



# AMERICAN ACADEMY of ACTUARIES

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January 14, 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: *Patient Protection and Affordable Care Act* (H.R. 3590) and *Affordable Health Care for America Act* (H.R. 3962)

Dear Speaker Pelosi and Majority Leader Reid:

This letter presents the comments of the American Academy of Actuaries'<sup>1</sup> Health Practice Council regarding key actuarial aspects of the *Affordable Health Care for America Act* (H.R. 3962) and the *Patient Protection and Affordable Care Act* (H.R. 3590). As you seek to reconcile differences between your two approaches to comprehensive health care reform, actuaries stand ready to assist your efforts. From an actuarial perspective, there are major policy and detailed technical issues that will determine the success of this endeavor that have yet to be addressed. We hope both the comments contained in this letter, as well as our offer to directly provide you analysis and advice, will be seriously considered.

We share your goals of reducing the number of uninsured, increasing the availability and affordability of coverage, and enhancing the focus on the quality of care and health spending growth. We are all stakeholders in the outcome of this process, whether insured or uninsured, employee or employer, health care provider, insurer, or patient. Therefore, a vibrant, viable and equitable result is one in which we can all share. At this critical juncture, as you work to make these goals a reality, it is our public responsibility to reinforce your efforts where the legislative policies are sound and to highlight the weaknesses of those we believe will not produce the intended results.

In particular, this letter discusses various aspects of the House and Senate bills, and provides specific comments on provisions related to: issue and rating rules / individual mandate, grandfathering, medical loss ratios, benefit provisions regarding medical necessity, risk sharing, the creation of new health insurance plan options, an excise tax on employer-sponsored insurance, and the CLASS Act. Following is an executive summary of more extensive remarks made later in this document.

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<sup>1</sup> 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.

## Executive Summary

- *Issue and rating restrictions / individual mandate*—The House and Senate bills both 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. The individual mandate provisions are relatively weak, however, which limits their effectiveness to reduce the adverse selection that would arise due to the new market rules. Allowing wider premium variations by age and/or strengthening the individual mandate would reduce adverse selection and increase the viability of the reformed market. 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 uninsured new enrollees to purchase only the lowest plan option rather than a more generous plan.
- *Grandfathering provisions*—To the extent that the proposed market reforms would result in significant premium increases for individuals with existing coverage, the grandfathering provisions in the bills would insulate to various degrees individuals with existing coverage from experiencing rate shock. In the Senate bill, however, 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 concern. If the Senate bill retains the earlier effective date, it should clarify that the new plan provisions designed to take effect in 2010 (e.g., prohibition of lifetime benefit limits) do not void grandfathered status. And both the House and Senate bills should include a mechanism for allowing plans with minor coverage changes to retain grandfathered status.
- *Medical loss ratios*—The House and Senate bills would both impose minimum medical loss ratio requirements on insurers in the individual and group markets. When imposing such requirements, it is important to recognize how these ratios vary across markets. 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. With respect to how loss ratios are calculated, it is important to include as part of claims not only the value of expenses for activities that improve health care quality, but also cost containment expenses. In addition, a sufficient lag time for adjustment is needed between enactment and the effective dates of medical loss ratio requirements.
- *Essential benefit package—medical necessity*—The House bill includes language that could void current health coverage agreements on the definition of “medical necessity.” The House bill defines an essential benefit package very broadly to include services provided “in accordance with generally accepted standards of medical or other appropriate clinical or professional practice.” This differs from the more comprehensive, court-approved medical necessity language commonly in effect for health plans and health care providers. Based on historical experience with policy provisions, replacing this definition could reduce the ability of physicians and health insurance companies to promote sound medical practice, evidence-

based medical practice, and quality of care. It could also hinder Congress' efforts to incorporate comparative effectiveness research.

- *Risk-sharing provisions*—The House and Senate bills both use risk-adjustment mechanisms to address the risks associated with plans attracting less-healthy participants relative to other plans. Risk adjustment helps make payments to plans more commensurate with the risk they are bearing, thereby reducing the incentives for competing plans to avoid individuals with higher than average health care needs. The temporary reinsurance mechanism in the Senate bill would provide additional protection to insurers against unexpected high-cost claims. In addition, the Senate bill's temporary risk-corridor mechanism would protect insurers from the pricing risk associated with extending coverage to the currently uninsured; it would also guard against windfall insurer profits.
- *Creation of 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.
- *Excise tax on employer-sponsored health insurance*—The Senate provision to impose an excise tax on high-cost plans is based in part on the premise that health spending growth can be reduced by discouraging overly generous health plans. However, by focusing on premiums, the provision is not necessarily targeted on overly generous plans. Allowing for adjustments beyond those related to early retirees and high-cost industries, or basing the excise tax on the actuarial value of the plan rather than the premium, would better target the tax.
- *CLASS Act*—The House and Senate bills each include 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 to limit adverse selection are needed.

The sections that follow provide more detail on these issues.

## Issue and Rating Restrictions / Individual Mandate

House H.R. 3962 as passed on Nov. 7, 2009	Senate H.R. 3590 as passed on Dec. 24, 2009
<b>Issue and Rating Restrictions</b>	
<ul style="list-style-type: none"> <li>• Guaranteed issue and renewal.</li> <li>• No pre-existing condition exclusions.</li> <li>• Allow premium variation based only on age (2 to 1 ratio), area, and family enrollment</li> <li>• Annual open enrollment period.</li> </ul> (§§211-213)	<ul style="list-style-type: none"> <li>• Guaranteed issue and renewal.</li> <li>• No pre-existing condition exclusions.</li> <li>• Allow premium variation based only on age (3 to 1 ratio), area, family enrollment, and tobacco use (1.5 to 1 ratio).</li> <li>• Annual open enrollment period.</li> </ul> (§1201)
<b>Individual Mandate</b>	
<ul style="list-style-type: none"> <li>• Requires individuals to have acceptable health coverage.</li> <li>• Penalty: 2.5 percent tax on adjusted gross income above the filing threshold, up to the national average premium.</li> <li>• Exemption for individuals with adjusted gross income less than the filing threshold.</li> </ul> (§401, §501)	<ul style="list-style-type: none"> <li>• Requires individuals to have qualifying coverage.</li> <li>• Penalty: The greater of a flat dollar amount (\$95 in 2014, \$495 in 2015, \$750 in 2016, indexed thereafter) and a percentage of household income (0.5 percent in 2014, 1.0 percent in 2015, 2.0 percent thereafter, up to the national average premium for a bronze plan).</li> <li>• Exemptions for those whose lowest cost option exceeds 8 percent of income and for those with incomes below the poverty level.</li> </ul> (§1501)

A major goal of the House and Senate bills is to increase access to insurance coverage, regardless of health status. Securing affordable coverage requires that insurance markets attract a broad cross section of risks. 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 to reflect this higher spending. By attracting healthier individuals, health plans will ultimately be able to keep premiums more affordable and stable.

Both the House and Senate bills would require guaranteed issue and renewal and would limit premium variations considerably. 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. However, both bills also include an individual mandate, employer responsibility provisions, and premium subsidies, which would mitigate the adverse selection arising from more restrictive issue and rating rules.

An individual mandate is an integral component of both bills. Such a mandate is necessary to ensure that adverse selection will not lead to dramatic premium increases or a premium spiral. However, the financial penalties associated with the bills' individual mandates are fairly weak compared to coverage costs, especially during the first years of the Senate plan when the financial penalties are being phased in. An individual mandate will bring low-risk individuals into a 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, low-risk individuals will be more likely to pay the penalty and forgo coverage, thus putting upward pressure on premiums.

In both the House and Senate bills, the low penalties associated with the individual mandate 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 so that low-risk individuals obtain and keep coverage. Moving to a narrow limit on premium variations by age, such as the proposed 2-to-1 and 3-to-1 limits, could result in dramatic premium changes, compared to what individuals are facing currently. In particular, younger individuals in states that currently allow underwriting and wider premium variations by age could see much higher premiums than they face currently (and may have chosen to forgo). The premiums for young and healthy individuals would likely be high compared to the penalty, especially in the early years, but even after fully phased in, thus likely leading many to forgo coverage.

Allowing wider premium variations by age and/or strengthening the mandate could help increase the value of obtaining coverage for young and healthy enrollees, thus increasing the viability of the market. Increasing financial penalties would increase the cost of forgoing coverage and could increase participation rates. Non-financial incentives could also be used to strengthen the mandate's effectiveness. Both the House and Senate bills contain provisions for annual open enrollment periods. This would limit an individual's ability to forgo purchasing coverage until health care needs arise. Allowing people to move up only one coverage level from one year to the next (i.e., from bronze to silver, but not from bronze to gold), would also help mitigate adverse selection. As would not allowing people to increase benefit levels within the year outside of the open enrollment period.

Adverse selection could also be reduced if, after the first year, new enrollees who were previously uninsured are allowed to purchase a bronze plan/basic plan only (or catastrophic plan, if available), rather than being able to enroll in a more generous plan. Then the next year they could move up one plan level. This would provide more incentives for people to purchase coverage sooner rather than later, and would limit the impact of adverse selection for those holding off purchasing coverage until they have health care needs. Charging higher premiums for those who hold off purchasing coverage or imposing additional waiting periods could also accomplish similar results.

