

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 State-based 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.



Improve Access to Care

Establish State-Based Public and Private Market Solutions, Provide States Flexibility to Design Cost-Effective Coverage Solutions, Revitalize the Private Individual Market, and Strengthen and Grow Employer-Sponsored Insurance



Make Health Care More Affordable

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



Strengthen and Modernize Medicare

Fund Medicare Advantage and Modernize Original Medicare



Reinvest in Health

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

Improve Access to Care through State-Based Health Care Market Solutions

Of the 324 million people in the United States, employer-sponsored insurance covers 174 million, Medicaid and related State-based health programs cover 75 million, Medicare serves 56 million, Exchanges cover approximately 10 million, and 28 million people remain uninsured.

There are many components of the Affordable Care Act (ACA) that should be immediately replaced with proven, more sustainable State-based public and private market solutions, improving consumer choice and access to higher quality, lower cost health care. Additionally, there are several elements of the ACA which should be retained as effective solutions, limiting disruption and ensuring necessary market reforms and funding are retained. These and other health reforms should protect and preserve the stability, choice, and success of existing market segments such as employer-sponsored insurance, Medicare Advantage, and Medicaid.

Exchanges have failed to achieve enrollment expectations of 26 million people in 2017 due to flawed product designs which limit choice, higher than expected per capita costs which discourage healthy individuals from enrolling and staying enrolled, and unsustainable economics driving reductions in competition and choice among health plans. Exchanges remain compromised by loopholes that permit enrollment or expansion of coverage as health needs develop.

Many of the ACA's insurance market reforms – while increasing costs – have generally been positive. Importantly, however, the ACA's Health Insurance Tax and other taxes, which have aggravated already untenable health care costs, need to be immediately repealed. The Health Insurance Tax is currently being priced into policies carrying into 2018 and will increase 27% from 2016 levels.

Medicaid expansion is succeeding in cost-effectively expanding access to care. More than 16 million additional people have enrolled in Medicaid since 2013. A State-based, structured mechanism for coverage – with more value, flexibility, and superior performance than Exchanges – Medicaid has proven to be over 20% more cost-effective than Exchange coverage at delivering affordable and stable health care to millions of individuals.

Exchange beneficiaries, as well as the remaining uninsured in the United States, would gain the most from being in suitably managed State-based public and private market structures which are more stable, efficient, and effective.

Establishing the State as the benefits/coverage owner will require the flexibility to provide a coherent portfolio of State-based market approaches that recognize health care as a local reality with considerable variation from market to market.

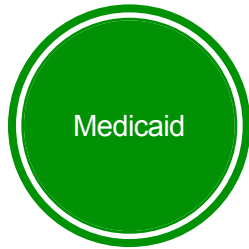
The following solutions are offered to achieve meaningful advances in access to coverage for millions of individuals, along with greater stability, affordability, and choice in health care and fit within the State-based markets approach described above.

State-Based Health Care Market Solutions

The Affordable Care Act's Exchanges should be transitioned to a simpler, flexible, and more affordable State-based coverage system shaped to fit the circumstances of the respective State communities. Access to coverage could increase – but would not decline – under this approach and would be sustainably funded. In addition to improving coverage for those who are currently insured, these State-based solutions would enable States to extend coverage to the remaining uninsured.

State-based Health Care Markets are...

A coherently organized portfolio of State-based public and private benefit coverage platforms dedicated to appropriately achieving targeted coverage, quality, and fiscal goals, including:



State-based Health Care Markets are better because they:

- Form a flexible and coherent market-based coverage system that is simpler and provides more choice;
- Are able to respond to the specific circumstances and needs of the State's communities;
- Are lower cost, using proven market-based solutions; and
- Achieve savings from discontinuing the cost to administer and support Federal Exchanges.

State-based Health Care Markets are established by:

Returning oversight of private insurance markets to States, and allowing insurers to offer innovative, cost-effective products that harmonize with States' other benefit coverage platforms.

Granting States the flexibility needed to **design, implement, and offer cost-effective, State-based Medicaid coverage solutions** in an effective and sustainable manner, by allowing States to:

- Passively enroll qualified individuals who cannot otherwise access creditable coverage;
- Design more localized, flexible health benefit designs to encourage appropriate use and place of services;
- Develop unique provider network structures that address geographic and population-specific needs;
- Establish provider payment rates based on the achievement of quality outcomes and affordability;
- Design and implement innovative consumer incentives and engagement tools;
- Establish appropriate consumer cost-sharing requirements, including income-specific copayments, deductibles, and premiums;
- Utilize financial tools – such as Health Savings Accounts (HSAs) – in benefit structures; and
- Implement enrollment strategies that simplify eligibility determinations.

