ACA Impact on Premium Rates in the Individual and Small Group Markets

Paul R. Houchens, FSA, MAAA

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) introduces significant changes in covered benefits, rating, carrier regulation, and the issuing of insurance coverage to Indiana's individual and small group markets beginning in 2014. The expansion of Medicaid eligibility and availability of premium subsidies in the individual insurance exchange will increase the access and affordability of insurance to a significant portion of the currently uninsured and individually insured population. The ACA's impact on premium rates in the individual and small group markets should be understood from the context of the individual or entity purchasing insurance and for the markets as a whole.

EXECUTIVE SUMMARY

While the magnitude of the ACA's impact on premium rates in the individual and small group markets cannot be known with certainty, the combination of the following factors are expected to result in greater premium increases in the individual insurance market and limited increases in the small group market:

- ***Benefit Expansion*** – Increases in the number and level of healthcare services covered by health insurance, particularly in the individual market, to meet essential benefits requirements.

- ***Adverse Selection*** – A higher propensity for less healthy individuals to both purchase insurance and increase their coverage level.

- ***Risk Pool Composition Changes*** – The population enrolling in the individual insurance market in 2014 may have a higher level of morbidity versus today's market populations. The State of Indiana currently operates a high risk pool, the Indiana Comprehensive Health Insurance Association. Unless a similar pool is continued, this population will enter the individual insurance market in 2014.

- ***Manufacturer and Carrier Fees Pass-Through*** – ACA provider and carrier assessments will be included in the development of premium rates.

- ***Provider Cost Shifting*** – The significant expansion of the Medicaid population may result in increased charges to commercial payors to account for low provider reimbursement under Medicaid.

Offsetting the potential drivers of premium increases, a decrease in carrier non-benefit expenses may occur due to ACA minimum medical loss ratio requirements for the individual, small, and large group insurance markets. The reduction in non-benefit expenses will be reflected in decreased premium rates or in the form of a rebate if the carrier exceeds the minimum medical loss ratio requirements.

Although many of the above factors are not within the State's control, the issue of adverse selection may be influenced by State policy. Adverse selection is created by the ACA due to guaranteed issue requirements in combination with a weak individual mandate, and rating limitations (particularly in the small group market). The State may wish to consider policies that promote a high insurance participation rate to mitigate the risk of adverse selection.

From the individual insurance consumer's perspective, premium rates will likely decrease for the majority of households below 400% FPL as they will be eligible for premium tax credit subsidies in the individual insurance exchange. If the individual currently has an insurance plan below the minimum benefit level mandated by the ACA, the increase in required benefits will increase premium amounts. Households above 400% FPL in the individual market

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.

June 2011

could experience premium increases due to expansion of insured benefits, adverse selection, and changes in the population composition of the individual market.

In the small group market, adverse selection is created between the group insured risk pool and option to self-fund the employer plan. The rating limitations imposed by the ACA on the small group market and the carrier market share assessments will create financial incentive for small employers, particularly those with relatively young, healthy workforces, to opt-out of the group insured risk pool in favor of self-funding.

EXPANSION OF COVERED BENEFITS

The pricing of health insurance is fundamentally based on estimates of future healthcare costs during the premium rate period that the insurer is contractually required to pay. Future ACA regulations will specify what healthcare services are 'minimum essential benefits' and must be covered through health insurance. Additionally, the ACA defines the percentage of essential benefits that must be paid by the insurance contract. With the exception of the catastrophic plans for individuals under 30, a person must have health insurance covering at least 60% of expected essential healthcare costs.

For individuals or employers that currently have an insurance policy with covered benefits below the required level under the ACA, premium increases will occur. Requirements under the ACA to cover preventive services at 0% cost sharing have already caused premiums to increase. However, premium increases should also be viewed in the context of the total healthcare spending for the policyholder, which is a combination of insurance premiums and out-of-pocket healthcare expenses. While the ACA will increase healthcare spending on insurance premiums, for some policyholders it will decrease patient out-of-pocket healthcare expenses, assuming their medical service utilization does not change.

