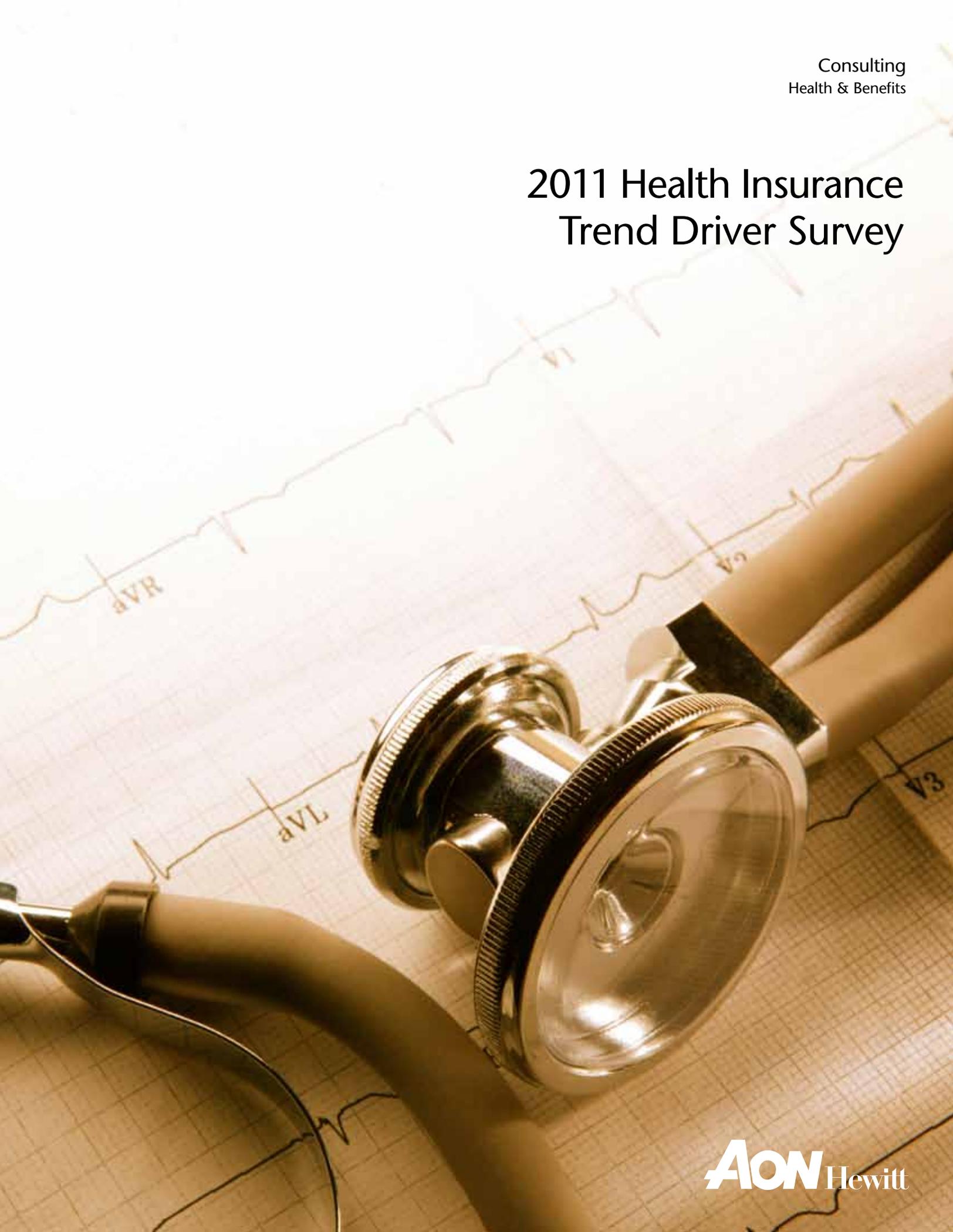


Consulting
Health & Benefits

2011 Health Insurance Trend Driver Survey



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Introduction

With the recent debates concerning the passage and implementation of the new health care reform law, health care costs have received increased public attention. One of the most important issues of concern is the rate at which health care costs are increasing. Health care trend is a key area of concern for the public, policy makers, and employers of all sizes. The elevated focus on health care trend will continue – and almost certainly increase – over the next few years as various components of the Patient Protection and Affordable Care Act (PPACA) are implemented. Changes will be implemented that will impact the size of the insured population and the benefits they receive, while health insurers will be required to publicly disclose additional details about premium increases. As Health and Human Services (HHS) has stated, the rate review regulations “will bring new transparency and scrutiny to health insurance rate increases.”

In an effort to increase understanding of the forces driving health care trend, Aon Hewitt conducted a survey of health insurance plans and is issuing the following report. The purpose of this report is twofold. First, the report will provide a general framework for looking at the health care trends and the relationship between trends and premium increases. Second, information collected from insurance plans regarding their expectations for the overall level of health care cost increases as well as the components driving these increases will be presented.

Using this framework, the report will individually discuss the impacts of core health care trend, changes in the covered population, fixed cost-sharing effects (e.g., deductible leveraging), and benefit changes driven by PPACA on premium increases. Beyond these global factors, several additional factors can impact premium increases in specific situations. Due to the highly individual nature of these additional factors, they will be discussed only briefly in the report.

In presenting survey responses, the report will focus on the variability of responses, both across lines of business and within a line of business. As the actual data collected from insurers indicates, there is a large amount of variation in certain trend components. For example, overall average projected increases due to PPACA were reported to be 1.5% for 2011. However, by line of business, projected increases varied from a weighted average total of 4.7% for individual policies to 0.8% for large group policies. There was further variation within each line of business. This perspective on variability of trend components will be important when attempting to understand specific premium increases.

Comparison to Other Surveys

Several other surveys of health care trend exist today – including the annual Aon Hewitt *Health Care Trend Survey* as well as surveys published by other industry experts. These surveys are often focused on a specific application, such as average premium increases that employers have experienced. As such, these surveys often examine a single measure of health care cost increases without the need to focus on the underlying components driving cost increases or the variability in potential trend. The measure of health care trend among these surveys often differs and can lead to confusion in public discourse over health care trend. For example, certain surveys report a trend that is based only on expected medical cost and utilization changes. Other surveys report a trend that represents premium increases net of the impact of discretionary benefit design changes. Such differences can make trend comparisons difficult.

