The Health Insurance Premium Impact of the Affordable Care Act: An Overview of Survey Results

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Douglas Holtz-Eakin, President*
American Action Forum

March 15, 2013

*The views expressed herein are mine alone, and not those of the American Action Forum. I thank Emily Egan, Sarah Hale, and Cameron Smith for their assistance. All errors are my own.

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee, thank you for the privilege of appearing today regarding the impact of the Affordable Care Act on health insurance premiums. The American Action Forum (AAF) keeps a close eye on the private health insurance market as well as implementation of the Patient Protection and Affordable Care Act (ACA). I am pleased to share my overview of the projected premium impacts.

I will make three primary points about the Affordable Care Act's impact on premiums:

- The requirements faced by insurers will be such that market forces push premiums higher, and health costs will be inclined to grow faster, rather than slower, as a result of the law;

- Younger Americans, who make up the plurality of the uninsured population now, will be forced to bear the largest premium increases, unless they go without insurance, which would, in turn, remove the healthiest from the insurance risk pool; and

- The structure of the law dictates that higher premiums and higher health care costs must translate into greater federal subsidies for those purchasing insurance on the exchanges. This budgetary pressure would be exacerbated by higher small group premiums, which provide incentives for small employers who currently provide coverage to drop it and expand participation in the exchanges.

The ACA and Insurance Premiums

The ACA makes a number of substantial changes to the health insurance market. While the market is currently regulated on a state-by state basis, the ACA introduces several new mandates applicable to health insurers nationwide. This testimony focuses largely on the projected impact of the law on plans operating in the small group and individual market, as gleaned from a survey of large insurers.

Premiums are the result of actuarial assessment of health care costs, benefits offered, cost-sharing requirements, and applicant data such as gender, age, tobacco use and pre-existing conditions. In 2014, plans will be mandated to expand benefits, precluded from having premiums vary based on gender or pre-existing conditions, and required to limit cost-sharing requirements overall (which includes doing away with cost-sharing for certain preventative services). While plans will be able to price premiums differently for enrollees of different ages, the range is limited to a ratio of 3 to 1. This means that costs for an older enrollee cannot exceed three times that of a younger, healthier enrollee – far below the ratios currently prevailing in markets.

Insurance plans will have to abide by the federal law in addition to relevant state regulations. It is worth noting that while the ACA allows for "grandfathered plans" – those exempt from ACA regulations – the restrictions are such that few will qualify for

grandfathered status. In practice, the major ACA reforms that come into effect in 2014 will apply to nearly all policies and significantly impact the setting premiums:

- Guaranteed issue – insurance companies will no longer be able to deny applicants;
- No exclusions for pre-existing conditions – companies will no longer be able to limit benefits for certain applicants;
- Community rating with tighter age bands – plans are unable to price plans based on the health status or gender of enrollees and are limited in their ability to price premiums based on age;
- Essential health benefits – the federal government has issued a regulation that 10 classes of benefits must be covered, with specifics to be decided by the states; and
- Mandated coverage – individuals will be mandated to purchase health insurance coverage.

Individually, these reforms are neither novel nor new. A number have been enacted at the state level. In general, when implemented without a mandate for coverage they have caused premiums to grow quickly to unaffordable levels. There is anecdotal evidence of premiums nearing $100,000 in New York, and insurers leaving the market in Kentucky altogether. Even in Massachusetts, a state that enacted a similar health reform bill that included a mandate for coverage, health care premiums are growing at an unsustainable rate.

In Massachusetts, which has a mandate and a guaranteed issue requirement in place, state health care spending on subsidized and employee coverage programs consumed 41 percent of the state budget in fiscal 2013. This is compared to 36 percent in 2010, and 29 percent in 2005. The Massachusetts health reforms went into effect in 2006. Even years after reform has been fully implemented, the state's Executive Office for Administration and Finance projects that health costs will consume 50 percent of the state budget by 2020.

The experience suggests that while supporters of the ACA argue that the individual mandate will add enough enrollees to health insurance pools to mitigate the upward pricing pressure that results from the major insurance provisions, this hypothesis has not been born out in similar state experiments.

Projected Premium Impacts of the ACA: Survey Results

In light of the analytic presumption that the ACA will place upward pressures on premiums, the overriding research question becomes: how much? To shed light on this, the American Action Forum conducted a survey of major insurance companies regarding the premium impact of the above-mentioned reforms. These results were published in February 2013.[1] Large, nationwide insurance firms, who together represent the vast majority of privately insured Americans, were surveyed regarding their projected premium changes in 6 regions

[1] http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf

(Chicago, Illinois; Phoenix, Arizona; Albany, New York; Atlanta, Georgia; Austin, Texas; and Milwaukee, Wisconsin) in the small group and individual markets. The premium impacts will differ depending on the existing, state-specific regulatory regimes that exist in the market before transitioning to the new 2014 rules. The survey goal was to pick a variety of cities including those with strict regulations on age rating and guaranteed issue (and other factors) as well as those that currently allow insurers flexibility. Using case studies also allowed one to determine premium impacts for population groups in certain markets rather than looking at an aggregate premium impact.

