July 2018

Value-Based Insurance Design (V-BID) Template for Fully-Insured Plans

Value-based Insurance Design uses financial incentives to encourage people to get the **right care**, at the **right time**, from the **right provider**. This template provides recommendations to health plans for comprehensive V-BID benefit designs for the fully-insured market, focused on two core components:

Preventive Care
Prescription Drugs
High Value Providers

Benefits of V-BID Plans

- Early detection of disease and better management of chronic conditions
- Increased use of preventive care and decreased use of expensive, specialty and inpatient care
- Smarter spending by encouraging use of high-value, cost effective services
- Improved quality of care
- Reduced Out-Of-Pocket costs for members

High Value and Low Value Services

High value services have a strong evidence base, enhance clinical outcomes and increase efficiency.

Low value services have a weak evidence base, minimal or no clinical benefit, and decrease efficiency.

University of Michigan VBID Center, VBID Infographic

Financial Incentives

Choose financial incentives appropriate to the structure of your health plan. Incentives could be for members who receive recommended high-value services or visit high-value providers, or they could be a reward for reaching health goals such as lowering blood pressure. If the financial incentive is based on health outcomes, participation in the V-BID plan should be voluntary, and plans must offer an alternative way to earn incentives for members who are unable to meet their health goals.

Plan Type	Financial Incentives
All plans	○ Bonus payment for complying with recommended services ○ Reduced premium for enrolling and complying with V-BID program ○ Exclusion of recommended services and drugs from deductible* ○ Employers may offer gift cards, payroll bonuses, premium contributions, etc.
Plans with copayment or coinsurance cost-sharing	○ Waived or reduced copayment or coinsurance for recommended services and drugs or visit to high value provider
Health Reimbursement Account or Health Savings Account	○ Contribution to HRA or HSA for recommended services and drugs ○ Contribution to HRA or HSA for visit to high value provider

*HSA-HDHP plans have specific IRS rules around what services can be offered pre-deductible. V-BID plans are still required to remain in compliance with state and federal regulations, including mental health parity regulations and health plan nondiscrimination laws.

Recommendations were developed by the Connecticut State Innovation Model (SIM) program and Office of the State Comptroller (OSC), with support from Freedman HealthCare, LLC, V-BID Health, LLC, and Dr. Bruce Landon, MD. Recommendations were informed by a multi-stakeholder V-BID Consortium with employer, plan, provider, consumer, and state representatives.

VBID Guiding Principles

These principles and recommendations were developed with the State Innovation Model VBID Consortium, a multi-stakeholder advisory group. The recommendations and implementation strategies that follow provide guidance on incorporating these principles into plan design.

1. VBID 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. VBID options should be flexible, allowing for adoption of select provisions, or all provisions, to meet diverse employers' needs and readiness for adoption.
3. VBID 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. VBID 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. VBID 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 and coordination of community services across the care continuum.
    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.
    e. Consumer engagement strategies that encourage employee empowerment.
    f. Communications to employees that clearly explain benefits and include information on changes to employee costs, changes in access and plan design
6. High-value providers are identified using transparent cost and quality of care metrics. Future recommendations 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. VBID 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.
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Preventive Care

Recommendation: Provide financial incentives to increase use of evidence-based age and gender appropriate preventive screenings.

Why?

- Reduces illness and death by diagnosing diseases earlier
- Cost-effective
- Aligns consumer incentives with provider performance metrics for preventive screenings

Plan Spotlight

The Connecticut State Employee Health Enhancement Program (HEP) 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. HEP has increased primary care visits by 75%, increased preventive diagnostic tests by over 10%, and decreased specialty visits by 21%.

Recommended High-Value Preventive Screenings

Services are based on the U.S. Preventive Services Task Force recommendations for targeted age, gender, and frequency of tests.

- ✓ Blood Pressure Screening
- ✓ Cholesterol Screening
- ✓ Obesity Screening
- ✓ Depression Screening
- ✓ Alcohol Screening and Counseling
- ✓ Breast Cancer Screening
- ✓ Cervical Cancer Screening
- ✓ Colorectal Cancer Screening
- ✓ Smoking Cessation

Implementation Tips

- Provide additional incentives for preventives services already provided at no cost under the Affordable Care Act (ACA), such as premium contributions or reductions or bonus payments.
- Consider making financial incentives conditional based on outcomes achieved (there must be an alternative way to earn incentives for employees who are unable to reach required targets).
- Design plans to ensure members choose or are assigned to a Primary Care Provider.
- For additional detail, see the Fully-Insured V-BID Employer Manual.
- Encourage the use of patient navigation services for colorectal cancer screening through health plans and health care providers to increase adherence.

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Additional Benefits Options for Preventive Care

For employers already offering incentives for recommended preventive care, additional services include:

- ✓ Treatment decision support/counseling for employees with conditions that have multiple treatment options, e.g. lung cancer, breast cancer, depression, etc.
- ✓ Surgical decision support for employees undergoing elective surgeries that have other treatment alternatives, e.g. low back surgery, hysterectomy, hip or knee replacement, etc.
- ✓ Complex case management
- ✓ Pain management
- ✓ Pre-natal and post-partum care

Low Value Care

Employers may consider discouraging unnecessary use of services that have been identified as "low value" for most people. Services may include:

- Diagnostic testing and imaging before low-risk surgery
- Vitamin D screening tests
- Prostate-specific antigen testing for me 75+
- Imaging for low back pain within 6 weeks of onset

Strategies for reducing low value care may include:

- ✓ Educating employees about low value service and how to talk to their doctor about what care is necessary for them through the Choosing Wisely® Campaign
- ✓ Steering employees towards high value providers who have met quality benchmarks related to low value care
- ✓ Requiring insurance pre-authorization for certain low value services identified above

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Prescription Drugs

Recommendations:

1. Reduce cost sharing for certain prescription drugs.
2. Implement prescription drug strategies that reduce cost sharing for employees and improve medication adherence to high value drugs.

Why?

- About 23% of healthcare costs are now for prescription drugs, more than what is spent on hospital stays
- Specialty drugs can cost $100,000 or more for one course of treatment, making them unaffordable for employers and employees
- Reducing financial barriers increases medication adherence
- Aligns consumer incentives with provider performance metrics for managing chronic conditions

Plan Spotlight

The Connecticut State Employee Health Enhancement Program (HEP) 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. HEP has increased primary care visits by 75%, increased preventive diagnostic tests by over 10%, and decreased specialty visits by 21%.

1. Recommended Prescription Drugs

Reduce cost sharing for at least two prescription drugs for all members.

- ✓ Beta-blockers
- ✓ ACE inhibitors and ARBs
- ✓ Insulins and oral hypoglycemics
- ✓ Long-acting inhalers and inhaled corticosteroids
- ✓ Statins
- ✓ Anti-depressants
- ✓ Smoking cessation drugs

Implementation Tips

- Reduce cost sharing for recommended prescription drugs by moving them to lower cost drug tiers for all members (Connecticut health insurance regulations restrict copayment variation based on a member's medical condition).
- Consider providing financial incentives for medication adherence programs.
- Update prescription drug lists as needed in accordance with FDA approval of new and more effective drugs.
- For additional detail, see the Fully-Insured V-BID Employer Manual.

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2. Recommended Strategies for Prescription Drugs

Strategy	Implementation Tip
90-day Supply: Reduce cost sharing for 90-day supply prescriptions for maintenance medications	Employers can work with their PBMs to negotiate mail order 90-day supply rates with retail pharmacies, so employees have more flexibility on where they can get their drugs
Specialty drug management: Provide no cost pharmacist and case management support to patients with complex needs	These strategies work best when used with high value provider network strategies, as many of these networks already provide pharmacist support and case management to patients with complex medical needs. See the High Value Providers page for strategies.
Precision benefit design: Reduce cost sharing for clinically indicated alternative therapies, like targeted cancer drugs and genomic medicine, including genomic testing.	Some therapies may be available through clinical trials. Coverage for clinical trials may be determined on a case by case basis. What is covered under clinical trials should be clearly communicated to employees.

Employee Protections

Employers are encouraged to work with their pharmacy benefits manager to ensure there are employee protective provisions in their prescription drug plans, such as:

1. Automatic generic substitution: Ensures members use effective, lower cost alternatives when available and appropriate. *Note: This does not refer to therapeutic substitution.*
   - Ensure the plan notifies all affected patients and their prescribing providers proactively prior to the change going into effect.
   - Include a waiver process for providers to indicate when dosage is critical or the employee has tried the generic unsuccessfully. In cases of waivers, employees may pay the brand name or the generic price, but should not be penalized.

2. Limit changes to drug formularies to once per year to help members manage their conditions while controlling costs. Ask your health plan to grandfather in members with certain medications when making changes to drug formularies

Making High Value Medications Affordable

Precision Co-Pay Assistance is a potential strategy to help employees afford the high costs of high value medications, especially in high deductible plans. These programs would differ from traditional co-pay assistance programs in that they

- ✓ Connect consumers to patient assistance resources for clinically appropriate medications.
- ✓ Forego utilization management and accumulators used in traditional programs.
- ✓ High value drugs are determined based on alignment with professional societies' guidelines.

Precision copay assistance strategies can help address co-pay accumulator programs that may result in financial barriers to high value drugs for consumers.

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High Value Providers

Recommendation: Provide financial incentives for visits to high-value providers. *A high-value provider is determined by transparent cost and quality metrics.*

Why?

- Aligns consumer incentives with provider incentives
- Builds on existing efforts by CT health plans to drive consumers towards high value providers

Recommended Strategies for High Value Providers

Choose one or more of the following five strategies.

Networks of High-Value Providers	Encourage visits to providers identified as high-value for performance on cost and quality metrics using a tiered or narrow network structure.
Accountable Care Organizations	Encourage visits to an ACO identified as high-value based on performance on cost and quality metrics.
High-Value Primary Care Physicians	Encourage visits to Primary Care Providers that have been identified as high-value based on performance on cost and quality metrics, such as high-value PCMH or Advanced Medical Home practices.
Centers of Excellence	Encourage employees in need of special services or surgeries to visit high-value providers of those services. Recommended services include: transplant surgery, knee or hip replacement, heart surgery, obesity surgery, spine surgery, fertility centers, cancer centers, or substance abuse.

Centers of Excellence

Centers of Excellence are teams of highly skilled experts in an area of medicine that meet cost, quality and other criteria as defined by a professional society, government entity, consumer group, health system or payer.

JAMA, Centers of Excellence, May 2018

Recommended Strategies for Appropriate Sites of Care

Recommendation: Incentivize employees to use the appropriate site of care for the medical situation by:

- ✓ Reducing cost sharing for primary care visits compared to urgent care and specialist visits, and reducing cost sharing for urgent care visits and specialist visits compared to ED visits.
- ✓ Reducing or waiving ED cost sharing if reason for visit is determined by plan to be appropriate, person was referred by another clinician, or visit results in a hospital admission.

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Implementation Tips

- Find recommendations for defining value for providers in the Guiding Principles in the Fully-Insured V-BID Employer Manual.
- Consider factors that impact provider access, such as geography, when designing networks.
- Employers may consider coverage for additional out-of-pocket costs associated with getting care from certain providers, such as travel to Centers of Excellence.
- Consider using a "smart shopper" program that rewards employees who select high value providers or Centers of Excellence for certain elective, discrete procedures.
- For all site of care strategies, employers should educate employees about the appropriate use of each site, and communicate benefits and cost sharing for visiting each site

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