American Academy of Actuaries

Issue Brief

JULY 2017

KEY POINTS

Key drivers of 2018 premium changes include:

- Medical trend, which is the underlying growth in health care costs;
- Legislative and regulatory uncertainty regarding cost-sharing reduction subsidies and enforcement of the individual mandate;
- Whether risk-sharing programs for high-cost enrollees are provided;
- Changes in the risk pool composition and insurer assumptions from 2017; and
- Resumption of the health insurer fee.

Average premium rate changes may not represent the rate change experienced by a particular consumer. A number of factors can result in a consumer's premium differing from the average rate change, including changes in plan selection, age/family status, tobacco status, geography, and subsidy eligibility.

American Academy of Actuaries
Objective. Independent. Effective.™

1850 M Street NW, Suite 300
Washington, DC 20036
202-223-8196 | www.actuary.org

Craig Hanna, Director of Public Policy
Cori Uccello, Senior Health Fellow

Drivers of 2018 Health Insurance Premium Changes

The 2018 health insurance premium rate filing process is underway. This issue brief outlines factors underlying premium rate setting generally and highlights the major drivers behind why 2018 premiums could differ from those in 2017. It focuses primarily on the individual market, but many factors are relevant to the small group market as well.

Premiums Reflect Many Factors

Actuaries develop proposed premiums based on projected medical claims and administrative costs for pools of individuals or groups with insurance. Factors that affect proposed premiums include:

WHO IS COVERED—THE COMPOSITION OF THE RISK POOL. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But the composition of the risk pool is also important. Although the Affordable Care Act (ACA) now prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of the risk pool as a whole. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher on average. If a risk pool disproportionately avoids those with higher expected claims or can offset the costs of those with higher claims by enrolling a large share of lower-cost individuals, premiums will be lower.

PROJECTED MEDICAL COSTS. Most premium dollars are used to pay for medical services and supplies, which reflect unit costs (e.g., the price for a given health care service or medication), utilization, the mix and intensity of services, and plan design. Unit costs and utilization can vary by geographic area due to the general medical practices of the region and from one health plan to another depending on the ability and leverage of the insurer to negotiate fees and care management protocols with health care providers.

OTHER PREMIUM COMPONENTS. Premiums must cover administrative costs, including those related to insurance product development, sales and enrollment, claims processing, customer service, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as risk charges and profit.

LAWS AND REGULATIONS. Laws and regulations, including the presence of risk-sharing programs, can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments, and fees that need to be included in premiums.

Major Drivers of 2018 Premium Changes

UNDERLYING GROWTH IN HEALTH CARE COSTS. The increase in costs of medical services and prescription drugs—referred to as medical trend—is based on not only the increase in per-unit costs of services, but also changes in health care utilization and changes in the mix of services. Projected medical trend in 2018 is expected to be consistent with 2017 medical trend; estimates are in the 5 percent to 8 percent range.[1] The growth in spending for prescription drugs has leveled off somewhat, as many relatively new high-cost drugs (e.g., those treating hepatitis C) are now built into the base. As a result, spending for prescription drugs is expected to only slightly outpace the costs for other medical services.

LEGISLATIVE / REGULATORY UNCERTAINTY. With the uncertainty surrounding potential legislative and regulatory changes to the ACA, insurers may need to incorporate additional provisions for risk within the premium rate setting process, including:

- *Cost-sharing reduction subsidies.* There is a significant amount of uncertainty regarding the future of federal reimbursement to insurers for cost-sharing reduction (CSR) subsidies. The ACA requires insurers to provide cost-sharing reductions to eligible low-income enrollees through silver plan variants. A legal challenge, *House of Representatives v. Price*, has called into question the funding for these reimbursements. Insurers may incorporate an adjustment to account for their potential additional costs.

  Due to the uncertainty of whether CSRs will continue to be paid, some state regulators have allowed or even required insurers to build CSR costs into their premiums. There are different approaches to adjust premiums, either allocating additional costs solely to silver plans or across all plans (it would be appropriate for all insurers in a state to follow the same methodology). If levied on silver plans only, premium increases could average nearly 20 percent, over and above premium increases due to medical inflation and other factors.[2] Although those who receive premium subsidies

1 "Analysis: Market Uncertainty Driving ACA Rate Increases"; Oliver Wyman Health; June 14, 2017.
2 "Estimates: Average ACA Marketplace Premiums for Silver Plans Would Need to Increase by 19% to Compensate for Lack of Funding for Cost-Sharing Subsidies; Estimated Increases Range from 9% in North Dakota to 27% in Mississippi"; Kaiser Family Foundation; April 6, 2017.

would be insulated from the full increase in premiums, nonsubsidized enrollees would face the full increase, potentially affecting their enrollment behavior and therefore the morbidity of the risk pool.

