U.S. Health Reform—Monitoring and Impact

Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018

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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**.

EXECUTIVE SUMMARY

Uncertainty over the future of the Affordable Care Act was a challenge for insurers and state regulators as they prepared for the 2018 plan year. Various insurers exited or reduced service areas in the health insurance marketplaces, while others threatened exits or delayed participation decisions. In several states, some or all counties seemed likely to have no insurance plan available for residents seeking marketplace coverage. But as of the start of open enrollment, no states had counties without an insurer for plan year 2018.

In this report, we examine six states that faced the prospect of bare counties for 2018: Iowa, Nevada, Ohio, Oklahoma, Tennessee, and Washington. Either the state had only one participating insurer, or the last remaining insurer in some counties announced a planned exit during the spring or summer of 2017. Interviews with insurers and state regulators provided insights into how they confronted the threat of bare counties.

- Most stakeholders agreed that uncertainty over federal policy is a primary contributor to decreased insurer participation in individual markets. The debate in Washington over "repeal and replace" legislation provided the backdrop for the program's uncertain future, but respondents most commonly expressed concerns over the federal government's commitment to making cost-sharing reduction (CSR) payments and enforcing the individual mandate. These concerns were compounded by insurers' financial losses in the early years of the marketplaces, the end of reinsurance after 2016, and the federal government's decision not to make full risk-sharing payments owed to insurers for 2014 to 2016.
- Each insurer's decision to participate was driven by many factors, but ultimately the decision had to align with the company's business strategy. These strategies varied with insurers' company culture and tolerance for risk, experience with the market and government programs, ties to the local community, and for-profit or nonprofit status. Insurers identified three factors driving their participation decisions: access to a provider network at reasonable cost, the risk pool within the relevant rating area and the insurer's ability to price for that risk, and the actions of competing insurers.
- State actions also helped prevent bare counties. Even where insurers could make a business case for participation, they sought assurances from state regulators of protection from financial losses resulting from unexpected policy changes and, in some cases, a more favorable regulatory stance on issues important to the insurer, such as network adequacy or the designation of geographic rating areas.
- State officials and insurers agreed that good longstanding relationships between regulators and the industry were an important foundation for negotiations over filling bare counties. But relationships alone were not sufficient; the decision to enter or stay in a county relied on other business factors or regulatory considerations.
- States used regulatory levers to encourage insurer participation. These measures included clarifying the means for meeting regulatory standards on network adequacy, allowing flexibility in plan offerings and the review of premium rates, sharing data on claims history, and allowing plans to assume no reimbursement for CSR payments in their rate filings.

- States also committed to future policies to stabilize the marketplace. Two states considered Section 1332 waivers that included reinsurance programs, although these waivers were ultimately withdrawn.
- One state used the Medicaid program as leverage, offering an advantage in Medicaid managed care contract billing to insurers that promised to participate in the state's marketplace. State officials in Nevada believe the incentive brought a new insurer into the state and ultimately helped prevent bare counties.

There is strong consensus among state regulators and insurers that the solutions used to prevent bare counties in 2018 are temporary and unsustainable without long-term federal action. Most regulators and insurers emphasized the need for continued funding of CSR payments and federal enforcement of the individual mandate. State officials see state innovation waivers as important for long-term market stabilization, but they raised concerns about the challenges in getting approval for these waivers.

INTRODUCTION

The debate over the future of the Affordable Care Act (ACA) has dominated headlines this year. But behind the scenes, states have worked to manage and sustain the health insurance marketplaces that will provide coverage options for approximately 10 million people in 2018.

