

Chatting with the Uninsured

A Letter from the Editor

by Gail M. Lawrence

It has been fascinating to watch the debate evolve and mature on the topic of health care financing reform. Some states have now taken bold steps toward the goal of universal coverage while other states are taking a more incremental approach. I am encouraged by this forward progress and the spotlight on this critical issue at the federal level.

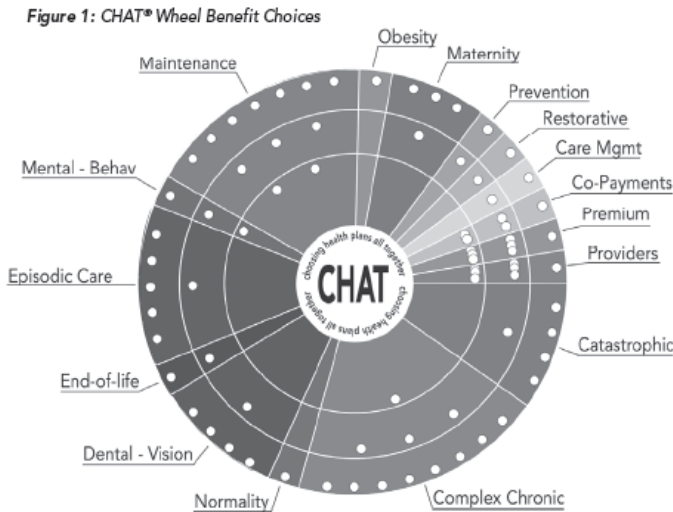
Health care policy continues to be a popular topic at our health meetings and the meeting in Los Angeles this past May was no exception. Len Nichols, a highly respected economist and policy wonk with New American Foundation, was a fascinating general luncheon speaker. There was also a follow-up session for questions from participants. Self-described as part-preacher, he was quite engaging as he shared insights into the political and cultural challenges for effecting change and proposed several key reforms. If you're a policy junkie, I highly recommend you check out sessions 13 and 14 of the meeting record.

Another policy pioneer, Marge Ginsburg, executive director of Sacramento Healthcare Decisions (SHD), hosted two "CHAT® sessions" where participants designed a health insurance plan for low income uninsured based on two-thirds of the cost of typical employment-based coverage. Sacramento Healthcare Decisions is a non-profit, non-partisan organization whose purpose is to bring community values into health care policy and practice. SHD is funded primarily by grants from philanthropic foundations, such as the California HealthCare Foundation.

The computer-based CHAT® program is an interactive software tool developed by physician-ethicists at the University of Michigan and National Institutes of Health. I was a participant in one of the two CHAT® sessions, each with 15-20 conference attendees. Using the CHAT® pie chart shown in Figure 1, participants were asked to allocate a fixed budget to a variety of health care services with varying levels of coverage. The available funds could also be used to lower premiums and co-payments and/or limit provider choice, but there were only 50 "markers" to spend and 76 possible places to put them. Definitions were provided for the types and comprehensiveness of the varying levels of services. We were first asked to each make our own plan design based on our individual views and values. We then worked in groups of three to begin the process of compromise and finally the entire group had to come to agreement on what this basic plan should look like.

While evidence-based medicine can help provide a strong foundation for helping us make choices as a society, the concept of minimum acceptable coverage may in large part be based on value judgments. It was certainly a lively discussion as each participant brought a unique perspective to the table. As expected, many participants were wearing their actuarial hats as they advocated the elimination of non-catastrophic, dollar-trading benefits such as dental or vision coverage.

My own perspective was influenced by watching my young adult children grapple with lapses in





Len Nichols, Lisa Trouville, and Marge Ginsburg enjoy some engaging conversation at the Health Spring Meeting reception.

coverage between jobs, waiting periods for benefits and employment layoffs. One's perspective and priorities are certainly different when you have no assets to protect, a limited income and a slight sense of invincibility. A high-deductible plan is not exactly appealing when you're bankrupt before you can even satisfy the deductible. With no assets to protect, the value of an insurance policy seems to be measured in terms of likely benefits received, making dental and vision coverage relatively appealing.

At the Spring Meeting, CHAT® was offered as a way of introducing actuaries to a different approach to benefits design—to challenge us to consider the trade-offs in a way that few of us had done before. But as a research exercise, CHAT® is also being used in different states to capture specific data on coverage priorities, as well as identify broad themes on how trade-offs are viewed by different populations. For example, SHD conducted a project with the uninsured in California last year. The results are available at www.chcf.org/documents/insurance/DesignCoverageForUninsured.pdf.

Some of the findings may surprise you. As a group, the uninsured had a strong sense of personal responsibility, which had several implications in their benefit design. First, they felt it was important to contribute toward the cost in

terms of premium and cost sharing on services. However, the cost must be affordable within the context of their income or they would not be able to either participate in the program or access health care services. In order to get more comprehensive benefits elsewhere, they were willing to give up their choice of providers and were receptive to requiring care management, including such things as mandatory patient education. Echoing the personal responsibility theme, the uninsured were willing to trade away coverage for health conditions created by poor choices in behavior, such as treatment for drug addiction or smoking cessation programs. These priorities often differed from those with higher income who already had insurance.

CHAT® participants also tended to exclude treatments that are not likely to be effective or less likely to be used, such as heart transplants and last-ditch efforts. Desirable benefits included those where “many people” had a need and could benefit, such as dental and vision care. Coverage related to keeping patients functioning, such as joint replacements, also had great appeal.

There are a number of takeaways for policy makers and even product development actuaries. Affordability is a critical issue and cost sharing may have to vary by income with special consideration for the chronically ill. Cost sharing could also be based on the relative effectiveness or cost-effectiveness of the treatment and financial incentives could be used to encourage healthy behaviors.

Thought-provoking and highly-engaging, CHAT® sessions can be arranged for other conferences and retreats. If interested, contact Marge Ginsburg at (916) 851-2828 or ginsburg@sacdecisions.org. To learn about using the CHAT® software for a local or state wide project, Marge Ginsburg can also give you information on how to obtain the software to do this. Other descriptions and results of CHAT® projects conducted by SHD can be accessed at www.sachealthdecisions.org. ■



Gail M. Lawrence, FSA, MAAA, is a consulting actuary. She can be reached at 515.224.4380 or at LawrenceConsulting@mchsi.com.