American Academy of Actuaries

Issue Brief

Drivers of 2020 Health Insurance Premium Changes

JUNE 2019

KEY POINTS

Key drivers of 2020 premium changes include:

- Medical trend, which is the underlying growth in health care costs;
- Recent and ongoing policy changes regarding the expanded availability of short-term limited duration plans, association health plans, and health reimbursement arrangements, as well as the elimination of the individual mandate penalty;
- Incorporation of projected risk adjustment data validation audit adjustments into 2020 premiums and any adjustments to assumptions used to build the cost of cost-sharing reduction subsidies into premiums.
- State actions to implement reinsurance programs, impose individual mandate penalties, or enact rules that would facilitate or prohibit the availability of alternative coverage options; and
- The reinstatement of the health insurance provider fee.

These drivers can interact in various ways and can vary by geographic region. Moreover, 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 change differing from the average rate change, including changes in plan selection, age/family status, geography, or subsidy eligibility.

American Academy of Actuaries
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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

The 2020 health insurance premium rate filing process is underway. Actuaries develop proposed premiums based on their projections of medical claims and administrative costs for pools of individuals or groups with insurance. Projected medical claims reflect unit costs and utilization levels, as well as the mix and intensity of services, all of which can vary by geographic area and from one health plan to another. The composition of the risk pool is also important, as medical claims will reflect the health status of the risk pool. Laws and regulations, such as benefit requirements, issue and rating rules, and risk-sharing programs, can affect the composition of risk pools and projected medical spending, as well as the amount of taxes, assessments, and fees that need to be included in premiums.

This issue brief outlines the major drivers behind why 2020 premiums could differ from those in 2019. The brief focuses primarily on the individual market, yet many of the factors discussed are also relevant to the small group market.

Major Drivers of 2020 Premium Changes

Underlying growth in health care costs.

The increase in costs of medical services and prescription drugs—referred to in rate filings as medical trend—is based on the increase in per-unit costs of services, changes in health care utilization, and changes in the mix of services. Projected medical trend for 2020 is expected to be consistent with that for 2019, which ranged from about 5 percent to 8 percent.[1] Although the growth in spending for specialty drugs is expected to remain high, spending growth for prescription drugs overall has leveled off and is expected to be similar to or slightly higher than medical spending growth.

1 Oliver Wyman Actuarial Consulting Inc., *Carrier Trend Report: January 2019 Analysis*, 2019.

Recent and ongoing policy changes.

Recent policy decisions and continued implementation of prior decisions will affect 2020 premiums.

Expanding the availability of short-term limited duration insurance (STLDI), association health plans (AHPs), and health reimbursement arrangements (HRAs). Per an executive order from President Trump,[2] final regulations were released in 2018 that lengthen the maximum duration of STLDI plans from 3 months to 12 months, broaden the ability of AHPs to be treated as large groups, and allow self-employed individuals to join AHPs. In June 2019, final regulations were released that expand the availability of and uses for HRAs.[3]

The changes to STLDI took effect October 3, 2018, while changes to AHPs were phased in from September 1, 2018, through April 1, 2019. Because they are not subject to all of the Affordable Care Act (ACA) issue, rating, or benefit coverage requirements, STLDI plans and AHPs can be more attractive to healthier individuals and groups. Market segmentation and adverse selection for ACA plans can result, leading to higher ACA premiums. The expanded availability of STLDI and AHPs may be exacerbated due to the elimination of the individual mandate penalty. To some extent, insurers may have already incorporated the increased availability of STLDI and AHPs into their 2019 premiums. But any expected increases in enrollment in these non-ACA-compliant plans can put additional upward pressure on 2020 ACA premiums, especially among insurers newly reflecting the new rules. The impact on premiums can vary by state; to prevent premium increases due to expanded STLDI or AHPs, some states have implemented or plan to implement rules limiting their sale.

