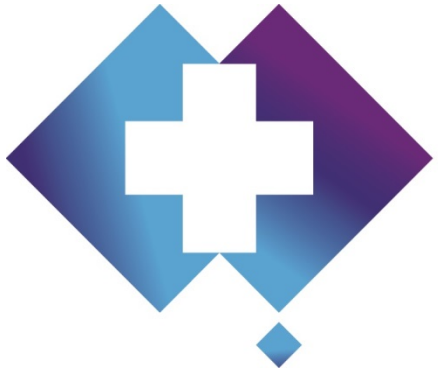


Private Healthcare Australia

Better Cover. Better Access. Better Care.

Panorama Rooms | Thursday 5 March, 2015 | 14:00

Mr David Abernethy

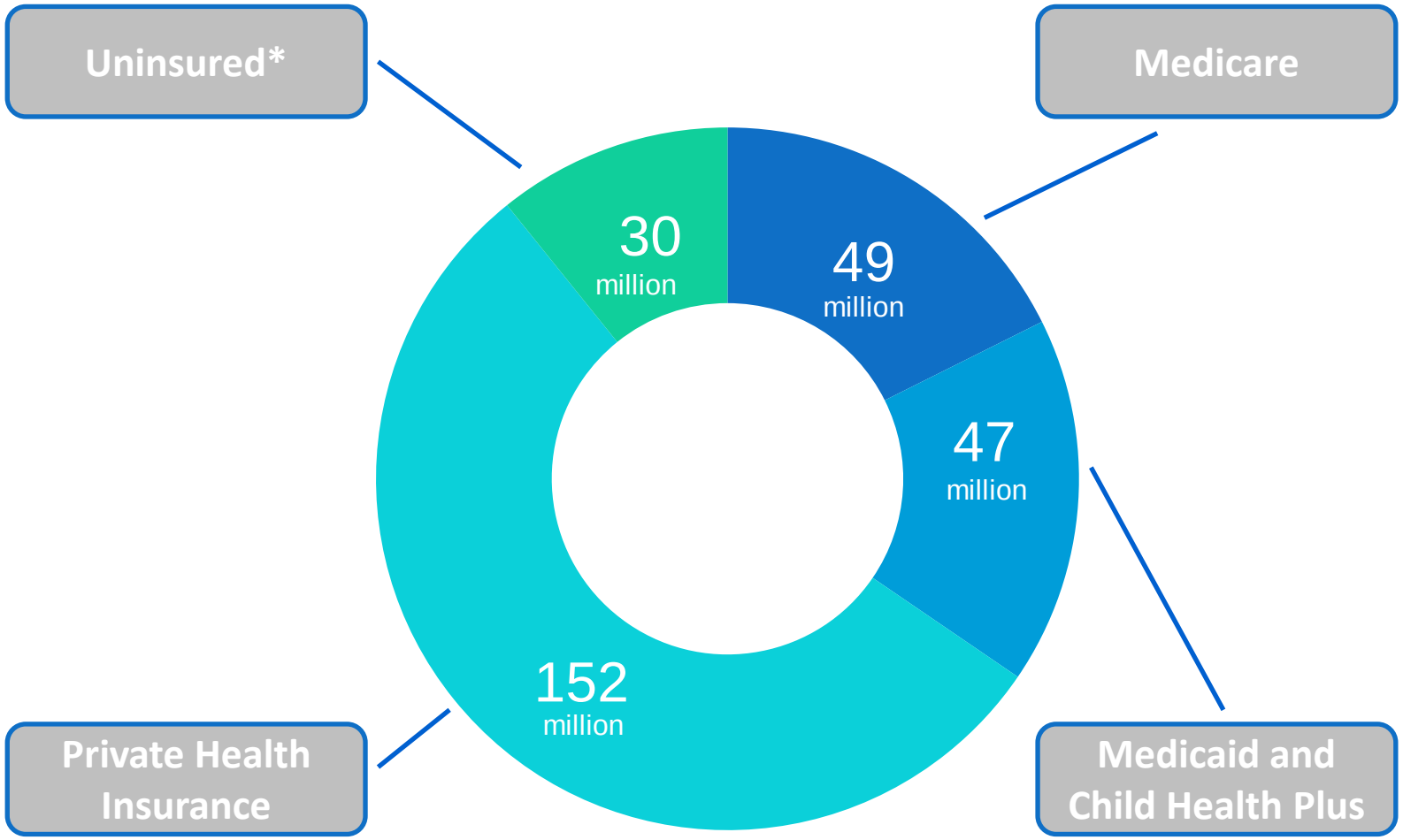
Health Policy & Government Relations Consultant, Washington, DC

