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*Creative Health Benefits Solutions for Today. Strong Policy for Tomorrow*

February 28, 2011

The Honorable Phyllis C. Borzi  
Assistant Secretary  
Office of Health Plan Standards and Compliance  
Employee Benefits Security Administration  
U.S. Department of Labor  
Room N-5653  
200 Constitution Avenue, N.W.  
Washington, DC 20210

**Attention: VBID, HHS-OS-2010-02, REG-120391-10 VBID**

Dear Assistant Secretary Borzi:

The National Business Group on Health appreciates the opportunity to respond to the Request for Information (RFI) regarding Value-Based Insurance Design (VBID) in connection with preventive care benefits under the Patient Protection and Affordable Care Act (Affordable Care Act). We appreciate the opportunity to provide more information on when cost-sharing for recommended preventive care services promotes the use of higher value, lower cost providers and facilities.

The National Business Group on Health (Business Group) represents over 316 companies, including many of America's largest employers (66 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

Employers who sponsor group health plans have long valued and focused on encouraging their employees and other plan participants to regularly receive evidence-based preventive care. As you know, many employers voluntarily offer first-dollar coverage of preventive care services to employees and their dependents and often provide coverage beyond the recommendations of the U.S. Preventive Services Task Force (USPSTF) and other government agencies when the clinical and medical evidence warrants it. They know that encouraging needed preventive medicine can dramatically reduce the incidence, health care demands, and long-term cost burden of chronic conditions as well as acute illness and helps to keep people healthier, longer. That is why the Affordable Care Act promotes evidence-based preventive care in several ways, including requiring non-grandfathered plans to provide government-recommended preventive services at no cost to plan participants.

While having no cost-sharing for evidence-based preventive care services is generally a good idea, and many employer plans have long done just that, an absolute ban on cost-sharing will actually hinder leading plans' efforts to encourage plan members to obtain these services at higher-value, more efficient providers and facilities. For example, colonoscopy fees often vary widely in local health care markets without noticeable quality differences. Hence, plans may institute cost sharing for procedures performed at high cost facilities, but have no cost sharing for lower price facilities. An absolute ban on cost sharing in all instances will also hinder plans' efforts to discourage use of provider- and preference-sensitive options that are not clinically necessary for recommended preventive care services. For example, plans may generally require cost-sharing for virtual colonoscopies, but have no cost-sharing for traditional colonoscopies, which are more effective. We believe that these plan innovations will be important for all patients and all plans in time. Therefore, we greatly appreciate the Departments efforts to seek additional information on these VBID elements that innovative employers have adopted to drive better quality at lower cost for employers and plan participants alike while, at the same time, promoting needed preventive care services. Therefore, we strongly encourage the Departments to foster VBIDs for preventive care services in any future regulations and guidance.

Employers that apply value-based group health plan designs as part of their employee health care strategies commonly cite the following objectives<sup>1</sup>:

- Improve patient medication adherence and self-management of chronic conditions;
- Encourage evidence-based care;
- Reduce adverse health events such as avoidable hospitalizations and emergency department use; and
- Reduce health care spending on a per-employee basis.

In the context of preventive care services, VBIDs are encouraging plan members to obtain necessary evidence-based preventive screenings, immunizations and other services as does the Affordable Care Act requirement. In later efforts to remove financial barriers for people with chronic conditions, employers waived deductibles, copayment and coinsurance requirements for evidence-based preventive medications and provided disease management and other services at no cost. Recent employer efforts in VBIDs encourage the use of high-quality, efficient providers and facilities and discourage the use of low-value, preference-sensitive, non-evidence-based services.

Because of our strong belief that VBIDs can improve the efficiency and effectiveness with which non-grandfathered plan members receive government-recommended preventive services, the Business Group is pleased to provide the following responses to the RFI's specific questions on best practices of VBIDs for recommended preventive

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<sup>1</sup> Watson T. Six stepping stones to achieving a value-based pharmacy design. *Benefitnews.com*. September 15, 2008. Accessed on March 3, 2009.

services, as well as data used to support and inform VBID benefit designs, measurements, and evaluations.

**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?**

Plan design tools in VBIDs include:

- Varying copayments and cost-sharing for services based on providers' or facilities' quality and efficiency;
- Premium reductions;
- Deductible waivers;
- Maximum allowable reimbursements in a geographic market (e.g., reference-based pricing); and
- Health account contributions

Employers using VBIDs in their plans suggest the following factors are important to their success:

- Clear objectives and realistic expectations about the extent to which VBIDs can change behavior;
- Careful analysis to identify opportunities and problems that can be successfully addressed with value-based designs;
- Targeted outreach to members with individualized supports;
- Cooperation among vendors and integration of related programs; and
- Defined evaluation methodologies.

Successful programs demonstrate improved health outcomes on relevant health measures and better medication adherence, reduced emergency department use, fewer preventable hospitalizations, and other similar measures of quality.

**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)?**

VBIDs have changed significantly over the last 10 years. Early adopters designed plans by *medications* (e.g., everyone who takes ACE inhibitors is eligible for reduced or no cost-sharing) or *conditions* (e.g., everyone with diabetes or asthma is eligible for reduced or no cost-sharing). The focus of VBIDs in these instances is to alleviate financial barriers to underuse.

It is becoming more common to use VBIDs to encourage evidence-based care in other aspects of the medical benefit, such as provider- and preference-sensitive procedures and

services. For example, several companies have lowered cost-sharing for patients who use decision aids before back surgeries, hip or knee replacements, hysterectomies and advanced imaging than for patients who do not use the decision aids. For preventive care services such as colonoscopies, plans' approach to VBIDs may encourage traditional colonoscopies over virtual colonoscopies, which is less clinically effective, unless patients are unable to undergo traditional colonoscopies for medical reasons. Similarly for preventive imaging, more plans are using VBIDs to encourage appropriate, safe, and necessary scanning. In these latter cases, plans are increasingly looking at VBIDs to address wide, unexplained variations in the prices of preventive care services, including colonoscopies and imaging.

**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?**

Increasingly, plans are using VBIDs to encourage patients to choose providers recognized for excellence (e.g., National Committee for Quality Assurance (NCQA) Diabetes Physician Recognition Program); and it will be more common to see providers paid differentially based on performance, bridging the value-based design and purchasing approaches.

Several quality metrics currently exist to assist plans in designating high quality/high value care (services or providers) with high value delivery records for preventive care services, including:

- USPSTF;
- American College of International Physicians (ACIP);
- CDC;
- NCQA;
- Healthcare Effectiveness Data and Information Set (HEDIS);
- NQF;
- Integrated Healthcare Association (IHA);
- Profession society guidelines/Disease Management Programs;
- Tufts Center; and
- The Blue Cross Blue Shield Technology Assessment Center.

Criteria for imaging providers often include the following:

- Quality Assurance

- o Accreditation requirements (American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO));
- o Quality Assurance (QA) programs in place; and
- o Safety programs in place.
- Equipment
  - o Age of equipment; and
  - o Appropriateness of equipment to exam screenings.
- Staffing
  - o Board certified physicians;
  - o Modality certified technicians; and
  - o Volume of exams.
- Service
  - o Accessibility; and
  - o Hours.

In another example, many employers and plans only cover genetic tests performed by laboratories certified by the Clinical Laboratory Improvement Amendments (CLIA).

As previously recommended in our September 2010 letter, the Departments could enhance VBIDs by continuing to permit higher cost-sharing for providers with lower performance on quality and safety programs, poorer ratings on patient safety measures (such as those endorsed by the National Quality Forum (NQF)) and providers who are not connected to patient-centered medical homes.

Coordinated care is essential to keeping up-to-date on preventive care and is especially important for those with special needs or complex medical conditions. The federal government should allow plans with strong primary care infrastructures through patient-centered medical homes to require cost-sharing for preventive care services not provided through the members' primary care providers to encourage plan participants to receive these services through their primary providers where they would not have any cost-sharing.

**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?**

Often plans eliminate cost-sharing for preventive services at high-value providers and facilities and apply the standard cost-sharing that applies to other preventives services, or to other physician and outpatient services covered by the plans.

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

**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)?**

Plans evaluate results on an annual basis or based on the entire contract period, typically two to three years. Currently available patient claims systems allow for accurate measurement of patient utilization and related cost sharing levels for designated high value preventive services.

CareScientific provides a calculator on its website so that employers can model the relationship between use of medications to treat chronic conditions and adverse outcomes, such as hospitalizations and emergency departments use.<sup>2</sup>

In 2007, Hewitt Associates introduced an actuarial model to help employers quantify the cost impact of value-based designs.<sup>3</sup> Mercer’s Dx-Rx Pairing program, launched in 2008, targets combinations of diagnoses and drug therapies with the medical evidence that these therapies actually improve health status and reduce overall medical costs.<sup>4</sup>

- 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?**

A national survey conducted by Mercer in 2010 found that 81 percent of large employers plan to offer VBID options in the near future.<sup>5</sup> The Business Group has not identified any employers who have dropped VBID for preventive care services.

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

The following are the main considerations for employers when choosing VBIDs:

- Identify preventive care services where the evidence base for effectiveness is strong and remove or lower cost-sharing to increase needed utilization.
- Identify needed preventive services where improved medication/treatment adherence can make a significant clinical and financial difference. This analysis may require involving health plans and PBMs to integrate data.

<sup>2</sup> Motheral BR. A tipping point for disease management? *Journal of Managed Care Pharmacy*. 2008;14:7:643-649.

<sup>3</sup> Hewitt launches new tool to help companies quantify cost impact of value-based health care designs. Hewitt Newsroom. August 14, 2007. [www.hewitt.com](http://www.hewitt.com)

<sup>4</sup> Mercer creates advanced pharmacy benefit design based on latest medical evidence. News Release. January 23, 2008. [www.mercer.com](http://www.mercer.com)

<sup>5</sup> Niteesh K. Choudhry, Meredith B. Rosenthal, Arnold Milstein. “Assessing the Evidence for Value-Based Insurance Design” *Health Affairs* Nov 2010.

- Identify needed preventive services where rates of screenings, immunizations, etc. are not at acceptable levels.
  - Identify needed preventives services where variations in provider quality and/or efficiency are sufficiently wide.
  - Identify preventive services with wide variation due to provider- and preference-sensitive setting, service, and other options that may be clinically inappropriate or unnecessary.
- 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)?**

Some employers currently offer VBID programs that target specific diagnoses or high-risk patients (diabetes, cardiovascular disease and asthma) and may offer them lower or no copayments than other members for the same medical services or drugs.

- 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?**

The administrative costs associated with implementing VBIDs varies based on the technology and expertise required to administer each program and the degree to which the plans must coordinate the programs among multiple vendors.

- 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?**

Some services may be medically appropriate for certain individuals and may be covered by plans, although with member cost-sharing based on the value of the services to the population. Often, however, plans may use prior authorization or appeals processes to determine whether higher cost services are the only medically appropriate choices for individuals and cover them with their usual cost-sharing arrangements.

In the absence of the medical profession reducing misuse and overuse of services, benefit design is a reasonable lever to encourage evidence-based care and informed decision-making.

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

Our answer to question #7 includes the main considerations for employers when choosing VBIDs.

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

Plans include information on VBIDs in health plan documents and in plan participant communications. Sometimes, plans will reach out to eligible employees through wellness, disease, or case management programs. The format in which participants receive this information may include e-mails, newsletters, employer websites, special workshops, programs or meetings, posters in the workplace, podcasts, or text messages. The most popular method of communication is e-mail, and a 60 percent majority of employers communicate either monthly or quarterly.<sup>6</sup>

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

Providers are informed of VBID features in the same way they receive other information on the plan.

**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?"**

Because much of VBIDs actually lowers costs for needed preventive care services, this question does not apply. In other cases where plans use VBIDs to encourage people to use higher value, more efficient providers and facilities and to discourage the use of unnecessary and inappropriate provider- and preference-sensitive services, the current options listed in question # 10 are sufficient safeguards. In addition, consumer protections under federal law, including the expanded protections in the Affordable Care Act, are quite sufficient to ensuring adequate access to preventive care services without cost sharing. Furthermore, the Department of Labor's rule governing the claims and appeals process for ERISA plans has worked well and many of our plans already voluntarily provide extra external reviews.

We believe that VBID methods encourage use of preventive care services with demonstrated evidence of effectiveness, discourage the use of services without demonstrated evidence of effectiveness and permit plans to encourage people to use

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<sup>6</sup> Center for Health Value Innovation. "Value-Based Design 2010: Survey Report 2011." Available at: <http://www.vbhealth.org/wp-content/uploads/VBD2010-Survey-Report-FINAL-2-11-2011.pdf>



providers and facilities with demonstrate effectiveness and greater efficiency. Effective VBIDs improve the quality for all plan participants while lowering costs for both plan participants and plan sponsors.

Again, thank you for the opportunity to provide comments in response to the RFI regarding VBIDs in connection with preventive care benefits under the Affordable Care Act. We look forward to continuing to work with you as you implement the various provisions of the new law. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling  
President

cc: The Honorable Hilda Solis, Secretary, U.S. Department of Labor  
The Honorable Timothy F. Geithner, Secretary, U.S. Department of Treasury  
The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services  
Mr. Steve Larsen, Director, Office of Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services (CMS)  
Mr. George H. Bostick, Benefits Tax Counsel, U.S. Department of the Treasury  
Ms. Nancy J. Marks, Division Counsel/Associate General Counsel, Tax Exempt and Government Entities, Internal Revenue Service, U.S. Department of the Treasury  
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