



February 28, 2011

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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
Attn: VBID

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

Dear Sir or Madam,

Northeast Business Group on Health (NEBGH) (formerly New York Business Group on Health) welcomes the opportunity to submit for consideration comments relating to the request for information (RFI) regarding value-based insurance design (“VBID”) in connection with preventive care benefits under section 2713 of the Patient Protection and Affordable Care Act (“Affordable Care Act”). This RFI was issued by the Department of Health & Human Services, Employee Benefits Security Administration, and Internal Revenue Service (collectively, “the agencies”) on December 28, 2010.

NEBGH is a network of employers, providers, insurers and other organizations working together to improve the quality and reduce the cost of health care in New York, New Jersey, Connecticut, and Massachusetts. We are an employer-driven not-for-profit coalition representing over one million covered lives associated with more than 150 organizations. Since 1982, NEBGH’s mission has been to help large, mid-sized, and small businesses by informing health care decisions, improving the health care delivery system, and controlling costs.

On behalf of our member employer purchasers that coordinate, receive and pay for health care services, NEBGH supports the development and advancement of regulations implementing provisions of the Affordable Care Act related to VBID, a relatively novel, yet promising approach to improving health and mitigating long-term health care cost growth. VBID is not solely a preventive care benefit design. Rather, it is a unique and consumer incentive-driven approach to addressing the broader issue of rising health care costs and the return on investment that purchasers experience. In the face of health care cost increases that show no relent, purchasers of health benefits deserve an option that allows them to utilize data-driven approaches to deliver common sense, high-value preventive health care that staves off costly and debilitating chronic conditions. VBID is one of the few avenues available to employers in helping to control soaring health care costs. And these are efforts usually met with enthusiasm



by organizational leadership as well as employees and their dependents who often appreciate encouragement and a financial incentive to live healthier and prevent, rather than have to treat, chronic disease.

The main thrust of our comments is that regulations should not narrowly define the confines within which VBID programs must operate. Instead, regulations ought to strengthen and support the ongoing development of and experimentation with VBID programs, thus providing employer plan sponsors and health insurance issuers with maximal flexibility to work with the clinical and academic communities to design innovative benefit structures that best fit their population's health and health care circumstances.

The following comments are responses to the specific questions enumerated in the December 28, 2010 RFI.

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?

At the heart of VBID is a basic principle of removing barriers to essential, high-value health care services. A variety of financial and non-financial incentives are used to encourage patients to use evidence-based treatments or services, in appropriate settings, which result in improved health. The model most commonly implemented by employer plan sponsors limits or reduces cost-sharing for certain classes of prescription drugs that will benefit individuals afflicted with one or more chronic conditions. Specific plan design tools employed by purchasers to incentivize certain patient behaviors in VBID programs include:

- Health Savings Account contributions
- Cost-sharing provisions (e.g., co-payments, deductibles, co-insurance) for targeted providers or services
- Other financial rewards (e.g., raffle entries, gym memberships, gift cards)
- Access to enhanced benefits or programs
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Employers, moreover, often times offer their members a variety of support tools to enhance the results they realize from participation in VBID programs. These might include:

- Comparative quality information
- Patient coaching and counseling
- Shared treatment decision support
- Personal health records and self-management tools
- Monitoring gaps in case

Employee participation in VBID programs in most employer-sponsored plans is purely voluntary. However, employers have shown increasing interest in deploying VBID initiatives to target their most costly and at-risk members, most notably those with chronic conditions. This approach to health benefit design endeavors to not only reconstruct the traditional notion of health benefits design, but also shift the focus of the health care debate away from cost alone to obtaining clinical value of health services that, as a by-product, bends the cost curve in the long-term.

Efficacy is typically related to the incentive offered and not the VBID program more generally, and can be measured using various clinical and/or financial outcomes. Different employers will



use different metrics to determine the impact of their VBID elements, depending on their goals, employee/patient population, and experience. Commonly used measures include:

- Setting of care delivery (e.g., ambulatory vs. inpatient setting)
- Medical expenditure (e.g., total spending on treatment for a given disease state/condition)
- Clinical outcomes (e.g., health status following intervention)
- Utilization of recommended service(s) (e.g., number of eligible employees receiving recommended screening)

Given the variety of possible incentives and evaluation modalities, flexibility in the design of VBID programs is crucial.

We recommend that employers and health plans be granted flexibility to tailor appropriate incentives in order to achieve better, more affordable health care on the part of their workforce and ultimately encourage their employees to use high-value, evidence-based treatment options.

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

VBID incentives are targeted, using one of four basic approaches. The University of Michigan's Center for Value-Based Insurance Design has pioneered the intellectual theory underlying these domains and explicates them in a way unmatched by others. What follows is a brief synopsis of these four methodologies:

1. **Design by service.** Select drugs or services, such as statins or cholesterol drugs, demonstrated to offer high value for the patients for whom they are indicated are provided at either no cost or at reduced cost-sharing levels. Pitney Bowes, an NEBGH member, implemented over the last decade a program whereby copayments are waived or reduced for certain drugs that treat asthma, diabetes, and hypertension. A study published in 2010 in the journal *Health Affairs* showed that Pitney Bowes's VBID strategy of eliminating copayments for a cholesterol-lowering statin resulted in 3.1 percent increase in monthly adherence among intervention patients.¹
2. **Design by condition.** Cost-sharing elements are waived or reduced for medications or services based on the specific clinical conditions with which patients have been diagnosed. UnitedHealth Group, for example, offers a diabetes-specific VBID program to their self-insured employer customers.
3. **Design by condition severity.** This approach calls for waived or reduced cost-sharing elements for high-risk members, for instance those with coronary artery disease, who might be eligible for participation in a disease management program.
4. **Design by disease management participation.** High-risk members who actively participate in an appropriate disease management program are provided reduced or waived cost-sharing. An extension of the design by condition severity approach above, this strategy offers rewards – for example, lower copayments for those who use the on-site clinic rather than alternative care sites – only to eligible members who actually participate in a given incentive program.

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What is important to note is that many employers and health plans have been providing first dollar coverage for many high-value preventive services for years. Although not always in conjunction with formal VBID structures, payers are highly cognizant of the favorable cost and health outcomes implications of reducing barriers to these valuable services.

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 consider proprietary?

Assessment of value must include a quality component. Determining value based on cost alone essentially ignores this important other component of the value equation. Therefore, we recommend that any value judgments not factoring in a quality component should be considered neither high nor low value. The focus of VBID designs has traditionally been to facilitate greater access to and use of high-value services, not just providers. Enhanced access to high-performing providers is a component of many VBID programs, but we support the designation of high- and low-value providers only when quality metrics are explicitly used in the determining which providers quality for which status.

A number of well-regarded organizations already have established quality metrics to assist health plans and employers in designating high quality/high value services and/or care. These include the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention (CDC), CDC's Advisory Committee on Immunization Practices, National Committee on Quality Assurance, National Quality Forum, Integrated Healthcare Association, Tufts Center, Blue Cross Blue Shield Technology Assessment Center, and numerous professional sub-specialty society guidelines.

We recommend that regulations not designate high-value services, but instead allow employers and health plans to work with the clinical and academic community in designating these services/providers.

Driving the design of VBID incentive structures are data that often times include information from multiple sources. Employers typically derive data from their own claims information, health insurance carrier-wide data, comprehensive payer databases such as Ingenix, and other regional sources. Strengthening access to all-payer databases will bolster payers' ability to design targeted and effective VBID incentive arrangements. Widespread and open access to large scale de-identified billing and discharge data sets would bolster VBID incentive development. Harmonizing data across private and public entities (including state and federal government) in a mandatory, uniform structure would meet the need for broad access to provider-specific, episode-based data that would support not only VBID development, but related evaluation efforts as well, conducted by both public and private stakeholders.

Several new methods of capturing and evaluating data should have synergistic effects on the effectiveness of VBID programs and the ability to track and measure outcomes. The development and adoption of electronic health records (EHR), accelerated by the Centers for Medicare and Medicaid Services' (CMS) Health Information Technology Meaningful Use incentive program under the American Recovery and Reinvestment Act (ARRA) of 2009, holds a great deal of promise in providing extremely detailed and valuable information related to the



effectiveness of VBID intervention and on an individual patient basis. Provisions in the Patient Protection and Affordable Care Act (Affordable Care Act) related to comparative effectiveness research, moreover, set the stage for the dissemination of actionable clinical evidence on the effectiveness of care that will drive and influence even more value-based decisions.

