OLIVER WYMAN

Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability

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Executive Summary

The nation is seeking effective solutions to meet the goals of improving the affordability of health insurance, extending coverage to many of the 45.6 million uninsured and reforming a fragmented healthcare delivery system. Central to the debate over healthcare reform in Washington is how to make health insurance more accessible and affordable for millions of Americans who purchase coverage in the individual market, as well as for small employers.

Legislation pending before Congress includes significant reforms to health insurance industry practices in both the individual and small group markets. These reforms would require insurers to: 1) offer coverage on a guaranteed issue basis without any pre-existing condition exclusions, 2) discontinue rating on health status and gender, 3) limit how much premiums vary because of age, and 4) sell only insurance policies that meet at least new minimum benefit levels.

We modeled the impact of these provisions, along with a variety of other changes included in pending bills, including subsidies, grandfathering, and reinsurance, to estimate the impact on insurance premiums in the individual and small group markets. We have done this on a national level and by state groupings based on their current state insurance rules.

Key Findings: Individual Market

The analysis demonstrates that an effective individual coverage requirement is a key factor in both assuring affordable coverage and reducing the number of uninsured. Specifically, the results illustrate the following key points.

1. ***Strong individual mandates are essential to make insurance reforms work:***

- **Insurance reforms alone will substantially increase claims costs in the individual market.** The individual market "risk pool" will be less healthy than today and will drive higher insurance premiums. We estimate the average medical claims for the uninsured are 20 percent higher than claims in the current individual market. In addition, certain segments with high medical utilization who are now insured through other arrangements will enter the individual market as a result of guaranteed issue and modified community rating requirements. This includes people enrolled in state high risk pools, people on COBRA through their former employers' coverage, and other group conversion policies.
- **Strong mandates, beginning in year one, coupled with meaningful penalties, will help to ensure enrollment of young, healthy individuals to balance inflow of higher cost people.** Young, healthier people are very price sensitive and are least likely to enter the insurance market without a strong mandate. We estimate a strong mandate will draw nearly 3 million

young and healthy members into the reformed individual market. The healthier insurance pool will result in lower premiums than with a weak mandate.

- **In addition to an effective mandate, other elements are critical to assuring the success of reform.** Two other key elements are important in assuring affordability of premiums:
  - **Age rating:** Pending legislation restricts the ability of health plans to provide age discounts to younger members by specifying certain age bands. ***We estimate that in most states, premiums for the youngest 30 percent of the population will increase by 69 percent under a 2:1 age band included in the Senate HELP and House Committee bills compared to a 5:1 age band.*** With the Senate Finance Committee provision of 4:1 age bands, premiums will increase for younger purchasers, reducing the likelihood that some will purchase coverage.
  - **Appropriate benefit requirements:** The bills before Congress require certain minimum benefit levels (e.g., actuarial values) that are higher than the average of what people are purchasing in the market today. We estimate that minimum benefit requirements will increase costs about 10 percent in the individual market and 3 percent in the small group market based on what is proposed in the Senate Finance Committee bill, which has the lowest requirements on new benefit plans. The costs would increase even greater under the House and Senate HELP Committee bills.

2. Without a strong mandate, premiums for purchasers in the new marketplace will increase significantly:

- We estimate that without strong individual mandates, **average annual medical claims in the reformed individual market five years after reform are expected to be 50 percent higher compared to today, not including the impact of medical inflation**.

  This would translate into premium increases of approximately $1,500 for single coverage for a year and $3,300 for family coverage in today's dollars for people purchasing new policies. Subsidies will entirely or partially offset these premium increases for some individuals. Eight million current individual market members and 25 million uninsured earn between 100 and 400 percent of the federal poverty level and will have access to subsidies through the exchange.

- **Adequate subsidies help participation, but are insufficient to drive effective coverage levels—**both a strong personal responsibility requirement and subsidies are needed. Over 18 million people, including both currently uninsured and existing individual market members, are ineligible for subsidies based on the Senate Finance Committee proposed subsidy schedules. For the very low income, below 200% of the federal poverty level (FPL), we believe a large percentage of the uninsured will purchase insurance because of the generous subsidies. However, take up rates will be much lower for those above 200% FPL without a meaningful penalty, since subsidies decline at higher income levels.

- **Weak mandates result in more uninsured**. Requiring insurers to guarantee issue coverage regardless of preexisting conditions—without an effective mandate—means that people can wait to purchase coverage until they need it, causing premiums to increase for most new

purchasers. We estimate that 12.6 million people will forego coverage, relative to an effective mandate.

3. ***The impact of reform on the individual market will vary significantly by geography.*** The vast majority of States have not enacted the reforms proposed in Federal bills. The states where two-thirds of the United States population reside will experience the highest premium increases. In these states, the reformed individual market claims are estimated to be up to 60-73%[1] higher than today with a weak individual mandate.

4. ***People with existing individual coverage may not see significant impact from rating and benefit changes.*** The bills "grandfather" existing coverage, so that people can keep their current coverage. These "grandfathered" policies will not be impacted by the rating changes described above. However, individuals with "grandfathered" policies will not be eligible for the new subsidies. We estimate that as many as 4.6 million people will stay in the "grandfathered" blocks after 5 years. However, these individuals would still be subject to premium increases as a result of insurer fees included in the Senate Finance Committee bill.

Key Findings: Small Group Market

Under reform, small group employers (2-50 employees) will experience rating changes similar to those proposed for the individual market. Key findings include:

1. ***Average premiums for small employers will increase:*** Under reform, small employers will experience premium increases as a result of rating rule changes and minimum benefit requirements. We estimate that small employers purchasing new policies in the reformed market, with an ineffective mandate, will experience premiums that are up to 19 percent higher in Year 5 of reform, not including the impact of medical inflation. About 9.5 million small group employees who have coverage today will stay covered under the "grandfathered" block in the initial post-reform years, but will face premium increases when the grandfathering phases-out.

2. ***Overall, the number of small employers offering coverage will decline:*** Under reform and after accounting for small employer tax credits, premium increases will lead to fewer small employers offering coverage. We estimate 2.5 million fewer members will be insured through small employer policies.

[1] Does not include medical inflation which will further increase premiums.

Overview of Modeling Approach and Methodology

Oliver Wyman has developed a comprehensive model to study the impact of different health insurance reform proposals on the individual and small employer health insurance markets.

The model is based on a database of actual claims, premium and underwriting information from over 375,000 small groups, representing 4.2 million covered lives, and 1.24 million individual policies, representing 1.6 million covered lives. The database includes blinded information on approximately 1-in-10 purchasers in the individual and small employer markets today. These data are representative of states across the country and reflect the varying rating rules that are used today. This allows the model to provide insight into the impact of reform at the state level.

The model differs from other models currently in use because it allows for the analysis of how insurance reforms will impact actual insurance policies. This is critical because most of the rating reform impact is felt at the "ends of the distributions." For example, the medical claims for the healthiest 10 percent of members are typically less than a quarter of the average claims, and the sickest 10 percent are often four to seven times more than the average. With actual insurance policy data, we can see how much premiums will shift, and therefore how enrollment is likely to shift, across the full distribution of policies.

Other analyses generally use synthetic health insurance units developed from survey data to evaluate the impact of reform. Because of this, other models may underestimate the real-world impact of rating changes, in particular, because they do not evaluate the impact on a distribution of actual policies.

Actuarial analysis is used to determine the premium impact of changes in rating regulations and the differential impact across geographic regions. The model estimates premium changes and migration among coverage categories over a five year period after reform is implemented. This multi-year view allows us to capture the impact of adverse selection, which can drive up average prices in an environment with no or weak mandates. Adverse selection theory holds that healthier individuals are more likely to drop or switch coverage when faced with cost increases, leaving the remaining pool more expensive to insure.

Our model estimates the costs of different coverage choices available in the market under a given reform scenario, determines market reaction, and shifts between different potential sources of coverage (e.g., the individual market, small employer market, large group market, government programs) and the uninsured. To evaluate the market reaction to different reform scenarios, we apply elasticities of demand for employers, employees, and consumers that are consistent with the academic literature and ranges used by the Congressional Budget Office and other models.

The elasticities, combined with the estimated cost changes to the employer or individual, allow us to determine how many members will enter or exit the market. We are able to track the membership inflow and outflow based on the health status and income levels of individuals. In addition to the rating changes, we also account for the savings individuals realize from subsidies and the cost of declining coverage if an individual mandate penalty is in place. Stated more simply, we are able to estimate the number of people that will be insured and their expected medical costs for any given reform scenario.

Results Consistent with Actual Market Experience

The results we see in the output of the model are consistent with the experience observed in the market. Among the trends that are readily validated by actual market experience are:

- Less healthy individuals are more likely to take up coverage and less likely to drop coverage when costs change.
- Healthy individuals are more cost sensitive. They are more likely to exit the market if costs increase and require stronger inducements to take up coverage if they are uninsured.
- Premiums will increase at a rate higher than average medical inflation if the pool enters a risk spiral, which occurs when the percentage of healthy members in the pool declines.

Key Model Variables

Our analysis includes the major elements of the Senate Finance Committee's proposal, the "America's Healthy Future Act of 2009" or AHFA, that will impact the cost of insurance in the individual and small employer health insurance market. These key elements include the following:

Reform Elements Included in Analysis	Description
Guaranteed Issue	Insurance for anyone who wants it in the individual market, with no pre-existing condition exclusions during the open enrollment windows
Modified Community Rating	Elimination of health status underwriting and other factors such as gender in pricing insurance coverage for both Individual and Small Group
Age Band Rating	Limiting the use of age as a rating factor to a 4:1 band
Minimum Benefit Requirements with 65% Actuarial Value	Anyone purchasing benefits must do so at least at the 65% actuarial value level
Grandfathering	People in the current market may keep the benefits they have if they choose, but they will not be subsidy eligible. Grandfathering will create two distinct risk pools – the "grandfather pool" and the "reformed market pool" – that have different risk profiles
Subsidies	Subsidies for individuals under 400% of the Federal Poverty Level with Medicaid expansion Subsidies for low-wage small employers
Risk Adjustment	Risk adjustment among plans to even out risk differences
Reinsurance	$20B in reinsurance for the first 3 years reform is implemented, funded through assessments on health plans
Mandates	Individual mandate with limited penalties for non-compliance Employer "free rider" assessment for firms with more than 50 employees that do not provide coverage to their workers

The AHFA also includes changes to the insurance market that were not explicitly evaluated in our model. These include optional risk corridors, which could protect certain plans from losses in the early years of reform, and the inclusion of a "young invincibles" product that could have higher cost-sharing than permitted for other products. We do not expect these policy provisions to have a substantial impact on average prices for new purchasers of health insurance coverage.

The AHFA also includes a number of fees and taxes on the health industry to help finance the proposal. These include a $6.7 billion annual assessment on insurers, assessments on drug and medical device manufacturers, and other assessments that are likely to impact premiums in the individual and small group health insurance market. The AHFA also imposed an excise tax on high cost benefit plans offered in the employer marketplace. The analysis for this report does not include the impact of these fees and taxes on cost and coverage in the individual and small employer markets. The excise tax on high cost benefit plans does not apply to the individual market and we estimate the impact on small group policies to be negligible.

We have not explicitly modeled the impact of health insurance exchanges. However, Oliver Wyman issued a report in 2008 on this subject that found that exchanges were unlikely to reduce health insurance premiums for individuals and small employers[2]. The Congressional Budget Office's analysis of the Senate Finance Committee proposal indicates that exchanges could reduce premiums by 4-5 percent in the individual health insurance market[3].

We evaluated the impact of health insurance reforms with and without including underlying medical cost inflation. The results of this report are presented in the absence of medical trend to isolate the cost impact of specific reforms. While the Senate Finance Proposal includes provisions that are intended to bend the cost curve over the long-term, the inclusion of medical trend would have increased our projected cost increases over the five-year period we examined.

Additional Methodology Detail—Estimated Medical Costs for the Uninsured Once They Become Insured

It is important to have an estimate of the expected utilization of healthcare services of the uninsured after they become insured. There are a handful of academic studies that have examined this issue, and the Congressional Budget Office has also estimated the potential cost of the uninsured.

Our analysis is generally consistent with the approach used by CBO. We estimate that the morbidity of the uninsured will be about 85 percent of the level of the current insured market - meaning the uninsured are generally healthier than the current insured market. However, the insured market is comprised mostly of members from the employer market. It is well known that the current individual market is generally healthier than the employer market in the majority of the U.S.

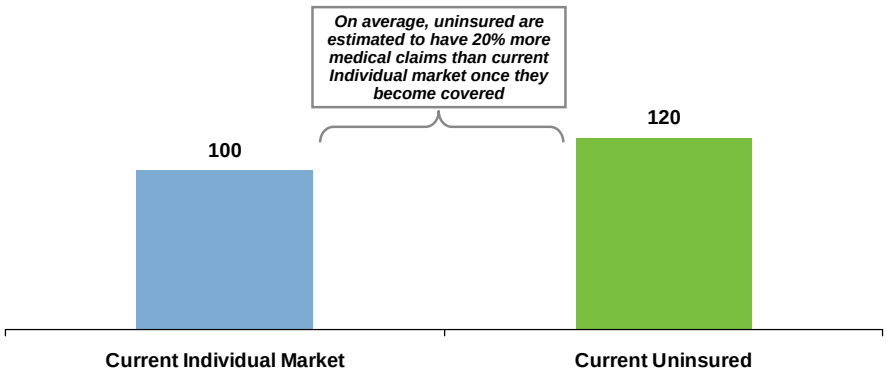
We estimate that the average uninsured will have average medical utilization about 20 percent higher than the current individual market. Given that many of the uninsured are likely to seek

[2] "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for Individuals and Small Employers?", Karen Bender, FCA, ASA, MAA and Beth Fritchen, FSA, MAA, Oliver Wyman Actuarial Consulting, Inc., September, 2008.
[3] Congressional Budget Office: Letter to the Honorable Max Baucus, Chairman, Committee on Finance, September 22, 2009

coverage in the reformed individual market, we expect that the average claims in the risk pool of the reformed market will increase as a result.

The uninsured are expected to have higher medical costs than the current Individual market

Expected Claims Cost (Indexed relative to current Individual Market)



Based on our review of available information, we estimate that the morbidity of the uninsured if given access to insurance would be essentially 85% of the currently insured. We note that this assumption is roughly consistent with assumptions that the CBO used in its evaluation of the available data[4].

Using premium, claims, and other available information we estimate that the morbidity of those insured through the individual market is roughly 70% of the morbidity of the entire universe of people insured through the individual, small group, and large group markets (including self-insured). This 70% factor is the result of the fact that people insured through the individual market, in most states, are medically underwritten[5]. Combining these two estimates, the uninsured will have morbidity that is roughly 20% greater than those currently covered in the Individual market.

We also used the distribution of claims expenses in the individual market to estimate the distribution of expected costs for the uninsured. We assume that the sickest 10 percent of the uninsured are estimated to have claims that are four to six times higher than the average in the current individual market, which translates to annual claims of $9,000 to $10,000. This amount is similar to the typical range observed in states' high risk insurance pools.

Impact of Insurance Reform on Today's Market

In most parts of the country today, insurers in the individual market are permitted to underwrite and design benefit plans with a variety of price points. This flexibility enables a stable, competitive insurance market. Perhaps most importantly, it offers the greatest affordability to attract younger and healthier members and helps encourage wider enrollment in health insurance.

The proposed insurance reforms will increase claims costs significantly in the individual insurance market. We estimate the average medical claims for the uninsured are 20 percent higher than claims in the current individual market. This is because some have not been receiving regular medical care

[4] Key Issues in Analyzing Major Health Insurance Proposals, Congressional Budget Office, December 2008.

[5] The American Academy of Actuaries recently released a paper in which they examine the impact of merging the small group and individual markets. In that paper, the authors conclude that "Merging the two markets into a single market, without adjustment, would likely result in higher premiums than currently exist for in the individual market." See *Critical Issues in Health Reform: Merging the Small Group and Individual Markets*, American Academy of Actuaries, September 2009.

and some have been unable to obtain coverage at an affordable price as a result of having chronic conditions.

In addition, certain segments with high medical utilization who are now insured through other arrangements will enter the individual market as a result of guaranteed issue and modified community rating requirements. This includes people enrolled in state high risk pools, people on COBRA through their former employers' coverage and other group conversion policies.

Our model assumes that people will generally act in their economic self-interest. Although individuals and families cannot predict their health care needs precisely, they often have a relatively good idea of their short term needs. Insurance reforms will tend to lower barriers and create stronger financial incentives for unhealthy people to become insured. As individuals work to optimize the costs and benefits of different coverage options, the market will become more prone to adverse selection that will increase costs over successive years, especially if insurance reforms are not coupled with an effective individual mandate.

Collectively, these factors will lead to a less healthy "risk pool" in the individual market which ultimately leads to higher average premiums. The rating reforms significantly alter the cost-to-value ratio that consumers will experience, and younger members will bear a greater burden of subsidizing premiums for older members. The high degree of cross-subsidization in the reformed market makes it imperative to have high levels of participation among young people to subsidize the older population.

Impact of Age Bands

Eliminating medical underwriting, requiring guaranteed issue and requiring minimum benefit packages with 65 percent actuarial value will increase premiums significantly for the youngest, healthiest 30 percent of members in the market today. Based on our analysis of actual polices, the premium increases will be greater than 50 percent for this cohort in most of the country in the first year of reform.

Forty-two states permit health plans to vary premiums based on age by 5:1 or more, with most of these allowing rates to be based on actuarial justification. The Senate Finance Committee proposal to limit variations based on age of 4:1 is more restrictive than all but 8 states today. This would create a strong disincentive for the young and healthy to participate even under the 4:1 age band in the AHFA.

In a previous analysis, Oliver Wyman, Inc. estimated that in most states, premiums for the youngest one-third of the population would increase by 69 percent under a 2:1 age band called for in the House and Senate HELP Committee bills, and by 35 percent under a 3:1 age band (being discussed as a compromise) relative to 5:1 age band. While these tighter age bands will reduce premiums for older purchasers, at least initially, most people under the age of 50 will see their rates increase significantly under tighter age bands.

The effect of tighter age bands on premiums compounds over time, and it becomes increasingly difficult to attract younger members into the insurance market. Without an effective mandate with meaningful penalties, people with higher expected utilization of medical services will be much more likely to purchase coverage, driving up premiums and reducing the number of people who would be covered. On the other hand, the young and healthy will have little incentive to maintain coverage as

they know they can get insurance when they anticipate a need[6]. As a result, the risk pool will deteriorate and premiums will rise without adequate cross-subsidies. This situation is not conducive to a viable insurance market.

Impact of Benefit Changes

The bills before Congress would also require that new purchasers buy health insurance products that meet certain minimum benefit requirements. The Senate Finance Committee proposal requires insurers in the individual and small group markets to offer "Gold" and "Silver" policies, which have an actuarial value (AV) of 80 percent and 70 percent respectively. The lowest actuarial value product that insurers could offer in this market would be the "Bronze" package, with an AV of 65 percent.[7]

In addition to the minimum actuarial value of benefit, the bill also includes a range of other changes that will impact the cost of benefit packages, including requirements to cover certain services (maternity, mental health services, etc.), unlimited annual and lifetime maximums, and other limitations that will increase costs. These changes do not directly affect the actuarial value of the plan, as described in the legislation, but will add to the actual cost of the products.

Oliver Wyman, Inc. reviewed current benefit offerings in the individual and small group markets to understand how the requirements proposed by the Senate Finance Committee legislation compare to benefit offerings today, and to assess the likely impact of the bill's requirements on premiums. The average actuarial value of coverage purchased in the individual health insurance market today is close to 65 percent, similar to what the Congressional Budget Office has estimated, however, one-half of individual market policies are significantly below the proposed requirement. For the small group market, we estimate that the actuarial value of products currently purchased is 75 percent, with about 20 percent of small groups having products with actuarial values below the Senate Finance Committee minimum of 65 percent.

We estimate that compliance with the benefit requirements in the Senate Finance Package would cause premiums for new purchasers to increase by approximately 10 percent in the individual market and 3 percent in the small employer market nationwide.

Reform Scenario Results—Impact of Strong Individual Mandates

Each of the major bills before Congress require individuals to purchase insurance coverage or face potential penalties. The bills generally also include requirements for large employers to purchase insurance or face a financial penalty. In general, the bills exempt the smallest employers from this requirement. In the case of the Senate Finance Committee bill, firms with fewer than 50 employees would be exempt from the requirement to provide coverage.

An amendment accepted during mark-up of the Chairman's Mark in the Finance Committee substantially weakened the bill's individual mandate. This amendment eliminated penalties for not maintaining insurance entirely in the first year insurance reforms become effective (2013). Modest

[6] The Act includes open enrollment provisions that may provide partial protection against people entering the market on an as-needed basis. However, it will not provide full protection against people deferring elective and non-emergency procedures until after they buy insurance. Also, individuals will face low penalties for dropping coverage after services are received.
[7] The Act also includes a catastrophic option for "young invincibles".

penalties are phased in, reaching a maximum of $750 per adult in 2017. This maximum penalty is likely to be only about 15 percent of an average premium in 2017, assuming current rates of medical cost inflation. The amendment also exempted individuals whose premiums exceed 8 percent of their adjusted gross income. In 33 states, the average cost of health insurance exceeds eight percent of median state income.[8]

Mandates with meaningful penalites are highly effective in encouraging a broad cross-section of the uninsured to purchase coverage when combined with subsidies. For example, the RAND Corporation's COMPARE model found that an individual mandate would have the greatest impact on increasing insurance coverage.[9] By itself, an individual mandate with a penalty of 80 percent of premiums could increase the number of people with insurance by up to 34 million, a 75 percent reduction in the uninsured. However, RAND estimates the net newly insured would increase by only 8.7 million if there were no penalties and subsidies up to 200 percent of the federal poverty level.[10]

A recent survey designed by Professor Joel C. Huber of Duke University, conducted by Knowledge Networks, and funded by the Blue Cross and Blue Shield Association found that fewer than one-third of the uninsured seeking individual coverage and making between 200 percent and 300 percent of the federal poverty level are likely to purchase coverage given the maximum penalty of $750 per year in 2017 under the Senate Finance Committee proposal, even after subsidies are provided. Approximately one in five uninsured making over 300 percent of poverty are likely to purchase unsubsidized individual coverage with a penalty of $750 per year, according to the survey.

To further evaluate the need for a strong individual mandate, we modeled two reform scenarios with different levels of penalties for the mandate. The "High Mandate" and "Low Mandate" scenarios illustrate the effect of individual mandates on affordability and total number of uninsured. The number of uninsured is estimated to be approximately 12.6 million people higher with the weakened mandate.

Further, with weak mandates, the risk pool of the individual market will be less healthy, have much lower participation among younger members, and experience much higher premium increases. The average medical claims of members in the reformed individual market will be 50 percent higher than the average in the market today (not including medical inflation). **This would translate into premium increases of approximately $1,500 for single coverage and $3,300for family coverage in today's dollars.**[11]

Younger, healthier members are particularly vulnerable to rating reform. They will experience premium increases greater than 50 percent relative to the current market in most of the U.S. With weak mandate penalties coupled with guaranteed issue, it will be less expensive for many people to choose to buy insurance only when needed. Strong mandates will draw nearly 3 million more young

[8] 2007 median state incomes and average state premiums. AHIP "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits". Census Bureau's American Community Survey.
[9] See: http://www.randcompare.org/publications/summary/finally_presidential_support_for_the_individual_mandate
[10] See individual mandate results (on net new coverage) at: http://www.randcompare.org/modeling/
[11] Premiums based on AHIP Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits with a 6% medical inflation factor

and healthy members into the reformed individual market. The healthier insurance pool will result in premiums lower than reform with weak mandates.

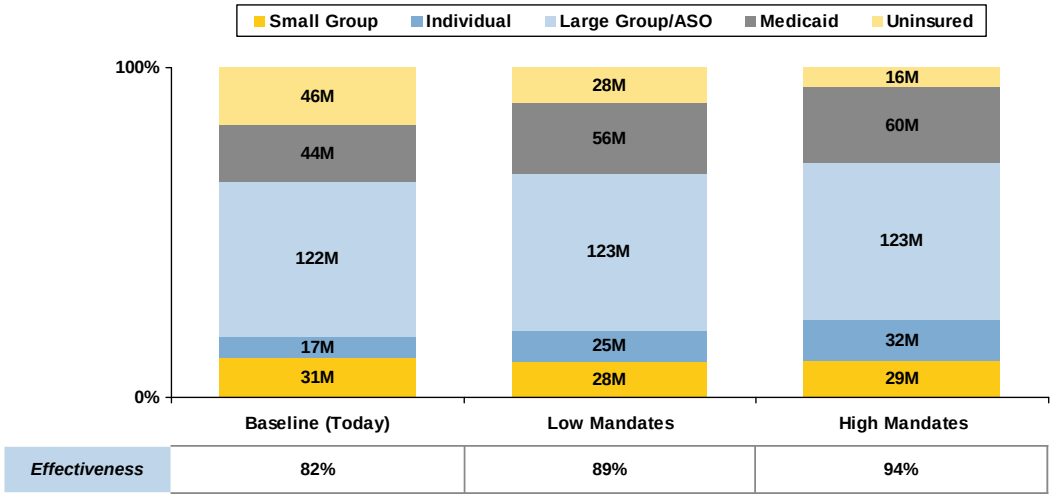
Mandates serve to complement subsidies. Subsidies will be most effective for individuals with low income levels. For the uninsured earning 100-200 percent FPL, we estimate that more than 60 percent of them will purchase insurance because of subsidies. However, more than 60 percent of the current individual market and about 20 percent of the uninsured have incomes above 300 percent FPL and will realize limited or no subsidy support. Over 18 million uninsured and existing individual market members are ineligible for subsidies based on the proposed structures. Higher income uninsured individuals are not likely to take up coverage without a meaningful penalty.

