

A Modern, High-Performing, Simpler Health Care System

UNITEDHEALTH GROUP®

A Modern, High-Performing, Simpler Health Care System

Future health care reform efforts should seek to make high-quality health care accessible and affordable for everyone by advancing proven, sustainable coverage solutions, reducing the complexity and costs that challenge the consumer experience today, and enabling and incentivizing innovative solutions to ensure a modern, 21st century health care system for the American people.



Expand Access to Care

Build Upon Proven State-Based Coverage and Employer-Sponsored Insurance



Make Health Care More Affordable

Promote Value-Based Payments, Advance Consumer-Directed Care, Limit Excessive Price Increases, and Eliminate Harmful Taxes



Support and Modernize Medicare

Fund Medicare Advantage and Modernize Original Medicare



Reinvest in Health

Create a 21st Century Workforce, Enable a Data-Driven, Interoperable System, Invest in Medical and Health Services Research and Innovation, and Prioritize Prevention

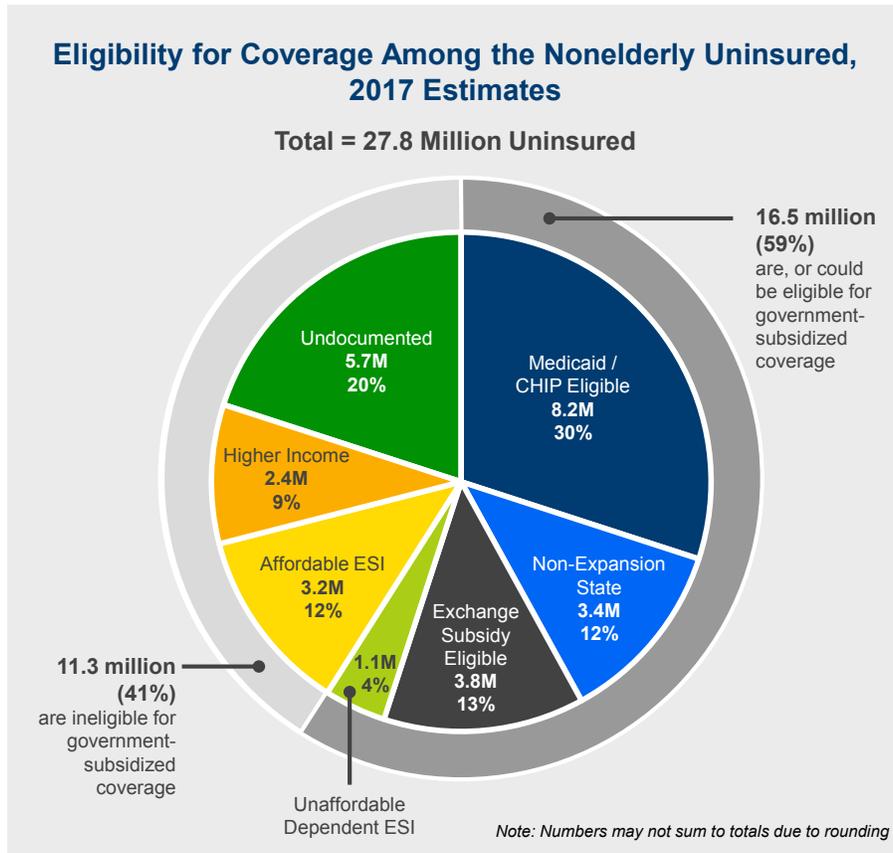
Expanding Access to Care by Streamlining and Modernizing Health Coverage Options

