



Health Insurance Market Overview

State Public Health Leadership Webinar

Deloitte Consulting LLP

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Agenda

Welcome

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Senior Advisor, Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention

Overview of the Health Insurance Market

Mike Van Den Eynde, MBA

Director, Deloitte Consulting LLP

Public Health's Role in ACA/Marketplace

Frederic Shaw, MD, JD

Senior Advisor for Health Reform, Office of the Associate Director for Policy, Centers for Disease Control and Prevention

Overview of Vermont Experience

Harry Chen, MD

Commissioner, Vermont Department of Health

Question & Answer Session

All

Overview of the Health Insurance Market

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Director, Deloitte Consulting LLP

Overview

Introduction

Size and role of commercial health insurance markets

Affordable Care Act (ACA) impact on health insurance and challenges created

Current state of Health Insurance Marketplaces and impact

Definitions of medical loss ratio, administrative costs, etc.

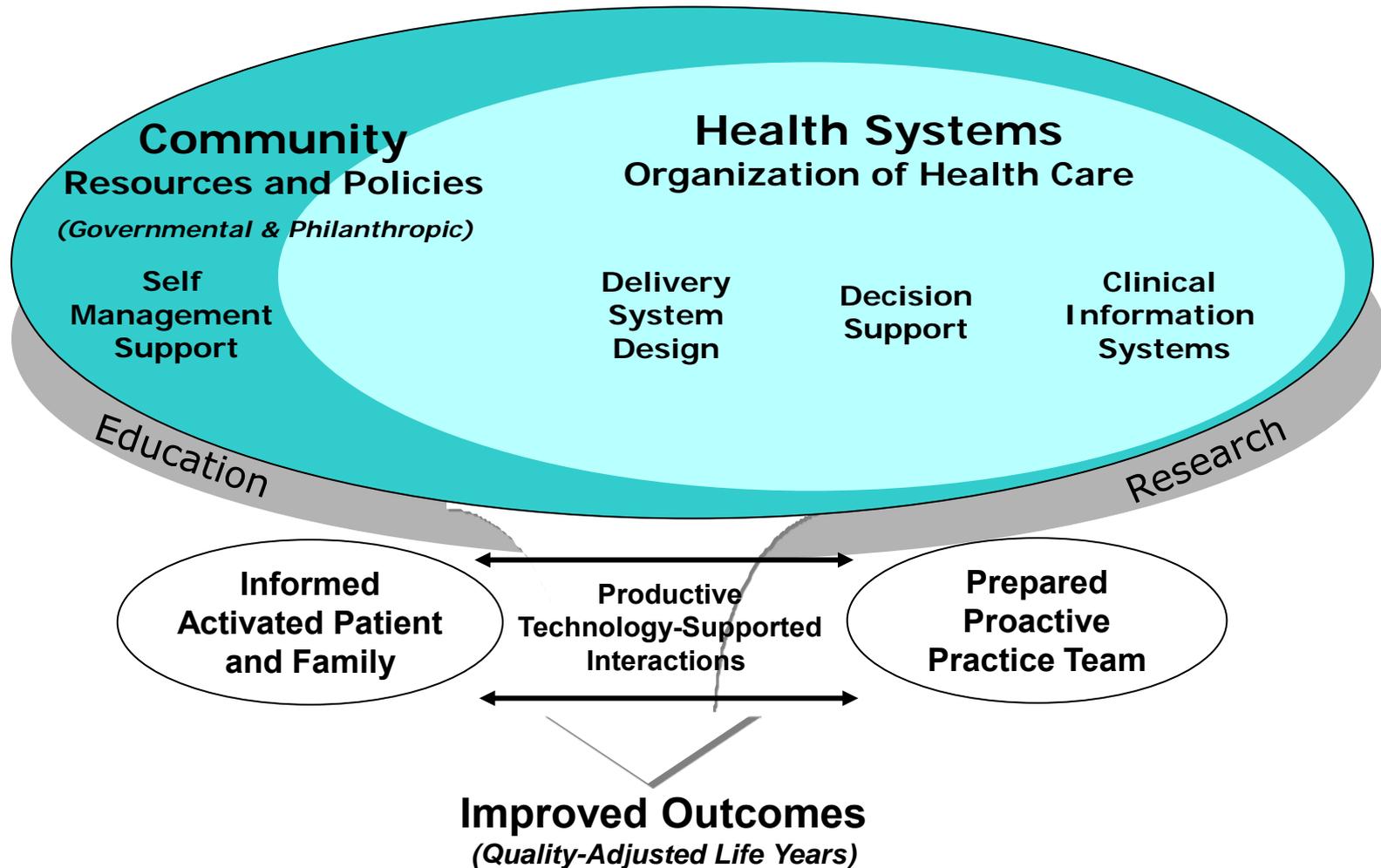
Medicaid expansion and impact

Impact of dual eligible on commercial market

Introduction

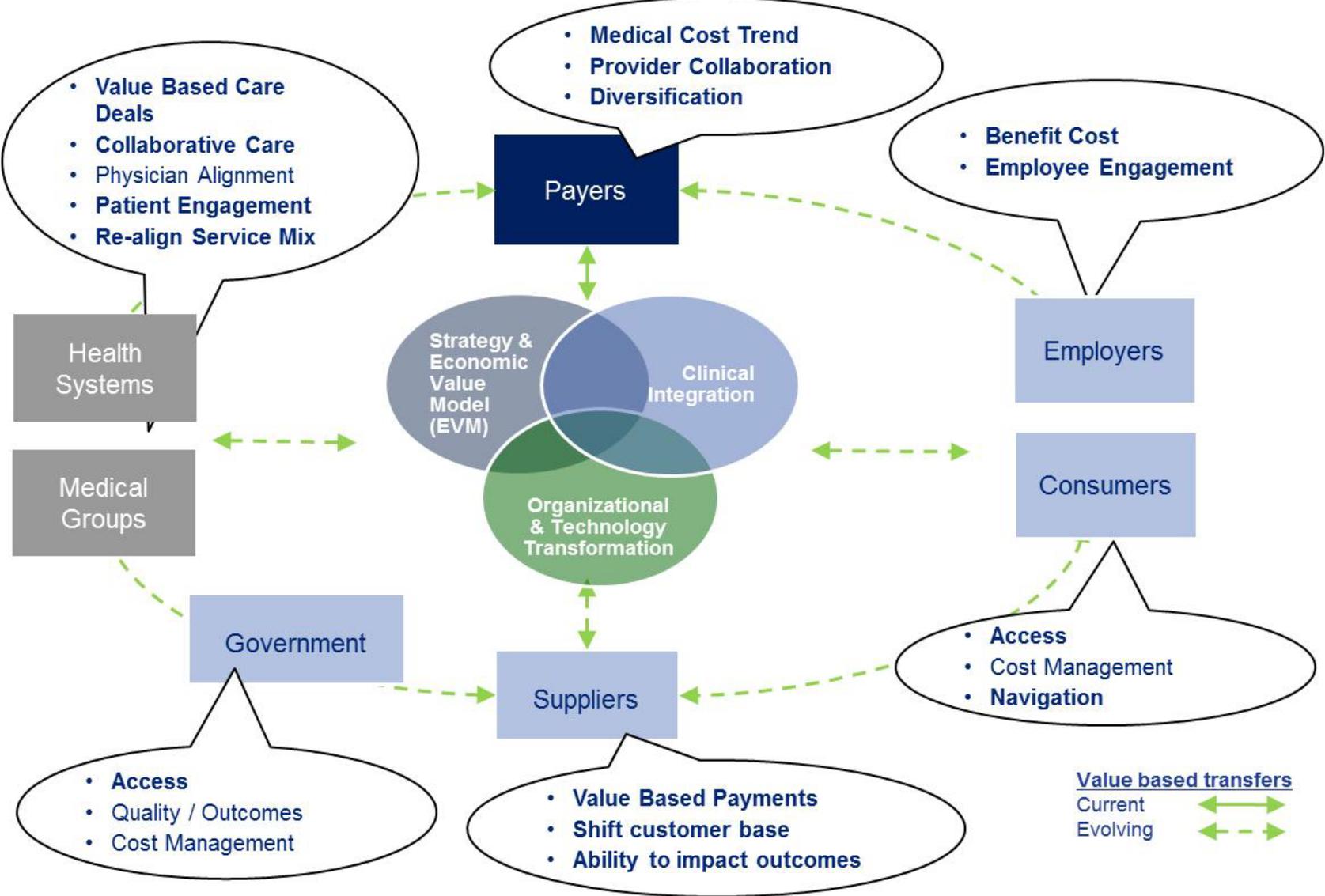
Chronic Disease Model for Systematic Care Management

The goal of the webinar is to create a foundation of understanding upon which to discuss the role of state health agencies in the health insurance market.

