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Session 8PD
Health Care Reform: What Next?

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Panelists: CHRISTINE M. CASSIDY†
CORI E. UCCELLO

Summary: First the NAIC reforms, then managed Medicaid, then Kennedy-Kassebaum. What are the next reforms looming on the horizon? What ideas are the NAIC, the states, Congress, and the Clinton administration considering? To what extent are actuaries playing a role in the process?

Mr. William F. Bluhm: I'm a consulting actuary with Milliman &Robertson in Minneapolis. Cori Uccello is a Fellow with the Urban Institute. She's going to discuss the generalized types of health care reforms. Cori will also explain how they model them at the Urban Institute. Cori is the only actuary at the Urban Institute. She's responsible for a variety of areas in the health and retirement policy areas. She recently did a paper that was highlighted in an article in *The Washington Post*. She's currently managing a project on health care coverage extensions.

She was previously an intern at the Congressional Budget Office (CBO) during the time of the big push on health care reform. Prior to that she was at John Hancock.

The second presenter is Christine Cassidy, director of public policy at the AAA. She's been with the Academy five years and manages the staff and the work

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for the five practice councils involved with public policy work, including the health area. Christine has worked in the political arena as a lobbyist and a campaigner for a well-known presidential candidate, and has worked for the Iowa State Legislature.

Christine's going to tell us about some specific proposals that are being put forth in the federal area. At the end, I'm going to give a little update about all the wonderful work the Academy's done.

Ms. Cori E. Uccello: I'm sure you remember the unsuccessful attempts that President Clinton and others made a few years back to pass comprehensive health reform. Since then, policymakers have taken a more incremental approach to health reform. The passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 is one example. In 1997, policymakers are considering incremental options for expanding health insurance coverage. They are looking at five targeted groups. The first are children and, in particular, low-income children, then other low-income individuals. There's also workers between jobs, early retirees, and high-risk and/or uninsurable persons.

There are some general types of options available for expanding health insurance coverage. I'm going to address primarily options aimed at expanding coverage among children, particularly low-income children, because that's where many of the Hill proposals are currently focused. I also want to provide a little information on how these options are analyzed. We, at the Urban Institute, are currently involved in a project that examines the effects of various types of options aimed at reducing the number of uninsured. Our role is to use our micro-simulation model to help compare the various proposals across various outcome measures, such as how many persons become newly covered, what is the cost of the proposal, and what are the distributional effects, that is, who are the ones benefitting from the proposal—those with low incomes or those with high incomes. I'll talk more about what micro-simulation is and how we use it to look at health reform options later.

First, to help establish the context in which reform options are being considered, I think it's useful to look at where people are currently obtaining their health insurance and how insurance coverage varies across groups. We'll also look at the composition of the uninsured.

Chart 1 shows the sources of health insurance coverage for the non-elderly population. This chart illustrates how important employer-sponsored insurance is. Almost two-thirds of the non-elderly population in the U.S. obtains health insurance through an employer-sponsored plan, either through their own employer or through dependent coverage of a spouse or a parent's employer. Another 4% of the non-elderly population receive coverage through private non-group insurance. Twelve

percent of the non-elderly have Medicaid, and an additional 3% have some other type of public coverage, such as Champus or military health care. This leaves 15% of the non-elderly, about 35 million people, without health insurance coverage.

There are two things that I should point out about this 15% number. First, it may be lower than some other uninsured numbers that you may have seen in the press. That's because we at the Urban Institute adjust our Medicaid numbers. Typically, people underreport Medicaid coverage when surveyed and, therefore, if you don't adjust for that you're going to be under-counting the people who are Medicaid covered. Also, among the uninsured, there are additional persons, about 2 million kids and another 1.5–1.7 million adults who are actually eligible for, but do not participate in Medicaid. While some of these persons may not participate because they simply are not aware that they are eligible, others know they're eligible, but decide not to participate either because they feel that there's a stigma associated with the program or it's demeaning to enroll in it or it's a hassle to do so.

CHART 1
HEALTH INSURANCE COVERAGE OF THE NON-ELDERLY

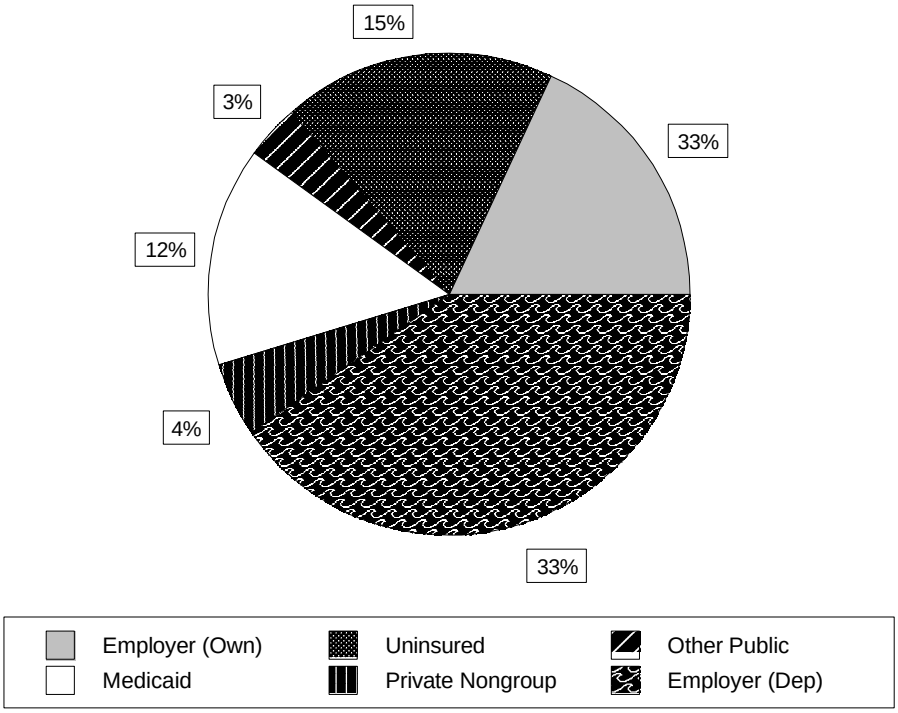

Chart 2 shows the sources of health insurance coverage by age and illustrates how different sources of coverage are important to different age groups. In particular, Medicaid coverage is very important to children younger than age 18. An

interesting point shown in this chart is that the 18–24-year-old age group is most likely to be uninsured.

CHART 2
HEALTH INSURANCE COVERAGE OF THE NON-ELDERLY, BY AGE

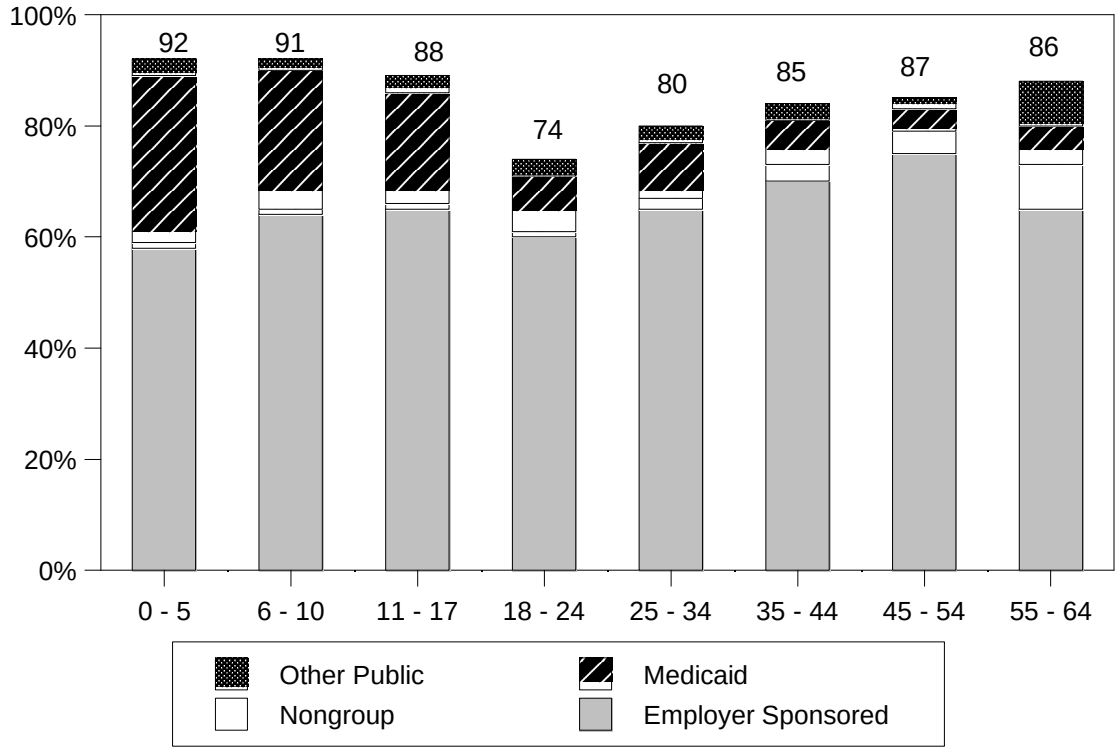

Table 1 shows the distribution of the uninsured across age. Most of the proposals that are being discussed focus on that 20% of the uninsured population that is under 18. Because, as I mentioned, most of the proposals I'm going to discuss target low-income children, I thought it would be useful to look at the health insurance coverage of children by family income.

TABLE 1
NON-ELDERLY UNINSURED, BY AGE

0–17	**18–24**	**25–34**	**35–44**	**45–54**	**55–64**
20%	19%	24%	18%	11%	8%

Chart 3 shows how Medicaid coverage is the predominant force of coverage for children in poverty, that is, children from families with incomes below 100% of the federal poverty line. Near-poor children, those in families with incomes between 100–200% of the poverty line, have coverage by employer-sponsored insurance, which increases among this group, although it's not enough to offset the decrease in Medicaid coverage. Therefore, the near-poor children are most likely to be

uninsured. In Table 2, the uninsured children are shown by family income and over half are either poor or near poor.

CHART 3
HEALTH INSURANCE COVERAGE OF CHILDREN UNDER 18
BY FAMILY INCOME AS A PERCENTAGE OF POVERTY

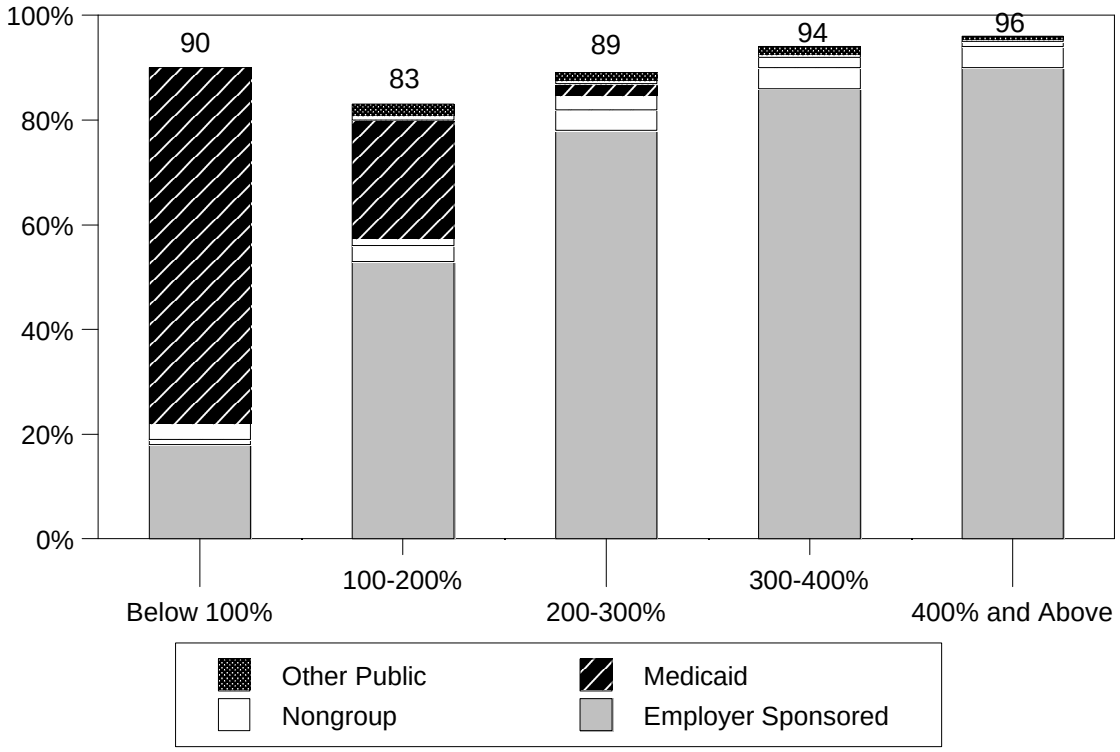

TABLE 2
UNINSURED CHILDREN UNDER 18
BY FAMILY INCOME AS A PERCENTAGE OF POVERTY

Below 100%	100–200%	200–300%	300–400%	400% and Above
24%	37%	21%	9%	9%

Now that we have a little more of an idea of the current coverage situation, I'm going to discuss three general options for increasing insurance coverage, especially among children. I'll explain some of the general types of options that are available for expanding coverage. These three are tax-credit options, premium subsidies, and Medicaid expansions.

The tax preferential treatment of employer-sponsored insurance is one of the reasons why most people who have health insurance coverage have obtained it through an employer-sponsored plan. However, there are some groups of people

who don't benefit as much from this tax preferential treatment. These are workers who are not offered health insurance coverage and low-income workers who pay low taxes and, therefore, don't benefit as much from the tax preferential treatment. Therefore, there are some proposals to expand the preferential tax treatment of health insurance coverage.

One example of a tax-credit proposal would be to provide a refundable tax credit of $500 for each child covered by health insurance (for families below a certain income threshold). Another option would be to provide a refundable tax credit equal to all or a portion of the family's actual premium costs (for families below a certain income threshold).

There are a few advantages to these tax-credit options. Tax-credit options are pretty easy to administer. A family would simply need to check off on their tax return that they covered their children with health insurance and would be able to obtain a tax credit. They would, however, have to prove in some way that they did cover their children with insurance. Another advantage is that Medicaid is somewhat associated with a stigma and people can be leery to actually enroll in Medicaid. There would be no stigma because families wouldn't have to apply for the credit at the welfare office, and the credit would be used for private health insurance, not Medicaid.

There are also a few disadvantages to these tax-credit options. First, if the tax credits are not advanced, people will have to pay for their health insurance premiums up front and then get the refund maybe a year or more later. Low-income families, in particular, may find this very hard to do. They may not be able to come up with the money to pay the premium.

Another potentially large problem with the tax-credit options is that a lot of the money may go to people who already have coverage. Everybody who already has coverage and meets income eligibility will get the credit. These costs could be partially offset by eliminating the tax preferential treatment of employer-sponsored coverage. I think there are a couple reasons why we can't just limit this to people who don't already have coverage. It is difficult to prove that someone did not have coverage. Additionally, even if you could, you may not want to. It penalizes those low-income families who have already decided to put out the money to pay for their insurance coverage. If you don't also give them the credit, you're putting them at a disadvantage compared to people who didn't already purchase the coverage. I think the primary goal of expanding coverage is just that, expanding coverage. I think a secondary goal could also be providing some kind of premium relief to people who are already obtaining health insurance coverage.

As we saw earlier, Medicaid is a very important source of coverage for low-income families. Persons ineligible for Medicaid, yet with low incomes, may not be able to afford employer-based plans (or private non-group plans). Therefore, some suggest providing premium subsidies to low-income families. One example of this would be to provide a sliding scale subsidy for use in the current market. Another option would be to establish a state insurance plan where premiums are based on income. A few states are already attempting this type of thing.

In contrast to some of the tax-credit options, premium subsidies would be provided up front. Another advantage to premium subsidies is that if they are used for non-Medicaid state insurance plans, such as the Healthy Kids plan in Florida. There isn't as much stigma as in a Medicaid plan, therefore, more low-income families may be likely to participate.

The disadvantages of providing up-front subsidies based on income is that if a family's income increases, they may have to pay back some or all of the subsidy. This may reduce participation. Similar to tax-credit options, some of the premium subsidies may go to families who already have coverage.

Spending some money on people who already have coverage isn't necessarily bad. Although the primary aim of these proposals is to expand insurance coverage among the currently uninsured, a secondary goal could be to provide some income relief to low-income families who have coverage.

Now, finally, I'll explain the Medicaid expansion options. As we saw earlier in the charts, Medicaid is a very important source of health insurance coverage for low-income children. All children up to age 6 in families with incomes below 133% of poverty and all children 6–18 in families with incomes below 100% of poverty are eligible for Medicaid. States are permitted to expand Medicaid coverage to those with higher incomes, and some, but not all, do.

Proposals to further expand Medicaid include expanding the eligibility to all children with incomes below 185% of poverty. In addition, because children in families with incomes just above the Medicaid cutoffs are ineligible for Medicaid, there are proposals to allow these families to purchase Medicaid at subsidized rates.

An advantage to expanding Medicaid is that it builds on the existing system. The administrative capacities are already in place and I think they could just be used under any type of Medicaid expansion system. In addition, it's beneficial for those without access to other coverage. Finally, but perhaps most importantly, it's well-targeted to those with low incomes.

There are some drawbacks to expanding Medicaid. First, there is a stigma associated with Medicaid. Some people do not like to enroll in it because it is welfare. Second, there is the possibility that some who already have private coverage will drop this coverage to take up Medicaid. You may have heard when a family with private insurance coverage finds out that their kids are eligible for Medicaid, they can drop their kids from the private coverage and just enroll them in Medicaid. There is much debate on the extent of this type of crowd-out, but I don't think it's high at all. There is no consensus as to the extent of crowd-out associated with Medicaid coverage, but new estimates suggest that it is not large. In addition, the crowd-out problem associated with Medicaid is likely smaller than the problem of providing tax credits or premium subsidies to those who already have insurance. I also think it's important to say that the crowd-out associated with a Medicaid-type program naturally would be less than a crowd-out of giving money to people who already have health insurance coverage through a tax credit or premium-subsidy-type option.

Those are three of the general types of options that are available for expanding coverage. I'd like to briefly discuss how we actually go about analyzing these options. As I mentioned earlier, at the Urban Institute we have a micro-simulation model that we use to help us analyze the effects of various health reform proposals. This model is called the transfer income model (TRIM). TRIM is essentially a large computer program that uses data from the current population survey, which is a national representative sample of about 60,000 households, as its input data. For each member of each household, we have detailed information on their demographics, such as age, sex, employment, and income. We also have information on whether or not they have health insurance coverage and, if so, from what source.

The huge computer program houses all the benefits and eligibility rules under various government tax and transfer programs. For instance, we can determine how much a family would owe in taxes, based on their income from their job and other types of earnings. We can also determine whether or not the family's eligible for Aid to Families with Dependent Children (AFDC), Medicaid, or various other types of government programs. We apply these rules to each household in turn and determine how that household is affected. We can then aggregate the households by using their appropriate weights to come up with national levels of the overall effects.

First, we start with the baseline. That is, the current situation. In our case, this would be the current health insurance status of each person in the data set. We use the Medicaid eligibility criteria to determine who is eligible to receive Medicaid.

Next, we simulate alternative scenarios. For instance, say we instituted a $500 tax credit to households in which the children are covered by health insurance for each child that's covered by insurance. We would look at each household, see if they met the eligibility requirements for this tax credit, and if they are eligible, determine whether they are going to participate. For uninsured families, we use some participation-rate assumptions that predict what proportion of uninsured families will take up insurance. We assume that all households that already cover their children will claim this tax credit.

That is what we do in a nutshell. I need to emphasize that this is a micro-level analysis. We look at each household, in turn, decide whether they're eligible and, if they are eligible, whether they participate.

There are, however, other considerations that we need to take into account when we're modeling these types of health-reform options. For instance, there are many participation-rate considerations we need to address.

- How do participation rates vary by premium costs and income level? We assume that participation increases as premium costs, as a percentage of income, decrease.

- How much will stigma reduce participation? If we are increasing access to coverage only through Medicaid expansions, will people be reluctant to join?

- How much will cash flow and/or uncertainty problems reduce participation?

- Is program participation limited to the uninsured, to those without access to employer-sponsored insurance, or is eligibility open to everyone who meets income eligibility rules? Some of the proposals on the Hill and some states have tried to limit their expansions of coverage to only those who are uninsured. Some states, however, have found it very difficult to implement and are now abandoning some of these efforts.

- Will people drop private coverage to take up public coverage?

- Will new programs increase participation in Medicaid, regardless of whether Medicaid is expanded?

There are other potential effects we need to consider, such as:

- Employer behavioral changes: Will employers drop coverage? Will they shift a greater portion of premiums to employees?

- If new programs are federally funded, will states shift optional Medicaid enrollees to the federal program?

- Adverse selection.

There are a few other behavior effects and different considerations we have to make.

- Will employers change their behavior? Will the implementation of a new health insurance program cause an employer to either drop coverage altogether or drop the dependent's portion of their coverage? Will they shift a greater portion of the premiums to the worker?

- In addition, if new programs are fully federally funded, will states shift their optional Medicaid enrollees to the federal program? Currently states have to pay for part of the cost of their Medicaid program, so it would be in their best interest financially to push some of these people into the fully federally funded program. Being an actuary, we have to take into account the adverse-selection side of these different options. Who is more likely to participate, and how is this going to affect the premium?

Christine is going to talk more about what she and the Academy are doing to look at various options.

Ms. Christine M. Cassidy: Expanding on what Cori has highlighted with the general types of health care reform proposals, I'm going to go through and show how these proposals relate to some of the current federal legislation.

As Cori pointed out, the theme this year is incremental reforms. Although the federal budget deficit is driving the debate on how to pay for some of the health care entitlements, such as Medicaid and Medicare, there continues to be pressure to try to find solutions on some reform initiatives within the private sector. In terms of incremental reform, the Clinton Comprehensive Reform Proposal was definitely labeled as a failure. On the other hand, the (Senator Edward M.) Kennedy (D–MA)-(Senator Nancy Landon) Kassebaum (R–KS) or the HIPAA legislation was seen as a success showing how incremental reform can succeed and get through Congress. Part of what is central to the debate is the fundamental question of what the role of the federal government should be. Should the federal government actually expand its reach over insurance plans through mandated benefits and other requirements, or should the federal government try to encourage a free market system? You'll see these questions throughout debates on any type of health care reform.

I'm going to discuss three central themes of incremental reform: uninsured children, increasing coverage to the elderly, and increasing coverage through some other means. In terms of the increasing coverage for uninsured children, currently there's about five general proposals: a voluntary program, a mandatory program, expanding Medicaid, creating a whole new entitlement program, and providing states with grants and vouchers.

In terms of the voluntary program, currently there's legislation introduced by Senator Thomas A. Daschle (D–SD) that would provide a tax credit. Senator Graham also has a proposal that would have an earned income tax credit. This is something that would be voluntary and has eligibility requirements. There's also a mandatory program that's been introduced by Representative Furse that would have a guaranteed issue similar to the HIPAA legislation. Expanding Medicaid eligibility has been a little more popular. As Cori pointed out, there's numerous advantages to trying to use a system that's already in place. Senators John H. Chafee (R–RI) and John D. Rockefeller (D–WV) have introduced legislation that would increase the matching rates to states for children whose family income is up to 150% of poverty. As Cori mentioned, there's some that go up to about 185% as well. On the House side, Representative Towns also had some legislation that would actually expand Medicaid eligibility. For those of you who know or have heard of the work that Representative Fortney Pete Stark (D–CA) has done, it won't surprise you that he is pushing for a whole new entitlement program, something in addition to Medicaid. The funding for this would not surprise anybody who knows Representative Stark's philosophy. This would include a premium tax that would be spread over the entire insurance market, so everybody would be paying for covering these uninsured children. Something else that's also been popular along the same lines is the voluntary program that would provide grants to states. Senators Orrin G. Hatch (R–UT) and Kennedy, which is a unique team, have legislation that would provide grants to states that would actually contract with private insurers to provide coverage to children up to 18 years of age, as well as pregnant women. Senator Arlen Specter (R–PA), on the Republican side, introduced some legislation that would also create vouchers for states.

One thing that's interesting with the Hatch-Kennedy legislation is that Representative Johnson has introduced a companion on the House side, and any time you have a companion legislation, a similar bill that's on the House and the Senate side, it increases its probability of passing over just having it introduced in one house. Another thing, with the Hatch-Kennedy and Representative Johnson proposals, which we'll get into later, is that their legislation would be funded through a cigarette tax. What's interesting about Senator Specter is that he was the first Republican to actually introduce any legislation on uninsured children. He took the lead in the Republican party.

In terms of the Academy's involvement, early in 1997, the Health Practice Council identified uninsured children as one of their key issues and created a work group. In January, when the Health Practice Council went for visits on the Hill, we received a request from Senator Daschle, who wanted the Academy to take a look at his legislation. A work group reviewed the legislation and did a critique on whether it was clear and technically correct. They had several conference calls with Senator Daschle as well as with Representative Richard A. Gephardt (D–MO). Representative Gephardt will be introducing legislation similar to Senator Daschle's and will actually include some of the Academy's comments to modify the legislation. We always see it as a success when we can clearly articulate what the issues are and the staffers can understand them and then take it the next step and actually make some changes to the legislation.

In terms of the politics surrounding this issue, it's definitely a priority for President Clinton. He stated it in his State of the Union Address and included it in his Budget Proposal. It's also been a priority for the democratic leadership. What happens every year in Congress, at the beginning of every session, is the two parties identify what their priorities are going to be and the first ten pieces of legislation that are introduced surround those bills. Senator Daschle's legislation was part of the ten-bill package that was unveiled by the Senate Democratic leadership. There was some controversy because the Republicans did not come out with a plan, which was why Senator Specter led the way.

There are two issues that are key to the debate on uninsured children. One of them is the funding issue. How are you going to pay for providing coverage to a population that is not currently being covered? A vote just took place to include the cigarette tax in the budget resolution and failed in the Senate. So the cigarette tax will not be included in the budget resolution on the Senate side. However, that doesn't necessarily mean that Hatch and Kennedy won't be successful through other means in getting it funded through a cigarette tax. Politically, that's a dead issue. The tobacco groups are too strong, but it will be an interesting debate to see how they're going to actually fund the issue.

Another issue that's key to the debate is whether or not to use the existing Medicaid system. How much of this crowding out that Cori talked about will come into play? What role does private insurance industry play in expanding coverage? In terms of the budget resolution, they've made it very vague as to any type of funding, who will be eligible, and where they will draw the line. It will all come out in the Congressional Committee discussion and is not part of the budget resolution. There will be legislation one way or another on uninsured children, because it is currently in the budget resolution. They have set money aside and Hatch and Kennedy are

going to continue pursuing something even further than what's in the budget proposal.

