TMG Health

Putting it all Together

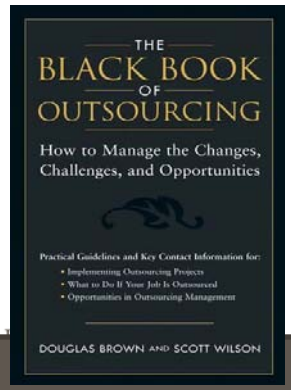
The *Leader* in Business Process Outsourcing Services for Medicare / Medicaid Health Plans

"Risks, Rewards, Adventure: The Health Plan of Tomorrow", by Stephen Wood, Ingenix Consulting

Experience

- **Most Experienced Business Process Outsourcing Vendor Serving MA, Part D and Medicaid plans for over 10 years**
- **Client Experience – Support over 30 clients serving 2.8M members in all 50 states**
  - **Local, Regional, Blues and Large National Plans**
  - **Implemented over 200 Employer Groups w/ 325,000+ members**
- **Proven/Tested Technology and Systems**
- **Dedicated Client-Centric Teams Using Medicare**
- **Focused Tools and Workflows**

Ranked #1 BPO for Medicare/Medicaid Management Services Organizations



TMG Health Background

- Management: Health Plan Background
- Founded to Serve Managed Medicare Plans
- 1,200 + Employees
- Service Centers in Scranton and Dunmore, PA.
  - All Service Teams are US-based
  - Third Center in Amarillo, TX
- Corporate Headquarters, King of Prussia, PA

Gartner survey of 60 health insurer executives revealed approximately 40% expressed intent to invest in BPO services

TMG Scope of Services

- Medicare Configured Managed Care Information System and TMG Proprietary Applications
- Enrollment & Disenrollment Processing
- Eligibility Maintenance (System of Record)
- CMS Eligibility Reconciliation and Tracking
- Premium Billing and Cash Receipts Posting
- Claims Processing/Payment & RAPS Submission
- Member & Provider Call Services
- Surveys (HRA, MSP)
- Printing and Fulfillment Services
- MM, A&G Systems

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TMG Health: Response to Reform

September 2010

Seeing the big picture to solve the biggest problems in health care.

see more. solve more.

Strategy Planning Framework

1. Is there an opportunity to participate in the new Health Benefit Exchanges?
2. Will funding for expanded Medicaid enrollment be sufficient?
   - What will likely change in Medicaid?
3. Will cuts to the MA payments undermine the viability of that program?
   - Are payment for quality bonuses enough to offset reductions?
4. What else in the post reform environment pose opportunities or risks?
5. What steps need to be taken NOW?

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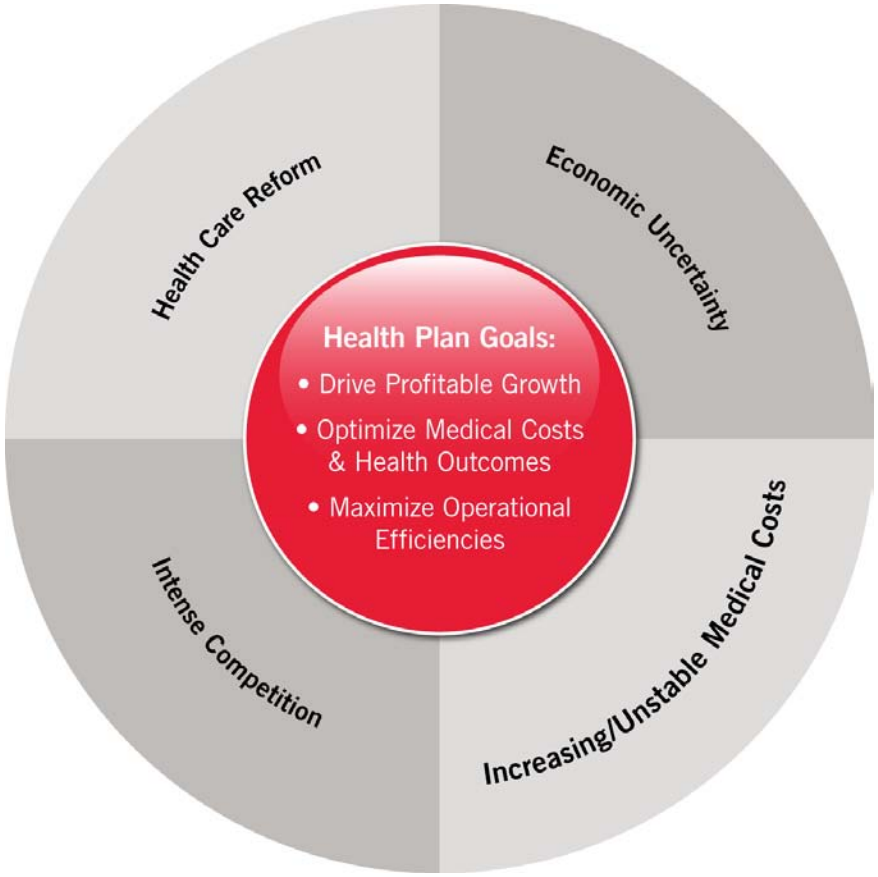
Forces and Trends of the Current Market



- Shifting and growing small group and individual markets
- Increasing Medicaid enrollment
- Reduction in MA funding
- Increasing regulation of MA products
- Future potential eroding enrollment levels in MA
- Payment for Quality/Stars
- Market pressures from hospitals and physicians
- Minimum MLR requirements underscore need for greater efficiency and outcomes

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New Marketplace Portfolio Planning

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Investigate

Investigate	Innovate	Implement	Improve
Document Current Market Place Offerings	Identify Strategic Alternatives	Operational Requirements Planning	Align Financial, Outcome and Operating Metrics
Assess the Impact of Market Place Forces	Narrow Focus Based on Organizational Competencies	Development and Implementation	Assign Management Accountability and Review Process
Build Base Case Scenario	Build Strategic Scenarios	Readiness Review and Go-Live	Implement and Track Program Effectiveness
4-6 Weeks	4 Weeks	Planning 3 Weeks Implementation 9-12 Months	Planning 3 Weeks Implementation = Ongoing

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Document Current Market Place Offerings

		Current Offering 1	Current Offering 2	Current Offering 3
Product	Consumer			
	Customer			
	Value Creation			
Distribution				
Geography				
Market Size				
Historical Growth				
Financial Contribution				
Competitive Fitness				
Key Competencies				
Management				

