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Moving Health Care Risk to the P & C World

Presented By:

GERALD W. FRYE

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Health Care Risk Drivers

ACA Drivers

- Mandated richer benefits
- No lifetime limits
- Limits on deductibles and out-of-pockets
- Guaranteed issue, community rating
- Outcomes of ACA

Health Care Drivers

- Specialty medications
- Medical technology

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Principles of Ratemaking

- **Principle 1:** A rate is an estimate of expected value of future costs.
- **Principle 2:** A rate provides for all costs associated with the transfer of risk.
- **Principle 3:** A rate provides for the costs associated with an individual risk transfer.
- **Principle 4:** A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

Excerpted from the Statement of Principles Regarding Property and Casualty Ratemaking

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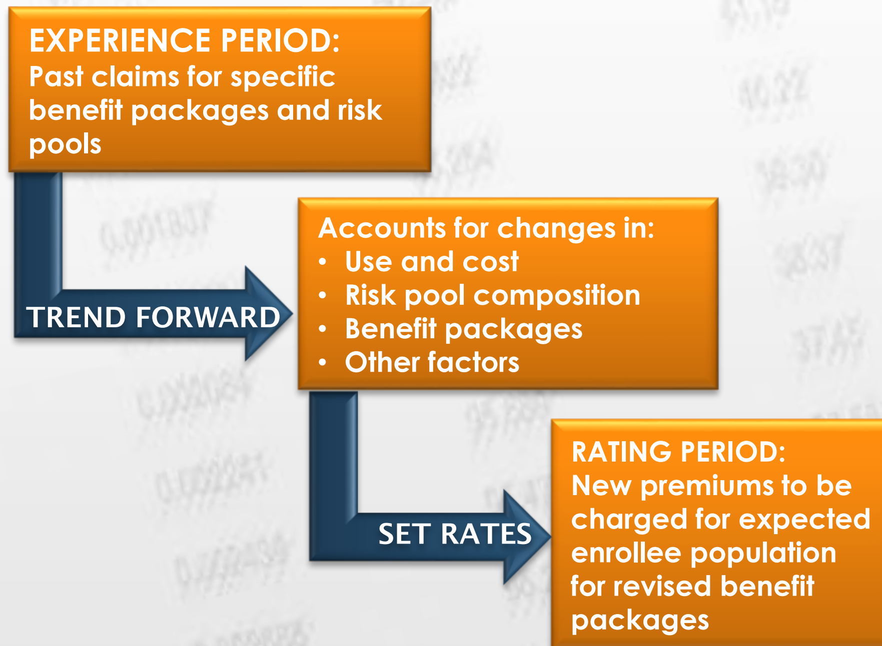
Traditional Pricing for Health Insurer Blocks of Business



Determination of Premiums

Key unknowns introduced by the ACA:

- Selection issues affecting Exchange risk pool
- Service use by the previously uninsured
- Essential health benefits
- Details of risk mitigation programs
- Change in behavior of health care providers

Source: "**The Challenges of Pricing Health Insurance for the 2014 Exchanges";** Alice F. Rosenblatt, FSA, MAAA, CERA AFR Consulting, LLC; *October 2012; National Institute For Health Care Management;* www.nihcm.org

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ACA Community Rating

Rating Restrictions – Health Insurance Premiums for Individual and Small Group

Rate factors limited to:

- Family structure
- Benefit plan design
- Geography
- Age (3:1 limit)
- Tobacco use (1.5:1 limit)

Rate may not vary by:

- Gender
- Health status
- Claims history
- Medical underwriting
- Group size
- Industry

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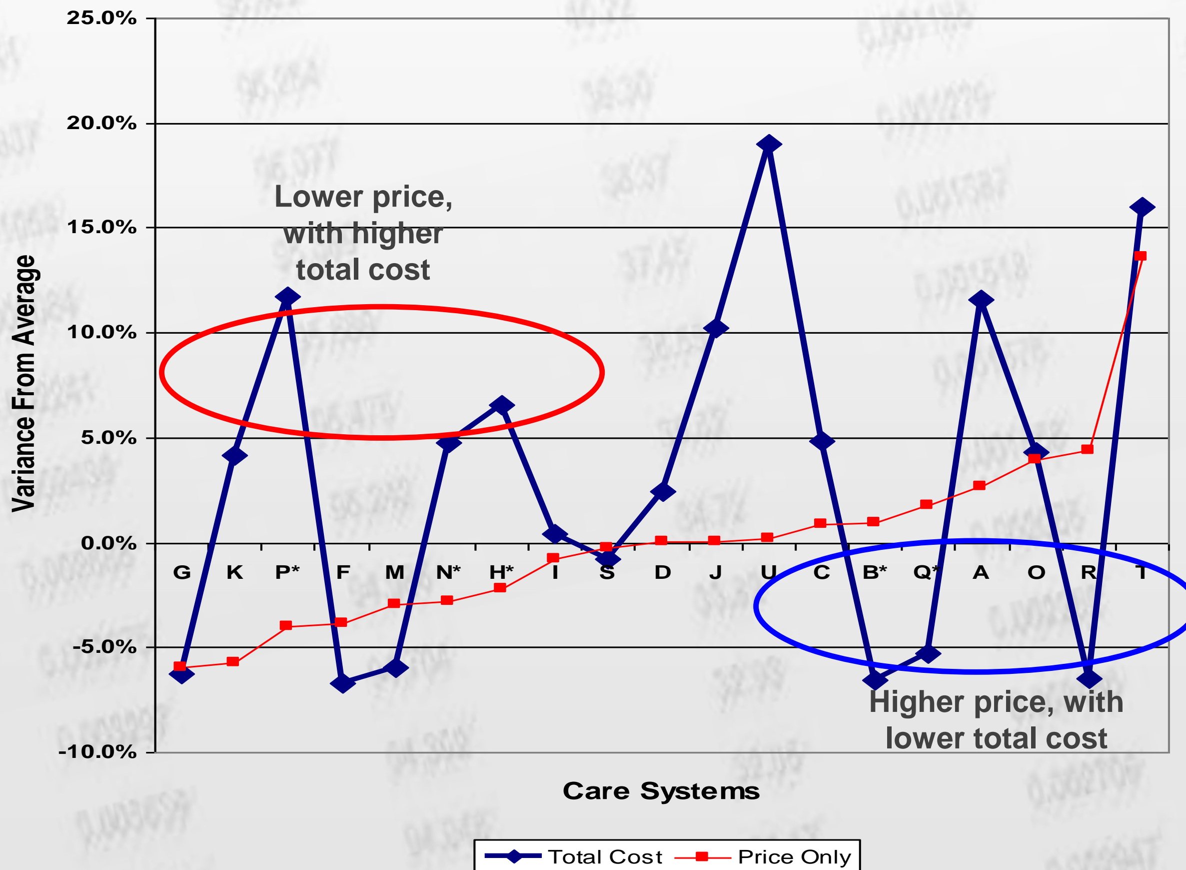
Price Does Not Predict Cost



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Rates and Cost of Exchange Coverage

Perceived Cost

True Cost

Subsidies help with affordability, but don't lower the true cost of insurance.

Subsidies

Underlying Medical Costs

Essential Benefits

Premium Taxes

Age Rating

Increased Cost-Shifting

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Perceived Cost in ACA

ACA Premium Credits	
Family Income	Max. premium payment as percentage of income
100 – 133% FPL	2%
133 – 150% FPL	3 – 4%
150 – 200% FPL	4 – 6.3%
200 – 250% FPL	6.3 – 8.05%
250 – 300% FPL	8.05 – 9.5%
300 – 400% FPL	9.5%

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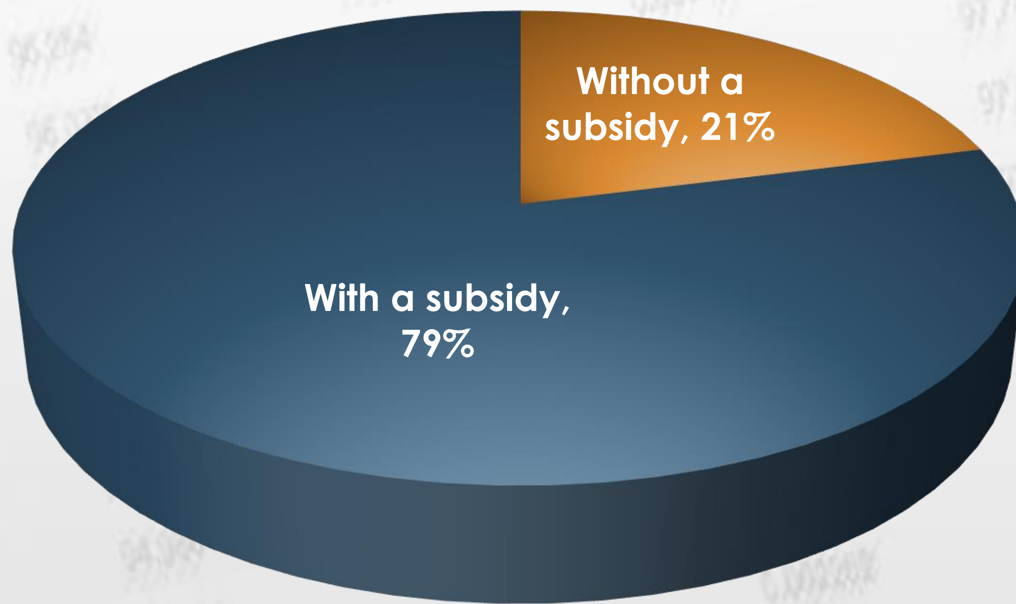
Subsidies and Enrollment



All data are from the Department of Health and Human Services, through Dec. 28, 2013.

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Premiums Vary by State

Average silver plan premium for a 40-year-old

370 450 520 $600

Source: Avalere Health

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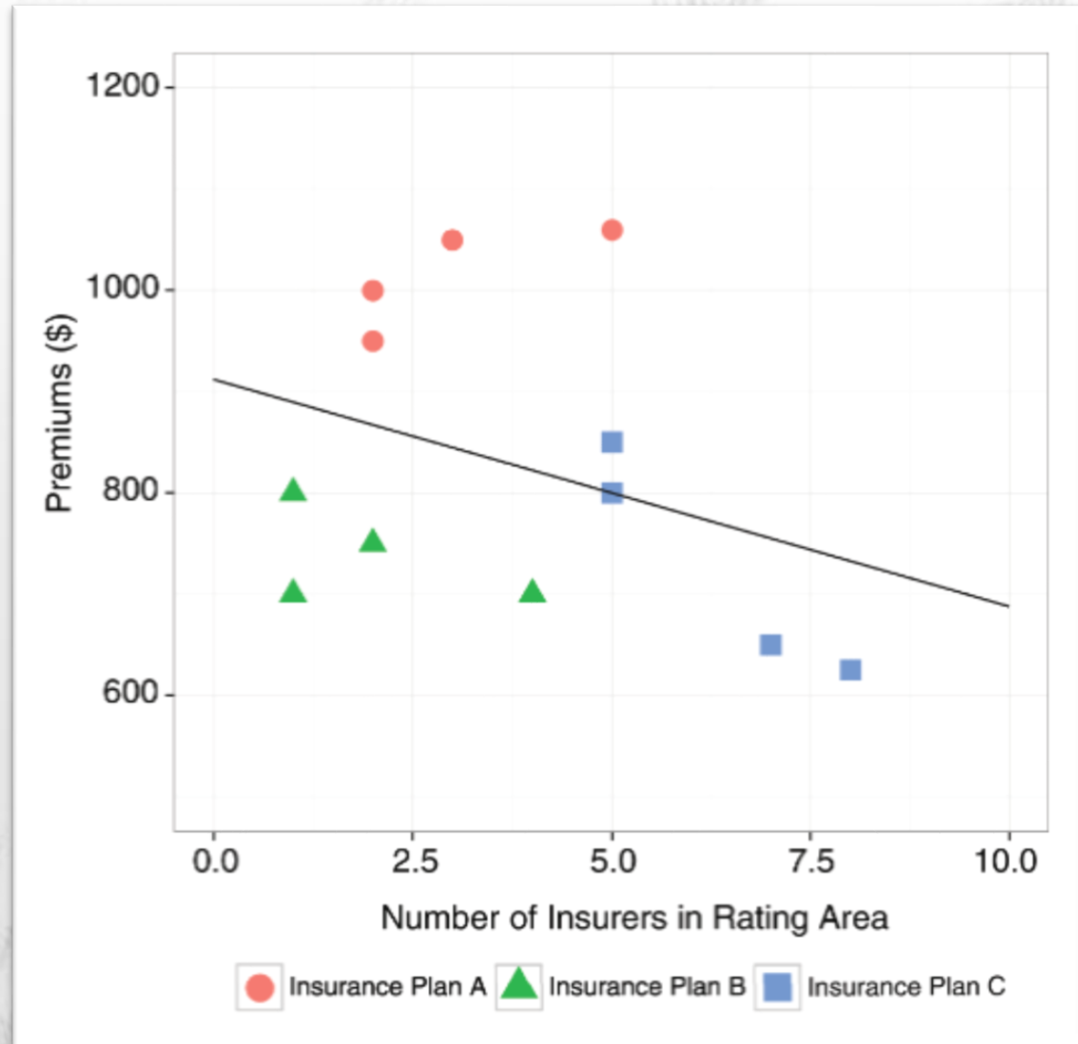
Premiums vs. # of Insurers

Figure 1. A simple linear regression (Ordinary Least Squares) is plotted comparing premiums on the number of insurers per rating area.



