

Research Findings: Independent Studies Estimate the Cost and Coverage Impact of the Affordable Care Act in Selected States

INTRODUCTION

As the federal government and the states move forward with implementation of the Affordable Care Act (ACA), policymakers must turn their attention toward how to achieve the one of the law's central goals—bringing those who have been uninsured into the system—in a way that promotes affordability and does not disrupt the coverage people have today.

There is widespread agreement that rising health care costs represent one of the most significant challenges facing the nation. Health care spending in the U.S. is expected to reach \$2.8 trillion annually—representing 18% of GDP.

This unsustainable rise in health care spending creates major affordability problems for businesses and families and is a major contributor to the nation's long-term fiscal challenges. Rising health care spending also crowds out other critically important federal and state investments—such as education, infrastructure, and research and development—and hurt our economic competitiveness in the global economy.

Clearly, more must be done to ensure a more sustainable and affordable health care system that provides incentives for safe, high-quality care for all Americans. To that end, many state departments of insurance and state exchange boards have begun requesting formal actuarial and economic forecasts of the impact of the ACA insurance reforms on their states.

These independent studies have found that some provisions, such as the essential health benefit (EHB) and actuarial value requirements, age band compression, and the health insurance premium tax, will result in higher premiums.

Other provisions, such as premium subsidies for certain individuals, cost-sharing subsidies, and the transitional reinsurance program are projected to hold costs down. Ultimately, the way these provisions interact will play a

crucial role in determining whether or not individuals have affordable coverage options when the ACA's market reforms take effect in 2014.

America's Health Insurance Plans has compiled the independent state studies to date and summarized their major findings in the following compendium. The major findings from the non-partisan, independent state studies include—

- ▶ **Major reductions are expected in the number of uninsured individuals and families in the respective states.**
- ▶ **Substantial premium increases will occur—particularly in states' individual health insurance markets—compared to the pre-reform market.** These increases are largely the result of the impact of: insurance market reforms (including tighter age-band compression), essential health benefit and related requirements that require families to “buy-up” coverage to meet the new standards; changes in the composition of the risk-pool; and other factors.
- ▶ **While premium subsidies help, they are not sufficient to ensure an affordable and stable insurance marketplace.** For example, studies for Maine and Wisconsin found that even after the application of premium subsidies, the majority of people in the individual market in these respective states would experience premium increases.
- ▶ **Premium changes will vary widely by person and by family—with the largest premium increases projected for younger individuals purchasing coverage on their own (due to changes in rating factors, such as tighter age-bands, and other factors).**

It is important to note that the independent studies were conducted prior to the release of long-awaited proposed regulations implementing key elements of the health reform law—including requirements related to essential health benefits, actuarial value and the insurance market reforms. The draft regulations—which provide additional details on the benefits required to be covered as well as patient cost-sharing requirements within the new exchange marketplaces in 2014—seek to balance the requirements of the statute while providing flexibility to minimize disruptions for businesses and consumers.

In addition, while the independent state studies are largely comprehensive, some of the studies do not factor in all of the provisions and elements of the health reform law that will likely affect private insurance premiums. For example, some of the state-commissioned studies do not factor in the projected impact of the risk-adjustment, reinsurance, and risk corridor (3Rs) programs under the ACA—which are intended to reduce adverse selection and promote market stability as the new insurance reforms are implemented in 2014. For example, the study conducted for the State of Wisconsin, noted that “our results do not account for any further reduction in premiums from state risk-adjustment/reinsurance.” The Administration has estimated that the

reinsurance program “will result in premium decreases in the individual market of between 10 and 15 percent” in 2014—thereby offsetting some of the expected rise in premiums as a result of other ACA-related provisions. At the same time, some of the studies do not incorporate the premium impact of new taxes and fees—including the new ACA health insurance premium tax—or certain elements of the insurance market reforms—such as the ban on pre-existing conditions into their premium projections. By not accounting for these factors, some of the state-commissioned studies may be understating the potential premium impact of the changes required under the ACA in their respective markets.

A critical component to achieving the goal of affordability is understanding the relationship between the new market reforms that will lead to higher premiums and new subsidies that will lower them. If a large increase in premiums encourages young, healthy individuals to forgo or drop coverage and instead pay a penalty, insurance markets will become unstable and unaffordable. These state studies can help policy makers understand the tradeoffs necessary and consider options and alternatives to ensure affordable coverage for all Americans.

INDEPENDENT ESTIMATES OF THE IMPACT OF ACA PROVISIONS BY STATE

State	Projected Average Increase in Non-Group Premiums due to the ACA (prior to the application of premium subsidies)	Projected Average Increase in Non-Group Premiums due to EHB Requirements (prior to the application of premium subsidies)	Percentage of Population Eligible for Subsidies*	Reduction in the Uninsured*
Alaska	30%-80%	3.2%	–	70% (96,000 newly covered)
Colorado	19%	2.2%	–	480,000 newly covered
Connecticut	43%	13%	–	227,000 newly covered
Indiana	75%-95%	20%-30%	–	–
Maine	40%	33%	54%	69,000 newly covered
Maryland	34%-36%	8%-10%	–	–
Minnesota	26%-42%	8%-11%	–	300,000 newly covered
Nevada	11%-30%	3%	–	–
Ohio	55%-85%	20%-30%	–	600,000 – 1 million newly covered
Oregon	27%-55%	6%-10%	50% of current individual market, 75% of currently uninsured	–
Rhode Island	2%-16%	0.13%	–	–
Wisconsin	30%	6%-7%	57%	340,000 newly covered

* Not all studies reported the percentage of those eligible for subsidies or the reduction in the uninsured



ALASKA: DESIGN OPTIONS FOR A HEALTH INSURANCE EXCHANGE—ACTUARIAL ANALYSIS

David M. Dillon, FSA, MAAA and Brian C. Stentz, ASA, MAAA (Lewis and Ellis, Inc. – Actuaries & Consultants), June 2012. Prepared for the Alaska Department of Health and Social Services, Division of Health Care Services

<http://hss.state.ak.us/pdf/ActuarialReport.pdf>

SCOPE: Provides the background research and data analysis necessary to design, develop, and sustain a health insurance exchange in Alaska; Assesses the impact of ACA provisions on Alaska’s insurance market.¹

STUDY DESIGN: Data from the Census Bureau, American Community Survey, Current Population Survey, the Kaiser Family Foundation, Medical Expenditure Panel Survey, and Urban Institute reports were used to establish a baseline model of Alaska’s current insurance marketplace. Actuarial modeling was used to make projections about the changes caused by various ACA provisions.

FINDINGS:

The ACA will reduce the uninsured population in Alaska by 70% (96,000 newly covered individuals).

About one-quarter of the currently uninsured population will enroll in Medicaid or CHIP, while almost 39% will purchase coverage inside the exchange. Approximately 50% of the current uninsured market will qualify for a subsidy to purchase coverage in the exchange.

Non-subsidized premiums in the individual market are estimated to increase by 30%-80%. “Providing coverage for the currently uninsured population, which on average is approximately 36% less healthy than the current insured, is driving the majority of this increase.”

While the average increase in premiums due to the Essential Health Benefits (EHB) requirements is 3.2% for the entire market, 12% of the market could see EHB “buy up” leading to a 26% premium increase.

This segment of the market currently purchases coverage that does not meet the ACA’s minimum actuarial value requirement.

Rates in the small group market are projected to change only slightly, with only an average increase of 1.1%.

But due to enhanced benefits to meet the minimum actuarial value requirement, a small portion of the small group market that purchases coverage today with a low AV may see increases of more than 21%.

The effect of age rating compression in the small group market will depend largely on the composition of the firm. The study found that “...some small employers with a young average age would see a change in premium greater than 9 percent based solely on their average age, and some employers with older average ages [would] see their premiums reduced by more than 29 percent.”

¹ Does not examine the impact of the ACA’s Medical Loss requirements or the impact of the 3Rs (risk adjustment, risk corridors, and the transitional reinsurance program).



COLORADO: HEALTH BENEFIT BACKGROUND RESEARCH

Jonathan Gruber, Ph.D. (MIT Department of Economics), January 2012.

SCOPE: Produced in response to an RFP from the Colorado Health Insurance Exchange, the report attempts to provide policy makers with firm understanding of the existing health insurance market in Colorado and to create a dynamic model of how individuals will respond to the implementation of the ACA.

STUDY DESIGN: Micro-simulation model based on nationally representative data from the Current Population Survey (CPS) and the Colorado Household Survey (COHS).¹

FINDINGS:

The ACA reduces the uninsured population in Colorado by 55%, covering an additional 480,000 individuals. A quarter of the newly insured will be covered by public programs, while almost one third will gain coverage through their employer. Thirty-eight percent of the previously uninsured will purchase coverage through the exchange with the assistance of a tax credit.

After the distribution of tax credits and subsidies, 13 percent of the individual market will face premiums that could be as much as 25 percent higher on average. This translates to over 400,000 households that will be worse off under the ACA's reforms. However, those that will be better off outnumber those that will be worse off by 3 to 1.

Almost 40% of the individuals currently in the individual market have policies that do not meet the 60% minimum AV requirement. On average, this will raise premiums in the individual market by 5.3%.

Folding the state's existing high risk pool into the exchange will further increase premiums. "[The model] estimates that high risk pool participants are estimated to have about 2.4 times the claims risk of the currently enrolled individual market population. Incorporating these individuals into the exchange raise ultimate exchange premiums by 5.5%."

¹ Does not incorporate the effects of the ban on pre-existing conditions exclusions nor the temporary reinsurance program.



CONNECTICUT: HEALTH INSURANCE EXCHANGE PLANNING REPORT

Kevin Lurito, FSA, MAAA, et al. (Mercer Government Human Services Consulting), January 19, 2012. *Prepared for the State of Connecticut Office of Policy and Management*

http://www.healthreform.ct.gov/ohri/lib/ohri/Mercer_report_on_CT_Exchange.pdf

SCOPE: Provide projections and guidance related to the planning, research and data analytics that will help to establish the policy direction and implementation strategy for the state's health insurance exchange.

STUDY DESIGN: Actuarial projections based on the Oliver Wyman Healthcare Reform Micro-simulation Model (HRM Model) and relied on information from the U.S. Census Bureau, the Medical Expenditure Panel Survey (MEPS), Dun & Bradstreet, annual statutory and financial statements of insurers issuing policies in the state and other sources.

FINDINGS:

The number of uninsured would decline significantly as a result of the ACA's coverage expansions. The report estimates that the "uninsured population in 2014 is projected to be roughly 40% of the 2010 level, decreasing to roughly 149,000 individuals" which represents a 4% uninsured rate. The report notes that the "uninsured rate in Massachusetts is 1.9% in 2010, but that Massachusetts' reforms included more generous subsidies and stronger individual and employer mandate penalties."

Average premiums are projected to increase significantly in the individual market in 2014. "Average premiums on a per capita basis in the individual market prior to the application of premium subsidies are **projected to increase by 43% from 2010 to 2014, from \$3,350 to \$4,800.** In addition to increases in medical trend, additional covered benefits as a result of the EHB package and new taxes and assessments, this change reflects changes in demographics, benefit plan changes and changes in the average morbidity of those enrolled."

Small-group market premiums are projected to increase moderately. "Average premiums on a per capita basis in the small-group market are projected to increase by 11% from \$5,000 in 2010 to \$5,550 in 2014. Increases due to medical trend, required increases in benefits covered, and new taxes and assessments combine to increase premiums by 29%. Changes in demographics, the average morbidity of those enrolled and benefit buy-downs made by employers lead to a decrease in premiums of roughly 14%. The result is an overall change of 11%."

Essential health benefit requirements increase non-group premiums by 13%. "Required increases due to the EHB package (i.e., primarily the required increase to an actuarial value of at least 0.60) account for roughly 30% of the increase in premiums, or 13%."



INDIANA: INDIVIDUAL AND SMALL GROUP PREMIUM CHANGES UNDER THE ACA

Jill S. Herbold, FSA, MAAA, and Paul R. Houchens, FSA, MAAA (Milliman, Inc.), May, 2011. *Prepared for the Indiana Health Care Exchange Policy Committee*

http://www.in.gov/aca/files/Individual_SmallPremium_Increases.pdf

SCOPE: To estimate the premium changes in the individual and small group markets due to provisions of the ACA.

STUDY DESIGN: Actuarial projections using statements of life and health insurance companies and HMOs operating in Indiana, other public sources, and information provided by the State Health Access Data Assistance Center to the Indiana Family and Social Services Administration.¹

FINDINGS:

Non-subsidized premiums in the individual market will increase by as much as 95% in 2014. The report estimates that the majority of this increase will be caused by two factors:

- merging Indiana’s current high-risk pool with the individual market, **which will cause premium increases between 35% and 45%**, and;
- the Essential Health Benefits requirement, **increasing premiums by an additional 20% to 30%**.

When combining the high risk pool population and the current individual commercially insured population, the current high-risk pool represents just 5% of covered lives, but accounts for approximately 30% of all medical costs. “The medical benefit costs for [high-risk pool] enrollees during calendar year 2010 were approximately 11 times higher than the commercially insured individual market.” Incorporating this population into the individual market accounts for the single greatest increase in 2014 premiums.

It is expected that the transitional reinsurance program established by the ACA will have a downward impact on premiums, but the report could not take this into consideration since regulations establishing the program had not been issued by HHS by the study’s publication date.

Changes that the ACA makes to the small group market, including risk pool composition changes, employers dropping coverage, and the inclusion of employers with up to 100 employees **are expected to increase premiums by 5%-10%**. The premium increase in the small group market is less pronounced than the individual market because small group plans in Indiana are more likely to already cover the Essential Health Benefits.

¹ Does not model the impact of the transitional reinsurance program



MAINE: THE IMPACT OF THE ACA ON MAINE'S HEALTH INSURANCE MARKETS

Jennifer Smagula, FSA, MAAA (Gorman Actuarial, LLC) and Jonathan Gruber, Ph.D. (MIT Department of Economics), May 31, 2011. *Prepared for the Maine Bureau of Insurance.*

http://www.maine.gov/pfr/insurance/reports/pdf/Impact_ACA.pdf

SCOPE: To assess the impact of the ACA on Maine's insurance markets.

STUDY DESIGN: Micro-simulation model based on nationally representative data from the Current Population Survey (CPS) and state administrative data.¹

FINDINGS:

The ACA's reforms will provide coverage to an additional 69,000 individuals. Half of the currently uninsured will receive subsidies to purchase coverage through the exchange while just under a quarter will receive coverage through public programs.

The ACA's Essential Health Benefits and related requirements will cause benefit "buy-up" in the marketplace—raising concerns about affordability.

The report finds that the law's new benefit requirements "will require a majority of the market to 'buy-up' and therefore will result in premium increases." Premiums in the individual market are estimated to increase by 33% due to the ACA's new benefit requirements, prior to the application of premium subsidies.

Even after tax subsidies are distributed, **57% of the individual market will experience premium increases as compared to pre-reform premiums.** The report estimated that the average premium increase would be 37%.

Forty-six percent of all policy holders in the reformed individual market will not be eligible for subsidies, and will experience the full amount of the premium increases caused by the ACA. Among the 54% of the individual market who will receive subsidies, one-fifth will still face higher premiums than they would have absent the law's reforms.

Eighty-nine percent of the small group market in Maine will experience an average premium increase of 12% in 2014. "These premium changes are primarily due to the elimination of a carrier's ability to use group size adjustments and the impact of the introduction of the exchange as there will be some selection as a small number of employers drop coverage."

¹ Projections do not reflect the impact of risk adjustment, risk corridors, or the transitional reinsurance program (3Rs), nor the impact of medical trend.



MARYLAND: POTENTIAL IMPACT OF THE AFFORDABLE CARE ACT ON THE CURRENT INDIVIDUAL AND SMALL GROUP MARKETS

Karen Bender, FCA, ASA, MAAA, Kelly Backes, FSA, MAAA, and John Welch (Oliver Wyman Actuarial Consulting, Inc.), June 16, 2011. *Prepared for the Maryland Health Care Commission*

http://mhcc.dhmd.maryland.gov/smallgroup/Documents/affordable_care_20110711.pdf

SCOPE: Assess the potential impact of the ACA on Maryland's current individual and small group markets.

STUDY DESIGN: Actuarial projections based on CareFirst premiums from ehealthinsurance.com and other publically available data sources.¹

FINDINGS:

Average non-group premiums are projected to increase by about 35% before the application of premium subsidies. The report's findings "demonstrate the upward pressure on premiums in the current market" and finds that "in order for gross premiums (i.e., premiums before premium subsidies) to remain stable, there would need to be a substantial increase in lower-cost members entering the individual pool."

Including maternity services and the minimum actuarial value requirements in Maryland's individual market would increase premiums by 8%-10%. The report only examined the inclusion of maternity services and increased AV standards because, at the time, Essential Health Benefit guidance had not been released. Maryland's selection of a "benchmark" Essential Health Benefits plan will determine if the "many Maryland-specific state-mandated benefits" are included in the minimum coverage requirements in 2014 and if there is additional premium increases due to those mandated benefits.

Combining Maryland's two existing high-risk pools and incorporating that population into the individual market will increase premiums by 26%. As of the date of publication, Maryland's high-risk pool was operating at a loss ratio of 242.5%. "This demonstrates the critical need to enroll many new, healthy members into the individual market in order to avoid a significant increase in premiums resulting from the merging of the high-risk pools with the existing medically underwritten individual market."

The small group market will see an average premium increase of 2%, mostly due to the higher AV requirements. The small group market in Maryland already mirrors many of the ACA's requirements with respect to Essential Health Benefits and is expected to have a relatively stable risk pool compared to the current market.

¹ Does not incorporate (1) the influx of newly insured members into the various markets (particularly the individual market), (2) the incentives associated with available premiums subsidies, or (3) the impact of reinsurance and risk adjusters.



MINNESOTA: COVERAGE AND FINANCIAL IMPACTS OF INSURANCE MARKET REFORMS

Bela Gorman (Gorman Actuarial, LLC) and **Jonathan Gruber, Ph.D.** (MIT Department of Economics), November 17, 2011. *Prepared for the Minnesota Department of Commerce.*

SCOPE: Examines the impact of the ACA – including its rating, premium, and economic effects – on Minnesota’s health insurance marketplace.

STUDY DESIGN: Combined economic modeling and actuarial modeling to provide a comprehensive analysis of population movements and costs resulting from ACA provisions.

FINDINGS:

After the ACA’s market reforms are implemented, almost 300,000 new Minnesotans will have health insurance coverage. Twenty-seven percent of the newly insured will gain coverage through their employers, 28% will be covered by public programs, and the remaining 45% will purchase coverage in the reformed individual market. Of the newly insured purchasing coverage in the individual market, 82% will be eligible for subsidies.

Average individual market premiums in Minnesota will increase by an estimated 29% due to new requirements in the ACA. In 2016, average individual market premiums—prior to the application of premium subsidies—are estimated to be about 29% higher due to a range of factors, including minimum essential health benefit requirements, the impact of merging the state’s high-risk pool (MCHA) into the exchange market, and changes in the risk pool composition. The report also finds that there will be a “managed competition effect”—created by enhanced competition through new exchange marketplace—that will have a dampening effect on expected premium increases, reducing expected premium increases by 7.5%.

Twenty-two percent of the current individual market is below 0.5 Actuarial Value (AV), while another 22% is between 0.5 and 0.6. Individuals who currently receive their coverage in these plans will see non-subsidized premium increases due to the “buy up” necessary to reach the ACA’s 0.6 minimum AV requirement.

Incorporating Minnesota’s current high-risk pool into the individual market will cause premiums to increase by 10% to 15%.

Twenty percent of the current small group market will see their premiums increase by more than 20%. The average increase will be about \$252 (per member, per month).



NEVADA: HEALTH INSURANCE MARKET STUDY

Bela Gorman, FSA, MAAA, Don Gorman and Jenn Smagula, FSA, MAAA (Gorman Actuarial, LLC), March 2012.
Prepared for the State of Nevada

<http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Reports/Nevada%20Health%20Insurance%20Market%20StudyGormanActuarialLLC.pdf>

SCOPE: Provides an analysis of the Affordable Care Act and an assessment of the impact of the ACA on the Nevada insured markets; examines the change in the number of Nevadans with coverage and the potential for premium volatility.¹

STUDY DESIGN: Data from the Current Population Survey, the Kaiser Family Foundation State Health Facts, and a health insurance carrier survey – seven carriers in the Individual Market, eight carriers in the Small Group Market and seven carriers in the Large Group (51-100) market – were used to establish a baseline model of Nevada’s current insurance marketplace. Actuarial modeling was used to make projections about the changes caused by various ACA provisions.

FINDINGS:

Nevada has more than half a million people uninsured and more than half of these people will be eligible for subsidies under ACA. Of the 557,000 Nevadans that are uninsured, 279,000 will be eligible for subsidies in the exchange, but 50,000 of those are expected to take up insurance through their employers. Approximately 36% of the currently uninsured population will be eligible for Medicaid, should the state approve an expansion.

Non-subsidized premiums in the Individual Market are estimated to increase by 11%-30%. A major component of this estimated increase is the change in the risk pool. “Due to the changing composition of the Individual Market risk pool in CY 2016, premiums could increase an additional 8% to 26% with a best estimate of 16%.” Forty-two percent of the current individual market will not be eligible for premium tax subsidies due to their income.

While the average increase in premiums due to the Essential Health Benefits (EHB) requirements is 3% for the entire Individual Market, 10% of the market could see EHB “buy up” leading to a 30% premium increase. This segment of the market currently purchases coverage that does not meet the ACA’s minimum actuarial value requirement.

Rates in the Small Group Market are projected to change significantly as current rating variables are eliminated or limited. “62% of the [small group market] is expected to experience an average 14% increase in their premium as a result of [the elimination of health underwriting], while 38% of the market is expected to experience an average 17% decrease in their premium as a result of this change.” Small group premiums may increase approximately 0.5% on average due to the essential benefits and actuarial value requirements; however, 10% of the market may experience an average premium increase of 7% due to the minimum actuarial value requirement.

¹ Does not examine the impact of the reinsurance program or the tax on health insurers.



OHIO: ASSIST WITH THE FIRST YEAR OF PLANNING FOR DESIGN AND IMPLEMENTATION OF A FEDERALLY MANDATED AMERICAN HEALTH BENEFIT EXCHANGE

Jeremy D. Palmer, FSA, MAAA, Jill S. Herbold, FSA, MAAA, and Paul R. Houchens, FSA, MAAA (Milliman, Inc.), August 31, 2011. *Prepared for the Ohio Department of Insurance*

<http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf>

SCOPE: A comprehensive assessment of the current state of insurance markets in Ohio and the expected impact of the ACA's market reforms.

STUDY DESIGN: Actuarial projections and economic modeling based on data from the 2010 Ohio Family Health Survey (OFHS), the 2010 Ohio insurance carrier survey, and various other data sources.¹

FINDINGS:

The ACA will reduce the uninsured population by as much as ten percentage points, providing coverage for an additional 600,000 to 1 million Ohioans. Almost half of new Medicaid enrollees are expected to come from the currently uninsured population. Those who remain uninsured after the market reforms take effect are projected to be those who elect to forego coverage or those whose employer terminates coverage in 2014.

After the market has stabilized in 2017, only one-third of the individual market will consist of individuals who are in the market today. Those who are uninsured today will comprise almost 40% of the individual market.

Individuals in the individual market will face unsubsidized premiums that are 55%-85% higher than they would be absent the ACA. "This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits." Additionally, for any given level of benefit coverage and age group, premiums in the reformed individual market are projected to be 8%-12% higher than comparable coverage in the reformed small group market.

While the impact on small group coverage is not as severe, the small group market in Ohio is projected to see premium increases ranging from 5%-15%. "This is attributable to minimum expansion of covered benefits and a more static insured risk pool. However, the [small group market] at the employer level will be impacted significantly by the introduction of Adjusted Community Rating, which may increase the level of adverse selection within the market and contribute to market premium increases."

¹ Does not examine the impact of the transitional reinsurance program.



OREGON: IMPACT OF THE AFFORDABLE CARE ACT ON SMALL GROUP AND INDIVIDUAL MARKET PREMIUMS

Wakely Consulting Group, July 31, 2012. *Prepared for the State of Oregon*

<http://www.cbs.state.or.us/external/ins/consumer/federal-health-reform/wakely-actuarialanalysis-20120731.pdf>

SCOPE: To examine the impact of each of the ACA's provisions on Oregon's individual, small group, and high risk health insurance markets.

STUDY DESIGN: Actuarial projections using data from the eight largest insurers in the state, including demographic information, plan design summaries, premiums, claims, and commissions. The Oregon Department of Consumer and Business Services, Insurance Division, provided publically available rate filing data and survey information.¹

FINDINGS:

Unsubsidized premiums in the individual market will be 27%-55% higher in 2014. "This increase is comprised of 2% to 30% due to ACA requirements and another 20% to 24% due to the addition of portability, high risk pool, and Healthy KidsConnect members into the individual market."

Almost 50% of those who purchase coverage in the individual market today will be eligible for subsidies in 2014. Seventy-five percent of the currently uninsured who will ultimately purchase coverage through the exchange will be eligible for subsidies and lower cost-sharing.

The essential health benefits and actuarial value requirements are projected to increase premiums in the individual market by 6% to 10%. "Plans that currently do not have prescription drug coverage are usually plans with high cost sharing and the least covered benefits, and the combined impact of adding all essential benefits increases these plans' premiums by as much as 20%."

Age band compression will increase premiums for 58% of the individual market, while lowering premiums for older enrollees. "The largest premium increase due to age slope changes is an 81% increase while the largest decrease is 25%."

Oregon's reinsurance program will not fully offset the premium increase associated with risk composition changes in the individual market. Incorporating previously uninsured individuals into the individual market is projected to **increase premiums by 15% each year over the 2014-2016 period.** The reinsurance program is only expected to reduce premiums by 8% in 2014, 4% in 2015, and only 2% in 2016.

Premiums in the small group market are projected to increase by approximately 3%. Individual firm behavior and current group risk composition could produce premium increase as much as 14% for some and decreases as large as 5% for others.

¹The impact of the risk corridor program was not included.



RHODE ISLAND: IMPACT OF THE ACA ON SMALL GROUP AND NON-GROUP MARKET PREMIUMS

Wakely Consulting Group, December 13, 2011. *Prepared for the State of Rhode Island*

http://www.naic.org/documents/committees_b_hcra_wg_120503_Wakely_RI_12-13-11.pdf

SCOPE: Requested by the state of Rhode Island Office of the Health Insurance Commissioner (OHIC), the report provides policy makers with detailed analysis to be used to support planning activities related to the creation of an exchange in Rhode Island.

STUDY DESIGN: Actuarial analysis using data from the three insurers that comprise the entire individual and small group market in Rhode Island, publically available rate filings, and information provided by OHIC.

FINDINGS:

Non-subsidized premiums are projected to increase by 8% on average. But the report notes that “this change is not uniform over all individuals, as some enrollees could see their premiums drop in half while others could see them increase by as much as 71%.”

Driving the majority of the premium increase in individual market is the influx of newly-insured individuals. These changes to risk pool composition are estimated to increase premiums by 5%.

Age rating compression will cause premiums to increase by 20%-29% for almost a third of the individual market, while 9% will see decreases of 41%-50%.

“Due to the currently existing rules and regulations in place in Rhode Island’s individual market, many of the aspects of ACA reforms that are expected to result in significant changes in other states are not impactful for Rhode Island.”

All three insurers in Rhode Island’s individual market include the statutorily mandated essential health benefits package, with the exception of pediatric vision services. “The overall impact of adding this essential benefit to the current benefit plans is 0.13%.”

No plan in the individual market falls below the ACA’s minimum actuarial value of 0.6. Over 40% of plans have AVs greater than 0.8.



THE IMPACT OF THE ACA ON WISCONSIN'S HEALTH INSURANCE MARKET

Jennifer Smagula, FSA, MAAA (Gorman Actuarial, LLC) and Jonathan Gruber, Ph.D. (MIT Department of Economics), July 18, 2011. *Prepared for the Wisconsin Department of Health Services*

<http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf>

SCOPE: Examines the impact of the Affordable Care Act—including its rating, premium, and economic effects—on Wisconsin's health insurance marketplace.

STUDY DESIGN: Micro-simulation model based on nationally representative data from the Current Population Survey (CPS).¹

FINDINGS:

The ACA will significantly reduce the number of uninsured residents in Wisconsin. The report finds that the number of the uninsured will fall by 340,000, or 65%, largely due to the individual mandate, tax credit subsidies, and Medicaid expansion. According to the report, “coverage for the previously uninsured is spread fairly evenly across ESI [employer-sponsored insurance], public insurance, and the exchange.”

The individual market will experience significant premium increases as compared to pre-reform premiums. “Prior to the application of tax subsidies 87% of the individual market will experience an average premium increase of 41%. The average increase for the entire individual market will be about 30%.”

Premium subsidies offset some of the increased cost of individual market coverage—but a majority of the individual market will nonetheless experience premium increases even after accounting for premium subsidies. The report estimates that “57% of the individual market (91,000 members) will be eligible for tax subsidies within the exchange.” However, **after the application of premium subsidies, “59% of the individual market will experience an average premium increase of 31%.** This is mostly due to the rating and product limitations, the merging of the HIRSP [high risk pool] population into the Individual Market and the introduction of the new exchange.”

The majority (53%) of the small employer groups will experience a premium increase as compared to pre-reform premiums. “The average premium increase will be 15%. 47% of small groups will receive, on average, a 16% decrease. These premium changes are primarily due to the elimination of carrier's ability to use health status as a rating variable and the elimination of group size adjustments.”

¹ Does not incorporate the impact of the risk adjustment, reinsurance, and risk corridor (3Rs) programs.