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Implementing the Affordable Care Act: Promoting Competition in the Individual Marketplaces

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Abstract A main goal of the Affordable Care Act is to provide Americans with access to affordable coverage in the individual market, achieved in part by promoting competition among insurers on premium price and value. One primary mechanism for meeting that goal is the establishment of new individual health insurance marketplaces where consumers can shop for, compare, and purchase plans, with subsidies if they are eligible. In this issue brief, we explore how the Affordable Care Act is influencing competition in the individual marketplaces in four states—Kansas, Nevada, Rhode Island, and Washington. Strategies include: educating consumers and providing coverage information in one place to ease decision-making; promoting competition among insurers; and ensuring a level playing field for premium rate development through the rate review process.

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BACKGROUND

Prior to the passage of the Affordable Care Act, consumers who bought coverage in the individual market faced a host of issues. Insurers could refuse to issue a policy if an individual had a specific health condition or could exclude coverage of a condition. For many people, premiums were prohibitively expensive because rates varied based on an individual's health status, age, and other factors, with average yearly premium increases of 10.8 percent nationally from 2008 to 2010.[1] Now, insurers offering coverage in the individual market must offer coverage to all individuals regardless of health status, and may only vary premiums based on age, family size, geographic location, and tobacco use. In addition to a number of other consumer protections, the Affordable Care Act also established the new individual health insurance marketplaces where consumers can shop for, compare, and purchase plans, with subsidies if they are eligible.

The law encourages insurers in the individual market to compete in a variety of ways. For instance, to obtain federal subsidies, eligible

consumers must purchase coverage through the marketplaces. This provides an incentive for insurers who want to gain access to those potential customers to offer marketplace coverage. Additionally, the tax credits offered are based on a benchmark plan—that is, the second-lowest-cost silver plan available on the marketplace—and consumers shop for plans by comparing the benchmark plan to other plans. This ability to comparison shop encourages insurers to compete on price and value. Finally, as a safeguard against unreasonable premium hikes, the states are required to review premium rate increases to ensure that such increases are reasonable.[2]

Early indications suggest that the Affordable Care Act's approach to developing a competitive environment in the individual marketplaces is working. A national survey found that the number of insurers offering health insurance coverage through the marketplaces increased from 2014 to 2015.[3] In addition, there was generally no increase in average premiums for marketplace plans from 2014 to 2015, including the average benchmark premium.[4] Finally, although not the focus of this study, recent analysis suggests only a modest increase in average premiums for lowest-cost silver plans from 2015 to 2016.[5]

This issue brief explores some of the ways in which the Affordable Care Act is influencing competition in the individual marketplaces in four states are promoting competition: educating consumers and providing coverage information in one place to ease decision-making; encouraging insurer participation; and ensuring a level playing field through the rate review process.

METHODS

We conducted interviews with stakeholders in Kansas, Nevada, Rhode Island, and Washington, based on the following criteria: insurers offering silver plans at or below the national monthly premium average of $314, premium increases from 2014 to 2015 of 1 percent or less for such plans, and at least one new insurer offering coverage on the marketplace in 2015.[6] These four states are also geographically diverse and have different individual marketplace models (i.e., federally facilitated vs. state-based). Stakeholders included representatives from insurers participating in the marketplaces, senior officials from the state departments of insurance, and senior staff members at the state-based marketplaces. Between January and March 2015, we conducted 15 interviews using standard protocol questions developed for this issue brief.[7]

FINDINGS

Marketplaces Promote Price Competition Through Comparison Shopping

One way the marketplaces encourage competition among insurers is by providing information to consumers—allowing them to see their coverage options in one place and make educated decisions. State officials and insurers in all four states said that the marketplaces have made progress toward this goal by providing a platform to make it easier to compare and purchase plans. Stakeholders across the study states suggested that the marketplaces have been most adept at promoting competition based on price.[8] One insurer noted that the marketplace has forced carriers to be more strategic from a pricing perspective when it comes to setting rates because consumers now can use the shopping portal to

quickly hone in on plans with low premiums.[9] However, insurers and state officials cautioned that shopping based solely on price has its limitations. Regulators and insurers consistently stated that consumers should consider other factors, including quality, cost-sharing structures, and provider networks. However, this information is not as easily comparable (or in some cases, not yet available) through the marketplace. For example, one insurer noted the importance of distinguishing innovative plans that may be attractive to consumers, like patient-centered medical home plans, from other plans offered on the marketplace. Some stakeholders expressed concern that consumers might have too many plans to wade through and suggested that marketplaces limit the number of offerings so consumers are not overwhelmed by choice and can meaningfully differentiate among their options.[10]

