February 28, 2011

Submitted electronically to 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

Attention: VBID

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

Dear Sir or Madam:

I am writing on behalf of the American Benefits Council ("Council") to comment on the Request for Information (RFI) Regarding Value-Based Insurance Design (VBID) in Connection with Preventive Care Benefits published by the Departments of Labor, Health and Human Services, and the Treasury ("Departments") on December 28, 2010 (75 Fed. Reg. 81544).

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans. Our members typically include preventive care coverage in their group health plans. Such coverage is highly valued by employers and their employees and dependents as a means of promoting health and improving productivity. In fact, many of our members have been important innovators in coverage of preventive care, often as a component of their wellness and other health promotion programs.

The Departments previously issued Interim Final Regulations (IFR)[1] providing essential guidance for employers and issuers regarding the implementation of section 1001 of the Patient Protection and Affordable Care Act ("ACA"), which added new section 2713 to the Public Health Service Act ("PHSA"). New PHSA section 2713 generally requires group health plans and health insurance issuers that are not grandfathered plans to provide coverage for certain preventive services and medications identified in specified recommendations and guidelines ("Recommended Preventive Services") without cost-sharing requirements.

The ACA expressly granted the Departments authority to develop guidelines for group health plans and health insurance issuers to utilize value-based insurance design[2] as part of their offering of preventive health services. As explained in the preamble and subregulatory guidance[3], the Departments intend to issue additional guidelines to permit a group health plan or issuer to utilize VBID. The Departments issued the RFI to solicit information on ways the Departments can encourage VBID in the context of preventive health services to inform future guidance.

Our comments and recommendations regarding the RFI are set out below. These comments are in addition to a prior Council comment letter[4] submitted in response to the IFR implementing PHSA section 2713.

Important Role of VBID in Improving Health Outcomes and Affordability of Coverage

As explained in Department guidance, Value-Based Insurance Designs are generally defined as health plan designs that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care.[5] The basic premise of VBID is to remove barriers to essential, high value health services. According to the Center for Value-based Insurance Design, VBID plans use a variety of financial and non-financial incentives to encourage patients to use high value evidence-based treatments or services to improve their health.[6] Many employer plan sponsors currently use VBID strategies, such as reducing copayments for select high value providers, drugs or

[1] 75 Fed. Reg. 41726 (July 19, 2010).
[2] According the Preamble, value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers.
[3] FAQs About Affordable Care Act Implementation Part V (December 22, 2010) http://www.dol.gov/ebsa/faqs/faq-aca5.html
[4] http://www.americanbenefitscouncil.org/documents/hcr_preventive-comments091710.pdf
[5] FAQs About Affordable Care Act Implementation Part V (December 22, 2010) http://www.dol.gov/ebsa/faqs/faq-aca5.html
[6] University of Michigan Center for Value-Based Insurance Design. A common VBID model is to eliminate or limit co-pays or other patient cost-sharing for certain classes of prescription drugs that will benefit individuals with chronic conditions. http://www.sph.umich.edu/vbidcenter/index.html

participation in disease management. Studies indicate the numbers of employers using or considering such strategies will grow.[7]

By specifically allowing for the utilization of "value-based insurance design" for purposes of complying with PHSA section 2713, Congress expressly recognized the important role of value-based insurance design in promoting the use of appropriate preventive services.

Cost-Sharing for Out-of-Network Coverage of Preventive Health Services

The IFR implementing PHSA section 2713 makes clear that a plan or issuer that has a network of providers is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. The IFR also provides that such plan or issuer may also impose cost-sharing requirements for recommended health services delivered by an out-of-network provider. The Council believes this provision is consistent with the concept of VBID and strongly recommends that any final regulations retain these provisions.

Determinations of Frequency, Method, Treatment or Setting

The IFR implementing PHSA section 2713 also provides that a plan may use "reasonable medical management techniques" to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the recommendation or guideline for Recommended Preventive Services. As explained in the preamble to the IFR, the use of reasonable medical management techniques allows plans and issuers to adapt the recommendations and guidelines to coverage where cost-sharing must be waived. The preamble further clarifies that, under the IFR, a plan or issuer may rely on established techniques and the relevant evidence base to determine frequency, method, treatment, or setting for which a Recommended Preventive Service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.[8]

In recent "frequently asked questions (FAQs)" guidance, the Departments included a helpful clarification regarding the use of reasonable medical management techniques to "steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services…".[9] The FAQ confirmed that a plan design is permissible under PHSA section 2713 where it does not impose a co-payment for colorectal cancer preventive services when performed in an in-network ambulatory

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[7] *Assessing the Evidence for Value-Based Insurance Design*, Health Affairs 29:11 November 2010. Citing Mercer National Survey of Employer Sponsored Health Plans, 2007-2008.
[8] 75 Fed. Reg. 41729
[9] FAQs About Affordable Care Act Implementation Part V (December 22, 2010) http://www.dol.gov/ebsa/faqs/faq-aca5.html

surgery center, but does impose a co-payment if the same service is performed at an in-network outpatient hospital setting, so long as the plan includes a mechanism for waiving the applicable co-payment for individual for whom it would be medically inappropriate to have the service provided in an ambulatory care setting.

The Council strongly supports the rule in the IFR permitting plans and issuers to rely on reasonable medical management techniques and the recent FAQ guidance illustrating how they may be used to encourage patients to use particular high-value settings and to control costs. We request that the rule permitting the use of reasonable medical management techniques be restated in future final regulations and any other future guidance. We also recommend that the Departments take into account a reasonable good faith interpretation of the rule for purposes of applying it to determine coverage limitations related to frequency, method, treatment or setting for the provision of a Recommended Preventive Service. This approach is consistent with the implementation approach the Departments have adopted for other aspects of interpretation where plans, issuers and others are working diligently and in good faith to come into compliance with the ACA.

Flexibility Key to Continued Innovation in VBID

The Council supports the development of additional guidelines for value-based insurance designs that ensure value and quality, while ensuring access to evidence-based preventive services. We commend the Departments for seeking additional public comment through the RFI and other actions aimed at informing future guidance related to VBID in the context of preventive health services.[10] We believe any future guidelines will need to provide sufficient flexibility to allow innovation in the structure and use of VBID to encourage the utilization of appropriate high-value preventive health services.

Thank you for the opportunity to comment and for considering the Council's recommendations. Please contact me at kwilber@abcstaff.org or 202-289-6700 with any questions or if we can be of further assistance.

Sincerely,

Kathryn Wilber
Senior Counsel, Health Policy

[10] See the response submitted by the Center for Value-Based Insurance Design for specific information regarding VBID practices and data as requested in the RFI.
http://www.sph.umich.edu/vbidcenter/healthreform/index.html