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ACCESS TO CARE

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Responsible HEALTH CARE REFORM

PART 2: ACCESS TO CARE

BY MAC MCCARTHY AND BARBARA NIEHUS

This is the SECOND ARTICLE in a four-part series about what actuaries see as ideal components of a health care reform package.

In the Feb./March 2010 issue of *The Actuary*, we introduced this series of articles, and reported on concerns and suggestions from the Healthcare Reform workshop session at the 2009 Conference of Consulting Actuaries (CCA) meeting. This article will focus on access to health care, especially noting the fact, expressed at that workshop, that access to health care is not the same as access to health insurance. Subsequent articles will address Cost Control/Efficiency and Funding/Financing.

To more thoroughly delve into actuaries' thoughts on access issues, we gathered additional input from the CCA's Healthcare Reform Taskforce (HRT) members and other health actuaries, some of whom provided written comments while others offered their opinions via a January 5th conference call devoted to this subject. Our purpose is to summarize these perspectives, provide food for thought, and foster knowledgeable debate over alternative approaches for addressing the issues. If there appears to be bias or implied preferences anywhere in this article, these should be taken as personal opinions of the authors, not a consensus of the HRT nor the CCA or any other actuarial organization.

At the time this article was written, Congress was still working on a national health reform bill.[1] Regardless of the result of that effort, access and related health care issues will be at the forefront for the foreseeable future. For the purpose of this article, "Access to Care" includes the ability of individuals both to avail themselves of appro-

FOOTNOTES:

[1] Each house of Congress had passed different health reform bills. Congressional leadership was still working on a compromise bill.

priate medical services and to have access to insurance coverage to help finance the cost of those services, although we realize these are intertwined. Also, the use of the term "insurance" is broadly defined to include all health care coverage, public or private, insured or self-funded plans.

BARRIERS TO ACCESS TO HEALTH SERVICES

In the United States today, the same health care providers often see three different categories of patients, with a different method for determining provider payments for each category.[2] Without getting into details—we'll save that for a later article—it works something like this:

- Services for those with government-provided insurance (Medicaid & Medicare) are paid at standard rates or formulas determined by the government;
- Services for those with private insurance receive payment according to fee arrangements negotiated in advance by the patient's insurance carrier, if the provider is in the carrier's network;
- Services for those without insurance, or insureds that go "out of network," are charged fees determined by the providers, with little or no regulation or market pressures. (For those with insurance, out-of-network care may be partially reimbursed by the patient's insurance carrier.)

Over time, these complicated payment schemes have contributed to a variety of access-to-health-services issues.

THIS CREATES A MEDICAL SYSTEM THAT IS DESIGNED PRIMARILY TO FIX MEDICAL PROBLEMS AFTER THEY OCCUR. …

For years, medical schools have produced many more specialists than primary care physicians, largely due to the fact that medical students are aware that payment schedules are more generous for specialty services. As a consequence, it can be more difficult to see a doctor for routine maintenance and preventive care than it is for a major illness. This creates a medical system that is designed primarily to fix medical problems after they occur rather than keeping people healthy, which is a rather poor risk management strategy.

There are exceptions to the over supply of specialty physicians. For instance, in the field of obstetrics, the high incidence of malpractice claims has driven up the cost of liability insurance and physician frustration levels often reach the point that few are entering this field and many are restricting their practices to gynecology or leaving the specialty altogether.

Many geographic areas, particularly rural and inner-city areas, suffer from an inadequate supply of some, if not all, types of medical providers. This may be exacerbated for individuals with network-based insurance plans who may have to travel considerable distances to find in-network providers.

Employed individuals often have difficulty accessing medical care during normal business hours, particularly during poor economic times when layoff concerns are heightened. This stress also occurs when the employee must take time off to accompany a child or dependent adult. The employee may feel that emergency room care is the only option for them and their dependents. Government and carrier fee schedules do not encourage providers to maintain nontraditional hours.