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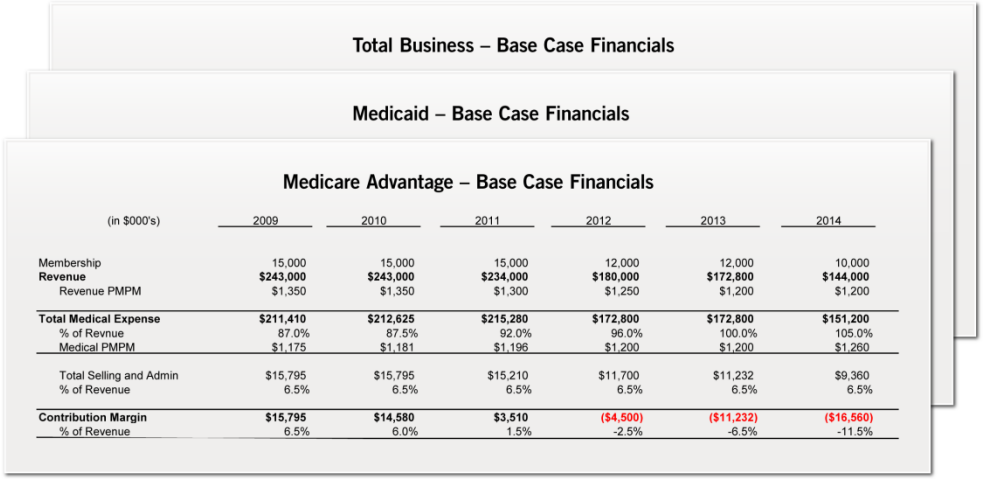
Build Base Case Scenario

Key Output

- Narrative of marketplace forces and the likely impact to the specific markets being served today
- Financial projection for each of the current product offerings based on local impact of health care reform
- Consolidated financial projections
- Outline of key financial assumptions and sensitivities



Total Business – Base Case Financials

Medicaid – Base Case Financials

Medicare Advantage – Base Case Financials

(in $000's)	2009	2010	2011	2012	2013	2014
Membership	15,000	15,000	15,000	12,000	12,000	10,000
Revenue	**$243,000**	**$243,000**	**$234,000**	**$180,000**	**$172,800**	**$144,000**
Revenue PMPM	$1,350	$1,350	$1,300	$1,250	$1,200	$1,200
Total Medical Expense	**$211,410**	**$212,625**	**$215,280**	**$172,800**	**$172,800**	**$151,200**
% of Revnue	87.0%	87.5%	92.0%	96.0%	100.0%	105.0%
Medical PMPM	$1,175	$1,181	$1,196	$1,200	$1,200	$1,260
Total Selling and Admin	$15,795	$15,795	$15,210	$11,700	$11,232	$9,360
% of Revenue	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
Contribution Margin	**$15,795**	**$14,580**	**$3,510**	**($4,500)**	**($11,232)**	**($16,560)**
% of Revenue	6.5%	6.0%	1.5%	-2.5%	-6.5%	-11.5%

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Innovate

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Sample Market Impacts Analysis: Los Angeles County

Implications and Analysis of Eligibility Changes and Insured Population Shifts

- Base case – micro simulation model at the national level
  - > Expected change for those currently with employer coverage:
    - 12% receive insurance through the exchange
    - 2% receive insurance through Medicaid
    - 1% become uninsured (possibly at lower than current reimbursement levels)
  - > Expected change for those currently uninsured:
    - Almost 10 million will get individual coverage through the exchange
    - 10 million will get individual coverage through their employers
    - 11 million will get individual coverage through Medicaid expansion (increasing demand for services, expected low level of reimbursement)
- Variable assumption modeling analyses
  - > Input assumptions
    - Employer decisions
    - Individual decisions
  - > Medical cost characteristics
  - > Premiums
  - > Large group versus small group
  - > Income level individuals

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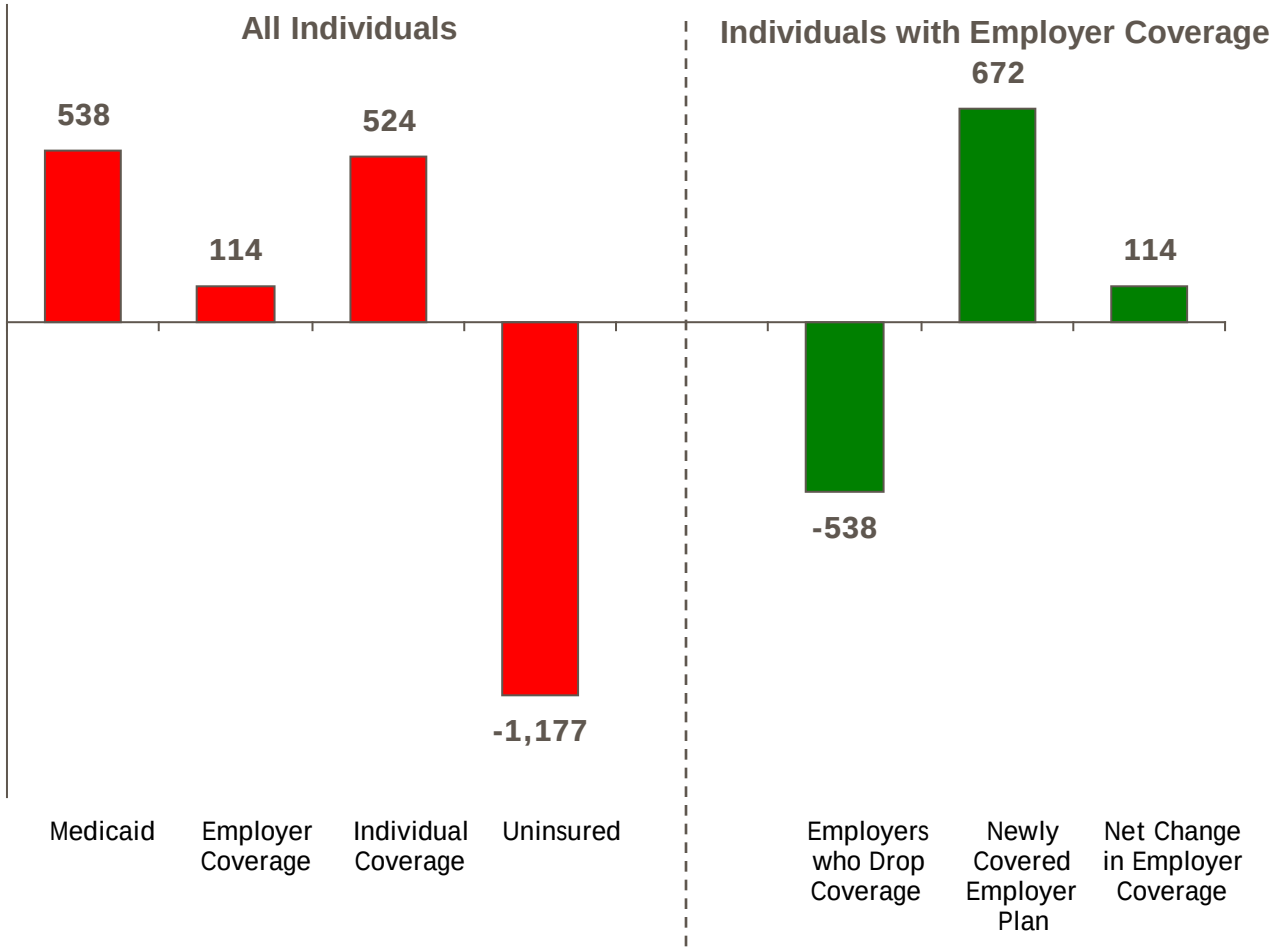
Changes in Sources of Coverage under the Act in Los Angeles County Assuming Full Implementation in 2011 (thousands)



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Change in Sources of Coverage Nationally
Los Angeles County California (thousands)

