# Unaffordable: Impact of Obamacare on Americans' Health Insurance Premiums

**by**

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**for the**
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# I – Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Chris Carlson, Principal and Consulting Actuary at Oliver Wyman. I have nearly twenty years of experience as a health care actuary and have been actively involved the last few years in helping stakeholders, including clients, regulators and actuarial colleagues understand and implement the changes required by the Affordable Care Act (ACA). I am delighted to have this opportunity to testify on the impact of the ACA on health insurance premium rates.

As an actuary, I represent a profession that maintains high standards of professionalism and provides critical independent thought and analysis to educate the policy decision makers on issues of great importance. Our work that is detailed in this testimony has been performed under the guidance of the Actuarial Standards of Practice.

My testimony will focus on two topics that I and the other actuaries at Oliver Wyman have studied extensively. These topics are:

- The analysis that we performed to measure the impact of the three to one age-rating limitation of the ACA on individual policyholders.

- The estimates we have developed on the increase in premiums that will be required to fund the health insurer taxes beginning in 2014.

Overall, we note that the age-rating limitations result in no change in the average premium. However, since current age-rating laws in most states allow for a five to one ratio in the highest to lowest rate, the change in the premium required for certain policyholders to compress to a three to one ratio is significant. Our study indicates that the impact of the age rating compression

will increase the average premium for policyholders between ages 21 and 29 by 29%. When combined with other changes in the market, such as increased actuarial value of benefits and essential health benefits, the overall increase in premiums for the policyholders ages 21 to 29 may be 42%. We note that this increase would only apply to individuals that are not eligible for any premium subsidies and have incomes above 400% of the Federal Poverty Level.

Beginning in 2014, health insurers will be assessed additional premium taxes required by the ACA. The amount to be collected in 2014 is $8 billion, increasing to $14.3 billion in 2018 and with trend thereafter. We estimate that the impact of these taxes will be to increase premium rates by 1.9% to 2.3% in 2014, and by 2.8% and 3.7% in years 2018 and later.

## II – Age-Rating Under the ACA

The ACA reforms the market rules that all health insurance providers must follow in the pricing of health premiums beginning on January 1, 2014. In general, premium rates are only allowed to vary by four criteria: geography, age, tobacco usage and actuarial value. Of these, there is a further restriction that the premiums may not vary by age by more than three to one from the highest age tier to the lowest age tier. In fact, the regulations that were promulgated by the Department of Health and Human Services mandated specific factors by age to be used, unless otherwise developed by an individual state.

Kurt Giesa and I, actuaries at Oliver Wyman, co-wrote an article for *Contingencies* magazine, which is published by the American Academy of Actuaries, which estimated the impact of the age rating compression on different age cohorts in states that currently allow age rating beyond three to one. The importance of this work is to help move beyond looking at premium changes based on broad averages, especially in a case where an average would mask substantial

differences. We believe it is especially important to look at the age cohort from 21 to 29, since even after accounting for ACA's provision requiring that adult children be allowed to remain on their parents' coverage until age 26 this age group has an uninsured rate that is roughly twice the uninsured rate for the nonelderly population.

To create our study, we used three primary data sources. The first was the 2011 Current Population Survey (CPS) conducted by the U.S. Census Bureau (use of the 2011 CPS data takes into account the impact of the ACA's adult child coverage provision, which became effective for plan years beginning on or after Sept. 23, 2010). For premium-level assumptions, we relied on Congressional Budget Office (CBO) estimates regarding selection and impact of increased benefit levels tied to actuarial values. We excluded the effects of medical cost trend because it's assumed to occur regardless of the ACA. (CBO estimates of premium increases include growth in the underlying cost of coverage related to an increase in benefits over what is purchased today, positive selection due to an assumed improvement in risk pool mix, and lower prices due to greater market efficiencies.) Our estimates of the level of premium assistance are generous, as we based them on average premiums. Had we based them on estimates of premiums for the second lowest- cost silver plan (as will be the case under the ACA), the assumed levels of premium assistance would have been lower and consumer out-of-pocket costs for health insurance and the premium rate changes in 2014 would have been higher.

To construct premiums by age in 2013, we relied on a set of proprietary rating factors maintained by Oliver Wyman. These rating factors are based on costs and are consistent with factors used in the industry. For 2014, we used the standard age curve that CMS put forward in its proposed Health Insurance Market Rules. We also collected data from two large health insurance issuers to

verify our estimates derived from CPS data on demographic distributions and found similar results when looking at these carriers' actual market data.

