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Legal & Public Affairs

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Office of Consumer Information and Oversight,
Department of Health and Human Services,
Attention: OCIIO-9992-IFC,
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code OCIIO-9992-IFC

In the preamble to the *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Care Services Under the Patient Protection and Affordable Care Act (26 CFR 54.9815-2713T, 29 CFR 2590.715-2713 and 45 CFR 147.130)*, the Departments indicated that they "recognized the important role that value-based insurance design can play in promoting the use of appropriate preventive service." The interim final rules specifically authorize the use of cost-sharing with respect to preventive care services delivered out-of-network when cost-sharing is eliminated for in-network preventive services. The preamble cited this as an example of a value-based insurance design that fosters better quality and efficiency. The preamble also indicated that "(t)he Departments are developing additional guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with respect to preventive benefits" and requested comments related to the development of such guidelines.

CIGNA is pleased to respond to the request made by the Departments for comments to assist in the development of guidelines for value-based insurance designs in connection with Section 2751 of the Public Health Services Act as added by the Patient Protection and Affordable Care Act. CIGNA is a global, health service organization dedicated to helping people improve their health, well being and sense of security. The guidelines to be developed by the Departments regarding value-based insurance designs by group health plans and health insurance issuers will have a profound impact upon the cost and quality of preventive care services. We, therefore, appreciate the Departments' willingness to receive comments on this critically important subject.

CIGNA supports the requirement in Section 2751 of the Public Health Services Act as added by the Patient Protection and Affordable Care Act that preventive care services be

covered with no patient cost-sharing. Improving access to preventive care services can improve health and reduce costs. The interim final rules clarified that cost-sharing is permitted for preventive services when delivered out-of-network provided preventive care is covered with no cost-sharing in-network. However, the elimination of cost-sharing for in-network preventive services without effective value-based insurance designs could have the effect of removing any incentive for network providers of preventive services to improve quality and cost-efficiency. While reimbursement rates for preventive services delivered in-network are negotiated, the reimbursement rates can vary widely among network providers. In addition, it is anticipated that network providers will seek to negotiate higher reimbursement rates for preventive services as a result of the increased demand for these services and the assurance of full coverage mandated by Section 2751. Unless effective "value-based insurance designs" that seek to foster better quality and efficiency are implemented, Section 2571 will have the unintended effect of making coverage less affordable and thwart quality improvement.

The "value-based insurance designs" being considered by employers sponsoring group health plans and health insurance issuers include:

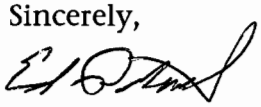
- Tiered Networks: Those network providers of preventive services that meet identified quality and cost-efficiency criteria would be designated for full reimbursement with no cost-sharing while some cost-sharing would be applied to the preventive services received from those network providers not achieving similar quality and cost-efficiency results. The number and geographic distribution of the designated network providers would have to be sufficient to ensure adequate access to preventive care services with no patient cost-sharing for plan participants and beneficiaries

- Reference-Based Pricing: In-network reimbursement for preventive services such as colonoscopies, laboratory and imaging services can vary widely within a geographic area. To encourage individuals to consider cost when choosing providers of these preventive care services, a group health plan may cap plan reimbursement at a specified dollar amount based on market norms. For example, plan reimbursement for a colonoscopy would be 100% of the network provider's reimbursement rate (i.e., no cost-sharing), but subject to a cap of $800. If the patient chooses a network provider whose charge for a colonoscopy is $800 or less, the expense would be reimbursed in full with no patient cost-sharing. The patient may, on the other hand, choose to receive services from a network specialist that charges more than $800. In that case, the patient would be responsible for any charges in excess of the $800 cap with no plan reimbursement. The cap would have to be high enough to assure that the number and geographic distribution of network providers charging less than $800 for a colonoscopy is sufficient to assure that plan participants and beneficiaries have adequate access to colonoscopy services with no cost-sharing.

Both of these value-based insurance designs are analogous to the example previously approved in the interim final rules. Moreover, these designs would encourage providers of preventive services to be meet quality standards and/or become more cost-efficient and each would drive patient accountability and engagement while ensuring access to critical, evidence-based preventive services and preserving individual choice. We request, therefore, that the Departments develop guidelines for value-based insurance designs that permit the types of designs described.

We appreciate your consideration of these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,



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