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?

Data indicating utilization, outcomes, costs, and quality of care, stemming from numerous, sometimes disparate, sources is used in determining appropriate incentive models and/or amounts in steering patients to or away from high-value or low-value services, respectively. Further research, much of which is being conducted at the University of Michigan's Center for Value Based Insurance Design, is currently being performed to better understand incentive models that encourage the use of high-value services. What has been concluded in the current literature, though, is that higher copayments or other cost-sharing elements is correlated with lower quality of care, higher health care costs, and decreased medication adherence.

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

- a) How is the impact of VBID on patient utilization monitored?**
- b) How is the impact of VBID on patient out-of-pocket costs monitored?**
- c) How is the impact of VBID on health plan costs monitored?**
- d) What factors are considered in evaluating effectiveness (for example, cost, quality, utilization)**

Health plans typically evaluate data and results on an annual basis or at the end of a contract period; for many large employers, this is usually every two or three years. The re-evaluation process consists of analysis across a number of units within the health plan, such as actuarial, underwriting, medical management and utilization. Many employer-based VBID programs have been in place for fewer than five years, so little evidence exists regarding established practices. As it pertains to VBID programs, innovation and experimentation is still the norm for many employers. Efforts to evaluate which incentive structures and program features best suit their population – and may be translatable to a broader, less homogenous population – are currently underway.

Despite the lack of robust data related to established best practices in employer-based VBID programs, the academic & research community has developed methodologies to measure the impact of VBID on health care costs, clinical outcomes, and medical expenditures. As a guiding principle, though, the more granular the clinical outcomes measure, the more accurate is the assessment of the real value of the VBID program features. Key components of these evaluation methodologies include:

- Using appropriate control groups (both internal and external to the employer group).
- Include non-medical benefits of health improvement, such as productivity, disability, absenteeism, and presenteeism.
- The incorporation of long-term follow-up. As alluded to above, VBID programs targeted to preventive services frequently result in short-term cost and utilization increases, with the goal of improving health outcomes and decreasing the likelihood of long-term costly illness.



- Measure clinical outcomes in addition to clinical process measures.

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 unaware of any of our employer members that have not continued their VBID program. In fact, based on recent communication, many of these same employers plan on expanding their program(s) and countless others intend on launching one in the very near future. Rising health care costs coupled with a changing health care landscape due to the passage and implementation of the Affordable Care Act have shifted tremendous momentum toward greater VBID adoption. A recent *Health Affairs* article cited a national survey conducted by Mercer in 2010 found that 81 percent of large employers plan to offer a VBID program in the near future.² Despite great interest, adoption is gradual among employers and health plans. Although surmountable, these obstacles are often cited by our employers as barriers to rapid adoption. Support by leadership in overcoming them is crucial to eventual implementation. These impediments include:

- **Quantification of return on investment.** Human resource and health benefit managers often find VBID implementation a hard sell, so to speak, to senior leadership if a quantifiable return on investment (ROI) is not demonstrable. While a debate persists regarding whether VBID strategies produce a short-term positive ROI, employers who champion the theory argue that widespread use of VBID programs results in long-term cost savings and a healthier, more productive workforce.
- **The need for expensive, sophisticated data analytics.** Because VBID requires targeted interventions that call for identifying specific patient groups, compliance levels, and the value of services, software capable of segregating the appropriate data is vital. Many current data systems that employers and health plans use are neither designed nor capable of providing the level of granularity needed for VBID analysis.
- **Perceptions of inequality.** Some plan members whose cost-sharing requirements are higher than those of other non-VBID participation members may elicit strong negative reactions. Transparent and clear communication regarding the goals of the program on the part of the employer may mitigate these effects.
- **Short-term increases in cost and utilization.** Reducing cost-sharing requirements for targeted prescriptions or services may result in higher short-term costs and utilization. However, the expectation is that targeted early intervention will result in improved health and fewer adverse complications in members with chronic conditions.

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

Health plans and employers should consult research and evidence-based clinical guidelines when contemplating implementation of new or additional preventive care benefits or treatments. Factors that employers may consider may include:

- Potential effects of incentives, both intended and unintended
- The health needs of their employee and dependent population

² Choudhry, N. K., Rosenthal M. B., Milstein, A. (2010). Assessing the Evidence for Value-Based Insurance Design. *Health Affairs*. 29(11), 1988-1994. doi:10.1377/hlthaff.2009.0324.



- Possible return on investment
- Administrative ease of implementing and maintaining the program, including tracking progress and results
- Current cost and utilization patterns
- Quality gap

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)?

Most VBID programs that our employer members have implemented focus on the provision of high-value pharmaceuticals that are prescribed regardless of individual risk level. Though, as noted in the response to question #2 above, more sophisticated VBID programs may stratify cost-sharing based on other features such as condition or disease severity (e.g., asthmatics with high ER utilization). Some VBID programs will, furthermore, solicit participants from within a population based on health characteristic(s) who may benefit from targeted incentives to encourage participation (e.g., individuals with depression who are not taking prescribed medication).

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?

Effective VBID administration requires sophisticated technology and data analytic software, but each program's requirements differ based on population profile, program design features, medical conditions targeted, and extant data. Employers and health plans may need, among others, the following capabilities:

- Analytics that support VBID program design features, member identification, member program compliance, and program effectiveness.
- Tools that can establish, maintain, and track progress of multiple VBID programs
- Establish and deploy rewards for program participation and/or outcomes
- An IT-based member interface/portal that allows users to enroll in VBID programs and track their progress
- Ability to demonstrate VBID ROI
- Ability of payroll system to provide reduced employee premium contributions
- Collaboration with pharmacy benefit manager(s) (PBM) to provide appropriately enhanced pharmacy benefits

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?

a) 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?

The recommended preventive services required to be covered without cost-sharing under the Affordable Care Act (and its related interim final rule) often provide guidance concerning the frequency, method, or setting for obtaining preventive services. When absent, though,



employers and health plans may use, as described in the interim final rule, “reasonable medical management techniques” to determine coverage limitations. Techniques currently used by health plans include prior authorization and utilization management.

We recommend that the regulations do not place constraints on the mechanisms and tools that employers and health plans can use to ensure their patient population(s) receive the medically appropriate, evidence-based care.

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

As part of their comprehensive health benefits strategy, many employers will often tie their VBID program to a wellness initiative, increasing the likelihood of success for both. Additionally, employers may provide other support mechanisms to encourage adherence, such as coaching and counseling, reminders, and culturally and linguistically sensitive member communications. Equally important are strategies that employers and plans use to offer ongoing feedback to ensure that quality and outcomes metrics and objectives are being met. We cannot stress enough the importance that a quality component plays in developing effective VBID programs.

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

Consistent communication and messaging are vital to creating an attractive VBID program for health plans, employers, and most importantly, patients. Being on the same page, so to speak, with regard to goals, expectations, and objectives is crucial to not only garnering member participation, but also in order for desired benefits to accrue. Employers are able to leverage traditional communication avenues (e.g., explanations of coverage and standard plan documents) to disseminate VBID program information as well as other novel and unique approaches. These include intranet communications, intra-office social media (e.g., blogs and podcasts), posters in the workplace, seminars, employer-hosted health fairs, or text message campaigns.

We recommend that employers be provided maximal flexibility in determining and implementing the most effective communication strategies related to VBID program education.

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

Employers and health plans have been steering patients to high-value settings for care for years. Steerage to high-value services, in contrast, is less pervasive. The distinction between the two types of steerage is important to note, though. The federal agencies responsible for implementing the insurance reform provisions of the Affordable Care Act acknowledged this important peculiarity in administrative guidance that was released in November 2010.³

Health plans play an important role in influencing and incentivizing provider behavior. Further adoption of EHRs will bolster plans’ ability to communicate the availability of VBID services. Current techniques plans use to support and communicate with providers include incentives such as pay-for-performance programs, the provision of care managers, financial support to induce workflow changes to support tracking and action on gaps in care, and continuing medical education (CME) programs.

³ For more information, see <http://www.dol.gov/ebsa/faqs/faq-aca5.html>



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 believe that consumers are well protected by existing statute and the section 2713 regulations as issued. Preserving flexibility on the part of employers and health plans is crucial to its future and success. The success VBID has enjoyed thus far is due in no small part on the ability of private sector entities to innovate with benefit designs and care management plans. In our view, the best way forward would be to ensure that VBID programs do not rely solely on cost control, but integrate quality components as well. To be sure, though, consideration should be given to ensuring that an appropriate and timely appeals process for medical management techniques is in place.

