The Shocking Truth Behind ACA Premium Changes: It's Complicated

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Agenda

- Basic concepts
- Projecting medical claims
- ACA-related rules affecting premiums
- Potential premium changes 2014+

Basic Concepts

Premiums reflect many factors

- Risk pools—who is covered
- Projected medical costs—health care utilization and prices
- Other premium components—administrative costs, taxes, profit
- Laws and regulations affecting:
  - Risk pools
  - Projected health spending
  - Other premium components
  - Limits on overall premiums (or premium increases)
  - Limits on how premiums can vary across individuals

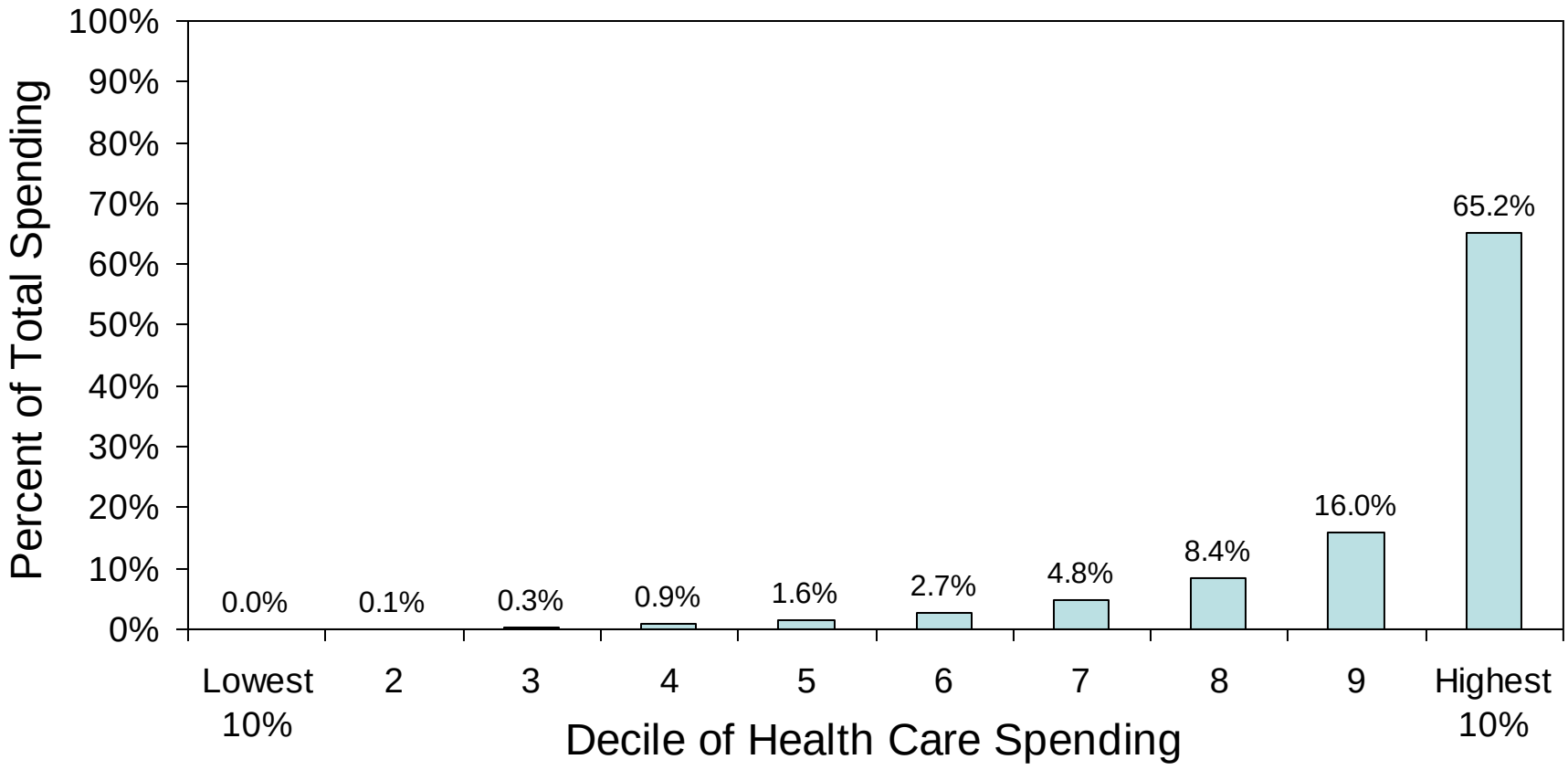
Risk pooling basics

- Risk pools are large groups of individuals (or groups) whose medical costs are combined to calculate premiums.

Risk pooling basics (cont.)

- Pooling risks together 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 the premiums can be.
- BUT, creating larger risk pools will not necessarily lower premiums.
- Must consider the size of the risk pool AND how it is comprised.
- If a pool attracts those with higher expected claims (i.e., adverse selection), premiums will be higher.

Distribution of health spending



Note: Data reflect personal health care expenditures for the civilian non-institutionalized population in 2009.
Source: American Academy of Actuaries calculations from NIHCM Foundation brief "The Concentration of Health Care Spending," June 2012 (Figure 1).

Projected medical costs

- The majority of premium dollars goes to claims

Other premium components

- Administrative costs
  - Distribution costs
  - Billing and enrollment
  - Underwriting
  - Claims adjudication and anti-fraud
  - Product development
  - Regulatory compliance
- Taxes, assessments, and fees
- Underwriting profit/contribution to surplus

Projecting Medical Claims

Projecting medical costs

- Measure prior medical spending
- Adjust data to reflect the future
- Use data to project future costs

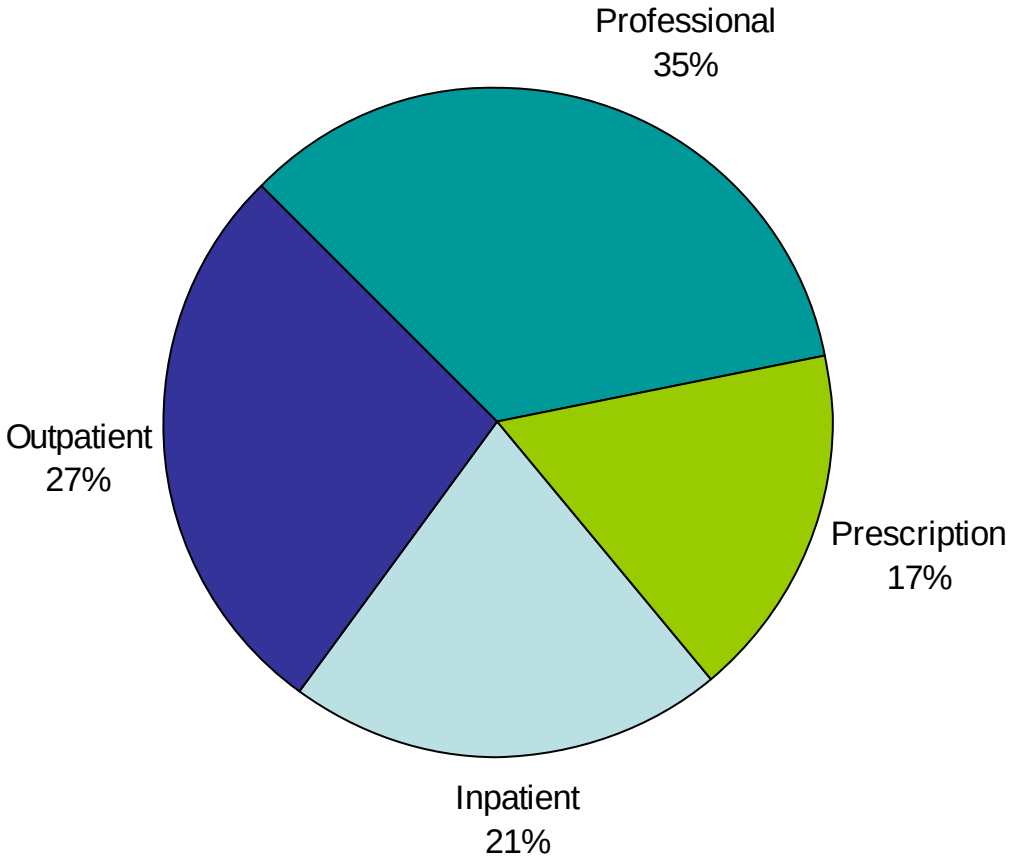
Components of claim costs

Claim costs =

$$\text{Utilization Frequency of Service} * \left(\text{Cost Per Service} - \text{Patient Cost Sharing} \right)$$

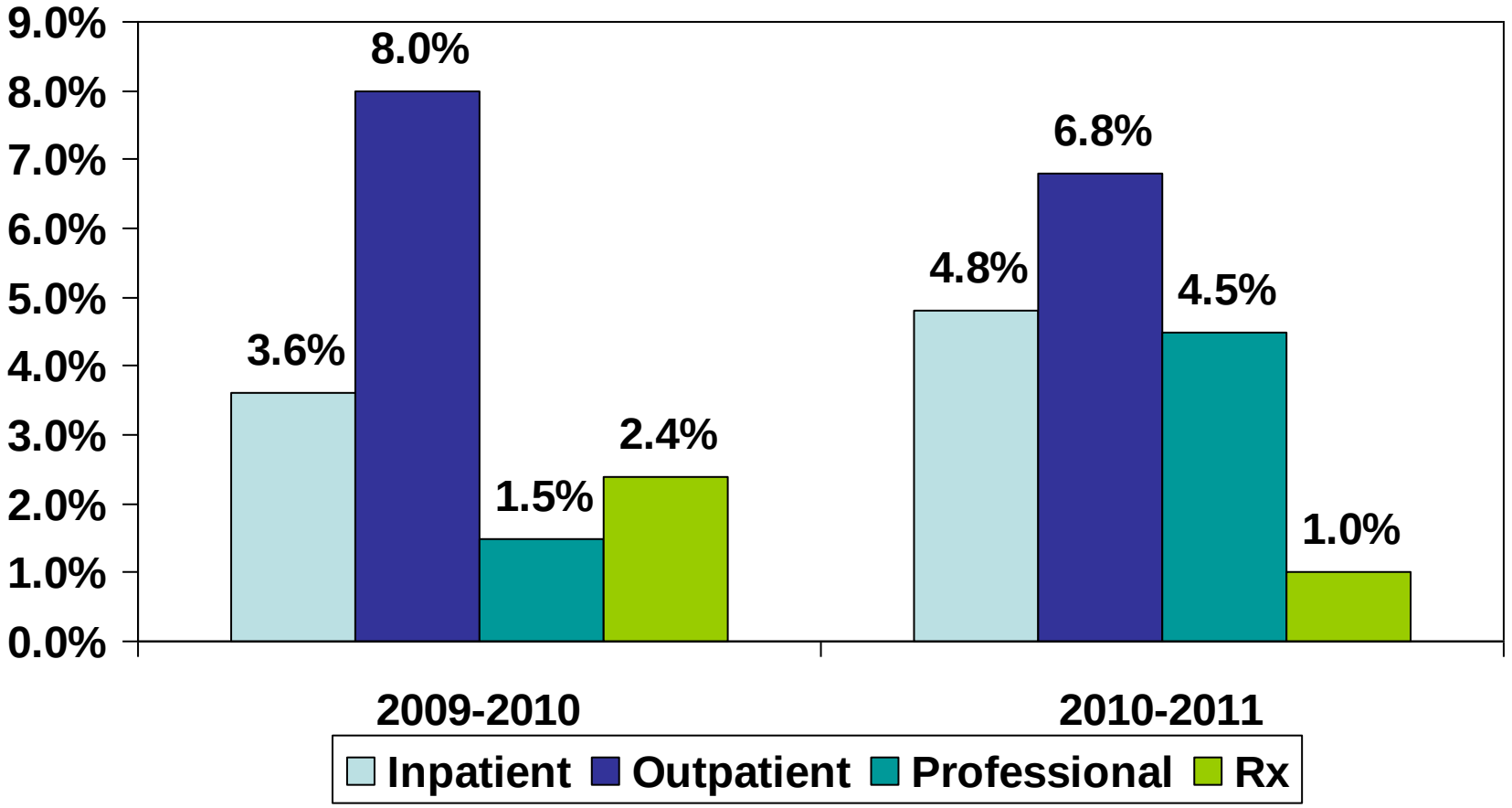
- Total costs across all services reflect unit costs, utilization, mix and intensity of services, and plan design
- Interactions between cost drivers are also important

Total spending by major service category, 2011



Note: Data reflect population under age 65 with employer-sponsored insurance
Source: Health Care Cost Institute, 2012

Change in per capita spending by major service category, 2011



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Source: Health Care Cost Institute, 2012

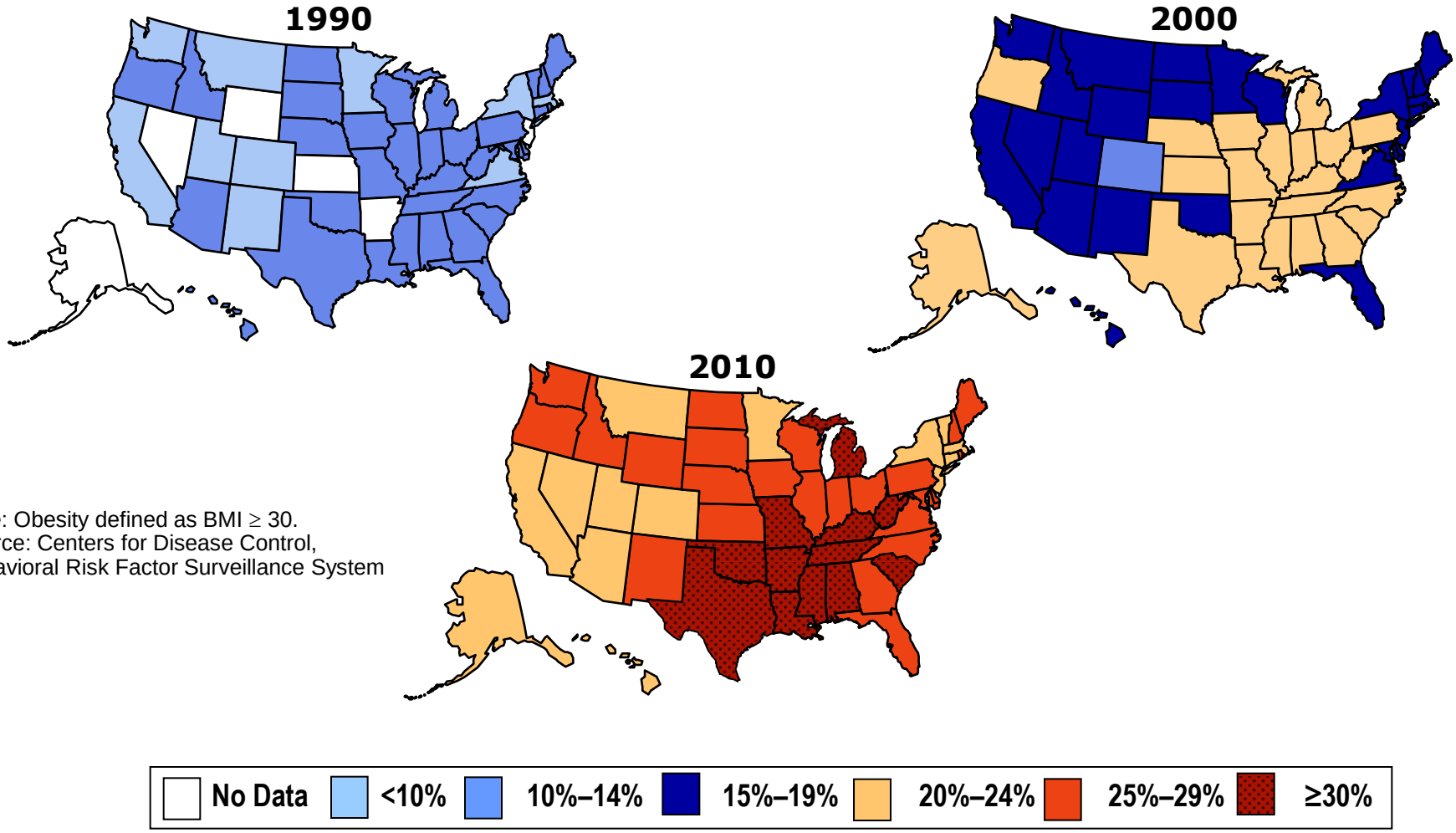
Unit cost drivers

- Inflation—growth in prices of medical input factors
- Relative negotiating power between providers and insurers
  - Hospital consolidation
- New technology
- Prescription drugs
  - Increased generic utilization puts downward pressure on average drug costs
  - Increase in specialty drugs puts upward pressure on average drug costs

