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The Affordable Care Act and Health Insurance Markets

Simulating the Effects of Regulation

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Summary

The Patient Protection and Affordable Care Act as modified by the Health Care and Education Reconciliation Act of 2010, collectively known as the Affordable Care Act, makes sweeping changes to the regulation of health insurance markets in the United States.

Specifically, the Affordable Care Act requires insurers in the nongroup and small group markets, including those offering coverage in the new state-level health insurance exchanges, to issue and renew policies to everyone who seeks coverage, regardless of health status. In addition, the Affordable Care Act limits insurers' ability to charge different prices based on individual characteristics. Insurers can vary prices based only on a few factors:

- (1) age
- (2) tobacco use
- (3) geographic location
- (4) family size
- (5) the actuarial value of the plan.

For these factors, only a certain amount of variation is allowed:

- The oldest adult in the risk pool cannot be charged more than three times as much as the youngest adult. This requirement is known as 3-to-1 rate-banding.
- In addition, smokers can be charged no more than 1.5 times more than nonsmokers (1.5-to-1 rate-banding).

These changes raise concerns that the Affordable Care Act could lead to substantial increases in premiums, especially in the nongroup market. For example, commentary in the *Wall Street Journal* published earlier this year suggested that premiums in some markets could double (Matthews and Litow, 2013). Large increases in premiums might occur because of requirements that health insurance be made available to all comers, regardless of health status, and that insurers cannot charge higher premiums based on such characteristics as health status or previous claims experience. Without other changes, these provisions could lead to adverse selection, in which only people with high expected expenditures enroll.

To address these concerns, the Affordable Care Act contains several provisions intended to increase the chances that younger, healthier individuals will get coverage. First, the act requires that all adults obtain a specified minimum level of coverage or pay a tax penalty. Second, the act offers tax credits that individuals with incomes between 100 and 400 percent of the federal poverty level (FPL) can use to buy coverage if they lack access through other sources, such as an employer or Medicaid. Other provisions, such as reinsurance and requirements that insurers limit the amount of premium revenue spent on non-claims costs, could also reduce premiums relative to what would be expected without the law, potentially making insurance more attractive for younger, healthier enrollees.

The changes, coupled with other policies introduced by the Affordable Care Act, are likely to affect enrollment, premiums, and the composition of the population enrolled in nongroup and small group plans. It is important for federal and state policymakers to understand the potential effects of these changes as they make decisions about setting up the health insurance exchanges.

In this report, we use RAND's Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model to examine these effects. Specifically, our analysis examines the likely effects of the Affordable Care Act on

- the number of uninsured individuals
- the number of enrollees in the nongroup and small group markets
- the cost of premiums
- the characteristics of enrollees.

We also consider the implications of two decisions confronting states: whether to expand their Medicaid programs to cover all adults with incomes below 138 percent of the FPL and whether to merge or combine their small group and nongroup risk pools. If risk pools are merged, enrollees in the small group and nongroup markets would face the same premiums for comparable coverage. If risk pools are split, premiums in the two markets could diverge. For ten representative states (Florida, Kansas, Louisiana, Minnesota, New Mexico, North Dakota, Ohio, Pennsylvania, South Carolina, and Texas), we estimate enrollment and premiums both with and without the Affordable Care Act. Then, for a subset of states, we conduct sensitivity analyses related to these critical state decisions.

The analysis is based on a microsimulation model, which—like all microsimulation approaches—has limitations. Current data on nongroup premiums are limited, and there are many uncertainties about how individuals and insurers will respond to the complex policy changes introduced by the Affordable Care Act. Nevertheless, state and federal policymakers must continue to implement the law, develop policy guidance and regulations, and make decisions about exchange operations, with little historical data available to gauge the potential effects of these decisions. Recognizing that all models have limitations, our analysis aims to provide decisionmakers with insight into the types of changes in enrollment and premiums that may occur as the Affordable Care Act is implemented.

Results: Number of Uninsured Individuals

Our analysis finds that **for all ten states and the United States overall, the Affordable Care Act could lead to a substantial decline in the number of uninsured nonelderly people.** We estimate that the 2016 uninsurance rate in the United States would be 19.6 percent without the Affordable Care Act, compared to 8.2 percent with the law, assuming that all states expand Medicaid. Across states, there is considerable variation in uninsurance levels in our 2016 estimates, ranging from a low of 5 percent in Minnesota to a high of 12 percent in Texas. States with larger immigrant populations, such as Texas and Florida, tend to have the highest uninsurance rates after Affordable Care Act implementation.

For three states—Texas, Louisiana, and Florida—we considered the potential consequences for health insurance enrollment in scenarios in which Medicaid was not expanded. Across the three states, we estimate that an additional 2.3 million individuals would be uninsured without Medicaid expansion and state uninsurance rates would increase by 5 to 6 percentage points, compared to scenarios that include Medicaid expansion.

Results: Nongroup Market Enrollment

We estimate that enrollment in the nongroup market will increase substantially across all ten states as a result of the Affordable Care Act. Without the Affordable Care Act, we estimate that fewer than 5 percent of the nonelderly population would be enrolled in nongroup coverage in 2016. With the Affordable Care Act, nongroup enrollment more than doubles, rising from 4.3 percent of the nonelderly population for the United States overall to 9.5 percent of the nonelderly population. The finding that nongroup enrollment could increase, despite the Affordable Care Act’s rating regulations, suggests that adverse selection (the tendency for a disproportionately large number of sicker individuals to opt into the market for health coverage) caused by these new regulations is mitigated by other provisions. For example, the individual mandate and federal tax credits for exchange enrollees with incomes between 100 and 400 percent of the FPL could keep younger and healthier people enrolled.

Results: Nongroup Premiums

The results for premium prices in the nongroup market are complicated and must be interpreted carefully because the law introduces complex changes and because of limitations of existing data and uncertainties about insurer behavior. The law’s requirement that individuals obtain plans with a minimum actuarial value will cause some enrollees to shift from less-generous into more-generous plans, which could result in higher premiums but also more-comprehensive coverage. In addition, some individuals could experience declines in out-of-pocket premiums even if their total premiums increase, due to eligibility for federal premium tax credits. Because the Affordable Care Act allows insurers to charge higher premiums to older individuals (within a 3-to-1 rate band) and tobacco users (within a 1.5-to-1 rate band), the change in average premiums could be different from the change in premium for an individual with a fixed age and tobacco use status. Finally, data currently available on nongroup premiums and enrollment are limited and vary substantially across sources, which affects the reliability of all predictions, including estimates presented in this report.

In analyses that held age, actuarial value, and tobacco use constant, we estimated that, for five of the ten states we examined (Florida, Kansas, Pennsylvania, South Carolina, and Texas), and for the United States overall, the law causes no change in premiums.¹ In three of the remaining states (Minnesota, North Dakota, and Ohio), we estimated that there could be premium increases of up to 43 percent, although these changes do not account for federal exchange tax credits. For two states (Louisiana and New Mexico), we estimated that premiums standardized for age, actuarial value, and tobacco use could

¹ While premium estimates differed with and without the law, we could not reject the possibility that these differences were due to chance alone.

decline as a result of the Affordable Care Act. Declines in premiums are possible in part because premium tax credits bring some people who are relatively less expensive into the market, reinsurance reduces nongroup premiums in the first few years of implementation, and the Affordable Care Act limits the amount of premium revenue that can be spent on non-claims costs. Even among states estimated to have an increase in total premiums standardized for age, actuarial value, and tobacco use, many enrollees will experience a decline in their out-of-pocket premium expenditures because part of the premium is subsidized via federal tax credits.

For three states (Texas, Louisiana, and Florida), we considered the effect of Medicaid expansion on nongroup premiums. If states fail to expand Medicaid, individuals with incomes in the range of 100 to 138 percent of the FPL will become newly eligible for exchange tax credits. We find that, for these three states, these newly eligible individuals could cause premiums standardized for age, actuarial value, and tobacco use on the nongroup market to rise by 8 to 10 percent, relative to scenarios that include Medicaid expansion. The increase in premiums reflects an influx of slightly lower-income and less-healthy enrollees onto the exchanges.

Results: Small Group Market Enrollment

For the United States overall, and for seven of ten states (Florida, Louisiana, Minnesota, New Mexico, Ohio, South Carolina, and Texas), we estimate that small group enrollment will be larger in scenarios that include the Affordable Care Act, with increases ranging from less than 1 to approximately 5 percentage points. Three states—Kansas, North Dakota, and Pennsylvania—are estimated to experience modest declines in small group coverage, ranging from 1.4 to 2.2 percentage points.

The finding that states could experience an increase in small group enrollment reflects the fact that workers will have increased demand for health insurance as a result of the act, due to penalties associated with not having insurance. In addition, although many lower-income workers will be eligible for exchange tax credits or Medicaid, higher-income workers benefit from the tax advantage associated with employer-sponsored coverage. Firms must make a single health insurance offering decision for all workers, and—for many businesses—the tax benefits to higher-income workers could dominate decisionmaking.

However, a limitation in our analytic framework is that it does not allow us to consider whether firms reduce workers' hours, change premium contribution rates, or alter their sizes in response to the law. This type of strategic response could lead small group enrollment under the Affordable Care Act to be lower than estimated if, for example, firms convert some workers to part-time status to avoid offering coverage.

Results: Small Group Premiums

We find minimal difference in small group premiums in scenarios with and without the Affordable Care Act. For the United States overall, and for nine of ten states (Florida, Kansas, Louisiana, Minnesota, North Dakota, Ohio, Pennsylvania, South Carolina, and Texas), we estimate that small group premiums

standardized for age, actuarial value, and tobacco use will be unchanged by the law.² These scenarios assume that the nongroup and small group risk pools are separated.

For one state that was not included in our group of ten (New York), we analyzed the potential effects of merging the small group and individual market risk pools. In this case, we found that small group premiums standardized for age, actuarial value, and tobacco use could be as much as 16 percent higher if the small group and nongroup markets are merged, relative to the case in which the markets are separated. Both the separated and combined risk pools scenarios assume that the Affordable Care Act is fully in effect. New York may be an unusual case because it has unusually strong regulations in both its nongroup and its small group markets.³ However, we estimate that—for all states considered in our analysis—nongroup enrollees in scenarios with the Affordable Care Act will be slightly older and less healthy than small group enrollees. These estimates imply that, for many states, small group premiums could increase if the nongroup and small group risk pools are combined.

Conclusions

We conclude that the Affordable Care Act will lead to an increase in insurance coverage and higher enrollment in the nongroup market. However, data limitations and uncertainties about insurer behavior make estimates uncertain, particularly when considering outcomes for the nongroup market. We find that the law has little effect on small group premiums, and we find large variation in the effects for nongroup premiums across states.

Our analysis suggests that comparisons of average premiums with and without the Affordable Care Act may overstate the potential for premium increases. Sweeping statements about the effects of the Affordable Care Act on premiums should be interpreted very carefully because the law has complex effects that will differ depending on individuals' age and smoking status, the actuarial value of the plan chosen, individuals' eligibility for federal tax credits, and state implementation decisions. Once we adjust for age, actuarial value, and tobacco use, nongroup premiums are estimated to remain unchanged at the national level and in many states. Further, after accounting for tax credits, average out-of-pocket premium spending in the nongroup market is estimated to decline or remain unchanged in all states considered and in the nation overall.

² That is, statistically, we cannot reject the hypothesis that premiums are equivalent in scenarios with and without the law.

³ New York has full community rating in both its small group and nongroup markets, meaning that all enrollees must be charged the same premium, regardless of age, gender, health status, or other demographic factors.