



University of Michigan
Center for Value-Based Insurance Design

June 28, 2010

Mr. Lou Felice
Chair, Healthcare Reform Solvency Impact (E) Subgroup
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64108-2662

Subject: Specific language recommendations providing that Value-Based Insurance Design is a quality improvement measure in Supplemental Healthcare Exhibit – Part 3

Dear Mr. Felice,

Thank you for your leadership in ensuring that the regulations implementing the Patient Protection and Accountable Care Act (PPACA) advance quality improvement initiatives to improve health outcomes. We write today to demonstrate that value-based insurance design (VBID), an innovative approach to benefit design that aligns incentives to promote patient health, is widely regarded as a quality improvement initiative, and to share with you specific language clarifying this aim. Prior to the NAIC call on June 24, we sent a letter containing general comments noting that VBID is a quality of care initiative that should be explicitly included in the numerator calculation of the MLR definition. Following the discussion of changes to Supplemental Healthcare Exhibit – Part 3, we now respond to your request for specific language as provided below.

VBID plans reduce or eliminate financial barriers to the purchase of “high-value” drugs or services in order to increase patient compliance and improve health outcomes. This quality enhancing approach to benefit design was recognized in the recent health reform legislation. Section 2713(c) of the PPACA explicitly permits the Secretary of Health and Human Services to develop guidelines for the use of value-based insurance design in advancing preventive care; VBID language was included in every version of the legislation throughout the legislative process. Numerous other sections of the law reference its principles as well. In addition, Senators Stabenow (D-MI) and Hutchison (R-TX) have introduced legislation (S. 1040) to establish a demonstration program requiring the utilization of VBID in order to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected medications can increase adherence to prescribed medication. Value-based insurance design is widely regarded among Members of Congress and their staff as a quality improvement measure directly related to better health outcomes.

As insurers are the point of coordination and customization for individual member benefits to implement VBID, we believe the MLR rules must not discourage insurers from investing in and implementing these applications to benefit members/consumers. As a result, we strongly assert that VBID should be included in the numerator of the MLR calculation. To that end, we believe that the language (as currently edited) in Column 5 under the exceptions list (on page 18), is contrary to the goal of improved health outcomes and the language in and intent of the PPACA. We urge you to delete this language in the Blanks Document:

“Costs associated with calculating and administering individual enrollee or employee incentives. This includes rewards or bonuses associated with wellness or health promotion programs (e.g., reductions in individual enrollee or group health plan copays, deductibles or premiums based on achieving specified health outcomes or engaging in specified health promotion activities);”

In its place, we believe this language explicitly allowing VBID should be added to the bulleted list in Column 1 on page 15:

“Expenses associated with the implementation and deployment of value-based insurance designs, including incentives and rewards for high-value health activities;”

Supporting Details for VBID Recommendation

In addition to the bipartisan support for VBID as a quality improvement mechanism noted above, extensive research conducted by academics at the University of Michigan Center for Value-Based Insurance Design, Harvard Medical School, and other institutions overwhelmingly supports the premise that VBID should be considered a quality improvement initiative and demonstrates that VBID contributes to the improvement of health outcomes. As you are likely aware, most common measures of quality focus on the use of services demonstrated by clinical research to improve health. For example, the Health Care Effectiveness Data and Information Set (HEDIS) is among the most widely accepted quality measurement systems and is founded on measurement of utilization of certain high value services. These include a wide range of services such as cancer screening services (e.g., mammography) and prescription drugs designed to improve management of chronic disease (e.g., diabetes and heart disease).

The published academic evidence is very clear that charging patients more for such services reduces their use. For example, research suggests that higher cost sharing will reduce quality as measured by HEDIS ¹.

More specifically, researchers have documented that:

¹ Chernew and Gibson. *Med Care Res Rev.* 2008;65:713

- Mammography is reduced following increases in copayment rates.²
- Relatively modest increases in cost sharing reduces utilization of important medications for managing chronic disease.³
- A doubling of copayments reduced use of anti-diabetes medications by patients with diabetes by 23% and reduced use of anti-hypertension medications by patients with hypertension by 10%.³
- When an employer increased cost sharing requirements by about \$10 to \$20 per prescription (depending on the exact medication), 21% of patients stopped taking their medication for high cholesterol (compared to 11% in a control group).⁴
- Higher cost sharing for prescription drugs had worse physiological outcomes (e.g. blood pressure), more visits to the emergency room, and even greater mortality.⁵
- Increases in cost sharing for ambulatory physician visits led to increased hospitalizations.⁶
- Equally worrying is that the impact of high copayments is concentrated on low income populations, and therefore worsening health care disparities.⁷

As noted above, value-based insurance design, which entails reducing copayments for such high value services, is demonstrated to have the opposite effect - improving quality. For example, evidence suggests that reduction in copayments of about \$10 per prescription increased patient adherence to treatment regimes for chronic disease.⁸ Recent reviews of the literature confirm these conclusions. Moreover, while research has not demonstrated this yet, it is likely that VBID can reduce health disparities.

Important industry stakeholders have confirmed the importance of VBID as a quality improving strategy. For example, in 2007, a VBID program adopted at the University of Michigan was awarded a Driving Value in HealthCare award by the National Business Coalition on Health, The Leapfrog Group and Bridges to Excellence. This award recognized the important role that VBID plays in promoting high quality care.

We are deeply concerned that the proposed language will discourage, and perhaps prevent insurers from adopting VBID programs that will improve the quality of care and reduce disparities. We believe that insurers interested in promoting the use of such valuable services as mammograms and chronic disease medications should not be discouraged from doing so. As the health care system moves forward and strives to address both cost and quality, programs such as VBID will be increasingly important to ensure that quality does not suffer.

Thank you for your attention to this matter. Please contact us if you require any additional

² Trivedi, et al. *N Engl J Med*. 2008;358:375

³ Goldman, et al. *JAMA*. 2004;291:2344.

information.

Sincerely,



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cc: Kathleen Sebelius, Secretary, Department of Health and Human Services
Richard Kronick, Deputy Assistant Secretary for Health Policy, Office of the Assistant
Secretary for Planning and Evaluation, Department of Health and Human Services
Steve Larsen, Deputy Director for Oversight, Office of Consumer Information and
Insurance Oversight, Department of Health and Human Services