

# How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Term?

## Timely Analysis of Immediate Health Policy Issues

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The impact of the Patient Protection and Affordable Care Act (PPACA) on small group and individually purchased (i.e., non-group) health insurance will depend upon many factors. These include the characteristics of the health insurance markets prior to reform, whether plans are grandfathered or are newly created under reform, the health status and claims experience of the covered group or individual, individual coverage decisions, policy decisions that will be made at the state level, and success of cost containment efforts. Thus, many factors will interact and affect premiums, making it difficult, if not impossible, to make generalized statements of the effect of the new law on premiums. Here, we present the central factors that will influence premiums for coverage of different types, identify the direction of that influence, but do not attempt to quantify the end result of the various interactions.

Prior to the passage of PPACA, in February 2010, California's largest for-profit insurance carrier, Anthem Blue Cross Blue Shield, announced large premium increases for those enrolled in its non-group health insurance coverage, increases as high as 39 percent. In addition, Anthem warned enrollees that the company might begin to increase rates more frequently than annually.<sup>1</sup> Following a public outcry and investigation by the California Department of Insurance, Anthem withdrew the planned

*Due to the complexity of rating practices today, there is no simple answer to the question of how the PPACA will affect premiums in the small group and non-group markets.*

increase.<sup>2</sup> However, the episode heightened concerns that insurers might dramatically increase premiums and attribute them inappropriately to health reform. This brief attempts to identify the ways in which the new law could impact premiums, a first step toward preparing analysts and policymakers for assessing the source of any future changes.

### Changes to Be Implemented in 2010

While the most significant changes to private health insurance markets under PPACA will not occur until January 1, 2014, there are a number of provisions that take effect in 2010. These changes affect both group and non-group plans and include: prohibitions on lifetime benefit limits and unreasonable annual limits, extension of dependent coverage to adult children up to age 26, prohibitions on rescissions, elimination of pre-existing condition exclusions for children, and elimination of waiting periods of more than 90 days.

The impact of these provisions on the premiums of current policy holders is a function of the type of coverage currently held. Federal regulations include estimates of the premium

impacts of these provisions.<sup>3</sup> In addition, we supply some rough estimates of these provisions that were provided confidentially by a private health actuary upon our request. The estimates from both sources are generally consistent, but both acknowledge the difficulty in generating such estimates and the uncertainty around them.

Those policies that did not include lifetime or annual limits prior to reform should see no premium impact of these provisions. For plans with lifetime maximums of \$2 million or higher, removing the limits entirely will tend to increase premiums by less than 1 percent (with the small group impact being smaller than non-group). And according to America's Health Insurance Plans, the vast majority of individual market plans have limits of \$5 million and above,<sup>4</sup> making it highly unlikely that this change will cause a noticeable impact on non-group premiums. Because small group plans tend to be more comprehensive than non-group plans, a measurable impact in that sector of the market is even less likely.

The federal agencies estimate that the provisions related to annual and lifetime limits will increase group premiums by about 1/2 of 1 percent



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and will increase non-group premiums by less than 1 percent.<sup>5</sup> While premiums could increase modestly in such a way, out-of-pocket costs for those using care will fall as a result, potentially leading to very significant savings for those with serious health care needs.

The prohibitions against pre-existing condition exclusion periods for children, including denials of coverage due to such conditions, should have little to no impact in the small group market, which already is required to guarantee issue policies. The federal agencies estimate the effect to be negligible in the group market. Again, the provision will decrease out-of-pocket costs for those who would have had care excluded from reimbursement without the reform.

If the insurer charges a significantly higher premium for the family newly enrolling in coverage with a sick child, then the premium impact will fall on those families specifically and will not affect the premiums of others. This is the most likely scenario, as it is typical of rating practices in most non-group markets today. The federal agencies estimate the average effect of the prohibition on pre-existing condition exclusions for children will be 1 percent or less in the non-group market.

As a percentage of policies sold, the number of rescissions is actually very small. Consequently, the prohibition under PPACA should not have a significant effect on premiums in either market. Some insurers are concerned that the language of the law will increase the number of applicants misrepresenting their health status, which, if true, could have larger effects. The federal agencies estimate the rescission provisions will increase

premiums by no more than a few tenths of 1 percent, while acknowledging that this is the roughest of the estimates provided.

Estimates of the group premium effect of extending coverage for young adults on parents' policies are provided in another of the Obama administration's interim final rules.<sup>6</sup> The effect of this provision can be expected to be small in the group market as well, with estimates ranging from .5 to 1.2 percent of premiums, depending upon the participation assumptions made. With regard to non-group coverage, similar issues arise as detailed for the pre-existing condition exclusion period for children. Carriers are expected to charge the specific families enrolling high-cost young adults in non-group plans significantly higher premiums than similar families with healthier adult children, then there will be little to no impact on the general population of insureds.

