Testimony Before the Ways & Means Committee of the U.S. House of Representatives

Hearing on Rising Health Insurance Premiums Under the Affordable Care Act

Christopher E. Condeluci, Esq.
Principal and Sole Shareholder
CC Law & Policy PLLC

July 12, 2016

Thank you Chairman Brady, Ranking Member Levin, and members of the Committee for the opportunity to speak with you today. My name is Chris Condeluci. I am the sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the Patient Protection and Affordable Care Act ("ACA"). Prior to starting my own practice, I served as Counsel to the Senate Finance Committee. During my time on the Finance Committee, I participated in drafting portions of the ACA, including the ACA Exchanges, the State insurance market reforms, and all of the taxes under the law.

In my current practice, I provide legal counsel on the statutory and regulatory requirements impacting stakeholders ranging from employers and insurance carriers to the ACA Exchanges and private exchanges. I also provide policy analysis relating to the manner in which the ACA is being implemented by the Obama Administration. This includes observing and analyzing the evolution of the newly reformed "individual" and "small group" health insurance markets, and the impact the ACA is having on large fully-insured and self-insured "group health plans."

Organization of Testimony

My written testimony is organized into four parts. First, I talk generally about some of the factors contributing to rising health insurance premiums under the ACA, and also the results that are produced from these factors. Second, I provide technical explanations of (1) the statutory rules and (2) the implementation decisions that I believe are the factors that are responsible for the current state of the insurance markets and the premium increases in the individual market. Third, I talk about the ACA's "risk stabilization" programs (often times referred to as the "3 Rs"), and explain how these programs are contributing to the most recent premium increases. And finally, I discuss various issues relating to employer-sponsored insurance.

Part I – Factors and Results

A. Factors Contributing to Premium Increases

It is important emphasize at the onset of my testimony that there is no one single event – or ACA implementation decision – that has contributed to rising health care costs and premium rates. Instead, there are a number of contributing factors that when added up in the aggregate, can objectively be viewed as the causes for the premium increases consumers are experiencing in the individual market. These factors include:

(1) The statutory requirements under the ACA itself – in particular, the minimum insurance standards that insurance policies sold in the individual and small group markets must now meet, in addition to the "adjusted community" premium rating rules.

   (a) These statutory requirements limit an insurance carrier's ability to develop plan designs that are attractive to younger, healthier individuals; and
   (b) The new minimum insurance standards – in addition to the 3 to 1 age variant now required when developing premium rates – push premium rates higher.

(2) Two ACA implementation decisions that have been made by the Obama Administration.

(a) The Administration's "transitional policy," which allowed individuals and employees of small employers to remain covered under a non-ACA-compliant plan past January 1, 2014 (the effective date of the ACA's insurance market reforms); and
(b) Limited enforcement of the eligibility criteria for enrollment during certain "special enrollment periods."

(3) The failure of the "individual mandate" penalty tax having its intended effect of encouraging younger, healthier individuals to purchase health insurance coverage.

B. The Results Produced From These Factors

It is also important to establish why premium rates are going up in the individual market. In other words, it is important to understand what results the factors discussed above (and described more fully below) are producing. In short, these factors are resulting in an "unbalanced risk pool." And, the consequences of an unbalanced risk pool are increased premiums.

An Unbalanced Risk Pool In the Individual Market

In the case of the individual market, an objective analyst will tell you that the current individual market risk pool is unbalanced (i.e., the risk pool is made of a greater number of less healthy, high-medical utilizers and a smaller number of younger, healthier individuals). For example, data from the Department of Health and Human Services ("HHS") indicates that only 28% of Americans enrolled in an individual market plan offered through an ACA Exchange are between the age of 18 and 34.[1] Actuaries have suggested that 40% of Exchange enrollees in this age cohort are needed to ensure a balanced risk pool.

In addition, insurance carriers have indicated that a larger percentage of high-risk individuals have entered the market than was originally anticipated, due in large part to enrollment during special enrollment periods. Specifically, insurance carriers participating in the ACA Exchanges have contended – and HHS has acknowledged – that an increasing number of people (1) have enrolled in an Exchange plan during a special enrollment period, (2) they have utilized a significant amount of medical services, then (3) these individuals ultimately dropped their insurance coverage shortly after receiving the medical care, which resulted in (4) these individuals failing to pay in enough premiums over the course of a full year to cover the medical claims they incurred. In my opinion, the drafters of the ACA never expected people would "game the system" this way, and the drafters actually expected HHS would enforce the eligibility criteria for special enrollment enrollees in a manner similar to the employer market, where eligibility must be proven before enrollment can be effectuated. But, this is a reality that has contributed to an unbalanced risk pool, and one of the root causes for the significant losses experienced by a majority of the insurance carriers participating in the new marketplaces.