The Aon Hewitt *2011 Health Insurance Trend Driver Survey* takes a broader look at trend and the relationship between trend and premium increases. To provide this broader view, the survey focuses on the following:

- The division of trends and premium increases into underlying components in order to provide a complete view of increases. This division includes what we define as “core trend,” as well as several other components that factor into premium increases.
- General variations between rate increase components across lines of business (individual, small group, and large group). These programs can vary significantly in terms of their marketing, plan design, underwriting, and membership. Some of the main points of difference include:
 - Individual health insurance policies are medically underwritten and premiums in most states can vary based on an individual’s health status or other demographic factors, unlike group health plans. These programs will undergo major changes because of health care reform.
 - Small group policies are typically subject to specific state regulatory requirements that affect pricing, underwriting, policy issue, and reporting. Small employer groups are often more likely to be directly impacted by changing economic conditions and they are likely to adjust their health insurance programs accordingly.
 - Large group policies may vary substantially in plan design and rating characteristics, reflecting the desire of larger employers to take a direct role in the design and management of their health benefit plans. Health care reform is expected to impact these policies less than individual or small group policies.

- Additional variability in rate increase components that occurs within lines of business. The trends experienced by different health plans can vary widely across different lines of business and from year to year. Some of the primary reasons for these differences in health care trends may include:
 - Regional differences in the underlying cost of health care services, attributable both to differences in the price of services and the delivery of health care services;
 - Economic changes that may influence the behavior of individuals seeking health care treatment, including the level of health care benefits provided by employers and the availability of and prices charged by health care providers; and
 - Differences in plans, such as provider networks, coverage of expenses, and the scope and effectiveness of health management programs.

About the Survey The 2011 Aon Hewitt *2011 Health Insurance Trend Driver Survey* was designed to provide a close examination of the factors that are driving the increase in health care costs. The public debate over health care reform has resulted in considerable confusion about the relationship between health care trends and the overall level of health insurance premium increases. In part, this may be due to the fact that the term “health care trend” is used in widely different ways by different speakers. For purposes of this survey, we define core health care trend in the following manner:

Core health care trend is the annual rate of change in the underlying cost and utilization of health care services, excluding the impact of benefit design changes (whether voluntary or required by legislation) and changes in the underlying makeup of the covered group.

Core trend, then, provides a fundamental building block for premium increases, but cannot fully explain premium increases. Various other factors, including covered population changes and regulatory changes, are important components of premium increases.

For purposes of this survey, Aon Hewitt asked health insurance plans to identify past and projected core health care trends and additional components of rate increases separately for three lines of business: individual insurance, small group insurance plans, and large employer programs.

We requested both recent trend experience from 2008 through 2010 and projected trends for 2011 and 2012. The survey was conducted in September 2010 and gathered information from 26 health plans, which provided information for health insurance programs covering over 32 million insured individuals through both employer-based medical plans and individually purchased insurance policies. Because data was generally collected during 2010, the 2010 amounts provided represent a blend of actual partial-year experience and expectations for the remainder of the year. The insured population represented by the health plans in the survey is broadly spread across the country and across different plan designs.

The data from the survey was then compared against other measures of health care trends, from government data and private sources.

Most survey respondents provided data for all five years. However, certain providers were not able to provide estimates for 2012. The information provided for 2012 represents approximately 70% of the covered lives for 2011 and earlier. This is consistent across all three lines of business. In presenting 2012 estimates, no adjustments are made for differences in the reporting group between 2012 and earlier years.

For notational purposes, throughout this report the trend shown for any particular year represents the trend from the prior year to the year shown. For example, the 2008 trends represent reported changes from 2007 to 2008, and the 2011 trends represent projected changes from 2010 to 2011.

Trend and Premium Overview

To help interpret the survey results, it is important to establish a framework for the connection between trend and premium increases.

As previously defined, core health care trend provides the foundation for any premium increase, but the actual increase in claims experienced by a health insurance policy is subject to many additional factors beyond the core health care trend. The main components that impact claims increases – and ultimately premium increases – can broadly be split into the following categories:

Core health care trend. This component reflects the trend of payments to health care providers and includes changes in the price of health care services, the mix of services provided, and changes in the overall level of health care utilization. Core health care trend represents the underlying force of increase for health insurance. In most situations, the core health care trend will represent the largest single component of any premium rate increase. It is expected to show less variability across lines of business and across different health plans than many of the other components that impact premium increases.

While core health care trend is often fairly similar across lines of business or health plans, it is important to note that there can be significant variation in core health care trend for several reasons. One key reason is geographic differences in health care costs. Provider networks and consolidation, prevailing practices related to the delivery of health care, and other factors can lead to material differences in trends by geographic region. Trends could differ by 3% or more due to geographic factors.

Changes in the covered population. Beyond the underlying force of increase for core health care trend, the claims experienced by a health insurance policy can be significantly impacted by changes in the demographics and health status of the covered population. Various changes in demographics can have an impact on health care cost, but the easiest factor to describe – and often the most significant factor – is the age of the covered population. Health care costs increase significantly with age, with average cost increases for each year that a person ages typically in the range of 1% to 4%. This change is in addition to the increase due to core trend.

Changes in the covered population generally occur gradually, but in certain circumstances these changes can be far more rapid. For example, if a workforce reduction results in fewer young participants in a group health plan, there could be a significant one-time shift in the covered population. Changes in the demographics of the insured group often vary significantly by plan and line of business, with the impacts being specific to an individual health plan or even an individual policy. Variability is often greatest in the individual line of business, due to the small number of participants with individual policies and the greater potential for change in this population.

To illustrate this with a simplified example, suppose a large employer has a population with an average age of 40. As a result of the economic downturn, this employer experiences less voluntary turnover and fewer early retirements, limits additional hiring, and downsizes its current workforce with staff reductions that largely impact shorter-tenured employees. As a result of these changes, the average age of the employer's workforce increases from age 40 to age 41. This increase in average age implies increased costs for the continuing participants. Assuming the impact of the change in average age is a 3% increase in costs, and assuming core trend of 8%, the total cost increase for this employer, prior to other factors, would be 11% (8% due to core trend plus an additional 3% due to the shift in the covered population).

On a global level, there is expected to be general upward pressure on health care costs as the U.S. population ages. Societal or workplace changes that focus on healthy living and reducing the burden of preventable diseases may help offset some of this upward pressure. The expansion of coverage under PPACA will also affect the covered population, but the impact is uncertain. An increase in coverage for healthy participants would improve the demographics of the covered population, but an increase in coverage for less healthy participants with many young participants opting out of coverage due to relatively low financial penalties under the individual mandate requirement could lead to additional cost increases.

Fixed cost-sharing effects (e.g., deductible leveraging). The cost increase components discussed thus far have been largely independent of plan design. However, the cost-sharing components of a health benefit plan can have a substantial impact on health care trend. While not necessarily obvious, plans with higher deductibles or other flat-dollar cost-sharing features often have higher trends than plans with lower deductibles. This phenomenon is known as "deductible leveraging." An example may help illustrate this impact. Compare two nearly identical plans, the first with a \$250 deductible and the second with a \$1,000 deductible. For a \$5,000 procedure, the first plan pays \$4,750 and the second plan pays \$4,000. The next year, the cost of the \$5,000 procedure increases by 6% to \$5,300. The first plan would pay \$5,050 (\$5,300 – \$250), with an overall trend increase of 6.3%. In this instance, deductible leveraging increased the trend by 0.3%. The second plan would pay \$4,300 (\$5,300 – \$1,000), with an overall trend increase of 7.5%. The high deductible plan experienced a 1.5% deductible leveraging impact in this example.

