

## Health Care Reform Premium Impact in New York

The impact health care reform will have on health insurance premiums in New York will be different from other states because New York in many ways has already adopted many of the insurance market reforms being proposed. In some ways, the rules in New York are already more restrictive. For example, New York has “pure community rating” and prohibits varying rates on the basis of age where the proposed federal reforms would limit age rating within a range of 2:1 or 4:1, depending on the legislation. However, since there is no federal preemption on tighter rating rules, the current rating constraints in the New York market would stay the same, absent a change in state law.

Because New York implemented market reforms without an effective individual mandate, the existing insurance markets, especially the individual market, exhibit adverse risk selection, where many individuals wait to get coverage until services are needed. An effective individual mandate in federal health care reform has the potential to improve the market and lower premiums, particularly in the individual market. However, an effective individual mandate is no longer being considered, and the proposed exemptions and extremely low penalties associated with the proposed mandates are unlikely to significantly improve New York’s market.

In other words, with New York having already implemented market reforms in a voluntary market, the main provisions of reform that will directly impact premiums when implemented are new benefit requirements and new taxes. This analysis shows how these provisions are expected to impact premium costs for individuals and groups exhibiting certain characteristics when the market reforms are implemented. These displays present real rates being charged to real individuals and groups today and show how those rates are generally expected to change post-reform, *without any adjustment for the increase in medical costs over time*. There are other provisions in health care reform that may over the long-term have a lesser and indirect impact on premiums in the private market that are not specified in this analysis. However, the impact from the examined provisions will have a direct impact on premiums and, we believe, will exceed any aggregate savings that can potentially be achieved through other provisions of proposed legislation. For example, we evaluated the impact of an insurance exchange, but as explained in the Appendix, concluded that the assessment to fund the exchange would roughly offset any reduction in insurer administrative costs.

While this analysis focuses on the underlying cost of the premium, we appreciate that there are also elements of reform that would shift a portion of those costs from lower-income individuals and certain employers to taxpayers in the form premium assistance and tax credits offsetting the costs of coverage. Therefore, we include a discussion of how these provisions may result in a lower post-subsidy cost for certain low-income individuals.

### Summary of Premium Cost Impact Analysis for Reforms

	<b>Percent Increase</b>
<b>Individual</b>	82%
<b>Small Employer</b>	6%

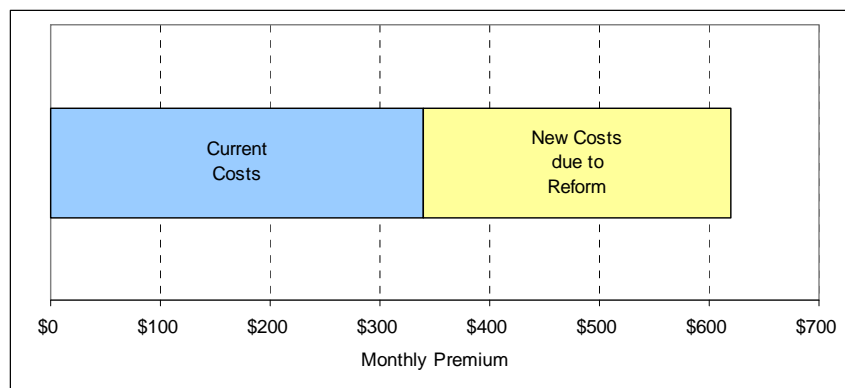
**Note:** Percent increase shown before any adjustment for the increase in medical costs over time

## Individual Market Case: Family with 2 Children, Average Health Status in New York City

Product: Contract Type, Gender and Subscriber Age: Underwriting Class:	<b>Traditional Hospital Only Family with 2 Children Age 40 n/a</b>	
	<b>Family Monthly Premium</b>	<b>% Increase</b>
Current premium	<b>\$340</b>	
Impact of guaranteed issue and no effective individual mandate, resulting in many waiting to purchase until services are needed	\$340	0%
Limiting age discount to 3:1	\$340	0%
Eliminating health status discount	\$340	0%
Requiring higher benefit level (70% actuarial value and required new benefits)	\$595	75%
Health insurer \$6.7B annual tax	\$613	3%
Pharmaceutical tax and medical device tax	<b>\$619</b>	1%
<b>Total Impact</b>	<b>\$340 to \$619</b>	<b>82%</b>

