YOUNG ADULT PARTICIPATION IN THE HEALTH INSURANCE MARKETPLACES JUST HOW IMPORTANT IS IT?

FEBRUARY 2014

Sara R. Collins

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Abstract: The participation of young adults in the health insurance marketplaces has received considerable attention. At issue is whether men and women ages 19 to 34—a group uninsured at disproportionately high rates but generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure the marketplaces' success. The conclusion of health insurance actuaries, health plan representatives, researchers, and federal officials invited to participate in a Commonwealth Fund meeting on the topic is that while young adult participation is important for the stability of the marketplaces and 2015 premiums, it was, and will continue to be, one of many factors that affect premiums. There is no single "right" rate of young adult participation that will guarantee success. In fact, health plan actuaries view health status for all age groups as being more important in their pricing decisions.

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EXECUTIVE SUMMARY

The participation of young adults in the Affordable Care Act's health insurance marketplaces has received considerable attention in the policy community and the media over the past few months. At issue is whether men and women ages 19 to 34—a group that historically has been uninsured at disproportionately high rates but is generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure that the marketplaces are a success.

There is little consensus, however, as to the level of young adult participation that is necessary to achieve balance in state individual market risk pools, or how important that is compared with the health status of enrollees irrespective of age. If participation by young adults is less than what insurers expected when they set premiums for 2014, what are the implications for the stability of the marketplaces and insurance premiums in 2015? In late January 2014, The Commonwealth Fund invited a group of health insurance actuaries, health plan representatives, researchers, and federal officials to discuss these and related issues. (See participant list.) This report provides an analysis of the meeting discussion. It is not intended to broadly represent the views of other experts or those of the insurance industry overall.

Young Adult Participation Less Important Than Health Status of Overall Enrollment Pool

Actuaries and researchers both agreed that while the participation of young adults in the marketplaces is important for stability of the marketplaces and 2015 premiums, it was, and will continue to be, *one of many different factors* that affects premiums of marketplace plans. In fact, young adult participation is not even the most important factor: health plan actuaries view health status—which determines what the likely use of heath care services will be—for all age groups as being more important in their pricing decisions.

In setting premiums, some health plans develop their own projections of young adult enrollment based on modeling of expected behavior under the health reform law's coverage provisions and the individual mandate to have coverage. This means that insurers' gains or losses for 2014 and the effect on 2015 premiums depend on how actual experience differs from what insurers expected. In other words, there is no single right percentage for young adult participation.

The young adult enrollment rate is less important than health status of all enrollees because carriers can still price an individual's policy based on his or her age within the law's three-to-one age bands. In other words, carriers can charge older adults as much as three times what they charge younger adults. While this gives less room for pricing variation than most states allowed prior to 2014, insurers can nevertheless still make adjustments to premiums based on age. Thus, even if enrollment among young adults is less than projected, it will potentially have less of an effect on insurers' gains or losses, according to the meeting participants, than will enrollment that turns out to be less healthy than expected. This is because insurers can no longer charge people premiums based on their health.

Health plans will need to file premiums in the second quarter of 2014 for the 2015 plan year that starts next January. Because open enrollment in the individual market and marketplaces ends on March 31, health plans will have, at most, three months of claims experience on which to base their premiums. To the extent that plan actuaries project that their 2014 premiums are less than adequate for 2014 enrollment, they will likely make an adjustment to their assumptions about plan risk pools in 2015 in order to ensure that 2015 premiums are at a sustainable level.

Several Factors Will Limit Insurers' Losses and Premium Rate Increases

Meeting participants were in agreement, however, that several factors would 1) limit losses and/or 2) temper premium increases in 2015. Factors that might limit losses include the ability to price based on age, and the Affordable Care Act's risk-sharing programs, which limit high-cost claims and offset insurer losses. In addition, a majority of enrollment in large insurance plans that comply with the law's standards may well consist of existing customers, if those customers choose to stay with their carriers. This group's health status is known

to carriers, and, since its members were previously charged premiums based on their health (before the law's 2014 reforms went into effect), they tend to be healthier than average.

The degree to which premiums increase this year is expected to be tempered, among other factors, by the health reform law's premium rate review provision, which requires health plans to justify premium increases of 10 percent or more, and the medical loss ratio requirement. This latter provision requires that plans spend a set percentage of their premiums on medical care, as opposed to profits and administrative expenses. Competition in less-concentrated markets may also temper price increases.

Health policy analysts conclude that lower-than-projected enrollment of young adults may be one of many factors that lead carriers to adjust their premiums to levels that are considered adequate, but it will not be the most important factor. Nor will lower enrollment among young adults, even in the extreme, lead to a so-called premium death spiral and market failure.

In 2014, premiums for the marketplace plans came in lower than what had been projected by the Congressional Budget Office. According to the actuaries in the Commonwealth Fund meeting, this outcome largely reflected the extensive offering of narrow provider networks, the restructuring of provider payment, and benefit design. While some degree of uncertainty will continue in health plan rate-setting into 2015, actuaries and researchers predict a gradual stabilization of the marketplaces and greater certainty among health plans when setting premiums in 2016 and beyond. While some health plans may see increasingly narrow provider networks to restrain premiums in plans this year, orher plans may view narrow networks as only one step in a long-term strategy of more fundamental changes to care delivery, including the spread of accountable care organizations.

INTRODUCTION

The participation of young adults in the Affordable Care Act's health insurance marketplaces has received considerable attention in the policy community and the media over the past few months. At issue is whether men and women ages 19 to 34—a group that historically has been uninsured at disproportionately high rates but is generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure that the marketplaces are a success.

There is little consensus, however, regarding the level of young adult participation that is necessary to achieve balance in state individual market risk pools, or how the relative importance of young adult enrollment to the success of the marketplaces compares with that of health status across all age groups. If the participation of young adults is less than what insurers expected when they set premiums for 2014, what are the implications for premiums in 2015 and for the very stability of the marketplaces themselves?

In January 2014, The Commonwealth Fund invited a group of health insurance actuaries, health plan representatives, researchers, and federal officials to discuss issues related to young adult participation, including:

- insurers' expectations for young adult participation in the marketplaces at the time they set plan premiums for 2014;
- how various rates of young adult participation will likely affect the financial experience of health plans in 2014 as well as insurance premiums in 2015;
- the significance of enrollee age versus health status for well-balanced risk pools;
- the effects of the Affordable Care Act's risk-sharing provisions;
- whether key conditions have changed since 2014 premium rates were set, and what the impacts are likely to be; and
- the expectations for enrollment, marketplace risk pools, and premium growth in 2016 and beyond.

This report provides an analysis of the discussion that took place. It is not intended to represent the views of the insurance industry or experts not present at the meeting.

HOW DID MARKETPLACE PLANS SET PREMIUMS FOR 2014, AND HOW IMPORTANT WAS YOUNG ADULT PARTICIPATION?

In 2013, when health insurance actuaries set 2014 premiums for marketplace plans, they faced significant uncertainty stemming from the many new variables that could potentially affect medical claims in 2014. The participation rate of young adults was only one of many interrelated factors they were considering. Other factors included:

- the Affordable Care Act's prohibition on underwriting, or setting premiums, based on health status;
- limits on what insurers may charge older adults relative to younger adults by a three-to-one ratio;
- the law's single risk pool provision, whereby new enrollees from both inside and outside the marketplaces are combined in a plan's existing pool for the purpose of setting premiums;
- the new minimum benefit standards;
- new standardized cost-sharing tiers based on a plan's actuarial value (bronze, silver, gold, and platinum), and the catastrophic plan option (for adults under age 30 and people who cannot find a plan that costs less than 8 percent of their income);
- narrow provider network products created by insurers and uncertainty about their effects; and
- the effect of the law's reinsurance program, which defrays the cost of high claims for insurers in the individual market, and the risk corridor program, which protects against large losses in the marketplaces.

Projections of Young Adult Enrollment

Some health plans such as Aetna develop their own projections of young adult enrollment based on modeling of expected behavior under the health reform law's coverage provisions and the individual mandate, according to Geoffrey Sandler, Senior Actuary, Health Policy, Aetna/Coventry. This means that insurers' gains or losses for 2014, as well as the effect on 2015 premiums, depend on how actual experience differs from what insurers expected. In other words, there is no single right percentage for young adult participation.

Some of the actuaries who participated in the Commonwealth Fund meeting expect that the first people to enroll, not only in the first year but over the next few years, will be older and sicker. They anticipate that as time goes on and the size of the penalty for not having health insurance rises, younger and healthier people will gradually enroll. Depending on the insurance carrier, premiums were set based on assumptions like these and others.

For example, according to one plan actuary's 2014 projections by age—though not necessarily representative of industry projections—enrollment of 19-to-34-year-olds in marketplace plans would account for about 29 percent of total enrollees under age 65. Enrollment for this age group was expected to account for 25 percent of enrollment in plans sold by the insurer outside the marketplaces. Thus, while some analyses and media reports have compared the enrollment rate for young adults to their share of the overall population that is eligible for marketplace plans (a commonly cited statistic is 40 percent of the eligible population), the more relevant benchmarks are the projected participation rates used by actuaries to set this year's premiums.

Limits on Insurers' Ability to Charge Older Adults Higher Premiums

Health plan actuaries and researchers at the meeting noted that the higher-than-expected number of older enrollees will be mitigated by the fact that insurers can, to a certain extent, price an individual's policy based on their age: carriers can charge older adults as much as three times the amount they charge younger adults. Although some actuaries pointed out that this three-to-one ratio is lower than what they were able to charge in most states prior to 2014, as well as lower than the expected actual cost difference across the entire age spectrum, the ability to charge older adults more—however limited that may be—is viewed as diminishing the adverse effects of higher-than-expected enrollment for this age group.

Inability to Charge People Based on Health Status

In contrast to age, health status can no longer be used in setting insurance premiums. Plan actuaries view the health status of new enrollees this year as the "big unknown." Ed Cymerys, former chief actuary of Blue Shield of California, said that uncertainty regarding the health status of their ultimate enrollment pool contributed to projections of claims costs that varied by as much as 25 percent higher or lower. Indeed, to the extent that enrollment is older and healthier, health plans actually are poised to do better, since premiums for older adults are higher. Health status, not age, is viewed as *the* critical factor for balancing the risk pool at any age level.

Single Risk Pool

Under the Affordable Care Act, premiums must now reflect the health risk of a single risk pool in a state; that is, health plan premiums are set to reflect the combined membership in plans that meet the health law's standards both inside and outside the marketplaces. Plans sold inside and outside the marketplaces must meet the same standards and are sold at the same bronze, silver, gold, and platinum benefit levels. Premiums for those plans are set for the full market, as health plans can no longer segment risk. This means that the health status of people who enroll in plans outside the marketplaces will also have an effect on overall premiums.

In addition, insurers that previously sold plans in the individual market will have members in 2014 who were enrolled in their plans prior to 2014. Some enrollment may be in grandfathered plans and thus would not be included in the single risk pool. And some

people may choose plans offered by another carrier, either directly or through the marketplaces. Yet, there was agreement among actuaries that the share of new enrollment for existing insurers will be small for many insurers that are not new entrants. For larger insurers, existing enrollment might comprise 75 percent or more of their overall enrollment. Because individuals in this pool were previously subject to underwriting, they tend to be healthier on average, and, importantly, their medical claims experience is known. This will mitigate the effects of new enrollment on overall premiums for larger insurers in markets where enrollees stay with their current carrier.

The Affordable Care Act's Risk-Sharing Provisions

Because of the considerable uncertainty surrounding the health status of enrollees in the new marketplace risk pools, Congress wrote three risk-sharing provisions into the Affordable Care Act. As Cori Uccello of the American Academy of Actuaries has pointed out, these provisions—the reinsurance program, the risk corridor program, and the risk adjustment program—were designed to 1) help ensure that carriers would be willing to sell health plans in the marketplaces even though they lost their ability to underwrite on health, and 2) decrease the incentive to avoid insuring potentially high-cost enrollees.[1] The reinsurance program limits exposure to expensive medical claims of individuals enrolled in plans both inside and outside the marketplaces. The risk corridor program limits losses as well as gains realized by plans sold through the marketplaces. Both programs are temporary; they phase out in three years, by which time it is expected that enrollment in marketplaces and health plans' certainty about their risk pools will both be greater. The risk adjustment program is permanent. (See sidebar on how these programs work.)

Reinsurance program. Meeting participants view the reinsurance program as a substantial source of funding that will considerably offset claims costs in 2014, and it was a factor in how health plans set 2014 premiums. Health plan actuaries said that the program reduced projected health care costs by 10 percent to 15 percent of their entire block of individual market business for 2014. The federal government's recent proposed changes reducing the threshold amount to $45,0000 mean that claims costs will be lowered by more than was recognized in the original pricing of 2014 premiums.

However, since the overall amount of reinsurance dollars is capped at the total amount of insurer fees collected this year, or $10 billion, there is some uncertainty about reimbursement amounts, since total payouts cannot exceed collected fees. Plan actuaries also expressed concern that the overall reinsurance pool will fall to $6 billion in 2015 and $4 billion in 2016, before phasing out altogether. This phase-out will place upward pressure on premiums in those years, though the enrollment of healthier people in 2015 and 2016 would temper this. Still, there was strong agreement that this provision of the law was a critical factor in calculating premiums this year and will continue to be important for stabilizing premiums over the next two years.

Risk corridor program. Risk corridors are designed to narrow losses and gains for insurers selling plans in the marketplaces as they gain knowledge of the health status of their enrollees. Some actuaries view this program as particularly important for new entrants to the market, and of lesser importance to large insurers. Unlike the reinsurance program, the risk corridor program is not budget-neutral: the federal government could end up paying more than it receives from health plans. However, the Congressional Budget Office is now projecting that, over the 2015–2024 budget period, risk corridor payments from the federal government to health insurers will total $8 billion, and the corresponding collections from insurers will amount to $16 billion, yielding net federal savings of $8 billion.[2] The experience in rolling out the Medicare Part D prescription drug program was similar: the government collected more in payments from health plans than they paid to plans, for a net gain of $2.74 billion.[3]

The Affordable Care Act's Risk-Sharing Programs

Reinsurance: Effective from 2014 to 2016, the reinsurance program aims to stabilize premiums in the individual insurance market during the first three years of the law's market reforms, which ban insurers from underwriting on the basis of health.[4] Under proposed rules, nongrandfathered plans sold in the individual market that experience claims costs in excess of $45,000 per individual are eligible for payments worth 80 percent of costs for expenses incurred between $45,000 and $250,000. For 2015, the federal government has proposed increasing the claims threshold to $70,000 and will also decrease the share of reimbursement.

The reinsurance program is funded through fees assessed on all health plans in the United States, including employer self-insured plans, at an amount of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. The program is budget-neutral: the federal government will lower payments if there is a potential that they will exceed collected fees.

Risk Corridors: The risk corridor program was designed specifically to address the uncertainty about the enrollee medical spending that insurers face when they set premiums for health plans sold through the marketplaces in 2014 through 2016. The program limits both gains and losses of insurers selling qualified health plans in the marketplaces. If an insurer's claims are much more than they expected when premiums were set, the insurer receives a payment from the federal government; if claims are much lower than expected, the insurer makes a payment. If claims are greater than 3 percent over expected claims, insurers receive a payment equal to 50 percent of the loss between 3 percent and 8 percent. If they are greater than 8 percent, they receive 80 percent of the excess loss above 8 percent. Conversely, if a plan's claims are less than 3 percent lower than expected, the plan makes a payment to the government equal to 50 percent of gains between 3 percent and 8 percent below; if they are less than 8 percent, they would make a payment of 80 percent of gains over 8 percent. The program is temporary, since premium pricing will become less uncertain as insurers acquire more knowledge of their enrollees' health status.

Risk Adjustment: The risk adjustment program is a permanent program intended to remove incentives for insurance carriers to design plans to attract the healthiest enrollees. Under the program, plans in the individual and small-group markets either receive payments from other plans in the market, if their actuarial risk (the health risk of their enrollees) is greater relative to the market average, or make payments to other plans, if their actuarial risk is less than the market average. Risk adjustment payments also flow across benefit tiers—that is, if bronze plans have enrollees with below-average actuarial risk, they might make payments to gold or platinum plans if they have enrollees with above-average actuarial risk.

HOW MIGHT VARYING RATES OF YOUNG ADULT PARTICIPATION AFFECT PLANS' FINANCIAL EXPERIENCE IN 2014 AND THEIR PREMIUMS IN 2015?

In the second quarter of 2014, just after open enrollment ends on March 31, health plans will have to file their premiums for the 2015 plan year that starts next January. The most important task for insurers will be to ascertain whether their 2014 premiums are likely to adequately cover their medical claims for the year, and whether they need to adjust the assumptions underlying their rates for 2015. Insurers will have demographic information about enrollment, including age, but there was general agreement that many more moving parts will factor into decisions about 2015 premiums than just the participation of young adults. These additional variables include the health status of their membership and the effect of regulatory and other changes since they set their 2014 rates.

Health Status of Risk Pools

The health status of their 2014 risk pools was the biggest unknown factor when insurers set 2014 premiums and, to some degree, it will continue to be uncertain as they set 2015 rates. This is because insurers will have at most three months of claims experience to judge the health status of their pools, with even less claims data for individuals enrolling toward the end of the period. Plans will also face uncertainty about the risk status of their competitors' enrollees who make up the rest of the statewide risk pool.

There was some disagreement about the adequacy of 2014 claims experience to set premiums for 2015. Recalling the rollout of the Medicare Part D program, one actuary said that insurers had had access to early claims data that allowed them to make informed decisions about their pricing for the following year. Some actuaries were less confident in their ability to assess experience based on early claims, noting that it may take longer to develop credible claims experience with medical records. Going into 2015, they said, there would be ongoing uncertainty about the health status of enrollees in marketplace plans.

Additional uncertainty exists regarding both the number and health status of people who might join plans during special enrollment periods after March 31. People can apply for health insurance after the open enrollment period under special circumstances, for example, when they lose coverage upon loss of a job or following a divorce. Based on experience, however, there was some consensus that this would be a group of people with a risk profile similar to that of the rest of the pool.

Changes in the Environment Since Insurers Set 2014 Rates

Adding to uncertainty about the health status of marketplace enrollment are changes in regulations and unexpected developments that occurred since carriers set their rates in 2014. These include the Obama administration's one-year allowance to let people with cancelled policies keep them at the discretion of state insurance commissioners, and lower-than-expected enrollment as a result of problems with the marketplace websites operated by the federal government and some of the states. Changes like these would affect the assumptions insurers make about the composition of their risk pools in 2015, as well as how many people in their plans they could spread fixed administrative costs over.

Renewals of health plans not compliant with minimum benefit standards. In November, the Obama administration decided to allow people whose coverage was cancelled to have their plans reinstated, even if these plans did not meet the Affordable Care Act's minimum benefit standards.[5] But the administration left it to each state's insurance commissioner, and health plans, to decide whether to pursue the practice. Several states had already allowed carriers to renew existing policies prior to the policy change.[6] If the people who keep their plans are healthier than average (since they were all underwritten based on health for pre-2014 coverage), their removal from the pool of people with policies that meet the law's benefit standards will lower that pool's health profile.

There is some disagreement about the likely impact of this change. While some actuaries saw this as removing healthy people from their pools, they expected the decision to have a rather limited effect, because 21 states have decided not to allow plans to extend policies, or have limited the ability of health plans to do so.[7] Still, actuaries view this as an uncertainty that could play into rate-setting in 2015.

Slow ramp-up of enrollment caused by marketplace website problems. A larger uncertainty is the total enrollment effect of technical problems with both state and federal marketplace websites. There is general concern that the difficult rollout period has slowed enrollment, particularly among people who are healthy. Health plans at the meeting reported seeing lower overall enrollment than they had projected for this point in time and larger shares of older enrollees than projected.

For example, Blue Shield of California had assumed that a high percentage of people eligible for a subsidy would sign up, noted Ed Cymerys, its former chief actuary, since the subsidy enables people to pay

only a little for a substantial benefit. But the technical glitches and complexity of signing up for the subsidy postponed the enrollment of eligible healthy people, who likely had less patience than individuals with big medical bills looming. Said Cymerys, "An individual's 'cost' is their premium, plus their time and aggravation, compared to the expected bills that the coverage would pay for."

The health plan actuary who provided projections of enrollment in the individual market, both inside and outside the marketplaces, also provided data on applications received by the beginning of January. By the beginning of January, of all applicants in marketplace plans, 25 percent were ages 19 to 34, while 23 percent were in that age range in plans outside the marketplaces. Both of these figures are close to projections. But older adults comprised 46 percent of marketplace plan applicants, higher than the projected share of 24 percent. So by January, this particular plan was seeing its enrollment skewed toward older enrollees, even though young adults were participating at expected rates.

Health plans differ in their expectations for enrollment by the end of March. Some doubt that enrollment will catch up to their projections, leading to an exacerbation of any adverse selection (causing the risk pool to skew toward poorer health risks) and an increase in administrative costs per enrollee. Others are more optimistic: they expect a second enrollment wave in March as the website issues are resolved and people, healthy men and women in particular, learn how to navigate the enrollment process and enroll in greater numbers as the March 31 deadline for coverage approaches.

Factors That Will Limit Losses and Rising Premiums in 2015

To the extent that health plan actuaries believe that their 2014 prices are less than adequate for their 2014 risk pools, they will likely make an adjustment to the assumptions about their 2015 risk pools underlying their 2015 rates. Meeting participants noted that publicly traded insurance companies will be under significant pressure from Wall Street to make adjustments to their 2015 assumptions if their 2014 pricing appears to be lower than costs in 2014. There was consensus among participants in the meeting that, if necessary, health plans are likely to make corrections in their assumptions to move to an adequate level of pricing in 2015.

There was agreement, however, that several mitigating factors would limit losses and/or limit the degree of premium increases. Factors that are expected to limit losses include:

- Only modest restrictions on the ability of health plans to price based on age.
- The health reform law's reinsurance and risk corridor programs, which lower claims costs and offset insurer losses in the first three years of the rollout.
- The single risk pool for plans with large enrollment in the individual market prior to 2014. To the extent that their members remain with them rather than shop and switch to a new plan, a majority of their enrollment may be existing members who were previously underwritten, and thus healthier, and whose claims experience is known.
- The extension of the law's Pre-Existing Condition Insurance Plan program to March 2014. Because enrollees in this program have higher medical costs, health plans will have substantially lower potential claims costs in 2014—on the order of $100 million, according to one actuary.

The degree of increase in 2015 premiums is expected to be tempered by:

- The Affordable Care Act's premium rate review provision, which requires health plans to justify premium increases of 10 percent or more.
- The law's medical loss ratio requirement, which requires that plans spend a set percentage of their premiums on medical care, as opposed to profits and administrative expenses.
- Continuing competition in less-concentrated insurance markets, though there is not an expectation of many new entrants to markets this year.

Effect of competition on premiums. Linda Blumberg and John Holahan of the Urban Institute and others have suggested that competition in less-concentrated insurance markets has been one of several factors that have kept premiums low this year, relative to Congressional Budget Office projections, in many states, and moreover will help limit premium increases in 2015.[8] Some meeting participants noted that Wall Street and shareholders will likely place pressure on publicly traded insurance companies to price products in ways that ensure costs are covered, and to revise assumptions about risk pools as quickly as possible. Both factors will likely be at play this year.

A related issue is the uncertainty carriers have regarding the health risk of their enrollees compared with the rest of the market. Under the risk adjustment program, health plans with risk greater than the market average receive payments from health plans with below-average risk. If the whole market experiences higher risk this year, the reinsurance and risk corridor programs would subsidize higher claims costs and offset losses. These programs thus also factor into insurers' views of their enrollment relative to the rest of the market and into pricing decisions.

Projections of Health Policy Researchers

Consistent with the view of actuaries, health policy analysts conclude that lower-than-projected enrollment of young adults may be one of many factors that lead carriers to adjust assumptions about their 2015 risk pools, but it will not be the most important factor. Even extremely low enrollment is not expected to lead to a so-called death spiral, where premiums increase so much that enrollment dries up and markets fail.

Using RAND's COMPARE model, Christine Eibner and colleagues Evan Saltzman and Amado Cordova estimated that 18-to-34-year-olds would comprise about 31 percent of total enrollment in 2015 inside and outside the marketplaces. Premium tax credits provide an incentive for relatively healthy people to enroll. In terms of premiums, Eibner argues that what is most important is how spending compares with what carriers are allowed to charge people based on their age. At any age, someone who is healthy and whose spending is less than the age rating allowed by the law is considered a "good risk." Eibner finds that young adults are somewhat more likely to be good risks than older adults. And for any given spending level, a healthy older person is preferable to a younger person, because the older person can be charged a higher premium.

Eibner finds that if the actual enrollment of young adults were to be 8 percentage points below what RAND COMPARE predicts, premiums might increase by 4 percent to 5 percent. However, although the COMPARE model accounts for the law's risk adjustment and reinsurance programs, it does not account for the risk corridor program. Therefore, estimates of premium change attributable to reduced enrollment of young adults would likely be lower if risk corridors were included in the calculations. Eibner found no evidence of a premium death spiral, even at very low levels of enrollment for this age group.

In a recent analysis, Larry Levitt, Gary Claxton, and Anthony Damico of the Kaiser Family Foundation estimated that young adults ages 18 to 34 comprise about 40 percent of the population that is potentially eligible for enrollment in the individual market, both inside and outside the marketplaces.[9] The researchers then conducted an exercise to determine the degree to which premiums might vary if enrollment were expected to be proportional to the potentially eligible population, but fell below that. In other words, if a health plan had set premiums assuming that enrollment of this age group would be about 40 percent of total enrollment, and enrollment ended up being somewhat less, what might be the effect on premiums in the following year as the plan revised its assumptions about its risk pool? The authors predict that if young adult enrollment ends up at 33 percent of enrollment, health care expenses, plus overhead and profits, might exceed premium revenues by 1.1 percent. If enrollment were to be about 25 percent of total enrollment, the authors predict that costs would be 2.4 percent higher than revenues. Insurers generally set their premiums to realize a 3 percent to 4 percent profit margin. Carriers thus might be expected to raise rates by 1 percent to

2 percent in 2015 to reflect revised enrollment assumptions, even in the extreme case. The researchers conclude that such increases would constitute an adjustment, rather than a death spiral.

EXPECTATIONS FOR ENROLLMENT, RISK POOLS, AND PREMIUM GROWTH IN 2016 AND BEYOND

While some degree of uncertainty will continue in health plan rate-setting into 2015, actuaries and heath policy researchers at the Commonwealth Fund meeting predicted a gradual stabilization of the marketplaces and greater certainty among plans in setting premiums for 2016 and beyond, after the first full year of claims experience is analyzed. One actuary noted that this was a multiyear process, and that it will take a few years for the market to reach new equilibriums, as the mandate penalties increase and insurers get new claims data. Linda Blumberg pointed out that while the troubled rollout of the marketplaces may have undermined enrollment in the first two months, the number of people enrolled has continued to climb now that many of those initial problems have been resolved. Enrollment will climb further as information about plan options and financial assistance is more widely disseminated, she said. Moreover, the tax associated with not having health insurance rises over the next few years, increasing the incentive for people to enroll.

Matthew Buettgens of the Urban Institute pointed out that people will gain information about insurance options through the tax-filing process: many tax software companies now include at least some Affordable Care Act subsidy eligibility information and enrollment assistance in their products. This will help boost enrollment by the end of March this year and during next year's open enrollment period, which starts in November.

In 2014, premiums for marketplace plans in most states came in lower than projected by the Congressional Budget Office. According to health plan actuaries at the meeting, this largely reflected the extensive use of narrow provider networks, the restructuring of provider payment, and benefit design. Some health plans may see increasingly narrow networks as a mechanism to lower premiums. For other plans, the use of narrow networks may be a starting point to forming accountable care organizations and other more fundamental delivery system reforms. According to one actuary, much of the low-hanging fruit has already been picked this year to achieve competitive premiums, and going forward it was going to be more challenging to look for new alternatives to address the underlying rate of medical cost inflation. But his health plan was committed to such a strategy as a means of ensuring that it will be a player in the market for the long run.

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NOTES

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