## Grandfathering Provisions and Selected Provisions Taking Effect in 2010

<b>Grandfathering Provisions</b>	
<b>House H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>• <u>Individual</u>: Individual health insurance coverage can be maintained indefinitely as it exists on Dec. 31, 2012 as long as there are no changes to the plan's terms or conditions, including benefits and cost-sharing. Premium increases must be applied uniformly to enrollees in the same risk group.</li> <li>• <u>Group</u>: Group health insurance plans can be maintained as they exist as of Dec. 31, 2012. Provides a five-year grace period thereafter to meet the new standards regarding insurance and benefit requirements.</li> </ul> (§202)	<ul style="list-style-type: none"> <li>• Individual health insurance policies and group health plans can be maintained as they exist on the day of enactment.</li> </ul> (§1251)
<b>Selected Provisions Taking Effect in 2010</b>	
Effective for plan years beginning on or after Jan. 1, 2010: <ul style="list-style-type: none"> <li>• <u>Lifetime limits</u>: Prohibits health insurers from using aggregate dollar lifetime limits.</li> <li>• <u>Pre-existing condition exclusions</u>: The allowable look-back period for pre-existing condition exclusions would be shortened from six months to 30 days. The period plans may exclude coverage of certain benefits based on pre-existing conditions would be shortened from 12 months to three months. Exempts collective bargaining agreements ratified before the date of enactment until the earlier of the date of termination of the agreements or three years after date of enactment. Pre-existing condition exclusions may not be imposed on the basis of domestic violence.</li> <li>• <u>Dependent coverage</u>: Requires all health insurers and employers to allow individuals through age 26 (not otherwise covered) to remain on parent's health insurance.</li> <li>• <u>Congenital/developmental conditions</u>: Requires health plans to provide coverage for diagnosis and treatment for a child's (age 21 or younger) congenital or developmental deformity, disease or injury.</li> </ul> (§§105-109)	Effective for plan years beginning on or after six months after enactment: <ul style="list-style-type: none"> <li>• <u>Lifetime/annual limits</u>: Lifetime limits and "unreasonable" annual limits prohibited for all group and individual health plans.</li> <li>• <u>Preventive coverage</u>: Requires all group and individual health plans to cover specified preventive services without any cost-sharing.</li> <li>• <u>Dependent coverage</u>: Requires all health insurers and employers to allow unmarried dependents until age 26 (not otherwise covered) to remain on parent's health insurance if plan otherwise offers dependent coverage.</li> </ul> (§1001)

The House and Senate bills both contain provisions that aim to limit the market disruption arising from moving to stricter issue, rating, and benefit design rules. The Senate legislation would grandfather coverage (individual and group plan policies) in which the individual is enrolled at enactment. Furthermore, under the individual mandate to be established under the Senate bill, grandfathered coverage would be considered "minimum essential coverage."

The House bill would allow for similar grandfathering provisions in the individual market. In the group market, plans in existence as of Dec. 31, 2012 would have a five-year grace period to meet the new standards regarding insurance and benefit requirements.

To the extent that proposed market reform provisions would result in significant premium increases for individuals with existing coverage (sometimes referred to as “rate shock”), the grandfathering provisions included in the House and Senate bills would insulate individuals with existing individual market coverage from experiencing that rate shock. The Senate bill would extend that protection to individuals with group coverage as well. The House bill would provide individuals with group coverage only temporary protection against rate shock, although the transition period allowed in the bill could ease the impact of moving to the new rating rules and benefit standards for groups.

In the Senate bill, coverage purchased by individuals after enactment but prior to when new insurance issue, rating, and benefit design rules become effective in 2014 would not qualify as grandfathered coverage. As a result, individuals with such coverage would face coverage termination and premium changes when the new rules go into effect in 2014. They would not have protection against rate shock unless their coverage already followed the new rules. Setting the effective date of grandfathered coverage as the day before the new rules become effective in 2014 would eliminate this concern.

The grandfathering provisions need to strike the appropriate balance between the goals of minimizing rate shock due to the new market rules and not exacerbating adverse selection concerns for new coverage. Delaying the effective date of the grandfathering provisions to the date the new market rules become effective would maximize the number of individuals insulated from rate shock. Young and healthy individuals (especially those who would not be eligible for a premium subsidy) might find it more advantageous (e.g., less expensive) to purchase coverage prior to the implementation of the new market rules and have this coverage qualify as grandfathered coverage. As a result, individuals purchasing coverage under the new rules could have higher medical costs than average, increasing the average costs of coverage in the exchange. Such a scenario assumes, however, that the individual mandate is strong enough to provide an incentive for young and healthy individuals to not only purchase coverage, but purchase coverage before the mandate takes effect. It’s unclear whether such incentives would be strong enough to result in adverse selection concerns beyond those already resulting from a weak mandate.

The combination of the grandfathering rules and the provisions that would take effect in 2010 would initiate rate filing and other administrative processes for both new and grandfathered coverage:

- The Senate bill does not specify whether the interim coverage changes with respect to annual and lifetime limits, preventive coverage, and dependent coverage extensions would void grandfathered status because they change policy provisions and cost-sharing requirements. If so, then essentially no one with coverage would be grandfathered unless their coverage already contained the newly required provisions. The Senate bill should clarify that any plans making changes to meet these new requirements would retain grandfathered status. And

more generally, both the House and Senate bills should include a mechanism for allowing plans with minor coverage changes to retain grandfathered status.

- Because the Senate bill specifies that the effective date for grandfathered coverage is the day of enactment, insurers would no longer be able to sell existing guaranteed renewable coverage after the enactment date. Coverage sold after that date would need to be terminated on Jan. 1, 2014. Amendments for all new policies and rates must be filed and approved before they can be used. New experience pools must be formed for rating. States that mandate issue-age rating must create a new construct. This could create a period when new coverage sales are delayed pending state insurance department approvals. Setting the effective date for the grandfathering provisions at Dec. 31, 2013 rather than the date of enactment would eliminate these issues.
- The new provisions designed to take effect in 2010 (e.g., elimination of annual and lifetime limits, limits on pre-existing condition exclusions) require unilateral (insurer-driven) policy revisions (contracts and endorsements) and rate filings. Such unilateral benefit revisions would conflict with guaranteed renewability provisions in existing individual contracts (and HIPPA renewability) as well as annual group contracts already in existence. In addition, a large volume of rate filings would need to be prepared and approved by state insurance departments. This could create an extended period in which plan benefits may be unclear and new sales are on hold. Making the new provisions effective no earlier than plan years 12 months after enactment would help address these concerns.



## Medical Loss Ratio Requirements

<b>Medical Loss Ratio Requirements</b>	
<b>House</b> <b>H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate</b> <b>H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>• Effective for plan years beginning on or after Jan. 1, 2010.</li> <li>• Health insurers in the small group, large group, Medicaid, CHIP, and Medicare Advantage markets are required to meet a medical loss ratio of not less than 85 percent. If plans fall below this level, rebates to enrollees are required. (Adjustments may be made if this requirement would destabilize the individual market.)</li> <li>• The provision sunsets when health insurance is offered through the exchange. (§102, §1173, §1755)</li> </ul>	<ul style="list-style-type: none"> <li>• Requirement to report loss ratios effective Jan. 1, 2010; requirement to provide rebates effective Jan. 1, 2011.</li> <li>• Health insurers in the large group markets are required to meet a medical loss ratio of not less than 85 percent. If plans fall below this level, rebates to enrollees are required.</li> <li>• Health insurers in the small group and individual markets are required to meet a medical loss ratio of not less than 80 percent (adjustments may be made if this requirement would destabilize the individual market). If plans fall below this level, rebates to enrollees are required.</li> <li>• The costs for activities that improve quality are included with claim costs when calculating medical loss ratios.</li> <li>• Administrative costs exclude federal and state taxes and fees.</li> <li>• Three-year average used beginning in 2014. (§2718)</li> </ul>

The stated intention of the House and Senate provisions related to medical loss ratios is to bring down the costs of health coverage and to ensure that consumers receive value for their health insurance premiums. However, medical loss ratios are imperfect measures of premium value. Current loss ratios vary by market segment, with loss ratios for plans in the individual market falling below those in the small group market, which in turn fall below those in the large group market. These differences arise due to several factors including lower average benefit levels and higher marketing, issue, and billing expenses in the individual market. Imposing unrealistically high medical loss ratio requirements may threaten plan solvency by making it difficult for premiums to cover claims and expenses. In particular, 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. Imposing such requirements could result in individual market insurers exiting the market. Both the House and Senate provisions allow for adjustments to ensure that the loss ratio requirements do not cause disruptions in the individual market. However, similar adjustments may be needed to avoid disruptions in the small group market as well, especially under the House bill, which imposes the same loss ratio requirements for small and large groups.