The survey was entirely anonymous. Survey results were submitted and aggregated by a third party, who then submitted the averages for each population and insurance market to the American Action Forum.

The major takeaway from survey results is that premium rate shock is forthcoming for the younger and healthier enrollees, whereas older, sicker, enrollees will see a reduction in premiums. On average, survey responses showed a premium increase for the younger and healthier of 149 percent in the small group market and 189 percent in the individual market. For small firms with older employees, premium reductions in the markets in question averaged 26 percent.

As shown in Tables 1 through 4, the different ACA insurance mandates have varied impacts depending on the population and insurance market. For example, the prohibition on using health status when determining premiums will raise premiums in a small group plan with younger, healthier workers by an average of 15 percent in Phoenix and 27 percent in Milwaukee. The same regulation impacts small group plans with older products by lowering premiums by an average of 29 percent in Atlanta but 39 percent in Phoenix.

Using actuarial estimates to determine premiums is not an exact science. It will be even more difficult for plans to insure a population that was uninsured prior to 2014, as their health needs and related costs may not be comparable to the previously insured population. 2014 will be a very interesting year for insurance firms navigating the new landscape for the first time.

It bears noting that in addition to the provisions in the ACA that exert upward or downward forces on premium prices, firms will also be impacted by federal rate review, which will pressure companies to keep premium costs down. It is unclear how this process will impact health plan premiums, and how it will work in concert with state insurance regulations which require plans to price premiums high enough to ensure solvency.

Table 1: Impact on Small Group Market - Younger and Healthier Workers						
Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$1,865	$1,740	$2,450	$1,806	$2,374	$2,047
Elimination of group size rating factor	3%	2%	2%	1%	2%	2%
Elimination of health status rating factor	17%	15%	21%	19%	27%	20%
Elimination of gender rating factor	21%	21%	35%	21%	35%	27%
Impose 3:1 age rating constraint	40%	39%	27%	39%	33%	36%
Increase to 60% Actuary Value	10%	11%	7%	14%	11%	11%
Required new benefits (EHBs)	1%	1%	2%	1%	2%	2%
Tobacco Use Rating Factor	-3%	-3%	0%	-3%	-2%	-2%
Elimination of other allowable rating factors	6%	1%	8%	2%	2%	4%
Change in the Risk Pool	1%	5%	1%	1%	4%	3%
Miscellaneous new rules	0%	0%	0%	0%	0%	0%
New taxes & fees	3%	3%	3%	3%	3%	3%
Transitional reinsurance contributions	2%	2%	1%	2%	1%	2%
Impact of exchange on operating costs	1%	1%	1%	1%	1%	1%
Average new monthly premium	$4,551	$4,075	$6,088	$4,346	$6,562	$5,124
Average percentage increase/decrease	144%	134%	148%	141%	176%	149%
Percentage entries are impacts due to the specific factor.						

Table 2: Impact on Small Group Market - Older and Less Healthy Workers						
Premium Factor	Chicago, IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$13,837	$12,474	$17,742	$14,148	$14,471	$14,534
Elimination of group size rating factor	3%	2%	2%	1%	2%	2%
Elimination of health status rating factor	-30%	-39%	-29%	-30%	-35%	-33%
Elimination of gender rating factor	-1%	-1%	-1%	-2%	0%	-1%
Impose 3:1 age rating constraint	-3%	-3%	-3%	-3%	-3%	-3%
Increase to 60% Actuary Value	0%	0%	0%	0%	0%	0%
Required new benefits (EHBs)	1%	1%	2%	1%	2%	2%
Tobacco Use Rating Factor	13%	13%	5%	13%	11%	11%
Elimination of other allowable rating factors	-11%	0%	-11%	-6%	-4%	-6%
Change in the Risk Pool	1%	5%	1%	1%	4%	3%
Miscellaneous new rules	0%	0%	0%	0%	0%	0%
New taxes & fees	3%	3%	3%	3%	3%	3%
Transitional reinsurance contributions	1%	1%	1%	1%	1%	1%
Impact of exchange on operating costs	0%	0%	0%	0%	0%	0%
Average new monthly premium	$10,293	$9,247	$12,254	$10,790	$10,948	$10,706
Average percentage increase/decrease	-26%	-26%	-31%	-24%	-24%	-26%
Percentage entries are impacts due to the specific factor.						

