

U.S. Health Reform—Monitoring and Impact

Effects of Medicaid Health Plan Dominance in the Health Insurance Marketplaces

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

INTRODUCTION

Medicaid insurers, managed-care organizations that offered coverage through Medicaid programs before 2014 but had not sold insurance in private insurance markets until then, have become increasingly dominant in many of the Affordable Care Act (ACA) health insurance marketplaces across the country. In 2020, Medicaid insurers are offering marketplace coverage in 255 of the 502 rating regions nationwide, and the regions in which the plans participate span 29 states and account for nearly two-thirds of the U.S. population.¹ Medicaid insurers also frequently offer the lowest-premium plans on the marketplace; in 2020, they offered the lowest-cost silver plan in 59 percent of the regions they participated in.¹ Over the past few years, Medicaid insurers nationwide have expanded their footprints in the marketplaces, including by entering new markets previously dominated by a single insurer.²

Prior research indicates that the presence of a Medicaid insurer in the marketplace tends to be associated with lower premiums and smaller premium increases.¹ A recent study of premiums and insurer participation in U.S. marketplaces between 2017 and 2020 found that states with the lowest-cost silver premiums usually had at least one participating Medicaid insurer, several competing insurers, or both.² Two factors associated with lower premiums among Medicaid insurers are their tendencies to have narrower networks and to contract with providers willing to accept lower payment rates. Lower premiums have benefits for both marketplace competition and for consumers. However, health system stakeholders have raised concerns, particularly in the early years of ACA marketplace operations, about the potential negative consequences of Medicaid insurer participation in the market, namely consumer access concerns related to limited networks, provider concerns related to inadequate reimbursement, and concerns that a Medicaid insurer's

presence would drive competing commercial insurers out of the market.³

In this brief, we examine the effects of Medicaid insurer participation on health insurance marketplaces, focusing on six state marketplaces in different U.S. regions. The brief is based on discussions with more than 20 health system stakeholders in the six states, discussions which explored how Medicaid insurers function in the marketplace and the advantages and disadvantages associated with their presence.

METHODS

For this study, we selected six states with one or more Medicaid insurers participating in the marketplace for the 2020 plan year: Arkansas, California, Florida, New York, Ohio, and Washington. Table 1 provides background information on the marketplaces and Medicaid managed-care environments in these states. In four of the six study states, every marketplace rating area had at least one participating Medicaid insurer in 2020 (Table 1, fifth column), and in three of those four states, a Medicaid insurer offered the lowest-cost silver plan in every rating area (seventh column). For study states with available marketplace enrollment data, the proportion of total marketplace enrollment attributed to a Medicaid insurer in 2018 ranged from roughly one-third (Florida) to nearly two-thirds (Ohio). Five of the six states have robust Medicaid managed-care programs, with at least three-quarters of Medicaid beneficiaries enrolled in a comprehensive, risk-based managed-care program (eleventh column).

We conducted 21 structured telephone interviews with key stakeholders in the six study states between December 2019 and February 2020. Interviewees included representatives

from state departments of insurance, hospital associations, medical or primary care provider associations; insurance brokers; and consumer advocates (we did not speak to all of these stakeholder types in all states). We asked interviewees for their observations about (1) how Medicaid insurer participation influenced marketplace dynamics, including

whether and how Medicaid insurers' price positions affected their market share, and (2) the pricing and participation strategies of their marketplace competitors. We also asked for their perspectives on the differences between Medicaid insurers' and commercial competitors' marketing strategies, business models, network types, and consumer complaints.

Table 1: Health Insurance Marketplace and Medicaid Managed Care Characteristics in Six Study States

State	Marketplace						Medicaid Managed Care			
	Total number of insurers in state marketplace	Marketplace rating areas				Enrollment in 2018		Number of Medicaid MCOs in 2017	Percent of state Medicaid enrollment in risk-based managed care	
		Total number of rating areas	Has participating Medicaid insurer		Lowest-cost silver plan offered by Medicaid insurer		Total marketplace enrollment			Share enrolled with Medicaid insurers
			2019	2020	2019	2020				
Arkansas	4	7	7	7	7	7	71,867	41%	N/A	N/A ¹
California	12	19	14	14	5	4	N/A	N/A	23	80% ²
Florida	9	67	26	30	14	7	1,815,484	30%	16	81%
New York	15	8	8	8	7	6	N/A	N/A	22	74%
Ohio	10	17	16	17	12	17	237,968	64%	6	83%
Washington	9	9	9	9	9	9	N/A	N/A	6	88%

Notes: MCO = managed-care organization.

¹ Arkansas only recently (late 2019) began enrolling Medicaid beneficiaries in risk-based managed care. At the time of this writing, risk-based managed-care enrollment was limited to people with significant developmental disabilities or serious behavioral health problems in the state.

² California's total Medicaid MCO count includes six health insuring organizations, member plans in California's county-organized health systems.

N/A: Not Applicable

Sources: Medicaid MCO data were taken from <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>.

Marketplace data were taken from Healthcare.gov for federally facilitated marketplaces and from state marketplace platforms for state-based marketplaces.

Enrollment numbers taken from Urban Institute analysis of the Centers for Medicare & Medicaid Services' Center of Consumer Information and Insurance Oversight marketplace issuer-level enrollment data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/issuer-level-enrollment-data>.

FINDINGS

Medicaid insurers are a critical and competitive option in health insurance marketplaces.

Across the six states we studied, Medicaid insurers participate in 80 of 127 marketplace rating regions (Table 1). In 54 of these 80 regions, a Medicaid insurer offers the lowest-cost silver plan (Table 1). Medicaid insurers, representing both national chains and local "homegrown" managed-care organizations, have been increasingly participating in the marketplaces, expanding their coverage areas in some states and entering others where they have no prior experience. Ambetter, a product of the Centene Corporation, has entered the marketplace in numerous states (including Arkansas) where it had no previous Medicaid business. A health insurance broker in Arkansas compared Ambetter to a commercial competitor, USABLE (an Arkansas Blue Cross Blue

Shield affiliate), noting that while USABLE had implemented steep price increases prior to 2020, Ambetter's prices remained static. Arkansas stakeholders felt the introduction of Ambetter was crucial for the marketplace because it offered consumers a more affordable option. Ohio interviewees reported a similar dynamic: CareSource had participated in Ohio's marketplace since its 2014 launch, offering a low-cost option early on. Another Medicaid insurer, Molina, joined a few years later, giving consumers an additional, more affordable option. Ohio respondents all indicated that offering consumers additional lower-priced choices in the market was hugely beneficial. The marketplaces incentivize insurers to compete against one another to offer the lowest-cost plans and thus gain enrollment. When asked about Medicaid insurers' impact on marketplace dynamics, an interviewee in Washington said, "I think that they push the competition, as they're supposed to. I don't think the [commercial] carriers like losing business to them, so they watch them pretty carefully."

Medicaid insurers' business models are the key to their competitive edge.

Leveraging Provider Networks

Medicaid insurers have leveraged their existing business models and provider relationships to enter and thrive in the marketplaces. One way they have succeeded is by initially introducing closed provider networks that are narrower than their competitors' in exchange for favorable provider payment rates. This trend has been growing in health insurance marketplaces and in private health coverage products overall, but the entrance and expanded presence of Medicaid insurers in the marketplaces may be accelerating it. A California interviewee credited the narrow networks with keeping premium increases low year after year, noting that "every one of our [marketplace] plans has had narrow networks day one. And that's part of what has been a factor in California's success. We've had relatively little rate increases across all of our plans." Another interviewee in Washington noted, "In Washington, [the Medicaid insurers] were the ones who immediately went to [evidence-based] managed-care, they went to tighter networks and promoted that." By moving the marketplace toward a more managed-care setting, Medicaid insurers have controlled costs and kept premiums low.

Many Medicaid insurers have built their marketplace business on preexisting relationships with providers serving their Medicaid managed-care enrollees. These relationships have advantages and disadvantages for insurers, because Medicaid and marketplace contracts with providers are typically negotiated jointly. With millions of enrollees in Medicaid managed-care programs, Medicaid participation may account for a significant share of insurers' businesses, particularly in expansion states. Many interviewees observed that Medicaid insurers leverage this by guaranteeing providers a large volume of Medicaid patients in exchange for lower payment rates. But, providers can also use jointly negotiated Medicaid and marketplace contracts to their advantage. As one interviewee in Washington observed, "They're going to have relationships between the Medicaid products and exchange products. For example, [two Medicaid insurers] backed off offering bronze products in the marketplace, because their providers in Medicaid complained about bad debt, and they basically said, 'If we're going to continue to get bad debt from marketplace customers, we're going to ask for a better deal on Medicaid.'"

Lower Administrative Costs

Another feature of Medicaid insurers' business models that contributes to lower pricing is their tendency to have lower administrative costs than their commercial counterparts. Commercial insurers must spend resources developing plan designs and tend to have larger marketing budgets.

Medicaid insurers spend less on actuaries and developing alternative plan designs, which are not required in Medicaid managed care. Medicaid insurers do not require the amount of resources commercial networks do for processing claims or maintaining networks (which are generally smaller). However, a leaner administrative base can mean Medicaid insurers may sometimes lack the infrastructure needed to handle the influx of covered lives and new systems involved in marketplace participation.

More Reliance on Utilization Review

Because of their history of operating as managed-care organizations for Medicaid programs, Medicaid insurers are familiar with utilization review methods and have applied this to their marketplace products. Most interviewees indicated that Medicaid insurers tend to have more stringent utilization review measures than commercial competitors, though a few said there were no differences in this area. Interviewees suggested Medicaid insurers were more likely to have stricter prior authorization and STEP therapy requirements and that Medicaid insurers have adopted more comprehensive care management practices. When asked about utilization control measures for Medicaid insurers versus those for commercial insurers, a New York interviewee said, "Yes, [measures for Medicaid insurers] are a little tighter. We see more denials... and more restrictive networks for ancillary services too." That interviewee also observed that commercial insurers have adopted tighter utilization management, seemingly in response to Medicaid insurers' policies.

Broker Commissions

Medicaid insurers might now pay higher broker commissions for marketplace products, at least in the states we studied. Historically, Medicaid insurers have not engaged with brokers in the marketplace, considering them unnecessary for boosting enrollment.⁴ However, the brokers we interviewed reported that Medicaid insurers have increased broker compensation to attract a broader pool of enrollees. Some interviewees indicated that the higher commission intended to get brokers' attention, reporting that brokers had virtually ignored Medicaid insurers in the early years of marketplace operations. Adding this incentive has boosted enrollment in these plans. When asked about Medicaid insurers' broker commissions, an Ohio broker reported, "At the beginning, no [we did not get a commission from Medicaid insurers], but as time has progressed, the marketplace business in Ohio is more popular than it was a few years ago. The compensation rates [between Medicaid and commercial insurers] are now very close, if not identical."

Familiarity with Covering Enrollees with Lower Incomes and Continuity across Programs

Serving Medicaid and marketplace enrollees offers distinct

advantages for Medicaid insurers by helping former Medicaid enrollees gain and maintain enrollment. By offering marketplace plans, Medicaid insurers can provide continuous coverage to people who may transition (sometimes called “churning”) between Medicaid and the marketplace. It states that expanded Medicaid (which include all states we studied except Florida), a portion of the Medicaid population (e.g., seasonal workers) becomes eligible for marketplace coverage during the year because of income fluctuations. This is beneficial to Medicaid insurers’ business models and consumers alike. Specifically, Medicaid insurers participating in the marketplace can also cover an entire family even when its members are eligible for different insurance programs, simplifying health coverage navigation and making it easier for families to receive optimal care. For instance, a family might have children enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) (because children are typically eligible for these programs at higher income levels than are adults) and parents enrolled in a marketplace plan. As one interviewee explained, “I think [Medicaid insurers in the marketplace] are serving a population that hasn’t been as well served in the past from a price point. There is a lot more continuity in families... children who are on CHIP, a natural evolution is that those parents will be on a [marketplace] plan with same network, same delivery system.”

Finally, many Medicaid insurers have a public mission to provide coverage to lower-income populations. As such, these insurers are a natural fit for the marketplace. The marketplace population tends to have lower incomes and have a similar risk profile and set of needs as the Medicaid population. Many Medicaid insurers offer wraparound services common in the Medicaid program but typically unavailable in commercial insurance plans. Some Medicaid insurers offer transportation to and from medical appointments and have a greater focus on care coordination, such as referral systems to social services like counseling, employment, housing, and legal resources. Some interviewees noted that this familiarity with serving a lower-income population has enabled Medicaid insurers to better manage premium increases and maintain profitability while serving new enrollees who were previously uninsured or had limited access to care. Discussing insurers faced with covering a lower-income population buying coverage through the marketplace, an Arkansas provider said,

“Our traditional insurance companies, they were a little panicked. They had no idea how to even plan for taking care of a population they had never paid any attention to. I think that probably meant that they had higher premiums. [By comparison, the Medicaid insurer’s] premiums have been lower...because their business model helped them know better how to plan for this population.”

Medicaid insurers have largely evolved and adapted to the commercial marketplace, and interviewees perceived few differences between these insurers’ plans and those of traditional commercial insurers.

Most interviewees noted that though there may have been some key differences between Medicaid insurers and commercial insurers in the early years of ACA marketplace implementation, those differences have largely diminished. When considering networks, provider rates, benefit designs, and marketing practices, one California broker said that they “don’t really see much of a distinction at all” between the two types of insurers.

Network Breadth

Interviewees commented that Medicaid insurers’ networks have slowly evolved to more closely resemble commercial networks: after having a high volume of federally qualified health centers and Medicaid providers in earlier years, to now including a broader range of providers. A state regulator in Washington suggested this growth was partly owed to insurers’ need to comply with network adequacy requirements and expand networks that were originally “too tight.” In other states, such as Arkansas, state law dictates a broader provider mix. One Arkansas law requires health insurers to accept a medical provider in their network if that provider agrees to the insurer’s terms and conditions.⁵ This “any willing provider” law covers licensed physicians and many types of specialists, including physical therapists, dentists, optometrists, psychologists, licensed professional counselors, long-term care facilities, rural health clinics, and licensed certified social workers. Though some hospital and provider associations still believe Medicaid insurers’ networks are narrower than those of their commercial counterparts, most other stakeholders said the industry as a whole has been moving toward narrower network offerings to control costs. A Florida broker explained that even large insurers that started with broad national networks, like Anthem, are adopting smaller, localized networks. In this way, the insurers seem to be meeting in the middle, as Medicaid insurers’ networks expand and traditional commercial insurers’ networks contract.

Reimbursement

When asked whether the rates Medicaid insurers pay their marketplace network providers are most similar to Medicaid, Medicare, or commercial rates, interviewees answered differently. A few hospital association representatives said Medicaid insurers’ reimbursement rates in the individual market are higher than Medicaid rates but lower than traditional commercial rates. Still, one association representative cautioned that rates would ultimately depend on how dominant an insurer is in the market; a smaller insurer

would likely have to pay providers more to entice their participation in the network compared to a larger insurer, which might have more leverage to negotiate lower rates. In Arkansas and New York, interviewees indicated that Medicaid insurers' physician reimbursement rates are increasingly nearing commercial rates to attract provider participation. As one interviewee explained, "Medicaid plans are paying more and more and more to catch up with commercial insurers." Yet other interviewees estimated that these reimbursements may be closer to Medicare rates, particularly for hospitals. These contrasting views stem from the fact that information on provider reimbursement rates is not publicly available. So, though pinpointing where Medicaid insurers' marketplace reimbursement rates fall on the spectrum is difficult, the general consensus is rates have increased in recent years.

Benefit Design

Because the ACA requires coverage of certain health services in the health plans sold through the marketplace, interviewees reported few differences between competing insurers' benefit designs. One Florida broker explained that complying with the state's benchmark plan forces insurers to offer benefit packages that "are almost virtually identical." Similarly, California requires all marketplace insurers to offer standard patient-centered benefit designs,⁶ so the plans are considered "100 percent equal." If anything, stakeholders suggested Medicaid insurers sometimes offer more generous benefits than traditional commercial insurers. Anecdotally, Medicaid insurers were more likely to cover certain services before deductible than their commercial counterparts, in addition to covering the social services described earlier. For example, in Ohio, Medicaid insurers reportedly tend to cover more dental, vision, and primary care, as well as fitness memberships.

Marketing and Advertising

Interviewees mostly agreed that Medicaid and commercial insurers market and advertise their products similarly. They felt that the Medicaid insurers in their state did not target advertising to a particular demographic; rather, they said all marketplace insurers have focused marketing efforts on price point and brand-name recognition. Some interviewees suggested commercial insurers seem to use more sophisticated advertising, such as social media and television commercials, compared with the Medicaid insurers that, at least in some states, advertise more on the radio, at community events, and through public transit ads. However, most interviewees noted that any advertising differences between the two "types" of insurers are nominal. As one state-based marketplace official put it, "There's not any systemic difference around marketing spend because every one of our

plans [regardless of "type"] approaches marketing somewhat differently."

Overall, when asked to explore the differences between Medicaid and commercial insurers, interviewees cited few distinguishing factors. One state regulator concluded that the Medicaid plans are "very confident" in what they are doing, and another said that now "they are just another plan on the marketplace."

Early skepticism regarding how Medicaid Insurers would compete in the commercial market has largely dissipated.

When Medicaid insurers first entered the individual market, many worried that they might lack the infrastructure or experience to serve a new consumer market, their networks might be too narrow, and their lower prices might drive other insurers to exit the market. However, interviewees specified that these concerns have largely not been realized.

No Significant Consumer Complaints

According to most interviewees, consumers enrolled in Medicaid insurers' plans have few complaints. When complaints do arise, they are not specific to the Medicaid insurers but are more broadly tied to insurance affordability issues and the gradual narrowing of networks across all insurers. For example, an Ohio insurance broker lamented, "[People] are not completely happy with their health insurance under any circumstances...[but] these [Medicaid] carriers are no different."

On the other hand, interviewees representing provider and hospital associations reported hearing complaints not from consumers but from their provider members, regarding the Medicaid insurers' payment rates and infrastructures. Stakeholders in Ohio reported a disconnect in payment negotiations that can strain the payer-provider relationship; Medicaid insurers tend to advocate for payment rates resembling those in the Medicaid program, because most of their business is rooted in Medicaid. In contrast, providers often seek reimbursement rates closer to those in other commercial plans, because they view the Medicaid insurers as any other private payer selling in the individual market. This perception has caused tension with providers who believe Medicaid insurers can no longer claim to be public payers. In Florida, these conflicting views have caused "major payment issues" and have been an "administrative nightmare" for some providers who believe the payment rates are insufficient. One medical association also noted that it can be more difficult for providers to "[get] in touch with the right person" working for a Medicaid insurer, because the Medicaid plans tend to be smaller and have less infrastructure than commercial insurers' plans. A provider association in Washington agreed with these

sentiments, saying the administrative processes of securing a first payment or getting prior authorization from a Medicaid insurer can be more challenging. Despite these challenges, no interviewees reported hearing complaints about the benefits or comprehensiveness of Medicaid insurers' plans.

State regulators reported that they have not had to step in and take much action against Medicaid insurers. Florida regulators have been pleasantly surprised by how well Medicaid insurers have integrated into a new market, describing them as responsive in addressing issues, such as early concerns related to network adequacy. Some respondents believe that because these insurers are accustomed to the highly regulated Medicaid market, they are used to operating within strict parameters and can easily adapt to changes in annual requirements. One California broker explained, "They know the regulators will come after them and...they just have checks in place."

No Indications of Undermining Competition

Most interviewees agreed that Medicaid insurers' increasing presence has not caused other traditional commercial insurers to drop out of the market or scale back their participation. One broker noted that two new insurers joined Washington's marketplace in 2020,⁷ even though Medicaid insurers, like Molina, are prevalent there. Interviewees also cited other states where commercial insurers were continuing to expand their presence. A Florida regulator noted, "We've had a lot of big carriers coming in...none of the big carriers...have been leaving, they have been increasing." Some states have regulations in place to deter insurers from dropping out. In New York, interviewees cited the governor's 2017 executive order warning that insurers dropping out of the individual market might jeopardize other contracts with the state.⁸ Though interviewees acknowledged that some insurers left the marketplaces early on because of financial losses and closures, the majority said these departures had nothing to do with a Medicaid insurer's presence.

Rather, the stakeholders interviewed like having Medicaid insurers in their markets but understand that robust participation might be impossible for many of them. One state-based marketplace official explained that it can be daunting for these plans, whose core business is in the Medicaid program, to pour resources into doing a small amount of business in the individual market. Others argued that provider contracting is becoming more difficult for Medicaid and commercial insurers as providers seek greater reimbursement and insurers struggle to contain health care costs. Interviewees said this reality is likely to have a larger impact on insurer participation than on the type of insurers selling in the market.

Many stakeholders felt positively about Medicaid insurers, believing such plans benefit consumers and add value to the market.

Overall, interviewees expressed positive impressions of the Medicaid insurers participating in their states' marketplaces, citing more advantages than disadvantages. Most noted that greater competition is valuable and that consumers benefit when there are more choices of competitively priced products. They suggested Medicaid insurers often provide options that are more affordable for consumers ineligible for subsidies. However, some interviewees remain skeptical of the broader impacts of Medicaid insurers' lower pricing. When considering whether a commercial insurer would lower its premiums to compete with a Medicaid insurer, one Ohio broker argued, "I think they'll walk away from the market before they would lower their prices." Thus, stakeholders see value in Medicaid insurers' more affordable products but believe these insurers' ability to influence other commercial insurers' pricing is limited.

Regulators appreciated the continuity Medicaid insurers have brought to their markets. They were quick to note that Medicaid insurers "stuck around" in the early years of marketplace implementation. One regulator expressed gratitude for these insurers, saying, "We appreciate that Celtic, in its various forms, has stayed around while some of our other carriers—Humana and United[Health Group]—haven't." As Medicaid insurers have continued participating in counties that would otherwise have had no insurers offering plans, they have brought greater stability to regulators' marketplaces. One Ohio broker reported that if the Medicaid insurers had not been part of the marketplace in 2019, the state could have had as many as 20 bare counties. With relief, this broker reflected, "I can't stress enough...thank goodness they are here."

From a consumer perspective, the continuity that Medicaid insurers provide for people who churn between Medicaid and the marketplace is no small matter. Across the board, broker interviewees explained that consumers' top concerns when selecting a plan are price and the ability to stay with their current health care providers. Brokers reported that familiarity with their insurers and their provider networks plays a major role in consumers' enrollment decisions. For consumers who maintain access to their current providers, this makes better care coordination possible.

Few respondents could identify any disadvantages of having Medicaid insurers in their marketplaces, though some expressed concerns with their narrower networks, provider reimbursement rates, and administrative processes. In some cases, issues tied to these concerns were so problematic

early on that interviewees believed some providers still view Medicaid insurers as carrying “a bit of a reputation” even if the issues were resolved years ago. However, by and large, interviewees cited no ongoing disadvantages of Medicaid insurers’ increased marketplace participation nor any inadequacies of their plans. As one state regulator summarized, “We have requirements. So long as they’re meeting those requirements, we’re happy to have them as a choice.”

CONCLUSION

Medicaid insurers are becoming increasingly dominant in the ACA’s marketplaces and have grown to compete effectively with traditional commercial insurers. By employing tighter networks, leveraging lower provider rates, and keeping their administrative costs down, these insurers have taken their experiences from the Medicaid program and applied them successfully in the individual market. Moreover, they have started adopting some commercial insurers’ practices, such as paying broker commissions, engaging in more marketing and advertising, and slowly increasing their payments to providers. Early on, stakeholders were skeptical of Medicaid insurers’ ability to enter a new market, but initial concerns with their networks, pricing, and impact on other insurers’ participation have largely dissipated. In fact, many feel there are no longer major distinctions between Medicaid and commercial insurers in the marketplaces. Most interviewees have positive perceptions of Medicaid insurers, crediting their ability to increase choice and affordability in the individual health insurance market.

ENDNOTES

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