BUSINESSFORWARD

IMPLEMENTING THE AFFORDABLE CARE ACT:

THE VALUE OF EFFICIENT HEALTH CARE EXCHANGES

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TOPLINES

With the health insurance exchanges established by the Affordable Care Act set to open in less than three months, there is some uncertainty about how the newly established insurance markets will function. In this policy brief, we turn to a rich body of economic research that infers what will happen when the exchanges open, identifying and quantifying the consequences for businesses and individuals.

Key findings from the report include:

PARTICIPATION: Participation can create a virtuous cycle where lower prices reflect the inclusion of young and healthy individuals and this in turn encourages them to participate. Compared to a baseline of "market unraveling," premiums for individuals ages 25-30 fall more than one-third with full participation.

COMPETITION: The current market for health insurance is best characterized as an oligopoly; a liquid health insurance exchange can add competitive pressure that brings prices closer to cost for everyone. In the Massachusetts exchange, premiums fell more than 10 percent because of reduced insurer markups alone.

CONSUMER CHOICE: The insurance exchanges will, contingent upon insurer participation, generate greater choice. Currently, most Americans are offered one or two health plan choices through their employer. One study estimates that the median consumer would be willing to pay increased premiums of up to almost 30 percent to include their ideal plan in their set of choices.

LABOR MOBILITY: One important contributor to 'job lock' is the lack of a viable alternative to employer-sponsored health insurance, and the ability of insurers to discriminate based on pre-existing conditions. Eliminating these barriers could reduce 'job lock' on the order of 25 percent.

1. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. An important part of the law establishes Health Insurance Exchanges where individuals and small businesses can purchase health insurance. With these exchanges set to be activated on October 1, this policy brief seeks to identify and even quantify some of the benefits from the efficient operation of the exchanges. There are four main channels through which the health care exchanges will affect businesses and individuals.

First, many states and businesses are served by a few and sometimes even just one insurance company. A liquid health care exchange will provide competition to existing insurance companies and bring down premiums. Second, most Americans get health insurance from their employer. Their choices are limited by the plans their employer offers. An insurance exchange gives them an outside option and potentially allows them to pick a plan best suited to their needs. This additional freedom of choice alone will make consumers better off. Third, the fact that health insurance is tied to current employment might make someone reluctant to move jobs and risk their insurance. Also, an individual might choose to work for someone else and get insurance for themselves and their family rather than start a new business and risk having no insurance. A well-functioning heath insurance exchange for individual insurance severs the connection between employment and insurance and increases labor mobility and allows less constrained occupational choice. Fourth, nearly 50 million Americans are uninsured and face the risk of getting sick and not being able to pay for health care. An insurance exchange gives them access to health care, reducing the risk they face and increasing their welfare.

This policy brief will survey existing research that relates to these issues.

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2. THE BENEFITS OF COMPETITION

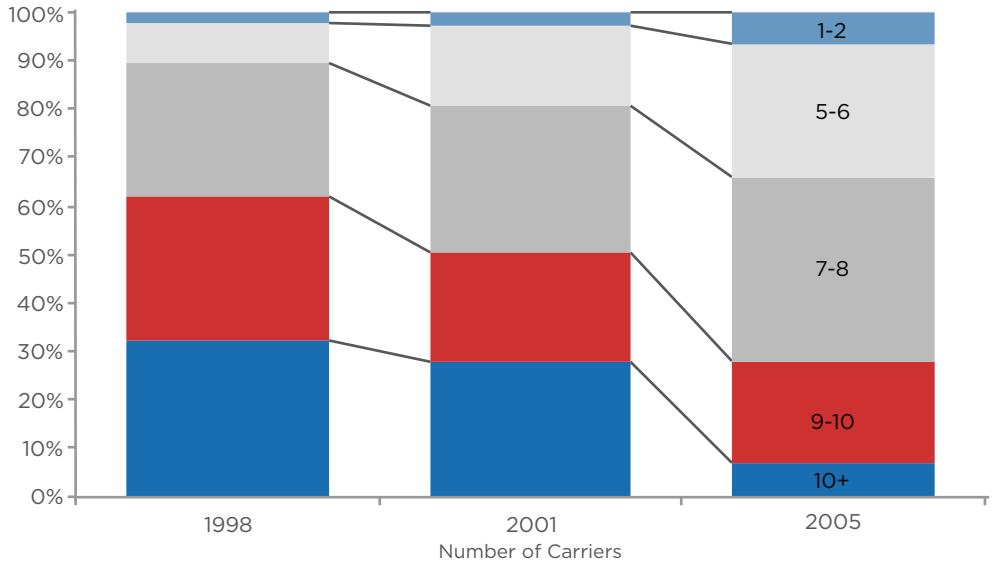
Businesses outsource many of their key functions and often procure their inputs via competitive tender to get as low a price as possible. The more competitive the bidding process, the lower the price. Health care is no exception. If the health care market is truly competitive, insurers who are hungry for business will undercut each other’s prices until they are close to the marginal cost of covering an additional person. But if the health insurance market is not competitive, a business purchasing insurance will be forced to pay higher prices. Also, health care costs will be higher than warranted by the fundamental costs of production.

If health insurance is not provided competitively, a liquid health insurance exchange can add competitive pressure that brings prices closer to cost. For small businesses, the exchange provides a much-needed additional source of supply (because they lack market power, small firms pay up to 18 percent more per worker than large firms for the same health care). The prices on the exchange can act as a bargaining chip with existing insurance providers or

even replace them completely. Beginning in 2017, state-run exchanges will have the option of allowing larger firms to participate.

Figure 1. Number of markets with no meaningful competition between insurers increasing.

Distribution of geographic markets by number of full health insurance carriers, 1998-2005



Source: Dafny (2010)

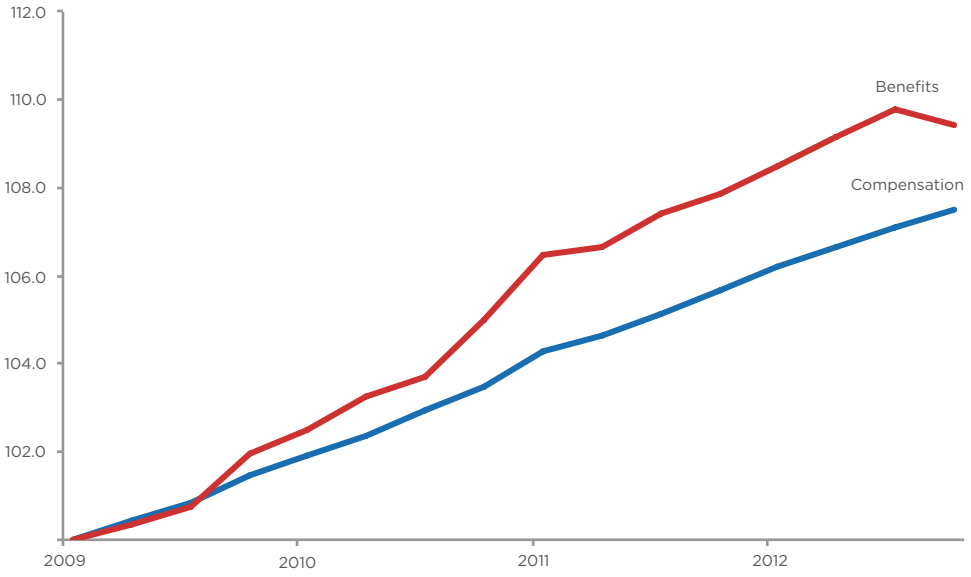
Dafny (2010) empirically evaluates the competitiveness of the health insurance market using an extremely comprehensive dataset that includes over 10 million individuals working for 776 employers in 139 geographic markets in the United States. The employers range from manufacturing and finance to consumer products. The median employer is large and operates in 47 geographic markets and insures 9,670 active employees.

If the health care market is competitive, businesses should not see the price of health insurance of a fixed quality and quantity change as a function of their own profitability. But Dafny (2010) finds that if a business makes more profits, it faces larger premium increases for the same health plans. The fewer the number of insurers, the greater their bargaining power in negotiations and the greater is the price increase. In fact, Dafny (2010) finds that premium increases are greatest in markets with six or fewer insurance providers. If higher premiums were a sign of higher benefits, then they would be going up everywhere independent of the number of insurance carriers. The fact that price increases are related to insurer concentration is further proof that the health care market is not competitive. In concentrated markets, if a company's profits increase by 10 percentage points, its insurance premiums increase by 1.2 percent. At the time of the study, 23 percent of employees worked in concentrated markets, up from

7 percent seven years earlier. Higher insurance costs affect employment by increasing the costs of compensation. And these higher costs are affecting almost a quarter of the U.S. workforce.

Figure 2. For employers, costs of benefits growing faster than overall compensation cost.

Employment cost index for compensation and benefits (indexed, 2009 Q2 = 100)



Source: Bureau of Labor Statistics

If health insurance is competitively provided, greater concentration should have little or no effect on premiums as prices will reflect costs and not market power. If the health insurance industry is best characterized as an oligopoly, greater concentration would allow insurers to exercise market power and raise premiums well above marginal cost without the fear of being undercut by competitors.

Identifying the relationship between concentration and premiums is hard because of reverse causality. For example, lower premiums might encourage insurees to trade up to more expensive high quality plans. If these are provided by smaller firms, premiums and concentration will be positively correlated but without any anti-competitive rationale. The key is to find some plausibly exogenous increase in concentration and study its impact on premiums.

Dafny, Duggan and Ramanarayanan (2012) study the 1999 merger of Aetna and Prudential Health Care. The reasons for this merger, such as the benefits of consolidation, are best thought of as exogenous to premiums. This deals with the reverse causality problem. Both of these firms were large and operated in many markets—but their share of these markets varied across geographic areas leading to dispersed postmerger concentration. The study uses the same data as in

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Dafny (2010) to study the impact of greater concentration on premiums. The authors find that greater concentration in local health insurance markets raised premiums by roughly 7 percent over eight years, all else equal. With private health insurance expenditures of $490 billion in the study's base year, 1998, this comes to about $34 billion per year, or about $200 per person extra cost to employer-provided health insurance coming from less competition, not from higher costs of health care provision.

Dafny, Duggan and Ramanarayanan (2012) also find that insurers not involved in the merger also raised prices as the merger reduced competition. Premiums remained high even after Aetna's market share fell again suggesting that the merger led to a new oligopolistic equilibrium with reduced price competition and higher margins.

In 2001, the American Medical Association found that half the areas it studied had highly concentrated health care provision. By 2008, this figure had gone up to 94 percent. During this period, the average, inflation-adjusted premium for employer-sponsored family coverage rose 48 percent. The Dafny et al. analysis implies that around 6 percent of this increase is accounted for by increased concentration.

These studies together convincingly show that the health insurance market is best characterized as an oligopoly where insurance carriers exercise market power. Heath insurance exchanges provide the potential to increase competition and bring premiums closer to the true costs of provision.

3. THE BENEFITS OF CONSUMER CHOICE

The overwhelming majority of non-elderly Americans purchase health insurance through their employer. These employers offer very few plans and sometimes only one. Consumers do not get much choice and left to their own devices, they might pick a plan that is different from the one their employer offers. The exchanges allow an individual to purchase their own insurance and, contingent upon insurer participation, generate greater choice. What is the benefit to consumers from having more choice?

Dafny, Ho and Varela (2013) give us some idea of what might be gained from giving consumers more choice. They use the data in Dafny (2010), including the premiums, plan design and market shares of different plans, to uncover consumer preferences for features of different plans. With this estimation in hand, they can determine what demand and prices would be if consumers had access to plans other than the ones their employer offers. They can also determine how much a consumer gains from purchasing a plan compared to some benchmark plan.

They find that a representative or median consumer would be willing to pay increased premiums of 13 percent to include the plan most people in the area prefer in their own employer's offerings. This underestimates the gains to choice because even if this plan is the most-preferred plan to the average consumer, it might not be the plan they themselves would choose.