Different states could have different ways to approach CSR uncertainty. Although some states are requiring insurers to submit two sets of rates, others are allowing insurers to submit two sets, while others are requiring rate submissions to assume that CSR reimbursements are made. Other workarounds include requiring insurers to create off-exchange silver plans that do not mirror on-exchange plans so that insurers would not have to build in a CSR-related premium increase. This approach is being pursued in California.[3]

- *Enforcement of the individual mandate.* Despite some early indications that the Trump administration would ease enforcement of the individual mandate, the Internal Revenue Service (IRS) processed individual mandate penalties this past tax season. Nevertheless, there is uncertainty regarding the mandate's enforcement moving forward, as exemplified by recent U.S. House Committee on Appropriations moves to end enforcement through a spending bill.4 A weakening or elimination of the individual mandate would be expected to increase premiums as lower-cost individuals would be more likely to forgo coverage.

- *Special Enrollment Period and Open Enrollment Period.* During the first years of the ACA, state and federal regulators have extended the Open Enrollment Period (OEP). In addition, more individuals enrolled during Special Enrollment Periods (SEP) than insurers projected. Insurers collect less premium from those members who enrolled later or during a SEP, which causes further upward pressure on premium rates. For the 2018 plan year, the OEP is shortened. Rather than being run from Nov. 1, 2017, to Jan. 31, 2018, it will only run to Dec. 15, 2017,[5] with the goal to reduce the potential adverse selection arising from longer OEPs. Further, the rules surrounding SEPs will be stricter, also reducing the potential for adverse selection. In theory, the impact of these changes should exert downward pressure on the rates. However, the extent of the impact is unknown, and how these changes will ultimately impact the morbidity of the risk pool is undetermined.[6]

- *Potential changes to the ACA.* Policymakers are considering changes to the ACA or to its regulations. These changes include: allowing states to vary the ACA's issue, rating, or benefit requirements; changing the premium and cost-sharing subsidies; expanding the availability of association health plans; and allowing carriers to sell across state lines. There is uncertainty regarding the potential increased utilization of services for enrollees who may fear they will lose coverage due to possible changes in federal or state legislation.

Insurers build risk margins into their premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion should costs be greater than projected. Given the uncertainty regarding potential legislative and regulatory changes and other uncertainties regarding claim costs, insurers may be inclined to include a larger risk margin in the rates. To the extent that insurers cannot determine the necessary premium rates to cover the projected costs due to legislative and regulatory uncertainty, they may decide to withdraw from the individual market.

3 "Supplemental Guidance on Rate Filing Instructions Related to the Cost-Sharing Reduction Program"; Covered California; June 6, 2017.
4 "Congress Moves to Stop I.R.S. From Enforcing Health Law Mandate"; *The New York Times*; July 3, 2017.
5 Patient Protection and Affordable Act; Market Stabilization; Final Rule; Department of Health and Human Services; April 18, 2017.
6 An Oliver Wyman survey showed that 86 percent of the insurers surveyed didn't or weren't planning to incorporate the impact of these new rules into their rates. See http://health.oliverwyman.com/transform-care/2017/06/ACA_rate_survey.html.

RISK-SHARING PROGRAMS FOR HIGH-COST ENROLLEES. Risk-sharing programs offer the opportunity to lower premiums in the individual market, depending on how they are funded and the requirements for enrollment.[7] For instance, several states are pursuing reinsurance and invisible risk pools approaches to help stabilize their individual markets. In addition, the House-passed American Health Care Act (AHCA) would provide federal funding for such approaches. Premium increases will be lower in states that newly incorporate a risk-sharing program, as long as the funding is external to the individual market.

CHANGES IN THE RISK POOL COMPOSITION AND INSURER ASSUMPTIONS. The ACA requires that insurers use a single risk pool when developing premiums. Therefore, as in previous years since the ACA's enactment, premiums for 2018 will reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace (i.e., exchanges). Health insurance premiums are set at the state level (with regional variations allowed within a state) and are based on state- and insurer-specific experience regarding enrollment volume and composition. In addition, because the ACA risk adjustment program shifts funds among insurers depending on the health status of an insurer's population relative to that of the entire market, premiums need to incorporate assumptions regarding the risk profile of the entire market. Changes in premiums between 2017 and 2018 will reflect expected changes in the risk profiles of the enrollee population, as well as any changes in insurer assumptions based on whether experience to date differs from that assumed in 2017 premiums. Importantly, market experience to date and 2018 projections vary by state, depending in part on state policy decisions and local market conditions.

When developing premiums for 2017, insurers had more information than they did in prior years, especially regarding the risk profile of the market as a whole. After more moderate premium increases in 2015 and 2016, premiums increased by 22 percent on average in 2017,[8] reflecting that, in many areas, experience was worse than projected. If the assumptions underlying 2017 premiums better reflect actual 2017 experience and if the risk pool is expected to be stable, then the high 2017 premium increases would be more of a one-time adjustment. If on the other hand a deterioration or improvement in the risk pools is expected, upward or downward pressure on 2018 premiums would result, respectively.

Average health costs for a given population in a guaranteed-issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher take-up rates typically reflect a larger share of healthy individuals enrolling. According to the Department of Health and Human Services (HHS), marketplace enrollment at the end of the open enrollment period increased from 8.0 million in 2014 to 11.7 million in 2015, increased again to 12.7 million in 2016, but dropped slightly to 12.2 million in 2017.[9] Insurers need to consider whether this decline is likely to continue or reverse in 2018. If the decline is expected to continue or increase in 2018, this will put upward pressure on 2018 premium increases.

HEALTH INSURER FEE. The health insurance provider fee was enacted through the ACA. The Consolidated Appropriations Act of 2016 included a moratorium on the collection of the fee in 2017. Insurers removed the fee from their 2017 premiums, resulting in a premium reduction of about 1 to 3 percent, depending on the size of the insurer and their profit/

7 *Using High-Risk Pools to Cover High-Risk Enrollees*; American Academy of Actuaries; February 2017.
8 *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*; Department of Health and Human Services; ASPE issue brief; Oct. 24, 2016.
9 "Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016–January 31, 2017"; Centers for Medicare and Medicaid Services (CMS). Enrollment figures are understated because they do not include off-marketplace enrollment in ACA-compliant plans, and overstated because they reflect plan selection only, with or without payment of premium. Also, as noted by CMS, "Caution should be used when comparing plan selections across OEPs since some states have transitioned platforms between years. Additionally, state expansion of Medicaid may affect enrollment figures from year to year; Louisiana expanded Medicaid in July 2016, which may have affected Marketplace enrollments in 2017."

not-for-profit status. Unless the moratorium is extended, the resumption of the fee in 2018 will increase premiums by about 1 to 3 percent.

Other Drivers

CHANGES IN PROVIDER NETWORKS. CMS recently announced that it is shifting the responsibility to evaluate network adequacy to the states (for states that have adequate review authority and capability). If states require some insurers to contract with additional providers, premiums for those insurers may increase slightly. Likewise, if states allow more restricted networks, there may be slight decreases in premiums.

The prevalence of plans built around more limited provider networks increased after the implementation of the ACA. Premiums for such narrow network plans have been lower than those of comparable plans. Although there may be some new narrow network plan offerings introduced for 2018, the number of such plans is not likely to increase as much as in previous years. However, if there are continued market withdrawals of broad network plans, the average premiums may be lower, not considering other premium change factors, albeit with less choice of provider.

BENEFIT PACKAGE CHANGES. Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums, even if a plan's metal level remains unchanged. For 2018, changes have been made to the rules regarding the allowable variation in actuarial value (AV), which measures the relative level of plan generosity. Plan designs must result in an AV within a limited range around 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans. Previously, variations of up to 2 percentage points above or below the target AV were allowed. For 2018, variations of up to 4 percentage points below the target or 2 percentage points above the target are permitted. For bronze plans, the allowed variation below the target is 4 percentage points and an upward variation of up to 5 percentage points is permitted if at least one major non-preventive service is covered before application of the deductible or if it is a health savings account (HSA)-qualified high-deductible health plan.[10, 11] The leaner plan designs allowed by the wider variations will have a downward effect on premiums, although an upward effect on cost-sharing.

Other changes in benefit packages could be made based on market competition or other considerations, putting upward or downward pressure on premiums, depending on the particular change. Changes would be expected to be minimal as long as the current essential health benefits (EHB) requirement is in place. Other plan design features, such as drug formularies and care management protocols, also could affect premium changes.

MARKET COMPETITION. Market forces and product positioning also can affect premium levels and premium increases. Health insurers are increasingly focused on local competition, offering coverage only in geographic regions in which they believe they have a competitive advantage. As such, there may be more price competition in those regions where many health plans are offered, and less price competition where fewer health plans participate.