Private Insurance Solutions in the US Social Insurance System for the Aged and Disabled

March 5, 2015

David S. Abernethy

US System Was and Is Fragmented



* Uninsured has dropped to less than 30 million at end of 2014

US System Was and Is Fragmented

Medicare	Medicaid and Child Health Plus	Private Health Insurance	Uninsured
• Operates primarily as a **fee-for-service payer** • Program sets prices it will pay based on various methodologies designed to restrict growth • Financed through combination of dedicated payroll tax and general revenue • Current costs about $500 billion annually	• Costs about $450 billion annually • Joint Federal/State program, administered by states with 1/3 of spending by states • Categorical eligibility • For most part does not cover non-disabled adults w/o children	• Covers **152 million** people	• **55 million** people uncovered prior to PPACA • **30 million** at end of 2014

American Medicare 101

- Over Age 65 and Disabled
- Social Insurance Program
- Employer and Employee Fund Premiums while working for Hospital Insurance
- Cost Sharing and General Revenue and Premiums while retired for Medical Insurance
- Premiums and General Revenue for Drug coverage

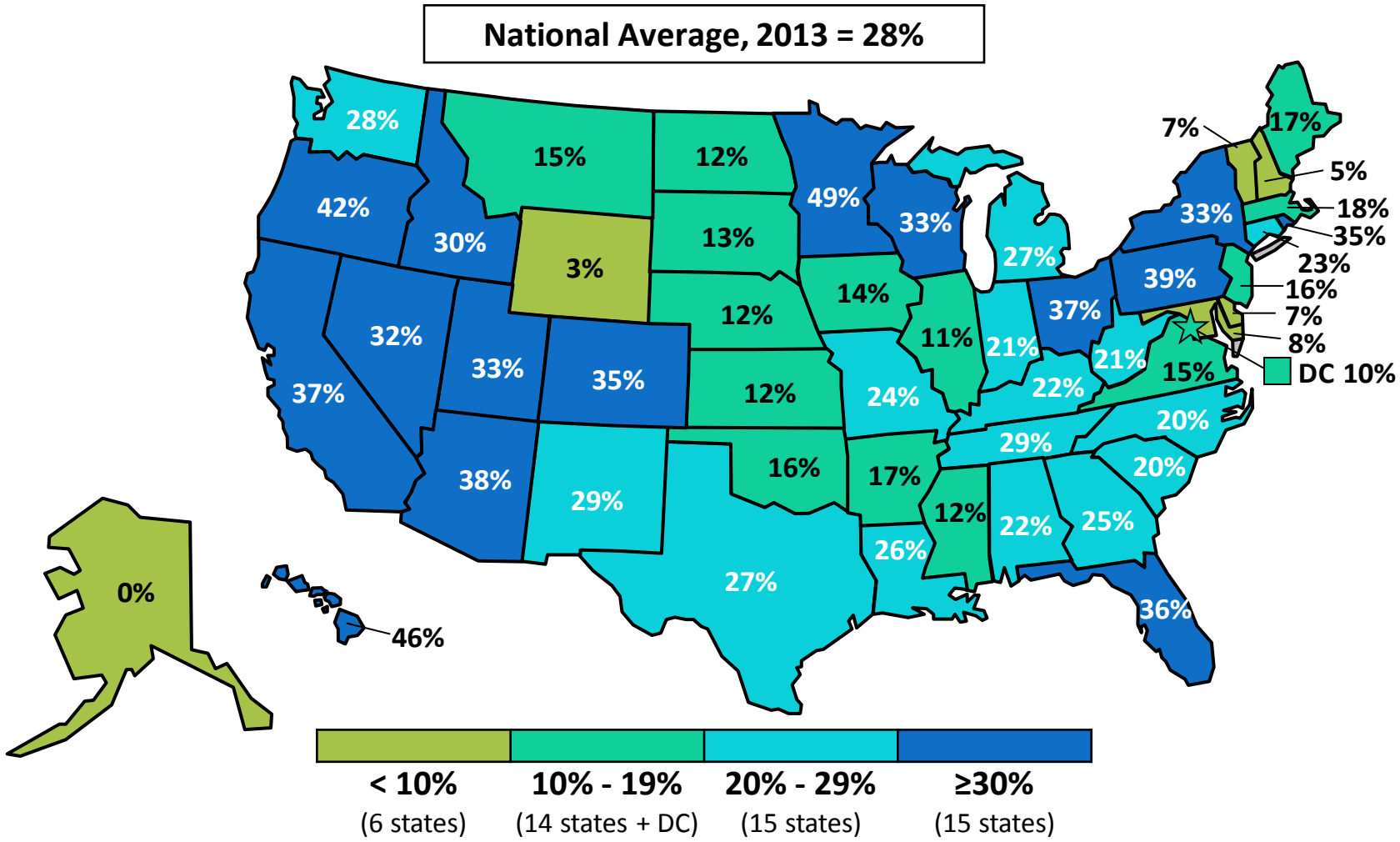
Original Medicare

- Hospital and Doctor Coverage
- Choose any Participating Provider (most do)
- Claims Paid, Cost Sharing Applied
- Mostly Fee-for-Service Payments
- Supplemental Insurance often purchased

Medicare Advantage

- Voluntary Program/Compete with Original Medicare
- Beneficiaries choose a Private Plan (for profit or not for profit) serving their area
- Beneficiaries choose to join MA and can leave any time
- Health Plans accountable to provide all Medicare benefits, plus more
- Monthly payment from Medicare risk adjusted (reflect higher and lower risk individuals)
- Health plans accountable for total care (hospital and physician) care
- Customer service is key
- Care management important to manage costs and quality
- Plans must return “savings” over FFS to beneficiaries in form of extra benefits

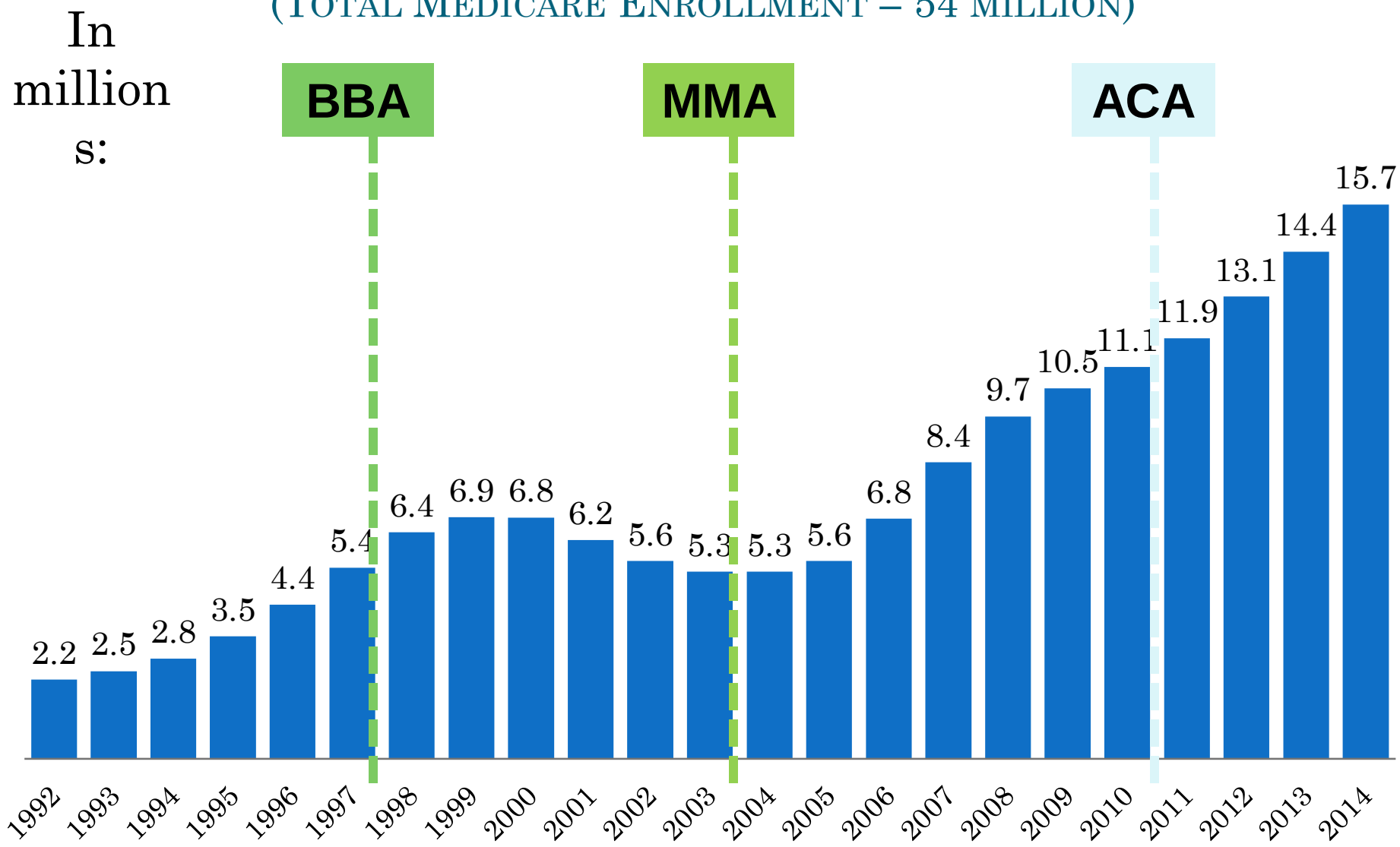
Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2013



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2013.

Total Medicare Advantage Enrollment, 1992-2014

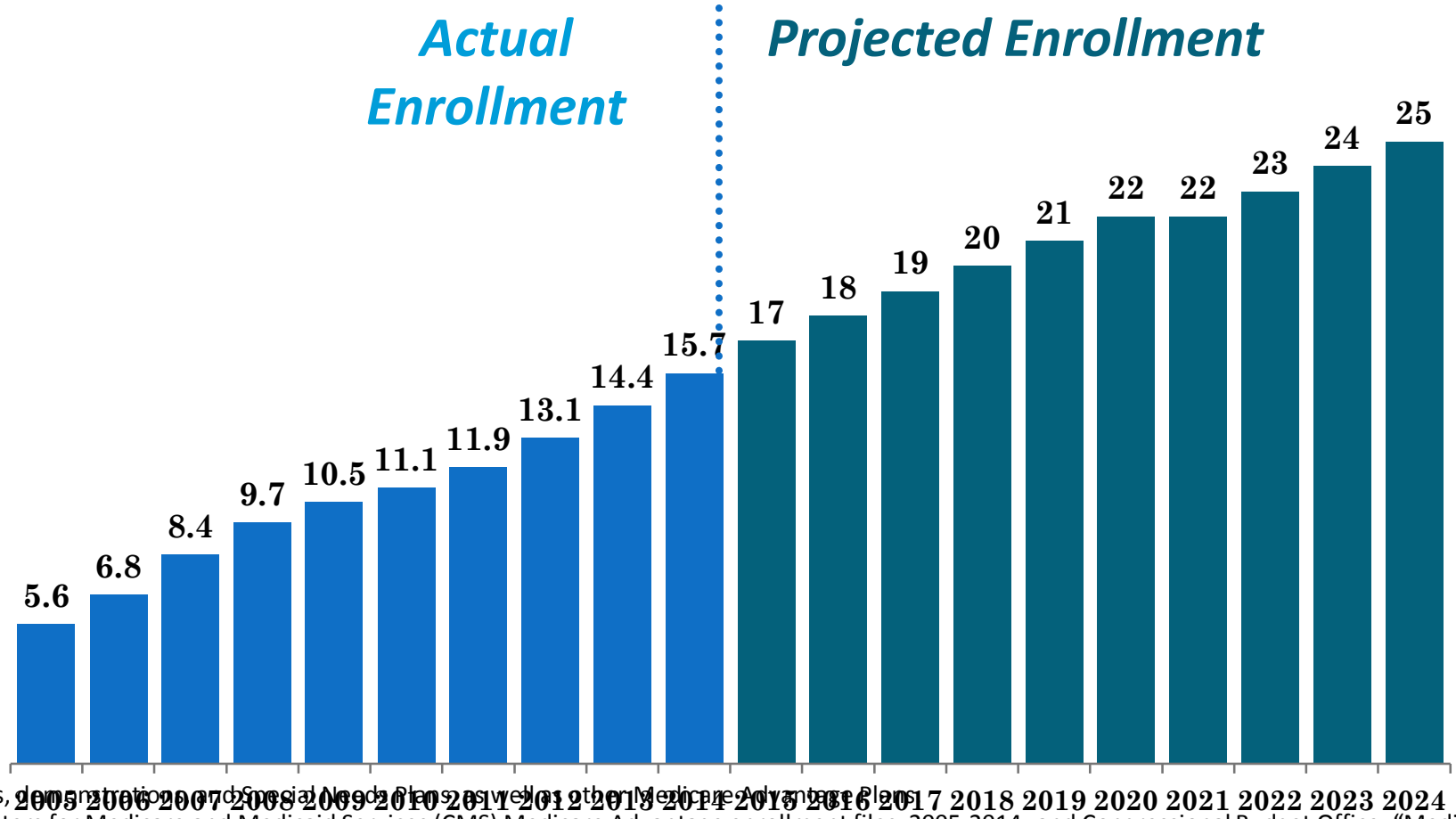
(Total Medicare Enrollment = 54 million)



NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001-2007. Report of the Medicare Board of Trustees, 2002.

Medicare Advantage enrollment has increased rapidly and is projected to continue to rise

Medicare Advantage Enrollment (in millions), 2005-2024

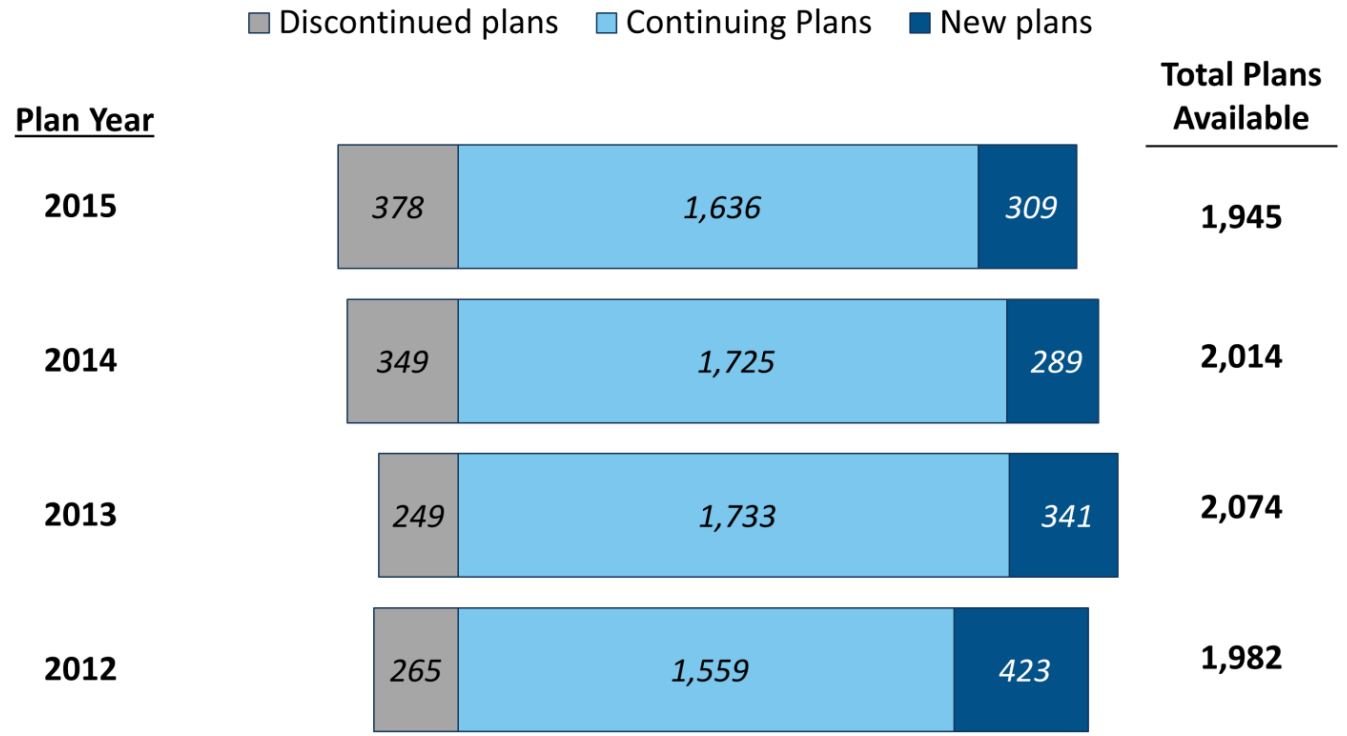


NOTE: Includes cost plans, MSAs, demonstrations and Special Needs Plans, as well as other Medicare Advantage Plans.
SOURCE: KFF analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage enrollment files, 2005-2014, and Congressional Budget Office, "Medicare Baseline," April 2014.

Wide Participation by Health Plans

Exhibit 2

Total Number of Medicare Advantage Plans Nationwide, Including Plan Exits and Entrants, For Plan Years 2012-2015



NOTE: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape Files for 2011 – 2015.

