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**Statement of
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The American Academy of Actuaries' Uninsured Work Group appreciates the opportunity to provide comments on issues concerning Americans without health insurance. The Academy is the non-partisan public policy organization for actuaries of all specialties in the United States.

The U.S. Census Bureau estimates that more than 43 million non-elderly Americans did not have health insurance in 2002, an increase of more than 2 million from 2001. A solution to the uninsured problem has so far been elusive, but the issue is again moving to center stage. The actuarial profession has extensive experience designing, pricing, and managing health insurance coverage for individuals, employers, and public programs, including Medicare and Medicaid. As the actuarial profession's voice on public policy issues, the American Academy of Actuaries has many insights that may benefit members of Congress as they design proposals to provide health coverage to the uninsured.

This document identifies many, but not all, of the myriad issues that should be considered when designing and evaluating proposals to expand health insurance coverage. Addressing these and other issues should help minimize any unintended consequences and increase the chances for success of any such proposal. This document does not cover implementation or administration, both of which will be critical to the success of any new initiative. Rather, in the sections that follow, we identify issues related to: the target population(s); the benefit packages; the costs to individuals, employers, and states; the impact on the health insurance market; the impact on regulation; and the impact on overall health costs.

Who Is the Target Population?

The uninsured population is not a homogeneous group. It includes, among others, low-income workers who do not have access to or cannot afford employer-sponsored coverage, early retirees not yet eligible for Medicare, adults who do not feel that insurance is a good way to spend their money (these people are often young, but not always), individuals ineligible for or unaware that they are eligible for public programs, and unhealthy individuals who cannot obtain insurance at any price.³ A proposal could use a single approach to increase coverage among the uninsured, or it could use different strategies for different segments of the uninsured.

Who is the target population?

- What uninsured population subgroup(s) does the proposal target?
- How well does the proposal target the intended group(s)? What is the expected participation among the intended group(s)?
- Will other groups also participate? If so, are they currently insured or uninsured?
- How will the eligible population be contacted and enrolled?

What are the conditions of eligibility?

A proposal may offer direct insurance coverage through a public program such as Medicaid, a premium subsidy for use in the private insurance market, or some other approach.

- Under what conditions does an individual or family member become eligible for coverage or premium subsidy under the proposal?
- Is there a requirement to be uninsured for a certain period in order to be eligible for coverage?
- How long will an individual or family member be eligible?

³ For more information on who the uninsured are, see the American Academy of Actuaries issue brief *Health Coverage Issues: The Uninsured and the Insured*, which is available on the web at http://www.actuary.org/pdf/health/uninsured_0903.pdf.

- Is the proposed coverage meant to be permanent or transitional? For example, is eligibility tied to being unemployed?
- Is eligibility tied to ineligibility for other private coverage, regardless of cost?
- If the proposal relies on public program expansions, how will the eligibility rules differ by state?
- If the proposal relies on private coverage expansions, will plans be widely available, regardless of state or rural/urban location?

What are the conditions of issue and is coverage portable?

The Federal Health Insurance Portability and Accessibility Act (HIPAA) provided Americans with increased access to health insurance.

- Will the coverage offered under the proposal change an individual’s HIPAA right to insurance without a pre-existing condition exclusion?
- Does the proposal contain open enrollment periods with guaranteed issue?
- What conditions, such as pre-existing condition exclusions, waiting periods, etc. will apply to uninsured individuals who wish to obtain coverage under the program?
- Will those who are already insured but want to move into the new program be subject to any pre-existing condition exclusions, waiting periods, etc.?
- If coverage eligibility is tied to certain requirements, such as being unemployed, are there any portability opportunities so coverage can be retained?

What Is the Benefit Package?

The benefit package must be considered when evaluating proposals to provide health insurance coverage for the uninsured. Most insurance typically protects against catastrophic losses that occur with low probability. Employer-provided health insurance, however, has usually covered not only the expenses associated with high-severity, low-incidence health services, such as hospitalization, but also high-incidence, low-severity health services, such as office visits. One recent trend has been to move toward higher deductibles, thus reducing or eliminating coverage for more predictable health expenses. Another trend has been for some states to allow “bare bones” policies, thus avoiding state coverage mandates that can increase premium costs.

What is the benefit design?

- Does the proposal provide comprehensive coverage with relatively low deductibles similar to traditional health insurance, or does it provide benefits more closely associated with catastrophic coverage?
- Will coverage abide by state-mandated benefit requirements or are “bare bones” policies allowed?
- Is any required provider network adequate to meet the health care needs of plan enrollees?
- How flexible is the benefit package to advances in medicine?
- Does the benefit design include cost-sharing provisions designed to encourage efficient use of health care?
- Will the benefit design allow an individual to pre-fund future insurance expenses (e.g., health reimbursement accounts)?

