Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance

Timely Analysis of Immediate Health Policy Issues

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Summary

As the 2014 start date for the ACA's full implementation approaches, insurers are calling attention to a potential "rate shock" – or substantial increase in health insurance premiums – that will push young adults out of the nongroup insurance market, leaving them uninsured and raising premiums for older adults. Accordingly, the industry advocates pulling back on the ACA's requirement that premiums for adults age 64 be no more than three times higher than the premium for adults age 21 for the same coverage (a constraint relative to the fivefold-or-more difference that applies in today's market). This paper compares the likely impact of the ACA's 3:1 rate band to a "looser" 5:1 alternative—using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine behavior of likely purchasers. The analysis considers not only the ACA's rating requirements but also the impact of subsidies and Medicaid, CHIP or other coverage that will limit the out-of-pocket health costs individuals and families actually pay.

Overall, we find that loosening the rate bands from 3:1 to 5:1 would have very little impact on out-of-pocket rates paid by the youngest nongroup purchasers, once subsidies are taken into account. This is not only the case for all likely purchasers, but also for two populations of particular concern: the 10 million 21-27 year olds who are currently uninsured and the 3 million who currently have nongroup coverage.

The vast majority of these young adults will be protected by Medicaid/CHIP, subsidies provided through the exchanges, or by their parents' employer-based coverage. By contrast, looser rate bands would significantly increase out-of-pocket rates paid by the oldest purchasers, who lack a parental option and are substantially less likely to be eligible for subsidies.

Introduction

Considerable attention has been given to the possible "rate shock" in nongroup insurance markets once the full reforms associated with the Affordable Care Act (ACA) are implemented in 2014. The insurance industry warns, in particular, that the 3-to-1 age bands included in the law will substantially increase premiums faced by young adults, pushing them out of the insurance market and leaving them uninsured.[1] These age bands constrain carriers from charging a 64-year-old more than three times the premium of a 21-year-old for the same coverage. The industry believes these bands should more closely align with the premium variation by age seen in today's nongroup insurance markets (typically at least 5 to 1).

This paper explores the full distributional implications of the 3:1 bands relative to the "looser" policy alternative of 5:1 bands, and specifically examines what the young adults currently covered through the nongroup insurance market and those uninsured will face once the reforms are fully in place. A complete analysis, such as the one presented here, requires an assessment of how other changes forthcoming in the ACA could also affect this population, including eligibility for tax credits to offset some of the costs of premiums and cost-sharing responsibilities, as well as Medicaid eligibility. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine these issues comprehensively.

Tighter age-rating bands will increase premiums charged for the youngest adults older than 20 and lower them for the oldest adults compared to looser age bands. However, most young adults currently covered by nongroup insurance will be shielded from the full effects of the narrower age-rating bands by the ACA's increased eligibility for Medicaid, the tax credits offered through the health insurance exchanges, or through access to employer-sponsored insurance.

Methods

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.[2] Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model estimates changes

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Table 1: CMS Proposed Standard Age Curve

Age	Premium ratio	Age	Premium ratio	Age	Premium ratio
0–20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64+	3.000

Source: *Federal Register*, vol. 77, no. 227, Monday, November 26, Proposed Rules.

in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We expect that behavioral changes by individuals and employers to the 2014 reforms will have reached equilibrium at most three years after implementation.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,[3] which is referenced in the final rules as well.[4] Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With the 5:1 rating, we followed the same approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the notice of proposed rulemaking.[5] As a result, premiums will vary not only with age, but also by the number of individuals in the family.[6] All individuals are simulated to enroll in ACA-compliant insurance plans.

