



AMERICAN ACADEMY of ACTUARIES

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March 22, 2017

The Honorable Paul Ryan  
Speaker, U.S. House  
H-232 Capitol Building  
Washington, DC 20515

The Honorable Nancy Pelosi  
Democratic Leader, U.S. House  
H-204 Capitol Building  
Washington, DC 20515

Re: H.R. 1628, *American Health Care Act* (AHCA)

Dear Speaker Ryan and Leader Pelosi:

On behalf of the American Academy of Actuaries' Individual and Small Group Markets Committee and Medicaid Subcommittee,<sup>1</sup> the U.S. national association for the actuarial profession, we hope you will take our comments into consideration on H.R. 1628, the *American Health Care Act* (AHCA), as well as on other provisions being considered as part of an approach to health reform. The American Academy of Actuaries' Health Practice Council (HPC) continues to encourage policymakers to improve the affordability and accessibility of health insurance coverage. The HPC has published a number of policy statements in this area (highlighted at the end of this letter) that provide additional detail related to the specific comments below. Our comments in this letter focus primarily on current reform efforts that introduce new approaches to federal Medicaid funding and the individual health insurance market.

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

## **Approaches to Federal Medicaid Funding**

Modifying the federal funding structure of the Medicaid program<sup>2</sup> from one based on a percentage of total program expenditures to one that caps or limits federal funding to states requires decisions in five key areas. How these elements are designed would impact the stability and long-term viability of the Medicaid program. They include:

- Approach to setting state caps;

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<sup>1</sup> The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

<sup>2</sup> Medicaid is a state-operated, state-/federal-funded public health care program that covers more than 70 million Americans.

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

While the following analysis focuses primarily on per capita cap projection development, the concepts also apply to the block grant option made available to states through the House Committee manager's amendment to H.R. 1628.<sup>3</sup> As outlined in the Academy's recent issue brief, [Proposed Approaches to Medicaid Funding](#), block grants provide potentially greater risk (and potentially greater reward) to states under different enrollment and cost change scenarios. States that might consider the block grant option should carefully weigh all such possibilities.

### **Approach to setting state caps**

The AHCA would set per-enrollee caps based on states' Medicaid expenditures in 2016 for five beneficiary categories, trended forward to 2019 by the medical consumer price index (CPI-U Medical). Medicaid per capita costs vary by state based on state decisions such as covered populations and benefits, provider reimbursement levels, and delivery system approach. Medicaid provider pass-through supplemental and upper payment limit (UPL) payment programs, as well as provider taxes, also vary widely by state.<sup>4</sup> Basing per capita caps on state-specific historical costs solidifies all these different decisions. This approach could be considered to reward states with richer programs while limiting the ability for states with leaner programs to expand coverage or increase provider reimbursement rates to be equitable with other states. The approach would also penalize states with the most efficient programs, because states with historically less-efficient programs would presumably have greater opportunities for savings to avoid state budget overruns.

Although state Medicaid programs are generally large enough to be fully credible in aggregate, expenditures, particularly for small(er) population categories, may vary by year. To the extent 2016 was a higher or lower year than average, using 2016 as a baseline may provide a significant advantage or disadvantage for states. It may be more appropriate to have flexibility to use an average of a few recent years of experience to determine a reasonable baseline.

### **Treatment of Medicaid expansion populations**

More than 14 million adults are currently covered through the Medicaid expansions.<sup>5</sup> Under current law, states receive enhanced federal funding for this population (federal match is 94 percent in 2018, phasing down to 90 percent by 2020). Discontinuing this enhanced funding could result in states discontinuing coverage, thus increasing the number of uninsured. Continuing this funding only for the states that opted to expand coverage, however, would further increase funding inequities across states.

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<sup>3</sup> <https://rules.house.gov/sites/republicans.rules.house.gov/files/115/PDF/115-AHCA-SxS-MNGR-Policy.pdf>

<sup>4</sup> The Commonwealth Fund, [Integrating Medicaid Supplemental Payments into Value-Based Purchasing](#), November 22, 2016.

<sup>5</sup> Kaiser Family Foundation State Health Facts "[Medicaid Expansion Enrollment](#)," January - March 2016. Accessed on March 20, 2017.

