

Health Insurance Premiums:
Past High Costs Will Become the Present and Future Without Health Reform
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Introduction

As Americans learn about the new health care law, a key question is: what will the Affordable Care Act mean for health insurance premiums paid by consumers and employers? This report examines the past, present, and future regarding the likely effects of the law on premiums – along with what might happen without it.

From 1999 to 2009, health insurance premiums skyrocketed while Americans' wages and cost of living grew at a much slower rate. Premiums more than doubled, rising by over \$7,500 for the average family with employer-sponsored insurance. The cost of an employer-based family coverage plan rose from 12 to 22 percent of family income over the decade. Health insurance costs jumped as a percentage of private sector compensation from 5.4 to 7.3 percent from 1999 to 2009, eroding workers' wages. Small businesses were particularly hard hit. The proportion of small employers offering health insurance dropped from 65 to 59 percent between 1999 and 2009. Part of the reason for rising costs has been reduced competition: these increases occurred at a time of tremendous consolidation in the insurance markets, both national and local.

The Affordable Care Act increases insurance company accountability by supporting States' review of premium increases, setting standards for the amount of premiums spent on benefits versus overhead (i.e., medical loss ratios), and posting insurance price information for transparency. A Small Business Health Care Tax Credit, reinsurance for early retirees, and premium assistance for uninsured people with pre-existing conditions have already provided targeted relief for millions of insured and uninsured Americans, and these changes are making a difference. Preliminary evidence suggests that rate increases for 2011 may be lower than in previous years. In addition, roughly 16.6 million workers are eligible for the tax credits which the Congressional Budget Office values at \$6 billion for 2010 and 2011. Several insurers are reporting a rise in small businesses offering coverage. Furthermore, tens of thousands of early retirees and thousands of uninsured people with pre-existing conditions have already gotten relief from high and often unaffordable premiums as a result of the new law's assistance.

In 2014, annual premiums are projected to fall compared to what they would have been without the Affordable Care Act. These savings could be as much as \$2,300 for middle-income families purchasing through Exchanges. A low-income family of four with an income of \$33,525 could save as much as \$9,900 in premiums and \$5,000 in cost sharing due to the extra help from new tax credits and cost sharing assistance. Small businesses, on average, could save up to \$350 per family policy due to lower costs in the Exchanges and could get tax credits for up to 50 percent of their premiums. Even large businesses will likely see lower premiums of \$200 per family due to an increase in healthier enrollees. After 2014, analysts predict that premium growth should slow because of the Affordable Care Act, adding another \$2,000 to family savings by 2019.

Without health reform, American consumers and businesses would face higher premiums, fewer insurance choices, and rapidly rising health care costs.

1999 – 2009: Relentless Health Insurance Premium Hikes and Fewer Choices

Premium growth in employer-based insurance: Rising health care costs have been felt acutely in both the employer-based and individual insurance markets. Total premiums for families with employer-sponsored insurance doubled from 1999 to 2009, from \$5,736 to \$13,375 – an increase of over \$7,500.¹ Even taking into account inflation, family employer-sponsored insurance premiums in 2009 were 1.8 times higher than they were in 1999.² To put this in context, total family premiums for employer-sponsored coverage rose from 12 to 22 percent of median income between 1999 and 2009.³ Workers signing up for single coverage experienced premium hikes similar to those who chose family coverage: premiums rose from \$2,268 in 1999 to \$4,824 in 2009.⁴ For private industry in the United States, health insurance costs contributed to the erosion of workers' take-home pay, measured as a percentage of compensation. From 1999 to 2009, businesses' health insurance costs rose from 5.4 to 7.3 percent of compensation, while compensation in wages and salaries dropped from 73.0 to 70.8 percent.⁵

Small businesses particularly hard hit: Small businesses face particular challenges from high and rising rates since they pay on average 18 percent more for the same health plan as would a large business.⁶ Broker fees can add as much as 10 percent to premiums⁷ and other administrative costs are as much as three times higher than those in the large group insurance market.⁸ Insurance companies are also allowed to increase a business' premiums if even one worker falls ill. As a result, between 1999 and 2009, the percentage of small businesses with fewer than 200 workers offering health insurance dropped from 65 percent to 59 percent⁹ and the percentage of small business employees enrolled in a health insurance plan offered by their employer dropped from 43 to 36 percent.¹⁰ And half the workers in small firms that do not offer health benefits remain uninsured.¹¹

Individual market insurance trends: Individual market premiums have also risen rapidly. A review of individual insurance plan rate filings in the subset of States that make these data available found that 50 percent to 72 percent of rates filed for 2008 through 2010, accounting for up to three quarters of enrollees in the individual market, include premium increases above 10 percent.¹² One recent survey found that 77 percent of people purchasing insurance in the individual market had been told their premiums would go up by an average of 20 percent.¹³ These rate increases appear to have contributed to the stagnation in growth in this market: at best, 5 percent of non-elderly Americans were insured through this market in both 1999 and 2009; data from other surveys show enrollment in this market declining over the decade.¹⁴ A recent study found that almost 75 percent of individuals looking for coverage on the individual market never bought a plan, with 61 percent of those citing premium costs as the primary reason.¹⁵

Another reason why the size of the individual insurance market has been limited is insurers' practice of screening out applicants with pre-existing conditions.¹⁶ In the non-group or individual market, prior to the Affordable Care Act, insurers in most States have been permitted to deny coverage, charge higher premiums, or carve out certain benefits like drugs prescribed for the condition an individual has. One national survey estimated that, between 2004 and 2007, 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were discriminated against because of a pre-existing condition.¹⁷

A recent analysis by the Department of Health and Human Services estimated that as many as 129 million non-elderly Americans have some type of pre-existing condition that could limit their health insurance choices depending on their circumstances.¹⁸ The same report found that 15 to 30 percent of people under age 65 in perfectly good health today are likely to develop a pre-existing condition over the next eight years.

Fewer insurance choices: As businesses and families have struggled with rising health care costs, the insurance industry has become increasingly concentrated. And research shows that markets with fewer insurers have higher premiums. From 1998 to 2006, consolidation of health insurers alone led to a premium increase of approximately \$34 billion a year, or \$200 per person.¹⁹ In 2009, 23 of 43 States surveyed had over 70 percent of their individual insurance market dominated two large insurers, up from 18 States the year before.²⁰ Fully 99 percent of major metropolitan markets surveyed were “highly concentrated” in 2006, meaning that most of the market was dominated by just a few insurers. This was a significant jump from 68 percent in 1998.²¹ The market share of the four largest firms has grown from just under 60 percent in 1998 to over 70 percent in 2005.²² Since 1996, close to \$90 billion has been spent by health insurers on acquisitions of other health insurers.²³

Little transparency or oversight: Competition has been hindered not just by increased consolidation but by the complexity and lack of transparency of the products. Prior to the Affordable Care Act, there was no standardized format to provide consumers with easy comparison shopping information. Consumers and small businesses in most States could not even get basic information on the performance of health insurance policies, such as how often they pay claims, how frequently they cancel coverage, and the size of their provider networks.

This lack of information was compounded by sporadic oversight. States have been responsible for regulating the insurance market, including the review of proposed premium increases and the conduct of insurers. In 2010, however, 14 States required no review of individual market rate increases at all, an additional 3 States reviewed only the proposed rate increases of HMOs, and in all but 5 of the remaining States, rates were deemed approved after 30 to 90 days if the State did not affirmatively approve the increase.²⁴ In addition, before the passage of the Affordable Care Act, 19 States did not have any laws regarding medical loss ratios, or the percentage of premium dollars spent on medical care and health care quality improvement, rather than on administrative costs. Yet, over 20 percent of consumers who purchased coverage in the individual market were in plans that spent more than 30 cents of every premium dollar on administrative costs. An additional 25 percent of consumers in this market were in plans that spent between 25 and 30 cents of every premium dollar on administrative costs. And in some extreme cases, insurance plans spent more than 50 percent of every premium dollar on administrative costs.²⁵

2010-2011: Affordable Care Act Brings Transparency and Accountability

Immediate policies to lower premiums: The Affordable Care Act, which became law on March 23, 2010, has started to put consumers back in charge of their health care by requiring insurance companies to be more transparent and accountable for their costs and actions, ending many of the worst insurance industry abuses, improving the quality of care, and lowering costs. It includes several provisions that tackle premium costs immediately, including:

- **Rate review grants and standards:** In August 2010, 45 States and the District of Columbia each received \$1 million grants to develop or make improvements to their existing rate review and approval practices, strengthening their processes and oversight capacities. States have already used these funds to hire staff, increase data reporting, and enhance their information technology. On December 21, 2010, HHS posted a proposed regulation regarding standards for rate review. The proposed regulation, anticipated to be finalized this summer, suggests that proposed rate increases above 10 percent in 2011 be posted and reviewed to assess whether they are unreasonable. This stepped-up, uniform, and public scrutiny of rates will both increase insurer accountability and empower consumers when shopping for insurance.
- **Medical loss ratio minimums and rebates:** On November 22, 2010, HHS posted the medical loss ratio rule which, consistent with recommendations by the National Association of Insurance Commissioners (NAIC), requires health insurers to spend 80 to 85 percent of consumers' premiums on direct care for patients and efforts to improve care quality. If they fail to do so, insurers must either lower their premiums or provide a rebate to consumers and employers.
- **Transparency through a new web portal called HealthCare.gov:** Launched on July 1, 2010, www.HealthCare.gov helps consumers see all insurance options, private and public, that are available to them in one place. Consumers can compare different plans' pricing and benefit information, which helps keep prices low through increased competition and transparency. To date, more than 4 million people have visited this website. The site is also available in Spanish at www.CuidadoDeSalud.gov.
- **Tax credits for small businesses:** Starting in 2010, the new law provided a Small Businesses Health Care Tax Credit that covers up to 35 percent of an employer's insurance costs. These tax credits allow small businesses to expand and compete. The Administration notified more than four million small business owners and non-profit organizations that they may be eligible to receive these new tax credits.
- **Reinsurance for health plans that cover early retirees:** The law provided \$5 billion for reinsurance payments for health benefit claims of retirees age 55 and older who are not yet eligible for Medicare, and for their eligible spouses, including surviving spouses, and dependents. The amount of the reimbursement to the employer or union is 80 percent of an individual's medical claims costs above \$15,000 and below \$90,000. Approved employers and unions can use these funds to provide premium relief and other health care cost relief to their retirees and workers and their families, to offset increases in their own health care premiums or costs, or for a combination of these purposes.
- **Accessible, affordable insurance for uninsured Americans with pre-existing conditions:** The law also provided \$5 billion to make health insurance affordable for many uninsured Americans with pre-existing conditions. In every State, there is now a Pre-existing Insurance Plan option for such individuals to purchase health coverage that has no rate-ups, waiting lists, benefit carve-outs or denials based on an applicant's pre-existing condition. This

program is a temporary program to bridge to 2014 when insurers will no longer be permitted to discriminate against any American based on a pre-existing condition.

Early Results On Costs Are Promising

The implementation of the Affordable Care Act has coincided with a significant slow-down in health spending growth. National health care spending increased by only 4 percent in 2009 compared to 6.9 percent five years earlier.²⁶ In 2010, family premiums in the employer-based market increased by only 3 percent compared to 11.2 percent in 2004.²⁷

Rate review efforts stepped up: Preliminary results indicate the new tools offered by the Affordable Care Act appear to be helping to slow down premium growth. In Connecticut, for instance, existing State authority bolstered by Federal resources from the Act led the State Insurance Commissioner to reject a proposed 19.9 percent premium increase by the State's largest insurer that would have raised costs for 48,000 consumers. This year, the Connecticut legislature is considering increasing its rate review authority in part because of the law's new resources and standards.²⁸ Heightened scrutiny of rate increases in California has led to increased review of a proposed 59 percent increase in one company's rates.²⁹ In Iowa, the Commissioner disapproved a 20 percent proposed increase, reduced a 60 percent proposed increase to 16.5 percent, and is using new authority to hold public hearings on proposed increases that exceed health care inflation.³⁰

