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UnitedHealthcare is pleased to bring you this issue of the Health Care Modernization News Flash to update you on health care issues under discussion in Washington, D.C. and in the states, and to share our perspectives on modernization of the health care system.

Our Perspective

UnitedHealth Group Identifies More Than \$300 Billion in Administrative Savings

On June 30, 2009, the UnitedHealth Group Center for Health Reform & Modernization released its second working paper that identifies ways that technology can save the health care system \$332 billion over the next ten years by modernizing the administrative and transactional aspects of health care. This paper is a companion document to the first working paper released by the Center that identified \$540 billion in medical cost savings for the federal government. The savings identified in this second paper would benefit the entire health care system including physicians, hospitals, health plans, consumers, employers, and the government. Twelve administrative savings proposals are presented in the paper and these proposals are derived from our “real world” experience not only as a large payer and care management organization, but also as one of the largest health care technology companies in the United States. Some of the identified savings proposals include:

- \$109 billion that could be saved by eliminating paper checks and remittance advice in favor of electronic funds transfer and remittance advice.
- \$47 billion that could be saved by using predictive modeling to prescore claims for Coordination of Benefits, upcoding, subrogation, fraud, and medical management prior to payment.
- \$41 billion that could be saved by creating a national payment accuracy clearinghouse to settle under-payments and over-payments.

Our experience suggests that the full potential of technology has not yet been realized and that a shared and consistent approach is needed across all payers in partnership with physicians and hospitals to unleash the savings identified in this working paper.

To learn more about the Center and to view this report visit:
www.unitedhealthgroup.com/reform.

National Spotlight

House Committees Release Draft Tri-Committee Health Reform Bill

As we head into July, the federal debate has become more defined as four of the five Congressional committees with jurisdiction over health reform have released draft health reform bills. On June 19th, the Education and Labor, Energy and Commerce, and Ways and Means Committees in the House of Representatives released a joint tri-committee draft health reform bill. Earlier in June, the Senate Health, Education, Labor, and Pensions (HELP) Committee released its health reform bill. The final committee with jurisdiction over health reform, the Senate Finance Committee, is expected to release its health reform bill soon after the 4th of July Congressional recess. House and Senate leadership hope to pass legislation in their respective chambers before August and get a final compromise bill to the President in October. Key components of the recently released House tri-committee bill include:

- **National Health Insurance Exchange:** By 2013, a National Health Insurance Exchange is to be established to replace the current individual health insurance market and provide an option for employers and public program enrollees in Medicaid and the Children's Health Insurance Program (CHIP). States would be allowed to apply to the federal government to establish state or regional exchanges. The Exchange is to establish health plan standards, facilitate the provision of comparative information, enrollment, billing, and other administrative functions, administer coverage subsidies, and respond to consumer grievances.
- **Public Plan:** No later than 2013, the Department of Health and Human Services is to develop and offer a Public Plan through the Exchange to compete with private insurers. The Public Plan is to comply with the same requirements as other private health plans participating in the Exchange, but provider payments from the Public Plan are to be similar to Medicare rates and providers participating in Medicare would be required to participate in the Public Plan for five years. The federal government would provide start up funding for the Public Plan, but it must become self-sustaining after initial start up.
- **Insurance Market Reform:** The legislation requires changes to the individual and group markets that prohibit pre-existing condition exclusions, prohibit premium rating based on health status, gender, or occupation and limit rating by age, require guarantee issue and renewal of coverage, require a medical loss ratio of 85 percent, prohibit annual or lifetime benefit limits and limit annual cost sharing, establish a Benefits Advisory Committee to recommend a minimum benefit package and three additional standard benefit plans, and establish a risk spreading mechanism to minimize unequal risk selection in health plans.
- **Coverage Mandates:** By 2013, all individuals would be required to have health insurance coverage. Those not complying with the mandate are to be assessed a tax up to the cost of the minimum benefit plan. Exceptions to the mandate are granted for religious objection and financial hardship. Employers would be required to provide 72.5 percent for single coverage and 65 percent for family coverage of the lowest cost minimum

benefit set plan or pay an eight percent tax on wages. Certain small businesses with payroll below a set level would be exempt.

