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# Lower Premiums in 2019 ACA Markets: What's the Actuarial Explanation?

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**F**or the first time, average premiums on the individual Affordable Care Act (ACA) marketplaces are decreasing in 2019. It's no surprise that this was a surprise to many who follow the dynamics of this market. The conventional wisdom is that President Trump has been less than supportive of the ACA, and that his actions would largely harm the market and further aggravate already-increasing premiums. But 2019 premiums are down 2 percent<sup>1</sup> on average in the federal exchange markets? What's the explanation here?

The retrospective media groupthink has been that insurers overshot rates in 2018 due to a vague notion of “market uncertainty” and that such uncertainty was ultimately not as bad as predicted. It logically follows that there is not really any good news to report, and that 2019 rate reductions are simply a classic rating correction from 2018. There have also been several news reports purporting that issuers have recently become smarter and better understand how the market works, enabling them to now be profitable.

You may have picked up on my skepticism. I wouldn't easily digest that large investment firms who lose billions of dollars in one year and regain it in the next have suddenly become smarter investors. I would look for favorable changes in the market that may have caused the fortunate shift. I don't think it's too much to ask that we evaluate insurance markets the same way.<sup>2</sup> As for “general uncertainty,” I prefer a little more precision. What were issuers uncertain about that might have impacted their rates? In this article, I explore the recent changes in the ACA marketplace and what issuers may have missed in developing premium rates in 2018. A proper understanding of these dynamics may foster better rate predictability and avoid surprises and the need for speculative explanations in the future.

## BACKGROUND

Enacted by Congress in 2010, the ACA brought numerous changes to health care markets, the most notable being

the transformation of the individual health market from a lower-risk, medically underwritten, market to a higher-risk guaranteed-issue market without pre-existing condition exclusions or health status as an allowable rating factor. To provide enrollment incentives, federal subsidies of varying amounts were made available to some enrollees to offset the high cost of premiums and cost sharing. Due to these targeted subsidies, the size of the individual market has grown significantly for some segments of the eligible population. With initially high ACA rates and high premium increases each year, issuers have struggled to enroll and renew other segments of the market, particularly those ineligible for premium subsidies. As the market is extremely price sensitive, a mechanical understanding of the premium and subsidy dynamics provides the right frame of reference to appreciate enrollment dynamics, and consequently premium rates and profitability results.

## INCENTIVES AND DISINCENTIVES

Unlike other government entitlements programs, ACA markets provide eligible enrollees with a more diverse mix of incentives. In Medicare and Medicaid markets, the level of government support in funding the health care costs or provision for premium payments is generally high enough to incent enrollment across a broad population. This is not the case in ACA markets.

Unlike Medicare and Medicaid, the ACA modified a current market rather than creating a new one. The intent was to alter the rules in the current individual market and provide federal assistance to targeted groups. This assistance was limited, largely for political considerations to maintain a proclamation of deficit neutrality in order to achieve the necessary votes in Congress.

As the ACA put upward pressure on rates, this new funding became critical. Fortunate for some and unfortunate for others, federal assistance does not align with price changes due to the ACA. This created strong but unbalanced incentives. This has resulted in a skewed enrollment distribution in the market. The detailed mechanics of the ACA are discussed in an article<sup>3</sup> in the September 2016 edition of this newsletter. Building from an illustrative example in that article, we consider hypothetical pre-ACA rates that will be used as a basis for incentive comparisons. The rates in Figure 0 reflect premiums for a relatively healthy group of people at two different ages; also note that the premium difference between ages is 5:1 rather than the ACA-mandated 3:1 range. These rates may be described as “actuarially-based,” or “fair” and “equitable” as defined in Actuarial Standards of Practice 12.<sup>4</sup> As they are not constrained by ACA regulations, the premium rates generally reflect the expected costs. ACA Metal levels (Bronze, Silver, Gold) are used to correspond to actuarial value in ACA markets. ‘A’ and ‘B’ are representative of two different companies.

Figure 0  
Pre-ACA Monthly Premium

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	180	210	240	200	233	267
64	900	1050	1200	1000	1167	1333

Figure 1  
Gross Monthly Premium (ACA 2014)

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	270	315	360	300	350	400
64	810	945	1080	900	1050	1200

Figure 2  
Subsidy Calculation (ACA 2014)

Age	Income	Maximum Subsidy Calculation	Maximum Contribution	Premium Subsidy
24	48,000	7.50%	300	50
64	48,000	7.50%	300	750

Figure 3  
Net Monthly Premium (ACA 2014)

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	220	265	310	250	300	350
64	60	195	330	150	300	450

Figures 1-3 are directly from the previous article (with the addition of Gold plan options for additional clarity) and illustrate the incentives in the ACA framework. Specifically, the market is more attractive to older adults who are eligible for premium subsidies. The implications of the subsidy structure are discussed at length in the previous article. “ACA 2014” is used as a title to later distinguish initial premium dynamics with changes effective in 2018.

Figure 1 illustrates the gross monthly premiums for two sample companies, A and B, offering plans in the three lowest-value tiers to sample individuals. Bronze is the lowest tier; Silver is the second-lowest tier; Gold is the third-lowest tier.

Figure 2 illustrates the subsidy calculation for a particular income level and age. This is determined by calculating the maximum monthly contribution that an enrollee pays for the benchmark plan (the second-lowest-cost silver tier plan, or ‘B Silver’). Assuming the maximum contribution percentage of 7.50 percent for an individual with an income of \$48,000 (reasonable approximation but not representative of any year),

the maximum monthly contribution for that individual is \$300 [ $\$48,000 \times 7.50\% / 12$ ]. The calculated subsidy is the gross monthly premium of the benchmark plan minus the \$300 maximum contribution from the enrollee.

Figure 3 illustrates the net monthly premiums that enrollees pay for each plan in the market after subtracting the subsidy from the gross monthly premiums.

### CSR BACKGROUND AND IMPACT

In 2017, President Trump inherited a new health care marketplace that was less than half the size as originally projected despite being promoted on an unprecedented scale, comprised of a highly skewed older and sicker population, and gradually declining in terms of both consumers and insurers.

The new administration has its first opportunity to put its fingerprints on the annual ACA regulation for 2019, as the previous administration accelerated the 2018 timing to extend President Obama’s influence as long as possible. Nonetheless,

Figure 4  
Gross Monthly Premium (ACA 2018)

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	270	378	360	300	420	400
64	810	1134	1080	900	1260	1200

Figure 5  
Subsidy Calculation (ACA 2018)

Age	Income	Maximum Subsidy Calculation	Maximum Contribution	Premium Subsidy
24	48,000	7.50%	300	120
64	48,000	7.50%	300	960

Figure 6  
Net Monthly Premium (ACA 2018)

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	150	258	240	180	300	280
64	0	174	120	0	300	240

President Trump acted in other arenas and had significant influence in 2018.

In addition to inheriting a challenging health insurance marketplace, the new president also inherited several related lawsuits. One dealt with the reimbursement of cost-sharing reduction (CSR) payments to issuers in the individual market. In addition to premium subsidies, CSR payments are a federal funding element used to subsidize health care costs of low income individuals. CSRs reduce cost-sharing (i.e., deductibles, coinsurance, copayments, out-of-pocket limits) for individuals with incomes up to 250 percent of the Federal Poverty Level (FPL). CSR payments are viewed by many stakeholders as a critical component of the ACA. If the payments are not funded by the government, insurers are still obligated to provide additional benefits to eligible enrollees and will consequently need to raise premiums to offset the lack of funding.

In 2014, the House of Representatives sued the Obama administration on Constitutional grounds, claiming that the administration funded CSR payments which were never appropriated by Congress. In 2016, the federal district court for the District of Columbia ruled that the payments were unconstitutional. The decision was stayed, which allowed the payments to continue while the White House appealed the decision. President Trump continued allowing the payments until late 2017, which he stopped per a recommendation from the Department

of Justice. The timing was very tight, but it allowed issuers to reflect the defunding in 2018 premium rates. Most states allowed issuers to properly reflect the CSR defunding impact in 2018; other states have allowed this reflection in 2019.

The impact of this change provided a boost to the market as the mathematical implications of the defunding causes premium subsidies to increase more than premiums, reducing the net premiums that subsidized enrollees have to pay, benefiting the market and resulting in more attractive options for prospective enrollees.<sup>5</sup> Continuing with our example, Figures 4–6 mirror Figures 1–3 but reflect 20 percent higher Silver premiums to offset the CSR defunding. The title “ACA 2018” is used to signify the new market dynamics.

In Figure 4, note that the higher benefit Gold plans are priced lower than the Silver plans; this has occurred in many markets.

As the premium subsidy is triggered from the second-lowest Silver plan, the calculated subsidy in Figure 5 is higher than Figure 2.

As the premium subsidy is higher, the net premiums in Figure 6 are generally lower than Figure 3. The exception is the second-lowest Silver benchmark plan which remains the same as an enrollee’s required contribution for the benchmark plans is preserved. It should be noted that Bronze plans are free in this scenario and Gold plans net prices are lower than Silver plans.

Figure 7  
CSR Impact

Age	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
24	-70	-7	-70	-70	0	-70
64	-60	-21	-210	-150	0	-210

Figure 8  
Age 24 Summary

Age 24	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Pre-ACA	180	210	240	200	233	267	180	210	240	200	233	267
ACA 2014	270	315	360	300	350	400	220	265	310	250	300	350
ACA 2018	270	378	360	300	420	400	150	258	240	180	300	280

Figure 9  
Age 64 Summary

Age 64	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Pre-ACA	900	1050	1200	1000	1167	1333	900	1050	1200	1000	1167	1333
ACA 2014	810	945	1080	900	1050	1200	60	195	330	150	300	450
ACA 2018	810	1134	1080	900	1260	1200	0	174	120	0	300	240

Figure 10  
Age Ratios

	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Pre-ACA	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
ACA 2014	3.00	3.00	3.00	3.00	3.00	3.00	0.27	0.74	1.06	0.60	1.00	1.29
ACA 2018	3.00	3.00	3.00	3.00	3.00	3.00	0.00	0.67	0.50	0.00	1.00	0.86

Moving to an analysis phase, Figure 7 illustrates the CSR impact on net premium rates. The CSR-induced premium reduction for Age 64 is logically three times as much as Age 24 except where the reduction is capped at a zero-dollar net premium.

Figures 8 and 9 compare the premiums for unsubsidized and subsidized enrollees Age 24 and Age 64 for all three market environments. The rate relationships shown here are helpful in understanding the enrollment dynamics changes in 2014 and 2018.

Figure 10 demonstrates the relationship of the varying age ratios for subsidized ACA enrollees. The ACA compressed the age ratio to 3:1; it varied pre-ACA, 5:1 has been suggested as an ACA alternative. For subsidized enrollees, the ratio is 1:1 for the benchmark plan and older enrollees actually pay less than younger enrollees for lower value plans (and higher value plans in 2018).

Using a color-coded scheme to represent market attractiveness, the color blue represents lower rates from a previous market

Figure 11  
Market Attractiveness of ACA 2014 Market relative to Pre-ACA Market

	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Age 24												
Age 64												

Figure 12  
Market Attractiveness of ACA 2018 Market relative to Pre-ACA Market

	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Age 24												
Age 64												

Figure 13  
Market Attractiveness of ACA 2018 Market relative to 2014 ACA 2014 Market

	Unsubsidized Enrollee						Subsidized Enrollee					
	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold	A Bronze	A Silver	A Gold	B Bronze	B Silver	B Gold
Age 24												
Age 64												

environment, grey indicates higher rates, and light blue indicates no change.

