University of Michigan
Center for Value-Based Insurance Design

September 30, 2011

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9989
P.O. Box 8010
Baltimore, Maryland 21244-1850

Re: Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans

CENTER FOR VALUE-BASED INSURANCE DESIGN

The University of Michigan Center for Value-Based Insurance Design (www.vbidcenter.org) was established in 2005 to develop, evaluate, and promote value-based insurance initiatives in order to ensure efficient expenditure of health care dollars and maximize benefits of care. The Center is the first academic venue in which faculty with both clinical and economic expertise conduct empirical research to determine the health and economic impact of innovative benefit designs.

OVERVIEW OF VALUE-BASED INSURANCE DESIGN

Value-Based Insurance Design (V-BID) is one of the most innovative and widely implemented approaches to enhance clinical outcomes and control the cost of health care. A broad and diverse coalition of health care and business leaders across the country, as well as political leaders from across party aisles, support expanded utilization of V-BID programs to simultaneously address quality improvement and cost containment, both for preventive care and the management of chronic medical conditions. The Medicare Payment Advisory Commission (MedPAC) advocated exploring V-BID as a way to improve Medicare and control its cost-growth,[1] and a bipartisan group of health policy experts organized by the Brookings Institution included V-BID as a recommendation to "bend the cost-curve" in health care reform.[2] In March, 2011, V-BID was also highlighted in the National Quality Strategy.[3]

[1] Medicare Payment Advisory Commission, "Improving Incentives in the Medicare System," Report to Congress 2009, 2010.
[2] Brookings Institution, "Bending the Curve through Health Reform Implementation," October, 2010. Available at: http://www.sph.umich.edu/vbidcenter/publications/pdfs/BrookingsBendingtheCurve102010.pdf
[3] Please see: http://www.healthcare.gov/law/resources/reports/quality03212011a.html

The goal of V-BID is to structure health plan design elements to optimize patient health through increased utilization of evidence-based health care services. In particular, V-BID lowers financial barriers to high-value services and provides disincentives for low-value care. Restructuring health insurance plans to provide patient incentives for evidence-based care can help refocus the health care system on quality outcomes rather than volume, especially if the provider payment system is restructured along similar lines.

ESSENTIAL COMMUNITY PROVIDERS AND HIGH-VALUE NETWORKS

The legislative history of the Patient Protection and Affordable Care Act (PPACA) demonstrates broad, bipartisan support from congressional leaders for using V-BID to improve health and provide more efficient care delivery. The Administration has also demonstrated strong support for V-BID in regulations and policy statements on preventive care and quality enhancement. Specifically, pursuant to PPACA Section 2713, the Rule for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act supported the use of V-BID in the delivery of preventive care. [4] Furthermore, HHS supported the use of value-based network designs in its December 22, 2010 Frequently Asked Questions publication, which permitted variations in cost-sharing for services by providers based on quality measures.[5]

As the Department of Health and Human Services has stated, value-based networks are an important means of promoting quality improvement and delivery reform. We appreciate the inclusion of language in the proposed Exchange rule that recognizes the need to preserve the viability of value-based networks:

> Requiring issuers to offer contracts to all essential community providers would allow continuity of service for enrollees with existing relationships especially in communities where the essential community provider has been the only reliable source of care. However, such a requirement may inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals. [6]

We are aware that cost is not the only barrier that low-income individuals and families face when accessing health care. As millions of low-income Americans—generally with more urgent and complicated health care needs—enter the health insurance exchanges, essential community providers will play an important role in meeting access needs in some geographic areas. Value-based networks should not be an impediment to such coverage in those geographic areas without sufficient access to providers. Correspondingly, in geographic areas without access concerns, the ECP requirement should not present a barrier to value-based networks. We believe the language in the interim final rule must provide a balance between initiatives to enhance access and efforts to improve quality. We also look

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[4] 26 CFR 41726 (July 19, 2010).
[5] Please see http://www.dol.gov/ebsa/faqs/faq-aca5.html.
[6] 45 CFR 41899 (July 15, 2011).

forward to monitoring the implementation of this aspect of the law to ensure that value-based networks are providing robust access to high quality providers.

OTHER PRINCIPLES IMPORTANT TO VALUE IN THE EXCHANGES

We believe that Health Insurance Exchanges will be strengthened by the inclusion of plans that incorporate V-BID. Whether adopted at the federal or individual state Exchange level, the following principles will help guide such an inclusive policy:

1) *Avoid over-prescriptive cost-sharing rules.* V-BID works by varying cost-sharing based on clinical evidence with regard to a specific population. Therefore, while the desire to set standardized benefits is understandable, setting uniform requirements for co-pays and deductibles can have the unintended effect of prohibiting value-based principles. The result of strict cost-sharing requirements without clinical nuance would be overutilization of low-value services as compared to high-value services. Additionally, once set, such rules would be difficult to change, making the timely adoption of best practices based on new clinical evidence impossible. Rather, a rule more protective of patients, such as one recommending that co-payments be related to clinical value, will allow flexibility while better protecting patients from high out of pocket costs for necessary services.

2) *Maintain flexibility in benefit designs.* Value-based benefits generally raise the actuarial value of a plan, even though they may reduce health spending in the long run, because they lower the up-front cost—and therefore lead to increased use—of high-value services. Under the ACA, plans in each tier—platinum, gold, silver and bronze—have corresponding limits in actuarial value. Consequently, states should take care when mandating specific benefits and services for plans. Too many prescribed benefits will exclude value-based designs, especially for the bronze and silver plans, which will be sold to the very populations who have the potential to benefit from V-BID the most.[7]

3) *States that utilize quality ratings for plans should incorporate value-based principles.* Value-based insurance design improves quality because it encourages patients to seek high-value care, improving health outcomes per dollar spent. The new quality rating tools available in the Exchange should provide consumers with the information they need to allow them to choose plans that include incentives for high value care. Should states find it appropriate, they can give preference to plans that incorporate value-based designs.

V-BID is an increasingly popular tool in private plans for improving quality and containing health care cost growth. According to one survey, between now and 2014, 49 percent of employers are planning to use or are considering using V-BID; 58 percent feel similarly about

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[7] Chernew ME, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, and Fendrick AM. Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care. J Gen Intern Med 2008 23(8):1131–6

value-based networks.[8] Policymakers must take care not to inadvertently impede the use of V-BID by plans participating in the exchanges.

Conclusions

Our multidisciplinary team of University of Michigan researchers introduced the concept of Value-Based Insurance Design over a decade ago. We have worked with hundreds of health care stakeholders to promote its implementation as well as its rigorous evaluation to ensure the result is always improved patient care. We are delighted to provide input to this process, and look forward to an ongoing interaction as the Departments develop further guidance advancing innovations in benefit design.

Again, thank you for your thoughtful approach to value-based networks and V-BID in this regulation. Please contact us if you require any additional information.

Sincerely,

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[8] Please see: http://www.towerswatson.com/press/5328#1