To offset losses (or lower profits) from government-determined Medicare and Medicaid fees, providers generally seek to negotiate significantly higher fees with privately insured plans (including self-insured employer plans). "Retail" prices are set even higher for out-of-network and uninsured people, in part due to the bad debt associated with billings for services not covered by an insurer. For patients without insurance or with high deductibles, providers may require payment up front. With growing numbers of patients covered by government plans and increasing pressure from carriers and plan sponsors to hold down price increases, more and more providers either refuse to accept Medicaid and Medicare patients or limit the number they will see. Some actuaries feel these are inevitable consequences of a three-tiered financing structure overlaid on a single tier health system.

There are a few alternatives to the private medical system, such as Veterans Administration hospitals, and state-supported and charitable clinics—but these are not broadly available, not well known by the population, and face significant funding and capacity challenges. Further, budgetary considerations have led many states to close some facilities and to cut back on the social services workers, who have served to channel needy persons to these facilities.

The multicultural nature of our society presents further challenges to access due to lan-

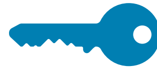
FOOTNOTES:

[2] There are exceptions, such as Veterans Administration hospitals, military facilities and a limited number of community care centers, but this statement is true for the vast majority of health care delivered today.

guage barriers and discomfort with traditional U.S. approaches to medicine. Many recent immigrants and subcultures have difficulty finding providers they trust and to whom they can relate.

High price is often cited as the reason that those without insurance, as well as those with high deductibles and limited benefits, do not seek medical coverage during the early stages of illness. But just as disconcerting as the price itself is the fear that comes from having no way of knowing in advance what the cost of care might be, due to the confusing and mysterious methodologies for setting prices. When someone is planning to have work done on a home or a car, an estimate can be obtained in advance to help make an informed decision—not so with health care.

An insurance card is often seen by patients, and used by providers, as the "ticket" to get in the door of the health care system. As long as there essentially is a single tier health care delivery system, access to health care insurance will be a necessary component of health care reform. However, insurance reform alone will not resolve all access-to-care problems.



BARRIERS TO ACCESS TO HEALTH CARE INSURANCE

Eligibility for public plans is defined by law. The two largest plans are Medicare and Medicaid. Enrollment for Medicare is managed through the Social Security Administration, and Medicaid enrollments are managed at the state level. For those covered by Medicare or Medicaid, it is important to locate providers who are willing to accept patients covered by the plan—this is especially difficult in states where Medicaid reimbursements are low.

Most private health care insurance in the United States is provided through employer-sponsored plans. The prevalence of employer-sponsored plans grew rapidly during the 1940s when war-time wage freezes required unions and employers to create new approaches for offering economic benefits to employees. Favorable tax treatment added to the proliferation of plans, until such plans became an expectation for employees and an important topic for collective bargaining. For the most part, employers are not required by law to provide health care insurance.[3] Many small employers do not offer a plan, primarily because of the cost and associated hassle of providing such plans. When an employer offers insurance, there is a great amount of flexibility regarding the types of plans being offered and the cost sharing between the employer and employee. Over the years, as costs have risen, employers have scaled back plan designs and passed along a greater proportion of the funding costs to employees.

Employers and insurers have developed a succession of approaches over the years to try to keep costs affordable. These types of efforts have led, in many cases, to financial penalties or non-coverage of certain types of care or treatment. Plan designs that involve high deductibles were conceived as encouraging the patient to be judicious in the seeking of care.

There has been little federal regulation of employer plans over the years. Insured plans are subject to state regulations, but most large employers and a growing number of smaller employers offer fully or partially self-funded plans that are exempt from state regulation. Employers typically self-insure to avoid state mandates and/or premium tax, and to be assured that they are paying their own costs and not subsidizing others. In 1986 the Consolidated Omnibus Budget Reconciliation Act (COBRA) required employers with 20 or more workers to offer the opportunity to continue employer coverage to certain employees who had lost their jobs or to dependents who lost coverage.[4]

AN INSURANCE CARD IS OFTEN SEEN BY PATIENTS … AS THE "TICKET" TO GET IN THE DOOR OF THE HEALTH CARE SYSTEM.

FOOTNOTES:

[3] Since 1974 Hawaii has required all employers to offer health care insurance to all employees working at least 20 hours per week.

COBRA allows employers to pass along the full cost of insurance (as defined in the law) to the participant.[5] And in many circumstances, an individual who had been covered through an employer group could opt for conversion coverage, albeit at different benefits and often higher premium, than that under which the individual had been covered.