The Opportunity

- **In 2017, national health care spending will reach \$3.5 trillion, accounting for 18% of the United States economy.** By 2025, it is projected to reach \$5.6 trillion – one-fifth of the economy. For many individuals, health care premiums and out-of-pocket costs will continue to increase faster than household income.
- **Sustainable health coverage is vital to ensuring meaningful access to care for consumers in the increasingly costly health care system.** Employer-Sponsored Insurance (ESI) remains the nation's largest coverage system, serving 178 million individuals, including most of the population under 65. Meanwhile, government's role in providing health coverage continues to expand. More than 90 million individuals will receive subsidized coverage in 2017 through Medicaid, CHIP, and Public Exchanges, at a cost of \$430 billion to the Federal government and \$270 billion to the States.
- **Despite this substantial and growing investment, an estimated 28 million individuals under 65 will be uninsured in 2017.** Many of these individuals, especially those who are eligible for no-cost or low-cost coverage, face substantial barriers to coverage including limited awareness of coverage options, confusing eligibility standards, complex and time-consuming application and enrollment processes, interruptions in coverage resulting from changes in income, poor understanding of the economic risks and health impacts of being uninsured, and often unaffordable premiums and out-of-pocket costs.
- **Many individuals who are eligible for government subsidies still can't afford Public Exchange coverage or can't readily access care with the coverage they have purchased.** Public Exchanges are more attractive to individuals with complex medical needs who anticipate higher-than-average utilization. This adverse risk selection is driving up premiums, further discouraging healthy individuals from enrolling or staying enrolled.
- **Expanding access to care will require policy and local market-based solutions that preserve and build on Employer-Sponsored Insurance; achieve more affordable, sustainable, and higher-value coverage for consumers; ensure stable payments for care providers; and create new cost-effective State-Federal partnerships** that expand coverage and use effective and enhanced State-based administration systems and proven enrollment strategies to simplify the application and enrollment processes for consumers.

An Estimated 28 Million Remain Without Coverage

Despite efforts to expand access to care for uninsured individuals, too many people – an estimated 28 million in 2017 – remain without coverage. The uninsured are more likely to defer needed health care or forgo it altogether, and often face unaffordable medical bills when they do seek care. The consequences can be severe and costly, particularly when preventable conditions or chronic diseases go undetected. There are proven and sustainable approaches and solutions that will lead to universal and affordable access to high-quality health care for millions of Americans across the country.



Provide Affordable, High-Quality Access to Care for the Remaining Uninsured

- Creating subsidized State-based coverage platforms that consolidate available Federal funding to provide stable, high-quality health care coverage
- Utilizing State-based administrative platforms to maximize the adoption of proven information systems, leverage data and analytics, and streamline administration
- Enabling a more robust and sustainable unsubsidized individual marketplace

Strengthen and Grow Employer-Sponsored Insurance

- Preserving and promoting the successful, innovative, and effective Employer-Sponsored Insurance model

Create a New State-Federal Coverage Partnership

A new State-Federal coverage partnership can be achieved by consolidating and creating subsidized State-based coverage platforms that leverage available Federal funding to provide stable, high-quality health care coverage for individuals. This new partnership would be best achieved by:

- **Consolidating available Federal Medicaid and Public Exchange funding streams** to finance newly designed, structured, State-based coverage systems.
- **Providing States additional flexibility to cover eligible individuals up to 400% of the Federal Poverty Level (FPL)** and to leverage the scale, longevity, and effectiveness of existing State-based administrative platforms.
- Creating a **unified eligibility framework** with variable consumer financial responsibility based on income, and seamless transitions to **allow individuals to remain in the same plan** with the same provider network when income shifts.
- **Replacing the complexity and inconsistency of the current subsidy structure** to advance simple, stable, and consumer-friendly coverage, to provide a simplified means test, and to prevent wide subsidy variation from one household income level to another.
- Ensuring Federal funding to States is fully dedicated to health care and **adequately resourced to provide sustainable access** for eligible individuals.
- States having the authority to **leverage non-monetary incentives**, such as wellness programs, to encourage individuals to engage more actively in their health care.
- Expanding authority and incentives for States to **open and pre-fund Health Savings Accounts (HSAs) for enrollees** to encourage consumer financial responsibility.
- **Meeting Federal benchmarks**, including consumer protections, quality measurement, enrollment, and access to care, **each State would have the flexibility** to create a regulatory framework for covered services and benefit design, network standards, provider payment rates – including value-based payment models – and cost-sharing requirements.
- **Providing incentives to States for achieving performance objectives**, including automatic increases in Federal matching funds tied to States' achievement of specified enrollment targets.
- **Amending the definition of “affordable” ESI** to include the cost of dependents to expand access to subsidized coverage.

