



UnitedHealth Group

February 28, 2011

Center for Consumer Information and Insurance Oversight
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW Room 445-G
Washington, DC 20201

Submitted Via Federal Rulemaking Portal: <http://www.regulations.gov>

RE: HHS-OS-2010-002; Request for Information regarding Value-Based Insurance Design in Connection with Preventive Care Benefits

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Department of Health and Human Services, Department of Labor and Department of the Treasury (the “Agencies”) with our response to the Request for Information regarding Value-Based Insurance Design in Connection with Preventive Care Benefits (75 Fed. Reg. 81544, December 28, 2010).

UnitedHealth Group is dedicated to making our nation’s health care system work better. We serve more than 75 million Americans, funding and arranging health care on behalf of individuals, employers and governments, in partnership with more than 5,300 hospitals and 730,000 physicians and other health care professionals. Recognized as America’s most innovative company in our industry by *Fortune* magazine, UnitedHealth Group brings innovative health care to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans. It is this experience that is the basis upon which we offer the following comments to ensure that innovation and flexibility continue to thrive in the health care marketplace.

Value-based insurance designs (“VBID”) are an important tool to enhance quality and efficiency in the delivery of health care services. While the Affordable Care Act (the “Act”) requires plans and issuers to cover recommended preventive services without cost-sharing, the Secretary of Health and Human Services (the “Secretary”) is permitted to develop guidelines to permit plans and issuers to utilize VBID in the provision of preventive care benefits. We appreciate the opportunity to provide input to the Agencies as they consider the development of guidelines for the continued offering of VBID.

Comments Regarding Value-Based Insurance Design

1. **What specific plan design tools do plans and issuers currently use to incentivize patient behavior, and which tools are perceived as most effective (for example, specific network design features, targeted cost-sharing mechanisms)? How is effective defined?**

There are several tools available to incentivize patient behavior. Providing information on quality and efficiency, innovative network designs, condition-specific programs, consumer incentives and reminders encourage different types of healthy and cost-effective behaviors based on individual health care needs.

- **Information Tools for Consumers and Physicians:** Transparency of quality and cost results associated with care providers assists consumers in making educated decisions regarding physicians and hospitals. Physicians can also use this information to improve quality metrics. Plan programs may provide special designation for physicians who provide quality and cost-efficient care to their patients. These physicians meet or exceed nationally recognized guidelines and are more likely to perform the appropriate tests and treatments at the right times for a variety of conditions. Such programs may also evaluate facilities that specialize in specific types of care, including cardiac care, spine surgery, total joint replacement and neonatology. UnitedHealthcare makes this type of information available to its members through a provider locator tool available on its member website.

Building on these programs, UnitedHealthcare has introduced procedure-specific quality and cost transparency for preventive services such as mammography and colonoscopy, as well as common surgical procedures such as cholecystectomy or obstetrical services, which provides more granular information for consumers. UnitedHealthcare makes this type of information available to its members through a treatment cost estimator tool available on our website.

Additionally, through our Centers of Excellence network, UnitedHealthcare helps patients with serious or long-term illnesses obtain care from facilities that meet high standards related to clinical outcomes, patient and family-oriented services and the practice of evidence-based medicine. Focus areas include transplants, cancer treatment, congenital heart disease, kidney disease and neonatal care.

- **Network Design:** Higher value networks, or preferred networks, are another tool to help patients or consumers achieve better quality and/or lower cost outcomes when obtaining health services. For example, benefit plans may offer products in which members who elect to receive care from plan-designated specialty physicians benefit from reduced out-of-pocket costs, including lower copayments or coinsurance. With these products, we see a greater use of quality and cost-efficient designated specialists where there is sufficient breadth of access to these physicians and for elective procedures.
- **Condition-Specific Plans:** Members with chronic conditions, including diabetes, asthma and coronary artery disease, participate in value-based plan designs to help manage their conditions. Participating members track their compliance with evidence-based prevention and condition management activities to maintain their health and receive

benefit incentives. By complying with these activities, members experience reduced cost sharing compared to the base plan design, including reduced cost sharing for condition-related office visits and medications on the condition-related health plan drug list. There may be additional cost savings for these members when they access plan-designated specialists within these condition-specific plans.

- **Employer-Sponsored Incentive Programs:** Employees are often offered voluntary benefit programs during open enrollment to encourage positive behavior and lifestyle changes in exchange for consumer incentives (e.g., gift cards, debit cards) or cost sharing credits. Programs are typically based on multi-year participation. As members gain more information about their health status and risks through biometric screenings and visits to their primary care physicians, recording this information in a health risk assessment or similar tool enables them to receive education and coaching on topics that are most relevant to their health status. Incentives may be awarded for the completion of health risk assessments or wellness coaching programs. This ideally results in individuals taking action to manage and improve their health.

In addition, member-based incentive programs that reward members for improved outcomes and not merely activities related to healthy behaviors are also available. As an example, financial incentives have been developed for achieving specific improvements in blood pressure, LDL cholesterol levels, blood sugar and body mass index. Members who do not achieve established improvements, but document engagement in health coaching activities are also eligible for the full incentives. This approach to incenting outcomes shows initial promise of having significant impact in improving behavior and results.

- **Broadly-Available Wellness Tools:** While incentives motivate many individuals, a certain portion of the population responds to simple reminders regarding preventive services. Our National Reminder Program identifies members who need preventive services and sends them targeted mail and email communications that encourage them to obtain the appropriate services. Reminders, which may include screening schedules, reminder checklists and other information that help track preventive services, are sent to members for diabetes management, childhood and adolescent immunizations, LDL cholesterol for coronary artery disease, women's health screenings and colorectal cancer screening. UnitedHealthcare has additional quality improvement programs, such as: an annual mailing suggesting that members who have not received HEDIS-recommended preventive care schedule an appointment with their physician; beta blocker medication reminders sent to members to help prevent future cardiac events; and phone call and mail reminders targeting parents of two to five-year olds seeking to improve immunization rates.
- **Value-based Provider Payments.** Although not specifically related to value-based insurance designs, it is important to note the reciprocal rewards developed for providers since they are increasingly being measured and incented for the results associated with similar preventive services for members. For example, physician communication and value-based payments to physicians may be based on cancer screening, immunization

rates, diabetes and coronary artery disease management, which align with the gaps in care and performance directed at members.

- **Culturally-Specific Programs:** UnitedHealthcare is working to address preventive screening disparities in ethnic populations. Our programs include personalized communication with an ethnically tailored message on the importance of colorectal cancer, breast cancer and cervical cancer screenings.

Effectiveness can be defined in a variety of ways, depending on the program and the related incentives. We believe programs should create awareness and empowerment, foster behavior and lifestyle changes, result in risk and illness reductions and support achievement of threshold targets and maintenance of improved health status.

Effectiveness can be measured through increased participation in health risk or similar assessments and wellness programs, as well as improvements in nationally recognized health indicators, including body mass index, blood pressure, cholesterol levels and non-smoking status. For condition-specific plans, effectiveness can be measured through statistically significant increases in compliance with evidence-based prevention and condition management activities. The resulting reduction in health care services can also be measured over time as members improve and maintain their health status.

2. Do these tools apply to all types of benefits for preventive care, or are they targeted towards specific types of conditions (for example, diabetes) or preventive services treatments (for example, colonoscopies, scans)?

UnitedHealthcare offers a range of value-based products, which address both general preventive services, health awareness and wellness, as well as evidence-based medical guidelines targeting specific conditions.

One example of a targeted approach is UnitedHealthcare's Orthopedic Decision Support program. Enrolled members with back, knee, shoulder or hip conditions are encouraged to participate in coaching, consider treatment alternatives and use plan-designated specialists and/or facilities. Members who complete the coaching program may receive credit toward out-of-pocket costs or a contribution to their health reimbursement account. Individuals who have surgery for their condition and use a plan-designated specialist or facility for their care have reduced out-of-pocket expenses.

The diabetic and pre-diabetic population was also selected for a value-based program based on statistics indicating that over one-third of the adult population is diabetic or pre-diabetic with considerable quality of life issues. Our Diabetes Health Plan targets diabetic and pre-diabetic members with the goals of reducing financial barriers to care and encouraging diabetic and pre-diabetic members to comply with evidence-based, diabetic preventive care guidelines. The Diabetes Health Plan uses claims analysis and biometric testing to identify eligible members, including previously undiagnosed pre-diabetics and diabetics. This plan offers benefit designs with savings on certain pharmaceuticals and diabetes-related medical supplies, office visits and additional condition-specific services. In addition, members are

provided with access to valuable educational and communication services to help the entire family manage the illness and related issues.

Employer plan sponsors can customize broader health improvement programs, including prevention, health and wellness, health coaching, health improvement activities and chronic condition management. Employer-specific programs provide members with information, motivation and financial incentives to encourage self-care. Personalized action plans and communications are designed to help members achieve better outcomes and reduce their medical costs.

- 3. What considerations do plans and issuers give to what constitutes a high-value or low-value treatment setting, provider, or delivery mechanism? What is the threshold of acceptable value? What factors impact how this threshold varies between services? What data are used? How is quality measured as part of this analysis? What time frame is used for assessing value? Are the data readily available from public sources, or are they internal and/or considered proprietary?**

One example where UnitedHealthcare defines a high-value setting is one in which a member either receives care from a plan-designated physician or facility and/or when the member receives care in a setting where the recommended care for preventive and chronic conditions has been delivered. To that end, incentives broadly focus on encouraging individuals to receive regular care with their primary physician or specialist and use specific physicians designated for quality or both quality and cost efficiency.

These programs use evidence-based, medical society and national industry standards, and rely on paid claims data to assess the quality and cost efficiency of care. Individual physicians are eligible for designation if they are contracted with and credentialed by our plan, practice in a specialty and geographic location that is included in the program, are board certified in their primary specialty and have an unencumbered license at the time of the designation. Physicians who are being tracked for potential fraud and abuse are not eligible for this designation.

Data used to determine high-value settings is readily available from both public sources and internal, proprietary information. Measure-specific benchmarks have been established, which are designed specifically for use with administrative claims data. To meet the quality criteria, a physician must perform at a level that meets or exceeds the equivalent of a specified percentile of performance, in aggregate, based on national benchmarks for each quality measure. Quality measures related to preventive care and chronic conditions are attributed to each physician who has significant involvement with the patient. We utilize chronic condition standards to determine the needed care, such as minimum expectations for physician visits for effectively managed conditions.

Our program counts several non-claims-based programs toward quality designation for the specialties appropriate to each program. These include National Committee for Quality Assurance (NCQA) recognition programs, Bridges to Excellence (BTE) programs and American Board of Internal Medicine (ABIM) Practice Improvement Modules[®]. For chronic condition value-based insurance design programs, such as the Diabetes Health Plan, we use

national quality standards, nationally available research, chronic condition research agency and foundation recommendations (e.g., American Cancer Society, American Diabetes Association).

4. What data do plans and issuers use to determine appropriate incentive models and/or amounts in steering patients towards high-value and/or away from low-value mechanisms for delivery of a given recommended preventive service?

Data used to determine appropriate incentive models and amounts in steering patients toward high-value settings include focus groups, actuarial data, health literature reviews and claims analysis. Identifying value levers and removing the financial barriers to care are essential components to incentive modeling. Member information is utilized to identify high-risk individuals and to target the types of programs offered.

5. How often do plans and issuers re-evaluate data and plan design features? What is the process for re-evaluation? How is the impact of VBID on patient utilization monitored? How is the impact of VBID on patient out-of-pocket costs monitored? How is the impact of VBID on health plan costs monitored? What factors are considered in evaluating effectiveness (for example, cost, quality, utilization)?

Evaluation of VBID operations and program effectiveness includes review of compliance rates, pre- and post-program member utilization of targeted high-value services, utilization of quality and cost-efficient designated physicians, and participation and completion in health education, coaching and condition management programs. Analysis includes comparing members that are in a value-based plan compared to those that do not have value-based plans to demonstrate behavior changes over an 18-month period.

Analysis of VBID programs also takes into account the benefit costs paid by the plan along with actual and projected savings, such as cost avoidance by limiting chronic condition complications. We measure the effect of various incentives as they relate to medical and pharmacy costs, and plans are monitored for overall medical spending as well as key indicators for utilization, such as emergency room utilization, medical home presence and acute hospital utilization, including readmission rates. Cost and utilization offsets are evaluated in assessing services with lower unit costs which may be targeted for higher utilization, such as medication use or home health services.

8. Do plans or issuers currently implement VBIDs that have different cost-sharing requirements for the same service based on population characteristics (for example, high vs. low risk populations based on evidence)?

Our VBID programs currently offer consumers the same value and incentives irrespective of population characteristics, as long as consumers qualify for the plans and enroll in the programs. Depending on a member's health status, utilization patterns and participation in health improvement programs, an individual may realize different levels of those benefits.

9. What would be the data requirements and other administrative costs associated with implementing VBIDs based on population characteristics across a wide range of preventive services?

VBID programs require additional administrative activities related to tracking of program members, processing claims with reduced cost sharing, network management and communications. These additional administrative activities and data requirements include:

- Implementing more complex claims adjudication processing
- Managing the administration of incentives outside the benefit plan
- Tracking member compliance with evidence-based medicine guidelines or other targeted actions
- Maintaining a network of physicians that meets nationally recognized standards of quality and cost efficiency
- Monitoring and reporting on disease state prevalence and compliance rates over time
- Developing and implementing consumer wellness, coaching and educational programs, including communications about these programs
- Managing data regarding current and ongoing population disease state prevalence and compliance rates
- Managing data regarding member-level health status and compliance with targeted actions to administer non-claims based incentives

10. What mechanisms and/or safety valves, if any, do plans and issuers put in place or what data are used to ensure that patients with particular co-morbidities or special circumstances, such as risk factors or the accessibility of services, receive the medically appropriate level of care? For example, to the extent a low-cost alternative treatment is reasonable for some or the majority of patients, what happens to the minority of patients for whom a higher-cost service may be the only medically appropriate one?

Base benefit designs may cover various levels of services and procedures. Our approach has been to recommend additional enhanced high-value benefits, as opposed to limiting a standard benefit set; as a result, all enrollees have access to the medical services their condition requires. Consumers eligible for incentives based on health actions or health results, but for whom special circumstances make those actions or results unachievable, are provided additional ways to qualify for those rewards.

12. How are consumers informed about VBID features in their health coverage?

Information on value-based programs is included in member benefit plan documents, on member websites, in ongoing member communications and presented at employer benefit meetings. Customer service representatives can also answer questions regarding claims, billing and program features.

13. How are prescribing physicians/other network providers informed of VBID features and/or encouraged to steer patients to value based services and settings?

Program and/or member-specific information is communicated to physicians, hospitals and other health care providers through provider web portals, member benefit eligibility information, EDI transaction data and newsletters, as well as reminder materials intended for members to share with their physicians. Notification vehicles may also include member ID cards and engagement with Medical Societies, Professional Societies and Administrative and Hospital Associations.

On behalf of the 78,000 employees of UnitedHealth Group, we thank you for your thoughtful consideration of our comments. We would be pleased to provide additional data and information to supplement the comments in this letter.

Sincerely,



Jeffrey D. Alter
Chief Executive Officer
UnitedHealthcare Employer & Individual