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Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges

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Abstract The new health insurance exchanges are the core of the Affordable Care Act's (ACA) insurance reforms, but insurance markets beyond the exchanges also are affected by the reforms. This issue brief compares the markets for individual coverage on and off of the exchanges, using insurers' most recent projections for ACA-compliant policies. In 2016, insurers expect that less than one-fifth of ACA-compliant coverage will be sold outside of the exchanges. Insurers that sell mostly through exchanges devote a greater portion of their premium dollars to medical care than do insurers selling only off of the exchanges, because exchange insurers project lower administrative costs and lower profit margins. Premium increases on exchange plans are less than those for off-exchange plans, in large part because exchange enrollment is projected to shift to closed-network plans. Finally, initial concerns that insurers might seek to segregate higher-risk subscribers on the exchanges have not been realized.

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BACKGROUND

The Affordable Care Act does not require insurers to sell through the new insurance exchanges, or marketplaces.[1] Although subsidized insurance for individual policies is available only through the exchanges, insurers can choose to sell outside of the exchanges to people who do not qualify for or claim premium subsidies.

Accordingly, two distinct segments have emerged in the individual market: coverage sold on the exchanges, mostly to people who qualify for a subsidy; and coverage sold through traditional channels to people who pay full price. This subdivision of the individual market provides an opportunity to explore how effectively the ACA exchanges are promoting value for consumers.

To investigate this question, we use insurers' filings with the federal government that demonstrate their compliance with the ACA's rating rules (for details, see the About This Study box on page 8). In this issue brief, we analyze insurers' filings for premium rates that took effect in 2016, for ACA-compliant products sold both on and off of the exchanges.[2]

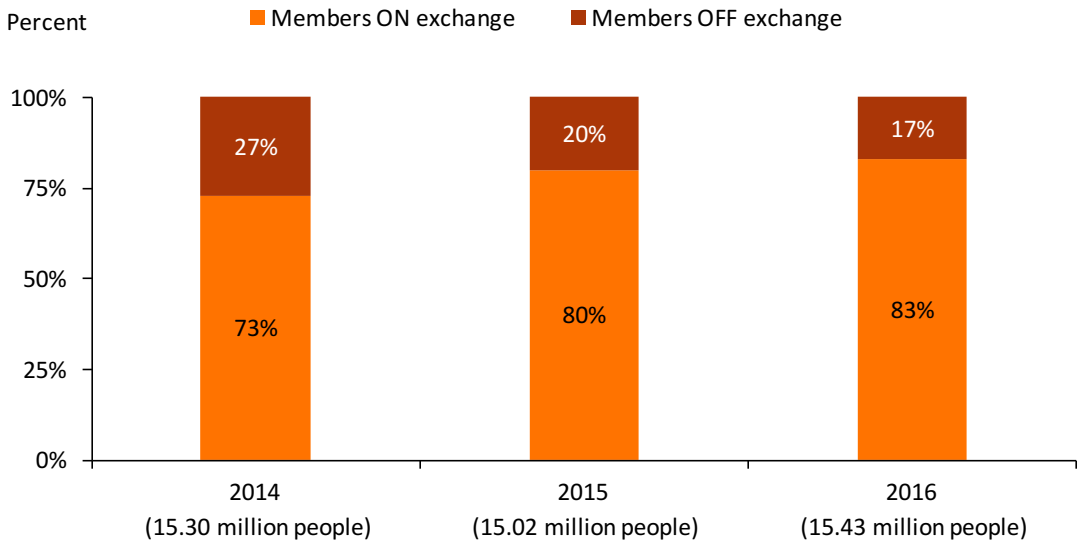
STUDY FINDINGS

Market Shares

Because the ACA's premium subsidies are available only through the federal and state exchanges, it is no surprise that the great majority of ACA-compliant coverage in the individual market is sold through the exchanges. For 2016, insurers project that only 17 percent of their anticipated 15 million ACA-compliant subscribers will purchase plans sold off of exchanges.[3] There has been a steady decline of projected nonexchange enrollment since 2014 (Exhibit 1).

