



## **Recent Estimates of the Senate Health Reform Bill's Impact on Health Insurance Premiums**

The Congressional Budget Office (CBO) recently released an analysis of how health insurance premiums would be impacted by the Senate health reform bill. We believe CBO's findings highlight the need for greater cost containment and other improvements to the Senate health reform bill.

### **Need for Greater Cost Containment**

The CBO report does not fully address the widespread concerns about the lack of cost containment features in the Senate bill. CBO notes in the report that some features of the bill have the potential to slow the growth of costs in the long run, and has noted elsewhere that the Medicare cuts would reduce health spending by that program if they were sustained over time. However, CBO's projections of the growth in Medicaid and subsidy costs in the latter years of the 10-year budget window suggest that the trend in underlying medical costs will remain far above GDP growth.

This concern is reinforced by the CMS Chief Actuary's recent analysis of the House bill, which concluded that, aside from comparative effectiveness research, the bill's other proposals aimed at containing costs would have "a negligible financial impact over the next 10 years." In addition, both the CMS and CBO reports confirm that new fees and taxes will be passed onto consumers and would thereby increase the cost of coverage.

Given the importance of bending the health cost curve to the ultimate sustainability of health care reform, more should be done to address underlying health care costs.

### **Need for Greater Mitigation of the Risks Associated with Market Reform**

While the CBO report helps to identify the critical assumptions on which estimates of premium impacts rely, it does not address the sensitivity of the estimates to alternative assumptions. CBO is required to do estimates in the face of uncertainties, and the report is unequivocal in stating that a "substantial degree of uncertainty" surrounds the estimates presented. This point and the candor with which it is presented is of vital importance to all participants in the health care reform debate because the estimates presented by CBO are highly sensitive to key assumptions for which there are no definitive answers – only alternative scenarios of the future, and the lessons of past, failed efforts of reform undertaken at the state level.

Most experts agree that it is essential to the workability of health reform that people have a powerful incentive to purchase coverage at their first opportunity, and not wait until they are sick to purchase coverage. CBO has assumed a "limited amount of adverse selection would occur in new nongroup plans" despite the fact that penalties for forgoing coverage are only \$95 at the start of reform and scale up slowly thereafter.

Premium estimates are highly sensitive to these assumptions. CBO estimates that changes in the enrollment mix of those receiving coverage in the nongroup market would reduce premiums by 7% to 10%.

However, if this assumption proves wrong, and adverse selection is worse than CBO projects, premiums in the nongroup market would soar, along with the associated cost of subsidies for low and moderate income individuals.

For these reasons, we remain concerned that compliance with the requirement for individuals to purchase coverage will be less than expected, and that so-called “adverse selection” will occur leading to a significant increase in premiums beyond what CBO has projected. The tables below show that a relatively modest change in the assumption about compliance and selection could lead to a large increase in premiums.

### **Need for Greater Attention to the Variation of Impacts on States & Younger Individuals**

CBO’s analysis of premiums on a national average basis is an important starting point, but this does not demonstrate how widely those premium impacts will vary depending on the existing regulatory environment. An illustration of premiums by age or state-by-state premium impacts may be difficult, but it is imperative to understand the impact of changed rating rules by the ages of purchasers, and the presence or absence of existing state rules such as guarantee issue.

***Premium Variation By Age:*** For example, moving from a 5:1 ratio (which is probably below the average in the vast majority of states) to 3:1 in the merged bill will increase costs for adults under 30 by roughly another 30% to 50% with the younger cohorts (e.g., those in their early 20s) seeing the most significant increases. These are increases that would be seen beyond the increase in premiums projected for the market in general. This has significant implications for the cost of coverage young people will face and whether they choose to join or stay in the pool or simply wait until they are sick to purchase coverage.

***Premium Variation By State/Regions:*** The impact of reform on premiums, especially for nongroup coverage, is likely to vary substantially on a regional or state basis. This reflects the fact that some states previously enacted guarantee issue and community rating reforms which led to significant premium increases in the individual market in those states. The current proposals would cause average premiums to decrease in those states while dramatically increasing premiums for people in states that currently allow medical underwriting.

### **Concern Over Increased Pressure for Cost Shifting**

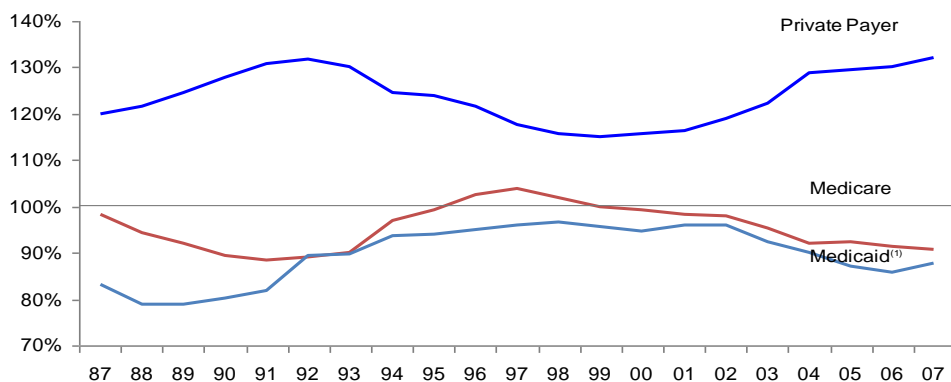
On the issue of cost shifting to employers and families with private coverage, CBO assumes that reform will reduce uncompensated care. While uncompensated care does increase private coverage costs, this effect is separate and distinct from the additional cost shifting that occurs as a result of under-payments from public programs such as Medicare and Medicaid. We believe these effects are unlikely to be offset fully under reform proposals that would cut Medicare by more than \$400 billion, reduce disproportionate share payments, and substantially expand Medicaid. In addition, the proposed expansion in coverage would not begin until 2014.

Experience has shown that when doctors and hospitals receive less money from Medicare and Medicaid, they charge more to families and employers with private coverage to cover those costs. According to a report by Milliman, Inc., the average family of four already pays \$1,500 in higher premiums as a result of this cost-shift.

The pressure on hospitals and other providers to cost shift is driven significantly by underpayments from public programs. Data from the American Hospital Association (previously cited by CBO) show that Medicare and Medicaid payments fall well below costs and that the underpayments have been growing from \$3.8 billion in 2000 to \$32 billion in 2008. In Medicare, hospitals received payment of only *91 cents* for every dollar they spent caring for Medicare patients in 2008. For Medicaid, hospitals received payment of only *89 cents* for every dollar they spent caring for Medicaid patients in 2008. The chart shown below, which plots payment-to-cost ratios for private payers, Medicare, and Medicaid from 1987 to 2007, also shows a strong and hard to ignore relationship between payment levels by private payers and those of public programs.

## The Impact of Cost-Shifting

**Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1987 – 2007 <sup>2</sup>**



<sup>1</sup> Key Issues in Analyzing Major Health Insurance Reform Proposals, Congressional Budget Office, December 2008, page 108.

<http://www.cbo.gov/ftpdocs/99xx/doc9924/toc.shtml>

<sup>2</sup> Avalere Health analysis of American Hospital Association Annual Survey data, 2007, for community hospitals.

For these reasons we are concerned that the combination of significant reductions in Medicare, the creation of a new government-run plan, and significant Medicaid expansion will exacerbate cost-shifting pressures even beyond those existing in the market today.

### **Difference Between Subsidies & Measures that Improve Affordability by Reducing the Rate of Growth in Health Care Spending**

Finally, CBO’s new report illustrates the key difference between lowering health costs and subsidizing them. Federal subsidies can help those receiving assistance afford coverage, but in

the same way that Pell Grants do not lower the cost of college tuition, subsidies do not reduce underlying medical costs. The lesson from the report, therefore, should be that if the health care reform bills under consideration really succeeded in lowering underlying health care costs, reform could be achieved at a substantially lower cost and threat to the nation's finances.

### **“Grandfathering”**

The topic of “grandfathering” often comes up in discussions over the impact of health care reform on health care premiums. Provisions that “grandfather” people into their current plans are important, but offer limited protection against higher costs. In particular, one-third of Americans change their coverage each year. Anyone who changes coverage because of a life event, such as changing a job, getting married or divorced, or moving to another state, would not be protected by the grandfather clause in the pending bill. The scope of the grandfathering provision under the legislation being considered is also unclear. For example, if routine benefit changes are made to enhance coverage, as is typical, it is not clear whether such changes would terminate the plan's grandfathered status.

More generally, if health care reform is also about increasing choices for individuals, policy makers should be wary of approaches to reform that rely on “grandfathering” in order to protect an individual's access to affordable choices.

### **Illustrating the Sensitivity of Results to Assumptions & Variations**

As discussed above, premium impact estimates on the proposed market reforms are highly sensitive to assumptions over compliance with the individual coverage requirement and the likelihood of adverse selection. In addition, while nationwide estimates are helpful, as CBO indicates, many individuals and families would experience changes in premiums that differ from the changes in average premiums.

To put these effects into perspective, the table below provides the results for several illustrative scenarios using an actuarial model developed by the HayGroup. The scenarios highlight two critical points: First, the results in any given scenario vary considerably between the vast majority of states that currently allow medical underwriting and states that currently require that coverage be provided on a guarantee issue basis. Five states (NY, NJ, VT, MA, ME) require that health plans offer all individual policies on a guarantee issue basis. The scenarios assume that the guarantee issue states represent roughly 15 percent of the current market. Second, as discussed above, the effectiveness of the personal coverage requirement has a dramatic impact on premiums.

Moving from a “medium” mandate assumption to a “low” mandate assumption more than doubles the impact on premiums. Because the CBO letter assumes only a “limited amount” of adverse selection would occur in the nongroup market, for illustrative purposes the scenarios below show the impact on premiums assuming no adverse selection, and an alternative assumption that allows for such selection. For a given mandate compliance rate, allowing for adverse selection produces premium increases that are roughly twice those produced under an assumption of no adverse selection.

	<i>(With a Benefit Buy-Up)</i>	<b>States that Allow Underwriting</b>	<b>Guaranteed-Issue States</b>	<b>National Average</b>
<b>"Low" Mandate Compliance Rates</b>				
	Standard Adverse-Selection Assumptions	71%	-10%	59%
	Assuming No Adverse Selection	44%	-14%	36%
<b>"Medium" Mandate Compliance Rates</b>				
	Standard Adverse-Selection Assumptions	43%	-20%	33%
	Assuming No Adverse Selection	24%	-23%	17%
<b>"High" Mandate Compliance Rates</b>				
	Standard Adverse-Selection Assumptions	26%	-29%	17%
	Assuming No Adverse Selection	12%	-32%	6%

“States that allow underwriting” represent approximately 85% of the current market, while “guaranteed-issue states” represent approximately 15% of the market.

### **Changes to Improve the Workability of Reform**

As indicated, we believe the new CBO report provides an opportunity for policymakers to consider the measures that must be put in place to make health care reform more likely to succeed. These measures include the following:

1. A system-wide approach to cost containment that reduces the rate of growth in underlying health care spending, and that guarantees reductions in growth by locking in the commitments of all key stakeholders.
2. Greater attention to the need for effective measures that limit the risks of adverse selection and ensure everybody is covered in the system.
3. Adequate flexibility to ensure coverage can be appropriately priced to bring young and healthy individuals into the system which will reduce premiums for everyone.
4. An alternative to premium taxes and other new fees that serve only to increase rather than reduce the cost of coverage.
5. Transition plans and early reform initiatives that are operationally feasible and do not disrupt or increase costs for those with existing coverage, or create duplicative regulatory regimes that add to administrative costs and create confusion.