---

[1] *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016, page 3 at https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

Importantly, when faced with an unbalanced risk pool, insurance carriers have historically increased premiums to cover the abnormally high medical claims that are not adequately offset by the premium revenue (and lower medical claims) generated from younger, healthier individuals. As premiums increase, however, insurance coverage becomes less attractive to younger, healthier individuals, as well as individuals (1) who are not eligible for a premium subsidy under the ACA and (2) who are paying the full cost of a plan's premiums out of their own pocket (and who tend to be younger and/or healthier). As a result, these individuals are less likely to enroll in a health plan, which effectively results in a stagnant risk pool of less healthy enrollees.

Attracting Younger and Healthier Individuals Into the Individual Market Risk Pool?

One logical solution to balancing out the individual market risk pool is attracting more younger and healthy individuals into the market. However, due to the manner in which the ACA constrains insurance carriers in developing plan designs that may appeal to younger and healthier individuals, these consumers are less likely to enter the individual market. In addition, the 3 to 1 age variant now required when developing premium rates increases premiums for younger, healthier individuals, which discourages these "good health risks" from obtaining coverage. If younger and healthier individuals do not enter the market, the risk pool will remain unbalanced, which will cause insurance carriers to continually increase premiums year-over-year. These increased costs will likely make individual market plans – even subsidized coverage made available through the ACA Exchanges – unappealing to younger and healthier individuals, thus serving as an additional deterrent to entering the risk pool. This circular pattern may continue for years to come, never abating.

Is the Individual Mandate Penalty Tax Working?

Another solution is allowing the individual mandate penalty tax to achieve its intended result, which is encouraging more Americans to obtain health insurance coverage, which will result in a greater number of individuals entering the ACA's newly reformed risk pool. If a greater number of younger, healthier individuals entered the insurance markets, this will result in more healthy risks entering the risk pool.

Unfortunately, to date, objective analysts have *not* found that the individual mandate is causing younger, healthier individuals to, for example, purchase an individual market plan through an ACA Exchange (evidenced by HHS's data discussed above). And, while the individual mandate penalty has increased by 600% in just three years,[2] the individual mandate penalty will only be indexed to the Consumer Price Index ("CPI") beginning in 2017 and beyond. This effectively means that the penalty tax will no longer increase significantly year-over-year. If the penalty tax is currently *not* having the intended effect of encouraging younger, healthier individuals to purchase health coverage now, it is unlikely that a slow-growing individual mandate penalty tax will have a substantive impact in future years, especially in the face of continued premium increases.

[2] In 2014, the individual mandate penalty tax was equal to the greater of (1) $95 or (2) 1% of an individual's (or a family's) household income. In 2015, the tax increased to the greater of (1) $325 or (2) 2% of an individual's (or a family's) household income, and in 2016, the penalty tax increases to the greater of (1) $695 or (2) 2.5% of an individual's (or a family's) household income.

Part II – Technical Explanations of Factors and Results

A. The ACA and the New Minimum Insurance Standards

Based on my experience during the debate and development of the ACA, I believe there were two main drivers for enacting the new health care reform law: (1) Expanding health insurance coverage to as many Americans as possible and (2) Requiring that insurance policies provide an adequate level of health care coverage. To meet this latter policy goal, the drafters of the ACA required insurance policies sold in the individual and small group markets to meet certain minimum standards beginning in 2014. These minimum standards include (1) the "essential health benefits" ("EHBs") requirement, (2) the cost-sharing limitations (otherwise referred to as the "out-of-pocket maximum limitations"), and (3) the "actuarial value" ("AV") requirement. The ACA's insurance market reforms also included two additional requirements that were intended to make the individual and small group health insurance markets much more functional markets. They include (1) the new "adjusted community" premium rating rules and (2) the "single risk pool" requirement. See **APPENDIX A** for a more detailed description of the ACA's minimum insurance standards and the premium rating and single risk pool requirements.