Enhance Existing Enrollment Strategies

The new State-Federal coverage partnerships would utilize the existing State-based Medicaid administrative platforms that currently cover more than 70 million Americans. These platforms would maximize the adoption of proven information systems, leverage integrated databases and analytics, and streamline administration and operational support. These new partnerships would be best administered by:

- **Allowing States to maximize enrollment among subsidy-eligible individuals through a passive enrollment option** that identifies eligible individuals on a prospective basis. While providing any individual the right to opt out of coverage, this approach would increase coverage and would attract healthy individuals, who are less likely to seek coverage, to the risk pool.

Enhance Existing Enrollment Strategies, cont'd

- **Providing financial support to States**, through existing Federal funding authority and operational support, for administration activities such as collecting eligibility data from local and State means-tested programs, wage and coverage data from private employers, and income and coverage data contained in State and Federal tax returns.
- **Empowering and incentivizing States to implement enrollment strategies that increase coverage, including:**
 - Offering multiple application pathways to provide consumers a standard enrollment process;
 - Ensuring there is “no wrong door” for consumers to initiate applications;
 - Leveraging public and private data sources to identify and enroll eligible individuals;
 - Helping consumers initiate applications and complete enrollment; and
 - Deploying high-impact, State-based marketing campaigns that explain the benefits of coverage.

Increase the Value of Unsubsidized Individual Coverage for Consumers

The Federal government can enable a more robust and sustainable unsubsidized individual marketplace by:

- **Giving States the flexibility to allow unsubsidized consumers who cannot otherwise access creditable coverage to enroll in the new State-Federal coverage partnerships** and pay the full premium and cost sharing.
- Permitting States to **establish localized health benefits and offer limited coverage policies** to provide consumer choice in the individual market.
- **Educating consumers** on the economic risks and health impacts of being uninsured.

Strengthen and Grow Employer-Sponsored Insurance

Employer-Sponsored Insurance (ESI) provides access to care for 178 million individuals and contributes \$900 billion in private funds to the health care system. The Federal government should preserve and promote this successful and effective private coverage platform by:

- **Supporting the current tax treatment of ESI and repealing the ACA’s Excise (Cadillac) Tax**, thereby preserving consumers’ access to benefits offered by employers.
- **Repealing the ACA’s Health Insurance Tax** to avoid higher premiums for employers and consumers.
- **Expanding access to, and incentives for, HSAs** to be used with any type of plan, not just high deductible health plans, and by allowing HSA contributions up to the plan’s maximum out-of-pocket expenditure.
- **Providing ERISA-like flexibility to employers to design and implement incentives and wellness programs**, thereby protecting consumer choice and opportunities to lower out-of-pocket health expenses.

Make Health Care More Affordable

Health care spending in the United States will total over \$3 trillion in 2016 – more than any other country in the World – exceeding \$10,000 per person for the first time. Yet, nearly 28 million adults remain uninsured, because for half of them health care coverage is unaffordable.

Health care costs for families have doubled in the last decade. However, paying more for unnecessary health care has failed to yield better outcomes and resulted in an estimated \$285 – \$425 billion in wasteful and avoidable spending. Specifically:

- Health care spending continues to grow – increasing 5.4% in 2015 – and is expected to rise to \$5.6 trillion, one fifth of the U.S. economy, by 2025.
- Drug prices rose 7% between September 2015 and September 2016, the largest one-year increase in prescription drug prices in 24 years.
- The average price of brand-name drugs rose 16% in 2015, up 98% since 2011.
- Since 2000, spending on clinical services increased, on average, at twice the rate of inflation with prescription drug spending exceeding almost 10% of national health expenditures since 2014.
- \$500 billion in annual ACA taxes have increased costs for States, employers and consumers.

In recent years, health care reform efforts have focused primarily on expanding coverage, and the affordability and sustainability of some existing and new coverage options have been significantly challenged.

Paying providers and manufacturers differently and enabling consumers to make better health care choices are meaningful and impactful solutions to achieving health care affordability, improved health, and higher quality care. Reforming existing laws and enacting new policies – to minimize inefficiency, enhance the consumer experience, and better leverage innovations – will make the health care system more accessible, affordable, and valuable for all Americans.

Make Health Care More Affordable

Previous efforts to reduce health care costs have often involved lowering payments for services and reducing benefits for consumers. These approaches fail to address the underlying inefficiencies caused by how we pay for and consume health care. Efforts to make health care more affordable require rewarding manufacturers and providers based on the value of products and services, while simultaneously empowering consumers with the information and incentives to seek the best quality care through progressive, consumer-directed approaches to health care.

Reforming existing laws and enacting new policies to keep up with technology and innovation will fuel an affordability agenda that lowers administrative costs, better calibrates prices, and eliminates the need for reliance on harmful health care taxes which only make health care more unaffordable.

To advance this affordability agenda, policy and market-based solutions should include:

Transitioning to Value-Based Pricing and Payments

Enabling and Incentivizing Consumer-Directed Health Care

Enhancing Health Care System Productivity

Transition to Value-Based Pricing and Payments

Employing value-based pricing to pay manufacturers and providers based on the clinical quality and cost-effectiveness of their products and services will drive the innovations, enhancements, and competition in health care to achieve better outcomes at lower costs. Specific solutions to achieve these outcomes include:

- **Over a defined multi-year period, implementing value-based pricing for drugs and devices** based on their clinical outcomes and cost-effectiveness relative to existing products, to limit excessive price increases.
- **Prioritizing FDA reviews of branded and generic drugs when fewer than three drugs are available** for a particular condition, to accelerate the availability of more drugs to stimulate price competition.
- **Strengthening anti-trust laws** to make pay-for-delay settlements unlawful, thereby ensuring timely market entry of generic drugs to drive prices down through competition.
- Adopting new payment models like **risk-sharing and performance-based contracts** that reward providers for delivering measurable, accountable, high-value health care, and prioritizing prevention over treatment.
- **Expanding the scope and use of bundled payments** to include the costs of all drugs, devices, and sites of care involved in a medical event, to drive more coordinated, evidence-based care that improves outcomes and lowers costs.
- **Setting payments based on service** – independent of the provider or health care setting – to reduce unwarranted use of higher-cost settings and specialized providers.
- **Capping provider payments from insurers for out-of-network billing**, when patients seek health care from in-network providers or facilities, to prevent abuse.
- **Encouraging States to develop and enforce standards** for freestanding emergency departments, dialysis centers, and substance abuse clinics to protect consumers and prevent abuse.
- **Prohibiting the use of Most Favored Nation clauses** between providers and insurers that stifle competition and limit affordable options for consumers.

Enable and Incentivize Consumer-Directed Health Care

Empowering consumers to seek high-value health care requires providing them with easy and accessible information as well as incentives to make well-informed decisions. Specific solutions include:

- Requiring payers, manufacturers, and providers to **share data with consumers on the quality and price** of health care products and services to help individuals make well-informed choices.
- **Accelerating the development of robust price and quality transparency tools** by ensuring the U.S. Department of Health and Human Services classifies these tools as quality improvements, not administrative costs, to drive responsible use of the system by consumers.
- **Disallowing out-of-network charges and balance billing to consumers** by out-of-network providers for individuals who seek health care at in-network facilities.
- **Expanding incentives** – such as lower cost-sharing, tiered network designs, and benefit enhancements – to reward consumers for seeking health care from high-quality, cost-efficient providers.
- **Expanding access to, and adoption of, Health Savings Accounts (HSAs)** by permitting their use with any type of plan and allowing individuals and employers to fund HSAs up to the plan's maximum out-of-pocket expenditure, to encourage savings.
- Allowing **flexibility for employers to tailor employee incentives and wellness programs** to provide opportunities for better outcomes and to reduce out-of-pocket health care expenses.

Enhance Health Care System Productivity

The U.S. health care system suffers from administrative complexity and inefficiencies, resulting from harmful taxes, outdated laws, and barriers to leveraging innovation. Revisiting and reforming existing laws and advancing initiatives to enhance health system productivity include:

- **Repealing government-mandated industry taxes and fees** – such as the Affordable Care Act's Health Insurance Tax and Excise (Cadillac) Tax – that drive up health care costs.
- **Accelerating interoperability and meaningful enforcement actions that mitigate data-blocking** – especially onerous, anti-competitive business practices and contract terms – to unlock siloed data, enable broad-based data sharing, close gaps in care, and advance analytics that drive improved health, better care, and lower costs.
- Adopting a **single, standardized set of provider performance measures** that support value-based payments and are electronically captured, clinically relevant, understandable to consumers, and useful for quality improvement.
- **Driving adoption of telemedicine** by authorizing Medicare and Medicaid payments for these services across all sites of care, to enable timely health care at lower costs.
- **Incorporating drug formularies and evidence-based treatment protocols** into electronic medical records to promote adherence to cost-effective, clinical best practices.

Support and Modernize Medicare: Create a Next-Generation Medicare Program that Meets the Unique and Increasingly Complex Challenges of America's Seniors

Each day, 11,000 people in the United States celebrate their 65th birthday and become Medicare-eligible. The program that was created to give America's seniors and individuals with disabilities access to health care will be insolvent in 2028, before Medicare reaches its own 65th birthday.

- Medicare enrollment is expected to grow rapidly from approximately 56 million seniors to 76 million, and spending is anticipated to reach nearly \$1.3 trillion in the next decade. Medicare spent approximately \$12,000 per beneficiary in 2015, and by 2025, annual per beneficiary spending is expected to reach nearly \$18,000 as utilization increases.
- Original Medicare's outdated volume over value approach encourages wasteful spending, fails to promote efficiency, and under-delivers for our nation's growing Medicare population.
- Nearly 70% of Medicare beneficiaries are enrolled in Original Medicare without access to systematic and proven best practices, such as care coordination and disease management programs, resulting in 66% of Original Medicare beneficiaries with multiple chronic conditions requiring a hospitalization at least once a year.
- Medicare Advantage (MA) delivers high-quality, coordinated care to 18.6 million seniors, while Original Medicare faces long-term sustainability challenges. Unlike Original Medicare, MA's patient-centered model demonstrates value and meets beneficiaries' needs:
 - 68% of MA beneficiaries are in plans rated 4 stars and above;
 - 20% fewer readmissions in MA compared to Original Medicare;
 - 91% of beneficiaries report high satisfaction;
 - 37% of MA beneficiaries have fixed annual incomes at or below \$20,000; and
 - 44% of Hispanics and 30% of African-Americans choose MA.

Despite this evidence and proven success, MA funding has been cut 14% since 2010, undermining the innovation that serves to protect and sustain Medicare.

- Previous policy changes have fallen short of meaningful Medicare modernization. Now is the time to take full advantage of a health care sector that is constantly updating clinical capabilities and innovating more effective and simpler strategies to transform Medicare.

Create a Next-Generation Medicare Program that Meets the Unique and Increasingly Complex Challenges of America's Seniors

Medicare provides vital benefits and services to America's seniors and disabled citizens. However, it is not on a sustainable path to provide access to the highest quality health care for all beneficiaries in the program. Modernizing Medicare should address the key challenges facing the program by advancing and scaling best practices, fostering innovation, and aligning incentives to ensure beneficiaries receive high-quality, consumer-friendly health care. Solutions that Support Medicare Advantage and Modernize Original Medicare include:

Support Medicare Advantage

- **Protecting, Building Upon, and Improving the Medicare Advantage Program**

Modernize Original Medicare

- **Providing All Beneficiaries with Proven Value-Based Care Management Programs**
- **Fostering Innovation and Empowering All Beneficiaries to Engage in Healthy Decision-Making and Appropriate Care**
- **Improving Original Medicare's Existing Infrastructure**