Another important federal law affecting both self-funded and insured plans is the Health Insurance Portability and Accountability Act of 1997 (HIPAA). For large and small employers, HIPAA addresses concerns regarding pre-existing limitation conditions and "job-lock" where an employee would be unable to change jobs because of ongoing medical treatment of a covered family member. HIPAA prohibits applying a new pre-existing condition limitation to a person who is changing coverage to a new plan, as long as there is not a major gap in coverage (63 or more days). It does not eliminate all use of pre-existing conditions; for example, if a new employee had no prior coverage and chooses to enroll, a limitation can apply for up to 12 months.

HIPAA also requires that, if a person had at least 18 months[6] of coverage under an employer plan, when that coverage terminated, the person has a right to purchase individual coverage (without limits on pre-existing conditions). HIPAA does not address what rates can be charged for those individual policies. In some—but not all—states, state regulation addresses what rates can be charged.

Because of HIPAA, any person who is covered for at least 18 months under a group or individual health care plan (including someone covered as a child of an employee) has a right to maintain continuous coverage without ever again being required to undergo assessment of health status (underwriting) or facing a new limit on pre-existing conditions. However, when there is no employer subsidy of the cost, the entire burden of the cost must be borne by the individual.

If the person loses group coverage and qualifies for COBRA, he/she can choose to extend coverage for the maximum period allowed. And when COBRA expires, or if COBRA is not available, HIPAA gives the person the right to purchase coverage from any carrier offering individual coverage in the state. The practical problem is that COBRA coverage or the individual policy can be very expensive. Many people are unaware of the rules or are unable or choose not to afford the costs and end up with a lapse in coverage (more than the 63 days proscribed by HIPAA). After a lapse in coverage, options become much more limited, and assessment of health risk plus application of new pre-existing condition waiting periods may be imposed.

So what happens to someone trying to purchase insurance in the individual market without qualifying under HIPAA? If the person has no medical problems, insurance can be found at a competitive (but still high) rate. Because of the high cost of insurance, frequently a plan with a high deductible will be chosen to make premiums more affordable.

If an insurance applicant has a history of medical problems, in most states the health insurer can decline coverage.[7] Alternatively, the in-

FOOTNOTES:

[4] Some states have passed "mini-COBRA" laws which expand the rule to smaller employers. COBRA coverage is a continuation within the employer's plan, so it terminates if the plan terminates (for example, if the employer goes out of business).

[5] The American Recovery and Reinvestment Act of 2009 (ARRA) provides a temporary government subsidy in certain cases equal to 65 percent of the total COBRA premium.

[6] Some states have more favorable laws that would result in a required period of less than 18 months.

[7] State laws vary. For example, in New York and New Jersey all health insurers who sell individual insurance must accept all applicants, at standard rates.

surer might modify coverage to exclude certain conditions and/or charge higher than standard rates. In the majority of states, there is some mechanism for someone who is otherwise uninsurable to purchase insurance (e.g., a state high-risk pool). This coverage is typically expensive and limits coverage of pre-existing conditions.

For individuals who cannot qualify for (or cannot afford) a traditional health care insurance policy, there are other alternatives available in the market. For people between jobs, a short-term (for example, six months) policy may be available for purchase. These plans can be affordable, but usually exclude all pre-existing conditions and provide only a temporary solution. Limited benefit plans (providing scheduled benefits up to, say, $10,000) can give the person an insurance card to get them in the health care provider's door and can also offer access to network discounts, rather than paying retail prices. These sorts of plans are useful tools in certain situations but fall short of providing the benefits of a traditional plan, and can be woefully inadequate for someone facing a serious illness or accident, or hospitalization.

CONSEQUENCES OF IMPERFECT ACCESS

A serious consequence of imperfect access to health care services is the impact on public health. For example, lack of access to medical care can result in portions of the population not getting needed immunizations. This can lead to spread of disease that would otherwise be much better controlled.

The United States scores poorly when compared to other industrialized nations in two major measures of population health: infant mortality and life expectancy. Our high infant mortality rates are correlated with socioeconomic issues. Stresses on state budgets have led to the scaling back or elimination of many social services programs and public health facilities that would otherwise have been available to work with at-risk mothers; and in many states, contraception for women covered through Medicaid is limited to a brief period following a birth. These women have a higher rate of unplanned pregnancy, and statistics report a higher rate of problems associated with unplanned pregnancies. The problem of infant mortality does not appear to have been recognized as a priority at either the state or federal level and the causes are not well understood. Similarly, lower life expectancy is correlated with both socioeconomic and lifestyle issues. It seems likely that, without providing supporting social services, simply increasing access to health care insurance will not create major improvements in these measures.

Imperfect access also leads to inefficient use of existing resources. For example, overuse of emergency rooms, particularly by the Medicaid populations, has been identified as a problem. As a result, emergency rooms are frequently overcrowded and often provide care that could be provided much more effectively and efficiently in another setting. Further, emergency room resources needed for true emergencies are often delayed while lower level care is being provided.

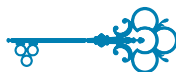
Provider networks (or participating providers) are common across private plans as well as Medicare and Medicaid. A shortage of providers or a shortfall of certain specialties can make delivery of care less effective, and clearly reduces consumer choice. Cost-shifting from public plans to private payors (as discussed above) and the resulting higher fees for private patients can also limit access and choice.

POTENTIAL SOLUTIONS TO INADEQUATE ACCESS TO SERVICES

When asked to think about access to services separately from access to insurance, the actuaries at the CCA workshop and the members of the Health Reform Taskforce came up with a diverse array of possibilities. None were seen as a panacea, but several taken in combination would significantly improve the current situation. Some will likely be necessary whether or not insurance reform takes place.

- Develop a new government-administered health infrastructure to widen the social safety net for people who fall through the cracks of the current health care system. This would be a fallback system of community care clinics and public hospitals, which some felt could be modeled upon the Veterans Administration system for health benefits. In addition, this system could focus on expanded social services for vulnerable populations such as Medicaid-covered pregnant women and the homeless. Additional social service staff and resources would be required to support these safety nets in the form of educational and communication efforts, and outreach programs.
- Address inappropriate over-utilization to free up supply and increase access. This would include medical malpractice reforms to remove incentives to overtreat and overprescribe, and regulation of physician ownership of ancillary service providers to remove perverse profit incentives. Malpractice reform could have the added benefit of encouraging physicians back into underserved, currently high-risk specialties. Renewed emphasis, and associated rewards, should be directed at diagnostic skills over treatment skills, particularly for primary care physicians.

- Encourage the development of more retail clinics, urgent care facilities, after-hours physician office services and worksite wellness facilities. Adjust fee schedules to encourage after-hours access to existing facilities and professional providers. Consider educational expense support in exchange for commitments to work in locations with inadequate service, after-hours care, primary care, etc.
- Increase the supply of primary care physicians (PCPs) to improve access. Ideas to accomplish this include: requiring time spent as a PCP before being allowed to specialize; offering financial incentives such as loan forgiveness; and increasing relative fee levels for PCP services over specialist services.
- Increase regulation of provider fees and required disclosures to help overcome the sticker shock (or fear thereof) related to health care services. The most discussed suggestion was a national fee schedule that would apply to all patients, regardless of insurance status. Likely this would require increasing Medicaid and Medicare fee levels and decreasing commercial insurance fees and dramatically lowering charges to people who lack insurance. Another thought was allowing providers to freely set prices, but require that all payers be charged the same. At the very least, it was felt that providers should be required to make fees readily accessible to patients and potential patients.
- Make greater use of allied health care professionals in order to address cultural issues and provider supply limitations. For instance, expand the use of physician assistants, licensed midwifes, nurse practitioners, pharmacist prescribing and complementary medicine practitioners.



