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Transparent Reinsurance for Health

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Summary:

Transparent reinsurance programs to address health insurance could emerge as significant opportunities.

http://insurancethoughtleadership.com/transparent-reinsurance-and-risk-corridors-for-health-exchanges/

Photo Courtesy of Anne

Transparent reinsurance programs could emerge as significant opportunities for healthcare providers, issuers, reinsurers, technology innovators and regulators to address health insurance.

The message is clear. Having to factor in higher costs associated with new entrants to the healthcare system gives insurance firms license to charge higher rates. If these new people were put into a reinsurance pot for three to five years with costs spread over all insurers, no one insurer would be unnecessarily burdened. After this period, costs for these entrants could be reexamined and a decision could be made on how to proceed with them, depending upon the deviation from the remaining population.

Several factors are coming into play.

United Health Group indicates it will be leaving all but a few of the 34 states where it is offering health insurance under Obamacare.

A fresh Blue Cross Blue Shield study finds recent Obamacare entrants have higher rates of specific illnesses and used more medical services than early entrants. "Medical costs of care for the new individual market members were, on average, 19% higher than employer-based group members in 2014 and 22% higher in 2015. For example, the average monthly medical spending per member was $559 for individual enrollees versus $457 for group members in 2015," the study found.

What emerges in conversations with economists, regulators and healthcare actuaries is a sense that properly designed, fair and transparent reinsurance could—and would—advance industry and public policy goals to continue insurance for all at affordable prices. This approach would represent tangible improvements over inefficient, incumbent systems. Information would be used by insurers and reinsurers, providers and regulators and, crucially, insureds to establish best performances for healthcare outcomes and expenses. Virtually everyone knows that state or regional reinsurance would have to be mandated, as voluntary systems could be gamed.

"The implementation of new policies, the availability of research funding, payment reform and consumer- and patient-led efforts to improve healthcare together have created an environment suitable for the successful implementation of patient-reported outcome measures in clinical practice," fresh research in Health Affairs also indicates.

Risk analysis technologies could help issuers, reinsurers, healthcare institutions and citizens rein in the healthcare system's enormous costs. Earlier this year, the Congressional Budget Office and Joint Committee on Taxation projected that, "in 2016, the federal subsidies, taxes and penalties associated with health insurance coverage will result in a net subsidy from the federal government of $660 billion, or 3.6% of gross domestic product (GDP). That amount is projected to rise at an average annual rate of 5.4%, reaching $1.1 trillion (or 4.1% of GDP) in 2026. For the entire 2017–2026 period, the projected net subsidy is $8.9 trillion."

CBO/JCT published this stunning projection amid consensus that $750 billion to $1 trillion of wasted spending occurs in healthcare in the U.S. "Approximately one in three health care dollars is waste," Consumer Reports says.

Key metrics should focus on estimates of risk using demographics and diagnoses; risk model descriptions; calculation of plan average actuarial risk; user-specified risk revealing and detailing

information; drill-down capabilities clarifying research; monitoring and control; and calculation and comparison measures to address reinsurance validation.

Several major refinements yielding and relying upon granular, risk-revealing data and metrics would support more efficient reinsurance. All would, and could, update reinsurance information and address customer experience, trust and privacy concerns.

As the industry has noted, ledger technologies could play fundamental roles as blockchains. Indeed, blockchain technologies are just now being introduced in the U.K. to confirm counter party obligations for homeowners' insurance.

"Advanced analytics are the key," remarked John Wisniewski, associate vice president of actuary services at UPMC Health Plan. "Predictive capability that looks at the likelihood a patient admission may be coming is the information that we can give to doctors to deal with the matter. … Whoever develops algorithms for people who will be at risk—so providers can develop plans to mitigate risk—will create value for issuers, providers and members alike."

Available technologies support the connecting of risk assessments with incentives for risk information.

Michael Erlanger, the founder and managing principal of Marketcore, said, "We cannot know what we cannot see. We cannot see what we cannot measure. These available technologies provide clarity for more efficient health insurance and reinsurance."

