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ACTUARIES

What's Really at Stake  
in Health Care Reform—1994 and After

A Summary of Major Findings  
of the  
American Academy of Actuaries

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The American Academy of Actuaries is a national organization formed in 1965 to bring together into a single entity actuaries of all specialties within the United States.

In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state officials on actuarial issues.



In 1994, the Academy's sixteen work groups produced a series of monographs on health care reform issues. This summary focuses on the findings from those monographs that are most central to the ongoing health care reform debate. The complete series, which includes analyses of budget development and enforcement, a review of premium estimates in the Clinton administration's proposal, administrative cost implications, ERISA, transition rules, implications for the Medicare program, and long-term care, is available upon request from the Academy.

A full list of these monographs appears at the end of this document



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## INTRODUCTION

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Already, last year’s deliberation on a radical, top-to-bottom restructuring of the entire U.S. health care system seems a great distance behind us. Yet many people remain firmly convinced that the present health care system is in need of significant repair. Regardless of the particular yardstick used—annual increases in costs, number of uninsured, percentage of workers “job-locked” due to pre-existing conditions—the system may seem unable to deliver full value for the enormous expenditures required to keep it going.

While the 1994 health care reform debate, which was largely fueled by the President’s 1,300-page Health Security Act, is over, many of the ideas about how to make the health care system work better are still under serious consideration.

To tease out the myriad ramifications of the elements of reform, the American Academy of Actuaries assembled sixteen work groups, each of which focused on one aspect of reform (the standard benefit package and community rating, to cite two examples).

Actuaries bring unique talents and expertise to this task: They provide the technical underpinnings for every aspect of health care financing in the United States. Further, because their work is based on actuarial principles—rather than a need to supply a backdrop for a particular scheme for health care reform—actuaries’ analyses can serve as an objective tool in debating policy.

The fruit of the Academy’s efforts was a series of sixteen monographs, which detailed the actuarial implications of health care reform plans. But also analyzed were some general issues that will be central concerns in contemplating any reforms to the current health care system.

Perhaps our choices about what sort of health care environment we opt to live under will, in the end, be motivated more by notions like equity and convictions about freedom of choice. But we should know upfront what the possible consequences of those choices will be. Might, for instance, the scheme we enact have dire consequences for the financial health of HMOs?

Upon many of the most fundamental issues in health reform—costs for all parties concerned or possible effects on availability of providers—actuaries have important things to say.

This summary focuses on findings from the Academy monographs that are most central to the ongoing health reform debate. A complete version of the series, which includes analyses of budget development and enforcement, a review of premium estimates in the President’s proposal, administrative cost implications, ERISA, transition rules, implications for the Medicare program, and implications for long-term care, is available on request.



## GROUNDWORK FOR REFORM

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Health care reform designed to keep the private health insurance market intact must incorporate measures to ensure that the market remains fiscally sound through a period of dramatic change. This effort starts with understanding the various risks that health insurers bear and the steps that must be taken to account for those risks in setting the goals of health reform.

### Financial Risk and Health Plan Solvency<sup>1</sup>

Health insurers are in the business of guaranteeing reimbursement for covered health benefits, or guaranteeing the direct provision of those benefits through a health maintenance organization. Both of these guarantees carry financial risks, which, if poorly managed, could precipitate the insolvency of a health plan. Not all plans are affected by each and every type of risk that exists in the insurance market. Nevertheless, these risks must be understood and managed in order to prevent insolvency, particularly in a reformed marketplace.

In a reformed health care system, the chances that a health plan will fail because of excessive risk could be greatly reduced by setting uniform national solvency standards. The standards should be based on the amount of risk a plan assumes, and should be used to determine whether the entity is financially fit to operate. The overall goal of a solvency structure under health care reform would be to provide a regulatory and industry framework to measure, monitor, and ensure that health plans have the financial capacity to provide health care for their members on an ongoing basis.

The Academy has developed a suggested framework for solvency standards:

- Solvency should be monitored and regulated at the health plan level by regulators, who are best able to respond to capital and business needs.
- Standards of solvency should be applied uniformly across all health plans, and should not vary by type of sponsor or by state. This objective would require a standardized financial statement, which does not currently exist. The standards should include minimum capital requirements based on the level of risk a health plan assumes.
- Plans should be required to get annual reports on surplus and rate adequacy from a member of the Academy. The report should evaluate the plan's short- and long-term financial status under a range of economic conditions. Actuarial reports are particularly important because they estimate future contingent liabilities and determine whether health plans have adequate reserves and premiums to cover future losses. Rate reports are needed to ensure that health plans don't purposely underprice their products to gain market advantage. Otherwise, irresponsible plans could gamble on gaining market share. If they lost, the rest of the market and the public would suffer the consequences—more financially weak plans and an increased incentive to deliver less than promised.

In general, health plan risks fall into the following categories:

***Insurance Risks.*** These risks stem from the insurance process itself, in which risks are pooled, and the average cost of paying future benefits is projected and funded in advance through premiums. Foremost among these risks is the chance that premium collections will fall short of the amount needed to cover actual costs. This can happen because costs were underestimated at the outset, or because of an unusually large number of high-cost claims.

The risk of inadequate income could be greatly exacerbated by health reforms that limit plans' ability to raise premiums, or impose unexpected assessments to finance high-risk populations or by the currently unknown risks associated with providing health benefits for the uninsured.

***Managed Care Risks.*** Managed care, which can take many forms, is designed to influence the cost and quality of health care services. A managed care network integrates the financing and delivery of health services through agreements with selected providers to furnish comprehensive benefits, often for fixed or discounted prices. Managed care enrollees get sizable financial incentives for using network providers.

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<sup>1</sup>Analysis does not include self-insured employer plans.



The financial risks associated with managed care include the possibility of providers in the network going bankrupt. The increasingly common practice of managed care plans guaranteeing only limited rate hikes to large buyers also increases providers' financial risk.

***Business Management Risks.*** One of the most basic business risks is that management will not have the requisite experience to manage the plan effectively. Expertise in marketing, advertising, benefit design, legal issues, accounting and auditing, claims processing, and government reporting are all essential to health plan management. Other risks in this category include insufficient capital and surplus levels, and the inability to draw enough members and premium dollars to cover fixed costs.

***Antiselection Risk.*** When people have a choice of health plans, they will generally pick the one that's most financially beneficial to them. That same choice is generally financially harmful to the health plan. Actuaries call this phenomenon "adverse selection" or "antiselection." Management of this risk is a major aspect of the professional services that actuaries' offer to benefit providers.

***Regulatory and Legal Risk.*** One major risk that is threatened by health care reform is that of rate caps which may limit the income of health plans. In the absence of an effective mechanism to fund or otherwise pass that risk along to others, premium caps may increase the risk of health plan insolvency. Other mandates regarding premiums, benefits, or other contractual provisions may have similar impact.

***Investment Risk.*** The basic formula underlying corporate solvency is: (Assets) minus (Liabilities) = Capital and Surplus. A corporation's assets may take various forms. There are financial risks associated with these assets—that the assets will not produce income as expected or be worth what was expected. An additional risk is that the cash flows from the asset will not be available at the appropriate time.

## Health Plan Pricing

Most health plans divide the general population into three major categories of business: individuals, small groups and large groups. Consumer values and expectations, along with health plans' products and pricing, differ among these categories. Traditionally, health plan prices have been based on classifications—such as age, sex and health status—of groups and individuals. Premiums are determined according to the particular risk factors of each class within those categories. The system, while complex, allows an added level of precision in setting premiums.

While some degree of uncertainty is innate to any premium structure, in some variations of a reformed health care system that level of uncertainty could soar. A fundamental factor in determining the cost of a health care plan is the profile of the population selecting the benefits. In a system in which everyone is guaranteed health coverage, for example, health plans may have to provide coverage for a population with which they have little or no experience.

The health plan proposed by President Clinton, for example, would have given individuals the ability to choose their health plans, rather than having their employers choose for them. Such a change would give health plans little control over the population that selects them. This would alter carriers' demographics and health characteristics in unpredictable ways, and insurers would assume significant pricing risk until their risk pool stabilized. Standardized benefits may heighten pricing difficulty: health plans whose benefits did not include all of the items in the standardized plan would have no historical experience data or experience on which to base new prices.

Furthermore, changes in the way providers are paid could compound pricing uncertainty. Provider payments comprise the bulk of health plan expenses. Changes in payment methods and amounts would make it more difficult to estimate expenses, and the pricing structure needed to cover them. For example, there are currently big differences in provider fee schedules within regions. The uniform regional fee schedule proposed in the President's plan, then, would redistribute revenue among providers, with uncertain ramifications for existing networks and health plans.

Pricing constraints, such as global health care budgets or premium caps, would further jeopardize the ability of health plans to remain solvent, since the limits could prevent some plans from collecting enough money to stay in business.



## INSURANCE MARKET REFORM

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In 1993, national health spending reached \$884.2 billion, with private health insurance accounting for 34% of the total, according to the Health Care Financing Administration (HCFA). The proportion of nonelderly uninsured in the total U.S. population, meanwhile, rose from 16.6% in 1991 to 17.4% in 1992. In its report on the spending data, HCFA suggested that the increase in the uninsured could reflect “an increase in the lack of affordable private health insurance coverage.”

A central goal of most reform proposals—outside of those that would turn all health care financing over to the federal government—has been, and will likely continue to be, making private insurance more affordable and widely available to lower- and middle-income Americans. Past initiatives have attempted to achieve this goal in a variety of ways. The Academy has analyzed some of the key options for private insurance reform, as well as the issues that should be considered amid such changes.

### Community Rating

In an effort to make private health insurance more affordable, many health care reform proposals promote community rating, or a variation of it, as the best way to achieve that. This rating method eliminates many of the factors, such as health status, which boost premiums for higher-risk groups and individuals. Pure community rating allows a health plan to vary its premiums for three factors only: family status, geographical area, and plan design. In contrast, community rating by class permits further variations for age and sex.

Many states that have enacted small group rating reforms, however, have found that a “big bang” approach can induce significant rate swings. Since community rating lumps all risks into a single category, premiums for high-cost individuals and employers drop. But, correspondingly, the healthier populations have to absorb significant rate hikes. For this reason, many states that want to get to pure community rating have opted to do so over a three-year transition period. During that time, rate differentials are gradually narrowed, to a point where pure community rating is achieved.

The Academy’s analysis of the impact of community rating reflected the drastic changes in premiums that could result absent a transition period. The analysis assumed that no individual or employer remained uninsured and that no adjustments were made to correct for risk variation among health plans. The Academy’s analysis reflects the estimated initial impact of converting to pure community rating and community rating by class on individuals and employers with fewer than 25 workers.

**Pure Community Rating.** The Academy found that, overall, if pure community rating were mandated, about 20% of the privately insured, nonelderly population would see their premium increase by more than 20%; about 12% would see premiums decline by more than 20%; and roughly 40% would get little or no rate increase.

For small employer groups, pure community rating would boost premiums by more than 20% for 20% of all businesses, while 8% would get the same level of decrease in rates. Among individual policyholders, 26% would get an increase of more than 20%, and 18% would get a decrease of that amount.

**Community Rating by Class.** Under community rating by class, overall, 9% of the nonelderly, privately insured population would receive premium hikes of more than 20%, while 6% would get equivalent decreases. Some 6% of small employers would get more than a 20% increase, while 4% would get more than a 20% decrease in rates. Among individuals, 11% would receive increases of more than 20%, and the same percentage would receive premium decreases of that magnitude.

**Subsidies.** In any system of community rating, subsidies would occur in varying degrees. In general, the young would subsidize the old by paying premiums higher than their actual risk level, males would subsidize females who are generally higher cost during child-bearing ages, and the poor may subsidize the wealthy, since younger workers generally earn less than older workers.



## Assessing and Adjusting for Health Risks

In a system of community rating, health plans need some method of adjusting their income to match—or at least approximate—their risk. Otherwise, the fiscal integrity of the health insurance system and the goals of health reform will be threatened. For example, if health plans were prohibited from basing premiums on age, then each plan would have to choose one average rate that implicitly assumed the average age of its insureds. Plans that could attract younger, lower-cost members would turn a higher profit, or sharpen their competitive edge by offering lower rates. In the absence of a mechanism to correct for risk, the result would be a health care system in which insurers had strong incentives to attract the lowest risks and avoid high-cost risks—the very situation health reform is designed to avoid.

This problem can be addressed with an actuarial technique called “risk adjustment.” The Academy considers risk adjustment crucial in a reformed health system that restricts carriers’ ability to link premiums directly to the risk level of groups or individuals.

Currently, the health risk posed by individual or group members of a health plan can be determined by the age, sex, health status, family composition, and other factors that have an impact on the amount of health care they are likely to need. The level of this risk bears directly on the benefit costs that a health plan may incur. To remain financially sound, then, health plans must assess the risk level of the population they insure and make sure that the premium income is adequate to cover the potential costs of that risk.

There are many different methods for calculating risk. For example, an assessment based on self-reported health status would assign a risk score based on what people included in a report on their own health. Risk could also be assigned by using demographic factors such as age, sex and family status. A diagnosis-related assessment method would determine risk according to the mix of illnesses, or the number of hospitalizations, an individual or group had experienced in the previous year.

In a reformed system that discourages or bars health plans from being selective about the risks they insure and from correlating premiums directly to the risk of the population insured, risk adjustment is needed to reallocate income among the health plans to match their allocation of risk. The adjustments offset differentials in the average costs that health plans incur resulting from variations in the risk level of the population they insure. Adjustments are made through a risk pool, which is administered by the state or other contracting agency. Plans with low-cost risks pay into the pool; plans with high-cost risks draw funds from it. This transfer of income among carriers can be done prospectively, through upfront transfers of premium among plans, or it can be done retrospectively, by settling accounts at year end.

Health plans may also use some amount of upfront risk adjustment, which is built directly into premiums and reflect the particular risks—such as family composition and geographic location—of an individual or group.

Risk adjustment mechanisms serve several purposes, including:

- Reducing the effects of risk selection. The adjustment allows carriers to compete on the basis of medical and administrative efficiencies, as opposed to how skilled they are at selecting the lowest-cost risks.
- Compensating carriers fairly and equitably for the risks they assume.
- Maintaining consumer choice of health plans based on medical and administrative efficiencies.
- Protecting the fiscal soundness of the health insurance system.

Health risk adjustment mechanisms can also help in analyzing medical outcomes and cost differentials among providers. For example, if two hospitals or doctors show widely divergent costs, the differential could be due to different provider practices or to the particular mix of illness (case mix) among the patients treated. Health risk adjustment mechanisms can be used to adjust for case mix differences, which facilitates a more objective and accurate comparison of providers.

No single risk adjustment approach has been sufficiently tested for accuracy, cost, and administrative efficiency to recommend it as the best option. However, the Academy has developed three models that illustrate how health risk assessments and adjustments are currently being used in some states, or how they might be used in a reformed system. Each model is discussed below.



***State Reinsurance Model.*** This approach was based on model regulations developed by the National Association of Insurance Commissioners. Twenty states have adopted a similar program. Under this model, states create a pool of carriers who act as a reinsurer for groups of 25 or fewer employees. The reinsurance offered through the pool essentially provides insurance for a health plan's high-risk business. The health plan pays for reinsurance at rates that are generally higher than its own gross premiums. This discourages dumping lower-risk business into the reinsurance pool.

Reinsurance does not cover all of a health plan's costs for claims, which further encourages carriers to use it with discretion. Reinsurers base their payment on benefits in a benchmark plan, developed by the state. The benchmark plan might, for example, have a \$500 deductible and 40% coinsurance rate, with a \$50,000 benefit limit per calendar year. All carriers in the state must offer benchmark products, without regard for a particular group's health status. In cases where a health plan's coverage is richer than the benchmark, carriers must pay the difference in benefits. Reinsurance also has its own copayments and deductibles. For example, reinsurance might cover 90% of a claim up to a limit, after a \$5,000 deductible.

Health plan rates may be adjusted upfront according to age, sex, geography, family composition and a variety of other factors. Some variation for health status may also be allowed. Of the three models, this allows the highest correlation between premiums and risk characteristics of the insured group.