## Changes to Be Implemented in 2014

### *Grandfathered Health Plans*

Much of the private insurance regulatory reforms included in the PPACA are intended to broaden risk pooling, or more broadly share health care risk across the healthy and unhealthy, in the affected markets. The broader the population over which the costs of the sick are spread, the smaller the premium effect of covering those with high medical needs. Consequently, keeping the pool of insureds as large as possible through an individual requirement to obtain insurance coverage is a critical component of increasing the accessibility and affordability of insurance coverage for the sick. Policymakers attempted to balance the desire for broad-based risk pooling

with concern over disruptions to current coverage for those already insured and happy with their arrangements. Hence they included grandfathering provisions in PPACA that exempt those maintaining their pre-reform coverage from many of the new stricter premium rating rules that will be implemented in the small group and non-group markets beginning in 2014.

As a result of grandfathering provisions, those retaining small group and non-group policies in which they were enrolled at enactment of PPACA will not be subject to the new limitations on factors used to vary premiums across enrollees/enrollee groups, nor will they be subject to minimum benefit standards.<sup>7</sup> These grandfathered policies cannot, however, be sold to new groups or individuals, and once an individual or small group terminates coverage in a grandfathered plan they cannot re-enroll. As a result, those staying in grandfathered plans should not see significant changes to their premiums as a consequence of reform. They will, however, be subject to the early implementation changes discussed above. Some of those with grandfathered coverage can be expected to choose to enroll in new coverage instead of staying in their current policies, due to lower administrative costs, expanded benefits offered, available subsidies, and/or more advantageous premium rating rules, although doing so would be purely up to the individual or group based upon their self-interest. Because the newer plans may be particularly attractive to those with health problems, especially those with non-group coverage, over time those remaining in grandfathered plans may actually be healthier on average. If this is the case, average premiums in

grandfathered plans will fall with time relative to what they would have been in the absence of reform.

Beginning in 2010, certain low-wage small employer groups, including grandfathered plans, will be eligible for tax credits to partially offset the cost of health insurance coverage. While eligibility is limited, those employers receiving the tax credit could reap substantial savings from it.<sup>8</sup> The subsidy does not actually change the premium, however, it merely shifts the responsibility for paying for part of it from the employer to the federal government.

### *Newly Issued Individual and Small Group Plans*

Beginning January 1, 2014, the factors by which small group and non-group premiums in non-grandfathered plans can vary will be limited. Currently, in most insurance markets, small group premiums vary significantly by health status and claims experience of individuals in the small group, by gender composition, by age composition, and by industry. The variations permitted within each of these factors may have no limit or some limit, depending upon state law. Non-group insurers in the vast majority of markets can vary premiums by these factors as well, and many states permit outright denials of coverage or offering of particular benefit/cost-sharing plans as a function of expected use of services by the applicants. Pre-existing condition exclusion periods are permitted in both markets today in almost all states. These risk classification strategies allow insurers to provide lower premiums to healthier individuals and groups, while effectively excluding those with higher expected health care needs or

charging them significantly more for coverage.

Rating variations in small group and non-group coverage under PPACA will be limited to geographic area, age, and tobacco use. Geographic areas will be determined by the states and reviewed by the Secretary. Under the 3:1 age rating limits, identical coverage for a 64-year-old cannot be set more than three times that of an 18-year-old. A tobacco user can be charged 1.5 times the premium for a non-user for identical coverage. In addition, small employers will be allowed to offer workers in their group plans discounts for participating in wellness programs and hitting designated health benchmarks. These discounts can be set up to as much as 30 percent of the cost of coverage. Ostensibly, these programs would be designed to promote health or prevent disease, but in practice, they are likely to effectively constitute a degree of health status-related rating in the group market. Non-grandfathered small group and non-group coverage will also be required to comply with minimum federal benefit standards, including standards for covered services, maximum deductibles, and out-of-pocket maximums.

Currently, rating rules vary considerably across states, and few impose benefit standards. It is unclear how states with tighter rating rules will respond to the federal minimums described above, but they are most likely to keep their current tighter rules in place. In New York, for example, the small group and non-group markets are highly regulated, subject to pure community rating and guaranteed issues rules, but there is no requirement to obtain coverage. Premiums in the non-group market in New York are extremely high as a consequence, with those choosing to

purchase in it tending to have very substantial health care needs; the healthy usually decline to enroll as a consequence of the high cost. Under PPACA, even if New York maintains its pure community rating rules, premiums for newly issued coverage in the non-group insurance market should be significantly lower than those in the pre-reform or grandfathered market. The savings in this market will result from the federal subsidies and the individual requirement to obtain coverage bringing in large numbers of healthier enrollees. For both some small groups and for the non-group market, premium savings should also result in New York from the lower administrative costs expected to be associated with exchange-based insurance coverage. New York might also decide to merge its small group and non-group markets for rating purposes, further lowering premiums in the non-group market, but potentially increasing small group premiums modestly relative to the no-merge case.<sup>9</sup>

