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February 28, 2011

Mr. Steve Larsen

Director

Office of Consumer Information and Insurance Oversight

Department of Health and Human Services

Hubert H Humphrey Building, Room 445

200 Independence Avenue, SW

Washington, DC 20201

Re: HHS-OS-2010-002: Value-Based Insurance Design

Dear Director Larsen:

The National Patient Advocate Foundation (“NPAF”) thanks you for the opportunity to submit responses to the Department of the Treasury, Department of Labor, and the Department of Health and Human Services’ request for information pursuant to the development of guidelines regarding the utilization of value-based insurance designs by group health plans and health insurance issuers with respect to preventive benefits. NPAF understands the aforementioned government agencies are interested in comments related to the development of such guidelines for value-based insurance designs that promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services.

NPAF is a non-profit organization dedicated to improving access to healthcare services through both federal and state policy reform. Its mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). In fiscal year 2009 (July 1, 2009 – June 30, 2010), PAF resolved 64,188 patient cases and received more than four million additional inquiries from patients nationally. Case management services include advocating for patients to assure their premium payments result in health insurance coverage as identified in their Explanation of Benefits. As PAF has considerable experience and expertise in advocating for consumers throughout the nation who experience health insurance challenges, its comments are limited to responding to question 14 as that question is directly aligned with NPAF expertise.

Question 14 asks, “*What consumer protections, if any, need to be in place to ensure adequate access to preventive care without cost sharing, as required under PHS Act section 2713?*”

Value-based insurance products are only possible if they are designed to provide for and promote educated health consumers. Health consumers need to be adequately informed of their

right to preventive care without cost-sharing. The information educating them of this right should come directly from the group health plans and health insurance issuers in a format that complies with the suggestions below. Consumers who are enrolled in group health plans benefit from informational brochures and communication items that are generally prepared and written in a standardized format. While this may not markedly enhance the readability of the content, it at least organizes the information in a consistent manner for consumers. According to research from the U.S. Department of Education, only 12 percent of English-speaking adults in the United States have proficient health literacy skills.¹ This leads to consumer frustration, but more importantly, it can lead to consumer decisions that do not support positive health outcomes such as the receipt of preventive care services.

Ensuring health consumer access to value-based insurance designs that promote consumer choice of providers or services that offer the best value and quality, while ensuring access to critical, evidence-based preventive services is only possible if the preventive service information made available to consumers by group health plans and health insurance issuers is written in a manner that he or she can understand. This goes beyond simply writing at a sixth grade reading level, but also being careful about the use of complex sentence structure, the use of unnecessary medical or economic terms and when certain medical or economic terms are needed, including definitions and explanations. Concrete language must be in place to ensure easy navigation through the contract, even if it means giving explicit instructions where a specific treatment is being discussed without having to refer to another page. Unfortunately, many patients do not read their plan language until they are confronted with a medical denial and/or a large medical bill, mainly because the plan language is too long and confusing.

It is also important to provide a foundation for the information that is being imparted i.e., explaining at the outset of the written communication what will be covered in the material and why it is important to be understood and followed. The importance of preventive services to a consumer's health in particular must be stressed and explained as their value may not be easily understood by consumers. It is crucial that necessary plan communication be furnished in a one paragraph missive as much as it is in a multi-page communication. Examples of how group health plans and health insurance issuers might clandestinely impose cost-sharing requirements interspersed throughout communication pieces will enhance readability and enable the uninformed consumer to better understand the information.

Increased consumer support is needed at the insurer level. Some consumers find that written and oral information is neither always accurate, nor is it clearly understandable. Telephone inquiries that are entered into a computer database enhances consumer needs while at the same time will enable the insurer to provide more efficient documented service that supports the information furnished, and the rationale for the information. We suggest that despite their best intention, some consumers are still finding it difficult to understand the specifics of their health plan and understanding prohibitions on certain preventive services might likewise be difficult to understand.

Qualifying events provide an opportunity for insurers to communicate necessary information to consumers, and provide them a similar opportunity to pose questions to their insurer regarding the specifics of the provisions of their particular plan. Policy information, and coordination of benefits, are confusing to many and as these qualifying events occur, insurers that are proactive in their communication will be able to allay concerns by communicating often and in clear language. We suggest that all plans, if not already doing so, communicate with consumers with cooperation of their employers during all phases of working life to include entry to employment, open enrollment periods, qualifying events, disability leave and retirement.

Information regarding preventive benefits should be made available on all group health plan and health insurance issuer documents related to qualifying events. All communications should also include information regarding cost-sharing prohibitions on certain preventive services.

Consumers need to receive information in writing that explains their options for continued insurance whether through retirement or COBRA. When employers provide written information to consumers, we suggest that the documentation be distinctive in nature so that consumers are alerted to the fact that the impending action is unique and not of a routine nature. We suggest that employers require signature confirmation to acknowledge that the person has been advised of his or her benefits and how it applies to their specific situation. This signed statement will explain in detail what he or she has been advised. We recommend that information be added to COBRA paperwork that explains their right to preventive benefits without cost sharing continues under COBRA.

When plan questions arise and a copy of a plan is desired, some consumers are being referred by some insurers to their employers. As a result, some consumers are not able to get answers to their questions from their employer, since employers are not as familiar with the specifics of the plan language as are insurers. We suggest that insurers take a more active role in providing plan language to consumers and in fielding their questions since they are best equipped to answer them. Developing joint Q&As that address common questions about preventive services for multiple insurance plans, and specifying a process that enables both insurers and employers to respond to specific one-time questions, would help them communicate collaboratively and more effectively with consumers.

The appeals process in its entirety can be extremely difficult for consumers to understand. Process elements that are particularly confusing include the number of appeals that are allowed, the appeal deadlines and how appeals can be lodged. A detailed explanation about the appeals process will enable consumers to feel more empowered. When a denial of coverage, for example, is received by a consumer, he or she will be better prepared to file an appeal if important information has already been made available. Consumers are taking advantage of online information to a greater degree than ever before, and the use of “real time” question and answer portals will enhance their ability to provide appeals information that the insurer needs in order to adjudicate the claim. Therefore, any information related to denial of preventive services, or any provision of preventive services that includes cost-sharing should likewise be available on these portals.

NPAF thanks you for the opportunity to comment. We would be pleased to respond to any questions about our recommendations that may arise regarding health literacy in the future.

Sincerely,



Nancy Davenport-Ennis
Chief Executive Officer and President