The Changing Health Insurance Market: Implications for Public Policy and for State Government Purchasers

Session 3: What does it mean to be insured?

Steven B. Larsen
Executive Vice President, AMERIGROUP
June 13, 2006

What do we mean by Insurance?

- The 3 A's: Affordable (sustainable), Accessible, and ***Adequate*** coverage
- Are all 3 "Achievable"?
- In both the public and private markets, the answer is currently no…
- We could probably agree on what is accessible or affordable…
- …. but adequacy is in the eye of the insured….

What do we mean by Insurance?

- Is there a consensus on whether ***adequate*** coverage should focus on prevention or catastrophic coverage?
  - "Insurance" is intended for accidental or unforeseen events….
  - Preventive services became the benchmark of adequate coverage, and state mandates and Medicaid emphasized preventive services - "an ounce of prevention is worth a pound of cure"
  - Current notions of adequate coverage, at least for enrollees, melds these concepts into a notion akin to personal universal coverage.

What do we mean by Insurance?

- The current trade off in the public and private sector is to swap affordability and access (and sustainability) for adequacy….i.e., benefits

- A few miles wider and a few inches less deep conflicts with the personal universal coverage notion, but is perceived by many policy-makers as a necessary or desirable trade off.

Trading Adequacy for Accessibility and Affordability

- Medicaid:
  - Oregon implemented benefit cuts and cost sharing
    - 40%-50% decline in enrollment of expansion population - 1/2 of decline due to cost-sharing
    - Not surprisingly, those who left reported delaying or deferring needed care.
  - Maryland implemented CHIP premiums, and enrollment dropped
    - Decision reversed by General Assembly - evidences ambivalence on trade off.

Trading Adequacy for Accessibility and Affordability

- Utah Medicaid:
  - Financed expansion of primary-care-only by limiting benefits and expanding cost- sharing for TANF population.
  - But in the expansion population:
    - 3/4 reported they needed care beyond the scope of coverage
    - 1/3 said they delayed or missed care due to cost or lack of coverage

Trading Adequacy for Accessibility and Affordability

- Maryland:
  - Expanded Medicaid primary care program
  - Specialty Physician and Inpatient coverage limited
  - Challenge:
    - How to manage the "big picture" i.e., the care that, if un-managed, drives the most costs?
    - Yes it expands access…is it the most cost effective expansion?
    - Reflects, again, the limitations of trading benefits for access

Trading Adequacy for Accessibility and Affordability

- The recent Medicare drug study in the NEJM found that:
  - Capping Rx for Medicare+ Choice enrollees reduced Rx costs, but overall medical costs, including non-elective admissions and ER, increased for those enrollees
  - Enrollees with caps had lower levels of drug adherence and poorer outcomes
  - No significant medical saving between those with and w/o caps

Trading Adequacy for Accessibility and Affordability

- The trend of swapping adequacy for access and affordability continues
  - Recent market developments, e.g., trends toward cost shifting to enrollees and benefit reductions, seem to favor a more "insurance" type system and less and "coverage" type systems:
    - CDHPs may limit progress on getting preventive services
    - The DRA expands cost-sharing and benefit changes - saving $3.2B

Trading Adequacy for Accessibility and Affordability

- For Medicaid, should we re-think the role of benefits in achieving affordability?
  - Benefit reductions and cost share, as traditionally made, can have mixed impacts on costs.
    - Drug caps can drive higher ER and inpatient
    - Higher cost sharing drives down enrollment and needed care…
- We must focus on the biggest cost drivers - to the system - not just in terms of the relative cost of particular benefits in a package of benefits.

Trading Adequacy for Accessibility and Affordability

- In Medicaid, the money is in treatment of the chronically ill….the 80/20 rule on steroids:
  - One estimate is that 10% of enrollees account for 72% of all expenditures
  - At AMERIGROUP, intense focus on just the "top" 500 members out of 140,000 drives dramatic cost savings
    - Keeping people out of the hospital is critical
    - One day out of the hospital is worth $1,000+ worth of Rx

Trading Adequacy for Accessibility and Affordability

- The DRA, and many states, have not sufficiently focused on these populations.
- From a Medicaid perspective, we need to think more programmatically by:
  - Focusing on the care management provided to the sickest and most expensive enrollees, and providing incentives to payors and providers
  - Focusing benefit limits or cost shares on high cost drivers

Trading Adequacy for Accessibility and Affordability

- A few thoughts on the Private Sector:
  - Limited Benefit policies historically have seen little traction.
    - For small business and middle-age "older" individuals, these policies were **not** perceived as a good value – i.e., benefit reduction exceeded premium reduction, premium reduction was insufficient, and conflicted with the "personal universal coverage" notion.
- In Maryland, small group purchasers typically "bought up" even from the "standard plan."

Trading Adequacy for Accessibility and Affordability

- But what do benefits cost:
  - Maryland Health Care Commission found that the "marginal" cost of mandated benefits is about 1.6% of premium - the full cost was 15%
  - Does this explain the lack of value proposition for limited benefit policies?
- More recently, Cigna, Aetna, Wellpoint and others report success in the limited benefit category.

Trading Adequacy for Accessibility and Affordability

- SOME CLOSING QUESTIONS:
  - How extensive is the appetite for "new" Limited Benefits Plans
    - CDHPs and "bare-bones" policies - will they overcome the personal universal coverage ideal?
  - What is the right mix of benefits and premiums that bridges adequate coverage in the public sector with the private sector?