Promoting Marketplace Competition Through Insurer Participation

Stakeholders indicated that the marketplaces are trying to encourage more insurers to participate. Regulators and marketplace officials in all four states expressly stated that they encouraged new insurers to enter the marketplace in 2015 and were willing to work directly with insurers to ensure a smooth entry process. That said, as one stakeholder indicated, an insurer ultimately must make the business decision as to whether it's worth the time, effort, and cost to enter the marketplace. Regulators and marketplaces can facilitate the entry process, but the ultimate decision rests with the insurer and depends on its assessment of the competitive landscape. Even if an insurer does participate in the marketplace, there is significant flexibility under federal and most state laws in terms of where the insurer markets and sells coverage. Of the study states, only Rhode Island requires insurers to offer marketplace coverage across the entire state.[11] In the larger study states (i.e., Kansas, Nevada, and Washington), insurers can limit their marketplace offerings to a single county (Exhibit 1), leading to significant within-state variation in the number of available plans on a county-by-county basis.[12] For example, in Nevada, only two of five insurers participating in the marketplace offer products in every county within the state.

Exhibit 1. Insurer Participation by County and Rating Area in the Individual Health Insurance Marketplaces, Plan Year 2015

State		Number of rating areas participating	Number of counties covered
Kansas	**Total**	**7**	**105**
	Coventry Health and Life	7	105
	Blue Cross and Blue Shield of Kansas	7	103
	Blue Cross and Blue Shield of Kansas Solutions	7	103
	Coventry Health Care of Kansas	4	21
	Blue Cross and Blue Shield of Kansas City	1	2
Nevada	**Total**	**4**	**17**
	Anthem Blue Cross Blue Shield	4	17
	Nevada Health Co-op	4	17
	Assurant Health	3	7
	Prominence	2	5
	Health Plan of Nevada	2	3
Rhode Island	**Total**	**1**	**5**
	Blue Cross and Blue Shield of Rhode Island	1	5
	Neighborhood	1	5
	UnitedHealthcare	1	5
Washington	**Total**	**5**	**39**
	Lifewise Health Plan of WA	5	39
	Moda Health Plan	5	39
	Premera Blue Cross	5	38
	Community Health Plan of WA	5	26
	Group Health Cooperative	4	19
	BridgeSpan Health Company	4	12
	Molina Health Care of WA	4	7
	Coordinated Care	3	13
	Kaiser Foundation Health Plan of the Northwest	2	2
	Columbia United Providers	1	1

Sources: Federal HealthCare.Gov 2015 Health Plan Information for Individuals and Families, https://www.healthcare.gov/health-plan-information-2015/; Washington State Office of the Insurance Commissioner, "2015 Individual Health Plans and Rates," http://www.insurance.wa.gov/your-insurance/health-insurance/individuals-families/health-plans-rates/; and Value Penguin, "Affordable Care Act (Obamacare) Health Insurance Exchanges," http://www.valuepenguin.com/ppaca/exchanges.

Insurers Are Competing on Premiums in the Marketplaces for 2014 and 2015

Premium tax credits and cost-sharing subsidies are tied to the benchmark plan (i.e., the second-lowest-cost silver plan).[13] In their second year of operation, many health insurance marketplaces saw either a change in the insurer offering the lowest- or second-lowest-cost silver plan or a decrease in premium in at least one rating area.[14] This finding suggests that insurers are competing to offer the lowest-cost silver plans to attract consumers who are shopping for coverage based on price and premium subsidies tied to those plans.[15]

In fact, from 2014 to 2015, the insurer offering the lowest-cost silver plan changed in Rhode Island (statewide), Washington (in at least one rating area), Nevada (in at least two rating areas), and Kansas (in at least three rating areas).[16] Additionally, the insurer offering the second-lowest-cost silver plan changed in Rhode Island (statewide) and Washington (in at least three rating areas). In Kansas, in the three rating areas examined, either Coventry Health and Life Insurance Company or Coventry Health Care of Kansas, Inc. offered the lowest-cost silver plan in 2014.[17]

