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HEALTH INSURANCE EXCHANGES

Claims Costs and Federal and State Policies Drove Issuer Participation, Premiums, and Plan Design

Why GAO Did This Study

Since 2014, millions of individuals have purchased coverage through the health insurance exchanges established under PPACA. PPACA altered the individual health insurance market by setting federal standards for coverage and subsidizing exchange coverage for certain low-income individuals. In the first 5 years of exchanges, issuers have moved in and out of the market and increased premiums, but little is known about issuers' claims costs or the factors driving their business decisions.

PPACA included a provision for GAO to examine exchange activities, including issuers' experiences participating in the individual market exchanges. This report examines (1) claims costs of issuers participating in exchanges, and (2) factors driving selected issuers' changes in exchange participation, premiums, and plan design. GAO reviewed data from nine issuers participating in five states, which were selected to represent a range in size, tax status, and exchange participation. The five states—California, Florida, Massachusetts, Minnesota, and Mississippi—were selected to provide variation in geography and whether they had a federally facilitated or state-based exchange. GAO also conducted a literature review, reviewed federal data, and interviewed the selected issuers, officials in the selected states, and stakeholder groups.

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What GAO Found

Since 2014, when health insurance exchanges established by the Patient Protection and Affordable Care Act (PPACA) began operating, issuers' medical costs for enrollees (claims costs) in the individual market have varied widely.

- **Claims costs were higher than expected in early years (from 2014-2016).** Reviewed studies and interviews with selected issuers indicate that claims costs for plans sold to individuals were higher than expected, in some cases between 6 and 10 percent higher in 2014. This was due to enrollees being sicker than expected, higher costs for some services, and certain federal policies, such as initial policies for special enrollment periods that issuers were concerned allowed for potential misuse.
- **Claims costs generally grew from 2014 to 2017, but selected issuers sometimes experienced wide swings in costs from year to year.** Most issuers attributed the volatility in costs, in part, to large changes in the number and health of enrollees each year.
- **Average monthly claims costs varied significantly across issuers in the same state.** For selected issuers, differences in per member per month claims costs within a given state were often more than \$100—significant given that median per member per month claims costs were about \$300.

Selected issuers also varied significantly in their decisions to expand or reduce their participation in the exchanges and make changes to premiums and plan design. Issuers cited several key factors driving changes.

- **Claims costs.** Selected issuers noted that claims costs drove their decisions regarding participation, premiums, and plan design. For example, increasing claims costs was a consistent factor driving premium increases.
- **Federal funding changes.** Selected issuers cited the planned phase out of federal programs that helped issuers mitigate risk, including payments and adjustments for issuers with higher cost enrollees, the limited funding for one of those programs, and the ending of federal payments for cost-sharing for certain enrollees, as reasons for reducing participation and increasing premiums.
- **State requirements and funding.** Selected issuers provided examples of state requirements that resulted in reduced participation and increased premiums. However, issuers also cited examples where state policies minimized premium increases or variations in benefit design for issuers participating in the state's exchange.

Looking to 2018 and 2019, selected issuers said that changes in federal and state policies would continue to affect decisions, particularly on premium changes.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

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Abbreviations

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| CMS | Centers for Medicare & Medicaid Services |
| HHS | Department of Health and Human Services |
| MLR | medical loss ratio |
| PPACA | Patient Protection and Affordable Care Act |
| QHP | qualified health plans |

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January 28, 2019

Congressional Committees

Since 2014, millions of individuals have enrolled in individual market health insurance plans purchased through health insurance exchanges established by the Patient Protection and Affordable Care Act (PPACA).¹ PPACA included provisions that were intended to make health insurance more available and affordable for individuals seeking coverage. These provisions included the establishment of exchanges—marketplaces where individuals can compare and select among plans that meet certain standards offered by participating private issuers.² PPACA also made federal financial assistance available to eligible individuals purchasing coverage through the exchanges.

In addition to the establishment of the exchanges, PPACA also set new federal requirements for issuers, including those offering coverage on the individual market. The individual market consists mainly of coverage sold directly to individual consumers without access to group coverage, such as what is offered by an employer. These federal requirements apply to coverage sold both through the exchanges and outside the exchanges, and represented a shift for the market, which had previously been regulated by the states. The new requirements included prohibiting issuers from denying coverage on the basis of a pre-existing condition and generally requiring issuers that participate on the exchanges to provide qualified health plans (QHP), which are plans that provide essential health benefits, among other things.³ The combination of the

¹Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010. Almost 12 million individuals selected or were automatically re-enrolled in an individual market health plan through the exchanges for plan year 2018 in the 50 states and District of Columbia. See, Centers for Medicare & Medicaid Services, Health Insurance Exchanges 2018 Open Enrollment Period Final Report (Baltimore, M.D., Apr. 3, 2018).

²An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

³Essential health benefits are a core package of health care services that include emergency services, hospitalization, maternity and newborn care, and preventive services, among others things, that all QHPs offered through the exchanges must cover. QHPs may also be offered outside the exchanges.

new incentives for coverage and the new requirements for issuers expanded the size of the individual market. However, it also created uncertainty for issuers about how to set prices given the lack of data on the health and likely use of medical services for those enrolling. Uncertainty in the individual market is not new. Historically, the individual market, which is smaller than other markets, such as the group market that is largely comprised of employers purchasing coverage for groups of employees, presented greater uncertainty and risk for issuers.

There have been concerns in recent years that certain changes under PPACA, along with subsequent federal policy decisions, have led to instability in the individual market. Reports point to issuers leaving the market, certain regions of the country being at risk of not having any issuers offering coverage, and large increases in premiums that may make coverage unaffordable for those who do not receive federal financial assistance. However, little is known about what is driving issuers' decisions about participation, premiums, and plan design and the extent to which the medical costs for enrollees—referred to as claims costs—are influencing those decisions. PPACA included a provision for GAO to examine exchange activities, including issuers' experiences participating in the exchanges.⁴ In this report, we examine:

1. What is known about the claims costs for issuers participating in individual market exchanges, and
2. the factors driving selected issuers' changes in individual market exchange participation, premiums, and plan design.

To examine what is known about the claims costs for issuers participating in the individual market exchanges (referred to in this report as exchanges), we performed a literature review to identify studies that reported original research on issuers' claims costs or financial performance in the individual market in general or exchanges specifically.⁵ Overall, we identified 26 relevant studies, which included

⁴Pub. L. No. 111-148, § 1313(b), 124 Stat 119, 185 (2010). Our first report to address elements of this provision was issued in September 2016. See, GAO, *Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist*, [GAO-16-761](#) (Washington, D.C.: Sept. 12, 2016).

⁵For this literature review, we searched research databases, including ProQuest, MEDLINE, Scopus, and DIALOG health care files, to identify studies published between January 1, 2014 and April 13, 2018, that met our criteria, including peer-reviewed studies. To identify additional relevant studies, we also conducted web searches between January and July 2018 and interviewed stakeholders.

academic papers, trade articles, and working papers. (App. I provides a list of the studies that we reviewed.) Additionally, we interviewed nine issuers participating in the exchange in one or more of five states between 2016 and 2018. We selected these five states—California, Florida, Massachusetts, Minnesota, and Mississippi—to achieve variation in whether the state had a state-based exchange or utilized the federally facilitated exchange, geographic area, and the number of issuers participating in the exchanges. (See app. II for additional information on our selected states.) We selected the nine issuers to achieve variation in size, tax status, and plan type.⁶ We reviewed data from the selected issuers on incurred claims, enrollment, medical loss ratios (MLR), and profitability—for the selected states in which they participated—in 2014 through 2017, and to the extent projections were available for 2018 and 2019.⁷ We also reviewed data and documents the selected issuers filed with the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) responsible for overseeing exchanges. In addition, we interviewed CMS officials and other stakeholders to obtain a broad perspective on issuers' claims costs.⁸

To examine the factors driving the selected issuers' changes in individual market exchange participation, premiums, and plan design, we reviewed state and federal data compiled by the Kaiser Family Foundation on exchange participation from 2014 through 2018 to assess whether the selected issuers expanded, contracted, or had no change in the extent of their participation in the selected states.⁹ With regard to changes in premiums, we reviewed data from selected issuers on premium revenue

⁶Our selected issuers are Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Minnesota, Centene, Florida Blue, HealthPartners, Humana, Kaiser Permanente, Molina Healthcare, and Neighborhood Health Plan. At least two of these issuers participated in each selected state.

⁷An MLR serves as a basic financial indicator, expressing the percent of premiums that insurers spend on their enrollees' medical claims and activities to improve health care quality, as opposed to administrative costs.

