

Deloitte Review

ISSUE 13 | 2013

Complimentary article reprint



The future of health care insurance: What's ahead?

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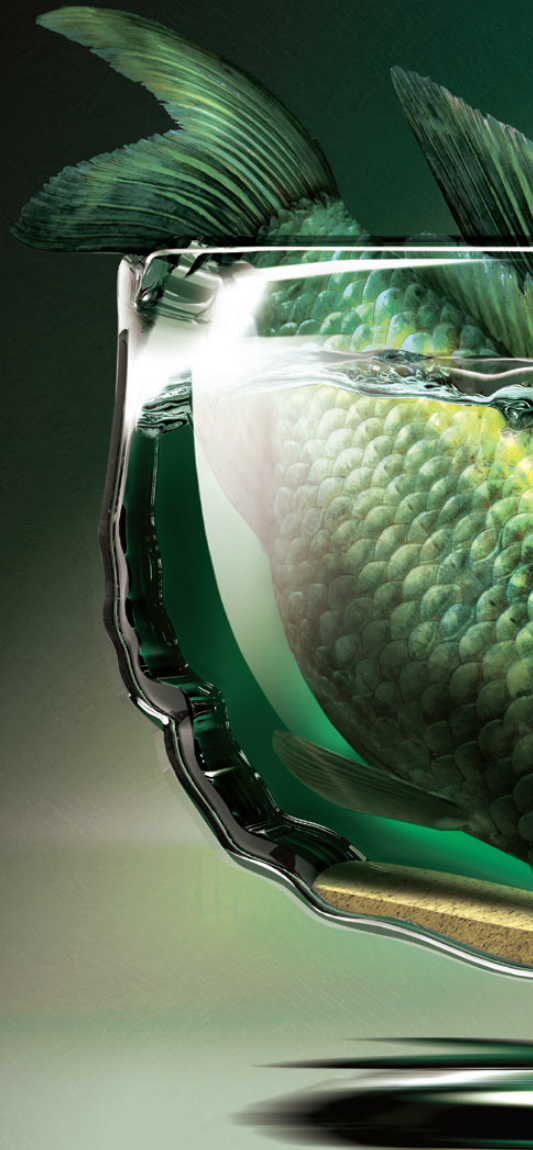
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The concept of insurance is fairly straightforward: Individuals or organizations purchase a service that mitigates their risk in the event of an unforeseen problem. It's about financial security—hoping it may not be required to use the coverage purchased but hedging just in case. In many insurance markets, premiums paid by policyholders are pooled so that the financial impact of a single event doesn't wipe out a household or organization. The majority pay, and over time, many receive a payout, but in a given year, a large majority do not. Health insurance is an exception where many policyholders use their insurance frequently. Thus, the math of insurance is about basics: pooling of risk from a large number of policyholders to fund a smaller number of unforeseen losses.



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For many types of coverage, the insurance industry has two customers:

- Employers, including not-for-profit organizations, purchase a variety of insurance services—property and casualty coverage to mitigate damages to physical property; directors and owners liability for errors of omission or commission; liability protections; and for many bigger businesses, health insurance coverage for employees, dependents, retirees, and so on. The same is true for health insurance: Today, 56 percent of employers purchase health insurance coverage for their employees.¹
- Individuals purchase homeowners, auto, and life insurance coverage as an after-tax discretionary investment. Insurance companies that target individuals frequently advertise on TV and are known for direct-to-consumer marketing campaigns. Health insurance is also sold to consumers—currently comprising 17 million—termed “the individual insurance market” by health insurers.²

... since the mid-1950s, employers have paid the bulk of costs for employee coverage while being timid about restrictions on how their employees use the benefit. That has changed.

But, in the United States, health insurance is different than other types of insurance coverage. It has its origins in Texas where physicians in the 1920s created a model to help individuals handle the costs of hospital care when needed.³

Two events drove the growth of the industry in the modern era: to recruit veterans returning from World War II, companies used their health insurance coverage to differentiate in recruiting efforts. And in 1972, as part of the Nixon administration, when wage and price controls were placed on employers to control runaway inflation, health insurance costs were not counted against constricted wage ceilings. Health insurance offered by employers became standard fare—first dollar coverage, modest (if any) co-payments, low premiums and deductibles, and large networks of doctors and hospitals from which to choose were common features of many plans. In effect, the workforce was treated to a benefit that mitigated the full gamut of risk from routine office visits and medications to hospitalization for serious medical problems. And Congress granted employers a tax exemption for their portion of premiums now worth \$216 billion today.⁴

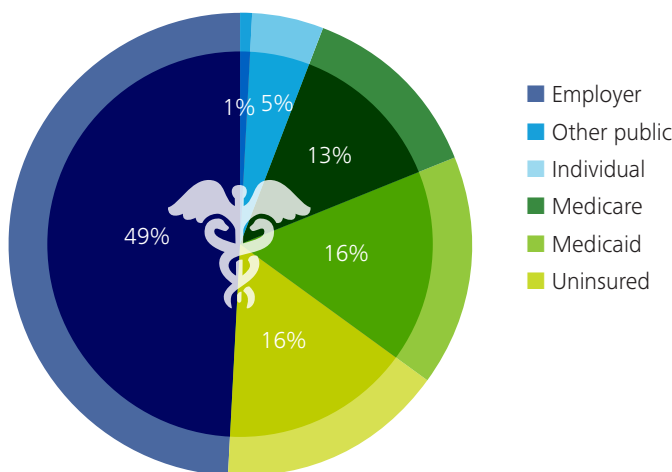
Health insurance, therefore, is different than other types of insurance coverage. Unlike insurance that covers risk for catastrophes or big-ticket items, health insurance evolved as a form of comprehensive coverage for everything from minor cuts

and routine visits to organ replacement and accidents. It's akin to a hypothetical automobile insurance plan that covers flat tires, not just collisions. And complicating matters, in traditional employer-sponsored coverage, the company pays 75 percent of the premium so the individual's share is relatively low and the tendency to overuse health services is high.⁵ Thus, consumers have little skin in the game. As a result of these structural flaws, health insurance is widely used because it covers everything—and it is expensive for the same reason.

WHERE IS THE INDUSTRY NOW?

Fast forward to the present, where the US health insurance industry plays a ubiquitous role in the nation's economy and in many American households. More than 160 million Americans are covered by employer-sponsored insurance plans.⁶ Another 17 million Americans purchase insurance for themselves in the private insurance market, and about 100 million are covered by government-sponsored insurance plans.⁷ Notably, in each of these categories, there are unique eligibility, enrollment, and premium requirements, and each is under intense regulatory scrutiny at the state and federal levels.

Figure 1. US breakdown of health insurance coverage, 2011



Source: Kaiser Family Foundation, *Health insurance coverage of the total population* <<http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3>>

Graphic: Deloitte University Press | DUPress.com

It's a big industry comprising about 400 operators, including 154 with more than 100,000 enrollees, with enrollment split almost evenly between investor-owned plans and not-for-profit plans.^{8,9} And it is growing at home and abroad as individuals,

governments, and companies seek to mitigate the financial risk of health cost while attracting/retaining employees.

Three major changes are reshaping the health insurance industry:

1. Changing role of employers in the insurance market: Many working Americans choose a plan from options preselected by their employer, often balancing the premium, out-of-pocket costs, and co-payments against the size and scope of coverage and provider participation. And, since the mid-1950s, employers have paid the bulk of costs for employee coverage while being timid about restrictions on how their employees use the benefit. That has changed. Employer activism is a forcing factor in the health insurance industry: Ten percent of employers, mostly smaller companies and organizations, dropped coverage altogether in the last decade.¹⁰ For those that have maintained the benefit, a three-pronged strategy has become the norm:

... the Congressional Budget Office (CBO) estimated up to 27 million could be newly insured, and over the decade only 4 million may lose coverage as a result of employers paying a penalty and walking away.

- *Shared financial responsibility with employees:* Shifting financial responsibility to employees via high deductible plans and defined contribution plans that replace benefits programs are increasingly the norm for employers. And employees are being encouraged to pay attention to prices for the services they use, in some cases through incentives to

purchase from “high value” providers, and in other cases limiting access to providers that are too pricey.

- *Narrowing networks of providers:* Employers are contracting with fewer providers (doctors and hospitals) to extract better prices and drive volume to those that deliver higher quality and lower costs. In some cases, larger employers are contracting directly with providers; in others, they are pooled through arrangements with health insurance companies to get better pricing in their contracts.
- *Focused efforts in employee wellness and prevention:* Lifestyle-related habits and chronic diseases contribute to 75 percent of health costs.¹¹ Employers are using coaching programs targeted to employees with chronic illnesses (obesity, diabetes, heart disease) and implementing incentives to encourage healthy lifestyles. Employers believe wellness-related activities—for those with medical problems already and to prevent the healthy from

becoming unhealthy—are strategic investments in their workforce strategy and in health cost containment.

2. Increased enrollment in government-sponsored health insurance plans:

Today, enrollment in federal and state insurance programs is over 100 million including Medicare, Medicaid, Federal Employee Health Plan, Children's Health Insurance Plan, State & Local Government Employee Health Plans, and Military Health Plans (Veterans Health/TRICARE).

Enrollment in each is increasing, and as a result, the influence of the government as a sponsor of the health insurance programs is growing. In some cases, government agencies purchase insurance coverage through private insurance companies: For example, 13 million Medicare enrollees have a Medicare Advantage Plan (Part C) purchased through a private insurer; another 32 million have a Part D Prescription Drug Discount Plan offered through private issuers; and private plans are routinely offered to federal, state, and local employees.¹²

The significance of the increased role of government as a sponsor in the US insurance market is size: It affords the government the ability to purchase for large numbers of enrollees and negotiate aggressive terms and conditions with private insurers who want to enroll and manage a plan on their behalf. The growing role of the government as a purchaser of coverage for employees from private health insurers is an important dynamic in the US health insurance market.

- 3. The Affordable Care Act and health reform:** The third factor driving fundamental change in the US health insurance industry was the passage of the Affordable Care Act (ACA) in March 2010. Prior to the ACA, there was no law that required employers to provide health insurance coverage to employees and no law that required individuals to buy it for themselves. Both have changed: The law requires employers with more than 50 full-time employees to provide affordable insurance or pay a penalty—\$2,000 per employee per year.¹³ And starting in 2014, US citizens not eligible for Medicaid or other public programs must purchase health insurance or pay a penalty that is the greater of \$95 or 1 percent of the difference between the household's taxable income and tax threshold, increasing annually for three years. As a result, the Congressional Budget Office (CBO) estimated up to 27 million could be newly insured, and over the decade only 4 million may

Figure 2. Affordable Care Act provisions directly impacting the commercial health insurance industry

Prohibits lifetime limits
Restricts annual limits
Restricts rescissions
Requires coverage for preventive services with no cost-sharing
Extends dependent coverage to age 26
Requires uniform explanation of plan benefits
Prohibits discrimination based on employee compensation
Requires quality of care reporting
Requires reporting of medical loss ratio and provision of rebates
Requires internal and external appeals processes
Patient protections
Annual rate review
Prohibits coverage exclusions for pre-existing conditions
Imposes adjusted community rating rules
Imposes guaranteed issue requirements
Imposes guaranteed renewability requirements
Prohibits discrimination based on health factors
Prohibits discrimination against medical providers
Requires coverage for essential health benefits
Limits out-of-pocket spending
Limits cost-sharing
Prohibits excessive waiting periods
Requires coverage for clinical trials for qualified individuals

Sources: ACA and Congressional Research Service [CRS] analysis, *Includes Sections 1302, 1341, 1342, 1343, 1101, 1104, 1001, and 1201)

lose coverage as a result of employers paying a penalty and walking away.^{14,15,16}

But the law also added a number of new regulatory constraints on how health insurance plans operate, adding new rules at the federal level and vesting responsibility in states to implement a number of major structural changes including Medicaid expansion and creation of health insurance exchanges. So while the industry is likely to see increased coverage as a direct result of the ACA, it also faces additional compliance and oversight from state and federal regulators.

Each of these three factors has contributed in a unique way to the changing landscape of the health insurance industry in the United States. Each is unique, but their combined impact is a significant disruption to the industry.

WHAT'S AHEAD FOR THE HEALTH INSURANCE INDUSTRY?

There are four likely themes that could help frame the future of the US health insurance industry:

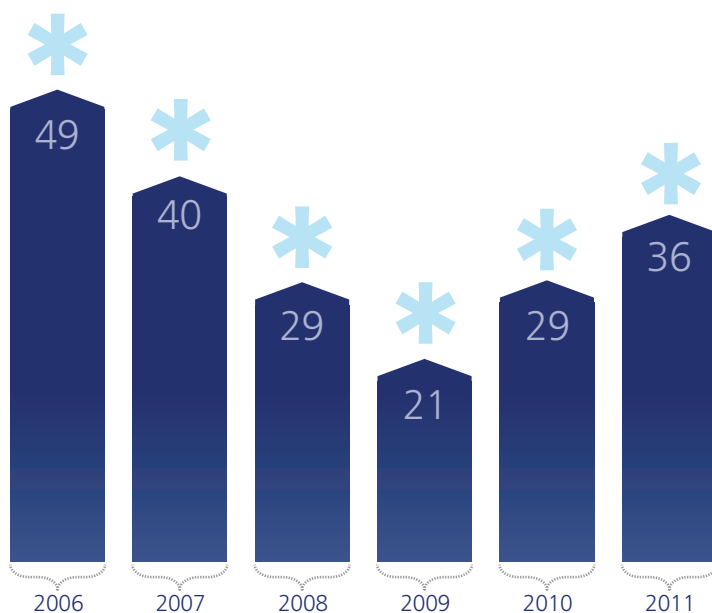
- 1. Enrollment growth at home and abroad:** Enrollment in insurance plans sold by private insurance companies may increase dramatically in coming years. Employers that provide coverage may offer high deductible plans that

transfer risk to employees while protecting them against catastrophic costs. Individuals lacking access to insurance through an employer and the self-employed may purchase individual plans through private insurers. The popularity of the Medicare Part C and Part D programs shows no sign of slowing, and individuals eligible for subsidies through state health insurance exchanges may expand the market by up to 24 million per the CBO.¹⁷ And, there's growing interest among state legislators and governors to contract with private plans to manage Medicaid enrollment. The health insurance industry's core value proposition—reducing costs by managing health—is a solid platform for growth. The core competencies and infrastructure necessary to manage individual and population health cost effectively are required in health care systems worldwide, so enrollment growth may be significant at home and exponential abroad for many US health insurance operators.

2. **Consolidation—fewer players with wider reach:** The insurance industry is heavily regulated and capital intense. The margins in its core business—managing health—are thin, so for many, it's a mandate to “go big or get out.” Consolidation is accelerating in the US health insurance sector and in some cases, globally.

