



Research Insights

■ Stabilizing Individual Health Insurance Markets

Summary

As the health insurance market of last resort, the individual, or nongroup, market fills a critical gap for millions of Americans who can't get coverage elsewhere. In 2014, market reforms and premium subsidies authorized by the Affordable Care Act (ACA) expanded the individual market by making coverage more accessible and affordable for millions of lower- and middle-income people. But dramatic premium increases in 2017 and 2018, driven by earlier underpricing and federal policy changes since 2017, have unsettled the individual market and resulted in much higher premiums for enrollees, especially higher-income people who are ineligible for subsidies.

Moreover, federal policies have encouraged alternatives to comprehensive individual health insurance—such as association health plans, health care sharing ministries, and short-term and disease-specific coverage—that offer lower premiums but may put consumers at serious financial and health risk, according to many health policy experts. While some states have moved to mitigate federal policies seen as destabilizing the individual market and putting consumers at risk, other states have taken a more hands-off approach. Overall, individual market premiums stabilized in 2019 and 2020 as pricing better tracked underlying claims trends. But compre-

hensive individual coverage for many unsubsidized people remains unaffordable as underlying health care costs continue to grow faster than the overall economy and workers' wages and incomes.

Federal and state governments are considering new ways to assure competition, accessibility, affordability, and stability in the individual market. This pursuit is driven by several factors including: the repeal of the federal health insurance mandate, wider availability of short-term and other plans that don't comply with ACA requirements, and the expiration of the ACA's risk corridor and reinsurance provisions.

This brief summarizes key points from a meeting convened by AcademyHealth in September 2019. Research and policy experts reviewed existing research on the individual health insurance market, including trends in market stability and federal and state policy options to address market stability. Additional research is needed to help policymakers understand and isolate what policies, especially at the state level, are working to make individual coverage more accessible and affordable. Research also can help identify how consumers are faring with health plans that don't meet ACA requirements for comprehensive coverage and how widespread that coverage is.

Genesis of this Brief:

This brief is based on a meeting of policymakers and researchers that took place in Washington, D.C., on September 6, 2019. AcademyHealth convened the meeting as part of its Research Insights Project. Funding for the conference was made possible by Grant No. 5R13HS018888-09 from the U.S. Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the U.S. Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. The Research Insights Project convenes invitational meetings, holds webinars, and produces reports and issue briefs to foster discussion of existing, relevant research evidence among policy audiences that need to implement health reform and develop new policy. Additional information and publications may be found on the project's website at <http://www.academyhealth.org/about/programs/research-insights>.

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Overview

The vast majority of Americans either get private health coverage from an employer or public coverage through Medicare, Medicaid, or other sources like military coverage. For a small segment of Americans—less than 5 percent—who can't get covered elsewhere, the individual health insurance market is their only option. Before enactment of the ACA market reforms and premium subsidies in 2014, an estimated 10.6 million people bought individual health coverage in 2013.¹ At that time, insurers in most states could price policies based on people's health status; exclude coverage of pre-existing conditions; cover or exclude certain services or benefits; and deny coverage outright. The result: Many people were either denied coverage, obtained less-than-comprehensive coverage or were priced out of the market.

A major ACA goal was to stabilize the individual health insurance market through federal reforms and premium subsidies aimed at making individual coverage more standard, accessible, and affordable. Key ACA market reforms included:

- requiring most people—healthy and sick and younger and older—to have health insurance;
- abolishing coverage exclusions for pre-existing conditions and requiring guaranteed issue;
- establishing standardized essential health benefits that must be covered by ACA-compliant health plans;
- setting plan actuarial values, or the percentage of total average costs for covered benefits that a plan will pay, based on metal tiers—bronze (60%), silver (70%), gold (80%), and platinum (90%);
- establishing medical loss ratios, or the share of premiums that must go to medical care and quality improvement, at 80 percent;
- requiring modified community rating of premiums, adjusted for an individual's geographic location, age, and use of tobacco; and
- creating state-based or federally run health insurance marketplaces, along with outreach and navigators, to help consumers shop for coverage.

Along with these new federal rules of the road, the ACA provided premium subsidies through tax credits to eligible people with incomes from 100 percent to 400 percent of the federal poverty level, or incomes ranging from \$29,435 to \$85,332 for a family of three in 2019.² The ACA also provided cost-sharing reductions (CSRs) that increased the actuarial value of health plans by reducing deductibles and other out-of-pocket spending for people with incomes up to 250 percent of poverty.

In 2014, the first year the new ACA market rules and premium subsidies were in place, individual market enrollment jumped to 15.5 million people—an increase of nearly 5 million people from 2013. In 2015, enrollment peaked at 17.4 million before dropping slightly in 2016 to about 17 million people. Sharp premium increases and other factors drove relatively large enrollment drops in 2017 to 15.2 million and then 13.8 million in 2018.³

In September 2019, AcademyHealth's Research Insights project convened a meeting of leading academic researchers and policy experts to discuss the current state of research on the individual health insurance market. The goal of the meeting was to review recent trends in individual health insurance market stability and identify the effects of a range of federal and state policies intended to strengthen the individual market's infrastructure. This brief summarizes the September meeting. Because the session was off the record, the brief conveys the general content of the meeting without attributing specific comments to particular participants. The discussion was informed by existing research though neither the discussion nor this brief incorporates a systematic review of the literature on the individual insurance market. A bibliography of relevant, current literature is included at the end of the brief.

ACA Provisions to Stabilize the Individual Market

The main purpose of health insurance is to spread the financial risk of an individual's medical care across a large group—or risk pool—of both healthy and sick people. If only sick people buy coverage, then a phenomenon known as **adverse selection** occurs, which left unchecked can lead to a so-called death spiral of higher and higher premiums that ultimately drive people from the market.⁴ A related concern is **risk selection**, which occurs when insurers try to avoid enrolling sicker people who are likely to need more costly care. Additionally, in the early years of market reform, as many previously uninsured people gained coverage, insurers faced a great deal of uncertainty about how to price coverage, which led to premium volatility until they gained claims experience to guide more accurate pricing.

Discussions about ACA provisions aimed at stabilizing the individual insurance market and decreasing volatility focused on mechanisms to address both adverse selection and risk selection. The provisions designed primarily to prevent adverse selection included a tax penalty for most people without health insurance to encourage healthy people to enter the market. At the same time, to make coverage more affordable for lower- and middle-income people, the law subsidized premium costs through tax credits tied to income and premium levels and authorized CSR payments to health plans covering lower-income people.

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The law also created the health insurance marketplace and navigator programs to actively market individual coverage and help consumers shop for coverage. Standardized benefits and reforms limiting alternative forms of individual coverage also were instituted to keep everyone, healthy and sick, in the same market and risk pools. Lastly, the ACA allowed states to expand their Medicaid programs, which has the effect of pulling low-income people who often have higher medical costs and can't afford private insurance out of the individual market.⁵

To minimize incentives for insurers to engage in risk selection and counter adverse selection, the ACA included the so-called three R's of risk adjustment, reinsurance, and risk corridors. The risk adjustment program redistributes funds from health plans with lower-risk enrollees to plans with higher-risk enrollees—in other words, the provision requires insurers to share the cost of high cost-enrollees. The temporary reinsurance program, which ran from 2014-2016, required the federal government to share the risk of high-cost enrollees with insurers by providing payments to plans once an enrollee's costs exceeded a certain threshold. Similarly, the temporary risk corridor program, which was in place from 2014-2016, limited health plan losses and gains beyond an allowable range to give insurers security to offer a new product knowing that their losses would be backstopped.⁶

Unraveling of Major ACA Stabilization Provisions

Given the lack of bipartisan support for the ACA's passage in 2010, the law has been subject to significant political uncertainty, including multiple efforts to repeal the law and numerous court challenges. Even before revamped individual insurance markets launched in 2014, the U.S. Supreme Court ruled in 2012 that the Medicaid expansion was voluntary for states. As of November 2019, 37 states and the District of Columbia had expanded Medicaid, while 14 states had not.⁷ In non-expansion states, instead of getting Medicaid coverage, eligible working-age people without children and incomes ranging from 100-138 percent of poverty are eligible for subsidized coverage in the marketplaces, while those with incomes below 100 percent of poverty are ineligible for subsidies and are therefore likely to remain uninsured.