⁸Stakeholder groups we interviewed include the National Association of Insurance Commissioners, the American Academy of Actuaries, the Society of Actuaries, and industry groups, such as America's Health Insurance Plans and the Alliance of Community Health Plans.

⁹The Kaiser Family Foundation is a non-profit organization focusing on national health issues. The organization's exchange participation data is compiled from federal data from healthcare.gov, state-based exchange enrollment websites, and issuer rate filings to state regulators.

from 2014 through 2017, and to the extent that projections were available for 2018 and 2019. We also reviewed data and documents filed by the issuer with CMS to supplement the premium data provided by issuers. To identify examples of plan design changes made by our selected issuers, we reviewed data submitted by issuers participating in the federally facilitated exchanges to CMS that detail covered benefits and cost-sharing requirements for QHPs. Specifically, we reviewed CMS data for 2014 through 2018 submitted by four selected issuers that participated in Florida—one selected state using the federally facilitated exchange. We also reviewed studies identified in our literature review to determine how participation, premiums, and plan design decisions—including covered benefits, cost-sharing requirements and provider networks—made by our selected issuers’ compared to national trends. Finally, we interviewed selected issuers and states, CMS, and stakeholders about exchange participation, premiums, and plan design changes and the reasons for any changes.

Our findings related to the experiences of the selected issuers in our selected states are not generalizable. To assess the reliability of issuer data, we interviewed knowledgeable officials and tested the data for apparent errors. To assess the reliability of the data from CMS and the Kaiser Family Foundation, we reviewed relevant documentation and interviewed knowledgeable officials. For the Kaiser Family Foundation data, we also tested the data for apparent errors and corroborated the findings with the selected issuers. On the basis of these efforts, we determined that these data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from December 2017 through January 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The individual market, also known as the non-group market, consists of individuals who obtain coverage on their own rather than through a group health plan, such as one offered by an employer, or through public health insurance programs, such as Medicare or Medicaid. Most consumers obtain health insurance through their workplace in the group market when available, as health insurance is generally cheaper for enrollees because

the employer typically pays a portion of enrollee premiums. Historically, the individual market has been more volatile than the group market, because it consisted of those who generally could not purchase insurance elsewhere.

Changes to the Individual Market under PPACA

PPACA introduced significant changes to the individual market, including how consumers shop for insurance coverage, the financial incentives for consumers and issuers to participate, and the rules governing issuers.

Establishment of exchanges

PPACA directed each state to establish an exchange—referred to as a state-based exchange—or elect to use the federally facilitated exchange established by HHS. For plan year 2018, 34 states had a federally facilitated exchange for the individual market, and 17 states, including the District of Columbia, had state-based exchanges.

Issuers are not required to participate in the exchanges, but those that do are generally required to offer QHPs that comply with certain requirements established by PPACA. For example, such plans are required to offer essential health benefits and follow annual limits on enrollee cost-sharing specified by HHS each year. CMS is responsible for overseeing issuer compliance with the exchange requirements for states using the federally facilitated exchange, while states with state-based exchanges are responsible for ensuring issuer compliance. Each state-based exchange has different time frames for review, but issuers participating in states that utilize the federally facilitated exchange have been required to submit applications for QHPs, including rates, between April and June of the previous year for plan years 2015 through 2018.

Financial incentives for consumers

PPACA required most consumers to have health insurance or pay a tax penalty, a requirement known as the individual mandate.¹⁰ Consumers purchasing coverage through the exchanges may be eligible, depending on their incomes, to receive federal financial assistance to offset the costs of coverage. PPACA created two types of federal financial assistance for consumers.

¹⁰Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (2010) (codified at 26 U.S.C. § 5000A). However, beginning January 1, 2019, individuals who fail to comply with the individual mandate will no longer face a tax penalty due to the enactment of subsequent legislation. See Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

Risk mitigation programs for issuers

- **Premium tax credits** are designed to reduce an eligible individual's premium costs and are generally for consumers with household incomes of at least 100 percent, but no more than 400 percent, of the federal poverty level.
- **Cost-sharing reductions** are designed to lower enrollees' deductibles, coinsurance, and co-payments and are for consumers who are eligible for premium tax credits, have household incomes between 100 and 250 percent of the federal poverty level, and enroll in certain plans.¹¹

As these types of federal financial assistance are only available for consumers purchasing coverage through the exchanges, issuers may be incentivized to participate in the exchanges.

To limit the increased risk issuers could face due to new market conditions, PPACA also required the establishment of three risk mitigation programs: a permanent "risk adjustment" program and two temporary programs—"reinsurance" and "risk corridors"—set to expire after 3 years.¹² Each of these programs uses a different mechanism intended to both improve the functioning of the individual market and to stabilize the premiums that issuers charge for health coverage both through and outside the exchanges.

- **Risk adjustment program.** This permanent program transfers funds from issuers with lower-than-average risk enrollees to those with higher-than-average risk enrollees within a respective state.
- **Reinsurance program.** This temporary program limited issuer risk for enrollees with very high-cost claims between 2014 and 2016 by transferring funds collected from contributing entities, including issuers and group health plans, to issuers in the individual market that incur high cost claims for enrollees.

Risk corridors program. This temporary program was designed to limit losses and profits of issuers offering QHPs from 2014 through 2016. Under the program, CMS collected amounts from issuers whose profits exceeded a certain threshold and used those funds to

¹¹HHS discontinued cost-sharing reduction payments to issuers in October 2017 due to a lack of appropriations for these payments.

¹²See Pub. L. No. 111-148, §§ 1341-43, 10104(r), 124 Stat. 119, 208, 211-12, 906 (2010) (codified at 42 U.S.C. §§ 18061-63).

make payments to issuers whose losses exceeded a certain threshold.

Issuer requirements

PPACA imposed new federal requirements on issuers in the individual market, all of which took effect by January 1, 2014, including

- **Guaranteed issue.** Issuers must generally accept every applicant who applies for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer;
- **Guaranteed renewability.** Issuers must generally renew coverage at the option of the enrollee;
- **Coverage of preexisting conditions.** Issuers are prohibited from excluding coverage for pre-existing conditions; and
- **Rating restrictions.** Issuers can adjust premiums based only on certain factors, such as geographic area, age, and tobacco use, and amounts by which rates may vary is limited in certain circumstances.¹³

These requirements were in addition to earlier requirements related to MLRs. Specifically, as of 2011, PPACA requires issuers in the individual market to spend at least 80 percent of their premium revenue on medical claims and certain other non-claims costs such as quality improvement activities, known as the MLR requirement.¹⁴ Issuers that do not meet this requirement are required to provide a rebate to their enrollees.

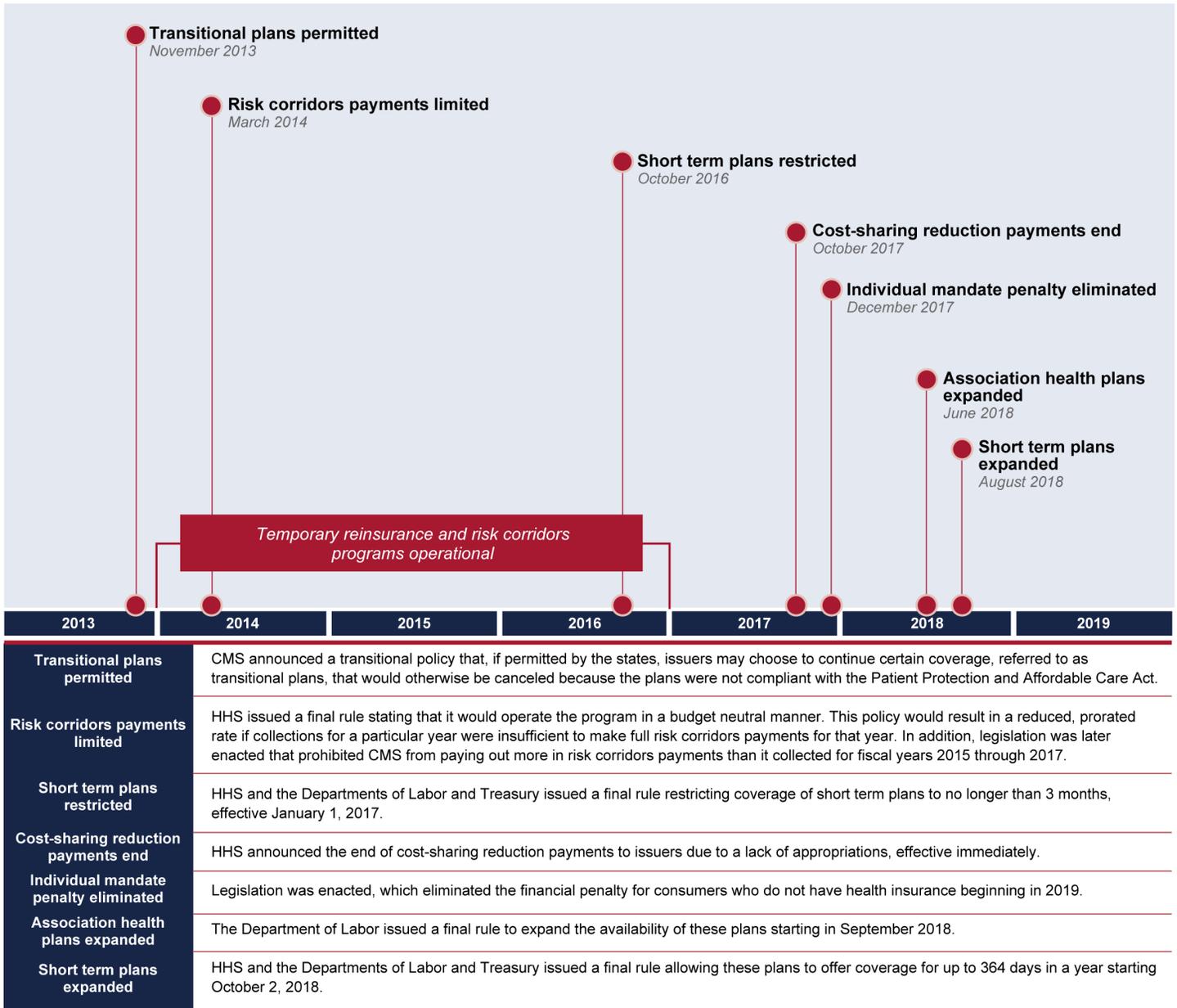
Other Federal Policies Affecting the Individual Market

Since the enactment of PPACA, additional federal policy changes have affected the individual market. See figure 1 for a timeline of several key changes.

¹³See generally Pub. L. No. 111-148 § 1201, 124 Stat. 119, 154 (2010). Certain of these requirements also apply to small and large group health plans.

¹⁴Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 885 (2010) (codified at 42 U.S.C. § 300gg-18).

Figure 1: Timeline of Selected Federal Policies Affecting the Individual Market, 2013 through 2018



Source: GAO analysis of documents from the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), and Departments of Labor and Treasury as well as relevant laws and regulations. | GAO-19-215

State Policies Affecting the Individual Market

States are the primary regulators of health insurance, and each state has standards and regulations to oversee issuers that offer health insurance within the state. As such, state oversight of the individual market can vary. For example, some states, such as Florida, have enacted state laws allowing state regulators to approve or disapprove issuers' premium rate changes before they go into effect, while other states, such as California, have not.

States also vary in policies affecting the size and risk associated with the individual market. For example, as of September 2018, 33 states and the District of Columbia have expanded Medicaid—a joint federal-state program that finances health care coverage for certain categories of low-income and medically needy individuals—to cover adults that earn at or below 138 percent of the federal poverty level.¹⁵ In states that did not expand Medicaid, individuals between 100 and 138 percent of the federal poverty level may be eligible for subsidized coverage through the exchange. Thus, when a state expands Medicaid, it changes the risk pool—a pool of consumers for which issuers' spread the risk of covering health care services—for the individual market. Other state policies also affect the size and risk associated with their respective individual markets. For example, Massachusetts enacted comprehensive health reform in 2006 that, among other changes, merged the individual and small group markets. Issuers that sell health plans to small businesses in Massachusetts must also make those plans available to individuals purchasing insurance in the individual market, and the risk pool for both markets is combined. Additionally, some states, including Minnesota, implemented state risk mitigation programs, such as reinsurance programs to help stabilize premiums.

¹⁵Under current law, states may opt to expand their Medicaid programs to cover nonelderly, nonpregnant adults who are not eligible for Medicare with incomes at or below 133 percent of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). According to CMS guidance, no deadline exists for states to implement the Medicaid expansion. Current law also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level. 42 U.S.C. § 1396a(e)(14)(I).

Claims Costs were Higher than Expected in Early Years of Exchanges; Selected Issuers' Experiences Varied Significantly

Multiple Factors Contributed to Higher than Expected Claims Costs in Initial Years of Exchanges

Studies we reviewed and interviews with selected issuers indicate that claims costs were generally higher than expected in the initial years of the exchanges, though the extent varied among issuers. Specifically, two studies we reviewed examined issuers' 2014 actual and projected per member per month claims costs for QHPs and found actual claims costs to be about 6 and 10 percent higher than projected.¹⁶ In addition, one of these two studies found considerable variation in how much the projected per member per month claims costs differed from actual costs in 2014, ranging from an average difference of 4 percent for the quartile of issuers that had the lowest claims to an average difference of 35 percent for the quartile of issuers with the highest claims.¹⁷ A third study that examined issuers' experiences in five states found that claims costs were substantially higher than issuers' expectations in 2014 and 2015, as evidenced by some issuers having claims that were 50 to over 100 percent greater than premiums in one state.¹⁸ Similarly, three of our

¹⁶One of these studies found the average actual and projected per member per month costs to be \$429 and \$406, respectively, or a difference of about 6 percent. The other study found the median actual and projected per member per month costs to be \$443 and \$402, respectively, or a 10 percent difference. See, M.A. Hall and M.J. McCue, "How Has the Affordable Care Act Affected Health Insurers' Financial Performance?," *The Commonwealth Fund*, vol. 18 (2016); and M.J. McCue and J.R. Palazzolo, "Analysis of Actual Versus Projected Medical Claims Under the First Year of ACA-Mandated Coverage," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 53 (2016).

¹⁷M.A. Hall and M.J. McCue, "How Has the Affordable Care Act Affected Health Insurers' Financial Performance?"

¹⁸The study also reported many issuers in that same state had claims costs that were nearly identical to premiums charged, thus leaving little revenue to cover administrative expenses. The study examined issuers' experiences in five states – California, Michigan, Florida, North Carolina, and Texas. M.A. Morrissey, A.M. Rivlin, R.P. Nathan, M.A. Hall, "Five-State Study of ACA Marketplace Competition: A Summary Report," *Risk Management and Insurance Review*, vol. 20, no. 2 (2017).

selected issuers told us claims costs were higher than projected from 2014 through 2016, and three selected issuers noted difficulties projecting claims costs in a new and changing market.¹⁹

Studies from our literature review and selected issuers attributed the difference in actual and projected claims costs in the initial years of the exchanges to issuers lacking historical data to support actuarial assumptions under the new market conditions, such as new requirements that prevented issuers from denying health care coverage or varying premiums based on health status. Studies indicated, and selected issuers told us, that these changes affected the morbidity of the risk pool, utilization of services, and the costs of services, in ways that were challenging to accurately estimate.

- **Morbidity of risk pool.** Four studies and five selected issuers indicated that consumers buying insurance on the individual market were sicker than expected. For example, one study examining enrollees in Blue Cross Blue Shield plans found that those who enrolled in 2014 and 2015 had higher rates of certain diseases, such as hypertension, diabetes, depression, human immunodeficiency virus, and Hepatitis C, than those who enrolled in the individual market prior to 2014.²⁰ Additionally, three selected issuers told us the numbers of enrollees with end stage renal disease were unexpectedly high.²¹ In one selected state (Minnesota), two selected issuers noted that claims costs were higher than projected after a larger than expected share of the state's high risk pool, which offered coverage to individuals with pre-existing conditions unable to obtain affordable coverage in the individual market, unexpectedly enrolled in the exchange in 2014.
- **Utilization of services.** Two studies cited higher than expected utilization of services as a driver of the higher than expected claims

¹⁹Two selected issuers participating in Massachusetts also commented that claims costs were higher than expected when the state exchange in Massachusetts was established in 2006.

²⁰Blue Cross Blue Shield Association and Blue Health Intelligence, *The Health of America Report, Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015* (March 2016).

