INSURANCE EXCHANGES AND INSURER COMPETITION

Reforms and Research Gaps

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Objectives

- Summarize laws pertaining to exchanges
- Highlight "big picture" and more detailed research questions
- Propose potential research designs
- (Discuss data sources)

What Does the Law Say?

The basics

- **At least 1 exchange must exist** by 2014 in every state
  - Up to 3 *could* exist: subsidized individual; unsubsidized individual; small employer (<50-100 employees)
- Exchanges must **regulate what plans can participate**, and ensure these **plans satisfy federal guidelines**
- Exchanges must **provide standardized comparative information** on plans
- Exchanges must **help individuals ascertain eligibility** for Medicaid and/or subsidies for purchase of exchange plans

What Does the Law Say?

The details: plan requirements

- Must cover "essential benefits"
- OOP maxima are income-based (and cannot exceed $5,950/$11,900 if <400% FPL)
- Premiums can only vary 3:1 for age, 1.5:1 for tobacco use, and by location and family structure [and possibly wellness prog partic]
- Must fall into one of four "tiers" or a "catastrophic plan" for ages <30 or those exempt

Category	% of covered benefits paid for average enrollee
Bronze	60
Silver	70
Gold	80
Platinum	90
Catastrophic	<60; deductible = OOP max

- Insurers in exchange must offer at least 1 gold and 1 silver plan

What Does the Law Say?

The Details: Individual Exchange Requirements

- Administer premium subsidies which are linked to income as well as the second-cheapest silver plan

% FPL	Max % of income
<133	2.0%
133-150	3.0%–4.0%
150-200	4.0%–6.3%
200-250	6.3%–8.05%
250-300	8.05%–9.5%
300-400	9.5%

- Administer cost-sharing subsidies linked to income *if* you enroll in a silver plan
- Provide ratings based on quality and price, survey satisfaction
- Must include at least one *nonprofit-sponsored* plan

What Does the Law Say?

The Details: Small Group Exchange Requirements

- **SHOP: S**mall **B**usiness **H**ealth **O**ptions **P**rogram
  - For businesses <50 employees (up to 100 at state option)
  - Employers select either a tier or a specific plan(s)
  - Deductibles limited to $2,000/$4,000
    - Otherwise same plan requirements
- Few details in legislation

What Does the Law Say?

The Details: Interactions With Non-Exchange Markets

- Same community rates are supposed to apply inside and outside the exchanges
  - "Within insurer": combine enrollees into a single "risk pool"
  - "Across insurers": state-defined risk-adjustment programs
- Many other requirements also apply to insurance offered outside the exchange
  - Coverage of essential benefits in small group/indiv markets
  - No annual/lifetime spending caps
  - Limits on deductibles and OOP maxima

But fewer regulations for self-insured and large groups

What Does the Law Say?

Interaction with Medicaid

- Eligibility for Medicaid and subsidies fluctuate with income
- Recent estimates suggest 28 million transitions within a *year*

Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges

--*Health Affairs,* Sommers & Rosenbaum 2011

- Law does not require minimum enrollment periods – but states could

What Does the Law Leave Open?

States Have Many Decisions to Make

- Exchange boundaries
  - Individual (subsidized & unsubsidized)/Small Group
  - Geographic span
- Plan regulations
  - Can limit plan participation through competitive bidding
  - Can decide whether/how to default residents into plans
  - Can impose plan structure beyond specified tiers
- Insurer regulations
  - Can extend exchange-related reqts to non-exchange plans
  - Can allow interstate carriers
  - Can make partic in one market contingent on partic in another
  - Must run risk-adjustment schemes

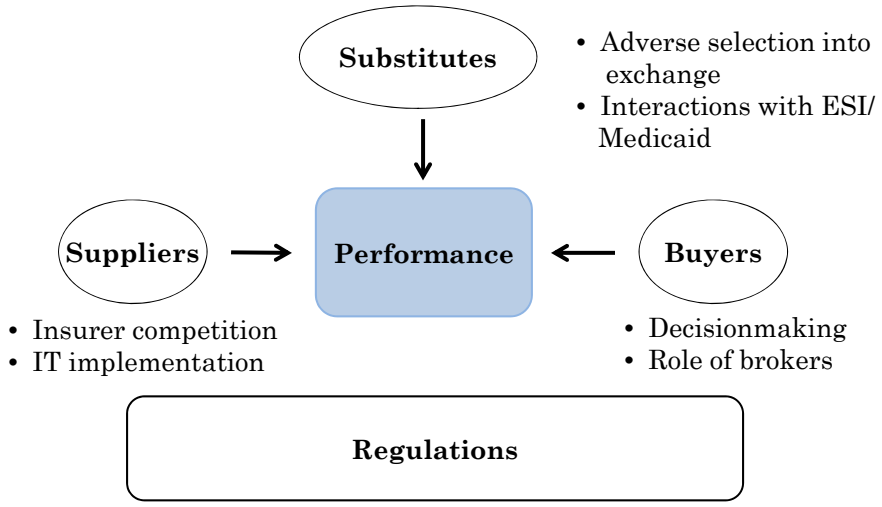
What Does the Law Leave Open?

States Have Many Decisions to Make

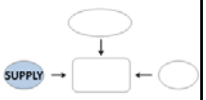
- And of course, the nuclear options
  - Can propose different way to cover as many people at same OOP and federal cost

    - Less nuclear: offer a "basic health plan" for those <200% FPL; state receives 95% of premium subsidies
  - Or can let the fed. government operate/outsource their exchange(s)

Forces Affecting Exchange Performance



Insurer Competition

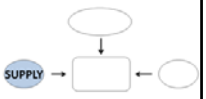


What Do We Know?

- Local markets are concentrated and becoming more so
- Increases in concentration cause increases in premiums
  - ~7% premium increase between 1998 and 2006 in large group market (Dafny, Duggan & Ramanarayan 2011)
  - *What is effect of concentration on premiums in indiv/sm group segment?*
- For-profits charge more than non-profits
  - There appears to be a causal effect – Dafny & Ramanarayanan (2011)

Key implication: obtaining robust competitive markets will generally require entry (or growth of small incumbents)

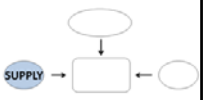
Insurer Competition, *continued*



What Don't We Know?

- *What are effective means to encourage insurer entry?*
  - Chicken-and-egg problem: members and provider discounts
  - *Where have we seen entry and when does it work?*
    - What is minimum efficient scale for an insurer (both national and local members)? How many needed for risk-pooling?
- *What sort of market structure – and what characteristics of participants – tend to yield competitive outcomes?*
- *What is effect of competition on product diversity and quality?*
  - Theoretical, structural and reduced-form work possible here
- *What is the effect of competition on the risk profile of the insured (when is cream-skimming exacerbated)?*
  - *Should states limit tier-jumping?*

How Can Exchange Policies Foster Competition?

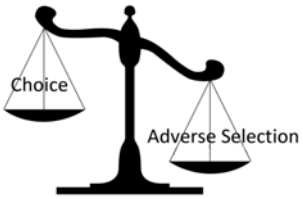


More Things We Don't Know

- Should exchanges take bids or include all who meet standards?
  - Theoretically, under what circumstances is each optimal?
  - *What have we learned from similar settings, e.g. Mediciad?*
    - *Does selective contracting raise market concentration?*
  - *Would "featuring" plans accomplish the same thing with lower costs /fewer adverse effects?*
- Should exchanges create additional standardized plan designs a la Medigap?
  - *Does standardization result in tougher price competition?*
    - Structural models assume yes – but does it happen?
  - *What type of standardization is most likely to reduce adverse selection?*

Interactions With Non-Exchange Markets – Individual Market

- Should states permit sales outside exchanges?



But fed govt. foots bill!

- Grave concern: adverse selection into exchange
  - By individuals without ESI offer
  - By individuals with ESI offer (sickest may choose exchange to avoid employment-induced churn; or "lemon-dropping" by employers)

Interactions With Non-Exchange Markets – Individual Market

Efforts to Combat Adverse Selection

- ACA includes many provisions to limit adverse selection
  - Individual mandate
  - Substantial minimum plan requirements
  - Employer penalties for employee takeup
  - Same "risk pool" to be used inside/outside exchange
    - Except for grandfathered plans
    - Doesn't apply if insurers can partic in only one market
  - Risk adjustment
    - Also transitional reinsurance *and* risk corridor programs
- **But no requirement to combine individual and small group markets**

Interactions With Non-Exchange Markets - Indiv/Sm Group

More on Adverse Selection

- Mechanisms by which insurers select favorable risks have been limited by ACA, but not eliminated
  - Limited *inside* exchanges:
    - Product design (now have summary AV measure)
    - Targeted marketing and access
  - Still possible
    - Selective market participation
    - Brokers' "street underwriting"
- Recent work suggests adverse selection may not reduce welfare by much
  - Starc (2011) – Medigap (adv selec restrains premium increases)
  - Lustig (2010) – Medicare Advantage
- *Do provider networks facilitate selection?*

Interactions With Non-Exchange Markets –Small Group

- Many similar issues, *but* some large-ish small groups will self-insure
  - Healthiest small groups will lean toward self-insurance
  - Can purchase stop-loss to avoid risk
  - Likely to be advocated by brokers (MLR minima don't pertain)

which begs the question

- What is the value of ESI in a post-exchange world?
  - *Do employers choose more wisely than individuals? Are grandfathered/self-insured plans efficiently customized?*
  - *Are there still economies of scale in serving groups?*
  - *Is internalization by firm of health externalities valuable?*
    - *Are workplace wellness programs important?*

Interactions With Non-Exchange Markets - Indiv/Sm Group

Risk Adjustment

- *What is the optimal approach to risk-adjustment?*
  - Should it be prospective or retrospective?
- Discouraging evidence on risk adjustment to date
  - Medicare Advantage – health-status based (Duggan, Kuziemko et al 2011)
  - Switzerland - demographics-based (van de Ven et al 2007)
  - Problems are arising in Part D

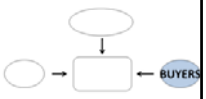
Interactions With Non-Exchange Markets – ESI

- How will exchanges affect ESI offer rate?
  - Increase in ESI offer rate in Mass is encouraging
  - Small groups: is pooling/short-term subsidy enough?
- How will exchanges affect quality and choice?
  - SHOP could expand choice set dramatically
- How will exchanges affect subsidies?
  - Dafny, Ho, Varela (2011) suggest subsidies could decline (and presumably wages will rise)

Interactions With Non-Exchange Markets – Medicaid

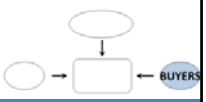
- One portal concept
  - Same income definition for subsidies and Medicaid eligibility
- How can states ensure continuity of care?
  - *How important is this in the Medicaid-only population?*
  - Variety of options – carrots to insurers to encourage participation in both markets, requirements to cover Medicaid PCPs even if enrollee transfers to exchange

What Choices Do Consumers Make?



- What choices do consumers make when presented with a given set of options?
  - Sizeable range of price elasticity of demand | ESI enrollment
  - Sensitive to brand/carrier identity
  - Implied sensitivity to provider choice is high (hospital choice literature, e.g. Ho 2009, Capps, Dranove, Satterthwaite 2003)
- What plan characteristics do consumers value?
  - The obvious ones, e.g. premium, drug coverage
  - But restricting variation to these dimensions limits creation of new dimensions
- Defaults raise participation (Madrian et al)

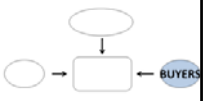
Are Choices Optimal?

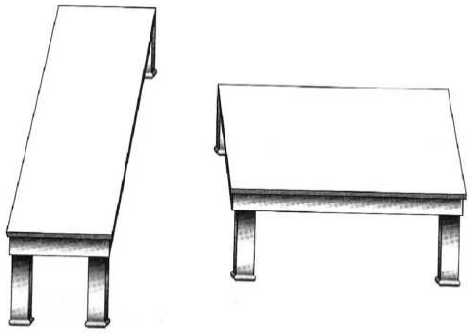


- No
  - Part D: Abaluck and Gruber (2010), Kling et al (2008)
    - Perfectly rational, fully-informed Part D enrollees could increase utility by 27% of Part D costs
  - Medigap: Starc (2011)
  - Healthplans: Handel (2011)

- But structural models assume optimal choices
  - Modelers may want to alter estimated utility parameters
  - .. or modify standard choice models

How Does Information or Framing Affect Choices?





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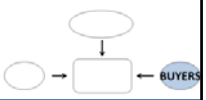
Two tables (Adapted from Shepard [1990])

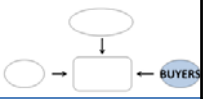
How Does Information or Framing Affect Choices? *continued*



- More choices cause poor decisions or none at all
  - More choices → less satisfaction with choice (Iyengar and Lepper 2000)
  - More choices → opt out of making a choice (Iyengar and Kamenica 2006)

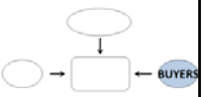
  But choice improves consumer-plan matches (Dafny, Ho Varela 2010)
- We overestimate likelihood of low-probability events
- We overweight "visible" costs
  - E.g. premiums vs. copays
  - Lowest price plan (Starc and Ericson 2011)
- We are myopic
  - Reduce maintenance medication when copays rise

What Is Optimal Choice Architecture / Choice Assistance?



- Personalized interventions are effective
  - Kling et al. (2008)
- How effective will default be?
  - Recent evidence suggests default may be less effective for low-income (field experiment on low-income tax filers; Bronchetti et al 2011)
- *Which plan would make the best default?*
  - Cheapest, as in Mass?
    - Strong revealed preference for cheapest (Starc and Ericson)
  - Preference for a plan that is also offered to Medicaid enrollees (so as to smooth transitions)?
- Who will be defaulted?
  - In/out of Medicaid, in exiting plans, high income?

Role of Brokers



- *Should broker commissions be regulated?*
  - Run 10-15% per year in indiv mkt; Mass Connector runs 3%
  - *Have brokers added value historically?* Use variation in state regulations on broker commissions (if any?) or in insurer broker commissions to study various outcomes
- Concerns
  - Is insurer entry hampered by need to build broker networks?
  - Do brokers engage in "street underwriting"?
  - Will brokers steer business out of exchange/into SI plans where their commissions can be higher?

Designing a Better Equilibrium

- *What is the optimal set of plans to offer the population in each exchange?*

Partial Equilibrium Approaches

- **Build a demand model** for given population, calculate utility under alternative choice sets (making some predictions about price, and holding plan characteristics constant), identify set that should be offered
  - Abaluck and Gruber (2011) find less choice is better (in Part D)...if govt picks the right set to offer
  - Dafny, Ho, Varela (2011) find employers choose the wrong set

Neither paper considers individual-level preference heterogeneity

Designing a Better Equilibrium

- **General Equilibrium Approaches**
  - **Add a static supply-side model** to incorporate pricing reactions, calculate profits, simulate policy changes
    - Town and Liu (2003) -- most of Med Adv cons surplus due to drugs; benefit of add'l plans due to premium competition, not variety
    - Lucarelli, Prince & Simon (2009) – if reduce # Part D plans offered, should also reduce dimensions of product differentiation to preserve price competition
    - Starc (2011) and Lustig (2011) – adverse selection not source of great welfare loss in Medigap/Med Adv

Designing a Better Equilibrium

- **Future: more bells & whistles**
  - Supply side
    - Endogenizing product design (Draganska, Mazzeo, Seim)
    - Incorporating role of bargaining (Ho 2009, Grennan 2011)
  - Explicit modeling of intermediaries (exchanges, employers)
- **Comments**
  - Reduced-form supply-side work could motivate models
  - Demand models assume optimality, which is questionable
    - Consider using imposed rather than actual demand models
  - Supply models assume equilibrium, which is very questionable
    - There is value in studying established markets

Data Sources

Insurer Data

- **Data quality is poor, and inconsistent across sources**
  - NAIC: enrollment and revenue at state-year-insurer level; segmented by individual, group, Medicare, Medicaid
  - AMA: market shares at MSA-insurer-year level available for 2007-2008 from American Medical Association (earlier if you have copies); segmented by HMO and PPO (with latter including more self-insured)
  - InterStudy: enrollment and revenue at MSA-year-insurer level; segmented by individual, group, Medicare, Medicaid but $$$$ and messy

Data Sources

Employer/Individual Data

- **Data quality is high, coverage/details thin in some sources**
  - MEPS-IC: captures employees' choice sets in 35-40K firms annually, details of plans offered (e.g. copays and deductibles) - but identity of carrier not reliably reported, not designed to produce state estimates
  - MedStat: includes insurance info and claims, very rich
  - Select states' hospital discharge datasets include payer identities and often HMO/non-HMO designation, e.g. CA, WV, MA
  - New exchanges