Wall Street’s 2014 Outlook for Health Plans: Forecast for the Industry and Individual Plans

Thursday, January 23, 2014

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Carl McDonald
Director and Senior Analyst
Citi Investment Research and Analysis

Joseph Marinucci
Director, Insurance Ratings Group
Standard & Poor’s Ratings Services
About the Speakers

CARL MCDONALD is a Director and senior analyst covering the managed care industry, having joined Citi Investment Research and Analysis in June 2010. He has followed the managed care industry for almost 15 years. He was named a top three analyst in the managed care sector in Institutional Investor's 2013 All America Research survey, and was the #2 managed care analyst in the 2013 Greenwich Associates survey. Mr. McDonald was the #1 earnings estimator in the Health Care Providers & Services industry according to the 2011 FT/StarMine analysis. Mr. McDonald holds a B.A. in Economics and a B.A. in American Studies from Brandeis University in Waltham, MA. Mr. McDonald is a Chartered Financial Analyst, and a member of the CFA Institute and the Boston Society of Security Analysts. Contact Mr. McDonald at carl.mcdonald@citi.com.

JOSEPH MARINUCCI is a Director in the Insurance Ratings group at Standard & Poor’s Ratings Services. He is a business professional with over 20 years of credit, financial and business operations experience. Mr. Marinucci is the designated health sector specialist for the insurance group, which includes engaging and coordinating with related health sector teams at Standard & Poor's. He is also responsible for company analysis, sector based commentary, investor outreach and project management. During his tenure with Standard & Poor's, Mr. Marinucci has been responsible for the analysis of a broad portfolio of high yield and investment grade insurance companies, healthcare systems and health service organizations. Previous to joining Standard & Poor's in 2000, Mr. Marinucci worked as a financial analyst with A.M. Best Company and as a manager in the Accounting and Corporate Finance departments of Empire Blue Cross Blue Shield (WellPoint Inc.) and Johnson & Higgins (Marsh Inc.) where he was primarily responsible for financial planning, reporting and analysis. Contact Mr. Marinucci at joseph.marinucci@standardandpoors.com.

Moderator: B.J. Taylor, associate editor of Medicare Advantage News and Health Plan Week

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WE BinA R PrO Gr A M

• Introductions/Administrative Reminders
• Speakers’ Presentations
• 30-Minute Q&A Session

WE BinA R MA t E R I A L S

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WE BinA R OU L Tin E

Part 1: Carl McDonald, Citi Investment Research and Analysis
• Stocks had a great year in 2013, but don’t expect that in 2014
• The unknowns for 2014: utilization, Blue Cross pricing, Medicare rates in 2015 and the health insurance industry fee
• We’re not as enthusiastic about private exchanges as some
• What do we still need to understand about the public exchanges?
• Medicare Advantage update
• Medicaid update
• Provider risk taking...maybe growth is plateauing?
• Again not expecting a lot of consolidation this year

Part 2: Joseph Marinucci, Standard & Poor’s Ratings Services
• S&P and credit ratings
• Criteria (updated methodology for 2013)
• Credit quality and key rating factors
• Economic considerations
• Reform
• Market segment considerations
• Financial trends and expectations
• M&A/partnering

Part 3: Questions and Answers
Wall Street’s 2014 Outlook For Health Plans

Jan. 23, 2014
An AIS Webinar

Carl McDonald, CFA
Director
carl.mcdonald@citi.com
617-247-6312

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We Aren’t Expecting The Managed Care Stocks To Do Much In 2014

● Managed care stocks had a tremendous year in 2013, rising around 40%
  – Most of the outperformance came in the first half of the year, driven by increased comfort that little of the earnings at the publicly traded plans come from individual and small group products, which have the greatest exposure to reform, and a growing realization that health reform would take time to be fully implemented
  – The stocks did very little in the second half, as it became clear that commercial cost trends weren’t decelerating anymore. Other potential health reform negatives (like the health insurance industry fee) also became better understood

● Nearly all of the 40% gain came from multiple expansion, rather than earnings upside
  – If the fundamental environment is similar in 2014, and earnings upside is again limited, it means the group significantly outperforms only if valuation multiples increase again
  – Managed care is still a cyclical industry, and margins are running at peak levels. In addition, the group has a heavy (and growing) reliance on government reimbursement, a revenue source that has been volatile historically

● Most plans expect overall earnings to be stable in 2014
  – At this point, the insurers believe earnings can grow in 2015, but not at the target growth rates
It’s Been Awhile Since Net Income Grew By A Meaningful Amount

- Earnings for the larger plans in 2014 should roughly equal what the industry earned in 2011
  - Net income was basically flat in 2012, grew an estimated 6% in 2013, and we’re projecting net income will fall under 5% this year
  - Earnings have continued to increase because the industry has consistently used the cash generated to repurchase share
  - The early commentary around 2015 from a couple of plans suggests net income growth of less than 5%

### Net Income By Plan, 2006-2014E ($ in millions)

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<td>Coventry</td>
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<td>Health Net</td>
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<td>Humana</td>
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<td>$834</td>
<td>$722</td>
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<td>United</td>
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<td>$3,660</td>
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<td>WellPoint</td>
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<td>$2,881</td>
<td>$2,927</td>
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<td>$2,555</td>
<td>$2,456</td>
<td>$2,585</td>
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<td><strong>Total</strong></td>
<td>$11,510</td>
<td>$13,043</td>
<td>$10,754</td>
<td>$10,686</td>
<td>$12,261</td>
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<td>Growth rate</td>
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<td>-18%</td>
<td>-1%</td>
<td>15%</td>
<td>8%</td>
<td>0%</td>
<td>6%</td>
<td>-4%</td>
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Note: United is actual for 2013. Coventry figure for 2013 estimates net income through the May 7 close of the Aetna acquisition. Source: Company notes and Citi Research
The Big Unknowns For 2014

- Will utilization be flat, up, or down this year?
  - Plans have generally assumed a modest increase in utilization in their earnings guidance

- Will the non-profit Blues change their pricing strategy?
  - The non-profit Blues hold more capital than ever before, and exchange enrollment hasn’t been as robust as expected. Does that make the Blues more aggressive, or do they just expect exchange enrollment to rise meaningfully in 2015?

- How much will Medicare rates fall in 2015?
  - The insurers had been assuming a 3-4% decline, but after a December call with CMS, the fear is that rates could drop 6-7%. At this point, the consensus view is that CMS will somehow mitigate the reduction to less than a 5% drop.

