



Thriving in an Age of Uncertainty: Assess and Plan in Response to Health Care Reform

Even before the post-election uncertainty about the survival of certain provisions, the Affordable Care Act had health plans and insurers scrambling to make sense of the health care landscape.

A mixture that will include all or at least some of the following—intensified rate reviews, new medical loss ratio (MLR) requirements, removal of lifetime limits, the requirement that individuals carry health insurance, guaranteed issue, accountable care organizations (ACOs), and changes to Medicare Advantage (MA)—will change how health insurers operate.

In short, health plan executives know that a series of high magnitude quakes are coming. Exactly how and when they'll hit is unclear, but the impact will be so dramatic that waiting for every detail of every regulation or political swing before responding will make it difficult to survive the aftershocks.

The overarching question for nearly the entire health care industry is: what can be done amidst this uncertainty? Eight activities are essential if health plans and insurers are to successfully adapt to the coming changes.

Analyze population shifts and associated financial impacts

With an estimated 30 million newly insured people likely to enter the risk pool through expansions in Medicaid and/or participation in health benefit exchanges, nearly every health plan or insurer must assess the likely population shifts and the corresponding financial impact.

How covered populations will shift for each organization will depend on numerous factors, including: demographics, changes in employer health insurance coverage, current state Medicaid coverage standards, and the existence or lack of a high-risk pool. Plugging those and other factors—such as risk-based capital

levels—into a reliable model will help insurers mitigate risk, invest intelligently and expand or contract as needed.

For example, the expansion of Medicaid is one population shift that could offer opportunities for managed Medicaid plans to capture more market share, reduce administrative costs through volume, or increase their value to providers. To determine a viable strategy, health plan models must recognize first that the majority of the expansion will be childless adults with higher incomes than today's Medicaid recipients. While states are still deciding how to set rates for this group, commercial plan actuaries can make some educated guesses about projected costs.

Models must also recognize that some states or regional markets will see a substantial increase in the eligible population, either in numbers or percentages; others will not. Market evaluations need to size these changes market by market. Plans can then run a series of what-if scenarios that model how states might manage the Medicaid changes.

Identify product and portfolio implications

New risks and opportunities pose difficult choices about health plan product portfolios. To test product and portfolio changes, insurers can examine a series of strategic questions that encompass geography, potential product innovation, risk, pricing, and reinsurance.

Medicare Advantage plans should be especially anxious to explore these questions. Over the next two to six years, legislation systematically reduces Medicare Advantage (MA) benchmarks to one of four price points, ranging from 115% of fee-for-service (FFS) to 95%. This will change the nature and appeal of the various markets for health plans offering these products.

But there is much more to consider if plans are interested in entering or remaining in the MA space, including coding trends and adjustments, the need to achieve a minimum 85% medical loss ratio, and the Medicare Advantage Health Plan Quality and Performance Rating System—commonly called the Stars ratings because the scores are reported on a 5 star scale. Stars ratings are a dramatic shift toward pay-for-performance and the only mechanism available to help mitigate or offset some of the rate reductions. But because there is a three-year lag time between measurement and bonus, an effective response means making the necessary adjustments now.

Evaluate distribution and channel strategies

Because products do not sell themselves, health insurers are already evaluating how their current distribution and channel strategies will play in the new environment.

Perhaps most significantly, at last estimate approximately 37 million people will eventually be insured through health benefit exchanges. Though requirements for participation in exchanges are still emerging, the Accountable Care Act defines some of the key elements. Either a state agency or not-for-profit agency will qualify

health plans to participate, oversee the qualification process, and provide access for individuals to select and enroll. In addition to commercial insurers, the exchanges could see Medicaid plans, and even new entrants that compete as pure-play exchange plans.

With these factors in mind, health plans and insurers should evaluate the possible impact of the exchanges in the context of their existing business and the region(s) in which they operate. Evaluations can include:

- Population estimates, premium subsidy estimates and cost characteristics
- Entry requirements and current regulatory environment
- Estimated costs of entry
- Operational requirements and high-level gap assessments of current capabilities
- Quality and certification requirements
- Competitive environment
- A look at whether current distribution systems can support the exchanges
- Members worth pursuing and product offerings/type of portal most likely to succeed

By evaluating the impact of the exchange on current business, growth opportunities, need for capital, and operational shortcomings, this preliminary review provides substantial insight into the risks and opportunities of participation.

Validate compliance strategy

Among the many new regulations with which insurers must comply, MLRs may be today's most pressing. In brief, large group carriers must demonstrate an 85% or better MLR. Individual and small group (2-50 employees) carriers must demonstrate an 80% or better loss ratio. The latter burden is especially onerous, because many individual carriers do not hit that mark today. Those that cannot will need to pay rebates to their members. Health and Human Services issued interim final regulations in late November but companies are still addressing the impact.

While the regulations included much more detail on which expenses can be included as part of the MLR calculation, companies must now translate the general regulatory guidance into the specifics applicable to their expense structure.

But MLRs are not the only compliance concern. Rate review provisions imply that health plans will need to have a lot more people—especially actuaries and underwriters—involved in completing regulatory filings and credibly documenting the reasons behind premium increases. Limited waiting periods, the elimination of pre-existing conditions, the increased coverage for dependent children through age 26, and the removal/reduction of lifetime limits all must be reflected in current product offerings.

In addition, over the next couple of years, all organizations will have to adopt and implement 5010 electronic transaction standards (January 1, 2012) and ICD-10 diagnosis codes (October 1, 2013). This will be a long and involved process, filled with potential pitfalls and we have already begun helping numerous clients make the transition.

Increase cost containment efforts

The new law is hardly the only incentive for improved cost containment. The staggering economy has been shrinking the rolls of commercial plans, leaving them with the highest risk lives and uncovered overhead. Medical and pharmacy costs continue to swell. Providers continue to shift costs to commercial payers because they are losing money on Medicare and Medicaid patients. Neither employers nor individuals are in any position to absorb higher premiums.

In the face of these factors, isolated measures will not have enough of an impact. Instead, health plans and insurers must creatively integrate medical and administrative cost reduction in a staged, short-term/long-term effort. Advanced analytics enable this approach, because they create easy-to-use reports with reliable, holistic, benchmarked views of the entire operation. Those views enable insurers to zero in on their most significant cost drivers. They can then apply a deep understanding of the industry, their market, their company's culture, and the regulatory and legislative environment to devise cost-cutting solutions that don't compromise care or efficiency.

For medical spend, the views enable confident evaluations of how current provider relations, health management, and pharmacy management strategies affect costs by quickly gathering and synthesizing data into business intelligence that answers a host of key strategic questions. For administrative costs, companies can quickly highlight how much money they lose on

everything from inefficiencies in enrollment, billing, claims adjudication and customer service operations to outdated coding procedures.

Finally, while step one involves identifying the obvious outliers and going after them hard, step two involves investing at least some of the savings in sustainable long-term strategies. In doing so, health plans and insurers can attain the above market savings that thriving under health care reform demands.

Strengthen current medical management programs

Because of the pressures in the new law to simultaneously improve outcomes and contain costs, insurers need to develop more active and energetic medical management programs. This means building on what works.

Using advanced analytical software, multiple organizations have devised effective medical management programs for cost-driving chronic conditions. The analytics effectively stratify patients and target those ready for change. By continuously evaluating results, health plans can steadily adapt and improve the value of these programs.

Improve provider relations

Health care reform has a number of carrots and sticks for improving provider alignment and engagement, not the least of which is the push for ACOs and patient-centered medical homes. This means that building and retaining a strong provider network—from recruiting to credentials verification and overall network management—has never been more important.

ACOs, for example, are alliances among insurers, hospitals, physician groups and, ideally, employers and individuals, where all players assume accountability for the dollars spent caring for a population and for the quality of that care. Such arrangements may make it easier for the insurer to begin exploring and implementing provider payment strategies that spread risk.

But the strategies must do more than control costs; they must also satisfy the insurer's best physicians and physician groups—who are critical to retain—and provide incentives for more aligned, evidence-based care. Some large provider organizations have already begun to work through methodologies and implement technologies that will enable bundled payments for a number of different treatment episodes. Health plans and insurers should seek opportunities to collaborate on these efforts.

Improve Consumer Engagement

Historically, the largest piece of an insurer's business has been employer focused—and for good reason. Today, employers pay for approximately 90 percent of all private policies (*McKinsey on Business Technology*, Number 20, Summer 2010). Now, however, numerous provisions in the Affordable Care Act will drive millions of consumers to contract directly with health insurers, increasing the need to improve consumer engagement strategies.

Specifically, health plans will need to upgrade their contact center, web sites, and various other tools to make them considerably more user-friendly and offer consumers greater control over their health benefits and greater awareness of how to improve their health and well being.

In with the Old, In with the New

While consistently assessing and planning in the eight areas above have been part of most health insurance operations for years, two developments dramatically change the process.

First, the Affordable Care Act dramatically increases the risks of failing to rigorously assess and plan. Its many, interwoven pieces—the compliance concerns, the way it will shift populations, the changing payment strategies, the ways it will change provider bargaining power—imply a depth of change that exceeds any industry change for at least a generation.

Second, tools and methodologies to assess the landscape, plan new initiatives, and evaluate programs on an ongoing basis have achieved a level of sophistication that matches the depth of change. Those health plans and insurers that can optimize the use of these tools and methodologies will be the ones that thrive in the years ahead.

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