

February 28, 2011

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

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

Dear Sir or Madam,

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

Aon Hewitt welcomes the opportunity to submit for consideration to the Department of Health and Human Services (HHS), the Internal Revenue Service (IRS), and the Department of Labor's (DOL) Employee Benefit Security Administration (EBSA) our comments relating to the agencies' request for information (RFI) regarding value-based insurance design. Our response to this RFI highlights our expertise in working with employers as they develop their health care strategy, evaluate their data, benchmark against others, create programs that engage and motivate employees to better manage their health, contain costs, and measure results.

Who We Are

Aon Hewitt is the global leader in human resource consulting and outsourcing solutions. The company partners with organizations to solve their most complex benefits, talent, and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates, and administers a wide range of human capital, retirement, investment management, health care, compensation, and talent management strategies. With more than 29,000 professionals in 90 countries, Aon Hewitt makes the world a better place to work for clients and their employees. The Aon Hewitt Health & Benefits Practice consists of 900 consultants that have the privilege of working with thousands of employers around the country.

Value-Based Insurance Design

The Patient Protection and Affordable Care Act (P.L. 111-148) (Affordable Care Act) gives the agencies authority to develop guidelines for group health plans and health insurance issuers offering group or individual health insurance coverage to utilize value-based insurance designs (VBIDs) as part of their offering of preventive health services.

Defining Value-Based Insurance Design

From Aon Hewitt's perspective, VBID can be defined as follows:

VBID is a benefit design that identifies clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and efficacious treatments for which copayments or coinsurance may be adjusted due to their high value and effectiveness when prescribed for particular clinical conditions.

To be more specific, VBID is the use of incentives or disincentives to accomplish the following:

- Encourage the appropriate use of high-value services, including preventive services and prescription drugs;
- Discourage the overutilization of low-value, non-evidence-based services;
- Increase utilization of high-quality, low-cost providers and facilities that adhere to evidence-based treatment guidelines;
- Decrease utilization of low-quality, high-cost providers and facilities; and
- Adopt healthy lifestyles, such as smoking cessation, healthy eating habits, and increased physical activity.

The incentives and disincentives may include such initiatives as premiums or employee payroll contributions differentiated by behavior, plan design provisions (e.g., deductibles, copayments) differentiated by behavior or value of service, funding of health savings accounts (HSAs) or health reimbursement arrangements (HRAs) differentiated by behavior, or behavior-based cash or non-cash rewards.

Setting the Context

It is important to clarify that most of the employers we work with regarding VBID focus on helping employees manage and improve clinical compliance for chronic conditions and not for preventive medical services/screenings. This may be viewed as secondary or tertiary prevention but is not primary preventive care as defined by the U.S. Preventive Services Task Force (USPSTF) A- and B-rated services.

Many large employers we work with already cover some, if not all, appropriate primary preventive services at reduced or no cost for plan participants. While primary preventive services are clearly value-based, the most practical extension of VBID is to improve health of participants with chronic conditions.

Studies show that our health care system contributes both to overutilization of many low-value services and to underutilization of many high-value services. Whereas much health care strategy in private industry has focused on correcting the former, a VBID approach is a concerted effort to arrive at the right holistic utilization mix.

It must be noted that value is an elusive concept, particularly when applied to health care. The generic implication is one of cost-benefit ratio, but when it comes to health, quantifying the net benefit of an intervention or medication is notoriously challenging, and costs are fluid and may be difficult to predict.

We believe that quantification of health benefit should be the exclusive province of science, but a uniform framework for such determinations would serve society's health and finances well. The American Recovery and Reinvestment Act's (ARRA's) investments in comparative effectiveness research have provided much-needed funding in this arena.

In addition to maximizing quality, health care purchasers, whether individuals, large or small businesses, states, or the federal government, impose budget constraints. A fundamental principle of VBID is to maximize the health purchased within a finite budget, which entails shifting subsidy from lower-value services to higher-value services. However, we know that although a service that is valuable for one patient may be less beneficial, or even harmful, to another, employers make decisions about how to set health care cost sharing equally across all services, a "one-size-fits-all" approach. In a typical VBID example, a decision to shift subsidy from high-tech radiology to primary care physician visits may result in a missed diagnosis

for an individual who decides to forgo a more expensive scan, *but overall health across a large group of consumers is likely to be improved*. While it is never our intent to harm an individual, we must recognize that the administrative and fiscal constraints within which we operate necessitate that in the process of maximizing societal health care value, some individuals may be adversely impacted.

