



February 28, 2011

Office of Health Plan Standards and Compliance Assistance

Employee Benefits Security Administration

Room N-5653

U.S. Department of Labor

200 Constitution Avenue NW

Washington, DC 20210

Attention: VBID

**Re: Request for Information Regarding Value-Based Insurance Design in Connection With Preventive Care Benefits**

**Position:** In the Patient Protection and Affordable Care Act implementation process, allow business coalitions, employers, unions and other plan sponsors the maximum flexibility to appropriately design and modify health care benefits to ensure the ability to continue to deliver high-value health care to employees and their dependents.

Dear Sir or Madam:

The National Business Coalition on Health (NBCH) appreciates the opportunity to comment on the request for information on how group health plans and health insurance issuers can employ value-based insurance design in the coverage of recommended preventive services under the Patient Protection and Affordable Care Act (PPACA), which were issued by the Departments of Health and Human Services, the Employee Benefits Security Administration, and Internal Revenue Service on December 28, 2010 (75 Fed. Reg. 75 FR 81544). We appreciate the time and consideration given to our following comments.

In terms of background, NBCH is comprised of a national network of state and local health coalitions, which represent 7,000 public and private employers, primarily self-insured employers, who voluntarily provide health insurance to 25 million Americans. NBCH and our member employer coalitions have a long history of value-based purchasing of health care and working as an organization, namely through the eValue8 health plan performance evaluation instrument, to encourage member coalitions, employers and providers to collaborate at the local, regional, and national level to improvement in the quality, safety, and efficiency of health care. The cornerstone of our health care policy platform is to ensure our nation has a sustainable, accessible, and affordable high quality health care delivery system. We firmly believe in the following principles which work to strengthen and support value-based insurance design (VBID):

- ✓ Greater understanding and accountability on the part of providers and consumers, leads to more cost-effective use of health resources.
- ✓ A transparent health care system in which the price and outcomes of standardized measures is available to the public is essential to our national, as well as our local coalition efforts to improve the quality and value of health care.
- ✓ Our member coalitions, their employer and union members, and the plans that they work with must have flexibility to appropriately design and modify health care benefits so they are able to continue to deliver high-value health care to employees and their dependents.
- ✓ VBID addresses the incentives and disincentives that affect beneficiary behavior as it relates to their health and health care- all strategies work together to produce better health. There are two overarching categories of VBID incentives- direct financial incentives and non-financial consumer support incentives.
- ✓ NBCH defines VBID broadly to include other types of incentives and consumer support to help ensure that consumers will utilize high-value services, adhere to preventive services and treatment guidelines; select high performance providers (doctors, nurse practitioners, pharmacists, hospitals, retail health clinics); and adopt other healthy behaviors.
- ✓ The opportunity to utilize VBID is not limited to large national companies, and the foundational elements are the same regardless of the size of the organization. The key is to align the most appropriate incentives so that everyone- the consumers, providers and the employer- is working toward the same goal of better quality, better value at a better cost.

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To inform future guidance, this RFI requests comments generally on VBID in the context of recommended preventive services, as well as comments to specific questions. The following is NBCH's response to the RFI questions:

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

To incent beneficiary behavior means to motivate beneficiaries to make the best choices of healthy behavior and treatment alternatives. Effectiveness is defined by the results produced by appropriate beneficiary behavior. Improving the U.S. health care system requires simultaneous progress toward “three aims”(i.e. Institute for Healthcare Improvement's Triple Aim Initiative) which are improving the consumer's experience of care, improving the health of populations, and reducing per capita costs of health care provided. These goals may involve the need to make new investments in one arena to support overall long term cost and value improvement. Effectiveness of a benefit design also can be evaluated by consumer uptake of recommended preventive services; setting of care delivery [i.e. – in/out of network, ambulatory/in-patient setting]; impact on medical spending; and clinical outcomes.

There currently are two major types of plan design tools (direct financial and nonfinancial consumer support tools) being used to encourage patient behavior. However, it is difficult to define which are the most effective as effectiveness is specific and contingent on the circumstances of the patient population.