POTENTIAL SOLUTIONS TO INADEQUATE ACCESS TO INSURANCE COVERAGE

There are a number of approaches to reforming the private insurance market to help make insurance more affordable and accessible:

- Require that the individual market offer insurance to all applicants on a guaranteed issue basis with no limits on pre-existing conditions. Experience under various state laws as well as COBRA and HIPAA have demonstrated that making insurance available is not a viable solution without also making it affordable. However, guaranteed issue requirements without mechanisms to address antiselection will lead to higher premium rates. There are a number of ways to avoid antiselection problems, with an effective individual mandate being the one most often discussed. An individual mandate must be enforced in a way that prevents people from moving in and out of the system as they need medical care—only paying premium when they expect to be submitting claims. Other mechanisms that alleviate antiselection include limited enrollment periods (e.g., an annual open enrollment); penalties for late enrollment (e.g., higher premiums for some period, such as five years); or allowing some less-severe pre-existing condition limitations. One, or a combination of these approaches, would be necessary since allowing people to game the system will increase the cost for everyone and lead to an unstable financial structure.
- Mandate employers to provide health insurance. In itself, a mandate will have little impact on the largest employers, since they already provide plans. It is likely that the smallest employers will be exempted. Successful business start-ups could encounter significant costs, just at a time when they cannot afford it. And once a mandate has been implemented, it is likely that additional rules will pile on, including reporting requirements, plan design requirements, contribution levels and other rules that could increase employer costs for expenses that are already considered uncompetitive in the global market.
- Provide premium subsidies based on income to the most needy. Note that this dovetails with rating restrictions. For example, limits on age bands will generally require younger people to pay higher premiums than their true underlying costs. If the youngest people are subsidizing older people, then publicly funded premium subsidies for low income young people will have to increase accordingly to make their coverage affordable. This is the most direct approach toward helping make coverage available,[8] but will be an expensive undertaking.

THERE ARE A NUMBER OF APPROACHES TO REFORMING THE PRIVATE INSURANCE MARKET TO HELP MAKE INSURANCE MORE AFFORDABLE AND ACCESSIBLE.

FOOTNOTES:

[8] It should be noted that even with the ARRA 65 percent subsidy of COBRA premiums, many people still deem it unaffordable.

- Put restrictions on plan design. There is a multitude of state and federal requirements adding to the cost of insurance, such as mental health parity, infertility treatments, chiropractic treatments and on and on. There has been discussion of setting minimum benefit thresholds, and, on the other extreme, possible taxation of "Cadillac Plans." For each of these issues, there are winners and losers, and there is always a trade-off of costs versus benefits. Simplification of plan designs may also result in reduced administrative costs.
- Encourage High Deductible Health Plans (HDHPs) as a way for individuals to take more responsibility for their health expenditures and reduce costs. Consumer driven health plans, including HDHPs, have been shown to result in lower costs without reduction of appropriate care (see the American Academy of Actuaries' monograph, *Emerging Data on Consumer-Driven Health Plans* at *www.actuary.org/pdf/health/cdhp_may09.pdf*). Deductibles for HDHPs are too high to be appropriate for many currently uninsuredshowever, so consideration should be given to tying minimum HDHP deductibles to income.
- Introduce a public plan that competes in the individual market. In order to maintain the current level of consumer options, it would be important that the public plan compete on a level playing field. A "level playing field" means that the new plan would negotiate with providers on the same basis, be expected to pay its fair share of expenses out of premium, pay premium taxes and comply with state laws comparable to insured plans, and meet the same solvency requirements, as private insurers. If those conditions aren't met, it is unlikely that insurers could compete in the market, contrary to the stated goal of increased competition.
- Mandate provider fee schedules that apply in the private market. These schedules could be either the same as Medicare schedules, or could be different. This could create major savings in administrative costs, related to fee negotiations and maintenance of multiple schedules. It would also have major consequences for health care providers, with some winners and some losers.
- Mandate minimum medical loss ratios. A mandate such as this one requires insurers to "pay back" a minimum percentage of premium in the way of claims, or face penalties. Its purpose is to prevent insurers from making unreasonable profits and encourage them to control administrative costs. Such a mandate can create a number of unintended consequences. If the threshold is set too high, it could result in carriers withdrawing from the market or becoming insolvent. It potentially punishes a carrier for investing in new initiatives to help control claim costs. And it can provide a perverse incentive to pay extra claims.

Another approach would be to abandon the current private market approach and move entirely to a government insurance program. This could be done by expanding Medicare and Medicaid to cover the entire population. The program could be delivered in a way similar to Medicare Advantage where it is provided and administered through private carriers. Many layers of simplification could result if only one provider fee schedule is used and all providers must participate. The role of employers and carriers would need to be carefully thought through. Because most insurance is employer based, the employers currently bear most of the cost of maintaining eligibility records and collecting employee contributions through payroll processing. These costs are not insignificant. Another practical reality is that Medicare and Medicaid have historically been underfunded. If they are the only game in town, hard questions would need to be answered to address both financing and cost controls.