From this limited example, it can be inferred that deductible leveraging can vary significantly by the type of benefits. The individual line of business often sells plans with higher cost-sharing provisions, such as high deductibles. Therefore, these lines are generally impacted more by deductible leveraging. Deductible leveraging impacts are more muted in small and large group lines of business, as member cost sharing is less.

Legislative and regulatory impacts. Unlike core health care trends, which drive health care costs every year, the impact of legislative/regulatory changes is often periodic. These changes generally result directly in short-term trend impacts as changes are effective, but they can also impact long-term trends, often indirectly. Due to the nature of legislative/regulatory changes and variations in the current state of health care, the impact of these changes on health care cost is likely to be highly variable, with disparate impacts being seen across different lines of business and different health plans. For many plans, the pre-2014 changes brought about by PPACA are expected to have an impact on trends in the short term, with these impacts expected to be far greater for plans in the individual line of business. The impact of PPACA on many large group plans is expected to be minimal.

Discretionary design changes/“benefit buy-down.” The impacts that have been discussed thus far are largely beyond the control of the party purchasing the insurance. Based on the premium increases that result from these factors, it is common for employers or other purchasers to make changes to their plan design in order to help control the impact of premium increases. For example, an employer faced with a large premium increase may elect to increase deductibles or copays in order to lower the premium increase. This is commonly referred to as “benefit buy-down.”

Rather than being the direct result of market forces or population changes, benefit buy-down decisions are discretionary and by their nature specific to individual plans and plan sponsors. Benefit buy-downs are best viewed as a reaction to potential premium increases rather than a direct component of premium increases.

Additional plan-specific factors impacting premium increases. Premium increases are further impacted by a variety of factors not captured in the items above that are related to specific market, provider, or plan circumstances. For example, certain providers may offer discounts based on participation in a health improvement program, with these discounts varying over time. Under certain conditions providers may discount a product to attract new membership and subsequently adjust premiums in later years. If an employer adds a new plan option, the increased participant choice and increased opportunity for adverse selection could impact premiums. In situations where premiums are at least partially experience-based, a significant change in the health status of a group of covered employees could materially impact premiums.

Insurers also need to maintain adequate reserves to protect against the possibility of future losses in excess of expectations. As a result, premiums are impacted by historical experience and the need to increase reserves or the ability to lower reserves.

As most of these examples indicate, the impact of these factors will be unique to specific situations and as such they are not included in this report. These factors are best viewed on a case-by-case basis.

Core Health Care Trend Experience

The majority of surveyed responses reported core health care trends between 7.0% and 10.0% during the past three years (Exhibit 1). The average core rates, weighted by covered membership, were 8.3%, 9.0%, and 7.9% for 2008, 2009, and 2010, respectively. The median trend rates did not vary significantly from these averages. However, it is clear from the chart that not all health plans experienced the same level of health care cost increases. In general, smaller health plans experienced more variability in health care trends than larger plans. While not evident from the chart, it is important to note that there is not a strong relationship between trend in one period and subsequent periods. Carriers experiencing a very high or very low trend in a particular year were not substantially more likely to experience a similarly high or low trend in a subsequent period. The core health care trend described in this section represents medical costs only, and does not include prescription drug costs. Prescription drug trend will be discussed separately.

To validate these survey results, the surveyed core trends have been compared to the change in the Standard & Poor's Economic Health Care Commercial Trend Index. This index measures the rate of change in allowed claim costs for commercial health insurance populations over time. As can be observed, the average surveyed trend is slightly higher than the change in the index, but the statistics are not significantly different. In addition, both measures indicate a decline in trend from 2009 to 2010. This decline may be related to the recession and the delayed impact of the economic downturn on health care trend. Prices for medical services follow a different supply-demand relationship than most other goods and services. With most of the direct cost of any particular service generally paid by a third party – in this case the insurer – rather than directly by the purchaser, and with a lack of information to guide purchasing decisions, the demand-side impact on medical prices tends to be relatively small. Prices are largely driven by supply-side factors, such as the development of new technology and procedures. Developing new medical technology and procedures is a lengthy and costly process, and therefore temporary reductions in spending during a recession can result in a temporary dip in future trend that is not realized for a year or more.

On a prospective basis, weighted average trends for 2011 and 2012 do not materially differ from the 2008 through 2010 levels, with projected trends of 8.3% in 2011 and 8.7% in 2012.

Exhibit 1: Core Health Care Trend

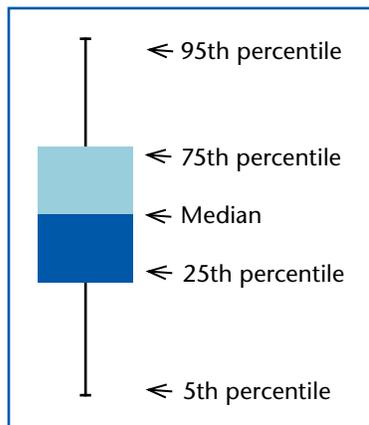
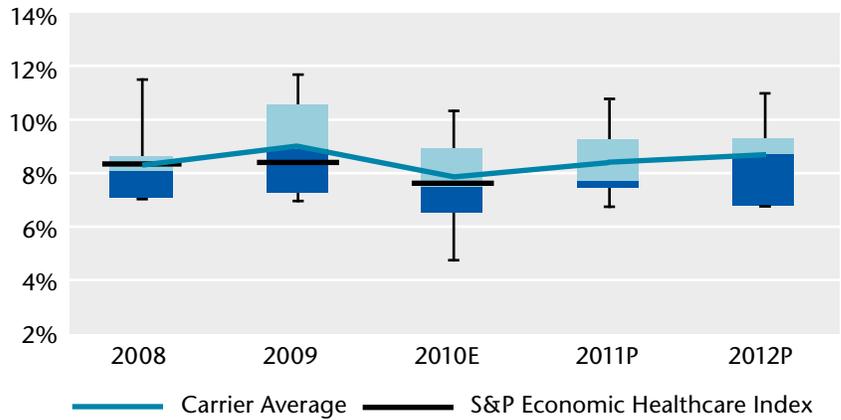
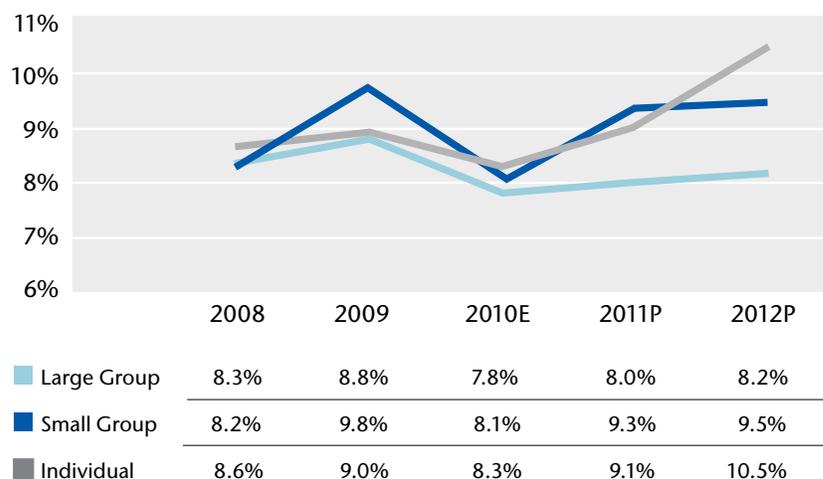


Exhibit 1 includes information on the weighted percentiles (percentiles weighted based on covered lives) for core health care trend. A similar format will be used in many other charts in this report.

Core health care trend averages for the past three years have been similar across the three lines of business surveyed (Exhibit 2). Because core health care trend is a measure of changes in the price of health care services and the utilization of services, we anticipate these measures would have a similar impact regardless of market segment.

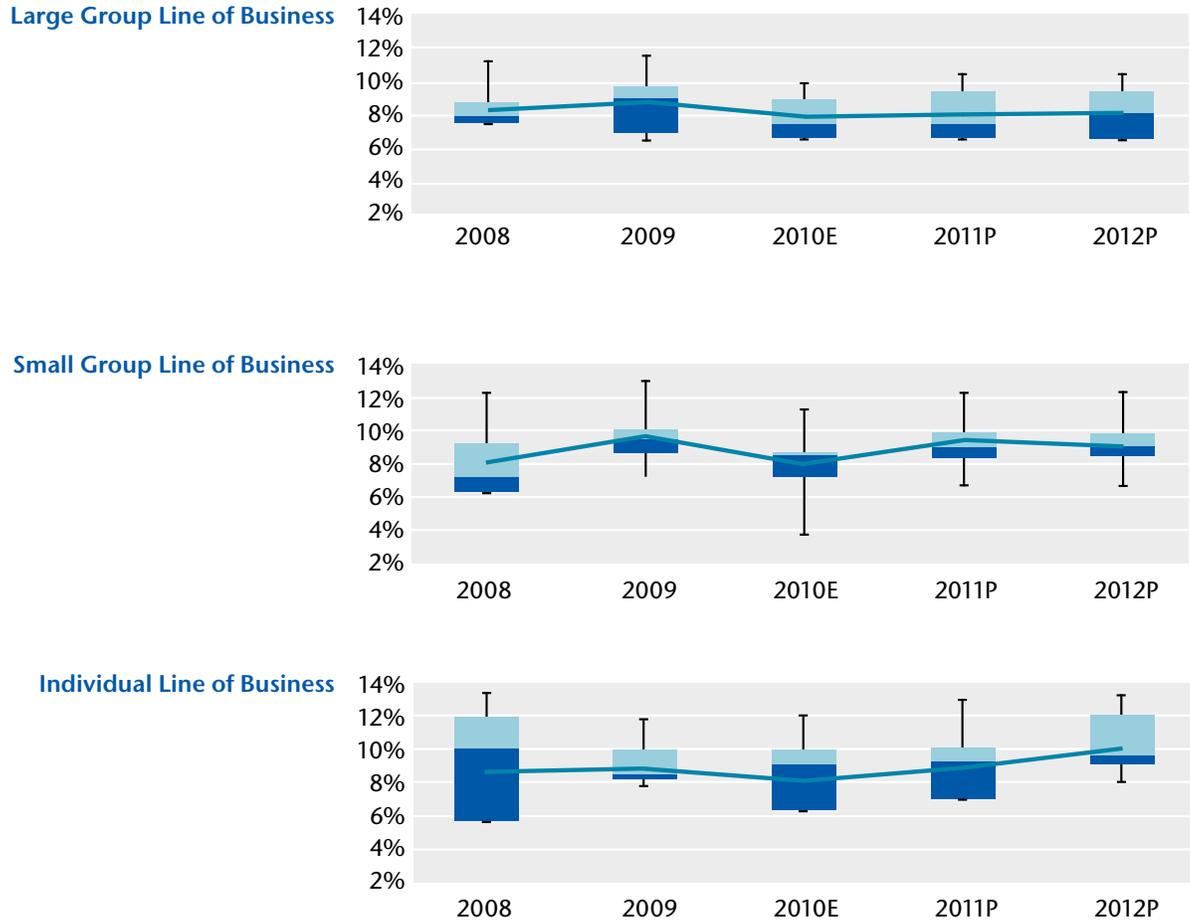
**Exhibit 2: Core Health Care Trend
by Line of Business**



However, we observe a wider spread between projected trends for large group and small group or individual plans in 2011 and 2012. Health plans are projecting core health care trends for large group plans to remain at current levels or increase slightly. On the other hand, the core trends for individual health insurance programs and small group plans are projected to increase in 2011 and 2012.

The charts in Exhibit 3 indicate the spread of survey responses by line of business. As would be expected, there is significantly more variability in trends for the individual line of business. This line of business has a far smaller population size, far larger turnover, and greater variability in terms of market practices than either the small or large group markets. Small group trends showed somewhat greater variability than large group trends, as would also be expected.

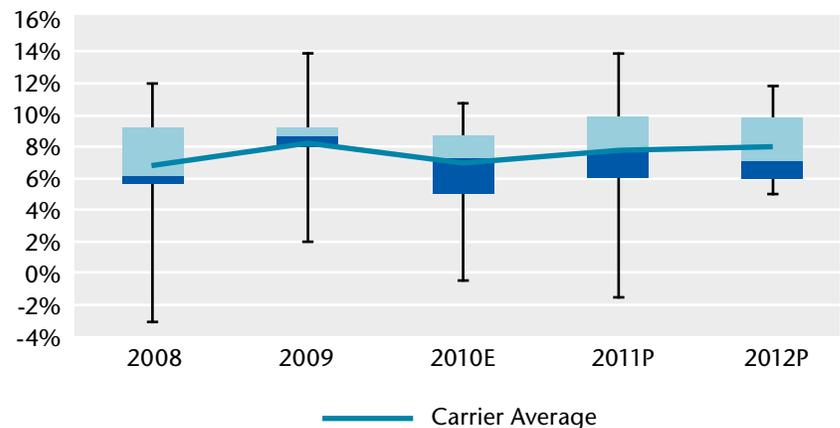
Exhibit 3: Core Health Care Trend by Line of Business



The graph on this page shows the range of prescription drug trends actually experienced by the health plans from 2008 through 2010 and the projected range of drug trend for 2011 and 2012.

