



Working for Cost-Effective, Quality Healthcare in the Tri-State Area

September 17, 2010

Submitted electronically via the Federal Rulemaking portal @ www.regulations.gov.

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
US Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Attention: RIN 1210-AB44

Re: Request for Comments Related to Patient Protection and Affordable Care Act (PPACA): Coverage of Preventive Services

Dear Sir or Madam,

New York Business Group on Health (NYBGH) welcomes the opportunity to submit for consideration comments relating to the interim final rules (IFR) for group health plans and health insurance issuers related to coverage of preventive services under the Patient Protection and Affordable Care Act (Affordable Care Act). The request was published in the *Federal Register* on July 19, 2010 by the Departments of The Treasury, Labor, and Health and Human Services (collectively, "the agencies").

NYBGH is an employer-driven coalition of many of the nation's largest purchasers of health benefits and is dedicated to improving the quality and efficiency of healthcare, locally and nationally. We are a not-for-profit coalition of more than 175 public and private employers, unions, health plans, providers, and other healthcare organizations operating in New York, New Jersey, and Connecticut. Since 1982, NYBGH has been representing healthcare purchasers in their efforts to drive healthcare reform and has aided employers in their quest for value in the healthcare system through efforts aimed at improving quality and moderating costs.

Discussed below are NYBGH's recommendations related to the agencies' development of guidelines regarding the utilization of value-based insurance designs (VBID) that encourage the use of preventive health care services of high value. First though, we commend the agencies for recognizing, in the IFR, the important relationship between value-based insurance design (VBID) and the provision of preventive services. Specifically, by allowing employers to require cost-sharing for recommended preventive services provided out-of-network, employees and their dependents will indeed be incentivized to seek high-value care while also ensuring them access to critical, evidence-based preventive services.

At the outset, we request that clarifying guidance regarding the items discussed below be released as soon as permissible. Many employers and health insurance issuers are in the final stages of designing their firm's benefit plans for the coming year. Because of that, employers who sponsor and/or administer calendar year plans will soon be printing and disseminating the necessary materials for open enrollment, which begins in earnest in October for many employers. Moreover, changes will need to be made to certain systems to ensure that claims for services provided after the beginning of the new plan year are properly processed and that explanations of benefits (EOBs) are accurate.

RECOMMENDATIONS FOR VALUE-BASED INSURANCE DESIGN GUIDELINES

With year-after-year increases in health care costs, employers that purchase health care benefits for their employees and their dependents are increasingly finding value in leveraging value-based insurance designs as part of their overall benefits strategy. Inherent in this is the explicit use of out-of-pocket cost-sharing requirements to encourage the use of certain evidence-based preventive services that result in high-value care and improved health status. Adherence to this approach stems from the theory that higher cost-sharing amounts discourage the utilization of only low-value care so long as patients have the ability to distinguish between low-value and high-value interventions. Similar use of financial incentives to alter behavior and change the utilization patterns of health care services is evident in other provisions within the Affordable Care Act. Accordingly, we recommend that future guidelines regarding the utilization of VBID follow suit and permit plan sponsors and issuers to structure VBIDs so that suitable cost-sharing mechanisms related to evidence-based preventive care services are indeed allowed.

The remainder of these comments offers the following three recommendations:

1. Allow employers maximum flexibility with regard to cost-sharing provisions of their VBID programs so that program parameters align with the health needs of their employees
2. Permit VBID programs to charge cost-sharing for low-value services even if they are offered on an in-network basis
3. Allow cost-sharing requirements for services that are high-price relative to the rest of the local market, even if the service is of high-value

