

# How the Affordable Care Act Has Affected Health Coverage for Young Men with Higher Incomes

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### ABSTRACT

**ISSUE:** The Affordable Care Act (ACA) regulates the price of health plans sold in the nongroup market. Premiums cannot be based on gender or health status, and price increases related to age are limited. These changes have lowered premiums for older, sicker people but raised them for younger, healthier ones — especially young men ineligible for premium subsidies. This has raised concerns that the latter have failed to gain coverage.

**GOAL:** Compare the impact of the ACA's rating rules on the number of insured young men, older adults, and others.

**METHODS:** We compared overall and nongroup coverage trends pre- and post-ACA among demographic groups, comparing residents of states where the rule changes had little effect on premiums to states where the rules had greater effect.

**FINDINGS:** People whose premiums fell because of the ACA's rating rules were slightly more likely to get nongroup coverage than those whose premiums rose. All groups, including higher-income young men, gained coverage because of the combined effects of ACA changes.

**CONCLUSION:** Coverage rose after the ACA took effect among all demographic groups. Taken together, the ACA's individual mandate, marketing efforts, and effects on how people perceive the value of having insurance outweighed the impacts of changes in rating and benefit rules.

### KEY TAKEAWAYS

- ▶ **The Affordable Care Act's rules limiting how much insurers can charge for health coverage led to lower premiums in the nongroup market for older, sicker people but higher premiums for younger, healthier ones — especially higher-income young men not eligible for premium subsidies.**
- ▶ **Nonetheless, coverage rates rose for all groups, including higher-income young men.**
- ▶ **Other factors, including the individual mandate and the perceived value of having insurance, appeared to have outweighed the impact of the ACA's rating and benefit rules.**

## BACKGROUND

Before the Affordable Care Act (ACA) was enacted, insurers in most states could vary their premiums in the nongroup market to reflect the anticipated health care costs of enrollees. They also could offer plans that varied in benefits covered. Young, healthy people in these states could purchase limited benefit packages at low premiums, while older, sicker people seeking comprehensive coverage would pay much more. Some states sought to counteract these practices by mandating coverage of specific benefits and restricting insurers' rate-setting practices. However, these efforts to restrict rating rules and expand benefits often led to higher premiums for younger, healthier people, causing them to forgo insurance altogether.<sup>1</sup>

The ACA prohibits insurers from varying premiums based on health status or gender. The law also limits the influence of age to a 3:1 premium ratio, which means insurers could charge an adult age 64 or older no more than three times the premium paid by a 21-year-old for the same coverage. In addition, insurance sold in the nongroup market must cover 10 categories of health benefits (maternity care, for example), called essential health benefits. As was the case in states with similar regulations prior to the ACA, these rule changes have increased the cost of coverage for younger, healthier people compared to the cost for older, sicker people. In states with previously unregulated markets, the ACA raised premiums for young people, men, and healthy people (relative to those who have pre-existing conditions).

### Premium Pricing

Prior to the ACA, young women paid as much as 45 percent more for health insurance than did young men.<sup>2</sup> A 64-year-old would pay about 4.8 times as much as a 26-year-old for the same coverage.<sup>3</sup> These differences imply that two new ACA requirements — eliminating gender rating and limiting age-related increases — would have raised premiums for low-cost plans sold to young, single men by about \$60 per month in 2014.<sup>4</sup> The Congressional Budget Office estimated in 2010 that changes in the actuarial value of coverage, including the

inclusion of the full set of essential health benefits, might raise nongroup premiums by a further 18 to 20 percent. That suggests a total increase in 2014 of about \$72 per month (\$864 annually) for young, healthy men ineligible for subsidies. For many older adults, in contrast, the new rating rules meant lower premiums compared to the pre-ACA market.

The ACA, however, also encourages younger, healthier people to join the insurance market. People with incomes below 400 percent of the federal poverty level (FPL) are eligible for premium subsidies. The law's individual mandate requires that people obtain coverage or pay a penalty. The law also increased the profile of having insurance coverage through advertising and marketing efforts. Proponents of the ACA anticipated that these elements would offset the impact of the new rating and benefit rules so that young, healthy people stayed in the insurance market.

Under the individual mandate, people who do not obtain coverage must pay tax penalties that vary by income. This penalty, which increased from 1 percent of income in 2014 to 2.5 percent of income in 2016, is levied on those who can obtain coverage for less than 8.05 percent of household income. For a young single man whose income fell at the median of incomes above the subsidy range, a failure to buy coverage triggered penalties of \$690 in 2014, \$1,225 in 2015, and about \$1,500 in 2016.<sup>5</sup>

While these penalties are substantial, some people have suggested that they are not large enough to induce young, healthy people to obtain coverage.<sup>6</sup> Notably, for young men in newly regulated nongroup markets in 2014, the penalty for not having coverage was smaller than the increase in costs. Penalties were somewhat higher than these increases in costs in 2015 and were about double the premium increases by 2016; the differences might not have been enough to encourage many young men to sign up. For older adults, both penalties and rating-rule changes encouraged older adults to enroll for coverage. For young men, the penalties and rating rules produced opposite effects. Penalties were an inducement to buy coverage while rating-rule changes reduced the incentive.

### The ACA’s Impact Varies According to a State’s Regulatory Environment

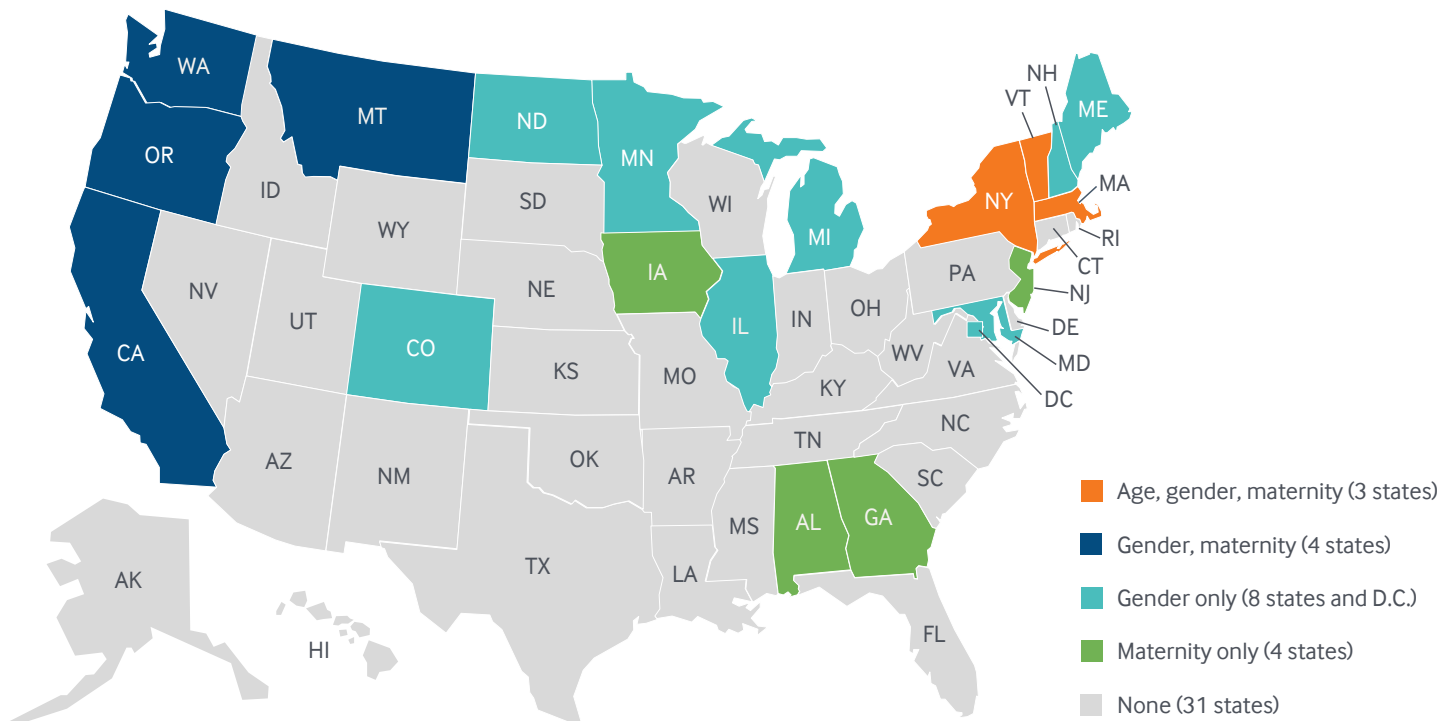
In this study, we examine the impact on coverage rates of the ACA’s new restrictions for age and gender, as well as the impact of the new essential health benefits (focusing on maternity benefits, which most frequently were excluded in pre-ACA coverage). We examine the population with incomes above 400 percent FPL, which is ineligible for premium subsidies. We looked at groups that saw either a decline or rise in premiums, and compared them to those that felt little impact from the ACA rule changes. In general, young, single men were disadvantaged by the changes to benefit and rating rules. People over age 55 saw premiums fall, while married middle-age people generally were not affected very much.

We wanted to separately evaluate the impact of new regulatory requirements, the individual mandate, and marketing. To do so, we compared how the ACA affected two groups of states. In one group, the law imposed new benefit and rating rules on nongroup markets, and in the

other group of states, these requirements already were in place. While the various ACA inducements to get coverage applied in all states, the benefit and rating rules did not.

As we show in Exhibit 1, several states already imposed some of these rules in their nongroup markets before the ACA, and so the new rules had less of an effect on premium patterns. Some states allowed age-band ratings that let insurers charge higher premiums for older adults compared to younger, healthier ones, who had lower medical expenses. Specifically, New York, Massachusetts, and Vermont had age bands prior to 2014 that were at least as restrictive (and sometimes more restrictive) than those under the ACA. Before the ACA’s coverage expansions, 16 states already prohibited insurers from varying premiums based on gender, and 11 states mandated inclusion of maternity benefits in nongroup coverage. New York, Massachusetts, and Vermont had implemented all these rating and coverage restrictions before 2014, while 31 states had implemented none of them.

Exhibit 1. State Benefit and Rating Rules Prior to the ACA’s Enactment



Data: Kaiser Family Foundation, *Pre-ACA State Maternity Coverage Mandates: Individual and Small-Group Markets* (Henry J. Kaiser Family Foundation, 2010); and Kaiser Family Foundation, *Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)* (Henry J. Kaiser Family Foundation, 2012).

## About Our Study Methods

In our main analyses, we compared the effects of the ACA on states that had more of these requirements prior to 2014 with the effects on states that had few of these rules. We define these states based on a pre-ACA assessment by Oliver Wyman, described in Appendix 1.<sup>7</sup> In our discussion, and in Appendix 2, we separately report results for each of the main ratings and benefit requirements. For more detail, also see [How We Conducted This Study](#).

To conduct these analyses, we used the Current Population Survey (CPS), the best source of data on nongroup coverage, and the American Community Survey (ACS), the most consistent source on overall uninsured rates, for the years 2010 to 2016. We identified people with incomes above 400 percent FPL as people who are unlikely to be receiving any subsidies under the ACA and compared patterns of coverage gains among groups that either benefited or were disadvantaged by the rating- and benefit-rule changes.

We also estimated whether all the ACA-related changes had a net impact on the percentage of people without insurance, looking at groups that experienced premium drops or increases because of these ACA rules. We considered competing factors that could influence these net impacts: 1) rating rules, which mattered mainly in those states that had newly adopted them; and 2) the combined effects of the individual mandate, heightened awareness of the importance of insurance coverage, and ACA marketing efforts, all of which affected coverage in all states.

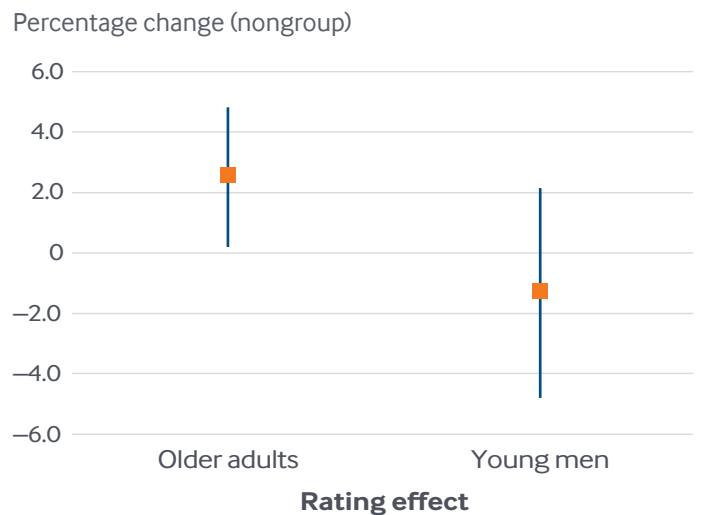
Throughout, we modeled the probability of people having nongroup insurance and of being uninsured using logistic regression and then computed the marginal effects. We modeled these probabilities for each of the individual provisions (age rating, gender rating, maternity) as well as their combined effect. In all sets of regressions, we controlled for age, race, gender, state, and education.

## FINDINGS

The ACA's benefit and rating rules lowered premiums for older people as compared to young single men. We looked at the results broken down by two sets of states: those that did not have restrictive rules for nongroup coverage prior to the ACA (Arizona and Kentucky, for example) and states like New York and Massachusetts that had such regulations in place pre-ACA (see Exhibit 1 and Appendix 1 for details).

We find that the effect of benefit- and rating-rule changes alone was to increase nongroup coverage among older adults (as compared to middle-age adults and young women) by about 2.5 percentage points more in the states lacking restrictive rules prior to the ACA than in the states where these rules had already been in place (Exhibit 2, Appendix 2a). By contrast, young single men in these states had a 1.3 point smaller gain in nongroup coverage

### Exhibit 2. Effect of ACA Rating-Rule Changes on Nongroup Coverage Among Young Men and Older Adults Versus Middle-Age Adults and Young Women



Notes: Analysis of the Current Population Survey, 2010–2013 and 2014–2016, of individuals ages 26–64 with incomes above 400% of the federal poverty level. Results are from regressions that control for age, race, gender, state, and education. Bars represent 90% confidence intervals.

Data: State regulatory regimes are derived from J. Grau and K. Giesa, *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets* (Oliver Wyman, Dec. 1, 2009). The effect of rating rules is estimated by comparing the effect of the ACA on coverage of young men (who saw premiums rise because of rating rules) and older adults (who saw premiums fall because of rating rules) in comparison with middle-age adults (who were not affected by rule changes) in states where rating-rule changes were new to changes in states where many such rules already were in place.

(not statistically significant) than did middle-age adults or young women.

Rating-rule changes had similar effects on uninsured rates. Uninsured rates for older adults fell by 0.6 percent more than they did for middle-age adults and young women in states where the ACA's regulations were newly effective (not statistically significant). Uninsured rates for young men, however, fell by 0.8 percent less than for middle-age adults and young women in these states (Exhibit 3a).

The ACA's overall effect stems from the combined effects of rating-rule changes and the law's other measures to encourage coverage. The net effect of all these changes together was to increase coverage among those who benefited from the new rating rules and among those who were disadvantaged by the rules (Exhibit 3b). The share of older adults without health insurance fell by 1.7 percentage points between the 2010–2013 and the 2014–2016 periods. The uninsured rate for young men fell even more, by 2.4 points, while that for all other adults fell by 1.3 points.

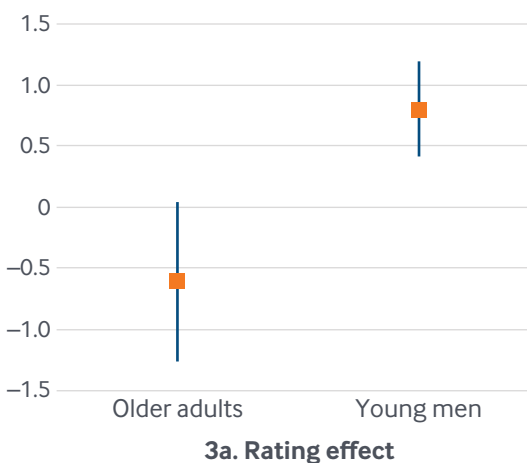
### Estimates for Specific Rating Rules

The factor that most contributed to changes in relative premiums was the ACA's 3:1 age-rating rule, which restricts insurers from charging an adult age 64 or older more than three times the premium paid by a 21-year-old for the same coverage. We estimate that, for young adults, this age-rating change lowered relative participation (relative to the least affected group) in nongroup insurance coverage in states that newly imposed this requirement (compared to states that already had the requirement in effect) by 2.2 percentage points (Appendix 2a). For young adults, this change led to smaller relative reductions in the number of uninsured compared with the 35-to-54 age group — a difference of 0.3 points (Appendix 2b). Again, for all age groups (younger, older, and middle-age) in states that were highly affected by the age-rating rules, the number of uninsured people fell.

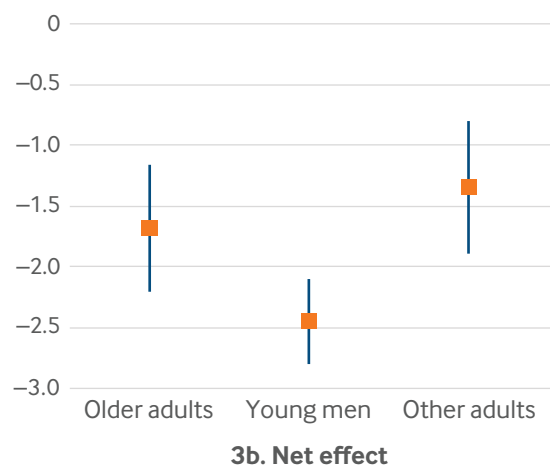
We also separately looked at the ACA's gender-rating rules (comparing the experience of single women under 50, single men under 50, and other adults, either married or over 50) and the inclusion of maternity benefits

**Exhibit 3. Change in Percentage of Adult Population Without Health Insurance (incomes above 400% FPL) in States Where the ACA's Benefit and Rating Rules Were Newly Implemented**

Percentage change (uninsured)



Percentage change (uninsured)



Notes: Analysis of the American Community Survey, 2010–2013 and 2014–2016, of individuals ages 26–64 with incomes above 400% of the federal poverty level. Results are from regressions that control for age, race, gender, state, and education. States are those with the highest predicted premium changes based on Grau and Giesa. Bars represent 90% confidence intervals.

Data: State regulatory regimes are derived from J. Grau and K. Giesa, *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets* (Oliver Wyman, Dec. 1, 2009). The effect of rating rules is estimated by comparing the effect of the ACA on coverage of young men (who saw premiums rise because of rating rules) and older adults (who saw premiums fall because of rating rules) in comparison with middle-age adults (who were not affected by rule changes) in states where rating-rule changes were new to changes in states where many such rules already were in place.



(comparing the experience of single women under 45; single men; and other adults, either married people or single women over 45). These changes substantially increased nongroup health coverage for young single women relative to other adults, but they had small, nonsignificant effects on nongroup coverage among young men relative to other adults.

## DISCUSSION

We compared the unregulated environment that existed in many states prior to the ACA. The law's rating and benefit rules led to lower premiums for older adults and young women but higher premiums for young men. Analysts have been concerned that the law's coverage and rating rules consequently may have driven young men out of the health insurance market. According to our analysis, as expected, in the nonsubsidized population those who benefited from the ACA's new rating rules gained nongroup insurance coverage at higher rates than those who were disadvantaged by the new rules.

However, the percentage of uninsured, nonsubsidized young men declined nearly as much in states with newly implemented rating rules as it did in states where the rules were well established. Across all comparisons, we found that the overall percentage of young, high-income men without health coverage fell in states with newly implemented ratings rules.

After the ACA's implementation, the increase in nongroup coverage and the fall in the percentage of uninsured young men likely were caused by the new financial penalties and the increased significance of coverage generated by the individual mandate and marketing efforts to promote the ACA.

Although the absolute cost of penalties relative to insurance premiums was relatively low (especially in 2014 and 2015) the law's net effect was to increase coverage among young men. The increased significance of coverage generated by the individual mandate had a greater influence on the rise in the number of insured people.

To understand why, consider that prior to the ACA, young single men very often went without health insurance, even though they could buy it on favorable, actuarially fair

terms. In 2013, 11.7 percent of young men ages 26 to 34 with incomes above 400 percent FPL were uninsured, about three times the rate of their counterparts ages 55 to 64 (3.9%). The ACA substantially narrowed that coverage gap.

By 2015, the share of young men in this income category who were uninsured had dropped by nearly five points (to 7.2%), while the share of older men who were uninsured had fallen by just 1.5 points (to 2.5%). The ACA's mandate increased both the incentive for having insurance and the importance of the decision. This combination greatly increased coverage among young men.

### HOW WE CONDUCTED THIS STUDY

We drew our sample from Current Population Survey (CPS) and American Community Survey (ACS) 2010 to 2013 (pre-ACA) and 2014 to 2016 (post-ACA). We restricted the sample to adults (ages 26 to 64) with higher incomes (above 400% of the federal poverty level). Sample sizes in the CPS and ACS were 249,910 and 4,806,458, respectively.

Using the CPS (ACS) sample, we modeled the probability of having nongroup insurance (of being uninsured) using logistic regression, and then computed the marginal effects. We modeled these probabilities for each of the individual provisions (age rating, gender rating, maternity) as well as their combined effect. In all sets of regressions, we controlled for age, race, gender, state, and education.

The explanatory variable that measures the effect of ACA provisions is a comparison between the change in outcomes over time (before and after 2014) and states (preexisting rating provisions vs. ACA mandate) among the group that benefited from the rule (those that are helped by ACA provisions), the group most disadvantaged by the rule (those that are likely to face higher costs because of the provision), and control groups (those less likely to be affected by the provision).

To model combined effects, we used estimates of the effects of all ACA rating regulations on state nongroup insurance premiums published by Oliver Wyman in 2009.

**Appendix 1. Predicted Combined Effect of Rating Rules on Premiums**

<b>0.11</b>	<b>0.38</b>	<b>0.57</b>	<b>0.61</b>	<b>0.75</b>
New York	Colorado	Hawaii	Alabama	Arizona
Vermont	Connecticut	Iowa	Alaska	Idaho
	Delaware	Louisiana	Arkansas	Kentucky
	Maine	Minnesota	California	Virginia
	Maryland	Nevada	District of Columbia	
	Massachusetts	New Mexico	Florida	
	Michigan	North Dakota	Georgia	
	New Hampshire	South Dakota	Illinois	
	New Jersey	Utah	Indiana	
	Oregon	West Virginia	Kansas	
	Pennsylvania		Mississippi	
	Rhode Island		Missouri	
	Washington		Montana	
			Nebraska	
			North Carolina	
			Ohio	
			Oklahoma	
			South Carolina	
			Tennessee	
			Texas	
			Wisconsin	
			Wyoming	

Data: J. Grau and K. Giesa, *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets* (Oliver Wyman, Dec. 1, 2009).

## Appendix 2. Regression Results

### 2a. Nongroup Coverage Probability

	Age rating	Gender rating	Maternity mandate	Combined effect
Groups with lower premiums in newly implementing states — after ACA (DDD)	0.0000155 (0.00558)	0.0139** (0.00688)	0.0139* (0.00783)	0.0251* (0.0140)
Groups with higher premiums in newly implementing states — after ACA (DDD)	-0.0224** (0.0101)	-0.00114 (0.00587)	-0.00683 (0.00602)	-0.0133 (0.0211)
N	249,910	249,910	249,910	249,910

### 2b. Uninsured Coverage Probability

	Age rating	Gender rating	Maternity mandate	Combined effect
Groups with lower premiums in newly implementing states — after ACA (DDD)	-0.00266* (0.00139)	0.000938 (0.00131)	0.00176 (0.00161)	-0.00609 (0.00396)
Groups with higher premiums in newly implementing states — after ACA (DDD)	0.00328*** (0.000505)	0.00189 (0.00157)	0.000585 (0.00120)	0.00802*** (0.00238)
N	4,806,458	4,806,458	4,806,458	4,806,458

\* p < .1, \*\* p < .05, \*\*\* p < .01.

Notes: Results are from regressions that control for age, race, gender, state, and education. Reported effects are marginal effects. Combined effect state classification is based on Appendix 1. Specific rule classifications are based on Exhibit 1 state allocations. Groups with lower and higher premiums are based on Appendix 3. Standard errors are shown in parentheses.

Data: 2a — Analysis of the Current Population Survey, 2010–2013 and 2014–2016, of individuals ages 26–64 with incomes above 400% of the federal poverty level; 2b — Analysis of the American Community Survey, 2010–2013 and 2014–2016, of individuals ages 26–64 with incomes above 400% of the federal poverty level.

## Appendix 3. Higher and Lower Premium Group Definitions for Appendix 2

Provision	Lower premiums	Higher premiums	Control
Age rating	Ages 55–64	Ages 26–34	Ages 35–54
Gender rating	Single women under age 50	Single men under age 50	All other adults
Maternity mandate	Single women under age 45	Single men	All other adults
Combined	Above age 55	Single men under age 35	All other adults



## NOTES

- <sup>1</sup> A. T. Lo Sasso and I. Z. Lurie, “Community Rating and the Market for Private Non-Group Health Insurance,” *Journal of Public Economics*, Feb. 2009 93(1–2):264–79.
- <sup>2</sup> L. Codisoti, B. Courtot, and J. Swedish, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (National Women’s Law Center, June 2008).
- <sup>3</sup> J. Fontana, T. Murawski, and S. Hilton, *Impact of Changing ACA Age Rating Structure: An Analysis of Premiums and Enrollment by Age Band* (Milliman Research Report, Jan. 31, 2017).
- <sup>4</sup> Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums for 2014*, ASPE Issue Brief (U.S. Department of Health and Human Services, Sept. 2013).
- <sup>5</sup> Computed based on IRS tax bulletins and our calculations of the income distribution of young single men.
- <sup>6</sup> R. Pear, “Health Law Tax Penalty? I’ll Take It, Millions Say,” *New York Times*, Oct. 26, 2016.
- <sup>7</sup> J. Grau and K. Giesa, *Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets* (Oliver Wyman, Dec. 1, 2009).

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