RECORD, Volume 29, No. 2*

Spring Meeting, Vancouver, B.C.
June 23–25, 2003

Session 84PD
The Uninsured and Underinsured

Track: Health

Moderator: CATHERINE M. MURPHY-BARRON
Panelists: KARL MADRECKI
THOMAS D. SNOOK
CORI E. UCCELLO

Summary: According to the Census Bureau, 14.6 percent of Americans—more than 41 million people—lacked any form of public or private health insurance coverage throughout 2001. Additionally, millions of people possess some form of insurance coverage that provides less than adequate catastrophic protection. Moreover, the numbers of uninsured and underinsured individuals are steadily rising, creating a public policy quandary of ever-increasing proportions. In this session, panelists discuss the causes and potential mitigations of America's uninsured problem. Particular focus is given to the actuarial profession's potential to contribute to the national public policy debate and the work of the American Academy of Actuaries' Work Group on the Uninsured/Underinsured.

MS. CATHERINE M. MURPHY-BARRON: I'm from Milliman USA in New York, and I'm also vice-chairman of the Academy's Work Group on the Uninsured/Underinsured. We're here today to talk about the uninsured. Current estimates have put the level of uninsured people at about 40 million in the United States. There are a million more who have some form of coverage, but that does not provide adequate catastrophic protection. According to all the reports coming out, these numbers are rising. It's a problem that's not easily solved, and it's also a controversial and emotional issue. It's getting increasing attention as we're moving into election season.

I feel it's also an issue that we as actuaries need to get involved in. We have all the skills necessary to look at potential solutions to the problems and put forth opinions as to whether we can solve the problem and find any unintended consequences that people have not thought about.

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We're going to start at the state level and take a look at what the states are currently trying to do. Tom Snook is going to describe what they've been doing in Arizona. Tom is a consulting actuary with Milliman USA in Phoenix. He has been with Milliman for about 15 years and has extensive experience in all aspects of the health-care industry.

Cori Uccello will review what's happening at the federal level. Cori is the senior health fellow at the Academy. She has participated in several briefings with congressional staff and has also prepared testimony related to health insurance. Prior to joining the Academy, she was senior research associate at the Urban Institute in Washington, D.C.

Karl Madrecki will give us an update on what the work group is doing currently. Karl is chairman of the work group, is a senior actuary at the BlueCross BlueShield Association and has 30 years of experience in operations, pricing, and underwriting. We'll get started with Tom.

MR. THOMAS D. SNOOK: I'm going to talk about a specific case study of some work that we did in Arizona, and I'll talk about the overview and the politics. I'll do this for two reasons. The first is to fill you in on the way one state is looking at this. The other, with an eye toward a broader view, is to look at the role that we in the actuarial profession can play and the value that we add as politicians and other policymakers go through this process of trying to tackle this difficult issue.

I'm going to give you an overview of what was going on in Arizona, lay the groundwork and set the stage. I'll talk about the role that actuaries played in the Arizona studies and talk in a little bit of detail about some of the studies and work that we did. I want to wrap up my presentation, for those of you that have been around awhile and remember the old SOA slogan, with "Ask an actuary." I think that was during Walt Rugland's presidency, where he was trying to get actuaries involved in more aspects of social life. I'm going to close with some general comments on what I think we in the profession can bring to the table in this discussion.

Here's the overview of what was going on in Arizona. In the late 1990s, there was a legislative task force formed by the Arizona legislature to study the big issue of access to health care. Obviously, the uninsured issue is a big piece of that. That task force comprised state senators, state representatives and some representatives from the community. That legislative task force held meetings and so on. They turned to something called the Arizona Health Care Cost Containment System (AHCCCS). In Arizona, we call it "access," even though it's not spelled that way. That's how we say it.

AHCCCS is the agency in Arizona that runs the Medicaid program. It runs the State Children's Health Insurance Program (SCHIP), all the premium-share programs and

all those related programs. It is even in the small-employer market. The AHCCCS agency staffed and did all the legwork for this legislative task force. It applied for a grant from Health Resources Services Administration (HRSA), the federal agency part of Health and Human Services, to study ways to reduce the number of uninsureds in Arizona.

HRSA has been giving a lot of these grants to many states, maybe close to all of them now. The Arizona grant was $1.2 million to go out and fund some studies to look at some issues.

Adjunct to the AHCCCS involvement, the legislative task force also set up a technical advisory group, comprising representatives from the industry to help the insurance and health-care industry in Arizona. That technical advisory group did include in its makeup an actuary named Sandy Gibson. I don't know how many know Sandy from BlueCross BlueShield of Arizona. As it turned out, after I put these charts together, I learned that when our work was done, and we went on our merry way, the legislative task force itself expanded, and Sandy became part of the task force. There wound up being an actuary on the task force.

AHCCCS got this grant and used the grant to do some research, fund some studies and prepare a report for the legislative task force, who in turn reported to the state legislature. AHCCCS retained two actuarial consulting firms, Milliman USA and Mercer Human Resource Consulting, to develop a series of papers on a variety of issues that I'm going to talk about in a minute. The Web address for these studies is www.ahcccs.state.az.us/studies/default.asp?ID=HRSA. You can download all 11 studies if you are interested in reading any of them.

In the interest of fair play, I will talk about what our competitors did. My esteemed colleagues at Mercer wrote seven papers, most of which were focused inward, looking at issues within Arizona. They did a profile of what the uninsured population looks like in Arizona; discussed rural health-care initiatives that had been started in Arizona and how they were doing; and studied the Arizona basic health benefit plan, which is a standard plan under small group reform in Arizona. Their findings, by the way, were that it wasn't a good plan, which I agree with.

They discussed health insurance administrative costs and did a study on the elasticity of demand for health care and how price-sensitive demand for health care is. Somehow in all this, they did a feasibility study on Arizona state employees going self-insured. It has nothing to do with all the other topics, but it somehow got rolled into this grant. You can see there's a long list of myriad topics where they're getting actuarial consultants involved.

The studies we did at Milliman were more outwardly focused, looking at what was going on in other states that might be of use in Arizona to address the uninsured issue. We talked about what was successful, what was not, and what the common threads were among efforts that were successful and the common threads among

those that were not. We wrote four papers, two of which I'm going to talk in more depth about. The four papers we wrote were specified by AHCCCS and the legislative task force. We didn't choose the topics because we probably would have chosen different ones.

We looked at purchasing pools, or small purchasing cooperatives, that have been implemented in a number of states. Our report was not favorable. We discussed high-risk pools, which I'm going to talk about in more detail in a minute. We studied incentives and mandates, or specific initiatives that states have undertaken to directly reduce the number of uninsured, such as expanding Medicaid eligibility.

Finally, for some reason, the agency had us do a rather lengthy paper on what goes on in Western Europe and other countries that have completely different approaches to health insurance. We looked at national health plans and so on. Because Arizona is something of a conservative libertarian state, I don't know why the task force wanted to know about that, but it did.

I'm going to discuss two of these papers—the high-risk pools and the incentives and mandates paper—in more detail. You may find the results interesting in their own right, but these papers can serve as illustrations of how actuaries' strengths can add value to the policymaking process.

As I said, we did a paper on high-risk pools and looked around at all the different states. We found that they were, under many definitions, successful. High-risk pools work well for individuals who need them. If you're sick or for whatever reason uninsurable, you can get health insurance provided you can afford to pay for it. As a result, high-risk pools probably can help reduce the number of uninsured somewhat.

We also found that high-risk pools provide some level of stability to the commercial health insurance marketplace, especially the individual insurance marketplace. The states that had effective high-risk pools had more stable individual markets and didn't have as many carriers exiting the market. We also found, though, that for the high-risk pool to be successful, it needs to be well-funded. What I mean by that is the funding of the high-risk pool needs to be spread over more than the enrollees in the high-risk pool.

That's obvious to everybody in this room. It's not, however, obvious to laypeople all the time, especially if those laypeople are politicians, so what states tend to do in the high-risk pools is set some premium-rate caps. A typical premium-rate cap may specify that the enrollee's premium for being in a high-risk pool cannot exceed some percentage of commercial rates in that state. That percentage might be something like 150 to 200 percent. That means, of course, that they have to get funding from other sources to pay the rest of the claims. Those can come from a number of sources, one being state subsidies straight out of the general tax

revenue. Another is insurer assessments, which are common and something we are all familiar with.

Two states, Minnesota and Wisconsin, have taxes levied against health-care providers that help fund the high-risk pools. Coincidentally or not, Minnesota and Wisconsin are the two states with the lowest rates of uninsured in the nation. I think that's probably coincidence, but who knows? There are other sources of funding, as well. A couple of states have used the old tobacco lawsuit money or lottery funds.

There are challenges that high-risk pools face, what they have to get over to be successful. First is that, if they have funding problems, and some states have limits on funding, this can often lead to enrollment caps. So once the high-risk pool hits a certain level of enrollment, it stops enrolling people. The bad part of that is it starts to destroy the whole point of having a pool. Not being able to insure a lot of people, it no longer is effective.

You have the enrollment-cap issue. You also have to balance all these different sources of revenue. What's the right amount for each party to be contributing? Should it be 150 or 200 percent for the enrollees? Should it just be assessments? This leads to some ongoing political negotiation that never goes away. You never know, so you get this hassle with the political negotiation, and the funding is always in question. Finally, you have an administrative challenge because the state has to get into the business of running a health insurance company if it's going to run its own high-risk pool.

The second paper I wanted to talk about briefly is this one we called "Incentives and Mandates." When I say mandates, I'm not talking about mandated benefits, such as going to see a chiropractor. I'm talking about a hodgepodge of different initiatives states have undertaken to directly reduce the number of uninsured. This hodgepodge of different types of initiatives was specified to us by the task force that wanted some information on it.

The first one we looked at was public programs—the expansion or creation of new public programs: SCHIP, the premium-sharing program for families who are low-income but not poor enough to be on Medicaid, and of course the Medicaid eligibility expansion itself, where we're adding more people to Medicaid. In Arizona, we implemented something like that when the economy was good and we were flush with cash, and now we're wondering how we're going to pay for it all.

What we found in our review is that these expansions of public programs or the creation of new public programs have been successful in enrolling targeted populations. We have tens of thousands of individuals in Arizona even, which is a smaller state, who presumably were going without health insurance before and who now have health insurance. We think we've made a direct impact on the number of uninsured.

One of the issues that gets debated, though, with these public programs is something called crowd-out. Crowd-out is a concept that says if you expand your public programs broadly, you may discourage employers from providing health insurance to their employees. In effect, and in extreme cases, an employer—probably a small employer hiring low-skilled and low-income labor—could potentially drop a health insurance program that it has if it knows that the public program will enroll most of its employees. Academics debate about how bad an issue crowd-out is, but everybody agrees that some of it goes on.

Another one of the things we looked at was tax credits and deductions. A few states have tried these, where they've given an income tax deduction or even a tax credit for health insurance premiums to low-income people. There are two or three states that have done this, and they're not having much of an impact at all. We think it's probably because people who are uninsured tend to be low-income and don't pay a lot of taxes, thus the tax credits are a small proportion of the total health-care premium.

We also looked at pharmacy subsidies for the elderly. A number of states were trying to implement these. We were doing this work in late 2001, and these programs were still new, so we didn't have a take on whether they were going to be successful or not. They don't really address the issue of the uninsured, though.

We also looked at small-group market reform. This is a big issue, with which we are all familiar, I'm sure. We had a number of mixed conclusions on small-group market reform, specifically looking at how effective the small-group market reform has been in reducing the number of uninsured. First of all, we found that usually, but not always, small-group market reform leads to a more stable small-group health insurance marketplace. It's going to depend on the specifics of the reform and the dynamics of the market in the state.

Health insurance is now more readily available to small employers. If you're a small employer and you want to buy health insurance for your employees, you can go out and buy it if you can afford it. That's the catch. Small-group market reform does not address affordability at all, so it doesn't seem to have had much of an impact on the number of uninsured.

We also looked at individual market reform. Our conclusions were that individual-health insurance market reform has largely been unsuccessful and has led to, this is my own personal editorial here, some disasters in states where insurers have exited the market in droves.

Concerning employer mandates, one state, Hawaii, mandates that all employers provide health insurance to their employees. That has been in effect since 1970, which was prior to the adoption by Congress of ERISA. ERISA was adopted in 1974. Hawaii was specifically given an exemption saying that it could do that. Otherwise,

if a state such as Arizona wanted to pass a law that said every employer in Arizona is going to have to provide health insurance to employees, you have some conflicts with ERISA that would need to get resolved. I'm not a lawyer, but you'd probably need to get an exemption passed by Congress.

This is the same issue that came into play in the early to mid-1990s, when a few states, including Washington and Massachusetts, adopted these pay-or-play reforms, where employers were going to be required to either provide health insurance or pay an extra tax. They passed the law, but none of those programs got implemented in those states.

I've given you a laundry list of all these different kinds of legislative initiatives. The big common theme that we found was that the programs that are most successful at reducing the number of uninsured involve some expenditure of public funds. I don't think that's surprising if you think about affordability as being the main barrier to health insurance for a lot of people.

As I said, I wanted to close my presentation by talking about the role actuaries can play in the uninsured issue. In the Arizona case study I just presented, actuaries were an integral part of the process, and I believe we added a great amount of thought and value. As I said, two different actuarial consulting firms each using a number of different consultants from the firm contributed, and there was also an actuary who wound up being on the legislative task force. As a profession, I think we were prominent and played a good role. But you're going to ask, "What happened?" Like every other state right now, Arizona is facing a budget crisis, so the legislative task force hasn't done anything in terms of getting any laws passed.

Generally speaking, looking beyond Arizona, as Cathy said a minute ago, the uninsured issue is important but highly sensitive. It's controversial. Even on the Academy work group, which I've just recently joined, we're finding some controversy in getting things done. It's an emotional issue, and it's a political issue. On top of all that, it's an enormously complex issue.

There are financial and economic considerations. Within that, you have a lot of different players, a lot of different moving parts with health-care providers, health insurance companies and public policy consumers. There are a lot of moving pieces. There's a lot of money flowing different ways. That's just the money. There's the idea of delivering medicine; there's a medical consideration; and there's the public policy consideration. It's almost like a perfect storm of different issues coming together that make one big tangled mess.

But we're actuaries, so we're pretty smart. Specifically, we're smart about health insurance. We're expert in how the financial structure of health insurance works. In particular, we understand what works in a health insurance program and why, and what doesn't work and why. We can give what I call professional, rational, logical thought to the process—rational, logical thought being something that politicians

need a lot of. We could help to separate the wheat from the chaff, identifying things that can be valuable in addressing this problem, as opposed to things that are not.

MS. CORI E. UCCELLO: You've heard from Tom about the perspective from the state on expanding health insurance coverage, and now I'll give you a view from the federal side.

It seems like over the past couple of years at every SOA meeting, I give an update of what's going on in terms of the uninsured from Capitol Hill. I always give the same talk because nothing has happened. This time, I get to talk about something that's passed. First, I'll talk about some recently enacted legislation, and you'll see that those are small, incremental efforts, so there are still a lot of the other proposals floating around. Then I'll talk a little bit about what the presidential candidates are proposing in terms of expanding health insurance coverage.

In terms of legislation that has passed, last summer the Trade Act was passed, and that included a health insurance tax credit for workers who were displaced by trade. There was also the tax-cut bill from a few months ago, which included $10 billion to states to help their Medicaid programs. I'll talk a little bit more about those.

For the tax credit that was included as part of the Trade Act, there's a 65 percent uncapped, advanceable tax credit for trade-displaced workers, as well as workers who are at least 55 years old and who are receiving any portion of their pension benefits from the Pension Benefit Guarantee Corporation (PBGC). This is a relatively small program targeted at only about 500,000 eligible or displaced workers, but there are proposals to expand this kind of approach to all workers receiving unemployment compensation. That would be about 3.5 million workers. There are also broader tax credit proposals that would be expanded for the entire population.

Before I get to the $10 billion tax payment to the states for Medicaid, I want to back up and talk a little bit about Medicaid's problems. Medicaid covers about 15 million low-income Americans, and it's jointly financed by the federal government and the states. It's an entitlement for individuals, which means that everyone who meets the eligibility criteria can enroll. It's also an entitlement to states, meaning that there will be federal matching funds for all the enrollees in a state and the costs that are associated with those enrollees, regardless of how many people are enrolled or how much it costs.

However, because of the economic downturn, state revenues have been declining, and at the same time Medicaid costs have been increasing. States are having a lot of trouble meeting even their share of the Medicaid funding. As a result, nearly half of the states are turning to either reducing their benefits or limiting eligibility. States are asking for more help from the federal government to help finance these costs.

The enacted tax-cut bill includes $10 billion to states for their Medicaid programs. Federal matching payments to states currently average about 57 percent. This would increase by about three percentage points to about 60 percent. That means the federal government pays about 60 percent of Medicaid costs, and the states pay about 40 percent. However, this provision is temporary, and it will expire in October 2004. The president and a task force of governors have been working on some longer-term solutions.

Under the president's Medicaid reform plan, he would offer states the option of remaining in the current program with the federal matching funds, or they could go into an alternative program, in which the open-ended federal matching funding would be replaced by capped funds. Instead of getting funding that depends on how many enrollees there are and how much the costs are, they would receive a certain allotment each year. Under this plan, they would get some upfront fiscal relief, but their payments in future years would be decreased to offset that. They're trying to make it budget-neutral.

The president's plan would also give states more flexibility on their eligibility requirements and on the services covered. Right now, states typically have to get a special waiver if they want to do something different from what's mandated.

Many governors, however, are concerned that the president's plan doesn't protect states against unexpected Medicaid costs. Costs could increase because of an economic downturn, high unemployment rates, some kind of terrorist act or a natural disaster. They are worried that the Medicaid rolls will swell, and they won't have enough funds to meet that through the capped system. They proposed an alternative funding plan, which continues the open-ended commitment from the federal side for spending on mandatory Medicaid eligibles, and that's about two-thirds of the Medicaid population, but they would cap the spending for the optional eligibles. These caps would increase to cover unexpected costs for the year. If something were to happen that would increase the Medicaid costs dramatically, they could receive additional payments from the federal government.

Under this plan, the federal government would also be responsible for spending on Medicaid dual-eligibles. Those are people who are in Medicare and also are eligible for Medicaid. In the past week or two, however, talks broke down between the president and the governors. Democrats, in particular, were concerned that states would be on the hook if Medicaid costs were to increase dramatically, so I'm not sure what's going to happen.

In terms of current proposals, there are two ways of increasing health insurance coverage. One is through private coverage expansion, and the other is through public expansion. In terms of current proposals to expand private coverage, tax credits are one way to do this. President Bush has proposed granting $1,000 to individuals and $3,000 to families through tax credits, and they could use this money only in the individual market. They could not use that money toward

employer group coverage. However, other tax-credit proposals would allow these credits to be used in the employer market, or they could be combined with children's health insurance program (CHIP) money to grant family coverage.

There are other options to give tax credits not to individuals but to employers. They would be especially targeted to small firms and those employing low-wage workers who are much less likely to offer coverage currently. There are also proposals out there to institute either employer or individual mandates. Either employers would have to offer coverage and cover their employees, or individuals would be required to have coverage. There are also some options to allow individuals or small groups to join the Federal Employees Health Benefits Program (FEHBP).

The president has also been trying to get association health plans passed. He's been pushing hard on that. It did pass in the House last week. It's not clear what's going to happen in the Senate, but I would predict that passage is unlikely, and they might not even bring it up to the floor. The president is also hoping to expand medical savings accounts (MSAs) to allow universal access, to lower the required deductible, and to allow first-dollar coverage of preventive care.

A few months ago or sometime late last year, the Department of the Treasury clarified that health reimbursement arrangements, those accounts that are used with consumer-driven or defined contribution or whatever you want to call those kinds of plans, can roll over tax-free. This could help increase the use of those types of plans.

In terms of public coverage expansions, one thing that advocates keep trying to push for is increasing Medicaid enrollment and CHIP enrollment for those who are already currently eligible. There are some people, some children, who are eligible for these programs but are not enrolling often because they don't even know that these programs exist, don't have information or have some language barrier that's impeding their access to these programs. There are also options to expand Medicaid or CHIP eligibility, in particular to parents of children who are eligible for these programs or even to low-income childless adults.

Early retirees can be especially prone to being without coverage at a time when they need it. For several years, there have been proposals to allow early retirees to buy into the Medicare program.

Last but not least, there are some proposals out there to institute a single-payer system. I don't think anything is going to happen in terms of a more substantive or a more comprehensive expansion of health insurance coverage this year, because Congress is focusing on Medicare prescription drugs. We're going to see that more in the presidential campaign.

I already talked about some of the president's proposals, and now I'm going to talk about four presidential candidates who have released their own plans for expanding

health insurance. A lot of times, you'll hear them saying that they are promoting universal health care. A lot of times when we hear that, we hear single-payer system. That's not necessarily what they're saying. By universal, they're saying they want everyone to have coverage, but it's not necessarily through a single-payer system, although there are some people who do advocate that. For this presentation, I've included presidential candidates who have put forth a health insurance expansion plan.

Under Congressman Gephardt's plan, in terms of private coverage expansions, employers must offer coverage. This is the employer mandate. He would help increase the subsidies for employers. He would replace the current deduction of employer premiums with a tax credit. Currently, employers can deduct the amounts they pay for employer coverage, which is a tax subsidy of approximately 30 percent. He would replace that with a tax credit of 60 percent. That would about double the tax subsidy for those employers who are currently offering coverage.

For those who aren't offering coverage, the subsidy would be even higher. Rather than the 60 percent refundable tax credit on the employer share of premium cost, those who aren't offering coverage now would get this credit on the full premium cost, whether they are paying the full share of that or not. He would also have a COBRA subsidy for specific eligible unemployed, but I couldn't find anywhere how he defines eligible. In terms of public coverage expansions, he would expand CHIP and Medicaid to parents of eligible children, and he would also allow Medicare buy-ins for those aged 55 to 64.

When Congressman Kucinich is talking about universal health care, he does mean a single-payer system. He is promoting something called Medicare For All, which is based on the Canadian model. He says that this would eliminate the role of private health insurers. But even in a single-payer model such as that in Canada, there is still room for private insurers.

Senator John Kerry's private coverage expansion would allow all Americans to join the FEHBP. Something else that he would do is have federally funded reinsurance in which the government would pay 75 percent of catastrophic claims, which are claims over $50,000. He says that this would lower premiums by about 10 percent, making coverage more affordable to all people and presumably giving greater access to those who have some kind of health condition. He would also give tax credits to small businesses and increase tax subsidies for people who buy coverage in the individual market, are displaced workers or are early retirees.

In terms of public coverage expansions, he would increase eligibility for Medicaid and CHIP and increase the federal funding for those programs. Under his plan, the federal government would assume the state share of cost for covering children in Medicaid. In exchange, states would have to expand their CHIP eligibility to cover kids up to 300 percent of the federal poverty line, parents up to 200 percent and

childless adults up to 100 percent. That's an increase over what they're currently covering now.

Former Governor Howard Dean is focusing more on public coverage expansions, and he would replace SCHIP with Family and Children Health Insurance Program (FCHIP). He would first expand coverage to children and young adults up to age 24 who have incomes up to three times the federal poverty line. For a single adult, the poverty level is about $9,000. For a childless couple, it's $12,000. For a family of four, it's $18,000. Three times the federal poverty level for a family of four would be about $54,000. He would make state participation in this kind of plan optional, but he would ensure that the federal payments would offset the new cost of these expansions.

In terms of private coverage expansions, he would have an FEHBP-like plan open to all individuals without access to group insurance, as well as the self-employed and small businesses. He would give more tax credits to people who are currently uninsured, for any premiums that they have that are greater than 7.5 percent of their adjusted gross income. He would mandate that employers that offer family coverage cover dependents up to age 24. He would also mandate that employers offering coverage must continue paying their share of the premium for two months after employees leave a job.

Those are the thumbnail sketches of what their plans are. The bottom line is: What will be planned? How many people will these plans cover? How much will they cost?

According to estimates from a news service summary, Richard Gephardt's bill would cover about 39 million uninsured and would cost in the first year about $213 billion. That would increase to almost $250 billion in the third year.

Under Dennis Kucinich's plan, he would cover everybody. He would cover all 41 million uninsured. This would come at a cost of $2.2 trillion when it's fully implemented. The way he would do this is add a 7-percent income tax to all employers, replacing what they currently spend on their premiums.

John Kerry's plan would cover about 27 million uninsured and it would cost about $72 billion per year for the first five years.

Howard Dean's plan would cover about 31 million uninsured at a cost of about $88 billion per year. Note that when I'm giving you these numbers, they are out of the 41 million people who are uninsured.

MR. KARL MADRECKI: There's nothing in actuarial science or our training that prepares us to deliver a rate increase to a group, to do underwriting, to explain it to a buyer, to do customer service or to take these issues of health care to the people. My hat's off to the people who can do that, who can deal with regulators and

legislators and those who can deal with the public because we're dealing with an entirely different set of notions, beliefs and values.

If I took everybody in this room or everybody who's on the uninsured work group, we know an awful lot about health insurance. But the perspectives on health insurance once you step out of this arena are different. People talk about things like affordable health care. If I took a poll, we would all agree that no health care is affordable. Why? Because we're pretty good at pricing and know what health care costs.

What does health-care cost mean to average citizens? It might be what they are required to pay in terms of their employee contribution. It has a different notion. Some of them have no idea what it costs. All they are interested in is that somebody else pays for it. It's a different arena in terms of orientation.

Another thing is choice. To me, if you give people choice of benefits, they are pretty smart. They figure it out after a couple of open enrollments, and I could argue that by giving choice you maximized the cost of your health care. Also, anything that doesn't involve choice in the political arena is absolute suicide. If the providers don't kill you for not allowing freedom of choice, the population will or the lawyers will get you because they'll say that somehow you're not providing adequate health care.

Another difference of opinion in terms of how things work is one of my favorites—deductibles. If we go from a $300 deductible to a $1,000 deductible, and you ask most people what that saves in a year, they'll say it saves $700 a year. These are things that we run into quite regularly.

Early on in the uninsured work group, with all of this wonderful knowledge, we asked how we were going to attack this issue. The first thing we had was tremendous guilt because we couldn't solve the problem. We got over that quickly because we realized how big the problem is. Then there's the issue of bias. It's difficult to talk about this subject without interjecting some of your own beliefs, be they single-payer, for example, or voluntary market. We realized we had to stay clear of those types of beliefs and be objective because that's the role of the Academy. If you want to be an interested party, go to another side of the room.

We also agreed that we wouldn't comment on proposed legislation. There's a real problem in commenting on something that's proposed that has no details in it whatsoever. That's a practical problem in terms of dealing with these issues.

What are we talking about? We're talking about the uninsured and the underinsured. I might as well be talking about the insured, the uninsured and the underinsured because some of the things that we're going to talk about regarding the uninsured and the underinsured are challenges that the insured population is also facing.

We talk about medical. What in the world is medical? We are using a broad context. One thing we don't mean is disability. Long-term care is an interesting one because, depending on whom you're talking to, long-term care is important. Generally speaking, we're looking at what we call the active population when we talk about the uninsured because everybody who's Medicare-eligible has medical coverage. We're not talking about hospital indemnity or anything like that–e.g., $200 a day in the hospital or certain schedules.

We're also talking about the insured—people who have health coverage. That's a stretch of the word because our notions of insured don't mean just insured by insurance companies. A great number of people are covered by self-insured ERISA-type plans, but we're lumping these together because they provide coverage and some element of protection to varying degrees. So, while we talk about medical coverages or insured medical coverages, we may be referring to all situations where you're covered in some way.