Meanwhile, legal action has rendered the future of the new AHP rule less certain, complicating 2020 premium development. A March 2019 ruling by the D.C. Circuit Court

2 President Donald J. Trump, "Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States," Oct. 12, 2017.

3 See Academy comment letters:

- On the executive order;
- On STLDI;
- On AHPs; and
- On HRAs.

prevents AHPs from enrolling new working owners or taking advantage of the broader eligibility criteria, however the administration is appealing the ruling.[4]

The regulatory changes expanding the availability of HRAs will take effect January 1, 2020. Although HRAs have typically been reserved as a supplement to a traditional group health plan, newly released rules would allow employers that satisfy certain guardrails to allow employees to purchase individual market coverage with HRA funds, or create an excepted benefit HRA that could be used to purchase excepted benefits such as STLDI coverage, dental coverage, or vision coverage. The impact of these rules on the individual market will depend on how effectively the guardrails prevent employers from transferring their most expensive employees to the individual market. An influx to the individual market of a balanced cohort of workers could help stabilize the individual market. However, if employers with less-healthy workers shift to offering individual market HRAs, the premiums in the individual market will increase.[5]

At the time 2020 premiums were being developed, the HRA rules had not yet been finalized and there was uncertainty regarding the specific rules and also when these changes would take full effect. Insurers may need to modify their rate filings to reflect the final rules.

Elimination of the individual mandate penalty. The ACA individual mandate was intended to keep healthy individuals in the marketplace in order to maintain a stable risk pool. The *Tax Cuts and Jobs Act* eliminated the individual mandate financial penalty beginning in 2019. Eliminating the penalty was expected to increase premiums as unsubsidized lower-cost healthy individuals are more likely to forgo ACA coverage. This is especially likely if, as discussed above, the availability of alternative coverage is increased, for instance through expanded STLDI plans or AHPs.

Most insurers already incorporated the expected effects of eliminating the mandate penalty into their 2018 and/or 2019 rates, under the assumption that healthier enrollees would leave individual market ACA plans. In many cases, these premium loads overstated the impact. As a result, depending on the characteristics of the state, some insurers may reduce 2020 premium loads for the elimination of the mandate penalty. For instance, states with higher shares of premium-subsidized enrollees may see less of an impact from the elimination of the mandate penalty as premium subsidies encourage enrollment. On the other hand, the impact of the penalty elimination could grow over time as more people become aware of the policy change, leading to continued upward pressure on premiums.

4 *State of New York v. U.S. Department of Labor*, March 28, 2019.
5 In the final rules, the administration estimates that workers in firms switching to individual market HRAs would be slightly less healthy than current individual market enrollees, and would increase individual market rates by about 1 percent throughout 2020–2029 as a result. "Health Reimbursement Arrangements and Other Account-Based Group Health Plans"; *Federal Register*; June 20, 2019.

Premium Changes From a Consumer Perspective

Premium changes are often the most visible and discussed aspect of the ACA's 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, such as plan selection, age or family status, geographic area, and premium subsidy eligibility.

Risk Adjustment Data Validation (RADV). The Centers for Medicare and Medicaid Services (CMS) conducts RADV audits to ensure that issuers are submitting accurate information for risk adjustment calculations. The first year of RADV-based adjustments will apply to the 2018 risk adjustment transfers using the results of the 2017 benefit year RADV audit. Under CMS RADV methodology, issuers may experience an increase or decrease to their risk score if they are considered to be error rate outliers. In markets with error rate outliers, all issuers' results will be impacted due to the zero-sum nature of risk adjustment.

The draft version of the Unified Rate Review instructions dated May 2019 noted that issuers could apply an adjustment to 2020 premiums to reflect RADV adjustments to 2020 risk adjustment transfers, to the extent a state allows. However, because the RADV results are not expected to be announced until 2021, there is uncertainty regarding the results and how they will impact 2020 risk adjustment transfers, especially because the adjustments can change every year. Given this uncertainty, issuers could decide to incorporate extra conservatism in their rating, putting upward pressure on premiums.

Cost-sharing reduction (CSR) subsidies. The ACA requires insurers participating in the individual market and offering coverage through the exchange to provide cost-sharing reductions to eligible low-income enrollees through modified versions of their silver plans. These silver plan variants have higher actuarial values (AVs) than the standard silver AV of 70 percent, with lower cost-sharing requirements and out-of-pocket limits. In October 2017, the federal government discontinued making payments directly to insurers to offset the cost of lowering cost-sharing requirements, and as a result, premiums in nearly all states were increased beginning in 2018 to account for the additional costs of providing CSR subsidies. In 2019, most state insurance regulators directed insurers to increase premiums only for silver plans (with more than half stipulating that increases should be levied on on-exchange silver plans only), while a few required the cost to be spread across all plans.[6]

6 The 2020 Notice of Benefit and Payment Parameters requested comments on how CMS can address silver loading in the absence of Congressional action to restore CSR funding. Such a change would occur no sooner than plan year 2021. If CMS requires insurers to spread the CSR cost across all plans for 2021, silver plan premiums will decrease (in some cases by 20% or more) while premiums for the other metal tiers would increase.

Loading premiums for CSRs will contribute to 2020 premium changes if insurers change their assumptions regarding the degree to which premiums need to increase to reflect the cost of CSRs, or if states change the way they direct insurers to load premiums for the cost. Enrollees eligible for premium tax credits are protected from the premium increases due to the premium subsidy increasing to cover the premium increase. Higher premiums lead to more individuals being eligible for premium subsidies and higher subsidy amounts for those eligible. When CSR costs are loaded only on silver plans, enrollees can use the increased premium subsidies to obtain low-cost or even free bronze plans (with an AV of 60 percent) and lower-cost gold plans (with an AV of 80 percent). Indeed, the share of marketplace enrollees choosing silver plans during annual open enrollment has decreased from 71 percent in 2017 to 63 percent in 2018 and to 59 percent in 2019.[7] At the same time, the silver tier enrollment has become more skewed toward highly CSR-subsidized enrollees—those with incomes below 200 percent of the federal poverty level, thereby qualifying them for an 87 or 94 percent AV silver plan variant. Among states using the Healthcare.gov platform for marketplace enrollment (the only states for which data are available), the share of highly CSR-subsidized enrollees in silver plans increased from 67 percent in 2017 to 73 percent in 2018, and to 76 percent in 2019.[8]

It can be difficult for insurers to set the appropriate silver premium load. Plans are more likely to enroll a high share of CSR-eligible individuals if they are the lowest or second-lowest silver premium plan. However, having a large share of highly CSR-subsidized enrollees increases the needed silver premium load. If insurers have a higher silver premium relative to other insurers, they'll get fewer CSR-subsidized enrollees, resulting in a lower needed silver premium load.

Changes in the risk pool composition and insurer assumptions.

Changes in premiums between 2019 and 2020 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 2019 premiums. As noted above, risk pool composition changes can arise from policy changes, such as the elimination of the individual mandate penalty and expanding the availability of STLDI plans, AHPs, and HRAs. More generally, risk pool composition assumptions reflect, in part, enrollment rates. Higher take-up rates typically result in a healthier risk pool, as those forgoing coverage are likely healthier than those obtaining coverage.

7 Centers for Medicare and Medicaid Services (CMS), 2017, 2018, and 2019 Marketplace Open Enrollment Period Public Use Files, available here.
8 Ibid.

According to CMS, marketplace enrollment at the end of the open enrollment period (OEP) dropped slightly from 11.8 million in 2018 to 11.4 million in 2019.[9] Most on-exchange enrollees receive premium subsidies and were therefore shielded from 2019 premium increases, including those due to the costs of CSRs being loaded onto premiums. Off-exchange enrollees, however, are not subsidized, and therefore more likely to forgo coverage due to premium increases, the elimination of the mandate penalty, or the increased availability of non-compliant coverage. Although off-exchange enrollment for 2018 and 2019 are not available, it likely dropped to a greater extent than on-exchange enrollment. If such a decline is expected to continue or increase in 2020, this will put upward pressure on 2020 premium increases.

Importantly, market experience to date and 2020 projections vary by state, depending in part on state policy decisions and local market conditions.

State actions.

Rate increases for 2020 could vary significantly by state. In addition to ongoing market-specific dynamics that affect each state differently, there have been actions undertaken or proposed by individual states that could result in large impacts on 2020 premiums. Several states have pursued actions that would put downward pressure on premiums include implementing a reinsurance program, imposing an individual mandate, and limiting or prohibiting the sale of STLDI plans or AHPs.

In an effort to provide their citizens a lower-cost option to ACA coverage, other states are exploring the sale of plans that don't comply with ACA requirements. A few states have passed laws allowing their Farm Bureaus to bypass ACA rules and sell health plans that are free from any state insurance regulation.[10] These plans are designed to meet the coverage needs of a healthy population at a lower cost to avoid individuals and families dropping health insurance coverage when it becomes unaffordable. As with AHPs and short-term limited duration plans, such alternative plan offerings could attract healthier enrollees. The ACA risk pool could be left with the less-healthy individuals as a result, increasing premiums.

9 CMS Health Insurance Exchanges 2019 Open Enrollment Report. 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."

10 "Kansas bypasses Obamacare; will other states follow?"; *Modern Healthcare*; April 23, 2019.

Federal fees.

The health insurance provider (HIP) fee was enacted through the ACA. The total amount of the HIP fee for 2020 is not known at this time. The HIP fee was scheduled to collect $14.3 billion in 2018, and according to statute the fee for calendar years after 2018 will be increased by the rate of premium growth. The *Extension of Continuing Appropriations Act of 2018* included a moratorium on the collection of the HIP fee in 2019. Barring another HIP fee moratorium for 2020, insurers may include the cost of this fee in their 2020 premiums, resulting in an increase in expected premiums by about 1 to 3 percent, depending on the size of the insurer and their for-profit/not-for-profit status.

The user fees for the federally facilitated and state-based exchanges are decreasing to 3.0 and 2.5 percent of premiums, respectively, a decrease of half a percentage point. This fee is applied only to premiums for enrollees purchasing through the exchange (including through a direct enrollment pathway). However, insurers are required to spread this cost over both exchange and non-exchange premiums as a level percentage of premium. As a result, the impact on premiums will vary depending on the proportion of off-exchange coverage, from 0 percent for issuers who do not offer any plans on the exchange to 0.5 percent for issuers who only sell policies on the exchange.

Other Drivers

Other drivers of premium changes can include:

- **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.
- **Market competition.** Market forces and product positioning can affect premium levels and premium increases.
- **Changes in provider competition and reimbursement structures.** Further provider consolidation could put upward pressure on premiums, whereas insurer mergers could increase insurers' negotiating leverage with providers. Insurer efforts to shift a portion of the risk to providers could put downward pressure on premiums.
- **Changes in administrative costs and risk charges.** Any changes in marketing and other administrative costs can put upward or downward pressure on premiums. In addition, any increased uncertainty in the market or market rules can lead insurers to increase risk margins. However, the ACA's medical loss ratio requirements limit the share of premiums attributable to administrative costs and margins.

- **Changes in geographic factors.** 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 2020 within a state could also result in a change in its geographic factors.

Summary

The 2020 health insurance premium rate filing process is underway, and how 2020 premiums will differ from those in 2019 depends on many factors. Key drivers include the underlying growth in health spending as well as insurer assumptions regarding how the risk pool composition could change due to recent and ongoing policy changes, such as the expanded availability of STLDI plans, AHPs, and HRAs and the elimination of the individual mandate penalty.

Some insurers may include projected RADV adjustments in their 2020 premiums based on the information now available from the 2017 benefit year RADV. In addition, the termination of funding of the CSRs has led to different strategies for building the cost into premiums, and insurers may need to make adjustments for 2020 rates. The reinstatement of the health insurer provider fee will contribute to 2020 premium increases but will be partially offset for marketplace issuers by a reduction in the exchange fee.

Premiums and premium changes could vary significantly by state depending on state market dynamics and any state-specific rules or initiatives, such as imposing an individual mandate requirement, implementing a reinsurance program, or having rules that would either facilitate or prohibit the availability of alternative coverage options. Premium changes faced by individual consumers will also reflect changes in plan selection, age/family status, geography, or subsidy eligibility.