



AMERICAN ACADEMY *of* ACTUARIES

Health Reform in the 21st Century: Proposals to Reform the Health System

Committee on Ways and Means
U.S. House of Representatives
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Statement Submitted for the Record by
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Chairman Rangel, Ranking Member Camp, and distinguished Members of the Committee:

As Congress examines the details of proposals to reform the health system, the American Academy of Actuaries'¹ Health Practice Council appreciates this opportunity to submit written testimony outlining the key issues that need to be considered when evaluating whether a reform proposal will lead to a viable health insurance system.

The Academy's Health Council has 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.

This statement provides the considerations underlying each of these key factors as well as comments on whether the provisions in the Tri-Committee health reform draft proposal conform with 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 draws only those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk. Adverse selection is a byproduct of a voluntary health insurance market. People can choose whether or not to purchase insurance coverage, depending

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.

in part on how their expectations for health care needs compare to the insurance premium charged. The higher premiums that result from adverse selection, in turn, may lead to more lower-risk individuals opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding such spirals requires minimizing adverse selection and instead attracting a broad base of lower-risk individuals, over which the costs of higher-risk individuals can be spread. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

How the various rules and regulations that apply to health insurance markets are defined can affect the degree of adverse selection. In particular, guaranteed-issue provisions, which prohibit insurers from denying coverage based on health status, can exacerbate adverse selection concerns by giving individuals the ability and incentive to delay purchasing insurance until they require health care services. Likewise, limiting or prohibiting premium variations by health status or other characteristics correlated with health spending can raise the premiums for younger and healthier individuals, relative to what they would pay if health status could be used as a rating factor. This could cause younger and healthier individuals to opt out of coverage, leaving a higher-risk insured population.

Increasing overall participation in health insurance plans, especially among lower-risk individuals, could be an effective way to minimize adverse selection. One way to achieve higher participation is to require individuals to have insurance coverage. Other types of incentives are also available to increase participation, including: limiting open-enrollment periods with penalties for delayed enrollment, subsidizing premiums, and instituting automatic enrollment (i.e., opt-out rather than opt-in provisions). The Medicare program includes some of these incentives. Nevertheless, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives. To be effective, however, penalties (or incentives) associated with an individual mandate need to be meaningful relative to the premium levels.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform draft proposal 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 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, the draft proposal also contains incentives for lower-risk individuals to purchase coverage. In particular, the proposal would require that individuals obtain coverage or pay a financial penalty of up to 2 percent of adjusted gross income. Employers would be required to offer and contribute to coverage for their employees or pay a fee based on 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 premium subsidies and coverage mandate would help to mitigate adverse selection arising from more restrictive issue and rating rules. It is important to recognize, however, that the impact of such requirements would vary across states, depending on their current market rules. For instance, in states that allow underwriting and premium variations by health status, the uninsured population may be less healthy, on average, than the insured population. Moving to guaranteed issue and prohibiting premium variations by health status would result in increased coverage among the less healthy population, potentially raising average premiums. The individual mandate would help moderate premium increases by ensuring that the healthy maintain (or obtain) coverage in those states.

In contrast, in states that already prohibit underwriting and limit premium variations by health status or other factors that are correlated with health spending, the uninsured population may be healthier, on average, than the insured population. The individual mandate would increase the participation among lower-risk individuals, potentially lowering average premiums in those states.

The effect of reform options, generally, on states with high-risk pools can also be complicated by whether the high-risk pool enrollees are incorporated into the individual market or whether the high-risk pools remain in place, even temporarily. According to the National Association of State Comprehensive Health Insurance Plans (NASCHIP), as of December 2007, 34 states had high risk pools enrolling about 200,000 individuals in the aggregate. These high risk pools act as the insurer of last resort for otherwise uninsurable individuals, and the eligibility rules, covered benefits, cost-sharing requirements, plan administration, and funding can vary considerably by state. Premiums for individuals are typically capped at a certain percentage above the individual market premium for a similar benefit package, and the remainder of the cost is funded by the state. The Tri-Committee draft proposal indicates that individuals in state high-risk pools could potentially qualify as meeting coverage requirements. However, states may choose to discontinue their high-risk pools after the implementation of comprehensive national reform.

