University of Michigan
Center for Value-Based Insurance Design

August 6, 2012

Submitted via email to info@hbex.ca.gov

California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

Re: Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability, Discussion Draft

To Whom It May Concern:

Thank you for inviting comments on the Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability draft document. The University of Michigan Center for Value-Based Insurance Design (V-BID) is pleased to offer these comments regarding the discussion to utilize V-BID in the Exchange.

The University of Michigan V-BID Center leads in research, development, and advocacy for innovative health benefit plans. Established in 2005, the Center works as a liaison between the research community and implementers – employers, plan designers, and policy makers to help synthesize and communicate research findings, and encourage the benefits of V-BID.

Overview of Value-Based Insurance Design:

Value-Based Insurance Design 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 goal of V-BID is to structure health plan design elements to optimize patient health through the increased use 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.

The V-BID concept supports many of the California Health Insurance Exchange (HIE) guiding values, including the goals of affordability while assuring quality and access and that of catalyzing California's health care system by stimulating "new strategies for providing high-quality, affordable health care." V-BID uses clinical nuance to drive the design of benefits, so that health plans can offer more comprehensive and effective coverage while simultaneously addressing the affordability of health insurance. The clinically nuanced approach supported by V-BID principles better utilizes the outputs of our clinical research enterprise, investments in health information technology, and payment reform initiatives, while encouraging the creation of a more personalized, cost-effective benefits package.

In its October, 2011 report to the Department of the Health and Human Services, the Institute of Medicine (IOM) highlighted the need to build increased value into health plans offered in the Health Exchanges, and specifically highlighted the role of V-BID in making that change. The report strongly endorsed the premise, central to V-BID, that clinical nuance should be a significant determinant of the benefits offered in the Health Exchanges, saying, "The committee believes that the EHB package should become more fully evidence-based, specific, and value-based over time."[1] The Committee also noted, "Benefit design and its subsequent *administration* can be instrumental in addressing the cost and quality of services and care delivered. Insurers and employers are experimenting with an array of medical management and cost-sharing designs (e.g., value-based insurance design)."[2]

Promoting Value-Based Options for California HIE Participants:

We applaud the careful and thoughtful consideration that the Exchange staff has given to the application of V-BID to the California HIE. The report recommends that limited customization of "major" cost-sharing components be allowed, including value-based plan modifications. The Center agrees with the Exchange staff analysis that customization is appropriate to accommodate value-based modifications in copayments.[3] Any process set up by the Exchange to approve of V-BID plan modifications should be designed to support innovation. We believe that an approval process that is administratively burdensome (or, equally troublesome, one that is too restrictive) will inhibit the use of V-BID.

Setting too-uniform requirements for copayments would have the unintended effect of prohibiting value-based programs and other innovations aimed to achieve a better

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[1] Institute of Medicine. Essential Health Benefits: Balancing Coverage and Costs. National Academies of Sciences, 2011, p. 23.

[2] Ibid, p. 59.

[3] Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability, Discussion Draft: July 16, 2012, p. 7. Accessed at: http://www.healthexchange.ca.gov/BoardMeetings/Documents/July_19_2012/CHBE-QHP_Discussion_Draft_7162012.pdf

patient experience, quality improvement and cost containment. As your report notes:

> ...Standardization of plan designs must be done carefully. Otherwise the Exchange may end up with product offerings that do not match well with consumer preferences...Additionally, if requirements are too restrictive, standardization could stifle innovation in plan design and service delivery that lead to improvements in value.[4]

The potential result of strict cost-sharing requirements without clinical nuance would be underuse of high-value services and overuse of low-value services. Additionally, once set, such rules would be difficult to change, making the timely adoption of best practices based on new clinical evidence less likely.

Preserving Innovative Plan Incentives:

The report considers two options with respect to allowing value-based variations in cost sharing: prohibiting value-based designs, or allowing value-based designs "that lower patient out-of-pocket costs or provide financial rewards."[5] (The report later notes that this incentives-and-rewards-only approach could be modified after "the first few years."[6]) The analysis supports the later recommendation on the grounds that, "It encourages the provision of health care services at lower cost to consumers, encourages healthy behaviors and patient compliance, promotes access to high value services, and enables the integration of new clinical evidence into care by providing appropriate incentives."[7]

While we agree that benefit standardization promotes the consumer's comprehension of the differences among plan options, we believe that insurers should be allowed to use both incentives ("carrots") and disincentives ("sticks") in the plans they offer in the HIE. Such disincentives, including higher co-pays or deductibles, can discourage the use of dangerous or unnecessary care. The federal government encouraged the use of both carrots and sticks in Section 2713 of the Affordable Care Act, which provides for individuals to receive USPSTF-recommended primary preventive care, without cost sharing, as long as that care is delivered by an in-network provider. The Department of Labor (DoL) specifically endorsed the use of disincentives to low-value providers in a "Q and A" that discussed site of care for a beneficiary to receive a colonoscopy without cost-sharing under section 2713. DoL clarified that insurers can use "reasonable medical management techniques" (combined with appropriate safeguards for exceptional cases) to steer individuals to

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[4] Ibid, p. 79.

[5] Ibid, p. 9.

[6] Ibid, p. 83.

[7] Ibid.

high-value sites of care, and require patient cost-sharing if care is delivered at an alternative venue.[8] We strongly agree with this approach because it builds both specific clinical services and sites of care into the design of a value-based program.

Commercial insurers, self-insured employers, and states such as Oregon and Connecticut have successfully implemented V-BID programs that include disincentives to discourage Emergency Room use for non-urgent care or lower the use of unnecessary and expensive diagnostic tests. The Choosing Wisely campaign has brought together many medical specialty organizations to identify commonly used tests or procedures whose necessity should be questioned.[9] The identification of low--value services by specialty societies and such organizations as the United States Preventive Services Task Force should allow the development and implementation of cost-saving "stick" V-BID programs.

We respectfully propose that the option to offer a range of value-based innovations, using both incentives and disincentives where the plan provides independent clinical evidence supporting the benefit design, be preserved in the final report.

Conclusion:

On behalf of the V-BID Center, thank you again for the opportunity to comment and for the thoughtful consideration that your report has given to the use of V-BID in the California HIE. Please contact me if you would like to discuss any of the issues we have raised in further detail.

Sincerely,

A.
Mark Fendrick, MD
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University of Michigan

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[8] United States Department of Labor. FAQs about the Affordable Care Act Implementation: Value-Based Insurance Design in Connection with Preventive Care Benefits. Accessed at: http://www.dol.gov/ebsa/faqs/faq-aca.html

[9] For more information, please see: http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx