Gail R. Wilensky

# 2017 shows signs of major ACA premium increases

**Around June of the past two years, as the first proposed rate increases started becoming public, the guessing began about how much the next year's premiums under the Affordable Care Act (ACA) would change. With this year being an election year, there is at least as much interest in the 2017 rates as there was in the previous two years. The timing could hardly make for more exchange drama. Open enrollment will begin the week before the November election, and the final rates will become publicly available a few weeks before that.**

Already the interest is high, in part because the early requested rates are coming in higher than the 2016 increases—although , as usual, with a lot of variation across plans and, in some cases, across areas within a given state. This development is not really surprising, because both not-for-profit and for-profit plans have been reporting sicker than expected enrollees, with many companies experiencing losses as a result.

## Early Requested Premium Increases

According to an Avalere analysis, average requested premium increases for 2017 for silver plans—the most popular plans among enrollees, covering about 70 percent of medical claims—were 12 percent higher than final 2016 premiums for the first nine states making requested premium increases public.[a] The requested increases for the second lowest-priced silver plan vary substantially. This plan is particularly relevant because its price is used in the formula for setting subsidies (which also are based on each person's own income). Three of the areas—Washington, D.C., Maine, and Oregon—requested increases of 16 percent. Meanwhile, two states—Washington and Indiana—requested premiums reductions of 7 percent and 1 percent, respectively.

It is important to keep in mind that requested rates frequently end up lower, and sometimes substantially lower, after they are reviewed by the regulators in each state. Rate increases of more than 10 percent are always reviewed, while those below 10 percent may be reviewed at the states' regulators discretion. For some states (although not all), these requested rate increases might be more accurately described as "opening bids" rather than expected increases.

## Why 2017 May Be Different

However, 2017 may be different from the previous two years—for one positive reason but mostly for negative ones.

The one positive development is that the insurance tax has been postponed for next year. The total amount of the tax is specified by law and allocated among insurers based on their total revenues. The postponement is of greatest benefit to for-profit insurance companies because they pay twice the amount of the tax, proportionally, that tax-exempt or not-for-profit insurers pay.

On the negative side, however, two provisions in the law that were designed to help shield insurance companies from unexpected bad health risks—risk corridors and reinsurance—expire in 2016. These provisions have not been as important to insurers as many had anticipated because not enough companies reported higher-than-expected profits to allow those that reported higher-than-expected losses to be able to fully

a. Pearson, C.F., "CORRECTION: Early Analysis Finds 2017 Proposed Exchange Rates Exceed 2016 Increases but Vary Widely by State," Avalere Health, June 3, 2016.

recoup their losses—at least not on a budget-neutral basis, which Congress mandated. Without legislative authority to spend more than the exchange participants contributed, the reinsurance provision was able to cover only about 12 percent of insurers' losses.

Several insurers also have been reporting losses from their exchange business, which has put pressure on companies to raise premiums. The losses could be reported for 2016 in part because 2016 was the first year in which proposed premiums could reflect actual experience rather than having to be based only on projections about a group that previously had been uninsured or insured using health underwriting. The bids for 2014 were simply guesses about who might sign up, and bids for 2015 were due in May 2014, at which point companies had no more than a couple of months of experience with their enrollees. Even with some actual experience, however, insurers cannot easily predict who will enroll for the next year, given enrollees' extreme price-sensitivity. This uncertainty has made it more challenging for companies to predict their exchange populations' likely health risks.

UnitedHealth Group Inc. announced in January that expected losses of more than $500 million on its 2016 plans (compared with earlier projections of $425 million) prompted it to pull back on 2017 exchange participation. A *Wall Street Journal* report discussing UnitedHealth's decision also cited Humana's decision to set aside a "premium deficiency reserve" to account for expected 2016 losses.[b] Although UnitedHealth Group is the biggest U.S. health insurer, it had not been a major participant in the ACA exchanges, so the impact of its announcement was more of an early warning sign of trouble ahead than a significant negative blow for enrollees.

Consistent with the reports from these two for-profit firms, the Blue Cross Blue Shield (BCBS) Association released a report in March that evaluated the health conditions and costs of the enrollees in 2014 and 2015.[c] The report indicated that enrollees in BCBS plans after the ACA have higher rates of disease and received significantly more medical care on average than did those who enrolled in BCBS individual plans prior to 2014. This finding was significant because the BCBS companies have participated more broadly in the exchanges than have any other insurance carriers.

The only companies that have seemed to perform well financially with the exchanges—at least to date—are Medicaid-focused companies like Centene.[d] It may be that the combination of enrollees' price sensitivity and the ACA requirement of a broad-based benefit package creates a situation in which the only companies that can do well financially are those that structure their business like a Medicaid managed plan—i.e., with broad-based benefits and a narrow network of providers that have agreed to accept low rates in return for the promise of increased business. Many of the other insurers participating in the exchange offer Medicaid managed care plans, so they know how to structure them, but they launched their initial exchange plans to look more like their employer-sponsored plans.

As is true for many parts of the ACA, the implementation, and ultimate design, of the plans in the exchange remains a work in progress. What is also clearly true is exchange participants must be even more careful this year than they were in the past when considering their options next November. The plan that was best in 2015 in terms of premium price and benefits may not be the best plan in 2016 and, in some cases, it could be the worst choice. ■

b. Mathews, A.W., "UnitedHealth Raises Forecast for losses on Affordable Care Act Plans," *The Wall Street Journal*, Jan. 19, 2016.

c. *Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015*, Blue Cross Blue Shield, March 2016.

d. Hilzik., M., "Healthcare Shocker: These Insurers Are Making Money on Obamacare," *Los Angeles Times*, April 27, 2016.

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