Cohen JN, Coppock A, Ghosh AK and Geisler BP 2015 [v1; ref status: awaiting peer review, http://f1000r.es/4zl] F1000Research 2015, 4:25 (doi:10.12688/f1000research.6039.1)

F1000Research

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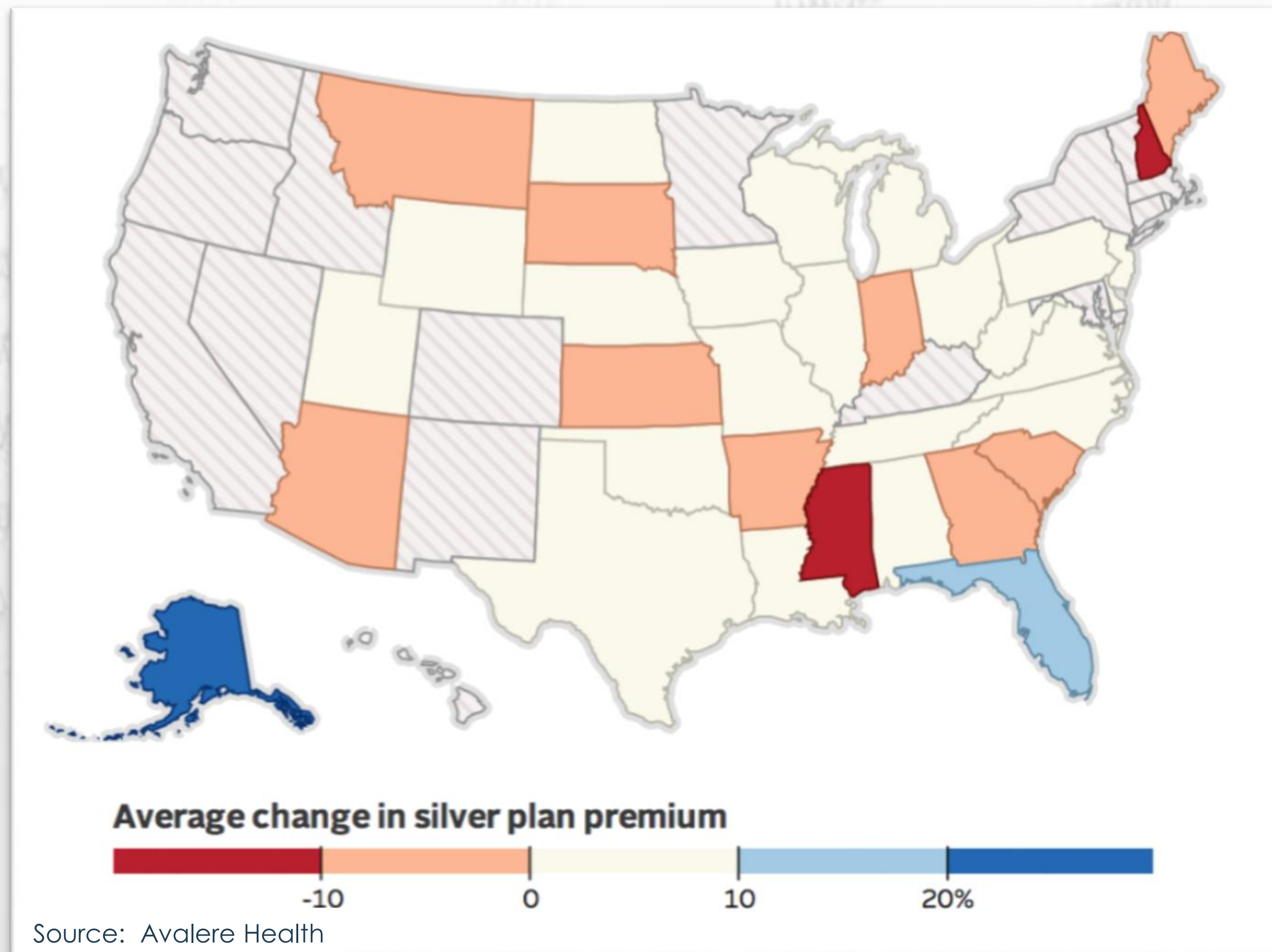
Premium Changes by State 2014 vs. 2015



Source: Avalere Health

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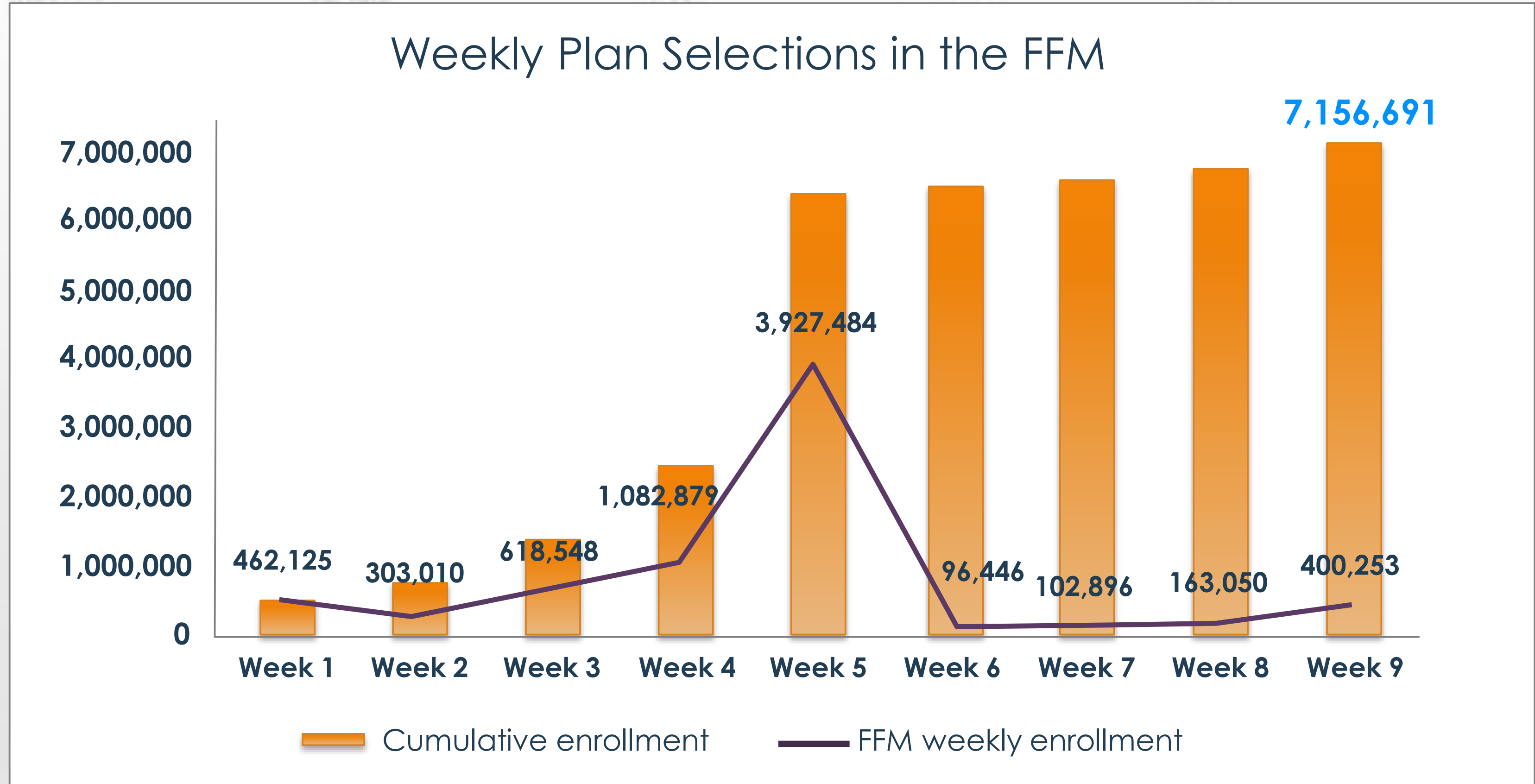
FFM Exchange Enrollment Nov. 2014 - Jan 21 2015

Enrollment ends Feb 15, 2015



More than 7.1 million individuals enrolled in coverage through FFM

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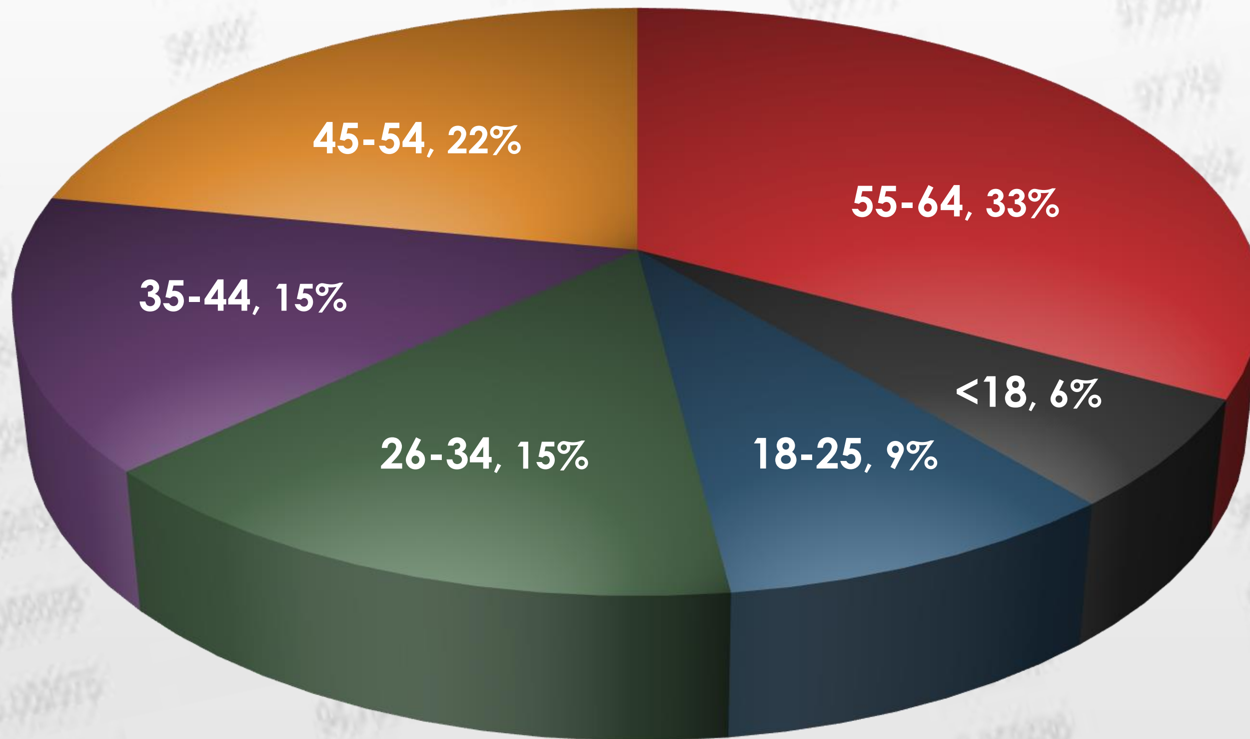
Enrollment by Age



All data are from the Department of Health and Human Services, through Dec. 28, 2013.

55-64 <18 18-25 26-34 35-44 45-54

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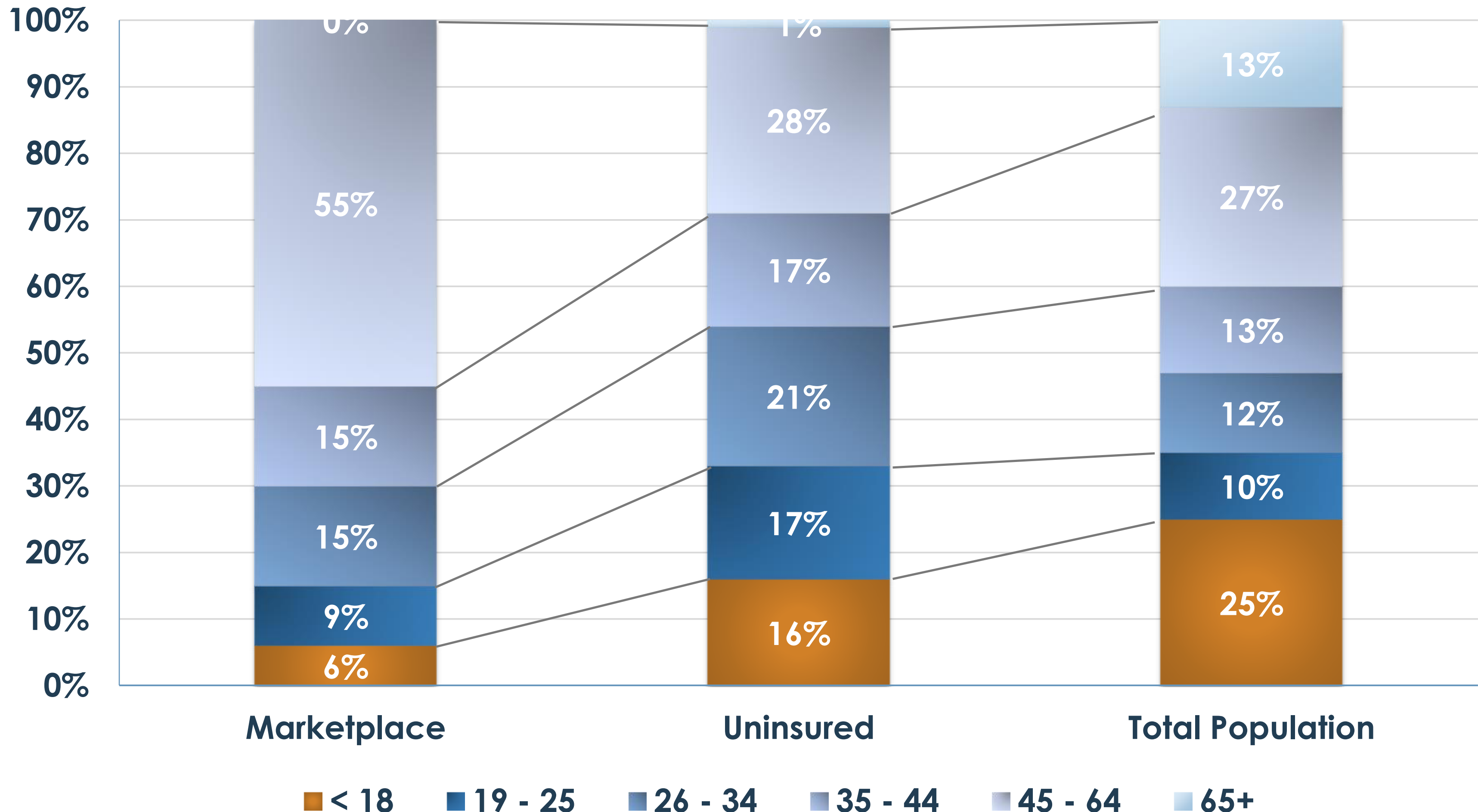
Profile of the Uninsured vs. Total Population by Age, 2011



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Marketplace Summary Analysis

- Last year 3.8 million individuals enrolled in marketplace plans during the last month.
  - Many plans are hoping that younger, healthier enrollees join before the deadline.
- The health insurance marketplaces remain a tale of "micro-market to micro-market."
- Rating, level of competition, level of public outreach and the characteristics and numbers of the eligible population vary dramatically by each state and market and contribute to diverse results.
- Health plans and other stakeholders are closely watching the results to gauge whether consumer retention stays consistent year over year.
- If the marketplaces prove to be "sticky" for health plans, the business could be more attractive to health plans, ultimately helping to drive greater interest and commitment to the market.

(Source: HHS, "Open Enrollment Week 10: January 17, 2015 — January 23, 2015," January 28, 2015)

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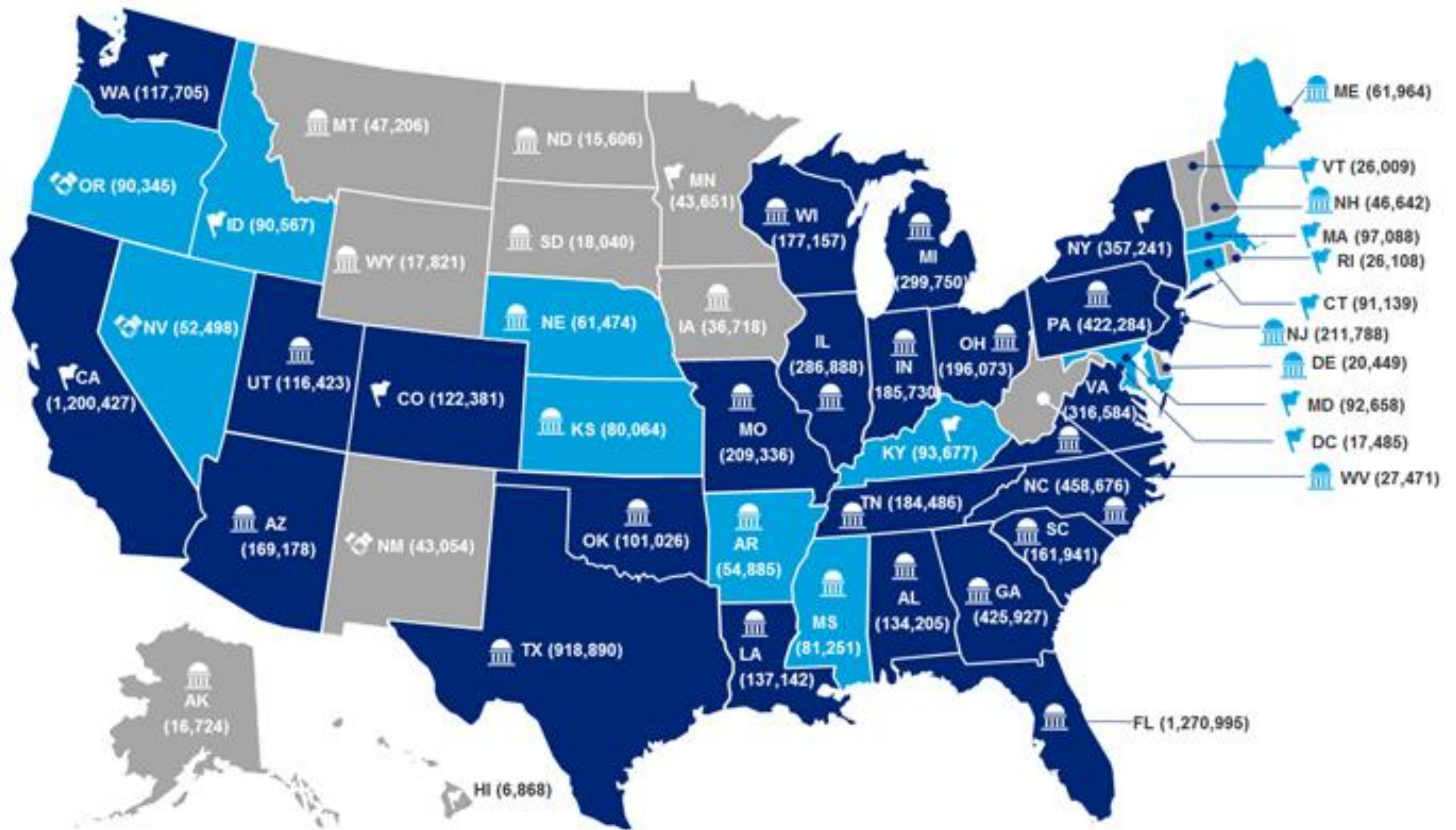

Legend:

1,000-50,000 individuals	50,000-99,999 individuals	100,000+ individuals

	State-based marketplace		SBM running FFM platform		Federally facilitated marketplace

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California – A Bellwether?

Source: Kaiser Health News

Blue Shield of CA is not selling in certain areas of California because it could not find enough providers willing to accept a level of payment that would keep premiums low. The company also is not selling where there is no contracted hospital within 15 miles.

Consequences of the lack of hospital and physician networks:

- 30,000 Individuals affected
- Anthem is now the only marketplace option
- Off-marketplace coverage available through two other carriers, but no subsidies for non-marketplace coverage

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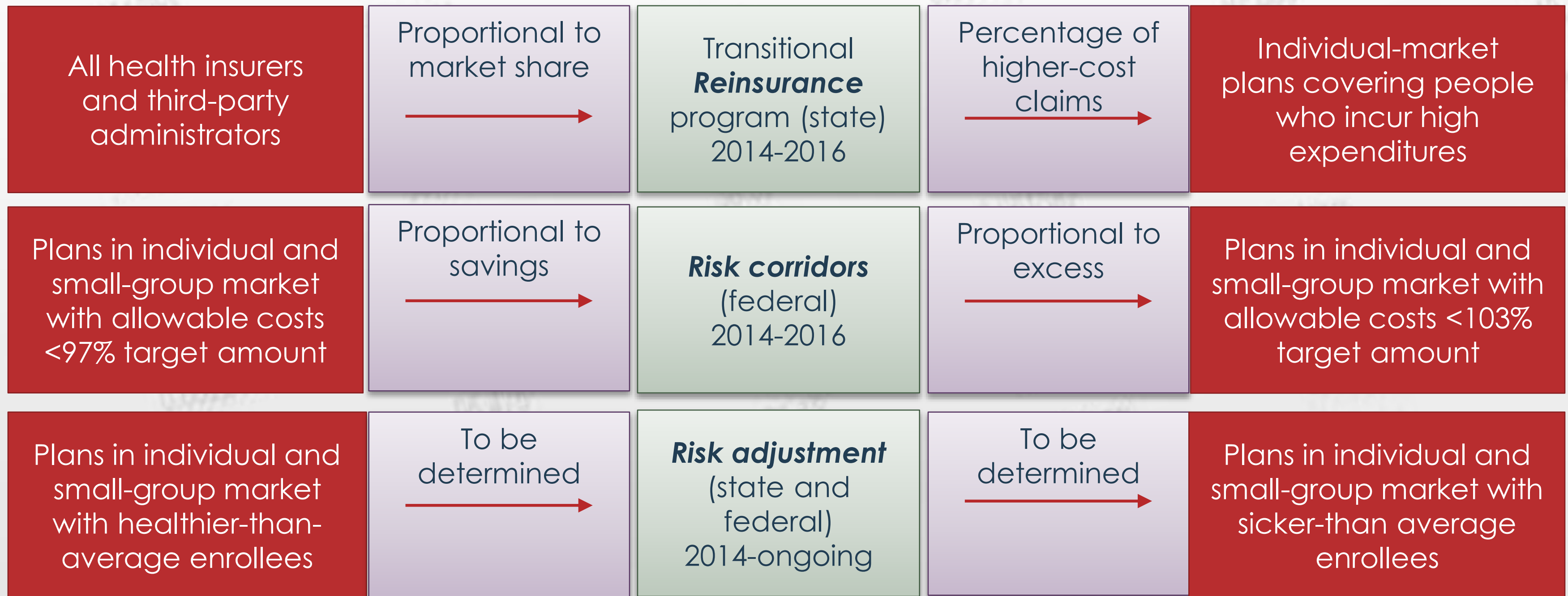
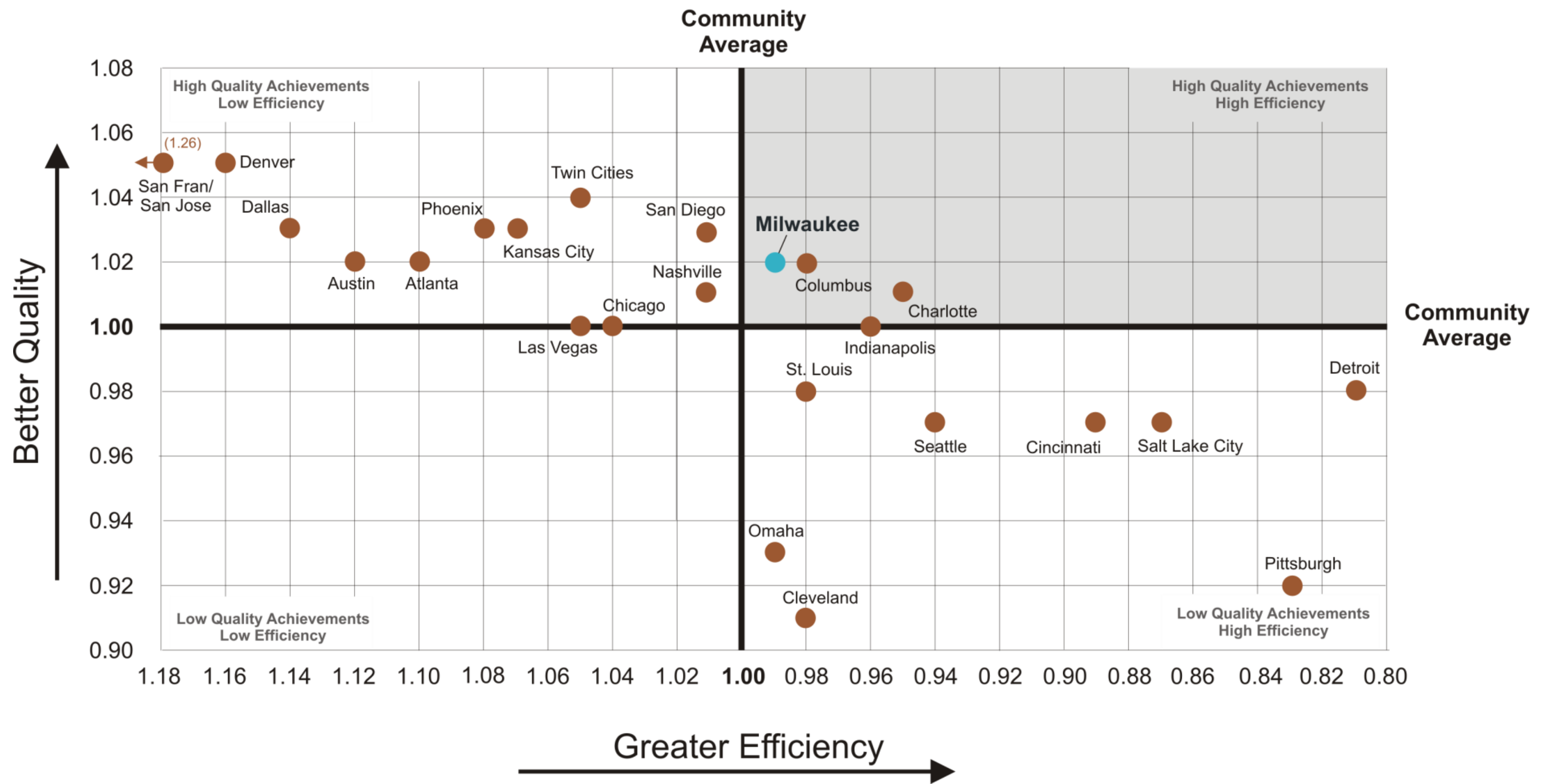
ACA Risk Management Tools



Weiner J P et al. Health Affairs 2012;31:306-315

©2012 by Project HOPE - The People-to-People Health Foundation, Inc.

