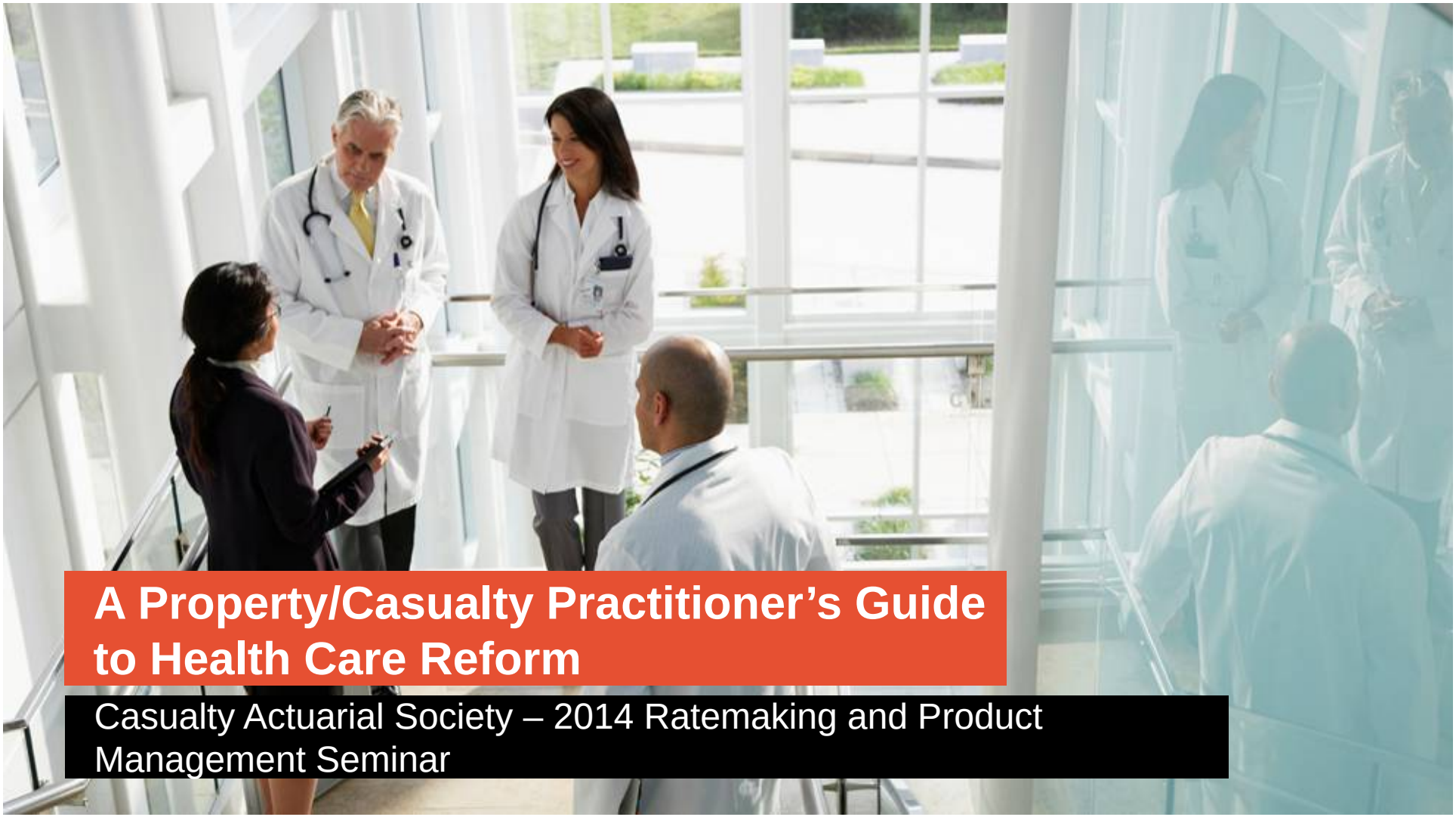

A Property/Casualty Practitioner's Guide to Health Care Reform

Casualty Actuarial Society – 2014 Ratemaking and Product Management Seminar

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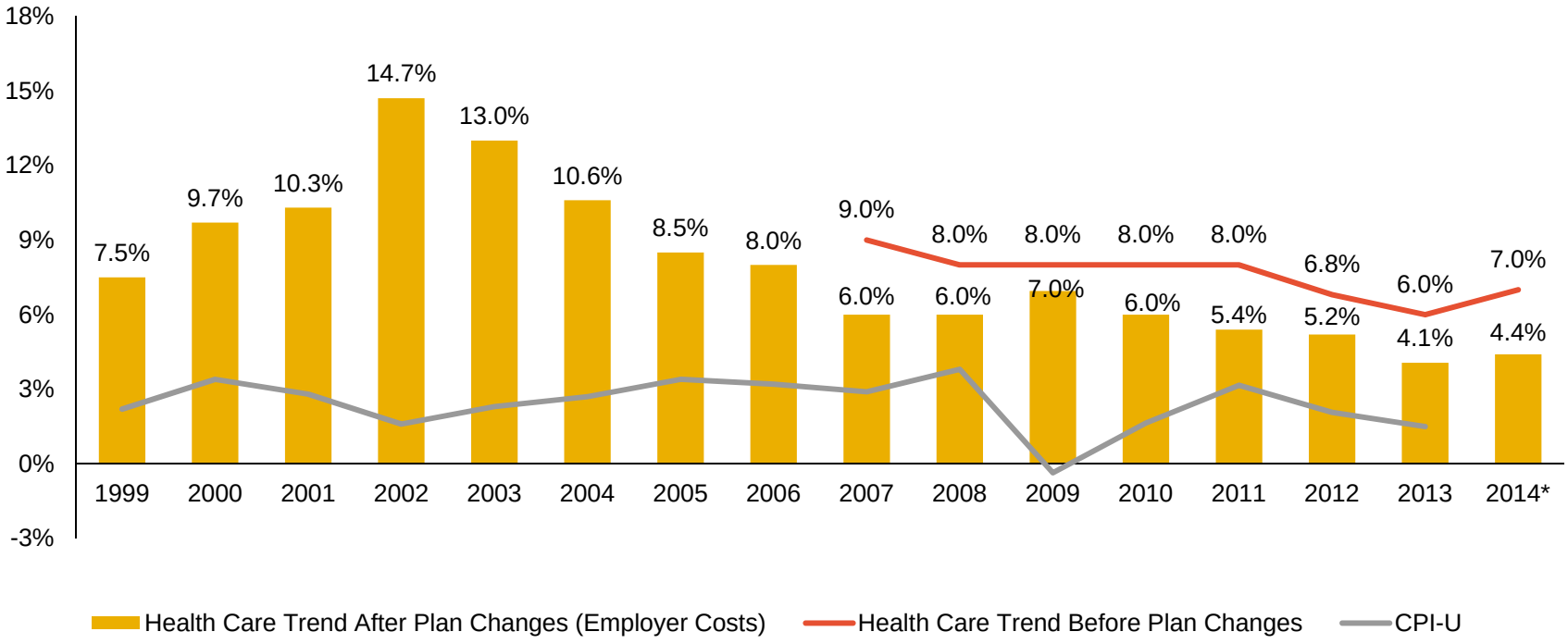
TOWERS WATSON

What is Healthcare Reform and what do we hope to accomplish in today's session as respects Property Casualty Insurance?

- What is Health Care Reform?
  - Patient Protection and Affordable Care Act (PPACA), Affordable Care Act (ACA), "Obamacare", signed into law on March 23, 2010
  - Broad goals are coverage expansion (public and private programs) and cost control
  - Roll out was immediate through 2018, many key provisions effective 1/1/2014
  - Supreme Court Challenge
    - Upheld constitutionality of the individual mandate (an exercise of Congressional authority to tax), BUT held that states cannot be forced to participate in the Medicaid Expansion provisions
- Health Care Reform and Property Casualty Insurance
  - As impact is uncertain, our goal is to introduce ACA provisions and hypothesize on their impact on PC insurance
  - In limited cases, we will supplement hypotheses with statistics or anecdotes
  - We welcome additional insight and opinions

So why have we gotten here?

Health care cost trends remain double the rate of inflation, even after employers have changed plan designs

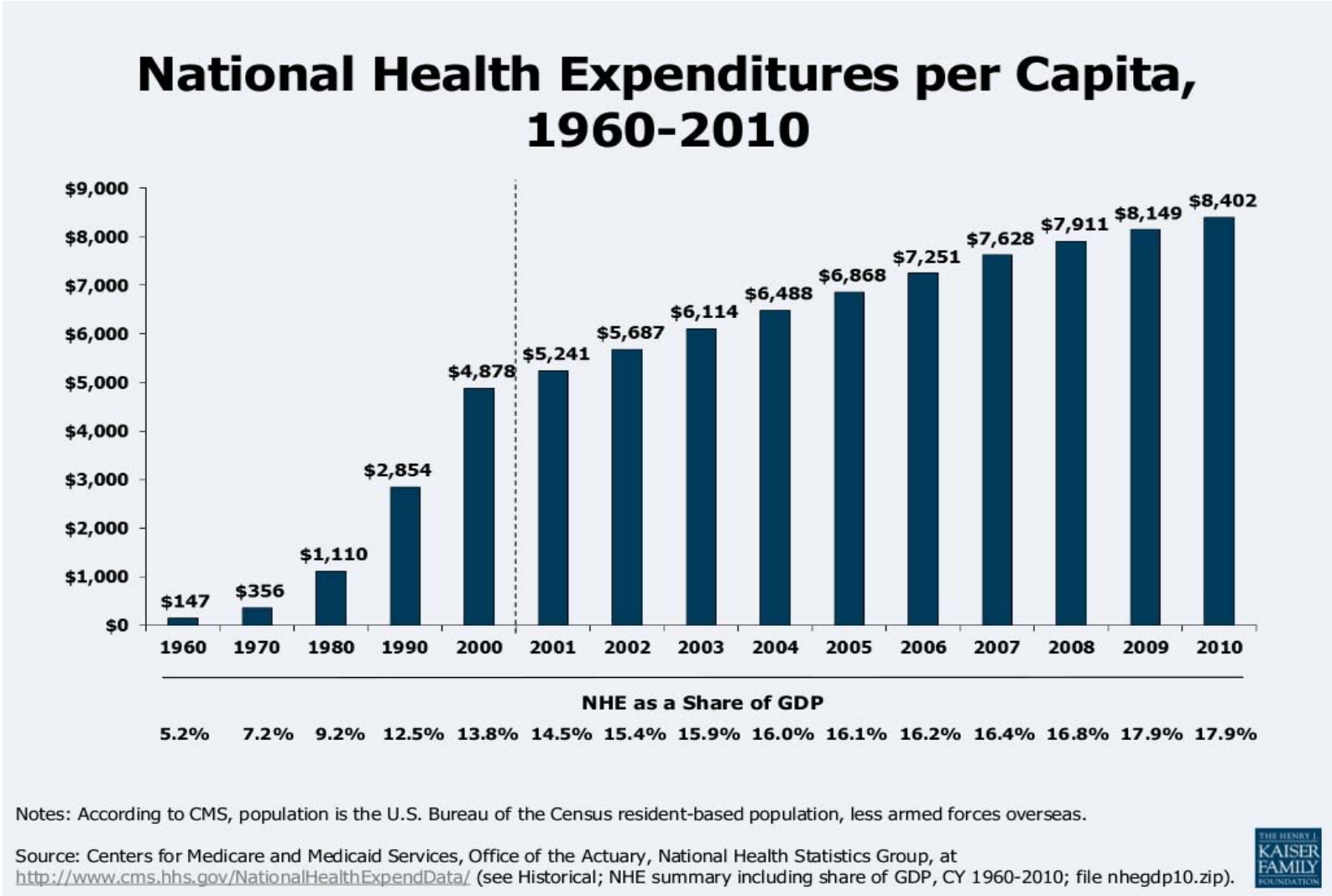


*Expected.

Source: 2014 Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care. Median trends for medical and drug claims for active employees. CPI-U extracted from the Department of Labor, Bureau of Labor Statistics.

Just “where” is the where?

US. Health expenditures are approaching 20% of GDP



Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).

And how do we compare to others?

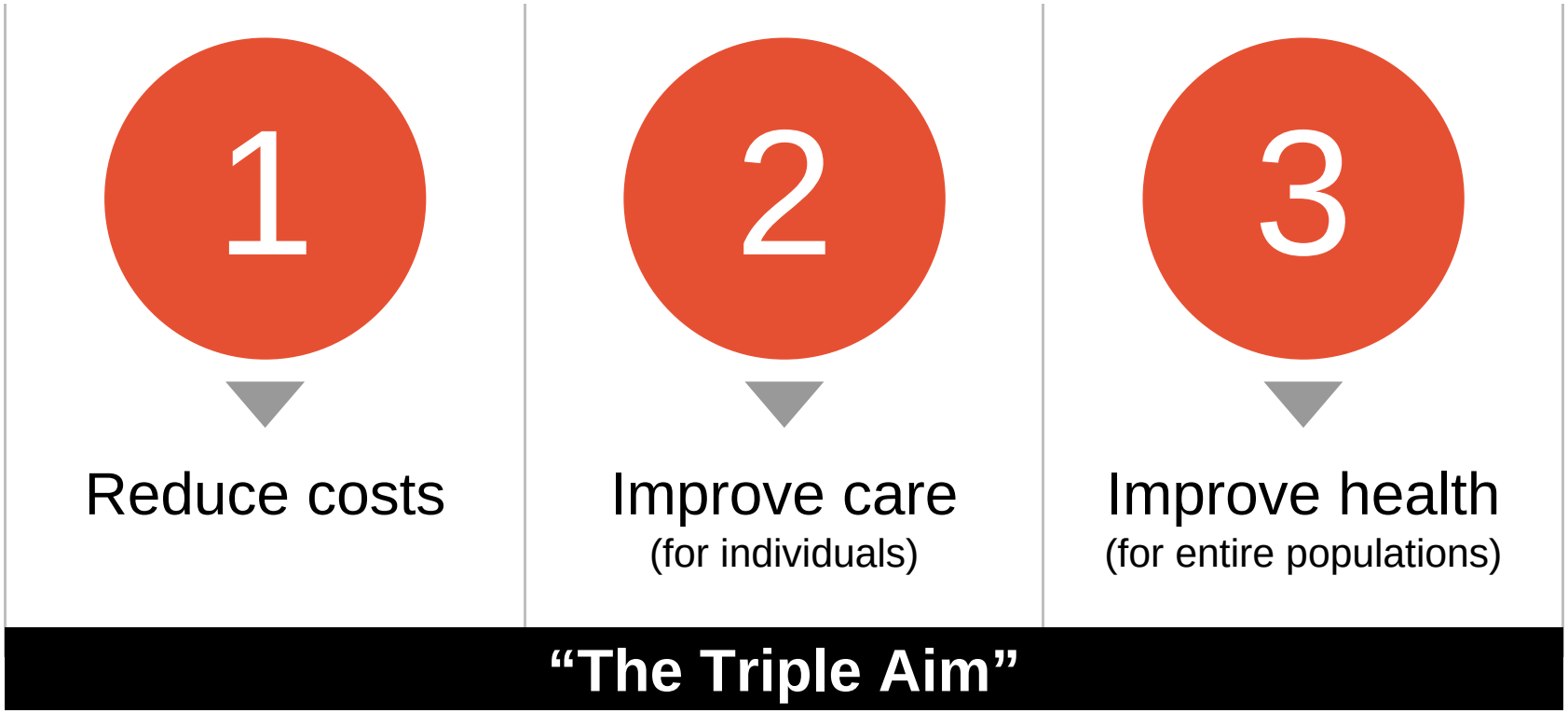
Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

[1] "Graphic: Health Spending by Public and Private Sector," *Kaiser Health News*, February 2010. http://www.kaiserhealthnews.org/Graphics/2010/020410Spending-By-Public-And-Private-Sectors.aspx

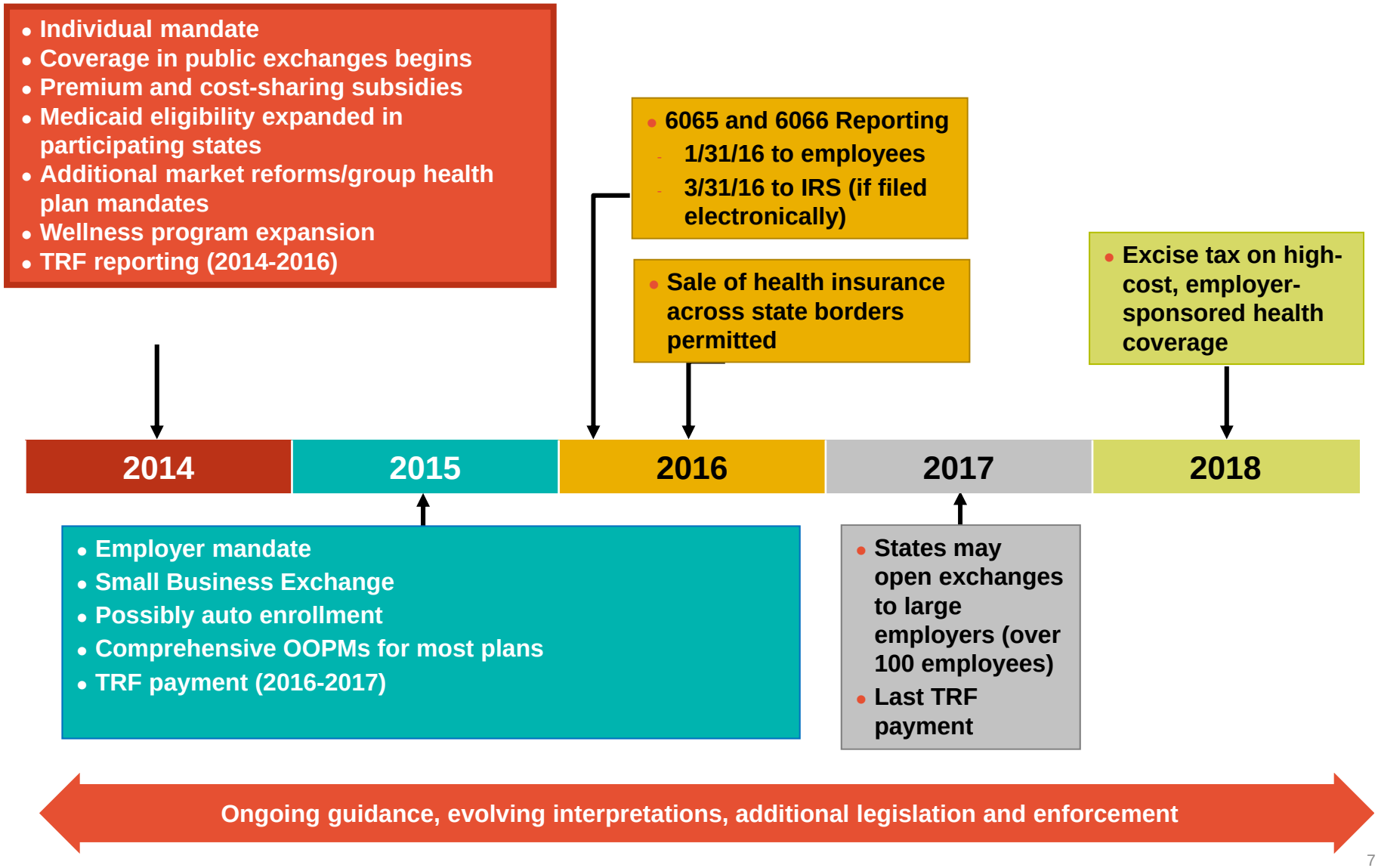
Health care reform takes aim at three key areas



