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United States Senate

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The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Dear Secretary Geithner, Secretary Sebelius, and Secretary Solis:

I am writing to comment and obtain clarity on the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act. I am concerned that the interim final rule includes a provision that may negatively impact employers who may have products or services that could fall under the requirements related to value-based insurance design as part of their offering of preventive health services.

I have always been a champion of health programs that improve quality and help to lower costs. I believe that we need to spend healthcare dollars more wisely and in a way that incentivizes patients to be thoughtful consumers, allowing them to take an active role in their care. Unfortunately, I am concerned that the interim final regulations may not allow innovative employers to continue offering insurance designs that incentivize employees to make informed healthcare decisions, particularly in the absence of clear guidance that recognizes the important role of value-based plan designs that promote the use of high-value, cost-effective healthcare providers and services.

According to the preamble, the interim final regulations "permit plans and issuers to implement designs that seek to foster better quality by allowing cost-sharing for recommended preventive services delivered on an out-of-network basis while eliminating cost-sharing for recommended preventive health services delivered on an in-network basis." It is my understanding that the

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interim final regulations in their entirety apply to group health plans and health insurance issuers for policy years beginning on or after September 23, 2010, unless the plan meets the grandfather provision. However, the comment period for the interim final rule ends on September 17, 2010, providing less than a week for the Departments to review comments and make any necessary modifications. It is also my understanding that the Departments are developing additional guidelines regarding value-based insurance designs and are seeking comments related to the development of those guidelines. This means that many important questions about how the interim final regulations apply to plans – including plans that offer products or services related to value-based insurance design – are not likely to be completely resolved by the implementation date.

This value-based insurance design provision is troubling for many companies who are providing their employees with information on costs and quality so that they can make informed healthcare decisions. One large self-insured company analyzed its paid claims data from 2006-2008 in its operating area and discovered that a colonoscopy can cost anywhere between \$900 and \$7,200. That is an eight-fold variance. In order to encourage employees to become active consumers, this company allows employees \$1,500 for a routine colonoscopy for individuals living in that geographic area. This company provides its employees with the names of providers who fit in that range and employees are then given the ability to choose a high-quality, cost-effective provider. If an employee wants to spend more than \$1,500 for a colonoscopy, then that employee is responsible for the difference in the amount. This is a pilot program, but the company plans to expand it nationwide in 2010.

I am concerned that the interim final regulations could thwart the ability of companies to offer preventive care while continuing to incentivize employees. If so, this could result in increased healthcare costs and negatively impact quality of care.

In order to obtain more clarity on the value-based insurance design provision of the interim final regulation, I would request the following information or clarification:

- How do the Departments define “value-based insurance design”?
- Would the type of arrangement for colonoscopies, described above, be considered “value-based insurance design”? Would it be allowed under the interim final rule if the plan design is not grandfathered and applies to both in-network and out-of-network providers? For example, if an in-network provider charges \$2,000 per colonoscopy, would the \$500 difference be considered not allowable as a cost-sharing requirement?
 - If the answer is yes, do the Departments believe that the interim final rule encourages more expensive care by insulating consumers from higher costs for the same procedure?
- In the event that a company does not currently have value-based insurance design but decides to implement value-based insurance design, will that company lose its grandfather status? If so, what would the statutory basis be for the loss of grandfathered plan status in such a case?

- Will the interim final regulation impede the ability of patients to see high-quality providers or Centers of Excellence?
- When do you expect additional guidelines regarding value-based insurance designs to be issued and when will those guidelines go into effect?
- Will the Administration consider delaying implementation of the value-based insurance design provision in the interim final regulation, given that comments have been requested relating to the development of such guidelines?
- In previous guidance issued by the Departments, there has been explicit recognition that plans will need to make some decisions on a "good faith" compliance basis in the absence of Department guidance in resolving key open issues. Will the Departments consider issuing a statement related to the value-based design provision to clarify that for the purpose of the first full plan year, beginning on or after September 23, 2010, the Departments acknowledge that group health plans and health insurance issuers offering group or individual health insurance coverage may be required to make similar "good faith" determinations on the applicability of the first dollar coverage for preventive services relative to value-based plan designs?

Thank you for your time and consideration of these important questions and comments. I look forward to your prompt response.

Sincerely,


JOHN ENSIGN
United States Senator