



## Value Based Insurance Design

### **Value-Based Insurance Design (VBID)**

Value-based insurance design is a health insurance model that promotes the use of high value health services by decreasing insureds' out-of-pocket costs. Generally, insurance plans using a value-based design will lower out-of-pocket costs for higher value health services and raise out-of-pocket costs for lower value health services.

According to the federal Centers for Disease Control (CDC), a “high value health service” is one with established clinical effectiveness and a cost proportional to the health benefit. The value of a health service varies based on several factors, including the age, health, and other characteristics of the individual receiving the service; the type of facility where the service is performed; and the type of medical provider performing the service.

According to the University of Michigan’s Center for Value-Based Insurance Design, VBID differs from traditional insurance design by recognizing that (1) not all medical services produce the same health benefit and (2) the health benefit of any specific service depends on many factors, including “when, where, and by whom the service is provided.” This is called clinical nuance.

### **Benefits of VBID**

According to the Center for Value-Based Insurance Design, value-based insurance:

1. shifts the cost for high value services from the patient to the insurance plan, but shifts the cost for low value services from the plan back to the patient;
2. increases patient utilization (i.e., how often patients use a service) for high value services and lowers utilization rates for low value services;
3. reduces hospitalizations and other higher cost services; and
4. allows insurers to reduce costs.

A 2013 Health Affairs article analyzed 13 VBID studies and found VBID plans increased medication adherence and lowered out-of-pocket costs without significantly raising medical spending for patients or insurers.

### **Potential Issues with VBID**

- Requires consumers to determine a service’s value, increasing the difficulty of them understanding and using their insurance
- Costs for “low value” services increase significantly
- “Low value” services include many services that patients might not agree are low value, including certain cancer drugs or surgeries
- Challenges surrounding who determines what services are “low value” and “high value” and how value is determined

## VBID in Connecticut

### *Health Enhancement Program for State Employees*

In 2011, Connecticut implemented the voluntary Health Enhancement Program (HEP), which incorporates some VBID elements.

State employees choosing to enroll in HEP received a list of certain high-value services they could access for little to no out-of-pocket costs and a description of how often they would need to utilize the service (e.g., an annual preventive visit for individuals over 50). Enrolled individuals with certain chronic conditions receive an annual \$100 incentive payment if they meet the HEP requirements.

Employees who do not enroll in HEP keep their traditional coverage, but must pay a monthly surcharge of approximately \$100.

### *HEP Results*

A [2016 analysis in Health Affairs](#) found that the HEP program increased adherence to chronic condition medications and decreased emergency room visits during the first two years, relative to employees of other states. However, the study noted the difficulty in isolating the program's effect from rising health care costs and HEP outliers, and concluded the program's impact on total cost was inconclusive and required a longer review period.

### *Proposed Legislation*

[SB 925](#) (2017) would have, among other things, required a health carrier to offer a VBID version of any of its policies covering prescription drugs. The bill defined VBID as any material term in a health insurance policy designed to increase the quality of covered benefits or health care services while reducing costs.

In developing VBID, health carriers would have been required to consider services and benefits that are (1) provided on an outpatient basis, (2) medically beneficial and cost-effective, (3) likely to prevent hospitalization or use of emergency services, (4) preventive, and (5) low risk for abuse or fraud.

## VBID in Medicare

In 2017, the federal Centers for Medicare and Medicaid Services (CMS) began testing a [VBID model](#) for Medicare Advantage Plans in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee; and will begin testing in Alabama, Michigan and Texas in 2018. In general, the model allows Medicare Advantage plans to offer a greater variation of plan designs for individuals with certain chronic conditions.

Plan designs must be approved by CMS and may include reduced cost sharing and additional services to enrollee.

## VBID Legislation in Other States

VBID legislation was introduced in at least two other states in 2017: Massachusetts and New Jersey.

In Massachusetts, two bills were introduced: [MA S546](#) and [MA H522](#), which among other things, would have eliminated cost sharing for certain high value services and required the health and human services secretary to establish a panel to make recommendations regarding high value cost effective services.

In New Jersey, [A888](#) would establish a task force to study, among other things, the components and efficacy of value-based insurance design.

Learn  
More

[CDC Issue Brief: Understanding Value Based Insurance Design](#)  
[University of Michigan Center for Value-Based Insurance Design](#)  
[National Conference of State Legislatures: Value-Based Insurance Design](#)

[“Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence,” Health Affairs \(April 2016\)](#)