***Standard Community Rating Model.*** Under this model, which New York began using on April 1, 1993, health plans charge all of their members the same basic rate, with some adjustments allowed for geography and family composition. In this type of system, which applies only to individuals and groups with fewer than 50 employees, risk adjustment is needed to offset variations in the composition of the various carriers' risk pools.

Based on the actual enrollment by age and sex of a carrier's insured population, payments are made from a state risk pool on a quarterly basis to those with higher-cost risks. The quarterly payments prevent cash flow problems. At the end of the year, risk pool payments are reconciled to correct under- or overpayments. In New York, for example, carriers with a relatively older population receive risk pool payments. Under current law, transfers may be as much as 3 percent to 15 percent of premiums.

In addition, there is a pool for specified conditions used to spread the cost of certain catastrophic cases across the state's insured population. Contributions to the pool come from all carriers, and this cost may be passed on to consumers in the basic community-rated premium.

***Managed Competition Model.*** This model includes a standardized benefit plan, which goes a long way toward eliminating adverse selection from the market and allows the most effective use of risk adjustments. For example, if all health plans offer prescription drug benefits, the risk of attracting high utilizers of that service is leveled.

Under this model, individuals and small groups of 50 or less would join a statewide or regional purchasing group. Health plans could be permitted to vary rates upfront by age, sex, geography, and family size, with a prospective adjustment for self-reported health status. Alternatively, plans could use medical underwriting to assess their risk level and make premium transfers accordingly.



## HEALTH CARE ALLIANCES (PURCHASING GROUPS)

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To increase the purchasing clout of health insurance buyers—particularly small groups—many health reform proposals include some form of state or regional purchasing groups, (termed “regional health alliances” in President Clinton’s reform plan). These groups enable buyers to pool their negotiating ability, thereby building strength through numbers and spreading their risk over a broader population.

### Purpose of Alliances

Depending on the role that purchasing groups assume in a particular reform proposal, they can serve a variety of purposes, including:

- Promoting and, in some cases, guaranteeing universal health coverage.
- Stimulating free-market competition in the health care and health insurance industries.
- Spreading risk for pricing purposes, to ensure that coverage is broadly available at the lowest prices possible.
- Achieving economies of scale and promoting efficiency in the administration, distribution and marketing of health coverage.
- Extending the economies of scale and bargaining power available to large buyers of health care coverage to small employers and individuals.
- Controlling health care costs and prices.

To achieve the economies of scale and bargaining power sought through a purchasing group, a large number of people must get their health insurance through it. This has raised in the past, and will likely continue to raise in the future, questions about which employers would have to be included in the alliance.

If local, state and federal employees and unemployed individuals are included, regional alliances could achieve economies of scale, stable risk pools and adequate bargaining power if only employers with fewer than 25 workers were included. Even in a sparsely populated state like Wyoming, this threshold would create a statewide alliance composed of 219,000 members. In California, it would yield 11.6 million members.

Achieving more ambitious goals through an alliance may, however, require a higher-size threshold for employer groups. President Clinton’s plan, for example, would have required that all groups with up to 5,000 employees purchase health care through an alliance. Larger groups may be desirable if the health alliance takes on such functions as funding subsidies for retirees, low-income or disabled individuals, promoting universal coverage and subsidizing health insurance for targeted segments of the population.

Furthermore, if the Medicaid population is included in the alliance, the scope of membership may have to be broadened to include all employers. Medicaid recipients generally incur higher medical costs than the overall insured population. If alliance members were the only ones subsidizing higher-cost Medicaid enrollees, virtually all employers would have to participate in the alliance to keep costs manageable. For example, while representing only 16% of the nonaged Medicaid recipients, disabled individuals incur 54% of nonaged Medicaid health care costs. The per capita costs of these 4 million disabled is over six times that of the nondisabled Medicaid population.

### Purchasing Group Structure

Health care costs vary substantially from one region of the country to another. This can also be true within geographic areas. In California, for example, the highest-cost area for fee-for service premiums for small groups in the state is 35% higher than the average per capita health insurance costs, while the lowest cost area is 12% below these average costs (HMO premiums in California have very little variation by region for small employers.). The range in per capita health insurance costs is even greater in New York. The highest-cost area is 30% higher than the average health insurance costs, and the lowest-cost area is 23% below these average costs.



In a community-rated environment that does not allow for geographic variation, some residents of high-cost areas would pay substantially less than the actual cost of their care, while the opposite would be true of residents in low-cost areas. The inability to vary rates geographically would also force health plans to compete on an uneven playing field. For example, health plans in high-cost areas could have trouble competing with health plans operating in broader or lower-cost areas.

To foster competition among purchasing groups and avoid cross-subsidies among various geographic areas, it would be necessary to either preserve geographic rate differences, or use a risk adjustment mechanism to compensate for major cost differentials.

Other options for addressing these issues would be creating multiple purchasing groups in each state or requiring all participating health plans to serve the entire alliance area.

## Mandatory Versus Voluntary Participation in Alliances

Another key structural issue is whether participation in purchasing groups should be mandated for certain groups and individuals, or whether membership should remain voluntary. This decision has crucial implications for how successful the alliance will be in achieving its objectives and in determining what these objectives should be.

Only mandatory alliances, for example, would be able to meet the goal of promoting universal coverage in a reformed health system that guaranteed health insurance for all citizens. Having a single point of control for all but very large groups would be a convenient way to monitor compliance with the mandate and to spread the cost of high-cost populations throughout the insured population. Mandatory alliances would also facilitate creation of a stable risk pool and government-imposed price controls.

Absent comprehensive health reform, a voluntary alliance would neither promote universal coverage nor facilitate price controls, except to the extent that it made coverage more affordable and available. Furthermore, in a state where alliances were required to offer community rates, take all comers, and offer all individuals the choice of all health plans in the alliance, the alliance could be at a severe disadvantage. Health plans outside the alliance could select the best risks in the state and set their prices accordingly. Purchasing groups in this scenario would make scant gains in efficiency, since they would be hindered by the existence of different rules for health plans outside the alliance. If, however, all health plans, including those outside of voluntary alliances, were subject to the same rating and risk selection standards, many of these drawbacks would be mitigated.

## Administrative Cost Savings

Any health care reform proposal that relies on a managed competition approach should consider carefully several issues:

- Duplication of regulation;
- Duplication of administrative function between purchasing groups, plans, employers and states;
- Clarity in delineating responsibility for functions; and
- Incorporation of incentives for investing in systems that improve the quality of care and reduce administrative expenses.

In addition to these issues, two other important points should be emphasized. First, standardization can be very important both for reducing administrative costs and helping make the medical financing and delivery system more manageable overall. Greater uniformity of regulation among states can be an important part of standardization.

Second, an accurate system for tracking enrollment is essential for premium collection. Any reform scheme that places the enrollment function with an organization other than the health plans and premium payers can work smoothly only if plan enrollment is accurately recorded and all parties are immediately informed of any change in enrollment status. Otherwise, the systems for collecting premiums and paying providers break down. Premium payers are not certain they are paying for the correct persons or in the correct amount. Health plans are also uncertain of who is on their rolls at any given time and cannot process claims. To protect their financial interests, both premium payers and health plans will be forced to maintain duplicate recordkeeping systems and invent methods for the ongoing validation of those records. Uncertainty also will be created for the public and medical providers, both of whom will come to expect frequent disputes over who is responsible for paying particular medical bills.



## BENEFIT DESIGN ISSUES UNDER HEALTH CARE REFORM

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Many of the health reform proposals that have been debated included a guaranteed standardized benefits package. This is a package of covered services and cost sharing provisions mandated by government as a standard or minimum level of coverage. Guaranteed standard benefit packages are intended to ensure a minimum level of coverage and to control cost by facilitating comparison-shopping among plans. A guaranteed standard benefit package consists of a list of health care services to be covered, along with limitations on reimbursement such as copayments, maximum payment limits, and coverage exclusions for certain procedures. A key element of the package is the type and extent of managed care included.

### Advantages and Disadvantages of Guaranteed Standardized Benefits

Guaranteed standardized benefits offer many advantages, including:

- The security of continuous, uniform coverage, even when employment or residence changes.
- A uniform package of benefits mitigates risk selection, which occurs in a choice environment.

There are also several disadvantages to such a policy:

- If the package is very specific about covered services, it is likely to generate intense controversy and debate about which benefits and providers will be covered.
- If the package is vague about coverage, it will be open to different interpretation by different health plans. This could lead to variations in benefits, and adverse selection leading to higher costs for providing coverage.
- Guaranteed benefits remove most of the coverage choices that exist today in the health insurance market. Premiums could increase significantly for individuals and groups that had chosen high-deductible or limited-benefit plans in order to keep their costs down.
- The process of benefit design will become enmeshed in the health care policy-making process. As a result, changes and additions to the package will come more slowly than before.

One important aspect of making the transition to a guaranteed benefit plan is the degree of change that people will experience when switching from their current benefits. This is extremely difficult to assess, given the myriad combinations of benefit offerings, covered services, reimbursement arrangements and provider networks available in the health insurance market today.

Designing a guaranteed standard benefit package within a limited health care budget is not an easy task. The questions facing policy makers are: what coverage to provide; who can be covered; and who is able and willing to pay for it.

### Impact of Mental Health Benefits on Health Plan Design

There are many different benefits that are part of some of the guaranteed standard benefit packages that have been debated. Mental health benefits is one of them; it serves as a good example of decisions that will need to be made when designing a guaranteed standard benefit package.

One of the primary challenges in designing mental health benefits under a managed care program is balancing the value that society places on consumer choice of providers with the cost savings that are possible when that choice is restricted. A related challenge is evaluating the social costs of limiting mental health coverage, including lost productivity from those who go without treatment, antisocial acts, the increased cost of treating physical symptoms caused by untreated mental illness, and the increased use of other social benefits such as welfare and law enforcement.



One concern in designing mental health benefits in a managed care setting is the potential for health plans to “game” the system. For example, plans might reduce the number and types of mental health care providers to discourage enrollment and utilization. Substance abuse treatment is one such area of concern. Many plans limit the number of these treatments per lifetime. It is unclear whether removing coverage for these services would either reduce the number of needed treatments or shift the cost from society to the patient.

Predictions on the future cost of any health care program can vary widely, but mental health coverage is particularly sensitive to external variables, such as social perceptions, levels of employment, epidemics, and even the weather. The cost of treating severely mentally ill patients, for example, is currently borne primarily by states. Moving these individuals into health plans at a community rate and charging for inpatient care at retail per diem rates could boost this cost dramatically. Case management can have a significant impact on the cost of providing mental health services. Although there are differences in the types of case management provided by state agencies and insurance companies, both address the need for ensuring effective care.

## THE HEALTH CARE REFORM DEBATE CONTINUES

These and other pressing issues will continue to challenge policy makers as they consider how to reform the nation's health care system. As the debate proceeds, at the national and state levels, the Academy's work, too, will continue.

This year, the Academy will add to its health care monographs series several new titles examining what have emerged as the key national health care issues: medical savings accounts, guaranteed issue/universal access, Medicare changes, and managed care effectiveness. In addition, the Academy will release several monographs prepared to address specific state health care reform efforts: community rating, any willing provider legislation, and Medicaid changes. These efforts will complement the next phase of the health care reform debate.

A list of the 16 monographs completed in 1994 appears at the end of this summary.



## MONOGRAPH SERIES ON HEALTH CARE REFORM

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- Monograph Number One, *Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Effective Health Care Reform*, discusses the importance of risk adjustment mechanisms under a managed competition model. It describes some general approaches to risk assessment and risk adjustment, identifies the pros and cons of several approaches, and suggests some potential implications.
- Monograph Number Two, *Standard Benefits in Health Care Reform: The Impact and Cost*, addresses some of the issues that affect the design and cost of standard benefit plans, and provides some estimates of the relative cost of different benefits in four sample plans.
- Monograph Number Three, *An Analysis of Mandated Community Rating*, describes the initial premium rate impact that a mandatory pure community rating or community rating by class system would have on various insured populations with a focus on the small employer market.
- Monograph Number Four, *Actuarial Solvency Issues of Health Plans in the United States*, addresses actuarial issues related to monitoring and regulation of insured health plan solvency. Proposed changes in the private insurance market have raised the concern that many health care plans could become insolvent, particularly at the outset of health care reform.
- Monograph Number Five, *Actuarial Issues Involved in Evaluating a Guaranteed Standard Benefit Package Under Health Care Reform*, discusses the actuarial issues involved in evaluating the design of guaranteed standard benefit packages, with a particular focus on the Health Security Act of 1993.
- Monograph Number Six, *Actuarial Issues Related to Budget Development and Enforcement Under Health Care Reform* examines the elements of the Health Security Act of 1993 that would be in place to control future increases in health care costs. Specifically, it addresses the actuarial implications of using a premium cap and an assessment mechanism to achieve a global health care budget in the United States.
- Monograph Number Seven, *A Review of Premium Estimates in the Health Security Act*, reviews the assumptions and methodologies used by the Clinton Administration to develop premium estimates in the Health Security Act.
- Monograph Number Eight, *Actuarial Issues in Designing Mental Health Benefits Under Health Reform*, examines the benefit design and cost issues for the mental health benefits proposed under the Clinton Administration's Health Security Act.
- Monograph Number Nine, *Administrative Costs for Regional Alliances and Health Plans Under the Health Security Act*, focuses on the functions necessary to administer health alliances and health plans under the Health Security Act of 1993.
- Monograph Number Ten, *Actuarial Issues Related to Pricing Health Plans Under Health Care Reform*, discusses the methods currently used by health plan managers to price health plans and how health plan premiums will be set under a reformed health care system.
- Monograph Number Eleven, *Actuarial Perspectives on Regional Health Alliances under Health Care Reform*, examines the intended purposes of regional health alliances and discusses the implications of various organizational structures on these purposes. In addition, the monograph discusses the size and membership of health alliances, health alliance structure, health alliance administration, and alternatives to health alliances.
- Monograph Number Twelve, *Actuarial Implications to ERISA under the Health Security Act*, addresses changes proposed in the Health Security Act to ERISA and the impact they would have for employers currently subject to ERISA. The monograph focuses on the provisions of ERISA that employers use in managing the costs of health benefit plans through self-insurance or through innovative arrangements with insurers and health maintenance organizations.

# WHAT'S REALLY AT STAKE IN HEALTH CARE REFORM



- Monograph Number Thirteen, *Actuarial Issues Related to Transition Rules Under Health Care Reform*, identifies issues which should be considered under proposed transition rules and the possible consequences of those rules. While the monograph refers to specific provisions of the administration's proposal, the general findings in the monograph are applicable to any major reform that relies on the private market.
- Monograph Number Fourteen, *Health Risk Assessment and Health Risk Adjustment—Current Initiatives*, gives an overview of state initiatives in risk adjustment, focusing on New York and California. It also reviews the experiences of risk adjustment in the Netherlands. The overview provides lessons to be learned when implementing and/or considering risk adjustment provisions in legislative reforms.
- Monograph Number Fifteen, *Actuarial Implications for the Medicare Program Under the Health Security Act*, examines three major ways that the Health Security Act would have impacted the Medicare program: 1) Expanding Medicare Part B to include a prescription drug benefit; 2) Decreasing program costs by reducing provider reimbursement levels and providing incentives to promote primary care; and 3) Enrolling beneficiaries in regional health alliances, via state-developed programs.
- Monograph Number Sixteen, *Long-Term Care: Actuarial Implications of Health Care Reform*, examines current and projected data on the size of the elderly population needing long-term care (LTC) and analyzes key LTC features of the Health Security Act, including informal care supplementation, inflation protection, and nonforfeiture. Two of the monograph's conclusions are (1) Before setting in place any permanent program to finance LTC, the impact of future rapid growth in needs for LTC services must be taken into account; and (2) Further research and experimentation is needed to compensate for the current lack of reliable data that can be used to accurately estimate the costs of both federal and private LTC benefit plans.

*The health care reform monographs listed above are available  
from the American Academy of Actuaries.*

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