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IN THE PUBLIC INTEREST

MEDICAID EXPANSION UNDER ACA AS MODIFIED BY THE U.S. SUPREME COURT

By Timothy F. Harris

(Some of the material in this article was taken from Health Care Coverage and Financing in the United States, the Actex book I wrote that was published earlier this year.)

A key component of the Affordable Care Act (ACA)[1] is the expansion of state Medicaid eligibility requirements to encompass lower income adults. Under the ACA, Medicaid eligibility is expanded to 138 percent of the federal poverty level (FPL). (It is actually 133 percent with a 5 percent income disallowance.) For all newly eligible persons, the federal government will pay for 100 percent of the costs for the calendar years 2014 – 2016. After that time period, the federal portion decreases to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter. In the case of states that have already expanded coverage, the federal portion increases in a similar step method so as not to penalize states for early expansion of coverage. States may expand their Medicaid programs prior to Jan. 1, 2014, but this expansion will be financed at the current Federal Medical Assistance Percentage (FMAP) until 2014.

The general public may think that Medicaid provides health insurance to all of the lower income populations, but that is typically not the case. Medicaid programs vary from state to state, but in many states Medicaid does not cover adults without dependent children unless they are disabled or meet some other specified criteria. This results in a large lower income population without any form of health coverage. However, some states do offer a limited program of some type for this population, often entirely funded by the state, without any federal sharing. Other programs for this population may be

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IN THE PUBLIC INTEREST

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LETTER FROM THE EDITOR

By Rachel W. Killian

I'm sure everyone will agree that 2012 was an exciting year! Especially for actuaries practicing in the United States, the Supreme Court Decision on the Affordable Care Act and the Presidential election had most of us on the edge of our seats. Now that we've closed the door on the year, we should take time to reflect on last year's issues and outcomes. After that, it is time to tackle the issues that will face us throughout the year ahead.

Reflecting on the current status of the U.S. social insurance programs and looking forward to tackling the issues ahead was certainly on the minds of the authors who contributed to our January publication. Our newsletter begins with a look at the problems and possible outcomes of the state Medicaid programs due to the Supreme Court decision on the Affordable Care Act. Further in the issue, we take a look at the Social Security program. In our June publication, we introduced the newly formed subgroups of the SIPF Section. We've included a second article on Medicare from The Government Health Care Subgroup. Last year they outlined various issues with the Medicare program, and, in this publication, they attempt to outline possible solutions. Also included in our January newsletter are two more thought-provoking articles. The article, "Breaking Promises," takes a look at why society has difficulty in making the hard choices that must be made to sustain the social programs that we have created. The second article keeps alive the theme of the June issue, where we explored an actuary's duty to the public.

In our attempt to "ring in the New Year," we've literally "turned some new corners." We are excited to bring to you two new sections in our newsletter. We've added a Chairperson's Corner along with another section at the end of the newsletter. In this last section we share advice and tips that actuaries can use in their everyday work and studies. Our first contribution includes advice on navigating through the overwhelming amount of information regarding health care reform and regulations as seen through the eyes of an actuary in the United States. Check this out in our Actuarial Tips and Tricks Corner found at the end of the newsletter. We hope you enjoy it!

Many of the issues surrounding the U.S. social insurance programs impact all of us in some way. Actuaries throughout the world are faced with many of the same problems with regard to the social insurance programs that exist in their own countries. We hope that you will find the following articles useful both personally and professionally. Feel free to contact us with your own thoughts on social insurance programs in any country and the many problems they face today.

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CHAIRPERSON'S CORNER

ACTUARIAL VALUES

By Steven Schoonveld

Professional organizations worth their weight each have standards of practice, codes of conduct, oaths, ethical guidelines, tenets, principles, or professional standards to which members must adhere or are encouraged to adhere. Most also have disciplinary boards with varying degrees of intensity. Those that are worth far more than their weight have values. Actuarial Values, and not the numerical kind, are what drive our standards of practice and codes of conduct as well as dictate how we practice.

Just as many of the actuarial concepts we absorbed through the education process are applicable across several areas of practice, so are our values. Whether an actuary is in pensions, health or long-term care; or works with investments, retirement systems or insurance products; or in the social insurance or public finance arenas, our values are consistent.

At our core, we build and manage financing systems and financial structures in roles within consulting firms, regulatory bodies, insurance companies, government agencies and in a variety of industries in non-traditional actuarial roles. We practice with the following general values in mind:

- We build and manage systems and structures that are designed to be **sustainable** and are not built to fail. We understand and can demonstrate the consequences of building weak structures and systems. In cases where there are obstacles to sustainability, it is imperative that we objectively opine and seek to overcome these obstacles.
- In any system or structure there are participants and stakeholders. We value the appropriate alignment of interests so that the system or structure is **affordable** both today and in the future to the participants. For example, insurance systems should be designed such that the insurance carriers, government bodies, producers, providers and policyholders can affordably participate without undue design burdens and in a fair and reasonable manner.
- Actuaries practicing in the investment space seek optimal return for the risk assumed. As actuaries in most systems and structures, we value the **efficient** use of funds and seek to optimize the intended goals.
- A similar value is the presence of appropriately aligned **incentives**. In order to provide for affordable and efficient systems and structures, incentives are often necessary.
- The systems and structures we build also provide for an appropriate level of **equity** between the participants.
- Finally, we recognize that there are often trade-offs that are necessary to achieve the objectives of financing systems. We value recognizing such considerations and note the obligation to determine the consequences of such.

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To the extent that the structure and choices within the financing systems or financial structures we work with offend these values, we are obligated to present the consequences of such choices. We, as actuaries, are often the sole trusted advisors to boards, senior business leaders, politicians and the public on these matters. If we do not advise objectively on the potential consequences of decisions made by these leaders, our reputations are at risk, and we must share in the responsibility for the outcomes.

This, indeed, is how we fulfill our obligation to act in the public interest. Our professionalism classes remind us that actuaries should be willing to walk away from a position or project. As a section serving the needs of social insurance and public finance programs, we cannot walk away. We are obligated not only to speak to the applicable actuarial principles and standards, but to pursue the values given above.

As we begin a new year of SIPF Section activities, it is my hope that we continue the focus on bringing actuarial principles and values to the social insurance and public financing systems we study. Please join me in welcoming our new Council members and please join your fellow section members as we continue to build a strong section which serves the public interest.

funded at the county level, especially for mental health services. The primary sources of care for the lower income, uninsured population are free clinics or the emergency room. The resulting emergency room bill may not be paid by the individual, the individual may not have insurance, and, as we'll see below, the individual may not be covered currently by Medicaid.

Note that states do typically cover the blind, aged, and disabled populations as well as pregnant women and individuals with breast cancer up to certain FPLs, possibly as high as 300 percent.

The ACA was designed to fill in the gap between Medicaid and commercial insurance coverage (individual and employer health plans) by covering those lower income non-custodial adults that typically rely on the emergency room for their medical services. The planned insurance coverage of the total legal resident population was supposed to look like the following when ACA was drafted:

FULL MEDICAID EXPANSION

- Up to 138 percent of the FPL—Medicaid (the percentage of the FPL is higher for children, up to 300 percent).
- 139 percent – 400 percent of the FPL—subsidized individual insurance in the exchange/employer coverage.
- 400 percent+ of the FPL—individual insurance in the exchange without subsidy/employer coverage.

PARTIAL/NO MEDICAID EXPANSION

- 0 – Y percent (Where Y is the percent of FPL to which a state makes a partial expansion; 100 percent is often considered) FPL—covered under existing or partially expanded Medicaid.
- Y percent – 138 percent FPL—most likely covered through individual policies in the exchange with full subsidies of out-of-pocket expenses and minimal premiums up to 100 percent FPL and less than full subsidies from 101 percent to 138 percent.
- 139 percent – 400 percent FPL—partially subsidized out-of-pocket expenses and premiums on individual policies in the exchange/employer coverage.
- 400 percent+ FPL—individual/employer in the exchange without subsidy/employer coverage.

In order to get an idea of the income levels that will qualify for Medicaid, the FPLs for 2012 for different family sizes are shown below in Figure 1.[2]

FIGURE 1:
2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families/households with more than eight persons, add $3,960 for each additional person.

PARADIGM SHIFT

Since the initial design of the ACA and the early projections of the impact of the ACA on state Medicaid budgets, there have been at least a couple of material events.

SUPREME COURT DECISION

The Supreme Court of the United States (SCOTUS), in its June 29, 2012 decision, reaffirmed the right of Congress to impose the individual mandate that requires most individuals to be covered by some form of health insurance, but it struck down the ability of the federal government to impose the ACA's integral Medicaid expansion on the states. The hammer in the ACA to force states to adopt the desired increase in

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Medicaid coverage was the threatened withholding of the federal government's share of the cost of existing state Medicaid programs, the FMAP. SCOTUS determined that this withholding of the FMAP on state Medicaid Programs is unconstitutional.

The elimination of the Medicaid expansion mandate led some states to declare that they were not going to expand their Medicaid programs. These states often cited their concerns that, as the federal budget became tighter, the higher Medicaid expansion FMAP might be reduced, thus shifting a greater portion of the cost of the Medicaid expansion to the states.

In addition, some states are considering expanding Medicaid to a lower FPL: 100 percent of the FPL for the uncovered populations is a common target. This has raised a number of questions and issues. The National Governors' Association submitted a list of questions to the U.S. Department of Health and Human Services (HHS) on July 2, 2012,[3] including:

- Would the enhanced ACA FMAP be paid on an expansion to a lower FPL, say 100 percent instead of 138 percent?

- If a state does not expand its Medicaid eligibility, what other ACA provisions will still apply to its Medicaid programs?

The National Association of Medicaid Directors had many additional questions in a letter to the Centers for Medicare and Medicaid Services (CMS) on July 3, 2012, including:[4]

- What would happen to the individuals between 101 percent of FPL and 138 percent of FPL? Will they be assumed to enroll in the individual health insurance exchanges?
- Will the 5 percent income disregard used in moving Medicaid expansion from 133 percent FPL to 138 percent FPL also apply to a lesser expansion, i.e., will 100 percent FPL become 105 percent FPL after the 5 percent income disregard?
- Can states phase in their expansion over years beyond 2014?

A few additional questions are:

- Will the proposed Disproportionate Share Hospital (DSH) program reductions under ACA be unchanged? DSH is designed to compensate hospitals for unpaid care and is scheduled to be reduced under ACA because it is anticipated that there will be fewer individuals unable to pay their hospital bills because more of the lower income populations will be covered under the proposed Medicaid expansion.

- One question that has been asked and answered is this. Will a state be allowed to reverse a decision to expand Medicaid if it proves to be unaffordable? CMS has indicated that this reversal would be allowed.

- Will there be increased subsidies of premiums and out-of-pocket expenses if the people in the gap between the state's Medicaid (or expanded Medicaid) and 138 percent FPL enroll in the exchange? Such

an increased subsidy could eliminate any cost for this population and would be consistent with their coverage under Medicaid expansion.

DETERIORATION

There have been a number of nationwide reports that have analyzed the impact of Medicaid expansion on state budgets. In addition, many (if not all) states have commissioned or prepared their own reports, often politically motivated, that projected the impact of Medicaid expansion on the states' budgets. The primary source of population data by FPL and by insurance status, which is used in preparing these reports, has been the U.S. Census Bureau's Current Population Survey (CPS) data. Reports prepared prior to September 2011, would have relied on 2000 census data, adjusted using ongoing CPS results. More recent data shows that the use of this earlier-period census data understates the impact of the recent economic downturn on both the number of uninsured and the proportion of the population in lower FPL's.

The tables in Figures 2 – 4 (right) show the change in these parameters as seen in the 2008 and the 2011 census data. Note that non-residents have not been removed from this data and that the Census Bureau in their survey does not ask about legal residence. Also, note that recently published studies and articles have shown that the number of uninsured did actually decrease from 2010 to 2011, due at least in part to the ACA expansion of coverage, under family coverage, to adult children up to age 26, while the comparison below is of 2008 to 2011.

The table in Figure 2 shows the impact of the economic downturn, which moved 2 percent of the population into lower income groups, thereby increasing the population that would be eligible for Medicaid expansion.[5]

FIGURE 2
Distribution of Population

FPL	2008	2011
Below 100%	13%	15%
100% to below 200%	19%	19%
200% to below 300%	17%	17%
300% and above	51%	49%
Total	100%	100%

The table in Figure 3 shows the change in the number of uninsured by FPL where, again, non-residents have not been removed, and Medicaid is considered a form of insurance.

FIGURE 3
Number of Uninsured (000s)

FPL	2008	2011	Percent Increase
Below 100%	11,900	13,674	15%
100% to below 200%	13,305	14,754	11%
200% to below 300%	8,869	9,312	5%
300% and above	10,631	10,811	2%
Total	44,705	47,052	5%

The table in Figure 4 shows the percentage of each FPL group that is uninsured. These results indicate consistent percentages of the FPL groups remaining uninsured, with the change in the number of uninsured by group being driven primarily by the change in the size of the group.

FIGURE 4
Uninsured Percentage by FPL Percentage Uninsured

FPL	2008	2011
Below 100%	30%	30%
100% to below 200%	24%	25%
200% to below 300%	17%	18%
300% and above	7%	7%
Total Population	15%	16%

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UPDATE

Based on the charts above, it is probably time to update earlier projections of the impact of the Medicaid expansion under ACA on state Medicaid budgets.