Leading up to open enrollment for 2018 marketplace coverage, the Trump administration in 2017 took a number of steps to weaken the ACA market reforms, including cutting funding for navigators to assist consumers with shopping for coverage and eliminating CSR payments to insurers. Despite the presidential ban, federal law required insurers to continue providing CSRs to people with incomes at or below 250 percent of the poverty level who bought silver plans in the marketplaces. In most states, regulators allowed insurers receive compensation for the CSRs they were obligated to offer lower income enrollees, known as silver loading, which

increased premiums for silver-level marketplace plans to make up for the loss of federal CSR payments.^{8,9}

Additionally, in December 2017, Congress passed the Tax Cuts and Jobs Act, which eliminated the individual mandate penalty, effective January 1, 2019. Then, in 2018, the administration finalized rules designed to encourage alternatives to comprehensive individual health insurance, including exempting association health plans from providing essential health benefits and prohibitions against charging higher premiums based on gender and occupation, as well as allowing short-term, limited-duration insurance (STLDI) plans exempt from the ACA's pre-existing condition and essential health benefit requirements to last to up to a year, instead of three months, and be renewed for up to three years. More recently, the administration finalized a rule allowing employers to use health reimbursement arrangements (HRAs) to fund premiums for their employees in the individual market. While the impact on the individual market is uncertain, some fear that employers with sicker and older workers will be more likely to adopt the new HRAs, leading to adverse selection and higher premiums across individual insurance markets.

Individual Market Stable but Increasingly Segmented and Unaffordable

Discussion about whether the individual insurance market is stable centered on three traditional definitions of market stability:

- An insurance market is stable if it tends toward equilibrium with both insurers offering coverage and consumers willing to buy coverage.
- An insurance market is stable if modest shocks do not cause large swings in market outcomes.
- An insurance market is stable if market outcomes change little over time.

Despite high premium increases in 2017 and 2018 and lots of policy twists and turns, insurers are now profitable and premium trends declined slightly in 2020. So, by any of the three definitions of stability, the individual market is stable. However, as one participant said there is "a lot not to like about this stable equilibrium" in terms of affordability, low enrollment levels, the fiscal cost of the subsidies, and limited plan choice.

Moreover, evidence also points to a fair amount of local market volatility related to a number of factors, including whether or not states expanded Medicaid, population characteristics, and the number of insurers participating in the marketplaces in specific geographic areas. All of these factors can affect plan affordability and plan choices, especially in rural versus urban rating areas and between subsidized and unsubsidized enrollees.

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Overall, research shows local individual insurance markets are fairly concentrated, and while they may be stable, they aren't very competitive. Premium levels are inversely related to the number of insurers in a market. Similarly, premium spreads—the difference in monthly premiums between the lowest cost plan and the benchmark silver plan—are inversely related to competition. So, in markets with monopolies, premium spreads are larger.

The individual market also is increasingly segmented—both in terms of subsidized and unsubsidized enrollees in ACA-compliant marketplace plans and enrollment in ACA-compliant and non-compliant health plans outside of the marketplaces. More is known about what's going on in the marketplaces, where about 30 percent of enrollment is unsubsidized. All signs point to unsubsidized people “peeling off” from ACA-compliant marketplace plans as premiums continue to rise, according to a participant.

Ironically for the Trump administration, the elimination of CSR payments made coverage more affordable for lower-income people because their subsidies increased as premiums increased when states allowed insurers to load cost sharing expenses into the benchmark silver plan in the marketplaces. However, unsubsidized people had to shoulder the full cost of higher premiums resulting from silver loading. As one participant said, “Plans silver loaded where they could, and plan affordability improved the most for the subsidized groups, but those who are unsubsidized, particularly in rural markets, fared the worst,” although there was considerable variation due to state and local market conditions.¹⁰

Proliferation of ‘Sketchy’ Coverage Complicates Market Understanding

In recent years, increased availability of data through the federal and state marketplaces has been a boon to researchers trying to better understand the dynamics of the individual insurance market. However, the proliferation of non-ACA-compliant insurance and other arrangements that in some cases escape regulatory scrutiny has added a new level of complexity to monitoring the individual market.

As one participant said, “Every week there's some new product that comes on the market that looks sketchy.” In states, where regulators aggressively work to protect consumers from fraudulent schemes, another participant observed that trying to keep up with questionable new products entering the market is like playing “whack-a-mole.”

Participants discussed possible ways to gather information about the non-compliant market, including surveys of consumers, but questioned whether consumers would know exactly what kind of coverage they have given the plethora of arrangements being offered. Arrangements such as health sharing ministries and direct payment for primary care, which do not qualify as insurance, also can fly under the regulatory radar. In the case of STLDI plans, which are regulated as insurance, the National Association of Insurance Commissioners will soon be asking states to assist with collecting data about offerings, which should help illuminate what's going on with those products for regulators, but the data will not be made publicly available.

Policy Levers to Increase Accessibility and Affordability

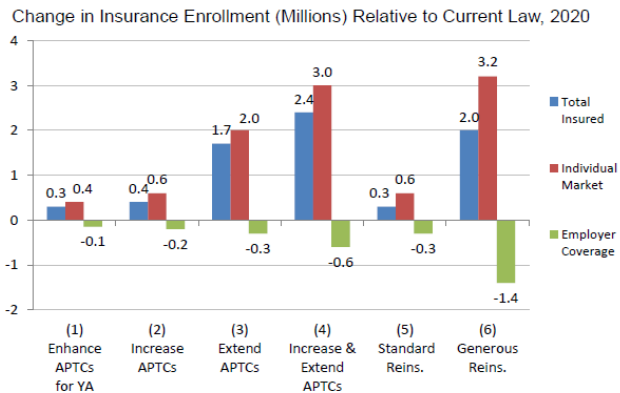
Following 24 percent and 37 percent average premium increases in 2017 and 2018, respectively, for the second lowest cost marketplace silver plan—also known as the benchmark silver plan—average premiums in 2019 decreased about 1 percent, according to a presenter. Going forward, premium trends likely will more closely track changes in underlying health care cost trends. While the more stable premium environment is good news, underlying national health care spending is projected to grow about 5.5 percent annually through 2027, outpacing average projected growth in gross domestic product (GDP) by 0.8 percentage point, according to the federal government.¹¹ Moving forward, there are a range of federal and state policy approaches that could strengthen individual insurance markets across the country by bolstering both accessibility and affordability of health plans offered in the marketplaces, as well as monitoring of coverage offered outside the marketplaces.

Federal Policy Interventions to Increase Marketplace Enrollment

RAND Health has modeled a number of policy proposals designed to increase enrollment in the individual market, which were shared at the meeting and range from targeted increases in premium subsidies for young adults to extending eligibility for premium subsidies to higher income people to reinstating a federal reinsurance program.¹² The policy bang for the buck depends on the specifics of each proposal. For example, a relatively modest \$50 monthly increase in subsidies for young adults aged 18 to 30 years old could increase enrollment in the individual market by an estimated 400,000 people, while extending subsidies to people with incomes above 400 percent of poverty could boost enrollment by an estimated 2 million people. Under a reinsurance program that would cover 100 percent of an enrollee's claims between \$45,000 and \$250,000, enrollment could increase by up to 3.2 million people. Exhibit 1 illustrates the estimated impact of different policy proposals, including increases in the total number of insured people, effects on individual market enrollment, and related changes in employer coverage.

Exhibit 1

Options Could Expand Individual Market Enrollment by 400,000 to 3.2 million



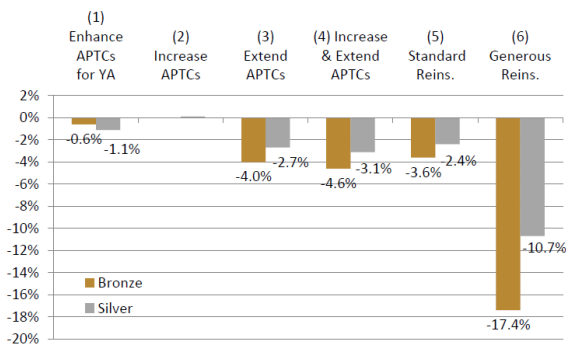
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The RAND model also estimates how each policy proposal would affect premiums. For example, increasing premium subsidies for currently eligible people would essentially have no effect on premiums for a 40-year-old nonsmoker, while the generous reinsurance proposal would decrease average premiums for bronze plans by 17.4 percent and average premiums for silver plans by 10.7 percent. Exhibit 2 shows the range of estimated premium changes related to each policy proposal.

Exhibit 2

Generous Reinsurance Could Reduce Bronze Premiums by Around 17 Percent



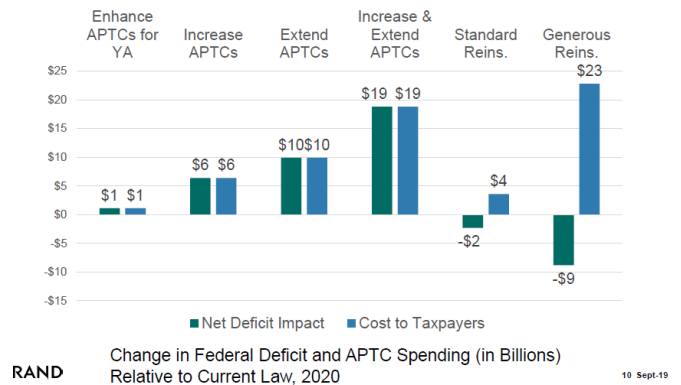
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Additionally, the RAND model incorporates two estimates of spending impact for each policy intervention: the net impact on the federal deficit and the cost to taxpayers. Under the various scenarios, the estimates for increasing premium subsidies result in both increased spending and concurrent deficit increases. However, because the reinsurance proposals would be funded by health plan fees, they would actually decrease the federal deficit, as shown in Exhibit 3.

Exhibit 3

Because They Are Funded by Health Plan Fees, Reinsurance Options Reduce the Deficit



RAND

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State Policy Interventions to Increase Marketplace Enrollment

While about half the states and the District of Columbia have taken steps to mitigate federal policies seen as destabilizing the individual market, other states have taken a hands-off approach, according to Georgetown University’s Center for Health Insurance Reforms (CHIR), which tracks state actions related to the individual market.

For example, the District of Columbia and a handful of states—California, Vermont, Massachusetts, Rhode Island, and New Jersey—require residents to maintain health coverage. Similarly, almost two dozen states have set higher standards for STLDI plans than required by federal regulation, while about a dozen prohibit non-compliant transitional health plans that predated the ACA and were “grandmothered” at the federal level. At the opposite end of the oversight spectrum, in three states—Iowa, Kansas, and Tennessee—health plans sold by the Farm Bureau are not considered health insurance under state law and are exempt from federal and state consumer protections applicable to the individual insurance market.

States also are experimenting with reinsurance programs; merging the small group and individual markets to create a larger and more diverse risk pool; so-called tying provisions that require insurers participating in markets for Medicaid and state employees to participate in the state’s individual market; and providing additional premium and cost-sharing subsidies to lower-income people. In the case of California, people with incomes up to 600 percent of poverty will be eligible for state-funded subsidies in 2020.

Some states also are increasing marketing and outreach efforts, including paying navigators to help consumers shop for health plans, to help offset federal reductions. Several participants stressed the importance of marketing the availability of individual insurance to consumers, especially young adults, with one saying that “health

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insurance does not sell itself and needs to be marketed.” In a similar vein, another participant observed that efforts to lower premiums are important, but “if no one knows premiums are lower, they won’t enroll.” According to CHIR, state-based marketplaces spent an average of \$13.23 per uninsured person for marketing, outreach, and navigator programs during the last open enrollment in late 2018 compared to \$0.51 per uninsured person in the federally facilitated marketplaces.

Another policy lever for states to consider is a public option plan. To date, only one state—Washington—has passed legislation authorizing a public option, which will be aimed at making coverage more affordable for unsubsidized people. Under the Washington law, the state will contract with issuers to offer state-procured standard health plans that meet ACA qualified health plan requirements in 2021. The main affordability strategy is a reference price that will require issuers to show the state that, in the aggregate, they are paying contracted providers no more than 160 percent of Medicare rates.

Future Research Needs

In recent years, health researchers and policymakers have made tremendous strides in better understanding the inner and often opaque workings of individual health insurance markets, in large part because of more and better data available through the marketplaces. But blind spots remain, especially related to noncompliant plans and other coverage arrangements, such as Farm Bureau plans and health care sharing ministries. Future research can help identify how consumers are faring with health plans that don’t meet ACA requirements for comprehensive coverage.

Research also is needed to help policymakers understand and isolate what policies, especially at the state level, are working to make individual coverage more accessible and affordable. “It would be so helpful to have a state-by-state market analysis, not only looking at stability and affordability, but what states have done policy wise,” a participant said.

Policymakers also are interested in research examining take up of insurance among unsubsidized people, price sensitivity across income and age brackets, and how standard benefit designs might change participation by age groups. Assessing the impact of the new HRA options on the individual market will be another area for researchers to focus on, participants observed.

For the first time since the ACA passed in 2010, the rate of Americans without health insurance ticked up in 2018. The Census Bureau reported in September 2019 that about 27.5 million people,

or 8.5 percent of the U.S. population, were uninsured for all of 2018, up from 7.9 percent in 2017. The increase in the rate of Americans going without health insurance adds a policy imperative to make the individual insurance market more accessible and affordable as more Americans may face shopping in the market of last resort.

About the Author

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Endnotes

1. Fehr, R., Cox, C., & Levitt, L., “Data Note: Changes in Enrollment in the Individual Health Insurance Market through Early 2019,” Kaiser Family Foundation (August 2019). Accessed at <https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/>.
2. U.S. Department of Health and Human Services, “Federal Poverty Guidelines.” Accessed at <https://aspe.hhs.gov/2019-poverty-guidelines>.
3. Fehr, et al. (August 2019).
4. Cox, C., Semanskee, A., Claxton, G., & Levitt, L., “Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors,” Kaiser Family Foundation (August 2016). Accessed at <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.
5. DeLeire, T., Dague, L., Leininger, L., Voskuil, K., and Friedsam, D., “Wisconsin Experience Indicates That Expanding Public Insurance To Low-Income Childless Adults Has Health Care Impacts,” Health Affairs (June 2013). Accessed at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1026>
6. Cox, C., et al. (August 2016).
7. Kaiser Family Foundation, “Status of State Medicaid Expansion Decisions: Interactive Map” (November 2019). Accessed at <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.
8. Dorn, S., “Silver Linings For Silver Loading,” Health Affairs Blog (June 3, 2019). Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20190530.156427/full/>.
9. Drake, C. and Abraham, J., “Individual market health plan affordability after cost-sharing reduction subsidy cuts,” Health Services Research (June 2019). Accessed at <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13190>
10. Sprung, A., and Anderson, D., “Mining The Silver Lode,” Health Affairs Blog (September 7, 2018). Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20180904.186647/full/>
11. “Health Affairs: Health Spending Projections Through 2027,” Health Affairs Blog (February 22, 2019). Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20190221.997607/full/>.
12. Liu, J., & Eibner, C., “Expanding Enrollment Without the Individual Mandate: Options to Bring More People into the Individual Market,” The Commonwealth Fund Issue Brief (August 13, 2018). Accessed at <https://www.commonwealth-fund.org/publications/fund-reports/2018/aug/expanding-enrollment-without-individual-mandate>.