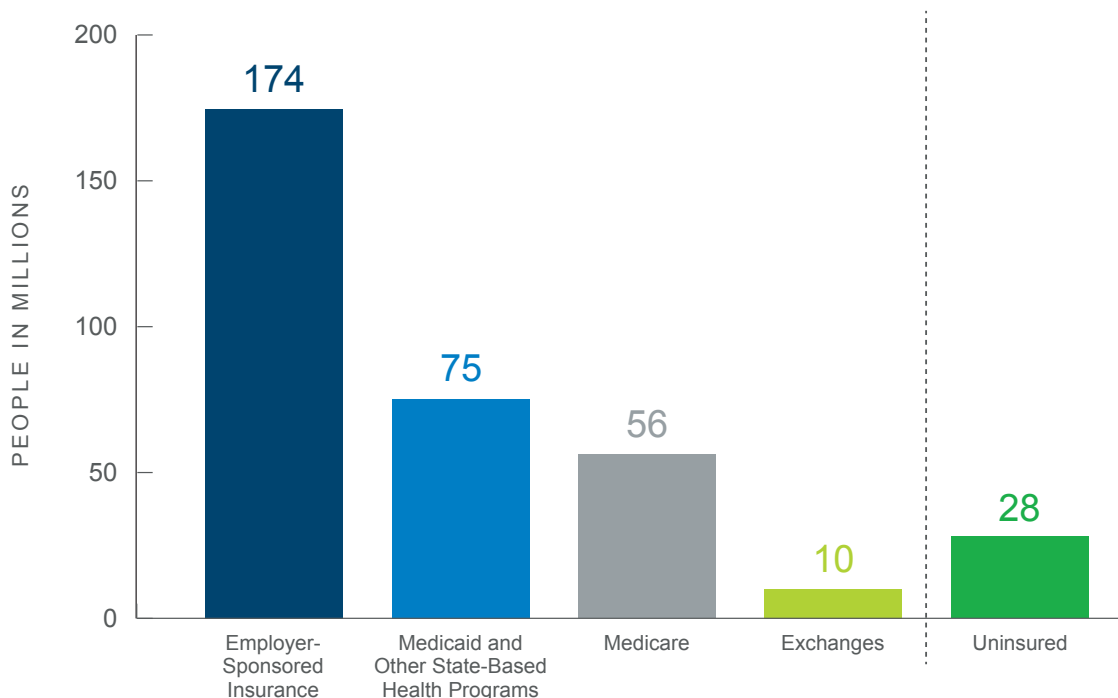
Ensure that Medicaid funding is fully dedicated to health care and adequately resourced to provide sustainable access for eligible individuals.

Immediate Actions to Stabilize Coverage and Improve Affordability

Taking the following actions – legislatively or administratively – would minimize disruption in the wake of a repeal effort by stabilizing access to coverage and improving affordability.

- Revitalize the Private Individual Market and restore consumer access and choice, by:
 - Eliminating federally-mandated essential health benefit requirements and metallic levels;
 - Restoring Age Rating Bands of 5:1;
 - Restoring short-term and limited coverage policies; and
 - Retaining the vast majority of ACA underwriting reforms and risk adjustment.
- Adequately fund Medicaid, retain the ACA's Medicaid expansion, and passively enroll eligible Medicaid beneficiaries.
- Transition the remaining insured under Exchanges and Exchange funding to State-based Market Solutions.
- Establish and fund structured and managed high risk pools – funded by the Federal government – to be administered by the States and private sector.
- Repeal ACA Taxes, including the Health Insurance Tax, immediately.
- Strengthen and grow Employer-Sponsored Insurance (ESI), by:
 - Supporting the current tax treatment of ESI;
 - Expanding access to, and incentives for, Health Savings Accounts; and
 - Allowing ERISA-like flexibility for all employers to tailor employee incentives and wellness programs.

U.S. Enrollment Totals by Market Segment, 2016



Note: Coverage estimates are neither exhaustive nor mutually exclusive and, therefore, do not sum to the population total. According to the U.S. Census Bureau, over 20% of insured individuals report coverage from multiple sources.

Make Health Care More Affordable

Health care spending in the United States will total over \$3.5 trillion in 2017 – more than any other country in the World – exceeding \$10,000 per person on average. Yet, approximately 28 million individuals 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 \$300 to \$400 billion in wasteful and avoidable spending. Specifically:

- Total health care spending is expected to rise to \$5.5 trillion, one fifth of the U.S. economy, by 2025.
- Prescription drugs account for 17% of total health care services spending.
- The average price of brand-name drugs rose 11% in 2016, up 208% since 2008.
- Drug spending is expected to rise 84% and hospital spending is expected to increase 71% between 2015 and 2025.
- Spending on hospital services increased by 5.6% in 2015 and surpassed \$1 trillion for the first time.
- \$500 billion in ACA taxes over 10 years have increased costs for States, employers, and consumers, including Medicare Advantage beneficiaries.
- The Health Insurance Tax is currently being priced into policies carrying into 2018 and will increase 27% from 2016 levels.

