



SOCIETY OF ACTUARIES

**SOA 08 Annual Meeting & Exhibit
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**Session 40, All Politics is Local: What the States are
Doing about Health Insurance Coverage and
Affordability**

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STATE MANDATED HEALTH COVERAGE

2008 SOA ANNUAL MEETING

Session 40

Daniel Bailey, FSA, MAAA



GENERAL CONTENT

- Report on the development of an issue brief by the AAA workgroup on State Mandated Coverage.
- What is mandated coverage, and how is state reform different than federal?
- What are states looking to accomplish?
- What do they need to consider?

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TOPICS

- How the uninsured problem underlies state mandated coverage programs
- Why some states are taking action
- Limits to state authority and purview—federal considerations
- The issue brief from the AAA
- Appendix—source materials on what some states are currently doing or considering.

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THE UNINSURED PROBLEM

- # of uninsured was 47 million in Jan '08, dipped to ~45.7 at mid-yr—(Medicaid & SCHIP enrollment increased during economic downturn)—discontent close to tipping point
- States have lost patience waiting for a federal solution—want a practical fix now—# of uninsured has increased while fed gov't remains deadlocked; some states pursuing solutions specific to their own needs.

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THE UNINSRD PROBLEM (cont)

- Varies by state—uninsured rate varies from 8.8% (MN) to 24.8% (TX). (US Census Bureau, '06/'07. Varies by source & definition.)
- MA plan (Connector) hailed as positive and encouragement to other states, but MA had lower uninsured rate than most states and means to fund program & subsidize those who cannot afford to pay full premium (with help from federal gov't & Medicaid). Future federal funding for MA is in question...

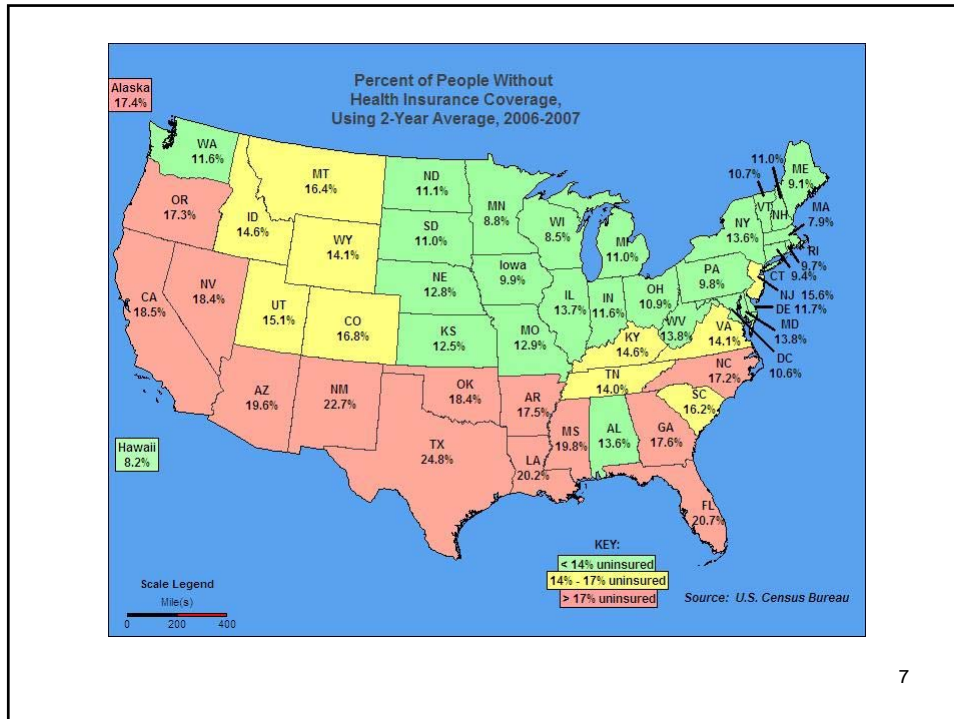
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Variability of Uninsured Rate

(based on US Census Bureau data, '06/'07 avg.)

<u>Unins Rate</u>	<u># of States</u>
l.t. 11%	12
11% to 14%	14
14% to 17%	10
g.t. 17%	14

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BUT...

- States need and rely on federal funding to launch new spending programs
- States budgets are more susceptible (than federal) to economic downturn—budget constraints challenge states to continue existing programs, let alone expand them or implement new ones—for example, some state’s budgets may be balanced, in part, by cutting Medicaid providers’ reimbursement.

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Medicaid

- Medicaid serves as a safety net, but since Medicaid accounts for almost $\frac{3}{4}$ of state health care spending, less money is left over to expand state health care programs during times of relative economic hardship
- Enrollment in gov't health programs increased by ~2.7 million in 2006
- Not all who are eligible are enrolled.

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AND

- Although states desire to reduce the ranks of uninsured and move toward universal coverage, ERISA (under federal authority) limits states' authority to run a pay or play program. This is a significant open issue
- States are not prevented from imposing a tax or fee on all employers, but the authority of states to tie the tax specifically to an ER health plan is limited.

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What's Likely? What's Not?

- States have the will to change, but not the authority and economic means of the federal gov't. In the near term, states are not expected to comprehensively solve the uninsured problem across the nation, though they may learn from each other and work toward universal coverage.
- States will continue efforts to make affordable health ins more available, esp. if fed does not
- Some states choose a coverage mandate, but the pay penalty is still in question.

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STATES ALREADY REGULATE...

- insurance, HMOs, managed care, medical providers, facilities, ..., restaurants, ..., etc-- can they take on another large program aimed at achieving universal coverage?
- State/federal relationship is continually changing (as is boundary between actions of each); for example, each state sets Medicaid rules for eligibility, benefit plan, and provider reimbursement.

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AAA WORKGROUP

- Issue brief is titled “Mandated Health Coverage Purchase: Considerations for Designing a State Program.” Will be available on AAA website
- An overview of actuarial considerations for states proposing such programs—some would also be applicable to a federal program
- Aimed at policymakers & other interested parties
- Intent on remaining objective and non-partisan
- Focused on the actuarial perspective that only our profession can bring to this public dialogue.

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WHAT STATES WANT

- States address health care access, coverage adequacy, and affordability
- Goal of mandated coverage is to reduce # of uninsured and improve access, delivery, and quality
 - Trade-off is cost to state and its taxpayers (some cost is also borne by federal gov't.)
 - Funding is necessary for those that cannot afford coverage.

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Some Potential Goals (not an exhaustive list)

- Reduce # of uninsured
- Increase access
- Lower uncompensated care
- Improve preventive care and utilization trends for serious illness (an ounce of prevention ...)
- Indirectly control cost
- Improve quality (esp. for the uninsured)
- Increase provider choice for the uninsured
- Encourage healthy people to be part of the pool.

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A FEW KEY CONSIDERATIONS

- The Health Benefit **Plan**—what set of benefits constitutes the minimum level of coverage—and how much will they cost?
- **Funding**—need a plan that extends to long-term and is sensitivity-tested for multiple potential variations in enrollment, utilization, cost, funding from taxes/assessments, etc.
- **Modeling** and Available Data—projecting the financial effect of policymaker decisions.

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A Post-Implementation Consideration

- How to **monitor and manage** the state mandated health coverage program to assure sustainability and deal w/ challenges that will continually & inevitably arise—plan and forecast issues, managing viability and assuring sustainability.

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BENEFIT DESIGN

- Establish a **minimum** threshold for the **benefit plan** to assure adequacy
- **Covered services**—essential vs. non. (Basic services, like inpatient, have lower elasticity than ancillary, e.g., acupuncture, vision, chiro, ...)
- **Covered diagnoses**
- **Member cost-sharing**
- **Cost containment** features: med. mgmt, coord. care, wellness & behavioral initiatives. ...
- Will more than one benefit plan be offered?

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Benefit Design Also Covers Some Broader Concerns Relative to Delivery System Structure

- Network & provider choice—will all providers be forced to participate? Affect of network and plan design on demand & utilization. If unit cost in network is lower, can plan use higher member cost-sharing out of network? Provider supply vs utilization demand
- Eligibility and participation rules
- Consider interplay of all of above--benefit, network, eligibility, etc on utilization and cost.

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The FUNDING section—

- Plan & budget
- Identify funding sources,
- Cash flow
- Monitor and manage the above
- Funds must be continually available for on time payments throughout the system

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Funding Sources

- EE and ER contributions
- OOP member cost-sharing
- General revenue, designated or not
- Provider assessments
- Sin taxes
- Other state & federal funding such as DSH
- Play or pay penalties
- Assessments on premium and prem equiv.
- Other sources, recurring and one-time.

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FUNDING (3)

- Program should operate on same financial basis as other insurance programs
- If providers don't get paid in a timely manner or have to perform unreasonable administrative effort to collect payment (such as cost-sharing in Medicaid), they will lose interest

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MODELING & AVAILABLE DATA

- Valuation of cost of alternate proposals
- Determining expected PMPM medical cost of newly covered—consider:
 - pent-up demand vs. learning to use new benefit
 - adverse selection
 - relative health status
- Consider affect of program on physician supply and affect on utilization.

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MODELING (2)

- Administrative costs of implementing and running the program
- Also consider:
 - take-up—the # who will actually enroll
 - crowd out—the # who will drop some form of current private coverage to pick up public subsidized coverage of greater value, and
 - other factors such as demographics, trend, rural vs. urban, condition of economy, private ins. market, state's rating/UW regulations, etc.

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Policymaker Decisions

- Benefit plan requirements. Eligibility req.
- Marketing & enrollment process (How is information about the program made available to the public? Application?)
- What competitive pressures between private HMOs and insurers will be allowed under a managed competition component?
- Potential unintended consequences???

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Issue Brief Summary

- Each state solution will seek to balance social, political, and local market issues
- Compromise between gov't & private sector is required on ongoing basis
- Benefit design is key determinant to cost
- Extensive modeling of forecast and budget is necessary; variability must be addressed using range of inputs to test viability.

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TWO CLOSING BULLETS ON STATE MANDATED COVERAGE

- This is a large and complex undertaking for any state; it involves an enormous effort to launch, a significant effort to sustain, and should not be taken lightly. Like any public program, funding will be an ongoing issue
- We are a long way from universal coverage for the non-elderly; both states & the federal gov't should continue to seek solutions.

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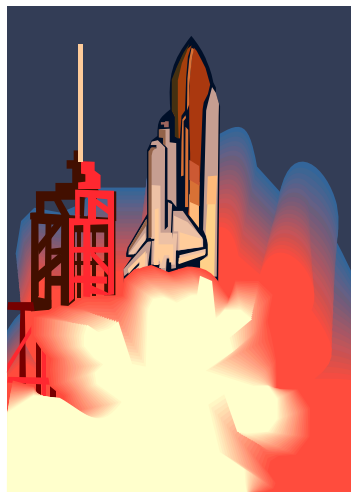
Some Other State Responses

- AFFORDABLE COVERAGE—State of NH “HealthFirst” program—health plan costing less than 10% of avg state wage (prior yr.)
NOTE: This is not an individual mandate.
- WA Basic Health Program state low-cost cvg w/ sliding scale subsidies and enrollment cap of ~105k people in 2008.

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Thank You!

Enjoy your stay
in Florida!



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APPENDIX

- Stay informed—there are many websites with information about state programs—the NCSL and AHIP have lists of programs, by state.
- <http://www.census.gov/prod/2008pubs/p60-235.pdf>
- <http://www.ncsl.org/programs/health/universalhealth2007.htm>
- <http://www.ncsl.org/programs/health/healthmc.htm>
- <http://www.kff.org/uninsured/upload/State%20Health%20Reform1.pdf>
- AHIP: “Selected Significant 2008 State Access Proposals: Major Provisions Checklist (as of September 2, 2008)”

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All Politics is Local: What are States Doing About Health Insurance Coverage & Affordability?

**The Society of Actuaries Meeting
Orlando, Florida
October 2008**

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Stakeholder Needs

The Healthcare Compact	
Stakeholder	Major Need
Hospitals	Eliminate uncompensated care
Physicians	Increase quality of patient care, strengthen physician-patient relationship
Other Care Providers	Increase patient choice of treatment options
Insurers	Stabilize insurance markets, allow flexibility for insured products
Employers	Support affordable health insurance
Consumers	Increase choice, improve quality, lower costs
Agents/ Brokers	Provide for competitive saleable market-based products
Uninsured	Provide affordable comprehensive coverage

Basic Principles

1. **Market-based** - allow a creative open competitive entrepreneurial market
2. **Increased Competition** - best solution to lower prices, better services, higher quality, greater convenience, and more choices.
3. **Personal Responsibility** - means taking ownership for good and bad health and healthcare decisions.
4. **Ownership** - possession of financial assets, choices of how to spend personal funds, and the right to information
5. **Portability** - coverage regardless of employment status and/or job changes
6. **Transparency** - meaningful and accurate information that is easily available and understood by consumers.
7. **Use of Technology** - to lower costs, improve efficiency and effectiveness of coverages, and appropriately identify and distribute information.

Desired/Achievable Outcomes

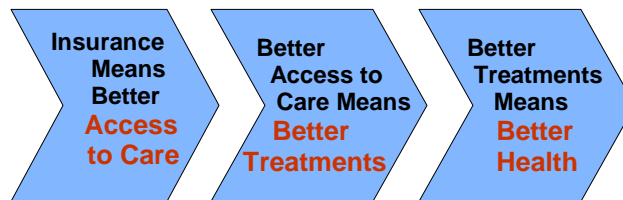
1. **Transformation** - more than minor tweaking
2. **Consumer Empowerment** - financial responsibility, information sharing, and decision/advocacy support
3. **Behavioral Change, Not Cost-shifting** - wellness, prevention, early intervention, and compliance
4. **Affordability** - premiums + affordability is also achieved through health choices and behavior changes
5. **Maximize Insurance, Minimize Third-party Reimbursements** – Insurance with account balances can provide full comprehensive coverage
6. **Increase Choices** - options for insurance coverage, care, treatment, providers
7. **Financial Security** - must include helping the sickest patients
8. **Improved Clinical Outcomes** – healthier population
9. **A Culture of Health** – wellness and prevention rather than disease and treatments.
10. **“Wholistic Care” (Physical, Mental, Spiritual, and Social)** - improve the medical and functional status regardless of the diagnosis or condition

Segmenting the Uninsureds

Uninsured Georgians By Segment		
	Percent	Estimated Number
Uninsured Not Needing Financial Assistance	30%	510,000
Uninsureds Needing Financial Assistance	35%	595,000
Uninsureds Eligible for Gov't Programs	20%	340,000
The Uninsurables	15%	255,000
	100%	1,700,000

The WG determined that segments #1 and #2 above were the largest targets with over 1.1 million lives. The segments represented areas where consensus solutions could potentially reach more than 500,000 uninsured Georgians

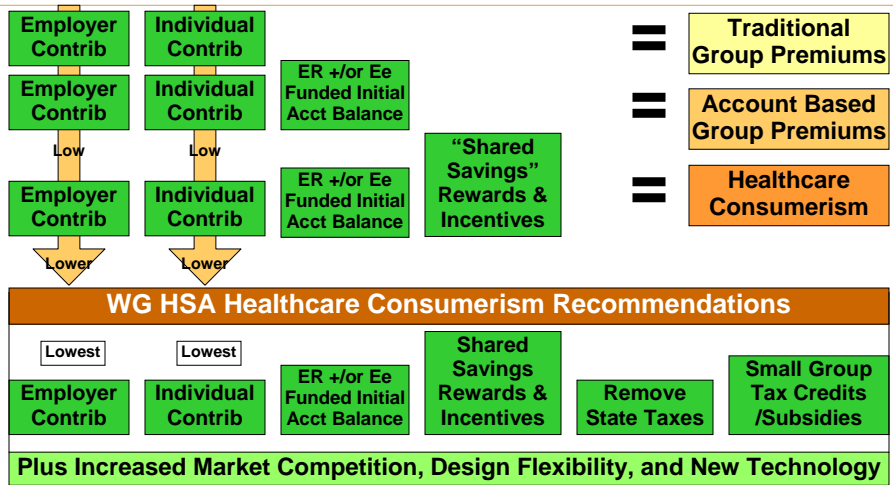
Key Tautology: Health Insurance Matters



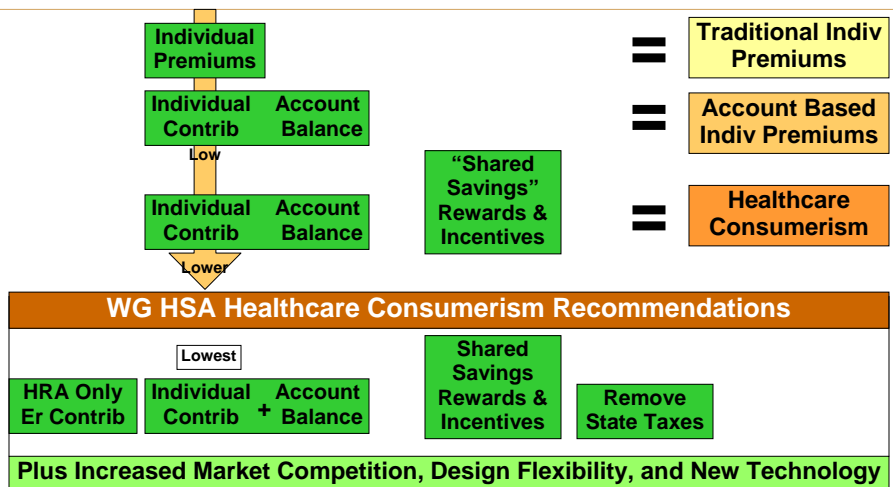
“Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic, and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage.”

- The Institute of Medicine

WG Recommendations Redefine Affordability (Group Plans)



WG Recommendations Redefine Affordability (Individual Plans)

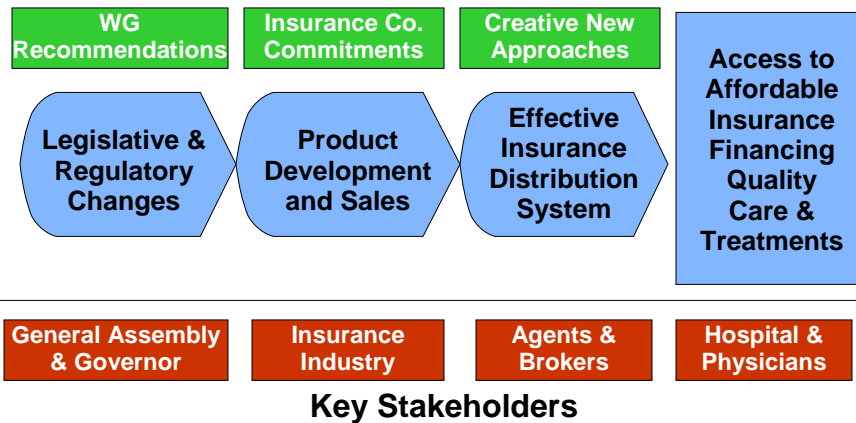


Affordability Redefined With New Generation Products

Affordability is no longer only the amount of money one pays in insurance premiums.

One can now cover a significant portion of a policy's cost by participation and rewards from wellness activities. Others, if ill or suffering from a chronic condition, can lower their costs with rewards and incentives for adherence to their physician's orders for care and treatment.

Key Roles and Responsibilities to Affordable Health Insurance for All Georgians



General Descriptions of Georgia Uninsured Work Group Recommendations

- (1) Remove existing state premium and income taxes on HSA eligible HDHPs,**
- (2) Allow flexible HDHP designs that include rewards and incentives,**
- (3) Provide tax encouragements for small businesses to offer HSA eligible plans,**
- (4) Encourage the use of health information technology,**
- (5) Create a receptive market for new HSA eligible plans,**
- (6) Encourage more carriers to compete for business in Georgia**

Specific WG Recommendations Applicable to HSA Eligible HDHPs only:

- 1. Remove state and other municipal premium taxes**
- 2. Allow state income tax deductibility of HDHP premiums**
- 3. Remove barriers to offering financial rewards for using health risk appraisals, health management, or disease management programs.**
- 4. Remove restrictions on reimbursements to non-preferred providers, if at least 60%.**
- 5. Allow employers with fewer than 50 employees, a \$250 tax credit per employee enrolled.**
- 6. Fund staffing at DOI for: (1) conducting a market survey of products offered in other states not yet sold in Georgia, (2) expediting processing of HSA eligible HDHPs, and (3) developing relationships with insurance carriers to encourage product development.**

Specific WG Recommendations Applicable to Other Issues

7. Remove any restrictions to use of Health Reimbursement Arrangement Only plans packaged with the purchase of individual health policies.
8. Fund a study to identify and remove unneeded application and marketing barriers for new products and new insurers that wish to sell in Georgia.

A Balanced Start to Helping Different Segments of Georgia's Uninsureds

1. Er's with Group Insurance –
 - a. Flexible HSA Designs,
 - b. Rewards/Incentives,
 - c. Premium tax reductions,
 - d. Small group tax credit
2. Er's without Group Insurance –
 - a. Tax advantaged HRA Only Plans,
 - b. Advantages of #3 for purchase of Individual Policies
3. Individual Health Plans -
 - a. Flexible HSA Designs,
 - b. Rewards/Incentives,
 - c. Premium tax reductions,
 - d. Ga. Income Tax deduction
4. Uninsurable – Georgia Free Clinic support

Health Insurance For All Georgians

It is true that these solutions outlined will reach only a piece of the uninsureds in Georgia.

Reaching 500,000 Georgians with affordable insurance is a good start.

The collaborative approach is working. A framework for a comprehensive approach is in place. The WG has established a foundation for reaching all Georgians without insurance.

The WG will continue to meet with dedicated effort, a spirit of collaboration and an expanded circle of interested parties to find solutions for the remaining segments of the uninsureds.

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Case Study

Ohio Healthcare Reform Initiative

Recommendations to Governor Strickland and
Ohio General Assembly

www.healthcarereform.ohio.gov

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- **Goals:**
 - ◆ Cover 500,000 uninsured by 2011
 - ★ Approximately 1.3 million uninsured in Ohio
 - ◆ Increase ability of small businesses to offer coverage
- **State Coverage Initiative (SCI) Team Representation**
 - ◆ 4 members of General Assembly
 - ◆ Union
 - ◆ Consumer Advocate
 - ◆ Business Roundtable
 - ◆ Health Policy Expert
 - ◆ Medicaid
 - ◆ Dept of Insurance
 - ◆ Governor's Policy Director
 - ◆ Public Health

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- **Advisory Committee**
 - ◆ 40 members representing Ohio stakeholders
 - ★ Medical Care Providers
 - Hospitals
 - Doctors
 - Nurses
 - ★ Brokers
 - ★ Consumers / Workers
 - ★ Insurance Carriers / Health Plans
 - ★ Pharmacies / Drug Makers
 - ★ Employers
 - ★ Governments
 - ★ Public Health
 - ◆ Consensus Approach

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Common Reform Approaches Considered

Premium Assistance for Low Income AL, IL, MI, UT	Minimum Loss Ratio CA, CO, NM, PA, WA
Connector / Exchange MA, UT, AL, KS, MI, MN	Rate Approval CO, GA, PA, WA
Cost / Quality Transparency AL, OK, WI	GI Individual Market IL, KS, MN
High Risk Pool AZ, CA	Increase Dependent Age KS, NJ
Rate Band / Community Rating Reforms AZ, ID, PA	Employer Mandate AL, CA, IL
Merge Small Group / Individual Markets MA	Individual Mandate AL, CA, IL, MI, MN
Tax Credits for Purchase AZ, UT	Wellness Initiatives CA, CT, IL, MD, MN, OR, PA, VT, WI
Reinsurance NY, AZ	Section 125 Plans

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Advisory Committee Consensus for Analysis:

Premium Assistance for Low Income	Minimum Loss Ratio
Connector / Exchange	Rate Approval
Cost / Quality Transparency	GI Individual Market
High Risk Pool	Increase Dependent Age
Rate Band / Community Rating Reforms	Employer Mandate
Merge Small Group / Individual Markets	Individual Mandate
Tax Credits for Purchase	Wellness Initiatives
Reinsurance	Section 125 Plans

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- Premium Assistance Considerations
 - ◆ What is affordable coverage?
 - ◆ Who are low income individuals?
 - ◆ Where do the funds come from?
 - ◆ Low Income & Health Status correlation
 - ◆ What about the cost of care?
 - ◆ Administration

- What does this mean for actuaries?

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- Connector/Exchange Considerations
 - ◆ What is it defined to?
 - ◆ Who governs?
 - ◆ Administration
 - ◆ Commissions / Marketing
 - ◆ Benefit Packages
 - ★ How many offerings?
 - ★ Same as outside connector?
 - ★ Same rating rules?

 - ◆ What does this mean for actuaries?

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- Rate Band Limitation Considerations
 - ◆ Discrimination vs. Risk Classification
 - ◆ Subsidization - More now, save later
 - ◆ Marketplace health / competition
 - ◆ How to keep young and healthy insured
 - ◆ Anti-selection of previously uninsured or insured with higher rates
 - ◆ Health Status of uninsured vs. insured

- What does this mean for actuaries?

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- Merge Small Group & Individual Market Considerations
 - ◆ Discrimination vs. Risk Classification
 - ◆ Subsidization
 - ◆ Marketplace health / competition
 - ★ Do individual-only carriers leave?
 - ◆ How to keep young and healthy insured
 - ◆ Does it require additional small group reforms to reduce the increase in rates?
 - ◆ Anti-selection

- What does this mean for actuaries?

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- Minimum Loss Ratio Considerations
 - ◆ Are carriers making excess profit?
 - ◆ Admin expense efficiencies / reductions
 - ◆ What level of risk margin & admin is acceptable?
 - ◆ Commission levels / Marketing

- What does this mean for actuaries?

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- Guarantee Issue Considerations
 - ◆ Anti-selection
 - ◆ Health Status of uninsured vs. insured
 - ◆ Is mandate necessary?
 - ◆ Medicare Part B type penalties
 - ◆ Subsidization
 - ◆ Conservatism / Variability of rates / rate approval

- What does this mean for actuaries?

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- Increase dependent age considerations
 - ◆ Rider at attained age
 - * Premium limitation
 - * Subdization of rates / funding
 - * Anti-selection
 - ◆ Increase age for all policies moving forward
 - * Cross-subsidization
 - ◆ How many new people are really covered?
 - * Do any young and healthy stay in market?
 - * Doesn't effect individual market access.
 - ◆ Affordability to family
- What does this mean for actuaries?

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- Individual Mandate Considerations
 - ◆ Enforcement
 - ◆ Administration
 - ◆ What populations are excluded / included
 - ◆ Affordability
 - ◆ Benefit Packages
 - ◆ Risk spread / premium rate affect
 - ◆ Possible substantial coverage increases
- What does this mean for actuaries?

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- Reinsurance Considerations
 - ◆ Funding
 - ◆ Administration
 - ◆ What levels of risk should the state take?
 - ◆ Premium reduction
 - * How will this be implemented by each carrier
 - * Possible high variability / conservatism
 - ◆ Claims predictability for carrier
 - ◆ Promotes participation of carriers in those markets
 - ◆ Cost of care?

- What does this mean for actuaries?

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- Section 125 Plan Considerations
 - ◆ Take advantage of existing admin structure
 - * What about small business?
 - ◆ Communication to consumers
 - ◆ Offer requirement would need law changes
 - ◆ Cost of care?
 - ◆ Enhance and expand current system

- What does this mean for actuaries?

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- Ohio recommendations include:
 - ◆ Requiring employers to establish § 125 plans
 - ◆ Reinsurance for individuals and small business
 - ◆ Extending group coverage to dependents up to age 29
 - ◆ Premium assistance for low income workers
 - ◆ Enrolling more Ohioans in Medicaid
 - ◆ Expanding Ohio's Medicaid eligible adults to enroll in Medicaid managed care plans
 - ◆ Reforms to the individual health insurance market

- What does this mean for actuaries?

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- Funding Considerations:
 - ◆ Restructured Medicaid and SCHIP funds
 - ◆ Sin taxes
 - ◆ Increases to state income tax
 - ◆ Additional contributions due to increased take-up of employer based coverage
 - ◆ Savings
 - ◆ Budget restraints
 - ◆ Tax other state residents (hotels, rental cars)
 - ◆ Uncompensated care funds
 - ◆ General revenue taxes

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- What are the issues surrounding stakeholders initiating reform?
 - ◆ Hospitals
 - ◆ Doctors
 - ◆ Brokers
 - ◆ Consumers / Workers
 - * Consumer Advocates / Unions
 - ◆ Insurance Carriers / Health Plans
 - ◆ Pharmacies / Drug Makers
 - ◆ Employers
 - * NFIB, Chambers of Commerce
 - ◆ Governments
 - * State Legislature, County/Cities, Dept of Insurance