### Notes:

- Methodology for each element presented in the Appendix.
- As stated in the chart, the hospital-only product is shown, which is very popular due to the high costs in New York. These types of products would be prohibited for new purchasers post-reform.
- Display reflects costs for new sales; to the extent that pre-reform benefits and rating rules are grandfathered, existing members will initially experience minimal impacts post-reform. However, new purchasers will face these pricing changes.



### Taxpayer Subsidy Offset

The table above shows the underlying cost of the premium, which is representative of the cost charged to the insurance exchange. The following table shows the extent to which this individual may be eligible for premium assistance in the Exchange (which is available for individuals up to 400% of the federal poverty level).

Federal Poverty Level: Premium Subsidy	Reform Premium after Subsidy	Total Impact after Subsidy
100% - 150%: 93% subsidy	\$43	-87%
150% - 200%: 82% subsidy	\$111	-67%
200% - 250%: 67% subsidy	\$204	-40%
250% - 300%: 48% subsidy	\$322	-5%
300% - 350%: 32% subsidy	\$421	24%
350% - 400%: 22% subsidy	\$483	42%
400%+: 0% subsidy	\$619	82%

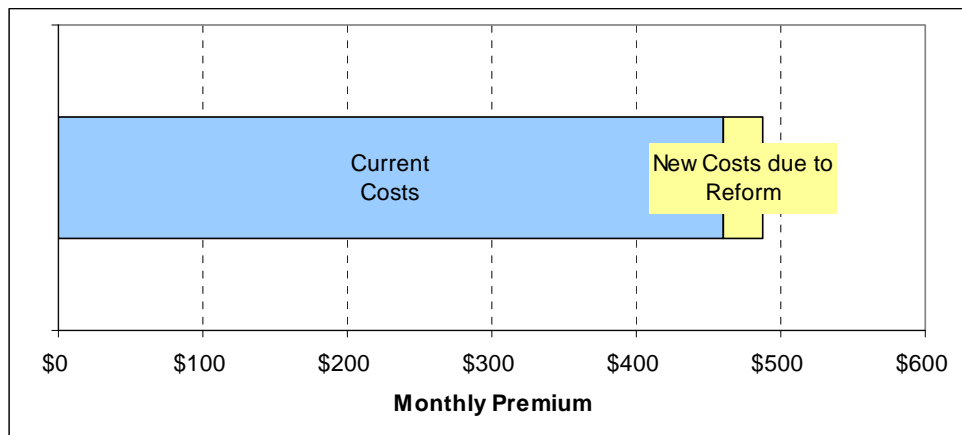
Some proposals also include reinsurance that would subsidize a portion of the costs for high-risk individuals purchasing coverage. However, these proposals phase-out after three years and the total amount available amounts to \$20B, which is less than 10% of the expected premium cost over this period.

## Small Group Case: Small Employer with Eight Employees in New York City

Small Employer Market Health Reform Impact State: New York		
<b>Product:</b>	EPO \$25/40	
<b>Underwriting Class:</b>	N/A	
	Single Monthly Premium	% Increase
Current premium	<b>\$460</b>	
Impact of insurance market reform changes without an effective mandate	\$460	0%
Limiting age discount to 3:1; eliminating gender rating	\$460	0%
Eliminating health status discount	\$460	0%
Elimination of other current, actuarially-justified rating variables	\$460	0%
Requiring higher benefit level (65% actuarial value and required new benefits)		
a. Specific to chosen group	\$460	0%
b. Average for Small Group pool	\$462	0%
Health insurer \$6.7B annual tax	\$473	3%
High-cost health insurer tax		
a. Attributable to this group	\$473	0%
b. Allocated across insured pool	\$485	3%
Pharmaceutical tax and medical device tax	\$488	1%
<b>Total Impact</b>	<b>\$460 to \$488</b>	<b>6%</b>

**Notes:**

- Methodology for each element presented in the Appendix.
- Display reflects costs for new sales; to the extent that pre-reform benefits and rating rules are grandfathered, existing members will initially experience minimal impacts post-reform. However, new purchasers will face these pricing changes.



### Taxpayer Subsidy Offset

The table above shows the underlying cost of the premium, which is representative of the cost charged to the insurance exchange. However, certain businesses may be eligible for a small employer tax credit, which shifts a portion of the premium cost onto taxpayers. The tax credit is limited in several ways: employer size, wages of employees, and only for the first two years coverage is purchased through the exchange. The CBO estimates that the small employer tax credit will cost about \$23B over 10 years, or \$2.3B per year. This amount reflects roughly 2-3% of small employer premiums across the U.S. and thus under this assumption will not likely broadly reduce premiums paid by small employers and their employees.

## **APPENDIX**

### **Impact of Guaranteed Issue with No Individual Mandate (Individual Market)**

#### **Background**

Study after study has demonstrated that without an effective individual mandate, traditional guaranteed issue requirements result in the opposite outcome of the goals of health care reform—higher costs, fewer choices, and more people uninsured. In the existing legislative proposals, not only does the individual mandate exempt large groups of people, but the penalty is also just a fraction of the average cost of coverage (which is over \$4,000 per year for most individuals). Under this construct, there is little to counteract the overwhelming, logical consumer choice to wait until they get sick to purchase coverage since a healthy individual who uses few medical services can pay the lesser amount, the penalty, and still be guaranteed coverage if and when services are needed. This dynamic has a very large impact on the cost of coverage because those who need services are often several times more expensive to insure than someone of “average” health status. Without healthy people in the pool, the cost of coverage will skyrocket. This element primarily impacts the individual market, but it can also encourage employees in groups to forego coverage with the knowledge that coverage can be purchased in the future when services are needed.

#### **Analysis**

The estimates shown in the displays above come from WellPoint’s experience of operating in multiple guaranteed issue individual markets that do not have an effective individual mandate to purchase coverage. The premiums in those guaranteed issue states are often multiples of those underwritten states. From our review, the impact of guaranteed issue in the absence of an effective mandate ranges from an increase of 20% to 80%, and thus we show the midpoint increase of 50%. The upper and lower bounds were developed based on a review of existing literature, company experience and other industry sources.

The Senate Finance Committee legislation does propose reinsurance to offset a portion of the costs associated with the adverse selection that will result from guarantee issue requirements. However, the reinsurance program is limited to three years, and the total funding is limited to \$20B over three years. The impact on premiums in the individual market is anticipated to total well over \$150B during this same period. Risk corridors and risk adjustment mechanisms are also proposed but do not add funding to the individual market and thus will not mitigate increased premiums in the aggregate.

## **Impact of Insurance Market Reform without an Effective Mandate (Small Employer Market)**

### **Background**

Current proposed health care reform legislation generally seeks to limit allowable rating variables to age, tobacco use, and family composition. In addition, proposals require that the relationship of the maximum premium to the minimum premium be limited to 2:1 or 4:1 for age (depending on the bill) and 1.5:1 for tobacco use. Geography is also introduced as an allowable variable, but to the extent it is used, it must reduce the variation present in either the age or tobacco use characteristics in order to comply with an overall rate limit of 6:1 (within a family category).

### **Analysis**

The largest impacts of the proposed legislation result from the restrictions to age rating and the elimination of health status as an allowable rating variable, without an enforceable mandate to retain a broad insurance pool and limit adverse selection.

The following table illustrates the average impact by age and gender that will result from moving from unlimited age and gender rating to a 3:1 limit on age rating and no rating for gender:

<b>ADJUSTMENTS BY AGE AND GENDER WITH 3:1 LIMIT</b>			
<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
<25	53%	-22%	21%
25-29	55%	-22%	20%
30-34	33%	-19%	11%
35-39	19%	-13%	6%
40-44	15%	-5%	6%
45-49	13%	1%	8%
50-54	11%	4%	8%
55-59	2%	0%	1%
60-64	-20%	-18%	-19%
65+	-39%	-35%	-37%

This table assumes that the overall cost of the pool remains unchanged, which is the assumption used to isolate the impact of the age and gender rating reforms.

As illustrated, the magnitude of the changes is most significant at the youngest and oldest ages, though the differences by gender are considerable. This will exacerbate concerns regarding adverse selection, in which traditionally healthier risks opt out of the market while older and generally more costly members retain coverage with more attractive rates. As the overall pool rate is based on the subsidization currently present between these two ends of the spectrum, the anti-selection impact will drive the rates in the pool upward as members with unfavorable premium impacts may forego coverage as it is no longer financially worthwhile for them. This issue could be significantly remedied by an effective individual mandate, but the current proposal does not create a strong enough incentive for those whose rates are adversely impacted to remain insured.

As younger, typically healthier members of the insured pool forego coverage, the overall health status of the insurance pool will deteriorate. This, in turn, will cause premiums to rise in the employer-sponsored market. As premiums rise in future years, more younger, healthier risks will forego coverage, as going without coverage makes more and more financial sense to them. This upward spiral in the premiums of the employer-sponsored pool will continue until a more effective mandate is put into place or the premiums in the employer market become unaffordable even for the older, less healthy risks.

A similar analysis holds true in the employer-sponsored market regarding the removal of health status as an allowable rating variable. In states where health status rating is currently allowed (see table below), those healthy risks that are closest to the bottom of the rating range will be most adversely impacted and likely to exit the insured market. In turn, the remaining insured population will be of worse overall health than the insured

population prior to the rating changes. This will drive up overall rates, and the spiral will continue until there is clear financial incentive to remain insured (e.g. a strong individual mandate) or rates become unaffordable even for the sickest members of the population.

**Health Status Range by WLP State**

<b>State</b>	<b>Health Status Range</b>
CA	+/-10%
CO	Prohibited
CT	Prohibited
GA	+/-25%
IN	+/-35%
KY	+/-50%
ME	Prohibited
MO	+/-35%
NH	Prohibited
NV	+/-30%
NY	Prohibited
OH	+/-40%
VA	No Legal Limit
WI	+/-30%

We have modeled the impacts of the rating reform changes on a subset of our small employer groups. The modeling includes approximately 50,000 small employer groups representing roughly 700,000 members. These members all reside in states that are generally flexible in terms of allowable rating variables, with rating for health status varying from +/-30% to +/-40%. As such, the impacts illustrated below should be of greater magnitude than those in markets where variation is restrained. For those markets, the impacts in our illustrations have been reduced accordingly.

Rating impacts were determined by internal actuarial analysis. Elasticity curves were then applied to resulting increases to determine the likelihood that members would persist into the new group market. The elasticity curves were based on internal historical patterns of termination activity relative to group premium rate actions in the studied markets. From this modeling, we then applied a claims distribution to examine the morbidity of the pool pre- and post-reform.

The table below illustrates the results of the initial iteration of the model (before consideration of rating impacts due to anti-selection):

<b>Rate Change due to Reform</b>	<b>Distribution of Groups</b>	<b>Avg Increase due to Reform</b>	<b>Persistency</b>
-100% to -50%	1%	-53%	98%
-50% to -40%	5%	-44%	98%
-40% to -30%	9%	-35%	98%
-30% to -20%	10%	-25%	98%
-20% to -10%	12%	-15%	96%
-10% to 0%	13%	-5%	94%
0% to 10%	14%	5%	93%
10% to 20%	13%	15%	86%
20% to 30%	11%	25%	75%
30% to 40%	7%	35%	61%
40% to 50%	4%	44%	42%
50% to 75%	2%	57%	13%
75% to 100%	0%	81%	0%
> 100%	0%	245%	0%
<b>Total for Decreases</b>	<b>50%</b>	<b>-20.2%</b>	<b>96%</b>
<b>Total for Increases</b>	<b>50%</b>	<b>20.5%</b>	<b>74%</b>
<b>Total Overall</b>	<b>100%</b>	<b>0.0%</b>	<b>83%</b>

