

Stabilizing and Strengthening ACA Nongroup Markets

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Timely Analysis of Immediate Health Policy Issues

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In Brief

Uncertainty about federal support for the Affordable Care Act (ACA) continues to threaten enrollment and stability in the nongroup insurance markets. Meanwhile, congressional Republicans are likely to continue their efforts to repeal and replace the law. But targeted policies could fix the ACA's problems without sacrificing its gains in coverage, affordability, and access to care. These policies would stabilize the nongroup insurance markets, encourage insurer participation, improve affordability, and rein in premium growth. We divide these policies into two categories: those that should be implemented immediately to stabilize the markets and those that would strengthen the ACA for the long term.

In the short term, the federal government must commit to reimbursing cost-sharing reductions for low-income marketplace enrollees, enforce the individual mandate penalties, increase funding for outreach and enrollment assistance, and reinstate the ACA's nongroup reinsurance as a permanent program.

In the long term, more action is needed to strengthen the marketplaces, expand coverage, reduce premiums and cost-sharing requirements, and encourage the broadest variety of insurers to participate. Consumer buying power and marketplace enrollment must increase. To fix structural problems in the nongroup market, the federal government could improve premium tax credits and cost-sharing reductions;

permit states to expand Medicaid to 100 percent of the federal poverty level, instead of 138 percent; fix the "family glitch"; eliminate non-ACA-compliant nongroup insurance products; and reverse current administrative decisions that hinder enrollment. The ACA should also emulate Medicare Advantage policies by changing the calculation of the benchmark premium to make the marketplaces more attractive to insurers, as well as capping provider payments to encourage nongroup insurer participation and reduce the pricing power of monopoly health systems. Standardizing nongroup insurance plans would also strengthen price competition.

Introduction

The ACA will continue to face legislative challenges, pending administrative policy decisions still threaten coverage and affordability, and fixable problems persist in many private nongroup insurance markets. Whether there is sufficient political will to address them is uncertain.

The ACA left Medicare and the employer insurance market largely as they were.¹ It expanded eligibility for Medicaid, and 31 states and the District of Columbia have taken advantage of that expansion. The ACA's greatest changes to private insurance apply to nongroup (individually purchased) insurance markets, and some of these changes have proven controversial and challenging to implement. Most of the complaints about the ACA circulated by political leaders and the media—escalating premiums,

high deductibles, counties at risk of losing all their insurers—concern the nongroup insurance market. This market has been problematic for insurers and consumers alike, both before and after the enactment of the ACA, and solving its problems will take significant political action.

Challenges of the Nongroup Market

The nongroup insurance market serves a mix of people including self-employed people, unemployed people, early retirees, and workers whose employers do not offer them insurance coverage. Some covered in this market are healthy young adults, but others have serious chronic illnesses.² Many more people are enrolled in nongroup coverage now than before 2014 because of the ACA's financial assistance, individual mandate, and prohibition on price and coverage discrimination against people with health problems.³ Still, the nongroup market constitutes a small share of Americans with health insurance, just 7 percent of the nonelderly population (younger than age 65).

Before the ACA's regulations took effect, young and healthy people could get low-cost coverage, and insurers could use benefit design, denials of coverage, and price discrimination to limit their risk. However, people with health problems often were excluded, and if they got coverage, their benefits generally were quite limited and cost-sharing requirements high. Furthermore, the nongroup market was small, about 4 percent of the nonelderly population.⁴

With the ACA's insurance regulations and premium and cost-sharing subsidies for people with modest incomes, the nongroup market has expanded significantly. These changes have lowered the health care costs of people with significant health needs while increasing costs for those who are very healthy (although the increased costs for the healthy are somewhat limited by premium tax credits). At the same time, insurers have been prohibited from denying coverage or setting higher premiums based on health status, must provide coverage for pre-existing health conditions, and must provide benefits that meet minimum federal standards. These strategies have gone a long way toward correcting the substantial problems in the nongroup market before 2014.

But these changes have created other challenges—namely, greater uncertainty for insurers, with risk that is harder to predict and manage. The individual mandate, subsidized coverage, and risk-adjustment strategies are all efforts to share the costs of high-need enrollees across the market; nonetheless, the nongroup market remains unattractive to many insurers. It is much smaller than Medicare or Medicaid and less capable of spreading risks fairly across insurers. With premium subsidies tied to the second-lowest-cost silver plan, competition for market share is intense and has dissuaded many insurers from remaining in the market. Finally, too many markets have too few insurers and/or providers. All these problems need to be solved to achieve a strong, sustainable nongroup market.

The Immediate Problem

Despite persistent structural challenges, analysts predicted that 2018 would bring lower premium growth and stronger insurer profitability in the nongroup market.^{5–7} But now the market faces considerable political uncertainty: Neither Congress nor the Trump administration has committed to paying cost-sharing reductions, and the administration has signaled that it does not intend to enforce the individual mandate penalties. Open

enrollment periods have been shortened, and federal outreach and enrollment funds will be cut (the administration announced a 40 percent cut in the Navigator program and a 90 percent cut in the ACA advertising effort).^{8,9} All these actions have caused more insurers to pull out of these markets or request large premium increases.^{10,11} Most recently, the Department of Health and Human Services announced that it will limit access to healthcare.gov every week during the 2018 open enrollment period, another action that will reduce coverage.

Immediate Policy Changes Needed to Stabilize Nongroup Markets in 2018

Four policies are immediately necessary as the first stage of strengthening nongroup insurance markets. First and foremost, the federal government must commit to reimbursing insurers on an ongoing basis for the cost-sharing reductions that insurers are required to provide to their low-income enrollees. Anything short of full commitment will lead to more insurer exits, higher premiums, and/or lower insurance coverage.¹² Second, clear enforcement of the individual mandate is necessary to increase coverage and stabilize the risk pool. Although the individual mandate is unpopular, there are no alternatives likely to be as effective.¹³ (In the next section, we suggest affordability improvements that would make the mandate less onerous, however). Third, investing more (not fewer) dollars in outreach and enrollment assistance will strengthen the markets by increasing the number of healthy enrollees who join the insurance market and the number of people who choose to maintain their current coverage. Fourth, permanently reinstating a government-funded reinsurance program for nongroup markets—like the one that was part of the ACA for three years, the one that is permanently part of Medicare Part D, and the ones proposed in the recent House and Senate repeal-and-replace bills—would lower premiums, reduce insurer risk in enrolling people with extremely high medical needs, and likely increase insurer participation in these markets.

More Must Be Done to Achieve Long-Term Success

Beyond these first four steps, more action is needed to strengthen the marketplaces for the long term, expand coverage further, reduce premiums and cost-sharing requirements, and encourage the broadest variety of insurers to participate. Although the ACA reduced the number of uninsured people by approximately 20 million by 2016 (according to the most recent estimates),^{3,14,15} an additional 5.7 million people are uninsured but eligible for Medicaid/CHIP, 4.8 million are uninsured but would be eligible for Medicaid if their state chose to expand eligibility, and 9.4 million are eligible to purchase coverage through the marketplaces (some with and some without subsidies).¹⁶ Even before the present political uncertainties, which are expected to significantly increase premiums in the private nongroup markets in 2018, 271 of 498 geographic rating areas had only one or two insurers selling marketplace coverage in 2017; these areas tend to be more sparsely populated but contain roughly one-third of the U.S. population. This lack of insurer competition is associated with higher benchmark premiums and higher growth rates in these areas.¹⁷ And the lack of provider competition in some areas, particularly rural areas, is associated with higher insurance premiums because it eliminates insurer negotiating leverage.¹⁸ The ACA has increased access, use, and affordability for many nonelderly adults and children,^{19–23} but people who rely on coverage in the nongroup insurance market—particularly those with incomes at 200 percent of FPL and higher—can still face high out-of-pocket costs (e.g., deductibles, co-insurance, out-of-pocket maximums) relative to their incomes.²⁴ This is especially problematic for people with substantial health care needs.

Strategies that increase the buying power of enrollees and increase enrollment would make participation more attractive to insurers. Policymakers also can learn from the Medicare Advantage and Medicare Part D markets to strengthen the ACA marketplaces. Medicare Advantage is a private insurance

marketplace that successfully competes with the traditional Medicare program, has high insurer participation, and is attracting a growing share of Medicare beneficiaries.

Strategies for Increasing the Affordability and Size of Nongroup Markets

Although the ACA has increased affordable access to adequate insurance, many Americans still face high health insurance premiums and out-of-pocket costs relative to their incomes. Affordability is the number-one reason people give for remaining uninsured.^{25,26} Improving affordability would increase coverage, reducing the number of people uninsured, and bring more healthy enrollees into the insurance pool, lowering average premiums. More enrollees make markets more appealing to insurers.

To attract uninsured consumers, additional financial assistance must be provided to lower premiums and cost-sharing requirements for nongroup coverage. This would not only reduce financial burdens but also boost enrollment, as people respond to lower premiums and more comprehensive coverage offerings. As we have suggested previously,^{27,28} premiums should be capped at lower percentages of income than they are in the current

schedule, and the schedule should extend to higher incomes, allowing the assistance to phase out without a cliff at 400 percent of the federal poverty level (FPL). Tying premium tax credits to the premiums of available gold (80 percent actuarial value) coverage instead of silver (70 percent actuarial value) plans would automatically lower out-of-pocket costs for all enrollees receiving tax credits, and cost-sharing subsidies could be increased for people with lower incomes.²⁹ We propose enhanced premium tax credit and cost-sharing reduction schedules, shown alongside the current-law schedules, in Table 1.³⁰

Other steps could be taken to make marketplace coverage available to a broader mix of people. Marketplace enrollment in Medicaid expansion states could increase if states were allowed to expand Medicaid eligibility to 100 percent of the federal poverty level, rather than 138 percent. People with incomes between 100 and 138 percent of FPL would move into marketplace coverage with enhanced premium tax credits and cost-sharing assistance (as shown in Table 1), increasing total marketplace enrollment.³¹ This approach could encourage more states to expand Medicaid eligibility, thereby reducing the substantial assistance gaps in those states and further reducing the number of uninsured.

Fixing the “family glitch” also would increase enrollment in the nongroup market. Under the current interpretation of the ACA, family members are excluded from enrolling in marketplace plans with tax credits if just one member of the family has access to employer-based, worker-only coverage that is deemed affordable (less than 8 percent of income). This can impose a large financial burden on the family because the cost of employer-based family coverage can still be very high relative to income. Fixing this glitch would lead to more families obtaining coverage through the marketplaces.

Regulation to eliminate non-ACA-compliant health plans would increase nongroup market enrollment and risk-pool stability. Noncompliant plans are currently still permitted and effectively discriminate against people with health problems. These plans operate outside the ACA’s uniform nongroup risk pool and enroll healthier people with low expected health care needs. These healthier people likely would enroll in the ACA’s nongroup markets if their short-term, limited-benefit, health status-rated plans did not exist. The Obama administration and some states placed limitations on the sale of these policies, but more must be done to curtail them.

Finally, administrative decisions must not hinder nongroup enrollment. For example, shortening the open enrollment

Table 1. Proposed Revisions to ACA Premium Tax Credits and Cost-Sharing Reductions

Income (% of FPL)	Premium Tax Credit Schedule: Household Premium as Percentage of Income		Cost-Sharing Reduction Schedule: AV of Plan Provided to Eligible Enrollees	
	2018 ACA Schedule: Pegged to Silver (70% AV) Premium, Indexed ^a (%)	Proposed Schedule: Pegged to Gold (80% AV) Premium, Not Indexed (%)	2018 ACA Schedule: Coverage Provided in a Silver Plan (%)	Proposed Schedule: Coverage Provided in a Gold Plan (%)
100-138	2.01	0-1.0	94	94
138-150	2.01-4.03	1.0-2.0	94	92
150-200	4.03-6.34	2.0-4.0	87	90
200-250	6.34-8.10	4.0-6.0	73	85
250-300	8.10-9.56	6.0-7.0	70	85
300-400	9.56	7.0-8.5	70	80
≥400	NA	8.5	70	80

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.

^a The 2018 ACA premium tax credit schedule can be found at <https://www.irs.gov/pub/irs-drop/rp-17-36.pdf>. Under the ACA, premium tax credits are indexed to change as a function of the increase in health care costs relative to general inflation. Our proposal would eliminate the indexing, keeping the percent-of-income caps fixed.

period and reducing hours of operation of healthcare.gov—as the current administration has done for plan year 2018—can only reduce the number of enrollees, weakening these markets. And any gains in reporting accuracy expected from additional documentation requirements for marketplace applicants ought to be carefully weighed against the hassle and barriers they cause, which could discourage enrollment.

Expanding Insurer Participation and Increasing Consumer Choice

Three additional policies should be adopted to strengthen the nongroup insurance market. The first would change the way the benchmark premium is calculated; this affects the size of nongroup premium tax credits, allowing people to choose from more plans without additional premium contributions. The second policy would cap the payment rates charged to nongroup insurers by health care providers, making it easier for insurers to enter new marketplaces and counteracting provider monopolies. The third policy would standardize the insurance options sold in the nongroup market, reducing the complexity of the enrollment process, improving comparability, and facilitating price competition.

Setting benchmark premiums. The strong price competition engendered by the ACA's reforms likely has caused some insurers to stay out of some markets. The ACA sets its premium tax credits based on the second-lowest premium silver plan in the enrollee's area of residence. Enrollees who choose a higher-priced plan are required to pay the full difference in the premium; this structure makes enrollees extremely price conscious. As we have shown elsewhere, enrollment is highly concentrated among the two lowest-priced plans.³² Thus, insurers have strong incentives to keep costs low, for example, by developing narrower provider networks or negotiating lower payment rates with a select group of hospitals and physicians. With little market share left for higher-premium options, insurers with broader provider networks or higher-cost structures do not find the nongroup marketplaces

sufficiently lucrative; this leads to insurer exits.

Competition in the Medicare Advantage market has been effective but considerably less intense than that in the ACA's marketplaces. The cost of the traditional Medicare fee-for-service program essentially sets the Medicare Advantage benchmark. Where traditional Medicare costs are very low, the benchmark is increased by 7.5 to 15.0 percent to make it easier for Medicare Advantage plans to participate. Where traditional Medicare costs are high, the benchmark is set to 95 percent of traditional Medicare costs. Insurers with costs above the benchmark must charge premiums to beneficiaries for the excess costs, and those with costs below the benchmark must either reduce premiums for beneficiaries and/or provide additional benefits.³³ Traditional Medicare also attracts a higher-risk population than Medicare Advantage plans do on average; because traditional Medicare is not risk adjusted with the other plans, using the traditional plan as the premium benchmark makes the market more lucrative for Advantage plans.³⁴

Although the marketplaces currently do not have a benchmark public plan, the marketplace benchmark premium could be computed differently to allow more insurers to achieve enough market share to participate. For example, the marketplace benchmark premium could be set to the median premium or to the higher of the median and the second-lowest premium available, instead of to the second-lowest-cost option as it is now. This change likely would allow insurers to make more plans, including those with broader provider networks, available with no additional out-of-pocket premium. This approach to determining the benchmark premium would increase federal costs initially, but as more competitors join the market, it could lower the premium growth rate relative to that in markets with one or two insurers, which are associated with higher premiums today. In principle, if a monopoly insurer charges extremely high premiums, other insurers could enter these markets and bring down premiums; in practice,

we have not seen this dynamic. But computing the benchmark premium as we have proposed could provide the incentive necessary to increase insurer participation and plan choice, potentially decreasing premium growth over time.

Capping provider payment rates. Another Medicare Advantage policy that could be adapted to ACA nongroup markets is its limit on balance billing of beneficiaries. Medicare Advantage enrollees treated by non-network providers cannot be charged more than traditional Medicare payment rates by those providers. This policy limits non-network providers' negotiating leverage and allows Medicare Advantage plans to provide non-network coverage to their enrollees at reasonable rates. The approach could be adapted to the private nongroup market by capping both in-network and non-network provider payment rates under nongroup plans at, for example, traditional Medicare rates plus a fixed percentage. Virtually all providers accept Medicare rates, so they would be likely to accept rates somewhat higher than Medicare's, especially because the nongroup market constitutes a small percentage of patients.

These caps would address two significant problems, one or both of which exist in virtually all nongroup markets with high 2017 premiums: insurer concentration and provider consolidation. Where one or even two insurers control a market, an insurer has little to no incentive to negotiate with providers for lower payment rates. Where a single provider system dominates the market, even motivated insurers have no leverage to negotiate lower rates; if the insurer does not pay the rates demanded by providers, it will not have a network to care for enrollees in that area. Capping payment rates not only would decrease premiums in these highly consolidated markets, but it also likely would increase insurer participation in these markets. It is extremely difficult for an insurer to enter a new market if it has no market share and thus no leverage to negotiate competitive payment rates with providers. With caps in place, new insurers can enter a market, pay reasonable payment rates to providers, and thus set

reasonable premiums, enabling them to gain a foothold in the area.

Standardizing benefit design. ACA-compliant nongroup insurers can offer multiple plans at each metal level, but some states limit the number and sometimes the structure of options each insurer is permitted to offer.³⁵ When insurers offer multiple plans at the silver level, for example, they vary deductibles, co-insurance, co-payments, and out-of-pocket limits but stay within the same allowed band around 70 percent actuarial value. These variations can be confusing to consumers as they try to compare plans on the multiple axes of premiums, benefits,³⁶ and cost-sharing requirements, and this confusion weakens price competition in the market. Sometimes all the lowest-cost plans are offered by the same insurer but with a slightly different mix of cost-sharing provisions. Other insurers may have premiums above the premium tax credit benchmark, meaning enrollees have to pay more out of pocket to enroll in coverage with a different insurer.

To increase price competition, cost-sharing could be standardized at each

metal tier. This is the approach taken by California, which has relatively low premiums and high insurer participation.³⁷ For example, in 2018, the California silver-level medical deductible will be \$2,500, the prescription drug deductible \$130, and the out-of-pocket limit \$7,000.³⁸ If all states adopted such a policy, each insurer would offer only one plan at each metal tier, and every plan on that tier would have the same set of cost-sharing requirements. This approach would make it easier for individuals to compare offerings from different insurers, and competition would be clearly based on price, breadth of provider network, and customer service; it would not be complicated by arcane variations in cost-sharing provisions. The resulting increase in competition could significantly slow premium growth.

Conclusion

Some of the policies proposed here would increase costs at least initially, for example, by increasing tax credits and cost-sharing reductions and loosening the computation of the marketplace benchmark premium. Other policies would lower costs, for example, by capping provider payment rates,

standardizing insurance packages sold in the nongroup insurance market, and limiting sales of noncompliant nongroup policies. In 2015, we estimated the cost of a similar mix of reforms to be 0.20 to 0.24 percent of GDP.²⁸ Taken together, the approaches delineated here hold considerable promise for stabilizing nongroup insurance markets, reducing the average health care risk of enrollees (and their premiums), increasing the number of participating insurers, reducing costs in high-premium areas, and further reducing the number of uninsured. The bottom line is that nongroup insurance markets must become larger, less expensive for consumers both in premiums and out-of-pocket costs, and less financially risky for insurers. The ACA has made significant strides in reducing the number of uninsured, improving affordability, and increasing access to meaningful coverage for people with health problems. But significant problems, particularly in the reformed private nongroup markets, remain. These problems are fixable with a cohesive set of policies, many of which have been successfully implemented in other contexts and have enjoyed bipartisan support.

NOTES

- 1 The ACA did make some changes to Medicare, such as providing a new preventive care benefit with no cost-sharing and closing the prescription drug benefit “doughnut hole.” But the program’s eligibility rules and general structure were left unchanged. There were also some changes to employer-sponsored insurance. Regulatory changes to small employer plans were more significant than changes to large employer coverage, but administrative decisions have delayed their full effect in many markets to date.
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