- How much of an impact will the health insurance industry fee have on the Medicaid business?
  - Our fear is that a few states will ignore the non-tax deductibility of the industry fee in the rate setting process, pressuring margins in some of the more profitable Medicaid states
  - We also worry about pent up demand from those gaining Medicaid coverage
Medical cost trend has been in a steady decline for most of the last decade
- Slowing inpatient cost trend growth has been the primary reason, driven mostly by lower utilization in recent years
Blue Cross Pricing Has Been Trending Down For Years

- We expect pricing will start to rise in 3Q13 as the Blues factor in the health insurance industry fee and other reform impacts.

Source: National Association of Insurance Commissioners and Citi Research
It’s Been Years Since Medicare Advantage Rates Increased

- There had been hopes that the rate cut would be smaller in 2015, with Medicare rates rising again in 2016

Source: Humana and Citi Research
Private Exchanges

- We’re less optimistic that private exchanges will take over the world the way some have projected
  - Private exchanges seem very interesting for employers with high turnover, low-wage employees
  - This option seems less attractive for many large, self-funded businesses
  - It’s not clear that private exchanges do much to slow the growth in cost trends, other than potentially shifting more costs onto consumers

- If we’re wrong, and private exchanges take-off, it could be a huge structural positive for the industry
  - If self-funded employers choose to switch to a fully insured private exchange, it lowers insurer margins significantly, but the dollar profitability is 4-5x as large

- Private exchanges are still relatively small today
  - Aon Hewitt is the largest, and they are expected to enroll over 600,000 people in 2014
  - Each of the large insurers will be introducing a private exchange in 2014
The Remaining Public Exchange Questions

- **Will the population be healthy enough?**
  - Our analysis suggests the average age of the exchange population is 43, relative to the average age of the non-elderly population in the U.S. of 32.
  - The insurers took some adverse selection into account in their pricing, but our sense is that plans didn’t assume such a big difference, particularly considering that the average age of the uninsured population is even younger than the overall non-elderly population.

- **How many people actually paid their premiums?**
  - Many plans have pushed the payment deadline to the end of January either because of non-payment or insurer problems issuing invoices.
  - Our estimate is that around 15-20% of the 2.15 million exchange enrollees will be disenrolled because of non-payment.

- **How many people that signed up were previously uninsured?**
  - According to the State of New York, over half the exchange population was previously insured, and New York previously had a very small individual pool.
  - A Wall Street Journal article concluded that around two-thirds of those that signed up through December were previously insured.
Admittedly, that isn’t saying too much:

- CIGNA and United are only in five markets, while Humana and WellPoint each participate in 14 states. Aetna appears to be the most active, with products in 17 states, but in many geographies, their premiums are not competitive.
- It’s possible that United, the biggest insurer in the country, enrolled fewer than 25,000 exchange lives by the end of 2013.

The publicly traded plans generally don’t believe there is a significant first move advantage on the exchanges:

- Exchange enrollment is expected to increase a lot in 2015/2016 as the penalty rises, and there’s historically been a lot of turnover in the individual market.
- It’s also possible that some plans that priced more aggressively in 2014 (and picked up more membership) may have to raise rates as some of the protection from the 3 R’s is phased out over the next few years.

Plans won’t have a lot more financial insight to determine 2015 participation:

- Bids are generally due in May, so by that point, plans will only have financial results for exchanges for January and February.
- If enrollment surges between January and March, that will add a degree of difficulty to 2015 pricing.
Medicare Advantage Update

● The January enrollment data from CMS suggests our estimate of 750,000 lives added in 2014 might be conservative
  – Several plans (most notably Humana) have indicated that open enrollment results were meaningfully better than expected, owing to both higher gross sales and lower disenrollment levels
  – In light of a 4-5% rate reduction in 2014, we were surprised that some of the bigger plans, like Humana, didn’t really alter their benefits all that much
  – In Humana’s case, they expect to offset the rate cut primarily through medical management, while United has aggressively reduced the breadth of their provider network in some geographies

● Will CMS come to the rescue again in 2015?
  – Last year, the obvious solution to the proposed rate cut was the doc fix adjustment. This year, there’s nothing that stands out as an easy answer.
  – CMS announced in December that the Medicare trend for 2015 would be basically flat, rather than the 3% trend assumption previously cited. Combined with the health reform related cuts, the more difficult to achieve Star bonus payments, a bigger industry fee, and other factors, rates could be down 6-7%
Medicaid Update

• The growth story is still very much on track
  – After growing revenue 28% in 2013, Centene is guiding for an increase of 25% in 2014
  – The growth drivers are consistent: dual eligible opportunities, continued state conversions, and the Medicaid expansion included in reform

• The near-term margin is our concern
  – It only takes one sizeable state to not fully adjust rates for the industry fee for it to pressure margins next year. Most states appear willing to include the base industry fee, but there’s a lot more discussion on the non-deductible gross up
  – The Medicaid plans will be generating more revenue from new business this year than in 2013, and there is a decade of evidence to suggest that Medicaid plans almost always lose money on new members for the first couple quarters

• It looks like the publicly traded plans will finally start generating some dual revenue in 2014
  – Several states have planned implementation dates in the first half of the year
Providers & Risk

- There’s some evidence that the willingness of providers to take risk has plateaued
  - Usually, hospitals don’t move all of their volume into a risk relationship at once. They start with a subset, and now they are waiting to see how the experiment turns out
  - The potential second wave of followers is still waiting on the early results from the pioneers

- Transferring the underwriting and actuarial expertise from insurers to providers is no easy task
  - Managed care plans have been at this for 20-30 years, and still make big mistakes on a fairly regular basis
  - The industry is being more thoughtful this time around, starting with graduated risk sharing rather than going straight to full risk arrangements

- There have been some hospital systems that formed insurance companies, but there hasn’t been as much activity as the press suggested over the last couple years
  - The regulatory and financial burden of establishing a health insurer are quite significant
We Aren’t Expecting A Lot Of Major Consolidation This Year

● The biggest issue is that the debt to capital ratios of the bigger plans are all relatively high
  – After recent acquisitions, Aetna (38%), CIGNA (34%), and WellPoint (37%) all have relatively high debt ratios
  – United has the financial capacity for deals, but they have anti-trust issues with nearly every publicly traded plan. Humana also has financial capacity, but they don’t seem too interested in the commercial risk business, and also have been vocal about not liking the Medicaid business all that much