Given a distribution of claims experience for this cohort of internal data, we were then able to model the relative health status of the persisting block against that of the initial small employer pool. The results suggest that the average premium would need to increase by approximately 12% to support the higher risk of the post-reform pool. Naturally, this will further magnify the anti-selection impact as rates for all would be raised to account for this.

We do recognize that the proposed legislation will allow states to phase-in the new rating rules over time, and that a phase-in may delay the full impact of anti-selection up to 5 years. However, we believe it is logical to expect that most states will move very quickly to implement the new rules in their small employer markets as the small employer tax credits will not be available to states until they have fully adopted these new rules. As a result, we found it more reasonable to assume quick implementation of the rating changes, with the thought that a slight delay could occur but that a five-year implementation window was unlikely.

## Limiting the Age Discount to 3:1 and Eliminating Gender Rating

Actuarially-justified rates for younger age segments are typically about 16% of the cost of older age segments (6:1). Thus, constraining the age rating distribution to 4:1 or 3:1—holding all else constant—typically results in younger individuals paying more and older individuals paying less for health insurance coverage. The percentage change is more dramatic for younger individuals than older individuals because the base premium for younger individuals starts from a much lower value.

Constraining age rating places additional stress on any individual mandate. To the extent younger individuals are asked to subsidize the costs for older individuals, those younger individuals are more likely to make the logical choice to forego coverage and pay a penalty.

For display purposes, the rate increases shown due to limiting the age discount also include the impact of eliminating rate variation based on gender, where men typically pay lower premiums until ages 50-55, and women pay lower premiums between ages 55 and 65.

The following display shows the existing individual market rules for the states analyzed:

Current Individual Age/Gender/Health Status Regulations by WLP State			
	Age	Gender	Health Status
CA	Allowed	Allowed*	No limits
CO	Allowed	Allowed	No limits
CT	Allowed	Allowed	No limits
GA	Allowed	Allowed	No limits
IN	Allowed	Allowed	No limits
KY	5:1 (incl. area)	Allowed	No limits
ME	1.5:1	Prohibited	Prohibited
MO	Allowed	Allowed	Allowed
NH	4:1	Prohibited	2.25:1
NV	Allowed	Allowed	Allowed
NY	Prohibited	Prohibited	Prohibited
OH	Allowed	Allowed	Allowed
VA	Allowed	Allowed	Allowed
WI	Allowed	Allowed	Allowed

\* Prohibited beginning 1/1/11

## **Eliminating the Health Status Discount**

Most individual and small group health insurance markets allow health insurers to vary rates by health status. Providing such discounts to healthier individuals encourages low-risk individuals and groups to purchase coverage in a voluntary market.

All of the current health care reform proposals eliminate rate variation by health status. This means that, holding all else constant, healthier individuals and groups will pay more and less healthy individuals will pay less (in states that currently do not prohibit health status rating). This dynamic is reflected in the analysis for this component.

Eliminating health status rating again places additional stress on any individual mandate. To the extent lower-risk individuals are asked to subsidize the costs for higher-risk individuals, those lower-risk individuals are more likely to make the logical choice to forego coverage and pay a penalty.

## **Elimination of Other Actuarially-Justified Rating Variables (Small Employer)**

In addition to the health status of the group, most small group markets allow rates to vary between groups by other factors that correlate with risk – such as industry and group size – where those anticipated to be lower-risk can receive premium discounts for these factors. Health care reform would prohibit the use of these factors, further compressing rates by increasing rates for lower-risk groups and decreasing rates for higher-risk groups. This dynamic is reflected in the analysis for this component.

