Health Care Reform – where it's all going

2016 May CAS Meeting

By: Ann M. Conway, FCAS, MAAA, CERA

May 16, 2016

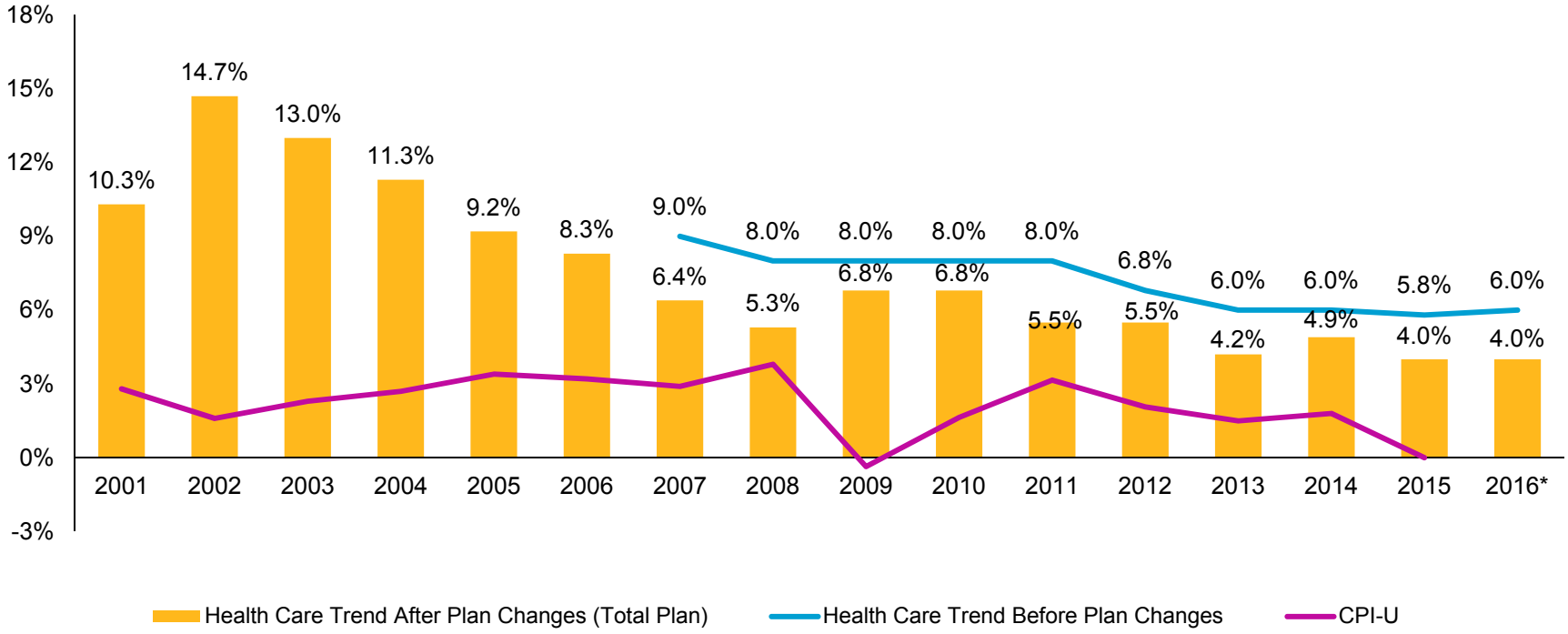
Willis Towers Watson

What is Health Care Reform and where is it going as respects to 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, improved health outcomes and cost control
  - Roll out was immediate through 2018 (now 2020), many key provisions effective 1/1/2014
- 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
  - We have a specific focus on workers compensation
  - For other lines, 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

