Additionally, the exchanges may attract health plans previously only serving the Medicaid population. Medicaid health plans entering the individual market may be focused on insuring individuals who were previously Medicaid-eligible or have income levels below 250% FPL. If these plans are able to secure competitive provider reimbursement rates, they may also attract other consumers.

Note that an insurer's pricing strategy may differ based upon the approach that the state exchange takes in its oversight of the market. The 0% to 5% reduction estimate does not include the impact of health plans introducing high value network products, which limit the number of hospitals and other providers from which insured members can obtain services at maximum reimbursement levels. These high-value network plans in some cases will also be coupled with more targeted managed care and disease management programs, which were discussed earlier in this paper.

## TRANSITIONAL REINSURANCE PROGRAM SUBSIDY

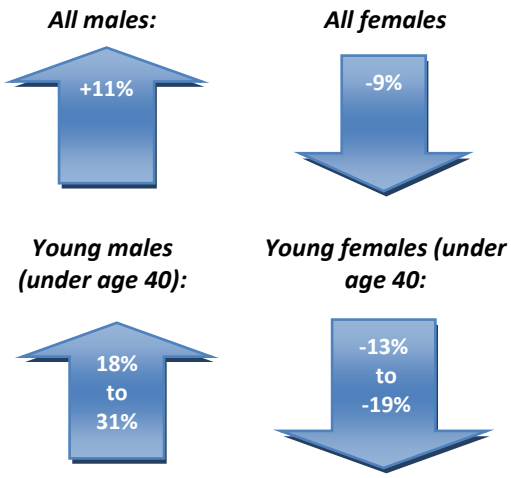
The transitional reinsurance program (ACA §1341) reimburses individual market health plans for 80% of the cost of claims amounts between $60,000 and $250,000. Total required funding in 2014 is $10 billion. If the full $10 billion is paid out in 2014, net claim costs could be reduced by 6% to 15%, depending on the rate of influx of uninsured and those currently with employer-sponsored insurance into the individual market and the exposure of current in-force members who qualify for benefits under the reinsurance program in 2014.


Health plans will likely assess a number of factors and balance a number of considerations in reducing premium rates for this subsidy. These considerations include: 1) the number of new individual market enrollees into their plans is uncertain; 2) as 2014 renewals will be staggered throughout the year, fewer members will qualify for the reinsurance benefit; 3) states not electing the Medicaid expansion offered by ACA may inadvertently dilute the reinsurance funding and result in higher insured claims expenses, and, 4) the transitional nature of the reinsurance program and the reduction in available subsidy over the three years. Because of these concerns, health plans may be reluctant to lower rates too much as the subsidies diminish and then totally go away after 2016. As such, the reduction impact on premium rates is expected to be in the 6% to 12% range for calendar year 2014.

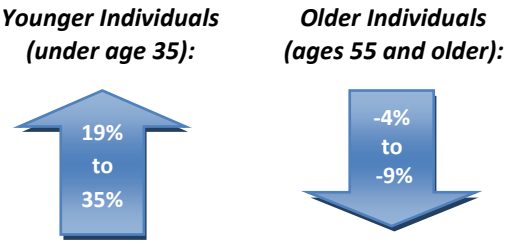
## FACTORS WITH VARIED IMPACT

ACA includes other requirements that will also impact premiums of an individual, depending on the individual's age, gender, health status, income level, where they live, and the type of coverage they have today. Clearly, younger or healthier males who are in low premium, high deductible plans today will see significant pre-subsidy premium increases. Those who are older or less healthy will likely see their premiums decrease as all individuals are brought together into a single risk pool.

**Unisex rating.** While some states currently require unisex rating for the individual market, most allow sex-distinct rating. Evidence is overwhelming that healthcare costs and utilization vary significantly by gender, particularly at young ages, even when maternity costs are excluded. However, ACA requires that all health plans be rated on a unisex basis beginning in 2014. This change has a very significant impact on pre-subsidy premium rates, particularly for younger people. Based upon a fairly typical rate slope used in the market, young females under age 40 can expect to see premium rates decrease by 13% to 19%, while young males will see pre-subsidy premiums increase by 18% to 31%. At older ages, the premium rate differentials decrease and become fairly nominal after age 55. Based on the distribution modeled, for states that allow gender-distinct rates, adult male rates increase by 11% and female rates decrease by 9% on average. Rates were modeled such that the same revenue is generated.