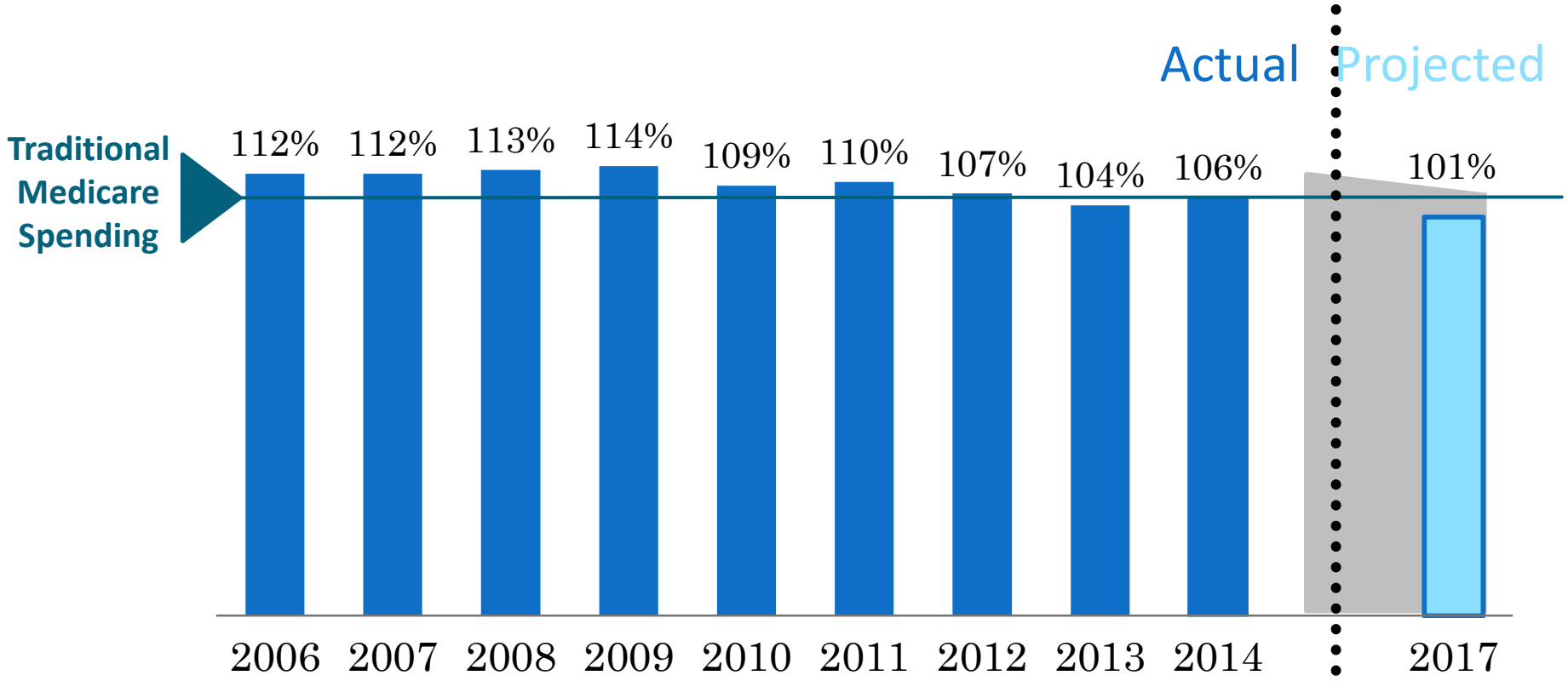
THE HENRY J. KAISER FAMILY FOUNDATION

Medicare Advantage

- Originally enacted as part of TEFRA in 1982, termed "Risk-contracting Program
  - Operational in 1985
  - Focused on contracts with HMOs
  - Payment set at 95% of average adjusted cost of traditional Medicare in each county
- Changed to Medicare+Choice in 1987 as part of Balanced Budget Act
  - US House Speaker Newt Gingrich said he would let Medicare's administrative agency HCFA "wither on the vine"
  - Expanded program to PPOs, Provider-sponsored organizations, and private fee-for-service plans
  - Some payments reduced below 95% in higher-cost areas while some increased far above 100%
    - Rural floor and floor for certain suburban counties
    - Payments reached as high as 125% of FFS
    - Overall average payments reached 102% of FFS in 2009
- Renamed Medicare Advantage as part of Medicare Modernization Act of 2003
- Payments further reduced in Affordable Care Act of 2010
  - Counties split into quartiles and paid at 95%, 100%, 107.5, and 115% of FFS
  - Imposed 85% minimum medical loss ratio
- ACA adds Star Ratings Program which affects payment

Medicare has been paying more for beneficiaries in Medicare Advantage plans than for those in traditional Medicare

Average Medicare Advantage Payments as a Percentage of Traditional Medicare Spending



SOURCE: Medicare Payment Advisory Commission (MedPAC) Report to Congress, 2006-2014.

Medicare Advantage Payments 101

- Medicare Advantage plans submit a bid to the government based on estimated costs per enrollee for traditional Medicare benefits
