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Research Report

A Two-Step Procedure to Estimate Participation and Premiums in Multistate Health Plans

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RAND Health

Sponsored by the U.S. Department of Health and Human Services

The research described in this report was sponsored by the U.S. Department of Health and Human Services and was conducted within RAND Health, a division of the RAND Corporation.

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Published 2013 by the RAND Corporation
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Summary

Section 1334 of the Affordable Care Act (ACA) directs the Office of Personnel Management (OPM) to enter into contracts with health insurance issuers to establish at least two multistate plans (MSPs) in each exchange in each state. Such plans must be offered in all 50 states and the District of Columbia by the fourth year of issuance. These plans, therefore, may be particularly attractive to individuals interested in purchasing insurance from issuers having a presence in multiple states. Some potential populations of interest are out-of-state students; interstate migrants; out-of-state workers; and temporary migrants, such as "snowbirds" and "sunbirds." These plans may also be attractive to individuals interested in increased access to out-of-state provider networks.

One goal of this study was to estimate the size and the characteristics of the populations that will be likely to enroll in the MSPs that will be offered through the state exchanges. Accordingly, we estimated the size, demographic characteristics (age, gender, and race), income, employment status, self-reported health, insurance status, and total medical expenditures[1] of out-of-state students, interstate migrants, and out-of-state workers at the national level. This work comprised Phase 1 of the project.

Another goal was to model participation in MSPs using the Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model, as well as to project how many participants will be eligible to receive the premium subsidies and cost-sharing reductions that the ACA makes available to low- and moderate-income exchange enrollees. This work—Phase 2 of the project—required important policy clarifications. A recently published Notice of Proposed Rulemaking (NPRM) by OPM clarified that it is OPM's intention that MSP premiums be set on a state-by-state basis.[2] Therefore, MSPs will not be allowed to pool risks across states. Moreover, the same NPRM indicates that OPM intends to adopt the state's structure of having either merged or split regulated nongroup and small-group markets for the purposes of risk pooling. According to the ACA, the decision to merge or split them will be made by each state.

Modeling MSP participation also entailed addressing two challenges.

First, the ACA and the subsequent NPRM by OPM blur the distinction between an MSP and another exchange plan for modeling purposes. They will both be subject to the same federal regulations—including guaranteed issue, rate banding, risk adjustment, the offering of metal-tier plans, and others—and to the same state regulations in the state in which they will both be sold, as long as the state regulations do not contradict the ACA. Moreover, concerning medical loss

[1] Throughout this report, "total medical expenditures" refers to those that include enrollee out-of-pocket costs.

[2] The NPRM will be eventually replaced by a Final Ruling (FR) in response to comments or other considerations. An FR was not available as of the time of this writing (February 2013).

ratios (MLRs), OPM expects that issuers will attain the MLR required under Section 2718 of the Public Health Service Act and regulations promulgated by the Department of Health and Human Services (DHHS). However, OPM reserves the authority to impose a different, MSP-specific MLR threshold in the interest of MSP enrollees. Therefore, there is not a clear distinction between MSPs and other exchange plans concerning MLRs. The main reason for the blurring of the line between MSPs and other health plans offered on the exchanges is OPM's desire to provide the level playing field of the ACA and to provide more flexibility to the states.

Second, our utility maximization algorithms make use of terms and factors derived from economic theory and empirical studies. Preferences for MSPs over other exchange plans may be driven by factors that are not readily quantifiable, that are not economic, or that cannot be derived from empirical observations.

For these reasons we decided to split the problem of projecting MSP participation and premiums into two steps. In the first step, the full COMPARE microsimulation model is used to project the choices that individuals and firms will make after the enactment of the ACA. We do not distinguish between enrollment in an MSP and enrollment in another exchange plan.[3] We performed this step both at the national level and for three states selected by the sponsors: Maryland, California, and Texas. For the second step, we did not come up with estimates of MSP participation. Instead, we provided a tool written in the R language to estimate MSP premiums. The main assumption in this step is that MSP participants will be a subset of those individuals and small firms' employees and dependents who, according to the COMPARE microsimulation results of the first step, decided to self-select into the exchanges.[4] The user of that tool separates those groups who in his or her opinion would prefer an MSP over another exchange plan, and the tool calculates the corresponding MSP premiums, taking into account rate banding, risk adjustment, reinsurance, and 9010 tax.[5]

An important point to consider for the final balance between participation in an MSP versus participation in another exchange plan pertains to the distinction between initial and final enrollments. Initial enrollment in an MSP may be driven by the interests of the population groups identified in this report, plus the preferences of other groups not yet identified. However, according to the law, anyone eligible for an exchange is also eligible for an MSP. Therefore, final enrollment will be most likely dictated by plan benefits and realized premiums. Regulations up to this date seem to blur the distinction between MSPs and other exchange plans, and, if this

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[3] Moreover, the current version of the COMPARE microsimulation model cannot distinguish between participation in the exchanges and participation in the regulated market outside the exchanges. This point will be explained in Chapter Two of this report.

[4] See footnote 3 above.

[5] Section 9010 of the ACA imposes a fee on private insurance enrollees. The fee is $11.3 billion in 2016 and grows in subsequent years. Nearly everyone who is covered under private insurance will pay a fraction of this amount as part of his or her premium. Section 1341 of the ACA establishes transitional reinsurance for the nongroup market. In 2016, all private insurance plans will pay a fee that will total $5 billion, of which $4 billion will be distributed to nongroup plans that are disproportionately affected by high-cost individuals. Reinsurance stops after 2016.

trend continues, the final balance of enrollment will be largely dictated by realized premiums. If the initial MSP enrollees have higher total medical expenditures than those on other exchange plans, they will drive MSP premiums upward, which may lead to adverse selection in the MSP. If the initial MSP enrollees have lower total medical expenditures, then the other exchange plans will potentially face adverse selection.[6] This strong dependence of the final balance of enrollment on the initial enrollee population is due to the current lack of differentiation between MSPs and other exchange plans. Final regulations still to be issued by OPM and DHHS may introduce differences and thus could affect the final outcome.

[6] In Chapter Four, we compare the total medical expenditures of the groups likely to be more interested in MSPs with the national average.