



## KEY POINTS

- Major drivers of 2016 premium changes include: the underlying growth in health care costs, the phase down of the transitional reinsurance program, and how assumptions regarding the composition of the 2016 risk pool differ from those assumed for 2015.
- Premiums in the small group market could also change due to the expansion of the small group market to include groups sized 51-100.
- Average premium rate changes may not represent the rate change experienced by a particular consumer. A number of factors can result in a consumer's premium differing from the average rate change, including changes in: age, tobacco status, geography, benefit design, family status, and subsidy eligibility.

## Drivers of 2016 Health Insurance Premium Changes

The 2016 health insurance premium rate filing process is underway, with insurers having submitted their premiums to state and federal regulators for review. This paper outlines factors underlying premium rate-setting generally and then highlights the major drivers behind why 2016 premiums could differ from those in 2015. It focuses primarily on the individual market, but some factors that will particularly affect the small group market are highlighted as well.

### 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 Affordable Care Act (ACA) now prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of the risk pool as a whole. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher on average for that pool. If a risk pool disproportionately avoids those with higher expected claims or can offset the costs of those with higher claims by enrolling a large share of 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. Unit costs can vary from one health plan to another depending on the ability and leverage of the issuer to negotiate fees with health care providers.

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**OTHER PREMIUM COMPONENTS.** Premiums must cover administrative costs, including those related to insurance product development, sales and enrollment, claims processing, customer service, 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, including the presence of risk-sharing programs, 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 2016 Premium Changes

**UNDERLYING GROWTH IN HEALTH CARE COSTS.** The increase in costs of medical services and prescription drugs, referred to as medical trend, is based on not only the increase in per-unit costs of services, but also changes in health care utilization and changes in the mix of services. In recent years, health spending growth has been lower relative to historical levels. There is, however, some uncertainty regarding the causes of these trends and whether they will continue. The economic downturn and slow recovery likely have contributed to this slowdown. More structural changes to the health care payment and delivery system also might have contributed to slower medical spending growth, through for instance, a greater focus on cost effective care. Nevertheless, medical spending will continue to grow and costs for prescription drugs, in particular, are expected to increase as more high-cost specialty drugs come to market (e.g., new drugs to treat Hepatitis C, high cholesterol, and cancer).

### REDUCTION OF REINSURANCE PROGRAM FUNDS.

The ACA transitional reinsurance program provides payments to plans in the individual health insurance market when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees. This reduces the claim costs that insurers expect to pay, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions required by the ACA 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.

The following chart shows the program's funding and design features over its three-year lifetime (the program sunsets after 2016):

#### Reinsurance Program Parameters

	2014	2015	2016
Program Funds	\$10 billion	\$6 billion	\$4 billion
Attachment Point	\$60,000 (subsequently lowered to \$45,000)	\$70,000 (subsequently lowered to \$45,000)	\$90,000
Reinsurance Cap	\$250,000	\$250,000	\$250,000
Coinsurance Rate	80% (subsequently raised to 100%)	50%*	50%*

\* Coinsurance rates may be changed retroactively depending on actual claims relative to program funding.

As the reinsurance funds decrease, there is corresponding upward pressure on premium rates, which will continue into 2016.

For 2016, the reinsurance program will reimburse insurers for 50 percent of an individual's health claims between \$90,000 and \$250,000, which would likely reduce net claims by about 4 to 6 percent. This compares to the rate reduction in 2014 of 10 to 14 percent

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and in 2015 of 6 to 11 percent. Insurers will be comparing the impact of these reinsurance parameters to those in their 2015 rates, which may have been based on the initially announced \$70,000 attachment point or the reduced \$45,000 attachment point.<sup>1</sup> The lower reduction in claims for 2016 relative to the parameters in 2015 translates to about a 2 to 6 percent increase in projected claims—with insurers using the initial 2015 attachment point on the lower end of this range, and those using the lower attachment point on the higher end of this range.

#### **THE COMPOSITION OF THE RISK POOL AND HOW IT COMPARES TO WHAT WAS PROJECTED.**

Premiums for 2016 will reflect insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status. How 2016 premiums change from 2015 will depend on how assumptions regarding the composition of the 2016 risk pool differ from those assumed for 2015.

When calculating 2015 premiums, insurers made assumptions regarding the characteristics of individuals obtaining coverage—based on 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 were newly insured in the post-ACA reform market in 2014. With another year of experience, insurers have gained more information regarding the risk profiles of their enrollee populations and how these compare to the profiles for the market as a whole, and will adjust their premiums accordingly, either up or down.

When developing their 2016 premiums, insurers had information regarding the demographic characteristics, claims, and risks

of their 2014 enrollees, and limited information on their 2015 enrollees. There is still uncertainty regarding risk pool profiles for 2016, however, due to several factors. First, many 2014 enrollees were enrolled for less than a full year, due to administrative challenges associated with the initial insurance exchange websites and the extended open enrollment period. When using 2014 experience to project 2016 enrollee risk profiles and spending, insurers might have needed to make adjustments to 2014 experience data to the extent that full-year enrollees had different demographics and claims experience than those who enrolled later. In addition, 2014 claims data may have needed to be adjusted to the extent pent-up demand caused a temporary increase in spending among the newly insured that wouldn't be expected to continue at that level in the future. There is considerable uncertainty regarding the size of such adjustments.

Second, for insurers that did not gain significant enrollment in 2014, their 2014 experience might not be indicative of future experience because smaller risk pools may be more subject to random fluctuations. In addition, the risk profile for these insurers could change over time if they have a significant increase in enrollment; new enrollees could have different characteristics than those enrolled in 2014.

Third, another characteristic of the individual market is that there is considerable turnover in enrollment, as enrollees often move between individual and employer group coverage. In addition, the ACA's guaranteed issue rule facilitates movement between plans in the individual market. This potential for turnover contributes additional uncertainty as to the risk profile an insurer will have in 2016.

Fourth, at the time insurers submitted their 2016 rate filings, they had only limited information regarding the risk profile of the

<sup>1</sup> 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 but subsequently reduced the attachment point to \$45,000. Because the rules implementing the lower attachment point were not formalized until after 2015 premiums were finalized, not all insurers used the lower attachment point in their 2015 premium calculations; it likely depended on state regulatory preferences.

market as a whole and did not know the full impact of the risk-mitigation mechanisms—risk adjustment, reinsurance (individual market only), and risk corridors. 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 each state’s market as a whole. The market-level outcome of the 2014 risk adjustment program was not known until June 30, 2015, after insurers had already submitted their 2016 rate filings. Until that point, insurers had limited ability to assess their risk position relative to the rest of the market. Depending on the state(s) in which they filed, insurers may be able to revise their 2016 rate filings to incorporate new information on risk-adjustment program outcomes.

Nationally, total 2015 individual market enrollment increased from 2014, but perhaps not as significantly as some insurers might have expected when establishing 2015 premiums. Average health costs for a given population in a guaranteed-issue environment can generally be viewed as inversely proportional to enrollment. A larger individual market enrollment as a share of the eligible population will tend to be associated with lower average costs, and lower enrollment will usually be associated with higher average costs. This is because those potential members with greater health care needs are more likely to enroll than those with lesser needs. Higher take-up rates typically reflect larger enrollment among healthy individuals. To the extent that insurers priced 2015 premiums with the expectation of significant enrollment growth in the market as a whole that has not yet materialized, 2016 premiums might need to increase to reflect the increased average costs of those anticipated to enroll. If insurers expect significantly increased enrollment in the market as a whole in 2016 over 2015 levels, premium increases will be moderated.

Other factors also will affect the composition of the 2016 risk pool and its impact on premiums, including:

- **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 (i.e., exchanges) must be combined when determining premiums. Premiums for 2016 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2015.
- **Transitional policy for non-ACA-compliant plans.** For states that adopted the transitional policy that allowed non-ACA-compliant plans to be renewed up until Oct. 1, 2016 and to remain in force as late as Sept. 30, 2017, the risk profile of 2016 ACA-compliant plans might continue to exhibit less favorable experience than that of the non-ACA-compliant plans. This would occur if lower-cost individuals continue to retain their prior coverage and higher-cost people move to new coverage. The transitional policy will affect premium changes in 2016 to the extent that enrollment in the transitional plans is expected to affect premiums differently than assumed in 2015 premiums.
- **State-by-state variations.** Health insurance enrollment, and the composition of that enrollment, is often reported on a national basis. However, health insurance premiums are set at the state level (with regional variations allowed within a state) and will be based on state- and insurer-specific experience regarding enrollment volume and composition, and whether the state adopted the transitional policy.

Importantly, if an insurer’s actual experience regarding the risk profile of its 2014 and 2015 enrollees differs from assumptions and losses occurred in 2014 and 2015, it cannot recoup past losses through higher premiums for 2016. However, assumptions and expectations for 2016 would be determined incorporating 2014 experience and possibly the experience of the first couple of months in 2015.

### **EXPANSION OF THE SMALL GROUP MARKET.**

In the current small group health insurance market, small employers are those employing up to 50 employees. For plan years beginning in 2016, the ACA expands the definition of small employers to include those with up to 100 employees. This change increases the number of employers that will meet the definition of a small group and could impact premiums for those employers as well as those already defined as being small groups.<sup>2</sup>

Under the expanded small group definition, groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others. In addition, groups sized 51-100 will face additional benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums. The more restrictive rating and benefit requirements could cause more groups sized 51-100, especially those with healthier, lower-cost employees, to self-insure, particularly among those for whom premiums would increase under the new rule. This could put upward pressure generally on small group market premiums.

The impact of the small group definition expansion will likely vary by state and over time. Under the transitional policy, employers with 51-100 employees may renew their existing large group coverage on or before October 1, 2016 for a 12-month period. Therefore, those that renew large group coverage during 2016 would not be part of the small group market until 2017. From January 1 to October 1, 2016, these employers will face a choice to either renew large group coverage, where insurers may charge rates that reflect the health status of the group, or move to the small group market where rates are based on the health status of the entire small group market and not a given employer. Since these employers are expected

to purchase the option that provides the lower cost coverage, the least healthy groups likely will find lower premiums in the small group market which could put upward pressure on 2016 small group rates in those states that allow the transitional policy. This upward pressure could be mitigated in later years, when all groups up to 100 are part of the small group market. However, upward pressure on small group rates could continue if healthy groups turn to self-insurance rather than purchasing fully insured coverage.

In states that do not allow the transitional policy, the impact on 2016 rates depends on the relative costs of the groups sized 51-100 compared to groups sized 1-50 as well as insurer expectations regarding the likelihood of groups sized 51-100 deciding to self-insure.

### **Other Drivers**

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**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 (ACO) structures offer incentives to provide cost effective and high quality care. Such efforts could put downward pressure on premium increases at least in the short term.

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<sup>2</sup> For more information, see Academy issue brief, [Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees](#). (March 2015)

## Premium Rate Changes from a Consumer Perspective

Premium rate changes are often the most visible and discussed aspect with respect to the Affordable Care Act's (ACA) impact on health insurance. However, rate changes can be measured using different approaches, making it difficult to compare rate changes among health insurers, among plans offered by an insurer, or among consumers.

In addition, the average rate change may not represent the rate change experienced by a particular consumer. The ACA requires that premiums vary only by age, tobacco use, geographic location, family status, and benefit design. Premium changes from a consumer perspective can then result from underlying medical trends and other aggregate premium factors, as well as changes in these consumer-specific factors. The following situations could result in changes a consumer experiences that may differ from the average rate change reflected in a filing.

### Changes in Age

All insurers are required to use a prescribed age rating curve (either the federal default curve or a state-established curve) when determining how to vary premiums by age. In other words, premium variations by age are the same regardless of insurer. Most individual consumers will experience a premium increase each year, due to moving from one age to the next. Such a change (on the order of 2-3 percent per year for individuals over age 24) is rarely included in any insurer-level rate change calculation since it does not represent a change in the underlying factors, but it is a change a consumer would experience.

### Tobacco Status

In most states, insurers are allowed to charge smokers more than otherwise similar non-smokers, and this surcharge can vary by state and by age. In other words, older smokers can be charged higher increases than younger smokers (or vice versa). In plans that vary the surcharge by age, consumers who smoke will see a premium change due to the change in the

tobacco use surcharge. In addition, consumers who have either started or stopped using tobacco products could see a premium change.

### Changes in Geographic Location

All states require the use of rating areas prescribed by Centers for Medicare and Medicaid Services (CMS). Insurers are not allowed to change the rating areas but are allowed to change how premiums vary across the areas due to differences in relative provider costs and medical management. Such a change may or may not be included in the average aggregate rate change from an insurer's perspective, but it is a change a consumer would experience depending on where they live. If a consumer moves from one rating area to another, that also may result in a premium change.

### Changes in Benefit Design

A plan's benefit design encompasses both the benefits covered as well as the associated cost-sharing requirements (e.g., deductibles, coinsurance, copayments). If the consumer switches to a new benefit design, the consumer could experience a rate change due to the benefit design change.

### Family Status

The ACA allows premiums to vary by family size. Family premiums reflect the premiums for each covered adult plus the premiums for each of the three oldest covered children younger than 21. Therefore, consumers with family coverage who experience a change in family composition could face a premium change.

### Subsidy Eligibility

The ACA provides premium subsidies in the individual market based on household income. Changes in income alone can result in upward or downward changes in the net premiums that any specific consumer may have to pay, even if there is no change in the underlying premium rates. A change in the available plans in the market also could affect the subsidy an individual receives.

**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.<sup>3</sup> In particular, changes in benefits or cost-sharing requirements may have been needed to comply with the metal-level determinations using the actuarial value (AV) calculator, which was recalibrated for 2016. Other changes in benefit packages could be made based on market or other considerations. Such changes could put upward or downward pressure on premiums, depending on the particular change. Other plan design features, such as drug formularies and care management protocols also could affect premium changes.

**RISK MARGIN CHANGES.** Insurers build risk margins into their premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion should costs be 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 the Department of Health and Human Services (HHS) has confirmed 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, it is not clear how any shortfalls would be funded.<sup>4</sup> This uncertainty could increase the risk of insurer losses if premiums are set too low. As a result, insurers might increase their risk margin to reflect the additional risk associated with pricing uncertainty. This would need to be balanced with market competition considerations.

**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 in previous years some insurers lowered their premiums after they were able to see competitors' premiums. However, underpricing in any one year could drive premium increases higher in future years, because in the long-run premiums need to be adequate to cover claims and expenses.

**CHANGES IN ADMINISTRATIVE COSTS.** Any changes in administrative costs will also affect premiums. For instance, changes can result from increased costs associated with ACA implementation or from spreading fixed costs over a different enrollment base than projected. In addition, the costs of creating the individual market exchanges are substantial, and HHS has determined that user fees of 3.5 percent are appropriate for Federally Facilitated Marketplace (FFM) operations. These fees became effective in 2014. Federal funding of state-run exchanges will no longer be available in 2016, so some states are implementing additional user fees. Moreover, as the ACA reforms have gone into effect, the important role that brokers play has been acknowledged, and reductions in commissions that may have been expected have not generally been realized. These costs all need to be reflected in premium rates. Depending on the circumstances in any particular state, these marketing costs can put upward pressure on premiums. However, the ACA's medical loss ratio requirements limit the share of premiums attributable to administrative costs and margins.

<sup>3</sup> ACA plans are categorized into four metal tiers (bronze, silver, gold, and platinum), based on the relative level of plan generosity. Actuarial value is used to measure plan generosity, and is based on the average share of medical expenses that a plan will cover, as opposed to being paid out of pocket by the consumer. In turn, actuarial value is measured using the AV calculator released by the Centers for Medicare and Medicaid Services (CMS).

<sup>4</sup> Other sources of funding are subject to federal appropriations. The Consolidated and Further Continuing Appropriations Act of 2015 specifically prohibits transfers from Medicare or other trust funds.

**HEALTH INSURER FEE.** After rising from \$8 billion in the aggregate in 2014 to \$11.3 billion in 2015, the Health Insurance Providers Fee is scheduled to again collect \$11.3 billion in 2016, after which it will resume increasing annually. 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 in 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. If insurers expect an increase in enrollment in 2016 relative to 2015, the health insurance fee would be lower on a per person basis, resulting in a small decrease in premiums relative to 2015 all else being equal.

**CHANGES IN GEOGRAPHIC FACTORS.** Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria. Insurers can use different geographic factors to reflect provider cost and medical management differences among regions, but are not allowed to vary rates based on differences in health status (which instead should be accounted for by the risk adjustment process). However it is possible that an insurer might have misestimated the combination of differences in provider costs and medical management of some regions compared to other regions. Another reason for changes in geographic factors could be new provider contracts that reflect different costs. A re-alignment of these differences could result in changes across the rating regions within a state.

## Summary

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The 2016 health insurance premium rate filing process is underway, with insurers having submitted their premiums to state and federal regulators for review. Some of the uncertainty regarding the health spending by plan enrollees that existed when insurers submitted their 2014 and 2015 rates remains for 2016. Although insurers have information on their enrollee demographics and health spending in 2014, at the time rates had to be filed, they had only limited information regarding the risk profile of the market as a whole and the full impact of the risk-mitigation mechanisms.

How 2016 premiums differ from those in 2015 will depend on many factors. Key drivers include the underlying growth in health costs, the reduction of funds available through the temporary reinsurance program, and how the composition of the risk pools for 2015 compares to what was projected. How enrollment differs from expected will vary by insurer and by state. Premium changes in the small group market can also be affected by the expansion of the small group definition.

Other factors potentially contributing to rate changes include modifications to provider networks, provider reimbursement structures, benefit packages, risk margins, administrative costs, or geographic region factors. Insurers also incorporate market competition considerations when determining 2016 premiums.