Appendix 1

Feedback on Benefit Design of Colorado Option Standardized Plan

The Colorado Division of Insurance (DOI) is engaged in a broad stakeholder process to gather feedback on the design of the Colorado Option's standardized plan. The DOI has put out a Google form with questions (in bold below) for stakeholders to provide feedback. The Committee on Value in Health Care has drafted the responses in blue.

1. **Colorado's Standardized plan will cover the 10 essential health benefits (EHBs) as required by the Affordable Care Act. These benefits are further defined by Colorado's proposed benchmark plan which is currently under review by the federal government. Please rank the 10 EHBs listed below based on what you think the standardized plan should incentivize through lower cost sharing (i.e. low or no copays or coinsurance)? Only one EHB per column is allowed. [1st choice to incentivize through lower cost sharing - 10th choice to incentivize through lower cost sharing]**
    a. Preventive and wellness services and chronic disease management
    b. Mental health and substance use disorder services including behavioral health treatment
    c. Maternity and newborn care
    d. Pediatric services, including oral and vision care
    e. Ambulatory patient services
    f. Prescription Drugs
    g. Hospitalizations
    h. Rehabilitative and habilitative services and devices
    i. Laboratory services
    j. Emergency services
2. **Please explain why the EHB's you chose above should be incentivized.**
    a. The Colorado Medical Society (CMS) has tried to rank the 10 EHBs above, but CMS cannot fully endorse this ranking—there are a variety of caveats and other considerations that must be taken into account.
    b. The choice of what types of care to incentivize through lower cost sharing should be done based on specific services, not categories of services.
    c. The EHB categories are too broad to serve as an effective way to rank high-value and low-value care.
    d. For example, for emergency services, it is important to differentiate between potentially true emergencies (by a reasonable layperson standard) and other services sought in the emergency room that can and should be handled in another setting.
    e. In addition, there are certain surgeries/procedures that should be incentivized to be performed in ambulatory surgery centers rather than hospitals.

f. Patients should not be bankrupted when they need to go to the hospital, but unnecessary hospitalizations should also be disincentivized.
g. Even with specific services (as opposed to categories of services) caution must be taken to recognize the relevant nuances. Services identified as low-value might be low-value the majority of the time, but high-value for certain patients in certain situations. We must be careful not to harm the most vulnerable. On the other hand, a relatively small number of high-utilizers drive a significant portion of health care costs, so efforts to reduce costs should be focused on the areas where the most savings can be found.
h. *With all that being said, CMS believes that preventive and wellness services and chronic disease management are the foundation of high-value care and must be prioritized. Mental health and substance use disorder services also must be strongly incentivized through lower cost-sharing.*
i. Please see CMS' comments submitted on August 12, 2021 (http://www.cms.org/uploads/2021812_CO_Option_Standardized_Plan_Design_Comments_SUBMITTED.pdf), for more information on CMS' stance on value-based insurance design.

3. **Plan design often requires tradeoffs. For plans that cover the same percentage of services (i.e. have similar actuarial values), plans with higher premiums will have lower out-of-pocket cost sharing and plans with lower premiums will have higher out-of-pocket cost sharing. Which is more important to you?**
    a. Lower Premiums
    b. Lower out of pocket cost sharing
    c. It's complicated
4. **Please explain your answer above.**
    a. Balancing higher premiums versus higher cost-sharing is complicated because it requires a tradeoff between uninsurance and underinsurance.
    b. Lower premiums will increase coverage, but higher cost-sharing across the board will discourage use of high-value services. That is why cost-sharing should vary depending on the value of the service to the individual.
    c. Lower premiums may be more important for lower-income populations, but the product they are buying still needs to be affordable to use.
    d. Once a patient is insured, though, physicians can more effectively provide care to patients with lower cost-sharing because out-of-pocket costs will not be as much of a barrier to patients getting recommended, high-value care.
    e. In the future, it may also be worth looking at lowering premiums and/or cost-sharing based on patients' healthy behaviors.
5. **HB21-1232 requires the standardized plan to cover some high value services with no additional cost sharing (i.e. pre-deductible). If cost sharing is reduced for some services, it often must be raised on other services in order to maintain the same coverage level (i.e. actuarial value). What services do you consider "high value"? What services should the standardized plan incentivize through lower cost sharing (i.e. low or no copays or coinsurance)? Why?**

   a. Please see CMS' comments submitted on August 12, 2021 (http://www.cms.org/uploads/2021812_CO_Option_Standardized_Plan_Design_Comments_SUBMITTED.pdf).

6. **Please rank these services based on what you think the standardized plan should prioritize for predeductible coverage (i.e. first dollar coverage with no copay or coinsurance)?**
   a. Other
   b. Primary care visits (e.g. 2 visits per year)
   c. Behavioral Health
   d. Prenatal and perinatal care
   e. Generic drugs
7. **If you selected "Other" above, please briefly explain what other services should the standardized plan prioritize for predeductible coverage.**
   a. Once again, the Colorado Medical Society (CMS) has tried to rank these categories of services, but CMS cannot fully endorse this ranking.
   b. Offering pre-deductible coverage for high-value services is extremely important, but it cannot be reduced to a ranking of discrete categories.
   c. We ranked "Other" first because we believe that prioritizing chronic disease management should be first. Chronic disease management, especially for those patients with multiple co-morbidities, often involves a combination of primary care visits, generic drugs, behavioral health care, and other services.
   d. Also, 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 two visits per year, but successfully managing chronic diseases for those complicated patients who are high health care utilizers will significantly reduce overall costs.
   e. There is also overlap between primary care and behavioral health as most behavioral health is done by primary care physicians.
   f. Finally, other services like palliative care are extremely valuable and should be covered pre-deductible.
8. **Some services may be considered "low value" because the risk of harm or cost exceeds the likely benefit for patients. Should some services be disincentivized? Which ones? Please explain.**
   a. Yes, certain low-value services should be disincentivized. CMS policy supports reducing "unwarranted variations in care" by striving "to provide appropriate care for every patient every time by reducing extraneous services or treatments including: unwarranted or unnecessary procedures and consultations; inappropriate medication use; unnecessary lab and diagnostic tests; inappropriate end of life care; and potentially harmful preventive services with no plausible benefit" (CMS Policy 185.994). CMS "advocate[s] for benefit design changes that use clinical information to show whether new health technologies/services are reasonable and necessary" (CMS Policy 185.994).

   b. Please see CMS' comments submitted on August 12, 2021 (http://www.cms.org/uploads/2021812_CO_Option_Standardized_Plan_Design_Comments_SUBMITTED.pdf). In addition, JAMA's "Less is More" series documenting the ways that overuse of medical care fails to improve outcomes, harms patients, and wastes resources is a helpful resource (https://jamanetwork.com/collections/44045/less-is-more).
   c. However, as mentioned above, services identified as low-value might be low-value the majority of the time, but high-value for certain patients in certain situations. We must be careful not to harm the most vulnerable. We must "maintain an awareness of warranted variation to protect patients with atypical conditions or needs" (CMS Policy 185.994).
   d. We recommend that the Colorado Option Advisory Board include experts who can track the evolving evidence that should inform the identification of low-value services.
   e. There should be a process for handling those exceptions for specific patients, but it will be important to design that process so it is fair, evidence-based, and not overly burdensome for patients and physicians.

9. **What additional comments do you have? What else should the Division of Insurance consider? Please use the space below to provide us with any other comments about the standardized plan or the stakeholder process thus far.**
   a. CMS also believes it is worth considering including social supports like transportation as covered benefits with low or no cost-sharing, particularly for lower-income patients.