

Individual and Small Group Premium Changes Under the ACA

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BACKGROUND

Milliman was requested by the Indiana Health Care Exchange Policy Committee (the Committee) to provide projections for premium rate changes in the individual and small group insurance markets due to the provisions of the Patient Protection and Affordable Care Act of 2010 (ACA).

This issue paper presents the estimated overall market premium changes and discusses key drivers and assumptions underlying the magnitude of the premium changes. The premium rate changes discussed in this paper do not reflect the impact of premium tax credit subsidies available to qualifying individuals in the insurance exchange. The ACA's premium rate impact on an individual-by-individual or group-by-group basis will vary substantially.

INDIVIDUAL MARKET

The estimated ACA-driven premium rate change for the Indiana individual insured market beginning in 2014 is 75% to 95%.

The majority of this premium increase is driven by two factors:

1. **High Risk Pool.** The State and insurance carriers currently subsidize the Indiana Comprehensive Health Insurance Association (ICHIA), which operates as the State's high risk pool. ICHIA serves approximately 7,300 individuals that are not eligible for employer-sponsored health insurance, and cannot obtain comprehensive individual insurance due to a medical condition. The medical benefit costs for ICHIA enrollees during calendar year 2010 were approximately 11 times higher than the commercially insured individual market. Due to the community rating and guarantee issue provisions of ACA, it is anticipated that ICHIA will be terminated on January 1, 2014 and its enrollees will enter the individual commercial insurance pool. When combining ICHIA and the current individual commercially insured populations, ICHIA enrollees account for less than 5% of covered lives, but approximately 30% of medical costs. The PCIP, which is the federally operated temporary high-risk pool funded through December 31, 2013 by the ACA, had 131 Indiana enrollees as of February 1, 2011. Although the costs of the PCIP population are unavailable, it is assumed the composite claim morbidity is significantly higher than the commercially individually insured population. Due to the ICHIA and PCIP enrollees having known medical conditions, it is likely that they will purchase insurance in the individual commercial market beginning in 2014. **Assuming enrollment growth and medical trend in the high risk pool populations consistent with the individual insured market through calendar year 2013, the estimated premium impact of merging the high risk pool population into the commercially insured individual market is between 35% and 45%.**

Section 1341 of the ACA allows states to establish a transitional reinsurance program for the individual insured market in calendar years 2014 through 2016. The reinsurance program is intended to make payments to health insurance issuers that cover high risk individuals in the individual insured market. The State may coordinate a high risk-pool with the program. **Due to currently undefined regulations governing the reinsurance program and temporary nature of the program, the impact of the transitional reinsurance program has not been quantified for this analysis. However, the reinsurance program may have a material impact on market premium rates.**



- Benefit Expansion.** Increases in the number and level of healthcare services covered by health insurance in the individual market to meet essential benefits requirements are estimated to increase premium rates between 20% and 30%. Current benefit level differences between the small group insured and individual markets were used to estimate the impact of the ACA benefit coverage requirements. Reported per person medical costs in the small group market by Indiana insurers in calendar year 2010 were approximately 25% higher than the individual market, net of estimated morbidity differences between the two populations.

Additional factors impacting premium rates in the individual market include:

- Other Risk Pool Composition Changes.** If a small portion of individuals currently uninsured elect to purchase insurance, it is expected that these individuals would have disproportionately higher medical benefit costs relative to the remaining uninsured population. This will increase premium rates relative to what would occur if a large percentage of the currently uninsured elect to purchase coverage.

With a large influx of uninsured individuals into the individual insured market beginning in 2014, one may believe that the high risk pool population impact will be dampened. However, given that both ICHIA and PCIP do not provide any premium subsidies to low-income households, current premiums for these programs may be unaffordable for low-income households, preventing chronically ill individuals from entering the programs. Census survey data also indicates that the uninsured population has a lower degree of self-reported health status relative to the individual insured population. Finally, experience in the Healthy Indiana Plan (HIP) indicated a portion of the previously uninsured population had high-cost conditions similar to those found in the ICHIA program. Therefore, it is unlikely that the impact of including the high risk pool population in the commercially insured individual market will be significantly mitigated by a large segment of the currently uninsured population entering the market.

- High Risk Pool Assessments.** ICHIA is partially funded from assessments on insurance carriers in the State. If ICHIA is terminated in 2014, the State will no longer require carrier funding for the program. This will result in a small decrease to the premium rates.
- Manufacturer and Carrier Fees Pass-Throughs.** ACA assessments on pharmaceutical manufacturers, medical device manufacturers, and health insurance carriers will result in premium increases due to higher per unit costs for these services.
- Provider Cost Shifting.** With the expansion of Medicaid eligibility to 138% of the federal poverty level (FPL), providers may increase charges on commercial payors to compensate for lower funding from government payors. The impact of such cost-shifting will be mitigated to the extent that the Indiana Medicaid provider payments are increased.

The minimum loss ratio requirements are not expected to have a material impact on premium rates. A review of per covered life administrative costs on a state-by-state basis indicated states that already have adjusted community rating in the individual market had administrative costs comparable to other states. Therefore, even though the medical benefit costs are estimated to rise substantially, a similar size increase in administrative costs is not expected. This effect will increase a carrier's medical loss ratio.

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SMALL GROUP MARKET

The estimated ACA-driven premium rate change for the Indiana small group insured market beginning in 2014 is 5% to 10%.

Risk pool composition. The primary factor driving premium rate increases in the small group insured market is risk pool composition changes that will occur due to employers terminating their sponsored health plans, individuals with non-qualified coverage entering the individual market, the inclusion of employers with up to 100 employees in the small group market, and employers electing to self-fund their sponsored health plan, rather than stay in the insured market. A higher proportion of small employers electing to self-fund their plans due to the adjusted community rating restrictions will increase overall market premiums, as the healthier groups leave the market. However, it is also anticipated that low-income individuals, who are estimated to have higher claims morbidity, are more likely to enter the individual market due to plan termination or eligibility for a premium tax credit on the insurance exchange. On a net basis, it is estimated that the small group insured risk pool will have a marginally higher claims morbidity.

The small group market will experience similar premium impacts as the individual insured market due to the **elimination of high risk pool assessments, manufacturer and carrier fees pass-throughs, and provider cost shifting.**

The small group insured market premium impact due to the ACA is substantially smaller than the individual market's impact due to the absence of a high risk pool population and existing benefit coverage levels that are likely to satisfy the minimum essential benefit and coverage requirements under the ACA.

LIMITATIONS

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Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain 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.

In developing the projections, we relied on data and other information from 2010 annual statements of life and health insurance companies and HMOs doing business in Indiana, other public sources, and a March 10, 2011 memorandum from the State Health Access Data Assistance Center to the Indiana Family and Social Services Administration. We have not audited or verified this data and other information. We performed a limited review of the data used directly in our analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The projections included in this issue brief are based on our understanding of ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of ACA, necessitating an update to the projections included in this issue brief.

The views expressed in this issue brief are made by the authors of this issue paper and do not represent the opinion of Milliman, Inc. Other Milliman consultants may hold different views.

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QUALIFICATION

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

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