Health Insurance Marketplaces: a Future?

Presentation to the Council of State Governments-Midwest
Health and Human Services Committee
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Keith Mueller, PhD
Interim Dean, University of Iowa College of Public Health
Director, RUPRI Center for Rural Health Policy Analysis

The Headlines

- Obamacare Collapsing
- Centene enters four states
- Iowa market is without an option
- Medica stays active in Iowa
- Premiums escalating
- State-based exchanges moderate rate increases

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The Reality

- It's complex
- It's a market, with entry and exit; firms assessing abilities to generate margin
- Drivers for behavior include market assessment, positive balance sheet

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Analysis: Key Variables

- Predictions of financial risk based on population profiles and ability to control cost
- Actuarial calculations based on those predictions and spread across population
- Rating areas and population density
- Dispersing financial risk: re-insurance; premium subsidies; subsidizing cost sharing
- Essential benefits requirements

Analysis: Adapting to New Markets

- Exiting: firms not accustomed to accepting full financial risk
- Entering: firms with experience in Medicaid managed care
- Exiting: narrow hospital networks and higher premiums
- Entering: small firms

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Analysis: Adapting to New Markets

Conclusion: "The available data reveal patterns of market entry and exit that are consistent with natural competitive processes separating out firms that are best suited to adapt to a new market"

Source: Craig Garthwaite and John A Graves (2017) "Success and Failure in the Insurance Exchanges" *The New England Journal of Medicine* 376;10: 907-910. March 9.

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Stating the Obvious: Population/Premium Relationship

- Markets with zero to 2 insurers in low population areas
- New plans less likely when there is an alternative market (outside of exchanges)
- State-based marketplaces with more insurers

Source: John Holahan, Linda J. Blumber, and Erik Wengle (2017) "What Characterizes the Marketplaces with One or Two Insurers?" *Timely Analysis of Immediate Health Policy Issues* Robert Wood Johnson Foundation and Urban Institute

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Consequences

- Market dynamics in 2017
- Where will it go in 2018?

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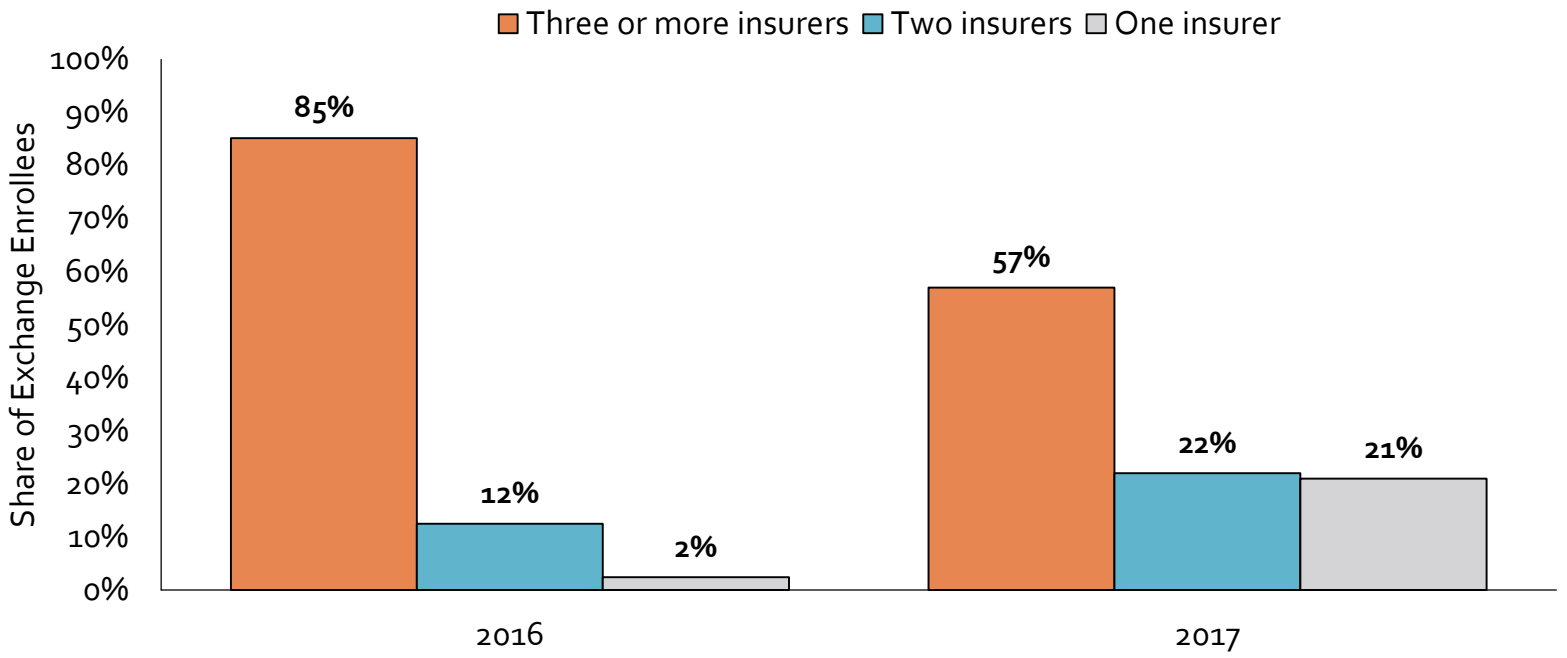
57% of exchange enrollees will have a choice of three or more insurers in 2017, down from 85% of exchange enrollees in 2016



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.

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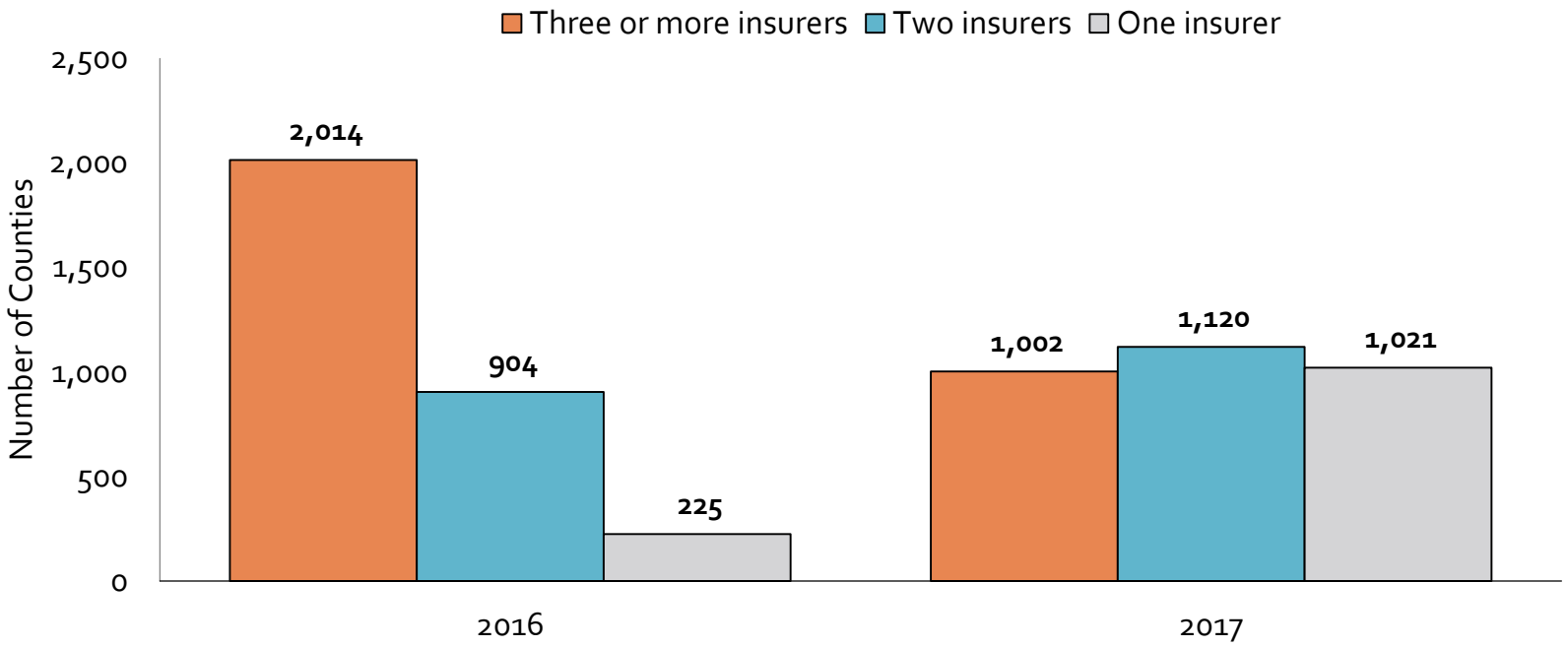
1,021 counties have only one exchange insurer in 2017 compared to 225 counties in 2016



