

In The Spotlight:

Stabilizing the Health Insurance Marketplace

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Since the fall of 2013, consumers have been able to shop for and enroll in health insurance plans through the Health Insurance Marketplace, created by the Affordable Care Act (ACA). The ACA has helped expand access to coverage by offering tax credits to eligible Marketplace enrollees. This has given consumers, many who were previously uninsured, a new means of obtaining health insurance. The ACA also has broadened benefits available through health plans by requiring coverage of ten [essential health benefits](#) and other benefit protections such as no lifetime or annual limits on benefits.

While consumers benefit from improved access to coverage, many health insurers have found the Marketplace population have high medical costs and so far have not been financially successful in this business. Improvements are needed to make the Health Insurance Marketplace more sustainable into the future. This *In the Spotlight* will examine Marketplace factors that have posed challenges to insurers' financial stability and provide consumers a better understanding of the importance of sustainability.

What Are Current Marketplace Stability Challenges?

The coverage expansion offered by ACA introduced a new, sicker population of covered individuals to the insurance pool. On top of this, the federal government has implemented a continuous stream of federal policy changes to the coverage offered to the newly insured and others. The combination of these factors have led to a few concerning effects on health insurers, detailed in the following sections:

- As described below, changes have impacted health insurers' "risk pools", or total risk assumed for their member population. Specifically, the balance between unhealthy and healthy individuals in the covered population has been affected by ACA. When the pool of individuals becomes predominantly unhealthy due to factors described below, the population as a whole is more expensive to cover and, therefore, coverage is less affordable for many consumers unless they qualify for federal subsidies (advanceable tax credits) to assist with premiums.
- At the same time, federal policies have resulted in constraints on the ways that health insurers can design their plan and benefits to keep coverage affordable.

As a result of these effects, many insurers – include large health insurers have posted significant losses on ACA business, with one study citing greater than \$2.2 billion in losses across the industry.¹ Some insurers may even leave the Marketplace - as UnitedHealthCare announced it would do in many states in 2017, including North Carolina.

¹ Blase, Brian et al. [The Affordable Care Act in 2014: Significant Insurer Losses Despite Substantial Subsidies](#). George Mason University Mercatus Center. April 2016.

Effects on Risk Pool

In a stable health insurance market, health insurers expect that at any given time, they will cover a mix of healthy and sick individuals in their member population. Premiums are set at a fixed, monthly rate to cover costs for healthy and sick individuals alike so that individuals costs are covered when emergencies come up. This balance helps keep premiums stable and reasonably priced, and is a key element of what makes health insurance work. If the health of the population becomes skewed because the majority of covered individuals are sick, then premiums increase to cover the cost of the sicker population.

Health Care Usage by Previously Uninsured. Prior to the ACA, millions of consumers were uninsured, primarily because they could not afford coverage due to its cost or due to low income, and some were denied insurance due to their health.² The guaranteed issue requirement under the ACA eliminates the issue of being unable to obtain coverage due to one's health. With the advance premium tax credits in the Marketplaces acting as "carrots" and the [individual mandate](#) requirements to serve as a "stick", the percent of uninsured dropped to 11.9% nationally by the end of 2015³, from a rate of around 20% in 2010.⁴ Many health insurers' newly insured member populations experienced higher rates of costly chronic conditions such as hypertension, diabetes, coronary artery disease, Human Immunodeficiency Virus (HIV) and Hepatitis C than those previously insured.⁵ The newly insured also used many more costly health care services than those enrolled prior to 2014; in 2015 the number of hospital admissions, a costly type of medical expense, was nearly twice as high among the newly insured population.⁶

Some of these high costs were expected to decline once newly covered individuals received the necessary medical care during the first year of access in 2014. However, costs continued to rise in 2015. Average monthly medical costs to insure newly enrolled individuals rose from \$501 in 2014 to \$559 in 2015, nationwide.⁷ This demonstrates increased need for health care services once the ACA went into effect.

