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"Examining the Effectiveness of the Individual Mandate under the Affordable Care Act"
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Chairman Buchanan, Ranking Member Lewis, and distinguished Members of the Subcommittee:

On behalf of the American Academy of Actuaries'[1] Individual and Small Group Markets Committee, we appreciate the opportunity to provide this written testimony for your subcommittee's January 24 hearing regarding the individual mandate under the Affordable Care Act (ACA). Our Academy committee recently issued a paper examining experience in the individual health insurance market under the ACA.[2] The paper outlines the conditions necessary for a sustainable individual health insurance market, examines whether these conditions are currently being met, and discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach. This testimony will highlight the paper's findings relative to the individual mandate.

Necessary Conditions for a Sustainable Individual Health Insurance Market

With respect to the individual market, the conditions necessary for a sustainable market include achieving enrollment that is sufficient and balanced, a regulatory environment that is stable and facilitates fair competition, participation by health plans that is sufficient for market competition and consumer choice, and slowing spending growth and improving quality of care. These factors

[1] The American Academy of Actuaries is a 19,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted 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.
[2] American Academy of Actuaries, *Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017.

will affect premium affordability; in turn, premium affordability will affect enrollment numbers and risk pools.

The ACA included the individual mandate to help achieve the condition of having individual enrollment at sufficient levels and a balanced risk pool. At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year. At the insurer level, enrollment must be high enough to achieve stability and predictability of claims and to benefit from economies of scale, so that per-enrollee administrative costs are low relative to average claims. Because the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less healthy individuals can be spread. Enrollment of only individuals with high health care needs, typically referred to as adverse selection, can produce unsustainable upward premium spirals. Attracting healthier individuals is needed to keep premiums more affordable and stable. The individual mandate was intended to be an integral part of the law. Along with the premium subsidies and other provisions, the mandate provides incentives for individuals in good health to obtain coverage, mitigating premium increases due to the pre-existing condition protections.

ACA Enrollment and Risk Pool Experience

Enrollment in ACA marketplace plans during the annual open enrollment period has increased from 8.0 million in 2014 to 11.6 million in 2015 and 12.7 million in 2016.[3] Including off-marketplace plans, ACA-compliant individual market enrollment in 2016 totaled about 17-18 million.[4] Due, in part, to the increased enrollment in the individual health insurance market, uninsured rates have declined. Nevertheless, enrollment has been lower than initially projected by the Congressional Budget Office (CBO) and others. One major reason for CBO's downward adjustment in enrollment projections is that more employers than projected are continuing to offer coverage, resulting in fewer individuals moving from employer coverage to coverage in the individual market. Lower-than-expected enrollment also suggests that affordability remains a challenge—in 2015, 46 percent of uninsured adults said that they had tried to obtain coverage but it was too expensive.[5] In addition, the ACA's individual mandate may be too weak to provide

[3] Department of Health and Human Services, ASPE Issue briefs, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," May 1, 2014; "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," March 10, 2015; "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," March 11, 2016. Figures reflect pre-effectuated enrollment, that is, the selection of a plan, with or without the first premium being paid. The open enrollment period for 2014 ran from October 1, 2013-March 31, 2014; enrollment figures cited also include additional special enrollment period activity through April 19, 2014. The open enrollment period for 2015 ran from November 15, 2014-February 15, 2015; enrollment figures cited also include additional special enrollment period activity through February 22, 2015. The open enrollment period for 2016 ran from November 1, 2015-February 1, 2016.

[4] Although there are no official marketplace enrollment numbers, the Department of Health and Human Services (HHS) estimates that in 2016, about 7 million individuals enrolled in individual marketplace coverage outside of the marketplace. (HHS, *ASPE Data Point: About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies*. October 4, 2016.) The majority of these individuals are likely to have ACA-compliant coverage; the Kaiser Family Foundation estimates that in 2016, only 12 percent of all individual market plans ae non-ACA-Compliant. (Liz Hamel, et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3*. Kaiser Family Foundation, May 20, 2016.)

[5] Kaiser Family Foundation, "Key Facts about the Uninsured Population," September 2016.

sufficient enrollment incentives. Outreach efforts may be insufficient to raise consumer awareness of the mandate and availability of premium assistance.

Lower-than-expected marketplace enrollment has been accompanied by concerns that the risk profile of enrollees was worse than many insurers expected.[6] The average risk profile for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to reflect a larger share of healthy individuals enrolling, and therefore a more balanced risk profile. In contrast, lower participation rates will tend to reflect a less-healthy risk profile, and in turn higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll than those with lesser needs.

As expected, evidence from the 2014 open enrollment period suggests that less-healthy individuals were more apt to sign up first. For instance, early marketplace enrollees were more likely to be older and use more medications than later enrollees.[7] Examinations of how the risk pool has been changing over time suggest that areas with stronger enrollment growth had greater improvements in their enrollee risk profiles.[8]

Options to Achieve Sufficient Enrollment Levels and a Balanced Risk Profile

One of the most popular elements of the ACA is that people with pre-existing health conditions cannot be denied health insurance coverage or charged more for that coverage. For this provision to work, however, healthy people must enroll at levels high enough to spread the costs of those who are sick. Otherwise, average costs, and therefore premiums, will rise. We now explore the potential implications of alternative approaches that aim to increase enrollment and attain a balanced risk profile.

Impose penalties for non-enrollment

One way of increasing enrollment is to penalize individuals who do not enroll. An individual mandate may be the best way of using penalties to increase enrollment, but only if it is effective and enforceable. Other options that impose penalties on individuals who initially forgo coverage but later enroll may provide some incentives to enroll when first eligible. However, their effect on the risk pool may come more from suppressing later enrollment or mitigating the costs of future adverse selection.

- *Individual mandate.* The ACA individual mandate penalty ($695 or 2.5 percent of income, whichever is greater) may not be strong enough to encourage healthy consumers to enroll. For instance, an annual income of $50,000 would result in a tax penalty of $1,250, which is

[6] Greg Ip, "The Unstable Economics in Obama's Health Law," *Wall Street Journal*, August 17, 2016.
[7] Julie M. Donohue, et al., "Early Marketplace Enrollees Were Older and Used More Medication Than Later Enrollees; Marketplaces Pooled Risk." *Health Affairs* 34(6): 1049-1055, June 2015.
[8] CCIIO, "Changes in ACA Individual Market Costs from 2014-215: Near-Zero Growth Suggests an Improving Risk Pool," August 11, 2016. Rebecca Owen, "An Examination of Relative Risk in the ACA Individual Market," Society of Actuaries, August 2016.

about half of the national average premium for a bronze plan.[9] A larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium.

Strengthening the mandate's enforcement could also increase its effectiveness. Currently, the mandate penalty is reported on the federal income tax form and is deducted from any tax refund. If no refund is owed, however, there are no consequences to the taxpayer if the penalty goes unpaid. Enforcing payment regardless of whether there is a tax refund would increase the mandate's effectiveness.

Increased outreach to ensure that consumers are aware of and understand the penalty as well as their coverage options and potential eligibility for premium subsidies would help increase the mandate's effectiveness, as would reducing allowed exemptions to the mandate.

- *Continuous coverage requirement / reduce access to coverage for late enrollees.* Another form of a late enrollment penalty would be to remove the pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period of time, such as 18 months. In other words, insurers would be allowed to underwrite individuals who do not enroll when first eligible or do not meet continuous coverage requirements. Individuals with pre-existing conditions could be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions.

  If this type of approach were structured to allow insurers to offer preferred premiums to individuals who meet underwriting requirements, however, the marketplace would in effect return to a pre-ACA environment. Healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less-healthy individuals would face higher premiums and potentially less generous or no coverage options. Similarly, if this approach moved away from requiring a single risk pool with risk adjustment among all plans, market fragmentation could occur and plans insuring higher-cost individuals would require higher premiums and could become less viable.

  A continuous coverage requirement in effect imposes a one-time open enrollment period. Instead of having only a one-time open enrollment period, or annual open enrollment periods as under the ACA, an intermediate approach would be to offer open enrollment periods every two to five years.

