

ADDITIONAL BACKGROUND AND FREQUENTLY ASKED QUESTIONS ON THE OLIVER WYMAN REPORT ON THE IMPACT OF HEALTH INSURANCE REFORMS

On Wednesday, October 14, Oliver Wyman issued a report containing the results of an independent study commissioned by the Blue Cross and Blue Shield Association (BCBSA) on the impact of insurance reforms on insurance premiums in the non-group (or “individual”) and small-group markets. (The report, “Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability,” is available at www.oliverwyman.com.) This is an area Oliver Wyman has worked in for decades, and we have a particular expertise in modeling the way insurance markets are likely to respond to changes such as those currently being considered by Congress.

The overall conclusion of our analysis is simple: For these types of insurance reforms to be successful and sustainable, it is imperative to get broad participation. Young and healthy people need to participate, and people cannot simply choose to buy insurance when they need it. This is true regardless of who is paying the premiums—individuals, companies, or the government.

Without question, the individual market will undergo the greatest change after reform. It will see significant growth in membership and dramatic alteration in the rules that insurers must follow in establishing premiums and selling their products. To fully understand how premiums and insurance policies will be affected, it is necessary to use actuarial science. The primary issue that concerns actuaries any time a market undergoes change is to understand what happens to the “risk pool.” In laymen’s terms, will the people insured in the market be relatively older, sicker and costlier, or will they be younger, healthier and less costly? In general, the changes to the risk pool ultimately determine the average premiums people will pay. If the pool becomes less healthy, premiums go up. If the pool becomes healthier, premiums go down.

In looking at the health reform plan that emerged from the Senate Finance Committee, we modeled the impact of all of the bill’s major elements related to insurance. Of these elements, however, three will have the greatest influence on the future risk pool, the accompanying medical claims, and, by extension, the premiums. These are:

- **Rating changes:** Guaranteed issue—the provision that requires insurance carriers to offer coverage to all who apply for it—will draw more people with high expected medical costs into the market; it also creates risk from people buying insurance only when needed. Guaranteed issue will certainly help to provide access to insurance for many people, but at a price. The elimination of health status rating and tighter age bands will also significantly increase premiums for younger and healthier people while reducing premiums for older and less healthy.

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

- **Minimum benefit requirements:** The mandated minimum benefit levels in the SFC bill are higher than many policies sold in the market today. Ensuring that people have adequate coverage is a logical goal of reform. Many people have inadequate coverage. However, raising the benefit levels raises costs.
- **Expected medical costs of the uninsured:** Consistent with CBO and others who have evaluated the impact of reform, we believe the uninsured will be healthier than the current *total* insured market. The *individual* market, however, is healthier than the total insured market. We estimate the uninsured, on average, will have medical claims about 20% higher than the current individual market.

The Senate Finance Committee bill contains several provisions to help mitigate the disruption of these insurance reform changes and improve affordability for the uninsured to access insurance. We evaluated the impact of each of the key provisions. While these “stabilizers” will reduce out-of-pocket costs for subsidy-eligible people and expand coverage, our analysis indicates that coverage will not be sufficiently broad to offset the disruption of the risk pool, and that average cost of medical claims within the risk pool will rise significantly. Specifically, it will be a challenge to have adequate participation among the young and healthy in the future, reformed market.

Our model provides a robust analysis of how the individual and small group insurance markets will be affected by rating reform and the coverage of millions of newly insured. The model was built over eight months and uses a database of information on actual insurance policies covering nearly six million people—more than 10% of all members in the individual and small group markets today.

Analysis of this type is inherently very technical and relies on actuarial science. But the broad strokes are quite straightforward and do not require specialized knowledge. Oliver Wyman believes that our report makes an important factual contribution to the debate over healthcare reform. To ensure that our findings are both accessible to a wider audience and correctly understood, we have prepared this briefing, which provides additional information about our methods and answers a number of questions that have been raised about the report in the past week.

Question 1: Is the source data you used for the analysis credible and representative of the total insurance market?

