _____
		<input type="checkbox"/> Provider who is part of an ACO identified as high value based on performance on cost and quality metrics		
		<input type="checkbox"/> Primary care physician or Patient Centered Medical Home that has been identified as high value based on performance on cost and quality metrics		

V-BID OPTIONAL BENEFITS for Fully-Insured Employers

V-BID Basic	Incentive	Amount
<input type="checkbox"/> Treatment decision support/counseling for members with conditions that have multiple treatment options with differing risks and benefits Condition(s): _____ _____ _____	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____
<input type="checkbox"/> Surgical decision support or second opinion before surgery for members undergoing elective surgeries that have other treatment alternatives Condition(s): _____ _____ _____	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____
<input type="checkbox"/> Chronic Disease Management program for members with chronic diseases Condition(s): _____ _____ _____	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____
<input type="checkbox"/> Pain Management for members with chronic pain	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance	\$ _____

	<input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	
<input type="checkbox"/> Healthy pregnancy program	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____
<input type="checkbox"/> Smoking Cessation for all members, as applicable	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____
<input type="checkbox"/> Complex Case Management, for members with complex conditions. Condition(s): _____ _____ _____	<input type="checkbox"/> Contribution to HSA <input type="checkbox"/> Contribution to HRA <input type="checkbox"/> Bonus Payment <input type="checkbox"/> Reduced Premium <input type="checkbox"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)	\$ _____

Appendix C: Overcoming Implementation Barriers

	Barrier	Strategies to Overcome Barriers
ECONOMIC	V-BID implementation will initially result in increased costs for employers and health plans due to increased utilization and reduced cost sharing.	<ul style="list-style-type: none"> ▪ Many employers have found implementing V-BID results in higher utilization of lower cost services, such as primary care, and lower utilization of higher cost services, such as ED visits and inpatient stays.⁶ ▪ Although healthcare cost savings may not be realized in the first year of implementation, other outcomes such as decreased absenteeism and presenteeism may result in greater productivity and potentially profit.⁷
	V-BID requires defining and standardizing what is meant by “high-value”, yet there is a lack evidence of the clinical and cost effectiveness of many services and providers.	<ul style="list-style-type: none"> ▪ The template in this manual recommends services for which there is an evidence base from academic, clinical and research bodies that these services improve health.⁸ ▪ Evaluation of several V-BID programs that target chronic diseases such as diabetes and cardiovascular disease have demonstrated that reduced cost sharing for medications related to these conditions results in increased medication adherence, decreased costs, and improved health.⁹ ▪ The concept of high value provider is being constructed by the SIM Steering Committee, including proposing specific criteria for measuring providers. Refer to the link on page 38 for the complete criteria.
PRACTICE	Determining eligible patient demographics to target for reduced cost sharing for high-value services requires data collection and expert review of data.	<ul style="list-style-type: none"> ▪ Most health plans, especially those that administer wellness programs and chronic disease management programs, have the analytic tools available to analyze claims data.¹⁰ ▪ Incentivizing biometric screenings and health risk assessments can help employers collect additional data on their populations. ▪ The template recommends several services targeted only by age and gender, which does not require claims analysis and is less administratively complex.
	Absence of risk factors in claims data.	<ul style="list-style-type: none"> ▪ This data may be collected through biometric screenings and health risk assessments. ▪ Although EHR data is typically not used in health plan systems, technology to integrate EHR and claims data is being explored and should be encouraged. ▪ Health plans may integrate V-BID with Disease Management programs, which typically make EHR and health assessment data available.
	Physicians may not feel incentivized to persuade/dissuade patients to use/refuse certain services.	<ul style="list-style-type: none"> ▪ Involve physicians in the conversation to identify patient groups that would benefit most from differential cost-sharing of certain services.¹¹ ▪ The template aligns provider and consumer incentives by incentivizing services that correspond to quality measures in many value-based payment arrangements.

