National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

July 12, 2017

Submitted electronically via: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9928–NC
P.O. Box 8016
Baltimore, MD 21244–8016

Re: RIN 0938–ZB39 – Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Department of Health and Human Services' (HHS's) request for information regarding goals for the individual and small group health insurance markets.

The National Business Group on Health represents 415 primarily large employers, including 73 of the Fortune 100, who voluntarily provide self-insured and insured group health plan coverage and other employee benefit plans to over 55 million American employees, retirees, and their families.

As our members continue to comply with the requirements of the Affordable Care Act and other applicable statutes, primary concerns will be (1) minimizing the administrative and cost burdens associated with those requirements and (2) maintaining and adapting plan designs to improve participant health, achieve higher-quality care, and lower overall health care costs. In addition, because our members employ and provide health benefits through a wide variety of work arrangements—including full-time, part-time, seasonal, temporary, and retiree—they strongly support robust, high-quality, and affordable individual and small group health insurance markets that will support individuals as they transition between different work arrangements and types of health coverage.

Therefore, the National Business Group on Health welcomes HHS's efforts to seek input on regulations or guidance that will empower patients, stabilize the individual and small group health insurance markets, and enhance affordability. To achieve these goals, we recommend that future HHS guidance ***encourage plan design features that promote clinical effectiveness, efficiency, and value-based benefit design.*** We believe that this approach will promote efficiency within the health care system; allow insurers to maintain and implement plan designs that promote evidence-based, value-driven care;

maximize benefit options for individuals; and ultimately reduce administrative and cost burdens. Our specific recommendations are as follows:

I. Demonstrated Evidence of Clinical Effectiveness

To prevent health care expenditures for unnecessary, redundant, or ineffective care, we support coverage of services and treatments with demonstrated evidence of clinical effectiveness. To this end, health plans should align with generally accepted standards of medical practice and promote clinically appropriate care. For example, when evidence warrants, our members' plans routinely use care and medical management tools based on clinical effectiveness such as:

- "Step therapy" for medications to encourage providers and patients to utilize proven effective drugs that are less costly or risky to patients' health than new "blockbuster" drugs with less evidence base;

- Radiology management programs to ensure that patients receive appropriate screening for their conditions or stages of treatment and are not subject to excessive radiation exposure or unnecessary scans; and

- Dental plan limits—related to frequency, age, and tooth structure—to provide low cost dental coverage, which has resulted in improved oral health with less than 3% of Americans reaching their annual dental limits. Without internal limits mitigating overutilization, the cost impact of providing oral health care services would rise considerably.

By prioritizing clinical effectiveness, plans can assure that patients receive the highest-value, safest, and most medically appropriate health care services to meet their individual needs. Such a focus will also help health plans maintain the balance between comprehensiveness and affordability of coverage while improving patients' health and access to health benefits. Insurer efforts to implement plan designs based on clinical effectiveness also would be consistent with HHS's efforts to promote evidence-based and value-based benefit designs.

II. Management Practices that Promote Efficiency

In addition to clinical effectiveness, we believe that promoting efficiency through best management practices within health plans will help keep health coverage affordable. Such best management practices include, but are not limited to:

- **Evidence-Based Benefits.** Link coverage to the effectiveness of treatments and establish cost-sharing, provider selection, and plan payments that support evidence-based care and discourage ineffective care. For example: Reduce or eliminate copayments for maintenance drugs prescribed for diabetes, asthma, and hypertension where the evidence base for the drugs' effectiveness is strong.

- **Targeted Evidence-Based Preventive Care.** Provide incentives such as first dollar coverage (or little or no copayment) for evidence-based preventive care services for targeted populations to improve participant health and reduce future health care costs. Offer education programs to improve patient awareness of preventive care.

- **Emphasis on Primary Care.** Pay more for care coordination and patient management and evaluation services. Choose providers that incorporate the "patient-centered medical home" concept and emphasize primary care coordination.

- **Meaningful Cost-Sharing.** Set cost-sharing for patients at levels that reduce excessive and inappropriate utilization but ensure access to needed medical care when appropriate. Vary cost-sharing based on clinical necessity and therapeutic benefit. For example: Reduce cost-sharing when patients meet requirements fostering evidence-based care such as using medical consultation services and decision supports or participating in disease or case management.

- **Prescription Drug Management.** Manage prescription drug use and pharmacy spending by establishing plan preferences for select generics and brand-name drugs. Consider "step" therapy, generic substitution requirements or incentives, generic education programs for plan participants and physicians, a separate deductible for prescription drugs, preauthorization for selected drugs, reduced cost sharing for mail order compared to retail purchase, mandatory mail order of maintenance medications, tiered copayments, coinsurance rather than copayments for medications, dose optimization, and quantity-duration protocols for certain medications.

III. Reasonable Limits to Promote Effective Care, Prevent Unnecessary Care, and Keep Coverage Affordable

We also strongly recommend that HHS, in developing guidance, take into account the significant role of benefit limits in health coverage. Employer-sponsored plans routinely place limits on a number of services, where they make sense clinically, to keep care affordable. Examples include limits on the following: bariatric surgery, chemical dependency treatment, chiropractic benefits, dental benefits, vision benefits, durable medical equipment, hearing aids, home health care and hospice, infertility benefits, out-of-network benefits, and physical and speech therapy.

Thank you for considering our comments and recommendations. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian J. Marcotte
President and CEO