

July 2018

# Stabilizing and strengthening the individual health insurance market:

## A view from ten states

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This report is available online at: [www.brookings.edu/research/stabilizing-and-strengthening-the-individual-health-insurance-market](https://www.brookings.edu/research/stabilizing-and-strengthening-the-individual-health-insurance-market)

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## **EDITOR'S NOTE**

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Center for Health Policy at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings

## **AUTHOR'S NOTE**

The author received support for this research from the Robert Wood Johnson Foundation (grant #75030). The views expressed here do not necessarily reflect the views of the Foundation.

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## Introduction

Market stabilization is currently the most critical regulatory challenge that public policy officials face under the private insurance component of the Affordable Care Act (ACA). Prior to the ACA, states had largely failed in their efforts to improve and reform their individual (non-group) health insurance markets.<sup>1</sup> Reform is inherently challenging due to the dynamics of the individual market, which focus heavily on risk selection and segmentation rather than pooling risk and broadening coverage.<sup>2</sup>

The ACA adopted a set of reforms aimed at correcting these market failings, which worked well for the first two years (2014 and 2015), but market conditions began to worsen substantially in 2016.<sup>3</sup> Insurers exited the individual market, both on and off the subsidized exchanges, leaving many areas with only a single insurer, and threatening to leave some areas (mostly rural) with no insurer on the exchange.<sup>4</sup> Also, most insurers suffered significant losses in the individual market the first three years under the ACA, leading to very substantial increases in premiums a couple of years in a row.<sup>5</sup>

For a time, it appeared that rate increases in 2016 and 2017 would be sufficient to stabilize the market by returning insurers to profitability, which would bring future increases in line with normal medical cost trends. However, Congress's decision to repeal the individual mandate and the Trump Administration's decision to halt "cost-sharing reduction" payments to insurers, along with other measures that were seen as destabilizing, created substantial new uncertainty for market conditions in 2018.

Moreover, this uncertainty continues into 2019, owing both to lack of clarity on the actual effects of last year's statutory and regulatory changes, and to pending regulatory changes that would expand the availability of "non-compliant" plans sold outside of the ACA-regulated market. These uncertainties further complicate insurers' decisions about whether to remain in the individual market and how much to increase premiums. Although the market has not entered a "death spiral," some observers see that as a real possibility, at least for the unsubsidized part of the market in some states.<sup>6</sup>

Various efforts in Congress have failed to reform or replace the ACA, which leaves state lawmakers scrambling to identify feasible and viable approaches to stabilize and strengthen the individual market. These strategies seek to encourage more insurers to enter and remain in the market, to improve the risk pool by reducing adverse selection, and to create market conditions that moderate premium increases. States are also considering what measures they might want to take to more directly counteract federal regulatory changes that are viewed as potentially destabilizing.<sup>7</sup> For instance, states might adopt a

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<sup>1</sup> See Alan Monheit & Joel Cantor, *State Health Insurance Market Reform* (Routledge Press, 2004).

<sup>2</sup> See Mark A. Hall, *Reforming Private Health Insurance* (AEI Press, 1995); Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (AEI Press, 1999).

<sup>3</sup> Mark A. Hall & Michael J. McCue, *How Has the Affordable Care Act Affected Health Insurers' Financial Performance?* (Commonwealth Fund, July 2016), <http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/the-affordable-care-act-and-health-insurers-financial-performance>.

<sup>4</sup> See note 35.

<sup>5</sup> Cynthia Cox, Larry Levitt, and Gary Claxton, *Insurer Financial Performance in the Early Years of the Affordable Care Act* (Kaiser Family Foundation, Apr 2017), <http://www.kff.org/health-reform/issue-brief/insurer-financial-performance-in-the-early-years-of-the-affordable-care-act>.

<sup>6</sup> E.g., CMS, Press Release, July 2, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html>; Anna Maria Barry-Jester, *The Obamacare Marketplaces Aren't In A Death Spiral: But They are in Real Trouble* (FiveThirtyEight, May 2017), <https://fivethirtyeight.com/features/the-obamacare-marketplaces-arent-in-a-death-spiral/>; Robert Laszewski, *Is Part of the Health-Insurance Market Entering a Death Spiral?* (National Review Aug. 2017), <https://www.nationalreview.com/2017/08/obamacare-death-spiral-exchange-enrollment-down-29-percent/>. See generally Seth Chandler, *ACA Death Spiral*, <http://acadeathspiral.org>.

<sup>7</sup> See note 67.

replacement for the ACA's individual mandate, or they might decide to restrict plans that can be sold outside of the ACA-compliant market.

Relevant experts widely agree that some stabilization measures are needed to improve the functioning of insurance market reforms.<sup>8</sup> Medicare's private market programs (Medicare Advantage and Part D prescription drug coverage) contain several *permanent* market stabilization features,<sup>9</sup> but only one of the three mechanisms built into the ACA is ongoing (risk adjustment); the other two have either expired (reinsurance) or were never fully implemented (risk corridors). Section 1332 of the ACA allows states to seek "innovation waivers" that provide federal financial support for alternate approaches to the ACA's central coverage provisions. Recent regulatory guidance explicitly invites states to use the section 1332 waiver process as a way to obtain federal support for innovative market stabilization strategies such as reinsurance and risk pooling.<sup>10</sup> These recent developments give states much more opportunity than they previously had to design tailored approaches to market stabilization.

### Approach and Methodology

This study is based on both an extensive documentary research at a national level and a series of in-depth case studies in 10 states, using field researchers from the *ACA Implementation Research Network* developed by the Rockefeller Institute of Government and co-sponsored by the Brookings Institution.<sup>11</sup> These 10 states, shown in Table 1, were selected to represent the following range of market and regulatory conditions:

- 1) have established their own reinsurance program (AK, MN)
- 2) are/were actively considering a reinsurance program (CO, ME)
- 3) faced the prospect of, but avoided, having one or more "bare" counties in their ACA exchange (AZ, IA, OH, NV)
- 4) have state-based exchanges and have expanded Medicaid (CO, MN, NV)
- 5) default to the federal exchange and have not (yet) expanded Medicaid (FL, ME, TX)
- 6) default to the federal exchange and have expanded Medicaid (AK, AZ, IA, OH)

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<sup>8</sup> See note 162.

<sup>9</sup> Sabrina Corlette & Jack Hoadley, *Strategies to Stabilize the Affordable Care Act Marketplaces: Lessons from Medicare* (RWJF, 2016), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2016/rwjf430816](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf430816); Timothy S. Jost, *Shoring Up the Health Insurance Marketplaces: Learning from Medicare's Prescription Drug Program*, April 7, 2017, <http://www.commonwealthfund.org/publications/blog/2017/apr/shoring-up-the-health-insurance-marketplaces>.

<sup>10</sup> Center for Consumer Information & Insurance Oversight, *Section 1332: State Innovation Waivers*, [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_state\\_Innovation\\_Waivers-.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html); Timothy Jost, *CMS Checklist for State 1332 Waivers Focuses On High-Risk Pools, Reinsurance* (May 2017), <http://healthaffairs.org/blog/2017/05/12/cms-checklist-for-state-1332-waivers-focuses-on-high-risk-pools-reinsurance/>.

<sup>11</sup> <http://rockinst.org/issue-areas/aca/> The following are the principal field researchers in the ten study states: William Riley and Katie Pine (AZ), Edmond Toy (CO), Patricia Schriefer (FL), Brad Wright (IA), Andy Coburn and Erica Ziller (ME), Elizabeth Lukanen and Emily Zylla (MN and AK), Leif Haase (NV), Amy Rohling McGee (OH), Tiffany Radcliff and Michael Morrissey (TX).

**Table 1: Key Characteristics of Study States**

	<b>Exchange Type</b>	<b>Medicaid Expansion</b>	<b>Average Gold Premium 2018</b>
<b>National</b>			\$518
<b>Alaska</b>	Federal	Yes	\$778
<b>Arizona</b>	Federal	Yes	\$627
<b>Colorado</b>	State	Yes	\$501
<b>Florida</b>	Federal	No	\$489
<b>Iowa</b>	Federal	Yes	\$787
<b>Maine</b>	Federal	Not yet	\$636
<b>Minnesota</b>	State	Yes	\$458
<b>Nevada</b>	Hybrid	Yes	\$516
<b>Ohio</b>	Federal	Yes	\$420
<b>Texas</b>	Federal	No	\$435

Source: Kaiser Family Foundation

Each field researcher addressed the following questions (abbreviated), developed after an initial literature review and through consultation with the project's advisors<sup>12</sup>:

- How stable/unstable is the individual market, and what threats to stability (if any) exist? To what extent do instability problems/concerns vary among local markets?
- What has driven price increases and insurer market participation the last couple of years?
- What effect is uncertainty over the ACA's future and over current administrative policy having on market stability?
- Does elimination of the "individual mandate" penalty affect market stability?
- How did regulators and insurers deal with ceasing payments for cost-sharing reductions? What effect did this have on market rates and enrollment?
- How helpful is reinsurance likely to be in improving market conditions?
- What are the expected impacts of proposed federal rules that would make short-term plans, or other non-ACA-compliant plans, more available?
- Are there other measures the federal government has taken, or is considering, that could improve or worsen market stability?
- Are there other measures that state officials are, or should be, considering to improve market stability?

In each state, 7-12 interviews were conducted with health insurers, regulators, insurance agents and navigators, health policy analysts, and consumer advocates, for a total of 90 interview subjects. Field researchers also collected relevant documentary information. This report is based on a synthesis of the field research, along with extensive information from national literature.

Inherent in any study of this sort is a risk of incorrect or biased information from those who are interviewed. Thus, this type of qualitative research is most reliable for the questions that are about verifiable facts, but less so when respondents are asked to use personal judgment or allowed to speculate (as many of our questions do). Therefore, information from interviews was triangulated with documented information whenever possible. Even when informants' views could not be verified, how they perceive market conditions remains relevant to understanding the behavior of market participants. But, caution should be exercised in assuming that respondents accurately perceive all of the market conditions and dynamics on which they were asked to comment.

<sup>12</sup> In addition to the field researchers in note 11, these advisers were Dick Nathan and Brookings colleagues Alice Rivlin, Paul Ginsburg, Matt Fiedler, Loren Adler, Caitlin Brandt, and Jason Levitis. Also, Andrés de Loera-Brust provided editorial help.

## Executive Summary

This study informs state and federal policy officials about the stability of the individual market, by examining causes of instability and identifying measures that might improve the individual market. The study is based on 90 in-depth interviews with market participants, regulators and observers in 10 states, coupled with extensive data and literature at both a state and national level. The major findings and conclusions are:

- Opinions about market stability vary widely across states and stakeholders, depending on varying perspectives, expectations, and market and political conditions.
  - Many observers and participants believe that stabilizing measures are urgently needed.
  - But, a good number of observers and participants believe the individual market will stabilize under the ACA's current structure if lawmakers and regulators simply avoid destabilizing actions.
  - There is widespread agreement that policy changes could improve the individual market.
- Enrollment has remained remarkably strong in the ACA's subsidized exchanges, despite sharp cuts to the open enrollment period and to federal funds for marketing and navigation.
  - Continued strong enrollment was attributed to people's strong desire for health insurance, coupled with the ACA's subsidy structure that buffers most exchange enrollees from price increases. Also, public controversy over the future of the ACA was seen as motivating eligible people to enroll.
  - Enrollment by people not receiving subsidies has dropped sharply, however. The absence of subsidies means that these people bear the full brunt of substantial premium increases.
- State vs. Federal Exchanges. States that operate their own exchanges have had somewhat stronger enrollment (both on and off the exchanges), and lower premiums, than states using the federal exchange. This appears to be due to several factors, including: state-based exchanges invest more in marketing and outreach; and these states are more proactive in supporting the ACA's regulatory structure.
- Insurer Participation. Despite substantial declines in insurers participating in the individual market, states were able to avoid any gaps in covered areas, and "bare counties" are not likely to emerge. Instead, some insurers that previously left or stayed out of markets now appear to be (re)entering.
  - A core of insurers remain committed to this market because enrollment remains substantial, and most insurers have been able to increase prices enough to become profitable.
- Premium rates have increased sharply over the past 2-3 years. Initially, this due to normal actuarial factors: insurers had underpriced relative to the actual claims costs that ACA enrollees generated.
  - Political Factors. More recently, a substantial portion of rate increases for 2018 were due to political and regulatory factors that arose in 2017. Efforts to repeal the ACA and changes to its regulatory enforcement created a great deal of uncertainty for insurers about emerging and future market conditions.
    - This uncertainty caused some insurers to leave or stay out of the market. For those that remained, political uncertainty caused them to increase rates a good deal more than required by general trends in medical costs.
  - Future Increases. Because most insurers have become profitable in the individual market, future rate increases are likely to be closer to general medical cost trends (which are in the

- single digits). But this moderation may not hold if additional adverse regulatory or policy changes are made, and some such changes have been recently announced.
- Cost-Sharing Reduction (CSR) Payments. Insurers were able to cope with the Trump administration's halt to CSR payments by increasing their rates for 2018. In most states, insurers loaded this additional cost factor entirely on their Silver plans sold through the exchanges.
    - The "silver loading" strategy allowed non-exchange enrollees to avoid paying the costs for this policy change. Also, this strategy increased the premium subsidies that most exchange-based enrollees received, which made some options even more affordable for them.
  - Individual Mandate. Most rigorous analytic studies conclude that repeal of the individual mandate penalty will adversely affect premiums and enrollment. However, the dominant view in study states and nationally is that this adverse effect will be less than many people originally thought. More subdued effect is thought to flow from several factors, including the weakness of the mandate penalty to begin with, and the strong motivator to continue enrolling in well-subsidized coverage.
    - Even if the mandate is not essential, many subjects viewed it as helpful to market stability. Thus, there is some interest in replacing the federal mandate with alternative measures.
  - Reinsurance. Many subjects viewed reinsurance as potentially helpful to market conditions, but only modestly so because funding levels typically proposed produce just a one-time lessening of rate increases in the range of 10-20 percent.
    - A barrier to implementing reinsurance is the need to provide additional state funding in order to obtain federal approval under section 1332.
    - Expanding Subsidies. Some subjects thought that a better use of additional funding would be to expand the range of people who are eligible for premium subsidies.
  - Non-complying Coverage. Concerns were expressed about coverage options that do not comply with ACA regulations, such as sharing ministries, association health plans, and short-term plans. By drawing healthier people out of the community-rated market, many subjects thought these options would increase prices in the ACA market, making coverage even less affordable for unsubsidized people with health conditions.
    - Potential Upsides. However, several credible analyses conclude that these less expensive coverage options would attract a sizeable number of healthy people, including many who otherwise would be uninsured. Some thought this outweighed harms to the ACA-compliant market; thus, there was some support for allowing separate markets (ACA and non-ACA) to develop, especially in states where unsubsidized prices are already particularly high.
  - Other federal measures, such as tightening up special enrollment, more flexibility in covered benefits, and lower medical loss ratios, were not seen as having a notable effect on market stability.
  - Measures that states might consider (in addition to those noted above) include: Medicaid buy-in as a "public option"; assessing non-complying plans to fund expanded ACA subsidies; investing more in marketing and outreach; "auto-enrollment" in "zero premium" Bronze plans; and allowing insurers to make mid-year rate corrections to account for major new regulatory changes.



## I. General Market Stability

In formulating the research focus for this project, stability was conceptualized as consisting of three aspects: (a) insurers remaining in the market, (b) premiums not increasing greatly more than those in the large group sector, and (c) no steep or sustained declines in enrollment. However, in asking subjects about market stability, we allowed them to articulate their own concepts and framing for what constitutes stability. Doing so, we heard a wide range of views about the market's current condition, both among and within states.

In Ohio, for instance, we heard views ranging from “very unstable” to “not stable” to “somewhat unstable” to “somewhat stable,” to “relatively stable” compared to other states. Concerns were especially pronounced in Iowa, where the market was variously called “dire,” “in chaos,” “chaotic,” “in crisis,” “a horror story,” “collapsed,” “disastrous,” “annihilated,” and “arguably in the worst shape in the country.”

Two Minnesota subjects questioned whether the ACA's individual market “ever has been or will be inherently stable,” because the ACA's market regulations create a somewhat “artificial” market that mixes good with bad risks,<sup>13</sup> creating “inherent instability.” “So, let's not presume we can get to stability with the right set of policies.” And, an Iowa analyst thought that a confluence of factors had made its market “doomed from the start.”

Elsewhere, we heard somewhat more basis for, if not optimism, at least not despair. For instance, Colorado sources noted that insurer participation has been fairly stable and some thought that rates are probably starting to stabilize. In Minnesota, a recent health department report saw “some cause for optimism, but also . . . continuing concerns” about market stability.<sup>14</sup> And, in Texas, a number of informants thought that the exchange market “is settling down.” “It used to be stressful, but now we're used to it. . . . It's steady. . . . The risk pool [became] expensive, but it's work[ing] okay.”

More favorable views were also heard in Maine, which, prior to the ACA, had similar guaranteed issue and community rating rules, but no subsidies or individual mandate. Under the ACA, Maine's individual market almost tripled in size, so subjects there commented that the market is more stable now than it was prior to the ACA, when it was heading toward a death spiral. Also noting improvement were subjects in Alaska, where the market was seen as “pretty close to disaster several years ago” with an “impending death spiral” that put it on the “verge of implosion,” but the state's reinsurance program (discussed below) has improved the market. Improved market conditions also were noted in Arizona, which faced the prospect of bare counties and had the largest premium increases in the country for 2017, but had no change in insurer participation, and essentially level premiums, for 2018, due to measures taken in 2016 (also discussed below). And, conditions were seen as much improved in Minnesota, where, prior to its new reinsurance program, various sources said the market had been “in turmoil,” “deeply troubled,” and “in shambles.”

However, these and other more favorable comments were heard only about the *subsidized* portion of the market.<sup>15</sup> Regarding those whose income is too high to receive substantial ACA subsidies, subjects across all states uniformly expressed concern, for reasons discussed more below. For instance, in Maine, which otherwise appears relatively stable, sources thought the market was “particularly fragile” outside the exchange, such that, some were concerned that the unsubsidized part of the market would

<sup>13</sup> This was said in contrast with the state's pre-ACA market that relied on a relatively well-funded high-risk pool to cover sicker people outside the normal market.

<sup>14</sup> Minnesota Dept. of Health, Evaluating the Stability of Minnesota's Individual Insurance Market (Jan. 2018), <http://www.health.state.mn.us/divs/hpsc/hep/individualmarket.pdf>

<sup>15</sup> Here and elsewhere, the report, and interview subjects sometimes conflate subsidized with on-exchange enrollees, and unsubsidized with off exchange enrollees, despite the fact that some unsubsidized people purchase through the exchange. Nevertheless, as a general approximation, equating exchange-based with subsidized enrollment is a useful shorthand because over 85 percent of exchange enrollees receive a subsidy, whereas no subsidies are available off the exchanges.

“go the way of” the state’s individual market prior to the ACA, which had become a virtual high-risk pool but without any subsidies.

Even for the subsidized exchange, some sources thought that the market is “on really thin ice” (Arizona). As a Maine observer put it, that portion of the market may be somewhat stable now, but “it’s not stable enough” and will “eventually become unsustainable” if the market “continually shrinks” due to federal policies and “other erosions.” Or, as a Minnesota insurer put this concern for the future:

[The market] feels pretty good today, that nothing big is going to drop on us this month. And so that, I think, is the first point, [that] by any reasonable standard, it is way too turbulent to say it's stable. Even if all of [us] are just dying to say, oh yeah, it's better now, because this data point is all right, [or] that data point is all right -- yeah, that's true, but the level of change and the number of different dynamics is pretty extreme so that I would hesitate to say it will be stable tomorrow or next month.

It is difficult to draw firm conclusions from this range of summary views. To some extent, market stability is in the eye of the beholder, subject to differences in criteria, expectations, and point of view. Also, views of stability can vary by location. Therefore, the remainder of this report aims to unpack this range of views, across states and for distinct aspects of stability.

## II. Enrollment

### A. Exchange Enrollment

Nationally, 11.8 million people enrolled in the Marketplace exchanges during open enrollment for 2018, a 3.7 percent drop from 2017,<sup>16</sup> similar to the previous year’s decline. This brought exchange enrollment to about the level it had been in 2015. However, because more 2018 enrollees followed through with their first month’s premium than in previous years, actual “effectuated” enrollment by February 2018 was 4 percent *higher* (10.6 million) than in Feb. 2017, which was the highest February level achieved so far.<sup>17</sup>

Based on this continued stability in enrollment, most interview subjects viewed open enrollment for 2018 as a success that left them “pleasantly surprised,” considering “all of the [political and regulatory] turmoil” that has affected the ACA in the past year. Nationally, CMS Director Seema Verma declared that this was the “most cost effective and successful open enrollment to date!”<sup>18</sup> Among our study states, even where enrollment appeared to dip there was broad agreement that any decline was “less than we feared” or expected. A health policy expert in Maine captured the common refrain:

I was one of those gloom and doom people because I thought that cuts in outreach were really going to hurt things and in the federal marketplace states it hurt a little but not nearly what I thought it would be. Which I guess goes to show that people know that they need health insurance.

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<sup>16</sup> CMS, Health Insurance Exchanges 2018 Open Enrollment Period Final Report (April 2018), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html>.

<sup>17</sup> CMS, Early 2018 Effectuated Enrollment Snapshot, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>. CMS reports only a 3 percent enrollment increase, but that appears to be based on older enrollment numbers for 2017. The updated 2017 numbers in CMS’s own report indicate a 4.6% enrollment increase.

<sup>18</sup> Seema Verma, April 3, 2018, <https://twitter.com/seemacms/status/981250136344088576>.

**Table 2: Changes in ACA-Compliant Enrollment**

	Exchange Type	2018 Exchange Enrollment	2017 Exchange Enrollment	2017 Un-Subsidized Enrollment
<b>National</b>		+4.6%	+0.5%	-20%
<b>Federal Exchanges</b>	Federal	+3.2%	+0.3%	-27%
<b>State Exchanges</b>	State	+5.8%	+4.9%	-12%
<b>Alaska</b>	Federal	+19.3%	-6.9%	-30%
<b>Arizona</b>	Federal	+8.0%	-9.8%	-73%
<b>Colorado</b>	State	+0.1%	+10.9%	-19%
<b>Florida</b>	Federal	+11.4%	+3.4%	-13%
<b>Iowa</b>	Federal	+0.6%	+0.6%	-39%
<b>Maine</b>	Federal	-2.1%	-3.2%	+6%
<b>Minnesota</b>	State	+21.2%	+39.9%	-53%
<b>Nevada</b>	Hybrid	+2.7%	+4.3%	-16%
<b>Ohio</b>	Federal	+0.1%	+3.2%	-12%
<b>Texas</b>	Federal	+8.1%	0.0%	-38%

Source: CMS data and reports.

Notes: Enrollment figures are “effectuated,” meaning they are based on those who enrolled and paid the first month’s premium by Feb. 1. Thus, they are lower than initial enrollment figures. Also, the latest CMS figures were used for effectuated enrollments in 2017, which differ somewhat from the figures CMS initially reported.

Open enrollment was not viewed as successful everywhere, however. Observers in several states thought that enrollment suffered due to recent federal actions to cut the open enrollment period in half and greatly reduce advertising and support for navigators.<sup>19</sup> In Iowa, enrollment actually increased a bit (Table 2), but it was still seen as disappointingly low, because take-up among eligible people in Iowa has remained far below national averages throughout the ACA’s history. Also, unsubsidized enrollment declined substantially.<sup>20</sup>

Florida saw a substantial increase in enrollment. Subjects there attributed this success in part to strong networks of nonprofit navigators and enrollment assisters that rely on local funding. Sources in many states also pointed to the boost they received from the substantial amount of free media coverage generated by the ongoing political controversies over Congressional attempts to repeal and replace the ACA and administration efforts to weaken the ACA’s funding and enforcement. Although some subjects (noted below) thought that this controversy confused people and so interfered with enrollment, others noted that their states worked especially hard (“busted our butts”) to counter the confusion and to use the general controversy to stimulate more interest in enrollment.

Nationally, Ogilvy (a large ad firm) reports that media coverage of ‘enrollment,’ ‘enrollment period’ and ‘deadline’ in an ACA-related context increased by 53%, 125% and 129%, respectively, over the prior year.<sup>21</sup> In Minnesota, an exchange official estimated that its “earned” (i.e., unpaid) media was valued at

<sup>19</sup> For the 2018 open enrollment, CMS reduced its national marketing budget by 90%, from \$100 million to \$10 million, and cut funding for navigators by 42%, from \$63 million to \$37 million.

<sup>20</sup> Sabrina Corlette and Kevin Lucia, The Road Not Traveled: How Policy, Business Decisions in Iowa Led to Higher Premiums (Commonwealth Fund, June 2018), <https://www.commonwealthfund.org/blog/2018/policy-decisions-iowa>.

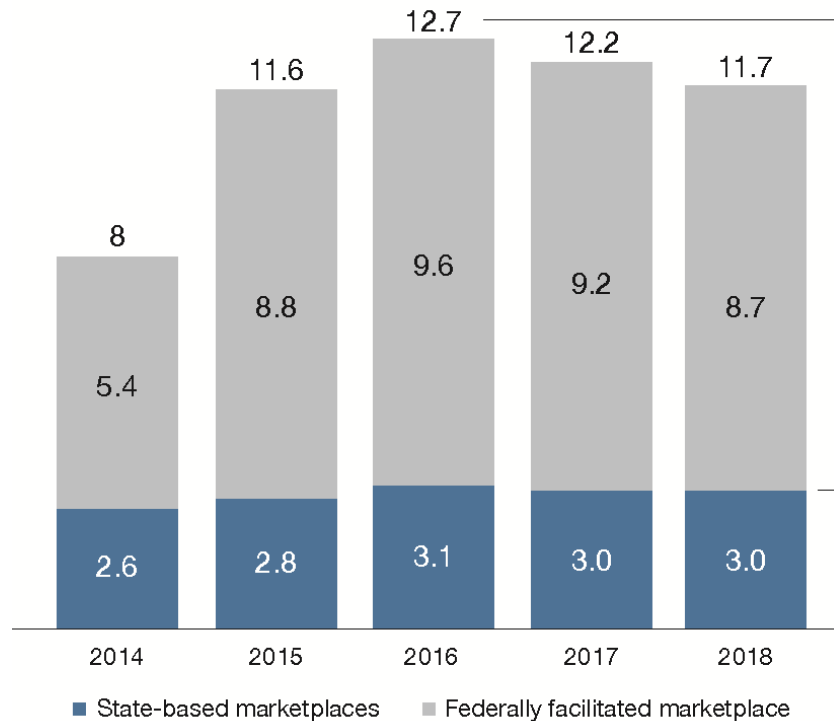
<sup>21</sup> Ogilvy, Health Care Press Coverage 2017 Enrollment Period vs. 2018 Enrollment Period (Jan. 2018), [http://board.coveredca.com/meetings/2018/01-18/Ogilvy-Enrollment\\_Coverage\\_Measurement-Final-01-18-18.pdf](http://board.coveredca.com/meetings/2018/01-18/Ogilvy-Enrollment_Coverage_Measurement-Final-01-18-18.pdf).

\$6.5 million, four times its paid media budget. Elsewhere, people commented that all the “media hoopla” and the shorter deadline caused people to “scramble” to renew or enroll. A few observers expressed concern, though, about what might happen in future years when the media “frenzy” dies down.

## B. State-Based Exchanges

A pattern that emerged, both nationally (Figure 1) and among most of the study states (Table 2) is that enrollment has been stronger in the 17 states that operate their own Marketplace exchanges than in the 34 that default to the federal exchange. This is likely due to states with their own exchanges being more committed, in various ways, to making the ACA work.

**Figure 1: Trends in Federal and State-Based Exchange Enrollment (in millions)**



Source: Covered California. Note: Here, enrollment figures reflect initial signups but not those who drop out for failing to pay their first month’s premium.

Enrollment increases were especially strong in Minnesota, for two distinctive reasons. First, the state was able to fix the substantial difficulties it had in earlier years with its on-line platform, enabling it to capture a larger share of people previously enrolled in ACA plans outside the exchange. Second, when the Blue Cross plan withdrew the PPO product that accounted for 40 percent of the market (100,000 enrollees), the state allowed other insurers to cap their enrollment to avoid taking too large a share of transferring members. This cap caused people to fear they might be left out if they did not enroll promptly, which created a strong incentive to enroll.<sup>22</sup>

<sup>22</sup> Some observers thought the incentive might be too strong, causing a “frenzy” of “hysteria” in which people were “freaking out.”

Sources in Colorado and Nevada attributed much of their success in “insulating” the market from recent federal policies to their ability to commit substantial funds to marketing and outreach, in order to offset the “drastic” cuts that “slashed” and “gutted” federal funds for these purposes.<sup>23</sup> Some sources also emphasized the need for state-based marketing to offset the Trump administration’s “messaging” and “narrative that intentionally feeds uncertainty [about the status of the ACA] and that undercuts the work that we were trying to accomplish” of informing people about the continued availability of highly subsidized coverage. A Minnesota source, for instance, emphasized that there is “just a negative narrative out there that is I think just so damaging to consumer confidence.”

In North Carolina, which uses the federal exchange, actuaries for the largest health plan attributed a portion of their 2018 premium increase to “[c]onsistent messaging from Federal policymakers stating their intent to abolish the ACA coverage mandates, [which we believe] will embolden many healthier individuals to drop coverage ... .”<sup>24</sup> Similarly, the Blue Cross plan in Florida said that “one of the first messages we knew we had to [convey] this last open enrollment is, ‘the ACA is still here.’ [W]e did not assume that people knew that, and they didn’t. They assumed that the President had ended it. ... So, it’s a very confused marketplace.”<sup>25</sup>

Supporting the benefits of positive messaging, a study from California reports that marketing efforts by its state-based exchange have resulted in a much stronger capture (79% vs. 64%) of the subsidy-eligible population than in federal exchange states, which has produced a risk pool in California that is 20 percent healthier than in federal exchange states.<sup>26</sup> One attraction of investing in marketing and outreach is that the positive returns potentially compound each year (until market saturation) since these efforts can both attract new enrollees and help keep existing ones. Thus, the California analysis estimates that increased marketing in other states could lower premiums nationally by 2 to 3 percent each of the next two years.<sup>27</sup>

In addition to having their own marketing budget, the two state-based exchanges that operate their own enrollment platforms (CO and MN) also attributed their relative success to their ability to extend open enrollment for several weeks beyond the federal window, which was only half the length of the previous year. Others, however, felt that shorter open enrollment in the federal exchange states was not necessarily a major disadvantage. They noted that the shortened open enrollment is similar to what is used in Medicare (for Part D coverage and Medicare Advantage plans), and that six weeks is sufficient time once people have become used to the open enrollment process since people, who by nature tend to “procrastinate,” are motivated by a deadline, especially if they “know they need insurance.”

Despite the split views on the need for longer open enrollment, there was general agreement that state-based exchanges give states more control over measures that can maximize enrollment.<sup>28</sup> Minnesota,

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<sup>23</sup> See note 19.

<sup>24</sup> Blue Cross and Blue Shield of North Carolina, Actuarial Memorandum (Aug. 2017), [https://ratereview.healthcare.gov/files/718681\\_11512\\_01012018\\_IND\\_RedactedAM.pdf](https://ratereview.healthcare.gov/files/718681_11512_01012018_IND_RedactedAM.pdf).

<sup>25</sup> What’s Ahead For The Individual Health Insurance Market (Brookings, March 2018), [https://www.brookings.edu/wp-content/uploads/2018/03/es\\_20180306\\_health\\_market\\_transcript.pdf](https://www.brookings.edu/wp-content/uploads/2018/03/es_20180306_health_market_transcript.pdf).

<sup>26</sup> Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens, Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets (Sept. 2017), [http://hbex.coveredca.com/data-research/library/CoveredCA\\_Marketing\\_Matters\\_9-17.pdf](http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf).

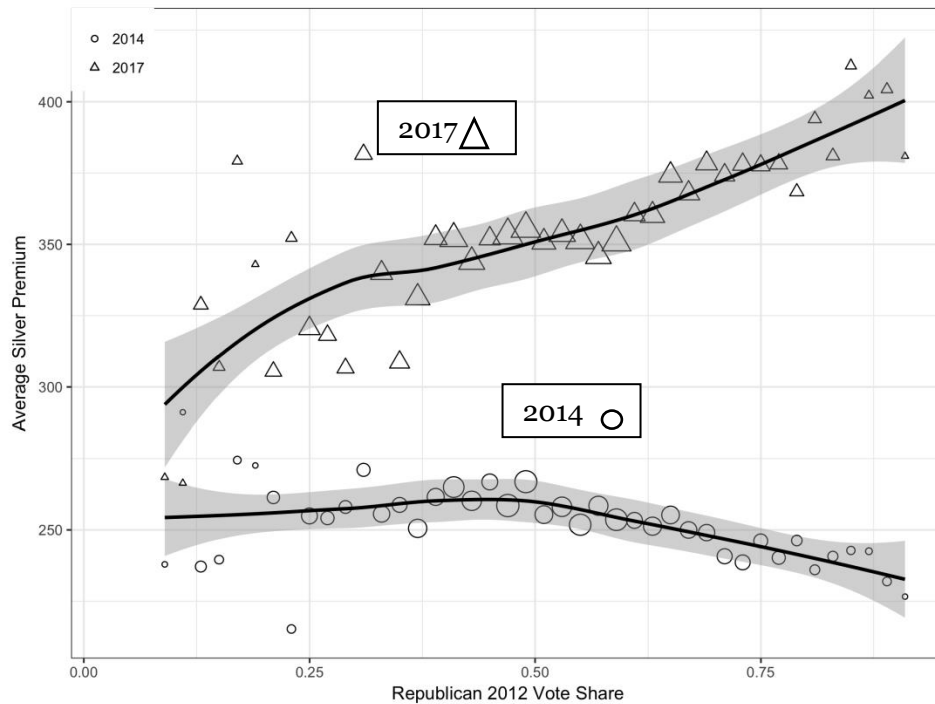
<sup>27</sup> Covered California, Individual Insurance Markets: Enrollment Changes in 2018 and Potential Policies That Could Lower Premiums and Stabilize the Markets in 2019 (April 2018), [http://hbex.coveredca.com/data-research/library/CoveredCA\\_2018\\_Individual\\_Market\\_Enrollment\\_4-25-18.pdf](http://hbex.coveredca.com/data-research/library/CoveredCA_2018_Individual_Market_Enrollment_4-25-18.pdf).

<sup>28</sup> For instance, an exchange official in Rhode Island has commented that “We could extend our open-enrollment period, control our marketing budget and nimbly mitigate the impact of the loss of cost-sharing subsidies [to insurers], which led to a very successful open enrollment.” Julie Appleby, Despite Changes That Undermined ACA Enrollment, Marketplaces ‘Remarkably Stable’, Kaiser Health News, Feb. 7, 2018, <https://khn.org/news/despite-changes-that-undermined-aca-enrollment-marketplaces-remarkably-stable>. For additional documentation and discussion, see Justin Giovannelli, Emily Curran, How Did State-Run Health Insurance Marketplaces Fare in 2017? (Commonwealth Fund, March 2018) <http://www.commonwealthfund.org/publications/issue-briefs/2018/mar/how-did-state-run-marketplaces-fare-in-2017>.

for instance, at the last minute added an extra “special enrollment” week onto the end of its 2016/2017 open enrollment period, in order to allow residents to take advantage of a just-enacted rebate for unsubsidized subscribers. A preference for a state-run exchange was also heard in Nevada, whose state exchange currently contracts to use the federal healthcare.gov platform. There, officials were frustrated both by the shortened open enrollment and by their sense that CMS was not sufficiently flexible in its service hours and maintenance downtime to accommodate the large Nevada workforce (in gaming and entertainment) that has atypical work schedules. For this and other reasons, Nevada recently appropriated funds to launch its own web platform by 2020. Similarly, Minnesota’s Democratic governor vetoed a Republican-led bill in May 2017 that would have required the state to move to the federal exchange, citing the recent successes of their state-based exchange.

One additional factor that has affected enrollment is political viewpoint. All else being equal, enrollment nationally has been lower in areas with more Republican voters, ostensibly due to more negative attitudes about the ACA.<sup>29</sup> Among our study states, sources in Alaska and Iowa especially noted that vocal opposition to the ACA by current or former public officials had dampened enrollment, even by people eligible for substantial subsidies. Owing to this lower take-up, national research shows that the risk pool is less healthy in Republican leaning areas, producing higher premiums in those areas in 2017, as reflected in the Figure 2. (Interestingly, this partisan relationship did not exist in insurers’ *initial* pricing decisions for 2014, but emerged subsequently.)

**Figure 2: ACA Individual-Market Premiums and Republican 2012 Vote Share**



Source: Samuel Trachtman, Polarization, Participation, and Policy Performance: The Case of ACA Marketplaces (May 2018), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3081991](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3081991)

Note: Each triangle (2017 data) or circle (2014 data) reflects a grouping of counties with similar Republican vote share. The size of each triangle/circle reflects the relative population of each county grouping.

<sup>29</sup> Amy E. Lerman, et al., Policy Uptake as Political Behavior: Evidence from the Affordable Care Act, *Am. Pol. Sci. Rev.* 111(4):755-770;2017, <https://doi.org/10.1017/S0003055417000272>.

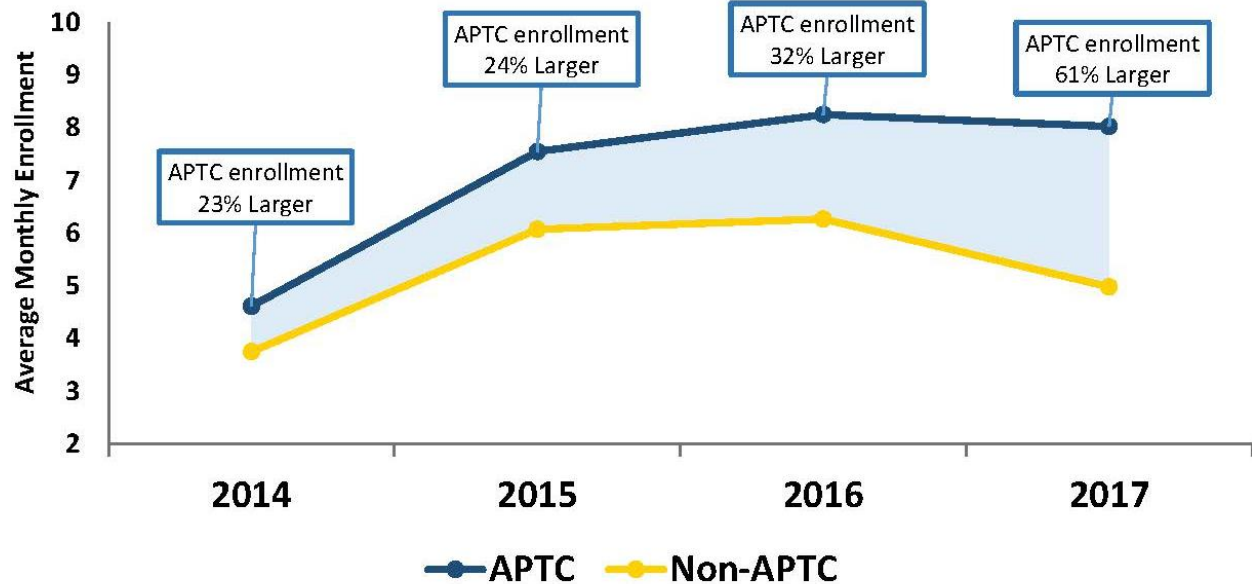


Further indication that supportive attitudes and regulatory measures improve the ACA risk pool comes from the rate increase data presented below (Table 4) and documented elsewhere,<sup>30</sup> which show that, although rate increases were very steep, over the past two years they were 5-10 percentage points lower in states operating their own exchanges than in those that default to the federal exchange.

### C. Unsubsidized Enrollment

Field interviews revealed an entirely different story about enrollment by individuals who are not eligible for an advance premium tax credit (APTC) subsidy. This story is somewhat more difficult to tell, however, because we lack clear and consistent data about off-exchange enrollment, where much (but not all) unsubsidized enrollment occurs. Most difficult to measure is enrollment in non-ACA compliant plans, such as those that have been “grandfathered” from prior to March 2010, or “grandmothered” from prior to January 2014. Nevertheless, data is available for ACA-compliant plans sold to unsubsidized (non-APTC) purchasers, either on or off the exchanges. For that population, Table 2 (above) and Figure 3 (below) show a notable decline starting in 2017, when ACA premiums began to spike.

**Figure 3: APTC and non-APTC Individual Market Average Monthly Enrollment\*, 2014-2017**  
(in Millions)



\*Includes enrollment in individual market health insurance sold on and off Exchange, but excludes grandfathered plans, transitional plans, excepted benefit plans and student health insurance plans.

Source: 2014-2017 Risk Adjustment Data and 2014-2017 Exchange Effectuated Enrollment and Payment Data

<sup>30</sup> Mark A. Hall and Michael J. McCue, Health Insurance Markets Perform Better in States That Run Their Own Marketplaces (March 2018), <http://www.commonwealthfund.org/publications/blog/2018/mar/health-insurance-markets-states>.

Whereas, through 2016, subsidized (APTC) enrollment had been only a quarter to a third higher than unsubsidized enrollment in ACA plans, the drop in unsubsidized (non-APTC) enrollment in 2017 increased the subsidized enrollment lead to 61 percent. The unsubsidized decline was substantially greater in some states than others. As Table 2 shows, states that defaulted to the federal exchange did twice as worse (-27%) than those operating their own exchanges (-12%).

In our study states, key informants reported variously that enrollment declines among unsubsidized people were “disturbing,” “surprising,” or reflecting a “precipitous” “exodus.” A number of observers feared that this portion of the market was becoming a virtual “high risk pool,” meaning that, for the most part, only people will remain who are have expensive health conditions.

These concerns were heard both in states with more successful and less successful open enrollment on their exchanges. For instance, in Minnesota, although exchange enrollment has increased substantially, unsubsidized ACA enrollment dropped -53 percent in in 2017, and the individual market overall (including non-ACA plans) has declined from 309,000 in 2015 to 166,000 in 2017, and further still in 2018. This decline was reported to be most notable in rural areas, where the proportion of the population with individual coverage has dropped by more than half in the past few years.

A similar pattern has occurred in Iowa, which has had an especially strong off-exchange market. In earlier years, Iowa had substantially more unsubsidized than subsidized subscribers in ACA plans, but, by 2017, unsubsidized subscribers constituted only 42 percent of the ACA market, meaning that Iowa’s unsubsidized enrollment dropped by almost half. Similar, or even more severe, trends were noted in Alaska, Arizona, and Texas, but in half the study states (CO, FL, ME, NV, OH), unsubsidized enrollment held fairly steady or declined only moderately through 2017. However, in several of those states, subjects feared that additional steep rate increases for 2018 (discussed below) drove away more people who do not qualify for subsidies.

Sharply increasing premiums accentuate the difference between those who do and do not qualify for subsidies. The ACA’s subsidy structure cushions the impact that premium increases have for those who qualify for a subsidy because the ACA caps the cost of the second lowest silver plan in each rating region to 9.7 percent of household income. Subsidies cease, however, for people above 400 percent of the federal poverty line (which, in the continental U.S., equates to almost \$50,000 for a single person or \$100,000 for a family of four). If people earn even a dollar more than the 400 percent ceiling, they receive no subsidy – a phenomenon known as the “subsidy cliff.”<sup>31</sup>

When the ACA exchange first started, the subsidy cliff was not nearly as dramatic as it is now because premiums were substantially lower. Scenarios vary based on a person’s age and family size, but, in general, in 2014 and 2015, people would typically pay the same or a similar amount for insurance whether they were just below and just above the 400 percent subsidy ceiling. Once insurance premiums started to increase steeply, in 2016, the subsidy cliff became much more pronounced, and especially so following premium increases in 2017 and 2018. Now, earning more than the subsidy ceiling can cause someone to pay several thousand dollars more for their insurance.<sup>32</sup> Insurer Medica, for instance, provided the following example for young parents with two children:<sup>33</sup> If a family’s income is \$98,000, their insurance premium for Silver coverage is capped at \$9,500 a year, but if family income is \$101,000, there is no cap and the insurance premium increases to \$27,000 a year (which is paid after taxes).

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<sup>31</sup> Louise Norris, Beware Obamacare’s ‘Subsidy Cliff’ (Oct. 2016), <https://www.healthinsurance.org/obamacare/beware-obamacares-subsidy-cliff/>.

<sup>32</sup> This cliff effect is made even more challenging by the fact that some people will not know for certain whether they are above or below the ceiling until they file their taxes several months following open enrollment -- at which point, if they have incorrectly enrolled in subsidized coverage because they underestimated their taxable income, they may learn that their insurance costs several thousand dollars more than they first thought.

<sup>33</sup> Medica Insurance Company, 2018 ACA Compliant Individual Rate Filing Observations, <https://iid.iowa.gov/documents/iid-medica-rate-filing-observations-2018>.



Steep premium increases would likely produce reduced enrollment even without the subsidy cliff, but the cliff creates an even greater divide in how rate increases affect enrollment, because only people who receive subsidies are sheltered from the brunt of premium increases. Indeed, for reasons explained below, the ACA's subsidy structure can end up actually *reducing* the net cost for some plans as the sticker price increases, since the subsidy is based on a particular reference plan (the second-lowest silver), which may end up increasing more than other plans. This auto-adjusting subsidy feature "insulates" most of the exchange market from price increases, but people above 400 percent of poverty remain fully exposed to those increases. Thus, only they are likely to find that premium increases make coverage substantially less affordable.

Accordingly, many observers noted that the individual market has "bifurcated" into essentially two submarkets: subsidized (through the exchanges), and unsubsidized (mostly off-exchange). The subsidized portion was seen by most informants as remarkably "resilient," "surprisingly robust."<sup>34</sup> But, those who are ineligible for subsidies are "SOL" [\*\*\* out of luck] because that part of the market "is going to be terrible" and there is "no help on the horizon" for them. A very experienced Maine broker summarized the situation:

We have two distinct populations in the market: those who are subsidized and those who aren't. The problem is now in the un-subsidized part of the market where premium increases have been high and [could] be brutal next year.

### III. Insurer Participation

Insurer participation in the individual market was much more challenging in some states than in others, both in 2018 and in 2017 (Table 3). Nationally, looking at the Marketplace exchanges, insurer participation dropped by about a quarter in 2018, but that decline was less than the one-third dropout in 2017.<sup>35</sup> Eight states had only a single insurer in 2018 (AK, DE, IA, MS, NE, OK, SC, WY), up from five such states in 2017, and rural areas in many states had only a single insurer.<sup>36</sup> Among federal exchange states, these single-insurer areas accounted for 29 percent of enrollees in 2018, up from 20 percent in 2017, whereas in 2016, only 2 percent of enrollees had only one insurer to choose from.<sup>37</sup>

Thus, the overall picture is that the major declines in insurer participation occurred after 2016,<sup>38</sup> but declines continued into 2018, although at a more diminished rate. That pattern is also seen in our study states (Table 3). Both in 2017 and 2018, six of our ten states saw declines, but only three states had declines both years, and declines were noticeably smaller for 2018 than for 2017, with the exception of Iowa. Moreover, as discussed below, it now appears that no additional declines are expected for 2019, and, indeed, insurer participation may increase somewhat.

<sup>34</sup> See also Reed Abelson, *Obamacare Is Proving Hard to Kill*, N.Y. Times, July 3, 2018, <https://www.nytimes.com/2018/07/03/health/obamacare-insurance-rates.html>.

<sup>35</sup> DHHS, ASPE, *Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange* (Oct. 2017), [https://aspe.hhs.gov/system/files/pdf/258456/Landscape\\_Master2018\\_1.pdf](https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf); Edmund F. Haislmaier, *2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink* (Heritage Foundation, Jan. 2018), [https://www.heritage.org/sites/default/files/2018-01/IB4813\\_1.pdf](https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf); Ashley Semanskee, *Insurer Participation on ACA Marketplaces, 2014-2018* (Kaiser Family Foundation, Nov. 2017).

<sup>36</sup> *Ibid.*

<sup>37</sup> Micah Weinberg & Leif Haase, *Improving Individual Health Insurance Markets* (Bay Area Council Economic Institute, Oct. 2017), <http://www.bayareaconomy.org/files/pdf/ImprovingHealthInsMarketsBACEI102717.pdf>; DHHS, ASPE, *Health Plan Choice And Premiums In The 2018 Federal Health Insurance Exchange* (Oct. 2017), [https://aspe.hhs.gov/system/files/pdf/258456/Landscape\\_Master2018\\_1.pdf](https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf).

<sup>38</sup> Note 35; Craig Garthwaite, Ph.D., and John A. Graves, *Success and Failure in the Insurance Exchanges*, *New Engl. J. Med.* 376:907-910 (2017), <https://www.nejm.org/doi/full/10.1056/NEJMp1614545>.

**Table 3. Insurers Participating In the ACA Exchange Market, Per State**

Location	2016	2017	2018
National	5.6	4.3	3.5
Alaska	2	1	1
Arizona	8	2	2
Colorado	8	7	7
Florida	7	5	4
Iowa	4	4	1
Maine	3	3	2
Minnesota	4	4	4
Nevada	3	3	2
Ohio	14	10	8
Texas	16	10	8

Sources: See note 35.

Iowa initially had half a dozen insurers, but its consumer-operated health plan (co-op) failed, and Aetna and United withdrew as part of nation-wide corporate decisions. A Wisconsin-based HMO was in one corner of the state for a while, but then withdrew due to losses and regulatory uncertainties. This left Medica and Wellmark Blue Cross. Initially, Wellmark remained out of the Iowa market, but as other insurers withdrew, it decided to enter for 2017. But it then left the Iowa market for 2018, due to substantial losses, along with “tumult in the market” stemming from Republican efforts to repeal the ACA and cancel cost-sharing payments, which left only Medica for 2018.

The situation in Iowa may be improving, however. Early this year, Wellmark announced that it planned to re-enter for 2019, noting that legislative and regulatory uncertainty has “dissipated just enough that we think we’re able to step back in,” as long as “there aren’t any significant changes to the ACA.”<sup>39</sup> There is also informed speculation that Wellmark’s re-entry decision was tied to the state’s recent decision to allow it to start selling non-ACA compliant coverage through the Farm Bureau. But, there is some concern that Wellmark’s re-entry, and its embrace of the non-ACA compliant market, may cause Medica to retract.

There were signs of potential market improvement in other states. Although Alaska has only a single insurer statewide, several informed observers thought that one or more insurers previously in the market could re-enter in the future, especially once “the federal government settles down on the ACA.” Florida has five insurers but only Blue Cross is statewide. Observers there thought some of the insurers who either are only off-exchange or are in a limited number of counties are “sitting on the sidelines” waiting to see what happens with the ACA politically and in the regulatory arena, hoping for more “predictability and stability” from the federal government. Following these interviews, the start-up insurer Oscar has announced plans to enter both Florida and Arizona, along with several other state or metropolitan markets.<sup>40</sup> In Maine, Anthem Blue Cross withdrew from the exchange for 2018, but it continued to keep just a toe in the off-exchange market in a remote corner of the state, to preserve its ability to re-enter the market fully (which it intends to do if the state implements its proposed

<sup>39</sup> Michaela Ramm, Wellmark to Return to Iowa Exchange, Sell ACA-compliant Plans, The Gazette, Feb. 8, 2018, <http://www.thegazette.com/subject/news/health/wellmark-to-return-to-iowa-exchange-sell-aca-compliant-plans-20180208>.

<sup>40</sup> Bruce Japsen, Oscar Health To Enter Six New Insurance Markets Despite Obamacare Attacks, Forbes, June 21, 2018, <https://www.forbes.com/sites/brucejapsen/2018/06/21/oscar-health-to-enter-six-new-insurance-markets-despite-obamacare-attacks>.

reinsurance program). In Ohio, Anthem Blue Cross withdrew both on and off the exchange but kept its off-exchange presence in just a single county, apparently so they can re-enter later if they want (and, indeed, Ohio recently reported that two additional, unspecified insurers have filed rates for 2019).<sup>41</sup>

Elsewhere, although significant market entries were not anticipated, market participants and observers felt that insurer participation was not likely to substantially worsen, as things now appear, because the major market contraction had already happened in 2016. For instance, Texas now has nine insurers, down from 14 in 2015, and only Blue Cross is statewide, but the major “exodus” was after 2016, due to sustained losses. For 2018, although Humana and a Nevada-based insurer (Prominence) left the Texas market, Centene entered the market and Oscar expanded its geographic territory, so the level of competition remains approximately the same as in 2017, with the number of single-insurer counties increasing only 5 percent. Texas sources thought that substantial additional retractions or exits are not likely because insurers are now profitable and enrollment remains sizeable; in fact, some sources thought that insurers that previously left might consider re-entering the exchange market.

As developments have ensued, market conditions for 2019 now appear to confirm these more optimistic predictions. Based on mid-year rate filings to date, no state so far has seen any insurers withdraw or retrench for 2019, and at least a dozen states are expecting a new insurer (or two) to enter (or re-enter).<sup>42</sup>

### A. Covering Bare Counties

A significant indication that the ACA marketplace is not on the precipice of collapse is the fact that no areas entirely lacked any insurers for the 2018 open enrollment, and no bare counties are expected for 2019. For a time in 2017, it appeared that as many as eight states might be facing such “bare” counties, but they all were able to secure full market coverage, using techniques like the following from our study states.<sup>43</sup>

In several study states (including Colorado, Maine, Minnesota, and Ohio), insurers and informed observers credited “cooperative,” “flexible,” “proactive,” and “problem-solving” state regulators with helping to keep insurers in the market and convince them to cover additional counties. Minnesota subjects in particular emphasized that insurers there “have largely stayed put through thick and thin” because there is an unusual degree of collective “desire to make the individual market stable [and] accessible [so that] everyone else gets insurance.” As one observer summarized, “the individual market is a little bit of a labor of love and sort of a commitment to the state [by insurers] as much as it is sound business.”

The most frequently mentioned form of regulatory flexibility was the ability in most states to either file two sets of rates, or to quickly revise previous rate filings, to account for the Trump administration’s abrupt decision (discussed in section IV.E) to stop funding cost-sharing subsidies. In Iowa, for instance, several sources noted that insurers were nervous about being in a market where cost-sharing payments were being used as a “political bargaining chip,” but Medica, now the state’s only insurer, decided not to withdraw once the insurance department allowed them to file contingency (backup) rates. In contrast, Medica’s exit from North Dakota was attributed to its not being allowed either to file alternative rates or to build into their rates the possibility of losing cost-sharing funding.<sup>44</sup>

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<sup>41</sup> Ohio Dept. of Insurance, Ohio Health Insurance Exchange 2019, <http://insurance.ohio.gov/Consumer/Pages/Exchange%20Overview.aspx>.

<sup>42</sup> Reed Abelson, Obamacare Is Proving Hard to Kill, N.Y. Times, July 3, 2018, <https://www.nytimes.com/2018/07/03/health/obamacare-insurance-rates.html>; Anna Wilde Mathews, Insurers to Expand Presence in Affordable Care Act Marketplaces Despite Uncertainty, Wall St. J., June 21, 2018.

<sup>43</sup> For additional documentation and thorough discussion, see also Kevin Lucia, et al., Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018 (Urban Institute, Nov. 2017), [https://www.urban.org/sites/default/files/publication/94571/2001591\\_bare\\_county\\_brief\\_1.pdf](https://www.urban.org/sites/default/files/publication/94571/2001591_bare_county_brief_1.pdf).

<sup>44</sup> Ibid.

Another flexible measure that regulators used in a couple of our study states was to relax network adequacy rules in less populous counties, or where insurers were having difficulty securing network contracts. As one insurer stated, “I can’t stress enough the importance of the [availability of a] provider network” in driving the company’s decision to offer plans in an area.

A more unusual measure, used in Minnesota, was to cap enrollment by insurers willing to remain or expand into an underserved area, in order to limit potential downside exposure. Although the enrollment caps were somewhat controversial, subjects thought that they were a “very effective tool for keeping conversations [going between regulators and insurers] in an otherwise very tense summer,” when the market was “on the verge of collapse.”

Reinsurance or other forms of risk-spreading did not emerge in our research as a strong potential driver of insurer participation. As discussed in section VI, reinsurance can play an important role in stabilizing insurance rates, but we saw little or no indication that reinsurance has been a key to an insurer’s decision to enter or leave a market altogether. Experience is still new with reinsurance, however, so its impact is not yet fully known. Also, it is quite possible that reinsurance could help participating insurers expand to cover more of a state they are in, even if it does not affect decisions to leave or remain out of a state altogether. Reinsurance can make insurers more comfortable with entering underserved areas because it directly addresses the concerns noted below about the greater difficulty in establishing actuarially sound rates in less populous areas or in areas where an insurer lacks data to project local medical costs.

The strongest measure mentioned for encouraging participation was tying marketplace participation to eligibility to bid for state contracts. None of our study states require exchange participation in order to serve state employees, but some observers in Colorado speculated that the plausible threat that their governor might do so contributed to the decision by Anthem (Blue Cross) to remain in the Colorado exchange, despite withdrawing in most other states.

States also have potential leverage through Medicaid managed care contracting. Nevada previously required Medicaid contractors to participate in its exchange. This requirement was cited as the likely reason that United Healthcare, despite withdrawing from exchanges elsewhere, has remained in Nevada’s exchange market (along with New York’s, which also ties exchange participation to Medicaid contracting). In 2017, Nevada downgraded exchange participation to an option that only garners extra points in the Medicaid competitive bidding process. As a result, Nevada’s Blue Cross plan (Anthem) was able, without losing its Medicaid contract, to reverse its previously announced plans to remain in the exchange for 2018. Reportedly, Nevada officials are considering whether to reinstate the requirement of exchange participation. In the meantime, Centene, an insurer that specializes in Medicaid managed care, entered the Nevada exchange for 2018 and agreed to cover the entire state, which gave it extra points for its Medicaid bid (which was successful). Had Centene not done so, 14 of Nevada’s 17 counties might have been bare (all but the Las Vegas and Reno areas).

Elsewhere, our study states do not tie exchange participation to Medicaid contracting, but observers in Florida and Texas noted that there is a natural overlap between the markets served by Medicaid and exchanges (including overlap among members of the same household),<sup>45</sup> such that it often makes good business sense for insurers to be in both markets. Although neither Florida nor Texas has expanded Medicaid, these large states have substantial Medicaid managed care populations. Accordingly, all five exchange insurers in Florida also have Medicaid contracts, as do most of the insurers in the Texas exchange.

### B. Maintaining Profitability

Despite these successful uses of persuasion, regulatory flexibility, and contracting incentives, observers and participants noted that insurer participation and market coverage is precarious, “on really thin ice,”

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<sup>45</sup> The medical needs of both populations are similar, and many lower-income people cycle regularly between private and public coverage as their work situation changes.

unless insurers are able to make a profit in the exchange market. Prior to the regulatory upheavals this past year, insurers were becoming profitable, and some handsomely so. Just as sustained losses through 2016 were the main reason that insurers previously left the market, the ability to now turn a profit was noted by many subjects as the reason for insurers now entering, or remaining in, these markets. As discussed more below, insurers now in the market are willing to adapt to almost any of a range of market rules, as long as the rules are clear and stable, so that they can rate for them accurately.

The continued likelihood of profits was noted by several sources as a reason there is not a substantial risk of bare counties becoming widespread because, with the ACA's built in subsidy structure, insurers that face no competition can basically "print money," as long as cooperative regulators allow them to set their premiums high enough to cover anticipated costs and a reasonable margin. This appeal of a competition-free market appears to be at play, for instance, in Arizona, where there are two insurers, but neither sells where the other does. Centene, a Medicaid-focused plan, covers only the two urban centers (Phoenix and Tucson), while the Blue Cross plan covers only the rest of the state. Previously, the state had over a half dozen insurers, but there was a "mass exodus" following a "bloodbath" of competitive pricing in which, each of the first two years, one insurer would substantially underprice the others, receive the bulk of enrollment, then scale back or exit due to substantial losses, causing subscribers to move virtually en masse to the next lowest plan, when the cycle would repeat itself.<sup>46</sup> Once the market reduced to a split-state, dovetailed structure, sources commented that it seems "relatively stable." Recently, however, two start-up out-of-state insurers (Oscar and Bright Health) have announced plans to enter the Arizona market.

Alaska appears to be another state where the market might gravitate to a single carrier structure. Currently, Blue Cross is the only insurer in the state, but discussants seemed hopeful that one or more carriers previously in the market (such as Moda) might consider re-entering if the market stabilizes. On the other hand, there was speculation that Blue Cross might withdraw from some of the counties where it lacks strong managed care networks. One source commented that "the future of the individual market in Alaska is going to be more localized networks within communities [where delivery systems] are willing to take a more value-based approach."

Similarly, Iowa has only a single insurer now (Medica), and although the Blue Cross plan recently announced that it would re-enter the market, some subjects speculated that this might cause Medica to retrench. Even when an insurer does not have a state-wide monopoly, it is becoming increasingly common to have only a single insurer in rural counties, leading one analyst to conclude:

The emerging norm appears to be one in which major metropolitan areas have two or three insurers offering exchange coverage but less populous areas have only one. However, Obamacare's subsidy structure makes it unlikely that parts of the country will have no insurers offering coverage.<sup>47</sup>

Other informed analysts, however, note that even monopoly status does not *guarantee* insurer participation.<sup>48</sup> Making a profit, or avoiding substantial losses, depends on accurately forecasting medical expenses. That is more difficult to do in thinly populated areas, where even just one very expensive patient can cause pricing to be inadequate. The ACA has a risk adjustment mechanism that aims to spread the burden of high risk patients among all insurers, but insurers do not feel that this

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<sup>46</sup> See Louise Norris, Arizona Health Insurance Marketplace: History and News of the State's Exchange (May 2018), <https://www.healthinsurance.org/arizona-state-health-insurance-exchange>. Subjects in Minnesota also commented on the "musical chairs," "game of chicken," or "yo-yo" pricing and enrollment dynamic that the ACA's shopping and subsidy structure can create. And, in Texas, an actuary commented that the "big swings in enrollment" caused by the "fierce price-cutting" in the ACA's exchanges can be "terribly unsettling" to actuaries.

<sup>47</sup> Edmund F. Haislmaier, 2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink (Heritage Foundation, Jan. 2018), [https://www.heritage.org/sites/default/files/2018-01/IB4813\\_1.pdf](https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf).

<sup>48</sup> Kevin Lucia, et al., Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018 (Urban Institute, Nov. 2017), [https://www.urban.org/sites/default/files/publication/94571/2001591\\_bare\\_county\\_brief\\_1.pdf](https://www.urban.org/sites/default/files/publication/94571/2001591_bare_county_brief_1.pdf).



mechanism reflects the full costs of truly “catastrophic” expense cases, plus, risk adjustment offers almost no solace to an insurer that is the only one in the state.<sup>49</sup>

### C. Dealing with Uncertainty

Another factor that gives even monopoly insurers pause about entering or remaining in the market is uncertainty over basic market rules. There are two forms of uncertainty: the actual effects of known changes in rules (actuarial uncertainty), and whether future adverse changes will occur (political uncertainty). Although actuarial uncertainty is always present, what has especially bedeviled ACA insurers is the political uncertainty over adverse changes in rules. Examples frequently mentioned were whether insurers will receive all of the payments that the ACA calls for, or whether core regulatory requirements will be enforced. As an Iowa Blue Cross official noted in explaining their decision to leave the market, “uncertainty makes insurers very nervous.”<sup>50</sup>

The ACA structure requires insurers to establish rates for the coming year well in advance so that rates can be reviewed prior to open enrollment. Plus, rates cannot be changed during the year once they are set because the initial rates are the basis for determining enrollment subsidies. This makes rate calculations challenging enough in normal regulatory climates, but when regulatory policies start to become highly uncertain, and rules change “midstream” during a rating year, insurers can view their continued participation as “untenable,” especially when there is a “lag” between the policy change and data indicating its actual effects.<sup>51</sup>

Thus, one Texas insurer lamented:

Some warning and ability to build into our rates is critical to remain in business. Products are based on having information for pricing up front. There has to be a certain point where they say ‘pencils down’ and rates are in place. That would help everyone with more stability.

Similarly, a Minnesota source explained that, due to the ACA’s price competitive subsidy dynamic, “People who show up in any given year can change a lot year-over-year, and as a result, it’s hard to predict [the next year’s rates. Add to that] changing rules and programs and it becomes impossible.” This was echoed by two Maine insurance officials who explained:

Political uncertainty is a problem because you have to lock in your rates early and then see what happens. . . . We deal with insurance risk. We don’t deal well with regulatory uncertainty. That’s not the kind of risk insurance was designed for.

Political uncertainty featured especially prominently in the decision by Anthem Blue Cross to withdraw from, or not enter, the exchanges in a dozen of the 14 states it serves. In Maine, one well-informed subject noted that Anthem withdrew there after years of being the “carrier of last resort,” even though its exchange business had finally become profitable. This source felt that, if the decision had been purely

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<sup>49</sup> As explained in note 107, CMS recently added a small reinsurance component to the ACA’s risk adjustment program, but it covers only 60 percent of a patient’s costs that exceed \$1 million in a year. Thus, insurers are still fully on the hook for up to \$1 million, and for 40 percent of the costs above \$1 million.

<sup>50</sup> Tony Leys, Wellmark to Halt Sales of Individual Health Insurance Policies, Des Moines Register, April 3, 2017, <https://www.desmoinesregister.com/story/news/health/2017/04/03/wellmark-halt-sales-individual-health-insurance-policies/99994906/>.

<sup>51</sup> One independent actuary explained: The market requires that rules that impact insurer finances can only be changed in concert with established premiums. It is crucial that insurers understand the rules before premium rates are developed and that the rules are properly enforced.

Greg Fann, The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode (Axene Health Partners, 2017), <https://axenehp.com/cost-sharing-reduction-paradox-defunding-help-aca-markets-not-make-implode/>. See also note 71, and Erin Trish, et al., To Promote Stability in Health Insurance Exchanges, End the Uncertainty Around Cost-Sharing and Other Rules (Brookings, April 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/04/20/to-promote-stability-in-health-insurance-exchanges-end-the-uncertainty-around-cost-sharing-and-other-rules/>.

local, Anthem might have remained in the market, but a national decision was made to withdraw from most exchanges, due to uncertainty in federal rules, especially over whether cost-sharing reductions would be paid.<sup>52</sup> This knowledgeable source thought:

There was so much [political] uncertainty and [I think] Anthem didn't and doesn't know what's going to happen with the ACA from day to day. [Rumor has it] that if it had been entirely a local decision, Anthem might have stayed in for 2018. The market in Maine appeared to be stabilizing. But at the national level Anthem just felt: what part of the regulations are they going to go after next? [I assume] they couldn't see staying in without knowing what the funding and regulations might be like on any particular day or month.

Likewise, a physician-led HMO in Ohio left the market, explaining that “the uncertainty in Washington, D.C., around the future of the Affordable Care Act . . . and the associated volatility in the marketplace have led us to conclude that we cannot effectively plan and price affordable health insurance to sell on the exchange.”<sup>53</sup> And, in Iowa, the CEO of one HMO commented that “it's really truly amazing that we could have this much uncertainty at any given time. . . . It's just very, very unique in my 36-year career.”<sup>54</sup>

Several subjects amplified that the Trump administration's decision to cancel cost-sharing reduction payments for the final quarter of 2017, well after it was too late for insurers to adjust their 2017 rates, and just a few days before their deadline to decide on 2018 participation, “had a concussive quality” and was the “straw that broke the camel's back” because it “sent a clear signal” to insurers that they “cannot rely on the federal government to keep its [funding] commitments” in the future, especially after having refused previously to fund most of the risk corridor payments promised by the ACA in 2014-2016.

The destabilizing effect of political uncertainty was expressed frequently across our study states, and was viewed as fundamental to whether the market can achieve stability in the future. Several sources in Texas, for instance, thought that destabilizing moves from the federal government have been sufficiently strong and illogical that it appears to them that the government might actually want greater presence of public insurance. For instance a Texas insurance source remarked:

The Administration is doing all they can to destabilize the market. It just creates frustration and makes a Medicare for All solution more likely [because we] won't go back to where all these people are not getting insurance any more. A government option is more likely now than it was before Trump tried to destabilize it.

And, in a Midwestern state, an insurer subject commented at length:

We unfortunately I think had a lot of withdrawals of political and personal trust from that bank over [the past year]. And some of that was political, some of it was necessary, some of it was not necessary. Where you had people of good faith trying to do the right thing and it was not -- nobody could still trust each other. And I'm not talking about across the insurers, but state regulators, governor, legislative leaders, nobody could trust each other that at the end they could reach a stable conclusion.... And so there's a market dynamic going on [that] can't just be in one state because you can't trust your local regulators will figure out a solution that doesn't screw you. Or you can't trust that the federal policy won't drop on you and all of a sudden your market position will go away.

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<sup>52</sup> This explanation is consistent with the company's own statements here, [https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/external\\_Q42017/Anthem\\_comments.pdf](https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/external_Q42017/Anthem_comments.pdf), and here, <https://www.anthem.com/press/ohio/anthem-statement-on-individual-market-participation-in-ohio/>.

<sup>53</sup> Thomas Gnau, Premier Health Plan to Exit ACA Exchange, Dayton Daily News, June 29, 2017, <https://www.daytondailynews.com/business/premier-health-plan-exit-aca-exchange/fzFZiybL6o9o2f5oZmoqWM/>.

<sup>54</sup> Paul Demko, How Iowa Became An Obamacare Horror Story, Politico, Oct. 23, 2017, <https://www.politico.com/magazine/story/2017/10/23/iowa-obamacare-aca-markets-215736>.

Beyond our study states, other researchers have documented similar explanations from insurers throughout the country.<sup>55</sup> For instance, a field interview study similar to this one reported that insurers are “just terrified that the feds are going to pull the rug out from underneath them in the middle of the plan year.”<sup>56</sup> And, the CEO of CareFirst, the Blue Cross plan that covers MD, VA, DC, has commented that “Continuing actions on the part of the administration to systematically undermine the market and make it almost impossible to carry out the mission,” of serving the individual market.<sup>57</sup>

To end on a positive note, insurers in many of our study states thought that ordinary actuarial uncertainty is not destabilizing under the ACA. Therefore, many subjects thought that, “absent the distractions” of changes in federal regulatory policy, participation in ACA market could stabilize and some insurers might reenter. Key is the point made earlier that the ACA’s subsidy structure makes that portion of the market “hard to kill.”<sup>58</sup> As a Maine health policy expert explained, “The subsidy structure saves everything. As long as we continue to have robust enough subsidies and subsidized people, the insurers will stay pretty solvent.”

This view is endorsed by the Congressional Budget Office, which recently explained:

[T]he marketplaces are stable in most areas in large part because most enrollees purchasing subsidized health insurance there are insulated from increases in premiums. The subsidies — combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements — are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.<sup>59</sup>

However, the CBO warned that

[s]ubstantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers’ decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country.<sup>60</sup>

Confirming this assessment, an insurer in Maine said that “if it were not for the prospects of association and short term plans, those things we are facing in 2019, we are at a relatively stable place.” And, from a Minnesota insurer: “the premiums are [finally] covering the medical bills, the only question is, can we just stop changing the rules? And then if we could [reduce] premiums it will all kind of stabilize over time.” As an Ohio regulator summed things up, “just not making changes for a while” would be the best thing to improve stability.

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<sup>55</sup> See Henry J. Aaron, et al., Turmoil in the Individual Insurance Market — Where It Came From and How to Fix It, *New Engl. J. Med.* 377:314-315 (2017); Center for Budget and Policy Priorities, Sabotage and Uncertainty Jeopardizing ACA Marketplaces, Insurers and Regulators Confirm (2017), <https://www.cbpp.org/sites/default/files/atoms/files/5-12-17quotes.pdf>; Congressional Democratic Staff Report, A Manufactured Crisis: Trump Administration and Republican Sabotage of the Health Care System (June 2017), <https://democratsenergycommerce.house.gov>.

<sup>56</sup> Kevin Lucia, et al., Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018 (Urban Institute, Nov. 2017), [https://www.urban.org/sites/default/files/publication/94571/2001591\\_bare\\_county\\_brief\\_1.pdf](https://www.urban.org/sites/default/files/publication/94571/2001591_bare_county_brief_1.pdf).

<sup>57</sup> Paige Winfield Cunningham, The Health 202: Leading Obamacare Insurer Says Things are 'Materially Worse' under Trump Administration, *Wash. Post*, May 1, 2018.

<sup>58</sup> Reed Abelson, Obamacare Is Proving Hard to Kill, *N.Y. Times*, July 3, 2018, <https://www.nytimes.com/2018/07/03/health/obamacare-insurance-rates.html>.

<sup>59</sup> CBO, Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028 (May 2018), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>.

<sup>60</sup> *Ibid.*



## IV. Premium Rates and Cost-Sharing Reduction

For the past two years, insurance prices in the individual market have increased at substantial double-digit rates across the country, as well as in most of our study states, resulting in combined increases mostly in the 50-60 percent range over two years (Table 4).

**Table 4: ACA Exchange Rates**

	Av. Gold Premium 2018	2017 Rate Increase	Average 2018 Change in		
			Exchange Premium Overall	Lowest Silver Premium	Lowest Gold Premium
<b>National</b>	\$518	25%	27%	32%	19%
<b>Federal Exchanges</b>		28%	30%		
<b>State Exchanges</b>		17%	22%		
<b>Alaska</b>	\$778	7%	-24%	-23%	-28%
<b>Arizona</b>	\$627	57%	0%	-2%	-5%
<b>Colorado</b>	\$501	20%	33%	30%	32%
<b>Florida</b>	\$489	19%	31%	42%	14%
<b>Iowa</b>	\$787	29%	86%	94%	41%
<b>Maine</b>	\$636	24%	38%	49%	21%
<b>Minnesota</b>	\$458	57%	-6%	-15%	-8%
<b>Nevada</b>	\$516	11%	33%	46%	25%
<b>Ohio</b>	\$420	17%	21%	38%	28%
<b>Texas</b>	\$435	34%	32%	41%	25%

Sources: CMS and state exchange data reported by Kaiser Family Foundation and Charles Gaba.<sup>61</sup>

Alaska and Minnesota were two notable exceptions. They saw rates declines in 2018, and Alaska had only a moderate single-digit increase in 2017, due mainly to the reinsurance programs those two states instituted (which are discussed below). Arizona is the other exception in 2018, but its two-year increase is similar to that in the other states, for reasons explained below.

Most subjects who commented on steep rate increases attributed those in 2017 to insurers “catching up” with the underlying level of medical claims that ACA enrollees were generating. For instance, in 2014 and 2015, Minnesota had the lowest rates in the country, which sources attributed to “grossly underrated” prices that were “totally out of whack with reality.” This level of underpricing meant that Minnesota insurers were hurt especially badly by the federal government’s failure to fund most of the “risk corridor” payments called for by the ACA. Also, Minnesota insurers failed to receive the full benefit of the ACA’s transitional reinsurance program because the state maintained its pre-existing high risk pool until the end of 2015, so some of the worst risks did not enter the market until 2016. One health plan representative explained that all of this “created some really challenging market dynamics here in Minnesota that were even more pronounced than in other states because of the successes that Minnesota had previously.”

<sup>61</sup> Notes for Table 4: The 2018 rate increase for federal vs. state exchanges was calculated by weighting each the increase CMS reported for each state by its 2018 February enrollment. Due to the “silver loading” pricing strategy discussed below, the distribution of metal types changed noticeably in 2018 from the prior year, which tended to magnify the 2018 increase in overall exchange premium. Therefore, the increase in Gold premiums is a better indication of price changes for those who do not receive a subsidy.

After Minnesota insurers began to have a more accurate measure of their full medical claims, they increased their rates for 2016 an average of about 40 percent, which was among the highest rate increases in the country that year, and a second round of even steeper increases was needed for 2017 to further catch up with actual costs. More than catching up, however, Minnesota insurers now appear to have overshot, as noted below, and so are now *reducing* their rates significantly.

Until 2017, Arizona also had among the lowest rates in the country, due to the “fierce price-cutting” dynamic noted below. But, for 2017, after a “mass exodus” of most insurers, the two that remained had extremely large rate increases of about 50-75 percent -- the steepest in the country that year by far. Similar, but less extreme, patterns were noted in several other states.

### A. Achieving Profitability

Following these earlier rounds of steep increases, observers in most of our study states thought that the market had become profitable by the second half of 2017. These impressions are confirmed by national analysts, which consistently report that the individual market became profitable in 2017.<sup>62</sup> Indeed, the individual market now appears to be substantially more profitable than it was prior to the ACA (Figure 4). Recently, the White House Council of Economic Advisers released an extensive report on “The Profitability of Health Insurance Companies,”<sup>63</sup> which explained in detail:

While insurers initially incurred losses in the ACA marketplaces as they adjusted to new regulations and a relatively unhealthy risk pool, insurers are now profiting on the [individual market], with higher premiums that are largely covered by federal premium subsidies. . . . Health insurance companies initially struggled to make a profit in the post-ACA individual and small group markets. Insurers were unsure how to price insurance with the new ACA requirements such as, guaranteed-issue, modified community rating, and an expansive minimum essential benefits requirement. They underpriced their products relative to their enrollees’ health risks. Many insurers left the market altogether. But the remaining insurers, despite the expiration over a year ago (2016) of the reinsurance and risk corridors programs which were meant to financially protect insurers, have started to make higher profits again. . .

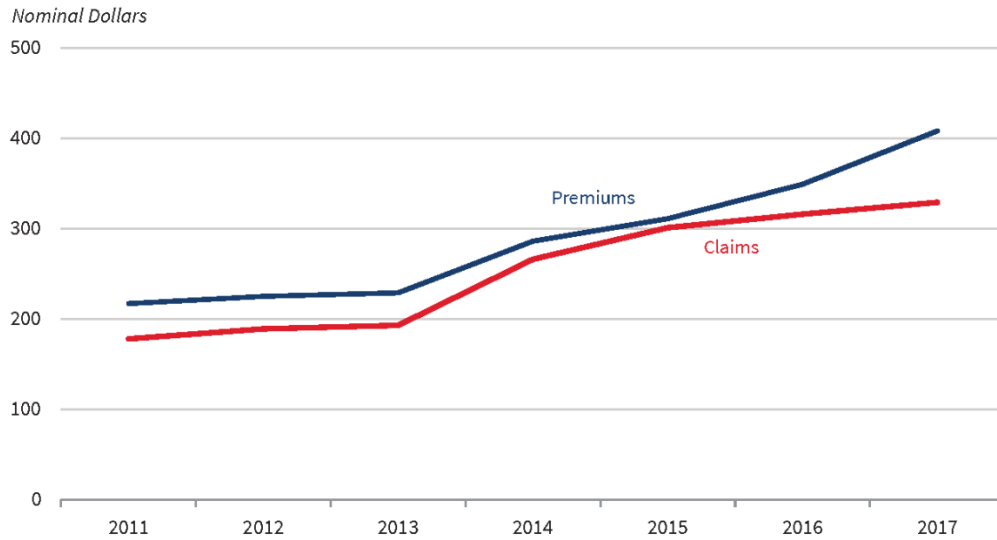
The White House report continues by documenting, as shown in Figure 4, that “the gap between individual market premiums and claims payments was much higher in 2017 than pre-ACA. . . . Gross profit margins (premiums less claims) have increased as the small number of remaining companies gained experience with the . . . risk pool.”

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<sup>62</sup> Beth Fritchen & Kurt Giesa, The Affordable Care Act's Stabilization (Oliver Wyman, June 2018), [http://health.oliverwyman.com/transform-care/2018/06/aca\\_survey.html](http://health.oliverwyman.com/transform-care/2018/06/aca_survey.html); Mathew Fiedler, Taking Stock of Insurer Financial Performance in the Individual Health Insurance Market Through 2017 (Brookings, Oct. 2017), <https://www.brookings.edu/wp-content/uploads/2017/10/individualmarketprofitability.pdf>; S&P Global, Are U.S. Health Insurers Finally Getting To Stable Ground In The ACA Individual Market? (Jan. 2018), [https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsf\\_code=LIME&sourceObjectId=10392499](https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsf_code=LIME&sourceObjectId=10392499); Cynthia Cox, et al., Individual Insurance Market Performance in 2017 (May 2018), <http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-2017>.

<sup>63</sup> White House Council of Economic Advisers, The Profitability of Health Insurance Companies (March 2018), <https://www.whitehouse.gov/wp-content/uploads/2018/03/The-Profitability-of-Health-Insurance-Companies.pdf>

**Figure 4: Individual Market Monthly Premiums and Claims per Enrollee**



Source: White House Council of Economic Advisers, 2018

More than simply achieving profitability, recent rate increases substantially *over-shot* their cost targets in two study states. In Minnesota, officials reported that, following a near-doubling of rates over two years, insurers generated a 16 percent operating margin in 2017, resulting in some insurers (such as Blue Cross) having to pay large consumer rebates for having achieved an excessively low medical loss ratio.<sup>64</sup> And, in initial rate filings for 2019, all five Minnesota insurers are proposing rate *decreases*, ranging from 3-12 percent.<sup>65</sup> Similarly, in Alaska, the Blue Cross plan decreased its 2018 rates -22 percent, despite the large cost-increasing federal changes discussed below. Plus, for 2017, it voluntarily returned \$25 million to the state’s reinsurance fund because its claims that year were “lower than anyone expected.”<sup>66</sup>

## B. Pricing for Uncertainty

Despite most insurers achieving profitability by 2017, steep price increases continued into 2018 for several reasons. One was insurers’ ordinary actuarial uncertainty over the extent to which their 2017 pricing had in fact achieved profitability. Rates for 2018 needed to be filed by mid-2017, to give time for review and revision prior to open enrollment in November. At that point in the year, however, insurers did not yet have a full picture of how accurate their prior year’s pricing was because claims tend to be higher in the fourth quarter once more patients have met their deductibles.

Moreover, in states with several competing insurers, sources explained that insurers face actuarial uncertainty each year about whether their risk pool will change substantially from the previous year, due to an inherent “volatility” in enrollment. This volatility is caused in part by the ACA’s subsidy structure, which is set to the second-lowest priced Silver plan. As competing insurers adjust their prices, the reference plan can change each year, causing highly price-sensitive subscribers to seek out cheaper options. A Texas actuary explained that this structure leads to “fierce price-cutting” as insurers attempt to gain, maintain, or regain market share each year. Not only can large numbers of subscribers change

<sup>64</sup> Christopher Snowbeck, Positive Blue Cross Results Trigger Rebates to Consumers: It is Legally Required to Return about \$30 Million of its 2017 Profit to Subscribers, StarTribune, April 9, 2018. The medical loss ratio is the percentage of premiums paid out in claims and quality improvement expenses. The ACA requires insurers to rebate to consumers any amount by which their premiums create less than an 80 percent loss ratio.

<sup>65</sup> Minnesota Commerce Department, Insurers’ 2019 Proposed Health Insurance Rates (June 2019), <https://mn.gov/commerce/consumers/your-insurance/health-insurance/rates/rate-filings/2019/#1>

<sup>66</sup> Naomi Klouda, Lower Claim Costs Lead to Large Reimbursement, Alaska J. Commerce, Dec. 4, 2017.

plans each year, but insurers that underpriced in the previous year will need steep increases the following year to avoid large losses, causing many of their new enrollees to switch again. This pricing dynamic can cause a “lot of churn” in enrollment, as much as 40 percent turnover (according to the Texas actuary), which “is terribly unsettling” to actuaries because they lack data to estimate the claims for their new pool of enrollees. Not knowing for sure, actuaries tend to price more conservatively, meaning with an additional rate cushion.

One insurance regulator noted that the extent of pricing uncertainty is indicated by how much insurers overestimate their risk adjustment payments each year. Risk adjustment is an element of the ACA that requires insurers that receive lower-cost subscribers to compensate those that enroll higher-cost subscribers – a factor that insurers take into account each year in setting their rates. In theory, estimated total risk adjustments should approach a net of zero across the market, but in practice most insurers conservatively predict that they will incur a risk adjustment liability rather than a credit. Thus, for 2018, Texas insurers overestimated their aggregate risk adjustment liability by \$646 million, which amounts to an extra \$58 per member per month being added to their rates.

In theory this risk adjustment rating factor is not necessarily detrimental since, if it ends up being excessive, insurers will either owe a consumer rebate, or will, at least in theory, modulate their rate increase the following year. What is notable, though, is that, that the excess rating for risk adjustment in Texas has not decreased each year, as should happen if insurers gained more confidence in their actuarial experience; instead, the excess has more than doubled from its 2016 level. Similarly, in Maine, an analyst explained that the “black box” of risk adjustment makes accurate pricing *more* rather than *less* difficult, explaining that risk adjustment can help “if you have relatively stable populations,” but with large swings and the inherent time lag in receiving accurate data, it is hard to know how to price for risk adjustment liability.

For these reasons, until year-to-year changes in pricing and market participation become more stable, some observers felt that insurers will continue to price “conservatively,” meaning that they will add an extra cushion on top of the trend in expected medical expenses. Some subjects contrasted this element of instability in the ACA market with the much more stable enrollment patterns under Medicare, where people remain enrolled for the duration of their life and make enrollment changes infrequently.

### C. Political Uncertainty

Although several subjects discussed these aspects of *actuarial* uncertainty, the type of uncertainty they mentioned much more frequently was the *political* uncertainty that burst on the scene in 2017. Section III.C discusses the effect of this uncertainty on insurers’ decisions to enter or leave the market. For insurers that remain in the market, political uncertainty also affects their pricing decisions. For 2018, we heard that political uncertainty following the 2017 elections affected pricing decisions much more strongly than did actuarial uncertainty.

More specifics from our study states are included in other sections that address specific elements of emerging federal policy (ceasing cost-sharing payments, repeal of the individual mandate penalty, expanding non-compliant plans). Nationally, additional examples have been collected from insurers in other states.<sup>67</sup> The Blue Cross plan in Tennessee, for example, explained that, in deciding to re-enter a part of the state it previously had exited, it had to increase 2018 rates more than expected, because, “[g]iven the potential negative effects of federal legislative and/or regulatory changes, we believe it will be necessary to price-in those downside risks, even at the prospect of a higher-than-average margin for the short term, or until stability can be achieved.”<sup>68</sup> And, Tennessee’s Commissioner of Insurance

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<sup>67</sup> See Center for Budget and Policy Priorities, Sabotage and Uncertainty Jeopardizing ACA Marketplaces, Insurers and Regulators Confirm (2017), <https://www.cbpp.org/sites/default/files/atoms/files/5-12-17quotes.pdf>; Congressional Democratic Staff Report, A Manufactured Crisis: Trump Administration and Republican Sabotage of the Health Care System (June 2017), <https://democrats-energycommerce.house.gov>.

<sup>68</sup> Blue Cross Blue Shield of Tennessee, Letter to Commissioner Julie McPeak, May 9, 2017, [https://cdn1.vox-cdn.com/uploads/chorus\\_asset/file/8487845/JDH\\_Letter\\_CommMcPeak\\_FV.o.pdf](https://cdn1.vox-cdn.com/uploads/chorus_asset/file/8487845/JDH_Letter_CommMcPeak_FV.o.pdf).

commented that, “until the insurers know the rules of the road, it’s that instability, that uncertainty, the insurers hate the most. They are going to price for that.”<sup>69</sup>

Overall, one national observer (Charles Gaba) calculated that, for 2018, the Trump administration’s “sabotage” of the ACA accounted for over half (17 percentage points) of the overall average rate increase of 28 percent.<sup>70</sup> According to his credible calculation, regulatory uncertainty and change accounted for 50 percent more of insurers’ rate increases than did the increase in underlying medical costs. For 2019, this analyst predicts that insurers will continue to add an additional margin to their rates to account for political and regulatory uncertainty, especially since they learned the hard way from the past year’s experience that they may not find out the full extent of regulatory change until their 2019 rates are already filed.

The American Academy of Actuaries also stresses the timing difficulty that regulatory change presents.<sup>71</sup> Even if insurers know the full extent of regulatory change in advance, it takes over a year to have sufficient real-world data to gauge the actual effects of changes in a complex market environment. Coupled with the fact that rates need to be filed about six months in advance and cannot be changed for a year once they take effect, this means that a full two years is usually needed to correctly adjust prices for regulatory change. Thus, if significant change occurs regularly, insurers will struggle to ever achieve a stable and predictable pricing pattern. As an Ohio insurer explained, the specifics of any particular regulatory change are often not as important as simply the uncertainty created by ongoing regulatory change, stating that “not knowing what to expect” is the bigger problem for “an industry that likes certainty.”

### D. Hope for the Future

Obviously, continuing rate increases are not sustainable at the levels experienced the past couple of years, so many subjects saw the recent pattern as an ominous sign of the market’s instability. Others, however, felt more optimistic because pricing in the individual market has, for the most part, reached a sustainable level and therefore, absent additional adverse regulatory changes, future increases should be moderated, more or less in line with the trend in medical costs. According to a Maine insurer, “If you put the whole market together, I don’t think the whole market was terrible before the uncertainty and federal changes [in 2017]. There was not a tremendous amount of underfunding [going into 2018] so we should have been pricing for trend at that point.”

Even better than leveling out, the Minnesota Council of Health Plans reported that average medical costs actually declined 15 percent overall in the 2017 individual market.<sup>72</sup> Elsewhere, a good number of insurers and analysts thought that “the worst may be over,” as one Colorado source put it. In Texas, for instance, several informants thought that the exchange market “is settling down” because insurers have been able to increase rates enough now to catch up with initial adverse selection: “It used to be stressful, but now we’re used to it. ... It’s steady. ... The [initial] risk pool [proved to be] expensive, but [it’s] work[ing] okay” now. Nationally, S&P Global recently predicted relative calm:

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<sup>69</sup> Holly Fletcher, Tennessee’s Insurance Chief Seeks Elusive Answers in Washington, *The Tennessean*, May 12, 2017, <https://www.tennessean.com/story/money/industries/health-care/2017/05/12/tennessees-insurance-chief-seeks-elusive-answers-washington/315186001/>.

