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Health Insurance: The Next Generation of the Individual Marketplace

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Health insurers, having adopted a wait-and-see mentality, must now consider their strategies for the individual exchange markets for 2018 and beyond as they file rates and products in May and June.

While regulatory changes made by both the Obama and Trump administrations (including reinstating reinsurance for claims over $1 million, restricting special enrollment periods, and increasing allowable child premiums) for 2018 are favorable, insurers face ongoing uncertainty regarding the repeal and replace of the Affordable Care Act (ACA). In addition, there are other levers Congress and the administration may pursue to either support or undermine the ACA exchanges in the near term.

One open issue insurers are monitoring is whether the federal government will continue to make cost-sharing reduction (CSR) payments to insurers. A component of the ACA, CSRs reduce cost-sharing for individuals with incomes between 100 and 250% of the federal poverty line buying insurance on the exchanges (~57% of exchange membership receives CSRs). The ACA requires insurers to provide CSRs regardless of reimbursement from the government, but insurers may terminate their contracts if the payments are not made. Congress may choose to fund the CSR payments for the remainder of 2017 and for 2018, and the Trump administration may choose to make the payments without appropriation, though neither option is assured, especially with regard to plan year 2018. Cessation of CSR payments would likely end the exchange market in 2017, or by 2018 at the latest, as insurers raise rates to offset the CSR payments or exit the market.

In recent interviews with the Marwood Group, insurance executives presented a notably more wary perspective on the exchange market than seen in 2010-2014. A number of for-profit insurers, including United, Aetna, and Humana, and regional Blue plans have opted to not participate in the individual exchanges market or only in very select geographies.

One third of U.S. counties have one insurer on the exchange and 37% have two insurers in 2017[1]. In many cases, the single insurers are regional Blue plans. Blue plans have traditionally been mission-oriented to offer insurance across all or most segments in their local markets. However, losing money in the individual market requires subsidization from other lines of business, including commercial group and Medicare Advantage, which are increasingly competitive. A number of Blue executives state they cannot afford to accept losses in these markets. If large Blues, such as Anthem, were to exit or significantly limit their participation in the market, other plans may follow,

[1] The Heritage Foundation, January 2017

potentially creating counties without any exchange plans available for individuals to purchase in compliance with the ACA mandate.

In 2018, Marwood expects that premiums will continue to rise as insurers improve their ability to price accurately for the risk and have reduced appetite to buy market share. Benefits and networks will continue to get leaner where possible to improve the premium affordability. This dynamic, combined with static penalties for not buying insurance, may drive increased adverse selection on exchanges.

In this future individual marketplace, health insurers will need to improve performance in the same core capabilities on which they have focused since the implementation of the ACA: pricing, product strategy, and high performing network design. But given the expected shift to a less healthy population, insurers will need to apply approaches more typically used in managing Medicaid and senior populations, with a focus on addressing potential near-term medical costs rather than long-term prevention, given the churn in Exchange membership.

For example, plans are working to identify member risk at or shortly after enrollment rather than waiting for the medical claims to accrue 60-90 days after enrollment. Bloom Insurance Agency, an insurance services company, is piloting health risk assessments at the point of sale for Medicare Advantage members. Some plans are using pharmacy claims data as the earliest indicators of risk, and others are using consumer purchasing data to predict the highest risk members.

In addition, insurers are building new programs around medical cost drivers in the Exchange population, such as opioid addictions. Programs may include analytics to identify patients receiving drugs in the same class from multiple pharmacies or to identify physicians with outlier prescribing behavior. Provider engagement programs also play a key role: payors are supporting innovations in treatment programs through primary care providers and educating referring clinicians on in-network substance abuse treatment providers.

Advances in technology, specifically the accessibility of patient data, analytics, and workflow tools, are making active risk management more timely and less labor intensive for insurers. However, insurers face long lists of competing demands for investment, and given the uncertainty in the exchange market, investments that enable performance across multiple business segments are likely to be prioritized.

Many insurers have been investing heavily in improving consumer experience, with several rationales: the insurance market will eventually be driven by consumer choice (beyond Exchanges), great consumer experience will attract the younger and healthier population, and consumers need tools to better manage their own behaviors and care. Some insurers are continuing with those investments at full speed, while others are quietly shifting focus to other investments, most notably to better manage medical costs and/or support care delivery transformation.

Going beyond 2018, insurers will continue to watch several key issues in the federal ACA repeal and replace initiative to inform their exchange market participation choices and their pricing/ product strategy including the individual mandate, continuous coverage provisions, the structure of consumer tax credits/ subsidies, the definition of essential health benefits, risk adjustment and reinsurance mechanisms, and Medicaid reform.

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