KEY TAKEAWAYS

Premium rates reflect many complex factors, and there is significant variation in rates across states and markets.

Affordability remains a top priority for enrollees with many consumers in this price-sensitive market selecting lower-cost coverage options.

Rising medical costs and prices, the phase out of the temporary premium stabilization programs, and ongoing risk pool effects in certain states add to the cost pressures in the Exchange market.
Factors Affecting Premiums in 2017 Individual Exchange Marketplace

Background

The Affordable Care Act (ACA) established new health insurance market rules that aim to improve access to high-quality and comprehensive care for millions of uninsured Americans. The health law includes a broad array of insurance market reforms—such as guaranteed issue, community rating, and prohibiting pre-existing condition exclusions—along with new coverage requirements, such as essential health benefit standards, limits on patient cost sharing, extending coverage to dependents up to age 26, barring annual or lifetime limits on coverage, and related consumer protections. These reforms are intended to work in tandem with the new insurance marketplaces, subsidies, and the individual coverage requirement to expand access to insurance.

Since the ACA was enacted six years ago, 20 million Americans have gained health insurance coverage through the Exchange marketplace, expanded Medicaid and related coverage expansions in the law.1 Expansions in coverage have pushed the uninsured rate to historical lows—according to several independent and non-partisan studies.2 As of March 2016, 12.7 million individuals have selected or re-enrolled in Exchange plan coverage (including 4.9 million who were newly covered).3 Nearly 80 percent of marketplace enrollees have access to a plan that costs less than $100 a month, after any applicable tax credits are applied.4

With the third open enrollment period now concluded, health plans are developing and pricing products for the 2017 open enrollment cycle—beginning later this fall (Nov. 1, 2016). Plans will soon be submitting proposed premium rates through the applicable state and/or federal regulatory approval process (see below for key rate filing timelines and deadlines).

The purpose of this issue brief is to describe and assess the various factors that will impact individual Exchange marketplace premiums for the 2017 plan/benefit year. Premium rates reflect many complex factors and there is significant variation in rates across states and markets. And the impact of any rate increase will depend on an individual’s income (including whether they qualify for premium tax credits), geography, age, and other factors. Moreover, the impact of any rate increase also depends on individual’s coverage preferences and options available to them.

In the Exchange marketplace, consumers are selecting coverage options that best meet their own financial and health care needs. Affordability remains a top priority for enrollees with many consumers in this price-sensitive market selecting lower-cost coverage options. Consumers also have the ability to shop among many competing plans—among the 3.9 million individuals shopping and actively re-enrolling in Exchange plan coverage, about 60 percent switched to a different plan than they had previously purchased in 2015.5

Exchange Premiums (2014-2016)

The implementation of the ACA insurance market reforms and benefit requirements had far-reaching implications for access and affordability of coverage for consumers. As is the case when consumers and health plans transition to new insurance markets, there was considerable uncertainty about a number of elements and factors that would affect premiums—including the underlying health risk of the population likely to enroll and the effectiveness of various provisions of the law—such as premium subsidies and the
individual coverage requirement—that are aimed at promoting coverage and enrollment.

The sweeping reforms introduced by the ACA in the Exchange marketplace make comparisons to the pre-reform marketplace difficult. That is because the ACA reforms require more comprehensive coverage than policies typically sold in the pre-reform individual market—including coverage for prescription drugs, maternity care, and mental health and substance abuse treatment services. However, a study by PwC found that “premiums for health plans offered on new state Exchanges under the Affordable Care Act are comparable to—and in some cases lower than—those being offered by employers with similar levels of coverage.”

Nationwide average premium increases for the Exchange marketplace have been moderate in 2015 and 2016—although premium increases tended to be higher in 2016 than previous years and there remains considerable state-by-state variation in premium increases.

While expanded access to coverage represents significant progress, challenges remain as the market is still working its way to stability. Financial losses in the Exchange marketplace have been substantial in many states driven by a confluence of factors including, most notably, ongoing regulatory changes and uncertainty about the population enrolling into the Exchange marketplace.

Affordability of premiums over the long term will require sustained attention and policy action to address underlying health care cost growth factors (including increasing prescription drug and provider prices) while also taking steps to promote market stability. These steps include:

- **Strengthening the risk adjustment program to promote greater payment accuracy.** The ACA risk adjustment programs play an important role in promoting market stability, a level playing field, and affordable coverage for consumers in the marketplace—particularly for patients with chronic health conditions. Additional targeted changes to improve the
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accuracy and effectiveness of the model—such as better accounting for the effects of partial year enrollment and including prescription drug data in the model—can help strengthen the risk-adjustment program so it can better fulfill its goals of promoting affordability and stability in the new marketplace.

• **Improving verification of special enrollment periods (SEPs).** While the Administration has taken steps to address the misuse of SEPs, more action is needed to assure appropriate use of SEPs—which is critical to assuring stability in the new Exchange marketplaces and promoting affordability for consumers. HHS recently clarified the availability of certain SEPs—notably, tightening the eligibility requirements for most instances of permanent move by requiring prior coverage to limit potential abuse. Earlier this year, the Administration also announced that it would conduct an assessment of enrollments made through SEPs. Additional policy steps include further streamlining and reducing the number of SEPs and implementing pre-enrollment verification for high-priority SEPs (such as permanent move and loss of minimum essential coverage).

• **Promoting stability and flexibility in benefit and network design to promote consumer choice and affordability.** Benefit design flexibility is a hallmark of private sector coverage and innovations in benefit and network design can help promote affordability and value for consumers in the new marketplace. Moreover, flexibility in network design—including the ability of plans to offer high-value network plans—provides consumers with options of affordable choices of plans and providers that meet their own financial and health care needs.

• **Enhancing the effectiveness of outreach and enrollment strategies to build on coverage gains.** Expanding participation in the new marketplace—including through more targeted educational and outreach efforts to subsidy-eligible individuals—can not only build on the progress made in reducing the number of uninsured but can also help stabilize the risk pool and promote more affordable premiums.

• **Extending the current moratorium or permanently repealing the health insurance tax (HIT).** Last year, Congress worked on a bipartisan basis to provide a one-year moratorium on the HIT tax for 2017—which will reduce premiums by over 3 percent, saving consumers enrolled in fully-insured coverage over $200 next year. Extending the moratorium or permanently repealing the HIT would further enhance affordability and lower premiums for consumers across all markets.

• **Other ACA changes.** The ACA establishes 3:1 age rate band requirements that may have led to higher premiums for certain younger consumers—particularly those that purchased individual market coverage prior to the ACA and are not currently subsidy eligible. Providing flexibility to states to adopt wider age bands—such as the 5:1 limit that existed in most states prior to the 3:1 age bands—could help encourage younger and healthier people to enroll in coverage which, in turn, could improve risk pool stability and affordability for consumers.

Additionally, changes to the ACA minimum medical loss ratio (MLR) requirement—such as considering health plans’ fraud prevention activities as quality improvement and not administrative expenses can lead to lower costs due to reduced fraud and abuse. Addressing these two issues—while not directly affecting 2017 premium rates—hold potential to improve market stability and affordability long term.
Factors Affecting 2017 Premiums

As health plans develop and finalize Exchange products and rate filings for the 2017 plan year, a number of factors will affect premiums. Some factors—such as underlying health care cost growth, phaseout of the temporary premium stabilization programs, increased utilization of services, and risk pool effects in certain states and markets—are expected to place upward pressure on premiums. Other elements—such as market competition, effectiveness of the individual coverage requirement, increasing awareness of the new marketplace, and availability of subsidies—hold the potential to mitigate premium increases as well as enhance affordability for consumers.

Medical Trend

After a period of historically slow growth rates, U.S. health care spending is once again on the rise (increasing 5.5 percent last year)—largely driven by increased spending due to coverage expansions in the ACA as well as substantial increases in prescription drug spending. According to the Centers for Medicare and Medicaid Services (CMS) national health expenditures report—which represents both public and private health care spending in the United States—a major driver of increased spending is the “sharp rise in prescription drug spending growth, which is projected to have accelerated from 2.5 percent in 2013 to 12.6 percent in 2014.”

