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An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges

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Each year insurers submit filings to state regulators detailing their plans to participate on the Affordable Care Act marketplaces (also called exchanges). These filings include information on the premiums insurers plan to charge in the coming year and which areas they plan to serve. Each state or the federal government reviews premiums to ensure they are accurate and justifiable before the rate goes into effect, though regulators have varying types of authority and states make varying amounts of information public.

In this analysis, we look at preliminary premiums and insurer participation in the 20 states and the District of Columbia where publicly available rate filings include enough detail to be able to show the premium for a specific enrollee. As in previous years, we focus on the second-lowest cost silver plan in the major city in each state. This plan serves as the benchmark for premium tax credits. Enrollees must also enroll in a silver plan to obtain reduced cost sharing tied to their incomes. About [71%](#) of marketplace enrollees are in silver plans this year.

States are still reviewing premiums and participation, so the data in this report are preliminary and could very well change. Rates and participation are not locked in until late summer or early fall (insurers must sign an annual contract by September 27 in states using Healthcare.gov).

Insurers in this market face [new uncertainty](#) in the current political environment and in some cases have factored this into their premium increases for the coming year. Specifically, insurers have been unsure whether the individual mandate (which brings down premiums by compelling healthy people to buy coverage) will be repealed by Congress or to what degree it will be enforced by the Trump Administration. Additionally, insurers in this market do not know whether the Trump Administration will continue to make payments to compensate insurers for cost-sharing reductions (CSRs), which are the subject of a lawsuit, or whether Congress will appropriate these funds. (More on these [subsidies](#) can be found [here](#)).

The vast majority of insurers included in this analysis cite uncertainty surrounding the individual mandate and/or cost sharing subsidies as a factor in their 2018 rates filings. Some insurers explicitly factor this uncertainty into their initial premium requests, while other companies say if they do not receive more clarity or if cost-sharing payments stop, they plan to either refile with higher premiums or withdraw from the market. We include a table in this analysis highlighting examples of companies that have factored this uncertainty into their initial premium increases and specified the amount by which the uncertainty is increasing rates.

Changes in the Second-Lowest Cost Silver Premium

The second-lowest silver plan is one of the most popular plan choices on the marketplace and is also the benchmark that is used to determine the amount of financial assistance individuals and families receive. The table below shows these premiums for a major city in each state with available data. (Our analyses from [2017](#), [2016](#), [2015](#), and [2014](#) examined changes in premiums and participation in these states and major cities since the exchange markets opened nearly four years ago.)

Across these 21 major cities, based on preliminary 2018 rate filings, the second-lowest silver premium for a 40-year-old non-smoker will range from \$244 in Detroit, MI to \$631 in Wilmington, DE, before accounting for the tax credit that most enrollees in this market receive.

Of these major cities, the steepest proposed increases in the unsubsidized second-lowest silver plan are in Wilmington, DE (up 49% from \$423 to \$631 per month for a 40-year-old non-smoker), Albuquerque, NM (up 34% from \$258 to \$346), and Richmond, VA (up 33% from \$296 to \$394). Meanwhile, unsubsidized premiums for the second-lowest silver premiums will decrease in Providence, RI (down -5% from \$261 to \$248 for a 40-year-old non-smoker) and remain essentially unchanged in Burlington, VT (\$492 to \$491).

As discussed in more detail below, this year's preliminary rate requests are subject to much more uncertainty than in past years. An additional factor driving rates this year is the return of the ACA's health insurance tax, which adds an estimated 2 to 3 percentage points to premiums.

Most enrollees in the marketplaces ([84%](#)) receive a tax credit to lower their premium and these enrollees will be protected from premium increases, though they may need to switch plans in order to take full advantage of the tax credit. The premium tax credit caps how much a person or family must spend on the benchmark plan in their area at a certain percentage of their income. For this reason, in 2017, a single adult making \$30,000 per year would pay about \$207 per month for the second-lowest-silver plan, regardless of the sticker price (unless their unsubsidized premium was less than \$207 per month). If this person enrolls in the second lowest-cost silver plan in 2018 as well, he or she will pay slightly less (the after-tax credit payment for a similar person in 2018 will be \$201 per month, or a decrease of 2.9%). Enrollees can use their tax credits in any marketplace plan. So, because tax credits rise with the increase in benchmark premiums, enrollees are cushioned from the effect of premium hikes.

Table 1: Monthly Silver Premiums and Financial Assistance for a 40 Year Old Non-Smoker Making \$30,000 / Year

State	Major City	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit			Amount of Premium Tax Credit		
		2017	2018	% Change from 2017	2017	2018	% Change from 2017	2017	2018	% Change from 2017
California*	Los Angeles	\$258	\$289	12%	\$207	\$201	-3%	\$51	\$88	71%
Colorado	Denver	\$313	\$352	12%	\$207	\$201	-3%	\$106	\$150	42%
Connecticut	Hartford	\$369	\$417	13%	\$207	\$201	-3%	\$162	\$216	33%
DC	Washington	\$298	\$324	9%	\$207	\$201	-3%	\$91	\$122	35%
Delaware	Wilmington	\$423	\$631	49%	\$207	\$201	-3%	\$216	\$430	99%
Georgia	Atlanta	\$286	\$308	7%	\$207	\$201	-3%	\$79	\$106	34%
Idaho	Boise	\$348	\$442	27%	\$207	\$201	-3%	\$141	\$241	70%
Indiana	Indianapolis	\$286	\$337	18%	\$207	\$201	-3%	\$79	\$135	72%
Maine	Portland	\$341	\$397	17%	\$207	\$201	-3%	\$134	\$196	46%
Maryland	Baltimore	\$313	\$392	25%	\$207	\$201	-3%	\$106	\$191	81%
Michigan*	Detroit	\$237	\$244	3%	\$207	\$201	-3%	\$29	\$42	44%
Minnesota**	Minneapolis	\$366	\$383	5%	\$207	\$201	-3%	\$159	\$181	14%
New Mexico	Albuquerque	\$258	\$346	34%	\$207	\$201	-3%	\$51	\$144	183%
New York***	New York City	\$456	\$504	10%	\$207	\$201	-3%	\$249	\$303	21%
Oregon	Portland	\$312	\$350	12%	\$207	\$201	-3%	\$105	\$149	42%
Pennsylvania	Philadelphia	\$418	\$515	23%	\$207	\$201	-3%	\$211	\$313	49%
Rhode Island	Providence	\$261	\$248	-5%	\$207	\$201	-3%	\$54	\$47	-13%
Tennessee	Nashville	\$419	\$507	21%	\$207	\$201	-3%	\$212	\$306	44%
Vermont	Burlington	\$492	\$491	0%	\$207	\$201	-3%	\$285	\$289	2%
Virginia	Richmond	\$296	\$394	33%	\$207	\$201	-3%	\$89	\$193	117%
Washington	Seattle	\$238	\$306	29%	\$207	\$201	-3%	\$31	\$105	239%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public. SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Looking back to 2014, when changes to the individual insurance market under the ACA first took effect, reveals a wide range of premium changes. In many of these cities, average annual premium growth over the 2014-2018 period has been modest, and in two cities (Indianapolis and Providence), benchmark premiums have actually decreased. In other cities, premiums have risen rapidly over the period, though in some cases this rapid growth was because premiums were initially quite low (e.g., in Nashville and Minneapolis).