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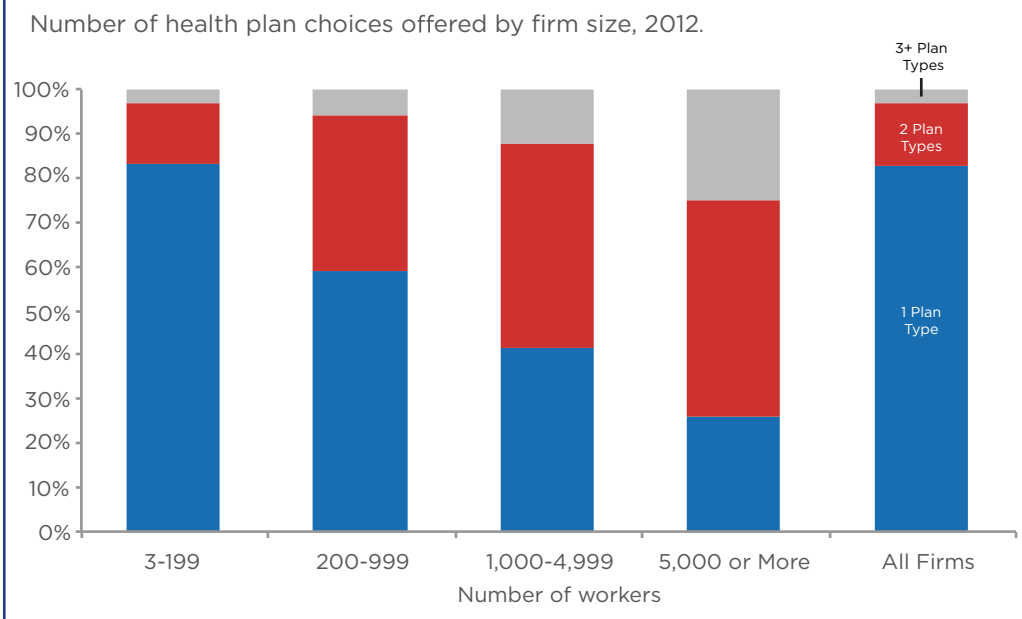
If, instead, individuals could choose their own ideal plan, they would be willing to pay 29 percent higher premiums to have this choice. In dollar terms, 13 percent higher premiums come to $310 for the representative individual and 29 percent comes to $688.

This analysis assumes that the plans enjoy the volume discounts in pricing enjoyed by large employers. But prices on individual exchanges might be higher because of greater administrative costs. Estimates of the extra administrative costs to individual plans range from 11 percent (the Lewin Group) to 23 percent (the Congressional Budget Office). These fall within the range of estimated gains from having more consumer choice. The more liquid and successful the exchanges the lower the administrative costs, because fixed costs will be spread out over a greater volume of trade. In fact, the significant utility gains from greater choice point to the importance of having liquid and efficient exchanges.

Figure 3. Most firms, especially small businesses, offer employees very few health plan choices.



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

4. LABOR MOBILITY, OCCUPATIONAL CHOICE AND HEALTH INSURANCE

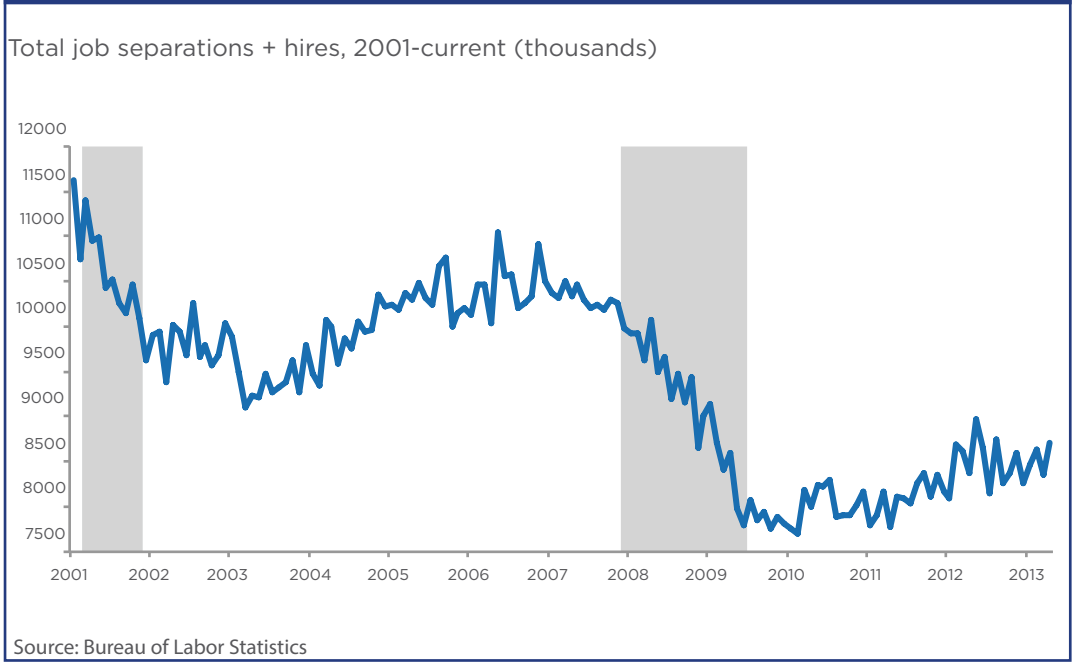
Labor market mobility is good for the economy. It creates the potential for matches that maximize economic value. During the recession, the number of

workers moving from job to job in a quarter ("job churn") dropped by more than 20 percent, and has remained low throughout the recovery. Lower job churn comes at a cost—Lazear and Spletzer (2012) estimate that the average job change produces a $1,000 productivity gain.

The fact that health insurance is mainly provided by employers distorts labor matches in a number of ways. First, consider an individual who is gainfully self-employed but uninsured. This individual is more likely to take a less ideal job because it carries health insurance. Second, an individual who currently has a job with health insurance may have the potential to start a successful business. But the loss of insurance acts as a deterrent to this risky move.

Other features of employer-provided health insurance also distort the labor market. First, pre-existing conditions may not be covered when someone switches jobs. So, even if a new job is a better fit for a business and potential new employee, someone may stay in the old job if they or their family have a pre-existing condition. Second, the new employer may offer different health plans to the old employer and someone's current doctor may not be included in the new plans. This again creates an incentive to stay in the old job.

Figure 4. Labor mobility fell sharply during the recession, has not recovered.



Source: Bureau of Labor Statistics

By providing a viable alternative to employer-sponsored health coverage, the health care exchanges can improve matches in the labor market. Also, the ACA requires coverage of pre-existing conditions, removing this potential distortion on labor mobility.

There is evidence that health insurance has been affecting labor mobility and occupational choice. For example, Madrian (1994) studies various properties of 'job lock.'

First, mobility should be higher for those with alternative sources of insurance, perhaps via a spouse or because they get Medicaid. Madrian finds that a representative 38 year old male is 25 percent less likely to change jobs if his current job carries health insurance but he has no other source of insurance. This insurance is not portable across jobs while coverage through a spouse is. In the latter scenario, decisions can be made in terms of economic value added alone and hence maximize efficiency. If insurance is not portable then the factors that deter movement such as the pre-existing restriction or changing health plan coverage are a binding constraint.

Second, Madrian (1994) finds that married men who are working in jobs without health insurance are twice as likely to change jobs if they have pregnant wives. Health insurance is much more valuable to someone expecting a child—so men seek new jobs which come with health insurance. Again, absent the health care issue, this is not necessarily the decision that maximizes value for the employer and employee or an entrepreneur with his own business.

Once the exchanges are up and running, reliance on employer-sponsored health insurance will no longer be a substantial barrier to job switching. An entrepreneur can now purchase family insurance on an exchange and not have to fold up his business because of an impending addition to the family. Since all health insurance contracts—on the exchange or otherwise—will now have to cover pre-existing conditions, this could reduce 'job lock' on the order of 25 percent.

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5. INSURANCE EXCHANGE OUTCOMES FOR THE CURRENTLY UNINSURED

The state health insurance exchanges mandated by the ACA are not up and running. Therefore, we have to rely on experience with an existing exchange, the Massachusetts Connector, which was set up in 2006 and on simulations and projections to assess possible outcomes in the exchanges.

Gruber (2011) reports on the Massachusetts experience. There was a large expansion of care and implementation was smooth. Importantly, premiums have fallen dramatically in the non-group market. While non-group premiums rose by 14 percent nationally (see America's Health Insurance Plans (2007, 2009)), they fell by 40 percent in Massachusetts. Also, the administrative costs of the Massachusetts Connector are funded by an insurance charge of only 3 percent. If this is representative of the costs on a national scale, then the large benefits to consumer choice we mentioned above can be realized at little extra cost.

A non-partisan and comprehensive projection of premiums in the exchanges has been conducted by CBO (2009). The CBO projects that premiums will drop 7–10 percent due to the comprehensive pool of health risks and a further 7–10 percent due to lower prices arising from enhanced competition and other factors. Thus, the total reduction is 14-20 percent, keeping the quality of benefits fixed.

The CBO also projects that individuals will buy policies with greater coverage and this will increase premiums by 27-30 percent. Hence, there will be an increase in premiums but this will be from purchase of higher quality insurance.

Handel, Hendel and Whinston (2012) (henceforth HHW) perform an interesting but as yet preliminary simulation of outcomes of health insurance exchanges. The main difficulty in such an exercise is in finding detailed data of individuals' risk preferences and likely health care outcomes to use in the modeling. But HHW have data from a firm that employs approximately 9,000 people per year and who themselves cover roughly the same number of dependents. Just under half the population is male. The mean age is 40 and the age distribution is uniform from 26 to 68. The data include the health insurance options available in each year, employee plan choices, and detailed, claim-level, employee and dependent medical expenditure and utilization information. Vitally, at some point, employees are forced to choose a health plan de novo from a new set of options. This allows HHW to identify risk preferences. Moreover, the richness of the data also allows HHW to use medical risk prediction software developed at Johns Hopkins Medical School to forecast projected medical risk for each individual. This is about as good a data set as one could reasonably hope for to simulate outcomes in a health insurance exchange.

The authors assume that insurers can offer only two plans, a "Bronze" plan that covers 60 percent of expenses and a "Platinum" plan that covers 90 percent of expenses—the ACA also allows trade of intermediate "Silver" and "Gold" plans. Given the data they have, the authors show that because insurers try to cream-skim and attract the lowest risk individuals, they offer good deals for the Bronze plans, making the Platinum plan unsustainable. It should be noted that the simulations are delicate and sometimes both plans are traded with the Bronze plan attracting 64 percent of consumers who are the lower tail of risk and the Platinum plan attracting the remainder. This is consistent with the Massachusetts experience where the Platinum plan does not get traded. Ericson and Starc (2012, Table 1) report that roughly 30 percent of individuals purchased catastrophic insurance, 40 percent purchased Bronze plans and the rest purchased Silver or Gold plans in the Massachusetts Connector in 2009.