## **Requiring a 65% or 70% Actuarial Value and Benefit Mandates**

The current health care reform proposals all set minimum (i.e., “floor”) benefit requirements for coverage in two ways:

1. By requiring a minimum “actuarial value” for coverage that reflects the percentage of “allowed claims” paid for by the product in the coverage pool. That is to say, if the benefit plan is designed to pay for 70% of the covered medical expenses for a standard population, it would have an estimated actuarial value of 70%.
2. By requiring all products include a wide range of benefits, such as no contract maximum, pediatric dental and no-cost preventive services. The inclusion of maternity coverage represents a new cost for most individual market products.

While well-intentioned, to the extent these items and benefit levels are not included in benefit packages today, they will increase premiums.

As stated below the displays, to the extent individuals and groups are allowed to keep products that do not meet these new requirements, there will be no impact for this element. However, identical individuals purchasing post-reform, or individuals who choose to change their current coverage, will be required to purchase the richer benefits and pay the higher prices.

Each health care reform bill identifies benefit levels for policies issued. The various thresholds reflecting the minimum percentage of covered medical expenses expected to be paid for by these plans, or their actuarial value, range from 65% to 76%.

Legislation also requires consistency amongst carriers in the services that are covered. The framework prohibits member-level cost-sharing for preventative benefits and lifetime or annual limits on specific benefits.

To better understand the impact of the minimum actuarial value standard on premiums in the small group market over time, we examined the distribution of our current product portfolio. We used a standard model to determine the actuarial value of products representing 95% of the covered small group members in our 14 WellPoint states. Consistent with guidelines on Actuarial Equivalence from the American Academy of Actuaries, we considered the cost-sharing differences by plan as well as differences in covered services, variation in cost-sharing by service, and appropriate utilization adjustments for different cost-sharing levels. A standard population representative of those with employer-provided coverage was used to evaluate the designs against one another.

The following table summarizes the results:

<b>SMALL EMPLOYER ACTUARIAL VALUE</b>				
<b>State</b>	<b>Average Actuarial Value (AV)</b>	<b>% of Members Below 65% AV</b>	<b>Average Increase Required to Meet 65% AV</b>	<b>Overall Increase to Average Premium</b>
California	70%	35%	19%	7%
Connecticut	76%	4%	6%	0%
Georgia	73%	18%	12%	2%
Indiana	73%	16%	10%	1%
Kentucky	78%	6%	8%	0%
Maine	90%	7%	4%	0%
Missouri	78%	9%	10%	1%
Nevada	68%	57%	8%	5%
New York	85%	2%	22%	0%
Ohio	78%	6%	13%	1%
Virginia	78%	10%	6%	1%
Wisconsin	74%	11%	11%	1%
<b>WLP Total</b>	<b>76%</b>	<b>17%</b>	<b>14%</b>	<b>2%</b>

Over time, we anticipate premiums in the small employer market would rise 2% to comply with the minimum actuarial value standard. In the short-term, it is important to acknowledge that the grandfathering laws will help to delay the full impact of this adjustment. Starting in 2013, however, small employers who wish to be eligible for tax credits will be required to purchase a plan through the state exchanges. At this point, we anticipate much of the grandfathered employer-sponsored membership will transfer over to the state exchange as employers seek the tax advantages available there.

Also, the Senate Finance Committee proposes to create a “young invincible” plan that will provide another option below the 65% minimum actuarial value. However, the plan will only be made available to individuals 25 years or younger. This demographic comprises only about 7% of currently insured small employer subscribers in WLP markets. As rating reform is put into place and results in significant increases to premiums for younger workers, we anticipate the percentage of subscribers age 25 or younger that are covered by their employer’s coverage will drop significantly. The “young invincible” plan seems unlikely to provide any material cost relief for employer-sponsored coverage in the post-reform environment.

These estimates are consistent with those provided in the 2009 Oliver-Wyman report, “Insurance Reforms Must Include a Strong Individual Mandate and Other Key Provisions to Ensure Affordability”. In that report, it was expected that the minimum actuarial value standard would raise small employer premiums by 3% for new purchasers in the market.

