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Sicker-Than-Anticipated ACA Enrollees Caused Major Problems for State Individual Health Marketplaces over Past Four Years, New Brookings-Rockefeller Research Finds

With Congressional action imminent, study offers insights into the challenge of ensuring that Obamacare replacement gives consumers choices among competing health plans at affordable cost.

Albany, NY — Due to the higher-than-expected costs of new Obamacare enrollees, many health insurers were unable to turn a profit and thus left the Affordable Care Act (ACA) marketplace exchanges — further increasing premiums for remaining enrollees — according to a new five-state study from the Center for Health Policy at Brookings Institution and the Rockefeller Institute of Government of the State University of New York (SUNY). The study highlights the difficulties of meeting the ACA's goals of competition and consumer choice, especially in rural areas and urban places with high concentration of providers.

The project analyzed five large, diverse states' experience with ACA marketplaces. State-based teams of field researchers engaged with insurance carriers, providers, state regulators, and consumer engagement organizations to find out why certain markets were successful and how less competitive markets might be improved. California, Michigan, Florida, North Carolina, and Texas had four years of experience in the open enrollment periods from 2014-17.

"Adverse selection" — enrollees who were sicker than anticipated — was the cause of much of the marketplace stress, Texas A&M's Michael Morrisey, Wake Forest University's Mark Hall, Rockefeller's Richard Nathan, and Brookings's Alice Rivlin found. That "misjudgment" and "uncertainty" ultimately caused some plans to incur losses and then withdraw from those marketplaces. By the 2017 enrollment period, marketplace competition in Florida, North Carolina, and Texas in particular had substantially decreased, causing many premiums to rise, although California and Michigan retained a reasonable number of insurers through 2017.

Project leads noted the importance of local competition among insurers, such as local hospitals and physicians, for any ACA replacement: Without an extensive and decentralized provider base, the local market could not easily sustain multiple insurers, and insurers had little leverage in negotiating with providers for lower prices. Competition among health insurers varied greatly not only across states but also within them, they found: While urban markets are usually more competitive than rural ones, researchers also found large differences among urban markets as well. For example, areas in and around Los Angeles paid lower premiums, while those around San Francisco paid much higher premiums. Even in Michigan, where competition remained somewhat strong through 2017, the least-costly silver premium ranged from a low of $233/month for a 40-year-old in urban Wayne County (Detroit) to $397 for a similar individual in rural Delta County.

California had the most successful marketplace of any examined due to its ability to maintain a relatively large number of insurers in its largest metropolitan areas. *Covered California*, the state-based exchange, enrolled nearly 1.4 million people in the first open enrollment period, and the uninsured population declined by over a half (from 17.2 in 2014 to 8.1 percent) in 2017.

In North Carolina, thanks to large insurers Aetna and UnitedHealthCare joining exchanges, competition started strong but by open enrollment in 2017, both insurers had withdrawn, citing higher than expected claim costs, turning North Carolina into one of the highest marketplace premiums states nationally.

In Texas, the marketplace "unraveled rather dramatically" with withdrawals being spurred by higher-than-expected claims, the researchers reported. By 2017, even major metro areas such as Houston and Austin had only three insurers offering coverage in the marketplace. A similar experience occurred in Florida, where Aetna reported that 99 percent of premiums went to claims costs in 2015; UnitedHealthcare and Cigna reported 108 and 256 percent, respectively. The carriers also noted that the risk-adjustment process was inadequate and sometimes harmful to their ability to turn a profit.

Several factors caused a substantial shift toward narrower insurer networks that offered more health maintenance organization (HMO) plans than broad preferred provider organization (PPO) plans, the authors found. Enrollees with pre-existing conditions disproportionately joined PPOs in order to maintain access to their current doctors and specialists, increasing the cost of offering these plans. Insurers also faced hurdles, negotiating lower prices within PPOs because they could not trade higher patient volumes for lower prices as they could when negotiating with HMOs. By the third year of the ACA, insurers reduced the number of PPO plans they offered and many switched to offering only HMOs. In Texas, no insurer currently offers a PPO product in the individual market.

Although the authors caution against generalizations from their five-state sample, they conclude that if policymakers craft an ACA replacement that continues to rely on insurer markets, they should bear in mind the large local differences that exist; there is uncertainty about adverse selection and risk; market competition is dependent on the local provider base; there is a tendency toward narrowing networks; and insurers adjust rapidly to recent experiences.

Read the five-state summary
Read the California study
Read the Florida study

Read the Michigan study
Read the North Carolina study
Read the Texas study

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