Insight

The Unintended Consequences of Insurance Design Flexibility

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Seven years after passage of the Affordable Care Act (ACA), the individual health insurance market continues to be plagued by high prices, lack of competition, and limited choices of plans. One reason for the high prices is the extensive regulations placed on insurers regarding the types and amount of coverage that must be offered in all insurance policies. Such regulations include the mandatory coverage of the ACA's list of ten "essential health benefits", the ban on annual and lifetime caps for such benefits, the limitations on who may purchase a catastrophic plan, and the required minimum actuarial values of such plans. Understandably, covering more services and benefits as well as limiting patients' out-of-pocket expenditures results in higher premiums.

As policymakers work to improve the market, a natural reflex is to roll back some of these regulations that have directly increased costs. One such deceptively attractive idea is to have it both ways: simultaneously maintaining protections for those who wish to have more comprehensive coverage, but allow broad freedom to design policies for the remainder. While this might initially appear to have merit, understanding the implications undercuts the desirability of this policy.

One version of this idea is to allow insurers who offer at least one qualified health plan (QHP) – as defined by the ACA or its successor – to also offer non-compliant plans off the exchange. (An important detail, not pursued herein, is whether subsidies would be allowed off the exchange.) The motivation is that individuals would benefit from the increase in choice that would provide the option of purchasing a more expensive and comprehensive insurance plan on the exchange, or a less expensive and less comprehensive plan off the exchange.

This is where the best of intentions goes wrong. In practice, this would bifurcate the risk pool through adverse selection. Individuals who expected to need coverage for the services offered in a QHP would, presumably, enroll in a QHP (on the exchange). Those that did not expect to utilize those services would enroll in the cheaper plan (off the exchange). The services most likely to not be included in the non-compliant plan that must be covered by a QHP include maternity care, hospital care, mental health and substance abuse; i.e., expensive services. Insurers can do this same math, so they would rightly assume that claims costs for individuals in QHPs would be significantly higher than the costs for individuals in non-compliant, off-exchange plans. Premiums would likely appropriately reflect those differences and they would be significantly higher for QHPs.

Under current law, the ACA requires that premiums be set by treating the entire individual market, both on- and off-exchange, as a single risk pool. Unless this language is changed, the advantage sought by allowing some plans to meet less stringent regulations would likely be rendered moot. Premiums for such plans could not be lowered because insurers have to price all premiums for the same plans on and off-exchange as though the individuals purchasing them are the same.

Alternatively, if one modified the statute and treated the setting of premiums by pricing two separate risk pools (or if it was determined that these are in fact different plans and can be priced differently), premiums for QHPs would skyrocket. The exchange would essentially become a high-risk pool without the funding of a high-risk

pool. The relatively low expected average risk of everyone purchasing a non-compliant policy would no longer be able to offset the high-risk of those self-selecting into an exchange plan.

The moral is that flexibility is not a panacea for solving the problem of costly insurance in the individual market. Instead, complex problems require complex solutions. The current individual market faces several complex problems. But this seemingly simple “solution” will unfortunately not resolve those problems.