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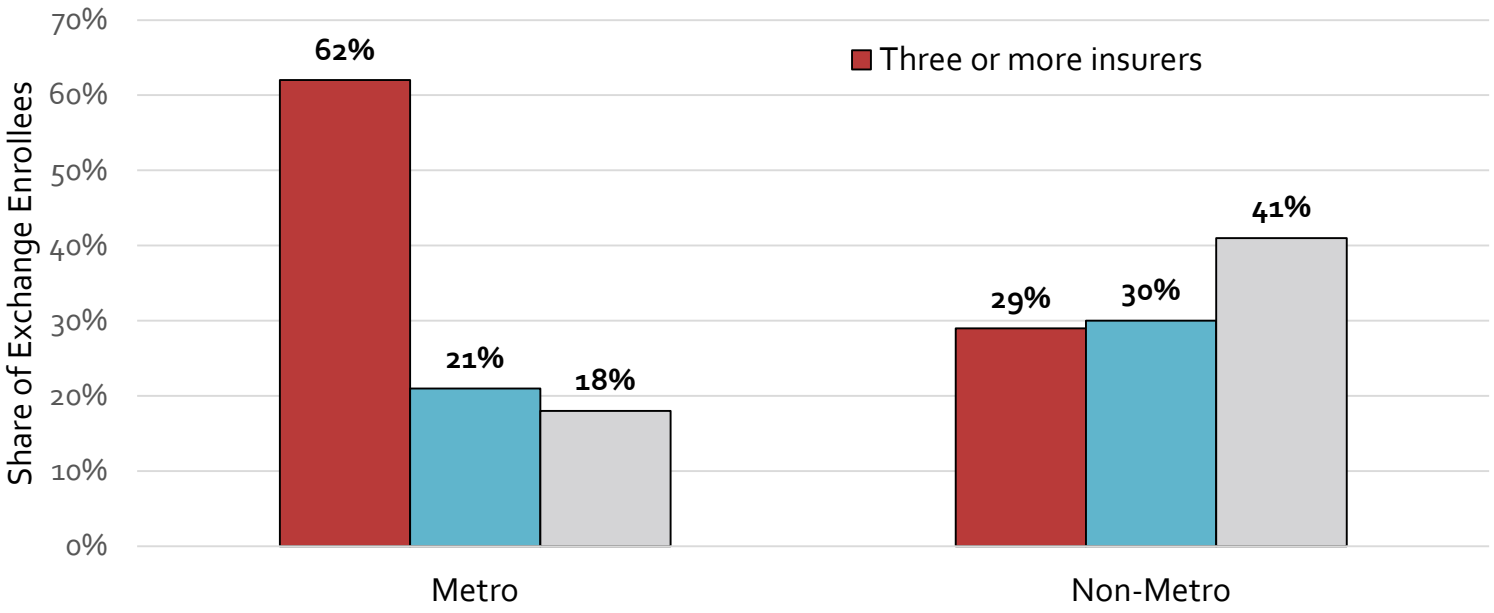
62% of exchange enrollees living in metro counties will have a choice of three or more insurers in 2017



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups. Metro/Non-Metro county classifications are based on definitions from the Federal Office of Rural Health Policy. Metro columns may not add up to 100% due to rounding.

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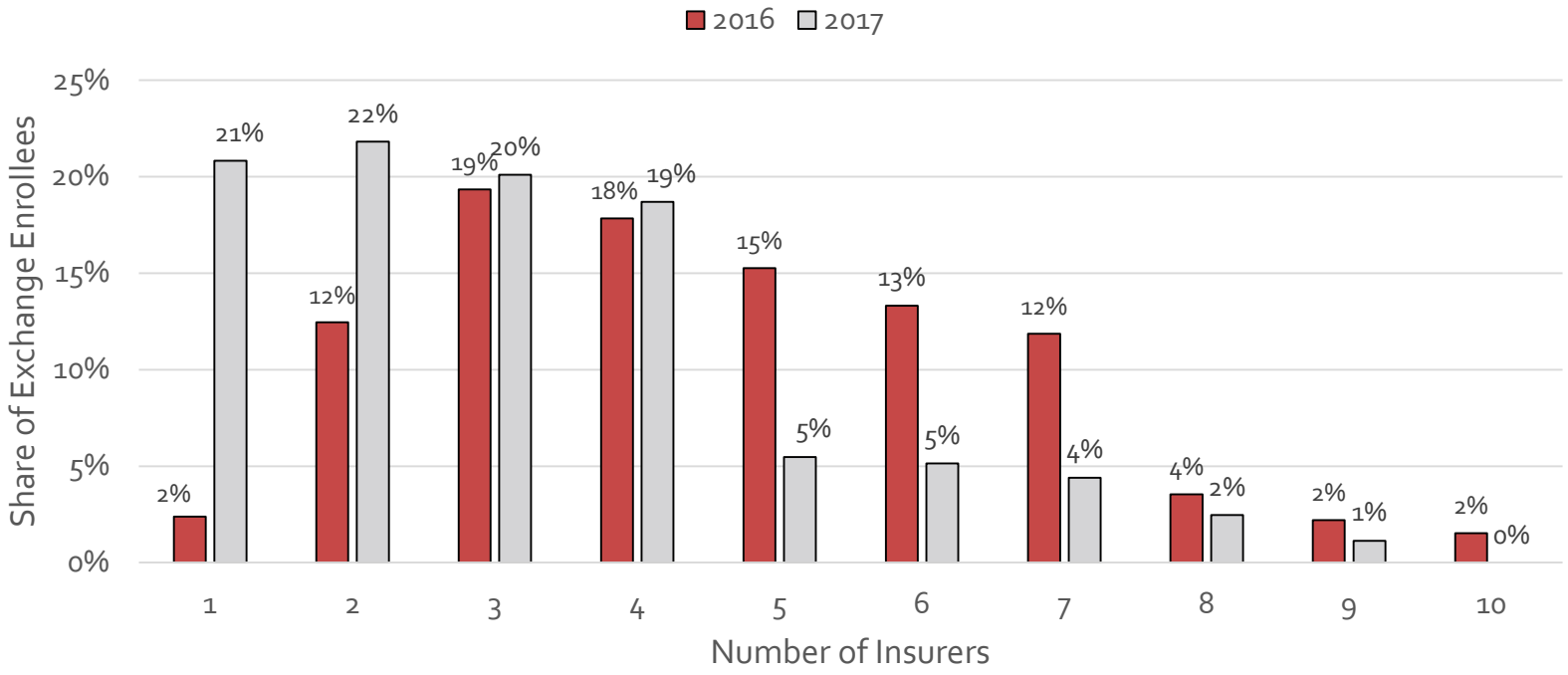
Distribution of Exchange Enrollees by Number of Insurers in 2016 and 2017



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. Enrollment is based on 2016 signups.

