VIA ELECTRONIC SUBMISSION

February 28, 2011

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: HHS-OS-2010-002
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Mr. Larsen,

As the industry leader in well-being improvement, we currently provide our health promotion, chronic care management, wellness and prevention services, both domestically and internationally, to approximately 40 million people on behalf of more than 1,000 employers and more than 100 health plans. Our purpose is ***to create a healthier world, one person at a time*** by delivering solutions that:

1. Keep healthy people healthy
2. Reduce health-related risks
3. Assure the provision of evidence-based care to those who are ill

In pursuit of our purpose, we are strong advocates of primary, secondary and tertiary prevention, and we appreciate the opportunity to comment on the Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care Benefits.

We strongly support the provisions of the Patient Protection and Affordable Care Act that require health plans to offer preventive services at no out-of-pocket cost to enrollees. This is a benefit that we offer our own employees and we believe it is essential to promoting optimal use of these services. Within our own self-insured employee health plan, we utilize many other incentives, in addition to no-cost preventive services – to promote optimal utilization. Our plan and incentive design incorporate the most current research in the field of behavioral economics to encourage our employees to become active participants in protecting and improving their well-being. Our answers to the questions below are drawn from our experience as a self-insured provider of health benefits to our employees.

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Comments Regarding Regulatory Guidance

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?**

Healthways uses a number of tools to incentivize preventive behaviors in our colleague population. These include:

- Cash incentives into a Health Savings Account (HSA) for:
  - Completing our proprietary health risk assessment tool, the Healthways Well-Being Assessment and biometric screening
  - Healthy outcomes including:
    - BMI below 27 or healthy waist circumference,
    - Nicotine free
    - Blood pressure below 140/90
    - Cholesterol (below 200)
    - Improving screening score by 5 points (year over year comparison)
  - Visits to fitness centers
  - Utilization of health promotion and tracking web portal
  - Preventive screenings
  - Participation in indicated interventions such as
    - Smoking cessation
    - Lifestyle coaching
    - Chronic condition management programs.
- Points redeemable for prizes for the same participation metrics above. These incentives cover all colleagues not just those that enroll in our medical plans.
- No out-of-pocket costs for preventive visits. Prevention services include but are not limited to the requirements under the Patient Protection and Affordable Care Act.
- Health plan premium incentives
  - In order to maintain eligibility to participate in our lowest deductible health plan, employees are required to complete the Well-Being Assessment, biometric screening and, if indicated, one of our well-being promotion programs.
  - Employees that use tobacco are charged higher premiums unless they complete our smoking cessation program.
- A Diabetes Maintenance Medication program that offers all diabetes drugs at a $7 co-pay if the participant participates in our chronic condition management program and completes regular preventive visits.
- Incentives are offered equally to employees and their spouses/partners.

Incentives play an important role in driving behavior change. In our experience, the loss-aversion incentives such as requiring participation in a program to maintain eligibility for our lowest deductible plan or charging higher premiums for tobacco use are the most effective in driving participation in our programs.

However, while incentives are important, to be effective they should be coupled with resources that support ongoing maintenance of healthy lifestyles. This support may include one-on-one coaching to achieve specific goals and, most importantly, ongoing efforts to establish a culture of well-being. For example, Healthways offers many healthy food options in our cafeteria and

provides detailed nutrition information for each item. We have introduced well-being ambassadors, employees who volunteer a portion of their time to focus on well-being initiatives. At our headquarters location our ambassadors lead "work-out Wednesdays" on campus and employees who participate are allowed to wear athletic clothing to work all day. We also rely on our senior leadership team to be engaged sponsors of our well-being programs. Further, we maintain a robust communication plan to regularly educate employees about healthy behaviors and how they can improve their own well-being.

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, and scans)?

Some of Healthways' programs help employees address general health risks by encouraging them to increase physical activity, promoting healthy eating and relieving stress. We also provide chronic condition management programs that cover more specific interventions targeted to individuals with cancer, diabetes, back pain, etc. Finally, we have created a special campaign around diabetes maintenance medications because of the prevalence in our population. Healthways looks at engaging our entire population by keeping healthy people healthy, lowering risk for our populations at risk and supporting optimal management of chronic conditions for our populations with health conditions.

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?**

Healthways works closely with our medical, pharmacy and behavioral health partners to track the provider utilization of our population. While we do not actively promote specific providers and treatment centers, we track and periodically review the most utilized providers used by our population. With a total enrolled population of 2,500, this has not been an area of focus in our benefit and well-being strategies. That being said, we believe that both efficiency and effectiveness of services is enhanced when providers are working at the top of their license or professional capability.

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?

Healthways uses claims data, the Healthways Well-Being Assessment and biometric screenings to identify and prioritize population risks. We use these data to create incentive models designed to encourage healthy behavior across our entire population. We design incentives to encourage employees who are healthy to maintain their health, to mitigate risks for employees who are at risk, and to encourage employees with chronic conditions to proactively manage their conditions and improve their well-being.

5. How often do plans and issuers re-evaluate data and plan design features? What is the process for re-evaluation? Specifically:

Healthways re-evaluates our plan design annually, including incentives, communications and other investments in promoting a culture of well-being.

a. How is the impact of VBID on patient utilization monitored? Each year, Healthways works with our health benefit consultant and health plan partners to determine our levels of appropriate utilization (e.g., preventive visits) and inappropriate utilization (e.g., unnecessary ER visits). Once we review data, we rely on the latest research in behavioral economics and behavior change models to refine our strategies and implement plan design features and incentives to encourage healthy behavior and appropriate utilization.

b. How is the impact of VBID on patient out-of-pocket costs monitored? Each year Healthways monitors employees' out-of-pocket costs and various utilization measures – including preventive services, medication adherence, and others - to determine if the level of out-of-pocket costs is appropriate or if there are any concerns about possible barriers to care. If our evaluation determines that we are discouraging proper utilization of services we will adjust plan design features and incentives accordingly.

c. How is the impact of VBID on health plan costs monitored? Each year we evaluate the cost of providing health benefits and incentives and make adjustments to reduce underlying risk factors of our employees and promote appropriate utilization. For example, in addition to providing preventive services with no out of pocket costs, we have experimented with providing financial incentives to employees who receive recommended preventive screenings. We have found that within our employee population utilization of preventive screenings remains very high even without additional incentive payments and, in some cases, we have reduced or eliminated these additional incentives. We remain committed, however, to providing coverage of preventive services at no out-of-pocket cost.

d. What factors are considered in evaluating effectiveness (for example, cost, quality, utilization)? Healthways evaluates a number of factors including overall ROI. Specific factors included in our evaluation include: increased appropriate utilization, decreased inappropriate utilization, cost per colleague, prevalence of unplanned absences, and hospital days. We utilize a scorecard to capture a lengthy list of metrics that help us to determine the focus of our resources for the next year.

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?

And

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

Within our employee health plan, we will only implement a VBID method if we measure the effectiveness of the incentive. Once we have implemented, we will use pre-determined measurements to determine the effectiveness. We re-evaluate our plan design features each year and if a particular VBID feature does not produce the desired results, we will discontinue its use. Likewise, if we find a more effective incentive, we will modify the plan design accordingly.

For example, next year we plan to modify our diabetes maintenance medication program to incorporate advanced behavioral economics models developed by our subsidiary HealthHonors. HealthHonors has developed a web-based application (and IVR system for those without Internet access) that provides users with economic and non-economic reinforcement (incentives) for performing healthy behaviors. The HealthHonors' system leverages behavioral economics science to help users make consistently good choices and have fun in the process. Recent evaluations of the HealthHonors medication adherence program found that it consistently achieves high rates of employee engagement and is substantially more effective than traditional incentive programs.

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)?

For our employee health plan, the only plan design feature we use that has different cost-sharing based on population characteristics is that employees who use tobacco products are charged higher premiums, unless they enroll in our tobacco cessation program. Apart from that, all employees are eligible to earn up to the same level of HSA incentive contributions each year, regardless of risk.

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?

For our employee health plan Healthways uses claims data, the Healthways Well-Being Assessment and biometric screenings to identify and prioritize population risks and to create incentive models designed to encourage healthy behavior across our entire population, and to evaluate the effectiveness of our plan design features. In our experience, the cost of administering a robust incentive program is approximately five percent of total program costs.

