Individual health insurance exchanges: What we know, what we don't know, and looking ahead to 2015

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The passage of the Patient Protection and Affordable Care Act (ACA) was a major moment for the health insurance industry. It aimed to create mechanisms for purchasing insurance, add vast populations to the ranks of the insured, and institute complex new regulatory layers. Insurers in the individual market faced a heady mix of opportunity and risk as they sallied forth toward participation in state and federal health exchanges.

With the vast machinery of ACA lurching into motion and exchanges open for business (albeit somewhat intermittently), many insurers are eager for the day when they can base their rates on hard data rather than abstractions. It is possible to gain insights from existing data such as insurer participation, participant enrollment levels, and limited claims data. At the same time, it is important to recognize that even 2015 (or 2016 given the recent announcements delaying portions of the law) will still be early days for the exchanges, and it will be several years before insurers have the claim data they are accustomed to.

WHAT WE KNOW: FEWER INSURERS THAN EXPECTED ON THE EXCHANGES

One goal of ACA was to get multiple carriers on the exchanges, increasing competition in some states and thereby—hopefully—driving premiums down. According to a report by the Kaiser Family Foundation[1] detailing information released by 18 states, insurer participation in the individual exchanges varies widely. New York tops the list with 16 participating insurers, and four states have more than 10 insurers. Of course, exchanges are not the whole story, and levels of competition have always varied from state to state.

However, given that increasing competition is an explicit goal of the ACA, a significant number of reporting states have limited consumer choice in 2014, at the time this article was published.

Maine, Rhode Island, and Vermont have only two participating carriers each, while Connecticut, Montana, and South Dakota each have only three. Population may be a factor in this divide: Five of those states are among the 10 least populated in the country. Additionally, some large, national insurers decided not to participate in some states. The goal was to decrease premiums by increasing the number of carriers, thereby increasing competition.

The ACA may not have reduced the number of carriers from pre-ACA levels; however, lower-than-expected insurer participation in the exchanges is likely to limit the impact of competition on premiums.

FIGURE 1: INSURER PARTICIPATION IN EXCHANGES, 2014

	STATEWIDE	RATING AREA OF LARGEST CITY		
STATE	NUMBER OF INSURERS	NUMBER OF INSURERS	NUMBER OF SILVER PLANS	NUMBER OF BRONZE PLANS
CA	12	6	8	9
CO	10	10	53	43
CT	3	3	4	8
DC	4	4	10	11
IN	4	2*	8*	15*
MD	6	6	N/A	N/A
ME	2	2	11	7
MT	3	3	8	6
NE	4	4	14	22
NM	5	5	8	7
NY	16	11	N/A	N/A
OH	12	10	30	27
OR	11	10	32	27
RI	2	2	4	3
SD	3	3	24	6
VA	9	7	15*	20*
VT	2	2	6	6
WA	4*	4*	11*	11*

Source: Kaiser Family Foundation
**Plan information not available for certain insurers. See methods for details.*

1 Cox, et al. "An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014." Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf.

In contrast to this overall trend, several states do have new carriers entering the market. For the most part, these carriers can be divided into three general types. First, there are plans that can be described as "startups." These privately funded endeavors view the ACA as an opportunity to profit through innovation. Second, there are plans sponsored by large existing healthcare providers such as hospital networks. Seeing that the ACA would require them to take on significant risk in their contracting with insurers, they have in some cases decided to form their own insurance companies to manage that risk while retaining market share. Third, some managed Medicaid insurers are entering the market to attract and retain the lower-income individuals they are already accustomed to managing. Although they are a relatively small part of the market, these three groups could have an impact larger than one would predict given their small share.

WHAT WE KNOW: RATES MAY BE ARTIFICIALLY LOW IN 2014

The fact that exchange premiums came in lower than expected (although in many cases higher than those of pre-reform plans after adjustments for trend) made major headlines when it was announced. Some of this may have been due to pressure from state regulators to keep premiums low. However, most insurers tried to set rates to attract as many people as possible to their plans in the hopes of maximizing revenue while still covering claim costs. Companies targeting the subsidized market have an additional incentive to keep premiums as low as possible to bring in a larger proportion of lower-income individuals eligible for a subsidy. However, a closer look at the premiums and the market forces that could impact the company's financial results calls into question how long these low premiums might last.

For context, look at the figures below prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), which advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development. These figures compare pre-implementation premium estimates from the Congressional Budget Office (CBO) to the average of actual individual market premiums reported in 11 states for a given plan level. They also compare the CBO figure to the average across all 11 states. Figure 2 shows the lowest-cost silver plan, while Figure 3 shows the second lowest-cost silver plan.

FIGURE 2: COMPARISON OF ASPE-DERIVED CBO 2014 PREMIUM ESTIMATE TO INDIVIDUAL MARKET LOWEST-COST ISSUER'S SILVER PREMIUM, WEIGHTED BY 2014 EXPECTED INDIVIDUAL MARKET AGE DISTRIBUTION

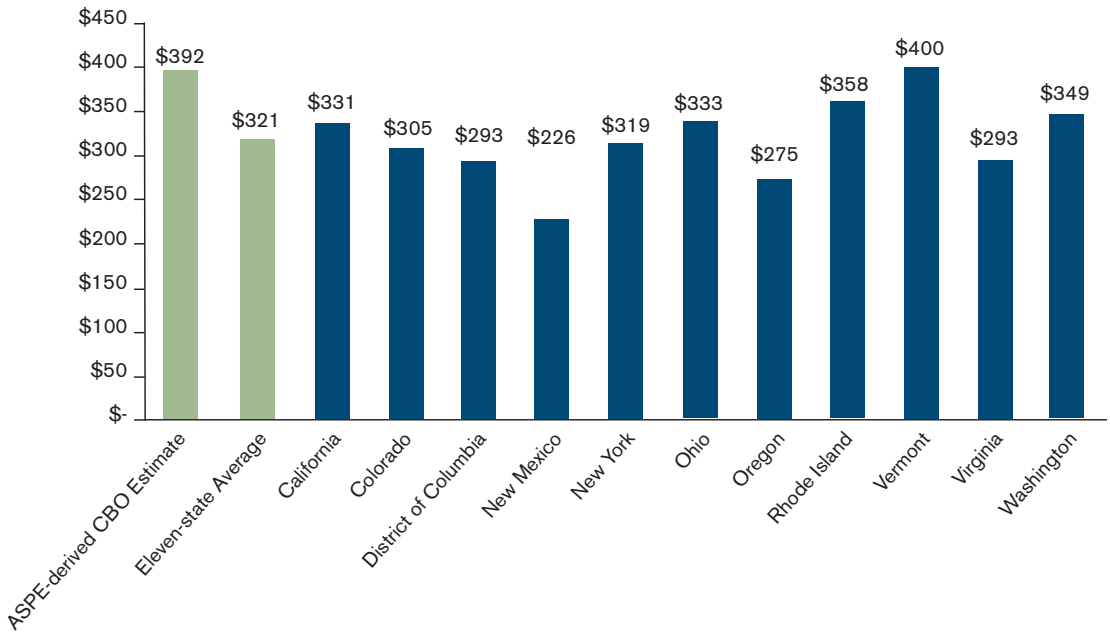
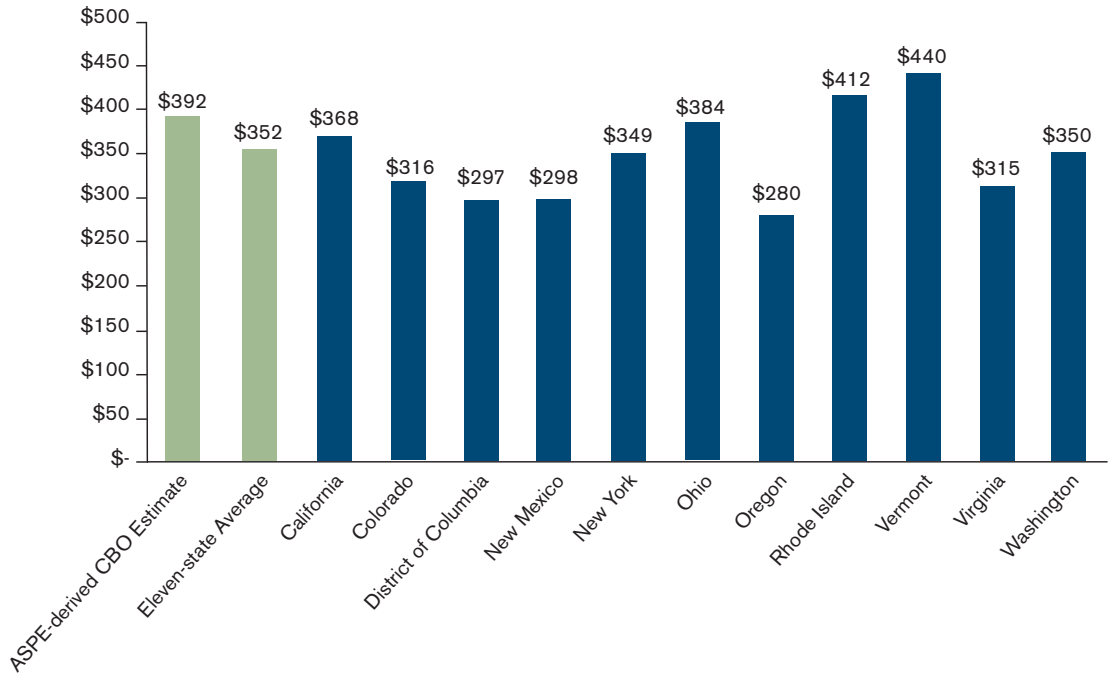


FIGURE 3: COMPARISON OF ASPE-DERIVED CBO 2014 PREMIUM ESTIMATE TO INDIVIDUAL MARKET SECOND-LOWEST-COST ISSUER'S SILVER PREMIUM, WEIGHTED BY 2014 EXPECTED INDIVIDUAL MARKET AGE DISTRIBUTION



The figures reveal significant variation among states. The state with the lowest average price for a silver plan is New Mexico, while the highest average price is in Vermont. It is possible that lack of competition has something to do with these numbers, as New Mexico has five carriers participating in the individual market exchange while Vermont has only two. Regardless, it is unlikely that claims costs vary as much as premiums. As such, we predict that some carriers will need to modify premiums significantly in future years to achieve their financial goals.

Pre-ACA regulations may also have influenced rate-setting. In the absence of experience with new populations, insurers were forced to use past experience as the basis for pricing. In states where community rating was already the norm, that experience may have been more relevant to a post-ACA world (with some adjustments still needed for the individual mandate), while states in which medical underwriting was permitted may be more difficult to price going forward in an adjusted community-rated market.

Finally, there are programmatic features of the ACA affecting 2014 rates, including risk adjustment and transitional reinsurance. Risk adjustment transfers funds from insurers with low-risk populations to insurers with high-risk populations. Before risk adjustment, insurers would file rates based on the population they attracted. State-level risk adjustment means that companies will file rates based on average claim costs for a given market across the entire state. Individual market rates for 2014 also reflect the impact of transitional reinsurance, a program designed to help prevent rate shock in the event that insurers experience higher-than-expected claim costs. However, as transitional reinsurance is phased out in 2015 and 2016, individual market rates will have to increase to cover the additional costs.

WHAT WE KNOW: THE MEDICAID GAP

The ACA includes a federally-subsidized expansion of state Medicaid programs. This expansion was intended to cover individuals whose incomes are not low enough to qualify for pre-ACA Medicaid nor high enough to qualify for subsidies on exchange policies. However, after the Supreme Court ruled that the federal government could not force states to expand Medicaid, a large number—22 in all—chose not to expand Medicaid funding or eligibility beyond current levels. In the absence of federal or state policy changes, this will leave a substantial group of people without access to the more affordable care they would have received under expanded Medicaid programs.

There is not yet a definitive answer to this "Medicaid gap," but there are several possible outcomes. Arkansas, for example, has requested a waiver to allow this uncovered Medicaid expansion population to purchase insurance on the exchange. However, while this solves the problem of providing coverage to these individuals, it changes the risk profile of that individual exchange pool, which has an impact on the premium rates charged within the exchange. On September 20, 2013, HHS proposed a rule that would enable states to create a Basic Health Program to cover the individuals that do not meet qualifications for Medicaid or exchange subsidies, but implementation of this program has been delayed until 2015.

WHAT WILL WE KNOW WHEN SETTING RATES FOR 2015

Given all the uncertainty surrounding rates in 2014, insurers are understandably looking forward to a year when they have more data on which to base major business decisions. Insurers will not have as much data as they'd like when the 2015 rating process begins next spring, but by then there will be a few key data points that insurers can use to adjust their strategy.

First, insurers in all states will know what their competitors' 2014 premium rates and benefit plan designs were. This will provide insight into the strategies at play and enable an insurer to adjust its own based on what the rest of the market is doing. For example, it may discover that a majority of its competitors were focused on driving rates down to maximize enrollment.

Insurers will also know what enrollment levels were during the 2014 open enrollment period. They will have a good sense of how well they met their enrollment targets, enabling them to adjust premiums to help control growth rates. If they can determine where the enrollees received their coverage (if any) prior to enrollment, this may enable them to determine whether the demographics of the new members matched their predictions and adjust their models accordingly. Additionally, they may be able to better understand the impact of state-level decisions (such as declining to expand Medicaid) on enrollment.

The best data for setting rates, of course, is claim experience. Unfortunately, by the time the season for setting 2015 rates rolls around, insurers will only have about three months of claim data to look at. Prescription data will probably be the best choice because it is processed fastest and is less subject to the vagaries of coding. Obviously, an insurer will have more claim data on customers who have been with that insurer before ACA came to pass, but this information should be considered in light of additional features in ACA plans that could affect utilization and cost.

STRATEGIES FOR SUCCESS IN 2015

No matter how much data is available, there are several strategies that any insurer can use to set competitive rates and maximize its chances of success in 2015 and beyond. Because plans are compared to other plans across the state, insurers need to actively manage their risk scores. This includes ensuring that coding accuracy is equal to or better than that of other plans. Under the tighter rules of the ACA, all participating insurers need to control expenses, especially administrative expenses, due to limits on medical loss ratios. Another cost-control measure available to insurers is to use limited provider networks. Finally, any plan targeting the subsidy population must price a plan at or close to the second-lowest-priced silver plan in the region.

In a sense, the ACA "resets" the insurance market by suddenly adding a major new population. Because of this, it will be several years before insurers have the claims data they are accustomed to. That makes it all the more critical for them to maximize the tools at their disposal.

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