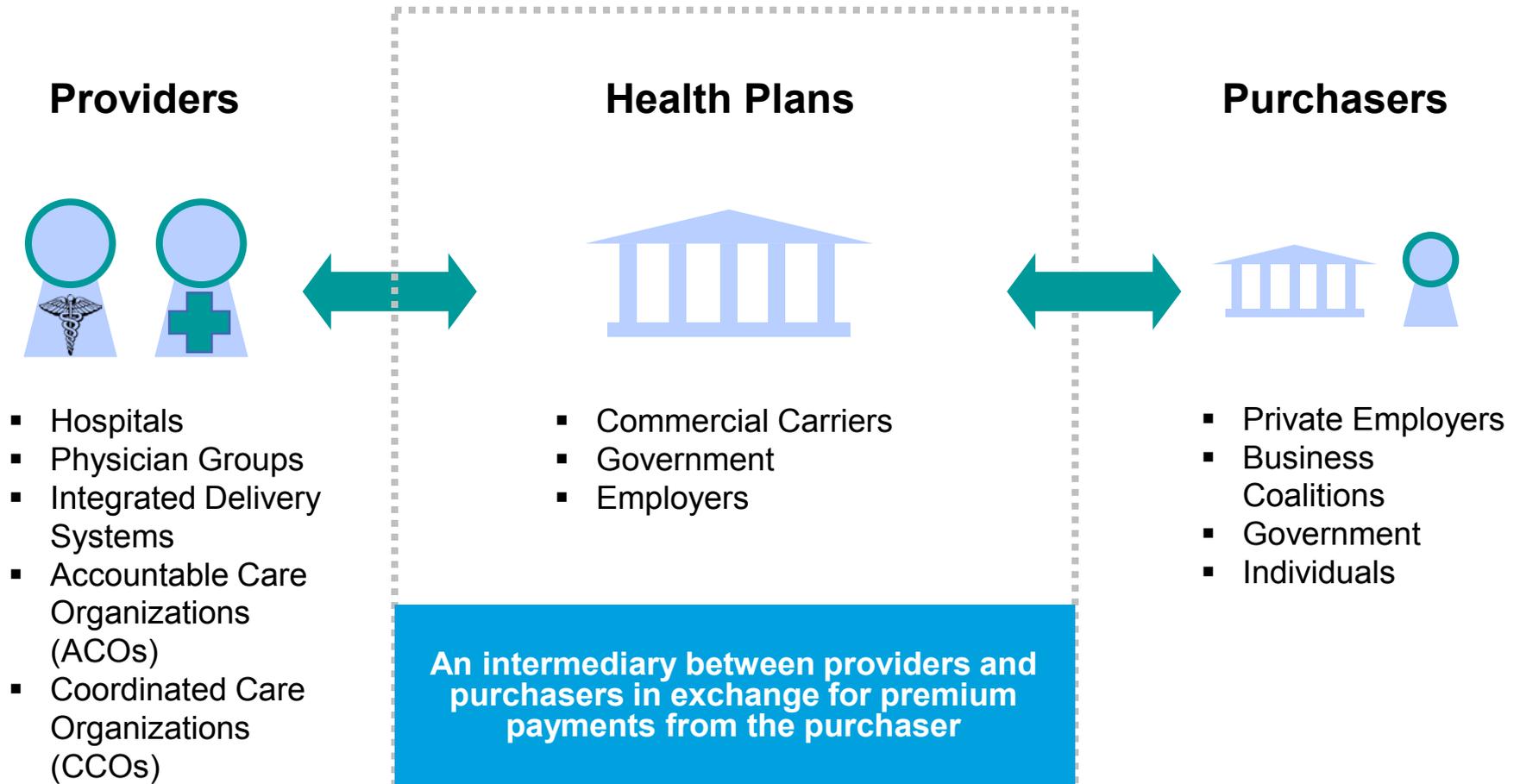


Source: The Wagner Model of Chronic Care was developed by the MacColl Institute.

Current stakeholders face fundamental challenges

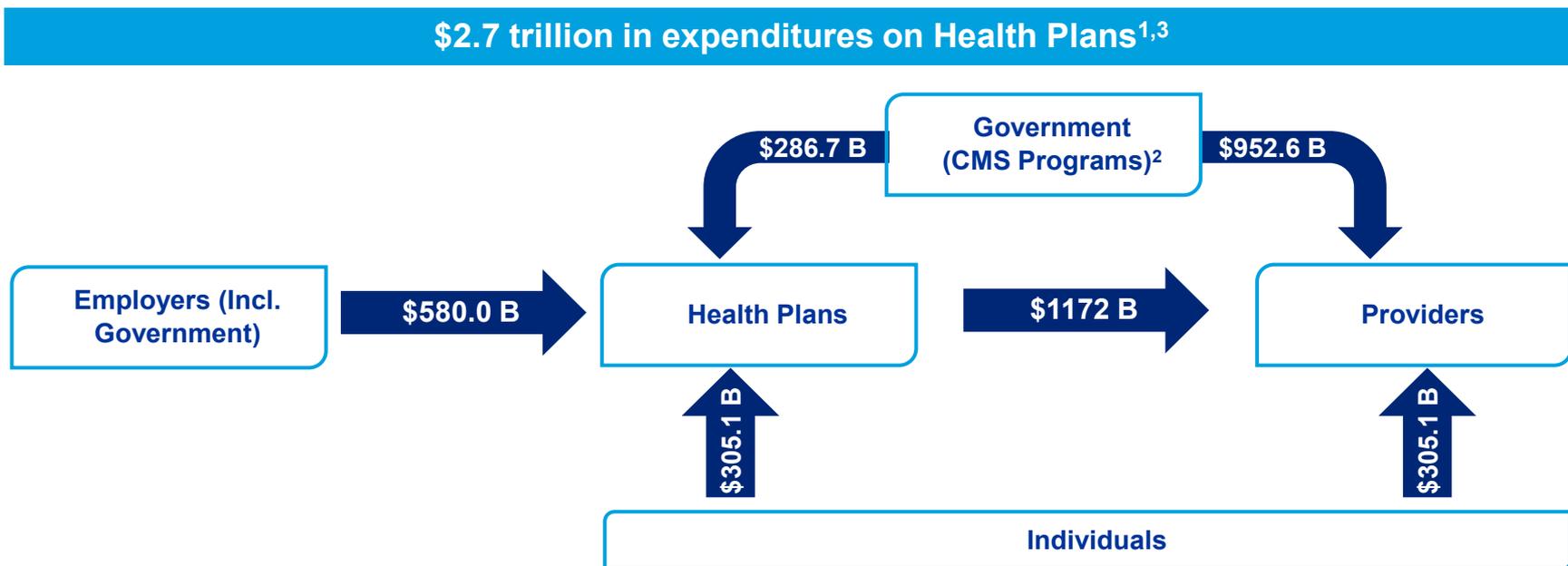


What is a Health Plan?



Flow of Funds (2012)

Health plans represent a significant cost to the US healthcare system; the value received for that investment is under scrutiny.



- Health plans consume **15.2%** of the \$1172 billion that flow through insurance providers' doors.
- As cost pressures in the US healthcare system continue to rise, the pressure to reduce this spending will continue to intensify.

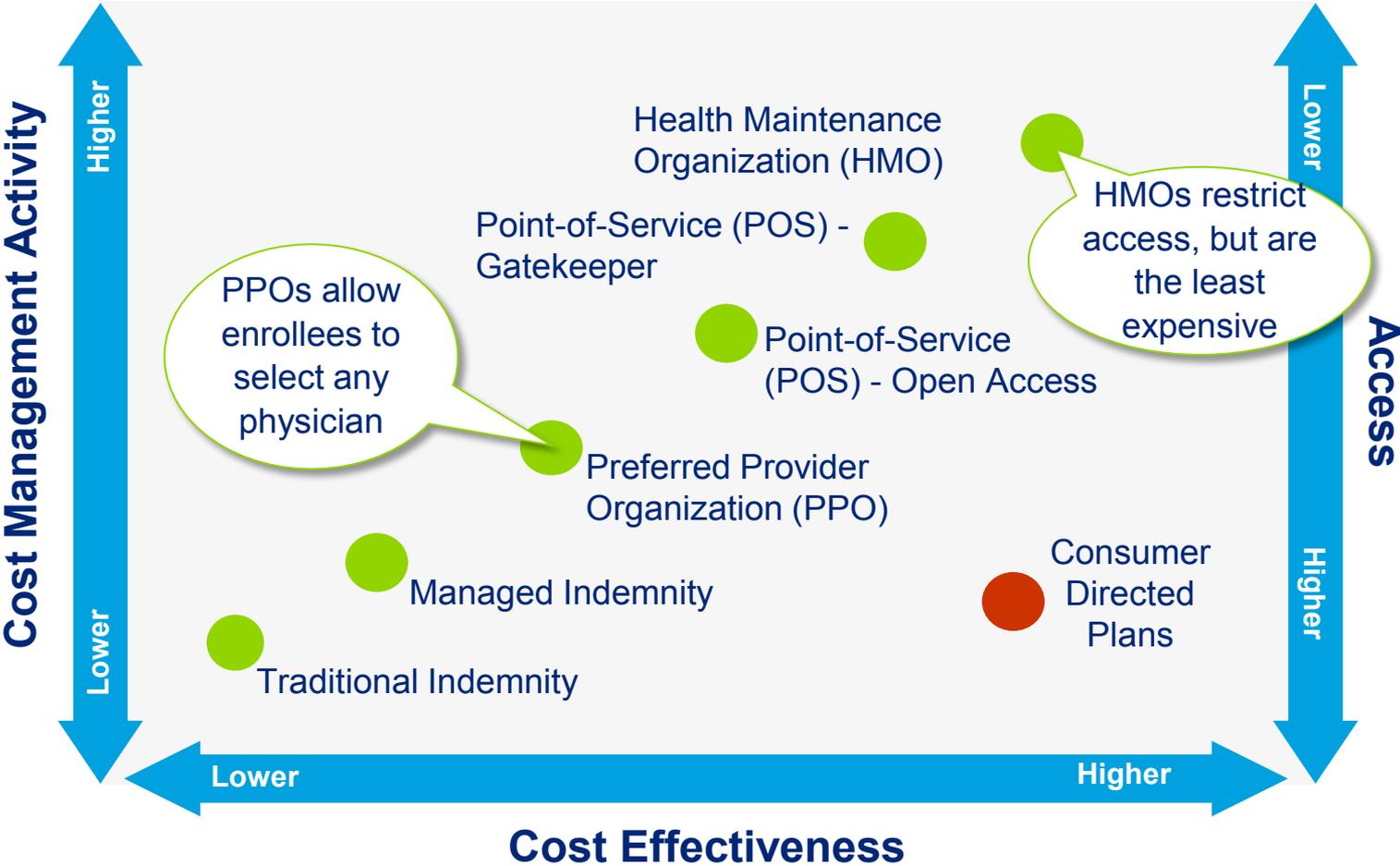
¹Source CMS

²Government spending for the purposes of this analysis include only that spending for CMS programs (Medicare, Medicaid, Veterans and SCHIP). It does not include government spending for: worker's compensation, Department of Defense, Maternal & Child Health, General Hospital/Medical NEC, ADAMHA/SAMHSA, Indian Health Services, OEO, Public Health Activities, Vocational Rehabilitation, Temporary Disability, General Assistance or State & Local Hospital/School Health.