Marketplace Uncertainty May Be Driving Competitive Premiums

Insurers and state regulators noted that during the first two years of the ACA marketplaces, insurers have had greater flexibility to price plans more competitively because of uncertainty in the marketplaces. Specifically, interviewees pointed out that insurers did not yet have the actual underlying claims data to substantiate 2015 premium rates. Because they lacked knowledge of the risk profiles of marketplaces enrollees, insurers had the flexibility to price aggressively or conservatively. As insurers acquire more data over time, their ability to compete on price may become more limited. For instance, medical loss ratio requirements will dictate the amount of premiums they must use to pay for medical services. Additional limitations include regulations against overpricing products, guaranteed issue and community rating requirements that regulate how premiums must be set, and actuarial value and essential health benefit requirements.

Once these uncertainties are eliminated, the real pressure point for premium pricing may shift to medical management and the reimbursement rates negotiated between providers and insurers. For instance, both state regulators and insurers said that it is much easier to leverage more favorable reimbursement rates with providers in urban areas, where provider competition tends to be more robust. An insurer in Nevada noted that in more rural areas, providers are able to extract higher reimbursement rates because of lack of competition. This results in higher medical costs, which translates to higher premiums. Rhode Island has addressed this issue by requiring insurers to include a specific provision in each hospital contract that limits yearly hospital reimbursement increases. Stakeholders generally agreed this requirement provides insurers with the necessary leverage to negotiate competitive reimbursement rates with hospitals.[18] Other respondents suggested that insurers are looking to establish long-term relationships with providers and develop networks and marketplace offerings around those relationships, but indicated that robust network adequacy requirements might stifle innovation around strategic provider–insurer partnerships.

Rate Review Plays a Role in Ensuring Fair Competition

To promote fair competition among insurers, the Affordable Care Act requires states to have an effective rate review program. Regulators review premium rate increases in the individual and small-group markets within and outside the marketplaces to ensure that such increases comply with the law's requirements and are not excessive, unjustified, or unfairly discriminatory.[19] In states that do not have an effective rate review program, the federal government reviews rates. All four study states are considered effective rate review states under federal law, as defined by the U.S. Department of Health and Human Services.[20] Additionally, they have the authority to approve or disapprove an insurer's premium rates.[21] Despite some similarities, stakeholders held varied opinions on the role of the rate review process itself.

State regulators, marketplace officials, and insurers uniformly agreed that a key function of effective rate review is to ensure that insurers remain solvent and can continue to pay claims for enrollees when they come due. Respondents in all four states believed their regulators were competently performing this function, but had different perspectives on rate review in other areas. In Kansas and Nevada, stakeholders generally agreed that the insurance department should not be in the business of setting premium rates, but rather should review them for adequacy and reasonableness. This is a critical role for state regulators, especially in an environment like the health insurance marketplace where insurers are incentivized to complete on price. In some cases, state regulators may need to push insurers to increase their rates so that their efforts to compete will not compromise solvency. In Washington and Rhode Island, stakeholders indicated that insurance regulators generally take a more aggressive approach and push back on the initial rates filed by insurers and try to extract lower ones, if appropriate. In Rhode Island and Nevada, regulators publicly post the insurers' initial filings and then allow insurers to revise their rates within a specified time frame after reviewing competitors' rates. Stakeholders said this practice resulted in lower premiums.

Despite varying perspectives, the final approved rates in all four study states in 2015 were lower than the rates initially filed. In some cases, the final rates were significantly lower (Exhibit 2). For example, in Rhode Island, the final approved base rate for individual market polices offered by Blue Cross and Blue Shield was 4.3 percentage points lower than originally requested.[22] This represents an average annual savings of $161 per year on premiums for consumers before accounting for federal premium subsidies. This suggests that regulators have the ability to put downward pressure on rates during the review process.

Exhibit 2. Proposed and Approved Health Insurance Rate Increases from 2014 to 2015

Company	Plan(s)	Proposed rate increase	Accepted rate increase
Kansas			
Coventry Health and Life Insurance Company	Individual PPO plan–Kansas City	16.38%	16.30%
	Individual PPO plan–outside of Kansas City	13.66%	13.00%
Nevada			
Assurant Health (Time Insurance Co.)	Individual PPO plan	18%	16%
Health Plan of Nevada	Individual HMO plan	8.90%	6.60%
HMO Colorado (Anthem Blue Cross Blue Shield)	Individual HMO plan	-3.90%	-6.90%
Rhode Island			
Blue Cross and Blue Shield of Rhode Island	Individual plan*	8.8%	4.5%
Washington			
Coordinated Care	Average across all individual plans	11.20%	7.20%
Group Health Cooperative	Average across all individual plans	11.20%	0%
Lifewise Health Plan of Washington	Average across all individual plans	8.90%	2.30%
Community Health Plan of Washington	Average across all individual plans	8.40%	0%
Premera Blue Cross	Average across all individual plans	8.10%	2.60%
Bridgespan Health Company	Average across all individual plans	1.70%	-2.90%
Molina Health Plan of Washington	Average across all individual plans	-6.80%	0%

* Base individual plan–no cost sharing plan issued to a 21 year-old.
Sources: Healthcare.gov, "Rate Review," https://ratereview.healthcare.gov/; "Health Insurance Rate Change Search Results," http://doi.nv.gov/rate-filings/results.aspx?action=search&status=&type=&cid; State of Rhode Island Office of the Health Insurance Commissioner, Press Release: OHIC Approves Commercial Health Insurance Rates for 2015, http://www.ohic.ri.gov/documents/Press-Release-rate-review-2014.pdf; and Washington State Office of the Health Insurance Commissioner, Search Health Insurance Rate Increases, http://www.insurance.wa.gov/health-rates/Search.aspx.

DISCUSSION

A main goal of the Affordable Care Act is to provide Americans with access to affordable coverage in the individual market. This will be achieved in part by promoting competition among insurers on premium price and value. Our research suggests that the individual marketplaces are creating an environment in which insurers are participating and competing for consumers. To foster this competitive environment, regulators in the four study states indicated they are encouraging new entrants to increase participation within the marketplaces and using the rate review process to ensure a level playing field.

State regulators, marketplace officials, and insurers agreed that in these early days of full implementation, competition was largely focused on premium price and not on improving value and quality for enrollees. For example, innovation in plan design—when it existed—appeared to be largely focused on features that would lower premiums rather than improve quality. In fact, one insurer introduced a narrow network plan that eliminated enrollees' access to out-of-state in-network providers solely to lower premium prices.

Stakeholders also agreed that although marketplaces are providing a platform to shop for and compare plans on price and other basic features, consumers lack the sophisticated decision-making tools to allow them to fully evaluate a plan in terms of quality, network design, and cost structures.

It may simply be a question of time before consumers can shop based on both price and value. Insurers may be better positioned to compete on value once the individual marketplaces stabilize. They need complete claims data to evaluate enrollee risk and a stable regulatory and competitive environment. This could take several years, but insurers will then be better positioned to identify real opportunities to compete on value, in addition to price.

In the meantime, state marketplaces can continue to foster a competitive environment by encouraging new entrants and enhancing marketplace platforms to assist enrollees in decision-making. In addition, federal officials recently reaffirmed the authority of marketplaces to selectively contract with insurers that provide quality and affordable coverage to individuals—this is also known as active purchasing. Regulators are exploring how best to use this authority in the federal marketplace to ensure that health plans "provide quality coverage to consumers to meet the Affordable Care Act's goals."[23] The early efforts of state-based marketplaces that have embraced selective purchasing may help to identify policies that show promise in promoting quality, value, and robust competition.[24]

Notes

[1] J. Gruber, *Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act* (New York: The Commonwealth Fund, June 2014).

[2] See 45 C.F.R. Part 154.

[3] J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

[4] Ibid.

[5] J. Gabel, H. Whitmore, A. Call et al., "Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation," *The Commonwealth Fund Blog,* Jan. 28, 2016.

[6] J. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

[7] Please note that Kansas is not a state-based marketplace, therefore, an interview was not conducted with a marketplace representative.

[8] More than half of the 2.2 million active re-enrollees who selected 2015 plans through the marketplaces in the HealthCare.gov states switched plans between the 2014 and 2015 plan years. See ASPE, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, issue brief (Washington, D.C.: U.S. DHHS, Assistant Secretary for Planning and Evaluation, March 10, 2015).

[9] Recognizing that comparison shopping, whatever its limits, has been driving competition, some stakeholders identified a tension in states' approaches to coverage renewals. Marketplaces in Kansas and Washington used a "passive" renewal process that sought to minimize coverage gaps by allowing most individuals to be automatically re-enrolled in a marketplace plan for 2015. In Rhode Island, enrollees were required to return to the marketplace and re-enroll in a marketplace plan, or else lose their coverage entirely. One regulator in Rhode Island indicated that active renewal benefited consumers because it spurred them to go back to the marketplaces and shop, where they found more affordable plans to choose from in 2015 as compared with 2014. See Health Source RI, "Ready to Enroll, or Renew Your Coverage?" (Providence, R.I.: Nov. 15, 2014).

[10] See also C. H. Monahan, S. J. Dash, K. W. Lucia et al., *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013).

[11] J. Holahan, R. Peters, K. Lucia et al., *Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States* (Princeton, N.J., and Washington, D.C.: Robert Wood Johnson Foundation and Urban Institute, July 2013).

[12] See State of Kansas Qualified Health Plan Submission Attestation Form, last updated Feb. 22, 2015, http://www.ksinsurance.org/documents/company/ah-life/2016-state-dental-attestations.pdf; Silver State Health Insurance Exchange, Current Policy to Align Service Areas with Rating Areas, May 9, 2013, http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/08_-_Service_Areas.pdf; State Health Insurance Exchange, 2016 QHP Certification, April 16, 2015, http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Carrier_2016/April16Webinar_finaldraft.pdf; and Washington Health Benefit Exchange, Guidance for Participation in the Washington Health Benefit Exchange, April 10, 2014.

[13] Eighty-seven percent of individuals that obtained coverage in the individual market in 2015 were eligible for premium tax credits and/or cost sharing reductions. See ASPE, *Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report for the Period: Nov. 15, 2014–Jan. 16, 2015* (Washington, D.C.: U.S. DHHS, Assistant Secretary for Planning and Evaluation, Jan. 29, 2015).

[14] C. Cox, L. Levitt, G. Claxton et al., *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces,* issue brief (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

[15] See also K. Swartz, M. Hall, and T. S. Jost, *How Insurers Competed in the Affordable Care Act's First Year* (New York: The Commonwealth Fund, June 2015).

[16] J. Gabel, NORC at the University of Chicago internal data set, Dec. 2014.

[17] Ibid.

[18] See R.I. Code R. 02-031-002, Section (10)(d)(3) (2015), which states:

> Hospital contracts shall include a provision that agrees on rates, and quality incentive payments for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if either:
>
> (i) the average rate increase, including estimated quality incentive payments, is greater than the U.S. All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner as soon as practicable for calendar year 2015, and by October 1 each year thereafter, based on the most recently published U.S. Department of Labor data). Such percentage increase shall be plus 1% between July 1, 2015 and December 31, 2015, plus 0.75% during calendar year 2016, plus 0.50% during calendar year 2017, 0.25% during calendar year 2018, and plus 0.0% following calendar year 2018, or
>
> (ii) less than 50% of the average rate increase is for expected quality incentive payments.

[19] See 45 C.F.R. Part 154.

[20] Center for Consumer Information and Insurance Oversight, "State Effective Rate Review Programs," fact sheet (Washington, D.C.: Centers for Medicare and Medicaid Services, CCIIO).

[21] See Kan. Stat. Ann. § 40-2215 (2015); Nev. Rev. Stat. Ann. § 686B.070 & .110 (2015); Nev. Rev. Stat. Ann. § 695B.230 (2015); R.I. Code R. 02-031-017 (2015); WAC 284-170-870; and Washington State SERFF Health and Disability Rate Filing General Instructions, March 9 , 2015, http://www.insurance.wa.gov/for%2Dinsurers/filing%2Dinstructions/file%2Dhealth%2Dcare%2Ddisability/rate%2Dfiling%2Dinstructions/documents/rates-hd-general-filing-instructions.pdf.

[22] State of Rhode Island Office of the Health Insurance Commissioner, "OHIC Approves Commercial Health Insurance Rates for 2015," press release (Providence, R.I.: July 17, 2014).

[23] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75488, 75541 (Dec. 2, 2015).

[24] S. Dash, K. W. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

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