
VALUE-BASED INSURANCE DESIGN EMPLOYER MANUAL

SELF-INSURED EMPLOYERS

FINAL DRAFT

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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.

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.

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.

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 self-funded 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 and health plan administrators 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 that trend by changing the health care cost discussion from ‘how much’ to ‘how well’.

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 for only those patients who need them, at the time that they need them. Financial savings may result from lower utilization of expensive services, such as reduced ER visits and inpatient stays, reduced readmissions, and reduced specialty care due to better management of chronic conditions.

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.

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 presenteeism¹ 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 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 for people with certain clinical conditions, 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, rather than just worrying about their bottom line, 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 that this is a top performance driver.

¹ 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 self-insured employers with different benefit structures.

For help designing your V-BID Plan, check out the V-BID Template Worksheet starting on page 32

V-BID TEMPLATE

This Manual presents a V-BID template for self-insured employers. While any employer can choose to implement this template, this template is designed to specifically address the needs of self-insured employers.

The V-BID template for self-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 and Drugs for All Applicable Members, Targeted by Age and Gender
Core Component 2: <i>Change Cost Sharing for Certain Conditions</i>	Change Incentives for Specific Services and Drugs by Clinical Condition
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 employers implement the recommended core benefits of all three components of this plan.** Employer guidance, justification for the recommendations, and examples of employers currently implementing the component are provided with each core component.

The template in this manual targets members with specific clinical conditions. Core Component 1 of the template includes certain services and prescription drugs for which cost sharing may be reduced for all members, and Core Component 2 of the template includes incentives for prescription drugs only for members with specified clinical conditions. Core Component 2 asks employers to select two conditions from the list to target; plans are encouraged to provide incentives for the visits, diagnostics, and drugs listed for those conditions.

Additional V-BID Options and Supplemental Benefits

For employers seeking 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 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 employers and health plans are strongly encouraged to implement all Recommended Core Benefits of the template, the V-BID Initiative recognizes that 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, or targeting certain clinical conditions within HSA-HDHP plans. 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 22 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 26 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 third party administrators (TPAs) who are designing and implementing V-BID plans, including suggestions on how to align V-BID plans with provider incentives and other consumer engagement strategies, and a toolkit with sample communications and marketing materials for senior leadership and employees, 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.² 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 and implement VBID plans.
 - 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. 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.

² 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 Appendix E on page 44 for the complete criteria under consideration.

V-BID TEMPLATE FOR SELF-INSURED EMPLOYERS

This template provides recommendations for a comprehensive V-BID benefit plan design for **self-insured employers**. It includes recommended core benefits to be implemented as part of a V-BID plan, and suggested additional benefits that employers may choose to implement with the core elements.

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, and contributions to Health Reimbursement Accounts, among others. Each employer should choose a method appropriate to the structure of the health plan offered. This table provides guidance on the mechanisms that work best for different components:

Plan Type	Incentive Mechanisms	Recommended for:
All plans	<ul style="list-style-type: none"> o Bonus payment for using recommended services, or o Reduced premium for using recommended services 	V-BID Component 1 (for ACA covered services)
Plans with copayment or coinsurance cost-sharing	<ul style="list-style-type: none"> o Waived or reduced copayment or coinsurance for recommended services and drugs or visit to high value provider 	V-BID Component 1 (for prescription drug coverage) V-BID Components 2 and 3
Health Reimbursement Account-eligible High Deductible Health Plan (HRA-HDHP)	<ul style="list-style-type: none"> o Contribution to HRA for recommended services and drugs, or o Exclusion of recommended services and drugs from deductible o Contribution to HRA for visit to high value provider 	V-BID Components 2 and 3
Health Savings Account-eligible High Deductible Health Plan (HSA-HDHP)*	<ul style="list-style-type: none"> o Contribution to HSA for adhering to recommended services or visits to high value provider 	V-BID Components 1 and 3
All plans ³	<ul style="list-style-type: none"> o Financial incentives external to health benefit plan designs, including gift cards, payroll bonuses, and other rewards programs 	Supplemental Benefits

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

³ If employers encounter barriers to integrating incentives or coverage of certain services as part of health plan benefits, they may choose to provide incentives outside of the plan design as an alternative. For example, the employer’s benefits department may offer gift cards to those who participate in a supplemental benefit program.

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.⁴

	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 VBID plan compulsory can offer the V-BID plan as the only health plan available to employees. Employers who choose to make the VBID plan voluntary can allow employees to opt-in.

If choosing an opt-in structure, the plan will need a significant enough incentive to encourage high rates of enrollment in the program. If offering an opt-in structure, the plan may require that enrollees use 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 use 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 state and federal regulations, including mental health parity regulations and health plan nondiscrimination laws. For more information about federal regulations, refer to the Online Resources section on page 52 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 counsel and/or health plan on approaches that incentivize drugs and services based on a member’s clinical condition. Employers are encouraged to work with their health plan on excluding any preventive services and medications that are allowable under IRS guidance from the deductible. 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 52 of the Employer Manual.

⁴ 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>

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

It is recommended that employers encourage the 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. Please refer to Online Resources on page 52 for more information on services that are mandated by the ACA.

	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
	<i>Prescription Drugs**</i>	
	Beta-blockers	All members prescribed drug for any indication
	ACE inhibitors and ARBs	All members prescribed drug for any indication
	Insulins and oral hypoglycemics	All members prescribed drug for any indication
	Long-acting inhalers	All members prescribed drug for any indication
	Statins	All members prescribed drug for any indication
	Smoking cessation drugs	All members prescribed drug for any indication

*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>

**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. Employers should seek legal guidance on approaches that incentivize drugs for clinical conditions through exclusions from the deductible and/or HSA contributions. Employers are encouraged to work with their health plan on excluding any preventive services and medications that are allowable under IRS guidance from the deductible.

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 22 of the Employer Manual for various methods for measuring compliance with screenings.
- For prescription drugs, it is recommended that cost sharing is reduced for generic, preferred brand, and brand name drugs for all targeted drug classes.

Justification for Recommendation

- This is the most basic component to implement – simplicity was emphasized by stakeholders interviewed and Consortium members. For more information about the Consortium and recommendation process, refer to the Recommendations Development Appendix on page 30.
- 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.
- Evidence from employers such as Pitney Bowes, Marriott International, and Proctor & Gamble suggests reducing cost sharing for certain drugs for all members prescribed these drugs increases medication adherence and decreases overall medical costs.² 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.
- Most employers currently implementing V-BID plans incentivize biometric screenings, cancer screenings, and at least one of these drugs.
- Evidence from the Connecticut State Employee Health Enhancement Program suggests incentivizing preventive services increases use of primary care and diagnostic screenings, and decreases use of higher cost services such as specialty care and hospitalization.³
- Consortium members emphasized the importance of behavioral health and substance use screenings for all members for 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 by reducing or waiving out of pocket costs for these services, or providing an 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.
	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, or comorbidities.

**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

Employers may encounter barriers to 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 Self-Insured Employers Implementing V-BID Component 1

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 1: Change Incentives for Specific Services for <i>All Applicable Members</i> Targeted by Age and Gender	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%
	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. Reduces cost sharing for condition-related services for specific conditions (Component 2) 	<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 INCENTIVES FOR SPECIFIC SERVICES BY CLINICAL CONDITION*

It is recommended that employers incentivize use of high value services for members with specific clinical conditions. **Employers are encouraged to select conditions that affect your specific employee population.** A member must be diagnosed with the condition to be eligible for an incentive.

	Chronic Conditions	Visits	Diagnostics	Drugs
Recommended Core Benefit Plan Design: Recommend employers target at least two conditions	Diabetes	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Nutritional counseling ▪ Smoking cessation 	<ul style="list-style-type: none"> ▪ HbA1c ▪ Eye exams ▪ Foot exams 	<ul style="list-style-type: none"> ▪ Insulin ▪ Diabetic supplies ▪ ACE inhibitors/ARBs
	Pre-diabetes	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Nutritional counseling ▪ Health coach ▪ Smoking cessation 	<ul style="list-style-type: none"> ▪ HbA1c ▪ Glucose test 	<ul style="list-style-type: none"> ▪ Anti-hypertensives ▪ Metformin ▪ Statins
	Asthma/COPD	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Smoking cessation ▪ Home visits 	<ul style="list-style-type: none"> ▪ Spirometry 	<ul style="list-style-type: none"> ▪ Long-acting inhalers ▪ Inhaled corticosteroids ▪ Oxygen
	Hypertension	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Smoking cessation ▪ Nutritional counseling 	<ul style="list-style-type: none"> ▪ Blood pressure testing 	<ul style="list-style-type: none"> ▪ Anti-hypertensives ▪ ACE inhibitors/ ARBs ▪ Statins
	Pre-hypertension	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Smoking cessation ▪ Nutritional counseling ▪ Health Coach 	<ul style="list-style-type: none"> ▪ Blood pressure testing ▪ Home blood pressure measurement 	<ul style="list-style-type: none"> ▪
	Depression	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Suicide and other risk assessments ▪ Cognitive behavioral therapy ▪ Smoking cessation 	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪ Anti-depressants
	Substance Use Disorders	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Risk assessments ▪ Evidence-based treatment programs ▪ Smoking cessation 	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪ Methadone ▪ Buprenorphine/Naloxone ▪ Detox medications

Congestive Heart Failure	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Smoking cessation ▪ Nutritional counseling 	<ul style="list-style-type: none"> ▪ Echocardiogram ▪ EKG ▪ Potassium and creatinine testing ▪ Digoxin level 	<ul style="list-style-type: none"> ▪ Beta-blockers ▪ ACE inhibitors/ARBs ▪ Spironolactone ▪ Diuretics ▪ Oxygen ▪ Digoxin
Coronary Artery Disease	<ul style="list-style-type: none"> ▪ Office visits related to condition ▪ Nutritional counseling ▪ Smoking cessation 	<ul style="list-style-type: none"> ▪ EKG 	<ul style="list-style-type: none"> ▪ Beta-blockers ▪ ACE inhibitors/ ARBs ▪ Aspirin ▪ Clopidogrel/Plavix

**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

- Some claims analysis is required to determine which conditions are most prevalent among your employee population, and which employees are eligible for incentives.
- While employers are encouraged to target conditions that most affect their employee population, diabetes is one of the most commonly targeted and evaluated conditions in V-BID plans due to its high prevalence and evidence showing that increased medication adherence to diabetes drugs due to lower cost sharing results in better health outcomes and direct healthcare savings.
- Office visits related to conditions can be identified through the coding used for the visit, so that physician offices know when to waive or reduce patients’ cost sharing.

Justification for Recommendation

- Over 57%, or two million, Connecticut residents have one or more chronic diseases, which drives healthcare spending and results in lost productivity.
- Studies have reported that as copays increase, adherence to chronic disease medications, such as diabetes, decreases.⁴ Evaluations of employer programs such as United Healthcare’s “Diabetes Health Plan” and Midwest Business Group on Health’s V-BID Plan have demonstrated that reducing cost sharing for high-value services such as chronic disease medications, increases medication adherence, resulting in better management of chronic conditions.^{5,6}
- The conditions selected are based on those for which there is evidence-based treatment, evaluations of other V-BID programs suggest that reducing financial barriers increases treatment adherence and improves health outcomes. The CMS Medicare Advantage pilot V-BID

program recommends reduced cost sharing for services for several of the recommended conditions. More information about the CMS selected conditions can be found at Innovation.cms.hhs.gov/initiatives/VBID or in the Online Resources section on page 52.

- Several employers, such as Hannaford Brothers, Wellpoint, Inc. and Caterpillar, Inc., among many others have reduced cost sharing for services and drugs related to chronic conditions as part of a V-BID plan and found this reduced overall spending.⁷

ADDITIONAL V-BID COMPONENT 2 OPTION: CHANGE INCENTIVES FOR SUPPLEMENTAL BENEFITS FOR MEMBERS WITH CLINICAL CONDITIONS

In addition to incentivizing high-value services for members with specific clinical conditions, employers may choose to also incentivize certain supplemental benefits for members with these conditions. This can be done by reducing, waiving or reimbursing out of pocket spending for these services, or by providing an incentive for those who participate in the supplemental benefit or program.

Examples of Types of Supplemental Benefits

- Transportation to appointment(s)
- 90-day supply mail-order prescriptions for chronic conditions
- Telemedicine, including virtual or audio consultations with the patient's usual healthcare provider
- Meals or other nutritional services
- Treatment Decision Support program

Implementation Guidance

- 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.
- All members with the targeted clinical condition should be eligible for participation in the disease management program to avoid discriminatory benefits.

ADDITIONAL V-BID COMPONENT 2 OPTION: CHANGE INCENTIVES FOR SERVICES FOR MEMBERS WHO PARTICIPATE IN CHRONIC DISEASE MANAGEMENT PROGRAMS

Employers may choose to require participation in a disease management program in order to receive incentives for condition-specific high-value services and/or supplemental benefits. Employers may also choose to make incentives conditional based on outcomes achieved in the disease management programs. Employers that choose an outcomes-based incentive must provide an alternative way to earn incentives for members who are unable to reach required targets. Further guidance on outcomes-based approaches can be found at [Nondiscrimination in Health Programs and Activities Proposed Rule](#) or in the Online Resources section on page 52.

Examples of Types of Disease Management Programs

- Disease-specific action plan

- Meetings with health coach or health educator for education on condition
- Medication adherence program
- Pharmacist counseling
- Nutritional counseling
- Behavioral health counseling
- Lifestyle change/wellness program specific to condition
- Weight management/weight loss program indicated for condition
- Smoking cessation program

Implementation Guidance

- Disease management programs are specific to improving health outcomes for a person’s condition. They are not a general wellness program for all members.
- Disease management programs may be offered as an additional benefit for members with specific clinical conditions, or may be part of the existing care management activities. If part of 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 these programs.
- All members with the targeted clinical condition should be eligible for participation in the disease management program to avoid discriminatory benefits.

Examples of Self-Insured Employers Implementing V-BID Component 2

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 2: Change Incentives for Specific Services by Clinical Condition	National	Lafarge North America “Building a Better You”	<ul style="list-style-type: none"> ▪ Reduced copays (\$5) for diabetes, asthma and hypertension medications 	<ul style="list-style-type: none"> ▪ Saved \$30M in medical and Rx costs over 3 years ▪ Doubled percent of patients adherent to meds ▪ Decreased ER visits and inpatient visits and days
	Connecticut	United Healthcare “Diabetes Health Plan”	<ul style="list-style-type: none"> ▪ Eliminated payments for diabetes-related supplies and Rx drugs for participation in routine disease maintenance exams for United Healthcare employees ▪ Provided employees 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 Appendix E on page 44) 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.⁸

ADDITIONAL V-BID COMPONENT 3 OPTION: CHANGE INCENTIVES FOR SPECIFIC SERVICES ONLY IF DELIVERED BY HIGH VALUE PROVIDER

Employers may choose to incentivize specific services only when delivered by a high value provider.

	Provider Type	Conditions	Services
Suggested Additional Benefits	Center of Excellence	<ul style="list-style-type: none"> ▪ Transplant surgery ▪ Knee or hip replacement ▪ Heart surgery ▪ Obesity surgery ▪ Substance use 	<ul style="list-style-type: none"> ▪ All care for specific condition ▪ Medications for specific condition
	Narrow network of high performing providers for specific chronic conditions	<ul style="list-style-type: none"> ▪ Coronary Artery Disease ▪ Congestive Heart Failure ▪ Diabetes ▪ Hypertension ▪ Cancer 	<ul style="list-style-type: none"> ▪ Office visits for condition ▪ Medications for condition ▪ Procedures for condition

*See V-BID Plan Guiding Principles for additional recommendations on how value should be defined for providers.

Implementation Guidance

As part of this option, employers may also cover additional out of pocket expenses associated with these services. For example, if employees need to travel to a Center of Excellence for a surgery, employers such as Lowe’s cover the cost of travel for the patient and a family member, in addition to the care received while at the facility. Employers should consider provider access and employees’ abilities to visit certain providers for follow up, especially if they require ongoing care from the provider.

Examples of Self-Insured 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 ▪ Transplants and infertility treatment is permitted at COEs only 	<ul style="list-style-type: none"> ▪ Increased cost savings as result of incentive program

Additional V-BID Component 3 Option: Change Incentives for Specific Services Only If Delivered by High Value Provider	National	Lowe's	<ul style="list-style-type: none"> Covers medical cost and travel cost for patient and one relative for employees who have cardiac procedures performed at Cleveland Clinic 	<ul style="list-style-type: none"> Anticipates reduced costs, lower readmissions, lower mortality
	National – Connecticut based	General Electric	<ul style="list-style-type: none"> Covers 100% of medical cost and up to \$2,000 of travel costs for employees who get hip and knee replacements at one of four COEs Incentivizes employees to use obesity surgery, organ transplant, and substance abuse COEs 	<ul style="list-style-type: none"> Anticipates reduced costs, lower readmissions, lower mortality

These plans were identified through materials from the V-BID Center as well as discussions with employers.⁹

IMPLEMENTATION STRATEGIES

Steps for Implementing a V-BID Plan

Below is an outline of steps that self-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.

Assess Employee Needs

to determine which clinical conditions to target

Discuss program goals with your Health Plan

to develop a customized V-BID Plan

Choose a V-BID Plan

to address the clinical needs of employees

Discuss Compliance Measures

to determine which employees are eligible for incentives

Develop a Communication Strategy

to share changes in benefit design with employees

Initiate V-BID Program

to increase the use of high-value services

Evaluate V-BID

to demonstrate V-BID successes and to maintain support for the program

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. **Health plan administrators and pharmacy benefits managers** have access to medical and pharmacy claims that they can analyze to determine disease prevalence and risk factors among members.

Get to Know Your Employees!
Biometric screenings and health risk assessments can help you determine which services are most valuable to your employees.

Analyzing this data will help identify areas of risk for increased health care spending due to health conditions that can be improved through enhanced treatment adherence and/or behavior change.¹⁰

Health plan administrators can also collect these data through employee biometric screenings and health risk assessments. The first V-BID component in the V-BID template recommends incentivizing certain biometric and mental health screenings, which may be used to collect additional data on the population. **Employers should work with health plans** to use this information to determine

which clinical conditions to target and which additional high value services or supplemental benefits to incentivize in order to have the most impact. Involving a clinician in this assessment is recommended to identify opportunities for intervention and improvement.

DISCUSS YOUR OPTIONS WITH YOUR HEALTH PLAN ADMINISTRATOR

Before implementing a V-BID plan, **employers** should discuss their goals with their health plan administrators to develop a customized V-BID program that makes sense for the company. **Health plans** can provide additional guidance on state and federal regulations, and can provide online tools for record keeping and tracking participation.

CHOOSE A V-BID PLAN TO IMPLEMENT AND DECIDE ON ANY ADDITIONAL BENEFITS

The V-BID template included in this manual provides employers with a recommended core benefits plan design that is based on the evidence supporting high value services, feedback from the Connecticut V-BID Consortium, expert opinion, and those V-BID elements that Connecticut employers are currently implementing. The goal of this template is to offer self-insured employers recommended V-BID benefits, while allowing for flexibility by providing additional options that may be incorporated into a plan design. Based on the result of their analyses, **employers should work with their health plan administrators** to choose which conditions to target and/or which additional benefits to incentivize.