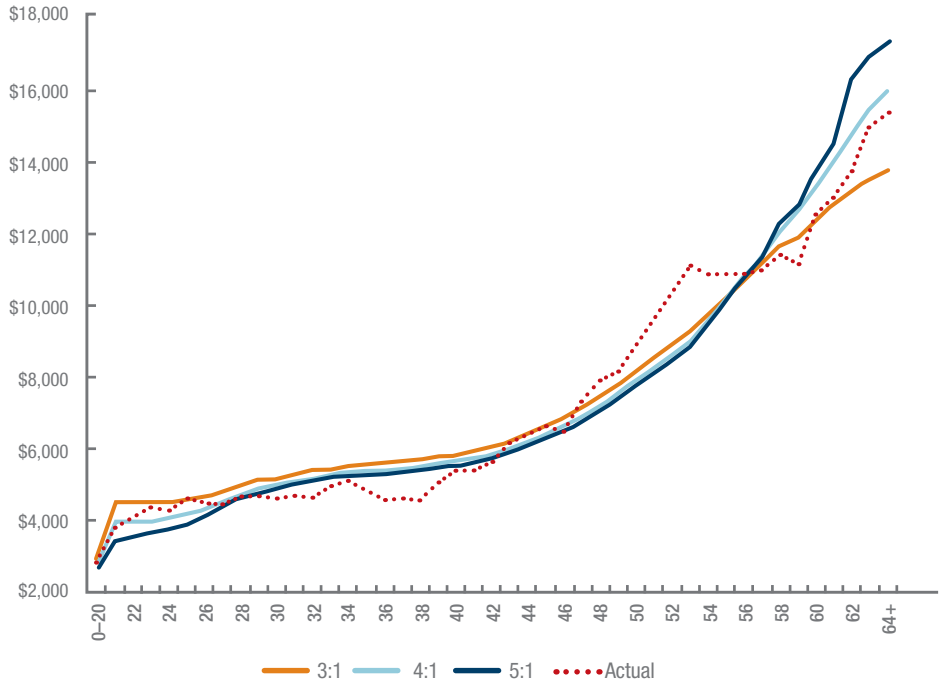
We simulate age-rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant. We also assume a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution. Additional methodological details are provided in the appendix.

Results

Exchange-Based Nongroup Health Insurance Premiums. Figure 1 illustrates the average premium by age for a silver-tier policy under the ACA as simulated in HIPSM using the CMS proposed standard age curve. Silver is the tier to which premium and cost-sharing subsidies in the nongroup health insurance exchange will be calculated. Using a bronze-tier plan would shift all the curves in the figure down; using gold or platinum plans would shift them up. While CMS only delineates the age curve for 3:1 rating since that is the approach required under the ACA, we adapt their gradient for 4:1 and 5:1 age-rating bands by changing the relative differences between age groups proportionately. While the remainder of the analysis focuses exclusively on comparisons of 3:1 and 5:1 ratings, we show 4:1 rating in figure 1 as well in order to clarify its implications relative to the other two, particularly for phasing down from looser to tighter bands as some in the industry have proposed.

The orange line represents the 3:1 premium gradient, the light blue the

Figure 1: Premiums at Different Age Compression Ratios, New HHS Method



4:1 gradient, and the dark blue line the 5:1 gradient. Since family premiums will be constructed in the post-reform nongroup market by summing the age-rated individual premiums of each family member, these curves reflect the age-rated premiums facing all nongroup enrollees expected to purchase coverage in the exchange, whether they would enroll in a single or family policy. By design, there is very little difference between the premium curves under the different age bands except for the youngest and oldest adults. Premiums are noticeably higher for those age 21 to 27 under 3:1 rating and are noticeably lower for those age 57 and older. The difference between premiums charged on behalf of those age 28 to 56 are considerably smaller across the different rating approaches, with the premiums under 3:1 slightly higher than under 4:1 and 5:1.

The red dotted line represents the variation in premiums that would be expected if age rating varied by the average covered expenses of those individuals actually expected to enroll in nongroup coverage under the ACA. The 3:1 age gradient developed by CMS is reasonably consistent with expected enrollee expenses, particularly for those up to age 27 and for those age 42 and older. Using the 5:1 age gradient would tend to undercharge young adults relative to their actual expenses and overcharge older adults relative to their actual expenses.

Table 2 shows the full average premiums for exchange-based nongroup coverage, by policy type (single versus family), and age of those covered for each of the two rating scenarios. The overall averages differ very little (less than 4 percent), due to slight differences in the age and health care risk of the nonelderly population enrolled in nongroup coverage and in the mix of policies purchased across the actuarial value tiers (bronze, silver, gold, and platinum).[7] For family policies, premium differences also reflect family size and age composition variation in those insured across the scenarios.

The largest differences in average single premiums between the age-rating scenarios, as would be expected, occur for adults age 21 to 27 and age 57 and up. Premiums for 21- to 27-year-olds are $850 lower under 5:1 than under 3:1 rating, while premiums for the 57- to 64-year-olds are $1,770 higher under 5:1 bands, on average. Average premiums for 18- to 20-year-olds are $150 lower under 5:1 rating than under 3:1 rating, about a 5 percent difference. Those age 28 to 56 would also see considerably smaller differences in average premiums under the two rating scenarios, in the range of 4 to 5 percent.

Similarly, average family premiums for those with older family members (57 and above) but without members 21 to 27 years old are significantly lower under 3:1 than under 5:1 rating. Conversely, those families with at least one member age 21 to 27 but without members from the older age group would save under 5:1 rating compared to 3:1. However, the savings for the younger units of moving to 5:1 rating would be about half the size of the increased cost that would be imposed on the older families. Differences in premiums across the rating regimes are much smaller for other mixed-age families.

Net Cost to Families, Taking Account of Premiums, Out-of-Pocket Costs, and Subsidies. As noted, premiums alone do not accurately portray the implications of different age-rating bands within the context of the ACA. Health care costs under reform also include out-of-pocket spending (e.g., deductibles, co-insurance), and federal subsidies reduce these costs for those with modest incomes. Table 3 shows the average 2017 health care costs faced by those insured through the nongroup insurance exchanges, by age, policy type, and income group, under the two age-rating band scenarios. For all insureds with incomes between 133 percent and 300 percent of the federal poverty level (FPL), within each age group, there is almost no difference in net costs between scenarios. This

Table 2: Average Premium for Exchange Based Nongroup Health Insurance Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals, 2017

	Premium Rating Option		
Age Group of Policyholder	**3:1**	**5:1**	**Difference**
Single Adults			
18–20	3,050	2,900	-150
21–27	4,850	4,000	-850
28–44	5,840	5,540	-300
45–56	8,930	8,560	-370
57+	13,160	14,930	1,770
Overall	6,930	6,660	-270
Family Units			
At least one age 21–27, none age 57+	11,580	10,340	-1,240
Other mixed-age families	16,200	15,440	-760
At least one age 57+, none age 21–27	23,450	25,930	2,480
Overall	16,970	16,570	-400

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Estimates include portions of premiums paid privately and via federal subsidies.

Table 3: Net Cost to Families for Nongroup Policyholders by Premium Age Rating Option, Age of Covered Individuals, and Income Relative to Poverty, 2017

			Out-of-Pocket by Income		
Age Group Single Units	**Age-rating restriction**	**Covered lives (thousands)**	**133–300% of FPL**	**300–400% of FPL**	**400%+ of FPL**
18–20	3:1	290	$1,390	$4,640	$3,910
	5:1	286	$1,370	$4,560	$3,760
	Difference		*-$20*	*-$80*	*-$150*
21–27	3:1	1,544	$1,530	$4,850	$5,820
	5:1	1,568	$1,530	$4,580	$5,350
	Difference		*$0*	*-$270*	*-$470*
28–44	3:1	1,718	$1,660	$5,030	$6,530
	5:1	1,735	$1,660	$4,920	$6,200
	Difference		*$0*	*-$110*	*-$330*
45–56	3:1	1,329	$1,830	$5,610	$11,360
	5:1	1,347	$1,840	$5,620	$10,860
	Difference		*$10*	*$10*	*-$500*
57+	3:1	718	$2,270	$6,250	$15,620
	5:1	672	$2,260	$6,250	$17,020
	Difference		*-$10*	*$0*	*$1,400*
			Out-of-Pocket Costs by Income		
Age Group Family Units	**Age-rating Restriction**	**Policies (thousands)**	**133–300% of FPL**	**300–400% of FPL**	**400%+ of FPL**
At least one age 21–27, none age 57+	3:1	353	$3,560	$7,770	$12,900
	5:1	369	$3,590	$7,220	$11,670
	Difference		*$30*	*-$550*	*-$1,230*
Other mixed-age families	3:1	2,315	$4,440	$10,030	$21,500
	5:1	2,388	$4,410	$10,000	$20,740
	Difference		*-$30*	*-$30*	*-$760*
At least one age 57+, none age 21–27	3:1	642	$4,730	$9,970	$28,410
	5:1	615	$4,710	$9,970	$30,730
	Difference		*-$20*	*$0*	*$2,320*

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Net cost is premiums plus out-of-pocket costs less subsidies.
FPL= federal poverty level

consistency results from the structure of the federal premium subsidies, which limit the amount of premium owed to a share of family income. The same is largely true for those with incomes between 300 percent and 400 percent of FPL, as this income group is also eligible for federal subsidies.

