AMERICAN ACADEMY *of* ACTUARIES

November 20, 2009

The Honorable Harry Reid
Majority Leader
U.S. Senate
522 Hart Senate Office Building
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
361-A Russell Senate Office Building
Washington, DC 20510

Re: *Patient Protection and Affordable Care Act*

Dear Majority Leader Reid and Minority Leader McConnell:

The American Academy of Actuaries'[1] Health Practice Council commends members of the Senate as you prepare to debate and vote on the *Patient Protection and Affordable Care Act*. 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 three key criteria that need to be considered when evaluating whether this legislation will lead to a viable health insurance system, and how the legislation can be improved to meet these goals. In particular:

- **For insurance markets to be viable, they must attract a broad cross section of risks.** Implementing market reforms to prohibit insurers from denying coverage and to restrict how much premiums can vary will result in adverse selection and upward pressure on premiums unless lower-risk individuals have incentives to purchase coverage. An individual mandate can bring lower-risk individuals into the pool. To be effective, however, the penalties for not complying with the mandate must be meaningful relative to the premium faced. The penalties in the *Patient Protection and Affordable Care Act* are very low, which is especially problematic given the bill's limits on premium variations by age, which will raise premiums for younger individuals. Strengthening the bill's individual mandate through higher financial penalties is needed to reduce adverse selection that would arise due to the new issue and rating restrictions.

- **Market competition requires a level playing field.** All plans, including any new public plans or health insurance cooperatives must operate under the same rules. As written, the public plan and cooperatives established under the legislation would be subject to the same market rules and benefit requirements that apply to public plans. They would also be required to negotiate rates with providers. The bill should retain these provisions and also ensure that start-up funds provided to these plans are adequate to meet not only pre-operational expenses but also solvency needs.

- **For long-term sustainability, health spending growth must be reduced.** Provisions to control health care spending should include not only one-time improvements that will help address short-

[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.

term goals, but also options that permanently reduce spending growth to address long-term goals. The *Patient Protection and Affordable Care Act* includes provisions that aim to reduce long-term spending growth by shifting the health care payment and delivery systems to focus on cost-effective and high quality care. Many of these efforts take the form of studies and demonstration projects. Policymakers need to focus intently on finding ways to control spending and ensuring that promising approaches and successful demonstration projects are adopted on a broad scale in a timely manner.

The comments that follow provide more detail on the considerations underlying each of these key factors as well as whether the provisions in the *Patient Protection and Affordable Health Care Act* match 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 average reflecting this higher risk. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

The *Patient Protection and Affordable Care Act* contains many provisions that would impact the extent to which insurance markets would attract a broad cross section of risks. The proposal includes insurance market reform provisions that would require guaranteed issue and renewal for all health insurance coverage and would also limit premium variations to reflect only age, geographic area, tobacco use, and individual/family status. Furthermore, any premium variations by age would be limited to a 3-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.

The bill contains incentives for lower-risk individuals to purchase coverage, but these incentives, especially those related to the individual mandate, are quite weak. In particular, the proposal would require individuals to have coverage or pay a financial penalty of $95 for 2014, $350 for 2015, $750 for 2016, and indexed thereafter. Premium subsidies would be available for low-income individuals and families to purchase coverage, as well as tax credits to certain small businesses. Employers would not be required to provide coverage, but employers with 50 or more workers who don’t offer coverage would have to pay $750 for each full-time employee if even one of their workers receives a subsidy through the health insurance exchange.

An individual mandate combined with the premium subsidies could help to mitigate adverse selection arising from more restrictive issue and rating rules. However, an individual mandate would bring lower-risk individuals into the pool only to the extent that it is effective and enforceable. To be effective, the penalties for not complying with the mandate must be meaningful compared to the

premium faced. Otherwise, lower-risk individuals would be more likely to pay the penalty and forgo coverage or drop the coverage they have, thus putting upward pressure on premiums.

The low penalties associated with the individual mandate in the legislation are particularly problematic given the market reform rules that limit premium variations by age. The narrower the allowed premium variation, the stronger the individual mandate needs to be in order to ensure that low-risk individuals obtain and keep coverage. Moving to a narrow limit on premium variations by age, such as the proposed 3-to-1 limit, could result in dramatic premium changes, compared to what individuals face currently. In particular, younger individuals in states that currently allow underwriting and wider premium variations by age could see much higher premiums than they experience currently (and may have chosen to forgo). The premiums for younger and healthier individuals will likely be high compared to the penalty, especially in the early years, but even after they are fully phased in, they are likely to lead many to forgo coverage.

Strengthening the individual mandate through higher financial penalties is needed in this legislation to reduce the adverse selection in the health insurance market that would arise due to the new issue and rating restrictions. Other incentives such as limited open enrollment periods, penalties for delayed enrollment, and automatic enrollment would also strengthen a mandate's effectiveness, and the Act does contain some of these elements. Nevertheless, higher financial penalties are needed.

Market Competition Requires a Level Playing Field

For health insurance markets to be viable, plans competing 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 higher-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, 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.

The bill 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. Exchanges would also be open to small businesses, with eligibility extended to larger businesses over time. The legislation would also provide for the creation of non-profit health insurance cooperatives.

As created under the *Patient Protection and Affordable Care Act*, the public plan and cooperatives would meet many of the requirements needed to ensure a level playing field. The public plan and cooperatives would be subject to 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. While the intention is for the public plan and cooperatives to be self-sustaining through premiums, 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 start-up costs. For cooperatives, the federal government would provide loans for start-up costs and grants to meet solvency requirements. For the public plan, the federal government could provide loans for initial operations, the purpose of which presumably includes funds to meet solvency requirements.

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 cooperatives or a public plan option and found that the costs could be substantial and could vary greatly.[2] Under modeled scenarios, we 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. The legislation specifies a limit on funds available for cooperatives. 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 sustained 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 that 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.

The *Patient Protection and Affordable Care Act* includes provisions that would generate health care savings, particularly in the Medicare program. The majority of savings would derive from reductions in certain provider payments and reductions in payments to Medicare Advantage plans. 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, the Act 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, 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,

[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.

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 demonstration projects. Analyses from the Centers on Medicare and Medicaid Services[3] and from the Congressional Budget Office[4] suggest that at least in their current limited form, these provisions will have only a minimal impact on health spending growth. Policymakers need to focus intently on finding ways to control spending and ensuring that promising approaches and successful demonstration projects are adopted on a broad scale and in a timely manner.

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 reforms before you, because they involve so many complex interactions including 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 the full Senate casts votes, we urge you to first and foremost examine these criteria as a litmus for determining the success of this reform effort. In particular, we believe that strengthening the individual mandate through higher financial penalties is needed to reduce the adverse selection that would arise due to the new issue and rating restrictions.

We welcome the opportunity to serve as an ongoing resource to you as health care reform legislation is considered in the Senate and through remainder of the legislative process. 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,

Cori E. Uccello, FSA, MAAA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

[3] Centers for Medicare & Medicaid Services memo on the *Estimated Financial Effects of the America's Affordable Health Choices Act of 2009 (H.R. 3962), as Passed by the House on November 7, 2009.* (November 13, 2009)
[4] Congressional Budget Office letter to Sen. Harry Reid on the *Patient Protection and Affordable Care Act.* (November 18, 2009)