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February 25, 2011

Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: HHS-OS-2010-002
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Request for Information regarding Value-Based Insurance Design in Connection with Preventive Care Benefits

Submitted via eRulemaking Portal: www.regulations.gov

Dear Sir or Madam:

Group Health Cooperative (Group Health) appreciates the opportunity to provide comments for the Request for Information regarding Value-Based Insurance Design in Connection with Preventive Care Benefits (VBID). Group Health is one of America's oldest and largest consumer-governed health care organizations. Founded in Seattle in 1947, the non-profit organization is governed by consumers. It's a leader in integrated care, and an important voice for health care reform. We provide coverage and care to more than 628,000 residents in Washington State and Northern Idaho who are covered by our health plans and get their care from Group Health physicians and nurses in one of our medical centers or from our more than 9,000 contracted community providers.

Currently, Group Health is the only carrier in the Washington state health plan market to offer a comprehensive VBID product to fully-insured groups. Group Health's approach to VBID is unique in that we are bringing together plan design (medical and pharmacy benefits), wellness programs, incentives, communications, and the Medical Home in an integrated product. We believe the combination of these aspects will drive better results than the less comprehensive approaches seen in the market.

The current VBID pilot product was loosely based on the Group Health Total Health program, which has been implemented for employees of Group Health and studied by the Group Health Research Institute. The Total Health program was launched in 2010, in conjunction with a health risk assessment and wellness program that includes financial incentives. It provides the

tools and support staff need to manage their health and in particular their chronic conditions. The health risk assessment participation rate is high (88%), indicating that staff are very engaged in the program. Health risk assessment results indicate adherence to recommended health screenings has dramatically improved in the past year.

In our response to the Department of Health and Human Services' request for information, we will discuss the opportunities for VBID development in both of the above programs.

We appreciate the opportunity to provide these comments for your consideration, and your willingness to consider these comments as you further incorporate value-based insurance design for the coverage of recommended preventive services.

Sincerely,

Megan Grover
Director, Regulatory Affairs
Group Health Cooperative

Attachment A

A. Comments Regarding Regulatory Guidance

1. What specific plan design tools do plans and issuers use to incentivize patient behavior, and which tools are perceived as most effective (for example, specific network design features or targeted cost-sharing mechanisms)?

Group Health believes that the evidence demonstrates that financial incentives are a powerful tool to influence behavior. VBID plans are predicated on the concept that cost shares are varied based on 'value' of a specific service, device, prescription or product. Cost shares should be minimized for high value services, and maximized for low value services. Group Health is piloting and rigorously evaluating a comprehensive VBID plan ("Total Health") with its employees, which uses the following incentives:

- Zero and reduced copayments for specific classes of medications used to treat chronic illnesses in which adherence is strongly associated with the risk of complication and hospitalization
- Copay waiver for office visits (up to two per year) related to care of six chronic conditions. This was intended to incent care planning at least annually for these populations.
- Copay waiver for outpatient chemical dependency treatment (to incentivize adherence with care plans)
- Increased copayments for advanced imaging procedures (CT, MRI, PET)
- Increased copayment for outpatient surgery
- Zero copayments for preventive care services (instituted before ACA)
- Partial and full rebates for completion of intensive behavioral obesity treatments (amount of rebate dependent on BMI reduction)
- Premium offset for completion of a health risk assessment and participation in health promotion activities.

Though Group Health's plan does not currently impose any coinsurance percentages, this cost-share option can certainly be varied in a similar fashion to copayments.

Even though much of the literature on VBID has focused on reducing financial cost-shares for medications, there remains considerable opportunity to focus on the identification of low-value or intermediate-value care. For example, in our Total Health program, we identified advanced imaging as one intermediate value service, and developed specific copayments for these services, where previously absent. The introduction of the copayment, which was accepted by a staff advisory group, was based on the relatively high cost of these procedures compared to plain X-ray films, and because considerable variation existed in their utilization.

The magnitude of the incentive is clearly important, as was demonstrated in the Rand Health Insurance experiment. For example, the health promotion literature directly correlates the health risk assessment completion rate with the size of a monetary incentive. However, less is known about the differential impact of incentives on populations based upon differing income class.

In addition, Group Health has collected data from 40 employers that have used various incentives through Group Health's wellness program for the years 2007-2011, and the new Group Health Value Based Insurance Design (VBID) pilot program launched January 1, 2011. This VBID pilot program is separate from the Total Health program described above, and has been offered to three employer clients. The most effective plan design tools used to incentivize patient behavior are as follows, in order from most to least effective.

1. Monthly employee premium increase for non-participation in wellness programs.
2. Monthly employee premium decrease for participation in wellness programs.
3. Benefit design enhancement for increased participation in wellness programs (e.g. lower deductibles, lower copayments, and waived cost shares).
4. Employer contributions to HAS and HRA accounts based on participation in wellness events or total programs.
5. Cash awards for participation in health and wellness events and programs.
6. Gift cars or debit cards for participating local vendors, using incentive companies such as IncentOne and Hallmark Insights.
7. Certificates, awards, acknowledgements from employer's top management.

- **How is effective defined?**

Effectiveness is defined by the observation of meaningful change in the metrics and targets used for each of the services. For example, lower cost shares for prescription medication should lead to improved adherence, which can be measured in a variety of ways. On the other hand, in respect to chronic care visits, our aim is for persons with one of the targeted chronic conditions to have one visit each year in which that diagnosis is coded. These measures of effectiveness are, in fact, intermediate measures, and do not measure if the change in behavior and adherence results in changes in health outcomes (e.g. quality of life, mortality, hospitalization). The VBID literature lacks data on these distal health outcomes. The Group Health Research Institute is currently conducting a research evaluation, funded by the Agency for Healthcare Research and Quality that is focused on these outcomes as well as the more intermediate measures.

2. Do these tools apply to all types of benefits for preventive care, or are they targeted towards specific types of conditions (for example, diabetes) or preventive services treatments (for example, colonoscopies or scans)?

Group Health believes that these tools likely apply to most, if not all, preventive and chronic care services. Much of chronic care represents effort to reduce complications or improve quality and longevity of life, and therefore we believe that VBID can be an important tool to improve the consumption of high value services, and reduce low value services. VBID tools can be used to incent medical management over surgical management for preference sensitive conditions where evidence is lacking that one approach is clearly superior to the other, and which a substantial cost (and therefore value) difference exists.

3. What considerations do plans and issuers give to what constitutes a high-value or low-value treatment setting, provider, or delivery mechanism?

- **What factors impact how this threshold varies between services?**
- **What data are used?**

- **How is quality measured as part of this analysis?**
- **What time frame is used for assessing value?**
- **Are the data readily available from public sources, or are they internal and/or considered proprietary?**

VBID health plan products are designed to improve patient health by enhancing compliance with specific high value interventions. The plans are geared toward long-term cost control and member engagement over a period of several years. The strongest considerations are given to those treatments and/or services that are evidence-based and have proven their value through controlled studies. These services include primary care, preventive care, and chronic disease maintenance drugs. Low value treatment is generally defined both as services that could be avoided by better managed care or elective procedures and services that are not proven to be effective, such as high-end radiology, low urgency use of emergency services, and some elective surgeries.

4. What data do plans and issuers use to determine appropriate incentive models and/or amounts in steering patients towards high-value and/or away from low-value mechanisms for delivery of a given recommended preventive services?

There is a longstanding scientific literature about the impact of increased cost-shares on utilization, however, less is known about the impact of reducing cost-shares.

The following data are important for a health plan and purchaser to support a value based plan design:

- Evidence of effectiveness of the service (strong, moderate, weak, insufficient)
- The cost-effectiveness of service (e.g. cost per avoided hospitalization)
- The relative cost of the service, compared to a comparable service of lower costs and equal efficacy (e.g. low-urgency ED visits)
- Actuarial assessment of the impact of a change in cost-share, and a sensitivity analysis of expected utilization change per unit cost change
- Assessment of potential impact of cost-share change on consumer satisfaction
- Assessment of ability to adjudicate claims for differential service cost-shares (e.g. coverage of service only for one gender)

Group Health determined through its experience with its Total Health program that an annual premium savings incentive per employee of $400 resulted in 94% participation in the benefits program. Given this significant result, we believe that a premium savings incentive of $500 annually is sufficient incentive for up to 97% of eligible members to enroll in a VBID plan.

5. How often do plans and issuers re-evaluate data and plan design features?

Contracts with purchasers are renewed on an annual basis, and the benefit structure can be modified at the time of renewal. Additionally, Group Health negotiated a multiyear contract with its union labor force.

- **How is the impact of VBID on patient utilization monitored?**

Group Health has developed a prototype dashboard to monitor key metrics expected to change with the introduction of the VBID. Purchaser specific data from the Health Risk Assessment (e.g. self-reported health status), quality measures, and pharmacy trend data are all monitored.

- **How is the impact of VBID on patient out-of-pocket costs monitored?**

We are not currently monitoring this impact.

- **How is the impact of VBID on health plan costs monitored?**

The overall per member per month total cost is monitored.

- **What factors are considered in evaluating effectiveness (for example, cost, quality or utilization)?**

Our dashboard measures cost, quality, utilization and productivity.

Overall, an annual evaluation of performance measures and reporting is recommended, and employer reporting for population outcomes is essential. Measures on utilization, costs, medication adherence, preventive visits, and scheduled chronic disease maintenance are all used for an effective evaluation of the program. The number of reports and details provided depends on the size of the employer. Reports may include some of the following measures: total loss ratio, cost & utilization, large claims, continuance table, top 20 providers used, top 20 drugs used, prescription drug by therapeutic class, prescription drug substitution, claims triangle, website utilization, DxCG risk adjustment, effectiveness of care (using HEDIS measures), care management/appropriateness of care, clinical variation, customized strategic summary, and post-hospital discharge (PHD). In addition, lifestyle coaching participation can be reported on a group-specific basis for outbound campaigns on tobacco, nutrition, physical activity, and stress (including early depression).

6. Are there particular instances in which a plan or issuer has decided not to adopt or continue a particular VBID method.

- **If so, what factors did they consider in reaching that decision?**

We are in the first year (2011) of implementing the VBID pilot program. The most challenging VBID pilot program requirement to effectively implement has been the biometric screening. Group Health required this as part of our pilot program launch in order to achieve additional baseline health metrics for the individual and for the employer. Implementation challenges include the added cost of biometric screening for the employer, and the logistics of screening, especially for employers with multiple worksites.

7. What are the criteria for adopting VBID for new or additional preventive care benefits or treatments?

All USPSTF A and B level services and ACIP approved immunizations are covered at no cost share to the member under the Affordable Care Act. To be included in VBID, additional preventive services would need to have a strong evidence base and be included in our current library of clinical guidelines.

8. Do plans or issuers currently implement VBIDs that have different cost-sharing requirements for the same service based on population characteristics (for example, high vs. low risk populations based on evidence)?

All pilot VBID plan designs are now implemented with high and low value services for the entire population regardless of risk stratification. Additionally, Group Health has plans to implement an approach based on population characteristics. For example, ultrasound screening for abdominal aortic aneurysms is recommended only for older males who have smoked during

their lifetime, and in turn we desire to limit the waived cost-share to males only. Unfortunately, our current data systems do not support the identification of smokers among this group, and therefore the waiver would have to apply to all older males within a specific age bracket. This is an excellent example of how VBID makes claims adjudication more complicated, and requires the ability to modify the rules as evidence changes.

9. What would be the data requirements and other administrative costs associated with implementing VBIDs based on population characteristics across a wide range of preventive services?

The administration of VBID claims requires a rules engine in the claims adjudication system to target benefits for services to specific populations.

