American Academy of Actuaries

Issue Brief

Drivers of 2023 Health Insurance Premium Changes

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Key Points

- Although COVID-19-related costs may be more predictable and the worst days of the pandemic appear to be over, there is still uncertainty regarding whether new variants will evade immunity and cause a resumption in more serious health problems.
- The expiration of the ARPA enhanced premium subsidies will likely cause a decline in enrollment and a worsening of the risk pool, leading to higher premiums.
- Medicaid redeterminations could cause an influx of people into the individual market, potentially improving the risk pool and lowering the premiums somewhat. Any effects would be less than those caused by the expiration of ARPA subsidies.
- Inflation may have some effect on provider costs, but because provider payments lag inflation, real effects might not occur until later plan years. Nevertheless, workforce shortages could put upward pressure on provider payment rates.

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The 2023 individual and small group health insurance premium rate filing process is well underway. Actuaries generally 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 cost 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. Risk pool composition is also important, as medical claims reflect the health status of individuals in the risk pool. Relevant laws and regulations that govern various aspects of insurance plans—such as benefit requirements, issue and rating rules, and risk mitigation programs—can affect the composition of risk pools and projected medical spending, as well as any amounts carriers need to include in premiums to cover the cost of taxes, assessments, fees they will pay, and risk/profit charges.

Each year, the American Academy of Actuaries Individual and Small Group Markets Committee publishes a public policy issue brief outlining the factors driving premium changes for the next plan year. The issue brief focuses on changes in gross premiums, rather than changes in premiums net of premium subsidies. For the 2022 rating cycle, the COVID-19 pandemic continued to generate uncertainties into the development of premium rates. While much of those initial uncertainties are abating, the 2023 rating cycle will see some related, additional impacts of the pandemic and the resulting economic impacts, including the expiration of the American Rescue Plan Act's (ARPA) enhanced premium subsidies and Consolidated Omnibus

Budget Reconciliation Act (COBRA) subsidies, the probable end to the public health emergency (PHE) and the resumption of Medicaid eligibility redeterminations; costs of new COVID-19 vaccines, testing, and treatments; the impact of long COVID; changes in telehealth and mental health utilization; and high inflation.

Because there is more information on how COVID-19 has affected and could continue to affect health care spending, carriers are expected to include adjustments in their 2023 rates. In some cases, these adjustments could be material and are expected to vary in size and direction by carrier and region. Issues surrounding the pandemic continue to be considerations for rate setting and will impact both the individual and small group health insurance markets.

In addition to the direct and indirect effects of COVID-19 on health spending, the potential ending of pandemic-related public policies can have an even greater impact on 2023. In particular, the expiration of ARPA subsidies is expected to shrink enrollment and worsen the risk pool, putting upward pressure on premiums. In contrast, the resumption of Medicaid redeterminations could shift individuals from Medicaid to subsidized individual market coverage. It's unclear whether this shift will improve or worsen the risk pool and how that could vary by state, but either way it is expected to have a lesser effect on the risk pool relative to the expiration of ARPA subsidies.

Similar to prior Academy issue briefs, this year's brief also examines how other factors such as state-based considerations and provider payment rates are expected to affect 2023 premiums.

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COVID-19 Impacts on 2021 Claims Experience

The Affordable Care Act (ACA) rate review process requires issuers to develop premium rates based on the most recent year of experience, which is two years prior to the pricing plan year. Adjustments are then applied to reflect expected differences in claim costs between the experience year and the pricing plan year. In the case of 2023 rates, the 2021 benefit year is, in most cases, being used by insurers as the experience period.

In 2021, most areas of the U.S. experienced two distinct peaks of COVID-19 infections.[1] The first was primarily in the summer of 2021, while the second began in the late fall and continued in many areas into early 2022. These waves increased utilization of COVID-related services, but the overall impact on medical utilization varied by region, with some regions experiencing a reduction in overall utilization and others seeing a modest increase. It currently appears that COVID-19 is moving from a health care crisis to a more predictable cost burden. Some costs for vaccines and testing may continue but likely at a much-reduced rate than experience in 2021 would suggest. Treatment costs for COVID-19 and long COVID will extend into 2023. The quantification of costs, availability, and actual prevalence of treatments is currently uncertain.

Our assessments are based on the current state of the COVID-19 pandemic. If a new variant becomes widespread and COVID-19 cases increase, and particularly if the new variant shows immune escape properties, the situation may change. The evolving nature of the pandemic leaves open the possibility of more waves of infection in the future.

Drivers of 2023 Rate Changes

When developing 2023 health insurance rates, carriers are likely to consider multiple scenarios involving differing assumptions and may consider the following:

- Changes to the composition of the individual market due to changes in premium tax credits and other factors.
- Changes to the composition of the small group market due to the continued shift of small employers to self-funded, level-funded, or other risk-rated coverage, or otherwise leaving the market.
- Changes in utilization patterns for telehealth visits and mental health care.
- Changes in provider contracting including the expected impacts of medical inflation.

1 "Daily State-by-State Testing Trends"; Johns Hopkins School of Medicine Coronavirus Resource Center.

A greater degree of uncertainty could lead to more conservative assumptions and risk margins for some carriers. Alternatively, carriers might lower risk margins, seeing an opportunity to capitalize on the increased exchange enrollment, particularly if the enhanced premium subsidies associated with the ARPA are continued. In many states, health carriers are permitted to file updated rates on a quarterly basis in the small group market, which could reduce the potential need for additional risk margin. However, individual market rates are filed annually and cannot be updated during the calendar year.

Changes in Risk Pool Composition—Individual Market

Shifts in enrollment could cause the underlying morbidity level of the individual pool to change, depending on the characteristics of those leaving and entering the market.

The composition of the 2023 individual market is likely to be different than that underlying the 2022 premium rates. Enrollment in individual market increased by approximately 21% from January 2021 to January 2022,[2] due to increased premium subsidies under ARPA, increased enrollment outreach and assistance, extended open enrollment opportunities, and other factors. There could be significant changes in 2023 enrollment due to the following reasons (in decreasing order of expected impact):

- Reduced premium tax credits available due to the expiration of ARPA. For 2021 and 2022, ARPA increased advanced premium tax credits for all eligible income brackets, including extending tax credits to those who earn over 400% of the federal poverty level (FPL). The increase in premium subsidies increased enrollment and made obtaining coverage an attractive option, even for people with low expected health care needs, thereby likely improving the risk pool. With premium subsidies returning to pre-ARPA levels, recent enrollment gains could be reversed, with a commensurate worsening of the risk pool.

- Resumption of Medicaid eligibility redeterminations. The U.S. Department of Health and Human Services (HHS) extended the federal Public Health Emergency (PHE) related to COVID-19 through mid-July 2022, and at least one more extension is likely through mid-October. States can begin initiating Medicaid eligibility redeterminations anywhere from two months prior to the end of the PHE to one month after the end of the PHE. States will have 12 months to initiate all redeterminations and 14 months to complete all redeterminations. States will differ with respect to how aggressively they perform redeterminations and terminate people

2 "Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period"; HHS Press Office; Jan. 27, 2022.

from Medicaid, as well as the extent to which they will facilitate enrollment in the individual market for those terminated. If Medicaid eligibility redeterminations begin in late 2022 or during 2023, many people are expected to shift from Medicaid coverage to the individual market, the employer group market, or become uninsured. This transition is likely to occur over a span of six months to a year, leading to a gradual phase-in of any health status changes and likely a higher-than-typical prevalence of partial-year enrollments. This shift could improve the risk pool and lower premiums somewhat, but the effects could vary by state and would have less effect on the risk pool relative to the expiration of ARPA subsidies.

- Fixing the "family glitch." Proposed ACA regulations would allow for workers who are not offered an affordable health plan through their employer—and their dependents—to purchase an individual market ACA plan and qualify for subsidies. The current affordability test deems plans with a required employee contribution for self-only coverage below 9.5% (adjusted for inflation) of household income as affordable, meaning neither they nor their dependents are eligible for individual market premium subsidies. When determining whether dependents have access to affordable coverage, the administration is proposing to base the affordability on the employee contributions for family coverage rather than self-only coverage.[3] This change would allow dependents who are currently covered by group insurance (and a fairly small subset of dependents who are not currently insured) to qualify for individual market subsidies and would lead to a transition from group coverage (and the uninsured population) to individual market coverage for some dependents. This change could slightly improve the risk pool, but would not be expected to have a material effect on premiums.

- Narrowing of Actuarial Value (AV) de minimis ranges.[4] Centers for Medicare & Medicaid Services (CMS) 2023 final regulations limit the extent to which plans can have AV values below the statutory value (e.g., 70%). As a result, the benchmark plan in many states could be somewhat more generous than in the past, with a premium that is also higher, and would result in increased subsidies for eligible individuals, potentially leading to an increase in the number of individuals who could receive a $0 bronze tier plan. Access to zero-premium plans could increase enrollment somewhat as well as slightly improve the risk pool.

