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Drivers of 2015 Health Insurance Premium Changes

Key Points

- Much of the uncertainty regarding the health spending by plan enrollees that existed when insurers submitted their 2014 rates remains for 2015.
- How 2015 premiums change from 2014 will depend on how assumptions regarding the composition of the risk pool differ from those assumed for 2014.
- Other major drivers of 2015 premium changes include the reduction of reinsurance program funds and the underlying growth in health care costs.

Additional Resources

- How Will Premiums Change under the ACA? (May 2013).

The Affordable Care Act's (ACA) 2014 open enrollment period for the individual health insurance market ended on March 31 and health insurers are already developing premium rates for the 2015 plan year. Insurers must submit their 2015 premiums to state and federal regulators this spring, with final approval decisions by the fall. Open enrollment for 2015 will begin November 15.

This brief outlines factors underlying premium rate setting generally and then highlights the major drivers behind why 2015 premiums could differ from those in 2014. It focuses on the individual market, but considerations for the small group market are similar.

Premiums Reflect Many Factors

Actuaries develop premiums based on projected medical claims and administrative costs for a pool of individuals or groups with insurance.

Who is covered—the composition of the risk pool

Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But, the composition of the risk pool is also important. Although the ACA prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of an insurer's risk pool as a whole. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher. If a risk pool disproportionately avoids those with higher expected claims or can offset those with higher claims by enrolling a large share of

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lower-cost individuals, premiums will be lower.

Projected medical costs

The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design.

Other premium components

Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus).

Laws and regulations

Laws and regulations can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments, and fees that need to be included in premiums.

Major Drivers of 2015 Premium Changes

Composition of the risk pool and how it compares to what was projected

Premiums for 2015 will reflect insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status. How 2015 premiums change from 2014 will depend on how assumptions regarding the composition of the 2015 risk pool differ from those assumed for 2014.

When calculating 2014 premiums, insurers made assumptions regarding the characteristics of individuals obtaining coverage—in terms of demographics, health status, prior health insurance status, etc.—and what their medical spending would be. There was much uncertainty regarding these assumptions because insurers had only limited experience data on individuals who would be newly insured in the post-reform market.

Although insurers now have information regarding the age and gender of their 2014 enrollees, they still will have only limited information on enrollee health status when 2015 premiums need to be determined, in light of the reporting lag between when health care services are provided and when claims are processed by insurers. Practitioners are observing that while some insurers are seeing 2014 enrollee demographics fairly similar to what they projected, others are seeing an older-than-expected enrollee population. In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases. Insurers will need to make assumptions regarding the extent to which the increase in the mandate penalty and overall awareness of the program increases enrollment in 2015 beyond that in 2014.

In addition, because the ACA risk adjustment program shifts funds among insurers depending on the relative health status of an insurer's population to that of the entire market, insurers need to consider not only the risk profile of enrollees in their own plans, but also the risk profile of enrollees in the market as a whole.

Other factors also will affect the composition of the 2015 risk pool and its impact on premiums, including:

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- **Single risk pool requirement.** The ACA requires that insurers use a single risk pool when developing rates. That is, experience inside and outside the health insurance marketplaces (aka exchanges) must be combined when determining premiums. Premiums for 2015 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2014.
- **Transitional policy for non-ACA-compliant plans.** For states that adopted the transitional policy that allowed non-ACA-compliant plans to be renewed, the risk profile of 2014 ACA-compliant plans might be worse than insurers projected. This would occur if lower-cost individuals retain their prior coverage and higher-cost people move to new coverage. The transitional policy was instituted after 2014 premiums were finalized, meaning insurers were not able to incorporate this policy into their premiums. For most states, the transitional policy for 2015 is known in advance and can be incorporated into assumptions regarding the composition of the 2015 risk pool. The impact on premiums could be greatest in states that had large, heavily-underwritten individual markets in place prior to 2014.
- **State-by-state variations.** Health insurance enrollment, and the composition of that enrollment, is often presented on a national basis. However, health insurance premiums are set at the state level (with regional variations allowed within a state) and will reflect state- and insurer-specific experience. For instance, enrollment volume and the composition of the risk pools could be worse than projected in states with ineffective outreach efforts and/or technical problems with the marketplaces. Insurers will incorporate that experience into their 2015 premium assumptions to the extent they expect such trends to continue. Insurers also will incorporate information on whether the state adopted the transitional policy for non-ACA-compliant plans and whether states are allowing that policy to continue through 2015.

Importantly, if actual experience regarding the risk profile of 2014 enrollees differs from assumptions and losses occur in 2014, insurers cannot recoup past losses through higher premiums for 2015. Instead, assumptions for 2015 will be reset incorporating available 2014 experience. As noted above, however, insurers will have only a few months of incomplete experience data prior to filing their 2015 rates.

Reduction of reinsurance program funds

The ACA transitional reinsurance program provides for payments to plans when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees in the individual market. This reduces the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans. These contributions are then used to make payments to ACA-compliant plans in the individual market.

For the 2014 plan year, $10 billion will be collected from health insurers and used to pay plans in the individual market when an individual's claims exceed $45,000 (the reinsurance attachment point). Insurers will be reimbursed for 80 percent of these individuals' health claims between $45,000 and $250,000. The amount collected for the reinsurance program will decrease to $6 billion for 2015, and to $4 billion for 2016 with no further scheduled collections.

The reduced reinsurance funds available for 2015 and 2016, coupled with a potential increase in enrollment in the individual market, will reduce the per enrollee reinsurance subsidy. By providing less of an offset to premiums, the reduction in reinsurance funds will result in an in-

crease in premiums. Reinsurance program payments for 2014 generally reduced projected net claim costs by about 10 to 14 percent.[1] For 2015, HHS initially announced that insurers would be reimbursed for 50 percent of an individual's health claims between $70,000 and $250,000.[2] Such reinsurance design parameters would likely reduce net claims by about 6 to 8 percent. This lower reduction in claims relative to the parameters in 2014 translates to about a 4 to 7 percent increase in projected claims, due only to the reduction in the reinsurance program and not factoring in any other factors such as medical trend.

More recently, however, HHS has noted an intention to reduce the 2015 reinsurance attachment point from $70,000 to $45,000 and perhaps also to change the coinsurance rate, depending on reinsurance fund collections and rollovers.[3] Incorporating the lower attachment point into 2015 premium determinations (and assuming no offsetting changes to the coinsurance rate) would result in a lower increase in premiums relative to the higher attachment point. But because formal rules implementing these potential changes have not yet been released, it's unclear the extent to which insurers will assume the lower attachment point in their 2015 premiums.

Underlying growth in health care costs

The increase in costs of medical services, referred to as medical trend, reflects not only the increase in per-unit costs of services, but also increases in health care utilization and intensity. In recent years, health spending growth has been low relative to historical levels. There is, however, some uncertainty regarding the causes of these trends and whether they will continue. The recent economic downturn and slow recovery have contributed to the slowdown. More structural changes to the health care payment and delivery system also may have contributed to slower health spending growth, through for instance a greater focus on cost-effective care or a slowdown in new medical technology. Premiums for 2015 will reflect assumptions regarding the extent to which the recent slowdown will persist.

Other Drivers

Changes in provider networks

In 2014, many insurers shifted to narrower provider networks to keep premiums affordable. Narrower networks can give insurers more leverage to negotiate lower provider payment rates, and they also can be used to direct enrollees to more cost-effective and high-quality providers. Broadening provider networks could put upward pressure on premium increases.

Changes in provider reimbursement structures

Any increased negotiating power among providers could put upward pressure on premium increases. On the other hand, insurers could pursue changes in provider reimbursement structures that move from paying providers based on volume to paying based on value. For example, accountable care organization structures offer incentives to provide cost-effective and high-quality care. Such efforts could put downward pressure on premium increases.

[1]Originally, the reinsurance program was scheduled to reimburse 80 percent of health claims between $60,000 and $250,000. Premiums filed for 2014 reflected these reinsurance program parameters. Subsequently, the reinsurance attachment point was lowered from $60,000 to $45,000. Further pro rata changes to these parameters are possible if total reinsurance funds collected differ from the total claims submitted for reimbursement.

[2]HHS Notice of Benefit and Payment Parameters for 2015 (Final Rule), Federal Register: 79 (47), March 11, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

[3]The intention to reduce the reinsurance program attachment point was stated in the preamble of Exchange and Insurance Market Standards for 2015 and Beyond (Final Rule), Federal Register: 79 (101), May 27, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf. The actual modification is expected to be formally proposed with the release of the 2016 Payment Notice in late 2014.

Benefit package changes

Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan's metal level remains unchanged.

Risk margin changes

Insurers build risk margins into the premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion in case costs are greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums. Changes to the level of uncertainty regarding claim costs or other aspects of ACA provisions can cause changes to the risk margins. For instance, although HHS has confirmed through recent regulations that full risk corridor payments are required to be made to insurers even in the event that such payments exceed risk corridor collections from insurers,[4] it is not clear how any shortfalls would be funded. This uncertainty could increase the risk of insurer losses if premiums are set too low. As a result, insurers could increase their risk margin to reflect the additional risk associated with pricing uncertainty..

Market competition

Market forces and product positioning also can affect premium levels and premium increases. Insurers might withstand short-term losses in order to achieve long-term goals. Due to the ACA's uniform rating rules and transparency requirements imposed by regulators, premiums are much easier to compare than before the ACA, and some insurers lowered their premiums after they were able to see competitors' premiums.

Changes in administrative costs

Any changes in administrative costs also will affect premiums. For instance, changes can result from increased costs associated with ACA implementation or from spreading fixed costs over a different than projected enrollment base.

Increase in the health insurer fee

In 2014, the ACA health insurer fee is scheduled to collect $8 billion from health insurers. The fee will increase to $11.3 billion in 2015 and gradually further to $14.3 billion in 2018, after which it will be indexed to the rate of premium growth. The fee is allocated to insurers based on their prior year's premium revenue as a share of total market premium revenue. In general, insurers pass along the fee to enrollees through an increase to the premium. The effect on premiums will depend on the number of enrollees over which the fee is spread—a greater number of enrollees will translate to the fee being a smaller addition to the premium. The increase in health insurer fee collections from 2014 to 2015 will, in most cases, lead to a small increase in 2015 premiums relative to 2014. Certain insurers may see larger increases, however, such as CO-OPs that did not write business in 2013 and therefore were not subject to the fee in 2014.

Changes in geographic regions

Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria. Changes in the number of geographic regions in the state or how those regions are defined could cause premium changes that would vary across areas. For instance, assuming no other changes, if a lower-cost region and a higher-cost region are combined into one region for premium rating purposes, individuals in the lower-cost area would see premium increases, and individuals in the higher-cost areas would see premium reductions.

[4]Exchange and Insurance Market Standards for 2015 and Beyond (Final Rule), Federal Register: 79 (101), May 27, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf.

Summary

The 2015 health insurance premium rate filing process is underway, as insurers are preparing and submitting their premiums to state and federal regulators for review. Much of the uncertainty regarding the health spending by plan enrollees that existed when insurers submitted their 2014 rates remains for 2015. Although insurers have information on enrollee demographics, only limited information will be available on enrollee health status and health spending.

How 2015 premiums differ from those in 2014 will depend on many factors. Key drivers include how the composition of the risk pools for 2014 compares to what was projected (to the extent this is identifiable), the reduction of funds available through the temporary reinsurance program, and the underlying growth in health costs. How enrollment differs from expected will vary by insurer and by state, with larger premium increases possible in states that adopted the transition policy allowing non-ACA-compliant plans to be renewed.

Other factors potentially contributing to rate changes include any modifications to: provider networks, provider reimbursement structures, benefit packages, risk margins, administrative costs, or geographic region definitions. The increase in the health insurance fee could put upward pressure on premiums if it is not offset by a commensurate increase in enrollment. Insurers also incorporate market considerations when determining 2015 premiums.