UnitedHealthcare and Health Reform
Agenda

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

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
An overview: the Affordable Care Act

When passed, the Patient Protection and Affordable Care Act committed $940 billion over 10 years with the goal to expand coverage to nearly 32 million of the 54 million uninsured Americans. Early belief was that this would be offset by a projected $438 billion in new taxes and more than $500 billion in spending reductions, largely in the Medicare program.

Patient Protection and Affordable Care Act includes:

• Creation of a new insurance marketplace, resulting in expanding access to coverage and the formation of state based Exchanges

• Sweeping insurance market reforms

• Fundamental changes to Medicare, expansion of the Medicaid Program, and reforms to Part D, closing the “Donut Hole” by 2020

• Fraud and abuse, health IT, and prevention and wellness initiatives, including the promotion of prevention programs across the health care system
Three Core Assumptions

• Healthcare modernization did not begin and must not end with the enactment of the Patient Protection and Affordable Care Act.

• Universal coverage will be sustainable only if there is relief to the accelerating healthcare cost burden on American families and businesses.

• Innovation and market based solutions are the key to improving healthcare quality and access for more individuals while also reducing costs.
Americans remain divided on the law

ACA Health Plan: Favor/Oppose

Source: Pollster.com, May 2011

Favor: 49.2%
Oppose: 39.4%
Key issues debated at federal & state levels

- Exchanges
- Medical Loss Ratio
- Rate Review Authority
- Medicare Advantage
- Medicaid Expansion
- Individual Mandate
- Accountable Care Organizations
- Challenges to Funding of Provisions of PPACA and/or Relevant Agencies
- Essential Minimum Benefits
- Health IT Definitions and Adoption Incentives
- Industry and “Cadillac” Taxes
What happens in 2014?

It’s not just Exchanges

- Guaranteed Issue
- Individual Mandate/Penalty
- Employer Mandate/Penalty
- Medicaid Coverage Expansion
- Premium Subsidies
- Cost-Sharing Subsidies
- Adjusted Community Rating
- Essential Health Benefits Package
- Cost-Sharing Limits
- Risk Adjustment & Reinsurance
- Co-ops & Multi-State Plans
- Individual and SHOP Exchanges


Highlights

- 30 million newly insured individuals
- Perhaps 80 million switching coverage source
- 20+ million purchasing through Exchanges
- Number covered by Medicaid increases by 15+ million
- Average subsidy of $5000-$6000 per subsidized enrollee
- Medicaid primary care reimbursement increased to Medicare rates (2013 and 2014)
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

~ 30 million individuals
~ 3 million individuals
~ 16 million individuals

Based on analysis by The Lewin Group published at http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf
## Health reform timeline

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 &amp; beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult child coverage until age 26</td>
<td>Annual fee on pharmaceutical manufacturers begins</td>
<td>60-day advance notice of material modifications</td>
<td>Administrative simplification begins</td>
<td>Annual insurance industry tax</td>
<td>High-value plan excise tax begins (2018)</td>
</tr>
<tr>
<td>Annual dollar limits restricted</td>
<td>Annual rate review process</td>
<td>Accountable Care Organization requirements</td>
<td>Annual fee on medical device sales begins</td>
<td>Coverage for all adult children until age 26 including those that have employer coverage (formerly not covered for grandfathered plans)</td>
<td></td>
</tr>
<tr>
<td>Early retiree reinsurance program (ERRP)</td>
<td>Appeals ombudsmen and process documentation G</td>
<td>Appeals provision fully implemented G</td>
<td>Comparative effectiveness fee increases to $2 per member/year</td>
<td>Deductible caps cannot exceed $2K for individual and $4K for family G</td>
<td>Insurance industry tax through 2018</td>
</tr>
<tr>
<td>ER coverage as in-network, no prior authorization G</td>
<td>Auto-enrollment for groups with 200+ FTEs (implementation delayed until regulations released)</td>
<td>Comparative effectiveness fee ($1 per member/year)</td>
<td>First medical loss ratio rebates to be paid by August</td>
<td>Guarantee issue and renewal rules G</td>
<td>Medicare Part D “donut hole” closed by 2020</td>
</tr>
<tr>
<td>Initial appeals review standards G</td>
<td>Discounts in Medicare Part D “donut hole”</td>
<td>New women’s preventive services with no cost sharing G</td>
<td>Employee notification of access to Exchanges</td>
<td>Health Benefit Exchanges</td>
<td>States can open Exchanges to CHIP eligibles (2015) and all employers (2017)</td>
</tr>
<tr>
<td>Lifetime dollar limits prohibited</td>
<td>HSAs/HRAs/FSAs: limitations for OTC medications</td>
<td>Quality bonus begins for Medicare Advantage plans</td>
<td>FSA contributions limited to $2,500</td>
<td>Individual &amp; employer mandates</td>
<td></td>
</tr>
<tr>
<td>Medicare Part D rebate for beneficiaries in the gap</td>
<td>Increase penalty for non-qualified HSA withdrawals</td>
<td>Quality of Care Reporting Requirements</td>
<td>High earner tax begins</td>
<td>Mandatory coverage for clinical trials G</td>
<td></td>
</tr>
<tr>
<td>No pre-existing conditions for kids until age 19</td>
<td>Minimum medical loss ratio (MLR): 85% for large group; 80% for small group and individual</td>
<td>Summary of Benefits and Coverage (SBC) and the Uniform Glossary</td>
<td>ICD-10 code adoption</td>
<td>No annual limits</td>
<td></td>
</tr>
<tr>
<td>Online consumer information at healthcare.gov</td>
<td>Non-discrimination rules apply to insured plans (implementation delayed until regulations are released) G</td>
<td></td>
<td>W-2 reporting on the value of employer-sponsored health benefits</td>
<td>No pre-existing condition exclusions</td>
<td></td>
</tr>
<tr>
<td>Preventive services with no cost sharing G</td>
<td>Small business wellness grants</td>
<td></td>
<td></td>
<td>OOP limits must comply with OOP limits for HSA qualified plans G</td>
<td></td>
</tr>
<tr>
<td>Rescissions prohibited except for fraud or non-payment</td>
<td></td>
<td></td>
<td></td>
<td>Rating restrictions G</td>
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<tr>
<td>Small business tax credit</td>
<td></td>
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<td>Standardized essential health benefits</td>
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<tr>
<td>Temporary high risk pool</td>
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<td>Tax credits and subsidies for individuals and small employers</td>
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<td></td>
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<td>Waiting period limits</td>
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Note: some provisions apply only to fully insured business (e.g., MLR and guarantee issue)
PPACA Fees and Taxes

The Patient Protection and Affordable Care Act (ACA or the Act) imposes several new fees and taxes that affect the health care industry:

• **Insurer’s Fee** – Beginning on January 1, 2014, ACA imposes a new tax on health insurers, totaling $8 billion in 2014, increasing to $14.3 billion in 2018, and indexed to premium trend thereafter. Revenue generated by the Insurer’s Fee will fund new premium tax credits available to individuals and families for insurance coverage purchased through the Exchange.

• **Reinsurance Fee** – For years 2014 to 2016, the Act imposes transitional fees on commercial health insurers to finance reinsurance payments for individual market coverage (totaling $25 billion).

• **Comparative Effectiveness Research Fee (CER Fee)** – Beginning with plan years after September 30, 2012, ACA imposes a new fee on plans (one dollar per covered life for the first year, two dollars per covered life in subsequent years) to fund research on the comparative effectiveness of medical treatments. The CER fee projected to generate $2.6 billion between 2013 and 2019.

• **Other Health Care Fees** – ACA also generates new revenue through an annual fee on pharmaceutical manufacturers and excise taxes on medical devices.
Implementing the ACA 2010-2011
Effective plan years 9/23/10 and beyond

Required for all

Essential Health Benefits (EHB)
- No lifetime limits
- No annual dollar limits on EHB
  Restricted annual limits are permitted as follows:
  • 9/23/10 but before 9/23/11: $750k
  • 9/23/11 but before 9/23/12: $1.25m
  • 9/23/12 but before 1/1/14: $2m

Adult children under age 26
- Requirement to cover adult children to age 26
- No restrictions on marriage and enrollment in school
- Grandfathered plans are not required to cover children to the age of 26 if the adult child is eligible to enroll in another eligible employer-sponsored health plan

Consumer protections
- Restrictions on rescissions
  • Prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation or for non payment of premiums
  Pre-ex removed for children under age 19
  • Group plans are prohibited from applying pre-existing condition exclusions for enrollees under age 19.

May choose not to include if grandfathered

Preventive services at no cost
- 1st first dollar coverage for mandated preventive services received from network providers based on services with ‘A’ or ‘B’ recommendation from USPSTF
- Routine immunizations as recommended by CDC
- Preventive care & screenings for infants, children and adolescents per HRSA, including Bright Futures

Appeals rights
- Plans must have effective appeals processes for appeals of coverage determinations and claims
- Notification of available appeals processes, along with an opportunity to review their file and present evidence.
- External review by independent reviewers

Patient protections
- Emergency services
  • Pay out-of-network services at network cost-share level for co-pays & coinsurance
- Physician access
  • Members may choose any participating PCP including pediatricians for child’s PCP
  • Women need no referral to access OB/GYNs

Most UnitedHealthcare fully insured plans include grandfathered provisions; inclusion of benefits does not affect grandfathered status. Some state requirements may vary age of adult dependent.
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

Rev. 7/18/11
Women’s expanded coverage

On Aug. 1, 2011, the Department of Health and Human Services released new coverage rules for women’s preventive health.

• No cost-sharing rules apply
• Apply to non-grandfathered plans and issuers
• Coverage required for plan years beginning on or after Aug. 1, 2012
• Medical management techniques may be applied
• Religious institutions that offer insurance are exempt from covering contraception services
Women’s expanded coverage

The new rules include:

Well-woman visits

Screening for gestational diabetes for all pregnant women

Human papillomavirus (HPV) DNA testing for women 30 years and older

Annual sexually-transmitted infection counseling

Annual human immunodeficiency virus (HIV) screening and counseling

FDA-approved contraception methods and contraceptive counseling

Breastfeeding support, supplies, and counseling

Domestic violence screening and counseling
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.
New preventive services collateral

- Simplify and strengthen messaging
- Provide examples of most common scenarios
- New materials
  - Member FAQs
  - Posters
  - Member emails
  - Member presentations
- Podcast / Webinar
- Employer toolkit
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

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase 1 of Appeals Provision implemented</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>
</tr>
<tr>
<td>for plan years beginning on or after September 23</td>
<td>• New EOB and ABD language related to internal and external appeal rights, and consumer assistance programs</td>
<td>• Language translation support</td>
</tr>
<tr>
<td>• Rescissions</td>
<td><strong>What’s coming…</strong></td>
<td>• Notice of availability of procedure and diagnosis information</td>
</tr>
<tr>
<td>• Full and Fair Review</td>
<td></td>
<td></td>
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<tr>
<td>• Conflicts of Interest</td>
<td></td>
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<tr>
<td>• Concurrent Review</td>
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<tr>
<td>• External Review</td>
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</tbody>
</table>

### 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 subscribers and group policyholders based on pro rata share of premium paid by each 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:

\[
\text{Medical (numerator)} \div \text{Premium (denominator)}
\]

- Medical (numerator): Incurred claims and expenses for activities that improve health care quality.
- 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

<table>
<thead>
<tr>
<th>Included in MLR calculation</th>
<th>Excluded in MLR calculation</th>
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</thead>
<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</td>
<td>Claims Adjustment Expenses excluded from medical</td>
</tr>
<tr>
<td>with an accredited program)</td>
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<tr>
<td>HIT Expense for Health Care Quality Improvements</td>
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<tr>
<td>(with significant limitations)</td>
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<tr>
<td>Medical Home (as defined in the Act)</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%
Minimum responsibilities of Exchanges

More than just a web portal

<table>
<thead>
<tr>
<th>Certify “Qualified Health Plans”</th>
<th>Operate web portal and toll-free number</th>
<th>Determine subsidy eligibility and maintain electronic cost calculator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect with public programs for eligibility/ enrollment</td>
<td>Implement health plan rating system/enrollee satisfaction system</td>
<td>Review patterns of rate increases</td>
</tr>
<tr>
<td>Determine exemptions from individual mandate</td>
<td>Communicate info to Dept of Treasury and employers</td>
<td>Establish a “Navigator” program to facilitate enrollment</td>
</tr>
</tbody>
</table>
Continuum of Coverage on Individual Exchange

- Individual Subsidy
  - 400%
  - 200%

- Basic Health Plan
  - 133% Federal Poverty

- Medicaid

- Individual Subsidy w/o Basic Health Plan
  - 400%

- Cost Share Subsidy
  - 250%
Currently Operating Exchange

Enacted Governing Legislation to Establish a PPACA Exchange Board

Enacted Legislation Expressing the Intent to Establish an Exchange

Legislation Under Consideration

Legislation Has Not Been Introduced; State Still in Session

Legislature Adjourned without Passing Governing or Intent Legislation

State Not Planning to Run Exchange/Refusing HHS grants

July 18, 2011
## 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>
</thead>
<tbody>
<tr>
<td></td>
<td>• Consumers seeking individual, family coverage</td>
<td>• Small business employers and their employees</td>
</tr>
<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 Exchange</th>
<th>SHOP Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State exchanges will be the <strong>only source</strong> of federal subsidy administration:</td>
<td>No individual subsidy assistance</td>
</tr>
<tr>
<td></td>
<td>• Premium and cost sharing subsidies for incomes up to 400% FPL</td>
<td>• Small employers eligible for tax credits (based on number of employees and average employee wages)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Decisions</th>
<th>Individual Exchange</th>
<th>SHOP Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Determine if they will combine Individual and SHOP Exchange risk pools or remain separate</td>
<td>January 1, 2014 – states determine eligibility for employers up to 50 or 100 employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Beginning in 2017, states have the <strong>option</strong> to expand to employers greater than 100 employees</td>
</tr>
</tbody>
</table>
Customer support
United for Reform Resource Center

Welcome to a new era of health care.

Timeline and provision summaries
• Commonly asked questions
• Video and audio
• Materials on various reform topics