²¹Regardless of age, most patients with end stage renal disease are covered by Medicare. Officials from one of these issuers noted that enrollees were directed to their plans by third party providers who procured higher reimbursement rates for their services from the issuers compared to Medicare.

costs, and three selected issuers cited it as well. For example, the study cited above also found that new enrollees utilized more hospital admissions, outpatient visits, emergency department visits, and prescriptions than those who were enrolled prior to 2014.²² The second study reported differences in actual and projected utilization for outpatient visits and prescriptions in 2014 to be 40 percent and 10 percent, respectively, for issuers with QHPs. Inpatient stays were also 30 percent longer than expected, according to the study.²³ This study noted that the increased utilization could be the result of a sicker-than-expected risk pool or the “pent-up demand” associated with previously uninsured or underinsured enrollees seeking care shortly after enrolling in coverage. In addition, one selected issuer said utilization increased the longer consumers were enrolled and attributed the increase to pent-up consumer demand lasting longer than anticipated.

- **Medical and pharmaceutical costs.** One study and five selected issuers indicated increased claims costs were also driven by higher-than-expected costs for medical and pharmaceutical services. For example, one study found the costs per service for professional visits were 23 percent higher than expected in 2014, and prescription drug costs were 4 percent higher.²⁴ Additionally, one of our selected issuers cited out-of-network emergency room visits and mental health care costs as reasons claims costs were higher than projected. Another selected issuer said increases in the costs of specialty drugs increased claims costs.

Studies from our literature review and selected issuers identified federal policies that contributed to claims costs being higher than expected in the initial years of the exchanges.

- **Special enrollment periods.** Three studies and two selected issuers indicated the misuse of special enrollment periods contributed to higher than projected claims, and CMS took steps to minimize misuse

²²Blue Cross Blue Shield Association and Blue Health Intelligence, *Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform*.

²³M.J. McCue and J.R. Palazzolo, “Analysis of Actual Versus Projected Medical Claims.” Additionally, another study also identified a 12 percent increase in the average number of hospital patient days per 1,000 enrollees in the individual market between 2013 and 2014. See, C. Cox, A. Semanskee, L. Levitt, *Individual Market Performance in 2017* (Washington, D.C.: Kaiser Family Foundation, 2018).

²⁴M.J. McCue and J.R. Palazzolo, “Analysis of Actual Versus Projected Medical Claims.”

in 2017.²⁵ Specifically, one study noted that short-term, urgent medical needs likely drove consumers to obtain coverage through special enrollment periods, more so than those who enrolled during the open enrollment period and continued coverage for part of the year.²⁶ Another study cited generous rules for special enrollment periods as allowing consumers to delay enrollment until they needed health care, and subsequently dropping health coverage after receiving treatment.²⁷ One selected issuer told us that individuals who obtain coverage through special enrollment periods negatively affected claims costs because they were enrolled for a shorter period of time compared to open enrollment enrollees, and had a high use of services.

- **Transitional Plans.** Three studies noted that the policy of allowing plans that were in existence prior to 2014, known as transitional plans, contributed to higher than projected claims in the initial years of the exchanges. According to one study, the decision to allow the continued purchase of transitional plans allowed healthy people to maintain their coverage and not purchase plans through the exchanges, thereby increasing average claims costs associated with QHPs in the initial years of the exchanges.²⁸ On a related note, one selected issuer said the timing of the decision to allow transitional plans to stay on the market was also detrimental because it was done after rates were already set for 2014, and so issuers had no ability to adjust rates for this sicker than expected risk pool.

²⁵A special enrollment period is a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in a QHP outside of the annual open enrollment period. In 2016, GAO reported that relying on an enrollees' self-attestation without verifying documents to support a special enrollment period triggering event could allow applicants to obtain coverage for which they would otherwise not qualify. See, GAO, *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period*, [GAO-17-78](#) (Washington, D.C.: Nov. 17, 2016). In 2017, CMS took steps to limit the misuse of special enrollment periods. In particular, the agency instituted a verification process to ensure eligible consumers were able to enroll in coverage through the special enrollment periods, rather than relying on self-attestation of a qualifying life event and the meeting of other eligibility criteria. CMS reports that these changes were implemented to improve the risk pool and stabilize the individual market. See, CMS, *The Exchanges Trends Report* (July 2018).

²⁶S. Dorn, B. Garrett, M. Epstein, "New Risk-Adjustment Policies Reduce But Do Not Eliminate Special Enrollment Period Underpayment," *Health Affairs*, vol. 37, no. 2 (2018).

²⁷M.A. Morrissey, A.M. Rivlin, R.P. Nathan, M.A. Hall, "Five-State Study of ACA Marketplace Competition."

²⁸J. Hsu, "The ACA and Risk Pools—Insurer Losses in the Setting of NonCompliant Plans," *New England Journal of Medicine*, vol. 374, no. 22 (2016).

Factors affecting issuer profitability

Claims costs. The costs associated with enrollees' medical and pharmaceutical services make up the largest component of issuers' premiums.

Accurate pricing. If issuers fail to set premiums high enough to cover both claims and administrative costs, then issuers may have financial losses.

Federal risk mitigation programs. The amount of payments received under the three programs established under PPACA could affect issuer profitability.

Source: GAO and Congressional Research Service. | GAO-19-215

Given that claims costs were higher than expected, issuers' profitability was affected and they generally incurred losses in the early years of the exchanges. According to five studies from our literature review that assessed issuers' financial losses in the individual market, issuers collectively lost billions of dollars each year from 2014 through 2016. However, profitability varied across issuers. For example, one study reported that 30 percent of issuers nationally were profitable in 2014, and issuers with narrowed networks and managed plan design had lower losses than those with broad networks.²⁹ Profitability for our selected issuers also varied from 2014 through 2016, with at least three reporting that they were profitable in a selected state each year.

Despite early losses, issuers' financial performance generally improved in 2017 compared to prior years, according to our literature review and interviews with selected issuers. Two studies that examined trends in MLRs—which generally measure the proportion of premiums spent on medical claims—through 2017 found that MLRs for the individual market began to decline in 2016 and continued declining into 2017, suggesting improved financial performance for issuers.³⁰ We observed a similar pattern in individual market MLRs for selected issuers; however, there was considerable variation across issuers and years (see table 1). Selected issuers that provided MLR projections for 2018 and 2019 generally expected similar trends to 2017.

²⁹McKinsey Center for U.S. Health System Reform, *Exchanges three years in: Market variations and factors affecting performance* (McKinsey & Company, 2016).

³⁰MLRs are calculated for all of an issuer's plans in the individual market, not just those that are offered through the exchange.

Table 1: Individual Market Medical Loss Ratios for Selected Issuers in Selected States, 2014-2017

Medical loss ratios measure the amount of premium revenue an issuer spends on certain expenses, such as an enrollee’s medical claims. Issuers in the individual market are required to spend at least 80 percent of premium revenue on enrollees’ medical expenses.

| | 2014 | 2015 | 2016 | 2017 ^a |
|--|------|------|------|-------------------|
| Issuers with MLRs less than 80 percent | 4 | 3 | 1 | 2 |
| Issuers with MLRs between 81 and 90 percent | 3 | 4 | 6 | 6 |
| Issuers with MLRs between 91 and 100 percent | 2 | 3 | 4 | 1 |
| Issuers with MLRs above 101 percent | 3 | 2 | 1 | 0 |
| Average MLR nationally ^b | 98% | 103% | 96% | 82% |

Source: GAO analysis of data and documentation from selected issuers and the Centers for Medicare & Medicaid Services. | GAO-19-215

Notes: The data are for nine issuers participating in one or more of five selected states: California, Florida, Massachusetts, Minnesota, and Mississippi. To the extent that an issuer participated in more than one selected state, we included medical loss ratios (MLR) in each state rather than an average across states. Selected issuers indicated that reported MLRs generally followed the calculation for MLRs defined in PPACA and are for a single plan year.

^aFor 2017, the table includes only 9 issuer and state combinations because one issuer left the individual market in 2017 and another issuer did not provide data for this year.

^bThe average MLR nationally in the individual market comes from C. Cox, A. Semanskee, L. Levitt, *Individual Insurance Market Performance in 2017*, (Washington D.C.: Kaiser Family Foundation, 2018).

