Roadmap for Transforming America's Health Care System

America's health care system requires transformational change to provide all health care participants with broader access and choice, improved quality and reduced health care costs. To truly bring our complex health care system into the 21st century, we must adopt new approaches and technologies that yield better health outcomes by improving connectivity, care delivery and use of public resources. Health care modernization did not begin and must not end with the enactment of the Patient Protection and Affordable Care Act; it requires collaboration between the public and private sectors and across the health care industry.

UnitedHealth Group strongly supports making high-quality health care accessible and affordable for everyone. Reaching this goal will require innovative solutions that address the underlying health care cost drivers that continue to burden consumers, employers, states and the federal government. According to the Centers for Medicare & Medicaid Services, total health care spending is expected to climb from a historical average of 12 percent of GDP to 19.8 percent of GDP by 2020. But our high spending doesn't always result in quality health outcomes: according to the World Health Organization, thirty countries have higher "full health" life expectancy rates than the United States. It's clear that all participants can realize more value from the approximately $2.5 trillion that the U.S. spends on health care annually. We believe that successfully addressing this fundamental challenge will require creative approaches and solutions that encompass the following core principles:

- Build upon the foundation of employer-based health coverage
- Optimize public resources
- Employ progressive approaches to health care benefits
- Modernize the way care is delivered to improve affordability and quality
- Modernize Medicare and Medicaid
- Make technology an enabling force for better health care

While there is no single answer for how to modernize America's health care system, the following actionable policy solutions address the core challenges and derive from our experience as one of the largest and most diverse participants in the health care system. By adopting these solutions, we can address today's key health care modernization objectives and help ensure that America is on the right path to helping people live healthier lives.

Strengthen and Improve Public Programs

Medicare and Medicaid are evolving at a slower pace than the rest of the health care system, and consequently offer an outdated and costly approach that too often rewards volume over value. Now is the time to focus on strengthening these critical programs so that they can deliver sustainable, high-quality benefits to current and future beneficiaries. By adopting approaches that utilize the entire care continuum and applying consumer-focused best practices, programs such as Medicare and Medicaid can achieve better outcomes for beneficiaries while simultaneously realizing significant cost savings.

Modernize Medicare to Improve the Quality of Care for Beneficiaries and Achieve Cost Savings

Modernizing the health care system cannot be achieved without modernizing Medicare. With growing numbers of Baby Boomers reaching retirement age every day, reforming Medicare's outdated approach of delivering high-volume -- rather than high-value -- care is critical for the health of beneficiaries as well as for the federal budget and the national economy. Utilizing proven solutions to help manage chronic conditions and improve care quality will enable Medicare to achieve better outcomes for beneficiaries, reduce avoidable costs and enhance the long-term sustainability of the program, whose 2010 expenditures totaled $523 billion dollars.