In the individual insurance exchange, enrollees can choose a plan that covers 60%, 70%, 80%, or 90% of estimated healthcare costs. With the introduction of premium tax credit subsidies for households up to 400% of the Federal Poverty Level (FPL), a richer benefit plan will be more affordable for many households. Therefore, while the average total premium for an individual insurance policy may increase due to the increased covered health expenses, the out-of-pocket premium for households eligible for the premium tax credit subsidy may decrease relative to today's market.

ADVERSE SELECTION CREATED BY GUARANTEED ISSUE

The ACA requires that individual and small group insurance in 2014 be guaranteed issue, without any pre-existing condition limitations. In order for a health insurance market to function under guaranteed issue, the participation of healthy individuals in the risk pool is necessary. Otherwise, the insured risk pool would be limited to individuals with known health conditions who have 'adversely selected' against the insurance market by purchasing coverage. To reduce the impact of adverse selection under guarantee issue, the ACA imposes an individual mandate, with exceptions, for an individual to either purchase insurance or pay a financial penalty. However, the penalty is significantly below the cost of insurance coverage, especially in calendar year 2014 when the penalty is only $95. Other requirements, such as fixed open enrollment periods, can be used in combination with the individual mandate to reduce adverse selection and encourage greater participation in the insurance pool. If the combination of the individual mandate and other state policies do not impel the participation of young and healthy individuals in the insurance pool, composite average premium rates for the remaining insured markets will likely rise.

In addition to adverse selection occurring with the decision to purchase insurance, adverse selection will also occur between the four benefit tiers offered in the individual and SHOP exchanges. For individuals with chronic health

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.

conditions, it will be in their best financial interest to purchase insurance that will cover a large percentage of their healthcare expenses during the coverage period, *i.e.*, the gold (80% actuarial value) or platinum plans (90% actuarial value) in the exchange. However, healthy individuals will be more inclined to purchase a bronze plan (60% actuarial value) since it will have the lowest premium cost in the exchange. Adverse selection may occur between the four benefit levels, which will raise the composite average premium rates in the market. Examples of policies to mitigate adverse selection include locking an individual into a benefit tier for more than one year, or allowing a policyholder to increase or decrease their benefit level by one tier each year.

ADVERSE SELECTION CREATED BY RATING REQUIREMENTS

Premium rates in the Indiana individual and small group markets are currently developed based largely on underwriting the individual or small group enrollee health status and adjusting the rates at time of issue and on renewal dates. Under the ACA, premiums for all individual and small group markets are to be developed using "adjusted community rating". This methodology does not allow health status to be used in rating, and only allows rate variation based on age, family size, and tobacco usage. Premiums for individuals or groups with above average expected healthcare costs will decrease, while conversely the premiums for individuals or groups that have relatively low expected healthcare costs will increase to the average of the community.

The ACA rating requirements also limit the premium adjustment factors for age to a 3:1 ratio. The actual variation in healthcare costs in the adult 19-64 year old population is approximately a 5:1 ratio. Similar to how the removal of health status leads to increased subsidies of the sick by the healthy, the age rating restrictions will result in the younger insured population subsidizing the insured costs of the older population in the insured risk pool. Like the subsidies of health status, these subsidies by age will also occur in the small group market as it changes through reform. Individuals and employers with younger than average workforces will have material premium increases due to the 3:1 rating band limitation.

While the ACA rating requirements will not change the composite premium rates in the market under a static insured population, in reality this will not be the case. As the cost of health insurance rises for young and healthy individuals, this will create a greater financial barrier to purchase insurance coverage and incentive to pay the individual mandate penalty. The incentive to be uninsured is mitigated by the rising cost of the penalty and the availability of premium tax credit subsidies for households with income below 400% FPL. If a significant number of healthy individuals do not participate in the individual risk pool, then this change in the insured population will increase the composite premium rates of the markets. Pursuing a strategy of high participation rates for health insurance is critical for the long term viability of the markets.

As employer workforce size increases, the employer has the option of purchasing a group insurance policy from a carrier, or self-funding the plan. Under a self-funded plan, a small employer would be at risk for its employees' healthcare expenses, while purchasing a stop-loss policy to avoid catastrophic expenses in aggregate or from any one individual under the plan. In the current Indiana small group market, the benefit of a self-funded plan is limited to small employers since carriers are allowed to vary premiums by +/-35% between employers based on the group's health status. Because of the health status rating allowance in the current market, a small group's premiums rates are largely reflecting its estimated future healthcare costs.

However, in combination with the 3:1 age rating requirement for the small employer market in the ACA, a cost advantage may be created for small employers with young, healthy workforces that self-fund their plans, rather than subsidizing other employers in the small group risk pool. As the employer size increases, the likelihood of self-funding will increase as annual healthcare costs become more predictable with a larger risk pool. If a significant portion of young and healthy small employers drop out of the small group insured risk pool, the premium costs for the employers remaining in the insured pool will further escalate.

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.

RISK POOL COMPOSITION CHANGES

Related to the issue of adverse selection, the premiums in the individual and small group markets will be dependent upon the health status of the individuals enrolling in the risk pools. Relative to the individual insurance risk pool today, the ACA will create significant changes to the covered population in the risk pool that will increase the average morbidity relative to today's market.

The following list of populations will likely be covered in the individual risk pool beginning in 2014:

Individually Insured – Individuals currently in the individual insurance market will remain in the market, with the exception of individuals with household income at or below 138% FPL who will become Medicaid eligible. Note, if Indiana elects to operate a Basic Health program (BHP) for the population between 139% and at or below 200% FPL, individuals in this FPL range currently insured will leave the individual market.

Uninsured – The majority of the uninsured above 138% FPL (200% FPL if the State operates a BHP) electing to begin insurance coverage. A portion of the uninsured will obtain employer-sponsored coverage that they had previously elected not to join. The uninsured population may have pent-up demand for healthcare services, as experienced in the Healthy Indiana Plan[1].

High Risk Pool – Individual's in the Indiana Comprehensive Health Insurance Association (the State's high risk pool) will enter the individual market if their household income is above 138% FPL (200% FPL if the State operates a BHP).

Medicaid/Healthy Indiana Plan Eligible – Individual's with household income above 138% FPL (200% FPL if the State operates a BHP) who are currently Medicaid eligible or enrolled in the Healthy Indiana Plan will enter the individual market.

Active Employees with Employer-Sponsored Coverage - Individuals who currently have employer-sponsored insurance will enter the individual risk pool if their employer terminates coverage, or if their employer coverage is considered non-qualified (triggering eligibility for the premium tax credit subsidy). Low-wage employers will be more likely to terminate plans due to the availability of premium subsidies in the individual exchange for employees in the absence of the employer-sponsored plan.

Retired Employees with Employer-Sponsored Coverage – Due to the lack of a mandate to continue employer-sponsored health plans for retirees, the 3:1 rating limitation, and the availability of premium subsidies for households below 400% FPL, employers may begin providing pre-65 retirees with specified dollar amounts to purchase health insurance in the individual market to reduce the employer's healthcare costs.

Active Employees Maintaining Work Status for Employer-Sponsored Coverage – For individuals with chronic health conditions, individual insurance in today's market can be prohibitively expensive. For this reason, an individual or spouse who might otherwise retire from the work force maintains active employment until Medicare eligibility for the sole purpose of the employer-sponsored insurance benefit. With adjusted community rating, guaranteed coverage, and premium subsidies in the individual exchange, the value of employer-sponsored insurance is reduced. Therefore, the state should anticipate a reduction in the percentage of individuals age 55 to 64 with active employment. These new retirees will enter the individual insurance risk pool.

---

[1] Experience Under the Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured. Rob Damler, FSA, MAAA. August 2009. http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.

In addition to these population changes to the individual market, there are two key provisions which also drive change for the small employer group insurance market. The first is the young adult workforce. The ACA has likely already reduced the size of the young adult population in the individual market by extending dependent eligibility for employer plans until age 26. The ACA also allows individuals under 30 to purchase a catastrophic health plan in the individual market, versus a plan with minimum creditable coverage (60% actuarial value), which further allows young adults to select against the standard metallic plans in the exchange. The 3:1 rating limitations will also result in the young adult population receiving premium increases relative to today's market.

In the small group market, the risk pool composition will largely be driven by two factors. First, the prevalence of healthier employer groups electing to self-fund, rather than staying in the small group risk pool. Second, the number of low-wage small employers that will terminate their plan due to the availability of premium subsidies for employees in the individual exchange. If a large percentage of low-wage small employers terminate their plan, then this may reduce the morbidity in the small group insured risk pool, as low-wage employees tend to have higher morbidity relative to high wage earners. If low-wage employers leave the market, this may reduce the rate at which employers switch to self-funding.

MANUFACTURER AND CARRIER FEES PASS-THROUGHS

The ACA imposes new fees on pharmaceutical manufacturers, medical device manufacturers, and health insurance carriers. As with any tax on business, these fees will be passed along to the consumer. While the fees on pharmaceutical and medical device manufacturers will be spread across all payors (commercial insurance, self-funded plan, public plans, government employee plans), the health insurance carrier assessment may significantly impact premiums in the individual, small, and large group insured risk pools. The non-tax deductible assessment amount is $8.0 billion in calendar year 2014, increasing to $14.3 billion in calendar year 2018. The assessments are allocated across the insurance industry by market share. However, self-funded plans, government entities, and non-profit plans meeting requirements are exempted from the assessments. Given that most large employers are already self-funded and many small employers may elect to become self-funded in the future, the assessment amounts will fall on the individual and remaining small group risk pools and will result in increased premiums in these markets.

PROVIDER COST SHIFTING DUE TO EXPANSION OF MEDICAID ELIGIBILITY

The ACA mandates minimum Medicaid eligibility for all households with income at or below 138% FPL. This is a significant expansion of Medicaid eligibility for many populations, such as childless adults. Although the majority of the newly eligible Medicaid population is uninsured, a portion of the expansion population will consist of individuals who currently have employer-sponsored or individual insurance.

The Medicaid program on a national basis has struggled to create sufficient provider access for Medicaid beneficiaries. In Indiana, Medicaid provider payments are approximately 60% of Medicare and 40% of commercial payors, which make many providers reluctant to serve Medicaid beneficiaries. In order for the providers that serve Medicaid beneficiaries to be financially solvent, commercial payors are charged higher costs to balance the low payments made by government payors. This practice is known as 'cost shifting'.

Milliman has estimated that Indiana's Medicaid population will increase between 40% and 55% due to the new ACA Medicaid eligibility standard[2]. For providers that will continue to serve the Medicaid eligible population, this will increase the proportion of their patient population and revenue from Medicaid. In order to maintain the financial stability of their practice, these providers will have to increase their charges to commercial payors. Since the premium

[2] Affordable Care Act (ACA) – Financial Analysis Update. http://www.in.gov/aca/files/AffordableCareActFinancialAnalysisUpdateOct2010.pdf Rob Damler, FSA, MAAA.

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.

for any health insurance policy is based on the underlying expected claim expenses, this will result in higher premiums in the commercial market, including the individual and small group risk pool. The degree of cost shifting that will occur may be mitigated if the State increases its Medicaid fee schedule or creates a Basic Health program.

CAPPING THE CARRIER NON-BENEFIT EXPENSE COSTS

The ACA mandates that carriers in the individual and small group markets meet a minimum medical loss ratio (MLR) percentage. The minimum medical loss ratio percentage is the carrier's benefit expense, divided by the total premium revenue (the actual minimum MLR calculation under the ACA has several additional considerations). The portion of premium that is not paid towards policyholder benefit expenses consists of administrative costs, capital requirements, and profit. Carriers not meeting the minimum MLR standard are required to rebate premiums to policyholders. The minimum MLR requirements are contained in the ACA to prevent carriers from making excess profits during the changes caused by reform and to encourage administrative efficiency. With the absence of medical underwriting in the individual and small group markets, administrative costs related to the issuing of policies will be reduced. As carriers will be competing largely based on premium price in the individual and small group markets in 2014, these administrative savings will be passed along to the healthcare consumer.

LIMITATIONS

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

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.

QUALIFICATION

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

This issue brief has been prepared solely for the internal use of and is only to be relied upon by the Indiana Health Care Exchange Policy Committee. Although Milliman understands that this issue brief may be distributed to third parties, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Copyright by Milliman, Inc.