

Timely Analysis of Immediate Health Policy Issues

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Summary

Despite improvements in recent weeks, the controversial launch of the HealthCare.gov website and the government's response to the furor over policy cancellations raise the likelihood of low enrollment levels in the Health Insurance Marketplaces' first year of operation. This could increase the chances of adverse selection—the disproportionate enrollment of higher cost individuals. The concern is that, if it were to occur, adverse selection would lead to higher premiums and government spending and the long-term destabilization of the nongroup Marketplaces. In this brief we argue that the Affordable Care Act (ACA) is unlikely to suffer long-term damage even if the Marketplaces experience low enrollment and some adverse selection in the first year.

First, some adverse selection in the early years of implementation was anticipated by policy-makers. Policies put in place under the law to account for this possibility, such as risk corridors and risk adjustment, will provide insurers with some significant financial protections. Second, low enrollment does not necessarily mean adverse selection. Components of the ACA, such as financial assistance for the low-income (who are disproportionately young adults) and lower premiums for young adults than older adults

(due to age rating), will tend to increase enrollment among the healthier populations. Third, while insurers may experience some losses in 2014 if adverse selection occurs, market competition will make it difficult for them to recoup those losses in 2015 by increasing premiums substantially. If enrollment grows throughout 2014 as technical problems are overcome and outreach efforts continue, leading over time to a broader mix of health care risks enters the Marketplaces, then competitive pressures are likely to dissuade insurers from ratcheting up premiums. In a competitive market, insurers must set premiums for 2015 based on expected enrollment in 2015, not based on any losses that occurred in 2014. Simply put, insurers cannot recoup losses without achieving significant market share, and achieving market share requires that they price their products competitively for expected enrollees in the coming year.

So while the troubled launch of the ACA's Marketplaces clearly undermined early enrollment, website improvements, policy strategies already in place, enrollment incentives, and competitive pressures in insurance markets are likely to blunt the implications in 2015 and beyond of this difficult start.

The Problem of Low Enrollment

News in the last weeks of dramatic improvements in the HealthCare.gov website have increased the chances that enrollment in the new Health Insurance Marketplaces (HIMs)—also known as Exchanges—will reach initial projections. But technical and other implementation obstacles could still materialize that may result in low 2014 HIM enrollment. These concerns combine with early renewals of 2014 policies and the ongoing policy debate over whether to allow individuals with prior nongroup insurance policies to maintain them through 2014. The issue we address is whether low enrollment, particularly among the healthy (and the

higher-than-average costs associated with it) would lead to adverse selection (i.e., the enrollment of a disproportionately high-cost population) and much higher premiums, thus destabilizing the nongroup market and compromising the broader-based sharing of health care risks intended under the law.

While the circumstances surrounding the introduction of the HIMs have been far from ideal, there are several compelling reasons to expect that the future size, stability, and cost of HIM-based nongroup health insurance will hit previously estimated targets. The stability and sustainability of the insurance pool of individuals covered through the HIMs depend on much more than a simple count

of the number of young adults enrolled since there are several provisions of the law that support the health of the pool. However, further policy action that would undermine the integrity of the nongroup insurance risk pool (e.g., allowing people to maintain cancelled policies indefinitely or allowing new enrollees to purchase plans not complying with the Affordable Care Act's standards) could overwhelm the protections in place.

Premiums for 2014 Are Already Set

The average health care costs in 2014 for those covered through the HIMs may in fact be higher than anticipated if enrollment



difficulties persist beyond the end of 2013 and if policy changes permit continuation of prior nongroup coverage that does not meet the ACA's standards through 2014 (as was proposed by President Obama on November 14, 2013). However, health insurance plans and premiums that meet the new standards set under the Affordable Care Act (ACA) have already been filed with state Departments of Insurance. Thus, these premiums cannot be changed and they will apply to all coverage sold for the 2014 plan year.

