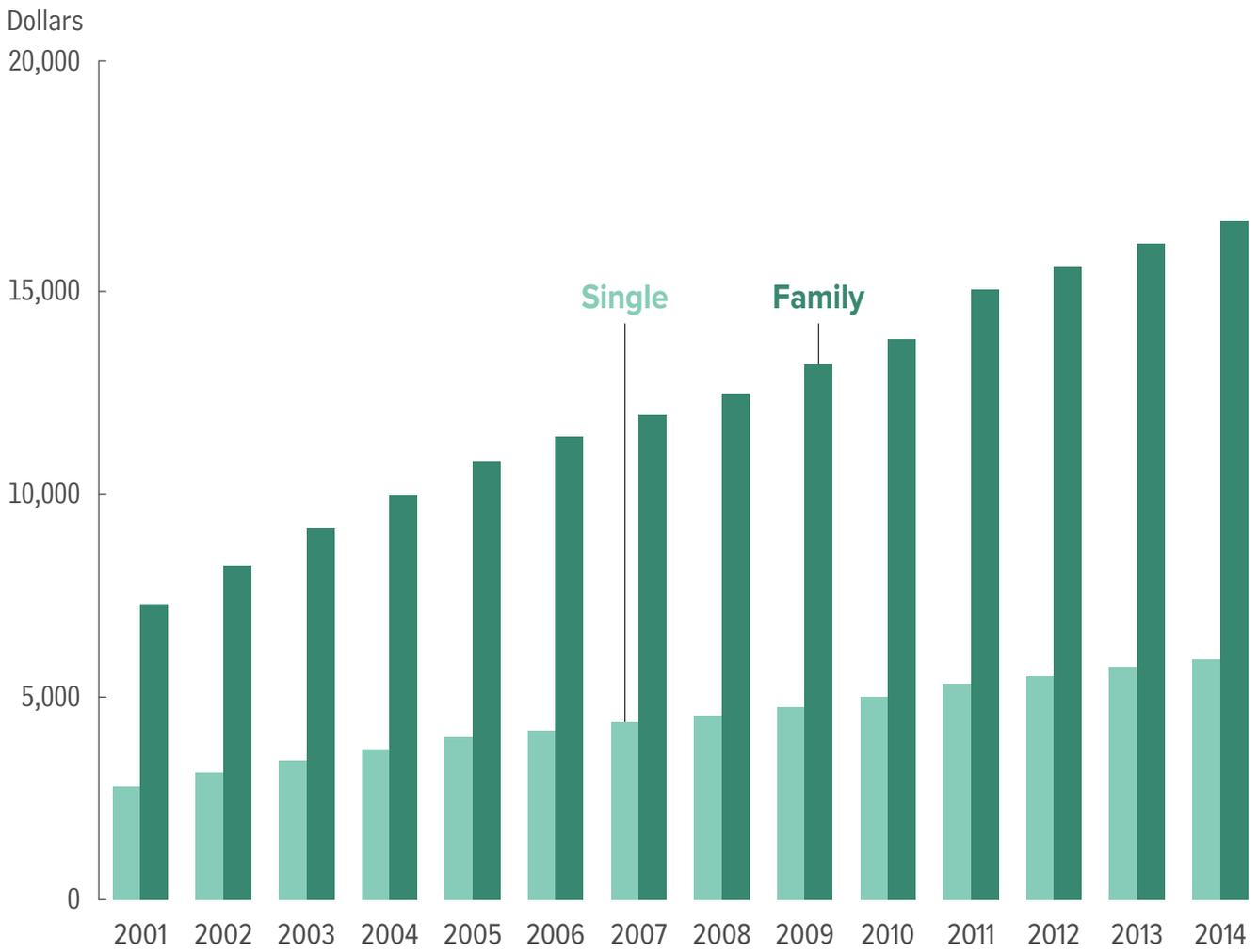


CBO

Private Health Insurance Premiums and Federal Policy



Average Premiums for Employment-Based Plans

FEBRUARY 2016

Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

The Congressional Budget Office's projections of health insurance enrollment and premiums for years after 2016 have not been updated since March 2015, except to incorporate the effects of enacted legislation. The agency will revise its projections for its next baseline, to be published in March 2016.

Unless otherwise indicated, all years referred to in this report are calendar years, not fiscal years.

Numbers in the tables and figures may not add up to totals because of rounding.

Key terms are defined in a glossary at the end of the report.



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Private Health Insurance Premiums and Federal Policy

Summary

Most Americans are covered by private health insurance, which they either obtain through employment or purchase individually. Insurance premiums—the payments made to buy that coverage by enrollees or by other parties on their behalf—are high and rising. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project that in 2016, the average premium for an employment-based insurance plan will be about \$6,400 for single coverage and about \$15,500 for family coverage.¹ Average premiums for coverage purchased individually (in what is called the nongroup market) are also high—but not quite as high as average employment-based premiums, mostly because nongroup coverage is less extensive and thus requires enrollees to make higher out-of-pocket payments when they receive care.

Although premiums for private insurance have grown relatively slowly in recent years, they have usually grown faster than the economy as a whole and thus faster than average income. Over the period from 2005 to 2014, premiums for employment-based insurance grew by 48 percent for single coverage and by 55 percent for family coverage. CBO and JCT expect them to grow at similar rates over the next decade—by about 5 percent per year, on average, or about 2 percentage points faster than income per capita. As a result of that growth, average premiums for employment-based coverage are projected to be about \$10,000 for single coverage and about \$24,500 for family coverage in 2025, nearly 60 percent higher than they were in 2016.

High and rising premiums for private health insurance are a matter of concern for enrollees. They also affect the

federal budget, because the federal government subsidizes most premiums—directly or indirectly—at a cost of roughly \$300 billion in fiscal year 2016. Lawmakers have therefore expressed interest in examining the factors that affect premiums. This report reviews the available evidence about premium levels and growth; analyzes the major federal subsidies, taxes, fees, and regulations that affect premiums; and examines how insurers' own actions affect premiums.

How Do Federal Subsidies, Taxes, and Fees Affect Premiums?

The federal government subsidizes health insurance premiums in two main ways. First, nearly all premiums for employment-based insurance are excluded from federal income and payroll taxes. That tax exclusion, estimated to cost more than \$250 billion in fiscal year 2016, subsidizes roughly 30 percent of the average premium for employment-based coverage. Second, under the Affordable Care Act (ACA), the federal government offers tax credits to people who buy nongroup coverage through a health insurance exchange and meet various other criteria. Those premium tax credits are projected to cost about \$40 billion in fiscal year 2016.

Not only do the subsidies reduce the portion of the total premium that enrollees must pay; they also affect the total amount of the premium. Both subsidies encourage relatively healthy people to enroll, which reduces insurers' average spending for enrollees' health care and thus helps to reduce premiums. However, the tax exclusion also provides an incentive for employers to offer, and for employees to select, more extensive coverage than they otherwise would—which raises total premiums. (The tax credits do not have that effect because their value, unlike the value of the tax exclusion, does not increase when people purchase more extensive coverage.) On balance, CBO estimates, the tax exclusion increases average premiums for employment-based coverage by 10 percent to 15 percent.

1. Those projections are lower than the estimates reported in some recent surveys; as this report explains below, different estimates may vary somewhat in the types of insurance policy that they encompass.

Various federal taxes and fees also affect premiums. Starting in 2020, a new excise tax on employment-based plans with relatively high premiums is scheduled to take effect; for people who buy those plans, the tax will roughly offset the incentive to obtain more extensive coverage that the federal tax exclusion provides. Consequently, employers and employees affected by the tax are expected to choose less expensive coverage than they would have otherwise—and as a result, the tax is expected to reduce average premiums. Other federal taxes and fees imposed on insurers, by contrast, tend to raise average premiums, because the insurers generally pass the costs on to all purchasers.

How Do Federal Regulations Affect Premiums?

Before the ACA was enacted, many federal and state regulations already affected private health insurance premiums, particularly for employment-based coverage. But the ACA significantly expanded the scope of federal regulations, especially in the nongroup market. This report focuses on regulations resulting from the ACA, because proposals designed to affect premiums often involve changing those regulations rather than the earlier ones.

One key regulation is the individual mandate, which took effect in 2014 and requires most people to obtain health insurance or pay a penalty. Like the subsidies just mentioned, the individual mandate reduces premiums by encouraging relatively healthy people to get coverage. The ACA also imposes an employer mandate, which requires larger employers to offer coverage that meets specified standards to their full-time workers or face a penalty. That regulation, which took effect in 2015, is not expected to change average premiums very much, but it will discourage employers from dropping coverage and thus will keep some workers from shifting to nongroup coverage.

Other ACA regulations apply only to insurance policies newly sold in the nongroup and small-group markets. (Employment-based coverage is sold in two markets: the small-group, which generally covers employers with up to 50 employees, and the large-group, which covers larger employers.) Many of the regulations tend to increase average premiums, particularly in the nongroup market. For example, when they sell those policies, insurers must now accept all applicants during specified open-enrollment periods, may not vary people's premiums on the basis of their health, may vary premiums by age only to a

limited extent, and may not restrict coverage of enrollees' preexisting health conditions. Insurers must also cover specified categories of health care services, and they generally must pay at least 60 percent of the costs of those covered services, on average.

Together, the ACA's regulations increase premiums noticeably in the nongroup market and have more limited effects in the other markets. However, the nongroup market represents a relatively small fraction of the total private insurance market, and according to CBO's projections, it will continue to do so—accounting for about 15 percent in 2025. As a result, CBO expects that premium increases stemming from the ACA's regulations will have a relatively small effect on the overall average of private health insurance premiums.

How Do Actions by Insurers Affect Premiums?

Insurance premiums depend partly on actions that insurers themselves take. Above all, insurers generally try to control their costs by restraining spending on health care—spending that accounts for about 88 percent of their premium revenues, on average. That restraint tends to reduce premiums. In order to limit spending on health care, insurers use various strategies, such as negotiating lower payment rates for services provided within their networks of doctors and hospitals; managing enrollees' use of care more closely; and increasing the amounts that enrollees pay out of pocket. Insurers may also try to attract relatively healthy enrollees and avoid less healthy ones, though federal and state regulations limit or prohibit such practices or reduce insurers' incentives to engage in them.

Competition also affects premiums. On average, premiums are lower in markets with more insurers. The reason is that those insurers have a stronger incentive to keep premiums low, because otherwise they might lose enrollees to their competitors. Premiums are also lower in markets with more hospitals and physicians, because insurers there have an easier time negotiating lower payment rates or excluding high-cost providers from their networks. The available evidence, however, indicates that many insurance markets are quite concentrated; that is, a small number of insurers account for the bulk of enrollment. Many markets for hospital care and some markets for physicians' services are concentrated as well. As a result, efforts to increase competition among insurers, like other efforts to reduce insurance premiums, may have complex effects.

Premium Levels and Growth Rates

Most nonelderly people have a private health insurance plan as their primary source of coverage.² CBO and JCT estimate that in 2015, about 153 million nonelderly people had employment-based coverage, nearly all of which was private.³ An additional 17 million nonelderly people were covered by a private insurance policy purchased individually in the nongroup market. All told, employment-based and nongroup plans covered roughly two-thirds of the nonelderly population and just over half of the total U.S. population. Over the next several years, the number of people with private health insurance is expected to rise, mostly because continued implementation of the ACA will expand the nongroup market.

An insurance premium is simply the price that is paid to obtain coverage; it is usually expressed on a monthly or annual basis. In general, this report examines the total premiums paid for insurance coverage—or in certain cases, the equivalent costs of obtaining that coverage—regardless of whether the costs are paid by enrollees, employers, or the federal government. People with employment-based coverage usually pay only a portion of the total premium directly, and their employer covers the remaining costs. But in CBO's view, the costs of premiums for employment-based coverage are ultimately borne by enrollees, so examining total premium payments for that coverage is a good way to understand the financial pressures that those premiums create.

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2. Many other people obtain insurance through a public program, such as Medicare or Medicaid. Of those people, millions receive their benefits through a plan that is run by a private company, such as a Medicare Advantage plan or a Medicaid managed care plan. However, those plans differ in many ways from employment-based and nongroup plans—for example, in the populations that they cover and the regulations that govern them—so they were not included in this analysis. Also, when responding to surveys, many people report having more than one source of insurance coverage, which can generate higher estimates of the number of people with private insurance; in its analyses, CBO assigns such people a primary source of coverage.
 3. In CBO and JCT's projections, employment-based coverage includes not only insurance provided by private and public employers but also insurance obtained through labor unions and multiemployer plans (often called Taft-Hartley plans), as well as insurance obtained by retirees from their former employers. A small share of that employment-based coverage (such as coverage provided through the military) is not provided by a private insurance plan. Also, a small number of people have coverage that is neither employment based nor nongroup, such as health plans established through churches or other groups; such people are difficult to identify in the surveys that CBO uses in its analyses.

Premiums for private insurance represent a considerable expense, averaging more than \$5,000 per enrollee per year. In 2015, they were expected to total about \$1.1 trillion, accounting for one-third of all spending on health care and nearly 6 percent of gross domestic product (GDP).⁴ Average premiums have generally risen faster than the economy as a whole, though their growth has slowed in recent years. CBO and JCT project that they will grow by about 5 percent per year, on average, over the next 10 years—about 2 percentage points faster than per capita GDP.

Premium Levels

Because payments of premiums are private transactions, obtaining precise and timely data about them can be difficult. Data about premiums for employment-based insurance are available primarily from surveys of employers. Although reliable data about premiums for nongroup coverage have been harder to obtain, some better data have recently become available. Different sources of data generally yield different estimates and cover different periods, but all of the data indicate that premiums for employment-based insurance are higher than premiums for nongroup insurance, on average—largely because employment-based insurance tends to provide more extensive coverage.

Premiums for Employment-Based Insurance. The most recent nationally representative data about premiums for employment-based insurance come from a survey of employers conducted by the Kaiser Family Foundation.⁵ In 2015, according to that survey, annual premiums averaged about \$6,250 for single coverage and about \$17,550 for family coverage.

The Kaiser survey also found that premiums varied substantially. Among workers with single coverage, 22 percent had a premium of less than \$5,000, and

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4. See Andrea M. Sisko and others, "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage and Improving Economy," *Health Affairs*, vol. 33, no. 10 (October 2014), pp. 1841–1850, <http://dx.doi.org/10.1377/hlthaff.2014.0560>. Those figures include premiums for private supplemental insurance coverage (often called Medigap plans) that Medicare enrollees buy individually or obtain through their former employers; such premiums constitute a relatively small share of the total.
 5. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), <http://tinyurl.com/oj7dhwp>.

Box 1.

Major Determinants of Private Health Insurance Premiums

The factors that determine health insurance premiums can usefully be grouped into four major categories:

- The **costs of health care generally**, which themselves are determined by the quantity and kind of services that people use and the prices that are paid for those services. Those components, in turn, are a function of the population's health and need for services, the state of medical technology and treatment options, physicians' patterns of practice, and various other considerations. Prices in particular can vary substantially among markets and within them.
- The **mix of enrollees** in a given plan or in the overall insurance pool, relative to the population as a whole. A group of enrollees that is older or sicker will tend to use more health care and thus will generate higher premiums, if other factors are held equal.
- The **extent of the coverage** provided by an insurance plan, which reflects both the scope of health benefits covered by the plan and the share of costs for those covered benefits that the plan pays. Plans that cover more services or pay a larger share of their costs will tend to have higher premiums.
- The **administrative costs and profits** that insurers generate.

The extent of competition among insurers and among health care providers, as well as actions taken by insurers and others, can affect premiums by influencing those four factors directly or indirectly. Insurers operating in more competitive insurance markets have stronger incentives to control costs and to limit profits, which would reduce premiums. For example, insurers may establish limited networks of providers or steer enrollees toward providers who tend to order fewer or less complex services—thus reducing the costs of care for their enrollees, which can yield lower premiums. In areas with limited competition among doctors and hospitals, by contrast, insurers may have more difficulty negotiating lower prices for those providers' services, which could result in higher premiums.

State or federal subsidies and regulations may change premiums by affecting the mix of people who enter or remain in the insurance pool; by encouraging people to purchase more extensive or less extensive coverage; or by changing the benefits that insurers offer, the administrative costs that they incur, or the profits that they retain.

13 percent had a premium of \$8,000 or more. Among workers with family coverage, 22 percent had a premium of less than \$14,000, and 15 percent had a premium of \$22,000 or more. The reasons for that variation are not fully understood, but they are probably related to the ways in which the major determinants of premiums vary among insurers and employers (see Box 1). The variation suggests that average premiums, though often a useful measure, mask substantial differences in the extent and characteristics of the coverage that different employers provide.

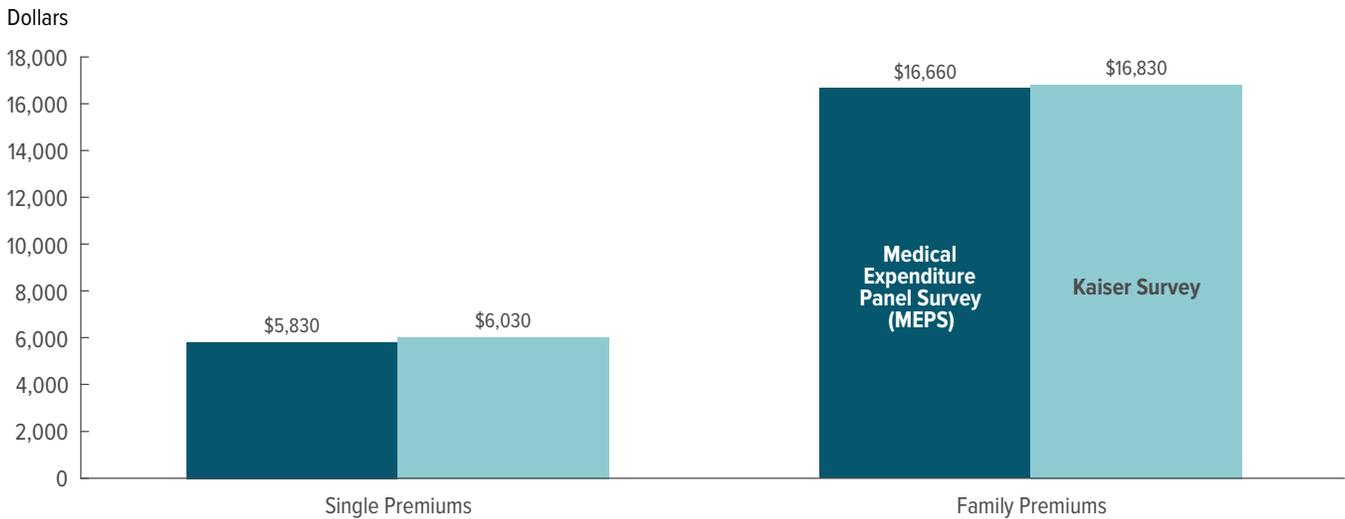
Another source of nationally representative data about premiums for employment-based coverage is the Medical Expenditure Panel Survey (MEPS), which is conducted by the Agency for Healthcare Research and Quality.

According to the most recent MEPS data, which cover 2014, those premiums averaged about \$5,830 for single coverage and \$16,660 for family coverage. The results from the Kaiser survey in that year were only slightly higher (see Figure 1).

The two surveys differ in several respects. For example, the MEPS separately asks employers about premiums for "self plus one" policies—which, as the name suggests, cover an employee and one spouse or dependent. The MEPS found that the average premium for those policies was about \$11,500 in 2014; if it had included them among family premiums, the average family premium that it found would have been reduced to about \$14,680. By contrast, the Kaiser survey does not ask employers about self plus one policies. Also, the MEPS may provide

Figure 1.

Average Premiums for Employment-Based Plans in 2014, According to Two Surveys



Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust) and from the insurance component of the *Medical Expenditure Panel Survey* (Agency for Healthcare Research and Quality).

In both surveys, employment-based coverage is defined as health insurance obtained through a worker’s employment or a retiree’s former employment, including coverage provided by private firms but excluding coverage provided by federal employers. The Kaiser survey includes coverage provided by state and local governments; the data from the Medical Expenditure Panel Survey used here do not.

the more accurate estimates, because it uses a much larger sample of employers than the Kaiser survey does; however, the Kaiser survey’s results are available sooner.

According to the 2015 Kaiser survey, about three-fifths of all workers with employment-based health insurance got it through a self-insured firm. A self-insured firm essentially acts as its own insurer and bears most or all of the financial risk of providing coverage to its workers.⁶ (Alternatively, a firm can buy a plan from an insurance company that bears the risk; that approach is called fully insured coverage.) A firm that is self-insured generally contracts with an insurance company or a similar entity to administer its plan but pays for employees’ health care costs directly. A resulting complication for measuring premiums is that self-insured employers do not make a premium payment to an insurer. Therefore, the Kaiser survey and the MEPS instead measure self-insured employers’ premium equivalent—their average costs for covered health care claims and administrative expenses, costs that would have been included in premiums if those employers had opted for a fully insured plan.

6. Self-insured employers may buy coverage (often called stop-loss coverage or reinsurance) to protect them from very high costs for medical claims.

Premiums for Nongroup Insurance. The ACA requires nongroup plans to report annually to the Centers for Medicare & Medicaid Services (CMS) on their premium revenues and enrollment. According to CBO’s analysis of those administrative data, nongroup premiums per enrollee averaged about \$2,780 in 2012.⁷

That finding differs in an important respect from the findings described above for employment-based plans: It is reported in terms of the average premium per enrollee. That is, it was calculated by dividing one component of the data (total premium revenues) by another (total enrollment). Unfortunately, those data do not allow analysts to calculate premium levels separately for single policies and family policies, which would allow clearer comparisons with the employment-based plans discussed above. However, insurers are also required to report data about fully insured employment-based plans, and those data furnish a basis for comparison. Premiums per enrollee for those plans averaged about \$4,360 in 2012—57 percent higher than nongroup premiums.

7. CBO analyzed data derived from 2012 filings of the Medical Loss Ratio Annual Reporting Form, which insurers must file with CMS. The data were compiled for CBO by Milliman, Inc., an actuarial firm.

Another limitation of the administrative data is that they take longer than the survey data to become available for analysis. However, the administrative data have two advantages over the survey data: They cover all plans, not just a sample, and they are probably more accurate.

Average premiums have been lower for nongroup plans than for employment-based plans primarily because nongroup plans have offered more limited coverage. In 2010, according to one recent study, the actuarial value of the average nongroup plan was 60 percent; in other words, that plan paid 60 percent of enrollees' health care claims. The average for employment-based plans was 83 percent.⁸ Reflecting that difference in estimated actuarial values, average out-of-pocket spending was \$4,127 for nongroup enrollees in family plans but \$1,765 for families with employment-based coverage. The study accounted for the fact that, by definition, plans with lower actuarial values require enrollees to pay a larger share of costs out of pocket. It did not, however, account for the fact that by paying a smaller share of claims, such plans encourage enrollees to use fewer services. If the study had accounted for that effect, the difference in out-of-pocket spending between nongroup and employment-based plans would have been smaller.

Another likely reason for nongroup plans' lower average premiums is that in most states, before 2014, insurers in the nongroup market could generally deny coverage to applicants who had high expected costs for health care. The insurers could also generally limit their coverage of any preexisting health conditions for people who did enroll. By contrast, federal and state laws significantly restricted both practices in the employment-based

markets. The precise effect of those practices on past nongroup premiums is difficult to estimate, however.⁹

Premium Growth Rates

Private health insurance premiums have generally grown faster than the economy as a whole. The Office of the Actuary at CMS estimates that the average premium per enrollee in all private markets grew from about \$2,320 in 2000 to about \$5,080 in 2013, indicating an average annual growth rate of 6.2 percent.¹⁰ However, private insurance premiums grew more slowly from 2005 to 2013 (4.5 percent per year, on average) than they did from 2000 to 2005 (9 percent per year). By comparison, the growth rate of per capita GDP from 2000 to 2013 was about 3 percent per year, on average.

Because enrollees in employment-based plans constitute the great majority of total enrollment in private health insurance, the growth of employment-based premiums accounts for most of the total growth in premiums. Tracking growth in premiums for nongroup plans alone is difficult, but over the longer term, they probably changed in a broadly similar fashion.

When premiums grow faster than the economy does, households have to use a larger share of their income to pay those premiums, on average. Another consequence of rising premiums has been a gradual decline in the share of the population that has private health insurance.

Growth in Premiums for Employment-Based

Insurance. Premiums for employment-based insurance grew sharply between 2000 and 2005 but more slowly thereafter (see Figure 2). Premium data reported in the MEPS and in the Kaiser survey are generally similar, and together those data indicate that average premiums for

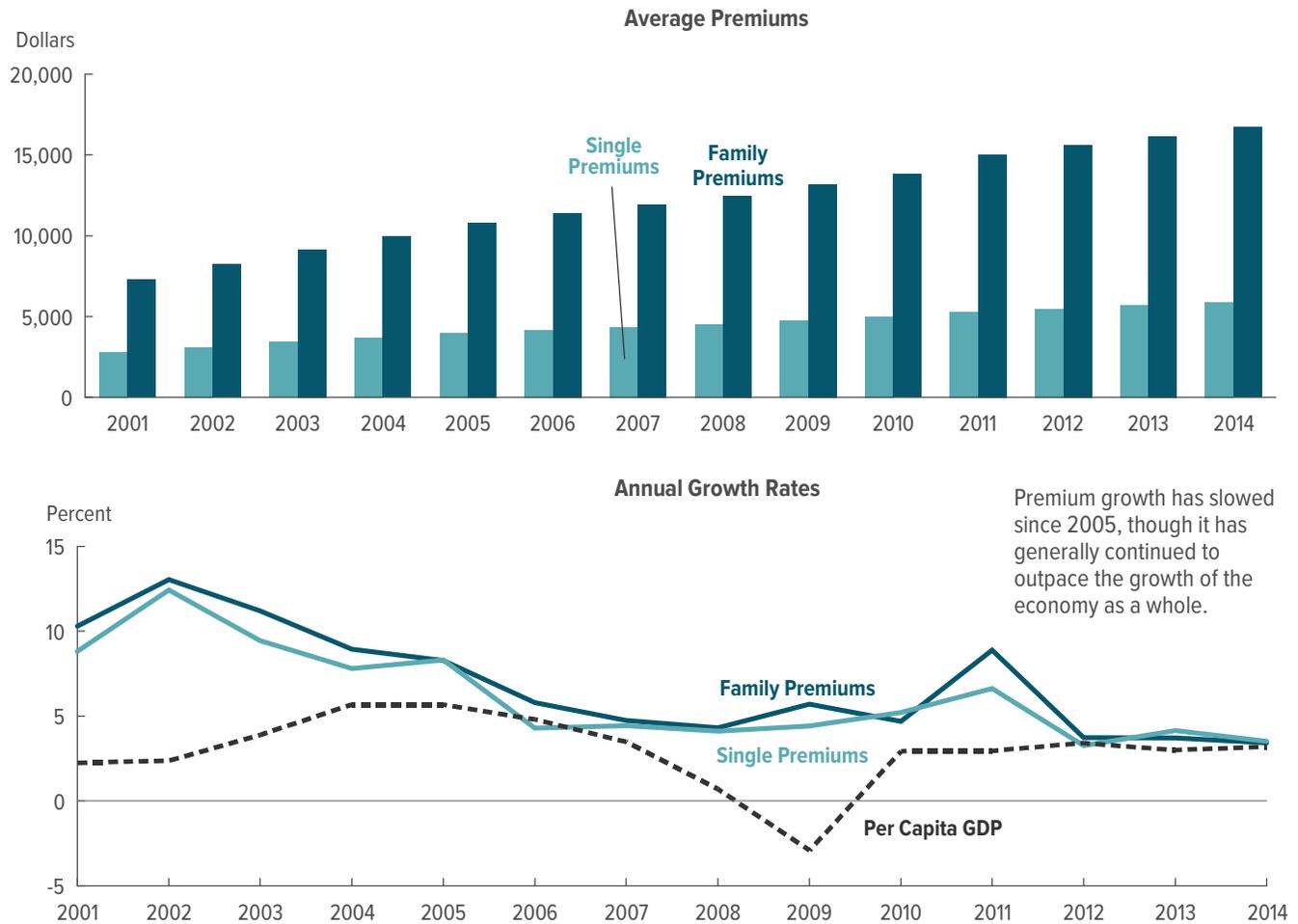
8. Jon R. Gabel and others, "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs*, vol. 31, no. 6 (June 2012), pp. 1339–1348, <http://dx.doi.org/10.1377/hlthaff.2011.1082>. The authors estimated actuarial values using a database of medical claims for enrollees in large employment-based plans, which generally cover a wide range of services. For nongroup plans that "did not cover a category, such as maternity and newborn services," the authors "classified all related charges for that plan as out-of-pocket expenses" (p. 1341). CBO reached similar conclusions about the actuarial values of employment-based and nongroup plans in an earlier study; see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), p. 63, www.cbo.gov/publication/41746.

9. For one analysis of the effects that those practices had on nongroup premiums, see Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs*, vol. 26, no. 3 (May 2007), pp. 770–779, <http://dx.doi.org/10.1377/hlthaff.26.3.770>.

10. See Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—Historical" (December 3, 2015), Tables 1, 3, and 22, <http://go.usa.gov/3WGtP>. To arrive at those figures, CMS defined total private health insurance premiums as total health consumption expenditures for private health insurance. The figures include spending by some forms of private insurance that are outside the scope of this report, such as dental insurance and Medigap plans.

Figure 2.

Annual Premium Levels and Growth Rates for Employment-Based Plans, According to Survey Data



Source: Congressional Budget Office, using data from the 2015 Employer Health Benefits Survey (Kaiser Family Foundation and Health Research and Educational Trust) and from the insurance component of the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality).

This figure shows premium levels and growth rates calculated by averaging the premiums reported in two surveys. Because the Medical Expenditure Panel Survey did not collect data about premiums in 2007, CBO used the average of that survey’s 2006 and 2008 results instead.

In both surveys, employment-based coverage is defined as health insurance obtained through a worker’s employment or a retiree’s former employment, including coverage provided by private firms but excluding coverage provided by federal employers. The Kaiser survey includes coverage provided by state and local governments; the data from the Medical Expenditure Panel Survey used here do not.

GDP = gross domestic product.

single or family coverage grew by more than 7 percent in every year between 2001 and 2005. The annual rate of growth has exceeded 7 percent only once since then, however—for family premiums in 2011—and has stood at roughly 4 percent since 2012.

The growth of premiums for employment-based insurance has generally exceeded growth in per capita GDP, but the difference has been smaller in recent years than in the early 2000s. Indeed, there was very little difference

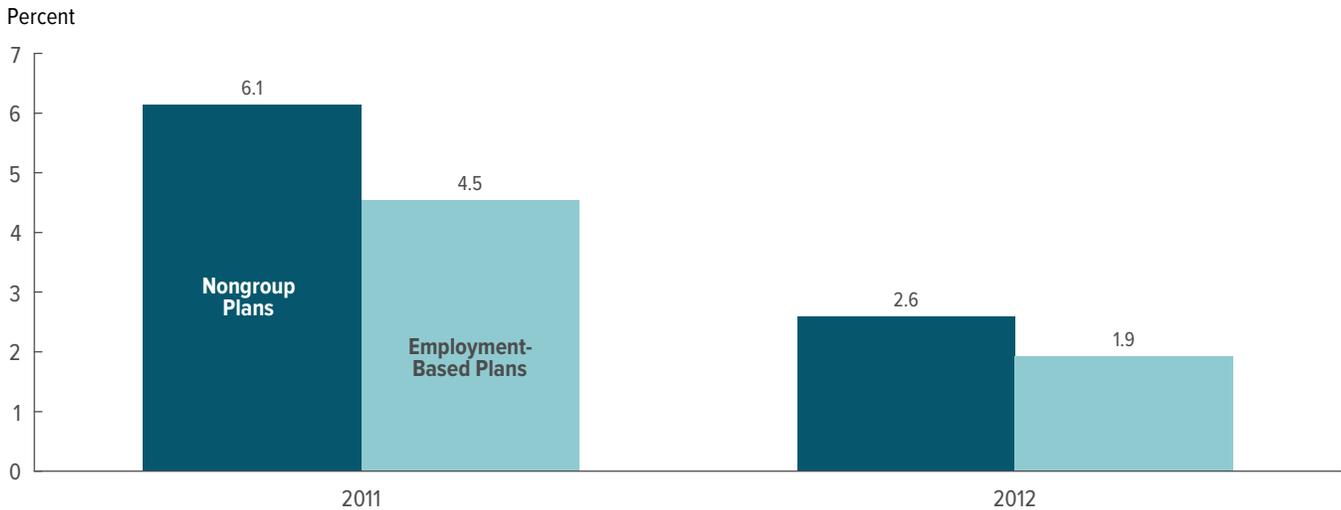
in 2006 and between 2012 and 2014. And the unusually large gap in 2009, when premiums grew more than 6 percentage points faster than per capita GDP did, was caused not by the rapid growth of the former but by a decline in the latter during the deep economic recession.

Growth in Premiums for Nongroup Insurance.

According to CBO’s analysis of data from insurers, the average premium per enrollee in nongroup coverage grew by 6.1 percent between 2010 and 2011 and by

Figure 3.

Annual Growth in Premiums for Fully Insured Plans, According to Data From Insurers



Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

The growth shown is of the average premium per enrollee, calculated by dividing total premium revenues for each year by total enrollment for the year (which equals the reported number of member-months divided by 12).

Nongroup coverage is insurance that an enrollee purchases directly from an insurer, rather than through an employer. Here, employment-based plans include not only insurance provided by employers but also insurance obtained through labor unions and multiemployer plans (often called Taft-Hartley plans), insurance obtained by retirees from their former employers, and insurance obtained through churches and other groups.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

2.6 percent between 2011 and 2012 (see Figure 3).¹¹ Those rates of growth were somewhat higher than the rates for fully insured employment-based plans that CBO derived from the same data.

Analyzing the growth of nongroup premiums over a longer period is difficult, because consistent and representative data about those premiums are hard to come by. One recent study used the rate filings and enrollment data that insurers had submitted to 30 state insurance departments since 2008. Although that study's scope was limited by "a lack of publicly available data and often inconsistent, inadequate quality of data," the authors concluded that premium growth in the nongroup market averaged about 10 percent per year between 2008 and 2011.¹²

11. CBO analyzed administrative data derived from two sources: insurers' 2010 filings of the Supplemental Health Care Exhibit with the National Association of Insurance Commissioners, and insurers' 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form with CMS. The data were compiled for CBO by Milliman, Inc. The two sources include enrollment and premium data for all fully insured plans in the United States and report those data in the same way.

Other sources of data indicate that nongroup premiums have grown more slowly than that, but whether those data are representative of the entire nongroup market is not clear. For example, according to the company eHealth, which sells insurance online, premiums for the nongroup policies that it sold grew by an average of 4.8 percent per year for single plans and 3.9 percent per year for family plans over the 2008–2011 period.¹³ Perhaps those growth rates are lower because the people

12. Jon R. Gabel, *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011* (submitted by NORC to the Department of Health and Human Services, November 2012), p. 9, <http://go.usa.gov/3k7Nx>. In calculating those aggregate results, the analysts weighted the premium change for each policy according to the number of enrollees in that policy. As a result, the findings reflect the fact that some people shifted to less expensive policies when their premiums rose. If the study had not taken that step, the average rate of premium growth that it showed would have been higher.

13. eHealth, *Cost and Benefits of Individual and Family Health Insurance* (December 2013), <http://tinyurl.com/k66fkgy> (PDF, 1 MB). Over the 2005–2013 period, according to that report, nongroup premiums grew at an average rate of about 4 percent per year for single plans and about 3.5 percent per year for family plans.

purchasing coverage online differ from those purchasing coverage in other ways, or perhaps the plans sold through eHealth differ from plans sold elsewhere.

Effects of Premium Growth on Coverage Rates. Rising premiums have contributed to a gradual decline in the share of the population that has private insurance coverage. According to one nationally representative survey, the share of people younger than 65 with private health insurance dropped from 77 percent in 1984 to 72 percent in 2000 and then to 62 percent in 2013.¹⁴ A study of private insurance coverage rates found that most of the decline that had occurred during the 1990s could be attributed to increases in premiums.¹⁵

Increases in premiums may reduce insurance coverage for several reasons. As premiums rise, some people may decide that coverage is not affordable. Others may forgo insurance because they expect that the health care services that they use will cost less than a premium will. Still others may expect or hope to receive charity care if they incur significant and unanticipated health care costs. Although people may reduce their expected costs by being uninsured, they also increase their financial risk.

Projections of Future Premiums

CBO and JCT's projections of future premiums for private insurance plans depend greatly on the past trends in premium growth that were just described; the projections factor in both the slow growth of recent years and the faster growth of earlier years. They also take into account other considerations. In particular, they were updated in March 2015 to incorporate recent data indicating that insurers' costs rose even more slowly in 2013 (the latest year for which data were available) than they had previously, and much more slowly than the agencies had expected.¹⁶ The projections also take into account projected growth in

personal income, which affects people's ability to buy health insurance.

On the basis of those factors alone, CBO and JCT estimate that premiums for private plans will increase by an average of about 4 percent per year from 2014 through 2018 and by between 5 percent and 6 percent per year from 2019 through 2025. However, the agencies have adjusted those projections to account for effects of the ACA, which increases projected nongroup premiums over the next few years but reduces projected employment-based premiums in the longer term.

Projections of Premiums for Employment-Based Insurance.

For employment-based health plans, the agencies' projections of premiums largely reflect projected growth in insurers' costs over the next few years. In 2016, CBO and JCT expect that the average premium for an employment-based insurance plan will be about \$6,400 for single coverage and about \$15,500 for family coverage. When calculating that estimate of the average family premium, the agencies included premiums for self plus one policies among family premiums. Because self plus one policies are typically much less expensive, an estimate of family premiums that includes such policies will be lower than estimates that exclude them, such as those in the Kaiser survey. CBO and JCT estimate that average premiums have grown by between 3 percent and 4 percent per year from 2014 through 2016.

Over the longer term, the agencies have reduced their projections of premiums to reflect the net effects of an excise tax that is scheduled to take effect in 2020. As this report discusses in more detail below, that tax will apply to employment-based plans with relatively high premiums, effectively increasing those premiums. However, employers and workers affected by it are likely to respond by seeking plans with lower premiums—a response that would outweigh the first effect and thus reduce average premiums. Further complicating that analysis is the fact that the costs of various tax-preferred accounts through which employees may pay for health care also count in determining whether the excise tax applies. As a result, affected employers and workers might respond to the tax by seeking plans with lower premiums or by reducing their use of those accounts. Predicting the extent to which they will do one or the other is difficult.

14. Those findings are from the National Health Interview Survey as reported in National Center for Health Statistics, *Health, United States, 2014*, DHHS Publication 2015-1232 (Department of Health and Human Services, May 2015), Table 111, www.cdc.gov/nchs/data/hus/14.pdf (15 MB).

15. Michael Chernen, David M. Cutler, and Patricia Seliger Keenan, "Increasing Health Insurance Costs and the Decline in Insurance Coverage," *Health Services Research*, vol. 40, no. 4 (August 2005), pp. 1021–1039, <http://dx.doi.org/10.1111/j.1475-6773.2005.00409.x>. Over a longer period, another contributing factor has been various expansions of public insurance coverage, such as the establishment of the Children's Health Insurance Program in 1997 and expansions of the Medicaid program. A third factor has been the recent recession, in which many people who became unemployed lost their insurance or shifted from private to public coverage.

16. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973.

The effects of the excise tax will increase over time. CBO and JCT project that in 2020, between 5 percent and 10 percent of enrollees in employment-based plans would be subject to the tax if their employers did not make any changes in response; in 2025, that share would be between 15 percent and 20 percent. The agencies also expect that many affected employers and workers will respond by adopting plans with premiums that are lower than they would have been otherwise. Taking into account both the premium increases stemming from the tax and the premium reductions stemming from responses to it, the agencies expect that average premiums among affected enrollees will be about 10 percent lower in 2020, and between 10 percent and 15 percent lower in 2025, than they would have been otherwise. All told, the agencies project that in 2025, the average premium among all employment-based plans will probably be about \$10,000 for single coverage and about \$24,500 for family coverage.

Projections of Premiums for Nongroup Insurance.

Although premium growth for nongroup plans is expected to reflect the same trends that underlie premium growth for employment-based plans, nongroup premiums are projected to grow somewhat more quickly over the next few years because of factors related to the ACA (including a phaseout of the reinsurance program discussed below). The agencies' analysis focuses on premium growth for a certain set of nongroup plans that are offered in the health insurance exchanges—known as reference plans—because federal subsidies are tied to those premiums and budget projections are based on them. The ACA defines a person's reference plan as the second-lowest-cost silver plan offered to that person through an exchange. (Silver plans are those that pay about 70 percent of the costs of covered health care services for a broadly representative group of enrollees; other levels of coverage, such as bronze and gold, pay different percentages.)

Between 2016 and 2018, CBO and JCT project, premiums for reference plans will increase at an average rate of about 8 percent per year. After 2018, they are projected to rise roughly in line with premiums for employment-based plans—that is, between 5 percent and 6 percent per year, on average. For the 2016–2025 period as a whole, premiums for reference plans are projected to grow by about 6 percent per year, on average. Of course, premiums for some plans or areas will grow more quickly or slowly than the nationwide average.

Translating those growth rates into projected premiums is complicated, because in most states, nongroup premiums depend in a complex way on the number of people covered by a policy and the ages of the enrollees. For example, in most states, a given plan's premium for someone who is 64 years old is exactly three times the premium for someone 21 to 24 years old; the premium for a 46-year-old is 1.5 times the premium for a 21- to 24-year-old; and the premium for someone younger than 21 is 0.635 times the premium for a 21- to 24-year-old.¹⁷ For a family policy, the total premium is usually the sum of the premiums that would be charged for each enrollee—but no more than three children younger than 21 count toward the total.

Analysts often focus on premiums for 21- to 24-year-olds because they are used as the basis for calculating premiums for other ages. CBO and JCT currently project that the average premium for a reference plan for a 21- to 24-year-old will increase from about \$2,800 in 2016 to about \$5,000 in 2025. A 46-year-old buying single coverage would face a premium that was 1.5 times that amount—that is, about \$4,200 in 2016 and about \$7,500 in 2025. For a family consisting of two 46-year-old parents and one child younger than 21, the average premium for a reference plan is projected to be about \$10,200 in 2016, which is twice the premium for a 46-year-old plus about \$1,800 for one child. That family premium will rise to about \$18,200 in 2025, according to CBO and JCT's projections.

Projections of premiums for private health insurance are highly uncertain, however. At present, a particular source of uncertainty is that the causes of the pronounced slowdown in spending of the past several years are not well understood. It is therefore difficult to determine whether that slowdown will persist or whether spending might accelerate instead. Projections of premium growth for plans sold in health insurance exchanges are even more

17. Vermont and New York do not allow premiums to vary by age, and a few other states use different systems of varying premiums by age in the nongroup market. For more information, see Centers for Medicare & Medicaid Services, "Market Rating Reforms: State Specific Rating Variations" (accessed November 23, 2015), <http://go.usa.gov/c2Fnd>.

Table 1.

Major Federal Subsidies, Taxes, and Fees Affecting Premiums

	Relevant Health Insurance Market				Nongroup
	Large-Group		Small-Group		
	Fully Insured	Self-Insured	Fully Insured	Self-Insured	
Tax Exclusion for Premiums	X	X	X	X	
Excise Tax on High-Premium Health Plans ^a	X	X	X	X	
Tax Preferences for Out-of-Pocket Spending	X	X	X	X	X
Premium Tax Credits (For exchange plans)					X
Cost-Sharing Subsidies (For exchange plans)					X
Transitional Reinsurance Subsidies ^b					X
Transitional Reinsurance Fees ^b	X	X	X	X	X
Health Insurer Tax	X		X		X

Source: Congressional Budget Office.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

The small-group market generally serves employers with up to 50 employees.

This table omits several smaller fees, including a user fee for health insurance exchanges, an assessment to cover the administrative costs of operating a system of risk adjustment, and an assessment to fund the Patient-Centered Outcomes Research Institute.

a. The excise tax is scheduled to take effect in 2020.

b. The system of reinsurance subsidies and fees affects only plans offered in 2014, 2015, or 2016.

uncertain, because the exchanges are so new. In CBO and JCT’s view, the agencies’ projections show the most likely outcome in what is nevertheless a wide distribution of possible outcomes.

Federal Subsidies, Taxes, and Fees That Affect Premiums

One important way in which the federal government affects premiums is by subsidizing the purchase of private health insurance. The two main subsidies operate through the tax code: a tax exclusion that subsidizes premiums for employment-based coverage, and tax credits for nongroup coverage purchased through health insurance exchanges (see Table 1). CBO estimates that the combined cost of those two subsidies in fiscal year 2016 will be roughly \$300 billion.

The two subsidies are structured differently and therefore have different effects on premiums. A particularly significant difference is that the tax exclusion, by providing an open-ended subsidy, encourages people to select more extensive coverage through their employer—raising premiums for employment-based plans. The tax credit does not have that effect, because its value does not increase

when people choose a nongroup plan that provides more extensive coverage.

Two smaller federal subsidies affect enrollees’ out-of-pocket costs. First, tax provisions subsidize some out-of-pocket spending on health care by enrollees, mostly those in employment-based plans. Second, certain enrollees in exchange plans may receive subsidies to reduce their cost-sharing requirements (that is, their out-of-pocket expenses). Those subsidies affect premiums in various ways.

Finally, the federal government imposes various taxes and fees on private insurance plans. Most of them raise premiums to a modest degree.

Tax Exclusion for Premiums

The largest federal subsidy for private health insurance stems from a feature of the tax code: Most premium payments for employment-based insurance are excluded from income and payroll taxes. Employers typically cover part of their employees’ premiums, and those contributions—like other forms of compensation, such as wages—are deducted as expenses when employers calculate their income taxes. Unlike wages, however, the employers’ contributions are

also exempt from the individual income and payroll taxes that employees pay; furthermore, the share of premiums that employees pay is usually exempt from income and payroll taxes as well. CBO has estimated that the subsidy cost about \$250 billion in fiscal year 2013 and expects it to cost more in 2016 because of growth in premiums.¹⁸

Employers typically cover the majority of their employees' premiums—on average, 71 percent of the premium for family coverage and 82 percent for single coverage, according to the Kaiser survey for 2015. Nevertheless, the subsidy resulting from the tax exclusion ultimately accrues to the employees, because the employers' contributions are simply another form of compensation. Most economists agree that an employer that pays for health insurance generally pays less in wages and other forms of compensation than it otherwise would, leaving total compensation about the same. As a result, the employers' costs are ultimately borne by their employees as a group. Buttressing that point, several recent studies indicate that rising premiums have been an important cause of slow growth in workers' wages and income.¹⁹

The size of the subsidy for any particular worker depends on two things: the amount of that worker's premium and the subsidy rate (that is, the percentage of the premium being subsidized). The subsidy is open-ended; that is, it

increases as premiums rise. And because the subsidy results from excluding premium payments from taxation, the subsidy rate equals the tax rate that workers would otherwise have faced on those payments—specifically, the workers' marginal tax rate, which is the rate that applies to their last dollar of income. The subsidy rate therefore tends to be higher for people with higher income, because those people usually face higher marginal tax rates. CBO estimates that the federal subsidy averages about 30 percent of the premium and that it ranges from roughly 20 percent to 40 percent of the premium for most workers. Workers in states with individual income taxes receive an additional subsidy because those states also exclude premiums for employment-based coverage from taxable income.

The tax exclusion exerts both upward and downward pressure on premiums for employment-based coverage—but on balance, CBO estimates, it increases them. On the one hand, the subsidy encourages relatively healthy workers to obtain coverage. (People with lower expected costs for health care would be less likely to obtain coverage without the subsidy; by contrast, people with higher expected costs would be more likely to purchase coverage regardless of the subsidy.) That reduces insurers' average spending for enrollees' health care and thus lowers average premiums. On the other hand, the open-ended nature of the subsidy gives employers and employees an incentive to select more extensive coverage than they otherwise would. Because premiums are paid with before-tax dollars whereas wages are subject to taxes, health insurance effectively costs less than other goods and services—so workers will tend to purchase more of it, up to a point. In CBO's judgment, the available evidence indicates that the second effect is stronger and that the tax exclusion increases average premiums for employment-based plans by 10 percent to 15 percent.

Excise Tax on High-Premium Health Plans

Starting in 2020, an excise tax will be levied on employment-based health plans with premiums that exceed certain thresholds. (The tax was originally scheduled to start in 2018, but legislation enacted in December 2015 delayed its implementation.) For those plans, the excise tax will largely counteract the incentives created by the federal tax exclusion—thus encouraging the affected firms and workers to seek less expensive coverage.

The excise tax will equal 40 percent of the amount by which annual premiums exceed the thresholds, which are projected to be about \$10,800 for single plans and

18. See Congressional Budget Office, *Health-Related Options for Reducing the Deficit: 2014 to 2023* (December 2013), p. 64, www.cbo.gov/publication/44906. The exclusion is a tax expenditure—a provision in the tax code that resembles federal spending by providing financial assistance to specific activities, entities, or groups of people. Its estimated cost here consists of reductions in income and payroll taxes. Such an estimate, however, may differ from a cost estimate for a proposal to eliminate the exclusion. That is because CBO's and JCT's estimates of tax expenditures, unlike their cost estimates, do not incorporate any behavioral responses of taxpayers or changes in the timing of tax payments. For a general discussion of tax expenditures, see Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2014–2018*, JCX-97-14 (August 2014), <http://go.usa.gov/cBPJ5>.

19. Gary Burtless and Pavel Svaton, "Health Care, Health Insurance, and the Distribution of American Incomes," *Forum for Health Economics and Policy*, vol. 13, no. 1 (February 2010), <http://dx.doi.org/10.2202/1558-9544.1194>; Paul Ginsburg, *Alternative Health Spending Scenarios: Implications for Employers and Working Households* (Brookings Institution, April 2014), <http://tinyurl.com/ksh9p47>; and Katherine Baicker and Amitabh Chandra, "The Veiled Economics of Employee Cost Sharing," *JAMA Internal Medicine*, vol. 175, no. 7 (July 2015), pp. 1081–1082, <http://dx.doi.org/10.1001/jamainternmed.2015.1109>.

\$29,100 for family plans in 2020. The thresholds are scheduled to rise at the rate of overall price inflation in later years.²⁰ Because prices are projected to grow more slowly than health insurance premiums, CBO and JCT expect the tax to affect more health plans and more people over time.

Although the tax is levied on insurers, plan administrators, and employers that self-insure, economic theory and empirical evidence indicate that they will pass on the cost of the tax to employers and workers in the form of higher premiums. However, CBO and JCT expect that many of those employers will seek to avoid the tax by offering their workers coverage with premiums that are below the thresholds; in fact, some evidence indicates that employers have already started to take steps in that direction.²¹ Because of that response, the projected result of the excise tax is lower average premiums, although premiums for most plans will not be affected within the next decade.

The excise tax will increase federal revenues, CBO and JCT expect, even though some employers will take steps to keep premiums below the thresholds. The reason is that, in order to attract and retain workers, employers offering less expensive coverage are expected to increase workers' wages correspondingly to hold total compensation about the same. Because those wages will be taxable, total tax revenues will increase. (If employers did not increase workers' wages or other forms of compensation, their profits would increase—and those profits too would generally be taxable.) Overall, the agencies project that revenues resulting from the excise tax will rise from \$2 billion in fiscal year 2020 to \$20 billion in fiscal year 2025; over fiscal years 2016 through 2025, those revenues are projected to total \$70 billion.²² Of that sum, between 20 percent and

25 percent will represent excise tax receipts, CBO and JCT estimate; the remainder will come from the projected changes in employees' taxable compensation.

Tax Preferences for Out-of-Pocket Spending

The tax code allows people who establish accounts of certain types to pay out-of-pocket costs for health care with before-tax dollars. For example, people with employment-based coverage may direct a predetermined part of their pay into flexible spending accounts (FSAs) for medical care. That money is excluded from income and payroll taxes, and the employees may use it to pay for health care expenses not covered by their insurance plan—though they may forfeit some of the money if they do not spend it by the end of the year.²³ Contributions to FSAs are limited to \$2,550 in 2016, and that limit is indexed to general inflation for later years.

Another tax preference for out-of-pocket spending is available to people enrolled in certain high-deductible health plans (HDHPs). If those enrollees have employment-based coverage, and if they establish and contribute to an associated health savings account (HSA), those contributions are excluded from income and payroll taxes.²⁴ The money may be used to pay for the enrollees' deductible—that is, the amount that an enrollee must pay out of pocket each year before the insurer begins to pay—and other medical expenses. Unspent contributions to an HSA may be rolled over from year to year, and if they are ultimately used to pay for health care, they are never taxed as income.²⁵

20. The thresholds are also subject to various adjustments and are higher for certain retirees and for workers in certain professions.

21. See Towers Watson and the National Business Group on Health, *The New Health Care Imperative: Driving Performance, Connecting to Value* (May 2014), p. 6, <http://tinyurl.com/olnnjo8>.

22. The excise tax will also affect federal revenues and outlays by changing people's sources of insurance coverage. Therefore, a recent estimate by CBO and JCT of the cost of repealing the excise tax by itself was somewhat larger than the figures shown here. For more information, see Congressional Budget Office, cost estimate for reconciliation recommendations of the House Committee on Ways and Means (October 2, 2015), www.cbo.gov/publication/50869. Because subsequent legislation delayed the implementation of the excise tax, the net cost of repealing it over the 2016–2025 period would be somewhat lower than that cost estimate indicated.

23. Employers may treat funds that remain in an FSA at the end of the year in one of two ways: They may allow employees to transfer up to \$500 into their FSA for the new year; or they may provide a grace period of two and a half months at the start of the new year, during which employees may use the remaining funds. See Internal Revenue Service, *Health Savings Accounts and Other Tax-Favored Health Plans*, Publication 969 (March 2015), www.irs.gov/publications/p969.

24. People purchasing a qualifying HDHP in the nongroup market are also allowed to establish and use an HSA; their contributions (up to the annual limit) are deductible from their income taxes but not from their payroll taxes.

25. HDHPs coupled with HSAs are sometimes called consumer-directed health plans, although that term also includes similar plans known as health reimbursement arrangements and medical savings accounts. For more information, see Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), www.cbo.gov/publication/18261.

To contribute tax-preferred funds to an HSA in 2016, people must be enrolled in a plan with an annual deductible of at least \$1,300 for single policies or \$2,600 for family policies, and the plan's annual limit on out-of-pocket costs cannot exceed \$6,550 for single policies or \$13,100 for families. Enrollees and their employers are generally allowed to contribute as much as \$3,350 for single coverage or \$6,750 for family coverage in 2016. All of those thresholds and limits increase each year at the rate of general inflation.

The tax exclusions for out-of-pocket spending have complex effects on premiums. Subsidizing people's out-of-pocket costs effectively reduces the price of their health care services, which encourages them to use more care—and greater use of care usually translates into higher premiums. But for HSAs, two factors work in the opposite direction. First, in order to take advantage of the tax exclusion, people must enroll in a qualifying HDHP. The exclusion thus encourages enrollment in HDHPs—which have relatively low premiums, because they have relatively high deductibles—and that helps bring down average premiums. Second, allowing employees to pay out-of-pocket costs with pretax dollars, just as they do for insurance premiums, increases their incentive to select HDHPs with higher out-of-pocket costs and lower premiums.

Two considerations tend to limit the effects that HSAs have on premiums. First, analyses have found that many of the enrollees in HDHPs who could have established an HSA have not done so.²⁶ Second, the value of tax-excluded contributions to HSAs (and to accounts of other types) will be added to plans' premiums for the purpose of determining whether the coverage is subject to the high-premium excise tax—so in effect, for some people, those contributions could be subject to the tax. That taxation will further restrain the use of HSAs.

Premium Tax Credits

Before 2014, few subsidies were available for nongroup coverage.²⁷ Now, however, some people who buy

nongroup coverage in health insurance exchanges qualify for tax credits that cover at least part of their premium. To qualify, they must meet four conditions: They must be U.S. citizens or otherwise lawfully present in the country; they must not be eligible for Medicare, Medicaid, or certain other sources of coverage; they must not have an offer of coverage from their employer or from a family member's employer that is considered affordable under federal law; and their income must generally be between 100 percent and 400 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).²⁸ The tax credit is refundable; that is, its value may exceed the income tax liability of the recipient.

Eligibility for the credits varies by state, because it depends on Medicaid eligibility, which also varies by state. For example, states may now expand Medicaid so that adults with income up to 138 percent of the FPL are eligible, but they are not required to do so. In states that have adopted that expansion, eligibility for the premium tax credits is generally limited to people whose income is between 138 percent and 400 percent of the FPL. In states that have not expanded Medicaid, people whose income is between 100 percent and 138 percent of the FPL may be eligible for tax credits as well—but people whose income is below 100 percent of the FPL are generally ineligible, even if they do not qualify for Medicaid. As of 2015, CBO estimates, about half of the people who met the new eligibility criteria for Medicaid lived in states that had expanded coverage. CBO expects that share to grow substantially over time.

The tax credit equals the difference between the premium for a person's reference plan and a specified share of that person's income (see Table 2). For example, in 2015, the share of income for a person whose income equaled 150 percent of the FPL was set at 4.02 percent; the credit therefore equaled the difference between that amount and the reference plan's premium. The specified percentages

26. See Robin A. Cohen and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2014* (National Center for Health Statistics, September 2014), Figure 6, <http://go.usa.gov/crcq>; and Paul Fronstin, *HSA Balances, Contributions, Distributions, and Other Vital Statistics*, Issue Brief 400 (Employee Benefit Research Institute, June 2014), <http://tinyurl.com/o26ht74>.

27. Then as now, self-employed people could deduct their premium payments for nongroup insurance from their taxable income, and all tax filers could deduct medical expenses (including premiums) that exceeded a specified share of their income. For more information, see Matthew Rae and others, *Tax Subsidies for Private Health Insurance* (Kaiser Family Foundation, October 2014), Part III, <http://tinyurl.com/ofjkw>.

28. For more information, see Internal Revenue Service, "Questions and Answers on the Premium Tax Credit" (accessed November 24, 2015), <http://go.usa.gov/craZQ>.

Table 2.

Premium Tax Credits and Premium Payments for Two Hypothetical Families in 2015

	Lower-Income Family of Four	Middle-Income Family of Four
Calculation of Family's Premium Tax Credit		
Family's Annual Income		
Percentage of FPL ^a	150	300
Dollar amount	35,775	71,550
Total Premium for a Reference Plan (Dollars)	10,000	10,000
What the Family Would Have to Pay for a Reference Plan		
Percentage of annual income	4.02	9.56
Dollar amount	1,438	6,840
Family's Premium Tax Credit (Dollars)	8,562	3,160
Calculation of Family's Payment for Various Plans (Dollars)		
Plan With Lower Premium		
Total premium	9,500	9,500
Family's premium tax credit	8,562	3,160
Family's Payment	938	6,340
Reference Plan		
Total premium	10,000	10,000
Family's premium tax credit	8,562	3,160
Family's Payment	1,438	6,840
Plan With Higher Premium		
Total premium	10,500	10,500
Family's premium tax credit	8,562	3,160
Family's Payment	1,938	7,340

Source: Congressional Budget Office.

The Affordable Care Act defines a person's reference plan as the second-lowest-cost silver plan available to that person through a health insurance exchange. Silver plans are those that cover about 70 percent of the costs of covered health care services for a broadly representative group of enrollees. The actual cost of a reference plan's premium may vary for several reasons; the \$10,000 shown here is merely illustrative.

FPL = federal poverty level.

a. Premium tax credits in 2015 were calculated on the basis of the 2014 FPL, which was \$23,850 for a family of four.

increase with income. For example, people with an income equaling 200 percent of the FPL paid 6.34 percent of their income for the reference plan in 2015, and people with an income between 300 percent and 400 percent of the FPL paid 9.56 percent. Those percentages of income are indexed to rise over time.²⁹

Lower-income families thus receive a larger tax credit than middle-income families do, but the value of the

credit generally does not depend on which plan any given family chooses. People receiving the credit can buy a more expensive plan and pay the additional premium, or they can buy a less expensive one and reduce their premium. (They may not receive a rebate if the premium is less than the amount of the credit, however.) Unlike the tax exclusion for employment-based premiums, therefore, the tax credits are not structured in a way that encourages people to buy more extensive coverage, and consequently they do not put the same kind of upward pressure on nongroup premiums.

In other respects, however, the tax credits and the tax exclusion have similar effects. Like the exclusion, the

29. For a discussion of the indexing provisions, see Congressional Budget Office, *Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (May 2011), www.cbo.gov/publication/41464.

credits encourage people with lower expected costs for health care—who may not value insurance as highly as people with higher expected costs do—to buy insurance. That helps keep premiums down. (It also helps offset the effects on premiums of new regulations, described below, that have made it easier for people with higher expected costs to purchase nongroup coverage.) At the same time, the tax credits effectively increase recipients' net income, just as the exclusion does—putting slight upward pressure on premiums, because recipients are likely to spend some of that increase on more extensive health insurance.

CBO and JCT estimate that in fiscal year 2016, the tax credits will cost the federal government about \$37 billion. The cost will grow in later years because of projected increases in premiums for exchange plans, even though the number of subsidized enrollees is projected to decline slightly. From fiscal years 2016 through 2025, the credits are projected to cost \$691 billion.³⁰

Cost-Sharing Subsidies

Some people who buy nongroup coverage through an exchange are also eligible for cost-sharing subsidies, which the federal government pays to their insurer to reduce their out-of-pocket expenses. To be eligible, people must generally have income that is between 100 percent and 250 percent of the FPL, be eligible for premium tax credits, and buy a silver plan.

The subsidies are designed to increase the percentage of covered health care costs that a silver plan pays (that is, the plan's actuarial value) for an average enrollee in various income groups. Specifically, the subsidies increase a plan's actuarial value from 70 percent to 94 percent for enrollees with income between 100 percent and 150 percent of the FPL; to 87 percent for enrollees with income between 150 percent and 200 percent of the FPL; and to 73 percent for enrollees with income between 200 percent and 250 percent of the FPL. The subsidies tend to increase average premiums in two ways: by making exchange plans more attractive to people with health problems (who would expect to gain more from the subsidies than other

people would); and by lowering the cost of health care, thus encouraging people to use more of it.

CBO and JCT estimate that in fiscal year 2016, the cost-sharing subsidies will cost the federal government about \$8 billion. Those costs, like the costs of the premium tax credits, will grow in later years. From fiscal years 2016 through 2025, the subsidies are projected to cost \$132 billion.

Transitional Reinsurance

A temporary federal program known as transitional reinsurance makes payments to insurers in the nongroup market whose enrollees, in plans sold between 2014 and 2016, incur particularly high costs.³¹ Any nongroup plan may receive payments, whether it is sold in the exchanges or not, as long as it complies with the new market and benefit standards that went into effect in 2014 (which are discussed further below).

The funding for the payments comes from a fee per enrollee that is levied on most insurers in the nongroup, small-group, and large-group markets and on employers providing self-insured coverage. The Department of Health and Human Services (HHS) set the fee at \$63 per enrollee for plans operating in 2014, \$44 per enrollee for 2015, and \$27 for 2016.

Qualifying nongroup insurers must pay the fee, but on average, the reinsurance payments that they receive will be greater than the fees that they pay. The reinsurance program therefore operates as a subsidy for those insurers—and by covering costs that would otherwise have to be financed by premiums, it reduces nongroup premiums. By law, the subsidy was supposed to total \$10 billion for 2014, \$6 billion for 2015, and \$4 billion for 2016. According to CMS, however, insurers' requests for 2014 payments were somewhat lower, totaling about \$8 billion.

Another way to measure the size of the subsidy is to examine its effect on premiums. Specifically, CBO and JCT have estimated that the reinsurance payments for 2014 made premiums for nongroup exchange plans approximately 10 percent lower than they would have been otherwise. That percentage is expected to decrease

30. A separate tax credit is available for certain employers that purchase small-group coverage: Employers with fewer than 25 full-time-equivalent employees may qualify for a credit covering a portion of the premium if the annual wages of their employees average less than \$50,000. CBO and JCT project that the subsidy will cost the federal government \$11 billion from fiscal years 2016 through 2025.

31. For the 2014 benefit year, CMS paid qualifying insurers 100 percent of their costs between \$45,000 and \$250,000; for 2015, it will pay 50 percent of those costs; and for 2016, it will pay 50 percent of their costs between \$90,000 and \$250,000.

in 2015 and 2016—both because the total payments will be smaller and because, as more people enroll in qualifying plans in those years, the payments will represent a smaller percentage of insurers' costs. After 2016, transitional reinsurance is expected to have no direct effect on nongroup premiums.

Insurers and employers operating in the small-group and large-group markets, by contrast, are ineligible to receive payments, so CBO expects that they will charge higher premiums in order to pay the fees. Because payments out and payments in are supposed to be equal, the effect of the program on average premiums overall—that is, in the nongroup, small-group, and large-group markets together—is expected to be negligible.

Other Taxes and Fees Imposed on Private Insurers

The ACA imposed several taxes and fees on insurers in addition to those mentioned above. One of them, usually called the health insurer tax, is allocated among insurers on the basis of their market share for fully insured plans, so it is effectively a tax on premiums for those plans. By law, it started at \$8.0 billion in 2014 and increased to \$11.3 billion in 2015 and 2016. Although recent legislation suspended the tax in 2017, it is scheduled to total \$14.3 billion in 2018 and will increase at the rate of premium growth thereafter.

Another is a user fee paid by insurers that participate in health insurance exchanges. The fee was set at 3.5 percent of premiums in 2014 for federally run exchanges and at various rates for state-run exchanges. Insurers offering plans in the federally run exchanges paid about \$400 million in user fees in fiscal year 2014 and about \$900 million in 2015; CMS expects them to pay about \$1.4 billion in 2016.³²

Two smaller fees are an assessment that primarily finances the Patient-Centered Outcomes Research Institute (PCORI), which was established by the ACA, and another to cover the administrative costs of operating a system of risk adjustment, which is described later in this report. All plans (including self-insured plans) pay the PCORI assessment, which is about \$2 per enrollee in 2016 and is set to increase at the rate of growth for national health expenditures thereafter. CBO estimates that health plans' payments

for that assessment will total about \$400 million in fiscal year 2016. The risk-adjustment assessment is \$1 per enrollee per year, but it applies only to fully insured plans in the nongroup and small-group markets in states that use the federal risk-adjustment system. CMS expects those payments to total about \$20 million in 2016.

CBO and JCT anticipate that insurers will generally pass the fees on to consumers in the form of higher premiums; for example, JCT has estimated that the health insurer tax will increase premiums for the affected plans by between 2.0 percent and 2.5 percent.³³ In some cases, however, the premium increases may not be as large as the fees—for example, if some of the money that insurers pay in user fees for health insurance exchanges substitutes for expenses that the insurers had to incur on their own before the exchange system existed.

Federal Regulations That Affect Premiums

A number of federal regulations related to health insurance affected premiums even before the ACA was enacted, but the ACA expanded the scope of federal regulations considerably, especially in the nongroup market. This report focuses on regulations resulting from the ACA, because proposals designed to affect premiums often involve changing those regulations rather than the ones that were previously in place.³⁴

The regulations resulting from the ACA include requirements for most people to have insurance and for larger employers to offer it. Together, those two requirements, which are called the individual mandate and the employer mandate, are expected to increase enrollment in private insurance plans. The individual mandate is also expected to reduce average premiums in the nongroup market by encouraging relatively healthy people to enroll.

33. For additional discussion, see Thomas A. Barthold, Joint Committee on Taxation, letter to the Honorable Jon Kyl, United States Senate (June 3, 2011), <http://tinyurl.com/oxyrdvj> (PDF, 371 KB).

34. The regulations discussed here include provisions of law as well as the regulations issued to implement them. Two of the regulations—the individual mandate and the employer mandate—involve penalties that are essentially taxes and could alternatively have been listed above in the discussion of subsidies, taxes, and fees. Some federal regulations affect competition among insurers and among health care providers, thus affecting premiums, but this report does not mention them, because it focuses on regulations resulting from the ACA.

32. Centers for Medicare & Medicaid Services, *Fiscal Year 2016 Justification of Estimates for Appropriations Committees* (February 2015), p. 14, <http://go.usa.gov/cn7MJ>.

Table 3.

Major Federal Regulations Affecting Premiums

	Relevant Health Insurance Market				
	Large-Group		Small-Group		Nongroup
	Fully Insured	Self-Insured	Fully Insured	Self-Insured	
Individual Mandate	X	X	X	X	X
Employer Mandate	X	X			
Regulations Governing Insurance Benefits					
Requirement to cover "essential health benefits"			X		X
Prohibition on excluding preexisting conditions	X	X	X	X	X
Minimum actuarial value (Generally 60 percent) ^a	X	X	X		X
Regulations Governing Insurance Offers and Pricing					
Guaranteed issue and guaranteed renewability ^b			X		X
Modified community rating ^c			X		X
Requirements for review of proposed premium increases			X		X
Risk Adjustment					
Minimum Medical Loss Ratios	X		X		X

Source: Congressional Budget Office.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

The small-group market generally serves employers with up to 50 employees.

In each market, plans that are "grandfathered" and certain other plans are exempt from many regulations.

- Large employers may be penalized under the employer mandate if they offer coverage that has an actuarial value of less than 60 percent.
- For the fully insured large-group market, guaranteed renewability applies; guaranteed issue does not.
- For large employers and for small ones that self-insure, the total premium or cost per enrollee may vary because of differences in the average health of each firm's enrollees. However, an individual employee's eligibility to enroll in a plan and that employee's required premium payment generally cannot vary on the basis of health.

Other regulations govern the benefits that insurers must cover and the prices that they may charge. Those regulations tend to increase average premiums, primarily in the nongroup market. They do that by requiring more extensive coverage than was typically purchased in the non-group market under prior law and by making it easier for people with high health care costs to obtain coverage in that market.

Another regulation establishes a program of risk adjustment, which takes money from insurance plans with healthier enrollees and gives it to insurance plans with sicker ones. Still another regulation establishes a minimum medical loss ratio (MLR), which is the share of premiums that may go toward insurers' administrative costs and profits. CBO and JCT estimate that those two regulations do not substantially affect average premiums but that they do affect the distribution of premiums among plans.

One complication that arises in assessing the effects of regulations on insurance premiums is that they differ by market, and those markets differ substantially in size (see Table 3). Of the roughly 180 million nonelderly people who will have employment-based or nongroup coverage in 2025, CBO and JCT project, about 75 percent will be covered through employers with more than 50 workers; those people will generally have coverage through the large-group market. An additional 10 percent will be covered in the small-group market, and the remaining 15 percent will be covered in the nongroup market. Another complication that arises in assessing the regulations' effects on premiums is that some parts of each market are exempt from certain regulations.

The Individual Mandate

Since 2014, an individual mandate has required most people to obtain health insurance. It is closely related to two other ACA regulations (discussed below), which

require insurers to offer coverage to all applicants and prohibit insurers from charging higher premiums to people with health problems. On their own, those other two regulations make it easier for people to wait until they develop health problems to sign up for coverage; the individual mandate discourages such delays.

People who do not comply with the individual mandate (and do not obtain an exemption) must pay a penalty. The penalty equals the greater of two amounts, each of which is subject to a cap: a fixed dollar amount assessed for each uninsured person in a household; and a share of the difference between the household's adjusted gross income and its income threshold for tax filing.³⁵ The fixed dollar amount per uninsured adult rises from \$95 in 2014 to \$695 in 2016 and will rise at the rate of general inflation thereafter; the penalty per child is half as large; and a household's total penalty may be no larger than three times the penalty per adult. The income-based penalty rises from 1 percent in 2014 to 2.5 percent in 2016 and later, but it may be no larger than the national average premium for a bronze plan sold in the exchanges. For people who are uninsured for only part of the year, the penalty is reduced.

Although most legal residents are subject to the individual mandate, a number of exemptions apply. For example, people who would have to pay more than a certain share of their income to acquire health insurance do not face a penalty; that share was 8.05 percent in 2015. People with income below the tax-filing threshold are also exempt. CBO and JCT expect that a substantial majority of the people who remain uninsured will receive an exemption. All told, the agencies expect that, on average, about 4 million people will pay the penalty during any given month in 2017 (including dependents who have the penalty paid on their behalf). Because some people will be insured in some months and uninsured in others, the total number of people who pay a penalty during that year will be greater.³⁶

35. The tax-filing thresholds depend on a person's age and filing status and increase annually. In 2015, the thresholds for people younger than 65 were \$10,300 for single filers and \$20,600 for married couples. For more information, see Internal Revenue Service, "Individual Shared Responsibility Provision—Reporting and Calculating the Payment" (accessed January 15, 2016), <http://go.usa.gov/crReY>.

Notwithstanding the exemptions, the mandate significantly reduces average premiums, CBO and JCT estimate. It does so by encouraging healthier people to obtain insurance, which lowers average spending on health care among the insured population. Although the penalty may be smaller than the premium that a person would have to pay for coverage, it nevertheless increases the cost of remaining uninsured and thus means that more people will gain financially by obtaining coverage. That financial analysis takes into account the benefits of having insurance—including a reduced risk of facing large medical bills—and the fact that people who pay the penalty receive no benefits in return. CBO also expects that some people will obtain coverage not for financial reasons but simply because the mandate exists. That expectation is based on an analysis of people's responses to other mandates and their tendency to comply with laws even when the expected costs of noncompliance are low.³⁷

A recent CBO estimate of the effects of repealing the individual mandate illustrates its impact on premiums. Specifically, CBO estimated in 2015 that repealing that mandate while maintaining all other provisions of current law would increase average premiums in the nongroup market by roughly 20 percent.³⁸

The Employer Mandate

The ACA also established an employer mandate, which requires larger employers to offer coverage to

36. For additional discussion about the penalty, see Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update* (June 2014), www.cbo.gov/publication/45397, and cost estimate for H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 (October 20, 2015), pp. 10–12, www.cbo.gov/publication/50918.

37. See David Auerbach and others, *Will Health Insurance Mandates Increase Coverage? Synthesizing Perspectives From the Literature in Health Economics, Tax Compliance, and Behavioral Economics*, Working Paper 2010-05 (Congressional Budget Office, August 2010), www.cbo.gov/publication/21600; and Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 48–54, www.cbo.gov/publication/41746.

38. Repeal would also increase the number of people without health insurance by about 14 million in 2025, CBO and JCT estimated, and would reduce federal deficits by \$305 billion over 10 years. See Congressional Budget Office, preliminary estimate of the budgetary effect of eliminating the requirement that individuals purchase health insurance and associated penalties (September 15, 2015), www.cbo.gov/publication/50821.

their full-time workers or face a penalty.³⁹ In 2016, an employer is liable for the penalty if it has 50 or more full-time-equivalent employees, if it does not offer them coverage, and if any of those employees receive premium tax credits. The coverage offered by the employer must have an actuarial value of at least 60 percent, and it must be offered to at least 95 percent of the firm's full-time workers. For 2016, the penalty is \$2,160 per full-time employee (after the first 30). Furthermore, larger employers that offer coverage may nevertheless be liable for a penalty if any of their full-time employees receive premium tax credits; for 2016, that penalty is \$3,240 for each of those employees.⁴⁰ In subsequent years, the amounts of both penalties are indexed to average growth in premiums.⁴¹

By itself, the employer mandate is not projected to have a noticeable impact on average insurance premiums, because it has only limited effects on the overall size and composition of the insured population. Although the mandate affects the allocation of coverage among markets—making the share of the privately insured population that has employment-based coverage larger than it would be otherwise, and the share that has nongroup coverage smaller—that shift also will not have a noticeable effect on average premiums.

Regulations Governing Insurance Benefits

States have traditionally been the primary regulators of insurance benefits. In 2014, however, many federal regulations established by the ACA went into effect that governed the benefits that new policies sold in small-group and nongroup markets must provide. Those that have the largest effects on premiums govern coverage of specified

health benefits, coverage of preexisting conditions, and minimum actuarial value.

Requirement to Cover “Essential Health Benefits.”

New plans sold in the small-group and nongroup markets must cover 10 categories of health benefits that the ACA defines as essential.⁴² Within federal guidelines, states specify which particular services and treatments are included in each category. Those specifications generally reflect earlier coverage patterns in each state's small-group market. The specifications probably vary more for some categories—such as rehabilitative and habilitative services and devices—both because they are difficult to define and because coverage of benefits in those categories varied widely under prior law. Other categories, such as hospitalization, are more clear-cut.

Prohibition on Excluding Preexisting Conditions.

Another federal regulation requires small-group and nongroup insurers to cover essential health benefits for the treatment of enrollees' preexisting health conditions. Insurers in the nongroup market commonly declined to cover services to treat preexisting conditions before 2014 even when a state generally required coverage of those services. Such exclusions were more limited in employment-based plans, partly because of prior federal regulations.

Minimum Actuarial Value. A third set of regulations specifies the share of costs for covered services that new plans must cover. Starting in 2014, the ACA requires the actuarial value of most newly sold plans in the nongroup and small-group markets to be at least 60 percent.⁴³

39. The implementation of that mandate and of the associated penalties was originally scheduled for 2014 but was delayed until 2015. For discussion of that delay, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), p.17, www.cbo.gov/publication/45231.

40. An employee of a firm that offers coverage may qualify for premium tax credits or cost-sharing subsidies if the law does not deem that coverage affordable by that employee, if the coverage is not offered to that employee, or if it does not meet federal requirements. For more information, see Internal Revenue Service, “Types of Employer Payments and How They Are Calculated” (accessed November 24, 2015), <http://go.usa.gov/c2MWj>.

41. For more information, see Minimum Value of Eligible Employer-Sponsored Health Plans, 80 Fed. Reg. 52678 (proposed September 1, 2015), <http://go.usa.gov/c2M94>.

42. The categories are ambulatory patient services (such as visits to a doctor); emergency services; hospitalization; laboratory services; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; pediatric services, including oral and vision care; prescription drugs; preventive and wellness services and chronic disease management; and rehabilitative and habilitative services and devices. (Habilitation services are health care services that help a person keep, learn, or improve skills and functioning for daily living.)

43. Some people, such as those younger than 30, may purchase catastrophic-coverage plans in the nongroup market; those plans have relatively high deductibles and limits on out-of-pocket costs. Several analysts have estimated that the actuarial value of those plans is about 57 percent, on average. See Gary Claxton and others, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Kaiser Family Foundation, February 2013), <http://tinyurl.com/nc3rrvj>; and Catherine Murphy-Barron and others, *Ten Critical Considerations for Health Insurance Plans Evaluating Participation in Public Exchange Markets* (Milliman, December 2012), <http://tinyurl.com/q3268tf> (PDF, 216 KB).

Actuarial value is the percentage of total costs for covered benefits that a plan pays when covering a standard population, which means that the plan will pay more for some enrollees and less for others—depending on the services that they use and the requirements for out-of-pocket spending that apply to those services.

Effects on Premiums. In 2009, CBO and JCT analyzed the effects on premiums of a proposal akin to the ACA; among other things, the proposal included regulations similar to the three sets of regulations just discussed.⁴⁴ In 2010, the agencies concluded that those estimated effects on premiums would probably be quite similar to the effects of the three corresponding sets of regulations in the ACA.⁴⁵ Although CBO and JCT have not formally updated the 2009 estimates, they would probably still be broadly similar to the effects of the ACA regulations if they were updated today. However, average premiums for exchange plans have proved lower than CBO and JCT originally anticipated, and one possible reason for that difference is that the regulations may have had smaller effects, on net, than the agencies expected.⁴⁶

The regulations in the proposal governing insurance benefits would have made nongroup premiums 27 percent to 30 percent higher in 2016 than they would have been otherwise, the 2009 analysis found (although other provisions in the proposal would have reduced premiums). Most of that increase would have resulted from the regulation of actuarial values, which had averaged about 60 percent; the other two sets of regulations, which required insurers to cover more services than was typical in the nongroup market and to cover preexisting conditions, would also have raised premiums, but less. An off-setting consideration was that standardizing insurance offerings would have fostered more vigorous competition by making it easier for consumers to compare nongroup

plans—which would have reduced premiums to a small degree, the two agencies estimated.

The estimated effects of the proposal on the other markets for health insurance were much smaller. CBO and JCT concluded that those regulations in the proposal would affect only a small share of policies sold in the small-group market and virtually no policies sold in the large-group market. Nearly all small-group plans were already covering most of the proposed benefits and already had actuarial values of at least 60 percent. Large-group plans were required by prior law to cover preexisting conditions in most cases; furthermore, they were exempted from most of the proposal's new regulations. As a result, the agencies estimated that the proposal would increase small-group premiums only slightly and would have negligible effects on large-group premiums.⁴⁷

Regulations Governing Insurance Offers and Pricing

The ACA also established regulations governing the terms under which insurance policies could be offered and priced. Some of those regulations raise average premiums by making it easier or less expensive for people with higher expected health care costs to obtain coverage. Others, which govern the review of insurers' proposals for premium increases, have effects on premiums that are probably small but are harder to estimate.

Guaranteed Issue and Guaranteed Renewability. Starting in 2014, the ACA required health plans to accept all applicants during specified open-enrollment periods and to renew that coverage at the employer's or enrollee's request. Those regulations tend to raise average premiums by increasing the likelihood that people with higher health care costs will enroll.

The effects on premiums are strongest in the nongroup market, because only a few states had previously imposed similar regulations on that market. The small-group market, by contrast, was already governed by guaranteed-issue and guaranteed-renewability requirements under

44. Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

45. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (Final Health Care Legislation) (March 20, 2010), p. 15, www.cbo.gov/publication/21351.

46. For more discussion about changes in projected premiums, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), www.cbo.gov/publication/45231, and *Updated Budget Projections: 2015 to 2025* (March 2015), www.cbo.gov/publication/49973.

47. The ACA, like the earlier proposal, includes provisions that apply in all markets, such as a prohibition on annual or lifetime limits on certain insurance benefits and a requirement to cover certain preventive services without cost sharing. CBO expects those provisions to have minimal effects on average premiums, in part because plans may alter cost-sharing requirements for other benefits to limit the overall effects on premiums.

prior law.⁴⁸ The large-group market was also subject to guaranteed-renewability requirements, and it is not subject to guaranteed-issue requirements.

Modified Community Rating. In addition, the ACA has instituted modified community rating of premiums; that is, it limits the degree to which premiums may vary and the factors that insurers may use to set them. Premiums for a given plan sold in a given area may vary only on the basis of the age of the enrollee, whether the enrollee uses tobacco, and the number of people covered by a particular policy. Even though premiums may vary on the basis of the enrollee's age, they may not vary for that reason by a ratio of more than 3 to 1 among adults, and variation because of tobacco use is also limited. Insurers are newly barred from varying a plan's premium on the basis of an enrollee's health status or sex. Previously, most states allowed insurers to charge higher premiums to enrollees who had more health problems and thus higher expected costs.

Modified community rating tends to raise average premiums for two reasons. First, prohibiting insurers from varying premiums on the basis of health lowers premiums for people with higher expected costs and raises them for people with lower expected costs; that encourages the former to enroll and discourages the latter, which results in a less healthy pool of enrollees. Second, the 3-to-1 limit on varying premiums by age increases premiums for younger enrollees and decreases them for older ones—because older people's health care costs exceed younger people's by a larger degree than that, on average. According to one recent study, for example, average spending among people who are 64 years old is about 4.8 times as high as average spending among people who are 21 years old.⁴⁹ The 3-to-1 limit thus encourages older people to enroll and discourages younger people, and because the costs of the former are greater, average premiums rise.

48. The Health Insurance Portability and Accountability Act of 1996 included guaranteed-issue and guaranteed-renewability requirements for the small-group market. See Hinda R. Chaikind and others, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, Report for Congress RL31634 (Congressional Research Service, January 2005).

49. See Dale H. Yamamoto, *Health Care Costs—From Birth to Death* (Society of Actuaries, June 2013), p. 44, <http://tinyurl.com/q5z2zb9>.

Requirements for Review of Proposed Premium

Increases. States have historically been responsible for reviewing and approving insurers' proposed premiums in the nongroup and small-group markets. The states' procedures vary widely, however: Some require insurers only to file their premium rates, whereas others apply strict scrutiny. As of 2010, according to several studies, insurers in about half of the states had to obtain approval for their premiums or premium increases.⁵⁰ In many of those states, oversight requirements applied differently to the nongroup and small-group markets, and in some cases, they applied only to particular insurers or types of plan. The specific rules governing the review and approval process also varied widely. To take just one example: Wisconsin's health insurance commission had the authority to reject premium increases that it considered excessive—but only in markets that, in the commission's judgment, lacked reasonable levels of competition among insurers.

Since its enactment in 2010, the ACA has provided federal funding to expand such state-level reviews. Also, insurers that increase premiums by more than a specified percentage (currently 10 percent) must submit a justification to HHS and the state. HHS does not have the authority to reject proposed increases, but if it or the state deems an increase unreasonable, the insurer must post an explanation of the increase on its website, and the state may choose to exclude the insurer from the state's health insurance exchange.

Reviews appear to yield premiums that are lower than those initially proposed by insurers. One study found that insurers' proposed premium increases in 2011 would have resulted in an average increase of 6.8 percent—but that in the end, premiums rose by just 5.4 percent.⁵¹ More recently, an HHS report found that average premium

50. See Kathryn Linehan, *Individual and Small-Group Market Health Insurance Rate Review and Disclosure: State and Federal Roles After PPACA*, Issue Brief 844 (National Health Policy Forum, September 2011), <http://tinyurl.com/7h36w32> (PDF, 430 KB); Sabrina Corlette and Janet Lundy, *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable* (Kaiser Family Foundation, December 2010), <http://tinyurl.com/ougbqt6>; and National Conference of State Legislatures, *States Implement Health Reform: Premium Rate Reviews* (December 2010), www.ncsl.org/documents/health/HRPremium.pdf (577 KB).

51. Cynthia Cox and others, *Quantifying the Effects of Health Insurance Rate Review* (Kaiser Family Foundation, October 2012), <http://tinyurl.com/pwqyp5s>.

increases in the nongroup and small-group markets fell by about 1 percentage point after going through review procedures in 2013.⁵² The final rates may have been lower than the proposed rates because they were modified by a state or an insurer, because a state denied an insurer's proposal, or because an insurer withdrew its proposal.

Whether reviews reduce premiums on net is not clear, however. For one thing, insurers might propose higher premiums initially than they would have otherwise, expecting them to be reduced during the review process. Also, over a longer period than the ones examined by those two studies, insurers might limit premium increases during years of high cost growth, when regulatory scrutiny is probably heavier, but make up for it with larger increases during years of low cost growth. Insurers probably have more latitude to take such steps in areas where the insurance market is less competitive.

Risk Adjustment

The ACA established several programs to redistribute risk among insurers. One of them is the reinsurance program discussed above, which takes funds from some insurance plans and distributes them to others to cover some of the costs of nongroup enrollees with very high levels of medical spending. Another is the risk-adjustment program, in which payments are based not on insurers' actual costs but on their predicted costs.⁵³ Specifically, certain insurers receive payments from the federal government if their enrollees have more health problems and thus are expected to have higher-than-average costs for health care. Conversely, plans with enrollees who are healthier have to make payments to the federal government.⁵⁴

52. Department of Health and Human Services, *Rate Review Annual Report for Calendar Year 2013* (September 2014), <http://go.usa.gov/3WGAE>.

53. The third is a temporary system of risk corridors, which will affect certain plans sold in the nongroup and small-group markets from 2014 through 2016. Under that program, insurers whose actual costs substantially exceed the costs that they had anticipated when they set their premiums receive a payment that covers part of the additional costs, and insurers whose costs turn out to be much lower than they had expected have to pay the government some of the difference. Because that program is temporary and because its operations have not had a significant effect on CBO's projections of premiums, it is not discussed more extensively in this report. For additional discussion, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), www.cbo.gov/publication/45231.

The risk-adjustment program applies to all fully insured plans that are newly sold in the nongroup or small-group markets. CMS estimates that transfers among plans for 2014 amounted to 10 percent of premiums in the nongroup market and 6 percent of premiums in the small-group market.⁵⁵ Overall, the program is budget neutral, and CBO currently projects that payments to and from the government will each total nearly \$150 billion over the next decade.

Because risk adjustment redistributes revenues among insurers, it is not expected to have significant effects on average premiums—but it does dampen variation in premiums. Insurers with sicker enrollees can charge lower premiums than they would have otherwise, because some of their costs will be covered by risk-adjustment payments that they receive, whereas insurers with healthier enrollees will not be able to charge correspondingly low premiums, because they will need to use some of their revenues to make risk-adjustment payments to the federal government.

Minimum Medical Loss Ratios

The ACA requires fully insured plans to maintain a minimum medical loss ratio. The MLR is generally defined as the percentage of premium revenues that insurers spend on medical claims. Requiring a minimum MLR is thus equivalent to capping the share of premiums that may go to insurers' administrative costs and profits, which are the other uses of premium revenues. However, in the calculation of MLRs, federal and state taxes and fees are deducted from premium revenues, so they do not count as administrative costs. Furthermore, administrative expenditures on certain activities designed to improve the quality of health care are treated as medical claims—so they too do not count as administrative costs. (For a more extensive analysis of insurers' administrative costs and profits, see the appendix.)

Since 2011, large-group plans have been required to maintain an MLR of at least 85 percent, and small-group

54. For more information, see Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (January 2014), <http://tinyurl.com/kajtag4>.

55. Those figures exclude payments to and from catastrophic coverage plans in the nongroup market. See Centers for Medicare & Medicaid Services, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (September 2015), p. 6, <http://go.usa.gov/cYnKj> (PDF, 1 MB).

and nongroup plans have been required to maintain an MLR of at least 80 percent. In general, plans not meeting those standards have been required to issue rebates to enrollees to make up the difference. According to one analysis, more than three-quarters of insurers met or exceeded the standards in 2011 and 2012.⁵⁶ Insurers not meeting the standards paid about \$1.1 billion in rebates in 2011, \$504 million in 2012, \$332 million in 2013, and \$469 million in 2014.⁵⁷

In those four years, the rebates effectively reduced the premiums that enrollees paid. Determining the program's net effect on premiums over the longer term is difficult, however, because insurers could respond either by limiting their administrative costs and profits (which would lower premiums) or by allowing costs for medical claims to increase (which would increase premiums). Before the ACA was enacted, CBO estimated that the MLR requirement would reduce premiums slightly.⁵⁸ More recently, the agency reaffirmed that judgment—but projected that by 2022, the requirement would make premiums only 0.1 percent lower than they would have been otherwise.⁵⁹

Exemptions

Because some plans are exempt from them, many federal regulations have limited effects on premiums. Self-insured plans, for example, are exempt from many regulations. Also, if plans in the nongroup and small-group markets were in effect before 2014, they may qualify for exemptions from most regulations.

Self-Insured Health Plans. When a health plan is self-insured, the enrollees' employer generally pays for their claims. The employer therefore bears most or all of the risk that those claims will be higher than expected. Most self-insured plans are administered by an intermediary, often an insurance company, which provides various services (such as enrollment and claims processing) and arranges contracts with health care providers. About 60 percent of the workers who have employment-based coverage are in a self-insured plan.⁶⁰

However, that share is much smaller among workers for small employers, partly because becoming self-insured tends to be more advantageous for large ones. For many years, federal law has effectively exempted self-insured plans from all state laws governing health insurance—an exemption that is particularly attractive to large employers, which are likelier to have workers in many states with different regulations. Also, the risk of self-insuring is greater for small employers, because they have fewer workers, and higher-than-expected costs for just a few could therefore result in a substantial percentage increase in the employer's costs. Employers can mitigate that risk by buying stop-loss insurance, which provides protection against catastrophic or unexpected expenses. Self-insured employers of all sizes may buy stop-loss insurance, but it is more common for smaller employers to do so.

The share of people with employment-based insurance who are enrolled in self-insured plans has increased over time—driven by increases among larger firms—but whether that trend will continue is unclear (see Figure 4). Some studies suggest that more small employers may choose to self-insure to avoid new fees and regulations that apply to fully insured plans.⁶¹ No such trend is

56. Government Accountability Office, *Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees*, GAO-14-580 (July 2014), <http://www.gao.gov/products/GAO-14-580>.

57. The 2011 data come from Government Accountability Office, *Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees*, GAO-14-580 (July 2014), www.gao.gov/products/GAO-14-580. The remaining data come from Centers for Medicare & Medicaid Services, "Medical Loss Ratio Data and System Resources" (accessed November 24, 2015), <http://go.usa.gov/cYnM9>.

58. Congressional Budget Office, cost estimate for the Patient Protection and Affordable Care Act, incorporating the manager's amendment (December 19, 2009), p. 19, www.cbo.gov/publication/41877.

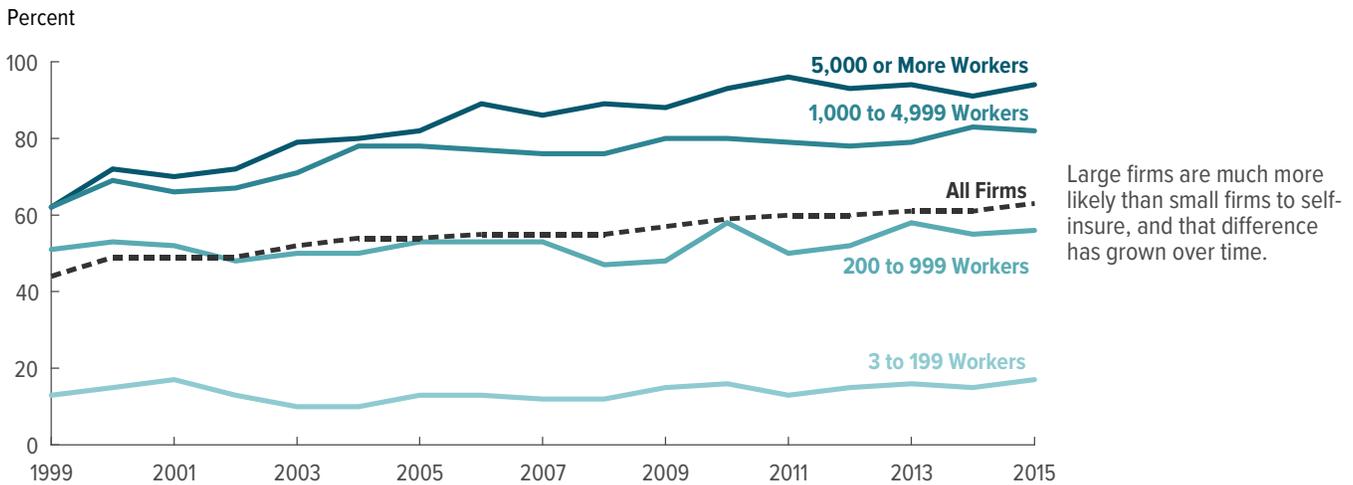
59. Congressional Budget Office, cost estimate for H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011 (November 7, 2012), p. 3, www.cbo.gov/publication/43702.

60. See Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Section 10, <http://tinyurl.com/oj7dhwp>.

61. Kevin Lucia, Christine Monahan, and Sabrina Corlette, *Factors Affecting Self-Funding by Small Employers: Views from the Market* (Urban Institute, April 2013), <http://tinyurl.com/pv732g5>; and Christine Eibner and others, *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)* (RAND Corporation, March 2011), www.rand.org/pubs/technical_reports/TR971.html.

Figure 4.

Share of Workers With Employment-Based Coverage Who Are in Self-Insured Plans, by Firm Size



Large firms are much more likely than small firms to self-insure, and that difference has grown over time.

Source: Congressional Budget Office, using data from the 2015 *Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust).

In this figure, employment-based coverage is defined as health insurance obtained through a worker’s employment or a retiree’s former employment, including coverage provided by private firms and state and local governments but excluding coverage provided by federal employers.

A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

evident yet, and whether it materializes will depend partly on whether state regulations allow small employers to buy more stop-loss coverage.⁶²

At the same time, other studies suggest that employers are becoming increasingly interested in offering their workers coverage through privately established insurance exchanges, in which employers make a defined contribution toward the premium and workers may choose coverage from a menu of insurance plans.⁶³ Many private insurance exchanges appear to offer only fully insured products, so

increased use of those exchanges could reduce the extent of self-insuring.

Certain Noncompliant Health Plans. Nongroup and small-group insurance plans in two additional categories are exempt from many of the regulations described above. First, plans that were in effect when the ACA was enacted in March 2010 and that have been maintained continuously without substantial changes are “grandfathered” and thus exempt from many of the regulations. However, the share of people enrolled in plans with that exemption is declining, partly because nongroup plans that are grandfathered may not have new enrollees. Employment-based plans do not face such a restriction; nevertheless, the share of workers at small firms who were enrolled in a grandfathered plan has also declined since 2011.⁶⁴

Second, certain plans that existed in the nongroup or small-group markets before January 2014, when many of the new regulations took effect, could also obtain an

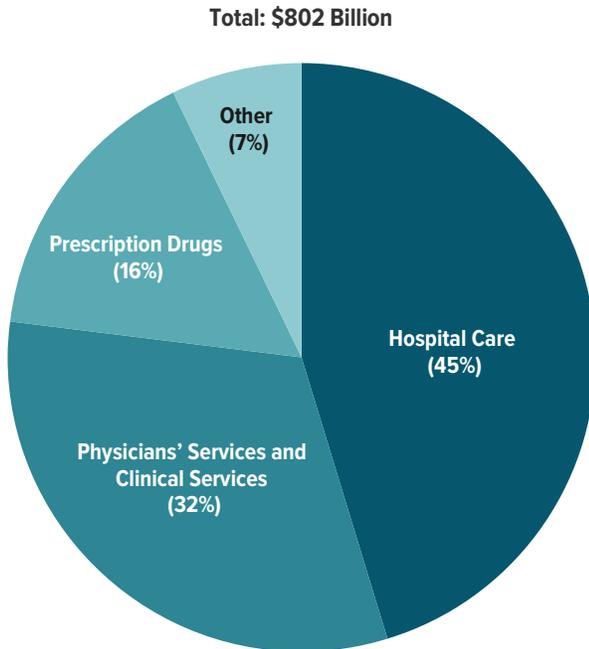
62. See Mark A. Hall, “Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers From Undermining Market Reforms,” *Health Affairs*, vol. 31, no. 2 (February 2012), pp. 316–323, <http://dx.doi.org/10.1377/hlthaff.2011.1017>. For more information, see Department of Labor, *Guidance on State Regulation of Stop-Loss Insurance*, Technical Release 2014-01 (November 2014), www.dol.gov/ebsa/newsroom/tr14-01.html.

63. Alex Alvarado and others, *Examining Private Exchanges in the Employer-Sponsored Insurance Market* (Kaiser Family Foundation, September 2014), <http://tinyurl.com/qy8yxr>; and HR Policy Association, *Private Health Insurance Exchanges: A Potentially Viable Alternative for Employer-Provided Health Care in Uncharted Waters* (September 2013), <http://tinyurl.com/qgwdzhv> (PDF, 168 KB).

64. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Section 13, <http://tinyurl.com/oj7dhw>.

Figure 5.

Spending on Health Care Claims by Private Insurers in 2014



Source: Congressional Budget Office, using data on national health expenditures from the Centers for Medicare & Medicaid Services.

This figure excludes payments for dental services and nursing home care.

exemption for a few years. That exemption depended, though, on whether the state in which the plan was offered took advantage of regulatory flexibility that HHS granted in late 2013 and early 2014. CBO and JCT expect that the percentage of people enrolled in such noncompliant plans will continue to decline over time, and the exemption will end in 2017.⁶⁵

Actions by Insurers That Affect Premiums

Premiums represent insurers' operating revenues; like other businesses, insurers aim to set prices low enough to attract customers but high enough to cover their costs and generate some profits. Those costs consist of payments for enrollees' health care claims and administrative costs. Any remaining premium revenues become profits.

Health care claims constitute the largest share of insurers' costs and thus are the most important consideration for

65. For more discussion, see Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014), pp. 9 and 17, www.cbo.gov/publication/45231.

insurers as they set premiums. To keep premiums down and stay competitive, insurers employ various strategies to control health care costs. Some strategies, such as increasing enrollees' cost-sharing requirements, reduce premiums primarily by shifting health care costs to people who use more health care, which also increases the variability of enrollees' costs. Other strategies, such as limiting enrollees to health care providers in a plan's network, may reduce total health care costs as well as premiums, but they may also raise concerns about the accessibility or quality of care. Or insurers may try to attract lower-cost enrollees, which can allow them to offer lower premiums, but that strategy may simply increase premiums for other plans correspondingly and thus have no effect on average premiums. Furthermore, some of the regulations discussed above prohibit such practices or limit insurers' incentives to engage in them.

Competition among insurers affects premiums as well. Operating in a more competitive market gives insurers a stronger incentive to limit the premiums that they charge and to constrain their administrative costs and profits—but in many parts of the United States, insurance markets are not very competitive.

Insurers' Costs

Insurers spend the great majority of premium revenues on enrollees' health care. According to CMS, private insurance plans paid \$802 billion in health care claims in 2014, excluding payments for dental services and nursing home care.⁶⁶ Of that money, 45 percent paid for inpatient and outpatient care provided by hospitals, 32 percent paid for physicians' services and clinical services, and 16 percent paid for outpatient prescription drugs (see Figure 5).⁶⁷ The remaining 7 percent paid for home health care, durable medical equipment (such as wheelchairs), and other health care.

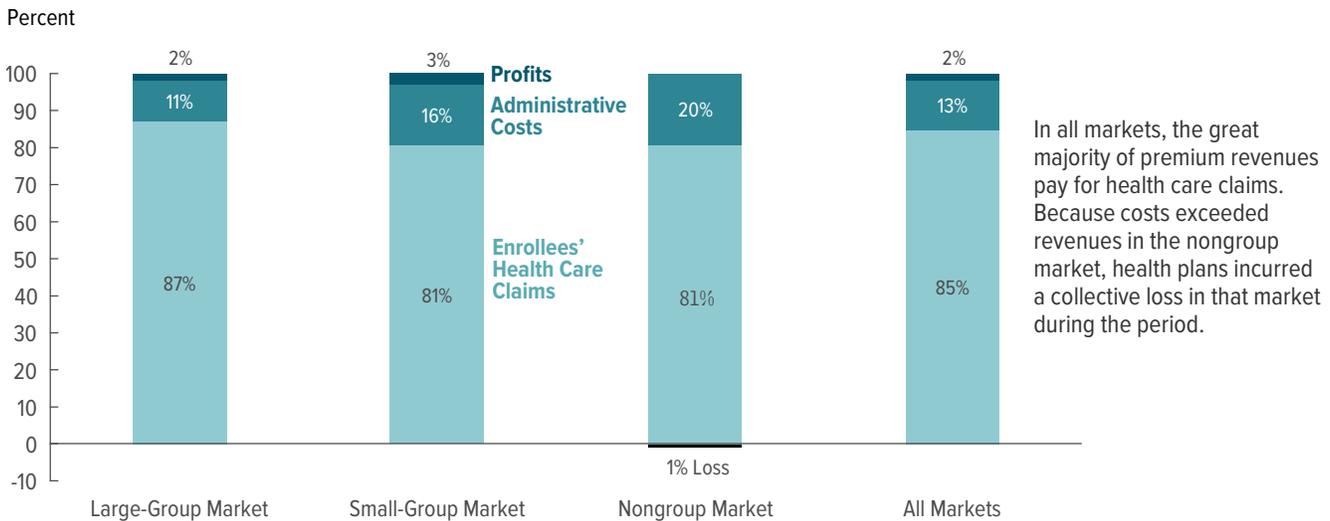
In 2012, according to CMS, such spending on health care accounted for 88 percent of private insurance costs, and insurers' administrative costs and profits accounted

66. That figure represents the payments made by insurers; it does not include enrollees' out-of-pocket payments. CBO excluded insurers' payments for dental services and nursing home care because those services are often covered by separate insurance policies that are outside the scope of this report.

67. Payments for physicians' services and clinical services commonly include fees for surgeons and anesthesiologists who deliver their services in hospitals, as well as payments for outpatient lab tests and imaging services, such as X-rays.

Figure 6.

Uses of Premium Revenues in Fully Insured Markets, 2010 to 2012



Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

The small-group market generally serves employers with up to 50 employees.

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

for the remaining 12 percent.⁶⁸ That estimate applies to the entire private insurance market; that is, it covers the nongroup, small-group, and large-group markets, and it includes both self-insured and fully insured plans.

Insurers' costs often differ by market, however, both in absolute terms and as a percentage of premium revenues. To examine such differences, CBO analyzed data on all fully insured plans sold from 2010 to 2012. All told, about 85 percent of premium revenues were used to pay health care claims, 13 percent went to insurers' administrative costs, and the remaining 2 percent constituted insurers' profits (see Figure 6).⁶⁹ In the large-group market, 87 percent of revenues went to health care claims, 11 percent went to administrative costs, and 2 percent became profits. Insurers in the small-group market spent a smaller share on health care and a larger share on administration—81 percent and 16 percent of revenues, respectively; the remaining 3 percent constituted their profits. Insurers in the nongroup market also spent 81 percent of revenues on health care claims, but their

administrative costs averaged 20 percent; as a result, they incurred losses equal to about 1 percent of premiums, on average. Those losses, which would not be sustainable over the long term, may have resulted from the recession and slow recovery—for example, if relatively healthy people decided to go without coverage when their income dropped—or from other temporary factors.

The differences among markets reflect a variety of factors. For example, certain administrative costs are fixed; in the large-group market, those costs can be spread over more enrollees and thus are generally lower per enrollee. Another example: Administrative costs per enrollee were *lower* for nongroup plans than for small-group plans when expressed in dollars—but because nongroup plans

68. Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—Historical" (December 3, 2015), Table 4, <http://go.usa.gov/3WGtP>. Those figures include spending by some forms of private insurance that are outside the scope of this report, such as dental insurance and Medigap plans.

69. CBO's definition of profits included only gains or losses resulting from the provision of insurance, which are sometimes called underwriting profits; it did not include gains or losses that insurers realized by investing assets. CBO treated taxes on profits as administrative costs, so its profit estimates are of net profits rather than gross profits. Also, as this report explains above, federal requirements specify the minimum medical loss ratio, or percentage of premium revenues spent on medical costs, that insurers must achieve. The MLR calculation, however, excludes taxes and fees and counts certain administrative expenses as medical costs. As a result, the calculated MLRs are higher, on average, than CBO's estimates of the percentage of premium revenues that go to health care claims.

tend to provide less extensive coverage and thus spend less on health care claims, the share of premiums going to administrative costs was noticeably higher in the non-group market. (For more analysis of administrative costs and profits for fully insured plans, see the appendix.)

Estimating how self-insured employers allocate premium revenues is more difficult. For one thing, detailed data about those plans' expenses are hard to obtain. Also, measuring total premiums for self-insured plans is complicated; instead, surveys of self-insured employers generally measure their premium equivalent—the costs incurred for health care claims and administration per enrolled employee—because those costs roughly match the costs financed by premiums for a fully insured plan. Furthermore, because employers generally offer health benefits as part of a larger compensation package, identifying the share of administrative costs attributable to the health benefits alone can be difficult. The way self-insured plans account for profits is also unclear.

On balance, however, self-insured plans appear to devote a larger share of premiums to health care claims, and a lower share to administrative costs and profits, than fully insured plans do. That difference can be seen by comparing CMS's estimate of the share of *all* private insurance revenues that were spent on health care claims in 2012 (88 percent) with the share that CBO observed for fully insured plans in that year (85 percent). To pull the overall average up to 88 percent, the share for self-insured plans must have been higher than 88 percent.

Insurers' Strategies to Control Their Spending on Health Care

Because spending on health care claims accounts for the majority of premium revenues, that spending is the largest factor that insurers consider when determining premium levels. Limiting it helps the insurers keep costs down—which they generally want to do, both to maximize their profits and to stay competitive. Insurers use a number of strategies to limit their spending on health care; in recent years, they have particularly emphasized increasing cost-sharing requirements. Such requirements are a prominent feature of high-deductible health plans, which have been growing more common, but they have also increased in health care plans generally.

Limiting Provider Networks. One way that insurers control their health care spending is limiting their provider networks—the doctors, hospitals, and other providers that

enrollees are required or encouraged to use. Insurers may include only providers that charge lower prices or that tend to provide fewer or less expensive services and treatments. Or insurers may negotiate lower payment rates with the network's providers, which may be willing to accept those rates in return for more patients. Many of the plans first offered in the health insurance exchanges used this strategy extensively, holding down their premiums by adopting very limited networks of providers that accepted relatively low payment rates.⁷⁰

Insurers may face several constraints in using the strategy, however. In areas where there are few doctors and hospitals competing against each other, it may be difficult for an insurer to develop a network that includes only some of the available providers. Even in areas with many doctors and hospitals, some high-cost providers may deliver such good care or have such good reputations that enrollees would be reluctant to join a plan that did not include them. More generally, enrollees may feel that the choices offered by an insurer's network are too limited. And certain regulations, such as those that require plans to include in their network any provider that accepts their payment terms, can make it difficult to craft a limited-network plan. Historically, states have enacted most of those regulations. The federal government does, however, require health plans participating in the federal health insurance exchanges to include providers of certain types (such as those considered "essential community providers").⁷¹ Moreover, CMS recently proposed regulations that would increase federal requirements governing those plans' networks, starting in 2017.

Managing Enrollees' Use of Services. Another strategy to control health care costs involves managing enrollees' use of services more directly. For example, insurers may cover certain expensive services only if they have authorized them in advance; require enrollees to get a referral from their primary care physician before seeing a specialist; decline to cover a more expensive treatment before enrollees try a less expensive one; or exclude certain

70. See Sabrina Corlette and others, *Narrow Provider Networks in New Health Plans: Balancing Affordability With Access to Quality Care* (Center on Health Insurance Reforms and Urban Institute, May 2014), <http://tinyurl.com/qhmr8v> (PDF, 310 KB).

71. See Centers for Medicare & Medicaid Services, *Final 2016 Letter to Issuers in the Federally-Facilitated Marketplaces* (February 20, 2015), pp. 22–31, <http://go.usa.gov/cYezh> (PDF, 472 KB).

expensive services or medications from coverage altogether. Such steps grew more common during the 1990s.

However, some enrollees may find this strategy cumbersome and intrusive, and some doctors may feel that their medical judgment is being questioned or that the treatments that insurers will readily approve are not the best options for their patients. Patients and doctors are generally allowed to appeal insurers' decisions about coverage, but pursuing appeals may delay treatment and be burdensome. Objections to this strategy and also to limited provider networks led to a shift away from both strategies after the 1990s, though their use has begun rising again in recent years.

Increasing Cost-Sharing Requirements. Over the past 15 years or so, insurers have made more use of a third strategy: increasing cost-sharing requirements and thereby increasing enrollees' out-of-pocket spending. Out-of-pocket spending consists of health care expenses for which insurance does not pay, such as deductibles, coinsurance (the share of costs that the enrollee must pay for each service), and copayments (fixed amounts that the enrollee must pay for certain services). Plans generally include an annual out-of-pocket limit—a maximum yearly amount that an enrollee can be required to pay for covered services received within the plan's network.

In addition to raising deductibles, coinsurance, and copayments, insurers often tailor cost-sharing requirements to encourage enrollees to use less expensive services or providers. For example, insurers usually charge lower copayments for generic drugs than for brand-name drugs, which tend to be more expensive. And insurers often design cost-sharing requirements to dovetail with their provider networks—say, by having two different coinsurance rates, one for the providers in a network and a higher one for other providers. In a related practice, balance billing, the insurer pays the same amount for a visit to any provider but requires the enrollee to pay the difference between that amount and the provider's fee.

Increasing cost-sharing requirements reduces insurers' spending on health care both directly and indirectly. The direct reductions occur simply because some spending shifts from the insurers to the enrollees. The indirect reductions occur because shifting costs to enrollees encourages them to use fewer services—which reduces total spending on health care and thus insurers' spending as well. Because demand for health care does not fall very

sharply when the amount that enrollees pay rises, the direct reductions tend to be larger than the indirect ones.⁷²

The strategy, however, increases enrollees' financial risk. That is, people who have more health problems will tend to pay more overall for their health care, and people who have fewer health problems will tend to pay less; the larger the cost-sharing requirements, the greater that difference will be. As a result, enrollees in plans with higher cost-sharing requirements face more variability in their health care costs.

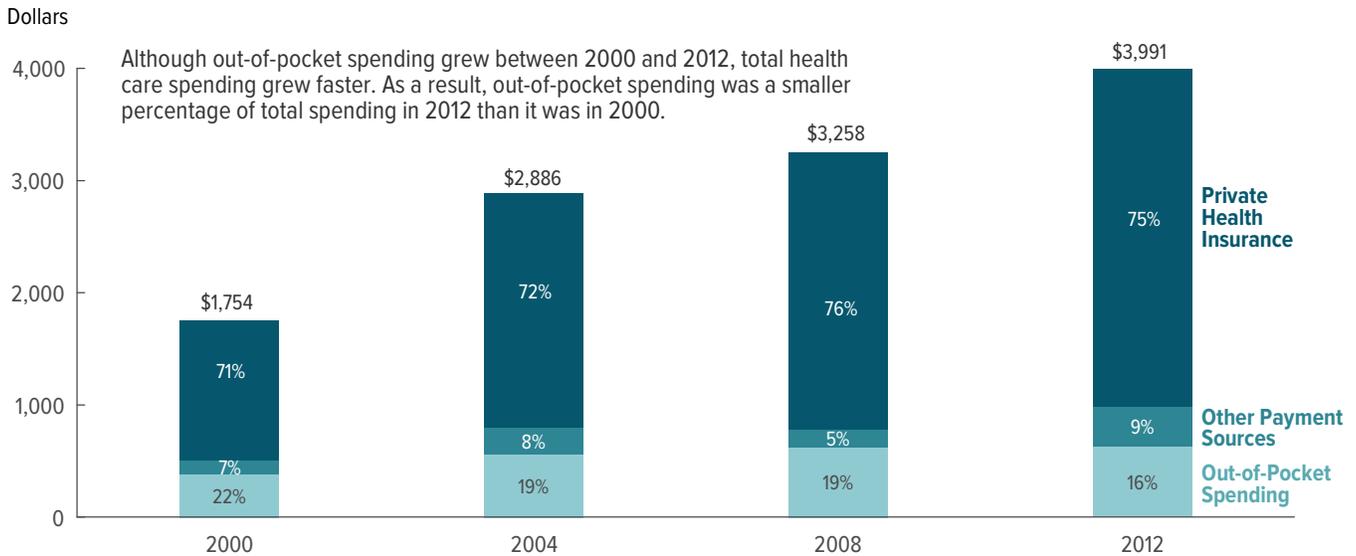
Insurers' use of cost-sharing requirements has grown over time in the market for employment-based coverage. One survey found that of all enrollees in employment-based plans, the share who were enrolled in a plan with an annual deductible for single coverage increased from 55 percent in 2006 to 81 percent in 2015; moreover, the average deductible for single coverage rose from \$303 to \$1,077 over that period.⁷³ Less is known about trends in the cost-sharing requirements of nongroup plans, though they have historically been higher, on average, than the cost-sharing requirements of employment-based plans.

Although the use of cost-sharing requirements has been increasing, CBO has found that the share of total health care costs for privately insured people that was paid out of

72. Studies have found that a 10 percent increase in the amount that people pay for health care indirectly reduces total spending on their care by about 1 percent or 2 percent, on average. Thus, a reduction in a health plan's actuarial value from 80 percent to 78 percent, which would increase the average share of costs that enrollees pay by 10 percent (that is, from 20 percent to 22 percent), would indirectly reduce total spending on their care by about 1 percent or 2 percent. By comparison, the direct reduction in insurers' spending in that case would be 2.5 percent—that is, the 2 percentage-point reduction in actuarial value divided by the initial actuarial value of 80 percent. (The direct and indirect effects on *premiums* would be slightly smaller, because those calculations include effects on administrative costs.) For more discussion about the effects of cost sharing on the use of services, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 61–62, www.cbo.gov/publication/41746.

73. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), Exhibits 7.2 and 7.32, <http://tinyurl.com/oj7dhwp>. The calculation of average deductibles included plans with no deductible. Average deductibles for family plans are more difficult to summarize because plans may have an aggregate deductible for all family members, separate deductibles for each member, or a combination of the two.

Figure 7.

Health Care Spending per Privately Insured Nonelderly Person

Source: Congressional Budget Office, using data from the household component of the Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality).

“Other Payment Sources” refers primarily to public programs (such as Medicare, Medicaid, and health care for veterans) that provide supplemental or partial coverage to some privately insured people.

pocket fell from 22 percent in 2000 to 16 percent in 2012 (see Figure 7). CMS estimates of national health expenditures also show that the share of *all* spending on personal health care that was paid out of pocket has declined over time, from 17 percent in 2000 to 14 percent in 2012.⁷⁴ Although that calculation includes health care spending for people enrolled in Medicare, Medicaid, and other sources of insurance, as well as for people who are uninsured, it is strongly influenced by the large share of people who are privately insured.⁷⁵

If cost-sharing requirements have been rising, why has the share of health care spending paid out of pocket been falling? Three factors may be at work:

- Costs that *are* covered by insurance have also been rising fairly rapidly—by about 7.5 percent per year

74. Centers for Medicare & Medicaid Services, “National Health Expenditure Accounts—Historical” (December 3, 2015), Table 3, <http://go.usa.gov/3WGtP>.

75. The decline in the share of health costs paid out of pocket explains why, even as growth in overall health care spending has exceeded growth in GDP, out-of-pocket payments as a share of GDP have held steady. From 2000 to 2012, according to CMS, national health expenditures grew from 13.4 percent of GDP to 17.4 percent—but as a share of GDP, out-of-pocket payments barely changed, rising from 1.96 percent of GDP to 2.03 percent.

between 2000 and 2012, according to the data on spending per privately insured person that CBO analyzed. Over the same period, according to those data, total health care spending per privately insured person grew slightly more slowly (by about 7 percent per year). The faster growth of spending covered by insurance thus reduced the *share* of total spending that was paid out of pocket.

- Increases in cost-sharing requirements may not translate into equal increases in total out-of-pocket payments. For example, when an enrollee’s deductible is raised, the enrollee does not owe as much in coinsurance as he or she would previously have paid; the deductible will replace some of the coinsurance.
- If increases in cost-sharing requirements prompt enrollees to reduce their use of services, their out-of-pocket spending may fall.

Nevertheless, the recent increases in cost-sharing requirements may explain why the decline in the share of spending paid out of pocket has been slower since 2000 than it was before 1995. According to the CMS estimates, the share of spending on personal health care that was paid out of pocket declined from 33 percent in 1975 to

Table 4.

Key Characteristics of Employment-Based Health Plans in 2015

	HMOs	PPOs	POS Plans	HDHPs ^a	All Plans
Share of Employment-Based Enrollment (Percent) ^b	14	52	10	24	100
Average Yearly Premium for Single Coverage (Dollars)	6,212	6,575	6,259	5,567	6,251
Average Yearly Premium for Family Coverage (Dollars)	17,248	18,469	16,913	15,970	17,545
Share of Enrollees With an Annual Deductible (Percent)	42	85	72	100	81
Average Deductible for Single Coverage (Dollars) ^c	431	814	886	2,099	1,077

Source: Congressional Budget Office, using data from the *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust).

In this table, employment-based coverage is defined as health insurance obtained through a worker’s employment or a retiree’s former employment, including coverage provided by private firms and state and local governments but excluding coverage provided by federal employers.

HDHP = high-deductible health plan; HMO = health maintenance organization; POS = point-of-service; PPO = preferred provider organization.

- a. The Kaiser survey counts plans as HDHPs if their deductibles are at least \$1,000 for single coverage or \$2,000 for family coverage. Federal regulations use higher minimums: \$1,300 and \$2,600 in 2015.
- b. Less than 1 percent of workers are enrolled in indemnity plans (sometimes called fee-for-service plans). Those plans allow enrollees to see any provider without a referral and generally do not distinguish between in-network and out-of-network providers.
- c. The calculation of average deductibles includes plans with no deductible. Average deductibles for family plans are more difficult to summarize because plans may have an aggregate deductible for all family members, separate deductibles for each member, or a combination of the two.

17 percent in 1995—a much steeper decline than the drop of 3 percentage points over the 2000–2012 period.

Cost-Control Strategies in Health Plans of Various Types. Health insurers offer plans of many different types, and those types are largely defined by their varying uses of the strategies outlined above. The result is that premiums differ among those types (see Table 4).

A defining characteristic of health maintenance organizations (HMOs) is that they do not cover services obtained outside their provider network, except in emergencies. Moreover, HMO plans usually require enrollees to select a primary care physician and to get a referral from that physician before seeing a specialist. But cost-sharing requirements in HMO plans tend to be relatively low; most do not charge a deductible, for example.

By contrast, preferred provider organizations (PPOs) tend to limit spending by using cost-sharing requirements; a large majority of them charge a deductible. But PPOs are less active than HMOs in managing enrollees’ use of services directly. For example, they generally do not require enrollees to designate a primary care provider or to obtain a referral before seeing a specialist, and they generally cover services received outside a provider network—though they encourage enrollees to receive in-network care by requiring lower out-of-pocket payments for it.

Point-of-service (POS) plans may be regarded as a middle ground between HMOs and PPOs. Like HMOs, POS plans generally require enrollees to get a referral from their designated primary care physician before seeing a specialist. Like PPOs, POS plans cover services provided both inside and outside a provider network but increase enrollees’ out-of-pocket payments for the latter. As HMOs have broadened their provider networks, the distinctions among these three types of health plan have blurred somewhat.

High-deductible health plans rely heavily on deductibles and other out-of-pocket payments to limit insurers’ spending on health care; they typically expect enrollees to manage their own care and may provide tools to help them do so, such as information about providers’ costs or quality. HDHPs often combine a high-deductible insurance policy with a tax-exempt account that enrollees may use to cover their deductible and other out-of-pocket costs.⁷⁶ Like PPOs, HDHPs usually cover services that enrollees receive from a wide range of providers and do not require enrollees to get referrals for specialty care.

76. The most common kinds of account are health savings accounts (which were described earlier in this report) and health reimbursement arrangements. See Congressional Budget Office, *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes* (December 2006), www.cbo.gov/publication/18261.

HDHPs have become much more prevalent in recent years; enrollment in employment-based HDHPs grew from 8 percent of workers in 2009 to 24 percent in 2015.⁷⁷ Two recent studies cite growth in HDHP enrollment as one reason for the recent slowdown in the growth of health care costs.⁷⁸

On average, premiums for single coverage obtained through employers are similar among HMOs, PPOs, and POS plans; premiums for family coverage vary more widely. HDHPs tend to have lower premiums but higher out-of-pocket costs than plans of other types do; for example, among employment-based HDHPs, the average deductible for single coverage was about \$2,100, more than double the average among the other types of plan.

Competing for Enrollees. Because prospective enrollees may differ significantly in their use of health care, insurers' costs depend strongly on the makeup of their enrollee pool. Insurers therefore have an incentive to seek enrollees with lower expected costs for health care and to avoid enrollees with higher expected costs—for example, by limiting coverage of certain procedures or treatments, requiring higher cost sharing for them, or limiting provider networks in ways that would make them less attractive to people with more health problems. An insurer that succeeds in doing so can charge lower premiums than its competitors can.

Insurers' incentives to seek low-cost and avoid high-cost enrollees have probably changed more in the nongroup market than in the other markets. Before 2014, nongroup insurers in most states could deny coverage to applicants or charge them higher premiums on the basis of their health, practices that could limit enrollment by people with higher expected costs. Both practices are now prohibited. So is engaging in favorable selection through the design of a health plan—but enforcing that prohibition

can be difficult, partly because it can be hard to distinguish such efforts from other steps to control a plan's costs.

The ACA's risk-adjustment program for the nongroup and small-group markets limits insurers' incentive to engage in favorable selection, but it is unclear how much. According to one recent study, "even with the best risk-adjustment formulas, insurers have substantial incentives to engage in risk selection."⁷⁹ But other researchers have a different view. Two recent studies have found that Medicare's current risk-adjustment procedures are effective at reducing favorable selection—and the ACA's risk-adjustment program is modeled on those procedures.⁸⁰

Competition Among Insurers

Competition among insurers also affects health insurance premiums. Insurers operating in competitive markets have a strong incentive to keep their costs and premiums down: If they do not, they may lose business to competitors. But if the market is concentrated—that is, if only a few insurers cover most of the enrollees in the market—that incentive is weaker. At the same time, insurers operating in competitive markets may have a more difficult time bargaining with doctors and hospitals if the markets for those providers' services are concentrated.

Extent of Competition. Several studies have found that most health insurance markets in the United States are not very competitive. For example, the American Medical Association reported that in 2012, there were 45 states in which the two largest health insurers together accounted for at least half of the private insurance market; in 17 of those states, a single insurer held at least half of the market.⁸¹ Furthermore, the study found, the insurance markets in 72 percent of the country's 388 metropolitan

77. Gary Claxton and others, *2015 Employer Health Benefits Survey* (Kaiser Family Foundation and Health Research and Educational Trust, September 2015), <http://tinyurl.com/oj7dhwp>.

78. Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, *Is This Time Different? The Slowdown in Healthcare Spending*, Working Paper 19700 (National Bureau of Economic Research, December 2013), www.nber.org/papers/w19700; and Anne B. Martin and others, "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," *Health Affairs*, vol. 33, no. 1 (January 2014), pp. 67–77, <http://tinyurl.com/lps9o3x>.

79. Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet, "Risk Selection Threatens Quality of Care for Certain Patients: Lessons From Europe's Health Insurance Exchanges," *Health Affairs*, vol. 34, no. 10 (October 2015), p. 1713, <http://dx.doi.org/10.1377/hlthaff.2014.1456>.

80. Joseph P. Newhouse and others, "Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges," *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2618–2628, <http://dx.doi.org/10.1377/hlthaff.2012.0345>; and Joseph P. Newhouse and others, *How Much Favorable Selection Is Left in Medicare Advantage?* Working Paper 20021 (National Bureau of Economic Research, March 2014), www.nber.org/papers/w20021.

statistical areas would be considered “highly concentrated” under federal guidelines.⁸²

Other studies have reported similar results. An analysis by the Government Accountability Office found that in the average state, the largest insurer accounted for about half of the nongroup and small-group markets for fully insured coverage, and the four largest insurers together accounted for nearly 90 percent of those markets.⁸³ In 2010, according to another study, there were 30 states in which a single insurer accounted for over half of all nongroup enrollees and 26 states in which the same was true for small-group enrollees.⁸⁴ Other evidence suggests that large-group markets are also highly concentrated, and recent literature reviews find that health insurance markets in the United States have become more concentrated over time.⁸⁵ Recently proposed mergers between major insurers could increase concentration further, depending partly on whether (and with what restrictions) those mergers are approved by federal regulatory agencies.

81. David W. Emmons and Jose R. Guardado, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (American Medical Association, October 2014), <http://tinyurl.com/pocd2gz>. The markets examined in that study consisted of fully insured and self-insured plans.

82. Market concentrations are often defined by means of the Herfindahl-Hirschman Index, or HHI, which is calculated as the sum of every firm’s squared market share and ranges from zero to 10,000. For instance, if one firm had 100 percent of the market, the market’s HHI would be 100 squared, or 10,000; a market consisting of four firms with a 25 percent market share apiece would have an HHI of 2,500 (or 25 squared times four). Under current federal guidelines, a market with an HHI greater than 2,500 is considered highly concentrated, and one with an HHI lower than 1,500 is considered competitive or not concentrated.

83. Government Accountability Office, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (August 2014), pp. 9–10, www.gao.gov/products/GAO-14-657.

84. Cynthia Cox and Larry Levitt, *How Competitive Are State Insurance Markets?* (Kaiser Family Foundation, October 2011), <http://tinyurl.com/oaoc9yu>.

85. See Martin Gaynor and Robert J. Town, “Competition in Health Care Markets,” in Mark V. Pauly, Thomas G. McGuire, and Pedro P. Barros, eds., *Handbook of Health Economics*, vol. 2 (Elsevier, 2011), pp. 499–637, <http://tinyurl.com/ptu3fzm>; and Martin Gaynor, Kate Ho, and Robert Town, *The Industrial Organization of Health Care Markets*, Working Paper 19800 (National Bureau of Economic Research, January 2014), www.nber.org/papers/w19800.

The Relationship Between Competition and

Premiums. Data limitations have long made it difficult to study the relationship between the degree of competition among insurers and the level of premiums. However, several recent studies of the new health insurance exchanges have found that premiums fall as the number of competitors in a market rises. According to a recent study that examined exchange plans in 2014, “premiums in less competitive markets [were] higher than in more competitive insurer markets.”⁸⁶ Another study estimated that premiums for exchange plans would have been about 11 percent lower if all insurers that had previously been active in each state’s nongroup insurance market had participated in the exchanges.⁸⁷

An important and related consideration is that many markets for hospital care and some markets for physicians’ services are also highly concentrated—and some evidence suggests that when that is the case, more concentrated insurance markets may actually *reduce* premiums.⁸⁸ That is because reduced competition among insurers would mean more bargaining power for them when negotiating with providers over payment rates—and lower payment rates tend to translate into lower premiums. Illustrating that point, one recent study found that when hospital markets were highly concentrated, premiums were slightly lower when the insurance market was also highly concentrated than they were when the insurance market was more competitive.⁸⁹

86. John Holahan and Linda Blumberg, *Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act* (Robert Wood Johnson Foundation and Urban Institute, August 2014), p. 3, <http://tinyurl.com/kn4md2q>.

87. Leemore Dafny, Jonathan Gruber, and Christopher Ody, *More Insurers Lower Premiums: Evidence From Initial Pricing in the Health Insurance Marketplaces*, Working Paper 20140 (National Bureau of Economic Research, May 2014), www.nber.org/papers/w20140.

88. For a summary of the extensive body of research indicating the concentration of markets for hospital care and physicians’ services, see Martin Gaynor and Robert J. Town, “Competition in Health Care Markets,” in Mark V. Pauly, Thomas G. McGuire, and Pedro P. Barros, eds., *Handbook of Health Economics*, vol. 2 (Elsevier, 2011), pp. 597–598, <http://tinyurl.com/ptu3fzm>.

89. See Erin E. Trish and Bradley J. Herring, “How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?” *Journal of Health Economics*, vol. 42 (July 2015), pp. 104–114, <http://dx.doi.org/10.1016/j.jhealeco.2015.03.009>.



Appendix:

Insurers' Administrative Costs and Profits

Insurers use their premium revenues to pay health care claims and administrative costs, and any remaining revenues become profits. The main body of this report examines insurers' strategies to control costs for health care claims, which account for the majority of premium revenues; it focuses less on the administrative costs and profits. This appendix therefore offers a more detailed analysis of how administrative costs and profits vary among the fully insured health care markets, using administrative data covering all policies that were sold in those markets between 2010 and 2012.¹

Insurers' Administrative Costs

The Congressional Budget Office's analysis found that in dollar terms, administrative costs per enrollee were highest in the small-group market, at \$687; they were \$548 in the nongroup market and \$472 in the large-group market (see Table A-1). As a share of premiums per enrollee, however, administrative costs in the nongroup market were noticeably higher, at 20 percent, than in the small-group market (16 percent) or the large-group market (11 percent). The main reason for the discrepancy is that nongroup plans provided less extensive coverage of enrollees' health care costs and therefore had lower premiums, on average; as a result, they had a smaller base of total costs over which to spread their administrative costs. By contrast, the administrative costs of large-group plans were lower—per enrollee and also as a share of premiums per enrollee—than those of other plans. That was partly because large-group plans had more enrollees over whom to spread fixed administrative costs and partly because large-group plans had higher medical claims per enrollee.

1. CBO analyzed administrative data derived from two sources: insurers' 2010 filings of the Supplemental Health Care Exhibit with the National Association of Insurance Commissioners, and insurers' 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form with CMS. The data were compiled for CBO by Milliman, Inc., an actuarial firm. The two sources include enrollment and premium data for all fully insured plans in the United States and report those data in the same way.

Insurers' administrative costs can be divided into four categories:

- **Costs for claims processing and adjustment**, which include a wide range of activities, such as managing enrollees' use of care, managing a plan's network of providers, ensuring that those providers have appropriate credentials, and processing appeals of a plan's coverage and payment decisions. Spending in that category was similar in the three fully insured markets: about \$100 per enrollee, or 2 percent to 4 percent of premium revenues.
- **Taxes and fees**, which may be levied at the federal or state level. They were highest in the small-group market, at \$159 per enrollee, and lower in the large-group market (\$112) and the nongroup market (\$74). Those differences were partly the result of differences in gross profits among the markets, which translated into different payments of corporate income taxes; for example, because profits per enrollee were highest in the small-group market, corporate taxes per enrollee were also highest in that market.
- **Costs for sales, marketing, and brokers' fees**, which were also highest in the small-group market—\$226 per enrollee—and lower in the nongroup market (\$157) and the large-group market (\$97). One reason may be that small employers are more likely to use brokers to buy insurance policies for their employees.
- **Other administrative costs**, including such items as corporate salaries, legal fees, costs for actuarial services, spending on information technology, and other overhead costs (which may be difficult to assign to particular activities). Those costs were highest in the nongroup market—\$221 per enrollee—and lower in the small-group market (\$200) and the large-group market (\$170).

Table A-1.

Insurers' Average Health Care Claims Costs, Administrative Costs, and Profits per Enrollee in Fully Insured Markets, 2010 to 2012

Dollars

	Large-Group Market	Small-Group Market	Nongroup Market	Overall
Health Care Claims Costs	3,693	3,421	2,164	3,387
Administrative Costs				
Claims processing and adjustment	94	103	96	96
Taxes and fees	112	159	74	118
Sales, marketing, and brokers' fees	97	226	157	139
Other administrative costs	170	200	221	185
Subtotal	472	687	548	539
Net Profits	78	129	-30	74
Total Premium	4,243	4,237	2,682	4,000

Source: Congressional Budget Office, using 2010 filings of the Supplemental Health Care Exhibit (National Association of Insurance Commissioners) and 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form (Centers for Medicare & Medicaid Services).

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

The small-group market generally serves employers with up to 50 employees.

Many recent changes in federal law may ultimately help constrain administrative costs, particularly in the nongroup and small-group markets. For example, the advent of health insurance exchanges, coupled with increased enrollment in nongroup plans, may help insurers achieve greater economies of scale for some fixed expenses in that market. Requirements to standardize the benefits and actuarial values of new plans may reduce the cost of designing and marketing such plans. Two prohibitions—on using a person's health status as a basis for offering or pricing a policy, and on declining to cover services for preexisting conditions—are likely to reduce costs associated with reviewing applications, varying the prices of policies, and determining which services treated an enrollee's preexisting conditions. Requirements to provide more extensive coverage and to maintain a minimum medical loss ratio also seem likely to increase the share of premiums going to medical claims and decrease the share going to administration.²

2. For more discussion, see Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

In the short term, however, some of the changes made by the Affordable Care Act are likely to generate additional administrative costs, such as the costs of adapting to the administrative requirements of the insurance exchanges and of determining how to price policies under the new rules.

Insurers' Profits

Profits are simply the difference between insurers' premium revenues and their costs for health care claims and administration. For-profit insurers have a clear incentive to maximize their profits: Shareholders or owners may demand those profits as compensation for the financial risks and costs that they have incurred. According to one recent analysis, however, roughly half of all people covered by private health insurance are enrolled in plans administered by nonprofit insurers.³ Nonprofit insurers are allowed to generate profits and to use them to pay rebates to enrollees—but not to distribute them to investors. As a result, they may have less of an incentive to generate profits.

3. Alliance for Advancing Nonprofit Health Care, "Basic Facts & Figures: Nonprofit Health Plans" (accessed November 24, 2015), <http://tinyurl.com/lojxcx2> (PDF, 171 KB). The calculation includes fully insured and self-insured plans and is based on a survey conducted in 2012.

Profits varied by market, according to CBO's analysis.⁴ They amounted to about 3 percent of premium revenues in the small-group market and 2 percent in the large-group market. Insurers in the nongroup market, by contrast, sustained a collective loss.

It is difficult to determine whether those profits and losses are typical. Year-to-year variations in profits and losses would not be surprising, particularly in the smaller nongroup market. And the results observed from 2010 to 2012 were probably affected by the economic recession and slow recovery, which may have increased the likelihood of losses. Although most of the Affordable Care Act's major provisions did not go into effect until 2014, some of its other provisions may have affected profits in earlier years. In particular, the law's requirements to maintain a minimum medical loss ratio—the percentage of premium revenues that insurers spend on medical claims and certain related activities—may have affected insurers' costs and profits in 2011 and 2012.

Another possible reason for the nongroup market's losses is that during the period in question, some states required

nonprofit insurers operating in that market to provide subsidized coverage to some unhealthy people who would otherwise have had difficulty obtaining insurance. (Most states require nonprofit insurers to provide some form of community benefit in return for their tax-exempt status.) The requirement tends to reduce those insurers' profits. And according to CBO's analysis, most of the losses in the nongroup market were borne by nonprofit insurers: Collectively, for-profit insurers in that market earned profits of about 0.4 percent of premium revenues, whereas nonprofit insurers incurred losses of about 3.2 percent of premium revenues.

Another explanation for the losses observed in the nongroup market is that the calculation may not be accurate; many insurers offer both nongroup and employment-based coverage, and determining how they should divide administrative costs among the markets is difficult. Alternatively, insurers operating in multiple markets may be willing to accept short-term losses in the nongroup market, as long as their profits in the employment-based markets are large enough that they remain profitable as a whole.

Finally, insurers sometimes try to attract more enrollees by charging premiums that do not fully cover their expected costs; to cover those temporary losses, they draw down excess reserves that they have already built up. Continued losses in the nongroup market would ultimately be unsustainable, however.

4. CBO's definition of profits included only gains or losses resulting from the provision of insurance, which are sometimes called underwriting profits; it did not include gains or losses that insurers realized by investing assets. CBO treated taxes on profits as administrative costs, so its profit estimates are of net profits rather than gross profits.



Glossary

actuarial value: The percentage of costs for covered health care services that a health care plan pays, on average, for a representative group of enrollees.

cost-sharing requirements: Rules regarding the costs (such as deductibles) that enrollees in an insurance plan are required to pay for covered health care services.

cost-sharing subsidy: A payment from the government to an insurer to reduce the cost-sharing requirements of some enrollees in coverage purchased through a health insurance exchange.

deductible: The amount that an enrollee must pay out of pocket each year for covered health care services before the insurer begins to pay.

employment-based coverage: Health insurance obtained through a worker's employment or a retiree's former employment. Includes coverage provided through labor unions and public employers.

flexible spending account (FSA): An account into which employees may direct a predetermined portion of their paycheck; that money is exempt from income and payroll taxes and may be used only to pay qualifying costs for health care.

fully insured plan: A health insurance plan in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected.

health insurance exchange: An entity through which individuals and small employers may shop for and purchase coverage and determine their eligibility for premium tax credits and cost-sharing subsidies. Exchanges are also known as marketplaces.

health savings account (HSA): An account into which a person with a qualifying high-deductible health plan (and that person's employer) may contribute funds that are exempt from income and payroll taxes. The funds remain tax-exempt indefinitely if they are used to pay for qualifying medical spending.

large-group market: The market for health insurance generally purchased by or through employers with more than 50 employees; states may limit the definition to employers with more than 100 employees, starting in 2016.

medical loss ratio (MLR): The percentage of premium revenues that insurers spend on medical claims and certain related activities.

nongroup coverage: Coverage that a person purchases directly from an insurer or through a health insurance exchange, rather than through an employer.

out-of-pocket costs: The costs for health care services that an enrollee pays, including deductibles, other cost-sharing requirements, and payments for services not covered by the health plan, but excluding premium payments.

premium: The payment made to an insurer in exchange for enrollment in a health plan; it may be paid entirely by the enrollee or through a combination of payments from the enrollee, an employer, and the federal government.

premium tax credit: A payment from the federal government to an insurer to cover a portion of an enrollee's premium for qualifying coverage purchased through a health insurance exchange.

reference plan: The second-lowest-cost silver plan available to a person through a health insurance exchange.

risk-adjustment system: A system that transfers funds from health care plans with healthier-than-average enrollees to plans with sicker-than-average enrollees; in the Affordable Care Act's risk-adjustment system, those payment adjustments occur retroactively.

self-insured plan: A health insurance plan in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

silver plan: A plan that pays about 70 percent of the costs of covered health care services for a broadly representative group of enrollees; other levels of coverage, such as bronze and gold, pay different percentages.

small-group market: The market for health insurance generally purchased by or through employers with up to 50 employees; states may expand the definition to include employers with up to 100 employees, starting in 2016.

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About This Document

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