

PUBLIC POLICY TOOLKIT

INTRODUCTION

THE AMERICAN ACADEMY OF ACTUARIES has prepared this public policy toolkit on some major issues in the hopes it will serve as an instrumental foundation during forthcoming debates in 2017 and beyond. These issue-focused guides offer information on select topics on which actuaries have expertise. The Academy hopes policymakers and their constituents find the toolkit useful to inform the debates over health care policy, Medicare, Medicaid, Social Security, lifetime income retirement, long-term care financing, flood insurance, financial services reform, and climate risk.

With the new administration and the convening of the 115th Congress, there will certainly be a change in direction on policy solutions, and this foundational toolkit can help frame the pros and cons of different options available to policymakers on technical considerations that actuaries are uniquely qualified to address.

The American Academy of Actuaries is the nonpartisan professional organization for actuaries in the United States. Actuaries are risk professionals who quantify and assist in managing risk, and apply their expertise and knowledge to a wide range of problems facing people in their everyday lives and businesses. In their work of estimating the costs of uncertain future events, actuaries utilize objective data in their modeling of risk.

The Academy is available to work with all policymakers in their exploration and refinement of policy options to provide objective and unbiased actuarial analysis of these key issues and many others. For more background on the American Academy of Actuaries, please visit us at actuary.org.



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PUBLIC POLICY TOOLKIT

HEALTH CARE

AFFORDABLE CARE ACT

BEFORE AND SINCE BEING SIGNED INTO LAW by President Obama in 2010, the Affordable Care Act (ACA) has generated some of the most significant public debate in recent years—it has been challenged in the Supreme Court and faced multiple efforts to modify and repeal it in Congress. The ACA was enacted to expand health insurance coverage to more Americans and begin reducing growth in spending on health care.

The ACA, referred to by many as “Obamacare,” contains provisions to bolster health insurance coverage by providing premium subsidies to low- and moderate-income Americans, requiring individuals to obtain coverage and larger businesses to provide health insurance to their employees, and expanding Medicaid eligibility to low-income individuals and families. The ACA has faced extensive attention both because of its implementation challenges as well as its achievements. The Academy’s Election Guides are presented to help you better understand the ACA as it is debated by candidates and to form your own opinion on the issues.

Key Provisions of the ACA

Individual Mandate

The ACA requires most Americans to obtain a minimum amount of health insurance coverage through employer-sponsored plans, the private insurance market, public insurance program such as Medicare or Medicaid, or pay a penalty.

Employer Mandate

Businesses that employ 50 or more workers are required to offer health insurance coverage to their employees or pay a penalty if an employee offered affordable coverage obtains a subsidy through the exchange.

Health Insurance Exchanges (Marketplaces)

Under the ACA, individuals purchasing coverage in the individual market can obtain their coverage through state-based insurance exchanges. These exchanges allow residents to compare plans offered from different insurers and apply any premium subsidies to the plan of their choice.

Premium Subsidies

Low- and moderate-income individuals and families earning between 100 percent and 400 percent of the federal poverty level are eligible to receive subsidies to help pay for health care insurance. The federal poverty levels used for 2017 premium subsidy eligibility are \$11,880 for individuals and \$24,300 for a family of four.

Medicaid Expansion

The ACA included a provision to expand Medicaid eligibility to 138 percent of the federal poverty level with federal funds supporting the new enrollees. However, the U.S. Supreme Court ruled in 2012 that states can choose whether or not to implement the Medicaid expansion. As of December 2016, 32 states and the District of Columbia have adopted the Medicaid expansion.

Pre-Existing Conditions

Insurers are prohibited from denying coverage or charging higher premiums to people with pre-existing medical conditions, such as cancer or heart problems.

Cadillac Tax

The ACA established a tax on high-cost, employer-sponsored health plans, often referred to as the “Cadillac tax.” The 40 percent tax on a health plan’s value that exceeds a certain thresholds intends to reduce health care spending by discouraging overly generous plans. The implementation of the provision has been delayed to 2020.



ACA Considerations for 2017

Many proposals have been made to change, restructure, or eliminate the ACA. Here are some questions to consider.

Would selling health care insurance across state lines lead to lower prices and better coverage? [READ MORE...](#)

What would eliminating the ACA's individual mandate do? [READ MORE...](#)

Would changing or eliminating the Cadillac tax change the fundamentals of the ACA?

[READ MORE...](#)

How would establishing association health plans (AHP) affect consumers and businesses? [READ MORE...](#)

Drivers of 2017 Health Insurance Premium Changes [READ MORE...](#)

ESTABLISHING ASSOCIATION HEALTH PLANS

SOME PROPOSALS THAT SEEK TO MODIFY OR REPEAL the Affordable Care Act (ACA) would try to expand the availability of small businesses to band together to offer health insurance through an association health plan (AHP). The success and practicality of such an approach for increasing coverage and reducing premiums would depend on how the rules governing AHPs were written.

If an AHP is allowed to follow the issue, rating, and benefit rules of a single state nationwide, it would impose different rules on carriers in the same insurance markets and portend serious implications for the viability of those markets. For example, if an AHP chooses to establish itself in a state with looser restrictions relative to others, the AHP would be allowed to use that state's requirements in all states, even those with greater regulatory requirements. Non-AHP insurance plans, however, would continue to be subject to each state's requirements. Such a scenario would fragment the market as lower-cost groups would move to establish an AHP and higher-cost groups would remain in traditional insured plans at higher premiums.

If the rules governing AHPs were consistent with those governing traditional insurance, there would be fewer concerns about market fragmentation. The ACA made many of the rules applying to the individual and small group markets uniform. If the encouragement of AHPs were coupled with an increased flexibility for states to change their issue, rating, and benefit requirements, however, AHPs could threaten the viability of the individual market in states with more restrictive rules. Similarly, if AHPs are allowed to follow the rules applying to large groups, they could avoid the more restrictive rules that apply to the small group market, resulting in market fragmentation and threatening the viability of the small group market.



Additional Resources From the Academy

Drivers of 2017 Health Insurance Premium Changes [READ MORE...](#)

HIGH-PERFORMANCE NETWORKS

MOST HEALTH INSURANCE PLANS USE PROVIDER NETWORKS

made up of doctors, hospitals, and other providers that the insurer contracts with to provide health care to its members. Provider networks are structured in a variety of different ways. High-performance networks (HPNs) are designed to deliver high-quality and efficient care; promote stronger relationships between the insurer, provider, and member; and provide a potentially lower-cost health care option. HPNs provide an additional option to consumers seeking to maximize their health care dollar and present both potential benefits and disadvantages to consumers through a variety of distinctive features.

Contractual agreements between health care providers and health insurers are a major driver of the U.S. health care system. Insurers contract with providers to provide members with access to care and to establish relationships with providers regarding the management of medical care, including efforts to improve quality, implement disease and other care management initiatives, and secure legal rights to monitor provider billing practices and perform claims auditing. Providers likewise enter into contracts with insurers to gain access to a consistent flow of patients, to receive direct payment from the insurer rather than patients, and to clarify expectations around disputing claims and reimbursements.

The providers with whom an insurer has contracted collectively form the insurer's network, which members can usually access at an in-network benefit level. Conversely, providers that are not contracted are usually accessed by members on an out-of-network (OON) basis, with reduced or no benefits. Insurers offer incentives through benefit plan designs that reduce the portion of costs the insured is responsible for in order to encourage use of in-network physicians. More recent trends have emphasized the development of HPNs that the insurer anticipates will optimize cost, improve quality, and improve efficiency.

High-performance networks are growing in popularity because consumers are insisting on more for their health care dollar, which leads insurers to provide the highest-quality care at an affordable premium, while rising health care costs and the creation of the exchanges have led insurers to develop more efficient networks. Additionally, new technological and data capabilities allow insurers to pinpoint which providers in an area deliver the highest-quality care in the most efficient manner, and enable insurers to develop management programs that can optimize their members' care experience within these networks. This is different from historical attempts to limit provider access based solely on cost. New technologies feature improved measurements of care quality, use evidence-based medical standards and protocols, and enable communication with members and providers.



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Drivers of 2017 Health Insurance
Premium Changes [READ MORE...](#)

Aspects of HPN Design

HPN networks feature one or more of the following characteristics:

- **Tiered Networks / Select In-Network Providers:** HPNs may categorize providers into two or more “tiers” based on quality and efficiency metrics. Quality is usually determined through adherence to care standards and evidence-based protocols. Tiered networks supported by plan designs aim to direct members to select providers, strengthen the insurer’s relationship with providers, allow for better care management opportunities, and achieve optimized pricing terms. Providers may accept lower reimbursement to be part of a limited group of top-tier physicians, which can result in increased patient flow. The insurer may return savings from these agreements to the consumer through reduced premium costs. Consumers may also see reduced costs in response to care management efforts, achieving fewer complications and faster recovery times. At the same time, consumers using an HPN product may have restricted access to the providers they want to use, which may include restricted access to academic and specialty hospitals with strong reputations. And while HPNs focus primarily on high-quality providers and only secondarily on lower-cost providers, HPNs may exclude some high-quality providers with elevated charge levels from the list of preferred providers when other high-quality but lower-cost providers are available in an area. The use of select providers in top tiers has contributed to the pejorative use of the term “narrow network” to describe HPNs.
- **Primary Care Physicians Requirement:** HPNs may require members to select a primary care physician (PCP) and consult or visit with the PCP prior to seeking specialist care or hospitalization. PCPs can help coordinate care across multiple providers and give guidance to patients regarding recommended care. Consumers also may benefit from a close relationship with a primary physician because they see the same familiar face when they access the health care system. At the same time, consumers who already have a relationship with a physician may need to establish a new relationship with a different provider in response to the HPN’s requirements.
- **Limited OON Benefits:** HPNs may rely on plan designs that incent members to access preferred providers instead of OON providers. Members still may be able to access OON providers, usually at higher cost-sharing levels, or the providers may be excluded from the plan altogether. Regardless of the providers’ tier status, members usually access emergency care at the preferred tier cost-sharing level. HPNs can be complex and difficult to navigate, and insurers’ efforts to assist members through provider directories, plan design summaries, treatment cost estimators, and other tools may not bridge this gap.
- **Access/Adequacy Requirements:** Access (e.g., distance/travel time for members to reach each type of provider) and adequacy (e.g., number of providers) are key considerations in designing or choosing a HPN product. Insurers want to provide networks that meet their members’ needs and meet state-specific legal requirements that regulate network design. Similarly, policyholders must evaluate whether the benefits inherent in the restricted panel are an acceptable trade-off relative to potentially more convenient access to a broader group of health care professionals.

Conclusion

HPNs will likely continue to play an important role in the U.S. health care system because of rising health care costs, insistence by consumers for higher-quality health care delivery systems, and increased competition among insurers. For example, recently released 2017 exchange regulation¹ highlight the growth of HPNs by establishing network adequacy thresholds and continuity of care guidelines; a prominent inclusion of a mechanism for network adequacy ratings transparency on the healthcare.gov website is another example of the increase in prevalence of HPNs.

¹ “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017: Final Rule,” Department of Health and Human Services.

ELIMINATING THE INDIVIDUAL MANDATE?

A KEY COMPONENT OF THE AFFORDABLE CARE ACT (ACA) requires most Americans to obtain a minimum amount of health insurance coverage through employer-sponsored plans, the private insurance market, public insurance program such as Medicare or Medicaid, or pay a penalty. This requirement, along with the premium subsidies for low- and moderate-income individuals, limited open enrollment period, and other ACA provisions, is intended to help ensure the viability of the insurance market.

The ACA prohibits insurers from denying coverage or charging higher premiums to individuals with higher expected costs due to their health status. These prohibitions generally would result in an increase in average health insurance premiums, unless a broad cross-section of people participate in the private health insurance market—the young as well as the old, and the healthy as well as the sick. By requiring enrollment even among healthy people, the ACA’s individual mandate addresses these adverse selection concerns, which is why the individual mandate is a fundamental aspect of the ACA.

The mandate was challenged before the U.S. Supreme Court, which decided in 2012 that the individual mandate passed by Congress was constitutional. Nevertheless, many efforts to modify or repeal the by Congress and proposals by presidential candidates would eliminate the mandate. Weakening or eliminating the mandate could result in fewer insured and higher premiums unless alternative provisions are implemented to create equally strong incentives for healthy individuals to obtain coverage.

Alternatives to the Mandate

Less-Frequent Open Enrollment Periods

The ACA includes an annual open enrollment period during which individuals can sign up for coverage; people cannot enroll outside of this period except under certain conditions. Less-frequent open enrollment periods, such as 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.

Late Enrollment Penalties

A late enrollment penalty is often suggested in combination with less frequent open enrollment periods. If an individual does not enroll in coverage when first eligible, subsequent enrollment would require a higher cost. This could be done, for instance, through a premium surcharge or a reduction in premium subsidy. Late enrollment penalties could also come in the form of limiting coverage for pre-existing conditions, higher premiums for those conditions, or even denial of coverage altogether.

Allow Greater Premium Variation

Under the ACA, premiums in the individual and small group health insurance markets are not allowed to vary by health status, and can reflect age variations up to a 3:1 ratio. Allowing greater variation in premium rates based on age would reduce costs for younger adults, likely increasing coverage. But premiums would rise for older adults.

Coverage Opt-Out With Payment for Uncompensated Care

Without an individual mandate or other mechanisms in the ACA to encourage enrollment, health care providers would see a rise in uncompensated care. A proposed alternative mechanism 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.

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

High-Risk Pools

If the ACA provisions prohibiting insurers from denying coverage or charging higher premiums based on health status were relaxed, 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. 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.



Additional Resources From the Academy

Academy Testimony to Congress on Individual Mandate [READ MORE...](#)

Drivers of 2017 Health Insurance Premium Changes [READ MORE...](#)

SELLING HEALTH INSURANCE ACROSS STATE LINES

ONE COMMON THEME FOR THOSE CALLING FOR MAJOR CHANGES to or replacement of the Affordable Care Act (ACA) is encouraging insurers to sell health insurance across state lines. That is, insurers licensed to sell insurance in any particular state would be allowed to sell insurance under that state's rules in other states.

The intention is to spur more competition, which could increase consumer choice, lower premiums, and improve services. For instance, an insurer could choose to follow the rules of a state with fairly unrestrictive benefit requirements in order to offer lower-cost coverage in another state. Although states currently have the ability to permit the sale of insurance across state lines, few have done so to date and no out-of-state insurers have entered the market in those states.

Health insurance is licensed and regulated primarily by state authority. Prior to the ACA, the rules regarding insurance issue, premium rating, and benefit requirements varied considerably by state. The ACA narrowed state differences in these rules by imposing more standardized requirements. Premium rate review and approvals continue to be conducted primarily at the state level, as are other consumer protections such as network adequacy requirements.

Practical Implications

Allowing insurance licensed in one state to be sold in another would raise concerns regarding how insurers would set up local provider networks and how consumer protections would be enforced. In addition, with many of the rules currently harmonized across states, there is less ability for insurers to exploit differences in rules in order to lower premium by avoiding certain requirements.

If the ACA issue, rating, and benefit requirements were relaxed and the state variation in rules returned, there would be more opportunity for insurers to take advantage of these differences. However, this could create an unlevel playing field. Less healthy individuals would purchase plans licensed in states with stricter regulations (e.g., guaranteed issue, community rating, comprehensive benefit requirements), and healthier people would purchase plans licensed in states with looser regulations. Such a result could lead to healthier people benefiting from less-expensive insurance, but those who are older and have more health care issues would face higher premiums.

Premiums for the plans licensed in states with stricter regulations would increase accordingly. Such a situation could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections.



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Drivers of 2017 Health Insurance Premium Changes [READ MORE...](#)

THE CADILLAC TAX AND CHANGING THE TAX TREATMENT OF EMPLOYER-SPONSORED COVERAGE

THE AFFORDABLE CARE ACT (ACA) provision that receives a lot of attention is the excise tax on high-cost employer sponsored plans, also referred to as the “Cadillac tax.” This tax imposes a 40 percent excise tax on the premiums that exceed certain thresholds. The intention, in part, is to discourage enrollment in very generous health plans that can drive up health care spending and premiums. Congress recently delayed the implementation of the tax from 2018 to 2020. The 2018 thresholds would have been \$10,200 for individual coverage and \$27,500 for family coverage, but they will increase to reflect the new start date and will increase with inflation thereafter.

There have been some calls to modify the tax or to eliminate it altogether. One concern with the tax is that plans with high premiums are not necessarily overly generous. For instance, businesses with an older workforce, in certain industries, or in certain parts of the country could face higher premiums, irrespective of the generosity of the plan. Although the law allows the excise tax threshold to be increased for businesses with older populations or in high-risk professions, the thresholds do not vary to reflect geographic variations in health spending.

Alternatives to the Cadillac Tax

Some proposals to replace the Cadillac tax would change the tax treatment of employer-provided health coverage. Currently, employer premium contributions are tax-deductible as a business expense and excluded from employee income and payroll taxes. For many workers, savings due to the tax exclusion can be substantial. The tax exclusion is more valuable to higher earners, however, because they face higher marginal tax rates. Not incurring these taxes provides a strong incentive for employers to sponsor health insurance. In addition, many employees, including union workers, also receive generous health care benefits that have been negotiated into their contracts.

One suggested alternative would cap the amount of premium payments that can be excluded from income for tax purposes (i.e., tax exclusion cap); this would be another way to encourage enrollment in less-generous plans. Another proposal would eliminate the tax exclusion altogether and replace it with a tax deduction or a tax credit for people with health insurance, regardless of whether it was received through an employer or purchased in the individual market. Such tax deductions or credits could be structured to vary based on income.

The impact of such proposals on employers' decisions to offer coverage, workers' decisions to purchase coverage through their employers or elsewhere, the number of uninsured, and health spending growth would depend on how they are designed. Considerations include whether the tax breaks are in the form of a tax deduction (which tend to favor higher-income workers) or tax credits (which can increase the benefit to lower-income workers, especially if they are refundable), and whether they vary by income. The amount of the tax exclusion cap or deductions/credits, whether and how they increase over time (e.g., with inflation), whether they vary based on factors outside of the employer's and worker's control (e.g., geographic area, age), and how they compare to tax advantages for coverage outside of the employer group market would affect the relative attractiveness of employer-sponsored coverage.



Additional Resources From the Academy

Academy Comments on Excise Tax on High-Cost, Employer-Sponsored Health Coverage [READ MORE...](#)

Drivers of 2017 Health Insurance Premium Changes [READ MORE...](#)

SINGLE-PAYER SYSTEM

WHAT IS A 'SINGLE-PAYER SYSTEM' FOR HEALTH CARE?

Some policymakers have proposed moving to a single-payer system as a way to meet the goals of achieving universal health insurance coverage, lowering health spending, and improving health care quality. In general “single payer” means the health insurance system covers the health care spending for all of a specified population and is financed by the government, typically from tax revenues.

Although the term describes how the system is financed, it does not define who employs the health care providers. The term “socialized medicine” differs from “single payer” in that the former refers to a system in which the government not only pay for the medical spending, but also owns the health care facilities and employs the physicians and other health care workers.

Examples of Single-Payer Systems

The Canadian health care system follows a single-payer model. It provides health insurance coverage for all legal residents and is jointly funded by the federal and provincial taxation. Each province designs and administers its own program, including setting payment rates for health care services and prescription drugs, and establishing overall health care spending budgets. Health care services are provided by private physicians and hospitals. Residents can purchase private insurance to cover services excluded from the public programs, such as vision and dental care, outpatient prescription drugs, rehabilitation services, home care, and private rooms in hospitals.

Medicare is often referred to a single-payer system, and some single-payer proposals are characterized as “Medicare for all.” Medicare is financed through federal income and payroll taxes as well as beneficiary premiums. The program covers medical services for eligible beneficiaries, and care is received from private health care providers. Medicare is not operated completely by the government, however, as private insurers participate through the Medicare Advantage and Part D prescription drug programs. In these Medicare programs, private insurers are paid by the federal government to provide insurance coverage and bear the risk if spending exceeds those payments.

Implications of Moving to a Single-Payer System

The impact of a single-payer system on insurance coverage rates, health care spending, providers, consumers, and taxpayers depends on the details underlying the system. Potential implications include:

Increased health insurance coverage rates. Universal or near-universal coverage is generally attainable in a single-payer system.

Lower provider payment rates. Single-payer systems usually set the provider payment rates for covered health care services. The United States currently has much higher prices for most medical services and prescription drugs than other developed countries. Under a single-payer system, the government could set lower payment rates and potentially control overall costs by establishing aggregate spending limits and by limiting utilization. Those mechanisms could lower health spending, but also could lead to delays in care. Any cost controls could be subject to political pressures and influences, which could limit cost savings.

Lower administrative costs. A single-payer system could reduce the costs of administering the system, lower the administrative burden on health care providers, and simplify enrollment and system navigation for consumers. These administrative efficiencies could be offset, at least in part, by costs associated with increased government involvement and oversight.

Higher taxes. To finance a single-payer health care system, broad public funding would be needed in the form of new or increased federal and/or state taxes. How those taxes are structured, and how they compare with current health insurance premiums, would affect the impact on consumers and how that impact would vary among consumers. The total financial impact on consumers also would reflect any cost-sharing requirements and how they compare to those under the current system, as well as any limitations in coverage.

Reduced role for private insurance. A single-payer system could replace all or most other private insurance, as well as other public programs (e.g., Medicaid). As in Canada, private insurance could be made available for services not covered by the single-payer system, such as dental and vision care. Private plans also could be incorporated as they are under the Medicare Advantage and Part D programs.

Reduced health care innovation. There are concerns that compared to the current market-based system, moving to a single-payer system could reduce the level of innovation available in both the delivery of health care and the design of health care benefits. For instance, the Medicare program can be slower to test and adopt delivery system innovations than the private insurance market.



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PUBLIC POLICY TOOLKIT

MEDICARE

MEDICARE HAS PLAYED A VITAL ROLE IN PROVIDING health care benefits to nearly all Americans age 65 and older. The Medicare program, however, faces long-term sustainability challenges. As the Baby Boomer population ages into the program over the next few decades, Medicare enrollment will grow dramatically and the number of workers paying into the system per beneficiary will shrink. Benefit payments are expected to exceed payroll taxes, threatening solvency of one of its major trust funds.

Medicare provides a wide range of health care benefits that are financed through two trust funds. The Hospital Insurance (HI) trust fund supports Medicare Part A, which covers inpatient hospital care and post-acute care services such as skilled nursing facility care and home health care services. The Supplementary Medical Insurance (SMI) trust fund supports Medicare Part B—hospital outpatient care, doctor visits, lab tests, and medical supplies—and Part D prescription drug coverage.

The HI trust fund, which receives income primarily from dedicated payroll taxes, is projected to be depleted in 2028, at which time revenues are projected to cover only 87 percent of program costs. The SMI trust fund receives about three-quarters of its funding from general tax revenues and about one-quarter from beneficiary premiums. The SMI trust fund is projected to remain solvent because its contributions are reset annually to meet expenditures.



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Like Social Security, Medicare faces the demographic challenge of larger numbers of beneficiaries coupled with a proportionately lower number of workers who provide payroll taxes. In addition, health care spending has been growing faster than the economy—and is expected to continue to do so—which puts additional strain on Medicare’s finances. Medicare will take up increasing shares of federal government and household spending, and could crowd out resources for other needs.

Medicare’s challenges are not solely financial. Medicare beneficiaries are a diverse group with diverse health care needs. Certain beneficiary populations are particularly vulnerable to having high health care needs, such as those with a disability, multiple chronic conditions, or cognitive impairments. In addition, many beneficiaries have limited resources to rely upon if faced with high out-of-pocket health costs. Another issue is whether the Medicare benefit design, which has remained mostly unchanged since it was enacted in 1965, is meeting the needs of beneficiaries.

Changes to Medicare

Putting Medicare on a more sustainable path for current and future generations of beneficiaries will require policymakers to make some choices regarding benefit coverage, provider and plan payments, and taxpayer funding. Some fundamental questions to consider when assessing candidates’ Medicare reform proposals include:

- How can we address Medicare’s long-term financing challenges?
- How can we balance the goals of ensuring that Medicare beneficiaries have access to high-quality health care that is also affordable to them and to the nation as a whole?
- How do proposals affect particularly vulnerable beneficiaries, including those with special health care needs or limited financial resources?
- Should we change the benefit structure of the traditional Medicare program and/or allow coverage of additional services to meet the needs of an aging population?



See the following for more information to help better understand these issues:

What are Medicare’s long-term financial solvency and sustainability challenges? [READ MORE...](#)

What is premium support, and could it help lower Medicare costs? [READ MORE...](#)

Could revising Medicare’s fee-for-service (FFS) benefit design improve the quality and cost-effectiveness of care? [READ MORE...](#)

Medicare’s Financial Condition: Beyond Actuarial Balance [READ MORE...](#)

MEDICARE BUY-IN OPTION

ONE METHOD OF EXPANDING HEALTH INSURANCE COVERAGE that policymakers have considered as part of the health care election platforms is a Medicare buy-in option. The idea is that a subset of those individuals not eligible for Medicare be allowed to buy in to Medicare for their health insurance coverage. Currently, eligibility for Medicare begins at age 65, or younger for those receiving Social Security disability benefits. A buy-in program would set a lower age for general eligibility, such as 50 or 55, at which age individuals may opt to buy in. Such a program would also have other beneficiary and health care system implications.

A buy-in program would set a lower age for general eligibility, such as 50 or 55, at which age individuals may opt to buy in. Such a program would also have other beneficiary and health care system implications.

There are approximately 63 million Americans between age 50 and 64. If a Medicare buy-in option is implemented for this age group, those mostly likely to participate are those who are uninsured (about 7 million) and those who purchase individual health insurance (about 9 million).¹ Most people in this age cohort currently get their health insurance through employer-sponsored coverage, as either an active or retired employee. Because employers usually subsidize a substantial portion of the cost of the coverage, a Medicare buy-in would be less financially beneficial for these individuals. Some exceptions are those electing COBRA coverage (no employer subsidy) and some early retirees with coverage that includes no or a low employer subsidy.

If the benefits, access to care, and total costs of a Medicare buy-in option compared favorably to existing options, the uninsured and those who purchase individual coverage may find a Medicare buy-in option advantageous. Significant differences between individual market coverage and Medicare, however, make a comparison of the benefits and costs to the individual a complex matter.

¹ “[13 Million Adults Could Be Eligible to Purchase Medicare Coverage Under Proposed Clinton Plan](#),” Avalere.

Beneficiary Considerations for Medicare Buy-In

Health Care Benefits

Medicare and typical private insurance plans cover hospitalization, outpatient and professional services, and prescription drugs. Medicare covers these under three separate parts, A, B, and D, each with its own set of cost-sharing rules that are not integrated and do not provide an overall cap on beneficiary out-of-pocket spending.²

Private insurance plans, whether individual or employer-based, may provide a more comprehensive benefit package than Medicare. These plans typically integrate all benefits and limit total member out-of-pocket spending. Under the Affordable Care Act (ACA), out-of-pocket expenses are further reduced for eligible individuals with incomes under 250 percent of the federal poverty level.

Provider Access and Continuity of Coverage

While Medicare benefits may not be as comprehensive as those available through private insurance, Medicare beneficiaries generally have a broad choice of providers, including nearly all hospitals. In comparison, many private health insurers have a defined set of health care providers that members can access, which may not include all doctors or nearby hospitals.

Allowing early eligibility into Medicare can enhance continuity of care if the beneficiary is covered under a single system for a longer period of time.

Premiums and Subsidies

The term “buy-in” assumes some level of required premium payment by the individual. The level of premium and the associated level of government subsidy, if any, would be key design elements. Premiums may be based on the actual expected cost for Medicare to provide the benefits for this population, making it self-sustainable, or they may be set below expected costs, requiring other government revenue to support the program. Premiums may vary by demographic factors, such as age or geography of the covered individual—similar to those in the private individual market—or by income, as Medicare Part B premiums are set.

The program also may be designed to include premium subsidies, similar to the advance premium tax credits available to qualifying individuals who purchase coverage through an ACA exchange. Subsidy eligibility also could be tied to whether the individual has another form of coverage, such as through an employer.

In setting premiums and subsidies, policymakers would need to consider how these relate to other available coverage programs. If premiums were set higher than other coverage options, the program may not be affordable or attractive to individuals. Conversely, if they were set lower than other coverage options, the program may attract individuals who already have employer-based coverage, or may lead to reductions in employer-subsidized early retiree coverage.

² Medicare Advantage plans (Part C) offered through private insurers have some flexibility in cost sharing that may allow for more integrated cost sharing, but they also may limit provider access.

Health Care System Considerations for Medicare Buy-In

Impact to Medicare and Medicaid

Policymakers would need to consider the impact of a buy-in option's design and financing on the overall Medicare program and its interaction with state Medicaid programs. Current Medicare premium levels do not vary by age, even though the program costs do. Including a younger population might lower per capita costs to Medicare, but those choosing to buy in may be less healthy and generate higher costs. If the premiums, less any subsidies, do not cover the actual additional health care costs, Medicare's financial condition would deteriorate.

Currently, low-income Medicare beneficiaries also can qualify for Medicaid benefits. Policymakers would need to consider whether to extend this benefit to those entering Medicare via a buy-in option and the implications for states' Medicaid programs and budgets.

Impact on Exchanges and Individual Insurance Markets

Introduction of a Medicare buy-in program could have a significant impact on the ACA exchanges. In 2016, 27 percent of exchange enrollees were age 55–64.³ Shifting some of this group to Medicare could reduce premiums for others in the individual market,⁴ but could also have a negative impact on operations, especially state-run exchanges that rely on larger enrollments for financial support.