Figure 3. Number of announced health plan-related M&A transactions

Number of transactions



Source: Deloitte Center for Health Solutions, *Unlocking value in health plan M&A: Sometimes the deals don't deliver*, 2012

Graphic: Deloitte University Press | DUPress.com

Margin erosion and increased regulatory oversight have driven increased merger activity among incumbent companies. In 2011, 20 managed care M&A transactions took place, totaling nearly \$8 billion, and more deals took place the year after the ACA was enacted than in each of the three years prior.¹⁸

The increased “urge to merge” is driven by necessity in many cases: Increased



Figure 4. US health insurance market

Significant absence of health insurer competition exists (based on revised Horizontal Merger Guidelines issued 2010 by the US Department of Justice and Federal Trade Commission)

83% of metropolitan markets rate as “highly concentrated”

At least one health insurer had a commercial market share of 50% or more

Roughly 50% of metropolitan markets

Two largest health insurers had a combined commercial market share of 70% or more

24 of 48 states studied

Average market share of state’s largest insurer

Individual market: 54%
Small group market: 51%

Average number of state insurers with at least 5% market share

Individual market: 4
Small group market: 4

States with least competitive commercial health insurance markets

From least to most competitive:
Alabama, Alaska, Delaware,
Hawaii, District of Columbia,
Maine, Michigan, Nebraska

Sources: AMA, “2011 Competition in Health Insurance: A Comprehensive Study of US Markets”; Kaiser Family Foundation, “How Competitive are State Insurance Markets?”

costs of operations and downward pressure on premiums by individual, employer, and government purchasers are a requisite for scalability and size. It's increasingly a competitive industry that historically pits strong "local" brands against "national" brands. Consolidation is expected to continue among US operators, as well as acquisitions of insurance companies in emerging and developed health systems of the world.

In all likelihood, there may be fewer US health insurers, but their enrollment and scope of operations may be broader.

3. Diversification—new products and services: The health insurance industry is in the enviable position to take advantage of these major drivers of innovation:

- *Consumerism:* Behavioral economics is a daunting term. It essentially means that individual behavior is influenced by a complex set of triggers—incentives, circumstances, needs, values, opportunities—that determine how we respond. The majority of health care costs worldwide

are the direct result of unhealthy lifestyles and/or failure to adhere to recommended treatment plans. Nevertheless, how does a health care system change how its citizens behave? The health insurance industry might provide new mechanisms to influence behavior—incentives, benefits design, and technologies—that reward desired responses from individuals and populations. As the individual (retail) insurance market grows, the ability to adapt health plans to individual needs and offer self-care tools that are useful when making decisions provides an attractive opportunity.¹⁹

- *Integrated health:* In an emerging trend, the convergence of clinical and administrative management of the system means bigger organizations that deliver and finance health care services (a.k.a. integrated health systems). Insurers are in an enviable position to collaborate with or acquire clinical delivery capabilities either through acquisitions or as business partners in accountable care organizations and medical homes. In some communities, health insurers may become business partners to hospitals and physicians

Ultimately, the health insurance industry's value proposition boils down to this: managing health costs without compromising safety and outcomes. The escalating costs of health care borne by employers, families, and taxpayers calls for innovative solutions that balance these dual goals.

who sponsor a plan. In others, health insurers might manage a provider's accountable care organization or medical home programs. In a few, health insurers may own and operate hospitals and clinics, and manage a network of employed physicians.

- *Big data:* Health care is rich in data and weak in information. As health insurers engage as business partners in large, regional/national integrated systems of care, they may amass huge amounts of data about what treatments work best, which diagnostics are predictive, what stimuli prompt optimal consumer engagement, how processes optimize efficiency, and what everything costs based on an individual's customized plan. And the emergence of state insurance exchanges, widespread adoption of electronic health records in medical practices and hospitals, and the ubiquitous presence of social media provide huge opportunities for further data gathering (as well as opportuni-

ties for its abuse). As a result, health insurers may play a lead role as intermediaries about health—structuring data into useful tools for individuals, employers, and providers.

The majority of health care costs worldwide are the direct result of unhealthy lifestyles and/or failure to adhere to recommended treatment plans. Nevertheless, how does a health care system change how its citizens behave?