We do, however, see net costs somewhat lower for the younger adult age groups purchasing policies under the looser rating scenarios. With 3:1 age rating, single premiums for a young adult in this income group are generally greater than the amount they would

Table 4: Number of Policies and Median Health Care Spending Relative to Income for Nongroup Insurance Purchasers by Premium Age-Rating Option, Age of Covered Individuals, and Income Relative to Poverty

		Income Relative to Poverty and Percentile of Financial Burden Distribution					
Age Group Single Units	**Age rating restriction**	**133–300% of FPL**		**300–400% of FPL**		**400%+ of FPL**	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
18–20	3:1	7.2%	233	12.9%	19	5.5%	14
	5:1	7.2%	228	13.0%	20	5.3%	14
	Difference	*0.0%*		*0.1%*		*-0.2%*	
21–27	3:1	7.2%	1,317	11.2%	48	9.6%	64
	5:1	7.2%	1,314	11.1%	42	8.1%	79
	Difference	*0.0%*		*-0.1%*		*-1.5%*	
28–44	3:1	7.2%	1,206	11.3%	49	8.4%	156
	5:1	7.2%	1,207	11.3%	47	8.0%	164
	Difference	*0.0%*		*0.0%*		*-0.4%*	
45–56	3:1	7.8%	875	13.9%	87	12.6%	143
	5:1	7.8%	874	14.2%	86	12.0%	148
	Difference	*0.0%*		*0.3%*		*-0.6%*	
57+	3:1	9.3%	483	18.7%	67	13.9%	86
	5:1	9.3%	485	18.7%	67	16.0%	72
	Difference	*0.0%*		*0.0%*		*2.1%*	
All	3:1	7.5%	4,115	13.2%	270	10.0%	464
	5:1	7.5%	4,108	12.8%	261	9.5%	477
	Difference	*0.0%*		*-0.4%*		*-0.5%*	

		Income Relative to Poverty and Percentile of Financial Burden Distribution					
Age Group Family Units	**Age rating Restriction**	**133–300% of FPL**		**300–400% of FPL**		**400%+ of FPL**	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
At least one age 21–27, none age 57+	3:1	8.4%	299	12.0%	26	14.5%	46
	5:1	8.6%	307	11.9%	28	13.2%	46
	Difference	*0.2%*		*-0.1%*		*-1.3%*	
Other mixed families	3:1	9.6%	1,465	14.2%	257	16.4%	601
	5:1	9.6%	1,461	14.4%	268	16.1%	621
	Difference	*0.0%*		*0.2%*		*-0.3%*	
At least one age 57+, none age 21–27	3:1	14.0%	332	19.4%	78	17.6%	174
	5:1	13.9%	331	19.4%	78	18.8%	153
	Difference	*-0.1%*		*0.0%*		*1.2%*	
All families	3:1	10.0%	2,096	14.7%	361	16.5%	821
	5:1	10.0%	2,099	14.7%	374	16.0%	820
	Difference	*0.0%*		*0.0%*		*-0.5%*	

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Analysis based on the ACA in 2017. Medicare recipients are excluded from the 57+ age group. Significant numbers of adult non-group policyholders age 27 or younger report being students. As a result, some in this age group will be eligible for student insurance through their colleges and universities. It is unclear how many will opt for school-based coverage over exchange-based coverage, so they are all included here. Numbers of single policies equal number of covered lives. More than one person is covered under each family policy. Median health care spending is premiums plus out-of-pocket costs, minus subsides.
FPL= federal poverty level

be required to contribute toward their coverage; the federal subsidy pays the excess of their premium over 9.5 percent of their income. If age rating is 5:1 instead, premiums for this age group would sometimes be lower than the 9.5 percent of income contribution requirement, in which case the federal subsidy would be $0. These young adults would thus pay modestly less, on average, for single coverage under 5:1 age rating even though they are eligible for subsidies by virtue of their income.