- Bids are compared to a benchmark, which is established by a statutory formula and varies by county
- Benchmark is the maximum amount Medicare will pay a plan in a given area
- Payments adjusted for demographic and health status (risk adjustment)
  - Demographic Adjustments: Age, Gender, Medicaid Status, Institutional Status
  - Health Status: 171 Health Condition Codes (HCCs)
  - Star rating

Affordable Care Act County Benchmark Groups

Benchmark cohort: as a percent of FFS costs	2009 Medicare beneficiaries (in millions)1	Share of Medicare beneficiaries	2009 Medicare Advantage enrollees (in millions)1	Share of Medicare Advantage enrollees	Share of Medicare Advantage enrollees living in urban counties
95%	18.3	41%	4.3	42%	93%
100%	11.4	25%	2.5	25%	81%
107.5%	8.7	19%	1.8	18%	70%
115%	6.7	15%	1.6	15%	59%
National	**45.2**	**100%**	**10.3**	**100%**	**81%**

Medicare Advantage Plans are regulated on many dimensions

- Audits
- Appeals
- Benefit Design
- Bidding Process
- Contracting Process
- Data and Reporting Requirements
- Marketing and Member Materials
- Provider Access

Star Ratings

- **Staying healthy**: screenings, tests, and vaccines: Includes whether members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions:** Includes how often members with different conditions got certain tests and treatments that help them manage their condition.
- **Member experience with the health plan**: Includes ratings of member satisfaction with the plan.
- **Member complaints and changes in the health plan's performance:** Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- **Health plan customer service**: Includes how well the plan handles member appeals.