Many plans do not have sufficient data to identify a target population with reliability and precision, especially if these data cannot be derived from actual claims. The use of health risk assessments may provide better precision to identify certain populations.

Other potential sources of costs related to questions, complaints and appeals that may result from the implementation of the system. Our experience has not demonstrated this to be a significant problem, but we invested a major effort in communicating with the staff about the new benefit structure.

A new CPT code for Chronic Disease Maintenance visits would help plans in applying cost share differentials for these maintenance visits. The current CPT codes are shared between maintenance and acute visits, causing difficulty in administration.

10. What mechanisms and/or safety valves, if any, do plans and issuers put in place or what data are used to ensure that patients with particular co-morbidities or special circumstances, such as risk factors or the accessibility of services, receive the medically appropriate of care?

-For example, to the extent a low-cost alternative treatment is reasonable for some or the majority of patients, what happens to the minority of patients for whom a higher-cost service may be the only medically appropriate one?

Clinical guidelines should be used to determine authorization for coverage for the higher-cost service to enable those patients to receive the most medically-appropriate care for their situation.

11. What other factors, such as ensuring adequate access to preventive services, are considered as part of a plan or issuer's VBID strategy?

We have implemented lower cost-shares for annual chronic care visits and visits for chemical dependency care. Additionally, we have increased cost shares for advanced imaging procedures and ambulatory surgery.

12. How are consumers informed about VBID features in their health coverage?

In our Total Health launch, employees received many messages over a period of many months, and continue to receive messages. Sound communication about benefits is a key strategy for successful implementation. All features that are part of the benefit design are also included in the members Certificate of Coverage, which provides all details of their coverage.

13. How are prescribing physicians/other network providers informed of VBID features and/or encourage steering patients to value based services and settings?

In our VBID plan, we have reduced cost shares on entire classes of drugs used to treat six chronic conditions. Physician ordering should not be affected since we are not steering patients to specific medications, and only provide reduced cost shares by classes of drugs. Additionally, we have offered a further incentive to encourage our employees to order their chronic medications through Group Health's mail order system. When launching a new plan design such as the ones above, Group Health trains providers on the new product through its provider relations staff.

14. What consumer protections, if any, need to be in place to ensure adequate access to preventive care without cost sharing, as required under PHS Act section 2713?

Network adequacy rules, similar to those currently contained within Washington State law ensure that members have access to the providers at the in-network cost-sharing level.

B. Comments Regarding Economic Analysis

-A number of federal laws (e.g., the Regulatory Flexibility Act) require agencies to provide an analysis of the impact of regulations on small businesses or where there is an annual effect on the economy of $100 million or more.

1. What costs and benefits are associated with expanded use of VBID methods?

-How do costs and benefits vary among different types of preventive screenings, lifestyle Interventions, medications, immunizations, and diagnostic tests?

Each of the services described above carries its own cost/benefit equation. Group Health believes that it has packaged a set of benefits and services in our pilot VBID plans that will achieve long-term cost control and member engagement in their health over a period of several years.

2. What policies procedures, practices and disclosures of group health plans and health insurance issuers would be impacted by expanded use of VBID methods?

- **What direct or indirect costs and benefits would result?**

Increased reporting, an important feature of VBID plans, carries additional cost and additional benefit to the member, employer and care delivery system. Health plans will have to become more efficient about creating such reporting and more creative in translating the meaning of such information to both the individual member and the employer. There is an opportunity with VBID plans to assist individuals with information and tools to become more actively engaged in their health status and health care

- **Which stakeholders will be impacted by such benefits and costs?**

Employers, individual members, providers and governmental payors will all be impacted by such benefit and costs.

3. What impact would expanded use of VBID methods have on small employers or small plans?

- **Are there unique costs or benefits for small plans?**
- **What special considerations, if any, should the Departments take into account for small employers or small plans?**

Group Health believes that VBID plan designs are beneficial to employers of all sizes. However, health plans will face the challenge of providing detailed reporting on small employer populations, while continuing to protect patient PHI (protected health information).