Objective	UnitedHealth Group's Solutions
Create More High-Quality Choices for Beneficiaries	• Create a "middle option" between Medicare Advantage and Medicare fee-for-service by establishing a "Medicare Connect" model that allows private organizations to administer Medicare fee-for-service while providing proven and innovative clinical interventions to yield better patient outcomes and to reduce costs (e.g., Nurse Practitioner Model, high risk case management and transitional case management). "Medicare Connect" would not bear full risk, would use Medicare's payment rates, and would include a PPO. Additionally, beneficiaries would receive incentives (e.g., lower cost-sharing, lower premiums) for using high-quality, high-efficiency providers. Charging lower premiums in the "Medicare Connect" model (compared to Medicare fee-for-service) would encourage enrollees to transition and guarantee federal savings; offering beneficiaries an opportunity to save on premiums through wellness incentives would also incent participation.
Preserve Medicare Advantage	• Roll back or modify the PPACA-mandated Medicare Advantage cuts, which negatively impact the beneficiary and endanger the program's viability. • Reinstate the Medicare Advantage Open Enrollment Period to make Medicare Advantage more accessible to beneficiaries. • Enhance the Medicare Advantage Star Rating program to ensure quality metrics are appropriate, outcomes-focused and rely on real-time data. • In the absence of a permanent solution to the Medicare physician payment system, ensure CMS incorporates reasonable assumptions of physician expenditures for the MA payment year prior to the annual MA rate announcement.
Modernize Medicare Benefits to Help Prevent Diabetes	• Incorporate innovative cost-saving, quality of life-improving benefits and services, such as the National Diabetes Prevention Program (an intensive lifestyle intervention program that's targeted towards adults with prediabetes), into Medicare offerings. This program can reduce the diabetes prevalence in pre-diabetic adults by as much as 8 percent by 2020 and can help control rising Medicare program expenditures, which are partly attributable to increased spending on chronic conditions.
Foster Medicare Program Sustainability	• Phase in an increase in the Medicare eligibility age to 67 to match the Social Security retirement age, and index to longevity. • Replace the current encounter-based payment methodology with models that emphasize quality and value (e.g., blended payment models for primary care and bundled payment models that pay for episodes of care for certain specialties). • Expand risk-based and shared savings payment approaches to promote quality among providers and remove the incentive for high-volume service. • Means test Medicare premiums to promote long-term sustainability and help keep the program more affordable for poorer individuals. Additionally, incorporate financial incentives for beneficiaries to reward good health management.
Incorporate Data-Driven Approaches to Improve Care Quality for Medicare Beneficiaries	• Utilize predictive modeling tools and comprehensive patient encounter data to identify missed preventive care and other gaps in care programs, prescribed courses of treatment, and recommended, evidence-based interventions. • Adopt a data-driven approach to target disease management interventions, using population data from CMS to identify chronically ill patients, and establish programs that employ case workers and nurses to follow up with them.

Modernize Medicaid to Improve Beneficiaries' Health and Ensure a Sustainable Future for the Program

The rapidly changing health care environment and budgetary landscape present uncertainty, challenges and opportunities for modernizing the Medicaid program. As states and the federal government prepare for approximately 9 million additional individuals to enroll in Medicaid in 2014 as a result of PPACA – growing to an estimated 16 million by 2019 -- policymakers have a unique opportunity to implement flexible solutions that acknowledge state differences while improving care for enrollees and controlling costs.

Objective	UnitedHealth Group's Solutions
Encourage Integrated Solutions to Reduce Medicaid Costs While Enhancing Quality	• Transition Medicaid to a managed care system that integrates all services (acute, long-term care, pharmacy, and behavioral health services) into a single managed care structure for all beneficiaries, facilitating close alignment of medical case management and disease management. Encourage states to adopt mandatory managed care models through targeted federal financial incentives, such as FMAP rewards or penalties. • Within a managed care system, support alternative payment models such as capitated and shared savings payment arrangements, pay for performance, and bundled payments to promote more efficient care delivery and to reward quality outcomes. • To help control Medicaid drug costs, provide incentives for states to expand their use of mail order pharmacies, as appropriate. • Modernize long-term care programs to allow for nurses to be deployed in nursing homes to assist in planning and coordinating care for patients, including the development of personalized care plans.
Foster Medicaid Program Sustainability	• In concert with realizing savings through managed care solutions, ensure CMS enforces actuarially sound Medicaid payment rates, as inappropriate rates discourage providers and health plans from participating in Medicaid and jeopardize the program's overall viability. • Implement predictive modeling analytics to identify high cost beneficiaries for targeted interventions and care management, which will result in better care at a lower cost.
Modernize the Administration of the Medicaid Program	• End long-standing administrative inefficiencies by establishing national standards to facilitate the exchange of information between Medicare and Medicaid and standardize each state's administrative transactions and processes. • States that choose to implement the Basic Health Program (BHP) should offer seamless coverage to enrollees moving in and out of Medicaid eligibility, extend existing Medicaid care management organizations' scope to also include BHP, and ensure a level playing field by mandating the same network adequacy standards.

Coordinate Care for Dual Eligibles to Improve Health Outcomes and Control Costs

Key to successful health care modernization is addressing the quality and cost issues associated with those individuals who are dually eligible for Medicare and Medicaid. Dual eligibles tend to have the most complex, chronic illnesses and are therefore some of the most vulnerable individuals within these programs. By coordinating their care between the Medicare and Medicaid programs, dual eligibles can benefit from better care quality while both states and the federal government can realize greater care delivery efficiencies.

Objective	UnitedHealth Group's Solutions
Promote Appropriate, Aligned Care for Dual Eligibles	• Make enrollment in a coordinated care program mandatory for dual eligibles. A single plan should be responsible for all health care services – acute, long-term care, behavioral health and pharmacy. Seamlessly integrating all Medicare and Medicaid benefits and services into one holistic, person-centered model of care under an aligned payment structure will reduce expenditures by improving utilization patterns through aligned financial incentives and eliminating cross-program cost-shifting. • Improve the waiver process to facilitate financially-integrated health plans by creating a new single waiver process that's specific to dual eligibles. Modify waiver budget neutrality requirements to allow for consideration of cross-program savings and expenditures. • Align the administrative policies (e.g., enrollment, marketing, appeals) between Medicare and Medicaid, and use Medicaid program rules as the baseline set of requirements for dual eligibles. Most sponsors of coordinated care plans and programs for dual eligibles are already operating under state Medicaid requirements. • Create a new quality and performance measurement program specific to plans serving dual eligibles. The program must account for the unique needs and acuity levels of the dual eligible population and prevent plans that serve this population from being relatively disadvantaged in quality and performance assessments. • Assure an appropriate financial incentive structure by sharing program savings among federal and state governments, providers and health plans. • Seek to prevent or delay individuals from becoming dually eligible through targeted intervention programs at skilled nursing facilities with coordinated transition management programs that are focused on preventing nursing home admissions and readmissions.

Strengthen and Improve the Employer-Based System

Systemic change resulting from passage of PPACA and economic pressures continue to challenge employers and employees alike. This new environment calls for broad and diverse health care offerings with appropriately aligned incentives. Additionally, all stakeholders – policymakers, employers and insurers – should harness opportunities for employers to continue to provide access to affordable, high-quality care.

Objective	UnitedHealth Group's Solutions
Reform Taxes to Foster a Positive Climate for Employer-Based Health Coverage and Lower Health Care Costs	Broadening the tax base and creating a more equitable tax system will foster economic growth and consequently a more favorable climate for employer-based health coverage. To accomplish this: • Reduce the corporate tax rate from 35 percent to 25 percent to enable employers to redirect their resources towards maintaining and/or expanding employee health care benefits. • Repeal the new insurance taxes imposed by PPACA that increase overall costs on health care (e.g., health insurance tax) and reform the overall tax structure to create a level playing field for all insurers. • Expand small business health care tax credits to businesses with up to 50 employees to lower the cost of providing health insurance to employees and encourage small employers to maintain or obtain health care coverage for employees.
Foster Competitive Markets	• Ban the use of Most Favored Nation clauses in health care. These anticompetitive arrangements between providers and dominant insurers stifle competition and effectively raise costs for other insurers, which limits affordable options for consumers.

