

IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON COSTS IN THE INDIVIDUAL AND SMALL-EMPLOYER HEALTH INSURANCE MARKETS

By Jason Grau & Kurt Giesa

Introduction

The nation is seeking to improve the affordability of health insurance, extending coverage to many of the 45.6 million uninsured and reforming a fragmented healthcare delivery system. Central to the debate over healthcare reform in Washington is how to make health insurance more accessible and affordable for millions of Americans who purchase coverage in the form of individual policies, as well as for small employers.

The Patient Protection and Affordable Care Act (PPACA), currently pending in the United States Senate, includes significant reforms to health insurance industry practices in both the individual and small-group markets. These reforms would require insurers to: 1) offer coverage on a guaranteed-issue basis with no exclusions for pre-existing conditions, 2) discontinue the practice of adjusting premiums (“rating”) on the basis of health status and gender, 3) limit how much premiums vary because of age (“age bands”), and 4) sell only insurance policies that meet new minimum benefit levels.

The consulting firm Oliver Wyman, which has extensive experience in health insurance and actuarial analysis, modeled the impact of these provisions, along with a variety of other changes included in the legislation, including subsidies, grandfathering, and reinsurance, to estimate their impact on insurance premiums in the individual and small-group markets.

The key implication of our analysis is simple: For these types of insurance reforms to be successful and sustainable, it is imperative to get broad participation. Young and healthy people need to be part of the insurance pool, and people cannot defer buying insurance until they are sick or at high risk. This is true no matter who is paying the premiums—individuals, employers, or the government.

In looking at PPACA, we modeled the impact of all the bill’s major elements related to insurance. Of the expected changes to the insurance market, four will have the greatest influence on the future insurance pool, medical claims, and, by extension, premiums:

- **Guaranteed issue:** Provisions that require insurance carriers to offer coverage to all who apply for it will draw more people with high expected medical costs into the market; it also creates risk that people will buy insurance only when they need it. Guaranteed issue will help provide access to insurance for high-risk people, but will increase average prices in the individual market.
- **Rating changes:** Tighter age bands and the elimination of health status rating will also significantly increase premiums for younger and healthier people, while reducing premiums for the older and less healthy.

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- **Minimum benefit requirements:** The Senate bill mandates minimum benefit levels higher than those in many existing policies sold in the market. Ensuring adequate coverage is a logical goal of reform. But raising minimum benefit levels raises costs.
- **Expected medical costs of the uninsured:** Consistent with the Congressional Budget Office (CBO) and others who have evaluated the impact of reform, we believe the uninsured are healthier than the current *total* insured market. But we disagree with CBO's belief that the uninsured are healthier than the current *individual* market, which is significantly healthier than the total insured market. We estimate the uninsured, on average, will have medical claims about 20% higher than the current *individual* market.

PPACA contains provisions to mitigate the undesirable effects of these changes and improve affordability. While these “stabilizers” will reduce out-of-pocket costs for those eligible for subsidies, our analysis indicates that they will not have a sufficiently broad effect on coverage to offset the disruption of the insurance risk pool. Specifically, it will be a challenge to have adequate participation among the young and healthy in the future, reformed market.

Our model provides a detailed, granular analysis of the impacts rating reform and the influx of millions of newly insured people will have on the individual and small-group insurance markets over a five-year period. The model was built over eight months and uses a database of information on actual insurance policies covering nearly six million people—more than 10% of the current membership of the individual and small-group markets. Because of this, we believe our model provides the most robust current evaluation of how reforms will affect actual insurance policies.

The key findings of our analysis are consistent with other recently published analyses, including CBO's report on the impact of the proposed legislation on premiums. However we differ from CBO on some critical assumptions that affect the magnitude of expected premium changes. Because of this, our predicted premium increases in the individual and small-employer markets are greater than CBO's. Some key points of disagreement include: 1) the estimated medical costs of the uninsured compared to the current individual market, and 2) the degree to which young, healthy people will opt out of buying insurance (“adverse selection”).

Additionally, we believe our access to actual insurance policy data and analysis across different geographic rating groups allows us to more accurately evaluate the impact of reform. We describe our approach and key differences from CBO in greater detail in this report. We also conducted sensitivity analysis across these key variables to show a range of potential impact.

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Key Findings: Individual Market

1. Premiums for many purchasers in the new marketplace will increase significantly because of reform:

- **We expect average annual medical claims in the reformed individual market five years after reform to be 54 percent higher than today's, not including the impact of medical inflation.** This would translate into premiums for people purchasing new policies of approximately \$4,561 for single coverage and \$9,669 for family coverage in today's dollars – representing a premium increase of \$1,576 and \$3,341, respectively. Subsidies will entirely or partially offset these premium increases for some individuals. Eight million people currently insured through the individual and 25 million uninsured earn between 100 and 400 percent of the Federal Poverty Level (FPL) and will have access to subsidies through an exchange.
- **Insurance reforms will bring less-healthy people into the individual-market risk pool, increasing costs—and premiums.** We estimate that average medical claims for the uninsured will be 20% percent higher than claims in the current individual market. In addition, certain segments with high medical utilization who are now insured through other arrangements will enter the individual market as a result of guaranteed issue and modified community rating requirements. This includes people enrolled in state high-risk pools, people with COBRA coverage through former employers, and people with other group conversion policies.
- **Limitations on age rating will shift costs toward younger people:** PPACA restricts the ability of health plans to provide age discounts to younger members by specifying certain age bands. *We estimate that in most states, premiums for the youngest 30 percent of the population will increase by 35 percent under the 3:1 age band included in the PPACA (compared to the 5:1 ratio common in many states today).*
- **PPACA requires individuals to buy insurance with higher levels of benefits—and thus higher premiums—than typically purchased today:** The act requires a minimum actuarial value of 60% for the lowest-cost “Bronze” plans. We estimate this requirement would increase premiums in the individual market. Additionally, the bill requires coverage of “essential benefits” (including maternity coverage, mental health and rehab services) that will increase costs about 10% in the individual market. We estimate that the proposed benefit design requirements, including covered services and 60% minimal actuarial value, would lead to an average total premium increase of 14 % in the individual market.

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2. The subsidies and mandates in PPACA are not sufficient to drive high participation of younger, healthier members:

- **The subsidies included in the bill will encourage participation, but are insufficient to drive effective coverage levels.** Subsidies will lead a large percentage of those with incomes below 200% of FPL to purchase insurance. But subsidies decline at higher income levels, and more than 18 million people, including both currently uninsured individuals and current members of the individual market, will be ineligible for subsidies. As a result, participation rates will be much lower for those above 200% FPL without a meaningful penalty.
- **The value-to-cost ratio of insurance will be greatly diminished for younger people, causing adverse selection.** PPACA bans the use of two tools insurance companies use to keep younger and healthier customers in the risk pool: health status rating and age rating bands that substantially reduce the cost of coverage for younger members. These reforms will significantly increase premiums for younger members, and subsidies will not fully offset the increases for many. More important, the value-to-cost ratio of insurance after reform will be significantly lower for young and healthy people than for older, sicker people, even when subsidies are taken into account. This is the sort of circumstance that leads younger, healthier people to opt out of buying insurance while their older, sicker counterparts opt in—a process called adverse selection. CBO’s analysis assumes adverse selection will have a relatively small impact. We disagree.
- **Weak mandates will result in more uninsured.** Requiring insurers to guarantee issue coverage regardless of preexisting conditions without an effective mandate means that people can wait to purchase coverage until they need it, causing premiums to increase for most new purchasers. PPACA includes relatively weak penalties for those who fail to buy insurance. We estimate that the use of a weak mandate rather than a strong one will cause 6 to 12 million people to forego coverage.

3. The impact of reform on the individual market will vary significantly by geography. The vast majority of states have not enacted the reforms proposed in Federal bills. The states where two-thirds of the United States population resides will experience the highest premium increases. In these states, we estimate that claims in the reformed individual market will be up to 61% to 75%¹ higher than today.

4. The affordability and sustainability challenges PPACA creates in the individual insurance market can be mitigated. Within the framework of the proposed reform, several factors could help drive greater participation of young and healthy members. Stronger mandates, more generous subsidies, and reduced minimum benefit requirements will increase participation. Additionally, relaxing the age bands will greatly improve the value of insurance for younger people. These

¹ Does not include medical inflation, which will further increase premiums.

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changes could reduce the uninsured by 16 million people and mitigate the average medical costs claims growth by 36 ppts in the individual market, compared to the current bill.

Key Findings: Small Group Market

Under reform, small-group employers (2-50 employees) will experience rating changes similar to those proposed for the individual market. Key findings include:

- 1. Average premiums for small employers will increase:** Under reform, small employers will experience premium increases as a result of rating rule changes and minimum benefit requirements. We estimate that small employers purchasing new policies in the reformed market will experience premiums up to 20% higher in Year 5 of reform, not including the impact of medical inflation.
- 2. Overall, the number of small employers offering coverage will decline:** Under reform and after accounting for small-employer tax credits, premium increases will lead to fewer small employers offering coverage. We estimate 2.9 million fewer members will be insured through small-employer policies.

Overview of Modeling Approach and Methodology

Oliver Wyman has developed a comprehensive model to study the impact of reform proposals on the individual and small-employer markets.

The model is based on a database of claims, premium, and underwriting information from actual insurance policies. It includes policies for 6 million insured members in the individual and small-employer markets. Approximately 48 million Americans are enrolled in these markets today, so we had access to data on almost one-eighth of total market membership. The database includes members from 12 states and covers four distinct geographic rating clusters that are not currently community rated with guaranteed issue.

These data are representative of states across the country and reflect the varying rating rules in use today. This allows the model to provide insight into the impact of reform at the state level.

The model differs from other models currently in use because it allows us to analyze the impact of insurance reforms on actual insurance policies. This is critical, because rating reform has most of its impact at the “ends of the distributions.” For example, the medical claims for the healthiest 10 percent of members are typically less than a quarter of average claims, and the claims of the sickest 10 percent are often four to seven times the average. With actual insurance policy data, we can see how much premiums will shift, and therefore how enrollment is likely to shift, across the full distribution of policies.

Other analyses generally use synthetic health insurance units developed from survey data to evaluate the impact of reform. Because of this, other models may underestimate the real-world impact of

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rating changes, in particular, because they do not evaluate the impact on a distribution of actual policies.

Actuarial analysis is used to determine how changes in rating regulations will affect premiums overall and across geographic regions over a five-year period after reform is implemented. This multi-year view allows us to capture the impact of adverse selection, which can drive up average prices in an environment with no or weak mandates. Adverse selection theory holds that healthier individuals are more likely to drop or switch coverage when faced with cost increases, leaving the remaining pool more expensive to insure.

Our model estimates the costs of coverage choices available in the market under a given reform scenario, determines market reaction and, predicts shifts between different potential sources of coverage (i.e., individual market, small-employer market, large-group market, and government programs) and the uninsured. To evaluate market reaction to reform scenarios, we apply elasticities of demand for employers, employees, and consumers that are consistent with the academic literature and ranges used by CBO and other models.

The elasticities, combined with estimated cost changes to the employer or individual, allow us to determine how many members will enter or exit the market. We are able to track membership inflow and outflow based on the health status and income levels of individuals. In addition to rating changes, we also account for the savings individuals realize from subsidies and the cost of foregoing coverage if an individual mandate penalty is in place. Stated more simply, we are able to estimate how many people will be insured and their expected medical costs for any given reform scenario.

The model produces results that are readily validated by actual market experience. They include:

- Less-healthy individuals are more likely to take up coverage and less likely to drop coverage when costs change.
- Healthy individuals are more cost sensitive. They are more likely to exit the market if costs increase, and if uninsured, they require stronger inducements to obtain coverage.
- Premiums will increase at a rate higher than average medical inflation if the pool enters a risk spiral, which occurs when the percentage of healthy members in the pool declines.

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Key Model Variables

We analyzed the major elements of the Senate leadership proposal, the Patient Protection and Affordable Care Act (PPACA) that will have an effect on the cost of insurance in the individual and small-employer health markets. These key elements include the following:

Reform Elements Included in Analysis	Description
<i>Guaranteed Issue</i>	Insurance for anyone who wants it in the individual market, with no exclusions permitted for pre-existing conditions during open enrollment windows
<i>Modified Community Rating</i>	Elimination of health status and other factors such as gender in pricing insurance coverage
<i>Age Band Rating</i>	The use of age ranges to help set premiums for insurance coverage. Limitations on age band rating are expressed as ratios: The 3:1 age band limit in PPACA means that insurance for the oldest members can be no more than three times the rate for the youngest members
<i>Minimum Benefit Requirements with 60% Actuarial Value</i>	Actuarial value refers to the average percent of covered medical expenses paid for by an insurance policy. Under PPACA, the newly insured must purchase plans that have a minimum 60% actuarial value and include certain “essential benefits.”
<i>Grandfathering</i>	People with existing coverage as of the date of enactment may retain their current benefits if they choose, but will not be eligible for subsidies. Grandfathering will create two distinct risk pools—the “grandfather pool” and the “reformed market pool”—with different risk profiles
<i>Subsidies</i>	Subsidies for individuals under 400% of the Federal Poverty Level on a sliding scale with households required to contribute up to 2-9.8% of their Adjusted Gross Income, as well as Medicaid expansion up to 133% of the Federal Poverty Level. Subsidies for low-wage small employers
<i>Reinsurance</i>	PPACA creates a pool of \$25 billion in reinsurance for commercial plans for the first three years after implementation of reform, funded through assessments on health plans and third-party administrators (TPAs); the plan excludes grandfathered coverage.
<i>Individual Mandate</i>	Individuals are required to have health coverage. The law includes penalties (though limited) for non-compliance.
<i>Employer Coverage Incentives</i>	The bill includes a “free rider” assessment for firms with more

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Reform Elements Included in Analysis	Description
	than 50 employees that do not provide coverage to their workers
<i>Catastrophic Plan</i>	A plan with high deductibles and coverage for a minimum of three primary care visits would be available only to people under age 30 or to those with a mandate exception due to affordability or hardship. The catastrophic plan would not be subsidy eligible

PPACA includes some provisions that were not explicitly evaluated in our model. For example, PPACA includes a number of fees and taxes on the health industry, including a \$6.7 billion annual assessment on insurers and third-party administrators (TPAs), assessments on drug and medical device manufacturers, and other assessments that are likely to affect premiums in the individual and small-group health insurance market. Other analysts have estimated that the insurer fee would add an additional 1.2 – 2.0 percent to private pre-tax premiums.²

PPACA also imposes an excise tax on high-cost plans in the employer marketplace. We did not analyze its impact on cost and coverage in the individual and small-employer markets. The tax does not apply to the individual market, and we estimate its effect on small-group policies to be limited, at least in the short term.

We have not explicitly modeled the impact of health insurance exchanges because we do not believe that exchanges will materially impact underlying medical claims costs. Oliver Wyman issued a report in 2008 on this subject that found that exchanges were unlikely to reduce health insurance premiums for individuals and small employers.³ CBO’s analysis of the PPACA proposal states that exchanges, elimination of underwriting, product standardization and other efficiencies could reduce premium increases by 7-10 percent in the individual health insurance market and 1-4 percent in the small-group market.⁴ For the purpose of estimating premiums post-reform, we incorporated an assumption that all potential efficiencies in underwriting, distribution and reduction product choice could save 4 percent. We believe that this is a generous assumption given the available evidence on the cost of underwriting and potential savings in the exchange.

The bill also provides for the creation of a government-administered “public option” that would be available through the exchange. We have not attempted to model risk-selection dynamics concerning the public option, but rather evaluate adverse selection against the total insurance pool. To the extent that the overall package of policies included in the bill result in deterioration of the

² Equity research reports from Oppenheimer, November 19, 2009 and Barclays Capital, November 20, 2009.

³ "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for Individuals and Small Employers?" Karen Bender, FCA, ASA, MAA and Beth Fritchen, FSA, MAA, Oliver Wyman Actuarial Consulting, Inc., September, 2008.

⁴ Congressional Budget Office: Letter to the Honorable Evan Bayh, November 30, 2009.

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risk pool, both the public option and private health plans would face higher claims costs and therefore higher premiums.

We evaluated the impact of health insurance reforms with and without including underlying medical cost inflation. The results of this report are presented in the absence of medical trend to isolate the reform specific cost impacts. While the Senate proposal includes provisions intended to bend the cost curve over the long term, the inclusion of medical trend would have increased our projected cost increases over the five-year period we examined.

Impact of Insurance Reform on Today's Market

In most parts of the country today, insurers in the individual market are permitted to underwrite and design benefit plans with a variety of price points. This flexibility enables a stable, competitive insurance market. Perhaps most important, it permits insurers to price products to attract younger and healthier members and helps encourage wider enrollment in health insurance.

The proposed insurance reforms will tend to lower barriers and create stronger financial incentives for unhealthy people to become insured. Our model assumes that people will generally act in their economic self-interest. Although individuals and families cannot predict their healthcare needs precisely, they often have a relatively good idea of their short-term needs. As individuals work to optimize the costs and benefits of different coverage options, the market will become more prone to adverse selection that will increase costs over successive years, especially if insurance reforms are not coupled with an effective individual mandate.

In addition, certain high-utilization segments currently insured through other arrangements will enter the individual market as a result of guaranteed issue and modified community rating requirements. This includes people enrolled in state high-risk pools, people on COBRA through their former employers' coverage, and people with other group conversion policies.

The following sections will provide detail on the major factors that will affect the expected medical claims and the number of people who will choose to purchase insurance.

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Expected Medical Costs of People Currently Uninsured

A key input in modeling health reform is the likely cost of insuring the currently uninsured. Based on our review of available information, we estimate the expected medical claims of the uninsured if given access to insurance would be 85% of the claims of the currently insured. This assumption is roughly consistent with assumptions used by CBO.⁵

But this figure is misleading in estimating the impact of reform in the individual market. Most people with health insurance in the United States receive their coverage through their employers. And it is well known that the current individual market is generally healthier than the employer market in most of the U.S. On this point, our assumptions differ from CBO.

Oliver Wyman relied on multiple data sources to validate the “morbidity” (a measure of expected medical utilization) of the current individual market relative to the employer-sponsored market. AHIP and Kaiser/HRET publish state-level average insurance premiums in the individual and employer-sponsored markets, respectively. The nationwide average annual premiums (represented in 2009 premium dollars) are \$3,049 per member in the individual market and \$5,038 in the employer-sponsored market. The premiums in the individual market are 61% of those in the employer market.

We also examined the relative differences in claims from actual health plan data. The table below shows the ratio of individual-market claims to small-employer-market claims. The ratio is highest in Clusters 2 and 3 which have more restrictive rating environments in the individual market (See the map on page 15 to view the different geographic rating clusters). Clusters 4 and 5, which represent 63% of the insured population in the U.S., have much lower ratios, indicating the individual market is significantly healthier than the small employer market (which is consistent with the average premiums above).

	Cluster 2	Cluster 3	Cluster 4	Cluster 5
Ratio of average annual medical claims per member (Individual to Small Group)	0.87	0.71	0.60	0.63

It is important to note that factors other than morbidity account for a portion of differences in premiums between the individual and small-group segments. Benefits are typically richer (i.e., have higher actuarial value) in the employer market, and administrative expenses are higher for individual policies than for employer-sponsored policies. These two factors will partially cancel each other out. Taking both into consideration, we estimated the morbidity of the individual market to be 70% of the total insured market. We believe this is a conservative estimate overall, however, we acknowledge that perfect data do not exist in this area.

⁵ *Key Issues in Analyzing Major Health Insurance Proposals*, Congressional Budget Office, December 2008.

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Combining these two estimates—that the expected per-person medical claims of the uninsured will be roughly 85% of the costs of the whole pool of those covered by insurance and that the morbidity of those in the individual market is roughly 70% of the morbidity of those in the whole pool—produces an estimate that the uninsured will have medical claims roughly 20% greater than those currently covered in the individual market ($1.20 \approx 0.85/0.70$). We note that this 20% is a nationwide value, and that state-by-state values will depend heavily on the regulations currently governing the operation of the individual health insurance market. In states where regulations already require guaranteed issue in the individual market, we estimate that the morbidity of uninsured will be *less* than those covered in the current individual market.

We recognize this variable is uncertain, and we conducted sensitivity analyses on it. We modeled the impact if we assume that the uninsured, once covered with similar benefits, have medical costs that are only 65% of those currently insured. This assumption is more conservative than CBO's range.

Impact of Rating Changes and Limitations on Age Rating

Provisions in PPACA that eliminate medical underwriting, require guaranteed issue, and mandate benefit packages with a 60% minimum actuarial value will increase premiums significantly for the youngest, healthiest 30% of current plan members.

Forty-two states permit health plans to vary premiums based on age by 5:1 or more, with most of these allowing rates to be based on actuarial justification. The Senate proposal to limit variations based on age of 3:1 is more restrictive than all but a handful of states today. This would create a strong disincentive for the young and healthy to participate in the insurance market even after subsidies are applied.

We estimate that in most states, premiums for the youngest one-third of the population would increase by 35% under the 3:1 age band called for in the Senate bill relative to 5:1 age band. While tighter age bands will reduce premiums for older purchasers, at least initially, most people under the age of 50 will see their rates increase significantly. Over a five-year period, we estimate that adoption of a 3:1 rating environment rather than a 5:1 environment would cause an additional 500,000 younger, healthier members to exit the market.

Impact of Benefit Changes

The bills before Congress would also require that new purchasers buy health insurance products that meet certain minimum benefit requirements. The Senate proposal requires insurers in the individual and small-group markets to offer “Gold” and “Silver” policies, which have an actuarial value (AV)

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of 80% and 70% respectively. The lowest actuarial value product that insurers could offer in this market would be the “Bronze” package, with an AV of 60%.⁶

Oliver Wyman reviewed plans currently offered in the individual and small-employer markets in 46 states, representing benefit information for 19.3 million members, and determined that the average actuarial value of coverage purchased in the individual health insurance market today is close to 65%, similar to CBO’s estimate.

We estimate that 5.4 million people currently insured in the individual market (approximately 32% of the total individual market) have policies that do not meet the 60% threshold and would have to purchase higher-cost plans as a result of this requirement. We estimate that reaching a minimum actuarial value of 60% for the Bronze plan would cause premiums in the individual market to increase by 6% (excluding the cost of other minimum-benefit requirements). For the small-group market, we estimate that the actuarial value of products currently purchased is 70%, with about 9% of small groups having products with actuarial values below the Senate minimum of 60%.

In addition to the minimum actuarial value of benefits, the bill also includes a range of other changes that will increase the cost of benefit packages, including requirements to cover certain services (maternity, mental health services, etc.), unlimited lifetime maximums, and other limitations. We estimated the cost of additional benefit requirements in the proposed Senate legislation using proprietary benefit valuation models and a detailed review of existing state benefit requirements.

In our previous report we estimated the impact of actuarial value alone. In this report, we also included the additional requirements of the essential health benefits package to evaluate the total premium impact of the proposed benefit mandate. It is essential that the impact of these changes be assessed together to understand their full impact on premiums.

We used Oliver Wyman’s benefit pricing model to estimate the cost of the average benefits by detailed type of service. The model contains claims experience from the commercial market, including utilization patterns and relative costs per service. It is used primarily to value the cost of benefits of one plan design relative to another for the commercial market. We first calibrated the model separately for individual and small group so that the overall allowed claims were consistent with what we would expect in each market based on the average premiums and typical individual and small group benefit plans. Then we re-ran the pricing model changing one benefit at a time to determine the incremental cost of each benefit.

While the pricing manual was the primary source of our estimates, we reviewed other published studies in order to determine a reasonable range for the cost impact of behavioral and habitative

⁶ The Act also includes a catastrophic option, but enrollment would be limited to those below age 30 or who are exempt from the mandate due to affordability.

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services.^{7,8,9} Our analysis accounted for state benefit mandates as they currently exist. For example, in Massachusetts individual policies already cover maternity, so the impact on individuals will be 0 percent despite a range shown with a low end that is greater than zero.

Our best estimate of the impact of total inclusion of the essential benefits package, without any regard to what the benefits provided in a typical benefit plan, would result in an average premium increase in the individual market of 10.2% and a smaller though still significant premium impact of 5.3% in the small-group market. However, there is uncertainty in how a provision of the bill pertaining to the “benefits provided under a typical employer plan” will be interpreted. This provision could serve to limit coverage for certain less common benefits, while increasing the scope of other benefits.

We incorporated into our model increases attributable to expansion of benefits of 2% for small group and 8% for individual policies, with the goal of trying to reflect results that, if anything, err on the side of understating upward pressure on premiums.

The combination of an increase in mandated benefits and an increase in the actuarial value of coverage options is likely to increase costs for individual and small-employer health insurance. We estimate that the proposed benefit design requirements, including covered services and 60% minimum actuarial value, would lead to an average total premium increase in the individual and small-group markets of 14% and 4% respectively.

The proposal includes a catastrophic plan with deductibles similar to those for Health Savings Accounts and a minimum of three primary care visits. The catastrophic option would be available only to people under age 30 or to those with a mandate exception due to affordability or hardship. In addition, individuals eligible for government subsidies would not be able to apply the subsidies toward the catastrophic plan. Our analysis of the catastrophic plan provision indicates that it would have a modest, but positive impact on the number of people covered, but a negligible impact on average premiums.

Impact of Subsidies

Subsidies would play an important role in reducing out-of-pocket costs for certain individuals, especially those below 200% of FPL, who are likely to purchase insurance under the proposed

⁷ California Health Benefits Review Program, Analysis of Senate Bill 1198 Health Care Coverage: Durable Medical Equipment, April 3, 2008, http://chbrp.org/documents/sb_1198_report.pdf (Accessed 11/11/2009).

⁸ Massachusetts Division of Health Care Finance and Policy, Comprehensive Review of Mandated Benefits in Massachusetts, July 7, 2008, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf (Accessed 11/12/2009).

⁹ Substance Abuse and Mental Health Services Administration, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, Chapter 4 <http://mentalhealth.samhsa.gov/publications/allpubs/mc99-80/prtych4.asp> (Accessed 11/12/2009).

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reforms. Subsidies will cover more than 90% of premium costs for individuals in this income range, significantly reducing financial barriers to purchasing coverage.

By contrast, our analysis of the Senate bill projects that 8.7 million will *not* be eligible for subsidies. Another 3.3 million people who purchase coverage will have incomes of 300-400% FPL and will be eligible for average subsidies of 45% of their premiums (which would not fully offset the cost increases we predict). Finally, 13.3 million lower-income individuals who purchase coverage will have incomes of 100-300% FPL. They will have access to subsidies of 70-90% of their premiums, which will offset much if not all of the increased premiums they will face.

Average Premium Subsidy by Federal Poverty Level			
100-200% FPL	200-300% FPL	300-400% FPL	400%+
91%	70%	45%	0%

Our modeling predicts that those who are eligible for subsidies will be more likely to purchase insurance than those who are not. However, subsidies will not ensure that young and healthy people participate. Short of achieving 100% coverage, adverse selection will always exist, and the young and healthy will be the most difficult to bring into the market. (This is discussed in greater detail in a following section that discusses the relative value-to-cost ratio for people purchasing insurance.) A recent report from CMS evaluating America’s Affordable Health Choices Act of 2009 reaches the same conclusion—that the people who remain uninsured under this type of reform proposal will be predominantly the healthy: “For the most part, these [uninsured individuals] would be individuals with relatively low health care expenses for whom the individual or family insurance premium would be significantly in excess of the penalty and their anticipated health benefit value.”¹⁰

Impact of Weak Individual Mandates

The Senate bill requires individuals to purchase insurance coverage or face potential penalties. An amendment accepted during mark-up of the Chairman’s Mark in the Finance Committee, and largely retained in the Senate leadership bill, substantially weakened the bill’s individual mandate. The individual mandate penalty in PPACA is set at just \$95 in the first year insurance reforms become effective (2014). This penalty rises gradually, reaching a maximum of \$750 per adult in 2016. This maximum penalty is likely to be only about 16 percent of an average premium in 2016, assuming current rates of medical cost inflation.

The amendment also exempts individuals whose premiums exceed 8% of their adjusted gross income (AGI). In 33 states, the *average* cost of health insurance exceeds eight percent of median state income.¹¹ In fact, in the first year of reform 25% of the exchange-eligible population will face

¹⁰ October 21, 2009 memo from CMS Chief Actuary Richard Foster, “Estimated Financial Effects of the “America’s Affordable Health Choices Act of 2009” (H.R. 3200), as Reported by the Ways and Means Committee.”

¹¹ 2007 median state incomes and average state premiums. AHIP “Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits”. Census Bureau’s American Community Survey.

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insurance costs in excess of the 8% AGI threshold and qualify for mandate exemption. Premium increases over a ten-year period will result in nearly half of the population qualifying for mandate exemption status.

Mandates with meaningful penalties, combined with subsidies, are highly effective in encouraging a broad cross-section of the uninsured to purchase coverage. For example, the RAND Corporation's COMPARE model found that an individual mandate would have the greatest impact on increasing insurance coverage.¹² By itself, an individual mandate with a penalty of 80% of premiums could increase the number of people with insurance by up to 34 million, a 75% reduction in the uninsured. However, RAND estimates the net newly insured would increase by only 8.7 million if there were no penalties and subsidies extended only up to 200% of FPL.¹³

A recent survey designed by Professor Joel C. Huber of Duke University, conducted by Knowledge Networks, and funded by the Blue Cross and Blue Shield Association found that fewer than one-third of the uninsured seeking individual coverage and making between 200% and 300% of FPL are likely to purchase coverage, even after subsidies are provided, given the maximum penalty of \$750 per year in the Senate proposal. Only about one in five uninsured making more than 300% of FPL are likely to purchase unsubsidized individual coverage with a penalty of \$750 per year, according to the survey.

With weak mandates, the risk pool of the individual market will be less healthy, have much lower participation among younger members, and experience much higher premium increases. Strong penalties provide significant incentives to discourage people from buying insurance only when needed. Otherwise, there is a strong incentive for people to simply pay the penalty rather than buy insurance. Mandates serve to complement subsidies. Subsidies will be most effective for individuals with low income levels. But more than 60% of the current individual market and about 20% of the uninsured have incomes above 300% of FPL and will realize limited or no subsidy support. More than 18 million uninsured and current individual market members are ineligible for subsidies based on the proposed structures. Higher-income uninsured individuals are not likely to take up coverage without a meaningful penalty.

Adverse Selection: Why Many Young and Healthy Will Choose to be Uninsured Under Reform

Adverse selection is a primary concern when determining whether an insurance market is stable and sustainable—or if it will be vulnerable to runaway cost increases as healthy people flee the market. Without strong stabilizers, the types of insurance rating reforms proposed in PPACA have proven to be susceptible to adverse selection. The key question is: Are the subsidies, mandates and other stabilizers in the Senate bill adequate to prevent adverse selection and keep premiums affordable in the market?

¹² See: http://www.randcompare.org/publications/summary/finally_presidential_support_for_the_individual_mandate

¹³ See individual mandate results (on net new coverage) at: <http://www.randcompare.org/modeling/>

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To answer this question, we completed a thorough evaluation of the expected medical costs and the consumer’s share of premiums. We developed a simple value-to-cost index to convey how the value of insurance will vary for people with different income levels, age, health status, geography, and other factors.

The value-to-cost metrics in the table below are based on the ratio of expected medical claims to *after-subsidy* premiums. The database of insurance policies allows us to calculate these values with relatively high precision, and we are able to account for all of the rating reforms, benefit requirements, and subsidies included in the bill. The higher the value of the index, the better the value of insurance to the individual, and the likelier they will be to obtain coverage. Not surprisingly, the value-to-cost index is highest for people with low incomes who will access generous subsidies.

Two things are striking in the value-to-cost results. First, the value index drops off very quickly for incomes above 200% of FPL. Second, the value is significantly higher for older and sicker members than for young and healthy members—ranging from two to seven times higher (comparing column [2] to [3]). This variation in relative value is driven by the rating changes in the reform (elimination of health status rating, guaranteed issue, and restrictive age bands). In states today that allow flexibility for rating, there is very little difference in the value index across “older and sicker” compared to “younger and healthier”.

Income (% of Federal Poverty Level)	Value-to-Cost Index		
	[1] National Average within Individual Market	[2] Average for “Older and Sicker” Members*	[3] Average for “Younger and Healthier” Members*
100-200% FPL	5.04	10.10	1.49
200-300% FPL	1.41	2.61	0.52
300-400% FPL	1.02	1.66	0.43
400%+	0.49	0.64	0.33
All incomes	1.00	1.51	0.48

* “Older and Sicker” and “Younger and Healthier” each account for 30% of the total membership

The proposed rating reforms—specifically eliminating health status rating and imposing tighter age bands—causes premiums to increase for younger and healthier members. The cost of insurance compared to the relative value is less compelling for younger people. Therefore, *within any income cohort* (e.g., 200%-300% of FPL), the value of insurance is highest for older populations and lowest for younger populations, and the percentage of older people who purchase coverage will be higher.

Without a strong mandate or other stabilizers, the insurance pool becomes vulnerable to what is commonly referred to as a death spiral. The effect of guaranteed issue and tighter age bands on premiums compounds over time, and it becomes increasingly difficult to attract younger members.

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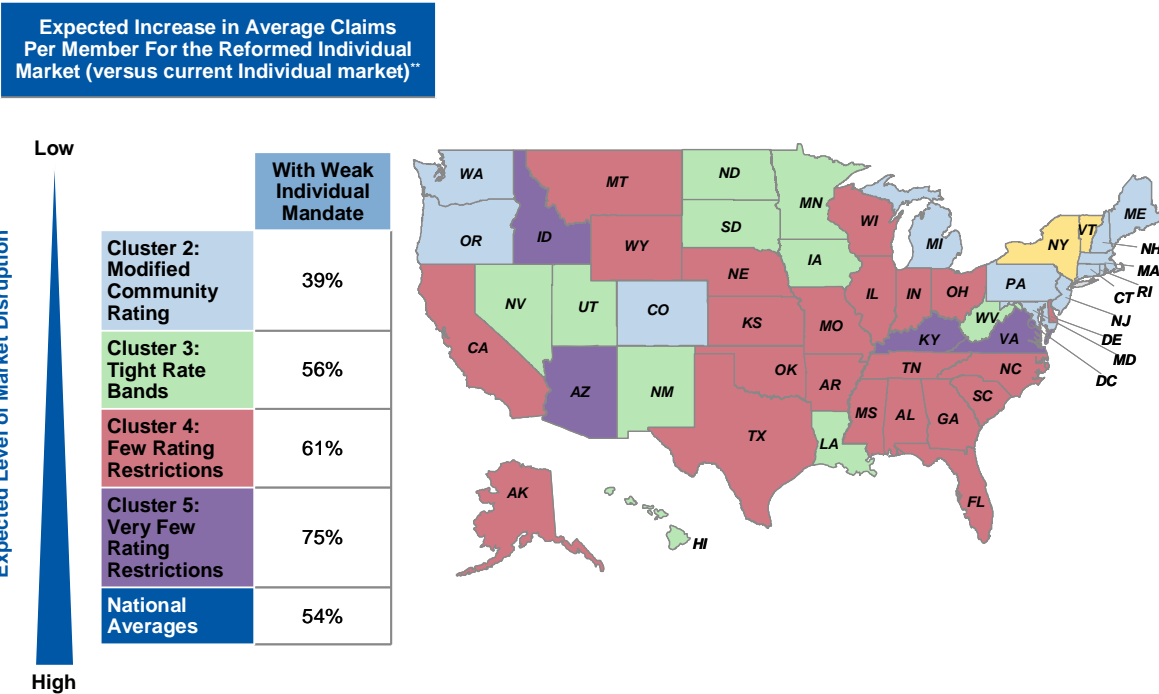
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People with higher expected utilization of medical services will be much more likely to purchase coverage, driving up premiums and reducing the number of people who would be covered. On the other hand, the young and healthy will have little incentive to maintain coverage, because they know they can get insurance when they anticipate a need.¹⁴ As a result, the risk pool will deteriorate and premiums will rise without adequate cross-subsidies. This situation is not conducive to a viable insurance market.

Estimated Future Membership and Medical Claims Costs

The impact of rating reform will vary significantly across different areas of the country, and each state will be affected differently. To illustrate these differences by geography, we created five clusters of states based on similarities in existing insurance rating rules. It is important to note that there is still variation within clusters, depending on each state’s unique characteristics. However, these clusters give a sense of the order of magnitude of change that will result from reform.

Expected medical claims growth in the reformed Individual market— Reform will have varying impacts on the expected medical claims



** Claim increases represent the effect of changes in risk profile of the insured pool. Increases do not include the effect of medical inflation which will further drive increases. Values reflect expected claims in year 5 of reform in “low mandate” scenario.

¹⁴ The Act includes open enrollment provisions that may provide partial protection against people entering the market on an as-needed basis. However, it will not provide full protection against people deferring elective and non-emergency procedures until after they buy insurance. Also, individuals will face low penalties for dropping coverage after services are received.

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Average medical claims in the nationwide reformed individual market will be 54% higher than the current average (not including medical inflation). This would translate into premium increases of approximately \$4,561 for single coverage and \$9,669 for family coverage in today’s dollars—representing a premium increase of \$1576 and \$3,341, respectively.¹¹