Table 3: Impact on Individual Market - Young, Healthy Male						
Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$63	$43	$51	$54	$58	$54
Impact of guarantee issue with individual mandate and premium subsidies	47%	46%	44%	45%	46%	46%
Elimination of health status rating factor	19%	15%	18%	14%	21%	18%
Elimination of gender rating factor	9%	11%	24%	11%	26%	16%
Impose 3:1 age rating constraint	25%	24%	21%	26%	20%	23%
Increase to 60% Actuary Value	18%	17%	11%	17%	13%	15%
Required new benefits (EHBs)	9%	9%	8%	9%	9%	9%
Tobacco Use Rating Factor	-1%	0%	0%	0%	0%	0%
Miscellaneous new rules	2%	1%	1%	1%	1%	1%
New taxes & fees	2%	2%	2%	2%	2%	2%
Transitional reinsurance contributions	-6%	-8%	-9%	-7%	-8%	-8%
Impact of exchange on operating costs	1%	2%	1%	1%	1%	1%
Average new monthly premium	$189	$119	$143	$153	$175	$156
Average percentage increase/decrease	202%	180%	179%	183%	203%	189%
Percentage entries are impacts due to the specific factor.						

Table 4: Impact on Individual Market - Older, Less Healthy Female						
Premium Factor	Chicago IL	Phoenix AZ	Atlanta GA	Austin TX	Milwaukee WI	All Cities Average
Average existing monthly premium	$1,167	$922	$1,021	$978	$1,363	$1,090
Impact of guarantee Issue with individual mandate and premium subsidies	47%	46%	44%	45%	46%	46%
Elimination of health status rating factor	-50%	-49%	-44%	-47%	-45%	-47%
Elimination of gender rating factor	-2%	-1%	0%	-1%	-1%	-1%
Impose 3:1 age rating constraint	-10%	-10%	-12%	-12%	-8%	-10%
Increase to 60% Actuary Value	0%	0%	0%	0%	0%	0%
Required new benefits (EHBs)	7%	6%	6%	6%	7%	7%
Tobacco Use Rating Factor	26%	26%	25%	26%	25%	25%
Miscellaneous new rules	2%	1%	1%	1%	1%	1%
New taxes & fees	2%	2%	2%	2%	2%	2%
Transitional reinsurance contributions	-4%	-6%	-7%	-6%	-6%	-5%
Impact of exchange on operating costs	0%	0%	0%	0%	0%	0%
Average new monthly premium	$997	$769	$881	$815	$1,238	$940
Average percentage increase/decrease	-16%	-17%	-11%	-40%	-5%	-18%
Percentage entries are impacts due to the specific factor.						

Implications

Beyond the direct impact of premium changes, these results have broader implications for the implementation of ACA. For the individual market, higher premium costs equate to a larger taxpayer burden to cover individuals with incomes 100-400 percent of Federal Poverty Level (FPL) who are purchasing subsidized coverage on the exchanges. In addition, fewer uninsured adults will be subject to the individual mandate tax if coverage would be an "unaffordable" cost to them – over 8 percent of their annual income. If the mandate tax

is not applicable, will young, healthy, uninsured individuals feel compelled to purchase insurance? Higher prices make it less and less likely.

At the other end of the age spectrum, will older Americans carry insurance year in and year out if they have unrestricted access to it when the need arises? Consider a middle-aged single adult who has had acute care in the past, but with no ongoing chronic health issues and an income of $46,000 annually (just enough to put her over 400 percent of FPL and be ineligible for insurance subsidies). If her only choices for insurance plans are over $1000 per month she is not subject to the mandate penalty/tax. When looking at table 4, the average monthly premium across the 6 markets will be *reduced* to $940. For this hypothetical adult, it may be financially beneficial to wait until insurance coverage is needed rather than purchase a plan that costs nearly a quarter of annual income.

The argument made numerous times by policymakers and stakeholders on both sides of the debate, especially during the Supreme Court's examination of the ACA's legal foundation, is that without a strong mandate, the insurance reforms such as community rating and guaranteed issue impossible. When individuals are guaranteed access to insurance products when they get sick (which is a worthwhile policy goal, of course, but more difficult in practice) they can wait until such illness occurs to purchase the insurance. Young adults acting rationally may look at a 150 percent increase in premiums and decide to opt out of the market for the time being. Older adults, such as the abovementioned hypothetical woman, may consider guaranteed issue and opt out of the market as well.

Higher premiums impact the small group employer market as well. With higher costs (or, costs that have been reduced by some percentage but stretch the budget of a small firm nonetheless) more firms may make the decision to drop coverage, especially if they have fewer than 50 employees and are not facing the penalty. There have already been many employer surveys, modeling projections and academic analyses that estimate employer drop to varying extents. Higher premiums only push the scales further toward a rational decision to drop coverage and shift employees onto exchanges where those with low or moderate incomes will have their insurance coverage subsidized by the taxpayer.

Thank you. I look forward to answering your questions.