



CONGRESSIONAL BUDGET OFFICE  
U.S. Congress  
Washington, DC 20515

*Douglas W. Elmendorf, Director*

November 30, 2009

Honorable Evan Bayh  
United States Senate  
Washington, DC 20510

Dear Senator:

The attachment to this letter responds to your request—and the interest expressed by many other Members—for an analysis of how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Specifically, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation have analyzed how health insurance premiums might be affected by enactment of the Patient Protection and Affordable Care Act, as proposed by Senator Reid on November 18, 2009.

I hope this information is helpful to you. If you have any further questions, please contact me or the CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

A handwritten signature in black ink that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf

Attachment

cc: Honorable Harry Reid  
Majority Leader

Honorable Mitch McConnell  
Republican Leader

## **An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act**

November 30, 2009

There is great interest in how proposals being considered by the Congress to change the health care and health insurance systems would affect premiums paid for health insurance in various markets. Consequently, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have analyzed how those premiums might be affected by the Patient Protection and Affordable Care Act, an amendment in the nature of a substitute to H.R. 3590, as proposed by Senator Reid on November 18, 2009. The analysis looks separately at the effects on premiums for coverage purchased individually, coverage purchased by small employers, and coverage provided by large employers.

### **Key Elements of the Proposed Legislation**

The proposal includes many provisions that would affect insurance premiums:

- New policies purchased from insurers individually (in the “nongroup” market) or purchased by small employers would have to meet several new requirements starting in 2014. Policies would have to cover a specified set of services and to have an “actuarial value” of at least 60 percent (meaning that the plan would, on average, pay that share of the costs of providing covered services to a representative set of enrollees). In addition, insurers would have to accept all applicants during an annual open-enrollment period, and insurers could not limit coverage for preexisting medical conditions. Moreover, premiums could not vary to reflect differences in enrollees’ health or use of services and could vary on the basis of an enrollee’s age only to a limited degree.
- A less extensive set of changes would be implemented more quickly and would continue in effect after 2013. Among other changes, health insurance plans: could not impose lifetime limits on the total amount of services covered; could rescind coverage only for certain reasons; would have to cover certain preventive services with no cost sharing; and would have to allow unmarried dependents to be covered under their parents’ policies up to age 26. Those changes would also apply to new coverage provided by large employers, including firms that “self-insure”—meaning that the firm, rather than an insurer, bears the financial risk of providing coverage.

However, current policies that had been purchased in any of those markets or that were offered by self-insured firms would be exempt from all of those changes if they were maintained continuously—that is, policies held since the date of enactment of the legislation would be “grandfathered.”

In addition, the proposal would: establish a mandate for most legal residents of the United States to obtain health insurance; set up insurance “exchanges” through which certain individuals and families could receive federal subsidies to substantially reduce the amount they would pay to purchase that coverage; make a public insurance plan available through those exchanges in certain states; penalize certain individuals if they did not obtain insurance coverage and penalize certain employers if their workers received subsidies through the exchanges; provide tax credits to certain small employers that offer coverage to their workers; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare’s payment rates for most services (relative to the growth rates projected under current law); levy an excise tax on insurance plans with relatively high premiums; impose fees on insurers and on manufacturers and importers of certain drugs and medical devices; and make various other changes to the federal tax code and to Medicare, Medicaid, and other federal programs. Each of those components of the legislation has the potential to affect the premiums that are charged for insurance, directly or indirectly; some would increase premiums, and others would decrease them.

## **Overview of the Analysis**

In general, the premium for a health insurance policy equals the average amount that an insurer expects to pay for services covered under the plan plus a loading factor that reflects the insurer’s administrative expenses and overhead (including any taxes or fees paid to the government) and profits (for private plans). An insurer’s costs for covered services reflect the scope of benefits that are covered, the plan’s cost-sharing requirements, the enrollees’ health status and tendency to use medical services, the rates at which providers are paid, and the degree of benefit management the insurer uses to restrain spending. Although the factors affecting premiums are complex and interrelated—and thus can be difficult to disentangle—this analysis groups the effects of the proposal on premiums into three broad categories:

- Differences in the amount of insurance coverage purchased,
- Differences in the price of a given amount of insurance coverage for a given group of enrollees, and
- Differences in the types of people who obtain coverage in each insurance market.

CBO and JCT estimated the effect of the legislation on premiums in three broad insurance markets—nongroup, small group, and large group—as well as the

contributions to the changes in premiums from each of those three sources of change. Several aspects of the analysis bear emphasis:

- The analysis focuses on the effects of the legislation on the average premium *per person*—that is, per covered life, including dependents covered by family policies. That approach provides an integrated measure of the impact on premiums for single coverage and family coverage, and those effects are expressed as percentage changes in average premiums. The analysis also summarizes the effects of the proposal on the dollar cost of the average premium *per policy* (rather than per insured person) and presents those effects separately for individual and family policies in each market.<sup>1</sup>
- Many individuals and families would experience changes in premiums that differed from the changes in average premiums in their insurance market.<sup>2</sup> As explained below, some provisions of the legislation would tend to decrease or increase the premiums paid by all insurance enrollees, while other provisions would tend to increase the premiums paid by healthier enrollees relative to those paid by less healthy enrollees or would tend to increase the premiums paid by younger enrollees relative to those paid by older enrollees. As a result, some individuals and families within each market would see changes in premiums that would be larger or smaller than, or be in the opposite direction of, the estimated average changes.
- The analysis examines the effects of the proposal in 2016 in order to indicate the impact that it would have once its provisions were fully implemented. To focus on permanent elements of the legislation, however, the estimates exclude the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only (which would be funded by an assessment on insurers).
- The analysis focuses on the effects of the legislation on total health insurance premiums that would be charged to individuals or employers before accounting for premium subsidies or the small business tax credit. The analysis also reports the effects of the legislation on the amounts the purchasers would ultimately have to pay, after accounting for those two forms of assistance. However, even when examining unsubsidized

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<sup>1</sup> In some cases, the translation from premiums per person to premiums per policy is complex. To the extent that proposals change the average number of enrollees in a family policy, the premium per person in family coverage could increase even as the premium per policy decreased (for example, if fewer children were covered); conversely, the average premium per person could decrease even as the premium per policy increased (for example, if more children were covered).

<sup>2</sup> Consistent with CBO and JCT's earlier estimate of the coverage and budgetary effects of the insurance coverage provisions in this proposal, this analysis addresses coverage of the nonelderly resident population.

premiums, the analysis incorporates the effects of those subsidies (as well as existing tax preferences) on the number and types of people who would obtain coverage in each market, because those effects would have an important impact on the total premiums charged.

- The analysis does not incorporate potential effects of the proposal on the level or growth rate of spending for health care that might stem from increased demand for services brought about by the insurance expansion or from the development and dissemination of less costly ways to deliver care that would be encouraged by the proposal. The impact of such “spillover” effects on health care spending and health insurance premiums is difficult to quantify precisely, but the effect on premiums in 2016 would probably be small.

This analysis contains several sections. The next section summarizes the findings. The following three sections describe the estimated effects of the legislation on total premiums paid to insurers through its effects on the amount of insurance coverage obtained, the price of a given amount of insurance coverage for a given group of enrollees, and the type of people who obtain coverage. A subsequent section analyzes the effect of the proposal on the net cost of obtaining insurance, taking into account both the subsidies that would be available to individuals for insurance purchased through the exchanges and the tax credits that would be provided to small businesses. The penultimate section discusses the effects of the excise tax on insurance policies with relatively high premiums (the effects of which are accounted for separately because they would apply only to a portion of the market for employment-based insurance in 2016). A final section briefly discusses some potential effects of the proposal that are not included in the quantitative analysis.

## **Summary of Findings**

The effects of the proposal on premiums would differ across insurance markets (see Table 1). The largest effects would be seen in the nongroup market, which would grow in size under the proposal but would still account for only 17 percent of the overall insurance market in 2016. The effects on premiums would be much smaller in the small group and large group markets, which would make up 13 percent and 70 percent of the total insurance market, respectively.

### **Nongroup Policies**

CBO and JCT estimate that the average premium per person covered (including dependents) for new nongroup policies would be about 10 percent to 13 percent higher in 2016 than the average premium for nongroup coverage in that same year under current law. About half of those enrollees would receive government subsidies that would reduce their costs well below the premiums that would be charged for such policies under current law.

Table 1.

## Effect of Senate Proposal on Average Premiums for Health Insurance in 2016

	Percentage, by Market		
	Nongroup <sup>a</sup>	Small Group <sup>b</sup>	Large Group <sup>c</sup>
Distribution of Nonelderly Population Insured in These Markets Under Proposal	17	13	70
<i>Differences in Average Premiums Relative to Current Law</i>			
<i>Due to:</i>			
Difference in Amount of Insurance Coverage	+27 to +30	0 to +3	Negligible
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	-7 to -10	-1 to -4	Negligible
Difference in Types of People with Insurance Coverage	-7 to -10	-1 to +2	0 to -3
Total Difference Before Accounting for Subsidies	+10 to +13	+1 to -2	0 to -3
<i>Effect of Subsidies in Nongroup and Small Group Markets</i>			
Share of People Receiving Subsidies <sup>d</sup>	57	12	n.a.
For People Receiving Subsidies, Difference in Average Premiums Paid After Accounting for Subsidies	-56 to -59	-8 to -11	n.a.
<i>Effect of Excise Tax on High-Premium Plans Sponsored by Employers</i>			
Share of People Who Would Have High-Premium Plans Under Current Law	n.a.	19	
For People Who Would Have High-Premium Plans Under Current Law, Difference in Average Premiums Paid <sup>e</sup>	n.a.	-9 to -12	
<b>Memorandum</b>			
Number of People Covered Under Proposal (Millions)	32	25	134

Source: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: n.a. = not applicable.

- The nongroup market includes people purchasing coverage individually either in the proposed insurance exchanges or in the individual insurance market outside the insurance exchanges.
- The small group market includes people covered in plans sponsored by firms with 50 or fewer employees.
- The large group market includes people covered in plans sponsored by firms with more than 50 employees.
- Premium subsidies in the nongroup market are those available through the exchanges. Premium subsidies in the small group market are those stemming from the small business tax credit.
- The effect of the tax includes both the increase in premiums for policies with premiums remaining above the excise tax threshold and the reduction in premiums for those choosing plans with lower premiums.

That difference in unsubsidized premiums is the net effect of three changes:

- Average premiums would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained. In particular, the average insurance policy in this market would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits. Those expansions would reflect both the minimum level of coverage (and related requirements) specified in the proposal and people's decisions to purchase more extensive coverage in response to the structure of subsidies.
- Average premiums would be 7 percent to 10 percent lower because of a net reduction in costs that insurers incurred to deliver the same amount of insurance coverage to the same group of enrollees. Most of that net reduction would stem from the changes in the rules governing the nongroup market.
- Average premiums would be 7 percent to 10 percent lower because of a shift in the types of people obtaining coverage. Most of that change would stem from an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed.<sup>3</sup>

Average premiums per policy in the nongroup market in 2016 would be roughly \$5,800 for single policies and \$15,200 for family policies under the proposal, compared with roughly \$5,500 for single policies and \$13,100 for family policies under current law.<sup>4</sup> The weighted average of the differences in those amounts equals the change of 10 percent to 13 percent in the average premium *per person* summarized above, but the percentage increase in the average premium *per policy* for family policies is larger and that for single policies is smaller because the average number of people covered per family policy is estimated to increase under the proposal. The effects on the premiums paid by some individuals and families could vary significantly from the average effects on premiums.

Those figures indicate what enrollees would pay, on average, not accounting for the new federal subsidies. The majority of nongroup enrollees (about 57 percent) would receive subsidies via the new insurance exchanges, and those subsidies, on average, would cover nearly two-thirds of the total premium, CBO and JCT

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<sup>3</sup> Although the effects of each factor should be multiplied rather than added in order to generate the total effect on premiums, there are also interactions among the three factors that make the sum of the individual effects roughly equal to the total effect. The ranges shown for the likely effects of each factor and for the likely overall effect on premiums were chosen to reflect the uncertainties involved in the estimates; however, the actual effects could fall outside of those ranges.

<sup>4</sup> Because of an error, the figures for average nongroup premiums in 2016 under current law that were reported in CBO's September 22, 2009, letter to Senator Baucus on this subject (which had been reported as being about \$6,000 for single coverage and about \$11,000 for family coverage) were not correct.

estimate. Thus, the amount that subsidized enrollees would pay for nongroup coverage would be roughly 56 percent to 59 percent lower, on average, than the nongroup premiums charged under current law. Among nongroup enrollees who would *not* receive new subsidies, average premiums would increase by somewhat less than the 10 percent to 13 percent difference for the nongroup market as a whole because some factors discussed below would have different effects for those enrollees than for those receiving subsidies.

The amount of subsidy received would depend on the enrollee's income relative to the federal poverty level (FPL) according to a specified schedule (see Table 2, appended).<sup>5</sup> Under the proposal, the subsidy levels in each market would be tied to the premium of the second cheapest plan providing the "silver" level of coverage (that is, paying 70 percent of enrollees' covered health care costs, on average). CBO and JCT have estimated that, in 2016, the average premium nationwide for those "reference plans" would be about \$5,200 for single coverage and about \$14,100 for family coverage. The difference between those figures and the average nongroup premiums under the proposal that are cited above (\$5,800 and \$15,200, respectively) reflects the expectation that many people would opt for a plan that was more expensive than the reference plan, to obtain either a higher amount of coverage or other valued features (such as a broader network of providers or less tightly managed benefits).

### **Employment-Based Coverage**

The legislation would have much smaller effects on premiums for employment-based coverage, which would account for about five-sixths of the total health insurance market. In the small group market, which is defined in this analysis as consisting of employers with 50 or fewer workers, CBO and JCT estimate that the change in the average premium per person resulting from the legislation could range from an increase of 1 percent to a reduction of 2 percent in 2016 (relative to current law).<sup>6</sup> In the large group market, which is defined here as consisting of employers with more than 50 workers, the legislation would yield an average premium per person that is zero to 3 percent lower in 2016 (relative to current law). Those overall effects reflect the net impact of many relatively small changes, some of which would tend to increase premiums and some of which would tend to reduce them (as shown in Table 1).<sup>7</sup>

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<sup>5</sup> Table 2 reproduces the table included in Congressional Budget Office, [letter to the Honorable Harry Reid providing an analysis of subsidies and payments at different income levels under the Patient Protection and Affordable Care Act](#) (November 20, 2009).

<sup>6</sup> Under the proposal, the small group market in 2016 would be defined to include firms with 100 or fewer employees, but the threshold for the exemption from the penalties imposed on employers would be set at 50 full-time employees. Because the proposal would have similar effects on premiums for large and small employers, reclassifying firms with 51 to 100 workers as small employers for purposes of this analysis would probably have little effect on the overall results, though the factors affecting premiums for those firms would be somewhat different.

<sup>7</sup> Because the aggregate amount of premiums for employment-based plans is large, even small percentage changes can have noticeable effects on the federal budget through their effects on the amount of compensation excluded from taxation because of the tax preference that applies to those premiums.

By CBO and JCT's estimate, the average premium per policy in the small group market would be in the vicinity of \$7,800 for single policies and \$19,200 for family policies under the proposal, compared with about \$7,800 and \$19,300 under current law. In the large group market, average premiums would be roughly \$7,300 for single policies and \$20,100 for family policies under the proposal, compared with about \$7,400 and \$20,300 under current law.<sup>8</sup> As in the nongroup market, the effects on the premiums paid by some people for coverage provided through their employer could vary significantly from the average effects on premiums, particularly in the small group market.

Those figures do not include the effects of the small business tax credit on the cost of purchasing insurance. A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016. For those people, the cost of insurance under the proposal would be about 8 percent to 11 percent lower, on average, compared with that cost under current law.

The reductions in premiums described above also exclude the effects of the excise tax on high-premium insurance policies offered through employers, which would have a significant impact on premiums for the affected workers but which would affect only a portion of the market in 2016.<sup>9</sup> Specifically, an estimated 19 percent of workers with employment-based coverage would be affected by the excise tax in that year. Those individuals who kept their high-premium policies would pay a higher premium than under current law, with the difference in premiums roughly equal to the amount of the tax. However, CBO and JCT estimate that most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums; those reductions would result from choosing plans that either pay a smaller share of covered health care costs (which would reduce premiums directly as well as indirectly by leading to less use of covered medical services), manage benefits more tightly, or cover fewer services.<sup>10</sup> On balance, the average premium among the affected workers would be about 9 percent to 12 percent less than under current law. Those figures incorporate the other effects on premiums for employment-based plans that were summarized above.

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<sup>8</sup> Those calculations also reflect an expectation that a large share of enrollees in employment-based plans would be in grandfathered plans throughout the 2010–2019 period.

<sup>9</sup> Beginning in 2013, insurance policies with relatively high premiums would be subject to a 40 percent excise tax on the amount by which the premiums exceeded a specified threshold. That threshold would be set initially at \$8,500 for single policies and \$23,000 for family policies (with certain exceptions); after 2013, those amounts would be indexed to overall inflation plus 1 percentage point.

<sup>10</sup> CBO and JCT assume that, if employers reduce the amount of compensation they provide in the form of health insurance (relative to current-law projections), offsetting changes will occur in other forms of compensation, which are generally taxable.

### **Uncertainty Surrounding These Estimates**

The analysis presented here reflects the cost estimate for the legislation that CBO and JCT provided on November 18. The same substantial degree of uncertainty that surrounds CBO and JCT's estimates of the impact that the proposal would have on insurance coverage rates and the federal budget also accompanies this analysis of the proposal's effects on premiums. Some components of those effects are relatively straightforward to estimate, such as the effect of imposing specific fees or the effect of a change in the amount of coverage purchased because of requirements for minimum coverage; however, estimating effects that depend heavily on how enrollees, insurers, employers, or other key actors would respond—to such things as the changes in the market rules for nongroup policies or the excise tax on high-premium policies—involve greater uncertainty. The projections of average premiums in each market under current law are also uncertain.

### **Differences in the Amount of Coverage Purchased**

One key factor contributing to the differences in average insurance premiums under the proposal is differences in the average amount of coverage purchased. Those differences reflect differences in both the *scope* of insurance coverage—the benefits or services that are included—and in the *share of costs* for covered services paid by the insurer—known as the actuarial value. With other factors held equal, insurance policies that cover more benefits or services or have a higher actuarial value (by requiring smaller copayments or deductibles) have higher premiums, while policies that cover fewer benefits or services or specify larger copayments or deductibles have lower premiums.

The main elements of the legislation that would affect the amount of coverage purchased are the requirement that all new policies in the nongroup and small group markets cover at least a minimum specified set of benefits; the requirement that such policies have a certain minimum actuarial value; and the design of the federal subsidies, which would encourage many enrollees in the exchanges to join plans with an actuarial value above the required minimum. (The excise tax on high-premium plans would also affect the amount of coverage purchased; the impact of that tax is discussed in a separate section of this analysis.) Those provisions would have a much greater effect on premiums in the nongroup market than in the small group market, and they would have no measurable effect on premiums in the large group market.

Specifically, because of the greater actuarial value and broader scope of benefits that would be covered by new nongroup policies sold under the legislation, the average premium per person for those policies would be an estimated 27 percent to 30 percent higher than the average premium for nongroup policies under current law (with other factors held constant). The increase in actuarial value would push the average premium per person about 18 percent to 21 percent above its level under current law, before the increase in enrollees' use of medical care resulting from lower cost sharing is considered; that induced increase, along with

the greater scope of benefits, would account for the remainder of the overall difference.

In the small group market, the greater actuarial value and broader scope of benefits provided for in the legislation would increase the average premium per person by about zero to 3 percent (leaving aside the effect of the excise tax on high premium plans, which is discussed separately, and holding other factors constant). Those requirements would have no noticeable effect on premiums in the large group market (again, excluding the effect of the high-premium excise tax).

### **A Broader Scope of Benefits Would Increase Nongroup Premiums**

Under the legislation, new nongroup policies would cover a broader scope of benefits than are projected to be covered by such policies, on average, under current law. In particular, the legislation would require all new nongroup policies to cover a specified set of “essential health benefits,” which would be further delineated by the Secretary of Health and Human Services (HHS) and would be required to match the scope of benefits provided by typical employment-based plans. As a result, new nongroup policies would cover certain services that are often not covered by nongroup policies under current law, such as maternity care, prescription drugs, and mental health and substance abuse treatment. Moreover, nongroup insurers would be prohibited from denying coverage for preexisting conditions, so premiums would have to increase to cover the resulting costs.

An additional consideration relates to state-mandated benefits. Under the proposal, states that mandated coverage of benefits beyond those required by the new federal rules would have to pay any costs of subsidizing those additional benefits. CBO and JCT assumed that, to the extent that states continued to mandate such benefits, they would make the resulting payments directly to insurers—so those costs would not be reflected in the premiums that enrollees observed when shopping for insurance in the exchanges. The reduction in premiums (relative to those under current law) resulting from this provision would be relatively small because many benefits that states mandate are already provided by typical employment-based plans and thus would be included in the “essential health benefits” that the proposal would require nongroup policies to cover.<sup>11</sup>

The legislation would further require that policies sold in the small group market cover the same minimum set of benefits as those sold in the nongroup market. That requirement would have relatively little effect on premiums in the small group market, however, because most policies sold in that market already cover those services and would continue to cover them under current law. Further, small group policies that are maintained continuously would be grandfathered under the proposal.

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<sup>11</sup> For an additional discussion of the average incremental cost of state-mandated benefits, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), p. 61.

### **A Greater Actuarial Value Would Increase Nongroup Premiums**

Under the legislation, new nongroup policies purchased after 2013 would have a substantially greater actuarial value, on average, than nongroup policies purchased under current law. Policies sold in the nongroup market are expected to have an average actuarial value of about 60 percent under current law, and new nongroup policies would be required to have an actuarial value of at least 60 percent (the level specified for the “bronze” plan) under the proposal. However, federal premium subsidies would be tied to a “reference premium” equal to the premium of the second lowest cost “silver” plan, which would have an actuarial value of 70 percent, and plans would also be available with actuarial values of 80 percent (“gold” plan) and 90 percent (“platinum” plan).<sup>12</sup>

People who received premium subsidies would be able to buy a plan whose premium exceeded the reference premium, although they would have to pay the entire additional cost of that more expensive plan. With the expected enrollment choices of people with subsidies and people without subsidies taken into account, the average actuarial value of nongroup policies purchased is estimated to be roughly 72 percent. The increases in actuarial value relative to that under current law would increase the premiums for those policies, because the policies would cover a greater proportion of their enrollees’ spending on medical care. Of course, the increases in actuarial value would also reduce enrollees’ expected out-of-pocket spending on copayments and deductibles, particularly for enrollees who used more medical services than average. The reduced cost sharing would lead to greater use of medical services, which would tend to push premiums up further.<sup>13</sup>

Among nongroup enrollees who would not receive new subsidies, the average actuarial value of their coverage would not differ as sharply from the average for the nongroup market under current law. Some would choose to enroll in a “young invincibles” plan to be offered under the proposal; that plan would have relatively high deductibles and a relatively low actuarial value (estimated to be less than 50 percent), and the premium would be correspondingly low. (That plan would generally not be attractive to individuals who could receive premium subsidies for more extensive coverage.) Moreover, if they wanted to, current policyholders in the nongroup market would be allowed to keep their policy with no changes, and the premiums for those policies would probably not differ substantially from current-law levels. But because of relatively high turnover in that market (as well as the incentives for many enrollees to purchase a new policy in order to obtain

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<sup>12</sup> Enrollees with income below 200 percent of the FPL would receive subsidies for cost sharing to increase the overall actuarial value of their coverage to either 80 percent or 90 percent. However, the plan in which they enrolled would have a premium that reflects an actuarial value of 70 percent, and that premium was used in the calculation of the average premium under the proposal.

<sup>13</sup> The increase in spending for health care that would arise when uninsured people gained coverage is accounted for separately; see the discussion below. For a discussion of the impact that cost sharing has on spending for health care and related considerations, see Congressional Budget Office, *Key Issues*, pp. 61–62, 71–76, and 110–112.

subsidies), CBO and JCT estimate that relatively few nongroup policies would remain grandfathered by 2016.

### **Effects on Premiums for Employment-Based Plans Would be Much Smaller**

The legislation would impose the same minimum actuarial value for new policies in the small group market as in the nongroup market. That requirement would have a much smaller effect on premiums in the small group market, however, because the great majority of policies sold in that market under current law have an actuarial value of more than 60 percent. Essentially all large group plans have an actuarial value above 60 percent, so the effect on premiums in that market would be negligible. In sum, the greater actuarial value and broader scope of benefits in the legislation would increase the average premium per person in the small group market by about zero to 3 percent (with other factors held constant). Those requirements would have no significant effect on premiums in the large group market.

## **Differences in the Price of a Given Amount of Coverage for a Given Population**

A second broad category of differences in premiums encompasses factors that reflect an “apples-to-apples” comparison of the average price of providing equivalent insurance coverage for an equivalent population under the legislation and under current law.<sup>14</sup> The main provisions of the legislation that fall into this category are the new rules for the insurance market, including the establishment of exchanges and availability of a public plan through those exchanges, which would reduce insurers’ administrative costs and increase slightly the degree of competition among insurers, and several new fees that would be imposed on the health sector, which would tend to raise insurance premiums.<sup>15</sup>

Some observers have argued that private insurance premiums would also be affected by changes in the extent of “cost shifting”—a process in which lower rates paid to providers for some patients (such as uninsured people or enrollees in government insurance programs) lead to higher payments for others (such as privately insured individuals). However, the effect of the proposal on premiums through changes in cost shifting seems likely to be quite small because the proposal has opposing effects on different potential sources of cost shifting, and

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<sup>14</sup> In this description, “equivalent coverage” means policies that have the same scope of benefits and cost-sharing requirements. The benefits received by enrollees in plans with equivalent coverage also depend on factors such as the benefit management being used and the size and composition of the provider network.

<sup>15</sup> The effect of the excise tax on health insurance plans with relatively high premiums is discussed separately, below. Also, to focus on permanent elements of the legislation, this analysis does not include the effect of the reinsurance that would be provided for new nongroup plans between 2014 and 2016 only. Those payments would be financed by a fee levied on all private insurers, so the effects would differ by market but the overall impact on premiums would be modest.

the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance.

CBO and JCT estimate that the elements of the legislation that would change the price of providing a given amount of coverage for a given population would, on net, reduce the average premium per person for nongroup coverage in 2016 by about 7 percent to 10 percent relative to the amount under current law. Those elements of the legislation would reduce the average premium per person in the small group market by about 1 percent to 4 percent and would not have a measurable impact on premiums in the large group market.

### **New Market Rules Would Reduce Administrative Costs**

Compared with plans that would be available in the nongroup market under current law, nongroup policies under the proposal would have lower administrative costs, largely because of the new market rules:<sup>16</sup>

- The influx of new enrollees in response to the individual mandate and new subsidies—combined with the creation of new insurance exchanges—would create larger purchasing pools that would achieve some economies of scale.
- Administrative costs would be reduced by provisions that require some standardization of benefits—for example, by limiting variation in the types of policies that could be offered and prohibiting “riders” to insurance policies (which are amendments to a policy’s terms, such as coverage exclusions for preexisting conditions); insurers incur administrative costs to implement those exclusions.
- Administrative costs would be reduced slightly by the general prohibition on medical underwriting, which is the practice of varying premiums or coverage terms to reflect the applicant’s health status; nongroup insurers incur some administrative costs to implement underwriting.
- Partly offsetting those reductions in administrative costs would be a surcharge that exchange plans would have to pay under the proposal to cover the operating costs of the exchanges.

In the small group market, some employers would purchase coverage for their workers through the exchanges.<sup>17</sup> Such policies would have lower administrative costs, on average, than the policies those firms would buy under current law,

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<sup>16</sup> Those market rules would also affect premiums by changing the scope of coverage provided and the types of people who obtain coverage, as discussed in other sections.

<sup>17</sup> In 2016, states would have to give all employers with 100 or fewer employees the option to purchase coverage through the exchanges. States could give larger employers that option starting in 2017. However, CBO and JCT expect that few large firms would take that option if offered because their administrative costs would generally be lower than those of nongroup policies that would be available in the exchanges.

particularly for very small firms.<sup>18</sup> The primary sources of administrative cost savings for small employers would be the economies of scale and relative standardization of benefits in the exchanges noted above; currently, the use of exclusions for preexisting conditions is rare in the small group market, so the rules affecting coverage of those conditions would have only a small effect on administrative costs in that market.

In addition, the administrative simplification provisions of the legislation would require the Secretary of HHS to adopt and regularly update standards for electronic administrative transactions such as electronic funds transfers, claims management processes, and eligibility verification. In CBO and JCT's estimation, those provisions would reduce administrative costs for insurers and providers, which would result in a modest reduction in premiums in all three broad insurance markets.

### **Increased Competition Would Slightly Reduce Premiums in the Nongroup Market**

The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees. In particular, insurers probably would adopt slightly stronger benefit management procedures to restrain spending or would slightly reduce the rates they pay providers. Those small employers that purchased coverage through the exchanges would see similar reductions in premiums because of the increased competition among plans.

One other feature of the proposal would also put a modicum of downward pressure on average premiums in the exchanges—namely, the provisions allowing exchange administrators to act as “prudent purchasers” when reviewing and approving the proposed premiums of potential insurers.<sup>19</sup> Although the administrators' authority would be limited, evidence from the implementation of an exchange system in Massachusetts suggests that the existence of such authority would tend to reduce premiums slightly.

CBO and JCT's analysis of exchange premiums has also taken into account the availability of a public plan through those exchanges in some states. Premiums for the public plan as structured under the proposal would typically be somewhat

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<sup>18</sup> Among small employers, administrative costs decline as a share of premiums as the size of the firm increases. Thus, the smallest employers would be most likely to see lower administrative costs for policies in the exchanges than what they would be charged under current law.

<sup>19</sup> Specifically, the legislation would require insurers seeking to participate in the exchanges to submit a justification for any premium increase prior to implementing it; the legislation also would give exchanges the authority to take that information into consideration when determining whether to make a plan available through the exchanges.

higher than the average premiums of private plans offered in the exchanges.<sup>20</sup> By itself, that development would tend to increase average premiums in the exchanges—but a public plan would probably tend to reduce slightly the premiums of the private plans against which it is competing, for two reasons:

- A public plan as structured in the proposal would probably attract a substantial number of enrollees, in part because it would include a broad network of providers and would be likely to engage in only limited management of its health care benefits. (CBO and JCT estimate that total enrollment in the public plan would be about 3 million to 4 million in 2016.) As a result, it would add some competitive pressure in the exchanges in areas that are currently served by a limited number of private insurers, thereby lowering private premiums to a small degree.
- A public plan is also apt to attract enrollees who are less healthy than average (again, because it would include a broad network of providers and would probably engage in limited management of benefits). Although the payments that all plans in the exchanges receive would be adjusted to account for differences in the health of their enrollees, the methods used to make such adjustments are imperfect. As a result, the higher costs of those less healthy enrollees in the public plan would probably be offset partially but not entirely; the rest of the added costs would have to be reflected in the public plan's premiums. Correspondingly, the costs and premiums of competing private plans would, on average, be slightly lower than if no public plan was available.

Those factors would reduce the premiums of private plans in the exchanges to a small degree, but the effect on the average premium in the exchanges would be offset by the higher premium of the public plan itself. On balance, therefore, the provisions regarding a public plan would not have a substantial effect on the average premiums paid in the exchanges.<sup>21</sup>

### **New Fees Would Increase Premiums Slightly**

The legislation would impose several new fees on firms in the health sector. New fees would be imposed on providers of health insurance and on manufacturers and importers of medical devices. Both of those fees would be largely passed through

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<sup>20</sup> Under the proposal, the public plan would negotiate payment rates with providers. CBO and JCT anticipate that those rates would be similar to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than private plans, on average, but would probably engage in less benefit management and attract a less healthy pool of enrollees (the effects of which would be offset only partially by the risk adjustment procedures that would apply to all plans operating in the exchanges). On net, those factors would result in the public plan's premiums being somewhat higher than the average premiums of private plans in the exchanges.

<sup>21</sup> The presence of the public plan would have a more noticeable effect on federal subsidies because it would exert some downward pressure on the premiums of the lower-cost plans to which those subsidies are tied.

to consumers in the form of higher premiums for private coverage. Self-insured plans would be mostly exempt from the fee on health insurance providers, and since large firms are more likely to self-insure, that fee would result in smaller percentage increases in average premiums for large firms than it would for small firms and for nongroup coverage.<sup>22</sup>

The legislation also would impose a fee on manufacturers and importers of brand-name prescription drugs, which would be allocated among firms on the basis of drug sales to government programs. Because that fee would not impose an additional cost for drugs sold in the private market, CBO and JCT estimate that it would not result in measurably higher premiums for private coverage. (The legislation would also impose an excise tax on high-premium insurance policies provided by employers; that tax is discussed separately below because it would affect only a portion of the insurance market.)

### **Effects Related to Cost Shifting Would Be Minimal**

Some observers have predicted that the proposal (and similar initiatives) would affect premiums for private insurance plans by changing the extent of cost shifting. The legislation would have opposing effects on the pressures for cost shifting:

- On the one hand, the legislation would reduce payments to hospitals and certain other providers under Medicare.<sup>23</sup> In addition, it would significantly increase enrollment in Medicaid, which pays providers appreciably lower rates than private insurers do. Those changes could cause premiums for private coverage to increase.
- On the other hand, the legislation would ultimately reduce the uninsured population by more than half, which would sharply reduce the amount of uncompensated or undercompensated care provided to people who lack health insurance. One recent estimate indicates that hospitals provided about \$35 billion in such care in 2008—an amount that would grow under current law but would be expected to decline considerably under the legislation.<sup>24</sup> That change could cause premiums for private coverage to decrease.

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<sup>22</sup> The fee would be levied on third-party administrators of self-insured plans in proportion to twice their administrative spending, which is substantially less than the total premiums that would be the base for the levy on plans purchased from insurers. Government health insurance plans such as Medicare and Medicaid would be exempt from that fee, but any public plan offered in the exchanges would be subject to it.

<sup>23</sup> The legislation would reduce Medicare payment updates for most services in the fee-for-service sector (other than physicians' services) and reduce Medicare and Medicaid payments to hospitals that serve large numbers of low-income patients, known as "disproportionate share" (DSH) hospitals.

<sup>24</sup> Recent evidence indicates that physicians collectively provide much smaller amounts of uncompensated or undercompensated care than hospitals. See Jonathan Gruber and David Rodriguez, "How Much Uncompensated care Do Doctors Provide?" *Journal of Health Economics*, vol. 26 (2007), pp. 1151–1169.

The net effect of those opposing pressures would depend on their relative magnitude and also on the degree to which costs are shifted. CBO expects that the magnitude of those opposing pressures would be about the same. Moreover, CBO's assessment of the evidence is that a small amount of cost shifting occurs but that it is not as widespread or extensive as is commonly assumed. The fact that private insurers pay providers higher rates, on average, than Medicare and Medicaid is not evidence that cost shifting occurs. For cost shifting to occur, a *decline* in the rates paid by some payers would have to lead to an *increase* in the rates paid by others; thus, for cost shifting from reductions in rates paid by Medicare to occur, providers would have to have initially been charging private insurers lower rates than they could have. Well-designed studies have found that a relatively small share of the changes in payment rates for government programs is passed on to private payment rates, and the impact of changes in uncompensated care is likely to be similar.<sup>25</sup> Overall, therefore, CBO's assessment is that the legislation would have minimal effects on private-sector premiums via cost shifting.

## **Differences in the Types of People Who Obtain Coverage in Different Insurance Markets**

The third broad factor that would affect average insurance premiums is differences in the types of people who obtain coverage in different insurance markets. If more people who are relatively healthy or relatively disinclined to use medical care participate in a given insurance market, then the average spending on medical services provided in that market will be lower, and the average premium in that market will be lower, with other factors held equal; conversely, if more people who are relatively unhealthy or are relatively inclined to use medical care participate in a given insurance market, the average spending on medical services and the average premium for that market will be higher, all else equal. Thus, a shift of less healthy people from one insurance market to another will tend to lower premiums in the "source" market and raise them in the "destination" market. Likewise, the number and types of people who would be uninsured under current law but would become insured under the proposal—and the effects of gaining coverage on their use of health care—would affect the average premiums charged in the markets in which they buy insurance.

Overall, CBO and JCT estimate that an influx of new enrollees into the nongroup market would yield an average premium per person in that market that is 7 percent to 10 percent lower than the average premium projected under current law. Changes in the types of people covered in the small group and large group markets would have much smaller effects on premiums, yielding a change in the small group market that could range from a decrease of 1 percent to an increase of 2 percent, and a decrease in the large group market of zero to 3 percent.

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<sup>25</sup> For a more extensive discussion of cost shifting, see Congressional Budget Office, *Key Issues*, pp. 112–116.

### **Key Characteristics of the Insured and Uninsured Under Current Law**

To assess the likely medical spending of prospective new enrollees in different insurance markets, it is useful to review some key characteristics of the insured and uninsured populations under current law. CBO and JCT's assessment of those characteristics is based on data from representative surveys of the U.S. population that examine people's health insurance coverage, health status, and use of health care.<sup>26</sup> This discussion addresses the projected distribution of the population in 2016, using as a reference point the 162 million people expected to be covered by employment-based insurance in that year under current law.

About 14 million people are expected to be covered by nongroup policies in 2016 under current law. Enrollees in nongroup coverage would be about 3 years older, on average, than enrollees in employment-based insurance—which would tend to raise their use of medical care—but would be slightly healthier, on average, at any given age—which would tend to lower their use of care. On balance, the average spending on medical care of nongroup enrollees would be somewhat greater than that of enrollees in employment-based insurance if they were enrolled in insurance plans with the same amount and structure of coverage.

By contrast, the 52 million people who are expected to be uninsured under current law in 2016 would be about 2 years younger, on average, than the population covered by employment-based plans and thus would be about 5 years younger than nongroup enrollees, on average. At any given age, the average health of the uninsured population would be somewhat worse than the average health of people with nongroup insurance. A large share of the uninsured population, however, would not be eligible to obtain subsidized coverage via the exchanges; instead, those with income below 133 percent of the FPL would generally be eligible for free coverage through Medicaid. That low-income group is relatively unhealthy, and once they are removed from the comparison, the disparity in health between the remaining uninsured population and current-law enrollees in the nongroup market essentially disappears. Therefore, considering only their age and their health status and holding other factors constant, the expected use of medical care by uninsured people who would be eligible for subsidized coverage in the exchanges would be less than that of current nongroup enrollees.

One other factor that would not be the same—and that would tend to accentuate this projected difference in utilization—is how much medical care the uninsured would use once they did gain coverage: They would tend to consume less medical care than current nongroup enrollees, even after adjusting for their age and health. CBO's review of relevant studies concluded that insuring the currently uninsured under a typical employment-based plan would generate an increase of 25 percent to 60 percent in their average utilization of care. (That average increase in utilization and spending would arise even though some newly insured people

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<sup>26</sup> For additional information on the data sources used and the methodology involved, see Congressional Budget Office, *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

would avoid expensive treatments by getting care sooner, before their illness progressed, or would receive services in a less expensive setting.) Despite that substantial increase in utilization, their use of care would still be below that of people with similar characteristics who are currently insured.<sup>27</sup> That remaining difference in average utilization probably reflects various differences between the insured and uninsured aside from differences in their age and health status, and the effect of obtaining insurance could be much larger for some people and much smaller for others.

### **A Limited Amount of Adverse Selection Would Occur in New Nongroup Plans**

The preceding discussion examined the types of people who would receive coverage in different markets under current law or would be eligible to receive coverage in different markets under the proposal. However, the effects of the proposal on the types of enrollees in each market would depend ultimately on who *chose* to receive coverage in those markets—with the most significant changes coming in the nongroup market.

Under current laws governing the nongroup market, insurers in most states do not have to accept all applicants, may vary premiums widely to reflect differences in enrollees' health status and age, and may exclude coverage of preexisting medical conditions. By themselves, the proposal's provisions changing those rules would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care. Therefore, in the absence of other changes to the insurance market, people who are older and more likely to use medical care would be more likely to enroll in nongroup plans—a phenomenon known as adverse selection. Such selection would tend to increase premiums in the exchanges relative to nongroup premiums under current law.

However, several other provisions of the proposal would tend to mitigate that adverse selection:

- The legislation would establish an annual open enrollment period for new nongroup policies similar to that typically used by employers, which would limit opportunities for people who are healthy to wait until an illness or other health problem arose before enrolling.
- The substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people. For people whose

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<sup>27</sup> CBO estimates that the uninsured currently use about 60 percent as much medical care as insured people, taking into account differences between the groups in their average age and health status. Providing all of the uninsured with health insurance coverage equivalent to a typical employment-based plan would thus be estimated to increase their demand for medical services to a level that is between 75 percent and 95 percent of the level of similar people who are currently insured (corresponding to an increase of 25 percent and 60 percent, respectively). For additional discussion of these estimates, see Congressional Budget Office, *Key Issues*, pp. 71–76.

income was below 200 percent of the FPL, those subsidies would average around 80 percent.

- The requirement that people have insurance would also encourage a broad range of people to take up coverage in the exchanges. CBO and JCT expect that some people would obtain coverage because of the penalties that would be levied for not complying with the mandate (which would be \$750 per adult and \$375 per child in 2016) and that others would obtain coverage simply because of the existence of a mandate; those expectations are based in part on people's compliance with other types of mandates.<sup>28</sup>
- The premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees (though federal subsidy payments would have to rise to make up the difference). That arrangement would dampen the chances that a cycle of rising premiums and declining enrollment would ensue.
- During the 2014–2016 period, as the mandate penalties were being phased in and other provisions were in the initial stages of implementation, the legislation would provide reinsurance payments to insurers that ended up with particularly high-cost enrollees. That reinsurance system (funded by an assessment on all insurers) would also limit the impact of adverse selection on insurance premiums.

On balance, CBO and JCT expect that some adverse selection into nongroup plans would arise, especially among people who received relatively small subsidies. However, the extent of such adverse selection is likely to be limited, and many nongroup enrollees would be in fairly good health.

### **The Characteristics of Enrollees in Nongroup Plans Would Be Substantially Different Than Those Under Current Law**

CBO and JCT estimate that about 32 million people would obtain coverage in the nongroup market in 2016 under the proposal, consisting of about 23 million who would obtain coverage through the insurance exchanges and about 9 million who would obtain coverage outside the exchanges. Relative to the situation under current law, with about 14 million people buying nongroup coverage, the different mix of enrollees would yield average premiums per person in that market that are about 7 percent to 10 percent lower. Some people who would enroll in nongroup coverage under the proposal would be uninsured under current law, some would have employment-based coverage, and some would have nongroup coverage under current law as well. To estimate how the different mix of enrollees in the nongroup market would affect premiums, it is useful to examine enrollment patterns and expected medical costs for each of those three groups.

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<sup>28</sup> For a discussion of compliance with mandates, see Congressional Budget Office, *Key Issues*, pp. 48–54.

First, CBO and JCT estimate that about a third of the nongroup enrollees estimated under the proposal in 2016 would be uninsured under current law. As discussed above, the pool of people who would be eligible for the exchanges and would otherwise be uninsured would be—relative to those who have nongroup coverage under current law—younger, roughly as healthy at any given age, and likely to use less medical care (given their age and health status). At the same time, the adverse selection discussed above means that the members of that pool who would choose to purchase coverage would be less healthy, on average, than all of the members of the pool together, particularly among those who would receive limited subsidies. On balance, CBO and JCT estimate that the enrollees who would be uninsured under current law would use significantly less medical care, on average, than individuals enrolled in nongroup coverage under current law (with other factors held constant).<sup>29</sup>

Second, CBO and JCT estimate that about a fifth of nongroup enrollees under the proposal in 2016 would have employment-based coverage under current law. Most of those people would not have an offer of employment-based coverage under the proposal; others would have such an offer but it would be deemed unaffordable, so they would be eligible to obtain subsidies through the exchanges. On average, those enrollees would be older and in poorer health than nongroup enrollees under current law, because the proposal's changes in the nongroup market would make that market more appealing to those types of people. The inflow of those people into the nongroup market would thus tend to increase average medical spending and average premiums per person in that market to some degree.

Third, CBO and JCT estimate that nearly half of the people enrolling in nongroup coverage under the proposal would have nongroup coverage under current law as well. Holding other factors constant, those enrollees would obviously not change average medical spending or premiums in the nongroup market relative to the levels under current law.

In the comparison of nongroup premiums under the proposal with those under current law, the differences discussed in this section would vary considerably among people. In general, the proposal would tend to increase premiums for people who are young and relatively healthy and decrease premiums for those who are older and relatively unhealthy. However, to fully evaluate the implications of the proposal for different types of people, it is necessary to include the effects of the subsidies that are discussed below.

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<sup>29</sup> People who report that they are in either fair or poor health tend to use much more health care than the average person, and otherwise uninsured people in fair or poor health would be more likely to enroll in nongroup coverage. Even so, they would constitute less than 10 percent of the otherwise uninsured group enrolling in nongroup coverage.

## **The Characteristics of Enrollees in Employment-Based Plans Would Be Slightly Different Under the Proposal**

CBO and JCT estimate that changes in the characteristics of people with insurance in the small group market would yield a change in the average premiums per person in that market that could range from a decrease of 1 percent to an increase of 2 percent. That difference would be the net effect of three principal factors:

- Under the legislation, new insurance policies sold in the small group market would be subject to the same rating rules as policies sold in the nongroup market. In particular, insurers in the small group market could not vary premiums to reflect the health of firms' workers. That change would reduce premiums for small firms whose employees are in relatively poor health—leading some of those firms that would not offer insurance under current law to do so under the proposal—and increase premiums for small firms whose employees are in relatively good health—leading some of those firms who would offer coverage under current law not to do so under the proposal. Consequently, the people covered in the small group market would be in somewhat worse health, on average, under the proposal than under current law, which would tend to increase average premiums in that market.<sup>30</sup>
- The individual mandate included in the proposal would induce some uninsured workers who would decline the coverage offered by their employers under current law to purchase such coverage. That change would reduce average premiums by a modest amount, because the people who would become insured would be in better health, on average, than their coworkers who would purchase insurance under current law.
- The individual mandate (and the small business tax credit) would also increase slightly the percentage of small firms that offer coverage. Those firms are likely to have healthier workers, on average, than small firms that would offer coverage under current law, largely reflecting the relative youth of workers at firms that would not offer coverage under current law compared with workers at firms that would. Consequently, their inclusion in the small group market would reduce average premiums in that market by a small amount.

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<sup>30</sup> That effect would be muted by the proposal's grandfathering provisions, which would allow insurers to continue to set premiums according to current rules as long as an employer's policy was continuously maintained; however, that option would also be most attractive to employers with relatively healthy workers and least attractive to employers with relatively unhealthy workers. The increased attractiveness of the nongroup market for older and less healthy workers would also temper the effect of the new rating rules on average premiums in the small group market, because some of those workers would shift from employment-based to nongroup coverage.

In contrast, CBO and JCT estimate that changes in the characteristics of people with insurance in the large group market would reduce average premiums per person in that market by about zero to 3 percent. One factor that would contribute to that difference is the shift of some less healthy workers to the nongroup market, as noted above. Another factor is the individual mandate, which would encourage younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so. Other factors that would slightly increase coverage of relatively healthy individuals under large group plans are the provisions of the legislation that would require large employers to automatically enroll new employees in an insurance plan and to offer coverage for unmarried dependents up to age 26. The proposal's restrictions on variation in premiums would have minimal effect on premiums in the large group market; many large firms self-insure and thus would not be affected by those changes, and firms that might be adversely affected could be grandfathered and thus avoid the restrictions.

## **Effects of the Proposed Exchange Subsidies and Small Business Tax Credit**

Under the proposal, the government would subsidize the purchase of nongroup insurance through the exchanges for individuals and families with income between 133 percent and 400 percent of the FPL, and it would provide tax credits to certain small businesses that obtained health insurance for their employees. Although the preceding analysis accounted for the effects of those subsidies on the number and types of people who would obtain coverage and on the amount of coverage that enrollees would obtain, the direct effect of the subsidies on enrollees' payments for coverage were not included in the figures presented above because the objective there was to assess the impact of the legislation on the average premiums *paid to insurers*. This section builds on the earlier calculations by quantifying how the exchange subsidies and tax credits would directly affect the average premiums *paid by individuals and families* who would receive that government assistance.

Premium subsidies in the exchanges would be tied to the premium of the second cheapest silver plan (which would have an actuarial value of 70 percent). The national average premium for that reference plan in 2016 is estimated to be about \$5,200 for single coverage and about \$14,100 for family coverage (see Table 2). The national average premium for all nongroup plans would be higher—about \$5,800 for single coverage and about \$15,200 for family coverage—because many people would buy more expensive plans.

Under the proposal, the maximum share of income that enrollees would have to pay for the reference plan would vary depending on their income relative to the FPL, as follows:

- For enrollees with income below 133 percent of the FPL, the maximum share of income paid for that plan would be 2.0 percent in 2014; for enrollees with income between 133 percent and 300 percent of the FPL,

that maximum share of income would vary linearly from about 4 percent of income to 9.8 percent of income in 2014; and for enrollees with income between 300 percent and 400 percent of the FPL, that maximum share of income would equal 9.8 percent.

- After 2014, those income-based caps would all be indexed so that the share of the premiums that enrollees (in each income band) paid would be maintained over time. As a result, the income-based caps would gradually become higher over time; for 2016, they are estimated to range from about 2.1 percent to about 10.2 percent.
- Enrollees with income below 200 percent of the FPL would also be given cost-sharing subsidies to raise the actuarial value of their coverage to specified levels: 90 percent for those with income below 150 percent of the FPL, and 80 percent for those with income between 150 percent and 200 percent of the FPL.
- Enrollees with income above 400 percent of the FPL would not be eligible for exchange subsidies, and enrollees with income below that level whose premiums for the reference plan turned out to be less than their income-based cap also would not receive subsidies.

CBO and JCT estimated that roughly 23 million people would purchase their own coverage through the exchanges in 2016 and that roughly 5 million of those people would not receive exchange subsidies.<sup>31</sup> Therefore, of the 32 million people who would have nongroup coverage in 2016 under the proposal (including those purchased inside and outside the exchanges), about 18 million, or 57 percent, would receive exchange subsidies. For the people who received subsidies, those subsidies would, on average, cover nearly two-thirds of the premiums for their policies in 2016. Putting together the subsidies and the higher level of premiums paid to insurers yields a net reduction in average premiums paid by individuals and families in the nongroup market—for those receiving subsidies—of 56 percent to 59 percent relative to the amounts paid under current law. People in lower income ranges would generally experience greater reductions in premiums paid, and people in higher income ranges who receive subsidies would experience smaller reductions or net increases in premiums paid.

The government would also provide some subsidies for the purchase of health insurance in the form of tax credits to small firms. Under certain circumstances, firms with relatively few employees and relatively low average wages would be eligible for tax credits to cover up to half of their contributions toward insurance premiums. Of the people who would receive small group coverage in 2016 under the proposal, roughly 12 percent would benefit from those credits, CBO and JCT estimate. For the people who would benefit from those credits, the credits would

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<sup>31</sup> See Congressional Budget Office, [cost estimate for the amendment in the nature of a substitute to H.R. 3590, the Patient Protection and Affordable Care Act](#) (November 18, 2009), Table 3.

tend to reduce the net cost of insurance to workers relative to the premiums paid to insurers by a little less than 10 percent, on average, in 2016. In the small group market, the other factors that were the focus of earlier sections of this analysis would cause premiums paid to insurers to change by an amount that could range from an increase of 1 percent to a reduction of 2 percent (compared to current law). Putting together the tax credits and the change in premiums paid to insurers yields a net reduction in the cost of insurance to workers in the small group market—for those benefiting from tax credits—of 8 percent to 11 percent relative to that under current law.

## **Effects of the Excise Tax on High-Premium Insurance Plans**

The legislation would impose an excise tax on employment-based policies whose total premium (including the amounts paid by both the employer and the employee) exceeded a specified threshold. The tax on such policies would be 40 percent of the amount by which the premium exceeded the threshold. In general, that threshold would be set at \$8,500 for single policies and \$23,000 for family policies in 2013 (the first year in which the tax would be levied), although a number of temporary and permanent exceptions would apply. After 2013, those dollar amounts would be indexed to overall inflation plus 1 percentage point.

CBO and JCT estimate that, under current law, about 19 percent of employment-based policies would have premiums that exceeded the threshold in 2016. (Because health insurance premiums under current law are projected to increase more rapidly than the threshold, the percentage of policies with premiums under current law that would exceed the threshold would increase over time.) For policies whose premiums remained above the threshold, the tax would probably be passed through as a roughly corresponding increase in premiums. However, most employers would probably respond to the tax by offering policies with premiums at or below the threshold; CBO and JCT expect that the majority of the affected workers would enroll in one of those plans with lower premiums. Plans could achieve lower premiums through some combination of greater cost sharing (which would lower premiums directly and also lower them indirectly by leading to less use of medical services), more stringent benefit management, or coverage of fewer services.

Thus, people who remained in high-premium plans would pay higher premiums under the excise tax than under current law, and people who shifted to lower-premium plans would pay lower premiums under the excise tax than under current law—with other factors held constant. On net, CBO and JCT estimate that the excise tax and the resulting behavioral changes, incorporating the changes in premiums for employer-sponsored insurance that were discussed earlier in this analysis, would reduce average premiums among the 19 percent of policies affected by the tax by about 9 percent to 12 percent in 2016.

## Other Potential Effects on Premiums

The proposal could have some broader or longer-term effects on the level or growth rate of health care spending and health insurance premiums. Such effects could arise from several sources, some of which would tend to raise premiums relative to the figures cited above, and others of which would tend to lower them. The uncertainties involved in assessing the magnitude of those effects are especially great. However, in CBO and JCT's judgment, those effects are unlikely to be large—especially by 2016, which is the focus of this analysis.

On the one hand, research by Amy Finkelstein suggests that expanded insurance coverage could have broader effects on the use of health care services than are captured by focusing on changes for the previously uninsured.<sup>32</sup> Examining trends in hospital spending, she found that the substantial increase in demand for medical services generated by the introduction of Medicare in 1965 accelerated the dissemination of new medical procedures more broadly and could account for about half of the overall increase in hospital spending for the population as a whole that occurred in subsequent years.

By that logic, the expansion of insurance coverage to millions of nonelderly people under this proposal could generate a larger increase in health care spending—and thereby health insurance premiums—than estimated here. However, several factors temper that conclusion. For one, the quantitative effect would presumably be smaller than that caused by Medicare because nonelderly people use less health care, on average, than elderly people. Moreover, Medicare initially paid hospitals on the basis of their incurred costs—an approach that gave hospitals little incentive to control those costs. The increase in hospital spending that resulted from Medicare's creation could well have been smaller under a less generous payment system or in an era of more tightly managed care. In particular, roughly half of the increase in insurance coverage generated by this proposal would come from expanded enrollment in Medicaid, which pays relatively low rates to providers. Incentives for cost control would also be greater in the proposed exchanges, because exchange enrollees would have to pay the full additional cost of joining a more expensive insurance plan. Regardless, any effects of expanded insurance coverage on the dissemination of new medical procedures would unfold slowly and would have little effect on health care and health insurance premiums by 2016.

On the other hand, the proposal includes numerous provisions that would encourage the development and dissemination of less costly ways to deliver appropriate medical services, either directly or indirectly. Examples of those provisions include the excise tax on high-premium insurance plans; the creation of a new Medicare advisory board that might limit the growth rate of Medicare

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<sup>32</sup> See Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics*, vol. 122, no. 1 (February 2007), pp. 1–37. For additional discussion of this study, see Congressional Budget Office, *Key Issues*, p. 111.

spending; and certain changes in Medicare's payment methods as well as new pilot and demonstration projects regarding other changes in payment methods (such as penalties for hospital readmissions that are deemed avoidable and incentives to coordinate patients' care). The changes in Medicare's payment methods could "spill over" to the private sector and decrease spending for health care relative to currently projected levels. However, the effects of those initiatives on Medicare's spending are uncertain and would probably be small in 2016 relative to the program's total spending, so any spillover to private insurance at that point would probably be small as well. In addition, the excise tax on high-premium plans would apply to a small share of plans in 2016, so its effects on the cost and efficiency of health care would also probably be small at that point.

All of those considerations serve to emphasize the considerable uncertainty that surrounds any estimate of the impact of any proposal that would make substantial changes in the health insurance or health care sectors, given the size and the complexity of those sectors. That uncertainty applies to the estimated effects of proposals on the federal budget and insurance coverage rates, as well as to their impact on premiums.

**TABLE 2. Analysis of Exchange Subsidies and Enrollee Payments in 2016 Under the Patient Protection and Affordable Care Act**

11/20/2009

**Estimate for "Reference Plan" in 2016 -- 2nd Lowest-Cost "Silver" Plan**

	Actuarial Value	Average Premium	Avg. Cost Sharing
Single Policy	70%	\$5,200	\$1,900
Family Policy	70%	\$14,100	\$5,000

**Single Person**

Income Relative to the FPL	Premium Cap as a Share of Income /a	Middle of Income Range /b,c	Enrollee Premium for Low-Cost "Silver" Plan	Premium Subsidy (share of premium)	Average Cost-Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing	
							Dollars	Percent of Income
100-150% /d	2.1% - 4.7%	\$ 14,700	\$ 300	94%	\$ 1,100	\$ 800	\$ 1,100	7%
150-200%	4.7% - 6.5%	\$ 20,600	\$ 1,200	77%	\$ 600	\$ 1,300	\$ 2,500	12%
200-250%	6.5% - 8.4%	\$ 26,500	\$ 2,000	62%	\$ -	\$ 1,900	\$ 3,900	15%
250-300%	8.4% - 10.2%	\$ 32,400	\$ 3,000	42%	\$ -	\$ 1,900	\$ 4,900	15%
300-350%	10.2%	\$ 38,300	\$ 3,900	25%	\$ -	\$ 1,900	\$ 5,800	15%
350-400%	10.2%	\$ 44,200	\$ 4,500	13%	\$ -	\$ 1,900	\$ 6,400	14%
400-450%	n.a.	\$ 50,100	\$ 5,200	0%	\$ -	\$ 1,900	\$ 7,100	14%

**Family of Four**

Income Relative to the FPL	Premium Cap as a Share of Income /a	Middle of Income Range /b,c	Enrollee Premium for Low-Cost "Silver" Plan	Premium Subsidy (share of premium)	Average Cost-Sharing Subsidy	Average Net Cost Sharing	Enrollee Premium + Avg. Cost Sharing	
							Dollars	Percent of Income
100-150% /d	2.1% - 4.7%	\$ 30,000	\$ 600	96%	\$ 3,300	\$ 1,700	\$ 2,300	8%
150-200%	4.7% - 6.5%	\$ 42,000	\$ 2,400	83%	\$ 1,800	\$ 3,200	\$ 5,600	13%
200-250%	6.5% - 8.4%	\$ 54,000	\$ 4,000	72%	\$ -	\$ 5,000	\$ 9,000	17%
250-300%	8.4% - 10.2%	\$ 66,000	\$ 6,100	57%	\$ -	\$ 5,000	\$ 11,100	17%
300-350%	10.2%	\$ 78,000	\$ 7,900	44%	\$ -	\$ 5,000	\$ 12,900	17%
350-400%	10.2%	\$ 90,100	\$ 9,200	35%	\$ -	\$ 5,000	\$ 14,200	16%
400-450%	n.a.	\$ 102,100	\$ 14,100	0%	\$ -	\$ 5,000	\$ 19,100	19%

Source: Congressional Budget Office and the Staff of the Joint Committee on Taxation.

Notes: All dollars figures have been rounded to the nearest \$100; n.a. = not applicable; FPL = federal poverty level.

a) In 2014, the income-based caps would range from about 4% at 133% of the FPL to 9.8% at 300% of the FPL, and that 9.8% cap would extend to 400% of the FPL; in subsequent years, those caps would be indexed.

b) In 2016, the FPL is projected to equal about \$11,800 for a single person and about \$24,000 for a family of four.

c) Subsidies would be based on enrollees' household income, as defined in the bill.

d) Under the bill, people with income below 133% of the FPL would generally be eligible for Medicaid and thus ineligible for exchange subsidies; the premium cap in 2014 for those with income below 133% of the FPL would be 2% of income.