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Thank you, Chairman Frank, Vice Chairwoman Rose, and members of the Committee. My name is Susan Pantely and I am here representing the American Academy of Actuaries. A health actuary with 40 years of experience, I currently serve as a co-vice chairperson of the Academy's Health Practice Council. I am pleased to be here today in my Academy role to provide a perspective from the U.S. actuarial profession on the critical issue of affordability.

The Academy is the national association representing all actuaries working in the U.S. We currently have more than 20,000 members who work in the health, life, retirement, and property/casualty practice areas. For more than sixty years, we have served the public and the U.S. actuarial profession by offering non-partisan, independent, and objective actuarial analysis and insight to policymakers and other stakeholders to support healthy, sustainable financial security systems.

The Academy recognizes how important insurance affordability is to all consumers, to the functioning of the health care system, and to sound public policy. We have many resources on this issue publicly available at actuary.org.

Since time is short, I want to focus on just a few critical takeaways:

- Health insurance premiums *reflect* costs rather than *drive* them.
- Costs in the insurance system are more manageable and predictable with stable insurance markets that have robust consumer, provider and insurer participation and competition.
- Public policy discussions surrounding improving affordability involve complex considerations and likely a combination of strategies.

A common point in discussions about affordability is insurance premium rates. We are frequently asked how premiums are calculated and what factors directly or indirectly influence costs.

A key point about premium rates is that they don't drive health care service costs---they *reflect* those costs. They are developed with forward-looking estimates of expected health care costs for the coming year and must account for federal and state rules.

Premium growth reflects rising underlying health care costs. The same promising and critical therapies that can represent medical progress often raise costs that are ultimately reflected in health insurance premiums.



To understand why premiums are increasing, it's critical to understand how premium rates are developed. There are two components that drive the expected cost of health care—utilization (how many services are expected to be used) and average cost (the cost of the services to be used). Actuaries estimate what insurers expect to pay for covered medical care and prescription drugs by estimating utilization and average cost based on recent experience and projected trends. Premiums also reflect benefit design and covered population characteristics.

The premium also accounts for administrative components, including claims payment, marketing, quality improvement, and profit. The medical loss ratio – or MLR – is a regulatory tool that measures the percentage of a premium dollar spent on medical claims and quality improvement versus administrative costs, marketing, and profits. In the commercial market, the Affordable Care Act sets minimum MLR standards—with at least 80% of premiums going to healthcare and quality improvements for individual and small group plans.

Once premiums have been appropriately calculated, they are submitted for regulatory review. Here in Texas, the Texas Department of Insurance reviews the proposed rates for the individual and small group markets to ensure that premiums are reasonable in relation to benefits, sufficient, and not excessive.

Now, let me turn to how stable and competitive insurance markets are good for affordability and access.

A stable health insurance market is one where premiums are predictable, coverage is available, competition exists, and consumers can rely on their coverage year-to-year.

Broad, balanced “risk pools” are a lynchpin to predictability and stability of premiums and improving affordability. Groups of individuals’ healthcare costs are combined to determine insurance premiums. Instead of each person paying only for their own care, the costs of healthier enrollees help offset the higher costs of sicker enrollees. By including both healthy and unhealthy people, premiums are kept predictable and stable because the higher costs are balanced by the lower costs. A well-balanced risk pool is essential for stable premiums for all enrollees and financial protection against catastrophic healthcare costs.

Predictable payment rules and stable funding within the health care system are also essential because they create conditions for sustainable, high-quality care and efficient resource use across communities. They can encourage long-term planning and investment by providers, reduce volatility that can be a barrier to increasing access to timely, high-quality, more equitable care, and reduce the likelihood of sudden premium hikes or benefit cuts.



Two hallmarks of a stable health insurance market are sufficient insurer participation and competition. A diverse range of insurers offering different benefits, networks, and service levels give consumers more options to match their needs. Competition spreads risk and limits the ability of any one insurer to set prices or exclude high-cost enrollees. Price competition forces insurers to offer better value, which can make coverage more accessible.

Tools to manage high-cost risks, like analytics to identify cost drivers, also help stabilize the health insurance market. High-cost claims have surged over the past years. When insurers cannot absorb high-cost claims, they may raise premiums, reduce coverage, or exit the market. An exodus of healthier enrollees from the market can leave only higher-cost patients in the risk pool, which further inflates costs.

Insurance design, cost sharing, market structure, and payment policies all influence how costs are distributed between consumers, employers, providers, and plans. Higher deductibles may result in lower premiums, but they increase out-of-pocket exposure. Consolidation among providers can limit patient choice and reduce competition. Consolidation among payers can reduce competition for members. Both of these can contribute to higher prices over time.

Clear, accurate information is necessary, but also not sufficient, to control costs. Meeting health care consumers where they are, rather than falling back on the complex language of the health care system, is an important challenge affecting affordability and access.

In conclusion, health insurance affordability has far-reaching impacts for consumers, other stakeholders, and the actuarial profession. The Academy's work on affordability and related issues continues, like our recent Broadening the Focus project that looks beyond traditional cost metrics to assess health care programs more holistically. We appreciate the invitation to be part of this hearing. There is much more to say and work to be done, and I look forward to your questions.

If you have any questions or would like to discuss these comments further, please contact Katie Dzurec (dzurec@actuary.org), the Academy's director for policy outreach.