Massachusetts is the only example of a state that has already implemented comprehensive health care reform of the general type of the PPACA. Overall, very little change in premiums should be expected in either the small group or non-group markets in Massachusetts, where age rating is already limited to a tighter 2:1 band, guaranteed issue is already in place in both markets, and an individual requirement to have coverage has already been implemented for adults. A number of differences between PPACA and Massachusetts law could have specific implications for that state.<sup>10</sup> However, with 97.3 percent of the state population insured as of 2009<sup>11</sup> and a large portion of the population covered under the grandfather provisions, little to no

change in the risk pools of insured individuals should be expected.<sup>12</sup>

Most other states permit substantially broader variations in premium rating, do not have guaranteed issue in their non-group markets, permit pre-existing condition exclusion periods, and have no or very limited benefit standards. For these states, newly issued policies subject to federal standards will create more sharing of health care risk than is found in current insurance policies offered there. More high-need individuals and small groups will have affordable access to health insurance coverage than has been the case in the past. Those states with high-risk pools may very well abolish them, as enrollees in those pools will now have access to standard non-group insurance coverage, and more may have access to employer coverage as well. The presence of higher-need individuals in these markets will tend to place upward pressure on average premiums, but this upward pressure will be offset at least in part by increased enrollment of the healthy resulting from both the provision of federal subsidies for the purchase of coverage and the individual coverage requirement. Significant premium savings will result for those with health problems or those in employer groups with others affected by health problems compared to options available to them today. Minimum benefit standards will tend to increase premiums relative to the situation without them, yet will result in lower out-of-pocket costs, particularly for those with significant health care needs.

Removal of gender-based rating will tend to benefit young women at the expense of young men, and to benefit older men at the expense of older women. Young adults newly

purchasing coverage will tend to face somewhat higher premiums than those available to them in today's markets in general. However, those currently reaping the advantages of youth and health under existing insurance arrangements can choose to keep their grandfathered coverage. Importantly, because they tend to be modest income and thus eligible for financial assistance in purchasing coverage, even the young adults who enroll in newly issued non-group insurance coverage through the exchanges are likely to be protected in great degree from the full effects of the 3:1 age rating bands and prohibitions against health status rating.<sup>13</sup> In addition, a lower cost catastrophic coverage option will be made available to young adults under age 30.

Administrative costs of insurance should be lower in the small group and non-group markets due to centralized marketing functions performed by the exchanges, reduced churning among small groups in particular, and elimination of insurance underwriting activities.<sup>14</sup> These efficiencies will tend to lower premiums relative to the non-reform case. In addition, a number of initiatives to promote transparency in insurance practices and to increase competition in insurance markets should place some downward pressure on premiums, at least over time. Examples include:

- requiring all non-grandfathered plans issued in the small group and non-group market to fit into one of the designated benefit tiers (platinum, gold, silver, bronze) and comply with the minimum benefit standards, making comparison shopping based on price more feasible for consumers;

- providing consumer-friendly materials comparing plan characteristics and price through the health insurance exchanges;
- reporting of detailed components of insurance plan administrative costs, so that consumers can discriminate between efficient and less efficient plans;
- reporting of consumer grievances, late payment experience, etc., so that consumers can identify plans that have lower costs due to efficient practices versus those that have lower costs due to inferior service;
- premium negotiation through the health insurance exchanges and ability of exchanges to exclude carriers based on large premium increases;
- premium monitoring at both the state and federal levels for plans offered inside or outside of the exchange; and
- risk adjustment within the exchange and non-exchange plans in the small group and non-group markets, allowing for plans to set prices based upon service provision and efficiency as opposed to the relative risk of its enrollee population.

Finally, the effectiveness of various strategies intended to contain health care spending under the PPACA has tremendous implications for the future growth path of insurance premiums in all markets. The substantial consolidation in both insurance markets and provider markets has fueled the growth in medical costs, and thus premiums, in recent years.<sup>15</sup> If the strategies delineated above and those included in new pilot programs<sup>16</sup> induce insurers to

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negotiate with providers more aggressively over payment rates, then the new law will have the ability to significantly slow health insurance premium growth. If insurers are not able to effectively negotiate with providers because of a lack of leverage, costs and premiums could continue to increase significantly for reasons not related to PPACA.

