FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

March 13, 2013

To: **Committee on Energy and Commerce Democratic Members and Staff**

Fr: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "Unaffordable: Impacts of Obamacare on Americans' Health Insurance Premiums."**

On Friday, March 15, 2013, at 9:00 a.m. in room 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, "Unaffordable: Impacts of Obamacare on Americans' Health Insurance Premiums."

I. THE HEALTH INSURANCE MARKET PRIOR TO THE ACA

Prior to the passage of the Affordable Care Act (ACA)[1] the health insurance market suffered from adverse selection, high administrative costs, and rising premiums. The number of employers providing coverage to their workers was declining, average premiums had more than doubled in a decade, the number of uninsured was rising rapidly, and many individuals and families with coverage – particularly in the individual market – had insurance policies that provided low value and little security.[2]

In many states around the country, insurers were permitted to charge individuals dramatically different premiums based on their age, gender, medical history, and other factors. Insurers routinely refused to cover individuals with pre-existing medical conditions and devoted significant resources to the process of medical underwriting – conducting detailed examinations of an applicant's medical history to determine the price at which they could profitably offer coverage to that individual, if at all. In the three years before the passage of health reform the

[1] The ACA is compromised of two public laws, P.L. 111-148 and P.L. 111-152.

[2] Department of Health and Human Services, *Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform* (Jan. 28, 2011) (online at http://www.healthcare.gov/news/reports/premiums01282011a.pdf), and J.R. Gabel et al. *Trends in Underinsurance and the Affordability of Employer Coverage, 2004-2007*, Health Affairs (June 2, 2009) (online at http://content.healthaffairs.org/content/28/4/w595.full.html).

four largest for-profit health insurance companies denied over 600,000 individuals coverage because of pre-existing conditions, with coverage denials increasing significantly each year.[3] As many as 129 million Americans with pre-existing conditions could have been denied coverage prior to reform.[4] The most recent data available indicates that insurers decline more than one in five applications for individual coverage, with some insurance companies denying as many as 70% of applicants in a given state.[5]

For consumers able to obtain coverage in the individual market, insurers frequently raised rates if a policyholder began to require increased care and set hard annual and lifetime limits on the amount of care covered. Insurers even rescinded coverage if an individual required certain types of treatment, with rescissions at times based on dubious claims that the policy holder failed to disclose a pre-existing medical condition.[6]

The Committee examined these practices in detail in the years leading up to the passage of the ACA.[7] Through hearings and investigations, the Committee found that the health insurance market was fundamentally flawed and required comprehensive reform. Numerous independent analyses confirmed that millions of Americans could not access affordable private

---

[3] Memorandum from Chairmen Henry A. Waxman and Bart Stupak to Members of the Committee on Energy and Commerce, *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance* Market, 111th Cong. (Oct. 12, 2010) (online at http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-existing.Condition.Denials.Individual.Market.2010.10.12.pdf).

[4] Department of Human Services At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (Nov. 2011) (online at: http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml).

[5] HealthPocket, *Health Insurance Application Rejection Rates Rising?* (Jan. 24, 2013) (online at http://www.healthpocket.com/healthcare-resources/health-insurance-application-rejection-rates).

[6] Families USA Foundation, *Failing Grades: State Consumer Protections in the Individual Insurance Market* (June 2008) (online at http://www.familiesusa.org/assets/pdfs/failing-grades.pdf) and Memorandum from Chairmen Henry A. Waxman and Bart Stupak to Members of the Committee on Energy and Commerce, *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance* Market, 111th Cong. (Oct. 12, 2010) (online at http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-existing.Condition.Denials.Individual.Market.2010.10.12.pdf).

[7] House Committee on Energy and Commerce, *Hearings on Making Health Care Work for American Families*, 111th Cong. (March 10, 17, 24, 31, April 2, 2009).

coverage in the individual market and that those who had coverage could not rely upon it to help pay for needed care while remaining affordable.[8]

Major insurance companies agreed that comprehensive reform and universal health insurance coverage were necessary to eliminate the controversial practices of medical underwriting and rescission and to create a more fair and stable market for consumers.[9] However, despite early statements of support for reform, insurers have consistently fought to maintain their ability to set arbitrary limits on coverage and charge consumers vastly different premiums based on age, gender, health status, and other factors.

II. KEY CONSUMER PROTECTIONS AND INSURANCE MARKET REFORMS IN THE AFFORDABLE CARE ACT

The ACA establishes new insurance market reforms and consumer protections across the health insurance market. The reforms are designed to create a functioning health insurance marketplace that follows the basic principals of shared risk and shared responsibility that are the hallmarks of true insurance.

The ACA requires the guaranteed issue and guaranteed renewal of coverage – meaning that insurance companies will no longer be allowed to deny coverage or refuse to renew coverage based on an individual's health status.[10] These key reforms end insurance companies' ability to exclude individuals with preexisting conditions or potentially greater health needs from the market.

In addition to opening up the insurance market to individuals previously excluded based on their health status, the ACA makes sure that insurers are no longer able to price individuals out of the market with exorbitant premiums. Beginning in 2014, premiums in the individual and small group market will only be allowed to vary based on age (by no more than a 3:1 ratio),

---

[8] S. R. Collins et al. *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, The Commonwealth Fund (Sept. 2006); The Henry J. Kaiser Family Foundation, *How Accessible is Individual Health Insurance for Consumers in Less-Than Perfect Health?* (June 2001) (online at http://www.kff.org/insurance/20010620a-index.cfm); C. Schoen et al. *How Many Are Under insured? Trends Among U.S. Adults, 2003 and 2007,* Health Affairs (June 2008) (online at http://content.healthaffairs.org/content/early/2008/06/10/hlthaff.27.4.w298.full.pdf); and The Henry J. Kaiser Family Foundation and American Cancer Society, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System* (Feb. 2009) (online at http://www.kff.org/insurance/upload/7851.pdf).

[9] House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009) (H. Rept. 111-50) (online at http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg73743/pdf/CHRG-111hhrg73743.pdf).

[10] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 39 (Feb. 27, 2013) (final rule).

tobacco use (by no more than a 1.5:1 ratio), family size, and geography. Insurance companies will no longer be allowed to raise premiums based on any other factors—including pre-existing conditions, gender, and health status.[11]

Starting in 2014, health plans also will be required to maintain single risk pools for all of their individual and small group enrollees in a given state.[12] Maintaining a single risk pool guarantees that insurers will not be able to price less healthy individuals out of the market by locking them into so-called 'closed blocks of business' where premiums rise inexorably without the broader group of enrollees in the risk pool to help defray the costs.[13]

The ACA also requires health plans in the individual and small group markets to pay for a guaranteed percentage of enrollees' health expenses, places firm caps on the amount of out-of-pocket spending that can be required under an insurance policy, and makes sure that insurers cannot place limits on the amount of coverage a policy will provide in a given year or over the insured's lifetime.[14] All plans sold in the exchange will have an actuarial value of 60, 70, 80, or 90 percent depending on the level of coverage purchased, meaning they will pay for that set percentage of enrollees' health costs. This requirement will increase the value of insurance coverage for millions of Americans currently in the individual market.[15] The cap on out-of-pocket spending guarantees that individuals with serious health needs will not face ever-escalating cost-sharing in order to receive needed care.[16] The end of lifetime limits on coverage and the phase out of annual limits ensure that coverage remains intact even if an individual's health care needs increase dramatically in a given year or as the individual gets older.[17]

Under health reform, insurers must meet new transparency standards and provide real value for consumers' premium dollar. Health plans are now required to limit profits and

---

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] Department of Health and Human Services, Department of Labor, and Department of the Treasury, *Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections;* 75 Fed. Reg. 123 (June 28, 2010) (Final Rule and Proposed Rule).

[15] J.R. Gabel et al, *More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can be Sold Through Exchanges as of 2014,* Health Affairs (June, 2012) (online at http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.full.pdf+html).

[16] Department of Health and Human Services, Department of Labor, and Department of the Treasury, *Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections;* 75 Fed. Reg. 123 (June 28, 2010) (Final Rule and Proposed Rule).

[17] *Id.*

administrative overhead and publicly justify all proposed rate increases over 10 percent. Since health reform became law, new insurance policies have been become more valuable because insurers are now required to cover preventive benefits with no cost sharing. Additionally, beginning in 2014, individual and small group health plans must include 10 categories of essential health benefits so that consumers can be sure that all plans provide coverage are similar in value to a typical employer plan in the state.[18]

In addition to these consumer protections, the ACA creates transparent and competitive marketplaces for quality insurance to be offered called Exchanges.[19] A Health Insurance Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy.

III. IMPACTS OF HEALTH REFORM ON PREMIUMS

A. Recent Premium Trends

While the ACA's most significant consumer protections and insurance market reforms go into effect in 2014, the evidence thus far is that key provisions in the ACA have lowered premiums across the health insurance market.

The ACA requires insurers to document, submit for review, and publicly justify rate increases of 10 percent or more. Since this provision of the law went into effect, the proportion of proposed rate increases over 10 percent declined from 75 percent in 2010 to 34 percent in 2012 to less than 15% so far in 2013. The average premium increases fell by more than 30 percent over the same period.[20] HHS estimates that this policy has already saved consumers more than $1 billion.[21]

---

[18] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation;* 78 Fed. Reg. 37 (Feb. 25, 2013) (Final Rule).

[19] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers;* 77 Fed. Reg. 59 (Mar. 27, 2013) (Final Rule).

[20] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act* (Feb. 22, 2013) (online at http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.pdf).

[21] HealthCare.gov, *2012 Annual Rate Review: Rate Review Saves Estimated $1 Billion for Consumer*, U.S. (Sep. 11, 2012) (online at: http://www.healthcare.gov/news/reports/rate-review09112012a.html).

Since 2011, insurers have also been required to spend at least 80% of enrollee premiums on medical care rather than on administrative costs and profits. Insurers are required to repay any excess premiums collected back to consumers in the form of rebates. Because of this provision, insurers have repaid more than $1.1 billion in rebates to more than 13 million Americans.[22]

The Congressional Budget Office (CBO) and the CMS Actuary have not observed widespread premium increases as a result of the Act. In 2012, CBO lowered its projections for health insurance premiums, saying the level of health insurance premiums in 2021 would be 8 percent less than previously projected.[23] National health expenditure data compiled by the CMS Actuary has observed low premium growth in the years since the enactment of the Affordable Care Act.[24]

B. Estimating Premiums After 2014

When the more significant consumer protections and market reforms go into effect in 2014 the majority of the health insurance marketplace is expected to see limited change in premiums.[25] Plans in the large group insurance market – both self insured plans and fully insured plans – already follow many of the same rules that will be required of the individual and small group markets in 2014, and premiums in that market are expected to be stable. The Congressional Budget Office has estimated that average premiums in the post reform individual market will grow at historically modest levels and that premiums will decline dramatically for many enrollees so when subsidies are taken into account.[26]

---

[22] Centers for Medicare & Medicaid Services, *The 80/20 Rule: How Insurers Spend Your Health Insurance Premiums* (Feb. 15, 2013) (online at http://cciio.cms.gov/resources/files/mlr-report-02-15-2013.pdf).

[23] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,* (July 24, 2012) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf).

[24] M. Hartman et al, *National Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration*, Health Affairs (Jan, 2013) (online at http://content.healthaffairs.org/content/32/1/87.full.pdf).

[25] L.J. Blumberg et al, *Implications of the Affordable Care Act for American Businesses*, Urban Institute (Oct. 2012) (online at http://www.urban.org/UploadedPDF/412675-Implications-of-the-Affordable-Care-Act-for-American-Business.pdf).

[26] Letter from CBO Director Douglas Elmendorf to Senator Evan Bayh (Nov. 30, 2009) (online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf) and Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf).

In the individual and small group market, which were the center of the most unfair and discriminatory practices prior to reform, premiums in 2014 will vary based on a number of factors. The degree to which a particular state previously permitted aggressive age, gender, and health status rating will have a significant impact on changes in premiums in that state under the new reforms.[27] In general, states that allowed for significant premium price discrimination will see premiums decline dramatically for the victims of prior discrimination and rise for some individuals who benefited from that discrimination.

Across the individual and small group markets consumers are expected to benefit from increased competitive pressure on insurers and declining administrative costs. Insurers who previously devoted significant resources to medical underwriting will be required to accept all applicants and will no longer face the high administrative costs of investigating claims histories to exclude individuals from coverage. With insurers no longer able to compete on the basis of effectively selecting a healthy population to insure and consumers able to compare plans in simple, transparent marketplaces, insurers will be forced to compete on price and value. CBO projected that new competition will drive down premiums in the individual market by 7-10 percent and that the new entrants to the insurance market will drive down premiums by another 7-10 percent.[28]

Income levels in a given state will also impact premiums in 2014. Due to the fact that individuals and families with incomes under 400 percent of the federal poverty level will be eligible for subsidies when they purchase coverage, enrollee income will be important in determining effective premiums in 2014.[29] The percentage of a state's population that is between 100 and 138 percent of the federal poverty limit will also impact premiums. CBO has estimated that this population is likely to have greater health needs than others in the individual market, meaning that states choosing not to expand Medicaid may see slightly higher premiums as this eligible population enters the exchange.[30]

---

[27] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx).

[28] Letter from CBO Director Douglas Elmendorf to Senator Evan Bayh (Nov. 30, 2009) (online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf).

[29] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx).

[30] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 24, 2012) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf).

Calculating changes in premiums in 2014 is also complicated by the marked improvement in the value of coverage that will become available on the individual market.[31] The phase out of annual coverage limits, the end of lifetime coverage limits, and the requirement that insurers cover a core set of essential health benefits will make coverage in the individual market far superior to much of the coverage currently offered. The new caps on out-of-pocket spending and the new actuarial value requirements will dramatically improve the value of coverage and limit insurers ability to keep premiums low by charging extremely high deductibles and imposing onerous cost sharing. In 2010, more than half of Americans who had coverage in the individual market were enrolled in plans that did not meet the actuarial value standards required under the Act.[32] A recent analysis revealed that more than a third of health plans in the individual market currently have higher out-of-pocket maximums than will be permitted under health reform in 2014.[33]

Analyses that have taken many of these factors into account have found that premiums are expected to fall for the millions of people who were either priced out of the health insurance market or charged higher rates based on their age, gender, and health status.[34] When premium tax credits are taken into account, the majority of those already in the individual market are expected to see their effective premiums fall. For a minority of individuals who were able access low cost plans in the individual market prior to reform, the new broader risk pool, the improvements in coverage value, the new consumer protections, and the limits on premium variation may result in higher premiums in 2014. However, since the majority of the individual market will be eligible for subsidies and will be receiving more valuable coverage, overall out-of-pocket spending on health care may fall even for individuals whose premiums increase, particularly if they face the need for significant medical care.

---

[31] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx).

[32] J.R. Gabel et al, *More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can be Sold Through Exchanges as of 2014,* Health Affairs (June, 2012) (online at http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.full.pdf+html).

[33] HealthPocket, *1 in 3 Health Plans' Out-of-Pocket Costs Fail ACA Standards* (Feb. 7, 2013) (online at http://www.healthpocket.com/healthcare-resources/1-3-health-plans-out-of-pocket-costs-fail-aca-standards/).

[34] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx) and J. Gruber, *The Impact of the ACA and Exchange on Minnesota*, Prepared for the Minnesota Department of Commerce (April 2012) (online at http://mn.gov/commerce/insurance/images/ExchGruberGormanFinalReport4-12.pdf).

Some recent analyses have highlighted the potential increase in premiums for this small subset of the current individual health insurance market.[35] In some cases these analyses and the public discussion of them have given the incorrect impression that consumers should anticipate large premium increases across the entire insurance market. It is important to note that these studies have focused on a small subset of the individual market and do not address employer based insurance and public programs, which cover over 90 percent of the population and are not expected to face significantly premium increases as a result of the ACA.

These analyses also ignore the significant shortcomings of coverage currently offered in the market and the discriminatory policies that have allowed for some current enrollees to pay artificially low premiums. Prior to reform, many policyholders' premiums were likely to rise significantly if their health care needs increased, meaning that the low pre-reform premiums did not reflect the real costs a consumer would face if they actually had to rely on their insurance to help pay for significant medical care. In fact, premiums in the non-group market are so unstable that a recent study found that 80% of health plans in the market raised premiums above the price consumers were quoted when they applied for the coverage.[36]

Furthermore, low premiums in the pre-reform market do not reflect lower overall costs to the consumer. Low premium plans often required consumers to meet high deductibles and cost sharing requirements, which are just as economically significant as premiums but are not factored into many recent analyses of potential premium increases. In fact, the benefits that will be available through the individual market under health reform would have reduced out-of-pocket spending for consumers had they been available in 2001 through 2008.[37] Average annual out-of-pocket spending on medical care and drugs might have been $280 less, with the near-elderly and people with low incomes saving more than $500 per year.

Some analyses describing potential premium increases also often fail to factor premium tax credits into the estimated cost of coverage in 2014. Advance premium tax credits will be available to Americans with incomes under 400 percent of the federal poverty limit if they purchase coverage through an exchange. These subsidies will go directly towards the cost of coverage, tangibly and immediately lowering effective premiums each month. CBO has

---

[35] D. Holtz-Eakin, *Insurance Premiums in 2014 and the Affordable Care Act: Survey Evidence*, American Action Forum (Jan. 2013) (online at http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf) and K. Giesa and C. Carlson, *My Generation*, Contingencies (Jan 2013) (online at http://www.contingenciesonline.com/contingenciesonline/20130102#pg33).

[36] Health Pocket, *80 Percent of Health Plans Charge Higher Premiums Than Quoted* (Feb. 19, 2013) (online at: http://www.healthpocket.com/healthcare-resources/80-percent-of-health-plans-charge-higher-premiums-than-quoted).

[37] S.C. Hill, *Individual Insurance Benefits To Be Available Under Health Reform Would Have Cut Out-Of-Pocket Spending In 2001–08,* Health Affairs (May 11, 2012) (online at http://content.healthaffairs.org/content/early/2012/05/11/hlthaff.2011.1206.abstract).

estimated that the majority of the individuals getting coverage in the exchanges will receive subsidies and it is misleading to ignore their impact on effective premiums.[38]

More fundamentally, when analyzing potential premium increases, it is important to note that in the pre-reform individual market, premiums were held down for some policy holders because millions of Americans were either excluded from coverage all together or given an offer of coverage with such unaffordable premiums and cost sharing that they were priced out of the market. When these previously uninsured individuals are allowed into the market, their premiums will be dramatically lower than they would have been if insurers offered them coverage prior to reform.[39]

C. Additional ACA Provisions and Recent Legislation Related to Premiums

While most Americans in the individual market will see their effective premiums fall as a result of the ACA, the Act does take additional steps to make sure premiums remain stable across the market. The ACA creates state-based reinsurance and risk adjustment programs as well as a Federal risk corridors program to protect against adverse selection in the market and provide certainty to insurers as they begin to cover new populations.[40] These programs will transfer funds between insurers if the populations they cover face higher than expected medical costs. The risk adjustment program is permanent while the risk corridors and reinsurance programs will last for three years.

Some have proposed amending the limits on age rating in the ACA to allow insurers to charge older Americans premiums that are more than 5 times those they charge to younger Americans.[41] This change from a 3:1 rating limit to a 5:1 rating limit is harmful to older Americans, dramatically raising health insurance costs on Americans who already spend a disproportionate share of their after tax income on health care.

The Urban Institute recently undertook an in-depth analysis of the age-rating in the ACA. The study found that allowing insurers to charge older Americans premiums five times higher than they charge younger Americans "would have very little impact on out-of-pocket rates paid

---

[38] Congressional Budget Office , *February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*, (Feb. 23, 2013) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

[39] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx).

[40] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Standards Relate to Reinsurance, Risk Corridors and Risk Adjustment*, 77 Fed. Reg. 57 (Mar. 23, 2012) (final rule).

[41] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 39 (Feb. 27, 2013) (final rule).

by the youngest nongroup purchasers, once subsidies are taken into account." The study found that not only would average premiums stay stable, but so would premiums for the 10 million currently uninsured 21-27 year olds and the 3 million 21-27 year olds who currently have nongroup coverage. While vast majority of this younger population would be protected by Medicaid/CHIP, subsidies provided through the exchanges, or by their parents' employer-based coverage, older Americans would face significantly higher out-of-pocket rates, more limited access to subsidies and no option to remain on their parent's coverage. [42]

As the Urban Institute study highlights, the ACA provides unique coverage options specifically for young Americans. The Act provides for a catastrophic health plan available to people under 30. The plan will have higher deductibles and cost sharing than those allowed under other plans and is expected to have lower premiums than plans available in the exchange.[43] Because of health reform, insurers that offer dependent coverage are now required to allow children to stay on their parents' plans until age 26. This policy has already provided coverage to more than 3 million young adults who would have otherwise been uninsured.[44] Finally, with young adults more likely to be uninsured and low income than older Americans, young Americans will benefit substantially from the ACA's Medicaid expansion and premium tax credits, with more than 10 million young people expected to benefit.[45]

IV. WITNESS LIST

Wendell Potter
Senior Analyst, Center for Public Integrity

Douglas Holtz-Eakin
President, American Action Forum

Chris Carlson
Actuarial Principal, Oliver Wyman

---

[42] L.J. Blumberg and M. Buettgens, *Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance*, Urban Institute (March, 2013) (online at http://www.urban.org/UploadedPDF/412757-Why-the-ACAs-Limits-on-Age-Rating-Will-Not-Cause-Rate-Shock.pdf).

[43] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 39 (Feb. 27, 2013) (final rule).

[44] Office of the Assistant Secretary for Planning and Evaluation *Number of Young Adults Gaining Insurance Due to the Affordable Care Act Now Tops 3 Million* (June 19, 2012) (online at http://aspe.hhs.gov/aspe/gaininginsurance/rb.shtml).

[45] A. Smith, *The Truth About Health Coverage Affordability and Age Rating Under Obamacare*, Young Invincibles (Feb, 15, 2013). (online at http://younginvincibles.org/2013/02/the-truth-about-health-coverage-affordability-and-age-rating-under-obamacare/).