



AMERICAN ACADEMY of ACTUARIES

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June 30, 2017

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

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

Re: The Better Care Reconciliation Act of 2017 (BCRA)

Dear Leader McConnell and Leader Schumer:

On behalf of the Health Practice Council's (HPC) Individual and Small Group Markets Committee and Medicaid Subcommittee of the American Academy of Actuaries,¹ the national association for the U.S. actuarial profession, we hope you will take our comments into consideration on the *Better Care Reconciliation Act of 2017* (BCRA). The Academy's 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 the Senate proposal's revisions to the individual health insurance market and new approaches to federal Medicaid funding.

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

Individual Health Insurance Market

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) has varied, with the markets in some states faring relatively well. More typically, however, the results thus far indicate the need for improvement along most of these criteria. In general, enrollment in the

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

individual market has been lower than initially expected and enrollees have been less healthy than expected. The uncertain and changing legislative and regulatory environment—including legal challenges, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—has contributed to adverse experience among many insurers. As a result of these and other factors, insurer participation and consumer plan choice decreased in 2016 and 2017. Insurers are currently making their decisions on whether to participate in the market in 2018, and if so, where to set their premiums. Continued uncertainty adds to the risk that insurers will discontinue their participation.

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

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

The comments that follow assess the provisions in the BCRA against these criteria. We separately assess the near-term and long-term impacts of the bill. Notably, 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.

Near-Term Effects

In the near term, the BCRA would fund the CSRs through 2019, eliminate the individual mandate retroactively to 2016, and provide significant external funding for short-term federal financial assistance. Although not specified in the bill, it is our understanding that the short-term assistance will be in the form of a reinsurance program that covers a portion of the claims for high-cost enrollees.

Explicitly appropriating funds for the CSRs would remove the related uncertainty for insurers and avoid the premium increases that would average nearly 20 percent if the CSRs are not paid.²

Eliminating the individual mandate would put upward pressure on premiums. The mandate was intended to encourage healthy individuals to enroll. Its financial penalty is usually low as a share of premiums, many individuals are exempt, and enforcement is weak. Nevertheless, the mandate, especially in conjunction with the premium- and cost-sharing subsidies, likely increases enrollment above what it would otherwise be. In their 2018 rate filings, some insurers have commented on the impact of a weakened or eliminated mandate. For instance, the Pennsylvania insurance commissioner announced that if the mandate is repealed, 2018 premiums would be an

² Kaiser Family Foundation; “[Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies; Estimated Increases Range from 9% in North Dakota to 24% in Mississippi](#)”; April 6, 2017.

estimated 15 percent higher on average.³ Eliminating the mandate removes the incentives for individuals to enroll, leading to a deterioration of the risk pool as those most likely to enroll in a guaranteed-issue environment are those with higher health care needs.

If known in advance, insurers can reflect an elimination of the individual mandate penalty in their premiums. Premiums for 2017, however, are already final and in force. The BCRA would eliminate the penalty retroactively, and many individuals could drop coverage this year. Those dropping coverage would 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.

BCRA would impose a continuous coverage requirement to mitigate the upward pressure on premiums. 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 have to wait six months before coverage becomes effective. Adding a waiting period could slightly increase enrollment. The larger impact would be to partially protect the risk pools from the high claims of individuals waiting to enroll until they have high health needs. Such a program may help to bring some additional stability to the individual pool, but may not be sufficient.

Short-term stabilization funding in the form of a reinsurance program could offset, at least in part, the premium increases arising from an elimination of the individual mandate. The BCRA allocates \$15 billion in both 2018 and 2019, and \$10 billion in both 2020 and 2021, for short-term stabilization funding, and it is our understanding that it would be used for a reinsurance approach. The bill also specifies that from 2019 to 2021 at least \$5 billion annually from the long-term state stability and innovation program be used by states for similar activities. 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.⁴ The impact of the BCRA stability funds on individual market premiums in the near term depends on the parameters of the program and how many people are enrolled in the individual market (i.e., how many enrollees the funds are spread among). There is a timeline issue that may preclude insurers from fully reflecting any available funds. Insurers are in the process of filing 2018 premiums. They will need to have final rules soon in order to incorporate any changes into the 2018 premiums. Importantly, external funds that are used to reduce premiums would also reduce federal premium subsidy payments.

³ Pennsylvania Insurance Department; [“Insurance Commissioner Announces Single-Digit Aggregate 2018 Individual and Small Group Market Rate Requests, Confirming Move Toward Stability Unless Congress or the Trump Administration Act to Disrupt Individual Market”](#); June 1, 2017.

⁴ American Academy of Actuaries; [Drivers of 2015 Premium Changes](#); June 2014.

Long-Term Effects

In addition to the elimination of the individual mandate, in the medium and long term, the BCRA would: change the premium tax credit structure, eliminate cost-sharing reductions, and widen allowable age rating; create a long-term stability and innovation program; allow more flexibility to Section 1332 State Innovation Waivers, potentially to loosen actuarial value (AV) and essential health benefit (EHB) requirements; and expand the use of association health plans (AHPs).

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 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 federal poverty level (FPL)⁵ 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 BCRA would continue to offer premium tax credits for the purchase of insurance, recognizing their importance in improving premium affordability. The way these tax credits are structured would differ from that under current law. Beginning in 2020, the BCRA would continue to set a cap on premiums as a percentage of income, but the caps would vary not only by income, but also by age. The caps would range from 2 to 4 percent of income for those with incomes up to 150 percent of FPL regardless of age. At higher incomes, caps would diverge by age, with older adults expected to pay a larger share of income toward premiums than younger adults, especially as income increases. The greatest difference occurs for those with incomes from 300 to 350 percent of FPL; adults younger than 30 would be expected to pay 4.3 to 6.3 percent of income toward premiums, whereas adults age 60 and older would be expected to pay 11.5 to 16.2 percent of income toward premiums. As under the ACA, the premium cap percentages increase over time if premium growth exceeds income growth, but they have the potential to increase faster under the BCRA. Income eligibility for premium subsidies would change from the current 100 to 400 percent of FPL to 0 to 350 percent of FPL.

⁵ The 2017 federal poverty level for the 48 contiguous states and the District of Columbia is \$12,060 for an individual and \$24,600 for a family of four. Federal poverty levels are set higher for Alaska and Hawaii. (Office of the Assistant Secretary for Planning and Evaluation; “[Poverty Guidelines](#)”; January 2017.)

The BCRA sets the benchmark plan to the median 58 percent actuarial plan (which is also the lowest range for bronze tier plans)⁶ rather than the second-lowest silver tier plan, resulting in an overall reduction in tax credits, which reflect the difference between the benchmark premium and the premium cap. For any given premium cap, enrollees would receive lower premium subsidies under BCRA than under the ACA. In addition, because the BCRA benchmark plan is less generous, it would require higher cost-sharing, most likely in the form of much higher deductibles,⁷ than the current silver benchmark plan approach.

Aside from changes to the subsidy structure, the BCRA would widen the allowable age variation in premiums from the 3-to-1 ratio in current law to a 5-to-1 ratio beginning in 2019. And the BCRA would eliminate the cost-sharing reductions beginning in 2020.

Compared to the current premium subsidy structure, the proposed legislation would generally have lower premium caps for enrollees who are younger, somewhat lower caps for those with incomes below 150 percent of FPL regardless of age, and higher caps for older adults with incomes exceeding about 200 percent of FPL. Adults with incomes below 100 percent of FPL would be newly eligible for premium subsidies under the BCRA. The overall reduction in premium subsidies could reduce enrollment in general. And the change in the subsidy structure, in combination with the change in age rating, would likely change the age distribution of enrollees by increasing the share of enrollees who are young adults and decreasing the share who are older adults.

The impact of the changing rules on the risk pool profile, and therefore overall premiums, also depends on the generosity of the benchmark plan and the elimination of the cost-sharing subsidies. The higher the net premium and potential cost-sharing outlays, the more likely the enrollee population will skew to the less healthy. Conversely, the lower the net premium and potential cost-sharing outlays, the more likely the enrollee population will be more balanced by encouraging enrollment of healthy individuals. Lowering net premiums for benchmark plans to younger adults could improve the risk pool profile by encouraging enrollment among healthy young adults. However, the elimination of the cost-sharing subsidies and the less-generous benchmark plan could result in a deterioration in the health status among low-income enrollees, even though they could face lower net premiums than under current law. The higher cost-sharing associated with the benchmark plan could discourage enrollment among subsidy-eligible individuals who don't expect to use a lot of health care services. Similarly, higher premiums for older adults due to the wider allowable age rating variation could reduce participation among healthy older adults.