Medical trend increases are similar in the commercial market—Milliman found that spending increased 6.3 percent in 2015—driven by prescription drug costs which “spiked significantly, growing by 13.6 percent from 2014 to 2015.” In a separate analysis, Milliman found that prescription drug trends have been “particularly high in recent years, driven in part by the high cost and demand for new high-cost specialty drugs.” Similarly, Segal Consulting projects health plan medical cost trends ranging from 6.8 to 9.9 percent in 2016. Prescription drug spending is a key factor fueling medical trend increases—with a projected specialty drug/biotech trend increase of 18.9 percent in 2016.

As premiums closely track medical trend and the fact that the vast majority of premium dollars goes to medical claims, increases in medical trend (which reflects both health care prices and utilization) are a key driver of health insurance premium increases. As medical trends continue to increase—driven in large part by prescription drug spending increases—this can be expected to lead to higher premiums for 2017.

Pharmacy Trend

The rapid rise in prescription drug spending—largely the result of high prices for new brand name drugs and price increases for some existing brand name drugs—is a major contributor to medical trend and premium increases across markets. Total prescription drug spending reached $457 billion in 2015—an all-time high—and prescription drug spending now accounts for 16.7 percent of the estimated $2.7 trillion spent on overall personal health care services.

Specialty drugs—in particular—continue to drive overall prescription drug costs, posing even greater pressure for consumers with more than 700 specialty drugs in the pipeline. Some newer specialty drugs may cost upward of $100,000 per year or course of treatment, and estimates suggest spending on specialty drugs could quadruple by 2020, reaching $400 billion.

Risk Pool Composition—including Impact of Transitional Policy

Broad-based participation and coverage is critical to an affordable and stable insurance marketplace. Incentives to assure broad participation—including among younger and healthier individuals—is crucial to a well-functioning and stable insurance market.
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Risk pool stability and participation levels vary significantly across states and reflect many factors—including whether the state elected to allow certain non-ACA compliant policies to continue into effect. According to the American Academy of Actuaries, “if lower cost individuals retain their prior coverage, and higher cost people move to new coverage, the medical spending for those purchasing new coverage could be higher than expected.”

Under recent guidance, CMS announced that transitional policies would expire by the end of 2017. According to Milliman, continued migration of individuals into ACA compliant plans is “expected to improve the health-status of the market as a whole, which could lower the relative cost of coverage on average.”

Impact of Coverage Transitions and Marketplace Turnover

Recent analysis underscores the challenges as well as opportunities presented by coverage transitions and plan switching. Compared to the employer and Medicare marketplace, the Exchange population is more likely to experience coverage transitions and switch plans based on price. According to an analysis by Avalere, 2.4 million Exchange customers—representing 25 percent of all shoppers in federal Exchange states—selected a different plan from their 2015 choice.

While price sensitive consumers can benefit from lower premiums when shopping for coverage, the data also underscore instability and turbulence in the market through significant turnover and transitions in coverage from year to year.

The impact of significant turnover and marketplace churn on marketplace premiums is uncertain. Engaged consumers comparing options and shopping for lower-cost and high-value plans is a key feature of competitive markets. By fostering private market competition and the drive toward value, this effect could place downward pressure on rates—as plans compete for business and innovate to develop lower premium options for consumers.

At the same time, this significant level of churn and turbulence in Exchange enrollment—including the effects of frequent plan switching—may have implications for continuity of coverage and care for Exchange enrollees, particularly for patients with chronic conditions.

Changes to the ACA Premium Stabilization Programs (3Rs)—Including Phase Out of Reinsurance and Risk Corridors Programs

The ACA Premium Stabilization Programs (3Rs)—risk adjustment, transitional reinsurance and temporary risk corridors program—play a critical role in promoting a stable and competitive market and affordable coverage, particularly for patients with chronic health care conditions.

The risk adjustment program is a permanent feature of the ACA that aims to promote long-term stability and a level playing field through risk transfers among plans in the individual and small-group market. The program—which is fully funded through assessments on health insurance plans—addresses the problem of adverse selection by making payments to plans that disproportionately enroll higher-risk and higher-cost individuals through assessments on plans that enroll lower-cost, lower-risk populations.

In 2014, the risk adjustment program resulted in $4.6 billion in total payment transfers—that is, payments from plans with healthier enrollees to plans with sicker and higher risk enrollees. According to CMS analysis, health plans that enrolled a disproportionate share of higher risk patients—by offering more robust drug coverage, including specialty hospitals in plan networks, or contracting with Ryan White providers—received risk adjustment payments to offset these high costs. Moreover, health plans that traditionally served as the insurer of last resort in a state and, as a consequence, have historically...
disproportionately enrolled expensive patients also received risk adjustment payments. By compensating plans that enroll high-risk individuals and protecting against the effects of adverse selection, the risk adjustment program plays an important role in promoting market stability and affordability. As implementation of the program continues, CMS is considering targeted policy changes to strengthen the risk adjustment program so it can work more effectively in meeting its goals.

While the risk adjustment program is a permanent feature of the ACA, two important premium stabilization programs—transitional reinsurance and temporary risk corridors— are phasing out for the 2017 benefit year. The phase out of these programs is expected to place upward pressure on rates for the 2017 plan year—particularly as it relates to the reinsurance program as payments to plans to offset high-cost claims will no longer be made available.

An analysis by Milliman found that some upward pressure on rates in 2017 will be due to the phase out of the reinsurance program as well as the “sunset of the risk corridor program and uncertainty regarding collections under the program.”

**Benefit and Network Design**

The benefits included in health care coverage and their cost-sharing parameters (copayments, coinsurance, deductibles, and out-of-pocket limits) play an important role in the rate-setting process. The ACA requires all health plans in the individual and small group markets to cover the Essential Health Benefits (EHB)—10 categories of benefits that reflected comprehensive coverage in the employer market prior to passage of the ACA. The EHB framework established by the ACA requires that consumers have access to comprehensive coverage, while promoting state and health plan flexibility to offer a range of coverage options. Some states may also require health plans to cover benefits that go beyond the scope of the EHB package. These additional benefits could further add to the cost of coverage.

Similarly, doctors and other health care providers that are included in a health plan’s network have a significant impact on premiums. By designing targeted, high-value networks based on quality and efficiency, health plans can provide access to care while keeping coverage affordable. According to research by McKinsey, narrowed or high-value network plans result in premium savings of over 20 percent as compared to traditional broader network plans.

**Pent-Up Demand and Utilization of Medical Services**

Individuals accessing health care coverage for the first time may have previously delayed going to a doctor about a condition or postponed procedures because of cost concerns. This can lead to a spike in utilization at the beginning of the coverage year.

While pent-up demand was a concern in the initial years of ACA implementation due to the large numbers of newly insured, it should become less pronounced as more individuals gain and maintain coverage and markets become more predictable.

**Special Enrollment Periods (SEPs)**

SEPs play an important role in promoting continuity of coverage and care during important life transitions (e.g., birth, marriage, divorce, a move or more). At the same time, current rules for the federal marketplace do not adequately verify eligibility for enrollment through SEPs. As a result, individuals can qualify for some SEPs without proof of eligibility or evidence of prior coverage.

A recent analysis found that SEP enrollment represented a significant share of marketplace enrollees, and such individuals had much higher claims costs and were far more likely to drop coverage than individuals who enrolled through...
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open enrollment. This misuse and misapplication of SEPs is placing upward pressure on premium rates—as a result of certain individuals purchasing coverage only when they need medical care. Greater verification of SEPs can help assure that individuals who qualify for SEPs get the coverage and care they need while—at the same time—promoting affordability for all Exchange consumers.

Market Competition

A robust marketplace where health plans compete on value is an effective way to hold down the cost of coverage while providing consumers with high-quality coverage options. Efforts to promote a competitive, level playing field where health plans are driven to develop innovative and effective coverage options will benefit consumers through more coordinated and efficient care, as well as lower premiums.