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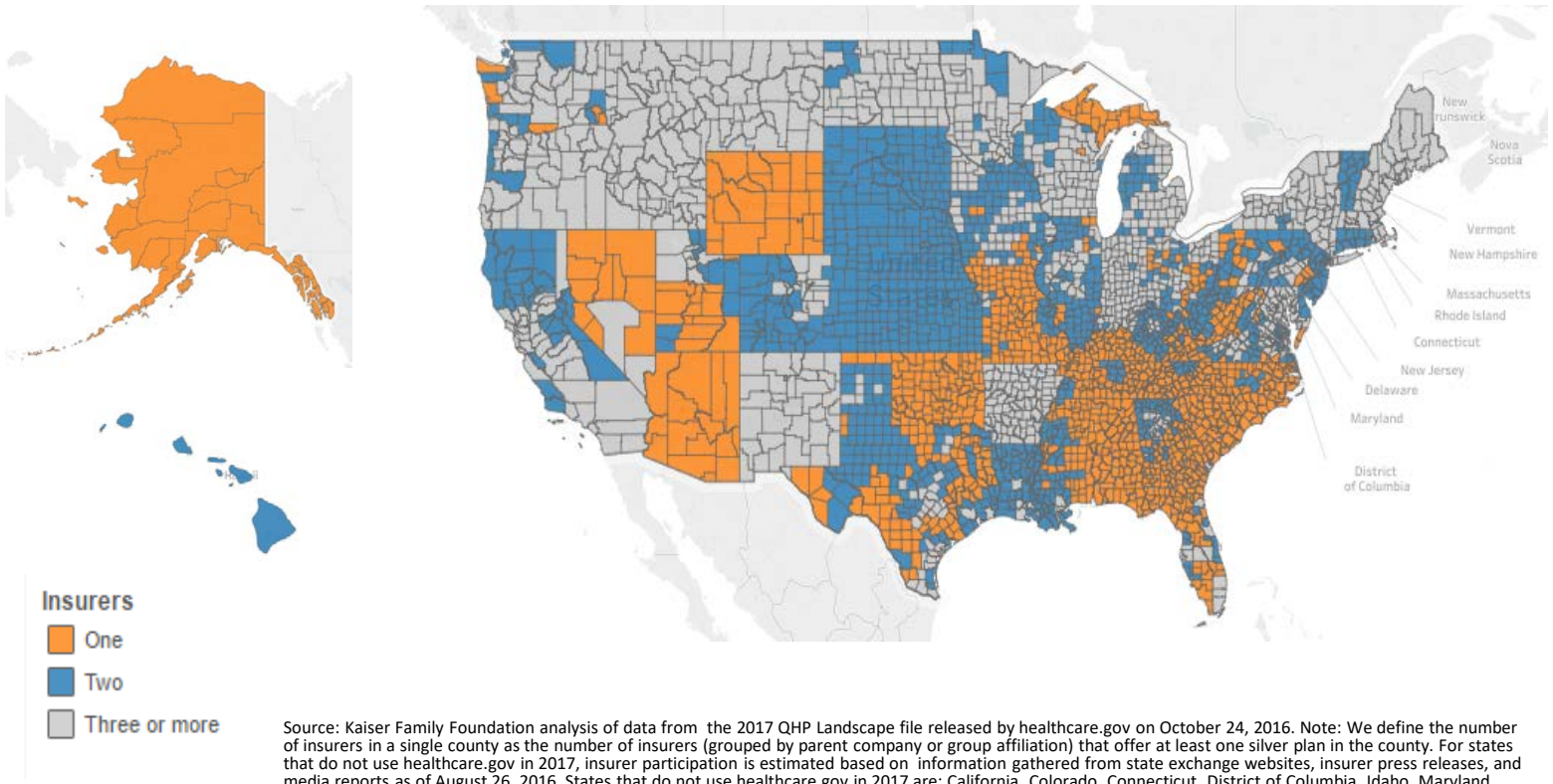
Insurer Participation by County in 2017



Source: Kaiser Family Foundation analysis of data from the 2017 QHP Landscape file released by healthcare.gov on October 24, 2016. Note: We define the number of insurers in a single county as the number of insurers (grouped by parent company or group affiliation) that offer at least one silver plan in the county. For states that do not use healthcare.gov in 2017, insurer participation is estimated based on information gathered from state exchange websites, insurer press releases, and media reports as of August 26, 2016. States that do not use healthcare.gov in 2017 are: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington. See the interactive map here:
https://public.tableau.com/profile/kaiser.family.foundation#!/vizhome/InsurerParticipationinthe2017IndividualMarketplace/2017InsurerParticipation

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Variables in Play

- Subsidies
- Market size as related to mandate
- Behavior of firms
- Changes to minimum benefits rating requirement, risk adjustment

State Actions

- Minnesota: Premium rebates and state-funded reinsurance
- Rating areas matter – determine risk pool and ability to include all sources of care across the continuum
- Network requirements
- Benefit requirements

Critical Success Factors for State Exchanges

- Leadership and governance
- Management of scope
- Experience and expertise of core staff

Source: W. David Helms (2017) "Lessons from State-Based Exchanges for Future Health Reform Initiatives" *Issue Brief*. Milbank Memorial Fund. April.

Crystal Ball: What's Next?

- Continue to experiment with markets
- Increased role for states
- Finding ways to spread, cover financial risk
- Should be thinking about ways to reduce financial risk through delivery system/payment reform and initiatives in population health

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For further information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

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The University of Iowa

Keith Mueller, PhD

Interim Dean, College of Public Health
Gerhard Hartman Professor, Health Management & Policy
Director, RUPRI Center for Rural Health Policy Analysis
145 Riverside Drive, S153A, CPHB
Iowa City, IA 52242
319-384-1503

keith-mueller@uiowa.edu

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Center for Rural Health
University of North Dakota
501 N. Columbia Road Stop 9037
Grand Forks, ND 58202

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- ✓ The National Organization of State Offices of Rural Health
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