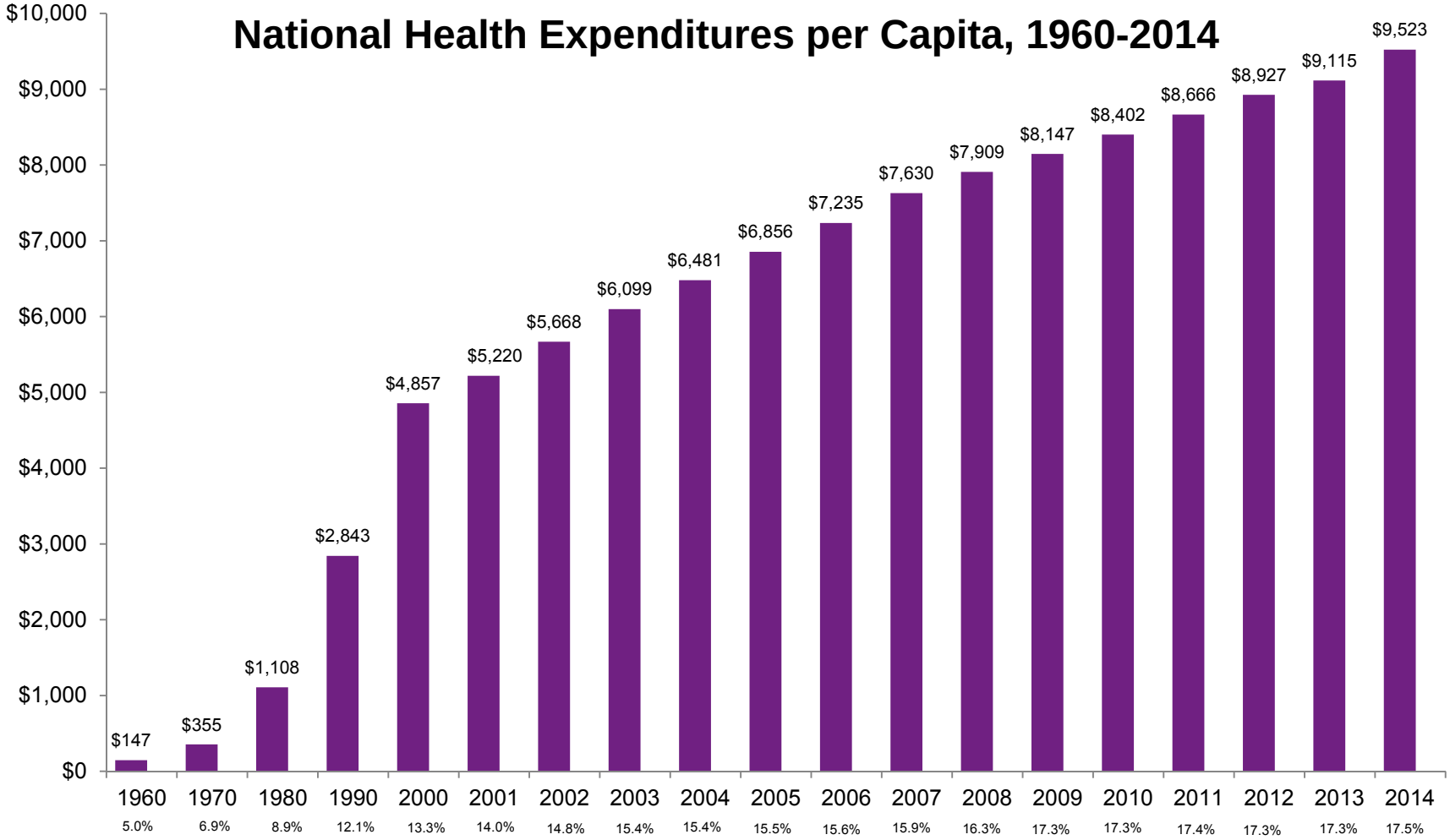


*Expected.

Source: 2015 Willis 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?

U.S. 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 1960-2014.

And how do we compare to others?

