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Year-to-Year Variation in Small-Group Health Insurance Premiums: Double-Digit Annual Increases Have Been Common Over the Past Decade

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Timely Analysis of Immediate Health Policy Issues

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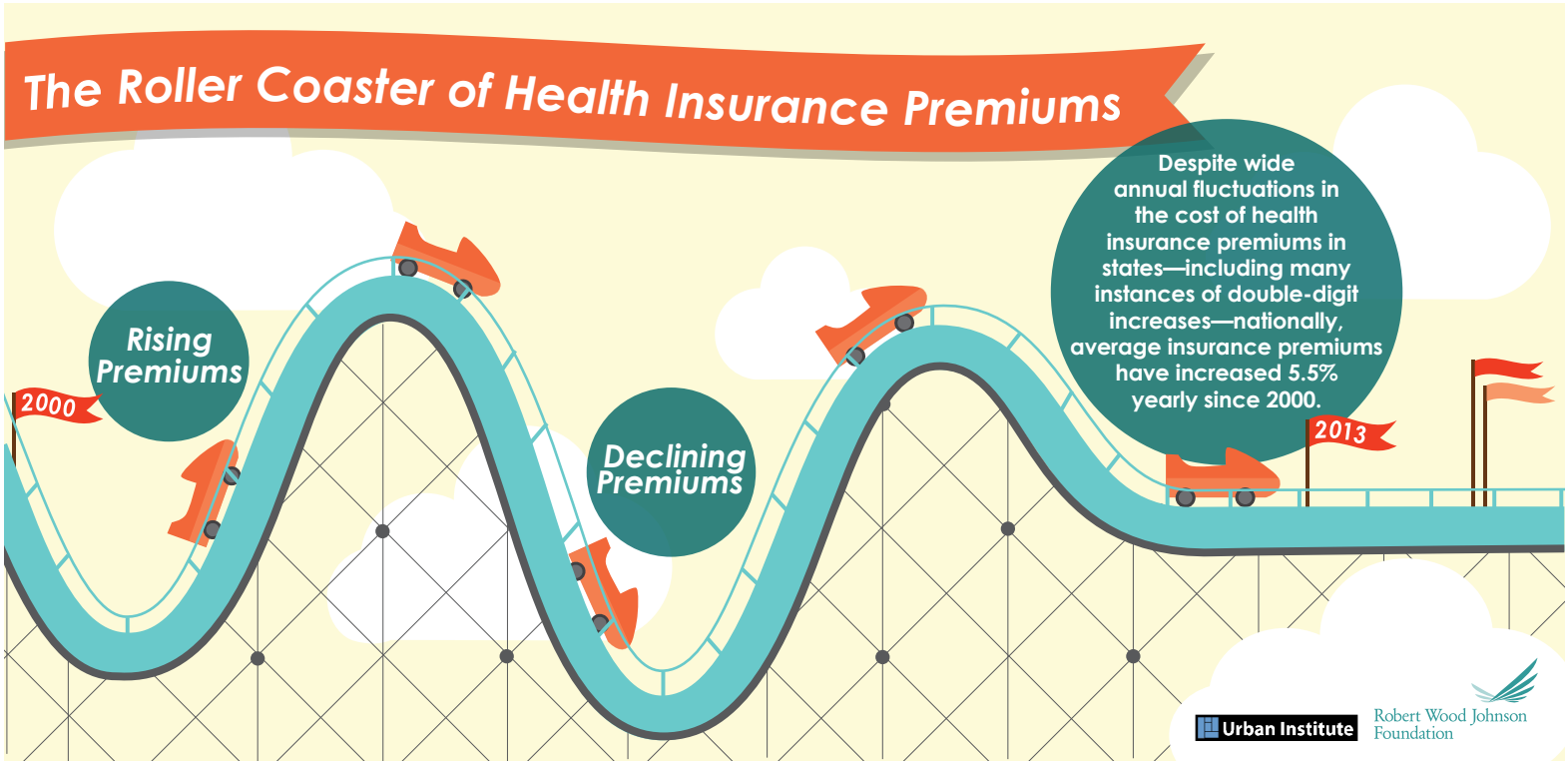
In-Brief

Insurance carriers, state departments of insurance and Marketplaces are beginning to gear up for the 2015 plan year open enrollment period, which will begin in mid-November. Accordingly, state departments of insurance are reviewing premium rates submitted by insurers earlier this year, and final approved rates for small-group and nongroup Marketplace plans will begin to be made public; different states will release the information on different schedules. In anticipation of next year's premium announcements and given some information already made public, concerns have surfaced about the potential for double-digit percent increases in nongroup and small-group health insurance premiums.[1]

As noted elsewhere,[2] premiums and their growth paths will differ across geographic areas and are a function of many factors, including:

- carriers' expectations regarding the enrollees' characteristics, and how those expectations have changed since 2014 premiums were set;
- patterns of disenrollment through the first half of 2014;
- regulatory and policy changes for 2015 (e.g., decreases in government reinsurance funding, state decisions to create Basic Health Plan programs and prevalence of people maintaining grandfathered and other non-ACA-compliant plans);
- the level of competition in insurance markets; and
- competition in health care provider (doctor and hospital) markets.

Our review of data from the Medical Expenditure Panel Survey—Insurance Component (MEPS-IC) indicates that double-digit relative increases in average premiums in the small-group insurance market have been frequent over the past 13 years. In addition, large increases in one year are often followed by significantly smaller increases (and sometimes even decreases) in the year that follows.



Approach

In this brief we review annual small-group health insurance premium growth since the year 2000 as documented by the MEPS-IC, in order to place changes that may occur in 2015 premiums in context. The MEPS-IC provides annual average premiums by employer size and samples across all employer plans regardless of the group's health care risk, benefit differences or cost-sharing differences. We use both state-level data and data for the 20 largest metropolitan areas. With very few exceptions, state-level data will understate fluctuations in premiums because it aggregates experience over multiple premium-rating areas, between which areas insurers are permitted to set different premiums for the same plans sold to people of the same age and smoking status.[3] In addition, available data do not allow us to capture employer-specific premium changes, nor do we have reliable data for annual changes in nongroup insurance premiums. However, though average premium growth in the small-group market shown here understates the variation experienced by individual employers and nongroup purchasers over the years, it serves as a better indicator of future premium variation in both the small-group and nongroup markets under the ACA because market reforms under the law eliminate the year-to-year premium variations experienced by individual purchasers caused by fluctuations in claims experience. Thus, average experience in the past serves as a reasonable proxy for individual or small-group specific experience in the future.

Before the ACA, insurers could typically set or increase premiums for small employers and individual purchasers as a function of the enrollees' health status or recent claims experience and other factors.[4] Bad experiences for even a very small number of enrollees could have a dramatic effect on average premiums for a small pool of workers or individuals. Employer- and individual-specific premium variation should be reduced significantly in ACA-compliant plans because of the prohibition of health status and past claims experience as insurer rating factors. These fluctuations are averaged out in the state and metropolitan area averages used here from previous years. And because state essential health benefit benchmarks that the ACA applies to the small-group and nongroup market are most frequently based upon the most-enrolled pre-ACA small-group insurance plan,[5] previous small-group insurance experience is a reasonable benchmark for future annual growth rates in both the ACA-compliant small-group and nongroup markets.

In addition, 2014 through at least 2017 should be thought of as transitional years for ACA implementation. Individuals and employers are in the early stages of learning about and understanding the law, its provisions, and the coverage options it provides. Accordingly, individuals' and employers' decisions about purchasing coverage at all and the type of coverage to purchase have yet to reach a steady state. Consequently, until insurance risk pools settle down to an equilibrium, near-term experience with premium variation in these markets is likely to be at least somewhat greater than what the future holds.

Findings

Table 1 shows the average annual growth in average premiums by state and firm size for employers with fewer than 100 employees. In addition, we provide statistics on the share of years during the study period in which the average premium increased by at least 10 percent (year-by-year relative changes in average premiums are shown for each employer size group in appendix Tables 1 through 3, available at http://www.urban.org/publications/413227.html)[6]. Though average annual increases in average small-group premiums most frequently fall in the 5 percent to 6.5 percent range, year-to-year relative increases fluctuate substantially. Large growth years are frequently followed by smaller or sometimes even negative average growth in years immediately following.

Between 2000 and 2013 it was more common than not that states saw annual average premium increases hit double digits at least one-third of the time. Thirty-four states saw average annual increases of 10 percent or more in the smallest firm size market in at least one-third of the years since 2000. The same was true for 31 states in the 10 to 24 worker group market and for 32 states in the 25 to 99 worker market.

These large fluctuations around the annual average growth are indicated by data in Table 1 providing the share of years with double-digit increases by state. Missouri and Oklahoma, for example, are states with reasonably low average annual growth in premiums for the smallest firms (those with fewer than 10 workers)—5.0 and 4.8 percent, respectively. Still, each state experienced double-digit increases in average premiums in this market in 36 percent of years from 2000 to 2013. Many states experienced such large increases even more frequently. Nebraska and Illinois, both states with low average annual growth over the 2000–2013 period (4.6 percent and 4.2 percent, respectively), experienced double-digit annual increases in this market in about half of the years studied (56 percent of years for Nebraska and 45 percent of years for Illinois). Five states (North Dakota, West Virginia, Colorado, Idaho and Alaska) and the District of Columbia saw annual increases in average premiums of 10 percent or more for firms of 10 to 24 employees in at least half of the years between 2000 and 2013. The same was true in seven states in the 25 to 99 firm size group and nine states in the firms with fewer than 10 workers category.

Table 2 presents findings for the largest 20 metropolitan areas in the country, using MEPS-IC data on employers with fewer than 50 workers,[7] over the years 2002 to 2013.[8] Again, we see that double-digit average premium increases are quite common, with 11 of the 20 metro areas experiencing such increases in one-third or more of the years studied. The annual growth rates in average premiums for small-group coverage ranged from a low of -34 percent in both the Tampa-St. Petersburg-Clearwater,

Table 1. Average Annual Growth in Average Premium and Share of Years With Double Digit Average Annual Increases in Small Group Single Premiums by State and Firm Size, 2000 to 2013

	Firm Size: <10 Workers		Firm Size: 10-24 Workers		Firm Size: 25-99 Workers	
	Average Annual Growth in Average Premium	Share of Years With Double Digit Increases	Average Annual Growth in Average Premium	Share of Years With Double Digit Increases	Average Annual Growth in Average Premium	Share of Years With Double Digit Increases
New England						
Connecticut	5.1%	27%	4.2%	27%	5.2%	36%
Maine	4.4%	40%	4.1%	0%	3.7%	20%
Massachusetts	6.1%	27%	5.8%	36%	7.0%	36%
New Hampshire	6.7%	44%	8.0%	22%	6.7%	56%
Rhode Island	4.7%	25%	5.3%	25%	5.8%	0%
Vermont	4.3%	25%	5.0%	25%	5.4%	25%
Middle Atlantic						
New Jersey	4.1%	18%	6.4%	36%	5.6%	36%
New York	4.5%	27%	5.1%	36%	5.1%	36%
Pennsylvania	6.7%	36%	5.2%	27%	5.4%	36%
East North Central						
Illinois	4.2%	45%	4.7%	36%	5.6%	27%
Indiana	8.6%	64%	5.7%	27%	7.0%	45%
Michigan	3.4%	27%	4.9%	27%	4.9%	27%
Ohio	7.5%	36%	5.6%	36%	5.6%	27%
Wisconsin	5.3%	36%	5.7%	36%	5.3%	36%
West North Central						
Iowa	5.5%	55%	5.4%	27%	5.6%	27%
Kansas	6.7%	33%	6.7%	44%	4.4%	44%
Minnesota	4.9%	45%	5.3%	36%	4.5%	27%
Missouri	5.0%	36%	4.4%	45%	5.2%	36%
Nebraska	4.6%	56%	5.9%	33%	5.4%	44%
North Dakota	8.1%	50%	5.7%	50%	6.7%	50%
South Dakota	6.9%	38%	8.4%	38%	6.9%	50%
South Atlantic						
Delaware	6.6%	50%	7.1%	40%	5.8%	40%
District of Columbia	5.1%	25%	7.4%	50%	5.1%	13%
Florida	5.6%	27%	5.8%	27%	5.3%	27%
Georgia	5.7%	36%	4.6%	36%	4.5%	27%
Maryland	5.7%	27%	6.1%	36%	6.0%	36%
North Carolina	5.1%	45%	2.9%	27%	6.2%	36%
South Carolina	5.7%	36%	5.8%	45%	4.9%	27%
Virginia	5.6%	27%	6.5%	36%	5.4%	36%
West Virginia	3.8%	22%	5.4%	56%	4.8%	33%
East South Central						
Alabama	6.0%	45%	6.1%	36%	6.4%	36%
Kentucky	5.6%	55%	4.5%	36%	6.5%	55%
Mississippi	4.9%	45%	5.6%	36%	4.6%	36%
Tennessee	6.2%	27%	3.7%	27%	5.2%	27%
West South Central						
Arkansas	3.9%	22%	3.2%	33%	4.3%	0%
Louisiana	5.6%	45%	4.5%	27%	5.3%	27%
Oklahoma	4.8%	36%	6.0%	36%	4.2%	27%
Texas	5.7%	36%	4.9%	18%	4.4%	55%
Mountain						
Arizona	5.8%	45%	3.2%	27%	7.8%	55%
Colorado	4.8%	45%	6.6%	55%	5.7%	45%
Idaho	3.6%	25%	5.0%	50%	5.9%	38%
Montana	9.8%	56%	6.8%	44%	5.3%	33%
Nevada	6.2%	50%	5.0%	30%	3.4%	30%
New Mexico	5.7%	44%	2.0%	33%	5.7%	22%
Utah	6.4%	36%	3.9%	18%	6.0%	45%
Wyoming	6.0%	38%	5.5%	38%	6.8%	38%
Pacific						
Alaska	6.1%	38%	7.3%	50%	7.1%	50%
California	6.4%	27%	7.1%	45%	6.8%	36%
Hawaii	5.5%	50%	4.9%	30%	5.8%	40%
Oregon	5.7%	18%	5.8%	27%	5.8%	18%
Washington	6.7%	36%	6.1%	27%	5.7%	36%

Source: Authors' calculations based on data from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

Table 2. Average Annual Change in Average Small Group Single Premiums (2002 to 2013) for the 20 Largest Metropolitan Areas Averages; Aggregate Premiums for All Employers with Fewer Than 50 Workers

	Average Annual Growth From 2002 to 2013	Minimum Annual Growth	Maximum Annual Growth	Share of Years With Double Digit Increases
New York-Northern New Jersey-Long Island, NY-NJ-PA MSA	4.6%	-4.9%	22.9%	11%
Los Angeles-Long Beach-Santa Ana, CA MSA	5.4%	1.7%	12.2%	22%
Chicago-Naperville-Joliet, IL-IN-WI MSA	4.7%	-1.9%	21.4%	11%
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD MSA	3.6%	-7.2%	20.8%	22%
Dallas-Fort Worth-Arlington, TX MSA	4.9%	-9.2%	28.7%	33%
Miami-Fort Lauderdale-Miami Beach, FL MSA (2009-2012, Miami-Fort Lauderdale-Pompano Beach, FL)	4.8%	-9.5%	20.4%	44%
Houston-Sugar Land-Baytown, TX MSA	3.4%	-11.4%	16.8%	44%
Washington-Arlington-Alexandria, DC-VA-MD-WV MSA	4.3%	-5.2%	17.9%	11%
Atlanta-Sandy Springs-Marietta, GA MSA	4.9%	-11.1%	35.4%	22%
Detroit-Warren-Livonia, MI MSA	3.8%	-13.9%	29.0%	33%
Boston-Cambridge-Quincy, MA-NH MSA	5.6%	-34.3%	28.1%	11%
San Francisco-Oakland-Fremont, CA MSA	4.9%	-11.0%	21.4%	33%
Riverside-San Bernardino-Ontario, CA MSA	5.5%	-6.2%	30.2%	56%
Phoenix-Mesa-Scottsdale, AZ MSA (2010-2012, Phoenix-Mesa-Glendale, AZ)	3.5%	-7.6%	24.6%	22%
Seattle-Tacoma-Bellevue, WA MSA	7.0%	-4.3%	18.1%	33%
Minneapolis-St. Paul-Bloomington, MN-WI MSA	4.4%	-11.9%	14.7%	22%
San Diego-Carlsbad-San Marcos, CA MSA	7.6%	-5.7%	25.4%	44%
St. Louis, MO-IL MSA	7.5%	-8.8%	32.9%	56%
Baltimore-Towson, MD MSA	4.6%	-5.1%	13.0%	44%
Tampa-St. Petersburg-Clearwater, FL MSA	1.9%	-33.9%	28.8%	33%

Source: Authors' calculations based on data from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

Florida, and the Boston-Cambridge-Quincy, Massachusetts, areas to a high of 35 percent in the Atlanta-Sandy Springs-Marietta, Georgia, area.

The Riverside-San Bernardino-Ontario area in California and the St. Louis MSA experienced an annual increase in average small-group premiums of 10 percent or more in five of the nine years for which data was available. The San Diego, Miami and Houston metropolitan areas all saw such increases in four of the nine years studied.

Conclusion

Although average annual increases in small-group premiums over the past 13 years averaged roughly 5.5 percent, double-digit average premium increases are common for states and large metropolitan areas. The average annual increases shown, which aggregate data across large numbers of employers, understate the variation actually experienced over the past decade. In fact, it is common for states and metro areas to experience such large relative increases at least one-third of the time, given recent experience. Experiences have varied by geographic area, by year, and by employer size.

It is likely that some insurance carriers in some areas will increase premiums in 2015 and any subsequent year by comparable amounts, but the increases will vary by insurer, plan, and geographic area, and such increases should be placed in the appropriate historical perspective. Large increases in one year are frequently followed by much smaller increases, or even average premium decreases. This may be especially true as insurers, employers and individual purchasers navigate the new insurance environment created by the ACA, moving toward a more stable equilibrium situation over the first few years post reform.

The ACA's market reforms, which prohibit insurers in the small-group and nongroup insurance markets from varying premiums based upon health status or claims experience of the enrollees, should decrease year-to-year premium variation relative to the pre-reform period. This will become especially evident once past the early implementation years in which the insurers are calculating the contours of the new playing field and consumer decisions reach equilibrium. However, increased costs due to changes in utilization (e.g. medical practice patterns and use of medical technologies) will continue to place upward pressure on health care spending and thus on premiums in all insurance markets. In addition, insurer perceptions of the effectiveness of risk-spreading tools, such as risk adjustment, risk corridors and reinsurance (the latter two temporary programs, the first a permanent one), can also affect annual changes in premiums.

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Notes

1 See, for example, Abelson R, "Health Insurers Raise Some Rates by Double Digits," *New York Times*, January 5, 2013, http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?pagewanted=all&_r=0 (accessed September 2014); Norman B, "Solving a 2014 Obamacare Problem Pushes Premium Hikes in 2015," *Politico*, August 13, 2014, http://www.politico.com/story/2014/08/obamacare-premium-increase-2015-109979.html (accessed September 2014); and Chang D and Madigan N, "Proposed Prices for Health Plans in 2015 Unveiled," *Miami Herald*, August 4, 2014, http://www.miamiherald.com/2014/08/04/4271376/proposed-prices-for-health-plans.html (accessed September 2014).

2 Holahan J and Blumberg L. "Marketplace Competition and Insurance Premiums in the First Year of the Affordable Care Act." Washington: Urban Institute, 2014, http://www.urban.org/publications/413203.html (accessed September 2014).

3 Rhode Island is an example of an exception to this rule; there is only one premium rating area designated for the entire state.

4 Corlette S and Volk J. "Real Stories, Real Reforms." Washington: Georgetown University Center on Health Insurance Reforms, 2013. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407972 (accessed September 2014).

5 Corlette S, Lucia KW and Monahan CM. "Moving to High Quality, Adequate Coverage: State Implementation of New Essential Health Benefit Requirements." Washington: Urban Institute, 2013. http://www.urban.org/UploadedPDF/412882-Moving-to-High-Quality-Adequate-Coverage-State-Implementation-of-New-Essential-Health-Benefits-Requirements.pdf

6 The MEPS-IC did not report results for 2007. Consequently, relative increases between 2006 and 2007 and between 2007 and 2008 are not available.

7 The MEPS-IC does not provide data by metropolitan area for the narrower small-group sizes because of sample size concerns and to prevent identification of individual employers.

8 The MEPS-IC began providing these data by metropolitan area beginning in 2002.