In previous 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 represent meaningful and impactful solutions to achieving health care affordability, improved health, and higher quality care. Leveraging private-sector tools, such as Pharmacy Benefits Managers (PBMs) – which save \$45 of every \$100 spent by directly negotiating with manufacturers – can lower costs by catalyzing payment reforms.

By reforming existing laws and enacting new policies – to minimize inefficiency, enhance the consumer experience, better leverage innovations, lower administrative costs and eliminate the need for reliance on harmful health care taxes, which only make health care more unaffordable – the following solutions will make the health care system more affordable, accessible, and effective for all Americans.

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 include:

- **Implementing value-based pricing for drugs and devices**, over a defined multi-year period, based on their quality, outcomes, and affordability relative to existing products, to limit excessive price increases.
- **Using Pharmacy Benefits Managers (PBMs) more widely** in government programs, such as Medicaid, to lower drug costs on behalf of consumers. PBMs saved seniors and the Federal government \$24 billion in Medicare Part D in 2015.
- **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 including 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.
- **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 ERISA-like flexibility for all 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 and Eliminate Harmful Taxes

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

- **Repealing the Health Insurance Tax** – and other Affordable Care Act taxes – which is currently being priced into policies carrying into 2018 and will increase 27% from 2016 levels.
- **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.
- **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.

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

The Medicare program, currently serving 56 million beneficiaries, is expected to grow to cover 75 million beneficiaries over the next ten years, with total Federal spending reaching \$1.4 trillion. The impact of continued enrollment growth and increasing costs is contributing to the program's anticipated insolvency by 2028 – two years before Medicare reaches its own 65th birthday.

With 11,000 new individuals entering the Medicare program each day and 66% of all beneficiaries living with three or more chronic conditions, the Original Medicare program is under significant stress. The confluence of these factors, coupled with an outdated program structure, will cause annual Medicare costs to reach nearly \$18,000 per beneficiary on average by 2025.

Approximately 70% of Medicare beneficiaries are enrolled in Original Medicare – an antiquated, volume over value approach that encourages wasteful spending, fails to promote efficiency, and under-delivers for our Nation's growing Medicare population. Original Medicare requires immediate solutions that reduce costs, improve quality, and modernize the health care experience for seniors.

Medicare Advantage, meanwhile, is delivering superior results to over 18 million beneficiaries, including 37% who have fixed annual incomes at or below \$20,000. The program's approach leverages private sector solutions that improve quality and reduce costs to meet seniors' health care needs. In fact, 68% of beneficiaries are currently in plans rated 4 stars and above, and 91% of beneficiaries report they are satisfied with Medicare Advantage.

While Original Medicare faces long-term sustainability challenges, Medicare Advantage is providing proven innovation in an effective and consumer-friendly manner. Medicare Advantage's high-quality, coordinated care approach results in beneficiaries experiencing 20% fewer hospital readmissions and a 20% increase in annual preventive care visits as compared to beneficiaries in Original Medicare. Beneficiaries enrolled in Medicare Advantage also receive financial protections not available in Original Medicare, such as reduced premiums and an out-of-pocket maximum, which provide needed financial security and predictability.

Despite the growing evidence that Medicare Advantage is outperforming Original Medicare, the Medicare Advantage program has been cut by 12% since 2010 – by both legislative and regulatory actions – undermining the very innovation, solutions, and results that serve as a model to modernize the Medicare program as a whole. The sustained underfunding of Medicare Advantage not only harms seniors but also harms employers, providers, governments, unions, and the health care system as a whole.

Strengthen Medicare Advantage

Policies that strengthen Medicare Advantage’s ability to reach its full potential in the marketplace are necessary to improve seniors’ health, reduce health care costs, and improve productivity of the health care system. Specific solutions include:

Ensuring Stable, Adequate, and Predictable Funding for Medicare Advantage

- **Ensuring sustainable and appropriate funding** during the annual regulatory rate-setting process;
- **Ensuring the risk adjustment system adequately and accurately reflects the costs** of delivering care;
- **Establishing a multi-year rate setting process** to allow for more predictable and stable offerings; and
- **Improving the simplicity and transparency of Medicare data.**

Building Upon and Improving the Medicare Advantage Program

- **Eliminating the ACA’s Medicare Advantage Benchmark Cap**, that reduces or eliminates quality bonuses for high-performing plans, which undermines advancements in paying for quality, reduces the incentive to improve quality, and disproportionately impacts 3 million Medicare Advantage beneficiaries;
- **Protecting comprehensive in-home primary care visits** that improve continuity and management of care;
- **Promoting customized, targeted beneficiary care by permanently authorizing Special Needs Plans;** and
- **Allowing Medicare Advantage the flexibility to offer customized benefits and cost sharing** to targeted beneficiaries who 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).