**Age band compression.** ACA places new limits on how much premiums can vary based on age, which will increase pre-subsidized premiums for younger individuals and families, while lowering premiums for older individuals. The impact is dependent on the age distribution expected for 2014 and the current rate slopes being used. An analysis we conducted on over a dozen distributions using a unisex age slope of 4.5-to-1 indicates that the age rating restrictions (after adjustment to unisex rates) will impact premiums on average as follows:



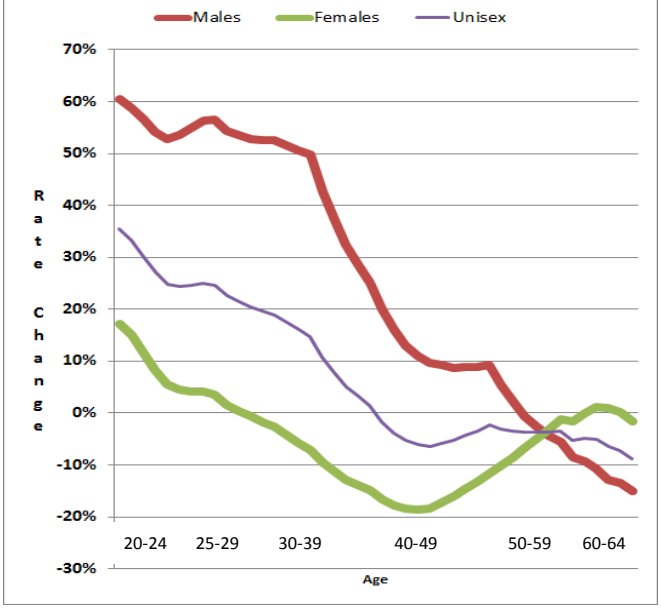

Age Range Avg.
Ages 21-29: +28%
Ages 30-34: +17%
Ages 35-39: +10%
Ages 40-49: -5%
Ages 50-59: -6%
Ages 60-64: -9%

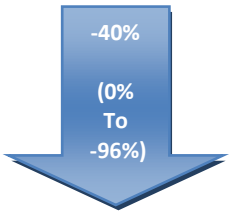
Keep in mind that these are changes from a unisex rate table due only to implementation of the 3-to-1 age compression using HHS age factors. The combination of the ACA unisex requirements and required 3-to-1 age factors are shown in the chart in Figure 2.

As can be seen, young males age 25 to 36 will see rate increases in excess of 50%, while females 25 to 29 will see an average net rate increase of 4%. However, females aged 35 to 59 will see rate decreases up to 18%. Males aged 55 and older will see rate decreases up to 15%.

I have also looked at a premium rate schedule in which the female rates were already less than 3-to-1. The older females for this plan will have a rate increase instead of a rate decrease because the regulation does not allow a health plan to continue to use a rate slope less than 3-to-1 unless a state requires it.

