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Look Before You Leap

Suggested Payer Responses to the Affordable Care Act (ACA)

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White Paper

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While the overall net benefit of the ACA can be (and is being) debated, it will clearly lead to a more challenging operating environment for payers.

In March of this year after months of contentious debate, the “Affordable Care Act” (ACA)¹ was signed into law. Often referred to as “healthcare reform”, the law as written focuses primarily on increasing access to insurance coverage and establishing a minimum value for insurance benefits, and not on dramatically impacting the system of care. As a result, the law impacts healthcare payers more directly and immediately than healthcare providers. Official Congressional Budget Office (CBO) estimates forecast that the act will lead to a 58% reduction in the uninsured population in 2019 (23M vs. 55M forecast under previous law), with just over half of the newly insured receiving coverage through Medicaid. The remainder are expected to purchase coverage from private insurers in the individual market – many via “exchanges” authorized by the ACA. Offsetting this projected benefit are the near universal projections, including those of the CMS Office of the Actuary, that health system cost and insurance premium increases are expected to accelerate, driven by higher utilization (itself a result of subsidies and mandates for richer benefits).

While the overall net benefit of the ACA can be (and is being) debated, it will clearly lead to a more challenging operating environment for payers, including:

- Restrictions on product and pricing strategy, limiting opportunity for innovation and differentiation
- Profit ceilings at the state (and possibly more granular) level, and a more challenging overall underwriting environment
- Churn and uncertainty in the small commercial market
- A growing, but highly regulated and likely less profitable individual market
- Ongoing uncertainty, as regulations take shape over the next several years
- Potential for blowback, additional regulations, and even dissolution of the private insurance market, if health care costs continue to escalate and blame is placed on payers

¹Also commonly referred to as the Patient Protection and Affordable Care Act. For brevity, we choose to follow the convention “ACA”, from the Department of Health and Human Services (HHS) or “the Act”

While much of the ACA does not go into effect until 2014, and there is uncertainty around many regulations essential to implementing the ACA (to be written over the coming years), there is no shortage of opinion on what payers should be doing NOW. While the recommendations from some industry experts appear quite sound, other advice appears appropriate for some – but not all – payers. And still some opinions we’ve read appear wrong.

We caution payers to resist the urge to follow the “conventional wisdom” on all fronts, and take just a bit more time now to think before acting. In our view, a payer would do well to consider the following, however the ACA evolves:

We caution payers to resist the urge to follow the “conventional wisdom” on all fronts, and take just a bit more time now to think before acting.

- Take the time to think through the strategic implications of the Act on your sources of competitive advantage and overall operating and service models
- Prepare for volatility and decline in the small group market
- Think twice about making significant investments in the individual market
- Capture cost reduction opportunities, focusing on process improvement and outsourcing of non-core activities
- Revamp accounting for Medical Loss Ratio (MLR) requirements, and consider reallocating resources and reorganizing departments to improve marginal profitability under the Act
- Don’t cut broker compensation – but do work to make it sustainable in the long term and try to transition it outside of the scope of MLR
- Don’t abandon efforts to address the cost of care
- Don’t give up on the debate

In this perspective, we’ll *very briefly* lay out what we believe are the most important elements of the ACA for health insurance payers. We will then describe general principles we believe should guide payer responses, and delve into some more specific recommendations. In some cases, we will concur with the conventional wisdom and will indicate as such; in other cases, however, we may dare to disagree and lay out alternative points of view.

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KEY PROVISIONS AND IMPLICATIONS OF THE ACA

While interpreting a 2,800+ page law is challenging, below we’ve made an effort to summarize, as briefly as possible, what we believe to be the most important aspects of the ACA for health payers. This summary is based on our reading of the law, supplemented by analyses and commentary from (and discussions with) industry executives, brokers and consultants, equity analysts, attorneys, think tank-types, and even management consultants.

	ACA Provision	Early Assessment
Individual Mandate	2014: Individuals required to have health insurance or pay a fine (or tax – depending on who’s asking) of \$695/person, up to \$2,085/household. Exceptions: children (<18) count as ½ a person, and those whose premium-to-income ratio would be >8% are exempt.	Could lead to an influx of participants to the individual market. However, many believe this is a “weak mandate”, meaning the penalty is not substantial relative to the cost of purchasing the kind of health insurance required by the act, and could lead to significant adverse selection.
Individual Subsidies	2014: Low income individuals and families offered tax credits to offset the cost of purchasing insurance in state-based exchanges. Lowest income groups (up to 133% of the Federal Poverty Level (FPL)) will be eligible for Medicaid (including childless adults). From 133% to 400% of FPL, tax credits will be provided in a sliding scale.	The subsidies should lead to an influx of participants in the Medicaid and individual markets. However, the value of these subsidies is large, particularly relative to the value of the tax benefit for employer provided insurance, and may create an incentive for small employers (and their employees) to exit the group market.
Employer Mandate	2014: Employers with 50+ employees must offer insurance coverage to their employees or be fined \$2,000/employee/year (indexed to premium inflation).	Some believe this to be a “weak mandate”, and, combined with generous subsidies, will lead employers with mostly low-wage workers to drop coverage.
Exchanges	2014: Websites, with phone and/or brick-and-mortar backup, established by individual states (or groups thereof), where individuals and small groups can compare coverage offered by insurers side-by-side. Insurers must meet essential benefits and actuarial value requirements. This will be “the only place to shop” to receive tax credits.	Lots of uncertainty about how these exchanges will evolve, e.g., whether exchange will have a “buyer” or marketplace role, if/how agents/brokers will participate, and if/when exchanges will be opened to large employers.
Essential Benefits	2014: To be detailed in future regulations, but to include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services, and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care.	“Mini-med” and other low-cost plan designs will no longer be allowed, leading to richer benefit plans on average.
Limitations on Cost Sharing	2010, 2014: Bans on copays for preventive services (already implemented by many payers).	Additional limitations on coinsurance and copays will be defined in forthcoming regulations, resulting in actuarially richer plans and boosting payer revenues in the near term.

	ACA Provision	Early Assessment
No Annual/ Lifetime Limits	2010, 2014: No annual limits or lifetime caps on “essential” benefits.	Will result in slightly richer plans (with corresponding revenue/premium increases).
Rating Restrictions	2014: Payers can no longer vary premiums based on health status, gender or a variety of other factors. Some variation allowed based on age (with narrow 3:1 ratio), geography, smoking status (1.5:1) and family size.	Will result in higher premiums for the young and healthy, and quite possibly, adverse selection and smaller underwriting departments.
State Premium Reviews	2014: Premium increases will be reviewed for “reasonableness” by state regulators, creating a “soft” limit on increases for insurers offering coverage in exchanges.	Expect more difficulty pushing through significant rate increases, particularly for individuals (which may be particularly challenging in the face of adverse selection).
Guaranteed Issue/ No Denial for Pre-Existing Conditions	2014: Payers must take all comers and will not be allowed to deny coverage or impose exclusions or waiting periods for anyone due to pre-existing conditions.	Although ACA discusses “open enrollment”, it is unclear whether it will be defined in such a way to avoid gaming and additional adverse selection.
Grandfathering	2010: Individuals and groups are allowed to maintain some aspects of their current benefit designs and avoid certain aspects of the ACA.	Insurers may find demand for maintaining old benefit designs drops off rather quickly. Most individuals and groups will give up on grandfathering within 2-3 years due to tight restrictions on benefit reductions and the limited value of grandfathering in final legislation.
MLR Requirements	2011: Insurers must have at least 85% large group and 80% individual and small group MLRs or provide rebates.	There is still significant uncertainty around what will be in the numerator and denominator of the MLR calculation, the level of aggregation (e.g., statutory entity, geographic market, product), and how rebates would be calculated and paid. What is clear is that the requirement installs a cap on profit, at least by market, and will impact all payers. Even those with average MLRs above the targets will have years and markets that won’t meet the standard.
Multi-State Plans	2014+: Competitive plans to be administered by the Federal Office of Personnel Management (OPM).	Big unknown/wildcard. Multi-state plans could range from hapless competitors, to big administration revenue opportunities, to trojan horse strong public options to compete with private payers.
Small Group Tax Credits	2010, 2014: Employers with <25 FTEs (with annual average wages <\$50K) are eligible for a 35-50% tax credit for insurance costs. Credit reduced as number of employees exceeds 10 and income exceeds \$25K. Credit ends after 2 years.	Limited scope and duration will mean limited impact.
New Taxes & Fees	2010: There are a range of new taxes (explicit and implicit) on individuals and business in the ACA, some of which will drive up medical costs. Direct taxes to payers include a fee, allocated based on premium share, expected to raise \$60B between now and 2019.	Will be passed through to customers. Higher resulting premiums will reduce product demand on the margin.
Medicare Advantage Cuts	2011: Cuts in payments to private payer administrators of Medicare Advantage (MA) plans.	Payers will need to reduce benefits and/or increase premiums, and may decide to reassess participation in the MA market.

GENERAL PRINCIPLES GUIDING PAYER RESPONSE

Our beliefs about payer responses to the ACA are guided by a few general principles:

1. **Payer Response Depends on Competitive Position:** Payer responses to the ACA should vary, depending on current market position and sources of competitive advantage. For example, a market share leader with a strong brand for customer service (i.e., the local BCBS plan) should necessarily respond differently than a lower share local payer or national payer.
2. **Take Time to Consider Your Response:** Despite exhortations from industry experts to “move quickly to gain strategic advantage”, the characteristics of this particular legislation are such that there is time and cause for deliberate, structured thinking before rushing down a particular path – one that could result in poor use of management time and firm capital.
 - *Many key elements of the ACA don't kick in until 2014.* Unlike typical legislation that demands an immediate response, there is a substantial time delay in the ACA, though we would agree there are elements that demand quick decisions (either because of near term requirements or a particularly long runway for implementation)
 - *No one knows the implications of regulations yet to be written.* There may be significant impact from ACA components that have not been fleshed out, such as the shape of “multi-state” plans administered by the Office of Personnel Management (OPM)
 - *There will be delays.* Even if ACA continues down the path intended, the size, scope and contestable nature of the remaining effort will almost certainly result in implementation delays, as various stakeholders draft and agree upon regulations, establish agencies and programs to administer them, and implement major aspects of the program. A recent paper from the Congressional Research Service actually deemed the number of agencies and commissions established by the act as “unknowable”
 - *Aspects of the legislation could change substantially.* We recognize that congress rarely reverses a benefit or entitlement once established. However, we are not convinced that the ACA will be fully implemented as currently written due to a number of factors, including:
 - The frontloading of costs and taxes, and delay in many benefits until 2014 and beyond
 - An anti-spending/deficit political environment, and significant, ongoing opposition to major portions of the legislation

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- Legal challenges from states² to specific provisions (primarily challenges to the individual mandate)

3. **Think Locally:** Despite the national scope of the ACA, many of the issues vary by geography. There are dramatic differences in insurance coverage, access to care, delivery systems, care costs, individual behaviors and health status, and certainly regulatory environments across states and even local markets. While there are strategic decisions that can and should be made at a national level, multi-state payers need to craft their responses specifically to state and local market conditions.

SPECIFIC RECOMMENDATIONS FOR PAYER RESPONSE

With these general principles in mind, following are our early thoughts on implications and recommendations for payers in response to the ACA.

We have concerns that some payers may have a “forest for the trees” problem, and could benefit from stepping back to assess the impact of the ACA on their sources of competitive advantage and overall service design and operating model.

1. **Conduct a Broader Assessment of the Strategic Impact of the ACA:** We’ve seen and heard about payers investing heavily to understand and begin preparing for the impact of the ACA. Many have established multi-functional task forces and teams to respond to the near term requirements. Others have set up comprehensive cost cutting programs. While we don’t disagree with these efforts, we have concerns that some payers may have a “forest for the trees” problem, and could benefit from stepping back to assess the impact of the ACA on their sources of competitive advantage and overall service design and operating model. Beyond asking, “What do we need to do to be compliant with the ACA?”, we think payers should be asking bigger questions, for example:
 - Does the Act compromise any major current source of competitive advantage and require a fundamental shift in strategy (e.g., from a high-touch to a low cost strategy)?
 - Are there functions/processes that call for significant increases or decreases in resource allocation (e.g., from product or underwriting to sales, health care management, and even accounting)?
 - Are there ways we can think about fundamentally changing service or operating models that would improve competitive position regardless of how the ACA implementation evolves (for example, could we offer tiered service models – with high-touch service available only outside of the construct of the ‘health plan’ for MLR calculation purposes)?
 - How should our response to the ACA vary based on local market characteristics?

²More than 30 states are mounting some form of legal challenge to the ACA

We believe that the growth in the individual private insurance market will be significantly less than the 10-15M predicted, and that adverse selection will be a much larger problem than government and industry participants have suggested.

2. Prepare for Small Group Market Volatility and Decline: The ACA will create significant churn in the small group market, and, we believe, will result in a reduction in small group market size over time:

- *Some 50+ member groups will enter the market to avoid employer mandate penalties (we've seen estimates of as high as 15M members, although with a relatively weak employer mandate, we would expect the figure to be lower)*
- *Some <50 member groups will enter the market to take advantage of near term tax credits (although probably fewer than expected, given tax credit expiration after 2 years)*
- *Many small groups will drop coverage – particularly those with low average wages, as the subsidies available to their employees in the individual market exchanges will create incentives for firms and workers to drop group plans and move to the individual market³*

We see a couple of important implications from this churn and market shrinkage:

- Payers participating in the individual market will need an approach to capture individual customers dropping from the small group market. These customers will be among the most attractive in a market plagued by adverse selection
- This is not the right time to unilaterally reduce broker compensation. In fact, this is the time to work to improve broker satisfaction and overall health, in advance of major volatility and increases in demand for service in the small group market

3. Be Wary of the Individual Market Opportunity: There is a widespread belief that payers should focus on individual market penetration, as approximately 20-30M previously uninsured become covered (many in the private market) as a result of the ACA. Suggestions of how to participate include:

- Developing new distribution strategies, including opening retail outlets, aggressively expanding web-based offerings, and preparing for state health insurance exchanges
- Investing in consumer focused and friendly product design
- Preparing to ramp-up mass market advertising to build awareness with individuals and small groups entering the market

³Incentives created by the huge disparity between the subsidies offered by the ACA for low and middle-income individuals and families vs. the value of the implicit tax subsidy in group health plans. One broker we spoke with estimated that 20-25% of his firm's small groups would drop coverage in 2014

While the individual market may seem like an obvious place to invest, we believe that it may not be as rosy as some forecast, and payers need to decide if and how to participate in the individual market – not just jump on the bandwagon. We agree that the market will get bigger, and small, sub-scale competitors will drop out, creating opportunities to pick up members. However, half or more of the previously uninsured will go straight to Medicaid rather than the private market. For those that do enter the private market, we believe that the numbers will be smaller than the 10-15M predicted, and that adverse selection will be a much larger problem than has been suggested, in large part because of the relatively weak nature of the individual mandate written in the ACA.

For those who believe the individual market growth projections and/or that adverse selection concerns are overblown, investing in the individual market won't be cheap or easy:

We conclude that the individual market will be smaller, more regulated, and significantly more challenging in which to earn a profit.

- Since exchanges – the centerpiece of the new individual market – are state-based, you will need to engage with a new, unique distribution channel in every state where you plan to compete
- The role of brokers in exchanges is highly uncertain – and may be nil. As a result, payers can expect lots of calls and questions, particularly from prospects brand new to the market. These questions will impact customer service costs and have MLR implications
- Outside of the exchange, some experts expect payers to develop “consumer strategies”, with retail storefronts, increased mass market advertising, social media marketing, etc. All of these efforts will have significant start-up⁴ and ongoing costs, and most are outside the traditional experience of payers

Our belief is that it will be hard to justify these investments and still meet MLR requirements. As a result, we conclude that the individual market will be smaller, more regulated, and significantly more challenging in which to earn a profit. We would argue that payers ought to develop a fuller understanding of the implications of the ACA for the individual market in the states where they compete before making significant investments.

⁴Start up costs could be significant, and will likely be underestimated by an industry that, frankly, lacks deep retail or consumer-centric expertise

Payers have plenty of departments and functions ripe for reengineering and process improvement that can generate near-term operating efficiency and cost reductions.

4. **Reduce Administrative Costs:** We agree with the general consensus that across the board administrative cost cutting is necessary in the face of the ACA (and would have, in fact, been quite beneficial without it). Based on our experience:
 - MLR requirements will hit payers harder than anticipated. While most large carriers' average MLRs meet requirements of the ACA, the final MLR calculations may reduce the most profitable markets/products to an average profitability⁵
 - Payers have plenty of departments and functions ripe for reengineering and process improvement that can generate near-term operating efficiency and cost reductions
 - Functions/activities that are not drivers of sustainable competitive advantage are candidates for outsourcing (with full recognition of the political hurdles that need to be overcome)
 - Payers will have the urge to focus on automation. They should resist this urge in the near-term, except in the case of projects with an unquestionable business case and very near-term payback. In our experience, IT investments rarely provide returns expected in the time frame promised. New MLR requirements will make mistakes much more expensive
5. **Account for MLR Requirements:** Payers should immediately begin an effort to evaluate their accounting for medical quality or care-related activities. Recognizing possible regulator and consumer group pushback, all legitimate categorization of costs to the numerator in the MLR calculation should be explored, especially given the likely market-by-market rebate requirements for MLRs below the 80%/85% thresholds. At least one payer, WellPoint, has already re-categorized some administrative costs to MLR in anticipation of the legislation.

Some of this work will be easy – simply shifting direct costs associated with a program that HHS designates as quality-related. Other changes will be more challenging, for example, determining how to allocate costs from shared resources (people, IT, and physical infrastructure). We would go a step further and suggest that this effort isn't simply about accounting. Payers can benefit by reallocating resources and reorganizing departments (eliminating layers and moving

⁵As of the writing of this perspective, the NAIC has not produced recommendations to the HHS, nor has the HHS made any final decisions on MLR issues. Regardless of how the formula is ultimately decided, payers will suffer as high profit markets/products will no longer be available to subsidize average or loss-making markets. For a great analysis of this issue, see "The Average Person Thinks He Isn't—Minimum Medical Loss Ratio Analysis", McDonald & Naklicki, Oppenheimer, April 2010

people) based on MLR qualification. This will increase marginal profitability and make the accounting treatment more straightforward (and frankly, will be a good excuse to reengineer processes and eliminate less productive overhead, reinforcing administrative cost reductions).

6. **Retool but Don't Move to Reduce Agent/Broker**

Compensation: Many industry experts have suggested that payers should reduce channel partner compensation, and we've heard and seen indications that several payers are already moving down this path. In our view, this approach is short-sighted, possibly damaging to channel relationships, and, if not matched by competitors, could create a head wind for sales and retention. Channel partners – agents, brokers, and consultants – have been and will continue to be a critical component in the private insurance market, both for individuals and groups as buyers, and as de facto service providers for payers⁶. Squeezing them now, when workloads are increasing due to the ACA is not the right approach.

At the same time, we believe that breaking the link between broker compensation and premiums should be on the table. Designed and executed correctly, this will lead to a moderation in compensation growth that will aid payers meeting their MLR requirements in the long term. It will require artful design and negotiation – and may even necessitate an increase in near-term compensation to brokers to avoid hits to sales and retention (justifiable, given the increased broker workload from the ACA). The compensation redesign also should be done in a way that leaves room for supplemental, creative compensation based on level of service provided (to payers and customers), sales growth and retention.

We also believe that payers should see the current environment as an opportunity to transform the broker compensation structure to a more client-paid model whereby channel compensation would be out of the MLR calculation. If there was ever a time to do so, it is during the ACA implementation process where clients, more than ever, should recognize the value of their brokers⁷.

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⁶Agents and brokers will perform a number of critical functions, and can, in fact, reduce administrative costs for payers during ACA implementation, as they will take a large portion of the flood of questions about plan design, grandfathering, decisions on whether to offer or drop coverage, etc., as regulations are written

⁷If you have any doubt about this, Google “broker” and “health reform” and see how many times you come across an article addressing employer questions about the ACA that includes something along the lines of “ask your broker if you have any questions or are unsure about this”

Given the strong public opposition and court challenges to portions of the ACA, it is likely that the law will evolve substantially. Payers would be wise to continue participating in the shaping of health care law.

7. **Don't Abandon Efforts to Address the Cost of Care:** While the ACA doesn't place a priority on cost reduction, the marketplace will still value and select payers that are able to impact medical cost trends (e.g., by using limited/tiered networks, improving health care management programs, and enhancing consumer-directed plans). Some of the most promising means of reducing costs may be at risk from the ACA (e.g., high-deductible/HSA plans). However, payers should not abandon them and should, in fact, work on the legislative and regulatory fronts to ensure their continuation.
8. **Don't Give Up on the Debate:** Make no mistake – the Act is bad news for payers. Some ACA proponents have no interest in the continuation of a private insurance market, and while they may make moves in the short term that appear to align with payer interests⁸, there are compelling reasons to believe that the Act will ultimately lead to the eventual dissolution of the private payer market. A vivid foreshadowing of this possibility was provided during the writing of this perspective, as an industry analyst announced sell recommendations for all managed care stocks and dropped coverage of the sector⁹ in response to the ACA's negative impact on long term industry outlook.

However, given the strong public opposition and court challenges to portions of the ACA, it is quite possible (and even likely) that the law will evolve substantially before being fully implemented. Payers would be wise to continue participating in the shaping of health care law for the next several years and beyond.

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⁸For example, requiring open enrollment for children-only policies without pre-existing condition exclusions required this year, in response to payer urging

⁹Aaron Vaughn, an analyst from Edward Jones, recently downgraded all payers he covered and indicated that his firm would drop coverage of the entire sector, saying "We are concerned that market structure changes, profit limitations and rebates, and ever-present political/regulatory pressures will negatively impact future profit growth and more than offset the anticipated influx of newly insured members (from reform)."

We recognize that payers face a massive undertaking to respond to the ACA, and many payers are making solid, well-informed decisions and taking necessary actions in a timely manner. We would caution payers, however, to resist the urge to follow the conventional wisdom on all fronts, and take just a bit more time now to think before acting. In our view, a payer would do well to consider the recommended actions outlined in this perspective, however the ACA evolves.

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