FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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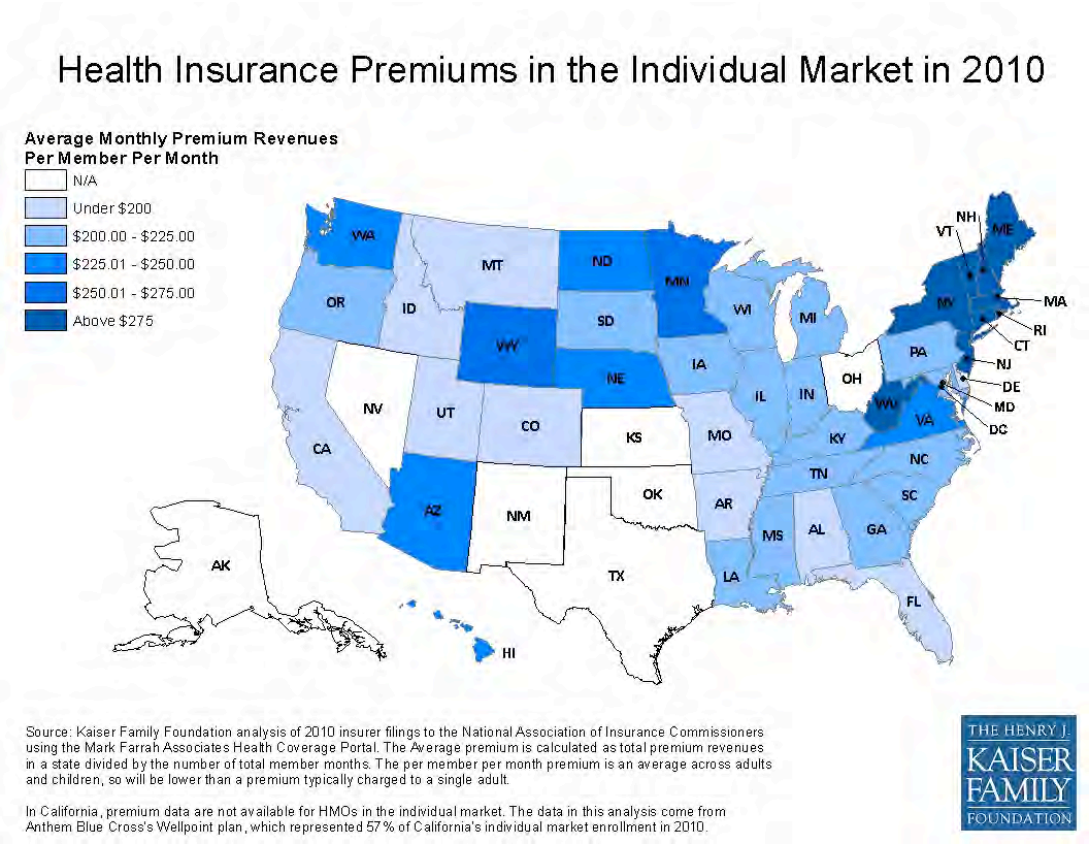
Mapping Premium Variation in the Individual Market

Starting in 2014, the Affordable Care Act (ACA) will substantially reform the way in which individuals buy health insurance on their own. People who do not otherwise get health insurance through their employer or through public programs will soon be able to buy coverage through purchasing Exchanges, which will provide online comparison guides explaining the choices available. Insurers offering coverage in the Exchanges will be required to provide coverage to anyone regardless of a pre-existing health condition, and rates for the same policy will vary only by age, family status, tobacco use, and geographic area.

How people perceive these changes may depend significantly on how the premiums compare to what they are buying today. However, information on the cost of the insurance people commonly buy in different parts of the country is difficult to come by. Insurers don't generally provide public reports of enrollment and premiums by insurance product and geographic area, and national surveys lack sufficient sample size and benefit detail to compare individual (non-group) insurance across areas. In addition, the market is quite fragmented: status and coverage varies significantly from insurer to insurer and product to product. For example, insurers in most states exclude people or impose surcharges based on their health status, while in some states this practice is not permitted.

Insurer filings to the National Association of Insurance Commissioners (NAIC) are a standardized source of information on health plan premiums and expenditures in the aggregate at the state level. We analyzed these data – compiled by Mark Farrah Associates – to assess how average premiums in the individual insurance market varied across the country for 2010.



Nationwide, the average monthly premium per person in the individual market in 2010 was $215, but the state-by-state range was substantial. Vermont and Massachusetts both had average per member per month premiums over $400 per month. The average premium revenues in Rhode Island, New York, and New Jersey were also relatively high, ranging from about $344 to $364 per month. Alabama ($136), California[1] ($157), Arkansas ($163), Idaho ($167), and Delaware ($169) had the lowest average monthly premiums in the country. (Note that these figures represent average premium revenue per member per month. This represents an average across adults and children, so will be lower than a typical premium charged to a single adult.)

There are a variety of reasons why premiums might vary, including: the cost of living, health care costs, state demographics (e.g., the age distribution of the population), plans' effectiveness at controlling costs, the benefits offered by plans, and the patient cost-sharing required. Though premiums are lower in some states, the people enrolled in these plans may have to pay higher deductibles or copayments that offset the savings in premiums. Thus, the map above does not take into account the relative protection offered by the plans. Also, states that have instituted reforms in their insurance markets to make coverage more accessible – such as Massachusetts, Vermont, New York, and New Jersey – may have higher average premiums because people with pre-existing health conditions are able to enroll. Conversely, states that permit medical underwriting may have average premiums that are low because the risk pools include a healthier than average population.

This analysis suggests substantial diversity in the insurance people buy across the country. Starting in 2014, the health reform law will require insurers to cover a standard essential benefit package in all states and to use defined tiers of cost-sharing. The minimum cost-sharing tier will require that all newly-purchased insurance in the non-group market have an actuarial value of at least 60%, meaning that the plan pays for at least 60% of the cost of covered benefits in the aggregate for a typical population. In addition, tax credits will be available to make coverage more affordable for people with incomes up to 400% of the poverty level ($43,560 for a single individual and $89,400 for a family of four in 2011 dollars). These changes should all help to narrow the variation in the insurance people buy in different areas of the country. But, a wide range of insurance policies will still be available (ranging from Bronze coverage at an actuarial value of 60% to Platinum coverage at an actuarial value of 90%), so patterns of purchase may still vary substantially across the country.

The health reform law will also require all insurers in the individual (non-group) market to accept everyone regardless of health status and prohibit premium surcharges for people with pre-existing health conditions. These rules should narrow the variation in how much people pay for insurance in different parts of the country, but premiums will likely continue to vary considerably due to differences in the cost of living in general and health care, in particular.

This brief was prepared by Cynthia Cox, Larry Levitt, Anthony Damico, and Gary Claxton of the Kaiser Family Foundation.

[1] Premium data are not available for HMO plans in California's individual market as these plans are regulated by the California Department of Managed Health Care, which does not report premium revenue by market segment. The data used in this analysis to calculate the average monthly premium revenue in California come from one plan, Wellpoint (Anthem Blue Cross), which represented 57% of enrollment in California's individual market in 2010.

Methodology

The state average premium values shown in the figure above represent the total premium revenue divided by the total member months of all major medical individual market plans for which data were available in each state in 2010. These data were downloaded from the Mark Farrah Associates Health Coverage Portal, which includes information from the National Association of Insurance Commissioners and California's Department of Managed Health Care. Of the fifty states plus the District of Columbia, Alaska returned no results from the search of individual plans. A state was classified as "not available" if a major plan was known to be missing and the number of people enrolled in individual major medical insurance, based on the NAIC data, was less than one third (33.3%) of the estimated number of non-elderly people with individual coverage in the state from 2008 – 2009 according to analysis in the Current Population Survey (see http://www.statehealthfacts.org/comparetable.jsp?ind=126&cat=3). The data download from the Mark Farrah Health Coverage Portal was executed on July 13, 2011.

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