* * *

Thank you again for providing this opportunity to provide input on the development of regulations related to VBID in connection with preventive care benefits under section 2713 of the Affordable Care Act. VBID programs, while not a panacea, are indeed an essential component of employers' efforts to improve health, contain costs, drive delivery system reforms, and advance continuous quality improvement strategies. We hope that our comments contribute to the development and refinement of VBID program elements that are consistent with the letter and spirit of the Affordable Care Act and result in a visible difference in how patients and providers interact with each other as well as with the broader health care and insurance system.

Please do not hesitate to contact me or Shawn Nowicki, Director of Health Policy, at 212.252.7440 x227, if you have any further questions or would like to discuss our feedback in greater detail.

Sincerely,



Laurel Pickering, MPH
Executive Director





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Data indicating utilization, outcomes, costs, and quality of care, stemming from numerous, sometimes disparate, sources is used in determining appropriate incentive models and/or amounts in steering patients to or away from high-value or low-value services, respectively. Further research, much of which is being conducted at the University of Michigan's Center for Value Based Insurance Design, is currently being performed to better understand incentive models that encourage the use of high-value services. What has been concluded in the current literature, though, is that higher copayments or other cost-sharing elements is correlated with lower quality of care, higher health care costs, and decreased medication adherence.

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

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Despite the lack of robust data related to established best practices in employer-based VBID programs, the academic & research community has developed methodologies to measure the impact of VBID on health care costs, clinical outcomes, and medical expenditures. As a guiding principle, though, the more granular the clinical outcomes measure, the more accurate is the assessment of the real value of the VBID program features. Key components of these evaluation methodologies include:

- Using appropriate control groups (both internal and external to the employer group).
- Include non-medical benefits of health improvement, such as productivity, disability, absenteeism, and presenteeism.
- The incorporation of long-term follow-up. As alluded to above, VBID programs targeted to preventive services frequently result in short-term cost and utilization increases, with the goal of improving health outcomes and decreasing the likelihood of long-term costly illness.



- Measure clinical outcomes in addition to clinical process measures.

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 unaware of any of our employer members that have not continued their VBID program. In fact, based on recent communication, many of these same employers plan on expanding their program(s) and countless others intend on launching one in the very near future. Rising health care costs coupled with a changing health care landscape due to the passage and implementation of the Affordable Care Act have shifted tremendous momentum toward greater VBID adoption. A recent *Health Affairs* article cited a national survey conducted by Mercer in 2010 found that 81 percent of large employers plan to offer a VBID program in the near future.² Despite great interest, adoption is gradual among employers and health plans. Although surmountable, these obstacles are often cited by our employers as barriers to rapid adoption. Support by leadership in overcoming them is crucial to eventual implementation. These impediments include:

- **Quantification of return on investment.** Human resource and health benefit managers often find VBID implementation a hard sell, so to speak, to senior leadership if a quantifiable return on investment (ROI) is not demonstrable. While a debate persists regarding whether VBID strategies produce a short-term positive ROI, employers who champion the theory argue that widespread use of VBID programs results in long-term cost savings and a healthier, more productive workforce.
- **The need for expensive, sophisticated data analytics.** Because VBID requires targeted interventions that call for identifying specific patient groups, compliance levels, and the value of services, software capable of segregating the appropriate data is vital. Many current data systems that employers and health plans use are neither designed nor capable of providing the level of granularity needed for VBID analysis.
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- Analytics that support VBID program design features, member identification, member program compliance, and program effectiveness.
- Tools that can establish, maintain, and track progress of multiple VBID programs
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employers and health plans may use, as described in the interim final rule, “reasonable medical management techniques” to determine coverage limitations. Techniques currently used by health plans include prior authorization and utilization management.

We recommend that the regulations do not place constraints on the mechanisms and tools that employers and health plans can use to ensure their patient population(s) receive the medically appropriate, evidence-based care.

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

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

Consistent communication and messaging are vital to creating an attractive VBID program for health plans, employers, and most importantly, patients. Being on the same page, so to speak, with regard to goals, expectations, and objectives is crucial to not only garnering member participation, but also in order for desired benefits to accrue. Employers are able to leverage traditional communication avenues (e.g., explanations of coverage and standard plan documents) to disseminate VBID program information as well as other novel and unique approaches. These include intranet communications, intra-office social media (e.g., blogs and podcasts), posters in the workplace, seminars, employer-hosted health fairs, or text message campaigns.

We recommend that employers be provided maximal flexibility in determining and implementing the most effective communication strategies related to VBID program education.

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Health plans play an important role in influencing and incentivizing provider behavior. Further adoption of EHRs will bolster plans’ ability to communicate the availability of VBID services. Current techniques plans use to support and communicate with providers include incentives such as pay-for-performance programs, the provision of care managers, financial support to induce workflow changes to support tracking and action on gaps in care, and continuing medical education (CME) programs.

³ For more information, see <http://www.dol.gov/ebsa/faqs/faq-aca5.html>



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 believe that consumers are well protected by existing statute and the section 2713 regulations as issued. Preserving flexibility on the part of employers and health plans is crucial to its future and success. The success VBID has enjoyed thus far is due in no small part on the ability of private sector entities to innovate with benefit designs and care management plans. In our view, the best way forward would be to ensure that VBID programs do not rely solely on cost control, but integrate quality components as well. To be sure, though, consideration should be given to ensuring that an appropriate and timely appeals process for medical management techniques is in place.

* * *

Thank you again for providing this opportunity to provide input on the development of regulations related to VBID in connection with preventive care benefits under section 2713 of the Affordable Care Act. VBID programs, while not a panacea, are indeed an essential component of employers' efforts to improve health, contain costs, drive delivery system reforms, and advance continuous quality improvement strategies. We hope that our comments contribute to the development and refinement of VBID program elements that are consistent with the letter and spirit of the Affordable Care Act and result in a visible difference in how patients and providers interact with each other as well as with the broader health care and insurance system.

Please do not hesitate to contact me or Shawn Nowicki, Director of Health Policy, at 212.252.7440 x227, if you have any further questions or would like to discuss our feedback in greater detail.

Sincerely,



Laurel Pickering, MPH
Executive Director





February 28, 2011

Submitted electronically via the Federal Rulemaking portal at www.regulations.gov

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
Attn: VBID

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

Dear Sir or Madam,

Northeast Business Group on Health (NEBGH) (formerly New York Business Group on Health) welcomes the opportunity to submit for consideration comments relating to the request for information (RFI) regarding value-based insurance design (“VBID”) in connection with preventive care benefits under section 2713 of the Patient Protection and Affordable Care Act (“Affordable Care Act”). This RFI was issued by the Department of Health & Human Services, Employee Benefits Security Administration, and Internal Revenue Service (collectively, “the agencies”) on December 28, 2010.

NEBGH is a network of employers, providers, insurers and other organizations working together to improve the quality and reduce the cost of health care in New York, New Jersey, Connecticut, and Massachusetts. We are an employer-driven not-for-profit coalition representing over one million covered lives associated with more than 150 organizations. Since 1982, NEBGH’s mission has been to help large, mid-sized, and small businesses by informing health care decisions, improving the health care delivery system, and controlling costs.

On behalf of our member employer purchasers that coordinate, receive and pay for health care services, NEBGH supports the development and advancement of regulations implementing provisions of the Affordable Care Act related to VBID, a relatively novel, yet promising approach to improving health and mitigating long-term health care cost growth. VBID is not solely a preventive care benefit design. Rather, it is a unique and consumer incentive-driven approach to addressing the broader issue of rising health care costs and the return on investment that purchasers experience. In the face of health care cost increases that show no relent, purchasers of health benefits deserve an option that allows them to utilize data-driven approaches to deliver common sense, high-value preventive health care that staves off costly and debilitating chronic conditions. VBID is one of the few avenues available to employers in helping to control soaring health care costs. And these are efforts usually met with enthusiasm



by organizational leadership as well as employees and their dependents who often appreciate encouragement and a financial incentive to live healthier and prevent, rather than have to treat, chronic disease.

The main thrust of our comments is that regulations should not narrowly define the confines within which VBID programs must operate. Instead, regulations ought to strengthen and support the ongoing development of and experimentation with VBID programs, thus providing employer plan sponsors and health insurance issuers with maximal flexibility to work with the clinical and academic communities to design innovative benefit structures that best fit their population's health and health care circumstances.

The following comments are responses to the specific questions enumerated in the December 28, 2010 RFI.

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?

At the heart of VBID is a basic principle of removing barriers to essential, high-value health care services. A variety of financial and non-financial incentives are used to encourage patients to use evidence-based treatments or services, in appropriate settings, which result in improved health. The model most commonly implemented by employer plan sponsors limits or reduces cost-sharing for certain classes of prescription drugs that will benefit individuals afflicted with one or more chronic conditions. Specific plan design tools employed by purchasers to incentivize certain patient behaviors in VBID programs include:

- Health Savings Account contributions
- Cost-sharing provisions (e.g., co-payments, deductibles, co-insurance) for targeted providers or services
- Other financial rewards (e.g., raffle entries, gym memberships, gift cards)
- Access to enhanced benefits or programs
- Premium discounts

Employers, moreover, often times offer their members a variety of support tools to enhance the results they realize from participation in VBID programs. These might include:

- Comparative quality information
- Patient coaching and counseling
- Shared treatment decision support
- Personal health records and self-management tools
- Monitoring gaps in case

Employee participation in VBID programs in most employer-sponsored plans is purely voluntary. However, employers have shown increasing interest in deploying VBID initiatives to target their most costly and at-risk members, most notably those with chronic conditions. This approach to health benefit design endeavors to not only reconstruct the traditional notion of health benefits design, but also shift the focus of the health care debate away from cost alone to obtaining clinical value of health services that, as a by-product, bends the cost curve in the long-term.

Efficacy is typically related to the incentive offered and not the VBID program more generally, and can be measured using various clinical and/or financial outcomes. Different employers will



use different metrics to determine the impact of their VBID elements, depending on their goals, employee/patient population, and experience. Commonly used measures include:

- Setting of care delivery (e.g., ambulatory vs. inpatient setting)
- Medical expenditure (e.g., total spending on treatment for a given disease state/condition)
- Clinical outcomes (e.g., health status following intervention)
- Utilization of recommended service(s) (e.g., number of eligible employees receiving recommended screening)

Given the variety of possible incentives and evaluation modalities, flexibility in the design of VBID programs is crucial.

We recommend that employers and health plans be granted flexibility to tailor appropriate incentives in order to achieve better, more affordable health care on the part of their workforce and ultimately encourage their employees to use high-value, evidence-based treatment options.

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

VBID incentives are targeted, using one of four basic approaches. The University of Michigan's Center for Value-Based Insurance Design has pioneered the intellectual theory underlying these domains and explicates them in a way unmatched by others. What follows is a brief synopsis of these four methodologies:

1. **Design by service.** Select drugs or services, such as statins or cholesterol drugs, demonstrated to offer high value for the patients for whom they are indicated are provided at either no cost or at reduced cost-sharing levels. Pitney Bowes, an NEBGH member, implemented over the last decade a program whereby copayments are waived or reduced for certain drugs that treat asthma, diabetes, and hypertension. A study published in 2010 in the journal *Health Affairs* showed that Pitney Bowes's VBID strategy of eliminating copayments for a cholesterol-lowering statin resulted in 3.1 percent increase in monthly adherence among intervention patients.¹
2. **Design by condition.** Cost-sharing elements are waived or reduced for medications or services based on the specific clinical conditions with which patients have been diagnosed. UnitedHealth Group, for example, offers a diabetes-specific VBID program to their self-insured employer customers.
3. **Design by condition severity.** This approach calls for waived or reduced cost-sharing elements for high-risk members, for instance those with coronary artery disease, who might be eligible for participation in a disease management program.
4. **Design by disease management participation.** High-risk members who actively participate in an appropriate disease management program are provided reduced or waived cost-sharing. An extension of the design by condition severity approach above, this strategy offers rewards – for example, lower copayments for those who use the on-site clinic rather than alternative care sites – only to eligible members who actually participate in a given incentive program.