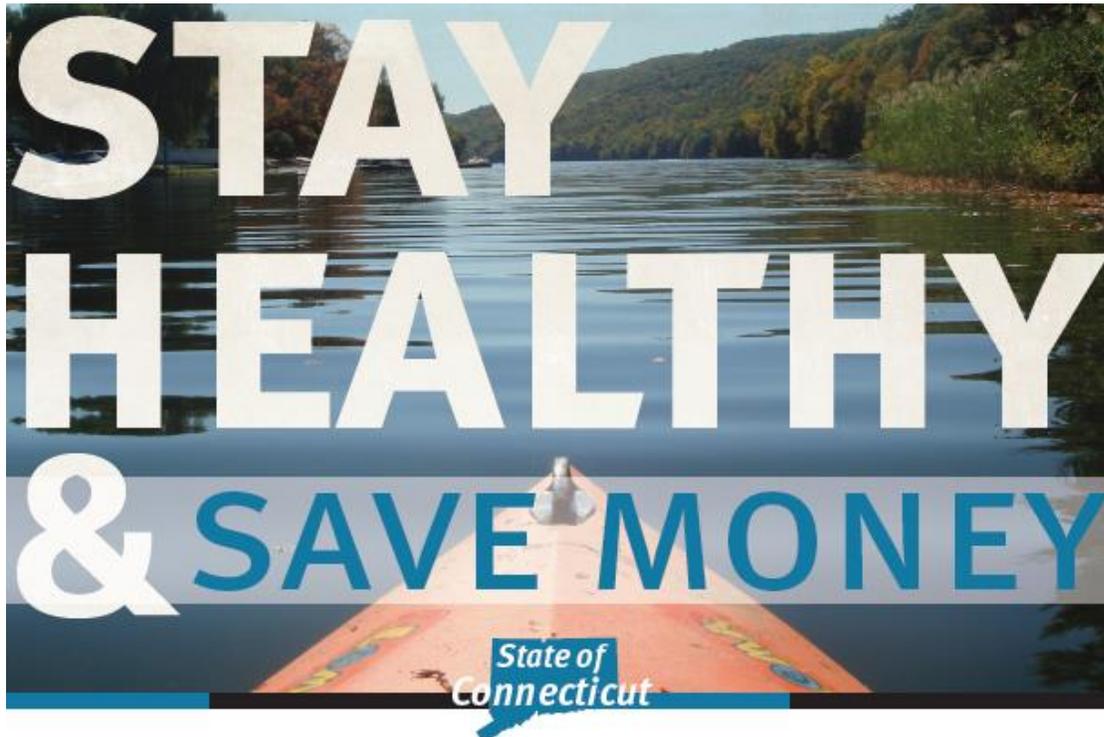
		<ul style="list-style-type: none"> Implementing a V-BID plan alongside the Connecticut Choosing Wisely campaign can help educate providers on how to have conversations with patients about what services are of high value and which are potentially unnecessary or harmful.
LEGAL	If patients refuse or fail to meet outcomes that qualify them for incentives, this is discriminatory.	<ul style="list-style-type: none"> Health plans are required to offer alternative ways for members to earn incentives if the incentives are based on meeting certain health outcomes or targets.
ADMINISTRATIVE	Identifying eligible members requires algorithms to measure compliance by patients and providers. Patients and/or providers may misreport information to qualify for V-BID.	<ul style="list-style-type: none"> Before implementing V-BID plans, employers and health plans should determine which methods they will use to measure member compliance.¹² Some employers implementing V-BID recommend using automated reporting as much as possible, and not relying on self-attestation. For many VBID elements, health insurance carriers can use existing information from claims data to identify eligible members. Many carriers are also exploring methods to automate the collection of information from EHRs.
CULTURAL	Getting employee buy-in and changing employee culture is challenging and takes too much time.	<ul style="list-style-type: none"> Engaging key stakeholders early, including senior leadership, union, and other employee leaders will increase buy-in. Integrating V-BID into a larger employee culture focused on healthcare and wellness can help increase buy-in. Repeated messaging about the plan through various communication channels is recommended by many employers.
	Motivating employees to change behavior is difficult	<ul style="list-style-type: none"> For large employers, bringing services to the employees (via on-site screening clinics, etc.) can increase participation. Implementing V-BID with other patient engagement strategies, such as wellness programs and other health initiatives, may increase participation.
	Explaining the program benefits to employees may be complex.	<ul style="list-style-type: none"> Employers should develop a comprehensive communication plan to communicate the V-BID benefits to employees before implementation. Describing eligibility requirements and incentive structures to employees will require outreach by HR. Many Connecticut employers have had great success with new member communication technologies to help communicate health plan benefits. Frequent communication through multiple channels will help explain the program.

Appendix D: V-BID Tool Kit and Resources

SAMPLE MARKETING AND COMMUNICATIONS MATERIALS

The following sample materials are based on examples of current marketing materials used by health insurers offering V-BID plans, strategies suggested in interviews, surveys by employers currently implementing V-BID, and best practices described in the literature on V-BID implementation.

Health Enhancement Program Sample Poster



HEALTH ENHANCEMENT PROGRAM (HEP) Requirements

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year			
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

Health Enhancement Program Sample Postcard

STAY HEALTHY SAVE MONEY
TIME TO SCHEDULE YOUR 2016 APPOINTMENTS




More info: www.CTHEP.com
 Or call Care Management Solutions at: **877.687.1448**
 (Mon-Thurs 8AM to 6PM, Fri 8AM to 5PM)

2016 HEP Requirements MORE INFO: www.CTHEP.com | 877.687.1448

PREVENTIVE SCREENINGS	AGE						
	0 - 5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings*	N/A	At least 1 per year	At least 1 per year	At least 1 per year			
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	1 screening between age 35-39**	As recommended by physician	As recommended by physician
Cervical Cancer Screening (Pap Smear)	N/A	N/A	Every 3 years (21+)	Every 3 years	Every 3 years	Every 3 years	Every 3 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT to age 75

*Dental cleanings are required for family members who are participating in one of the state dental plans
 **Or as recommended by your physician

For those with a chronic condition: The household must meet all preventive and chronic requirements to be compliant. As is currently the case under your state health plan, any medical decisions will continue to be made by you and your physician.

Sample Script for Engaging [Company Leadership](#):

Please note: this script uses an example of a V-BID plan that a company could implement. The script would need to be adapted to the specifics of the company and the proposed V-BID Plan benefits.

“In the next [X] months, the Company will be implementing some changes to our health benefits plan. These changes have three primary goals:

- 1- To improve health outcomes by encouraging the use of high-value services—which have been distinguished as such by validated cost and quality measures—applicable to all employees, including preventive services and certain prescription drugs
- 2- To increase medication adherence by reducing financial barriers to effective prescription drugs that target chronic conditions affecting some employees.
- 3- To encourage employees to visit high-value providers who deliver superior care based on cost and quality metrics

In order to achieve these outcomes, we will be offering a Value-Based Insurance Design (V-BID) plan. V-BID plans seek to improve health outcomes while controlling for rising healthcare costs by providing financial incentives to employees for high-value services and providers. These services and providers are distinguished as “high-value” by validated cost and quality measures which address cost of care—including price and utilization—clinical quality, and patient experience.

All of our employees will be eligible for an HRA contribution for certain high-value services and for visits to identified high-value providers. By contributing to an employee’s HRA, this V-BID program aims to relieve some of the financial burdens that are common barriers to adhering to medication regimens. The following incentives will be provided to employees for the following high value services:

- 1- All employees will receive an HRA contribution of \$250 if they participate in the following clinical services:
 - Biometric and Mental Health Screenings
 - Cancer Screenings (as appropriate for each employee’s age and gender)
- 2- All employees will have reduced costs for the following high-value drugs if they are prescribed these medications:
 - Beta-blockers
 - ACE inhibitors and ARBs
 - Statins
 - Anti-hypertensives
- 3- All employees will have reduced copayments for visits to ACO X, which has been identified as a high value provider network based on cost and quality metrics.

In order to maximize the impact of these changes, effective communication with employees is essential. The Company will depend on its leadership to understand and promote these benefits. As such, we would like to offer the Company leadership an opportunity to ask questions and voice any concerns about the proposed changes.”

Sample Materials for [Engaging Employees](#)

Frequent and effective communication is essential to gaining employee buy-in and increasing participation in a V-BID plan. Communication materials should aim to educate employees on what Value

Based Insurance Design is, the benefits of participation, and how employees can earn incentives. In addition to the infographics noted on page 37, below is sample language that can be adapted by employers to communicate with employees.

