SmarterHealthCareCoalition

March 2, 2020

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9916-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans

Dear Administrator Verma:

The Smarter Health Care Coalition (Coalition) appreciates the opportunity to provide comments on the HHS Notice of Benefit and Payment Parameters for 2021 (NBPP). Specifically, the Coalition supports the promotion of value-based insurance design (V-BID) in the proposed rule and has worked closely on the "V-BID X" project cited in the proposed rule. We applaud CMS' efforts to expand options for Qualified Health Plans (QHPs) to offer benefits based on the principles of V-BID.

The Coalition represents a broad-based, diverse group of health care stakeholders, including consumer groups, health plans, life science companies, employers, provider organizations, and academic centers. The Coalition is squarely focused on achieving "smarter health care" by removing barriers to clinically-nuanced health care services and medications. Our goal is to better align health care spending with value, improve the patient experience, and lower health care costs by supporting innovative benefit design that encourages the use of high-value care, and discourages the use of low-value care. A key focus of the Coalition includes the application and implementation of clinically nuanced, V-BID principles to health plans to provide enrollees better access to care that is truly beneficial to them based on their individual conditions and needs. We specifically provide recommendations regarding the V-BID portions of the proposed rule.

**Proposal:** CMS proposes additional specificity regarding cost-sharing flexibilities to increase the proliferation of V-BID on the Exchanges. Within unchanged statutory AV requirements and non-discrimination provisions, CMS offers a template model (University of Michigan V-BID Center's "V-BID X" project) to encourage plans to alter cost-sharing based on clinical value. The goal of the model is to drive utilization of high value services and reduce the use of low value services, without increasing premiums or deductibles. Many of the vetted high-value services are drugs, services, and equipment important to the management of chronic conditions, but also contain items relevant to behavioral health, substance use disorders, and HIV.

Issue: CMS specifically seeks comments on how to communicate V-BID to consumers on Healthcare.gov and how to collect information from QHPs on value-based elements.

Recommendations: the Coalition recommends an alternative approach to displaying "V-BID" or "value-based" on Healthcare.gov. First, consumers are generally unaware of what "value-based insurance design" means and, second, the concept of "value" can be misinterpreted from the clinical meaning intended by projects like "V-BID X". Instead, CMS should indicate when plans offer specific benefits of V-BID, such as low or zero cost-sharing for drugs and services to manage chronic conditions. The Coalition recommends adding a designation such as "Enhanced Coverage for Chronic Conditions," which could guide people to a specific section of the Summary of Benefits and Coverage (SBC) detailing cost-sharing changes. This could help consumers make an informed decision about plans best suited for their specific condition and situation. In terms of QHPs communicating plan elements to CMS, details could be reported to CMS through the existing QHP certification process (e.g., SERFF template) or accompanying documents:

- Leverage existing "preventive care" template rows for high-value services. Consumers are increasingly aware of the $0 cost-sharing for high-value preventive services (e.g., vaccines) required by the Affordable Care Act. Similarly, that row detailing zero out-of-pocket preventive services could include high-value services with reduced or zero cost-sharing.

- Add a description of special VBID services as a tag-along SBC document. Exchanges already display a PDF or linked version of each plan's SBC – it may be possible to add a second document into the same PDF, which explains other special VBID plan design elements. This could include cost-sharing changes for both low- and high-value services.

- Include "Enhanced Coverage for Chronic Conditions" as a filter on Healthcare.gov. Alternatively, or in addition, HHS could allow consumers to use keywords to search for preferential cost-sharing based on conditions, services, or drugs that are important to them. QHPs that have indicated to HHS that they have preferential cost-sharing for high-value services that match keywords will have preferential listing.

Issue: CMS seeks comment on minimum standards for "V-BID" designation. V-BID X was designed to show that increasing utilization on a slate of high-value services, equipment, and drugs could be achieved with no increase in premiums. Based on V-BID X, CMS outlines a value-based QHP model that could be adapted by plans in their respective markets, selecting services and cost-sharing that work best for their consumers. The table listed in the proposed rule should not be seen as a prescriptive list or a standard. It is important for the evolution of V-BID in public and commercial plans to be flexible.

Recommendation: CMS should further clarify that the V-BID X plan is just one template from which plans could adapt value-based principles. As the V-BID X research notes specifically:

> "It is important to note, however: there is no one way to design a value-based health plan for the exchange market; the elements of the V-BID plan described in this report should

be viewed as one possible approach that represents a "proof of concept," to be adapted by issuers given the lessons and recommendations presented, rather than a prescriptive list of services or cost-sharing changes. This report also details the collaborative process used to arrive at a standard V-BID plan, but plans may take a different approach."

While the Coalition does not recommend a specific set of rules with respect to what could be designated a "VBID" plan on the Exchanges, there are core principles of value-based insurance design that could be considered. For example, that services designated by health plans as high or low value need to be vetted externally by clinical evidence. The Coalition does not recommend, however, creating a prescriptive list of conditions, services, or drugs that should be included in a "value-based" QHP or any specific AV requirements. The Coalition also recommends CMS encourage QHPs to carefully select low-value services that have low clinical heterogeneity (i.e. almost always low-value), are harmful when used inappropriately, and easily identifiable in claims data.

The Smarter Health Care Coalition is ready to assist in advancing your efforts to improve the health outcomes of Marketplace enrollees. If you have any questions, please contact Michael Budros (mbudros@healthsperien.com). We encourage you to advance the recommendations above to ensure consumers access to the quality care they need when the need it.

Sincerely,

Andrew MacPherson, Co-Director  Ray Quintero, Co-Director  Katy Spangler, Co-Director