Ninety-two percent of adults age 21 to 27 enrolling in single plans[8] in exchange-based coverage have incomes below 300 percent of FPL—in other words, the vast majority of young adults enrolled in these plans would not face different health care costs regardless of the rating bands chosen because of the protection afforded them by the ACA's subsidies (calculated from number of policies provided in table 4).[9] The same is true for 88 percent of 18- to 20-year-olds, 85 percent of 28- to 44-year-olds, 79 percent of 45- to 56-year-olds and 76 percent of those age 57 and older. Only about 4 percent of the youngest age group purchasing single plans have incomes high enough to make them ineligible for subsidies,[10] compared with about 14 percent of the oldest age group. Over 80 percent of the youngest families buying coverage are eligible for financial assistance for exchange-purchased family coverage.

The largest differences in costs across the age rating scenario are apparent for those with incomes over 400 percent of FPL, those who are ineligible for subsidized coverage. Average net costs for higher-income young adults age 18 to 20 buying single coverage are $150 lower under 5:1 rating than under 3:1, and the cost difference for 21- to 27-year-olds is $470. In contrast, those age 57 and older purchasing single policies would face $1,400 higher average costs under 5:1 age rating than under 3:1 rating. Similar patterns are seen for families with different age compositions. Again, the gains to the young adult families from moving to a 5:1 age rating approach would be half the increased costs imposed on the older families.

Net costs for older adults are considerably higher than for the younger adults, not only because of age rating and its consequent higher premiums, but also because older adults' use of medical care tends to be significantly higher, meaning their out-of-pocket spending is considerably higher as well. Thus, average spending under 3:1 rating by single 21- to 27-year-olds with incomes above 400 percent of FPL is $5,820, while it is $15,620 for singles age 57 and older of the same income. Likewise, average direct costs for older families under 3:1 rating are $28,410 compared with $12,900 for younger families.

Health Care Financial Burdens for Those Purchasing Exchange-Based Nongroup Coverage. Table 4 provides median direct health care expenses relative to income for those buying health insurance coverage through the nongroup exchanges. As indicated by the average expenses shown in table 3, the choice of age bands has almost no effect on the financial burdens of those with incomes at or below 400 percent of FPL, which account for about 85 percent of policies sold through the nongroup exchanges. While higher-income 21- to 27-year-olds buying single coverage would see a 1.5 percentage point higher health care financial burden under 3:1 than under 5:1 rating (9.6 percent of income compared with 8.1 percent), their 57- to 64-year-old counterparts would see their financial burdens lesson by over 2 percentage points (13.9 percent of income compared with 16.0 percent). The impact on the other age groups would be substantially smaller. Median financial burdens for 21- to 27-year-old single-policy purchasers outside the subsidy eligibility range would be about half that for those age 57 or older; the differential would shrink under 3:1 rating, but the burdens would remain significantly higher for the older adults. Similar patterns are seen for family policies where the members have different age compositions.

Status of Current Nongroup Enrollees Under the ACA. Current (pre-ACA) young nongroup enrollees constitute a central concern related to the implications of new insurance market rules. This population is most at risk for experiencing disruptions to their current coverage. While tables presented above include all those purchasing coverage in the nongroup markets post reform (both those newly purchasing and those continuing on from prior nongroup coverage), we now change our focus to those with current nongroup coverage.

Table 5, section A shows the number (in thousands) of covered lives in today's nongroup market by age and status under the ACA.[11] As we saw previously, the one group for whom 3:1 age-rating bands potentially have the largest negative implications is young adults age 21 to 27. Of the 2.9 million adults in this age group with pre-ACA nongroup coverage, 67 percent would be eligible for either Medicaid or CHIP under the ACA or for exchange-based subsidies for the purchase of private nongroup insurance, thus being protected from the potential negative effects of age rating on their premiums. Of the remaining 33 percent, two-thirds are up to age 26 and in families with an offer of coverage from an employer (data not shown), and thus could obtain coverage that way instead of through the nongroup market via the ACA's provisions regarding expansion of dependent coverage in private plans. More than three-quarters of the 1 million younger adults (age 18 to 20) with nongroup coverage would also be eligible for financial protection under the law. Older adults with current nongroup insurance coverage, those most assisted by the ACA's 3:1 age-rating bands, are significantly less likely to be eligible for financial assistance under the law than their younger counterparts.