Effects of Special Enrollment Periods. After a loss of prior coverage or a life-changing event has occurred, Special Enrollment Periods (SEPs) enable consumers to enroll in coverage outside of the annual enrollment period on the Marketplace. These include enrollment opportunities for events like having a baby, moving or marriage. While these types of enrollments may cause a shift in a health insurers' risk pool because they take on extra, new or different risk for less than one full year, these types of enrollments do not necessarily cause imbalance. However, challenges arise when individuals can easily gain coverage through an SEP for a partial year without proper verifications about their use. Without verification and rules in place, an individual could buy coverage through an SEP when he or she is sick and then disenroll later. This scenario would cause imbalance to the risk pool because it encourages sicker individuals to join- not a mix of both sick and healthy.

² Kaiser Family Foundation. [The Uninsured: A Primer](#). November 2015.

³ Gallup. [US Uninsured Rate 11.9% in Fourth Quarter of 2015](#). January 2016.

⁴ Kaiser Family Foundation. [Key Facts about the Uninsured Population](#). October 2015.

⁵ Blue Cross Blue Shield Association. [Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015](#). March 2016.

⁶ Blue Cross Blue Shield Association. [Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015](#). March 2016.

⁷ Blue Cross Blue Shield Association. [Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015](#). March 2016.

A recent study shows that this phenomenon may have been happening on the Health Insurance Marketplace. The study finds that individuals who purchase coverage through an SEP are more than 40% more likely to stop paying for their coverage than individuals who enroll through the annual enrollment period.⁸ At the same time, consumers who enroll in coverage through an SEP cost 10% more to insure (per member per month) than consumers who enroll during annual open enrollment.⁹ The coverage lapse trend coupled with the higher cost to cover consumers who use SEPs suggests that health insurers may not be receiving sufficient premium to cover these members over the course of the plan year.

Due to the impacts on the risk pool and premiums, verification of eligibility for Special Enrollment Periods is important. In an apparent understanding of potential for abuse, the federal government announced in February 2016 that it will implement a new confirmation process to validate eligibility for certain SEPs. This is a much-needed step, but the initial plan is to perform verification after consumers are already enrolled and the number of SEPs targeted for verification is small.¹⁰ Upfront verification would be a more consumer-friendly approach because it avoids conflicts on the back end that consumers, health care providers, insurers and Marketplaces must reconcile. New guidance was also released in May 2016, which requires individuals to have prior coverage in order to be eligible for the “permanent move” special enrollment period, beginning July 2016.¹¹

Impacts of Coverage Grace Periods. Covered individuals who do not pay their premium on time and who do not receive an advanced premium tax credit (APTC) through for Marketplace coverage may receive a grace period of around 30 days to pay their premium (as determined by the state in which they live). In contrast, the ACA allows for a longer, 90-day grace period for consumers who receive income-based APTCs to pay their premium. So, if such a consumer misses a monthly premium payment after making an initial premium payment, they are given a period of 90 days to get up-to-date on their premiums before their health insurer is required to end their coverage.¹² The insurer must pay for all services rendered in the first 30 days of the grace period and may hold the claims rendered in days 31-90, as applicable, which will be processed and paid if the individual pays all the premiums owed. If the three months of premium is not paid at the end of the grace period, then coverage is terminated back to the end of the first 30 days.¹³ The extended length of the grace period for subsidized consumers may present the chance for some individuals to get coverage for 30 days without paying premiums, and decide at the end of their grace period whether to allow coverage stop paying for coverage.¹⁴

Essentially, current grace period rules allow individuals to make a decision about coverage based on whether it benefits them to have it. This may allow healthier individuals to pull out of the risk pool because

⁸ Carlson, Chris and Kurt Geisa. [Special Enrollment Periods and the non-Group ACA-Compliant Market](#). Oliver Wyman. February 2016.

⁹ Carlson, Chris and Kurt Geisa. [Special Enrollment Periods and the non-Group ACA-Compliant Market](#). Oliver Wyman. February 2016.

¹⁰ US Department of Health and Human Services. [Fact Sheet SEP Confirmation Process](#). February 2016.

¹¹ US Department of Health and Human Services. [Fact Sheet Special Enrollment Period for the Health Insurance Marketplace](#). May 2016.

¹² Healthcare.gov. [Premium Payments: Health Insurance Grace Periods and Termination](#).

¹³ Michael Kolber and Hans Leida. [How Consumers Might Game the 90-day Grace Period and What Can Be Done About It](#). November 2014.

¹⁴ Michael Kolber and Hans Leida. [How Consumers Might Game the 90-day Grace Period and What Can Be Done About It](#). November 2014.

they do not use as many health care services during the grace period. A new study shows that sicker individuals who drop coverage persistently re-enroll the next year. According to a consumer survey, 21% of consumers stopped paying premiums at some point during 2015, and 4 out of 5 of those individuals re-enrolled in 2016.¹⁵ These individuals effectively churn in and out of the risk pool, causing insurers, providers and other consumers to bear the cost of their care when the individual does not pay premiums.

Impacts of Hardship Exemptions. The individual mandate is a key component of the ACA that helps to balance the risk pool between healthy and sick individuals. The ACA identified nine “hardship” exemptions for individuals who experience life situations that prevent them from getting coverage. The federal government subsequently created 15 additional exemptions, applying a broad interpretation of hardship. Each exemption excuses individuals from paying the penalty associated with not having coverage for part or a whole coverage year. In effect, the exemptions eliminate all of these individuals from the risk pool. In 2014, the Congressional Budget Office projected that of 30 million estimated uninsured Americans in 2016, only 4 million would pay the individual mandate penalty, with the vast majority qualifying for an exemption due to hardship, unaffordability or other reasons.¹⁶

Plan Design Limitations

The ACA set new requirements for what types of benefits to cover and the way in which those benefits should be covered. In terms of benefits that insurers must cover, ACA established ten Essential Health Benefits that covers benefits for all individuals such as maternity coverage, and required health insurance issuers to cover certain recommended preventive health services with no cost-sharing. The ACA also set thresholds on how these benefits must be covered by prohibiting lifetime or annual dollar limits on most benefits, requiring that products meet “actuarial value” benefit richness requirements, and by establishing out-of-pocket dollar maximums for most benefits to limit consumers’ exposure to cost-sharing during the benefit year. While these requirements standardized protections for consumers, they also shift costs- or add new ones- to the health coverage.

Health insurers have long relied on a variety of tools to manage the health of their member population and improve affordability of insurance coverage. These tools help to manage costs borne by consumers and insurers for health care. Such tools are increasingly important as policies make benefits richer and easier to access. The design of [prescription drug formularies](#) and provider networks help health insurers guide consumers to lower-cost, higher quality care.

- **Prescription drug formularies:** A health insurer may use tools to adjust cost-sharing for prescription drugs and use programs like step therapy and prior authorization help to help ensure safe, effective and cost-conscious drug use. Recent federal policies have set requirements around how formularies and drug cost-sharing may be designed and how consumers may access prescription drugs. Examples include prescribed processes and criteria for access to non-formulary drugs and limitations on use of mail-order benefits on formularies. Such policies limit insurers’ flexibility to manage costs and quality of drug coverage.

¹⁵ McKinsey & Company. [2016 OEP: Reflection on Enrollment](#). May 2016.

¹⁶ Congressional Budget Office. [Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update](#). June 2014.

- **Provider networks:** A health insurer may choose to adjust the size of its networks to incentivize consumers to use particular high quality, cost-effective or innovative providers. Networks may be narrowed to include only these types of providers, or tiered to offer better benefits for use of these providers. Similar to drug policies, the federal government has set policies that have introduced greater federal oversight and has indicated an interest to set detailed access standards across provider specialties. Such policies may impede the success of health insurers in their efforts to keep coverage affordable while serving a sicker population.

Other Challenges: Lack of Risk Corridor Payments

The risk corridor program is one of three premium stabilization programs in the ACA. This particular program's purpose is to protect against the risk of each insurer under-pricing or over-pricing during the initial years of the ACA (2014 through 2016). Health insurers that experience losses above a defined threshold receive payment under the program and health insurers with profits above a defined threshold pay into the program. In late 2014, the government unexpectedly announced that the risk corridor program would be administered on a "budget neutral" basis – meaning that all payouts would have to be supported by collections from insurers making excess profits. Subsequently, the government modified its position, making the program budget neutral based on the entire three years of the program – meaning that a shortfall in payouts due to a shortfall of collections in one year could be offset by collections in subsequent years. Insurers did not have a reason to expect this "budget neutrality" when they set premiums for 2014 and counted on its protections.

Because the pool of members in 2014 was sicker than most insurers expected and priced for, most insurers were due a payment for 2014 (to be paid in 2015). With the budget neutral policy, funding for 2014 was insufficient and it is expected to be for the additional two years of the program. As reported by the federal government in October 2015, insurers collectively contributed \$362 million into the risk corridor program for excess profits and requested \$2.87 billion in payments for excess losses; the federal government paid approximately 12.6% of what insurers were due.¹⁷ A continuation of expectedly high health care expenses for ACA members in 2015 once again left many insurers eligible for payment for that year. (Final reporting for 2015 will be due in July 2016, so official numbers for amounts due for payout and due to be paid in are not available at this time.) Without financial protection of the risk corridor program, insurers' financial position for the initial years of the ACA is weakened, which adds to the challenge of market sustainability.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina recognizes that Marketplace stability is a major issue, and continues to develop recommendations to address these concerns. To stabilize costs and create a sustainable Health Insurance Marketplace, the [levels of risk](#) must be dispersed more effectively to ensure balance and active participation. Additionally, federal policies must not add costs and significantly limit

¹⁷ US Department of Health and Human Services. [Risk Corridors Payment Proration Rate for 2014](#). October 2015.

coverage options. Moving forward, BCBSNC offers several recommendations to improve the ACA and accomplish these goals:

- Stronger enforcement of the individual mandate that requires coverage. Everyone needs to pay in. To work correctly, any health insurance market needs a large pool of customers, including those who use relatively few medical services. The ACA allows too many healthy people to avoid coverage.
- Stop adding to the list of hardship exemption criteria. The ACA lists nine and CMS has added fifteen more through regulation.
- Eligibility for hardship exemptions from the individual mandate should be confirmed annually.
- Tighter control of eligibility for special enrollment periods. The ACA allows far too many exceptions outside of its open enrollment periods. Allowing sign-ups outside the open enrollment periods leads to people enrolling when they're sick and dropping coverage when they're better. Recent steps by the government to limit and verify eligibility for special enrollment periods are a step in the right direction – but they don't go far enough.
- Shorten the 90-day grace period for those who receive government subsidies to help pay their premiums. The lengthy grace period creates an opportunity to drop coverage and pay less than owed. In this timeframe, if customers do not obtain any services in the first three months of their policy, they can skip payment, let their coverage lapse, and enroll at another time. However, if they do need services, they pay their premium and get their claims paid. Those exploiting this window have the assurance that their health care needs will be covered, without committing to the system until they are sure they will use it for more costly services.
- Do not set new benefit mandates that health insurers must cover for all individuals, as these increase cost of coverage for everyone. Allow health insurers flexibility to vary benefits to meet the needs of their member population.
- Allow health insurers flexibility to use tools and innovation to manage prescription drugs or provider networks in order to promote affordability of coverage.
- Fully fund programs to help stabilize the insurance market. In particular, the “risk corridor” program that insurers pay into has been woefully underfunded. Insurers pay into programs to help even out gains and losses, but the federal government changed the rules for funding the program after insurers made decisions based on the old rules; just 12 percent of what was owed to insurers for their losses in 2014 under the program.

For More Information:

George Mason University Mercatus Center. The Affordable Care Act in 2014: Significant Insurer Losses despite Substantial Subsidies: <http://mercatus.org/publication/affordable-care-act-2014-significant-insurer-losses-despite-substantial-subsidies>

Oliver Wyman. Special Enrollment Periods and the non-Group ACA-Compliant Market: <https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf>

Milliman. Headwinds Cause 2014 Risk Corridor Funding Shortfall: <http://us.milliman.com/insight/2015/Headwinds-cause-2014-risk-corridor-funding-shortfall/>

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