Health Care Modernization News Flash

UnitedHealthcare
Healing health care. Together.

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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 and Cisco Launch First National Telehealth Network to Expand Access, Improve Efficiency, and Reduce Costs

UnitedHealth Group has partnered with Cisco to build the first national telehealth network to improve access to physicians and specialists in underserved areas. The new "Connected Care" program combines UnitedHealth Group's national provider network including over 590,000 physicians and care professionals and 4,900 hospitals and Cisco's video conferencing and other collaborative network technologies to provide patients with access to physician, specialist, and hospital services in rural settings, retail locations, workplaces, and in a patient's home. The program will enable real-time connectivity and consultations among doctors, nurses, and health system professionals around the country and will be built on an open network that will integrate multiple vendors' technologies with Electronic Health Records to create a more connected system of health care. Connected Care creates a new health care delivery model that connects people with high quality health care services when distance is an obstacle and reduces health care costs by improving productivity and efficiency in health care delivery.

More details on the Connected Care program can be found at www.ConnectedCareAmerica.com

UnitedHealth Group and the National Hispanic Medical Association Partner to Raise Awareness About the Need to Strengthen the Primary Care Workforce

In an editorial published by the El Nuevo Herald in Miami, Florida, UnitedHealth Group and the National Hispanic Medical Association urge Congress to address the lack of primary care providers in underserved areas. As stated in the editorial, reducing costs, expanding access, and improving care are the objectives that should be pursued by Congress, but there must be a well-trained, compassionate, and diverse primary care workforce to achieve these objectives. There is a need to make primary care a more attractive specialty for doctors and encourage those from underserved communities to pursue a career in primary care medicine. In the early 1970s, the average surgeon earned 30 percent more than a family physician, now they earn twice as much. Since 1997, the number of new medical students choosing primary care as their specialty has declined by 50 percent. To address these issues, Congress

should support new federal loan and training programs through the National Health Service Corps, strengthen K-12 education in underserved communities, support the infrastructure of community health centers as they provide quality care in underserved communities and serve as a training ground for new physicians, and expand funding for the Public Health Service's Health Careers Opportunity Program and Centers of Excellence.

National Spotlight

House Tri-Committee Leaders Revise Joint Health Reform Bill, CBO Estimates Cost at $1 Trillion

On July 14th, the Education and Labor, Energy and Commerce, and Ways and Means Committees in the House of Representatives released a revised joint tri-committee health reform bill titled "America's Affordable Health Choices Act." The three committees are using this bill as a base for consideration in their respective committees. Much of the language in the revised bill is similar to the earlier draft bill, with some notable changes including: 1) termination of the CHIP program in 2013, 2) removal of most people eligible for Medicaid from the Exchange, 3) a requirement that prohibits states from reducing Medicaid eligibility levels, 4) new language on individual market rescissions, 5) new language that requires plans to meet a medical loss ratio test in 2013 based on a federally established definition and calculation methodology, 6) removal of Medigap guarantee issue provisions, and 7) new language eliminating the January to March open enrollment period for Medicare Advantage. The Congressional Budget Office (CBO) has estimated that this version of the bill would cost $1.04 trillion and would reduce the number of people uninsured to 17 million by 2019. To offset the $1.04 trillion cost, the bill raises revenues primarily from a surtax on higher income taxpayers and reduces spending in Medicare by changing provider payment updates in fee-for-service Medicare, reducing payment rates for Medicare Advantage, and changing the manufacturer drug rebate program under Part D for beneficiaries eligible for Medicare and Medicaid. The Education and Labor and Ways and Means Committees have passed the revised bill with amendments. The bill is still under consideration in the Energy and Commerce Committee. Once all three committees have passed the bill, the three amended bills will be merged and brought to the House Floor with the intention of House passage before the end of July.

