COLORADO
House of Medicine

October 20, 2021

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, #110
Denver, CO 80202

RE: Colorado Option Standardized Plan Design

Dear Commissioner Conway,

We appreciate this opportunity to provide comments about DRAFT Preliminary Emergency Regulation 21-E-XX - Concerning Colorado Standard Option Health Benefit Plan as the next step in our ongoing feedback throughout the Colorado Option standardized plan design process. Prior comments from the Colorado Medical Society (CMS) and Colorado House of Medicine (HOM) have emphasized guiding principles, identified priority areas, and recommended specific strategies and steps. This feedback has been focused on how to promote health, reduce disparities, and design a Colorado Option plan that enables the provision of high-value health care for the benefit of Coloradans. The following comments and questions are respectfully offered to highlight key issues as the end of the plan design process approaches.

- Section 5(D): "Coverage must provide essential health benefits as defined in Colorado Regulation 4-2-42. Carriers are not permitted to add benefits outside of those outlined in Regulation 4-2-42."
    - Carriers cannot add benefits outside the essential health benefits? HB21-1232 says the "standardized plan must…Include, at a minimum, pediatric and other essential health benefits" (emphasis added).
- Section 5(D): "Carriers must follow the defined cost-sharing requirements for the benefits listed in Appendix A. Carriers may vary cost-sharing amounts for essential health benefits not listed in Appendix A."
    - So carriers have no flexibility to incentivize high-value services and disincentivize low-value services within a benefit category for which there is a defined copay or coinsurance in Appendix A? Doesn't this preclude carriers from implementing value-based insurance design (VBID) principles? While we certainly agree that primary care and behavioral health care are high-value overall, beyond that, identification of high-value and low-value care must be done at the service level and not the category level—the value of individual services within a benefit category can vary. In emergency room services, for example, it is important to differentiate between potentially true emergencies (by a prudent layperson standard) and other services sought in the emergency room that can and should be handled in another setting.
    - The slide deck from the second stakeholder meeting on August 12th said, "Are there services we want to disincentivize (e.g. low value care)? Low value care: 'certain treatments, diagnostic tests, and screenings where the risk of harm or cost exceeds the likely benefit for patients.'" As was seemingly acknowledged here and throughout the stakeholder engagement process, disincentivizing low-value care through increased cost-

sharing can and should be a key method for reigning in health care costs, yet it is not operationalized in this draft regulation. The regulation not only fails to enable carriers to disincentivize services that have been identified as low-value, it actually prohibits carriers from doing so by requiring them to follow the defined cost-sharing for entire benefit categories, without regard to evidence about whether a particular service is high-value or low-value. The regulation should implement this VBID approach. As we have previously emphasized, disincentivizing low-value care through higher cost-sharing must be done carefully and with an evidence-based, physician-led exception process that recognizes individual patient needs and protects the vulnerable. Any increase in cost-sharing should be evaluated to ensure it is transparent to the consumer and does not have a disproportionate impact on low-income populations and communities of color.
    - We once again would like to refer the DOI to JAMA's "Less is More" series documenting the ways that overuse of medical care fails to improve outcomes, harms patients, and wastes resources (https://jamanetwork.com/collections/44045/less-is-more).
- Section 5(E)(1): "A minimum of three behavioral health visits and three primary care visits without copays, deductibles, or coinsurance."
    - We agree that improving access to primary care and behavioral health services is critically important, but three free visits is an arbitrary number that does not facilitate the crucially important, cost-saving care that chronic disease patients need in order to effectively manage their conditions and keep them from utilizing higher-cost services down the line (emergency room visits, hospitalizations, etc.).
    - There should not be a limit on the number of primary care visits per year for which there is first-dollar coverage, particularly when those visits are for chronic disease management. For example, reducing hospitalizations for a diabetic will require more than three visits per year, but successfully managing chronic diseases for those complicated patients who are high health care utilizers will significantly reduce overall costs and reduce health disparities.
- Section 5(E)(2): "A minimum of three prenatal care and preconception visits without copays, deductibles, or coinsurance. Subsequent prenatal care and preconception visits shall be subject to the same cost sharing structure as primary care visits."
    - As above, three free visits is an arbitrary number. A healthy pregnancy would typically have around 13 or 14 prenatal visits; more may be indicated if there are complications. Any limits on obstetrical care-related visits and any copayment, coinsurance, or deductible requirements will have a chilling effect on patients' utilization of important prenatal services, especially for the most vulnerable patients. The DOI should consider basing any requirement for patient cost-sharing for these services on the Medicaid model.
    - We also suggest the DOI consider implementing value-based bundled payments for maternity care, though this of course must be done carefully so as to avoid unintended consequences.
    - We recommend the inclusion of postpartum visits in the same bucket of services as prenatal care and preconception visits.

- Section 5(E)(3): "Carrier formularies shall have four drugs tiers defined as follows and that allow copay only cost sharing: a. Tier 1: Preventive Care Drugs; b. Tier 2: Generic Drugs; c. Tier 3: Preferred Brand Drugs; d. Tier 4: Non-Preferred Brand Drugs; e. Tier 5: Specialty Drugs"
    - How will preventive care drugs be defined?
    - We believe that drugs for managing chronic diseases are just as important as preventative drugs. Making such drugs more affordable would enable providers to care for chronic disease patients more effectively.
- Appendix A
    - We do not see anything in Appendix A that operationalizes key components of VBID, like mechanisms to facilitate chronic disease management and address social determinants of health. As we've said in prior comments, these are foundational elements to providing high-value care and reducing racial health disparities–elements that we believe are essential to achieving the cost-saving goals within the plan required by HB21-1232. We are concerned that without utilizing these VBID approaches, the plan will, by default, not meet patient needs, not get at some of the true drivers of health care costs, and simply cause health insurance carriers to push the required cost cuts onto the backs of physicians and other providers alone.
    - If the cost-saving impacts of evidence-based VBID approaches are not recognized—if the plan design does not account for the fact that high-value services are up-front investments in patients' health that prevent future utilization of costly services—then the plan design process appears to disregard a key part of the equation in a way that hamstrings this whole effort. While we understand that the DOI is constrained by the actuarial value limits of the metal tiers, we are concerned that the modeling informing the design of the standardized plan does not take into account the true value of high-value services. The selection of three free visits for behavioral health, primary care, prenatal care, and preconception services is evidence of this problem. The DOI indicated during the last stakeholder meeting that including more of these visits would have made the plan too "rich"—but of course the inclusion of more free visits makes the plan too "rich" if the modeling only takes into account the cost of these services and not the value (the downstream cost savings) they bring that actually makes them high-value. The modeling, and therefore the plan design, does not take into account the savings that would come from increasing access to primary care physicians or outpatient specialty care to manage chronic conditions, which has been shown to reduce unnecessary diagnostic testing, referrals for urgent care visits, emergency room visits, and hospitalizations for chronic disease patients.
    - We do not see anything in Appendix A that specifically adopts or operationalizes most of the best practices for addressing key, state-identified disparities (including tobacco use and cessation, diabetes and pre-diabetes, cardiovascular disease, asthma, and obesity).
    - We do not see anything in Appendix A that encourages the delivery of care at appropriate, high-value sites of service. For example, there are certain surgeries/procedures that should be incentivized to be performed in ambulatory surgery centers rather than hospitals.

- We do not see anything in Appendix A that addresses social supports (e.g., transportation and other social services) that would improve patients' access to care.

- Other
  - We do not see anything about ongoing data collection and evaluation to monitor how the standardized plan is affecting consumers and particularly how it is affecting racial health disparities.

We have repeatedly emphasized that we need to focus on quality and access and not just cutting costs—this plan must drive better value in health care, increase competition, and enable broad provider participation. Without using a plan design that invests in keeping patients healthy by focusing on prevention and chronic disease management and that drives the provision of high-value care, there are few options left to commercial plans besides sweeping, blunt provider payment cuts and onerous utilization management procedures that harm patients and burn out physicians and other providers.

Thank you again for the opportunity to provide feedback. We know that much work remains and hope that these comments are helpful as we all work toward the shared goals of finding cost savings for patients so they will have greater and more equitable access to high-quality care.

Sincerely,

Mark Johnson, MD, MPH
President
Colorado Medical Society

Co-signed:
Colorado Academy of Family Physicians
Colorado Orthopaedic Society
Colorado Society of Eye Physicians & Surgeons

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