3 "Affordability of Employer Coverage for Family Members of Employees"; Internal Revenue Service; *Federal Register*; April 7, 2022.
4 "10. Standardized Plan Options (§ 156.201)"; U.S. Department of Health and Human Services; *Federal Register*; May 6, 2022.

Additional legislation being considered at both the state and federal level also has the potential to impact individual market enrollment and the risk pool. Such provisions include: extending the ARPA subsidies beyond 2022, small group affordability testing, closing the Medicaid coverage gap, and reinsurance programs. However, because initial rate filings are due by between early May and late July and final rates are filed beginning in August, it would be difficult for plans to incorporate any premium-related effects of such legislation if enacted into law, especially if enacted after final rates are due. Because of the increase in premiums that the expiration of ARPA enhanced premium subsidies would cause, as well as the possibility that the ARPA subsidies could be extended, some states are requesting two sets of rates or information on rate differentials for ARPA premium extensions. This practice would facilitate the use of rates appropriate to whether ARPA subsidies are extended. Nevertheless, many states are not asking for two sets of rates and if the ARPA extension occurs late in the year, it may be too late for carriers to revise rates.

Changes in Risk Pool Composition—Small Group Market

Small businesses continue to be affected by a challenging hiring environment, which varies over time as the impacts of the pandemic evolve and change. Even after the expiration of the federal Pandemic Unemployment Assistance (PUA), Pandemic Unemployment Compensation (PUC), and the Pandemic Emergency Unemployment Compensation, hiring difficulties persist. Those small employers that have seen the biggest declines in employment also tend to be those that are less likely to offer insurance, meaning the impacts of these challenges on small group health insurance enrollment, and therefore morbidity, may not be significant.

The new economic impact that small employers are challenged by is inflation. Inflation has increased to levels not seen since 1982.[5] Small business owners are finding it necessary to increase employees' wages and the prices they charge for their goods and services.[6] It remains to be seen whether employers will stop offering coverage, reduce levels of coverage, or decrease employer contributions to mitigate increases in their other business expenses. Any changes could vary by industry. If employers reduce their commitments to health coverage, both the small employers themselves and their employees (who may be subjected to higher employee contributions) that choose to stay in the fully insured ACA markets may do so because their plan population is of higher-than-average morbidity. Whereas small employers with healthier populations could opt

5 "Inflation surges 7.5% on an annual basis, even more than expected and highest since 1982"; *CNBC*; Feb. 10, 2022.
6 "Small Business Expectations for Better Business Conditions at Record, 48-year Low"; NFIB Research Foundation; April 2022.

to stop offering employer-based coverage or continue to move toward other alternative arrangements available to small groups (e.g., self-funded/level-funded plans, association health plans).

Small employers had been migrating toward alternative arrangements even before increases in inflation were observed.[7] The more that groups with lower-than-average morbidity leave the ACA fully insured small group market, the more there will be continued upward pressure on fully insured premium rates as that market becomes more concentrated with higher utilizers of health care services.

Ultimately, the impact on small group premiums will depend on each carrier's assessment of these moving pieces and how they are playing out in local markets.

COVID-19 Treatments and Testing Costs

Beginning in January 2022, commercial health insurers were required to cover the costs of at-home COVID-19 tests for the duration of the PHE. Although the costs of such over-the-counter (OTC) tests had not been factored into 2022 premiums, the new rule has had limited effect for most carriers. Consumers may still be capitalizing on free tests provided by the federal government, whether at home or through public health operations. The availability of continued federal support for at-home tests may be limited in 2023, however, as the federal government has indicated that it is running out of available funding and prepaid therapeutics. In addition, there are signs that individuals increasingly desire to resume normal life activities and end the use of protective measures, including testing. In the first months of this year, the limited availability of OTC tests at pharmacies along with initial challenges with getting the program up and running reduced the costs borne by issuers. It is unclear which, if any, of these dynamics will influence OTC testing utilization and issuer costs in 2023.

As the pandemic moves on from the crisis of 2020 and 2021, treatment costs for COVID-19 are likely to fall more in line with other upper respiratory infections such as colds or the flu, especially for the fully vaccinated. With rising vaccination rates, commercial carriers should see an overall stabilization in costs. Recent variants seem to be more contagious than prior variants,[8] though hospitalization rates and other severity indicators have generally fallen from high levels earlier in the pandemic. It is not clear how much of this is driven by higher rates of vaccination, natural immunity, and improved standards of care.

7 "Summary of Findings – 9805;" *2021 Employer Health Benefits Survey*; Nov. 10, 2021.
8 "What You Need to Know About Variants"; Centers for Disease Control and Prevention; April 26, 2022.

In addition to testing supplies, the federal government has been procuring and funding vaccines and therapeutic treatments, such as monoclonal antibody treatments and oral antivirals. When government funding ceases, private carriers will be responsible for these vaccine and therapeutics. At this time, it is unclear when this transition will take place and how the procurement of these drugs will be transitioned to the private market, though current federal projections indicate that this transition could occur prior to 2023. Unlike many other provisions, the availability of federally funded therapeutics is not statutorily tied to the end of the PHE but rather is limited by available federal funds.

Medical Loss Ratio (MLR) Impacts

In 2021, carriers paid out historically high MLR rebates due to the low incurred costs in plan year 2020. MLR rebates increased from $769 million in 2020 to $1.7 billion in 2021 in the individual market and from $310 million to $423 million in the small group market.[9] Although the 2021 plan year MLR data are not yet available, many carriers reported significant increases in claim costs due to COVID-19 and pent-up demand. The underwriting gain in commercial markets could significantly decrease in 2021, resulting in a much higher MLR and lower MLR rebates. As a result, carriers whose experience supports a larger rate increase are less likely to consider the impact of a projected MLR rebate for the 2021 and 2022 plan years.

State-Based Considerations

Each state has its own unique circumstances, which may vary by market. Affordability in the individual market and the small group market remains a concern in many states, leading them to initiate their own mechanisms to reduce premium rate increases for populations of interest. These changes typically either affect provider reimbursement levels or focus on reinsurance for a portion of claims. If a state implements new initiatives intended to reduce premiums in 2023, the rate of premium growth would be reduced, and premium reductions may be realized. Carriers in these markets will monitor state actions in order to determine the effect that these changes may have on their specific book of business.

9 "Data Note: 2021 Medical Loss Ratio Rebates"; Kaiser Family Foundation; April 12, 2021.

In those states that implemented premium reduction mechanisms in past years, premium increases may have been lower than normal in 2021 and 2022. However, the return of more normal health care cost increases as the pandemic fades in influence and as these mechanisms mature is likely to result in a return to normal premium rate increases for 2023. For example, state section 1332 reinsurance waivers typically reduce premiums in the initial year with some variability in increases in year two. Thereafter, premiums tend to increase at a rate close to the national or regional increases, which are largely driven by health cost inflation. In other words, although reinsurance can result in premiums lower than they would be otherwise, beyond the first year of the reinsurance program the rate of premium growth is less affected.

In the individual market, states that operate their own Exchange may also have unique considerations. These may include the nature and utilization of special enrollment periods in recent years as well as any changes in special enrollment periods in 2023. In addition, some states may have premium and cost-sharing subsidies on top of those available through the federal government. These state-based subsidies can have a meaningful influence on enrollment levels and plan selections and may be accompanied by additional rate filing and reporting requirements. Some states are also moving toward their own set of standardized plan designs and may have additional requirements for filing of non-standardized plan designs including limitations on actuarial value and whether plans may be offered on the Exchange.

Provider Practice Patterns and Reimbursement Rates

Telemedicine has taken off under the pandemic. While telemedicine was available pre-pandemic, its utilization was marginal in large part due to a patchwork of state regulatory approaches. During the pandemic, these state barriers have been significantly eased.[10] Three policies appear to be of note. First, a broader variety of providers have been permitted to use telemedicine, including nurses and mental health professionals. Second, members have been able to utilize telemedicine across state lines, increasing access to national telehealth networks. Third, providers and patients have had more flexibility with regard to the communications medium used for the telemedicine appointment, permitting members to use familiar services such as FaceTime, Skype, and Zoom, and potentially audio-only phone calls.

10 "Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19"; Manatt, Phelps & Phillips, LLP; April 2022.

Telemedicine seems to be much more convenient for the patient and could stay at an elevated level, though this may depend on state actions to extend some of the pandemic flexibilities beyond the end of applicable emergency periods. At this point, it is unclear whether increased telemedicine utilization would reduce utilization of more traditional services in a non-pandemic-influenced health care ecosystem or would increase spending overall. As a result, the overall influence and direction of increased telehealth services on overall health spending remains uncertain.

Higher inflation is likely to drive increases in all types of reimbursements. Provider contract rates tend to lag general inflation, as rates are typically set in advance and may cover a multiyear period. Many hospital contracts between carriers and hospital systems have already been negotiated for 2023 and these likely do not reflect the significant inflation of the past year. These established rates are unlikely to change unless inflation is significantly higher than anticipated, increasing labor costs in a way that threatens provider financial viability. While the drivers of recent inflation do not directly influence health care, they do affect the health care supply chain and will likely be reflected in higher labor costs as employees seek to maintain standards of living in a higher-cost environment. The effect of inflation will likely be meaningfully reflected in contract rates that take effect in late 2022 and early on in 2023 as prospective contracting catches up with labor costs. As of publication, inflation remains high, which may result in higher rates of health cost increases in following years for multiyear contracts.

The current nursing staffing shortage may also influence private market payment rate increases. Competition for nurses, including traveling nurses used to meet increased demand, has led to increases in nursing salaries.[11] Hospital contracted rates are likely to increase significantly due to the resulting increase in hospital costs. This dynamic may be present to a smaller degree in other segments of the healthcare job market if the current tight job market continues to create pressure for higher salaries in order to retain workers.

Medicare reimbursement rates serve as the basis for many organizations' negotiations with providers. The ratio of private plan payment rates to Medicare rates can change over time. If the changes in Medicare rates are not keeping up with provider costs in the market, providers may further increase their negotiated reimbursements with private payers above those that, in general, are already substantially in excess of Medicare allowable reimbursements. For instance, inflation adjustments for Medicare payments tend to lag costs due to the long lead time necessary to establish rates. This (and other changes to Medicare payments) can create timing issues, which reduces the correlation

11 "Rising cost of traveling nurses having ripple effect on area hospitals"; *11alive.com*; Feb. 21, 2022; "Nurse Salaries Rise as Demand for Their Services Soars During Covid-19 Pandemic"; *The Wall Street Journal*; Nov. 22, 2021.

between Medicare payment rates and private market costs. It is likely that current changes in costs may have some directional impact on provider reimbursement rates, even when negotiated relative to Medicare. CMS produces projections of national health expenditures, and recently produced updated projections for 2021 through 2030 suggesting that the cost of private coverage will increase by about 7.4% over 2022. This increase is over twice the projected increase in Medicare per capita spending.

Mental health utilization has increased significantly since the start of the COVID-19 pandemic, increasing from about 4% of outpatient visits in 2019 to about 8% of outpatient visits in 2021. Increased utilization has been at least partly driven by significantly higher rates of mental health services provided via telehealth relative to other medical services.[12] Increased demand is at least partly due to increased mental health needs arising from COVID-19's broad changes to the economy and social patterns. Availability of services continues to be a challenge, and carriers will consider the competing influences of increased demand, limited supply, the evolution of telehealth regulation, and the ever-evolving influence of the pandemic as they estimate mental health utilization and cost in 2023.

Summary

Rate setting in the ACA-compliant individual and small group markets is complex, and pricing actuaries are considering a wide range of factors when determining rate levels. How 2023 premiums will differ from those in 2022 depends on many factors. When developing 2023 health insurance rates, carriers are likely to project claims under multiple scenarios due to the uncertainty regarding COVID-19 as we move out of the pandemic phase and into a phase where costs may be more predictable. However, there is still uncertainly as to whether current vaccines will be effective against new variants and whether new variants will cause a resumption of increased costs and more serious complications.

Actuaries will also consider the expected changes to the 2023 individual and small group risk pools due to regulatory and legislative actions regarding incentives to obtain and retain medical coverage and the expected impact of the end of the PHE. Specific to the individual market risk pool, the major driver leading to higher premiums is the expiration of the ARPA premium subsidies, which will likely cause a decline in enrollment and a worsening of the risk pool. The expected resumption of Medicaid

12 "Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic"; Kaiser Family Foundation; March 15, 2022.

redeterminations in late 2022/2023 will likely cause many people to shift from Medicaid coverage to individual market coverage, the employer group market, or become uninsured. This shift could improve somewhat the individual market risk pool.

While new information continues to emerge regarding the epidemiological, economic, and health care impacts of COVID-19, there is still a wide range of potential effects on 2023 health insurance premiums. Among the other factors to be considered are the historically high inflation rate and the increased rate of mental health services. Inflation may have some impact on provider costs, but because provider payments lag inflation, real effects might not occur until later. Nevertheless, workforce shortages could put upward pressure on provider rates.

All health care is local, and rate changes will likely vary between individual and small group plans within the same geographic area, as well as variations between geographic regions. The expectation is that individual and small group premiums will increase at a greater rate than was experienced in 2022 and 2021, with average individual increases expected to exceed small group increases for similar plan designs.

For more information, please see the Academy infographic illustrating the factors discussed in this issue brief.