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

DETERMINE A METHOD FOR MEASURING COMPLIANCE WITH RECOMMENDED SERVICES AND PROGRAMS

In order to determine which employees are eligible for incentives, **health plan administrators** 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, **health plan administrators** can use claims data to identify which members complied with recommended services and are eligible for incentives. If incentives are based on outcomes, the health plan administrator will need to determine a mechanism for the provider to communicate whether targets were achieved, as claims data would not contain this information. Tracking

compliance with recommended services should be the role of the health plan administrator, or a third party. 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 PLAN TO EDUCATE EMPLOYEES ABOUT V-BID BENEFITS

Employee communication, education and engagement are key to the success of any V-BID plan design.¹¹

Employers should work with their HR departments to develop a communications strategy before implementing V-BID plan designs. 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. **Health plan administrators** should also develop 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 26.

IMPLEMENT YOUR CUSTOMIZED V-BID PLAN

Once the **employer and health plan administrator** have decided on a V-BID plan design, **employers** should choose a date for open enrollment that allows ample time to communicate to employees the new plan offering, and for the employer and health plan administrator to iron out all of the details. 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 28 and Overcoming Barriers Appendix on page 40.

DEVELOP AN EVALUATION PLAN AND ASSESS THE IMPACT OF V-BID

It is recommended that **employers work with their health plan administrators** to develop an evaluation plan to measure the impact of the V-BID plan design. This will help the **employer** to track success on certain measures to inform senior management and maintain support for the program. The **employer** should define goals for the program and select specific, quantifiable measures to evaluate its success.¹²

Goals may include:

- Increasing preventive screening rates
- Increasing medication adherence among employees with targeted conditions
- Improving certain health outcomes and/or biomarkers
- Reducing emergency department utilization and hospital stays
- Decreasing overall total medical expenditures

Employers should work with their health plan administrator on how these metrics can be measured, and on establishing baselines for the selected measures prior to or at the time the plan is first implemented. **Employer Human Resources departments** will be critical to measuring certain metrics, such as reduced absenteeism, whereas **health plan administrators'** claims analysis and data collected from biometric screenings and health assessments will be important for measuring improvement in health outcomes and changes in utilization.

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.

USE INCENTIVE AMOUNTS THAT WILL MOTIVATE EMPLOYEES' BEHAVIOR

- Incentive amounts need to be appropriate for your 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, and Connecticut HEP found that a premium penalty of \$100 per month for not meeting program requirements resulted in high levels of compliance.
- 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. Requesting employee feedback on V-BID plan design incentive mechanisms can help employers gauge this.

MAKE SERVICES CONVENIENT FOR EMPLOYEES

- Large 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 Toolkit on page 47.

MODIFY PLAN DESIGNS THROUGHOUT IMPLEMENTATION AS NEEDED

- Plan designs should be modified at least annually as new health risks emerge, and as employees give feedback on the plan. Communicating annual changes to the plan also increases employees' awareness of the plan and may present an opportunity to expand enrollment.
- Plans may be modified to implement more clinically nuanced aspects that may have been too complex to administer before appropriate systems were in place.

SET REALISTIC EXPECTATIONS FOR REALIZING RESULTS

- It is important to set realistic expectations with senior management about which goals can be achieved and when. While return on investment may take several years to realize, other measures of success, such as increased medication adherence, improved biomarkers, and reduced absenteeism may be realized within several months of implementation.¹³

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 both employers and health plan administrators. While health plan administrators 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 by 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' healthcare 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, videos, and postings to Intranet sites. In-person communication through "lunch and learns" or benefits fairs may be particularly effective.
- Customize communication materials to appeal to specific employee groups, such as different ages, genders and cultural groups within the organization. Interactive online benefits communication tools can help with customized messaging. Many health plans offer these to their employer clients, but you can also find standalone products for your HR department.
- 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 initiatives.
- 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 to monitor employee satisfaction after the first year of operation and identify areas for improvement. Evaluation of the communication campaign should be ongoing.

Choosing Wisely®: Educating Consumers on Low Value Services

Choosing Wisely®, an initiative of the American Board of Internal Medicine (ABIM) foundation, promotes informed patient-provider communication to prevent use of unnecessary care and low-value services. Employers choosing to implement a V-BID plan should also consider pairing this plan with a Choosing Wisely campaign to provide their employees with patient-friendly materials on what care is best for them and the right questions to ask their physicians when presented with various healthcare decisions. This education promotes shared-decision making, which can reduce the use of low-value services and ultimately reduce healthcare costs for employers. For more information on the initiative, see page 44.

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 healthcare care quality and spends healthcare 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 and includes specific criteria for measuring providers. Refer to Appendix E on page 44 for the complete criteria under consideration. The Steering Committee has identified a standard set of quality measures and the Consortium recommends their use, along with cost measures focused on total cost of care, 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 Appendix E on page 44 for these principles.

HOW WILL IMPLEMENTING V-BID IMPACT MY BOTTOM LINE?

With the flexibility of the V-BID template, it is difficult to estimate whether an individual employers’ V-BID plan will result in net cost savings. However, adopting a V-BID plan means spending healthcare dollars more wisely by incentivizing effective and appropriate services for only the patients who need these services at the time that they need them. Financial savings may result from lower utilization of more expensive services due to better management of chronic conditions. This could also potentially result in a different experience rating for the company, lowering premium rates in future years.⁵

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.

WHAT IS THE ROLE OF MY HEALTH PLAN ADMINISTRATOR IN PLANNING AND IMPLEMENTING V-BID?

It is recommended that employers receive assistance from their health plan administrators in assessing the clinical needs of their employee population, measuring certain outcomes for the V-BID program, choosing which conditions to target and/or benefits to incentivize, and tracking compliance with

⁵ While this is a possible outcome of a V-BID plan, additional evaluations are needed to provide evidence of this.

recommended services. Doing so will allow employers to develop a customized program that makes the most sense for the company. Health plan administrators can also provide additional guidance on state and federal regulations as well as provide online tools for record keeping and evaluation measures. While employers are encouraged to develop a comprehensive communications plan for introducing the V-BID plan design to employees, health plans should develop supplemental materials around what V-BID benefits and incentives will be offered.

I AM A NATIONAL EMPLOYER. HOW DO I HANDLE THE ADMINISTRATIVE BURDEN OF CHANGING TO A V-BID PLAN FOR MY CONNECTICUT EMPLOYEES?

While administration of a V-BID plan can be more complex, several national employers have successfully implemented V-BID plans. Dedicating ample resources to administration of the plan and gaining senior management buy-in is key. Many national employers utilize electronic tools offered by their health plan administrator or a third party contractor to track program participation and eligibility for incentives. National employers may rely on a health plan's provider directory to identify high value providers within Connecticut networks.

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 comprehensive communication plan to explain, in detail, V-BID benefits to employees before implementation. Describing eligibility requirements and incentive structures to employees will require outreach by HR departments. Many Connecticut employers have had great success with new member communication technologies to help communicate health plan benefits. For more information on communication best practices, refer to page 26. For sample visual aids and communication and marketing scripts, refer to Appendix F, starting on page 47.

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

Using and 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. Employee outreach and engagement strategies are outlined in Appendix D, page 43.

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. 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 Worksheets

CORE COMPONENT 1: CHANGE INCENTIVES FOR SPECIFIC SERVICES FOR ALL APPLICABLE MEMBERS

V-BID	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 ✓ Beta-blockers for all members prescribed drug for any indication ✓ ACE inhibitors and ARBs for all members prescribed drug for any indication ✓ Insulins and oral hypoglycemics for all members prescribed drug for any indication ✓ Long-acting inhalers for all members prescribed drug for any indication ✓ Statins for all members prescribed drug for any indication ✓ Smoking cessation drugs for all members prescribed drug for any indication 	<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 INCENTIVES FOR SPECIFIC SERVICES BY CLINICAL CONDITION

V-BID	Recommended Core Benefits	Incentive	Amount
<p>Component 1: Change Incentives for Specific Services by Clinical Condition</p>	<p><input type="checkbox"/> Diabetes</p> <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Nutritional counseling ✓ Smoking cessation ✓ HbA1c ✓ Eye exams ✓ Foot exams ✓ Insulin ✓ Diabetic supplies ✓ ACE inhibitors/ARBs 	<p>I will provide employees with diabetes 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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	<p>\$ _____</p>
	<p>Choose at least two conditions</p>	<p><input type="checkbox"/> Pre-Diabetes</p> <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Nutritional counseling ✓ Health coach ✓ Smoking cessation ✓ HbA1c ✓ Glucose test ✓ Anti-hypertensives ✓ Metformin ✓ Statins 	<p>I will provide employees with pre-diabetes 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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus)

<p><input type="checkbox"/> Asthma/COPD</p> <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Smoking cessation ✓ Home visits ✓ Spirometry ✓ Long-acting inhalers ✓ Inhaled corticosteroids ✓ Oxygen 	<p>I will provide employees with asthma/COPD 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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	<p>\$ _____</p>
<p><input type="checkbox"/> Hypertension</p> <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Smoking cessation ✓ Nutritional counseling ✓ Blood pressure testing ✓ Anti-hypertensives ✓ ACE inhibitors/ ARBs ✓ Statins 	<p>I will provide employees with hypertension 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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	<p>\$ _____</p>
<p><input type="checkbox"/> Pre-hypertension</p> <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Smoking cessation ✓ Nutritional counseling ✓ Health Coach ✓ Blood pressure testing 	<p>I will provide employees with pre-hypertension 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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	<p>\$ _____</p>

:	<input type="checkbox"/> Depression <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Suicide and other risk assessments ✓ Cognitive behavioral therapy ✓ Smoking cessation ✓ Anti-depressants 	I will provide employees with depression that use any of these services with a: <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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	\$ _____
	<input type="checkbox"/> Substance Use Disorders <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Risk assessments ✓ Evidence-based treatment programs ✓ Smoking cessation ✓ Methadone ✓ Buprenorphine/Naloxone ✓ Detox medications 	I will provide employees with substance use disorder that use any of these services with a: <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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	\$ _____
	<input type="checkbox"/> Congestive Heart Failure <ul style="list-style-type: none"> ✓ Office visits related to condition ✓ Smoking cessation ✓ Nutritional counseling ✓ Echocardiogram ✓ EKG ✓ Potassium and creatinine testing ✓ Digoxin level ✓ Beta-blockers ✓ ACE inhibitors/ARBs ✓ Spironolactone ✓ Diuretics ✓ Oxygen ✓ Digoxin 	I will provide employees with congestive heart failure that use any of these services with a: <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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	\$ _____
	<input type="checkbox"/> Coronary Artery Disease <ul style="list-style-type: none"> ✓ Office visits related to condition 	I will provide employees with coronary artery disease that use any of these services with a:	\$ _____

	<ul style="list-style-type: none"> ✓ Nutritional counseling ✓ Smoking cessation ✓ EKG ✓ Beta-blockers ✓ ACE inhibitors/ ARBs ✓ Aspirin ✓ Clopidogrel ✓ Plavix 	<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"/> Reduced Coinsurance <input type="checkbox"/> Other (e.g. gift card, vacation time, payroll bonus) 	
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CORE COMPONENT 3: CHANGE INCENTIVES FOR VISITS TO HIGH VALUE PROVIDERS

V-BID	Recommended Core Benefits	Incentive	Amount
<p>Component 3: Change Incentives for Visits to High Value Providers</p>	<input type="checkbox"/> Network providers who have been identified as high value based on performance on cost and quality metrics	<p>I will provide employees that visit any of these providers with a:</p> <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

V-BID -----	Incentive	Amount
<input type="checkbox"/> Transportation to appointments related to condition and/or treatment 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"/> 90-day supply mail-order prescriptions for chronic 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)	\$ _____
<input type="checkbox"/> Virtual/audio/telephonic counseling or consultations: 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"/> Meals or other nutritional services 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)	\$ _____

<p><input type="checkbox"/> Treatment decision support/counseling for members with conditions that have multiple treatment options with differing risks and benefits</p> <p>Condition(s): _____ _____ _____</p>	<p><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)</p>	<p>\$ _____</p>
<p><input type="checkbox"/> Surgical decision support or second opinion before surgery for members undergoing elective surgeries that have other treatment alternatives</p> <p>Condition(s): _____ _____ _____</p>	<p><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)</p>	<p>\$ _____</p>
<p><input type="checkbox"/> Chronic Disease Management program for members with chronic diseases</p> <p>Condition(s): _____ _____ _____</p>	<p><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)</p>	<p>\$ _____</p>
<p><input type="checkbox"/> Pain Management for members with chronic pain</p>	<p><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)</p>	<p>\$ _____</p>

<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.¹⁴ ▪ 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.¹⁵ ▪ It is recommended that health plans and employers work with their health plan administrator on evaluating the actuarial value of the proposed V-BID plan.
	High turnover of employees means that some employers will not see ROI	<ul style="list-style-type: none"> ▪ Even employers with high turnover may seem some immediate positive outcomes from V-BID benefits for all members, such as increased medication adherence and reduced utilization of high cost services.¹⁶ ▪ Employers with high turnover should work with their health plan administrator to focus plans on incentivizing services with potential for cost savings in the short-term, such as visits to high value providers and surgery decision support.
Practice	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.¹⁷ ▪ 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.¹⁸ ▪ The concept of high value provider is being constructed by the SIM Steering Committee, including proposing specific criteria for measuring providers. Refer to Appendix E, page 44 for the complete criteria.
	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"> ▪ While data collection and analysis can be challenging, most health plans and employers will find they have enough existing data to determine high risk groups. Most health plans, especially those that administer wellness programs and chronic disease management programs, have the analytic tools available to analyze claims data.¹⁹ ▪ 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.

Practice	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 VBID 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.²⁰ ▪ The template aligns provider and consumer incentives by incentivizing services that correspond to quality measures in many value-based payment arrangements. ▪ 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"> ▪ Employers and 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.
	There are regulatory barriers to differential cost sharing for members with specific clinical conditions for HSA-HDHP plans	<ul style="list-style-type: none"> ▪ The V-BID Center at University of Michigan has established a multi-stakeholder initiative to advocate for the expansion of the IRS preventive care safe harbor guidelines to allow HSA-HDHPs to cover additional evidence-based service before the deductible.²¹ ▪ Future V-BID initiatives in Connecticut may include recommendations for changes to certain state regulations that limit V-BID benefits.
Administrative	There are administrative challenges with administering and managing incentive benefits across states for national employers.	<ul style="list-style-type: none"> ▪ While administering incentive programs across states can be administratively complex, several national employers have successfully implemented V-BID plans. Dedicating enough resources to administration of the plan, and gaining senior management buy-in is key.
	Administering different incentive schemes for different members can be challenging.	<ul style="list-style-type: none"> ▪ Technology may play a key role in reducing administrative challenges associated with implementing more complex V-BID plans.

Administrative	<p>Identifying eligible members requires algorithms to measure compliance by patients and providers. Patients and/or providers may misreport information to qualify for V-BID.</p>	<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.²² ▪ Some employers implementing V-BID recommend using automated reporting as much as possible, and not relying on self-attestation. ▪ For many VBID elements, health plans can use existing information from claims data to identify eligible members. Many health plans are also exploring methods to automate the collection of information from EHRs.
Cultural	<p>Getting employee buy-in and changing employee culture is challenging and takes too much time.</p>	<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. ▪ While it may take time to change employee culture, employers can begin communicating about V-BID benefits while still in the planning phases, which allows employees to adjust to the changes while the employer has time to work out the details. ▪ Repeated messaging about the plan through various communication channels is recommended by many employers.
Cultural	<p>Motivating employees to change behavior is difficult</p>	<ul style="list-style-type: none"> ▪ Incentives need to be significant to employees to motivate them to change behavior. Soliciting feedback from employees and evaluating the V-BID program throughout implementation can help determine what incentives to offer and how to modify them. ▪ 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 may increase participation. ▪ Making V-BID an opt-in plan can increase participation, especially if employees have to meet certain requirement to maintain enrollment in the plan. This also requires a strong incentive structure to motivate employees to opt-in and stay in, such as reduced premiums.
Cultural	<p>Explaining the program benefits to employees may be complex, and employees may think targeting of certain groups is discriminatory</p>	<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. ▪ Emphasizing how the plan benefits all employees is key. When surveyed, employees have not reported thinking V-BID plan designs were discriminatory.²³

Appendix D: Consumer Engagement Strategies

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.

In 2015, the Deloitte Center for Health Solutions conducted the Survey of US Health Care Consumers to determine what motivates consumers to change health behaviors, take a more active role in managing their health, and better engage with their providers and the healthcare system.²⁴ Their findings indicate upward trends in consumer engagement in certain areas for which employers and health plans could provide additional resources and tools, and even incentives. Many Connecticut employers who participated in the employer survey and focus group are currently engaging in these innovative strategies to motivate their employees toward achieving health goals. These strategies may be implemented alongside V-BID plans to help engage employees and increase employee buy-in for V-BID plans.

Consumer Engagement Strategy²⁵	Alignment with V-BID Benefits
Tools for shared treatment decision making with providers	Treatment decision support tools may be used part of a supplemental benefit offered in a V-BID plan design.
Resources about treatment options and how to research health concerns	Treatment decision support resources may be used as part of a supplemental V-BID benefit, or to all members.
Information about provider cost and quality, such as through provider performance scorecards	A V-BID guiding principle is that metrics used to measure provider cost and quality are transparent. Provider scorecards can be provided to members when communicating benefits for visiting high value providers.
Technology to measure fitness and health improvement goals	This may be part of a disease management program for members with chronic conditions.
Technology to monitor health issues, especially chronic conditions	This may be part of a disease management program for members with chronic conditions.
Technology to support medication adherence	This may be part of a disease management program for members with chronic conditions.
Digital communication with providers	In future V-BID initiatives, provider accessibility, including digital access, may be a dimension through which “value” is defined. One employer implementing this strategy suggested it helped improve utilization of primary care services and decrease ER visits.
Premium discounts for participating in health improvement/wellness/fitness programs	Employees may already be used to these incentive structures, making it easier for them to understand similar incentives structures in V-BID plans, such as premium discounts for participating in high value screenings.
Incentives for participating in disease management programs	This may be offered as a supplemental benefit as part of a V-BID plan.
Secure website or patient portal to access records, schedule appointments, order Rx refills, etc.	Health plans may use websites and patient portals to communicate members’ eligibility for incentives and to help track utilization of high value services.

Appendix E: Provider-side Reforms and the SIM Quality Council Core Measure Set

ALIGNING WITH PROVIDER-SIDE REFORMS

V-BID is not a standalone strategy. Rather, it is part of a holistic approach to health care reform, with the intent of aligning incentives for members and providers, to deliver the highest-value services and avoid the lowest-value ones. Self-insured employers should be mindful of the interaction between employee-focused strategies, such as V-BID, and provider-side reforms, such as value based payment and alternative payment arrangements that hold providers accountable for total cost of care.

In a contracting environment where alternative payments are used, V-BID is well-suited to reinforce, from the member's perspective, a movement toward higher value care. Below are some areas where reinforcement between V-BID and provider-side efforts may harmonize. In addition, nearly any V-BID component is reinforced when paired with total cost of care accountability or other alternative payment models for providers.

VBID Feature	Provider-Side Feature
Member incentive to use high-value drugs	P4P for generic prescribing, provider bonus payment for efficient pharmacy utilization
Member incentive to use high-value providers	Limited networks, Global or bundled payments
Member incentive to use high-value services	Total cost of care accountability and other alternative payment models (including for ACOs or PCMHs), bundled payment for certain care (such as hip/knee replacements, chronic condition management), value based payment for meeting quality metrics (e.g. achieving screening rates)
Discourage use of low-value services or drugs	Prior authorization for certain services or drugs, Global or bundled payments

When possible, employers should seek health plans administrators with the experience and ability to implement provider payment arrangements that enhance the effectiveness of the employer's V-BID plan. Connecticut employers may also leverage other initiatives to align V-BID plans with provider-side reforms:

CONNECTICUT CHOOSING WISELY COLLABORATIVE

Choosing Wisely[®], an initiative of the American Board of Internal Medicine (ABIM) foundation, promotes informed patient-provider communication to prevent use of unnecessary care and low-value services. The Connecticut Choosing Wisely Collaborative aims to support the growth of *Choosing Wisely*[®] initiatives in the State and works with provider groups and facilities to educate providers on low value services to avoid, and how to communicate with patients about these services. Employers should discuss with their health plans whether the insurer is engaged with the Connecticut Choosing Wisely Collaborative, and how they can integrate these concepts in their provider networks.

CONNECTICUT SIM QUALITY COUNCIL PROVISIONAL CORE MEASURE SET

The SIM Quality Council Provisional Core Measure Set provides a reference set of quality measures that payers may use in their value-based payment models across the state. Encouraging alignment on quality measures will also help to streamline and reduce administrative burdens of care delivery on provider organizations.

The V-BID initiative seeks to align the recommended consumer benefits with provider incentives; therefore, many of the high value services included in the V-BID plan designs are also targeted in the Core Measure Set. These measures present an ideal opportunity for plans to synchronize their insurance designs with value based payment arrangements, and may also be leveraged by health plans for identifying high value providers.

The provisional core measure set includes 30 measures recommended for the commercial/Medicaid population and two additional measures recommended for Medicaid only.

#	Provisional Core Measure Set	NQF	ACO	Steward	Source*	Equity	MQISSP
Consumer Engagement							
1	PCMH – CAHPS measure**	0005		NCQA		✓	✓
Care Coordination							
2	Plan all-cause readmission	1768		NCQA	Claims	✓	
3	Annual monitoring for persistent medications (roll-up)	2371		NCQA	Claims		
Prevention							
4	Breast cancer screening	2372	20	NCQA	Claims		
5	Cervical cancer screening	0032		NCQA	Claims		
6	Chlamydia screening in women	0033		NCQA	Claims		
7	Colorectal cancer screening	0034	19	NCQA	EHR	✓	
8	Adolescent female immunizations HPV	1959		NCQA	Claims		
9	Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024		NCQA	EHR		
10	Preventative care and screening: BMI screening and follow up	0421	16	CMMC	EHR		
11	Developmental screening in the first three years of life	1448		OHSU	EHR		✓
12	Well-child visits in the first 15 months of life	1392		NCQA	Claims		✓
13	Adolescent well-care visits			NCQA	Claims		✓
14	Tobacco use screening and cessation intervention	0028	17	AMA/PCPI	EHR		
15	Prenatal Care & Postpartum care***	1517		NCQA	EHR		✓
16	Screening for clinical depression and follow-up plan	418	18	CMS	EHR	✓	
17	Behavioral health screening (pediatric, Medicaid only, custom measure)			Custom	Claims		✓
Acute & Chronic Care							
18	Medication management for people w/ asthma	1799		NCQA	Claims	✓	✓
19	DM: Hemoglobin A1c Poor Control (>9%)	0059	27	NCQA	EHR	✓	
20	DM: HbA1c Screening****	0057		NCQA	Claims		✓
21	DM: Diabetes eye exam	0055	41	NCQA	EHR		
22	DM: Diabetes: medical attention for nephropathy	0062		NCQA	Claims		
23	HTN: Controlling high blood pressure	0018	28	NCQA	EHR	✓	

24	Use of imaging studies for low back pain	0052		NCQA	Claims	
25	Avoidance of antibiotic treatment in adults with acute bronchitis	0058		NCQA	Claims	✓
26	Appr. treatment for children with upper respiratory infection	0069		NCQA	Claims	
Behavioral Health						
27	Follow-up care for children prescribed ADHD medication	0108		NCQA	Claims	
28	Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only)	2800		NCQA	Claims	✓
29	Depression Remission at 12 Twelve Months	0710	40	MNCM	EHR	
30	Depression Remission at 12 months – Progress Towards Remission	1885		MNCM	EHR	
31	Child & Adlscnt MDD: Suicide Risk Assessment	1365		AMA/ PCPI	EHR	
32	Unhealthy Alcohol Use – Screening			AMA/ PCPI	EHR	

*Council recommendation regarding measures that require EHR or other data for production

**ACO CAHPS is under consideration as an alternative

***Council requests comment on appropriateness for ACO performance measure

****Continued need for this measure will be re-evaluated after NQF 59 is in production

Appendix F: V-BID Tool Kit and Resources

SAMPLE MARKETING AND COMMUNICATIONS MATERIALS*

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	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/FBST to age 75

*The above is an example for marketing purposes only. This is not intended to serve as a recommendation on screenings by age. Such decisions should be evidence-based and in line with the needs of the employee population.

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	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.

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.

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 incentives.

“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—among all employees, including preventive services and certain prescription drugs
- 2- To improve company productivity by decreasing absence from the workplace due to illness and the incidence of sick employees reporting to work
- 3- To reduce health care costs for both the company and the employees with the greatest health needs (e.g. those with chronic conditions)

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. Some incentives, such as an HRA contribution, will target a specific population: after analyzing our employee health care claims data, with guidance from our health plan administrator, we have identified diabetes as a condition that has adversely affected our employees. By contributing to an employee’s HRA, this V-BID program aims to relieve some of the financial burdens that are common barriers to managing chronic conditions or 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
- 2- Employees with diabetes will receive waived copayments for the following visits, services, and drugs:
 - Office visits related to condition
 - Nutritional counseling
 - Smoking cessation
 - HbA1c
 - Eye exams
 - Foot exams
 - Insulin
 - Diabetic supplies

- ACE inhibitors/ARBs
- 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 to their departments. 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 52, below is sample language that can be adapted by employers to communicate with employees.

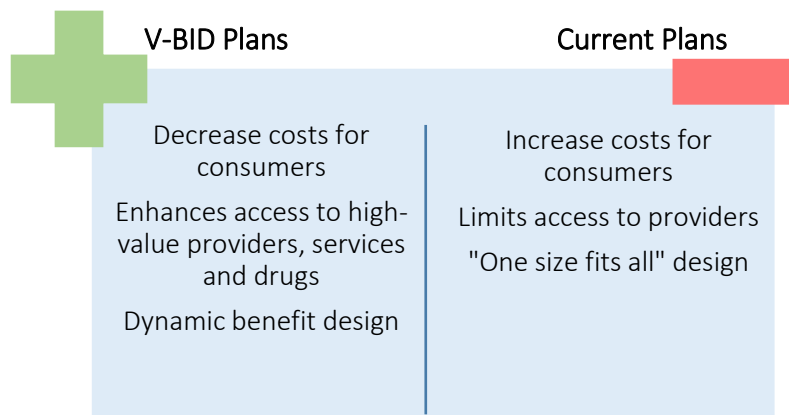
Please note: these scripts use an example of a V-BID plan that a company could implement. The scripts would need to be adapted to the specifics of the company and the proposed V-BID Plan incentives.

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 all copayments waived for staying healthy and keeping your diabetes under control if you use of the following visits, services and drugs:
 - Office visits related to condition
 - Nutritional counseling
 - Smoking cessation
 - HbA1c
 - Eye exams
 - Foot exams
 - Insulin
 - Diabetic supplies
 - ACE inhibitors/ARBs
- 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 shown a commitment to care quality and have been 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 program visit [company benefits website].

To learn more about the V-BID incentive program, visit our [company benefits website].

EDUCATIONAL INFOGRAPHICS

[Clinical Nuance Infographic](#)²⁷

[V-BID Infographic](#)²⁸

[Reward the Good Soldier](#)²⁹

[V-BID Center High Deductible Health Plan Infographic](#)³⁰

ONLINE V-BID RESOURCES

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

[Consumer Criteria for Value-Based Insurance Designs](#)³¹

*Connecticut's Advanced Medical Home Standards⁶

[VBID Center](#)³²

[Value-Based Insurance Design Pro's and Con's](#)³³

[Value-Based Insurance Design Overview](#)³⁴

[V-BID Center Fact Sheet on Connecticut's Health Enhancement Program](#)³⁵

[V-BID Center Fact Sheet on Increasing Flexibility to Expand IRS Safe Harbor Coverage in HSA-High Deductible Health Plans](#)³⁶

[Agency for Healthcare Research and Quality](#)³⁷

[CMS Medicare Advantage Program](#)³⁸

[Choosing Wisely](#)³⁹

[Connecticut State Innovation Model Program Management Office: V-BID Initiative](#)⁴⁰

[U.S. Preventative Services Task Force](#)⁴¹

[American Board of Internal Medicine Foundation](#)⁴²

[Health Enhancement Program](#)⁴³

V-BID DESIGN AND IMPLEMENTATION RESOURCES

["Overcoming Barriers to Shared Decision Making"](#) webinar by the Agency for Healthcare Research and Quality (AHRQ).⁴⁴

⁶ *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](#).

[Evidence-Based Practice and Health Technology Assessment](#)⁴⁵

[Standardization of Patient Reporting and Outcome Measures](#)⁴⁶

[Differences Between Wellness Rewards Programs and V-BID](#)⁴⁷

[“Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States” a report by NORC at the University of Chicago](#)⁴⁸

[Guide to Selecting Doctors, Hospitals and Other Providers](#)⁴⁹

[Guide to Clinical Preventative Services](#)⁵⁰

[Reducing Administrative Costs](#)⁵¹

[“Innovative Payment for Advanced Primary Care Delivery”](#) a report for the Maine Health Management Coalition prepared by Discern Health⁵²

[Strategies for Reducing Health Care and Administrative Costs](#)⁵³

RELEVANT STATE AND FEDERAL REGULATIONS

[Affordable Care Act Mandates](#)⁵⁴

[Nondiscrimination in Health Programs and Activities Proposed Rule](#)⁵⁵

[Mental Health Parity and Addiction Equity Act of 2008](#)⁵⁶

[Americans with Disabilities Act of 1990](#)⁵⁷

[Genetic Information Nondiscrimination Act of 2008](#)⁵⁸

PREDICTING AND UNDERSTANDING RETURN ON INVESTMENT

Employers are encouraged to evaluate the impact of their V-BID plan, and develop metrics to measure Return on Investment (ROI). The likelihood of achieving a positive ROI as a result of V-BID implementation can be improved if the V-BID plan:

1. Targets specific conditions within employee/member populations

Targeting specific conditions and populations will increase the likelihood of a positive ROI because it limits the incentive to only those who will benefit from being compliant. Additionally, members with chronic conditions are more likely to use costly medical services or have complications. Utilization of expensive services may decrease through V-BID benefits.

2. Includes improved productivity measures in evaluations of V-BID efficacy

Reducing financial barriers to high-value services will keep the workforce healthier. Increased productivity and reduction in absenteeism and presenteeism may have a significant impact on company performance.

3. Integrates health and wellness services into its communication and implementation strategy

Incorporating V-BID with pre-existing health and wellness programs offered by the employer may improve consumer buy-in and program results.

4. Maintains a realistic time frame for evaluation measures

Employers and health plans implementing V-BID must be aware of the time needed to realize the benefits of V-BID implementation. When programs are designed to target specific chronic conditions, it is important to recognize that these conditions will not improve overnight. Employers implementing V-BID initiatives should not be discouraged if there is not an immediate ROI, as cost savings may take several years to be realized.

Elements of an ROI Calculation	Savings to Purchaser	Costs to Purchaser
Co-pays or other financial incentives of enrollees filling prescriptions or receiving services prior to implementation of VBBD		increase
Co-pays or other financial incentives of newly engaged enrollees		increase
Treatment costs associated with newly engaged enrollees		increase
Employee Support programs (e.g., disease management, health coaches)		no change
Implementation costs (e.g., communication, vendor fees)		may increase
Savings of direct medical costs associated with newly engaged enrollees	may increase	
Productivity	may increase	

Source: <http://www.nbch.org/NBCH/files/ccLibraryFiles/Filename/00000000222/VBBD%20Purchaser%20Guide.pdf>

Additional resources:

1. [An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition](#), from the American Academy of Actuaries, 2011⁵⁹
2. [Value- Based Benefit Design: A Purchaser Guide](#), from the National Business Coalition on Health, 2009⁶⁰

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.⁶¹

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).⁶²

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.⁶³

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 publicly-that they have the skills necessary for delivering the highest quality of patient care. ABIM is a non-profit, physician-led group.⁶⁴

Angiotensin Receptor Blocker (ARB). ARBs are prescribed to treat conditions such as high blood pressure and heart failure.⁶⁵

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.⁶⁶

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.⁶⁷

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.⁶⁸

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.⁶⁹

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.⁷⁰

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.⁷¹

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.⁷²

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.⁷³

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.⁷⁴

Health Reimbursement Account (HRA). An HRA reimburses employees for employer-approved medical expenses.⁷⁵

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.⁷⁶

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.⁷⁷

Premium. The amount of money a person pays for her/his health insurance or plan. This amount is usually paid monthly, quarterly or annually.⁷⁸

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.⁷⁹

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.⁸⁰

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.⁸¹

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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