● The M&A focus will likely be consistent
  – Nearly every deal over the last 12 months has either been focused on government (Medicare & Medicaid), international, providers, or health IT

● There are still some possibilities
  – Health Net has talked about strategic alternatives for some time
  – Universal American has a Medicare focus and a market cap of less than $650 million, and a lot of cash on the balance sheet
  – WellCare has an interim CEO, and an interesting collection of Medicare / Medicaid assets
Highlighted Reports

Health Reform
I Am Altering The Deal. Pray I Don’t Alter It Any Further: Updated Exchange Regulations
November 26, 2013
https://ir.citi.com/PD47wkt7Z368Vb4G36YrVY7GaKjJypGtwaKpV9HW6iIZ%2BzOQ%3D%3D

A Ruler Isn’t Always Straight: Insurers Allowed To Extend Cancelled Individual Policies
November 14, 2013
https://ir.citi.com/BmX1wXD6MOZGrPlU4I48ot1R%2BbBYidke%e2%BgkeF1Nv%3D

Healthcare Exchange Outlook: Buy-Side Survey Reveals Modest Expectations
September 15, 2013
https://ir.citi.com/LwekgWsOEUFhTZ3tty1oPFbKk3e6ECeckmumwry%66vWtybeh4g%3D%3D

You May Delay, But Time Will Not: Large Employer Reform Requirements Pushed to 2015
July 3, 2013
https://ir.citi.com/wGZjd5Da2zA%2FpEJ1QMPE6WktnP%2Fzfu4un%2Fn8YHJS%69tvlL2%2Bv%3D%3D

A Good Lawyer Knows The Law. A Great Lawyer Knows The Judge: 2011 Commercial Risk Analysis
January 28, 2013
https://ir.citi.com/nAv9mlgEepDmRprW3I8KTVmQy5Opr2w3FtDOR4WE%3D

No One Ever Went Broke Making a Profit: Second Round of Reform Regulations
December 3, 2012
https://ir.citi.com/w%2BssDdKJmvCFI4fU4FfrSkB8YJk%2BvA%GhKcsIrnOZr3%DBhS%3D%3D

At Times In Conflict With The Facts, But Never Inhibited By Them: Reform Regulations Released
November 20, 2012
https://ir.citi.com/Fb2RPf3BFKU07aqPlcjaDGJ7kuc%2Ba8a7g2cnQ16G7UbQf1XPV92NQ%3D%3D

The Non-Profit Blues
I’m Only In Non-Profits For The Money: 2012 Non-Profit Blue Cross Financial Analysis
December 10, 2013
https://ir.citi.com/3Cveh3YHvS0tYzUlPHf5W20wufUOh%2Bok5StW48tpWLSnPVa%2F79A%3D%3D

Be Moderate In Everything, Including Moderation: 2Q13 Non-Profit Blue Cross Pricing Analysis
September 16, 2013
https://ir.citi.com/i6D0Mu7ATYmsQ9nyBdMipkojUQ6wNY0bhotZUbF814%3D

Medicare
Try To Learn Something About Everything & Everything About Something: December 2013 CMS Medicare Enrollment Data
January 2, 2014
https://ir.citi.com/MzhMjwLnjlNn5JMtl80UpYaBhyLuW%2FrBoBAC4xeMdl6VAdJC8Ytzg%3D%3D

I Wish I May, I Wish I Might, Wish Upon A Star Tonight: 2015 Medicare Advantage Star Rating Analysis
October 18, 2013
https://ir.citi.com/VdKNPQOZ0Y%2BxCeDU5jysSBrocO2eLapBjQRVgAwMVU%3D

For All The Ways To Express Ourselves, The Printed Word Always Speaks Best: Highlights From Medicare Day
May 9, 2013
https://ir.citi.com/9p3iTqY%2FhW55Pe2NUU1e0spPn%5u0Gii8JHR%2BhJdj%3D

Armageddon Averted: Final 2014 Medicare Rates Announced
April 2, 2013
https://ir.citi.com/c0lwX3zklIL8hzQRC%2F7sL5R%6AvdAvOo%3Djho3o5g5%2BZ0%3D

A Fine Is A Tax For Doing Wrong. A Tax Is A Fine For Doing Well: Minimum Medicare MLR Regs Released
February 18, 2013
https://ir.citi.com/pAuMlIU0n2yFKrH1MMhg5NfGM8Sv0CjwjsU3GFW%4F0%3D

The Duals
It’s Like Watching The Sun Set. The Ending Is Inevitable: A Primer On The Dual Eligible Opportunity
December 19, 2011
https://ir.citi.com/HEBoX%2FpF7ngmsrPGu8VB5%E%2Bf5UMQ3Z9Ac58inFo8%3D
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ADDITIONAL INFORMATION IS AVAILABLE UPON REQUEST
U.S. Health Insurers - Ratings, Analytical Framework, Sector Review

Joseph Marinucci
Director / Insurance Ratings
Jan. 23, 2014
An AIS Webinar
S&P Ratings
What It Is

- Forward-looking opinions about relative credit risk, i.e., the creditworthiness of an entity or its securities that:
  - Strive to be globally comparable across sectors
  - Incorporate views on relative likelihood of default that:
    - Refer to the timely payment of interest and principal and,
    - Are applied to entities and securities

And What It Is Not

- Absolute measures of default probability
- Investment advice, a recommendation to purchase, sell or hold securities, or a comment as to market price or suitability for an investor
- A measure of liquidity or market value
- A way of defining “good” or “bad” companies, or a direct assessment of corporate governance
- An audit of the company or its auditors
- A guarantee of credit quality or of future credit risk
What An **Insurance** Rating Is And What It Is Not

**What it is**

- A forward looking assessment of an insurance company’s ability to pay out policy claims:
  - A typical rating assign to an insurance company is a FSR. A Financial Strength Rating “FSR” is an Indicator of an insurance company’s financial capacity to meet policyholder’s obligations.
  - In cases such as other financial obligations outside of policy holder claims are assessed, we assign a CCR. A counterparty credit rating “CCR” is an opinion of an obligor’s overall financial creditworthiness to pay all its financial obligations.
  - In cases where only the analysis is applied to a specific financial obligation, we assign an Issue credit rating “ICR”.

**And What it is not**

**Absolute measures of meeting policyholder’s obligation:**

- Investment advice, a recommendation to purchase, sell or hold insurance products and/or services, or a comment as to market price or suitability for an investor
- An absolute measure of liquidity or market value
- A way of defining “good” or “bad” companies
- An audit of the company or its auditors
- A guarantee of credit quality or of future credit risk
S&P Global Framework For Rating Insurance Companies
What are the steps to an Insurance Rating?

Key Highlights of the Insurance Ratings Framework:

- Framework of rating methodology is evolutionary
- Enhances transparency and specificity of insurance criteria
- Enhances comparability of insurance ratings through clear, coherent and globally consistent criteria framework
- More explicitly reflecting comparative analysis
- The methodology for analyzing the creditworthiness of insurers is forward-looking. The metrics use projections for the current and upcoming two years, as informed by the past five years, unless otherwise stated.
- The assessment of an insurer’s SACP and GCP is adjusted by up to one notch in either direction to capture a more holistic view of creditworthiness; and to recognize sustained, predictable operating and financial underperformance or outperformance, informed by comparative analysis.
- The holistic analysis includes rare or strongly positive or negative characteristics, including the insurer’s legal constitution and ownership, which the criteria do not separately identify.
How do we derive to an Insurance Industry and Country Rating Assessment (IICRA)?

**Key Highlights of an IICRA:**

- It addresses the risks typically faced by insurers operating in specific industries and countries, and is generally determined at a country or regional level.

- The risk assessment applicable to each industry and country combination is derived by combining the average of the four country-related assessments into a country-risk assessment and the average of the five industry-related assessments into an industry-risk assessment, each on a scale.
## Anchor Matrix

<table>
<thead>
<tr>
<th>Business risk profile</th>
<th>Financial risk profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>aa+</td>
</tr>
<tr>
<td>Very Strong</td>
<td>aa</td>
</tr>
<tr>
<td>Strong</td>
<td>a+</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>a or a-</td>
</tr>
<tr>
<td>Fair</td>
<td>bbb+</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>bbb-</td>
</tr>
<tr>
<td>Highly vulnerable</td>
<td>bb-</td>
</tr>
</tbody>
</table>

*When outcomes in adjacent cells diverge by two or more notches the anchor may be set one notch higher or lower based on relative business risk or financial risk strength or weakness within the cell or a trend in these risks.*
U.S. Health Insurer Sector Review
Health Care
2014: The Emerging New Frontier

The U.S. health care system is in the midst of significant changes. Although many forces affect health care delivery, Standard & Poor’s Ratings Services focuses on the pace of change and the ultimate impact of reforms on the solvency and sustainability of U.S. health insurers, for-profit health care, and state and local governments.

After viewing our cross-sector trends and insights below, take an in-depth look at industry subsectors.

U.S. not-for-profit hospitals and health care systems are confronting a complicated and changing environment. Negative pressures in the sector are accelerating after a period of steady recovery from the recession of 2008. Learn more about U.S. Not-For-Profit Health Care.

Overall, we consider the credit quality for U.S. health insurers to be strong. Health insurers remain on generally sound footing and have managed their operations reasonably well through a period of economic and legislative transition. Learn more about U.S. Health Insurance/Managed Care.

U.S. for-profit health care, which includes companies in a wide variety of subsectors, is being challenged to adapt to the ever-expanding complexities of the health care system. Although the Affordable Care Act is grabbing the most headlines, we do not believe it will affect ratings meaningfully in 2014. Learn more about U.S. For-Profit Health Care.
Agenda - 2014 U.S. Health Insurer Sector Overview

- Sector Highlights and Economic Considerations
- Portfolio Commentary and Rating / Outlook Distributions
- Rating Drivers
- Rating Risks
- Key Sector Considerations
U.S. Health Insurer Sector Highlights

- Credit quality for the U.S. health insurers is strong
- Sector fundamentals underpin rating stability
- Current ratings reflect capacity to withstand a period of moderate strain
## 2013 - 2014 Economic Scenarios For U.S. Health Insurance

<table>
<thead>
<tr>
<th>--FORECAST/SCENARIOS*--</th>
<th>Baseline impact on sector</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>--December--</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2012 (actual)</strong></td>
<td>Baseline impact on sector</td>
</tr>
<tr>
<td>Comment/Outlook on baseline forecast</td>
<td></td>
</tr>
<tr>
<td>Real GDP (% change)</td>
<td>Neutral</td>
</tr>
<tr>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>1.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Payroll employment (mil.)</td>
<td>Somewhat favorable</td>
</tr>
<tr>
<td>135.9</td>
<td>136.9</td>
</tr>
<tr>
<td>Employment has a direct impact on the availability of insurance and the mix of business in the marketplace. We expect the pace of hiring to be sustained through 2014. At this rate, the U.S. will have finally recovered the nine million jobs lost in the recession.</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate (%)</td>
<td>Somewhat favorable</td>
</tr>
<tr>
<td>7.5</td>
<td>7.6</td>
</tr>
<tr>
<td>Recent data suggest the job market continues to strengthen. Moderately lower unemployment should benefit consumer income and confidence. We expect the unemployment rate to decline to less than 7% by year-end 2014. We believe that an improving labor market is probably the best indication of an economic turnaround.</td>
<td></td>
</tr>
<tr>
<td>S&amp;P 500 Common Stock Index</td>
<td>Somewhat favorable</td>
</tr>
<tr>
<td>1,625</td>
<td>1,589</td>
</tr>
<tr>
<td>Equity market gains (S&amp;P 500 index)</td>
<td>Somewhat favorable</td>
</tr>
<tr>
<td>about 19% in 2013 followed by a significantly more moderate but still very beneficial return of about 12% in 2014. Anticipated price appreciation expected to benefit insurer capital bases.</td>
<td></td>
</tr>
<tr>
<td>10-year Treasury note yield (%)</td>
<td>Neutral</td>
</tr>
<tr>
<td>2.30</td>
<td>2.00</td>
</tr>
<tr>
<td>A moderately higher but still low Treasury note yield is beneficial to capital-market funding but detrimental to fixed-income portfolio returns. The Fed has indicated that it plans to start tapering its quantitative easing. Health insurer liabilities are short-term and underwriting drives profitability.</td>
<td></td>
</tr>
<tr>
<td>CPI (% change)</td>
<td>Neutral</td>
</tr>
<tr>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>General inflation is expected to remain subdued. But medical inflation remains above the CPI level and the spread is expected to widen somewhat through 2014 following three years of compression.</td>
<td></td>
</tr>
</tbody>
</table>

| Industry Economic Outlook              |                           |
|                                        | Neutral | Slightly negative | Neutral | Neutral | Neutral | Slightly positive |

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Ratings Distribution For U.S. Health Insurers

As of November 30 of each year; 30 interactively-rated companies and groups

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Rating Trends For U.S. Health Insurers

As of November 30, 2013

As of November 30, 2013

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Ratings Outlook For U.S. Health Insurers

As of November 30 of each year; 30 interactive ratings.

As of November 30 of each year; 30 interactive ratings.
Key Rating Drivers

• Industry risk
• Business conditions
• Financial fundamentals
• Governmental fiscal pressures
• Political discord
• Reform (Affordable Care Act)
U.S. Health Insurance Marketplace (Public Exchanges)

Source: Affordable Care Act website

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U.S. Health Insurance Market Considerations

- Structure and growth potential
- Regulatory and legislative environment
- Barriers to entry
- M&A
S&P Perspective On Select Health Insurers
S&P Perspective on Select Health Insurers

• UnitedHealth Group: A / Pos / A-1 (outlook revised in October 2013)

• WellPoint: A- / Stable / A-2 (affirmed in June 2013)

• Aetna: A- / Pos / A-2 (outlook revised in June 2013)

• Cigna: A- / Pos / A-2 (rating upgraded, outlook revised in June 2013)

• Humana: BBB+ / Stable / NR (rating upgraded in July 2013)
Thank You
2014 Outlook

New Year Promises More ACA Flux, Putting Health Plans at Center of Market Evolution

Reprinted from the Dec. 23, 2013, issue of AIS’s weekly newsletter Health Plan Week. Call (800) 521-4323 for more information.

Not many in the health insurance sector could have pinpointed the depth and longevity of the 2013 marketplace turmoil fed by the chaotic start of open enrollment for public exchanges and numerous diversions from the reform law’s original deadlines and structure for individual and small-group markets. While the Affordable Care Act (ACA) and its implementation will continue to be the center of attention in 2014, a slew of other factors from installing ICD-10 codes to shrinking Medicare and Medicaid reimbursement to feeding an increasingly consumer-centric, web portal-based insurance system will dominate carrier strategizing for the next 12 months, stakeholders say.

In a survey of more than a dozen insurers, consultants, actuaries and other market watchers, it is clear exchanges of all stripes — private and public — will be important to 2014 planning, as will broader “big picture” trends like designing narrow networks and helping employers to “define” defined contribution schemes. “The surprisingly rapid interest, and acceptance, of large employers in the private exchange marketplace, for both active employees and retirees, is a trend insurers will need to continue to follow closely and decide which private exchanges they will partner with going forward,” Richard Stover, principal and consulting actuary, Buck Consultants, a Xerox Corporation company, tells HPW.

2014 Figures to Be Challenging

A pair of lawyer-consultants says private exchange options for small and large group markets will grow in 2014, including expansion of “defined contribution” options for employees. “These developments will begin to transform small and large group markets from ‘wholesale’ — with issuers marketing to employers, benefit consultants, agents and brokers — to ‘retail’ with issuers marketing directly to employees, rather than to employers and their representatives,” attorney Jack Rovner, a principal for The Health Law Consultancy in Chicago, and Kathryn Roe, an attorney and managing member for same consultancy, tell HPW.

Brian Lobely, senior vice president of marketing and consumer business for Independence Blue Cross in Philadelphia, tells HPW his carrier’s primary focus is the shift to being a consumer-facing entity. Active in both the public and private exchanges, he says the advances in defined-contribution business, especially for national accounts, “is gaining steam.” Independence has its own private exchange for group sizes of two to 99 and will be expanding to 100 employees and more in 2014. They are also active on all the major exchanges run by consultancies including Aon Hewitt and Mercer. Lobely sees a big challenge in meeting consumer demand for not only insurance but for the overall look and feel of online purchasing. “They [consumers] are looking for what they experience in other industries like banking…There are the same expectations for health insurance,” Lobely says.

A new market entrant in the New York public exchanges, Oscar Health Insurance, preaches the gospel of web-facing, consumer-friendly insurance and sees that as becoming
even more important in 2014. “At Oscar, we think that member engagement is simultaneously a major challenge and a major promise for health insurers in 2014,” Oscar co-CEO Mario Schlosser tells HPW. “In the new world of exchanges, people will make their own decision as to which insurer’s products they like, so insurance companies can’t make things more complicated. Rather, we think that insurance companies need to step up to this challenge and guide members through their health care decisions, with smart tools and intuitive information,” he adds. “Insurers that do this well will be loved by members. Insurers that don’t will eventually be avoided.”

**Insurers Had Better Put Consumers Out Front**

The so-called “disruptive” trend of consumers becoming more empowered in their health insurance decision making is something carriers have got to get a handle on, says Bill Copeland, national managing principal of Deloitte Consulting LLP’s life sciences and health care practice. “After several years of shifting responsibility for copays, premiums and deductibles, it’s no longer just the employer paying for coverage — it’s the consumers’ money, and they will want a say in how and where to spend it,” he tells HPW.

The movement to online sales, which many agents and brokers see happening, begs the question of how a carrier should handle the administrative issues that hometown agents took care of before, be they from public or private exchange sales. “The biggest issues will be the monthly billing, collection and reconciliation of subsidy premiums with the Treasury [on public exchanges]. The opportunity will be there for agents to transfer more of their sales online and increase revenue. My personal belief is that private exchanges are the future,” Rick Bailey, president of brokerage Rick Bailey & Company, Inc., in Woodstock, Ga., and former president of the Georgia Association of Health Underwriters, tells HPW. Bailey and his company are launching a private exchange for brokers named the American Health Insurance Private Exchange (www.ahipe.com).

**Work on 2015 Public Exchanges Starts Now**

Carriers knee-deep in trying to get open enrollment on the public exchanges moving in the right direction for 2014 also must use the first months of next year to plan for 2015, making for an even more intense first quarter when it comes to ACA marketplaces. “Carriers in the ACA exchanges will need to start setting 2015 premium rates in early 2014, before much creditable experience will be available, even with the administration’s proposed delay in the 2015 open-enrollment period to Nov. 15, 2014,” Stover says. “The low initial enrollment rates will be concerning to insurers if those trends continue. But in setting rates for the 2015 year, insurers will have a much better sense of their competitors and competing rate levels, as well as plan designs and network size.”

Cori Uccello, senior health fellow, American Academy of Actuaries, tells HPW she agrees that 2014 will offer at least a little bit of a guide for 2015 public exchange strategizing. “Calculating health insurance premiums for 2015 will depend on new but limited data on 2014 enrollment and spending,” she says. “Actual experience data for the first few months of 2014 will be available as actuaries develop the premiums for 2015. Nevertheless, complete enrollment and spending data, as well as results from the risk-sharing programs (risk adjustment, reinsurance and risk corridors), won’t be available until the 2016 premiums are calculated.”
Which Insurers Win, Which Lose?

Asked what type of insurer will profit most from trends in place for 2014, Brian Weible, vice president and actuary at Wakely Consulting Group, tells HPW he thinks the big winner will be managed Medicaid plans. “The federal expansion to 138% of poverty and states’ push to move the Medicaid population into managed care will likely be a win for all states choosing to expand Medicaid and even some that don’t, like Florida,” he says. At least in the short term, Weible continues, the ACA’s provision requiring the federal government to pay 100% of the Medicaid expansion costs should give states some breathing room on rates. “This opportunity is hardly a secret as you look at last year’s acquisitions of Medicaid health plans by biggies that haven’t historically led in that space, like WellPoint’s acquisition of Amerigroup” (HPW 7/6/12, p. 1), he says.

On the opposite end, the big losers could be those carriers tied to Medicare markets. Weible says the cuts implemented by the ACA and the expiration of CMS’s bonus payments to three-star plans under the star ratings demonstration program in 2015, coupled with recent announcements of lower trends in payments, will likely result in reductions in benefits, service areas and enrollment for Medicare Advantage (MA) plans. “It’s always possible that a knight in shining armor will arrive right before final 2015 rates are announced in April 2014 (just like the magical ‘doc/SGR fix’ arrived between the announcement of draft vs. final rates this year),” he says, referring to CMS’s decision to assume that Congress would again delay the huge cut in Medicare physician pay that would occur on Jan. 1, 2014, under the Sustainable Growth Rate formula. Based on that assumption, CMS partially reversed some of the payment cuts proposed in the draft 2014 call letter. “Barring the knight, I expect at least a couple years of contraction in MA — even with bleed-in of baby boomers and some opportunities for niche plans and integrated dual plans (also being met with lukewarm reception by health plans).”

Vital for success in 2014 will be carriers’ ability to pivot quickly to whatever happens in the marketplaces and keep their minds on prices, says Steve Wojcik, vice president, public policy for the National Business Group on Health. “Insurers can also expect continuing pressure from patients and employers to increase price transparency,” he says. “Another big challenge, related to transparency, is to deal with price pressures from acceleration of provider consolidation, especially hospital-led consolidation, and as a response to a growing percentage of their revenues coming from government (expanded Medicaid and subsidized state exchange) coverage. Revenue shifting and transparency don’t mix well.”

What ‘Surprises’ Lie Ahead?

By their nature, surprises cannot be predicted, but insurance industry thinkers see a few issues as possible areas that may keep health carriers on edge in 2014. One staring insurers in the face is public exchanges, which Weible says are a real wild card looking forward. “Before the president’s recent tinkering, I think projections were 50/50 regarding the success of the exchanges in 2014,” he says. “Now, with the option to keep existing plans (non-Essential Health Benefit compliant) for nearly another year, I think the odds are long as far as 2014 going well for the exchanges.” He adds that health plans were hoping that market turbulence would be limited to 2014, but with individuals now permitted to keep current plans and the delay in online enrollment functionality in the small group exchange, it now appears that 2015 may be even more turbulent than 2014. “Over my 20-plus years in the health care industry, I’m certain I’ve never seen a period when the overall health care market...
was in such flux, and (at least in my opinion) opportunities were so polarized by the product markets,” Weible says.

Some Pinpoint Outlier Issues as Important

For other market consultants, there are less obvious issues for insurers to watch for next year beyond exchange enrollment data snafus and the roll out of the ACA in general. Joseph Paduda, principal, Health Strategy Associates, LLC, and author of the Managed Care Matters blog, says a key issue is the backlog of orthopedic cases that will hit specialists later in 2014. “There’s no doubt there is a plethora of not-yet-65 [year-old] Americans in dire need of hip, knee and shoulder replacements. As these folks obtain coverage, they will start to jam up orthopedists’ calendars and the operating rooms of ASCs [Ambulatory Surgical Center] and hospitals alike. Payers will have to work to get these procedures vetted, approved and paid, plus the physical therapy and meds associated with the care,” he tells HPW. The good news resulting from this challenge is this backlog will work its way through the system, and in a couple of years’ time be “digested.”

For David Williams, co-founder of the Health Business Group and MedPharma Partners consultancies, and author of the Health Business blog, it is the Oct. 1, 2014, start for ICD-10 coding that will be very important (HPW 9/16/13, p. 1). “Most observers have focused on the challenges that provider organizations will face in preparing for implementation. There is an implicit assumption that health plans are well prepared. However, in reality many health plans are likely to struggle and may encounter serious difficulties in processing claims and paying bills,” he says. At a minimum, plans are likely to ask providers for more thorough clinical documentation to justify the codes they submit. “Providers are already concerned that the shift to ICD-10 will lower their incomes. And if health plans struggle with the launch of ICD-10 it will make life that much tougher for providers and ultimately patients. The year 2014 will be a challenging one for health plan/provider interactions in any case, due to the implementation of Obamacare. The switch to ICD-10 will make things even stickier,” Williams stresses.

Deloitte’s Copeland, who spoke earlier about the disruptive trend of consumerism, sees a second disruptive trend: the advent of plans offering clinical services — both professional and technical — and of providers offering financing products. “I expect to see cross-sector convergence on the agenda at almost every health plan board meeting in 2014. Should we buy mini clinics, a physician practice, build a virtual care network to generate new revenue? How do we guard against providers setting up their own insurance plans?” he says.