4. Value—the balance of costs and care: Notably, in the heat of the health reform debate of 2009, President Obama used a phrase that is perhaps the essence of one of the

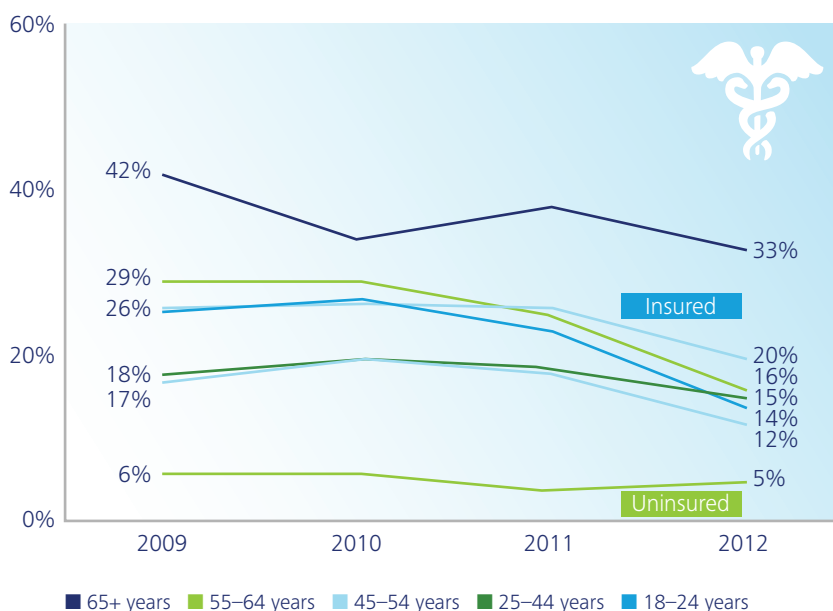
health insurance industry's greatest challenges: trust. On numerous occasions he reiterated this reference to trust, and while encouraging the passage of health care reform, cited a need to “keep them honest,” in reference to insurance providers.

Like any industry that is highly regulated, highly visible, big, and getting bigger, US health insurers are in the spotlight. It is an industry that elicits strong feelings and wide ranging opinions.

- Many physicians think health insurance plans limit access to needed coverage they recommend and impose unnecessary administrative paperwork that's burdensome and costly.²⁰
- Many employers think health insurance benefits are a necessary but costly talent recruitment and retention strategy.²¹

- Consumers who can afford health insurance coverage think it a hedge against back-breaking health care costs. Yet even those with coverage do not feel completely secure. See our latest findings from the 2012 Deloitte* Survey of US Health Care Consumers.
- Ironically, seniors on Medicare feel the most secure of all insurance populations—perhaps the reason politicians are hyper-sensitive to changes that might arouse their passion to protect the program.²²

Figure 5. Percentage of consumers who feel their household is financially prepared to handle future health care costs



Source: Deloitte Center for Health Solutions, “Deloitte 2012 Survey of US Health Care Consumers,” June 2012

Graphic: Deloitte University Press | DUPress.com

Trust is an issue for the industry. The potential loss of financial security as a result of health costs is a widespread fear, even among those with health insurance.

Health insurers understand the challenge. Their response to date has not fully remedied the trust gap fully. Some are rebranding, some are methodically changing their business model to enhance relationships with consumers, and all are active in educating legislators and community leaders about the role and scope of their operations. It may likely take more effort. Increased transparency about the business operations in a health plan—how coverage and denial decisions are made, how

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doctors and hospitals are evaluated and compensated, how premiums are spent—is clearly a step in that direction.

Ultimately, the health insurance industry's value proposition boils down to this: managing health costs without compromising safety and outcomes. The escalating costs of health care borne by employers, families, and taxpayers call for innovative solutions that balance these dual goals. The health insurance industry has an opportunity to deliver on this value proposition, leveraging its unique competencies in partnerships with providers.

Bets of the demise of the health insurance industry are ill-advised. It's an industry with challenges but with substantial opportunity. If managed care is a dubious concept in some circles, unmanaged care is the greater risk. Therefore, the future of the insurance industry is bright—at home and abroad. **DR**

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