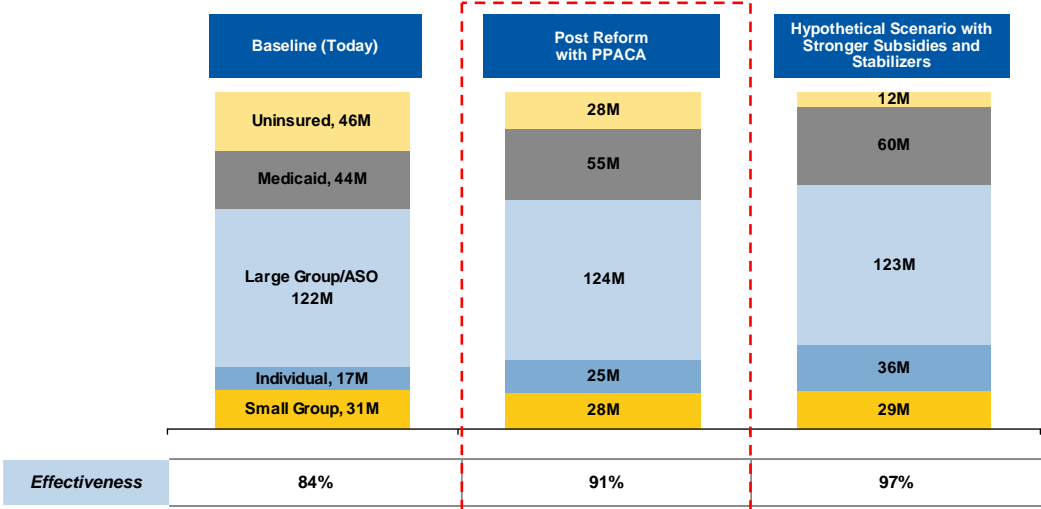
The premium increases resulting from these increased reform market medical claims creates affordability issues in the market and results in lower overall coverage levels. This can be seen by the 91% effectiveness level achieved under the PPACA reform components.

In an effort to better understand the relative impacts of reform on the market based on achieving a high participation level (97%), we modeled a scenario that would entail reform elements that when combined have a synergistic, stabilizing effect. To achieve 97% effectiveness, the hypothetical scenario changed several key aspects of PPACA. Unlike PPACA, the hypothetical scenario included: 1) relaxing the age band rating to 5:1, 2) eliminating minimum benefit requirements and actuarial value standards, and 3) stronger mandates and subsidies, particularly among the current unsubsidized and low-subsidy populations.

Under this scenario the average medical claims costs grow by 18% - one third of the 54% increase under current PPACA. This results in lower premium increases that increase affordability and drive additional membership into the market. In fact there are 16 million fewer uninsured, including 4 million additional young and healthy members entering the market under this scenario.

Scenario Comparison—Impact of Effective Stabilizers

Membership Distribution by Segment (<65 Population)



Note: Effectiveness rates are calculated excluding unauthorized immigrants

¹¹ Premiums based on AHIP Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits with a 6% medical inflation factor

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In addition to the hypothetical scenario, we also conducted sensitivity analysis to evaluate the impact of assuming that the uninsured, once covered with similar insurance benefits, will have medical costs only 65% of the costs of those currently insured. (This is much more conservative than academic studies and CBO assumptions.) With this assumption, the 54% increase becomes a 29% increase in average medical costs—still higher than CBO’s estimates. The other major difference that drives our higher estimate is adverse selection. We believe adverse selection will be an issue, and the people who remain uninsured will generally be healthier than those who purchase coverage. We believe our value-to-cost analysis, as well as the report from CMS’s Chief Actuary support our conclusion.

Observed Market Experiences With Insurance Reform

Our analysis and the model demonstrate the need to couple insurance reforms with a strong, effective individual mandate to purchase insurance. Without a coverage requirement, rating reform and guaranteed issue alone combine to create an affordability barrier for all. Further evidence to support that conclusion comes from states that have implemented guaranteed issue and rating reforms without a mandate. Some examples:

- **New York and Vermont:** Average premiums in the individual market today are about 60% higher than the national average
- **New Jersey:** Reform caused much higher premiums forcing thousands of individuals to drop coverage. The individual market decreased from 157,000 people in 1993 to 88,000 in 2007
- **Maine:** Individual market enrollment in Maine dropped from 90,000 to 41,000 between 1993 and 2007 following the state’s reforms

Even in Massachusetts, there is evidence that individuals are selectively jumping in and out of the market when they need healthcare. Data from health insurers in Massachusetts indicate that the number of people in the individual market with coverage of less than 12 months has doubled post reform. These individuals have a significantly higher claims to premium ratio when compared to those who had coverage for more than 12 months but let it lapse or those that are active.

Without strong penalties, similar types of behavior are likely to emerge in the reformed individual market—resulting in significantly higher premiums for the insured.

Impact on Small Groups

Under reform, small employers will experience premium increases as a result of rating rule changes and minimum benefit requirements. We estimate that small employers purchasing new policies in the reformed market will face premiums up to 20% higher in Year 5 of reform, not including the impact of medical inflation. About 9.9 million small-group employees who have coverage today will stay covered under the grandfathered block in the initial post-reform years, but will face premium increases when grandfathering phases out. After accounting for small-employer tax credits, premium

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increases will lead to fewer small employers offering coverage. We estimate 2.9 million fewer members will be insured through small-employer policies.

Conclusion

Based on our analysis we believe that in order for reform to be effective in the market, it must include adequate stabilizing levers. Subsidies and mandates that support high participation rates minimize the level of disruption and reinforce a sustainable market. While lawmakers may have reduced penalties for not purchasing insurance because they are concerned about the risks of forcing people to purchase unaffordable coverage, failure to include an effective personal responsibility requirement could result in the failure of reform by causing premiums to skyrocket for all those who responsibly purchase insurance coverage.

This report illustrates the need to couple insurance reforms with adequate incentives for individuals to maintain continuous insurance coverage, including an effective mandate. The provision of subsidies alone will not offset the impact of insurance reforms on average premiums in the market. A balanced, sustainable insurance pool, that ensures everyone is covered, is critical to making healthcare affordable for all. This has been validated through state experience in markets where guaranteed issue and rating reforms have been implemented without coverage requirements or mandates.

While the Senate proposal includes provisions such as reinsurance and grandfathering to mitigate the cost of insurance reforms in the initial years of reform, these reform elements will not be successful unless coupled with an effective coverage requirement.