Taxes and Fees

The ACA included many taxes and fees on health care coverage that put upward pressure on premiums. These include the health insurance tax, user fees for Exchanges and the risk adjustment program, and fees to fund the Patient Centered Outcomes and Research Institute (PCORI).

Congress recently provided for a one year moratorium of the health insurance tax in 2017, which will reduce the overall impact of taxes and fees on 2017 premiums. As a result, individuals purchasing coverage on their own are expected to save more than $200 in premiums next year.

Individual Mandate Penalty

The mandate for individuals to have health care coverage is a critical mechanism in the ACA’s coverage expansion. Without a strong incentive to maintain coverage, individuals could forego purchasing health insurance until they need medical attention—creating adverse selection and driving up the cost of coverage for everyone.

For 2017, the ACA’s penalty for not maintaining coverage remains at $695 or 2.5 percent of household income, whichever is higher. As greater consumer awareness of the marketplace options grows (including the penalty for not having coverage), many experts believe this may encourage more individuals, particularly younger and healthier individuals, to participate in the marketplace—which, in turn, would improve risk pool stability and affordability.

Insurance Subsidies—Premium Tax Credits and Cost-Sharing Reductions

While the ACA’s financial assistance provisions reduce the cost of coverage to consumers with incomes up to 400 percent of the federal poverty level (FPL), additional cost-sharing subsidies that reduce copays and deductibles are available to those making 250 percent or less of FPL.

Results from the first three open enrollment periods show that financial assistance in the form of premium tax credits and cost-sharing reductions plays a key role in promoting broad-based participation in the marketplaces. Of those consumers shopping for coverage for 2016, 83 percent qualified for a premium subsidy of $294 per month (on average). More than half of enrollees in 2015, 56 percent, received cost sharing reductions.

While financial assistance (premium tax credits and cost-sharing reductions) help enhance affordability for those eligible for them, they do not directly address underlying health care cost drivers or premiums.

Greater Consumer Awareness and Effectiveness of Outreach

At the close of the third open enrollment period, 12.7 million individuals selected or re-enrolled in Exchange plan coverage and the number of uninsured Americans has declined by 20 million since the passage of the ACA. Improving outreach and enrollment strategies to build on this early
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Success and further expand coverage—particularly to the 12.5 million Americans who are eligible for financial assistance under the ACA but remain uninsured—can help promote market stability. By increasing participation and coverage, improved outreach and enrollment—such as enhanced outreach through employment, public schools, and through non-health related means-tested programs—can help improve risk pool stability and place downward pressure on premiums.

Conclusion
Health insurance premiums are set based on a complex set of factors that reflect the cost of providing coverage in a state and in a market. These factors include local market dynamics, such as the extent of hospital and provider consolidation, the characteristics of the covered population, and local price and utilization trends.

For the 2017 plan year, there are a number of specific factors that will impact premiums. Some will place upward pressure on premiums—rising medical trends and prices, the phase out of the temporary premium stabilization programs, and ongoing risk pool effects and challenges in certain markets and states—while other factors can mitigate increases and promote affordability—such as the individual coverage requirement, premium subsidies, and increased awareness of coverage options and effectiveness of outreach and enrollment initiatives. Assessing the various factors can help policymakers and stakeholders identify and address the cost drivers and build on the early success of the Exchanges—with the goal of assuring stability in the market and affordability for consumers.

Related Topic

“Maximum out-of-pocket limits included in the Affordable Care Act protect individuals and families from high medical spending, including those covered by Exchange plans in the individual market and employees and their dependents covered by small and large employers.”

Source: Patient Cost Sharing Under the Affordable Care Act. AHIP, 2015
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4. Ibid.


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25 Preliminary estimates of nationwide risk 2014 risk corridors payments and charges were released on October 1, 2015. HHS will collect $362 million from those health plans with less than expected medical spending. Under the parameters of the risk corridor calculation, HHS will pay out $2.87 billion to those plans with greater than expected medical spending. However, HHS will pay approximately 12.6% of the requested risk corridor payments for the 2014 plan/benefit year. HHS stated that it will use collections from program years 2015 and 2016 for the remaining 2014 funds. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf