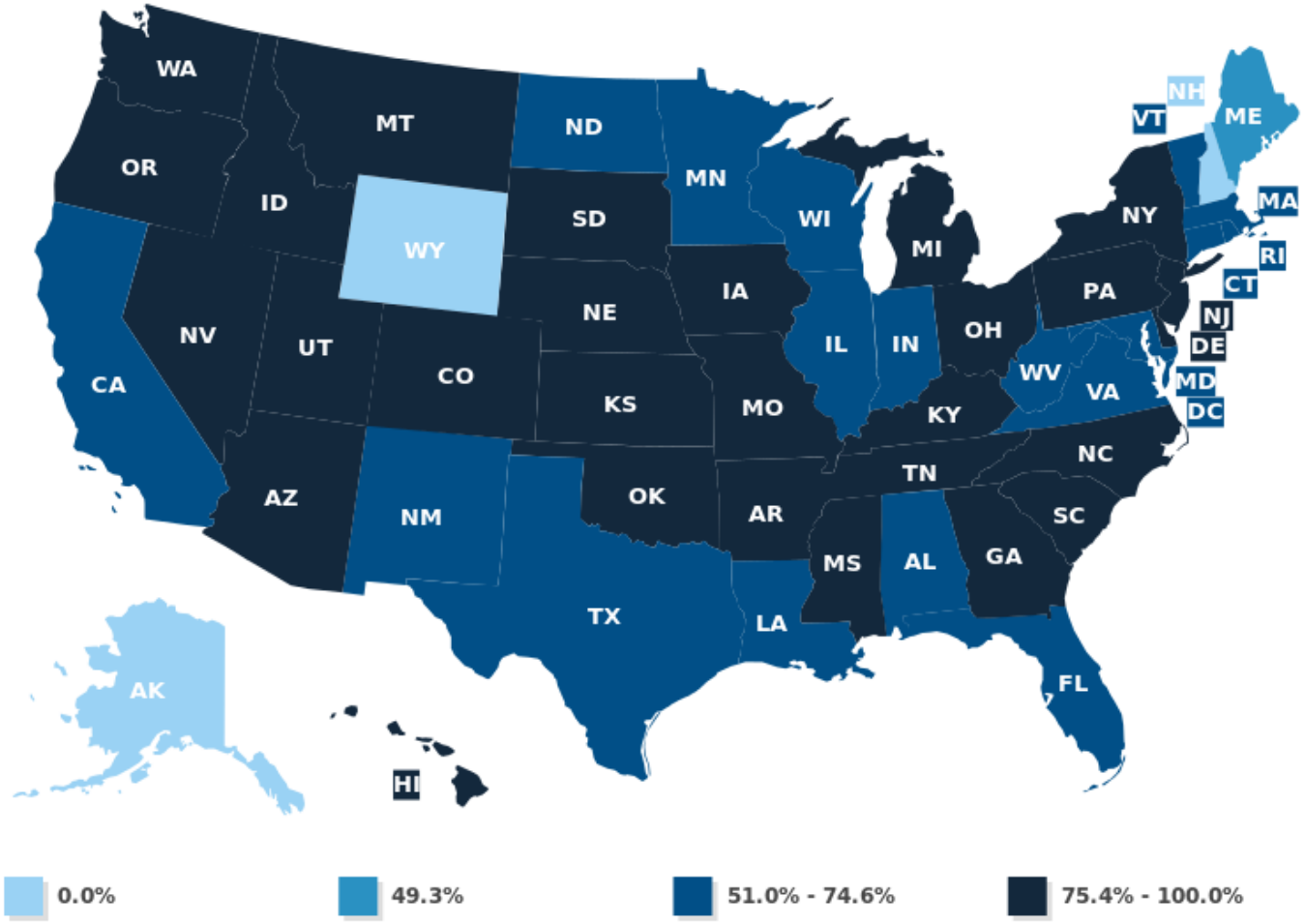
Star Ratings

- Health plans incented to get best possible star rating.
- Additional payments for best programs, payment cuts for lower rated plans.
  - Up to five percent increase in payment for 5-star plans
  - Bonus must be used to pay for extra benefits
- Open enrollment longer for five-star plans.

Protecting Medicare Advantage

- Very fast growth track after long slow increase.
- Beneficiaries see value; like what they had pre/65.
- Effective grassroots…over 1.7 million beneficiaries in coalition.
- Grasstops – Key decision makers (politicians, business owners).
- Effective and Coordinated Communications Strategy to support the program has been key to its growth.

Medicaid Managed Care is 74.2% of 42 Million Beneficiaries



Health Plan Role

- Nearly half of U.S. health expenditures is in government programs…important to diversify into these growing programs.
- Some health plans only service government programs, most serve both government programs and private individual and employer markets.
- Government programs can be important part of the overall health plan business and plans can leverage their expertise to support government programs.
- Significant commitment of resources, compliance, customer service, and financial management.