While a range of ACA provisions will be implemented in 2014, perhaps the most important for young adult insurance premiums are the provisions for age band compression and the provisions related to advanced premium assistance tax credits and cost-sharing reduction assistance. The essence of age band compression is that younger people pay more for their coverage so that older people can pay less. As with many other issues that affect pricing, this is effectively a matter of the amount of cross-subsidization that will flow among different enrollees with respect to their health insurance premiums. We need to distinguish the cross-subsidies that are the result of age band compression from the general pooling of risk that underlies all insurance. While insurance generally provides a retroactive cross-subsidy among insured individuals to protect against unknown risks, age band compression is a prospective cross-subsidy from the young to the old.

Our analysis shows that under the ACA, premiums for people aged 21 to 29 with single coverage who are not eligible for premium assistance would increase by 42 percent over premiums absent the ACA. People aged 30 to 39 with single coverage who are not eligible for premium assistance would see an average increase in premiums of 31 percent. Those with single coverage aged 60 to 64 who are not eligible for premium assistance would see about a 1 percent average increase in premiums. Our estimates of these effects are shown in Chart 1 and reflect the assumptions described above. These estimates assume a starting age band of about five-to-one, reflecting states where coverage currently is underwritten.

Our core finding is that young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the FPL, or roughly $25,000, can expect to see higher premiums than would be

the case absent the ACA, even after accounting for the presence of the premium assistance. Similarly, single adults up to age 44 with incomes beginning above approximately 300 percent of FPL can expect to see higher premiums, even after accounting for premium assistance. This is because in today's market, younger enrollees can buy coverage that more closely reflects their expected actuarial costs based on their age, and this coverage is pooled with other similar risk classes in accordance with standard actuarial principles. In addition, the ACA requires that all nongroup coverage meet essential health benefit requirements, both with respect to the type of services covered and with respect to the actuarial value of the coverage.

Consider, for example, a 25-year-old person with income at 300 percent of FPL, or $33,510. This person currently could purchase coverage for about $2,400 per year, or 7.2 percent of his or her income. Age band compression and the other changes to the ACA would result in premiums (before premium assistance) increasing by 42 percent to $3,408. As shown in Chart 2, this person at 300 percent FPL will be required to pay 9.5 percent of his or her income, or $3,183, toward the cost of coverage. The cost of his or her actual premium would increase by $783, even with the $225 in premium assistance. (The impact of cost-sharing reduction assistance at these income levels is not relevant because the assistance completely phases out at household incomes above 250 percent of FPL.)

While our analysis focused primarily on the impact of age band compression, the interaction of age band compression and the elimination of premium variation related to health status also deserves attention. Analysis of representative carrier data suggests that eliminating health status as a rating factor itself may increase premiums by roughly 17 percent to 20 percent for those who have preferred rates because of lower-than-average health risks. Young adults often qualify for these preferred rates. These increases would be in addition to any premium rate change due to

age compression, required increases to benefits, or other factors discussed above. On the flip side, older individuals often cannot get coverage in the nongroup market or afford coverage if it is offered. The ACA addresses many of these concerns for older persons separate from the issue of age band compression. It mandates that nongroup coverage be offered on a guaranteed-issue basis. The ACA's prohibition on varying premiums based on health status will lower rates for older people. And the same arguments that apply with respect to premium assistance for younger individuals apply to those who are older—for anyone with household income up to 400 percent of FPL, the ACA makes premium assistance available that caps spending on coverage at 9.5 percent of income, or a lower amount for incomes less than 300 percent of FPL. The difference between young and old at similar income levels is that younger individuals at a given income level are much less likely to find it economically rational to purchase coverage if it takes up 9.5 percent of their income, while older individuals have a greater expectation of health care cost spending as a percentage of income.

In light of these trade-offs, it is important to consider ways of mitigating the effect on rates for younger people while leaving benefits of the ACA in place for older people in the pre-65 age cohort.

