Policy INSIGHTS

From the Kaiser Family Foundation

February 6, 2013

Why Premiums Will Change for People Who Now Have Nongroup Insurance

The federal government recently released draft regulations that address the benefits, market rules, and rating practices for nongroup coverage. Before reform, the nongroup market was widely acknowledged to be broken, with restricted access, limited benefits, high administrative costs, and frequent and large premium increases subject to inadequate oversight. Recent requests for large premium hikes for nongroup coverage in some states, at a time when the group market is experiencing very low increases, have revived concerns about current pricing practices and the effectiveness of regulatory oversight. The ACA seeks to address many of these issues, essentially remaking the nongroup market starting in 2014 by instituting new rules and a platform for increased transparency and price competition. Newly available premium and cost-sharing subsidies will vastly expand the number of people who will get coverage there. With so many changes and new participants, there understandably is a great deal of speculation about what the products will look like and how premiums in 2014 will compare to premiums in the nongroup market.

Overall, we expect that average, unsubsidized premiums for nongroup coverage will be somewhat higher under reform than they are today (as does the Congressional Budget Office). This is because many people will be getting better insurance. The law requires that all nongroup insurance provide a package of essential benefits, which includes items like maternity care and mental health that often are not covered in nongroup policies now. And, while patient cost sharing will still be quite high, everyone's out-of-pocket costs will be capped, which is not always the case today.

In addition, guaranteed access to coverage for people with pre-existing conditions may very well increase average premiums as well, as people with higher health costs come into the insurance system. Hopefully this will be balanced by attracting reasonably healthy young, uninsured enrollees also, using the carrot of premium subsidies in exchanges and the stick of the individual mandate.

Eliminating medical screening and other current industry practices, without other policy changes, would markedly increase premiums: this can be seen from the high premiums

and low enrollment in the handful of states where insurers must accept all applicants today. The ACA, however, provides significant financial assistance that will help many of the current uninsured afford coverage. Cost is the primary reason people do not have health insurance, and new premiums subsidies (combined with cost-sharing assistance so that lower income families can use the coverage) will significantly reduce financial barriers to coverage in 2014. New premium subsidies will attract large numbers of new applicants to the nongroup market, many in good health. The individual responsibility provision will add an additional incentive for healthy people to purchase coverage, and restricting access to annual and special enrollment periods will reduce the likelihood that people will wait until they develop health problems before seeking coverage. In addition, to address transitions issues (i.e., the concern that the less healthy will be the first to enroll), the ACA provides for $20 billion (a meaningful amount given the size of the market) in transitional reinsurance to offset adverse selection in the first three years of the program. The ACA also redistributes the premium burden among different enrollees by eliminating premium differences for gender and limiting variation premiums due to age to a maximum of three to one. Compared with existing practice, the new rules will lower premiums for older people and many women, while raising premiums for young people (particularly young men). This has led to concerns that these young people will suffer “rate shock,” though as we discuss below, the potential for premium increases among young people is mitigated by the fact that many of them will be eligible for premium subsidies. People under age 30 also are able to enroll in a special catastrophic plan that will provide coverage roughly similar to bronze plans and with rates that may be much less affected by the age limitation.

Each of the insurance market changes in the ACA that may raise or lower premiums overall or redistribute them among different groups of people is explained below.

Access to coverage

The ACA addresses access to coverage in two fundamental and related ways. First, insurers must accept all applicants, including those with pre-existing conditions, during open enrollment periods and charge sick people and healthy people the same premium. Second, the ACA provides significant premium and cost-sharing subsidies to assist low- and moderate-income people with the cost of coverage.

These provisions will change the population covered by nongroup insurance when they take effect in 2014. Health plans now offering nongroup coverage can exclude people with health problems, and the high turnover that market now experiences means that a significant portion of nongroup enrollment is made up of people who have recently passed health screening. Many nongroup policies also limit benefits for the first year or so for any pre-existing health issues that enrollees may have. Other industry practices, such as durational rating and opening and closing policies to new enrollees, can also be

used to keep premiums for new enrollees low, but can mean significant increases for policyholders who keep their coverage for longer periods, particularly if they develop health problems. All of these techniques work together to produce low premiums for those who can pass underwriting and an overall risk pool of nongroup enrollees today that is healthier than the population who will be eligible in 2014.

Eliminating medical screening and other current industry practices, without other policy changes, would markedly increase premiums: this can be seen from the high premiums and low enrollment in the handful of states where insurers must accept all applicants today. The ACA, however, provides significant financial assistance that will help many of the current uninsured afford coverage. Cost is the primary reason people do not have health insurance, and new premiums subsidies (combined with cost-sharing assistance so that lower income families can use the coverage) will significantly reduce financial barriers to coverage in 2014. New premium subsidies will attract large numbers of new applicants to the nongroup market, many in good health. The individual responsibility provision will add an additional incentive for healthy people to purchase coverage, and restricting access to annual and special enrollment periods will reduce the likelihood that people will wait until they develop health problems before seeking coverage. In addition, to address transitions issues (i.e., the concern that the less healthy will be the first to enroll), the ACA provides for $20 billion (a meaningful amount given the size of the market) in transitional reinsurance to offset adverse selection in the first three years of the program.

The ACA design is intended to open access to the now restrictive nongroup market, and, with a combination of market rules, tax credits and tax penalties, to produce stable risk sharing with risk pools that have a reasonable mix of people in good and poor health. It will probably not produce the “healthier-than-average” nongroup risk pools that seem to exist now in some states, which means that premiums for nongroup coverage under reform will need to be higher to reflect the cost of covering a more average mix of healthy and less healthy people.

Essential health benefits

A second set of factors affecting premium change is the benefit design and associated cost sharing. The ACA defines essential health benefits that must be offered in the nongroup market beginning in 2014. While there will be some variation from state to state, the benefits generally will be based on benefits provided now in the small group market, with a couple of small additions (e.g., habilitation and pediatric dental). This, combined with ACA requirements to cover preventive services and for mental health parity, will result in nongroup benefits under reform that will be more protective than those in many nongroup policies today. Nongroup policies offered in the market now often have no coverage for routine maternity care and impose limitations on mental

health and prescription drug benefits that will not be permitted when reform rules take effect in 2014. The more complete benefits will increase premiums when compared to current nongroup policies because there is more coverage.

The ACA also specifies five levels of cost sharing for nongroup policies, defined in most cases by an actuarial value, which is the average percentage of costs for covered benefits that the health plan will pay for. The ACA allows for a wide range of actuarial values, from 60% (bronze) to 90% (platinum), plus a somewhat lower level of coverage (catastrophic) which will be available to people under age 30 and others who find other coverage offerings unaffordable. Policies after reform still will be able to have significant cost sharing: the actuarial value calculator recently proposed by HHS shows that a single policy with a $5,900 deductible, 10% patient cost-sharing and a $6,350 out-of-pocket limit will meet the requirements of the bronze actuarial value level, and a family policy could have a deductible and an out-of-pocket limit twice as high. While a policy with this much cost sharing would hardly qualify as generous (e.g., most employer-based plans have deductibles that are thousands of dollars lower than this, there certainly are nongroup policies currently available that require enrollees to pay even higher shares of their expenses. Setting a minimum actuarial value (in most cases) of 60% will, by itself, increase premiums for current nongroup enrollees with very high cost sharing.

The benefit and cost-sharing changes for nongroup coverage under the ACA move that market from one largely defined by coverage limitations to one with a more complete level of benefits and catastrophic protection, similar to the level of protection that people with group coverage enjoy. Nongroup cost sharing will still be higher on average, but with real limits on catastrophic expenses. This additional protection will increase premiums for current enrollees with more limited benefits and very high cost sharing, but will also lower their out-of-pocket expenses when they need care.

Premium rating rules

Another set of factors that affects premium change under reform is how risk will be pooled. The ACA changes the way that health plans use an individual's demographic and health characteristics when setting premiums, and also requires plans to pool the risk of all enrollees with nongroup coverage in a market when setting rates. Unlike the access and benefit provisions discussed above, which change the average cost of coverage in a market, changes in how rates are set primarily affect how costs are distributed across different enrollees within a market, which means that some people will pay less and others more. Age rating in particular has received a good deal of attention recently, but these other factors matter as well.

Demographic factors

Health plans under reform will be able to vary the premium for a nongroup policy only to reflect a policyholder's family size, age (with a 3 to 1 limitation), location, and tobacco use. Premiums in the current market vary much more widely based on demographics, so these limitations, by themselves, will result in some people paying more and some paying less. Two of the more important relate to age and gender. It is now common for health plans to use age as a rating factor because older people, on average, have many more claims than younger people. Premium differences for the same coverage between a 21-year-old male and a 64-year-old male can easily be 500 percent. The premium difference in current policies between women of those ages is less, because younger woman are generally charged higher premiums than men their same age (even when routine maternity is excluded) and older woman are often charged lower premiums than men their same age. The gender and age-rating limitations in the ACA, by themselves, will have the effect of raising premiums for younger people and lowering them for older people. Younger men in markets where health plans vary rates by age and gender will be most affected, because premiums will adjust both to reflect the limit on age rating and the elimination of gender rating. The premium impact of the gender and age limitations (assuming the same benefit and cost-sharing) may be quite large (an increase of maybe 65% to 75%, or perhaps more, for younger men), before taking into account any premium subsidies discussed below.

Health status rating and single risk pool

Beginning in 2014, health plans will no longer be able to surcharge new enrollees with health problems, and will be required to pool the experience of all nongroup enrollees in a market when setting rates. Current practices can cause less healthy people to pay more for the same coverage, even if their health issues developed after enrollment. In many states nongroup health plans can charge new entrants higher premiums. Insurers also are able to set premiums for a policy (i.e., distinct group of benefits) or group of policies based on who enrolls or is projected to enroll, which means that policies with similar benefits can have very different premiums depending on how they were sold, when they were sold and whether they are still being actively marketed. These practices can lead to less healthy people being disproportionately concentrated in certain policies, and the high premium increases they face can cause people to give up coverage. Ending these practices will tend to lower premiums for some current nongroup enrollees with health problems and will increase them for enrollees who are healthy.

Marketplace changes

The ACA changed not only the coverage that will be offered in the nongroup market but also the environment in which it will be offered. Several provisions should reduce costs associated with selling coverage, but some new fees will work in the opposite direction. Two ACA provisions already in effect, enhanced review of nongroup premiums and

higher minimum loss ratios (enforced through required rebates) have put pressure on health plans to reduce their administrative costs and lower their rate requests. Beginning in 2014, new health insurance exchanges will make nongroup coverage offerings more transparent, and provisions establishing a common essential health benefits package and standard cost sharing tiers will make coverage much easier to understand. These changes will allow consumers to more easily compare premiums and benefits and will focus competition more squarely on price and value. The variety of benefit constructs, coverage limits and cost sharing differences in the market today make meaningful comparisons quite difficult.

Price competition in exchanges will be enhanced by the premium tax credit structure, which ties the amount of the tax credits to the premium for the second lowest-cost silver plan in each market. Health plans with premiums above this level will be much less attractive to the millions of new and existing purchasers expected to receive premium tax credits, putting strong pressure on insurers to create more efficient networks and lower costs in order to be more price competitive. Health plans report pursuing strategies to reduce their costs through tighter, lower-cost networks to be offered though exchange plans [1] [2]. These efforts should complement the broader payment and delivery system reforms (spurred on by the Medicare provisions under the ACA) that health plans are pursuing in their other commercial and government lines of business.

There also are several ACA provisions that increase the cost of selling coverage. These include a new tax on health insurers, a small fee ($2 per member per month) to help fund the Patient-Centered Outcome Research Trust Fund, fees on medical devices that may be passed on to patients and purchasers, and fees (3.5% of premium) to fund the insurance exchanges.

The net impact of these changes is unknown, but there is a strong argument that they should result in lower premiums. The incentives for more efficient delivery and lower administrative costs, reinforced by the minimum loss ratio and rate review provisions, should set the stage for a more robust effort by the industry to limit costs and cost increases in this market. The large number of new enrollees also will provide greater incentive for the health plans to invest in cost control programs for the nongroup market.

The issue of rate shock for younger people who now have nongroup coverage

Recent discussion about premium rates under health reform have focused in on the potential rate shock for younger enrollees who will pay higher premiums under reform, with suggestions that phasing in the 3:1 age limitation could moderate the impact. As discussed above, there are a number of factors that will affect the premiums that nongroup enrollees will see under reform. Some will affect all buyers: the coverage is better; the limits on cost-sharing, while hardly generous, are more protective than some

of the policies currently available, and the risk pool will more likely reflect the general population rather than a select, healthy one. Other changes, such as the elimination of gender rating and the limits on age variation, largely redistribute the premium burden, advantaging some populations and disadvantaging others (particularly younger men). The suggested phase-in of the 3:1 age rating limit is intended to address one part of the rate shock concern, at least temporarily, but it would not affect changes in premiums due to better benefits and cost-sharing protections and a more inclusive marketplace.

So does a phase-in make sense to at least partially mitigate the premium impact on younger enrollees? There are a few additional factors that might be considered in answering that question.

The first is that most current nongroup enrollees will be eligible for premium tax credits, which will limit the share of the premium that they will be required to pay to a percentage of family income. We used income and coverage data from the Survey of Income and Program Participation to estimate the differences in the amounts that current nongroup enrollees would pay for the same silver plan under a 3:1 limit and the unlimited age rating that exists in the market today. We estimate that 80% of current nongroup enrollees would pay less under the 3:1 limit for equivalent coverage, once premium subsidies are taken into account. While many younger enrollees would see higher premiums under the 3:1 age limit, they would not pay more because they would receive a tax credit that caps their premium obligation as a percentage of their income. It is important to note that this is not an estimate of the percentage of current nongroup enrollees who might pay more for coverage under reform, taking all factors into account; we only looked at the impact of the different age-rate limits because that is a policy that has been advanced by some in the industry and others. This analysis does not consider premium increases because the coverage is better or because the risk pool is more representative of the general population.

A second consideration is that catastrophic plans available under reform may accomplish much of what the advocates of phasing in the 3:1 age limit are trying to accomplish: a low-cost plan with rates that reflect the medical spending of younger enrollees. The ACA permits health plans to offer a catastrophic health plan to people under age 30 and to people who otherwise would be required to pay more than 8% of their income for a health plan. While the catastrophic plans are part of the single risk pool that health plans must have for each market, the proposed regulations from CMS allow plans to adjust premiums for the catastrophic plans to reflect the demographics of its enrollees. Enrollment in catastrophic plans is likely to be younger, on average, than enrollment in the other tiers, because under the proposed rules people under age 30 can easily enroll in a catastrophic plan but people who are older must first get a certification from an exchange that premiums for other available coverage would exceed 8% of their income. The certification requirement will likely slow any enrollment of older

people into catastrophic plans, leaving a younger risk pool. Catastrophic plans also will be treated separately under risk adjustment, which means that catastrophic premiums will not go up if enrollees in catastrophic plans are healthier on average than enrollee in other tiers.

This all means that the catastrophic plans, if implemented as proposed, may have premiums that are more reflective of a younger and healthier population than plans in other tiers. Since the actuarial value of the catastrophic plans is very close to that of bronze plans (57% v. 60%), the premiums for younger people in catastrophic plans may be quite close to what you would get if you permitted unlimited premium variation for age in bronze plans. We estimate that the premium for a younger person in their twenties may be as much as 29% less in a catastrophic plan than in a bronze plan, assuming that catastrophic enrollment is primarily under age 30. This would cushion the potential rate shock for existing, young nongroup enrollees with low cost coverage, particularly those who would not receive a premium tax credit or who would rather pay a very low price for less coverage.

A third consideration is the high turnover in the current market. A fairly high percentage of people who buy nongroup policies have their coverage for a year or less, which means that many of the people who the age rating phase-in is designed to help may not be planning to keep their current health plans anyway. A project that the Foundation did with the online broker eHealthInsurance found that, among nongroup purchasers aged 18 to 24, 38% of males and 44% of females had given up their policies by the end of their first year of coverage and 60% have given up their policies by the end of the second year. This study is a little old and involved on-line purchasers, so it may not be representative of all younger purchasers. But given these high lapse rates, policy makers may want to get additional information about the purchase and retention of patterns of younger purchasers to help them understand how many current nongroup policyholders would actually benefit from a phase-in of the age rating limit. The availability of premium tax credits and the catastrophic plan already limit the number of current nongroup policyholders who would actually benefit from a phase-in; the high lapse rates only further reduce that number.

In the big picture, the ACA addresses many of the shortcomings of the current nongroup market by providing access to a complete set of health benefits with protections against catastrophic out-of-pocket costs. The higher level of benefits, the better protection against catastrophic costs and wider access to coverage each tend to increase the average level of premiums, although out-of-pocket costs for enrollees will go down due to the better protection they receive. The more competitive marketplace created under the ACA, greatly enhanced by the structure of the premium tax credits, will push in the other direction, forcing health plans to become more efficient and better managers of

the premiums they receive. There already is some evidence that plans are working to create less costly, more efficient networks to offer with plans sold in exchanges.

Limiting premium variation for age to 3:1 will increase premiums for younger people when compared to current rating practices, but several policies in the ACA limit the impact. The premium tax credits will protect many current nongroup enrollees from paying more due to their age, and the manner in which the federal government has proposed to implement the catastrophic health plan may blunt the impact of the age constraint, providing younger people with access to a low-cost policy that is more reflective of their age and relative health.

--Gary Claxton, Larry Levitt, and Karen Pollitz (with analysis by Anthony Damico)

---

[1] Justin Lake, Andrew Valen, Michael Newshel, J.P. Morgan Securities LLC, "Managed Care and Providers Wrap-Up," J.P. Morgan Health Conference, (January 2013).

[2] Christine Arnold, Cowen and Company, "4Q12 Hospital Survey Results Suggest Mixed Views on Reform Impact," Health Care, (February 2013).