The ACA Minimum Insurance Standards and New Premium Rating Rules Push Premiums Higher

An objective argument can be made that the ACA's minimum insurance standards and other requirements such as the "adjusted community" premium rating rules are direct causes for premium increases under the ACA. For example, with respect to the "adjusted community" premium rating rules, the Congressional Budget Office ("CBO") estimates that this new requirement tends to raise premiums for two reasons:

- First, prohibiting insurance carriers from varying premiums based on "health status" lowers premiums for high-risk individuals, but these actions raise premiums for people with lower health risks. The result: Higher-risk individuals are encouraged to obtain health insurance coverage, while lower-risk individuals are discouraged from obtaining such coverage, producing an unbalanced risk pool of enrollees (which, as stated above, has historically resulted in higher premiums).

- Second, the 3 to 1 limit on varying premiums by age increases premiums for younger individuals and decreases premiums for older individuals because older individual's health costs exceed younger individual's by a larger degree than a 3 to 1 ratio. For example, CBO cites a study that shows that health care spending for a 64 year old is about 4.8 times as high as spending for a 21 year old.[3] Based on this, CBO explains that the 3 to 1 limit effectively encourages older people to enroll, while discouraging younger people from obtaining coverage, which again, results in an unbalanced risk pool and increased premiums.

[3] *Health Care Costs – From Birth to Death*, Society of Actuaries, June 2013, page 44 at http://tinyurl.com/q5z2zb9.

CBO also estimates that the EHB and AV requirements – along with the requirement to offer health insurance coverage to individuals with a pre-existing condition (i.e., "guarantee issue") – increases premiums in the individual market by 27% to 30% relative to pre-ACA prices.

Arguments have been made that the ACA's minimum insurance standards have effectively increased the adequacy of health insurance relative to pre-ACA health plans, and that the added cost of providing more comprehensive health coverage is outweighed by the fact that policyholders now have greater protections than they had previously. This argument has merit if you place a greater emphasis on the fact that the ACA's insurance market reforms provide more comprehensive health coverage than pre-ACA plans. However, when examining how and why premiums are increasing under the ACA, there is direct evidence that covering additional benefits and medical services carries with it increased costs.

The ACA Minimum Insurance Standards Limit an Insurance Carrier's Ability to Develop Attractive Plans Designs, So the Young and Healthy Are Not Enrolling

The ACA essentially "standardized" the types of health plans that may be offered in the individual and small group markets by requiring plans to cover the EHBs and satisfy the AV requirements. For many individuals, however, the EHBs include benefits and services they do not want or need. But, these individuals are required to pay for these services regardless, which simply increases the cost of the coverage in the eyes of these individuals, thereby making the notion of purchasing insurance unappealing (and therefore, these individuals never enter the risk pool). Younger, healthier individuals are often the type of health care consumers finding ACA-compliant plans (and coverage of the EHBs) unattractive, contributing once again to an unbalanced risk pool in the individual market.

The AV requirement is also prescriptive in relation to the amount of the cost that is shared between the insurance policy and the underlying insured. Interestingly, however, there is generally no significant issue with the percentages of the cost that must now be shared between the health plan and the insured. The issue stems from the fact that the AV requirement is inextricably linked with the EHB requirement. That is, the AV of a health plan is calculated based on the provision of the EHBs to a standard population. As a result, to satisfy the AV requirement, the health plan must cover all of the EHBs at the specified cost-sharing levels (e.g., 60% for a "bronze" plan or 70% for a "silver" plan). As stated above, for many individuals, the EHBs include benefits and services they do not want or need, yet to be ACA-compliant, a health plan must cover these benefits and medical services at the specified cost-sharing levels to satisfy the AV requirement.

Accordingly, an objective argument can be made that standardized plans constrain an insurance carrier's ability to develop plan designs for a specific "niche" of consumers in the market (e.g., young and healthy consumers who may only looking for coverage of a limited number of medical services with a very low price-tag, along with high-risk individuals with a specific chronic disease like diabetes or heart disease). If insurance carriers could tailor plans for these particular populations, arguments can be made that more younger, healthier individuals may enter the risk pool, and the carriers could better manage the high-utilizers, which could keep premiums low across-the-board.

B. Implementation Decisions Made By the Administration Has Also Contributed to Increased Premium Rates

There are two specific implementation decisions made by this Administration that can be attributed to the recent premium increases in the individual market: (1) The Administration's "transitional policy" and (2) The limited enforcement of the eligibility criteria for enrollment during certain special enrollment periods.

The Administration's "Transitional Policy"

On November 14, 2013, HHS announced what is commonly referred to as the "transitional policy." According to HHS's "transitional policy," a State could allow the health insurance carriers operating within the State to continue to offer individual and small group market health plans that do not comply with the ACA's new insurance market reforms (e.g., the EHBs and AV requirements, the "adjusted community" premium rating rules, and the single risk pool requirement). On March 5, 2014, HHS extended this "transitional policy," allowing ACA non-compliant individual and small group market health plans to remain in force all the way through October 1, 2017. And on February 29, 2016, HHS extended this "transitional policy" yet again, but the Department indicated that the policy would expire on December 31, 2017.

It is important to emphasize that the policyholders covered under a non-ACA-compliant health plan were placed into their own risk pool. In other words, because these health plans were not subject to the ACA market reforms, insurance regulators were required to impose the insurance laws in effect prior to the ACA's effective date, thus requiring these plans to be separated out from the ACA-compliant plans (so individuals covered under a non-ACA-compliant plan did not enter the newly reformed ACA risk pool). Many analysts believe that individuals covered under non-ACA-compliant plans tend to be healthier. Thus, as a result of the "transitional policy," healthier individuals did not enter the ACA's risk pool as less healthy/high-utilizers were purchasing insurance through, for example, the ACA Exchanges. This contributed to an unbalanced risk pool.

Eligibility Determination Process for Enrollment During a "Special Enrollment Period"

Under the ACA, individuals are able to enroll in an individual market health plan outside of the annual "open enrollment" period (i.e., during a "special enrollment period") if such individuals experienced a "life changing event" (like getting married, having or adopting a baby, or aging off of a health plan, just to name few). The ACA and HHS regulations also set forth a number of other reasons for enrollment during a special enrollment period, including a permanent move, gaining citizenship, and losing health coverage under, for example, an employer-sponsored plan or Medicaid.

In cases where individuals sought to enroll in a health plan offered through an Exchange, the Exchange did not require the individual to provide proof (e.g., some sort of documentation) that he or she experienced a life changing event or otherwise qualified for a special enrollment right under HHS regulations. This lack of enforcement during the eligibility determination process opened the door for "gaming of the system," where people waited until they got sick before they enrolled. Specifically, the insurance industry has provided evidence that people were willing to the take the risk and refrain from enrolling in health coverage during the annual open enrollment period, only to attempt to enroll in a health plan if they got sick after the open

enrollment period ended. In many cases, these individuals subsequently incurred significant medical bills, and then dropped their coverage, leaving the carriers with higher than expected medical claims and little premium revenue to cover those claims.

HHS – and other Exchanges like the California Exchange – now require documentation proving that an individual is indeed eligible to enroll during a special enrollment period. But, the tightening of the special enrollment eligibility process comes *after* the disruption that has contributed to an unbalanced individual market risk pool.

C. Individual Mandate

CBO estimates that the individual mandate penalty tax will reduce premiums in the individual market by roughly 20%. CBO bases this estimate on the agency's belief that the penalty tax encourages healthier people to obtain insurance, which, according to CBO, lowers average spending on health care among the insured population, thus lowering premiums for all individual market policyholders. CBO further states that while the penalty tax may be smaller than the amount of premiums an individual would otherwise pay for health insurance coverage, the tax nevertheless increases the cost of remaining uninsured, which means that more people will gain financially by obtaining coverage. CBO also suggests that some people will obtain coverage not for financial reasons, but simply because the mandate exists.

Despite CBO's estimates, objective data informs us that the individual mandate penalty tax is *not* encouraging younger, healthier people to obtain insurance. For example, the Internal Revenue Service has indicated that 45% of the 7.9 million people who paid the individual mandate penalty tax in 2014 were under age 35.[4] As a result, health care spending is *not* decreasing among the insured population, as CBO suggests it would. Instead, health care spending is increasing. And, such increased spending is placing inflationary pressure on premiums, pushing them higher. In addition, this increased health care spending – in the form of significant medical claims incurred by individual market policyholders – is producing financial losses for insurance carriers offering health plans in the individual market, thereby requiring these carriers to increase premiums to make up for their losses.

All told, the expectation that premiums would decrease on account of the individual mandate penalty tax is not materializing. Instead, it appears that the exact opposite is occurring. That is, the individual mandate is not encouraging younger, healthier individuals to enter the risk pool, which is actually resulting in an unbalanced risk pool and higher premiums.

Part III – The "Risk Stabilization" Programs

The drafters of the ACA knew that the individual insurance market reforms would cause significant disruption. For this reason, the drafters created the reinsurance, risk corridor, and risk adjustment programs (the "3 Rs") to help stabilize the markets while insurance carriers figured out (1) how to insure the influx of less healthy, high-utilizers and (2) how to deal with, among other reforms, the new "guarantee issue" and "adjusted community" premium rating requirements. The drafters were told by actuaries that it would probably take three years for the individual market to stabilize. And based on this information, the drafters limited the

[4] See *Strengthening the Marketplace by Covering Young Adults*, June 21, 2016 at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html.

reinsurance and risk corridor programs to three year programs (i.e., they will sunset as of December 31, 2016). The risk adjustment program, on the other hand, is a permanent program.

A. The Expiration of the Reinsurance Program Will Increase Premiums

To date, it appears that the reinsurance program has been the most successful of the 3 Rs, paying out $7.9 billion in 2014 and $7.8 billion in 2015 to insurance carriers offering health plans in the individual market. HHS also estimated that the reinsurance program would reduce premiums by 10% to 15% in 2014 and 5% to 6% in 2015 relative to the expected cost of premiums without the availability of reinsurance payments.[5] The reinsurance program, however, is expiring at the end of 2016, which means expected premium costs in 2017 will not experience a reduction like in years past. And, insurance carriers will no longer be able to factor payments under the reinsurance program into the development of their premium rates, which effectively means premium rates will be adjusted higher.

B. The Risk Adjustment Program Is Actually Causing Premiums to Increase

The permanent risk adjustment program is intended to provide payments to insurance carriers that disproportionately attract high-risk populations, and also collect payments (known as a "risk adjustment charge") from insurance carriers that insure lower-risk, younger/healthier lives. While the program was expected to moderate premiums in the individual health insurance market by essentially reimbursing carriers that experienced abnormally high medical claims incurred by its high-risk population, the program is actually causing premiums to increase. For example, some carriers have opted against developing low premiums for fear of attracting younger, healthier individuals who end up producing a risk adjustment charge for the carrier. In other words, carriers are trying to avoid lower-risk lives by pricing their plans higher.

In addition, those carriers that have experienced a risk adjustment charge – and those carriers that estimate that they will have a risk adjustment charge in a future coverage year – are specifically increasing their premiums to make sure that they can generate enough premium revenue to cover the payment obligations (the built-in increase is sometimes as high as 15%). State Insurance Commissioners are even suggesting to certain insurance carriers that they should increase their rates to make sure they can pay their risk adjustment charge without dipping into reserves. Alternatively, State Insurance Commissioners are shutting down carriers whose financial solvency is impaired by the payment obligations under the risk adjustment program. This reduces competition within the State, which has historically impacted premiums in a negative way.

Part IV – Issues Relating to Employer-Sponsored Insurance

A. Increased Costs Under the ACA

Small Group Health Plans

No one can dispute that – prior to the ACA – premium increases in the small group health insurance market were significant year-over-year. As a way to manage the continual premium

[5] 78 Fed. Reg. 15410, 15413 (March 11, 2013) and 79 Fed. Reg. 13744, 13826 (March 11, 2014).

increases, small employers routinely switched insurance carriers, shopping around for the best price. This "churn" added abnormally high administrative costs to an already volatile market.

Unfortunately, the ACA did little to address the premium increases in the small group market. Actually, it appears that the ACA has contributed to the recent rise in premium rates for many small employers. These increases are a direct result of the requirement that small group health plans cover the EHBs and meet the AV requirement. Another key driver to premium increases in the small group market can be attributed to the "adjusted community" premium rating rules. It is true that those small employers with an older workforce actually benefit from the new premium rating rules (based on the 3 to 1 age variation), and as a result, these employers may see a decrease in their premium rates. But, a greater percentage of small employers are adversely impacted by these new rules (in particular, because of the 3 to 1 age variation).

Large Group Fully-Insured and Self-Insured Group Health Plans

During the health care reform debate, the drafters of the ACA accepted the argument that large group fully-insured and self-insured group health plans (of any size) provided an adequate level of health care coverage. In other words, the drafters subscribed to the belief that these employer plans would by definition meet many of the ACA's minimum insurance standards (discussed above and in more detail in APPENDIX A), and as a result, the drafters exempted large group fully-insured and self-insured group health plans (of any size) from these new requirements.

However, the ACA did require employer plans to meet certain new coverage requirements, including covering an adult child up to age 26, paying for certain preventive services without cost-sharing, prohibiting annual and lifetime limits on benefits that would otherwise qualify as EHBs, and complying with specific out-of-pocket maximum limitations. While these new requirements did not increase the cost of an employer plan significantly, actuaries have found that the cost of an employer plan increased by 4% to 8% on account of the ACA.

B. The "Exclusion" for Employer-Sponsored Insurance

As the Committee knows, employer and certain employee contributions used to pay for health insurance coverage are not considered taxable income to an employee for income and FICA tax purposes. These contributions are shielded from tax under what experts call the "exclusion." For decades, both liberal and conservative economists have suggested that Congress should place a limitation on the exclusion. The drafters of the ACA did just that by enacting the Excise Tax on High-Cost Employer-Sponsored Health Coverage (otherwise known as the "Cadillac Tax").

CBO projects that the Cadillac Tax will reduce premiums by 10% in 2020 and between 10% to 15% by 2025. CBO justifies these reductions by suggesting that the exclusion increases premiums by 10% to 15% because this tax preference encourages employees to spend more on health care services, thus raising premiums for employer-sponsored plans. CBO explains that the presence of the Cadillac Tax will force employers and employees to respond by seeking plans with lower premiums, which will reduce health care spending and premiums overall.

There is significant political pressure to repeal the Cadillac Tax. But, there appears to be continued interest among members of Congress on both sides of the aisle to continue to limit the exclusion in the event the Cadillac Tax is removed. If Congress pursues some sort of limitation on the exclusion – in an effort to achieve the premium reductions that CBO estimates will be produced under the Cadillac Tax – I believe any new limitation must be structured with *precision*, so as to address many of the flaws of the current exclusion generally, and the Cadillac Tax specifically.

The current exclusion is "regressive." To address this flaw, the value of the tax benefit for mid- to upper-income employees could be limited to 28% of the cost of the insurance coverage that is under the threshold of any limitation on the exclusion. For employees in lower tax brackets, an additional "exemption for health insurance" – similar to the current "dependent exemption" – could be offered, which would further reduce a lower-income employee's tax liability, if any.

As former Counsel to the Senate Finance Committee, I understand that the goal for limiting the exclusion is to reduce offers of "comprehensive" health coverage (like 100% pay-all plans and plans with no- or low-cost-sharing). Typically, the dollar value of a health plan is a proxy for its "richness." However, the dollar value for a comprehensive plan providing "rich" benefits in Arkansas may equal the same dollar value for a less comprehensive, high-deductible health plan ("HDHP") in California. To address these differences, the dollar value of any new limitation placed on the exclusion *must* vary by geography.

Alternatively, limiting the exclusion could be based on the greater of a dollar value or the "actuarial value" of the plan. An AV metric (which is a measure of how much the insurance pays for medical expenses) would effectively impose a tax on the comprehensive plan in Arkansas, while shielding the HDHP in California from any tax.

Policymakers often use the Tax Code to encourage behavior. Congress should continue to encourage employees to save their own money in Flexible Spending Arrangements ("FSAs") and Health Savings Accounts ("HSAs") on a tax-free basis to help pay for out-of-pocket medical costs. In doing so, Congress should *not* count employee contributions to both FSAs and HSAs toward any limitation on the exclusion. Providing such an exception is necessary in light of recent data showing that employee out-of-pocket costs have increased six times faster than wages have increased over the past ten years.

Finally, unlike the Cadillac Tax, any new limitation on the exclusion *cannot* be indexed to the CPI. An equitable index rate would be "medical inflation."

