

Drivers of 2019 Health Insurance Premium Changes

JUNE 2018

KEY POINTS

Key drivers of 2019 premium changes include:

- Medical trend, which is the underlying growth in health care costs;
- Recent legislative and regulatory changes, including the elimination of the individual mandate penalty, the pending expanded availability of short-term limited duration plans and association health plans, and whether changes are made regarding how insurers are instructed to load premiums to account for cost-sharing reduction subsidies;
- Changes in the risk pool composition and insurer assumptions from 2018; and
- Any state actions to implement reinsurance programs, impose individual mandate penalties, or enact rules that would facilitate or prohibit the availability of alternative coverage options.

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, or 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

© 2018 American Academy of Actuaries. All rights reserved.

The 2019 health insurance premium rate filing process is underway. Outlined in this issue brief are the factors actuaries consider in setting premium rates, and an overview of the major drivers behind why 2019 premiums could differ from those in 2018. The brief focuses primarily on the individual market, yet many of the factors discussed are also relevant to the small group market.

Premiums Reflect Many Factors

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

PROJECTED MEDICAL COSTS. Most premium dollars are used to pay for medical claims, including those for medical services and prescription drugs. Claims 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. Spending for health care services can vary by geographic area and from one health plan to another within an area due to varying regional medical practice patterns and the degree to which insurers in a region have leverage to negotiate fees and care management protocols with health care providers.

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. Recent and pending policy changes must also be considered in premium development.

WHO IS COVERED—THE COMPOSITION OF THE RISK POOL. Pooling risks allows the costs of less-healthy individuals to be subsidized by healthy individuals. In general, the larger the risk pool, the more predictable and stable claim costs can be. But the composition of the risk pool is also important. Although the Affordable Care Act (ACA) 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 commensurately higher, all other factors remaining equal.

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.

Major Drivers of 2019 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 2019 is expected to be consistent with that for 2018, 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.

RECENT AND PENDING POLICY CHANGES. Recent policy decisions will affect 2019 premiums. In addition, final regulations are currently in progress that would implement an executive order from President Trump.²

- *Cost-sharing reduction (CSR) subsidies.* The ACA requires individual market insurers participating in the individual market 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, with lower co-payments and out-of-pocket limits. The federal government had been making payments directly to insurers to offset the cost of lowering cost-sharing requirements, but those payments were discontinued in October 2017. As a result, 2018 premiums in nearly all states were increased to account for the additional costs of providing CSR subsidies. Most state insurance regulators directed insurers to increase premiums only for silver plans, while some states required the cost to be spread across all plans and a few did not allow insurers to load in any cost.

Loading premiums for CSRs will contribute to 2019 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.

¹ Oliver Wyman Actuarial Consulting Inc., *Carrier Trend Report: January 2018 Analysis*, 2018.

² President Donald J. Trump, “[Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States](#),” Oct. 12, 2017.

Members of the Individual and Small Group Markets Committee include Barb Klever, MAAA, FSA—*Chairperson*; Joyce Bohl, MAAA, ASA—*Vice Chairperson*; Karen Bender, MAAA, ASA, FCA; Eric Best, MAAA, FSA; Philip Bieluch, MAAA, FSA, FCA; Alfred Bingham, MAAA, FSA; Frederick Busch, MAAA, FSA; April Choi, MAAA, FSA; Andrea Christopherson, MAAA, FSA; Sarkis Daghljan, MAAA, FSA; Richard Diamond, MAAA, FSA; Beth Fritchen, MAAA, FSA; Rebecca Gorodetsky, MAAA, ASA; David Hayes, MAAA, FSA; Juan Herrera, MAAA, FSA; Shiraz Jetha, MAAA, FCIA, FSA, CERA; Jason Karcher, MAAA, FSA; Rachel Killian, MAAA, FSA; Kuanhui Lee, MAAA, ASA; Raymond Len, MAAA, FCA, FSA; Timothy Luedtke, MAAA, FSA; Scott Mack, MAAA, ASA; Ryan Mueller, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Jason Nowakowski, MAAA, FSA; James O’Connor, MAAA, FSA; Bernard Rabinowitz, MAAA, FSA, FIA, FCIA, CERA; David Shea, MAAA, FSA; Steele Stewart, MAAA, FSA; Martha Stubbs, MAAA, ASA; Karin Swenson-Moore, MAAA, FSA; Tammy Tomczyk, MAAA, FSA, FCA; David Tuomala, MAAA, FSA, FCA; Roderick Turner, MAAA, FSA; Cori Uccello, MAAA, FSA, FCA; Dianna Welch, MAAA, FSA, FCA.

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 using the increased premium subsidies toward plans in other tiers can result in free or low-cost bronze plans and lower-cost gold plans. In states where insurers aren't directed to spread the CSR premium load over all plans, individuals not eligible for premium subsidies will have access to coverage without the additional CSR load.

The exchange open enrollment results for 2018 showed a shift from silver to bronze plans and increased enrollment in gold plans,³ likely reflecting enrollees applying higher premium subsidies toward other plans, especially in states that used silver loading. For 2018, 29 percent of enrollees selected bronze plans, up from 23 percent during 2017 open enrollment. The share of enrollees choosing gold plans increased from 4 percent in 2017 to 7 percent in 2018. The silver enrollee population could become more skewed toward highly CSR-subsidized enrollees (i.e., enrollees eligible for silver plans with actuarial values of 87 and 94 percent) if highly CSR-subsidized enrollees are more likely to retain silver coverage and non- or less-CSR-subsidized enrollees (i.e., enrollees eligible for silver plans with actuarial values of 70 or 74 percent) shift to bronze or gold plans. If insurers expect a greater degree of concentration than assumed in 2018 rates, the load may need to increase. Although it is also possible that highly CSR-subsidized enrollees are moving to free bronze coverage, doing so would expose them to higher cost sharing than if they remained in silver plans, due to cost-sharing subsidies that are available only for silver plan enrollees.

CSR premium loads reflect the share of enrollees insurers expect to receive CSR subsidies and the share of enrollees expected to fund this CSR cost. If the enrollment shift from silver plans was different than insurers anticipated or if insurers anticipate more enrollment shifts for 2019, then CSR loads may change. The enrollment shift could be greater in 2019 if larger premium subsidies result in increased consumer awareness of the availability of lower-cost bronze and gold plans. CSR premium loads also reflect insurer assumptions regarding the distribution of enrollees eligible for each CSR variant.

CSRs will also contribute to premium changes if insurers are required to change the way they load premiums for CSRs in 2019 compared to 2018. For instance, if insurers that loaded only silver premiums for CSRs in 2018 were required to spread the CSR cost across all plans for 2019, the loads on silver plans would go down, but the premiums for other metal tiers would increase. Insurers would expect enrollees, including those not eligible for premium subsidies, to re-evaluate their coverage and metal level choices. In states with competitive environments, insurers would be incented to not offer the lowest- or second-lowest-cost silver plans because these plans would expect to enroll the majority of more highly CSR-subsidized enrollees. A greater concentration of highly CSR-subsidized enrollees would increase the chance that the average load applied to all plans would be insufficient to cover the CSR cost. This dynamic could lead to insurers re-evaluating participation on exchanges. In addition, if off-exchange plans are not exempted from imposing a CSR load on premiums, off-exchange enrollment could go down and insurers with only off-exchange plans would be at a competitive advantage relative to insurers with both on- and off-exchange plans.

³ Centers for Medicare and Medicaid Services (CMS), "[Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016–January 31, 2017](#)," March 15, 2017; CMS, "[Health Insurance Exchanges 2018 Open Enrollment Period Final Report](#)," April 3, 2018.

If insurers that were not allowed to load premiums for CSRs in 2018 are allowed to do so for 2019, then premiums would increase accordingly. If insurers that were directed to spread premium increases over all plans in 2018 are allowed to load premiums only on silver plans in 2019, then silver premiums would increase, but the loads on other plans would go down.

- *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. With guaranteed issue requirements and the elimination of pre-existing condition exclusions, a mechanism was needed to keep people from waiting to purchase insurance until they needed it. A stable health insurance market needs to have lower-risk individuals participate and to share in the cost of health care. The recently enacted *Tax Cuts and Jobs Act* eliminated the individual mandate financial penalty beginning in 2019. Eliminating the penalty is expected to increase premiums as unsubsidized lower-cost healthy individuals will be more likely to forgo coverage. This is especially likely if, as discussed below, the availability of alternative coverage is increased, for instance through expanded short-term limited duration plans or association health plans.

When developing 2018 premium rates, many insurers included an increase anticipating a weakening of the individual mandate. The elimination of the mandate altogether will also lead to premium increases in 2019, potentially to a lesser extent in plans that already assumed a low level of enforcement in 2018. Also, the impact on average premiums will vary by state, given varying percentages of enrollees eligible for premium subsidies. States with higher shares of premium-subsidized enrollees may see less of an impact from the elimination of the mandate as premium subsidies encourage enrollment.

- *Expanding the availability of short-term limited duration (STLD) plans and association health plans (AHPs).* Proposed regulations have been released that would implement President Trump's executive order to lengthen the maximum duration of STLD plans from 3 months to 12 months and to expand the availability of AHPs.⁴ Until final rules are released, it is unclear whether these alternative coverage sources will be available beginning in 2019 or at a later date. Some insurers may be assuming alternative coverage sources will be available in 2019, thus affecting 2019 premiums.

STLD plans have been traditionally used by people who know they have only a short-term loss of coverage, for instance between jobs. These plans are not required to follow ACA issue, rating, or benefit coverage requirements. As a result, STLD plans would be more attractive to lower-cost individuals because of lower premiums for STLD plans compared with ACA-compliant plans. Market segmentation and adverse selection for ACA plans could result, leading to higher premiums for ACA plans.

Similarly, proposed rules have been released that would broaden the ability for AHPs to be treated as large groups and for self-employed individuals to be eligible for AHPs. Large group plans have more flexibility than ACA plans regarding rating rules and benefit coverage requirements, potentially creating adverse selection concerns for ACA plans. AHPs could offer lower premiums to lower-cost individuals than ACA plans, leading to higher ACA premiums.

As noted above, the effects of expanded availability of STLD plans or AHPs would be exacerbated given the elimination of the individual mandate penalty.

⁴ See Academy comment letters on the executive order and proposed rules at: [actuary.org/executive_order](https://www.actuary.org/executive_order), and [actuary.org/STLD_comments](https://www.actuary.org/STLD_comments) and [actuary.org/AHP_comments](https://www.actuary.org/AHP_comments).

Without the regulations having been finalized, there is uncertainty not only regarding the specific rules but also when any expanded availability would be effective. Insurers pricing their ACA plans need to anticipate the extent to which their risk pool will be affected by healthy lives opting out of the risk pool in favor of an STLD plan or an AHP. Effects could vary by state, based on any state laws and regulations regarding STLD plans and AHPs. In addition, proposed rules allowing AHPs located in one state to be sold in other states could further complicate ACA premium setting.

CHANGES IN THE RISK POOL COMPOSITION AND INSURER ASSUMPTIONS. Changes in premiums between 2018 and 2019 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 2018 premiums. As noted above, policy changes in effect beginning in 2019, such as the elimination of the individual mandate penalty, could lead to a further deterioration of the risk pool.

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. 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.

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 and to 12.7 million in 2016, but dropped to 12.2 million in 2017 and to 11.8 million in 2018.⁵ Insurers need to consider whether this decline is likely to continue or reverse in 2019. If the decline is expected to continue or increase in 2019, this will put upward pressure on

⁵ CMS, “[Health Insurance Exchanges 2018 Open Enrollment Period Final Report](#),” April 2, 2018. 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 [open enrollment periods] 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.” (CMS, “[Health Insurance Marketplaces 2017 Open Enrollment Period Final Enrollment Report: November 1, 2016–January 31, 2017](#),” March 15, 2017.)

2019 premium increases. National information on off-exchange enrollment is unavailable.

Most on-exchange enrollees receive premium subsidies and were therefore shielded from 2018 premium increases, including those due to the costs of CSRs being loaded onto premiums. Net premiums could have decreased for premium-subsidized enrollees if they used higher premium subsidies toward lower-cost bronze coverage. Off-exchange enrollees, however, were not shielded from premium increases and off-exchange enrollment might have dropped to a greater extent than on-exchange enrollment. Importantly, market experience to date and 2019 projections vary by state, depending in part on state policy decisions and local market conditions.

STATE ACTIONS. Rate increases for 2019 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 2019 premiums. For instance, some states have implemented or propose to implement reinsurance programs. By offsetting the insurer costs for high-cost enrollees, reinsurance reduces premiums, all else equal, and reduces rate increases in the first year of the program. Some states are exploring imposing an individual mandate penalty, which could lower premium increases.

Other states are exploring allowing the sale of plans that don’t comply with ACA requirements. As with AHPs and short-term duration plans, such alternative plan offerings could attract healthier enrollees. The ACA risk pool could deteriorate as a result, increasing premiums. On the other hand, if states already have or implement rules limiting the sale of short-term duration plans or AHPs, rate increases due to federal expansions of such plans will be mitigated.

Other Drivers

SUSPENSION OF HEALTH INSURER FEE. The health insurance provider (HIP) fee was enacted through the ACA. The HIP fee is scheduled to collect \$14.3 billion in 2018 and insurers built this cost into their 2018 premiums. The *Extension of Continuing Appropriations Act of 2018* included a moratorium on the collection of the HIP fee in 2019. Insurers will exclude the cost of this fee in their 2019 premiums, resulting in a reduction in expected premiums by about 1 to 3 percent, depending on the size of the insurer and their for-profit/not-for-profit status.

CHANGES IN PROVIDER NETWORKS. The Centers for Medicare & Medicaid Services (CMS) recently shifted 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.

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. Unlike in 2018, there have not been any changes to the rules regarding the allowable variation in actuarial value (AV), which measures the relative generosity of the benefits provided by a plan. However, the data underlying the AV calculator was updated to reflect another year of medical trend, which could increase a plan's AV. In addition, the maximum out-of-pocket amount will increase from \$7,350 (single) / \$14,700 (other than single) in 2018 to \$7,900/\$15,800 in 2019. Such changes could necessitate other plan design changes in order to remain within the allowable AV ranges or could result in upward or downward pressure on premiums if the AV increases or decreases within the allowable AV range. For instance, some insurers may elect not to increase plan out-of-pocket maximums in order to maintain more consistency from year to year. However, the resulting increase in AV (the value of a constant out-of-pocket maximum increases when

medical trend increases total health spending) could put upward pressure on premiums.

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 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. In contrast, for 2017, many insurers reduced the number of markets in which they would participate and in some cases, exited the market completely. This trend continued into 2018, when increased legislative and regulatory uncertainty, combined with insurer financial losses, led to additional market withdrawals. In 2018, 26 percent of enrollees (in 52 percent of counties) have only one participating exchange insurer, up from 21 percent (in 33 percent of counties) in 2017.⁶

Insurers have more information than they did previously regarding the risk profile of the enrollee population, and there may be less uncertainty for 2019 than there has been in the past. Among insurers remaining in the market, there have been signs that experience has begun to stabilize or even improve somewhat.⁷ As a result, some insurers may decide to enter or re-enter the market, or to expand into new areas. These decisions would likely reflect local market

⁶ Kaiser Family Foundation, "[Insurer Participation on ACA Marketplaces, 2014-2018](#)," Nov. 10, 2017.

⁷ Kaiser Family Foundation, "[Individual Insurance Market Performance in 2017](#)," January 2018.

dynamics. An increase in participating insurers could lead to more competition and downward pressure on premiums.

CHANGES IN PROVIDER COMPETITION AND

REIMBURSEMENT STRUCTURES. The recent trend of health care provider consolidation is likely to continue in many local markets. 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 affect premiums. 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 2019 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 2019 health insurance premium rate filing process is underway, and how 2019 premiums will differ from those in 2018 depends on many factors. Key drivers include the underlying growth in health spending, which will increase premiums relative to 2018. 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 2019 rates.

Premiums will reflect insurer assumptions regarding the risk pool composition and how it will change in 2019. The elimination of the individual mandate penalty puts upward pressure on premiums to the extent it threatens to deteriorate the risk pools and hasn't already been incorporated into premiums.

Expanding the availability of alternative coverage sources, such as short-term limited duration plans (STLD) and association health plans (AHPs), could also contribute to premium increases depending on the final federal rules pertaining to these plans and when the plans could go into effect. 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.

The moratorium of the health insurer fee will offset a portion of 2019 premium increases. 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 2019 premiums.

Premium changes faced by individual consumers will also reflect increases in age and other factors. Changes in loading for CSRs can impact subsidy levels and the net cost for subsidized enrollees. 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 current plan being discontinued.

The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Premium Changes From a Consumer Perspective

Premium changes are often the most visible and discussed aspect of the Affordable Care Act's (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.

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

As insurers enter or exit marketplaces or otherwise change their plan offerings, consumers could have different choices of insurers or plans. If particular plans are discontinued, consumers may be re-enrolled in a different plan. Even if their current plan continues to be available, consumers may choose to enroll in a different plan. Either of these scenarios could lead to a consumer's premium change that differs from the state's or insurer's average premium change.

Changes in Age/Family Status

Most individual consumers will experience a premium increase each year, due to aging one year.

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.

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.

Geographic Area Factors

All states require all insurers within the state to use identical rating areas approved by the Centers for Medicare and Medicaid Services. Insurers are not allowed to change the rating areas, but they 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 on household income and the premium for the second-lowest silver plan. 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. And even if there is no change in income, premium subsidies can increase if premiums increase. Changes in how states load premiums to cover cost-sharing reductions (CSRs) can also affect premium subsidies.

Insurers are required to notify subsidized enrollees of premium changes before open enrollment. However, the notification is based on the current year subsidy and will not reflect subsidy changes due to any premium changes, including how premiums are loaded to account for CSRs. Individuals may not be aware of the impact of the subsidy changes unless this process is changed or insurers develop additional communications. A change in available plans offered in the market also could affect the subsidy an individual receives.