As state Medicaid ACA impact models are updated, a couple of additional items that were at times missed in some earlier projections should be considered.

NON-RESIDENTS

One of the early political issues for the ACA was the debate over the potential eligibility within the ACA health insurance process of individuals not legally residing in the United States. It is now quite clear that one must prove legal residence in order to qualify for participation in the exchange or to demonstrate eligibility for Medicaid. In addition, legal immigrants must typically wait for five years before becoming eligible for Medicaid. Our review of some of the earlier nationwide projections of the impact of ACA on state Medicaid budgets found that these projections did not adjust for these excluded populations.

VARYING STATE MEDICAID PROGRAMS

Various state Medicaid and related programs are not always the same. It is not possible to accurately model the impact of ACA for the states without knowing the specifics of the states' many Medicaid and related programs. A review of the details of a state's various state Medicaid programs will likely show that some of the state's existing programs may be absorbed by ACA's Medicaid expansion at the higher expansion level of FMAPs. This would result in the federal government picking up a greater portion of the Medicaid costs of a population that was already covered under a Medicaid waiver. It may even result in an entire state-funded program being swept into Medicaid expansion. In one state we noted hundreds of millions of dollars shifting from the state to the Federal Government under the auspices of the ACA. This state had programs already covering large numbers of individuals who would move either to Medicaid expansion or to the ACA health insurance exchanges with heavy subsidies.

MEASURE TWICE AND CUT ONCE

A state's decision of whether or not to expand the Medicaid program is certainly something that requires considerable investigation, modeling, input from stakeholders, and, ultimately, a decision.

Medicaid expansion is an important piece of the puzzle that is being pulled together with ACA to provide increased healthcare through health insurance to more Americans. Procrastination and inaction by the states will complicate the other moving pieces of ACA, including the operation of state health insurance exchanges and employer health insurance where employers may actually be subject to increased penalties, while lack of a thorough review of the financial implications for a state may lead to budgetary constraints.

ENDNOTES

1. The Patient Protection and Affordable Care Act of 2010 and the Healthcare and Education Reconciliation Act of 2010 are collectively referred to as the Affordable Care Act (ACA).
2. U.S. Department of Health and Human Services (HHS, February 9, 2012) 2102 HHS Poverty Guidelines. Retrieved Oct. 10, 2102, from http://aspe.hhs.gov/poverty/12poverty.shtml
3. Crippen, D. (July 2, 2012). Affordable Care Act: Letter to Secretary Kathleen Sebelius, HHS. National Governors Association. Retrieved Oct. 10, 2012, from http://www.nga.org/cms/home/federal-relations/nga-letters/executive-committee-letters/col2-content/main-content-list/july-2-2012-letter---affordable.html#
4. National Association of Medicaid Directors (July 3, 2012). NAMD's SCOTUS questions. Retrieved Oct. 10, 2012, from http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_submitted_questions_120703.pdf
5. U.S. Census Bureau Current Population Survey. A Joint Effort Between the Bureau of Labor Statistics and the Census Bureau Retrieved Oct. 10, 2012, from http://www.census.gov/cps/

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OUR ACTUARIAL MANDATE FOR SERVICE TO THE PUBLIC

By Robert D. Shapiro

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The beginning of an article that appeared in the first issue of our *Social Insurance and Public Finance* newsletter (January 2010), began with a quote from Jim Hickman, FSA, MAAA, ACAS, 2006. Jim was and is a revered member of our profession and his words resonate strongly whenever the topic of "public service" comes up. He said:

> "The words 'profession,' 'professional' and 'professionalism' frequently appear in statements, programs and in the organization chart of the American Academy of Actuaries and related actuarial organizations. They are important words and deserve to be constantly on our minds and in our conscious. The concept of a professional carries with it the idea of service to the public. Today a unique opportunity, one could also say a professional obligation, for public service presented to actuaries. In the United States, the national social insurance systems face serious problems. Any list of domestic issues has Medicare and Social Security in prominent places."

Most of us would nod our heads in agreement as we read Jim's comments. However, the answers to two core questions, "What does public service mean?" and "Do U.S. actuaries mean it?" that Jay Jaffe raised in his article that appeared in our last publication, are not clear. We need to clarify what "acting in the public interest" really means, and tighten the framework for the profession and individual actuaries within it for living this mandate in everything they (we) do.

CONCERNS WITH OUR CURRENT REALITY

Obviously actuarial science is an important cornerstone of our profession and of being an actuarial professional. However, it is not enough merely to pass exams, keep up-to-date and do "good actuarial work." We also have to engrain the responsibility for always acting in the public interest in everything the actuary does. Both science and public interest must be reflected in all of the actuary's activities.

Like any strong profession, the actuarial profession has a set of practice standards and a discipline process. However, although "professionalism" and "public interest" are mentioned in our Code of Professional Conduct, standards and continuing education process, what this all means is not spotlighted in the documents. Although we think we know what unreasonable assumptions and methods are versus reasonable ones, are we willing to label them as such when they occur?

AN URGENT NEED

In many cases, for a long time some of our most prominent financial and personal security systems have used methods and assumptions that have created generational inequities. They have accomplished this by some combination of front loading benefits, deferring contributions, and/or encouraging excessive usage of benefits. Examples include pension benefits calculated primarily on earnings in later years with investment earning assumptions much higher than warranted, health care benefits that encourage people to spend someone else's dollar through little effective cost sharing, and Social Security benefits greater than the floor level they were intended to achieve. These methods and assumptions have created overuse of resources from current and past generations and put future generations in a huge hole. Was this reasonable? To argue this is actuarially sound is possible in some cases but it is not consistent with the intent of such programs, or the promises made. Actuaries, in general, did not make the decisions to follow such methods of assumptions, but did actuaries warn of the consequences or inequities of such decisions? Sometimes yes, but sometimes no. And, if we did, why were our voices ignored? Did we continue to shine a light on the issues?

Moreover, how does one argue that using such methods or making such assumptions is

consistent with the public interest? Many of us believe the process followed and implemented has put the country and the actuarial profession on a slippery slope and that it is our responsibility to exit from this slope before we go off the cliff.

Therefore, our profession needs to ring the alarm bells loud and clear. We must demonstrate these generational inequities and demand that our systems return to the intent for which they were established. Otherwise, the actual results will be very different from the intent, often hurting the very people we are supposed to protect.

Is this the legacy these systems wish to leave behind? Is this what actuaries envisioned when they worked on the creation, modification or simply commented on the functioning of these systems? We don't think so, but the public may perceive that and care little who did what, if they collapse and fail to deliver on their promises.

WHAT CAN WE DO?

The Social Insurance and Public Finance (SIPF) Section council published the special issue of its *In The Public Interest* newsletter because it sees this issue of "acting in the public interest" as critical to addressing many of our SIPF and broader actuarial profession challenges. It is hoped that all actuaries (both SIPF and other qualified actuaries in the United States) will see the importance of addressing these challenges holistically … consistently across the entire profession and its professional bodies. Our true professional responsibility will only be realized if we holistically address how we operate and deliver actuarial reports. We need to leave the slippery slope of today and get back to systems that can be generationally sustainable and maintainable, if we are to truly fulfill our mission of serving in the public interest!

We actuaries serve many publics … our clients, our profession, our companies and our other stakeholders, in addition to the public, but

everything we do should be done in a way that "meets the public interest." The core question is, "How does the actuarial profession engrain the responsibility for public interest in everything the actuary does?"

We hope you will provide us with input. If we fail to address this challenge immediately, we risk both failing "the public" (our country and the citizens in our country) and our profession.

... our profession needs to ring the alarm bells loud and clear.

BREAKING PROMISES

By Tia Goss Sawhney

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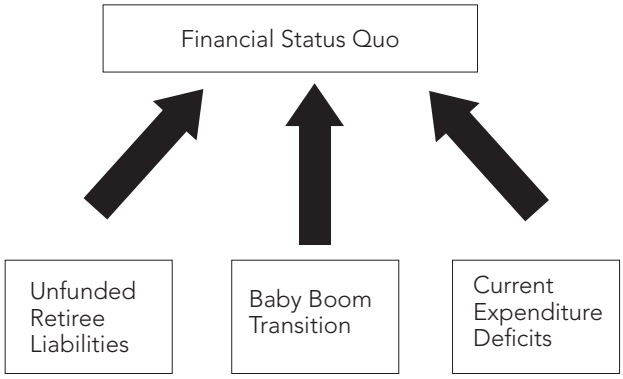
Forces of unprecedented strength are set to fracture the financial status quo of our states, nation and the developed world. At the broadest level these forces are current expenditure deficits, unfunded retiree liabilities, and the transition of the baby boom adults from productive labor years, within which they can contribute to paying governmental debts, to non-productive high health care cost years, during which they draw down (personal and) governmental assets.



Current expenditures and unfunded retiree liabilities have received most of the press. However, the aging of the baby boom generation is just as important and is possibly overlooked, in part, because it is unprecedented. This is the largest generation ever to enter retirement, in terms of both absolute size and also as a percentage of the total population. The baby boom generation is expected to live longer in their retirement years than any other generation has in history. The aging of the baby boom is also very possibly overlooked because of the natural exuberance of its members. Many baby boomers and other members of society incorrectly "wish the problem away" by saying that "they will work forever." The reality is that bodies and minds degrade with age, and skills become obsolete. As a result, most people will not have lifetime employment. Many members of any aging population will want all available medical technology and services to assist in their fight against aging, illness, frailty and, ultimately, death.

The relative strength of the individual forces varies somewhat depending upon where one resides geographically in the developed world and from which perspective one considers the problem. From the vantage point of those residing in the United States, we can look at the past decade. The U.S. government has funded two wars, expanded and added various programs, stimulated the economy and decreased taxes. This has resulted in a massive accrual of current expenditure deficits. Public pension and private pension funds have been underfunded for many years. The recent U.S. mortgage and housing market collapse and the concurrent recession have only made matters worse by increasing government deficits and decreasing the value of assets that support pension plans. We have all read the articles that propose changes to address our various financial challenges such as Medicare, Medicaid, Social Security, federal deficits and state and local deficits as stand-alone problems. Considered separately, the changes necessary to solve each problem are staggering and inevitably elicit cries of protest from entrenched interests. Yet, solving any one of these problems individually is not sufficient. We need solutions that address all of these problems simultaneously.

There are no easy, pain-free technical fixes that will mostly preserve the status quo. A simultaneous solution is going to involve gut-wrenching changes, negotiated in the political arena. Major interests are going to be hurt as the status quo cracks. As a society and sub-societies within, we have overspent for decades and made forward-looking promises without proper consideration of how we will pay for them. The bills for the spending and promises are coming due over the next few years, just when our ability to pay the bills will be diminished by the exit of the baby boomers from the workforce. We are going to need to break promises.

Therefore, as a nation we must make tough political decisions, with full knowledge that some major interests are going to oppose attempts to break down the status quo. The defining question we must answer is how the pain will be shared among the major interests and individual citizens of the United States. So, who are the major interests? In my opinion, there are four major interest groups that can come up with the money that is missing from the financial equations of the next couple of decades:

Major Interests/Funding Sources

Taxpayers	Bondholders
Current and future retirees	Health care, social services, and education recipients

These are the core stakeholders of the status quo. Specific individuals, of course, often fall into multiple interest groups. Society will need to extract funding from the interest groups, in part, by breaking some of today's promises. The key questions are whether we do this in an orderly way that shares the pain or wait for a financial collapse, and whether we place the burden on a subset of the interests or share the burden among many interests.

Note that the interests in the chart above do not include waste, fraud, abuse, or other inefficiencies. Do these exist in government and private systems, and how large of a relative impact might they have? Yes, they exist, but collectively, they are not big enough to be the solution to the problems. In addition, they are not clearly established or easily eliminated. One interest's waste, fraud, abuse, or inefficiencies are often another interest's stream of revenue or services—a stream that they will fight to guard. Improved government efficiency is an admirable and necessary goal, but efficiency efforts are not a panacea for our problems.

Our society is faced with tremendously difficult choices. No one wants to break promises, especially politicians, irrespective of party. It is often much easier simply to do nothing. But delays push us toward the chaos of financial collapse, which will not be pretty. If anyone believes that collapse is impossible, I recommend that they read *This Time Is Different: Eight Centuries of Financial Folly*, by Kenneth S. Rogoff and Carmen M. Reinhart (2010). Devastating economic collapses, much bigger than the recent recession, do happen, and they can happen to us.

No one wants to have a promise that has been made to them broken, especially big, powerful interests. Consider the interests in the context of Illinois, a state flowing in red ink (full disclosure: I am a State of Illinois employee). Last year personal income taxes increased from 3 percent to 5 percent, which is a 67 percent tax rate increase. Another tax increase would not seem acceptable to the citizens of Illinois, especially in an election year. On the other hand, our budget is billions of dollars short and, even if we make our required pension contributions, our pension plans will still be desperately underfunded. Most state, local, and school employees are covered under union contracts that do not support retirement cuts. As I mentioned once, it is an election year, and union employees and retirees make up a large percentage of the voters. Given this apparent impasse, it may seem that the only other choice for the state of Illinois is to renege on promised bond payments. Bondholders, however, are the most influential members of our society, and we need their confidence for future borrowing. Reneging on promises to the bondholders in the form of defaults can only be made as a last resort.

Social services and education are areas where cuts could also occur. Education is not an area that many feel good about reducing; therefore, social services, including health care, would

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... as a nation we must make tough political decisions, with full knowledge that some major interests are going to oppose attempts to break down the status quo.

... we must acknowledge that there is no panacea that will fix it all. ...

more likely be cut. Many of us might support the concept of cutting government-funded health care and social services with respect to 'other people,' but feel the cuts are unacceptable when they are cut with respect to ourselves, someone that we love, or just someone whose face we recognize. We, admirably, don't have the societal tradition of passively letting people in our communities literally or figuratively die on the street, even if their condition is of their own making. If generosity toward family and fellow man is not sufficient reason to preserve these services, alternatively, consider the economic impact of health care and social service dollars being paid to businesses that very much want to preserve their revenue streams.

We have a huge problem. I believe in this country and in our ability to adapt and change. We must try to accomplish this in an orderly fashion, rather than as a reaction to financial collapse, and we must start now. First, we must acknowledge that there is no panacea that will fix it all, with little pain for few people. Next, we must recognize that tomorrow will not be what we, individually and collectively, had planned. Finally, we must negotiate via our political processes how we can share the burden of change. Negotiation will require stepping beyond the firm lines often drawn by today's political parties and politicians and avoiding the tendency to assign blame. We got into this together; we should get out of it together.

Undoubtedly, these changes will be hard, and the choices will be difficult; however, if we get started now, we have a fighting chance to not only avoid financial collapse, but to prosper in the face of adversity. Are we up to the task?

THE MEDIUM-TERM PLAN FOR SOCIAL SECURITY

By Jeffery Mark Rykhus

What lies ahead for Social Security? Let's examine the current condition of the Social Security Trust Fund and the options that can reasonably be used to extend the solvency of the fund, being mindful of Social Security's dual role of individual equity and social adequacy.

THE 2012 SOCIAL SECURITY TRUSTEES REPORT

The Trustees Report (http://www.ssa.gov/oact/TR/2012/tr2012.pdf) states that, under the intermediate assumptions, the expected date of exhaustion of the combined Old Age Survivors and Disability Insurance (OASDI) trust funds is 2033. Taxes payable at that time will still be sufficient to pay about 75 percent of scheduled benefits (declining to 73 percent of scheduled benefits by 2086, the end of the current 75-year projection period). Contrary to popular opinion, this projected exhaustion date is, by no means, a Social Security "bankruptcy" date, but it certainly provides clarity for our discussion.

The projected date of exhaustion has fluctuated between 2027 and 2042 over the last two decades, extending mightily during the Clinton years of economic boom, and contracting during the most recent severe recession. Social Security actuaries have done a great job with these projections, but no one knows how the economy, the big driver of the trust fund exhaustion date, will perform.

TRUST FUND DEPLETION

Based on that intermediate projection, we must ask, "What general pattern do the Social Security actuaries expect for trust fund depletion?" The answer lies with a heuristic device I call the Three-Four-Five Rule. Actuaries expect three years of minimal depletion, four years of intermediate spending down, and five years of severe spending down. What follows is, of course, a projection. In nominal dollars, when trust fund principal is used to pay benefits, we expect that the first three years will average less than $50 billion annually (2021 – 23). This is followed by four years of larger spending down, from $100 to $200 billion annually (2024 – 27). The finale will be severe: five years of average annual budget drag of $400 to $500 billion (2028 – 32). Most of a $3 trillion fund disappears in less than a decade and must be covered by borrowing or other means. How do we forestall a half trillion annual hit to the general budget for five years in a row?

BENEFIT REDUCTIONS

Let's consider the impact of legislated benefit reductions and other possible benefit reductions. Scheduled increases in normal retirement age (NRA), to age 67, will begin again in 2022 and will be completed in 2027. People who are age 55 this year will retire (at NRA) in the middle of that period. Historically, people over age 55 have been given a pass on any proposed Social Security benefit reductions, including normal retirement age increases. We are currently in an 11-year hiatus between an age 66 NRA and an age 66 years and two months' NRA. Certainly, accelerating the increase in

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NRAs is an option, but its potential effect on the trust fund over the next two decades is becoming increasingly limited.

After all, President Reagan chose to give citizens two decades to make plans for increased NRAs, with early 1980s legislation starting to be implemented in the 2000s. He was right to be cautious about cutting people's retirement income. Other than normal retirement age, any other type of benefit reduction is completely new to Social Security and should probably be handled the same way Reagan handled NRAs. Using this as a benchmark, benefit reductions, in general, will have minimal impact on trust fund depletion over the next two decades. Since we are no longer realizing budget surpluses from Social Security payroll taxes, investment of the trust fund in marketable securities could only be done with respect to past surpluses already invested in government bonds. The viability of that option can be debated elsewhere. The only other option is to increase revenue.

REVENUE INCREASES

Social Security tax rates rose between five and seven times per decade, from the '50s to the '80s. The payroll tax was 10.16 percent in 1980 and rose gradually over a 10-year period to 12.4 percent, where it stands today, unchanged since 1990. President Reagan also brought the taxable maximum high enough to cover 90 percent of wage income, with the intention of keeping it there, but it has slipped to nearly 83 percent of wage income because of faster wage growth in the top income tier. Via the 1983 Social Security Amendments, revenue enhancements were in place within seven years, and benefit cuts were planned over five decades. President Reagan's Social Security plan from the '80s should guide us today.

Revenue increases are nothing new. Social Security is now, once again, a developing system, because of the impact of the baby boomers over the next 40 years. Policymakers must realize that the baby boomers are an extraordinary shock to the system, not only because of their sheer size, but also because their presence has allowed lower tax rates for decades.

THE THREE-LEGGED RETIREMENT STOOL

Over the decades since Social Security became law, a certain balance on the three-legged stool of retirement income has been achieved and then lost. Now, the stool has pretty much been kicked out from under us. Here's what we've seen and what to expect as a result of recent decades: (1) fewer defined benefit plans in force, covering far fewer workers; (2) wage growth stagnation among the lower three to four quintiles of workers; (3) smaller investment returns; (4) more stock market investment risk and economic uncertainty risk, affecting both retirement investments and future job prospects; (5) reduced life spans among the least educated workers.

INCREASING NORMAL RETIREMENT AGES

Increased life expectancies form the basis for both past and present normal retirement age

proposals, and this merits special attention. To start with, most overall life expectancy increases have occurred because of decreases in death rates at lower ages rather than at higher ages (see 2012 Trustees Report). This means, simply, that more people (who have paid into Social Security much of their lives) can now expect to get at least a dollar of that money back, before dying, than did previous generations. This is a much bigger reason for increased Social Security spending than that of people living longer within retirement.

If this fact were widely known in the public sphere, people would say that it's only fair that more people benefit from a universal program. They would expect actuaries to use life expectancy within retirement (after NRA), not life expectancy at birth, in their arguments to raise the NRA. Consequently, the decision of some actuaries to use life expectancy at birth to bolster their calls for increased NRAs is questionable.

People also have a strong desire to know their exact retirement age well before retirement so they can plan. Using formulas involving life expectancy to determine NRAs, while appealing to many actuaries, doesn't help policymakers explain to their constituents what their retirement ages will be. Moreover, new studies have shown that increases in life expectancy are confined to the relatively well-educated and well-off. College graduates of all races enjoy about a decade more of expected life span, compared to the least-educated, who have seen declines in life expectancy of up to four years since 1990.

It is important to also note that increasing the normal retirement age is a regressive benefit change. Not only do lower benefit workers tend to be at a disadvantage in terms of life expectancy, but they have fallen even further behind recently, and their retirement income often consists only of Social Security.

OTHER SOLVENCY PROPOSALS

Much of this life span research has occurred since 1983, so its effects would have been unknown during the last round of Social Security changes. What benefit reductions might be more progressive than normal retirement age increases? Here are some solvency proposals: Individual Changes Modifying Social Security *(http://www.ssa.gov/oact/solvency/provisions/index.html)*. These options are not currently graded by progressiveness, but perhaps that is an option that will be pursued in the future. This much is clear. We absolutely need to focus our efforts on bolstering the trust fund in the near future and reducing the projected losses over the next two decades.

RECOMMENDATIONS

Based on the preceding information and ideas, here are my recommendations.

1. Require both the Trustees Report and Individual Changes Modifying Social Security (solvency proposals) to model proposed changes over the next 20 – 30 years and to include modeling of the trust fund impact over that time period.
2. Build consensus on the minimum length of time that policyholders should allow citizens to plan for their retirement, with advance notice of benefit cuts.
3. Focus on revenue changes to build up the trust fund prior to the full force of all the baby boomers reaching retirement.
4. Grade solvency proposals by progressiveness. Some are much more progressive than others. Both revenue and benefit change proposals should be graded.
5. Focus on revenue increases in the short term and benefit reductions over the long term, and realize that benefit changes cannot have a large impact over the next two decades.
6. Engage in the nuts and bolts of action. Despite our tendency as actuaries to say nothing, we must advocate for specific changes and support those changes with good reasons.

After we have placed the impact to the trust fund in the central role, there are three Social Security revenue changes that are quite simple

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We absolutely need to focus our efforts on bolstering the trust fund in the near future. ...

and mimic the 1983 amendments. Following these are some more provisions that were not included in 1983, but which I recommend to counteract the regressive nature of raising the payroll tax percentage (Item 1).

(1) Gradually raise the Social Security tax rate by 2.7 percentage points, to 15.1 percent, consistent with the 1980's percentage increase.
(2) Raise the taxable maximum to 95 percent of all wage income, to account for its many years at 85 percent or below.
(3) Include all new state and local workers in the Social Security system.
(4) Rather than using average wage indexing to increase the taxable maximum, use wage indexing using only the top 5 percent of earners.
(5) Expand covered earnings to cover employer and employee premiums for employer-sponsored health insurance.
(6) Use a smaller tax above the revised taxable maximum for higher earners (say 3 percent for earnings above the maximum).
(7) Reduce or eliminate the benefit credit for earnings above a certain point for higher earners.

Overall adequacy of retirement income is more important than ever. We must agree that we have waited too long to fix our Social Security problems with benefit cuts alone. We can fix them with a balance of revenue, weighted toward earlier years, and benefit cuts, weighted toward later years, in the 75-year projection period.

RECONSTRUCTING MEDICARE IN THE PUBLIC INTEREST

By Malgorzata Jankowiak-Roslanowska, Burt Jay and Mark Litow of The Government Health Care Subgroup of the Social Insurance and Public Finance Section

[Editors Note: The following represents the opinion of the authors, and not the opinion of the Society of Actuaries or the opinion of SOA's Social Insurance and Public Finance Section. The suggestions made below have not been quantified or validated by the SOA or its researchers.]

In the June, 2012 publication, we explored numerous problems plaguing the Medicare program and the Federal Budget. As a follow-up to that article, we are presenting possible solutions to these problems. We feel that it is necessary to reconstruct the Medicare program.

All of the ideas we will present are intended to mitigate the extraordinary high cost and inefficiencies found in the program. The focus of our proposed actions is to reduce overuse of medical treatment, third party payment, and fraud and other abuses, while maintaining or improving access to treatment. Within the Medicare program, we have spent many decades gradually encouraging behaviors such as overuse and numerous other problems that exist today. We, the citizens of the United States, should realize that we cannot expect behavior change overnight. The fixes will take time, and they should be implemented gradually.

Listed below are 10 proposed adjustments to reconstruct Medicare, designed so the program will use resources more efficiently and, ultimately, become self-sustaining. Note that the proposed items below are presented at a high level. These ideas are the opinions developed by some members of the Government Health Care Subgroup of the SIPF and are not intended to be an exhaustive list of all changes that could be implemented.

1. Increase the age of eligibility for Medicare benefits over time (i.e., two or three months every year, over 50 years, to an eligibility age of 73 to 77). This would reduce the average benefit lifetime by somewhat more than would occur if the eligibility age was increased consistent with life expectancy increases. This will serve as a slight "catch-up" for the oversight in not previously incorporating a benefit age increase, with no impact to current beneficiaries. Individuals under age 65 would need to adjust their retirement health benefit planning accordingly, but at least they would have some time to do so. Plans for medical care reform for younger populations would also need to be adjusted accordingly due to the increase in eligibility age that the Affordable Care Act (ACA) does not currently have provisions for.

The fixes will take time, and they should be implemented gradually.

2. Move disabled (under age 65) into the Medicare program and duals (who are on both Medicaid and Medicare) into the Medicaid disabled program, or a separate program, based on need. These populations should have a benefit program that includes a cost sharing subsidy for families that cannot afford the yearly cost. These groups could be included in the state exchanges cre-

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ated under the ACA, as long as the subsidy level was appropriately established for this group. Another solution would be to include these individuals under a separate program; subpopulations of disabled individuals and dual-eligibles could be combined or maintained in a completely separate program. Combining these groups with the Medicare aged population under the same benefit design is not appropriate, as the needs and resources of the aged and the disabled subpopulations are not consistent.

3. Increase Part A and B deductibles (particularly Part B) substantially, along with implementing other cost reduction and risk reduction provisions. The current benefit structure should be modified to create incentives to control utilization by consumers, provide more complete catastrophic benefits, use care management where appropriate, and modify benefits/contributions consistent with need. Integration of Parts A, B, C and D of Medicare will require modifying some provisions so that the new benefit structure is consistent across types of services. This would eliminate inconsistencies that exist today such as those between physician services in Part B and drug services in Part D. Changes could include:

   i. Substantially higher deductibles for Part B services.
   ii. Covering Part B catastrophic costs.
   iii. Integrating Part D into Part B and applying deductibles to these services as well.
   iv. Covering catastrophic Part D claims.
   v. Removing the concept of lifetime reserve days on Part A and adjusting any deductible consistent with medical trends.
   vi. Encourage use of care management for more serious medical conditions.

