Gail R. Wilensky

REPRINT July 2015

hfm
healthcare financial management association hfma.org

# 2016 exchange rate hikes: how big will they be?

**The proposed rate hikes for insurance premiums in the federally facilitated and state-based exchanges, announced in early June, once again have raised concerns about how affordable the plans in the Affordable Care Act (ACA) will be.**

The ACA requires that health insurance companies offering individual or small-group plans file their proposed rates each year by May 15 (or as late as June 5 in a few states that run their own exchanges). By June 1 (or June 19 for some states), all proposals for insurance rate increases that are greater than 9.9 percent along with their rate justifications are to be made public by the Centers for Medicare & Medicaid Services (CMS) or state regulators for a period of public comment. Final rates are to be posted publicly at the end of October, with the next enrollment period scheduled to begin Nov. 1. (The Supreme Court's ruling in *King v. Burwell*, which was expected in late June or early July, may affect enrollment plans in numerous states.)

## Large Increases Proposed

Some of the premium increases reported for 2016 in early June were startling—a 50 percent increase requested by the Blue Cross Blue Shield plan of New Mexico, for example. Among other instances, Alliant Health Plans is asking for an average increase of 38 percent in Georgia, Blue Cross and Blue Shield of North Carolina is seeking an average increase of 26 percent, Blue Cross and Blue Shield of Illinois is asking for an average increase of 29 percent, and Highmark in Pennsylvania and CareFirst BlueCross BlueShield of Maryland are asking for 30 percent increases.

By comparison, the premium increases for 2015 averaged a modest 5.4 percent, according to PwC's Health Research Institute.[a] Like the premiums for 2014, however, these premiums were based on scant information.

The premiums for 2014 obviously were just guesses about the characteristics and healthcare needs of the people who would choose among the various insurance plans in the exchanges. The proposed rates for 2015 did not have much more information to go on. Those proposals were due in May of 2014, when the plans had very limited experience to use in basing their estimates. Large numbers of individuals had delayed their sign-up until the last week of the open season, creating so many difficulties for some of the websites that many states delayed the March 31 closing by one to two weeks. Given the lag time between services provided and the submission of bills for payment, insurance plans had little opportunity to assess and predict 2015 rates based on 2014 experience.

Thus, the proposed rates for 2016 are the first to reflect the actual experience of plans—some of which have been reporting substantial losses. BlueCross Blue Shield of Tennessee, for example, reported losing $141 million on individual policies sold in the exchange, paying $1.14 per dollar of premium collected. Not surprisingly, it has requested a substantial increase—36 percent.

## Mitigating Considerations

Although these proposed increases may appear to be a source of concern for ACA supporters and for many who buy insurance in the exchanges, there are at least two mitigating considerations.

a. "A Look at State ACA Participation and 2015 Individual Market Health Insurance Rate Filings," PwC Health Research Institute, updated as of May 18, 2015.

The first is that they are only *proposed* increases. Most states have a review and negotiation process in place for proposed insurance rate increases. Although some states appear to have more aggressive and effective rate review processes than other states, CMS has deemed most to be effective. In states where CMS has determined there is not an effective process in place, the agency has the option of taking over the rate review function.

Historically, some states have seen significant "pushback" by the rate-reviewing authorities. In Maryland, for example, CareFirst asked for a 30 percent increase for 2015, but was granted only 16 percent. In states with this type of history, it is hard to know whether plans are requesting increases that are higher than what they need or expect to receive as a strategy for improving their chances of being approved for the increases they actually need.

The second mitigating consideration is that although some plans have proposed significant increases, other plans in the same states are requesting much smaller increases and, in some cases, even proposing rate decreases. In Maryland, for example, Kaiser Foundation Health Plan of the Mid-Atlantic States has requested a 4.8 percent increase, and Evergreen Health Cooperative a 9.7 percent increase, and both Cigna and UnitedHealthcare have proposed small decreases in their rates from the previous year.

The pattern in Maryland is similar to what has been observed in other states. The dominant exchange player, in this case CareFirst, has proposed a substantial increase in its premiums for the following year, indicating a willingness to lose some of its market share. Similar behavior was observed in 2015, when some plans with the lowest 2014 premiums experienced large sign-ups and then proposed substantial increases for 2015.

## Implications for Consumers

The extent to which consumers might be affected by big premium increases in 2016 will depend largely on the size of the subsidy they receive (assuming the subsidies remain in place after the *King* decision). The increases would affect those who receive significant subsidies far less than they would those whose subsidies are relatively small, although given their lower incomes, many of the former also would be adversely affected by any increase in the amount they have to pay. The fact that the amount of a subsidy depends both on the individual's income and on the cost of the second-lowest silver plan in the individual's area makes it all the more important for consumers to establish how much subsidy they are likely to receive before they select their plan.

The range of premium changes being requested also means that even people who are satisfied with their 2015 plan choice should investigate their options for the 2016 enrollment cycle. A plan that was attractive for 2015 in terms of benefits and premium cost, net of subsidy, may not be so attractive for 2016, and conversely, plans that were less attractive in 2015 may appear far more attractive.

Educating patients about the importance of checking out their options on a yearly basis has been a challenge. Given the trust many people place in their physicians, this is an area where physicians could provide an important public service to their patients, encouraging them to check the premium costs and insurance benefits in the options available to them rather than just continuing with the previous year's choice. The U.S. Department of Health and Human Services should consider an active outreach to physicians during next year's enrollment period, or states could consider adopting Rhode Island's strategy—requiring an active reenrollment rather than allowing for auto-reenrollment. ■

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of the Health Care Financing Administration, now the Centers for Medicare & Medicaid Services; and a former chair of the Medicare Payment Advisory Commission (gwilensky@projecthope.org).