AMERICAN ACADEMY of ACTUARIES

Committee on Ways and Means
U.S. House of Representatives

Hearing on Health Care Tax Credits to Decrease the Number of Uninsured

February 13, 2002

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Introduction

The American Academy of Actuaries appreciates the opportunity to comment on issues related to providing tax credits to decrease the number of uninsured. The Academy was asked to address three issues related to options for expanding health insurance to displaced workers and the expansion of high-risk pools: (1) whether a tax credit would result in a corresponding increase in premiums on the policies that displaced workers could purchase, (2) whether costs would increase for employers and/or insurers if displaced employees were not required to complete their COBRA eligibility before they could purchase a HIPAA qualified health plan in the non-group market using their government subsidy, and (3) the level of funds necessary to provide a premium buy down for participants in high-risk pools. We will address each of these issues in turn.

Will Insurers Increase Premiums in Response to Tax Credits for Displaced Workers?

Whether insurers will increase premiums in response to providing tax credits for displaced workers depends on the duration of the credit, whether the credit is temporary or will be available to all future displaced workers, and any underwriting restrictions imposed on non-group insurers. Generally, credits of limited duration (e.g. 12 months) likely will have less effect on premiums than credits of longer or unlimited duration. Similarly, credits that are temporary (i.e. available only to workers displaced within a given time frame) will have less effect on premiums than credits available to all future displaced workers. Premiums for non-group insurance issued on a guaranteed basis may be more affected by tax credits than premiums for non-group insurance that is underwritten.

H.R. 622 would provide tax credits equal to 60 percent of premiums for up to 12 months for workers losing their jobs between March 16, 2001 and December 31, 2003. Credits can be applied to the 2002 and 2003 tax years. Non-group coverage is available to displaced workers on a guaranteed issue basis if they are HIPAA eligible,[1] but the only plans available on a guaranteed issue basis are the HIPAA plans in their state of residence. Given this scenario, it is unlikely that insurers would significantly increase premiums if tax credits were provided to these displaced workers.

Most non-group policies are written on an individual policy form. These policies are regulated by state insurance departments that must approve the rate levels. The insurance departments have criteria that these types of policies must meet before the department will approve a rate increase. These criteria are based on the experience of the contract and are compared against required loss ratios (incurred claims divided by earned premiums). They would not allow for a rate increase without justification based on claims experience. Generally, states use past claims experience, but expected future changes in experience may be submitted in some instances. In other words, companies are not free to set the rates at whatever level they choose. Furthermore, all policyholders of similar demographics must be charged the same premium. In other words, one person could not be charged a higher premium than another person with similar demographics simply because he's a displaced worker. For these reasons, individual policies would not see a significant increase in premium if a tax credit were made available.

[1] The bill changes the prior coverage requirement to be HIPAA eligible from 18 months to 12 months for these people.

In some states, policies that are not regulated like individual policies can be sold in the non-group market. These are written using a trust vehicle. The rates on these products can be set by the company without approval from the insurance department. However, much like any other industry, competition will act to keep rates low. If Company A raises its rates above Company B, it risks losing its customers.

Some states do not use a high-risk pool for the HIPAA guaranteed issue mechanism. If for any reason a certain company in such a state would get a disproportionate amount of HIPAA eligibles, the company could affect its overall claims experience enough for it to require an increase in rates. The increase needed would depend upon the proportion of HIPAA eligibles it obtains compared to what it had planned for in its pricing. Even if this rate increase should be needed, it likely would be much lower than the level of the 60 percent tax credit. In these states, both HIPAA eligible and non- eligible people are subject to extra premium surcharges based on their health conditions.

In states that use high-risk pools as the HIPAA mechanism, an increase in the number of insureds in these mechanisms may increase the amount of funding required. This could increase the assessments made to insurance carriers. Currently, the level of assessment is usually around 1 percent of total premiums charged by the carriers. Even if the assessments doubled or tripled over time, which would seem unlikely, the rate increase this would cause would be minimal compared to the 60 percent tax credit.

What is the Impact of Eliminating the Requirement That COBRA Eligibility Be Exhausted Before HIPAA Non-group Eligibility?

Currently, HIPAA requires that individuals exhaust their COBRA eligibility before becoming eligible for a HIPAA qualified plan in the non-group market. One option being considered in conjunction with providing tax credits to displaced workers is eliminating this requirement. In other words, displaced workers would be allowed to use tax credits for either COBRA coverage or non-group coverage, or they could move to a HIPAA qualified policy at any point during their COBRA coverage period, including immediately at termination of the group coverage.

Currently, COBRA suffers from adverse selection and premiums collected from COBRA participants fall below claims for these participants. In 2000, average COBRA costs exceeded the average costs for active employees by 54 percent.[2] Although people are more likely to elect COBRA coverage if they are unhealthy, demographics can also explain part of the difference in costs between active workers and COBRA participants. COBRA participants are older than active participants,[3] presumably because younger COBRA eligibles can find less expensive coverage in the non-group market, especially if they are healthy. COBRA coverage can be an attractive option, however, for older COBRA eligibles.

An important issue is whether costs would go up, compared to the current environment, for employers and/or non-group insurers if displaced workers were not required to complete their COBRA before being eligible for a HIPAA qualified plan in the non-group market. To help

[2] Charles D. Spencer & Associates, Inc. "2000 COBRA Survey: One in Five Elect Coverage, Cost is 154% of Active Employee Cost." *Spencer Research Reports* (Chicago, IL, August 25, 2000): 329.04.-1.

[3] Paul Fronstin. "Health Insurance Portability: COBRA Expansions and Job Mobility." EBRI Issue Brief No. 194 (February 1998).

address this question, it is useful to consider the insurance options for workers terminating employment.

Workers terminating employment can be assumed to be in one of two categories based upon health. They either can or cannot qualify for a medically underwritten health insurance policy in the non-group market. For each of these health categories, displaced workers today can go to one of three insurance status categories after losing employment (assuming that they do not get another employer based plan or go to a government program). For people who can pass underwriting, the three insurance categories are: COBRA, a non-group policy, or uninsured. For people who cannot pass underwriting the three insurance categories are: COBRA, HIPAA eligible plan (after exhausting COBRA eligibility), or uninsured.

For people who could qualify for a non-group policy, the effect of a tax credit would be to make coverage more affordable. As a result, many people who chose to go uninsured in the absence of a tax credit would be encouraged to purchase coverage. This influx of relatively more healthy people initially into both COBRA plans and the non-group marketplace would improve the experience of both plans. In addition, in the current environment, some people who would pass underwriting may choose to purchase more limited and inexpensive plans in the non-group market rather than the more expensive COBRA plans which often have richer benefits than people choose to buy in the non-group market. A tax credit may induce some of these people to stay with their COBRA plan rather than go to the non-group market. This may especially occur among younger displaced workers. This would improve the experience of the COBRA plan, but could worsen the non-group experience by removing some of the better risks.

On the other hand, some of the unhealthy people who went uninsured in the absence of a tax credit would now purchase a COBRA plan or a HIPAA eligible plan. This influx of relatively unhealthy people could worsen the experience of both COBRA and HIPAA non-group plans. It is also possible that some relatively unhealthy people currently enrolled in a more limited non-group plan would instead choose to stay in COBRA if it offers more comprehensive coverage. While this would happen with less frequency than the other situations it would shift some of the poorer risks from the HIPAA non-group plans to the COBRA plans.

The net effects on the COBRA and non-group markets of a tax credit for displaced workers, combined with an elimination of the requirement of exhausting COBRA eligibility before HIPAA eligibility, are unclear. In particular, it is unclear whether the influx of healthy participants would offset the higher costs of new unhealthy participants. To answer this question, we would need more information on the relative share of the displaced worker population that is unhealthy and the effect of reducing premium costs on the COBRA and non-group purchasing behavior of displaced workers by health status and other demographics, especially age.

Subsidizing High-Risk Pools

We have been asked to estimate the funds needed to provide a premium buy-down for participants in state high-risk pools. Specifically, how much it would cost the federal government to provide a subsidy to all states if the subsidy were predicated on reducing the premium to a level lower than normally associated with high-risk pools today. In particular, H.R. 622 would provide states grants of up to 50 percent of the losses they incur in connection with the operation of a pool, if premiums charged under the pool were restricted to no more than

150 percent of the premium for applicable standard risk rates. Although the Academy could not estimate the specific cost to the federal government for such a proposal within the time frame required for this statement, we can provide some insights into this issue.

Communicating for Agriculture prepares periodic reports that provide detailed information on state risk pools, including operating statistics. According to the most recent report published in 2001, 29 states have created high-risk pools, including 24 that use the risk pool for portability under HIPAA.[4] Total enrollment in these pools in 2001 exceeded 127,000 individuals, and continues to grow. In 2000, risk pool expenditures totaled $691 million, including $651 million in incurred claims and $40 million in administrative costs. Premiums, however, covered only $391 million of expenditures, with the remaining funding coming from assessments on health insurers or other entities ($250 million) and from state appropriations.

State risk pools provide a source of health insurance coverage to individuals who might otherwise be unable to purchase insurance due to health conditions. Premiums charged for coverage under these pools exceed the standard rates for healthy individuals in the non-group market, but fall below what would be charged in the non-group market in states that allow for higher premiums for unhealthy individuals. Most states cap premiums for coverage in high-risk pools at no more than 200 percent of average standard rates. Indeed, for the risk pool to qualify as the HIPAA portability option, premiums must be capped at 200 percent of the standard rates, or less. However, several states cap risk pool premium rates at lower amounts. For instance, Minnesota, Oregon, and California cap premiums at 125 percent of standard rates. Many other states cap premiums at 135 to 150 percent of standard rates.

An important consideration regarding the costs associated with lowering the premium cap is how the costs associated with individuals entering the pool at the lower premiums compare to the costs for those already entering the pool at the higher premiums. If premiums are reduced, some individuals who do not buy a high-risk pool product due to the expense would likely buy one in the future. It is possible that the experience of these people would not be as bad as the current high-risk pool population. They would, however, be expected to generate claims in excess of their premium in most cases. This would create additional dollar losses for the program that would not have existed before the subsidy. To induce states to lower their premium caps, it is likely that an additional subsidy would be needed to cover these new losses, as well as the subsidy needed for the current population.

One potential method of assessing the extent to which experience of the new entrants would differ from the current pool is to examine how the loss ratios of risk pools with higher premium caps differ from loss ratios of risk pools with lower premium caps. Presumably, if lower premium caps encourage a broader, relatively more healthy, risk pool, loss ratios for states with low premium caps would be lower than those with high premium caps. An examination of loss ratios for state risk pools, however, reveals no clear trend between loss ratios and premium cap percentages. The lack of any discernable trend may reflect differences in the calculation of the base rates to which the premium cap percentages are applied. In addition, some state pools actually charge rates lower than the maximums prescribed, some states charge different rates to HIPAA-eligible vs. other pool insureds, and some states have a low-income subsidy program. Other differences may also contribute to the lack of correlation between loss ratios and premium

[4] Communicating for Agriculture, Inc. *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, Fifteenth Edition, 2001/2002, Fergus Falls, MN: Communicating for Agriculture & the Self-Employed (2001).

caps, including how eligibility for the pool is defined and whether the enrollment is capped. All of these differences would need to be considered when determining the relative risk of new entrants if premiums were lowered.

Estimating the federal subsidy required to encourage risk pools to lower their premium caps would also need to consider additional factors. First, the incremental growth in pool enrollment that may be experienced when premium caps are reduced would need to be estimated. These estimates need to recognize that even without changes in premium cap percentages, enrollment in most risk pools is growing, in part due to the economic downturn. Perhaps more important, enrollment growth would also need to be estimated for pools that have capped enrollment. Second, increases in health care costs will further increase the difference between premiums paid to risk pools and the claims incurred. Finally, how the federal government defines risk-pool losses will affect the amount of subsidy. Defining losses broadly as the difference between claims and administrative costs less premiums will require higher federal subsidies than if losses are defined as net of assessments. However, the more narrow definition of loss will penalize states that partly fund their risk pools through assessments rather than solely through state appropriations, which might lead them to reduce or modify their assessment methodology.