Yes. As an independent firm, Oliver Wyman believes that the data we collected on insurance policies purchased today is both credible and representative. The analysis utilizes a database of actual insurance policies for 6 million insured members in the individual and small-employer markets. Approximately 48 million Americans are enrolled in these markets today, so we had access to data on almost one-eighth of all members (covered by all insurers). The database includes members from 12 states and covers four distinct geographic rating clusters that are not currently community rated with guaranteed issue. Data from at least two states were included for each of the geographic rating clusters. We believe that these data are representative, or even conservative, relative to the benefit plans and rating practices of the rest of the industry.

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

Question 2: Did the report ignore provisions included in the Senate Finance Committee bill that might lower your estimates?

No. Our report considers all major elements of the Senate Finance Committee bill pertaining to insurance reform. For simplicity, we reported the change in average medical claims, and isolated the effect of key rating reform and benefits changes. No effort was made to selectively include factors that increase costs while excluding those that might reduce costs.

We did not include the effects of medical cost inflation in this report, which would have increased our cost estimates over the five-year period evaluated. Medical inflation alone would add at least 5% annually to the expected medical costs. Over the time horizon we are evaluating, the impact of rising costs due to medical inflation dwarfs the potential efficiencies gained through an exchange, delivery system reform, or other factors. Our report also did not estimate the impact of a number of fees and taxes on the health industry in the Senate Finance Committee proposal. This includes the \$6.7 billion annual assessment on health insurance coverage. Some of these assessments would raise premiums in the individual and small-group markets over and above our estimates.

As stated in the report, elements that were not explicitly evaluated include optional risk corridors, the inclusion of a “young invincibles” product, and potential administrative savings related to establishment of health insurance exchanges. As detailed below, we do not believe that inclusion of these factors would have a significant impact on the claims costs projected by the model.

We believe that our model fairly reflects the major components of the Senate Finance Committee bill that would have a significant effect on claims costs in the individual and small group markets, including factors such as reinsurance and premium subsidies that will tend to stabilize the market.

Question 3: Didn't the Congressional Budget Office predict that the Senate Finance Committee bill will lower health care premiums in the exchange and make health insurance more affordable?

The CBO has not yet released an estimate of the premium impact of reform looking at the cumulative effect of all the key elements proposed. The CBO has looked at the post-subsidy cost of a particular product for individuals in the non-group (individual) market. We do not dispute that subsidies will reduce the premium impact for many people. But more than half of those covered in today's individual market will not be eligible for subsidies. We estimate 18 million people currently insured in the individual market or currently uninsured will not be eligible for subsidies.

While it has tried to estimate the impact of health insurance exchanges, to the best of our knowledge, CBO has not yet released any findings on the effects of exchanges in isolation. The

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

widely cited CBO figure of 5% potential cost savings apparently includes factors in addition to savings on administrative costs.¹

Like everyone involved in the health insurance reform debate, we are hopeful that greater efficiencies can be realized in selling and administering health insurance. But the exchanges would have no effect on the underlying medical claims cost increases we predict in the model. (As mentioned earlier, medical expenses will be the primary driver of expected future premiums.) Moreover, we do not expect exchanges to have a substantial impact on premiums when looked at in isolation. An Oliver Wyman report issued in 2008 on health insurance exchanges, which reviewed information on previous state experience with purchasing cooperatives, predicted that exchanges were unlikely to reduce health insurance premiums for individuals and small employers.²

Question 4: Does the report take into account the impact on out-of-pocket costs of the tax credits (subsidies) provided in the bill?

Yes. Our analysis does take into account the impact that both individual and small employer tax credits would have on individuals taking up coverage, small employers offering coverage and their employees taking up coverage. Our report explicitly mentioned that premium increases for many will be offset by the availability of subsidies in the executive summary (see excerpt below).

Subsidies will entirely or partially offset these premium increases for some individuals. Eight million current individual market members and 25 million uninsured earn between 100 and 400 percent of the federal poverty level and will have access to subsidies through the exchange.

As mentioned in the report, we estimate that 18 million of those currently in the individual market or uninsured pool would be ineligible for subsidies. More than half of those purchasing individual insurance coverage today would be ineligible for subsidies. In a weak-mandate scenario, many of the ineligible uninsured would fail to purchase coverage, and some of the currently insured would drop insurance when faced with higher premium costs.

¹ Excerpt from Congressional Budget Office, letter to the Honorable Max Baucus dated September 22, 2009: "In summary, the premiums for policies sold in the proposed insurance exchanges would differ from the premiums that would be paid under current law for a variety of reasons—some of which would tend to make exchange premiums higher than current-law premiums and some of which would tend to make them lower. Moreover, the differences in premiums would partly reflect differences in the actuarial value of insurance plans, so there would be differences in cost-sharing requirements that would have the opposite effects on household budgets (other factors held equal). Further, the characteristics of people enrolled in the proposed exchanges would differ from the characteristics of people enrolled in employment-based coverage or the individual market under current law, so differences in average premiums would not equal the differences in premiums faced by a given group of enrollees across those different settings. In light of those complexities, quantifying the net effects of the Chairman's proposal on the amounts paid by individuals and families to obtain health care is very difficult. CBO has not modeled all of those factors and is unable to quantify them or calculate the net effects at this time."

² "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for Individuals and Small Employers?" Karen Bender, FCA, ASA, MAA and Beth Fritchen, FSA, MAA, Oliver Wyman Actuarial Consulting, Inc., September 2008.

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

Our modeling predicts that under a weak mandate, such as that proposed by the Senate Finance Committee bill, those who are eligible for subsidies will be more likely to purchase insurance than those who are not. Among those who purchase new private coverage under a weak-mandate scenario, we predict that 5.5 million will *not* be eligible for subsidies. Another 1.1 million people who purchase coverage will have incomes of 300-400% FPL and will be eligible for subsidies of 21-35% of their premiums (which would not fully offset the claims cost increases we predict). Finally, 13.5 million lower-income individuals who purchase coverage will have incomes of 100-300% FPL. They will have access to subsidies of 39-88% of their premiums, which will offset much if not all of the increased premiums they will face.

Nearly 5 million people would remain in “grandfathered” policies and would be ineligible for subsidies unless they changed their coverage. Our model predicts that most of these individuals would not be eligible for subsidies if they changed their coverage (or if the grandfathered policies are forced to sunset over time).

Subsidies would play an important role in reducing out-of-pocket costs for certain individuals, especially those below 200% of FPL, who are likely to purchase insurance even in our low mandate scenario. However, presenting information only for those who are subsidy eligible would present an incomplete picture that would not reflect the premium increases that millions of Americans would face under our low mandate scenario.

Some have asked why we did not present these results as an average, taking into account the net cost after subsidies applied across the entire population. There are two reasons. First, the growth in the average claims costs of the pool provides a measure of the sustainability of the insurance pool. If costs in the pool increase due to a higher proportion of older and less healthy people, the costs will rise at a rate significantly higher than medical inflation. The pool would be vulnerable to a “death spiral” and unsustainable. Second, no one will pay an average premium. Those who are not eligible for subsidies would have to pay the total price of insurance, while those who are subsidy eligible would receive credits to offset some or all of these costs. Moreover, someone must pay for the increased costs related to reforms absent an effective mandate, either the individual or the taxpayer. In all likelihood, the net cost of taxpayer funded subsidies will be higher per insured individual with an ineffective mandate than with an effective one.

Question 5: The report focuses on the need to attract more young and healthy members into the market. Younger people typically earn less than older people, so won't subsidies ensure we get high participation among the young and healthy?

No. Short of achieving 100% coverage, adverse selection will always exist, and the young and healthy will be the most difficult to bring into the market. A recent report from CMS evaluating “America’s Affordable Health Choices Act of 2009” reaches the same conclusion that the people who remain uninsured under this proposal will be predominantly healthy people: “For the most part, these [uninsured individuals] would be individuals with relatively low health care expenses for

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

whom the individual or family insurance premium would be significantly in excess of the penalty and their anticipated health benefit value.”³

There is a correlation between age and income, but there is very wide variation of incomes within age cohorts. There are significant numbers of people younger than 35 who earn above 400% FPL and will not be eligible for subsidies—just as there will be many people in their mid-fifties who earn less than 200% of FPL and will be eligible for very generous savings. In short, the people earning less than 200% of FPL (and receiving the most generous subsidies) are a very diverse group.

The proposed rating reforms—specifically eliminating health status rating and imposing tighter age bands—causes premiums to increase for younger and healthier members. The cost of insurance compared to the perceived value is less compelling for younger people. Therefore, *within any income cohort* (e.g., 200-300% of FPL), the value of insurance is highest for older populations and lowest for younger populations, and the percentage of older people who purchase coverage will be higher.

Question 6: Aren't the uninsured believed to be healthier than the overall population? Won't that help to reduce the average costs in the individual market?

Yes to the first question and no to the second. Consistent with CBO and others, we believe the uninsured will be healthier than the total insured market—with expected medical claims about 15% lower. The individual market, however, is considerably healthier than the employer-based insurance market. We estimate the morbidity of the individual market today is about 70% of the morbidity in the total insured market. Combining these two factors, we estimate the uninsured on average will have average medical claims about 20% higher than the individual market.

Oliver Wyman relied on multiple data sources to validate the relative morbidity of the current individual market relative to the employer sponsored market. AHIP and Kaiser/HRET publish state-level average insurance premiums in the individual and employer-sponsored markets, respectively. On average, nationwide annual premiums (in 2009 premium dollars) are \$3,049 per member in the individual market and \$5,038 in the employer-sponsored market. Premiums in the individual market are 61% of those in the employer market. Similar ratios were observed when we examined the relative differences in claims across the individual and small group markets from the Blue Plan database.

It is important to note that factors other than morbidity account for a portion of the differences in premiums between the individual and small group segments. Benefits are typically richer (i.e., have higher actuarial values) in the employer market. Also, administrative expenses are higher for individual policies than for employer-sponsored policies. These two factors will partially cancel each other out. Taking both of these factors into consideration, we estimated the morbidity of the

³ October 21, 2009 memo from CMS Chief Actuary Richard Foster, “Estimated Financial Effects of the “America’s Affordable Health Choices Act of 2009” (H.R. 3200), as Reported by the Ways and Means Committee.”

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

individual market to be 70% of the total insured market. We believe this is a conservative estimate overall. However, we acknowledge that perfect data do not exist in this area.

Question 7: Is the impact of minimum benefit requirements on premiums overstated in your report?

No. We were very conservative in our assumptions about the impact of required benefit changes, and the entire premium impact was based on increasing actuarial values to the minimum threshold. We relied on distributions of all products purchased in the individual and small group markets for 15 health plans to determine average actuarial values today. These plans represented all regions of the country. Our analysis concluded that these plans had an average actuarial value of about 60% today. The Congressional Budget Office reached a similar conclusion, finding that actuarial values generally range from 40% to 80%, with an average value that is between 55% and 60% in the individual market.⁴ In its analysis of the Finance Committee bill, CBO concluded that policies sold in the individual market “are expected to have an average actuarial value of about 60 percent.”⁵

New coverage sold to individuals and small employers must provide certain minimum benefits, including some categories of services that are less commonly purchased today. For example, maternity coverage is treated as an additional “rider” in many states today. Mandating that benefit alone might add 4% to premiums. Additionally, new coverage would face limitations on cost-sharing for preventive services, limits on out of pocket costs for lower income individuals, and annual or lifetime limits on benefits would be eliminated. We did not include the estimated premium impact from these required covered services.

When considering all of these factors, we believe our prediction that costs would increase by 10% for individual products and 3% for small employer products is conservative. Moreover, we assumed that individuals and small employers would only increase their level of benefits to the *minimum* actuarial value allowed by law, and we did not increase costs if they were to purchase Silver or Gold plans.

Question 8: Does the report take into account special "young invincibles" plan that may offer lower premiums to young adults?

The Senate Finance bill provides for sale of a “young invincibles” product, a catastrophic-only policy for those age 25 or younger, with coverage levels set at the HSA current law limit. The legislative language for these plans does not state a target actuarial value for these plans or state

⁴ See: <http://www.cbo.gov/ftpdocs/99xx/doc9924/Chapter3.7.1.shtml>

⁵ See: http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

whether they would be exempt from other minimum benefit requirements that would generally increase the cost of coverage in the individual insurance market.⁶

As we disclosed in the report, we did not explicitly model the impact of the “young invincibles” product. But we do not think that the availability of this product will have a significant impact on claims costs or final premiums in the aggregate. Among the existing insured, we believe nearly all “young invincibles” would choose to grandfather, and many are presently enrolled in policies similar to the proposed young invincible product.

The young invincible product will provide a lower cost option—which we believe is essential. But it has limited eligibility, and we do not believe it will draw significantly more people into the market. Massachusetts has a “young invincibles” product similar to that proposed by the Senate Finance Committee. The uninsured rate among the 19-24 age group was 20.4% in 2002, before reform was implemented and the policy became available and 19.7% in 2007 after the policy was available, even though Massachusetts has an individual mandate in effect.⁷

Costs for these policies may not be substantially lower than other product options as a result of other policies in the bill. Young invincible policies would be pooled with and subjected to the same rate compression requirements as all other individual market products. These requirements would have the effect of reducing the premium differences between different product levels.

Question 9: Did the analysis include the benefits of risk pooling of an exchange?

As stated earlier, our report focused on expected medical claims in the insurance pool. Whether pooling increases or decreases premiums will depend on what market is examined. While pooling individuals and small groups together lowered costs for individual purchasers (and increased costs for small employers) in Massachusetts, the same result is not likely in many other markets. This is because the individual market was so expensive in Massachusetts that combining markets lowered the rates for individual purchasers. In states with a healthy individual market, the opposite result is likely to occur.

The American Academy of Actuaries recently released a paper in which they examine the impact of merging the small group and individual markets (risk pooling). In that paper, the authors conclude that “Merging the two markets into a single market, without adjustment, would likely result in higher premiums than currently exist for in the individual market.”⁸

⁶ During the Finance Committee mark-up, Committee staff commented that the young invincible policies could have an actuarial value of about 50%.

⁷ http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_07.ppt#264,4, Massachusetts Uninsured Rates by Age, Ages 0-64

⁸ See *Critical Issues in Health Reform: Merging the Small Group and Individual Markets*, American Academy of Actuaries, September 2009.

OLIVER WYMAN

Additional Background and Frequently Asked Questions on the Oliver Wyman Report on the Impact of Health Insurance Reforms

Exchanges will have limited ability to reduce administrative costs. Again, we are hopeful that administrative efficiencies will be realized in the future. But it is important to note that many of the non-subsidy related functions they will perform will duplicate functions performed by health plans, or insurance agents or brokers. When an exchange takes on enrollment functions, insurers must continue their own enrollment functions to assure appropriate services, claims payment, etc. Thus, while an exchange may assume certain administrative functions, it may not eliminate these functions or their related costs. While it has been argued that exchanges would save money by eliminating costs related to underwriting, any reduction in this area will be a function of changes in insurance rating and underwriting rules and not due to the exchange. Moreover, underwriting costs in the individual market represent less than 1% of premium costs.⁹

Other functions of an exchange, such as facilitating individual choice of plans (for employees in group coverage), are likely to increase administrative costs and result in adverse selection issues. Whether an exchange can reduce the distribution of insurance enough to offset these costs or its own administrative costs is unclear. Evidence from past state experience with purchasing cooperatives indicates that savings will be difficult to achieve.

Question 10: Did you consider investments in prevention, reducing waste, and other policies that may help bend the long-term health cost curve?

We evaluated the impact of health insurance reforms with and without including underlying medical cost inflation. The results of this report are presented in the absence of medical trend to isolate the cost impact of specific reforms. The inclusion of medical trend would have increased our projected cost increases over the five-year period we examined. As an example, reducing medical cost inflation from 6% to 5% would still mean that individuals would pay more for insurance in year five of our report. We decided to present these results in the most defensible way, absent the considerable uncertainty that exists around predicting future changes in underlying medical costs.

Conclusion

It is important to acknowledge the good that health reform is likely to accomplish. We estimate that the Senate Finance Committee bill will bring coverage to millions of Americans, and it will make healthcare significantly less expensive for the old and sick. We believe that subsequent rounds of reform that focus on reforming health care delivery, and especially the way care is paid for, will have the power to bring spending under control while improving quality for all. That process will take a number of years to accomplish. In the meantime, it is crucial that costs be kept within reasonable bounds. Our analysis suggests quite strongly that under current proposals, broader participation is necessary to improve affordability. We applaud members of Congress on the work they have done so far on reform, but the SFC bill should be further strengthened to improve coverage, affordability, and sustainability.

⁹ Sherlock Company benchmarking data.

OLIVER WYMAN

*Additional Background and Frequently Asked Questions on
the Oliver Wyman Report on the Impact of Health Insurance Reforms*

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About Oliver Wyman

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