Figure 11 indicates that the ACA was attractive for Age 64 individuals and unattractive at Age 24. Closer examination of Figures 8 and 9 illustrate that the ACA intuitively benefitted subsidized individuals more.

Figure 12 indicates that Bronze plans in the revised ACA market are attractive (relative to pre-ACA market) for Age 24 individuals. This is due to the CSR-induced additional premium subsidies. It also illustrates unsubsidized Silver premiums are unattractive at all ages, hence the recent migration away from Silver plans. Migration is also occurring for subsidized enrollees (except those who desire CSR benefit) as Bronze and Gold plans are priced more attractively than Silver plans.

Figure 13 isolates the CSR impact and compares the revised ACA market to the original ACA market. For unsubsidized enrollees, Silver premiums have increased and enrollees are

advised to migrate from Silver plans. While not included in this illustration, off-exchange Silver plans may not have the CSR-induced premium load; in that case, there would be no change from 2014. For unsubsidized enrollees, premiums are favorable in all scenarios except the benchmark plan. The lower cost Silver plan is negligibly favorable; while not shown, a higher cost Silver plan would be negligibly unfavorable.

In summary, President Trump's CSR defunding has changed the net premium dynamics for subsidized enrollees. The market is now more attractive and the proportion of enrollees who are subsidized will continue to grow. While ACA premiums rates have favored older enrollees, the new premium subsidy dynamics has made the market more attractive for younger individuals eligible for premium subsidies. The profitability of issuers in 2018 and the rate decreases in 2019 might indicate that the risk mix has shifted more than issuers anticipated. Premium rates in 2020 will be fully based on 2018 experience; let's not be surprised if rate increases remain low.



## CONCLUSION

ACA market rates dropped for the first time in 2019. This is a reflection of issuers expecting lower costs in the market than they have in the past. Some of this is due to an expected more favorable risk mix; some of it may also be due to new or returning issuers who have a lower cost structure.

The individual market is extremely price sensitive. When unexpected changes in enrollment or prices occur, it is helpful to understand what dynamics may have precipitated a market change. In 2018, it was the defunding of CSR payments. The illustrative examples in this article demonstrate how the marketplace is now friendlier to subsidized enrollees via higher premium subsidies, and notably now more attractive to young adults eligible for subsidies. The magnitude of the CSR-induced market change may have been the largest uncertainty in the 2018 premium rates.

The calculations in this article reflect actual market mechanics, but many of the inputs are illustrative and not indicative of premiums in a particular market. Realistic market-specific inputs may be substituted and will likely show similar results. The record profitability in 2018 and lower rates in 2019 don't suggest that issuers' market intelligence has changed; they don't suggest that issuers erroneously believed the market would get worse; they suggest that the market is actually better. At least that's one actuary's explanation, with some numbers to go along with it. ■



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## ENDNOTES

- 1 <https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf>
- 2 I'm expecting to receive hate mail about the underwriting cycle.
- 3 <https://www.soa.org/Library/Newsletters/In-Public-Interest/2016/september/ipi-2016-iss13.pdf>
- 4 Rates are "fair" or "equitable" if "Rates reflect material differences in expected cost for risk characteristics." [http://actuarialstandardsboard.org/wp-content/uploads/2014/07/asop012\\_101.pdf](http://actuarialstandardsboard.org/wp-content/uploads/2014/07/asop012_101.pdf)
- 5 [http://axenehp.com/wp-content/uploads/2017/08/ahp\\_inspire\\_20170809.pdf](http://axenehp.com/wp-content/uploads/2017/08/ahp_inspire_20170809.pdf)
- 6 <https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2018/>
- 7 <https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf>
- 8 <https://www.soa.org/Library/Newsletters/Health-Watch-Newsletter/2014/may/hsn-2014-iss-75-fann.aspx>
- 9 <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf>
- 10 <https://www.soa.org/Library/Newsletters/Health-Watch-Newsletter/2016/may/hsn-2016-iss-80-fann.aspx>
- 11 <https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf>