February 28, 2011

Submitted Via Federal Rulemaking Portal: http://www.regulations.gov

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

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

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care Benefits ("RFI"), which was published in the Federal Register on December 28, 2010.[1] This RFI solicits comments generally on Value-Based Insurance Design ("VBID") in the context of recommended preventive services. To inform future guidance, this RFI also solicits additional information on best practices of VBID. The Patient Protection and Affordable Care Act ("PPACA," the "Statute," or the "Law") acknowledges the importance of Value Based Insurance Design in §1001. §1001 amends the Public Health Service Act ("PHSA") by inserting a new PHSA §2713, a provision that requires plans and issuers offering group or individual health insurance coverage to cover recommended preventive services without cost sharing. Under the new PHSA §2713, the Secretary of Health and Human Services (the "Secretary") "may develop guidelines to permit a group health plan and health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance design."[2] As with other regulatory items promulgated under this Act, the VBID RFI was published jointly by the Department of the Treasury, the Department of Labor and the Department of Health and Human Services (the "Departments").[3]

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[1] Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care Benefits, 75 Fed. Reg. 81,544-81,547 (December 28, 2010) (hereinafter "VBID RFI").

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119 (2010). "Sec. 2713. Coverage of Preventive Health Services. (c) Value-Based Insurance Design."

[3] Pursuant to the request in the RFI, the Chamber is submitting these comments to one of the Departments - The Department of Health and Human Service's Office of Consumer Information and Insurance Oversight, with the understanding that these comments will be shared with the Department of Labor and the Department of Treasury, as well.

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

OVERVIEW

As the Chamber articulated in our comments in response to the Interim Final Rule on Coverage of Preventive Services ("Preventive Service Coverage IFR"),[4] we appreciate the Departments exploration of Value-Based Insurance Design. We were pleased that this practice was specifically recognized in the Statute and we applaud the Departments on-going inquiries about VBID.

We also appreciate the clarification issued by the Departments which permits the use of VBID in the in-network delivery of preventive services.[5] As the Departments' appreciate, assuring 100 percent coverage for all in-network "preventive" services would have removed any incentive for network providers of preventive services to improve quality and cost-efficiency. The Departments were wise in their decision to adopt a more nuanced approach that will further enhance the benefits of VBID in controlling cost and rewarding quality by permitting differentiation among in-network providers' delivery preventive care services.[6] We agree that plans and issuers should have the ability to graduate cost sharing amounts for in-network providers to incent further quality and cost-efficiency. To prohibit such differentiation in cost-sharing for all in-network preventive services could have effectively removed any incentive for network providers of preventive services to improve quality and cost-efficiency. We applaud the Departments acknowledgement of this important element.

However, despite general recognition by the Departments that VBID can "promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services,"[7] we are troubled by the limited scope. We urge the Departments, as they assess the current best practices used by insurers and employers alike in the area of Value-Based Insurance Design, to consider the system-wide benefits that can be realized by permitting and encouraging such designs. Flexibility is critical.

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[4] Group Health Plans and Health Insurance Coverage Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726–60 (July 19, 2010) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147) (hereinafter "Preventive Service Coverage IFR").

5 Fifth Set of Affordable Care Act Implementation FAQs, Issued December 22, 2010. Value Based Insurance Design in Connection with Preventive Care Benefits, Answer to Question 1. (available at: http://www.hhs.gov/ociio/regulations/implementation_faq.html)

[6] As detailed in the sub-regulatory guidance issued on December 22, 2010: "The regulations the Departments issued…recognized the ***important role that VBID can play in promoting the use of appropriate, high value preventive services and providers***. (emphasis added) ***Plans may use reasonable medical management techniques to steer patients towards a particular high-value setting*** such as an ambulatory care setting for providing preventive care services, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by having a mechanism for waiving the otherwise applicable copayment for the preventive services provided in a hospital.

[7] Preventive Service Coverage, 75 Fed. Reg. at 41,729.

TAKE A MORE EXPANSIVE APPROACH

As health reform is implemented, more work remains to be done to control costs and properly realign reimbursement and quality. Additional reform efforts likely must tailor payments to the quality and efficiency of the care delivered, rather than the quantity of services provided. One proven approach is Value-Based Insurance Design.

1. Different Contexts for VBID

   The full benefits of VBID cannot be realized if it is limited to preventive care. Therefore, we urge the Departments to permit the use of VBID in all areas. Plans and issuers should be not only permitted, but encouraged, to implement VBID as to all kinds of coverage.

   For example, as we articulated in our comments in response to the Preventive Service Coverage IFR, the Chamber recommends that the Departments permit variations in co-pays or co-insurance for medication therapies when designated pharmacies or pharmacy benefits managers are utilized. This practice is commonly referred to as step therapy, where employees and plan participants are incented to begin drug therapy for a medical condition with the most cost-effective and safest drug therapy first before progressing to other more costly or risky therapy, if necessary. The aims are to control costs and minimize risks.

   Another good example is the use of "high performing networks," a special category within some provider networks. In these tiered network plans, enrollees' cost sharing obligations vary based on the quality of the care provided by the practitioner. The Chamber, as representative of the employer community, requests that efforts to encourage VBID also permit plan sponsors to vary cost sharing obligations for plan enrollees who opt to select practitioners that are deemed to be of "high quality", and are in a specified "high performing" provider network. Rewarding employees and enrollees with lower co-payments for obtaining services from high value providers should be allowed across the gambit of services and benefits. Even applying VBID to the delivery of chronic disease management would properly incent employees and enrollees to seek care from the higher value and more effective programs. Wide application of VBID would encourage providers to meet quality standards and become more cost-efficient, as well as drive patient accountability and engagement while ensuring access to evidence-based services and preserving individual choice.

2. Protect VBID From Other Statutory Limitations

   There are a number of provisions in the Statute that are intended to protect consumers. These include: prohibition of lifetime and annual limits,[8] an annual limitation on cost sharing (or out-of-pocket maximums),[9] and annual limitation on deductibles.[10,11] While

[8] Patient Protection and Affordable Care Act, Pub. L. No 111-148, § 1001, 124 Stat. 119 (2010). "Sec. 2711. No Lifetime or Annual Limits."

[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302 (c)(1), 124 Stat. 119 (2010).

[10] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302 (c)(2), 124 Stat. 119 (2010).

we appreciate that these provisions were incorporated into the Statute in order to protect consumers, we urge the Departments to consider instances where these "protections" will unintentionally harm consumers and undermine the goals of reform. As these "protections" are implemented, we implore the Departments to empower VBID efforts to control cost and reward quality.

Practically speaking, we ask the Departments to understand that there are many contexts in which VBID can be adopted to reform the delivery system. Plans, issuers and employers must have the ability to use VBID to steer consumers, enrollees and employees to providers and products that are a better value. Hamstringing the ability to steer consumers to quality care because of a limitation placed on a consumer's annual deductible will only exacerbate costs and limit choice. Plans that offer consumers more choice through the availability of out-of-network providers or lesser covered services should not be penalized. To do so, will not only inhibit the ability of plans to use VBID but will also result in fewer patient choices. Just as the Departments accounted for this issue by permitting cost sharing in the delivery of preventive services by out-of-network providers, we urge the Departments to similarly permit compliant coverage to assess cost-sharing based on quality and efficiency.

To be specific, we respectfully request the Departments to adopt the following principle: In determining whether a health plan's design is PPACA-compliant, features that provide access alternatives to other PPACA-compliant coverage generally may be ignored. For example, because a plan could provide PPACA-compliant coverage that is limited to in-network services, if an out-of-network option is made available, PPACA limits on, e.g., out-of-pocket maximums or annual limits should not be applicable to the out-of-network option. The reason is obvious: such access alternatives expand the alternatives available to participants beyond PPACA minimum requirements, and higher co-pays, out-of-pocket maximums, and lower limits are used to encourage participants to use the VBID basic coverage.

FLEXIBILITY IS CRITICAL

Given that the Chamber's members are the country's largest purchasers of health insurance, we also remain mindful of the critical need for flexibility. Beyond the importance of taking an expansive approach to VBID, we urge the Departments to afford employers maximum flexibility in designing benefits and caution against regulating away the ability to innovate and respond to the needs and desires of employees.

Beyond the extensive insurance reforms contained in the Law, the country needs delivery system and payment system reform. While some provisions in the Statute address this, much more needs to be done. We urge the Departments to maximize the potential contained in the provisions that touch on delivery system and payment reform. Consumers and providers alike must be incented to control costs. Reimbursement structures must be revised to reflect the

[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119 (2010). "Sec. 2707. (b) Cost Sharing Under Group Health Plans."

importance of quality and efficiency. In order to do this, we urge the Departments to encourage the further adoption of delivery system reform efforts that have been developing in the private insurance market sector such as VBID, rather than restrict them and hinder their expansion.

CONCLUSION

We appreciate the opportunity to comment on this proposed rule and are happy to discuss any of our comments informally, or by way of testimony in hearings conducted by the Department. We support the general principles of improving health care coverage and access. We look forward to working with you to protect the fundamental goals of health reform that we jointly support.

Sincerely,

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