Affordable premiums have been filed by insurers in most areas throughout the country. While some areas have seen high premiums, competitive pressures heightened by the ACA, including greater transparency of plan offerings and prices, increased comparability of plans, and incentives to be one of the two lowest priced plans in an area (the second lowest cost plan is the one to which federal financial assistance is targeted) have led to many plans setting premiums at lower-than-anticipated levels. These premiums and plan options will continue to be available in 2014, even in the event of lower-than-expected enrollment and insurer concerns that those enrolling may be older and more costly than predicted.

Fewer Enrollees Than Expected Would Lower Government Subsidy Costs in Aggregate

Low enrollment in subsidized HIM plans in 2014 would mean that the federal government would spend less on financial subsidies for HIM-based enrollees than budgeted. If there is significant adverse selection into the HIM-based plans, the federal subsidy cost per person receiving a subsidy would be higher than anticipated due to premiums being higher; however, in aggregate, government spending would be lower. Households enrolling in plans would face the same prices as they would have otherwise, but fewer Americans would newly obtain insurance because of the technical problems, so the number of uninsured would not fall to the degree previously estimated by the Congressional Budget Office.¹

Components of the Law Provide Some Compensation to Insurers for First Year Adverse Selection that May Occur

Policy-makers anticipated that the first few years of the ACA's implementation might generate low enrollment, with consumers requiring additional time to understand the law's requirements, learn about the new insurance options and financial assistance, explore specific plan options in their area, and decide to participate. Policy-makers also recognized that during a period of phasing-in participation, those most likely to anticipate using medical care are those most likely to enroll in new plans that guarantee issue, include essential health benefits, prohibit premium rating based on health status, and prohibit coverage exclusions of pre-existing conditions. In other words, adverse selection into the new ACA-compliant plans during the initial period was anticipated in the law. Thus, the ACA includes two temporary programs expressly designed to provide financial protection to nongroup insurers during the first three years of implementation: risk corridors and reinsurance.

Risk Corridors. During the 2014 to 2016 period, the federal temporary risk corridor program will redistribute funds from HIM-based qualified health plans with lower-than-expected costs to those with higher-than-expected costs. This program is intended to increase stability in the HIMs during implementation of the new reforms. Essentially, it is a risk-sharing program between qualified health plans and the federal government, designed to mitigate the uncertainty associated with the enrollment characteristics of early participants in HIM-based plans. And, importantly, while carriers experiencing lower-than-expected costs (i.e., those that experience favorable selection) are required to pay *into* the program, there is no requirement in the law that the program be revenue neutral. This means that if a preponderance of qualified health plans enroll higher-cost individuals than expected, the federal government will pay all of them consistent with the formulas delineated.

Under the risk corridors, a plan's allowable costs are compared to its target (insurer anticipated) amount. A plan's allowable costs include claims made in addition to adjustments for temporary reinsurance payments and risk adjustment payments, as well as spending on quality and health information technology.² If the ratio of allowable claims costs exceeds or falls below the target amount by 3 percent, the plan's associated losses or gains are internalized by the insurer itself. However, half of a plan's actual costs exceeding its targeted amount by 3 percent to 8 percent are reimbursed by the program, and 80 percent of a plan's costs exceeding the targeted amount by more than 8 percent are reimbursed by the program.³ In parallel, plan costs falling below the targeted amount require plans to pay into the program at identical rates.

Thus, in the case of significant adverse selection in HIM-based qualified health plans, the risk corridor program will reimburse plans for substantial shares of losses associated with higher actual claims relative to claims that were estimated to occur when premiums were set. The program will not reimburse plans for all of these types of losses, but it does create a significant level of protection. Also, Congress could choose to make the temporary risk corridors more protective by increasing the share of unexpected expenses reimbursed by the program (e.g., increasing the first level of reimbursement above 50 percent and/or increasing the second level above 80 percent).

Reinsurance. The ACA also provides for a temporary reinsurance program to operate from 2014 through 2016 in all states. The program will impose assessments on insured and self-insured group health plans, distributing the funds to non-grandfathered individual health insurance plans that insure high-risk people. The objective is to stabilize costs in the individual insurance market in the transition period following implementation of insurance market reforms that will significantly improve access to insurance for people with substantial health expenses. The federal approach sets a \$60,000 attachment point—that is, the level of individual incurred

medical expenses above which reinsurance funds will be made available. There is then an 80 percent coinsurance rate, or the share of medical expenses for which the insurer will be reimbursed above the attachment point, and a \$250,000 cap, above which no reinsurance payments will be made. The federal assessment on group plans is \$5.25 per enrollee per month in 2014. In aggregate, \$10 billion (an amount set in the law) is expected to be collected in 2014 from insurers and third-party administrators running self-insured plans to fund the program; the program funds will fall to \$6 billion in 2015 and \$4 billion in 2016.

If enrollment in nongroup plans is lower than expected in 2014, there will be more funds collected from group insurance plans per nongroup enrollee than was originally anticipated. Therefore, there may be some room to loosen the reinsurance parameters set in regulation and provide insurers enrolling higher-cost individuals with even more assistance than had been planned. This could be done, for example, by increasing the reinsurance cap, lowering the individual attachment point, or increasing the coinsurance rate. Also, more federal dollars could be invested in making the program more generous to insurers in these ways.

Low Enrollment Under the ACA Does Not Automatically Lead to Adverse Selection

While economic and actuarial models predict that, all else being equal, individuals most likely to enroll in health insurance coverage are those with higher anticipated medical needs, other considerations specific to the ACA may work in the opposite direction. Primary among these are the financial subsidies for purchasing private nongroup coverage through the HIMs. Under the law, the premium paid by low-income individuals and families for the second lowest cost silver plan in their area is capped at a percentage of their income. This cap increases with higher incomes, so a person or family with income at 138 percent of the federal poverty level would pay no more than 3 percent of income for the plan, whereas those with income of 300 percent

to 400 percent of the federal poverty level would pay no more than 9.5 percent of income for the same plan.

There is a strong correlation between age and income. For example, in the third quarter of 2013, median weekly earnings by 20- to 24-year-old workers were \$454, roughly half the median for 55- to 64-year-old workers of \$893.⁴ Also, young adults are significantly less likely to have offers of employer-based health insurance than are their older counterparts. Taken together, young adults are more likely to qualify for subsidized coverage for HIM-based plans and will tend to qualify for larger subsidies because of their lower incomes. Also, because of the law's allowance of insurers to charge a 64-year-old up to three times the premium of the youngest adult for the same coverage, unsubsidized insurance in HIM plans is significantly less expensive for young adults than it is for older adults. These circumstances will tend to increase the likelihood of participation by young adults relative to older adults.

Young adults are also more likely to be facile with internet-based interfaces, and may be less intimidated by interactions with the HIM technology than older adults. Also, the continued presence of the individual responsibility requirement (i.e., the individual mandate) increases the likelihood that all individuals, regardless of age, will obtain qualifying insurance coverage.⁵

This is to say that substantial adverse selection in HIM-based plans is not a foregone conclusion, but a phenomenon that must be monitored and measured.

Insurers May Not Be Able to Recoup 2014 Losses in 2015

If significant adverse selection occurs in HIM-based nongroup insurance plans in 2014 and the ACA's compensatory strategies (i.e., risk corridors and reinsurance) prove insufficient to offset sizable losses by insurers, some have predicted that the insurers will increase premiums a great deal in 2015 to recoup their 2014 losses. The argument is that such sizable premium increases (were

they to occur) could lead to higher-than-anticipated federal subsidy costs in 2015, lower participation by individuals and families, a consequent escalation in adverse selection, and a destabilization of the new marketplaces. However, this vision of the implications of 2014 adverse selection for 2015 and beyond ignores the competitive pressures on insurers in many markets and the importance of federal financial assistance.

It is reasonable to expect that HealthCare.gov and the state websites that have experienced technical challenges since their October launch will be functioning effectively by the middle of 2014. In such a case, future enrollment will be considerably easier, information about plan options and financial assistance will be more broadly disseminated, and all of the factors that insurers and analysts originally predicted would attract a sizable and heterogeneous population to enroll in the nongroup plans would be in place. Many applicants for HIM-based coverage will qualify for subsidies which limit their premium contributions as a percentage of income, regardless of the full premium cost, which will draw in enrollees of all health statuses, as had been predicted previously. Also, the financial penalties associated with the ACA's individual responsibility requirement to obtain coverage increase in subsequent years, which will tend to increase enrollment among healthier individuals over time.

Thus, insurers that increase 2015 premiums because of the 2014 experience as opposed to the coming year's expected enrollment and medical expenses could put themselves at a competitive disadvantage in gaining market share and a strong foothold in the type of market in which they had intended to compete. Bidding high makes a plan less likely to be the second lowest cost plan in an area, which means that enrollees would be required to pay more for that coverage than the percent of income cap provided for by the federal subsidies. This would decrease plan enrollment and hurt profits. Insurers presumably do not look at their business over a two-year horizon where any year's shortfalls must be made-up in the following year; they cannot recoup

losses if they have no market share, so they must make decisions for the longer term. Insurers need to develop strategies based on their expectations for the 2015 market and their ability to attract large numbers of and desirable types of customers. In particular, young and healthy enrollees will be more likely to enroll in HIMs in the second year, and an insurer that prices too high will drive those preferred enrollees to other plans that do not.

However, insurance markets dominated by one or two insurers may be able to pass 2014 losses forward into 2015 premiums due to a lack of competitive pressure. Although, even in those markets, subsidies will limit the effect of such increases on many households, allowing a heterogeneous mix of individuals and families to obtain affordable coverage

as the website, outreach, and enrollment processes improve. Thus, the effects of adverse selection in 2014 on future premiums and the future risk pool could dissipate rather quickly, allowing the market to reach equilibrium with a representative set of health care risks within a reasonably short period of time.

Conclusion

The troubled launch of the ACA's Marketplaces clearly undermined enrollment, however, improvements to the website suggest dramatic improvements have been made. But some technical problems and other implementation challenges may persist and, as a result, dampen first year enrollment. Moreover, large numbers of renewals in nongroup insurance plans held in 2013, perhaps

increased by President Obama's recent proposal, could also result in enrollment levels substantially lower than the Congressional Budget Office's projections. Lower enrollment in the Health Insurance Marketplaces and other ACA compliant nongroup insurance plans may mean a higher average cost population than anticipated as well. However, neither of these potential circumstances is likely to affect the long term viability of the reforms or to substantially affect the nongroup premiums faced by consumers in future years. Provisions in the law that offset the effects of adverse selection in the first three years of implementation, financial subsidies structured as caps on the share of income devoted to premiums, and competitive pressures in insurance markets would blunt the implications in 2015 and beyond of this difficult start.

Notes

- ¹ CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. Washington: Congressional Budget Office, 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCare-ActHealthInsuranceCoverage_2.pdf
- ² Allowable administrative costs are set consistent with the law's medical loss ratio (MLR) requirements. If a plan has received payments from the reinsurance program or risk adjustment, allowable costs for the risk corridor program net out these payments to avoid double-counting.
- ³ Winkelman R, Peper J, Holland P, et al. "Analysis of HHS Final Rules on Reinsurance, Risk Corridors and Risk Adjustment." State Health Reform Assistance Network Research Brief. Princeton, NJ: Robert Wood Johnson Foundation, 2012. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72568.
- ⁴ "Usual Weekly Earnings of Wage and Salary Workers, Third Quarter 2013." News release, November 1. Washington: U.S. Bureau of Labor Statistics, 2013. <http://www.bls.gov/news.release/pdf/wkyeng.pdf>.
- ⁵ Buettgens M and Carroll C. *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care*. Washington, DC: The Urban Institute, 2012. <http://www.urban.org/publications/412480.html>.

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