**Figure 2**
**Comparison of Premium Rate Changes by Age Due to ACA 3-to-1 Unisex Requirement**

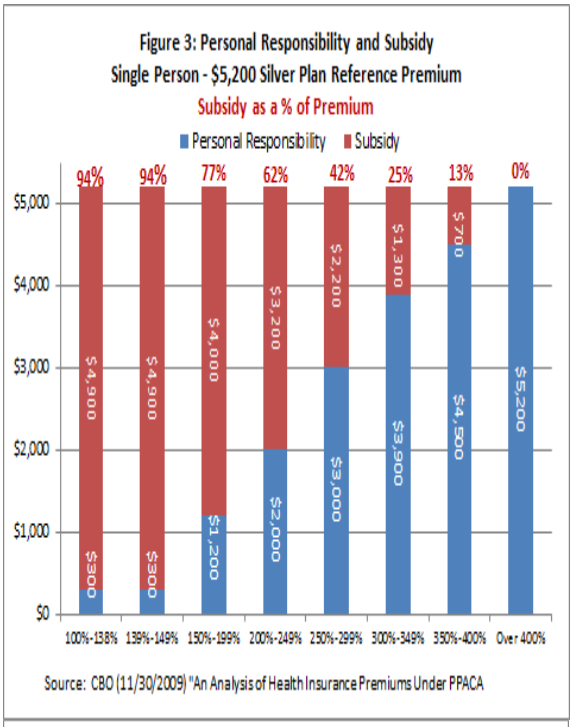


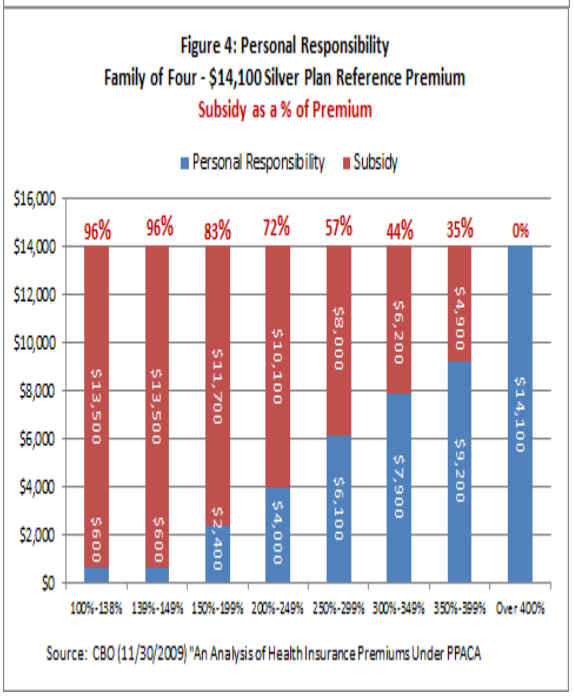




**Premium and benefit subsidies.** A hallmark provision of ACA is the availability of premium subsidies (prepaid tax credits) and cost-sharing reductions (CSR) for low- and middle-income people who do not have access to affordable employer-sponsored insurance. The CBO estimates that the average subsidy per subsidized enrollee (both tax credits and CSRs) will be $5,510 in 2014.[28] The premium subsidies equal the excess of the premium for the second-lowest-priced silver plan over a specific percentage of an individual's household income, which ranges from 2% for those in households 100% to 133% of FPL up to 9.5% for those in the 301% to 400% FPL range. Our modeling indicates that this averages in 2014 to about 40% of the silver plan premium for the individual market, a very substantial benefit, making insurance much more affordable than it otherwise would be. For those opting for a bronze plan, the average subsidy would reduce premium rates even more. For some people in the lower income levels, no premium would need to be paid. However, by choosing a bronze plan rather than a silver plan, individuals with household incomes under 250% FPL would lose access to available cost-sharing subsidies (CSRs) associated with the purchase of silver-level exchange plans, which may be more cost-effective for them to purchase.

[28] Congressional Budget Office (February 2013). Effects of the Affordable Care Act on Health Insurance Coverage—February 2013 Baseline, Table 3.

However, it should be noted that, while ACA provides premium subsidies to help low- and moderate-income Americans purchase insurance, millions of other people will not be eligible for subsidies. According to the Congressional Budget Office (CBO), more than 40% of people purchasing coverage in the individual market today would be ineligible for premium subsidies. Further, as shown in the charts in Figures 3 and 4, the amount of the subsidy declines significantly as incomes rise.[29] For example, single persons with incomes between 250% and 300% of FPL would receive subsidies sufficient to cover 42% of the cost of the second-lowest-cost silver plan. Those with incomes between 350% and 400% of FPL would receive subsidies sufficient to cover just 13% of the premium. For a family of four these percentages are 57% and 35%. The subsidies for families will be greater than those for a single person as a percentage of premiums. Subsidies will cover a greater percentage of bronze plan premiums than shown in the figures.




[29] Congressional Budget Office (November 30, 2009). An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act.

**Geographic rating.** Health plans will no longer be able to define their own geographic rating areas, as they can in today's marketplace. The geographic areas will be defined by states or the federal fallback metropolitan statistical area (MSA) rule. The number of rating zones will be limited to one more than the number of MSAs in the state. Some states could set fewer zones. They can be defined only by MSAs, counties, or 3-digit ZIP Codes.

***Lower Cost to Higher Cost Zones:***


***Higher Cost to Lower Cost Zones:***


Health plans will still be able to set their own geographic area factors for each rating zone, provided they are actuarially justified. This will impact premiums rates to the extent that the new rating areas will differ from those currently being used by health plans, which is highly likely. These impacts will vary by geographic area and health plan. Some people will see rate increases that are due to this change, while others will see their rates drop. The regulations do not allow for any type of transition for the changes. While the net impact over the entire state should be zero given a static population, rate changes (up or down) could be significant for those living in zones that get changed. There is too much variation by plan to evaluate the potential premium impact of this new ACA rule or even the number of people that will be affected by this change.

It should also be noted for individuals who receive a premium subsidy tax credit, out-of-pocket premiums are somewhat insulated from the impact of geographic rating, as an individual's premium expense for the second-lowest-cost silver plan will be capped at a defined percentage of income, regardless of the overall premium rate. For the population eligible for premium subsidies, geographic rating will mostly impact the federal government's cost rather than out-of-pocket premiums.

Thus, for certain individuals, particularly those younger or healthier, several more layers of costs will be added to premiums in 2014. Percentage reductions for older and sicker people will be lower than the increases for the young and healthy.