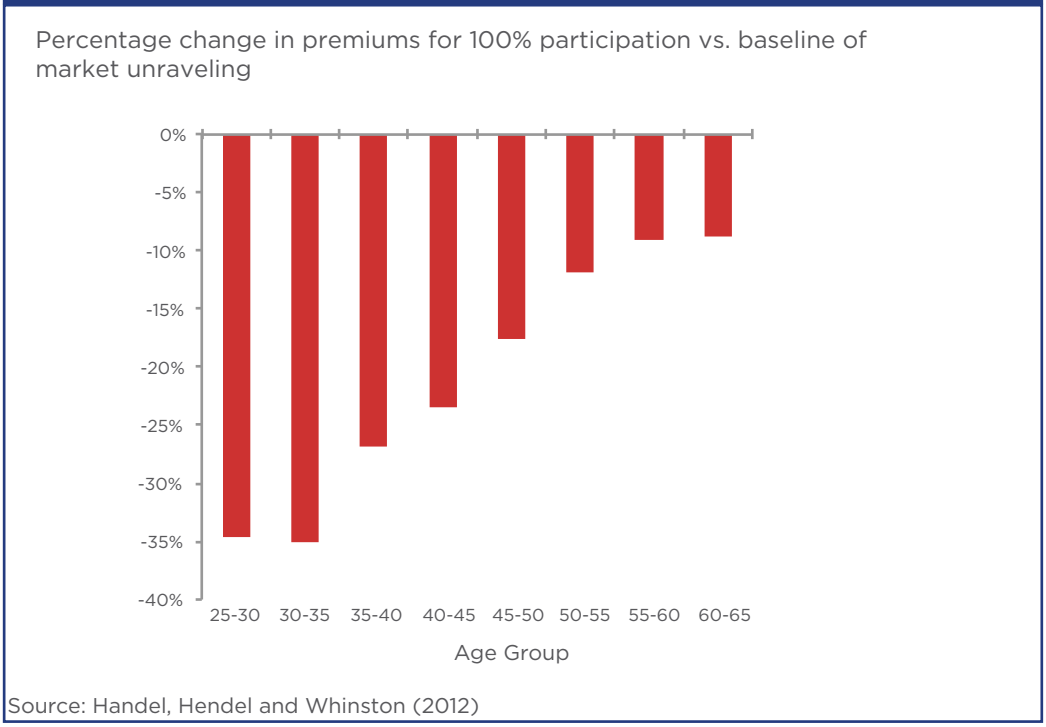
Hence, the HHW analysis is the worst-case scenario where only the Bronze plan gets traded. But even in this scenario, we can ask what the exchange market looks like and how much welfare it generates for individuals. After all, someone who is uninsured would be liable for the entire expenses and hence would suffer potentially large fluctuations in income. The Bronze plan covers 60 percent of their expenses and cushions them if they do get unlucky and get sick.

HHW find that the cost of the Bronze plan will be around $4,000. This is the average cost of insuring all individuals at 60 percent while satisfying the minimum quality requirements (e.g., the plans must cover pre-existing conditions and have no lifetime or annual limits). At this price, a full 80 percent of individuals see gains from coverage as opposed to remaining uninsured.

If the mandate is not enforced or the subsidies prove insufficient to persuade everyone to participate, the cost of the plan increases by 25 percent to $5,300. The importance of achieving full participation becomes clearer if we disaggregate the data further by age. The ACA permits age-based pricing because costs of providing insurance increase by age. With full participation, premiums in the Bronze plan are as low at $1,800 for individuals in the 25-30 age group. Premiums increase to $2,700 if the mandate is not enforced. There is a 50 percent increase in premiums caused by adverse selection in the 25-30 age group.

These figures identify the costs from mishandling the implementation of the health insurance exchanges. Increasing participation reduces costs for everyone, including those who decide to participate. A young person who balks at paying $2,700 may gladly join when the price is $1,800. Her participation and the participation of others like her reduces prices for everyone. This virtuous circle cannot flourish without encouraging full participation in the exchanges.

Figure 5: Virtuous cycle of increased participation has significant potential to bring down premiums.



Source: Handel, Hendel and Whinston (2012)

> **“Increasing participation reduces costs for everyone, including those who decide to participate.”**

The simulated price assumes the health exchanges are competitive so the price reflects the average cost of insuring the population. We noted above that even regions with six or more insurers can be quite uncompetitive. Hence, it is vital that the states and the federal government get the support they need to establish competition in the exchanges.

A recent study by Hackman, Kolstad and Kowalski (2013) (henceforth HKK) allows us to get an idea of the benefits of reducing adverse selection and increasing competition. HKK decompose the effect of these two factors on premiums and welfare in the market for individual insurance in Massachusetts. The Massachusetts Connector increases participation and hence reduces adverse selection as more low risk individuals obtain insurance. It also increases competition as individuals have more choice among plans. Both effects should reduce premiums and increase welfare. HKK have data on premiums post- and pre-reform. They also have data on claims expenditures. Therefore, they can identify insurance company mark-ups and costs of insurance separately. They find premiums fall by 20 percent (about $1,140) because of the Massachusetts reform. Of this, about $440 comes from less adverse selection and $700 from reduced markups.

Hence, there is a remarkable congruity of findings across independent researchers across different studies using different data and different methodologies to study adverse selection and competition. The health care market is not fully competitive and exchanges can have considerable impact in reducing markups. The health care market is also subject to adverse selection and increased participation reduces premiums and increases welfare for everyone. In fact, HKK find an annual welfare gain per person per year in Massachusetts of 8.4 percent of medical expenditures paid by insurers.

Moreover, there are a number of ways the price could be lower or welfare higher. For those below 400 percent of the poverty level, there are subsidies. For those under 30, there is the option of just getting catastrophic coverage. The Silver and Gold plans offer greater coverage and those markets may be liquid. These factors can only increase the gains from getting insurance.

“The health care market is not fully competitive and exchanges can have considerable impact in reducing mark-ups.”

6. CONCLUSION AND SUMMARY

The market for health insurance in the U.S. is extraordinarily inefficient. Insurers, particularly in concentrated markets, exercise market power and collect considerable rents. Without a robust individual market for insurance, there is little credible alternative to purchasing coverage without an employer’s sponsorship—creating a powerful disincentive to job switching, and limiting the potential benefits of choice in picking a health plan. And almost 50 million Americans go without any health insurance coverage, exposing them to significant health care risk.

The stakes for getting the implementation of state-run health care exchanges right are high. Forcing increased competition between insurers could help break an oligopolistic equilibrium in which businesses see their premiums rise 1.2 percent for every 10 percentage point increase in their own profitability. Expanding the set of coverage choices for consumers could result in welfare gains of up to almost $700 for individuals who are able to choose their ideal health plan. Weakening the connection between employment and health insurance by offering viable alternative plans in the exchanges could reduce 'job lock,' which has soared in the recession and subsequent recovery, by one-quarter, and create better matches in the labor market. And across studies, independent researchers have found that health insurance exchanges make the entire population better off by increasing competition and reducing adverse selection.

There are also other benefits to the expansion of health care. Currently, emergency room visits by uninsured Americans are covered by the insured. By encouraging uninsured Americans to pay for their own health care, the health insurance exchanges make even those who do not use them better off.

References

America's Health Insurance Plans, 2007. "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability and Benefits." America's Health Insurance Plans, Washington, DC, http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

America's Health Insurance Plans, 2009. "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits." America's Health Insurance Plans, Washington, DC, http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

Congressional Budget Office, 2009. "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." Letter to the Honorable Evan Bayh (November 30). Congressional Budget Office, Washington, DC, http://www.cbo.gov/doc.cfm?index=10781.

Leemore Dafny, 2010, "Are Health Insurance Markets Competitive?," American Economic Review, 100(4): 1399-1431.

Leemore Dafny, Katherine Ho and Mauricio Varela, 2013, "Let them Have Choice: Gains from Shifting away from Employer-Sponsored Health Insurance and Toward an Individual Exchange," American Economic Journal: Economic Policy, forthcoming.

Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan, 2012, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," American Economic Review, 102(2):1161-1185.

Keith M. Marzilli Ericson and Amanda Starc (2012), "Pricing Regulation and Imperfect Competition on the Massachusetts Health Insurance Exchange," mimeo, Wharton

Jonathan Gruber, 2011, "The Impacts of the Affordable Care Act: How Reasonable Are The Projections?" NBER Working Paper 17168, http://www.nber.org/papers/w17168

Martin B. Hackmann, Jonathan T. Kolstad and Amanda E. Kowalski, 2013, "Adverse Selection And An Individual Mandate: When Theory Meets Practice," NBER Working Paper 19149, http://www.nber.org/papers/w19149

Ben Handel, Igal Hendel, and Michael D. Whinston, 2012, "Equilibria in Health Exchanges: Adverse Selection vs. Reclassification Risk," mimeo, Northwestern University.

"The Impact of House Health Reform Legislation on Coverage and Provider Incomes," The Lewin Group Testimony before the Energy and Commerce Committee, U.S. House of Representatives, June 25, 2009. Downloaded 9/23/2009 from http://www.lewin.com/content/publications/June25TestimonyUpdate.pdf.

Edward P. Lazear and James R. Spletzer, 2012, "Hiring, Churn and the Business Cycle," NBER Working Paper 17910, http://www.nber.org/papers/w17910

Brigitte C. Madrian, 1994, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?," Quarterly Journal of Economics, Vol. 109, No. 1, pp. 27-54

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