REPORT HEALTH CARE

How to Lower Health Insurance Premiums? Not All Ideas Are Equal

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In the midst of a partisan divide on health policy, Republicans and Democrats agree widely on one goal: lowering health insurance premiums, particularly for those who purchase health insurance on their own in the Affordable Care Act's (ACA) Health Insurance Marketplaces.

The debate over the American Health Care Act (AHCA) and the ACA has sparked a multitude of ideas about how to bring down premiums, or how to moderate any premium increases. But, while many of these policies may in fact lower premiums, it is just as important—perhaps even more important—to examine the details of how each policy would lower premiums and how American consumers would be affected overall.

When pursuing policies that lower premiums, there are often tradeoffs that may undermine the overall value of health insurance. For example, a policy reducing the standards for and coverage of mental health and substance abuse services included in a health insurance plan would lower premiums, but simply by shifting the cost of this care directly to consumers—an accounting change. Everyone might pay less in premiums for their coverage, but the costs of treatment for opioid abuse, for example, would fall squarely on those in need of care. Additionally, a policy that raises premiums for older consumers could make average premiums decrease overall, but only because such a change would discourage older Americans from getting insured in the first place. The insured population might pay less as a whole, but older individuals might risk going uninsured precisely at the time when they need health coverage the most. These types of tradeoffs that simply shift cost or reduce coverage in order to achieve lower premiums are an unwanted policy outcome. Instead, policies that can reduce premium and premium growth directly, such as reinsurance, additional targeted tax credits, and payment reform—while at the same time minimizing unwanted tradeoffs—should be considered by policymakers.

This report analyzes more than a dozen legislative and administrative proposals to lower premiums or to moderate premium increases by examining their tradeoffs and overall impact on consumers. Understanding this overall impact can help guide policymakers toward decisions that benefit consumers by lowering premiums in ways that do not reduce insurance protections and do not come at the expense of other consumers.

What Goes Into Pricing Health Insurance Premiums?

Health insurance premiums are set at a price that will ensure sufficient funds to pay for the projected cost of people's health care services plus the cost of administering the health insurance plan (such as profits to the managing company). Broadly speaking, public policy can substantially affect premiums by changing:

1. **Who has insurance.** Policy can affect premiums by changing the average risk of the insurance pool. For example, both a policy that encourages a greater number of healthy individuals to join the market and a policy that drives

sicker individuals out of the market would lower average premiums, but the latter would be at the expense of coverage loss for those who may need it the most.

2. **What is covered.** Policy can affect premiums by changing the risks that the coverage insures against. For example, a policy that adds benefits to an insurance plan aimed toward bringing down the total cost of care (for example, contraceptive services) and a policy that gives health insurers the ability to reduce covered benefits (for example, categories of essential health benefits) both could lower premiums, but the latter could dramatically increase out-of-pocket costs for many.

3. **The bang for the buck.** Policy can affect premiums by changing the value of the insurance product. While ignored in the AHCA, policies in this category aim to reduce premiums by addressing the underlying total costs of health care, either by promoting value-driven health care spending or increasing competition, which puts downward pressure on health care costs and overhead.

Examining Policy Proposals to Lower Health Insurance Premiums in Marketplaces

Below is a taxonomy of premium-reducing proposals; some administrative, and others legislative. The taxonomy analyzes a policy's mechanism to achieve lower premiums and the policy's implications for consumers. Using current law as the baseline, policies are evaluated as to whether they accomplish the bipartisan goal of lowering premiums without reducing overall benefits or affordability.

Policy Area 1: Changing Who Has Insurance

Targeting Additional Tax Credits to Younger Americans

- **Policy:** Increase the ACA's advanced premium tax credits for younger individuals purchasing coverage on the Marketplaces.

- **Mechanism for changing premiums:** Lowering net premiums for younger individuals makes the purchase of insurance more attractive for this group, which tends to be healthier, on average. When greater numbers of healthier individuals enter the market, the average risk in the insurance pool declines, resulting in lower average premiums.

- **Impact on consumers:** The policy directly decreases net premiums for younger Americans through greater tax credits and indirectly decreases premiums for all consumers through an improvement in the average risk in the insurance pool. A study by the Commonwealth Fund found that enhancing the ACA's current tax credits by $50 per month for people between ages 19 and 30, with smaller enhancements for those between ages 30 and 35, would increase enrollment by individuals under the age of 30 by almost 1 million people and reduce average market premiums by 0.6 percent.[1] For a larger effects on coverage and premiums, this policy could be scaled up or targeted to particular age groups.

Reinsurance Programs

- **Policy:** Included as a temporary program under the ACA and proposed under the AHCA, reinsurance programs provide cost-based reimbursement to health insurance companies with high-cost enrollees. The AHCA also includes an additional allowance for an "invisible risk-sharing program," which can be thought of as a prospective reinsurance program based on both health diagnoses and costs.

- **Mechanism for lower premiums:** Reinsurance has the effect of reducing the financial risk health insurance companies face when they are not allowed to discriminate against individuals with pre-existing conditions, or underwrite risk. Because insurers are directly compensated for the costs of high-cost enrollees and because a reinsurance programs lowers cost uncertainty (by putting a cap on the costs associated with high-risk enrollees), insurers are able to price their premiums lower in any given year. Lower premiums consequently attract healthier individuals to join the market, which could further lower future premiums. An invisible risk-sharing program uses this overall mechanism, but because health insurance companies prospectively identify individuals with particular health diagnoses, uncertainty in pricing for high-cost enrollees for companies is reduced but uncertainty remains for high-cost enrollees without identified diagnoses.

- **Impact on consumers:** Studies of reinsurance programs find that they lower premiums for all ages. The American Academy of Actuaries estimated that the reinsurance program under the ACA reduced premiums by roughly 10 percent in its first year when the funding was similar to that proposed under the AHCA.[2] Concerning the funding in the AHCA specifically, the Congressional Budget Office (CBO) found that when used for reinsurance, the proposed stability fund money would "exert substantial downward pressure on premiums in the nongroup market in 2020 and later years and would help encourage participation in the market by insurers."[3] Invisible risk pool programs, with adequate external funding, would also reduce average premium for all ages and increase enrollment overall. However, there are several reasons that reinsurance may be more efficient than invisible risk sharing. An analysis from Milliman suggests that such premium reductions would be lower (1–4 percent reduction assuming underlying

ACA market) under an invisible risk pool than those experienced under the ACA's reinsurance program but at higher annual costs[4]; there are clear administrative disadvantages to the invisible risk pool programs as well, such as the need to collect and report health care conditions.

Outreach and Enrollment Activities

- **Policy:** Increase funding and efficiency in targeted outreach and enrollment activities, including communication around the individual mandate. The specific details of this policy could include increased federal and state outreach activities, but also incentives for health insurers, agents, brokers, and community organizations to increase outreach.

- **Mechanism for lower premiums:** Targeted outreach and enrollment activities can reach individuals who otherwise may not come into contact with the health care system, who do not know about available financial assistance, and who are not aware of the requirement to have insurance. On average, people who are eligible for Marketplace coverage but remain uninsured are healthier than those who are currently insured in the individual market. Conducting outreach to bring eligible uninsured individuals into the market not only provides new enrollees the benefits of insurance, but it can reduce premiums in the Marketplaces for all enrollees.

- **Impact on consumers:** A recent study found that markets with higher volumes of insurance advertisements saw greater reductions in their uninsured rate.[5] Actions by the Trump administration to end advertising before the close of open enrollment in 2017 was reported to have deleterious effects on coverage, particularly for younger and healthier individuals who are likely more affected by reminders and deadlines.[6] However, reversing course and committing to outreach, including continued deployment of the most effective methods, could have positive effects on market premiums and stability.

Change Age Rating Rules to Five-to-One

- **Policy:** Under current law, health insurers may not charge older adults more than three times the amount they charge younger adults for premiums in the individual and small group markets. The AHCA seeks to increase the limit to five times the amount charged for a younger adult.

- **Mechanism for lower premiums:** Widening the allowable variation due to age decreases premiums for younger enrollees and increases premiums for older enrollees. Increasing affordability for younger enrollees encourages enrollment of younger and healthier individuals and decreases affordability and enrollment of older enrollees. Through a combination of greater numbers of younger enrollees and lower numbers of older enrollees, average premiums go down.