You probably picked up on it a little bit that when I was talking about medical coverage, I didn't address scope and benefits because every one of us in this room who is covered under a health-coverage benefit plan probably has different benefits. We treat the individual with a $10,000 deductible the same as a union that has a $5 copay on everything as if they are synonymous in that both are "insured." We began to realize that when people are talking about health coverage or medical coverage, we may not even know what they are talking about. At least one thing we know is we're not necessarily talking about the same thing. But if you notice, in all of these they are all generically referred to medical coverage.

We did feel we were qualified to help policymakers. There are areas where actuaries can add value in these considerations. Certainly we're good at our ability to budget and price, but in arriving at our budgets and our prices, we make an awful lot of assumptions. We hope to take our tools into the broader arena and try to use them when we're commenting on these issues.

We felt that where we don't have some specific proposal to comment on, perhaps we could develop some fundamental questions that policymakers will face or a checklist of sorts and then use those in the future to evaluate proposals that come about. Quite honestly, while we've done a lot of work, we still don't have a very big toolbox with which to analyze the different proposals. As a result, we do have an uninsured work group, but there's a lot of overlap with the SOA and with Medicare Reform. We'd like to split our work group. We're more than happy to sign up some people. We have some good projects. That's my solicitation for today—please, come join us.

You've heard a lot of talk about numbers. Another thing besides the definition of medical coverage that we learned is that we found ourselves trying to do different presentations on who the uninsured are and how many of them there are. We

quickly learned that counting the uninsured is better left to individuals who are better equipped to deal with this issue. Most of the numbers that we came across are done by statistical sample. The Current Population Survey (CPS) is the most common one. It surveys 50,000 households. It's an extrapolation to the U.S. population. It's difficult to tell right now with the recent Congressional Budget Office (CBO) study whether there are 21 million uninsured, 31 million uninsured, 41 million uninsured or 60 million uninsured. We'll talk a little bit about those different notions.

Another area where we ran into that was in Medicaid. Are there 25 million people covered by Medicaid or 39 to 40 million people covered by Medicaid? I found counting issues a little strange because I thought this was an exact science when I first became involved. But then I began to realize how enormous the problem is of dealing with the U.S. population and the way we have information or what information I thought we had that we don't have.

The numbers that are collected by survey involve interviewers with varying degrees of training. You have to deal with whether you're covered for a short amount of time or whether you are covered or uncovered for a year. There are all kinds of overlaps. Regardless of whether it's 21 or 60 million, or anything in between, or how many people are on Medicaid, health coverage is a big problem. We agree on that, but we're not going to try to second-guess as actuaries the counts in the population. If you're a statistician, you can have an awful lot of fun with that one. As I said, we decided that reconciliation of counts was not one of our focal points. We didn't want to referee that one.

Lack of health coverage is a big problem, and it's a bigger problem because of all the other issues that are going on right now. The current medical sponsors' ability to pay is going to drive uninsureds. Retiree medical coverage is going to be the most vulnerable first. After that it's going to be the employers asking, "Can I afford this?" It's all variations of the same thing.

One of the things that we thought we could do is step back and look at different studies of why people don't have health insurance or at least characteristics of people who don't have health insurance. Among those characteristics are varying degrees of low-income levels, varying degrees of good health or ill health and citizenship. We thought perhaps if we sat back, we might be able to derive some observations that might enable us as a group to comment on some things.

We thought we'd develop some observations and treat them as if they were mutually exclusive even thought they are not. For just about anything you're going to do, others are going to have a different reason for why they think somebody is not insured, or they may have a different priority in terms of the primary reason for being uninsured. The fact of the matter is, as I've already said, it's not important which is the first reason you think is causing it. It's still a major problem. It's okay

to have different views because we don't think it affects the underlying issues that are involved at all.

We came up with a schematic. Anything you do with the uninsured has to do with income. I think we would all agree on that. One thing to note is Medicaid eligibility is not the same from state to state. There are different levels of eligibility in terms of income, family status and a whole variety of other things. Given that there are a number of people who are eligible for public programs but are not signed up, estimates vary as to what proportion of the uninsured population is eligible but not signed up. The obvious problem that goes along with that is if they were all signed up, they'd probably bankrupt their states.

The other problem with Medicaid is that it's an in-and-out type of thing. When you need care, they sign you up on the spot if you're eligible. But there's an element in that if you were a policymaker, you would have to consider that you have existing programs. We saw that when people were talking about funding for states (the interplay between the governors and the beltway) because Medicaid is a federal program implemented at the state level.

There's another segment of low-income people, which is noncitizens who have been here fewer than five years. Noncitizens who have been here fewer than five years don't have the same status as citizens. If you're here more than five years and are low-income, you could be eligible for Medicaid. There's a category of low-income people who are poor noncitizens who have been here fewer than five years, and they would require separate consideration if you were developing policy.

Above the Medicaid income threshold, you get into the voluntary health coverage market, including high-risk people. There are some high-risk people below the Medicaid income threshold, but below the threshold they have access to coverage. The high-risk individuals are a concern in terms of the voluntary market. How do you deal with high-risk people in the voluntary market?

We came to the realization that we began to refer to those above the Medicaid threshold as financially uninsured. The notion became one of you are voluntarily uninsured because there are a number of people who are uninsured who could afford health-care coverage but choose not to purchase it. Remember we didn't define health-care coverage. Does that mean first-dollar coverage? Does that mean a $10,000 deductible? Among the financially uninsured, after you consider those that are voluntarily uninsured, you would have those for whom the health-care coverage is unaffordable From that observation, we get into issues of affordability. Whenever you get into issues of affordability, we're talking about priority, attitude and expectation. You have certain things that you may consider essential expenditures. What is your disposal income to go out and buy health care? However, we do have to admit that we're dealing with a population that's not acclimated or inclined to pay for health care, and that includes existing workers. Look at the labor problems with employers. Again, their concept of the cost of

health care and what they should be paying toward that is an issue of what I would call beliefs and values that we may have to overcome if we're going to reform or expand our health-care program.

One of the things that we thought we'd take off on as a group is to look at what medical coverage is and what medical insurance should cover. Is medical coverage insurance? I can give you a preliminary conclusion from a personal perspective—part of medical care is insurance and part of it isn't. Your day-to-day expenditures that are budgetable would not qualify for insurance because they are budgetable. It's not good value to buy insurance. That's dollar-trading. Also, what do you do once you know you're sick? This is where the problem comes in in the voluntary market because that takes it out of the insurance realm. If you know you're going to use services, it's no longer insurance in the open market.

We thought we'd tackle what medical coverage is. Another issue from our illustration would be to get into what the role of individuals, employers and governments is in health-care financing. This is a big thing to take on, but it's going to take all three—individuals, employers and the government. There isn't going to be enough money unless individuals are willing to kick in, unless the employers are willing to kick in, and governments are willing to kick in. It's going to raise some interesting issues of essentials versus discretionary expenditures when you get into the role of the individual.

If you think about it a little bit, there was a proposal for a tax credit for $1,000 and $3,000. Ask yourself what you can buy for $1,000 and $3,000. There's a disconnect among the difficult issues to be dealt with in the uninsured population.

Are we all going to have to give up a percent of our income to health care? Are we all going to be taxed? Usually these things are income-related. We're not saying we would suggest something, but how do you analyze these particular issues? We're talking about financing or redistributing anywhere from 14 to 20 percent of our gross domestic product. We're not talking about easy issues. We're talking about real money. We're not just talking about demand side; we're talking about supply side, too. We're talking about big economics intertwined with actuarial thinking.

Another favorite illustration of mine of the issues to be dealt with is the individual versus the family, because one of the interesting things in employer-sponsored health care is even though a family typically pays more out-of-pocket for its health-care coverage, if you looked at one minus the employer contribution, the family employee is probably getting two to three times the dollar amount in health-care coverage if you were to equate it as income. In other words, the employer's subsidy as a dollar value is much greater for the family.

If you throw this into the open market, you're going to expose that difference, and then how do you treat the family? I think in a lot of these areas, there's a potential to harm the family. It's a difficult thing to deal with in terms of policy because the

United States loves families. The IRS has let this one go on for a long time and I think sanctions that. It's a difficult concept once you get beyond equal pay. We tend to be a country that thinks in terms of income levels.

There are plenty of areas where actuaries can add value. Geography is always an interesting one. If you remember during Clinton Care, nobody wanted to be in the pool with New York City. In Illinois, nobody wanted to be in the pool with Chicago. How are you going to pool it? Do you think one state is going to send one of its citizens to another state for health care if it's paying for it? A lot of issues go into: What is your medical coverage? Who can you use for medical coverage? Where can you go for your health care? They are all related.

MS. UCCELLO: I want to cut in and say something here. I forgot to say how much the president's plan would cost. It would cover six million of the uninsured and cost $40 billion a year.

MR. TOM AHMANN: I have a question about the high-risk pools and the analysis that was done. How did you measure the reduction of the uninsured? Given what we just heard, we don't even have a good clue about the real number of uninsureds. You get the idea that my question has to do with the cause and effect issue.

MR. SNOOK: We didn't measure anything in relation to the uninsured. We turned to papers that attempted to do that and presented a variety of results. If you have an individual who would be otherwise uninsurable but who has health insurance through the high-risk pool, you've eliminated that person from the ranks of the uninsured. The people who are in the high-risk pool are people who can't get health insurance otherwise. Every member of the high-risk pool couldn't get health insurance from any other source. Mostly those pools have a requirement that you've been rejected by two insurance companies or something like that. It's self-defined. You're looking at me like I'm crazy.

MR. AHMANN: You're not crazy as far as I'm concerned. I think it's a difficult issue. The reason I was asking and what I was thinking about as a follow-up question is, and I'm not really sure you can answer this; the high-risk pools are seen as a possible alternative to doing nothing. Other possible alternatives were also thrown up on the screen where you force the insurance companies to guarantee issue. I expect that the effects on the system as a whole and the number of insureds in the state may be that the state might have a lot of hidden effects, so that even if you did measure who is in the high-risk pool, it may be that say one-third of the number of people are affected by the solution that the state offers.

MR. SNOOK: Yes, you can construct an argument that because of insurer assessments, it drives health insurance premiums up, and so some people are knocked out of the insurance pool because of affordability issues and somehow in

there it triggers the threshold. I don't think that's likely just because of high-risk pools, but I see your point.

MS. JOAN OGDEN: I am a pro bono member of the Utah Health Insurance Association, which commissioned a market research study of the uninsured in Utah. It was instructive. We found that 17 percent of the uninsured in Utah exceeded 200 percent of the poverty level. In Utah, that would be $36,000 for a family of four. Of that 17 percent, 12 percent made more than $150,000 a year. We also found that of those under 200 percent of poverty level, 20 percent paid full premium for their own coverage by choice.

When we asked them what health insurance or what health benefits ought to cover, the responses surprised us. First, they want doctor visits. Two, they want dental care. Three, they want glasses. Way down, they wanted prescription drugs. Hospital care was so far down on the list it was astonishing. This is what people think they want in terms of health-care benefits.

KIRK TWISS: In Tom's presentation, you mentioned the issue of prescription-drug-purchasing coalitions that states are starting to put together. I think in light of the Supreme Court decision on the Maine program, this could be an active area in the near future. I was wondering if maybe the other panelists would comment on how they think these will play out and if they will have any impact on the underinsured?

MR. MADRECKI: Could you repeat the question, please?

MR TWISS: The prescription drug purchasing pools that states are starting to set up for seniors. It was mentioned as a bullet point in Tom's presentation. I just wondered if the rest of the panel would comment on that.

MR. MADRECKI: I'll take a whack at that one. In looking at pharmacy dynamics, one of the things that concerns me about discount programs, for example the federal government stepping in, is you're starting to affect price. We're not quite sure what the counteraction is going to be from the pharmaceutical industry on the rest of the payers because it is one of these things where you squeeze a balloon, and it can come out somewhere else.

We pay different drug prices in the United States than they do here in Canada. They have a price master here, and they agree with the drug companies as to what they're going to pay. In most cases, it's different and sometimes less than we're paying in the United States. There's also this notion of what in the world is average wholesale price (AWP), which makes it like hitting a moving target.

When I look at the expansion of the notion of a discount card, it's unclear to me what that will result in. It's an interesting phenomenon because you're talking about displaying prices. That could be everything from a big chain pharmacy to a

Mom-and-Pop store. I don't know how you price at point of sale to be perfectly honest and what that's going to mean. Are you going to put up price charts for all the pharmacies? I just really don't know.

HOBSON CARROLL: I have three questions and comments. First of all, I've done a lot of work in the past few years on what I call low or maximum benefit plans for the working poor. I'm not talking about discount cards. I'm talking about real medical care along the lines that she mentioned about the Utah survey. This goes back to a question in the opening comments about not having adequate catastrophic care. I would like to point out that what is catastrophic is in the eye of the beholder. For a lot of these people, they're not looking for more than $50,000 worth of benefits or even less.

Second, regarding these plans by the presidential candidates, I think that one of the basic truths is that you have to get everybody in the system. I didn't see anybody except for Kucinich, of course, who said that everybody has to have health insurance coverage that meets a certain minimum in this country, and then we'll worry about how they get it and provide the vehicles for allowing them to get there.

The last comment concerns the health-care financing role players. I didn't see providers up there. It seems to me that they are going to have to play a big role along with government, people and employers, who all have to give up something to make it work.

MR. MADRECKI: One thing you can anticipate is that for every action there will be a reaction on the part of the providers. One of the things that we thought as a group we would delve into as we were considering the definition of medical coverage is you could reverse this whole thing and agree on which provider you'd want to pay, as opposed to trying to define medical coverage in terms of medical necessity. What would happen if you gave up freedom of choice? How should you pay providers and who should own health-care assets?

I agree with you wholeheartedly that there is a tremendously powerful lobby on the other side of the fence whose reactions should not be underestimated. Witness Resource-Based Relative Value Scale (RBRVS) last year when they got the change because I don't know what the doctors are going to do next year. I believe they're doing another decrease.

MR. TREVOR HOLLAND: I'm going to state an assumption based on an impression and ask my question. My impression is that a lot of those people who are uninsured currently do receive medical care by going to clinics and hospitals. That's my assumption. My question is: Have any of the work groups looked at what the cost savings from the clinics and hospitals would be if those uninsured people were covered under insurance plans of one form or another?

MS. UCCELLO: It's true that people who are uninsured do get some care, but there

are many studies that show that they also forego some needed care. It's not the case that they get all the care that they need. Two studies came out recently by Jack Hadley and John Holahan that examine how much money is being spent on the services for the uninsured and how you could fold that back into the system, but I can't remember the numbers offhand.

MR. HOLLAND: Do you happen to know whether any of the cost that you were referring to, the plans for the various presidential candidates, for example, would net out those savings?

MS. UCCELLO: I don't know how the costs of those plans were calculated, but I don't think that they netted those out.

MR. MADRECKI: I would say that in the ideal world on a perfect price elasticity because we talk about cost shift in the private sector and bad debt. In theory I would say the providers should drop their prices in the real world to compensate for that. Then there would be that additional point because of the foregone health care.

The other thing that came to my mind when you asked your question was that in counting the uninsured, we don't include illegal aliens, which is a major problem in a lot of border states such as Texas and California, where they use a lot of those resources. That's a tough one to deal with politically.

MR. SNOOK: There was a study done in Arizona, another border state. This showed the burden the health-care providers in the state have to bear in terms of extra uncompensated care for migrant workers from south of the border. It's quite substantial. It creates a burden and keeps physician compensation down, so it discourages physicians from moving to the state.

MS. OGDEN: Incidentally, you can get an executive summary of the Utah Health Insurance Association study by contacting the executive director at congresman@AOL.com and requesting the executive summary. The full study is available but for a price, and I don't know what that is.

MR. LARRY NITZ: Everyone talked about the uninsured, and they talked about the Medicaid-covered. Often we mean the Medicaid-eligible. In Hawaii, one of the largest holes is that group of people who cannot manage to fill out on a periodic basis an approximately 24-page form set in about six-point type. It's just been revised to simplify it. Having seen the form myself—I've only been a professor for 35 years—I can't fill it out, either.

There is something about the question of whether there is goodwill on the part of social service agencies to enroll all of those who under the law are their charges, or whether this is just a device to drive them away from the doors so we have something to complain about. Any time someone shows me a 24-page form that we're going to give to the poor and to people who are a little bit disorganized, I

have to question the goodwill and the good faith of that organization as a provider of whatever it is.

MS. UCCELLO: On the flip side of that, I remember when CHIP programs started, and just down the street from me, they were enrolling kids at McDonalds with little three-by-five cards, so there are efforts. I think there's a wide gamut of enrollment procedures for these programs.