The literature we reviewed and selected issuers cited continued experience with the new market conditions and increased premiums as reasons for improved financial performance in 2017. Specifically, two selected issuers said 2017 was the first year that multiple years of claims data associated with the new market conditions were available to set premiums for the next year. Six studies and three selected issuers reported that premium increases, rather than decreases in claims costs, were the impetus for improved financial performance for issuers in 2017.³¹

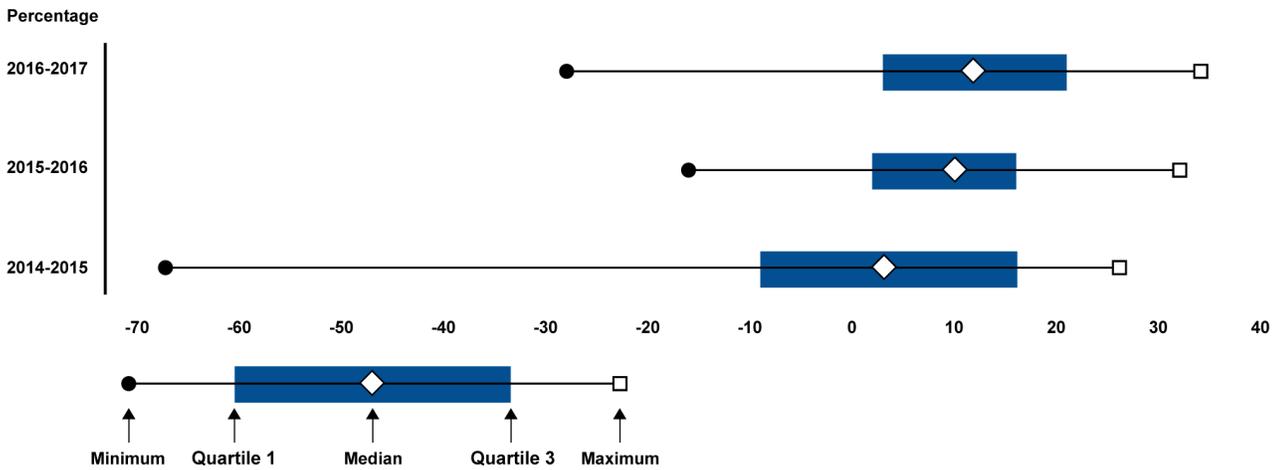
³¹One study noted that issuers may have set premiums artificially low in the early years of the exchanges (2014 through 2016) to attract enrollees. See M. Fiedler, *Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017*, (USC-Brookings Schaeffer Initiative for Health Policy, 2017).

Selected Issuers' Claims Costs Generally Increased Over Time and Varied Significantly within Selected States

Claims costs generally increased for our selected issuers between 2014 and 2017, though costs varied greatly by issuer and by year. For example, from 2014 to 2015, when growth in per member per month claims costs averaged 13 percent nationally, selected issuers' experienced changes in per member per month claims costs ranging from a decrease of 67 percent to an increase of 26 percent.³² The level of variation narrowed for the next 2 years (see figure 2). Further, selected issuers experienced considerable swings in claims costs—both increases and decreases—year to year. For example, one issuer experienced a 13 percent increase in per member per month claims costs between 2015 and 2016, and a 28 percent decrease the next year, while another issuer experienced a 16 percent decrease between 2015 and 2016 and a 15 percent increase in the following year. For 2018 and 2019, projections from selected issuers indicate that per member per month claims costs will generally continue to increase.

³²This national average is based on per member per month claims costs for issuers' with QHPs that may be purchased through the exchange. The article also reports claims costs increased an average of 7 percent per member per month between 2015 and 2016. See, M.J. McCue and M.A. Hall, *On the Road to Recovery: Health Insurers' 2016 Financial Performance in the Individual Market*, (Washington, D.C., The Commonwealth Fund: 2018). Another study estimating claims costs for issuers with QHPs reported between about 1 and 3 percent increases in per member per month claims costs each year between 2014 and 2017. See M. Fiedler, *Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017*.

Figure 2: Percent Change in Per Member Per Month Claims Costs for Individual Market Exchange Enrollees for Selected Issuers in Selected States, 2014 through 2017



Source: GAO analysis of data from selected issuers and the Centers for Medicare & Medicaid Services. | GAO-19-215

Notes: The data are for nine issuers participating in one or more of five selected states: California, Florida, Massachusetts, Minnesota, and Mississippi. To the extent that an issuer participated in more than one selected state, we included data on changes in costs for each state rather than an average across states. For years 2014 through 2017, the table includes 12 issuer state combinations.

Most selected issuers attributed the volatility in per member per month claims costs, in part, to changes in the number and health needs of enrollees from year to year. Specifically, all selected issuers had a greater than 50 percent increase or decrease in enrollment in at least one year between 2014 and 2017. Six selected issuers had enrollment increases of over 100 percent in at least one of these years. Such dramatic changes in enrollment can change the issuers' risk pool, potentially increasing claims costs beyond what was expected for medical and pharmaceutical services or even decreasing costs if the new enrollees are healthier than expected. Many issuers cited enrollee price sensitivities, changes in the participation and products of competitors, and state policy changes as factors affecting enrollment.

Per member per month claims costs also varied significantly across issuers participating in the same state. Data from our selected issuers in four selected states indicated that the difference in issuers' average claims costs within a given state was often well over \$100 per member per month, a significant amount given that the median per member per month claims costs ranged from about \$300 to \$350 (see table 2). Additionally, it was not always the same issuer in each state that had the lowest or highest claims costs in each year.

Table 2: Differences in Selected Issuers' Per Member Per Month Claims Costs for Individual Market Exchange Enrollees in Selected States, 2014 through 2017

| State | Difference in dollars | | | |
|---------|-----------------------|------|------|------|
| | 2014 | 2015 | 2016 | 2017 |
| State A | 221 | 165 | 198 | 228 |
| State B | 164 | 155 | 217 | 123 |
| State C | 74 | 149 | 237 | 89 |
| State D | 480 | 295 | 222 | 249 |

Source: GAO analysis of data from selected issuers. | GAO-19-215

Notes: The dollar amounts provided represent the difference between selected issuers with the highest and lowest per member per month claims costs in a given state. For each of the four states, there were between two and four issuers providing data. The states include California, Florida, Minnesota, and Mississippi. We did not include the fifth state—Massachusetts—because of data limitations.

Selected Issuers Attributed Changes in Exchange Participation, Premiums, and Plan Design to Claims Costs and Other Factors

Selected Issuers Cited Various Factors for Changes in Their Exchange Participation

Decisions to expand or contract participation in the individual market exchanges from 2014 to 2018 varied significantly among our nine selected issuers. Three selected issuers expanded their participation, three selected issuers contracted their participation, and three selected issuers had no changes in participation (see table 3). These changes ranged from expanding or contracting the number of counties in which a selected issuer participated in a selected state, to expanding into, or leaving, a state altogether. The experiences of our selected issuers from 2014 to 2018 are consistent with trends nationally in that the number of issuers participating in the exchanges generally declined, though the numbers of issuers participating varied widely by state and even by

county.³³ For example, while 8 issuers participated in Florida’s exchange in 2014, only 4 issuers participated in 2018, with many counties only having 1 issuer. In contrast, California had 11 issuers participating in the state’s exchange in 2014 and 2018, and most counties had 2 or more issuers offering plans on the exchange in 2018.³⁴

Table 3: Change in Individual Market Exchange Participation for Selected Issuers in Selected States, 2014 and 2018

| Participation status | Number of issuers | Examples of changes |
|----------------------|-------------------|--|
| Expanded | 3 | Centene expanded its presence in Florida from 3 to 22 counties; expanded in Mississippi from about half of all counties to offering coverage statewide; and moved into California through the acquisition of another issuer. |
| Contracted | 3 | Blue Cross Blue Shield of Minnesota participated statewide in 2014 but was not offering coverage in 10 of 87 counties by 2018. Humana offered coverage in certain areas of Florida and Mississippi in 2014. By 2018, the company no longer participated in either state and reported leaving the individual market in all states. |
| No Change | 3 | Florida Blue offered coverage statewide throughout these years. Neighborhood Health Plan participated in most counties in Massachusetts in 2014 and continued in the same counties in 2018. |

Source: GAO analysis of data from the Kaiser Family Foundation and selected issuers, and other documents. | GAO-19-215

Note: These data represent changes in participation for nine selected issuers in the following states: California, Florida, Massachusetts, Minnesota, and Mississippi.

Selected issuers described various reasons for changes in exchange participation, including claims costs, the success of their pricing strategy, actions by competitors, state policies, and the level of funding through federal risk corridors program. Often, these issuers described a combination of those factors.³⁵

³³One study reported issuer participation dropped by less than a third in 2017 and about a quarter in 2018, and eight states had a single issuer participating in the exchange. See M. Hall, *Stabilizing and strengthening the individual health insurance market: A view from ten states*, (USC-Brookings Schaeffer Initiative for Health Policy, Washington, D.C., July 2018).

³⁴A. Semanskee, C. Cox, G. Claxton, M. Long, R. Kamal, *Insurer Participation on ACA Marketplaces, 2014-2018*, (Washington, D.C., Kaiser Family Foundation, November 2017).