Creating a long-term state stability and innovation program. In addition to the short-term federal funding in 2018–2021 expected to be used for a reinsurance-type program, the BCRA would allocate funds to the states for the purpose of lowering patient costs and stabilizing markets. Funding would vary by year: \$8 billion in 2019, \$14 billion in 2020 and in 2021, \$6 billion in

⁶ Because of the ACA's maximum out-of-pocket limits, it is difficult for bronze plans to achieve an actuarial value as low as 58 percent.

⁷ In 2017, the average deductibles for individual coverage in silver and bronze plans are about \$3,600 and \$6,000, respectively. (Congressional Budget Office; [Cost Estimate of H.R. 1628 Better Care Reconciliation Act](#); June 26, 2017.)

2022 and in 2023, \$5 billion in 2024 and in 2025, and \$4 billion in 2026. As noted above, for years 2019–2021, at least \$5 billion of the state allotment must be used toward arrangements with insurers to stabilize premiums and promote market competition, and our understanding is that these would be reinsurance-type programs. The remainder of a state’s allocation could be used toward providing financial assistance to help high-risk individuals without access to other coverage obtain insurance in the individual market, to provide payments to health care providers, or to provide cost-sharing assistance. Beginning in 2022, states have a required match rate of 7 percent, which increases by 7 percentage points each year, reaching 35 percent in 2026.

Depending on how these funds are used, they could help to lower premiums and stabilize the market. 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 with the short-term stability funding, external funds that are used to reduce premiums would also reduce federal premium subsidy payments.

As noted above, the BCRA would eliminate the cost-sharing reductions beginning in 2020. The Congressional Budget Office projects that in 2016, \$7 billion were used to provide cost-sharing reductions for eligible enrollees.⁸ States could use their stability fund grants to partially 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 through 1332 waivers.

Current law requires insurers selling coverage in the individual and small group markets to meet actuarial value (AV) 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. Current law also requires that insurers cover 10 essential health benefits (EHBs) and specific rules regarding the extent to which those benefits are covered are determined through regulation.

Although the BCRA keeps those provisions in place, its proposed changes to the Section 1332 waiver process would make it easier for states to revise or eliminate those standards. The current Section 1332 application process requires that the proposed alternative approach offer coverage and cost-sharing protections at least as comprehensive, cover as many people, and not increase federal spending. In contrast, under the BCRA, the 1332 application process would be expedited and would only require that the alternative approach not increase federal spending. The prohibitions on 1332 waivers eliminating guaranteed issue and community-rating rules would remain, but states could opt to revise or eliminate AV and EHB requirements. Increasing plan design flexibility would allow insurers more flexibility, but it could make it more difficult for consumers to compare plans and could increase adverse selection concerns.

Removing AV requirements could reduce plan generosity, thereby increasing the out-of-pocket cost-sharing requirements enrollees would face. If out-of-pocket spending limits remain in place,

⁸ Congressional Budget Office; [Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026](#); March 2016.

bronze-level plans would likely remain a plan generosity floor, but insurers would be allowed to have lower-AV plans if the out-of-pocket spending limits were also relaxed or eliminated. This would result in lower-premium options for consumers. If insurers no longer have to comply with the current-law requirement that they offer at least one silver plan and one gold plan as a condition for participating on the exchange, they might focus more on offering bronze- and lower-level coverage to offer lower premiums and to avoid attracting unhealthy enrollees into more generous coverage. The lower premiums associated with less-generous coverage compared to more-generous coverage could be preferable for some consumers, especially those who would receive lower premium subsidies under the BCRA. 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. The risk adjustment process would continue to mitigate insurer incentives to avoid high-cost individuals. Nevertheless, larger differences in relative plan generosity would lead to more selection risk, which would increase the risk adjustment transfers across AV levels and could further complicate the risk adjustment process.

States could use 1332 waivers to reduce the EHB requirements or eliminate them altogether. The costs of specific benefits, such as maternity care or mental health and substance abuse services, are relatively small when spread over the entire insured population.⁹ Eliminating such services would not necessarily result in a large reduction in premiums. However, if those coverage requirements are removed and consumers are allowed to choose whether to have specific benefits, the additional premiums for those specific benefits will be high because insurers would expect that only enrollees who expect to use them would opt for them. Also, reducing the comprehensiveness of coverage would erode out-of-pocket protections, as only out-of-pocket spending used toward covered benefits would count toward an enrollee's out-of-pocket limit, and annual and out-of-pocket limits would not apply to non-essential benefits. Reducing the comprehensiveness of coverage or increasing the variation of EHB requirements would increase the need for risk adjustment to reduce insurer incentives to avoid high-cost enrollees or enrollees with particular conditions. However, increased flexibility in benefit designs could make the implementation of risk adjustment more challenging. As a result, a reduction in or elimination of EHB requirements could lead to a deterioration in pre-existing condition protections.

Expanding access to association health plans (AHPs). The BCRA would create small business health plans that in effect are federally certified AHPs. Expanding AHPs would create challenges to market stability. 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 pre-empted from state regulation by being self-insured, different rules would be imposed 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

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

AHPs would face increased risk of insolvency without clearly defined regulatory authority and capital requirements similar to insuring entities.

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.

By paying the CSRs over the next two years and creating a stability fund, the BCRA would reduce uncertainty and put downward pressure on premiums in the short term. On the other hand, eliminating the individual mandate would reduce enrollment and put upward pressure on premiums. The continuous coverage requirement with the six-month waiting period could slightly offset the reduction in enrollment and reduce some of the costs to plans of people waiting to enroll until they have high health costs.

Over the long term, provisions in the BCRA that would change the premium tax credit structure and eliminate CSRs could have unintended consequences. By itself, widening allowable age rating could encourage younger adults to enroll. Nevertheless, the risk pool could deteriorate due to lower overall premium subsidies tied to less-generous plans and the elimination of the individual mandate. The long-term stability funds could help stabilize the market, but only if they are used for activities that would lower net premiums. Allowing more flexibility in plan generosity and comprehensiveness through a less-rigorous 1332 waiver process could reduce premiums by reducing the scope of benefits covered, but would also increase out-of-pocket costs and could erode pre-existing condition protections. Allowing expanded access to AHPs could threaten the viability of non-AHPs, which could make it more difficult for high-cost individuals and groups to obtain coverage.

Approaches to Medicaid Funding

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

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

While the following analysis focuses primarily on per capita cap projection development, the concepts also apply to the block grant option. As outlined in our recent issue brief,¹⁰ 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.

¹⁰ [Proposed Approaches to Medicaid Funding](#); March 2017.

Approach to setting state caps. Medicaid per capita costs vary by state based on state decisions such as covered populations and benefits, provider reimbursement levels, and delivery system approach. Medicaid provider pass-through supplemental and upper payment limit payment programs, as well as provider taxes, also vary widely by state.¹¹ Basing per capita caps on state-specific historical costs solidifies all these different decisions. This approach could be regarded as rewarding 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. This 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. BCRA does attempt to push caps toward a national average by increasing/decreasing caps (modestly) if they are 25 percent below/above national averages (with five very rural states excluded). Because age distribution and disease burden within population cohorts may change over time, consideration should also be given to allowing adjustments where there are significant demographic and health risk changes.

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. While the eight consecutive quarter calculation allows for smoothing of a historical baseline, it may be prudent to allow the secretary of the Department of Health and Human Services to establish new state baselines on a periodic basis.

Treatment of Medicaid expansion populations. More than 14 million adults are currently covered through the ACA Medicaid expansions.¹² 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). Phasing out this enhanced funding, especially combined with the scheduled Disproportionate Share Hospital (DSH) cuts for expansion states as originally proposed, could result in states discontinuing coverage, thus increasing the number of uninsured.

For a non-expansion state that decides to expand coverage after fiscal year 2016, the per capita cap for the expansion population would be based on the historical data for the non-elderly, non-disabled 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 2015.¹³ 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.¹⁴ Thus, the application of current adult per capita costs for expansion adults might lead to insufficient caps for a newly adopted expansion state population. The introduction of an adjustment factor to reflect the morbidity variance in the calculation could

¹¹ The Commonwealth Fund; [Integrating Medicaid Supplemental Payments into Value-Based Purchasing](#); Nov. 22, 2016.

¹² Kaiser Family Foundation State Health Facts; “[Medicaid Expansion Enrollment](#)”; January–March 2016. Accessed on June 30, 2017.

¹³ Centers for Medicare & Medicaid Services (CMS); [2016 Actuarial Report on the Financial Outlook for Medicaid](#); 2016.

¹⁴ CMS; [Medicaid Policy Brief](#); May 2011.

increase the per capita base amount to a level more reflective of the expansion population in a new expansion state, and so states should be able to recommend risk adjustment methodologies.

Growth rate methodology. Projected per-enrollee Medicaid health care costs over the long term are expected to outpace CPI-U¹⁵ Medical, as health care cost growth is driven not just by unit cost increases, but also by utilization increases, new treatments (e.g., costly biological drugs recently made available), and unexpected events such as natural disasters or pandemics.¹⁶ With the reduction of the growth rate to reflect the CPI-U, the projected per-enrollee federal Medicaid health care funding over the long term will be further constrained. The CPI-U is projected by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary to be approximately 1.6 percentage points below CPI-U Medical (i.e., 2.6% vs. 4.2%) for 2019–2025.¹⁷ On the other hand, Medicaid health care cost per enrollee are projected to trend at 4.8 percent by 2025.¹⁸

As discussed above, state Medicaid per capita health care cost trends are driven by changes in the cost of services, new technologies, and utilization of services. 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). Per above, it is not anticipated the CPI-U will keep pace with total health care cost changes, therefore, it will likely be difficult for states to sustain or improve their current programs. Efforts to close budget gaps including eligibility and benefit changes may reduce Medicaid spending, but they will not reduce total spending; the cost of care will be transferred to providers, insurers, employers, and to the individuals who seek needed care.

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

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

¹⁵ Consumer Price Index for All Urban Consumers.

¹⁶ CMS; [2016 Actuarial Report on the Financial Outlook for Medicaid](#); 2016.

¹⁷ Department of Health and Human Services; [2016 Actuarial Report on the Financial Outlook for Medicaid](#); Table 16, Page 59.

¹⁸ *Health Affairs*; “[National Health Expenditure \(NHE\) Projections, 2016-25](#)”; Exhibit 2, Page 3; Feb. 15, 2017.

designated for other state programs to Medicaid. Additionally, BCRA phases down the provider tax safe harbor from 6 percent (as allowed under current regulations) to 5 percent in 2025, limiting a funding lever for states. States obviously do not have unlimited funding for their Medicaid programs, so not allowing additional state flexibility could create a financially unsound funding mechanism for Medicaid programs. The block grant option for states does provide several elements of flexibility for state consideration.

Continuing actuarial soundness requirements. Currently, more than 60 percent of Medicaid enrollees are covered through Medicaid MCOs.¹⁹ To ensure that the capitation rates paid to these MCOs recognize all reasonable, appropriate, and attainable costs for the services they provide, federal law requires actuarial soundness of the capitation rates they receive from the state.

Payment of actuarially sound capitation rates to MCOs provides that:

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

Though not addressed in BCRA, 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 does not serve the public interest. Capitation rates that are above such levels unnecessarily increase the cost of the Medicaid program to the public. Rates that are below those levels are unsustainable in the long term and may cause MCOs to exit the Medicaid program. This leads to breaks in continuity of care for beneficiaries, potentially lowering quality of care and increasing costs.

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

Sincerely,

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

¹⁹ CMS; [Medicaid Managed Care Enrollment and Program Characteristics, 2014](#); Spring 2016.

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

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

[*How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*](#) (Issue brief, May 2017)

[*Steps Toward a More Sustainable Individual Health Insurance Market*](#) (Issue brief, April 2017)

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

[*Comments to U.S. House on American Health Care Act \(AHCA\)*](#) (March 2017)

[*Comments on market stabilization proposed rule*](#) (March 2017)

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

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

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

[*An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*](#)
(Issue paper, January 2017)

[*Comments to Congress on Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements*](#) (December 2016)