Allow Maximum Flexibility to Encourage VBID Alignment with Employee Health Needs

There is no one-size-fits-all approach to VBID; in fact, the value of preventive services varies by individual. This assertion is supported and evidenced by the age, gender, and medical condition or risk nuances associated with the preventive services included in the current recommendations of the US Preventive Services Task Force as outlined in the IFR. Hence, enrollee cost-sharing requirements should be based on the value (clinical benefit relative to cost) of each service or provider to the individual and should not be the same for all enrollees based simply on the price of the service. Employers varying in size (i.e., number of employees and revenue), geographic location, governance structure, and employee demographic have each greatly benefited from a number of different approaches to VBID, each leveraging one that fit their employees' unique health needs. Notably, the commonality between each of these programs was their commitment to utilizing a model that was clinically sensitive to the variation in benefits both across medical services and among patients. By providing purchasers the flexibility to vary cost-sharing based on the evidence of

effectiveness for the circumstances of each enrollee, they will be better suited to tier services in such a way that begets and yields superior benefits relative to other options.

Additionally, not all designs stem from the same philosophical maxim. VBID programs typically employ one of four design approaches: by service, condition, condition severity, or disease management participation. To account for wide design and clinical benefit variations among plan sponsors and issuers, we recommend that future guidance related to VBID guidelines permits the maximum flexibility allowed under the Affordable Care Act with respect to the cost-sharing aspects of their VBID programs so that the parameters indeed align with the health needs of their employee population.

Cost-Sharing for Low-Value Services

Low-value care offers little clinical benefit relative to the cost of the service regardless of who is providing it. Routine colonoscopies, for instance, confer high value for individuals aged 50 or older and are recommended by numerous credible clinical and quality organizations. However, when performed on an otherwise healthy 26-year old individual this same procedure is wasteful and serves little clinical benefit relative to the cost of providing the service regardless of whether it was provided on an in- or out-of-network basis. Although the Affordable Care Act and the related IFR require the provision of in-network recommended preventive services without cost-sharing, we recommend that VBID plans be permitted to charge cost-sharing on low-value preventive services even if provided on an in-network basis.

Cost-Sharing for Services Priced Highly Relative to the Local Market

Health care value can fluctuate based on the price of services too. Many employers have or are in the process of making the prices of certain services more transparent through a number of different avenues. Through these efforts, it has become clear that the same service in any geographic area can vary in price by a factor of up to between 3 and 5. A preventive colonoscopy, for instance, in any given locale can cost \$8,000 through one provider, but may cost \$3,500 through another, *ceteris paribus*. If an individual chooses to have his/her colonoscopy delivered by the provider charging \$8,000 instead of by the one charging \$3,500, the plan sponsor or issuer should be able to impose cost-sharing requirements so as to incentivize the consumer to seek high-value care. Thus, we recommend that the agencies permit plan sponsors or issuers to require cost-sharing for the delivery of a service whose price is above a certain threshold when compared to the same service's prevailing local market price. Again, we urge that plan sponsors and issuers be granted maximum flexibility and discretion when it comes to instituting this specific VBID element so as to be properly responsive to unique local market conditions.

Conclusion

VBID is not solely a preventive care benefit design. Rather, it is a unique and consumer incentive-driven approach to addressing the broader issue of rising health care costs and the return on investment that purchasers experience. In the face of health care cost increases that show no relent, purchasers of health benefits deserve an option that allows them to utilize data-driven approaches to deliver common sense, high-value preventive health care that staves off costly and debilitating chronic conditions. Prior to the passage of the Affordable Care Act—and continuing for the 2011 plan year—many employers cover all preventive services without any cost-sharing. In a VBID arrangement, employers will likely

continue covering preventive services with little or no cost-sharing, but in such a way that leads to improved near- and long-term clinical outcomes while also getting a better handle on moderating rising health care costs that are on an unsustainable path. VBID is one of the few avenues available to employers in helping to control soaring health care costs. And these are efforts usually met with enthusiasm by employees and their dependents who often appreciate encouragement and a financial incentive to live healthier and prevent, rather than have to treat, chronic disease.

Thank you again for providing this opportunity to submit comments. Please do not hesitate to contact me or Shawn Nowicki, Director of Health Policy, at 212.252.7440 x227, if you have any further questions or would like to further discuss our feedback in greater detail.

Sincerely,

A handwritten signature in cursive script that reads "Laurel Pickering".

Laurel Pickering, MPH
Executive Director