4. Provide subsidies to poor individuals to pay part of premiums and reduce cost sharing to some degree.

5. Continue to provide options to individuals to purchase Medicare Advantage. This could be accomplished with a payment equal to something a little less than the projected cost for Medicare coverage each year. The minimum benefits required to be purchased should be substantially less than currently exists under Medicare, perhaps 50 to 75% of total current benefit levels, so that people are not required to spend all of the money on health coverage. Any money not spent on health coverage would go into individual medical accounts that could be spent on cost sharing. Medicare Supplement carriers could expand to include this type of coverage, although no coverage for services under deductibles would be allowed.

6. Undo price controls gradually so that Medicare reimbursement is much closer to or consistent with average commercial rates. This change should occur concurrently with the implementation of incentives to control utilization and along with greater transparency of charges, thereby allowing consumers to participate in cost control.

7. For individuals who are under some prescribed age of 25 or 30, allow their Medicare contributions to accumulate into a separate, interest-earning fund that belongs to the individual and is accessible after the eligibility age for their Medicare benefits. Prior to the Medicare eligibility age, money in these separate funds would remain with the government for accounting purposes, in order to avoid creating a bigger Federal deficit in the short term. This approach includes some redistribution of monies from high earners to low

earners, so that all eligible individuals have a minimum amount in their account each year and at their eligibility age. However, for those individuals between the new prescribed young individuals and the Medicare eligibility age, a combination of the two benefit funding systems might be used, or, alternatively, the current system with adjustments as noted above. This change represents a gradual movement from a defined benefit to a defined contribution system. Implementation would take place within the next 50 years or more. Covering the cost of the gradual amortization of the current unfunded liabilities will come from:

a. The savings from changes in the benefit structure that reduces utilization substantially
b. Additional pre-tax contributions as described in item #8, below
c. Investment income on both the utilization savings and additional contributions

8. Additional pre-tax contributions under age 65 to fund future benefits and slowly amortize the unfunded liabilities of today.

9. Add a new safety net that covers the costs for individuals who exhaust their accounts, including insurance coverage purchased.

10. Create a risk management system that:
    a. For the youngest individuals, the new system is effectively a 401(k) type system for healthcare. The only safety net needed in this group is for those individuals whose accounts become exhausted.
    b. For those individuals who will soon be eligible, increases in the eligibility age, deductibles, cost sharing, and changes in price control schedules are made consistent with differences in actual versus expected experience over time, through a yet-to-be-developed formula.
    c. For individuals whose eligibility age falls between the ages of the individuals in Item a. and Item b., the risk management system is a blend of the two.

In general, the changes suggested above would very slowly modify the current Medicare system from a defined benefit system to a defined contribution system. This would slowly eliminate the huge unfunded liabilities and debts created by Medicare. The current system, where the Federal Government sets the rules, pays all the benefits, and continually pushes more and more liabilities and problems to future generations, would change to one where the Federal Government oversees and manages Medicare, but users, payers and providers have more control. The defined contribution system would include special protections for those most in need, and accounts would eventually become the property of the individual/family estate. However, this change must be implemented very slowly, so that the Federal Budget is not compromised. Providers would have every incentive to help and to treat individuals/families, rather than being coerced to participate by the Federal Government. If this provider motivation is not corrected, it will ultimately threaten the availability of treatment and the development of medical innovations for this population.

Our proposal, if enacted, would create a self-sustaining Medicare system within which future generations pay for their own aged healthcare, replacing the inter-generational subsidies that currently fund Medicare. We will no longer ask future generations to bear a burden that is increasingly beyond their means. In addition, our ideas reflect an alternative that we believe better conforms to the intent of Medicare, which is to protect seniors against costs they cannot afford, while enabling them to secure high quality medical treatment when necessary.

We invite others to respond to our proposal and engage in an ongoing dialogue about shaping the future of Medicare.

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ACTUARIAL TIPS & TRICKS CORNER

KEEPING UP WITH THE LAW

By David G. Hayes

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If you have not been paying attention to the U.S. health care reform discussion and wanted to get up to speed on what all of the excitement is about, where would you start, and how would you do it? Why would you need to do so, and is there a preferred method?

This article will specifically address how to find out more about health care reform, but also talk a little about an actuary's duty to keep up-to-date in their chosen area of practice. What duty do actuaries have to stay current? Well, they have the following obligations:

- Satisfy continuing education requirements of both the Society of Actuaries (SOA) and the American Academy of Actuaries (AAA). Precept 2 of the Code of Professional Conduct addresses the qualification standards of an actuary based on basic and continuing education. Continuing education can take the form of research on current topics pertaining to your chosen area of practice.
- The consulting actuary has an obligation to their clients to stay up-to-date on topics affecting the clients and their businesses.
- The company actuary has an obligation to their company to stay current on topics affecting the company and its financial performance.
- The actuary may have a responsibility to the public, if they are opining on current changes to a public program, such as Medicare or Medicaid.

What are the best ways to research new topics or changes affecting your business? You can try the following:

- Basic Internet Search—You can always try an Internet search engine, but then you have to sift through all of the non-relevant information.
- Check with the AAA or the SOA—Both the AAA and the SOA have committees and workgroups that have been formed to address a variety of practice areas and subjects. These workgroups often prepare guidance for the practicing actuary.
- Contact your consulting actuary—Consultants try to stay at the forefront of changes in the market, along with various rules and regulations; therefore, many times they have already completed some or all of the necessary research.
- Contact your local Department of Insurance or the National Association of Insurance Commissioners (NAIC)—When new laws are created, regulations typically have to be issued in order to administer the laws. Often, insurance departments and the NAIC help to prepare these regulations.
- Ask your peers—If you work with a group of actuaries, you can share some of the burden by sharing knowledge. Having a Lunch and Learn is a great way to interact with your fellow actuaries.

Let's get to the topic at hand: Health Care Reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Some also refer to this as the Affordable Care Act (ACA). Actually, ACA refers collectively to PPACA and the

Healthcare and Education Reconciliation Act. The remainder of this article will refer to the law as PPACA. PPACA's focus was to reduce the number of uninsured Americans and to reduce the overall costs of health care; however, these goals are still up for debate.

Since we discussed Internet searches, the following list of websites, including specifics, are good places to learn more information about PPACA. Each website is listed along with a brief description of its contents.

http://www.healthcare.gov/law/full/—This contains a full version of the law and also provides the Supreme Court's ruling on PPACA.

http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act—Although a Wikipedia search can sometimes provide hit or miss results, this link provides a good overview of the law and the timing of when provisions of the law will be enacted. In addition, this link provides hundreds of additional references and links.

http://www.kff.org/ and *http://healthreform.kff.org/*—In general, The Kaiser Family Foundation website contains a lot of information on health care; they also have a section devoted to health care reform. The health care reform website contains a summary of PPACA and its provisions, state-by-state information, educational items on topics such as the individual mandate, and calculator/estimators for determining items such as how premium subsidies will be determined.

http://www.cbo.gov/—The Congressional Budget Office (CBO) website provides cost estimates of enacting PPACA. These estimates include the original estimates and revised estimates, after incorporating the Supreme Court's ruling. The site also has a cost estimate if PPACA is repealed.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/index.html—Similarly, the Office of the Actuary for the Centers for Medicare & Medicaid Services publishes cost estimates and studies for many health care programs and proposals. They have an entire section of studies devoted to the estimated impact of health care reform proposals.

http://www.naic.org/—The National Association of Insurance Commissioners (NAIC) website lists current publications, including Model Laws, committees, and activities of the NAIC. For those of you preparing rate filings, the NAIC has developed the System for Electronic Rate and Form Filing (SERFF). Many states require companies to file premium rates using the SERFF system. More information on SERFF can be found here: *http://www.serff.com/*.

http://cciio.cms.gov/—The Center for Consumer Information & Insurance Oversight website provides information to consumers, companies, and industry professionals. PPACA established provisions for transparency in health care premium rates. As a result of this new transparency, an effective rate review process was established to prevent unreasonable rate increases. The fact sheets

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and frequently asked questions section of the website provide a lot of good information on PPACA and its provisions.

http://www.ncsl.org/—The National Conference of State Legislatures website gives state status updates on all health care reform efforts, including exchanges.

http://www.hhs.gov/—The U.S. Department of Health and Human services website provides links to federal regulations, U.S. government grants and funding, and press releases.

http://www.soa.org/—The SOA website provides links to all of the professional interest sections, current news, and SOA-sponsored publications and research. A resource that people may not know about is the electronic discussion list or Listserv. The SOA has many public Listservs that you can join to participate in the discussion of current topics.

http://www.actuary.org/category/site-section/public-policy/health/health-reform-aca-implement—The AAA has a section of their website devoted to health care reform and PPACA implementation.

http://www.actuary.org/content/academy-committees-homepage—This section of the AAA website provides a listing of all of the current AAA committees.

http://www.actuary.org/category/site-section/public-policy/practice-notes—This section of the AAA website provides a listing of practice notes and guidance on current issues.

In addition to the websites listed above, most states have both legislative and insurance department websites where useful information can be found.

While this is not an exhaustive reference list, hopefully it provides you with a starting point for researching both health care reform and other actuarial topics.

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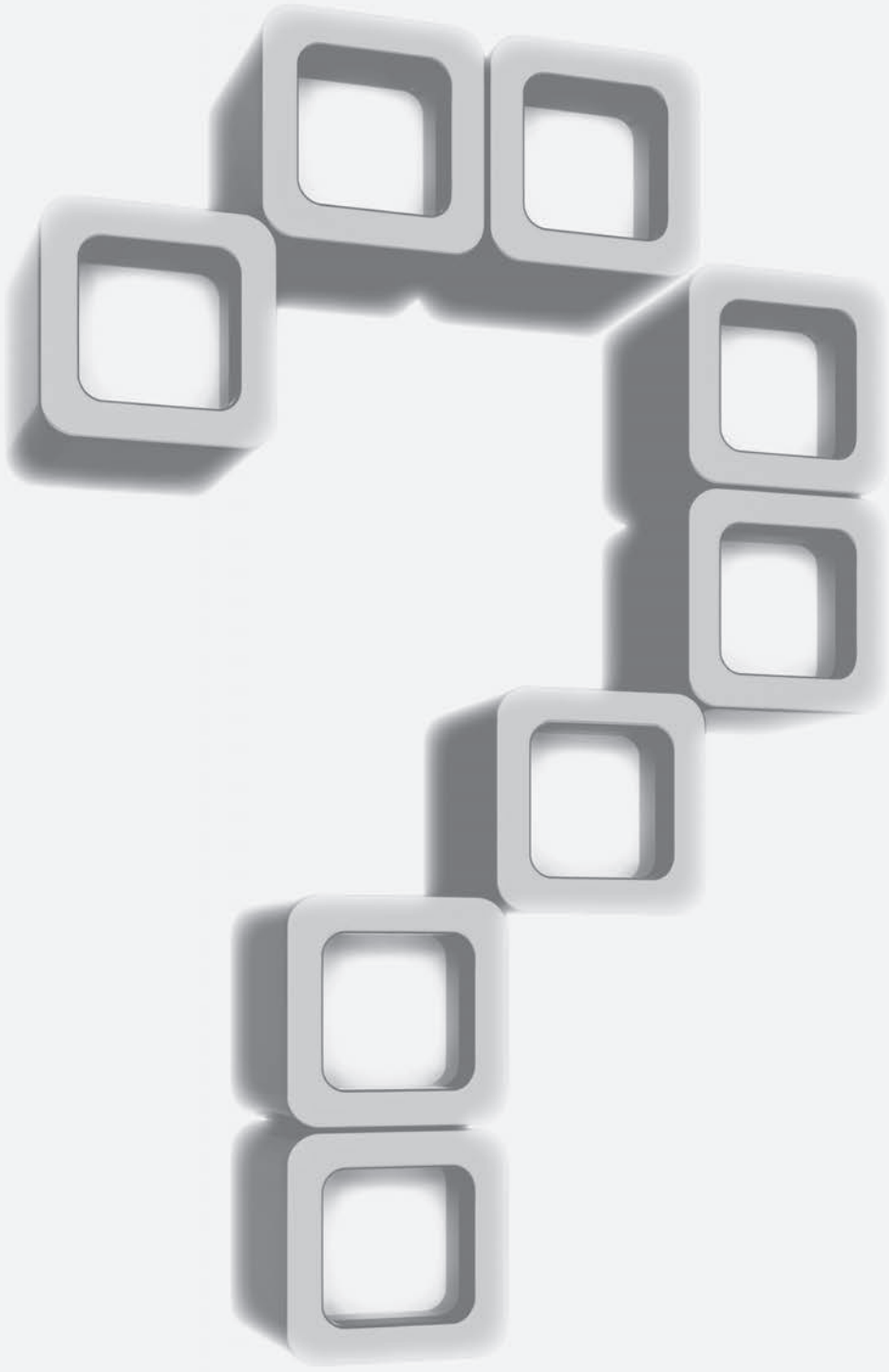

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