As currently written, the AHCA allows for continuation of Medicaid expansion coverage for those enrolled in the program as of Dec. 31, 2019, who do not have a break in coverage of more than one month. Federal funding for this “grandfathered” population would be based on a per capita amount tied to 2016 costs for this population (assuming states implemented expansion prior to the 2016 base year). The AHCA also requires a six-month redetermination of eligibility for the expansion population as well as additional documentation requirements (as opposed to the annual redetermination under current law). This approach to grandfathering the population and introducing potential barriers to continued participation could result in adverse selection among the Medicaid expansion population. Medicaid beneficiaries who continue to be grandfathered because their income stays below 133 percent of federal poverty level (FPL) and maintain continuous coverage could be the least healthy of the group, thus changing the characteristics of the group compared to the underlying 2016 base.

Under the AHCA, non-expansion states would have the option to expand adult coverage through 2019; however, any newly expanding state would receive its regular federal medical assistance percentages (FMAP) and not the current enhanced FMAP. The per capita cap for the expansion population would be based on the 2016 costs for the non-disabled, non-aged adult population. Based on the *2016 Actuarial Report on the Financial Outlook for Medicaid*, the average national per-enrollee spending for expansion adults was nearly 28 percent higher than the per-enrollee spending for non-aged, non-disabled adults in 2015.<sup>6</sup> While the averages represent a different mix of states and are thus not apples-to-apples, prior studies have indicated that Medicaid costs associated with childless adults are above those of “traditional” Medicaid adults.<sup>7</sup> Thus, the application of other adult per capita costs for expansion adults might lead to insufficient caps for the expansion population.

### **Growth rate methodology**

The manager’s amendment to AHCA uses CPI-U Medical (+1 percentage point for those elderly and disabled) to increase the per capita caps over time. Projected per enrollee Medicaid health care costs over the long term are expected to outpace CPI-U Medical as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., the costly new biological drugs recently made available), and unexpected events such as natural disasters or pandemics.<sup>8</sup> States can also make investments in one year with an expectation of program improvements or savings in future years (e.g., paying incentive bonuses to managed care organizations (MCOs) for improved outcomes). If CPI-U Medical does not keep pace with total health care cost changes, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

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<sup>6</sup> Centers for Medicare & Medicaid Services (CMS), [2016 Actuarial Report on the Financial Outlook for Medicaid](#), 2016

<sup>7</sup> CMS, [Medicaid Policy Brief](#), May 2011

<sup>8</sup> CMS, [2016 Actuarial Report on the Financial Outlook for Medicaid](#), 2016

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

### **Program flexibility provided to states**

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

### **Continuing actuarial soundness requirements**

Currently, more than 60 percent of Medicaid enrollees are covered through Medicaid MCOs.<sup>9</sup> To ensure that the capitation rates paid to these MCOs recognize all reasonable, appropriate, and attainable costs for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state. Payment of actuarially sound capitation rates to MCOs provides that:

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

Though not addressed in the AHCA, policymakers should continue to require actuarial soundness of capitation rates to ensure sustainability of capitated models. Payment of rates above or below levels necessary to induce MCOs to participate in the Medicaid program do not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the Medicaid program to the public. Rates that are below those levels are unsustainable in the

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<sup>9</sup> CMS, [Medicaid Managed Care Enrollment and Program Characteristics, 2014](#), Spring 2016.

long term and may cause MCOs to exit the Medicaid program. This leads to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs.

## **Individual Health Insurance Market**

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

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

Experience from the first three years of the Affordable Care Act (ACA) varies, with the markets in some states faring relatively well. More typically, however, the results thus far indicate the need for improvement along most of these measures. In general, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. Insurer participation and plan choice have been declining.

The comments that follow provide considerations underlying each of these key criteria as well as whether the provisions in the AHCA conform to these criteria and would lead to a more stable and sustainable market. When evaluating the overall impact, it is important to consider not only the impact of particular provisions, but also how the various provisions interact to affect enrollment decisions, premiums and cost sharing, and federal spending.

By creating a state stability fund, the AHCA could help lower premiums and stabilize the market, depending on how a state chooses to use the funds. The AHCA also recognizes that eliminating the individual mandate must be accompanied by other measures that would encourage enrollment, especially among healthy individuals. However, the legislation's continuous coverage requirement would likely not be strong enough to avoid lower enrollment and a deterioration of the risk pool. Additional measures would likely be needed to ensure market stability.

### **Individual enrollment at sufficient levels and a balanced risk pool**

Providing insurance protections to individuals with pre-existing conditions by prohibiting coverage denials, exclusions, or higher premiums based on health status requires that insurers enroll enough healthy individuals to spread the costs of the less healthy. Current law includes several provisions that aim to reduce the potential adverse selection effects of these protections. These include imposing a financial penalty for individuals who remain uninsured and providing premium and cost-sharing subsidies to lower the cost of coverage. Each encourages healthy individuals to obtain coverage. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. Increasing the incentives for enrollment, especially among those who are healthy, could increase overall enrollment and improve the risk pool.

The AHCA includes several provisions that would affect enrollment levels and the composition of enrollees:

Eliminating the individual mandate penalty and imposing a continuous coverage requirement.

The AHCA would eliminate the individual mandate penalty and replace it with a continuous coverage requirement. Individuals with a coverage gap of 63 days or more during the previous 12 months would be able to obtain coverage with pre-existing condition protections, but would pay a 30 percent premium surcharge for a year if purchasing coverage in the individual or small group market.

The current individual mandate is relatively weak because its financial penalty is usually low as a share of premiums, many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in combination with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. The AHCA includes a continuous coverage requirement intended to at least partially offset the deterioration of the risk pool resulting from an elimination of the individual mandate. The continuous coverage requirement would create some incentive for healthy individuals to obtain coverage—they would avoid a premium surcharge if desiring individual market coverage at a future time. Nevertheless, healthy individuals could forgo coverage and enroll during open enrollment or a special enrollment period when they need health care services. Delaying coverage would require payment of a penalty only upon enrollment and then only for a limited time period, as opposed to the current-law penalty, which applies every year an individual is uninsured. Lower enrollment among healthy individuals would likely result, especially if they would have to pay the premium surcharge due to having prior gaps in coverage, putting upward pressure on premiums, all else equal. The Congressional Budget Office (CBO) estimates that, given an elimination of the individual mandate, the continuous coverage requirement and penalty would initially increase enrollment in 2018, as people would enroll to avoid a future surcharge.<sup>10</sup> Thereafter, however, requirements to pay the surcharge or provide evidence of continuous coverage would reduce enrollment, especially among healthy people. Policymakers could consider whether lengthening the penalty period or adding a waiting period could strengthen the continuous coverage requirement.

If known in advance, insurers can reflect an elimination of the individual mandate penalty in their premiums. Premiums for 2017, however, are already final and in force. The AHCA would eliminate the penalty immediately, and CBO estimates that millions of enrollees in the individual market would drop coverage during 2017. Those dropping coverage would more likely be healthy individuals and those without immediate health care needs; individuals with ongoing or immediate health care needs would be more likely to retain coverage. As a result, the risk pool could deteriorate and premiums could be insufficient to cover claims in 2017. This may create further uncertainty for insurers as they consider how they plan to participate in 2018.

Changing the premium tax credit structure, eliminating cost-sharing reductions, and widening allowable age rating. Premium affordability can be a major factor for people as they decide whether to purchase coverage. Premiums reflect the composition of the risk pool, projected

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<sup>10</sup> Congressional Budget Office (CBO), [Cost Estimate of the American Health Care Act](#), March 13, 2017.

medical costs, insurer expenses, rules regarding how premiums can vary among individuals, and any premium subsidies.

Under current law, premium tax credits are based on income and the cost of the second-lowest silver tier plan, and are available for exchange enrollees with incomes up to 400 percent of the FPL without access to employer or public coverage. In addition, cost-sharing reductions are available to reduce the out-of-pocket costs for enrollees with incomes up to 250 percent of FPL. Nevertheless, premium affordability continues to be a problem.

Current law sets a cap on premiums as a percentage of income, with the cap increasing with income. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit. Such a structure automatically reflects how premiums vary by age and geographic area—premium subsidies are larger for enrollees who are older, lower-income, or living in high-cost areas. Cost-sharing reductions are provided through plans with enhanced actuarial values.

