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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attn: HHS-OS-2010-002
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., SW.
Washington, DC 20201

Re: HHS-OS-2010-002 Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care

Dear Sir/Madame:

UPMC Health Plan and the UPMC Insurance Services Division (collectively "UPMC") are pleased to submit the following comments in response to the Request for Information Regarding Value-Based Insurance Design in Connection with Preventive Care.

First and foremost, UPMC is pleased that the Department of Health and Human Services (the "Department") recognizes the important role that value-based insurance design (VBID) can play in promoting the use of appropriate preventive services. We commend the Department for seeking input from industry experts as to how plans can continue to employ VBID principles and remain compliant with other regulatory requirements. The continued growth of products designed to incentivize the use of value-based services (including preventive services) is contingent upon plans being afforded flexibility with respect to product-design. Reading any regulation, including the preventive service regulation, to prohibit such flexibility would serve no one.

UPMC has long been committed to encouraging and incentivizing its members to utilize evidence-based, cost-effective medical services. To assist it in meeting these ends, UPMC has developed innovative and unique value-based products. We begin our comments with a brief overview of those products and conclude with specific responses to questions posed by the Department.

UPMC'S VALUE-BASED DESIGN

VBID has generated much discussion in the recent past, particularly since the Accountable Care Act (ACA) was enacted into law. VBID is touted as an alternative to the "one-size-fits-all" benefit designs of old; a new design which removes barriers to essential, high-value health

services. "Removal of barriers" generally means the reduction (or in some cases elimination) of deductibles and/or copayments for certain evidence-based treatments and medications. Ironically, this somewhat limited approach to VBID design could become the "one-size-fits-all" alternative to standard design. While we agree that reducing deductibles and copayments is certainly one means by which barriers to high-value services may be reduced, it is not the only way. We at UPMC have developed a multifaceted approach to value-based design.

UPMC's VBID products are built upon the foundation that "the right tools, the right intervention, the right motivation, the right circumstances" are most likely to lead to the best results. While UPMC's value-based products do, of course, provide members with access to preventive (and other) care at no (or reduced) member cost-sharing, UPMC discovered long ago that affording members "access" to such services did not necessarily result in actual utilization. Members needed to be incentivized to take responsibility for their health in creative and novel ways.

UPMC encourages such responsibility and member-action by offering lower deductibles and other incentives to those who complete a Health Risk Assessment (HRA) and/or complete various additional "healthy steps." Healthy steps include discrete activity-based actions (e.g. undergoing a biometric screening); compliance-based activities (e.g. following-through with medication or care regiments); and outcome-based accomplishments (e.g. meeting physical exercise or healthy eating goals). All told, UPMC offers its employer groups the choice of over 200 healthy steps; employer groups select the "healthy steps" that best meet their needs. Thereafter, as explained more fully below, each individual member is directed toward the healthy steps determined by UPMC to be most critical to that individual member. Importantly, the decision as to which, if any, steps are ultimately taken rests squarely with each member; participation in UPMC's VBID is voluntary.

In recognition of the fact that not all services offer the same value to all members, UPMC has developed a means by which to identify those members who are currently, or at some point in the future may be, in need of specific services. To accomplish these ends, UPMC developed and utilized sophisticated algorithms and data-analytic tools to create a member-centric database and registry. The database and registry contains a comprehensive record-set for each member including, but not limited to, claims information, diagnostic lab and pharmacy data, assessments from electronic medical records, and self reported data from member HRAs. Additional data is generated by UPMC and added to the database and registry through a sophisticated predictive modeling tool, which allows UPMC to identify those members most likely to develop chronic conditions in the future. All data is synthesized and analyzed to proactively identify those members best suited for specific clinical interventions and coaching opportunities. Members are then assigned to outreach and specific programs based upon specific identified risks. Coaches are made available to assist members with everything from health and wellness initiatives to complex condition and/or condition management. Again, member participation in these initiatives and programs is voluntary.

Understanding that members often have more than one lifestyle risk or disease state, UPMC utilizes an integrated and "whole person" approach to working with its members. Health coaches work with each member on all existing risks and disease states, rather than parsing out each of these conditions and dealing with them separately. This holistic approach allows

UPMC's health coaches and other personnel to develop a comprehensive understanding of each member and to accurately and quickly identify budding areas of concerns and/or need for further behavior change.

In addition to reinforcing healthy behaviors and maximizing care adherence through the use of health coaches, UPMC encourages desired behaviors by offering members the opportunity to earn a number of different incentives, including financial incentives (reduced or waived deductibles), gift cards, promotional items, and prizes (all within the limits imposed by applicable law). Like the healthy steps themselves, employer groups are empowered to select the specific incentives they desire to offer their employees. Importantly, UPMC not only incentivizes its members, it concurrently rewards and incentivizes its treating providers as well. Specifically, providers are rewarded for administering evidence and value-based services, maintaining stringent quality standards and producing measurable clinical outcomes.

While incentives are a critical component of UPMC's VBID products and strategy, incentives alone are inefficient to produce lifestyle change; research demonstrates that individuals presented with opportunities to make lifestyle changes will take advantage of them only if they feel a readiness to change. As such, UPMC works with employer groups to develop a long term strategy, pursuant to which healthy step requirements are incrementally increased over time.

UPMC has determined that, as important as incentives are in promoting individual responsibility and lifestyle change, consistent member communication is equally important; fully-informed members make better decisions. Using a wide-range of touch points (including a member portal, mailings, phone contacts, work-site trainings, emails and mobile phone applications) and with member consent, UPMC routinely reaches out to each member with tailored messaging regarding his/her specific conditions, modifiable risk factors, treatment alternatives, risks and costs. Such messaging not only aids members in changing behaviors and making sustainable progress, it also engenders a supportive, collaborative and cooperative atmosphere within which to do so and becomes a motivational-incentive in its own right. UPMC not only communicates directly with its members, it also communicates routinely with employer groups and with care providers throughout the benefit term. Consistent communication is a critical component of UPMC's VBID.

Equally critical to VBID is useable data; data and data-analytics are the bedrocks upon which UPMC's VBID products are based and the barometer by which such products are evaluated. A member's adherence, progress or lack-there-of is tracked and routinely relayed back to that member in real-time. Employer groups routinely receive aggregated reports, which assist them in fashioning and modifying benefit-designs and educate them as to clinical and fiscal trends, and employee-population health, lifestyle-improvement, adherence and utilization. Treating providers receive up-to-date information regarding patient utilization and treatment-adherence, which ultimately assist them in more effective care-management and cost-containment. Health coaches receive updates as to their individual member engagement and outreach efforts. Finally, UPMC mines its own data to evaluate the short and long-term effectiveness of its value-based products on member participation, compliance and clinical progress, as well as on broader population health improvement and cost containment. Without data, UPMC's VBID would not exist.

We move next from this general overview of UPMC's value-based products to our responses to some of the specific questions posed by the Department.

UPMC'S RESPONSES TO SPECIFIC QUESTIONS POSED

1. **What specific plan design tools do plans currently use to incentivize patient behavior and which tools are most effective?**

   As set forth more fully above, UPMC utilizes a broad array of financial incentives to encourage and reinforce member behavior, including reduced or waived deductibles, gift cards, promotional items, and prizes (all within the limits of applicable law). UPMC provides incentives not only to its members, but also to its treating providers for, among other things, closing clinical gaps in care, complying with clinical guidelines and best practices and administering evidence-based medicine. In addition to tangible, financial rewards, UPMC also influences and reinforces member behavior by offering non-material incentives as well. For example, UPMC routinely communicates with members (and their treating providers), administering real-time feedback, encouragement and reinforcement. Individual health coaches are available to work in very close collaboration with members or on an as-needed basis; the members alone decide. Members are provided educational opportunities on individual and group bases regarding the costs, risks, advantages and disadvantages of various screening and treatment options.

   The effectiveness of any given tool varies across members -- for some, tangible financial rewards are most powerful; for others, a close collaborative relationship with a health coach and champion is most important. A wide-range of available incentives and reinforcers is critical to the success of any value-based product.

2. **Do these tools apply to all types of benefits for preventive care or are they targeted toward specific types of conditions or preventive services treatments?**

   Some incentives, communications and educational opportunities are broadly available to all members including, but not limited to, nutritional education, stress prevention and certain preventive services at no cost-sharing. Other incentivized services are available only to members who meet certain criteria including, for example, certain cancer screening tests and immunizations. Still other incentives are targeted specifically toward those members with identified conditions (e.g. heart disease, hypertension, obesity, diabetes) or who will benefit from or are in need of certain services or treatment as identified by UPMC's database and registry. Determinations as to which incentives should be broadly available and which available on a more limited basis are based upon the national standards established by, among others, the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Specific member-level determinations are made by UPMC based upon evidence-based clinical guidelines (including those above) and medical necessity criteria.

3. **How do plans determine what constitutes a high-value treatment setting, provider, or delivery mechanism? How is quality measured as part of the analysis? What time-frame is used to assess value?**

   To make general determinations about high-value treatment settings, providers and delivery mechanisms, UPMC looks first to any national standards established by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration in these regards. UPMC also looks for any guidance issued by various national organizations such as the American Academy of Pediatrics, American Medical Association, and American Cancer Society. Likewise, UPMC relies upon guidelines published by CMS or other national entities with respect payment schedules, and to entities such as NCQA HEDIS, CMS, NQF, JCAHO, and AHRQ with respect to quality guidelines.

   For specific decisions as to precisely which providers and/or delivery mechanisms constitute "high-value," UPMC looks to its extensive database for information as to which providers best close clinical gaps in care, comply with clinical guidelines and best practices, administer evidence-based medicine, maintain stringent quality standards and produce measurable clinical outcomes. Specifically, providers are evaluated with regard to their (1) improvement trend, (2) trending against national or local best practice benchmarks, and (3) variation analysis. UPMC is ever mindful, of course, that value may mean different things to different stakeholders. For members, high-value providers may be those who provide care and treatment that is easily accessible, is affordable and is effective. For employer groups, high-value may mean those providers who positively influence cost-trend. For UPMC, high-value services are those that improve population health, enhance member experience, and reduce overall medical costs. UPMC considers all of the above (and more) when making decisions relative to value.

4. **What do plans use to determine appropriate incentive models and/or amounts in steering members toward high-value mechanisms?**

   As mentioned above, UPMC's employer groups are initially encouraged to select the types and amounts of incentives (within the confines of applicable law) they desire to impact their employees' behaviors. UPMC consults national standards and guidelines to further shape its reinforcement-protocols. Individual members are further guided toward specific clinical interventions and coaching opportunities through UPMC's database and registry. Coaches are made available to assist members with everything from health and wellness initiatives to complex condition management.

   Treating providers are simultaneously incentivized for closing clinical gaps in care, complying with clinical guidelines and best practices and administering evidence-based medicine. As would be expected, the incentives required to impact provider versus member behavior differ, both in terms of type and amount.

5. **How often do plans evaluate data?**

As mentioned above, the very existence of UPMC's value-based products are contingent upon real-time, objective data and ongoing data analysis. Data (both at the population and individual member levels) shapes UPMC's VBIDs. The effectiveness of UPMC's value-based designs generally and of targeted interventions specifically are rigorously tested, analyzed and refined. The performance of members, providers and health coaches is closely tracked; real-time feedback is provided whenever possible. As would be expected, VBID does not always result in immediate changes in utilization and savings; as such, the success or failure of a given initiative is often measured over an entire contract period (or beyond). As such, while ongoing and consistent evaluation is critical, sustained measurement over time (including over months and years) is equally important. UPMC utilizes all available data-sources to evaluate and analyze the effectiveness of its value-based products, including its sophisticated claims engine, lab and pharmacy data, assessments from electronic medical records, and self reported data from member HRAs. The effectiveness of UPMC's value-based products is measured across myriad variables, including change in population risk-profiles, population lifestyle improvement, healthy-steps taken, physical exams and screenings obtained, treatment adherence, clinical-measure improvements, member and provider reports and evaluations, medical cost trend and even reduced absenteeism or increased productivity of members.

6. **Do plans currently implement VBIDs that have different cost-sharing requirements for the same service based on population characteristics?**

The regulations implementing the ACA itself expressly advocate differential cost-sharing requirements for different populations by relying upon recommendations and guidelines provided by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration as sources for preventive services. A preventive service may constitute a value-based service for one individual who meets certain age or other requirements but may be of no value or, in some cases, may be harmful for another individual. As such, UPMC appropriately conditions cost-sharing requirements upon population characteristics. UPMC also attempts to drive certain members toward certain interventions and services via use of its database and registry. Going forward, it is essential that UPMC and other carriers be permitted to continue to tailor value-based products in these manners; any regulation that thwarts or prohibits individually tailored interventions and incentives serves no one.

7. **What safety-valves do plans put in place to ensure that patients with particular co-morbidities or special circumstances (accessibility of services) receive medically appropriate care?**

UPMC has various safety mechanisms in place to ensure that all patients, including patients with various co-morbidities or other special circumstances receive medically

appropriate care. First, UPMC is ever mindful that, regardless of the various matrices in place to incentivize value-based services, decisions about care and treatment are ultimately made by treating providers and their patients. A provider, for example, may determine that his/her patient cannot reach a specific target for medical reasons and request an alternative goal. Likewise, UPMC has an exception process in place that allows for coverage of higher cost services if an individual's treating provider provides a medical rationale specific to that patient.

Second, UPMC monitors the actual and potential out-of-pocket cost (OOPC) maximums for all members in an attempt to predict and track the cost impact of various benefit-designs on individual members. UPMC utilizes a sophisticated modeling tool to predict the cost-impact of various plan designs at the group-level and shares this information with employer groups to assist them when making decisions about various benefit-structures and designs.

Next, UPMC monitors whether all members of a particular employer group are receiving appropriate care – not just those members who voluntarily participate in the VBID initiative. Finally, UPMC maintains a robust quality performance program, pursuant to which it solicits input from employer-groups, members and providers relative to availability of care, access and other quality-related issues.

8. What other factors, such as ensuring adequate access to preventive services, are considered as part of a plan's VBID strategy?

UPMC routinely monitors and assures that preventive and other services meet established access standards. UPMC is currently exploring the feasibility of alternative delivery models as well, including self-monitoring and testing devices, "E" and other virtual-visits and group visits. UPMC will implement some or all of these alternatives only when it is satisfied that actual care engagement, care-adherence and healthy behavioral change will be favorably impacted.

9. How are consumers informed of VBID? Providers?

As mentioned above, regular sustained communication with employer groups, members and providers may well be the most critical component of VBID. Using a wide-range of touch points (including a member portal, mailings, phone contacts, work-site trainings, emails and mobile phone applications), UPMC routinely reaches out to each member with tailored messaging regarding his/her specific conditions, modifiable risk factors, treatment alternatives, risks and costs. Providers are not only routinely "informed" of our value-based protocols, they play a critical role in partnering with UPMC to design and evaluate them.

10. What costs and benefits are associated with use of VBID methods?

The "value-based" plan designs described above have been shown to reduce costs and improve adherence to evidence-based care. Targeting certain desired lifestyle changes

and reinforcing treatment-adherence has lowered the incidence of disease (e.g. statistically significant reductions in cardiovascular risk-factors and improvement in diabetes management) and lowered aggregate health care costs. Some changes, such as differential payment and cost-sharing for generic drugs, result in immediate cost reduction. Cost saving, however, is not always demonstrable in the short term – some measures do not show reduction until the plan designs are in place for substantial period of time.

11. What impact will VBID have on small employers or small plans?

UPMC is confident that the cost-saving and care-adherence achieved via its value-based designs can benefit small employers and plans. Smaller employers have not always readily embraced the need for or benefit of actively engaging their employees in what can at times appear to be a plea for increased utilization of certain services. As such, as stated many times above, communicating with these employer groups as to the potential benefits of value-based designs (including reduced absenteeism, reduced Workers Compensation claims and increased productivity) is critical. UPMC is hopeful that, as VBID continues to be the topic of national discussion, even small employers will warm up to the idea of targeted benefit designs. We are confident that wisely designed plans with targeted incentives can bend the cost curve even for smaller employers.

Thank you for providing us the opportunity to offer input into value-based insurance design, particularly as it relates to preventive services. We appreciate your consideration of our comments and wish to extend to the Department, our willingness to further discuss our value-based products in more detail or to clarify or expand upon any of the comments made above. We look forward to working with you in the future.

Sincerely,

Daniel Vukmer, Esq.
Vice President & General Counsel
Chief Compliance Officer