What Are the Costs to Individuals/Families?

Many proposals to increase insurance coverage rely, at least in part, on the private insurance market. To make coverage in this market more affordable, proposals often provide subsidies that cover all or part of an individual's insurance premiums.

Are premium subsidies proposed?

- What are the premium subsidy levels? Are they expressed as a percentage of premiums or as a flat amount?
- How do the subsidies vary by income or age? Do subsidies vary by income levels of the individuals within a state, or nationwide?
- Will they reflect state premium variations?
- How will the subsidies be distributed?
- Will they be provided in advance, as a refund of costs, or both?
- Where can individuals use their subsidies? Can they be used toward only one coverage plan, or toward any appropriate coverage the person may be eligible for?

What are the net costs payable by individuals/families?

The cost of participating in an insurance plan includes not only the premium, but also any cost-sharing requirements. On one hand, high cost-sharing requirements will reduce premiums, all else being equal. On the other hand, some individuals, especially those with low incomes, may choose not to enroll in plans with high cost-sharing requirements, even if the premium would otherwise be affordable.

- What is the premium required, net of any subsidies?
- What is the deductible and are there any other cost-sharing requirements? Are there any cost-sharing subsidies for low-income individuals/families? Is alternative care available at no, or low, cost?
- Is there an out-of-pocket maximum that limits the amount of cost sharing?
- Are there any lifetime or annual benefit maximums?
- Are there any financial penalties imposed for not having coverage in place?

Will insureds know the true costs of their health care?

Insurance shields most Americans from the true costs of their health care. Workers who obtain insurance through their employer typically pay only part of the premium, and may not know the total premium costs, including the employer premium share. Perhaps even more important, when receiving health care services, insured Americans typically see only their out-of-pocket costs, not the total costs billed or paid. Some data suggest that the lack of understanding regarding the total costs of care provides insureds with incentives to over utilize health services.

- Will the proposal make insureds more aware of the total costs of their health care?
- Does the proposal include incentives intended to encourage insureds to be more efficient users of health care services?

What Is the Cost to Employers?

Although most insured Americans obtain their coverage through the workplace, the majority of the uninsured are in working families. Some employers, especially small employers, do not offer insurance.

Moreover, many employers who do offer and subsidize coverage are responding to growing coverage costs by shifting more costs to workers through increased premiums or cost sharing, thus making it more expensive for workers. Many proposals aim to increase the share of employers offering coverage as well as increase the affordability of that coverage. Such proposals may include providing additional tax subsidies to employers offering coverage, mandating that employers offer coverage, providing reinsurance to employers to lower the costs of coverage, and facilitating the formation of purchasing pools for small employers. Whether such provisions would be successful at increasing the availability of employer-sponsored coverage and, ultimately, whether they will reduce the number of uninsured depends on several issues:

Are tax subsidies available to employers who sponsor coverage?

Currently, employers who offer insurance coverage are allowed to deduct their premium contributions as a business expense.

- Would any additional subsidies be available for employers who offer coverage?
- Would employers be required to pay a minimum share of the premiums to qualify for the subsidies?
- Would the subsidies apply to the costs for all workers, or would they be limited to those with low incomes, or other targeted populations?
- What conditions, if any, are placed on the availability of additional subsidies? For instance, are certain benefits required? Are minimum enrollment targets included? Are employers required to pass along any premium savings due to subsidies to the employees?

Does the proposal include other provisions designed to make it easier for employers to offer coverage?

- Does the proposal allow collective employer actions, such as purchasing pools or association health plans (AHPs)?⁴
- Will reinsurance be made available to reimburse employer plans for high-cost individuals?
- Does the proposal include some form of coverage sharing that would form a partnership among the employer, the government, and the insured?

Note that the potential impact of some of these types of provisions on the insurance market is discussed in the next section.

What are the estimated net costs to employers and are they predictable over time?

- What are the premium costs to an employer affected by the proposal, net of any subsidies? Are they higher or lower than those currently available?
- What are the associated administrative costs? Are they higher or lower than current administrative costs?
- Are premium costs more predictable over time?
- Are there any costs for employers who do not offer coverage, or otherwise do not participate in the proposal?

Are new subsidies available for insurance outside the employer group market?

Proposals that increase the availability or affordability of insurance outside the employer group market could also impact whether some employers continue to sponsor coverage, regardless of

⁴ For more information on AHPs, please refer to the Academy's April 28, 2003 letter to Congress regarding the Small Business Fairness Act of 2003 (H.R. 660 and S. 545), which is available on the Academy's website at http://www.actuary.org/pdf/health/ahp_042803.pdf.

whether any changes are made to the employer market. For instance, if subsidized insurance is available in the individual market, some employers may be less inclined to offer coverage to their workers.

- Does the proposal increase the availability or affordability of coverage outside the employer group market?
- Could the proposal prompt some employers to discontinue offering coverage for workers and/or their dependents? Is this consistent with the long-term goals of the proposal?
- Does the proposal include any incentives for employers to continue offering coverage?
- If workers can use individual tax credits to pay for their share of employer-sponsored coverage premiums, will employers shift more of the premium costs to workers?

How Will the Proposal Impact the Health Insurance Market?

How will the proposal affect the different private insurance market segments (small group, large group, and the individual market)?

There is not a single unified market for private health insurance. The three main segments are: large (employer) group, small (employer) group, and individual. There are major differences in the underwriting and pricing of the coverage in these three markets. These differences are due to competition, the regulatory environment (primarily state), and to the fundamental purchasing decisions made in the different markets.

Large-group insurance (generally over 50 employees) is driven more by competition than by regulation, at least in the underwriting and pricing functions. Insurers generally accept any employer and provide coverage to any enrolled employee or family. Prices are set at the group level and typically are based in whole or in part on the prior and expected medical costs of the specific group. An average price is charged for each employee and family unit, without variation for age, gender, or health status. Larger employers often self-insure the underwriting risk. State benefit and coverage mandates apply to the insured groups but not to the self-insured groups due to exemption under the Employee Retirement Income Security Act of 1974 (ERISA).

Small-group insurance (2 to 50 employees) is subject to significantly more state regulation of the rating and underwriting practices. All groups and eligible employees must be offered coverage regardless of health status. Surcharges based on health status for individual employees are not permitted. Premiums charged for each employee may be either the average of the group or based on the age and gender of the specific employee. Some states mandate community rating, whereby an insurer is required to pool the medical cost experience of all small groups in determining the expected average medical costs and premiums. The average rates serve as the basis of the rates charged to a specific employer. State variations often set limits on the maximum or minimum difference from this average, and also on the percentage rate increase an employer must pay in a given year due to experience. For example, the minimum may be 75% of the average, the maximum may be 150%, and the rate increase limit is the increase in the average plus 15%.

The individual insurance market is tightly regulated. Rating practices permitted by the states vary from community rating to full age/gender rating with initial underwriting loads (extra premiums) permitted. Many states permit individuals to be denied coverage due to poor health, or to have specific pre-existing conditions excluded for the life of the policy. Other states require that all applicants be accepted and all conditions covered. In most states, renewal rate

change to reflect the change in an individual's health status is not permitted. However, the rates for the entire pool, both new and renewal business, may be increased to reflect the experience of the pool. A sub-segment of the individual market is composed of those who are guaranteed coverage regardless of health. In some states the entire market is guaranteed issue. This guaranteed issue right comes under the state group conversion regulations or under the federal HIPAA portability provisions. Although coverage must be offered to these individuals, the premium rates charged are typically higher than the rates for underwritten individuals. The excess premium charges may or may not be regulated by the state.

- Does the proposal change the underwriting methodology allowed in the different markets?
- Does the proposal increase or decrease the risks to be borne by any of the private market pools?
- Does the proposal change any ERISA exemptions for employers that self-insure coverage?
- Does the proposal give flexibility to both the insured and the insurer to provide products appropriate to the risk the insured wants to cover?
- Will the proposal allow insureds to move between markets?

Will the proposal affect the risk composition of the insured population?

Different insurance expansions can affect the insured-risk composition of the market differently. Proposals that remove the high-cost or otherwise uninsurable population from the individual and group markets and put them into a high-risk pool will reduce the coverage costs of the remaining population. The resultant lower premiums could make insurance more affordable among some of the currently uninsured. Similarly, if reinsurance is provided to insurers to cover the costs of high-cost enrollees, premiums could be reduced. Note, however, that such high-risk pools and reinsurance arrangements are mechanisms to spread cost, not eliminate it, and will reduce premiums only to the extent they are financed by a population broader than the privately insured population.

On the other hand, if healthy individuals are more likely to drop one type of coverage for another, premiums for those remaining with the original coverage will increase. Some may find the higher premiums unaffordable, and drop coverage as a result. Insurance plans that are left with a disproportionate share of unhealthy individuals are much less likely to be viable in the long term, which could ultimately result in more uninsured individuals if those dropping coverage are unable to find more affordable coverage elsewhere.

- Does the proposal include high-risk pools, and if so, how are they financed?
- Does the proposal provide reinsurance to cover the costs of high-cost enrollees, and if so, how is it financed?
- Other than into high-risk pools, will the proposal result in healthier individuals opting for one type of plan and unhealthy individuals opting for another? If so, is this the desired result?

Is adverse selection manageable?

