

Will Premiums Skyrocket in 2015?

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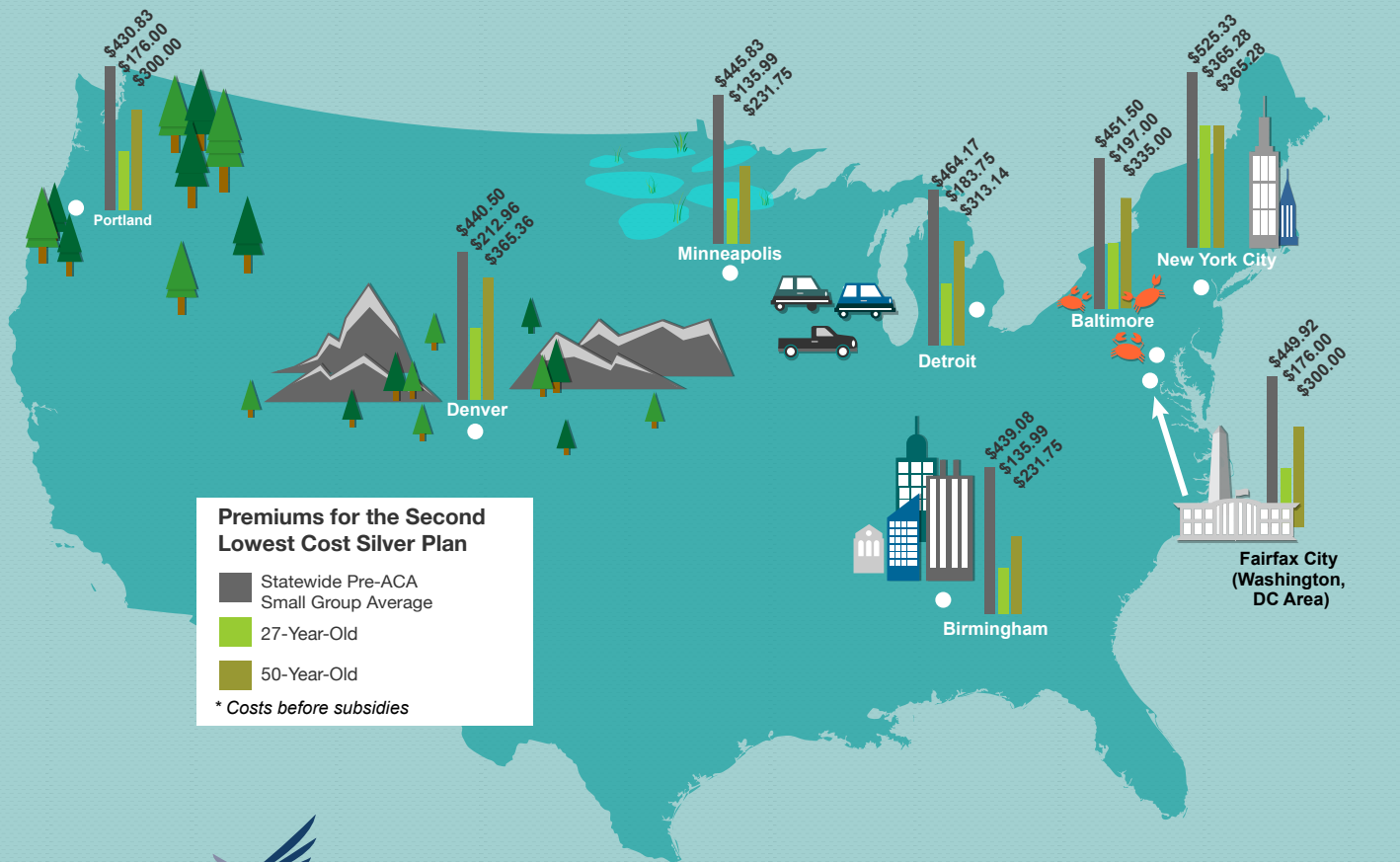
Timely Analysis of Immediate Health Policy Issues

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In-Brief

The first open enrollment has ended and a surprisingly large number of people, 8.0 million, have enrolled in Marketplace insurance plans.¹ Medicaid rolls have also increased, particularly in states that have expanded Medicaid, and early evidence suggests that the number of uninsured is falling.² But with open enrollment behind us, a new set of concerns is surfacing: a major one is whether premiums will increase sharply in 2015. Some experts have predicted sharp increases, arguing, for example, that premiums were artificially low in 2014 and that insurers will attempt to recoup any 2014 losses by increasing premiums in 2015.³ In this brief, we review 2014 premiums and the effect of market competition on rates. We further suggest that this experience provides the best guidance as to what we are likely to see in 2015. We conclude that while there may be reasons to believe that premiums will increase substantially, particularly in less competitive markets, there are even stronger reasons to believe that premium increases will be moderate (in line with underlying cost growth) rather than growing by double-digits.

Market Competition Led to Surprisingly Low Monthly Premiums in 2014; Same Expected for 2015



The 2014 Experience With Market Premiums

The 2014 premium setting experience is useful in projecting what might occur in 2015.⁴ In general, in 2014 premiums were moderate and below original expectations in most markets, even in rural areas.⁵ There was high insurer participation in most urban markets, though less so in rural areas, and fairly intense competition. The most compelling explanation for lower than expected premiums is the managed competition structure of the Marketplaces. Subsidies in the individual nongroup market are tied to the second lowest cost silver plan. Individuals buying a more expensive silver plan or a gold or platinum plan would have to pay additional amounts. This creates strong incentives for insurers to price aggressively to gain market share. In general, the evidence suggests that this is what occurred in most markets, resulting in competitive rates.⁶

The insurers participating in the nongroup market consist of existing insurers such as Blue Cross plans, new entrants including Medicaid plans and co-ops, and, in a few cases, new start-up insurers. Large commercial insurers such as Aetna, United, and Cigna participated only in some markets. Some insurers priced aggressively to gain market share; others, particularly the national commercial companies, were more cautious to avoid risk. Anecdotal evidence, as well as reported results for New York, is that those that priced their products low seem to be getting the bulk of enrollees, but there are also reports of individuals choosing well-known brand names, such as Blue Cross plans.⁷

The premiums in 2014 are shown in Table 1. We examine data on premiums in cities in eight states. The states are generally representative of insurance markets around the country. Some have many participating plans, some have Medicaid plans and/or co-ops, and others have one dominant carrier.

We found that in general, premiums for adults in the nongroup market compare favorably with premiums in the pre-reform small employer market. It is difficult to

evaluate premiums in the pre-reform individual market; policies often have limited benefits or large cost sharing requirements, and there could be largely healthy people in plans due to medical underwriting. Because benefits offered and premium pricing tended to vary with the characteristics of the individual enrollee, average premiums are not comparable. This has been less the case in the nation's small group markets, although small group medical underwriting persisted in almost all states through 2013, and cost sharing requirements tended to be lower and benefits higher than in nongroup policies. The ACA's market reforms tend to move nongroup policy offerings closer to small group policies in benefits and cost sharing requirements. However, since small employers tend to choose plans with lower cost sharing requirements than the typical nongroup insurance individual purchaser, the small group average premiums shown in Table 1 should be reduced by 10-15 percent in order to be more comparable to the ACA compliant silver plans most often chosen by nongroup purchasers.

Even with 10-15 percent reductions, premiums set by the lower cost Marketplace nongroup insurers are, in general, still less expensive, often by a considerable margin. In Table 1, we show individual market premiums for 27- and 50-year olds; the average small group premiums should reflect an average age distribution in small firms that falls somewhere in that age range. In all eight states, there are nongroup premiums that fall below what we observed in the pre-reform small group market. Several carriers report offering narrow network products, and limiting networks when possible to providers accepting lower payment rates. Interestingly, we see higher premiums in many rural markets than in urban areas, primarily because of the lack of competition in those markets as well as the difficulty in negotiating with the limited supply of physicians and hospitals there.⁸

Table 1 shows premiums in one large urban area in eight selected states. The key characteristics of these states are as follows.

Colorado. There is strong competition among eight carriers in the Denver market, with Kaiser Permanente and Humana having the lowest premiums. In two other markets we examined, the Rocky Mountain Health Plan, based in Grand Junction, was the most competitive plan followed by Anthem Blue Cross. The latter is considerably more expensive than the former. Premiums in the rural county for the three lowest cost plans were all higher than in Denver.

Maryland. CareFirst is dominant in the state's commercial market and had the lowest premiums in all regions, followed closely by the Blue Cross multistate plan and Kaiser Permanente. The latter is a strong competitor in Baltimore and the Washington, DC metro area where the bulk of the Maryland population resides. The state's new co-op, Evergreen, and United have much higher premiums.

Minnesota. Minnesota's market is characterized by competition among several local commercial plans. Preferred One has the lowest premium rates in most markets, followed by Health Partners. Because of more competition, rates are lower in Minneapolis than in other parts of the state. The significant competition in all markets led to the lowest premiums of any of the eight states.

New York. There was significant participation of Medicaid plans, particularly in New York City, but also throughout the state. In New York City, the lowest cost plans were a Medicaid plan (MetroPlus) and the state's co-op (Health Republic). In many other markets, the lowest cost plan was offered by Fidelis Care, a statewide Medicaid plan. The Blue Cross Plans and Emblem, a large local commercial plan, had premiums well above the lowest, but benefited from name recognition. It is also noteworthy that the second lowest cost silver plan in rural Allegheny county, offered by Blue Shield of Western New York, was substantially higher than the second lowest cost plan in New York City.

Oregon. There was substantial competition among local commercial plans in the markets we examined, including Moda Health, Health Net, Lifewise, and

Pacific Source. Oregon's premiums reflect this competition and are among the lowest of the eight states.

Alabama. Blue Cross Blue Shield (BCBS) is the overwhelmingly dominant carrier in the state, although it has competition in the Birmingham area from Humana. In other areas, BCBS is the only carrier but premiums are surprisingly low throughout the state; BCBS did not exercise the market power that it has.

Michigan. Blue Cross Blue Shield is also a dominant carrier in Michigan, but it has substantial competition from Humana and Total Healthcare in the Detroit market. Elsewhere in the state, the Blue Cross HMO product generally offers the lowest premiums. The second lowest cost plan in markets outside of Detroit have higher premiums than seen in the Detroit market, reflecting either the lack of competition in those insurance markets or the market power of local providers.

Virginia. Anthem Blue Cross Blue Shield has substantial market share throughout most of the state. CareFirst, also a Blue Cross product, offers coverage in the northern-most section of the state. The Blue Cross products are HMOs and among the lowest-cost plans in most parts of Virginia. Anthem does have significant competition in most parts of the state from Optima Health, an insurer connected to a major

hospital system. In Fairfax County, the Innovations Health Insurance company, a new plan co-owned by Aetna and the Inova hospital system, has the lowest premiums and appears to be competing successfully against Anthem, CareFirst Blue Choice, and Kaiser Permanente in the Northern Virginia market.

Thus, in most markets we studied, at least in urban areas, there seems to be considerable competition. The Blue Cross plans are often the lowest cost plans but not always. In some markets, particularly New York, Medicaid plans have driven premiums to relatively low levels; elsewhere, Medicaid plans are less important. Co-op plans also offer fairly low rates in New York, but not in the other markets. Rural markets in many of these states have higher premiums than urban markets, reflecting substantially less competition at the carrier or provider level, or both. The result of competition in these markets has led to premiums for silver plans that are relatively low, despite the structure of the markets differing quite a bit across states. The incentives that led to those outcomes are essentially unchanged for 2015 though there are factors that could result in changes.

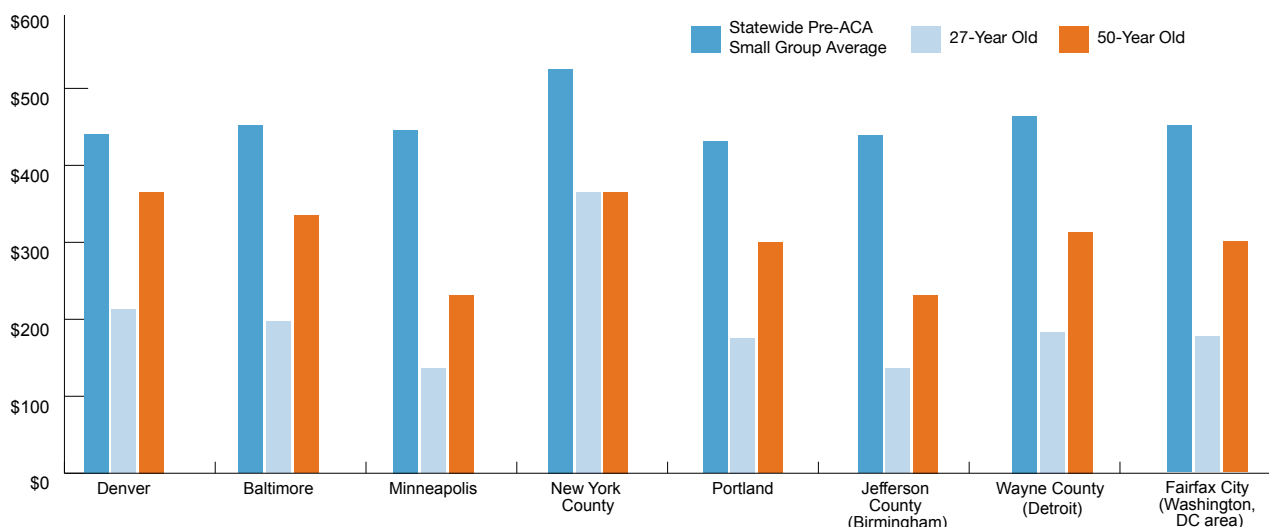
What Does This Mean For 2015?

One could argue that premiums will increase considerably in 2015 because

first round premium setting was overly aggressive, and insurers may attempt to make up for any 2014 losses in 2015. But in competitive markets, unless all insurers behave similarly, those that increase premiums will suffer the loss of market share to those that continue to price more aggressively.⁹ Markets with limited competition (e.g., Alabama, rural areas of many states) could see larger increases in premiums due to their market conditions; for example, carriers could exploit market power in ways they did not in 2014. In some states, insurers that achieved relatively little market share in 2014 could leave, resulting in less competitive markets. There could also be pressure to expand provider networks. This could come from the federal government or from the states' own political environments. The market may also dictate that insurers broaden their networks, if desirable consumers appear to be avoiding narrow network plans. Broadening networks is likely to require carriers to offer higher payment rates to providers, leading to higher premiums. Finally, 2015 premiums will depend on how insurers respond to the reduced funding levels for reinsurance in 2015 and the new policy for fiscal neutrality for risk corridors.

But the forces that would result in more moderate increases in 2015 are likely to be stronger. First, the underlying rate of growth in health care costs remained

Figure 1. Premiums for the Second Lowest Cost Silver Plan (Before Subsidies) in Selected Cities, by Age



Source for Pre-ACA averages: MEPS (2012) Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State: Less than 50 Employees.

Table 1. Premiums for the Lowest Cost Silver Plan (Before Subsidies) for the Top Lowest Cost Insurers in Selected Cities

State	Location	Insurer	Type	Premium	
				27-year-old	50-year-old
CO	Statewide	Pre-ACA Small Group Average		\$440.50	
	Denver	Kaiser Permanente	HMO	\$208.52	\$357.77
		Humana	HMO	\$212.96	\$365.36
		Colorado HealthOP	PPO	\$232.10	\$398.23
MD	Statewide	Pre-ACA Small Group Average		\$451.50	
	Baltimore	CareFirst Blue Choice*	HMO/POS	\$187.00	\$319.00
		CareFirst BCBS (MSP)	PPO	\$197.00	\$335.00
		Kaiser Permanente	HMO	\$221.27	\$377.11
MN	Statewide	Pre-ACA Small Group Average		\$445.83	
	Minneapolis	PreferredOne*	PPO	\$126.21	\$215.09
		HealthPartners	PPO	\$135.99	\$231.75
		Blue Cross Blue Shield of Minnesota	PPO	\$150.72	\$285.95
NY	Statewide	Pre-ACA Small Group Average		\$525.33	
	New York County (Contains Manhattan)	MetroPlus Health Plan	HMO	\$359.26	\$359.26
		Health Republic	PPO	\$365.28	\$365.28
		Oscar	PPO	\$384.72	\$384.72
OR	Statewide	Pre-ACA Small Group Average		\$430.83	
	Portland	Moda Health*	PPO	\$159.00	\$270.00
		HealthNet	POS	\$176.00	\$300.00
		Providence	EPO	\$192.00	\$327.00
AL	Statewide	Pre-ACA Small Group Average		\$439.08	
	Jefferson County (Contains Birmingham)	Humana	PPO	\$209.16	\$356.46
		Blue Cross and Blue Shield of Alabama	PPO	\$211.24	\$360.00
MI	Statewide	Pre-ACA Small Group Average		\$464.17	
	Wayne County (Contains Detroit)	Humana Medical Plan of Michigan, Inc.	HMO	\$156.16	\$266.14
		Total Health Care USA, Inc.	HMO	\$183.75	\$313.14
		Blue Care Network of Michigan	HMO	\$198.76	\$338.73
VA	Statewide	Pre-ACA Small Group Average		\$449.92	
	Fairfax City (Washington, DC, area)	Innovation Health Insurance Company	PPO	\$213.00	\$362.00
		CareFirst Blue Choice	HMO/POS	\$222.97	\$379.99
		Kaiser Permanente	HMO	\$225.54	\$383.55

*Insurer offered the two lowest cost plans in the area noted.

Source for Pre-ACA averages: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2012 Medical Expenditure Panel Survey – Insurance Component. Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: Less than 50 employees http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf.

slow through 2012—3.7 percent in 2012 and is projected to be 3.8 percent in 2013—though there is some evidence that spending growth has picked up (6.3 percent from first quarter of 2013 to first quarter of 2014).¹⁰ This will have some effect on premiums but is not enough to cause a spike. Second, enrollment in Marketplace plans should be substantially higher in 2015 than 2014, with improved IT systems, higher individual mandate penalties, and greater awareness of the law and its insurance options. The recent surge resulted in 8.0 million Americans being insured in Marketplaces throughout the country, and this surge seems to have improved the mix of risks as seen by the increased enrollment of younger groups.¹¹ Enrollment is likely to continue

to increase over the course of 2014 through special open enrollment for those experiencing significant life changes (e.g., changes in family composition, changing work circumstances, changing income circumstances). CBO projects an additional 7 million individuals will enroll in Marketplace plans in 2015. This is likely to assure an even more stable mix of risks available to insurers. Third, the cost sharing in the silver tier, the plans most often selected, are high enough to dampen utilization. And the presence or threat of narrow networks will help constrain provider payments.

Finally, the increasing size and attractiveness of the nongroup markets could intensify the amount of competition

from insurers. Not only are plans participating in 2014 unlikely to exit, but others could enter. Large insurers that stayed out of many Marketplaces or bid at high premium rates—Aetna, United, Cigna—could enter more Marketplaces in 2015 and price more aggressively because of the higher enrollment and the perception of a more stable risk pool.¹² United has already indicated that it will be more active; the same is true of Blue Cross Blue Shield plans where they did not participate in 2014. How these scenarios will play out is hard to know, but claims that premiums will skyrocket are unwarranted based on 2014 experience and the evolving conditions for 2015 suggest otherwise as well.

CONCLUSION

There are several reasons to believe there could be significant premium increases in 2015, e.g., underpricing in 2014, increases in health care costs, and pressure to broaden networks. But the dominant force behind the surprisingly low premiums in 2014 remains intact—the strong incentives for markets to be highly competitive, which forces insurers to set premiums aggressively to attain or retain market share. These incentives should be even stronger in 2015 with increased enrollment and a more stable risk pool. High deductibles and narrow networks will continue to place downward pressure on spending. It also must be noted that it is not the increase in a particular insurer’s premiums that matters; rather it is the premiums of the second lowest cost silver plans in each market that matter and these should rise more slowly.

Notes

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- 3 Alonso-Zaldivar R. “[7M Enrolled Doesn’t Guarantee Health Law’s Success](#).” Associate Press, April 5, 2014.
- 4 Holahan J, Peters R, Lucia K. “[The Launch of the Affordable Care Act in Selected States: Insurer Participation, Competition, and Premiums](#).” Washington, DC: The Urban Institute, 2014.
- 5 Millman J. “[Lower premiums \(yes, really\) drive down Obamacare’s expected costs, CBO says](#).” Washington Post, April 14, 2014; Radnofsky L. “[CBO Projects Lower Premiums in Health-Insurance Exchanges](#).” The Wall Street Journal, April 14, 2014; Office of the Assistant Secretary for Planning and Evaluation. *Health Insurance Marketplace Premiums for 2014*. September 2013
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- 7 NY State of Health. *The Official Health Plan Marketplace December 2013 Enrollment Report*. January 13, 2014. http://info.nystateofhealth.ny.gov/sites/default/files/December%202013%20Enrollment%20Report_Jan%2013%202014_0.pdf
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- 11 Millman J, “[Facing Obamacare deadline, more young people signed up in March](#),” Washington Post, April 4, 2014.
- 12 Cheney K and Norman B. “[Insurers see brighter Obamacare skies](#).” Politico, April 15, 2014.

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