AMERICAN ACADEMY *of* ACTUARIES

Committee on Ways and Means
U.S. House of Representatives

Hearing on
Health Reform in the 21st Century:
Insurance Market Reforms

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Statement of
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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.

As Congress considers various proposals to reform the individual health insurance market, the American Academy of Actuaries'[1] Health Practice Council appreciates this opportunity to submit written testimony outlining an actuarial perspective on market reforms. According to the latest estimates from the U.S. Census Bureau, about 45 million Americans under age 65, or 17 percent of the nonelderly population, lacked health insurance in 2007. The economic downturn has most likely led to an increase in the number of uninsured. Increasing access to health insurance coverage depends on making insurance more affordable, to individuals as well as to states and the federal government. Instituting health insurance market reforms are increasingly viewed as a method of increasing the availability of affordable insurance coverage. Although the potential impact of any given reform will depend on its specific details, actuarial considerations will be vital when determining whether particular proposals will lead to improved markets with increased access to affordable coverage. In particular:

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

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 high risks; they must enroll low risks as well. If an insurance plan draws only those with high 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 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 low risks 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 low-risk individuals, over which the costs of high-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. For instance, guaranteed-issue provisions can exacerbate adverse selection concerns, by giving individuals the ability and incentive to delay purchasing insurance until they have health care needs.[2] Likewise, pure community rating and adjusted community rating rules can raise the premiums for healthy individuals, relative to what they would pay if health status could be used as a rating factor.[3] This could cause healthy individuals to opt out of coverage, leaving a higher-risk insured population. Allowing insurers to deny coverage or to charge higher premiums to high-risk individuals can help reduce adverse selection by making insurance more attractive to healthy risks, but at the cost of reduced access to coverage and higher premiums for the higher-risk population.

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[2] Guaranteed issue provisions require that all health insurance applicants must be offered coverage, regardless of their health status or likelihood of large medical expenditures.

[3] Under pure community rating, every insured under a particular insurance plan pays the same premium; premiums cannot vary by factors such as age, gender, and health status. Under modified (or adjusted) community rating, premiums are allowed to vary, often within limits, by certain characteristics, such as age and gender. However, premiums are not allowed to vary by health status.

Increasing overall participation in health insurance plans could be an effective way to minimize adverse selection. Requiring individuals to have insurance coverage is one way to increase participation rates, especially among low-risk individuals, and thereby reduce adverse selection risk. 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). Medicare Parts B and D include some of these incentives. Nevertheless, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives.

In the absence of universal coverage, some degree of adverse selection is inevitable. And even with universal coverage, some insurance plans could end up with a disproportionate share of high-risk individuals. If plan premiums do not reflect this, the plan could be at risk for large losses. As a result, plans could develop strategies to avoid enrolling less healthy individuals. Risk adjustment could be used to adjust plan payments to take into account the health status of plan participants. This would reduce the incentive an insurer might have to avoid enrolling higher-risk individuals. 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; low-risk individuals will migrate to the plans more advantageous to them. In other words, the plans that have rules more amenable to high-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 high-risk individuals, depending on which set of plans is subject to rules that are more advantageous to those in poorer health.

Similarly, adverse selection can occur when insurance is allowed to be purchased across state lines. High-risk individuals will purchase plans from states with stricter regulations (e.g., those mandating guaranteed issue and community rating), and low-risk individuals will purchase plans from states with looser regulations (e.g., allowing underwriting and premium variations by health status). Premiums for the plans in states with stricter regulations will increase accordingly, which could lead to even fewer insurance purchases among the low-risk population.

For long-term sustainability, health spending growth must be reduced

According to National Health Expenditure data, health care spending increased 6.1 percent in 2007. Although this is the lowest growth rate in a decade, it far exceeds the 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 may be in vain. Reining in health insurance premiums in the near term will be for naught if rising health spending means that premiums will return to their original levels within a few years, and continue to rise rapidly thereafter. Therefore, to have the potential for sustainable success, health reform proposals need to focus on controlling 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 technology 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 add value, not just costs. Another driver of health spending growth is that current provider payment systems do not align provider financial incentives with the goal of maximizing the quality and value of 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 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 of the utilization increases are for necessary care, some are not. Benefit 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.

Conclusion

Health insurance market reforms have the potential to increase the availability of affordable health insurance coverage and, thereby reduce the number of uninsured Americans. However, for reforms to be viable, they must adhere to actuarial principles. In particular, insurance markets must attract a broad cross section of risks, especially low-risk individuals. Otherwise, adverse selection will result, potentially leading to a premium spiral. In addition, market competition requires a level playing field. Subjecting market competition to the same rules and regulations will help minimize adverse selection between plans and markets. And finally, health spending growth must be curtailed in order to ensure long-term sustainability.