The management of prescription drugs by health plans differs somewhat from the delivery of provider networks in that many health plans subcontract with pharmacy benefit management (PBM) firms to provide overall management of pharmacy networks and pricing. There was a wide range in the annual pharmacy trends experience reported by health plans, with some health plans reporting negative trends during the 2008 through 2010 period. We believe these reported trends are more likely to represent the impact of one-time changes, rather than a true reduction or leveling of actual pharmacy cost trends. The projected trends for 2011 and 2012 do not materially differ from the most recent pharmacy trend experience reported by the health plans.

Exhibit 4: Pharmacy Trend

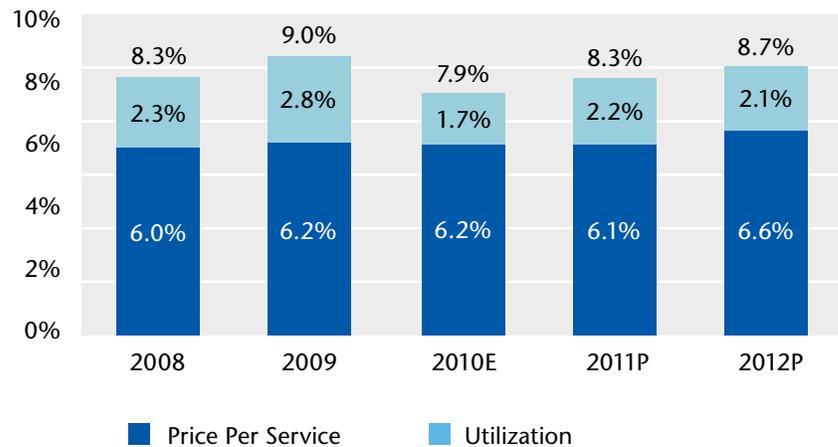


The average reported pharmacy trend is generally 0.5% to 1.0% less than the average medical trend in recent years, and this same relationship holds in projected amounts for 2011 and 2012. This relationship between average medical and average pharmacy trends is consistent across data provided for each line of business. Due to the similarity between medical and pharmacy trends and the large portion of total health care spending due to medical services, core health care trend on a blended medical and pharmacy basis would not be materially different from core health care trend on a medical-only basis.

Changes in Price and Utilization of Services

Core health care trend can further be split into two components: the change in price of services and the change due to the number and type of services provided (also referred to as “utilization”). The average price increase for health insurance plans has been consistently near 6.0% over the three years from 2008 through 2010 (Exhibit 5). This level of increase is projected to continue during the next two years, with health plans projecting annual increases of 6.2% in 2011 and 6.5% in 2012. Average utilization increases have ranged from 1.7% to 2.8% over the past three years. Reported utilization increases were at a low of 1.7% in 2010. This could be related to the delayed effect of the economic slowdown on the development of new medical technology. For 2011 and 2012, the surveyed health plans are projecting utilization increases of 2.2% and 2.1%, respectively.

Exhibit 5: Core Trend by Component



As Exhibit 5 indicates, the largest portion of core health care trend is driven by increases in price, with price increases accounting for over 70% of core health care trend. The relatively high level of price trends experienced may reflect the negotiating advantage gained through the consolidation of hospitals into large health care systems that can effectively negotiate the price of services with health plans, and the expectation that this will continue to put upward pressure on prices over the next two years. Projected price increases for 2011 and 2012 may also reflect the concern among health care provider systems that revenue from private insurance may need to be increased if the revenue received for patients of public health programs (Medicare and Medicaid) continues to be reduced.

Other Components of Health Care Cost/Premium Increases

As previously discussed, core health care trend is often the largest force driving increases in health care costs, but there are several other factors that also contribute to overall health care cost increases. Total cost increases can vary significantly from core health care trend due to these additional factors. The survey collected data on the following additional drivers of health care costs:

- Changes in the covered population (i.e., changes in demographic factors such as aging or changes in family size of an insured group);
- Impacts of deductible leveraging (fixed cost-sharing effects); and
- Estimated impacts of changes in benefit design and administration due to PPACA mandates.

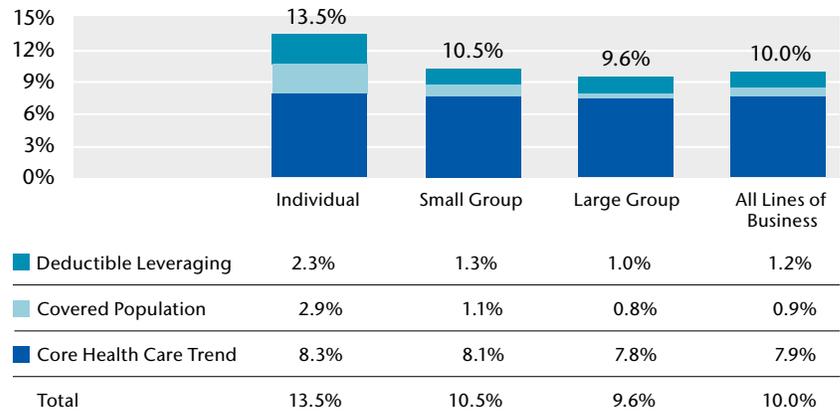
Discretionary plan changes, or benefit buy-downs, will also be a factor in determining ultimate premium increases, but since these changes are largely a reaction to cost increases and due to the highly individual nature of these changes, impacts of discretionary plan changes are excluded from this analysis.

In addition, there are further plan-specific factors that could impact premiums. These include a range of items, such as provider marketing or employer decisions regarding plan options. As these factors are highly unique to specific situations, they are also excluded from this analysis.

Unlike core health care trend, which tends to be fairly consistent across lines of business, the impacts of many of these additional factors often vary significantly by line of business. For example, deductible leveraging impacts are often higher for individual policies due to the higher deductibles and cost sharing often associated with these policies. Likewise, individual lines of business can be more sensitive to changes in covered population.

Exhibit 6 summarizes estimated 2010 total cost increases by line of business, including impacts for changes in covered population and deductible leveraging. As expected, the increase over core health care trend due to other factors is largest for individual lines of business at 5.2%. The corresponding increase for small group is 2.4%, and the increase for large group is even lower at 1.8%.