- *Late enrollment premium penalty.* In addition to or instead of an individual mandate penalty, individuals who do not enroll in coverage when it is first available could be subjected to a premium surcharge if they later enroll. For instance, the Medicare program increases Part B and D premiums by 10 percent of premium for every 12 months that enrollment is delayed past the initial eligibility date. (Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums

[9] Internal Revenue Service, "Individual Shared Responsibility Provision—Reporting and Calculating the Payment." Accessed on October 31, 2016.

probably play a larger role.) The higher premium is paid for the lifetime of the enrollee. Such a penalty would be more challenging to implement under the ACA. It would be difficult to track an individual's eligibility and enrollment over time, especially when individuals change employers or move between different coverages. Communicating the nature of the penalty to consumers could also be difficult. In addition, as the penalty accumulates over time, premiums could become prohibitively expensive, potentially further suppressing subsequent enrollment, potentially more so among healthy individuals.

Provide enrollment incentives

In the ACA, the individual mandate is the stick and premium subsidies are the carrot used to encourage enrollment, especially among healthy individuals. Although much attention is focused on the enrollment experience among young adults, who on average have lower health care costs, enrolling low-cost individuals of all ages should be the goal. Enrolling healthy older adults can be even more advantageous than enrolling healthy younger adults, because of the higher premiums paid by older adults. Regardless of age, attracting low-cost individuals depends on whether they deem that the value of the health insurance available exceeds the premiums charged. Reducing premiums through premium subsidies, tax credits, or other means could increase the perceived value of insurance, even to healthy individuals. The impact of any change in subsidies on enrollment, premiums, and government spending would depend on the details of the approach.

- *Premium subsidies.* Premium subsidies for ACA coverage are based on income and the cost of the second-lowest silver tier plan, and are available for individuals with incomes up to 400 percent of the federal poverty level (FPL). Nevertheless, premium affordability appears to continue to be a problem. Premium subsidies could be increased, perhaps targeting different subsets of enrollees. One option would be to increase the premium subsidies for all individuals currently eligible for premium subsidies—those with incomes between 100 and 400 percent of FPL. This would help address the concern that premiums remain unaffordable for low- and moderate-income individuals. Another option would be to increase subsidies for a subset of individuals currently eligible for premium subsidies (e.g., individuals with incomes of 250-400 percent of FPL, younger adults, older adults) if affordability issues are seen as greater for those subgroups. A third approach would be to extend subsidies to individuals with incomes exceeding 400 percent of FPL, in recognition that even higher-income individuals can face affordability problems. By increasing subsidies, net premiums would decline, increasing the incentives for even healthy individuals to obtain coverage.

- *Restructured premium subsidies.* The ACA premium subsidy structure sets a cap on premiums as a share of income, and the cap increases with income as a share of FPL. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit, which can be used toward any plan in the marketplace. If the plan chosen costs less than the second-lowest silver tier plan (e.g., the lowest silver tier plan, a bronze tier plan), the enrollee will pay less than the premium cap. Because premiums for older adults are more expensive than premiums for younger adults, older adults will receive a higher premium subsidy than younger adults with the same income. Using that subsidy toward a lower-priced plan could result in an older adult paying a lower net premium

than a younger adult with the same income. Conversely, if a higher-cost plan is chosen, older adults would pay a higher net premium than younger adults with the same income.

The subsidy structure could be changed so that subsidies vary by age, instead of or in addition to varying by income. For instance, subsidies could be targeted to increase enrollment among young adults. Regardless of how they are structured, subsidies need to be sufficient so that premiums are affordable, especially for low- and moderate-income households.

- *Reimbursement for high-risk enrollees.* The ACA included a transitional reinsurance program that uses contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. To the extent that the group insurance market (including self-funded plans) has a healthier risk profile than the individual market, this mechanism in effect acts as a risk adjustment program between the individual and group markets. The program was in effect from 2014 to 2016 only. A permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums. For instance, during the reinsurance program's first year, the $10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.[10] Such a program to pool high risks could be implemented at the state or federal level and could use the current funding mechanism or another. For instance, the state of Alaska recently established a comprehensive health insurance fund that will act like a reinsurance program, thereby lowering 2017 premium rate increases.

Modify insurance rules

Under the ACA, premiums cannot vary by health status, but are allowed to vary by age, up to a 3:1 ratio. The ACA also imposes rules regarding the comprehensiveness of coverage. These rules can affect average premiums and out-of-pocket costs. They also affect how premiums vary across individuals.

- *Wider premium variations by age.* Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent ($70 per month), resulting in an increase in young adult enrollment.[11] However, premiums for 64-year-olds would increase by 29 percent ($274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by $11 billion in 2018 under the current ACA subsidy structure.

- *Increased access to catastrophic coverage or the addition of a lower tier "copper" plan.* Less generous coverage could be appealing to younger adults and healthy people of all ages more generally. The ACA offers a catastrophic plan option to adults under age 30 and older

[10] American Academy of Actuaries, *Drivers of 2015 Premium Changes*, June 2014.
[11] Evan Saltzman and Christine Eibner, "Insuring Younger Adults through the ACA's Marketplaces: Options to Expand Enrollment," Commonwealth Fund blog post and technical appendix, December 16, 2016.

adults who have a hardship exemption from the individual mandate. However, individuals are not allowed to use premium tax credits toward catastrophic plans and the actuarial value of catastrophic plans is similar to bronze plans. As a result, current participation in catastrophic plans is quite low—less than 1 percent of marketplace enrollees.[12] Allowing broader access to catastrophic coverage with even lower actuarial values and allowing premium tax credits to be used toward this coverage could increase enrollment, especially among healthy individuals. Under current law, however, increased enrollment in catastrophic plans won't affect premiums for the metal level plans—although catastrophic plans are part of the single risk pool, catastrophic plan premiums are allowed to be adjusted to reflect the expected impact of catastrophic plan eligibility. In addition, catastrophic plans are treated separately in the risk adjustment program.

Adding a copper tier plan, with an actuarial value lower than that of the bronze tier plans, could result in increased enrollment among young and healthy individuals. However, the lower premiums associated with these plans mean that it would be more difficult to spread the risk of higher-cost enrollees in more generous plans. In addition, by their nature, both catastrophic plans and copper tier plans would have higher out-of-pocket cost-sharing requirements than other plans. This may be less of an issue for high-income individuals, but these types of plans are a less viable option for low- and perhaps even moderate-income individuals. (Individuals with incomes less than 250 percent FPL are eligible for cost sharing subsidies, but only if they purchase silver tier plans.)

- Increased benefit design flexibility. Designing benefit packages that would be more attractive to healthy enrollees could increase their participation. For instance, offering primary care visits or generic drugs with low copayments before the deductible could be a way to increase the value of benefits. Although insurers already have flexibility to vary plan designs within the actuarial value constraints, the health savings accounts (HSA) rules prohibit paying most non-preventive benefits prior to the deductible. Relaxing those rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits while also potentially reducing costs.

Conclusion

As one of the conditions needed for the individual market to be sustainable, enrollment numbers must be sufficient and the risk profile must be balanced. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has generally been lower than expected and enrollees have been sicker than expected. Both of these factors have contributed to substantial premium increases in many, but not all, states.

Many options have been put forward to improve the short- and long-term sustainability of the individual market, either through changes to the ACA or by replacing the ACA with a different approach. If as part of this a goal is to provide coverage to people with pre-existing conditions at standard premiums, it is vital to enroll enough healthy people to spread the costs of those who are sick. Currently, the ACA's individual mandate, annual open enrollment period, and premium subsidies aim to achieve a balanced risk profile. Increased penalties for non-enrollment could

[12] CMS, *March 31, 2016 Effectuated Enrollment Snapshot*. June 30, 2016.

help improve the risk profile, as could improving premium affordability, for instance through increased premium subsidies or additional funding for high-risk enrollees. Weakening the incentives for participation, however, could further exacerbate adverse selection issues and lead to higher premiums and more uninsured.