Coverage Under Current Law		Coverage Through Exchange			Private coverage			Medicare, TRICARE and other	Medicaid	CHIP	Uninsured
		Employer	Individual with Subsidy	Individual No Subsidy	Employer	Individual	Retiree				
Employer Workers & Dependents	4,357	206	249	117	3,593	0	0	0	159	2	30
Non Group	647	18	161	42	107	260	0	0	43	1	15
Employer Retiree	100	0	0	0	0	0	100	0	0	0	0
TRICARE	92	0	0	0	0	0	0	92	0	0	0
Medicare	765	0	0	0	0	0	0	765	0	0	0
Medicare & Dual Eligible	256	0	0	0	0	0	0	256	0	0	0
Medicaid	1,575	32	1	0	60	0	0	0	1,482	0	0
CHIP	267	6	0	0	11	0	0	0	0	250	0
Uninsured	2,182	101	270	71	336	0	0	0	431	13	959
Total	**10,240**	**364**	**681**	**230**	**4,107**	**260**	**100**	**1,112**	**2,114**	**266**	**1,005**

(2014 Outcomes using 2011 Population – as if Fully Implemented)

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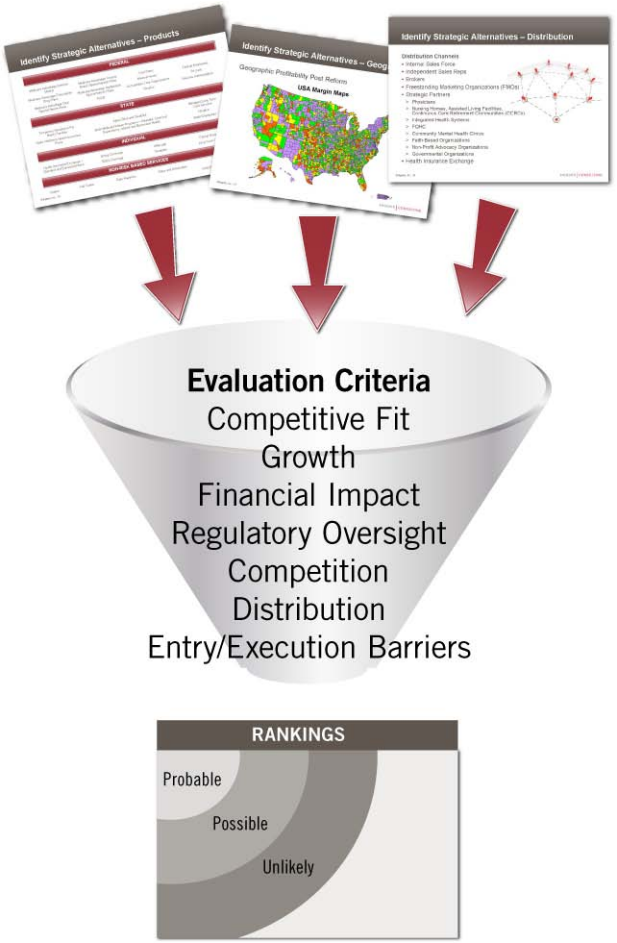
Stack Ranking of Portfolio Alternatives



Probable

- Develop Detailed Business Plans
- Competitive and Market Place Analysis
- Sales and Marketing; Member Outreach
- Provider and Medical Management
- Operations – Claims, Call, Transaction Processing
- Technology Requirements

Possible

- Identify required information to move to Probable or Unlikely
- Establish Timeline for analysis

Unlikely

- Document Rationale for not Pursuing
- Establish Criteria to Reevaluate

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Build Strategic Alternatives

Key outputs

Operational gap assessment

Competitive analysis

Financial modeling

Scenario planning

Key success factors

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Implement

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Implement and Track Program Effectiveness

- Align financial, outcome and operating metrics
- Leverage business intelligence tools to develop focused reports
- Define management accountability and review process
- Implement and track program effectiveness

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Improve

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PPACA:

1.0 Health Benefit Exchanges
2.0 Medicaid
3.0 Medicare
4.0 Additional Considerations

Health Benefit Exchanges

- Health Benefit Exchanges
  - > State agency or not-for-profit entity
  - > Vehicle providing access to qualified health plans to individuals and small businesses
  - > Certifies, recertifies and decertifies qualified health plans
- Responsibilities include but not limited to:
  - > Eligibility determination and enrollment
  - > Plan ratings based on relative quality and price
  - > Administration of individual subsidies
  - > Administration of quality based performance standards
- Regulatory standards will address such things as:
  - Marketing practices and benefit design
  - Quality improvement and performance standards
  - External accreditation
- Qualified Health Plan
  - > Certified as meeting specific criteria
  - > Provides essential health benefits
  - > Offered by an insurer licensed and in good standing

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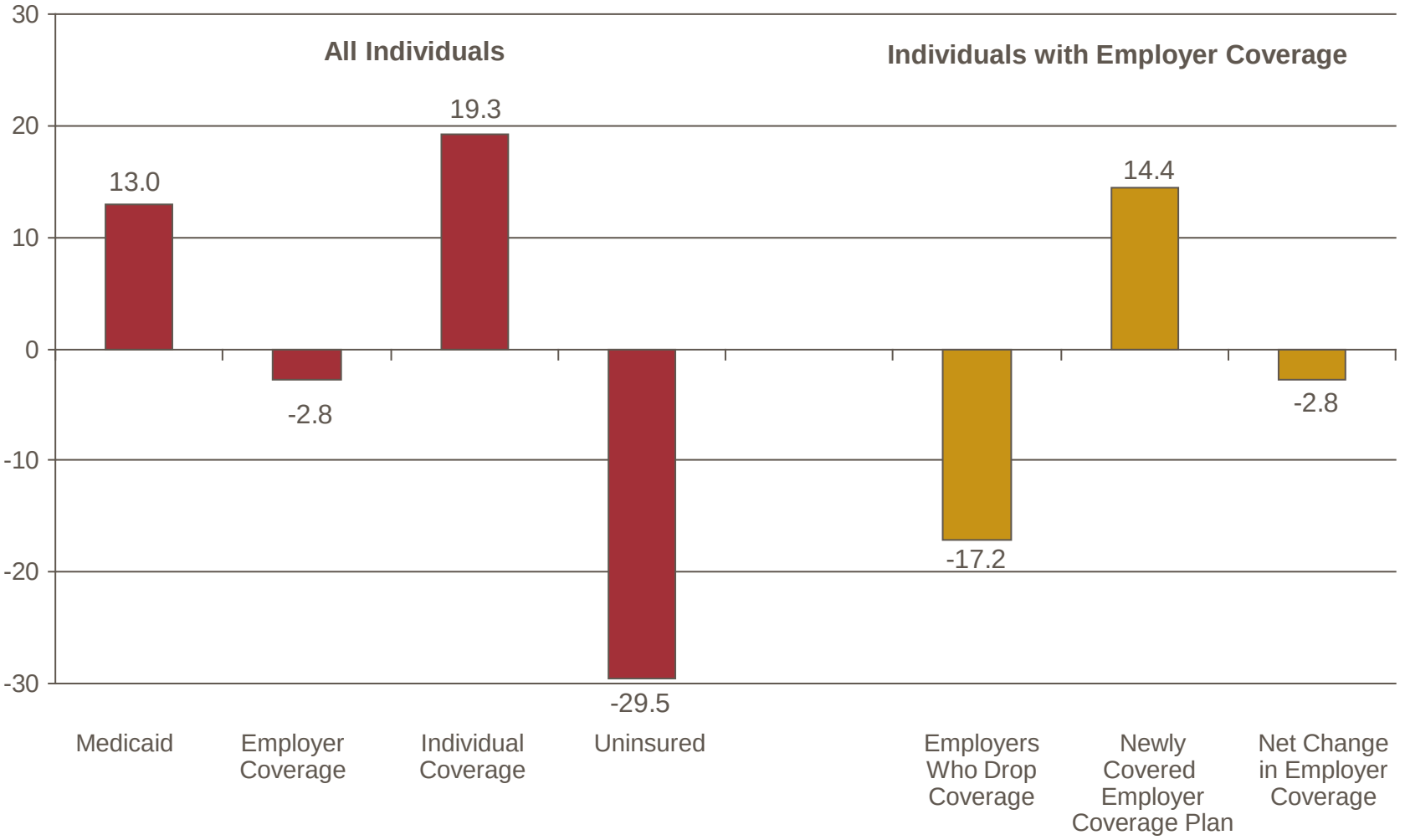
Changes in Sources of Coverage under the Act Assuming Full Implementation in 2011 (millions)