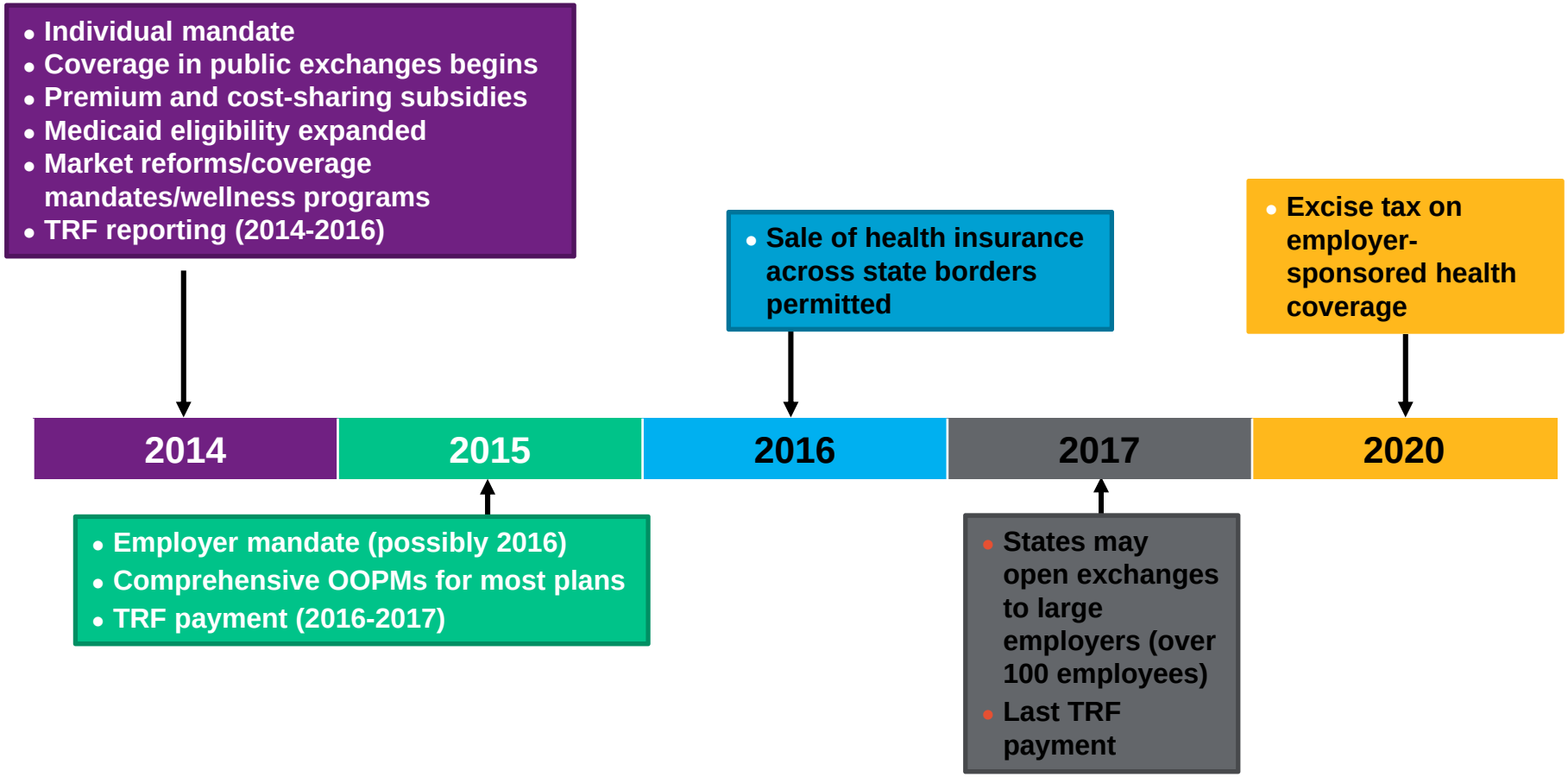
COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

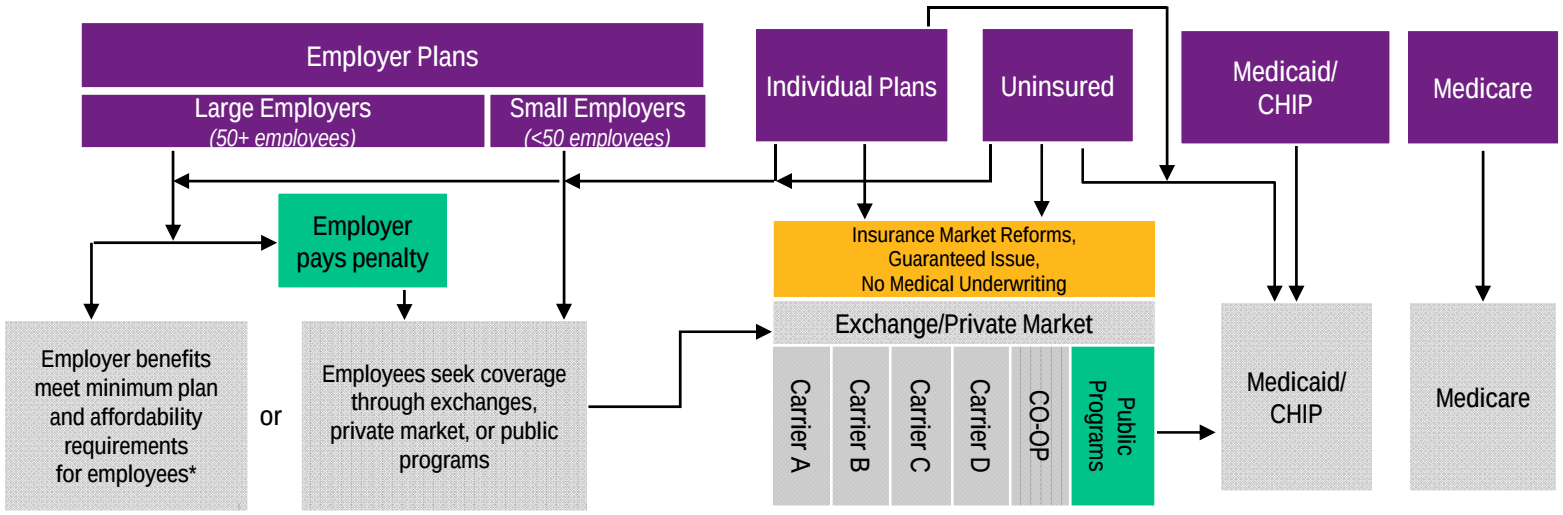
Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Although PPACA was enacted in 2010 the real impact began in 2014



Health care reform takes aim at three key areas

While the goals are relatively simple, the system dynamics are not



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

- Significant market changes
  - 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

The employer role in health care benefit delivery is likely to shift

Current State

- Employee controls all aspects of plan design and funding
- Employer responsible for plan administrator, enrollment and communication
- Employer subsidy linked solely to employer plans
- Employee may not see full value of health care benefit

Private Exchanges for Actives/Pre-65s

- In formative stages
- Employers need to evaluate to risk and financing
  - If fully insured, costs may be higher
  - Adverse selection risk
- Employer retains financial subsidy and initial eligibility determination; other administrative responsibilities passed to the exchange

Private Medicare Exchanges

- Well established; provide individual market for Medicare enrollees
- 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

- Intended to create functioning individual market
- 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

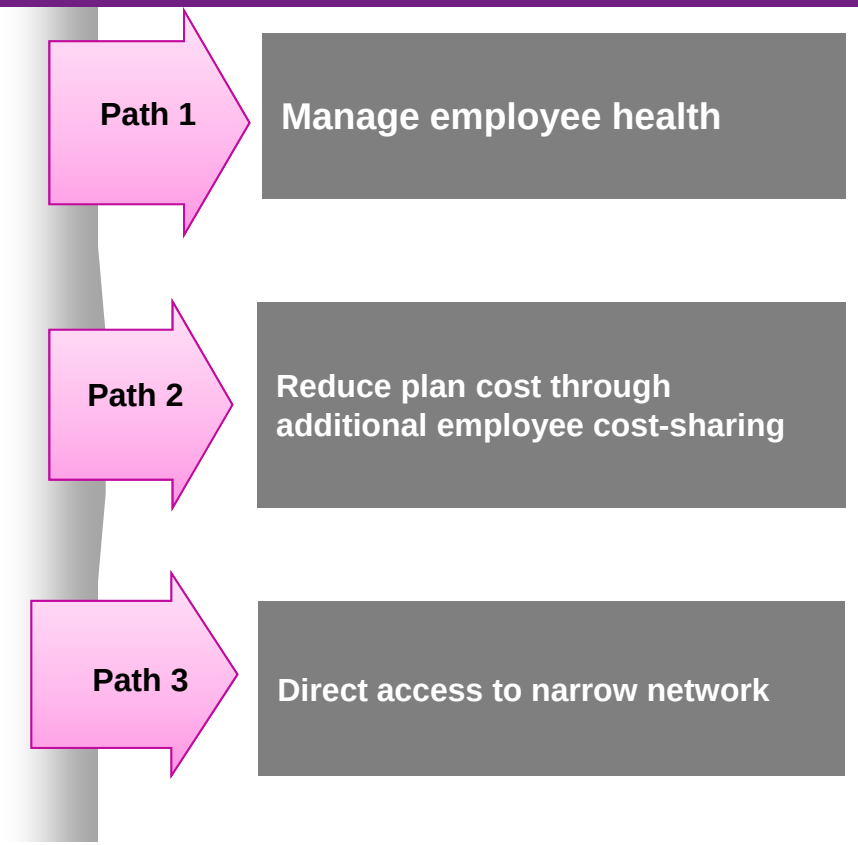
Expanded opportunities for disintermediation of employer role in benefit financing and delivery for health coverage

Excise tax risk will be a major driver of employer decisions prospectively

Excise or "Cadillac" Tax

- 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.
- Current active cost thresholds
  - $10,200 individual
  - $27,500 family
- Will be updated before effective date
  - Adjust for employee mix, age, and/or gender

Employer Health Plan Design will focus on excise tax mitigation



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

- Guaranteed issue and individual mandate expected to reduce uninsured population
  - Congressional Budget office currently estimates that by 2018, 26 million people will be uninsured under the ACA in comparison to 49 million people that would be uninsured without the ACA
  - Newer enrollees may be higher cost, and use more medical services, which has premium implications
  - 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

Impact of PPACA on health care delivery systems

- Immediate expansion of Medicaid coverage
  - Sicker patients
  - Lower reimbursement rates
- Increased competition for patients with private insurance
- Shifting employer role in health care provision
- Greater provider accountability will 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

How will changes in the health care delivery model impact consumers and how will their behaviors change in response?

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

- Workers compensation
  - Employers, employees, and health care providers
  - Insurance and other risk-financing mechanisms
- Medical professional liability
  - 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

How this could LOWER liability

- Earlier treatment can lead to better outcomes
- Early prenatal care reduces pregnancy risk
- Future economic losses possibly smaller for those eligible for expanded coverage

How this could RAISE liability

- Capacity shortage can lead to increased errors
- More units of service ➔ more potential risk
- Increase in insurance not associated with decline in ED utilization

CBO estimates from April 2016, expect that in 2016 under ACA 22 million less uninsured, and uninsured population at 27 million

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 needs

Likely Impact

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

How this could LOWER liability

- Non physicians more likely to follow algorithms
- HCE currently have lower costs

How this could RAISE liability

- Different level of expertise could lead to missed diagnoses
- Physician shortage could lead to inadequate supervision
- Current nursing shortage could be exacerbated

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 state specific

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 Impact

- 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”
- Ability to analyze data could lead to improved protocols
- Better coordination of care could reduce errors

How this could RAISE liability

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

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 liability

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

How this could RAISE liability

- Providers may seek alternative sources of income to close the gap from reduced Medicare revenue
- Changing fee schedules have disproportionate impact by specialty

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

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

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)

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

HR2: Medicare Access & CHIP Reauthorization Act (2015), 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

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 fully 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.

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
- RAND: How will the PPACA affect liability insurance costs?
  - http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR493/RAND_RR493.pdf
- WCRI: The Impact of ACA on Case-Shifting from Group Health to Workers Compensation

Contact Information

Willis Towers Watson

Ann M. Conway, FCAS, MAAA, CERA
Managing Director

The Prudential Tower
800 Boylston Street
Boston, MA 02199-8103

T +1 617 638 3774

ann.conway@willistowerswatson.com