Utilization drivers

- Demographic and health factors
  - Age
  - Disease prevalence
- Provider incentives
  - Fee-for-service payment structure
- Consumer incentives
  - Plan generosity (benefits covered, cost sharing requirements)
- Other utilization management tools affecting provider and/or consumer incentives

Obesity trends among U.S. adults



Note: Obesity defined as BMI ≥ 30.
Source: Centers for Disease Control, Behavioral Risk Factor Surveillance System

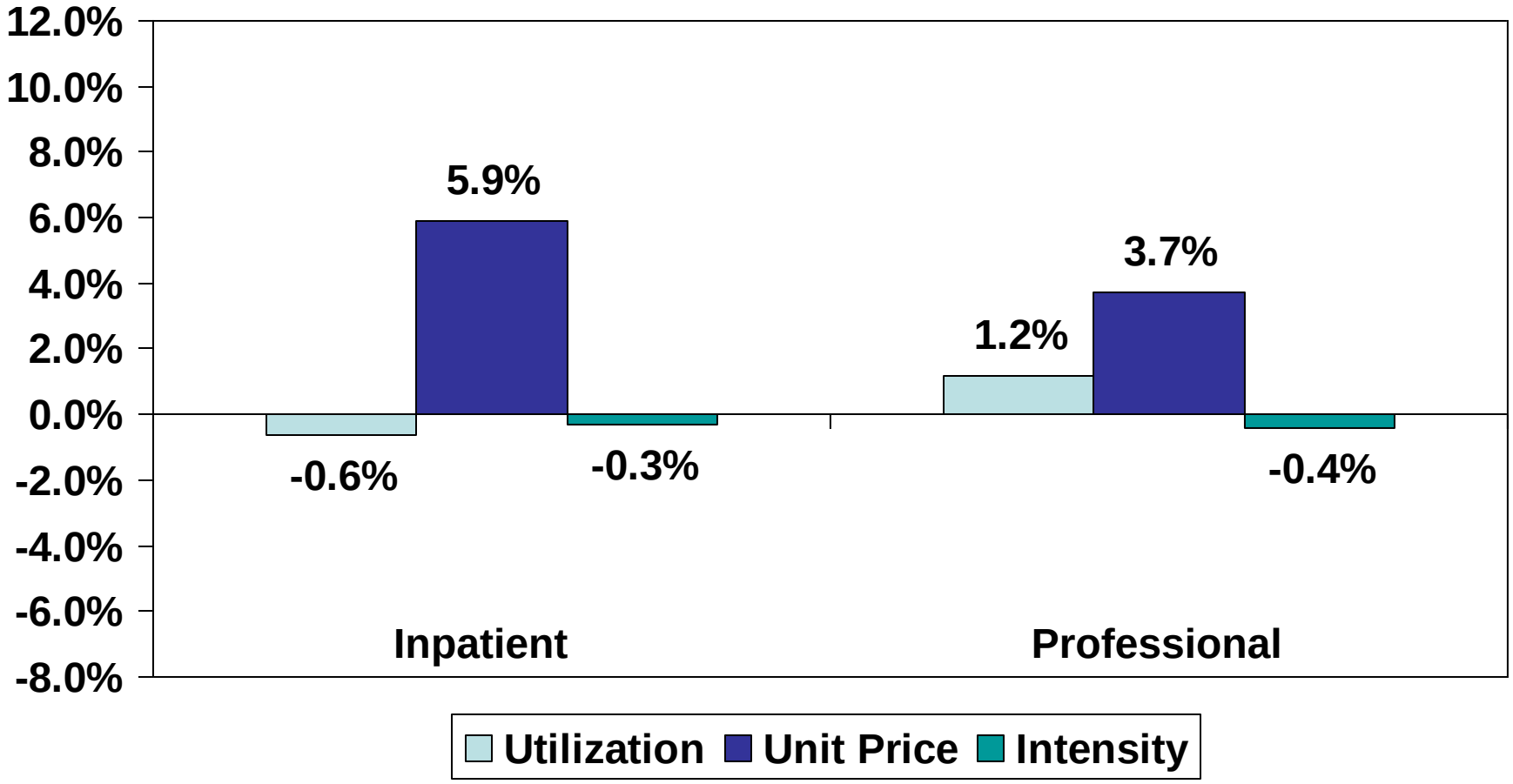
Intensity drivers

- Technology
  - Introduction of new technology
  - More widespread use of existing technology
- Disease severity

Plan design drivers

- Higher cost sharing reduces plan spending
  - Nets out patient share of spending
  - Potentially lower utilization
- Specific benefits covered
  - Different benefits will have different impacts on costs
  - Limits on specific benefits must also be considered

Components of spending changes, 2010-2011



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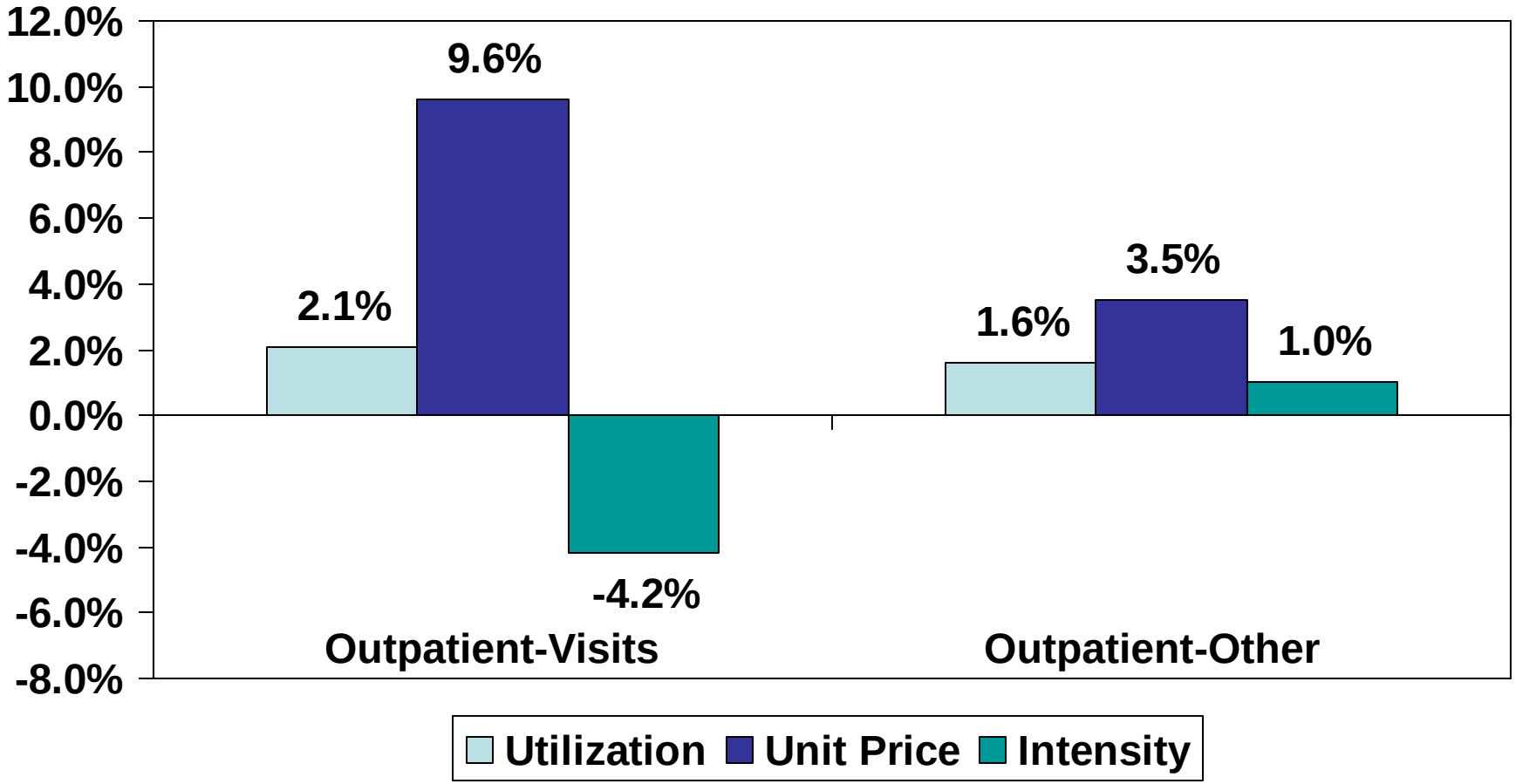
Source: Health Care Cost Institute, 2012

Components of spending changes, 2010-2011



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Source: Health Care Cost Institute, 2012

Will the recent slowdown in spending growth continue?

- Recent economic downturn contributed to slower growth in health care spending
- Evidence suggests that at least some of slowdown may be due to more structural changes to the health care payment and delivery system

ACA Rules Affecting Premiums

Rules affecting the composition of the risk pool 2014+

- Guaranteed issue—issuers must accept any individual or employer that applies for coverage in the individual or small group market
- Individual mandate—provides incentives for individuals to obtain coverage, regardless of health status
- Premium subsidies—by lowering cost of coverage, provides incentives for individuals to obtain coverage, regardless of health status

Benefit coverage rules 2014+

- Plans must cover the essential health benefits
- Plans must meet actuarial value requirements
  - A health insurance plan's actuarial value indicates the average share of medical spending that is paid by the plan, as opposed to being paid out of pocket (OOP) by the consumer

Administrative costs rules 2014+

- Medical loss ratio (MLR) requirements in effect since 2011 limit the share of premiums that can be used for expenses other than medical claims and quality improvement activities

Limits on premium increases

- Definition of an “unreasonable” rate increase in 2011
  - Increases of 10 percent or higher had to be submitted to HHS
- Definition of an “unreasonable” rate increase 2012+
  - For states with an effective rate review program, HHS can approve a different rate increase threshold
  - For states without an effective rate review program, HHS will set the threshold (still at 10 percent)

Limits on premium variations 2014+

- Premiums allowed to vary only by:
  - Age (3:1)
  - Family size
  - Tobacco status
  - Geography
  - Metal tier
- Premiums not allowed to vary by:
  - Health status
  - Gender
- Single risk pool—issuers must use a single risk pool for each of the individual and small group markets when developing premiums

Potential Premium Changes 2014+

Important to distinguish average premium changes from those faced by individuals

- Changes in premium averages
- Changes in premiums faced by individuals
- Changes in premiums by state

Factors affecting average premium changes

- Changes in the composition of the risk pool
  - Increased ability of high-cost individuals to purchase coverage due to guaranteed issue requirement
  - Effectiveness of the individual mandate and premium subsidies at attracting low-cost individuals
  - Employer offer decisions and the demographics and health status of any employees shifting to the individual market
- Increases in plan generosity due to essential health benefit and actuarial value requirements

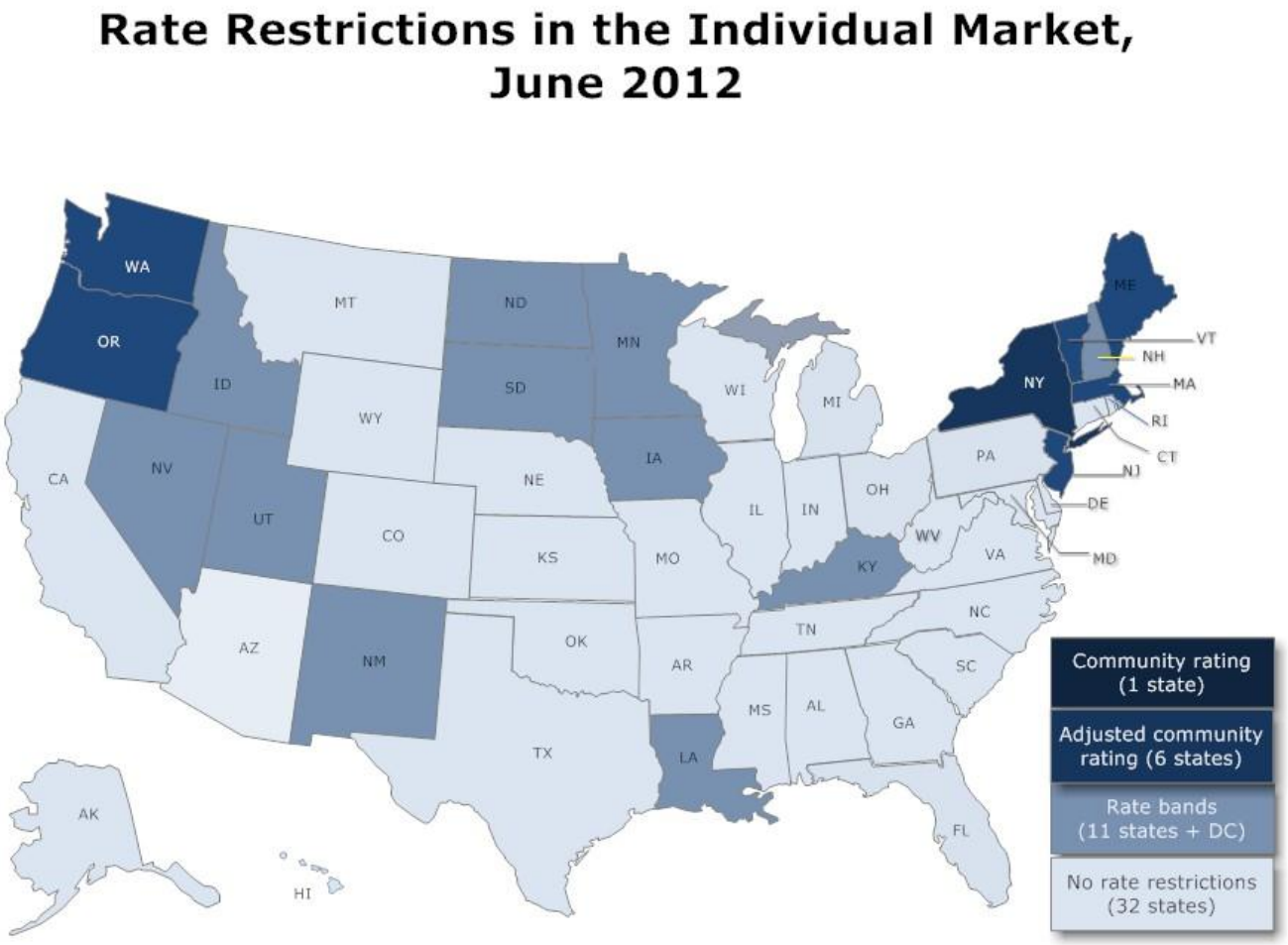
Factors affecting premiums faced by individuals

- Premium changes will vary by individual characteristics, including age, gender, and health status
- Premiums will shift:
  - from older adults to younger adults due to 3:1 age restriction
  - between men and women, depending on age, due to prohibition of gender rating
  - From less healthy individuals to more healthy individuals due to prohibition of health status rating

Factors affecting premium changes by state

- Premium changes will vary by state based on how each state's pre-ACA rules compare to those under the ACA
- Premiums could decline in states that already limit premium variations
- Premiums are more likely to go up in states with no or few rate restrictions
- Among individuals, the largest relative premium increases for younger adults, and the largest reductions for older adults, will occur in states that don't currently restrict premium variations by age

Premium changes will vary by state, depending on pre-ACA rules



Source: Kaiser Family Foundation

Factors mitigating rate shock / adverse selection

- Premium subsidies available to individuals with incomes less than 400% of the federal poverty level (FPL)
- Individual mandate provides incentive to purchase coverage, regardless of health status
- Catastrophic plans available to individuals up to age 30 and individuals exempt from the mandate
  - Premiums can be adjusted to reflect expected enrollee spending
- Temporary reinsurance program will offset portion of the costs of high-cost individuals, thereby reducing premiums

Options to further address rate shock / adverse selection

- Strengthening the individual mandate would mitigate premium increases due to a less healthy enrollee population
  - Less frequent open enrollment periods
  - Penalties for late enrollment
- Automatic enrollment for small employers
- More generous premium subsidies
- Enhanced public outreach and consumer education
- Extend/increase the reinsurance program

Premium changes in the small group market

- Small impact of guaranteed issue—guaranteed issue already required in small group market
- Impact of plan generosity requirements much lower than in the individual market—small group plans more likely to already meet requirements
- In most states, insurers currently allowed to vary rates across groups, depending on group demographics, health status, group size, and industry
  - ACA premium variation restrictions (same as in the individual market) will increase premiums for groups with younger/healthier workers, decrease premiums for groups with older/less healthy workers

Summary—Premium changes will reflect many factors

- 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 workers shifting to coverage in the individual market
- How each state's current issue and rating rules compare to those beginning in 2014
- Each individual's demographic characteristics and health status (and income when determining premiums net of subsidies)

Questions?

For More Information

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