State officials and insurance executives have managed these markets in the face of considerable uncertainty over federal policy—whether a major restructuring of the ACA would become law and how the federal government would operate the marketplaces in 2018. Meanwhile, the Trump administration repeatedly threatened to stop reimbursing insurers for cost-sharing reduction (CSR) plans offered to low-income people—and ultimately did so in October. Furthermore, the risk of weak enforcement of the individual mandate threatens to create a smaller and sicker risk pool for the individual market.[1] These concerns were compounded by the announcement of major decreases in federal funding to support the expansion of marketplace enrollment, including cuts to marketing and in-person consumer assistance, a shorter enrollment period than in previous years, and frequent shutdowns of HealthCare.gov during the open enrollment season.[2]

In the face of this federal uncertainty, many insurance companies have agreed to continue to participate in the marketplace but proposed significant premium rate increases for the 2018 plan year. Other insurance companies have cited uncertainty as a significant factor in their decisions to limit participation in state marketplaces or to withdraw altogether. This threatened to leave some states with no health insurance plan to serve residents in some areas in 2018. This report focuses on what insurers considered when deciding to participate in the marketplaces in a volatile policy environment and how states exercised their authority and policy tools to stabilize those markets. It also highlights how the lack of a stable federal policy framework limits the long-term effect of states' actions.

ABOUT THIS REPORT

In this report, we examine a subset of states that faced the prospect of bare counties for 2018: either they had only one insurer participating in most or all of the state, or the last remaining insurer in certain counties announced a planned exit during the spring or summer of 2017. This report focuses on Iowa, Nevada, Ohio, Oklahoma, Tennessee, and Washington, although Indiana, Missouri, Virginia, and Wisconsin also faced the risk of some bare counties in the same period.

For this report, we reviewed media coverage of marketplace participation over the spring and summer of 2017, along with federal and state legislative or administrative actions affecting the ACA marketplaces. With that base of information, we conducted structured interviews with regulators and insurers from the six study states. In all, we conducted interviews with people representing 13 organizations (sometimes multiple people from an organization participated in the interview). Interviewees included representatives of insurance departments in all states and representatives of marketplaces in Nevada and Washington, the only two study states with state-based marketplaces. We interviewed marketplace insurers in all but one of the states; in that state, one insurer provided written information. Interviews were conducted in August and September 2017. Because state circumstances differ and continue to change rapidly, we cannot generalize our findings in the six states to the nation with certainty. However, our findings highlight challenges and opportunities for states as they attempt to manage continued federal policy uncertainty affecting insurance regulation and the ACA's marketplaces.

BACKGROUND

In the first few years that marketplaces operated under the ACA, few people were concerned about bare counties. The 2014 health insurance marketplaces saw an influx of new and established individual market insurers willing to compete for consumers' subsidized insurance dollars. The average state had five competing insurers. Competition increased in 2015 and 2016, with an average of six insurers per state, although some smaller states (New Hampshire, West Virginia, and Wyoming) had only a single participating insurer in one or more of these years.[3]

The data reveal the 16 percent of all counties that had a single insurer in 2014, including additional states where competition was lacking. In 2015 and 2016, less than one in ten counties were served by only one insurer (Table 1). Because rural counties have lower population density, the share of the population lacking insurance company competition is lower. For example, in 2016, the 7 percent of counties with a single insurer represented just 2 percent of marketplace enrollees.[3]

Table 1: Number of Insurers by County, 2014–2018

Year	Counties with 1 insurer	Counties with 2+ insurers	Share of counties with 1 insurer
2014	515	2628	16%
2015	175	2968	6%
2016	225	2918	7%
2017	1036	2107	33%
2018	1524	1619	49%

Source: Authors' calculations based on data from the Kaiser Family Foundation and the US Department of Health and Human Services.

Semanskee A, Cox C. Insurer participation on the ACA marketplaces, 2014–2017. Menlo Park, CA: Kaiser Family Foundation; 2017. http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017. Published June 1, 2017. Accessed September 2017.

2018 projected health insurance exchange coverage maps. Centers for Medicare & Medicaid Services website. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-09-20-Issuer-County-Map.pdf. Updated September 20, 2017. Accessed October 2017.

For the 2017 plan year, competition decreased because some companies suffered significant financial losses from their marketplace business and pressures grew on premiums more generally.[4] The scheduled end of the reinsurance program after 2016 contributed to these premium increases. Some marketplace insurers had lost confidence in the federal government's ability to be a reliable business partner because of congressional action that prevented full risk-sharing (risk corridor) payments from 2014 to 2016.[5] Several national companies scaled back their marketplace participation. In 2017, the average number of companies per state dropped to four, and five states had only a single insurer participating in the marketplace (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming). Overall, almost one-third of counties (representing 21 percent of enrollees) had only a single insurer.[3]

In late 2016 and early 2017, independent analyses found that the ACA's marketplaces were on track to stabilize, and insurers gained confidence in their financial viability.[6] However, the 2016 election threatened the future of the ACA; the new administration's interest in the long-term viability of the marketplaces remained unknown. In 2017, the U.S. Senate and House of Representatives together voted several times on proposals to repeal and replace the ACA. Concurrently, the Trump administration repeatedly threatened to stop reimbursing insurers for CSR plans—which it ultimately did in October 2017. The administration also suggested in a January 20, 2017, executive order that it would relax enforcement of the ACA's individual mandate, which insurers consider a critical incentive for healthy people to enroll in coverage.[7]

This environment contributed to the exit of two large national insurers, Aetna and Humana, in 2018; Anthem and UnitedHealth also scaled back their participation substantially. Only one national insurer, Centene, has stepped up its participation for 2018. According to the most recent estimates, nearly half of all counties, representing 29 percent of enrollees, will have only a single insurer in 2018.[8]

Throughout the spring and summer of 2017, as plan bids and premium rates were developed and submitted, 145 counties in eight states (5 percent of all counties nationwide) had no insurer committed to marketplace participation (Table 2). Two-thirds of those counties are rural (nonmetropolitan). Although these counties account for just 1 percent of marketplace enrollees, their residents faced the real and frightening possibility of becoming uninsured. In other states, including Iowa and Oklahoma, regulators worried that the last remaining insurer would exit the market. Ultimately those outcomes were averted, mostly with the participation of a single insurer in at-risk counties, but in some cases with the participation of multiple insurers.

Table 2: Counties at Risk of Having No Insurer for 2018 and Counties With One Insurer

State	Number of counties at risk of having no insurer for 2018 at some point during 2017	Number of counties with no insurer for 2018	Share of at-risk counties that are nonmetro counties	Number of counties with one insurer for 2018	Share of all counties that have one insurer for 2018
Iowa*	0	0	N/A	99	100%
Nevada	14	0	86%	14	82%
Ohio	20	0	85%	31	35%
Oklahoma*	0	0	N/A	77	100%
Tennessee	16	0	31%	78	82%
Washington	2	0	100%	4	10%
Other States	93**	0	67%	1221	45%
TOTAL	**145****	**0**	**68%**	**1524**	**49%**

Source: Authors' calculations based on data from the US Department of Health and Human Services and the Kaiser Family Foundation.

2018 projected health insurance exchange coverage maps. Centers for Medicare & Medicaid Services website. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-09-20-Issuer-County-Map.pdf. Updated September 20, 2017. Accessed October 2017.

Counties at risk of having no insurer on the marketplace (exchange) in 2018. Kaiser Family Foundation website. https://www.kff.org/interactive/counties-at-risk-of-having-no-insurer-on-the-marketplace-exchange-in-2018/. Published August 18, 2017. Updated September 15, 2017. Accessed September 2017.

Notes: N/A = not applicable.

* Though Iowa and Oklahoma had no immediate risk of bare counties in 2018, state regulators had deepening concerns about whether their only insurer would continue participating in the marketplace.

