



AMERICAN ACADEMY *of* ACTUARIES

March 8, 2010

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

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

Re: Heath Reform Reconciliation Package

Dear Speaker Pelosi and Majority Leader Reid:

Should the U.S. Congress move forward with budget reconciliation legislation that would enact significant health reform components, including provisions in the *Patient Protection and Affordable Care Act* (H.R. 3590) and its House-passed counterpart, aspects of the President's reform proposals discussed at the Blair House meeting and certain bipartisan proposals suggested by President Obama last week, the American Academy of Actuaries'¹ Health Practice Council (HPC) strongly reiterates the need to modify the legislation to avoid unintended consequences.

From an actuarial perspective, there are major policy and detailed technical issues that will determine the success of these reforms that have yet to be addressed. We urge you to seriously reconsider certain issues already approved in legislative form or and to consider the implications of some additional proposals as discussed in this comment letter. The Academy's HPC will make available to you the actuarial expertise to help address these concerns and to work with you develop workable outcomes.

- *Strengthen the individual mandate*—Both the House and Senate-passed bills would impose new issue and rating restrictions, including narrow restrictions on allowable premium variations by age. Both bills would also impose an individual mandate, an integral component of health reform, and an open enrollment period to limit the ability of individuals to delay purchasing coverage until they have health care needs. The individual mandate provisions are relatively weak, however, which limits their effectiveness to reduce the adverse selection that would arise due to new market rules. Increasing the financial penalties would strengthen the mandate, as would not allowing individuals to increase their benefit levels outside of the annual open-enrollment period, allowing individuals to move up only one coverage level from one year to the next, and after the first year, allowing previously

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.

uninsured new enrollees to purchase only the lowest plan option rather than a more generous plan.

- *Make the grandfathering provisions effective*—To the extent that proposed market reforms would result in significant premium increases for individuals with existing coverage, the grandfathering provisions in the bills would insulate to varying degrees individuals with existing coverage from experiencing rate shock. In the House bill, individual coverage would be grandfathered as of Dec. 31, 2012, with group plans in existence on that date subject to a five-year grace period to meet the new standards. However, in the Senate-passed legislation, the grandfathering provisions would not extend to individuals purchasing coverage after enactment but prior to when new market reforms become effective in 2014. Such individuals would not have protection against rate shock unless their coverage already followed the new rules. Making the effective date for the grandfathering provisions Dec. 31, 2013 rather than the date of enactment would eliminate this gap. If the effective date is left unchanged, legislation should clarify that the new plan provisions designed to take effect in 2010 (e.g., prohibition of lifetime benefit limits) would not void grandfathered status and that plans with minor coverage changes would retain grandfathered status.
- *Modify the medical loss ratio requirements*—Both the House and Senate-passed bills would impose minimum medical loss ratio requirements on insurers in the individual and group markets. From a practical standpoint, it would be difficult to impose a new minimum medical loss ratio requirement soon after the enactment of such a policy change. Appropriate time would be necessary for plans to submit new rates to regulators for approval. Plans typically file their premiums six to 12 months before they become effective, and also need time prior to rate filing in order to develop the rates. The agent and broker compensation structure would also make immediate implementation of a new medical loss ratio requirement difficult. Legislation should allow for a sufficient lag time for adjustment between enactment and the effective date of medical loss ratio requirements. In addition, it is important for any such legislation to reflect how medical loss ratios vary across markets and how it would be difficult for insurers in the individual market to satisfy the loss ratios that are typical in the current small and large group markets. Final legislation should also be clarified to make clear that when calculating loss ratios, the value of expenses for activities that improve health care quality and cost containment expenses are included as part of claims.
- *Create a level playing field for new health insurance plans*—The House and Senate bills would both facilitate the creation of health insurance cooperatives. In addition the House bill would create a public plan option and the Senate bill would create multi-state plans. These new plans would meet many of the requirements needed to ensure a “level playing field,” such as operating under the same rules governing private plans and requiring that premium rates be actuarially sound. However, unlike private plans, the public plan and health insurance cooperative would have access to government loans to fund start-up costs. The allocations for these loans might not be enough to cover plan start-up 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 due to adverse selection. The presence of risk-sharing mechanisms would reduce, but not eliminate, the losses associated with inadequate initial pricing or higher-than-expected claims.

- *Base insurance oversight on actuarial principle*—Recent proposals would increase the oversight of health insurance premiums and premium increases through the creation of a Health Insurance Rate Authority. If such a regulatory panel is included in a final health reform package, its regulatory oversight model should be based on actuarial principles. Furthermore, the panel would need to be advised by actuaries, who would examine the assumptions made on rate increases and whether actuarial standards of practice were followed. Health insurance premiums have to be adequate to pay projected claims, expenses, and supporting risk charges. In addition, any premium oversight should be done in conjunction with insurer solvency oversight to ensure that rates are adequate and plan solvency is maintained.
- *Modify the excise tax on employer-sponsored health insurance*—The Senate-passed legislation would impose an excise tax on high-cost plans. One goal of this tax is to lower health spending growth by discouraging overly generous health plans. However, by focusing on premiums, the provision is not necessarily targeted on overly generous plans. The Senate-passed legislation would adjust the premium thresholds for retirees and high-cost industries. Allowing further adjustments to reflect the enrollee population and firm size, or basing the tax more directly on the actuarial value of the plan rather than the premium, would better target the tax.
- *Strengthen the eligibility requirements in the CLASS Act*—The Senate-passed legislation bill includes the CLASS Act, a voluntary insurance program for purchasing long-term care services. However, the program is likely to suffer from severe adverse selection leading to high premiums and threatening the long-term viability of the program. Additional restrictions on eligibility and changes to benefit provisions are needed to limit adverse selection. Options to reduce or mitigate the impact of adverse selection include: requiring eligible participants to be actively at work for at least 30 hours per week at the time they enroll in the program; increasing the waiting period; using a benefit elimination period; using a benefit period duration that is less than a lifetime; and paying benefits based on a reimbursement basis rather than on a cash basis. A marketing/education allowance in the premiums could also help increase participation levels, thereby reducing adverse selection.

On behalf of the American Academy of Actuaries' Health Practice Council, I wish to again urge you to carefully reconsider your legislative approach according to the concerns outlined above. Our actuaries welcome the opportunity to serve as an ongoing resource to you on health care reform issues throughout this 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,

Alfred A. Bingham, Jr., MAAA, FSA, FCA
 Vice President, Health Practice Council
 American Academy of Actuaries