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3-7-2012

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Starc, Amanda and Kolstad, Jonathan T.. Designing Health Insurance Exchanges: Key Decisions. LDI Issue Briefs. 2012; 17 (5). http://ldi.upenn.edu/policy/issue-briefs/2012/03/07/designing-health-insurance-exchanges-key-decisions

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Designing Health Insurance Exchanges: Key Decisions

Abstract

A cornerstone of health care reform is the establishment of state-level insurance exchanges where individuals and small businesses can purchase health insurance in an online marketplace. This report reviews the experience of Massachusetts in developing a health insurance exchange and offers policymakers guidance on key features and likely consumer responses.

Keywords

health insurance, private insurance/exchanges

Disciplines

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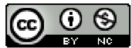

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LDI Issue Brief

Leonard Davis Institute of Health Economics | Volume 17, Issue 5 • February 2012

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Designing Health Insurance Exchanges: Key Decisions

Editor's note: A cornerstone of health care reform is the establishment of state-level insurance exchanges where individuals and small businesses can purchase health insurance in an online marketplace. States are required to develop an exchange by 2014, or participate in a federal one. The exchanges will help people without employer-sponsored insurance find and choose a health plan to meet their needs. This Issue Brief reviews the experience of Massachusetts in developing a health insurance exchange and offers policymakers guidance on key features and likely consumer responses.

States will develop websites to encourage "one-stop" shopping for health insurance

The 2010 Patient Protection and Affordable Care Act (ACA) mandates that all Americans carry health insurance and requires that states establish "health benefit exchanges" to facilitate individual purchase of health insurance. When fully operational, the exchanges will be the portal for an estimated 24 million people to purchase health insurance.

- Exchanges serve both a retail and regulatory function. Exchanges help connect individuals with insurers, potentially reducing transaction costs and search costs—the retail function. However, exchanges also make substantive decisions that shape how the insurance market works—the regulatory function.
- States have substantial latitude in designing and regulating these exchanges, and the choices they make will shape the market for individually-purchased health insurance. But little is known about how consumers will act in such settings. Understanding consumer demand in exchanges and the incentives of insurers is important for predicting what will happen and whether social goals will be achieved.
- Massachusetts is ahead of other states in its experience with health insurance exchanges and may provide insight into key policy decisions for other states and their likely impact.

Massachusetts has operated a health insurance exchange since 2007

In 2007, Massachusetts established a state-wide insurance exchange and an individual mandate to obtain insurance. The exchange (the "Health Connector") facilitates individual and small-group purchase of insurance through the Commonwealth Choice Program and through a separate, subsidized Commonwealth Care program for low-income people. Prior to Massachusetts health reform, 89.5% of residents were insured. Today, 98% are insured.

The Connector shapes the market for individual coverage in Massachusetts in a number of ways. It operates the exchange's website and chooses which features of insurance plans are highlighted. It determines the "minimum creditable coverage (MCC)" a plan can offer to comply with the insurance mandate. It also regulates premiums through modified community rating rules.

- In Massachusetts, MCC is defined as a policy that provides prescription drug coverage, three check-ups, caps deductibles at $2,000 for an individual and $4,000 for a family, and caps out-of-pocket expenditures at $5,000 for an individual and $10,000 for a family.
- The Connector groups plans into three categories, from least to most generous: bronze, silver, and gold. The actuarial value (percent of health costs insured for a typical individual) is 55% for bronze, 70%-80% for silver, and 85%-95% for gold.
- The Connector has applied "modified community rating" rules to the Commonwealth Choice program. Specifically, rates for the same product have to fall within a 2:1 band across ages and geography: for a given plan, the highest quoted premium can be at most twice the lowest quoted premium. In addition, no medical underwriting is allowed, and plans are guaranteed issue (you cannot be denied) and guaranteed renewable (your plan cannot be cancelled by the insurer).

Study examines consumer behavior in the Massachusetts exchange

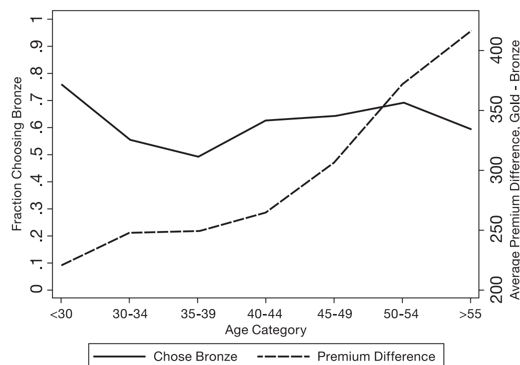
Ericson and Starc analyzed the choices consumers made in the unsubsidized exchange and identified the potential for strategic insurer behavior given these choices.

- The data include 24,196 enrollees ages 27-64 who signed up for individual coverage through the Commonwealth Choice program from July 2007 to December 2009. The analysis excluded enrollees 26 and under because they could choose a separate set of Young Adult Plans, which are less generous than the bronze plans.
- Ericson and Starc supplemented these data with detailed price quotes taken in November and December 2009, to capture the set of prices consumers actually faced. Consumers picked a plan from a set available to them at posted prices, which varied by age and zip code. This subset includes 1,059 enrollees.
- Using the price data, the investigators estimated a model of consumer choice that accounts for price, whether the plan was the cheapest available, and the age of the enrollee.

Most people choose lower-cost plans

The results indicate that consumers gravitate toward the cheapest alternative, and that some consumers are more sensitive to price than others.

- A majority of enrollees (60%) chose a bronze tier plan, the lowest level of coverage sufficient to satisfy the mandate. About 30% chose the silver tier, and just 10% chose the gold tier.
- The plans chosen by consumers in the exchange differ from the typical employer-sponsored insurance plan. The bronze plan is less generous that the typical employer plan. While bronze plans have an actuarial value of about 55%, typical employer-sponsored HMO and PPO plans have actuarial values of 80%-93%.
- About 20% of enrollees chose the cheapest plan available to them. The average premium paid was $420 per month.
- Sensitivity to price varies by age. As the graph below shows, the percentage of enrollees choosing bronze plans remains roughly constant across ages, while the marginal cost of choosing a more generous plan nearly doubles. This indicates that older consumers have a lower distaste for price, a higher preference for more generous coverage, or both.
- Results of the model of consumer choice indicate that the youngest individual (age 27) is twice as sensitive to price as a 64 year old. The effect of being the cheapest plan available remains significant at both ages, amounting to a price reduction of $26 a month for the 27 year old and $46 a month for a 64 year old.



AGE TRENDS IN CHOICE AND COST OF PLANS

Notes: Solid line shows the fraction of each age category choosing a bronze generosity plan. The dashed line shows the average cost of a gold plan minus the average cost of a bronze plan, averaged over all enrollees in each age category.

POLICY IMPLICATIONS

By analyzing consumer behavior in the Massachusetts exchange, this work provides early insight for policymakers who design health insurance exchanges, and for researchers who study such exchanges. The results indicate that the plans consumers choose in an exchange setting are markedly different from the demand in existing markets. In the Connector, a forerunner of the mandated state-wide exchanges, consumers gravitate toward the cheapest and least generous plans.

- Given consumer demand, how an exchange defines minimum creditable coverage and how it applies modified community rating will be critically important. State exchange designers should not only consider the nature of consumer demand, but also how insurers might price and market their products in response to consumer demand and regulation.
- Some of these policy issues have been addressed in the ACA, but many of the details remain to be worked out. Four tiers of plans will be offered, with

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POLICY IMPLICATIONS
Continued

differing actuarial values: bronze (60%), silver (70%) gold (80%) and platinum (90%). The plans will differ based on the cost sharing they require, not the benefits they offer.

- The ACA mandates modified community rating across plans in a way similar to Massachusetts, except that premiums can vary by age by a factor of three (meaning that a plan can charge an older enrollee three times the premium of a younger enrollee). Given the finding that older people are less price sensitive than younger people, insurers may have a large incentive to increase premiums to older consumers.
- The constitutionality of the federal individual mandate is now before the Supreme Court. Some commentators have questioned whether community rating rules are feasible without having everyone in the system. This decision will have a major impact on how and whether exchanges can deliver on the promise of facilitating coverage, choice, and competition in the health insurance marketplace.

This Issue Brief is based on the following articles: K.M. Marzilli Ericson and A. Starc. Heuristics and heterogeneity in Health Insurance Exchanges: evidence from the Massachusetts Connector. American Economic Association Review, upcoming May 2012; K.M. Marzilli Ericson and A. Starc. Age-based heterogeneity and price regulation on the Massachusetts Health Insurance Exchange. Jan 6, 2012 draft. See also M.B. Hackmann, J.T. Kolstad, and A.E. Kowalski. Health reform, health insurance, and selection: estimating selection into health insurance using the Massachusetts health reform. American Economic Association Review, upcoming May 2012; J.T. Kolstad, A.E. Kowalski. The impact of an individual health insurance mandate on hospital and preventive care: evidence from Massachusetts. NBER Working Paper 16012, May 2010.

Published by the Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104.
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Issue Brief

Published by the
Leonard Davis Institute
of Health Economics
University of Pennsylvania

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