

ACA Premium Impact – Variability of Individual Market Premium Rate Changes

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BACKGROUND

The Patient Protection and Affordable Care Act (ACA) introduces significant changes in covered benefits, rating methodology, carrier regulation, and requires guaranteed issue of insurance coverage in Indiana's individual health insurance market 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. In a previously released issue brief, [Individual and Small Group Premium Changes under the ACA](#), we estimated that average market premium rates would increase 75% to 95% in the individual market prior to the application of the premium tax credit subsidy. This paper discusses the variability of estimated out-of-pocket premium rate changes (after the application of the premium tax credit subsidy) in the individual insurance market. Our analysis was performed by sampling current individual market premium rates and comparing these premium rates to estimated rates after the ACA's rating reforms have been implemented. All projections developed for this paper assume the individual mandate requirement of the legislation is found enforceable. Should the mandate be found unenforceable, the estimates provided in this paper will require revision.

EXECUTIVE SUMMARY

The ACA's impact on out-of-pocket premium rates in the individual market will vary significantly based on an individual's income level, gender, age, and health status. Premiums in Indiana's current individual market are largely based on a rating cohort's expected future healthcare costs. Insurers are allowed to develop premium rates based on an applicant's age, gender, and health status. Because of these rating allowances, significant variability in current premium rates exists between individuals at a given age with similar insurance coverage. Beginning in 2014, the ACA allows premium rates to vary in the individual market by age (limited to a 3:1 ratio), family size, geographic location, and tobacco usage (limited to a 1.5:1 ratio). These rating rules are referred to as 'Adjusted Community Rating', as they do not allow premiums to vary by an individual's health status. In Indiana, these requirements introduce three different subsidies into the development of individual premium rates prior to the application of the premium tax credit subsidy.

1. **Gender** – Young males, on average, currently pay significantly lower premium rates than young females because of lower expected healthcare costs. This is in large part due to maternity, family planning, and reproductive health costs, although even without these costs included, there are still cost differences by gender. **The elimination of gender rating will result in premium increases for young males, which will subsidize the premium rates for young females. Current market premiums may vary by as much as 70% between genders for adults under 40.** At older ages, this disparity between male and female claim cost is less significant.
2. **Age** – Although the ACA permits premiums to vary by age, the adjustment is limited to a 3:1 ratio. Actual unisex claim cost variation between the youngest and oldest adult individuals in the insured risk pool is approximately 4:1. This variation is based upon total claim costs and not on plan benefits. The variation increases as plan deductibles and other fixed cost-sharing parameters increase. For a \$5,000 deductible, 80/20 coinsurance plan with a \$7,500 out-of-pocket limit, the unisex slope is a 6-to-1 ratio. **The 3:1 age rating limitation will result in the young insured population subsidizing the older population in the risk pool.**¹
3. **Health Status** – The ACA does not allow insurance carriers to vary premium rates by an individual's health status. Currently, Indiana insurance carriers may reject an applicant, charge a higher premium for individuals with pre-existing health conditions, or issue a policy with a pre-existing condition exclusionary waiver. Further, maternity benefits are generally excluded from individual health insurance coverage. Individuals that are not

¹ Mary Van Der Heijde and Doug Norris. Milliman. The young are the restless: Demographic changes under health reform. <http://insight.milliman.com/article.php?cntid=7879>.



issued commercial coverage may qualify for coverage in the Indiana Comprehensive Health Insurance Association (ICHIA), which is the State's high risk pool. **The elimination of health status rating will result in premium increases for healthy individuals and premium decreases for individuals in poor health.**

Individual premium rate changes will also be impacted by the proportion of health care expenses covered under an insurance policy. The ACA requires individuals 30 and over to purchase minimum essential coverage that has an actuarial value of at least 60%. For an individual purchasing catastrophic health insurance in the current individual market (policies that cover less than 60% of healthcare expenses), premium rates will increase because of the minimum actuarial value requirement. Individuals currently purchasing plans with an actuarial value above 60% will be less impacted by the minimum coverage requirements. However, these individuals may still be significantly impacted by requirements to cover benefits not typically covered in current individual market plans, such as maternity services.

The ACA also introduces a premium tax credit subsidy for qualifying households between 139% and 400% FPL that limits a household's premium contribution to a maximum percentage of household income. **For low income households, the premium subsidy tax credit may significantly reduce out-of-pocket premium costs, particularly for older individuals who are charged higher premium rates.**

Individuals who are older and in poor health are likely to experience significant premium decreases as the result of the ACA rating requirements and premium subsidies. Many such individuals that may be uninsured today because of unaffordable premium rates may be able to afford insurance in 2014.

However, a material portion of the current individually insured population may experience very large premium increases as the result of the rating subsidies introduced by the ACA. Young, healthy, males will have the largest premium increases with the implementation of the ACA rating rules, as this population is adversely financially impacted by each of the ACA subsidies. Other individuals will financially benefit from the gender or age subsidies, which will dampen their premium rate increases.

Premium rate changes should also be viewed in the context of required out-of-pocket cost sharing. **As individuals purchase insurance plans with lower cost sharing requirements, because of minimum requirements, more affordable out-of-pocket premiums (as the result of the premium tax credit subsidies), or benefit subsidies for low income individuals, cost sharing expenses will decrease.** This will result in covered individuals having lower deductible or coinsurance payments when a high cost health event occurs.

CURRENT MARKET PREMIUMS

In order to understand why premium rate changes related to the implementation of the ACA rating reforms will occur, it is important to comprehend the extent that current market premium rates vary by age, gender, and health status. Current rating laws in Indiana's individual market do not require insurers to issue policies to every applicant. Applicants who are not accepted for individual coverage for health status reasons (and do not have access to Medicaid or employer-sponsored coverage) may be eligible for participation in Indiana's high risk pool program (ICHIA). Figures 1 and 2 illustrate sample gender and health status specific premium rates for individuals age 35 and 55 for policies with deductibles between \$5,000 and \$5,500 (figure 1) and \$2,500 (figure 2). The premium rates illustrated in Figure 1 represent coverage levels that may be below the ACA's minimum essential benefit requirement, which is defined as insurance coverage having a minimum 60% actuarial value (bronze level coverage). Individuals without minimum essential health coverage, with some exceptions, will be subject to the individual mandate penalty beginning in 2014. Premium rates in Figure 2 reflect a benefit value that may be comparable to the silver plan (70% actuarial value) offered in the exchange.



The figure 1 premium rates, effective November 1, 2011, for individuals with ‘excellent’ current health status were obtained by querying ehealthinsurance.com, and applying for the Anthem² Lumenos HSA Plus \$5,500 deductible (and out-of-pocket maximum) plan as a non-smoker residing in Marion County, Indiana. The Lumenos Plan does not cover maternity services. The premium rates for individuals with assumed ‘poor’ current health status are taken from the ICHIA quoted Plan 5 premium rates for Marion county residents and reflect a \$5,000 deductible and \$5,900 out-of-pocket maximum. Plan 5 is the lowest premium cost plan in the ICHIA program, but it also requires the greatest level of cost sharing. Maternity coverage is included under the ICHIA plan.

Figure 1

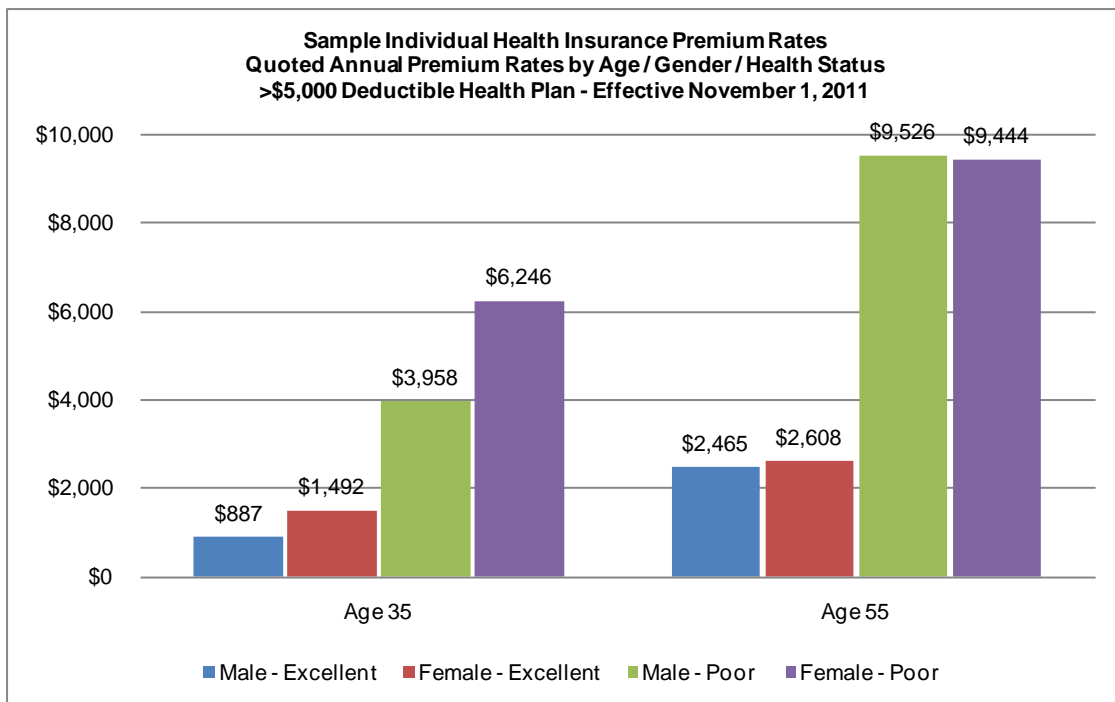


Figure 1 indicates significant premium rate differentials by gender, health status, and age for health insurance policies that require a similar level of cost sharing. A 35 year-old female in poor health would pay a premium rate that is 600% higher than that paid by a male, age 35 in excellent health. Commercial individual health insurance premiums largely reflect the expected claim cost of the insured cohort. Young adult females are charged a higher premium than males because they have higher relative claim costs. ICHIA premium rates are set by state regulations governing the high risk pool. Even though the ICHIA premium rates are multiple times higher than the commercial market premiums, the premium rates are still inadequate to cover the claim cost of the enrollees and only support 46% of the total operating costs of the ICHIA program³. Claim cost overruns and program administrative expenses are paid from insurer assessments and State general fund revenue. Without these current subsidies, premium rates for these unhealthy people could be 6 to 10 times higher than standard health rates.

While the premium rates for individuals in excellent health may be considered affordable at relatively low income levels, particularly for younger individuals, premiums rates within the ICHIA program may be considered unaffordable

² Anthem (parent company Wellpoint) has the highest market share of covered lives in Indiana’s individual health insurance market based on December 31, 2010 annual statement filings.

³ Indiana Comprehensive Health Insurance Association Board December 2010 Financials. https://www.onlinehealthplan.com/content/html/acs/12/12_Dec_2010_Financial.pdf.

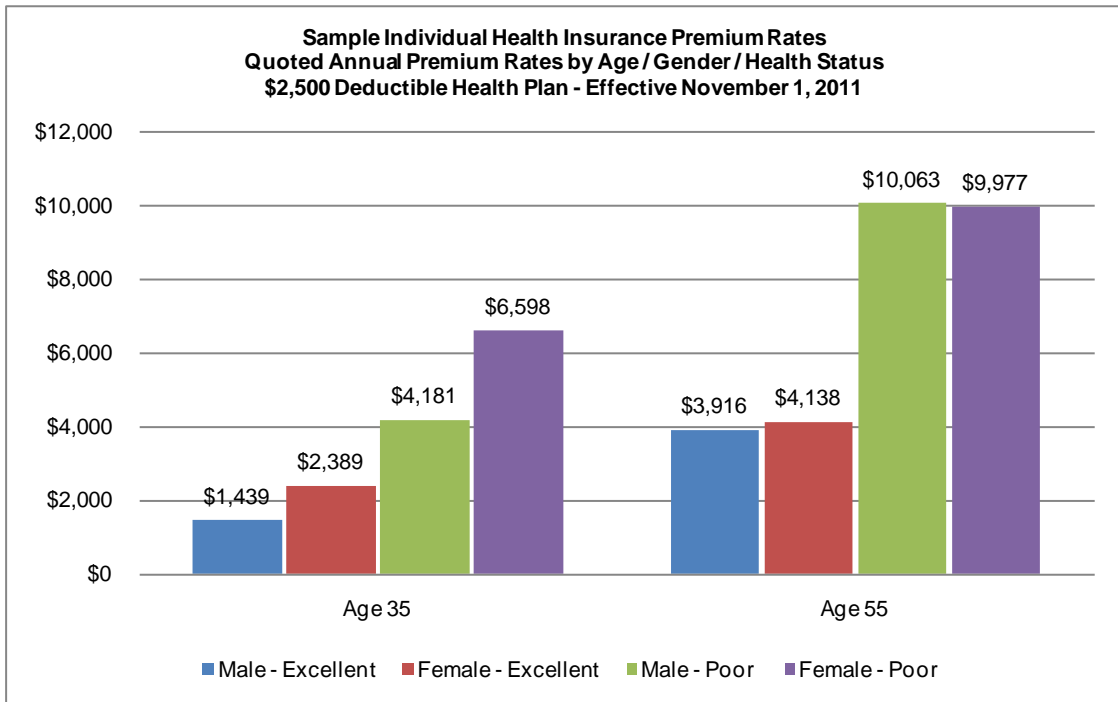
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for low income individuals. In addition to the high premium rate, the ICHIA enrollees are likely to incur thousands of dollars of out-of-pocket expenses until the \$5,000 deductible is reached. Lower deductible ICHIA plans are available, but require even higher premium payments. Many low-income individuals with chronic health conditions that are currently uninsured will enter the individual market in 2014 with the introduction of guaranteed issue, adjusted community rating, and available premium tax credit subsidies. Similarly, many currently insured unhealthy people who are paying higher than standard rates will be able to upgrade to improved comprehensive coverage with lower out-of-pocket costs at the same or lower premium rates.

The figure 2 premium rates for individuals with ‘excellent’ current health status were obtained by querying ehealthinsurance.com, and applying for the Anthem Lumenos HSA Plus \$2,500 deductible (and out-of-pocket maximum) plan as a non-smoker residing in Marion County. The Lumenos Plan does not cover maternity services. The premium rates for individuals with ‘poor’ current health status are taken from the ICHIA quoted Plan 4 premium rates for Marion county residents and reflect a \$2,500 deductible, 20% coinsurance, and a \$5,000 out-of-pocket maximum (including the deductible). Maternity coverage is included under the ICHIA plan.

Figure 2



As in figure 1, figure 2 also indicates significant premium cost disparity for a given age by gender and health status.

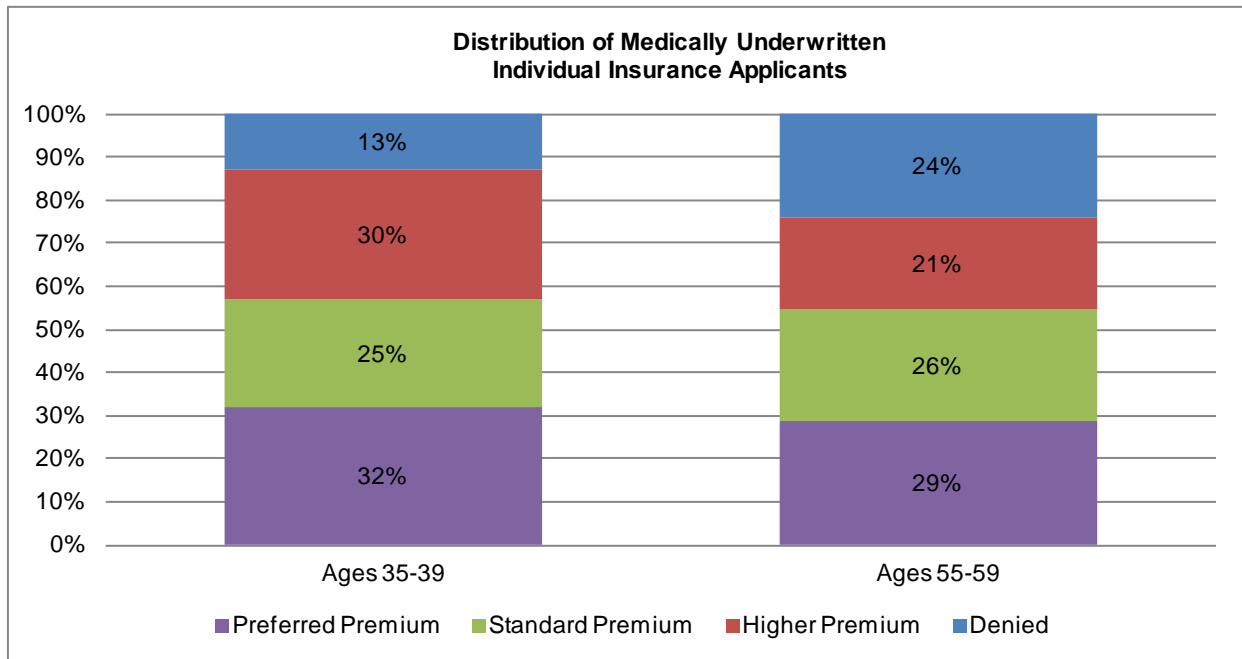
After the ACA rating reforms have been implemented, there will be no premium differentials between individuals based on health status and gender. Each of the four population cohorts at a given age will pay an identical premium rate for the same health insurance policy.

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The premiums quoted on ehealthinsurance.com are most likely only available to individuals in excellent health. These individuals would receive the 'preferred rate'. For individuals that have minor health concerns ('fair health status'), the insurer may still issue a policy, but the premium rate would be increased to reflect additional health risks. Individuals in fair health would receive the 'standard' or 'non-preferred' premium rate. Figure 3 illustrates the distribution of medically underwritten individual insurance applicants at ages 35 and 55 by premium class or application denial based on a 2008 survey of insurance carrier underwriting practices.

Figure 3



Source: AHIP Individual Health Insurance, October 2009.
<http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf>

For both age groups, a similar percentage of applicants are issued coverage at 'preferred' or 'standard' rates. For applicants age 35 to 39, 13% of underwritten applicants are not issued coverage, but this percentage increases to 24% for applicants age 55 to 59. Applicants that are denied coverage may be eligible for state high risk pool programs, such as the ICHIA program.

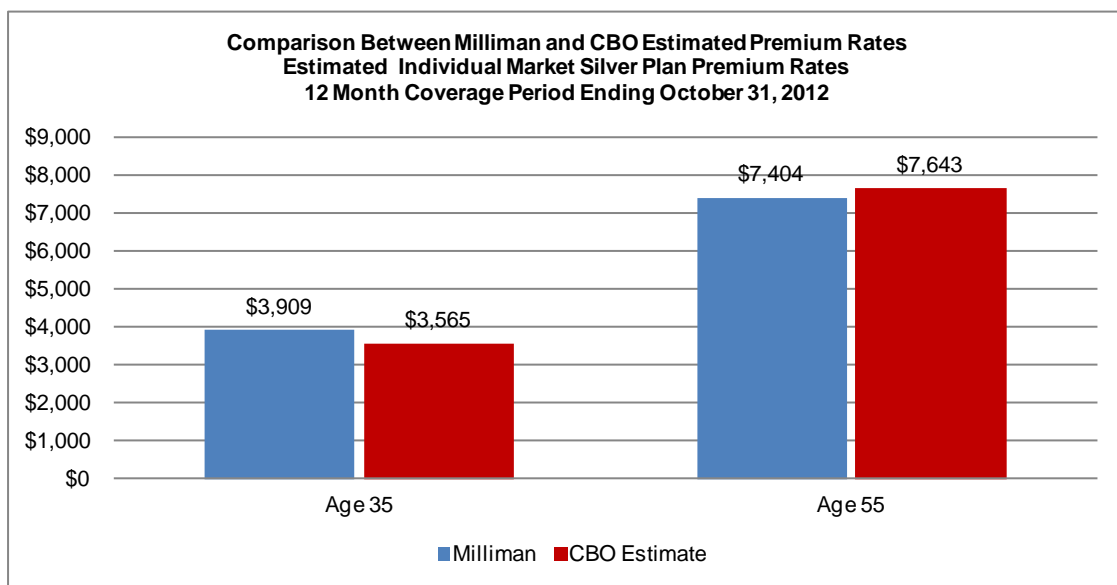
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PREMIUM RATES UNDER THE ACA

Figure 4 illustrates estimated premium rates for a silver plan (70% actuarial value) for a person age 35 or 55 after the implementation of the ACA rating reforms (prior to the application of the premium tax credit subsidy). To illustrate a comparison of Milliman’s premium rate estimates for Indiana and those developed by the Congressional Budget Office (CBO), the Kaiser Health Reform Subsidy calculator was used to develop age-specific premium estimates based on the CBO analysis for a medium geographic cost area. Both Milliman Indiana silver plan premium estimates and the CBO estimates have been trended to the 12 month coverage period ending October 31, 2012 to facilitate comparison with current market premiums. Figure 4 indicates that our estimates and the CBO premium estimates for a silver plan are comparable.

Figure 4



Note: The Kaiser Health Reform Subsidy calculator may be accessed at <http://healthreform.kff.org/SubsidyCalculator.aspx>.

In a previously released issue brief, [Individual and Small Group Premium Changes under the ACA](#), we estimated that average market premium rates would increase 75% to 95% in the individual market prior to the application of the premium tax credit subsidy. This estimate is considerably higher than the CBO’s national estimate of 10% to 13%.⁴ In current state individual health insurance markets, there is considerable variation in rating practices. Several states currently require adjusted community rating, which results in the individually insured population having significantly higher health status than in states like Indiana, where full medical underwriting is practiced. Therefore, ACA premium impact estimates for individual states may differ significantly from the CBO’s national estimates as the result of variations in current rating practices.⁵

On a national basis beginning in 2014, it is anticipated that the benefit disparity between the individual and group insurance markets will be significantly less, and the morbidity level of the individual market will be above or comparable

⁴ Congressional Budget Office. “Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act. November 30, 2009. www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf.

⁵ For further discussion on current state rating practices, please see: Houchens, Paul. “2010 Commercial Health Insurance Market: New Financial and Enrollment Data Available from the Supplemental Exhibit”. Milliman. October 31, 2011. <http://publications.milliman.com/publications/health-published/pdfs/health-insurance-market-10-31-11.pdf>.

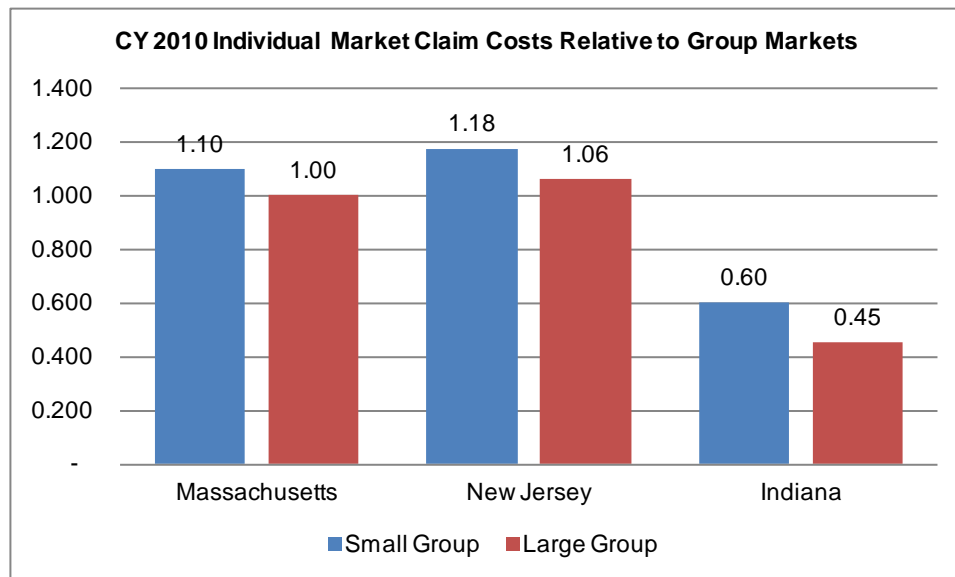
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to the group insurance markets as the result of the ACA requirements. Therefore, current differences between insured benefit claim cost between a state’s individual health insurance and group health insurance markets can be used to approximate the magnitude of the individual market premium rate change for a state in 2014.

Figure 5 illustrates relative claim costs between the individual and group health insurance markets for Massachusetts, New Jersey, and Indiana. Relative to each other, each state has unique rating laws in the individual health insurance market. Massachusetts already has implemented several of the major features of the ACA, such as an individual mandate, adjusted community rating in the individual and small group markets, and premium subsidies. New Jersey also only permits adjusted community rating in its individual market, but does not have an individual mandate or offer premium subsidies to purchase insurance. In states such as New Jersey, significant adverse selection occurs as individuals in poor health are more likely to purchase health insurance versus individuals in excellent health.

Figure 5



Notes:

1. **Source: December 31, 2010 Supplemental Health Exhibit filings collected during June 2011 using Insurance Analyst Pro®, Highline Data.**
2. **Claim cost experience has not been adjusted for age/gender/in-state geographic/income mix and actuarial value differences between markets.**

Figure 5 indicates that claim cost experience in Indiana is significantly lower in the individual market than in the group markets, while the claim costs in the Massachusetts’ individual health insurance market is comparable to the group health insurance markets. Per member claim costs in Massachusetts’ individual market are at or above per member claim costs reported in the group insurance markets. Given the similarity of some major features of the Massachusetts’ health insurance reforms to the ACA, Massachusetts insurance market experience may serve as a predictor of claim cost and premium directional changes under the ACA. For states like Indiana, where health status rating is allowed in the current individual market, it is anticipated that the health status of the new individual market will become substantially higher than that shown in Figure 5, and thus result in premium increases. However, in other states that already prohibit health status rating such as New Jersey, premium subsidies and the individual mandate may encourage a larger proportion of healthier individuals to purchase insurance and improve the health status of the individual market.

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PREMIUM TAX CREDIT SUBSIDY OVERVIEW

The ACA creates a premium tax credit subsidy for qualifying households to purchase health insurance in the state insurance exchange. The calculation of the subsidy amount is based on a household's federal poverty level (FPL). At a given FPL percentage, the household will not pay more than a specified percentage of its household income to purchase the second lowest cost silver plan in the exchange. For example, a household at 200% FPL will not be required to pay more than 6.3% of its annual income to purchase the second lowest cost silver plan in 2014. Figure 6 converts the FPL measure to household income for households of 1, 2, or 4 members and illustrates the maximum premium the household will pay for the second lowest cost silver plan offered in the exchange.

Figure 6
Illustration of Maximum Required Premium Contribution for Second Lowest Cost Silver Plan
(Estimated 2012 Federal Poverty Level Percentages)

	Federal Poverty Level				
	139%	150%	200%	250%	400%
Income - 1 Person Household	\$15,400	\$16,600	\$22,100	\$27,600	\$44,200
Income - 2 Person Household	\$20,800	\$22,400	\$29,900	\$37,300	\$59,700
Income - 4 Person Household	\$31,500	\$34,000	\$45,400	\$56,700	\$90,700
Maximum Premium Contribution as a Percentage of Household Income (CY 2014)	3.4%	4.0%	6.3%	8.1%	9.5%
Maximum Annual Premium - 1 Person Household	\$500	\$700	\$1,400	\$2,200	\$4,200
Maximum Annual Premium - 2 Person Household	\$700	\$900	\$1,900	\$3,000	\$5,700
Maximum Annual Premium - 4 Person Household	\$1,100	\$1,400	\$2,900	\$4,600	\$8,600

Note: Values are rounded.

The value of the premium tax credit subsidy is based on the premium of the second lowest cost silver plan for an individual's age and family size. However, this does not require the household to purchase the second lowest cost silver plan. The value of the premium tax credit subsidy may be applied to any qualified health plan offered through the exchange. For example, a single person at 200% FPL will pay a maximum of \$1,400 for the second lowest cost silver plan. If the actual premium of the second lowest cost silver plan was \$5,000, the \$3,600 subsidy amount (\$5,000 - \$1,400), can be applied to the purchase of any plan offered on the exchange. If the person chose to purchase a bronze plan, the out-of-pocket premium cost would be lower than a silver plan. Conversely, if the person chose to purchase either a gold or platinum plan, the out-of-pocket premium would increase. However, unless a silver plan is purchased, the person would forfeit the opportunity to get the cost-sharing subsidy offered to households under 250% FPL.

Beyond calendar year 2014, the maximum premium contribution as a percentage of household income will "be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year."⁶ It is estimated that future premium growth will exceed future household income growth. Therefore, the maximum premium contribution households pay as a percentage of household income will increase over time. Based on CMS Office of the Actuary per capita premium estimates⁷ and CBO forecasts of the

⁶ Congressional Budget Office. "Additional Information About the CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges." May 12, 2011. http://www.cbo.gov/ftpdocs/121xx/doc12188/05-12-Subsidies_in_Exchanges.pdf.

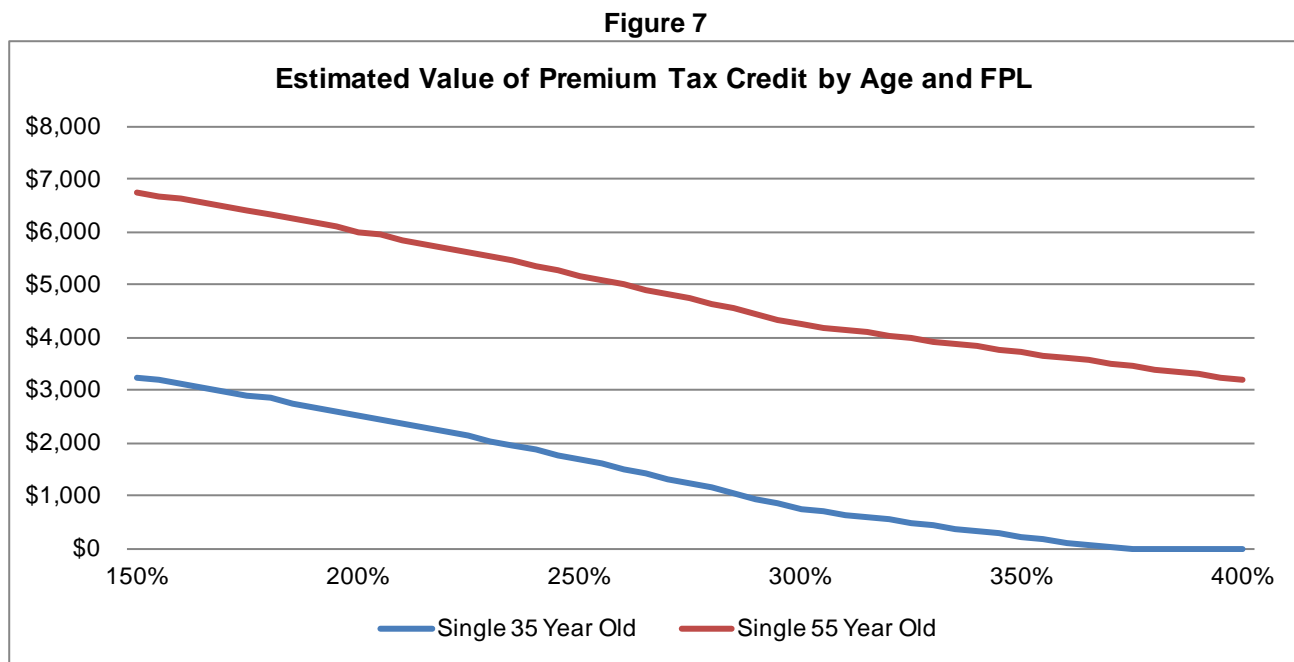
⁷ Centers for Medicare and Medicaid Services, Office of the Actuary. "National Health Expenditure Projections 2010-2020". Table 22. <http://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>. Premium per capita growth estimates based on combined 'Employer-sponsored Private Health Insurance' and 'Exchanges' projections.

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Consumer Price Index for all urban consumers (CPI-U)⁸, it is estimated that by 2020, a household's maximum premium contribution whose income is between 300% and 400% FPL will be approximately 11% of household income (vs. 9.5% in 2014). Without the indexing of the premium contribution percentage, the federal government's share of premium costs would increase significantly for subsidized households, as premium rates are estimated to grow faster than overall inflation.

Figure 7 illustrates the estimated value of the premium tax credit subsidy for individuals ages 35 and 55 by household FPL.



Notes:

1. Estimated silver plan premium of \$3,900 and \$7,400 for 35 year old and 55 year old, respectively.
2. Premium estimates based on 12 month period ending October 31, 2012. Income based on estimated CY 2012 FPL. Premium tax credit subsidy calculated based on calendar year 2014 percentages.
3. The percentages used to determine the premium tax credit subsidy value will be adjusted annually to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

As illustrated in figure 7, with an increase in household income, the value of the premium tax credit subsidy decreases. Even at the 400% FPL threshold, the premium tax credit subsidy is estimated to have significant value for many individuals and households. However, for younger individuals, such as a 35 year old, it may be possible that full premium costs of the second lowest cost silver plan are low enough to not require any premium tax credit subsidy payments for individuals with household income approaching 400% FPL. Therefore, the premium tax credit subsidy may have no value for a portion of younger individuals below 400% FPL.

⁸ Congressional Budget Office. "The Budget and Economic Outlook: Fiscal Year 2011 to 2021". Table 2-1. http://www.cbo.gov/ftpdocs/120xx/doc12039/01-26_fy2011outlook.pdf. We have estimated that household income growth will exceed CPI-U by 1% annually. Beginning in CY 2019, the premium percentages will be indexed to excess premium growth relative to increases in the CPI-U index.

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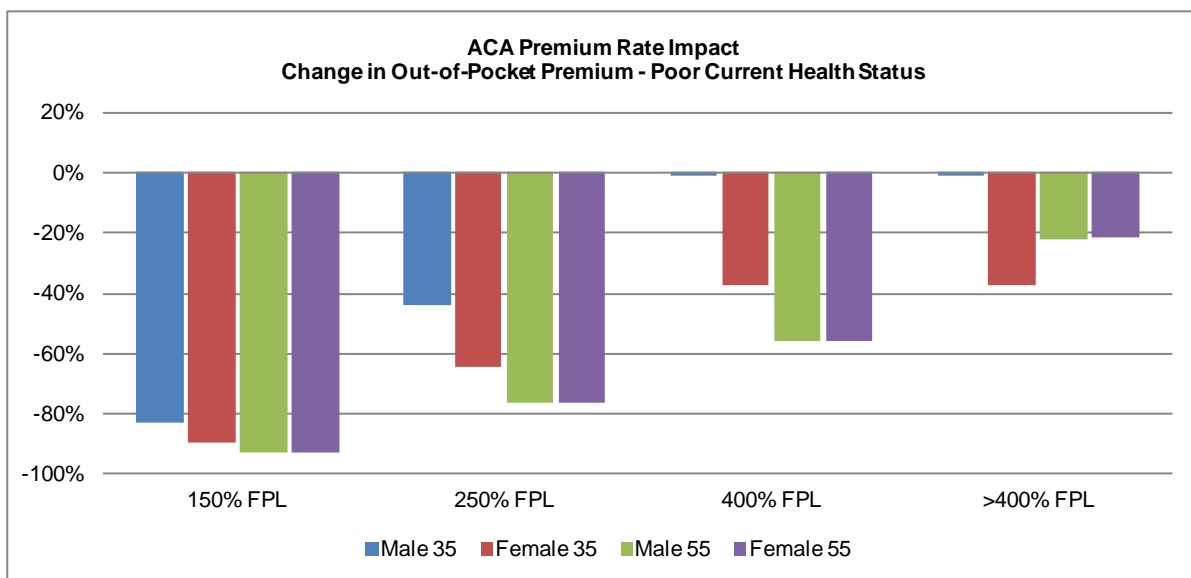


PREMIUM RATE IMPACT NET OF PREMIUM TAX CREDITS BY HEALTH STATUS AND CURRENT BENEFIT COVERAGE

Figures 8 through 10 illustrate the estimated ACA premium rate impact net of available premium tax subsidies for individuals ages 35 and 55, by gender, health status, and household income level relative to the premium rates illustrated in figures 1 and 2. These charts are intended to *illustrate the range of estimated premium decreases or increases after the ACA's rating reforms have been implemented*. The actual out-of-pocket premium change for an individual or household will be dependent on their age, gender, health status, income level, and current insurance benefit level.

For individuals with poor current health status in the ICHIA program, the ACA will result in substantial out-of-pocket premium decreases for the vast majority of individuals at all income levels as illustrated in Figure 8.

Figure 8



Notes:

1. Premium rate changes based on silver plan purchase at all income levels. Percentage changes relative to premium rates for ICHIA Plan 5 (Figure 1). Premium decreases relative to Plan 4 (Figure 2) will be greater.
2. Premium estimates based on 12 month period ending October 31, 2012.
3. Estimated silver plan premium cost \$3,900 and \$7,400 for 35 year old and 55 year old, respectively.

In addition to substantial out-of-pocket premium reductions, the plans offered through the insurance exchange will provide a higher level of covered benefits for many individuals currently enrolled in the ICHIA program. This may result in a significant decrease in cost sharing expenses for individuals currently enrolled in high deductible health plans. For example, for a 55 year-old male at 150% FPL, current ICHIA premiums are \$9,500 and \$10,100 annually for a \$5,000 deductible and \$2,500 deductible policy, respectively. With the implementation of the adjusted community rating rules and the premium tax credit subsidy, the individual's out-of-pocket premiums may decrease to only \$700. The new policy will also cover a significantly higher share of the individual's health care expenses, as the individual will be eligible for cost sharing subsidies that may be equivalent to a \$500 deductible policy. **For low income participants in the ICHIA program, many may experience a reduction in annual health care expenses (premium and cost sharing) between \$5,000 and \$10,000. Many individuals, particularly those 50 and older, that are currently uninsured because of unaffordable premium rate levels in the ICHIA program will have substantially less expensive out-of-pocket premium rates and will likely enter the individual insurance market (excluding households that are Medicaid eligible).**

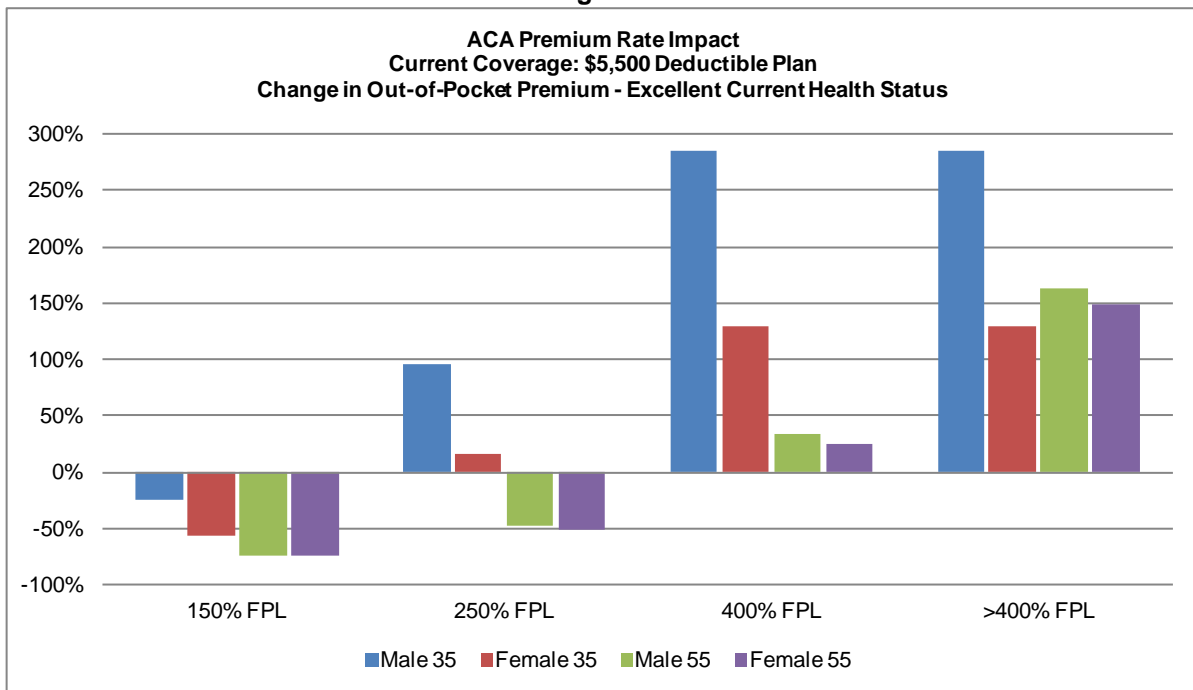
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Figures 9 and 10 illustrate the premium rate change for individuals with excellent current health status that are currently purchasing the Anthem Lumenos HSA Plus \$5,500 deductible and \$2,500 plans, respectively. These individuals, below 400% FPL would qualify for the lowest premium rates offered in the current medically underwritten individual market. In 2014, they will no longer pay a lower premium rate relative to an individual in poor health.

For individuals currently purchasing the \$5,500 deductible plan, it is assumed that with the exception of the individuals at 150% FPL, the bronze plan will be purchased in the exchange, which is the lowest premium option available. For individuals at 150% FPL, it has been assumed they will purchase a silver plan to access available cost sharing subsidies that will increase the actuarial value from 70% to 94%.

Figure 9



Notes:

1. Premium estimates based on 12 month period ending October 31, 2012.
2. Estimated bronze plan premium cost \$3,400 and \$6,500 for 35 year old and 55 year old, respectively.
3. Premium rates changes reflect a person in excellent health status. Individuals with less than excellent health status will experience lower increases or greater decreases in premium rates.

The \$5,500 deductible plan would likely not meet the ACA's minimum essential coverage requirements because the actuarial value is estimated to be less the minimum required 60%. **Purchasing coverage that has a higher actuarial value will increase premiums, but will result in lower out-of-pocket cost sharing. Therefore, a portion of the premium increase attributable to an expansion of covered benefits will be mitigated by lower cost sharing requirements.**

Figure 9 illustrates that a 35 year old male in excellent health with income at or above 250% FPL is estimated to experience significant out-of-pocket premium increases, even after application of the premium tax credit subsidy. Premium increases for 35 year old males at higher income levels may exceed 200% or a \$2,000 annual premium increase. The premium increases for the 35 year old female, while still substantial at higher income levels, are less than the male because of the elimination of gender rating, which eliminates the current disparity in premium rates between young males and females.

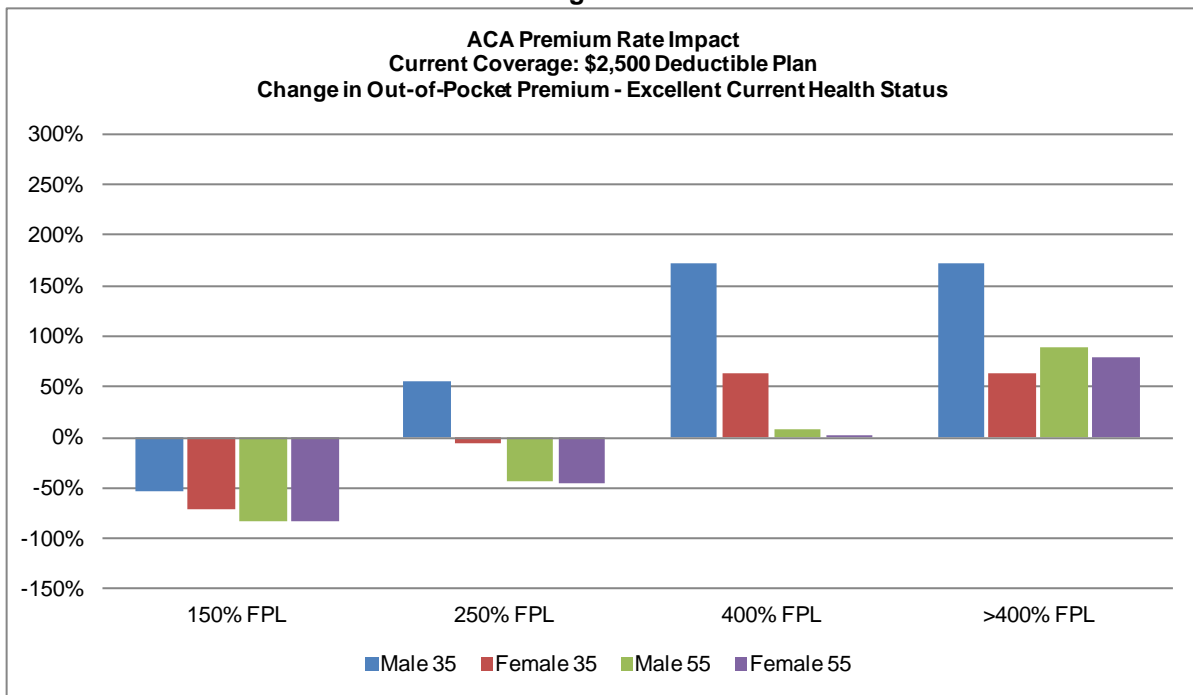
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Premium increases for individuals age 55 are mitigated by the premium tax credit subsidy at lower income levels. 55 year old males and females at 250% FPL are estimated to experience a 45% or \$1,300 out-of-pocket premium reduction. Premium increases for higher income individuals age 55 are less than 35 year olds because of the 3:1 age rating limitation required the ACA. The age rating limitation results in the older population being subsidized by younger individuals in the risk pool.

Figure 10 illustrates the estimated premium rate changes for healthy individuals that currently are covered by a \$2,500 deductible plan, which may be comparable to the silver plan offered in the insurance exchange. **It is assumed that these individuals will elect to purchase the silver plan in the exchange in order to maintain a similar health insurance benefit level. Premium changes would be lower if a bronze plan was purchased.**

Figure 10



Notes:

1. Premium estimates based on 12 month period ending October 31, 2012.
2. Estimated silver plan premium cost \$3,900 and \$7,400 for 35 year old and 55 year old, respectively.

For individuals at higher income levels, the premium rate increases illustrated in figure 10 are lower than those shown in figure 9. For example, a 35 year old female above 400% FPL currently purchasing a \$5,500 deductible plan is estimated to experience a premium increase of 125% (\$1,500 to \$3,400). The same person purchasing a \$2,500 deductible plan currently is estimated to experience a premium increase of 60% (\$2,400 to \$3,900). A \$2,500 deductible plan is estimated to be above the minimum 60% actuarial value requirement for minimum essential health insurance coverage. Therefore, these individuals will be less impacted by the ACA's insurance benefit expansion requirements.

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INCOME DISTRIBUTION FOR THE UNINSURED & INDIVIDUALLY INSURED POPULATIONS

To understand the impact of ACA-related premium rate changes on the overall post-ACA individual insurance market, it is important to understand the income distribution of the currently uninsured and individually insured populations. As individual premium rate changes vary significantly by income, the percentage of the new individual market population qualifying for the premium tax credit subsidy will influence the overall out-of-pocket premium rate change. Figure 11 illustrates the estimated calendar year 2010 income distributions for adults (age 20 and over) who are uninsured (331,000) or individually insured (133,000) **with income at or above 139%** (households with income below 139% are eligible for Medicaid beginning in 2014). These populations are likely to represent the majority of the individual insurance market beginning in 2014.

Figure 11

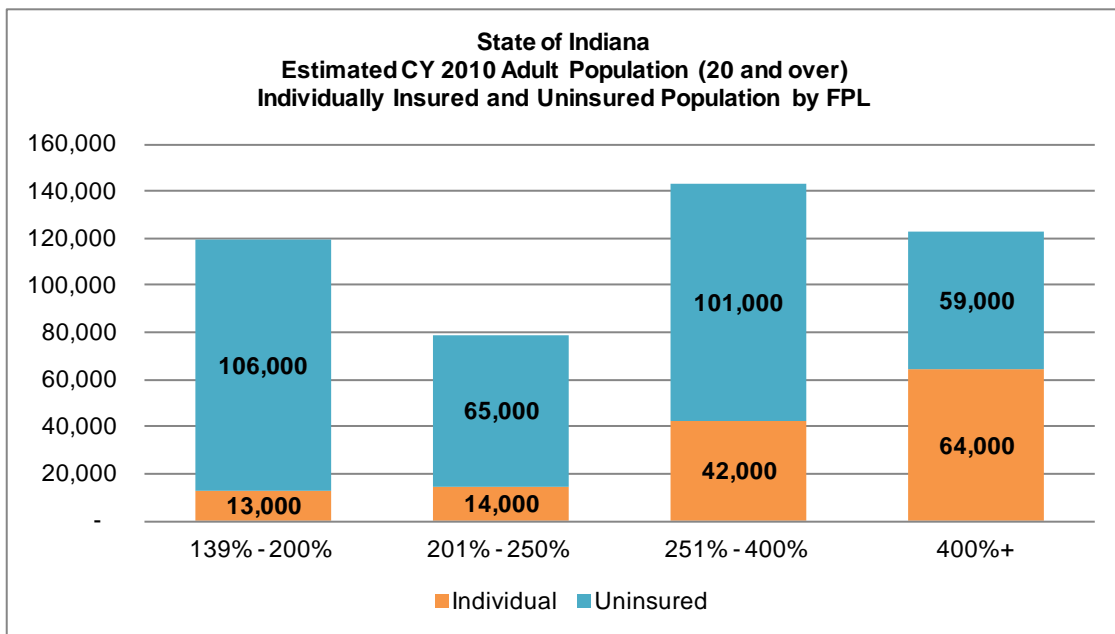


Figure 11 indicates only 20% of the current individual insurance market population has income below 250% FPL. However, approximately 50% of the current uninsured population above 138% FPL has income at or below 250% FPL. On the basis of household income only, approximately half of the current individually insured adult population will qualify for the premium tax credit subsidy as the result of having household income below 400%. 80% of the current Indiana uninsured population will qualify for the premium tax credit subsidy based on the estimated distribution of household income, and ignoring potential access to employer sponsored coverage. Based on interim regulations, families eligible for employer-sponsored coverage that have required contributions for self-only coverage of less than 9.5% of household income are not eligible for the premium tax credit subsidy.⁹

⁹ United States Department of Treasury, Internal Revenue Service. REG-131491-10: Health Insurance Premium Tax Credit. <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>.



CONCLUSION

The impact of the ACA's insurance rating reforms and premium tax credit subsidies will create significant household out-of-pocket premium reductions for some Hoosiers and significant premium increases for others in Indiana. Given that the current market premiums vary significantly by health status, age, and gender, it should not be surprising that the elimination of health status and gender as rating factors for individual health insurance premiums would create significant premium changes in the State. Additionally, the 3:1 age rating requirement will result in higher premiums for young adults.

While the introduction of the premium tax credit subsidies ensure that health insurance will be significantly more affordable for individuals in poor health or with low income, the stability of the overall individual health insurance market is less certain. Healthy individuals, in particular young males, may experience very significant premium rate increases, exceeding 100%. While the ACA does impose an individual mandate to purchase a minimum level of health insurance, the mandate penalty is estimated to be less than half the cost of insurance for households with income as high as 800% to 1500% FPL. If a significant portion of healthy individuals either fail to purchase insurance or decide to become uninsured because of premium increases, overall market premiums will be adversely impacted. Consideration may be needed for policies beyond the individual mandate that encourage young and healthy individuals to enter the insured risk pool.

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.

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.**

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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