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Marketplace Insurer Exits Are Not Inevitable

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President Trump has pointed to recent reports about insurers pulling out of the Health Insurance Marketplaces as evidence that "Obamacare is dead."[1] This conclusion is premature at best, and misleading at worst. Analyses by experts[2] and analysts[3] alike suggest that the Marketplaces set up under the Affordable Care Act (ACA) have been positioned for improvement in 2018. Unfortunately, the president may be making his prediction a self-fulfilling prophecy through actions, inactions, and open questions that cause Marketplace insurers to exit. This negative approach was underscored on May 22, with the Trump administration's motion to extend uncertainty rather than defend the current cost-sharing subsidy payment system.[4] Yet, it is not too late to prove Marketplace pessimists wrong.

This report describes actions that the Department of Health and Human Services (HHS) and states can take to ensure Americans in every county have access to Marketplace plans next year.

Background

Health insurers do not have to make their final decisions about participation in the 2018 Marketplaceuntil August 2017.[5] Yet, already, a number of insurance companies have stated they intend to withdraw from the Marketplace much earlier. For example, Aetna[6] said it will no longer offer any Marketplace plans; Humana[7] said the same earlier in the year; and Medica,[8] the last insurer in Iowa and Nebraska, expressed concerns about its ongoing participation.

These early exit announcements are not the norm. In each of the past four years, there have been no so-called "bare counties": areas in a state in which no individual (or nongroup) market insurer offered plans through the Marketplace. This matters, because only Marketplace enrollees may receive financial assistance (premium tax credits and cost-sharing reductions or subsidies). Putting aside the risks created by the current administration, previous years were riskier for insurers than 2018. For example, in 2014, insurers participated despite having basically no information on potential enrollees, concerns about the Marketplace website, and trepidations about entering a fundamentally reformed market. Yet, across the county, all eligible individuals have had access to Marketplace plans and, last year, nearly 80 percent of enrollees had access to two or more insurers.[9]

The recent insurer panic makes sense, however, in the context of a new administration and Congress intent upon repealing "Obamacare" and willing to "let it be a disaster."[10] Actuaries,[11] economists,[12] state insurance regulators,[13] and insurers[14] alike predicted significant premium increases due to uncertainty about the Trump administration's key policies. For example, premiums could be 19 percent higher[15] if the president makes good on his threat[16] to end cost-sharing subsidies according to experts. Another 15 to 20 percent[17] could be added if agencies fulfill his day-one executive

order[18] to waive or provide exemptions to individual shared responsibility provision (the individual mandate). The administration has also left open other policies and made other changes that could result in a worse risk pool in the Marketplace in 2018 (see Table 1).

Table 1. Trump Administration Actions Affecting the Marketplace Risk Pool

Actions	Why Actions May Yield Sicker Enrollees and Higher Premiums
Potential Actions	
Stop payment to Marketplace insurers for cost-sharing reductions (subsidies)	Ending $7 billion in annual subsidies that bring down copays and deductibles for low-income Americans could cause some insurers to withdraw from the Marketplace in the short-run; remaining insurers would raise their premiums to offset this loss, reducing unsubsidized enrollees
End enforcement of the individual mandate	Failing to enforce the requirement to either buy insurance or make a payment would result in fewer healthy enrollees
Reduce marketing budget and efficacy	Decreasing marketing funded by insurance company user fees and/or using fewer data analytics to effectively target eligible individuals would result in fewer healthy enrollees
Reduce other Marketplace program supports	Reducing call center hours or staff, navigator grants, technology support for HealthCare.gov or the Data Services Hub could limit opportunities for eligible people to sign up, resulting in fewer healthy enrollees
Fail to finalize rule on patient steering	Allowing dialysis centers to steer higher-cost patients from Medicare to the Marketplace drives up premiums, reducing unsubsidized enrollees
Actions to Date	
Shortened open enrollment for 2018	Reducing opportunities for outreach and efforts would limit enrollment of young, healthy uninsured people
Extended transitional relief through 2018	Allowing insurers to renew healthier enrollees in plans under older rules fragments the risk pool, with sicker enrollees ending up in Marketplace plans
Allowed lower actuarial value in silver plans and thus tax credits	Reducing premium tax credits for people who don't receive cost-sharing subsidies could cause some healthier ones to disenroll
Required documentation for all people signing up during special enrollment periods	Increasing paperwork burden may discourage some people from waiting until they are sick to sign up but may also dissuade enrollment by healthier people, as an initial test by HHS suggests[19]
Stopped next phase of individual mandate enforcement	Failing to enforce the requirement to either buy insurance or make a payment would result in fewer healthy enrollees

This year's early insurance company withdrawals may also reflect the lack of engagement and regular operation of the Marketplace. The Marketplace requires guidelines and actions to work properly. These range from determining budgets and plans for marketing, technology, in-person assistance, and the call center to working reliably with partners like state regulators, insurers, consumer groups, agents and brokers, and others. HHS to date has emphasized problems with this system rather than solutions.[20] But, HHS continues to announce rule changes for 2018, so there is still time for it to engage.[21]

There are a number of actions that have been, should be, and could be taken to ensure that every qualified American has a choice of a Marketplace plan with financial assistance in 2018,[22] including federal actions that can be taken alongside state-level actions (see Table 2).

Table 2. Actions to Ensure Marketplace Plan Access

What the Administration Can Do	What States Can Do
Facilitation	Regulatory relief
Plan certification and other flexibilities	Service area designation
Targeted marketing	Plan management
Modified risk adjustment	Bigger risk pool
Negotiation	State Innovation Waivers
Aligned service areas	Leverage Medicaid
Tying rule	Leverage other plans

What the Administration Can Do

Most of the actions described below relate to HHS in its role as primary manager of Marketplaces intwenty-nine states, although some could apply in the six states where Marketplaces are run through partnerships.[23] Some of the potential regulatory changes would apply in all states.

1. **Facilitation:** Facilitation was the only tool needed in the past four years to guarantee that Marketplace health plans were offered in all areas of the country. HHS worked closely with insurers and state insurance

commissioners to raise awareness of entry opportunities, help insurers adapt plan offerings to underserved areas, and provide technical assistance.[24] This sometimes involved tailored solutions that recognized unique state and local circumstances, such as working with Medicaid managed care plans newly entering an area to meet network adequacy standards. In the past, this always involved the director of the Center for Consumer Information and Insurance Oversight; it frequently involved the Administrator of the Centers for Medicare and Medicaid Services; and it occasionally involved the Secretary of HHS and White House officials. In short, leadership worked—and could couple with best practices going forward.

2. **Plan certification and other flexibilities:** The secretary of HHS, Tom Price, has flexibility in determining the criteria used to certify qualified health plans offered through the Marketplaces. He could adapt those criteria as needed to ensure Marketplace plans remain in underserved areas while maintaining core consumer protections. This could include flexibility on accreditation requirements, network adequacy provisions, and justification for rate increases, among others. These sort of actions would not require a regulation change, although the administration could, for example, modify rate review policies to take into account the higher administrative cost of health plans offering Marketplace coverage in underserved areas.

3. **Targeted marketing:** HHS could increase its spending on marketing and let stakeholders know its plans without any regulatory changes, which would instill confidence that additional enrollees will sign up in 2018. Beyond spending at least 3 percent of user fees for consumer education and outreach, HHS has flexibility in how it allocates its marketing budget.[25] It could use increased funding for marketing in underserved areas as an inducement for insurers to offer coverage there. Similarly, HHS could offer supplemental navigators grants in potentially underserved areas to improve the "risk mix" among their enrollees, making them more attractive to insurers.

4. **Modified risk adjustment:** Starting in 2018, the risk adjustment model for the individual market will include a small payment to be used for high-cost patients, similar to reinsurance.[26] Adjustment for high-cost patients brings greater cost certainty for insurers, lowering the price of entry into a costly (and therefore underserved) market. Through rulemaking, the administration could lower the current million dollar attachment point.

5. **Negotiation:** Many state-based Marketplaces use their leverage in certifying insurers that want to offer plans through the Marketplace to achieve goals such as improved affordability, quality, and access. The secretary of HHS could, through regulation, strengthen his ability to negotiate with insurers to serve all areas within a state in which he is operating the Marketplace. For example, the secretary could use this leverage to extend the original service area proposed by a Marketplace plan or secure cooperation of different insurers to ensure all qualified

individuals have access to Marketplace plans.

6. **Aligned service areas:** "Rating areas" allow for geographic adjustments to premiums within a state to reflect local costs, while "service areas" describe the geographic boundaries for a plan's enrollees. States set the rating areas for the Marketplace, with a federal default being Metropolitan Service Areas (MSAs) plus the remainder of the state that is not included in an MSA. This policy has resulted, for example, in sixty-seven rating areas in Florida, where counties are the basis of those rating areas.[27]Additionally, an insurer's service area may cover only a portion of a rating area. HHS could modify its regulations to have default rating areas with a minimum population size and require insurers to offer plans that cover the entire rating area. This would pool the most rural residents with other state residents to help spread out risk and drive down premiums. States could still have flexibility to set rating areas as long as they meet minimum population standards. This would prevent insurers from only offering within "more desirable" portions of a rating area.

7. **Tying rule:** Rather than relying on the secretary to negotiate with plans for access, HHS could implement a "tying" rule, like that previously used for the small business Marketplace.[28] This rule would require any insurer seeking to offer Marketplace health plans in part of a Marketplace (typically healthier and wealthier) to also offer Marketplace plans where it offers off-Marketplace coverage (typically with a less-well off or rural population). There tend to be no "bare counties" when it comes to off-Marketplace individual coverage and small group coverage. Networks and health plans exist in all areas of the country to serve different populations. A tying rule could automatically extend choice where parts of states are underserved.

What States Can Do

States that run their own Marketplaces, that conduct plan management functions, or that simply regulate their own insurers can deploy policy and other tools to ensure access to at least one Marketplace insurer in all areas of their state.

1. **Regulatory relief:** States are the primarily regulators of the individual market and have more tools and authorities than does HHS. They could, in the interest of securing federal financial assistance for all their residents, modify the basic rules for insurers interested in operating in their state (for example, entry and exit rules, licensure, and solvency standards).