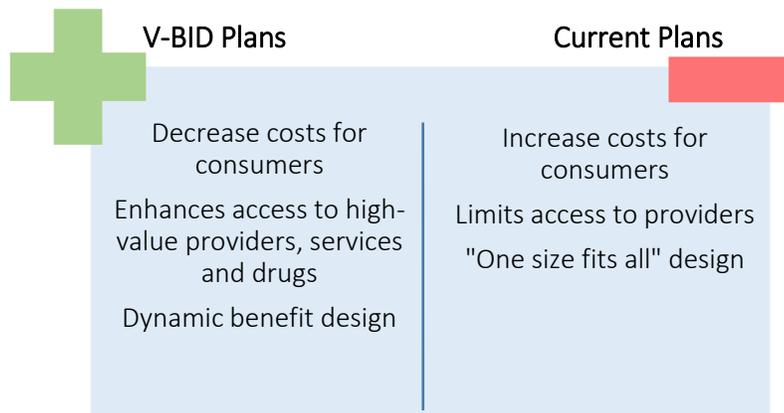
Please note: these scripts use an example of a V-BID plan that a company could implement. The scripts would need to be adapted to the specifics of the company and the proposed V-BID Plan benefits.

Sample Script 1: What is Value-Based Insurance Design?

Be sure that your employees understand how V-BID works and why your company will be moving to a V-BID plan. Start talking to your employees early in the process, and make sure they know the timeline for implementation.

“In [X months], [the Company] will be implementing some changes to our health benefits plan. Our new plan will be a Value-Based Insurance Design benefits plan.

Value-based Insurance Design (V-BID) plans offer incentive programs designed to reward patients who visit high-value providers and use high-value services and drugs. You may be wondering: “if these services are “high-value” will I pay more?” The answer is no. V-BID plans actually make it easier for you to complete these visits and receive these drugs and services by reducing their costs, and consequently alleviating the financial barriers to accessing these medically beneficial services.”



Adapted from: http://vbidcenter.org/wp-content/uploads/2016/02/Clinical_Nuance_Infographic.pdf

Sample Script 2: Why Should I Participate in the V-BID Plan?

Be sure to highlight that a V-BID program is not only good for your employees’ wallet, but it will improve their health as well. When employees are healthy, this will not only impact their performance at work but will help them to lead fuller lives outside of work.

“Have you ever felt that the cost of an office visit, drug or medical service has stood in the way of managing or improving your health? Prioritizing your health is made easy with value-based insurance design (V-BID) programs. V-BID programs minimize the cost for these visits, services and drugs that you are responsible for covering, making it easier for you to receive the right services at the right time from the right providers. By joining a V-BID plan you are joining a healthier workforce; you are becoming one of several employees throughout the country who have been able to maintain and achieve better health

outcomes. By improving your health, you are improving your productivity at work, and you are spending your valuable personal time doing things you *want to* be doing!”

Sample Script 3: How Do I Earn Incentives?

Use clear and concise language when describing your incentives. Be sure to include how the incentive is earned (participation in a program, visiting certain providers, adhering to prescription drug plan, etc.), how they will receive this incentive (through copay reduction, premium reduction, bonus payment, etc.), and how much money they can expect to earn or save through participation.

“Earn money by completing the following visits or choosing the following drugs and/or services:

- Earn \$250 contribution to your HRA account by using these services:
 - Biometric and Mental Health Screenings
 - Cancer Screenings
- Have lower copayments for any of the following prescription drugs:
 - Beta-blockers
 - ACE inhibitors and ARBs
 - Statins
 - Anti-hypertensives
- Reduce the cost of your office visits by making appointments with [ACO X].
 - Question: Why should I choose a provider from [ACO X]?
 - Answer: These providers have distinguished as “high-value” because of the cost and quality of the services they provide.
 - For a list of providers who participate in our V-BID plan, visit [carrier’s benefits website].

To learn more about the V-BID incentive plan, visit our [carrier’s benefits website].

EDUCATIONAL INFOGRAPHICS

[Clinical Nuance Infographic](#)¹³

[V-BID Infographic](#)¹⁴

[Reward the Good Soldier](#)¹⁵

[V-BID Center High Deductible Health Plan Infographic](#)¹⁶

ONLINE V-BID RESOURCES

[Consumer Centric V-BID Plan Design](#)

[Consumer Criteria for Value-Based Insurance Designs](#)¹⁷

*Connecticut's Advanced Medical Home Standards^v

[VBID Center](#)¹⁸

[Value-Based Insurance Design Pro's and Con's](#)¹⁹

[Value-Based Insurance Design Overview](#)²⁰

[V-BID Center Fact Sheet on Connecticut's Health Enhancement Program](#)²¹

[V-BID Center Fact Sheet on Increasing Flexibility to Expand IRS Safe Harbor Coverage in HSA-High Deductible Health plans](#)²²

[Agency for Healthcare Research and Quality](#)²³

[CMS Medicare Advantage Program](#)²⁴

[Choosing Wisely](#)²⁵

[Connecticut State Innovation Model Program Management Office: V-BID Initiative](#)²⁶

[U.S. Preventative Services Task Force](#)²⁷

[American Board of Internal Medicine Foundation](#)²⁸

[Health Enhancement Program](#)²⁹

V-BID DESIGN AND IMPLEMENTATION RESOURCES

[SIM Quality Council Proposed Measure Sets](#)

["Overcoming Barriers to Shared Decision Making"](#) webinar by the Agency for Healthcare Research and Quality (AHRQ).³⁰

[Evidence-Based Practice and Health Technology Assessment](#)³¹

[Standardization of Patient Reporting and Outcome Measures](#)³²

[Differences Between Wellness Rewards Programs and V-BID](#)³³

["Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States" a report by NORC at the University of Chicago](#)³⁴

[Guide to Selecting Doctors, Hospitals and Other Providers](#)³⁵

[Guide to Clinical Preventative Services](#)³⁶

[Reducing Administrative Costs](#)³⁷

^v *A final version of Connecticut's Advanced Medical Home Standards is in development and will be made available at the [Connecticut SIM Program Management website](#).

[“Innovative Payment for Advanced Primary Care Delivery”](#) a report for the Maine Health Management Coalition prepared by Discern Health³⁸

[Strategies for Reducing Health Care and Administrative Costs](#)³⁹

RELEVANT STATE AND FEDERAL REGULATIONS

[Affordable Care Act Mandates](#)⁴⁰

[Nondiscrimination in Health Programs and Activities Proposed Rule](#)⁴¹

[Mental Health Parity and Addiction Equity Act of 2008](#)⁴²

[Americans with Disabilities Act of 1990](#)⁴³

[Genetic Information Nondiscrimination Act of 2008](#)⁴⁴

GLOSSARY OF TERMS

Absenteeism. A habitual pattern of absence. For the purpose of this manual, absenteeism refers to absence from the workplace.

Accountable Care Organization (ACO). ACO's are comprised of a group of doctors, facilities and health care providers who voluntarily organize together to deliver high quality care to their Medicare patients and to ensure that patients receive timely and necessary care.⁴⁵

ACE inhibitor. Angiotensin-Converting-Enzyme (ACE) inhibitors are a drug prescribed to treat a variety of conditions including high blood pressure, scleroderma and migraines. Examples of common ACE inhibitors are: Benazepril (Lotensin), Captopril, Enalapril (Vasotec), Fosinopril, Lisinopril (Zestril), Moexipril (Univasc), Perindopril (Aceon), Quinapril (Accupril), Ramipril (Altace), Trandolapril (Mavik).⁴⁶

Affordable Care Act (ACA). Enacted by the Obama administration, the ACA, along with the Health Care and Education Reconciliation Act (2010) improved accessibility and affordability of preventative care to many Americans.⁴⁷

American Board of Internal Medicine Foundation (ABIM). Since 1936, ABIM has worked to establish uniform standards amongst physicians. Certification by the ABIM represents the highest standard in internal medicine and means that certified internists have demonstrated-both professionally and publically-that they have the skills necessary for delivering the highest quality of patient care. ABIM is a non-profit, physician-led group.⁴⁸

Angiotensin Receptor Blocker (ARB). ARBs are prescribed to treat conditions such as high blood pressure and heart failure.⁴⁹

Benefit design. Benefit design describes the rules by which health care services are covered by a health plan, eligible providers from which members can receive services from and requirements and/or restrictions relating to costs and cost-sharing related to those services.⁵⁰

Centers for Medicare & Medicaid Services (CMS). Through Medicare, Medicaid, Children's Health Insurance Plan (CHIP) and the Health Insurance Marketplace, these services aim to broaden the scope of Americans who receive coverage and to improve health by lowering costs and coordinating care to prevent illness.⁵¹

Centers of Excellence (COE). The term COE is commonly used to distinguish health care centers in which providers are specialized in particular services or programs that can produce better health care outcomes for patients.⁵²

Choosing Wisely. An ABIM Foundation initiative that promotes conversations between patients and providers to discuss care that is appropriate and evidence-based and to question procedures that are no evidence-based and potentially harmful. Connecticut's Choosing Wisely campaign focuses its efforts on

educating providers on non-evidence based procedures and how to best communicate appropriate services to patients.