Protect, Build Upon, and Improve the Medicare Advantage Program

- **Ensure stable, adequate, and predictable funding for Medicare Advantage by:**
 - Improving the simplicity and transparency of Medicare data;
 - Protecting comprehensive in-home primary care visits that improve continuity and management of care;
 - Avoiding any increase in the Medicare Advantage coding intensity adjustment;
 - Establishing a multi-year benefit cycle; and
 - Ensuring the risk adjustment system is adequate and accurately reflects the costs of delivering care.
- **Promote customized, targeted beneficiary care** by permanently authorizing Special Needs Plans.
- **Allow Medicare Advantage the flexibility to offer customized benefits and cost sharing** to targeted enrollees that fall within certain clinical categories (i.e., diagnosed with certain chronic diseases) or social determinants (i.e., low-income beneficiaries and/or those living in rural areas) to encourage the use of services that are of highest value to beneficiaries and will lead to high-quality, cost-effective care.

Modernize Original Medicare

Provide All Beneficiaries with Proven Value-Based Care Management Programs

- **Provide beneficiaries with access to established care management services** so that coordinated care is delivered to all beneficiaries in the most effective setting at the most appropriate time to improve health care outcomes.
- **Authorize adequate payment for proven care management services**, including evidence-based prevention and wellness programs, transitional care management and clinical programs, chronic disease management, advanced illness, telehealth, and digital health services.

Modernize Original Medicare, cont'd

- **Require integrated services**, including disease management programs, palliative approaches, psychological care, and social services to help beneficiaries live in the setting of their choice.
- **Fund patient-centered medical home models** for the program's most frail and vulnerable beneficiaries to improve health outcomes and reduce costly interventions, such as unnecessary hospitalizations and emergency department visits.
- **Expand utilization of real-time predictive modeling tools and comprehensive patient encounter data** to identify appropriate evidence-based interventions.
- **Develop an alternative funding model for in-home primary care delivered by physicians and nurse practitioners** to reduce barriers and address clinical, environmental, and social determinants of health. This model should include a physical assessment, behavioral assessment, and medication review with results shared electronically with the beneficiary and a primary care physician to ensure appropriate clinical follow-up and seamless care delivery.

Foster Innovation and Empower Beneficiaries to Engage in Healthy Decision-Making and Appropriate Care

- **Provide funding for proven lifestyle intervention programs and community-based activities** that prevent the on-set of chronic disease.
- **Authorize and fund consumer-friendly tools** that include group sessions, coaching, robust online transparency tools, and other capabilities to help meet the needs of beneficiaries.
- **Establish a Medicare-specific Health Savings Account (HSA)** and authorize Medicare beneficiaries to save before and during retirement for Medicare-related out-of-pocket costs.
- **Expand the use of beneficiary incentives** to help seniors receive appropriate preventive services, participate in wellness programs, make healthy choices, and engage with programs that identify and manage disease earlier.
- **Authorize flexible incentive design** by allowing Medicare beneficiaries to receive tangible incentives through sweepstakes, donation platforms, and other programs to foster a modernized, consumer-friendly environment.
- **Modernize and standardize quality measurement across the Medicare program by:**
 - Aligning and synchronizing quality measures across Original Medicare, Medicare Advantage, and other value-based payment models;
 - Utilizing quality measures focused on clinical outcomes; and
 - Offering consumers access to timely, actionable information for decision-making by ensuring all quality measurement information is publically available in a user-friendly format.

Improve Original Medicare's Existing Infrastructure

- **Expand value-based payment approaches** to promote quality among providers and remove the incentive for high-volume services.
- **Utilize means testing** to support long-term stability of Medicare.
- **Provide beneficiaries simple, consumer-friendly information** to make comparisons on clinical quality and price.
- **Require that providers submit public, timely, and accurate directory information** to allow consumers to identify doctors, treatment facilities, and other care providers.
- **Authorize Part D's utilization of innovative tools and data analytics** to connect beneficiaries to appropriate clinical care.