**Table 2: Monthly Benchmark Silver Premiums
for a 40 Year Old Non-Smoker, 2014–2018**

State	Major City	2014	2015	2016	2017	2018	Average Annual % Change from 2014 to 2018	Average Annual % Change After Tax Credit, \$30K Income
California	Los Angeles	\$255	\$257	\$245	\$258	\$289	3%	-1%
Colorado	Denver	\$250	\$211	\$278	\$313	\$352	9%	-1%
Connecticut	Hartford	\$328	\$312	\$318	\$369	\$417	6%	-1%
DC	Washington	\$242	\$242	\$244	\$298	\$324	8%	-1%
Delaware	Wilmington	\$289	\$301	\$356	\$423	\$631	22%	-1%
Georgia	Atlanta	\$250	\$255	\$254	\$273	\$308	5%	-1%
Idaho	Boise	\$231	\$210	\$273	\$348	\$442	18%	-1%
Indiana	Indianapolis	\$341	\$329	\$298	\$286	\$330	-1%	-1%
Maine	Portland	\$295	\$282	\$288	\$341	\$397	8%	-1%
Maryland	Baltimore	\$228	\$235	\$249	\$313	\$392	15%	-1%
Michigan*	Detroit	\$224	\$230	\$226	\$237	\$250	3%	-1%
Minnesota**	Minneapolis	\$162	\$183	\$235	\$366	\$383	24%	6%
New Mexico	Albuquerque	\$194	\$171	\$186	\$258	\$395	19%	1%
New York***	New York City	\$365	\$372	\$369	\$456	\$504	8%	-1%
Oregon	Portland	\$213	\$213	\$261	\$312	\$343	13%	-1%
Pennsylvania	Philadelphia	\$300	\$268	\$276	\$418	\$515	14%	-1%
Rhode Island	Providence	\$293	\$260	\$263	\$261	\$248	-4%	-1%
Tennessee	Nashville	\$188	\$203	\$281	\$419	\$507	28%	2%
Vermont	Burlington	\$413	\$436	\$468	\$492	\$491	4%	-1%
Virginia	Richmond	\$253	\$260	\$276	\$296	\$379	11%	-1%
Washington	Seattle	\$281	\$254	\$227	\$238	\$306	2%	-1%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public. SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Changes in Insurer Participation

Across these 20 states and DC, an average of 4.6 insurers have indicated they intend to participate in 2018, compared to an average of 5.1 insurers per state in 2017, 6.2 in 2016, 6.7 in 2015, and 5.7 in 2014. In states using Healthcare.gov, insurers have until September 27 to sign final contracts to participate in 2018. Insurers often do not serve an entire state, so the number of choices available to consumers in a particular area will typically be less than these figures.

Table 3: Total Number of Insurers by State, 2014 - 2018

State	Total Number of Issuers in the Marketplace				
	2014	2015	2016	2017	2018 (Preliminary)
California	11	10	12	11	11
Colorado	10	10	8	7	7
Connecticut	3	4	4	2	2
DC	3	3	2	2	2
Delaware	2	2	2	2	1 (Aetna exiting)
Georgia	5	9	8	5	4 (Humana exiting)
Idaho	4	5	5	5	4 (Cambia exiting)
Indiana	4	8	7	4	2 (Anthem and MDwise exiting)
Maine	2	3	3	3	3
Maryland	4	5	5	3	3 (Cigna exiting, Evergreen ¹ filed to reenter)
Michigan	9	13	11	9	8 (Humana exiting)
Minnesota	5	4	4	4	4
New Mexico	4	5	4	4	4
New York	16	16	15	14	14
Oregon	11	10	10	6	5 (Atrio exiting)
Pennsylvania	7	8	7	5	5
Rhode Island	2	3	3	2	2
Tennessee	4	5	4	3	3 (Humana exiting, Oscar entering)
Vermont	2	2	2	2	2
Virginia	5	6	7	8	6 (UnitedHealthcare and Aetna exiting)
Washington	7	9	8	6	5 (Community Health Plan of WA exiting)
Average (20 states + DC)	5.7	6.7	6.2	5.1	4.6

NOTES: Insurers are grouped by parent company or group affiliation, which we obtained from HHS Medical Loss Ratio public use files and supplemented with additional research.

¹The number of preliminary 2018 insurers in Maryland includes Evergreen, which submitted a filing but has been placed in receivership.

SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Uncertainty Surrounding ACA Provisions

Insurers in the individual market must submit filings with their premiums and service areas to states and/or the federal government for review well in advance of these rates going into effect. States vary in their deadlines and processes, but generally, insurers were required to submit their initial rate requests in May or June of 2017 for products that go into effect in January 2018. Once insurers set their premiums for 2018 and sign final contracts at the end of September, those premiums are locked in for the entire calendar year and insurers do not have an opportunity to revise their rates or service areas until the following year.

Meanwhile, over the course of this summer, the debate in Congress over repealing and replacing the Affordable Care Act has carried on as insurers set their rates for next year. Both the House and Senate bills included provisions that would have made significant changes to the law effective in 2018 or even retroactively, including repeal of the individual mandate penalty. Additionally, the Trump administration has sent mixed

signals over whether it would continue to enforce the individual mandate or make payments to insurers to reimburse them for the cost of providing legally required cost-sharing assistance to low-income enrollees.

Because this policy uncertainty is far outside the norm, insurers are making varying assumptions about how this uncertainty will play out and affect premiums. Some states have attempted to standardize the process by requesting rate submissions under multiple scenarios, while other states appear to have left the decision up to each individual company. There is no standard place in the filings where insurers across all states can explain this type of assumption, and some states do not post complete filings to allow the public to examine which assumptions insurers are making.

In the 20 states and DC with detailed rate filings included in the previous sections of this analysis, the vast majority of insurers cite policy uncertainty in their rate filings. Some insurers make an explicit assumption about the individual mandate not being enforced or cost-sharing subsidies not being paid and specify how much each assumption contributes to the overall rate increase. Other insurers state that if they do not get clarity by the time rates must be finalized – which is August 16 for the federal marketplace – they may either increase their premiums further or withdraw from the market.

Table 4 highlights examples of insurers that have explicitly factored into their premiums an assumption that either the individual mandate will not be enforced or cost-sharing subsidy payments will not be made *and* have specified the degree to which that assumption is influencing their initial rate request. As mentioned above, the vast majority of companies in states with detailed rate filings have included some language around the uncertainty, so it is likely that more companies will revise their premiums to reflect uncertainty in the absence of clear answers from Congress or the Administration.

Insurers assuming the individual mandate will not be enforced have factored in to their rate increases an additional 1.2% to 20%. Those assuming cost-sharing subsidy payments will not continue and factoring this into their initial rate requests have applied an additional rate increase ranging from 2% to 23%. Because cost-sharing reductions are only available in silver plans, insurers may seek to raise premiums just in those plans if the payments end. We estimate that silver premiums would have to [increase by 19%](#) on average to compensate for the loss of CSR payments, with the amount [varying substantially by state](#).

Several insurers assumed in their initial rate filing that payment of the cost-sharing subsidies would continue, but indicated the degree to which rates would increase if they are discontinued. These insurers are *not* included in the Table 4. If CSR payments end or there is continued uncertainty, these insurers say they would raise their rates an additional 3% to 10% beyond their initial request – or ranging from 9% to 38% in cases when the rate increases would only apply to silver plans. Some states have instructed insurers to submit two sets of rates to account for the possibility of discontinued cost-sharing subsidies. In California, for example, a surcharge would be added to silver plans on the exchange, increasing proposed rates [an additional 12.4% on average](#) across all 11 carriers, ranging from 8% to 27%.

Table 4: Examples of Preliminary Insurer Assumptions Regarding Individual Mandate Enforcement and Cost-Sharing Reduction (CSR) Payments

