issue brief

Considerations Related to Pricing Individual and Small Group Health Insurance under Health Reform

Executive Summary

At an invitational meeting convened by AcademyHealth in April 2011, expert researchers, policymakers, insurers, actuaries, and analysts discussed issues related to insurance pricing in the individual and small group markets once the Affordable Care Act (ACA) is fully implemented on January 1, 2014. The ACA's multiple provisions related to rates and risk (e.g., rate review, medical loss ratio requirements, rating changes, risk adjustment, reinsurance, risk corridors) are expected to affect the pricing of insurance in the individual and small group markets.

The following capture key take-away points from the meeting:

Shaping of Risk Pools

- Changes in the size of the risk pool and the proportion of healthier versus sicker enrollees in that pool will have significant impacts on small group and individual premiums in the post-2014 marketplace.

- A major concern of insurers is that premiums be set in a way that ensures healthy individuals remain in the risk pool.

- Whether or not large numbers of high risk uninsureds enroll in plans beginning in 2014 depends somewhat on current market practices since individual markets in the handful of states that currently practice guaranteed issue and/or community rating will likely have already insured the sickest individuals who can afford coverage. However, for other states, where medical underwriting is current practice, larger numbers of high risk uninsureds may enroll in 2014. In addition, current high risk pool and pre-existing condition insurance pool members may move to the new guaranteed issue market.

Uncertainty in the Marketplace

- Lack of familiarity with a new risk adjustment system could lead to greater uncertainty in the insurance pricing process, potentially adding a "risk premium" to the price of policies. By contrast, the temporary nature of the transitional reinsurance and risk corridor programs render them less urgent for insurers than issues related to the risk pools and to risk adjustment.

- There could be significant churning with associated premium fluctuations during the first few years of full implementation of the ACA.

- Pricing, selling, and purchasing insurance in the individual and small group markets may be more complex beginning in 2014 due to plans being offered inside the exchanges and outside, multiple choices of plans, and the availability of multiple programs and subsidies for individuals and families. Although the roles of agents and brokers will evolve in response to this additional complexity, they will have continuing responsibility for informing potential enrollees about various plan choices and helping them determine their eligibility for various subsidies.

- It is less clear whether agents and brokers (versus health insurance exchanges or navigators) will address post-enrollment questions. It is also uncertain who will assist enrollees when life or job changes impact their eligibility for subsidies.

Robert Wood Johnson Foundation

Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

Determinants of Pricing

- Reform issues that may affect pricing in the individual and small group markets include initiatives to increase transparency, accountable care organizations (ACOs), enrollment in Medicaid and other public health care programs, and new health care cooperatives or co-ops. The magnitude of these effects remains unclear. Opinions are mixed about whether the expected growth in Medicaid enrollment and demand for services will result in cuts in provider payments under Medicaid. In addition, there is likely to be significant variation in states' responses to Medicaid expansion, including the level of enrollment and the effect on provider payments of higher federal matching rates on new eligibles.[1]

In concluding remarks, meeting participants stressed (1) the benefit of regulatory guidance on important issues being released as early as possible, with ample time for review and as much specificity as possible; and 2) carefully managing expectations regarding the impact of health reform, especially the number of people to be covered and impacts on cost.

Overview

In April 2011, the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative sponsored an invitational meeting to foster discussion among expert researchers, policymakers, insurers, actuaries, and analysts focused on insurance pricing in the individual and small group markets once the Patient Protection and Affordable Care Act (ACA) is fully implemented on January 1, 2014. The purpose of this brief is to provide a summary of the meeting discussion and inform other interested individuals.[2]

Discussion at the meeting focused on key policy, research, and regulatory questions including:

1. What factors will insurers take into account when pricing their products?
2. What will be the impact on prices of risk-related provisions in the ACA, including risk adjustment, risk corridors, reinsurance, minimum medical loss ratio (MLR) requirements, and limits on underwriting?
3. What impact will health insurance exchanges have on administrative and marketing costs in the small group and individual markets? How will the roles of brokers and agents change in 2014?
4. How will health insurance exchanges and other changes in the marketplace such as accountable care organizations (ACOs) and co-ops affect health care costs?