## Summary

There is no simple answer to the question of how premiums in the non-group and small group market will be affected by the PPACA. The variability of current rating practices

in these markets across states, the current ways in which individuals and small groups of different characteristics are advantaged and disadvantaged, as well as PPACA's grandfathering provisions mean that different consumers will be affected differently. However, it is fair to say that the provisions implemented in 2010 will have very little effect, in general. Reforms implemented in 2014 will tend to have larger effects in most states, as risk is spread more broadly than is done in these markets today. However, the grandfathering provisions and subsidies will play significant roles in dampening

potential redistribution. In addition, reforms designed to promote competition and contain costs will tend to lower premiums over time, relative to the no reform case.

## Notes

<sup>1</sup> Duke Helfand. 2010. "Anthem Blue Cross Dramatically Raising Rates for Californians with Individual Health Policies." *Los Angeles Times*. February 04.

<sup>2</sup> Ina Jaffe. 2010. "Anthem Blue Cross Withdraws Planned Rate Increase." *National Public Radio*. April 29.

<sup>3</sup> Department of Treasury, Department of Labor, Department of Health and Human Services. "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections." *Federal Register*, June 28, 2010. Available at: <http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=3MeDy2/0/2/0&WAISaction=retrieve>.

<sup>4</sup> AHIP. 2009. "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits." Available at: <http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>.

<sup>5</sup> The annual limit policy does not apply to grandfathered non-group policies.

<sup>6</sup> Department of the Treasury, Department of Labor, Department of Health and Human Services. 2010. "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act." Available at: [http://www.hhs.gov/ociio/regulations/pract\\_omnibus\\_final.pdf](http://www.hhs.gov/ociio/regulations/pract_omnibus_final.pdf).

<sup>7</sup> The same applies to new employees or previously unenrolled employees or dependents in firms offering grandfathered plans.

<sup>8</sup> Eligible employers must have no more than 25 full-time employees with average annual compensation not to exceed \$50,000. The credit may cover as much as 35 percent of the employer paid premiums prior to 2014, but is reduced for each full-time employee above 10 and for average compensation in excess of \$25,000. After 2014 the credit is only available for employers participating in a health insurance exchange and for a maximum of two years, but the maximum credit increases to 50 percent of the employer premiums.

<sup>9</sup> Linda J. Blumberg, A. Bowen Garrett, Matthew Buettgens, Lisa Clemans-Cope, John Holahan, Aaron Lucas, Paul Masi and Baoping Shang. 2009. "Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options." Final Report to the New York State Department of Health and the New York State Department of Insurance. Available at: [http://www.urban.org/UploadedPDF/411925\\_ny\\_health\\_insurance.pdf](http://www.urban.org/UploadedPDF/411925_ny_health_insurance.pdf).

<sup>10</sup> For example, if minimum federal benefit standards are higher than the current Massachusetts requirements, this could put some upward pressure on premiums, but federal guidance is still forthcoming.

<sup>11</sup> Sharon Long and Lokendra Phadera. 2009. "Estimates of Health Insurance Coverage in Massachusetts from the 2009 Massachusetts Health Insurance Survey." Report to the Massachusetts Division of Health Care Finance and Policy. Available at: [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his\\_policy\\_brief\\_estimates\\_oct-2009.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_policy_brief_estimates_oct-2009.pdf).

<sup>12</sup> One clear change from current Massachusetts law, however, is that small groups are defined as having 50 or fewer employees, as opposed to the PPACA's definition of 100 or fewer workers. Such a definition using 50 employees is very common across the country. As a consequence of this change, newly issued policies will merge together slightly larger employers with smaller ones (and in Massachusetts, those in the non-group market, since small group and non-group markets are already merged there) for premium rating purposes. It is unclear whether the smaller groups offering coverage to their workers differ significantly in average health care costs from the workers in the 51 to 100 size group, making it difficult to predict any premium effect of such a change.

<sup>13</sup> Linda J. Blumberg, Matthew Buettgens, and Bowen Garrett. 2009. "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens." *Timely Analysis of Immediate Health Policy Issues*. Available at: [http://www.urban.org/UploadedPDF/411970\\_age\\_rating.pdf](http://www.urban.org/UploadedPDF/411970_age_rating.pdf).

<sup>14</sup> Linda J. Blumberg and Karen Pollitz. 2009. "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals." *Timely Analysis of Immediate Health Policy Issues*. Available at: [http://www.urban.org/UploadedPDF/411875\\_health\\_insurance\\_marketplaces.pdf](http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf).

<sup>15</sup> John Holahan and Linda Blumberg. 2008. "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" *Urban Institute Health Policy Center Brief*. Available at: [http://www.urban.org/UploadedPDF/411762\\_public\\_insurance.pdf](http://www.urban.org/UploadedPDF/411762_public_insurance.pdf).

<sup>16</sup> See Stephen Zuckerman. 2010. "What Are the Provisions in the New Law for Containing Costs and How Effective Will They Be?" *Urban Institute Policy Brief*, forthcoming.

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