UnitedHealthcare and Health Reform

Keith Emmons, M.D.
Medical Director of United Healthcare
Agenda

• Overview of UnitedHealthcare approach
• Today’s environment
• Timeline
• Implementing reform provisions 2010 – 2011
• Preventive services
• Medical Loss Ratio (MLR)
• Exchanges
• Accountable Care Organizations (ACOs)
• Support
2011

Economy
Slow uneven economic growth
Unemployment hovers around 9%

Health Reform
Strategy development and
implementation of health reform

Consolidation
M&A, JV / alliances, select market
exits, and vertical integration

Increasing Consumer Responsibility
Adoption of more affordable plan
designs, burden shift to consumers

Delivery System Transformation
Increased use of retail clinics,
care transferred to outpatient settings

Innovation
Consumer-centric tools, mobility
apps, social media, wellness

Strategic imperatives impacting our business

- Affordability
- Consumer Empowerment
- Health care Exchanges
- Focus on Prevention and Healthy Lifestyles
- Payment Innovations
- Distribution Enhancement
- Transparency
• Turning data into “actionable” information – it guides our thinking
• A core element in many of our products and services
• Our competence in health information distinguishes us from other health care related companies

**Technology**
• The enabling capability of our enterprise
• Distinctive in scale
• Diverse capabilities and creative application

**Health Care Management**
• Deep understanding in how health care works – clinically,
• administratively, operationally, and financially
• Through our business we engage directly with all key participants
• in the health care system

**The value of UnitedHealthcare has relied on these three core competencies working together**
Positioned to serve the market capabilities to help improve the system

**Health Benefits**
- Health care coverage and benefits businesses, unified under a master brand
  - Medicare and Retirement
  - Community and State
  - Employer and Individual
- Diverse benefits business
- Ensuring 38 million individuals get the best care
- Positioned well for post health care reform

“Helping people live healthier lives”

**Health Services**
- Technology-enabled health services business, encompassing:
  - OptumHealth
  - OptumInsight
  - OptumRx
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services
- Pharmacy solutions

“Making the health care system work better for everyone”
Engage health reform at multiple levels

UnitedHealth Group and our 87,000 employees are committed to comprehensive health reform because we firmly believe everyone deserves access to quality, cost effective health care.

As we work with our various stakeholders to implement reform and engage in ways to modernize and improve the health care system, we will focus on the following:

**Support**
Help customers understand requirements, implement changes and realize opportunities created by the new Patient Protection and Affordable Care Act (PPACA)

**Compliance**
Analyze changes and what they mean for stakeholders. Minimize disruption as we help ensure complete, timely, flexible support for provisions across the full system of health care services

**Advocacy**
Actively engage with governmental agencies and industry groups to ensure reform efforts reflect market needs and bring greater quality, affordability, access and simplicity to health care

**Innovation**
Deliver practical, market-based improvements that address the biggest health care challenges facing patients, providers, plan sponsors, and governments
By 2019...

• 30 million people or more are expected to enter the new health insurance exchanges

• 3 million fewer Americans will receive coverage through their employers, a result of small employers dropping their coverage

• 16 million new customers will gain coverage through Medicaid and CHIP expansions

Based on analysis by The Lewin Group published at http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf
Preventive vs. diagnostic

Certain services can be done for preventive or diagnostic reasons. When a service is performed for preventive screening reasons and is appropriately reported it will be adjudicated under the preventive services (meaning no cost share) benefit.

**Preventive services** are done on a person who:

- does not have symptoms
- has had screening (s) done within the recommended interval/age
- has a preventive service done that results in a therapeutic service done at the same encounter and as an *integral* part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered part of a preventive service

**Diagnostic services** are adjudicated under the applicable medical benefit and are done on a person who:

- has symptoms that require further diagnosis
- has the service done because abnormalities found on previous studies require further diagnosis
- had abnormalities found on previous preventive or diagnostic studies that would require the same studies within shortened time intervals from the recommended preventive screening time intervals
Scenario: Colonoscopy

Member annual physical

Doctor services rendered based on age/gender/risk factors

Government USPSTF A & B mandates
- Colorectal Cancer Screening – Fecal Occult Blood Testing, Sigmoidoscopy or Colonoscopy
  - USPSTF Rating: A

Population
- All adults, beginning at age 50 until age 75

UnitedHealthcare Standard
- Preventive services are payable with no age limit

Employer covered benefit plan covers UnitedHealthcare standard preventive services at 100%

Information based on plan being reform compliant.

Paid as preventive
Not paid as preventive

UnitedHealthcare pays claims preventive services at 100% based on covered benefit plan
Scenario: Physical with lab testing

Member annual physical

Doctor services rendered based on age/gender/risk factors

Government USPSTF A & B coverage
Age appropriate and risk appropriate
blood screening for cholesterol

UnitedHealthcare Standard
Age appropriate and risk appropriate
blood screening for cholesterol

Lab screening for Cholesterol *
Urinalysis
Blood chemistry panel

* No prior diagnosis

Note: lab work outlined under PPACA as covered as part of annual preventive visit will be paid with no cost share. Many lab tests are not covered as preventive, but may be covered under plan medical coverage.

Information based on plan being reform compliant.

Paid as preventive

Not paid as preventive

UnitedHealthcare pays claims preventive services at 100% based on covered benefit plan

Rev. 7/18/11
Coverage Determination Guidelines

- Providers are notified of all updated Coverage Determination Guidelines via Network Bulletin and portal.
- Employers will be notified of substantive additions or deletions in medical policy.
Appeals provisions overview

• “Adverse Benefit Determination” definition expanded and wording added to EOBs and other adverse determination communications

• Full and Fair Review procedures defined

• Conflicts of Interest criteria established

• New standards regarding Notices to plan participants defined

• Continued coverage necessary while outcome of an appeal is pending

• Federal External Review process defined

Definition of Adverse Benefit Determination

Includes

• a “denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit (pre-service or post-service)

• a denial of part of a claim due to the terms of the plan regarding coinsurance, copayments, deductibles

• retroactive rescissions of coverage, except for termination of coverage for non-payment of premiums
## Appeals implementation readiness

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tbody>
<tr>
<td><strong>Phase 1 of Appeals Provision implemented for plan years beginning on or after September 23</strong></td>
<td><strong>Phase 2 of Appeals Provision implemented for plan years beginning on or after July 1</strong></td>
<td><strong>Full implementation of Appeals Provision as plans renew beginning on or after January 1</strong></td>
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<tr>
<td>- Rescissions</td>
<td>- New EOB and ABD language related to internal and external appeal rights, and consumer assistance programs</td>
<td>- Language translation support</td>
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<td>- Full and Fair Review</td>
<td>- Notice of availability of procedure and diagnosis information</td>
<td>- Notice of availability of procedure and diagnosis information</td>
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<td>- Conflicts of Interest</td>
<td>- Pilot and then full implementation by Q4 of new EOBs by year end</td>
<td>- Portal strategy communications to broker, members and employers</td>
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<tr>
<td>- Concurrent Review</td>
<td>- Portal strategy communications to broker, members and employers</td>
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<tr>
<td>- External Review</td>
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### What’s coming…

- Pilot and then full implementation by Q4 of new EOBs by year end
- Portal strategy communications to broker, members and employers

### HIGHLIGHTS AND IMPACTS

- Transparency regarding services delivered, associated charges and determinations on what and how much is paid
- Impacts to administration of appeals and enhancements to member notices communicating a denial or reduction of benefits
Medical Loss Ratio
Federal MLR law overview

• The Affordable Care Act requires insurers to spend a minimum percentage of premium dollars on clinical services and activities designed to improve health care quality

• Regulation specifies that insurers must spend:
  • 80% of premium dollars on claims and quality improvement expenditures for individual and small group markets
  • 85% for large group markets

• Measured on a calendar year basis beginning January 1, 2011

• Applies to comprehensive fully insured commercial business

• An issuer must provide a rebate to individual and group policyholders if the issuer fails to meet or exceed the minimum MLR percentage

• Rebates must be distributed by August 1, following the end of the MLR reporting year
Calculating the MLR

- MLR calculation will be performed for each legal entity broken down by state and further by line of business (individual, small group and large group).
- Group customers are organized by employer situs (i.e., contract issuance state) for the purposes of these calculations.
- MLR defined as follows:

<table>
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<tr>
<th>Medical (numerator)</th>
<th>Incurred claims and expenses for activities that improve health care quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Premium revenue less Federal &amp; State taxes, licensing &amp; regulatory fees and adjusted for ACA risk adjustments, risk corridors, and reinsurance</td>
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# Activities that improve health care quality

<table>
<thead>
<tr>
<th>Included in MLR calculation</th>
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<tbody>
<tr>
<td>Case &amp; Disease Management</td>
<td>HIPAA &amp; ICD-10 Implementation Costs</td>
</tr>
<tr>
<td>Nurseline</td>
<td>Concurrent &amp; Retrospective Utilization Review</td>
</tr>
<tr>
<td>Fraud &amp; Abuse (the lesser of expenses and recoveries)</td>
<td>Provider Credentialing</td>
</tr>
<tr>
<td>Certain Wellness Expenses (e.g. coaching and incentives)</td>
<td>Provider Contracting / Network Management</td>
</tr>
<tr>
<td>Prospective Utilization Review (conducted in accordance with an accredited program)</td>
<td>Claims Adjustment Expenses excluded from medical</td>
</tr>
<tr>
<td>HIT Expense for Health Care Quality Improvements (with significant limitations)</td>
<td></td>
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<tr>
<td>Medical Home (as defined in the Act)</td>
<td></td>
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<tr>
<td>Discharge Planning</td>
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Exchanges
Exchanges: What happens in 2014

• An exchange is a mechanism to facilitate purchase of health insurance coverage that satisfies requirements for affordability and quality
• 2014 is when state-based Exchanges for individual and small group markets must be implemented
• Rating rules (adjusted community rating with rates only varying by age, tobacco use, geography, and family status)
• Essential benefit requirements with limits on individual cost-sharing
• Subsidies up to 400% of FPL
• Mandates - penalties for individuals who don't obtain coverage, and for employers with over 50 employees who don't offer minimum essential coverage
• Criteria are determined by actuarial value

Bronze - 60%  Silver - 70%  Gold - 80%  Platinum - 90%
### Individual and SHOP Exchanges

#### What is the difference between the Individual and SHOP Exchanges?

<table>
<thead>
<tr>
<th>Eligible Purchasers</th>
<th>Individual Exchange (American Health Benefit Exchange)</th>
<th>SHOP Exchange (Small Business Health Options Program)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Consumers seeking individual, family coverage</td>
<td>• Small business employers and their employees</td>
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<tr>
<td></td>
<td>• Primarily those without access to affordable employer coverage</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Assistance</th>
<th>Individual and SHOP Exchange risk pools or remain separate</th>
<th>State exchanges will be the only source of federal subsidy administration:</th>
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<tbody>
<tr>
<td></td>
<td>• Determine if they will combine Individual and SHOP Exchange risk pools or remain separate</td>
<td>- Premium and cost sharing subsidies for incomes up to 400% FPL</td>
</tr>
<tr>
<td></td>
<td>• January 1, 2014 – states determine eligibility for employers up to 50 or 100 employees</td>
<td>• No individual subsidy assistance</td>
</tr>
<tr>
<td></td>
<td>• Beginning in 2017, states have the option to expand to employers greater than 100 employees</td>
<td>• Small employers eligible for tax credits (based on number of employees and average employee wages)</td>
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Engaging providers and accountable care organizations
ACO & other modernization efforts

Accountable care is not a panacea but rather one of a number of complementary initiatives chartered by the Affordable Care Act to help achieve the three-part goal of lower costs, improved care, and better health.

Other delivery-reform efforts such as expanded use of medical homes, bundled payments, value-based purchasing, adoption of information technology, and payment reforms are under way or under consideration.

A critical success factor for ACOs will be their effective integration with these other efforts.

Dr. Berwick, CMS Administrator, New England Journal of Medicine
Implications of delivery system reform

Strategic implications for the network

New compensation methodologies
Growing interdependence among network providers
Shift toward “bundled payment” structures
Focus on Primary Care
Coordinated care across episodes and time

NETWORK STRATEGY 2.0

1. Performance-Based Contracting
   a. Hospital
   b. Physician

2. Risk-Based Compensation/Delivery System Configuration
   a. Patient-centered Medical Home
   b. Accountable Care Organization
   c. Shared Savings
   d. Capitation

3. Primary Care Transformation
4. Episodic Payment
5. Medical Necessity
6. NextGen Facility Designation
7. Transparency
8. Supply Chain Management
Evolving provider incentive models

Almost 12% of our total spending on health care services is tied to incentive contracts

Provider incentive models in place today on a selective basis:

- Capitation; Physician, Hospital. Ancillary, Global Capitation
- Shared Savings
- Shared Risk
- Patient-centered Medical Home
- Performance-based Contracting
- Episode/Bundled Payments; Global payment for select services
Characteristics of successful ACOs

Key Objectives

1. Reduce medical costs/trend
2. Deliver best possible quality outcomes
3. Improved population health and patient experience

1. Risk sharing
   • Provider takes clinical & financial accountability to drive a lower PMPM trend than the market
   • Health plan takes financial risk as well

2. Organization should organize its assets under the six criteria:
   • Physician leadership
   • Disciplined financial accounting and systems
   • Robust clinical programs
   • Health information technology to identify missed opportunities and inefficiencies
   • Efficient mechanism to distribute funds to various providers based upon performance
   • Patient engagement capabilities

3. Performance-based contracting is entry point but enterprise must evolve
UnitedHealthcare ACO: Pilot strategy

Current State – Southern Arizona ACO (SAACO)

• UnitedHealthcare is the payer partner in Southern Arizona Accountable Care Organization (SAACO)
  • We are participating in the nationally prominent Dartmouth-Brookings ACO collaborative
  • Pilot is located in Tucson, Arizona
  • Includes Tucson Medical Center and independent physicians in the community.

Future State – Additional ACO pilots

• Selecting 8-10 ACO pilots in 2011
  • Candidate list of ACO prospective partners
  • Leveraging diagnostic tool to identify high-potential hospitals and health systems
  • Assessing strategic opportunities with the ACO to support growth
Questions?