

Health Insurance Benefit Design

John Watkins, Pharmacy

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Agenda

- Benefit Design: What and Why John Watkins
- Benefit Design Strategies David Barnes
- Actuarial Considerations Pamela Wells

Benefit Design: What Is It? Why Do We Need It?

John Watkins, RPh, MPH, BCPS

Runaway Health Care Costs: Could This Be the Future of U.S. Health Care??



U.S. Health Policymakers Have Failed To Find Solutions

- Unrealistic attitude toward resource constraints
- Fragmentation
- Sociocultural values/attitudes in the U.S.
 - Autonomy
 - Wellness
 - Entitlement
- Pluralistic society

Diverse Payers Struggle With Benefits

- CMS (Medicare)
- Centralized Federal Systems (DOD, VA)
- State and local governments
 - Medicaid
 - Government Employee Benefit Programs
- Bewildering variety of private payers
 - National for profit (Aetna, CIGNA, United)
 - Local and regional plans (Premera, Regence)
 - Staff model HMOs, integrated systems (Group Health)



Before Insurance & Modern Medicine



“Doctors knew how to relieve suffering, set bones, sew up cuts and open boils on small boys. Perhaps the greatest service the old doctor rendered was during childbirth...”

“The doctor was eagerly awaited when disaster came. He did his best.”

Arthur Hertzler, *The Horse and Buggy Doctor* (1938)

Health Care Financing in the 20th Century

- New technologies
- Affordable prices
- Rising expectations
- Modern health insurance
 - Employment based
 - Catastrophic coverage
 - Patients paid everyday expenses



What Is a Health Benefit?



- Contract specifying coverage and cost shares
 - Silos (medical, dental, pharmacy, etc.)
- Insurer may provide health services or contract with service providers
 - Open vs closed networks
 - Tiered networks
 - Any willing provider laws
- Original purpose was to spread risk, provide coverage for low probability high cost events

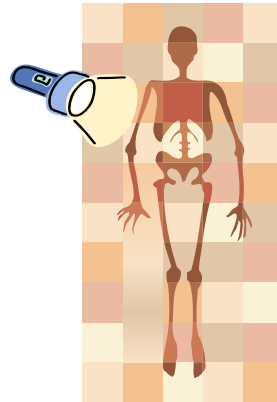
The Purpose of Insurance



- Purpose is to protect the insured from low risk, high cost events.
- Insurance has a moral obligation to cover only those products which are *medically necessary* and *fiscally responsible*.
- Covering products that don't meet these criteria is a subsidy for industry. That's not the function of insurance.
- Covering everything (even at a discount) is irresponsible, undesirable, inflationary and unsustainable.
- The issue should not be about coverage, it should be about *medical necessity*, which is really about evidence.
- If we can't learn to restrict, the unfortunate alternative is rationing.

Jeff Shornick, MD, MHA

Anatomy of a Benefit



- Scope of coverage
 - Included & excluded services
 - Covered providers & venues
 - Coverage limits (maximum \$\$)
- Member cost share
 - Copay – fixed amount per service
 - Coinsurance – percent of paid claim cost
 - Deductible
 - Out of pocket maximum (stop loss)

Goals of Benefit Design



- Support clinical quality of care
- Obtain best value for limited premium \$\$
- Maintain affordability of benefit
- Be competitive in local insurance market
- Spread risk
- Minimize unintended consequences
 - Adverse selection
 - Moral hazard

Health Insurance Benefit Design

David Barnes
Sr. Manager, Product Strategy & Development

Product Strategy & Design

Cross Functional Effort



Operations

- System feasibility
- Ease of administration



Clinical

- Appropriateness
- Trends/Advancement



Market Research

- Focus Groups
- Conjoint Analysis
- Satisfaction Surveys



Product Management

- Competition
- Market
- Portfolio performance
- Innovation



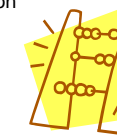
Sales

- Distribution
- Market demand
- Consultative



Legal

- Mandates
- Filing Products & Rates

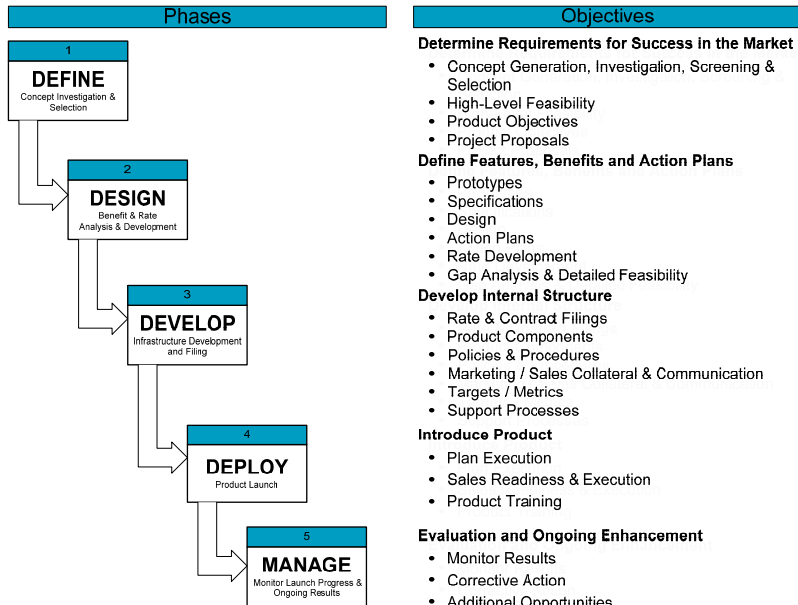


Underwriting & Actuary

- Risk assessment
- Pricing

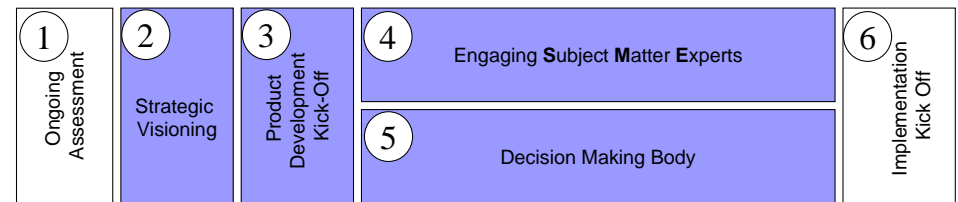
Product Development Lifecycle

Phased Process



Product Development Lifecycle

Process & Intent: Define & Design



1. Ongoing Assessment

- Monitor portfolio performance, competition, regulatory developments, and make adjustments as appropriate

2. Strategic Visioning (Date)

- Review portfolio performance, competitor positioning, market conditions, regulatory developments, and timeline. Goal is to confirm or adjust product strategy and define scope for product development effort

3. Product Development Kick-off (Date)

- Orient Implementation Team as to the scope of Product Development effort and review analysis from strategic visioning session

4. Engaging Subject Matter Experts (Ongoing)

- Engage areas of expertise on a one-off or workgroup basis to streamline feasibility process

5. Decision Making Body (Dates)

- Review analysis of existing portfolio performance and proposals that support strategic positioning

6. Implementation

- Execute implementation both internal and externally. Support development of contracts, marketing materials, training, and product launch

Premera

Corporate Mission - Provide peace of mind to our members about their health care coverage

Product Strategy - Attract, maintain, & grow profitable membership

Tactical Objectives

- Administrative efficiency
- Balanced portfolio (tradeoff between choice & efficiency)
- Better Health (personal & financial)
- Differentiate from the competition
- Maintain & build on position as innovator
- Meet state & federal mandates
- Reduce barriers to care
- Strive for simplicity

The Actuarial Perspective: Benefit Design in Health Insurance Products

Presented by Pamela Wells
Sr. Actuarial Analyst

January 26, 2006

Overview

- Background – Actuaries and Insurance
- Risk
 - Adverse Selection and Moral Hazard
- Using Benefit Design to Control Risk
- Variance of Adverse Selection Risk by Market Segment

What is an Actuary?

- A business professional who deals with the financial impact of risk and uncertainty.
 - Source: <http://en.wikipedia.org>
- Expert in:
 - Evaluating the likelihood of certain events,
 - Designing creative ways to reduce the likelihood of uncertain events, and
 - Decreasing the impact of undesirable events that do occur.
 - Source: www.beanactuary.org/about/whatis.cfm

The Actuarial Profession

- Society of Actuaries (SOA)
 - Associate (ASA)
 - Fellow (FSA)
- Casualty Actuarial Society (CAS)
 - Associate (ACAS)
 - Fellow (FCAS)
- American Academy of Actuaries (AAA)
 - Member (MAAA)
- Canadian Institute of Actuaries (CIA)

What is Insurance?

- A form of risk management primarily used to hedge against the risk of a contingent loss.
- The equitable transfer of the risk of a potential loss, from one entity to another, in exchange for a premium.
 - Source: <http://en.wikipedia.org>

Why Insurance is Worthwhile

- Catastrophic Contingent Events
 - Risk of something REALLY bad and expensive occurring that you wouldn't be able to afford
 - Example: Community Assistance
- Cash Flow Risk
 - Risk that you won't have enough money to cover your financial obligations when they are due
 - Example: Cable TV

How Health Insurance Works

- Pooling of Funds Example:
 - 10,000 People in Pool
 - Chance of Student's Mid-Term Disease (SMTD) is 1 in 1000
 - We expect 9,990 people to have \$0 in claims
 - We expect 10 people to have \$120,000 each in claims
 - Nobody knows who those people will be
 - Total EXPECTED cost for everyone is \$1,200,000
 - Spread the expected cost evenly across all the participants:
 - \$120 Per Member Per Year (PMPY)
 - \$10 Per Member Per Month (PMPM)

What is Risk?

- Risk is the potential that the outcome is not what you expected
- In terms of Health Insurance:
 - To the individual - the potential for injury or illness to occur and cause financial obligations larger than you can comfortably bear
 - To the insurer - the potential that the obligation to pay on behalf of our members is larger than expected due to many possible causes

Major Risks faced by Health Insurance Companies

- Premium Insufficiency
 1. Adverse Selection
 - Consumer knows more about their health than the insurer does
 2. Moral Hazard
 - Tendency of insured people to take more risks than they would if they were uninsured
 - Tendency of insured people to use services more frequently than necessary

Adverse Selection Example

- Prior example: SMTD
 - 10,000 people in pool with a chance of SMTD of 1 in 1000 in a NORMAL group of people
 - Consider two companies: Each has 5,000 members out of the total pool
 - Company A has a product that is more generous to people with SMTD than Company B's product... but Company A doesn't know it
- What happens?

Adverse Selection Example

	Company A	Company B	Everyone
a Members in Pool	5,000	5,000	10,000
b Cost of SMTD per Occurrence	\$120,000	\$120,000	\$120,000
c Expected Occurrence of SMTD in Pool	5	5	10
d Expected Cost of SMTD to Pool (b X c)	\$600,000	\$600,000	\$1,200,000
e Expected Cost of SMTD PMPM (d + a + 12)	\$10	\$10	\$10
f Actual Occurrence of SMTD in Pool	8	2	10
g Actual Cost of SMTD to Pool (f X c)	\$960,000	\$240,000	\$1,200,000
h Actual of SMTD PMPM (g + a + 12)	\$16	\$4	\$10

Moral Hazard Example #1

- 1 in 10 chance of getting Repetitive Goat Syndrome (RGS) if you participate in Competitive Off-Road Goat-back Racing (Corging)
- RGS costs \$1,000 to cure
- Without insurance, a 10% chance of having to pay \$1000 is too much for John to afford
- With insurance, John has a \$10 copay for RGS... so he has a 10% chance of having to pay \$10

"I've always wanted to try Corging..."

Moral Hazard Example #2

- Carpal Feline (CaFe)
 - a debilitating repetitive stroking disorder
 - easily manageable if diagnosed early
- Testing recommended once every two years for cat owners; tests cost \$250
- Without insurance Jane would get tested only as recommended
- With insurance Jane gets tested twice per year, even though not necessary

Using Benefit Design to Reduce Adverse Selection

- Know your environment
 - Don't be significantly more generous in services covered than your competitors
 - Know the demographics of your market (age, gender, education & income level, etc.)
- Place some reasonable limits
 - Dollar limits on services that can get exorbitant (prosthetics & medical equipment)
 - Visit or usage limits on services often subject to selection or overuse (mental health, chiropractic)
- **Proper balance of premium level to value of services offered**

Using Benefit Design to Reduce Moral Hazard

- Cost Sharing
 - Prescription Drug Tiers
 - Encourage generic usage with lower cost to member
 - Encourage use of more effective brand name drugs with "preferred" and "non-preferred" classes of drugs with different cost sharing
 - \$10/\$20/\$40
 - Deductibles
 - Up front cost to discourage unnecessary use of services
 - Simple cold
 - Service "preference"
 - ER versus Office Visit cost

Benefit Design Examples: Which sounds best to you?

- **WiseChoices** - \$249 per month for 35 year old non-smoker
 - No deductible, 10% coinsurance on most services, \$30 office and preventive visit copay, \$10/\$45/50% Rx benefit, immunizations and preventive screenings covered in full
- **WiseEssentials** - \$111 per month for 35 year old non-smoker
 - \$1500 deductible, 25% coinsurance on most services, deductible waived on first 6 office and preventive visits, immunizations and preventive covered in full, NO maternity coverage, NO Rx coverage
- **WiseSavings** - \$128 per month for 35 year old non-smoker
 - \$1700 deductible, 20% coinsurance on most services including office visits, immunizations and preventive visits covered in full, NO maternity coverage, NO Rx coverage, HSA qualified for tax advantaged savings

Adverse Selection Variance by Market Segment

- Major Segments:
 - Individual & Family Market
 - Small Group Market (2 to 99)
 - Associations
 - Large Group Market (100+)
 - Super-Jumbo Groups
 - Self-Insured Market
- Major Variances:
 - Number of options to choose between
 - Degree of customization available
 - Degree of regulation

Adverse Selection Variance: Number of Options

- Individual & Family Market
 - Can choose from all individual plans offered by all carriers in their area
- Small Group Market (2 to 99)
 - Generally choose from only one or two designs from a single carrier
- Associations
 - Generally choose from several designs from a single carrier
- Large Group Market (100+)
 - Generally choose from a few designs from one or two carriers
 - Cafeteria Plans
- Self-Insured Market
 - Can choose from as many or as few designs as they wish to have

Adverse Selection Variance: Degree of Customization

- Individual & Family Market
 - Cannot customize plan designs
- Small Group Market (2 to 99)
 - Cannot customize plan designs
- Associations
 - Association can customize designs, members groups cannot
- Large Group Market (100+)
 - Moderately sized groups generally don't customize due to costs
 - Larger groups often customize a few benefits for a fee
 - Jumbo groups can customize almost anything to any degree
- Self-Insured Market
 - Can customize almost anything to any degree

Adverse Selection Variance: Degree of Regulation

Regulation by Market	Mandated Benefits	Premium Control	Underwriting Control	Rating Control
Individual	Must Comply with 32 Mandates for Individual Plans	File & Use	Standard Health Questionnaire	Community Rated
Small Group	Must Comply with 39 Mandates for Group Plans	File & Use, but OIC can order cease & desist	Guarantee Issue	Community Rated
Associations	Must Comply with 39 Mandates for Group Plans	Must File the Methodology	Guarantee Issue	Rates Can Vary by Health & Demographics
Large Group	Must Comply with 39 Mandates for Group Plans	Must File the Methodology	Guarantee Issue	Rates Can Vary by Health & Demographics
Self Insured	Not subject to state benefit mandates.	No Filing Required	Not Applicable	No Rating Controls

Summary

- Actuaries deal with financial risks
- Insurance pools some risks to reduce impact
- Major risks faced by insurance companies:
 - Adverse Selection
 - Moral Hazard
- Adverse selection and moral hazard risk can be reduced by benefit design
- Severity and type of Adverse selection varies by market segment

Conclusions:

- Health benefit design is complex
 - The design process is very cross-functional
 - Silos are a problem
 - Some of the factors are not obvious
- Designs must fit the customer's needs
- The market is complex and changing rapidly – difficult to predict the future