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February 28, 2011

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

ATTENTION: HHS-OS-2010-002

**RE: Value-Based Insurance Design in Connection with Preventive Care Benefits**

Dear Secretary Sebelius:

WellPoint Inc. (WellPoint) appreciates the opportunity to respond to the "Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care Benefits" published in the Federal Register on December 28, 2010. We look forward to working with the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (Treasury) to successfully implement these reforms.

WellPoint works to simplify the connection between Health, Care and Value. We help to improve the health of our communities, deliver better care to members, and provide greater value to our customers and shareholders. WellPoint is the nation's largest health benefits company in terms of medical enrollment, with more than 33 million members in its affiliated health plans, and a total of more than 69 million individuals served through all subsidiaries. As an independent licensee of the Blue Cross and Blue Shield Association, WellPoint serves members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. In a majority of these service areas, WellPoint does business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, Empire Blue Cross Blue Shield, or Empire Blue Cross (in the New York service areas). WellPoint also serves customers throughout the country as UniCare.

**Overview**

WellPoint recognizes the benefits members reap when barriers to essential, high-value services are eased or removed, and therefore we thank the Departments for their interest in pursuing

value-based insurance designs (VBID) as a means of promoting high-value, clinically effective, evidence-based preventive care.

While Section 2713 of the Public Health Service Act - which was created by the Affordable Care Act, and is related to the application of zero-cost sharing to certain preventive services - states that the HHS Secretary “may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs,” we note that VBID models are applicable to many evidence-based treatments, services, interventions and settings. We ask that future guidance reflect that reality.

Though VBID is in its infancy, the early evidence suggests that these models hold great promise as a means of promoting high value treatments, services and care settings, which should lead to better health outcomes. V-BID programs are often tied to wellness/prevention initiatives because V-BID programs become more effective when at-risk populations are identified.<sup>1</sup> In order to continue to develop appropriate applications of VBID, issuers need regulatory and legal flexibility that permit pursuit of innovative plan designs that will drive the VBID concept forward. WellPoint asks that the Departments keep this in mind as future VBID guidance is developed. In addition, we believe the federal government can help promote VBID as a tool for promoting value. We look forward to working with the Departments to share our expertise to help ensure continued flexibility and viability for VBID.

Again, we appreciate this opportunity to offer input into the development of VBID guidance. Our responses and insight into many of the questions in the request for comments are addressed below.

### ***Plan Design Tools Used to Incent Patient Behavior***

WellPoint employs value-based insurance models that focus on removing barriers for patients so that they will be more likely to access specific health benefits and, in some cases, access them at particular sites of service. These models, which thus far have focused on increasing treatment compliance in chronic disease populations, are voluntary, require enrollment in an Anthem prescription drug plan and rely upon cost sharing incentives, disease management (DM) participation requirements and networks of preferred providers to encourage patients to seek the high-value care they need.

The Anthem Condition Care Incentive Program (ACIP) is a “by condition” model which provides members financial incentives in order to promote adherence to maintenance medications, use of preferred providers and preventive services, and compliance with routine testing for the targeted disease conditions. ACIP targets five conditions – chronic obstructive pulmonary disease (COPD), heart failure, asthma, diabetes and coronary artery disease – by offering reduced co-pays for clinically effective medications, screenings and therapies to increase compliance.

Anthem Healthy Actions is our “by service” model, which is a product offering that does not require enrollment in the Condition Care program for members to qualify for the benefit. The “by service” model offers waived and/or reduced cost sharing to members taking condition-specific

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<sup>1</sup> These wellness program incentives may include payments of cash incentives for completing health risk assessments (HRAs) or providing incentives for reaching health targets (such as adherence with required medications). These wellness programs are independently subject to detailed regulatory requirements under HIPAA and the Americans with Disability Act. V-BID programs complement these appropriate wellness programs.

medications found on a pre-selected list of medications for the targeted conditions. Members are not required to be engaged in a health coaching program to receive the benefits, and the five targeted conditions mirror those offered through ACIP. The ultimate goal of the “by service” model is to remove or minimize the financial barriers to medication compliance.

Lastly, WellPoint just recently launched select “Site of Service” benefit pilots in two of our states in order to encourage members to utilize lower cost settings of care, including preventive services treatments and non-life threatening care. For example, one state plan, upon renewal, migrated their small and mid-size groups (those under 200) from co-pay plans to plans with lower co-pays for ASCs. In another state, employer groups would select whether or not they want to select these benefit designs for their employees.

Through incentives and member education, the “site of service” benefit encourages members to obtain health services such as colonoscopies at lower cost ambulatory surgery centers of equal or greater quality rather than at higher cost inpatient or outpatient facilities or the use of a retail health clinic or urgent care center instead of an emergency room.

### ***Effectiveness of Patient Incentive Tools***

The effectiveness of value-based insurance models is the subject of significant, on-going research. Thus far in the early stages of VBID adoption, research suggests that the right financial incentives do improve medication adherence. Research continues to further demonstrate that increases in medication adherence also lead to better health outcomes, less- costly health interventions and reduced absenteeism in the workplace over the long term.

An incentive that is truly effective is one that helps elevate compliance with treatment regimens for costly chronic conditions. Evidence suggests that waived or reduced member cost sharing for condition-specific pharmaceuticals appears to be the most intuitive and effective VBID approach. Effectiveness is defined as an increase in compliance with those medications and services where cost sharing reductions are present. Effectiveness is then measured by the change in the member’s medication possession ratio, use of preventive care, lab screenings and office visits, and use of acute medical services, such as emergency room and inpatient hospital visits.

Given the promise that VBID holds, we ask for significant flexibility in the Departments’ future guidance to continue to permit innovation and further discovery of how to drive better value in our health care system. This could include modifying coverage of lower value services or treatment options to promote higher quality of care and cost savings.

### ***Efficacy, Safety and Quality Drive Value***

The determination of value is dependent upon the level of efficacy of a service or treatment option, the safety profile of a service or treatment option, and the quality scores of a preferred provider. WellPoint has a dedicated clinical team comprised of physicians, pharmacists and other clinical experts to determine the appropriateness of including treatments and services, including preventive treatments and services, in our value-based programs. In order to make these critical determinations, WellPoint relies on internally-generated evidence and publicly available data sources to measure the value of a service or treatment option. WellPoint culls claims data, conducts extensive literature reviews, examines the nationally recognized quality measures

published by such organizations as NCQA and NQF and utilizes a unique formulary, which ensures that our drug list is appropriately driving desired outpatient outcomes. WellPoint also relies upon comparative effectiveness research and Health Core research studies. We then use this information to determine appropriate treatments and services for our value-based programs and the proper incentives to best encourage members to utilize the treatment or service. This process also informs the annual examination of the effectiveness of the programs once they have been instituted.

VBID should be adaptable in its ability to bring patients high-quality, high-value medical care in the most effective settings of care. As new evidence comes to light, and as the medical needs of patients are evaluated, our VBID programs evolve in a flexible manner to accommodate such circumstances. Therefore, we again encourage HHS to develop and adopt regulations that promote workable VBID solutions by allowing such flexibility and adaptability to continue.

Finally, it should be noted that several quality metrics are already in place to assist plans in threshold-designating high quality/high value care [services and or providers], such as:

- USPSTF
- ACIP
- CDC
- NCQA / HEDIS
- NQF
- Blue Cross Blue Shield Technology Assessment Center

### ***Current Plan Structure and Potential for Success in a VBID Program***

A critical step in assessing the potential effectiveness and viability of a VBID program is to evaluate the current plan design. Our experience and research indicates that rich plan designs, where member cost sharing is already low for all services and clinical settings, are not the best candidates to implement VBID as further financial incentive provide little additional motivation for these members to change behavior or engage in a care management or prevention program.

The adoption of a value-based design to target a particular condition is best determined by using baseline claims experience and performing an opportunity assessment. Depending on the membership base (including gender, age, and prevalence of disease), issuers can offer a tailored program that most effectively impacts the membership adopting the benefit offering. Specifically, we examine script and cost sharing data to determine appropriate incentive structures that will encourage a particular behavior, such as medication adherence or annual, appropriate screening. Additionally, studies have shown that financial rewards coupled with member engagement can further increase compliance to preventive care and medication. Consequently, WellPoint has found that a successful VBID program is one that incorporates pharmacy and medical benefits along with disease management or counseling to educate and engage members in their health care decisions.

In regard to cost sharing sensitivity, our research suggests that a minimum reduction in coinsurance of ten percent, or a \$10-15 reduction in co-pays, from a standard plan to a VBID plan, generally works to incent patients to change behavior. In several compliance studies, WellPoint has seen that members who are offered low co-pays for the medications are actually more compliant than members who have no co-pay for their medications.

The ACA requires zero cost sharing for certain preventive services, but we appreciate the Department's acknowledgement in recent sub-regulatory guidance that plans may use reasonable

medical management techniques VBID approaches to drive patients to high-value settings of care for these services. As cited in the guidance, plans may charge zero cost sharing for a colonoscopy received in an ambulatory surgery center (ASC) while charging a co-pay if that same procedure is performed in a hospital outpatient department. WellPoint asks that HHS make explicit in future regulation that the use of this type of VBID design is permitted and encouraged. Additionally, we hope that HHS will expand their vision of VBID beyond preventive services to include the essential health benefits, and chronic care management, in particular.

### ***Evaluation of Value-Based Insurance Designs***

WellPoint evaluates its value-based programs annually using data from a full plan year. The evaluation process involves an examination of pharmaceutical and medical services utilization, member and plan paid cost monitoring, which are determined by opportunity assessments. Employer groups' utilization rate for health care services, screenings and medications can identify disease prevalence, gaps in care and stratification of risk levels.

WellPoint also relies on actuarial analyses and long term outcomes data to help identify which services and treatment options provide the greatest value in helping members live a healthier life.

Though we evaluate our VBID programs annually, the benefits of value-based insurance designs do not show up immediately; they accrue over years as changes in medication adherence begin to improve health and reduce emergency room and inpatient visit expenses associated with chronic conditions.

### ***Communication with Members and Providers Regarding VBID Program***

WellPoint takes every opportunity to make our members aware of the VBID programs available to them. At each touch point with our customers, we seek to identify opportunities that would be beneficial and share that information with the member. Additionally, communication regarding our VBID offerings and the associated benefits are distributed by our employer customers in the form of employee newsletters and information sessions, and by the plan in the welcome letter, the summary of benefits and intermittent fliers and email messages. As WellPoint's VBID strategy traditionally has augmented a disease management program, members engaged in DM programs also receive information regarding VBID program benefits and eligibility.

For our "site of service" benefit pilots, WellPoint conducted provider education via phone calls, face-to-face visits and provider bulletins. In addition, one market is testing a special communication to members that provides talking points to support member discussions with providers about site of service alternatives.

### ***Costs and Considerations Associated with VBID Programs for Plans and Employers***

Upfront investment by the plan and a participating employer is required for successful VBID program implementation. For plans, value-based health programs typically have higher costs associated with increased analytics, as well as additional administrative, infrastructure and legal costs. For example, there is a need to receive and review historical claims where possible to provide a customer with an effective opportunity assessment. Additionally, the benefit needs to

be in place consistently for at least one to three years to adequately monitor and evaluate the impact of the benefit on the employer's health care trend.

For employers that choose to pursue a VBID strategy, most do so with the understanding that their return on investment (ROI) will not be attained in the short term, nor necessarily in the form of lower premiums. One side effect of lowering the barriers to treatments and services is an increase in utilization, which in and of itself drives up costs. However, the benefits of increased medication adherence and use of preventive screenings, for example, will accrue to the employer over time as health costs shift to more appropriate services and settings and as the health and well-being of employees improves.

Finally, WellPoint believes it is important that plans or issuers consider the requirements of the Genetic Information Non-discrimination Act (GINA) when information on patient risk is acquired for V-BID purposes. In order to protect patients from discrimination by insurers based on genetic inheritance, GINA generally does not allow insurers or health plan administrators to ask for their genetic information or use it to determine coverage or rates. This should no longer be a significant concern in 2014, given the market rules for health insurance require guaranteed issue and limited rating categories. It is important to note that certain USPSTF services need family history information to select the right population for preventive treatments and services. This discrepancy may need to be clarified in future regulations.

### ***VBID in the Fully-Insured, Small Group Market***

Clinically, VBID programs have applicability across all insurance market segments (individual, small group and large group markets, fully-insured and self-insured). However, from a risk and adverse selection perspective, many VBID designs are currently not practicable for the individual and small group fully-insured markets. This is due to a myriad of factors, to include a fluid coverage population and churn among carriers.

"Site of care" VBID programs can and do work in the individual and small group markets as they rely upon innovative benefit design to steer members to preferred providers that operate in higher-value sites of care.

### ***Considerations for Expansion of VBID Programs to More Treatments, Settings and Services***

Significant work and resources are required to expand VBID. As detailed earlier in our response, value-based programs are driven by conducting and reviewing research. Expanding to new conditions of focus for the VBID program would require the identification of a good disease state candidate: one that is a significant cost driver, has low levels of compliance and is often associated with a condition that is asymptomatic. Once a disease state is identified, an evaluation of the evidence based treatment guidelines must be conducted, and appropriate incentives to encourage use should be established.

From a plan execution and administrative standpoint, VBID programs are deeply embedded in our core operating systems. Extensive configuration and development are required to maintain and expand the drug and service incentives offered including those that are now required under the zero-cost sharing preventive services provisions of the ACA. Significant costs are associated with

this build out. Additionally, the expansion of a fully automated, integrated VBID program would require a significant investment by WellPoint to expand the benefit offering and establish connectivity to our preferred network, membership and claims system.

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Again, WellPoint appreciates this opportunity to offer our experience and insight surrounding VBID to inform future guidance. Should you have any questions or wish to discuss our comments further, please contact me at (916) 403-0522 or [Anthony.Mader@WellPoint.com](mailto:Anthony.Mader@WellPoint.com).

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthony Mader', with a stylized flourish at the end.

Anthony Mader  
Vice President, Public Policy