Industry Business and Labor Committee
March 18, 2010

Chairman Keiser and members of the Industry Business and Labor Committee, for the record I am Rod St. Aubyn, Director of Government Relations for Blue Cross Blue Shield of North Dakota (BCBSND). I appear before you today to testify about the impact of the proposed federal health care reform bills on BCBSND members.

I want to first state that BCBSND has publicly stated that we support health care reform and offered our services in drafting responsible legislation that truly will help control health care costs and begin to "bend the cost curve." During this process, we have been in constant contact with our congressional delegation. They have been successful in having some of our concerns addressed in the Senate bill. One of those involves the rating rules. The current ND law allows a 5:1 rating rule in the individual market. The House bill reduced that to 2:1 at the urging of AARP. We were concerned about the effect that change would have on young people securing health insurance. We wanted the rating rules to stay at 5:1 with a possible transition to 3:1. The Senate did not adopt the transition, but did raise it to 3:1. While we were not totally satisfied, it is a significant improvement compared to the House bill. However many other issues that we identified still exist that will have adverse consequences for many of our members.

I must first clarify that I cannot categorically say exactly what the impact may be since this is truly a "work in progress." As you may know we are aware of the provisions passed by the Senate, but what the President is proposing and other changes being negotiated by House leadership to be incorporated in the "Reconciliation Bill" are still unknown. We have heard some of the details, but they are far from certain. What is troubling is the lack of transparency regarding the Reconciliation Bill. Press reports late last week indicated that all the points being considered were presented by House Democratic Leadership to their caucus members, yet this proposed bill will not be released until it has been officially scored by the Congressional Budget Office and approved by the Rules Committee. Then at that time, it will be publicly released, with the intent of possibly voting on the Reconciliation Bill and **not** officially voting on the Senate health care bill. The Senate bill will be "deemed and passed" upon the approval of the Reconciliation Bill by the House. Their rules will allow a vote within 72 hours after the final bill changes and rules are approved by the House Rules Committee. We were informed that the House vote could occur yet this weekend. Yet we will have very little time to analyze the changes and virtually no time to express our concerns.

I will be addressing what I know is in the Senate bill and what I have heard is being incorporated by the President and House Leadership. While there are both positive and negative components to the proposed legislation, I can confidently state that the cost of health insurance will in fact increase significantly in North Dakota. Due to the proposed subsidies, there will be both winners and losers within our individual premium payers. However, our actuarial analysis shows that group health insurance rates may go up as much as 15%. The

individual policyholder premiums are projected to increase between 75% and 100%. Keep in mind this in addition to the normal medical and utilization increases we experience each year. I will try to identify exactly why we expect these premium increases below:

- **Individual Mandate/Guaranteed Issue With a Weak Penalty** – The original individual mandate was proposed with a weak penalty in the original Senate bill ($95 in 2014, $495 in 2015 and $750 in 2016 or increasing percentages of taxable income up to 2% in 2016). The President's penalty starts out even lower ($95 in 2014, $395 in 2015 and $695 in 2016), but the percentages of taxable income rate goes up to 2.5%. If an individual's monthly premium is $200 per month ($2,400/yr), why in the world would any young healthy individual carry insurance if they could instead pay the $95 annual penalty and just take insurance when they are sick, since it is guaranteed issue?
- **Guaranteed Issue** – We support the guaranteed issue, but as I have just illustrated it has to be accompanied by an effective individual mandate with a very strong penalty. However, you must realize that implementing a guaranteed issue will increase health care claims. ND has the CHAND program (high risk pool), which guarantees coverage for those individuals that are denied in the individual market because of medical conditions or health risks. Their premiums are set by state statute at 135% of an average individual product in ND. However, even with that increased premium, CHAND loses approximately $5 million a year. Guaranteed issue will transfer those costs into the regular individual market pool resulting in higher costs.
- **Expansion of Dependent Coverage** – The bills expand coverage for dependents up to the age of 26. While current ND law provides for dependent coverage for those that are full-time students up to the age of 26, these bills do not require that the dependent be a full-time student.
- **Elimination of Lifetime and Annual Limits** – Currently, if an individual reaches their lifetime limit, they can automatically transfer into CHAND. This legislation eliminates any lifetime and annual limits. It is common to have some annual/lifetime limits on some medical services – i.e. Infertility services $20,000 lifetime, Diabetes Education Services $1,000, PKU food products $3,000/member/benefit period, outpatient nutrition care services, Hearing Aids, Prosthetic limbs.
- **Richer Benefits and Fewer Choices** – The plans being considered have significantly richer benefits, lower or more limited cost-sharing permitted, and fewer choices for the consumer. Currently we offer over 30 different plan options in our group market and over 20 options within the individual market. Groups and individuals can pick and choose the multiple options to best fit their needs and to also control their costs. These bills limit those choices that can be offered as qualified plans to a Platinum Plan (90% actuarial value), a Gold Plan (80% av), a Silver Plan (70% av), and a Bronze Plan (60% av) and another plan called the Catastrophic Plan for those up to age 30 or those exempt from the individual mandate. I might add it is estimated by an actuarial firm that millions of people will be exempt from the individual mandate. Some of these exemptions include financial hardships, religious objections, American Indians, those without coverage for less than 3 months, undocumented immigrants, incarcerated individuals, and the poor. These bills also require maternity coverage and for pediatric

dental and vision care, which typically are not covered benefits for standard health insurance. These are usually covered under separate dental or vision plans. In addition, preventive screenings will be added based on "A" or "B" recommendations of the US Preventive Services Task Force. You may remember that this is the agency that made the news recently when they changed the recommendation for Mammogram Screenings for women. BCBSND typically utilizes their recommendations, but that determination is currently made by our Medical Directors in consultation with other professionals in the medical profession. We do not automatically follow recommendations by this entity.

- **New Taxes** – New taxes will be imposed on numerous entities which will have to be passed on to the premium payer. Those new taxes include:
  - $2.3 billion annual fee on the pharmaceutical manufacturing sector, increasing by $10 billion over 10 years.
  - $67 billion health insurance tax over 10 years.
  - Excise tax on medical device manufacturing sector totaling $20 billion over 10 years.
- **Higher Administrative Costs Due to Duplicative Processes** – The reported President's proposal includes a duplicative and bureaucratic rate review process. This is a function best left in the hands of state regulators. Our state regulators are far from pushovers, as evidenced by our past rate filings. They have a vested interest in ensuring that insurers in ND remain solvent to protect North Dakota citizens and yet prevent insurers from overcharging premium payers. The President's plan will establish a separate rate review process. We do not know the specifics since the bill has not yet been published, but having this duplicative process will increase our administrative cost for filing rates, potentially create a costly delay in the review process, and could create a real nightmare. What if the State Regulator approves a rate due to solvency issues and the Federal regulator denies the rate because they feel the rate is excessive? And conversely, what if the state reduces a requested rate increase from 15% to 10% and the Federal reviewer would rule that the 15% was reasonable? Who makes the final decision? Who does the insurer appeal the decision to? As a former legislator, I view this as an improper encroachment from the Federal government in an area reserved to state authority.

With all of these health insurance reform changes, little has been proposed to actually control health care costs and bend the cost curve. As I previously mentioned, we support responsible health care reform. However, what is currently being considered will do little to control costs and will actually increase the costs of health insurance premiums. Because of the proposed subsidies, some individuals may see some decrease in their own personal net costs, but others will realize some significant increases.

Mr. Chairman and Committee Members, thank you again for the opportunity to testify. I would be willing to try to answer any questions the committee may have.

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