- **Coverage Subsidies:** Sliding scale subsidies varying by income would be available through the Exchange for individuals and families with incomes below 400 percent of the federal poverty level (\$88,000 for a family of four) so that premiums would not exceed 10 percent of income. Sliding scale subsidies varying by employee income and employer size worth up to 50 percent of premium would be available to employers with less than 25 employees whose average wage is below \$40,000.
- **Medicaid Reform:** The legislation expands Medicaid eligibility for all individuals to 133 percent of the federal poverty level (\$14,000 for an individual) and requires an 85 percent medical loss ratio for Medicaid managed care organizations. It also establishes new preventive services benefits, increases payments for primary care, and implements a medical home pilot project to reduce costs and improve outcomes through use of preventive services and care coordination.
- **Medicare Reform:** The legislation restructures provider payment rates and requires the Department of Health and Human Services to develop new payment methods to promote coordinated care and reward quality and efficiency in areas such as hospital readmissions, post-acute care, imaging, and primary care. The bill reduces payment rates and establishes an 85 percent medical loss ratio for Medicare Advantage plans. The legislation also eliminates the coverage gap (donut hole) in Part D by 2023 and reauthorizes Special Needs Plans (SNPs) that integrate care for beneficiaries with coverage through Medicaid and Medicare.
- **Other Health System Reforms:** The legislation also makes investments in the health care workforce to improve access to primary care, makes investments in prevention and public health programs, establishes national centers for quality improvement and comparative effectiveness research, establishes mechanisms to simplify administrative functions, and enhances efforts to reduce fraud, waste, and abuse.

White House and Senator Baucus Reach Agreement with Pharmaceutical Industry to Reduce Prescription Drug Costs for Medicare Part D

The White House and Senator Baucus of Montana, chairman of the Senate Finance Committee, have reached an agreement with the Pharmaceutical Research and Manufacturers of America (PhRMA) to reduce Medicare prescription drug costs for seniors. The agreement has also been endorsed by the AARP. The agreement includes \$80 billion from the pharmaceutical industry to reduce the coverage gap or "doughnut hole" in the Part D program by providing a 50 percent discount to beneficiaries on prescription drugs purchased in the coverage gap. It is anticipated that Senator Baucus will include provisions of this agreement in health reform legislation expected to be released by the Senate Finance Committee after the 4th of July Congressional recess.

State Spotlight

Connecticut Governor Weighing Two Health Reform Bills Passed by the Legislature

Connecticut Governor Jodi Rell is currently considering whether to sign or veto two health reform bills passed by the Legislature. The Connecticut Healthcare Partnership bill (HB 6582) allows non-state public employers, municipal employers, non-profit employers, and small employers to buy into the state employee benefit plan beginning in 2010. The Sustinet Plan bill (HB 6600) establishes the Sustinet Health Partnership Board of Directors which is to make recommendations by 2011 on the creation of a public self-insured health plan that would provide residents with access to timely, affordable, high-quality care. The Board is to make recommendations regarding: 1) contracts with insurers or other entities for administrative purposes, 2) the solicitation of bids from health care providers, 3) the establishment of deductibles, standard benefit packages and cost-sharing levels for different providers, 4) the implementation of an individual mandate paired with guaranteed issue, 5) the elimination of preexisting condition exclusions, 6) the implementation of auto-enrollment in the plan, 7) the use of reinsurance or stop-loss coverage, 8) the feasibility of funding premium subsidies for individuals with incomes between 300 and 400 percent of the federal poverty level, and 9) the establishment of a clearinghouse to provide information about Sustinet and private health care plans.

Massachusetts Connector Board Cuts Commonwealth Care Funding by 12 Percent

On June 24th, the Massachusetts Connector Board voted to cut \$115 million, or 12 percent, from the Commonwealth Care program which is the subsidized insurance plan for low-income residents enacted under the 2006 Massachusetts health reform law. The cuts are being made to address the state budget deficit and the increasing cost of rising enrollment by the newly unemployed in the Commonwealth Care program. To arrive at the \$115 million in savings, low income residents who qualify for subsidies will no longer be automatically enrolled in the program which is estimated to reduce enrollment by 18,000, dental coverage will be eliminated for 92,000 enrollees, and payments to managed care plans will be delayed. These changes go into effect on July 1, 2009.

Virginia Governor Introduces Virginia Health Exchange Network

Virginia Governor Tim Kaine has announced the creation of the Virginia Health Exchange Network (VHEN) which is a web portal to connect health plans, providers, and state agencies to standardize and simplify health care administrative processes. Private health plans and public payers are to provide information to the VHEN to allow providers to access eligibility and benefit information for health plan members on a real-time basis. The VHEN is also structured to expand into other service areas in the future such as health records and financial management.