* Estimates available at market value

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Change in Sources of Coverage under the PPACA Assuming Full Implementation in 2011 (millions)

Current Source of Coverage		Private Coverage Through Exchange			Private Coverage out of Exchange		Medicaid & CHIP (excl duals)	Medicare, TRICARE & Other	Uninsured
		Employer	Individual		Employer	Individual			
			With Subsidy	Without Subsidy					
Employer Workers and Dependents	**154.4**	6.8	8.6	3.9	130.5	0	3.7	0	1.0
Non-Group	**14.3**	0.4	3.5	0.6	2.1	6.7	0.7	0	0.2
Employer Retiree	**3.7**	0	0	0	3.7	0	0	0	0
TRICARE	**6.1**	0	0	0	0	0	0	6.1	0
Medicare	**33.2**	0	0	0	0	0	0	33.2	0
Medicare Dual Eligible	**6.8**	0	0	0	0	0	0	6.8	0
Medicaid/CHIP	**41.7**	0.6	0.4	0.1	1.4	0	39.2	0	0
Uninsured	**49.2**	2.4	7.6	2.2	7.6	0	11.0	0	18.5
Total	**309.5**	**10.1**	**20.1**	**6.8**	**145.3**	**6.7**	**54.9**	**46.2**	**19.7**

Can Estimate for Plan Market

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The Competition: Who will Participate?

- Types of insurers/plans
  - > Multi-line insurance carriers
    - BCBS, United, HealthNet
  - > Medicare and/or Medicaid plans
    - Molina, Kaiser, Centene,
  - > Pure-play exchange plans ?
- Commercially licensed individual market insurers
  - > Healthmarkets, Golden Rule, Countryside
  - > Existing or newly licensed
- New Entrants

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Short Term Priorities: Health Exchanges

- Early assessment of participation
  - > Many unknowns but lead time could be long
- Factors to consider
  - > Population estimates, premium subsidy estimates and cost characteristics
  - > Outline requirements of entry
  - > Estimate costs of entry
  - > Outline operational capability requirements and high level gap assessment
  - > Quality and certification requirements
  - > Regulatory environment
  - > Competitive environment
  - > Qualification process

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Medicaid

1. Expands enrollment to additional populations
2. CHIP expansion
3. Long Term Care:
   - Establishes a national, voluntary insurance program for purchasing community living assistance services (CLASS)
   - Senate make further improvements to Medicaid home and community based services for disabled up to 150% poverty.
4. Improve coordination of care for dual eligibles through a new office within the Centers for Medicare and Medicaid Services
5. Likely additional Medicaid managed care program development

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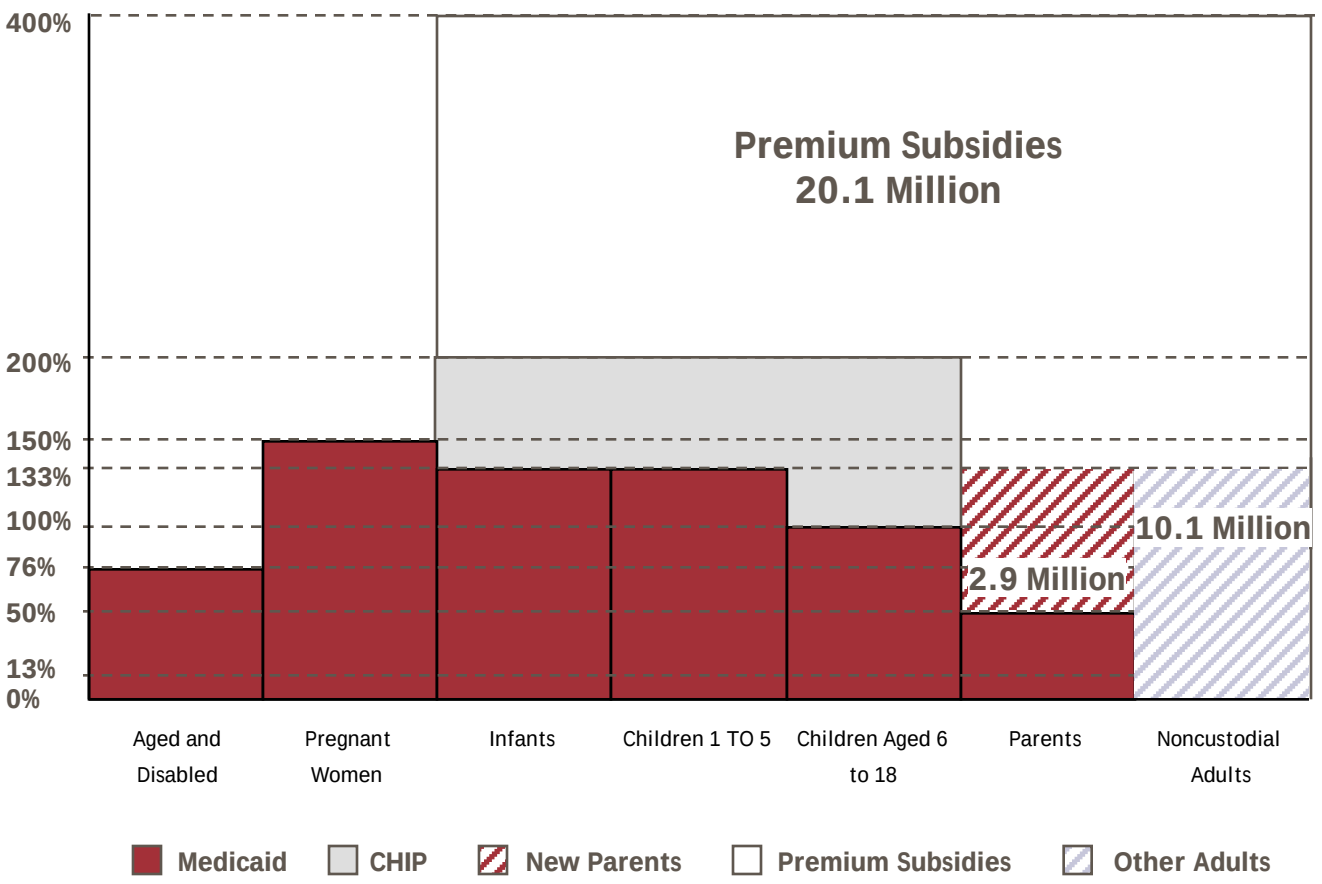
Expansions in Publicly Financed Eligibility



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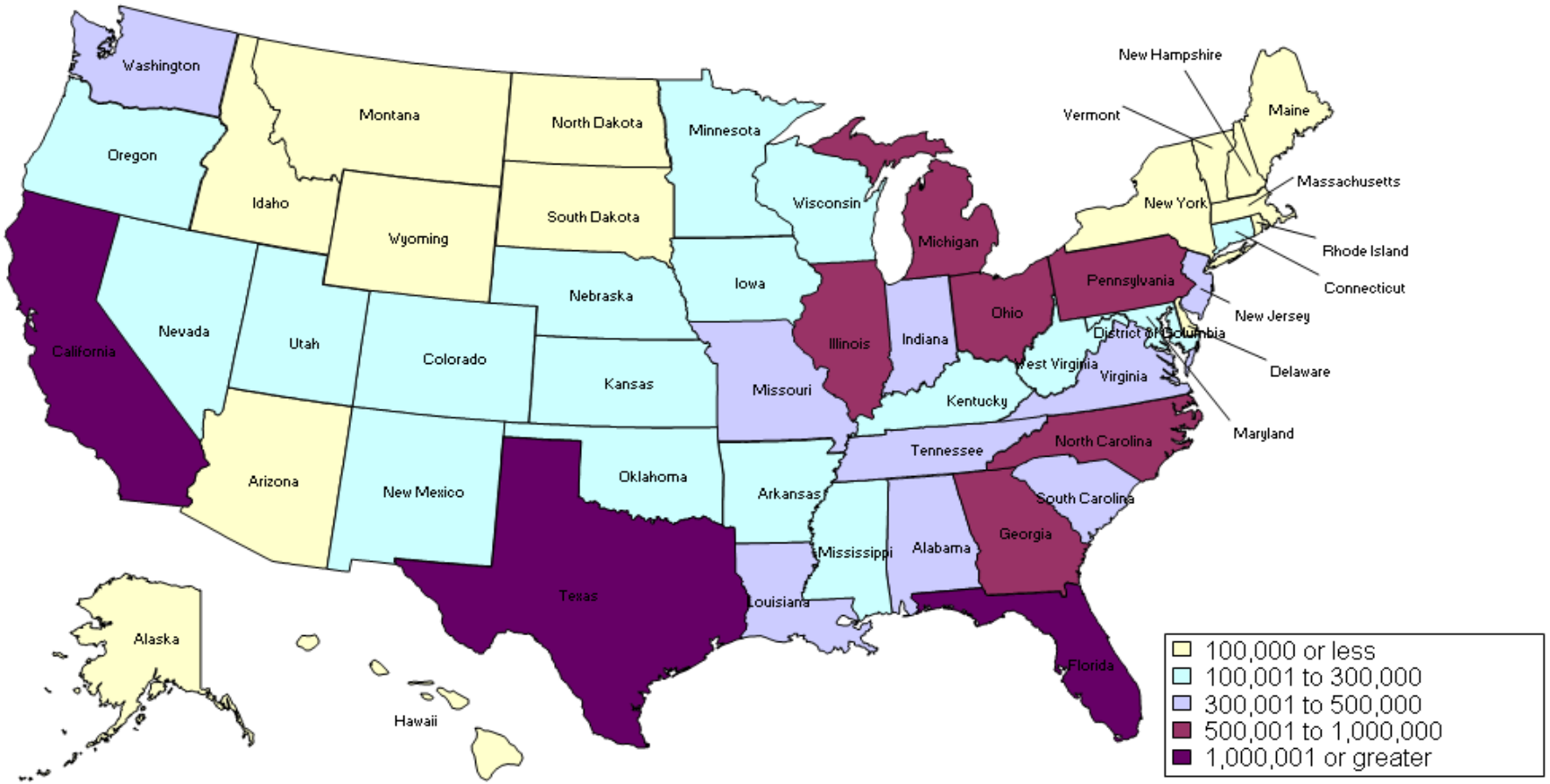
Expanded Medicaid Population by State



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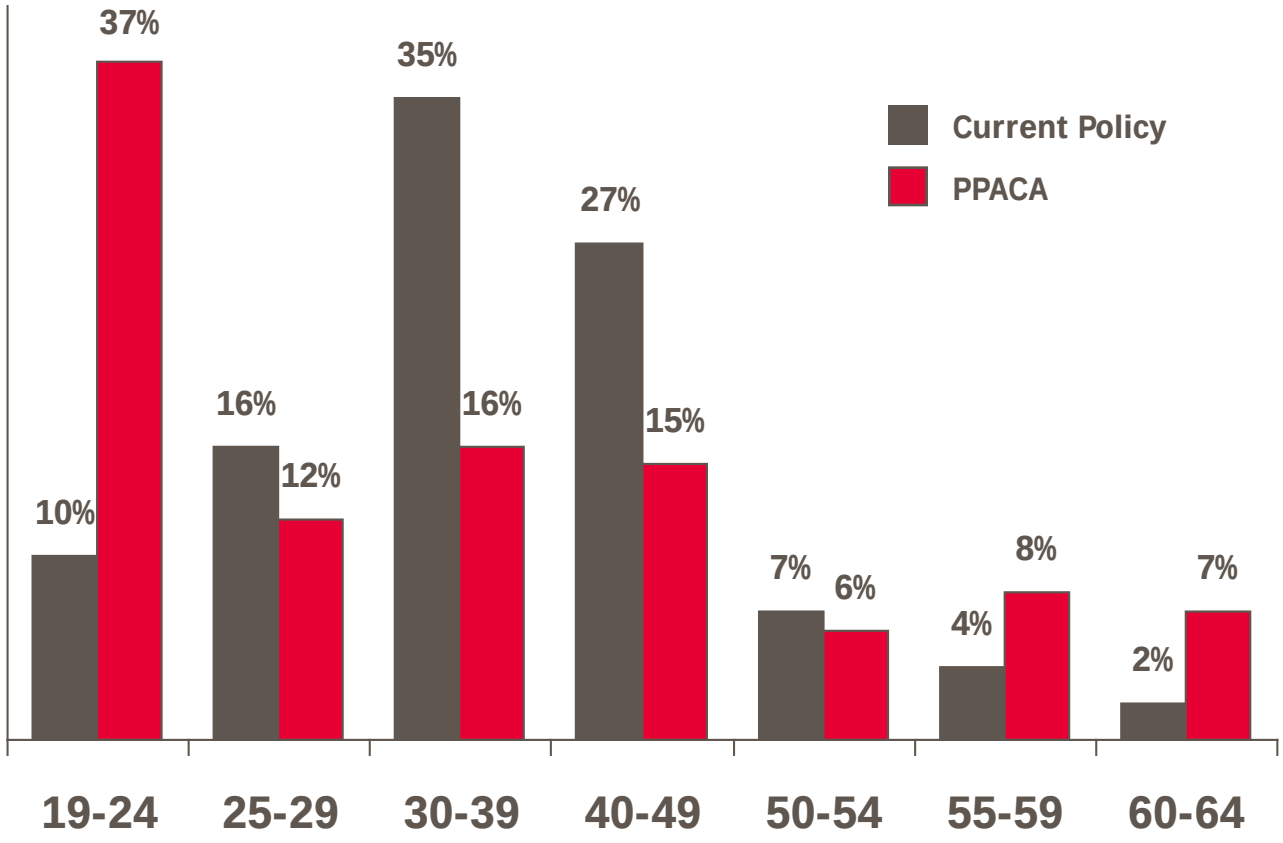
Distribution of Currently Eligible Parents and Newly Eligible Adults under PPACA for Medicaid by Age



