

February 28, 2011

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: HHS-OS-2010-002, Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.,
Washington, DC 20201.

RE: Value-Based Insurance Design under ACA's Preventive Services Mandate

To Whom it May Concern,

Thank you for the opportunity to comment on the implications of the Affordable Care Act's preventive services mandate on value based insurance design. We will briefly review how our clients are approaching value based design and preventive services, and offer our recommendations regarding federal rulemaking in this area.

We understand the importance of preventive care, and share your desire to be sure that increased expenditure for preventive care leads to higher levels of preventive care delivery, as opposed to higher costs per unit for the preventive care being delivered.

The Affordable Care Act's mandate to provide preventive services rated A or B by the US Preventive Services Task Force is an important landmark; multiple studies show that lower member cost share is associated with higher adherence to chronic disease medications, and higher rate of use of other valuable services.

Our clients have increasingly embraced value based design elements for pharmaceutical products, especially those for treatment of chronic diseases such as diabetes, hypercholesterolemia, and hypertension. The movement toward lower or absent member cost sharing for preventive services has increased with the passage of ACA, and even many of our clients who have "grandfather" status at this point are decreasing or eliminating member cost share for preventive services. Many of our clients have data warehouses, and carefully track utilization of key preventive services including influenza immunization, mammography, cervical cancer screening, and colon cancer screening.

A few of our clients offer free or diminished member cost share based on member participation in programs. For instance, a high technology company offers free diabetes medications and supplies if a covered member participates in a diabetes telephonic disease management program. Many of our clients offer cash, cash equivalents, premium discounts, or health care savings account deposits for participation in disease management or maternity management programs. We also have clients who have differential premium structures based on member program participation.

We also see many clients implementing value based networks, where an employee would have a lower cost-share to see providers within a high value network.

Early value based design was focused on lowering cost for high value services. Increasingly, we see employers seeking to raise member cost-sharing on lower value services. This could include new copayments or higher coinsurance for ambulatory high cost imaging tests, or higher member cost share for preference-sensitive procedures, especially if the member does not participate in a shared decision-

making program. Value-based programs could be expressed as either rewards or penalties by many self-insured employers who could increase member premium to fund rewards or decrease member premium to account for assessed penalties.

There is a move toward 'reference based pricing' for services which are elective, discretionary or widely available at a high level of consistency and quality, and have highly variable prices. This includes procedures such as imaging tests or endoscopies.

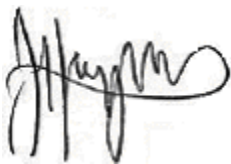
We have reviewed our National Data Collaborative¹ claims database, to identify cost differences among participating providers for professional fees for three important preventive services: screening mammography, screening abdominal ultrasound for aneurism in current or former smokers, and screening colonoscopies. We have chosen these services because they are elective, common and well-defined, making them most amenable to reference-based pricing. Patients would be most likely to be able to "shop" as consumers for value in purchasing these preventive health care services.

Service ²	Average	25%ile	50%ile	75%ile	Highest
Screening Digital Mammography	\$117	\$50	\$95	\$174	\$750
Screening Abdominal US	\$136	\$43	\$107	\$200	\$370
Screening Colonoscopy (not high risk)	\$493	\$264	\$389	\$701	\$3000

As you can see, the inter-quartile differential is often as much as the median cost of the procedures, and the highest paid amount is often six times the average cost. We believe that mandating zero member cost sharing at all providers, even those outside the contracted network, would encourage rampant increase in the prices for these services, which would ultimately limit our clients' ability to afford to support preventive care services. As such, we recommend that benefit sponsors be given the freedom to limit support for zero cost-share services to those facilities that offer their services at affordable prices, provided there is reasonable, timely access to the service.

Thank you for the opportunity to comment on this issue. Please feel free to contact us if you have any questions.

Sincerely,



Jeffrey Levin-Scherz, MD MBA

¹ The NDC has 2.3 million lives, and covers 47 large employers who use 20 different health plans.

² All fees shown are professional only. Technical and facility fees are often billed separately.