## High-Cost Health Insurance Tax

### Background

The Senate Finance Committee legislation as amended imposes an excise tax on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The threshold is currently set at \$8,000 for single coverage and \$21,000 for family coverage. As part of the phase-in of the new legislation, the 17 highest cost states will be subjected to a 20% higher threshold in the first effective year, a 10% higher threshold in the second effective year, and a 5% higher threshold in the third effective year. The tax will be 40% on the amount of coverage exceeding the threshold amount. When comparing to the threshold amount, the total aggregate value of all employer-sponsored health coverage must be considered, including:

- Premiums for health insurance coverage (medical and pharmacy);
- Premiums for dental, vision, and other supplementary health insurance coverage;
- Coverage in the form of reimbursements under an FSA or HRA; and
- Employer contributions to an HSA.

### Analysis

We studied over 250,000 small employers accounting for over 2.5M members to examine the impact of the excise tax on our insured small employers.

The following table illustrates the potential impacts to our insured small employer groups:

State	Current # of Groups	5 Years From Now (2014)		
		% Groups > Threshold	Tax on Prem > T'hold (\$mill)	Tax as % of Premium
Connecticut	11,453	20.0%	13.4	2.6%
Georgia	14,567	7.2%	5.0	0.8%
Maine	5,493	3.3%	0.4	0.3%
New Hampshire	6,305	23.3%	7.9	3.1%
New York	44,331	9.5%	33.1	2.5%
Virginia	25,652	10.1%	14.0	1.5%
East Subtotal	107,801	10.9%	73.8	2.0%
Indiana	10,920	8.6%	5.4	1.1%
Kentucky	9,438	4.5%	1.8	0.5%
Missouri	13,246	5.4%	2.3	0.5%
Ohio	21,509	3.3%	2.6	0.3%
Wisconsin	3,178	5.8%	0.8	0.6%
Central Subtotal	58,291	5.1%	12.9	0.6%
California	77,531	10.2%	42.0	1.7%
Colorado	10,322	6.6%	2.9	1.1%
Nevada	2,366	5.5%	0.6	0.7%
West Subtotal	90,219	9.7%	45.4	1.6%
Total	256,311	9.2%	132.0	1.5%

Nearly 1 in every 10 groups would be impacted by the tax in the first year after its introduction. And, the tax would result in additional 1.5% premium charge on average.

Over time, more of our employer groups would be subject to the tax as health care trends continue to exceed standard inflation trends in the absence of reform targeted at claims cost containment. Our analysis shows that over 20% of our small employer groups could be subject to the tax by 2019, with the average impact to premium of 3.7%. The Congressional Budget Office estimates that this tax will cost employers more than \$200B from the time it is introduced until 2019. Some proponents of this tax have stated that employers will react to approaching the tax threshold by purchasing leaner benefits. However, as stated above, the

legislation also creates a “floor” for benefit designs that will result in a limited ability to purchase leaner products.

The following table illustrates the results for fully insured large employer groups, covering over 20,000 groups and 6.3M members:

**Impact of High-Cost Insurance Tax on Large Employers**

State	Current # of Groups	5 Years Forward (8/1/2014)		
		% Groups > Threshold	Tax on Prem > T'hold (\$mill)	Tax as % of Premium
Connecticut	758	21.6%	27.8	2.3%
Georgia	1,297	3.6%	3.7	0.3%
Maine	192	8.9%	1.1	0.3%
New Hampshire	281	38.8%	9.3	4.2%
New York	1,032	34.3%	37.4	0.9%
Virginia	1,124	4.9%	5.5	0.5%
East Subtotal	4,684	15.9%	84.9	1.0%
Indiana	2,870	13.8%	20.9	3.0%
Kentucky	4,749	6.4%	5.2	0.9%
Missouri	872	4.1%	2.9	0.6%
Ohio	2,074	4.8%	15.6	1.1%
Wisconsin	369	12.2%	4.8	2.0%
Central Subtotal	10,934	8.0%	49.5	1.4%
California	5,598	8.2%	113.3	2.1%
Colorado	557	7.7%	3.8	0.9%
Nevada	172	5.8%	1.2	1.3%
West Subtotal	6,327	8.1%	118.3	2.0%
Total	21,945	9.7%	252.7	1.4%

New rating rules for small employers were incorporated into this analysis. We restricted the allowable variance in the premium to a level comparable to that specified in “America’s Healthy Future Act of 2009”.

To provide implicit conservatism in our estimates, we did not include the impact of the anti-selection forces that would be at work in the post-reform employer market. We do anticipate an increase in the average costs for small employers as currently lower-risk employer groups drop group coverage and thereby raise the overall morbidity and risk-level of the remaining insured groups. This will serve to put upward pressure on our estimates as the impact is magnified over time.

Also, while we were able to account for contributions to health care savings accounts, we did not incorporate any dental or vision expenditures that many employers experience today. Again, this should add some conservatism to our figures, though we anticipate the impact of adding those coverages to be negligible.

There are cases where the tax would be triggered in markets where the rating rules are already more strict than the proposed Federal rating limits, such as New York. This market already employs full community rating for small employers, and yet, due to the richness of benefits in the state and the impact of a deteriorated risk pool from the anti-selection of community rating, a relatively significant tax is calculated for this market. The phase-in rules which allow for a higher threshold in this market will help to alleviate the pressure initially, though our model does take this into account.

## **New Health Insurer Annual \$6.7B Tax, Pharmaceutical Tax, Medical Device Tax**

### **Background**

Health care reform legislation introduces several new broad taxes and fees that will further drive up health insurance premiums:

- An annual fee on manufacturers and importers of branded drugs
- An annual fee on manufacturers and importers of medical devices
- An annual fee on health insurance providers

### **Analysis**

As the Congressional Budget Office noted in its September 22, 2009 letter titled “An Analysis of Premiums Under the Chairman’s Mark of America’s Healthy Future Act”, these fees and taxes represent new costs for affected companies and are expected to be passed on to purchasers. Ultimately, these taxes will be paid for by consumers in the form of higher health insurance premiums.

Also, under the amended version of the proposal, none of these new fees are to be considered deductible for U.S. income tax purposes. When translated into premium, the taxes must be increased to cover federal income taxes and state income tax or premium tax as applicable.

The annual fee on health insurance providers is \$6.7B that will be apportioned among insurers according to their market share. Using annual statement data, we’ve estimated WellPoint’s market share to be approximately 12%. Therefore, we would be assessed a fee of \$0.8B. To cover federal income, state income and premium taxes, the fee must be raised by almost 60% to \$1.3B. This alone would raise premiums in the fully-insured markets by 2.5%. If employers are not willing to raise their contributions to offset this amount, the percentage increase to employee contributions will be significantly greater for employer-sponsored coverage.

The fees on manufacturers and importers of branded drugs and medical devices total \$6.3B annually. Unlike the health insurance provider fee, these new fees will affect both fully-insured and self-insured consumers. Also, federal, state, and other governmental entities will not be excluded from the impacts of this tax. As a result, the impact to insured premiums is significantly diluted. We anticipate these fees would raise premiums by approximately 0.5%.

### **Health Insurance Exchange**

While the existence of a health insurance exchange and its impact on premium was considered for this analysis, we believe the assessment to fund the exchange and any resulting lower insurer administrative costs will roughly offset each other.

For example, a review of 5 WellPoint states determined that the average percent of premium attributable to sales accounts for 4% to 6% of premium in the small group market. The Massachusetts Connector—the health insurance exchange in Massachusetts—charges an assessment on coverage sold in the exchange that falls within this range to fund its operations—much of which is attributable to sales and marketing.

### **Cost-Shifting from Public to Private Coverage**

Similar to other analyses, we do believe that a higher proportion of services being paid by public coverage at lower reimbursement rates will result in an exacerbation of the cost shift from public to private coverage. However, as stated above, this analysis focused on elements that would directly impact premiums quickly post-reform.