

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY & COMMERCE  
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

“HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND  
AFFORDABLE CARE ACT”

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STATEMENT OF  
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Mr. Chairman, Ranking Member, and members of the Committee—thank you for the opportunity to testify today about the premium impact of the Affordable Care Act. My testimony will make five key points:

- 1.) Concern has focused on the premium impact for young adults. But young adults who now have non-employer coverage and higher incomes are a small fraction of the population.
- 2.) Recent studies by health insurance companies and actuaries affiliated with the insurance industry lack transparency, are self-serving, and omit key factors.
- 3.) These studies do not measure up when compared with actual rate filings and analyses by independent experts.
- 4.) Emerging evidence indicates that the Exchanges are working as intended—competition among plans and providers is already lowering premiums.
- 5.) Premiums should not be the exclusive focus of investigation. In the new, modernized market, consumers will get a lot more for their money.

**Young adults who now have non-employer coverage and higher incomes are a small fraction of the population**

First, it is important to be clear about who will be affected by reforms and how. Among Americans with health insurance coverage, nearly 90 percent are covered by employer plans,

Medicare, Medicaid, or other government programs.<sup>1</sup> These Americans will not be affected by reforms to non-employer coverage under the Affordable Care Act.

Now consider the remaining 10 percent of the population. Concern has focused on the premium impact for young adults with higher incomes, who will not be eligible for full subsidies. But the fraction of the population that now has non-employer coverage, is between the ages of 19 to 29, and has income above 250 percent of the federal poverty level is **0.5 percent**.<sup>2</sup>

That fraction is even smaller after excluding women, who will see premium savings from the elimination of gender rating. And the fraction is smaller still after excluding young adults who will be eligible for their parents' coverage: Among young adults who will not be eligible for subsidies, **two-thirds** will be eligible for their parents' coverage.<sup>3</sup> Finally, the fraction is even smaller after excluding young adults who now have non-employer coverage that is "grandfathered"—in other words, that is exempt from reforms. For example, in Maryland, 60 percent of CareFirst's enrollees in non-employer coverage are grandfathered.<sup>4</sup>

By contrast, the Affordable Care Act will benefit millions of Americans who have been offered Swiss cheese insurance, who were priced out of the market, or who were denied insurance altogether. Tens of millions of Americans will gain health insurance coverage. All Americans

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<sup>1</sup> Author's calculation based on data from the U.S. Census Bureau.

<sup>2</sup> Maura Calsyn and Lindsay Rosenthal, "How the Affordable Care Act Helps Young Adults," The Center for American Progress, May 2013.

<sup>3</sup> Linda J. Blumberg and Matthew Buettgens, "Why the ACA's Limits on Age Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance," The Urban Institute, March 2013.

<sup>4</sup> Jay Hancock, "Maryland Offers Glimpse at Obamacare Insurance Math," Kaiser Health News, April 24, 2013.

will at long last benefit from the security and peace of mind of knowing that, if misfortune strikes, they will not suffer financial catastrophe.

### **Studies lack transparency, are self-serving, and omit key factors**

Second, these types of studies are not new, but they have always suffered from a lack of transparency. Health insurance companies are happy to disclose their conclusions, but refuse to disclose their assumptions and underlying data. It is unclear why members of Congress would want to take insurance companies at their word, or rely exclusively on actuaries who are affiliated with the insurance industry. It should go without saying that insurance companies have every incentive to pad their premium proposals.

These studies always omit key factors that greatly influence the costs people would pay out of pocket. In fact, one of the insurer submissions to this Committee acknowledged these omissions:

“The analyses are not a comprehensive summary of all PPACA-related premium impacts.”<sup>5</sup>

While some of the studies take into account some of these factors, none of them take into account all (or even most) of the following factors:

- Premium tax credits. For example, in California, people who make less than 400 percent of the federal poverty level will get tax credits that reduce their average premium costs by

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<sup>5</sup> U.S. House of Representatives Committee on Energy and Commerce Majority Staff, “The Looming Premium Rate Shock,” May 13, 2013.

more than 65 percent.<sup>6</sup> According to the Urban Institute, 70 percent of young adults who now have non-employer coverage will be eligible for Medicaid or Exchange subsidies.<sup>7</sup>

- The availability of parents' coverage for young adults up to age 26.
- The availability of catastrophic plans for young adults up to age 30. Because premiums for these plans can reflect the expected costs of younger enrollees, they will be lower than premiums for Bronze plans.
- Insurance for insurers that incur high costs, known as "reinsurance." For example, in California, reinsurance is projected to lower premiums by 9 percent.<sup>8</sup>
- Administrative savings. The independent Congressional Budget Office projected that administrative savings will lower premiums for non-employer coverage by 7 to 10 percent.<sup>9</sup> Some administrative tasks currently performed by insurers can be performed by Exchanges, taking advantage of economies of scale. Some tasks, like medical underwriting, can be eliminated. In California, administrative savings are projected to lower premiums by 4.5 percent.<sup>10</sup>
- The medical cost trend that would occur anyway. For example, in California, the projected premium increase in the absence of the Affordable Care Act is 9 percent.<sup>11</sup>
- The extent to which individuals are enrolled in "grandfathered" plans that are exempt from reforms.
- Savings from competition among plans and providers, as explained more fully below.

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<sup>6</sup> Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

<sup>7</sup> Linda J. Blumberg and Matthew Buettgens, "Why the ACA's Limits on Age Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance," The Urban Institute, March 2013.

<sup>8</sup> Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

<sup>9</sup> The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.