To optimize utilization of services and medications, employers find economic incentives the most practical and effective. The body of literature is unambiguous that health care consumers will purchase more of a given service or medication when it costs less, and vice versa. By manipulating incentives and disincentives through plan design cost sharing, employers increase the benefit purchased per health care dollar. Similarly, to optimize the mix of providers and facilities used, employers have turned to high-performance networks (based on balancing quality and cost). These restrict consumer choice but can provide increased value, and they may be designed to treat specific conditions or to provide specific services. For example, a large national retailer recently contracted directly with the Cleveland Clinic to provide all heart surgeries that met certain conditions for medical appropriateness. This type of provider steerage allows employers flexibility to optimize costs and benefits in ways that make the most sense for their participants. *Maintaining the ability to design flexible benefit and network structures in response to changing evidence of value is critically important as we reform the way health care is delivered.*

The framework of our response outlines the process we follow with an employer as they begin the journey of planning, evaluating, and implementing a VBID program. We will share our perspectives on most, but not all, of the questions contained in the RFI. We have focused on the areas where we have the most expertise.

Highlights From the Aon Hewitt Annual Health Care Survey

Employer Perspective

To help frame some of our responses, it is helpful to share some timely data from the Aon Hewitt Annual Health Care Survey.

In 2011, 1,027 executives, whose companies employ approximately ten million employees and represent a broad spectrum of industries, completed the survey. In terms of company size representation, just over two-thirds (67%) of participating companies have 5,000 or fewer U.S. benefit-eligible employees, about one-quarter (24%) have between 5,000 and 25,000 U.S. benefit-eligible employees, and 10% have over 25,000 U.S. benefit-eligible employees.

For most employers, this decade requires benefit strategies designed to balance rising health care costs while optimizing performance through targeted, strategic, and value-added interventions aimed at improving the overall health of the workforce, lowering costs, and improving business performance.

Employers were asked to identify the top health care outcomes they would like to achieve in 2011 and the most significant challenges facing their organization (internal or external) in terms of accomplishing these objectives.

The top five health outcomes revolve around:

- *Improving health;*
- *Lowering cost;*
- *Lowering participant health risks;*

- *Increasing awareness; and*
- *Improving participation in disease management programs.*

Barriers associated with achieving these goals include motivating participants to change, reluctance to change, and unpredictability of cost, followed by government regulations and managing the health of an aging workforce.

To accomplish these objectives and overcome barriers, over the next three to five years, employers plan to focus their efforts on using incentive and disincentive tactics, promoting a culture of health in the workplace, promoting disease management and other consumer-driven health plan (CDHP) and VBID strategies, and managing high-cost claimants.

Specifically, the survey also notes some plan design tools that employers use to reward employees for specific health behaviors, including:

- Premium reduction;
- Funding of an HRA or HSA in conjunction with a CDHP;
- VBID (enhanced benefits for essential services); and
- Out-of-pocket cost reductions (deductibles, coinsurance).

Employers are increasingly promoting the importance of employees taking responsibility for their health by offering tools (e.g., health risk assessment, biometric testing) to raise participants' awareness of their health status and risks but show less interest in providing on-site preventive, primary, and urgent care services.

The majority of communication efforts are condition-specific (e.g., diabetes focused) and companies are considering other types of targeted communications based on demographics and social media to reinforce smart health behaviors and actions from plan participants over the next three to five years. These approaches attempt to create a culture of health that is more proactive than reactive in addressing issues of employees' changing health risks.

As health plan designs evolve to control costs, they will increasingly require people to take accountability for their health. Health plan designs are shifting focus from "react and repair" to "predict and prevent." Incentives are being used to nudge employees in the right direction by rewarding them for healthy behaviors and making it more difficult to justify unhealthy behaviors—where the employer provides the most generous benefits to those who are doing the most to maintain or improve their health. In contrast, penalties are also being used as a means to motivate employee behavior change with the potential to improve outcomes and reduce costs. Balancing incentive and penalty tactics can also promote more employee and dependent accountability and involvement in their own health and health care decision making.

VBID Prevalence

In 2011, almost one-quarter (23%) of participants report they will offer VBID approaches in their health plan (e.g., providing lower copayments or cost sharing for particular medical services, treatments, or drugs). Another 55% are considering VBID as part of their strategy over the next three to five years.

Close to one-quarter (22%) of employers are also steering participants (through plan design or lower cost) to high-quality hospitals or physicians for specific procedures or conditions (e.g., hospital A has high-quality outcomes and is less expensive for cardiac surgery), and another 54% plan to do so over the next three to five years.

In addition, 91% of organizations that offer VBID approaches in their health plan do not impose any requirements (e.g., completion of health risk assessment, required program participation, behavior compliance, physician qualification form) to receive enhanced benefits at this time.

When organizations were asked if they are or will be targeting specific health conditions (e.g., asthma, diabetes) through the VBID plan features, only 16% reported doing so, with diabetes, asthma, hypertension, and cardiovascular disease being the most common conditions targeted.

While VBID plan designs are on the leading edge of insurance reform, employers will need to closely monitor and measure the health improvement benefits and cost savings potential these types of design features can offer. By allowing different cost-sharing provisions for different services, value can be enhanced without removing the essential role of cost sharing in the overall system. VBID can address several important inconsistencies in the current system and work synergistically with other initiatives such as CDHPs, disease management programs, and pay-for-performance to optimize health care effectiveness and efficiency.

Effectiveness of programs can be defined in many ways. Most employers create a set of metrics during the planning process that may contemplate areas such as:

- Percent of employees participating in a certain program/activity;
- Utilization of recommended services;
- Improved compliance with evidence-based treatment;
- Medical and prescription drug cost (trend mitigation); and
- Appropriate use of care setting (e.g., emergency room versus office visit).

VBID Landscape

In today's economic environment, VBID is one of many solutions employers are implementing to improve health risk and mitigate cost. Value—clinical benefit achieved relative to cost expended—is largely absent from the current health care environment. Instead, disconnected conversations about cost and quality lead to mixed messages for plan participants. The goal of VBID is to get more value out of an employer's health care dollars by reducing financial barriers to essential care and improving patient compliance, in efforts to reduce overall direct costs (e.g., hospital and emergency room charges) and indirect costs (e.g., productivity and absences) to payers.

A wide spectrum of VBID plans exists today, but the fundamental principles are based on two general approaches: clinically valuable services and select clinical diagnoses.

Clinically Valuable Services

The first approach simply targets clinically valuable services (or classes of medications) for copayment or cost-sharing reduction. This concept suggests that prescriptions for drugs treating chronic medical conditions such as hypertension, lipid disorder, or diabetes should cost nothing or very little to the patient, compared to the expenses for non-chronic medical conditions. The philosophy suggests that if people do not have barriers (such as cost) to access necessary medications and services, they are more likely to utilize them appropriately. Additionally, through appropriate medication utilization, the patient is more likely to prevent the major complications known to accompany these disease states, thus reducing total medical spending and increasing overall productivity.

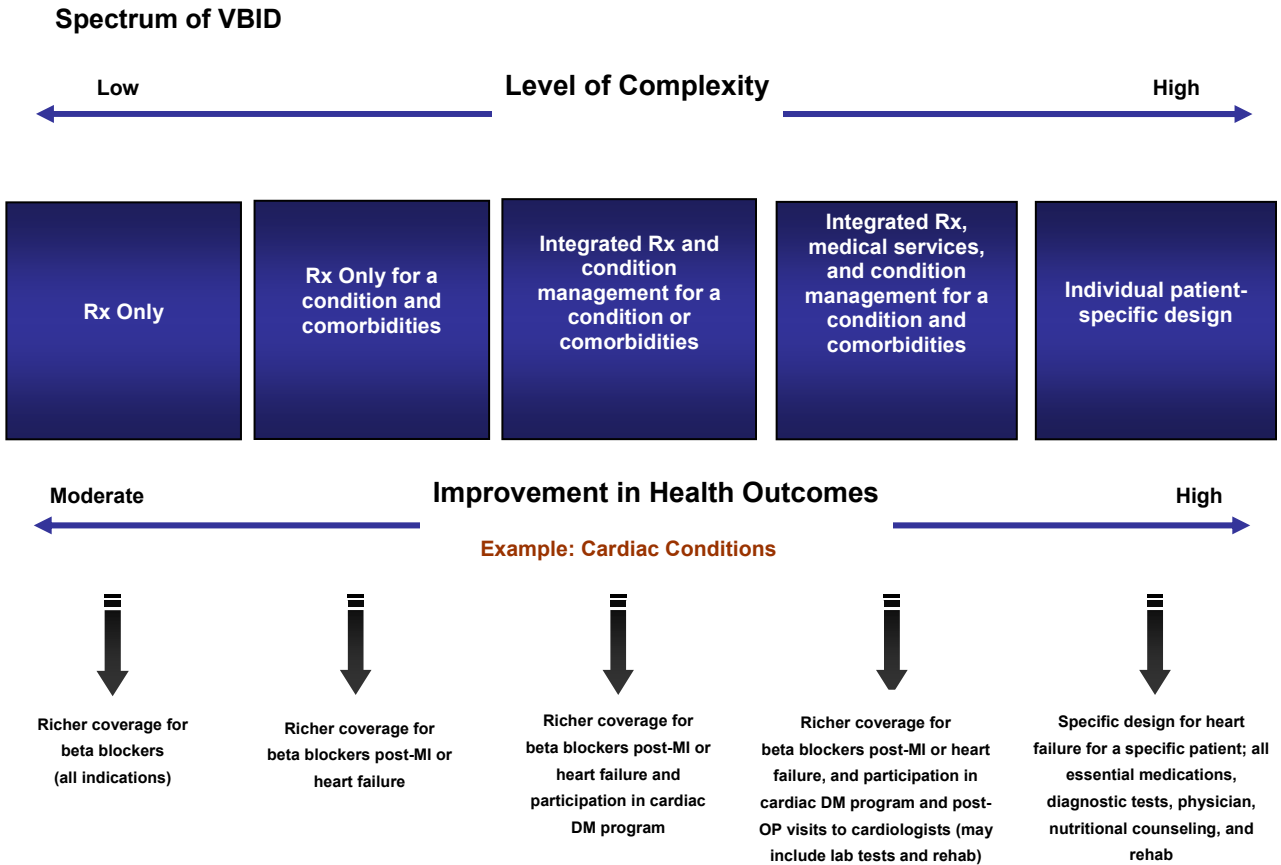
Although this approach may provide substantial benefit for some users (e.g., covering a class of drugs called beta blockers for patients with heart failure or after a heart attack), it provides less value for other patients (e.g., those who use beta blockers for performance anxiety). This approach does not attempt to differentiate between these types of patients.

Select Clinical Diagnoses

The second approach targets patients with select clinical diagnoses (e.g., heart failure) and lowers copayments for specific high-value services (e.g., beta blockers and angiotensin converting enzyme (ACE) inhibitors). Designs cover what is considered to be “gold standard” medication therapy classes and services based on clinical practice guidelines for the disease being targeted. Only medications or medical services used to treat the targeted chronic condition are covered under the incentive-based plan. Medical services or medications for other indications (chronic or acute) have the non-incentive-based copayment or coinsurance applied. Although it requires a bit more technological sophistication with integrated medical and pharmacy data, this approach creates a differential copayment based on the patients’ own characteristics. Programs designed in this manner target the disease states that provide the greatest return on investment (ROI) to lower direct and indirect medical cost. Ultimately, the long-term result should be an overall reduction in total health care spending.

Although this approach in targeting patients is less common, two well-known programs, designed by the municipality of Asheville, North Carolina, and the University of Michigan, have been implemented in this manner. Both of these organizations successfully created programs that reduced the copayments for selected medications for patients with diabetes, coupled with education and marketing campaigns and patient coaching support.

To help further illustrate the point, the diagram below outlines a spectrum of VBID approaches employers may evaluate and implement.



