

# Milliman group health insurance survey illustrates cost-management strategies due to healthcare reform



Insurers look to quality initiatives, risk-sharing arrangements, and increased transparency

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Milliman's 2010 Group Health Insurance Survey includes premium, trend, and other key metrics that can be used to benchmark healthcare expenses. Finalized in October, the 2010 survey also addresses the steps insurers are taking due to recent healthcare reform legislation, including the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010. There are some clear trends present in the responses from insurers across the nation.

The 2010 Group Health Insurance Survey was the perfect opportunity to measure insurer reaction to healthcare reform. It appears that reform is changing several fundamental aspects of providing health insurance. The laws as written today could greatly impact provider contracting, enrollment and distribution of health insurance products, corporate direction, and the viability of certain insurance markets (in particular the individual and small group market). The survey indicates that quality incentives, risk sharing arrangements, and price transparency will likely become more common as the result of reform.

## KEY RESULTS

*Due to healthcare reform legislation, we are considering making the following provider contracting changes and cost-saving initiatives:*

- Insurers plan to utilize more quality incentive bonus programs (69% agreed versus 6% disagreed). Often referred to as pay-for-performance (P4P) incentives, these programs provide a financial bonus for providers based on a set of performance and quality measures. Such programs may help reduce healthcare costs while also promoting quality care. Providers are encouraged to use evidence-based medical practices (such as using the Milliman Care Guidelines), leverage technology such as electronic medical records to reduce errors and redundancy, and offer support tools to help patients improve their health.
- Insurers plan to introduce more risk sharing with providers (63% agreed versus 14% disagreed). Risk-sharing arrangements have an upside for insurers and providers alike. Insurers need to meet medical loss ratio targets, reduce per capita spending, and better control/predict future cost increases. Risk-sharing contracts, if designed properly, can achieve these goals. Providers can gain from risk sharing by controlling costs under fixed payment structures and by providing consistent income to providers. Proper risk adjustment is the key to success under these arrangements.
- Insurers plan to provide more price transparency for members (62% agreed versus 8% disagreed) and more aggressively tier provider networks (52% agreed versus 16% disagreed). Making price information more publicly available has the primary goal of helping patients make informed decisions on their care. Transparency may also foster competition among providers as insurers benchmark provider costs versus others and limit member access based on quality, efficiency, and price. Tiered networks utilize differing out-of-pocket expenses to help steer patients to use lower-cost providers. To be successful, this action would require price transparency and an out-of-pocket expense differential large enough to steer most customers to the lower-cost providers.
- Insurers plan to reduce broker commissions (53% agreed versus 16% disagreed). Healthcare reform may redefine the role of brokers and the brokers' business model. It is possible that, post-reform, a broker will be paid like some financial advisors, where the prospect pays for their services directly and explicitly rather than receiving a commission from the insurer. This topic continues to evolve with reform legislation.
- Few insurers plan to reduce employee compensation (4% agreed versus 52% disagreed). However, about twenty-five percent of insurers admit they may need to reduce their number of employees. Reducing compensation is often a last-resort action. A high percentage of insurers responded *neutral* (44%) to reducing employee compensation. Reducing the number of employees does seem more likely than reducing employee compensation, as federal mandates reduce product options and plans need to meet minimum loss ratio targets. In the short term, many insurers appear to be short staffed as they react to the reform legislation.

***Due to healthcare reform legislation, we are adjusting our near-term strategy by:***

- The vast majority of insurers are preparing to participate in the exchanges in 2014 (83% agreed versus 2% disagreed). The government will require most people to have health insurance by 2014. The PPACA requires states to set up insurance exchanges to expand access to coverage.
- A significant majority of insurers plan to strengthen their self-insured options for employers (66% agreed versus 9% disagreed). Increasing insurance premiums combined with uncertainties about healthcare under the new laws may be leading employers to consider self-insured options. Insurers appear to be planning for this possibility.
- 44% of insurers expect to expand further into the individual market while 18% disagreed. Conversely, only a few insurers responded that they may exit the individual markets in some areas (12% agreed while 62% disagreed).
- 43% of insurers agreed that they may expand further into the small group market while 16% disagreed. Reform coverage mandates could greatly increase the total individual and small group insured populations. Very few insurers responded that they may exit the small group markets in some areas (6% agreed while 70% disagreed).
- 43% of insurers agreed that they may expand further into the large group market while 14% disagreed. Very few insurers responded that they may exit the large group markets in some areas (2% agreed while 81% disagreed).

#### **METHODOLOGY**

Milliman asked insurers what provider contracting changes and cost-saving initiatives they are considering making due to healthcare reform legislation. The survey provided seven specific provider-related changes they may be considering. Milliman also asked insurers how they may be adjusting their near-term strategy due to healthcare reform (nine possible changes). Insurers were asked to respond if they strongly agreed, somewhat agreed, were neutral, somewhat disagreed, or strongly disagreed.

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#### **GROUP HEALTH INSURANCE SURVEY DETAILS**

The Milliman survey is unique in that it asks HMOs and PPOs to provide premiums and trends based on a given set of group health benefits and demographics. The survey removes three important factors that can skew the results presented in other health cost surveys: changes in plan design, shifts in premium sharing between employer and employee, and member demographics. These trends, therefore, reflect the increase in medical utilization and costs experienced/anticipated by the HMOs and PPOs.

The survey report is provided free to respondents and is available to others for purchase. It includes premium rate levels and trends for any area in which at least three different companies responded. Averages, 25th, and 75th percentiles are provided by metropolitan area, state, region and nationwide. Milliman also provides hospital inpatient cost and utilization data, physician reimbursement levels, medical expense ratios, and profit levels compiled from Milliman's available databases.

The Milliman survey was sent to HMOs and fully insured PPOs that serve the nation's commercial large- and mid-group employer market. More than 60 insurers participated this year, representing a total enrollment of about 100 million members. Results for HMOs and PPOs are shown separately when possible. This marks the 17th year that Milliman has conducted the survey.

#### **CAVEATS**

The percentages provided in this report are a tabulation of unaudited survey responses. Commentaries are the opinions of the authors and do not represent those of Milliman or any other Milliman consultant.

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