January 2019

HEALTH INSURANCE EXCHANGES

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

GAO Highlights

Highlights of GAO-19-215, a report to congressional committees

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.

View GAO-19-215. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

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.