Breadth of Impact

Looking at the uninsured by FPL and age in 2011 shows that 11.2 million people (or almost 25 percent of the uninsured in 2011) were between the ages of 21 and 29, and roughly 1.4 million of these individuals will not be eligible for premium subsidies because their household income exceeds 400 percent of FPL. At the same time, close to another 2.6 million uninsured individuals are estimated to have incomes above 225 percent of FPL, the crossover point above which those

purchasing single coverage can expect to pay more out of pocket for coverage than they otherwise would, even after accounting for premium assistance. In total, this means that close to 4 million uninsured individuals aged 21 to 29—or roughly 36 percent of those currently uninsured within this age cohort (4 million/11.2 million)—can expect to pay more out of pocket for single coverage than they otherwise would, even given the availability of premium assistance.

Roughly 7.6 million people, or 40 percent of those covered in the nongroup market in 2011, had incomes above 400 percent of the FPL and would be ineligible for premium assistance. Taking into account both the 400 percent FPL phase-out level and the 225 percent FPL crossover point, we estimate that almost 80 percent of those ages 21 to 29 with incomes greater than 138 percent of FPL who are enrolled in nongroup single coverage can expect to pay more out of pocket for coverage than they pay today—even after accounting for premium assistance. With a crossover point of about 300 percent of FPL for those aged 30 to 44, we estimate that about one-third of those older than age 29 with incomes greater than 138 percent FPL who currently are insured with individual contracts will see higher premiums even after accounting for premium assistance.

Also of potential importance to the cost of coverage for young adults are two ACA provisions: the creation of a catastrophic plan option and coverage of adult children to age 26 through their parents' group coverage. The ACA provides that beginning in 2014 issuers can offer a catastrophic plan option to those under age 30 and to others for whom the cost of coverage is deemed unaffordable. The ACA's provisions on cost-sharing applicable to "metallic level" coverage and the actuarial value requirements do not apply to these plans. If they are substantially more affordable than other coverage, catastrophic plans may prove an important option for young adults to keep premiums affordable (though premium assistance will not be

available to those purchasing the catastrophic coverage, regardless of income). The ACA also includes provisions allowing parents to keep adult children on their employer-sponsored group coverage up to age 26. This provision is already in effect, and early indications are that it has helped to cover more young adults. Because this coverage is by definition group coverage, however, increasing dependent coverage for young adults in this way does not improve the quality of the risk pools in the nongroup market. In fact, comparing the 2011 CPS data against earlier periods suggests that one effect of the adult child coverage provision on the nongroup market has been to increase the proportion of older enrollees in relation to younger enrollees.

From a policy perspective, the issue of age band compression and whether its effect on the cost of coverage for young people is outweighed by the value of premium assistance matters for at least two reasons.

- Equity—While judging fairness and the trade-offs implicit in age band compression raises subjective questions, technical analysis can help objectively unmask distributional differences relevant to this question.

- Market Efficiency—If people aged 21 to 29 are asked to pay substantially more for their coverage than they otherwise would, will they choose to obtain or maintain coverage at all?

This question has clear implications for insurance markets, which rely on the presence of balanced risk pools in order to provide affordable coverage. Younger people tend to be healthier and have expected health care costs that are lower than those of older people. An adult near retirement age, for example, is generally expected to have health care costs that are roughly six to seven times or more than those of the average male aged 21 to 29. If healthy young people choose to leave the risk pool or join in proportionately fewer numbers relative to those with

immediate health care needs, the effect would be to create an unbalanced risk pool and higher prices for those seeking coverage.

Our analysis raises questions as to whether younger individuals will perceive coverage as cost effective. In our analysis, we blended young males with young females to look at age 21 to 29 cohorts as a whole. Had we broken the analysis out by gender, it would show a greater impact on young males (meaning premium increases would be higher and the crossover point would occur at a lower FPL level) and less of an impact on young females. The CBO's 2009 analysis of premiums under the ACA suggests that more young people would obtain coverage under the ACA than under current market conditions, leading presumably to the conclusion that risk pools for nongroup coverage in 2016 would be younger and healthier than today's markets. More recent estimates at the state level by various parties have reached different results. These analyses have focused on factors such as the impact of guaranteed issue and the elimination of underwriting. Important to all these analyses are assumptions regarding the effectiveness of the individual coverage mandate, which could encourage young people to obtain and retain coverage even if it is not otherwise in their perceived economic interest to do so. In this regard, the ACA requires that every individual maintain coverage or pay a tax penalty that is equal in 2014 to the greater of $95 or 1 percent of modified adjusted gross income, with the penalties for not maintaining coverage gradually increasing over time—phasing up to the greater of $325 or 2 percent for 2015 and ultimately the greater of $695 or 2.5 percent of income after 2016. The relatively low penalties associated with the individual mandate make the effectiveness of the mandate uncertain, particularly in the first few years of reform when stability is essential and the penalty can be expected to fall well below the annual cost of the minimum standard of coverage required under the ACA. This situation was given clarity in the June 2012 ruling from the U.S.

Supreme Court—the law does not require maintenance of coverage, only maintenance of coverage or payment of the tax penalty.

Given the significance of these issues, policymakers should assess how various ACA provisions affect the underlying affordability and cost of coverage for younger individuals, in order to better understand issues that may affect their decisions to obtain and/or maintain coverage. Understanding these issues requires analyses that go beyond consideration of broadly stated averages, which can mask the effects on important subpopulations. There are several options for mitigating the potential impact of age band compression. One approach, provided the ACA allows for this, would be to phase in the age band requirements over a period of years, thus allowing the market to stabilize with respect to other changes before full implementation of age band compression requirements. This might also bring about higher enrollment levels among young adults, which could lead to a healthier risk pool overall and help hold down premium rates for everyone— young and old.

Another complementary possibility would be to ensure that the pricing rules for catastrophic coverage provide adequate flexibility to increase the likelihood that these policies will be affordable. This appears to be the approach that CMS had taken in its recently released "Notice of Benefit and Payment Parameters for 2014." Affordability is especially important for young adults who have incomes that make them ineligible for premium assistance or are above the 225 percent FPL crossover point. For these individuals, an affordable catastrophic coverage plan could mean the difference between obtaining and going without coverage. Because these plans are not eligible for premium assistance and are limited to those age 30 and younger (and those for whom coverage is "unaffordable"), there would be a natural limiting point with respect to the number of people who would be expected to enroll. As a result, the potential impact on coverage

costs for older people because of the reduced level of cross-subsidy from those enrolled in catastrophic coverage would be limited.

## III – Insurer Taxes

The ACA, establishes an annual fee on the health insurance sector – effective in 2014. The new fee applies with some exceptions to any covered entity engaged in the business of providing health insurance (including private plans that participate in public programs), but does not include self-insured employer-provided health plans. The amount of the fee will be $8 billion in 2014, increasing to $14.3 billion in 2018, and increased based on premium trend thereafter. The fees are non-deductible for federal tax purposes. As we explain later, this feature implies that for each dollar assessed and paid in fees, more than a dollar in additional premium amounts must be collected (e.g. $1.54 for every $1.00 in fees, assuming a 35% federal corporate income tax rate). In total, on a statutory basis, between 2014 when the fees are first imposed and 2019, the total amount assessed (and actually collected from health insurers) will be at least $73 billion. Net revenues to the federal government, however, will increase by a lesser amount as reflected in revenue effect estimates by the Joint Committee on Taxation ("JCT") which show federal revenues increasing by $60.1 billion over 10 years (2010-2019). As highlighted below, both the JCT and CBO conclude that the new fee on health insurance plans would increase premiums.

The CBO prepared an estimate of the impact of the market reforms required by the ACA in a letter to Senator Evan Bayh on November 30, 2009. However, in this document, the CBO made no explicit calculation of the impact of the insurer fees on average premiums in the market. Instead, they stated "these fees would largely be passed through to consumers in the form of higher premiums for private coverage."

In a June 2011 letter to Senator Jon Kyl, the JCT explained that the fee on health insurance providers is similar to an excise tax based on the sales price of health insurance contracts. They estimated that repealing the health insurance industry fee would reduce the premium prices of plans by 2.0 to 2.5 percent, and that eliminating this fee could decrease the average family premium in 2016 by $350 to $400.

Our analysis quantified the impact of the fees imposed on health insurers under the ACA on the cost of health insurance coverage in both the commercial and public sectors. Our analysis estimates that the insurer fees will increase the costs of fully insured coverage by an average of 1.9% to 2.3% in 2014, further increasing over time such that by 2023, the fees will ultimately increase costs on average by 2.8% to 3.7%. This implies a material increase the average dollar cost of fully insured coverage, raising the average cost of such coverage by several thousand dollars over a 10-year period beginning in 2014.