UnitedHealthcare and Health Reform

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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

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2011

Economy
Slow uneven economic growth
Unemployment hovers around 9%

→ Lagging effects of economy will continue to pressure costs

Health Reform
Strategy development and implementation of health reform

→ Strategy refinement and Health Exchange development

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

→ Further M&A / market exits and acceleration of vertical integration

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

→ Greater accountability for care & adoption of wellness programs

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

→ Growth in accountability of care (ACOs) & alternative delivery models

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

→ Personal dashboards, population specific products/programs, greater transparency

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

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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"

UnitedHealthcare COMMUNITY & STATE

UnitedHealthcare EMPLOYER & INDIVIDUAL

UnitedHealthcare MEDICARE & RETIREMENT

OPTUM

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"

OPTUMHealth OPTUMInsight OPTUMRx

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

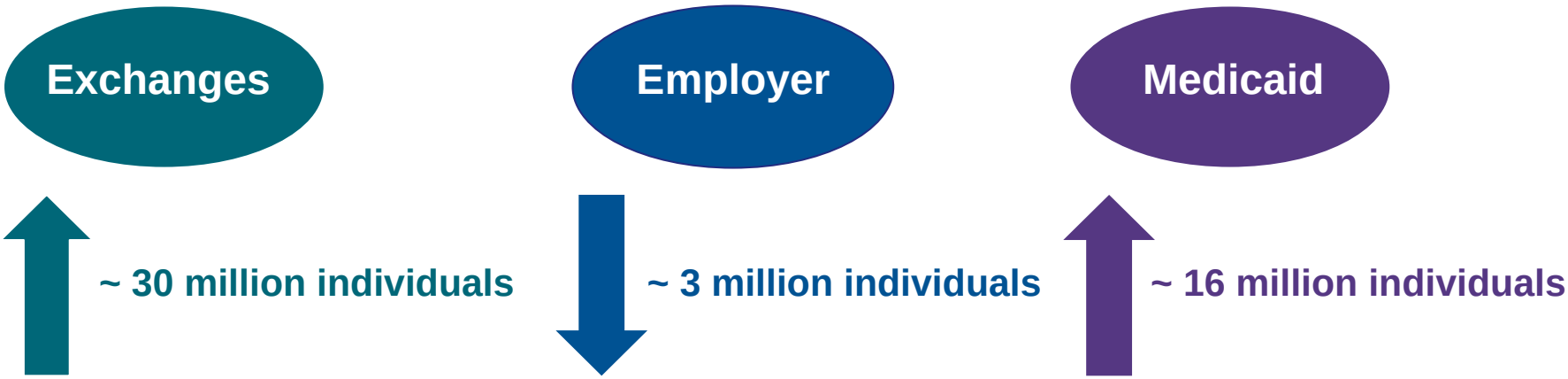
Innovation

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

Increasing access to coverage

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

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

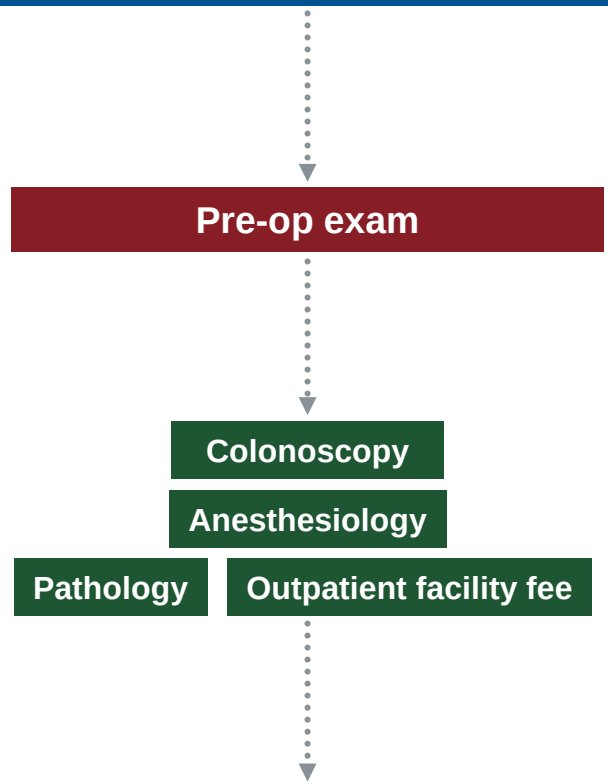
Population

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%



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

Information based on plan being reform compliant.

Paid as preventive

Not paid as preventive

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

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.

Lab screening for Cholesterol *

Urinalysis

Blood chemistry panel

* No prior diagnosis

Information based on plan being reform compliant.

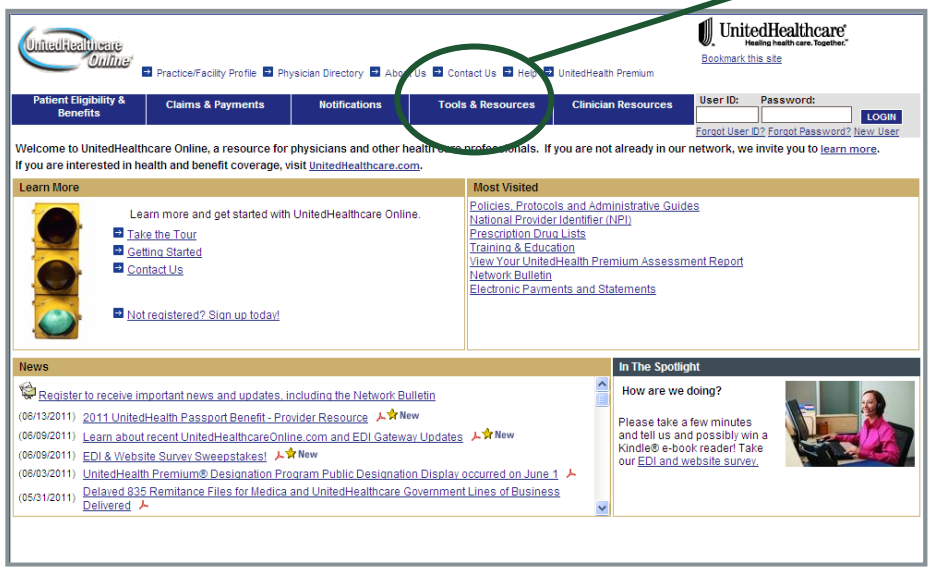
Paid as preventive

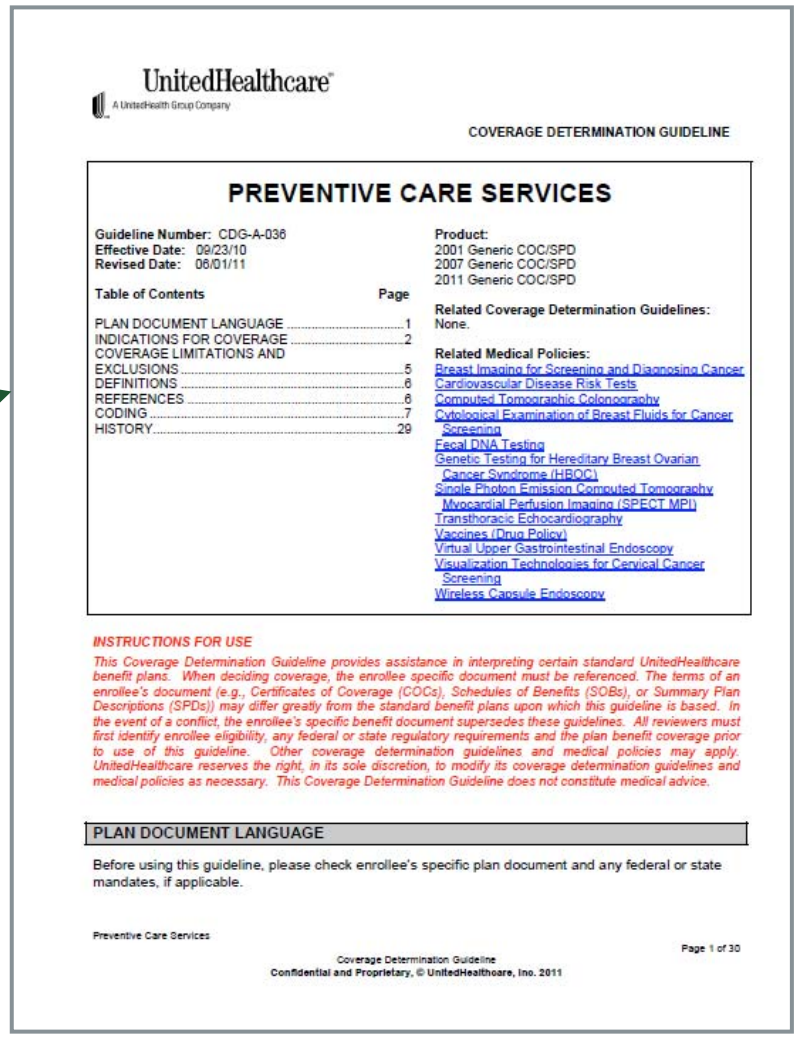
Not paid as preventive

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

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.

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COVERAGE DETERMINATION GUIDELINE

PREVENTIVE CARE SERVICES

Guideline Number: CDG-A-036
Effective Date: 09/23/10
Revised Date: 06/01/11

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Product:
2001 Generic COC/SPD
2007 Generic COC/SPD
2011 Generic COC/SPD

Related Coverage Determination Guidelines:
None.

Related Medical Policies:
Breast Imaging for Screening and Diagnosing Cancer
Cardiovascular Disease Risk Tests
Computed Tomographic Colonography
Cytological Examination of Breast Fluids for Cancer Screening
Fecal DNA Testing
Genetic Testing for Hereditary Breast Ovarian Cancer Syndrome (HBOC)
Single Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI)
Transthoracic Echocardiography
Vaccines (Drug Policy)
Virtual Upper Gastrointestinal Endoscopy
Visualization Technologies for Cervical Cancer Screening
Wireless Capsule Endoscopy

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs)) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee's specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.

PLAN DOCUMENT LANGUAGE

Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.

Appeals

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

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2010

Phase 1 of Appeals Provision implemented for plan years beginning on or after September 23

- Rescissions
- Full and Fair Review
- Conflicts of Interest
- Concurrent Review
- External Review

2011

Phase 2 of Appeals Provision implemented for plan years beginning on or after July 1

- New EOB and ABD language related to internal and external appeal rights, and consumer assistance programs

What's coming…

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

2012

Full implementation of Appeals Provision as plans renew beginning on or after January 1

- Language translation support
- Notice of availability of procedure and diagnosis information

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:

Medical (numerator)

Incurred claims and expenses for activities that improve health care quality

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Premium (denominator)

Premium revenue less Federal & State taxes, licensing & regulatory fees and adjusted for ACA risk adjustments, risk corridors, and reinsurance

Activities that improve health care quality

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Included in MLR calculation

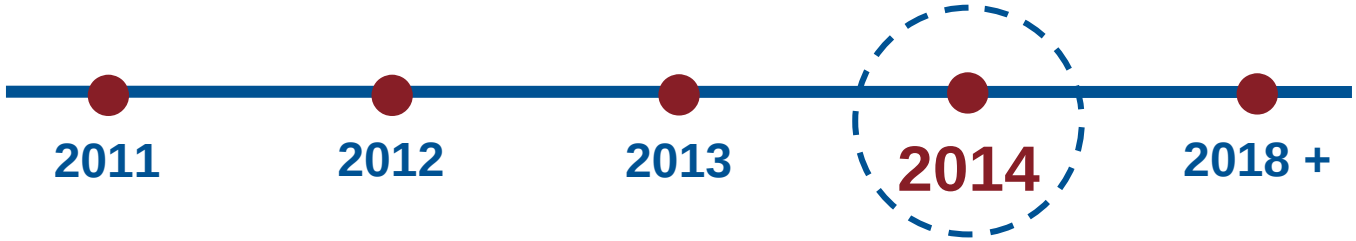
- Case & Disease Management
- Nurseline
- Fraud & Abuse (the lesser of expenses and recoveries)
- Certain Wellness Expenses (e.g. coaching and incentives)
- Prospective Utilization Review (conducted in accordance with an accredited program)
- HIT Expense for Health Care Quality Improvements (with significant limitations)
- Medical Home (as defined in the Act)
- Discharge Planning

Excluded in MLR calculation

- HIPAA & ICD-10 Implementation Costs
- Concurrent & Retrospective Utilization Review
- Provider Credentialing
- Provider Contracting / Network Management
- Claims Adjustment Expenses excluded from medical