³As a result of using only CMS program spending and of excluding other private health care spending including industrial in-plant services and other private revenues including philanthropy, the numbers on the chart do not total to \$2.7 trillion.

Commercial Health Insurance Products

Health plans offer a variety of products to their customers which control access and costs.



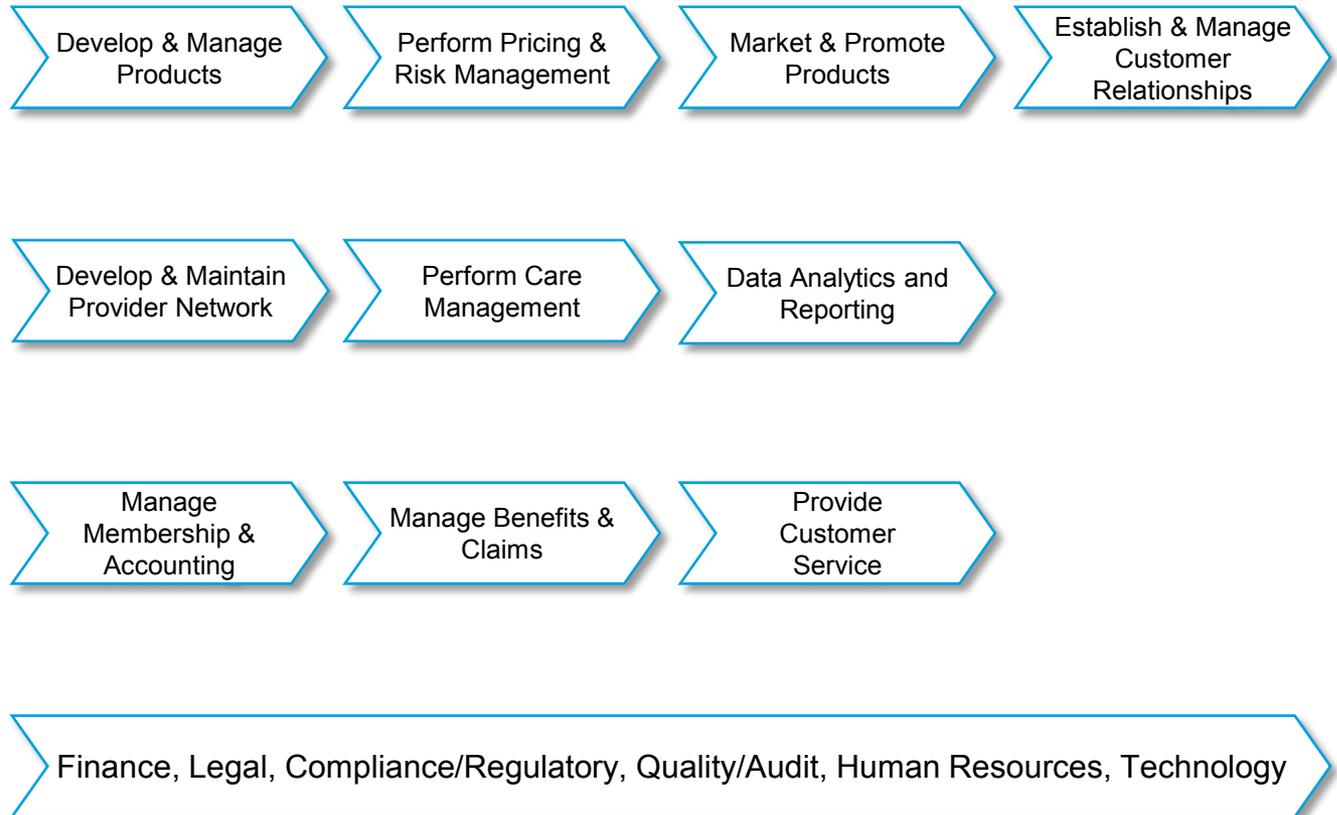
High Level Overview: Health Plan Value Chain

Health plans seek to deliver value and achieve competitive differentiation in the marketplace by optimizing performance across key activities and addressing the changing dynamics of the health plan value chain.

Health Plan Functions

- Product
 - Sales
 - Marketing
 - Actuarial
 - Underwriting
-
- Network
 - Care management
 - Medical Informatics
-
- Enrollment
 - Billing
 - Benefits
 - Claims
 - Service

Health Plan Core Processes

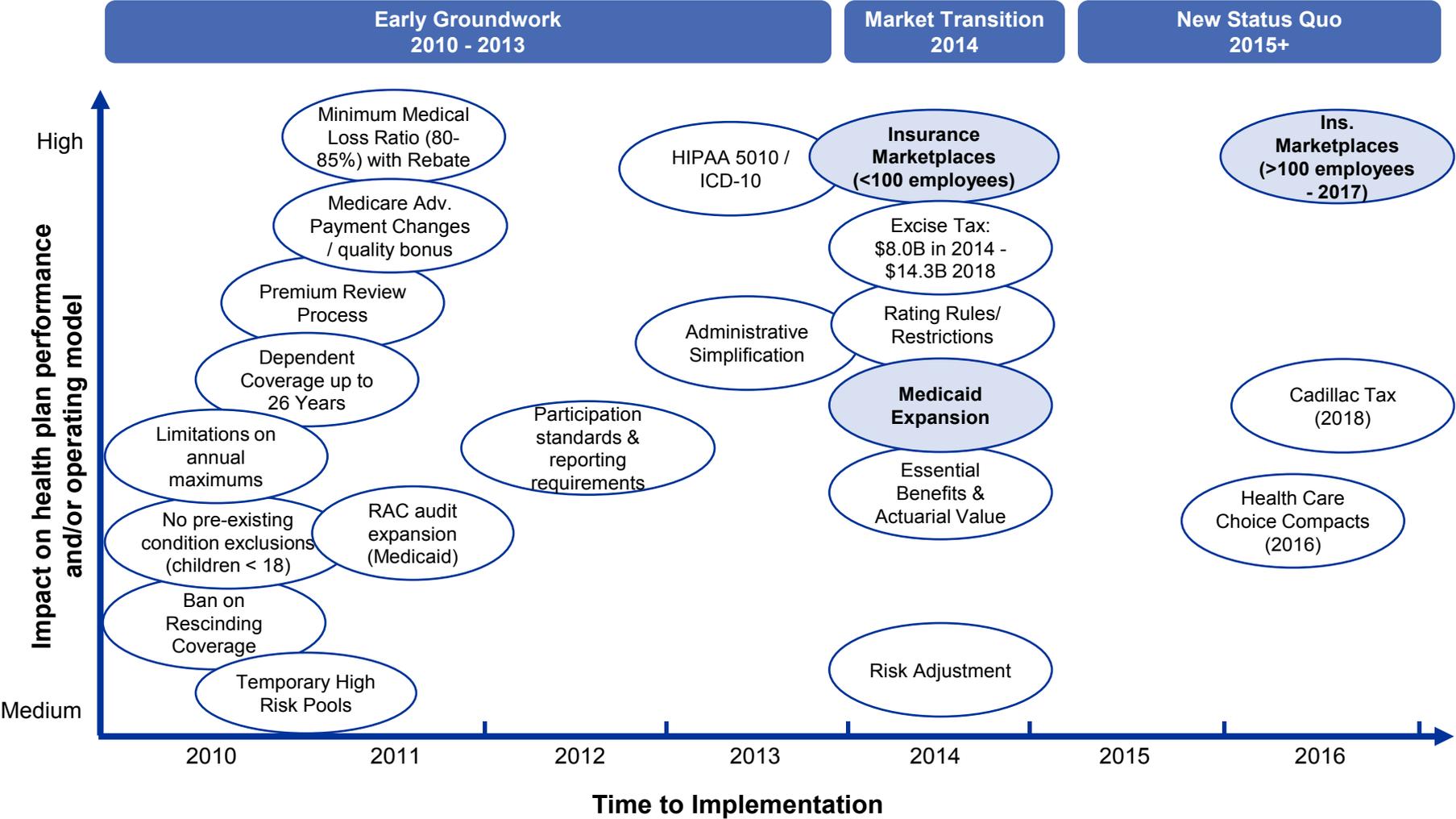


————— **ACA Impact on Health Insurance** —————

Health reform's transformation will unfold over many years

These provisions will unfold in three phases over the next 5–10 years.

