

Willis Re MANAGING EXTREMES

- Massachusetts healthcare reform
 - Decreased uninsured population 40-50%, primarily via Medicaid expansion
 - Lowered hospital WC claim frequency by 5-10%
 - No discernible impact on hospital WC claim severity or duration of treatment
 - Impact in Massachusetts may be function of low WC reimbursement rates

2

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- Why Massachusetts?
- The RAND study
 - Data
 - Results
 - Limitations
- Pending Supreme Court decision
- Conclusions

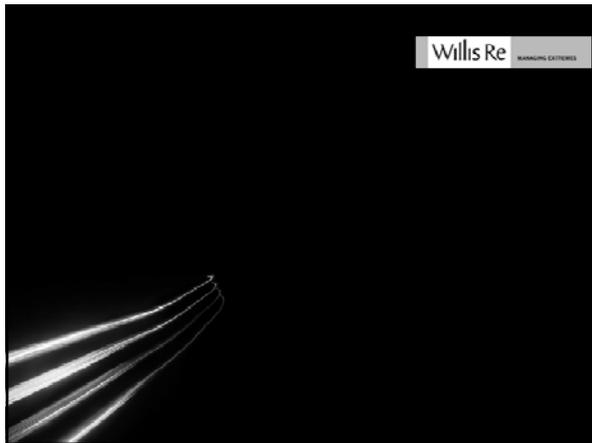
3

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- Massachusetts 2006 health reform
 - Individual mandate
 - Employer mandate
 - Health insurance exchange
 - State subsidized low cost plan
 - Expanded Medicaid eligibility
- All five features are pillars of federal healthcare reform

4

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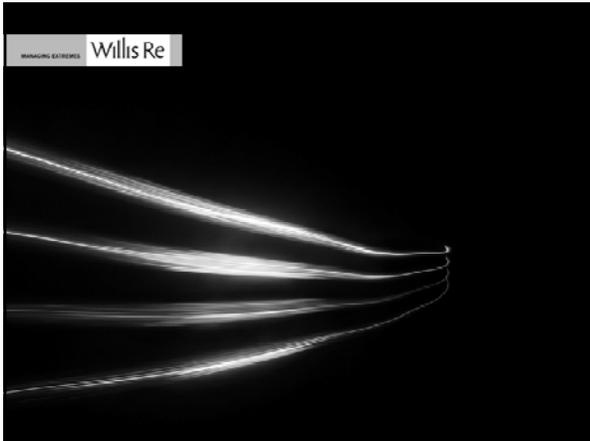


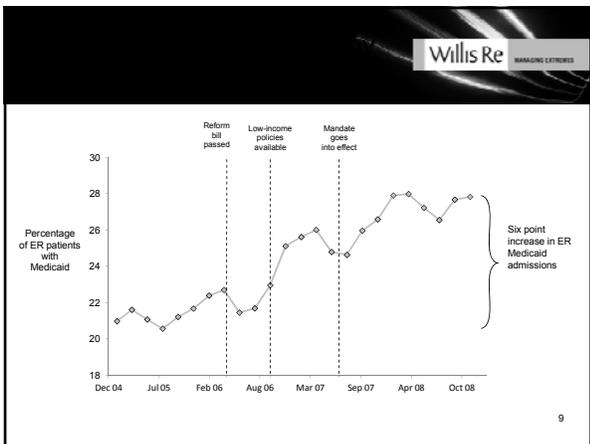
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- MA Agency for Healthcare Research and Quality data from 2005 to 2008
 - Covers pre and post reform period
 - Represents 99% of MA hospital visits
 - 9.5 M ER visits, 340K WC
 - 3.4 M inpatient hospital visits, 14K WC
- Key assumption: Impact on hospital WC costs proxy for impact on total WC medical
 - ER classification endures