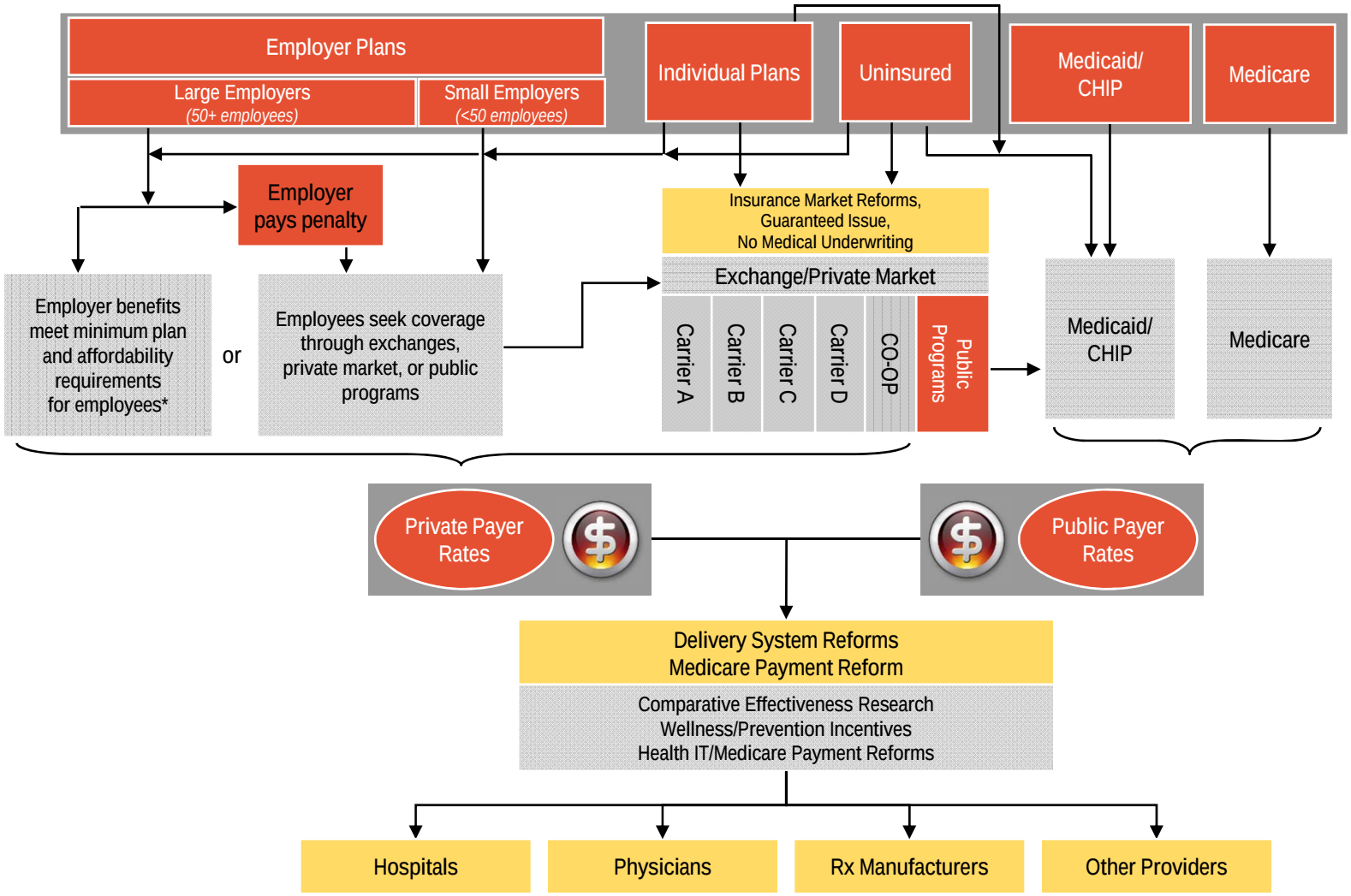
PPACA implements broad, historic changes to U.S. health care

- Expands access to health insurance and care
  - Individual Mandate
  - Guaranteed issue of coverage in private insurance market with restricted rating factors
  - New and complex requirements for employers
  - State Exchanges\Marketplaces –
    - Online marketplace where individuals and small businesses can compare policies and buy insurance - "As of 3/17/2014, HHS reports over 5 million enrolled through the Federal and State Marketplaces"
    - States have either implemented their own exchanges or use the Fed exchange Healthcare.gov (at 3/7, 17 + DC have Exchanges)
  - Expanded Medicaid eligibility if approved by individual states – At 2/7/2014, 25 states + Wash DC have opted in
  - Subsidies and/or premium tax credits for low and modest income individuals
- Focus on containing medical costs and improving health
  - Incentives to create medical homes and Accountable Care Organizations (ACOs)
    - Most health care systems are re-examining their delivery of care model
  - Measures to reduce waste, fraud, and abuse while improving quality outcomes
    - Comparative effectiveness research
    - Value-based Medicare payment structure
    - Resources to address fraud, screening/compliance for CMS, penalties
  - Incentives for prevention and wellness
    - No cost-sharing for preventive services
    - Support for employer-based wellness programs

PPACA implementation: the original plan



For the "near term", much of the current structure of the health insurance market remains, but with new dynamics



Source: Kaiser Family Foundation

The private health insurance market faces continuous uncertainty as the details of ACA emerge

- Significant market reforms
  - Guaranteed issue/elimination of medical underwriting
  - Modified community rating
    - Rating factors limited to age, tobacco use, geographic area, and family consideration
    - Limited variation in rating factors
  - Minimum coverage requirements
    - “Essential” Health Benefits
    - Actuarial Value (e.g. “metal” tiers)
  - Limitations on out of pocket maximums, annual/lifetime limits
  - Transparent marketplace
    - Exchanges
    - Rate review
- Rate stabilization programs
  - Risk adjustment
  - Reinsurance
  - Risk corridor

Public programs benefit from some reforms and provide platform for pilot programs

- Medicare
  - Medicare Advantage rates restructured to reflect differences in Medicare fee-for-service rates
  - Quality bonuses for Medicare Advantage plans and primary care providers
  - Reduce Medicare payments for preventable hospital readmissions and hospital-acquired conditions
  - Bundled payment pilot for various services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge
  - Hospital value-based purchasing program
- Medicaid
  - Increase prescription drug rebates
  - Prohibit federal funding for Medicaid services related to health care system acquired conditions

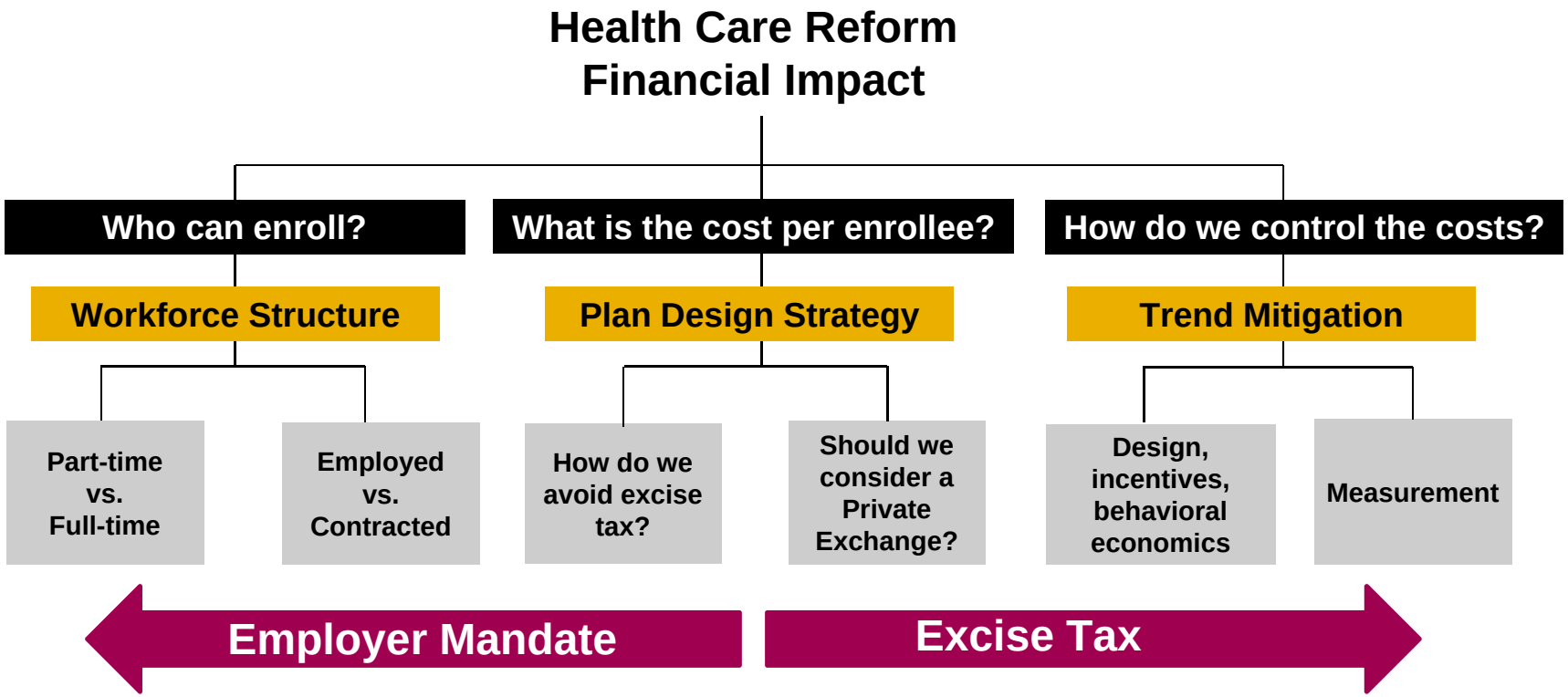
Changes to delivery of care are to promote prevention and quality

- Focus on preventive medicine and primary care
  - Low or no cost-sharing for preventive and primary care services
  - Increased Medicaid reimbursement rates to primary care providers
- Financial incentives to enhance coordination of care through ACOs and Patient Centered Medical Homes (PCMH) in public programs
  - ACO providers share in savings –through Medicare Shared Savings Program
  - May support trend toward employed physician model
  - These models may expand beyond public programs
- Patient Centered Outcomes Research Institute (PCORI) and CMS Innovation Center
  - PCORI to conduct research to help providers and patients make informed decisions using evidence based information
  - CMS Innovation Center – testing “innovative” payment delivery and cost models
- Payment linked to quality metrics
  - Medicare value-based purchasing program for hospital with plans to expand beyond
  - Quality bonuses
  - Plan quality ratings listed on exchanges

Demand for medical services is a source of risk and uncertainty under ACA

- Guaranteed issue and individual mandate expected to reduce uninsured population
  - Individual mandate may or may not be effective
    - Congressional Budget Office currently estimates 7 million will use exchanges
  - Varying opinions on relative morbidity of uninsured populations and impact of pent-up demand
  - Cost-sharing design of private health plans may change incentives to seek care
- Focus on primary care and preventive medicine will increase demand for these services, but how much?
  - Need to balance cost control with quality service
  - Increased reliance on physician extenders to meet demand
  - Specialists may be differently impacted

Employer coverage options and workforce dynamics may shift



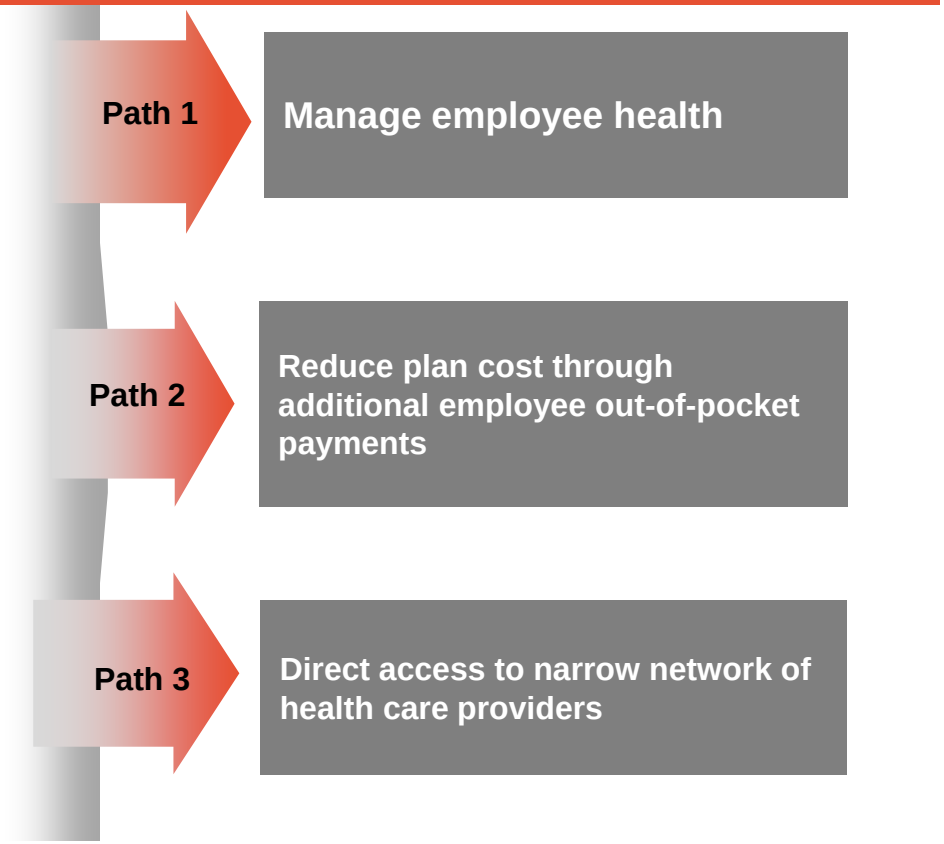
Employer direction and speed of change will likely vary significantly by industry

Excise tax risk for employers effective 2018

Excise or "Cadillac" Tax

- Non-deductible 40% tax on excess of employer "health plan" cost over cost thresholds
  - Cost based on COBRA rate
  - Includes pre-tax contributions to HSAs/FSAs, on-site clinics, etc
- 2018 Active cost thresholds
  - $10,200 individual
  - $27,500 family
- Indexed
  - CPI-U plus 1% for 2019
  - CPI-U only, beginning in 2020

Employer Health Plan Design will focus on excise tax mitigation



The shifting employer role in health care benefit delivery

Traditional ⟶ **Partial Exit** ⟶ **Full Exit**

Current State

- Employer controls all aspects of plan design, funding, vendor configuration
- Employer responsible for all aspects of plan administration, enrollment and communication
- Employer subsidy linked solely to employer plans
- Employee does not see or appreciate full value of health care as employer subsidy is part of hidden compensation

Private Exchanges for Actives/Pre-65s

- In formative stages; several prior efforts have not succeeded
- Significant barriers relating to risk and financing
  - If fully insured, costs may be higher
  - Adverse selection risk
- Employer still retains financial subsidy and initial eligibility determination; other administrative responsibilities passed to the exchange

Private Medicare Exchanges

- Well established now due to functioning individual market for Medicare enrollees offering universal coverage without underwriting restriction
- Individual plans offer higher value vs. group plans (MA, Part D)
- Employer may continue financial subsidy via HRA
- Employer ceases all other aspects of governance and plan management

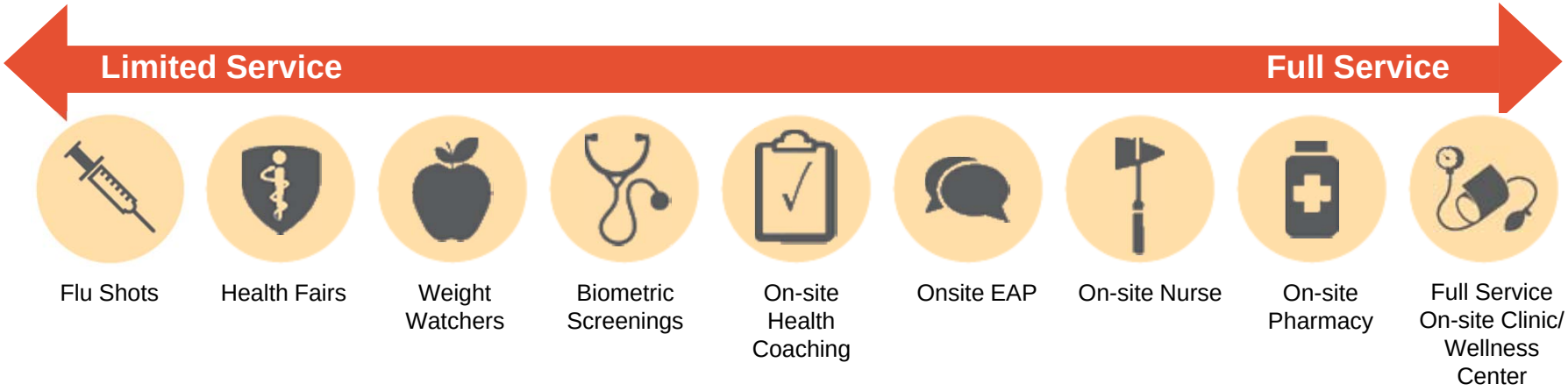
Public Exchanges

- Once enacted, will create functioning individual market
- Universal coverage without underwriting restriction
- Availability of federal subsidies to offset premiums and OOP
- Active employees subject to play or pay decision and associated costs and complications
- Opportunity for pre-65 retiree exit due to high value of reform coverage and lack of play or pay decision

Expanded opportunities for disintermediation of employer role in benefit financing and delivery for health coverage

The On-site Service Continuum

- Employers offer a wide range of services on-site, leveraging technology, the power of an in-person experience and new contracting arrangements



Technology Enablers

- Telemedicine
- Kiosks
- Mobile Applications

- 100% of employers provide flu shots on-site, 81% provide biometrics, 24% provide a full pharmacy, and 8% offer telemedicine services

Source: Employer On-site Clinic Survey fielded May 3, 2012 – May 25, 2012, representing 74 companies and 1.7 million employees

Impact of PPACA on health care delivery systems

- Immediate expansion of Medicaid coverage
  - Possible sicker patients
  - Lower reimbursement rates
- Increased competition for patients with private insurance
- Shifting employer role in health care provision
- Greater provider accountability may lead to integrated care models
- Emphasis on healthcare information technology (HIT)
- "Uneasy" intersection of increased patient demand and decreased physician supply
- Increased focus on efficiency, outcomes, and cost effectiveness

The above items represent significant changes in health care delivery.

How will this impact consumers and how will their behaviors change in response?

Property/casualty risk profiles are likely to evolve in reactions to these changes

- Medical professional liability
  - Health care providers
  - Insurance and other risk-financing mechanisms
- Workers compensation
  - Employers, employees, and health care providers
  - Insurance and other risk-financing mechanisms
- Directors & officers, errors & omissions, and employment practices liability
  - Health care providers
  - Employers
  - Health insurers
- Fiduciary liability
- Automobile liability

Discussion of PPACA and Property/Casualty Coverages

- In the following slides, we identify areas for discussion on the impact of ACA on property/casualty insurance
- Our opinion is that it is still too early to definitively state these impacts – and how they will vary by state.
- The information within the next few slides is meant to provoke thought and discussion. It is NOT an exhaustive listing of all possible impacts.

Decrease in the uninsured population

Provision

- Individual mandates/ guaranteed issue
- Subsidies to expand private insured population
- Medicaid eligibility expansion

Likely Impact

- Fewer uninsured and more units of service delivered
- More patients on Medicaid

CBO estimates from February 2014, expect that in 2014 under ACA 13 million less uninsured, and uninsured population at 45 million

How this could LOWER liability

- More access ➔ Healthier workers, fewer injuries, less delay in diagnosis (WC)
- Could be claim/cost shift to Group Health as GH system less administrative burden to access (WC)
- GH will now cover pre-existing conditions previously absorbed by WC may as EE had no alternative (WC)
- Earlier treatment can lead to better outcomes (MPL)
- Early prenatal care reduces pregnancy risk (MPL)
- Future economic losses possibly smaller for those eligible for expanded coverage (MPL)

How this could RAISE liability

- Could be claim/cost shift from GH as GH likely to have deductibles, co-pay, etc. (WC)
- Capacity shortage can delay return to work (WC) or lead to increased errors (MPL)
- More units of service ➔ more potential risk (MPL)
- Increase in insurance not associated with decline in ED utilization (MPL)

Change in provider model to increase use of non-physician practitioners (NP, PA, Pharmacists/"Health Care Extenders")

Provision

- Increased access will lead to increased use of HCE to meet need

Likely Impact

- Expanded scope of care for HCE's, pharmacists, etc.

Current debates in many states to increase the scope of practice of NP/PAs – thus the resulting impact on liability on this provision may most likely be be state specific

How this could LOWER liability

- Non physicians more likely to follow algorithms (WC & MPL),
- HCE currently have lower costs (WC & MPL)

How this could RAISE liability

- Different level of expertise could lead to missed diagnoses (WC & MPL)
- Physician shortage could lead to inadequate supervision (WC & MPL)
- Current nursing shortage could be exacerbated (WC & MPL)

Adoption of Health Care IT

Provision

- PPACA and American Recovery and Re-investment Act of 2009 offer large incentives to providers to adopt EMRs and Computerized Physician Order Entry (CPOE)

Likely Impacts

- Greater use of these tools could lead to improved coordination of care and data for analysis

CRICO analysis released in Feb 2014 found that of 1 years worth of claims included vulnerabilities with incorrect info in EHRs, conversion issues and system failures

How this could LOWER liability

- Could lead to fewer communication errors of provider "orders" (WC & MPL)
- Ability to analyze data could lead to improved protocols (WC & MPL)
- Better coordination of care could reduce errors (MPL)

How this could RAISE liability

- Inadequate training and/or inappropriate use (e.g., 'cut/paste') could increase adverse outcomes (WC & MPL)
- Delays in data transfers, and/or incomplete or missing data could increase errors (MPL)
- Additional exposure for data breaches (WC & MPL)
- Data provided could be used against defendants within litigation (MPL)
- Attention to completion of EHRs could negatively impact patient interaction (MPL)

Change in Medicare Fee Schedules

Provision

- Changes to FFS rates and hospital payments
- Less frequent fee updates
- Establish independent board to review growth in Medicare spending

Likely Impact

- Fees change for services tied to Medicare fee schedule
  - Workers Compensation
  - Health Care Costs for Personal Injury Claims

How this could LOWER costs

- Fees tied to the Medicare schedule could decrease (WC & MPL)
- If fees for specialty services decrease, there may be less incentive to do these procedures (WC & MPL)

How this could RAISE costs

- Providers may seek alternative sources of income to close the gap from reduced Medicare revenue (WC & MPL)
- Increased utilization delays RTW (WC & MPL)
- Changing fee schedules have disproportionate impact by specialty (WC & MPL)

Accountable Care Organizations

Provision

- Ability to earn bonuses based on overall costs of an attributed population
- ACO's to develop voluntarily based on efficiencies, will share in cost savings, will report on quality and costs

Likely Impact

- Further provider consolidation and possible return of capitation-like arrangements
- Requirements: adequate primary care participation, processes to promote evidenced-based medicine, reporting on quality, costs and care coordination

An early Rand study (published in Feb 2014 JAMA) of 32 PCMH showed limited quality improvement and no improvement in costs or utilization over three years (2008 – 2011)

How this could LOWER liability

- Increased coordination and collaboration can lead to lower malpractice risk
- Single organization has liability for a claim rather than multiple ones
- Coordination of defense across providers
- Reporting on quality and costs could provide transparency on best practices

How this could RAISE liability

- Larger organizations more likely to have higher limits of liability
- Increased exposure to "managed care" liability relating to denial of care types of claims under tighter cost controls
- Consolidation process could increase D&O exposure (antitrust)
- Could exacerbate primary care physician shortage

Value-Based Payment Models

Provision

- Medicare to establish "Hospital Value Based Payment Program" – provide incentive payments for meeting performance criteria – includes both improved care and safety
- Reduce\prohibit payments for re-admit and hospital-acquired conditions

Likely Impact

- Hospitals are financially rewarded based on performance
- Will increase efforts to eliminate 'defective' care

Proposed legislation in Congress, "Standard of Care Protection Act", specifies that no federal health guidelines that are not designed to establish a standard of care cannot be interpreted as a standard of care in a medical malpractice claim

How this could LOWER liability

- Increased incentive for patient safety; should lower loss frequency and possibly severity
- Improvement of care due to transparency of quality information

How this could RAISE liability

- Failure to qualify for incentive payments could be interpreted as evidence of negligence
- Transparency of information on quality could lead plaintiff attorneys to target "underperforming" providers
- The incentive model may exacerbate supply shortages

Employer health benefit decisions

Provision

- Employer must pay excise tax if cost of coverage (after plan provisions) exceed thresholds
- Introduction of Exchange concept

Likely Impact

- Employers continue to reduce plan benefits to shift greater out-of-pocket costs to employee
- Increased focus on wellness programs for employer plans
- Changes in contracting and network requirements
- Potential shift out of direct coverage delivery to Exchange

How this could LOWER WC costs

- Emphasis on wellness could produce healthier workers, fewer injuries, shorter claim duration
- May pave the way for WC provider contracting changes where allowed

How this could RAISE WC costs

- Exposure to greater cost-sharing may encourage employees to seek care through WC
- Potential cost-shifting from employer health plans
- Employer transition away from health plan management may shift focus away from employee health management – reducing health status and increasing reliance on WC

Employer workforce decisions

Provision

- Employer must provide coverage to full-time employees (>= 30 hours/week)
- Low paid workers don't have access to federal subsidies if they are eligible for affordable employer coverage

Likely Impact

- Employers may look to increase part-time roles and cut back full-time roles
- Employers may consider outsourcing lower paid workers to enable access to Exchange subsidies
- Employees purchasing coverage "on their own" likely to have less generous benefit or more limited access

How this could IMPACT WC costs

- Shift in population may result in an employee demographic that differs from today
- May result in transition of WC liability from employer to outsourcing company

How this could RAISE WC costs

- Shift to a part-time workforce may engage a different skill level / type of employee / turnover rate, which may impact WC costs
- Employees who feel they have "less" health care coverage may look more to WC as a source of health coverage

Individual health coverage decisions

Provision

- Individual mandates / guaranteed coverage
- Increased Medicaid eligibility
- Federal subsidies available for employees not benefit eligible
- Eventual auto enrollment in employer plans for eligibles

Likely Impact

- Fewer individuals uninsured
- More individuals on Medicaid
- Greater access to health care services

How this could LOWER WC costs

- More access to health care services ➔ healthier workers, fewer injuries, shorter claim duration
- Could be claim/cost shift to newly acquired group or individual health coverage as system less burdensome to access
- WC may have had to previously absorb some questionable medical claims costs

How this could RAISE WC costs

- Capacity shortage can delay treatment, and return to work resulting in higher indemnity benefits (Specialist availability expected to be less impacted than primary care)
- Could be claim cost shift from Group Health due to deductibles, co-pays, etc. which are expected to increase to cover cost of reform

Other Property/Casualty Lines of Business

- Directors and Officers Liability\EPLI
  - Anti-trust concerns for larger systems
  - Merger and Acquisition exposure
    - St Lukes FTC decision in Boise, Idaho
  - Health Insurers
  - Considerations Public\Private; For-Profit\Non-for-Profit
  - Concerns on workforce demographics and PPACA requirements
- Automobile Liability
  - Care delivery could impact costs
  - Offset potential – need to understand collateral source rules
- Fiduciary Liability
  - ERISA legislation imposes *personal liability* on "fiduciaries" and "parties at interest" for discretionary judgment authority related to establishment and maintenance of employee benefit plans.
  - Increased employer exposure with complexity of ACA for employer sponsored health care plans, including communication requirements to employees

Conclusions

- It is too early to understand the actual impacts of Health Care Reform on PC coverages
- The impacts will vary by state, reflecting differences in ACA implementation, regulatory environments, tort and no-fault provisions
- Insurance professionals can prepare now to collect, analyze and monitor data. Be prepared to react in a timely manner.

Sources of Additional Information

- CMS - Centers for Medicare and Medicaid Services
  - http://www.cms.gov/
- Kaiser Family Foundation
  - http://kff.org
- Robert Wood Johnson Foundation - Health data
    - http://www.rwjf.org/en/research-publications/research-features/rwjf-datahub.html
- Broad consumer overview recommended by Kaiser Family Foundation
  - http://kff.org/health-reform/video/youtoons-obamacare-video
- California Healthcare Foundation
  - http://www.chcf.org/programs/healthreform/aca140
- HHS Assistant Secretary for Planning and Evaluation
  - http://aspe.hhs.gov/health/reports/2012/ACA-Research/index.cfm

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