In 2014–2016, many markets saw increased insurer participation and new entrants offering coverage for the first time, sometimes at very competitive premium levels. More recently, the opposite occurred, with many insurers indicating that they were reducing the number of markets they would participate in for 2017—in some cases even exiting the market completely. In 2017, 33 percent of counties (covering about 21 percent of enrollees) have only one participating insurer.[12] The increased legislative and regulatory uncertainty combined with continued losses has

10 The ACA already requires coverage of preventive services without being subject to deductible or other cost-sharing requirements.
11 Patient Protection and Affordable Act; Market Stabilization; Final Rule; Department of Health and Human Services; April 18, 2017.
12 "Insurer Participation on ACA Marketplaces, 2014-2017"; Kaiser Family Foundation; June 1, 2017.

led to additional market withdrawals for 2018, while other insurers have announced plans to expand into new markets.

In counties where the marketplace has only one insurer left, the premiums may rise as that single insurer bears the entire risk of the market and there is limited competitive pressure to keep premiums low. However, the single insurer will also consider the impact of rate increases on retention and risk levels and will be subject to rate review, which may put some offsetting downward pressure on rates.

In markets where there are no longer any insurers on the marketplace, premiums for off-marketplace policies could rise significantly. Under current law, low-income enrollees do not have access to premium subsidies off-marketplace and will therefore experience the full increase in premiums in addition to the loss of subsidies if they purchase off-marketplace coverage. This will likely reduce the number of insureds, as subsidy-eligible individuals may find non-subsidized coverage unaffordable. Those retaining coverage, even without a subsidy, will likely be those who expect higher medical spending. Because of this potential for adverse selection, insurers may be more likely to exit the individual market entirely (on- and off-marketplace) rather than exit only the marketplace.

CHANGES IN PROVIDER COMPETITION AND REIMBURSEMENT STRUCTURES. Consolidation of health care providers is ongoing in many local markets. This trend is likely to continue. Ideally, consolidation improves the quality and efficiency of health care delivery, but it also increases providers' negotiating power. Any increased negotiating power among providers could put upward pressure on premiums. On the other hand, insurer mergers could have the opposite effect if they increase insurers' negotiating leverage with providers. Finally, partnerships between health care plans and providers offer a new business model that is intended to reduce premiums with higher levels of managed care and quality.

Insurers are pursuing provider reimbursement structure changes that move from paying providers based on volume to paying based on value, and often shifting a portion of the risk to the providers. For example, accountable care organization structures offer incentives to health care providers to deliver cost-effective and high-quality care, and may penalize providers for failing to meet certain targets. Such efforts could put downward pressure on premiums, at least in the short term. To the extent providers are unwilling to take additional risk and choose not to participate, these changes also could contribute to narrower networks and fewer choices for consumers.

CHANGES IN ADMINISTRATIVE COSTS. Changes in administrative costs will also affect premiums. Some health plans are finding that increased and changing regulatory requirements associated with the administration of provisions in the ACA are increasing their administrative costs. Decreases in enrollment can result in increased costs due to allocating fixed costs over a smaller membership base. Premiums must cover all of these costs. Depending on the circumstances in any particular state, changes in marketing and administrative costs can put upward or downward pressure on premiums. As noted above, increased uncertainty in the market may lead insurers to increase risk margins to protect themselves from adverse selection. However, the ACA's medical loss ratio requirements limit the share of premiums attributable to administrative costs and margins.

CHANGES IN GEOGRAPHIC FACTORS. Within a state, federal rules allow health insurance premiums to vary across geographic regions established by the state. Insurers can use different geographic factors to reflect provider cost and medical management differences among regions, but are not allowed to vary premiums based on differences in health status (which should be accounted for by the single state risk pool construct and risk adjustment process). An insurer might change its geographic factors due to changes in negotiated provider charges and/or in medical management of some regions

compared to others. A decision to increase or decrease the number of regions in which the health plan intends to offer coverage in 2018 within a state could also result in a change in its geographic factors. Another key reason for changes in geographic factors could be new provider contracts that reflect different relative costs. A realignment of these differences could result in changes across the rating regions within a state.

Summary

The 2018 health insurance premium rate filing process is underway, and how 2018 premiums will differ from those in 2017 depends on many factors. Key drivers include the underlying growth in health costs, which will increase premiums relative to 2017. Another key driver is legislative and regulatory uncertainty. Questions regarding funding of the CSRs and enforcement of the individual mandate are putting upward pressure on premiums and threaten to deteriorate the risk pools. Other regulatory actions, such as tightening of SEP eligibility and shortening of the OEP, have been taken to limit adverse selection and stabilize the risk pool. In addition, some states have incorporated risk-sharing programs for high-cost enrollees that will put downward pressure on premiums.

Another premium driver relates to changes in the risk pool composition and insurer assumptions. Insurers have more information than they did previously regarding the risk profile of the enrollee population and are revising their assumptions for 2018 accordingly. The resumption of the health insurer fee will increase 2018 premiums. Other factors potentially contributing to premium changes include modifications to provider networks, benefit packages, provider competition and reimbursement structures, administrative costs, and geographic factors. Insurers also incorporate market competition considerations when determining 2018 premiums.

Premium changes faced by individual consumers will also reflect increases in age, particularly for children, due to new and higher child age factors. Changes in an enrollee's geographic location, family status, or benefit design could result in premium increases or decreases depending on the particular changes. In addition, if a consumer's particular plan has been discontinued, the premium change will reflect the increase or decrease resulting from being moved into a different plan, which could be at a different metal level or with a different insurer. Average premium change information released by insurers or states could reflect the movement of consumers to different plans due to their prior plan being discontinued.

Premium Changes From a Consumer Perspective

Premium changes are often the most visible and discussed aspect with respect to the ACA impact on health insurance. However, premium changes can be measured using different approaches, making it difficult to compare premium changes among health insurers, among plans offered by an insurer, or among consumers.

In addition, the average premium change within a specific insurer may not represent the premium change experienced by a particular consumer. The ACA requires that premiums vary only by age, tobacco use, geographic location, family status, and benefit design. Premium changes from a consumer perspective can then result from underlying medical trends and other aggregate premium factors, as well as changes in these consumer-specific factors. The following situations could result in a consumer's premium change differing from the average premium change reflected in a premium rate filing.

Changes in Plan Selection

Citing losses and continued legislative and regulatory uncertainty, several large national insurers as well as many regional and state-specific insurers have withdrawn from the marketplace. Some insurers have expanded into new areas. The result from the consumer's perspective is different or fewer choices of insurer, and in many cases fewer metal level or plan-type options. Consumers may be re-enrolled in a different plan due to a discontinuance of their prior plan or may choose to enroll in a different plan even if their prior plan is still available. Either of these scenarios could lead to a premium change for a consumer that differs from the state's or insurer's average premium change.

Insurers that stay in the market may make changes to their benefit plans (e.g., modifying cost-sharing requirements, changes in networks, addition/deletion of benefits beyond EHBs), which could impact consumer's premiums.

Changes in Age/Family Status

Most individual consumers will experience a premium increase each year, due to aging one year. Effective Jan. 1, 2018, HHS is implementing changes to the age factors for children in the federal default standard age curve.[13] HHS is replacing the single age band for individuals age 0 through 20 with multiple child age bands to better reflect the actuarial risk of children and to provide a more gradual transition from child to adult age rating.[14]

As a result of the change in factors, there will be a 20-50 percent increase in child rates, depending on age. Because of the single risk pool and index rating requirements, the increase in child rates results in a decrease in adult rates, albeit of a significantly smaller magnitude. The actual decrease will vary by insurer, depending upon the adult/child enrollment.

The ACA allows premiums to vary by family size. Family premiums reflect the premiums for each covered adult plus the premiums for each of the three oldest covered children younger than 21. Therefore, consumers with family coverage who experience a change in family composition could face a premium change. Family contracts with dependents under age 21 will experience the full impact of the change in the age factors discussed above.

Tobacco Status

In most states, insurers are allowed to charge smokers more than nonsmokers, and this surcharge can vary by state and by age. For instance, older smokers can face higher surcharges than younger smokers. In plans that vary the surcharge by age, consumers who smoke will see a premium change due to the change in the tobacco use surcharge. In addition, consumers who have either started or stopped using tobacco products could see a premium change. Finally, carriers are allowed to change their tobacco rating factors with sufficient justification. This change in rating factors, similar to the change in age rating factors noted above, will also cause changes to consumer premiums.

Geographic Area Factors

All states require the use of rating areas approved by CMS.[15] Insurers are not allowed to change the rating areas, but are allowed to change how premiums vary across areas due to differences in networks, relative provider charge levels, and levels of medical management. While the overall impact of area factor modifications will be included in the average aggregate premium change reported in the rate filing each insurer submits, the actual change a specific consumer experiences may vary significantly depending on where he or she lives. In addition, a consumer moving from one rating area to another may experience a premium change due to the differences in area factors.

Subsidy Eligibility

The ACA provides premium subsidies in the individual market based upon household income. Changes in income alone can result in upward or downward changes in the net premiums that any specific consumer may have to pay, even if there is no change in the underlying premiums. A change in available plans offered in the market also could affect the subsidy an individual receives.

13 *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program*; Department of Health and Human Services; Dec. 22, 2016.
14 This change does not apply to states that have established their own uniform age ratings curve.
15 All insurers in a given state must use identical rating areas.