<sup>70</sup> Charles Gaba, How Much More are YOU Paying this Year Due to #ACA Sabotage? (April 2018), [http://acasignups.net/sites/default/files/styles/inline\\_default/public/2018\\_sabotage\\_effect04.jpg?itok=nJNTvnGF](http://acasignups.net/sites/default/files/styles/inline_default/public/2018_sabotage_effect04.jpg?itok=nJNTvnGF). See also Charles Gaba, 2018 Rate Hikes, <http://acasignups.net/2018-rate-hikes>

<sup>71</sup> American Academy of Actuaries, Comments on Executive Order to Departments of Labor, Treasury, and Health and Human Services (Nov. 2, 2017), [https://www.actuary.org/files/publications/Executive\\_Order\\_Academy\\_Comments\\_110717.pdf](https://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf). See also note 51.

<sup>72</sup> Medical Bills up 3 Percent per Person in 2017 (April 2018), <https://mnhealthplans.org/wp-content/uploads/2018/04/2018.04.03-Council-Financials-News-Release-2018v3.pdf>



We expect another round of premium price increases in 2019 that would include adjustments for the mandate repeal, updated regulations around short-term and association health plans, and continuous product tweaks based on the growing experience in this market. Beyond 2019, if insurers can get to a consistent, stable footing, and assuming no major regulatory changes, we expect annual premium rate increases to not cause sticker shock each year for the nonsubsidized ACA individual market enrollees.<sup>73</sup>

These statements were made, however, prior to the most recent (mid-2018) set of federal regulatory changes that greatly expand the ability to purchase non-complying plans outside of the ACA market. Also, the federal government has given very recent indications that it may suspend the ACA's risk adjustment program.<sup>74</sup> Thus, although insurers in a number of states have initially requested only single-digit rate increases for 2019,<sup>75</sup> on-going developments can cause insurers to increase their rate requests.

### E. Cost-Sharing Reduction (CSR) Payments

As has been much discussed, the Trump administration decided in mid-October last year, after an extended period of mixed signals, to cease paying insurers for the cost-sharing reductions (CSRs) required by the ACA because the ACA failed to fully authorize these payments and therefore the government maintained that legal authority was lacking to continue them. Subsequent efforts to restore the payments failed in Congress.

Cost-sharing reduction under the ACA refers to the provision that allows lower-income people to purchase essentially the equivalent of Gold or even Platinum coverage, for the price of a Silver plan. This is done by requiring insurers to reduce subscribers' out-of-pocket costs (in the form of deductibles and copayments) for subscribers below 250 percent of the poverty level, and even more so for those below 200 percent of poverty. Prior to the Trump administration's October 2017 change in policy, the federal government had reimbursed insurers for this reduced cost-sharing, even though Congress refused to appropriate funds for this purpose. When the federal government stopped making these payments, however, this did not excuse insurers from the ACA's requirement of continuing to reduce cost-sharing. This mismatch between insurers' obligations and federal payments meant that insurers simply had to absorb the sudden loss of over \$1 billion for the last quarter of 2017.<sup>76</sup> For 2018, however, insurers were able to increase their rates to account for the loss of CSR payments. Indeed, this CSR rating component appears (from multiple sources) to be the single largest driver of insurers' 27 percent average rate increase for 2018.<sup>77</sup>

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<sup>73</sup> S&P Global, Are U.S. Health Insurers Finally Getting to Stable Ground in the ACA Individual Market? (Jan. 2018), [https://www.capitaliq.com/CIODotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&ns1\\_code=LIME&sourceObjectId=10392499](https://www.capitaliq.com/CIODotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&ns1_code=LIME&sourceObjectId=10392499)

<sup>74</sup> Stephanie Armour and Anna Wilde Mathews, Trump Administration Expected to Suspend ACA Program Related to Insurer Payments: Companies Could Take Financial Hit From Freezing of Risk-Adjustment Payouts, Wall St. J., July 6, 2018.

<sup>75</sup> Charles Gaba, 2019 Rate Hikes, <http://acasignups.net/rate-hikes/2019>

<sup>76</sup> National Association of Insurance Commissioners, Oct. 10, 2017, [http://www.naic.org/newsroom\\_statement\\_171013\\_csr\\_funding.htm](http://www.naic.org/newsroom_statement_171013_csr_funding.htm). For instance, in Maine, ceasing CSR payments prevented one of the last surviving insurance co-ops created by the ACA from breaking even for the first time. Like the other co-ops nationally, the one in Maine struggled financially from the outset, to the extent that it almost went bankrupt, but it managed to survive tumultuous swings in enrollment through 2015 and 2016. Following a 25% rate increase for 2017, this co-op was projecting that they would break even for the first time by the end of 2017, until the Trump administration's cancellation of CSR payments for the final quarter, which will cause the co-op another year of significant losses.

<sup>77</sup> Note 70; Rabah Kamal, et al., How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums (Kaiser Family Foundation, Oct. 2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>.

Importantly, however, in most states, the bulk of this CSR increase was not spread across the market as a whole. Instead, most states either allowed, or required, insurers to load most<sup>78</sup> or all of the rate impact only on silver plans sold through the exchanges.<sup>79</sup> Various market participants praised this strategy as “really, really smart,” a “wise move that should be heralded,” because it produced two key effects that greatly, or entirely, mitigated adverse consequences for most subscribers. First, in states where none of the CSR increase was loaded on plans outside the exchange, unsubsidized subscribers were held largely harmless by the CSR-related increases.<sup>80</sup> Thus, as shown in Table 4, in most study states<sup>81</sup> increases in Gold plan premiums, which approximate increases outside the exchanges, were substantially less than increases for on-exchange Silver plans. But, this was not the case in Colorado, which did not permit the Silver-loading strategy due to uncertainty over whether federal regulators would allow the strategy.<sup>82</sup> Now that the strategy is permitted, Colorado officials intend to allow Silver-only CSR rating for 2019.

The second benefit for subscribers of loading CSR increases only on Silver plans was to substantially increase the subsidies that most exchange subscribers receive. Thus, CMS reported that plan selections by people who received a subsidy cost an average of 18 percent *less* than in 2018 than in 2017,<sup>83</sup> whereas premiums for unsubsidized subscribers on the federal exchanges increased 30 percent. This occurred because the second lowest Silver plan in each market determines the amount of subsidy, which sheltered most exchange subscribers from the bulk of the increase. More than this, non-Silver plans became even *more* affordable for subsidized subscribers because Silver-only loading increased Silver rates substantially more than rates for Bronze or Gold plans. Accordingly, average subsidies increased substantially more than did premiums (39% compared to 27%).<sup>84</sup> The increased subsidies were dramatic enough that lower-income subscribers in many states had the option of zero-premium (i.e., free) Bronze plans, or Gold plans that cost little or no more than Silver plans.<sup>85</sup>

Market participants across our states remarked on how beneficial the Silver-loading strategy proved to be, stating that this imaginative approach “did the market a favor” and was “a major contributor to stability.” The Blue Cross plan in Florida explained that, “because of the way our state is lined up [with

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<sup>78</sup> Several insurers noted that, even with the full amount of lost CSR payments loaded only on silver plans, this distortion in relative prices can have an unpredictable “risk dynamic” that affects enrollment in other plan types, and so some insurers felt that they needed to cushion their other rates as well, to some extent. See Karan Rustagi, et al., *Impact of CSR De-funding on Market Stability* (Wakely, Aug. 2017). This is further illustration of the point noted above that the uncertainty created by regulatory change can add to rate increases beyond merely the immediate revenue effects.

<sup>79</sup> Rabah Kamal, et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums* (Kaiser Family Found., Oct. 2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>; Sabrina Corlette, et al., *States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments* (Commonwealth Fund, Oct. 2017), <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>. In some states, insurers had to or chose to load their rate increases on Silver plans both on and off the exchange.

<sup>80</sup> They were, however, negatively affected by market-wide rate increases resulting from other changes in regulatory policy, such as nonenforcement of the individual mandate, and increased availability of underwritten plans that do not comply with ACA standards.

<sup>81</sup> Arizona was an exception because, for reasons noted above, insurers there did not increase *any* of their rates substantially.

<sup>82</sup> This pattern in our study states is consistent with the following national pattern. In states where the CSR load was spread across all plans, rates for both Silver and other plan types increased roughly 10-15 percent, whereas in states that used Silver-only loading, Silver plan rates increased 15-30 percent or more. Rabah Kamal, et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums* (Kaiser Family Foundation, Oct. 2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>.

<sup>83</sup> CMS, News Release, April 3, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-03.html>.

<sup>84</sup> CMS, *Early 2018 Effectuated Enrollment Snapshot*, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>.

<sup>85</sup> Explaining and reviewing all of this, see sources cited in note 88, and Greg Fann, *The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode* (Axene Health Partners, 2017), <https://axenehp.com/cost-sharing-reduction-paradox-defunding-help-aca-markets-not-make-implode/>.

Silver-loading], I really don't need a cost share reduction [payment] to return to the market in Florida.”<sup>86</sup> An experienced broker in Maine thought that keeping Bronze plan rate increases low was critical to “keeping people in the market and getting others to [join].” And an insurer said:

I was wrong [about the expected negative impact of eliminating CSR payments] and glad to be wrong. People started talking about the silver loading early and it made all the difference. You ended up with free bronze plans and gold plans costing the same as silver. It increased the costs to the federal government, but people weren't too harmed. Now people would be hurt if you restarted the payments.

This acceptance of a regulatory change that was once thought to auger doom for the market, is a surprising turn of events. The ACA's unique subsidy structure, coupled with either proactive or agnostic state regulators, yielded a rating strategy that left most subscribers no worse off, and many better off.<sup>87</sup> Accordingly, not only are many or most insurers willing to live with this aspect of the status quo, some leading consumer advocates actively oppose restarting CSR payments, at least without funding additional subsidies. The Center on Budget and Policy Priorities, for instance, writes that, “thanks in large part to state regulators' timely intervention — the market adjusted to the loss of CSRs more quickly and smoothly than most experts anticipated. . . . Now that the market has adjusted to the loss of CSRs, restoring these payments — without compensating improvements in subsidies — would have significant adverse effects for consumers”<sup>88</sup> by reducing subsidies to their previous levels.

Thus, as one independent actuary has argued, it appears that the substantial legal, political, and public policy controversy over non-payment of cost-sharing subsidies has turned out to be mostly just a distraction from more fundamental structural issues that affect market stability:

If the rules and policies are known ahead of time, the lack of reimbursement for CSR payments itself does not harm the market. It actually improves it by increasing premium subsidies to [subsidy] eligible enrollees. . . . Neither a decision to fund or defund CSRs will stabilize the exchanges, but either determination will allow us to return our focus to addressing the structural issues that plague the individual market.<sup>89</sup>

Nevertheless, uncertainty over what the Trump administration and Congress would do, and when they would do it, created a great deal of consternation during the rate-setting process for 2018. Now that those decisions have been made, the major lasting harm is the lingering political uncertainty this turn of events created for insurers and consumers about what other aspects of the ACA might be changed or undermined.

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<sup>86</sup> What's Ahead for the Individual Health Insurance Market? (Brookings, March 2018), [https://www.brookings.edu/wp-content/uploads/2018/03/es\\_20180306\\_health\\_market\\_transcript.pdf](https://www.brookings.edu/wp-content/uploads/2018/03/es_20180306_health_market_transcript.pdf).

<sup>87</sup> The primary disadvantage was for Silver-plan subscribers not receiving a substantial subsidy. To avoid a significantly greater price increase (than they otherwise would face), they either had to switch to a different plan type, or purchase their Silver plan off the exchange. Thus, some knowledge and effort were required for them to avoid the extra costs of Silver-loading. Also, moving off exchange can be disadvantageous for someone whose income drops midyear because then they cannot switch to a subsidized plan mid-year. See Louise Norris, The ACA's Cost-Sharing Subsidies (June 2018), <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/#states>.

<sup>88</sup> Individual Market Stabilization Proposals Should Avoid Raising Costs for Consumers (March 2018), <https://www.cbpp.org/sites/default/files/atoms/files/3-9-18health.pdf>. See also, Families USA agrees: Stan Dorn, Under the Guise of “Health Insurance Stabilization,” Congress Should Not Axe Financial Help for Low-Wage Families (March 2018), <https://www.printfriendly.com/p/g/RHWncK>.

<sup>89</sup> Greg Fann, The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode (Axene Health Partners, 2017), <https://axenehp.com/cost-sharing-reduction-paradox-defunding-help-aca-markets-not-make-implode/>.



## V. Individual Mandate

Starting in 2019, the IRS will no longer impose a tax penalty on people who fail to enroll in ACA-compliant affordable coverage.<sup>90</sup> But, even prior to then, many observers noted the widespread impression that the Trump administration was greatly reducing enforcement of the individual mandate – to the extent that, in the minds of some, the mandate is already “effectively gone.” In one national survey, only 59 percent of people lacking insurance knew that the mandate was still in effect at the start of open enrollment for 2018.<sup>91</sup> Observers in several study states noted more generally the level of “complete confusion” among consumers about the status of the ACA, resulting from the “misinformation and confusion coming out of Washington.”

Due in part to this underlying confusion, most informed observers felt that repeal of the mandate penalty would have only a moderate impact, but views differed to some extent, and some views were not consistent with existing evidence. Among those who have expressed more concern, the American Academy of Actuaries warned, prior to the repeal, that if the mandate were eliminated, “insurers would likely reconsider their future participation in the market,” due mainly to uncertainty about the resulting market conditions, which “could lead to severe market disruption and loss of coverage among individual market enrollees.”<sup>92</sup> One national analysis estimated that mandate repeal, along with greatly reduced funding for marketing and outreach during shortened open enrollment, will reduce the size of the ACA-compliant individual market by more than 25 percent on average, and by as much as 40 percent in nine states.<sup>93</sup>

In our study states, a number of insurers pointed to impending repeal of the mandate, or uncertainty over its current enforcement, as contributing substantially to their large rate increases for 2018. For instance, one Texas insurer attributed 15 percent points of its rate increase to “non-enforcement of the mandate and reduced advertising and outreach,” as did the largest insurer in Maine. Another Texas source thought that the mandate’s repeal “will spin everything out of control. We will probably have to have a [high] risk pool. All the rates will go through the roof.”

The great majority of informed subjects, however, thought that the mandate’s repeal would (as expressed by another Texas source) have only a “modest effect” on market prices or enrollment. This subdued effect was attributed to two main factors. First, most observers thought that the mandate was relatively weak, in comparison with the actual cost of insurance, and thus was only a small motivation to purchase insurance. As an experienced broker in a high-cost state put it, “I heard pretty routinely of people who just basically said screw it, I’m going to pay the tax penalty because [that] was less money than trying to pay for coverage.” An insurer in the same state concurred:

because our premiums were so high, we felt that the individual mandate probably wasn't going to have that big of an impact on us. That people that wanted insurance and could possibly afford it, with or without subsidies, were going for it. And those that couldn't afford it, they couldn't afford it anyway. So the individual mandate being effective or not, the penalty of the individual mandate, it wasn't going to make them make a decision. They'd already made it.

<sup>90</sup> Technically, the ACA’s requirement to enroll in affordable insurance remains on the books, but Congress repealed any tax penalty consequence for not doing so. Thus, there is general agreement that the individual mandate has been effectively repealed.

<sup>91</sup> Kaiser Health Tracking Poll (Oct. 2017), <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-october-2017-experiences-of-the-non-group-marketplace-enrollees/>.

<sup>92</sup> Potential Adverse Consequences of Eliminating the Affordable Care Act’s Individual Mandate (Nov. 21, 2017), [http://www.actuary.org/files/publications/Letter\\_to\\_Senate\\_Tax\\_Reform\\_Individual\\_Mandate\\_11.21.17.pdf](http://www.actuary.org/files/publications/Letter_to_Senate_Tax_Reform_Individual_Mandate_11.21.17.pdf).

<sup>93</sup> Linda J. Blumberg, et al., The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending (Urban Institute, March 14, 2018), [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf).

Also, more people were falling outside the mandate simply because insurance had become so expensive that it no longer met the mandate's affordability criterion.

Adding to the mandate's basic weakness, several observers noted the ease with which noncomplying people could avoid the penalty, through hardship exemptions. A source in Maine, for instance, spoke to the mandate's limited effectiveness:

The mandate is important. But it's unclear how effective loss of the mandate will be. I suspect it's not as bad as people think because it wasn't really a particularly effective mandate. Some people definitely figured out their way around it. It's not really enforceable as it is now, so people can buy in and out. . . . The size of the penalty was getting to be significant, but the exemptions were broad so too many people were able to get out of the mandate.

Similarly, Milliman (a large actuarial firm) summarized that "the enforcement of these penalties has not been strict enough to fully achieve the mandate's policy aims,"<sup>94</sup> as did a Stanford health policy expert, who said that "the ACA's statutory exceptions from the individual mandate, as well as weak enforcement of the mandate by the Obama Administration, have made it far less effective than the architects of the law hoped."<sup>95</sup>

The second reason given for the mandate's repeal having a subdued impact is the fact that a majority of ACA subscribers receive substantial subsidies, which is seen as bolstering the market even in the absence of a mandate. The Obama administration took pains to market ACA coverage from a carrot rather than a stick perspective, meaning that the affordability of subsidized insurance was stressed, rather than the penalty for not enrolling. "People need and want insurance," a Maine health policy expert said, so what is important is making it affordable, rather than punishing those who opt out, and the ACA's subsidy structure makes insurance a "great deal" for many subscribers.

Many observers noted that affordability was enhanced for 2018 in particular by the fact that many more people were able to enroll in \$0 premium Bronze plans, meaning that the insurance was totally free. Also, Gold coverage, which previously was a lot more expensive, became much more affordable. This occurred because of how insurers changed their prices for Silver plans to account for the Trump administration's cancellation of cost sharing payments. As discussed in section IV.E, because cost sharing reductions (CSRs) are available only under Silver plans, most insurers loaded their entire CSR rate increase only on their Silver plans, which also serve as the benchmark used to determine the size of premium subsidies. Thus, disproportionately increasing rates for Silver plans made other metal levels even more affordable to subscribers who receive a subsidy.

For unsubsidized subscribers, however, there is some national evidence indicating that the individual mandate was effective in encouraging roughly a million people who were not eligible for subsidies to purchase individual coverage.<sup>96</sup> Extending those data to partially subsidized subscribers, one analyst estimated that the individual mandate induced roughly 8 million people to purchase coverage.<sup>97</sup> Other analysts, however, believe that some estimates of the impact of mandate repeal (e.g., the CBO's) are excessive because "it is not the mandate penalty, but the intrinsic financial incentives available to most eligible enrollees that drive enrollment."<sup>98</sup>

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<sup>94</sup> Fritz Busch, Paul R. Houchens, The Individual Mandate Repeal: Will It Matter? (Milliman, March 2018), <http://www.milliman.com/insight/2018/The-individual-mandate-repeal-Will-it-matter/>.

<sup>95</sup> How Will the Tax Bill Impact Health Care? 5 Experts Weigh In, PBS News Hour, Dec. 14, 2017, <https://www.pbs.org/newshour/economy/making-sense/how-will-the-tax-bill-impact-health-care-policy-5-experts-weigh-in> (quoting Lanhee Chen).

<sup>96</sup> Matthew Fiedler, How Did the ACA's Individual Mandate Affect Insurance Coverage? Evidence from Coverage Decisions by Higher-Income People (Brookings, May 2018), <https://www.brookings.edu/wp-content/uploads/2018/05/coverageeffectsofmandate2018.pdf>.

<sup>97</sup> Ibid.

<sup>98</sup> Quoting an S&P Global analysis, <http://acasignups.net/17/11/28/sorry-gop-you-cant-have-it-both-ways>.

Sources in Maine noted that, prior to the ACA, their state had guaranteed issue and community rating rules similar to the ACA's, but without any mandate or subsidies, their market suffered a great deal as a result ("virtual death spiral"). Under the ACA, sources noted that Maine's individual market is much improved, growing rapidly to almost three times its prior size. These sources believed, however, that it was the ACA's subsidies, rather than the mandate, that caused enrollment to swell. Therefore, they thought the mandate's repeal is highly unlikely to return the market to the state it was in previously.

An Alaskan actuary summarized this full range of views:

I think there's a lot of differences of opinion about [the mandate's repeal]. I think if you had to say what is the consensus of all those opinions is that it's damaging, but it's probably not as severe as what would have initially been thought. It will have some upward pressure on premiums, but how much, that's a big question. I think . . . it will have some impact, but it won't necessarily have as much as what people originally thought it would

Validating these impressions, a wide variety of respected actuaries and analysts have concluded that repeal of the mandate is likely to affect ACA premiums no more than about 10 percent, and possibly less.<sup>99</sup> As a Texas insurer quipped, "in the ACA world, that is a small increase." A Colorado source noted that the rate impact in that state might be somewhat higher than the projected national average because fewer subscribers in that state receive premium subsidies. However, In Colorado and elsewhere, multiple sources noted that much of that impact has already been felt in the premium increases for 2018, when insurers began to doubt that the Trump administration would actively enforce the mandate penalty, even if it remained on the books.

Accordingly, most insurers and analysts we interviewed thought that rates would be affected only about 5 percent or less when the repeal of the mandate penalty goes into effect for 2019 and that this increase will be limited to a one-time correction.<sup>100</sup> Some sources, such as one Minnesota health policy expert, thought that there will be virtually no future effect, stating that "people think it's gone already. I don't know that we'll see any greater effect than we already have seen." No source thought that the mandate's repeal by itself would cause many, or any, insurers to leave or avoid the market. At most, one source thought, if an insurer were "on the fence already, this could be the straw that breaks camel's back," but that will not be the case for most insurers who have remained in the market through everything else that has happened.<sup>101</sup> The fundamental structure of the ACA's subsidies, which shelter the majority of subscribers from substantial rate increases, will allow the market to reach a stable equilibrium once insurers price for the changed mandate rule, in the view of most actuaries.

That view holds, however, as long as other major regulatory changes are not made. Of concern, then, are a set of additional changes underway, which the following section addresses. An Ohio insurer noted

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<sup>99</sup> PWC, Impact of Individual Mandate Penalty Elimination and Other Market Factors on Coverage Nationally and in California (May 2018), <http://board.coveredca.com/meetings/2018/05-17/PWC%20Slide%20Deck%20-%20pdf.pdf>; Linda J. Blumberg, et al., The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending (Urban Institute, March 14, 2018), [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf); <http://acasignups.net/17/11/28/sorry-gop-you-cant-have-it-both-ways>.

<sup>100</sup> Confirming this impression, a recent survey of two dozen insurers reports that, on average, 5 percent points of their 2019 rate increases will be based on ceasing the individual mandate penalty. Beth Fritchen & Kurt Giesa, The Affordable Care Act's Stabilization (Oliver Wyman, June 2018), [http://health.oliverwyman.com/transform-care/2018/06/aca\\_survey.html](http://health.oliverwyman.com/transform-care/2018/06/aca_survey.html).

<sup>101</sup> In agreement, see also S&P Global, Are U.S. Health Insurers Finally Getting to Stable Ground in The ACA Individual Market? (Jan. 2018), [https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsl\\_code=LIME&sourceObjectId=10392499](https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsl_code=LIME&sourceObjectId=10392499), which says:

In 2019, we expect one more episode of "should we stay or should we go" debate for some insurers, concerning their participation in the ACA individual market. The mandate repeal will give some insurers pause and could lead to a few exits. But we don't expect mass exits from this market in 2019. Most of those that maintained their presence in this marketplace would likely adjust as the market moves from a weak mandate to a non-existent mandate. At the same time, we don't expect a meaningful number of new entrants to this market in the near term.

that general uncertainty over the ACA's future and its other regulatory provisions is a greater concern than eliminating the mandate, a sentiment echoed by a Minnesota state official, who said the mandate's repeal is "the least of our problems," pointing instead to the anticipated growth in non-complying ACA plans.

Thus, although repeal of the mandate on its own is not expected to be as damaging as many people feared, the market could suffer significantly in combination with other deregulatory measures. Stated another way, the fact the ACA's "weak mandate" had only modest effect does not necessarily lead to the conclusion that repealing the mandate is the right move. None of our study states is actively considering reinstating the mandate or replacing it with another measure. However, a few non-study states have considered or recently adopted a state-based mandate,<sup>102</sup> and several of our interview subjects thought that a strengthened enrollment incentive in some form could improve the market. In addition, it was noted that even a modest increase in overall enrollment could meaningfully reduce the number of uninsured.

A few subjects pointed to enrollment incentives under Medicare Part B as a possible model. Under Medicare, Part B premiums (which cover outpatient services) increase each month that a beneficiary delays enrollment past their initial eligibility date – a penalty to which the elderly appear highly attuned. However others thought that the elderly are uniquely motivated to obtain coverage, especially when a singular enrollment decision affects premiums for the remainder of their life. Therefore, it is difficult to draw conclusions about what alternatives to the individual mandate might be effective for the ACA's market.

## VI. Reinsurance

Across the political and public policy spectrum, government-funded reinsurance is widely touted as a promising approach to stabilizing the individual market.<sup>103</sup> For instance government reinsurance is an ongoing feature of Medicare's private insurance structure for Part D drug coverage.<sup>104</sup> The ACA had a transitional reinsurance program that, for three years, reimbursed insurers for much of their claims costs for subscribers who incurred costs above a threshold (initially, \$45,000 but raised to \$90,000).<sup>105</sup> That program was designed to help stabilize the individual market until insurers became accustomed to the new market rules and conditions.<sup>106</sup> It was funded by a fee assessed on all health insurance, including large insured and self-insured groups.

By design, the ACA's reinsurance program phased out after 2016,<sup>107</sup> which contributed to the large premium increases for 2017 (noted above). The three-year phase-out was premised on the expectation that the market would stabilize over that time period, but in reality insurers did not have fully credible actuarial data in hand for setting their premiums until the ACA's third year, and the market's dynamics

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<sup>102</sup> Dania Palanker, et al., State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers (Commonwealth Fund, June 2018), <https://www.commonwealthfund.org/blog/2018/state-efforts-pass-individual-mandate-requirements-aim-stabilize-markets-and-protect>.

<sup>103</sup> See sources cited in note 162.

<sup>104</sup> MedPAC, Sharing risk in Medicare Part D (June 2015), <http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-pdf>.

<sup>105</sup> 'Reinsurance' Program Critical to Shoring up the ACA (Harvard School of Public Health, Aug. 2017), <https://www.hsph.harvard.edu/news/features/reinsurance-aca/>.

<sup>106</sup> Mark A. Hall, The Three Types of Reinsurance Created by Federal Health Reform, Health Aff. 29(6): 1168-1172 (2010), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0430>.

<sup>107</sup> However, a much smaller version of reinsurance, covering "only a handful" of people, has been reinstated as part of the ACA's risk adjustment program, covering 60% of claims that exceed \$1 million for any one person. Erin Trish, Why Risk Adjustment is a Crucial Component of Individual Market Reform (Brookings, Jan. 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/01/25/why-risk-adjustment-is-a-crucial-component-of-individual-market-reform/>.

(such as insurers exiting at the last minute) continued to create challenging pricing conditions. Although some critics continue to characterize reinsurance as little more than an insurer “bail out,”<sup>108</sup> the more prevalent view is that reinsurance helped the market during the ACA’s first three years. Therefore, a wide range of analysts and policymakers propose reinstating reinsurance in some form (either similar to the ACA’s approach or using an alternative approach), as a way to help improve the market.<sup>109</sup>

Noting that reinsurance is a permanent feature of Medicare Part D’s prescription drug coverage, advocates reason that the ACA’s insurance market has an even greater need for an ongoing stabilization program due to much greater turnover in enrollment than with Medicare recipients (who remain on the program for life), and due to the greater volatility in ACA plan selection. Interview subjects noted that, although the ACA’s subsidies may have resulted in a relatively stable number of enrollees overall, the level of turnover among plans is such that as much as 40 percent of a given insurer’s enrollment can be new each year, which is “terribly unsettling” to actuaries, making it very difficult to establish accurate pricing each year. The ACA’s permanent risk adjustment program is meant to buffer some uncertainty, but it is viewed as not fully compensating for extremely high-cost enrollees.<sup>110</sup>

By sheltering insurers from the highest-cost subscribers, reinsurance makes premiums more predictable and thus removes some of the uncertainty from pricing decisions. That greater certainty helps insurers to price less conservatively (that is, with less of an extra cushion), and it can encourage them to enter or remain in geographic areas where they lack actuarial confidence. The latter feature might be especially helpful in ensuring coverage of thinly populated areas, where just one or two very expensive patients could cause large losses.<sup>111</sup>

More than just reducing uncertainty, government-sponsored reinsurance simply reduces the total costs that market premiums need to cover, by tapping into funding outside the individual market. Because reinsurance lowers premiums across the market, it offers at least some help to those who earn too much to receive an ACA subsidy and thus who face the subsidy “cliff.” As one insurance source in Texas put it, reinsurance, by benefiting everyone, is “a dream” because drawing from outside funding and mitigating market uncertainty helps to lower rates both on and off of the subsidized exchange.

Several of the recent Congressional proposals to “repeal and replace” the ACA contained funding for reinstating some form of reinsurance, but none were enacted. States, however, can consider instituting reinsurance, partially supported by federal funds, through what are called “section 1332 waivers.” This refers to the ACA provision that allows states to allocate their anticipated ACA funding in different ways that achieve the statute’s basic goals, as long as doing so does not increase federal costs. If a state-supported reinsurance program reduces ACA premiums and thus premium subsidies, the program can free up federal funds that, when redirected into the reinsurance program, can further reduce premiums and their subsidies. This “virtuous cycle” gives a moderate “multiplier effect” to any state-based contribution.<sup>112</sup>

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<sup>108</sup> Michael Cannon, Failed ACA Reinsurance Program Shows: Government Subsidies Don’t Reduce Premiums (Cato Institute, March 2018), <https://www.cato.org/blog/obamacares-failed-reinsurance-program-shows-government-subsidies-do-not-reduce-premiums>.

<sup>109</sup> See sources cited in note 162.

<sup>110</sup> For more explanation, see sources in notes 107 and 111.

<sup>111</sup> Kevin Lucia, et al., Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018 (Urban Institute, Nov. 2017), [https://www.urban.org/sites/default/files/publication/94571/2001591\\_bare\\_county\\_brief\\_1.pdf](https://www.urban.org/sites/default/files/publication/94571/2001591_bare_county_brief_1.pdf). As this report explains, the ACA’s permanent risk adjustment program is also designed to produce these benefits, but it does not fully account for especially high cost patients, and, because it is funded entirely by transfers from other participating insurers, risk adjustment offers no protection to an insurer that is the only one in the market.

<sup>112</sup> For further explanation and discussion, see John Bertko, Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance (Covered California, Jan. 2018), [http://hbex.coveredca.com/data-research/library/CoveredCA\\_Reducing\\_Premiums\\_1-10-18.pdf](http://hbex.coveredca.com/data-research/library/CoveredCA_Reducing_Premiums_1-10-18.pdf).



This modest multiplier effect is self-limiting, however. Once market premiums reach a new equilibrium, a reinsurance program funded at a given level is expected to produce only a one-time premium reduction which, although sustained, is not expected to gain strength over time. According to various national projections, reinsurance programs funded at levels that have been proposed would likely reduce premiums in the range of 10 to 20 percent.<sup>113</sup> Although helpful, that is (as one source put it) “not jaw dropping either. It’s a one-time shot in the arm.” Nevertheless, the Congressional Budget Office, among others, believes that, by addressing the riskiest part of the market, even this relatively modest support “would contribute substantially to the stability of the nongroup market,” in part by offsetting the uncertainty created by other regulatory changes that “make it difficult for insurers to predict the mix of enrollees on the basis of their recent experience.”<sup>114</sup>

### A. Examples from Study States

Two of our study states, Alaska and Minnesota, have implemented a reinsurance program using a section 1332 waiver, and several others have either considered or applied for such a program. Complex program details are reported elsewhere.<sup>115</sup> Here, the focus is on the stabilizing effects (actual or expected) of these programs.

Alaska’s reinsurance program, which was instituted for 2017, is widely viewed as a success. With about \$60 million funding, premiums were reduced at least 20 percent.<sup>116</sup> Observers noted that Alaska’s market is especially well suited for reinsurance because it is so small (fewer than 20,000 people) and thus a handful of patients can account for a disproportionate share of costs. The Blue Cross plan reported, for instance, that a quarter of its costs in the first half of 2015 were generated by just 37 members. This risk can be even more daunting for insurers with less market share because, as one analyst noted: “You just need a couple of people with \$1 million in claims, which these days is not unusual, ... but say it’s a \$40 million market, ... a couple of people with \$2 million of claims just basically raises rates double-digits for the whole buying population.”

Despite the Alaska program’s success, no one thought that its market faces entirely smooth sailing. Capturing the general sentiment, one market participant said:

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<sup>113</sup> The Office of Management and Budget reportedly projects that, nationally, premiums would be lowered roughly 1 percent for every \$1 billion in reinsurance funding. <https://www.axios.com/white-house-aca-subsidies-lower-premiums-1520352713-cf2b15f9-9d5e-4e1b-b736-23cfc15cef67.html>. Consistent with that rule of thumb, the Congressional Budget Office has estimated that \$12 billion in reinsurance funding would reduce premiums by 10 percent (in 2026). CBO, American Health Care Act: Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>. See also Covered California, Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance (Jan. 2018), [http://hbex.coveredca.com/data-research/library/CoveredCA\\_Reducing\\_Premiums\\_1-10-18.pdf](http://hbex.coveredca.com/data-research/library/CoveredCA_Reducing_Premiums_1-10-18.pdf) (a \$15 billion reinsurance would reduce premiums 12 percent nationally, but would cost government only \$5 billion due to reduced premium subsidies).

<sup>114</sup> CBO, American Health Care Act: Budget Reconciliation Recommendations of the House Committees on Ways and Means and Energy and Commerce, March 9, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

<sup>115</sup> Families USA, 1332 Waivers in the States, <http://familiesusa.org/1332-waivers-states>; National Conference of State Legislatures, Innovation Waivers: State Options and Legislation Related to the ACA Health Law (June 2018), <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>. See generally Am. Academy of Actuaries, Using High-Risk Pools to Cover High-Risk Enrollees (Feb. 2017), <http://www.actuary.org/content/using-high-risk-pools-cover-high-risk-enrollees>; Scott Harrington, Stabilizing Individual Health Insurance Markets With Subsidized Reinsurance: A Comparison of Approaches (Univ. Penn., Sept. 2017), <https://ldi.upenn.edu/brief/stabilizing-individual-health-insurance-markets-subsidized-reinsurance>; Jean Abraham and Lynn Blewett, Insurer Exit from the Individual Market: Affected Populations, Impacts, and State Efforts to Stabilize Markets through Reinsurance, <http://www.academyhealth.org/node/15586>.

<sup>116</sup> Some sources indicate a greater premium reduction. For instance, following the program’s introduction, Blue Cross reduced its pending rate increase from 42% to a 7%, but there are indications that a portion of this reduction was also due to the insurer having learned that, initially, it had overestimated its prior year’s claims expense and so needed less of a premium increase than it first thought, even without reinsurance.

I think [our reinsurance program has] been fantastic in many ways in terms of providing some downward pressure on health care premiums. It was a market that desperately needed that. But I think if I were to caution somebody, I would caution them to not lean on it too much, because in reality, it's mostly a band aid. ... The problems that we are facing in Alaska are deep and structural and they're not going to be addressed by tweaking. ... At the end of the day, we are still dealing with the same fundamental issues, which are a small pool of sick people and high costs. And so, really, none of the proposals [circulating] address that fundamental issue.

Inspired in part by Alaska, Minnesota instituted a reinsurance program for 2018, which, with \$271 million annual funding, also reduced rates close to 20 percent from what they otherwise would have been, producing a -10 percent decrease overall in 2018.<sup>117</sup>

However, views in that state were not nearly as positive, due in large part to the federal government using these reduced rates to cut funding by over \$50 million a year for the state's "basic health plan," which covers people at or below 200 percent of poverty.<sup>118</sup> Misunderstanding and confusion over this technical aspect of the 1332 waiver process, coupled with the fact that CMS did not inform the state about the impact on basic health plan funding until the eleventh hour, when it was too late to alter the proposal, led the Governor to describe the federal application process as "nightmarish."<sup>119</sup>

Others interviewed felt the state had been double crossed through "outright sabotage for political gain" because the federal government initially encouraged the waiver proposal, and state officials felt reassured all along that the proposal would be approved, even though it was clearly premised on not losing any funding for the state's basic health plan. Thus, several observers and participants thought that the federal government's "reversal" "seemed politically motivated" and that the state was "being penalized . . . because of politics" for "coming up with an innovative idea."

Whether ill motivated or not, there is bipartisan agreement among study states and others<sup>120</sup> that the 1332 waiver process needs to be expedited and to have somewhat more transparent and flexible standards. In the words of one subject, "there are tremendous opportunities in the 1332 waiver [just] sitting there if we had an administration that was amenable to moving that forward."

Had Minnesota known in advance that its reinsurance proposal would result in cuts to its basic health plan, sources thought there is a good chance it would not have submitted the proposal at all, or at least it probably would have submitted a different proposal. The state has sued to reverse the federal cut to its basic health plan funding. Even if the suit succeeds, however, officials said that there is no decision yet whether its reinsurance program will extend beyond 2019. As in Alaska, we heard that even a successful version of Minnesota's program is only a temporary "band aid," and that more fundamental market changes are needed (such as a "public option," or extending subsidies to people above 400

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<sup>117</sup> Also encouraging is that, in initial rate filings for 2019, all five Minnesota insurers have proposed rate decreases ranging from 3-12 percent. Minnesota Commerce Department, Insurers' 2019 Proposed Health Insurance Rates (June 2019), <https://mn.gov/commerce/consumers/your-insurance/health-insurance/rates/rate-filings/2019/#1>. However, much or most of that decrease is probably due to Minnesota insurers having previously overshot their actual costs in their 2017 rates, prior to implementing the new reinsurance program.

<sup>118</sup> This occurred because funding for a state basic health plan, like the 1332 waiver, cannot exceed what the federal government would otherwise spend, and the reinsurance plan reduced this baseline spending calculation. The state, however, argued that the baseline for the basic health plan should not change due to the reinsurance program, since the two programs are separate.

<sup>119</sup> Letter from Gov. Mark Dayton to Sec'y Tom Price, Sept. 19, 2017, [http://mn.gov/gov-stat/pdf/2017\\_09\\_19\\_Governor\\_Dayton\\_Letter\\_to\\_Secretary\\_Price\\_1332\\_Waiver.pdf](http://mn.gov/gov-stat/pdf/2017_09_19_Governor_Dayton_Letter_to_Secretary_Price_1332_Waiver.pdf).

<sup>120</sup> Letter to Secretaries Mnuchin and Price from Minnesota Congressional Delegation, Sept. 14, 2017, <https://emmer.house.gov/sites/emmer.house.gov/files/2017%2009%2014%20Section%201332%20MN%20Delegation%20Letter%20SIGNED.pdf>. Oklahoma is another state that felt burned by the 1332 waiver process. Its proposal was similar to those from Alaska and Minnesota, and it had received assurances it would be reviewed expeditiously, but the state learned it would not receive approval by their end-of-September deadline for open enrollment, so Oklahoma withdrew its proposal, expressing sharp frustration. Joel Ario, Failure to Approve Oklahoma Waiver Undermines Trust Between HHS And States (Health Affairs Blog, Sept. 30, 2017), <https://www.healthaffairs.org/do/10.1377/hblog20170930.062255/full/>.

percent of poverty, or more fundamental health care cost controls). According to one public official, “we bought ourselves time [by figuring] out our short-term solution, which state-based reinsurance is. And now we have the ability hopefully to then have a conversation about, okay, what is the long-term solution for a stable market that maybe can even grow, cross your fingers.”

Reinsurance has also proven to be controversial in Iowa. In mid-2017, the state submitted a 1332 waiver proposal (which it called a “stop gap” plan) that contained a reinsurance component, but went beyond just that to more fundamentally restructure how premium subsidies are calculated and distributed.<sup>121</sup> This larger set of features made the proposal much more challenging to justify under ACA criteria. Moreover, Iowa did not propose to contribute any of its own funding for the reinsurance component, as Alaska and Minnesota had done, but instead sought only to redistribute federal low-income subsidy funding to a reinsurance pool that would lower rates modestly for all subscribers.

The federal government failed to decide Iowa’s application in time for open enrollment (despite reported assurances of a quick review), so the state reluctantly withdrew its proposal near the end of October 2018, and has no plans to resubmit it. Views differ on whether the proposal met the ACA’s requirements of budget neutrality and not lessening support for low income people.<sup>122</sup> Accordingly, some observers think the federal government’s lack of prompt approval was justified by the merits.<sup>123</sup> Others, however, speculate that the failure to approve was motivated by the Trump administration’s desire to “sabotage” ACA stabilization efforts.

According to reports, the Iowa proposal was developed in cooperation with Wellmark, Iowa’s Blue Cross plan, with their assurance they would reenter the market if the plan is approved. Wellmark has announced, however, that it will re-enter the market anyway. One circumstance that made reinsurance especially appealing in Iowa is the publicly-discussed presence of a single individual with a chronic genetic condition (hemophilia) that was costing Blue Cross several million dollars a year, which contributed to its decision to leave the market after just one year. Observers also thought that this single patient made other insurers reluctant to enter or remain in the market, knowing that this individual would likely transfer enrollment to one of them. One analyst explained that a state with a single catastrophic case that is roiling the market might be ideal situation for a limited reinsurance program, especially because commercial reinsurance will not cover high-cost patients that are already known.

Had Iowa’s proposal been implemented, RAND estimated that it would have reduced premiums by up to 40 percent. The state’s actuary, however, estimated a rate reduction for Medica (the only existing insurer at the time) of only 16 percent. One apparent difference between the two analyses is that RAND assumed that reinsurance would bring Blue Cross back into the market, which would help to further improve the risk pool and thus reduce prices beyond the nominal amount of the reinsurance funding.

In Maine, when the ACA took effect the state suspended the reinsurance program it had only recently implemented, in order to take full advantage of federal reinsurance. Now that the ACA’s transitional program has expired, Maine has recently proposed reinstating its program, supplemented with federal funding through a section 1332 waiver. Previously, the state’s program was credited with a 20 percent reduction in premiums, but the market size then was less than half of its current size, so actuaries

<sup>121</sup> The plan would have replaced the ACA’s formula for premium tax subsidies with one that would reduce help to lower income people but extend subsidies to people above 400 percent of the poverty level. Also, the state proposed to eliminate the Marketplace health insurance exchange and allow insurers to sell subsidized insurance directly.

<sup>122</sup> Critics argued that low-income people would be disadvantaged. See Timothy Jost, Iowa Waiver Application Presents Crucial Decision Point For Administration (Health Affairs, Aug. 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170824.061669/full/>; David Anderson, Iowa’s 1332 Waiver and CSR Populations (Aug. 2017), <https://www.balloon-juice.com/2017/08/24/iowas-1332-waiver-and-csr-populations/>. However, one analysis concluded that all income groups would actually benefit, but the same analysis concluded that, by extending subsidies to more people, the proposal would increase federal spending. Sarah Nowak, et al., The Effects of Iowa’s Proposed Stopgap Measure on Health Insurance Costs and Coverage (RAND, 2017), [https://www.rand.org/pubs/research\\_reports/RR2228.html](https://www.rand.org/pubs/research_reports/RR2228.html).

<sup>123</sup> Seth Chandler, Rejection Of Iowa Plan Is Not “Sabotage” of the Affordable Care Act, The Apothecary (Forbes), Oct. 6, 2017, <https://www.forbes.com/sites/theapothecary/2017/10/06/rejection-of-iowa-plan-is-not-sabotage-of-the-affordable-care-act>.



project that the renewed program will reduce rates by only 9 percent, and the effect might be even more muted. In initial rate filings for 2019, Maine insurers on the exchange attribute only a 2-5 percentage point savings if reinsurance is reinstated.<sup>124</sup> Although the Blue Cross plan has indicated that it will re-enter the market if reinsurance is reinstated, no subjects in Maine thought that reinsurance would substantially change market dynamics. As one source put it, this “will help but it’s not a panacea. Reinsurance depends on how much money you bring into the system and this won’t bring in much new money.”

Interestingly, sources indicated that it is not entirely certain Maine will institute the program even if it is approved – due in large part to the unsettling experiences other states have had with the section 1332 waiver process recently. As one insurer explained, restarting reinsurance will require a “leap of faith” that there will be “the constancy and reliance that we need” that the federal government will actually pay the projected funds. “In the face of that uncertainty, it is hard to know how to rate for the impact” of reinsurance. Another informed source said that the reinsurance board was “unanimous in their trepidation” about whether the federal funds would come through, worried that CMS “will pull a ‘Lucy’”—that is, yank away the funding football just as they’re wound up to kick it. However, subsequent experience in several states with new reinsurance programs may ease this fear.

If not, an insurer further explained that uncertainty over program funding can dampen its success, due to the “self-fulfilling prophesy” aspect of the federal “pass-through funding.” Recall that federal funding is based on the extent of insurers’ premium reductions, but those in turn are based on how much federal funding is expected. This feedback loop can have a “virtuous” aspect, whereby the more insurers believe reinsurance will work, the more they will lower their rates, which generates more federal pass-through funding for the reinsurance program, encouraging even more rate reduction. But, to the same effect, if insurers lose confidence that federal funding will be as expected, they will dampen any rate reductions, which could further reduce actual federal funds, leading to a negating premium cycle.

A few other study states have given reinsurance only passing consideration but have not actively studied it, in part because of the math required to make the section 1332 pass-through funding work. In Ohio, sources noted that, because premium rates are substantially lower than average and Ohio has expanded Medicaid, there is less premium subsidy funding available to redirect through a 1332 waiver, which makes a reinsurance plan more difficult to develop. In Texas, insurers have made some effort to convince the legislature to pursue reinsurance, but sources there saw little chance of moving forward because a successful 1332 waiver appears to require a base of additional state funding, which Texas is highly unlikely to support due to deep-seated political opposition to the ACA. This source felt that there would be more support for such a program in Texas if the federal government were to contribute new funds to reinsurance (as had been proposed in Congress). Nevertheless, we heard no indication that reinsurance would affect any insurers’ decisions about market participation in Texas.

Reinsurance was also under active consideration in Colorado, until legislation failed in their Republican-controlled Senate. The version passed by the House was projected to reduce premiums 20-30 percent. Sources said that reinsurance probably would not affect any insurer’s decision about entering or remaining the market, but the particular version developed in Colorado could be especially helpful in insurers’ decisions about whether to expand into rural counties, where costs are higher and the population sparser.<sup>125</sup> Nevertheless, Colorado sources shared the views expressed elsewhere that something more than just reinsurance will be needed to improve the market; thus, people should avoid the “false assumption” that reinsurance will “fix things.”

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<sup>124</sup> Maine Bureau of Insurance, 2019 Individual and Small Group Health Insurance Rate Filings, [https://www.maine.gov/pfr/insurance/legal/upcoming\\_hearings/pdf/2019\\_proposed\\_rate\\_filings\\_summary.pdf](https://www.maine.gov/pfr/insurance/legal/upcoming_hearings/pdf/2019_proposed_rate_filings_summary.pdf). The Blue Cross plan, however, which sells only off the exchange, attributes a 22.5 percent premium difference to reinstated reinsurance.

<sup>125</sup> The bill took an innovative approach that would have paid for a greater proportion of high-cost claims in rural than in urban areas, in order to target the relief where it is needed the most.

## B. Expanding Premium Subsidies

One measure in addition to, or instead of, reinsurance is simply to expand subsidies to people who continue to face unaffordable premiums – especially those above 400 percent of the poverty level who are subject to the steep subsidy cliff. Reinsurance helps that segment of the population only indirectly, by reducing premiums across the board. Reinsurance is also indirect in that it reimburses insurers' claims costs after they have set their premiums, with the hope that this will help to keep premiums lower, but reinsurance offers no guarantee that all of its funding will accrue to the benefit of consumers in the form of lower premiums. Some of this funding might instead go toward increasing insurers' profits.

For example, a study of Medicare Part D's reinsurance program concluded that only about half of its reinsurance payments flow through to benefit consumers in the form of reduced premiums or better benefits; the rest is retained by insurers, and in less competitive markets, they retain over 80 percent of the reinsurance benefit.<sup>126</sup> Similarly, under the ACA, various estimates indicate that reinsurance appears to be a very expensive way to increase the number of people purchasing insurance. Milliman's analysis for Maine's reinsurance proposal, for instance, estimated that its proposed \$55 million in reinsurance funding would reduce the number of uninsured by only roughly 1,000, which equates to \$55,000 per additionally insured person.<sup>127</sup> Relative inefficiency is also reflected in a report by RAND, which analyzes various scenarios for improving the individual market. RAND's analysis suggests that, for the levels of funding they specified, expanding subsidies could cost half as much per new enrollee as funding reinsurance.<sup>128</sup>

Therefore, some interview subjects questioned whether reinsurance is the best use of funds for market stabilization. Prior to adopting reinsurance for 2018, Minnesota in fact used \$500 million of state funding in 2017 to rebate 25 percent of the premium to individual market subscribers who did not receive subsidies, in order to offset part of the massive rate increases that year. Unfortunately, the appropriation was not authorized until the end of open enrollment and so, for most people, it came as a pleasant surprise to people who had already enrolled, rather than being available earlier as an inducement for more people to enroll. Accordingly, observers thought that this was “a complete lost opportunity” or questioned whether it “makes sense” to “pour so much money into serving a small population of the market.”

Nevertheless, several Minnesota subjects thought that a direct consumer subsidy is an alternative worth considering for the future. Unlike reinsurance, one source noted that the rebate is “something people understand and don't have to reinterpret.” Another noted that “at least you know that it's offsetting directly versus thinking that the health plans are spending those resources effectively.” Others thought that the reinsurance program that Minnesota instituted following the one-year rebate was “just flushing money down the toilet,” by giving it to insurers without accountability for how it is used. One source commented that reinsurance is “hugely expensive for the number of people that are in the individual market,” and another commented “I've never seen a larger waste of taxpayer dollars in my time.”

However, even if expanding direct subsidies were preferred to reinsurance, direct subsidies would be much less effective than reinsurance in capitalizing on *federal* funds (via a 1332 waiver). Extending subsidies to people above 400 percent of poverty might reduce overall premium costs some, by bringing healthier people into the market, but the effect on market-wide premiums is much more attenuated for targeted subsidies than for market-wide reinsurance. Therefore, although targeted subsidies may be

<sup>126</sup> Marika Cabral, Michael Geruso, Neale Mahoney, Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage (National Bureau of Economic Research, July 2017), <http://www.nber.org/papers/w20470>.

<sup>127</sup> Milliman, Section 1332 State Innovation Waiver Actuarial Analyses and Certification and Economic Analyses (March 2018), [https://www.maine.gov/pfr/insurance/mgara/exhibit\\_a\\_milliman\\_modeling\\_final.pdf](https://www.maine.gov/pfr/insurance/mgara/exhibit_a_milliman_modeling_final.pdf).

<sup>128</sup> Jodi Liu & Christine Eibner, Expanding Individual Market Enrollment without the Individual Mandate: Options to Bring More People into the Market (RAND, forthcoming 2018), <http://www.commonwealthfund.org/about-us/experts/liu-jodi>.

more effective in inducing more people to enter the market, this is less effective in reducing premium subsidies for existing subscribers, which is the key to using a 1332 waiver proposal under the ACA to secure supplemental federal support for market stabilization. Thus, without additional federal legislation, it appears that states would have to fund almost all of the cost of targeted subsidies on their own.

## VII. Non-compliant Plans

There is increasing discussion of whether state and federal regulators should allow, or restrict, non-compliant plans. Non-compliant plans are not subject to the ACA's requirements of open enrollment, community rating, and coverage of essential health benefits without exclusion of pre-existing conditions (plus additional consumer protections). Previously, such non-compliant plans existed mainly in the form of grandfathered and "grandmothered" plans – those that have been continuously renewed since either prior to March 2010 (grandfathered) or January 2014 (grandmothered).<sup>129</sup> Initially, these plans may have weakened ACA risk pools somewhat, by keeping some better risks out of the ACA's community-rated market,<sup>130</sup> but most interview subjects felt that any such effect has now greatly subsided because, over time, fewer people have continuously maintained their older coverage, and insurers are now starting to discontinue these legacy plans altogether.

Of greater concern is the possibility of marketing non-compliant plans to new enrollees. This might occur in at least four forms.<sup>131</sup> The ACA exempts "sharing ministries" created by faith-based groups to cover health care costs in a fashion that is not considered to be insurance. It is estimated that membership in these ministries has shot up from fewer than 200,000 to more than a million.<sup>132</sup> Subjects in several study states (AK, FL, IA, MN, TX) had noticed increasing presence of or interest in Christian ministries.

A few states, such as Tennessee, and now Iowa (as of 2018), allow the Farm Bureau to sell coverage to its members outside of ACA regulation, by declaring, similar to sharing ministries, that these membership benefits do not constitute normal insurance. Notably, Farm Bureau membership does not require any actual affiliation with farming.<sup>133</sup> Anyone may join for an annual fee which, in Tennessee, is just \$25 a year.

Building on the Farm Bureau example, the federal government recently finalized rules that expand the ACA's exemption of "association health plans" more generally – to allow business and professional

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<sup>129</sup> Grandmothered plans are also called "transitional" plans. They were permitted by an executive order from President Obama. In about fifteen states, however – mainly those with state-based exchanges -- either regulators have not permitted transitional plans, or insurers decided to discontinue them.

<sup>130</sup> Ashley Semanskee, et al., Effect of State Decisions on State Risk Scores (Kaiser Family Found., Oct. 2016), <https://www.kff.org/health-reform/issue-brief/data-note-effect-of-state-decisions-on-state-risk-scores/>; Wakely Consulting, Analysis of Alternative Policy Decisions in Iowa's Individual Market (May 2019), [https://www.commonwealthfund.org/sites/default/files/2018-06/Alternative\\_Scenarios\\_for\\_Iowa\\_5\\_25\\_18\\_final.pdf](https://www.commonwealthfund.org/sites/default/files/2018-06/Alternative_Scenarios_for_Iowa_5_25_18_final.pdf).

<sup>131</sup> Christina Lechner Goe, Non-ACA-Compliant Plans and the Risk of Market Segmentation (March 2018), <http://healthyfuturega.org/wp-content/uploads/2018/03/Non-ACA-Compliant-Plans-and-the-Risk-of-Market-Segmentation.pdf>; Karen Pollitz and Gary Claxton, Proposals for Insurance Options That Don't Comply with ACA Rules: Trade-offs In Cost and Regulation (Kaiser Family Foundation, Apr 18, 2018), <https://www.kff.org/health-reform/issue-brief/proposals-for-insurance-options-that-dont-comply-with-aca-rules-trade-offs-in-cost-and-regulation/>.

<sup>132</sup> Religious Ministries Rapidly Becoming More Common, From Less Than 200K in 2014 to Over 1 Mill: PBS News Hour, 1 Million Americans Pool Money in Religious 'Ministries' to Pay for Health Care, Jan 16, 2018, <https://www.pbs.org/newshour/health/1-million-americans-pool-money-in-religious-ministries-to-pay-for-health-care>.

<sup>133</sup> In contrast, the agricultural co-op law recently enacted by Minnesota covers only those who work in or service the agricultural industry. Christopher Snowbeck, Farmer Cooperative Health Plans may Rattle Individual market in Minnesota, StarTribune, Nov. 14, 2017, <http://www.startribune.com/farmer-cooperative-health-plans-may-rattle-individual-market-in-minnesota/457321193/>.

associations of all types to sell non-compliant plans.<sup>134</sup> Unlike Farm Bureau plans, however, association health plans will not be available to literally everyone, but instead only to businesses. However, the new federal rule includes sole proprietorships.

Finally, the ACA exempts short-term coverage – plans that are designed for gaps in conventional coverage and thus typically are not renewable for an extended time. The Obama administration limited these plans to a single, 3-month coverage period, but the Trump administration has proposed extending short-term coverage to a full year, and possibly allowing this coverage either to be renewed or “stacked” in a fashion that allows it to continue beyond a year.<sup>135</sup>

Owing to the regulatory complexity of these various non-compliant options, interviews focused mainly just on short-term plans, although discussion in some states also included sharing ministries, Farm Bureaus, and association plans. For any of these non-compliant options, the key is that the plans do not have to cover preexisting conditions or a full range of benefits. Thus, these plans can (and do) limit coverage to exclude existing illnesses or more expensive conditions such as maternity care, mental health care, organ transplants, or any treatments costing more than a defined ceiling. Also, there are no federal regulatory limits on varying prices to reflect age or gender. And, for several of these non-compliant options, prices can be increased substantially, or coverage can be denied altogether, for those with significant health risks.

Experience with a Farm Bureau exemption is not extensive enough to draw firm conclusions, but most people who have reported on the Tennessee market believe that its exemption has harmed the market.<sup>136</sup> Tennessee has among the highest ACA premiums and the highest risk scores in the country (on par with Alaska), and it has had difficulty maintaining full state coverage – not just in the past two years, but from near the beginning of the ACA’s reforms. Some analysts question whether the Farm Bureau’s enrollment of roughly a quarter of the market (73,000 people, about 50,000 of whom were in grandfathered plans) is a large enough block to account for this extent of destabilization, since Tennessee has a variety of other factors that predispose it to having a less healthy marketplace. Nevertheless, there is little dispute that the Farm Bureau exemption has weakened Tennessee’s ACA market.

For short-term and other non-compliant plans, however, views differ significantly, both in our study states and among national experts, on how disruptive or destabilizing they might be for the ACA-regulated individual market. In official comments to DHHS on its proposed rule expanding short-term plans, support for these plans was expressed by insurance brokers, insurers that sell these policies, and public officials from Alaska, Arkansas, Iowa, Montana, and New Mexico, none whom have state-based exchanges.<sup>137</sup> From the opposing viewpoint, patient advocacy and provider groups have been especially

<sup>134</sup> Christina Cousart, The New Association Health Plan Rule: What Are the Issues and Options for States (National Acad. for State Health Policy, June 2018), <https://nashp.org/the-new-association-health-plan-rule-what-are-the-issues-and-options-for-states/>.

<sup>135</sup> See Georgetown Univ. Health Policy Institute, State Options to Protect Consumers and Stabilize the Market (Dec. 2017), [https://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2017/rwjf441920](https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920).

<sup>136</sup> Michael Cohen, et al., Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market (Wakely Actuarial Consulting, April 2018), <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-LimitedDuration-Plans-Report.pdf>; Kevin Lucia and Sabrina Corlette, What’s Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges (Georgetown Univ., April 2017), <http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/>; Tennessee: Individual Market Just Barely Viable—For Now, Managed Care Magazine, July 9, 2017, <https://www.managedcaremag.com/archives/2017/7/tennessee-individual-market-just-barely-viable-now>; Erin Mershon, This Tennessee Insurer Doesn’t Play by Obamacare’s Rules — and the GOP Sees it as the Future, STAT News, Nov. 13, 2017 <https://www.statnews.com/2017/11/13/health-insurance-tennessee-farm-bureau/>; Sarah Kliff, Tennessee Has Insurance Rules Like the Ones Trump Proposed. It’s Not Going Well, Vox, Oct 12, 2017, <https://www.vox.com/policy-and-politics/2017/10/9/16449558/lowdown-tennessee-insurance-markets>.

<sup>137</sup> Georgetown University Center on Health Insurance Reforms, Stakeholder Views on the Proposed Short-Term Plan Insurance Rule (June 2018), <http://chirblog.org/stakeholder-views-proposed-short-term-plan-insurance-rule-key-takeaways-review-comment-letters/>.

critical of expanding non-compliant plans,<sup>138</sup> but strong opposition to the proposed rule for short-term plans was also voiced by ten states that operate their own exchanges, and by seven of nine large national insurers.<sup>139</sup> These states and insurers were concerned (variously) that the rule would “segment the ACA’s single risk pool,” create a “shadow health insurance market for healthy consumers,” cause premiums to “skyrocket,” and result in an “adverse selection ‘death spiral’” – although concerns were more muted from a number of these negative commentators.

The American Academy of Actuaries has also expressed serious concerns about non-compliant plans:

If some plans were allowed to avoid the ACA rules altogether, ... rather than having a single risk pool, in which costs are spread broadly, there would be in effect two risk pools—one for ACA-compliant coverage and one for noncompliant coverage. As a result, average premiums for ACA-compliant coverage could far exceed those of noncompliant coverage, thereby destabilizing the market for compliant coverage. The instability would be exacerbated if market rules facilitate movement of people between the two pools (e.g., if people with noncompliant coverage can easily move to compliant coverage when health care needs arise).<sup>140</sup>

Also, national literature notes that, because the ACA sets no limit on overhead and profit margins for non-compliant plans, medical loss ratios for short-term plans tend to be much lower (60-70% is common), which means that insurers can reward brokers more for selling these, making them “likely to market these plans very aggressively.”<sup>141</sup>

In our study states, we heard similarly divergent views about greater availability of short-term plans. In opposition, various insurers, regulators, and experienced analysts expressed concerns in the following terms: a “real danger,” and a “very deleterious” “threat to stability” that “could definitely be a disruptor,” “weaken the market,” and make a real “mess in the marketplace” by “segment[ing] the market and completely destabiliz[ing] it.” Negative attitudes ranged from “some apprehension” to being “deeply concerned” and “incredibly nervous about the impact this could have on the market” because “splitting the risk [pool] could be a real problem for the stability of the market in the future” so we are “watching with great concern.” Because “health plans are really, really good at segmenting” risks, setting up parallel markets with different underwriting and coverage rules “could be a bullet to the heart of the marketplace,” “potentially [causing] a death spiral,” in which case “it’s all over.”

Others with worrisome views were somewhat more modulated, but they still noted that non-compliant plans are the primary, and perhaps the only, serious threat to an individual market that otherwise is proving to be “remarkably resilient” and is finally “starting to stabilize.” A subject in Maine, for instance, commented that, “if it were not for the prospects of [association and short term plans], those things we are facing in 2019, we are at a relatively stable place.” The largest insurer on Maine’s exchange projected that it would have filed for a small *reduction* in 2019 rates if not for repeal of the individual mandate and expansion of short-term plans, but instead it is seeking a 9 percent increase.<sup>142</sup>

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<sup>138</sup> Ibid; Noam Levy, Trump’s New Insurance Rules Are Panned by Nearly Every Healthcare Group that Submitted Formal Comments, L.A. Times, May 30, 2018.

<sup>139</sup> Note 123.

<sup>140</sup> Risk Pooling: How Health Insurance In The Individual Market Works (July 2017), <https://www.actuary.org/files/publications/RiskPoolingFAQ071417.pdf>.

<sup>141</sup> Linda J. Blumberg, et al., The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending (Urban Institute, March 14, 2018), [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf). See also Shelby Livingston, How Stakeholders in the Short-Term Medical Market are Gearing Up to Attract More Customers, Modern Healthcare, April 19, 2018, <http://www.modernhealthcare.com/article/20180419/TRANSFORMATION04/180419913>.

<sup>142</sup> Charles Gaba, Maine: Preliminary 2019 ACA Rate Hike Request: Either 6.2% or 9.6% (Depends On Reinsurance); Rates Would DROP W/Out Sabotage Factor, June 5, 2018, <http://acasignups.net/18/06/05/maine-preliminary-2019-aca-rate-hike-request-either-62-or-96-depends-reinsurance-rates>.



One reason to worry that greater availability of non-compliant plans could be even more disruptive than previously is that, until now, the ACA's individual mandate deterred enrolling in most versions of these plans.<sup>143</sup> Although various versions of non-compliant plans, such as those sold by Farm Bureaus, have been legal to sell, purchasing them did not avoid the ACA's penalties for failing to enroll in affordable coverage. Now that the individual mandate has been repealed, a number of informed sources expressed concern that uptake of non-compliant options will be considerably greater and thus non-complying plans will become more destabilizing.

One respected actuarial firm estimated, for instance, that if the individual mandate were still in effect, expanded availability of short-term plans would increase premiums by 2-7 percent, and reduce ACA market enrollment by 8-15 percent. But, because the mandate has been repealed, the actual impact of expanding short-term plans is expected to be much more substantial -- increasing premiums from 8-13 percent, and reducing enrollment by 21 to 26 percent (depending on how reluctant people are to buy this limited coverage).<sup>144</sup>

None of our study states prohibit short-term plans, but prior to the ACA's three-month rule, several of them limited their duration to six months (e.g., CO, ME, NV), and subjects in these states expected regulators to return to their six-month limit rather than permit the full 12 months anticipated in a revised federal rule. Also, several study states keep a fairly close oversight of how short-term plans are marketed, to reduce the chances of consumers being misled about their reduced protections and noncompliance with the ACA. Several subjects thought that this state-based regulatory oversight would limit damage to the marketplace. However subjects in several states (AZ, OH, TX) did not expect regulators to set any state-specific limits.

Even without state-based protections, some subjects thought that greater availability of short-term plans would have only "minimal effect," because people eligible for subsidies will still prefer comprehensive coverage. For those who are not subsidy-eligible, a few subjects noted that short-term plans were "never very popular" before, even though they were available. One larger insurer noted it had stopped selling these plans altogether once the ACA took effect because COBRA continuation coverage was still available through the group market, and the ACA's special enrollment periods in the individual market now covered most situations where people might need short-term coverage. An Arizona broker thought that most people who want short-term plans probably already have them, so there may not be that many more new purchasers. And, an experienced broker in Maine noted that, because short-term plans are not renewable, he assumed that people who purchase them eventually "have to come into the market" anyway.

Summing up a mix of both sets of views, one state-based exchange official said: "I don't think [expanded availability of short-term plans] necessarily means catastrophe, but each time we get avenues for low users to bail out of the common group, it means the risk pool in the [community-rated pool] gets worse."

Views from national experts are similarly divided, or uncertain. Some believe that, although short-term plans will harm the market somewhat, especially for middle income people not eligible for large

<sup>143</sup> The primary exception is for sharing ministries, which the ACA treated as meeting the individual mandate.

<sup>144</sup> Michael Cohen, et al., Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market (Wakely Actuarial Consulting, April 2018), <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-LimitedDuration-Plans-Report.pdf>. Another large actuarial firm reached a broadly similar conclusion in analyzing the Washington D.C. market. Oliver Wyman, Potential Impact of Short-Term Limited Duration Plans (April 2018), <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf>. And, while RAND's analysis concluded that short-term plans would have a notably smaller effect than others have predicted, it too concluded that most of that effect derives from repealing the individual mandate. Preethi Rao, et al., What Is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans Is Increased? (RAND, June 2018), [http://www.commonwealthfund.org/~media/files/publications/fund-report/2018/jun/rao\\_short\\_term\\_plans\\_enrollment.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2018/jun/rao_short_term_plans_enrollment.pdf).



subsidies,<sup>145</sup> the damage will not likely be major because ongoing ACA subsidies anchor the market, and because enrollment in short-term plans “has been very low historically, and without an assumption of changes in insurer behavior and consumer attitudes, simply extending their duration will not affect enrollment substantially.”<sup>146</sup> Similarly, the financial analyst firm S&P Global concluded:

We don't expect short-term plans, association health plans, and the repeal of the individual mandate to put the ACA individual market into a tail spin. However, these legislative changes reduce the possibility of improving the average morbidity profile of the ACA individual market. There will likely not be a sharp decline in enrollees because of these legislations. At the same time, such regulatory updates will lower the chances of new enrollees with lower average morbidity entering the marketplace, which would have been beneficial for the market's risk profile. And beyond that, the path forward will continue to be choppy if there are continued attempts at repeal-and-replace that either cut funding or reduce the scale of the ACA markets.<sup>147</sup>

The chief actuary for CMS has issued an analysis that supports both sets of views.<sup>148</sup> Of concern, he assumes that, “[d]ue to the lower premium, 90 percent of healthy individuals with incomes over 400 percent of the Federal poverty level (and therefore unsubsidized) who have nongroup coverage, and roughly one-third of healthy individuals with incomes between 300 and 400 percent of the Federal poverty level who have non-group coverage, would ultimately choose to purchase” a short-term policy. As a result, he projects that enrollment in the ACA-compliant market will drop by about 15 percent (1.8 million drop by 2022). Also, because “a large number” of those who switch to short-term coverage will be “healthy ... individuals,” this means that premiums in the ACA market will increase.

However, the CMS chief actuary estimates that the additional price increase will amount to only about 6 percent, because the market will reach a new, stable equilibrium, aided in part by the fact that more people become eligible for subsidies as premiums increase. Moreover, the CMS actuary notes that the cheaper cost of short-term policies will draw more people into at least some form of coverage. Projecting that short-term plans will attract about 10 percent more people than the ACA-compliant market will lose, the CMS actuary estimates that about 200,000 people will have short-term coverage who otherwise would likely be uninsured. However, some (unspecified) number of “unhealthy people who are dropping [ACA] coverage as a result of the [6 percent] higher premiums” will become uninsured because they do not qualify for underwritten short-term insurance.

Analysts at the Urban Institute also anticipate mixed effects from expanded availability of short-term plans.<sup>149</sup> Using a sophisticated microsimulation model, their main conclusions are similar to the CMS actuary's estimates, projecting about a 19 percent reduction in the ACA-compliant market in states that do not restrict short-term policies, leading to an 8 percent increase in premiums. However, the Urban Institute also projects twice as many otherwise-uninsured people purchasing short-term policies as

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<sup>145</sup> Karen Pollitz and Gary Claxton, *Proposals for Insurance Options That Don't Comply with ACA Rules: Trade-offs In Cost and Regulation* (Kaiser Family Foundation, Apr 18, 2018), <https://www.kff.org/health-reform/issue-brief/proposals-for-insurance-options-that-dont-comply-with-aca-rules-trade-offs-in-cost-and-regulation/>.

<sup>146</sup> Preethi Rao, et al., *What Is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans Is Increased?* (RAND, June 2018), [http://www.commonwealthfund.org/~media/files/publications/fund-report/2018/jun/rao\\_short\\_term\\_plans\\_enrollment.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2018/jun/rao_short_term_plans_enrollment.pdf).

<sup>147</sup> S&P Global, *Are U.S. Health Insurers Finally Getting To Stable Ground In The ACA Individual Market?* (Jan. 2018), [https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsf\\_code=LIME&sourceObjectId=10392499](https://www.capitaliq.com/CIQDotNet/CreditResearch/RenderArticle.aspx?articleId=1977710&SctArtId=446012&from=CM&nsf_code=LIME&sourceObjectId=10392499).

<sup>148</sup> CMS, Office of the Actuary, *Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule* (April 2018), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

<sup>149</sup> Linda J. Blumberg, et al., *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, March 14, 2018), [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf).

does the CMS actuary. Therefore, they estimate that 1.7 million more people will have at least some type of coverage if short-term plans become more available.<sup>150</sup>

Analysts at RAND project an even larger positive impact: they estimate that increased availability of short-term plans could attract 5 million people. Although most of those would be drawn from the existing individual and group markets, roughly 2 million would otherwise be uninsured, under RAND's microsimulation model. Similarly, the Congressional Budget Office projects that, while the expanded availability of non-compliant plans would reduce the number of people in the regulated market, it would increase the number of people with some type of coverage by approximately 1 million.<sup>151</sup> And, both RAND and CBO project that the shift in healthier enrollees from the ACA market to short-term coverage would increase individual market premiums by only 2-3 percent.

Thus, some states may view expanding medically-underwritten non-compliant options as a viable public policy option to address the steeply increasing costs that unsubsidized people face. Although some current enrollees will be harmed, the ACA's subsidies will buffer major price increases. However, for those who have pre-existing health problems and are not eligible for subsidies, not only would non-compliant options offer no help, this would leave them worse off. Drawing even more good risks out of the regulated market threatens to turn the unsubsidized portion of the individual market into a full-cost high-risk pool – one that offers coverage to those who need it the most, but with no help covering increasingly unaffordable costs.

To mitigate damage to the market and improve options for people who are unsubsidized and uninsurable, more permissive states could consider a proposal made by two different policy analysts: to impose a tax on short-term policies (or at least on the higher-than-normal profits they generate) to raise funds that can be redirected to reduce costs for those who have no choice but to remain in the ACA-regulated market.<sup>152</sup> Perhaps in that manner fewer people would be disadvantaged by creating more affordable options for those who remain in reasonably good health.

## VIII. Other Stabilization Measures

### A. Federal Actions

This final section addresses a variety of additional stabilization measures suggested by interview subjects or discussed in national literature. Early in the Trump Administration, DHHS issued a set of “market stabilization rules,”<sup>153</sup> which included tightening up on eligibility for special enrollment (outside of open enrollment),<sup>154</sup> and providing insurers more flexibility in designing standardized

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<sup>150</sup> Similarly, the Center for Health and Economy projects a 5-9 percent increase in premiums, reducing ACA enrollment by roughly 800,000, but that cheaper short-term plans would attract 3 million subscribers, producing a net coverage increase of roughly 2.4 million. Center for Health and Economy, *The Proposed Modifications to Short Term Limited Duration Insurance Plans* (June 2018), [http://healthandeconomy.org/wp-content/uploads/2018/06/06-25-2018\\_STLDIs.pdf](http://healthandeconomy.org/wp-content/uploads/2018/06/06-25-2018_STLDIs.pdf).

<sup>151</sup> CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf>.

<sup>152</sup> One proposal calls this a “free-rider assessment,” meaning that it taxes those who still can take advantage of the ACA's consumer protections when they choose to, but avoid having to pay the added costs until they need to. *Reducing The Externalities Caused By Limited Benefit Plans* (Health Affairs Blog, Oct. 5, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171021.343210/full/>. See also Georgetown University Health Policy Institute, *State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans* (Dec. 2017), [https://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2017/rwjf441920](https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920).

<sup>153</sup> Sabrina Corlette, *Stepping into the Breach: State Options to Protect Consumers and Stabilize Markets in the Wake of Federal Changes to the Affordable Care Act* (Georgetown Univ., Aug. 2017), [https://chir.georgetown.edu/sites/chir/files/state\\_options\\_unwinding\\_the\\_aca.pdf](https://chir.georgetown.edu/sites/chir/files/state_options_unwinding_the_aca.pdf).

<sup>154</sup> Outside of open enrollment, the ACA requires insurers to accept applicants within 60 days of specified life changes, such as a change in jobs, marriage/divorce, etc. Some insurers complained that it was too easy for people to self-certify that they meet

plans.<sup>155</sup> More recently, DHHS gave states more flexibility in designing the “essential health benefits” required by the ACA, and allowed them to lower the minimum medical loss ratio for insurers.<sup>156</sup>

Overall, we heard very little response, either positive or negative, about these various federal stabilization measures. The overwhelming attitude was that they were of little consequence, (“just more crap around the margins,” according to one unedited source).

Some insurers we interviewed thought that firming up verification for special enrollment eligibility helped to reduce adverse selection, but some consumer advocates feared that the added red tape will make adverse selection worse by discouraging healthy people from enrolling, whereas sicker people will persist through the required paperwork.

A few insurers had taken advantage of greater flexibility in meeting the ACA’s actuarial value standards, but they did not feel this would “make very much difference” overall, and most had not felt the need to “go to this trouble.” Similarly, no insurer attached much importance to how essential health benefits are defined, because, as one noted, insurers still need to cover all of the 10 categories that the ACA designates and, as another noted, most were already covering the bulk of these categories, other than maternity care.

A public official in Florida said that non-participating insurers in that state had been asked if lowering the required medical loss ratio<sup>157</sup> to the 70-75 percent range would encourage them to join the market, but they said no because market dynamics still remain too unpredictable, and building more profit or overhead into their rates would not help if doing so resulted in an uncompetitive rate.

Rather than pointing to these or different federal measures that would further improve the market, the dominant response about federal initiatives was that the federal government, as a Maine source put it, “is making the problem worse.” According to a Texas insurer, “the Administration is doing all they can to destabilize the market.”<sup>158</sup> Thus, as a regulator in another red state opined, the best thing that federal regulators can do improve market stability is “just stopping what they’re doing for a while” – a sentiment that was widely shared across states and market participants.

For instance, after these interviews were completed, the federal government announced that it is suspending the ACA’s risk adjustment program, due to conflicting decisions from lower courts about whether its payments are being properly calculated.<sup>159</sup> Also, the Justice Department announced its position in a pending lawsuit that the ACA’s guaranteed issue and community rating provisions will become unenforceable once Congress’s repeal of the individual mandate tax penalty takes effect in

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the special enrollment conditions, and thus people were using this leeway to wait until they were sick to enroll. In response, this rule tightens special enrollment verification requirements.

<sup>155</sup> The ACA requires cost-sharing to be set such that Bronze plans *on average* pay for 60% of covered benefits, Silver plans pay for 70%, Gold for 80%, etc. The Trump administration loosened these metrics somewhat in response to insurers’ complaints that they were too restrictive. Now, actuarial values can now fall within a range of -4-+2% of the mandated target. Timothy Stoltzfus Jost, First Steps of Repeal, Replace, and Repair, Health Aff., 36(3): 398-399 (March 2017).

<sup>156</sup> CMS, Notice of Benefit and Payment Parameters for 2019, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf>.

<sup>157</sup> See note 64 for further explanation.

<sup>158</sup> For similar views elsewhere, see sources cited in note 55 and Center for Budget and Policy Priorities, Sabotage Watch: Tracking Efforts to Undermine the ACA, <https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca>.

<sup>159</sup> Anna Wilde Mathews and Stephanie Armour, Trump’s Latest Affordable Care Act Move Adds to Insurers’ Uncertainty, Wall St. J., July 9, 2018. The one court that issued an adverse decision did not require this suspension nationally, and federal agencies usually do not voluntarily implement lower court rulings they disagree with nationwide, so it is unclear why the Trump administration is considering a nation-wide suspension, leading some experts to think, “It Sure Looks Like the Trump Administration Is Trying to Sabotage Obamacare Again,” Jordan Weissmann, Slate, July 8, 2018, <https://slate.com/business/2018/07/risk-adjustment-payments-trump-administration-seemingly-tries-sabotaging-obamacare-again.html>. See also, Jonathan Cohn, Trump Administration May Be Preparing A New Obamacare Sabotage Effort., Huffington Post, July 2018), [https://www.huffingtonpost.com/entry/obamacare-sabotage-risk-adjustment\\_us\\_5b40e39ae4b09e4a8b2d96cb](https://www.huffingtonpost.com/entry/obamacare-sabotage-risk-adjustment_us_5b40e39ae4b09e4a8b2d96cb); Nick Bagley, Taking a Dive on Risk Adjustment, Incidental Economist, July 9, 2018, <https://theincidentaleconomist.com/wordpress/taking-a-dive-on-risk-adjustment/>.

2019. It remains to be seen whether courts will uphold that position, but some national commentators view the mid-year announcement of that legal position as being timed in order to further disrupt the ACA market. According to one informed critic, “Of all the things the Trump administration has done to destabilize the market, this may be the most major. What’s an insurer that is setting rates now supposed to do ... ?”<sup>160</sup>

The major exception to this “just leave things alone” viewpoint is government-funded reinsurance. For that strategy, various sources noted that realistically states cannot do reinsurance entirely on their own. Therefore, many of them would welcome federal funding that made some form of risk spreading (such as reinsurance or a high risk pool) a more established feature of ACA markets.

### B. State Actions

Looking, then, to what states might do on their own, one option mentioned in several states is to allow people to buy into the state’s Medicaid program, in order to obtain more favorable pricing by providers, and to reduce overhead costs incurred by insurers.<sup>161</sup> We heard that this “public option” possibility has been proposed or discussed (at least to some extent) in Iowa, Maine, Minnesota, and Nevada, but so far it has not come to fruition. Nevada has come the closest; there, the legislature approved a Medicaid public option in 2017, but the governor vetoed the bill, out of concern that expanding Medicaid to a buy-in population could make contracting with providers more costly for the existing Medicaid population.

Another measure mentioned in a number of states is to target subsidies to those who are near or above 400 percent of poverty and thus face the steep “subsidy cliff” described above. In Colorado, for instance, its House passed a bill that would provide additional subsidies to those who are 400-500 percent of poverty, but this failed to advance in the Republican-controlled Senate. Obviously, the main difficulty for states is to identify feasible sources of funding for new subsidies, but, if available, the idea (as discussed in section VI.B) is to use any available funds in a more targeted way to help uninsured people who currently face unaffordable options. A desire to do this was mentioned by several sources in Minnesota, and one in Maine.

Finally, a Maine insurer noted that it would be helpful to allow mid-year correction to rates, especially following any significant changes in federal rules. Having that option would reduce the need for actuaries to guess, many months in advance, what mid-year changes might occur or what the actual effects will be of changes recently made. However, changing rates midyear could be difficult to allow within the ACA structure, which determines subsidies only once a year, during open enrollment, based on premiums as a percent of income.

Beyond measures that address the insurance markets, subjects frequently noted the need to “tackle the [underlying medical] cost problem,” which is “the big gorilla in the room.” For instance, several Texas subjects mentioned drug prices in particular as a big driver of cost increases, and so they thought it could help to give the government more authority to negotiate drug prices. And, in Alaska, several subjects pointed to the state’s rule that requires insurers to pay handsomely for out-of-network care (full charges up to the 80<sup>th</sup> percentile of prevailing full charges) as a barrier to insurers negotiating better discounts.

The national literature on suggestions for stabilization covers the full range of ideas presented in this report,<sup>162</sup> and so will not be reviewed in detail. However, one proposal made by several commentators

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<sup>160</sup> Stephanie Armour, Justice Department Won’t Defend Affordable Care Act in Lawsuit Brought by States, *Wall St. J.*, June 7, 2018. See also Timothy S. Jost, Trump Administration Court Filing Threatens Coverage for Preexisting Conditions (Commonwealth Fund, June 2018), <http://www.commonwealthfund.org/publications/blog/2018/jun/trump-administration-preexisting-conditions>.

<sup>161</sup> Mattie Quinn, ‘Medicaid-for-All’ Rapidly Gains Interest in the States, *Governing*, June 2, 2018, <http://www.governing.com/topics/health-human-services/gov-medicaid-buy-in-state-bill.html>.

is to automatically enroll otherwise-uninsured people who are eligible for substantial subsidies. Automatic enrollment is feasible, however, only when the subscriber owes no premium, but fortunately the way most insurers handled Silver-loading for cancelled cost-sharing payments has produced “zero dollar” Bronze plans in a good number of markets around the country. Therefore, this idea has renewed promise, although logistically it would appear to be tricky to identify eligible people who have not actually applied.

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To conclude this review of the state field reports, a Minnesota health plan representative brought a great deal of wisdom to the discussion by invoking “the adage that a rocket explosion isn't the result of one problem, it's the result of a series of problems that all work together. To me that is exactly what happened with the individual market. And so I don't think there's one single fix that does it.”

In finding the best path forward, these additional thoughts are instructive, also from (two different) sources in Minnesota (which is known for having an especially cooperative public policy community):

At the end of the day, I think the only thing I'd say [that can help] is the trust. ... [W]ouldn't it be great if we could take the politics out? I sound naïve or like I don't have my feet on the ground, but I really think that's the only way it's going to get done. We need some people with some courage to come forward [to craft a more permanent solution]. ... [H]ealth care is too important to play politics with. People's lives [are at stake].

## Conclusion

The ACA's individual market is in generally the same shape now as it was at the end of 2016. Prices are high and insurer participation is down, but these conditions are not fundamentally worse than they

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<sup>162</sup> See, e.g., sources cited in notes 9, 27, 37, 55, and 112. In addition, see (in no particular order):

- John Kasich, John Hickenlooper, et al., [Bipartisan Letter to Congressional Leaders], Aug. 30, 2017, [https://www.colorado.gov/governor/sites/default/files/press\\_releases/bipartisan\\_governors\\_blueprint.pdf](https://www.colorado.gov/governor/sites/default/files/press_releases/bipartisan_governors_blueprint.pdf)
- State Health Exchange Leadership Network, Letter to Sen. Alexander and Rep. Murray, Aug. 29, 2017, [https://nashp.org/wp-content/uploads/2017/01/HELP-Letter\\_SBMsandSBMFPs\\_Aug2017.pdf](https://nashp.org/wp-content/uploads/2017/01/HELP-Letter_SBMsandSBMFPs_Aug2017.pdf).
- Linda Blumberg & John Holahan, Stabilizing and Strengthening ACA Nongroup Markets (Urban Institute, Sept. 2017), <https://www.urban.org/research/publication/stabilizing-and-strengthening-aca-nongroup-markets>
- Health Reform Roundtable, A Bipartisan Answer to “What Now?” for Health Reform (Aug. 2017), <http://www.convergencepolicy.org/wp-content/uploads/2017/06/FINAL-Roundtable-statement-8.7.17.pdf>
- Bipartisan Policy Center, Stabilizing the Individual Insurance Market: What Happened and What Next? (March 2018), <https://bipartisanpolicy.org/wp-content/uploads/2018/03/BPC-Health-Stabilizing-The-Individual-Health-Insurance-Market.pdf>
- Michael E. Chernew & Christopher Barbey, Supporting The Individual Health Insurance Market (Aug. 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170807.061419/full/>
- Michael A. Morrissey, Turmoil in the Health Insurance Marketplaces: What are the Policy Options? (Leonard Davis Institute, Oct. 2016), <https://ldi.upenn.edu/brief/turmoil-health-insurance-marketplaces>.
- Jeanne Lambrew, et al., Recommended Actions For States To Protect Their Health Insurance Markets (Health Aff., Jan. 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180117.926755/full/>
- Milliman, Five Key Ways To Help Stabilize The Individual And Small Group Health Insurance Markets in 2018 (March 2017), <http://www.milliman.com/uploadedFiles/insight/2017/five-ways-stabilize-health-insurance-market.pdf>
- Oliver Wyman, Stabilizing the Individual Health Insurance Market (Aug. 2017), <http://www.oliverwyman.com/our-expertise/insights/2017/aug/stabilizing-the-individual-health-insurance-market.html>.



were at the end of the Obama administration. For a variety of reasons, the ACA's core market has withstood remarkably well the various body blows it absorbed during 2017, including repeal of the individual mandate, and halting payments to insurers for reduced cost sharing by low-income subscribers.

There are two key elements to the market's resilience. The primary one is the ACA's subsidy structure, which keeps insurance affordable for the majority of current subscribers, regardless of what happens to unsubsidized market prices. The second key stabilizing element is the willingness of state regulators to give insurers the rate increases they need to regain and maintain profitability. Especially important was the flexibility in most states to allow insurers to adjust their rates for Silver plans in a manner that protected most higher-income subscribers from the brunt of premium increases need to make up for lost cost-sharing payments, and that, at the same time, increased subsidies (and thus reduced net prices) for many lower-income subscribers. The prospects for continued enrollment of a sizeable number of subsidized and profitable subscribers has kept insurers from abandoning the market.

Much more troubled, however, is the unsubsidized portion of the ACA's individual market. Although insurers also continue to serve this market segment, steep price increases have been needed to achieve profitability and to counteract regulatory disruption, which is driving more unsubsidized people out of the market.

Also troubling is that, although stability is not fundamentally worse now than the year before, neither have conditions improved markedly, in most states. Absent the regulatory changes and political uncertainty that emerged in 2017, it appears that the ACA's individual market could have achieved a good deal more stability than it has. Especially troubling for insurers is the fact that, when recent changes have been made, insurers often were given no opportunity to adjust their pricing prior to the changes taking effect. This unpredictability caused some insurers to leave or avoid the market, and causes those who remain to increase prices more than they otherwise need to in order to have more cushion for the unknown.

Nevertheless, several measures hold some promise for improving the market, though each has limits. Reinsurance, partially funded through a "section 1332 waiver," can lower premiums roughly 10-20 percent, and encourage insurers to enter or remain in more sparsely populated areas. However, reinsurance is seen as only a stop-gap measure whose benefits are limited.

Rather than (or in addition to) reinsuring insurers, directly targeting funds to unsubsidized subscribers holds more promise for larger reductions in their premiums, and thus greater increases in coverage. However, supplemental federal funding is not available for expanding subsidies, so the strategy would need to be funded entirely by states.

Increased availability of coverage options outside the ACA-regulated market presents both a threat to stability, and a potential opportunity for a compromise improvement. The threat arises from allowing parallel markets to form that segment people according to their health status and medical needs. To avoid that, and to protect ACA markets that are working reasonably well, some states may want to limit these non-ACA-compliant options. However, in states where the ACA market is beyond repair for unsubsidized people, offering them a less expensive non-ACA option may be the least-worst path forward. Doing that is not likely to substantially harm those who remain eligible for subsidies. But unsubsidized people with existing health problems would be made worse off. That damage might be mitigated, however, by devising creative ways to target subsidies to those who now need them the most, perhaps by assessing the growing non-compliant portion of the market.

States might also consider the "public option" of allowing both subsidized and unsubsidized subscribers to buy into existing Medicaid programs, which have lower provider reimbursement rates. Expanding the pool of people covered by Medicaid provider rates, however, might cause some providers to leave the Medicaid program, or require the state to pay higher provider rates.

Beyond these more creative approaches, there are a variety of more obvious measures that could help stave off market deterioration. Investing in marketing and enrollment assistance can improve the risk pool, as can replacing the individual mandate with an alternative incentive for enrollment. Also, giving



insurers some flexibility to adjust their rates mid-year can increase their confidence in remaining in the market and being more parsimonious in setting their initial rates.

The measures currently available to states are unlikely, however, to improve the individual market to the extent that is needed. Although the ACA market is likely to survive in its basic current form, the future health of the market -- especially for unsubsidized people -- depends on the willingness and ability of federal lawmakers to muster the political determination to make substantial improvements.

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