Medical loss ratio likely to lead to rebates: This year, health insurers must either meet the new minimum loss ratio requirements by spending at least 80 percent of premiums on care and quality improvement or offer customers rebates in 2012. Already, 75 million Americans in plans covered by this rule are benefiting from insurers' efforts to lower administrative costs and increase the value of their coverage. We estimate, in the small group market, one million enrollees could receive rebates averaging \$312 per enrollee. In the large group market, another million enrollees could receive average rebates of \$166 per enrollee. And roughly 3 million Americans in individual market plans will receive rebates of approximately \$164 per enrollee.³¹

Patient protections and improved benefits have had minimal impact on premiums: According to a recent study by Hewitt Associates, the most immediate insurance reforms of the new law — including the extension of dependent coverage to age 26 for many young adults, and the elimination or reduction of certain lifetime and annual limits on benefits — will add only 1 to 2 percent of the projected rate increase for 2011.³² Another survey by Mercer of more than 1,000 employers found the Affordable Care Act provisions would increase employer costs by 2 percent.³³ In Ohio, the chief policy officer at the Ohio Department of Insurance projected that the health reform provisions that took effect in 2010 would contribute “only marginally” to the total costs of health plans offered to workers.³⁴ And one investment analyst recently wrote: “Our broad theme for our 2011 outlook is one of stability and clarity that has not been seen in managed care since 2007.”³⁵

Benefits to small businesses: National data are not yet available, but one study estimates that approximately 16.6 million workers are in firms that qualify for the Small Business Health Care Tax Credit.³⁶ The Congressional Budget Office estimated roughly \$6 billion in these tax credits

will be provided in 2010 and 2011.³⁷ To illustrate its savings, a firm with 10 workers who are earning an average of \$20,000 could receive credits of \$35,000.³⁸ There are signs that insurance sales to small businesses are increasing. Blue Cross/Blue Shield of Kansas City, which reached out to local employers to make sure they were aware of the credit, is reporting a 58 percent increase in the number of small businesses buying insurance since April 2010. This translates into 400 new small businesses buying coverage for 9,000 employees in the area.³⁹ UnitedHealth Group enrolled 75,000 new customers in firms with fewer than 50 employees. Coventry Health Care in Maryland signed contracts to cover 115,000 new workers, an 8 percent increase.⁴⁰ One small business owner and former head of a local Chamber of Commerce said of the tax credit, “Now that I know I can afford health care for my company, I’m more willing to bring on more employees, and they will be better employees, too, because they’ll want to work for a company that offers health care.”⁴¹

Lower premiums for some of the people who need coverage the most: Two new programs created by the law, the Early Retiree Reinsurance Program and the Pre-existing Condition Insurance Plan, have reduced premiums and health care costs for thousands of Americans and businesses. More than 5,000 businesses, unions, States, local governments, and non-profit organizations in all 50 States are participating in the Early Retiree Reinsurance Program to help keep coverage available to tens of thousands retired workers ages 55 to 64 and their families. Plans receiving the reinsurance can use it to lower premiums, lower cost sharing, and/or lower their own costs in an effort to sustain coverage for early retirees. And thousands of previously uninsured Americans with pre-existing conditions have taken advantage of the premiums offered at standard rates offered for the Pre-existing Condition Insurance Plan. Prior to this coverage option, in many States, such individuals could be charged two to five times as much as people of average health for the same individual market policy.

The Future: Lower Premiums, More Choices, and Lower Growth, Starting in 2014

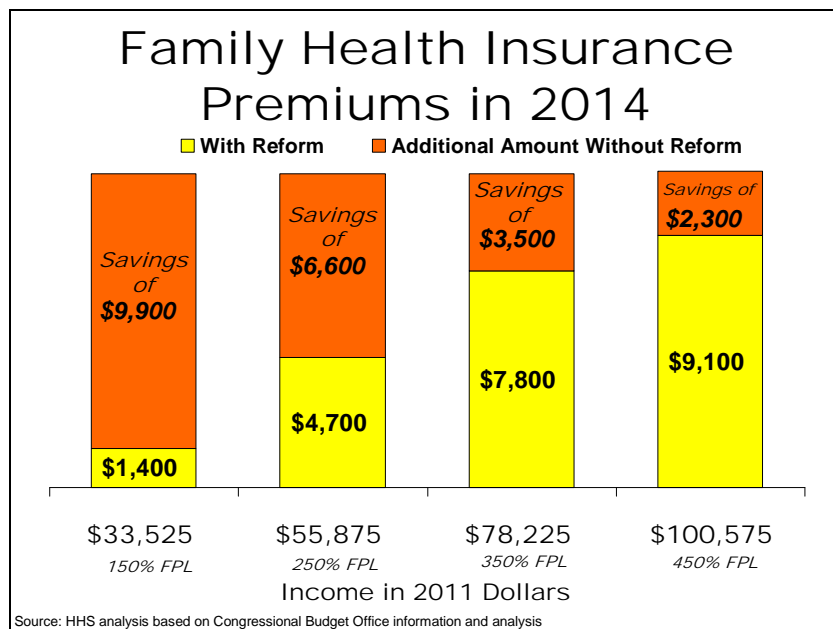
Critical new policies to lower premiums: The Affordable Care Act implements a set of policies in 2014 aimed at removing some of the reasons why health insurance is costly and increasing competition to drive down costs. These include:

- **Expanding insurance pools:** State-based Exchanges will begin operations to give individuals and small businesses pooled purchasing power to get private health insurance at lower premiums. Premium tax credits and cost sharing reductions will make that coverage affordable for low-income individuals, families, and workers in certain small businesses. In addition, due to the individual responsibility provisions, more, healthy people will purchase insurance, further spreading the cost of care for those who need it – both in the Exchanges and for large businesses.⁴²
- **Reducing insurance overhead:** Exchanges will make it easier and less costly to purchase health insurance, offering clear and standard information on plans to consumers. In addition, the cost of medical underwriting will go away as insurers’ ability to charge more or cover less for people with pre-existing conditions will be completely prohibited.

- Increasing competition and choice:** The Affordable Care Act ensures that individuals in all parts of the United States have a choice of health insurance plans. At least two “multi-state plans” that offer coverage nationwide will be available. Grants and loans are available to create non-profit co-op plans as well. These new choices complement the design of the Exchanges, which will encourage new private health plans to develop and compete given that there will be a level playing field of competition based on price, quality, and services offered.

Savings for individuals and families: The Congressional Budget Office (CBO) produced estimates of the impact of the Affordable Care Act on premiums.⁴³ For people purchasing non-group coverage through the Exchanges, it estimated savings of 7 to 10 percent resulting from the increase in the size of the insurance pool as well as the nature of the new enrollees, who, in light of the premium tax credits and the individual responsibility provisions, are likely to be healthier than existing enrollees. An additional 7 to 10 percent savings would result from providing the same set of services to the same group of enrollees – primarily because of the new rules in the market such as eliminating insurance underwriting. CBO also credits some of the savings to increased choices and competition. Together, these savings range from 14 to 20 percent. CBO also assumed that individuals and families would have, on average, coverage that is more comprehensive than what they have now, meaning that the savings would offset by higher premiums due to better coverage. It is important to note that this benefit enhancement is a choice, not a requirement.

Assuming 20 percent premium savings, families purchasing insurance through Exchanges could save as much as \$2,300 per year and individuals could save up to \$800 in 2014 compared to individual market coverage with the same level of benefits without the law. With premium tax credits, the savings from health reform range from \$9,900 for a family of four with income of \$33,525 to \$3,500 for a family with an income of \$78,225 (see Figure and Methodology).



Premium savings are only part of picture for low-income individuals and families. They also may qualify for reduced cost sharing under the Affordable Care Act. For the same families with incomes of \$33,525 and \$78,225, this could add \$5,000 and \$1,500 respectively to the premium savings (see Table in Methodology).

Savings for businesses: CBO estimates that premiums in the small group market could be up to 2 percent lower than they would have been without the Affordable Care Act. Assuming family premiums for small businesses without the law of \$17,200, this translates into roughly \$350 per family.⁴⁴ Savings will come primarily from insurance reforms and the competitive nature of the Exchanges. In addition, small businesses will have the option to purchase a low-cost “bronze” plan whose premiums could be \$2,500 lower for singles, \$6,100 lower for families, in 2014.⁴⁵ Moreover, the Small Business Health Care Tax Credit increases in 2014, paying 50 percent of small businesses’ premium costs. For example, a firm with 10 workers who earn an average of \$20,000 a year could receive credits for all of its workers that total \$50,000 in 2014.⁴⁶

Large businesses will also see a premium reduction of up to 3 percent according to CBO, primarily because of increased enrollment of healthy workers and dependents. While the savings are estimated by CBO to be about \$100 per worker and \$200 per family, for large companies this adds up to millions in savings.⁴⁷

Savings in the long run: A high priority of the Affordable Care Act is not just lowering premiums, but slowing their growth over time. As such, a number of its policies aim to keep premiums affordable, including:

- **Lowering uncompensated care and administrative costs:** By insuring over 30 million Americans not now covered, the new law lowers the “hidden tax” of uncompensated care that often gets passed along to already-insured people. The law also accelerates, standardizes, and regularly updates operating rules for electronic transactions and requires health plans to certify compliance. This will make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.
- **Limiting the incentive for high-cost group health insurance plans:** In order to encourage insurance plans to target efficient plan designs and reduce administrative costs, an excise tax on insurance companies and plan administrators will start in 2018 for any health coverage plan that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage (subject to phase-ins and exemptions).
- **Building rate review into Exchanges:** The law requires each Exchange to consider excessive premium increases and the reasonableness of proposed rate hikes when determining a health plan’s participation in the Exchange.
- **Targeting areas of underlying cost growth:** The law has numerous policies to test and implement ideas to coordinate care, develop innovative payment systems, reward quality and prevent medical errors, reduce waste, fraud and abuse, and empower patients and providers with information to best guide their treatments. It also makes a significant investment in evidence-based prevention. While quantifying savings in the short run is

difficult, there are long-run benefits to lessening preventable illness. The effects of these policies will directly and indirectly slow private premium growth.

Independent analysts suggest that the combination of these policies could slow the growth of health spending by 1 percentage point a year starting in 2014.⁴⁸ By 2019, this could save 9 percent or \$2,000 for a family policy, in addition to the savings that come from the policies implemented in 2014.

Health Insurance Premiums Would be Higher Without Health Reform

Without the Affordable Care Act, health insurance premiums would be higher in the short and long run:

- **In 2011**, there would be:
 - A potential return to double-digit premium increases due to the loss of heightened rate review and transparency;
 - No premium rebates of \$164 to \$312 per enrollee for roughly 5 million Americans in plans with low medical loss ratios;
 - Fewer workers in small businesses covered due to the loss of the new Small Business Health Care Tax Credit which provides an estimated \$6 billion in premium relief in 2010 to 2011;
 - Tens of thousands of early retirees without the premium relief and security of the reinsurance program; and
 - Thousands of uninsured Americans unable to access affordable premiums in the Pre-existing Condition Insurance Plan.

- **In 2014**, there would be:
 - Increased premiums payments in the individual market of up to 20 percent or \$2,300 for families and \$800 for individuals;
 - The loss of a tax credits as well as Exchange savings for low-income families that could be as much as \$9,900 for a family of four with income of \$33,525. This same family would also lose access to cost sharing assistance that, on average, is valued at \$5,000;
 - Increased premiums for small businesses of up to \$350 per family as well as the loss of access to a 50 percent tax credit for small, low-wage firms that would offset the costs they incur in covering their employees; and

- Increased premiums for large businesses of up to \$200 per family due to the continued risk selection among their workers and families.
- **In 2019**, the failure to slow the growth of premiums could add another \$2,000 to the cost of a family policy.

METHDOLOGY

The table below uses CBO data to illustrate the savings that could be achieved under health reform in 2014. It uses the CBO single premium data for 2016, deflated to 2014 using its last public estimate of private premium growth (6 percent). Family premiums are calculated by multiplying the single premium by 2.7, the standard ratio of family to single premiums (CBO assumes that the composition of a family policy will change under the new law). It then applies the maximum savings for the individual market of 20 percent, assuming that individuals do not decide to purchase better coverage. The tax credits are calculated by applying the maximum premium payment in the law to the 2011 income (using the latest poverty thresholds) inflated by 1.7 percent (CBO's August 2010 projection for 2012-2014). Premiums vary by age, region and other factors, so these estimates are illustrative.

The cost sharing estimates were calculated by taking the average out-of-pocket spending for a silver plan in 2016 – \$1,900 for an individual and \$5,000 for a family according to CBO – and deflating to 2014 assuming 6 percent health cost growth (see above). Assuming a linear relationship between the actuarial value of a silver plan (70 percent) and the average out-of-pocket cost sharing, the reduced cost sharing amounts were calculated using the schedule in the law for individuals and families at different income brackets. This was subtracted from the average out-of-pocket costs for a bronze plan to assess the savings.

The potential premium effects in the text and chart are rounded to the nearest \$100. Note: the premium effects shown here differ from earlier estimates from HHS due to the January 20, 2011 update of the poverty guidelines.

Illustrative Health Insurance Premiums and Cost Sharing under Health Insurance Reform

Single Person								
2011 Income		2014 Premium	2014 Avg.	2014 Premium	Affordability	Premium	Premium Savings	Cost Sharing Savings
Annual \$	% of Poverty	Without Reform ¹	Cost Sharing ²	With Reform ³	Credit ⁴	Person Pays	With Reform	With Reform
\$14,702	135%	\$4,196	\$2,250	\$3,357	\$2,877	\$479	\$3,716	\$1,915
\$16,335	150%	\$4,196	\$2,250	\$3,357	\$2,669	\$687	\$3,508	\$1,915
\$21,780	200%	\$4,196	\$2,250	\$3,357	\$1,913	\$1,443	\$2,752	\$1,520
\$27,225	250%	\$4,196	\$2,250	\$3,357	\$1,051	\$2,305	\$1,890	\$730
\$32,670	300%	\$4,196	\$2,250	\$3,357	\$92	\$3,265	\$931	\$560
\$38,115	350%	\$4,196	\$2,250	\$3,357	\$0	\$3,357	\$839	\$560
\$43,560	400%	\$4,196	\$2,250	\$3,357	\$0	\$3,357	\$839	\$560
\$43,669	401%	\$4,196	\$2,250	\$3,357	\$0	\$3,357	\$839	-

Family								
2011 Income		2014 Premium	2014 Avg.	2014 Premium	Affordability	Premium	Premium Savings	Cost Sharing Savings
Annual \$	% of Poverty	Without Reform ¹	Cost Sharing ²	With Reform ³	Credit ⁴	Family Pays	With Reform	With Reform
\$30,173	135%	\$11,328	\$5,930	\$9,063	\$8,079	\$984	\$10,345	\$5,040
\$33,525	150%	\$11,328	\$5,930	\$9,063	\$7,652	\$1,411	\$9,918	\$5,040
\$44,700	200%	\$11,328	\$5,930	\$9,063	\$6,101	\$2,962	\$8,366	\$4,000
\$55,875	250%	\$11,328	\$5,930	\$9,063	\$4,331	\$4,731	\$6,597	\$1,930
\$67,050	300%	\$11,328	\$5,930	\$9,063	\$2,363	\$6,700	\$4,628	\$1,480
\$78,225	350%	\$11,328	\$5,930	\$9,063	\$1,246	\$7,817	\$3,512	\$1,480
\$89,400	400%	\$11,328	\$5,930	\$9,063	\$129	\$8,934	\$2,395	\$1,480
\$89,624	401%	\$11,328	\$5,930	\$9,063	\$0	\$9,063	\$2,266	-

Source: DHHS

1. CBO 11/30/09 estimate of prior law national average individual market single premium (\$5,500), deflated to 2014 assuming 6% annual premium growth and adjusted pro-rata for a plan with an actuarial value of 60%. Family premium is the single premium multiplied by a family factor of 2.7
2. CBO 11/30/09 estimate of average cost sharing under reform (\$1,900 / \$5,200), deflated to 2014 assuming 6% annual health cost growth, pro-rated for a plan with an actuarial value of 60%.
3. Assumes CBO 11/30/09 gross savings of 20%, not counting the premium cost of buying up benefits.
4. Income inflated to 2014 assuming general inflation of 1.7% per year (CBO, August 2010)

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