- **Impact on consumers:** The Commonwealth Fund estimated that a policy change to the ACA to allow five-to-one age rating would increase total enrollment and bring average premiums down 5.9 percent across the individual market. They also estimate that the policy would increase premiums for those over age 47 (by over 25 percent for ages 60 and older). Furthermore, they estimate that a change in age rating decreases the number of covered individuals aged 47–64 by 700,000 people. As a result, this policy does achieve the goal of average premium reduction in the market, but it does so at the expense of coverage for older Americans who may need insurance the most. In fact, when the study estimated the average market premium assuming the same age distribution present in the market today, it found that average premiums actually increase by 5.8 percent after five-to-one age rating is introduced.[7]

Moving to Flat Premium Tax Credits

- **Policy:** The AHCA proposed to change the ACA's tax credits—which are currently tied to an individual's income and their local market premiums—to a flat tax credit that only varies by age (two-to-one) and is available to individuals with income over 50 percent higher than the current limit.

- **Mechanism for lower premiums:** On average, this proposed policy would reduce premium tax credits by $1,600 per year in 2020 for current enrollees. Enrollees who are older, low-income, and from high-cost areas would be hit particularly hard due to the design of the tax credits.[8] As a result, fewer older and low-income individuals, as well as people from high-cost areas, would enroll in the Marketplaces. The proposal would also increase tax credits for younger and wealthier Americans, encouraging enrollment from these groups. On balance, greater participation from younger Americans and lower participation from older and low-income Americans would reduce average premiums.

- **Impact on consumers:** CBO analysis of the AHCA's tax credits (combined with the bill's other changes) concludes that premiums would be 10 percent lower on average. But, here again, the details matter. Economic models from the Brookings Institution find that much of the premium decrease under this policy results from a shift in the type individuals who have insurance.[9] When the age mix of the insurance population is held constant, premiums actually increase 4 percent, and when the both the age and benefit generosity are held constant, premium increase 13 percent.[10] Ultimately, the increase in costs for older and low-income Americans drive them out of insurance coverage, leaving some of the most vulnerable without financial or health protections.

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Allowing Premium Tax Credits for Plans off the Marketplaces

- **Policy:** Included in drafts of the AHCA and in proposed legislation[11] from Senators Lamar Alexander and Bob Corker, this idea would allow individuals to use premium tax credits to purchase qualified health plans off of the Marketplaces as well as non-ACA-compliant coverage (for example, limited duration coverage). Tax credits for the purchase of these plans would not be advanceable (i.e., paid monthly to insurers during the tax year), like those for insurance purchased on the Marketplace, and would be provided as a refundable tax credit through annual taxes.

- **Mechanism for premium reduction:** Allowing individuals to purchase non-ACA-compliant coverage off the Marketplace provides an incentive for healthier individuals to buy plans with fewer benefits and protections. Noncompliant plans are, on average, cheaper because they typically cover less health care and attract a healthier population. However, when healthier individuals leave the Marketplace, average premiums increase for the population who remains.

- **Impact on consumers:** Despite the fact that individuals purchasing noncompliant coverage would likely pay lower premiums, they would receive less protection. Additionally, healthier individuals will now be out of the ACA-compliant risk pool, leaving those left in the Marketplace pool to face higher premiums. The overall result may be an inefficient segregation of risk and rising premiums, as well as fewer plan choices, in the Marketplace.

High-Risk Pools

- **Policy:** Historically, high risk-pools served as an alternative insurance program to guaranteed access to insurance for people with pre-existing conditions. Under the AHCA, states could choose to use the proposed stability funding for high-risk pools.

- **Mechanism for premium reduction:** By placing individuals with preexisting conditions into a separate risk pool with significant funding and enrollment, premiums for people who remain in the individual market could decrease.

- **Impact on consumers:** Such policies have failed in the past to produce adequate health insurance for individuals in

the high-risk pool *and* to bring premiums down for people in the remaining market.[12] Looking forward, there continue to be large limitations to this policy including administrative and privacy considerations for the identification of "high-risk" individuals, limited funding, and less protection from unexpected high-costs than a pure cost-driven reimbursement mechanism like that of a reinsurance program.

Continuous Coverage Requirements

- **Policy:** The AHCA proposed to repeal the individual mandate and replace it with a continuous coverage requirement. Under this policy, individuals would be charged 30 percent higher premiums if they were not continuously insured over the previous twelve months.

- **Mechanism for premium reduction:** The intent of the policy is to incentivize continuous enrollment from both younger and older individuals through the future threat of increased premiums if they experience a coverage gap or drop coverage. In theory, if the policy were successful to a greater extent than the current mandate, it could reduce premiums. However, the policy may have the opposite of its intended effect by discouraging healthy uninsured individuals from enrolling in the Marketplaces.

- **Impact on consumers:** Unlike the ACA's individual mandate, which reduces average premiums by incentivizing enrollment for those who can afford it but choose to go without insurance, this policy would penalize individuals seeking to get insurance. CBO estimates that despite some initial enrollment encouragement, this policy would result in roughly 2 million fewer people purchasing coverage.[13] This drop in enrollment would likely lead to an increase in average premiums because the healthiest individuals would be the least willing to pay the penalty and most reluctant to enter the risk pool.

Policy Area 2: Changing What Insurance Plans Cover

Allow Actuarial Value (AV) Differences

- **Policy:** Both the AHCA and final rules from the Trump administration include an allowance for insurance companies to offer plans with lower actuarial value (AV) than are set by statute in the ACA. (AV is a summary measurement of the average percentage paid by the health plan versus enrollees for covered health care services).[14]

- **Mechanism:** When insurance plans take on less risk (lower AV), premiums decrease. The premium decrease is a direct result of a shift in risk from the health plan to consumers who will be forced to pay higher deductibles and

other out of pocket costs.

- **Impact on consumers:** One analysis by Center on Budget and Policy Priorities concluded that, under the rule from the Trump administration, individuals who benefit from tax credits would pay the same amount in premiums as before the rule, but for less generous coverage.[15] For example, the report finds that under the new rule, deductibles could increase by $550, even though people would pay the same premium. And, in its final rule, the Department of Health and Human Services (HHS) agrees with this assessment stating that "the change in AV may reduce the value of coverage for consumers, which can lead to more consumers facing increases in out-of-pocket expenses, thus increasing their exposure to financial risks associated with high medical costs."[16]

- A separate analysis by the Kaiser Family Foundation, which examined the AHCA policy to repeal the requirement for plans to have standard actuarial value levels, concluded that deductibles would be $1,550 higher as a result of lower actuarial value average in the market.[17]

Reducing Essential Health Benefits

- **Policy:** The ACA instituted key protections—called essential health benefits—for people with individual and small-group market health plans. This means that when consumers purchase health insurance, they can be confident that their plan covers services in ten benefit categories. An amendment to the AHCA sponsored by Representative Tom MacArthur and backed by key house republicans and rumored action from the Trump administration would attempt to turn benefit coverage decisions back to states and health insurers, allowing insurers to provide coverage for fewer basic health care services.

- **Mechanism for lower premiums:** When health insurance companies cover fewer health care services, the average costs for uncovered services shifts away from premiums to consumers who need—but are no longer covered for—such health services. So consumers end up paying more in the form of higher out of pocket costs.

- **Impact on consumers:** An analysis from Harvard and NYU economists examined the impact in 2015 of the of eliminating essential health benefits requirements.[18] We extended this estimate to examine the potential loss of benefit coverage if the current provisions of Title 1 of the ACA were turned over to the states. If the past is any guide, our work suggests that reverting to pre-ACA levels of coverage could strip essential benefits from millions of self-insured businesses, including eliminating coverage for maternity services for 13 million women, coverage for mental health for 4 million Americans, coverage for substance use disorder for 7 million Americans, and coverage for prescription drugs for 2 million Americans.[19]

Value-based Insurance Design and Benefit Coordination

- **Policy:** Incentivize insurers to design benefit packages that encourage the use of under-used but high-value care through the addition of services such as benefit coordinators or disease management programs, or through changes in cost-sharing requirements.

- **Mechanism for lower premiums:** By making it easier for consumers to purchase and receive the right care at the right time, individuals may be able to avoid future higher medical costs. Upfront investments can help reduce future costs and lower premiums overtime.

- **Impact on consumers:** A large body of evidence suggests that higher out-of-pocket costs for consumers reduces the use of both high- and low-value health care services, and in many cases, leads to worse health outcomes. When cost-sharing is lowered for high-value services—such as contraception and medications to help individual manage chronic disease—consumers are better able to access the care they need.

Policy Area 3: Changing the Value of Health Insurance Plans

Begin an Active Purchaser Policy for Federal Marketplaces

- **Policy:** This policy would allow HHS to take a more active role in contracting with health insurance companies seeking to offer coverage on the Marketplaces.

- **Mechanism for lower premiums:** While this policy itself would not directly lower premiums, it could indirectly do so by allowing HHS to structure contracts with issuers to reduce the overall cost of health care in the individual market, and to promote competition. For example, HHS could require health insurance companies to offer coverage in more service and rating areas within the state or to participate in delivery system reform initiatives.