2. **Service area designation:** States set the rating and service areas for their health plans, and some have used this authority to ensure statewide access to Marketplace plans. For example, Montana and Connecticut require insurers to provide plans statewide.[29] New York's Marketplace negotiates service areas with its insurers.[30] State

action can prevent insurers from only offering plans in areas with healthy people at the expense of those with sicker, older, or otherwise high-cost enrollees.

3. **Plan management:** States have the option of assuming primary responsibility for certifying qualified health plans for their Marketplaces. This affords flexibility in engagement with health insurers, tailored outreach to consumers, and policy choices that may better meet a state's needs such as a longer open enrollment period. Experience suggests that insurer choices and enrollment tend to be higher in states that assume an active role than those that let HHS assume those functions.[31] The Trump administration is encouraging states to certify their own health plans, and this greater involvement can improve Marketplace choice and competition.[32]

4. **Bigger risk pool:** States have had the option since 2014 of ending transitional or so-called "grandmothered" health plans—plans that follow the state rules that predate the ACA that may allow for practices such as medical underwriting and bare-bone benefits. To date, fifteen states have phased out such plans,[33] and evidence suggests this improved their risk pools and Marketplace choices.[34] Conversely, states with large fractions of individual market enrollees in pre-ACA plans, such as Iowa, may be at greater risk of having no Marketplace insurers in 2018. Most states can administratively end transitional policies, bringing residents into plans with the full protections of the law and making Marketplace offerings more attractive. They could also phase out other types of substandard plans, such as those offered by farm bureaus.[35] Additionally, the District of Columbia requires insurers to offer individual and small group market plans only through the Marketplace, maximizing risk pooling and robust Marketplace plan choices.[36]

5. **State Innovation Waivers:** The administration recently issued a checklist for section 1332 State Innovation Waivers to promote reinsurance for the individual market.[37] These waivers may also be used for other types of programs to improve Marketplace access, so long as they meet the statutory tests of covering as many people with comprehensive, affordable coverage without increasing federal costs (compared to baseline). This approach could include integrating catastrophic plans into the single risk pool and allowing premium tax credits to be used for such plans for young adults, or requiring providers to accept Medicare rates for the highest cost Marketplace enrollees, as has been recommended by those who created the Maine Invisible Risk Sharing Program.[38]

6. **Leverage Medicaid:** Taking the option to extend Medicaid to adults with incomes below 138 percent of the poverty threshold is associated with a 7 percent reduction in Marketplace premiums.[39] This is because lower-income populations tend to have greater health needs. Because this option is heavily federally subsidized, this not only benefits state budgets, but also lowers private premiums. For states that have already expanded Medicaid, a growing number of states are using their leverage to meet Marketplace as well as Medicaid goals. Arkansas's

private option uses Medicaid funds to buy people with income below 138 percent of poverty into Marketplace plans, thus increasing enrollment and interest by insurers in offering in the state's Marketplace.[40] Nevada gives points to insurers seeking Medicaid managed-care contracts if they also offer Marketplace coverage. States that harness the synergies of these two programs may improve choices and lower costs for their residents.[41]

7. **Leverage other plans:** States could also leverage their relationships with insurers in the Children's Health Insurance Program (CHIP) or their state employee health plan to ensure Marketplace plan access. A number of states have used CHIP plans to cover their workers' children, and state employees tend to live in all regions, thus ensuring that the health plan's network of providers is sufficient.[42] Some states have engaged in all-payer models on pricing[43] and value-based purchasing;[44] such systems could also be leveraged to ensure plan choices statewide. States may also condition state licensure for the individual market, Medicaid managed care, or Medicare Advantage on participation in the Marketplace.

Conclusion

Ordinary, not extraordinary, measures are needed to ensure all Americans have access to Marketplace plans. The choice of a Marketplace plan has been maintained nationwide, even when the financial risks for Marketplace insurers were graver than they are today. And the Marketplace has worked consistently well in engaged states, irrespective of whether their politicians supported the ACA. In Nevada, for example, Marketplace premiums and premium growth have been consistently below the national average, and the number of insurer choices has been relatively high and steady.[45]

Ordinary, not extraordinary, measures are needed to ensure all Americans have access to Marketplace plans.

Beyond the potential strength of Marketplaces with engaged management, there is the basic fact that a sole insurer in an underserved area can set premiums based on cost with little competitive pressure. This helps explain why Arizona's benchmark premiums increased by 116 percent for 2017: only one insurer offered coverage in most of the state.[46] The ACA's premium tax credit structure insulated nearly 80 percent of all enrollees from most of this increase, and thus enrollment in the state for 2017 was largely unchanged.[47] In short, the system is designed to offer strong financial incentives to maintain access to health plans.

These incentives can be undermined, however, by actions and inactions by the administration or state officials. From the president's Day 1 executive order[48] to his threat to stop cost-sharing subsidies,[49] there is little evidence that this administration will fulfill its responsibilities under current law to run the Marketplace. That said, there is still time for leadership to prevent Americans from losing their access to Marketplace plans next year.

Notes

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