The AHCA would continue to offer tax subsidies for the purchase of insurance, recognizing their importance in improving premium affordability. The way these tax subsidies are structured would differ from that under current law. Beginning in 2020, the AHCA would replace the current premium subsidy structure with a flat tax credit by age, ranging from \$2,000 for individual market enrollees under age 30 to \$4,000 for enrollees age 60 and older. The credits grow over time by CPI plus 1 percentage point. They would be available in full for enrollees with incomes up to \$75,000 (\$150,000 for joint filers) and phase out for those with higher incomes. In addition, beginning in 2018, the AHCA would allow states to widen the allowable age variation in premiums from the 3-to-1 ratio in current law to a 5-to-1 ratio. Also beginning in 2020, the AHCA would eliminate the cost-sharing reductions.

Compared to the current premium subsidy structure, the proposed legislation would offer lower premium subsidies to enrollees who are older, lower-income, and living in high-cost or rural areas, and higher premium subsidies to enrollees who are younger, higher-income (up to the point at which the credits phase down to zero), and in lower-cost areas.<sup>11</sup> Over time, the tax credits would become less valuable as health spending and premium growth rates typically exceed CPI plus 1 percentage point. The elimination of the cost-sharing reductions would further increase the out-of-pocket costs for lower-income enrollees. The new subsidy structure, in combination with the change in age rating, would likely change the age distribution of enrollees by increasing enrollment among younger adults and reducing enrollment among older adults. The impact of subsidy and age rating changes on the risk pool profile also depends on the health status of enrollees. For example, lower subsidies for poorer and older individuals under the AHCA could reduce participation among healthy individuals from these subgroups. The higher the net premium, the more likely the enrollee population will skew to the less healthy.

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<sup>11</sup> CBO, [Cost Estimate of the American Health Care Act](#), March 13, 2017. Cynthia Cox, Gary Claxton, and Larry Levitt, [“How Affordable Care Act Repeal and Replace Plans Might Shift Health Insurance Tax Credits,”](#) Kaiser Family Foundation, March 10, 2017. Anna Mathews, [“GOP Health Plan Would Hit Rural Areas Hard,”](#) *Wall Street Journal*, March 13, 2017.

Conversely, the lower the net premium, the more likely the enrollee population will be more balanced by encouraging enrollment of healthy individuals.

The manager's amendment to the AHCA would reduce the threshold for claiming the medical expense deduction from 10 percent to 5.8 percent. However, the intention is to provide the Senate the flexibility to increase available premium tax credits to older adults.<sup>12</sup> The impact on tax credits, net premiums, enrollment, and the risk pool would depend on the amount of additional funding available and how the additional tax credits are targeted.

Creating a patient and state stability fund. The AHCA would allocate funds to the states for the purpose of lowering patient costs and stabilizing markets. In aggregate, \$15 billion would be allocated to states in 2018 and in 2019, and \$10 billion would be allocated each year from 2020 to 2026. Unless states choose another option, the default mechanism for 2018 and 2019 is for plans to be reimbursed a portion of the claims for high-cost enrollees. Using funds in this way can help to lower premiums and stabilize the market. For instance, the ACA created a transitional reinsurance program that was in effect from 2014 to 2016; the \$10 billion in funds available in 2014 were estimated to reduce premiums by about 10-14 percent.<sup>13</sup> The impact of the AHCA stability fund on individual market premiums in 2018 and 2019 depends on how the funds are allocated to states, whether a state decides to use the default option or another approach, and how many people are enrolled in the individual market (i.e., how many people the funds are spread among). Also there is a timeline issue that may preclude insurers from fully reflecting any available funds. Insurers are in the process of developing 2018 premiums. They will need to have final rules soon in order to incorporate any changes into the 2018 premiums.

The AHCA gives states broad flexibility in using the stability funds, including providing payments to health care providers, providing cost-sharing assistance, promoting access to preventive services, providing financial assistance to high-risk individuals, and reducing the cost of insurance coverage in the individual and small group markets. The impact on premiums would depend on how the funds are used. For instance, if funds are used to provide direct premium subsidies or to lower insurer claims for high-cost enrollees, net premiums would be reduced. However, if funds are used to directly increase payments to providers, premiums would not be affected.

As noted above, the AHCA would eliminate the cost-sharing reductions beginning in 2020. CBO projects that in 2016, \$7 billion were used to provide cost-sharing reductions for eligible enrollees.<sup>14</sup> States could use their stability fund grants to restore those subsidies, which would decrease the out-of-pocket costs for low-income enrollees. However, diverting funds for that purpose would reduce the amount of funds a state could use to lower premiums, for instance through reimbursing plans for a portion of their high-cost claims.

Eliminating actuarial value requirements and essential health benefits. Current law requires insurers selling coverage in the individual and small group markets to meet actuarial value

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<sup>12</sup> House Energy and Commerce Committee, "[House Republicans Announce Updates to Strengthen American Health Care Act](#)," Press Release, March 20, 2017.

<sup>13</sup> American Academy of Actuaries, [Drivers of 2015 Premium Changes](#), June 2014.

<sup>14</sup> CBO, [Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026](#), March 2016.

standards. Plans are categorized into benefit tiers (e.g., bronze, silver) based on their relative generosity. For example, bronze plans, the lowest coverage tier, must cover about 60 percent of average health spending. The AHCA would eliminate the actuarial value standards and allow insurers broader flexibility to design cost-sharing requirements, but it could make it more difficult for consumers to compare plans. Bronze-level plans would likely remain a plan generosity floor because current law out-of-pocket spending limits would continue. Insurers would be able to avoid the current law requirement that they offer at least one silver plan and one gold plan as a condition for participating on the exchange. As a result, insurers might focus more on offering bronze-level type coverage to offer lower premiums and to avoid attracting unhealthy enrollees into more generous coverage, although the risk adjustment process would continue to mitigate insurer incentives to avoid high-cost individuals. The lower premiums associated with bronze-level coverage compared to more generous coverage could be preferable for some consumers, especially those who would receive lower premium subsidies under the AHCA. However, less-generous coverage would increase out-of-pocket cost sharing incurred by enrollees receiving health care services and could lead to an increase in uncompensated care.

Current law requires that insurers cover 10 essential health benefits and specific rules regarding the extent to which those benefits are covered are determined through regulation. Although no changes to the essential health benefit requirements are proposed in AHCA, there have been suggestions that those requirements would be reduced or eliminated through changes in regulation.<sup>15</sup> The costs of specific benefits, such as maternity care or mental health and substance abuse services, are relatively small when spread over the entire insured population. Eliminating such services would not necessarily result in a large reduction in premiums. However, if those coverage requirements are removed and consumers are allowed to choose whether to have specific benefits, the additional premiums for those specific benefits will be high because only enrollees who expect to use them will opt for them.

### **Stable regulatory environment that facilitates fair competition / Sufficient health insurer participation and plan offerings to provide consumer choice**

A stable marketplace requires that rules be consistently applied to all competitors in order to prevent particular insurers from being inappropriately advantaged or disadvantaged. Inconsistent regulations can distort and fragment the market, reducing competition and limiting consumer choices. Uncertainty in the regulatory environment can also impact premium adequacy and stability. Under current law, competing plans generally face the same rules. However, the uncertain and changing regulatory environment has contributed to adverse experience among insurers and declines in insurer participation and consumer plan choice. For instance, in states using the federal marketplace, 21 percent of enrollees have only one participating insurer for 2017.<sup>16</sup> Even more people could be affected in 2018 as additional insurers have decided to or are considering withdrawing from the market.

Eliminating the individual mandate, changing the premium subsidies, and eliminating cost-sharing subsidies could potentially increase the uncertainty and instability of the individual health insurance market, and result in additional insurer withdrawals and reduced consumer

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<sup>15</sup> Speaker Ryan Press Office, "[The Three Phases of Repeal and Replace](#)," March 7, 2017.

<sup>16</sup> Caroline F. Pearson, [2017 Open Enrollment Preview](#), Avalere, October 25, 2016.

choice. The stability fund could offset the potential deterioration of the risk pool, at least in part. However, there is also uncertainty with respect to how a state would direct the use of its stability funds and whether the details would be finalized soon enough for insurers to incorporate them into 2018 premiums. Allowing the sales of insurance across state lines and expanding access to association health plans (AHPs), highlighted as components of subsequent health reform efforts, could further destabilize insurance markets.

Allowing the sales of insurance across state lines. Although not included in the AHCA, it has been suggested that selling across state lines is a solution; allowing insurance sales across state lines has been discussed as a component of health reform, with the goal of increasing competition in states with few competitors and offering more affordable coverage in states with high premiums. However, premiums would reflect local health costs, regardless of where an insurer is licensed. In addition, out-of-state insurers, especially small or regional insurers, could have more difficulty developing provider networks and negotiating provider payment discounts, further limiting the ability to lower premiums.

From a market stability standpoint, allowing insurance sales across state lines could lead to competitors being subject to different rules, resulting in market fragmentation. Under current law, most of the issue, rating, and benefit rules applying to the individual and small group markets are similar nationwide. If insurers are allowed to sell across state lines and states are given more flexibility regarding market rules, insurers licensed in states with less restrictive rules will attract healthier enrollees, whereas insurers licensed in states with more restrictive rules will attract less-healthy enrollees. Premiums for insurance licensed in states with the more restrictive rules would increase, and the viability of those insurers would be threatened. Younger and healthier individuals would be able to find coverage in less restrictive states, but older individuals and those with health problems could find it more difficult to obtain coverage.

Expanding access to association health plans (AHPs). Expanding AHPs, for instance through H.R. 1101, the *Small Business Health Fairness Act of 2017*, would cause similar challenges to market stability as allowing insurance sales across state lines. Although AHPs would be offered in competition with other small group and individual market plans, they could operate under different rules. The consequence of different rules for AHPs versus state-regulated insured plans is a fragmentation of the market resulting from an unlevel playing field. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals. If an AHP is allowed to follow the issue, rating, and benefit rules of a single state nationwide, or be preempted from state regulation by being self-insured, it would impose different rules on insurance providers offering coverage in the same market. The viability of many state-based markets would be challenged as a result. If the rules governing AHPs were consistent with those governing non-AHPs, there would be fewer concerns about market fragmentation. Aside from market fragmentation concerns, self-funded AHPs would face increased risk of insolvency without clearly defined regulatory authority and capital requirements similar to insuring entities.

### **Low health spending growth and high quality of care**

Because most premium dollars go toward paying medical claims, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires controlling health care costs. Medical spending trends for the individual market reflect those for the health system as a

whole. In recent years, health spending has been growing relatively slowly compared with historical averages, but there are signs that health spending growth rates are beginning to increase. There is also evidence that we are not spending our health care dollars wisely. Therefore, it is important not to overlook the need for a continued focus on controlling health care spending and improving quality of care.

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To be sustainable, the individual market requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings. Experience from the first three years of the ACA varies, with the markets in some states faring relatively well. More typically, however, the results thus far indicate the need for improvement along most of these measures.

Provisions in the AHCA that would eliminate the individual mandate and impose a continuous coverage requirement with a penalty, change the premium tax credit structure, and eliminate cost-sharing reductions could have unintended consequences. Rather than increasing the stability and sustainability of the individual market by improving the enrollee risk pool, they could result in a deterioration of the risk pool. Creating a patient and state stability fund, on the other hand, could improve the stability of the market and lower premiums, depending on how the funds are used. Although not included in the AHCA, other phases of reform could include allowing the sales of health insurance across state lines and expanded access to association health plans. These approaches could threaten the viability of non-AHPs and plans in states with more restrictive rules, which could make it more difficult for high-cost individuals and groups to obtain coverage.

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We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact Heather Jerbi ([jerbi@actuary.org](mailto:jerbi@actuary.org)), the Academy's assistant director of public policy, at 202-785-7869, or David Linn ([linn@actuary.org](mailto:linn@actuary.org)), health policy analyst, at 202-785-6931.

Sincerely,

Karen Bender, MAAA, ASA, FCA  
Chairperson, Individual and Small Group Market Committee  
American Academy of Actuaries

Michael E. Nordstrom, MAAA, ASA  
Chairperson, Medicaid Subcommittee  
American Academy of Actuaries

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

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

[\*An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes\*](#)

(Issue paper, January 2017)

[\*Selling Insurance Across State Lines\*](#) (Issue brief, February 2017)

[\*Association Health Plans\*](#) (Issue brief, February 2017)

[\*Using High-Risk Pools to Cover High-Risk Enrollees\*](#) (Issue brief, February 2017)

[\*Proposed Approaches to Medicaid Funding\*](#) (Issue brief, March 2017)