Modernize Original Medicare

Modernizing Original Medicare is necessary to address the key challenges facing the program. Specific solutions include:

Providing All Medicare Beneficiaries with Proven Value-Based Care to Improve Health Outcomes

- **Providing beneficiaries with access to proven care management programs** including evidence-based prevention and wellness programs, transitional care management programs, care coordination, and advanced illness, telehealth, and digital health services;
- **Requiring integrated services**, including disease management programs, palliative approaches, psychological care, and social services to help beneficiaries live in the setting of their choice;
- **Expanding utilization of real-time predictive modeling tools and comprehensive patient encounter data** to identify appropriate evidence-based interventions; and
- **Developing an alternative funding model for in-home primary care delivered by providers**, including nurse practitioners, to reduce barriers to care and address clinical, environmental, and social determinants of health. This model should include a physical and behavioral assessment and medication review with results shared electronically with the beneficiary and providers to ensure appropriate follow-up and seamless care delivery.

Modernize Original Medicare, cont'd

Fostering Innovation and Empowering Beneficiaries to Engage in Healthy Decision-Making

- **Providing funding for proven lifestyle intervention programs, community-based activities, and consumer-friendly tools** that prevent the onset of chronic disease;
- **Establishing Medicare-specific Health Savings Accounts (HSAs)** and authorizing Medicare beneficiaries to save before and during retirement for Medicare-related out-of-pocket costs;
- **Expanding 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; and
- **Modernizing and standardizing quality measurement across the Medicare program by:**
 - Aligning and synchronizing quality measures across all Medicare benefit options;
 - 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.

Improving Original Medicare's Existing Infrastructure to Ensure the Sustainability of the Medicare Program

- **Expanding value-based payment approaches** to promote quality among providers and remove the incentive for high-cost, low-value services;
- **Utilizing means testing** to support the long-term stability of Medicare;
- **Providing beneficiaries simple, consumer-friendly information** to make comparisons on quality and price;
- **Requiring that providers submit public, timely, and accurate directory information** to allow consumers to identify doctors, treatment facilities, and other care providers; and
- **Authorizing 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.

As 20 million people have gained access to care since 2010, the health care delivery system has been further strained without the appropriate investments in necessary innovation, research, and care delivery capabilities.

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.

Barriers to leveraging and exchanging standardized data hamper the health system's ability to drive continuous improvements and innovations in medical research and care delivery.

Collectively, these gaps in resources and capabilities are inhibiting Americans from accessing more effective treatments and interventions to improve their health and well-being.

In recent years, investment has decreased in medical and health services research and development, social services, and prevention efforts. Specifically, the U.S. share of global medical research funding declined from 57% in 2004 to 44% in 2011.

Meanwhile, the prevalence and costs of chronic diseases continue to grow, underlying 7 of 10 deaths annually. 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. The targeted use of evidence-based prevention – including screenings, immunizations, and lifestyle interventions – can improve health and productivity.

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 actionable data. As outlined in the following solutions, 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.

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 nurse practitioners and other clinicians 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. 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:

- **Accelerating and achieving interoperability through rapid development and implementation of common, streamlined data standards, reflecting private-sector capabilities**, 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.
- **Prohibiting data blocking – which impedes seamless information exchange between providers, payers, and consumers** – by defining and enforcing meaningful penalties, including those outlined in the 21st Century Cures Act.
- **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 Federal Agencies to enhance their capabilities to complement and support private-sector research by:

- 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.
- Leveraging 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 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 chronic conditions would improve the health of Americans while lowering overall health care costs. Improving outcomes requires both an increased adoption of evidence-based preventive services and targeted investments 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**, to prevent, identify, and manage disease earlier.
- **Increasing investment in Federal and private-sector led R&D 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.

 @UnitedHealthGrp

UNITEDHEALTH GROUP®

UnitedHealth Group
9900 Bren Road East, Minnetonka, MN 55343

©2017 UnitedHealth Group. All Rights Reserved. UnitedHealth Group is a registered trademark with the U.S. Patent and Trademark Office.

March 2017