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How Will Premiums Change Under the ACA?

Key Points

Premium changes due to ACA health insurance market reform rules will vary across states and individuals and will reflect many factors, including:

- **The effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees,**
- **New benefit requirements which may increase plan generosity but reduce out-of-pocket costs,**
- **Employer offer decisions and the demographics and health status of any employees shifting to coverage in the individual market,**
- **How each state's current issue and rating rules compare to those beginning in 2014, and**
- **Each individual's demographic characteristics and health status (and income when determining premiums net of subsidies).**

On Jan. 1, 2014—a deadline that is fast approaching—the Affordable Care Act's (ACA) health insurance issue and rating rules that apply to the individual and small group markets will go into effect. These rules will affect not only overall average premiums, but also the specific premiums that individuals will face. Importantly, premium changes will differ across states and individuals.

Much uncertainty remains regarding how premiums will change. This brief, which focuses primarily on the individual health insurance market, aims to examine the various factors that can affect premiums. In doing so, it can help readers better understand the drivers of any premium changes in 2014. Although the brief focuses on gross premiums—before any premium subsidies are taken into account—it notes the impact of premium subsidies on individual decisions to purchase coverage and the resulting effects of those decisions on gross premiums.

The discussion begins with an overview of the basic concepts underlying premium calculations, and then highlights various ACA-related provisions and how premiums may change as a result.

Premiums reflect many factors

Premiums are set to cover the medical claims and administrative costs of the pool of individuals or groups with insurance.

WHO IS COVERED—the composition of the risk pool. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums

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can be. But the composition of the risk pool is also important. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher. If a risk pool disproportionately avoids those with higher expected claims, premiums will be lower.

PROJECTED MEDICAL COSTS. The majority of premium dollars goes to medical claims.

OTHER PREMIUM COMPONENTS. Premiums must cover administrative costs, including those related to product development, enrollment, claims adjudication, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit.

LAWS AND REGULATIONS. Laws and regulations can affect risk pools, projected medical spending, and other premium components.

Factors driving medical claims

The total costs of medical claims reflect unit costs, utilization, the mix and intensity of services, and plan design. These categories can overlap because the underlying drivers of health spending can affect more than one of these categories. The interaction between categories is also important.

UNIT COST DRIVERS. Prices for medical goods and services reflect inflation, the relative negotiating power between insurers and health care providers, and the costs of new medical technology.

UTILIZATION DRIVERS. Utilization trends depend on the underlying demographics and health status of the population. On the provider side, they also reflect incentives in the payment system. For instance, the fee-for-service system encourages greater utilization. On the consumer side, they also reflect plan generosity—plans covering a wider array of services with lower cost-sharing requirements likely incur greater utilization.

INTENSITY DRIVERS. The introduction of new technology and more widespread use of existing technology can lead to the use of more intense and costly medical services. An example of technology-induced intensity increases is the shift from X-rays to more advanced imaging such as CT scans and MRIs. Greater disease severity also can increase treatment intensity.

ACA rules affecting premiums

Premiums will change under the ACA due to provisions beginning in 2014 that affect the composition of the risk pool, benefit coverage rules, administrative cost rules, and limits on premium variations.

RULES AFFECTING THE RISK POOL. Guaranteed-issue requirements will prohibit insurers from denying insurance coverage to those with high-expected health costs, which will tend to increase premiums in states that formerly allowed medical underwriting. On the other hand, the individual mandate and premium subsidies will provide incentives for individuals in good health to obtain coverage, mitigating premium increases due to guaranteed issue.

BENEFIT COVERAGE RULES. Plan generosity may increase due to essential health benefit and actuarial value requirements, thus increasing premiums, but lowering out-of-pocket costs.

ADMINISTRATIVE COST RULES. Medical loss ratio (MLR) requirements, already in effect beginning in 2011, limit the share of premiums that can be used for expenses other than medical

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claims and quality improvement activities.

LIMITS ON PREMIUM VARIATIONS. Premiums charged to older adults are limited to three times those charged to younger adults. Aside from age, premiums will be allowed to vary only by family size, tobacco status, geographic area, and metal tier. Premiums will not be allowed to vary by health status or gender.

SINGLE RISK POOL. Insurers must use a single risk pool for each of the individual and small group markets when developing insurance premiums. This means insurers cannot separate their insured populations into different pools, with higher premiums charged to one segment and lower premiums charged to another.

Potential premium changes in 2014 and beyond

When projecting and examining premium changes, it is important to distinguish between changes in average premiums and the drivers of those changes from changes in premiums faced by particular individuals and the drivers of those changes. Notably, premium changes will vary by state depending on how each state's pre-ACA rules compare to those under the ACA.

CHANGES IN AVERAGE PREMIUMS. Changes in overall premium averages will depend on changes in the composition of the risk pool, which is the underlying demographics and health status of the insured population. This in turn will reflect the effectiveness of the individual mandate and premium subsidies designed to increase coverage among young and healthy individuals, combined with the increased ability of high-cost individuals to purchase coverage due to the guaranteed-issue requirement. In addition, average premiums could increase due to plan generosity requirements. Note that while increases in plan generosity can increase average premiums, they also can reduce consumer out-of-pocket costs.

In addition to previously uninsured individuals obtaining coverage, an important consideration is whether and how individuals will shift between different types of coverage. Such shifts can affect the composition of the risk pool. For instance, if employers drop coverage and the workers instead obtain coverage in the individual market, the impact on premiums in the individual market depends on the demographics and health status of those shifting coverage. If those shifting coverage are young and healthy, the result would be downward pressure on average premiums in the individual market. If those shifting coverage are older and less healthy, the result would be upward pressure on average premiums.

Individuals moving out of high-risk pools and into the individual market also will impact premiums. Presumably, these individuals will have high costs and put upward pressure on premiums. Offsetting this effect, at least in the near term, will be the temporary reinsurance program in effect from 2014 to 2016. This reinsurance program will provide payments to plans with individuals who incur high medical costs. These payments have the effect of subsidizing premiums in the individual market. Although the payments will phase down between 2014 and 2016, the individual mandate penalties will increase during this period, which may increase the mandate's effectiveness at encouraging low-cost individuals to obtain coverage.

CHANGES IN PREMIUMS FACED BY INDIVIDUALS. Different individuals will face different premium changes based on their age, gender, health status, and, as discussed below, state. In most states, the compression of premiums due to the age rating restrictions will increase the relative rates for younger adults and reduce them for older adults. The prohibition on the ability to charge different premiums by gender will shift costs between men and women, depending on age. In states that currently allow premiums to vary by gender, premiums are typically higher for younger women than younger men and for older men than younger women. Premiums will shift between men and women accordingly so that these gender-related differences will

be eliminated. The prohibition of health status rating will increase the relative premiums for healthy individuals and reduce them for those in poorer health.

The distribution of individuals by health costs is skewed, with more low-cost individuals than high-cost individuals. If the low-cost individuals, who are vulnerable to the largest gross premium increases, elect to leave (or not join) the individual market after the ACA 2014 rules take effect, upward pressure on premiums will result. The premium subsidies and individual mandate could reduce this effect.

PREMIUM CHANGES WILL VARY BY STATE. How premiums change, on average and across individuals, will vary by state based on how each state's pre-ACA rules compare to those under the ACA. In states that already limit the extent to which premiums can vary across individuals, especially those with guaranteed-issue requirements, average premiums potentially could decline as lower-cost individuals obtain coverage due to the individual mandate and premium subsidies. In states with no or few rate restrictions, premiums are more likely to go up, to reflect an influx of higher-cost individuals. In addition, premium changes will vary depending on each state's distribution of the population by income and insurance status (including access to employer coverage) and regional differences in utilization rates and provider prices. Among individuals, the largest premium increases for younger adults, and the largest reductions for older adults, will occur in states that don't restrict premium variations by age.

FACTORS MITIGATING RATE SHOCK/ADVERSE SELECTION. Premium subsidies will directly lower the net premium costs for individuals with incomes less than 400 percent of the federal poverty level. As a result of these lower premiums, more individuals will obtain coverage, regardless of health status. The individual mandate also provides an incentive to obtain coverage, regardless of health status. Taken together, these provisions will help mitigate premium increases caused by the guaranteed-issue provision. Although young adults not eligible for premium subsidies are most at risk for premium increases, they will have access to catastrophic plans. The premiums for these plans can be adjusted for expected enrollee spending, meaning premiums could be lower to reflect a younger enrollee population.

OPTIONS TO FURTHER ADDRESS RATE SHOCK/ADVERSE SELECTION. Although the ACA includes provisions aimed to mitigate premium increases and rate shock, more can be done. Strengthening the individual mandate would help mitigate premium increases due to a less healthy enrollee population. Approaches could include less frequent open enrollment periods, penalties for late enrollment, more generous premium subsidies, and enhanced public outreach and consumer education. Another option would be to extend and/or increase the reinsurance program subsidies.

Premium changes in the small-group market

Much of the focus on premium changes has been in the individual market. In the small-group market, however, premiums are likely to change as a result of the ACA as well. And, as in the individual market, the premium changes will vary across states and across groups.

Currently, insurers in all states are required to offer guaranteed issue for small groups, meaning that they cannot be denied coverage.[1] Neverthe-

[1]The Health Insurance Portability and Accountability Act (HIPAA) prohibits insurers from denying coverage to small employers based upon health conditions of the employees. However, HIPAA does allow insurers to enforce minimum participation and employer contribution requirements. Under the ACA, insurers will continue to be able to enforce minimum participation and employer contribution requirements, but only for small groups enrolling outside of the designated month-long annual open enrollment period. The prohibition on minimum participation and employer contribution requirements within the one month open enrollment period could result in some upward pressure on premiums.

less, in most states, insurers are allowed to vary rates across groups, depending on the group's demographics, health status, group size, and industry. Beginning in 2014, small-group insurers will be required to use the same limited set of premium-rating factors as used in the individual market—age (limited to a 3:1 variation), family size, tobacco status, geographic area, and metal tier. Premiums will not be allowed to vary by health status, gender, or other small-group characteristics. As a result, premiums could go up in small groups with a disproportionately high share of young and/or healthy workers and down in small groups with a disproportionately higher share of old and/or unhealthy workers. The smallest groups, which are currently often charged higher premiums than larger groups, could see premium reductions, while larger groups could see premium increases. Again, however, the degree to which small-group premiums will change due to ACA premium-rating restrictions will vary according to a state's current rating rules. The changes will be largest in those states that currently allow the greatest flexibility in rating and much lower in those states with existing rating rules similar to those required by the ACA.

In general, the small groups that will experience the greatest increases will be the lower-cost groups, while the groups experiencing the greatest decreases will be the higher-cost groups. Just as the distribution of individuals by health care costs is skewed, the distribution of groups by health care costs is skewed, with more low-cost groups than high-cost groups. If the low-cost groups, which are vulnerable to the largest premium increases, elect to leave the small-group market after the ACA 2014 rules take effect, upward pressure on small-group premiums would result.

The ACA's essential health benefit and actuarial value requirements also could impact premiums in the small-group market, but likely to a much lesser extent than in the individual market. Small-group plans are more likely than individual market plans to already cover most, but perhaps not all, of the required essential health benefits. In addition, the level of plan generosity (i.e., actuarial value) of small-group plans typically is above that of plans in the individual market. As a result, the increases in small-group premiums due to essential health benefit and actuarial value requirements will likely not be as substantial as those in the individual market.

Conclusion

ACA market reform provisions beginning in 2014 will affect premiums. Examining only average premium changes, however, will mask the underlying reasons for the changes and how premiums will change across individuals and groups. How premiums will change depends on many factors, including the effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees into the insurance market, the new benefit requirements that may lead to higher premiums but lower out-of-pocket costs, employer decisions regarding whether to continue offering insurance and the health status of those whose coverage is dropped, how each state's current issue and rating rules compare to those beginning in 2014, and each individual's demographic characteristics and health status (and income when determining premiums net of subsidies).