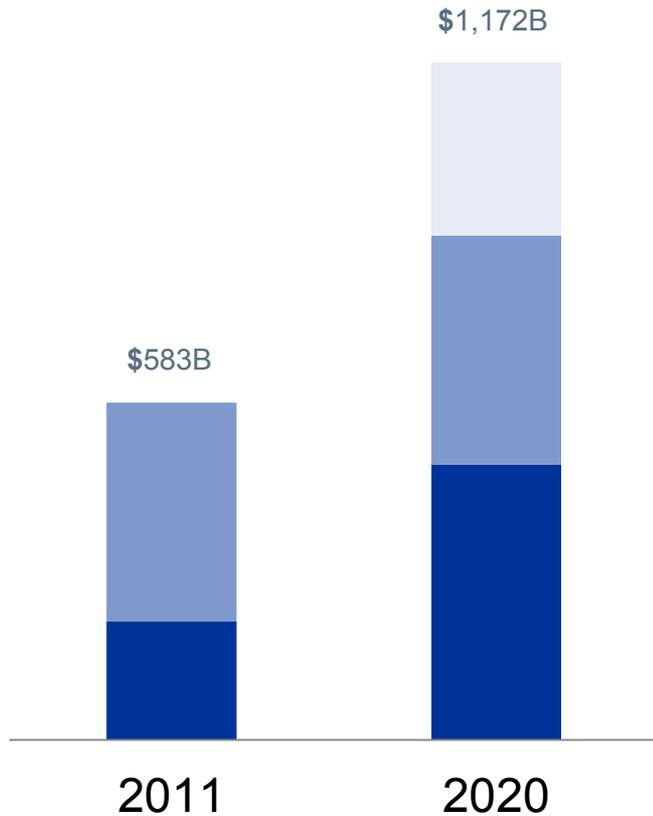
Timeframes and Highest Impact Provisions



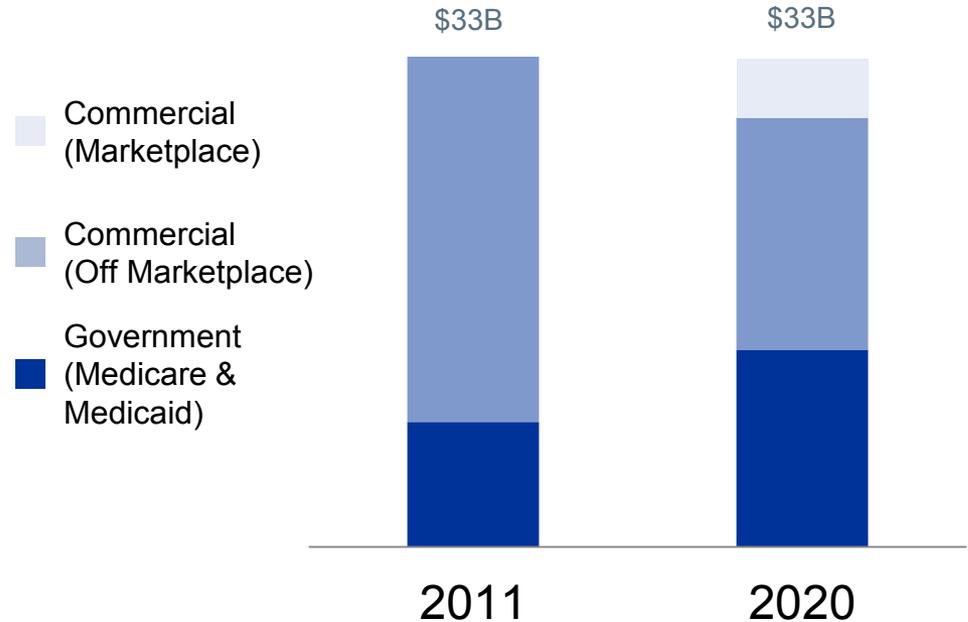
Health reform impact on health plans

Health reform will bring long-awaited customer growth, but will also compress industry margins, neutralizing profit growth.

Industry premium revenues (2011/2020)



Industry operating profit (2011/2020)



Source: Deloitte analysis

Note: Not to scale versus revenue

Health plans must make strategic choices in three areas to define their future

Health plans must address three major strategic questions to create an effective post-reform strategy. To answer these questions, plans must understand the legislation changes and the market's likely response.

Reform Impact Areas	Markets	Incentives	Standardization
Strategic Choices	Which markets should you serve? Which products and services should you offer?	What incentives will influence providers and consumers to make efficient and effective healthcare decisions?	In the face of increased standardization, how will you create opportunities for differentiation?
Statutory Changes	<ul style="list-style-type: none">▪ Marketplaces▪ Medicare and Medicaid▪ Large groups and employers	<ul style="list-style-type: none">▪ Transparency▪ Provider reimbursement and delivery systems	<ul style="list-style-type: none">▪ Products and pricing▪ Administrative standardization

Health Insurance Marketplaces will fundamentally alter the industry

Health plans must develop strategic strategies for each Insurance Marketplace (sub-state, state or region and individual and/or small group).

Key Changes

- By 2014, States will establish marketplaces for individuals and small groups (in 2015) consisting up to 50 or 100 individuals.
- Health plans must cover minimum essential benefits with actuarially equivalent plan designs.
- Marketplaces will use standard forms and processes to determine program eligibility and plan enrollment.
- In 2014, the HHS Secretary will rate each plan on the Marketplaces on quality, price, and patient satisfaction.

Expected Outcomes

- In 2014, Marketplaces will become a significant distribution channel for the individual markets.
- Transparency around quality and member satisfaction will play increasingly large roles in consumer plan selection over time.
- Marketplaces will lower barriers to market entry.
- Many different marketplace models will emerge, requiring different strategies and operations in different states.

Strategic Choices

Which states represent the best growth opportunities for Health Plans?

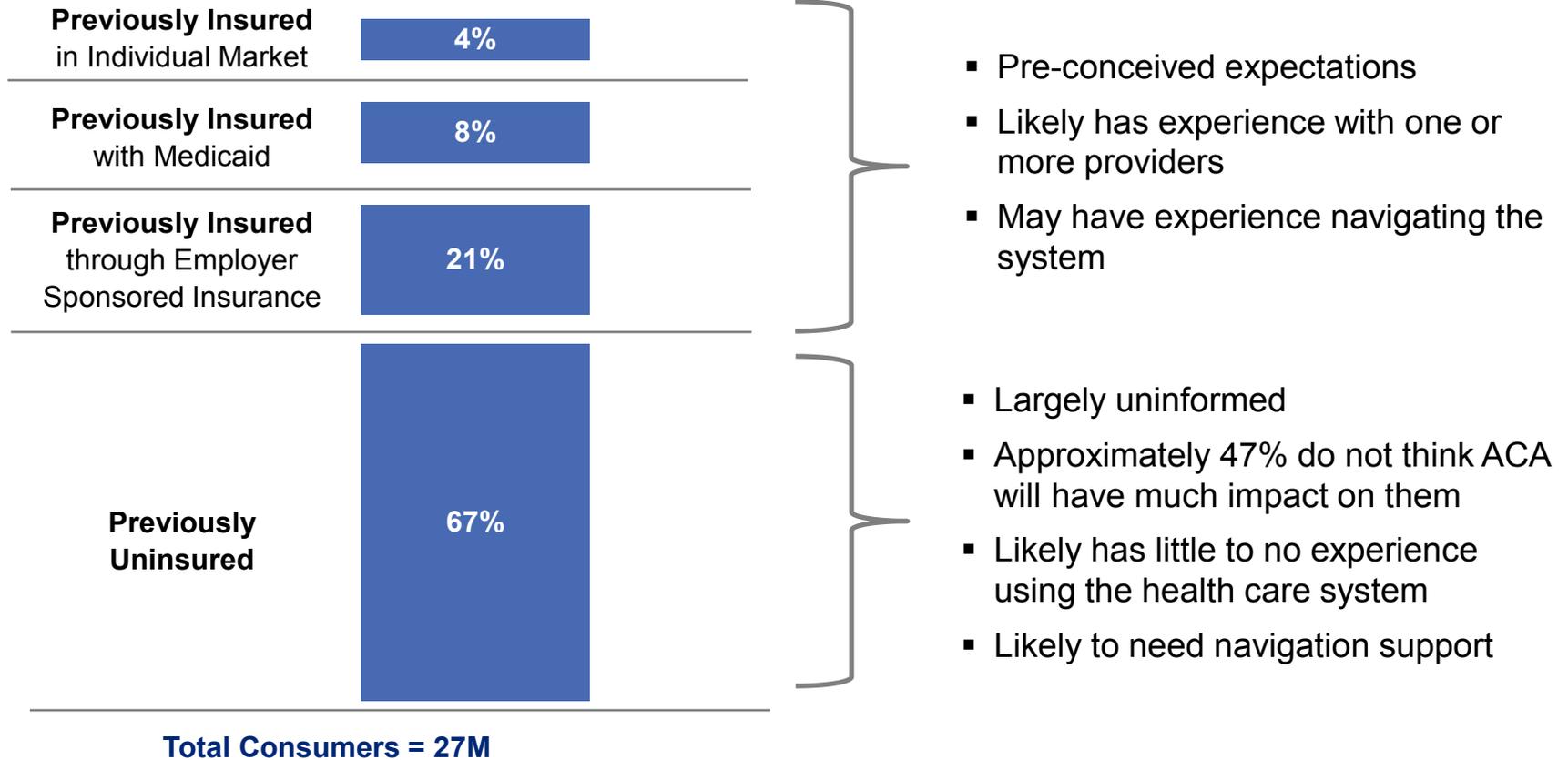
How will Health Plans differentiate products on the Marketplaces?

Which products will Health Plans offer on each Marketplace, and how will they price them?

Most Marketplace consumers will be previously uninsured and inexperienced

These individuals will have a different set of expectations and needs than previously insured consumers.

Individual Marketplace Consumers



Source: Kaiser Family Foundation “A Profile of Health Insurance Exchange Enrollees” March 2011; “Uninsured but Not Yet Informed” August 2011

Fundamental change for health plans

While much of how states will implement marketplaces is still largely unknown, the legislation suggests a fundamental change in individual and small group markets.

1

The health plan market will change dramatically

- Shift of oversight and ownership of key processes from health plans to marketplace
- Increase in development of different capabilities
- Greater transparency and disclosure

2

Retail market will expand

- Shift to retail fueled by the marketplaces

3

Insurance Marketplaces will change the way plans do business

- Will strongly influence product design, pricing, placement (e.g. in versus out of the marketplace).