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?

We utilize our current high deductible plan design to encourage employees to make informed choices about their appropriate level of care. We encourage the colleague to have informed conversations with their provider to determine the most effective utilization of health services. Also, we provide access to tools to compare costs for similar procedures in their geographic locations. In the event a higher-cost product or service may be the only medically appropriate one for a particular patient, the service may be covered in accordance with applicable plan design and cost-sharing. A patient or provider may also submit requests to review coverage decisions.

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 provide access to preventive services with no out-of-pocket costs to employees. The primary factor for all of our strategies is the effectiveness of encouraging improved well-being in our population. We do this by encouraging all employees to participate in a comprehensive well-being assessment and by offering coaching and other interventions to help improve emotional, financial, social and community health in addition to their physical health.

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

We use a variety of communication modalities including new employee orientation, e-mail, meetings, mailers, leadership training, desk drops, posters, flyers, and guides. We are moving towards text- and application-based communications to make sure we are reaching our entire population.

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

We do not have a communication strategy for the provider community as our population is only about 5,500 (employees and dependants) total members and we are spread over 26 locations.

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?

We recognize that provider networks are an important plan feature. We believe the requirement to provide access to preventive services with no cost sharing for the provision of services in-network only is appropriate as long as health plan enrollees have reasonable access to network providers. In this context, "reasonable access" should take into account possible access barriers, including at least the location of providers, whether they are accepting new patients and language spoken. To help ensure accessibility of in-network providers, plans can effectively and efficiently utilize other licensed health professionals to administer some preventive services, such as immunizations, lab tests, etc.

<u>Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act</u>

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?

The fundamental assumption underlying comprehensive well-being improvement efforts is that the benefits significantly exceed the costs. Evidence supporting this concept can be found in two recent actuarial studies that demonstrate the potential value for even modest risk reductions in both the under-65 and over 65 populations[i] [ii]. Further evidence of the effectiveness of individual components of a comprehensive well-being improvement solution abounds in the literature. Although individual interventions have different pay-off periods – chronic care management yields net savings much faster than tobacco cessation, for example – the additive and cumulative effects of a comprehensive solution provided over a lifetime will significantly reduce progression to disease, demand for services and costs. Given that conclusion, the use

of any VBID techniques that drive individuals' engagement in such programs is desirable as long as the cost of the design and intervention contributes to net cost reduction for the population.

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

The aggressive use of proven VBID techniques to drive population engagement in well-being improvement solutions assumes a strategic commitment of plans, providers, employers and governments to a delivery and payment system with an increased, if not exclusive, focus on prevention and quality. The adoption of such a strategic focus would affect the policies, procedures, practices and disclosures of all stakeholders, although until the structural components of the reformed system are in place, it will be difficult to determine the impact on any specific stakeholder group. However, , we can expect, as a nation to be healthier, to have lower per capita demand for care and significantly lower per capita 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?

Small employers are particularly vulnerable to the cost of low well-being among their employees – both because rising premium costs can be particularly burdensome and because of the burden for absences of personnel for reasons related to poor health or well-being. As noted above, the fundamental assumption underlying comprehensive well-being improvement efforts is that the benefits significantly exceed the costs. Because small employers are especially vulnerable to the cost of low well-being among employees, they also have the greatest opportunity to benefit from proven investment in well-being improvement. Accordingly we recommend that the Department ensure that guidance on value based insurance design and incentives makes these plan design features available to all payers. The inclusion of the costs of such programs as part of "medical cost" has already been incorporated in the MLR formula and regulation so there is no meaningful downside for a plan to make these services available.

We appreciate the opportunity to submit our comments. We would welcome the opportunity to provide additional information about our experience in promoting prevention, health and overall well-being.

Sincerely,

Stefen F. Brueckner
President

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[i] Rula EY, Pope JE and Hoffmann JC. Potential Medicare Savings through Prevention and Risk Reduction. *Popul Health Manage*. Popul Health Manag. 2011;14 Suppl 1:S35-44.

[ii] Rula E, Pope JE and Hoffman JC. Savings Potential from Prevention and Risk Reduction for the Commercially Insured. Healthways Center for Health Research. May 2010.