Moving on to the next topic, increasing coverage to the elderly and high-risk individuals. There are a couple proposals that have been introduced, with one really strong piece of legislation from Senators Rockefeller and Chafee. Again, there's a companion bill on the house side by Representatives Johnson and John D. Dingle (D–MI). What this legislation will do is guarantee issue for Medigap upon disenrollment from a HMO within one year. They also have a guaranteed six-month open enrollment for any disabled beneficiary who is eligible for Medicare. A couple other modifications—there would be guaranteed issue for somebody who's eligible for Medicare when an employer plan ceases or when benefits are reduced. In addition, there would also be guaranteed issue if an HMO goes out of business or if the beneficiary moves out of the area. What's also interesting in the Rockefeller-Chafee bill is it includes disabled and end stage renal diseases (ESRDs) into the Medigap market.

President Clinton included in his Budget Proposal some Medigap provisions, but he did not include any details in his proposal. What he did include, though, was the desire to have open enrollment, and to prohibit any kind of preexisting conditions for people going into the Medigap market. The main concern was to make sure that there was Medigap portability. There's been concern on the Hill about this anti-managed care initiative going on. They do not want seniors to feel as though they're locked into any type of HMO plan.

Senate Finance is also looking at some proposals, but nothing specific. Basically, they're just looking at some lower cost options that could be included in some of the Medigap plans.

In fall 1996, Senators Rockefeller and Chafee introduced legislation in the 104th Congress and an identical bill in 1997, which I went over earlier with the S302. In 1996, they asked the Academy to take a look at their legislation, because they were very serious to make sure that this legislation passed in 1997. The Academy put a group together and examined the legislation. The main topic of the Academy's comments was the adverse selection that could take place in this legislation. They also looked at the impact of adding the disabled into the Medigap market and some of the transition concerns that the Academy had with enacting this legislation. The Academy had various meetings and conference calls with the Senators' staffs and, also, with Representatives Johnson and Dingle on the House side, who wrote the companion bill. We recently had a meeting with them and we've got some follow-up work that's going to take place. Because Senate Finance doesn't have any clear

direction as to what they want to do, they're still in the brainstorming session and the Academy is participating in meetings with them.

One issue separate from Medigap, but does include some of the coverage for the elderly and high-risk individuals, is Medicare reform in general. We received an official request from Representative Stark on Medicare reform. He has a scenario in mind that if you do a little bit of everything you can save Medicare, and you can have it solvent into the future. The Academy is taking a look at his request and actually seeing that his assumptions are valid and how much savings really needs to take place.

Some of the politics surrounding the Medigap reform are really based on the anti-managed care climate. Everything is tied into not having seniors and the elderly locked into an HMO, and giving them the option to disenroll from HMOs for various reasons. The one thing that we have found from having these meetings with Hill staffers is they really think that Medigap reform is the magic bullet. Medigap reform is going to help the elderly. It's going to give security to the elderly and their health care reform, and it's also going to save money for Medicare. It is interesting that they've come to that conclusion. There is another Academy group that is looking at what the effects of Medigap and the utilization of Medigap have on Medicare.

In terms of Medicare reform, once again, Congress has decided to take the incremental approach instead of a comprehensive reform approach. Currently, the budget resolution agreed upon will secure the Medicare program for ten years. Part of the cuts and part of the savings are actually from provider cuts, and some of the changes to the adjusted average per capita cost (AAPCC) methodology. They've also done something interesting, which is a form of means testing for the Part B services. They're going to increase the premium for Part B services except for the lowest income beneficiaries. They have put money aside so the low-cost beneficiaries will not have an increase in premium. Overall, the outcome of this is that it's likely that there will be some type of Medigap legislation, again, because people on the Hill think that this is the magic bullet and it's going to solve Medicare reform. That, combined with the ten years that they've bought themselves to try to actually address the Medicare financial crisis, as it keeps being referred to, they think will help.

There are miscellaneous proposals that are out there just to improve health insurance coverage in general. This includes legislation by Representative Harris Fawell (R–IL) that would amend ERISA by expanding access to health insurance coverage for employees of small employers through open markets. It proposes the voluntary formation of association health plans, which also has been referred to as

Multiple Employer Welfare Association (MEWAs). Representative Fawell's legislation has strong bipartisan support, and it is very likely that even though he will not have stand-alone legislation, this will be attached on either the budget resolution or some other form of legislation as it goes through Congress.

There's been some concern about association health plans. They attract the healthier people. There's also some cost shifting and some market segmentation that can take place. There's always the enforcement issue of how you're going to actually regulate these health plans. The Department of Labor (DOL) has been criticized for their lack of regulation with MEWAs, and because it's connected with ERISA, obviously the states have no control over it.

Another proposal that you hear a lot about is provider-sponsored organizations and including them in the Medicare program. This was included in President Clinton's proposal. There are also various bills before Congress to include provider sponsored organizations (PSOs), which goes back to the free-market theme of "let's let the market evolve and not try to limit what the market can do." This is also tied into some work that the Academy's been doing with the NAIC on risk-based capital. Currently, the NAIC is about to finalize a formula for managed-care organizations, but Bill will get into that later.

Another theme that's been going on for improving health insurance coverage is mandated benefits. Again, this ties into that anti-managed-care environment that's going on in the Hill. There are numerous special interest groups trying to persuade members of Congress why their benefits need to be included and mandated. Last year, it was mental health and maternity stay. This year, there's been a thrust for breast cancer protection. Keeping in line with the anti-managed-care theme, there are about 18 bills on various topics from emergency care coverage, gag rules, and insuring some standards for health care quality within the managed-care environment. The one thing that the people on the managed-care side keep as a topic for discussion is the impact that these initiatives have on the actual cost savings for managed care. This also gets into the debate of what is the role of the federal government. Should they be mandating these benefits or is this something that the market should be evolving and letting individuals decide for themselves?

In terms of Academy involvement in health care insurance coverage legislation, the Academy is preparing to comment on Representative Fawell's legislation on the Association Health Plan (AHP). The Academy is also doing considerable work with the PSOs and the solvency regulations for risk-bearing entities. The Academy's also going to be taking a look at mandated benefits as well and what the ramifications are on the cost side of any type of mandated benefits. I will let Bill talk more about the Academy involvement.

Mr. Bluhm: One of my hats is to be the vice president of the Academy in charge of health issues, and I'm going to talk a little bit about what we've been involved with. I'll discuss three things. The first is what our goals are in this area from the Academy's point of view, what we've accomplished in the recent past, and what's going on in 1997, although what's currently going on is still evolving. We had our Health Practice Council meeting recently and we put some new things into the bucket of things we're looking at and took some other things out. We also defined some new directions.

I'm going to start with the Academy's mission statement because I think it's a good one. It does a good job of outlining what direction we're trying to go in, and what we're trying to accomplish. It is to insure that the American public recognizes and benefits from (1) the independent expertise of the actuarial profession and the formulation of public policy, and (2) the adherence of actuaries to high professional standards in discharging their responsibilities. That guides what we do. That mission statement has been translated into four strategic directions and that is how it is implemented. The first of those directions is to figure out the key issues so we know what we're going after. The second is to develop access and the ability to communicate with the public policymakers so we can have that impact. The third is to interact with the SOA on things involving research, where that research is useful to help that public policy debate. And the fourth is to essentially give the policymakers the benefit of some free advice from the profession on public policy issues.

Target audiences are federal and state officials; that's probably the number one. Other audiences include players in the public policy area primarily, and the news media. The profession is a target audience as well, either to get you to be part of it, or at least be aware of it, and maybe take some ownership in it as part of the efforts of your profession in outreaching.

I'm going to intersperse some quotes that we've picked up along the way on some of the work we've done. This first is from President Clinton. President Clinton said, "We gave these numbers to actuaries from major accounting firms and major Fortune 500 firms who have no stake in this other than to see that our efforts succeed. So I believe our numbers are good and achievable." Which has a lot of things wrong with it, but it also had some good things. We have the President of the United States talking about his major initiative and the theoretical and financial underpinnings of it, and saying, well, the actuary said it's OK, so it's got to be OK. To me that says yes, we did it. That's a big success story.

Some of the other things we do include getting testimony to Congress, which is an interesting process. It's one of the things that many people view as a perk of getting

involved with public policy issues. You eventually get to testify in front of Congress. We respond to requests from federal and state officials. This is probably the most significant part of what we do because we're trying to build our presence as the experts to the staff people who are advising all these officials. These staff people call and ask us for our opinion and our views on things, and the more successful we are at giving them good advice, the more they will call us in the future and build the profession's presence. That's the whole goal as you saw in the mission statement. In addition, there are some written communications of various types. The major ones are monographs and issue briefs. The monographs you've probably seen. They're 8-1/2" x 11", folded, bound treatises on specific issues. They are single subjects having to do with health care reform that the Health Practice Council thought would be recurring themes or issues that needed a certain length in order to explain what the implications are and have people understand them. The issue briefs are a much shorter, more focused discussion of very specific single issues typically on four, printed sides. From what I understand, that shortness makes it more likely that it will actually be read by the members of Congress themselves or the legislators rather than the monographs, which are more likely to be read by their staff specialists in those areas.

In 1997, we've testified three times before Congress in the health area. The staff actually manages this process. They get three or four requests a week from federal or state officials which amounts to probably a couple hundred a year of varying size and difficulty.

Of the monographs and issue briefs we've produced, we have completed some on tax reform, but we were talking about building the process around five or six more to be done in 1997. The academy has 25 or so monographs available. Some of them are getting slightly outdated. That's part of our process.

Other examples of public policy impact that we've had include medical savings accounts (MSAs), where we had a significant impact, individual health care reform, especially the Kennedy-Kassebaum bill in 1996, Medicare, and health organizations' risk-based capital.

There was a report produced on medical savings accounts by a working group. Part of what we do is when we find one of these subjects, we try to get a working group together of people who are knowledgeable or want to be knowledgeable in that area. They then produce a report or do whatever needs to be done. In the process, this report was coordinated with all of these different groups in order to make sure we were covering all the bases and that they understood what we were saying. There was a major effort on the part of staff to coordinate everything and keep it organized. There were a variety of Capitol Hill committees, as well as executive

branch groups. The result was gratifying. Representative Bill Archer (R–TX) gave this quote. "The Academy's technical advice has been extremely useful to our committee this session, notably on the complex issues of medical savings accounts and pension reversions. I look forward to further assistance from the Academy actuaries on other pension and health care matters." Rep. Pete Stark said, "Last year the AAA helped us on the Hill understand some of the thorniest technical aspects of health care reform. The recently released Academy report on medical savings accounts is a most helpful analysis of that issue. My staff and I will be using it a lot in the coming months."

The second area where we've had an impact was individual health care reform. Included are issues related to Kennedy-Kassebaum. The testimony before the House Commerce Committee and the Environment Subcommittee had to do with solvency issues. That subcommittee is the one responsible on the House side for solvency issues. We gave a briefing to the Alliance for Health Care Reform. George Washington University held a policy forum. The briefing to the National Conference of State Legislators (NCSL) and the report to the NAIC were all built around Kennedy-Kassebaum. The report to the NAIC was an effort to help them interpret what the impact was going to be and what states would have to do in order to implement the Kennedy-Kassebaum proposal. The Kennedy-Kassebaum said here's what you've got to do, but it didn't take into account the wide variety of situations that states were in and that was what this report tried to do. There were many Congressional requests on this. Part of what we had done with Kennedy-Kassebaum included providing support to both Kennedy and Kassebaum. I got to sit in the day before the agreement was reached. I sat in for half an hour with Senator Kennedy and he was asking pointed questions about what the impact was on the marketplace of different options, which he was apparently looking at in striking a deal to get this bill passed on the last day, so that was an exciting opportunity.

Senator Kassebaum said, "I marvel at what actuaries do, the information that they provide, and the objectivity and credibility that they bring to the public debate. The Academy has helped us to confront the facts behind the political rhetoric, no matter how the chips may fall." For me, it's going to be a classic quote. I hope to use it in many future speeches. Senator Rockefeller said, "We are keenly interested in the Academy's assessment of the Kassebaum-Kennedy bill." Not quite as flowery.

The next subject is Medicare. Medicare is probably our number one issue for 1997. We've established several different groups to try to address this and split the product. It's a big issue with other issues involved, and it's been diced up into pieces so that we can grapple with consistent pieces of it. There is a Cost Savings Task Force, which is developing a Medigap monograph and the Expanding

Beneficiary Choice Task Force. These two task forces are the major efforts being made. We've categorized the issues into either cost savings issues or expanding beneficiary choice issues, kind of financial versus plan designed ideas. That Cost Savings Task Force has a subgroup that is developing the monograph, which Christine referred to earlier, is going to try to discuss what the impact is on Medicare utilization of having Medsup policies. For example, if people have 100% coverage, do they use their benefits more? It seems like a simple question, but it doesn't appear to percolate through without a lot of effort on Capitol Hill. The Beneficiary Choice Group has a couple work groups. The Medigap Portability Work Group, which started up in response to specific requests and led to the testimony that Larry mentioned, and as Christine mentioned, Representative Stark's request. His response is that we may be saying the sky is falling on Medicare but we can probably get things into balance if we're willing to give up a little on the benefits and charge a little bit more on the tax rate, and maybe pay physicians and hospitals a little bit less. We can piece that all together and make it work. He asked us to help him understand whether that's true or not, and so we're going to be trying to do that. The three Congressional testimonies that you heard about from Larry are these.

Senator Daniel Patrick Moynihan (D–NY) said, "The Committee's appreciation goes to the actuarial profession for its valuable assistance to the public policy process. It's particularly admirable in light of all the costly billable hours it represents," which I found particularly gratifying. I guess part of my reaction has to do with health risk-based capital, which I had invested a lot of time in developing the original formula that the Academy recommended to the NAIC. They have, however, changed their direction and it appears that the NAIC is not going in the direction of having a unified formula for health organizations as was originally requested and built by the Academy. They are creating a managed-care organization formula, which uses some parts of the Academy's recommendations, but appears to be undergoing the political process, which is feeding some significant changes. We hope to still have some input into it and still comment on it, but if you were counting on things going through in a rational way, you may want to take a look at this.

Some of the other things that are going on, as you heard, are efforts regarding uninsured children, Medigap portability, and codification. If you haven't heard about it, the NAIC is recodifying all of its model laws and regulations. It's potentially going to have some significant impact, which is becoming one of the points of focus for us. There is a new task force that's been appointed at the request of the NAIC to take a look at the Standard Valuation Law (SVL) and to "start with a clean sheet of paper." It's going to be an interesting process. I have tried to put my two cents in. I believe that this SVL effort may well be the most significant thing

that we do for health insurance over the next couple of years because of the state the valuation process is currently in with respect to health organizations. We are also looking at mandated benefits, which is a catch-all phrase for this miscellaneous stuff that Congress is starting to meddle in, which Christine called the anti-managed care kind of legislation.

To give you an idea of what we're seeing as critical, these are the 1997 key issues. The 1998 issues are to be published in September.

- Medicare reform is number one.
- Health care entities assuming risk, which is a long way around saying PSO, physician hospital organizations (PHO), or new organizations like that.
- Implementation of Kennedy-Kassebaum, which we've since decided probably is no longer as big an issue as it was.
- Uninsured children, which may be 1998's version of KK this year.

Then there's the ongoing priorities, which are things that we probably don't want to lose sight of but maybe not focus as much resources on. That includes codification, long-term care regulations, Medicaid managed care, and MSAs. Attention is being given once again to loss ratios, which seems to come around. When I went to my first SOA meeting in 1977, there was a lot of discussion about loss ratios at the time. There were discussions about finally getting out communication about loss ratios, how to use them, and what they mean, and so forth. I think it's going to be one of those things that haunts us forever. Some issues, such as insolvency programs, I guess that might mean solvency programs as well, Health Organizations' Risk-Based Capital (HORBC) and other health care reform initiatives are priorities now. My final message is that we'd love to have you involved if you want to be involved.

Mr. Anthony J. Houghton: I think the term *reform* is a loaded one. It makes it sound as if they're eliminating abuses and making things better when, in reality, in many of these state programs where they had reforms, they were really putting in restrictions and limitations on underwriting and pricing. The states were basically putting in required benefits and subsidies for one part of the market versus the other. Much of that was, presumably, with the purpose of getting access for groups or individuals who couldn't acquire insurance and to keep people from being priced out of the market. I'm thinking of the under-50, small-group legislation.

I think it will be important now that we've had some of these programs put into place to find out what has actually happened versus the objectives. If the objective was to get a larger proportion of the target population covered at a reasonable cost, what has actually happened in states like New York, New Jersey, Connecticut, and all these others who've adopted some of these programs? Do we have more people covered? Are the prices fairer than they used to be? Have we had people priced

out of the market because they were the ones, based on the changes, that had to subsidize others and they couldn't afford to subsidize those others? I think it would be good for people to follow up on some of these things to show what has happened, because sometimes in advance we have suggested to people what would happen if you had guaranteed issue, or if you eliminated preexisting conditions, and so forth. It would be nice to follow up and show people what has happened.

Mr. Bluhm: I think that's a great idea, Tony, and we should probably pass that along. There's a combined meeting of the Health Practice Advancement Committee of the Society and the Health Section Council that we may want to pass that along to, but I agree with you.

Mr. David P. Mamuscia: What is the status on mental health parity provisions of Kennedy-Kassebaum? I understand that they're supposed to put them into effect January 1, 1997, but I also understand that there weren't final regulations as to how they're supposed to play out. Could you help us with that a bit?

Ms. Cassidy: That's still true. Final regulations have not been out on that, and they keep postponing when to expect them.

From the Floor: Will they be postponing the date for implementation? It only seems reasonable that they should.

Ms. Cassidy: They will almost have to but, again, they haven't said anything officially on that. All the regulations on the Kennedy-Kassebaum legislation have been slow in coming, unfortunately.

From the Floor: I'd just like to comment that we find it, like most things that are mandated, to be very complicated and it could mean a lot of different things to a lot of different customers. I have a prediction that it won't go into effect.

Ms. Cassidy: One thing is that when the regulations haven't come out it's the good-faith effort.

Mr. Daniel L. Wolak: From what we see right now with self-funding, I think there's been almost a movement from self-funding back to capitated HMOs, that's just how the market works. I think with self-funding, the under-50 life market is just a tough market to make money and probably also for the fully insured plans. A couple questions would be, (1) Do you often get calls where an actuary would look at one of your briefs and say, I don't know if I agree with that viewpoint?, and (2) Are there any comments or discussion about situations in which there is a concern for market

segmentations? You're a lot closer to the issues than I am. I feel a little uncomfortable commenting on that, but I'd enjoy hearing thoughts you would have to further expand examples of market segmentation.

From the Floor: I recall the Fawell bill. If market segmentation is an issue, I'm asking if there is a situation in Kentucky or West Virginia where this happened, and if that's an example of what we're trying to look out for and comment on.

Mr. Bluhm: It is a classic concern that's built into these issues that we're involved with and developing, like the Kennedy-Kassebaum monographs and other monographs. I would encourage you to get involved with the working groups. I want to express to you that I appreciate what you did. When Dan was faced with that issue, he called the Academy to try to talk about how to make sure that we didn't get into a spitting match out in the public, which was a great thing to do. It let us work through what the issues were, talk about them, and connect them with the people that needed to be connected. I thought the results came out well. What the Health Practice Council tries to do with that kind of issue is bubble those things up and decide if they are big enough to address by themselves as an issue brief or if they should be part of another monograph.

Mr. Robert M. Duncan, Jr.: Bill asked me to mention an issue to you that involves the support of the Academy and involves actuaries. It could involve your financial futures actually. There's a bill in the California legislature now, a Democratic bill, which would hold the actuary directly accountable, directly liable, for the setting of capitation rates in HMOs. The legislative staff believed that they could put that in there because there is currently law in California, and similar in the nation, that involves the liability for cash-flow testing and asset-adequacy testing as an actuarial responsibility. Why not hold the actuaries responsible for capitation work as well? The problem in HMOs, of course, is as you ratchet down utilization and costs, it begins to impact both on insureds and providers. I thought about this bill a great deal, and I contacted the Academy for help. Fortunately, I had long discussions with Lauren Bloom, who contacted Bill. Bill wrote a letter for us and we sent all that material off to the legislative staff. That still wasn't quite enough. These people were going to hang on tight for this one. Apparently they'd gotten hold of the language in *Actuarial Standard of Practice* (*ASOP*) *16*. If you haven't read that, I would read it very carefully. I think what you want to know is, in issues like this where you have a chance to have a impact on a legislative bill, you can rely on the Academy for support. Something as important as this where the actuaries across the country could be affected if this type of bill was picked up and passed around. I'm also on the Actuarial Standards Board (ASB), which does the writing of these ASOPs, and we have a review process in the group that I'm working in that is going to look at all of the health ASOPs and look for potential flaws in things that have

already been written and to look to the future, more importantly, as to how these ASOPs ought to be possibly rewritten. One of the other concerns that we would have is that if these capitation rates weren't sufficient that an actuary in a competing plan, a consumer, or a provider, technically under common law, could take the actuary to the ABCD. You want to be aware of that. That was one of the other considerations we thought about in the liability of this law. The good news is that for various other reasons the legislative committee has taken out the language. We don't know what else is left there, but they are certainly after us. My caveats to you are to read your ASOPs very carefully and ask for AAA support whenever you need it.

Don't assume that actuaries will not be involved in the major, local managed-care decisions of the next ten years in health plans. Don't underestimate legislative intent wanting to use actuaries for undesirable political purposes.

Mr. Bluhm: I'll second that one.

Ms. Leslie F. Peters: I would like to ask Christine to follow up on an item you mentioned in your presentation—that legislators are seeing Medigap reform as a magic bullet. Can you comment specifically on what they think is going to happen?

Ms. Cassidy: Because Medicare reform is such a political hot button, basically, there's two choices that they see. Either you cut benefits or increase taxes. Neither one of those are very positive actions, so they've come to the assumption that if you either increase Medigap coverage or make it more accessible, try to save it by revamping what plans are available, that, in turn, will have a positive effect on the Medicare expenditures that can then bring the cost down.

From the Floor: Do they think that the impact would be enough to save the hospital insurance trust fund?

Ms. Cassidy: Yes. Unfortunately, over time. Another thing that they're seeing is that if you have these Medigap policies then you'll use those policies instead of actually using the Medicare program. This is also why, when we were talking about the subgroup that's producing a monograph, it's to actually explain to them how Medigap even evolved and what the effects are on the Medicare program. Unfortunately, the elected officials have gotten it into their mind that Medigap is their magic bullet. On the good side, the legislative staff realizes that this really is not the magic bullet that they're thinking it is. That's why they've turned to the Academy to try to get assistance.

Mr. R. Foster Seaton: I've read the HIPAA bill, actually a copy of the Conference Report. After dealing with the reforms that we went through with Omnibus Budget Reconciliation Act (OBRA), the question I have in light of reforms, whether it's HIPAA or further reforms, is do any of you who work with the legislators and the government agencies also deal with the judicial branch and, if so, do you anticipate any difficulties in the legality of these laws, their constitutionality? Is anything going to end up in the Supreme Court? For instance, reading the law it said they've turned this point over to the secretary to make regulations, because they recognize that it's entirely unenforceable or unworkable and they're going to leave it to somebody else to work it out. That's the sort of thing that leads to changing the laws. I've had to deal with trying to administer programs that conform to law only to have them turned around as soon as you get them going. What do you anticipate there?

Mr. Bluhm: I haven't heard of anything in the law, at this point, that the discussion has gotten to the point of talking about making test cases out of it. I understand what you're saying, but I think it may be too early in the evolution of this to do that.

From the Floor: But does the Academy coordinate with judicial on—

Mr. Bluhm: The Academy and Wilson may want to address this as well, but I think the Academy acts as amicus curiae, friend of the court. It becomes a friend of the court who gets involved in specific cases that impact the profession. Generally, we don't get involved in cases that affect the industry.

Ms. Cassidy: We do not look at legislation in the making, however, from a legal standpoint for members of Congress or states. We don't give a legal briefing, in effect. We look at the actuarial aspects of legislation and try to keep that succinct and keep it to what an actuary can do as opposed to pass on whether this is a great piece of legislation. That is, we would look at things that would impact an actuary's ability to work or the liability of work done by actuaries.

Mr. Bluhm: Yes, I think part of it is, if there's a case that involves the industry and there's big issues involved, typically the litigants involved would hire their own expert witnesses to provide actuarial opinions. Part of the things we've had to face and try to deal with is how do we, as the Academy, provide input in the public arena without taking food out of the mouths of members of the Academy, and that may be sort of one of those areas.

Mr. Geoffrey Marsh: I have a couple of questions for Ms. Uccello regarding uninsured children. I'm looking at Chart 3, where you illustrate the health insurance coverage of children under 18 by family income as a percentage of

poverty, and the 10% below the 100% poverty line who are apparently uninsured. What does the adult statistic look like for that same grouping? The 23% who did not have coverage for the adults and 10% who do not have coverage for children, what accounts for them not having coverage? What reasons typically are there for people not to have coverage below 100% of the poverty line?

Ms. Uccello: I think some people may just not want it and some people may not have access to it. Chart 3, which has the coverage by age, shows the 18–24 year olds were actually the highest uninsured age group. I think they may play somewhat of a part in this. It may also be that some children and adults who are eligible for Medicaid don't enroll for some reason. People who are below poverty but not eligible for Medicaid, if they're adults, are either not offered insurance or they can't afford it.

From the Floor: Could there be people included who had a job where they had insurance and moved to a job where there was a probationary period for a couple of months?

Ms. Uccello: That could be possible, but these figures show whether or not you had these types of coverage at any time during the previous year.

Mr. Mamuscia: We have a healthy children's program. It's called Caring for Children. It's a voluntary program. We donate our administrative services. We develop grant money and the coverage is free to the children, but they have to be sponsored. We've had some losses in enrollment simply because outreach efforts have failed, and I'm really not sure we know the reasons why. Much like your question, why are they uninsured? We have the money. We have the coverage, yet we can't seem to get those who are eligible for the coverage to come forward and sign up.

Ms. Uccello: I think that's part of the group who is Medicaid-eligible but not enrolling. I don't think you can understate the amount of people not being aware that they're actually eligible for the program. I think that there are ideas now to allow enrollment and information in schools and other places that will help increase awareness of Medicaid and other state-type programs.

Mr. Houghton: We have some small groups where they might have a $500 deductible plan but they do not cover well care, only illness and sickness. You can have a member of that group who has a child, he has coverage, but the child's regular office visits aren't covered, or if they are covered, they do not exceed the deductible. People who have to pay out-of-pocket and people who are deciding whether or not to have coverage may decide they're likely only to have those

expenses that will not be reimbursed and, therefore, they're not really at risk and they're just hoping they don't have that big, catastrophic claim. It might not be a $1,000,000 claim, but might be a $10,000–15,000 hospital claim. But when they do get it, they do not always go without care. They normally get the care some place, and frequently are not able to pay the hospital.