

VALUE-BASED BENEFIT DESIGN:

A Purchaser Guide



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Understanding Value-Based Benefit Design and Taking Appropriate Action

This Guide is the second in a series of Purchaser Guides being developed by the National Business Coalition on Health to explain major new employer health care benefit purchasing strategies. This Guide was developed in response to the growing interest in and adoption of Value-Based Benefit Design (VBBD) plans, which build enrollee incentives into the benefit design and premium contribution structure to encourage enrollees to use specific high value services or providers or to adopt healthy behaviors.

This Purchaser Guide provides;

1. an overview of what constitutes VBBD,
2. the business case for VBBD,
3. what a purchaser must consider in adopting a VBBD,
4. the implementation steps that must be taken,
5. what barriers exist to impede a successful implementation, and
6. how VBBD may be utilized in the future.

This Guide also provides supplemental resources, including links to websites of organizations that are active in the VBBD space, model RFI/RFP language and case studies of organizations that have implemented VBBD.

JUMPSTART: Recommended steps to get started. For purchasers who want to know where to begin, here are six recommended steps that a purchaser can take right away.

1. If you are fully insured, determine if there is a plan with a lower premium tied to VBBD principles. Be aware this is not synonymous with so-called consumer directed health plans, high deductible plans or cost-shifting designs. Survey health plans in your market area to determine which are currently offering plans with enrollee incentives to use high value services or providers, or to adopt healthy behaviors.
2. Know your population. It is important to not blindly leap ahead in this complex area where there is no good “cookie cutter” approach. Model the adoption of a VBBD plan in your company by engaging your health plan or a consultant to conduct preliminary analyses of medical and prescription drug claims.

If possible, ask your employees to complete a Personal Health Assessment (PHA). Consider offering an incentive to increase the number of responses you will receive.

Communicate that all results are confidential and will only be used to identify opportunities to improve employee health and well-being to the benefit of everyone.

With the assistance of a clinician, analyze the claims information and the PHA answers to identify opportunities to increase treatment compliance, improve prevention among all employees, and enhance the health status of your enrollees.

Calculate the costs and estimate potential cost savings of providing VBBD incentives to use high value services, providers or programs.

3. If the results look favorable and you want to move forward, obtain senior management buy-in to implement a pilot program that incorporates some combination of the following:
 - a. reduced copayments for essential drugs in exchange for participation in a disease management program.
 - b. incentives for participating in wellness activities
 - c. incentives for enrollees to use high performing providers (if known)
 - d. premium share reduction in exchange for adherence to preventive and chronic care guidelines.
4. Determine the capabilities of health plans to offer and support VBBD plans. Using an RFI process will result in more systematic information, which can be compared across carriers. See Appendix A: Model RFI Language.
5. When partnering with your health plan to implement the pilot, pay close attention to:
 - a. coordinating the program with your disease management or health coach vendor and pharmacy benefit manager (PBM);
 - b. developing and implementing a multi-faceted communication plan that emphasizes the benefit of the program to all enrollees and brings providers into the communication loop, and
 - c. collecting baseline information so that the impact of the VBBD pilot can be evaluated.
6. Collaborate with other employers or with your local health care coalition to influence health plans to offer VBBD plans in your market area for both fully insured and self-insured groups.

WHAT IS VALUE-BASED BENEFIT DESIGN?

Basic Definition

Value-Based Benefit Design is the explicit use of plan incentives to encourage enrollee adoption of one or more of the following:

- appropriate use of high value services, including certain prescription drugs and preventive services;
- adoption of healthy lifestyles, such as smoking cessation or increased physical activity, and
- use of high performance providers who adhere to evidence-based treatment guidelines.

Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans, such as a Health Savings Accounts.

VBBD grew out of the recognition that some medical services are of greater value to specific individual enrollees than to others when three factors are considered: 1) medical evidence of the effectiveness of a particular treatment, 2) the cost of the treatment, and 3) the resulting benefit of the treatment.

Recognizing that the value of services varies by individual, VBBD advocates that enrollee cost sharing be based on the value (benefit net of cost) of the service/lifestyle program/provider to the individual enrollee, and should not be the same for all enrollees or be based simply upon the price of the service.² Instead, basic health insurance design should tier costs of medical services, prescription drug and lifestyle programs based on the evidence of effectiveness, and tier office visit co-pays for providers by evidence of performance. This tiering of services, lifestyle programs and providers should direct individuals toward choices that will yield superior benefit relative to other options.

Research has demonstrated that financial incentives can influence health-related behavior,³ and that the cost of services, including prescription drugs, impacts use of services⁴ and compliance rates.^{5,6} Therefore, by removing barriers to needed, valuable services, or by providing positive incentives to participate in health promotion programs, VBBD initiatives can optimize the likelihood of patients complying with recommended treatment plans and engaging in healthy behaviors. In turn, healthier people generally have lower health care costs, and there is evidence that patients with specific chronic conditions who maintain their treatment regimens have lower overall health care costs.⁷

In a Hewitt Associates 2008 survey of 500 large employers, each with over 10,000 employees, 12% of respondents reported currently utilizing some type of VBBD initiative, and 5% were planning on implementing VBBD.

Caterpillar provided incentives through lower premiums to employees and dependents who completed a health risk assessment and participated in a disease management, case management, or risk reduction program. Caterpillar reports a 50% reduction in disability days among the general employee group.¹

Examples

Increasing medication compliance rates: Marriott International reduced co-pays for five classes of medications used to treat high blood pressure (ACEs and ARBs), diabetes (including oral therapies and insulin), high cholesterol (statins) and asthma (inhaled corticosteroids). Lower co-pays were available to any enrollee taking the drugs at the time of implementation and to any enrollee who was not taking the medications, but identified by a clinical alert system as someone who would benefit from taking the drugs. Subsequent analysis found that compliance rates increased significantly for all classes of drugs except corticosteroids⁸

Encouraging use of preventive services: As part of a broad-based plan to improve employee wellness by using a sophisticated system of incentives, IBM offers a PPO plan that provides fully paid preventive care and routine primary care that is not subject to a deductible and has a lower than normal coinsurance cost share paid by beneficiaries. Services are covered regardless of the reason IBM employees visit their primary care providers. This is just one of the programs IBM has implemented to restructure coverage to emphasize preventive care and services for chronic conditions, and reward healthy behavior changes.⁹

Encouraging use of health management programs: Health-Partners, a Minnesota health insurer, requires, as part of its Healthy Benefits Program, that enrollees annually complete a Personal Health Assessment and participate in either a disease management program or a wellness program to earn a reduction in premiums or co-payments/deductibles.¹⁰

Promoting use of high performing providers: For the last four years Gulfstream has provided employees with incentives to use quality-based physicians (defined as those who meet evidence-based medical guidelines) by offering reduced office visit co-pays. Employees are also provided incentives to comply with physician orders and to receive routine preventive services. During this time period, Gulfstream has seen increased testing and monitoring of key diabetes clinical measures, and an increased number of employees receiving mammograms and having cholesterol levels tested.¹¹

Enrollee Support Services

Implementing a VBBD initiative must also incorporate a range of enrollee supports including a purchaser-wide communication strategy and a clinical outreach strategy to targeted enrollees through disease and case management programs and through disease education initiatives. If a VBBD initiative provides incentives to participate in health promotion programs, a wide range of options is needed to meet the needs of all enrollees. A dynamic process of consumer education and engagement focused on specific high value services is an integral component of VBBD implementation. VBBD cannot merely be a static plan design change.

The following chart provides a visual presentation of the various components of VBBD:

Enrollee Eligibility

VBBD initiatives can be either targeted or non-targeted. A VBBD initiative that provides incentives for all users of a drug, service, program or high value provider regardless of patient diagnosis, is referred to as a “non-targeted” VBBD. In contrast, a targeted VBBD initiative limits the incentive to specific individuals. For example, a targeted VBBD initiative for cholesterol reducing agents (statins) would limit co-pay reductions to those members who have known heart disease. Limiting the incentive to that

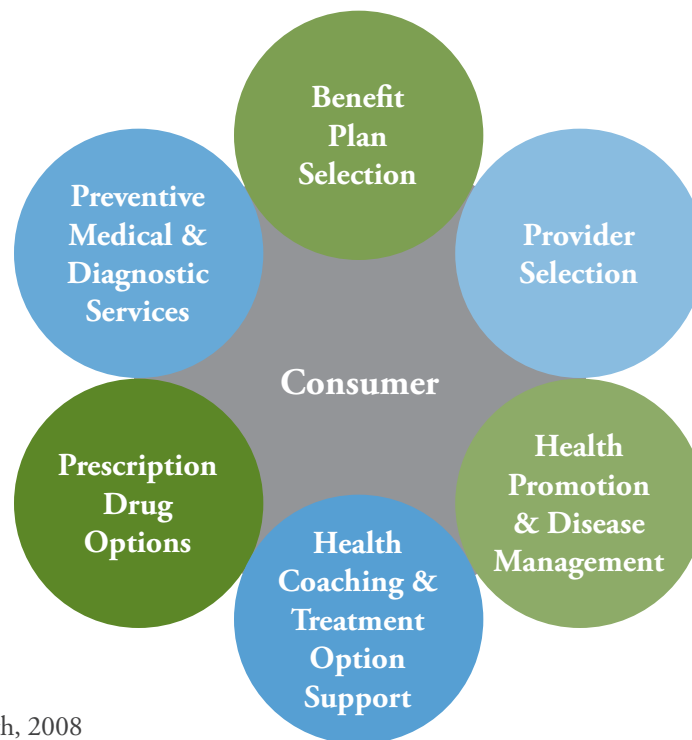
group is justified based on evidence-based research that this group is specifically benefited by continued statin use.¹² A non-targeted initiative would provide incentives to all enrollees using statins, regardless of diagnosis or reason for use.

Differentiating VBBD from CDHD and Value-based Purchasing

VBBD differs from what is commonly referred to as a Consumer-Driven Health Plan (CDHP) in a fundamental way. In a CDHP, perhaps more appropriately called a high deductible plan, the enrollee is responsible for the cost of services subject to the deductible. With heightened cost awareness and incentives not to spend wastefully, it is the enrollee’s responsibility to determine what is of value. In a VBBD, the value proposition is integrated into the incentive structure. A VBBD plan does not have the potential risks associated with a CDHD plan – the risk of deferring needed services to either avoid paying the full cost of the services or to build the balance in a tax deferred account.

VBBD is also distinguishable from Value-Based Purchasing. Value-Based Purchasing is focused on the manner in which a purchaser using its buying powers to maximize the value that it receives from its contracted insurers or third-party administrators for its entire health benefit program. Employing VBBD might be one strategy a purchaser uses in pursuing Value-Based Purchasing.

A VISION FOR VALUE-BASED BENEFIT DESIGN



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WHAT IS THE BUSINESS CASE FOR VBBD?

ROI Business Case

Determining ROI

The most straightforward Return on Investment (ROI) calculation for VBBD initiatives assesses the costs to the purchaser of a) reduced co-pays or other financial incentives and of b) any increased utilization that results from the incentives. It then compares those costs to the reduced medical costs that result from increased treatment adherence by the newly engaged enrollees. More expansive ROI calculations include program costs, such as communication initiatives and disease management and other support programs, as well as productivity increases associated with reductions in absenteeism and presenteeism.