Senate HELP Committee Passes Health Reform Bill, Finance Committee Delays Bill Introduction

On a 13 to 10 party line vote on July 15th, Senate Democrats on the Health, Education, Labor, and Pensions (HELP) Committee passed their health reform bill, the "Affordable Health Choices Act." Since the first draft of the bill released in early June, changes were made to reduce the cost estimate from the Congressional Budget Office (CBO) by roughly $400 billion. The CBO estimates that the health reform bill that passed the HELP Committee would cost $615 billion over ten years and that 20 million of the 46 million uninsured would gain coverage. The cost of the HELP bill excludes changes to the Medicare and Medicaid programs as only the Finance Committee in the Senate has jurisdiction over these programs. The main drivers of the decrease in the cost estimate for the HELP bill include a reduction in the eligibility for and level of premium

subsidies for individuals and families and the addition of an employer mandate and penalty. Some of the other major changes to the bill include: 1) details for a public or "community" plan in each state Gateway or Exchange to be administered by a non-profit entity with provider rates negotiated by the Department of Health and Human Services, 2) a limitation on group participation in the Gateway or Exchange to employers with less than 50 employees, 3) the ability of states to add benefits to the federal minimum benefit set, and 4) changes to market rules to allow rating for tobacco use and increased premium discounts of 30% to 50% (as opposed to 20% currently under HIPAA) for wellness and healthy behavior. The HELP Committee bill will need to be reconciled with the bill that the Senate Finance Committee passes, which has yet to be introduced, before it is voted on by the full Senate. The Finance Committee has delayed its bill introduction to reconsider a few key issues including a public plan option and whether to tax employer-provided benefits.

State Spotlight

Connecticut: Governor Vetoes Two Health Reform Bills, Legislature Overrides SustiNet Veto

Connecticut Governor Jodi Rell vetoed two bills that would have created a "public plan" for state residents and an option for non-state employers to buy-in to the state employee plan. On July 8th , the Governor vetoed the SustiNet Plan bill (HB 6600) that established the SustiNet Health Partnership Board to make recommendations on the creation of a public, self-insured health plan for all state residents and the Connecticut Healthcare Partnership bill (HB 6582) that would have allowed non-state public employers, municipal employers, non-profit employers, and small employers to buy-in to the state employee benefit plan. On July 20th , the Legislature voted to override the Governor's veto of the SustiNet Plan bill, but failed to overturn the veto of the Healthcare Partnership bill.

Massachusetts: New Health Plan and Payment System Reforms Advanced

Legislative leaders, the health plan association, and business groups have unveiled a legislative proposal that would create a new product called the "Affordable Health Plan" for small employers and individuals to purchase inside and outside of the Connector. The proposal establishes a minimum medical loss ratio (MLR) of 85 percent and limits underwriting surpluses in the small group and individual market. In addition, the proposal caps reimbursement to providers for the "Affordable Health Plan" at no more than 110 percent of Medicare rates and prohibits cost-shifting to other products. Supporters state that this proposal would reduce premiums for small groups by approximately 20 percent. The legislation would sunset upon implementation of recommendations from the state's Payment Reform Commission. Separately, the Commission, created under last year's cost containment legislation, released their final recommendations to reform the provider payment system on July 16th. The recommendations include the phase in of a global payment system over five years that would establish an upfront, single per person provider payment adjusted for health status and other factors related to a person's health care needs and a backend provider payment for meeting quality performance measures. Other key features of the recommendations include an emphasis on the importance of patient-centered medicine with doctors and other providers coordinating

evidence-based, high quality care to help reduce health care costs and a plan to facilitate the payment transition for providers including a phase in of risk sharing under the new payment model and infrastructure to support technical assistance, training, and information technology for providers.

Wisconsin: Governor Signs Budget That Impacts Insurance Market Rules and Public Programs

Governor Jim Doyle has signed a budget bill that changes the rules in the individual health insurance market and expands eligibility for public programs. Effective in 2010, all health plans sold in the individual market will have to use a uniform application. In addition, insurers will be prohibited from “looking back” more than one year to establish a pre-existing condition exclusion. The exclusion period for pre-existing conditions is reduced from two years to one year and the new rules allow an individual to change their coverage policy upon renewal without being subject to new pre-existing condition exclusions or premium rating based on health status. The new individual market rules enacted in the budget bill also require independent third party review of pre-existing condition exclusion denials and coverage rescissions. In response to the state's estimated $6.6 billion state budget deficit, the budget bill also calls for a $625 million reduction in Medicaid funding resulting in significant changes to the state's Medicaid program including reductions in provider reimbursements for specific procedures, modifications to provider reimbursements based on quality outcomes, the introduction of evidence-based health care initiatives, and the reduction of administrative rates for insurers. The state budget also increased the state's hospital assessment to leverage additional federal matching funds to be used for increased reimbursements to hospitals, and in part, to pay for an expansion of the state's Medical Assistance programs for childless adults with family incomes at or below 200 percent of the federal poverty level.