The impact of an individual mandate can also vary by when it is implemented, compared with other market reforms. The Tri-Committee's draft proposal does not explicitly specify the timing of the implementation of the individual mandate compared with the imposition of guaranteed issue and modified community rating rules. To help ensure the enrollment of low-risk individuals, thereby minimizing adverse selection, it is important that the individual mandate be imposed in conjunction with the move to stricter issue and rating rules, not after.

With respect to the degree of premium rate compression required in the draft proposal, achieving universal coverage through coverage mandates or other means reduces or eliminates

altogether adverse selection in the health system as a whole by age, health status, and other characteristics that are correlated with health spending. If universal coverage could be achieved, it would be less necessary, from a plan solvency standpoint, to vary premiums by risk characteristics. The question of how to distribute the costs across the population would then become an issue of balancing the tradeoffs between individual financial equity and social equity. The draft proposal 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 percent of adjusted gross income, potentially reducing the effectiveness of the individual mandate. A broader allowable range in premium variations by age may cause less disruption, especially for younger individuals.

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. One way to avoid adverse selection between plans is to ensure that all plans competing for the same participants operate under the same rules. An issue particularly relevant to this discussion relates to whether large groups would be eligible to purchase coverage through the Health Insurance Exchange. According to the draft proposal, initially only individuals and the smallest firms would be allowed to purchase through the Exchange. In subsequent years, however, larger firms would be allowed to purchase through the Exchange. An adverse selection concern arises if eligibility for the Exchange is extended to large firms which would normally self-insure. In particular, large firms with higher than average health spending could potentially benefit by joining the Exchange, whereas firms with lower than average health spending would continue to self-insure. Such adverse selection would increase the average premiums for those in the Exchange. It may be more appropriate to limit eligibility for the Exchange to firms that would not normally self-insure.

Another issue related to potential adverse selection between plans is that plans could be at risk for financial losses if they enroll a disproportionate share of participants with above average health spending, especially when premiums are not allowed to vary by health status or other risk factors. Such threats to a plan's financial health could provide insurers an incentive to develop strategies to avoid enrolling less healthy individuals. To avoid these incentives and help ensure plans receive payments that are adequate relative to the risks they are bearing, the draft proposal includes a risk adjustment mechanism to adjust plan payments to take into account the health status and other risk characteristics of plan participants. This would help minimize the impact of adverse selection between plans in the Exchange. Nevertheless, it is important to recognize that risk adjustment mechanisms cannot fully mitigate the impact of adverse selection. In addition, some type of reinsurance mechanism could limit insurers' downside risk by protecting against unexpected high-cost claims.

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.

For example, if a regional health exchange or connector is created, and plans are offered inside and outside the exchange, the rules governing plans inside and outside of the exchange need to be the same. Otherwise either the plans inside the exchange or outside the exchange could get a disproportionate share of higher-risk individuals, depending on which set of plans is subject to rules that are more advantageous to those in poorer health. Level playing field issues arise not only with respect to health insurance exchanges, but also if insurance is allowed to be purchased across state lines or if a public plan option is offered alongside private plans.

From an actuarial perspective, creating a fair and competitive marketplace requires several elements.

- All plan options must operate under the same rules. The issue and rating rules as well as any benefit package requirements must be the same for all health plans. In addition, any premium subsidies must be available for all plan options and any default enrollment mechanisms need to allocate eligible participants between all participating plans. Adhering to the same rules and regulations will help minimize selection between the plans, and will help ensure competition is based on efficiencies and quality of care rather than on differences in enrollee risk characteristics.
- Premium rates must be actuarially sound. Premiums must be adequate to cover claims incurred, all related operating expenses, cost of capital charges and a risk charge. To ensure plan solvency in the event that plan expenditures exceed premiums, private plans are required to carry capital/surplus (an excess of assets over liabilities) to cover potential deficits and to fund major investments in support of infrastructure. Premiums include a risk charge to absorb minor adverse fluctuations in claims and/or expenses from expected, and to accumulate target surplus (that is, a level of surplus appropriate to the risk). The danger of not having such mechanisms is that deficits in any given year would cause increases in premiums needed in subsequent years, above those needed due to increased health spending. Capital charges reflect the cost of obtaining operating capital.

