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Changes to Health Insurance Exchanges Expected for Enrollment Year 2015

The first three articles of this four-part series on Health Insurance Exchanges explored issues pertinent to beneficiaries and insurers in light of the opening of the Federal Health Insurance Marketplace, as well as other health insurance options, such as *Consumer Operated and Oriented Plans* (CO-OPs) and *Employer Insurance Plans*. This fourth and final installment discusses the expected changes for the *Health Insurance Exchanges* in enrollment year 2015, as well as the issues pertinent to consumers as the open enrollment period approaches in November 2014.

An expected 35 states will be relying on the federal government to run their health insurance exchanges in 2015, down from 36 in 2014.[1] Idaho and New Mexico are setting up state-run health insurance exchanges, while Oregon is shutting down its state-run exchange due to technical difficulties with its marketplace website, and the website's resulting inability to enroll a single resident in a health insurance plan.[2] At the end of the open enrollment for 2014, the federal healthcare exchange site, healthcare.gov, experienced a higher success rate for enrollment than many state exchanges, which had technical difficulties and enrollment issues.[3] These difficulties deterred many other states from setting up their own state exchanges for enrollment year 2015, although some state governments are still expected to implement state exchanges by 2016.[4] Since the passage of the *Patient Protection and Affordable Care Act* (ACA), states have received $4.8 billion in grant funding for the establishment of state exchanges from three sources:

(1) Planning grants, which were awarded in the amount of $1 million to 49 states and DC, to help provide resources towards planning for state exchanges;

(2) Exchange establishment grants, which assisted states who had made some progress from the planning grants, or were further along in the process of establishing an exchange; and,

(3) Early innovator grants, which were designed to assist states with the implementation of information technology systems, and have been awarded seven times.[5]

However, states will likely face funding challenges in 2015, as the ACA requirement for these exchanges to be financially self-sufficient goes into effect January 1, 2015, and the *U.S. Department of Health and Human Services* (HHS) will no longer award the aforementioned grants.[6]

The open enrollment period for 2015 will begin on November 15, 2014, and close on February 15, 2015.[7] During this new enrollment period, 13 million consumers are expected to enroll in health insurance exchanges, a significant increase over the 8 million consumers that enrolled in 2014.[8] The opening date for 2015 enrollment was delayed by a full month from the original date of October 15, 2014, which has caused some political turmoil, as the enrollment period will now open 11 days after Election Day.[9] This extension was implemented to give insurance companies more time to evaluate the pool of customers from 2014, i.e., to determine the demographics of their insured population as well as any associated risks.[10] Even with a surge in younger and healthier enrollees toward the end of the 2014 enrollment period,[11] some insurers have found an older-than-expected population demographic, which negatively affects the risk pool, and could lead to higher premiums in 2015.[12]

Pricewaterhouse Coopers has reported preliminary estimates of health insurance rates for 2015, which reflect an 8% rate increase, on average.[13] However, the figures vary widely by state, as health insurance rates in Arizona and Colorado are estimated to decrease by 23%, while health insurance rates in Arkansas are expected to increase by 50%.[14] One provision in the ACA was developed specifically to curb such rate hikes, specifically through enforcement of rate reviews. Rate reviews ensure that any increase of 10% or more undergoes a scrutinized review to ensure that it is based on solid evidence and reasonable cost assumptions.[15] All but five states currently conduct their own rate reviews, and thus experience variability in deference between states.[16] Accordingly, as regulators review the current proposed rate figures, the wide variance is expected to decrease.[17] Additional changes for 2015 were outlined in the final rule, *Exchange and Insurance Market Standards for 2015 and Beyond*, published in May of 2014.[18] Some of the more pressing issues to consumers are discussed below, and include:

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(1) The role of navigators;

(2) Premium stabilization programs;

(3) The *Small Business Health Options Program* (SHOP); and,

(4) Auto-renewal of exchange health insurance policies.[19]

Navigators, *Certified Application Counselors* (CACs), and non-navigator assisters augment the traditional agents and brokers by assisting consumers with the insurance exchange enrollment process.[20] The Final Rule issued by *Centers for Medicare and Medicaid Services* (CMS) on navigators "*lessens state control over navigators by preempting state laws, or portions of them, if they 'prevent the application of the provisions of Title I of the Affordable Care Act'.*"[21] This provision is intended to restrict states from implementing any laws which would inhibit navigators from the completion of their federal duties. CMS stated, "*Congress made clear that while states continue to have authority to enact laws that affect programs established under the Affordable Care Act, that authority is not unlimited.*"[22] This effectively ensures that navigators will be able to provide information to customers which is fair, impartial, and in their best interest.[23]

Another important change involves the premium stabilization programs. These programs include the temporary reinsurance program, the temporary risk-corridor program and the permanent risk-adjustment program.[24] The risk-corridor program was implemented as a budget neutral measure, providing subsidies to insurers with overly expensive client populations and assessing payments to those with a healthier population. For 2015, the risk-corridor program will receive a 2% increase for administrative costs and the profit margin floor.[25] These changes adjust the formula used to determine the size of subsidies to be paid to or deducted from the insurer, allowing for increases in payments to insurers with decreasing assessments.[26]

Additionally, employee choice and premium aggregation will be permitted in the federal SHOP exchange in 2015, which allows employers to give employees a choice in health plans at a designated actuarial, or "*metal*", level which the employer selects, also known as the "*employee choice model*."[27] Premium aggregation allows the employer to pay one aggregate payment to the health plan providers based on the total number of employees enrolled.[28] In order to ease the transition to this model, a clause was added which allows State Insurance Commissioners to appeal the employee choice option in their state if concrete evidence is provided which delineates how a delay in employee choice until 2016 would be in the best interest of small business employers and employees.[29]

The Final Rule on *ACA Annual Eligibility Redeterminations for Exchange Participants* was released by the Centers for Medicare & Medicaid Services (CMS) on September 2, 2014, and provided guidance on eligibility reporting procedures, as well as policies for auto-renewing insurance plans, in most cases.[30] For consumers, auto-renewal in the same insurance plan for the 2015 enrollment period may cause significant issues. If enrollees auto-renew, with no changes to their policy, they will receive the same dollar amount of federally provided subsidies that they received in 2014.[31] Industry experts warn that the levels of subsidies applied in 2014 could be dated and incorrect for the 2015 enrollment period, with expected changes to premiums for many insurers.[32] These changes will likely affect which plans are the "*benchmark plans*," the second-lowest priced *Silver* plan, which, in turn, affects the dollar amount of subsidies to be provided.[33] Therefore, if the "*benchmark plan*" has higher costs in 2015, an individual who auto-renews will not get the larger subsidy that they previously received in 2014, and the individual will have to pay more out-of-pocket.[34] Avalere Health reported that "*Automatic re-enrollment could conceivably mean people will pay more in premiums unless they proactively take steps to comparison shop,*"[35] and that, "*[b]efore consumers renew their 2014 plan, they should consider the trade-off between continuity of care and lower monthly premiums.*"[36]

Overall, the most prominent changes that consumers are likely to notice with the 2015 health insurance exchanges are the potential changes in premiums, and issues surrounding auto-renewal for existing policies. As the 2015 open-enrollment period draws nearer, consumers would be well-served to closely examine their health insurance needs, and evaluate what insurance plan best satisfies those needs.

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