Risk Varies by Market



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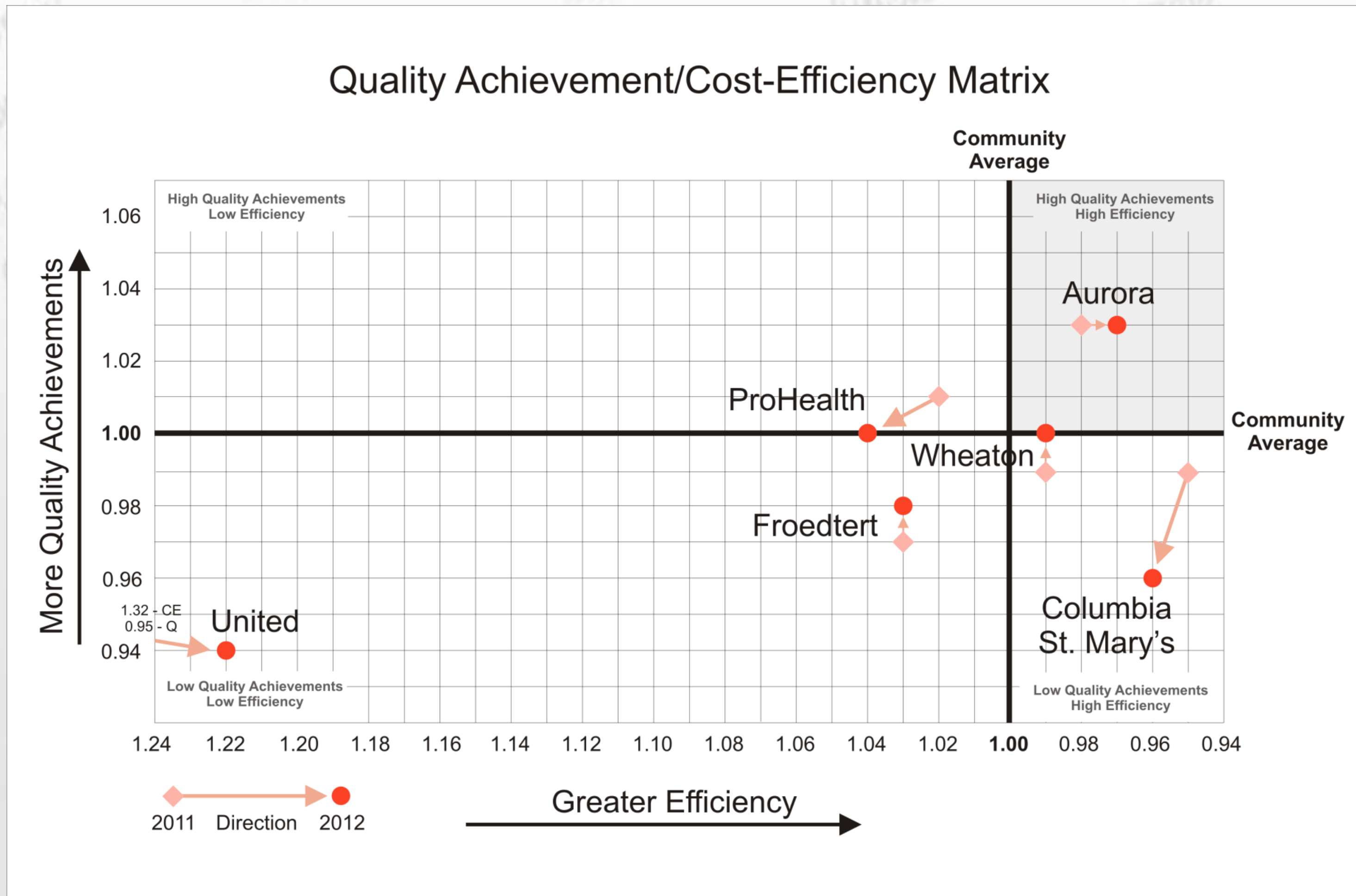
Risk Varies by Health System

Metro Milwaukee



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Risk Varies by Clinical Care

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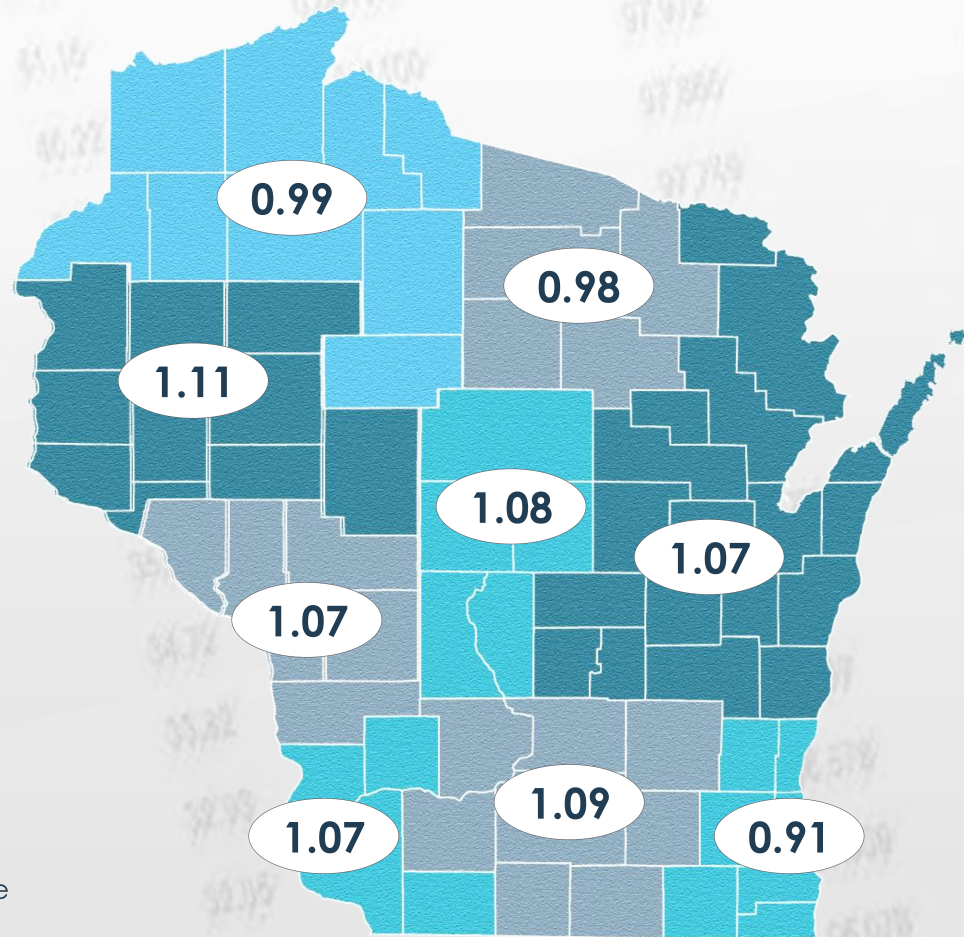
Risk Varies by Population

Poorer health (lower scores) can cause cost efficiency and quality variation.



Source: The *County Health Rankings & Roadmaps* Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

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Elements of Population Risk

Poverty

Socio-economic status

Where you live

Access to primary care

Cultural diversity

Market competition, ACOs and consolidation

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Yin and Yang Impact

Providers

- Increase of patients and higher risk patients
- Physician access issues
- 100% payment for preventive screenings
- Reimbursement for previously uninsured patients
- Low reimbursement drives physicians out of plans
- High deductibles could lead to bad debt losses

Payers

- Increased membership
- Limited risk underwriting
- Essential Health Benefits
- 100% coverage for preventive screenings
- No benefit dollar limits
- Rate setting problematic
- Revenue gains
- Better or worse margins

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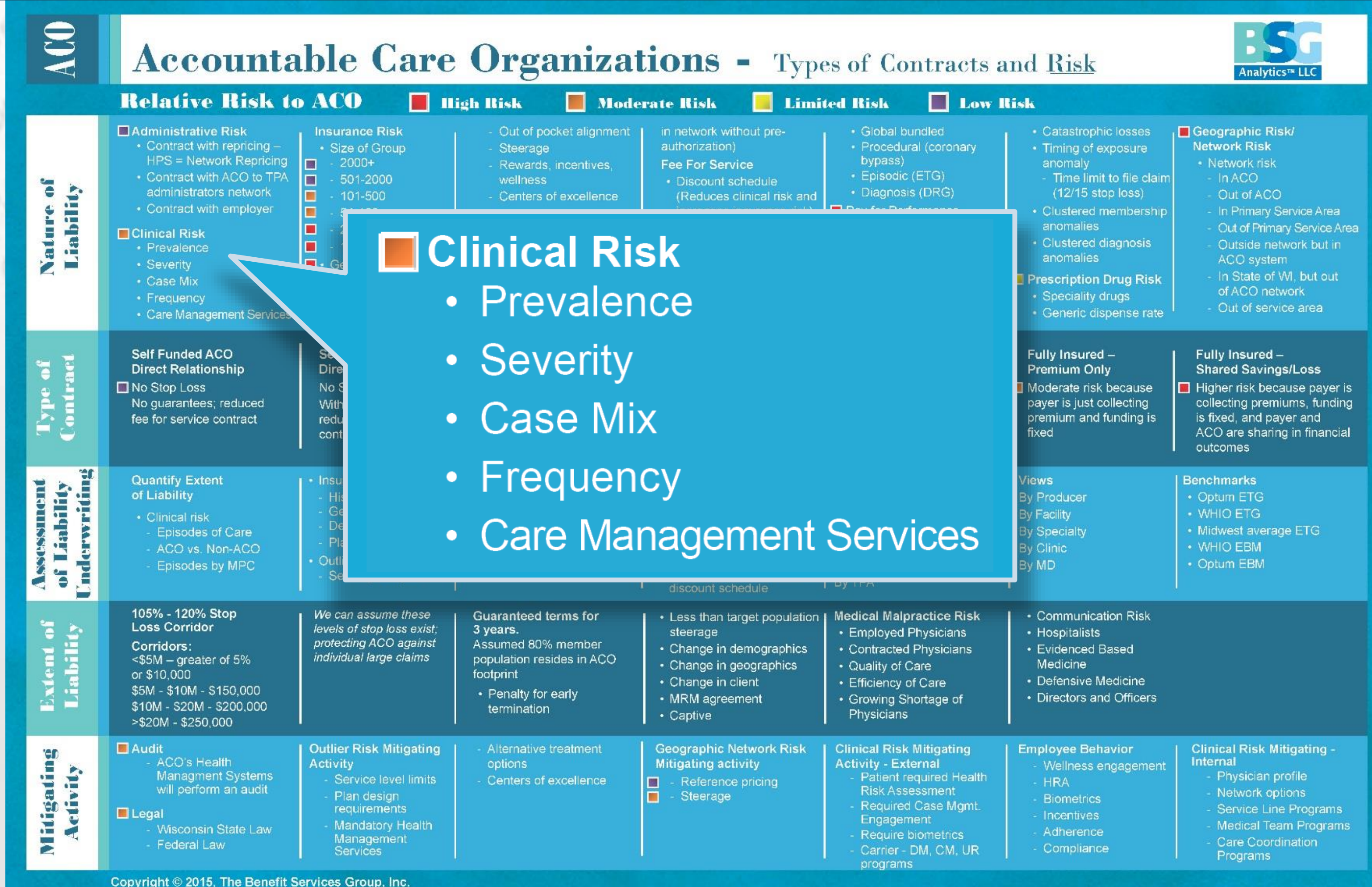
Appendix

Health Care Risk Map



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Health Care Risk Map

ACO

Accountable Care Organizations - Types of Contracts and Risk

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Relative Risk to ACO — High Risk | Moderate Risk | Limited Risk | Low Risk

Nature of Liability

Administrative Risk
- Contract with repricing – HPS = Network Repricing
- Contract with ACO to TPA administrators network
- Contract with employer

Clinical Risk
- Prevalence
- Severity
- Case Mix
- Frequency
- Care Management Services

Insurance Risk
- Size of Group
  - 2000+
  - 501-2000
  - 101-500
  - 51-100
  - 2-50
  - 1
- Geographic
- Demographi
- Plan design
  - Plan provi

- Out of pocket alignment
- Steerage
- Rewards, incentives, wellness
- Centers of excellence
- Legislation
  - Federal

in network without pre-authorization)

Fee For Service
- Discount schedule (Reduces clinical risk and increases insurance risk)
- Unit Price
- ACO Unit Pricing vs.

- Global bundled
- Procedural (coronary bypass)
- Episodic (ETG)
- Diagnosis (DRG)

Pay for Performance
- Outcome based (Balances insurance

- Catastrophic losses
- Timing of exposure anomaly
  - Time limit to file claim (12/15 stop loss)
- Clustered membership anomalies
- Clustered diagnosis ...alies

...ption Drug Risk
...ality drugs
...ric dispense rate

Geographic Risk/ Network Risk
- Network risk
  - In ACO
  - Out of ACO
  - In Primary Service Area
  - Out of Primary Service Area
  - Outside network but in ACO system
  - In State of WI, but out of ACO network
  - Out of service area

Type of Contract

Self Funded ACO Direct Relationship
No Stop Loss
No guarantees; reduced fee for service contract

Self Funded A... Direct Relatio...
No Stop Loss
With guarante... reduced fee f... contract; self f...

...sured – ...n Only
...e risk because ...just collecting ...and funding is

Fully Insured – Shared Savings/Loss
Higher risk because payer is collecting premiums, funding is fixed, and payer and ACO are sharing in financial outcomes

Assessment of Liability Underwriting

Quantify Extent of Liability
- Clinical risk
  - Episodes of Care
  - ACO vs. Non-ACO
  - Episodes by MPC

- Insurance risk
  - Historical tre...
  - Geographic
  - Demographi...
  - Plan design
- Outlier risk
  - Severity ana...

...cer

...lity

Benchmarks
- Optum ETG
- WHIO ETG
- Midwest average ETG
- WHIO EBM
- Optum EBM

Extent of Liability

105% - 120% Stop Loss Corridor
Corridors:
<\$5M – greater of 5% or \$10,000
\$5M - \$10M - \$150,000
\$10M - \$20M - \$200,000
>\$20M - \$250,000

We can assume... levels of stop loss exist; protecting ACO against individual large claims

3 years.
Assumed 80% member population resides in ACO footprint
- Penalty for early termination

steerage
- Change in demographics
- Change in geographics
- Change in client
- MRM agreement
- Captive

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...unication Risk
- Hospitalists
- Evidenced Based Medicine
- Defensive Medicine
- Directors and Officers

Mitigating Activity

Audit
- ACO's Health Managment Systems will perform an audit

Legal
- Wisconsin State Law
- Federal Law

Outlier Risk Mitigating Activity
- Service level limits
- Plan design requirements
- Mandatory Health Management Services

- Alternative treatment options
- Centers of excellence

Geographic Network Risk Mitigating activity
- Reference pricing
- Steerage

Clinical Risk Mitigating Activity - External
- Patient required Health Risk Assessment
- Required Case Mgmt. Engagement
- Require biometrics
- Carrier - DM, CM, UR programs

Employee Behavior
- Wellness engagement
- HRA
- Biometrics
- Incentives
- Adherence
- Compliance

Clinical Risk Mitigating - Internal
- Physician profile
- Network options
- Service Line Programs
- Medical Team Programs
- Care Coordination Programs

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Clinical Risk Mitigating Activity - External
- Patient required Health Risk Assessment
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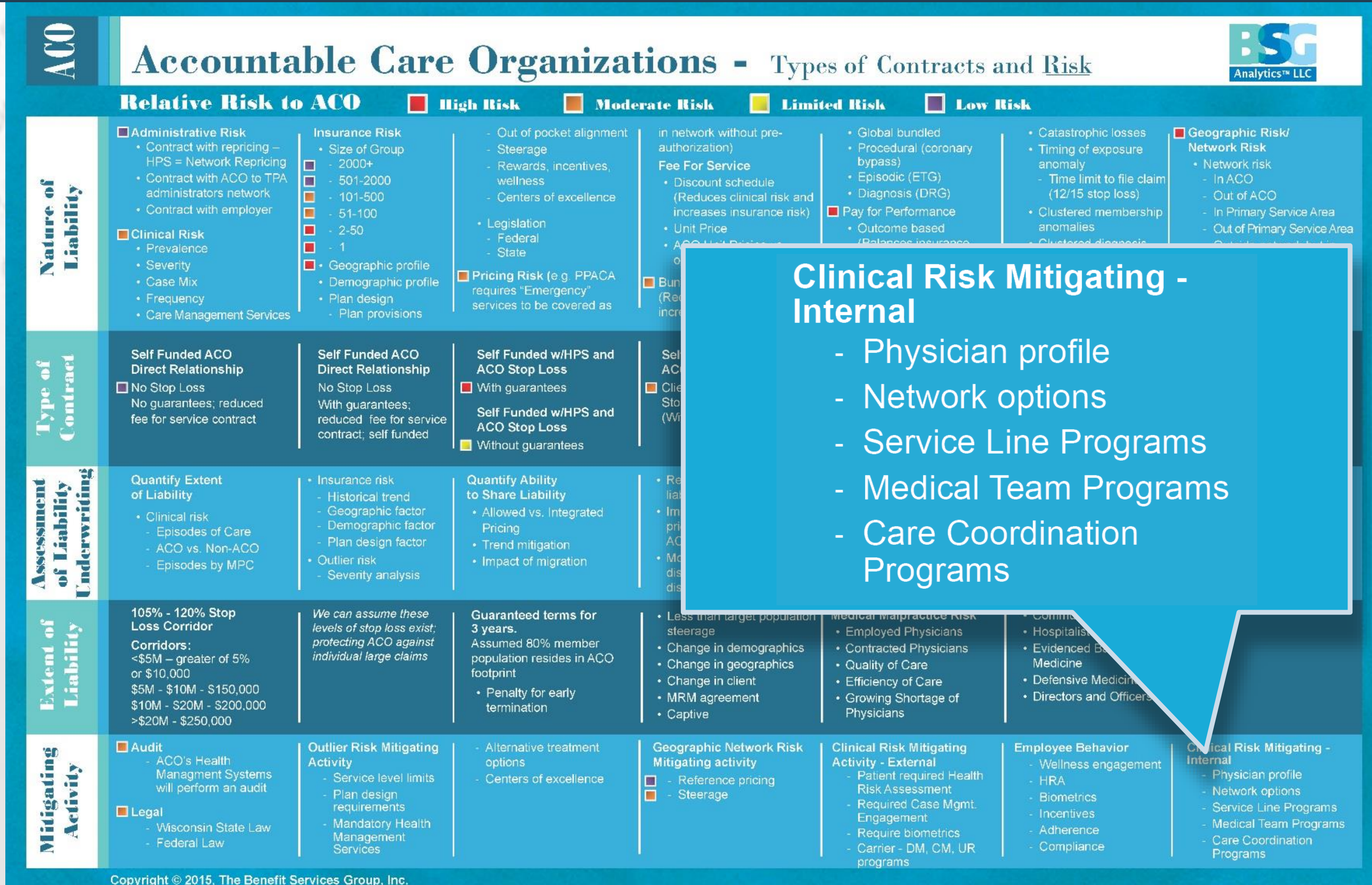
Health Care Risk Map



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Health Care Risk Map

Medical Malpractice Risk
- Employed Physicians
- Contracted Physicians
- Quality of Care
- Efficiency of Care
- Growing Shortage of Physicians

- Communication Risk
- Hospitalists
- Evidenced Based Medicine
- Defensive Medicine
- Directors and Officers

ACO | Accounta...

Relative Risk to...

Nature of Liability	Administrative Risk • Contract with repricing – HPS = Network Repricing • Contract with ACO to TPA administrators network • Contract with employer Clinical Risk • Prevalence • Severity • Case Mix • Frequency • Care Management Services						...ographic Risk/ ...twork Risk ...Network risk ... In ACO ... Out of ACO ... In Primary Service Area ... Out of Primary Service Area ... Outside network but in ACO system ... In State of WI, but out of ACO network ... Out of service area
Type of Contract	Self Funded ACO Direct Relationship No Stop Loss No guarantees; reduced fee for service contract	reduced fee for service contract; self funded	ACO Stop Loss Without guarantees	(With guarantee)		...um and funding is	...lly Insured – ...ared Savings/Loss ...gher risk because payer is ...llecting premiums, funding is fixed, and payer and ACO are sharing in financial outcomes
Assessment of Liability Underwriting	Quantify Extent of Liability • Clinical risk - Episodes of Care - ACO vs. Non-ACO - Episodes by MPC	• Insurance risk - Historical trend - Geographic factor - Demographic factor - Plan design factor • Outlier risk - Severity analysis	Quantify Ability to Share Liability • Allowed vs. Integrated Pricing • Trend mitigation • Impact of migration	• Review extent of shared liability • Impact of change in unit price from market price to ACO price • Moving from current discount schedule to ACO discount schedule	Views By Carrier (A... By Employer By Captive By Stop Loss Carrier By Employees By TPA	...ws ... Producer ... Facility ...y Specialty By Clinic By MD	Benchmarks • Optum ETG • WHIO ETG • Midwest average ETG • WHIO EBM • Optum EBM
Extent of Liability	105% - 120% Stop Loss Corridor Corridors: <$5M – greater of 5% or $10,000 $5M - $10M - $150,000 $10M - $20M - $200,000 >$20M - $250,000	*We can assume these levels of stop loss exist; protecting ACO against individual large claims*	Guaranteed terms for 3 years. Assumed 80% member population resides in ACO footprint • Penalty for early termination	• Less than target population steerage • Change in demographics • Change in geographics • Change in client • MRM agreement • Captive	Medical Malpractice Risk • Employed Physicians • Contracted Physicians • Quality of Care • Efficiency of Care • Growing Shortage of Physicians	• Communication Risk • Hospitalists • Evidenced Based Medicine • Defensive Medicine • Directors and Officers	
Mitigating Activity	Audit - ACO's Health Managment Systems will perform an audit Legal - Wisconsin State Law - Federal Law	Outlier Risk Mitigating Activity - Service level limits - Plan design requirements - Mandatory Health Management Services	- Alternative treatment options - Centers of excellence	Geographic Network Risk Mitigating activity - Reference pricing - Steerage	Clinical Risk Mitigating Activity - External - Patient required Health Risk Assessment - Required Case Mgmt. Engagement - Require biometrics - Carrier - DM, CM, UR programs	Employee Behavior - Wellness engagement - HRA - Biometrics - Incentives - Adherence - Compliance	Clinical Risk Mitigating - Internal - Physician profile - Network options - Service Line Programs - Medical Team Programs - Care Coordination Programs

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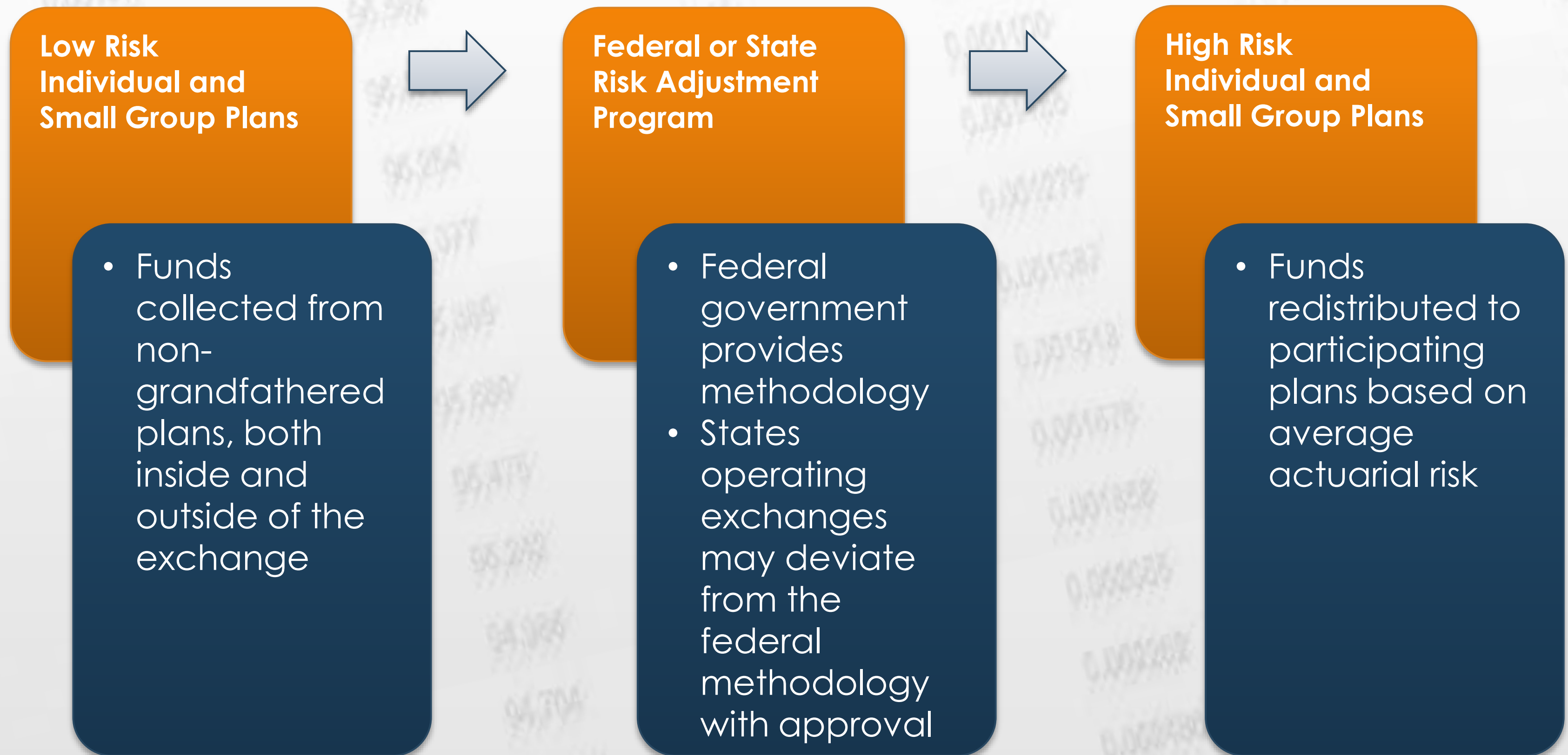
The Three Rs: Risk Adjustment



Source: Kaiser Family Foundation

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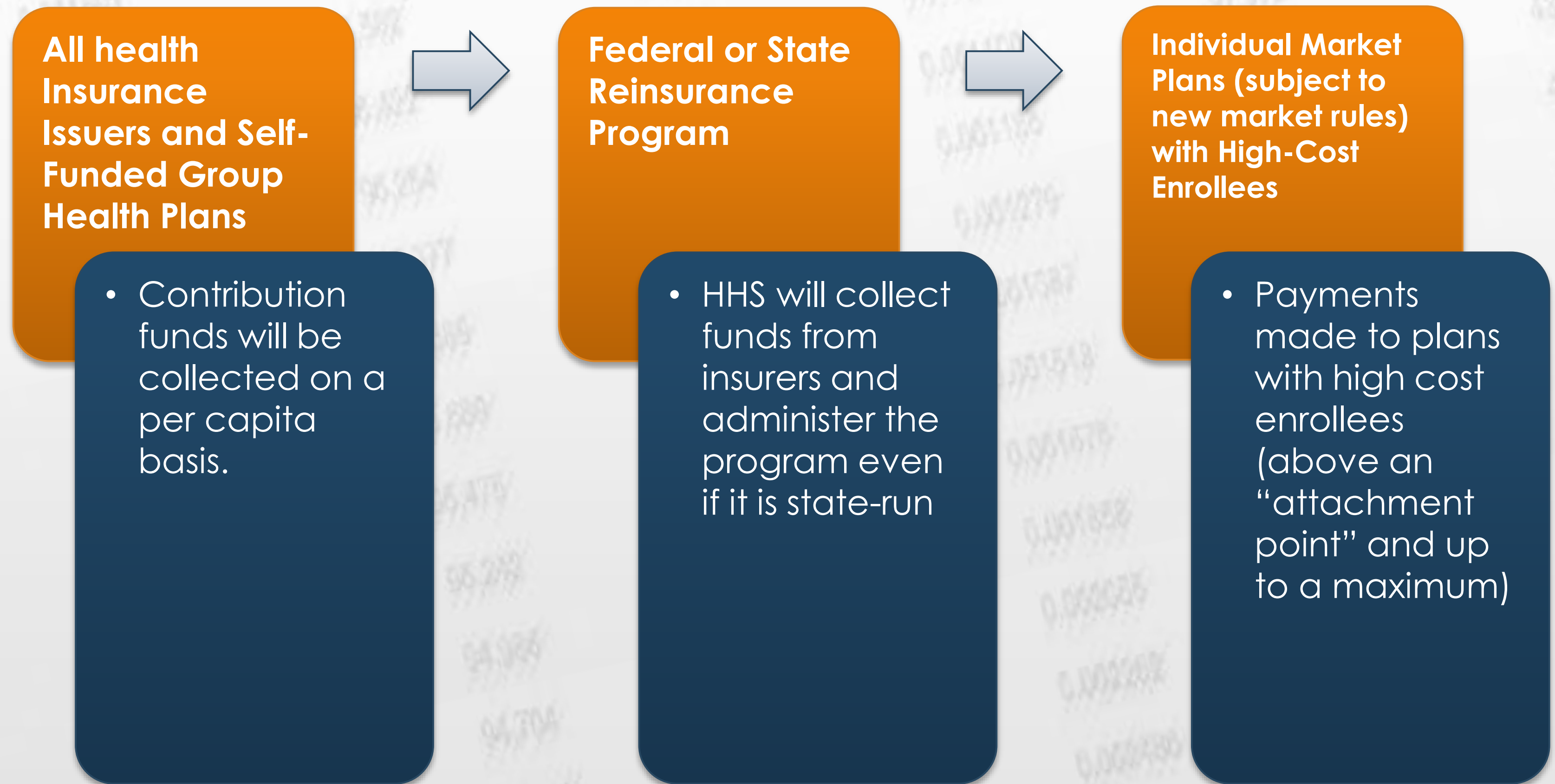
The Three Rs: Reinsurance



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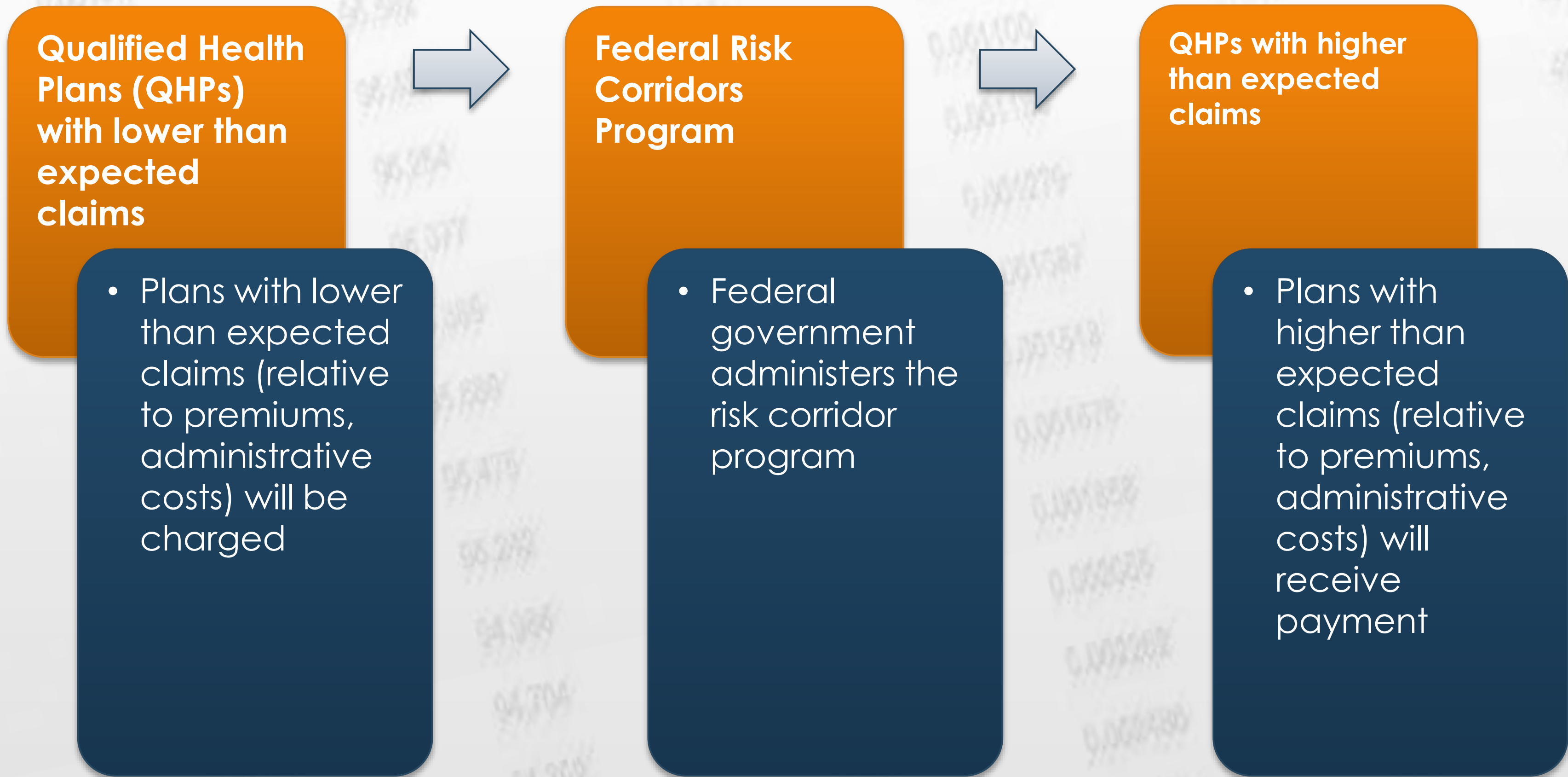
The Three Rs: Risk Corridors



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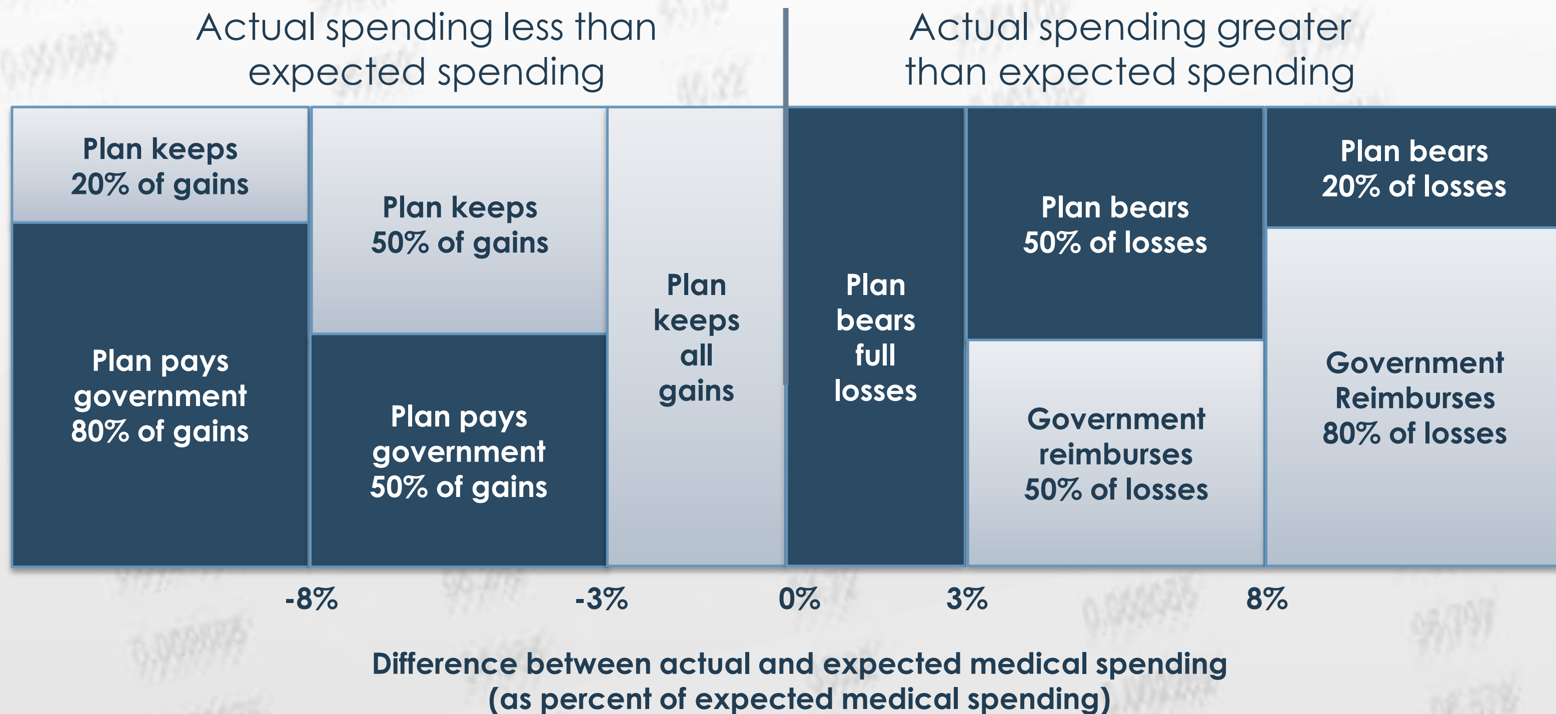
ACA Risk Corridors



Source: Reprinted with permission from the American Academy of Actuaries, Fact Sheet: ACA Risk-Sharing Mechanisms, 2013.

Cite as: "Health Policy Brief: Risk Corridors," *Health Affairs*, June 26, 2014 http://www.healthaffairs.org/healthpolicybriefs/

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Table 1: Summary of Risk and Market Stabilization Programs in the Affordable Care Act			
	Risk Adjustment	**Reinsurance**	**Risk Corridors**
***What* the program does**	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Provides payment to plans that enroll higher-cost individuals	Limits losses and gains beyond an allowable range
***Why* it was enacted**	Protects against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets	Protects against premium increases in the individual market by offsetting the expenses of high-cost individuals	Stabilizes premiums and protects against inaccurate premium setting during initial years of the reform
***Who* participates**	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges	All health insurance issuers and self-insured plans contribute funds; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment	Qualified Health Plans (QHPs), which are plans qualified to be offered on a health insurance marketplace (also called exchange)
***How* it works**	Plans' average actuarial risk will be determined based on enrollees' individual risk scores. Plans with lower actuarial risk will make payments to higher risk plans. Payments net to zero.	If an enrollee's costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap). Payments net to zero	HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims. Plans with actual claims less than 97% of target amounts pay into the program and plans with claims greater than 103% of target amounts receive funds. Payments do not have to net to zero.
***When* it goes into effect**	2014, onward (Permanent)	2014 – 2016 (Temporary – 3 years)	2014 – 2016 (Temporary – 3 years)

Source: Kaiser Family Foundation

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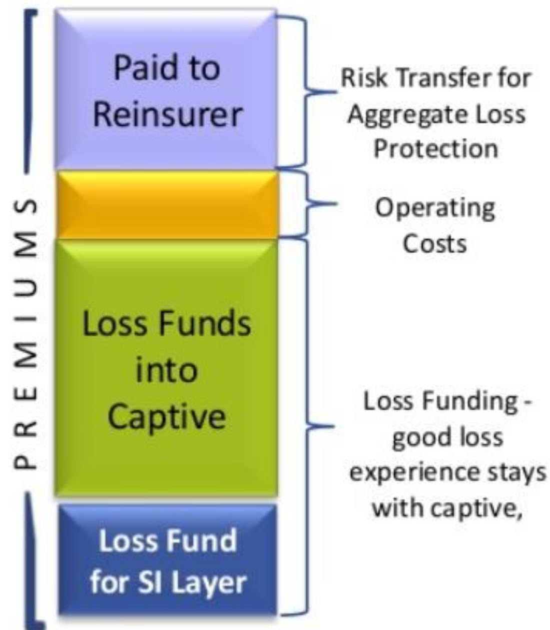
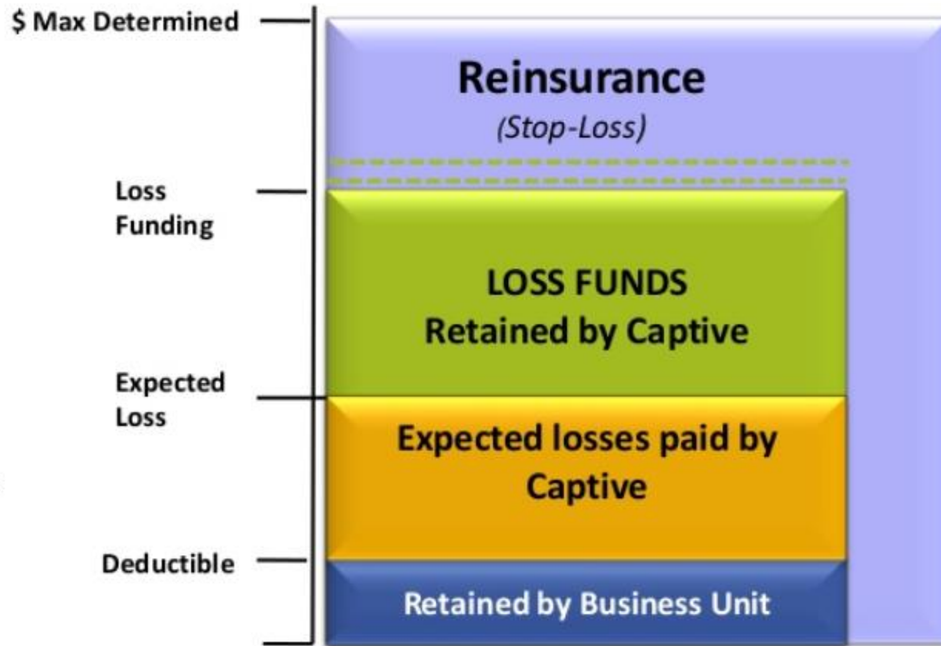
How Stop Loss Captives Work

Where Premium Goes



How Losses Are Paid Out



Long-Term Strategies:

1. Grow LOSS FUNDS by retaining and managing more risk in the captive, lessen dependency on other insurance over-time
2. Accrue value in the captive

http://www.slideshare.net/SpringConsultingGroup/evolving-role-of-captives-october-2013

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Definitions of Physician Payment Models

- Traditional payment models include fee-for-service payments (FFS) or salary with or without bonus potential
- Value-based payment models include: FFS payments combined with a monthly care coordination fee
- Bundled payments: one payment for all the services around a particular patient's treatment or episode of care – paid to a physician or to a hospital which then pays the physician from that bundle
- Procedural episode-based payments and/or complex and chronic disease management episode-based payments (this option was only presented to specialists in the survey)
- Shared savings arrangements where a physician is rewarded if patients have better-than-average quality/cost outcomes
- Shared savings arrangements, where a physician is penalized if patients fail to have better-than-average quality/cost outcomes
- Capitation payments per-patient-per-month (PPPM) covering physician-related services
- Capitation payments PPPM covering payment for pharmacy, hospital, and other services as well as physician-related services

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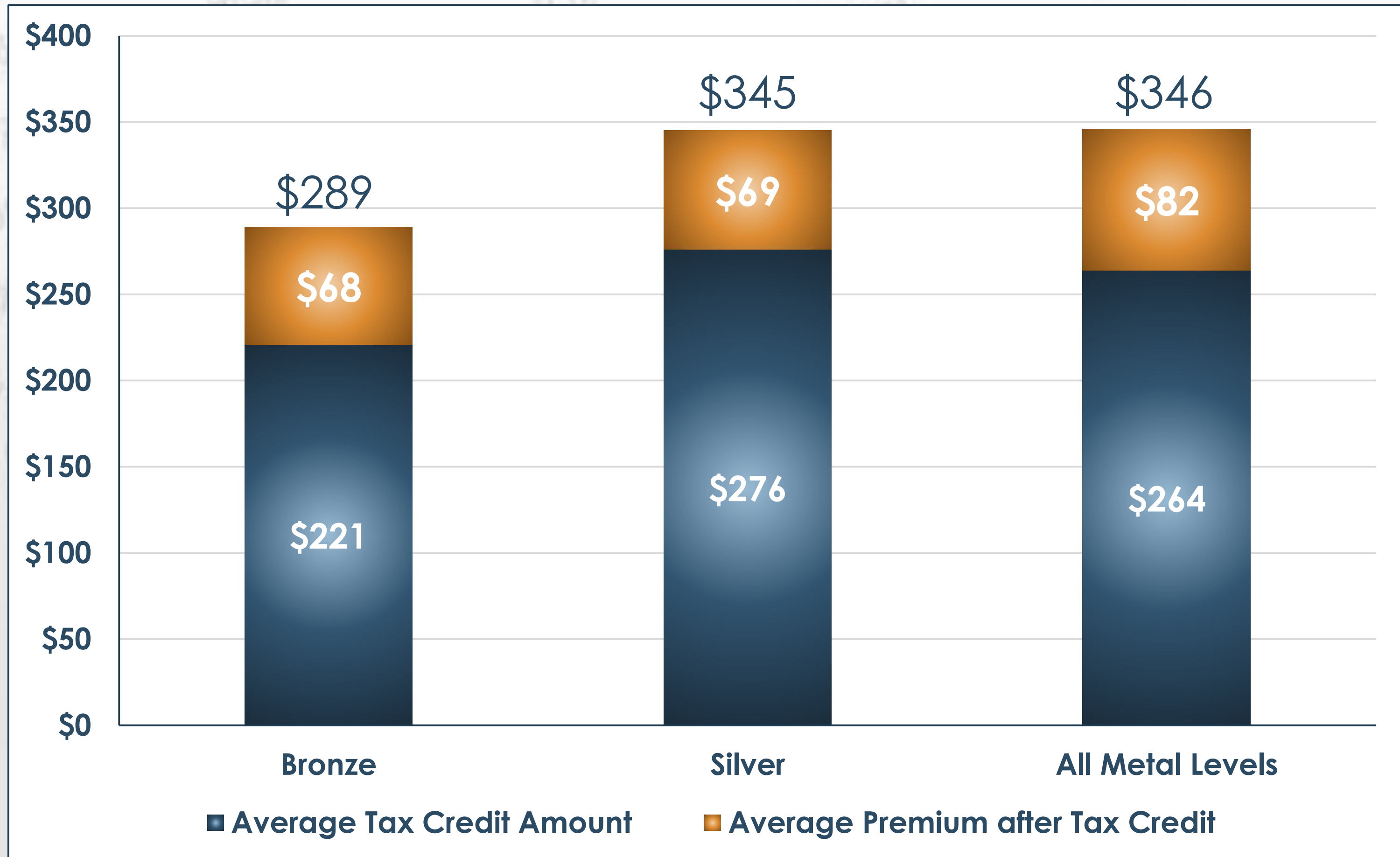
Average Monthly Tax Credit and Premiums for Individuals Receiving Subsidies on the Marketplace



Source: ASPE computations of CMS federally-facilitated marketplace data as of 5/12/2014

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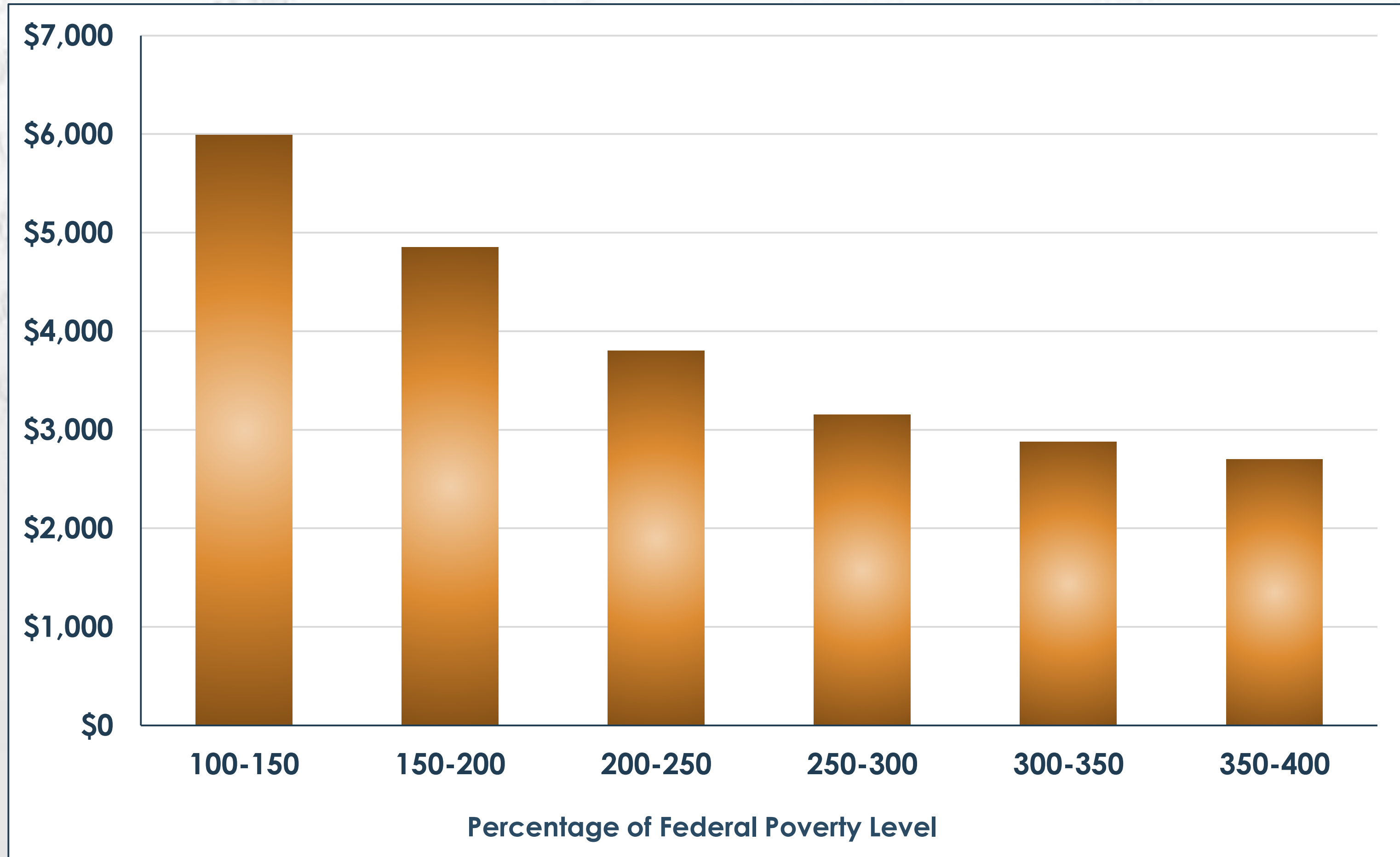
Average Available Subsidy Per Household by Income