To ensure that any public plan premiums are self-supporting, and not reliant on general tax revenues, deficit spending, or intergenerational transfers, the public plan should include both a risk charge and a premium rate stabilization fund. Under this approach, public plan premiums would include capital charge and risk charge mechanisms to pay for the cost of capital and to fund a stabilization fund. A risk charge may look like a profit, but it is actually a cost of doing this business.

- Provider payments must be comparable for all plans. This is a particular issue if a public plan option is available. Setting a public plan's provider payment rates dramatically lower than those for private plans could help control plan costs, but could also result in cost shifting to private plans and reduced access to providers. Public plan provider payments should be set to balance the tradeoffs between ensuring adequate access to care and controlling plan costs.
- Any state requirements must apply equally to all participating plans. States place a variety of other requirements on private health plans, and these would need to also apply to a public plan option for the playing field to remain level. For instance, many states assess health plans to fund high-risk mechanisms, regulatory activities, and guarantee funds. States also require a variety of other non-benefit requirements on health plans, ranging from consumer protections to market conduct examinations and audit and actuarial certification requirements. These requirements would need to apply to all participating plans, whether private or public, as appropriate.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform draft proposal 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.

The public plan would need to follow the same market rules and benefit requirements that apply to private plans. Although the stated intention of the public plan option is for it to be self-sustaining through premiums, it is unclear whether the draft proposal's provisions would ensure that. The draft reform proposal states that the premium rates shall include a contingency margin. But if this margin includes only a risk charge and not a capital charge, any ongoing costs of capital will not be reflected in the premium. In addition, the creation of a rate stabilization fund is not included in the draft proposal.

The public plan option would also undermine the level playing field requirement that provider rates be comparable to the rates used by private plans. The draft proposal specifies that provider payments in the public plan would be set at Medicare rates (with 5 percent bonuses for certain providers), at least initially. This would create serious concerns regarding cost shifting to private plans as well as access to care issues for those enrolling in the public plan if providers refuse to see patients at the reduced rates. Even the largest private health insurance plans have commercial provider contracts significantly higher than 5 percent above Medicare rates, in almost all geographic markets.

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

According to National Health Expenditure data from the Centers for Medicare and Medicaid Services, health care spending increased 6.1 percent in 2007. Although this is the lowest growth rate in a decade, it far exceeds the general rate of inflation, and exceeds the growth in the overall economy as well. If health spending continues to grow at this pace, as projected, health insurance premiums will continue to increase as well. Unless health care costs are controlled, efforts to achieve universal coverage could be undermined. Reining in health insurance premiums in the near term will be meaningless if rising health spending returns premiums to their original levels within a few years and continues to rise rapidly thereafter. To have the potential for sustainable success, health reform proposals need 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, and there are options to address many of them, each offering promising opportunities to improve quality while reducing costs. The introduction of new technologies and treatments can increase health care spending by increasing utilization, particularly of higher-intensity services. More comparative effectiveness research should be conducted to better ensure that new technologies and treatments truly add value over their added costs. Another driver of health spending growth 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. Restructuring provider payment systems could result in more coordinated, cost-effective, and higher quality care.

Comprehensive insurance benefits, by lowering the cost of care to the insured, can also result in increased utilization of health care services. Although some utilization increases are for necessary care, some are for care that is unnecessary or of limited benefit. Plan design features such as cost-sharing requirements can be used to encourage more effective use of health care services. However, any incentives to make insureds, particularly those with chronic conditions, more sensitive to benefit costs should be balanced so that individuals are not discouraged from seeking needed care. Value Based Insurance Design (VBID), a relatively new concept in insurance benefit design, attempts to better target cost-sharing requirements so they more effectively encourage needed care, yet discourage unnecessary care.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform proposal includes provisions that would shift the health care payment and delivery systems from rewarding quantity of care to rewarding quality of care. The proposal 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. A comprehensive and coordinated approach to addressing quality and costs is needed to fundamentally transform the health system to ensure its long-term sustainability.

Conclusion

The American Academy of Actuaries' Health Practice Council has identified three key considerations that are vital when determining whether particular reform approaches will lead to a sustainable health 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. As Congress moves forward on a health reform proposal, it should ensure that its provisions adhere to these criteria.