UNINTENDED CONSEQUENCES

Legislators need to beware the potential unintended consequences of the solutions for which they agree to vote. Examples of problems that have arisen from efforts to address access problems include:

- Extending coverage to a large number of people, particularly those who heretofore have not had coverage and have postponed care, will increase the demand for medical services, and may overwhelm

the existing supply of providers. Contingency plans should be in place.

- Increased demand for services, by the law of economics, will put upward pressure on price. This could easily cause health care expenses to escalate even faster than they would have otherwise. As costs go up, premiums go up. Employer costs will rise; the need for individual publicly funded subsidies will grow. Consistent with these comments, Congressional Budget Office (CBO) projections indicate that the proposed legislation will cause premiums for individual coverage to be higher than they otherwise would have been. This can and should be addressed.
- As discussed above, rating restrictions can result in subsidies from one group to another and, over time, merely change the nature of the uninsured group, rather than a true reduction. This needs to be closely monitored and responded to accordingly.
- Additional restrictions and requirements may result in more carriers becoming insolvent or choosing not to participate in certain markets. If there are significant insolvencies, unfunded claims will need to be covered somehow, and guaranty associations will be stressed.[9] The end result could be less competition in the health insurance market and fewer consumer choices.
- State budgets will be hit particularly hard by Medicaid expansion, when many states are currently barely covering their costs. State and municipal workers in many cases have traded off salary for security and better benefits—which now may be taxed as "Cadillac Plans." All of this leads to less funding available for needed social services.
- All of the proposals discussed to date leave a large number of uninsureds. In the absence of social safety nets, these people will have an even tougher time finding access to care and may have the added burden of penalties for being unable to afford insurance.

CONCLUSIONS/RECOMMENDATIONS

Legislators should look for solutions that are affordable and sustainable. In order to come up with meaningful solutions, it is first necessary to publicly acknowledge that our country has limited resources and that sacrifices (financial and otherwise) will be necessary to achieve universal access.

Actuaries generally agree that this country has done a very poor job of learning from initiatives that have already been tried, including state, federal and private initiatives. A comprehensive study should be completed to look at what has worked, what hasn't worked, and why.

It is reasonable and appropriate to desire that each person have access to an appropriate level of health care. However, it is not possible to achieve such a goal without significant change to our overall health care structure. Certainly, simply providing access to insurance coverage will not be sufficient.

We as a society need to honestly acknowledge that it is important to prioritize our efforts. We need to treat this as a method of dealing most efficiently with finite resources.

WRAPPING IT UP

Access issues really cannot be separated from cost and efficiency. Seeing to it that the right services are provided in the proper setting at the right time will certainly be more efficient, which should lead to lower cost and still greater access. Access and funding are also related, as different strategies to improve access will require significantly different funding. Investing in a new public health care infrastructure will have higher front-end costs, but may be cheaper in the long run. Subsidies for insurance are ongoing and increase with trend and may further insulate consumers from true cost of health care and fuel additional cost inflation.

Certainly, our division of health care reform discussions into Access, Cost & Efficiency and Funding is artificial, as they are all inextricably intertwined. However, it is helpful to break complex problems down into component parts to make the analysis manageable. Please look to future issues of *The Actuary* for our treatment of Cost & Efficiency and Funding & Financing parts.

Many voices were raised to contribute to this article, and we thank them. Certainly some may have interpreted the discussions differently than we have, or feel we left out important considerations. We encourage them to let us know and also to continue to speak up on health care reform issues. We especially want to express gratitude to Joan Ogden, FCA, MAAA (Joan Ogden Actuaries) and John Dante, FSA, FCA, MAAA (Dante Actuarial Consulting) for their tremendous assistance gathering and organizing the material as well as superb reviews of our early drafts. A

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FOOTNOTES:

[9] Guaranty Associations are established by the states to provide a safety net for consumers in the event of an insurance company insolvency. Funds for the Guaranty Associations are provided by assessments against insurance companies operating in the state. For more information, see *www.nolhga.com*.