ACA Implementation—Monitoring and Tracking

High Premiums in Nongroup Insurance Markets: Identifying Causes and Possible Remedies

January 2017

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Robert Wood Johnson Foundation

URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

INTRODUCTION

The repeal of the Affordable Care Act (ACA) is now high on the political agenda for 2017. Congress has repeatedly expressed its intent to repeal and replace the ACA, but the body has not reached consensus on a replacement package. The law's opponents may find that repeal carries a large political price because the ACA has significantly increased insurance coverage, expanded access to care, and introduced an array of popular consumer protections for those with health problems.

There is considerable uncertainty about the repeal and replace process at this time. Fearing political consequences of losses of coverage, there could be agreement on a series of fixes to the ACA. If the law is repealed, there could be a lengthy transition period during which the non-group insurance market would remain under ACA rules to some extent. The types of replacement plans proposed by some members of Congress suggest a non-group market with different kinds of tax credits (smaller than the ACA's for the average recipient and varying by age but not by income) and less regulation.

Yet, even under a scenario of the types they envision, prominent concerns that have been discussed with respect to the ACA's markets—adverse selection and the distribution of health care risk—would persist for insurers. Insurer and provider concentration would also continue to plague certain markets under an alternative approach. A Medicare premium support plan, another policy being considered by members of Congress, could lead to Medicare markets that look a lot like the ACA's Marketplaces and would likely face most of the same types of challenges. For all these reasons the ACA Marketplace experience with premium growth is important to understand, even if policymakers are destined to make changes to the law in the near future.

Premiums for marketplace nongroup insurance coverage (not adjusting for premium tax credits) are projected to increase by 21 percent on average in 2017.[1] Although premium increases will vary widely across and within states and across different insurers, a significant number of geographic areas are experiencing larger increases in 2017 than they did in the first years of ACA implementation.[2] Based on these larger increases, some have concluded that the marketplaces are fundamentally flawed and unsustainable.[3] But to draw such broad conclusions on the stability of these markets is to oversimplify the problem of premium increases. First, many markets, especially those in highly populated urban areas, continue to operate effectively with reasonable premiums and lower premium growth. Second, some markets with recent high premium growth likely were underpriced in the early years of reform, so pricing is now "catching up" to national averages.[4] Therefore, high premium growth in a year or even two does not necessarily indicate a fundamental flaw in the ACA because the premium levels may have been "too low" in the preceding years and will now reach levels that are reasonable, as opposed to "too high."

The markets most deserving of attention are those where high premium growth has led to high premium levels because of: (1) adverse selection into the ACA-compliant nongroup insurance market as a whole, possibly resulting from low enrollment; (2) high concentration of the area's insurer and/or provider markets; and (3) adverse selection

among the ACA-compliant nongroup insurers, insufficiently corrected by risk-sharing mechanisms under the law, and leading to higher premiums because of lack of trust in risk adjustment. We explain each of these potential causes of high premiums and discuss policy options that could address them. Though strong policy tools are available in each case, no single policy tool can address all three sources of market weakness. Thus, we also identify the types of data necessary to facilitate diagnosis and appropriate treatment.

ADVERSE SELECTION AGAINST THE ACA-COMPLIANT NONGROUP INSURANCE MARKET AS A WHOLE

High premiums and/or low insurer participation may be caused by adverse selection against the entire nongroup insurance market. In areas affected by this type of adverse selection, nongroup insurance enrollees have higher average health care needs than those in the general population (e.g., those with employer-based insurance). One possible cause of adverse selection is a low rate of enrollment, where enrollees tend to have higher expected health care costs and thus have the most to gain from health insurance coverage. In such cases, the problem is adverse selection against the full ACA-compliant nongroup insurance market, including enrollees both inside and outside the marketplaces. Because the law treats the entire ACA-compliant nongroup insurance market as one unified risk pool, the health care risks of those inside and outside the marketplaces must be viewed in combination. However, if the problem is inadequate sharing of health care risk between insurers within the nongroup insurance pool, then the problem is not adverse selection against the nongroup pool as a whole but a deficiency in the risk-adjustment mechanism (discussed below).