Exhibit 1

Projected ACA-Compliant Membership On and Off of the Health Insurance Exchanges, 2014 to 2016



Data: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Medical Loss Ratios

The ACA's insurance exchanges were intended to improve the value of health coverage for consumers in two ways: 1) by making insurers compete on price, and 2) by reducing overhead sales costs. One indication of whether these goals are being achieved is the medical loss ratio that insurers target, on and off of the exchanges. The medical loss ratio reflects what portion of total premiums an insurer expects to spend on health care services and quality improvement, with the remainder earmarked for overhead costs and profits.

We compared the projected medical loss ratios in 2016 for insurers that sell all of their products on the exchanges with those that only sell off of the exchanges.[4] To minimize the effect of outliers, we report median rather than mean values. As shown in Exhibit 2, insurers selling exclusively off of the exchanges project a median medical loss ratio that is two percentage points lower than those that sell on the exchanges. This reduced loss ratio is largely accounted for by greater administrative costs: median administrative costs are 2.5 percentage points higher off of the exchanges. Also, median profit ratios are almost one point higher off of the exchanges.

Exhibit 2

Projected ACA-Compliant Median Financial Performance Ratios On and Off of the Health Insurance Exchanges, 2016

	All Insurers	Insurers selling all products ON the exchanges	Insurers selling all products OFF the exchanges
N=	543*	214	192
Medical loss ratio	78.8%	79.2%	77.3%
Administrative ratio	12.4%	11.7%	14.2%
Tax and fee ratio	6.0%	6.4%	5.0%
Profit ratio	2.3%	2.0%	2.8%

Note: Median values are not additive across the four performance measures.
* The total for "All insurers" exceeds the sum of insurers "all ON" and "all OFF" because some insurers offer plans both on and off exchanges.
Source: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Although exchange insurers projected lower administrative costs and planned to devote less of their earnings to profits, they do project higher taxes and fees—a result of the fees insurers must pay to exchange administrators for plans purchased through them.[5] These exchange fees are spread, however, across all of an insurer's business, including off-exchange business. Accordingly, the median tax and fee ratio on the exchanges in 2016 is only 1.4 points higher than the ratio off of the exchanges.

It's not clear whether the exchanges themselves cause insurers to devote a lower proportion of premiums to overhead and profits. It is possible that insurers with historically higher overhead or profits choose not to participate in the exchanges. However, it is also possible that the exchange structure makes insurers more efficient by reducing sales and administrative costs and by increasing competition. If so, then those advantages also should be reflected in their off-exchange policies, because they must pool their ACA-compliant business on and off the exchanges for rating and medical loss ratio calculations.

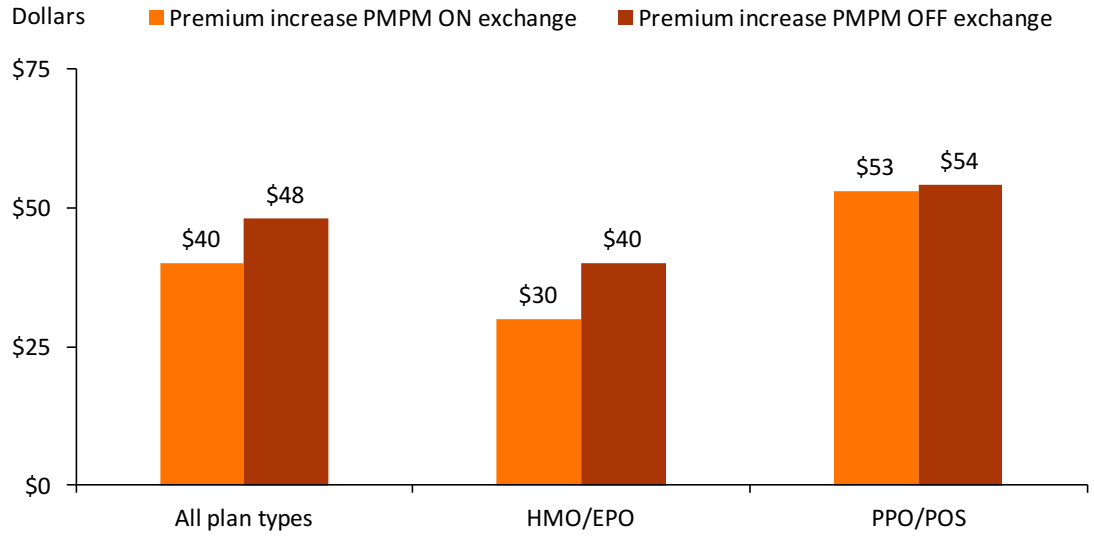
Changes to Premiums and Plan Types

We also analyzed how insurers projected their enrollment and premiums would change in 2016, based on the type of provider networks offered.[6] As shown in Exhibit 3, premiums increased somewhat more for plans sold off of the exchanges than for those sold on them ($48 vs. $40 per member per month). In large part, this lower premium increase among exchange plans appears attributable

to a shift of enrollment toward HMO and "exclusive provider organization" (EPO) plans that limit coverage to contracted provider networks except in emergencies, and away from PPOs or "point of service" (POS) plans that include out-of-network coverage.[7] Also shown in Exhibit 3, premiums increased substantially more for PPO/POS plans than for HMOs and EPOs, both on and off the exchanges. The plan-type differential was especially large on exchanges, where PPO/POS premium increases were 77 percent greater than for HMOs/EPOs ($53 vs. $30 per member per month).[8]

Exhibit 3

Premium Increases Per Member Per Month, by Plan Type, On and Off of the Health Insurance Exchanges, 2016



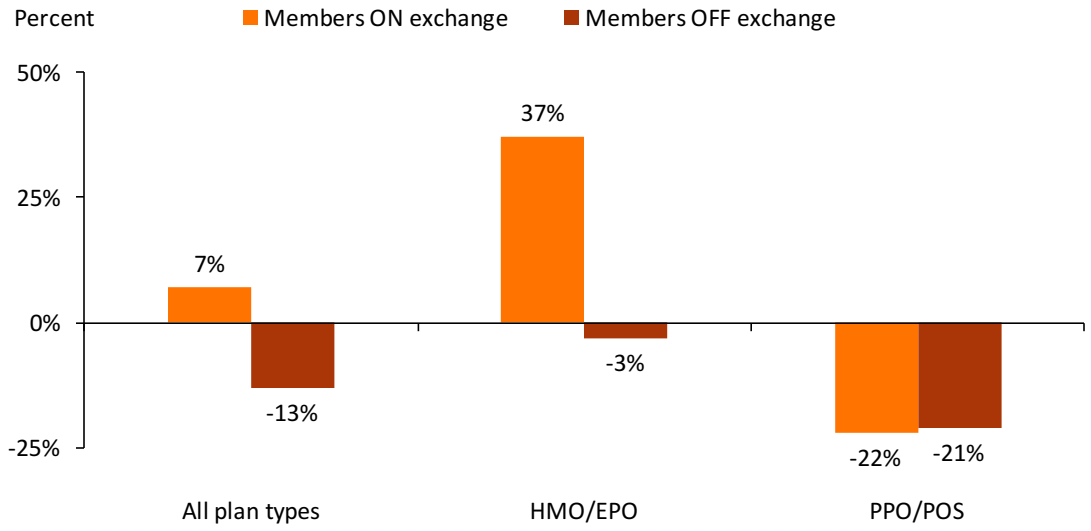
Note: PMPM = per member per month.
Data: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Also notable is the substantial increase in HMO/EPO enrollment projected for on-exchange enrollment (Exhibit 4).[9] Plans sold predominantly on exchanges projected a 37 percent increase in HMO/EPO enrollment, but a 22 percent decrease in PPO/POS enrollment. For off-exchange plans, insurers predicted a 21 percent decrease in PPO enrollment, but no increase in HMO/EPO enrollment.

These differences may indicate that consumers shopping for individual plans on the exchanges are more sensitive to prices. Alternatively, insurers with fewer HMO/EPO provider networks may be less inclined to sell through exchanges. And, both may be true: HMO/EPO insurers may be increasing their presence on exchanges because that is where they gain the greater market advantage over PPO insurers.

Exhibit 4

Change in Enrollment, by Plan Type, On and Off of the Health Insurance Exchanges, 2015–2016



Data: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Risk Selection

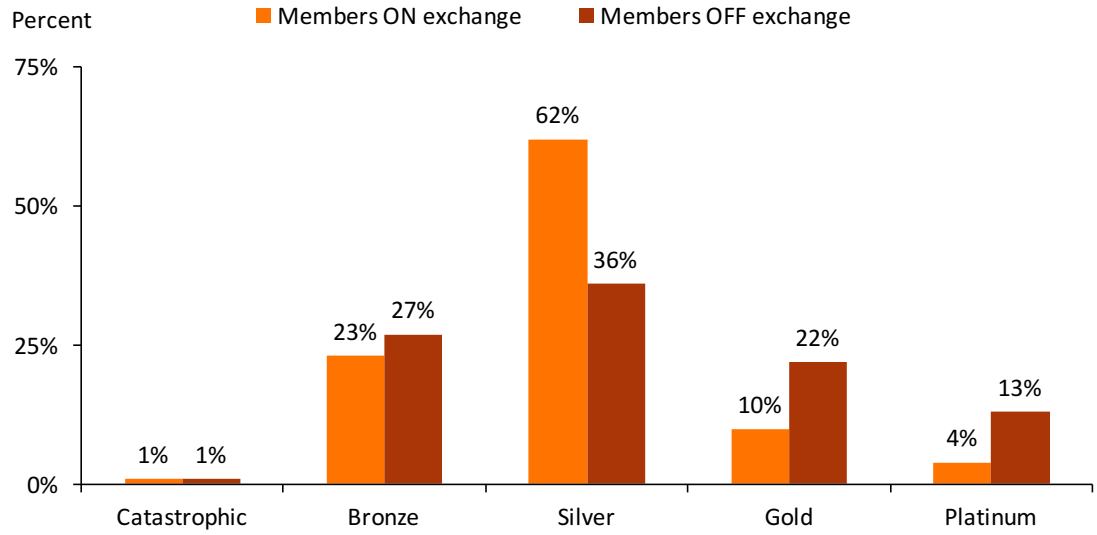
Prior to the exchanges opening for business, analysts speculated that insurers might attempt to segregate higher-risk subscribers on the subsidized exchanges and use the off-exchange market as a way to sell to lower-risk people at lower rates. If successful, such an "adverse selection" strategy could increase the cost of government subsidies.

The ACA, however, has several provisions that keep risk segregation in check. First, it requires insurers to maintain a single risk pool for their ACA-compliant plans in the individual and small-group markets in each state. A single risk pool means that insurers must use the same premium rating factors for all subscribers and plans within a state's individual or small-group market, rather than using different rates for separate risk pools. Second, the ACA has a risk-adjustment mechanism in the individual and small-group markets that requires insurers with lower-risk subscribers to subsidize those that enroll people who are expected to incur more medical claims.

These risk-spreading mechanisms appear to be working. We see little evidence of insurers actively pursuing risk segmentation, for example by offering leaner (i.e., lower cost but less generous) plans off of the exchanges to attract healthier people. Based on our analysis of insurers' federal filings, this does not appear to be occurring (Exhibit 5). Bronze-level plans, which cover only 60 percent of medical expenses on average, constitute a similar proportion of coverage both on and off of the exchanges, about one-fourth of projected enrollment in 2016.

Exhibit 5

Projected ACA-Compliant Membership On and Off of the Health Insurance Exchanges, by Metal Tier, 2016



Note: Total members ON exchange = 12.76 million; total members OFF exchange = 2.67 million.
Data: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Notably, the richest plans, at the gold and platinum levels, are much more prevalent off of the exchanges than on them, constituting 35 percent of nonexchange enrollment versus only 14 percent of exchange enrollment. Greater sales of gold and platinum plans off of the exchanges is likely due, at least in part, to the fact that wealthier purchasers do not qualify for subsidies, and so those who can afford plans that come with lower deductibles and other cost-sharing are more likely to shop outside of the exchanges.[10]

Another factor dampening the potential for adverse selection against the exchanges are differences in the provider networks that insurers offer on and off of the exchanges. The exchanges facilitate shopping based on head-to-head price comparisons; therefore, to be competitive, insurers formed narrower provider networks with physicians and hospitals that were willing to give deeper discounts.[11] Narrow networks may not be appealing to people with complex health problems who tend to prefer a wide choice of specialists. Therefore, people with preexisting conditions may be more likely to shop for off-exchange plans.

CONCLUSION

The ACA's market reforms appear to be working as intended in the individual market, both on and off of the exchanges, based on available data that compare these two market segments in 2016. Nationally, the portion of the individual market operating outside of the exchanges is diminishing steadily. Projected median profit levels are similar between companies that sell on and off of the exchanges. However, insurers that sell only outside of the exchanges project that a higher percentage

of premium dollars will go to administrative costs than do insurers that sell all products on the exchanges. Premium increases on exchanges are less than for plans sold off of the exchanges, in large part because exchange enrollment is projected to shift to closed-network plans. Finally, we see little indication that risk segmentation is causing adverse effects within the ACA-compliant individual market.

Notes

1 States could, if they chose to, make use of the exchanges mandatory in the individual and small-group markets, but so far only Washington, D.C., has done so.

2 These data do not include grandfathered or other noncompliant plans in which people have renewed their enrollment from 2014. In 2015, such plans accounted for only 16 percent of individual market enrollment, which is half the level of the previous year. L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2* (Henry J. Kaiser Family Foundation, May 2015).

3 As explained in the About This Study box on page 8, however, plans sold predominantly on exchanges also can have some off-exchange enrollment. Therefore, these projected percentages are not precise market shares.

4 These are simple, unadjusted loss ratios that do not take account of several factors allowed by the ACA's minimum loss ratio regulation.

5 S. J. Dash, J. Giovannelli, K. Lucia et al., "State Marketplace Approaches to Financing and Sustainability," *To the Point (Commonwealth Fund blog),* Nov. 6, 2014.

6 We identified 6,627 plans with premium rate increase data in 2016, of which 3,755 are sold on exchanges, consisting of 2,158 HMO and EPO plans and 1,597 PPO and POS plans. An additional 2,872 plans are sold off of the exchanges, consisting of 1,279 HMO and EPO plans, 1,547 PPO and POS plans, and 46 indemnity plans.

7 States often regulate HMOs and PPOs under different sets of insurance laws. These separate regulatory regimes have given rise to the alternative terms, EPO and POS, when insurers established under one regulatory regime decide to offer a plan that is structured like those in the other regime. Thus, EPOs are essentially the same as HMOs but are sold by companies that are regulated as PPOs. Likewise, POS networks are structured like PPO networks but are sold by insurers regulated as HMOs. Regardless of the state regulatory regime, the key distinction, for our purpose, is whether the plan limits coverage to a contracted provider network (HMO and EPO) or covers care provided out of network (PPO and POS).

8 See also J. Appleby and J. Rau, "As HMOs Dominate, Alternatives Become More Expensive," *Kaiser Health News,* Nov. 25, 2015.

9 See also K. Hempstead, *Burnt Offerings? PPOs Decline in Marketplace Plans* (Robert Wood Johnson Foundation, Nov. 3, 2015).

10 Also, one likely reason that exchanges have a much greater proportion of their enrollment at the silver level (62% versus 36%) is that lower-income people who are eligible for reduced out-of-pocket cost-sharing must choose a silver plan to receive the full benefit of that subsidy.

11 S. F. Haeder, D. L. Weimer, and D. B. Mukamel, "Narrow Networks and the Affordable Care Act," *Journal of the American Medical Association,* Aug. 18, 2015 314(7):669–70.

About This Study

Data come from the "unified rate review template" (URRT) spreadsheets for 2016 that insurers must file with CMS' Center for Consumer Information and Insurance Oversight (CCIIO), documenting how they develop their premium rates for ACA-compliant plans. The URRT includes two sections: the market-level analysis section, which develops a projected single risk pool rate from prior experience data; and the product/plan section, which reports projected premiums and enrollment for the coming year, in each health plan. This database provides the change in premium per member for plans offered on and off of marketplace exchanges, as well as the components of costs (claims, administrative) and profit margins driving premium changes.

There were 543 unique insurers in different states. We used projected membership to classify insurers and products as selling predominantly on exchanges versus outside of the government exchanges. For plans sold on exchanges, insurers also must offer these plans outside of the exchanges. Therefore, some "on-exchange" plans also have off-exchange enrollment. However, because the majority of enrollees receive subsidies that are available only through the exchanges, enrollment in these plans is predominantly on-exchange and therefore the exchange dynamics determine the pricing of these plans even when sold off exchange.

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