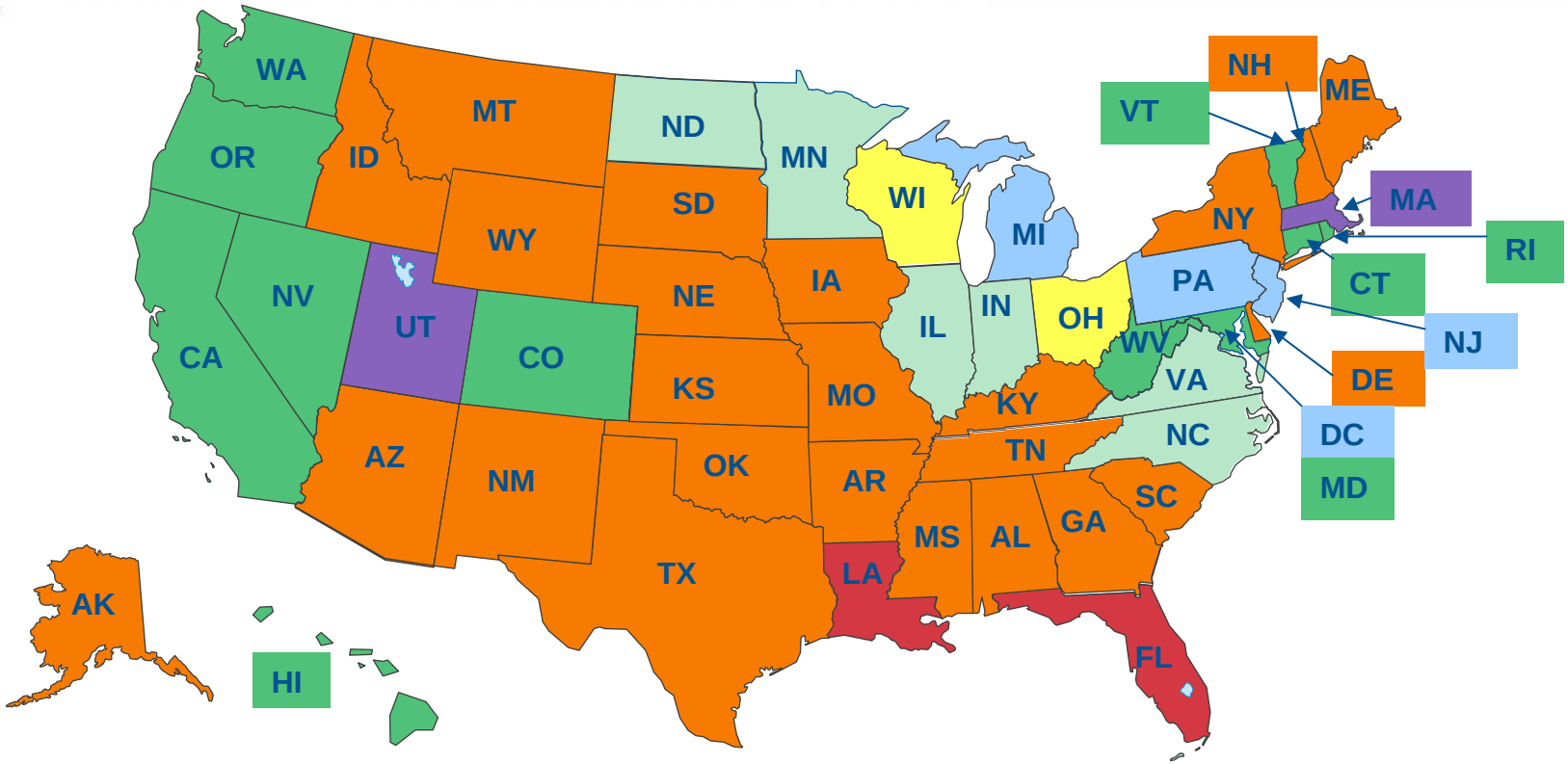
Exchanges

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

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What is the difference between the Individual and SHOP Exchanges?

	Individual Exchange (American Health Benefit Exchange)	SHOP Exchange (Small Business Health Options Program)
Eligible Purchasers	• Consumers seeking individual, family coverage • Primarily those without access to affordable employer coverage	• Small business employers and their employees
Federal Assistance	• State exchanges will be the **only source** of federal subsidy administration: – Premium and cost sharing subsidies for incomes up to 400% FPL	• **No** individual subsidy assistance • Small employers eligible for tax credits (based on number of employees and average employee wages)
State Decisions	• Determine if they will combine Individual and SHOP Exchange risk pools or remain separate	• January 1, 2014 – states determine eligibility for employers up to 50 or 100 employees • Beginning in 2017, states have the **option** to expand to employers greater than 100 employees

Engaging providers and accountable care organizations

ACO & other modernization efforts

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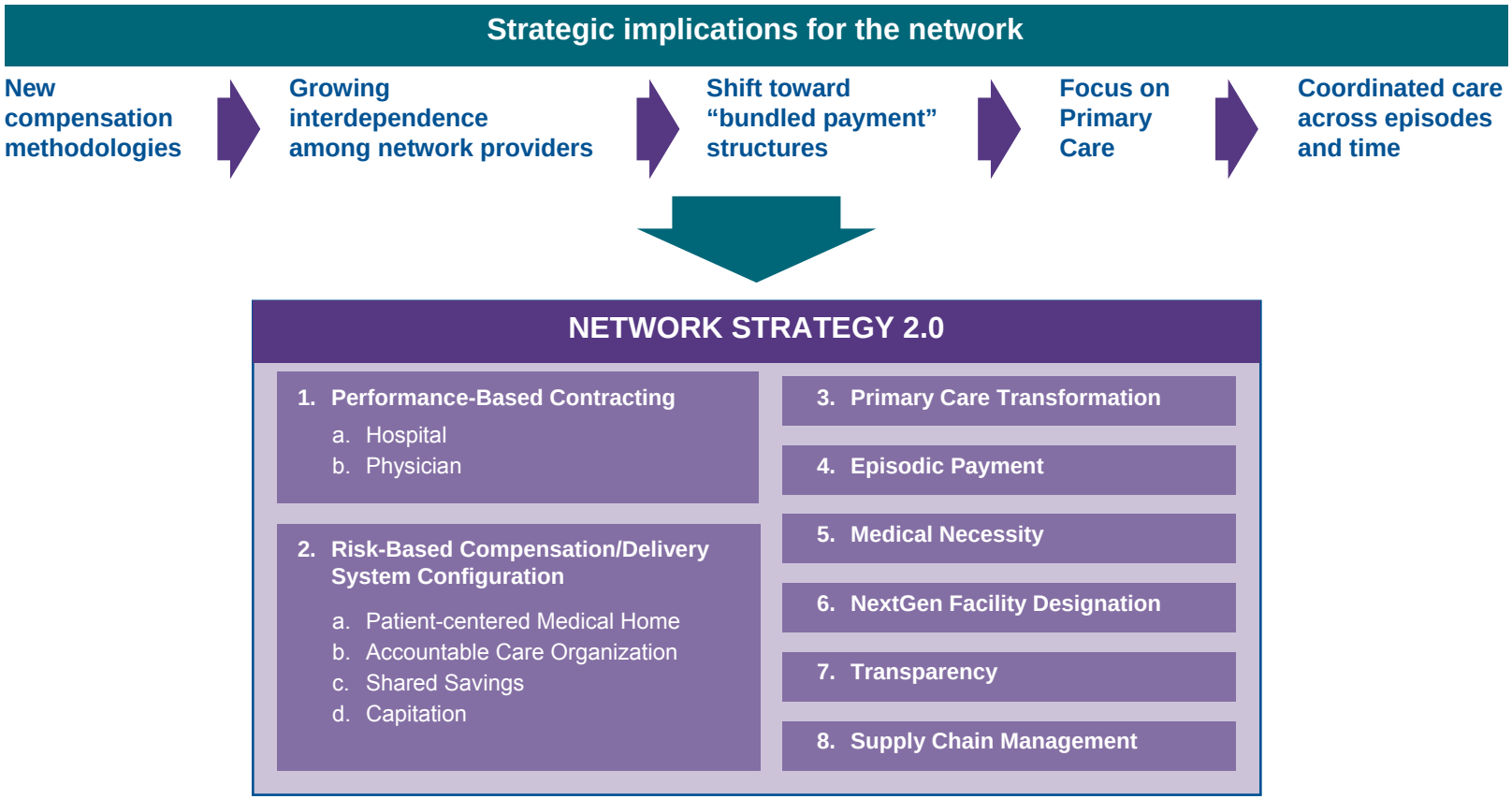
Accountable care is not a panacea but rather one of a number of complementary initiatives chartered by the Affordable Care Act to help achieve the three-part goal of lower costs, improved care, and better health.

