September 22, 2017

The Honorable Mitch McConnell
Majority Leader, U.S. Senate
S-230 Capitol Building
Washington, DC 20510

The Honorable Chuck Schumer
Democratic Leader, U.S. Senate
S-221 Capitol Building
Washington, DC 20510

Re: The Graham-Cassidy-Heller-Johnson Proposal

Dear Leader McConnell and Leader Schumer:

On behalf of the American Academy of Actuaries[1] Health Practice Council (HPC), I would like to offer comments on the legislation recently proposed by Sens. Graham, Cassidy, Heller, and Johnson ("GCHJ"). Our comments focus primarily on the proposed revisions to the individual health insurance market and approaches to federal Medicaid funding.

The HPC encourages policymakers to improve the affordability and accessibility of health insurance coverage and has published a number of policy statements in this area (highlighted at the end of this letter) that provide additional detail related to the specific comments below.

We appreciate this opportunity to provide input on these unique actuarial issues and encourage you to consider our comments as you move forward. Our long-established mission is to inform public policy deliberations in an objective and unbiased way.

Executive Summary

To be sustainable, the individual market requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings.

In the near term, GCHJ would not address cost-sharing reduction (CSR) funding and would eliminate the individual mandate. As a result, it would exert upward pressure on premiums. GCHJ would fund short-term financial assistance to states in 2019 and 2020. Depending on how it is used, this funding could offset some of the upward premium pressure. But overall, premiums would likely increase, enrollment would likely decline, and more insurers may withdraw from the market.

[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.

Beginning in 2020, GCHJ would terminate federal funding for the ACA's premium and cost-sharing subsidies, Medicaid expansion, and Basic Health Program. Instead, a portion of the federal money previously used for these programs would be converted to Market-Based Health Care grants to states. Funding would be redistributed from states that expanded Medicaid or had higher enrollment of low- and moderate-income individuals in individual market plans to states that didn't expand Medicaid or had lower enrollment among low- and moderate-income individuals.

States would be able to use the funding for a broad range of purposes (e.g., helping high-risk individuals purchase insurance, stabilizing premiums and promoting insurance market participation, paying providers for health care services) and would be able to waive many of the current market rules that provide protections to individuals with health conditions. There is a great deal of uncertainty regarding how states would use their funds and whether they would waive current market rules. In addition, there is concern whether, given actuarial, administrative, and legislative complexities, states would have the ability to make and implement their decisions in time for 2020 enrollment.

Unless the funds allocated in the proposal are used to create stable markets by maintaining a level playing field for insurers and achieving a balanced risk pool, GCHJ would likely lead to higher individual market premiums, lower enrollment, eroded protections for those with pre-existing conditions, lower insurer participation, and more unstable markets than under current law.

GCHJ would also modify the federal funding structure of the Medicaid program. Aside from terminating the Medicaid expansion and incorporating that funding into the Market-Based Health Care grants to states, it would set expenditure caps for the traditional Medicaid population. The caps would limit federal funding on a per enrollee basis based on inflation rates that are projected to be outpaced by long-term Medicaid costs. In combination, these modifications could result in lower federal financing per enrollee than is received under current law.

Individual Health Insurance Market

Criteria for a Stable Market

We have identified four criteria necessary for the stability and sustainability of the individual health insurance market:

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Low health spending growth and high quality of care.

Experience under the ACA has varied, with the markets in some states faring relatively well. More typically, however, the results thus far indicate the need for improvement along most of these criteria. In general, enrollment in the individual market has been lower than initially projected and enrollees have been less healthy than expected. The uncertain and changing legislative and regulatory environment—including legal challenges, allowing individuals to

retain pre-ACA coverage, and constraints on risk corridor payments—has contributed to adverse experience among many insurers. As a result of these and other factors, insurer participation and consumer plan choice decreased in 2016 and 2017, and some insurers have announced they will withdraw from the market in 2018. Insurers are currently finalizing their decisions on whether to participate in the market in 2018, and if so, where to set their premiums. Continued uncertainty adds to the risk that insurers will discontinue their participation.

To improve the stability and sustainability of the individual market, several actions are needed in the short term. These include:

- Continued funding of the CSR reimbursements;
- Enforcement of the individual mandate;
- Increased external funding through increased premium subsidies or to offset costs for high-cost enrollees; and
- Forestalling legislative or regulatory actions that could increase uncertainty or threaten stability.

When evaluating the overall impact of GCHJ, it is important to consider not only the impact of particular provisions, but also how the various provisions interact to affect enrollment decisions, premiums and cost sharing, insurer participation, and federal spending.

GCHJ Near-Term Effects

In the near term, GCHJ would eliminate the individual mandate retroactively to 2016 and provide external funding in 2019 and 2020 to address coverage and access disruption. In addition, eligibility for catastrophic plans would be expanded to include all individuals.

Continued uncertainty regarding CSR funds would put upward pressure on premiums. GCHJ does not include a provision to fund CSRs. Decisions to not pay the reimbursements or even uncertainty about whether the reimbursements would be paid could result in 2018 premium increases averaging about 20 percent for silver plans, over and above premium increases due to medical inflation and other factors.[2] These estimates could understate silver plan premium increases; silver plan enrollment would likely shift toward lower-income enrollees with higher cost-sharing subsidies, thus necessitating higher premiums. Federal spending would likely increase if CSR payments are not made, as the increase in federal premium subsidies would exceed federal savings due to eliminating CSR payments to insurers.[3]

Eliminating the individual mandate would put upward pressure on premiums. GCHJ would eliminate the mandate retroactively to 2016. The mandate was intended to encourage healthy

[2] Congressional Budget Office (CBO), "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017. Kaiser Family Foundation, "Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies; Estimated Increases Range from 9% in North Dakota to 24% in Mississippi," April 6, 2017.
[3] CBO, August 2017.

individuals to enroll. In practice, its financial penalty[4] is usually low as a share of premiums, many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in conjunction with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. In their 2018 rate filings, some insurers have cited the impact of a weakened or eliminated mandate. For instance, the Pennsylvania insurance commissioner announced that if the mandate is repealed, 2018 premiums would be an estimated 15 percent higher on average.[5] Eliminating the mandate would remove the incentives for individuals to enroll, leading to a deterioration of the risk pool, as those most likely to enroll in a guaranteed-issue environment are those with higher health care needs.

If known in advance, insurers can reflect an elimination of the individual mandate penalty in their premiums. Premiums for 2018 are nearly final, and premiums for 2017 are already final and in force. GCHJ would eliminate the penalty retroactively, and many individuals could drop coverage during the balance of 2017. Those dropping coverage would on balance likely be healthy individuals and those without immediate health care needs; individuals with ongoing or immediate health care needs would be more likely to retain coverage. As a result, the risk pool could deteriorate and premiums may be insufficient to cover claims in 2017.

Short-term assistance to states could offset, at least in part, the premium increases arising from an elimination of the individual mandate or the elimination of CSR funding, but not both. GCHJ would allocate $10 billion in 2019 and $15 billion in 2020 to be used to "fund arrangements with issuers to assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within states." However, fund allocations would be at the discretion of Centers for Medicare and Medicaid Services (CMS) administrator. It is unclear where and how the funds would be allocated, and therefore the extent they would affect premiums and insurer participation is unknown and could vary by state. If funds are targeted to particular states—for instance, those at highest risk of having no participating insurers—then funds would not be available to other states to offset higher premiums caused by eliminating the individual mandate and/or CSR funding. If funds were used to offset an elimination of CSR funding, little or no funds would be left to address other market stability concerns.

Increasing the availability of catastrophic plans could provide an additional coverage option. Currently, catastrophic plans are available to young adults and individuals who qualify for a hardship exemption from the individual mandate. GCHJ would expand catastrophic plan eligibility to all individuals regardless of age. The actuarial value of catastrophic plans is similar to bronze plans. Although catastrophic plans are part of the single risk pool, current regulations allow catastrophic plan premiums to be adjusted to reflect the expected impact of catastrophic plan eligibility. As a result, premiums for catastrophic plans can be lower than for bronze plans. However, if catastrophic plan eligibility is broadened, the premium advantage relative to bronze

[4] For 2017, the penalty is the greater of 2.5 percent of household income (up to the national average price of a bronze plan) or $695 per adult and $347.50 per child (up to a maximum of $2,085).
[5] Pennsylvania Insurance Department, "Insurance Commissioner Announces Single-Digit Aggregate 2018 Individual and Small Group Market Rate Requests, Confirming Move Toward Stability Unless Congress or the Trump Administration Act to Disrupt Individual Market," June 1, 2017.

plans would likely disappear, as plan eligibility would no longer be different than the metal level plans.[6]

Uncertainty regarding longer-term market structure could affect near-term insurer participation. Current uncertainty regarding the enforcement of the individual mandate and whether the cost-sharing reductions will be funded are contributing to higher premiums and insurer withdrawals from the market. Questions regarding how states would structure their insurance rating rules, coverage requirements, and premium subsidies under the GCHJ block grant structure beginning in 2020 add to the uncertainty and potential instability regarding future enrollment, premium rates, and risk pool profiles. In light of this uncertainty, insurers might reconsider their current participation in the market and some may choose to exit in the near term. This could lead to more market disruption and loss of coverage among individual market enrollees.

GCHJ Long-Term Effects

Beginning in 2020, GCHJ would replace federal funding for ACA premium subsidies, cost-sharing subsidies, Medicaid expansion, and the Basic Health Program with Market-Based Health Care grants to states. Over 2020–2026, funding for the block grants would be about 8 percent lower than that under current law.[7] Funds would be allocated to states by a complex formula that would change over time. In general, funds would be redistributed from states that expanded Medicaid or have high enrollment of individuals with premium subsidies to states that didn't expand Medicaid or have low enrollment of individuals with premium subsidies. Nearly two-thirds of states would receive lower funding under GCHJ than under current law over the 2020–2026 period.[8] As a result, states that expanded Medicaid coverage or that had high enrollment of low- and moderate-income individuals into individual market coverage would receive less funding than under current law.

GCHJ would allow states to use their block grant funding for a broad range of purposes, including helping high-risk individuals purchase insurance, stabilizing premiums and promoting insurance market participation, paying providers for health care services, funding assistance to lower out-of-pocket costs, helping individuals purchase coverage, and providing insurance coverage for Medicaid-eligible individuals. States could decide to provide premium or cost-sharing subsidies but would need to set up an infrastructure to do so if they don't already have one in place.

GCHJ would retain the ACA market rules but would allow states to waive many of them. Insurers would still be prohibited from denying coverage to individuals with pre-existing

[6] Although they are part of the single risk pool, catastrophic plans are risk adjusted separately from metal tier plans. Broadening the availability of catastrophic plans could lead to some insurers offering only catastrophic plans. Such insurers could set lower catastrophic premiums because they wouldn't share any of the adverse selection costs borne by more generous metal tier plans. Because of single risk pool requirements, insurers with metal tier plans are not allowed to raise premiums to reflect that the catastrophic plans could be attracting the lower risks; metal tier premiums could be inadequate as a result. Potential ways to avoid this concern include allowing only insurers who offer metal tier plans to offer catastrophic plans, or to calculate risk adjustment for catastrophic plans and metal tiers together.

[7] Kaiser Family Foundation, "State-by-State Estimates of Changes in Federal Spending on Health Care Under the Graham-Cassidy Bill," September 2017.

[8] Kaiser Family Foundation, September 2017.

conditions, but other provisions could undermine these protections. States could loosen premium rating rules, including those related to health status (but not gender), essential health benefit (EHB) requirements, and minimum medical loss ratios. As a result, states would be able to widen the age rating bands, charge higher premiums to people with health conditions, reduce or eliminate certain EHB categories or EHB requirements altogether, and reduce or eliminate minimum coverage levels (i.e., actuarial value). And although it appears that states would not be allowed to waive out-of-pocket cost sharing limits, those limits would become less meaningful if insurers are allowed to exclude benefit categories from coverage.

Projecting the effects of the Market-Based Health Care grants is difficult, because they depend on each state's action. The lower overall federal funding would likely result in more uninsured in the aggregate. The effects on a particular state's individual market, premiums, and enrollment would depend on its funding allocation and how it uses its block grant.

Many states, especially those in which the legislature meets infrequently, could find it difficult to make and implement decisions, rules, and necessary infrastructure by 2020, given the actuarial and administrative complexities. Moreover, insurers would need to know about any market rule changes by early to mid-2019, when they are developing 2020 premium rates. Markets in states that do not take action to use block grants would operate under the ACA market rules, but there would be no federal premium or cost-sharing subsidies and no individual mandate. In those states, enrollment would be expected to plummet, premiums would skyrocket, and insurers would likely be reluctant to participate in the market.

States would be able to use their block grants to provide premium or cost-sharing subsidies, or for reinsurance programs or high-risk pools. Depending on how they are structured, these mechanisms could help avoid a destabilization of the market by encouraging enrollment among heathy individuals to achieve a balanced risk pool. Nevertheless, unless a state enacts its own individual mandate or an alternative incentive to encourage enrollment among healthy individuals, the risk pool would likely be worse than under current law, especially in states in which federal block grant funds are lower than federal funds for ACA coverage under current law. Even in states in which block grants would exceed current law federal funding, there are many potential uses for the money, some of which wouldn't lower premiums (e.g., paying providers for health care services).

To lower premiums, some states might decide to exclude certain benefit categories. The costs of specific benefits, such as maternity care or mental health and substance abuse services, are relatively small when spread over the entire insured population.[9] Eliminating such services would not necessarily result in a large reduction in premiums. However, if those coverage requirements are removed and consumers are allowed to choose whether to have specific benefits, the additional premiums for those specific benefits will be high because insurers would anticipate that only enrollees more likely to use them would opt for them.

Also, reducing the comprehensiveness of coverage would erode out-of-pocket protections, as only out-of-pocket spending used toward covered benefits would count toward an enrollee's out-

[9] Rebekah Bayram and Barbara Dewey, "Are Essential Health Benefits Here to Stay?" Milliman white paper; March 2017.

of-pocket limit; annual out-of-pocket limits would not apply to non-essential benefits. Reducing the comprehensiveness of coverage or increasing the variation of EHB requirements would increase the need for risk adjustment to reduce insurer incentives to avoid high-cost enrollees or enrollees with particular conditions. However, increased flexibility in benefit designs could make the implementation of risk adjustment more challenging. As a result, a reduction or elimination of EHB requirements would lead to a deterioration of pre-existing condition protections.

Similarly, allowing insurers to vary premiums by health status would erode pre-existing condition protections. Although premiums would be lower for healthy individuals, whose participation is needed to achieve a balanced risk pool, individuals with health conditions would pay higher premiums than they do under current law, making it more difficult for them to afford coverage.

To waive current ACA market rules regarding premium rating, benefit coverage, etc., states would be required only to describe how the state intends to "maintain access to adequate and affordable health insurance coverage for individuals with pre-existing conditions." However, these requirements are much weaker than under the current 1332 innovation waiver process, which requires actuarial and economic analyses to demonstrate coverage would be at least as comprehensive and affordable as under ACA market rules.

Funding for the block grants would expire after 2026, meaning funding would need to be reauthorized for 2027 and beyond. This adds uncertainty for states as they make their decisions for 2020 and could affect whether and how they decide to use the block grant funding. It also raises uncertainty for insurers as they consider their long-term market participation strategy.

Approaches to Federal Medicaid Funding

Modifying the federal funding structure of the Medicaid program[10] from one based on a percentage of total program expenditures to one that caps or limits federal funding to states would have significant implications. Details regarding the approach to actuarial soundness requirements, setting caps including growth rate assumptions, and program flexibility provided to states may impact the stability and long-term viability of the Medicaid program.

More than 15 million adults are currently covered through the Medicaid expansions undertaken pursuant to the ACA.[11] Under current law, states receive enhanced federal funding for this population (federal match is 94 percent in 2018, phasing down to 90 percent by 2020). GCHJ would eliminate funding for the ACA Medicaid expansion as well as coverage for childless nondisabled adults. As noted earlier, the federal funds used for Medicaid expansion, the premium and cost-sharing subsidies, and the states' basic health programs would be combined under a block grant, the Market-Based Health Care grant.

[10] Medicaid is a state-operated, state- and federal-funded public health care program that covers more than 70 million Americans.
[11] Kaiser Family Foundation State Health Facts "Medicaid Expansion Enrollment," accessed on September 21, 2017.

GCHJ would establish a formula by which block grant funds would be distributed to states, with a targeted goal that by 2026, every state would receive the same base dollar amount on a per person basis using the low-income population as the basis for financial parity. From an actuarial perspective, the formula may not provide the financial parity across states intended by the sponsors of the legislation. In order to determine that level of parity, the formula would need to take into account both the block grants as well as traditional Medicaid funding for all low-income populations below an established threshold (e.g., 138 percent of the federal poverty level).

Continuing actuarial soundness requirements

As of 2014, more than 60 percent of Medicaid enrollees are covered through Medicaid managed care organizations (MCOs.)[12] To ensure that the capitation rates paid to these MCOs recognize all reasonable, appropriate, and attainable costs for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state.

Though not addressed in GCHJ, policymakers should continue to require actuarial soundness of capitation rates with all federal funds, including the Market-Based Health Care grant funds, to ensure sustainability of capitated models both within and outside the Medicaid program. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid and low-income coverage programs do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the federally funded programs to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the program. This would lead to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs. Furthermore, if actuarial soundness requirements would require a sustainable rate to be outside of the proposed 25 percent threshold under the Medicaid per capita allotments, states could see a reduction in future federal funding. The reduced federal funding may result in increased pressure to lower capitation rates below the actuarial soundness requirement or face budget overruns.

Approach to setting state caps

GCHJ would set per-enrollee caps based on states' Medicaid expenditures during a state-specified base period. Medicaid per capita costs vary by state based on state decisions such as covered populations and benefits, provider reimbursement levels, and delivery system approach. Medicaid provider pass-through supplemental and upper payment limit (UPL) payment programs, as well as provider taxes, also vary widely by state.[13] Basing per capita caps on a state-specific period solidifies all these different decisions. This approach could be considered to reward states with richer programs while limiting the ability for states with leaner programs to expand coverage or increase provider reimbursement rates to be equitable with other states. The approach would also penalize states with the most efficient programs, because states with historically less-efficient programs would presumably have greater opportunities for savings to avoid state budget overruns.

[12] CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, Spring 2016.
[13] The Commonwealth Fund, "Integrating Medicaid Supplemental Payments into Value-Based Purchasing," November 22, 2016.

GCHJ does attempt to push Medicaid per capita amounts toward a national average by increasing / decreasing per capita amounts (modestly) if the state specific amounts are 25 percent below / above national averages (with certain rural state exclusions). Because the age distribution and disease burden within population cohorts may change over time, consideration should also be given to allowing adjustments where there are significant demographic and health risk changes. These considerations could be applied in a manner similar to the proposal for the adjustments to the Market-Based Health Care grant allotments.

Although state Medicaid programs are generally large enough to be fully credible in aggregate, expenditures, particularly for small(er) population categories, may vary by year. To the extent the base period was a higher or lower year than average, using that specific period as a baseline may provide a significant advantage or disadvantage for a state. It may be more appropriate to have flexibility to use an average of a few recent years of experience to determine a reasonable baseline.

Growth rate methodology

GCHJ would vary the annual growth rate by enrollee category: For the non-elderly, non-disabled, non-expansion adults and children populations, the rate would be CPI-M through 2024 and CPI-U thereafter; for the elderly and disabled adult populations, the rate would be CPI-M +1 percentage point through 2024 and CPI-M thereafter. Projected per-enrollee Medicaid health care costs over the long term are projected to outpace CPI-M as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., the costly new biological drugs recently made available), and unexpected events such as natural disasters or pandemics.[14] States can also make investments in one year with an expectation of program improvements or savings in future years (e.g., paying incentive bonuses to MCOs for improved outcomes). If CPI-M does not keep pace with total health care cost changes, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

Additionally, efforts to reduce total costs, such as implementing or increasing participant premiums or increasing the burden on participants seeking coverage, could deter enrollment among those who are healthy and have relatively low health care costs, resulting in selection that in turn drives up per capita costs because those with health needs will continue to be motivated to enroll. This selection dynamic would drive up per capita costs, making it more difficult for states to stay within their per capita caps. This change in underlying morbidity could be calculated and payments adjusted via a risk scoring tool. An alternative approach, although less precise in matching payment to risk, would be to address selection funding concerns by applying an enrollment floor, such that the aggregate cap would be calculated by multiplying the indexed per capita rates by the greater of actual enrollment for that year and a historical enrollment baseline.

[14] CMS, 2016 Actuarial Report on the Financial Outlook for Medicaid, 2016

Program flexibility provided to states
Under current law, states must comply with specific Medicaid program requirements to receive federal funding. Because moving to per capita caps would shift more funding risk to states, the states would need the flexibility to modify components (such as eligibility, benefits, provider payments, provider access, delivery system, premiums and cost sharing, etc.) of their Medicaid programs to stay within their budgets to avoid having to either raise additional revenue through taxes or assessments or reallocate funding designated for other state programs to Medicaid. States do not have unlimited funding for their Medicaid programs, so not allowing state flexibility could create a financially unsound funding mechanism for Medicaid programs. The block grant option for states under GCHJ does provide several elements of flexibility for state consideration.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, senior health policy analyst, at linn@actuary.org or 202-785-6931.

Sincerely,

Shari Westerfield, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

cc: Members of the U.S. Senate
Members of the U.S. House
U.S. Governors

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For more information, see related publications from the American Academy of Actuaries:

Steps Toward a More Sustainable Individual Health Insurance Market (Issue brief, April 2017)
Selling Insurance Across State Lines (Issue brief, February 2017)
Association Health Plans (Issue brief, February 2017)
Using High-Risk Pools to Cover High-Risk Enrollees (Issue brief, February 2017)
Proposed Approaches to Medicaid Funding (Issue brief, March 2017)
How Changes to Health Insurance Market Rules Would Affect Risk Adjustment (Issue brief, May 2017)
An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes (Issue paper, January 2017)
Comments to U.S. House on American Health Care Act (AHCA) (March 2017)
Comments on market stabilization proposed rule (March 2017)
Comments to U.S. Senate on the Better Care Reconciliation Act (BCRA) (June 2017)
Comments to U.S. Senate HELP Committee on Stabilizing the Individual Health Insurance Market (September 2017)