The bills "grandfather" existing coverage, so that people can keep their current coverage. These "grandfathered" policies will not be impacted by the rating changes described above. However, individuals with "grandfathered" policies will not be eligible for the new subsidies. There are many reasons people switch coverage and therefore, are likely to purchase a new policy that meets the new rules. For example, they could move to another state, change employment, or have a change in family status. Experience in the individual market shows that one-third of policies lapse in the first year after purchase.

Grandfathering is helpful to reduce premium impacts in the first years and we estimate that 4.6 million people could be in the "grandfathered" blocks after 5 years. However, given the one-third lapse rate noted above, most of these individuals will likely migrate out of the market over this time. As such, the majority of purchasers in the individual market will see much higher premium increases.

Scenario Comparison—Impact of Effective Stabilizers

Membership Distribution by Segment (<65 Population)



The impact of rating reform will vary significantly across different areas of the country, and each state will be affected differently. To illustrate these differences by geography, we created 5 clusters

of states based on similarities in existing insurance rating rules. It is important to note that there is still variation within clusters, depending on each state's unique characteristics. However, these clusters give a sense of the order of magnitude of change that will result from reform.

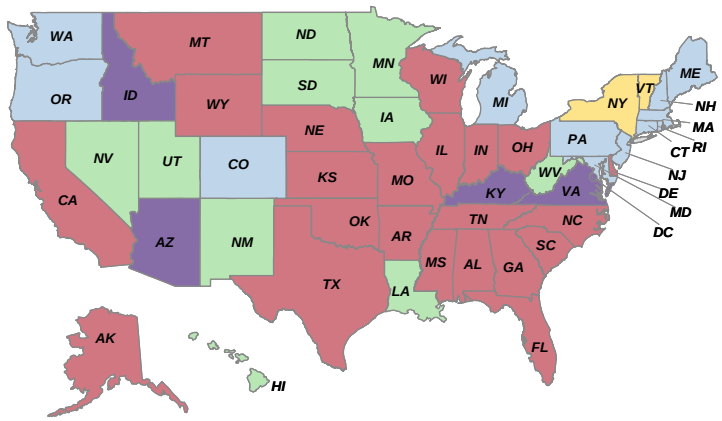
States in cluster 5 will experience the greatest premium increases. Shifts in the risk pool and relative premium increases in the reformed individual market will be greatest in cluster 5 states.

Expected medical claims growth in the reformed Individual market—Reform will have varying impacts on the expected medical claims

Expected Increase in Average Claims Per Member For the Reformed Individual Market (versus current Individual market)**

Market Disruption: Low → High

	With Weak Individual Mandate
Cluster 2: Modified Community Rating	30%
Cluster 3: Tight Rate Bands	43%
Cluster 4: More Flexibility for Healthy	60%
Cluster 5: Most Flexibility for Healthy	73%
National Averages	50%



** Claim increases represent the effect of changes in risk profile of the insured pool. Increases do not include the effect of medical inflation which will further drive increases. Values reflect expected claims in year 5 of reform in "low mandate" scenario.

Observed Market Experiences with Insurance Reform

Our analysis and the model demonstrate the need to couple insurance reforms with a strong and effective individual mandate to purchase insurance. The evidence from states that have implemented guaranteed issue and rating reforms without a mandate further demonstrates the need for a coverage requirement or mandate. Without a coverage requirement, rating reform and guaranteed issue alone combine to create an affordability barrier for all. Examples of states that have enacted insurance reforms without a requirement to purchase coverage are:

- **New York and Vermont:** Average premiums in the individual market today are about 60% higher than the national average
- **New Jersey:** Reform caused much higher premiums forcing thousands of individuals to drop coverage. The individual market decreased from 157,000 people in 1993 to 61,000 in 2007

- **Maine:** Individual market enrollment in Maine dropped from 90,000 to 41,000 between 1993 and 2007 following the state's reforms

Even in Massachusetts, there is evidence that individuals are selectively jumping in and out of the market when they need healthcare. Harvard Pilgrim Healthcare has written about their experiences with people gaming the system to access insurance only when needed:

"Between April of 2008 and March of 2009, about 40% of the people who purchased individual insurance from Harvard Pilgrim stayed covered by us for less than 5 months. Even more amazing, they incurred, on average, about $2,400 per person in monthly medical expenses—roughly 600% higher than what we would have expected."[12]

Lacking strong penalties, we expect similar types of behavior would occur in the reformed individual market—resulting in significantly higher premiums for those that are insured.

Impact on Small Groups

Under reform, small employers will experience premium increases as a result of rating rule changes and minimum benefit requirements. We estimate that small employers purchasing new policies in the reformed market, with an ineffective mandate, will experience premiums that are up to 19 percent higher in Year 5 of reform, not including the impact of medical inflation. About 9.5 million small group employees who have coverage today will stay covered under the "grandfathered" block in the initial post-reform years, but will face premium increases when the grandfathering phases-out.

After accounting for small employer tax credits, premium increases will lead to fewer small employers offering coverage. We estimate 2.5 million fewer members will be insured through small employer policies.

Conclusion

While lawmakers may have reduced penalties for not purchasing insurance because they are concerned about the risks of forcing people to purchase insurance if it is not affordable, failing to include an effective personal responsibility requirement could result in the failure of reform by causing premiums to skyrocket for all those who responsibly purchase insurance coverage.

This report illustrates the need to couple insurance reforms with an effective mandate. The provision of subsidies alone will not offset the impact of insurance reforms on average premiums in the market. A balanced, sustainable insurance pool, that ensures everyone is covered, is critical to making healthcare affordable for all. This has been validated through state experience in markets where guaranteed issue and rating reforms have been implemented without coverage requirements or mandates.

While the Senate Finance Committee proposal includes provisions such as reinsurance and grandfathering to mitigate the cost of insurance reforms in the initial years of reform, these reform elements will not be successful unless coupled with an effective coverage requirement.

[12] This can be found at: http://www.letstalkhealthcare.org/ma-health-reform/a-costly-wrinkle-in-the-merged-market/

Appendix

Impact of Major Insurance Reforms: New Individual Market Purchasers

(Estimates reflect year 5 impact, excluding medical inflation)

	National Average	Cluster 2 States	Cluster 3 States	Cluster 4 States	Cluster 5 States
Insurance reforms with weak personal responsibility requirement	+40%	+20%	+33%	+50%	+63%
New minimum benefit package at 65% actuarial value	+10%	+10%	+10%	+10%	+10%
Total Claims Increases (excluding medical inflation)	**+50%**	**+30%**	**+43%**	**+60%**	**+73%**

This does not include the insurer tax

Analysis assumes weak individual mandate, modified community rating, subsidies and grandfathering; clusters represent states with similar insurance rules.

Impact of Major Insurance Reforms: Young Individual Market Purchasers

(Estimates reflect year 1 impact, excluding medical inflation)

	Premium Increases for Youngest, Healthiest 30% of People			
	Cluster 2 States	Cluster 3 States	Cluster 4 States	Cluster 5 States
Insurance reforms with weak personal responsibility requirement	+25%	+33%	+37%	+50%
New minimum benefit package at 65% actuarial value	+10%	+10%	+10%	+10%
TOTAL Premium Increases (excluding medical inflation)	**+35%**	**+43%**	**+47%**	**+60%**

This does not include the insurer tax

Analysis assumes weak individual mandate, modified community rating, individual and small employer subsidies, reinsurance, and grandfathering; clusters represent states with similar insurance rules.

Impact of Major Insurance Reforms: New Small Group Purchasers

(Estimates reflect year 5 impact, excluding medical inflation)

	National Average	Cluster 2 States	Cluster 3 States	Cluster 4 States	Cluster 5 States
Insurance reforms with weak personal responsibility requirement	+16%	+19%	+20%	+21%	+26%
New minimum benefit package at 65% actuarial value	+3%	+3%	+3%	+3%	+3%
Total Claims Increase (excludes medical inflation)	**+19%**	**+22%**	**+23%**	**+24%**	**+29%**

This does not include the insurer tax

Analysis assumes weak individual mandate, modified community rating, subsidies and grandfathering; clusters represent states with similar insurance rules.