³⁵One study noted that sustained financial losses through 2016 were the main reason issuers left the exchanges, while the ability to turn a profit is keeping issuers in the market in 2018 and potentially re-entering in 2019. See M. Hall, *Stabilizing and strengthening the individual health insurance market: A view from ten states*.

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- **Expansion in multiple states.** Centene cited the company's accurate claims projections and pricing in 2014 and 2015 as the reason for its expansion into new counties and states. In particular, the issuer said it was reasonably conservative in setting rates in those years and focused on the low-income population that was eligible for subsidies. The company's understanding of the individual market has given it confidence to expand its business model into other states, according to the issuer, and the company acquired another issuer to expand its business into California in 2016.
 - **Contraction in Minnesota.** Blue Cross Blue Shield of Minnesota told us that it contracted its operations because of a state law prohibiting issuers from canceling an enrollee's coverage, except under limited circumstances, as well as unexpectedly high claims costs.³⁶ As a result, issuers in the state were required to make existing health plans compliant with PPACA but rate increases on those plans were subject to state approval. The issuer said that in 2016 it became clear to the company that even with high rate increases, the company would not be able to continue in its current state because it lost over \$500 million from 2014 through 2016 because claims costs were greater than their premium revenue. In order to stem the losses, the issuer said it closed down its entity that offered preferred provider organization plans throughout the whole state, and continued offering coverage through its other entity providing health maintenance organization plans in various counties in the state. Further, the issuer said that changes in the way in which the federal risk corridors program was funded, which limited risk corridors payments to issuers, also affected the company's decision to contract.³⁷

³⁶See Minn. Stat. § 62A.65 (2018). The limited circumstances for cancellation include non-payment of premiums, fraud, and misrepresentation. In January 2014, the Minnesota Department of Commerce issued a report examining the effect of the state's guaranteed renewability requirement on individual health insurance plans. It recommended the state allow time for PPACA provisions to be fully implemented before considering any modifications to this provision. See, Minnesota Department of Commerce, *Guaranteed Renewability Report on Minnesota*, (St. Paul, M.N., January 31, 2014).

³⁷CMS originally indicated that the risk corridors program would not be operated in a budget neutral manner. In 2014, CMS announced it would operate the program in a budget neutral manner. In addition, legislation was enacted that prohibited CMS from paying out more in risk corridors payments than it collected for fiscal years 2015 through 2017. As a result, if risk corridors collections were insufficient to make risk corridors payments for a year, payments to eligible issuers would be reduced pro rata to the extent of any shortfall. For the risk corridors program's 3-year period, collections from profitable issuers fell short of the full amount of risk corridors payments due to unprofitable issuers.

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- **Exit from exchanges.** Humana cited its pricing strategy as a factor contributing to the company contracting in selected states and ultimately leaving the individual market and all exchanges nationwide. Humana noted that it had the lowest or second lowest prices in many markets between 2014 and 2016, but over time, their prices became less competitive compared to other issuers. The issuer said sicker beneficiaries and broad provider networks led to higher costs, and as a result, Humana increased premiums. The issuer told us premium increases made the company's plans less attractive to enrollees.

Selected Issuers Attributed Premium Increases to Claims Growth and Reductions in Federal Funding

Consistent with national trends, selected issuers told us that they generally increased premiums from 2014 through 2018 and projected increases to continue in 2019.³⁸ The extent of increases varied across selected issuers and over time as indicated by the amount of premium dollars received per member per month, referred to as average premium received. For example, increases in average premium received were fairly small between 2014 and 2015 (ranging from 2 to 9 percent), and then became more widespread between 2015 and 2016 (ranging from 1 to 33 percent). This widespread variation continued in 2017, and was projected to continue through 2018.³⁹ Though less frequent, many issuers reported decreases in average premium received, which could reflect lower premium rates, members choosing lower-cost plans, or both. (See table 4.).

³⁸The percent change in premium rates nationally were 3 percent between 2014 and 2015, 8 percent between 2015 and 2016, 24 percent between 2016 and 2017, and 37 percent between 2017 and 2018. These trends reflect changes in the rates for the plan used as the benchmark for determining federal assistance for coverage. The rates are based on a 27 year old purchasing coverage through the federally facilitated exchange. See HHS Office of the Assistant Secretary for Planning and Evaluation, *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange*, (October 30, 2017).

³⁹A 2017 GAO report found that premium rates for the plan used as the benchmark for determining federal assistance for coverage were more likely to increase than decrease and generally increased more from 2016 to 2017 than from 2015 to 2016. GAO's analysis found that the median change across all counties included was 11 percent from 2015 to 2016 and 28 percent from 2016 to 2017. See GAO, *Health Insurance Exchanges: Changes in Benchmark Plans and Premiums and Effects of Automatic Re-enrollment on Consumers' Costs*, [GAO-18-68](#) (Washington, D.C. Nov. 14, 2017).

Table 4: Percent Change in Per Member Per Month Premium Received by Selected Issuers for Individual Market Exchange Enrollees in Selected States, 2014-2018

| Percent change in premium received | Number of issuers | | | |
|------------------------------------|-------------------|--------------|--------------|---------------------------|
| | 2014 to 2015 | 2015 to 2016 | 2016 to 2017 | 2017 to 2018 ^a |
| Less than 0% | 5 | 5 | 0 | 1 |
| 0 to 10% | 6 | 5 | 3 | 4 |
| 11 to 20% | 1 | 1 | 3 | 0 |
| 21 to 30% | 0 | 0 | 3 | 0 |
| Greater than 30% | 0 | 1 | 3 | 5 |

Source: GAO analysis of data from selected issuers and CMS. | GAO-19-215

Notes: The data are for nine selected issuers participating in at least one of five selected states: California, Florida, Massachusetts, Minnesota, and Mississippi. To the extent that an issuer participated in more than one of our selected states, we included data on changes in costs for each state rather than an average across states.

^aThe change from 2017 to 2018 is based on projections of premium revenue issuers expect to receive in 2018. The column includes only 10 issuer state combinations as one of the selected issuers left the exchanges in our selected states for 2018.

Selected issuers told us there were a variety of factors that drove premium increases between 2014 and 2018, including increasing claims costs and changes in federal funding. Increasing claims costs were cited by selected issuers and state officials in four selected states. However, most selected issuers also cited the availability of federal funding as a factor driving increases, particularly in 2017 and 2018, years in which many selected issuers reported significant increases—more than 20 percent—in per member per month premium revenue.

- Phase out of federal reinsurance and risk corridors programs:** Two selected issuers told us that as these temporary programs were phased out in 2016 per PPACA, they raised premiums in 2017 to account for the loss of those payments.
- End of cost-sharing reduction payments:** Three selected issuers told us the loss of cost-sharing reduction payments contributed to their premium increases in 2018.⁴⁰ Officials from two of these issuers reported that by 2017, better data allowed for more accurate pricing and more moderate rate increases. However, the end of federal cost-sharing reduction payments accounted for 20 percent of premium

⁴⁰Issuers are required to reduce cost-sharing amounts for individuals eligible for cost-sharing reductions. To reimburse issuers for this reduced cost-sharing, HHS made payments to issuers until October 2017, when it discontinued these payments because of a lack of an appropriation for the payments.

increases in 2018, according to one issuer.⁴¹ The same issuer noted that the enrollees most affected by these increases would be those not eligible for premium tax credits, and expected that some of those people would leave the market. Issuers we interviewed in one selected state (Minnesota) said they were less affected by this change, because most enrollees who were eligible for cost-sharing reduction payments did not purchase coverage through the exchange but instead received coverage through Medicaid or the state's basic health program.⁴²

Several issuers told us state policies also affected premium increases, both minimizing and increasing the extent of increases. For example, the issuers cited state oversight in California and Minnesota as affecting the extent of any premium increases.

- **California.** The two selected issuers in California providing premium data had fewer significant price increases each year, compared to selected issuers across our other selected states. One attributed this to California's level of engagement. California's exchange, Covered California, determines which issuers will be allowed to offer plans on the exchange through a competitive process and has standardized benefits across certain plans offered through the exchange.
- **Minnesota.** Two selected issuers in Minnesota told us state policies were a factor in premium increases. One issuer cited the state's guaranteed renewability law, which the issuer said made it difficult to

⁴¹In July 2018, GAO reported that premiums across all plans offered on the federally-facilitated exchange increased an average of about 30 percent, with the elimination of cost-sharing reduction payments being a driver. The report noted that decreased affordability of plans likely resulted in lower enrollment in exchange plans for consumers that were not eligible for advance premium tax credits. See, GAO, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance*, [GAO-18-565](#) (Washington D.C., July 24, 2018).

⁴²The Basic Health Program is an alternative to QHPs under which states may offer subsidized coverage to certain low-income, non-elderly individuals who are otherwise not eligible for other types of coverage, but may purchase coverage through the exchange. Minnesota's program became effective in January 2015 and covers consumers with household incomes over 133 through 200 percent of the federal poverty level.

State officials noted that, while issuers in the individual market were largely shielded from the loss of cost-sharing reduction payments, the state was severely affected by this loss of funding, which provided a portion of funding for its Basic Health Program. In August 2018, CMS paid Minnesota an additional amount to operate its Basic Health Program as a result of a lawsuit the state filed after CMS reduced Basic Health Program payments due to the termination of cost-sharing subsidies.

cancel or modify plans, as a significant factor for increased premiums in 2015 and 2016. However, both issuers cited the adoption of a state reinsurance program as a factor in reducing premium increases or driving premium reductions in 2018.⁴³

Selected issuers and stakeholders anticipated that changes in federal and state policies would continue to affect premium increases in 2019 and beyond.

- **Elimination of individual mandate penalty.** Five issuers and stakeholders noted that the elimination of the individual mandate penalty could affect premiums moving forward. A report by the Congressional Budget Office noted that the full effect of this change would not be observable in 2019, the first year in which the penalty will no longer be in effect, but instead in 2020 and beyond, once issuers have data on the extent to which it affected the risk pool.⁴⁴ According to state officials in Massachusetts, the elimination of the federal individual mandate penalty is unlikely to affect premiums, because the state has its own penalty.⁴⁵
- **Rule changes for short-term and association health plans.** The federal government has also issued two new rules that seven selected issuers and seven stakeholders anticipate will affect premiums going forward. Specifically, three selected issuers expect that new rules increasing the availability of short-term health plans could result in

⁴³Section 1332 of PPACA permits states to apply for a State Innovation Waiver to waive specified PPACA requirements related to, among other things, the maintenance of insurance coverage for individuals, exchange functions, and subsidies for exchange coverage. In 2017, Minnesota enacted a law to establish a state-based reinsurance program designed to stabilize premiums in the individual market by partially reimbursing issuers for high-cost claims, and authorized funding for years 2018 and 2019. In September 2017, HHS and the Department of Treasury approved Minnesota's waiver allowing the state to use federal funds to cover a significant portion of the funding for the reinsurance program. Other states have also received approval for 1332 waivers for reinsurance programs as of August 2018, including Alaska, Maine, Maryland, New Jersey, Oregon, and Wisconsin.

⁴⁴The report also found that the number of uninsured consumers is expected to rise by 3 million between 2018 and 2019 primarily as a result of the elimination of the federal penalty and the higher premiums associated with that change. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2018*, (May 2018).

⁴⁵As of September 2018, several states, including New Jersey, Vermont, and the District of Columbia, have enacted similar legislation requiring the purchase of insurance in either 2019 or 2020.

healthier consumers choosing those plans over QHPs.⁴⁶ Such a move could increase the morbidity of the risk pool in the individual market and lead to increased premiums. Six selected issuers and five stakeholders cited similar concerns with new rules expanding the availability of association health plans that are exempt from many of PPACA's reforms.⁴⁷ As with the elimination of the individual mandate penalty, state policies may limit the effect of these policy changes. For example, California prohibited the sale of short-term plans effective January 2019.⁴⁸ Officials from Massachusetts noted that its state laws around guaranteed issue and renewability and rating rules work as a disincentive for issuers to offer short term plans.

⁴⁶Short-term plans, or short-term, limited-duration insurance is a type of health insurance coverage that is designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage and are not subject to many of PPACA's market reforms, such as the requirement to cover essential health benefits. In August 2018, the Departments of HHS, Labor, and Treasury issued a final rule to expand the availability of these plans from limiting coverage to 3 months to allowing coverage up to 12 months at a time, beginning on October 2, 2018. See 83 Fed. Reg. 38,212 (Aug. 3, 2018).

⁴⁷Association health plans are a type of health insurance offered through business associations and other entities to jointly offer health insurance and other fringe benefits to their members or employees. In June 2018, the Department of Labor issued a final rule to broaden the types of association health plans that are regulated as group insurance and, therefore, are not subject to certain PPACA reforms, such as the requirement to offer essential health benefits, beginning September 1, 2018. See 83 Fed. Reg. 28,912 (June 21, 2018).

The Congressional Budget Office estimated that beginning in 2023, approximately 5 million people will enroll in either association or short-term health plans under the recently-issued association health plan and short-term plan rules. The office estimates the effect of these enrollees, who tend to be healthier, enrolling in association health plans and short-term plans instead of the individual market, will be to raise premiums 2 to 3 percent in the individual market. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2018*.

⁴⁸In California, short-term plans are generally those with a duration of less than one year.

Federal Requirements Limited Changes to Benefits for Selected Issuers, but Competition and Claims Costs Drove Changes in Cost-Sharing and Provider Networks

All of the selected issuers told us they made no significant changes to the benefits covered under their plans due to essential health benefit requirements under federal law, and in some cases state requirements. In particular, selected issuers participating in California's exchange noted the state further requires issuers to ensure that plans have the same benefit designs, including cost-sharing.⁴⁹ California officials noted that this requirement allows consumers to make their plan choice based on provider network and premiums alone, and not benefits.

However, seven selected issuers described making adjustments to benefits in states where they had the flexibility to do so. These included changes to cost-sharing for specific services and to pharmaceutical coverage, both of which could affect members' costs and access to the care.⁵⁰ For example, three selected issuers participating in Florida increased deductibles or cost-sharing for specialty drugs and emergency room visits. (See table 5.) Regarding changes to pharmaceutical coverage, two selected issuers told us they added additional coverage tiers, which can increase consumer costs for certain drugs, or narrowed their formulary and pharmacy network to help mitigate rising claims costs.

⁴⁹The standardization applies to all plans within a certain actuarial value, known as a metal tier. For example, all plans in the silver metal tier have the same benefit design, including cost-sharing, regardless of what issuer offers the plan.

⁵⁰PPACA limits the amount of annual cost-sharing that enrollees may incur in their coverage. Pub. L. No. 111-148, 124 Stat. 165 (2010). In 2014, the maximum annual limit on cost-sharing was \$6,350 for an individual and \$12,700 for a family. In 2018, the maximum annual limitation on cost-sharing was \$7,350 for individual coverage and \$14,700 for family coverage.

Table 5: Illustration of Cost-Sharing for Selected Services and Issuers in Florida, 2014 and 2018

| Issuer | Deductibles (\$) | | Cost-sharing for specialty drugs | | Cost-sharing for emergency room visits | |
|--------------|------------------------------|-----------------------------|----------------------------------|-----------------------------|--|-------------------------------|
| | 2014 or first year in market | 2018 or last year in market | 2014 or first year in market | 2018 or last year in market | 2014 or first year in market | 2018 or last year in market |
| Centene | 6,500 | 5,500 | no charge* | 20% coinsurance* | no charge* | 20% coinsurance* |
| Florida Blue | 5,750 | 6,050 | \$150 copay | 50% coinsurance* | 10% coinsurance* | \$650 copay* |
| Humana | 4,600 | 3,550 | 50% coinsurance* | 50% coinsurance* | 20% coinsurance* | \$600 copay before deductible |
| Molina | 1,700 | 4,950 | 30% coinsurance | 50% coinsurance* | \$250 copay | \$400 copay* |

Source: GAO analysis of data from the Centers for Medicare & Medicaid services. | GAO-19-215

Note: These data represent plans with the same actuarial value available in Miami-Dade County for each of our selected issuers. Benefits marked with an * indicate that the co-pay or coinsurance is after the deductible is paid.

Several selected issuers noted that changes in cost-sharing for specific services were made to be consistent with competing issuers or to incentivize enrollees to use preventive services. In particular, two issuers said they did not want to be outliers in the market when compared to other issuers participating in the exchanges in their state. One issuer told us some of the cost-sharing changes were made to incentivize the use of preventative and routine services and to avoid enrollees using unnecessary emergency services.