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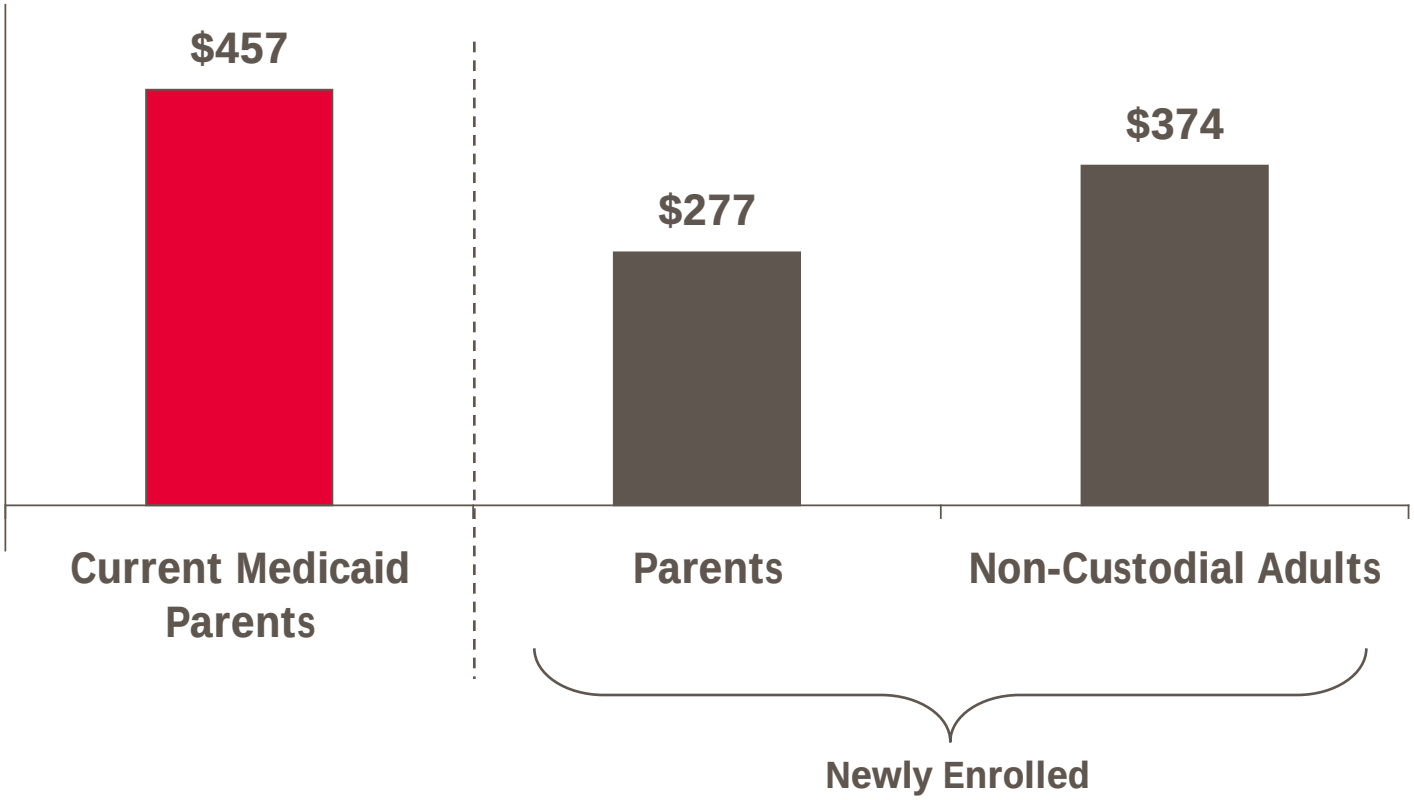
Estimated Average Cost per Person per Month (PMPM) under the Medicaid Expansion



Note: Assumes no enrollment “drift” from the pregnant women and other eligibility groups.

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Short Term Priorities: Medicaid

- Medicaid expansion
  - > Will state/market see a substantive increase in eligibles?
- Plan capacity to manage growth
  - > Operational infrastructure
    - Are existing operations scalable?
  - > Network – Size
  - > Medical management and quality
    - Scale, clinical needs, performance incentives or penalties
  - > Compliance
    - Current performance
    - Future requirements
- Different population characteristics
  - > Financial/actuarial considerations
- IC and Lewin works with Medicaid plans nationwide to assess this opportunity

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2010 YTD Medicare Advantage Enrollment

- AEP Results
  - > 5.12% increase in total MA enrollees
  - > Total number exceeds 10.9 million as of January, 2010 report
  - > 9.18% decrease in number of MA contracts
  - > Total PDP enrollment only increased by 1.24%
  - > Total PDP enrollment exceeds 17.6 million
  - > Total enrollees 28.6 million (2.69% increase over 2009)
- OEP
  - > 5.48% increase in total MA enrollees
  - > Total number exceeds 11.5 million as of April, 2010 report
  - > Total PDP only increased by .78%

Source: AEP - 01/2009 & 01/2010 CMS MA Monthly Summary Reports
OEP – 04/2009 & 04/2010 CMS MA Monthly Summary Reports