With respect to how loss ratios are calculated, the Senate bill appropriately recognizes the value of expenses for activities that improve health care quality. Activities for such expenses as well as cost containment expenses should be combined with the cost of medical claims when calculating medical loss ratios. The National Association of Insurance Commissioners (NAIC) defines cost containment expenses, which are amounts that the insurer spends in order to manage the cost of

medical claims.<sup>2</sup> These expenses include case management, disease management, 24-hour nurse hotlines, wellness programs, provider network development, as well as fraud detection and prevention programs. As these expenditures are more akin to benefits than administrative expenses or provisions for risk, it would be appropriate to include cost containment expenses as part of the value of benefits in the loss ratio calculation. Including these expenses in the loss ratio calculation would encourage insurers to effectively manage the quality, efficiency, and cost of care for policyholders.

The Senate bill also appropriately recognizes federal and state taxes and fees as beyond the control of the health insurer and should not be included as administrative expenses in the loss ratio calculation.

From a practical standpoint, it would be difficult to impose a minimum loss ratio requirement in 2010, as contained in the House bill. Plans typically file their premiums six to 12 months before they become effective, and need time prior to rate filing in order to develop the rates. Therefore, a sufficient lag time would be needed between the enactment of the legislation and the effective date of the minimum loss ratio provision. The Senate bill recognizes that such a lag time is needed and has a later effective date. However, the Senate version should clarify that any rebates would not be paid until 2012, after experience is closed for 2011.

Loss ratios can vary from one year to the next due to random fluctuations in health claims. The three-year averaging effective in 2014 under the Senate bill would help smooth any year-to-year fluctuations.

There are many technical aspects related to the implementation of medical loss ratios and most of these details would presumably be set through the regulatory development process. The legislation should allow the Secretary sufficient flexibility when promulgating the regulation to appropriately account for various complexities, such as:

- Minimum loss ratios should be applied to all plans sold by an insurer in a market segment and not at a benefit level, individual, or employer level. This would allow for a sufficient sample size to minimize random fluctuations and would also balance selection between plans.
- Medical loss ratio calculations should be done on a calendar-year basis rather than a plan year or renewal basis. This would be consistent with the approach taken with respect to modifications to current regulatory reporting requirements and would also be consistent with loss ratio reporting requirements for Medicare Supplement business.

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<sup>2</sup> The Statutory Statement of Accounting Principles (SSAP) No. 85, promulgated by the NAIC, stipulates that an insurer is not entitled to classify expenditures as being cost containment expenses unless it can support the contention that claims would have been higher if those expenditures had not been made.

## Essential Benefit Package—Medical Necessity

<b>Essential Benefit Package—Medical Necessity</b>	
<b>House H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>Essential benefit package is defined as health benefits coverage that provides payment for services provided “in accordance with generally accepted standards of medical or other appropriate clinical or professional practice.” (§222(a)(1))</li> </ul>	<ul style="list-style-type: none"> <li>No provision.</li> </ul>

The House bill includes language that, perhaps inadvertently, could void current health coverage agreements on the definition of "medical necessity," thereby making it more difficult for health plans to promote quality and cost-effective care. The House bill defines an “essential benefit package” very broadly to include services provided “in accordance with generally accepted standards of medical or other appropriate clinical or professional practice.” This differs from the more comprehensive, court-approved medical necessity language now in effect based on negotiations between dozens of health plans and health care providers. That language provides that:

“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- a) in accordance with generally accepted standards of medical practice;
- b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medical necessity issues arise in many circumstances, including but not limited to the following:

- Treatments not medically appropriate for an individual patient’s needs;
- Treatments of inappropriate duration, intensity, or frequency;
- Treatments not consistent with scientific evidence;
- Treatments provided in an inappropriate clinical site or by inappropriate personnel;

- Treatments more costly, but not more effective, than other available treatment;
- Treatments provided primarily for the convenience of the patient, physician, or other health care provider.

Based on historical experience with policy provisions, replacing the court-approved, collaborative definition negotiated between health plans and providers would reduce the ability of physicians and health insurance companies to promote sound, evidence-based medical practice, and quality of care. It could also weaken Congress' efforts to incorporate comparative effectiveness research.

## Risk-Sharing Provisions

<b>Risk-Sharing Provisions</b>	
<b>House</b> <b>H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate</b> <b>H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>• <u>Risk adjustment</u>: Requires risk adjustment for plans participating in the exchange. (§306)</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Risk adjustment</u>: Requires risk adjustment in the individual and small group markets (excluding grandfathered plans). After risk adjustment is applied, reinsurance and risk corridors would apply.</li> <li>• <u>Reinsurance</u>: Creates a temporary reinsurance program for 2014 to 2016 to cover high-risk individuals in the individual and small group markets. The program would be administered by a nonprofit entity. Required insurer contributions to the program would total \$25 billion over three years. These funds would be allocated to plans to cover the spending by high-cost enrollees.</li> <li>• <u>Risk corridors</u>: Creates temporary risk corridors in the individual and small group markets for 2014 to 2016. Plans would receive payments from the government if costs exceed 103 percent of the target; plans would make payments to the government if costs are less than 97 percent of the target. Specifically, plans bear the full risk for spending within <math>\pm 3</math> percent of target. The government would bear 50 percent of spending incurred when spending exceeds <math>\pm 3</math> percent but less than <math>\pm 8</math> percent of the target. The government would bear 80 percent of spending exceeding <math>\pm 8</math> percent of the target. Risk corridors are applied after any reinsurance payments.</li> </ul> <p>(§§1341-1343)</p>

The House and Senate bills contain provisions that aim to limit certain risks that insurers bear. As mentioned above, insurers face the adverse selection risks associated with overall participation rates. They can face plan-specific adverse selection as well; that is, their plans could attract a less-healthy group of participants relative to other plans. Insurers can also face the risk of incurring unexpected high-cost claims. In addition, plans can be subject to risks associated with pricing the plan inadequately. A major goal of health reform legislation is to reduce the number of uninsured. However, it may be difficult for insurers to price plans targeted to the uninsured given that they lack sufficient data on health spending for the uninsured. Moreover, future spending by the newly insured could increase once they obtain coverage. Understating premiums could result in large losses to private insurers. Overstating premiums could result in large gains to the insurers and/or reduce participation in a plan. Risk-sharing provisions, such as risk adjustment, reinsurance, and risk corridors can be used to mitigate some of these risks. These provisions are used in Medicare's prescription drug plans to limit the financial risks that insurers bear.

## Risk Adjustment

Both the House and Senate bills would restrict the extent to which plans are allowed to vary premiums across various characteristics. They both also include a risk-adjustment mechanism, which can mitigate the risk associated with plan-specific selection by helping ensure that health plans are compensated for the risks they enroll. In other words, risk-adjustment mechanisms reallocate premium income among plans to take into account risk factors that are not fully incorporated into premiums, such as enrollee demographics and health status. Risk adjustment helps make payments to plans more commensurate with the risk they are bearing, thereby reducing the incentives for competing plans to avoid individuals with higher-than-average health care needs. Risk adjustment may also help stabilize experience among private plans, causing less disruption for plan participants.

Importantly, however, although risk adjustment can help adjust for the differences in participant health status across plans, no current risk-adjustment system is designed to fully adjust for these differences. Furthermore, risk adjustment alone will not address other financial risks that insurers face.

## Reinsurance

A reinsurance mechanism, such as the temporary reinsurance program included in the Senate bill, provides protection against high-cost claims and can supplement risk adjustment's protection against the effects of adverse selection. Such a mechanism could also help stabilize premiums for the first years of operation of the exchanges, especially if its funding were external rather than reliant on transfers between insurers (the Senate bill, in effect, transfers monies between insurers).

## Risk Corridors

Risk corridors, such as those included in the Senate bill, can be used to mitigate pricing risk by limiting an insurer's potential losses. They can also be used to limit an insurer's gains to minimize windfall profits.

The risk corridors under the Senate bill would be temporary and would be in effect for the first three years of the exchanges only. This time frame would be consistent with the time it would reasonably take insurers to gather enough data on the health claims of the newly insured so that pricing risk is minimized.

Medicare Part D uses reinsurance and risk corridors, which widen over time, in addition to risk adjustment. Although these risk-sharing mechanisms have added administrative burdens on insurers, they have been adapted to fairly readily and have provided a useful protection, especially for the first few years of a new program. Pricing risk for extending comprehensive medical and prescription drug coverage to the uninsured could be even greater than that of Medicare prescription drug plans, due to the greater variation of medical claims. Risk corridors could encourage competition in exchanges by limiting the downside risk for insurers entering this market, especially during the early years.

There are many technical aspects related to the implementation of risk-sharing mechanisms and most of these details would presumably be worked out through the regulatory development process. Final legislation should allow the Secretary sufficient flexibility when promulgating the regulation to appropriately account for various complexities. For instance:

- As with minimum loss ratios, the application of risk corridors should be at a high level, that is, all plans sold by an insurer in a market segment and not at a benefit level, individual, or employer level.
- Risk-sharing mechanisms should include the proper incentives for plans to manage their risks appropriately and to be adequately capitalized.

## Creation of New Health Insurance Plans

<b>Creation of New Health Insurance Plans</b>	
<b>House</b> <b>H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate</b> <b>H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>• <u>Public Plan</u>: Creates a new public health insurance plan to be offered in the exchange. Plan must meet same requirements as private plans. Start-up funding of \$2 billion is available for initial administrative costs and to provide for initial claims reserves needed to cover 90 days worth of claims. The start-up funding is recouped over 10 years. The plan must be self-sustaining after this initial funding. (§§321-331)</li> <li>• <u>Health Insurance Cooperatives</u>: Facilitates the establishment of non-profit member-run health insurance cooperatives to provide insurance through the exchange. Funding of \$5 billion is available for initial start-up costs and to meet state solvency requirements. The start-up funding is recouped over 10 years. (§310)</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Health Insurance Cooperatives</u>: Facilitates the establishment of non-profit member-run health insurance cooperatives to provide insurance in the Exchanges. Funding of \$6 billion is available for loans for initial start-up costs and grants to meet state solvency requirements. Loans are recouped in five years and grants are recouped in 15 years. (§1322)</li> <li>• <u>Multi-State Plans</u>: The Office of Personnel Management would contract with insurers to offer at least two multi-state plans in each exchange (at least one must be a non-profit plan). Any state with allowable premium variations by age lower than 3-to-1 may require multi-state plans to adhere to its stricter age rating requirement. Enrollees in multi-state plans would be pooled separately from enrollees in the Federal Employees Health Benefit Plan (FEHBP). (§1334)</li> </ul>

For health insurance markets to be viable, plans competing to enroll the same participants must operate under the same rules (i.e., a “level playing field”). 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 House and Senate bills would each 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 plans would meet many of the requirements needed to establish a “level playing field.” The public plan, cooperatives, and multi-state plans would be subject to the same market rules and benefit requirements that apply to private plans. In addition, the plans would be required to negotiate rates with providers, rather than having the advantage of using Medicare provider rates or otherwise being allowed to set rates.

The intention is for the public plan (in the House) and the health insurance cooperatives to be self-sustaining through premiums. Unlike private plans, however, they would have access to government loans to fund start-up costs, including initial administrative expenses and 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.<sup>3</sup> Under modeled scenarios, it was 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 House and Senate legislation specify a limit on funds available for the public plan and the cooperatives. However, 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 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.

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<sup>3</sup> 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](http://www.actuary.org/pdf/health/tech_coops_nov09.pdf).

## Excise Tax on Employer-Sponsored Health Insurance

<b>Excise Tax on Employer-Sponsored Health Insurance</b>	
<b>House H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>No provision.</li> </ul>	<ul style="list-style-type: none"> <li>40 percent excise tax on employer-sponsored health insurance costs that exceed \$8,500 for individual coverage and \$23,000 for family coverage. Increased threshold amounts (\$1,350 for individual coverage, \$3,000 for family coverage) for retirees age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions.</li> <li>Thresholds are phased-in over three years for the 17 highest-cost states.</li> </ul> (§9001)

One of the drivers of increasing health spending is the generosity of health insurance coverage. By lowering the out-of-pocket costs to the insured, health insurance coverage can help ensure access to necessary care. However, very generous plans can also result in an overutilization of unnecessary care.

In part to help finance health reform, the Senate bill includes a provision that would impose an excise tax on high-cost employer-sponsored plans. This provision would likely have the impact of discouraging overly generous benefit packages, which could in turn help reduce health spending growth.<sup>4</sup> As currently written, however, the provision may not effectively target overly generous plans. The provision focuses on premiums, which do not necessarily reflect plan generosity. In addition to plan benefit provisions, premiums reflect the age, industry, occupation, size, and geographical area of the enrollee population, as well as existing payment levels to health care providers. The Senate provision adjusts for these factors in part by allowing for higher thresholds for early retirees and in certain high-risk occupations. In addition, thresholds are temporarily higher in high-cost states. Nevertheless, allowing for further adjustments to reflect the enrollee population and considering the actuarial value of the plan rather than the premium would better target any tax.

Even appropriately targeting overly generous plans has the risk of discouraging necessary care if employers react to the tax by increasing enrollee cost-sharing requirements. To help ensure that necessary care is not compromised, final legislation should allow for innovative plan designs that would tie cost-sharing requirements to the value of the health care treatment.

<sup>4</sup> American Academy of Actuaries and Society of Actuaries, *Federal Health Care Reform 2009: Excise Tax on High-Cost Employer Plans*. January 14, 2009. Available at: [http://www.actuary.org/pdf/health/cadillac\\_jan10.pdf](http://www.actuary.org/pdf/health/cadillac_jan10.pdf).

