Maryland Health Quality and Cost Council - VBID Task Force

Value Based Insurance Design - Comments

Submitted Friday, September 12, 2014

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The Maryland Women's Coalition for Health Care Reform (Coalition) is a non-partisan, statewide alliance of thousands of individuals and 99 organizations committed to ensuring that the needs and interests of consumers are foremost in the implementation of health care reform. We appreciate the opportunity to submit comments to the Value Based Insurance Design (VBID) Task Force of the Maryland Health Quality and Cost Council and are joined in these by the 16 organizations listed below.

We were supportive of language in the 2011 Exchange law stating that the "... feasibility and desirability of the Exchange engaging in value-based insurance design..." could be examined. In large part this was because we believe that VBID "promotes access to needed services and higher quality care..."[1] and that it does this by aligning "... patients' out-of-pocket costs, such as co-pays and premiums, with the value of health services."[2] We also concur with the primary objectives as outlined in the Request for Public Comments. However, at this stage, we have **two primary concerns**.

- The **process** to date has lacked transparency and as well as participation by a broad-based group with diverse experiences and expertise. And, from our perspective, the lack of consumer representation is particularly concerning and evident in both the content and framing of the proposed definition.
- The **proposed definition** falls well short of addressing the core premise, as stated above. In addition, the conflation of VBID with wellness is an issue of great concern.

To address these issues our **principal recommendation** is to reconstitute the VBID Task Force and to charge it with preparing a definition that more directly reflects the core VBID principles, which we explain more fully below.

I. VBID Task Force and Consumer Engagement

There are two key components to successful implementation of each of Maryland's complex health care reform initiatives. The first is a thoroughly transparent process that supports the goals of effective participation and accountability. The second, requires the active participation of those with

[1] Issue Brief - V-BID Policies in State Health Exchanges, Center for Value Based Insurance Design, University of Michigan
[2] Center for Value Based Insurance Design, University of Michigan

appropriate expertise and experience to inform the process. This must include not only the traditional "stakeholders" (payers, providers, hospitals, etc.), but also those who are central to, and directly impacted by, the reform efforts - consumers.

Unfortunately, the process to date for the development of the VBID design has failed in both areas.

For example:

- There was no effort made to widely circulate the request for comments. The signatories to these comments have all been active respondents to requests for comments in multiple related areas and yet none of us received the request directly. In addition, nowhere on the MHQCC site that we could see was there a notice about the opportunity to comment.
- In its December 2013 charter, the membership of the Task Force was to be comprised of 20 individuals with specific areas of expertise. However, its membership, as of June 2014, in no way included the type of broad representation, including consumer representation, called for in the charter.
- Meetings of the Task Force were not made public and no minutes were maintained. While staff did offer to respond to our questions this is hardly a standard for transparency.
- A proposal for a VBID website was presented in June 2014 to the MHQCC. It appears to have been developed without any input from consumers or others to whom it would be directed, or any preliminary testing as it is wholly inadequate in providing the type of information that consumers will require. Given the recent experiences with Maryland Health Connection this would appear to be a remarkable oversight.

These and related issue could be rectified by:

(1) **Reconstituting the VBID Task Force** and ensuring that there are individuals with adequate and appropriate expertise and experiences to inform the process. This should, of course, include consumer representatives. If it is determined that Maryland consider an approach that targets specific medical conditions, then there should be representatives from those communities, including consumer representatives. In addition, however, there should be more broad-based consumer perspectives; and

(2) Providing **greater transparency for the entire VBID process**. One simple step would be to provide a list serve for those interested in receiving information on a regular and timely basis. This should include notices of meetings, meeting minutes, and relevant research, white papers or other background materials that explain the process and outcomes of the Task Force's work.

In looking at its options the MQHCC could look to the approach that the Health Services Cost Review Commission (HSCRC) has taken with the Hospital System Modernization Waiver process. Not only does this leverage consumer representation in multiple areas, but it also ensures transparency with a comprehensive website where all relevant information is readily available

2. VBID Definition
We appreciate that the task force has asked for comments specifically related to the proposed VBID definition. However, due to the lack of transparency of the process itself and any evidence of what was considered in developing the definition, we strongly believe that the Task Force needs to reconsider the definition in its entirety.

As currently written, the definition:

- Does not comport with accepted VBID's emphasis on cost-sharing, co-pays and deductibles that are designed, as stated above, to remove barriers.
- Conflates wellness and the VBID: The signatories here are fully in support and in fact, many have advocated for years, for better access to preventive care and early intervention. However, VBID and wellness programs are very different insurance initiatives that are independent of each other. (See Families USA fact sheet on the key differences) Insurers are currently allowed to implement wellness initiatives in certain insurance markets, not including the small group market. By adding wellness principles and incentives, or even worse making VBID incentives contingent on completion of a wellness screening or activity, Maryland could be in violation of federal law.
- Can be read as supporting savings for carriers, rather than the desired outcome of facilitating consumers' access to high-quality and evidence-based care.

In the following we suggest revisions to the VBID definition below, but with the caveats as described above:

> VBID plans are designed to lower or remove financial barriers to essential, high-value clinical services and discourage the use of low-value health services and providers. The essential tool to effect this is a decrease in cost-sharing, including but not limited to, co-payments and deductible exemptions. Carriers providing VBID plans are required to clearly communicate with their members and provide tools to help them to use their health plan more effectively and efficiently. By aligning out of pocket expenses, such as co-payments, cost-sharing and deductibles with the value of services, VBID plans offer incentives to their members for using the health care system efficiently. VBID plans are required to include the following elements:

- Incentives to use high-value services for at least three medical or behavioral health conditions. A high-value service is one that provides considerable clinical benefit, relative to the cost;
- Disincentives to discourage low-value or non-evidence based services for at least three medical or behavioral health conditions. A low-value service is one that does not provide substantial health benefit relative to the cost.

The proposal should also clearly define an incentive for use of high-value service as "reduced or no cost-sharing." As drafted there is no mention of what constitutes an incentive, rather it appears to leave that to the insurer, which does not align with the principles of VBID. If a true VBID plan were available in the MHBE market, it could address one of the most frequent barriers to care- high deductibles in the silver and bronze plans.

In addition, because there is no indication of what research, if any, went into the identification of the medical conditions we believe it is premature to recommend which ones should qualify for VBID incentives or disincentives. There has been considerable research on this issue[3]. Therefore, we recommend that the VBID Task Force do a thorough review of available research and employ a thoughtful and inclusive process prior to finalizing a definition.

We believe that, with a more inclusive process and the use of data-driven evidence based studies, a revised VBID definition would meet the necessary criteria of being consumer-centric with the goal of removing barriers to consumers' access to high value treatments and services.

In conclusion we would like to raise one other concern related to accountability and oversight. We understand the MHQCC has undertaken VBID as part of its Evidence Based Medicine Subcommittee, but if VBID were to be implemented, it is not clear which government entity would be responsible for:

- Determining which medical conditions qualify for incentives; deciding what type and how many incentives qualify as a VBID plan; and ensuring that a given VBID plan adequately protects consumers; and
- Certifying that a plan meets the standards as set forth in the definition.

We assume that in the latter case it would be the Maryland Insurance Administration consistent with their role of certifying plans for sale on Maryland Health Connection. However, who would be responsible for the complex decisions regarding incentives and consumer protections? These are questions that should be addressed as the definition is developed.

Again, we appreciate the opportunity to submit our comments. We look forward to working with MHQCC as this process moves forward

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Signatory Organizations

Advocates for Children and Youth

Asian American Center of Frederick

Community Behavioral Health Association

Equality Maryland

Johns Hopkins Health Care

[3] Among the resources are the U.S. Preventive Services Task Force; the Agency for Healthcare Research and Quality , and the Institute for Clinical and Economic Review

League of Women Voters of Maryland

Maryland Addictions Directors Council (MADC)

Maryland Clinical Social Work Coalition, sponsored by the Greater Washington Society for Clinical Social Work

Maryland Nonprofits

Mental Health Association of Maryland

National Council on Alcoholism and Drug Dependence - Maryland Chapter

Primary Care Coalition of Montgomery County

Progressive Cheverly

Public Justice Center

Unitarian Universalist Legislative Ministry of Maryland

University of Maryland Carey School of Law, Drug Policy and Public Health Strategies Clinic