Issue Brief **August 2013**

Office of Insurance Regulation's Estimate of Individual Market Premium Increases Under PPACAC Misleads Consumers

Summary:

Starting October 1, 2013, Floridians will be able to shop for and purchase private health insurance plans through the new Health Insurance Marketplace[1] (previously known and sometimes referred to as the Exchange) created through the Patient Protection and Affordable Care Act (PPACA), the federal health reform law. Coverage purchased through the Marketplace could take effect as early as January 1, 2014.

On July 31, the Florida Office of Insurance Regulation (OIR), the state entity responsible for regulating health insurance policies and rates (i.e., premiums)[2], released a chart and related information under the heading "Individual Monthly Health Insurance Premiums Before and After PPACA.[i]" Unfortunately, the information provided by OIR provides no credible comparison of the impact of PPACA on rates. Its continued use as a basis for official projections is likely to result in direct harm to consumers.

Qualified Health Plans & Grandfathered vs. Non-Grandfathered Plans:

Health plans sold in the Marketplace[3], known as Qualified Health Plans, must not only meet standards requiring that they provide a strong benefit package and limit cost-sharing (out-of-pocket costs), they also be made affordable for many low- and middle-income Floridians through the availability of Advance Premium Tax Credits (i.e., federal subsidies). While *all* health plans that are new or significantly modified since 2010 (referred to in PPACA as "non-grandfathered" plans) will be required to meet the benefit and cost-sharing standards starting in 2014, only those sold in the Marketplace can be purchased with the

---

1 The Health Insurance Marketplace will be accessible on-line at www.healthcare.gov.

2 As a result of the passage of CS/SB 1842 during the 2013 legislative session, OIR will no longer directly regulate health insurance policies or rates for any non-grandfathered plan (specifically including Qualified Health Plans sold in the Marketplace) during plan years 2014 and 2015.

3 For purposes of this brief, the term "Marketplace" refers to plans sold in the individual health insurance market only (i.e., self-purchased coverage). By contrast, the SHOP (Small Business Health Options Program) Marketplace, which is not the subject of OIR's analysis or this brief, will offer coverage in the small group market.

help of Advance Premium Tax Credits to make them more affordable.[4]

By contrast, many Floridians will remain enrolled in "grandfathered" plans, which will remain exempt from the most important requirements of PPACA. In particular, grandfathered plans may have extremely limited benefits and/or massive cost-sharing requirements that often render comparison with Qualified Health Plans meaningless. For this reason and others discussed in this report, recent analysis published by the Florida Office of Insurance Regulation comparing the 2013 average premium among *all* plans sold in the individual market (both grandfathered and non-grandfathered) with 2014 premiums for Qualified Health Plans only is misleading.

The Office of Insurance Regulation's Analysis

OIR's analysis consists of two comparisons: the "Gross Annual Premium Comparison" and the "Silver Plan Comparison." A full discussion of the nature of what exactly OIR purports to be comparing in each is beyond the scope of this brief. In summary, however:

1) The "Gross Annual Premium Comparison" seeks to compare, for each insurer (or HMO) selling Qualified Health Plans (QHPs) in the Marketplace, the overall statewide average of all premiums throughout the individual market in 2013 ("before PPACA")[5] with each of those individual insurer's average premiums in 2014 ("after PPACA").

2) The "Silver Plan Comparison" seeks to compare, again for each insurer selling QHPs, the estimated overall statewide average premium for a hypothetical plan in 2013 (after making adjustments) with each of those insurer's average premium for a Silver-level[6] plan in 2014.

OIR's analysis pertains only to Florida's individual (i.e., direct-purchase) health insurance market. In relative terms, Florida's individual market is small, with about 500,000 primary insureds and 700,000 total persons covered.

The remainder of this brief consists of a synopsis of the problems with these comparisons. However, some additional context is needed. Regardless of the conclusions that can or cannot appropriately be drawn from OIR's report, this discussion has no relevance for the vast majority of Floridians. OIR's analysis pertains only to Florida's individual (i.e., direct-purchase) health insurance market. In relative terms, Florida's individual market is small, with about 500,000 primary insureds and 700,000 total persons covered.[ii] So although changes within the individual market are of critical concern for those

[4] By definition, Qualified Health Plans, which have never been sold prior to the launch of the Marketplace, are non-grandfathered plans.

[5] This brief uses the terms "before PPACA" and "after PPACA" for consistency with OIR terminology. However, PPACA was enacted in 2010. By contrast, OIR for its part consistently refers to 2013 as "before PPACA."

[6] A Silver plan is a plan that covers all PPACA-required benefits (known as "Essential Health Benefits"), where the plan pays approximately 70% of the expected total cost of care for a typical enrollee. Most Floridians purchasing coverage and using Advance Premium Tax Credits in the Marketplace are expected to buy a Silver plan.

Floridians, it must also be noted that that group constitutes less than five percent of Florida's population. In particular, OIR's report cannot be used to draw any conclusions whatsoever regarding the impact of PPACA on premiums for Floridians who have coverage through a job, Medicare, etc.

Problems with the "Gross Annual Premium Comparison"

1. **OIR Compares Values that Cannot Be Compared, then Averages Values that Cannot Be Averaged**

Without explanation, OIR first compares *each individual insurer's* after-PPACA average premium with *one single statewide* before-PPACA average premium taken across all insurers in the individual market. OIR misleadingly refers to the amount by which those two numbers differ in each case as the "change" in premiums.

Furthermore, several of the insurers included in the comparison have minimal or no current presence in Florida's individual market. These insurers had very few or no individual market policyholders in 2013, and they project that their market presence in 2014 will be very limited. For these insurers, OIR calculated the difference between before- and after-PPACA premiums by comparing premiums for a very small number of 2014 policyholders with the average across the entire statewide market in 2013, and those insurers were barely even participants in that market, if they participated at all.

Nevertheless, to arrive at its final estimate of a 39.3% average rate increase under PPACA, after *first* calculating the "percent change" for these currently non-existent plans, OIR *then* assigned them exactly the same weight in the statewide "average" calculation as an insurer with hundreds of thousands of current policyholders.

To summarize, OIR's problematic series of actions included adding the 11 meaningless "percent change" values together, averaging those values as if they had equal weight, and then representing the result as an estimate of the statewide average change in rates.

OIR's Focus on PPACA's Impact on the Current Individual Market Creates "Apples and Oranges" Comparisons and Does Not Account for the Fact that Such Comparison Will Often Be Moot

The plans for which premiums have implicitly been factored into OIR's statewide average before-PPACA premium include a wide array of low-value plans. These include high-deductible plans as well as "mini-med" plans (i.e., plans that have extremely limited benefit levels or that do not cover certain types of benefits, such as prescription drugs, at all).

Insurers can no longer sell such inadequate plans after January 1, 2014, but most who wish to remain enrolled in these plans may do so. The fact is, most of these consumers currently have no choice but to remain in inadequate coverage for lack of other options. However, because new plans can no longer impose waiting periods for pre-existing conditions or set premiums based on health status, these

consumers will be free to leave their current plans and immediately buy meaningful coverage. For those that use the Marketplace, many will gain coverage made affordable through the availability of Advance Premium Tax Credits.

Therefore, even if OIR's method of comparing rates before and after PPACA had been appropriate, justifying its assertion that the average premium for enrollments in Cigna plans, for example, will be 55.3% higher in 2014, that number would still not represent the typical premium increase for a current Cigna plan enrollee.

Even if OIR's method of comparing rates before and after PPACA had been appropriate, justifying its assertion that the average premium for enrollments in Cigna plans, for example, will be 55.3% higher in 2014, that number would still not represent the typical premium increase for a current Cigna plan enrollee.

For one, these before- and after-PPACA averages are weighted across all plan offerings, and PPACA brings new plan offerings that naturally have higher premiums than mini-med and other inadequate plans. For another, if a low- or moderate-income Cigna plan enrollee is currently enrolled in less adequate coverage than (s)he could obtain through the Marketplace and yet still faces a significant premium increase in 2014, (s)he need not remain in that plan. (S)he likely can obtain better, more affordable coverage through the Marketplace. OIR's estimates do not take this post-PPACA reality into consideration.

1. Omitting the Impact of Advance Premium Tax Credits in the Marketplace Makes 2014 Rates Seem Much Higher Than They Will Actually Be

Even if only a portion of the 700,000 Floridians who currently have their coverage through the individual market transition to the Marketplace and access Advance Premium Tax Credits (APTCs) there, actual average premium contributions will drop markedly, potentially erasing most or all of the supposed pre-/post-PPACA premium gap.

Premium contributions for those who qualify for APTCs are calculated as a percentage of income[iii]. In the case of an individual, monthly payments would range from $20 at 100% of the federal poverty level to $360 at 400% of poverty. What the total premium amount would have been (i.e., before subsidies are factored in) is therefore entirely irrelevant in this context.

To gain a sense of how significant of an impact APTCs will have on those who access them, consider that the average premium in Florida's *small group* market was $450 per month in 2012.[iv] (That average is certainly higher for PPACA-compliant plans in the individual market, so $450 is useful as a conservative placeholder.) Premium payments for such a plan would be reduced by a bare minimum of $90 per month with the use of APTCs, and as much as $430. Thus, factoring in the impact of the availability of these tax credits across the board could significantly reduce the actual average premium payment made by Floridians in the individual market.

2. OIR Continues to Rely on Incomplete Plan Comparisons Based on Premiums Alone

Finally, a structural problem that appears throughout OIR's statements regarding the potential impact of PPACA on the cost of health insurance is its basing of cost comparisons on premiums alone. Premiums for a plan with a $10,000 deductible will obviously be lower than premiums for a Qualified Health Plan sold in the Marketplace, but the former cannot be considered a low-cost plan from the consumer's perspective. In addition, some consumers purchasing Qualified Health Plans in the Marketplace will not only see their premiums reduced by the use of Advance Premium Tax Credits, they will qualify for "Cost-Sharing Subsidies" that lower their deductibles and coinsurance as well. OIR's measurement of plan affordability based on a comparison of premiums alone, without consideration of cost-sharing requirements, is incomplete and potentially misleading.

A structural problem that appears throughout OIR's statements regarding the potential impact of PPACA on the cost of health insurance is its basing of cost comparisons on premiums alone.

Problems with the "Silver Plan Comparison"

OIR's "Silver Plan Comparison" incorporates many of the same flawed assumptions as the "Gross Annual Premium Comparison", and overlays some additional ones as well. In particular, the concerns raised in #1, #3 and #4 above apply to this comparison as well. Furthermore:

Some consumers purchasing Qualified Health Plans in the Marketplace will not only see their premiums reduced by the use of Advance Premium Tax Credits, they will qualify for "Cost-Sharing Subsidies" that lower their deductibles and coinsurance as well. OIR's measurement of plan affordability based on a comparison of premiums alone, without consideration of cost-sharing requirements, is incomplete and potentially misleading.

3. OIR's Assumption that a Silver Plan and the "Normalized" Version of its Standard Plan A Are Equivalent is Based on a Misapplication of the Term "Value"

The comparison OIR offers is between a Silver Plan and "Standard Plan A, as defined in Rule 69O-149.204 [Florida Administrative Code]." Standard Plan A is purely hypothetical and in fact is not actually offered by any insurer in Florida. Even if Standard Plan A were not purely hypothetical, the two plans would be not directly comparable, at least without significant adjustments to account for their differences.

OIR does state that Standard Plan A has in fact been "adjusted to reflect the value of a Silver Plan." By this, OIR indicates that it estimated the expected average *total cost* of care delivered under the plan, and then assumed that the insurer will pay 70% of that expected cost (with the consumer paying the remaining 30%.) In insurance terminology, this 70% is referred to as the plan's "Actuarial Value." Under the ACA, Silver Plans must have Actuarial Values of 70% +/-, so the use of a 70% multiplier does make sense.

From there, however, problems quickly become apparent. Because Actuarial Value only makes sense

when measured in the context of a standard set of covered benefits used by a standard consumer population, the tool that makes the 70% calculation possible is the Actuarial Value Calculator (Calculator) defined in federal PPACA rules.[v] OIR in fact indicates that they did make use of the Calculator.

However, the Calculator is grounded in the above-mentioned standard assumptions, particularly the assumption that plans will cover all Essential Health Benefits. Yet Standard Plan A (last amended in 2004) does not provide for such coverage. Furthermore, under Standard Plan A, PPOs[vi] may apply a lifetime cap on total benefits, which has been prohibited in all new plans since 2010 under PPACA. Thus, Standard Plan A does not even meet the criteria for using the Calculator under federal rules.

The result of the omission of these benefits and limits is that the expected total cost of covered benefits under Standard Plan A will be lower than the expected cost of covered benefits under a Silver Plan, and perhaps significantly lower. Thus, OIR's statement that Standard Plan A has been "normalized to Silver Plan value" simply means that OIR multiplied the *lower* expected total cost of Standard Plan A by 70 percent. Consequently, some portion of the difference in the hypothetical premiums for Standard Plan A and the indicated Silver Plan can be solely attributed to the fact that Standard Plan A's benefit package is less robust. In short, Standard Plan A's true Actuarial Value is uncertain, but it is less than that of a Silver Plan.

4. In the Case of Standard Plan A, OIR Provides No Basis for Using Actuarial Value to Track Back to Premiums

Finally, in terms of what consumers pay, Actuarial Value refers strictly to cost-sharing (deductibles, co-insurance, etc.) The calculation of Actuarial Value itself includes no consideration of premium amounts.[vii] Consequently, even if Standard Plan A could be adjusted to assume the Actuarial Value of a Silver Plan, it is entirely unclear how OIR could take information pertaining solely to cost-sharing under Standard Plan A and translate that to an average premium amount. Absent a clear methodology for such a translation, the comparison is invalidated.

This report was researched and written by Greg Mellowe. Karen Woodall is Executive Director of FCFEP and Alan Stonecipher is Communications Director.
FCFEP is a member of the KidsWell cooperative.

Endnotes

i Florida Office of Insurance Regulation (OIR), Individual Monthly Health Insurance Premiums Before and After PPACA, July 2013

ii OIR, CY 2012 Gross Annual Premiums and Enrollment: Accident and Health Markets, July 2013, p.3

iii Specifically, payments are capped as a percentage of family Modified Adjusted Gross Income (or MAGI), as defined in PPACA.

iv Internal Revenue Service, Instructions for Form 8941, Credit for Small Employer Health Insurance Premiums (2012), p.5

v 45 CFR §156.135

vi Preferred provider organizations, as contrasted with health maintenance organizations (HMOs).

vii 45 CFR §156.20