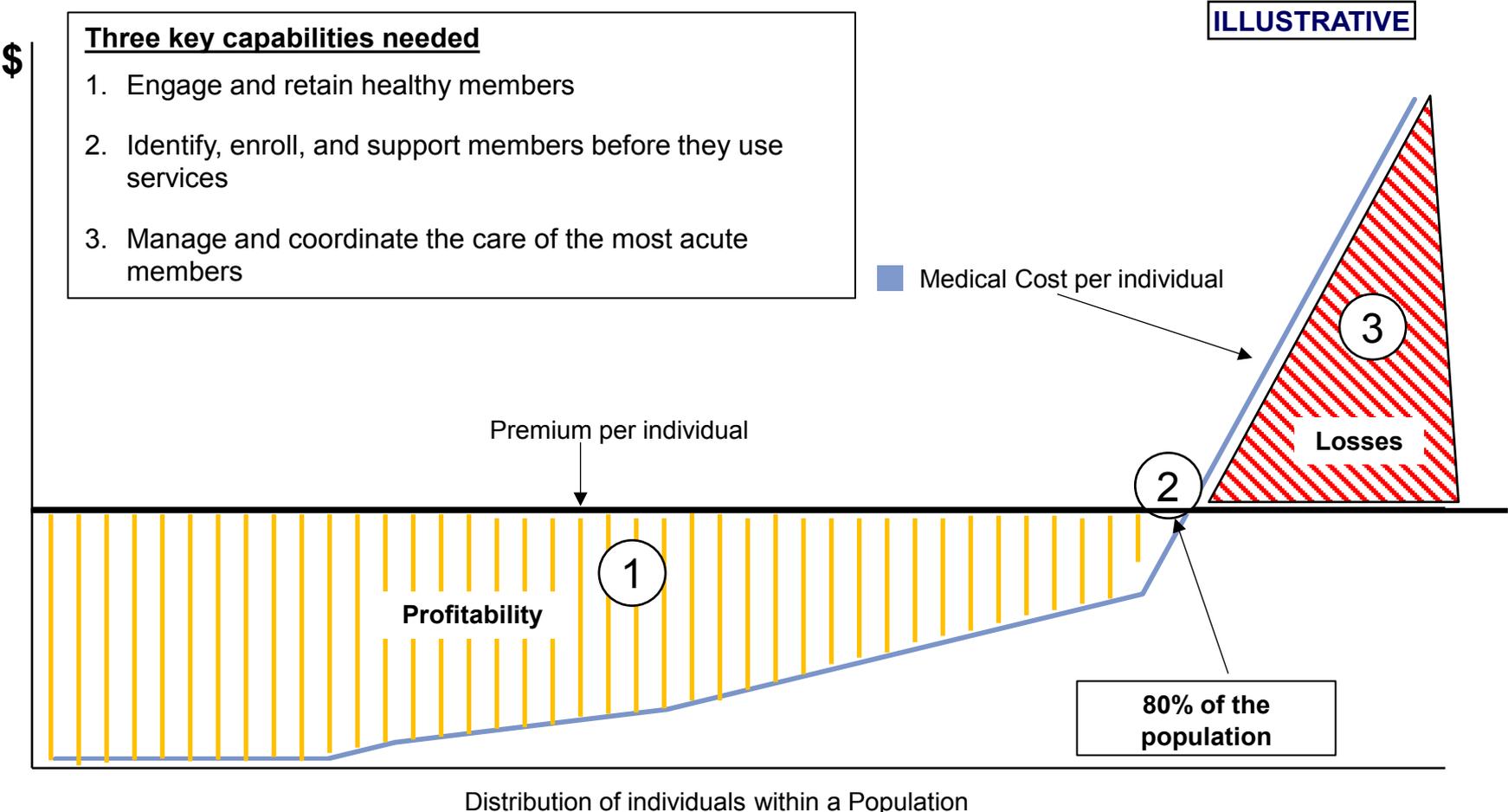
4

Risk management and health management capabilities will become more important

- Increase in development of innovative strategies to control risk and adverse selection
- Must manage a “sicker” population cohort

Health reform brings a new focus on identifying members before they utilize care

The following graph illustrates a sample distribution of the medical costs and premiums for a commercial population.



Source: Deloitte analysis

Changes to Medicare and Medicaid will alter the dynamics of those markets

Continued growth in Medicare and expanded Medicaid eligibility will create growth opportunities for plans that can profitably serve these members.

Key Changes

- By 2014, Medicaid will be expanded up to 133% of FPL and the aging population will result in roughly 10 million new Medicare members.
- Multiple pilots across the country related to dual eligible members will be a major cost for CMS.
- High-quality MA plans will be eligible for up to a 5% quality bonus based on HEDIS metrics and customer satisfaction.

Expected Outcomes

- High potential membership growth opportunities for health plans.
- New opportunities for innovative care delivery models.
- Many State Medicaid programs will look to health plans to serve this increase in membership.
- The profitability of Medicare Advantage products will depend greatly on a plan's ability to achieve the quality bonus.

Strategic Choices

What markets represent the best Medicaid growth opportunities?

How can the bonus for the Medicare Advantage plan quality be captured?

How will Health Plans manage the costs the high needs members?

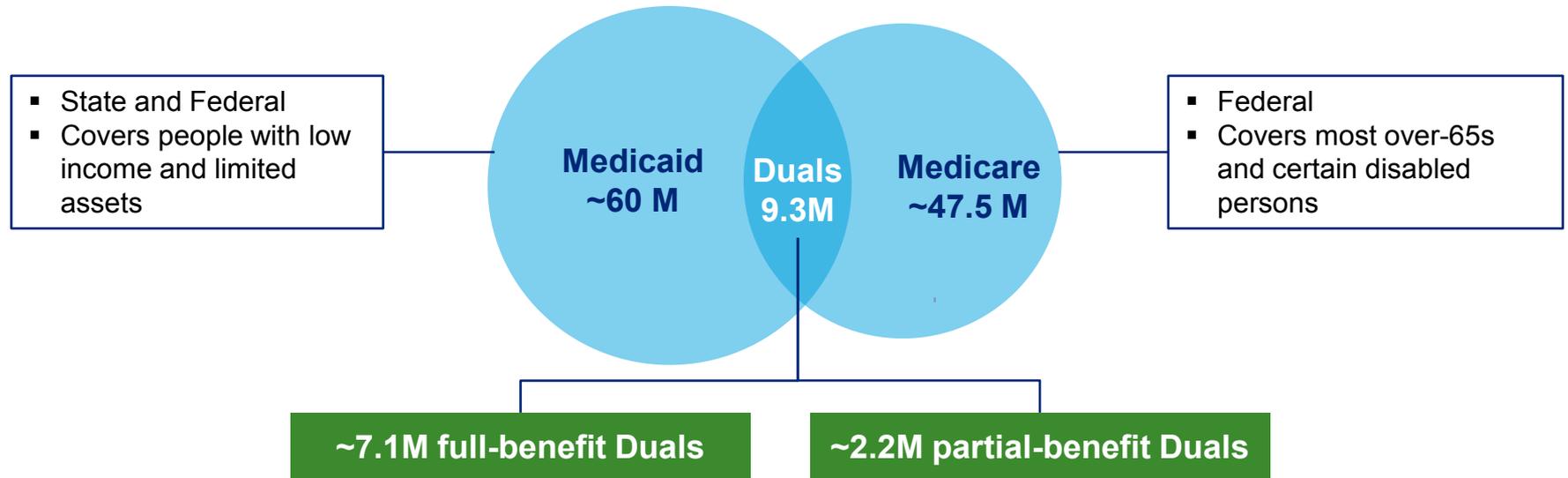
Beyond capturing churn, Medicaid MCOs will need additional capabilities to succeed in expansion and Marketplace-driven markets

	Influencing Elements	Key Considerations and Implications
 <p>Product Design</p>	Essential Health Benefits (EHB)	<ol style="list-style-type: none"> 1. Wide variance in the implementation of EHB rules by state 2. Structure changes in the bidding process 3. Possible minimum guaranteed coverage period for Medicaid or Marketplaces
 <p>Operations</p>	Cost, Contracting, and Administrative Burden	<ol style="list-style-type: none"> 1. Cost will play a significant role in consumer choice 2. Network adequacy and contracting will be critical considerations for plans 3. Managing and allocating premium and subsidy collections from multiple sources will be complex
 <p>Marketing</p>	The roles of Agents, Brokers, and Navigators*	<ol style="list-style-type: none"> 1. Variability in the use of brokers and navigators will affect the way a Medicaid MCO interacts with Marketplaces and new populations 2. Documentation distributed to enrollees may be created by several different entities and communicated through multiple channels inside Marketplaces

*Navigators are health plan employees who help individuals select appropriate products

Sources: Deloitte health reform coverage model (comparison of baseline and high employer coverage-drop scenarios), CBO estimates, KFF.

The 7M full-benefit Duals are a heterogeneous population with diverse health care requirements



Duals are among the sickest, poorest and highest cost (per capita) beneficiaries

- Average per beneficiary payments per year¹:

– Dual eligibles:	~ \$30,000
– Medicare:	~ \$9,000
– Medicaid ² :	~ \$2,800

Duals vary greatly in terms of living situation, health status and age:

- Approximately 61% are **aged** (>65)
- Over 40% have **chronic conditions**
- More likely to be **disabled** than other Medicare beneficiaries (39% vs. ~20%)
- More than 40% have **cognitive or mental impairments**
- A significant portion (>15%) **live in institutional long-term care settings**

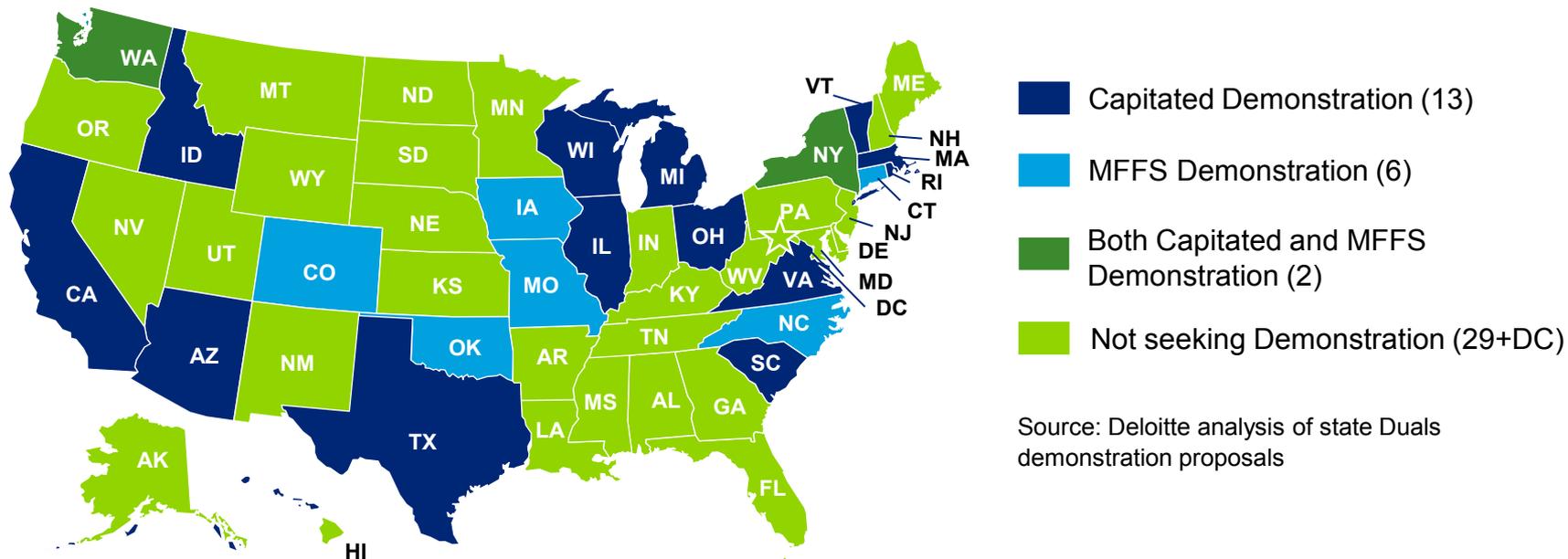
¹ Medicaid Non-Dual TANF

² KFF report(April 2012) FY08 and MACPAC (June 2012)MACPAC) — FY09

Sources: CMS, Kaiser Family Foundation, MedPac, Citigroup

Plans will likely face unique requirements for Duals in participating markets due to differences State Demonstration designs

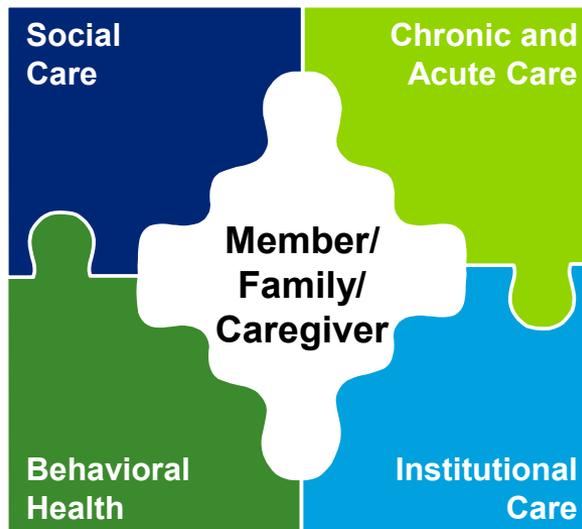
State Actions Towards Integrated Services (February 2013)



Plans will have significant room for experimentation in their Duals management approach within the existing and evolving requirements for integrated care in participating markets.

Collaboration with community-based resources can enhance the delivery of an integrated Patient- Centered Care model

Plans should develop and implement patient-centered care delivery strategies and interventions that bring together the medical, long term care, mental health, and substance use services.



Leading Requirements

- Patient-centered approach
- Coordinated and seamless care across the continuum of providers
- Timely assessment of member risks and needs
- Delivery model that utilizes interdisciplinary care teams
- Development of individualized longitudinal care plans that describe services and intended outcomes
- Facilitated transitions across types of setting and levels of care
- Increasing Medicare and Medicaid benefits
- Working with current state waiver programs to transition members into the Duals coverage

Source: Deloitte analysis

Employers will continue to seek cost containment opportunities

Health plans must continue to find new and innovative ways to effectively serve their large group customers and demonstrate value.

Key Changes

- Coverage is extended to dependent children up to age 26.
 - Pre-existing condition, annual and lifetime limits are eliminated.
- Plans in existence on March 23, 2010 can maintain existing coverage if no significant changes.
- Beginning in 2017, states may allow large groups to purchase health insurance on Marketplaces.

Expected Outcomes

- Most large & medium employers will continue to offer benefits.
- The number of employers who choose to grandfather their existing health plans will decrease.
- Self-funded plans will demand the same level of administrative efficiency (MLR) from health plans as fully-funded plans.

Strategic Choices

What long-term value can Health Plans deliver employers?

Will Health Plans invest its resources in the large or individual/ small group markets?

How will Health Plans communicate and engage with large group employers?

Provider reimbursement and delivery system models will shift to incent value

Health plans play a key role in designing and implementing provider incentive structures.

Key Changes

- Medicare payments will be increasingly tied to quality.
- Demonstration projects will allow testing of new kinds of delivery models such as ACOs and Medical Homes.
- Physicians must submit data on quality measures or face payment reductions
- HHS will collect and make available data on provider quality and use

Expected Outcomes

- New care models emphasizing quality, care coordination and cost management will emerge and be adopted .
- Opportunities for health plans to provide services to customers and collaborate with providers.
- Plans will innovate as new reimbursement models prove effective and become more familiar with local market forces.



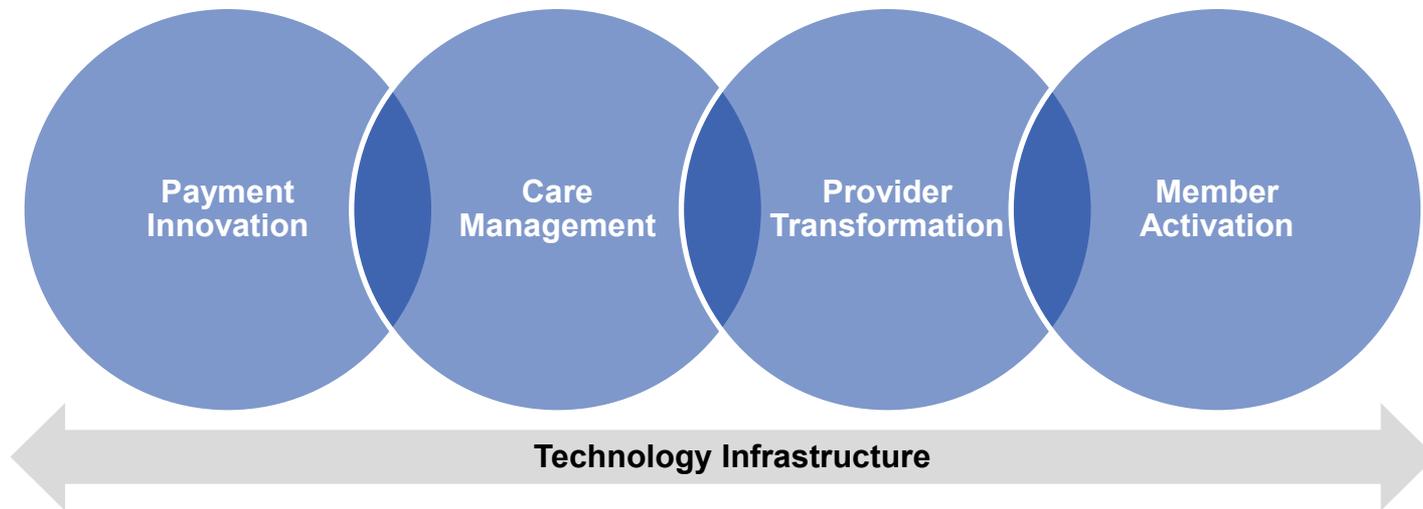
Strategic Choices

How will Health Plans structure and implement emerging changes in reimbursements?

How can Health Plans leverage technology and analytics to identify quality and value?

How will Health Plans collaborate with providers?

Key Solution Components that Drive a Shift to Accountable Care



Payment Innovation

- Moving from volume to value-based payment models

Care Management

- Promoting ensured access and proactive longitudinal population health care built around the needs of the patient

Provider Transformation

- Giving providers the information, tools, and resources they need to move towards a proactive, coordinated, population health model (cross continuum management of a patient)

Member Activation

- Engaging attributed members as active participants in the model and encouraging the establishment of a relationship with a trusted provider

Technology Infrastructure

- Creating the information and work flow tools that will enable the transformation for all constituents across the continuum

Payment Reform – Past and emerging payment methodologies

Evolving reimbursement strategies enable increased provider impact on services and overall cost effectiveness. The ideal methodology will depend on an organization’s capabilities and long term vision.

	Reimbursement Methodology	Description	Examples	Low
Support better performance	Fee-for-Service	Payment for specific services rendered by provider to patient	<ul style="list-style-type: none"> ▪ % of charges ▪ Fee schedule (RBRVS) 	LEVEL OF RISK SHARING High
	Per Diem	Payment per day of inpatient care	<ul style="list-style-type: none"> ▪ Medical/surgical: Maternity ▪ ICU/CCU, NICU 	
	Bundled Payments	Case payment for a particular case based on DRG or case rate	<ul style="list-style-type: none"> ▪ Case rate ▪ MS-DRG 	
Pay for better performance	Pay for Performance	Provider payments tied to one or more objective metrics of performance	<ul style="list-style-type: none"> ▪ Guidelines-based payment ▪ Nonpayment for preventable complications 	
	Episode Based Payment	Case payment for a particular procedure or condition(s) based on quality and cost	<ul style="list-style-type: none"> ▪ Osteoarthritis ▪ Coronary Artery Disease 	
	Service Defined Capitation	Per-person payment for a specific specialty service	<ul style="list-style-type: none"> ▪ PCP visit ▪ Lab work 	
	Condition Specific Capitation	Per-person payment for a specific condition or group of conditions	<ul style="list-style-type: none"> ▪ Diabetes ▪ Cancer cases 	
Pay for higher value	Provider Defined Capitation	Per-person payment regardless of volume of care for the patient	<ul style="list-style-type: none"> ▪ Managed care/ Health Plan payment model 	
	ACOs	Capitation to an Integrated Delivery System for full risk of all services of a member group	<ul style="list-style-type: none"> ▪ Global payment ▪ ACO shared savings program ▪ Medical home ▪ Hospital-physician gain sharing 	

Health reform will increase the transparency of quality, costs, and profits

This will force health plans to rethink and redefine their value proposition in the market.

Key Changes

- Medical loss ratio (MLR) reporting will be required and results will be public .
- Individuals and small businesses will be able to compare available insurance coverage options.
- Employers will be required to inform employees of all coverage options.
- Establishment of the Patient-Centered Outcomes Research Institute.

Expected Outcomes

- Increased transparency will have more influence on consumer purchasing decisions.
- Consumers will demand additional information and value as they increase their understanding of coverage options.
- Use of clinical data will take comparative effectiveness “local” and inform formulary and coverage decisions.
- Brand and “brand value” will be important contributors to health plans’ success.

Strategic Choices

What is an appropriate brand strategy in the new, transparent world?

Is now the right time to invest in consumer-oriented transparency?

Can or will MLR performance become a competitive advantage?

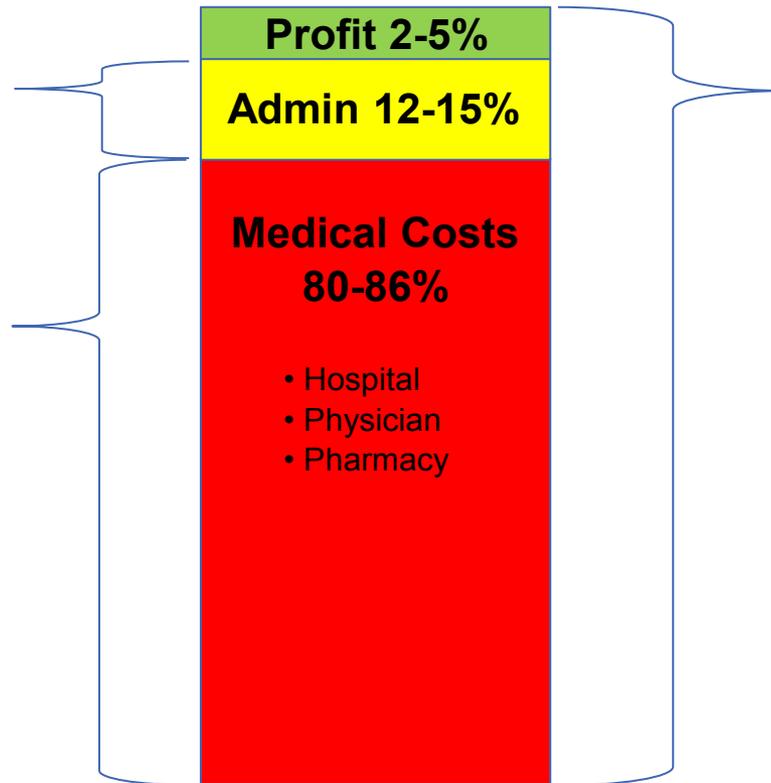
Commercial Funding Types

Employers will choose between Administrative Services Only (ASO) or Full Risk funding types.

Administrative Service Only (ASO)

- Employer pays for the administrative cost of providing a network and processing claims
- Employers assumes risk for medical costs but does not pay a profit premium

Health Plan Revenues



Full Risk

- Employer assumes no risk for medical costs, but the health plan charges a profit for taking that risk

Medical Loss Ratio (MLR) Provision

Medical loss ratio is defined as the percentage of premiums spent on reimbursement for clinical services and activities that improve health care quality.

Minimum Standards

- Large group insurers must spend at least 85% of premium dollars to improve health care quality
- Individual and small groups must spend 80% on claims and activities for quality improvement

Calculation

- MLR calculations will be based on the aggregate experience of the licensed issuer for each state.
 - Evidence-based medical cost activities that improve health care quality will be included in the calculations.
 - Activities designed primarily to control or contain costs will be considered administrative.

Medical Loss Ratio continued

In order to be counted and reported as a quality-improvement activity, the activity must meet the following requirements:

- Be designed to improve health quality
- Be designed to increase the likelihood of desired, measurable health outcomes
- Be directed toward individual health plan members
- Be grounded in evidence-based medicine

Administrative Costs

- Claims Processing
- Billing and Enrollment
- Sales and Marketing Costs
- Finance & HR costs
- Executive salaries
- Most IT costs
- Utilization management programs
- Prevention and Wellness services provided to all members of a community (i.e. free flu shots in a shopping mall parking lot)

Medical Costs

- All Payments for Provider Services providers
- Patient case management fees
- Provider incentive payments (P4Q)
- Case and disease management programs
- Wellness programs provided exclusively for members
- Quality initiatives – telephonic outreach programs to increase mammogram rates
- IT costs to support care management and quality improvement programs

The combination of ICD-10 and administrative simplification will create significant challenges and opportunities for health plans

ICD-10 administrative simplification, and other standardization requirements will require health plans to make considerable and continued investments over the next 5–7 years.

Key Changes

- Diagnosis coding must be upgraded from ICD-9 to ICD-10 by 2013.
- Mass automation of administrative procedures implemented by 2016.
- Minimum MLR requirements must have been met by 2011.
- In 2010, plans begin to submit premium increase justifications to the state for review.

Expected Outcomes

- Successful health plans will achieve administrative operating costs that are no more than 8-9% of premiums.
- Small and medium plans will seek to merge, be acquired, or partner to defray the investment costs of administrative simplification and ICD-10.
- Simplification will decrease marginal transaction costs and allow health plans to contract with lower volume providers without sacrificing margins.

Strategic Choices

Do Health Plans want to leverage standardization to keep up?

Or do Health Plans want to invest to create competitive advantage?

How will Health Plans preserve margin with MLR requirements and premium increase reviews?

The Path Forward

As health plans contemplate reform's changes and make strategic choices, they will define their new post-reform strategy

Reform Strategic Choices

Which markets should a Health Plan serve? Which products and services should you offer?

What incentives will influence providers and consumers to make efficient and effective healthcare decisions?

In the face of increased standardization, how will Health Plans create opportunities for differentiation?

Statutory Changes

- Marketplaces
- Medicare and Medicaid
- Large groups and employers

- Transparency
- Provider reimbursement and delivery systems

- Products and pricing
- Administrative standardization

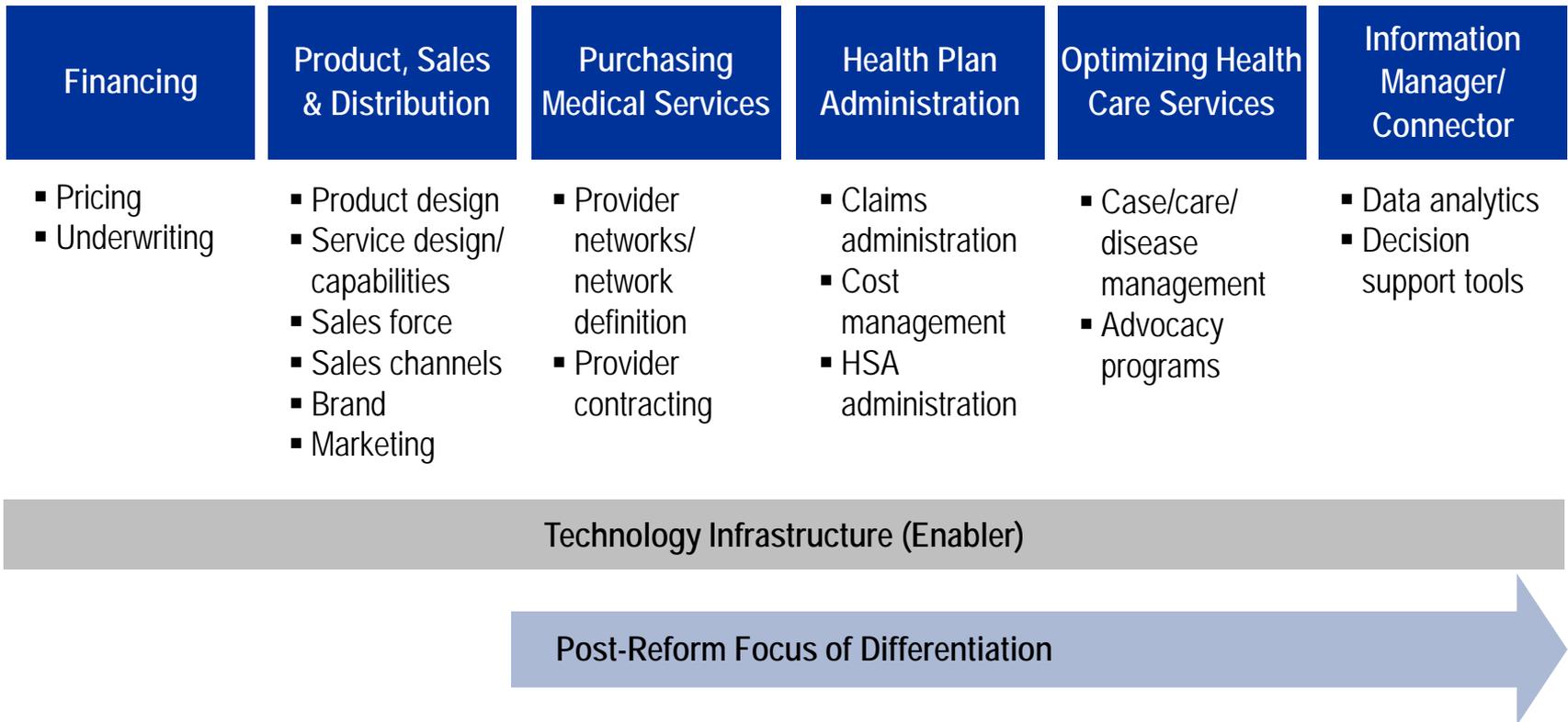


**Post-
Reform
Business
Strategy**

A Shift in the Capabilities Required

The source of value in the health plan market post-reform will shift towards the ability to manage information and impact the quality and medical cost trends.

Traditional Health Plan Roles & Opportunities for Differentiation



Different models of success will emerge

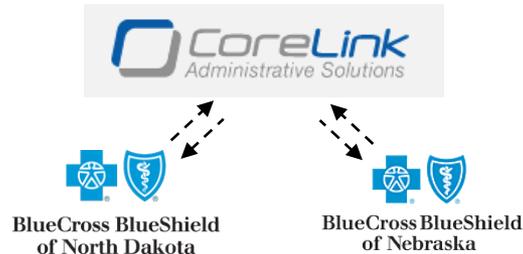
Diversification



- UnitedHealth Group provides a diverse array of services including:
 - Behavioral benefit solutions, clinical care management, financial services and specialty offerings
 - Database and data management services
 - Integrated suite of pharmacy benefit management services
- In 2010, non-core revenue was 9% of total revenue

United Healthcare Group leads the industry with \$40.5B market cap¹

Shared Services Model



- CoreLink is a long-term IT investment, initially funded by Blue Cross Blue Shield of Nebraska and North Dakota
 - Provides systems support and streamlined services for claims and customer service
 - Claims processors and customer service employees share the system that supports their jobs

BCBS of Nebraska and North Dakota credit CoreLink for driving admin costs to \$0.07 of every premium dollar²

Provider Focused Plan



- Kaiser Permanente (KP) allows coordination between the health plan, hospital and physicians & medical group
- Regional Kaiser health plans are evaluated on how well they manage patients across the lifetime continuum of care³

Three KP plans (representing 82% of total KP membership) are ranked in the top 15% of U.S. health plans⁴

¹United Healthcare Group market cap on December 8, 2010.

²Blue Cross Blue Shield of North Dakota: *Sharing the Wealth*, Inside Healthcare, May 2009.

³Organized Health Care Delivery System Case Study, Commonwealth Fund, June 2009.

⁴NCQA's Health Insurance Plan Rankings 2010-11, Detailed Report, July 2010.

Implementing a new business strategy will require bold action, responsiveness to market realities, and flexibility

Drive Alignment through Accountability

- Build value-based-payment and benefit models
- Launch community health status and consumer-based incentive models
- Drive adoption of Comparative Effectiveness

Differentiate through Collaboration

- Offer support services to ACO provider organizations
- Grow through collaborative delivery system investments
- Develop community health consortiums and collaborative disease management

Expand Roles through Innovation

- Build information-intensive products and consumer health-related markets
- Design value-based networks to increase value and spur healthy competition
- Co-brand with other innovators and trusted names

Health reform's "winners" will be those health plans that are adaptive to change, innovative in strategy and execution, and willing to take risks.

Public Health's Role in ACA/Marketplace

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Overview of Vermont Experience

Harry Chen, MD

Commissioner, Vermont Department of Health

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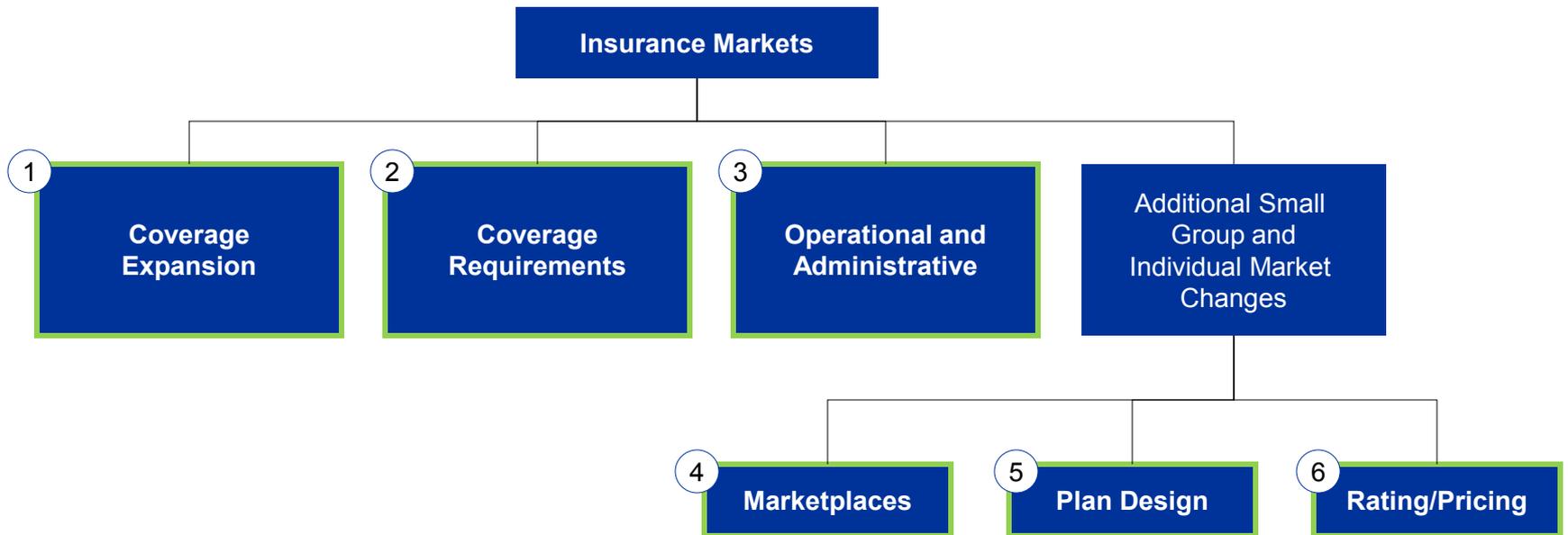
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Appendix

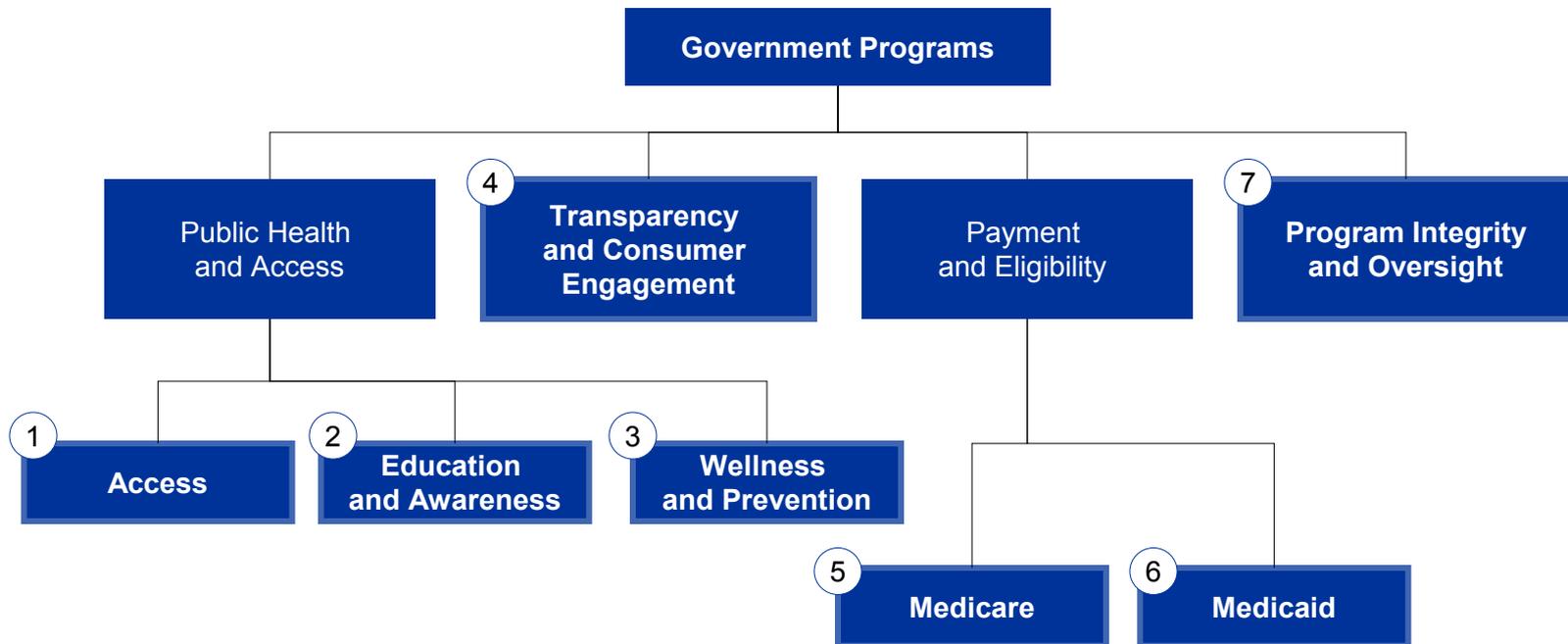
Key Provisions of the Reform Legislation – Insurance Markets

The ACA expands the availability of health coverage and fundamentally restructures health insurance markets to support expanded access and larger risk pools.



Key Provisions of the Reform Legislation – Government Programs

The ACA makes a number of changes to various government programs. The most significant changes are to coverage and reimbursement mechanisms in the Medicare and Medicaid programs. Other provisions relate to public health initiatives, education and awareness, wellness and prevention, information transparency, and increased efforts to combat fraud, waste, and abuse.



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