Objective	UnitedHealth Group's Solutions
Incent Employees to Adopt Healthy Lifestyle Choices	• Modify PPACA to raise the HIPAA limitation on wellness rewards to 50 percent. This will further enhance rewards to individuals for improving their health and achieving their wellness goals, and will incent more employers to adopt wellness programs. • Reward consumers for choosing high-quality, high-efficiency providers by informing them of the providers who exceed clinically-led, evidence-based quality and efficiency standards. Consumers can receive a share of the savings from high-value care through lower cost sharing amounts or rebates; remaining savings are realized by the provider and employer. • Integrate the Diabetes Prevention Program, an intensive lifestyle intervention program that's targeted towards adults with prediabetes, into employer plans. Offering this program to more adults with prediabetes could reduce diabetes prevalence by up to 8 percent by 2020.
Develop Exchanges to Maximize Choice and Competition For All Products Inside and Outside Exchanges	In order to provide affordable choices, Exchanges must be developed in a way that supports competition among health plans by balancing the need for national uniformity with state flexibility and employer/consumer demands and promoting responsible consumer behavior. This can be accomplished by: • Developing fair marketplaces that provide a level playing field for all health plans, such as by applying the same open enrollment period rules both inside and outside the Exchange and ensuring that Exchange governance policies are not politicized. • Fostering consumer choice by allowing insurers to offer a variety of plans for consumers both inside and outside the Exchange. • Promoting consumer and health plan participation in Exchanges, including allowing employees eligible to enroll in Small Business Health Exchanges to choose any health plan offering within a specific level of coverage set by the employer and maintaining a separate risk pool from the individual market to encourage participation among health plans. • Avoiding duplication of existing state regulatory functions such as rate review to reduce administrative redundancies and delays in product availability, and to ensure seamless consumer eligibility, verification and enrollment. • Standardizing health plan certification to promote competition among plans, improved administrative efficiencies and predictable product offering choices for consumers.
Support a Market-Focused Definition of Essential Benefits	Essential Health Benefits should be defined and provided in a way that balances benefit requirements and affordability and provides sufficient flexibility to respond to ever-evolving medical science. To that end: • Permit plans to use medical necessity and medical management tools (including evidence-based standards and utilization review) when implementing an Essential Benefits product design. • Ensure rules for determining network adequacy are based on existing state law, promote tiered networks, narrow networks and specialty networks, and utilize Centers of Excellence to deliver high-quality care. • Allow high deductible health plans with an HSA to qualify as silver and bronze plans, promoting consumer choice and engagement. • Prohibit states that choose to add requirements above the Essential Benefits from passing the costs on to health plans, and ultimately to consumers. The costs of these additional services should be transparent to consumers. • Allow employers and consumers to design benefits, including opting-out of certain coverage requirements from the list of Essential Benefits. • Repeal Any Willing Provider laws in applicable states to ensure that quality-based networks can be developed.

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Repeal, or Alternatively, Modify the Federal Medical Loss Ratio Requirement to Avoid Market Disruption	• MLR provisions should be repealed, or alternatively, modified to:
	  • Include a definition of "small employer" to be a group size of up to 100.
	  • Include initial conversion costs associated with ICD-10, fraud prevention program costs and costs associated with all-payer claims databases within the definition of "quality" for the purposes of the MLR calculation.
	  • Adopt a simplified rebate distribution approach and a "safe harbor" provision to assure timely rebates to employees, reduce the administrative burden on employers and relieve the unfair liability risk placed on insurers.
	• Grant waivers of MLR requirements for the individual market to prevent market destabilization, and extend MLR waivers to the small group market.