## Community Living Assistance Services and Supports (CLASS) Act

<b>CLASS Act</b>	
<b>House</b> <b>H.R. 3962 as passed on Nov. 7, 2009</b>	<b>Senate</b> <b>H.R. 3590 as passed on Dec. 24, 2009</b>
<ul style="list-style-type: none"> <li>• Establishes a voluntary insurance program for purchasing long-term care services; automatic enrollment with opt-out provision; provides for a minimum average daily benefit of \$50.</li> <li>• Requires premium payments for five years before benefits are available.</li> <li>• Requires premiums to be set at a level to ensure 75-year solvency.</li> <li>• Eligibility limited to working adults and non-working spouses.</li> </ul> (§2581)	<ul style="list-style-type: none"> <li>• Establishes a voluntary insurance program for purchasing long-term care services; automatic enrollment with opt-out provision; provides for a minimum average daily benefit of \$50.</li> <li>• Requires premium payments for five years before benefits are available.</li> <li>• Requires premiums to be set at a level to ensure 75-year solvency.</li> <li>• Eligibility limited to working adults; non-working spouses are not eligible.</li> </ul> (§8002)

The House and Senate bills each include versions of the CLASS Act, a voluntary insurance program for purchasing long-term care services. An aim of these provisions is to address increased expenses for long-term care services under state Medicaid programs and impending demographic changes that would put further pressure on these programs. Another goal is to provide more financial support to allow individuals with functional limitations to continue residing in the community. Although there are a few key differences between the House and Senate versions, the fundamental concerns are the same.

Both the House and Senate bills require that premiums for the program established by the Act be set to ensure 75-year solvency, which would help protect the program against insolvency. However, given the way the program is structured, severe adverse selection would result in very high premiums that are likely to be unaffordable for much of the intended population, threatening the viability of the program. For instance, a recent analysis by a joint work group of the Academy and the Society of Actuaries concluded that even with only modest adverse selection, the average monthly premium required to maintain solvency over a 75-year period would be \$160.<sup>5</sup> Premiums would be even higher without changes to the eligibility criteria to reduce adverse selection.

Moreover, the solvency of the program could be threatened if participation is so low that premium increases alone would not be enough to fund benefits—taxpayer funding and/or benefit reductions may be required. Changes to the program in the final legislation should be taken to reduce adverse selection to increase the viability of the program.

To achieve a reasonable spread of risk among participants, a viable, actuarially sound program requires restrictions on eligibility to limit adverse selection, especially among individuals with disabilities. The need to manage adverse selection is of particular importance with any voluntary program in which participants may opt in and opt out. Both the House and Senate bills provide

<sup>5</sup> American Academy of Actuaries and Society of Actuaries. *Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program*. Letter to the U.S. Senate Committee on Health, Education, Labor, and Pensions. July 22, 2009. Available at: [http://www.actuary.org/pdf/health/class\\_july09.pdf](http://www.actuary.org/pdf/health/class_july09.pdf). The \$160 premium estimate reflects an average daily benefit of \$75 and level premiums after enrollment.

for a five-year waiting period; however, the presence of this vesting period would not be enough to reduce the risk associated with guaranteed issue to employees. Such adverse selection can be particularly problematic if eligibility is extended to non-working spouses, as in the House bill. Individuals with pre-existing/chronic conditions would have access to the benefits immediately following the five-year period, and the limited vesting period could encourage some individuals to delay participation until such need is apparent. The potential magnitude of this adverse selection, both at inception of the program and ongoing, could put the viability of the program at risk.

Without significant program changes to minimize adverse selection, the program would not be sustainable in the long term without premium increases or benefit reductions. An alternative approach that would reduce the impact of adverse selection would be to require eligible participants to be actively at work for at least 30 hours per week at the time they enroll in the program. This would encourage early participation and provide for a sufficient underwriting proxy. Enrollment by non-working spouses of employees on a guaranteed issue basis is a significant source of adverse selection, which also should be addressed for the program to be actuarially sound. Spouses should be subject to the actively-at-work requirement or subject to a short-form questionnaire that would serve as a proxy for the actively-at-work requirement.

Further program changes that could help increase sustainability include:

- The use of a benefit elimination period, a benefit period duration that is less than lifetime, and/or benefits that are paid based on a reimbursement basis rather than on a cash basis.
- An initial premium structure that provides for scheduled premium increases for active enrollees at either the annual CPI or an alternative annual rate.
- A consistent definition of eligibility for all benefits and benefit levels with use of the HIPAA-defined activities of daily living (ADL) triggers and cognitive impairment definitions.
- A marketing/education allowance in the premiums to increase participation levels.

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On behalf of the American Academy of Actuaries' Health Practice Council, I wish to again urge you to carefully consider the concerns outlined above and our offer to assist you further should you wish it. Our remarks are intended to guide you in achieving the best possible actuarial outcome in the final legislation.

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](mailto:jerbi@actuary.org)).

Sincerely,

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Vice President, Health Practice Council  
American Academy of Actuaries