Context: Three Rs: Reinsurance, Risk Corridors and Risk Adjustment

When Congress enacted the ACA, the legislation created reinsurance and risk corridors through 2016 and established risk adjustment transfer as a permanent element of health insurance. These three Rs—reinsurance, risk corridors and risk adjustment—were designed to moderate insurance industry risks, making the transition to ACA coverage and responsibilities. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) administers the programs. All address adverse selection—that is, instances when insurers experience higher probabilities of losses due to risks not factored in at the times policies are issued. All also address risk selection, or industry preferences to insure healthier individuals and to avoid less healthy ones.

With the expiration of ACA reinsurance and risk corridors, along with mandatory reporting requirements this December, healthcare providers, issuers, reinsurers, technology innovators and regulators can now evaluate their futures, separate from CMS reporting.

Virtually all sources commend reinsurance and risk adjustment transfer as consistently as they deride risk corridors. Reinsurance has paid out well, while risk corridors have not. Risk adjustment transfer remains squarely with CMS.

ACA numbers

While House Republican initiatives try and fail to repeal the ACA, and some news programs and pundits say it is unsustainable, approximately 20 million subscribers are enrolled in Obamacare: with 12.7 million as marketplace insureds, with others through Medicaid and as young adults on parent plans. President Obama, in March, remarked: "Last summer we learned that, for the first time ever, America's uninsured rate has fallen below 10%. This is the lowest rate of uninsured that we've seen since we started keeping these records." Subscription ratios are off the charts. Premium increases have been modest, approximately 6% for 2016, experts find. "I see no risk to the fundamental stability of the exchanges," MIT economist Jonathan Gruber observed, noting "a big enough market for many insurers to remain in the fold."

Transitional Reinsurance 2014-16: Vehicle for Innovation

One of the great benefits of the ACA is eliminating pre-existing conditions and premium or coverage variables based on individual underwriting across the board. Citizens are no longer excluded from receiving adequate healthcare, whether directly or indirectly through high premiums. Prices for various plan designs go up as coverage benefits increase and as co-pays and deductibles decrease, but the relative prices of the various plans are calculated to be actuarially equivalent.

To help issuers make the transition from an era when they prided themselves on reducing or eliminating less healthy lives from the insureds they covered, to an era where all insureds are offered similar ratings, the ACA introduced reinsurance and risk corridors to cover the first three years (2014 through 2016), in addition to risk adjustment transfer, which will remain in force.

The concept is relatively simple: Require all issuers to charge a flat per-dollar, per-month, per-"qualified" insured and create a pot of money with these "reinsurance premiums" that reimburses issuers for excess claims on unhealthy lives. Issuers would be reimbursed based on established terms outlined in the ACA.

Reinsurance reimburses issuers for individual claims in excess of the attachment point, up to a limit where existing reinsurance coverage would kick in. Individuals involved with these large claims may or may not be identified in advance as high-risk. The reimbursed claim may be an acute (non-chronic) condition or an accident. The individual may otherwise be low-risk.

The important aspect is that all health insurance issuers and self-insured plans contribute. By spreading the cost over a large number of individuals, the cost per individual of this reinsurance program is small to negligible. Non-grandfathered individual market plans are eligible for payments. A state can operate a reinsurance program, or CMS does on its behalf through this year.

As a backstop, the federal government put some money in the pot through 2016—just in case the pot proved inadequate to provide full reimbursement to the issuers. In a worst-case scenario, the sum of the reinsurance premiums and the federal contribution could still be inadequate, in which case the coinsurance refund rate would be set at less than 100%.

As it turned out, 2014 reinsurance premiums proved to be more than adequate, so the refund rate was 100%, and the excess funds in the pot after reimbursement were set aside and added to the pot for 2015, just in case that proves inadequate.

Reinsurance functions on this timetable through this year:

Year	Reinsurance Payments	US Treasury Funds	Total Contributions
2014	$10B	$2B	$12B
2015	$6B	$2B	$8B
2016	$4B	$1B	$5B

Contributions remain in the state where they are collected

CMS transferred approximately $7.9 billion among 437 issuers—or 100% of filed claims for 2014, as claims were lower than expected— and it has yet to release 2015 payments. The results for 2015 are coming this summer.

From the outset, states could, and would, elect to continue reinsurance, the CMS contemplated. In 2012, the CMS indicated that "states are not prohibited from continuing a reinsurance program but may not use reinsurance contribution funds collected under the reinsurance program in calendar years 2014 through 2016 to fund the program in years after 2018."

Subsequent clarification in 2013 did not disturb state discretion. Current regulation specifies that "a state must ensure that the applicable reinsurance entity completes all reinsurance-related activities for benefit years 2014 through 2016 and any activities required to be undertaken in subsequent periods."

One course of action going forward from 2017 and varying from state-to-state could be mandatory reinsurance enacted through state laws. Healthcare providers, issuers, reinsurers, regulators and legislators could define the health reinsurance best suited to each state's citizens.

Reinsurers could design and manage administration of these programs possibly at a percentage of premium cost that is less than what is charged by the federal government today. While these reinsurance programs would be mandated, they could include a component of private reinsurance. For example, reinsurers could guarantee the adequacy of per-month reinsurance premiums with provisos that if these actuarially calculated rates turned out to be inadequate in any given year or month, there will be an adjustment to account for the loss in the following year. Conversely, if those rates turn out to be too high, 90% or more is set aside in an account for use in the following year. This way, reinsurers could participate by providing a private sourced solution to adverse claims.

Risk Corridors

Risk corridors apply to issuers with Qualified Health Plans (exchange certified plans) and facilitate transfer payments. The CMS noted: "Issuers whose premiums exceed claims and other costs by more than a certain amount pay into the program, and insurers whose claims exceed premiums by a certain amount receive payments for their shortfall." Technically, "risk corridors mean any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount," as the CMS designated.

Issuer claims of $2.87 billion exceeded contributions, so the CMS transferred $362 million among issuers; that is, a 12.6% proration or a $2.5 billion shortfall in 2014.

Risk corridors are politically contentious. Sen. Marco Rubio (R-Florida) likened risk corridors to bailouts. The HHS acknowledged it will "explore other sources of funding for risk corridors payments, subject to the availability of appropriations… includ[ing] working with Congress on the necessary funding for outstanding risk corridors payments." And, a knowledgeable analyst, Dr. David Blumenthal, noted that risk corridors are not bailouts.

Going forward, evaluations of risk corridors will demand due diligence. Several health exchanges failed from any number of factors—from too little capital for growth experienced, inadequate pricing, mismanagement or risk corridor payments.

Whether innovation can yield effective risk corridors or whether risk corridors will simply fade out as transitional 2014-2016 regulation will depend on institutional and industry participants. Risk corridors did not score unalloyed approbation among sources.

Risk Adjustment: Permanent Element of ACA

Risk adjustment remains in force and impels issuers with healthier enrollees to offset some costs of issuers with sicker ones in specific states and markets and of markets as a means toward promoting affordable health care choices by discouraging cherry picking healthier enrollees.

The HHS transferred approximately $4.6 billion for risk adjustment among issuers for 2014.

At first blush, one might postulate that risk adjustment does the job and that reinsurance and risk corridors could just as reasonably fade out. There is some logic to that argument.

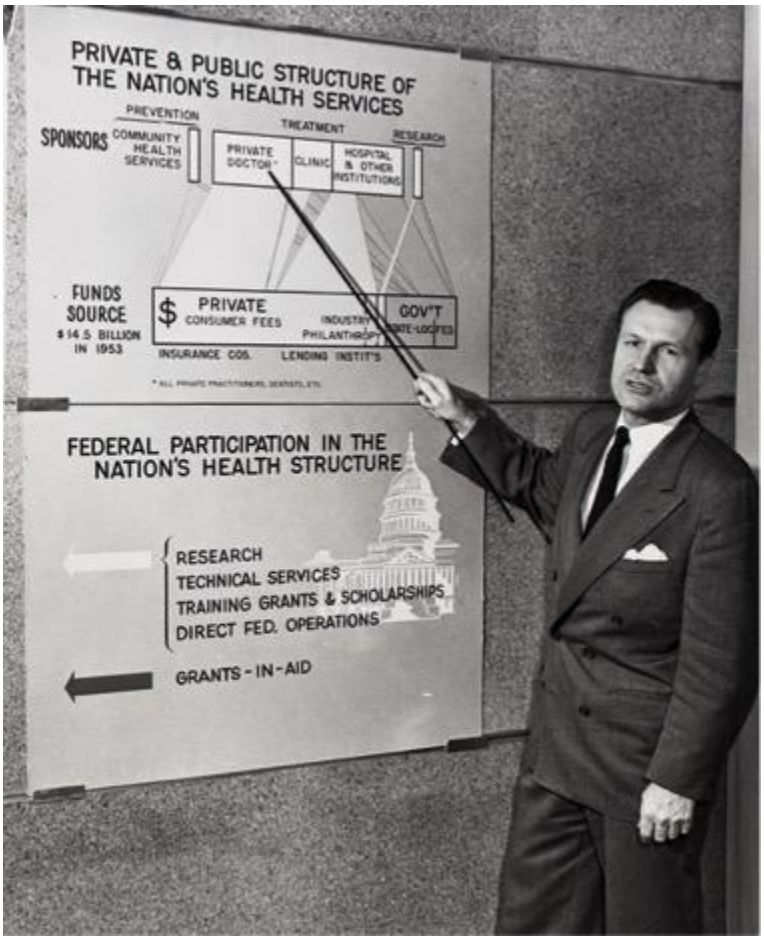
On the other hand, state or regional level reinsurance could make up for risk adjustment shortfalls. In some instances, risk adjustment seems to be less friendly to issuers that take on higher-risk individuals, rather than rewarding high tech issuers and providers with back office capabilities coding claims in such a way as to tactically game risk adjustment.

Evaluating and cultivating these opportunities are timely amid the uncertainties of the presidential and congressional elections that may yield executive and legislative lawmakers

intent on undoing ACA provisions, starting with risk corridors. Such legislation could produce losses for issuers and reinsurers.

Nelson A. Rockefeller Precedent

In 1954, then-Undersecretary of Health Education and Welfare Nelson A. Rockefeller proposed reinsurance as an incentive for insurers to offer more health insurance. S 3114, A Bill to Improve the Public Health by Encouraging More Extensive Use of the Voluntary Prepayment Method in the Provision of Personal Health Services, emerged in the first Eisenhower administration to enact a federally funded health reinsurance pool. Rockefeller intended the reinsurance as a means toward an end, what would eventually be dubbed a "third way" among proponents of national health insurance. President Truman and organized labor championed the approach into the mid-'50s. So did the Chamber of Commerce and congressional Republican adversaries of the New Deal and Fair Deal, who were chaffing to undo Social Security as quickly as they could. The American Medical Association also supported this third way because it opposed federal healthcare reinsurance as an opening wedge for socialized medicine. Despite limiting risk and offering new products, insurers demurred because of comfort zones with state regulators and trepidation about a federal role.



Nelson A. Rockefeller, then-undersecretary of the Department of Health, Education and Welfare, presenting a federally funded health reinsurance plan, 1954. Source: Department of Health Education and Welfare—now Health and Human Services

Rockefeller's health reinsurance plan would "achieve a better understanding of the nation's medical care problem, of the techniques for meeting it through voluntary means, and of the actuarial risks involved," HEW Secretary Oveta Culp Hobby testified to a Senate subcommittee in 1954.

Rockefeller's health reinsurance plan did not make it through the House. Organized labor decried it as too little, the AMA said it was too intrusive. Upon hearing news of the House vote, a frustrated Dwight Eisenhower blistered to reporters, "The people that voted against this bill just don't understand what are the facts of American life," according to Cary Reich in *The Life of Nelson A. Rockefeller 1908-1958*. "Ingenuity was no match for inertia," Rockefeller biographer Richard Norton Smith remarked of industry and labor interests in those hard-wired, central-switched, mainframe times.

"'It's déjà vu all over again' like Yogi Berra," said one insurance commissioner immersed in the ACA on hearing Ike's quote.

Source: Yogi Berra Museum & Learning Center

The idea of national health insurance went nowhere despite initiatives by Sen. Edward M. Kennedy (D-Massachusetts) in the late '70s and President Bill and First Lady Hillary Clinton roughly 20 years ago, until Congress legislated Obamacare.

Innovative, Transparent Technologies Can Deliver Results

Nowadays, more than 60 years after Rockefeller's attempt, innovative information technologies can get beyond these legislative and regulatory hurdles. Much of the data and networking is at hand. Enrollee actuarial risks, coverage actuarial values, utilization, local area costs of business and cost-sharing impacts on utilization are knowable in current systems. Broadband deployment and information technology innovations drive customer acquisition and information management costs ever lower each succeeding day. Long-term efficiencies for reinsurers, insurers, carriers, regulators, technology innovators and state regulators await evaluation and development.

Reinsurance Going Forward From 2017

So, if state reinsurance programs can provide benefits, what should they look like, and how should they be delivered?

For technology innovators—such as Google, Microsoft, Overstock, Zebra or CoverHound—these opportunities with reinsurance would apply their expertise in search, processing and matching technologies to crucial billion-dollar markets and functions. The innovators hope to achieve successes more readily than has occurred through retail beachheads in motor vehicle and travel insurance and credit cards and mortgages. One observer noted that some of those retail initiatives faltered due to customer experience shortfalls and trust and privacy concerns. Another points out that insurers view Amazon, Apple and Netflix as setting new standards for customer experiences and expectations that insurers will increasingly have to match or supersede. A news report indicated that Nationwide already pairs customer management data with predictive analytics to enhance retention.

Reinsurers including Berkshire Hathaway, Munich Reinsurance Company, Swiss Reinsurance Company Limited and Maiden Holdings could rationalize risks and boost earnings while providing a wealth of risk management information, perhaps on a proprietary basis.

For issuers, state-of-the-art transparent solutions improve the current system by enabling issuers to offer more products and services and becalm more ferocious industry adversaries while lowering risks and extending markets. Smaller, nimbler issuers may provide more innovative solutions and gain market share by providing the dual objectives of better health outcomes with lower costs.

For regulators, innovative, timely information sustains the indispensability of state regulators ensuring financial soundness and legal compliance—while allowing innovators to upgrade marketplace and regulatory systems, key regulatory goals that Iowa's insurance commissioner, Nick Gerhart, pointed out recently. Commissioner Gerhart envisions regulators as orchestra conductors, acknowledging that most insurance regulatory entities are woefully understaffed to design or operate such reinsurance programs themselves, but they will, and they can lead if the participants can provide turnkey capabilities.

Think of health insurance and reinsurance as generational opportunities for significant innovation rather like the Internet and email. When the Department of Defense permitted the Internet and email to evolve to civilian markets from military capabilities in the 1980s, the DOD initially approached the U.S. Postal Service. Senior Post Office management said it welcomed the opportunity to support email: All users need do is email correspondence to recipients' local post offices by nine p.m. for printing, enveloping, sorting and letter-carrier delivery the following day.

Similarly, considerable opportunities chart innovative pathways for state and regional health reinsurance for 2017 and beyond.

One path, emulating the post office in the ’80s, keeps on coding and bemoans a zero sum; it would allow the existing programs to fade away and will respond to whatever the president and Congress might do.

Another path lumps issuer health reinsurance as an incumbent reinsurer service without addressing the sustainability of state health exchanges or, indeed, any private health insurers in the absences of risk spreading with readily available information technologies.

The approach suggested here—mandated state health reinsurance—innovates to build sustainable futures. Enabling technologies empower all stakeholders to advance private and public interests through industry solutions advancing affordable healthcare.