



February 28, 2011

141 Northwest Point Blvd
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

Daniel Maguire, Director
Office of Health Plan Standards and Compliance Assistance
200 Constitution Ave, NW, Ste N-5653
Washington, DC 20210

Executive Committee

President

O. Marion Burton, MD, FAAP

President-Elect

Robert W. Block, MD, FAAP

Immediate Past President

Judith S. Palfrey, MD, FAAP

Executive Director/CEO

Errol R. Alden, MD, FAAP

Board of Directors

District I

Carole E. Allen, MD, FAAP
Arlington, MA

District II

Henry A. Schaeffer, MD, FAAP
Brooklyn, NY

District III

Sandra Gibson Hassink, MD, FAAP
Wilmington, DE

District IV

Francis E. Rushton, Jr, MD, FAAP
Beaufort, SC

District V

Marilyn J. Bull, MD, FAAP
Indianapolis, IN

District VI

Michael V. Severson, MD, FAAP
Shakopee, MN

District VII

Kenneth E. Matthews, MD, FAAP
College Station, TX

District VIII

Mary P. Brown, MD, FAAP
Bend, OR

District IX

Myles B. Abbott, MD, FAAP
Berkeley, CA

District X

John S. Curran, MD, FAAP
Tampa, FL

RE: 45 CFR Part 17 - Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care

Dear Mr. Maguire:

The American Academy of Pediatrics (AAP), a non-profit professional organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates this opportunity to comment on the Office of Health Plan Standards and Compliance Assistance Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care, as published in the Federal Register on December 28, 2010.

In testimony provided before the United States Senate on Health, Education, Labor and Pensions in early 2009, a Fellow of the American Academy of Pediatrics (AAP) stated that preventive health care is a fundamental investment in the health of all children and adults. The testimony noted the vital contribution preventive care plays not only in ensuring the future health of children, but also the future economic infrastructure of the United States.

In pediatrics, preventive health is vital because it can have lifelong impacts. Inadequate attention to preventive care in the design of any health care system mortgages the future health and welfare not only of children, but of society itself. Research across a broad range of interventions has shown that preventive health and wellness for children consistently produces a high return on investment. Three key principles govern pediatric preventive care: 1) prevention works, 2) families matter, and 3) health promotion is everybody's business.

Rapidly increasing scientific, evidence-based, evidence-informed, and/or evidence-influenced knowledge consistently emphasizes the relationship between optimal child health and welfare, and adult health. There is no greater testament to the value of prevention and early intervention during childhood than the demonstration of poor adult health directly related to the absence of optimal care during childhood. Any efforts undertaken to restructure health benefit plans to accommodate a growing interest in value based insurance design for preventive care services must understand the potential risks that could result in diminished access to a set of benefits that promote healthy children today and a creative and productive workforce tomorrow.

Thank you for the opportunity to comment on this request for information. If the AAP may be of any further assistance, please don't hesitate to contact Robert Hall in our Washington, D.C. office at 202/347-8600 or rhall@aap.org. We look forward to future collaborations as you explore this option more fully.

Sincerely,

A handwritten signature in black ink that reads "O. Marion Burton MD". The signature is written in a cursive style.

O. Marion Burton, MD, FAAP
President

OMB:epz

HHS-OS-2010-002 REQUEST FOR INFORMATION REGARDING VALUE-BASED INSURANCE DESIGN IN CONNECTION WITH PREVENTIVE CARE BENEFITS

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, design features, targeted cost-sharing mechanisms)? How is effective defined?*

Many of the tools plans currently deploy are based on experiences in the adult population (eg, disease management, design features, etc.) There are few, if any, examples in the pediatric population. This puts children and families at an immediate disadvantage, and potentially, at serious harm if there are no data to support their effectiveness in children. In a quick scan of the published literature on value-based insurance design, there is a noticeable gap in the number of programs that include children (eg, dependents of employees.) This suggests that before plans make a decision to fold the pediatric population into these innovative insurance products, more studies must be conducted to evaluate their true impact on children's access to services. This is particularly troublesome for children with special health care needs who require preventive care services as well as a wide array of interventions and services to manage and treat their chronic conditions.