Sustaining a viable private health plan typically requires minimizing adverse selection, which occurs when relatively fewer healthy individuals enroll in a plan. However, this adverse selection is the norm in a high-risk pool. Therefore, it is important to consider the health characteristics of those who will become newly insured. In particular, will only the unhealthy choose to participate, or will the healthy participate as well? If this segmentation occurs, is it planned for in the proposal? Under a private group type plan the key to minimizing adverse selection is to increase participation, especially among healthy individuals. This can be

accomplished through various means, including high premium subsidies, automatically enrolling eligible participants, and requiring higher premiums and/or other penalties for those who delay enrollment.

- Do insurance subsidies or other incentives encourage enrollment among not only the unhealthy but also the healthy?
- Does the proposal require the individual to obtain coverage?
- Does the proposal require an employer to provide coverage?

Are risk-sharing provisions included?

In the absence of universal coverage, some degree of adverse selection is inevitable and should be planned for. Risk adjustment and/or other types of reinsurance arrangements can reduce the incentives an insurer might have to avoid enrolling high-risk individuals. For instance, risk adjustment would adjust the payments to insurance plans to account for the health status of plan participants. As mentioned above, reinsurance is another option to limit insurers' downside risk. Under aggregate reinsurance, all or a percentage of a plan's total claims exceeding a predetermined threshold would be reimbursed. Individual reinsurance can reimburse a plan for high claims from individual plan participants.

- Does the proposal include risk adjustment to reduce the incentives among insurers to avoid high-risk individuals?
- Are reinsurance provisions included?

What Are the Costs to States?

Medicaid and coverage under the State Children's Health Insurance Program (SCHIP) are not reaching all the people they are designed to serve for many reasons. With state budget deficits increasing, states may have modified their Medicaid and SCHIP programs to reduce costs. These cost reductions have been in the form of increased eligibility requirements or the termination of eligibility categories, decreased benefits or provider fee schedules, and more aggressive contract negotiations with managed care plans that may administer a state's Medicaid or SCHIP program. Managed care plans may in turn withdraw from providing Medicaid or SCHIP coverage.

- Will the proposal increase Medicaid or SCHIP coverage through increased benefits, provider fee schedules, decreased eligibility requirements, or new eligibility categories?
- Will the proposal increase or decrease the financial burden to states and the federal government?

Will enrollment in public programs increase?

Implementing broader outreach programs to reach those who are eligible for public programs but do not know it may decrease the current number of uninsureds.

- How does the proposal address bringing greater awareness of Medicaid and SCHIP programs to those who are eligible?
- Will administrative language and cultural barriers be reduced so that Medicaid and SCHIP enrollment will be more efficient and effective?

What Is the Impact on Regulation?

Individual states are responsible for regulating the individual, small- and large-group insurance markets and monitoring the financial solvency of insurance companies. ERISA controls many aspects of self-funded programs provided by larger employers.

- Will the proposal affect each state's ability to regulate its local insurance market?
- Will the proposal reduce or increase an individual state's regulatory burden?
- Which states will have to increase/decrease their regulatory activities as a result of the proposal?
- Will ERISA need to be modified to allow any changes required under the proposal?
- Can the federal government handle any new requirements?

How Will the Proposal Be Funded?

Proposals that include public program expansions or subsidies for private insurance coverage will need to be funded by state and/or federal revenues. Consideration of funding sources should also include an analysis of the sustainability of the funding over a relevant period of years and the proposal's impact on administrative costs.

- How will funding be provided?
 - ◆ Federal government
 - ◆ State governments
 - ◆ Individuals (e.g., taxpayers, program participants, uninsured, etc.)
 - ◆ Employers (e.g., insured, self-insured, not currently offering insurance, etc.)
- Will funding be on an annualized basis or will it include long-term funding mechanisms?

What Is the Impact on Overall Health Costs?

According to the Centers for Medicare and Medicaid Services (CMS), the United States spent \$1.6 trillion on health care in 2002 or 14.9 percent of gross domestic product (GDP). CMS projects spending to increase to \$3.4 trillion, or 18 percent of GDP, by 2013. Because rising health expenditures have contributed to insurance being less affordable and less available, managing the growth in health care costs is key to long-term solutions for reducing the number of uninsured. Medical malpractice reform, better contract negotiations with health care providers, more consumer awareness of the cost of healthcare, and others have all been suggested as potential ways to stem this growth.

- How will the proposal address the rising costs of health care?

Conclusion

Whether a proposal to reduce the number of uninsured is successful depends on many factors. We have tried to present many, but by no means all, of the issues that need to be considered as Congress drafts and evaluates proposals to extend health insurance coverage to the uninsured. Addressing these issues will improve the likelihood that such proposals will have a significant affect on reducing the growing number of Americans who lack health insurance coverage.