Clinical Nuance. Recognizes that medical services differ in the benefit provided, and that the clinical benefit derived from a specific service depends on the patients using it, as well as when, where, and by whom the service is provided.

Compliance. The consistency and accuracy by which a person follows her/his medical regimen as prescribed by a healthcare provider.⁵³

Connecticut SIM Quality Council's Provisional Measure Set. A set of measures developed by the Connecticut SIM Quality Council for measuring provider performance.

Connecticut V-BID Consortium. An employer-led, multi-disciplinary group convened by Freedman HealthCare. The role of the Consortium was to serve as an advisory body for the V-BID Initiative in Connecticut, advising on strategies for employer and health plan engagement and making recommendations for the development of a V-BID Employer Manual, including benefit design recommendations and justifications and employer guidance for V-BID implementation.

Copayment. A type of cost-sharing. Copayments are fixed amounts that a patient is required to pay for a given service. Any outstanding cost not covered by the copayment is covered by a third party payer.⁵⁴

Cost-sharing. A term used to describe the amount that a patient is expected to pay out-of-pocket to a provider in return for a service without reimbursement from a third-party payer. Four common approaches include: copayments, co-insurance, deductibles, and balanced billing.⁵⁵

Deductible. A type of cost-sharing in which the patient is expected to pay 100% of the cost for all rendered services until their spending satisfies the deductible. Once the deductible is met, other forms of cost-sharing, such as copayments or coinsurance, apply. For preventative services, the deductible requirement may be waived, in which case the patient may be expected to pay other forms of cost-sharing or none at all.⁵⁶

High Deductible Health Plan (HDHP). A benefit design plan that features higher deductibles compared to traditional insurance plans. HDHPs can be combined with health savings accounts or health reimbursement arrangements allowing for patients to pay for qualified medical expenses pre-tax.⁵⁷

Health Enhancement Program (HEP). Implemented in Connecticut in 2011, HEP is a voluntary program for all employees, retirees and dependents enrolled to comply with a schedule of wellness exams and screenings and to participate in disease counseling and education specific to existing health conditions. If a participant is compliant, they become eligible for reduced cost-sharing and other benefits; if not, patients are subject to a monetary penalty.

Health Maintenance Organization (HMO). A type of insurance plan that limits a patient to only receive coverage for care delivered by a provider who is contracted by the HMO. HMOs provide integrated care with a focus on wellness and prevention.⁵⁸

Health Reimbursement Account (HRA). An HRA reimburses employees for employer-approved medical expenses.⁵⁹

Health Savings Account (HSA). An HSA is an employee's tax-exempt account for covering medical expenses. Subject to IRS rules, employers can make contributions to an employee's HSA to go towards the cost of health care services.⁶⁰

Preferred Provider Organization (PPO). A type of health plan that consist of a network of providers and facilities. There is reduced cost sharing for an enrolled member uses providers and facilities that belong within the PPO; however members may use out-of-network providers and facilities at a higher cost.⁶¹

Premium. The amount of money a person pays for her/his health insurance or plan. This amount is usually paid monthly, quarterly or annually.⁶²

Presenteeism. Working while sick, which can cause productivity loss, poor health, exhaustion, and workplace epidemics.

Primary Care Physician (PCP). A physician or health care provider that provides, coordinates or helps a patient access and utilize health care services.⁶³

State Innovation Model (SIM) Initiative. An initiative of the CMS, the SIM initiative provides financial and technical support to developing state-led, multi-payer health care delivery models with the goal of improving health system performance, quality of care while simultaneously reducing costs.⁶⁴

SWOT analysis. An analysis of strengths, weaknesses, opportunities, and threats.

Transparency. Describes the availability of information on price and quality of health care services, providers and facilities.⁶⁵

Value-Based Insurance Design (VBID). Value-based insurance design (V-BID) refers to insurance plans that utilize clinical nuance in realigning consumer incentives with high value health services. The aim of V-BID is to increase healthcare quality and to decrease costs by using differential cost sharing for consumers to promote use of high value services and high performing providers.

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