V-BID Basic Plan Template

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

Applicable Employer Types:

- Fully-insured employers with a stable employee base

Recommended Incentive Mechanism(s)

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

Plan Type	Incentive Mechanisms
All plans	○ Bonus payment for complying with recommended services ○ Reduced premium for complying with recommended services
Plans with copayment or coinsurance cost-sharing	○ Waived or reduced copayment or coinsurance for recommended services and drugs ○ Waived or reduced copayment or coinsurance for visit to high value provider
Health Savings Account-eligible High Deductible Health Plan (HSA-HDHP)*	○ Contribution to HSA for complying with recommended services or visiting high value provider
Health Reimbursement Account-eligible High Deductible Health Plan (HRA-HDHP)	○ Contribution to HRA for recommended services and drugs ○ Contribution to HRA for visit to high value provider ○ Exclusion of recommended services and drugs from deductible
All plans[1]	○ Financial incentives external to health benefit plan designs, including gift cards, payroll bonuses, and other rewards programs

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

Recommended V-BID Structures

Incentive Structure

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

	Participatory	Outcomes-Based
All Members	Incentive for participating in recommended service, e.g. biometric screening	Rewards based on meeting certain targets, e.g. falling within normal BMI range on biometric screening
Targeted Members	Incentives for participation in chronic disease management program, e.g. no cost diabetic supplies for members with diabetes who participate in nutritional counseling	Rewards for members with certain clinical conditions that meet certain targets, e.g. bonus payment for members with diabetes whose HgA1c levels fall within certain range

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

Implementation Guidance

- Please note: When offering V-BID benefits, plans are still required to remain in compliance with the Department of Labor's mental health parity regulations. For more information about the federal regulations, refer to Appendix [ ] on page [ ] 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.[i] Employers should seek legal guidance on approaches that incentivize drugs and services based on a member's clinical condition. For more information about the IRS guidance for HSA-HDHPs, refer to Appendix [ ] on page [ ] of the Employer Manual.

RECOMMENDED V-BID COMPONENTS

Recommended V-BID Component 1: Change Incentives for Specific Services for *All Applicable Members,* Targeted by Age and Gender

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

	Services	Applicable Members*
Recommended Core Benefit Design	*Biometric and Mental Health Screenings*	
	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
	Cancer Screenings	
	Breast Cancer Screening	Women depending on age group
	Cervical Cancer Screening	Women depending on age group
	Colorectal Cancer Screening	Applicable members depending on age group and gender

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

Implementation Guidance

- For high value services included in the core benefit design that are already mandated to be covered at no cost to the patient by the ACA, **it is recommended that plans provide an additional incentive, such as a bonus payment or premium reduction, 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, for example blood pressure or cholesterol within a certain range. 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.
- 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 pg. [ ] of the Employer Manual for various methods for measuring compliance with screenings.

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

Justification for Recommendation

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

Additional V-BID Component 1 Option: Change Incentives for Specific Supplemental Benefits for All Applicable Members*

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

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

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

Implementation Guidance

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

Examples of Employers Implementing V-BID Component 1

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 1: Change Incentives for Specific Services for *All Applicable Members* Targeted by Age and Gender	National	MassMutual	• HSA funding for achieving biometric makers within certain range and participating in annual physical exams and cancer screenings	• Over 75% participation • Improvements in biometrics
	Publicly funded Connecticut-based	Connecticut State Employee Health Enhancement Program	• 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	• Primary care visits increased by 75% • Preventive diagnostic visits increased over 10%, and • Specialty visits decreased by 21% in the first year

Recommended V-BID Component 2: Change Cost Sharing for Specific Prescription Drugs for *All Applicable Members**

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

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

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

Implementation Guidance

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

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

Justification for Recommendation

- Evidence from employers such as Pitney Bowes, Marriott International, and Proctor & Gamble suggests reducing cost sharing for certain drugs for all members prescribed these drugs increases medication adherence and decreases overall medical costs.[iii] 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 will specific conditions.
- Several Connecticut employers and health plans currently offered value based prescription benefits plans, and highly recommend this strategy for other employers.

Examples of Employers Implementing V-BID Component 2

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 2: Change Cost Sharing for Specific Prescription Drugs for *All Applicable Members*	National	Marriott International	• 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	• Improved medication adherence in four out of five drug classes • Decreased non-adherence by 7 – 14%
	Connecticut	United Healthcare "Diabetics Health Plan"	• Eliminated payments for diabetes-related supplies and Rx drugs for participation in routine disease maintenance exams • Provided free access to online health educators and disease monitoring systems	• 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

This component recommends 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 these provider types	Network of primary care and specialty providers who have been identified as high value based on performance on cost and quality metrics
	Primary care or specialty provider who is 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 [ ]) was developed through an intensive stakeholder engagement and public process, and provides a standardized set of validated metrics that may be leveraged for identifying high value providers.
- While many employers and health plans offer tiered networks of facilities, the current recommendations focus on only primary care and specialty providers, for which performance measurement based on cost and quality is more firmly established in Connecticut. At this time, this initiative will not include tiered networks in its recommendations while efforts to tier facilities based on transparent cost and quality metrics are still ongoing. Nevertheless, incentivizing use of specific high value facilities through tiered networks may be a future direction for the next generation of V-BID plan designs.

For guidance and recommendations on how value should be defined for providers, please see the V-BID Plan Guiding Principles on pg.[_]

Justification

- 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 future V-BID templates.

- Quality measures align with 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.[iv]

Examples of Employers Implementing V-BID Component 3

	Employer Type	Employer	V-BID Strategies	Program Results
V-BID Component 3: Change Incentives for Visits to High Value Providers	Publicly funded	New York City Employees	• 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	• Program implemented in 2016 – anticipated savings of $150M
	National - Connecticut based	Pitney Bowes	• Incentivizes use of high performing physicians through tiered network	• Increased cost savings as result of incentive program

[i] http://www.irs.gov/irb/2004-33_IRB/ar08.html

[ii] http://vbidcenter.org/wp-content/uploads/2016/03/CT-HEP-infographic-3-30-16.pdf

[iii] Fendrick, M., MD. "Value-Based Insurance Design Landscape Digest". *National Pharmaceutical Council*. July, 2009. Retrieved from < http://vbidcenter.org/wp-content/uploads/2014/08/NPC_VBIDreport_7-22-09.pdf>

[iv] "2015 Connecticut Plan Guide for Businesses with 51-100 eligible employees." *Employer Plans*. Aetna. Web. March 11, 2016. < https://www.aetna.com/employers-organizations.html> and https://www.anthem.com/health-insurance/about-us/pressreleasedetails/VA/2012/939/anthem-blue-cross-and-blue-shield-launches-innovative-program-to-enhance-primary-care-by-paying-physicians-more-for-quality-and-cost-improvements