- **Impact on consumers:** Consumers in active purchasing Marketplaces have the potential to gain more stable, affordable health plan options and a greater choice of insurers.[20]

Plan Standardization

- **Policy:** In the Federal Marketplaces, insurers currently have the option of providing standardized plans. Standardized plans cover the same benefits and have the same cost-sharing structures (deductible, copays, and so

on). This policy could either require health insurers to offer some or only standardized plans. In California, for example, insurers seeking to offer coverage on the Marketplace must submit plan bids for standardized plans developed by its Marketplace using benefit design research.[21]

- **Mechanism for premium reduction:** Standardized plans make it easier for consumers to compare health insurance options. Such comparisons allow consumers to be a better judge of plan quality and, subsequently, health insurers are driven to compete on value (price per standardized benefit) rather than on premium price alone.

- **Impact on consumers:** Research suggests that when plans are standardized, consumers are better able to shop for what they want, making a judgment on the price per benefit gained rather than on premium or brand alone.[22] Better-informed decision-making drives greater benefit per premium dollar paid by the consumer.

Incentivize Alternative Payment Contracts

- **Policy:** In concert with states such as California, health insurance companies could be required to enter into alternative payment contracts with providers to promote better quality, more coordinated care. Examples of alternative payment contracts include Integrated Healthcare Models or Accountable Care Organizations, which are structured as a group of providers that are responsible for coordinating care for patients across time, health care delivery setting, and health care conditions. Such groups are set up to be paid by the health insurance company to deliver good outcomes across care dimensions rather than the typical payment structure that pays providers separately for each service provided, regardless of quality.

- **Mechanism for lower premiums:** Moving to alternative payment contracts with providers over the typical fee-for-service contracts can help bring down the overall cost of health care. Given that the vast majority of premiums are represented by health care costs, any reduction in the cost of care for the covered population will reduce premiums.

- **Implication for consumers:** Through a focus on payments for increased quality and coordination of care, consumers could not only see lower premiums but also higher quality health care through their Marketplace plans.

Public Plan Option/Fallback

- **Policy:** The House-passed version of the ACA had a public plan offered side-by-side with private plan options. A version of the Senate ACA bill along with other proposals called for a public plan option as a fallback option where there is not adequate competition in the Marketplace.

- **Mechanism for premium reduction:** A public plan would compete with private health insurance companies to drive down the price of insurance in the market. Depending on the specific policy, such competition, and subsequent lowering of average premiums, could come through both the greater pressure for competing private plans to lower their administrative margins and/or increase their price negotiations with providers. The public plan itself would likely have lower overhead costs as well as lower payment rates for health care providers than private plans.

- **Implications for consumers:** Consumers could see lower premiums in the Marketplace and enjoy greater stability and choices. The magnitude of such changes would depend on the details of the public option policy as well as the geographic distribution.

Delivery System Reform and Lower Drug Prices in Medicare

- **Policy:** The ACA and the Medicare Access and CHIP Reauthorization Act (MACRA) began to move the health care system toward alternative payment models that incentivize and hold health care providers and institutions accountable for outcomes experienced by patients.[23] Policies to further advance the shift from a volume-based health care system to one of value, like expanded bundled payment models and additional types of accountable care organizations can be explored. Additionally, legislative and executive action on new ways to pay for prescription drugs could be sought and implemented.

- **Mechanism for premium reduction:** While these policies are not specific to the Marketplace, changes in Medicare payment rates help decrease price in the private sector. Decreases in private sector prices contribute to lower premiums for customers.

- **Impact on consumers:** One of the most often cited studies in this area finds that a $1 change in Medicare's relative payments changed private payments by $1.16.[24] Additionally, another study finds that a 10 percent reduction in Medicare payments is associated with a reduction in private market prices of 8 percent.[25] Such findings suggest that policies that push down Medicare cost growth also exert downward pressure on prices in the individual market, which could reduce the premiums individuals can expect to pay for Marketplace plans.

Conclusion

Lowering premiums and premium growth in the Marketplaces is a bipartisan and worthy policy goal. However, using premiums as a standalone metric, without considering the total impact on consumers, can result in policies that could be harmful overall. Assessing proposals using the framework in this report may help policymakers deliver on President

Trump's promise of a health insurance market that is "much less expensive and much better."

Notes

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