Impact on Employer Coverages

Reform ideas that have the potential to expand governmental financial involvement always raise questions of whether employers will react by diminishing their involvement in providing health care coverage. Employers are concerned about health care costs for workers and covered retirees in the very age group that a Medicare buy-in program would target. Employer support for early retiree coverage, already diminished in the past 25 years, would probably give way in many cases to a Medicare buy-in program, depending on benefit and premium levels.

Impact to Health Care Providers

Medicare typically pays providers less for services compared to private insurance plans. If the Medicare buy-in program results in individuals switching from private plans to Medicare, providers may see a reduction in their compensation. On the other hand, if the Medicare buy-in program reduces the number of uninsured individuals, for some providers—especially hospitals—the lower reimbursement rates may be offset by a decrease in uncompensated care.

Conclusion

In designing and implementing a Medicare buy-in option, policymakers would need to consider many aspects of the program, such as eligibility criteria, the expected costs, and setting premiums and subsidies for affordability, as well as the implications on other programs, such as the ACA, employer-sponsored coverage, and Medicaid.

³ “[Health Insurance Marketplaces 2016 Open Enrollment Period: January Enrollment Report—For the period: November 1–December 26, 2015](#),” Department of Health and Human Services.

⁴ Under the ACA, there are limits on age rating, resulting in premiums for younger enrollees subsidizing premiums for older enrollees.

MEDICARE'S LONG-TERM SUSTAINABILITY CHALLENGE

MEDICARE SPENDING WILL INCREASE DRAMATICALLY over the next few decades as the Baby Boomer population ages into the program and health spending per beneficiary grows. At the same time, number of workers per enrollee will shrink. As a result, benefit payments are expected to exceed payroll taxes, threatening solvency of one of its major trust funds. And Medicare will make up increasing shares of federal government and household spending, meaning decreasing shares will be available for other needs.

Medicare's Hospital Insurance (HI) Trust Fund Income Falls Short of the Amount Needed to Pay HI Benefits

Medicare's HI trust fund receives revenues from payroll taxes and pays for beneficiaries' inpatient hospital and post-acute care services. It had built up a surplus of \$197 billion at the end of 2014 but is projected to be depleted in 2028. At that time, tax revenues are projected to cover only 87 percent of program costs, with the share declining to 79 percent in 2040.

No current provision exists for general fund transfers to cover HI expenditures in excess of dedicated revenues, so additional revenues would need to be raised, benefits cut, or some combination of the two. Eliminating the looming deficit over the next 75 years would require an immediate 25 percent increase in payroll taxes, or an immediate 16 percent reduction in expenditures, or some combination of both.

Higher Supplementary Medical Insurance (SMI) Costs Increase Pressure on Beneficiary Household Budgets and the Federal Budget

Medicare's SMI trust fund—which covers physician services, hospital outpatient care, and prescription drugs—receives about three-quarters of its funding from federal general tax revenues and one-quarter from beneficiary premiums. The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. But increases in SMI costs will require increases in beneficiary premiums and federal tax dollars, which will add pressure to the federal budget. SMI general revenue funding is scheduled to increase from 1.7 percent of GDP in 2016 to 2.7 percent in 2090.

SMI premium increases similarly will place pressure on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost sharing) for Parts B and D combined currently equal 23 percent of the average Social Security benefit. These expenses will increase to 34 percent of the average Social Security benefit by 2090.

Increases in Total Medicare Spending Threaten the Program's Sustainability

Because Medicare spending is expected to continue growing faster than GDP, greater shares of the economy will be devoted to Medicare over time, meaning smaller shares of the economy will be available for other priorities. Medicare expenditures as a percentage of GDP are projected to grow from 3.6 percent of GDP in 2015 to 6.0 percent of GDP in 2090.

Tough Medicare Choices

The Affordable Care Act enacted in 2010 contains provisions designed to reduce Medicare costs, increase Medicare revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency. But these do not go far enough to solve Medicare's financial challenges, which will require tough choices by policymakers on changes to benefit coverage, provider and plan payments, and taxpayer funding.



Additional Resources From the Academy

Medicare at 50: Is It Sustainable for 50 More Years? [READ MORE...](#)

Medicare Subcommittee Issue Brief on Trustees' Report [READ MORE...](#)

Addressing Health Care Cost Growth in Medicare: A Framework [READ MORE...](#)

Medicare's Financial Condition: Beyond Actuarial Balance [READ MORE...](#)

MEDICARE: PREMIUM SUPPORT

PREMIUM SUPPORT IS A REFORM OPTION that has been proposed as a way to improve Medicare's financial condition. Currently, Medicare beneficiaries can choose to enroll either in the traditional fee-for-service (FFS) Medicare program or in a private Medicare Advantage (MA) plan. Under traditional Medicare, beneficiaries receive a specified benefit package, and pay a Part B premium. Medicare Advantage plans must cover the same benefits offered under FFS, but can also offer additional benefits, such as vision, hearing, or wellness coverage. MA enrollees also pay the Part B premium, but depending on the plan, might have to pay an extra premium. In some cases, the MA plan might pay part of the Part B premium.

Under a premium support approach, Medicare beneficiaries would receive a government contribution to apply toward the premium of a health plan of their choice, potentially with the traditional Medicare program being one of the choices. Beneficiaries who choose a plan with a premium greater than the government contribution would be responsible for paying the difference.

A premium support approach would limit the federal contribution toward Medicare, which could more directly foster competition between plans. This could encourage insurers to develop and beneficiaries to choose more cost-effective health plans. On the other hand, depending on how the government contribution is determined, premium support could simply shift costs to beneficiaries rather than reduce overall Medicare spending. Ensuring overall Medicare savings rather than just savings to the federal government may require that plans are structured to facilitate higher-quality care and more cost-effective health care payment and delivery systems.

Several details are important in determining how beneficiaries would fare and whether Medicare spending would be contained.

What Is the Government Contribution?

Options for setting the initial government contribution include setting it at the estimated average per-beneficiary cost under the current Medicare program or using competitive bidding to determine the amount (e.g., the lowest bid, a percentage of the average bid). Contributions could be set nationally or by region. Depending on the specific option chosen and premiums for plans offered, beneficiary premiums could be greater or less than what they would have paid under the current Medicare program.

Another question is how the government contribution would increase over time. Indexing the government contributions to general inflation or another index that doesn't keep pace with health spending growth could put pressure on insurance plans to contain costs. Yet, such a practice also could risk a greater share of Medicare costs being shifted to beneficiaries over time, either through higher premiums or higher cost sharing. Tying government contributions to plan bids could help prevent costs from being shifted to beneficiaries because bids would track better to changes in health spending.

Can Beneficiaries Keep Their Traditional FFS Medicare?

A premium support program could be structured such that the current FFS plan remains available to all Medicare beneficiaries, is available only to beneficiaries already enrolled in Medicare at the time premium support is implemented, or is eliminated. Retaining the FFS option for all current and future Medicare beneficiaries would provide greater continuity with the current program, but rules might be needed to ensure fair competition between FFS and the private plan options. Allowing only current Medicare enrollees to continue having the FFS option would mean that over time the FFS program would consist of older beneficiaries with higher per capita costs. That could have negative consequences for the financing of the program unless funds are shifted from other plans to reflect the higher-cost FFS population. Eliminating the FFS program altogether could have implications for the costs of the private plans, as the FFS program serves as a constraint on MA provider payment rates.

How Is the Benefit Package Defined?

Similar to the current requirement for MA plans, plans operating under a premium support structure could be required to provide at least the same benefits offered in traditional Medicare FFS. An alternative would allow for more leeway in designing benefit packages so innovative benefits and designs could be more quickly adopted. If more flexibility were allowed, it would also be important to ensure that such flexibility does not lead to adverse risk selection issues. Plans should not be allowed to use benefit design flexibility to attract only lower-cost enrollees or avoid higher-cost enrollees.

Are Low-Income Beneficiaries Financially Protected?

Low-income individuals can be more at risk for avoiding or delaying health care due to costs. Currently, many low-income Medicare beneficiaries receive premium subsidies, cost-sharing subsidies, or expanded benefits, funded and administered in part by state Medicaid programs. A premium support program could be structured to include such protections, however several complex issues would need to be resolved including how such protection would be funded, whether state-by-state variations in Medicaid coverage would be retained, and the how the plan bidding process would reflect these protections.



Additional Resources From the Academy

A Guide to Analyzing Medicare Premium Support [READ MORE...](#)

Medicare's Financial Condition: Beyond Actuarial Balance [READ MORE...](#)

REVISING MEDICARE'S TRADITIONAL BENEFIT DESIGN

IMPROVING THE QUALITY AND COST-EFFECTIVENESS of care under the Medicare program is a key health policy challenge. While many efforts are rightly focused on realigning financial incentives in Medicare's provider payment and delivery system, better aligning incentives on the beneficiary side should also be considered. In particular, updating the program's traditional fee-for-service (FFS) benefit design (i.e., its cost-sharing features) and addressing other shortcomings of the current benefit structure could help encourage Medicare beneficiaries to seek more cost-effective care.

Current Medicare Fee-For-Service Benefit Design

Like most other health insurance plans, Medicare uses patient cost-sharing requirements—deductibles, copayments, and coinsurance—to help balance the cost of the program with the comprehensiveness of the benefits provided. Patient cost sharing directly lowers Medicare spending by shifting a portion of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing health care utilization.

Whereas private health insurance programs typically have integrated benefit structures that are designed to manage hospital and non-hospital expenses in a coordinated fashion, the Medicare Part A (inpatient hospital) and Part B (physician and outpatient hospital) benefits are structured very differently from each other—and the patient cost-sharing provisions are not coordinated between the two. In addition, traditional Medicare doesn't cap beneficiary cost sharing, leaving beneficiaries unprotected against catastrophic health costs. In part because of this, most Medicare beneficiaries have supplemental coverage that provides such protection by filling in the cost-sharing requirements. Although this supplemental coverage protects against catastrophic costs, it also reduces the incentives for beneficiaries to seek cost-effective care. Medicare Advantage plans, unlike traditional Medicare, are required to include an out-of-pocket cap and have more flexibility in terms of offering alternative cost-sharing requirements.

Unifying Part A and B Deductibles and Adding a Cost-Sharing Limit

To address some of the limitations of the current benefit design, proposals have been suggested that would combine a new cost-sharing limit with a unified Part A and Part B deductible. The copayment and coinsurance requirements also could be restructured. These changes would result in more coordinated Part A and Part B cost-sharing requirements and would bring the traditional program's benefit design more in line with the structure of private health insurance programs.

Unifying the Part A and Part B deductibles has the potential to better align beneficiary incentives designed to reduce unnecessary care and promote more cost-effective care. But the majority of Medicare beneficiaries have supplemental coverage that can limit the effectiveness of the incentives in Medicare's cost-sharing requirements. Beginning in 2020, Medigap plans will be prohibited from covering the Part B deductible for new Medicare beneficiaries. Additional changes also may need to be considered to avoid limiting the effectiveness of any new cost-sharing design incentives, while at the same time protecting beneficiaries with limited financial resources or chronic conditions who may be more sensitive to increases in cost-sharing requirements.

Enhanced Benefit Targeting

While redesigning the FFS benefit structure could help to better align beneficiary incentives to seek cost-effective care, broad changes in cost sharing would not necessarily distinguish between necessary and ineffective care. In the longer term, moving to a value-based insurance design (VBID) and allowing supplemental benefits for beneficiaries with certain conditions could allow for better targeting of health care services. Under a VBID approach, cost sharing would be lower for high-value services and higher for low-value services. Behavioral design principles could improve adherence to evidence-based treatment protocols. Research that focuses on interventions among the chronically ill could help distinguish between low-value and high-value services and better target interventions.



Additional Resources From the Academy

Medicare at 50: Does It Meet the Needs of the Beneficiaries? [READ MORE...](#)

Revising Medicare's Fee-For-Service Benefit Structure [READ MORE...](#)

Medicare's Financial Condition: Beyond Actuarial Balance [READ MORE...](#)

PUBLIC POLICY TOOLKIT

MEDICAID

MEDICAID IS A JOINT FEDERAL-STATE PROGRAM that funds health care services on a means-tested basis for eligible low-income Americans. Although states must operate within certain federal requirements, each state sets its own Medicaid regulations and provider reimbursement rates, and decides who qualifies for benefits and what benefits to provide. This program is different than Medicare, a federally run program that covers seniors and certain people with disabilities in the U.S.

Medicaid typically provides a comprehensive set of health care services, although access to care may be a challenge in some areas where not enough health care providers accept Medicaid patients. Out-of-pocket costs for Medicaid beneficiaries are low, with no or very low premiums or copayments. States may operate Medicaid programs in which health care providers directly bill the state agency or may utilize managed care organizations (MCOs) that coordinate a beneficiary's health care needs.

Medicaid Population

States have the option to extend coverage beyond the above populations to individuals who have higher income levels than the federal minimums.



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The Affordable Care Act (ACA) provided an option for states to expand Medicaid coverage, targeting non-elderly (primarily childless) adults with incomes at or below 138 percent of the federal poverty level (FPL).¹ The expansion provides health insurance to non-elderly adults with incomes above states' limited eligibility levels, thus reducing the level of those uninsured, both at the state and national level. Due to a June 2012 ruling by the U.S. Supreme Court, Medicaid expansion is optional for states, rather than mandatory as originally provided for in the ACA. Currently 32 states plus the District of Columbia have opted for expansion, and two states have not made a decision regarding expansion.

Dual Eligibles

Dual eligibles refer to individuals (older Americans and younger individuals with disabilities) who qualify for both Medicare and some level of Medicaid services. Medicare is the primary payer for dual eligibles, with Medicaid covering certain gaps in coverage not provided by Medicare (e.g., payment of Medicare premiums, deductibles, and cost-sharing). Dual eligibles often are some of the poorest, least healthy individuals in the Medicare and Medicaid programs.

Medicaid Coverage

Medicaid mandatorily covers an array of services which include, but are not limited to: physician services, inpatient and outpatient hospital services, long-term care services and supports, laboratory and X-ray services, and family planning services. Almost all states cover services that are deemed optional (not mandated) by the federal government, including prescription drugs, and preventive, rehabilitative, and hospice care. In states opting for expansion under the ACA, newly eligible adults covered by Medicaid will receive Alternative Benefits Plans that may or may not match Medicaid program benefits, but which are required to include all 10 essential health benefits that are offered in the exchanges.²

Medicaid Services

- Inpatient and outpatient hospital services
- Physician, midwife, and nurse practitioner services
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21
- Laboratory and X-ray services
- Family planning services and supplies
- Federally qualified health center (FQHC) and rural health clinic (RHC) services
- Freestanding birth center services and pharmacotherapy for pregnant women (added by ACA)
- Nursing facility (NF) services for individuals age 21+
- Home health services for individuals entitled to NF care
- Tobacco cessation counseling
- Non-emergency transportation to medical care

¹ <http://aspe.hhs.gov/poverty/14poverty.cfm>

² As defined in section 1302(a) of the Patient Protection and Affordable Care Act. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

Legend:

- Adopted (32 States including DC)
- Not Adopting At This Time (19 States)

States marked with an asterisk (*) indicate they have since rescinded their adoption.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Medicaid Financing

The federal share for Medicaid – which varies by state based on a formula – ranges from 50 percent to almost 74 percent for 2015. A higher medical assistance percentage is provided to states with lower per capita income. For certain benefits or populations, states may receive federal matching funds at a higher percentage than through the formula calculation.

As provided under the ACA, the federal government will fund 100 percent of the cost for Medicaid expansion beneficiaries in those states that opted for it through 2016; that share will decline gradually to 90 percent by 2020 and beyond.

Long-Term Care

Medicaid, which is the nation's largest funder of long-term care services, has historically been heavily programmed toward institutional care for long-term care services. But through changes provided in ACA, states have been given additional flexibility and federal funds to provide services in-home, and through senior centers and other community groups. Additionally, a dozen states are testing models to better integrate and coordinate long-term care services and supports between Medicare and Medicaid for dual eligibles.

The Long-Term Care Partnership Program is a joint state public-private program to incentivize individuals to purchase private long-term care insurance in order to help them pay for long-term care services. Provided for by a 2005 federal law³ that expanded the partnerships beyond limited state pilot programs, the purchase of the coverage was regarded as a benefit to both the policyholder and the public in order to help eliminate, reduce, or delay the need for those individuals to access Medicaid long-term care coverage, which has often been done by a Medicaid "spend-down" where assets have to be spent before Medicaid covers long-term care services.

Conclusion

The Medicaid program is vital to the health of millions of low-income Americans, including children, adults, seniors, and persons with disabilities. States are given flexibility to tailor their Medicaid programs, within certain parameters, to their own unique needs and circumstances. The ACA has added a considerable expansion of Medicaid eligibility to a broader population, including basic, essential benefits plans for newly eligible adults. The growing cost of the Medicaid program remains an ongoing fiscal challenge for both state and federal governments, even with the federal government funding most of Medicaid expansion populations going forward.

³ The Deficit Reduction Act of 2005 created the Qualified State Long Term Care Partnership program.

PUBLIC POLICY TOOLKIT

SOCIAL SECURITY

SOCIAL SECURITY IS THE MOST SIGNIFICANT public program for retirement security in the United States. Ninety percent of Americans who are 65 and older receive benefits from the program, which provides an average of nearly 40 percent of their income.

In 2016, the program provided benefits to more than 60 million retirees, survivors of deceased workers, disabled workers, and dependents. Social Security currently receives more in payroll taxes and interest income than it pays out in benefits, but as more Americans retire and continue to live longer, this is projected to change. While not imminently facing insolvency, Social Security does face long-term financial viability challenges unless changes are made.

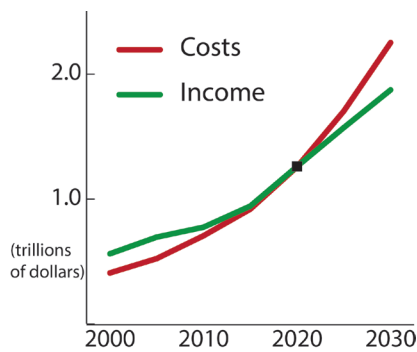
Social Security is designed to be a pay-as-you-go system: Current benefits are supported by payroll taxes from current workers, who later retire and then collect benefits from tomorrow's workers. Payroll taxes today comprise about 85 percent of Social Security's income, with the remainder coming from taxes on Social Security benefits and investment earnings on its trust funds. Demographic shifts of Americans living longer and having smaller families will translate into a ratio of fewer workers supporting each beneficiary over the next several decades, which is challenging Social Security's long-term sustainability.



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Program's Costs Estimated to Exceed Income Around 2020



Social Security is supported by two trust funds – the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) funds. The DI trust fund faced depletion in 2016 but, in late 2015, Congress changed the funding formula for the disability insurance program. The DI trust fund is not projected to be exhausted until 2023. The OASI trust fund that pays benefits to retirees and their dependents is projected to run out of surplus assets in 2035.

When the program began, the payroll tax rate rose over time, and Social Security's trust fund had been used mainly as a buffer against short-term fluctuations in income and expenses. In 1983, Congress adopted changes to maintain a level tax rate beginning in 1990, and the trust fund was expected to grow in order to pay off higher costs later. Initially, the goal was to keep the system solvent through 2058, but higher costs have led Social Security's trustees to estimate the trust funds will be depleted in 2034, according to the latest trustees report. After that, existing payroll taxes will support 79 percent of benefits. Several proposals have been made to alter Social Security's financing.

The combined OASDI trust fund, which most analysts focus on, totaled \$2.8 trillion in 2015 and is expected to increase to \$2.89 trillion in 2019. It then faces large annual withdrawals until depleted in 2034, when only 79 percent of the promised benefits can be paid unless changes are made.

This does not mean that Social Security is "going broke." Smaller adjustments adopted soon could help avoid more drastic options required later to maintain the program's fiscal integrity. Yet, Social Security has not received the focus during the presidential campaign that its importance warrants thus far, especially in light of the need to act in the near term to address Social Security's long-term financial sustainability.

Options to provide adequate long-term financing for Social Security involve revenue increases, benefit cuts, or some combination of the two. Here are some questions to consider.

How would raising Social Security's retirement age address the program's challenges? [READ MORE...](#)

Should benefits be lowered or raised, and how would that change affect Social Security's solvency? [READ MORE...](#)

Will changes to Social Security disproportionately affect women? [READ MORE...](#)

Should payroll taxes be raised or should limits on paying payroll taxes be raised or eliminated? [READ MORE...](#)

SOCIAL SECURITY BENEFIT CHANGES

CHANGING BENEFITS TO CURRENT OR FUTURE RETIREES could have a large impact on Social Security, especially in the long term. Benefit changes can provide a solution, or a partial one, to addressing Social Security’s long-term funding challenge. These could include raising Social Security’s full retirement age that would lower the program’s costs. While it would be an extreme approach to suggest making Social Security solvent for the next 75 years through immediate benefit cuts only, to illustrate: Benefits would need to be immediately lowered by about 17 percent for all current and future beneficiaries to assure long-term solvency.

Besides an across-the-board decrease on current and future benefits, other proposals could change benefits and alter Social Security’s long-range finances.

Should Cost-of-Living Adjustments (COLA) Be Altered to Reduce Social Security’s Costs?

Some argue the consumer price index (CPI) used by Social Security to calculate annual COLAs overestimates inflation and instead support using the “chained CPI” in order to reduce Social Security’s deficit. Supporters say a change in the COLA could be implemented quickly without radically restructuring the program, and, unlike other changes, could be applied to people already retired. However, there are concerns that many retirees would find it harder to adjust to this change because much of their income is fixed and they have fewer options to make up for a benefit cut.

Should COLAs Be Changed to Reflect Different Segments of the Population?

Proposals have been made to adjust the program’s COLAs based on spending patterns of seniors. The Department of Labor’s Bureau of Labor Statistics constructed an experimental CPI for the Elderly (CPI-E) based on a typical basket of goods and services for retirees, and the index has risen slightly faster than the current CPI. Some propose using the CPI-E or other methods of recalibrating the calculation of COLAs, but they would typically increase Social Security’s funding challenge.

Should Social Security's Primary Benefit Formula Be Changed?

Social Security benefits are calculated by averaging workers' highest 35 years of earnings and then applying a formula to calculate a retiree's primary insurance amount (PIA) benefit. This formula uses bend points that provide for a higher percentage of benefits paid for lower-income contributions, and reduces the percentage for higher-income contributions. While workers who contribute more into the system receive higher retirement benefits, the formula is designed to pay a higher percentage of benefits to beneficiaries who were lower-earning during their working years relative to their contributions.

The Academy's Social Security Game

[Explore options](#) for Social Security reform and how changes will affect younger workers, retirees, and the program's long-term health.

To reduce Social Security costs, some have proposed modifying the PIA formula in ways that would lower benefits for everyone but reduce them faster for retirees who made the highest contributions. Another suggestion has been to average 38 or 40 years of workers' earnings, which would take into account lower-income years and ultimately reduce benefits.

Should Spousal and Dependent Benefits Be Changed?

At full retirement age, the lower-paid, or non-working, spouse receives 50 percent of the other's benefit unless the lower-paid spouse can receive a higher benefit based on his or her own earnings history. When one spouse dies, the survivor receives 100 percent of the deceased spouse's benefit or the surviving spouse's own benefit, whichever amount is higher. Social Security also pays benefits to former spouses, dependents, and parents in certain circumstances.

Spousal benefits under Social Security were established during an era when single wage earners predominated; some observers question whether the same level of spousal benefits are still necessary because most workers now qualify for benefits based on their own earnings. Under current rules, two-earner couples receive proportionately lower benefits relative to the Social Security taxes they contributed.

To remedy this inequity, proposals have been made to lower the benefits for non-working spouses, possibly from 50 percent to 33 percent, as well as provide to the survivor a minimum benefit of the couple's combined benefits. These changes also could lower costs to the Social Security program depending on how they were structured.

Means Testing for Social Security

One way to reduce Social Security costs is to reduce or eliminate benefits paid to wealthy retirees, whose assets and income would be measured by some sort of means test. Advocates say that reducing or eliminating benefits for those whose income or assets exceed certain thresholds would help preserve Social Security as a safety net for those who truly need it. Opponents say it would fundamentally alter the program that pays benefits to all workers who contribute into the system for a specified period of time and could erode support for the program, especially by the wealthy who might view Social Security as simply another income tax.



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Social Security Reform Options [READ MORE...](#)

Issue Brief on 2016 Social Security Trustees Report [READ MORE...](#)

CHANGING SOCIAL SECURITY'S FINANCING

APPROXIMATELY 85 PERCENT of Social Security's funding currently stems from payroll taxes on earnings of most workers. Employees and employers each pay a tax of 6.2 percent of an employee's wages (Federal Insurance Contributions Act [FICA] tax), while self-employed workers pay the entire 12.4 percent (Self-Employment Contributions Act [SECA] tax). The rest of the program's income comes from taxes on Social Security benefits and investment earnings of the trust fund.

Should the Payroll Tax Be Increased?

Payroll taxes are limited on annual earned income—called the taxable maximum, which is \$127,200 in 2017—and do not apply to investment and other non-wage income. By way of an illustration, if Social Security were to be made solvent over the next 75 years by only changing payroll taxes rates, it would require an immediate increase of 2.75 percentage points. Few are suggesting this course of action because it would place a large burden on employers and workers, especially those earning less than the taxable minimum. Gradual, small increases in payroll taxes could increase Social Security's income while not placing too great of a burden on employees and employers.

Should the Limit on Taxable Earnings Be Raised?

Some experts support raising, or even eliminating, the taxable maximum limit as a way to increase Social Security revenues. Advocates cite a disproportionate tax burden on lower-income workers, who pay an equal or higher portion of their total income to Social Security than wealthier taxpayers. Many oppose increasing burdens on any taxpayers regardless of income and assert that ensuing revenue increase would be relatively small compared to other proposals.

When the taxable maximum structure was most recently changed in 1982, it was set to cover 90 percent of earnings. Proponents suggest that the ratio of taxable earnings to covered earnings should be restored to 90 percent. Opponents suggest that increases in the taxable maximum would simply result in behavior changes that negate the policy change.

Should the Taxpayer Base Be Expanded?

Some federal, state, and city employees do not pay Social Security taxes because they are covered by a public retirement system. It has been argued that requiring these workers to pay into Social Security, and later collect benefits, could add revenues to the program and reduce the long-term deficit.

Should the Trust Funds Assets Be Invested Elsewhere?

Social Security's trust fund assets are invested almost entirely in non-marketable, special-issue U.S. government securities that represent loans to the U.S. Treasury's general fund. The bonds pay market rates of interest. Some have advocated that greater returns could be achieved, on average, in the stock markets.

However, equity returns are highly variable, which could cause short- and long-range actuarial projections to fluctuate significantly from year to year. Additionally, the vast sums involved could have unintended effects on the stock markets.

Should General Revenues Be Raised?

Social insurance programs in many other countries receive some financing from general taxes, and that approach could help with Social Security's solvency challenge. Such an undertaking would require raising income taxes or raising revenues elsewhere, such as creating a national value-added tax. However, it has been argued that such proposals could compromise Social Security's basic principle of a self-supporting program that is financed by its participants.

Should Individual Accounts Be Created?

Some reform proposals would allow workers to accumulate contributions in individual accounts under Social Security as a source of retirement income. Supporters say workers could exert more control over their accounts, obtain better returns on their contributions, and reduce the burden to future generations. However, the establishment of individual accounts within Social Security would not by itself address the program's financial problems.

The Academy's Social Security Game

[Explore options](#) for Social Security reform and how changes will affect younger workers, retirees, and the program's long-term health.



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Social Security Reform Options [READ MORE...](#)

Issue Brief on 2016 Social Security Trustees Report [READ MORE...](#)

RAISING SOCIAL SECURITY'S RETIREMENT AGE

WHEN SOCIAL SECURITY FIRST STARTED PAYING regular monthly benefits in 1940, males born in that year were expected to live about 61.5 years on average and females almost 66 years. In 2015, Americans' average life expectancy had risen by about 15 years, and is projected to increase further over time. While we are fortunate to live in an era of health and prosperity that supports longer lives, improving longevity brings with it additional implications that need to be addressed, such as the increased costs to Social Security as the wave of baby boomers retires over the next 20 years.

In 1983, legislation was enacted to gradually push back what is termed as the full retirement age—the age at which a person may first become eligible for full or unreduced retirement benefits—from 65 to 67 years of age. For those born in 1960 and later, the full retirement age remains at 67. What this one-time revision did not address is that those born after 1960 will live longer on average after reaching their retirement age and thus collect more Social Security benefits than prior generations.

Proposals have been made in recent years to further lift the full retirement age in an effort to reduce Social Security's costs and respond to Americans' lengthening lifespans. As one part of a larger solution to solve Social Security's long-term financial problems, the American Academy of Actuaries supports raising the full retirement age above 67.

Why Change It Now?

The sooner steps are taken to address Social Security's solvency challenges to preserve the program for the next generation, the more likely it is that these solvency-oriented reforms can be made in a way that is easier for American workers and retirees to adapt to them.

While Social Security is not imminently facing insolvency, the long-term trend is that the program's costs will outpace its revenues. Without changes, Social Security's OASDI accumulated trust fund will be depleted in about 2034, at which point benefits will have to be cut, taxes raised, or some combination will be required.

Most reform proposals made in recent years to raise the retirement age support a gradual phase-in. One proposal would raise the full retirement age by one month every two years to match improvements in longevity. Another proposes steeper but gradual increases to further reduce Social Security's future costs.

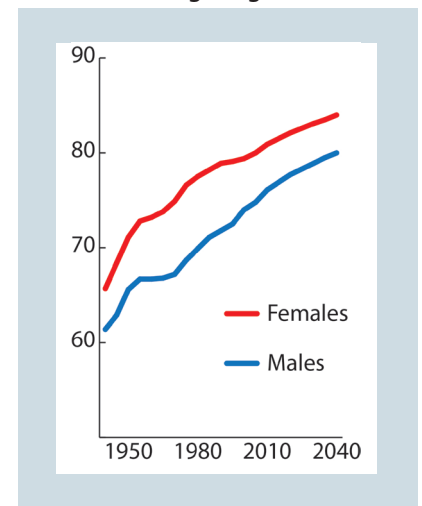
What Are the Advantages of Raising the Retirement Age?

Social Security would be made more sustainable over the next several generations because its costs would be lower. How much the costs would be lowered would depend on the specifics of how fast and how high the retirement age would be raised.

Such a step would also preserve equity among generations because future retirees would receive similar benefits to their parents and grandparents. Without a change in the retirement age, future retirees would collect more benefits over their lifetimes than earlier retirees because their increased average lifespan would allow them to live more years in retirement.

Additionally, raising the retirement age would give workers more time to build their retirement savings while still enjoying a long period of retirement.

Americans Living Longer



Longevity Improvement for Americans Varies

Low-wage workers and those with physically demanding jobs generally have shorter-than-average lifespans and could face disproportionate benefit cuts from a higher retirement age. In addition, some workers in physically demanding jobs may not be able to work beyond a certain age. But there are ways to mitigate these effects that include making changes to disability rules to benefit specific workers who are unable to perform their jobs after reaching a certain age.



Additional Resources From the Academy

Raising the Retirement Age for Social Security [READ MORE...](#)

Issue Brief on 2016 Social Security Trustees Report [READ MORE...](#)

Social Security Reform Options [READ MORE...](#)

IS SOCIAL SECURITY WORKING FOR WOMEN?

SOCIAL SECURITY PROVIDES BENEFITS on a gender-neutral basis and yet, because of historical differences in the American workplace, family structure, and longevity, the program provides different levels of retirement security for women and men. Women are likely to rely more on Social Security benefits than men.

Women Are More Likely to Have Breaks in Employment

Women leave the workforce temporarily or permanently for pregnancy, child care, and other family care responsibilities more than men. As a result, women tend to have shorter work histories that lead to smaller Social Security benefits.

Women on Average Earn Less

Benefits are based on wages reported to the Social Security Administration, and higher wages mean higher monthly benefits. While women's incomes have increased relative to men's over time, they still lag. In 2014, the average covered wage reported to the Social Security Administration was \$50,000 for men and \$39,000 for women, according to the Social Security Administration.

Women Are More Likely to Be Single, Widowed, or Divorced in Retirement

Individuals generally rely more on Social Security benefits than couples do, according to the Census Bureau.

Married by Age Group

	Women	Men
65-74	47%	71%
75-84	29%	67%
85 and older	12%	49%

Women Generally Live Longer and so Will Need More Assets in Retirement

Because women on average live longer than men, their time in retirement will be longer and their need for retirement income must last longer than for men. In addition, because women generally have less wealth and income from other sources, this money must be spread out over a longer expected lifetime. Thus, Social Security benefits are typically a more significant component of women's retirement security.

Options That Could Address Challenges Faced by Women

Modify the Computation Period for Benefits

Social Security currently uses a 35-year averaging period of wages in its formula to calculate benefits, so people who take time out from the workforce to care for children or other family members face lower benefits. To address this issue, it has been suggested that workers receive special credit for income for a certain number of years of child care or that the averaging period could be reduced to 30 years to knock out no-income years.

Enhance Benefits for Low Earners with Long Careers

Guaranteeing that individuals who have worked at least 30 years at the minimum wage would retire with an income of between 100 percent and 120 percent of the poverty line would protect low-income workers, disproportionately women, against poverty.

Change Spousal Benefits

Some have suggested changing the spousal benefit, which currently provides retirees with 50 percent of their spouse's benefit or their own earned benefit, whichever is higher. Surviving retirees receive the higher amount of their own benefit or their spouse's.

Proposals have been made to lower the 50-percent spousal benefit or eliminate it in favor of an earning-sharing proposal for couples. These could benefit dual-earner retirees, and make it fairer for couples who contribute more into Social Security, but could reduce benefits to low-earning and nonworking women.

Additional Resources From the Academy

Academy Testimony to U.S. Senate Hearing on "Social Security: Is a Key Foundation of Economic Security Working for Women?" [READ MORE...](#)

Issue Brief on 2016 Social Security Trustees Report [READ MORE...](#)

Social Security Reform Options [READ MORE...](#)

How Would Social Security Reform Proposals Affect Women?



Reduce benefits across board

One proposal would reduce all Social Security benefits for all beneficiaries by 3 percent. This option would have a greater impact on women because of their longer life expectancy and greater reliance on Social Security relative to other types of retirement income.



Increase payroll tax

The payroll tax rate for Social Security is 12.4 percent, split equally between employers and employees. Increases to the tax rate provide a greater hardship on lower-paid workers, which would affect more women, although the immediacy of the impact could be lessened if phased in gradually.



Increase full retirement age

Raising the full retirement age beyond the current 66-67 age range would encourage healthy workers with jobs to continue their employment. This would reduce benefits for men and women who could not find or continue in employment in older ages.



Change benefit formula

There are several approaches to changing the benefit formula. One would reduce the formula percentages each year, and another would increase the 35-year averaging period for calculating benefits. Most of these options would result in lower benefits and generally disproportionately affect women because of their relative longevity and workforce participation.



Lower COLAs

Another change would reduce cost-of-living adjustments (COLA) that Social Security beneficiaries receive annually. Lower COLAs reduce benefits cumulatively, which would have a bigger impact on the oldest elderly, who comprise mostly women.



Increase limit on taxable earnings

Payroll taxes are capped (the limit is \$127,200 in 2017). Raising, or even eliminating, the limit would affect women less than men generally.

net positive ☒, net negative ☒, net neutral ☐

PUBLIC POLICY TOOLKIT

LIFETIME INCOME

RISKY BUSINESS: LIVING LONGER WITHOUT INCOME FOR LIFE

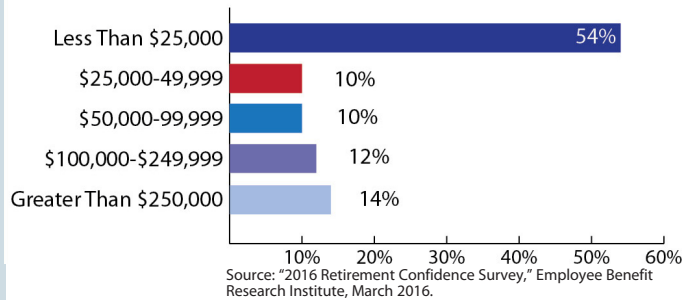
AMERICANS PLANNING FOR RETIREMENT TODAY face more individual responsibility and risk for their retirement incomes than prior generations experienced, partly due to the decline of traditional defined benefit pension plans that paid monthly benefits. Now that the Baby Boomer generation has started to retire, many are discovering that they may have not taken sufficient steps to manage the challenges that come with replacing their former paychecks with adequate monthly income during retirement. Part of this challenge involves longevity risk—the risk of living beyond life expectations—that adds more complexity to retirement planning because people face outliving the income provided by their assets.



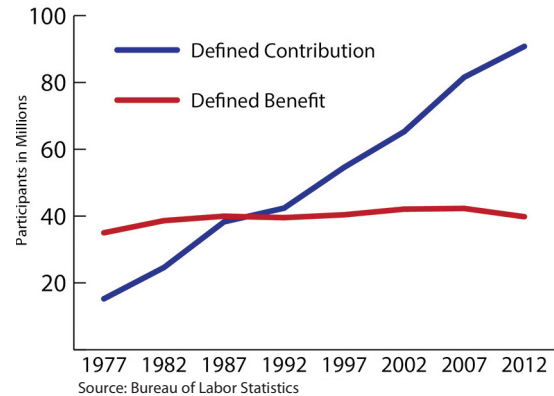
AMERICAN ACADEMY of ACTUARIES

Objective. Independent. Effective.

WORKERS' CURRENT LEVEL OF SAVINGS AND INVESTMENTS



DC PLANS VS. DB PLANS



Some retirees have taken lump-sum distributions from their 401(k) defined contribution accounts, individual retirement accounts (IRAs), and other retirement funds that they amassed over decades of work and may not have had access to adequate information about how to use those funds to create an income stream to pay their everyday living expenses in retirement. While adding money monthly to a 401(k) or IRA account during the working years might become routine for some, workers and retirees often face hurdles to obtain unbiased, easy-to-understand information about how to finance their retirement and where to find the right solutions to manage their lifetime incomes.

What can be done to lower these obstacles and better prepare current and future retirees to secure and manage their lifetime income needs?

Many approaches are needed to help future retirees secure lifetime incomes to provide them with the security and dignity of personally managing their retirement. These approaches include public-policy changes, changes within retirement plans, and broad-based public education efforts. These solutions require participation from all stakeholders: policymakers, actuaries, employers, financial planning advisers, and financial product and service providers.

Legislators should be raising the visibility of the challenges of securing income for life. Possible approaches include:

Altering Federal Retirement Policies

- Address Social Security’s long-term funding issues to ensure confidence in the program’s stability and assure retirees that they can plan accordingly.
- Increase the Social Security maximum age for delayed retirement credit beyond the current age 70 to allow additional flexibility in addressing longevity risk.
- Modify the age for required minimum distributions (RMD) in retirement plans beyond 70½ years to reflect increasing life expectancies, and implement proposed regulations that allow longevity annuities to satisfy RMD rules.
- Reduce insecurity about pensions by highlighting the value of life and health guaranty associations and the Pension Benefit Guaranty Corporation, and ensuring the programs remain sufficiently strong.
- Provide well-targeted tax incentives to encourage use of lifetime income solutions.

Emphasizing Financial Literacy and Education

- Improve information provided to workers to raise their understanding about how to prepare for retirement, and focus on the concept of lifetime income by expressing benefits in terms of monthly lifetime income in periodic retirement plan statements.
- Provide additional lifetime-income education and make available lifetime-income products when people receive lump-sum distributions from a retirement plan or are faced with decisions about whether to cash out a defined benefit pension plan through a lump-sum distribution.
- Expand existing initiatives of the U.S. Department of Labor and other public entities that currently disseminate objective retirement information.

Refocusing Retirement Plan Designs

- Add design flexibility, which in some cases would require changes to federal statutes or regulations, to facilitate greater exercise of lifetime-income options. For example, make it easier for defined contribution plan providers to offer lifetime-income allocation choices for workers and partial annuitization at distribution for new retirees.

Securing income throughout retirement is important for all Americans as they plan and save for retirement, and ultimately manage their accumulated funds. Steps need to be taken to facilitate these efforts to achieve secure lifetime incomes for more retirees.



Additional Resources From the Academy:

Lifetime Income Initiative [READ MORE...](#)

Risky Business: Living Longer Without Income for Life [READ MORE...](#)

Actuaries Longevity Illustrator—An online tool designed to provide personalized perspectives on your longevity risk—the uncertainty of how long you and your spouse/partner might live [READ MORE...](#)

PUBLIC POLICY TOOLKIT

LONG-TERM CARE FINANCING

ESSENTIAL CRITERIA FOR REFORM PROPOSALS

THE INCREASING GROWTH IN STATE MEDICAID BUDGETS due in part to the long-term care (LTC) needs of a growing elderly population combined with the low level of penetration into the potential market by private LTC insurance, have prompted a number of proposals for reforms in the way LTC is financed in the United States. Proposed reforms can be expected to address both public and private financing mechanisms, as well as mechanisms involving both types of financing.



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In 2012, the American Academy of Actuaries hosted a roundtable, “A National Conversation on Long-Term Care Financing,” comprised of stakeholders from public policy, actuarial, research, private provider, and retirement benefits backgrounds to discuss potential reforms to the LTC system. Building further upon that conversation, the Academy’s LTC Criteria Work Group developed criteria in the following areas that should be considered in any discussion on reform:

1. Coverage (with reference to how many individuals are covered by the reform);
2. Comprehensiveness of benefits;
3. Quality of care;
4. Understandability and choice;
5. Affordability;
6. Risk management and cost control; and
7. Financial soundness and sustainability.

The terms “system,” “program,” and “plan” are used interchangeably because the criteria are intended to cover reforms using both public and private financing mechanisms, or hybrid combinations. Furthermore, while “participants” and “members” are terms often associated with public and private programs, they are also used interchangeably to reflect the breadth of possible proposed reforms.

I. Level of Coverage and Attributes

Reform proposals should consider the level and makeup of coverage—how many people are expected to be covered and the attributes of those people. Both the total number of people covered and the attributes of those covered will be affected by whether the LTC system is mandatory or voluntary.

Reform proposals should describe how the LTC system will provide coverage to subsets of the population having different attributes. Subsets of the population will have differing needs for LTC services and differing abilities to pay for such services. Examples of population attributes to consider include:

1. Demographic characteristics, such as age, gender, and marital status;
2. Health status characteristics, such as current general health condition and need for LTC services, and expected future need for LTC services; and
3. Wealth and income characteristics, which could be measured in various ways such as value of assets or lifetime income earned.

Likely the most influential feature driving the number and attributes of people covered under an LTC system is whether it uses a mandatory or voluntary design for providing coverage. Voluntary designs will likely have participation levels below 100 percent, while mandatory designs by definition imply all (or nearly all) individuals are covered under the system. Alternatively, a hybrid system could be constructed that blends features of both. For example, the system may provide a mandatory component that does not cover all expected LTC needs, with an option to purchase additional coverage on a voluntary basis.

The design of voluntary programs should anticipate not only the expected number of people covered but also the mix of individuals by the population attributes noted above, as the attributes of individuals covered will have a large impact on program costs. Proposed voluntary designs should anticipate enrollment counts for the various attribute groups, and clearly define how they will control costs based on that expected mix of individuals. Design elements that can address this risk include:

1. Underwriting to understand potential current and future LTC needs;
2. Vesting periods before benefits can be accessed to address individuals currently needing LTC;
3. Limiting the target population to those with expected lower LTC needs (e.g., those actively working); and
4. Use of active or passive enrollment (i.e., opt-in/opt-out).

Reform proposals should require performance of sensitivity testing and careful consideration of the interaction of expected enrollment mix, expected LTC needs, and revenue needed to cover those LTC costs.

II. Comprehensiveness of Benefits

Reform proposals should clearly communicate the comprehensiveness of benefits provided by the LTC system—that is, the amount of risk that is covered by the system should be defined clearly, including benefit criteria and benefit limitations. Communicating the comprehensiveness of benefits requires an understanding that the needs of the targeted population vary by geographic regions, as well as transparency in stating the levels and types of care being provided. The following concerns should be addressed when determining a proposed reform’s level of comprehensiveness. When communicating this comprehensiveness, it is important to understand and communicate how these challenges interact.

1. **Location of Care**—Where can members receive care? This includes, but is not limited to, nursing homes, assisted living facilities, and care given in the home. Proposals should have clear definitions for the locations of care and for the handling of transitions to different care settings. In addition, proposals should be able to address the continually changing manner of providing care in these settings as well as the future evolution of new and innovative care settings. Future care settings may include alternatives to today’s typical home and community care systems, such as those that are modeled after Continuing Care Retirement Communities, those that use new types of informal care, and those that use rehabilitation center/transition care centers, to name a just a few possibilities.
2. **Eligibility of Care**—When is a member’s care covered as part of the proposed plan? Common measurements define the severity of an individual’s impairment. For example, eligibility may be defined in terms of an inability to perform activities of daily living or an evaluation of cognitive impairment. Eligibility for care provided in certain settings or locations may depend on the nature or degree of an individual’s impairment.

3. **Limits of Total Coverage**—What are the overall coverage limits, and how do benefits used under the program count toward these limits? This includes clearly defining when coverage starts, the duration of coverage, and how this program will interact with other programs and/or coverages. Proposals should set forth elimination or waiting periods in the program. The duration of coverage can be defined in terms of a maximum dollar amount or in terms of a maximum period of time.
4. **Limits on the Level of Care Covered**—What are the maximum amounts paid during a specified period of time? Common time periods used for this type of limit have been daily or monthly maximums. Proposals should clearly describe whether the maximums increase with inflation or continue at current levels, and whether they vary by location of care. Proposals should define whether periodic benefits are paid in full or whether the benefits are limited to the actual expenses that the member incurs. Finally, proposals should be clear as to how the benefits are coordinated with other private and public means of payments.

III. Quality of Care

Like many other aspects of life, people contemplating long-term care should evaluate the costs and the benefits of their choices. Quality of care is an aspect of the benefits they choose, and a good reform will offer (1) an ability to assess or measure the quality of the care, (2) incentives to maintain or improve the quality, and (3) a mechanism to make the consumers and the providers aware of the quality of care.

1. **Quality Measurement and Assessment Framework (Qualitative and Quantitative)**
A standardized framework is needed to monitor and objectively benchmark the quality of the care. For example, Medicare's rating systems (Five-Star Quality Rating System for nursing homes and Home Health Star Ratings for home health care providers) cover a wide range of metrics and could be used as a benchmark for objective standards for all existing types of providers of care. Also, AARP state scorecards offer an objective measure that could be modified to accommodate provider performance.

As types of care and providers of care evolve, a quality measurement and assessment framework should be set up to cover all of them, and be flexible to respond as new locations of care and providers emerge.

Quality measurement should cover multiple domains, including patient and family centeredness, transitional care processes, performance outcomes, safety, timeliness, efficiency, equity, and cost-effectiveness. Patient and caregiver surveys could be an additional source of data.

2. **Quality Incentives**—Quality incentives should be considered for the overall industry as well as for individual providers. Though not necessarily an exhaustive list, the key incentive targets might include:
 - a. The supply of providers in a geographic area (assuming quality depends on adequate supply);
 - b. Evidence-based caregiver training (e.g., family caregiver support training for cognitively impaired patients);
 - c. Appropriate location of care within a facility or residence;
 - d. Appropriate care transition (e.g., reducing re-admission to hospitals);
 - e. Consumer transparency related to the structure of the care provided, including expected length of care, location of care policies, and what situations the provider of care could accommodate or not (e.g., assisted living facilities may not be able to provide adequate care for severe conditions);
 - f. Suitability and accountability of the provider of care (e.g., consider whether a family member has the capability, credentials, and training to provide care at home); and
 - g. Prevention (e.g., fall prevention, safety, wellness management, medication management, and activity level).
3. **Quality Awareness**—Awareness of the quality of care is needed from both a provider and a patient perspective. Awareness can be achieved with initial education, access to and readability of educational resources, and identification of what types of coverage the patient is eligible to receive. Education and educational resources may include information regarding fall prevention, wellness management, medication management, safety features, the availability of services and providers, and services that help the provider and caregiver perform their work well for the long term. Educational resources may also make users aware of other services available, whether charitable, publicly operated, or private.

IV. Understandability and Choice

Well-designed reforms will recognize that the needs of individuals and families vary widely. Program benefits may be designed to vary in order to accommodate these differences. For example, a reform may offer optional elimination or waiting periods where the offered choices may be intended to vary depending on differences in individual ability to rely on other resources such as assistance from family members, assets and income sources, or public and private programs.

Simpler reform designs may include very basic coverages and eligibility requirements that do not change over time. These designs may limit user choice, but they may also be simpler to understand and easier to administer. However, if the reform is too basic, those managing it may not have the ability to (1) address unique and changing needs of individuals and families over time or (2) address environmental changes that emerge (such as the economy, government budgets, or cultural values).

More complex reform designs may include the flexibility of the reform to adapt over time. However, the more complex the system, the more difficult it may be for the individual user to understand how the effects of the program may change over time. A complex system may be more difficult to administer.

Complex systems may also make the value proposition more difficult to assess. Complexity is introduced when reforms include many choices for individuals. It may be difficult for individuals to understand which choice might be best for them. Alternatively, allowing more choice within a reform may make it easier for individuals to select a program based on knowledge of their own expected emergence of need. Without sufficient education, it could be difficult to prevent individuals from being inadequately or excessively covered, potentially engendering public distaste for the program or poor results if selection against the program occurs.

Whether the reform establishes a simple or complex system/program, some level of education will be necessary as the reform takes effect and throughout the existence of the program. Any educational tools developed should help consumers understand their needs, the benefits provided by the program, and how their use of the program can affect the cost of the program in the future. If consumers are allowed to modify their choices over time, those eligible for the program need to be reminded or re-educated periodically about these choices. Ongoing choices and the need for education may therefore require administrative staff to help users navigate the system throughout the life of the program.

Consumers may also need help in understanding that specific cost-control features in benefit designs are intended to prevent overutilization that could increase consumers' own costs later. They may need assistance in preventing early use of benefits that they could need later.

Finally, when making a choice within the program, consumers should be able to discern their needs, their circumstances, and the availability of assistance. They can only make appropriate selections when benefit limitations are stated clearly, without ambiguity, and when their cognition is not impaired.

V. Affordability

Affordability varies by level and source of family or individual income, type of coverage, other household expenses, whether the program costs are permitted to change over time, and other factors. Therefore, affordability is a key financial issue for each purchaser. The "purchaser" may be an individual or a family unit. A family unit, frequently having two wage earners, is an important point for consideration because LTC programs could consider the impact of benefits and services on the family unit. Affordability may be usefully described on an after-tax, available-dollars basis including income and assets, both of which will likely change over the life of the purchaser. Households would likely subtract expected amounts spent for necessities such as food, clothing, shelter, transportation, medical care, and prescription drugs. Their remaining funds drive the ability to pay the LTC program contributions, so that the purchaser may ask, "What part of my/our remaining funds would I be willing to give up as a contribution in order to purchase the LTC benefit?"

Purchasers should consider the continuing affordability of the program over their remaining lifetime. Continued affordability will be influenced by the contribution structure of the program. A program could be designed like Medicare Part B or Part D, with increasing premiums that are redetermined annually, or with a levelized premium structure like that of many insurance products. In the case where the purchaser expects to live on a fixed retirement income without inflation adjustment, the affordability of the LTC program may become strained for them if the program is subject to anticipated continual jumps to higher contribution levels (by design), or unanticipated increases (e.g., rate increases on levelized premiums). Programs without guarantees or limits on contributions or benefits will require purchasers to carefully evaluate their answer to the affordability question over the long term, especially in the case of those with fixed retirement income and when the initial participation decision was based on contribution levels near a purchaser's upper bounds of affordability.

VI. Risk Management and Cost Control

In order for any reform to be sustainable, risk management and cost control elements should be considered. A risk evaluation system should be developed prior to rolling out the program. Cost controls should be established that allow for alignment of interests of all stakeholders. Performance of the program should be evaluated based on the predefined criteria, and cost controls should be modified as needed.

A risk evaluation system may depend on projection models, sensitivity testing, stress testing, and evaluation of emerging risks used to identify, assess, measure, mitigate, and manage various risks faced by the program. Also, these may be useful in designing and evaluating risk management and controls in LTC reforms. For example, some programs may depend on sound management of the program's assets and liabilities, and projection models will help direct the managers of the program under expected economic environments and help prepare the managers for corrective actions under adverse situations.

Reforms will need to provide benefits that are perceived to be sufficiently comprehensive while at the same time not encouraging overutilization. To control costs, there will need to be features that limit benefits and unintended utilization. The interests of the users of the program and the financiers of the program should be aligned. Care should be taken so that individuals are not able to profit from using services and are not encouraged to use services that may not be necessary. Possible controls may include reimbursing a portion of actual expenditures, rather than paying a stipulated cash benefit, and by not reimbursing for care provided by family members.

Ongoing risk evaluation and management over the program's lifetime is necessary in order to be able to determine whether the program is performing according to expectations. Before a reform is implemented, a pre-planned feedback mechanism that studies the effectiveness of the reform is important. Any ongoing evaluation of the program used to monitor its known and emerging risks should be designed around the controls and risk evaluation that were initially developed and made available as part of the program so that corrective action can be made to the program over time. Corrective actions or controls might include changing the amount of money paid into the program or limiting or changing the benefit payments or eligibility requirements to receive benefits.

As the program matures and is evaluated over time, it will be affected by more factors than those internal to the design and users of the program. It will also be affected by the changing economy, political environment, and demographics of those covered by and contributing to the program. It is possible that some demographic changes can be predicted more accurately than changes to the economy and the political environment. Whether these changes are predictable or not, various scenarios should be evaluated before implementation so the emerging risks underlying these potential changes can be evaluated and potential controls can be designed so the program can react to any changes in these areas that emerge over time.

Any program that includes long-term projections will require significant assumptions to develop those projections. The assumptions will be developed from available data, and critical judgment will need to be applied to determine when to adjust the assumptions based on emerging experience and the credibility of that experience. An appropriate margin should be applied to the assumptions.

As part of the initial and ongoing monitoring of a program, clear definitions of relevant statistics are needed; e.g., for such areas as the expected amount of coverage the proposal will provide for the targeted group. For proposals that place limits on the level of coverage, chosen statistics should account for the likely shift in expected use caused by the coverage limits.

VII. Financial Soundness and Sustainability

A new program's financial soundness and sustainability refers to the ability to deliver what is promised, knowing that these promises extend well into the future. The ability to deliver on promises also includes the new program's interface with other existing programs without disturbing the ability of the existing systems to meet their own commitments. Consideration of the following four key questions will help determine whether a program is financially sound and sustainable.

1. Can consumers be confident that the program will indeed deliver what was promised?

Sound risk management and cost controls give confidence to consumers that the program will deliver on all of its promised future obligations. The funding structure of the program is important. Because the need for LTC increases with age, there is good reason for the sake of program sustainability to design the program using systematic prefunded pooling of homogenous risks in which participants make substantial contributions during their working years, continue to contribute during their retirement years, and receive most of their benefits in the last few years of life or possibly die without ever needing LTC. A reasonable fear of consumers is the risk that the program runs out of money precisely at the point where the participants are most in need and unable to care for themselves. This risk can be minimized by designing cost controls into the program. Controls may need to change when the market's environment changes over time. For example, if the reform were to restrict initial underwriting on the future cohorts of applicants, resulting in higher-risk participants, the program would need to address the higher risk with a different control to address the changes brought on by the restricted underwriting. Another hypothetical example would be a modification of certain controls due to advances in medicine, such as a cure for Alzheimer's disease.

Alternatively, a pay-as-you-go system makes use of young and healthy participants effectively paying the current costs of the participants receiving benefits. More precisely, costs from the generally older participants in need of LTC can be funded by the contributions of all the participants. This design allows the older members of the first cohort to claim benefits with a lower level of contributions than under the prefunding design.

Another alternative may be a partially prefunded system that attempts to buffer some of the risk of a pay-as-you-go system by accruing sufficient funds to meet established sustainability criteria. However, any program that is not fully prefunded may need to address a changing mix of contributors and benefit users if it is to be sustainable into the future.

2. Is the program too complex or too simplistic?

The level of program complexity generally depends on its design. While prefunding and pay-as-you-go systems are considered comparatively simple, a partially prefunded design can be quite complex, as such a system depends on defining the relative size of the prefunding component. Pay-as-you-go or fully prefunded programs may become more complex if they are likely to evolve into a partially prefunded design over time. For example, a program that is characterized as prefunded but is projected to run out of funds in, say, 75 years, would be properly described as being only partially prefunded. Programs having changing mixes of prefunding and pay-as-you-go could be complex. Other design considerations that influence the complexity of any insurance-based program include benefit triggers, definition of qualified locations of care, elimination period definitions, and many other product-specific options. The amount of choice provided to participants complicates accurate forecasting of the level of future benefits, and an assessment of the program's sustainability may be affected by the ability (or inability) to reasonably predict future benefits resulting from their choices.

3. Does the financial program make appropriate use of the funds invested?

Sound investing of the program funds enhances the performance of the program, which is particularly important for programs that have an appreciable degree of prefunding. Choices for investments will depend on whether the program is private or public, with greater restrictions likely on the options for public programs (based on observation historically of public programs). The options for private programs, absent regulatory restriction, allow greater flexibility in investment options, which means that the trade-off between risk and return becomes a more important consideration when evaluating financial soundness and sustainability of the program.

4. Can the designers ensure that the program interacts well with existing private insurance and public programs?

Part of the complexity of designing a new LTC program is that there is currently in place a patchwork of existing programs. Public programs, including Medicaid, Medicare, and those administered by the Veterans Health Administration, and others jointly cover close to two-thirds¹ of the cost of formal LTC services being provided today. These programs combine with existing inforce insurance coverage provided by private LTC insurers and include a small percentage of “public/private partnership” policies. Thus, critical questions come into play: How is any new program to interact with these existing public and private programs? Is the new program intended to displace all or part of the existing programs? Is the new program intended to provide coverage to persons not currently covered by any existing program? How do definitions of a qualifying event vary between programs? Are participants in existing programs penalized by the reform?

Conclusion

Some recent attempts at reforming how long-term care is financed in the United States have failed because they did not adequately consider these seven essential criteria. For example, the CLASS Act² enacted as part of the Affordable Care Act—and subsequently repealed—failed to consider at least two of the criteria: Affordability and Financial Soundness and Sustainability.

Proposals for reform of the LTC system to provide access to affordable long-term care for the elderly in the United States need to address the seven essential criteria discussed above if the reforms are to be of value and to endure for the long term. Conversely, any proposal that fails to do so will yield LTC reforms that are less valuable and less likely to endure.

Furthermore, the criteria often rely on three activities: adequate education of the consumer, awareness of any alignment or misalignment between the interests of consumers in the program and the interests of those financing the program, and, from an actuarial perspective, sensitivity testing (testing the impact of alternative assumptions). When a proposed reform’s conformity to the seven essential criteria is evaluated, these activities will be useful in helping the reform to achieve the ultimate goal of providing necessary and adequate care to the elderly in the population.

The American Academy of Actuaries has unique expertise to advise and assist public policymakers with aspects of these criteria related to risk and financial security issues.

¹ *The Long-Term Care Financing Crisis*, by Diane R. Calmus. Center for Policy Innovation; Feb. 6, 2013.

² Community Living Assistance Services and Supports (CLASS) program.

PUBLIC POLICY TOOLKIT

FINANCIAL SERVICES

INSURANCE CAPITAL STANDARDS

INTERNATIONAL AND U.S. REGULATORS are developing new solvency and capital standards for insurers to help prevent a major economic event from threatening global financial markets. Capital standards are requirements on the amount and types of capital insurance companies must hold to prevent them from becoming too leveraged and risking insolvency. These new standards could have a profound effect on domestic and international insurers, which in turn could affect the price and availability of insurance products to businesses and consumers.

Although U.S. insurers are regulated at the state level, the National Association of Insurance Commissioners (NAIC) and the Federal Reserve Board are developing new proposals for U.S. insurance capital standards for insurers. Globally, the International Association of Insurance Supervisors (IAIS) is developing solvency and capital standards for large multinational insurers, although its decisions are not legally binding on U.S. companies. However, these new standards could significantly impact some large, multinational U.S. insurers that compete with foreign companies in other jurisdictions that operate under different rules.



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For all domestic and international policymakers developing capital standards, the American Academy of Actuaries' Solvency Committee has developed a comprehensive set of principles to assist them. These include:

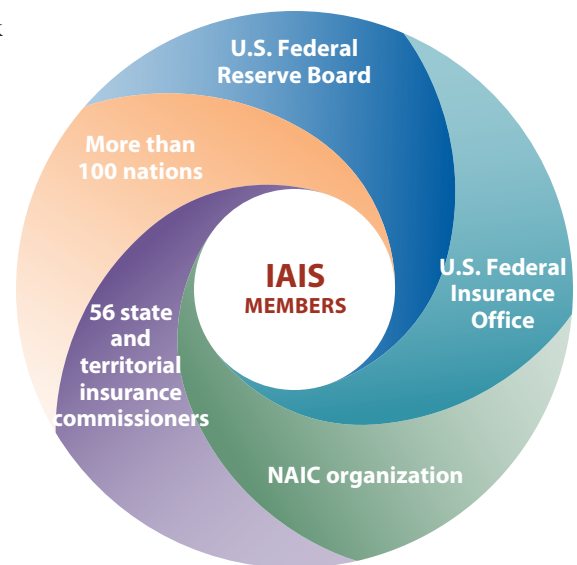
- Creating a group solvency regime with clear regulatory purposes and goals.
- Establishing metrics for standards that are useful to all relevant parties.
- Promoting responsible risk management and encouraging risk-based regulation.
- Taking into consideration the local jurisdictional environments.
- Making solvency standards compatible across accounting regimes.
- Minimizing pro-cyclical volatility.
- Presenting a realistic view of an insurance group's financial position and exposures to risk.
- Using internally consistent assumptions in capital or solvency models.
- Focusing on the total asset requirement, so that the insurer can meet obligations and capital is accessible in times of stress.
- Demonstrating that capital is accessible during times of stress.

Regulatory Tracks

Several organizations and government entities are individually developing new insurance capital standards. Various proposals may not be reconciled, which could force international insurers to comply with different, and possibly contradictory, standards. Here is a list of the major efforts:

IAIS

- Developed a basic capital requirement framework for G-SIIs that measures their assets, and life and non-life insurance activities. The BCR will be privately reported by G-SIIs to groupwide supervisors in 2015.
- Developed the higher loss absorbency (HLA) rule, which will require G-SIIs to hold additional capital because of their systemic importance in the international financial system; the HLA rule was subsequently endorsed by FSB in September 2015.
- Creating ICS for G-SIIs and IAIGs. The ICS framework is expected to be completed in 2018 and implemented in 2019. It is not intended to affect or replace existing arrangements or capital standards in local jurisdictions. The ICS is expected to replace the BCR and be further refined after its completion.



Federal Reserve Board

- Developing a new capital standard for U.S. insurer groups. The Capital Standards Clarification Act, signed into law in December 2014, clarifies the board is not required to apply bank-based capital standards to insurers. The board requested public comment on an advanced notice of proposed rulemaking (ANPR) in 2016 on conceptual frameworks for capital standards that could apply to systemically important insurance companies.

National Association of Insurance Commissioners

- Developing a proposal for group solvency and capital standards for U.S.-based, insurance groups.

Alphabet Soup

Experts in the area of insurance capital standards use numerous acronyms to refer to groups, designations, and requirements. The most-used acronyms include:

BCR – basic capital requirement.

Framework created by the IAIS that measures G-SII's assets, and life and non-life insurance activities.

FSB – Financial Stability Board.

Organization established by the G-20 after the 2008 financial crisis to address vulnerabilities in global financial system.

G-SII – global systemically important insurer.

Designation by FSB of a multinational insurance group that could harm the global financial system if it were to become insolvent and fail.

HLA – higher loss absorbency.

Additional capital requirement being developed by the IAIS for G-SIIs to reflect “their systemic importance in the international financial system.”

Large Global Standardize Group Insurers

The Financial Stability Board, working with the International Association of Insurance Supervisors and representatives from many nations, has identified nine G-SIIs.

U.S.

American International Group Inc.
MetLife Inc.
Prudential Financial Inc.

CHINA

Ping An Insurance (Group) Company of China, Ltd.

EUROPE

Aegon N.V.
Allianz SE
Aviva plc
Axa S.A.
Prudential plc

IAIG – internationally active insurance group.

Large international group that includes at least one sizeable insurance entity with over \$50 billion in assets and writing premiums in at least three jurisdictions

IAIS – International Association of Insurance Supervisors.

International standards-setting organization, tasked by the FSB to promote effective and globally consistent supervision of the insurance industry to maintain global financial stability.

NAIC – National Association of Insurance Commissioners.

U.S. standard-setting and regulatory support group governed by state insurance regulators.

SIFI – systemically important financial institution.

Designation by the Financial Stability and Oversight Council for U.S. firms whose collapse would pose a serious risk to the economy.



Additional Resources From the Academy

Solvency Committee Submits Comments to IAIS on Global Insurance Capital Standard [READ MORE...](#)

Financial Regulatory Task Force comments to the Federal Reserve Board on proposed rules on [CAPITAL REQUIREMENTS](#) and [ENHANCED PRUDENTIAL STANDARDS](#).

NEW RISK REGULATORS AND REGULATIONS

THE 2008–09 FINANCIAL CRISIS SHOOK CONFIDENCE in global financial institutions. Policymakers in the United States and abroad responded with steps aimed at reducing systemic risks to the domestic and worldwide financial systems. In the United States, new federal regulatory and oversight bodies were created to foster better coordination and consistency among financial regulators and to try to bridge potential supervisory gaps.

Additionally, the National Association of Insurance Commissioners (NAIC) launched its Solvency Modernization Initiative to update U.S. insurance regulations to improve the solvency regulatory framework for insurers in the United States. This initiative has included work related to enhancing capital requirements, governance and risk management, group supervision, reinsurance, and other key issues.

New U.S. Regulatory Bodies and Roles

Financial Stability Oversight Council

The Dodd Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank) created the Financial Stability Oversight Council (FSOC), which is responsible for identifying risks and responding to threats to the nation's financial system. FSOC is housed within the U.S. Treasury Department, and its voting members comprise federal banking, securities, and financial regulators, and an independent insurance expert. Nonvoting members include the director of the Federal Insurance Office (FIO), the director of the Office of Financial Research, and representatives of the nation's state insurance, banking, and securities regulators.

The council may designate U.S. nonbank financial companies as systemically important financial institutions (SIFIs)—entities whose material financial distress, or size, concentration, interconnectedness, or mix of its activities could pose a serious risk to the economy—that should be subject to enhanced oversight.

Makeup of Financial Stability Oversight Council		
Voting Members		Nonvoting Members
<ul style="list-style-type: none"> • Secretary of the Treasury • Chairman of the Board of Governors of the Federal Reserve System • Comptroller of the Currency • Director of the Bureau of Consumer Financial Protection • Chairman of the Securities and Exchange Commission 	<ul style="list-style-type: none"> • Chairperson of the Federal Deposit Insurance Corporation • Chairperson of the Commodity Futures Trading Commission • Director of the Federal Housing Finance Agency • Chairman of the National Credit Union Administration • Independent member with insurance expertise 	<ul style="list-style-type: none"> • Director of the Office of Financial Research • Director of the Federal Insurance Office • State insurance commissioner designated by the NAIC • State banking supervisor designated by the Conference of State Bank Supervisors • State securities commissioner designated by the North American Securities Administrators Association

FSOC’s scope includes:

- Facilitating regulatory coordination to reduce gaps in the regulatory structure and secure a more stable financial system.
- Promoting information collection and sharing among agencies and gathering additional information from individual companies to assist in identifying risks.
- Designating nonbank financial companies for consolidated supervision.
- Recommending stricter standards for the largest, most interconnected firms, especially in cases where activities threaten widespread financial stability.
- Breaking up companies that present a “grave threat” to the financial security of the United States.

Federal Insurance Office

Dodd-Frank also created FIO within the Treasury Department to monitor the insurance sector and determine whether underserved communities and consumers have adequate access to affordable insurance products. Although not given domestic regulatory authority under Dodd-Frank, the office identifies any industry activity that could lead to a crisis in the financial system as a whole. Its authority extends to all lines of insurance except health, long-term care, and crop insurance.

FIO also assists with the administration of the Terrorism Risk Insurance Program and is one of the U.S. representatives on international insurance matters, including at the International Association of Insurance Supervisors (IAIS).¹ Additionally, FIO provides recommendations to FSOC on matters such as insurer SIFI designation.

Federal Reserve

The Federal Reserve (Fed) received added responsibility as a supervisor for certain insurance holding companies designated by FSOC as a result of Dodd-Frank’s enactment. Additionally, the Fed assumed oversight of consolidated insurance holding companies that own an insured bank or thrift following the elimination of the Office of Thrift Supervision by Dodd-Frank.

¹ See next page “International Regulatory Bodies” for more information

International Regulatory Bodies

Financial Stability Board

The Group of 20² established the Financial Stability Board (FSB) in 2009 and gave it a broad mandate to promote global financial stability. Although not legally binding on any nation, FSB's policies are developed by policymakers from the world's largest economies, and the organization works to set standards that member countries may adopt for their jurisdictions. The Fed, Securities and Exchange Commission, and Treasury Department are the U.S. representatives to the FSB.

International Association of Insurance Supervisors

Established in 1994, the International Association of Insurance Supervisors (IAIS) is composed of authorities from 140 countries and is an international standard-setting body for insurance supervisors. The IAIS implements principles and standards to facilitate the supervision of the insurance sector in the respective jurisdictions of its members. Its mission includes promoting policyholder protection and global financial stability by establishing a process to assess systemic risks of insurers and coordinating the efforts of national insurance supervisors and other global financial regulators.

The IAIS developed a basic capital requirement and higher loss absorbency standard for "global systemically important insurers" and is creating an insurance capital standard designed to apply to all "internationally active insurance groups." The United States is represented at the IAIS by FIO, the NAIC, and the Fed. (For more information on the IAIS, see Academy's [Insurance Capital Standards](#).)

New State Regulations

Solvency Modernization Initiative

The NAIC began its Solvency Modernization Initiative in 2008 in an effort to mitigate some risks to insurers through: added regulations, developing financial tools, conducting oversight to prevent failures, and providing a financial-protection backstop in case of an insurer liquidation.

In 2011, the NAIC adopted the Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act, a proposed state regulation that requires insurers and insurer groups to assess their own current and future risks to provide regulators a better understanding of how well these companies can withstand financial stress. As of December 2016, 40 states have adopted ORSA legislation, which places requirements on large and medium-sized insurers to analyze their own underwriting, market, operational, liquidity, and other material risks that could affect their capability to meet policyholder obligations.

² A forum of 19 countries plus the European Union representing both developed and emerging economies whose size or strategic importance gives them a particularly crucial role in the global economy. Its role is to coordinate policies at the international level to promote global financial stability.

The NAIC also has adopted or is currently working on several changes to requirements for risk-based capital (RBC)—minimum amounts of capital that insurers must hold to protect consumers, insurers, and the overall economy. A few examples of changes and enhancements include the introduction of principle-based reserving for life insurance, catastrophe risk factors in the RBC formula for property/casualty insurance, and the NAIC’s ongoing work to update the investment risk factors for all RBC formulas.

Additionally, the NAIC has adopted or is continuing work on provisions to improve governance and risk management, insurance group supervision, reinsurance, and statutory accounting and financial reporting. Examples include the introduction of Actuarial Guideline XLVIII, which applies to life captives and the ongoing work to consider a group capital calculation.

PUBLIC POLICY TOOLKIT

CLIMATE RISK

MANY AMERICANS HAVE KEENLY FELT the effects of extreme climatic events: increased droughts in the western United States; higher rainfall and snowfall in the eastern part of the country; and greater damage from tornadoes, hurricanes, and floods.

While climate scientists continue to refine their models, most data shows record-breaking warm temperatures in many parts of the world over the past several years. Acknowledging that the public debate on climate risk has often been contentious, the American Academy of Actuaries encourages the public to inform itself with objective information and data to more fully engage in the debate.

Insured and uninsured losses due to weather-related activity vary widely on a yearly basis, but the trend over the past 30 years points to an increase in both the number of weather-related loss events and total loss amounts.¹ A key component of weather-related damage has been increased building along U.S. coastlines and rivers, and in other areas prone to hurricanes, forest fires, and severe storms. A rise in extreme weather-related events could increase losses in the future. While

¹ "Rise in Weather Related Risks," Munich Re Group. <https://www.munichre.com/us/weather-resilience-and-protection/rise-weather/rise-weather-risk/index.html>.



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there is ongoing scientific debate on how fast the earth's climate is changing and how much is influenced by human activity, alterations in weather patterns have been observed worldwide, including:

- Global mean surface temperatures have increased by 0.6 degrees Celsius since 1951.²
- Seven of the 10 warmest years on record for America's contiguous 48 states have occurred since 1998.³
- The fraction of global land area experiencing extremely hot summertime temperatures has increased tenfold over the past 50 years.⁴

North American Threat

Over the past three decades, the number of weather-related loss events in North America grew by a factor of five, according to a 2012 report by Munich Re. This compares with a fourfold increase in Asia, 2.5 in Africa, 2 in Europe, and 1.5 in South America. North America faces every type of hazardous weather risk—hurricanes, tornadoes, drought, flood, wildfire, and storms, according to the report. One reason is that no east-west mountain range exists in North America to prevent southern warm air from colliding with cold Arctic weather fronts.

Rising Property/Casualty Costs

As weather-related damages increase, the costs fall on insurers, businesses, and consumers. Four of the world's five largest natural catastrophes ranked by insured losses in 2015 occurred in the United States, including winter storms, tornadoes, and wildfires, according to Munich Re. The National Oceanic and Atmospheric Administration (NOAA) recorded 88 U.S. weather/climate events that each had losses exceeding \$1 billion between 2006 and 2015, compared with only 46 such events in the previous decade. A large proportion of these losses is not insured, and so the cost falls on individuals, businesses, and governments.

Here is NOAA's breakdown⁵ of weather-related events:

- ✓ The western U.S. has experienced hotter and drier temperatures over the past decade, which has led to more wildfires and crop failures. There were 16 drought and wildfire events where each loss exceeded \$1 billion in 2006-2015, according to NOAA data, compared with 10 similar events between 1996 and 2005.
- ✓ Damage from winter storms and freezes generally hit the eastern half of the United States. NOAA reported five winter storm and freeze events where losses exceeded \$1 billion between 2006 and 2015, compared with five similar events in 1996-2005.
- ✓ Water damage remains a problem, mainly in the South and Midwest. NOAA reported 18 flood and hurricane events with losses exceeding \$1 billion between 2006 and 2015, compared with 19 from 1996-2005.

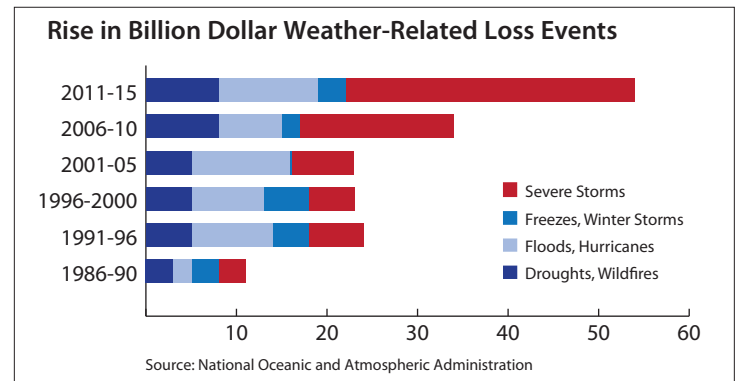
² "IPCC Fifth Assessment Report: Climate Change 2013," Intergovernmental Panel on Climate Change. http://www.ipcc.ch/pdf/assessment-report/ar5/wg1/WG1AR5_SPM_FINAL.pdf.

³ "Climate Change Indicators in the United States, 2012," Environmental Protection Agency. <http://www.epa.gov/climatechange/pdfs/climateindicators-full-2012.pdf>.

⁴ "Perception of Climate Change," James Hansen, et al. Proceedings of the National Academy of Sciences of the United States of America, March 29, 2012. <http://www.pnas.org/content/109/37/E2415>.

⁵ National Oceanic and Atmospheric Administration, <https://www.ncdc.noaa.gov/billions/mapping>.

✓ The biggest increase in damage from weather events over the past decade came from severe storms, which NOAA classifies as tornadoes, hailstorms, severe thunderstorms, derechos, and flash floods. There were 49 such events with losses exceeding \$1 billion from 2004-2013, compared with 12 between 1996 and 2005.



Actuaries Climate Index and Actuaries Climate Risk Index

In order to monitor climate changes, the American Academy of Actuaries has joined a group of North American actuarial organizations to develop the Actuaries Climate Index (ACI), which focuses on measuring the frequency and intensity of extremes in key climate indicators based on controlled observational data of temperature, precipitation, drought, wind, and sea level. The ACI covers the United States and Canada, but could be expanded to other parts of the world where reliable data is available.

As a follow-on to the ACI, the Actuaries Climate Risk Index (ACRI) will assess who and what is at risk because of climate change, and quantify that risk. The ACRI will reference where people live and the surrounding infrastructure, and look for relationships between climatic and socioeconomic factors. Both indexes will function as a useful tool for actuaries, policymakers, and the general public.

GLOBAL NATURAL LOSS EVENTS (2015)

Number of Events	1,060
Overall Losses	\$90 billion
Insured Losses	\$27 billion
Fatalities	23,000

LARGEST U.S. COVERED LOSSES

Feb. 16-25; Winter storm	\$2.1 billion
May 23-28; Severe storms	\$1.4 billion
April 7-10; Severe storms	\$1.2 billion

Source: "Natural Loss Events Worldwide," Munich Re, https://www.munichre.com/site/corporate/get/documents_E-192541734/mr/assetpool.shared/Documents/5_Touch/Natural%20Hazards/NatCatService/Annual%20Statistics/2015/2015_Weltkarte_e.pdf

Additional Resources From the Academy

Actuaries Climate Index—An online tool designed to help inform actuaries, public policymakers, and the general public about climate trends and some of the potential impacts of a changing climate on the United States and Canada. [READ MORE...](#)

PUBLIC POLICY TOOLKIT

FLOOD INSURANCE

PLUGGING HOLES IN U.S. FLOOD INSURANCE

FLOOD INSURANCE IS VITAL TO PEOPLE AND BUSINESSES that are located along the coastline or major rivers and waterways throughout the United States. But losses caused by flooding can also burden American taxpayers who live outside of the path of destruction because they are often obligated to pick up the tab for flood losses caused by major hurricanes and river flooding, which can destroy thousands of homes in a single disaster.

The National Flood Insurance Program (NFIP) was established in 1968 to provide flood insurance to homeowners, renters, and business owners in participating communities through collaboration between the federal government and private property insurance companies. The NFIP allows flood risks to be pooled on a nationwide basis so that the fund can theoretically absorb losses from periodic regional storms. The NFIP's founding goals were to identify flood risks, set minimum national building standards in flood zones and encourage communities to exceed those standards, and provide flood insurance at affordable rates.



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The NFIP now has about \$23 billion in debt to the U.S. Treasury. Those funds were borrowed in order to pay off insurance claims from several major storms over the past decade. Insurance premiums paid by property owners in flood-prone areas are not expected to be enough to both cover future insurance claims and retire the NFIP's debt. Additionally, with climate change raising the likelihood of higher-intensity and costlier storms, insurance premiums will continue to be insufficient to cover losses, and the NFIP's debt may rise further.

Costliest U.S. Storms*		
Hurricane Katrina	Aug. 2005	\$16.3 billion
SuperStorm Sandy	Oct. 2012	\$8.25 billion
Hurricane Ike	Sept. 2008	\$2.67 billion
Hurricane Ivan	Sept. 2004	\$1.61 billion
Hurricane Irene	Aug. 2011	\$1.34 billion

*NFIP payouts
Source: FEMA

However, raising flood insurance premiums too much too quickly could prompt homeowners and businesses to cancel their flood insurance policies or even relocate to other parts of the country. In an effort to make the NFIP more financially stable, Congress passed in 2012 the Biggert-Waters Flood Insurance Reform Act, which substantially cut subsidies on flood insurance that had been provided to some property owners. Congress later delayed some premium increases after concerns were voiced by policyholders.

The statutory authority for the NFIP expires on Sept. 30, 2017. Consequently, Congress is expected to review the program and consider revisions in the coming months.

Steps to Address the NFIP Debt

1. Adjust insurance premiums

The American Academy of Actuaries supports charging actuarial appropriate premiums that reflect the hazards of better-defined categories of insured risks. This would make the NFIP more financially stable on a long-term basis and more likely to be able to fully fund future losses. The Academy also recognizes that some policyholders in high-risk locations may require rate subsidies in some form.

2. Change policies on properties that report multiple flood losses

About 1 percent of NFIP-insured properties have accounted for more than 33 percent of the claims paid, according to one estimate. Owners of properties that have incurred multiple claims for flood damage currently pay rates that are below cost.

3. Expand insurance coverage

If a higher percentage of property owners in participating communities within flood-prone regions bought flood insurance, the added revenue would be available to help pay off future claims.

4. Improve flood maps

Over the past few years, the Federal Emergency Management Agency (FEMA) has been updating flood maps to provide more accurate information about flood risks. The sooner FEMA can finalize updated flood maps, the more quickly insurance premiums can be adjusted to more accurately reflect the flood risk of a specific property. There also has been discussion about using newer mapping technology to allow more detailed risk assessments.

5. Shift private insurance companies into flood-insurance market

Insurers have started offering commercial multi-peril policies that include flood coverage, and residential coverage above the limits available from the NFIP. However, private insurance still comprises a very small portion of the market. Legislation has been proposed in Congress that would help expand the private marketplace and make coverage more widely available.



Additional Resources From the Academy

Presentation on Role of Private Market in Flood Insurance (July 2014) [READ MORE...](#)

The National Flood Insurance Program: Past, Present... and Future? (July 2011) [READ MORE...](#)

Note: A new Academy monograph on the NFIP will be released in early 2017.

PUBLIC POLICY TOOLKIT

CYBER-RISK

MANAGING THE RISKS IN CYBERSPACE

A GROWING NUMBER OF large retailers, insurers, government agencies, and other organizations are reporting cyberattacks that attempt to steal personal data.¹ Hackers also have taken trade secrets or damaged networks with malicious computer software after gaining access to organizations' computer networks. One response has been more businesses and individuals seeking protection through a cyber-risk insurance policy, which has become an emerging line of business. A cyberattack on a single business could affect thousands of businesses or millions of consumers.

¹ [The Global State of Information Security® Survey 2017](#); PwC; 2016.



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Protecting Insurer Data

Insurers, particularly those in the health care field, make tempting targets for hackers because they house large amounts of consumer data, ranging from Social Security numbers and employment data to details about family members. Health insurer Anthem suffered a major data breach in 2015 that exposed information from 79 million customers, and many other insurers have had their company information compromised as well.

Cyber-Risk Insurance

Besides protecting their policyholder and other proprietary data, some insurers offer private insurance coverage of certain cyber-risks, such as the hacking into computer networks by outside parties either with political motivations or seeking to profit, accidental or intentional release of sensitive data by employees, and physical damage or business disruption.

While relatively new, the market for cyber-risk insurance coverage is expected to grow rapidly. Nearly \$484 million for standalone cybersecurity policies and about \$1 billion in cybersecurity package policies were written in 2015, according to an NAIC survey of 500 insurers.²

Most standard commercial policies do not insure against many cyber-risks, and businesses that seek such coverage must purchase special policies that could cover:

- Theft of customer lists, trade secrets, and other valuable private data
- Business interruption damages from a cyberattack
- Damages caused by introduction of malicious computer software
- Costs from employees who accidentally or maliciously disclose sensitive business information
- Costs of complying with state and federal data-breach laws
- Reputational damage

Cybersecurity also affects personal lines of insurance, and some homeowner's policies now offer identity theft protection. Automobiles are increasingly dependent on computer technology, which could be vulnerable to hacking. Other at-risk household items include so-called smart thermostats, wireless-enabled front door locks, and appliances that are connected to the internet and to each other.

² [“Early NAIC Analysis Sheds Light on Cybersecurity Insurance Data,”](#) National Association of Insurance Commissioners; June 30, 2016.

Within auto or property insurance companies, substantial data exists on accidents, and actuaries can calculate the risks, prices, and reserves necessary. However, there is far less data on cyber-risks because data breaches are relatively new, which makes calculating prices and reserves more difficult. Insurance prices set too high will limit the number of businesses that find coverage economical or individuals who can afford coverage, while prices that are too low could lead to insurers not being able to pay all claims.³

Recent Major Data Breaches		
COMPANY	POTENTIAL USERS	YEAR
Weebly	43 million	2016
Verizon	1.5 million	2016
Anthem	79 million	2015
Securus Technologies	70 million	2015
Yahoo!	500 million	2014
eBay	145 million	2014
JPMorgan Chase	76 million	2014
Home Depot	56 million	2014

Source: Academy research

Because personal and commercial cyber-risk coverage is evolving, most policies are being created uniquely for each policyholder in order to define the circumstances that trigger payouts. Insurers that write commercial cyber-risk policies typically will review companies' antivirus and malware-protection software, frequency of system and software updates, and performance of firewalls. Insurers also will analyze how a company's employees, vendors, and customers access data, especially those having access to critical data. Another key area is a firm's post-breach response plan as it relates to the risk management of its networks, websites, and intellectual property.

New Policies and Regulations

Because cybercrime is a growing threat, various government entities are taking steps to reduce the risks. Congress passed the Cybersecurity Act of 2015, a law that creates a mechanism for data sharing among companies and federal agencies, authorized various government and non-government entities to monitor certain information and take defensive measures for cybersecurity purposes, and contained provisions to strengthen cybersecurity protections at federal agencies.

State insurance regulators have monitored breached companies and receive input from law enforcement to ascertain what insurers are doing to take appropriate steps to protect data. The National Association of Insurance Commissioners (NAIC) has taken a leading role in addressing cyber-risk in the insurance industry, and has:

- Released principles of best practices for insurers and regulators on protecting insurers' data from hacking.
- Established a roadmap⁴ of cybersecurity protections for consumers in cases of data breaches that include: notices from insurers in cases of identity theft, one year of identity theft protection paid for by insurers, and the right to place a 90-day initial fraud alert on credit reports.

³ [Testimony](#) by North Dakota Insurance Commissioner Adam W. Hamm before the U.S. House Subcommittee on Cybersecurity, Infrastructure Protection, and Security Technologies; March 22, 2016.

⁴ "NAIC Roadmap for Cybersecurity Consumer Protections"; NAIC and the Center for Insurance Policy and Research; 2015.

- Collected reports for analysis from more than 500 insurers that have provided businesses and individuals with insurance for cyber-risks through policies that mainly were additions to commercial and personal policies.
- Started drafting a model law for state legislatures to consider. Provisions in the model law include requirements on insurers to: implement information security programs; and investigate and notify regulators, consumers, affected payment card companies, and consumer-reporting services about data breaches.

Conclusion

While insurers provide coverage for many types of risks, there currently is limited data to analyze on cyber-risks, which involve complex technologies that are constantly changing. Additionally, cyberattacks involve new targets, threats, and perpetrators. These changes limit the usefulness of historical data for predicting future costs of cyber-risks. U.S. businesses and consumers have become increasingly reliant on computer technology, and insurers and regulators are trying to catch up with the ensuing cyber-risks.