Reinvest in Health

The United States health care system is the most costly in the world, yet it underperforms on key health metrics, including life expectancy at birth, survival with many diseases, and mortality.

- More than 141 million Americans live with a chronic condition such as diabetes, heart disease, obesity, or asthma and that number is expected to climb to 171 million by 2030.
- Uneven provider distribution and shortages impede effective health care delivery that can save or improve patients' lives and reduce the burden of acute and chronic diseases – by 2020, there will be an estimated shortage of over 20,000 primary care physicians.
- The U.S. share of global medical research funding has declined by nearly 23%, from 57% in 2004 to 44% in 2011.
- Barriers to leveraging and exchanging standardized data hamper the health care system's ability to drive continuous improvements and innovations in medical research and care delivery.

Collectively, these gaps in resources and capabilities to support medical research and care delivery are inhibiting Americans from accessing more effective treatments and interventions to improve their health and well-being. Financial impediments are hampering the U.S. health care system's ability to innovate and deliver high-value care, including:

- Funding for medical and health services research and development, social services, and prevention efforts has decreased, while the prevalence of and costs associated with chronic diseases are growing, underlying 7 of 10 deaths annually.
- Annual funding for public health activities is inadequate and inconsistent.
- As 16.5 million people have gained access to care since 2013, the health care delivery system has been further strained without the appropriate investments in necessary innovation, research, and care delivery capabilities.

To ensure the U.S. health care system is the most modern, innovative, and effective in the world will require targeted investments that seek to develop a next-generation health workforce, accelerate medical and health services research, emphasize prevention, and leverage the power of data. Reinvestment in health should promote innovations in science and technology to reduce health care costs, expand access to high-quality care, develop new cures, and improve the health of all Americans. Specifically, a reinvestment in health should seek to:

- **Create a 21st Century Health Workforce**
- **Enable a Data-Driven, Interoperable Health Care System**
- **Invest in Medical and Health Services Research and Innovation**
- **Prioritize Prevention**

Create a 21st Century Health Workforce

Meeting the complex care needs of an increasingly diverse population in a rapidly evolving delivery system requires sufficient resources, as well as policies, aimed at attracting, training, equipping, and effectively deploying primary care providers and other health care professionals in high demand to modernize and improve the effectiveness of the U.S. health care system. Specific solutions include:

- **Rewarding providers for high-quality care** by leveraging value-based payments that emphasize primary care and prevention to attract and retain primary care providers and other health professionals in high demand.
- **Funding recruiting, loan forgiveness, and other incentive programs** in underserved areas and specialties to foster local, culturally-competent talent and redistribute existing clinician capacity.
- **Aligning scope of practice guidelines for each health professional to the highest level** accepted across the nation to attract and effectively deploy clinicians and expand delivery system capacity.
- **Expanding the capacities of medical education programs and eliminating unnecessary barriers and regulatory constraints to the practice of medicine**, including credentialing and malpractice laws, to increase and optimize clinician capacity.
- **Financing curriculum modernization for medical schools and other clinical and health administration programs to train the workforce** to effectively address factors driving patients' health and outcomes and support delivery system transformation. To ensure workforce preparedness, training should include:
 - Team-based and technology-enabled care delivery;
 - Hands-on training in non-hospital and community-based settings;
 - Work with community health workers and community-based organizations;
 - Integrating mental and behavioral health into primary care delivery; and
 - Awareness of cultural differences that impact health and outcomes.

Enable a Data-Driven, Interoperable Health Care System

A modern, connected, informed, and effective health care system requires access to secure, actionable data when and where it matters most to enable continuous improvement and innovation. Realizing the full potential of data can be achieved by:

- **Authorizing rapid development and implementation of a common, streamlined set of data standards for interoperability** to leverage investments from Meaningful Use and enable seamless, secure, and timely electronic information exchange for improving clinical care, the consumer experience, and productivity of health care resources.
- **Advancing the adoption of health information exchange capabilities by incentivizing the use of open architectures, connected databases, and common patient identifiers** to securely share actionable data and more easily combine data sets for deeper clinical insights.
- **Establishing and enforcing meaningful penalties to prohibit data blocking** that impedes seamless information exchange between providers, payers, and consumers.
- **Incentivizing all care settings to electronically collect and share data with providers, payers, and consumers** to enable personalized and coordinated care plans and treatments.
- **Funding public-private partnerships focused on expanding access to, and use of, Federal and State government health care data**, thereby advancing innovation, developing evidence-based treatments, and improving patient outcomes.

Invest in Medical and Health Services Research and Innovation

Identifying, promoting, and advancing new and more precise cures and interventions will improve outcomes, prevent diseases, and reduce public health risks. Accelerating such medical and health services innovation in the U.S. will require targeted increases in funding and adjustments to the budgets of select Federal Agencies to enhance their capabilities to complement and support private-sector research. Specific solutions include:

- Advancing efforts at the National Institutes of Health (NIH) to **accelerate innovation and adapt to rapid changes in science**. Key initiatives should include expanding existing research and development (R&D) programs, developing new research platforms to share pre-competitive research to improve R&D productivity, and ensuring balanced resource allocation between basic science and condition-specific research programs.
- Maximizing the utility of the Food and Drug Administration's (FDA) resources to **accelerate safe and timely access to new drugs and devices including generic and second-to-market equivalents**. Key initiatives should include analyzing post-market drug outcomes data to identify new and targeted uses for existing drugs, streamlining generic drug review programs, and developing a national device evaluation and surveillance system.
- Directing Centers for Disease Control (CDC) funding to **expand prevention research and enable timely diagnosis and response to public health threats**. Key initiatives should include analyzing patient data to identify more precise prevention and treatment protocols, developing surveillance tools to proactively detect emerging health risks, and ensuring appropriate resources to respond to outbreaks and epidemics.
- Preserving and increasing Agency for Healthcare Research & Quality (AHRQ) funding to **continue its mission of developing care standards to improve health care quality and patient safety**. Key initiatives should include accelerating translation of evidence into diagnostic and clinical guidelines, expanding comparative effectiveness research to support value-based care delivery, and tracking and analyzing the impact of new treatments on patient safety.

Prioritize Prevention

Preventing or delaying the onset of new cases of chronic conditions would improve the health of Americans while lowering overall health care costs. Improving outcomes for all Americans by emphasizing prevention and health promotion requires both an increased adoption of existing evidence-based preventive services and targeted investments to expand the breadth and depth of prevention efforts to address key determinants of health, including social and environmental factors. Specific solutions include:

- **Authorizing flexibility and removing restrictive caps on incentive designs to support consumers seeking preventive services**, in order to prevent, identify, and manage disease earlier.
- **Increasing investment in Federal and private-sector led prevention research and development of data tools to identify and develop new, effective prevention programs** that are personalized for age, gender, and condition, and targeted in areas with greatest clinical and social burden.
- **Ensuring prevention resources and wellness initiatives are designated as quality improvement activities**, not administrative costs, to drive widespread adoption of evidence-based programs.
- **Amending the Congressional Budget Office (CBO) scoring methodology** to reflect the initial investments, as well as the long-term outcomes and resultant budget savings, of successful prevention programs.
- **Funding proven, evidence-based lifestyle intervention programs and community-based activities** that prevent the on-set of chronic disease.

At UnitedHealth Group, we help solve the world's health care challenges and improve health care for all – care recipients, providers and payers alike. This is achieved through two distinct business platforms: UnitedHealthcare, a health care benefits company, and Optum, a health services and innovation company. Collectively, these distinct yet connected capabilities allow us to improve access to care, achieve higher quality care, reduce costs, increase transparency, and ultimately produce superior health outcomes. This commitment to innovation and momentum for change inspire the women and men of UnitedHealth Group to continuously help people live healthier lives and make the health system work better for all.

Learn more about our ideas at www.unitedhealthgroup.com/modernization.

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