Status of Currently Uninsured Under the ACA. Table 5, section B shows the post-reform eligibility status of those currently uninsured, by age. Young adults without insurance far outnumber those young adults with

Table 5:

A. Post-Reform Eligibility Status of Those with Current Nongroup Coverage, by Age Group
(numbers in thousands)

	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		
Age group	Number Currently Covered	Share of Those Currently Covered	Number Currently Covered	Share of Those Currently Covered	Total with Current Nongroup in Age Group
18–20	785	78.0%	221	22.0%	1,006
21–27	1,927	66.9%	951	33.1%	2,878
28–44	1,434	41.0%	2,067	59.0%	3,501
45–56	1,342	41.4%	1,903	58.6%	3,244
57–64	1,105	50.3%	1,094	49.7%	2,199
Total	6,593	51.4%	6,235	48.6%	12,828

B. Post-Reform Eligibility Status of Those Currently Uninsured, by Age Group
(numbers in thousands)

	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		
Age group	Number Currently Uninsured	Share of Those Currently Covered	Number Currently Uninsured	Share of Those Currently Covered	Total Currently Uninsured in Age Group
18–20	1,918	82.7%	400	17.3%	2,318
21–27	6,954	70.5%	2,913	29.5%	9,867
28–44	10,700	62.9%	6,307	37.1%	17,007
45–56	7,065	66.2%	3,615	33.8%	10,680
57–64	3,167	74.3%	1,098	25.7%	4,265
Total	29,804	67.5%	14,333	32.5%	44,137

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Analysis based on the ACA in 2017.

nongroup coverage today. For example, almost 10 million 21- to 27-year-olds today are uninsured, compared with just under 3 million with nongroup coverage. Over 70 percent of uninsured young adults will be eligible for financial assistance—either through Medicaid or the exchanges—once the ACA is implemented. Over 80 percent of uninsured young adults age 18 to 20 will also be eligible for Medicaid or tax credits in the nongroup exchanges. Consequently, the vast majority of these young adults, a central target population for enrollment in the nongroup market beginning in 2014, will also be shielded from significant financial effects of the change to narrower age-rating bands.

Aggregate Costs and Rates of Insurance Coverage. Consistent with our previous analyses on the distributional effects of age-rating options,[12] the current analysis shows virtually no difference in overall insurance coverage of the nonelderly across age-rating scenarios (appendix table 1). In addition, there is extremely little difference in the distribution of insurance coverage within age categories. Also consistent with our earlier work, aggregate government, employer and household costs under the ACA are not significantly affected by the choice of age-rating bands, with aggregate costs differing by less than 1 percent between 3:1 and 5:1 rating (appendix table 2). While larger percentages of young adults are eligible for exchange-based subsidies due to being lower income, lowering their premiums does not decrease total federal subsidies significantly since the average premiums for the older adults increase so substantially under 5:1 rating.

Conclusions

The modified community rating rules that will be implemented under the ACA in January 2014 will change how individually purchased insurance premiums will be determined in the vast majority of states. The law will significantly reduce the current market's variation in premiums between older and younger adults purchasing the same coverage. However, the claims by some in the insurance industry that this change will have dramatic implications for the out-of-pocket costs of young adults are unfounded. Those most affected by the changed rating rules will be those age 21 to 27, for whom average premiums will tend to be higher under 3:1 rating than under looser rating rules, and those age 57 and above, for whom average premiums will tend to be lower under 3:1 rating. However, the 3:1 age gradient developed by CMS is a reasonable proxy for the health expenses of those expected to enroll in the new nongroup marketplace, particularly for those up to age 27 and for those age 42 and older.

Appendix Table 1: Distribution of Health Insurance Coverage Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals 2017

Age Group	Age Rating Restriction	Private Health Insurance	Public Coverage	Uninsured	Total
Children, < 18	3:1	53.4%	41.4%	5.2%	100.0%
	5:1	53.4%	41.4%	5.2%	100.0%
18–20	3:1	34.5%	48.3%	17.2%	100.0%
	5:1	34.5%	48.3%	17.2%	100.0%
21–27	3:1	55.5%	28.5%	16.1%	100.0%
	5:1	55.5%	28.8%	15.7%	100.0%
28–44	3:1	71.5%	16.0%	12.4%	100.0%
	5:1	71.6%	16.1%	12.3%	100.0%
45–56	3:1	73.5%	17.7%	8.8%	100.0%
	5:1	73.5%	17.7%	8.8%	100.0%
57–64	3:1	65.4%	26.4%	8.2%	100.0%
	5:1	65.4%	26.4%	8.2%	100.0%
All nonelderly	3:1	63.3%	27.2%	9.4%	100.0%
	5:1	63.4%	27.3%	9.4%	100.0%

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017.

Appendix Table 2: Aggregate Government, Employer, and Household Costs for the Nonelderly Under Comprehensive Health Care Reform by Premium Age Rating Option 2017 (in billions)

	Reform	
	3:1	5:1
Government Spending		
Medicaid/CHIP and household subsidies	597	597
Employer subsidies	6	5
Less assessments and penalties	8	8
Net government spending	595	594
Uncompensated Care	48	47
Employer Spending, incl. assessments	844	838
Household Spending, incl. penalties	482	480
Total Public and Private Spending	1,969	1,959

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.
Notes: Affordable Care Act simulated in 2017. Household spending includings health insurance premium payments by workers and others as well as direct out-of-pocket spending on medical care.

In addition, large majorities of the young adults purchasing nongroup insurance today, those uninsured today, and those expected to purchase nongroup coverage under the fully implemented ACA, would be shielded from the negative effects of tighter age-rating rules. This financial protection will come from the availability of federal subsidies for the purchases of private nongroup insurance and, for some current nongroup purchasers and the currently uninsured, the expanded Medicaid program.

Appendix: Methodology

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.[13] The core of the national model is two years of the Current Population Survey's Annual Social and Economic Supplement, matched to several other national datasets, including the Medical Expenditure Panel Survey–Household Component.[14] Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We choose 2017 because we expect that behavioral changes by individuals and employers to the reforms being implemented in 2014 will have reached equilibrium at most three years after implementation.

This approach differs from that of the Congressional Budget Office (CBO) or the Centers for Medicare and Medicaid Services (CMS) actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief and are not repeated here.[15]

For purposes of this analysis, we assume that the nongroup and small group markets are not pooled together in computing premiums. However, states choosing to do so could decrease the magnitude of any nongroup premium increases associated with the ACA.[16] Small firms are defined as those of 100 (full-time-equivalent) or fewer workers as all states must use this definition beginning in 2016. We simulate the affordability exemption to the individual mandate that observers expect to be in the forthcoming regulations; this differs from the interpretation of the Joint Committee on Taxation and CBO that we used in earlier modeling. We assume that dependents will not incur mandate penalties if they do not obtain coverage and the lowest available family premium is above 8 percent of family income. A family would still be barred from subsidized exchange coverage if the lowest single premium offered to one member was less than 9.5 percent of family income. The Basic Health Plan option was not modeled.

The Supreme Court's ruling on the ACA means that states may decide whether or not to expand Medicaid coverage to nonelderly adults. Our analysis assumes that all states take advantage of the opportunity to increase eligibility to those with incomes below 133 percent of FPL. Beginning in 2014, states do not have to maintain Medicaid eligibility for adults above 133 percent of FPL. We assume that states would discontinue eligibility for adults eligible under Section 1115 waivers or Section 1931 who are above that income threshold. Other categories of adults could be affected, notably the medically needy and pregnant women, but we do not model any change in their eligibility due to the difficulty in identifying them in our underlying survey data.

We assume that college student plans are required to be Essential Health Benefit compliant plans starting in 2014. The structure of the CPS is intended to include students temporarily residing away at college in their parents' permanent residence if they are tax dependents of their parents. Consequently, full-time students reporting on the CPS that they reside independently are treated as independent tax units. However, we recognize that the survey may not correctly identify all full-time students living at school as to whether they are tax dependents of their parent or not, particularly those living outside university housing.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,[17] which is referenced in the final rules as well.[18] Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With 4:1 and 5:1 rating, we followed the same approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the notice of proposed rulemaking.[19] As a result, premiums will vary not only with the age, but also by the number of individuals in the family.[20]

A number of factors that could impact premium differences by age are not taken into account here. We do not model the option for catastrophic coverage for adults under age 30 as provided under the ACA. This coverage option makes lower-cost coverage with higher cost-sharing requirements than the bronze level available to young adults, creating a lower premium option than those modeled here. As a consequence, average premiums for the young adults presented will overstate the actual averages under full implementation of the law. In addition, we do not model specific tobacco use–related premium adjustments (permitted in the small group and nongroup markets under the ACA) or premium adjustments due to wellness programs (permitted in the group market under the ACA). Tobacco adjustments are more likely to increase premiums of younger adults than older adults as they are somewhat more likely to use tobacco products.[21] Wellness adjustments are more likely to increase premiums of older adults, as the health problems they most frequently target (e.g., high blood pressure, high cholesterol, abnormal blood sugar) are more likely to occur among the older population. Depending upon how widespread these premium rating approaches are used, they could significantly affect decisions of adults of different ages and their decisions to enroll in insurance coverage in the small group and nongroup markets, and thus could also affect premiums in those markets.

We simulate age rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant and assuming a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution.

Endnotes

[1] For example, Karen Ignani, says, "Unless the restrictions on age rating are loosened, younger people will face significant cost increases at the same time the broader coverage expansion begins to take effect in 2014" ("Now is the time to focus on affordability," http://blogs.reuters.com/great-debate/2012/07/10/now-is-the-time-to-focus-on-healthcare-affordability/).

[2] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[3] http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf.

[4] http://www.ofr.gov/OFRUpload/OFRData/2013-04335_PI.pdf.

[5] A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students age up to age 23.

[6] For the remainder of this paper, "family" is used to refer to the health insurance unit.

[7] For example, in a small number of cases, older adults purchase plans from a higher tier under 3:1 rating than they would under 5:1 rating because the more comprehensive coverage is more affordable under the narrower rating bands.

[8] Single policies each cover one individual (i.e., number of policies is equal to the number of people covered by those policies). Each family policy covers more than one person.

[9] 92 percent is calculated from table 4 as follows: In 2017, we estimate that the total number of single policies for adults age 21 to 27 held through nongroup exchange plans will be 1,429,000. We also estimate that 1,317,000 of those policies will be held by individuals with income at or below 300 percent of FPL. 1,317,000/1,429,000 = 92 percent.

[10] Another 4 percent of this age group has income between 300 and 400 percent of FPL. They are eligible for subsidies by virtue of their income, but as we saw earlier, under 5:1 rating some will not actually receive a subsidy because the premium cost they would face is less than the 9.5 percent of income premium cap they receive from the federal government.

[11] Here, we include full-time adult students reporting nongroup coverage under the current system. Although much of this coverage is student insurance through colleges and universities, we are unable to identify specifically the source of any particular nongroup plan.

[12] Blumberg LJ, Buettgens M and Garrett B. "Update: Age Rating under Comprehensive Health Care Reform." Insight on the Issues brief. Washington: AARP, 2010. Available at http://assets.aarp.org/rgcenter/ppi/health-care/i000-age-rating.pdf; and Blumberg LJ, Buettgens M and Garrett B. "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens." Timely Analysis of Immediate Health Policy Issues. Washington: The Urban Institute, 2009. Available at http://www.urban.org/publications/411970.html.

[13] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[14] HIPSM uses data from several national datasets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

[15] Buettgens M, Garrett B, and Holahan J. "America under the Affordable Care Act." Washington: The Urban Institute, 2010. http://www.urban.org/publications/412267.html.

[16] See Blavin F, Blumberg LJ, Buettgens M, Holahan J and McMorrow S. "How Choices in Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage." Health Affairs 31 (2012):2290–2298. Relatedly, The November Notice of Proposed Rulemaking on market rules (http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf) specifically allows small groups and small group issuers to "deconstruct" group premiums, assigning the underlying age-adjusted (and tobacco-adjusted) cost of coverage to each member of the group. Depending upon the frequency with which small employers and carriers use this option, and depending upon how those employers structure their premium contributions and how that affects workers of different ages, some workers could change their insurance enrollment decisions, which could in turn affect small group and nongroup risk pools and premiums. We do not take this possibility into account in the estimates presented here.

[17] http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf.

[18] http://www.ofr.gov/OFRUpload/OFRData/2013-04335_PI.pdf.

[19] A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students up to age 23.

[20] "Family" is used to refer to the health insurance unit.

[21] Trends in Tobacco Use. Washington: American Lung Association, 2011. Available at http://www.lung.org/finding-cures/our-research/trend-reports/Tobacco-Trend-Report.pdf.

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