PHS Migration Recommendation

August, 2006

PHS Program Recommendation

UnitedHealth Group

If adopted, the following recommendation will reduce the costs of the PHS Migration program by ~$13 million ($8M FOI, $5-6M Product) and supports the key objectives of the migration:

1. Membership Preservation
2. Speed to Market
3. Cost-Effective

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PHS Migration

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Front Office Integration

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Objective

•Provide integrated customer and broker experience including consolidated billing and eligibility while maintaining claim administration on separate platforms.

Key Assumption	Challenge
Reduces timeline to offer consolidated customer experience for dual option/ platform (quick hit)	•PPO and HMO product expected to be delivered in same timeframe, diminishing ROI •Significant work effort to implement (new functionality)- est costs ~$8M •System queue constraints •Same SME resources required for FOI, product and migration work
Reusability for future acquisitions	•Requires development for each acquisition •Limited Reusability: est. 10-35% depending upon approach
Allows significant operational savings	•Without FOI Uniprise will achieve $70M of $76M of savings outside of FOI •Next major savings opportunity achieved through UP enablement/ full migration •Operational complexity and increased labor costs for reconciliation and quality control between data within legacy PHS and UHC systems

Recommendation

•Close program until a reusable solution can be developed

•Reusability of functionality is limited (~35% max) as it would require front-end mapping for each new platform and impacts the entire suite of eligibility (CES, CDB) and eBill applications

- eBill= (eBill MMR – master member repository, eBill ICE – Invoice calculation engine, Peoplesoft Invoice, Peoplesoft Accounts Receivable, eBill datamart, and eBill EBPP – electronic payment & presentment)

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HMO Product Strategy

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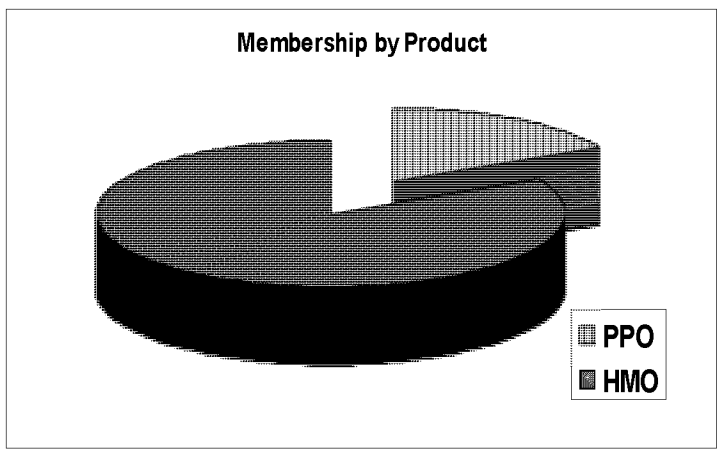
Recommendation

–Build PHS HMO Products on UP (including license/ legal entity, benefits, gatekeeper & capitation capabilities)

- –Utilize UP Team expertise to drive business requirements
- –Leverage Core Gated HMO capabilities built/ scheduled for MAHP, HP & Medica
- –Identify synergies with Medica HMO deliverable in Q2 2007

Rationale

- Lead Product in 7 of 8 states
- Brand recognition
- Market Differentiator
- No Comparable UHC Product



- 83% of total legacy PacifiCare membership is in HMO (1,656,349)

- **Pacific Region: 85% (1,411,075)**
  - CA: 79% (1,315,000)
  - NV: 3% (47,775)
  - OR: 1% (23,400)
  - WA: 2% (24,900)
- **SW Region:15% (235,274)**
  - AZ: 5% (77,368)
  - CO: 7% (116,906)
  - OK: 2% (36,200)
  - TX: 1% (24,800)

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Membership By Product- PPO

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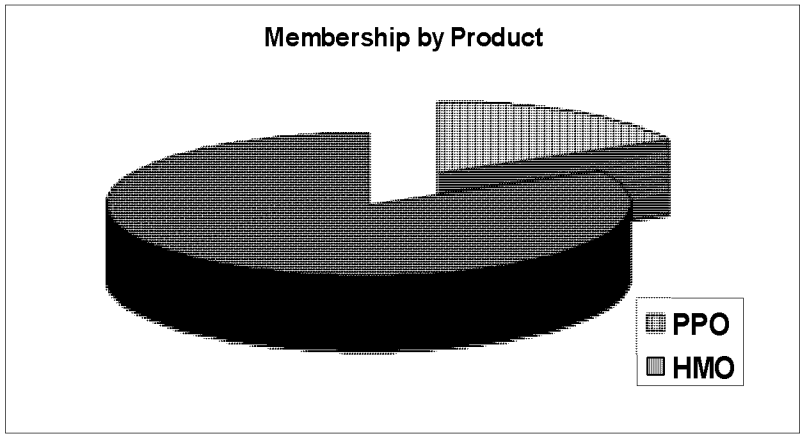
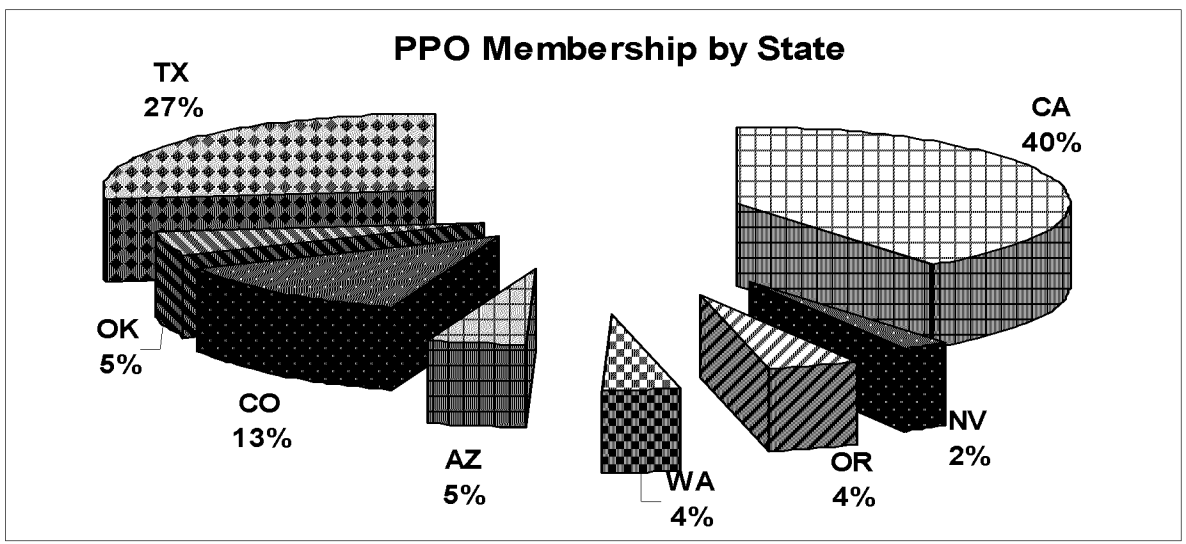
- 17% of total legacy PacifiCare membership is in PPO (346,690)

- **Pacific Region: 50% (175,283)**
  - CA: 40% (138,826)
  - NV: 2% (7,258)
  - OR: 4% (15,507)
  - WA: 4% (13,692)

- **SW Region: 50% (171,407)**
  - AZ: 5% (16,736)
  - CO: 13% (44,330)
  - OK: 5% (17,042)
  - TX: 27% (93,299)





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Insurance Product Comparison & UP Build

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- **Minimal differences between UHC & PHS PPO's do not warrant system build**
  - UT Pre-OOM estimate for replication of PHS insurance products on UP is ~$5-6 million
  - Pricing & Actuarial has stated that medical costs differences resulting from COCs are negligible
- Below are examples of the key product differences requiring system development:

Feature	Key Functionality/ Benefit Difference	Impact (Move to UHC)
Deductible	PHS utilizes terminology "additional deductibles" instead of "copayments"	**Member Impact Neutral-** communication of terminology difference required. If terminology remains different, could cause member, provider & employer confusion. **No pricing impact.**
Member Liability Order of Processing	When UHC applies copay, no deductible is applied. PHS applies copay after deductible.	**Member Impact Positive-** UHC plan allows utilization of copay upon first visit. PHS requires deductible to be met first (increased member OOP). **Impact on pricing (UHC > ~10% for applicable services)-** Member liability increased on copay plans.
Member Liability (Benefit Limits & Duration)	PHS supports additional flexibility in application of service limits (e.g. combinations of dollar vs limit maxs) and durations (e.g. per day, per month, per policy period, etc)	**Member Impact Neutral-** Impact varies based upon combination of max & duration.
Notification Requirements	PHS has expanded notification requirements (applied at procedure code level)	**Member Impact Positive-** Reduced notification requirements. Aligns with current UHC PPO Care Management strategy.
OON Reimbursement	PHS allows 3 variations (fee schedules) for OON reimbursement. UGC utilizes one (MNRP).	**Member Impact is Negative** Higher member costs for OON services. MNRP reduces medical costs and simplifies administration of OON reimbursement.
Penalty Reduction	PHS administers different penalty amounts (deductibles) in versus out of network. UHC applies a single penalty (reduction in coinsurance %) for both in and out of network.	**Negative impact to member.** Member liability would be higher than PHS for most services requiring notification.
Outpatient Surgery	PHS applies per day dollar limit for OON services that varies between IN & OON. UNET cannot administer per day max.	**Neutral-** If member has multiple procedures in same day, may exceed max. Likelihood of this being issue very low.

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Insurance Product Comparison & UP Build

UnitedHealth Group

- **Minimal differences between UHC & PHS PPO's do not warrant separate product designs**
  - Pricing & Actuarial has stated that medical costs differences resulting from COCs are negligible
- Below are examples of the key product differences NOT requiring system development:

Feature	Key Functionality/ Benefit Difference	Impact (Move to UHC)
Pre-existing Conditions	UHC does not standardly apply pre-existing. PHS applies pre-existing.	**Positive- Analysis of PHS CBA on this decision is forthcoming.**
Outpatient Diagnostics	UHC covers at 100%, no deductible, PHS applies deductible and coins.	**Positive for member, UW impact is negligible.**
Rehab Services	UHC uses visit limits, PHS utilizes a annual dollar max across all therapies.	**Positive for member, UW impact is negligible.**
Emergency Health Services	UHC does not apply deductible to these services, PHS applies deductible.	**Positive for member, UW impact is negligible.**
Home Health Care	UHC has fewer visit limits (60) than PHS (100)	**Negative for member (less benefits), UW impact is negligible.**

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PPO Product Strategy- Pacific

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Recommendation

- Replicate (Re-file) UHIC Product Portfolio on PLIC license
  - Fast-track re-filing process
    - Leverage relationships with current regulatory contacts
    - Good faith approach to bring UHC value prop to PHS members
- Migrate (w/ Uniform Notification of Change) to UHC-like product on PLIC license upon renewal

Legal/ Regulatory Environment:

- Undertakings in place to ensure revenue/ taxes stays within CA
  - PLIC domiciled in CA, UHIC in MN
- UHC must show good faith in adhering to undertakings
- Elimination of PLIC license (withdrawal) not likely approved by regulators due to revenue/ tax implications
- Moving PHS membership to UHC license would risk exposure of UHIC license to PLIC undertakings

Rationale

- UHC National Network would support new PLIC products
- Avoid regulatory/political issues & negative public perception
- Minimal differences between current UHC & PHS PPO
  - Most changes have positive/ neutral impact to members

- Eliminate costs for UT development (est $5-6M)
- Avoid system queue & resource contention (HMO vs PPO build)
- Products already filed & approved on UHIC license in overlap states

Risks

- Inability to communicate definitive migration timeline until product filing approved
- Delays in re-filing will impact migration schedule

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PPO Product Strategy- SW

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Recommendation

- Replicate (Re-file) UHIC Product Portfolio on PLIC license
- Migrate (w/ Uniform Notification of Change) to UHC-like product on PLIC license upon renewal

SW Pricing Issue

- Current pricing differences in SW :
  - Different Risk Pools- PHS' book of business has better age/sex ratio resulting in lower experience and ability to price at lower end of rate bands
    - Utilization of UHC license will require solution to be developed to maintain separate risk pools in the short term
    - TX, CO, OK have "affiliated company" laws that will not allow PHS & UHC to maintain separate pools long term
  - UW & actuarial methodologies
    - PHS utilizes a lower base rate for the initial/illustrative rate and often rates up
      - 80% time, sold rate > illustrative rate
      - Average 22% rate-up
    - UHC's initial/illustrative rate is typically the same as the sold rate
      - 80% sold rate = illustrative rate

Benefits

- Allows separate risks pools to be maintained for maximum period of time
- Products already filed & approved on UHIC license in overlap states
- UHC National Network would support new PLIC products
- Minimal differences between current UHC & PHS PPO

•Eliminate costs for UT development (est $5-6M)
•Avoid system queue & resource contention (HMO vs PPO)
•Solve short term pricing issue in SW Region

Risks

- Inability to communicate definitive migration timeline until product filing approved
- Delays in re-filing will impact migration schedule

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Product Strategy- Insurance (non PPO)

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- Indemnity (700 members)
  - Product withdrawal- offer comparable UHC IND product
- HDHP (6500 members)
  - Product withdrawal- offer comparable UHC HDHP product
  - Integrated member experience with UHC H.S.A (via Exante)
- OR EPO (3000 members)
  - Product withdrawal- offer comparable UHC EPO product
- SDHP (~80,000 members)
  - No comparable UHC product
  - Revisiting product strategy with Definity Product Group
  - Options are:
    - Product withdrawal
    - Leave as is on RIMS/ ASI
    - Determine if viable product for all SB
      - > Add to UHC portfolio at cost of ~$3-5M

STATE	INS	HMO	TOTAL	% INS	% Total
AZ	**16,736**	77,368	94,104	**17.8%**	4.7%
CA	**138,826**	1,315,000	1,453,826	**9.5%**	72.6%
CO	**44,330**	116,906	161,236	**27.5%**	8.0%
NV	**7,258**	47,775	55,033	**13.2%**	2.7%
OK	**17,042**	26,200	43,242	**39.4%**	2.2%
OR	**15,507**	23,400	38,907	**39.9%**	1.9%
TX	**93,299**	24,800	118,099	**79%**	5.9%
WA	**13,692**	24,900	38,592	**35.5%**	1.9%
TOTAL	**346,690**	**1,656,349**	**2,003,039**	**17.3%**	**100.0%**

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Resources

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- Current resources do not have appropriate skill sets/ knowledge
- Core Leads/ SMEs required to drive program not focused on PHS
  - Jill Lammer- Product Lead
  - Sheila Nelson- UW Lead
  - Frank Romano- Strategy & Execution
  - Dawn Willis- Strategy & Execution
- Additional BA resources required to complete gap analysis and drive business requirements
- Program requires dedicated PMs and BAs from each business area (including PHS)

Area	Resource Type/ Responsibilities	Addl FTE
Program Lead PMO	Responsible for overall project plan, status reporting	2
Migration	Responsible for migration scheduling and tracking, ad hoc reporting	1
Market Deployment Mangers	Manage customer migrations by LOB (SB, KA-PRIME, KA-ACIS, Public/USS, Feds).	4
Business Analysts	Write BRDs, participate in design, perform UAT	
	Product	5
	UPCT	5
	Vendor Interfaces	3
	Miscellaneous (fill gaps)	8
Test Director	Coordinate enterprise testing	1
	Total	29

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