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In the Spotlight: Premium Impacts in 2015

Beginning in November 2014, individuals and small businesses will face another Annual Enrollment Period for the Health Insurance Marketplace. With the promise of a new year comes new questions about whether and how the cost of coverage will change. This *In the Spotlight* will take a look at factors that affect premium rates, especially for individual and small group policies, so that consumers better understand their new rates when plan renewal time comes around in November.

What Changes Due to ACA will Impact Premiums?

Rating Limitations

Due to the ACA, most health insurers (insurers) face greater limitation than in the past on their ability to vary members' premium rates.

- For instance, insurers are no longer able to vary members' rates by health status or gender. For non-grandfathered health plans, the only characteristics an insurer may use to vary premium rates are age (3:1 ratio maximum), geographic area, benefit design, family size, and whether the consumer smokes tobacco.[1]
- The law requires insurers to place non-grandfathered plan members into single "risk pools" within a market for each individual and small group markets. Premium rates are developed based on the expected claims experience within individual and small group pools, separately, and rates are applied uniformly across the pools based on the factors described above. If the pool of consumers incurs low cost claims, then the premiums may be relatively low whereas if the pool incurs high cost claims, then premium rates may be relatively more expensive.[2]

Benefit Enhancements

The ACA mandates that most health plans contain richer benefits, which provide greater access to health care services to consumers once they purchase coverage.

- For most plans, insurers must provide coverage of "essential health benefits," or services that fall within 10 categories, like prevention, prescription drugs and pediatric services. Prior to reform, insurers often included many of these services in the plan design, with additional optional benefits as riders on the policy. This helped to keep premiums lower for those who knew they did not need a service.
- The ACA eliminates health plan's ability to deny coverage because of preexisting conditions.[3] Examples of this may include conditions like heart disease, diabetes, cancer or multiple sclerosis to name a few. This, in combination with the rating requirements, means that many members may pay more in premium rates to cover the costs of a few sick members.

[1] 45 CFR 147.102
[2] 45 CFR 156.80
[3] Guaranteed renewability provisions: Individual 45 CFR 148.22; Small Group 45 CFR 146.152

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Other Fees to Insurers

To pay for many of the positive aspects of reform, the ACA mandated that insurers pay several taxes and fees to the federal government. Below are examples of federal requirements.

- ACA Insurer Fee: All insurers must pay a tax to the federal government based on "net premiums written". In 2014, this will equal approximately $8B nationwide, and will increase to $11.3B in 2015.[4]
- Reinsurance Fee: All insurers must pay a flat fee per member for fully insured and self-insured members (whose employers uses a third-party administrator) to support the temporary reinsurance program, which is meant to stabilize the market during ACA implementation. The fee is estimated to be $12B for 2014 and $8B for 2015, nationally.[5]
- PCORI fee: All insurers must pay a flat fee per member to support the Patient-Centered Outcomes Research Institute which performs comparative effectiveness research for medical and drug treatments. This is estimated to cost $2 per member per year to each insurer.[6]

It is important to keep in mind that the ACA includes checks to ensure that amidst all these changes, the majority of the premium is allocated for members' medical expenses, per the Medical Loss Ratio rules, and insurers must issue rebates to consumers if rates are too high for the medical expenses incurred. Additionally, any rate increases over 10% must be deemed "reasonable," according to the Centers for Medicare & Medicaid Services' (CMS) rate review program.

What Will Change in 2015?

Despite all that consumers and health insurers have already undergone in 2014 to absorb these new rules and effects on premium rates, more change may be in store for 2015. Looking forward, premium rates may need adjustment to account for greater fees imposed on health insurers and a better understanding of our new members.

- **Insurer fees expected to increase:** As shown above, fees imposed on insurers are expected to increase in 2015, placing more pressure on health insurers to manage new financial demands while providing robust service and benefits.
- **Reinsurance benefits will decrease:** In an effort to stabilize premiums and prevent high dollar claims from causing huge spikes in individual insurance premiums, the ACA includes a program known as "reinsurance". As part of this program, the cost of paying high dollar claims is spread among all the insurers in a market. Insurers that experience unusually high claims are eligible for a "reinsurance payment" to stabilize their total claims cost and in turn prevent these high dollar claims from significantly increasing in premiums. In 2015, claims eligible for reinsurance payments will decrease significantly and insurers will be responsible for a far greater number of these high dollar claims as well as a far greater cost of each claim. This will significantly increase total claims cost and in turn result in higher premiums to help insurers cover the cost of this increase in high dollar claims.
- **Experience of members:** It was expected that consumers in the risk pool in 2014 would be generally young and healthy, due to requirements like the individual mandate that required everyone to have

[4] 26 CFR Pts. 57 & 602
[5] 45 CFR 153.220
[6] 77 CFR 72722

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coverage. However, Federal policy changes late in 2013, such as allowing some individual and small group policyholders to keep policies issued before the ACA and delay ACA requirements under the "transitional" program, led to a less-healthy risk pool than was expected. Now in 2015 health insurers have a better understanding of the new population and will adjust premiums to better fit the health experience of their member population.

Health Insurance Marketplace Challenges

Changes to premiums may further impact consumers who plan to use the Health Insurance Marketplace for their plan renewal during 2015 Annual Enrollment Period. Remember, Marketplace Advanced Premium Tax Credits (APTC) for individual plans are tied to the Second Lowest Cost Silver Plan on the Marketplace.[7] If the cost or identity of this plan changes for 2015 due to changes in premium rates, consumers may see significant changes in the APTC amount or plan choices available to consumers.

CMS is offering two primary solutions[8] to help consumers in NC navigate the renewal process on the marketplace:

1. During the Annual Enrollment Period, November 15, 2014-February 15, 2015, consumers may log on to the Marketplace to reassess their APTC and shop for plans.[9]
2. If consumers do not actively update their APTC amount (as applicable) and their plan choice, they will likely be reenrolled into their current plan at their 2014 APTC amount. It will then be up to the consumer to reconcile with IRS during annual tax filing any over- or under-payments of their APTC.[10]

Consumers in NC who received Marketplace coverage during 2014 should expect to receive a notice from their health plan and the Health Insurance Marketplace about their renewal options during the fall of 2014. Please contact your health plan or the Health Insurance Marketplace for specific questions or if you do not receive a notice.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina (BCBSNC) supports open dialogue about the causes and effects of premium increases to consumers. BCBSNC understands the significant impact of costs of care and coverage on consumers, and offers a broad range of plans that allow consumers to choose the level of coverage at a price that they are willing to pay. In this era of constant change, BCBSNC aims to smooth out the process by anticipating implications of federal policy decisions, planning appropriately and responding with options to minimize the effect on North Carolina consumers.

For More Information:

BCBSNC Let's Talk Cost campaign: http://connect.bcbsnc.com/lets-talk-cost-2013/the-cost-problem/

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[7] 26 USC Sec. 36B
[8] Exceptions apply. For instance, if consumers did not check the appropriate box on the original application to have APTC redetermined, APTC will be cancelled at end of 2014.
[9] 45 CFR 155.335
[10] 45 CFR 155.335

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