In calculating an ROI for VBBD, time frame is very important. Because the purchaser is now assuming the costs previously borne by the already engaged members, the purchaser's total health care costs may increase in the short term before direct medical costs start to decline.

Evidence of a Positive ROI

The currently available research evidence documenting a positive ROI from VBBD initiatives is limited, preliminary and mixed¹³. While self-reported positive financial returns have received wide media coverage¹⁴, there are no published studies that evaluate financial returns using rigorous research methodologies.

The authors of a recently published study¹⁵ of a large service industry employer VBBD initiative found medication compliance rates to have increased substantially for all but one drug class with the implementation of VBBD. While not the subject of the article, the authors suggested that the reduction in direct medical

costs realized by the increased compliance offset the increased costs associated with newly engaged enrollees. The authors were uncertain that the reduced direct medical costs also offset the costs of the co-pays previously paid by the enrollee and now paid for by the purchaser.¹⁶

A preliminary, unpublished, three-year study by Wellpoint of the State of Maine's diabetes VBBD initiative indicates that Maine is realizing a net savings of \$1000 per diabetic enrollee¹⁷. Generally, consultants who have active VBBD practices are reporting that it is too soon to say whether estimated ROIs will be realized.

Why is There Hope for a Positive ROI?

The VBBD theory of pricing medical services, lifestyle behaviors and providers based on value is sound. A simulation of 6.3 million adults taking cholesterol-lowering drugs (statins) that eliminated co-payments for statin therapy for patients with high and medium risk for cardiovascular disease and raised co-payments for low-risk patients taking statins yielded a total savings of more than \$1 billion annually.¹⁸

The anecdotal evidence from early adopters, who implemented a range of programs to improve employee health, including VBBD, is also positive. For example, IBM was able to maintain a health care cost trend of 3% to 4% when a comparative average was 12% and higher.¹⁹ Pitney Bowes has reported similar successes. It is difficult to isolate the impact of the VBBD component of their strategies because both of these purchasers employed a number of VBBD and non-VBBD strategies simultaneously. Currently, it is not known which combination of programs will assure a positive ROI.

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	

How to Increase the Likelihood of a Positive ROI

The likelihood of having a positive ROI can be increased by 1) implementing a targeted, rather than a non-targeted program; 2) offsetting VBBD costs with other plan design changes; 3) including productivity increases in the analysis of effectiveness, 4) building an effective communication strategy and implementing a basket of integrated services designed to promote health and wellness, and 5) extending the timeframe for evaluating returns. Each of these aspects of ROI enhancement is discussed below.

1. Targeted vs non-targeted plan design. An assessment of the ROI for a non-targeted program must include in its analysis the cost of financial incentives and treatment for all the newly engaged enrollees, as well as the cost of financial incentives associated with all enrollees who were engaged prior to the initiation of the VBBD program. The savings associated with the new adherents may not be sufficient to offset the total costs of financial incentives and treatment for all participating enrollees.²⁰

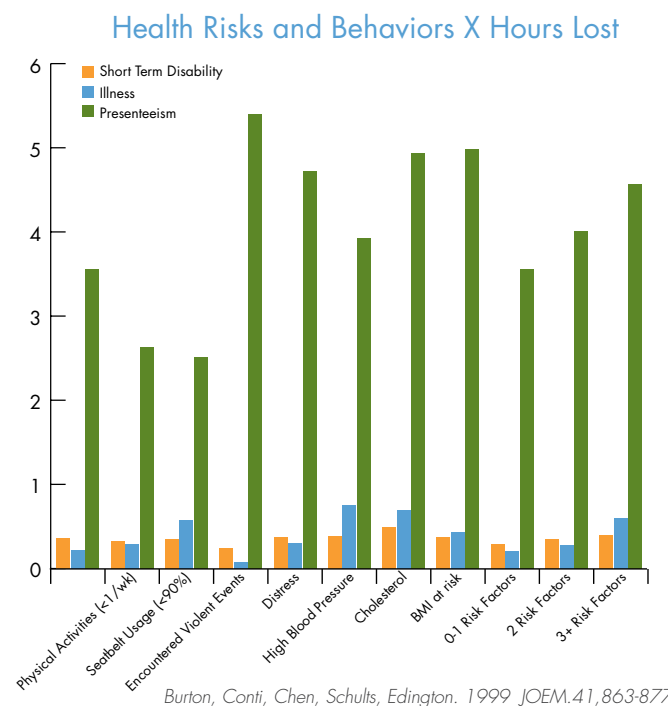
If a VBBD initiative is targeted towards specific individuals, the likelihood of a positive ROI is increased, because a targeted VBBD initiative limits the incentive to those who can most benefit from improved compliance. For example, an ROI calculation for a VBBD initiative that reduced co-pays for statin drugs for people who have had a cardiac event would include only the cost of co-pays paid by this subgroup of members, rather than all enrollees on statins as with a non-targeted program. While this sounds like a simple way to develop a program with a positive ROI, there are a number of operational and administrative issues associated with this approach, which are discussed in Section V below.

2. Offsetting VBBD Costs with Other Benefit Design Changes. An ROI calculation that considers only financial incentives and treatment costs can be structured to reach breakeven by increasing co-pays or deductibles for other treatments, which are not as high value, in amounts sufficient to offset the increased costs associated with the VBBD program. Hewitt Associates has developed an interactive actuarial program that uses utilization information and evidence-based assumptions to model what plan design adjustments would be needed to achieve the desired offset. The Hewitt program at this time models only VBBDs covering prescription drugs, but is being expanded to cover other services.²² Any consulting firm an employer is considering should have a history of working on a regular basis with actuaries to calculate the cost of implementing a VBBD initiative and any offsetting plan design adjustments being considered.

The number of newly compliant enrollees may also depend on their economic strata and whether the reduction in co-pay amount is sufficient to get their attention. Health Partners of Minnesota has found that to incentivize participation, typically copay differentials must be between \$20 and \$40.²¹

3. Expand the scope of the ROI calculation to include the costs of presenteeism. Employers are increasingly recognizing the indirect costs associated with major chronic conditions. Studies by the Integrated Benefits Institute (IBI) found that 55% of a study population had more than one co-morbid chronic condition, and that this population had lost time equal to 1,900 days for every 100 full-time equivalents per year.²³ Moreover, the IBI study also found that for those with two or more chronic health conditions, lost time from presenteeism was about two times that of absenteeism.²⁴

The chart below displays the estimated number of hours lost associated with specific health risks and behaviors. The relative hours lost due to illness, short-term disability and presenteeism demonstrate the significant impact of presenteeism on employer costs.²⁵



- In 2004 Dow Chemical calculated that the direct and indirect costs of medical claims, industrial hygiene and occupational health -- including the costs of absenteeism and presenteeism -- totaled \$750 million.²⁶
- Gulfstream estimated that 10-20% of its employees lost an average of 6 workdays per employee annually due to the flu.²⁷ The company expected a 3:1 return on a free flu shot program that was designed to reduce the number of lost days due to the flu.
- City of Springfield, Oregon implemented the "Asheville Model," which pairs diabetics with pharmacy students to provide educational and coaching support services. The city also waived medication co-pays and office visit co-pays for medical visits associated with diabetes. The city reports a 30% reduction in sick days for the diabetics who received the counseling support compared to those who received only written educational materials.²⁸

4. The promise of VBBD is that by improving the health of enrollees the costs associated with implementing a VBBD initiative will be offset not only by reduced direct medical costs, but also by increased productivity. To date there have been no rigorous evaluations using control groups to test whether this promise can be realized. There are, however, several employers reporting or expecting to report positive results when factoring in reductions of indirect costs.
5. **Program Structure:** Leaders in implementing VBBD initiatives consistently emphasize that to have an effective program purchasers must implement a set of complementary strategies that are integrated to achieve better employee health. When this integration of services is achieved and effectively communicated, more favorable results are realized because of the synergy. Gulfstream has implemented one of the most comprehensive initiatives of this kind. The company reports²⁹ holding health care costs to 3.4% per year for four years. Its program is targeted at early health risk detection, engaging employees in actively managing their health and partnering with primary care physicians to meet specific quality goals. Employees are provided with incentives, including cash payments and lower co-pays, to complete a personal health assessment, obtain preventive services, use physicians who meet quality standards and comply with their doctors' orders. Service providers (e.g., disease management companies and health plans) are held to specific quality standards, and providers are given incentives to meet specific quality goals. Best practices for implementing a VBBD initiative are discussed in more depth in Section V, below.
6. **Timeframe for Analysis.** Purchasers should be cognizant of the time needed to realize financial benefits from improved treatment adherence and healthier lifestyles to develop. Chronic conditions by definition are for a lifetime and it can take years to identify and quantify the savings from a reduced number of hospital admissions due to improved control of chronic conditions, such as diabetes. Similarly, all the benefits of smoking cessation will not be realized until future incidences of cardiovascular disease are avoided. Because of the timeline required to realize some savings, purchasers undertaking VBBD initiatives are advised to not expect evidence of savings before 2 years post implementation. Theoretically incentives to direct consumers to more efficient providers could provide more immediate results; however, the limited studies relating to this strategy suggest that savings for this too may take some time to materialize because of the need to have substantial redirection to realize measurable savings.

ROI: In Conclusion

While it is too soon to say definitively that VBBD initiatives will result in a positive ROI, advocates of VBBD make the strong point that VBBD provides “an opportunity to fundamentally change the way health benefits are structured, and to reframe the national debate on healthcare to focus on the value of health services – not on cost or quality alone.”³³ VBBD principles, therefore, can be used to achieve any cost target more efficiently, even if the VBBD incentives by themselves do not save money. By focusing on value, an employer can spend its health care dollar more wisely and can impact employee's health for the better.

Importance of on-site clinics: A recent Mercer LLC survey reports that 31% of employers with 500 or more employees offer on-site clinics to provide their employees with primary care and wellness services.³⁰ Some large purchasers that have aggressively implemented VBBD initiatives have also provided incentives for employees to use the on-site clinics. On-site clinics often result in an earlier return on investment for the VBBD program because the clinics provide quicker feedback regarding employee behavior (e.g., whether prescriptions have been filled, whether lab tests have been done, etc.). As a result, the purchaser has better data sooner, resources to outreach to employees that need follow-up, and more opportunities to communicate with employees, even including making house calls.^{31,32}

On the other hand, on-site clinics present challenges by further fragmenting care unless there is a high degree of communication with the employee's primary physician and encounter information is integrated into the stream of claims and other sources that can be used to track and leverage employee engagement.

SETTING THE STAGE FOR EMBARKING ON VBBD

To develop this Guide, employers and employer coalitions, insurers, and thought leaders (including consultants and academic researchers) were interviewed. A literature review and web search were also conducted. The results of this research have been consolidated and organized to present in the sections below the best practices for considering, implementing and evaluating a VBBD strategy.³⁴

Initially Assessing the Appropriateness of VBBD for a Purchaser

A VBBD program is appropriate for consideration by all but a few purchasers. There appear to be two, and possibly three, purchaser characteristics that suggest it might not be worthwhile to pursue VBBD.

- First, if the purchaser has a very high employee turnover rate, there is limited opportunity to garner any cost savings or productivity benefits from incentives that motivate use of high value services or programs that take several years to realize savings. However, developing a VBBD program that provides incentives to use high value providers for specific services or procedures might be worth exploring.
- Second, if the workforce is young and healthy with few chronic conditions or compliance rates with chronic medications are very high, there is likely little opportunity to benefit from improved medication or treatment compliance. However, some innovative VBBD programs are focusing on healthy behaviors, such as weight loss or smoking cessation, which offer more savings opportunities for younger or highly compliant populations.
- Third, most experience with VBBD initiatives is with companies with over 10,000 employees. One consultant suggests that companies with fewer than 5,000 covered lives may find the administrative costs associated with VBBD initiatives (e.g., data collection and analysis, communication strategy, evaluation) too high in light of the potential benefit. Business coalitions, such as the Mid-America Business Coalition on Health Care³⁵ and the Pittsburgh Business Coalition on Health³⁶, are combining members' covered lives to achieve economies of scale to support VBBD initiatives for small to mid-sized companies.

Integrating VBBD into the Purchaser's Strategic Vision

To be successful, a VBBD initiative cannot be a "one-off HR program."³⁷ Improving the health of a business' employees must flow directly from the purchaser's strategic goal to improve

productivity. That necessarily leads to thinking about employees as human capital to be nurtured, rather than as a cost center to be managed. Integrated benefit offerings are then developed and implemented to achieve the goal of improving productivity through improved health, and reduced absenteeism and presenteeism.³⁸ VBBD, therefore, becomes more than a cost cutting program. Rather, it becomes a strategic foundation for managing all the funds a purchaser expends on programs that touch the enrollee's well-being, including programs such as long- and short-term disability, employee assistance plans, sick leave, and worker's compensation.

Senior Leadership Buy-in

Senior leadership buy-in to the VBBD strategy is essential. The Human Resources director must be involved in the purchaser's strategy discussions where the implications of a value-focused approach can be discussed, understood and adopted by all of senior leadership.

Senior leadership must also accept that implementing a VBBD initiative is a multi-year undertaking and participate in defining the annual goals of the VBBD initiative. Senior leadership must hold the HR director accountable for meeting those annual goals.

Finally, senior leadership must be actively involved in promoting the VBBD initiative and goals throughout the organization. (See Section V below for a discussion of Communication Strategies.)

For companies with sites in different geographic locations, buy-in at the site level is also critical. To be successful the program must be standardized, but have flexibility to allow customization at different sites.

To retain senior management buy-in, the Human Resources Director can consider the following best practices.

- First, establish clear, concrete program goals and sound metrics to track of progress towards meeting goals, including period-over-period comparisons.
- Second, report metrics to management and throughout the company on a regular and predictable reporting cycle.
- Third, use a reporting construct that is consistent with that used to measure progress towards production, sales and other standard management goals.
- Finally, promote wide acceptance of the program by creating a high level, cross-functional team responsible for overseeing the health and wellness initiatives.

For more advice on best practices, see Appendix B: Engaging Senior Management.

Establishing Realistic Expectations

Before implementing a VBBD initiative, senior leadership must be realistic in defining the program's success. Because it could take several years to reach a breakeven point, the timeframe for achieving an acceptable ROI must be agreed upon at the outset.

Senior leaders must also consider program effectiveness measures, including measures of clinical process, outcome measures and productivity goals. One example of an annual goal might be to increase diabetes drug compliance by 10%. A productivity goal might be to reduce sick days by 20% for asthmatics.

To keep the program on target, at the start of a VBBD initiative and annually thereafter, senior leadership must agree upon how the program's effectiveness will be measured and then take stock periodically as to whether the program is meeting its goals.

Timeline

One of the biggest barriers identified during interviews for this Guide was the failure by senior management to give the program adequate time to run before determining whether to continue it. As noted above, some of the savings derived from improved health will not be realized prior to 2 years after implementation. It is therefore critical to agree to a program timeline that is consistent with the measures that senior management has agreed to use to measure success.

For example, if one of the measures is to increase diabetes medication compliance by 10%, that can easily be measured on a monthly or quarterly basis through pharmacy data. If, on the other hand, reducing the number of cardiovascular-related heart attacks is one of the measures of success, it could take years to determine if the number has been reduced.

Because both the goals and timelines may have a clinical component, it is very important to have the corporate medical director, or a consulting clinician, participate in the discussions around selecting measures and determining acceptable timeframes.

IMPLEMENTATION OF VBBD INITIATIVES USING BEST PRACTICES

Step One: Population Analysis

The bedrock of an effective VBBD initiative is data collection and analysis designed to identify the areas of greatest opportunity for the purchaser. The best practice is to integrate data from multiple sources to create as complete an employer profile of risks and opportunities as possible.

Available Data: Purchasers generally have more data available than they realize. At a minimum, the data to be analyzed must include medical claims and prescription drug data, as well as data from a PHA, if available.

Several consultants recommend holding a vendor conference to bring the vendors into the process of outlining the data that are needed, determining the format for sending in data and setting the timeline for receiving data. Vendors' input is also important regarding what they can and cannot provide; however, expect to push vendors to provide the data considered most important. Consultants can be helpful in facilitating vendor meetings and determining what is reasonable to expect from vendors.

Large corporations may have the internal resources to create a database and analyze the data collected. For purchasers that do not have that capability, there are several sources to investigate for data management support:

- consulting groups;
- insurers and third party payers;
- Pharmacy Benefit Managers (PBMs);
- brokers, and
- data aggregators.

Understanding the Data: The goal of data collection and analysis is to identify the purchaser's areas of risks for losses due to health-related issues that are subject to influence through improved treatment compliance and/or health behaviors. Data analysis is partly an art form because of the vagaries of claims coding and requires a sophisticated analyst. What information can be extracted from the data will directly impact the structure of the VBBD initiative, particularly who will be targeted for VBBD incentives.

Because of the clinical nature of the data, it is key that there is a clinician on the team who has experience performing this type of analysis. Throughout the process, the clinician will be expected to have a working knowledge of the most recent research findings regarding effectiveness of care, be able to identify opportunities

to reduce illness or injury, and translate those opportunities into workable programs. The clinician will also need to have the ability to translate medical information so that the data analysts can structure data queries to locate specific subpopulations, such as locating only people on statins who have had a prior cardiac event. The clinician could be the purchaser's medical officer or someone affiliated with a consultant or vendor, so long as that clinician will be open and objective throughout the process.

For more ideas on data integration, please see Appendix C: Data Analysis.

Deciding What Population Should Be Targeted for VBBD.

VBBD incentives can be linked to a specific services (including prescription drugs) to specific providers, to program participation and to specific enrollees. VBBD incentives that are linked to specific services or providers commonly referred to as "non-targeted VBBDs," are available to anyone who uses them. This approach is relatively easy for vendors (PBMs and health plans) to administer. The limitations of this approach are that 1) there are a finite number of drugs whose use is limited to a condition for which it provides high value, 2) not all the drugs a person with the targeted condition takes would be covered by VBBD, limiting the effectiveness of the incentives and 3) identifying the specific service for VBBD incentives becomes more complicated when the value of the service must be determined by pre-qualifying and non qualifying events where claims coding doesn't distinguish among them.

VBBD programs that target specific program participation, such as participating in disease management or health promotion programs require close coordination among the different vendors managing the programs, the health plan and PBM to assure that participation is accurately tracked and the incentives are correctly administered. How participation in health promotion programs will be tracked must be carefully planned, if a method other than self-reporting is required.

Limiting VBBD incentives to only individuals who have specific conditions has the benefit of providing incentives for enrollees who will most benefit from the service. To successfully implement a targeted program, a purchaser must partner with an entity capable of providing very sophisticated clinical decision support that can identify the targeted population through complex data analysis. Data aggregators and some health plans have the capability to integrate data from numerous sources, identify the targeted population and feed the data to the PBM

or third party administrator. Currently, health plans and PBMs find it operationally easier to target specific services, providers or programs rather than people who have certain diagnoses. Diagnostic data on outpatient claims often are not reliable and identifying patients by diagnosis can take 30 to 90 days before the needed claims information is available.

Step Two: Developing the VBBD initiative

The specific VBBD initiatives must grow directly out of the data analysis that identified the areas of opportunity for the purchaser. A purchaser with a large number of employees with diabetes who are not compliant with the recommended drug regimen will develop a different program than a purchaser that finds that most of its risks are associated with employees with a high rate of obesity. Most VBBD initiatives begin with prescription co-pays because most costs can be definitively calculated, benefits reasonably modeled and compliance tracked electronically. Because compliance with drug treatment regimens, particularly for diabetes, and cardiovascular disease, is likely to result in savings of direct health care costs, most VBBD initiatives to date have focused on adjusting co-pay levels for drugs that specifically treat those conditions.

Reducing Financial Barriers and Providing Positive Incentives. The first component of a VBBD strategy is to reduce financial barriers to high value services or provide positive incentives for making lifestyle changes. As described earlier in the Guide, high value services are those that comparative evidence analyses have demonstrated to be effective in improving the health or well-being of an individual.

The most commonly used approaches to removing financial barriers currently used are –

- reducing co-payment amounts for prescription drugs and equipment (e.g., glucose test strips and needles) used to treat a specific condition, such as diabetes;
- reducing co-payment amounts for specific prescription drugs or equipment used to treat a specific condition when the individual participates in a disease management program;
- reducing co-payment amounts for office visits billed as wellness visits;
- modifying deductibles for completing a personal health assessment (PHA);
- modifying deductibles for participating in a disease management or wellness programs;
- modifying co-pays or deductibles for completing a shared-decision tool before proceeding with preference-sensitive treatments, and
- reducing co-payment amounts for using high quality providers.

Beyond gift certificates and discounts for services or goods (which are structured independent of the insurance design), the most commonly used approaches to providing positive incentives for making lifestyle changes are –

- reducing premium contributions for completing a PHA;
- reducing premium contributions for smoking cessation;
- reducing premium contributions for participating in either a disease management or wellness program;
- making a contribution to an employee's Health Savings Account (HSA) for completing a PHA, and
- making a contribution to an employee's HSA for participating in a disease management or wellness program.

Providing Education and Support. To successfully implement a VBBD initiative, the purchaser must also work with its vendors to provide a solid infrastructure of support for the employees eligible for VBBD benefits, and help them to overcome non-financial barriers to improved adherence. Vendors must be able to identify those with the condition who are not compliant with their treatment regimen and reach out to them through a disease management/case management/health coaching initiative that provides education and support. This involves trained coaches engaging employees at whatever level of understanding they have about their condition, jointly establishing personal care goals that they believe are achievable, and working with them to achieve their goals. Once the first goals are achieved, a new set of goals are established and supported until the employee is capable of self-managing his or her condition. Most health plans that are providing services to self-insured clients have disease management, pharmacy management and wellness programs or contract with vendors to provide these services.

The implementation of a VBBD initiative creates new complexities that must be managed. The key is to assure that the program processes and communication messages between the purchaser and the vendors are coordinated. For example, the health plan that is identifying diabetics who are not taking their drugs must be able to quickly and accurately provide patient information to the disease management company. The disease management company must then use the purchaser's communication themes in explaining the program during its outreach calls. It is best to coordinate outreach through a single case manager rather than bother enrollees with one call to manage diabetes and separate calls for preventive services. What message comes first and who conveys it is important to

Coding limitations: Dell has not been able to implement a program that differentiates between physician office visit co-pays for preventive services (\$10 co-pay) and those for diagnostic services (\$20 co-pay) because the CPT (billing) codes used by all insurers do not provide for this distinction. Both insurers and providers with whom they have spoken were supportive of their objective, but could not overcome the coding limitation.³⁹

determine so that opportunities to interact and change behavior are not lost. Finally, HIPAA requirements must be met when arranging inter-organizational data sharing that include personal health information.

Patient Accountability. Some VBBD initiatives specifically limit incentives to those who are willing to participate in a support program. The logic is that patients with chronic conditions must assume some accountability for caring for themselves. The desired accountability can be evidenced by the employee's continual participation in the support program. Some consultants have expressed concern that making participation in a support program mandatory will create union issues, raise questions and appear punitive. These consultants prefer to focus on the value of these support programs to encourage participation. To place the VBBD initiative in a broader context, they advocate a message that acknowledges both that individuals are unique and that their decisions and behavior affect everyone by impacting costs. Therefore, better health care decisions and healthier behaviors will meet both employee and purchaser needs.

If participation in support programs is mandatory, the coordination issues among vendors are more complex. Processes are needed to assure that incentives are limited to those who are meeting participation requirements.

Beginning with a Pilot Program: One option is to begin with a pilot VBBD initiative that focuses on only one condition. Diabetes is often selected because of its prevalence throughout the United States, the availability of an evidence-based treatment protocol, the use of drugs for treating the condition that only diabetic patients use, and the high likelihood of realizing cost savings when compliance rates are improved. A pilot could also be limited to one purchaser site.

Since a smooth implementation is essential, it is important to build in enough time to run several claims processing tests and try out the communication messages before going live. Allowing adequate testing time is critical to assuring success.

Step Three: Develop a Communication Strategy

There is no single right method for developing and implementing a communication strategy, because a communication strategy must be rooted in each employer's culture. Some employers, such as the University of Michigan, have rolled out an enterprise-wide, aggressive public messaging campaign targeting all employees and promoting the value of its VBBD initiative for diabetics. Other purchasers that have rolled out a VBBD initiative as a pilot have launched a low-key communication strategy. These different communication approaches may also be tied to how senior management views VBBD: as a new way of defining how to provide health care services with an emphasis on health and wellness or as an additional tool among others to make health care benefits more effective.

In developing an effective communication strategy, consider these best practices:

- Develop a communication plan for a 6- to 12-month period. VBBD is a new concept that takes time for all employees and their dependents to understand and embrace.
- Consumers find the idea that higher quality services will cost less counter-intuitive. Therefore, it is important to emphasize that the VBBD initiative is reducing barriers to services that bring greatest benefit to certain enrollees, which benefits everyone.
- Communications must come from senior management on a regular basis. Stress that the confidentiality of the health care information will be honored.

For more information on best practices, please see Appendix D: Communication Strategies.

Step Four: Vendor Management

Effective vendor management is one of the most overlooked aspects of developing and implementing a VBBD. The best practice goal is to have vendors act like partners: to have them share the purchaser's objectives and solutions. Effective vendor management is important from a very practical perspective. Large companies can have as many as 11 or 12 different vendors that touch the VBBD initiative as data sources, analysts or users; providers of services; claims processors; disease management/case management or health coaches, or program evaluator. All vendors must have the same understanding of the program's purpose and functional requirements, processes must interrelate smoothly, and messaging must be consistent and reinforcing. Because mistakes will happen and unexpected problems will arise, there must be a quick and efficient problem identification and resolution process with the purchaser and the vendors. In accordance with value-based purchasing principles, vendors must have measurable performance standards against which they are evaluated. Managing vendors effectively is time consuming and demanding, but essential for success.

An employer should expect the following minimum support services from its vendors:

- either serving as a data aggregator or sharing data with one;
- having the capability of merging non-claims data, such as from a Personal Health Assessment, with medical and pharmacy claims data, if serving as the data aggregator;
- having mechanisms to send targeted messages to beneficiaries based on the individual's health status and whether the individual is achieving the desired VBBD initiative goals;
- assuring the availability and data integration of personal care tools (see discussion below of Beneficiary Decision Support Tools);
- having mechanisms to connect members to appropriate care;
- working with the employer and all other vendors to develop cross-vendor processes and effectively implement them, and
- participating in the evaluation process and making program quality improvements, as required.

Examples of Consumer Support Tools

- a Personal Health Record populated by the individual and by the health plan;
- a Personal Health Assessment questionnaire with interactive feedback on risk mitigation options; and follow up to channel enrollees into appropriate programming
- disease-specific information and tools to track compliance with evidence-based treatment protocols;
- prescription drug support, including information on covered drugs, co-payments, substitute drugs and cost comparisons, and drug-drug interactions;
- shared decision support tools, such as evidence based information on alternative treatments for specific conditions, and their respective risks and benefits (variable by enrollee circumstances);
- calorie counters for food and exercise;
- provider quality and cost score sheets;
- information about community wellness resources;
- links to disease management services;
- links to other health-related sites, and
- a benefits explanation.

Beneficiary Decision Support Tools

As discussed in other sections of this Purchaser Guide, an effective VBBD initiative must include other programs that will engage and support the beneficiary in making his or her health care decision. Integrating a disease management/case management or health coaching is essential. Employers also have the opportunity to provide other types of decision support tools, such as disease-specific information and treatment protocol, to educate members regarding health care options. A more sophisticated technology has emerged that reaches beyond definitions, education and treatment protocol. Shared-decision technology interactively collects patient information that will influence the benefits and risks of treatment alternatives. Drawing upon evidence from research, shared-decision tools provide objective conclusions regarding the patient-specific benefits and risks of treatment alternatives such as chemotherapy, radiation therapy, surgery and watchful waiting. This technology is particularly useful for interventions for conditions such as cancer or where service demand is highly variable and preference- or supply-sensitive. These tools are provided online and/or integrated with nurse-line services.

Involvement of Health Care Providers

While not regularly done, involving the beneficiaries' health care providers in understanding the goals and structure of the VBBD initiative is highly desirable. There is mounting research evidence that the effectiveness of the patient-provider relationship directly relates to healthy outcomes. Open, informed communications between patient and providers is one of the cornerstones of an effective patient-provider relationship.⁴⁰ Educating providers about the VBBD initiatives, therefore, can enhance their effectiveness. Since patient non-compliance is a frequent source of frustration for providers, an employer's interest in improving compliance rates will be welcome. Purchasers can establish communications directly with providers or by working with the health plans, which communicate regularly with their contracted providers.

IBM's Paul Grundy argues that to maximize the effectiveness of VBBD it must have a strong underpinning of preventive and primary care service delivery, such as provided through the Medical Home model. (The NBCH Purchaser Guide to the Patient-Centered Medical Home is available at http://www.nbch.org/documents/pcpcc_guide_070908.pdf). He believes that large employers can use benefit design to encourage each employee, spouse and dependent to establish a strong personal relationship with a primary care provider who will work with his or her patients to make effective health care decisions.⁴¹

Legal and Regulatory Framework

Data sharing among vendors and with the purchaser that includes personal health information must meet all HIPAA privacy requirements. Similarly, any discussions of specific employee conditions must meet all state and federal confidentiality requirements. If PHAs are completed on-line, a secure web portal managed by a trusted third-party, such as the health plan, wellness vendor or disease management vendor, is essential. These confidentiality protections need to be conveyed to all enrollees as part of a communication plan.

A concern employers raise is whether employees who do not receive the VBBD incentive will see the program as discriminatory. One insurer indicated that several clients that had originally expressed interest in a targeted VBBD initiative decided to implement a more broadly based program, in part out of concern about employee reaction to a targeted program. This insurer also noted that it had not heard of any actual case of discrimination occurring among employers using other value-based plans.⁴²

There is “front line” evidence that the majority of employees not eligible for the VBBD benefit do not see the program as discriminatory. The University of Michigan rolled out its VBBD initiative for diabetics with an employer-wide publicity and communication campaign. All employee feedback about the program has been favorable.⁴³

A recent employee survey included a question about how workers would feel if their co-workers received an incentive for getting healthy (such as quitting smoking) or managing their health. Survey results indicated that a total of 85% of respondents reported that it was okay with them for co-workers to receive incentives. 48% of respondents hoped that they would also get an opportunity to earn incentives and 37% either did not personally need incentives or recognized that some people need more motivation to get healthy than do others. Only 13% felt that it was unfair for co-workers to get a bonus for lifestyle behaviors that they already practice.⁴⁴

The communication strategy can help mitigate negative employee reaction by emphasizing the benefits of a healthy workforce for all workers. By promoting the value proposition for both the individual and the employee population as a whole, an employer can position the program to be of benefit for everyone, not just those who receive the direct benefits. Unionized purchasers must include specific outreach to unions as part of its communication strategy to minimize a negative view of the program.

One other legal concern warrants mentioning. If VBBD initiatives are to involve Health Savings Accounts (HSAs), the legality of including preventive services for chronic diseases in the definition of “preventive services” for HSAs must be investigated.^{45,46}

Evaluation

The evaluation methodology must address at the inception of the VBBD planning process. The first step is to define the goals of the VBBD program and how success will be measured. The measures selected to evaluate the program must be specific, quantifiable, and able to be collected. The measures also need to be linked to the goals of the VBBD initiative and the business case accepted by senior management. For example, if the VBBD initiative focuses on improving diabetes medication compliance rates, measures should include medication compliance rates, as well as expected clinical results such as improved HbA1c (blood sugar) levels, reduced inpatient hospitalizations and reduced use of the emergency room. The purchaser’s clinical expert will be an important player in developing the disease-specific measures. If productivity is an element of the business case, measures must include reduced absenteeism and presenteeism.

It is essential to develop and collect data on baseline benchmark measures so that changes due to implementing VBBD initiatives can be measured over time. Coordination among vendors is key to assuring that the necessary data are collected in the manner needed to measure program effectiveness.

The evaluation data are also critical in improving the program over time. The data will reveal what is and is not working and how the program should be adjusted. Depending on the nature of the adjustments, the evaluation measures and data being collected may need to be adjusted to align with the updated measures.

For some measures, such as medication compliance rates, change will be seen within three to six months. Reduced direct medical expenses cannot be expected prior to two years from the program’s implementation. However, savings may be at measurable levels sooner if the covered population includes a large number of people with chronic conditions who are non-compliant or the VBBD initiative is able to achieve significant redirection of enrollees to high performance providers.

Sustainability of VBBD Goals over Time

Because the VBBD concept is relatively new, it is not known whether implementing VBBD initiatives will result in long-term compliance, or merely temporarily improve compliance with treatment regimens.

Organizations that have addressed the sustainability question have been successful in maintaining employee engagement over time by promising continuing VBBD benefits to those who meet specific program requirements. For example, Health Partners, a Minnesota health insurer, implemented its Healthy Benefits program four years ago and currently covers 57,000 lives. To receive reduced premium contributions or co-pays, Healthy Benefits requires each enrollee to complete a personal health assessment (PHA) at open enrollment and during that year to complete one program that is responsive to health risks identified in the PHA. Participation in a disease management program counts as the required participation; as does participating in smoking cessation, weight loss and other wellness programs. In each year thereafter, the enrollee must complete an PHA, document satisfaction of the prior year’s program requirement and enroll in another program to qualify for the reduced co-pay or premium.

Health Partners reports that in four years one large employer has seen improved employee health, such as a decrease in average BMI, and a 3.8 percentage point reduction in its health care cost trend.⁴⁷

Staff Resources

As mentioned earlier in the Purchaser Guide, it is essential to have a clinician involved in the data evaluation process and in determining appropriate measures of program effectiveness.

In addition to clinical expertise, the employers that were interviewed and had over 20,000 employees and broad-based, integrated VBBD initiatives estimated that they had four to five FTEs working on VBBD initiatives, with one to two dedicated to the program. Purchasers have found that working cross functionally - human resources, communications, clinician, data analysis, vendor contracting - on developing and managing a VBBD initiative is beneficial because of the opportunity to share different perspectives and break down silos.

Most organizations hire consultants to assist either with specific tasks, such as data analysis, or with development and implementation of the entire VBBD initiative, including plan design development, vendor management, communication and evaluation.

Even when consultants are used, employers must have staff who can be directly involved in the development and implementation of a VBBD initiative. These required staff skills include:

- data analysis and evaluation;
- policy and strategy development;
- understanding of benefit design development and implementation;
- communication and public relations, and
- negotiating/influencing skills with health plans and other vendors.

There are also several organizations available to assist employers:

- The Center for Health Value Innovation (www.vbhealth.org);
- The University of Michigan Center for Value-based Insurance Design (<http://www.sph.umich.edu/vbidcenter>), and
- The Integrated Benefits Institute (www.ibiweb.org).

SIX KEY BARRIERS TO IMPLEMENTING A VBBB INITIATIVE AND RESPONSES

The employers, consultants, insurers and advocates that were interviewed identified the following as the key barriers to implementing VBBB.⁴⁸

First, it is not easy for purchasers to make a strong business case for VBBB. In the short-term, costs may increase because of increased utilization and reduced co-pay costs for enrollees. It also takes time to realize savings in direct medical costs due to improved health. A break-even ROI will likely depend on increased productivity and reduced absence, both of which can be difficult to measure.

Response: *It is too early to determine if estimated ROIs will consistently be realized. The strength of a business case needed, therefore, will depend on the nature of the VBBB program, and the culture and leadership style of the purchaser. A VBBB program proving incentives for enrollees to use high performance providers may evidence savings sooner than programs encouraging better treatment compliance. It is possible to implement a VBBB initiative on a pilot basis to test employee acceptance and a likely return on investment.. Also, several validated tools exist to measure presenteeism and are being used by health plans and purchasers in their ROI calculations.⁴⁹*

Second, there is a lack of evidence of the comparative clinical and cost-effectiveness of most services⁵⁰, and of high value providers. As a result, implementing VBBB initiatives can only have limited impact. Moreover, when high-value services are identified, they may be applicable only to a subpopulation that is difficult to identify through data evaluation.

Response: *There are a sufficient number of high value services, particularly with regard to the two most common conditions – diabetes and cardiovascular disease – for most purchasers to act upon to improve employee health. VBBB initiatives that incorporate wellness activities, such as smoking cessation and weight loss have numerous opportunities for realizing improved health. More comparative effectiveness research is needed, but that should not be a reason to not move forward with VBBB.*

Third, data collection is challenging.

Response: *Data collection is a challenge, but one that can be overcome. Purchasers must expect to dedicate resources to extracting data. The good news is that there is plenty of existing data to use, and there is no need to generate new data. Experts are available to assist purchasers with this. Furthermore the ability of health plans and other vendors to contribute data and/or provide the analytical tools should become one criterion for vendor selection and vendor evaluation.*

Fourth, the success of VBBB requires all participants to be engaged over multiple years.

Response: *Setting realistic expectations and timelines is key for maintaining senior management commitment. As demonstrated by Health Partners' self-reported success, it is possible to structure a VBBB initiative that maintains consumer engagement over time and results in improved health outcomes.*

Fifth, employers express concerns regarding how employees will view the VBBB initiative and whether concerns over fairness will undermine the program and trust in the purchaser.

Response: *Purchasers are wise to be aware of this possible reaction. By emphasizing in a well-crafted communication plan that a) the program's goal is improving all employees' health, and b) that wellness benefits all, the likelihood of employees seeing the program as discriminatory is mitigated. To date, surveys that have surfaced examining this concern have not revealed adverse employee reaction regarding discriminatory practice.⁵¹*

THE FUTURE OF VBBD

The VBBD approach is likely to move forward on five distinct, but related tracts.

First, health plans, PBM, and disease management and wellness vendors are building more robust administrative infrastructures to administer a VBBD. Currently, health plans are fairly limited in what they can do regarding claims analysis to identify VBBD targeted populations.⁵² Recognizing this deficiency, health plans are building the capability to smoothly administer targeted programs. For 2009 or 2010, health plans are creating condition-specific benefit structures, such as a diabetic plan design that reduces office visit co-pays and deductibles, as well as prescription drug co-pays for this specific population. More regional health plans, in addition to the large national plans, will develop the capability to administer these different types of VBBD offerings.

Second, the range of behaviors targeted by VBBD initiatives and the associated conditions will expand. Currently VBBD initiatives focus on diseases, such as diabetes and heart-related diseases that when well managed are likely to result in a decrease in related medical costs. If purchasers include productivity improvements in their ROI analysis, it will be reasonable to expand VBBD initiatives to cover conditions such as depression, anxiety and gastrointestinal diseases which greatly impact presenteeism. Health plans, as evidenced by Health Partners' Healthy Benefits plan design, will be expanding the focus of VBBD incentives to encompass health promotion.

Third, currently VBBD initiatives are available to self-insured accounts. VBBD plans are less frequently offered to fully insured accounts.⁵⁴ If reported outcomes from VBBD initiatives are positive, more insurers will offer VBBD plans to their fully insured accounts. Some insurers are reportedly considering outcomes based contracting in which the purchaser receives a lower rate if it will work aggressively with the health plan to obtain high participation and compliance rates.⁵⁵

Fourth, VBBD plans will start to implement financial disincentives to discourage the use of services proven to be inappropriate in certain circumstances, such as use of CT or MRI scans as a diagnostic tool for low back or knee pain.⁵⁶ By using disincentives, purchasers will begin to implement the second half of the value equation – higher costs for low-value services.

Fifth, there could be increased synergy between the VBBD plan and the Patient-Centered Medical Home. In the PCMH, the treatment team is trying to promote prevention and better management of chronic illnesses. VBBD plans are providing patient incentives to receive those same high value services. While this could be a powerful intersection of health care initiatives, there will need to be more practices functioning as Medical Homes before this confluence of initiatives becomes meaningful.

Consumer Engagement: United Healthcare is studying “activation levels” across populations to identify what levers (e.g., financial incentives, health coaches, etc.) lead to changed behavior for different types of activities, such as exercise, preventive screening, and choosing practitioners. United has created a Consumer Activation Index which will tell a purchaser what needs to be done to move its employees to adopt healthier behaviors.⁵³

CONCLUSION

The theoretical underpinnings of VBBD are sound. By taking actions that will improve the health and productivity of their employees, employers are using their health and welfare programs as something more than a means to attract and retain workers.

The challenge is to implement the theory in the messy reality in which employers operate. Purchasers create some of these challenges by promoting a fragmented benefits system by carving out services among multiple vendors, failing to create an integrated data repository, and maintaining on-site clinics that are not interacting with the employee's primary care provider. In addition, our current fee-for-service system encourages the use of high-cost, low value services and pays extra for errors. The

challenge to purchasers is to use purchasing power to counter fragmentation and misuse of scarce health care resources. Whether the VBBD strategy yields desired financial gains will depend upon the ability of employers to a) overcome operational challenges, and b) to pursue the strategy long enough to assess its impact on the organization and its employees and their dependents.

There are some promising early self-reported findings, and several large U.S. employers have made a substantial commitment to the VBBD strategy as a human resources priority by adopting as a corporate goal the responsibility of promoting enrollee wellness by increasing the value of services purchased.

APPENDIX

A: Model RFP Language

The following questions may be used in whole or in part by a purchaser with an RFI (or RFP). For some of these questions, additional, more detailed questions can be found within the National Business Coalition on Health's eValu8 RFI tool. See questions 1.6.1, 1.6.2 and 1.6.3 of the eValu8 RFI tool.

Evidence is emerging that reducing financial barriers (such as reduced co-pays, reduced premium contributions, and contributions to fund-based plans) to or providing incentives to use high value services (services for which there is evidence that they are cost effective and clinically effective in improving the health status or well-being of the individual) in conjunction with aggressive consumer support services can increase patient adherence to treatment protocol and reduce the health risk of the purchaser's population. Plans that incorporate value-based consumer incentives are generally referred to as Value-Based Benefit Design (VBBD).

1. Please describe the Plan's view of the effectiveness of VBBD to improve the health status of covered lives and reduce purchaser costs. .
2. Please describe what specific steps the plan will take to help a purchaser decide if VBBD will be a beneficial strategy to pursue with regard to its health care coverage.
3. Based on the plan's experience, describe what criteria it uses to evaluate if a purchaser will benefit from VBBD.
4. Describe in detail the plan's capabilities to assist a purchaser in evaluating VBBD as a health plan option by:
 - a. Aggregating medical and pharmacy claims data, mining the data for VBBD opportunities and modeling the impact of VBBD plan options.
 - b. Including other data, such as long-term and short-term disability claims, and personal health assessment survey results, in the claims aggregation and analysis process described in 4a, above.
 - c. Providing the purchaser with a comprehensive assessment of the results of the data analysis described in 4 a and b, above and assisting the provider to interpret the results of the analysis.
5. Describe in detail the plan's capabilities to implement and administer a VBBD plan that:
 - a. Waives or reduces co-payments/coinsurance for specific prescription drugs;
 - b. Waives or reduces co-payments/coinsurance for preventive office visits;
 - c. Waives or reduces co-payments/coinsurance for preventive services, such as annual colonoscopy for people over 60 years of age;
 - d. Waives or reduces deductibles linked to completion of health risk assessments;
 - e. Waives or reduces deductibles linked to participation in disease management programs;
 - f. Waives or reduces deductibles linked to participation in wellness programs, such as weight loss or smoking cessation;
 - g. Waives or deduces drug co-payments/coinsurance for individuals with specific diagnoses;
 - h. Waives or deduces co-payments/coinsurance for specific service received by individuals with specific diagnoses, such as lab tests for patients with diabetes;
 - i. Waives co-payments/coinsurance by selecting a high value treatment modality or provider;
 - j. Offers different co-payment /co-insurance levels for different providers based on quality and cost assessments of the providers;
 - k. Offers discounts on health/wellness-related activities (weight loss programs, health club membership, etc.);
 - l. Offers health plan premium reductions for participating in disease management or in health risk reduction programs (smoking cessation, weight loss, etc.), and
 - m. Offers other value-based positive incentives.
6. Describe whether each of the capabilities detailed in question 5 can be limited to enrollees with diagnoses of:
 - a. Asthma;
 - b. Hypertension;
 - c. Hyperlipidemia
 - d. Diabetes
 - e. Depression
 - f. Prior cardiac event
7. Detail what consumer support programs the Plan has available to provide coaching and educational support to individuals with specific chronic conditions. Indicate whether these programs are internally run services or provided by a subcontractor.
8. Detail what wellness programs the Plan has available that

are designed to improve the health and well-being of all individuals, including healthy and low-risk individuals. Indicate whether these programs are internally run services or provided by a subcontractor.

9. Detail what specific mechanisms the Plan has in place to assure that different parts of the Plan's organization and vendors all coordinate to offer a smooth-running VBBD plan.
10. How many accounts does the Plan currently support that have implemented some aspect of VBBD?
11. What issues have arisen in implementing a VBBD plan and how did the Plan address the issues.
12. Please provide the names of three accounts that have implemented a VBBD plan with the Plan, with at least one being available to enrollees for more than 12 months.

B: Engaging Senior Management

The following is additional information on how to engage senior management in supporting VBBD initiatives. The focus is on how to present information to senior management in a way that catches their attention.

CFOs when surveyed by the Mid-America Business Coalition on Health had the following advice to VBBD champions:

- Think about what to say and the process to sell your idea;
- Communicate constantly and often;
- Be present during key discussions;
- Get in the queue for funding;
- Integrate VBBD approach into the strategic goals of the purchaser, such as seeking the Baldrige Award;
- Do not forward attachments in e-mails – copy, paste and highlight key points you want to make, and
- Don't give up.

Consistent with this advice, Tom Welsh, Director of Human Resources at PPG Industries, has built management support for his value-based initiatives in key part through the use of current, accurate data to measure and communicate program effectiveness. First, he has established clear, concrete program goals and sound metrics, which provide senior management with specific data to track progress towards meeting goals. Examples of program goals and associated metrics are:

- hold cost increases over a five-year period to one-half of the national average increases for companies of comparable size;
- the percentage of employees who have completed an HRA, with a goal of maintaining HRA participation at or above 80% in any three rolling years;
- the percentage of employees at low risk for disease and illness, with a goal of maintaining 70% of the population at low-risk at any point in time;

- the percentage of employees who have received biometric screenings for blood pressure, cholesterol and body mass index, with a goal of achieving screening rates of 80% of employees at any point in time.

Second, he had developed specific methodologies for calculating the metrics and reports results to management and throughout the company on a regular and predictable reporting cycle. This process keeps the program front and center on the company's agenda. Third, he uses a reporting construct that is consistent with that used to measure progress towards production, sales and other standard management goals. Senior management understands how to interpret these measures and it puts value-based incentives on a similar footing as core management goals. Fourth, he reports year-over-year and period-over-period comparisons to track trends, since it is very important to demonstrate success to maintain senior management engagement. Fifth, because of the company's structure, he is able to report head-to-head comparisons of metrics among the different company facilities.⁵⁷ This provides senior managers with an important topic of discussion when visiting the different company facilities to review performance.

Tom has also promoted wide acceptance of the program by creating a high level, cross-functional team responsible for overseeing the health and wellness initiatives. In addition to himself, the committee is composed of the Corporate Medical Director, and high-level representatives from Finance, Communications, and Environmental Health and Safety.

C: Data Analysis

Successful VBBD initiatives grow out of the analysis of data that identifies where the VBBD initiative can be most effective. To create a complete picture of areas of opportunity compile and analyze data from a variety of sources, including:⁵⁸

- demographics:
 - age, gender, education, ethnicity, recruitment and retention levels;
- standard health plan or third party administrator reports, including:
 - cost drivers;
 - how people access services;
 - drug adherence rates;
- dental utilization and costs;
- Short Term Disability utilization and costs;
- Employee Assistance Plan utilization and costs;
- disease management/case management experience;
- Long Term Disability utilization and costs;
- Health Risk Assessments and biometric data collected;
- workers' compensation utilization and costs;
- lab results;

- Family Medical Leave Act requests;
- employee satisfaction survey results;
- participation rates in employer incentive programs;
- productivity/presenteeism data;
- absenteeism data, and
- wellness vendor experience.

The purchaser will hold some of the data internally; other data will be available from vendors. Purchasers often find it more challenging to retrieve information from “siloes” internal sources, than it is to obtain information from vendors.⁵⁹ As challenging as it is, extracting as much data as possible is an important first step.

The Mid-America Coalition on Health Care (MACHC) is developing data tools for collecting data from a variety of employer and vendor sources. Each data tool will identify what data are available from what specific sources and of those data which are the most crucial to collect. Still in its early stages, expect a data map indicating the source and suggested frequency of data collection to be posted on the MACHC website (www.MACHC.org) over the next twelve months.

D: Communication Strategies

An effective communication strategy is required to successfully implement a VBBD initiative. Best practices point to the following features of a well-structured communication strategy^{60,61}:

- Develop a communication plan for a 6- to 12-month period. VBBD is a new concept that is going to take time for all employees and their dependents to understand and embrace.
- Consumers find the idea that higher quality services will cost less counter-intuitive. Therefore, it is important to emphasize that the VBBD initiative is reducing barriers to services that bring greatest benefit to employers, which benefits everyone.
- Communications must come from senior management on a regular basis. Communication can include sending out a quarterly email from a different senior manager that discusses the VBBD initiative, creating a video, posting daily messages on a purchaser website, and modeling desired behavior.
- Stress that the confidentiality of the health care information will be honored.
- Understand each constituent group. Employers are likely to have employees of different ages and different cultural backgrounds. Develop messages that will appeal to the different age and cultural groups within the purchaser. Consider holding focus groups to understand their key concerns around their health.
- Communicate to get buy-in throughout the organization. Make your communication multi-modal to appeal to the different age and cultural groups within your organization, including using text messages and purchaser blogs, face-to-

face meetings, guest speakers, and messages in the restrooms. Communicate through the disease management nurses, purchaser newsletters, purchaser meetings, union meetings, targeted and purchaser-wide e-mail messages, materials sent to the employee’s home, and EAP counselors.

- Reach the audience based upon their current situation and what is meaningful to them. One purchaser is trying to reach its employees by articulating the value proposition of its VBBD initiative for its employees as, “you can never save enough money to pay for poor health in retirement.”⁶² Once the VBBD initiative is implemented, give encouraging messages to those who are doing desired activity (e.g., taking chronic medications). For enrollees not evidencing the desired behavior, send them individualized messages telling them of the program’s benefit to them and give them an action step to take.
- If a significant percentage of enrollees are not employees, the communication strategy must be far reaching. Spouses are an essential target group, particularly if the majority of the employer’s work force is male. Generally women are the health care decision-makers in a family.
- Reinforce the key messages at every opportunity, using every vendor that will be touching the employer’s enrollees. Think out of the box. For example, EAP counselors need to know about VBBD initiatives. There may be an opportunity to remind an employee when helping them work through a crisis that they need to continue taking care of themselves and that there are reduced co-pays for their chronic medications.
- Do not reinvent the wheel. Often, employers can use their health plan’s and other vendor’s resources and slightly customize them to meet their needs.
- Consider branding the VBBD initiative. For example, Dow Chemical calls its program “Total Rewards” to emphasize that the focus is on good health for the whole self, including emotional, mental, physical, and financial.⁶³ Similarly, Whirlpool is developing a theme around employee involvement, called “Your Health, Your Way; Your Career, Your Way and Your Wealth, Your Way.” Whirlpool will be developing consistent and integrated messaging about how these three employee program areas are interrelated.⁶⁴ In both examples, the underlying messages are that these integrated programs are intended to benefit employees, the employer is committed to supporting and improving employee health, and employees have an important role in achieving better health.
- If the employer is going out to bid at the same time that a VBBD initiative is being considered, incorporate VBBD requirements into the RFP. The RFP can incorporate specific communication requirements for the vendors.
- Be aware that in most organizations there is a very active “viral” network (e.g., informal communications through word-of-mouth, blogs, etc.) about new programs. Try to tap

into that network by providing real-life examples of how the new program has personally benefited different employees. Include testimonials on the purchaser's website or purchaser's intranet site.

- Use terminology that encourages employees to be active participants in their health care. Use “coach” rather than “counselor”, and describe “health” as a way of being, rather than just an absence of disease.
- Consider a consumer satisfaction survey after the first year of operations to gauge program acceptance and to identify possible improvement areas.

For an excellent overview article that provides employers with strategies to help them successfully communicate benefit offerings and benefit changes to employees, including suggestions on how to communicate to change beneficiary behavior and how to engage employees in making the “right” benefit decision, see “Effective Health Communications: Guidance for Employers” available from the National Business Group on Health at www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/5_healthcommunication.pdf.

Employer Profile	Brief description of VBBD plan design	Key messages	Description of the resources required to administer	Summary of findings or evaluations
<p>Caterpillar*</p> <p>80,000 employees 120,000 covered lives</p> <p><i>4 plans</i></p> <p><i>Geographic spread of employee locations:</i> worldwide</p> <p><i>Nature of business:</i> Forestry Logistics, Energy Solutions – world's largest maker of construction and mining equipment</p> <p><i>Unique features:</i> Fortune 100 company \$36B sales and revenue 50% sales outside US Unions involved Average age of employee 47 yrs (male) Employee turnover <10%</p>	<p>Employee incentive \$900 reduction on yearly insurance with HRA participation (for each employee, spouse, and retiree under age 65)</p> <p>Remove barriers to disease/care management and EAP (resulted in 80,000 enrolled)</p> <p>Employees, Spouses and Retirees)</p> <p>Collaborative disease management with providers, with integrated claims, pharmacy and self-report database.</p> <p>Caterpillar scorecard; shows employee improvement against CAT aggregate AND employee improvement over time.</p>	<p>Make small changes.</p> <p>Get big results.</p> <p>Achieve your...</p> <p>Healthy Balance</p> <p>We can Help</p>	<p>Full-time Medical Director for Health Promotion and 4-5 FTE in health promotion and another 4-5FTEs in health plan design.</p>	<p>90% HRA participation</p> <p>50% of enrollees in diabetes management experienced HbA1C reduction (7.2 as compared to average of 8.7 one year previous)</p> <ul style="list-style-type: none"> • 96% of enrollees are measuring A1C • 72% meeting Surgeon General's activity recommendations • 98% are on aspirin <p>In the general employee group:</p> <ul style="list-style-type: none"> • 50% Reduction in disability days • Smoking cessation rates of 35%, even after 3 years.
<p>City of Springfield, Oregon*</p> <p><i>Number of insured 1,100 (430 employees)</i></p> <p><i>2 plans offered (1 PPO & 1 HMO)</i></p> <p><i>Geographic spread of employee locations:</i> Springfield, Oregon</p> <p><i>Nature of business:</i> municipality</p> <p><i>Unique features: relatively small employer that includes both union and non-union employees</i></p>	<p>Measured the improvement in diabetes management through a randomized study based upon the Asheville model.</p> <p>Enroll eligible employees based on a diagnosis of Type I or Type II diabetes.</p> <p>Randomize participants into two groups: control and intervention.</p> <p>Waive co-payments for prescription medications and medical visits related to diabetes control.</p> <p>Control group received printed educational materials.</p> <p>Intervention group received one-on-one counseling with pharmacist experts to encourage adherence with the total health management of diabetes, including physician and lab visits, retinal and foot exams, medication and testing, and exercise and nutrition.</p>	<p>Not available</p>	<p>Partnered with Oregon School of Pharmacy.</p>	<p>Hemoglobin A1C dropped 30% in the control group (comparable to other studies) and 50% in the intervention group with pharmacy consultants.</p> <p>Sick leave decreased by 30% for the intervention group (pharmacist-consultant group).</p> <p>Low-density lipoprotein (LDL) dropped more in the intervention group:</p> <ul style="list-style-type: none"> • Goal: LDL concentration of less than 100 mg/dL. • Baseline: 107mg/dL for control group, 101mg/dL for intervention group. • Mean changes at study end: decrease of 1.6mg/dL in control group, decrease of 5.8mg/dL in intervention group.
<p>Dell</p> <p>27,000 employees insured</p> <p>3 plans used nationally</p> <p><i>Geographic spread of employee locations:</i> Every state with key locations</p> <p><i>Nature of business:</i> Computer business</p>	<p>Reduced co-pays on generics and meds for specific conditions.</p> <p>Free diabetic medication and supplies at a reduced or eliminated copay for enrolling in a Well at Dell diabetes program.</p> <p>Free NRT supplies or smoking cessation drugs except Chanti x available at a reduced co-pay for enrolling in a Well at Dell health improvement program.</p> <p>Employees also receive incentive for completing HRA survey, enrolling and completing a program. Starting 1/09, the HRA incentive is as follows:</p> <ul style="list-style-type: none"> • \$130 annually / \$5 per paycheck for employee which can be applied against medical contributions or deposited in HRA for completing survey and enrolling in a program and an additional \$200 for completing program. A possible total of \$330. Same incentive 	<p>Assess, Act, and Achieve - Offers employees effective tools to make the right decisions and improve their health and well being.</p> <p>Employees really trust each others perspectives. We use an internal blog for employee-to-employee communication, which works well; we monitor for accuracy of statements.</p>	<p>Three to four head counts including the Director, and integrated vendor partners.</p>	<p>As of 12/31/2008, 959 members have enrolled in QuitNet and 114 have completed the program.</p> <p>As of 2/20/2009, 19,100 Dell participants have taken the HRA. Of those, 14,900 are eligible for coaching, and 53% have enrolled.</p> <p>No formal measurement of compliance or cost savings has been performed but early indications suggest that generic fill rates are increasing since introduction of program and enrollment in PPI step-therapy may have generated a reduction in cost.</p>

Employer Profile	Brief description of VBBD plan design	Key messages	Description of the resources required to administer	Summary of findings or evaluations
<p>Dow Chemical</p> <p>22,000 employees insured</p> <p>1 plan nationally (HMOs geographically based)</p> <p>5 unions to consider with regard to health insurance matters (for <10% overall population)</p> <p><i>Geographic spread:</i> MI, TX and LA then smaller presence in CA, OH, WVA & NJ.</p> <p><i>Nature of business:</i> manufacturing</p> <p><i>Unique features:</i> Dow has far more retirees than actives (40K almost 2:1). 60 M: 40 F – average age 47 yrs – population in flux.</p>	<p>Zero co-payment for many preventive services (tobacco cessation and weight reduction) and \$500 wellness allowance.</p>	<p>Program called ‘Total Rewards’.</p> <p>Dow has an internet page with daily messages. They have positioned everything as a benefit with several buckets: medical / health / different related (everything is viewed as part of Total Rewards)..</p> <p>“Good health for the whole self (emotional, mental, financial not just physical)” .</p>	<p>Mostly a cross-functional approach with one to two FTEs dedicated to project (may add up to four to five FTEs).</p>	<p>No specific measured outcomes for VBBD. Health improvement, and overall controlled cost outcomes tracked for broader health & human performance efforts.</p>
<p>Gulfstream*</p> <p><i>Number of insured: 21,000 (9,000 employees)</i></p> <p><i>Geographic spread of employee locations:</i> GA, CA, WI, TX, Mexico, London</p> <p><i>Nature of business:</i> aerospace</p>	<p>HRAs with biometric screenings offered in a “House Call” setting throughout the facility to encourage employee participation.</p> <p>\$0 co-pay generic drugs for asthma, diabetes, high cholesterol, heart disease and hypertension.</p> <p>Incentives for employees (reduction in office visit co-pays) to use the quality-based physicians.</p> <p>Incentives (20% off their annual E&M coded office charges) to clinicians for meeting established standards, using evidence-based medicine guidelines.</p> <p>Employees must be compliant with their doctors’ orders to help their physicians qualify as a recognized quality-based physician and eligible to offer reduced office visit copays.</p> <p>Service providers held to specific standards. Health plans, disease management companies, etc. are also held to quality protocols and are measured on their ability to deliver high quality health management service.</p>	<p>“Partners 2 Health”</p> <p>Goal: “Engage employees to take an active role in their own health care – securing appropriate preventive screenings and complying with their physician’s plan of care – to reduce the incidence of hospital inpatient admissions and lower Gulfstream’s health care cost trend.”</p>	<p>Not available</p>	<p>Reduced total health cost increase trend to 3.4% for the last 4 years.</p> <p>Measures over a 4 year period showed increased lab tests/monitoring of HbA1C, mammography, diabetic eye exams and lipid profiles.</p> <p>Further claims data showed reductions of amputations, frequency of heart attacks and strokes and overall health costs per patient in the diabetic Population.</p> <p>Reduction in overall pharmaceutical costs (98.4% generic substitution rate).</p> <p>Reduced mastectomies in the group of women getting annual mammograms.</p> <p>Improvement in physician adherence to evidence-based medicine treatment protocols.</p>
<p>IBM*</p> <p><i>Employees 350,00</i></p> <p><i>US employees 130,000</i></p> <p><i>US Covered Lives 500,00</i></p> <p><i>Geographic spread of employee locations:</i> nationwide</p> <p><i>Nature of business:</i> innovation in technology</p> <p><i>Unique features:</i> Fortune 100 company with \$100B in revenues in 2005</p>	<p>Rebates are offered for HRA completion, exercise and nutrition participation (recorded online).</p> <p>Supporting preventive and EAP coverage from Day 1.</p> <p>Smoking cessation program offers rebates of \$150 for enrollment.</p> <p>Track disability as part of integrated analysis.</p> <p>Elevate personal health management to a job expectation. CSuite involvement is a prime component of positive health management, including a visible Senior VP of Human Resources.</p> <p>Disease management (provided through an outside vendor) performance is tracked to total health management.</p>	<p>Global Well-Being</p>	<p>In 2004, IBM paid \$7.7M for Disease Management, resulting in an ROI of 225%</p>	<p>Premiums are 6% to 15% lower than industry norms, and employees pay 26% to 60% less than industry levels.</p> <p>Health and Well-Being programs drive over \$175M in annual savings.</p> <p>Improved health risk levels contributed up to \$20M in savings in 2005</p> <ul style="list-style-type: none"> • Reduction in ER visits • Reduction in hospital admits • Decrease in medical and pharmacy costs

Employer Profile	Brief description of VBBD plan design	Key messages	Description of the resources required to administer	Summary of findings or evaluations
<p>Marriott</p> <p>3,000 employees identified with chronic conditions</p> <p>4 plans used nationally</p> <p><i>Geographic spread of employee locations:</i> nationwide</p> <p><i>Nature of business:</i> hospitality</p> <p><i>Unique features:</i> hourly workforce cultural and language diversity – 150+ primary languages</p>	<p>Marriott targets employees with chronic conditions and their dependents. They have lowered co-payments for specific medications and services related to those conditions.</p>	<p>“You’re important”</p> <p>“Taking your medication is important”</p> <p>“We want to help you”</p>	<p>ActiveHealth Management administers the program</p>	<p>Conducted an analysis of claims data. The results indicated that removing co-pays for associates that absolutely needed the medication contributed to fewer claims for this population.</p>
<p>Pitney Bowes</p> <p>22,000 employees insured</p> <p>3 national health plans used; Rx carveout</p> <p><i>Geographic spread of employee locations:</i> hourly workforce national product side NY, NJ, & CT about 5K employees</p> <p><i>Nature of business:</i> mail and document management</p> <p><i>Unique features:</i> 2 distinct employee populations</p> <p>1) hourly pd employees that work at other employer: and</p> <p>2) the rest of the population that works with our products (mail machines etc).</p>	<p>Preventive care is provided at no cost or single co-pay (includes dental, hearing and vision screenings).</p> <p>Tiered pharmacy benefit: (10%/30%/55%) out of pocket capped at \$1,700 or \$1,200/year</p> <p>Certain chronic disease brand medication (asthma, diabetes, high blood pressure) moved from tiers 2 and 3 to tier 1. No cost for statins for diabetics and members having cardiac event. Benefit design decisions are based on what is the overall cost not just cost of Rx but medical outcome of treating the compliant employee.</p> <p>Healthcare University, employees receive \$75, that goes into Health Savings Account, for completing a HRA. They are also eligible to receive up to \$150 in reduced premium for setting up goals around smoking cessation, weight loss, etc. \$50 incentive is paid for each questionnaire completed and there are 3 throughout year.</p>	<p>Keep it simple</p> <p>Communication with offsite employees is very difficult always struggling to find ways to communicate with them –can’t put up posters, they have no access to computer, problems keeping current demographic information on them, most have cell phone and are reluctant to take or return our calls (uses up their minutes).</p>	<p>Two FTEs developed model with consultant and implemented through Caremark.</p>	<p>Conducted some intense modeling for certain diagnosis non-compliance asthma, diabetes, hypertension (regardless of tier moved to lowest co-pay). Seeing a strong return on higher compliance over time and lower medical costs (fewer emergency room visits, hospitalizations). Evolving process and will continue to evolve based further drilling/analysis of data.</p>
<p>PPG Industries</p> <p><i>Number of US participants:</i> 60,000 (active and retirees)</p> <p>45 plans</p> <p><i>Geographic spread of employee locations:</i> 50 states</p> <p><i>Nature of business:</i> coatings, glass, fiber glass and chemicals manufacturing</p> <p><i>Unique features:</i> population is older than comparable companies</p>	<p>Local plant managers compete against each other in achieving program goals. Each manager provides resources and there are opportunities for corporate funds to promote a wellness culture. Activities are determined locally and can include healthier cafeteria food, employee walking or weight loss competitions, etc. Winning plants are given additional funds to promote health. Bottom 10 performing plants are identified quarterly in detailed reports to senior management.</p>	<p>Your health is important. You must take personal responsibility to improve your health.</p>	<p>Cross functional team composed of the HR director, the Corporate Medical Director and representatives from Finance, Communications, and Environmental Health and Safety.</p>	<p>PPG has held its health care trend to ½ the national average for the last seven years, saving an estimated \$142 million.</p>
<p>State of Washington</p> <p>125,000 subscribers (260K active members) insured</p> <p>4 plans used nationally</p> <p><i>Geographic spread of employee locations:</i> across state</p> <p><i>Nature of business:</i> state employees</p> <p><i>Unique features:</i> two thirds of population in self-funded plans</p>	<p>No enrollee cost sharing for preventive visits based on US task force recommendations A& B, tobacco cessation counseling (with NRT products), and glucometers</p> <p>3 tiered RX benefit plan (lowest cost share tier includes diabetic supplies and insulin and generics)</p> <p>incentive for completing HRA, exercise and flu shot (part of a whole package that includes up to one bonus incentive/year).</p>	<p>Targeted to getting employees personal investment in how to manage their health and health care.</p>	<p>Two to three FTEs.</p>	<p>None to date</p>
<p>Information in this matrix was obtained primarily through interviews with employers and from their websites and press releases. For employers with an * after their names, their information was obtained from The Center for Health Value Innovation: www.vbhealth.org.</p>				

REFERENCES

- ¹ Caterpillar Case Study. Institute for Health Value Innovation. Accessed at www.vbhealth.org on November 13, 2008.
- ² Chernew M and Fendrick AM. Editorial. "Value and Increased Cost Sharing in the American Health Care System." Health Services Research, Health Research and Education Trust, vol. 43, number 2, pages.451-457 (2008).
- ³ See for example, Johnson L, Study: Paying smokers to quit boosts success rate. The Boston Globe, February 12, 2009. Accessed at http://www.boston.com/news/health/articles/2009/02/12/study_paying_smokers_to_quit_boosts_success_rate/ on February 12, 2009.
- ⁴ Wells D, Ross J, Detsky A. "What is Different About the Market for Health Care?" JAMA, vol. 298, Number 23, pages 2885- 2887.
- ⁵ Goldman D, Joyce G and Zheng, Y. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," JAMA, vol. 298, number 1, page 61 (2007).
- ⁶ See also presentation by A. Mark Fendrick, "Value Based Insurance Design: Returning Health and Wellness to the Health Care Cost Debate," slides 35, 36, 41 and 48 (available at www.sph.umich.edu/vbidcenter/pdfs/dallasvbid1108.pdf).
- ⁷ In a presentation at the Pacific Business Group on Health's Pharmacy Symposium, April 2008, Jane Barlow, MD reported study results documenting the reduced costs of diabetics who are compliant with drug regimens.
- ⁸ Chernew ME, Shah, MR, Wegh A, Rosenberg SN, Juster IA, Rosen AB, Sokol MC, Yu-Isenberg K, and Fendrick MA. "Impact of Decreasing Copayments on Medication Adherence within a Disease Management Environment." Health Affairs, Vol 27, Number 1, pages 103 – 112 (2008).
- ⁹ Martin Sepulveda, MD, FACP, Vice President for Integrated Health Services, IBM Corporation. "Putting Prevention and Healthy Behaviors at the Forefront of Employee Health Insurance Benefit Design." Accessed at www.americashealthrankings.org/2008/ibm_success.html on December 12, 2008.
- ¹⁰ Interview with Andrea Walsh, EVP of Health Partners, on November 11, 2008.
- ¹¹ Gulfstream Case Study, "Achieving new heights with improved health." Accessed at www.vbhealth.org on November 13, 2008.
- ¹² Fendrick AM and Chernew ME. "Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment." The American Journal of Managed Care, Vol 12, Special Issue, SP 5-SP 10 (December 2006).
- ¹³ Hunt S, Maerki S, and Rosenberg W. "Assessing Quality-Based Benefit Design" Prepared for the California HealthCare Foundation and Pacific Business Group on Health, April 2006. This study found limited good evidence of positive short- or long-term return on investment for VBBD.
- ¹⁴ See for example, Fuhrmans V. A Radical Prescription: Wall Street Journal, May 10, 2004, Page R3; and Fuhrmans V. New tack on copays: cutting them. Wall Street Journal. May 8, 2007: D1.
- ¹⁵ Chernew MD, Shah MR, Wegh A et al., op.cit.
- ¹⁶ Interview with Michael Chernew, PhD., Department of Health Care Policy, Harvard Medical School, on November 20, 2008.
- ¹⁷ Interview with Greg Hughes, Senior Product Manager with Wellpoint, on December 18, 2008.
- ¹⁸ Goldman DP, Joyce GF, and Karaca-Mandic P. "Varying pharmacy benefits with clinical status: the case of cholesterol-lowering therapy" American Journal of Manage Care, vol. 12, pages 21-28 (2006).
- ¹⁹ Interview with Paul Grundy, MD, Vice President for Wellness, IBM, on December 9, 2008.
- ²⁰ Chernew MD, Shah MR, Wegh A et. al., op. cit. This study showed that a co-pay reduction of 50% can result in a 7% to 14 % increase in compliance. If compliance is increased 10% (for example), this means that a purchaser with 100 diabetic members who have a compliance rate of 60% will have four new enrollees taking their drugs (i.e., 10% of 40) when co-pay costs are reduced by 50%.
- ²¹ Interview with Andrea Walsh, op. cit. and email correspondence dated February 17, 2009.
- ²² Interview with Jennifer Boehm, Principal, Health Management, Hewitt Associates, on December 2, 2008.
- ²³ Parry T. "Disease vs. Populations – The Impact of Chronic Conditions." IBI Research Insights. August 2008. Downloaded from www.IBIweb.org on November 27, 2008.
- ²⁴ Ibid.
- ²⁵ Mayo Clinic, Health Management Resources. "Presenteeism and the Value of Productivity Instruments, NASA." December 1, 2005. (Accessed at http://ohp.nasa.gov/disciplines/hpromo/hpwteam/meetings/presentations/2005_12_pres.pdf on December 10, 2008).
- ²⁶ Interview with Steve Morgenstern and Gary Billotti, Dow Chemical Company, on December 3, 2008.
- ²⁷ Gulfstream Case Study, op. cit.
- ²⁸ City of Springfield, Oregon Case Study in "Value-Based Plan Boosts Health and Reduces Sick Days." Institute for Health Value Innovation. Accessed at www.vbhealth.org on November 13, 2008.
- ²⁹ Gulfstream Case Study, op. cit.
- ³⁰ AIS's Health Business Daily, Today's Data Point for February 2, 2009.
- ³¹ Interview with Dan Hatfield, Partner, The Segal Company, on October 24, 2008.
- ³² Interview with Chris McSwain, Director of Global Benefits, Whirlpool, on November 10, 2008
- ³³ Fendrick AM and Chernew ME. "Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment", op. cit.
- ³⁴ See also a high level outline of issues associated with VBBD is

- presented in a Milliman publication entitled: “Value-based insurance design (VBID): Questions adopters should ask” and available at www.milliman.com/expertise/healthcare/publications/published/pdfs/valuebased-insurance-design-08-01-08.pdf.
- ³⁵ The Mid-America Business Coalition on Health Care is developing VBBD processes to support its members. It recently completed its process for collecting member company data.
- ³⁶ The Pittsburgh Business Coalition on Health has successfully piloted the implementation of the Asheville Model, linking diabetics with pharmacists who will act as health educators and coaches, for seven of its members.
- ³⁷ Interview with Andrea Walsh, op. cit.
- ³⁸ Interview with Chris McSwain, op. cit.
- ³⁹ Interview with Aldy Duffield, Senior Manager, Global Benefits at Dell Inc., on November 10, 2008.
- ⁴⁰ “Defining the Patient-Physician Relationship for the 21st Century.” 3rd Annual Disease Management Outcomes Summit, October 30 – November 2, 2003. Sponsored by American Healthways, Inc. (Accessed on January 25, 2009 at <http://www.patient-physician.com/docs/PatientPhysician.pdf>).
- ⁴¹ Interview with Paul Grundy, MD, Vice President for Wellness, IBM, on December 9, 2008.
- ⁴² Interview with Dr. Ed Pezalla, Medical Director for Pharmacy, Aetna Health Plan, on November 19, 2008 and email exchange on 2/16/09.
- ⁴³ Interview of Mark Fendrick, op. cit.
- ⁴⁴ Larry Boress presentation, op.cit.
- ⁴⁵ Chernew ME, Rosen AB and Fendrick AM. “Value-Based Insurance Design.” *Health Affairs*, vol. 26, number 2, pages w195-w203 (2007). Published online 30 January 2007).
- ⁴⁶ An IRS Private Letter Ruling (available at <http://www.legalbitstream.com/scripts/isyswebext.dll?op=get&uri=/isysquery/irlbe82/1/doc>) stated that a policy that covered a specified number of prescription drugs was not a permitted coverage or preventive care under section 223 of the Code. However, this Private Letter Ruling did not specifically address the question whether prescriptions for chronic illnesses are preventive services.
- ⁴⁷ Interview with Andrea Walsh, op. cit.
- ⁴⁸ Cyndy Nayer, Executive Director of the Center for Health Value Innovation, also identified as barriers a misalignment of incentives with regard to drug rebates (moving drugs to lower tiers may jeopardize manufacturer rebates), high IT costs to overhaul or replace the legacy system and the failure to include providers in the incentive system (necessary to maximize the number of people participating in VBBD).
- ⁴⁹ For example, see Work Limitations Questionnaire, developed by Debra J. Lerner, MS, PhD at Tufts University, available at <http://160.109.101.132/icrhps/resprog/thi/wlq.asp> and the World Health Organization Health and Work Performance Questionnaire available at <http://www.hcp.med.harvard.edu/hpq/>
- ⁵⁰ A listing of public sources that document the effectiveness of specific technology and services can be found at http://www.businessgrouphealth.org/pdfs/ebbt toolkit_medicalvidence.pdf.
- ⁵¹ December 5, 2008 e-mail correspondence from Cyndy Nayer, Executive Director of the Center for Health Value Innovation.
- ⁵² Interview with Karen Graham, Human Resources, Marriott International, on December 2, 2008.
- ⁵³ Interview with Vince Kerr, MD, President Care Solutions, National Accounts and Executive VP, Network and Clinical Solutions, United Healthcare, in December 2008.
- ⁵⁴ For example, of the insurers interviewed, Health Partners of Minnesota and United HealthCare offer VBBD plans to fully insured accounts.
- ⁵⁵ Interview with Cyndy Nayer, op. cit.
- ⁵⁶ Dr. Michael Modic, chairman of the Neurological Institute at the Cleveland Clinic is quoted as saying that scans are pre-surgical tools, not screening instruments, and should be used only after conservative treatments have not worked and surgery is necessary. Kolata G. “The Pain May be Real, but the Scan is Deceiving.” *Wall Street Journal*, December 9, 2008, page D3.
- ⁵⁷ Interview with Thomas Welsh, Director of Human Resources for PPG Industries, January 22, 2008.
- ⁵⁸ Interview with Bill Bruning, President and CEO of Mid-America Coalition on Health, on November 24, 2008.
- ⁵⁹ Ibid.
- ⁶⁰ Interview with Chris McSwain, op.cit.; interview with Dean Hatfield, op.cit.; interview with Andrea Walsh, op. cit.; interview with Michael J. Taylor, Partner, Powers Perrin, on November 4, 2008; interview with Vince Kerr, MD, op. cit.; Jennifer Boehm, Principal, Health Management, Hewitt Associates on December 3, 2008; and interview with Steve Morgenstern and Gary Billotti, Dow Chemical, on December 3, 2008.
- ⁶¹ “The Employee Perspective on Value-Based Benefit Design”, presentation by Larry Boress, President and CEO of Midwest Business Group on Health at the National Business Coalition on Health Annual Conference, November 10, 2008 in Washington, DC.
- ⁶² Interview with Chris McSwain, op. cit.
- ⁶³ Interview with Steve Morgenstern and Garry Billotti, op.cit.
- ⁶⁴ Interview with Chris McSwain, op. cit., interview with Dean Hatfield, op. cit., interview with Andrea Walsh, op.cit., and interview with Michael J. Taylor, op. cit..

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