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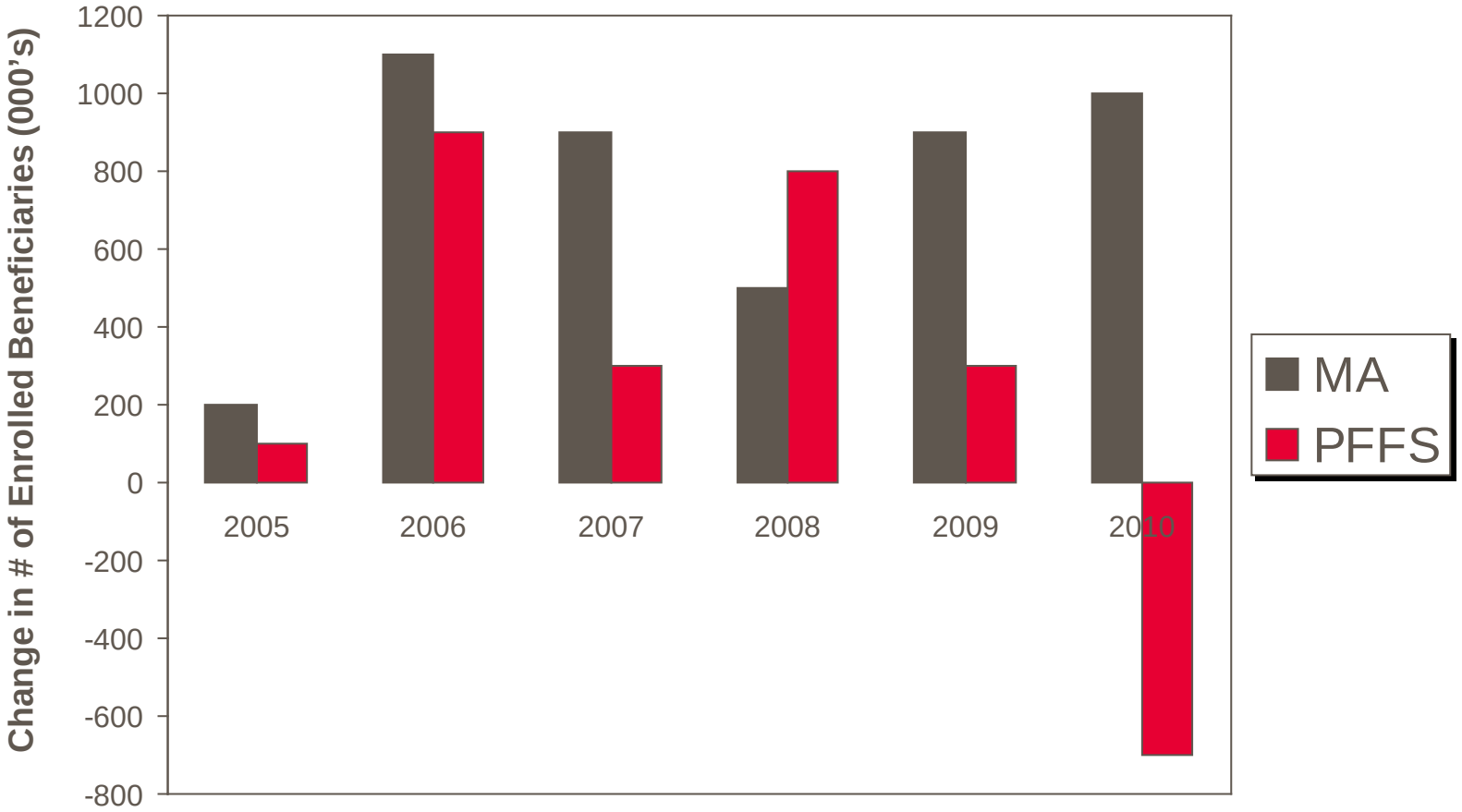
Impact of sunset of PFFS largely offset by PPO/HMO growth



Source: 2007, 2008, 2009, 2010: February CMS Monthly Summary Reports

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Current Results: 2011Bid Changes/Challenges

- MOOP: Max Out of Pocket requirements
  - > 3400/6700
  - > Applies to SNPs and EGWPs as well as MA
- Meaningful Difference Test (OOPC test)
  - > Effort to limit number of plan offerings
  - > Minimum enrollment levels – forcing plan consolidation
- Benefit design restrictions – discriminatory benefit test
- PPACA increased payments to rural providers through increased GPSI factors
- Risk adjusters for Part D
- Coverage in the 'gap' for Part D
- TBC – reduction in ability of Plans to manage to corporate profit target. Changes regulated at contract level.

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Major Issues for Medicare Advantage (MA) Plans

- Change in payment rate methodology to MA plans
- Continue MA versus FFS coding adjustments
- Minimum 85% loss ratio
- Enrollment period reductions
- Filling in coverage gap
  - > Immediate and over coming eight years
- Elimination of tax deduction for RDS payments to employers
- Payment for quality to MA plans
  - > Up to 10% in certain markets
- Office of coordinated care established

Continues administrative pricing — linked to FFS costs

Regulation drafting critical

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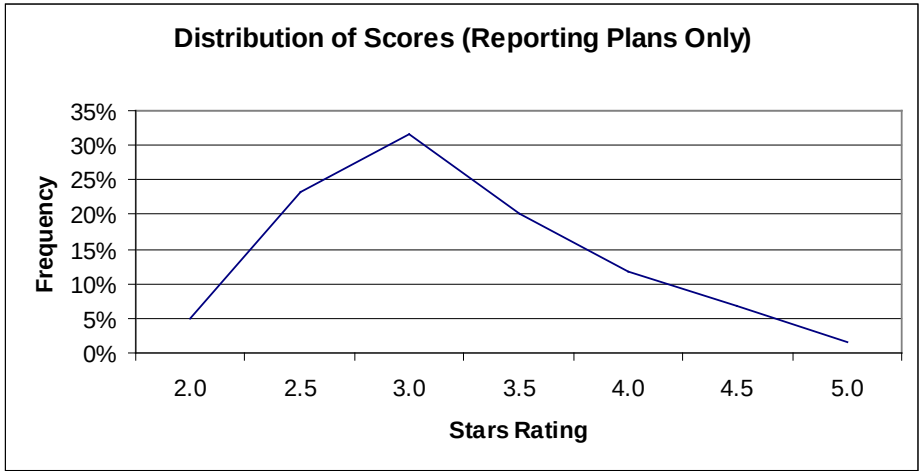
Pay for Performance – a way to boost revenue

- Pay for Performance based on existing Stars rating system
  - > CAPHS, HOS, and HEDIS measures
  - > Majority are
- Bonus payments to plans receiving four or more Stars
  - > Effective 1/1/2012
  - > Worth 5-10% of premium
- Modifies rebate system
  - > Reduced from uniform 75%
  - > Rebate based on a plan's Star rating
  - > Three year phase in
    - Beginning January 1, 2012
- How many plans will qualify?
  - > Quality Bonus - 20% of MA plans
  - > Highest level of Rebate - 10% of MA plans

Year	New	Ongoing
2012	1.5%	1.5%
2013	2.0%	3.0%
2014+	3.5%	5.0%

Stars	Rebate %
<3.5	50%
3.5 to 4.5	65%
>=4.5	70%



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Low Performance Risks

- Compliance risk for CMS audits if less than 3 stars
- If less than 3 Stars for three years in a row the below icon will appear in Plan Finder next to the plans for that contract

	Caution: For three years in a row, the Medicare program has given this plan a low ***overall*** rating. If you are considering enrolling in this plan, look closely at the detailed ratings for this plan.

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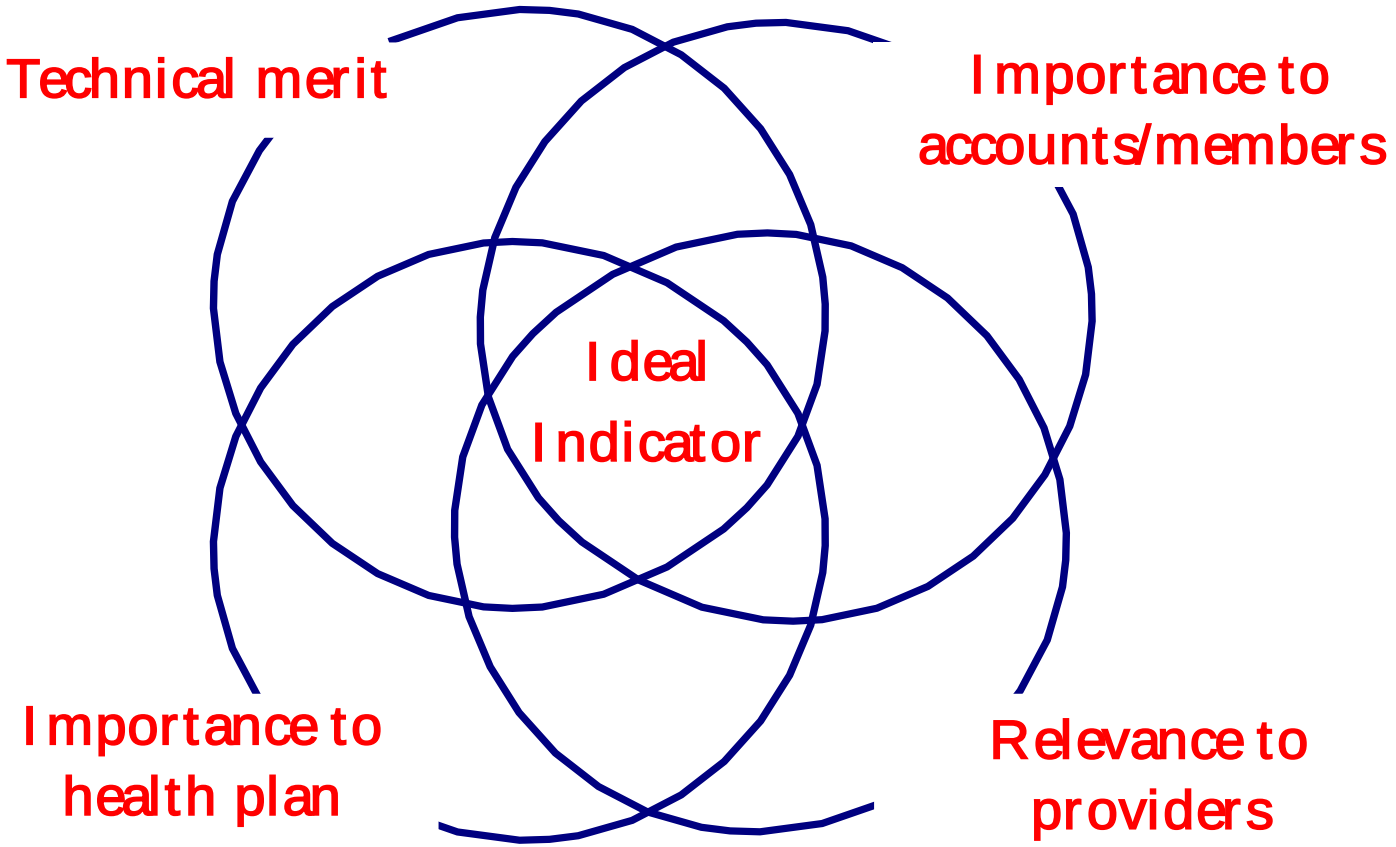
Selecting P4P Programs to Support Stars



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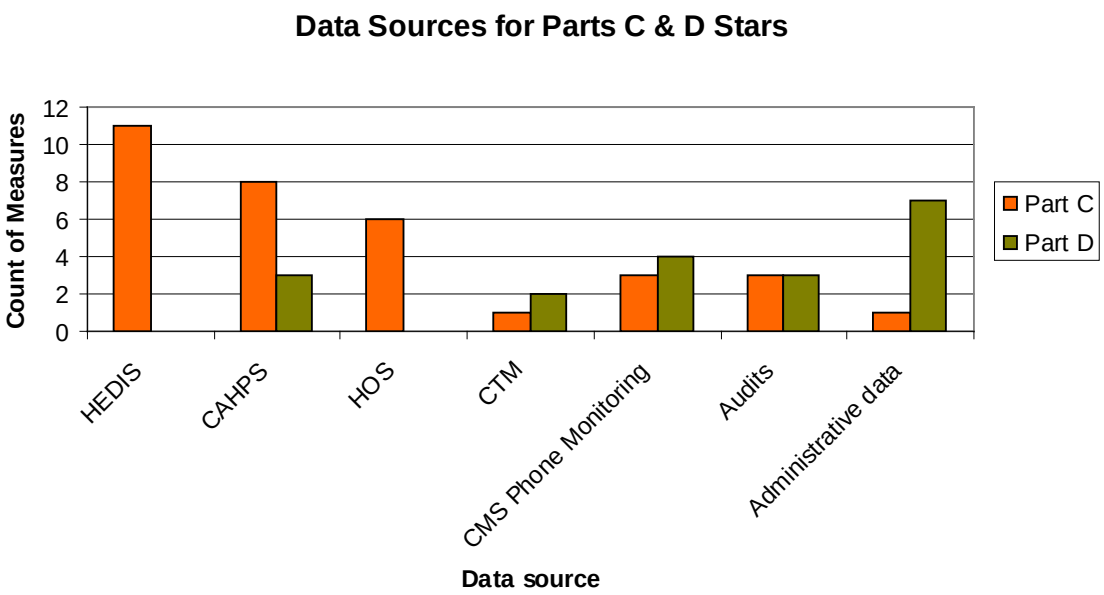
Short Term Priority – Stars Improvement

- You can not fix everything at once or maybe at all
  - > How far from 4 Starts is the plan?
  - > Where does the plan stand in relationship to its market and competitors?
  - > Evaluate plan performance across measures
  - > Identify root causes and set improvement priorities
- Fix what you can reasonably expect to influence
  - > Identity both short and long term intervention strategies
  - > Monitor and refine solutions based on actual performance
- Quality and performance measurement will only play a greater role going forward
  - > Think long term, cross product and as a strategy to differentiate and position plan in the future



Dashboard and Modeling

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Other MA Priorities

- Administrative cost benchmarking
- Medical management program review
  - > ROI on ongoing activities
- HCC coding and chart reviews
  - > Making sure Plan gets appropriate payment for enrolled risk
- Evaluate impact of enrollment period changes
- Identify portfolio diversification opportunities beyond SNP
- Evaluate ongoing program financial feasibility
  - > Scenario planning – exit to expansion

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Navigating the Road Ahead

- Accountable Care Organization Demonstration
- Community Health Center expansions
- State financing of Medicaid
- Premium Subsidized Health Exchange populations
  - > Competitor movement into Medicaid?
- Managed Long Term Care program development
- ICD-10/5010 implementation

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Navigating the Road Ahead

- Identify the opportunities
- Understand the risks
- Develop a comprehensive road map
  - > Set a course
    - Define where in the health insurance continuum the plan wants to be positioned
  - > Align across lines of business
  - > Establish timelines and set priorities
- Determining what investments are needed
  - > Staying in place versus growth and expansion
  - > Compliance and regulatory requirements
  - > Capital
  - > Technology
- Be nimble and adapt as the rules of the road are defined

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