National health reform legislation became law when the ACA was enacted on March 23, 2010. Multiple provisions of the ACA (e.g., rate review, MLR requirements,[3] rating changes, risk adjustment, reinsurance, risk corridors), as well as uncertainty in certain markets, will affect how insurers price their products once the legislation is fully implemented on January 1, 2014. Although there is some past experience and research to help predict the effects of each of these provisions by themselves, there is little or no evidence about how they will interact to influence premiums and market dynamics. The need to account for new individuals entering the market with no available risk profiles (i.e., individuals currently without insurance by choice, or because they are unable to purchase or afford insurance) and the effects of rules related to health insurance exchanges, around which there is still regulatory uncertainty, will further complicate insurer pricing decisions.

Factors Affecting Health Insurance Pricing Decisions

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created new standards for guarantee issue, guarantee renewal, and pre-existing condition exclusion in the individual and small group markets.[4] The ACA brings multiple new reforms to these markets (see Table 1).

Impacts of and Interaction Among ACA Insurance-Related Provisions

Meeting participants engaged in a robust discussion of risk and the impact various ACA-related reforms could have in the small group and individual markets. Topics included the composition of risk pools, including the likely risk profiles of newly insured individuals beginning in 2014; risk adjustment; and risk corridors and reinsurance.

Risk pools

The ACA requires insurers in the small group and individual markets to consider enrollees in all of its products in the applicable market to be members of a single risk pool for the purpose of determining premiums[5] (i.e., this pool will include individuals who enroll in plans offered inside a health insurance exchange and those who enroll in plans offered outside the exchanges). States may treat the individual and small group markets separately or merge these markets.[6] One of the major concerns anticipated by insurers for 2014 is that premiums be set in a way that ensures healthy individuals remain in the risk pool. The size of the risk pool and the proportion of healthier versus sicker insureds in that pool are important determinants of an insurer's viability in the marketplace. Participants discussed several possible scenarios and outcomes, including:

- If insurers price incorrectly and set premiums too high, there is a great risk of people (particularly younger and healthier people) becoming uninsured.
- If the individual mandate is ineffective and lower risk individuals drop out of the pool, the average risk of enrollees remaining in the pool will increase.
- If sicker individuals who anticipate higher use of health care services enroll in plans offered by brand-name companies and healthier individuals who do not anticipate high use of health care services enroll in plans offered by less established companies, an effective risk adjustment system will be

Table 1. **Key ACA Provisions in the Individual and Small Group Markets**[7]

- Establishes "grandfathered" plans[8] to allow individuals and businesses to keep their current plans; many ACA provisions do not apply to grandfathered plans.
- Prohibits group health plans (new and grandfathered) and issuers in the individual and group markets from excluding coverage for pre-existing health conditions.
- Prohibits group health plans and issuers in the individual and group markets from basing eligibility for coverage on health status-related factors.
- Requires health insurance issuers in the individual and small group markets to determine premiums for coverage using adjusted community rating rules. Premiums will only be allowed to vary by individual vs. family coverage, geographic area, age (with variation in rates limited to a 3:1 ratio), and tobacco use (with variation in rates limited to a 1.5:1 ratio).
- Requires insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets to publicly disclose the proposed increases and the justification for them.
- Establishes two temporary programs to mitigate risk if there is an unexpected increase in risk in the individual market among enrollees and across insurers: reinsurance for the individual market and risk corridors for the individual and small group markets, as well as a permanent risk adjustment system.
- Requires issuers in the individual and small group markets to offer coverage that includes an "essential health benefits package" with certain categories of benefits specified in the law.
- Requires health insurance issuers to report information on their MLR (proportion of premium revenues spent on clinical services and quality improvement) and provide a rebate to their customers if they do not meet the minimum MLR.[9]

Historically, several types of factors have affected insurance pricing in the individual and small group markets (see Table 2). These factors include the domains of coverage/benefits, enrollee characteristics, regulatory factors/uncertainties, insurer/market characteristics, and other external characteristics. As the ACA is implemented, some of these factors will persist, others will no longer be permitted, and a variety of new factors may be added that impact pricing in these markets.

needed to compensate the brand-name companies for the additional risk.

- If financial penalties for certain employers who do not provide employees with coverage are inadequate, small employers will not take advantage of insurance availability through the health insurance exchanges and begin to offer coverage for the first time. In fact, some small employers currently offering coverage to their employees may drop coverage, leaving the employees to purchase individual coverage through the exchanges. It is expected that some of the low-income employees of small businesses who drop coverage will be eligible for Medicaid, requiring potentially unanticipated federal government subsidies.
- If a large number of healthy enrollees drop coverage, the impact on health premium rates will be larger than if a small number of high cost people are added to the risk pool.
- If individuals enrolling in non-grandfathered, guaranteed renewal, individual policies between March 23, 2010, and January 1, 2014, will be required to purchase a new policy through a health insurance exchange, they may have to pay a higher premium (e.g., if they are currently in a medically underwritten policy and are lower risk, they are likely paying a lower premium than would be available in the exchanges). There could be between 6.8-8.5 million people holding such policies at the time the exchanges are launched, and due to lack of clarity on this issue, insurers may stop writing policies that are guaranteed renewal between now and January 1, 2014.

To what extent will the risk pool be filled with the highest cost uninsureds?

After discussing the importance of maintaining healthy people in the risk pool, and identifying the considerations listed above related to the risk pool, meeting participants were asked about the expected amount of insurance uptake by the highest cost uninsureds once the exchanges and other health reform provisions are implemented. A majority of the group thought the most likely scenario was that new enrollees would be heavily composed of the highest cost uninsureds, some thought that there would be "average" uptake of insurance by the highest cost uninsureds, and a few thought there would be low uptake by the highest cost uninsureds.

Several participants noted that current market conditions will definitely impact which scenario comes to fruition. In the relatively few states (MA, ME, NJ, NY, and VT) whose markets are currently characterized by guaranteed issue and/or community rating in the individual market, for example, the sickest members are already insured. Some of the sickest

Table 2. **Factors Suggested by Meeting Participants as Affecting Pricing in the Individual and Small Group Markets**

Type of factor	Factors that have historically influenced pricing	Anticipated changes in factors expected to influence pricing under the ACA
Coverage/benefits	• Benefit levels and cost-sharing amounts	• Premium contribution discounts that employers will be able to offer to employees engaged in wellness activities
Enrollee characteristics	• Demographics • Geographic area • Health status of enrollees (in the individual market only)* • Industry (in the small group market)	• Smoking status of enrollees (for individual market) • Behavioral effects/responses to changes in copayments, deductibles, and out-of-pocket maximums
Regulatory factors/ uncertainties	• Regulatory environment and requirements	• Efficacy of the individual mandate and of employer requirements • Implementation of a risk adjustment system • Whether the state establishes a basic health program (BHP) and the price for coverage in that program
Insurer/market characteristics	• Projected claims costs • Projected non-benefit costs (e.g., administrative costs, marketing expenses, commissions) • Profit margin requirements • Case mix of enrollees • Extensiveness of network contracts (PPO, HMO) • Any insurance cycle characteristics (often a multi-year cycle with a few profitable years followed by a few unprofitable years)	• Changes in carrier behavior if rate reviews are instituted above a certain threshold (e.g., 9.9% increases if the threshold for rate review is 10%) • Requirements related to medical loss ratios (especially for plans substantially below the required 80% MLR for individual and small group markets)
Other external characteristics	• Market characteristics • Technological advances	• Increased demand for services but no corresponding increase in supply of providers (requiring substitution of providers and increased use of physician extenders) • Number of and type of competitors • Composition of risk pool • Exchange competition, tied to the second lowest cost "Silver" plan • Transparency of tier levels of benefits

*The ACA prohibits group health plans and issuers in the individual and group markets from basing eligibility for coverage or premiums on health status-related factors.

and highest cost uninsureds are expected to enroll in Medicaid rather than in fully insured policies in the individual and small group markets. Participants remarked on the low participation in the current high risk pools and suggested that this may be a predictor of future uptake in the exchanges. However, because premiums will be heavily subsidized in the exchanges, participation rates in the high risk pools may not be a good predictor of participation in the exchanges. While the sickest of the sick would likely qualify for Medicaid, many states are concerned about managing the movement by individuals between Medicaid and the exchanges. Participants noted that what is needed is clear guidance from the U.S. Department of Health and Human Services (HHS), both informally and through regulations, that will apply to new individuals entering the market.

Finally, some cautioned against "over promising" that the creation of large pools in the individual market will drive down health care costs. Insurers going into 2014 will undoubtedly make adjustments to premium prices to compensate for the level of risk they are likely to face.

Risk adjustment

The ACA requires states to apply risk adjustment to non-grandfathered issuers and health plans in the small group and individual markets. Risk adjustment refers to a process in which payments to health plans are adjusted to take into account the risk that each plan is bearing based on its enrollee population,[10] with the intent being

that insurers will be indifferent to sick and healthy enrollees. When risk adjustment is implemented in these markets under ACA, payments to insurers will be adjusted based on the differences in the risk characteristics (demographics, diagnoses) of the populations enrolled. This will help to ensure that "plans receive adequate payments when rating restrictions limit the extent to which premiums are allowed to vary by known risk factors."[11] Although the risk adjustment system to be used in these markets has not yet been determined, it is expected that insurers whose enrollees are below-average risk will make payments to a risk adjustment entity, which in turn will make payments to insurers whose enrollees are above-average risk.[12] Risk adjustment systems can be designed to accomplish goals including: 1) compensating insurers for any risk maldistribution they assume, and 2) reducing the effects of risk selection to allow competition based on medical and administrative efficiency and quality of care rather than ability to select risk.[13]

Meeting participants anticipated that the development and implementation of a risk adjustment system could increase uncertainty in the insurance pricing process by potentially adding another variable to pricing calculations in the small group and individual markets; they added that the uncertainty has the potential to raise premiums. Despite extensive research and practical application of various risk adjustment models in various markets across the country, and in Medicare, Medicaid, and private plans, meeting participants noted there is no "perfect" risk adjustment model. Several considerations were identified that should be taken into account in designing and implementing a risk adjustment system:

1. What behaviors or outcomes is the risk adjustment intended to incent (e.g., making insurers indifferent to risk prior to enrolling new members)?

2. How will risk adjustment payments be determined? Will the system be prospective (with premiums adjusted in advance to reflect the expected medical expenses of different enrollees) or retrospective (with payments adjusted at the end of the year after claims are incurred)?

3. Will risk adjustment be implemented uniformly across the country or allowed to vary geographically?

Reinsurance and risk corridors

Beginning in 2014, the ACA requires that 1) each state establish a temporary reinsurance program for the individual market, and 2) the secretary of HHS establish and administer temporary risk corridors for payments to qualified health plans (QHPs)[14] in the individual and small group markets. Reinsurance programs help insurers deal with unexpectedly high health care claims costs, basically functioning as "insurance for insurers." Under the ACA, all health issuers and third party administrators of self-insured group health plans will be required to contribute to a temporary, three-year, reinsurance program for individual policies. The formula for payments provides that aggregate amounts will total $10 billion in plan year 2014, $6 billion in plan year 2015, and $4 billion in plan year 2016.[15] The implementation of a temporary risk corridors program for the 2014-2016 plan years will adjust payments to QHPs according to a formula based on each plan's actual expenses relative to a target amount (with payments to plans increased if their expenses exceed a certain percentage above the target, and payments to plans decreased if their expenses exceed a certain percentage below the target).

Meeting participants expressed varying points of view about how they were planning for reinsurance and risk corridors and their likely impacts. There was a general sense that the temporary nature of these two programs rendered them less urgent (and they were receiving less attention from insurers) than issues related to the risk pool and to risk adjustment.

Other issues

Several other concerns about regulation and competition in the small group and individual markets post January 1, 2014 were identified. State officials noted that if health insurance rates go up dramatically, the corresponding need for and increase in subsidies will have a substantial impact on federal and state budgets; they acknowledged that this impact is variable depending on the number of enrollees at high premium levels. Others pointed out that because larger insurers are more likely to be able to lower administrative costs to meet the mandated MLR thresholds of 80-85 percent, markets may become more concentrated. Other factors that cause market uncertainty for insurers include legislative proposals for cross-border sales; the potential for new market entrants that may come in and price aggressively at the outset; and regulatory exemptions for certain carriers, religious groups, and association plans. The general sense among meeting participants was that there may be significant churning with associated premium fluctuations during the first few years of full implementation of the ACA.

How Will the Exchanges Affect the Insurance Marketplace?

A key component of the ACA involves the establishment of health insurance exchanges, through which individuals and small business will be able to compare and purchase qualified health plans. Only legal residents who are not incarcerated may obtain coverage through the exchanges.[16] A small employer may participate in the exchanges if all of its full-time employees are eligible for one or more QHPs offered in the small group market through an exchange that offers qualified health plans.[17] Each state is required to establish an exchange by January 1, 2014,[18] or the federal government will establish and operate one in the state.[19] With the exception of Alaska, all states and the District of Columbia have received exchange planning and establishment grants from HHS.

Beginning January 1, 2014, the ACA requires all newly sold individual and small group health insurance plans, both those sold inside health insurance exchanges and those sold outside, to be categorized in one of four levels of coverage.[20] The increasingly valuable precious metals – bronze, silver, gold, and platinum – correspond to increasing actuarial value of the plans (i.e., the share of health care costs that the plan pays for a typical group of enrollees vs. the remaining amount paid by the enrollees through deductibles, copayments, and coinsurance). Plans can also offer a lower actuarial value catastrophic coverage plan in the non-group market to individuals meeting certain criteria.[21] The ACA does specify a range of services[22] that must be included in the essential benefits package, but for other than preventive services, it does not specify what plan designs should be in terms of deductibles, copayments, and coinsurance; rather, the use of the actuarial value standard allows for flexibility among plans in benefit design.

The ACA further requires that insurers offer a qualified health plan in the silver level and a qualified health plan in the gold level in the exchange and that they agree to charge the same premium rate for each qualified health plan offered inside and outside the health insurance exchange.[23] While it is clear that enrollees in policies with coverage beginning January 1, 2014, or after would be in same risk pool, as noted above, the regulatory language is not as clear regarding enrollees in policies offered between March 23, 2010, and January 1, 2014. Meeting participants thought that additional clarity regarding regulatory language would likely affect insurer marketing and guaranteed renewal of these policies.

The discussion of exchange operations identified two significant, unresolved issues:

- How active a price negotiator the exchange will be; and
- Whether the exchange would accept all qualified insurers that want to participate.

One participant noted that the exchange as an active negotiator requires more regulation, and that every new layer of regulation makes the market less attractive to insurers and employers. Another participant noted that it is much easier to have a single set of products and prices inside and outside the exchange. However, there are trade-offs and challenges in such standardization (e.g., complexity of product offerings vs. ease of comprehension for consumers). Another participant noted that the value of the exchanges is in the work and negotiating done on behalf of the consumer and the resulting package of services sold. Various other considerations related to exchange operations included 1) whether enrollees in health plans inside the exchanges will be able to switch plans on a regular basis; and 2) since the exchange rather than the insurers will be paying broker commissions for plans offered inside the exchange, what will it mean for prices to be the same inside and outside of the exchange.

Essential Benefits Package

Participants raised a number of issues concerning the structure of the essential benefits package. Some participants said it was important to have a standard benefit package and not allow plans to "top up" by offering additional benefits. With a regulated price, "rich" essential benefits package, and "tight" medical loss ratios, competition between insurers would be on quality and relative value to the consumer, rather than on plan features. Allowing significant variation in benefit packages distorts the market and causes problems for both consumers and regulators. One participant noted that while agents and brokers generally support (and can profit from) variation in benefits, smaller insurers in states with one or two dominant carriers find it difficult to compete on the basis of price with comparable products. Other participants suggested that there are risks to an essential benefits package that is "too prescribed"; in particular, coverage may become less responsive to patient needs as the delivery of care evolves.

Shifting Responsibilities and Costs

Participants discussed the potential for the redistribution of responsibilities and associated costs between exchanges and insurers. Several participants noted that the administrative costs of enrolling and maintaining people in plans were not likely to decrease, rather that they would just be different (e.g., lower sales costs related to brokers and agents, higher costs related to maintaining the exchange). One participant noted that exchanges will not want to be perceived as competitors to the insurers; yet, an issue to be resolved is where the insurer role ends and the role of the exchange begins. Insurers are likely to field many more phone calls once the exchanges are launched, but it is unclear whether the entry of exchanges into the market will generally increase or decrease administrative and other costs for insurers. For example, while underwriting costs will fall, risk management costs will continue.

Navigators, Brokers, and Agents

Another significant area of uncertainty in the operation of exchanges is the role of brokers, agents, and "navigators."[24] Brokers and agents, who typically receive commissions from insurers for policies they sell, currently play a significant role in the individual and small group markets by helping clients shop for a health insurance plan, and provide assistance in "navigating" their insurance once enrolled. At the same time, however, one meeting participant pointed out that for smaller insurers, fees to brokers and agents can be significant because of market churning, very high first year commissions, and "field underwriting" fees. The value proposition of exchanges taking on the administrative functions (and costs) historically handled by agents and brokers is currently unclear. One factor that may influence this is the role that brokers and agents have traditionally had in the market.

It is unclear whether transactions in the individual and small group markets will be more or less complex beginning in 2014. Some believe complexity will result from plans being offered inside the exchanges and outside, multiple choices of plans

(the precious metals), and the availability of multiple programs and subsidies for individuals and families.[25] This additional complexity may result in agents and brokers taking on the responsibility of informing potential enrollees about various plan choices and helping them determine their eligibility for various subsidies. It was less clear whether agents and brokers would continue to address post-enrollment questions (e.g., regarding benefits or plan use) or whether that responsibility would fall solely to the plan, and how information would be provided to assist enrollees when life or job changes impact their eligibility for subsidies.

Because of all of these uncertainties, there are multiple possible scenarios (that are not mutually exclusive) and results for agents, brokers, and navigators going forward:

- Agents, brokers, and navigators will know when people are eligible for multiple social service programs (e.g., Supplemental Nutrition Assistance Program or SNAP) and can help make them aware of those programs as well as health programs;
- Brokers and agents could move away from a commission model and be allowed to bill for their services;
- Brokers and agents could provide decision support services that help consumers a) choose between a limited number of health plan choices (i.e., once they have narrowed their choice set to a few plans), and b) negotiate the process of enrolling in Medicaid or a plan offered through the exchange when the enrollee's circumstances change and their eligibility for one program or another changes.

One participant noted that in their state, some brokers sell additional types of insurance (e.g., dental, vision, disability) as well as other services to small businesses (e.g., finance, human resources, payroll services) and that some small employers have appreciated having the ability to purchase multiple support/operations services through one vendor; the exchange will be different in that it will only sell health insurance. Another noted that the role of licensure comes into play when considering the respective roles of navigators, brokers, and agents, and that there is an opportunity to certify navigators.

What Other Factors Will Affect Small Group and Individual Premiums?

Meeting participants identified other aspects of health reform that may affect pricing in the individual and small group markets. Topics included initiatives to increase transparency, accountable care organizations (ACOs),[26] enrollment in Medicaid and other public health care programs, and health care cooperatives or co-ops.[27]

Transparency

The ACA promotes the provision of more information to consumers on numerous topics, including health plan prices and benefits. Meeting participants were mixed in their assessments of the impact of transparency on prices and consumer behavior. Some anticipate a short-term impact and believe that publicly revealing the differences in rates helps to reduce the variation in rates (both increasing prices on the low end and decreasing prices on the high end). One participant noted that there are calls for transparency regarding plan benefits and agent/broker commissions, but questioned whether there would be transparency regarding provider costs, which are notoriously difficult to compare. Another participant stated that it will be hard for payers to report out quality information when they do not have any control over the providers (i.e., in non-integrated delivery systems).[28]

Accountable Care Organizations

Meeting participants also were mixed in their assessments of the impacts of ACOs on premiums. One participant suggested that with ACOs, insurers will be negotiating with larger provider units, which will tend to benefit the providers in terms of rates or prices because of their relative strength in the market.[29] Another participant noted that price transparency can be helpful but that it needs to be coupled with quality information, and that as ACOs begin to grow, it will be challenging to measure price since it will be for a bundle of services rather than individual services. Participants discussed the thorny issue of patient attribution, noting that in some cases, providers would not know the patients for whom they are responsible until the end of the year. Another participant noted that with ACOs, real transparency is promoted because both parties have to put all the cards (costs) on the table to negotiate shared savings.

Drawing distinctions between new efforts and prior ACO-like experiences, it was noted that something very different about ACOs in their current configuration is the ability to have an information technology (IT) infrastructure that allows more integration and coordination of care and reduced duplication of services through shared information (e.g., electronic health records, test results), and that this will help both with pricing and with the actual delivery of care. Another participant described a fundamental shift inherent in today's ACOs—moving from a "what do I do for this individual patient with piecemeal reimbursement" approach to a "what does the entire organization do for this patient" approach, which amounts to asking whether care is being provided in the best way possible.

Medicaid

Other factors that will potentially impact prices include the growth in Medicaid enrollment and demand for services, and possible resulting cuts in provider payments under Medicaid.[30] One participant suggested that this would lead to more cost shifting of lost revenue from government programs to the commercial side of the insurer's business and wondered whether commercial rates would continue to increase to support (cross-subsidize) public programs.[31]

Co-Ops

Although meeting participants indicated that they did not have much experience with co-ops, the general consensus was that they were unlikely to significantly impact the individual and small group markets since there are significant barriers to market entry for new plans. One challenge related to market entry for the co-ops includes having to meet state regulatory and capital requirements.[32] Another challenge relates to being able to price competitively, which requires providers with whom co-ops can negotiate favorable contracts or discounts (usually dependent on having a certain number of enrollees).

Concluding Thoughts

The discussion concluded with final suggestions by participants to HHS about how best to develop the regulations necessary to implement the insurance-related provisions in the ACA. They focused their remarks in four areas:

Timing

Requesting that regulatory guidance on important issues (e.g., the operation of the exchanges, risk adjustment, rate review, addressing adverse selection, specifying which rules apply to which segments of the market, qualified health plans, network adequacy) be issued as quickly as possible, with ample time for review, and with as much specificity as possible. Participants requested clarity between federal and state requirements and responsibilities, and some suggested a federal framework with flexibility for states that would be operationalizing the regulations. A request was made for frequent communication through conference calls between the federal government and states, with bi-directional information flow to assist states in understanding federal requirements and federal policymakers in understanding implementation challenges.

Actuarial Values

Achieving consistency in determining actuarial value in order to simplify tasks for regulators and limit potential abuses.

Risk Adjustment

- Specify a consistent method and format for data collection to be used for risk adjustment across states to minimize inconsistencies.
- Specify the locus of authority.
- Have a limited number of acceptable risk adjustment methodologies.
- When setting up a risk adjustment system, "do no harm" (i.e., do not take away insurance company incentives to get and keep people healthy). The additional payment should be tied to efficient delivery of care rather than cost of care. The market should be as large as possible and as good a value proposition for new consumers as possible to make the risk adjustment system work such that insurers will be making a margin on healthy people and also a margin on sick people (rather than traditionally where insurers make a margin only on healthy people).

Managing Expectations

Carefully manage expectations regarding the impact of health reform and the number of people to be covered, as well as impacts on cost. Encourage health plans to be realistic in terms of pricing and help everyone understand how much more there is to do in health care beyond 2014 to really get needed change.

About the Author

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Endnotes

1. Holahan J, Headen I. Medicaid coverage and spending in Health Reform: national and state-by-state results for adults at or below 133% FPL. Kaiser Commission on Medicaid and the Uninsured; 2010 May. 48 p. Available from: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf
2. The meeting was moderated by Donna Novak, President & CEO, NovaRest. Meeting participants were assured anonymity, so comments made during the meeting are not attributed to any individual. Rather, many themes were echoed by multiple meeting participants and are so identified; in cases where only one or two participants identified a specific issue, that is so noted.
3. The ACA (§1001) requires health plan issuers to have medical loss ratios (MLR) of at least 80 percent in the small group and individual markets. The MLR is the proportion of premium revenues spent on clinical services and quality improvement.
4. Chollet D, Kirk AM, Simon KI. The impact of access regulation on health insurance market structure; 2000 Oct. Available from: http://aspe.hhs.gov/health/reports/impact/index.html#toc
5. Chaikind H, Fernandez B, Newsom M, Peterson CL. Private health insurance provisions in PPACA (P.L. 111-148). Washington (DC): Congressional Research Service; 2010 Apr. 52 p. Report No.: 7-5700.
6. *Ibid.*
7. Chaikind H, Fernandez B, Newsom M, Peterson CL. Private health insurance provisions in PPACA (P.L. 111-148). Washington (DC): Congressional Research Service; 2010 Apr. 52 p. Report No.: 7-5700.
8. Grandfathered plan refers to a health plan or health insurance coverage in which an individual was enrolled on March 23, 2010, and includes plans and coverage renewed after this date (*Ibid*).
9. Health insurance issuers implementing medical loss ratio (MLR) requirements under the Patient Protection and Affordable Care Act; Interim Final Rule. Washington (DC): Office of Consumer Information and Insurance Oversight; 2010 Dec 1, 72 p. Report No.: 45 CFR Part 158 OCIIO-9998-IFC RIN 0950-AA06.
10. Chaikind H, Fernandez B, Newsom M, Peterson CL. Private health insurance provisions in PPACA (P.L. 111-148). Washington (DC): Congressional Research Service; 2010 Apr. 52 p. Report No.: 7-5700..
11. Lodh M, Raleigh ML, Uccello CE, Winkelman RA. Risk assessment and risk adjustment. Washington (DC): American Academy of Actuaries; 2010 May. 8 p.
12. *Ibid.*
13. *Ibid.*
14. A qualified health plan (QHP) is defined in the ACA (§1301) as one that is certified as meeting specific requirements; provides the essential health benefits package; and is offered by a health insurance issuer that is licensed in good standing in each state that it offers coverage, agrees to offer at least one QHP at the silver level and one at the gold level in each exchange, and agrees to charge the same premium for each QHP offered inside or outside of the exchange.
15. Section 1341(a)(3)(B)(iv) of the ACA provides that in addition to insurers' aggregate contributions, each issuer's contribution amount for any calendar year reflects its proportionate share of an additional $2 million for 2014, an additional $2 million for 2015, and an additional $1 million for 2016. The law further provides that these additional contribution amounts shall be deposited in the Treasury and not used for the reinsurance program. Available from: http://democrats.senate.gov/pdfs/reform/patient-protection-affordable-care-act-as-passed.pdf

16. Chaikind H, Fernandez B, Newsom M, Peterson CL. Private health insurance provisions in PPACA (P.L. 111-148). Washington (DC): Congressional Research Service; 2010 Apr. 52 p. Report No.: 7-5700.
17. *Ibid.*
18. *Ibid.*
19. *Ibid.*
20. *Ibid.*
21. *Ibid.*
22. *Ibid.*
23. *Ibid.*
24. According to the ACA (§1311), navigators shall conduct public education activities to raise awareness of the availability of qualified health plans; distribute fair and impartial information concerning enrollment in QHPs, and the availability of premium tax credits and cost-sharing reductions; facilitate enrollment in QHPs; provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate State agency for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchanges. A navigator shall not be a health insurance issuer or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a QHP.
25. Other participants suggested that it is the status quo that is convoluted; that transparency of benefit levels and prices may ultimately improve and add clarity to the system.
26. ACOs are entities that are accountable for the quality, cost, and overall care of a population. ACOs may distribute bonus payments to participating service providers who meet performance targets or impose penalties if targets are not met.
27. Section1322 of the ACA created the Consumer Operated and Oriented Plan program; the co-op program is designed to foster the creation of qualified nonprofit health insurance plans to offer QHPs in the individual and small group markets in the States in which the issuers are licensed to offer such plans. (Report of the Federal Adivsory Board on the consumer operated and oriented plan (CO-OP) program. Washington (DC): Center for Consumer Information and Insurance Oversight; 2011 Apr. 70 p. Available from: http://www.ama-assn.org/resources/doc/psa/april-15-coop-ltr-faca-report.pdf)
28. A counter argument is that PPOs have long responded to NCQA quality reporting requirements.
29. It may be too early to predict the effect of ACO development on the physician/insurer relationship; insurers may have the financial resources physicians need to develop an ACO infrastructure and the collaboration could be advantageous to both.
30. However, there is evidence to suggest that "the impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond." (Holahan J, Headen I. Medicaid coverage and spending in Health Reform: national and state-by-state results for adults at or below 133% FPL. Kaiser Commission on Medicaid and the Uninsured; 2010 May. 48 p. Available from: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf)
31. However, there is evidence to suggest that "states that do not have state funded programs but make substantial contributions to uncompensated care can thus reduce the spending and will benefit from a large influx of federal dollars. While most states will experience some increase in spending, this is quite small relative to the federal matching payments and low relative to the costs of uncompensated care that they would bear if they were no health reform." (Holahan J, Headen I. Medicaid coverage and spending in Health Reform: national and state-by-state results for adults at or below 133% FPL. Kaiser Commission on Medicaid and the Uninsured; 2010 May. 48 p. Available from: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf)
32. The ACA reduces this barrier by providing loans to support capital to meet solvency requirements. (Report of the Federal Adivsory Board on the consumer operated and oriented plan (CO-OP) program. Washington (DC): Center for Consumer Information and Insurance Oversight; 2011 Apr. 70 p. Available from: http://www.ama-assn.org/resources/doc/psa/april-15-coop-ltr-faca-report.pdf)