Contact Uccello at uccello@actuary.org, Bailey at rick@rickbaileycompany.com, Williams at dwilliams@mppllc.com, Schlosser via Nick Rosen-Wachs at nick@derris.com, Ed Gadowski for Stover at edward.gadowski@buckconsultants.com, Rovner at jrovner@hlconsultancy.com, Roe at kroe@hlconsultancy.com, Emerman for Wojcik at emerman@eaglepr.com, Paul Dunker for Copeland at pdunker@deloitte.com, Weible at brianw@wakely.com, Lobely via Karen Godlewski at karen.godlewski@ibx.com and Paduda at jpaduda@healthstrategyassoc.com. ♦

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2014 Outlook

MA Business Is Likely to Have ‘Rough Year’ As Pay Cuts, New Fee, HRA Changes Loom


If you thought 2013 was tough financially for the Medicare Advantage business, 2014 will make it seem like nothing. This at least seems to be the consensus of industry consultants, actuaries and attorneys queried by MAN. They cite not just a bigger impact from payment-rate cuts under the Affordable Care Act (ACA) but also such other factors as the impact of risk-adjustment changes being planned by CMS and of the new insurer fee in envisioning a much more difficult business climate.

“2014 is going to be a rough year” for MA, says, for instance, consultant John Gorman, executive chairman of Gorman Health Group, LLC. Among other factors, he tells MAN, this year will be the “lowest point” for the ACA-based pay cuts, which “will be felt by the vast majority of plans.” Just how severe the impact will be, though, will be determined largely by the final call letter for 2015 that is due out in early April and is likely to include new risk-adjustment changes, Gorman adds.

While the call letter governs payments for next year, its impact will begin already in 2014 by causing plans to adjust to the tightening revenue squeeze. Pat Dunks, a principal and consulting actuary at Milliman who also envisions a challenging year, lays out the basic math. Although pay cuts under ACA are completed already for the so-called two-year phase-in counties where prevailing MA rates were close to Medicare fee-for-service (FFS) rates to begin with, he notes that four-year counties won’t complete that phase-down till 2015 and six-year plans till 2017.

Then there is the effect of the start of the ACA’s fee on insurers that Gorman and others figure could chop a couple of percentage points from MA insurers’ profit margins — which often aren’t much higher than 2% to begin with now, he points out — on those products in 2014. The start of an MA minimum medical loss ratio requirement of 85% this year (MAN 2/28/13, p. 1) won’t have much impact, though, according to Gorman, since most MA plans already have MLRs of 85% or above.

There is more potential bad news on the money front coming for MA plans in 2014 in the form of an increased number of risk adjustment data validation (RADV) audits and more “demand letters” for monetary penalties stemming from them, predicts Gorman. The precise impact will depend largely on how CMS decides to calculate the FFS adjuster it plans to adopt under terms of its 2012 memo (MAN 3/1/12, p. 1) — a methodology Gorman expects to see in the call letter for 2015.

That document, for this reason and others, becomes even more critically important than usual. Expectations are that its bottom line will mean little or no payment hike to offset the ACA reductions, even if CMS assumes another short-term “doc fix” to prevent a drop in Medicare physician fees. Those fees otherwise would plummet effective January 2015 under the Sustainable Growth Rate (SGR) methodology and thereby lower the allowable MA rate changes.
Dunks figures that such an SGR fix would mean maybe a 0.5% rate increase for 2015, based on CMS statements in a recent actuarial call. But this would be offset by several other parts of the payment calculation, he tells MAN. Among them, according to Dunks, are another 0.25% minimum coding-intensity adjustment increase, a perhaps 0.25% to 0.50% pay reduction from the phase-in of the remaining changes in Hierarchical Condition Category (HCC) risk adjustment that CMS began for 2014, a cut of up to about 0.50% in benchmark rates — varying by county — from the continuing phase-out of indirect medical education (IME) from payment rates, and a reduction stemming from slowing of medical cost trends.

**HRA Change Could Have Biggest Impact**

Perhaps, though, the biggest potential change in the call letter will relate to what CMS decides regarding limitations on the use of health risk assessments (HRAs) for diagnosis and payment purposes. CMS suggested in the preliminary 2014 call letter that it might disregard diagnoses obtained totally from HRAs and not confirmed by a subsequent clinical encounter. But it backed off that a little in the final call letter (MAN 4/11/13, p. 1) in the face of industry concerns and clarity issues, saying it will aim to include such a provision for 2015 instead.

CMS will wind up taking a tougher line on HRAs than it has, but “it doesn’t want to throw out the baby with the bath water” by halting in-home visits that can be useful for MA beneficiaries, observes Gorman. The agency is likely to impose new restrictions on HRAs to assure that they result in “real care…and not just data collection,” he predicts, which could “throw the risk-adjustment vendor industry into disarray.” And Dunks says any major restrictions on use of HRAs would have a “significant” adverse financial impact on MA plans.

Not all of the possible developments in 2014, though, are negative for MA plans. There is, for instance, bipartisan agreement on a framework that could bring a permanent end to the SGR, points out Bruce Merlin Fried, managing partner in the Washington, D.C., office of the law firm Dentons U.S. LLP and formerly the health plan overseer at CMS predecessor HCFA.

Moreover, he envisions continued enrollment gains for MA plans in 2014, although he also acknowledges MA industry profits will face a “headwind.” Fried adds that while there already has been “so much consolidation” in the industry in recent years, there is likely to be “a little more” this year. Part of that, he tells MAN, will involve more health systems getting into MA.

“This is a program that’s harder than it looks,” Fried asserts, referring to the MA industry. It requires “a certain level of scale,” and “it’s all about execution,” he says.

**Cuts in Provider Networks Are Big Issue**

Those comments also could pertain to another business issue facing providers and MA plans in 2014: the number of physicians in plans’ networks. This subject has climbed to top of mind for the insurers in light of both the payment squeeze and the litigation that has arisen on UnitedHealthcare’s mass terminations of physicians from provider networks (MAN 12/19/13, p. 1).

“Payers are squeezing on reimbursement, so plans must look hard at their delivery systems and see who the best providers are,” says Fried. He terms it logical that MA plans would want to remove less efficient clinicians from their networks or subject beneficiaries to more cost sharing in broader provider networks, and envisions a year of “tough negotiations” with providers to create the kind of collaboration needed.
A key reason for this, says Gorman, is the impact of providers on MA plans’ star quality ratings, which lead to needed bonuses paid by CMS. Many other plans are doing the same thing United did in terms of profiling providers and assessing their impact on star ratings, he maintains, albeit in a “less notable way...What United did was a mushroom cloud.”

It was no surprise that the company’s situation came to a head in Connecticut, which is a “hotbed of academic medicine” that tends to be more expensive without evidence that it’s better, he says. Gorman calls United’s mass physician terminations “a negotiating tactic” aimed at getting providers to change their behavior, and predicts it will work with some physicians but not others. It is unlikely, he suggests, that 2014 will bring more such broad physician termination actions as the one in Connecticut.

Contact Gorman at jgorman@gormanhealthgroup.com, Dunks at pat.dunks@milliman.com and Fried at bruce.fried@dentons.com.

2014 Outlook

Many Duals Programs Finally Will Launch; SNP Joint Ventures Gain


2014 figures to be the big year for the start of integrated care initiatives for Medicare-Medicaid dual eligibles both within and outside the CMS-backed Financial Alignment Demonstration (FAD). In addition, while it may be 2015 before good outcomes data from the FAD or separate state initiatives become available, and although plan payment rates are still an issue, it appears that nothing can derail duals programs — or a prominent role in them for MA Special Needs Plans (SNPs).

Aiding the SNPs’ situation are two congressional developments last month. First, as part of the new budget law Congress adopted, all SNPs got a one-year reauthorization, so they now can operate through 2015. Moreover, in the Senate Finance Committee markup of a bill to end the Sustainable Growth Rate (SGR) methodology that each year threatens Medicare physician fee cuts, SNPs for duals (D-SNPs) would get reauthorized through 2020. The measure, however, also would require D-SNPs to increase integration of Medicare and Medicaid services.

Good Outcomes Data May Not Come Till ’15

While the prospects of this bill in the House still are in question, the overall direction on duals is not. “The bell has rung” for duals programs in 2014, says, for instance, Jeff Myers, the new president and CEO of the Medicaid Health Plans of America trade group. The “most salient point” about duals programs this year, he tells MAN, is that they’ll start to roll out via both the FAD and state initiatives, with data on their results beginning to appear late in 2014. But it will be 2015 before more meaningful outcomes data are generally available.

Washington state already has started the managed fee-for-service portion of its FAD initiative, and Massachusetts’ capitated FAD program completed the initial voluntary-enrollment portion at the end of 2013 and moved to auto-assignment beginning Jan. 1. Illinois is slated to begin its CMS-approved initiative Feb. 1. Ohio may not be far behind, and California now is targeting July. Indeed, all eight of the FAD states approved by CMS
are expected to be in operation before the end of 2014, as might some of the remaining 14 applicants.

Wisconsin said this month it withdrew its FAD application in light of the state’s differences with CMS on approaches for duals integration. It may wind up being one of several states to start their own duals programs this year. Tennessee also could be one of these, says Rich Bringewatt, co-chair of the SNP Alliance trade group, noting that its recent TennCare Medicaid managed care contract awards (MAN 12/19/13, p. 8) included a requirement that all selected plans operate D-SNPs in every county they serve.

In recent weeks, Virginia, which in 2013 won CMS approval to participate in the FAD, finalized contracts for the demo with Humana Inc., WellPoint, Inc. and Virginia Premier Health. And Medicaid plan specialist Centene Corp. said on Dec. 18 that it agreed to buy a majority stake in MA plan sponsor Fidelis SecureCare of Michigan, Inc., which the Michigan Department of Community Health picked as one of eight plans for its duals initiative (MAN 11/21/13, p. 4). The Michigan program still is awaiting CMS approval.

Myers calls the Centene-Fidelis joint venture “reasonable” in light of the different approaches needed in Medicaid (especially on long-term care services and supports) and MA. It “wouldn’t surprise me” to see more such linkages, he says.

The financial resources these partnerships can bring are important since nobody queried by MAN expects payment-rate problems in duals initiatives to disappear anytime soon. It was largely payment rates that led to the decision to drop out by three of the six health plans chosen in Massachusetts’ FAD demo (MAN 7/25/13, p. 1), including two members of the Association for Community Affiliated Plans, notes ACAP CEO Meg Murray. ACAP members continue to be “concerned” about payment levels in the FAD, she tells MAN, but no other ACAP members have withdrawn.

“This is a very difficult and expensive population,” Myers says of duals, contending that there has been too much focus on getting immediate savings on duals rather than placing the initial emphasis on improving treatment of duals via full integration. “There will be savings ultimately,” asserts Myers, but “the key [now] is not to put the cart before the beneficiary-improvement horse.”

However, expenditures are a big priority for many states, and this is why many of the duals demos will start by the second quarter, says consultant John Gorman, executive chairman of Gorman Health Group, LLC. “These things can’t be delayed much longer for budgetary reasons,” Gorman tells MAN, since other items in state budgets will “get crowded out” if duals initiatives keep getting postponed.

The SNP Alliance’s Bringewatt agrees that more big delays in duals demos are unlikely, especially since there now are final contracts in a few states that can provide “a template” for other states. That said, though, he also points to states’ recent need to focus on health insurance exchange-related issues as cutting into their “capacity” for putting resources into duals programs.

Despite those other demands, some states clearly are making big commitments on duals, and Bringewatt sees this continuing throughout 2014, aided by active support from the National Association of Medicaid Directors for duals programs that use a D-SNP foundation (MAN 9/26/13, p. 1). If the Senate Finance Committee SGR bill becomes law, it could aid the trend with a provision that empowers the CMS duals office to institute a unified process for
handling appeals and grievances in D-SNPs, he adds. Such an integrated process was part of a separate duals program approved by CMS for Minnesota in 2013.

The evidence of how duals programs have fared so far is minimal and mixed, with much of it coming from the initial voluntary phase in Massachusetts. The state in early December reported that more than 4,700 duals had signed up voluntarily but also that 17% of duals invited to join the demo had opted out. Bringewatt is “pleased” with the enrollment figures and says the three participating plans — all of them SNP Alliance members — are too. Most of the enrollment so far there is going into one long-established plan, Commonwealth Care Alliance.

The 17% initial opt-out rate reported, says Valerie Wilbur, the SNP Alliance’s other co-chair, is “a little high” and a bit of a surprise.

Neither she nor Bringewatt, however, expects this kind of a figure to halt the burgeoning of duals programs. “We’ve crossed the Rubicon on [duals] integration,” says Bringewatt, and the question no longer is whether such integration will occur but instead how.

Contact Myers at jmyers@mhpa.org, Bringewatt at rbringewatt@nhpg.org, Wilbur at vswilbur@nhpg.org, Gorman at jgorman@gormanhealthgroup.com and Murray at mmurray@communityplans.net.