Source: American Action Forum, April 3, 2014

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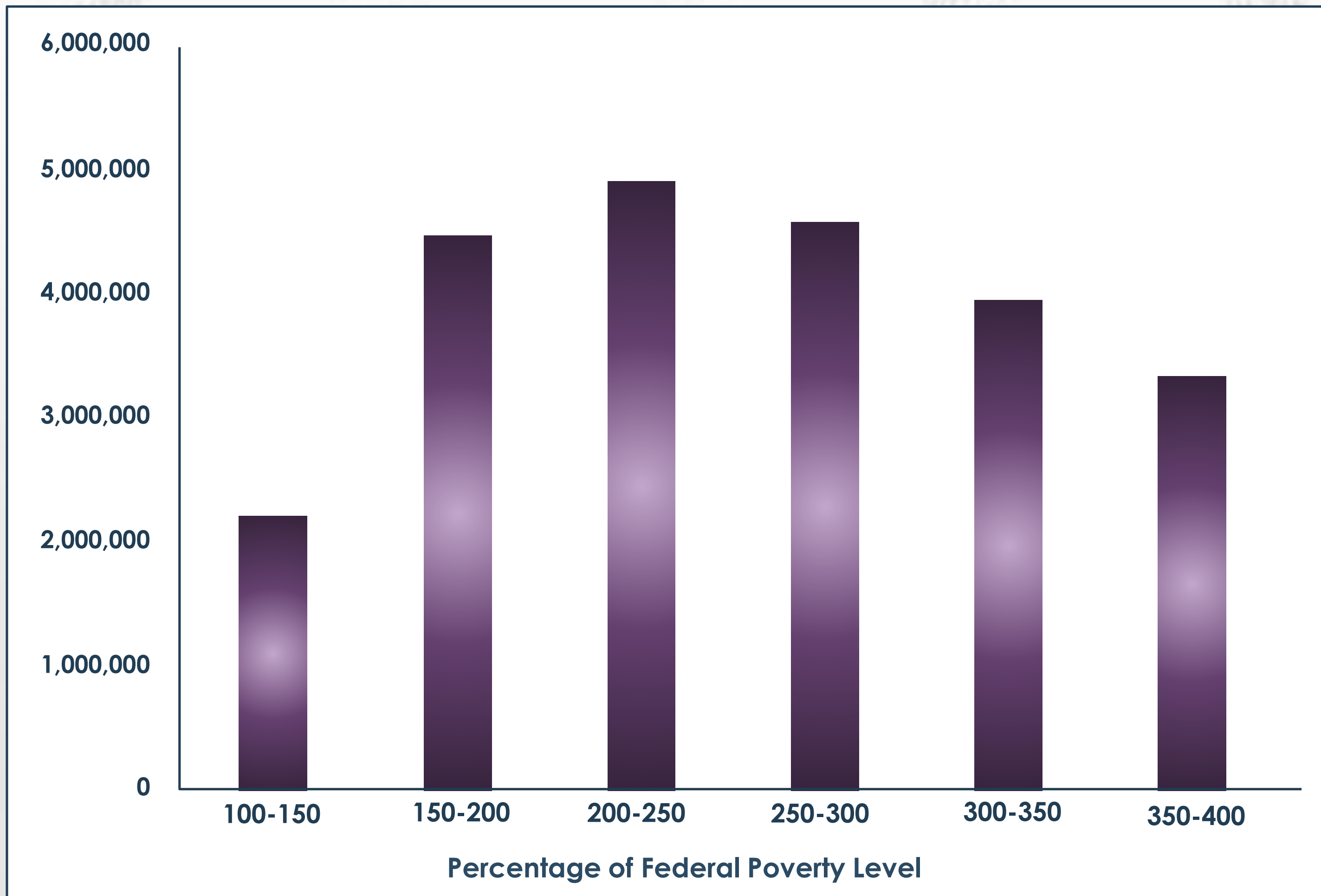
Potentially Eligible Population by Income



However, not everyone in that income range actually receives a subsidy. Because the subsidy is based on a benchmark premium price and a designated income percentage, households that already have access to what is considered affordable coverage are not given any additional subsidy.

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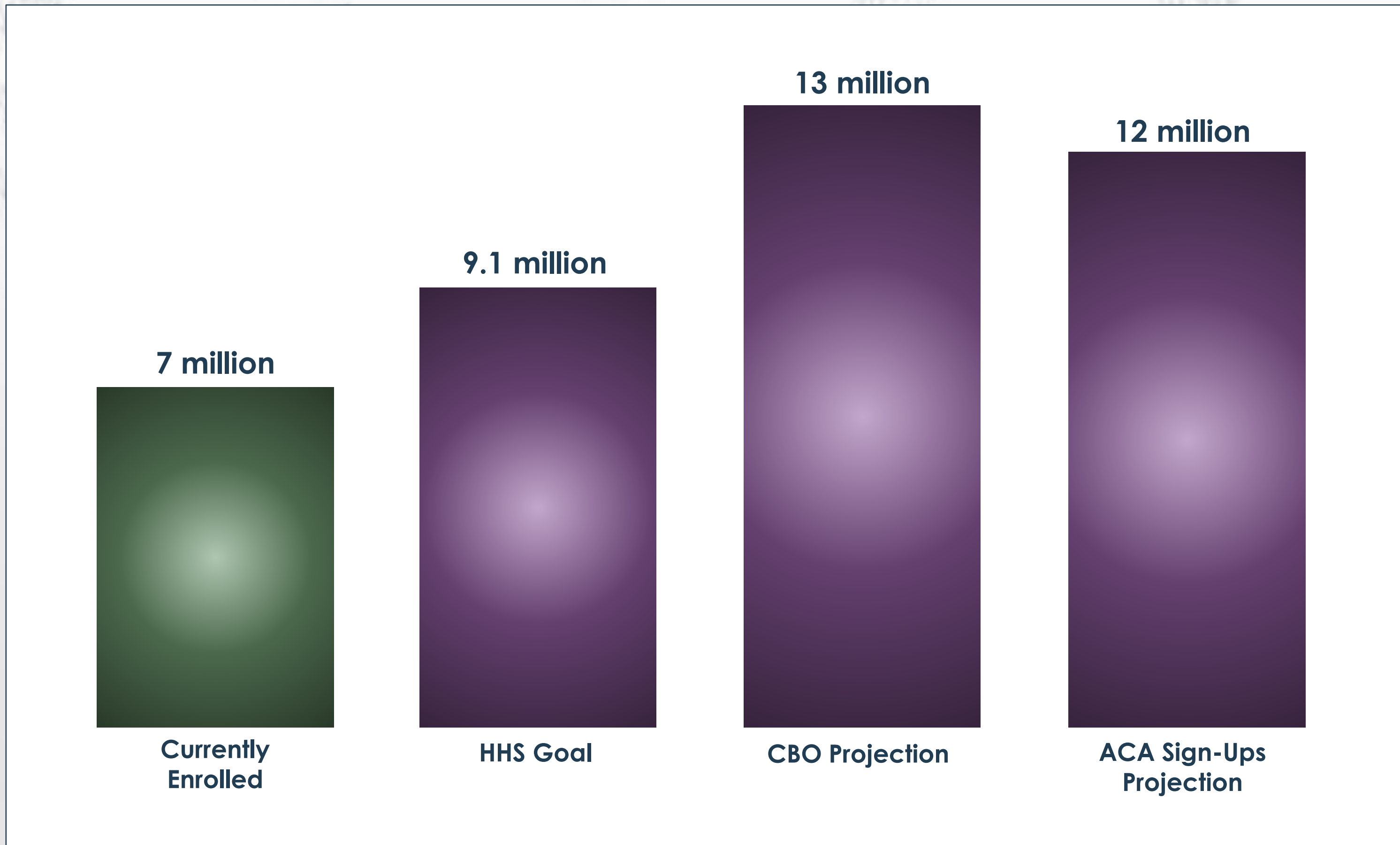
How Many will Sign Up in 2015



Source: (Health and Human Services, Congressional Budget Office, ACASignUps Net)

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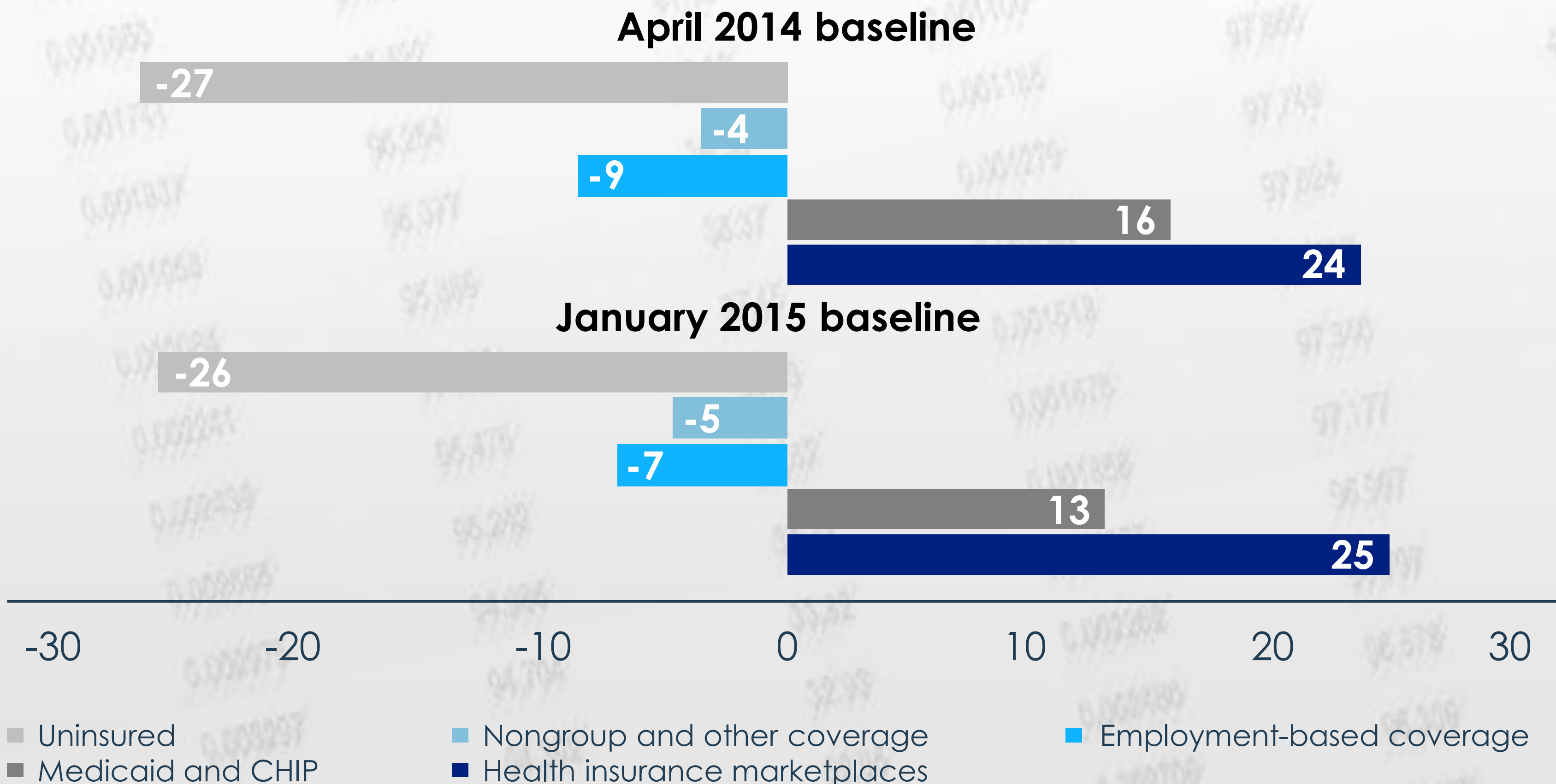
Change in the Number of People with Insurance Coverage in 2024, in Millions



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Analysis: Many plans are expecting a final rush as consumers approach the enrollment deadline. This happened last year when 3.8 million individuals enrolled in marketplace plans during the last month. Many plans are hoping that younger, healthier enrollees join before the deadline. Many navigators, nonprofit groups and agencies are working to increase enrollment with hard-to-reach and/or reluctant population segments. As enrollment grows, plans could be looking into these national figures to understand each market (geographic and population-based) better. Effective strategies for increasing enrollment in the Latino population, for example, could help plans learn and export best practices to other markets.

The health insurance marketplaces remain tale of "micro-market to micro-market." Overall, enrollment rates can be helpful, but marketplace dynamics vary by state and population. Rating, level of competition, level of public outreach and the characteristics and numbers of the eligible population vary dramatically by each market and contribute to diverse results. Analyses may need to go beyond the national numbers to local geographies and populations to gain the real insights. Moreover, health plans and other stakeholders are closely watching the results to gauge whether consumer retention stays consistent year over year. If the marketplaces prove to be "sticky" for health plans, the business could be more attractive to health plans, ultimately helping to drive greater interest and commitment to the market.

(Source: HHS, "Open Enrollment Week 10: January 17, 2015 — January 23, 2015," January 28, 2015)

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