Adopt Meaningful and Objective Rate Review Standards to Promote Stable and Sustainable Markets	• As State Departments of Insurance (DOIs) best understand local market conditions, allow DOIs to determine whether premium increases are appropriate based on state law. • Since health care costs are derived from factors such as utilization, networking requirements, and the use of new and emerging technologies, rates must reflect these costs and be based on consistent, objective, actuarially-based standards. Use of external, backward-looking benchmarks or thresholds that are tied to regional or national trends do not reflect the underlying drivers of health care costs. • Expand the transparency objectives of federal and state Rate Review rules to require all health care stakeholders to provide rationale to the appropriate agencies for the base rates and rate increases they charge.
Promote Consumer-Directed Health Care Options	Support health care cost transparency and management by: • Allowing consumers and employers to use account dollars to pay for insurance premiums on a tax preferred basis, and allowing individuals to rollover up to $500 of the funds in their flexible spending accounts (FSAs) from one year to the next. • Permitting Health Savings Accounts (HSAs) to cover the use of prescription drugs as preventive care without being subject to HSA plan deductibles. • Expanding medical expenses that qualify for payment under an HSA to include verifiable wellness activities. • Allowing self-employed business owners to receive coverage under an HRA arrangement that they currently provide to their employees, and allowing this coverage to count as creditable coverage. • Repealing the restrictions on health care spending accounts, such as the prohibition against reimbursement for over-the-counter drugs.
Establish Medical Malpractice 'Safe Harbors' for Physicians who Practice in Accordance with Evidence-Based Standards	• Modify malpractice laws appropriately to reflect that physicians who practice within evidence-based guidelines will not be at risk of losing their license, can continue to secure malpractice insurance and are not at risk of significant financial loss. Adopting safe harbor laws and "apology harbor" laws would improve the quality of care and reduce the practice of defensive medicine, which would help lower overall health care costs.

Modernize the Health Ecosystem through Intelligent, Connected and Aligned Technology

Information technology is a core element of a modernized health care system. It bridges long-standing communications and information-sharing barriers, and creates powerful linkages among all participants in the health care continuum. By adopting coordinated, interoperable technology, providers, payers and patients are empowered to obtain and use data to make accurate and efficient decisions, making the health care system work better.

Objective	UnitedHealth Group's Solutions
Prevent, Detect and Recover Improper and Fraudulent Payments through Data and Technology-Driven Program Integrity Initiatives	• Expand access to meaningful data across the health care continuum (federal, state and commercial) to foster robust business intelligence and data mining in order to proactively detect and prevent fraud and abuse. • Expand the Medicare and Medicaid Recovery Audit Contractor (RAC) program to include services beyond recovery efforts, including credit balance, subrogation and prospective identification of fraudulent payments, in order to help contain Medicare and Medicaid program costs. • Consider terminating the current Medicaid Integrity Contractor Program as it is inefficient and duplicative of other program integrity efforts, and transfer resources to Medicaid RACs.
Incent the Adoption of Telemedicine to Deliver Health Care Services in Rural and Other Underserved Areas	• Encourage early acceptance and adoption of telemedicine services by allowing patients to receive minor and routine care without a prior in-person encounter with the provider. • Permit interstate licensure and credentialing for telemedicine health professionals. • Continue funding for federal broadband but implement program reforms to fund for-profit entities (e.g., many physician offices) and innovation pilots, and prioritize interoperability with the Rural Health Care Support program.
Leverage Interoperable Information Technology through the Meaningful Use Program to Improve Quality and Lower Costs	• Establish provider interoperability by requiring participation in a Health Information Exchange if the provider receives taxpayer funding for EHR adoption. • Implement predictive modeling analytics to identify beneficiaries with conditions (such as diabetes) that place them at risk of incurring high costs, and implement targeted interventions and care management for these populations. • Use clinical quality measures reported in the program to track providers based on their quality and efficiency, and pay differentiated Medicare rates based on performance. • Adopt legal safe harbors for physicians who adopt technology and experience a problem with their systems.
Reduce Administrative Waste and Improve Interoperability and Connectivity Using System-Wide Data and Transmission Standards	• Add administrative claims transactions and electronic insurance eligibility to the functions required of EHRs in the Medicare and Medicaid Meaningful Use program. • Adopt common quality designation standards and create a single health information database for credentialing. • Eliminate the explanation of benefits for each transaction and replace with monthly personalized health statements, delivered through secure online portals, where possible. • Create a national payment accuracy clearinghouse to settle underpayments and overpayments before improper payments are made. • Promote a single set of data and data transmission standards to facilitate a nationwide exchange of information.