AMERICAN ACADEMY *of* ACTUARIES

November 6, 2009

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H-232 U.S. Capitol Building
Washington, DC 20515

The Honorable John Boehner
Republican Leader
U.S. House of Representatives
H-204 U.S. Capitol Building
Washington, DC 20515

Re: *Affordable Health Care for America Act* (H.R. 3962)

Dear Speaker Pelosi and Republican Leader Boehner:

The American Academy of Actuaries'[1] Health Practice Council commends members of the House as you prepare to debate and vote on the *Affordable Health Care for America Act* (H.R. 3962). We share with you the goals of reducing the numbers of uninsured, increasing the availability of affordable coverage, controlling health spending growth, and improving the quality of care. On behalf of the council, I appreciate this opportunity to provide the following comments outlining the key issues that need to be considered when evaluating whether this legislation will lead to a viable health insurance system.

We have identified three key criteria for whether particular reform approaches will lead to a sustainable health care system with increased access to affordable health insurance. In particular:

- For insurance markets to be viable, they must attract a broad cross section of risks;
- Market competition requires a level playing field; and
- For long-term sustainability, health spending growth must be reduced.

Our comments that follow provide the considerations underlying each of these key factors as well as whether the provisions in the *Affordable Health Care for America Act* conform to these criteria.

Insurance Markets Must Attract a Broad Cross Section of Risks

For health insurance markets to be viable, they must attract a broad cross section of risks. In other words, they must not enroll only higher-risk individuals; they must enroll people who are lower risks as well. If an insurance plan attracts only those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

average to reflect this higher risk. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

H.R. 3962 contains many provisions that would impact the extent to which insurance markets would attract a broad cross section of risks. The proposal would require guaranteed issue and renewal for all health insurance coverage and would also limit premium variations to reflect only age, geographic area, and family size. Furthermore, any premium variations by age would be limited to a 2-to-1 ratio between the highest and lowest premiums. Implementing these changes without making other changes to the incentives to purchase insurance coverage would exacerbate the extent of adverse selection, especially in the individual health insurance market. Individuals with higher than average health needs would be more likely to purchase coverage, while those with lower than average health needs would be more likely to forgo coverage, and the result would be higher premiums on average, relative to current premiums.

However, H.R. 3962 also contains incentives for lower-risk individuals to purchase coverage. In particular, the proposal would require individuals to have coverage or pay a financial penalty of 2.5 percent of adjusted gross income above the filing threshold, up to the national average premium. Employers would be required to offer and contribute to coverage for their employees or pay a fee of 8 percent of payroll. In addition, premium subsidies would be available for low-income individuals and families to purchase coverage as well as tax credits to certain small businesses.

The individual and employer mandates combined with the premium subsidies would help to mitigate adverse selection arising from more restrictive issue and rating rules. Appropriately, the mandates and accompanying penalties are imposed at the same time as the market reform rules are implemented, not after.

It is important to recognize that the impact of new market rules would vary across states, depending on their current market rules. In addition, the impact on limiting premium variations would vary across individuals. H.R. 3962 prohibits any premium variations except for those by age, geographic area, and family size. Moving to a narrow limit on premium variations by age, such as the proposed 2-to-1 limit, could result in dramatic premium changes, compared to what individuals are facing currently. In particular, younger individuals in states that currently allow underwriting and wider premium variations by age could see much higher premiums than they face currently (and may have chosen to forgo). The premium may also be high compared to the penalty of 2.5 percent of adjusted gross income, potentially reducing the effectiveness of the individual mandate. A broader allowable range in premium variations by age could cause less disruption, especially for younger individuals.

Increasing overall participation in health insurance plans, especially among lower-risk individuals, through an individual mandate and premium subsidies could be an effective way to minimize adverse selection. Even with a mandate, however, some individuals will choose to forgo coverage, especially if their expected health care needs and penalty for forgoing coverage are low. As a result, some degree of adverse selection will still occur in the health insurance system as a whole. Combining the mandate with not only tax penalties, but also other incentives such as limiting open-enrollment periods, imposing penalties for delayed enrollment (e.g., higher

premiums, imposing pre-existing condition exclusions), and instituting automatic enrollment (i.e., opt-out rather than opt-in provisions) could strengthen its effectiveness.

Even if adverse selection is minimized in the health insurance system as a whole, some insurance plans could end up with a disproportionate share of high-risk individuals. H.R. 3962 includes a risk adjustment mechanism for plans participating in the Health Insurance Exchange. This would help minimize the impact of adverse selection between plans in the exchange. Nevertheless, it is again important to recognize that risk adjustment mechanisms cannot fully mitigate the impact of adverse selection.

Market Competition Requires a Level Playing Field

For health insurance markets to be viable, plans trying to enroll the same participants must operate under the same rules. If one set of plans or insurers operate under rules that are more advantageous to high-risk individuals, then they will migrate to those plans; lower-risk individuals will migrate to the plans more advantageous to them. In other words, the plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. Over time, the premiums for these plans will increase to reflect this, leading to more adverse selection and threatening the viability of those plans.

From an actuarial perspective, creating a fair and competitive marketplace requires several elements: (1) all plan options must operate under the same rules; (2) premium rates must be actuarially sound; (3) provider payments must be comparable for all plans, and (4) any state requirements must apply equally to all participating plans.

H.R. 3962 would establish a Health Insurance Exchange and would create a new public plan option to be offered through the Exchange. Individuals would be able to purchase qualified coverage through the Exchange, and the ability for employers to purchase coverage through the Exchange would be phased in gradually by employer size, beginning with the smallest employers. Except for grandfathered coverage, qualified health insurance coverage would no longer be available in the individual market outside of the Health Insurance Exchange. H.R. 3962 would also facilitate the creation of non-profit health insurance cooperatives.

As created under H.R. 3962, the public plan and cooperatives would meet many of the requirements needed to ensure a level playing field. The public plan and cooperatives would need to follow the same market rules and benefit requirements that apply to private plans. In addition, the public plan would be required to negotiate rates with providers, rather than having the advantage of using Medicare provider rates. Under H.R. 3962, the intention is for the public plan and cooperatives to be self-sustaining through premiums. However, they would have access to a significant benefit not available to the private sector—the federal government would provide them loans (and in certain cases grants) to fund pre-operational expenses and to establish initial risk capital to ensure plan solvency.

A joint project undertaken by the Academy's Health Practice Council and the Society of Actuaries modeled the necessary start-up capital for either health insurance co-operatives or a

public plan option and found that the costs could be substantial and could vary greatly.[2] Under modeled scenarios, actuaries projected that start-up capital requirements ranged from approximately $1.7 billion to $45.6 billion. The wide range in projected start-up capital is attributable to three unknowns—how many people enroll, the difference between pricing assumptions and actual claims, and average enrollee claims. Although H.R. 3962 allocates funds for start-up costs, these allocations may not be enough to cover plan needs if enrollment is higher than expected, if initial pricing is not adequate to cover claims and expenses, or if average enrollee claims are higher than expected.

For Long-Term Sustainability, Health Spending Growth Must Be Reduced

To have the potential for sustainable success, health reform proposals need to include mechanisms that will control the rate of health spending growth. And because there is mounting evidence that the money being spent for health care is not providing enough value and that the vast variations in health spending across the country aren't correlated with variations in health care outcomes, spending growth should be addressed within the context of quality and value reforms.

Several factors contribute to the growth in health spending. A major factor is the misalignment in current provider payment systems between provider financial incentives and the goal of maximizing the quality and value of the health care provided. Instead, the most common provider payment mechanisms reward more care, and more intense care. Another factor is the introduction of new technologies and treatments increase health care spending by increasing utilization, particularly of higher-intensity services. In addition, comprehensive insurance benefits, by lowering the cost of care to the insured, can also result in increased utilization of health care services.

H.R. 3962 includes provisions that would generate health care savings, particularly in the Medicare program. The majority of savings would derive from reductions in provider payments, reductions in payments to Medicare Advantage plans, and discounts for certain Part D prescription drugs. Although these types of savings will help address short-term goals, options to more permanently reduce spending growth are needed to address long-term goals.

To this end, H.R. 3962 also includes provisions that would help shift the health care payment and delivery systems from rewarding quantity of care to rewarding quality of care. The legislation includes many cost containment and quality improvement strategies focused on the Medicare program and the public plan option, including provider payment and delivery system reforms that provide incentives for coordinated and cost-effective care. Such a comprehensive and coordinated approach to addressing quality and costs is needed to fundamentally transform the health system to ensure its long-term sustainability. However, acknowledging that the impact on health spending and health outcomes of many potential programs is still unclear, the legislation directs many of these efforts in the form of studies and pilot programs. Policymakers should work to ensure that promising approaches and successful pilot projects are adopted on a broad scale in a timely manner.

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[2] American Academy of Actuaries and Society of Actuaries, *Federal Health Care Reform 2009: Start-Up Capital Costs for Health Care Co-ops and a Public Plan*. October 30, 2009. Available at: http://www.actuary.org/pdf/health/tech_coops_nov09.pdf.

Summary

The American Academy of Actuaries' Health Practice Council strongly supports three key considerations for a sustainable health insurance system with increased access to affordable health insurance. In particular, for insurance markets to be viable they must attract a broad cross section of risks; market competition requires a level playing field; and for long-term sustainability, health spending growth must be reduced. Outcomes of the policy changes before you, because they involve so many complex interactions and market behavior, may not be fully known until implementation. Even actuaries must make certain assumptions in their projections, based on experience and expertise, as to what the exact effects will be. However, as your membership casts their votes, we urge you to first and foremost examine these criteria as a litmus for determining the success of this reform effort.

We welcome the opportunity to serve as an ongoing resource to you as health care reform legislation is considered in both houses of Congress and into a conference committee. If you have any questions or would like to discuss these comments further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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Senior Health Fellow
American Academy of Actuaries