With regard to provider networks, selected issuers varied in the extent to which they reported changes and the reasons for those changes. Specifically, three selected issuers reported narrowing provider networks, and one reported adding plans with a narrow network. Other selected issuers reported no substantive changes to provider networks, or expanding provider networks as they expanded their participation into new counties and states. Interviews with officials from selected states also indicated that issuers varied in their approach to provider networks for exchange plans. For example, Massachusetts officials told us that, although issuers in their state have historically had relatively robust networks, certain issuers were moving to offering products with more limited networks. Minnesota officials also told us that issuers were narrowing provider networks. In contrast, officials in Mississippi told us that in their annual reviews of issuers' networks against network

adequacy standards, they have not observed narrowing of provider networks.⁵¹

Interviews with stakeholders and findings from two studies we reviewed also indicate that some issuers have narrowed provider networks for exchange coverage over time. For example, one study examining competition in five states noted that issuers' in those states have begun to offer narrow networks for the plans offered on the exchanges.⁵² This study found that in the initial years of PPACA, many issuers offered preferred provider organization plans, which tend to have broader provider networks than health maintenance organization plans; however, by 2016, issuers reduced the number of preferred provider organization plans available and some issuers only offered health maintenance organization plans.

Selected issuers who told us they narrowed provider networks or added plans with a narrow network said they did so to reduce and better manage claims costs and to price plans competitively to other issuers.⁵³ According to one study and interviews with stakeholders and officials from selected states, the narrowing of provider networks is one of the primary ways issuers can manage claims costs, which works by issuers channeling enrollees to fewer providers and negotiating lower prices in return.⁵⁴ The study, however, also noted the narrowing of provider networks may also work to lower claims because sicker enrollees are incentivized to seek coverage from other issuers where their specialists or hospitals are covered. Further, a stakeholder and one selected issuer told us the ability to manage providers, such as through ensuring accurate coding of an enrollee's diagnosis or treatment, is a key component in benefiting from federal risk adjustment payments as issuers only receive

⁵¹However, state officials told us that there are multiple rural hospitals that have closed or are at risk of closing in the state and that is raising significant network adequacy concerns.

⁵²M.A. Morrissey, A.M. Rivlin, R.P. Nathan, M.A. Hall, "Five State Study of ACA Marketplace Competition."

⁵³One study suggested issuers with narrower networks performed better in the individual market in 2014 through 2016, as issuers that had plans with health maintenance organization networks had lower financial losses in the aggregate than issuers with plans based on preferred provider organizations in 2014, and lower premiums increases in 2015 and 2016. See McKinsey Center for U.S. Health System Reform, *Exchanges three years in: Market variations and factors affecting performance*.

⁵⁴See, M.A. Morrissey, A.M. Rivlin, R.P. Nathan, M.A. Hall, "Five State Study of ACA Marketplace Competition."

credit for an enrollee's risk if it is documented.⁵⁵ Thus, issuers may forfeit risk adjustment payments if providers do not accurately record such information.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of the Department of Health and Human Services, appropriate congressional committees, as well as other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



John E. Dicken
Director, Health Care

⁵⁵CMS officials noted that CMS also validates risk adjustment data in states where HHS operates the risk adjustment program to ensure that issuers are providing accurate data.

List of Committees

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The Honorable Richard Neal
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Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: List of Relevant Studies Identified in Literature Review

Blase, B., D. Badger, E.F. Haislmaier, and S.J. Chandler. *Mercatus Working Paper: Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future*. Arlington, Va.: Mercatus Center at George Mason University, June 2016.

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Hsu, J. "The ACA and Risk Pools – Insurer Losses in the Setting of Noncompliant Plans." *The New England Journal of Medicine*, vol. 374, no. 22 (2016): 2105-2107.

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McCue, M.J., and M.A. Hall. *Comparing Individual Health Coverage On and Off the Affordable Care Act's Insurance Exchanges*. New York, New York: The Commonwealth Fund, August 2015.

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Morrisey, M.A., A.M. Rivlin, R.P. Nathan, and M.A. Hall. "Five-State Study of ACA Marketplace Competition: A Summary Report." *Risk Management and Insurance Review*, vol. 20, no. 2 (2017): 153-172.

S&P Global Market Intelligence. *The U.S. ACA Individual Market Showed Progress in 2016, But Still Needs Time to Mature*. New York, New York: S&P Global Inc., April 2017.

Appendix II: Information about the Individual Market and State Policies in Selected States

| | |
|----------------------|--|
| California | <p>Type of exchange: State-based exchange</p> <p>Number of issuers participating in the exchange: Two to seven in any given county in 2016, and one to six in any given county in 2018.</p> <p>Size of market: 2.4 million covered life-years in the individual market in 2016, with 1.3 million enrolling through the exchange.</p> <p>Key state policies identified by selected issuers, state officials, or stakeholders as affecting the individual market:</p> <ul style="list-style-type: none">• California’s exchange has standardized benefits across certain plans offered on the exchange, including cost-sharing requirements. State law provides that if the exchange standardized benefits, then issuers must offer those standardized benefits in plans sold through and outside the exchanges.• State uses a competitive process to selectively contract with exchange issuers.• State expanded Medicaid eligibility to include nonelderly adults with incomes up to 138 percent of the federal poverty level.• State law prohibits the sale of short term plans (plans that extend for less than one year) effective January 2019. |
| Florida | <p>Type of exchange: Federally facilitated exchange</p> <p>Number of issuers participating in the exchange: Two to six in any given county in 2016, and one to three in any given county in 2018.</p> <p>Size of market: 1.9 million covered life-years in the individual market in 2016, with 1.3 million enrolling through the exchange.</p> <p>Key state policies identified by selected issuers, state officials, or stakeholders as affecting the individual market:</p> <ul style="list-style-type: none">• State allows the sale of transitional plans. |
| Massachusetts | <p>Type of exchange: State-based exchange</p> <p>Number of issuers participating in the exchange: Six to 10 in any given county in 2016, and four to seven in any given county in 2018.</p> <p>Size of market: About 313,000 covered lives in the individual market in 2016, with about 311,000 enrolling through the exchange.</p> <p>Key state policies identified by selected issuers, state officials, or stakeholders as affecting the individual market:</p> <ul style="list-style-type: none">• State law established an exchange and subsidized coverage for consumers in 2006, prior to the enactment of the Patient Protection and Affordable Care Act.• State expanded Medicaid eligibility to include nonelderly adults with incomes up to 138 percent of the federal poverty level.• State subsidizes coverage for individuals with incomes up to 300 percent of the federal poverty level in addition to the federal subsidies.• State has an individual mandate that generally requires individuals over the age of 18 in the state to obtain health coverage or pay a penalty.• State merged the individual and small group markets. |

**Appendix II: Information about the Individual
Market and State Policies in Selected States**

Minnesota

Type of exchange: State-based exchange

Number of issuers participating in the exchange: Two to four in any given county in 2016, and one to four in any given county in 2018.

Size of market: About 261,000 covered life-years in the individual market in 2016, with about 66,000 enrolling through the exchange.

Key state policies identified by selected issuers, state officials, or stakeholders as affecting the individual market:

- State expanded Medicaid eligibility to include nonelderly adults with incomes up to 138 percent of the federal poverty level.
- State operates a Basic Health Program, which covers individuals with incomes above 133 percent to 200 percent of the federal poverty level.
- State law prohibits issuers from canceling an enrollee's coverage in most circumstances.
- State provided a one-time 25 percent premium discount in 2017 for all individual market enrollees who were not otherwise eligible for assistance through premium tax credits or cost-sharing reductions.
- State received approval for a 1332 waiver in 2017 that establishes a state reinsurance program to assist issuers' with high cost claims starting in 2018.

Mississippi

Type of exchange: Federally facilitated exchange

Number of issuers participating in the exchange: Two to three in any given county in 2016, and one in any given county in 2018.

Size of market: About 138,000 covered life-years in the individual market in 2016, with about 65,000 enrolling through the exchange.

Key state policies identified by selected issuers, state officials, or stakeholders as affecting the individual market:

- State allows the sale of transitional plans.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services, states officials, the Kaiser Family Foundation; and state laws and regulations. | GAO-19-215

Notes: Covered life-years represent the average number of lives insured, including dependents, on a pre-specified day of each month over the 12 months in the reporting year. Covered lives represent the total number of lives insured as of the last day of the reporting year.

Key policies in each state were identified through interviews with nine selected issuers participating in the exchanges in one or more of these states, state officials, and stakeholders. The policies listed are not a comprehensive list of all policies that may affect the individual market in these states.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Susan Barnidge (Assistant Director), Rebecca Hendrickson (Analyst-in-Charge), Reed Meyer, and Robert Dougherty made key contributions to this report. Also contributing were Sam Amrhein, Muriel Brown, Sarah Gilliland, Emei Li, and Jenny Rudisill.

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