



AMERICAN ACADEMY of ACTUARIES

**Public Hearing: Health Care Reform
Testimony by Shari A. Westerfield, MAAA, FSA
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Thank you Commissioner Praeger and distinguished committee members for holding this hearing to address the issues surrounding the potential enactment of federal health care reform legislation. My name is Shari Westerfield, and I serve as the chairperson of the American Academy of Actuaries'¹ State Health Committee. The Academy is the non-partisan, public policy organization representing actuaries of all specialties in the United States.

On behalf of the Academy's Health Practice Council, I appreciate the opportunity to provide this testimony today. The two health care reform bills currently under debate, and of course subject to change, would require the states to interpret, implement, integrate, and co-ordinate with the federal regulators to varying degrees. The National Association of Insurance Commissioner's formal role appears to be advisory, including assisting federal regulators, as well as overseeing the implementation in the states under some aggressive timelines.

My remarks today will focus on:

- The development and filing of all new policy forms and rates,
- The implementation and/or oversight of multiple risk-sharing mechanisms,
- A change in the market dynamics and risks impacting solvency standards, and
- A change in the financial reporting needs and other insurer information.

Policy Forms and Rating

Both the *Affordable Health Care for America Act* (HR 3962, the House-passed bill) and the *Patient Protection and Affordable Care Act* (currently being debated by the Senate) define minimum benefit standards for all plans available post-reform, impose tighter rating and underwriting rules, and specify pooling requirements. All policy forms and rates would need to be filed and approved prior to the effective date of the new standards, which is either 2013 (House) or 2014 (Senate).

Given the new requirements, the NAIC and the states will play a key role in the development of uniform provisions across the states. The NAIC individual health rate filing guidelines will likely need major revisions, completed in a timely manner, which will allow adequate time for insurers to submit and regulators to review all the filings. Federal regulatory review of filings could also be required.

Insurers will need to develop new premium rates that reflect all the potential new health insurance reforms, restrictions, and requirements, many of which affect utilization of health care services including:

- Guaranteed issue with no pre-existing condition limitations,
- Lower member cost sharing (may vary based on income),
- Expanded scope of benefits, and
- New definition of "medical necessity."

¹ The American Academy of Actuaries is a professional association with over 16,000 members, whose mission is to assist public policymakers 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.

Because these deviate significantly from current insurance practices in most states, most insurers may not have adequate experience data to price these new policies confidently. Many assumptions need to be made, including the effectiveness of any coverage mandate across various risk classifications. Regulators can expect these assumptions, and resulting premium rates, to vary across insurers. If these assumptions prove to be inaccurate, regulators should expect insurers to request rate adjustments, or even new rating structures, as actual experience data emerges within a few years of the effective date of the requirements.

Both bills include minimum health insurance benefit standards based on the benefits paid by the insurer as a share of total allowed costs, often referred to as the “actuarial value.” The determination of the value appears to be a prospective estimation of the benefits assuming a standardized population. Regulators will likely assist with the interpretation of how this calculation is performed and reported. Items that should be considered include the definition of “allowed” claims and treatment of reinsurance (and other risk-sharing mechanisms), coordination of benefits, and subrogation.

The eventual premium rates, and future rate increases, also reflect how insurers pool their policies. The House bill requires all individual and group policies to be pooled together, including large groups. However, larger fully-insured groups are currently experience rated (i.e., the group’s claims experience is weighted into premium development calculations). Regulators should expect more of such groups to self-fund in order to be removed from the single pool. In the Senate bill, there are separate pools for the individual and small group markets; however, states are given the option to merge those pools.

Both bills allow for in-force policyholders to choose to retain their current policies under the current rating laws (i.e., “grandfathered” blocks). Under this scenario, the regulators would oversee the grandfathered blocks of business, as well as the new plans subject to stricter issue and rating rules.

Risk-Sharing Mechanisms

Both bills contain provisions for a risk-sharing mechanism, based on risk adjusters, to mitigate adverse selection in the guaranteed issue individual and small group markets. Historically, risk-adjustment mechanisms have reduced the effect of selection but have not fully offset all risks.

The NAIC would likely assist federal regulators in developing and implementing the methodology and criteria for assigning risk scores and for collecting and distributing funds to and from insurers. Risk-adjustment mechanisms can require significant amounts of administration by both regulators and insurers. Risk data (e.g., health status, claims experience, etc.) are needed on each insured member for any participating insurer. When implementing a risk-adjustment system, regulators should consider the data issues, including the specific data fields, how to and who should capture them, where to store them, and how to use them.

The Senate bill also contains a provision for a transitional reinsurance program (2014 through 2016) that identifies high-risk individuals whose claims are partially reimbursed by funds assessed on all health insurers. The NAIC would coordinate with the Secretary of the U.S. Health and Human Services Department, with input from the American Academy of Actuaries, to develop and implement the program at the state level. The program differs slightly from traditional reinsurance. Claims eligible for reimbursement are based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions. The reinsurance entity does not assume the risk for these claims, but rather allocates funds from the insurer assessments to offset part of the claims. A non-profit reinsurance entity would administer the program. Data on high-risk individuals, including their conditions and claims detail, would also need to be captured, analyzed and stored.

The Senate bill also contains a provision for the establishment of risk corridors for insurers in individual and small group markets from 2014 through 2016 similar to the Medicare Part D program. The implementation of the risk corridor provision appears to be under the authority of federal regulators, although state support may be requested.

Market Dynamics and Solvency Standards

Given the complexities of the proposed bills, regulators could witness changes in market dynamics. In order to meet all the health insurance reforms and requirements, health insurers would likely need to invest significant time and resources into developing new products, administrative processes and information systems. As currently written, both bills would create a government-run health plan, which may or may not be subject to state regulation. The House and Senate bills contain start-up loans and grants for the development of healthcare co-ops, which could impact the market dynamics in some states. Insurers would need to make decisions on their future directions. Those that are capable of adapting quickly are more likely to be successful.

Other bill provisions include multi-state compacts, whereby states would be able to form a compact to allow insurers to sell individual policies in any, or all, states participating in the compact. The Senate bill also would allow insurers to develop and sell a national standardized benefit plan across states.

Such changes within the marketplace, coupled with new health insurance reforms and rating and underwriting restrictions on insurers, would also affect the risks of the business of health insurance. Therefore, the NAIC solvency standards would need to be updated to reflect these changing risks. In particular, underwriting risk factors and other market risk factors should be reviewed.

Financial and Other Insurance Reporting

Some provisions of the proposed bills relate to insurers' loss ratios. In light of the benefit standards and potential new fees and risk-sharing mechanisms, clear regulatory definitions of how the premiums and benefits are to be determined in the ratio will be needed. Other provisions relate to insurers' premiums and administrative services fees. Since current annual statement reporting differs by the type of blank filed, changes to current exhibits or supplemental reporting may be needed.

Conclusion

The issues raised in this testimony are only a few of the challenges that the NAIC will face if federal health care reform is enacted. The Academy's State Health Committee welcomes the opportunity to assist the NAIC as appropriate as it considers the issues discussed during this hearing. I commend Commissioner Praeger and this committee for focusing on the issue of health care reform implementation. Thank you again for the opportunity to testify, and I am happy to answer any questions.