One specific area of concern is the use of cost-sharing arrangements in the payment for pharmaceuticals. This approach uses a "demand side" intervention focusing on changing patterns of consumption. All too often plans manipulate out-of-pocket costs without any regards to the therapeutic value of the medication. This new practice is of heightened concern to the Academy because, in the context of children and families, cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes. The availability of therapeutic alternatives for high cost drugs accessed by children with complex conditions is limited. In fact, using the simple equation put forth in determining the "value" of a health care intervention, these drugs could be priced out of the range for many families with low and medium family household income levels.

Furthermore, poorly designed cost-sharing approaches can put children's access to needed services and interventions at risk. A 2008 study published in the *Archives of Pediatrics and Adolescent Medicine* discovered that children in a high cost-sharing group were less likely to purchase bronchodilators, inhaled corticosteroids, and leukotriene receptor antagonists compared with the low cost-sharing group (odds ratio, 0.76; 95% confidence interval, 0.67-0.86) and were less likely to purchase dual agents compared with the low cost-sharing group (odds ratio, 0.70; 95% confidence interval, 0.66-0.75). The cost-sharing level affected the use of asthma medications, with the highest cost sharing group exhibiting significantly lower use of maintenance medications and newer dual agents. There is little debate over the economic reality that families with increased out-of-pocket expenses will not consume medically necessary healthcare services. Many studies demonstrate that when confronted with higher costs, individuals purchase less care.

Additionally, numerous studies have reported out that social environmental determinants also play a role in childhood asthma. In the 1990s, the National Institutes of Health (NIH) sponsored National Coordinated Inner City Asthma Study demonstrated that controlling environmental triggers led to better asthma outcome and decreased emergency room visits. The Harlem Children's Zone Program added more robust home interventions and improved the model. The Children's Hospital Boston further refined this model and achieved even better outcomes (Source: Love AS, Spiegel, J. The inner city asthma intervention tool: best practices and lessons learned. *Ann Allergy Asthma Immunol.* 2006;97(Suppl 1): S36-39; Nicholas S et al. Reducing childhood asthma through community based service delivery – New York City, 2001-2004. *MMWR.* 2005;54(01): 11-14; Office of Child Advocacy, Children's Hospital Boston. Asthma Management Approach Reaps Rewards.

http://www.childrenshospital.org/kidvocate/image/_spring09_final.pdf.) As a result, practice-based improvement activities can be greatly enhanced by community-based interventions. These studies demonstrate the power of combining high quality guidelines-focused clinical care and community interventions to create programs that show substantial clinical improvements and cost savings.

Another specific tool used more frequently is targeted disease management programs (eg, diabetes, asthma, etc.). Although there are a few studies that have demonstrated that these programs can be effective in reducing employers' health care costs and improving patient compliance, these programs often focus on promoting healthy adult behaviors in order to ensure integration into the work place. However, in many cases a child's work place is a school and most of the existing targeted chronic disease management programs fail to include components to aid them integrating into the school setting. Schools play a vital role in promoting the health of children, including health education programs, food services, and promotion of physical activity. These programs, coupled with the delivery of primary care in the medical home, constitute a community-system of care that delivers value and cost-savings to the system.

Current cost-measurement approaches have also obscured value in health care and led to cost-containment efforts that are incremental, ineffective, and sometimes even counterproductive to achieving a balance between cost containment and ensuring high quality care. . Today, health care organizations measure and accumulate costs around departments, physician specialties, discrete service areas, and line items such as drugs and supplies — a reflection of the organization and financing of care. Costs, like outcomes, should instead be measured around the patient. Measuring the total costs over a patient's entire care cycle and weighing them against outcomes will enable truly structural cost reduction, through steps such as reallocation of spending among types of services, elimination of non-value-adding services, better use of capacity, shortening of cycle time, and provision of services in the appropriate settings. (Source: Michael Porter, What is Value in Health Care. *New England Journal of Medicine*, December 23, 2010, pages 2477-2481.)

In the context of pediatrics, the most effective approach plans can employ is to ensure that the child's medical home serves as the nexus for the delivery of all primary and secondary preventive care services. In a medical home, care is delivered or directed by competent, well-trained physicians who provide primary care, managing and facilitating all aspects of pediatric care: preventive, acute and chronic. A medical home provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including those with special health care needs. The Academy has led the development of a body of literature surrounding the medical home, including dozens of studies that examine the impact of care coordination on patient outcomes. Although not necessarily a tool in the traditional sense, the "medical home" is the "clinical engine" needed to ensure that all of the value-based approaches to insurance design are effectively and efficiently deployed.