Exhibit 6: Estimated 2010 Total Cost Increases by Line of Business

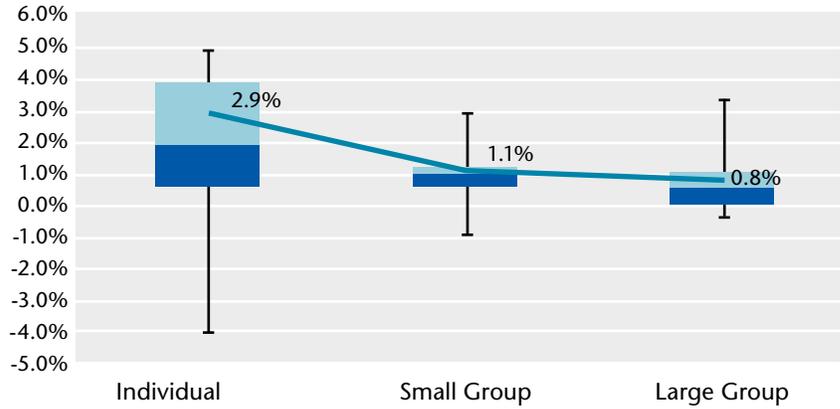


Change in Covered Population

Beyond variability between lines of business, impacts of changes in the covered population and deductible leveraging show a large degree of variability within each line of business. This variability is generally greatest in the individual line of business, and is illustrated in the following exhibits.

Exhibit 7 shows the range of reported impacts for the change in covered population by line of business in 2010. The data clearly shows a larger range for individual lines. The data ranges also show negative impacts reported by some health plans, illustrating that covered population changes can either increase or decrease health care costs. The actual impacts will vary based on specific changes in the demographics and health status of the insured population on a plan-by-plan basis. However, even though some carriers reported decreases in costs due to changes in the covered population, the weighted average impact for each line of business and the median is an increase, indicating that most large carriers experienced increases in trend due to population changes.

Exhibit 7: Range of Impacts – Covered Population Impact by Line of Business for 2010

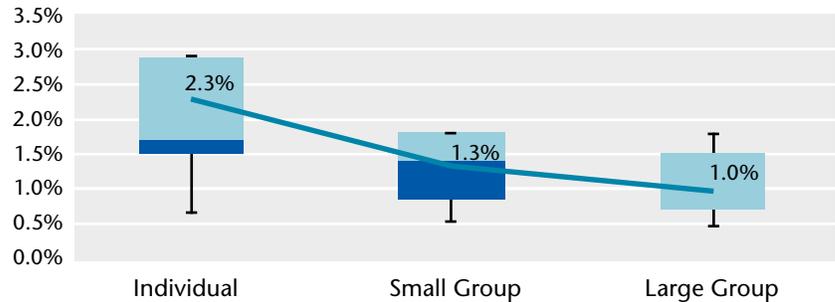


Deductible Leveraging

The impact of deductible leveraging will vary based on the underlying levels of cost-sharing components (deductibles, copays, etc.) of each plan. Exhibit 8 summarizes the general range of deductible leveraging impacts reported by health insurers for 2010. When estimating deductible leveraging impacts, it is important to look at the specific benefit provisions applicable to a policy or book of business.

Overall, the largest impacts and widest range of impacts were reported for individual lines of business. Reported impacts were significantly lower for small group and large group lines of business. As expected, deductible leveraging has the largest impact on individual lines of business due to the higher prevalence of high deductible plans in the individual market.

**Exhibit 8: Range of Impacts –
Deductible Leveraging by
Line of Business for 2010**



**Legislative Changes –
PPACA**

The passage of health care reform legislation in 2010 will have major effects on private health care markets, with the first changes already going into effect in the second half of 2010. The full impact of the changes may not be felt until after 2014.

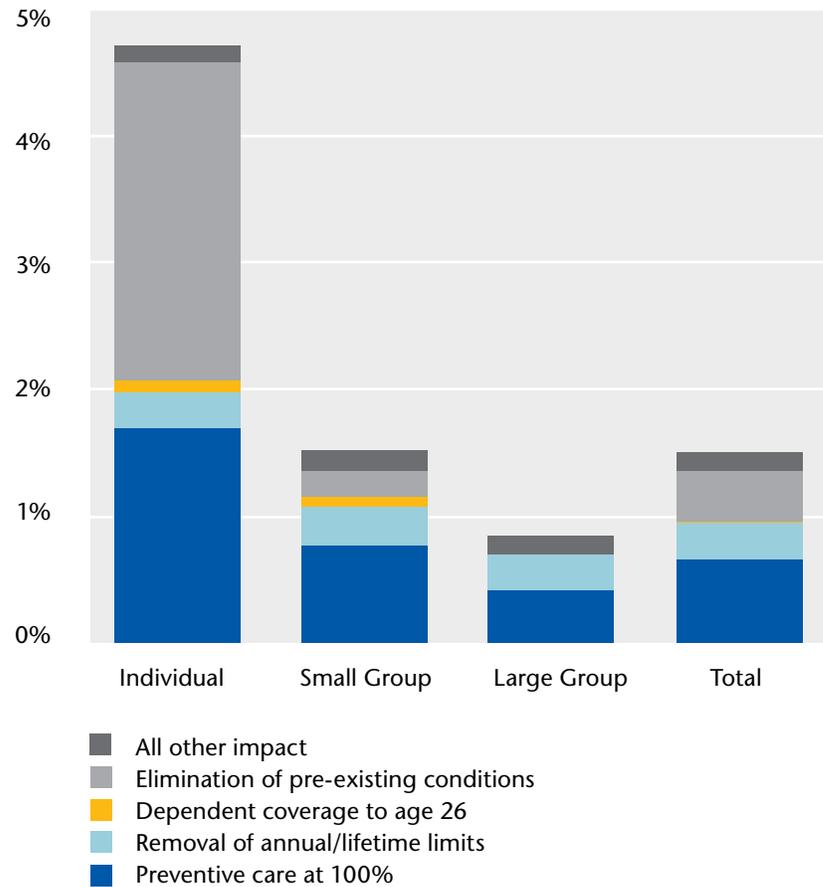
In general, the impact of PPACA on trends in private insurance can be split between direct impacts and indirect impacts. Direct impacts include the effects of specific changes made to comply with the new law – such as providing preventive coverage at 100%. Indirect impacts include any changes to the health care delivery system that result in changes in the underlying price of services or utilization and therefore impact plan premiums. Indirect impacts include fees and taxes on producers, such as pharmaceutical companies and medical device manufacturers, which may be passed through to users of health care in the form of higher prices. Indirect impacts also include the potential effects of PPACA on “cost shifting.” Cost shifting describes the situation that occurs when providers increase costs for commercial payers to make up for lower payments from other sources. For example, if hospitals are unable to collect payments when care is provided to those without insurance, they will need to increase prices for those with insurance to cover this shortfall. There are also arguments that cost shifting occurs when Medicare and Medicaid payments are below certain levels, resulting in commercial price increases in order to at least partially offset decreases in public funding. PPACA changes in public funding, which largely begin in 2012, and later changes to expand coverage for the uninsured could have material indirect effects on trend.