State	Insurer	Average Rate Increase Requested	Individual Mandate Assumption	CSR Payments Assumption	Requested Rate Increase Due to Mandate or CSR Uncertainty
CT	ConnectiCare	17.5%	Weakly enforced ¹	Not specified	Mandate: 2.4%
DE	Highmark BCBSD	33.6%	Not enforced	Not paid	Mandate and CSR: 12.8% combined impact
GA	Alliant Health Plans	34.5%	Not enforced	Not paid	Mandate: 5.0% CSR: Unspecified
ID	Mountain Health CO-OP	25.0%	Not specified	Not paid	CSR: 17.0%
ID	PacificSource Health Plans	45.6%	Not specified	Not paid	CSR: 23.2%
ID	SelectHealth	45.0%	Not specified	Not paid	CSR: 20.0%
MD	CareFirst BlueChoice	45.6%	Not enforced	Potentially not paid	Mandate: 20.0%
ME	Harvard PilgrimHealth Care	39.7%	Weakly enforced	Potentially not paid	Mandate: 15.9%
MI	BCBS of MI	26.9%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Blue Care Network of MI	13.8%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Molina Healthcare of MI	19.3%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 9.5%
NM	CHRISTUS Health Plan	49.2%	Not enforced	Potentially not paid	Mandate: 9.0%, combined impact of individual mandate non-enforcement and reduced advertising and outreach
NM	Molina Healthcare of NM	21.2%	Weakly enforced	Paid	Mandate: 11.0%
NM	New Mexico Health Connections	32.8%	Not enforced	Potentially not paid	Mandate: 20.0%
OR*	BridgeSpan	17.2%	Weakly enforced	Potentially not paid	Mandate: 11.0%
OR*	Moda Health	13.1%	Not enforced	Potentially not paid	Mandate: 1.2%
OR*	Providence Health Plan	20.7%	Not enforced	Potentially not paid	Mandate: 9.7%, largely due to individual mandate non-enforcement
TN	BCBS of TN	21.4%	Not enforced	Not paid	Mandate: 7.0% CSR: 14.0%
TN	Cigna	42.1%	Weakly enforced	Not paid	CSR: 14.1%
TN	Oscar Insurance	NA (New to state)	Not enforced	Not paid	Mandate: 0%, despite non-enforcement CSR: 17.0%, applied only to silver plans
VA	CareFirst BlueChoice	21.5%	Not enforced	Potentially not paid	Mandate: 20.0%
VA	CareFirst GHMSI	54.3%	Not enforced	Potentially not paid	Mandate: 20.0%
WA	LifeWise Health Plan of Washington	21.6%	Weakly enforced	Not paid	Mandate: 5.2% CSR: 2.3%
WA	Premera Blue Cross	27.7%	Weakly enforced	Not paid	Mandate: 4.0% CSR: 3.1%
WA	Molina Healthcare of WA	38.5%	Weakly enforced	Paid	Mandate: 5.4%

NOTES: The CSR assumption “Potentially not paid” refers to insurers that filed initial rates assuming CSR payments are made and indicated that uncertainty over CSR funding would change their initial rate requests. In Michigan, insurers were instructed to submit a second set of filings showing rate increases without CSR payments; the rates shown above assume continued CSR payments. *The Oregon Division of Financial Regulation reviewed insurer filings and advised adjustment of the impact of individual mandate uncertainty to between 2.4% and 5.1%. Although rates have since been finalized, the increases shown here are based on initial insurer requests. ¹Connecticare assumes a public perception that the mandate will not be enforced.

SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Discussion

A number of insurers have requested double-digit premium increases for 2018. Based on initial filings, the change in benchmark silver premiums will likely range from -5% to 49% across these 21 major cities. These rates are still being reviewed by regulators and may change.

In the past, requested premiums have been similar, if not equal to, the rates insurers ultimately charge. This year, because of the uncertainty insurers face over whether the individual mandate will be enforced or cost-sharing subsidy payments will be made, some companies have included an additional rate increase in their initial rate requests, while other companies have said they may revise their premiums late in the process. It is therefore quite possible that the requested rates in this analysis will change between now and open enrollment.

Insurers attempting to price their plans and determine which states and counties they will service next year face a great deal of uncertainty. They must soon sign contracts locking in their premiums for the entire year of 2018, yet Congress or the Administration could make significant changes in the coming months to the law – or its implementation – that could lead to significant losses if companies have not appropriately priced for these changes. Insurers vary in the assumptions they make regarding the individual mandate and cost-sharing subsidies and the degree to which they are factoring this uncertainty into their rate requests.

Because most enrollees on the exchange receive subsidies, they will generally be protected from premium increases. Ultimately, most of the burden of higher premiums on exchanges falls on taxpayers. Middle and upper-middle income people purchasing their own coverage off-exchange, however, are not protected by subsidies and will pay the full premium increase, switch to a lower level plan, or drop their coverage. Although the individual market on average [has been stabilizing](#), the concern remains that another year of steep premium increases could cause healthy people (particularly those buying off-exchange) to drop their coverage, potentially leading to further rate hikes or insurer exits.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Premium data are current as of August 7, 2017; however, filings in most states are still preliminary and will likely change before open enrollment. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes.