

ACA Implementation—Monitoring and Tracking

Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices

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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 the Patient Protection and Affordable Care Act of 2010 (ACA). 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.

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) is facing an uncertain future, with a new president and Congress committed to its repeal. Health insurers have no legal obligation to participate in the ACA's marketplaces, but without them, millions of consumers would be unable to obtain the federal premium subsidies that help make health insurance affordable.

Through a set of structured interviews with a range of insurers participating in the ACA marketplaces, this paper explores how they are likely to respond to different potential repeal scenarios that have been floated by opponents of the law. These include an immediate repeal of the ACA's requirement that individuals purchase insurance or pay a penalty (the "individual mandate") but a delay in repealing the law's financial subsidies, a "repeal and delay" strategy in which Congress repeals the law but delays the effective date for one or more years, and a midyear cutoff of the ACA's cost-sharing subsidies for low-income enrollees. Insurers outlined the following responses to these potential repeal scenarios:

- An immediate repeal of the individual mandate will not lead insurers to exit the market in 2017, in part because of their contractual obligation to remain. However, insurers reported they would "seriously consider" a market withdrawal in 2018 if the mandate is repealed without an effective replacement. Insurers reported that at a minimum, their premiums would need to increase in 2018 to reflect the likelihood of a sicker risk pool.
- A "repeal and delay" strategy without a concurrent replacement for the ACA would destabilize the individual market. Although insurers saw value in a buffer period

to adjust to a new regulatory structure and educate consumers about changes, they perceived "significant" downside risk in remaining in the marketplaces while the details of an ACA replacement are in doubt. There was no consensus among insurers about how long a transition period should be, but most insurers estimated that the task of adapting to a new regulatory framework would take multiple years.

- The elimination of cost-sharing reduction payments in 2017 would cause insurers significant financial harm. Most insurers believed they would be forced to exit the marketplaces or the entire individual market as quickly as state and federal law would allow; other insurers indicated they would try to implement a midyear premium increase.

The anticipated partial or total repeal of the ACA has given rise to considerable uncertainty about the future of the law's health insurance marketplaces and coverage for the projected 13.8 million people who will be enrolled in marketplace plans in 2017. We find that so long as policymakers enact concrete replacement policies and provide the insurance industry significant time to implement them, insurers are generally confident that they could manage a transition to a new regulatory regime. However, if the ACA is repealed after a delay but not concurrently replaced, or if the individual mandate is immediately ended, insurers expect material market exits and significant premium increases in 2018. If cost-sharing subsidies cease in mid-2017, the destabilization of the marketplaces will accelerate regardless of whether the ACA is repealed.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) is facing an uncertain future, with a new president and Congress committed to its repeal. How policymakers approach a rollback of the law is of critical importance, not just to the estimated 22 million people who have gained coverage, but also to the private health insurers upon whom much of the ACA's coverage expansion depends.¹ Health insurers have no legal obligation to participate in the ACA's marketplaces, but without them, millions of consumers would be unable to obtain insurance or the federal premium subsidies that help make that insurance affordable.

Insurers participating in the ACA's marketplaces, which launched in 2014, had a rocky experience for the first few years. In part because of fierce price competition, many experienced significant financial losses, particularly in 2014 and 2015, and some decided to discontinue their participation as a result.^{2,3} In many markets, insurers raised their premiums significantly; other markets saw more moderate premium growth.⁴ Emerging data for 2016 suggest that the financial picture is improving

for many marketplace insurers, with market analysts predicting continued improvement in 2017.⁵ However, this emerging market stability is threatened by the considerable uncertainty over whether and for how long the marketplaces will continue to exist if the ACA is repealed.

Through a set of structured interviews with a range of insurers participating in the ACA marketplaces, this paper explores how they are likely to respond to different potential repeal scenarios that have been floated by opponents of the law.^{6,7} These include a "repeal and delay" strategy in which Congress repeals the law but delays the effective date for one or more years, an immediate repeal of the ACA's requirement that individuals purchase insurance (the "individual mandate") but a delay in repealing the law's financial subsidies, and a midyear cutoff of the ACA's cost-sharing subsidies for low-income enrollees. We find that the uncertainty over how Congress will act and when insurers will obtain information about the rules under which they must operate will lead many to reassess their participation in these markets and others to significantly increase premiums.

BACKGROUND AND METHODOLOGY

A key goal of the ACA is to help consumers obtain affordable coverage through health insurance marketplaces, where private insurance companies would compete on price and quality. Achieving this goal was premised on a three-part social bargain: First, insurers would no longer be allowed to deny coverage or charge higher rates to people with pre-existing conditions. Second, to prevent people from waiting until they are sick to sign up for insurance, consumers would be expected to maintain health coverage or pay a penalty (the individual mandate). Third, to make that coverage more affordable, low- and moderate-income consumers buying through the marketplaces could receive income-based premium tax credits and cost-sharing subsidies. These three policies are often referred to as the "three-legged stool" of the ACA because repealing or dismantling any one of them would cause the insurance market to collapse.^{8,9}

These reforms, along with an expansion of the Medicaid program, were implemented in 2014 and have resulted in 22 million people gaining coverage.¹ Approximately 11.1 million people have enrolled through the marketplaces,

with a projected 13.8 million enrolling for 2017.¹⁰ The vast majority—85 percent—of marketplace consumers receive premium tax credits, and 57 percent have deductibles and other cost-sharing reduced through federal cost-sharing subsidies.¹¹ However, the marketplaces depend on private insurance companies to deliver these benefits, and many of these companies struggled financially in the first two years of the marketplaces. Several factors contributed to these financial difficulties, including a lack of data about new enrollees' health status and utilization of services, aggressive pricing by new market entrants, and the decision by Congress to cut a key risk mitigation (the "risk corridor") program after insurers were locked into their prices. The resulting shortfalls in revenue caused a number of insurers, including the large national carriers UnitedHealthcare, Aetna, and Humana, to curtail their marketplace participation.¹² Other insurers significantly increased their premiums for 2016 and 2017, and some smaller plans became insolvent. However, emerging financial data from 2016 suggest that price hikes and the implementation of cost containment strategies have helped insurers find their financial footing and chart a path to profitability.⁵

Yet just as the health insurance marketplaces have begun to achieve stability, a new Congress and administration committed to repeal of the ACA are taking office. At the time of this writing, congressional leaders have begun the process of repealing key provisions of the law through a legislative procedure known as budget reconciliation. While the specific content of a repeal bill is not yet certain, lawmakers are expected to take steps to end the ACA's individual mandate and financial subsidies, among other provisions. Further, repeal legislation would likely take effect in stages. Though some parts of the ACA, such as the individual mandate, may go away immediately, other provisions, including the financial subsidies, may continue for a limited time. Republican leaders suggest that such a transition period, which may last for multiple years, will provide a buffer for consumers and give Congress additional time to decide how to replace what it has repealed.¹³ But there is another, more immediate threat to the ACA's marketplaces: Without need for congressional action, the new

administration could cease subsidies that help reduce the cost-sharing of low-income marketplace enrollees. However, under the law, insurers would still be legally required to provide cost-sharing reductions (CSRs) to eligible enrollees, leaving them with significant financial shortfalls under such a program.¹⁴ These potential administrative and legislative actions create an environment of great uncertainty and risk for insurers participating in the individual market and for consumers that rely on their coverage.

To better understand how insurers might respond to this uncertainty, researchers conducted structured interviews with executives of 13 insurance companies participating in the individual market in 28 states. The companies included large, for-profit carriers operating across multiple states, regional nonprofits, former Medicaid-only plans, and integrated, provider-sponsored plans. Interviews were conducted between December 5, 2016, and January 11, 2017.

FINDINGS

Most of the insurers we interviewed had not anticipated the election outcome and, just a few weeks after the election, were still assessing the range of potential policy changes they could face in 2017 and beyond, as well as the impact on their companies. However, all of them are still actively selling their plans to consumers via the ACA's marketplaces and remain committed to these markets at least through the current year. These insurers have had a mix of experiences. Many have lost money on their marketplace business, and others are barely breaking even. A few have made money. Some have dramatically reduced their offerings in the ACA marketplaces, while others have expanded their presence. All viewed the uncertainty about federal policy towards the marketplaces as bad for their businesses and for the overall stability of the individual market, both inside and outside the marketplaces. At the same time, the insurers we interviewed expressed confidence that they could manage policy changes, even dramatic ones, as long as the rules are made clear and they are given sufficient time to implement them. However, all expressed significant concerns with one or more of three potential scenarios floated by policymakers: (1) immediate repeal of the individual mandate with delayed repeal of financial subsidies, (2) delayed repeal of the ACA without its concurrent replacement, and (3) a cutoff of cost-sharing subsidies in 2017. We discuss their responses below.

Repeal of Individual Mandate Likely to Lead to Higher Premiums, Market Exits

Marketplace insurers have faced, and often overcome, a number of regulatory and financial challenges. However, they have not yet experienced a regulatory environment in which one of the fundamental pillars of the ACA is eliminated. Prior congressional efforts to repeal the ACA have included an immediate repeal of the individual mandate, coupled with a delayed repeal of the law's premium and cost-sharing subsidies.¹⁵ Respondents noted that the individual mandate is a key part of an interlocking set of policies designed to ensure a viable risk pool in the reformed individual market. In surveys, as many as 40 percent of marketplace enrollees have indicated they would not have enrolled without the mandate.¹⁶ The insurers we interviewed worried about the ramifications of removing it: "Pulling one leg out of the stool, we crash [individual market insurers] to the ground," one respondent predicted. Insurers, particularly those mission-driven to serve low-income people in the individual market, were reluctant to state categorically that the elimination of the mandate would cause them to exit the marketplaces. Most expressed that at a minimum, repealing this incentive to remain in coverage would be an additional blow to a marketplace that has had difficulty finding its footing and would lead to higher premium rates.

As one insurer put it, the belief of some federal policymakers that “you [could] remove [the individual mandate] and not do something damaging to the individual market” was not realistic.

Repeal of the Individual Mandate Is Likely to Affect Insurer Participation in 2018

Insurers have contractual and legal obligations to continue to offer their current year (2017) marketplace coverage and respondents did not view the repeal of the individual mandate as changing that reality.¹⁷ One insurer stated, “We have [in our state] a market that is hanging on by a lifeline, and if you remove the individual mandate, that in and of itself is like the last nail in the coffin, but it is not in and of itself going to dramatically change things [at least in 2017].” Another respondent pointed out that open enrollment for this year likely would be over by the time repeal occurred, and another suggested that even if legally possible, “insurers absolutely won’t look for an escape clause” in 2017.

The story was different for 2018, however. In the absence of a mandate or an effective replacement policy for 2018, some insurer respondents indicated they would seriously consider a marketplace exit. One respondent noted that for those insurers “already losing money” and on “the edge of pulling out of the marketplace,” participation in 2018 in the wake of a mandate repeal is unlikely. Other insurers may hedge their bets by filing proposed 2018 plans and rates with state regulators in time for the May 2017 deadline. However, under current regulatory timeframes, they have until September 2017 to assess enrollment and disenrollment in their own plans, the stability of their risk pool, and the position of their competitors in the marketplace, before making a final decision about whether or not to participate in the 2018 marketplace. One insurer suggested that if there are indications going into 2018 that an individual mandate repeal has significantly deteriorated the risk pool, “you would likely see carriers pull off the marketplace in 2018.”

Some insurers hoped to continue to participate in the marketplace in 2018, “if there is a fiscally sound way” to do it. For one large insurer, this intention was grounded in a long-term commitment to serve the individual market; others, especially smaller, nonprofit plans, were driven by their mission to serve the community. For example, a former Medicaid-only plan noted that its commitment “to serve [lower-income] people with affordable health insurance” meant its leadership would seek to continue participation in the 2018 marketplace, even in the event of an individual mandate repeal.

Insurers to Raise Premiums in Response to an Individual Mandate Repeal

Insurers who believe their company will stay in the marketplaces for as long as possible acknowledged that their premiums would have to increase to accommodate an individual mandate repeal. One large insurer noted that the prevailing industry estimate puts the likely premium increase effect of a repeal in the range of 5 to 15 percent, although at least one analysis put this even higher, at above 20 percent. Because increasing premiums can act as a strong deterrent to healthy people buying coverage, one insurer suggested that if members of Congress are committed to repealing the individual mandate, they should counteract that decision by pulling every policy lever to help sustain the market. The insurer noted that “levers” should address areas the industry believes are contributing to adverse selection in the marketplace and could include implementing more stringent criteria for people seeking to enroll outside of the open enrollment period or preventing the steering of people with high health costs from Medicaid and Medicare to marketplace plans. Another respondent warned that in order to ensure continued insurer participation in 2018, it would be critical to replace the individual mandate with another mechanism that has a “binding effect on [consumers]” and is effective enough to maintain a viable risk pool.

Without a Concrete Replacement for the ACA, Delayed Repeal Is Unlikely to Calm Markets

The insurers we interviewed described “repeal and delay” without concurrent replacement of the ACA as fundamentally destabilizing. These insurers were not shy in offering criticism of the ACA’s implementation or in identifying targeted policy changes they said would help put the marketplaces on more secure footing. However, they were deeply wary of wholesale revisions to the health law that would undermine its incentives to maintain continuous coverage without providing a concrete alternative.

These concerns carried over to scenarios in which repeal did not take effect right away. Should new legislation establish a sunset date for certain ACA provisions like the mandate and subsidies but not end them immediately, respondents still anticipated market deterioration in the absence of a coherent replacement structure. As one insurer put it, “if there is substantial writing on the wall” that the markets are going to cease to exist because of legislative changes, the company would start making plans to unwind its participation.

Uncertainty Over the Timing and Substance of Replacement Legislation Is Likely to Affect Insurer Pricing and Participation

The asserted justification of the “repeal and delay” strategy is to provide consumers a transition period under the current coverage framework and policymakers additional time to decide on what comes next. Though insurers saw value in a buffer to adjust to a replacement regulatory structure and to help educate consumers about coverage changes (see the next section), they perceived “significant” downside risk in remaining in the marketplaces as long as the details of an ACA replacement were in doubt. One respondent suggested a multiyear transition period would be needed, “but the problem is, how long is it going to take before [we] know” what the replacement is? This theme, that uncertainty was perhaps the “biggest risk,” recurred throughout our discussions: “Not knowing what replacement means, it’s very hard to plan. ... There [are] so many different possibilities” that might follow repeal, said one insurer. The respondent noted that “it’s concerning” and will cause a rethink around pricing and participation. Another insurer expanded on this sentiment:

Having clarity on where we’re going as soon as possible is the most important factor in getting carriers to play and stabilizing the markets. One of the things that causes rates to go up, adverse selection, etc., is a lack of certainty in what to do—it keeps carriers out of the marketplace, it keeps carriers from being aggressive in their rating. ... Clarity sometimes, even if the situation is not ideal ... is better than the absolute perfect solution.

Other respondents agreed that the consequences of uncertainty would manifest in higher premium rates, as insurers attempt to protect themselves against market fluctuations and the likelihood of losses from a deteriorating risk pool. Respondents suggested it was too early to tell whether consumers were already behaving differently in light of the possibility of repeal; they speculated that some individuals might be more likely to buy in the near term to secure coverage while the marketplaces remained open, but others might be more likely to stay out of the market in anticipation of the new administration’s replacement policy. Respondents observed that their 2017 products were not priced to reflect any of these possibilities. They indicated that in future years, they would need to be more conservative in developing their rates, and worried that this dynamic—rising prices, deteriorating risk pool—increased the risk of a death spiral.

Uncertainty is likely to undermine business decisions beyond pricing as well. Respondents suggested their companies

would have to “shrink back,” rethinking staff contracts, for example, or declining additional capital investments or new lines of business. One insurer with a limited footprint in the individual market noted it would be stuck in a holding pattern until learning what the replacement plan would be. Another with much broader marketplace involvement said it hoped to remain in the states in which it participated but was concerned about the consequences of being the last insurer left in markets that, in effect, were slated to expire.

Insurers Favor a Transition Period *After* a Replacement Plan is Enacted

Insurers expressed optimism about their ability to adapt to an ACA replacement structure emphasizing continuous coverage, provided they are given sufficient lead time with the new plan to make appropriate adjustments. Respondents stressed that developing a product, pricing it, and bringing it to market takes a long time. Products for 2018 are already well under development and filing deadlines for 2018 coverage are only a few months away.¹⁸ One insurer reported “making our decisions” about next year (2018) in the first quarter of 2017. Several insurers also pointed out—sometimes with reference to the extended ramp-up period for the ACA itself—that the process of promulgating and implementing regulations for a new statutory scheme can be extremely time-intensive at the federal level and may involve significant input from states as well.

Although no consensus emerged from our discussions on exactly how long a transition period ought to be, insurers generally estimated that the task of adapting to a new regulatory framework would require multiple years. One insurer, citing reports of a proposed two-year transition between the ACA and its replacement, suggested such a proposal created only a “very narrow path,” and another respondent argued that three years were needed “at minimum.” One large insurer observed that a lot of its current advocacy efforts focused on ensuring that people understand “how long this stuff takes”—two to three years—“and that’s after the [replacement] legislation gets signed.”

Many insurers suggested, consistent with findings already discussed, that business decisions were more likely to be affected by the rules governing markets during the transition period than by the precise length of the transition. One respondent stated, “I’m not so jazzed about the idea of ‘Let’s push it out, push it out, push it out,’” because if parts of the ACA’s three-legged stool framework are repealed without immediate replacement, the transition period “could really suck.”

Elimination of Cost-Sharing Reduction Payments Could Lead to a Collapse of the Individual Market as Insurers Drop Products

The insurers we interviewed foresaw huge disruption for health insurers and the individual health insurance market if the ACA's cost-sharing reduction payments are eliminated. The law requires health insurers to enroll individuals in cost-sharing reduction (CSR) plans if they have income between 100 and 250 percent of the federal poverty level and choose the silver level of coverage. CSR plans have higher actuarial values and lower cost-sharing than regular silver plans. Silver plans have an actuarial value of 70 percent, compared with actuarial values of 73 percent, 87 percent, and 94 percent for CSR plans; the level of cost-sharing reduction is graduated based on the enrollee's income. For example, an enrollee with income between 100 and 150 percent of the federal poverty level would be eligible for a CSR plan of 94 percent actuarial value. The premium for a CSR plan is no different from the premium for a regular silver plan. The additional cost to the insurer is reimbursed by the federal government through CSR payments.

Cost-Sharing Reduction Payments May Cease in the Middle of 2017, Leaving Insurers with Billions of Dollars in Unreimbursed Costs

Federal CSR payments to insurers may cease either because of a pending lawsuit or because of action taken by the Trump administration. In July 2014, the U.S. House of Representatives passed a resolution authorizing a lawsuit, *House v. Burwell*. The suit alleges that the Obama administration unlawfully spent funds not appropriated by Congress by reimbursing health insurers for the CSR costs.¹⁹ A district court judge found in favor of the plaintiffs and the Obama administration appealed the decision. The appeals court could rule in favor of the House plaintiffs, the Trump administration could drop the defense of the lawsuit, or the Trump administration could unilaterally decide to discontinue the CSR payments. In all three situations, insurers would still be legally obligated to provide CSR plans to eligible enrollees, but they would no longer receive compensation from the federal government. If any of the above scenarios occur, the timing of the cessation of CSR payments is unknown. They could end sometime in the middle of 2017, leaving insurers with unreimbursed costs for people enrolled in those plans for the 2017 plan year. Alternatively, the Trump administration may choose to cease payments for 2018 or a future plan year.

Eliminating CSR reimbursements would cause significant financial harm to insurers. More than half of the individuals enrolled in the federally facilitated marketplace receive cost-sharing subsidies. One insurer in our study has about 70 percent of its marketplace enrollees in CSR plans. The

cost of the CSRs is estimated to be \$9 billion in 2017 and \$11 billion in 2018.¹ The insurers we interviewed indicated almost unanimously that failing to provide CSR reimbursement would be financially devastating.²⁰ One respondent stated that ending CSR payments midyear would “undermine the [health insurance] industry,” causing a negative effect on stock value. Multiple respondents asserted that they could not financially support CSR plans without the reimbursement, especially given that some plans are already losing money in the marketplaces. Two respondents discussed the damage to the business relationship between insurance companies and the federal government if the payments ceased midyear, with one noting that if the federal government were to “renege on a promise midyear, [it] would be a huge blow to companies across the country.”

Fear of a Death Spiral Would Drive Many Insurers to Leave the ACA Marketplaces or the Entire Individual Health Insurance Market if Cost-Sharing Reduction Payments Cease

Most respondents said they would exit the marketplaces or the entire individual market if CSR payments ceased. These insurers want to remain in the marketplaces and see them stabilize, but the loss of CSR payments would lead to a nonviable insurance market. One respondent referred to available choices if CSR payments cease as “a lot of bad options.” None of the respondents mentioned receiving information or guidance from state regulators about options available for midyear changes if the payments were to cease. However, most of the respondents were unequivocal that maintaining CSR plans without reimbursement was not sustainable and that the insurers would eventually drop out of the marketplace or the entire individual market.

A number of respondents said they would consider raising rates. Four insurers thought regulators might exempt them from the prohibition on midyear rate increases if the CSR reimbursements were terminated because a “material assumption” used in the creation of the 2017 rates would change in the middle of the year. But several insurers were concerned that the market would be destabilized by raising rates, leading to adverse selection problems for the risk pool. One respondent noted that his company would be left with the “sickest of the sick” because of the increased cost and that he was “not sure [premiums] could ever be priced [high enough] to achieve ... more stability.”

One respondent from a nonprofit community health plan said that the loss of CSR payments midyear was the “only thing” that would cause plans to exit the marketplaces in 2017. This respondent said that if payments were eliminated midyear, “for us and any other plan like us, from what I’ve heard, there’s no

way that we could financially stay in the market, because those are so critical to the financial integrity of our pool and of our finances.”

State law would govern timing of departure and whether insurers are able to exit a market midyear. One respondent did not envision a midyear departure in 2017 because of limits under state law, but expected to use the company’s experience in 2017 to determine the feasibility of remaining in the market in 2018. This respondent noted that under state law, they would need to notify enrollees of their departure 90 days before the start of the open enrollment period, so they would need to make that determination by the middle of 2017. Another respondent said that state insurance commissioners would have to declare an emergency under state law to “provide cover for the industry to depart.” A third respondent expected to depart from the marketplaces between 30 and 90 days after the termination of CSR payments, stating that “in an environment where we’re losing tens of millions of dollars per year, we will take whatever action [is] necessary and legal.”

Dropping out of the ACA marketplace while remaining in the individual health insurance market did not seem to be a viable option because adverse selection would make the individual market unsustainable. Two respondents noted that such a move would create a death spiral in the outside market. One mentioned that their enrollment would be reduced by at least 70 to 80 percent without the CSR plans or the premium tax credits available only through the marketplaces.

Although insurers have a statutory obligation to offer the reduced cost-sharing plans if they participate in the marketplace, a few respondents thought that the CSR plans would need to be eliminated if the payments are eliminated. Absent such a change in law, an insurer might choose to drop out of the marketplace and offer plans on the outside market, where no such requirement applies. The respondents who suggested that dropping CSR plans might be necessary still saw chaos in the market because cost-sharing would increase so dramatically for enrollees. One respondent noted that there would be a 3000 percent increase in the deductible for an individual losing the most generous CSR. Health care would no longer be affordable with cost-sharing under a silver plan. Thus, insurers predicted much smaller enrollment. One respondent representing an integrated care plan noted that the enrolled population would also become less healthy because enrollees would not be able to afford to attend to their health care needs. This respondent also expressed concern about the impact on providers when enrollees are not able to pay the cost-sharing associated with services.

Although insurers have not planned for the elimination of CSR payments, they do have significant concerns about its adverse effects. During our discussions with the respondents, we saw that most viewed CSR plans and CSR payments as integral to the sustainability of the individual health insurance market. Removing the payments would undermine the ability of insurers to offer CSR plans, and many respondents foresaw adverse selection leading to a death spiral in the market.

CONCLUSION

The anticipated partial or total repeal of the ACA has given rise to considerable uncertainty about the future of the health insurance marketplaces and coverage for the projected 13.8 million people who will be enrolled in marketplace plans in 2017. In a series of structured interviews with 13 insurers participating in marketplaces in 28 states, we discussed possible insurer responses to three repeal scenarios: (1) immediate repeal of the individual mandate with delayed repeal of financial subsidies, (2) delayed repeal of the ACA without a concurrent replacement, and (3) a cutoff of cost-sharing subsidies in 2017. We find that as long as policymakers

enact concrete replacement policies and provide the insurance industry sufficient time to implement them, insurers are generally confident that they could manage a transition to a new regulatory regime. However, if the ACA is repealed after a delay but not concurrently replaced, or if the individual mandate is immediately ended, insurers expect material market exits and significant premium increases for the 2018 plan year. If the third scenario occurs and cost-sharing subsidies cease in mid-2017, the destabilization of the marketplaces will accelerate regardless of whether the ACA is repealed, with insurers exiting or raising premiums midyear.

ENDNOTES

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20. Insurers participating in the two states with Basic Health Programs (Minnesota and New York) were less certain about the financial ramifications of a termination of the CSR payments. This is because the population receiving CSRs in the marketplaces in these states is much smaller than that in other states. Basic Health Plans (BHPs) cover people with incomes up to 200 percent of the federal poverty level. Thus, insurers participating in the marketplaces in states with BHPs only have individuals between 200 and 250 percent of the poverty level enrolled in CSR plans, and the CSR is relatively small at this income level, increasing the actuarial value of plans from 70 to 73 percent. These insurers were still concerned about CSR payment cessation, but not to the same degree as others. The remainder of this section focuses on insurers offering plans in states without a BHP.

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