APPENDIX A

The "Essential Health Benefits" Requirement

The "essential health benefits" ("EHBs") are a list of ten (10) specified medical services that must be covered under individual and small group market plans.[6] The Department of Health and Human Services ("HHS") issued regulations implementing the EHB requirement, effectively permitting States to designate an "essential health benefits"-benchmark plan that may also include State benefit mandates that were in existence as of December 31, 2011.

The Cost-Sharing Limitations

The cost-sharing limitations require that amounts paid under a health plan in the form of cost-sharing (e.g., co-insurance, co-payments, and deductibles) cannot exceed the maximum out-of-pocket limits for a high-deductible health plan ("HDHP") defined under the health savings account ("HSA") rules for 2014. These amounts – otherwise referred to as the "out-of-pocket maximum limitations" – are indexed each year to what is known as the "premium adjustment percentage," which is a measure of premium increases over a specified period of time. Specifically, the overall out-of-pocket maximum limits will increase each year by the percentage by which premiums in the preceding year exceed the average premiums for a "benchmark" plan in 2013. In 2015, the premium adjustment percentage was 4.3%, increasing the out-of-pocket maximums to $6,600 for single and $13,200 for family coverage. In 2016, the premium adjustment percentage was 8.3%, increasing the out-of-pocket maximums to $6,850 for single and $13,700 for family coverage, and in 2017, the premium adjustment percentage is 13.2%, increasing the out-of-pocket maximums to $7,150 for single and $14,300 for family coverage.

The AV Requirement

According to the AV requirement, individual and small group market health plans must offer varying "levels of coverage" designed to provide benefits that are actuarially equivalent to a specified percentage of the full actuarial value of the benefits provided under the plan. In layman's terms, the AV requirement provides that the insurance coverage must pay for a specified percentage of the cost of a particular benefit or medical service covered under the plan, and the individual policyholder is responsible for paying the remainder of the cost. For example, in the case of a "silver" plan (which is required to have a 70% AV, plus or minus 2%), the insurance coverage will pay 70% of the cost of a covered benefit and the remaining 30% of the cost must be paid by the plan participant out of his or her own pocket (through some combination of deductibles, co-pays, and/or co-insurance).

---

[6] These ten (10) specified medical services include: Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care.

The "Adjusted Community" Premium Rating Rules

As discussed in the body of the testimony, the drafters of the ACA endeavored to make the individual and small group insurance markets much more functional markets. To achieve this policy goal, the drafters prohibited insurance carriers from under-writing an insurance policy based on the health status of an insured. Premium rates can only vary by age (by a 3 to 1 ratio), by tobacco (by a 1.5 to 1 ratio), by geography, and by family size. These new requirements apply equally to the individual and small group markets.

The "Single Risk Pool" Requirement

The drafters of the ACA also sought to expand the risk pools in the individual and small group markets. Specifically, the drafters developed the "single risk pool" requirement. Under the single risk pool requirement, the health risks of all individuals purchasing insurance in the individual market must be pooled together. Similarly, all of the health risks of employees of small employers purchasing coverage under a small group health plan must be pooled together.

However, there is a very important caveat to this single risk pool requirement in both the individual and small group markets. Specifically, the health risks pooled together in the respective markets will be pooled within the insurance carrier that is under-writing the particular health insurance policy. In other words, while the health risks in the respective markets are required to be pooled together in a single risk pool, those risks are pooled together on a carrier-by-carrier basis.

Another important caveat is this: While the drafters of the ACA sought to create the Exchanges to serve as a marketplace through which health insurance in the individual and small group markets could be sold, the drafters also wanted to preserve the market that existed "outside" of the Exchange. As a result, according to the ACA, consumers are currently permitted to purchase a health plan through the Exchange, and they are also permitted to purchase a health plan outside of the Exchange. Based on this, one would think that there are two separate risk pools in the individual and small group markets. But, in order to make the insurance markets work properly, there is actually only one risk pool that includes the health risks of individuals/employees purchasing a health plan both *inside* and *outside* of the Exchange.

> **Example**: If Person A purchases an individual market plan through the Exchange from Carrier XYZ, and Person B purchases an individual market plan outside of the Exchange also from Carrier XYZ, the health risks of Person A and Person B are pooled together in Carrier's XYZ risk pool. If, however, Person B purchased an individual market plan from Carrier QRS, then Person B would *not* be pooled together with Person A.

The small group market single risk pool requirement works the same way.