



August 17, 2016

The Honorable Kevin Brady
Chairman, Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member, Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of Associated Builders and Contractors (ABC), a national construction industry trade association with 70 chapters representing nearly 21,000 chapter members, I am writing in regard to today's hearing on the individual and employer mandates in the President's health care law and the associated penalties.

Providing quality health care benefits is a top priority for ABC and its member companies. ABC continues to call on Congress to advance common-sense health care solutions that will provide greater choice and affordability and allow private insurers to compete for business.

On March 23, 2010, President Obama signed into law the massive health care law, known as the Affordable Care Act (ACA). Five years later, the ACA continues to create uncertainty and confusion in the construction industry, making it difficult for the nation's contractors to plan for the future and create jobs.

Generally, under the employer mandate provisions of the ACA, employers with 50 or more full-time employees and full-time equivalent employees must offer full-time employees a certain level of coverage or be subject to a penalty. The increased costs related to this onerous mandate continue to be of significant concern to ABC members. ABC has advocated for repeal of the employer mandate and is in full support of Rep. Boustany's *American Job Protection Act* (H.R. 248), which would repeal the job-killing employer mandate provisions.

By forcing employers to offer government-prescribed health insurance, ABC members will no longer have the choice or flexibility to structure health care coverage options that meet the needs of their fluctuating workforce. The resulting increased costs will jeopardize the ability of ABC member companies to maintain affordable coverage options for their employees and force some to drop coverage all together.

In addition, the implementation of the ACA's employer mandate provisions requires significant employer education. The regulations implementing the employer mandate are complex and confusing and many questions remain.

We appreciate your attention to this important matter and look forward to working with you to repeal the burdensome and costly employer mandate.

Sincerely,

Geoffrey Burr
Vice President, Government Affairs



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**Testimony of Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries**

Submitted for the Record

**U.S. House of Representatives Ways and Means Subcommittee on Health Hearing
Individual and Employer Mandates in the President's Health Care Law
April 14, 2015**

Chairman Brady, Ranking Member McDermott, and distinguished Members of the Subcommittee:

On behalf of the American Academy of Actuaries'¹ Health Practice Council, I appreciate the opportunity to provide written testimony on your subcommittee's recent hearing on the individual and employer mandates under the Affordable Care Act. My comments will focus on the individual mandate.

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 higher-risk individuals; they must enroll people who are lower risks as well. If an insurance plan draws predominantly 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 risk.

Adverse selection is a byproduct of a voluntary health insurance market. When people can choose whether or not to purchase insurance coverage, their decisions reflect in part how their expectations for healthcare needs compare to the insurance premium charged. Adverse selection results in higher premiums that, in turn, may lead to more lower-risk individuals 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 lower-risk individuals, over which the costs of higher-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 to which adverse selection occurs. In particular, guaranteed-issue

¹ The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and 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.

provisions, which prohibit insurers from denying coverage based on pre-existing conditions, can exacerbate adverse selection concerns by giving individuals the ability and incentive to delay purchasing insurance until they require health care services. Likewise, limiting or prohibiting premium variations by health status or other characteristics correlated with health spending can raise the premiums for younger and healthier individuals, relative to what they would pay if these characteristics could be used as rating factors. Such pure or modified community rating rules could cause younger and healthier individuals to opt out of coverage, leaving a higher-risk insured population.

The individual mandate is important to reducing potential adverse selection arising from guaranteed issue and modified community rating rules

Increasing overall participation in health insurance plans, especially among lower-risk individuals, is an effective way to minimize adverse selection. The Affordable Care Act (ACA) includes an individual mandate, which is an integral component of the law. The mandate, along with the premium subsidies and other provisions, provides incentives even for individuals in good health to obtain coverage, mitigating premium increases due to guaranteed issue and modified community rating. Without the individual mandate, fewer people would be insured and the risk pool would be more heavily weighted to those with higher costs. The result would be higher premiums.

Alternatives to the individual mandate

In the absence of an individual mandate, other mechanisms could be used to either encourage lower-cost individuals to purchase coverage and/or to offset the higher costs associated with adverse selection. However, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives. Below is an annotated list of potential alternatives, many reflecting options explored by the Government Accountability Office (GAO) in consultation with health policy experts, including representatives from the American Academy of Actuaries.² These options could be pursued alone or combined with one or more other options. When assessing any of these options, policymakers must balance providing individuals, especially healthy individuals, with incentives to enroll when first eligible against not being overly punitive so that individuals who delay enrollment face barriers so high that they find it difficult to ever enroll subsequently. In addition, the impacts on particularly vulnerable populations, such as those with low incomes or pre-existing health conditions, need to be considered.

Less frequent open enrollment periods. When guaranteed issue requirements prohibit insurers from denying coverage to individuals with pre-existing conditions, open enrollment periods limit the extent to which individuals can delay obtaining coverage until they need it. The ACA includes an annual open enrollment period during which individuals can sign up for coverage. Enrollment is not allowed outside of this period except under certain qualifying circumstances, such as a change in marital status.

² Government Accountability Office, “Private Health Insurance Coverage: Expert Views on Approaches to Encourage Voluntary Enrollment,” 2011. Available at: <http://www.gao.gov/new.items/d11392r.pdf>.

Less frequent open enrollment periods, for instance, having a one-time open enrollment period or an open enrollment period every two to five years instead of annually, would provide a greater incentive for people to purchase coverage sooner rather than later. It would reduce adverse selection arising from individuals delaying enrollment until they have high healthcare needs.

Late enrollment financial penalty. A late enrollment penalty is often suggested in combination with less frequent open enrollment periods. If an individual does not enroll in coverage when it is first available, subsequent enrollment would require a higher cost. This could be done, for instance, through a premium surcharge or a reduction in premium subsidy. Imposing a higher premium on those who delay enrollment could provide an incentive for people to purchase coverage when it is first available. Premium penalties may need to be significant if a goal is to offset the costs of those who delay enrollment until they have high-cost healthcare needs. Otherwise, the increased costs stemming from adverse selection would be spread to other enrollees in the form of higher premiums.

The late enrollment penalty in the Medicare program imposes a higher premium on individuals who don't sign up for Part B or Part D when initially eligible and don't have creditable coverage. Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums likely play a larger role.

Late enrollment access penalty. Rather than charging a higher premium for those who delay enrollment, another form of a late enrollment penalty would be to remove the guaranteed issue and modified community rating requirements for late enrollees. In other words, insurers would be allowed to underwrite for those who do not enroll when first eligible. Individuals with pre-existing conditions could then be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions. By limiting or excluding coverage for pre-existing conditions, such a penalty would reduce premium increases resulting from adverse selection.

Expanded reinsurance program. The ACA includes a temporary reinsurance program to offset the higher costs to plans of higher-risk individuals enrolling during the early years of the program. It was expected that higher-risk enrollees would be more likely to enroll sooner, and lower-risk individuals would eventually enroll, due to the individual mandate and its penalties which increase over time. The reinsurance program is funded through assessments on all plans and provides payments to plans in the individual market. In 2014, the reinsurance program reduced net claim costs in the individual market by 10-14 percent, leading to lower premiums.³ The reinsurance program is temporary and phases out between 2014 and 2016, resulting in lower offsets to premiums over time.

In the absence of an individual mandate, extending and expanding the use of reinsurance through larger assessments or other funding could help offset costs of higher-risk

³ American Academy of Actuaries, "Drivers of 2015 Health Insurance Premium Changes," 2014. Available at: http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf.

insureds, thereby moderating premiums. Lower premiums could encourage enrollment by even healthy individuals.

Allow greater premium variation. Under the ACA, premiums in the individual market are not allowed to vary by health status, and are allowed to vary by age by only a 3-to-1 ratio. Allowing greater variation in premium rates based on age would reduce costs for younger adults, increasing the likelihood they would purchase coverage. But, costs for older adults would increase, potentially making coverage unaffordable.

High-risk pools. If the requirements regarding guaranteed issue and modified community rating were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average premiums would be lower but high-risk individuals would have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but these have generally been small, coverage has been limited and expensive, and they have typically operated at a loss.⁴ In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-risk individuals in the individual market can incur high health costs, which would put upward pressure on premiums.

Coverage opt-out with payment for uncompensated care. Without an individual mandate or other mechanisms to encourage enrollment, health care providers will see a rise in uncompensated care. As an alternative to the mandate, an option would be to allow individuals to opt out of coverage, but require that they pay a share of uncompensated care costs through an annual assessment.

Weakening or eliminating the individual mandate could threaten the viability of the health insurance market

When health insurance markets include guaranteed issue and modified community rating requirements to ensure that coverage is available to people with pre-existing conditions, market viability depends on attracting a broad cross section of risks. If individuals with lower-cost health care needs opt to forgo coverage, average costs of those purchasing coverage will be higher, potentially creating a premium spiral. By encouraging enrollment among low-risk individuals, the ACA's individual mandate helps mitigate these adverse selection concerns.

Weakening or eliminating the individual mandate could result in adverse selection that would raise premiums and threaten the viability of the market, unless alternative provisions are implemented that would create equally strong incentives for low-risk individuals to obtain coverage. Alternatives include less frequent open enrollment periods with penalties for late enrollment, an expanded reinsurance program, high-risk pools, allowing greater premium variations across individuals, or allowing coverage opt-outs with assessments for uncompensated care. Although such voluntary incentives would provide incentives for healthy individuals to obtain coverage when first eligible, they would likely not be as effective as a strong individual mandate. In addition, special

⁴ Congressional Research Service, "Health Insurance: State High Risk Pools," 2011.

consideration would be needed to ensure access to coverage for vulnerable populations, for instance those with low incomes or pre-existing health conditions.