SOCIETY OF ACTUARIES

Article from:

Small Talk

November 2009 – Issue 33

Impact of Proposed Health Care Reform on Smaller Insurance Companies

By Cabe Chadick and David Dillon

Disclaimer

This commentary includes observations and opinions that are solely attributable to the authors and not their firms, their clients, or actuarial organizations. If federal health reform is enacted, we are confident that many of our observations are likely to prove incorrect by a measure and that we have missed remarking on consequences realized, both intended and unintended.

There are several key issues under the umbrella of "health reform" currently being considered by five congressional committees. The key issues as we see them, and in no particular order, are:

1. Individual Mandate
2. Individual and Small Group Reform
3. Low Income Subsidies
4. Health Insurance Exchange Gateways
5. Mandated Benefit Packages
6. Employer Mandate
7. Public Option
8. Medicare and Medicaid Expansion
9. Tax-cap on Employer Deduction of Health Insurance

The above reform categories include many specific proposals, and this heightens importance of the phrase "the devil is in the details." We will quickly go over a few key details we have observed to likely have consequences to small health insurers. Each of the details below is worth its own discussion and further study by the insurers and parties impacted. We apologize for our brevity of coverage.

Individual Mandate/Low Income Subsidies/ Employer Mandate

The proposed individual mandate would require all Americans to have health insurance. To assure access to affordable coverage, the proposals would expand the Medicaid program and provide premium subsidies for families earning some defined multiple (e.g., 400 percent) of the federal poverty limit. Similarly, the proposal contains a mandate that employers employing 25 or more employees must provide health insurance coverage. Such mandatory purchase of health insurance and financial incentives can be considered a good thing, even for smaller insurers. We would expect there would be an initial boom in additional business for health insurers. However, if the enacted health reform legislation includes a public option, instead of a "boom" there may be a "bust"—lost business from the private sector to the public.

Individual and Small Group Insurance Reform

The insurance reforms proposed for the individual and small group markets have the biggest and most obvious potential for changing the way that small health insurers act. These insurance reforms would apply to all coverage sold inside and outside of the health insurance exchange gateways.

Following are some of the insurance reform proposal specifics within the federal bills under consideration:

- Require guaranteed issue
- Require guaranteed renewability
- Prohibit pre-existing condition exclusions
- Forced participation in the small group market by insurers of individuals and vice versa
- Allow rating only by age, tobacco, geography, family makeup
- Require limited rating bands (e.g. 2:1 ratio for age)
- Require a nationwide minimum loss ratio standard

- Adjust payments to plans based on the risk profile of specific insureds
- Require plans to report data to regulators
- Require plans to implement affordability credits
- Establish uniform marketing standards
- Establish grievance and appeals mechanisms
- Prohibit insurers from rescinding health insurance coverage except in cases of fraud
- Require plans to contract with essential community providers
- Require plans to participate in risk pooling and reinsurance

Health Insurance Exchange Gateways

Health reform proposals establish an "exchange" that would offer a selection of health coverage alternatives. Initially, individuals and small firms would be eligible for the exchange, but the newly created "Commissioner of Health Choices" would have authority to open the exchange to all firms beginning in the third year. Eligibility to participate in the exchange would be phased in over three years. In year one, individuals and employers with 10 or fewer workers would be eligible. In year two, employers with 11-20 employees would become eligible. And in year three, employers with over 20 lives up to a defined limit established by a federal "Health Choices Commissioner" would be eligible.

One presumed intent behind the exchanges is they would be established and operated such that insurers ***only*** compete on price and "quality." That is, insurers could no longer compete on benefit offerings or risk selection. Those are both areas in which some insurers, small and large, have excelled. The exchanges would standardize benefits and offerings to consumers such that there would be little difference other than price to differentiate an insurer's product. However, the silver lining is that insurers who don't get brokers' and agents' attention compared to larger health plans (e.g., because of A.M. Best ratings) may finally get noticed, especially if their pricing is attractive. Another attractive part of the exchanges is that insurers who do not offer the most competitive commission payment structure may get more attention from a distribution basis (i.e., exchange gateway) that is independent of agents.

One of the reform options—popular among members of both political parties at the federal level—is to open up health insurance offerings "across state lines." That is, state insurance regulation would be pre-empted. This would allow insurers to offer health insurance plans in states where they were previously not allowed. This proposal—while thorny at the state level—could be very attractive to smaller insurers, especially those interested in moving into states whose major barriers to entry include onerous state regulation.

Mandated Benefit Design

The proposals require certain benefit packages to be offered. A standardized benefit design across insurers contrasts with how some smaller health insurers use their offered benefit packages as a means to differentiate themselves in the market. For example, a growing market for some insurers is the group limited benefit plans, or "mini-medical" plans. Depending on outcomes for federal mandated benefits, these types of plans could be out of compliance. Even if an insurer could still offer their mini-medical plans, they may be required to offer the mandated minimum benefit packages (e.g., where the federal "basic" plan provides that all medical cost-sharing doesn't exceed 30 percent of allowed costs) required under the new federal law or within the framework of the health insurance exchange gateway. This could force smaller insurers who do not want to offer major medical plans to decide between not offering any type of health insurance and writing guaranteed-issue health insurance in the individual and small group markets.

Here are some of the benefit requirements in the health reform proposals that could impact small health insurers:

- Require plans to offer one basic plan for each service area
- Require plans to provide regulatory-defined minimum benefit design
- Increase benefit mandates (e.g., dependent coverage to age 26)
- Require plans to meet network adequacy requirements
- Require plans to make information regarding plan benefits service area, premium and cost-sharing, and grievance and appeal procedures available to consumers
- Require plans to provide culturally and linguistically appropriate services

Public Option

One of the most controversial parts of the health reform proposals would be to establish a public plan that would compete with private insurers for enrollment of individuals and small employers. We anticipated that the plan would have pricing advantages over insurers because of a) leveraging Medicare payment methodology (i.e., participating providers would receive Medicare plus 5 percent), b) lack of profit margin, c) administrative economies of scale, and d) massive taxpayer subsidies.

One advertised presumption is that the new public option would compete under a level playing field with insurers. One would presume that a level playing field would include:

Continued on **page 12**

- Reasonable profit margin
- Risk-based capital requirements
- Premiums that support all costs, both claims and administrative costs
- Deficiency reserves in the case of insufficient premiums
- Cost of the capital to fund operations and losses
- Premium taxes to respective state insurance departments
- Independent examination of financial solvency

However, all of the above requirements that every insurer operating in the United States must meet and pay for, are not likely to be borne by this federally sponsored public option. To emphasize this point further, the estimated 10-year cost of the taxpayer subsidy to this "start-up" health plan is over $1 trillion. The Lewin Group has estimated that over 100 million Americans would become covered under the proposed public option, assuming the public option is made available to all employer sizes. That equates roughly to $1,000 per insured per year (i.e., $83.33 PMPM) taxpayer subsidy, for the public plan to use in its pricing and competition with private plans. Having an insurance competitor with such an advantageous and forgiving capital supporter should scare any private insurer, small or large.

Another drawback to the public option for smaller insurers is possible increases to negotiated medical provider payments (i.e., PPO fee schedules could rise). These changes could occur as the portion of medical providers' business from Medicare-type payment levels (i.e., via Medicare, the public plan, as well as Medicaid) increases. We could expect that medical providers will want to recover their revenue shortfall through cost-shifting increases in charges to those who continue to be covered under private insurance.

A possible silver lining to the new public option is a drawing away of higher risk insureds. One reason insureds may be drawn to the public plan is a desire to move away from a private health plan's restrictive network. If the public option has a broad network with very attractive premium prices, then it is not unreasonable to assume that persons with a worse than average risk profile wanting the broadest provider access at the cheapest price will be attracted to the public option.

Another silver lining to the public option is that private insurers may be able to beat the public option on claims management, which if achieved could be quickly realized in premium price differentiation. Whereas private insurers typically employ utilization management programs (e.g., precertification for high-cost procedures, disease management, concurrent utilization review and discharge planning) designed to avoid unnecessary utilization of health services, Medicare (and likely the public option) does not have pre-authorization or similar management techniques. In fact, the public option is being advertised as a means to "keep the private insurers honest," which presumably means that the public option will be "friendlier" in its claims management. One can even imagine TV commercials, similar to what one sees today, from durable medical equipment providers offering to get public plan insureds their latest medical device, handling all the claims management with no hassle to the insured. Again, this "friendly" type of claims management will show up as higher public plan premiums, if and only if the public plan truly operates on a level playing field that allows no ongoing taxpayer subsidy to premiums therein.

Medicare and Medicaid Expansion

There are proposals to expand materially who is covered under both Medicare (i.e., through lowering eligibility age to 55) and Medicaid (i.e., through expanding the income limits). One might argue that expanding the income limits for Medicaid eligibility is likely to capture previously uninsureds and not represent too much of an encroachment on private carrier's prospective individual and small employer markets. However, it is more likely that the potential complete takeover of health insurance for U.S. citizens 55 and older will seriously encroach on the private health insurance markets. The individuals in these ages make up a disproportionate share of the dollars spent on medical care compared to their percentage makeup of the working population.

Tax-cap on Employer Deduction of Health Insurance

This proposal is likely to change materially the benefit designs purchased by employers. One possible consequence is for employers to reduce their benefits offered to the essentials of medical insurance, including higher cost-sharing, as well as not include supplemental coverages such as dental, vision, etc. Similarly, those employers who self-insure or purchase a separate plan to cover portions of the cost-sharing of high-deductible medical plans could possibly reduce those benefits as well. These behaviors would materially affect smaller insurers who offer these employer-paid supplemental coverages. ●

Cabe W. Chadick, FSA, MAAA, is senior vice president & principal at Lewis & Ellis, Inc. in Richardson, Texas. He can be reached at *cchadick@lewisellis.com*.

David M. Dillon, FSA, MAAA, is vice president & principal at Lewis & Ellis, Inc. in Richardson, Texas. He can be reached at *ddillon@lewisellis.com*.