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)?*

As underscored in question one, a majority of the methodologies for benefit redesign in use today target the adult population. Very few are designed to apply to the unique needs of children. Pediatric preventive health care is fundamentally different from adult preventive care. It is recommended that all children receive regular well-child visits based on the American Academy of Pediatrics' (AAP)/Bright Futures Recommendations for Preventive Health Care, also known as the Periodicity Schedule, which sets out a series of examinations at specific developmental stages. In addition to receive immunizations and important screenings, children are tracked for appropriate growth and developmental milestones.

There is no comparable analog in adult health for this schedule of regular preventive visits to the physician, or for tracking growth parameters such as head circumference and Body Mass Index.

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?*

Health care experts widely view the development of evidence-based practice as essential to improving health care value. This is where the value equation becomes a troublesome approach in pediatrics, particularly with preventive care. Reliance on strict definitions of evidence to compute "value" is a serious detriment in pediatrics because the evidence base is limited. Large-scale clinical trials, and in turn evidence-based medicine, are not as extensive in pediatrics as in adult medicine. The Bright Futures' guidelines referenced earlier in this document state that for many interventions that are commonly performed in child or adolescent care, no, or few, double blind clinical trials have conclusively linked the intervention with intended health outcomes. Absent evidence does not demonstrate a lack of usefulness or value, however. The lack of evidence of effectiveness most often simply reflects the lack of study. Health plans and issuers must take this under serious advisement when determining what separates high value from low value treatment settings, providers, and delivery mechanisms.

A prime example of this is in the area of pharmaceuticals and medical products. Although the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Equity Act (PREA) have taken great strides towards ensuring that medical products and pharmaceuticals used in children are studied in children, there is much work to be done to close the gap between children and adults in collecting information on safety and efficacy. As a result, many drugs, biologics, and medical devices are prescribed for off-label use by pediatricians. Pediatric clinical interventions are less frequently tested in double-blinded, randomized controlled trials. This leads to a serious scarcity in data that can be used to measure the value of a drug, device, or product used in the pediatric population.

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 no specific evidence from health services research to address whether consumer financial incentives should be structured as rewards, penalties, or a combination of the two. In economic situations other than health care, it has been shown that people are less responsive to potential financial gains than they are to potential financial losses, even when the gains and losses are of equal dollar amounts. In the midst of a medical problem, moreover, patients are even less likely than usual to adhere to economists' standard assumptions about rational choices.

Having noted this, there are various data streams plans tap into to acquire the requisite data to model incentive programs. Some gather these data through a Personal Health Assessment (PHA). PHAs are considered important for building an effective wellness program. By having enrollees complete a PHA, health plans are able at an earlier point in time to identify and engage high risk enrollees in making lifestyle and medical care changes to reduce the risk of future illness. However, PHAs are only one source of information an employer should review in developing an understanding of opportunities to reduce or better manage costs. Other data sources include: enrollment demographics, medical and pharmacy claims data, and information from disease management, Employee Assistance Programs (EAP), and disability programs, as well as information regarding worker absence and

productivity. Many, if not all, of these data sources do not collect a comprehensive array of pediatric data.

5. How often do plans and issuers re-evaluate data and plan design features? What is the process for re-evaluation? Specifically: (1) how is the impact of value based insurance design on patient utilization monitored? (2) how is the impact of value based insurance design on patient out-of-pocket costs monitored? (3) How is the impact of value-based insurance design on health plan costs monitored? (4) What factors are considered in evaluating effectiveness?

Given the infancy of value-based insurance design and deployment, empiric evidence on the performance of preventive care interventions is limited. To ensure that access to critical services are not jeopardized or that families do not experience undue financial hardship by increasing out-of-pocket costs, health plans should be required to report out data on a quarterly basis to both the federal government and state insurance commissioners. The Academy recommends that the Institute of Medicine or another objective health services research entity be commissioned to study these questions and recommend a standardized reporting protocol all health plans must use to monitor critical elements of these programs.

6. Are there particular instances in which a plan or issuer has decided not to adopt a particular value-based insurance design method? If so, what factors did they consider in reaching that decision?

The Academy does not have access to the information needed to respond to this question. But, the Academy would like to register its concerns on potential approaches plans will use to identify low-value services. We recognize that building negative incentives into value-based insurance design programs to discourage use of low-value care will involve a number of challenges, including identification of appropriate candidates; the scope of services to be covered (i.e., whether these programs should be expanded beyond drugs to address medical devices, procedures, and diagnostics); and whether these programs should target specific subgroups.

At this juncture, the Academy would like to cite the results of a published article that examined the challenges associated with the identification of low-value services. The more salient study conclusions are noted below:

As many observers have noted, identifying inefficient areas of medicine is surprisingly difficult. Even those interventions deemed excessively costly usually help some patients and may be high value in selected subgroups. Linking incentives to narrow clinical indications will likely require upgrades to existing infrastructure. Current IT systems typically do not capture the level of clinical detail required to link payment to specific indications or patient subgroups, for example.

Of course, targeting low-value services presents political challenges because it involves discouraging care that may offer positive if marginal health benefits. In contrast, providing incentives for high-value services creates “winners,” and thus encounters little resistance.

However, limiting attention to the promotion of high-value services in VBID programs is the health policy equivalent of one hand clapping. It deals with the easy part of the problem and does nothing to dissuade the costly care of marginal benefits (Source: Neumann PJ; Auerbach HA; Cohen JT, PhD; and Greenberg D. Low-Value Services in Value-Based Insurance Design. Am J Managed Care. 2010;16(4):280-286)

7. What are the criteria for adopting value-based insurance design for new or additional preventive care benefits or treatments?

Evidence of effectiveness would seem to be the predominant criteria plans and issuers would use to design value based insurance products for new or additional preventive care benefits or treatments. As noted earlier, this approach creates a serious detriment to children due to the lack a pediatric evidence base from which to draw data. Furthermore, even data are available (eg, comparative effectiveness) the next natural question to be posed is whether the service provides favorable value, and if so, to what degree (eg, high, intermediate/uncertain, or low). Once again, the paucity of data would suggest that pediatric services would be graded as low or intermediate resulting in higher cost sharing strategies which would restrict children's access to these services. The above scenario maps out the dangers in relying on strict definitions of evidence in adopting new or additional preventive care services. Additionally, pediatric preventive interventions sometimes have downstream impacts only after a child has achieved adulthood. This is particularly the case with services and interventions around early brain and child development where removing inappropriate barriers to access to these services is essential to ensuring optimal growth, development, and successful lives. Imposing a time horizon of less than multiple years' time for the value equation is inappropriate in the pediatric context.

8. *Do plans or issuers currently implement value based insurance designs 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 cost-sharing approaches must be “clinically sensitive” to minimize the potential adverse health consequences that may result when increased out-of-pocket expenditures deter use of needed clinical services. The Academy can not report out on whether plans use different approaches in the design of cost-sharing methodologies, except to say that the populations studied are almost exclusively adult. Thus, close to one-third of the US population is often excluded from these studies. Additionally, the Academy does believe that evidence shows that health care resources are more effectively used when cost sharing becomes a function of the value of the specific health care service to a targeted patient group. For example, individuals with coronary artery disease (targeted group) who use high value effective clinical interventions (eg, statins, beta-blockers) should experience no co-payments.

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

To adequately monitor the impact of value-based insurance design on a wide range of outcomes the necessary data have to include information on the utilization of the targeted service or services as well as the utilization of complements or substitutes to the targeted service. So, for example, if the design decreased cost sharing for the use of controller medications for asthma in an attempt to encourage their use, one would want to monitor not only what happens to the number of prescriptions for these medications over time but also the results of what happens to the use of rapid acting beta agents or rescue medications, what happens to the use of over-the-counter preparations that asthmatic families often use for cough in the presence of an asthma attack, what happens to the use of allergy medications, what happens to the likelihood of receiving an annual influenza vaccine, etc. Then the health outcome being targeted would need to be evaluated including excess service utilization (emergency department use, excessive trips to the doctor, hospitalizations, etc.), days missed from normal activities, work missed by parents to care for sick children, etc. Finally, a composite measure of patient or family satisfaction with the new financial arrangement would increase the validity of the design. To understand the marginal impact of the new value based insurance design, however, these same set of outcomes would need to be monitored in a comparable set of patients who were not exposed to the new design in order to know precisely what was being induced by the new arrangements and which changes may have been occurring for reasons unrelated to value-based insurance design.

The Academy also harbors special concerns for the population of children with special health care needs or multiple complex conditions. Given the rarity of some of the conditions these children experience, plans and issuers may not elect to collect critical data on these vulnerable children yet they may be subject to the requirements of value based insurance products. Excluding data for these populations poses serious problems in monitoring the effect new program designs have on this vulnerable population of children. There also is a problem with children and adolescents with co-morbid conditions that may require visits to providers that may be both in- and out-of-network. Mechanisms need to be installed to ensure that data are collected and evaluated for these children (eg, diagnosed with an eating disorder who also need mental health care that may be provided out-of-network.)

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?*

Children's access to medically necessary health care services is paramount in the design of a new health insurance product. There should be no obstacles for children and families to receive the care their physician believes in his or her professional clinical judgment is needed to resolve an acute condition, manage a chronic illness, or prevent a future malady. It might be assumed that children would benefit if the health insurance industry uses tools such as cost-effectiveness analysis and cost-benefit analysis to aid in decision-making. But even those tools lead to subjective results, and should not be relied upon solely to address the unique needs of children. Once any form of quantitative analysis becomes the tool of choice to designate a service as either high or low value, there is the risk that certain services will be "priced out" of the income range of many families. Many benefits of health interventions for children are lifelong benefits or occur only later in a child's development. Due to the standards used in determining the array of benefits that populate value based insurance products, many services used by children will be assigned progressively less value if the window of time for analysis of impact is too brief.

In sum, the whole underlying premise of incentive alteration is that it needs to be tailored to the outcome that is desired. A plan cannot expect that value based insurance design will achieve cost savings for every patient in the plan. Some will continue to need to use more expensive alternatives. Those individuals may benefit from targeted incentives in other areas of their health care.

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

Applying the ruler of medical necessity will not disappear under value-based insurance design benefit structures. The Academy recommends that the "Early and Periodic Screening, Diagnosis, and Treatment" (EPSDT) program definition should serve as the medical necessity standard for all children. EPSDT requires states to assess a child's health needs through initial and periodic examinations and evaluations to assure that health problems are diagnosed and treated early, before they become more complex and costly. EPSDT also requires states to pay for the medically necessary treatment of those conditions. While health care must be made available to treat, correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services, conditions need not be newly discovered during a screen. All conditions must be treated to help insure the child's healthy development.

Furthermore, from an operational perspective, the Academy recommends that health plans describe the processes by which physicians and other health care professionals must provide justification for the

medical necessity of health interventions they prescribe or order. Descriptions of these processes should include:

- How to provide clinical evidence supporting coverage of interventions that meet the needs of the individual child;
- How to incorporate appropriate pediatric medical or surgical specialty or expert opinion or testimony supporting coverage of interventions;
- How to assist families or physicians who wish to appeal medical necessity denials; and,
- How and when coverage decisions are made.

12. *How are consumers informed about value based insurance design features in their health coverage?*

Developing messages on value-based care can not avoid references to evidence-based care, and the latter may serve as a stumbling block to understanding and acting on the key concepts of new and emerging insurance products. These same stumbling blocks suggest that existing information and supports on traditional health insurance products would not be as effective as they could be. According to the results of a focus group of consumers sponsored by the American Institutes for Research, there are three core challenges to communicating with employees: (1) fundamental disconnect between the tenets of evidence-based medicine and the knowledge, values, and beliefs held by many employees, (2) employees have limited experience with becoming more actively involved and find it hard to engage, and (3) employees don't necessarily trust important existing communication channels. (Source: Carman KL, Maurer M, Yegian JM et al. Evidence that consumers are skeptical about evidence-based health care. *Health Affairs*.2010 July 29(7): 1400-1406.)

The messages modeled for consumers need to familiarize them with such terms as “medical evidence”, “clinical guidelines”, “quality performance measurement.” In fact, this same set of focus groups also discovered that many employees believe that guidelines and standards restrict choice, inhibit innovation, are inflexible and biased, and may represent low standards. This interesting set of observations poses an intriguing dilemma facing plans and issuers in designing an effective communication campaign for consumers.

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

This is a key question since; much of what is ‘purchased’ in the health care arena is directed by the physician rather than by the patient themselves. Up until now for pharmaceutical purchases, formularies have been used to restrict the purchase of certain drugs by members of a specific plan and that probably has had some impact on the prescribing patterns of providers. But the ultimate question has to do with utilization of other types of services: imaging, ancillary services, sub-specialty referrals, hospitalizations, etc. The ultimate value based insurance design in this instance is simply to downstream the risk, i.e. give the providers a pot of money to take care of their patients and if it costs more to do so then they (the providers) bear the burden of that excess charge while if they manage to care for them for less money they keep the savings. Getting the pot of money right sized, however, will be a non-trivial undertaking. This is essentially the ACO model.

Additionally, although not specific to one program, the Academy would hope that any communication strategies deployed are designed in tandem with the construction of the value-based insurance product. A more effective message to providers/physicians can be crafted if it embodies the facts and data that were

used during the development phase. Developing the communication strategy at the tail end of the development phase runs the risk of overlooking key elements of the program.

The Academy also is concerned that the process of steering patients to value-based services and settings may jeopardize the patient's access to the medical home and result in unnecessary and costly fragmentation of care. To preserve the clinical integrity of the medical home, incentives to promote behavior change should be consistent with the principles of the family-centered/patient-centered medical home. The incentive structure also should encourage patient autonomy and foster family and patient participation in shared decision-making, without punitive consequences, and should firmly recognize and support the physician's ethical duty to provide care and the physician's ethical responsibility to discuss all appropriate care options with the family and patient.

In sum, the incentives should not marginalize a physician's goal of honest, open, and just interaction among patients, health care professionals, plans and issuers, and employer groups.

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?*

Section 2713 of the Affordable Care Act states that the "Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs." There is much ambiguity around the definition of value-based insurance design and this could lead plans and issuers to erect additional barriers around the provision of preventive care services eg, restricting providers, implementing vouchers or other incentive programs. Noted below are the Academy's clinical, payment, and administrative recommendations to ensure that the intent of Section 2713 is also maintained during the design of value-based insurance design products

Clinical Issues

- State explicitly that *Bright Futures* health supervision visits are the guidelines referred to in Section 2713.
- Affirm explicitly that coverage for these services is required under the new law.
- State clearly that all components of pediatric well child visits (including immunization administration, health supervision, anticipatory guidance), in accordance with the *Bright Futures* periodicity schedule, must be free of financial barriers, including copayments and deductibles.
- Encourage insurance companies to remove other barriers or disincentives for physicians in providing comprehensive *Bright Futures* services to their patients and families.

Payment Issues

- Require insurers to follow CPT guidelines for payment of well child services, as well as separate payment for all services that are appropriately reported under current CPT guidelines.
- Bar insurers from passing on to physicians and other health care providers the cost of eliminating cost-sharing. Children's access to preventive services will be harmed if physicians and other health care providers are required to absorb the elimination of cost-sharing by payers.
- Recognize that payment should support the medical home. Communication within the medical home occurs face-to-face in the visit, by telephone or by electronic media. To enhance access, meet the needs of the family, and encourage care that is comprehensive and family-centered, mechanisms for reimbursing all aspects of professional services and communications, particularly for care coordination and case management provided in the medical home as well as community-based services, must be addressed.

Administrative/Informatics Issues

- Require insurers to follow CPT guidelines for payment of well child services, as well as separate payment for all services that are appropriately reported under current CPT guidelines.
- Bar insurers from passing on to physicians and other health care providers the cost of eliminating cost-sharing. Children's access to preventive services will be harmed if physicians and other health care providers are required to absorb the elimination of cost-sharing by payers.
- Recognize that payment should support the medical home. Communication within the medical home occurs face-to-face in the visit, by telephone or by electronic media. To enhance access, meet the needs of the family, and encourage care that is comprehensive and family-centered, mechanisms for reimbursing all aspects of professional services and communications must be addressed.

The Academy would like to conclude this section by expressing its concern with a response to a set of "Frequently Asked Questions" published jointly by the Departments of Health and Human Services, Labor and Treasury (specific to the market reform provisions of the Affordable Care Act) that stated the following:

Plans may use reasonable medical management techniques to steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by having a mechanism for waiving the otherwise applicable copayment for the preventive services provided in a hospital.

The Academy is concerned that "reasonable medical management techniques" is not defined in the regulation and, if interpreted incorrectly, could impede regular access to preventive services for children.