To determine the effect of adverse selection, policymakers will need representative data on health conditions, medical service utilization, and/or health expenditures in both the general population and the ACA-compliant nongroup market in a particular geographic area. Such data are currently difficult to acquire, even though the ACA provides the federal government with substantial authority to collect this information directly from insurers. State regulators also have the authority to request the data from insurers. All-payer data sets could be valuable to the extent that they include claims for enrollees in self-insured employer plans and identify substate geographic areas and the sector of the insurance market in which the claims are made (i.e., nongroup versus employer). Developing effective policies to strengthen these markets requires better data than we have today, and it is in insurers' interest to provide that data since evidence of adverse selection could lead to policy remedies that would benefit them financially.

If a market area sees significant adverse selection against ACA-compliant nongroup insurance plans in total, a number of policy solutions are available. The following strategies could be targeted to the specific areas experiencing nongroup market adverse selection and can be used individually or in combination.

Investing in outreach and enrollment assistance

Additional government financed outreach and enrollment assistance specifically targeted to individuals eligible for the largest amounts of financial assistance could significantly increase marketplace enrollment, especially among younger adults with lower medical service needs.[5] Ideally, efforts by governments and insurers would take place in both the annual open enrollment period and in special enrollment periods (SEPs). Insurers are especially concerned about adverse selection during SEPS; this might be valid, but there are large numbers of SEP eligibles, most of whom are healthy, who are not being enrolled due to insufficient outreach efforts by insurers and government.[6]

Providing additional financial assistance for purchase of marketplace coverage, combined with higher penalties for remaining uninsured

As we have shown elsewhere,[7] many individuals still face large health care costs relative to income if they enroll in marketplace coverage, and marketplace assisters report that affordability remains the chief barrier to higher rates of enrollment.[8] More generous premium tax credits and/or cost-sharing assistance for marketplace coverage could increase enrollment significantly, improving the

nongroup insurance risk pools as it decreases the number of uninsured Americans. The additional assistance can be combined with higher penalties for those remaining uninsured. This combined approach would be more successful in reducing the periodic churn in and out of insurance—a major concern for insurers—and would further improve the stability of the risk pools. Without additional premium assistance, however, most uninsured will remain exempt from penalties because coverage is not affordable for them under the law.

Eliminating the "family glitch"

The ACA, as currently regulated, prohibits all family members from obtaining marketplace-based premium tax credits and cost-sharing reductions if at least one family member has an offer of worker-only (i.e., single) coverage that is deemed affordable given family income, regardless of the cost of family coverage. The 6.1 million families in this situation spend almost 16 percent of their income on employer-based health insurance—much more than they would pay if they were eligible for premium tax credits through the marketplaces.[9] Fixing this so-called glitch would significantly reduce these families' health care financial burdens while simultaneously increasing marketplace enrollment among predominantly healthy working families, thereby improving the nongroup insurance risk pools.

Retaining Reinsurance

The reinsurance program included in the ACA was designed to lower the costs associated with potential adverse selection into the ACA-compliant nongroup insurance market by subsidizing those insurers enrolling a population with disproportionately high medical needs. The reinsurance program was funded by assessments on all insurers (including those selling coverage in the employer group market), a broad based revenue source.[10] The program was limited to three years.[11] By contrast, the Medicare Part D program includes both permanent reinsurance and risk corridor programs.[12] The ACA was based in the idea of spreading the health care costs of those with expensive medical needs across a broad, heterogeneous swath of the population. A permanent and sufficiently funded program of reinsurance could effectively spread the high costs of very sick individuals over a much larger segment of the population, increasing additional costs for those outside of the nongroup market by only a small amount while lowering high premiums in the nongroup market attributable to adverse selection.[13]

Regulating sales of non-ACA-compliant nongroup insurance products

Only ACA-compliant nongroup insurance policies (sold either inside or outside the marketplaces) are part of the uniform nongroup insurance pools and satisfy the individual responsibility requirement (i.e., the individual mandate). However, many commercial insurers continue to sell policies that are not ACA-compliant and do not meet guaranteed issue, renewal, benefit, or actuarial value standards, with premiums still set as a function of the enrollee's own health status. While enrollees in these noncompliant plans may be required to pay an individual mandate penalty, very healthy consumers may find these experience rated policies less expensive, even with the penalty and without financial assistance. If insurers are encouraging the healthiest consumers to buy these policies, they may be weakening the ACA-compliant insurance risk pool. Prohibiting or otherwise limiting the sales of noncompliant policies or requiring that they share health care risk with the compliant market could lower average premiums for compliant plans. The recently finalized regulation on short-term policies is a step in the right direction, although further action likely is warranted.[14]

Lowering the Medicaid income threshold to 100 percent of the federal poverty level

As we have written elsewhere,[15] allowing states to expand Medicaid to adults with incomes at or below 100 percent of the FPL—instead of 138 percent of the FPL, as required under the ACA—could encourage more states to participate in the expansion. Such a policy change could also increase marketplace enrollment in those states that have already expanded Medicaid eligibility. To the extent that expansion states moved adult Medicaid enrollees with incomes between 100 and 138 percent of the FPL into nongroup marketplace coverage, the size of the nongroup markets would increase and the average health care risk of enrollees likely would improve also, because many in this income group are young, healthy adults. This policy change would necessitate higher levels of marketplace financial assistance (both premium and cost-sharing) for people with incomes between 100 and 138 percent of the FPL in order to offset financial burdens caused by the shift from Medicaid to the marketplaces. By the same token, people in this income group should not be excluded from eligibility for marketplace financial assistance because of an employer-based offer.

INSURER AND PROVIDER CONCENTRATION

Insurer and provider concentration can lead to higher premiums (and faster premium growth) because of the exercise of market power. High insurer concentration can mean that a particular market has a single insurer or one dominant insurer with one or more additional smaller insurers that have limited market share. High provider concentration can mean that the market is dominated by a single hospital or hospital system; such concentration is especially problematic when hospital systems have employed large numbers of physicians. In smaller towns or rural areas, physicians can be in limited supply, making the ones in the area "must-have" providers. Large single or multispecialty groups can also have the same effect even in larger markets.

In this brief, we consider four types of markets. The first type is a market with many insurers and many providers. In this case, insurers have a considerable amount of negotiating leverage over provider payment rates because of their ability to exclude one or more provider systems and rely upon others. Insurers can develop narrow network products with below-average provider payment rates, and thus they can offer insurance products with lower premiums. Significant competition between insurers in a transparent, ACA-type market generally ensures that lower premiums are passed on to consumers.

The second type is a market with many insurers but a single dominant hospital system or an otherwise limited number of providers. In this case, no individual insurer has significant leverage over the monopolistic provider(s). Providers can set higher rates without the fear of competition or exclusion from insurers' networks because the insurers recognize that providers are necessary to maintain an adequate network in that geographic area. This generally leads to upward pressure on premiums.

The third type is a market with a dominant insurer but many competing providers or provider systems. In this case, the dominant insurer has significant leverage because it can choose to contract with some providers and exclude others. The question is whether the insurer has any incentive to use that leverage, since it does not face competition from other insurers to hold down premiums. Marketplaces have limited ability to affect this dynamic, unless other smaller insurers gain market share and induce the dominant insurer to compete as a consequence of premium transparency. However, insurers with little market share will have trouble negotiating preferable provider payment rates compared to the dominant one. Smaller insurers with pre-existing Medicaid provider contracts are one exception because they had already negotiated lower payment rates with insurers in the area for publicly insured patients. Generally, however, markets dominated by a single insurer tend to have higher premiums than those in a more competitive market.

The fourth type of market has a dominant insurer and a single or otherwise "must-have" provider; many rural areas and some urban areas have a must-have provider or provider system. This case is similar to the second market type: Without alternative providers available, even a strong insurer has little or no leverage in negotiating payment rates. As a result, this type of market also tends to have high premiums.

The first type of market, with many competing insurers and providers, exists in many large urban areas; this explains why premiums in many of these markets are relatively modest and have experienced below-average annual growth rates.[16] However, in the other three types of markets, insurer and/or provider concentration can lead to premiums and premium growth higher than those in a more competitive market.

Provider payment rate ceiling

One way to address the problem of high premiums resulting from insurer and/or provider concentration is to establish a public insurance option and introduce it in all or some nongroup insurance marketplaces.[17] This approach is highly controversial and would face strong opposition from the insurance industry and others. An alternative approach is to follow the precedent of Medicare Advantage and establish a ceiling on payment rates that providers can charge to any ACA-compliant nongroup insurers (inside and outside marketplaces) and their enrollees. Insurers could negotiate lower payment rates with providers, but no provider would be paid more than the ceiling.

The payment rate caps could be set at Medicare levels plus 10 or 20 percent, for example. These payment rate limits would allow more insurers to compete in a given market because they would not need to have substantial market share in order to negotiate competitive rates to create a new provider network. In addition, the limits would constrain the ability of monopolistic providers to overcharge insurers. Insurers that want to establish a limited network could create a PPO option, knowing that their enrollees going out of network would still have the payment rates charged by those providers constrained by the caps. Providers would have an incentive to be in-

network, agreeing to payment rates below the statutory caps to increase patient volume. The more limited gains in out-of-network payment rates increase the attractiveness to providers of being in-network. This policy approach should give consumers greater access to a broad range of providers without alienating insurers. A rate ceiling could also reduce the impact of "surprise bills" from out-of-network providers. Providers, particularly those with strong market power, would resist limits on their payment rates; however, this policy is far less likely to engender political opposition from the insurance industry than a public option approach would.

ADVERSE SELECTION AMONG INSURERS PARTICIPATING IN AN ACA-COMPLIANT NONGROUP INSURANCE MARKET

A third problem that could lead to high premiums and low participation in the ACA-compliant nongroup insurance market is inadequate risk adjustment. Risk adjustment is a permanent element of the ACA (unlike the reinsurance and risk corridor programs) and is intended to move a portion of premium dollars from nongroup insurers enrolling a disproportionate share of low-cost individuals to insurers enrolling a disproportionate share of high-cost individuals. The risk-adjustment program is budget neutral; it moves premium funds between nongroup insurers but does not rely on additional public funds being paid into the program. If a risk-adjustment system is not sufficiently effective, insurers enrolling a disproportionate share of higher-cost individuals must increase premiums to compensate for the higher-cost pool of enrollees; as a result, these insurers become less competitive and may be forced out of the market. If insurers do not trust the risk-adjustment mechanism, they may set premiums high as a defensive posture against potentially enrolling a disproportionate share of high-cost individuals.

Designing a risk-adjustment program is a complex undertaking. To remove the incentives for insurers to select the healthiest enrollees (a practice central to the vast majority of nongroup insurance markets before the 2014 reforms), the program must ensure that insurers enrolling higher-cost individuals are not put at a competitive disadvantage for doing so and that insurers enrolling lower-cost individuals are not able to profit from doing so.

Structuring a risk-adjustment mechanism to sufficiently reward higher-cost insurers without rewarding inefficiency is a substantial challenge and continues to be a work in progress.

Some potential fixes to risk adjustment mechanisms include adding additional variables to the payment calculation, basing payments on a blend of prospective and retrospective information, and implementing strategies to reduce insurer gaming of the calculations. Assuming that the current system operates effectively for most enrollees but falls short for the extremely high cost cases (e.g., those exceeding $1 million in claims per year), a strategy that blends a reinsurance component with the risk-adjustment system—like that proposed by the Obama administration for 2018—might be very helpful.[18]

The Centers for Medicare & Medicaid Services have already made modifications to the risk-adjustment system that are slated for implementation in 2017; additional modifications are proposed for 2018. Risk adjustment plays a key role in broadening the sharing of health care risk in the nongroup insurance market, and thus it is critical to assess the extent to which its limitations may be reducing insurer participation, compromising competition in some areas, and leading to rising premiums.

CONCLUSION

Marketplaces in many areas throughout the United States have experienced high premiums and insurer attrition for the 2017 plan year. In this brief, we identify three potential sources of these difficulties, not all of which exist in all markets, and we emphasize that some markets continue to work competitively and without any significant difficulties. First, some ACA-compliant nongroup insurance markets have enrolled a population with above-average health care risks relative to a broad cross section of the nonelderly population (e.g., the population enrolled in employer-based insurance). In these cases, above-average claims have led to high and increasing premiums and losses for some

insurers that were large enough to force them out of the market. Second, some markets have high insurer and/or provider concentration. The exercise of monopoly or near-monopoly power in these markets can lead to high provider payment rates and high premiums. Third, in some markets, the risk-adjustment system may not have sufficiently shared health care risk across insurers *within* the nongroup insurance market, either moving too much money away from lower-cost insurers or moving too little money toward higher-cost insurers. In such cases, insurers may have increased premiums to compensate for their losses. An inadequate risk-adjustment system could also induce all insurers in a market to increase premiums because they fear that they may be selected against but not receive appropriate compensation through the risk-adjustment mechanism.

In this paper, we argue that each problem requires a different approach. Some policies may be implemented in some states and substate areas and not in others. However, a more uniform national strategy could incorporate a range of policies that collectively could address all these problems, with policies designed to be binding only in the specific areas where they are warranted. Because different markets have different problems, some policy solutions will be essential in some markets and have little or no impact in others. Implementing these policies nationally would obviate the need to design and legislate policies on an ongoing basis as market conditions change over time.

To address the problem of low enrollment and adverse selection against the entire nongroup market in an area, first, we suggest a significant increase in outreach and enrollment assistance and more generous premium tax credits and cost-sharing assistance. Second, penalties for not obtaining health insurance may also be increased, once coverage is made more affordable with increased financial assistance. Third, there should be a permanent reinsurance program funded from a broad-based source (e.g., general revenues or a tax on all insurance plans *and* stop-loss plans sold to self-insuring employers) that would subsidize nongroup insurance market plans with extremely high claims (e.g., $1 million or more).

Fourth, there should be increased regulation of sales of non-ACA-compliant nongroup insurance products (e.g., short-term policies, disease-specific policies, indemnity plans). These products are most attractive to those in relatively good health. Phasing them out, eliminating them entirely, or assessing them in order that they share in the risk of the ACA compliant market, will make individuals more likely to purchase ACA compliant plans and improve the risk pool. Finally, fixing the family glitch and lowering the Medicaid eligibility threshold to 100 percent of the FPL would also increase marketplace enrollment while improving the private nongroup insurance pools' risk profiles.

In principle, the problems of insurer and provider concentration could be solved with a public insurance option, but this would be extremely difficult to implement. For starters, the government would have to develop a large new organization, and the approach is certain to face opposition from the insurance industry. An alternative that could be more politically palatable (at least to insurers) is a cap on provider payment rates paid by any ACA-compliant nongroup insurer within a particular market (e.g., Medicare plus some percentage). Insurers could develop networks at lower provider payment rates, but providers would be prohibited from charging nongroup insurers above the statutory limit. This would be more attractive than a public option to insurers, though many providers would probably be opposed to any legislation limiting their payment rates (even though these limits would apply to the fairly small population enrolled in nongroup coverage). In markets where provider payment rates are already low (e.g., those with high levels of competition), this policy would have little or no effect. But it could have a significant effect in markets where few insurers compete or where providers have significant market power and insurers have little or no negotiating leverage.

Problems with the risk-adjustment mechanism may persist even after CMS implements improvements in 2017. The inclusion of prescription drug use in the risk-adjustment formula is a step in the right direction. Other improvements are beyond the scope of this paper and require additional research. However, we believe the approach proposed by the Obama administration for 2018, which would add a reinsurance-type component for insurers incurring extremely high claims in a given year, could be very helpful.

Ideally, the federal government would adopt an array of these policies and apply them nationwide. As noted above, not all would be binding in all markets in any particular year. But implementing each policy on an as-needed basis in each particular time and place would leave the overall program vulnerable to political challenges, market instability, and logistical delays. However, in the face of federal inaction, individual states could choose to implement the specific policies that apply to them. These mechanisms should lead to increased enrollment, a fairer distribution of risk among insurers, greater insurer participation in ACA-compliant nongroup markets, more stable risk pools, and more predictable increases in premiums year to year.

ENDNOTES

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18. The Obama administration proposal includes a risk-adjustment component for insurers incurring claims of $2 million or more. Further analysis is needed to assess whether that attachment point is the right level.

About the Authors and Acknowledgements

Linda Blumberg is a Senior Fellow and John Holahan is an Institute Fellow in the Health Policy Center at the Urban Institute. The authors are grateful for comments and suggestions from Sabrina Corlette, Kevin Lucia, and Stephen Zuckerman.

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