



**Office of Insurance Regulation's Estimate of Individual Market Premium Increases
Under PPACA Misleads Consumers
*Preliminary Analysis***

On August 1, the Florida Office of Insurance Regulation (OIR) released a [chart and related information](#) under the heading "Individual Monthly Health Insurance Premiums Before and After PPACA." Unfortunately, for an array of reasons discussed below, the information provided by OIR provides no credible comparison of the impact of PPACA on rates whatsoever. Furthermore, its continued use as a basis for official projections is likely to result in direct harm to consumers.

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

First, however some additional context is needed. Regardless of the conclusions that can or cannot appropriately be drawn from OIR's report, this discussion has no relevance for the vast majority of Floridians. OIR's analysis pertains only to Florida's individual (i.e., direct-purchase) health insurance market. In relative terms, Florida's individual market is small, with about 500,000 primary insureds and 700,000 total persons covered. So although changes within the individual market are of critical concern for those Floridians, it must also be noted that that group constitutes less than five percent of Florida's population. In particular, OIR's report cannot be used to draw any conclusions whatsoever regarding the impact of PPACA on those who have coverage through a job, Medicare, etc.

Problems with the "Gross Annual Premium Comparison"

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

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

Furthermore, several of the insurers included in the comparison have minimal or no current presence in Florida's individual market. These insurers had very few or no individual market policyholders in 2013, and they project that their market presence in 2014 will be very limited. For these insurers, OIR

calculated the difference between before- and after-PPACA premiums by comparing premiums for a very small number of 2014 policyholders with the average across the entire statewide market in 2013, and those insurers were barely even participants in that market, if they participated at all.

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

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

2. OIR’s Focus on PPACA’s Impact on the Existing Individual Market Creates “Apples and Oranges” Comparisons and Does Not Account for the Fact that the Comparison Will Often Be Moot

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

Insurers can no longer sell such inadequate plans after January 1, 2014, but most who wish to remain enrolled in these plans may do so. The fact is, most of these consumers currently have no choice but to remain in inadequate coverage for lack of other options. However, because new plans can no longer impose waiting periods for pre-existing conditions or set premiums based on health status, these consumers will be free to leave their current plans and immediately buy meaningful coverage. For those that use the Marketplace, many will gain coverage made affordable through the availability of Premium Tax Credits.

Therefore, even if OIR’s method of comparing rates before and after PPACA had been appropriate, , justifying its assertion that the average premium for enrollees in Cigna plans, for example, will be 55.3% higher in 2014, that number would still not represent the typical premium increase for a current Cigna plan enrollee. For one, these before and after averages are weighted across all plan offerings, and PPACA brings new plan offerings that clearly have higher premiums than mini-med and other inadequate plans. For another, if a low- or moderate-income Cigna plan enrollee is currently enrolled in less adequate coverage than (s)he could obtain through the Marketplace and yet still faces a significant premium increase in 2014, (s)he need not remain in that plan. (S)he likely can obtain better, more affordable coverage through the Marketplace. OIR’s estimates do not take this post-PPACA reality into consideration.

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

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

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

To gain a sense of how significant of an impact Premium Tax Credits will have on those who access them, consider that the average premium for an individual covered through Florida's *small group* market was \$450 per month in 2012, according to the Internal Revenue Service. (That average is certainly higher for plans in the individual market that would meet PPACA requirements, so \$450 is useful as a conservative placeholder.) Premium payments for such a plan would be reduced by \$90 to \$430 per month through the use of Premium Tax Credits. Thus, factoring in the impact of the availability of Premium Tax Credits across the board could significantly reduce the effective average premium payment by Floridians in the individual market.

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

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

Problems with the "Silver Plan Comparison"

OIR's "Silver Plan Comparison" incorporates many of the same flaws as the "Gross Annual Premium Comparison", and overlays some additional ones as well. In particular, **the concerns raised in #1, #3 and #4 above apply here as well.**

5. OIR's Treatment of a Silver Plan and the "Normalized" Version of its Standard Plan A as Equivalent is Based on a Misapplication of the Term "Value"

The comparison OIR offers is between a Silver Plan and "Standard Plan A, as defined in Rule 69O-149.204." Even if Standard Plan A were not purely hypothetical in nature, the two plans would be not directly comparable, at least without significant adjustments to account for their differences.

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

From there, however, problems quickly become apparent. Because Actuarial Value only makes sense when measured in the context of a standard set of covered benefits used by a standard consumer population, the tool that makes the 70% calculation possible is the Actuarial Value Calculator (Calculator) published by federal CMS. OIR in fact indicates that they did make use of the Calculator.

However, the Calculator is grounded in those standard assumptions, particularly the assumption that plans will provide all Essential Health Benefits. Yet Standard Plan A (last amended in 2004) does not. Furthermore, PPOs under Standard Plan A may apply a lifetime cap on total benefits, which has been prohibited in all new plans since 2010. Thus, Standard Plan A does not even meet the criteria for using the Calculator as developed by CMS.

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

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

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

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