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May 23, 2017

Chairman Orrin G. Hatch
U.S. Senate, Committee on Finance
Dirksen Senate Office Building, SD-219
Washington, DC 20510-6200

Ranking Member Ron Wyden
U.S. Senate, Committee on Finance
Dirksen Senate Office Building, SD-219
Washington, DC 20510-6200

Re: Improving the Individual Health Insurance Market and Changing the Approach to Medicaid Funding

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the American Academy of Actuaries' Health Practice Council (HPC),[1] I appreciate the opportunity to provide input to the Senate Finance Committee as it considers making changes to health insurance market rules and the Medicaid program. The HPC continues to encourage policymakers to improve the affordability and accessibility of health insurance coverage. Our comments in this letter focus primarily on potential steps to improve the stability and sustainability of the individual health insurance market and new approaches to federal Medicaid funding.

The Academy appreciates this opportunity to comment on these unique actuarial issues. Our mission is to inform public policy deliberations in an objective and unbiased way.

Individual Health Insurance Market

Serious challenges to the stability and sustainability of the individual health insurance market exist for 2018, especially as some insurers have announced they are or are considering withdrawing from the market. The market stabilization rule recently finalized by the Centers for Medicare and Medicaid Services (CMS) includes provisions that are intended to improve the stability of the individual market.[2] Nevertheless, many challenges and areas of uncertainty remain. Whether and how these challenges are addressed will affect enrollment, premiums, insurer participation, and consumer choice.

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[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] Centers for Medicare and Medicaid Services, "CMS issues final rule to increase choices and encourage stability in health insurance market for 2018," April 13, 2017.

Several conditions are necessary to achieve a stable and sustainable health insurance market.[3] These include:

- Enrollment at sufficient levels for stable and predictable claims. In addition, when protections for individuals with pre-existing conditions are provided, it's important to attract healthy individuals for a balanced risk pool.
- A stable regulatory environment that facilitates fair competition.
- Sufficient insurer participation and plan offerings to provide insurer competition and consumer choice.
- Low spending growth and high quality of care, because most premium dollars go toward paying medical claims.

To improve individual health insurance market stability and sustainability, actions need to be taken to reduce legislative and regulatory uncertainty and to improve market stability. Continuing uncertainty could lead to additional insurers exiting the market, leaving consumers with fewer insurance choices—or none at all. Improving the market would entail funding cost-sharing reductions (CSR) reimbursements, enforcing the individual mandate (or other continuous coverage provisions), directing external funding to offset premiums, and avoiding destabilizing actions.

Continued funding of CSR reimbursements. The Affordable Care Act (ACA) provides cost-sharing reductions to eligible low-income enrollees with reimbursement from the federal government to insurers for these reductions. A U.S. district court ruling in a challenge bought by the U.S. House of Representatives determined that a congressional appropriation is required to make such reimbursements.[4] The case is now on hold because both parties asked for a continuance to allow time for a resolution.[5]

For actuaries to assess premium requirements, they need to know whether those reimbursements will be funded or if those benefits would continue. Two studies estimate that decisions to not pay the reimbursements or even uncertainty about the reimbursements could result in 2018 premiums increases averaging from nearly 20 percent to 30 percent for silver plans, over and above premium increases due to medical inflation and other factors.[6,7] The continued uncertainty or prospect of higher premium increases could cause more insurers to withdraw from the market, potentially leaving more areas of the country with one or even no participating insurers. Funding of the CSR reimbursements through congressional appropriations or other means is needed as soon as possible to avoid these premium increases or potential further market withdrawals.

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[3] American Academy of Actuaries, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes,* January 2017.
[4] *U.S. House of Reps. v Burwell*, (D.D.C. May 12, 2016).
[5] U.S. House of Reps. v. Price, Joint Motion to Continue Abeyance, February 21, 2017.
[6] 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. (The Kaiser Family Foundation does not consider the movement of people out of silver plans in response to the rate changes and acknowledges this is an underestimate.)
[7] Oliver Wyman Health, "New Analysis: Potential Impact of Defunding CSR Payments," May 12, 2017. (Assumes that insurers will price silver at a 91 percent actuarial value (AV), which represents a 30 percent increase over a 70 percent AV plan, not including induced utilization impacts.)

Enforcement of the individual responsibility penalty. The individual responsibility penalty (the individual mandate) was intended to encourage healthy individuals to enroll, but its financial penalty is 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 be without a mandate. If enforcement is further reduced, or if the mandate is eliminated altogether—as in the House-passed American Health Care Act (AHCA)—the result could be a deterioration of the risk pool and higher premiums.