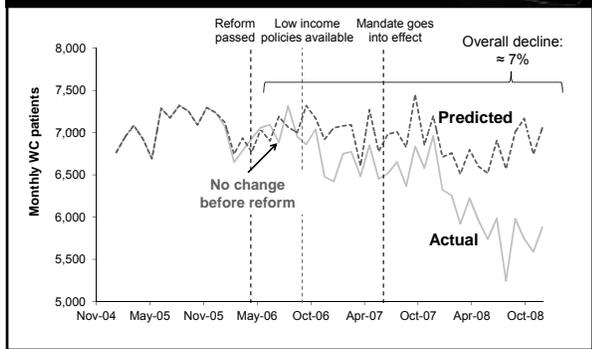
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- Using the Massachusetts hospital data, we examined whether health reform:
 - Impacted insurance coverage, and how
 - Changed the number of hospital bills received by WC insurers (claim frequency)
 - Changed WC patients' billed charges (claim severity)



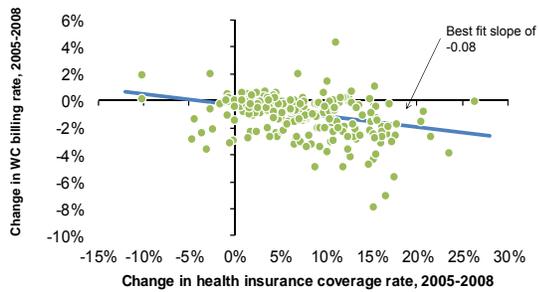


- RAND model predicts number of bills in 2006-2008 based upon 2005 pre-reform data
- Accounts for patient demographics, type of injury, time and day of week, and other factors
- Differences between realized bills and predicted bills may indicate impacts of reform
- Data from early 2006, before reform in effect, serves as “reality check” for model



- What about recession?
- Chronic frequency declines?

- If coverage expansion is the driver, WC bills should decline most among populations with largest increases in coverage.
- Approach:
 - Divide people into cells by age / race / ZIP.
 - Control for change in county-level change in unemployment
 - Compute 2005 to 2008 coverage change in each cell
 - See if groups affected most by reform had largest WC shifts

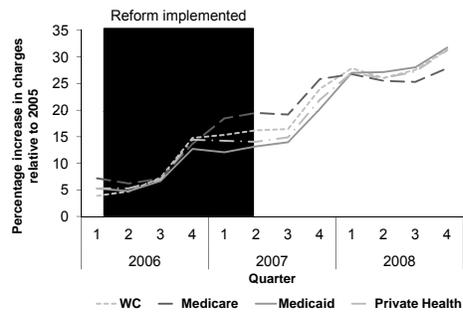


- WC Billing change due to increased coverage

$$= (\text{Change in Coverage} \times \text{Best Fit Slope}) / (\text{Pre-reform WC Billing Rate})$$

$$= (6 \times -0.08) / 4.2 = \underline{-11.4\%}$$
- Indicated decrease in WC billing in line with predicted vs actuals
 - More granular
 - Controls for unemployment

- RAND looked at this in two ways:
 - Top 20% ER vs all ER bills
 - Inpatient vs ER
- In both cases the observed WC billing declines were similar regardless of claim size
- WC claim mix not affected by Mass reform



- No change in number of procedures or length of hospital stay
- Similar patterns for hospital inpatients

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- Massachusetts nuances
 - Very low WC reimbursement rate
 - Medicaid expansion differs by state
- Impact of recession
 - RAND considering update to reflect data through 2012
- Hospital data only

19

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- Status quo
 - Currently 56M on Medicaid
 - Starting in 2014 expanded eligibility causes rolls to grow by 16-24M
 - Impact not uniform by state
- Individual mandate unconstitutional, but severable
 - As above
- Mandate unconstitutional and not severable
 - State by state reform effects

20

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- Decreased uninsured population 40-50%, primarily via Medicaid expansion
- Coverage expansions resulting from reform reduced WC hospital bill frequency by 5-10%
 - Shifted billing to other insurers
- No discernible impact on claim severity
- Insured population with greatest increase in coverage likely to have greatest decrease in WC billing
- WC reimbursement levels relative to other coverage may impact billing decline

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- Impact of Health Care Reform on WC Medical Care
 - http://www.rand.org/pubs/technical_reports/TR1216.html
- How will Health Care Reform Affect Costs and Coverages
 - http://www.rand.org/pubs/research_briefs/RB9589.html

22

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23
