

AHIP Response

Technical Answers to Questions Pertaining to the PWC Report on the Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage

A recent report from PricewaterhouseCoopers¹ examines the potential impact of key provisions of the Senate Finance reform proposal on the cost of private health insurance premiums and premium-equivalents for self-insured plans.

The report estimates the potential impact of four elements of the proposed reforms on the cost of private insurance premiums: insurance market reforms, the tax on high-value plans, cost shifting of reductions in Medicare and Medicaid hospital payments, and new fees imposed on certain industries.

Below are some questions that have arisen about technical aspects of the report and to what extent other factors were considered.

Question: Did the analysis consider the subsidies individuals would receive to purchase coverage?

Answer: Yes. The analysis takes into account the presence of this assistance in estimating the number of additional people who will obtain insurance under the reforms, and those insured under the current system. As noted in the report, the estimated premiums reflect the total premium for coverage before subsidies.

Comment: The purpose of this report was to measure the potential impact on underlying costs and premiums. As stated above, the projected premiums presented in the analysis do not reflect net costs for those who receive premium assistance, but rather assess the impact of the selected proposals on premium costs for private insurance. Increased premium costs will affect individuals not eligible for subsidies, many individuals eligible for subsidies, and the overall cost to the government.

The subsidies are only available to individuals who purchase coverage on their own through one of the newly proposed health insurance exchanges. Government data from the Current Population Survey show that nearly half of those with individual coverage today (42%) have incomes greater than 400% of federal poverty and would receive no assistance (and the current grandfathering provision does not fully protect currently insured individuals as explained below).

In addition, we have found based on internal estimates, that many individuals who would be eligible for subsidies based on their income will still experience an increase in premiums before reaching the percentage of income limit. Based on AHIP's own analysis of premium increases in the individual market (informed by premium and subsidy amounts from the Kaiser Family Foundation's Health Reform Subsidy Calculator) we found the following results:

- An individual with income of about 300 to 350% of poverty could see a 184% or more increase in rates before getting relief from the premium assistance.
- Young people with incomes as low as 250% of poverty could see over a 52% increase in rates otherwise available to them before getting relief.²

¹ PricewaterhouseCoopers, Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage, October 2009.
October 14, 2009

These estimates highlight the problems of relying on subsidies, in the absence of an effective coverage requirement, as a remedy to address underlying issues of affordability.

Question: Did the analysis consider reinsurance, risk adjustment, and risk corridors in determining premiums?

Answer: The analysis considered the reinsurance provision, which serves to reduce the estimated increase in premiums for individual coverage. Risk adjustment helps to level out premiums among different insurance carriers, but does not impact the overall level of premiums in the market. Risk corridors provide short-term relief for health plans with an unexpectedly large number of claims with high medical expenses, but in the long-run do not impact premium levels. As a result, risk adjustment and risk corridors are not included in the analysis.

Comment: Without funding from outside the individual market, risk adjustment only helps level out differences in premiums between different insurance companies based on the risk profiles of the insured individuals - it does not change the overall level of premiums in the market. The reinsurance specified in the Finance Committee bill is designed as a temporary (3 year) provision. It was designed to ease the transition to market reforms as a complement to a strong and effective coverage requirement. It was not intended to serve as long-term replacement for a strong and effective coverage requirement, and will not reduce overall costs.

Similarly, risk corridors do nothing to reduce the cost of coverage over the long run - they only provide a short-term fix for health plans that are negatively impacted by the enrollment of an unexpectedly large number of sick individuals.

Question: Did the analysis consider the impact of grandfathering of existing coverage?

Answer: The analysis considered grandfathering of existing plan benefit levels.

Comment: The model results presented in the analysis did not assume that anyone with existing coverage would need to increase or “buy up” their benefits to comply with the proposed reforms. In addition, the model did not assume a “separate pool” for those with existing coverage as the Finance Committee intends to “risk adjust” between existing and new individual policies, and for the rating reforms to apply to existing coverage. By definition, this will lead to a blending of rates and a significant increase in premiums for those with existing coverage. Had the analysis modeled a separate risk pool for those with existing coverage, the prevailing rates for those obtaining new coverage would have been even higher.

In addition, the breadth of the grandfathering provision with respect to the grandfathering of benefit levels for those with existing coverage is unclear in the “conceptual” format. The effectiveness of this provision may be determined in the legislative language depending on the extent to which it specifies whether routine benefit modifications would end the grandfathering provision: for example, the movement of a drug from say a non-preferred to a preferred tier or other routine changes.

² These results are very similar to internal estimates, and are based on Kaiser figures for the “lower cost areas” with respect to premium levels.

Question: Did the analysis consider the benefits of the “young invincible plan”?

Answer: Yes. The analysis assumed that such plans, which exist in the current market today, would continue to exist without a separate rating pool.

Comment: A recent briefing paper from the actuarial firm Milliman titled “*Young invincible provision points to lingering questions about costs and sustainability,*” reflects the issues associated with this proposal.³

Question: Did the analysis consider the impact of the phase-in of new rating rules in the small-group market?

Answer: Yes. The analysis assumes that such changes are phased in over the first 3 years.

Comment: The provision in the Finance Committee bill that new rating rules for the small group market be phased in over a period of up to 5 years is subject to the discretion of the states and the Secretary. Moreover, the reforms in the small-group market may have the unintended consequence of encouraging small firms to self fund, resulting in healthier small groups exiting the fully insured market with the effect of raising costs for those that remain. The results presented in the analysis did not reflect the cost pressures associated with this potential.

Question: Did the analysis consider the proposal for a small business tax credit?

Answer: Yes. The analysis assumed that small businesses would maintain their coverage at existing levels as a result of the small business tax credit. In the absence of the credit, small businesses would be expected to reduce coverage and employees would migrate to the exchange.

Question: Are the premium increases attributable to an increase in benefit levels?

Answer: The analysis reflects the estimated change in premiums based on existing benefit levels.

Question: Did the analysis consider administrative savings from the proposal?

Answer: Yes. The analysis assumed a reduction in administrative costs in the individual market, phasing in from 5 percent to 10 percent.

³ Milliman Health Reform Briefing Paper, “Young Invincible Provision Points to Lingering Questions about Costs and Sustainability, 2009. <http://www.milliman.com/perspective/healthreform/pdfs/young-invincible-provision-points.pdf>.

Comment: The inclusion of administrative savings is intended to account for reforms such as those involving the creation of exchanges that may create potential administrative efficiencies (e.g., the elimination of medical underwriting and reduction in marketing and administrative costs).

The Congressional Budget Office (CBO) estimated that net administrative costs in the exchange would fall by 4 to 5 percentage points, taking into account expected surcharges on plans to cover exchange operating costs. CBO estimated that these surcharges would add about 3% to premiums, on average. (September 22, 2009 letter to Chairman Baucus). The experience in Massachusetts is that these surcharges fees account for 4% to 4.5% of premiums.⁴

Question: Did the analysis consider the impact of the delivery system reforms in the proposal?

Answer: As stated in the report, the analysis only estimated the impact of the four identified provisions (insurance market reforms, tax on high-value employer plans, changes in Medicare and Medicaid funding to hospitals, and new fees on selected industries).

Comment: The reform package includes provisions that may help to reform the delivery system. However, these measures largely focus on public programs, lack a system-wide focus, and by pushing on only one side of the health care cost “balloon” rather than adopting a system-wide approach, generate concerns over cost shifting to the private sector. In addition, CBO projected that most of the delivery system reform proposals in the mark would only lead to modest decreases in costs over the 10-year period (and in some cases are budget neutral or result in higher costs).⁵ And, it was recently revealed that hospitals (representing more than 31% of national health care spending) were excluded from the “IMAC” proposal, limiting the effectiveness of the provision

Numerous recent press articles have likewise highlighted concerns over the proposal's limited impact on overall costs.⁶

Question: Did the analysis assume the industry fees (medical device manufacturers, pharmaceutical manufacturers, and health insurers exclusive of Cadillac plans) will be passed through?

Answer: The analysis assumes that the industry fees are an additional business cost that will be passed through in the form of higher prices. While the fees on medical device and pharmaceutical manufacturers impact the entire market, the fees on health insurers impact only fully-funded plans, exclusive of self-insured plans.

Comment: During the mark up, CBO stated that it believed these fees would be passed through by an amount equal to the fees.⁷ In this regard, the Congressional Joint Tax Committee (JCT) recently revised their estimate

⁴ See *Minutes of the Board of the Commonwealth Health Insurance Connector Authority*, June 12, 2008.

⁵ Congressional Budget Office analysis of the Chairman’s Mark for the America’s Healthy Future Act, As Amended. October 7, 2009.

⁶ The Boston Globe, Health plan’s effect on costs may be slight, October 12, 2009.; The New York Times, Current Health Care Legislation Will Not Control Medical Costs, Experts Warn, October 12, 2009.

⁷ Congressional Budget Office Letter to Chairman Baucus, September 22, 2009.

increasing their projection of the revenue collected to account for the non-deductibility of the new taxes.⁸ In addition, the insurer tax only applies to the fully-insured market, which means that the base for spreading the fixed amount of the tax will likely be cut by nearly a half and principally limited to individuals and small businesses.

Question: Did the analysis assume that individual policies offered in the exchange would be impacted by the tax on high-value ("Cadillac") employer plans?

Answer: No. The analysis did not subject insurance exchange plans or any other individual market plans to the tax on high-value employer plans. To illustrate the geographic impact of the tax on high-value employer plans, the analysis utilized benefit levels equivalent to the exchange plans to benchmark the potential impact on employer plans in different states and metropolitan areas.

Question: Did the analysis assume employers adjust benefit levels in response to the tax on high-value plans?

Answer: As mentioned above, the report reflects the estimated change in premiums based on existing benefit levels. Premium levels for plans above the threshold include the impact of the excise tax. Averaging these results across employer-group coverage adds an average of 5% to large and small group premiums in 2016 as indicated in the report.

Comment: If employers changed their benefits and increased cost sharing to avoid application of the tax and returned premium savings to employees in the form of wages, employees would still face effectively higher costs for health benefits. They would in most cases have to use after-tax dollars to purchase health services which previously were purchased with pre-tax dollars. The end result would be an increased effective price to consumers for the same level of health care, unless underlying health care costs are brought under control (see separate discussion regarding the impact of proposed delivery system reforms).

Question: Did the analysis assume cost-shifting of Medicare and Medicaid reductions to the private sector?

Answer: The analysis includes the impact of reductions in Medicare and Medicaid payments to hospitals and the expected increases in reimbursements from treating more insured patients. The net impact is estimated to result in lower payments to hospitals by public programs, which is assumed (based on historical data) to be passed through in the form of higher charges to the privately insured.

Comment: Data from the American Hospital Association (AHA) demonstrates that private payers pay 130 percent of costs, Medicare pays 91 percent of costs, and Medicaid pays 86 percent of costs. A report from Families USA indicates that approximately 63 percent of care provided to the uninsured is paid with the rest being shifted to the private market.⁹ The legislation includes cuts in Medicare and Medicaid payments to hospitals, which would increase pressure on hospital margins. The analysis assumes that these are cuts are

⁸ Joint Committee on Taxation letter to Mark Prater et. al. Revenue Estimate. October 6, 2009

⁹ Families USA, "Hidden Health Tax", 2009. <http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf>

offset by improved reimbursements attributable to the newly covered population. The potential for additional cost-shifting in reform is important because pressures on public programs could have unintended consequences for the private market.

Question: How did each of the four provisions reviewed contribute to the overall increase in premiums?

Answer: The impacts by market of each of the proposals are presented in the chart on page 13 of the report. Weighting across the different market segments, the insurance market reforms have the largest impact on premiums, the tax on high-value employer plans has the next largest impact, and the new fees and cost shifting have smaller impacts. The relative impact of these proposals may differ if a particular market segment is examined.