Working With Employers

Studies have shown that a reduction in cost share alone does not necessarily lead to the highest levels of long-term adherence or compliance with medication use. The value derived from VBID will depend heavily on programs used in conjunction. Integration with other programs and vendors is crucial, and the implementation process needs to be in partnership with pharmacy benefit managers (PBMs), medical plans, disease management vendors, wellness programs, and any other program that will support the VBID program. The key to the success of publicized programs such as the City of Asheville and Pitney Bowes is that they combine incentivized copayments with professional coaching, counseling, and education campaigns.

While the idea behind VBID has been around for nearly a decade, today's advances in disease management and data-sharing technology are expanding the concept. At its simplest, a VBID program will target clinically valuable medication classes within a targeted disease state for copayment reduction. This approach focuses on the medication, rather than targeting benefits to individual patients.

With advances in technology, the ability to collect and share electronic medical records and health assessment data continues to improve. This allows VBID programs to address a wider range of disease states and covered services. In its most advanced form, VBID considers both the patient's condition and all

the available treatments. A program of this type targets patients with select clinical diagnoses and lowers copayments for specific high-value services. All treatments are considered, and those with greater value are given higher priority using a blend of clinical judgment, health economics, and actuarial techniques.

Landmark programs such as the City of Asheville and Pitney Bowes, along with the lack of acceptance of numerous incentive-only programs, have proven again that incentivized copayments must be combined with professional coaching, counseling, and education campaigns. Lowering copayments and coinsurances alone will produce diminishing results with time.

Integration with PBMs, medical plans, disease management vendors, and wellness programs is critical for a successful VBID program. Without those partnerships, the implementation and ongoing data exchange process will become tedious and ultimately fail.

Employers typically consider adopting a customized value-based approach that incentivizes targeted disease states to encourage appropriate behavior and increase the health and productivity of their employees. The following approach is recommended when considering VBID:

1. Benchmark to assess risk
2. Determine targeted conditions or medications
3. Quantify the opportunity
4. Create a plan design that differentiates cost sharing for high-value services or drugs
5. Validate net cost or savings through actuarial modeling
6. Ensure legal and administrative approval
7. Implement with medical or pharmacy vendors
8. Develop a targeted communication and marketing campaign
9. Measure ongoing results to ensure achievement of quality and financial goals

Aon Hewitt Approach

When Aon Hewitt collaborates with an employer to design an optimal VBID program, we first assess the baseline endemic risks and utilization misalignment. For a traditional medication-oriented VBID, this entails measurement of chronic condition prevalence and prescription drug compliance. A typical large employer, for example, rarely has significant prevalence of Alzheimer's disease and would be ill-advised to expend administrative resources to manage such a condition. Even among large employers with similar prevalence of a given condition, some populations are already highly compliant with evidence-based treatment, while others are not. Targeting VBID initiatives to the particular disease and compliance profile of a group makes the most sense to maximize efficiency.

Once appropriate interventions have been identified, we use actuarial and econometric models to assess the likely outcomes on compliance and plan costs. This stage is often interactive, requiring a balance of fiscal constraints and maximization of expected population health. For example, an employer may have an interest in lowering population cholesterol but find that the cost of lowering statin copayments is too great and the benefit too distant to warrant the investment, instead finding greater value in a different condition.

Some employers work through this due diligence process and ultimately decide not to implement a VBID approach. Barriers to implementation include: higher than average compliance with value-based treatments, lack of evidence quantifying clinical and financial ROI, upfront investment cost, high turnover such that the employer is unlikely to realize any benefits of investment in the chronically ill, perceived employee inequity, and privacy concerns. For many employers, these obstacles can be overcome with a strong business case supported by relevant data and a robust communication campaign.

Each employer determines how best to communicate with plan participants and health care partners. Some employers rely on their vendors (PBMs and health plans) to outreach directly to participants who qualify for VBID, while other employers take a more direct approach and share information about the program through intra-company media.

In years following a VBID implementation, Aon Hewitt revisits measurement of condition prevalence and utilization alignment. This allows us to contemplate the expansion (or more targeted focusing) of VBID initiatives as scientific understanding, participant risk profile, or compliance change.

As a general matter, summary plan descriptions (SPDs), as well as certificates of insurance or benefit descriptions incorporated into the SPD by reference, will be impacted any time an employer changes its plan design. However, Aon Hewitt does not view the expansion of an employer's use of VBID as positively or negatively impacting such communications. Instead, employers typically communicate plan designs (and how to use them) as part of annual enrollment.

The more significant cost and concern pertains to the Employee Retirement Income Security Act's (ERISA) reporting and disclosure rules, in general (ERISA Section 2520.104b-1). While the DOL provides a safe harbor for electronic delivery, many large employers continue to send summaries of material modifications and SPDs to plan participants via U.S. mail. This process is very costly and typically results in slower delivery of updated plan design information. Most participants, including retirees, have access to the Internet today. It would be much more cost-effective and environmentally friendly if employers could meet their disclosure requirement for all plan participants through a postcard or one-page mailing that directs participants to a web site where an updated SPD is posted to satisfy the safe harbor. (The postcard could put the onus on the participant to indicate that the participant needs to receive the information in paper if the participant does not use a computer as part of his or her "ordinary work duties.")

While employers are generally appreciative for the current disclosure through electronic media safe harbor, most large employers would like to see this requirement go a step further. This will be particularly important once summaries of benefits under Section 2715 of the Affordable Care Act are required to be updated. It will be imperative that employers be given an easier (and more cost-effective) method of communicating updates to participants benefits, including those who do not have computers as part of their ordinary work duties, or those who are retired.

VBID Future

The concept of VBID continues to evolve, but the underlying premise is to align financial incentives with improvements in value and quality care. The future of VBID will lead to progress down multiple paths in the future.

Enhanced Integration of Data—One of the most immediate areas where we will see changes involves the enhanced integration of data from PBMs, health plans, disease management vendors and wellness vendors. Significant investments are being made by all parties to create the appropriate infrastructure for data transmission. Once in place, VBID programs will expand beyond the common current focus of prescription medications and be able to easily offer medical, laboratory, and prescription drug services at an incentivized member share.

VBID Coverage Expansion—The range of disease states and medications covered under VBID will continue to expand. Currently, the focus is on common disease states such as diabetes, respiratory disorders, and heart disease that when well managed will likely result in a reduction of overall medical

costs. It is conceivable that future VBID plans will also include conditions like depression, anxiety, and gastrointestinal disorders—all conditions that have a significant ROI when including the impact of presenteeism into the savings.

Fully Insured Plan Offerings—It is also conceivable that VBID programs, which are currently initiated in self-insured accounts, will start to be offered for fully insured plans if self-insured VBID programs continue to have financial success.

Utilization of Health Care Services—VBID is a natural fit to accomplish the goal of optimizing health care through more effective utilization of health care services. There is evidence that money being spent on health care services is not providing enough value to patients and the overall health care system. By structuring plan designs with incentives, VBID will lower the financial barriers to high-value evidence-based treatments. Encouraging the use of high-value services will allow patients to receive better quality and more effective care. It will allow the focus of health care to be placed on value rather than volume.

Pharmacogenomics—Personalized medicine has made great advances through the field of *pharmacogenomics*—an area of science that studies how a person’s genetic information affects his or her response to medication. This new field of science helps doctors understand more about which drugs and dosages will work best for an individual patient. For plan sponsors, pharmacogenomics provides a basis for more informed coverage decisions and more cost-effective care for plan members. Within VBID programs, we envision that pharmacogenomics will be utilized to determine what members receive a medication at an incentivized copayment or coinsurance, based on their own genetic makeup. For now, personalized medicine holds great future promise, but only if it becomes widely available and affordable.

Closing

Aon Hewitt believes value-based plan designs will continue to evolve and become more complex and sophisticated. In the future, employers will begin to look at value-based designs at an individual level, where employers will offer higher coverage for medical services and prescription drugs when particular criteria are met, such as evidence-based medical guidelines, personal health advocates/coaches, and condition management compliance.

Aon Hewitt applauds the agencies’ inclusion of VBID in the Affordable Care Act and for requesting additional information from market leaders. We look forward to furthering the guidance and expansion of VBID. If you have any questions or comments, please contact the undersigned at the telephone number or email address provided below.

Sincerely,

Aon Hewitt

Jennifer M. Boehm, Principal
(847) 295-5000
jennifer.boehm@aonhewitt.com

Trevor Fast, FSA, FCA, MAAA
(847) 295-5000
trevor.fast@aonhewitt.com