¹ Choudhry, N. K., Fischer, M. A., Avorn, J., Schneeweiss, S., Solomon, D. H., Berman, C., Jan, S., Liu, J., Lii, J., Brookhart, M. A., Mahoney, J. J., Shrank, W. H. (2010). At Pitney Bowes, Value-Based Insurance Design Cut Copayments And Increased Drug Adherence. *Health Affairs*. 29(11), 1995-2001. doi:10.1377/hlthaff.2010.0336.



What is important to note is that many employers and health plans have been providing first dollar coverage for many high-value preventive services for years. Although not always in conjunction with formal VBID structures, payers are highly cognizant of the favorable cost and health outcomes implications of reducing barriers to these valuable services.

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 consider proprietary?

Assessment of value must include a quality component. Determining value based on cost alone essentially ignores this important other component of the value equation. Therefore, we recommend that any value judgments not factoring in a quality component should be considered neither high nor low value. The focus of VBID designs has traditionally been to facilitate greater access to and use of high-value services, not just providers. Enhanced access to high-performing providers is a component of many VBID programs, but we support the designation of high- and low-value providers only when quality metrics are explicitly used in the determining which providers quality for which status.

A number of well-regarded organizations already have established quality metrics to assist health plans and employers in designating high quality/high value services and/or care. These include the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention (CDC), CDC's Advisory Committee on Immunization Practices, National Committee on Quality Assurance, National Quality Forum, Integrated Healthcare Association, Tufts Center, Blue Cross Blue Shield Technology Assessment Center, and numerous professional sub-specialty society guidelines.

We recommend that regulations not designate high-value services, but instead allow employers and health plans to work with the clinical and academic community in designating these services/providers.

Driving the design of VBID incentive structures are data that often times include information from multiple sources. Employers typically derive data from their own claims information, health insurance carrier-wide data, comprehensive payer databases such as Ingenix, and other regional sources. Strengthening access to all-payer databases will bolster payers' ability to design targeted and effective VBID incentive arrangements. Widespread and open access to large scale de-identified billing and discharge data sets would bolster VBID incentive development. Harmonizing data across private and public entities (including state and federal government) in a mandatory, uniform structure would meet the need for broad access to provider-specific, episode-based data that would support not only VBID development, but related evaluation efforts as well, conducted by both public and private stakeholders.

Several new methods of capturing and evaluating data should have synergistic effects on the effectiveness of VBID programs and the ability to track and measure outcomes. The development and adoption of electronic health records (EHR), accelerated by the Centers for Medicare and Medicaid Services' (CMS) Health Information Technology Meaningful Use incentive program under the American Recovery and Reinvestment Act (ARRA) of 2009, holds a great deal of promise in providing extremely detailed and valuable information related to the



effectiveness of VBID intervention and on an individual patient basis. Provisions in the Patient Protection and Affordable Care Act (Affordable Care Act) related to comparative effectiveness research, moreover, set the stage for the dissemination of actionable clinical evidence on the effectiveness of care that will drive and influence even more value-based decisions.

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³ For more information, see <http://www.dol.gov/ebsa/faqs/faq-aca5.html>



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 believe that consumers are well protected by existing statute and the section 2713 regulations as issued. Preserving flexibility on the part of employers and health plans is crucial to its future and success. The success VBID has enjoyed thus far is due in no small part on the ability of private sector entities to innovate with benefit designs and care management plans. In our view, the best way forward would be to ensure that VBID programs do not rely solely on cost control, but integrate quality components as well. To be sure, though, consideration should be given to ensuring that an appropriate and timely appeals process for medical management techniques is in place.

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Thank you again for providing this opportunity to provide input on the development of regulations related to VBID in connection with preventive care benefits under section 2713 of the Affordable Care Act. VBID programs, while not a panacea, are indeed an essential component of employers' efforts to improve health, contain costs, drive delivery system reforms, and advance continuous quality improvement strategies. We hope that our comments contribute to the development and refinement of VBID program elements that are consistent with the letter and spirit of the Affordable Care Act and result in a visible difference in how patients and providers interact with each other as well as with the broader health care and insurance system.

Please do not hesitate to contact me or Shawn Nowicki, Director of Health Policy, at 212.252.7440 x227, if you have any further questions or would like to discuss our feedback in greater detail.

Sincerely,



Laurel Pickering, MPH
Executive Director