The indirect impacts of health care reform are difficult to quantify and to separate from underlying core trend. The survey questions therefore focused on the direct impacts of health care reform.

The majority of the cost increases for these items will impact 2011 trends. Some respondents may have reflected certain indirect impacts in either projected core trend or in their response for “all other impacts” related to PPACA.

Exhibit 9 shows the 2011 impact in more detail.

**Exhibit 9: 2011 Health Care Reform
PPACA Trend Impact**

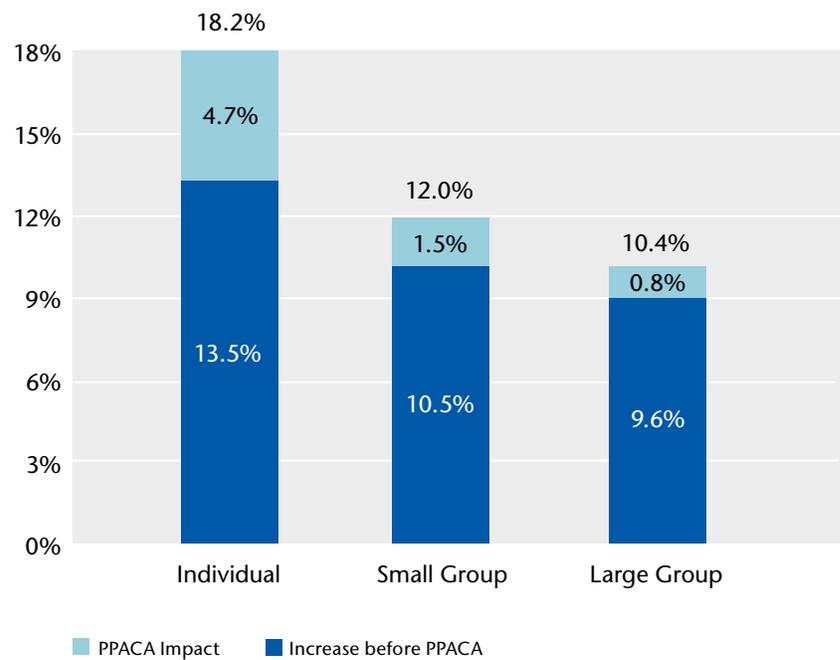


Overall, PPACA is anticipated to increase costs by an average of 1.5% in 2011 across the surveyed health plans. Other surveys have offered similar cost estimates. However, it is important to understand that these averages cannot be easily extrapolated to any particular health insurance policy or across different lines of business.

As with other components, projected PPACA impacts vary significantly by line of business. Prior to PPACA, the Health Insurance Portability and Accountability Act (HIPAA) limited pre-existing condition exclusions that could be applied in employer-provided insurance. Therefore, the PPACA limitations on pre-existing condition exclusions will have a minimal impact on large and small group plans. Likewise, group plans were more likely to provide preventive coverage at 100% prior to PPACA. Overall, for 2011 health plans reported estimated increases due to PPACA of 4.7% for individual policies, 1.5% for small group plans, and 0.8% for large group plans on a weighted average basis. These impacts are additive to the other trend components discussed previously.

We do not have complete data to show reported 2011 trend components by line of business, based on limited data provided for projected population changes in the individual and small group market. As a result, Exhibit 10 shows illustrative trends by line of business as if the impacts for core trend, population changes, and deductible leveraging remain the same from 2010 to 2011, combined with 2011 PPACA increases.

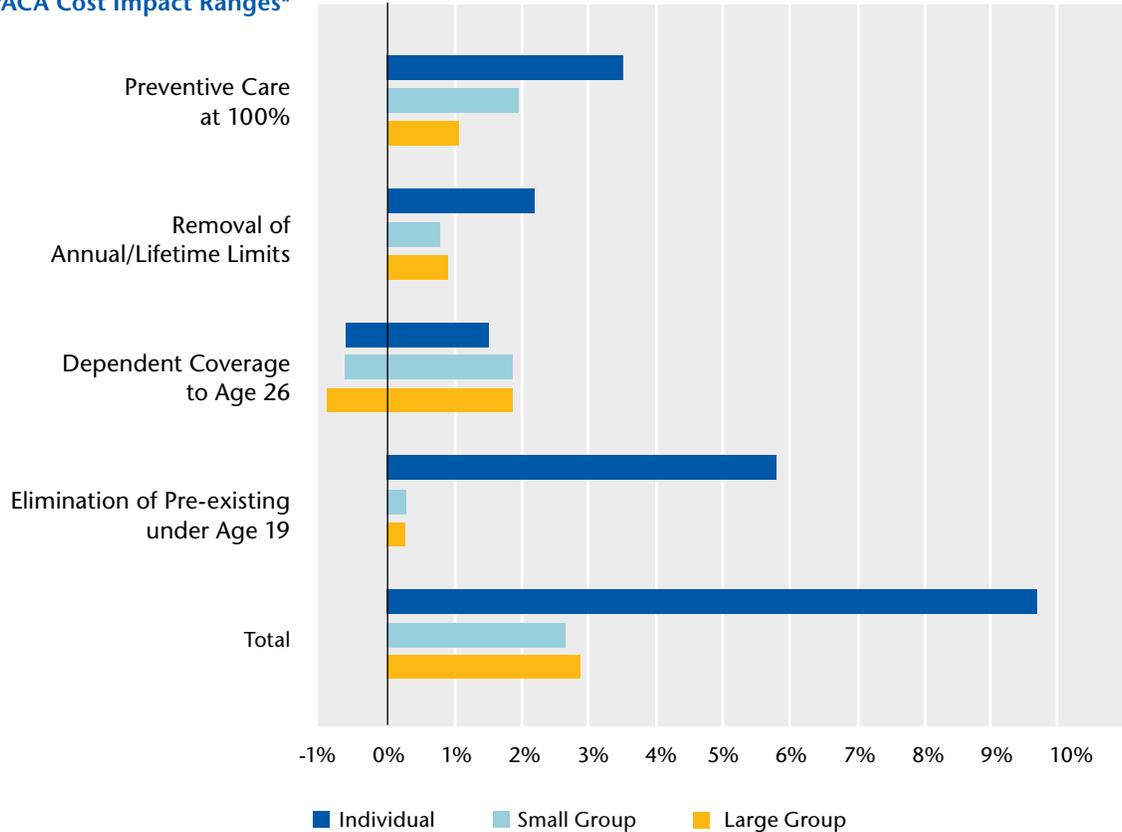
Exhibit 10: Illustrative Total Cost Increases by Line of Business Including PPACA Impact*



*Exhibit 10 shows illustrative total cost increases based on 2010 increases by line of business prior to PPACA from Exhibit 7 and projected first-year impacts of PPACA (2011 PPACA impacts). Full data was not reported on all trend components by line of business for 2011, with information on the impact of estimated covered population changes being the most difficult for plans to report. As a result, illustrative examples are shown. These examples represent total projected cost increases if core trend, deductible leveraging, and covered population impacts remain constant from 2010 to 2011. Exhibit 12 shows total reported 2011 trend projections blended across all lines of business.

Within a line of business, there was also a wide range of reported impacts for many PPACA provisions, as would be expected. Exhibit 11 shows the range of the average impacts for key PPACA provisions reported by different carriers. This provides an illustration of variability between different providers on a book of business basis. While these amounts provide an overall range for understanding key PPACA impacts, they are naturally not all-encompassing. Individual plan impacts will fall outside these ranges under specific conditions. To help further understand the breadth of cost impacts, the survey asked health plans for cost ranges across their books of business for the impact of covering preventive care at 100% and the removal of lifetime/annual limits. As an example of potential variation by plan, respondents reported increases as high as 15% for including preventive care and as high as 5% for removing lifetime/annual maximums.

Exhibit 11: Range of Impacts – PPACA Cost Impact Ranges*



*The ranges shown in Exhibit 11 represent the range of average impacts reported by carriers. They do not reflect the overall range that could be experienced for any given policy. For certain items, we requested sample data to illustrate impacts across different policies for certain provisions, with carriers reporting increases as high as 15% for covering preventive care at 100% and 5% for the removal of lifetime/annual maximums.

While the average cost of expanding coverage to young adults up to age 26 is 0% overall, for any given health plan this cost has been estimated to be slightly negative to about 2% more costly. Eliminating pre-existing condition requirements for those under 19 is not expected to impact group policies to any large extent, but may significantly increase the cost of individual plans. Removing annual/lifetime maximums and covering preventive care at 100% is expected to have a far larger impact on some individual policies than on group policies.

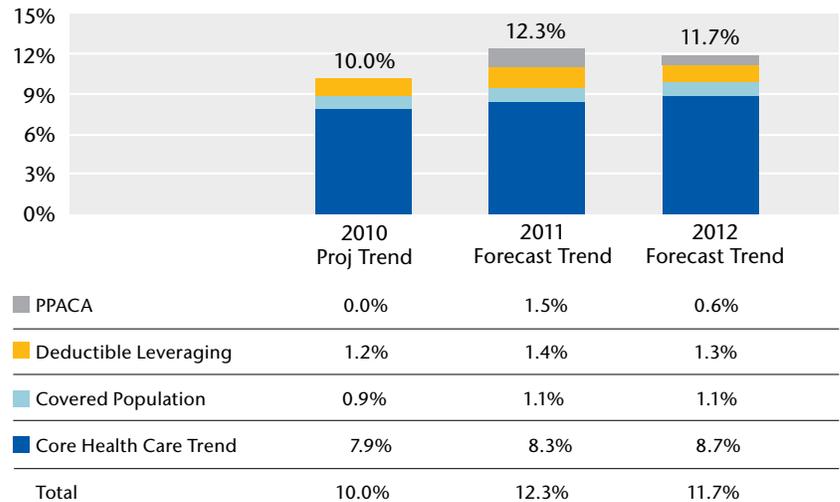
As the range of survey responses shows, in certain cases – especially in the individual market – providers are expecting high cost increases for certain policies when all components of cost increases are considered. Certain individual policies could see premium increases of 20% or greater based on reported trend components. As an illustrative example, a policy could have core trend increases of 8%, with additional increases of 2% for deductible leveraging, 3% for changes in the covered population, and 10% for PPACA-related changes. The survey responses also clearly indicate that other policies are expected to have far smaller trend increases. As an illustrative example, a policy with minimal changes due to PPACA and changes in covered population could see a premium increase closer to core trend of 8%. Determining whether a particular premium increase for a given policy is appropriate requires a thorough understanding of the components driving the premium increase.

Regarding the impacts reported for extending dependent coverage, it is important to understand the reason for the negative impacts. For consistency, the survey asked for all information to be reported on a “per member” basis. Per member averages are developed by dividing total costs by the total number of insured plan members, including employees/primary policyholders and all their dependents. Since dependents under age 26 are generally healthy, extending coverage to this group may result in bringing more low-cost members into the plan and thus lowering the per member cost.

An alternative cost measure commonly used is cost on a “per employee” basis. This measure divides total claims by the number of employees/primary policyholders. Dependent counts are not included in determining the average, and as a result the average cost on a per employee basis will increase (or decrease) as the number of covered dependents per employee increases (or decreases). Although the survey did not ask for impacts on a per employee basis, our general expectation is that extending coverage to dependents under age 26 would generally result in cost increases between 0% and 4%, depending on population demographics and pre-PPACA eligibility provisions of the plan. Measuring impacts on a per employee basis instead of on a per member basis would not have as significant of an impact on the other trend components that have been discussed.

Summary Exhibit 12 highlights the estimated impacts of these additional cost drivers that have been discussed in 2010, 2011, and 2012, based on a weighted average basis across all lines of business. Several of the prior exhibits focused on 2010 or 2011 impacts by line of business. We did not receive sufficient data to report on full 2012 trends by line of business. As a result, 2012 amounts are being presented in aggregate only.

Exhibit 12: Additional Components of Total Health Care Cost Increases*



*As discussed above, the estimates for each of these factors show significant variability between and within different lines of business. For example, as noted in earlier parts of the report, the projected PPACA benefit impact for individual policies is a weighted average total of 4.7% for 2011.

Conclusion

Premium increases and health care trend are key focuses of public policy today and will continue to be over the next several years. A starting point to understand premium increases is a measure of core health care trend – a measure of the force of increases in health care costs due to price and utilization changes that are fairly consistent across lines of business and providers. Core health care trends reported by insurers have generally been between 7.5% and 10.0% over the prior three years, and core trends are generally expected to remain in this range for 2011 and 2012.

After reviewing core trend, it is important to consider the additional factors that contribute to overall premium increases – including changes in the covered population, deductible leveraging, and benefit changes driven by PPACA. These items are usually smaller than core trend, but can still have a significant impact on premium increases. On average, reported impacts for covered population changes and deductible leveraging show that these items increased estimated 2010 health care costs by an additional 1.8% to 5.2% over core health care trend, depending on line of business. Many PPACA impacts will first be largely reflected in 2011, with average projected impacts by line of business ranging from 0.8% to 4.7%.

These additional components of health care trend increases also tend to be more volatile across different plans than core health care trend. Beyond the average impacts shown above, careful consideration should be given to demographic and design-specific considerations of a particular plan when assessing overall premium increases.

If you have questions or would like to discuss these findings with an Aon Hewitt Health Care expert in your market, please send an email to aon_national@aon.com.

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