## OTHER CONSIDERATIONS

**Catastrophic plan.** ACA allows insurers to offer a "catastrophic plan" to people under age 30 and to anyone who is exempt from the individual mandate because of not being able to find affordable coverage or who is eligible for a hardship exemption. The catastrophic plan has an actuarial value less than 60% (it has been estimated to have a 57% AV), but enrollees are not eligible for a tax credit (premium subsidy), even if their household income is less than 400% of FPL. However, unlike the metallic plans, the pricing for the catastrophic plan can be adjusted to reflect the age mix and experience of those expected to purchase the plan, and it is in its own risk pool for risk adjustment purposes. These exceptions will allow lower pre-subsidy premium rates for this plan more than is likely to be available for the bronze plans.

While the ACA allowance of a catastrophic plan offers a lower-priced option to young and other eligible people, by effectively pulling it out of the single risk pool and making it more attractive to young people who tend to be the healthiest in the population, it increases the morbidity levels left in the single metallic plan risk pool and thereby will result in even higher premium rates for the metallic plans. The size of this impact is dependent on the percentage of the population that opts for the catastrophic plan instead of purchasing a bronze plan. Based upon the Milliman 2012 HCGs, if all of the adults under age 30 were to purchase a catastrophic plan, the metallic plan premiums would need to increase by almost 4%. Due to the availability of premium subsidies for metallic plans, this is not likely. However, those opting for catastrophic plans will likely be healthier on average than the twenty-somethings opting for metallic plans.

**Risk mitigation.** To mitigate adverse selection and pricing risk for issuers, ACA included three strategies: a transitional reinsurance program to partially reimburse plans for high-cost enrollees; a permanent risk adjustment program aimed at moving funds from plans with lower risk (and lower costs) to plans with higher risks (and higher costs); and a temporary risk corridor program.

The impact of the reinsurance program was discussed earlier. In theory, programs such as risk adjustment are designed to allow plans to price assuming they will get an average number of sick and healthy enrollees. The risk adjustment program may impact rates on a specific health plan basis, but over time will result in premium rates moving closer toward one another. The risk adjustment program may have little or no impact on the market premium rates as a whole. However, entering 2014, there remains much more uncertainty than in the current rating environment. The risk corridor program was created to help reduce the financial impact of mispricing that is due to the uncertainty. The overall goal of the risk mitigation is to encourage insurers to provide their best estimate premiums and limit the risk charges a health plan might otherwise include to account for potential adverse uncertainty. However, these programs will not be able to rectify all differences in actual plan risk, and insurers will need to balance risk mitigation program challenges with the remaining uncertainty as they set their 2014 premiums.[30]

[30] National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee (June 27, 2012). Rate Review White Paper.

## CONCLUSION

Insurers are facing an environment for 2014 that will be radically different than what we see today. Many new ACA requirements are guaranteed to increase health insurance premiums prior to the application of the premium tax credit subsidy. Additional requirements will further increase premiums for many, particularly younger or healthier individuals. An additional concern is that, when faced with high premiums, younger and healthier individuals may choose to forgo purchasing health insurance until they need it, which will only serve to increase costs for all other individuals in the healthcare system. The premium and cost-sharing subsidies available through ACA exchanges, along with the individual mandate requirement, should help assure their greater participation in the single risk pool. The ACA requirements are also likely to result in significantly lower out-of-pocket premium rates for individuals currently unable to afford insurance or individuals who struggle to pay insurance premiums on a monthly basis. Many of these individuals may have chronic health conditions, be near Medicare eligibility, or have limited financial resources. For the individual insurance market risk pool to remain a stable market in 2014 and beyond, it is vital that young and healthy individuals enter and remain in the insurance market in addition to individuals with an immediate need for healthcare services.

## RELIANCE AND LIMITATIONS

This analysis was prepared for America's Health Insurance Plans (AHIP) to provide illustrations regarding the potential impact of certain provisions of the Patient Protection and Affordable Care Act (ACA) on current premium rates. The analysis is not intended for other purposes.

In performing this analysis, I relied on data and information from various sources. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in this analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

It is important to note that the actual premiums charged in 2014 will not necessarily reflect the estimates in this report. Instead, 2014 individual premiums are being determined now. They will depend significantly on how insurers expect costs to change under ACA. Differences between the estimates presented in this paper and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is highly likely that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Values were not normalized to account for the impact of influences that may be insurer-specific, including items such as provider network arrangements, distribution of business, risk pools, and market strategies. Assumptions used were intended to be reflective of the average nationwide market.

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