<sup>10</sup> Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

<sup>11</sup> Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

## **Studies do not measure up when compared with actual rate filings and independent analyses**

Because these studies are not reliable, it is instructive to compare some of them with actual rate filings and analyses by independent experts.

A recent report by the Lewin Group and Optum projects a 32 percent average cost increase for non-employer coverage nationwide.<sup>12</sup> Under this analysis, because the Affordable Care Act guarantees all sick people access to insurance, the pool of insured people could become less healthy overall, increasing expected costs.

But the independent Congressional Budget Office came to a different conclusion on this point, finding that the influx of new enrollees will actually *lower* premiums by 7 to 10 percent, on average.<sup>13</sup> This huge difference seems to be driven by the Lewin/Optum report's assumption that there will be an influx of unhealthy people from large employers. Note that the CBO did not see fit to change its analysis in its most recent estimates.

To illustrate how the Lewin/Optum report is speculative and incomplete, consider actual rate filings in Washington. The Lewin/Optum report projected an average cost increase of 14 percent.<sup>14</sup> But we now know that many Washingtonians will actually see lower rates. For example, a 21-year old could buy a similar Blue Cross plan—except with a lower deductible—

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<sup>12</sup> Randy Haught and John Ahrens, “Cost of the Future Newly Insured under the Affordable Care Act,” March 2013.

<sup>13</sup> The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.

<sup>14</sup> Randy Haught and John Ahrens, “Cost of the Future Newly Insured under the Affordable Care Act,” March 2013.

for 15 percent less next year.<sup>15</sup> The average proposed premium increase is 7 percent—less than the projected medical cost trend that would occur anyway in many states.<sup>16</sup>

The experience in Washington is noteworthy because just last year, the executive vice president of the Blue Cross insurer warned that premiums would increase by 50 to 70 percent.<sup>17</sup> The hysteria did not match up with the reality.

Finally, consider California. According to the majority staff report, one insurer projected a premium increase of 23 to 66 percent.<sup>18</sup> But an independent analysis projected that the Affordable Care Act will *lower* total health care costs by more than 40 percent, on average, for most people who now have non-employer coverage.<sup>19</sup>

### **Competition among plans and providers is already lowering premiums**

When the independent Congressional Budget Office projected premiums under the Affordable Care Act, it theorized that competition in Exchanges would lower premiums.<sup>20</sup> Consumers would be able to more easily shop for and compare plans. Now that theory is becoming reality.

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<sup>15</sup> Mike Baker, “Some may see lower rates under Obama health law,” The Associated Press, May 14, 2013.

<sup>16</sup> Washington State Office of the Insurance Commissioner.

<sup>17</sup> Mike Baker, “Some may see lower rates under Obama health law,” The Associated Press, May 14, 2013.

<sup>18</sup> U.S. House of Representatives Committee on Energy and Commerce Majority Staff, “The Looming Premium Rate Shock,” May 13, 2013.

<sup>19</sup> Milliman, “Factors Affecting Individual Premium Rates in 2014 for California,” March 28, 2013.

<sup>20</sup> “The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees.” The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.

In Oregon, when premium proposals were posted publicly online, two insurers immediately lowered their proposed rates to remain competitive.<sup>21</sup> One insurer lowered its proposed rate by 15 percent and another lowered its proposed rate by even more. Clearly, these insurers had been inflating their projected costs; one insurer said its actuarial projections had been too pessimistic.

Competition is also lowering the prices that hospitals charge. Some insurers are demanding and receiving price discounts of 10 percent or more from hospitals in exchange for a larger volume of new patients.<sup>22</sup> In California, provider price discounts are projected to lower premiums by 6 percent.<sup>23</sup> The potential premium savings from provider price discounts are particularly significant in Exchanges that will offer Medicaid managed care plans.

### **Consumers will get a lot more for their money**

When comparing premiums before and after the Affordable Care Act, it is important not to lose sight of the benefits of insurance market protections and improved coverage. The law's market protections guarantee access to insurance to people who are ill or who have pre-existing conditions, and they prohibit insurers from charging them higher rates. They also limit how much more insurers can charge older people versus younger people. Other reforms require coverage of prescription drugs, mental health care, maternity care, and other essential benefits.

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<sup>21</sup> Nick Budnick, "Two Oregon insurers rethink 2014 premiums as state posts first-ever rate comparison," *The Oregonian*, May 9, 2013.

<sup>22</sup> Anna Wilde Mathews and Jon Kamp, "Another Big Step in Reshaping Health Care," *The Wall Street Journal*, February 28, 2013; Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

<sup>23</sup> Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.



Exchanges will therefore offer brand new, modernized products. Comparing their prices to the prices of old Swiss cheese insurance products is like comparing the price of an iPhone to the price of a Sony Walkman. It is not a meaningful comparison.

Nor should we focus exclusively on premiums. Premiums are not consumers' only costs; they also pay deductibles, co-insurance, and co-payments. While providing more coverage increases premiums, it lowers out-of-pocket costs. A narrow focus on premiums also ignores the millions of Americans who have been shut out of a dysfunctional market.

Furthermore, premiums reflect a snapshot in time. Just because you are young and healthy now does not mean you will always be. In the current dysfunctional market, premiums can spike uncontrollably for both individuals and small businesses, as a result of many factors that are totally beyond their control. In the modernized market, when people get sick or are diagnosed with a medical condition, or just grow older, their premiums will remain stable.

Finally, it is important to keep in mind the reforms that are at issue here, and their purpose. Repealing these reforms would increase premiums for women, older people, sick people, and people with pre-existing conditions. These premium impacts must be part of the discussion.

Mr. Chairman, this concludes my testimony, and I am happy to answer any questions members of the Committee may have.