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.

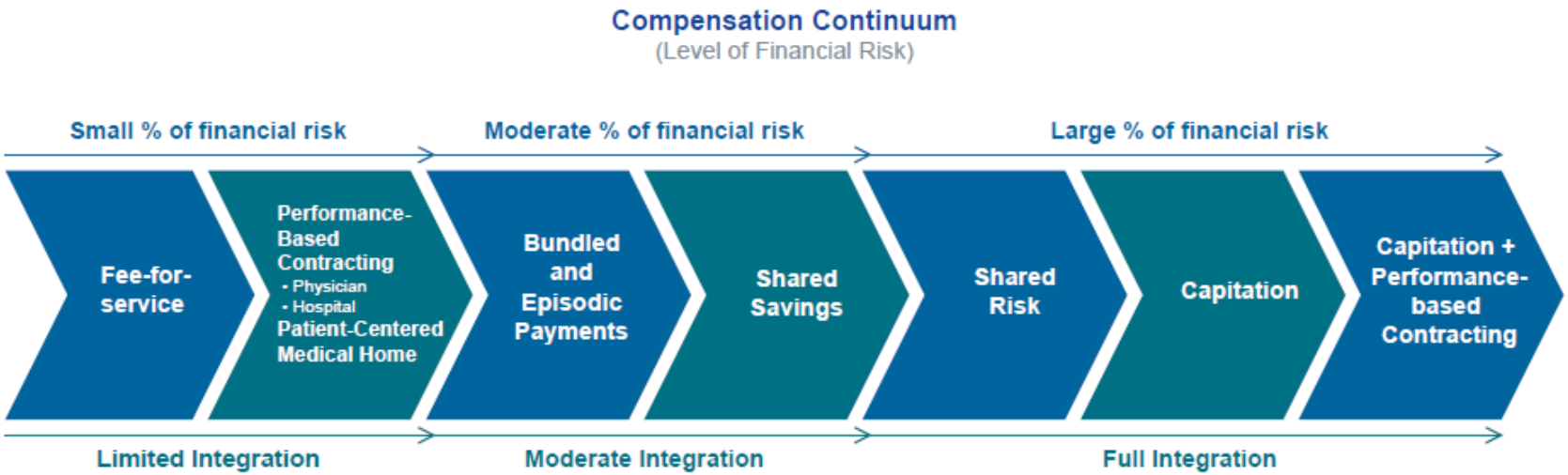
A critical success factor for ACOs will be their effective integration with these other efforts.

Dr. Berwick, CMS Administrator, *New England Journal of Medicine*

Implications of delivery system reform



Evolving provider incentive models



Continuum of risks represents multiple value-based contracting options. UnitedHealthcare is working to deploy a variety of options with its network of providers based on their readiness to accommodate varying levels of risk.

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

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

Characteristics of successful ACOs

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Key Objectives

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

Success Characteristics for Accountability

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**

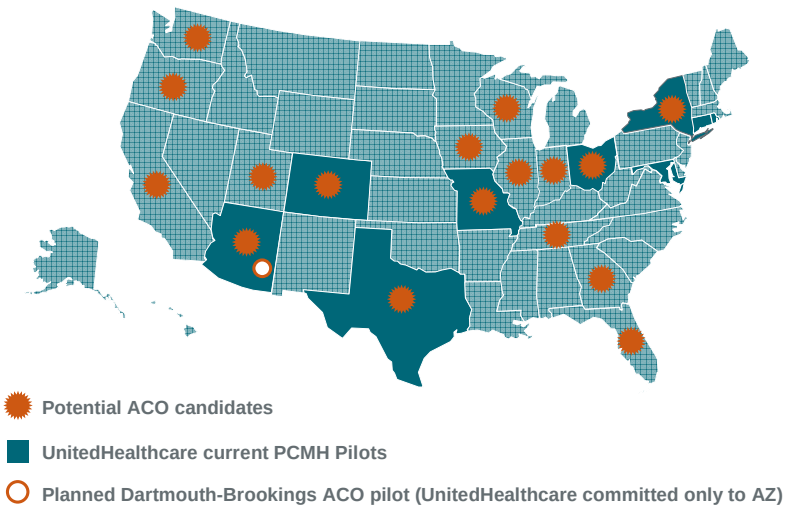
UnitedHealthcare ACO: Pilot strategy

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



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Questions?