A Report of The Heritage Center for Data Analysis

How Health Care Reform Will Affect Young Adults

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CDA10-02 January 27, 2010

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Abstract: *Both of the current House and Senate health care bills disproportionately burden younger, healthier Americans with higher insurance premiums. To ensure that these young people buy health insurance anyway, Congress has decided to nudge them into purchasing insurance by enforcing a penalty for those who fail to buy coverage. Heritage Foundation analysts estimate that many under age 35 will opt out of buying insurance altogether, choosing to pay the penalty instead. If younger workers do not join the risk pool, insurers will be forced to raise premiums even higher to cover higher-benefit payouts to older people. Either way, younger Americans will have less disposable income—which means they are able to buy and save less—a lose-lose situation.*

The House and Senate are locked in intense negotiations over the complex provisions in the two health care bills. Many of the provisions are now in flux, including the structure of the individual mandate, insurance rules, and subsidies. Although the bills are intended to expand coverage, many of the young Americans who are currently without coverage will remain uninsured. Analysis by the Heritage Foundation's Center for Data Analysis (CDA) suggests that roughly 93 percent of uninsured households under age 35 who face a penalty for remaining uninsured would rather pay the penalty than buy health insurance.

Both the House and Senate bills include the combination of modified community rating, which limits an insurer's ability to vary premiums by age, and guaranteed issue, which requires insurers to cover anyone who tries to purchase insurance. These provisions would disproportionately affect younger and healthier people by raising health insurance premiums to levels they would otherwise not pay. Moreover, if fewer young and healthy people buy coverage, the premiums for others will increase. So, to ensure participation by the young and healthy, the House and Senate offer income-based subsidies to help offset the cost of coverage and impose an individual mandate to require individuals to purchase coverage or pay a penalty. Unfortunately, trying to fix one flawed policy (the rating restrictions and guaranteed issue requirements) by adding another flawed policy (the mandate and costly subsidies) only makes the policy outcome even worse.

Additionally, the penalty and premium increases may have more far-reaching and negative consequences for a much greater portion of the economy. This is because the difference between what those in the under-35 age group spend today and what they will spend on the new higher premiums or the penalty tomorrow must come from either consumption in other sectors of the economy or from personal savings. If the difference comes from forgone consumption, the mandate may depress other areas of the economy by eliminating gains from trade. If the difference is paid in the form of decreased savings, this may have additional future implications for retirement and work decisions, as a failure to save in the present has a significant cost that is much greater than either the increase in premiums or the penalty.

THE BURDEN ON YOUNGER WORKERS

In its analysis of the Senate bill, the Congressional Budget Office (CBO) suggests that health insurance premiums for the non-group market

would increase significantly, while premiums for the group market would stay roughly the same relative to current law.[1] However, other groups have produced estimates showing larger premium increases, while even the CBO acknowledges that premiums could be much higher than it projects. The size of the premium increases will depend substantially on how many younger and healthier people buy insurance.

Many uninsured younger people have chosen to remain without insurance because they are in good health. Under the proposed Senate legislation, this group is prodded into insurance by a penalty—reaching $750 or 2 percent of their income, whichever amount is larger, in 2016—for failing to buy insurance.[2] However, the CDA finds that many of those under 35 will choose to pay the penalty instead of buying insurance. This will likely result in higher insurance premiums than projected, and will leave many young people worse off by making them at least $750 poorer.

Younger workers who buy insurance in the non-group market will be disproportionately affected by the current health care bills. As the CBO notes, younger people will pay more to subsidize older people through the use of age-rating bands, where the oldest people cannot be charged more than two times the rate charged to the youngest people under the House bill, and no more than three times under the Senate bill. Thus, this rating band means that the premiums of older, less healthy people will be subsidized by the premiums of younger, healthier people.

The higher premium faced by younger adults as the result of the age rating would cause a greater number of younger people to not purchase insurance than would otherwise have been the case if insurers were allowed to price plans appropriately by age. Currently, data from the recent Medical Expenditure Panel Survey suggests that roughly 36 percent of the uninsured between the ages of 18 and 25, and about 29 percent of the uninsured between 26 and 35, are offered insurance by their employer. However, if the price of insurance were to rise, even a greater number of younger, price-sensitive workers would likely turn down their employer's offer.

Both bills also include a subsidy to lower the price of insurance to entice people to purchase coverage in the government-run health insurance exchange. The Senate bill includes a subsidy for those with incomes up to 400 percent of the poverty level that steadily decreases with income. However, using data from the March 2009 Current Population Survey, CDA analysts estimate that this subsidy would cover only about one-third of the cost of an insurance plan purchased in the exchange by a single person under age 35.

As previously noted, the CBO finds that under the Senate bill, premiums in the non-group market will be 10 to 13 percent higher than under current law.[3] However, these premium increases assume that younger people will indeed enter both the non-group and group markets, helping hold down premiums. The CBO estimates that premiums for the non-group market will be reduced by 7 to 10 percent because younger and healthier workers will be involved.[4] However, our analysis suggests that these premium reductions may be exaggerated, since many young workers will likely decide to pay the penalty rather than buy insurance coverage.

MANY YOUNGER WORKERS WILL OPT OUT

As the analysis by the Center for Data Analysis found, many young people who are currently uninsured will pay the penalty rather than buy insurance. The CDA estimates that the mandate and subsidy structure in the Senate proposal, in combination with the 2:1 rating bands set in the House bill, will result in only 12 percent of single uninsured individuals under the age of 35 whose incomes are high enough to face the individual mandate penalty, and who are eligible to participate in the exchange, purchasing insurance. Likewise, only about one-fifth of those buying family plans who fall into the same group would purchase insurance under this scenario. Furthermore, less than 5

1. Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009, at *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf* (January 19, 2010).
2. Individuals with very low incomes (where the premium would be more than 8 percent of their family income) are exempt from the mandate to purchase health insurance.
3. CBO, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," p. 4.
4. *Ibid*., p. 6.

percent of households that are uninsured and do not qualify for the subsidies would buy insurance. A significant result of these astounding low take-up rates is that more than 93 percent of uninsured households that face the penalty would rather pay the penalty than buy insurance.

It is important to note that the premium estimates in the CDA analysis reflect the enactment of health reform legislation assuming the adoption of an age ratio of 2:1 as proposed in the House bill, with the mandated penalty for individuals who do not purchase insurance, and with the subsidy structure of the Senate bill.

CDA findings confirm other independent analysis of the similar provisions. A study by the Lewin Group finds that younger workers would pay higher premiums. A family headed by someone between the ages of 25 and 34 would face the steepest costs of increased health spending, averaging $287 more annually under the Senate proposal.[5] A family headed by someone between the ages of 35 and 44 would spend $166 more annually on health care. These costs could be even higher if younger, healthier workers opt out of the insurance system. Workers who are already offered insurance, but choose to remain uninsured, will be even less likely to buy insurance, given the higher costs.

An alternative report by the consulting group Oliver Wyman finds that younger workers would be significantly less likely to purchase health insurance due to insufficient subsidies and a low mandate penalty[6] relative to the price of purchasing insurance. Oliver Wyman's report, prepared for Blue Cross and Blue Shield, estimates that overall premiums would increase by 54 percent in the non-group market since many young people will opt out. Young workers will quickly determine that they would rather pay the smaller mandate penalty than the spiraling insurance costs.

Another report by the RAND Corporation finds that a mandate with a penalty equal to 80 percent of the cost of insurance would reduce the ranks of the uninsured by about 22 million.[7] However, for single individuals under age 25 who will be participating in the exchange, the mandate in the Senate bill is less than half of the value of an individual premium. For those between the ages of 26 and 35 and participating in the exchange, the mandate is roughly 25 percent of the value of single coverage. Thus, a lower mandate will also result in a lower take-up rate as younger, healthier workers will choose to pay the penalty rather than face high premiums.

CONCLUSION

The insurance pool will quickly become less healthy as fewer younger adults purchase insurance. Older individuals, who generally have more health issues than younger people, will continue to buy insurance, raising premium costs and driving even more healthy individuals out of the pool. This quickly becomes a vicious downward cycle as insurance costs increase, which will drive out of the market more and more of those who are less costly to insure. Insurers will have no choice but to raise premiums, as they face paying out far more in benefits to cover a sicker pool, or leave the market altogether.

Younger workers will have less disposable income as they are forced to pay more for either insurance or a new tax under the mandate. In fact, the CDA estimates that many of those under 35 will opt out of buying insurance altogether, and instead pay the penalty rather than buy a more expensive insurance plan. If younger workers do not join the risk pool, insurers will be forced to raise premiums to cover higher-benefit payouts to older people. The mandate will impose significant costs on younger individuals who will be forced to either forgo saving or consumption.

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5. The Lewin Group "Comparing Costs and Coverage Impacts of the House and Senate Leadership Health Reform Bills: Long-Term Costs for Governments, Employers, Families and Providers," December 9, 2009, at *http://www.lewin.com/content/publications/Lewin_Senate_and_House_Bill_Compared.pdf* (January 19, 2010).
6. Jason Grau and Kurt Giesa, "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets," December 1, 2009, at *http://www.oliverwyman.com/ow/pdf_files/YBS009-11-28_PPACA120309.pdf* (January 19, 2010).
7. RAND, "RAND Compare: Effects of Individual Mandate Policy Options," December 11, 2009, at *http://www.randcompare.org/analysis/mechanism/individual_mandate* (January 19, 2010).

METHODOLOGY

The primary analysis in this paper uses data from the 2009 March Supplement of the Current Population Survey (CPS), the 2008 Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC), and the 2006 Household Component of the Medical Expenditure Panel Survey (MEPS-HC). All of the population figures are based on data from the CPS, while access rates to employer-sponsored health insurance for the uninsured are calculated using the MEPS-HC. The estimated average health insurance premiums in the absence of reform were calculated using data from the MEPS-IC, while the CDA uses premiums calculated by the Urban Institute to simulate a scenario where insurance reform legislation is enacted.[8] The take-up rates for health insurance are based on estimates produced by the Lewin Group.[9] The penalty for not complying with the individual mandate is assumed to be $750 in 2016, proposed in the Senate's newest health care bill, H.R. 3590.

8. Linda J. Blumberg, Matthew Buettgens, and Bowen Garrett, "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens," Urban Institute, October 2009, at *http://www.urban.org/publications/411970.html* (January 19, 2010).
9. The Lewin Group, "Summary Description of the Health Benefits Simulation Model (HBSM)," 2007.