A question arises for us whether there are any alternatives to the individual mandate that could result in a more balanced risk pool. Continuous coverage requirements have been introduced in the AHCA. But if the associated penalty is too low, it won't do enough to encourage healthy individuals to enroll sooner rather than later. If the penalty is too high, then the only people with prior gaps in coverage willing to pay the penalty are those who have high health care needs. Auto-enrollment, successful in increasing participation in retirement savings plans, has the potential to achieve high participation rates if logistical hurdles such as how to identify eligible enrollees could be overcome. The residual, transitional, and voluntary nature of the individual market could make those efforts especially difficult, however.

Increased external funding. If the individual mandate is a "stick" to encourage enrollment, then premium subsidies are a "carrot." Weaker sticks could be offset by stronger carrots. One approach is to increase premium subsidies by extending premium tax credits to all enrollees; increasing premium tax credits for currently subsidy-eligible enrollees; or increasing them for specific subgroups, such as young adults.

Currently, premium tax credits are available for exchange enrollees with incomes up to 400 percent of the federal poverty level without access to employer or public coverage. In effect, premiums as a percentage of income are capped, with the cap increasing with income. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit. Such a structure automatically reflects how premiums vary by age and geographic area—premium subsidies are larger for enrollees who are older, lower-income, or living in high-cost areas.

Changing the structure of the premium tax credits would affect premiums and enrollment. For instance, providing a flat tax credit by age, as would be the case under the AHCA for those who are health insured, would delink the tax credit from the premium. This could result in lower premium subsidies to enrollees who are older, lower-income, and living in high-cost or rural areas, and higher premium subsidies to enrollees who are younger, higher-income, and in lower-cost areas. If the tax credits do not keep pace with premium increases, the tax credits would become less valuable over time. Such a subsidy structure, especially if implemented with a widening of the age rating rules, would likely change the age distribution of enrollees by increasing enrollment among younger adults and reducing enrollment among older adults. The impact of subsidy and age rating changes on the risk pool profile also depends on the health status of enrollees. For example, lower subsidies for poorer and older individuals under the AHCA could reduce participation among healthy individuals from these subgroups. The higher

the multiple of younger age premium applied to older Americans, the more likely that older Americans will not enroll. This means that, the higher the net premium, the more likely the enrollee population will skew to the less healthy. Conversely, the lower the net premium, the more likely the enrollee population will be more balanced by encouraging enrollment of healthy individuals.

External funding to offset insurer costs for high-cost enrollees, for instance through high-risk pools, would be another way to lower premiums, increase enrollment, and improve the risk pool. There are different ways to structure high-risk pools. One way is a traditional high-risk pool approach. Prior to the ACA, many states used traditional high-risk pools to provide coverage in a separately run insurance pool to individuals who were not able to get insurance due to pre-existing health conditions. Another high-risk pool approach is to use "invisible" risk pools, where enrollees remain in the individual market, but all or a portion of their claims are reimbursed by the high-risk pool. Invisible high-risk pools are typically characterized as determining eligibility based on conditions. Alaska's program, for instance, provides payments to insurers for individual enrollees who have one or more of 33 identified high-risk conditions. Reinsurance is a third approach, which is similar to invisible high-risk pools in that enrollees would remain in the individual market. But rather than being condition-based, payments to plans for high-risk enrollees would be based on claims exceeding a specific dollar threshold. The ACA's transitional reinsurance program followed this approach; during its first year, the $10 billion reinsurance fund was estimated to reduce premiums by about 10 to 14 percent.[8] Funding high-cost claims in the individual market through external sources would result in lower premiums, which would in turn reduce federal spending for premium tax credits.

<u>Avoiding legislative or regulatory actions that could increase uncertainty or threaten stability</u>. It is important not only that actions to stabilize and improve the market be taken, but also that actions that would destabilize the market be avoided. For instance, allowing insurers to sell coverage across state lines could result in unintended consequences such as market segmentation that could threaten the viability of insurers licensed in states with strict benefit coverage, issue, or rating rules. The ability for high-risk individuals to obtain coverage could be compromised as a result. If rules governing insurance are consistent across the states, as they are currently, market segmentation could be minimized. However, potential premium savings would also be minimal, as premiums would continue to reflect local health care costs, regardless of location of the insurer.

Similarly, expanding the use of association health plans (AHPs) could result in unintended consequences, such as market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage, AHP insolvencies if they are not subject to clear regulatory authority and solvency requirements, and lack of consumer protections if AHPs are not subject to state-level protections.

Opening up non-ACA-compliant plans to new purchasers would also destabilize ACA-compliant markets.

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[8] American Academy of Actuaries, *Drivers of 2015 Health Insurance Premium Changes*, June 2014.

Approaches to Medicaid Funding

Modifying the federal funding structure of the Medicaid program from one based on a percentage of total program expenditures to one that caps or limits federal funding to states requires decisions in five key areas. How these elements are designed would impact the stability and long-term viability of the Medicaid program. They include:

- Approach to setting state caps;
- Treatment of Medicaid expansion populations;
- Growth rate methodology;
- Program flexibility provided to states; and
- Continuing actuarial soundness requirements.

While the following analysis focuses primarily on per capita cap projection development, the concepts also apply to the block grant option. As outlined in the Academy's recent issue brief,[9] block grants provide potentially greater risk and potentially greater reward to states under different enrollment and cost change scenarios. States that might consider the block grant option should carefully weigh all such possibilities.

Approach to setting state caps. 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.[10] Basing per capita caps on state-specific historical costs 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.

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 2016 was a higher or lower year than average, using 2016 as a baseline may provide a significant advantage or disadvantage for states. It may be more appropriate to have flexibility to use an average of a few recent years of experience to determine a reasonable baseline.

Treatment of Medicaid expansion populations. More than 14 million adults are currently covered through the Medicaid expansions.[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). Discontinuing this enhanced funding could result in states discontinuing coverage, thus

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[9] American Academy of Actuaries, *Proposed Approaches to Medicaid Funding*, March 2017.

[10] The Commonwealth Fund, Integrating Medicaid Supplemental Payments into Value-Based Purchasing, November 22, 2016.

[11] Kaiser Family Foundation State Health Facts, "Medicaid Expansion Enrollment," January–March 2016. Accessed on March 20, 2017.

increasing the number of uninsured. Continuing this funding only for the states that opted to expand coverage, however, would further increase funding inequities across states.

Federal funding for "grandfathered" populations would be based on a per capita amount tied to 2016 costs for this population (assuming states implemented expansion prior to the 2016 base year). This approach to grandfathering the population and introducing potential barriers to continued participation could result in adverse selection among the Medicaid expansion population. Medicaid beneficiaries who continue to be grandfathered because their income stays below 133 percent of federal poverty level and maintain continuous coverage could be the least healthy of the group, thus changing the characteristics of the group compared to the underlying 2016 base.

The per capita cap for the expansion population would be based on the 2016 costs for the non-disabled, non-aged adult population. Based on the *2016 Actuarial Report on the Financial Outlook for Medicaid*, the average national per-enrollee spending for expansion adults was nearly 28 percent higher than the per-enrollee spending for non-aged, non-disabled adults in 2015.[12] While the averages represent a different mix of states and are thus not "apples-to-apples," prior studies have indicated that Medicaid costs associated with childless adults are above those of "traditional" Medicaid adults.[13] Thus, the application of other adult per capita costs for expansion adults might lead to insufficient caps for the expansion population.

Growth rate methodology. Projected per-enrollee Medicaid health care costs over the long term are expected to outpace CPI-U[14] Medical as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., costly biological drugs recently made available), and unexpected events such as natural disasters or pandemics.[15] 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 managed care organizations (MCOs) for improved outcomes). If CPI-U Medical 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 enrollments 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

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[12] Centers for Medicare & Medicaid Services (CMS), *2016 Actuarial Report on the Financial Outlook for Medicaid*, 2016.

[13] CMS, *Medicaid Policy Brief*, May 2011.

[14] Consumer Price Index for All Urban Consumers.

[15] CMS, *2016 Actuarial Report on the Financial Outlook for Medicaid*, 2016.

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.

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 obviously do not have unlimited funding for their Medicaid programs, so not allowing state flexibility could create a financially unsound funding mechanism for Medicaid programs. A block grant option for states does provide several elements of flexibility for state consideration.

Continuing actuarial soundness requirements. Currently, more than 60 percent of Medicaid enrollees are covered through Medicaid MCOs.[16] 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. Payment of actuarially sound capitation rates to MCOs provides that:

- Obligations to the public are met;
- Payments are appropriate for both the state and the federal government;
- The rates promote program goals such as quality of care, improved participant health, community integration of enrollees, innovation in the delivery of care, and cost containment, where feasible; and
- Medicaid service providers are paid rates that encourage them to participate in the Medicaid program.

Though not addressed in the AHCA, policymakers should continue to require actuarial soundness of capitation rates to ensure sustainability of capitated models. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid program do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the Medicaid program to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the Medicaid program. This leads to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs.

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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, health policy analyst, at linn@actuary.org or 202-785-6931.

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[16] CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, Spring 2016.

Sincerely,

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American Academy of Actuaries

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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)
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)