Direct to consumer financial incentives/rewards- cost-sharing provisions

1. Premium reduction- this is a monthly reminder/incentive
2. HSA contributions
3. HRA- reward for completion
4. Access to enhanced benefits or programs (lower copays, deductibles)

5. Other financial rewards [gift cards, raffle entries, etc.]

Nonfinancial consumer support incentives:

1. Comparative quality information
2. Monitoring gaps in care
3. Personal health records and self management tools
4. Shared treatment decision support
5. Environmentally/culturally sensitive care
6. Patient coaching and counseling

**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, scans)?**

A sizeable proportion of NBCH's coalition members' employers provided plans with generous first dollar coverage for preventative services prior to the passage of PPACA. All of the tools (prevention, diagnosis, treatment and monitoring) are interconnected and should be unified relative to preventive services and to management of specific conditions such as diabetes. Lifestyle choices, adherence choices, provider choices need to be connected. It is important to have an all encompassing prevention and wellness strategy so that it's more effective in the long-term.

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

Plans and issuers have used various quality metrics to determine high and low-value providers, networks, and hospitals for many years. In addition, purchasers have specified more cost-effective settings (e.g. ambulatory vs. inpatient) and treatment modalities (e.g. laparoscopic surgery vs. open) where there is no evidence of a difference in quality, but evidence of lower cost or quicker return to work. It is important to utilize available quality metrics as the key variable in making distinctions. However, when quality measurement is less of a differentiating factor, then we have also seen incentives to access high quality providers using regional reference pricing. Ultimately, more transparency and comparative information on quality and pricing is needed to be publicly accessible.

To make decisions about these incentives and disincentives, employers have relied on their own claims data, carrier-wide data, larger databases like Ingenix and other regional sources. In that regard, strengthening access to all payer data is fundamental to improving the decisions relating to incentives and to national public reporting efforts. De-identified billing and discharge data in every state, and all similar datasets held by federal agencies (i.e., HHS, Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Quality & Research (AHRQ), etc.) must be subject to existing freedom of information (FOI) laws. The framework for de-identified billing and discharge data must be strengthened, namely by defining a mandatory, uniform national structure for gathering and releasing billing and discharge data in every state and within the federal government. However, in addition to the need for the federal government to harmonize data gathering there is a critical need for broad access to provider-specific, episode-specific data to support evaluation and scrutiny by independent groups, such as employer coalitions and consumer groups.

**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 service?**

The Center for Value Based Insurance Design has conducted literature reviews and its own research to better understand incentive models to encourage use of high value care. According to research and analysis by the Center for VBID, the academic evidence is clear that charging high copayments or deductibles for evidence-based services reduces their use, leads to lower quality of care and potentially higher costs. This finding is consistent across all types of services including ambulatory office visits, mammograms, medications for managing chronic disease and other quality metrics. Equally troublesome is that the impact of high levels of patient cost-sharing is concentrated on low-income populations, supporting the view that high copayments exacerbate health disparities. Value-based insurance design, through lowering copayments for such high-value services [as in Sec 2713], is demonstrated to improve quality without increasing aggregate medical expenditures and can be judiciously installed to accommodate varying socio-economic issues. Most VBID implementation has revolved around lowering patient cost-sharing for effective medications that treat high volume chronic diseases. In most instances cost-sharing has not been completely eliminated as is the case of Sec 2713.

**5. How often do plans and issuers re-evaluate data and plan design features? What is the process for re-evaluation?** It is NBCH's experience with insurers that they evaluate plan design features on an ongoing basis and usually make changes to plans annually as blocks of business renew with plans.

In terms of the process, it seems that some insurers have cross-functional teams that analyze: overall return on investment (ROI); financial performance looking at claims data for utilization trends; internal operational issues that affect financial performance and customer satisfaction; competitor and market activities; regulatory mandates; customer feedback. Another issue is the challenge of measuring cost savings results based on change in one factor of behavior. As an example, does no copay for hypertension drugs actually improve adherence, and lower blood pressure, and save money? True ROI is very difficult to prove and requires advanced data systems and analytics, smaller plans may not have the intensive resources to invest in the complex analysis required. There are many other cost savings activities that are much easier to achieve.

**6. Are there particular instances in which a plan or issuer has decided not to adopt or continue a particular VBID method?** It is our understanding that plans look to their customers to help define what design features are desired (eg. benefits, incentive structures, biometric screening, health risk assessments, communication aids, wellness program content, reporting) and what is most cost-effective, clinically relevant and feasible to produce.

**If so, what factors did they consider in reaching that decision?** Not all employers have the internal capability to manage all the potential VBID/wellness features. Insurers have to assess and balance employer size, employee confidentiality, cost of delivering program features and employer commitment to VBID concepts when designing and offering these products.

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

Our experience with employers and coalitions suggests that important criteria for VBID adoption include the range of the population in need of the intervention, the expected return on investment over the course of employment. Consideration needs to be given to ancillary services that need to be provided to

influence the effectiveness of an intervention- including the cost of such services, the criticality of the coverage (life or death), as well as the strength of the evidence as a preventive intervention.

In addition, PPACA Sec 2713 clearly describes the criteria for adoption the V-BID program as follows:

- Receiving an A or B rating from the United States Preventive Services Taskforce
- Immunizations recommended by the Advisory Committee on Immunization Practices
- Preventive care and screenings supported by the Health Resources Administration (HRSA) for infants, children and adolescents
- Additional preventive care and screenings recommended by HRSA for women

**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)?**

Yes, we have observed different levels of sophistication by which an employer or carrier makes cost sharing requirements. They vary based on employee characteristics (e.g. disease state) or behaviors (success of reaching health goals or participation in a coaching program) of the consumer. Achieving lower risk factors (quitting smoking, weight loss, seat belt use, low blood pressure, cholesterol and stress management) are characteristics and behaviors that are taken into consideration. We are aware of plans that take characteristics and behaviors into consideration when setting rewards and cost-sharing requirements.

**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?**

Many of the preventive services can be tracked using claims, although there exceptions like immunizations and smoking cessation counseling. If we include in the meaning of “prevention” adherence to chronic care guidelines to “prevent” secondary adverse events, data requirements would be extended to items like pharmaceutical possession ratios. Many of the important “outcome” measures can only be found in medical records and/or HRA instruments (smoking status, blood pressure, laboratory results). These clinical results are hard to obtain from physician offices but may be more accessible when connected with a comprehensive health and wellness program involving interventions such as on-site blood drawings and blood pressure measurement. Demographic information (gender and age) also is useful which is derived from employment information.

**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 level 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?**

From NBCH’s experience, typical mechanisms to ensure medically appropriate care to patients with special circumstances is provided proven medical management techniques, such as prior approval, step therapy and utilization management of chronic care. We have found that these activities can help to make the consumer cost-sharing the same or comparable to the lower cost option.

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

There are direct financial elements such as direct reward, variable copayments, variable deductibles and premium share, as well as non-financial elements, namely support mechanisms such as coaching and counseling, quality provider information, reminder mechanisms (to patients, to doctors, etc.) to close gaps in care, culturally sensitive communication to plan members, and consideration of health literacy limitations. The key is to align the most appropriate incentives so that everyone- the consumers, providers and the employer- is working toward the same goal of better quality, better value at a better cost

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

Communication and messaging are essential to educating consumers about VBID options. As an example, a personal health record in a plan could be designed to send messaging appropriate for age, gender, health needs and circumstances. Employers and plans should utilize a variety of social networking mechanisms such as text messaging, e-mail, hand held device to reach individuals according to their communication and social media preferences. The communications should be tailored to the individual by using the expansive informatics that is accessible to plans. Plans need to carefully utilize resources and leverage information to lessen gaps in care.

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

Large health plans in particular have an impressive variety of tools and capabilities. But there are two problems, consumers don't know about them unless their adequately marketed, and second, doctors don't know about them. Plans need to try to be a more supportive resource to practices to serve as an extension of their practice. Plans should be communicating with providers in an appropriate way to allow them to know what's covered for individual patients.

Plans have considerable opportunities to help support and improve the care provided by physician practices. Plans should provide doctors with education and support such as general education of guidelines and health plan offerings, notification of member eligibility, continuing CMEs , reminder systems for gaps in care, promotion of coverage- including codes to use for reimbursement, incentives for conducting screening, incentives for program referral (education about a plan-sponsored smoking cessation program), as well as pay for performance by incorporating patient completion of preventive serves as a component or factor in physician reward structure.

Plans can provide care managers that can interact with members on behalf of the practice. They already are spending money on this type of patient support, but their uptake and effectiveness is compromised by lack of a connection with physician practices. Carriers also can provide physician practice support for workflow changes to support tracking and action on gaps in patient care. They also can establish customized care plan approval created by plan for physician/practice approval.

**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?**

There needs to be an employer firewall between data collected by a third party and personal health information. Information needs to be presented in a culturally sensitive and circumstantially sensitive manner. Thank you for your consideration of these comments. If you have any questions, please do not hesitate to contact me at [awebber@nbch.org](mailto:awebber@nbch.org), or 202.775.9300.

Sincerely,

A handwritten signature in black ink that reads "Andrew Webber". The signature is written in a cursive, flowing style.

Andrew Webber  
President and CEO