** Includes independent cities in Virginia that substitute for counties.

State-Specific Summaries (more detailed summaries in Appendix 1)

Iowa. In 2017, Iowa's marketplace had four participating insurers, but three (Aetna, Gunderson, and Wellmark) opted to exit for 2018. Medica will be Iowa's only insurer in 2018; in 2017, it is the only insurer for 13 of 99 counties. Wellmark may have re-entered the marketplace as a second insurer for 2018 if Iowa's Section 1332 waiver application had been approved, but the waiver was withdrawn (Section 1332 waivers are described in more detail below).

Nevada. In 2017, three insurers participated in Nevada's state-run marketplace. Two, including the only statewide insurer (Anthem), exited for 2018. Two others (Aetna, Centene/SilverSummit) announced their intention to enter the marketplace, in part because of incentives in Medicaid bidding (described below). Aetna announced its departure from the individual marketplace after a disappointing performance on its new Medicaid contract. The two remaining insurers (Centene and UnitedHealth) covered only three urban counties, leaving 14 bare counties in rural Nevada. This changed in August when Centene expanded to cover those counties.

Ohio. Since 2014, Ohio has had multiple insurers in its marketplace; eight insurers continue in 2018. But the exit of the only statewide insurer for 2018 left 20 potentially bare counties (out of 88). In July, five insurers agreed to cover 19 of the 20 bare counties: Buckeye Health Plan (offered by Centene), CareSource, Medical Mutual, Molina, and Paramount Health Care. In August, CareSource agreed to cover the last bare county. All but one of these 20 counties will be served by a single insurer in 2018.

Oklahoma. Only one insurer (Blue Cross Blue Shield of Oklahoma [BCBS-OK]) participated in Oklahoma's marketplace in 2017. Early in 2017, Oklahoma's insurance commissioner warned that the state may lose its last insurer, although BCBS-OK said that no decision had been made. In this context, the state sought a Section 1332 waiver, notably to establish a state reinsurance program (as described below). BCBS-OK remains the state's only insurer for 2018.

Tennessee. In 2017, Tennessee's marketplace included three insurers. But the largest insurer, Blue Cross Blue Shield of Tennessee (BCBST), exited from the state's metropolitan areas, leaving only a single insurer in 73 of the state's 95 counties. For 2018, one insurer (Humana) withdrew, while another (Oscar Health) entered for one region. For a time, it appeared that the Knoxville area would be bare for 2018, but BCBST agreed to re-enter that market. Nevertheless, 78 of 95 counties will have only a single insurer in 2018.

Washington. In 2017, Washington's state-based marketplace had six participating insurers. Community Health Plan of Washington exited for 2018, and the Cambia Group withdrew its two marketplace products (Bridgespan and Regence Blue Shield). This left four participating insurers, but two potentially bare counties. In June, Premera Blue Cross elected to enter one county, and both the Cambia Group's Bridgespan and Molina entered the other. This county became Cambia's only on-exchange offering in the state.

OBSERVATIONS FROM THE STATES

Uncertainty Over Federal Policy Is a Primary Contributor to Decreased Insurer Participation in Individual Markets

Insurance executives and state officials interviewed for this study indicated that the primary push for insurers to drop out of individual markets has been instability and uncertainty surrounding the future of federal policy related to the ACA—specifically, whether the federal government would continue to make CSR payments and enforce the individual mandate. However, the risks associated with an uncertain policy environment are compounded by the significant financial losses borne by many insurers in the marketplaces from 2014 to 2016, the end of reinsurance after 2016, and the government's decision not to make full risk-sharing payments owed to insurers for 2014 to 2016. Interviewees also pointed to various state factors that have affected insurer decisions to remain in or drop out of markets.

Respondents from all study states said that the uncertainty over federal policy and the lack of federal action to stabilize the individual insurance market were forcing insurers to leave the ACA's marketplaces. Several insurers cited the federal "threats" to health care reform and their inability to know the "risk and rules of the road" as reasons to reduce their individual market presence or, at a minimum, exercise caution going into the 2018 plan year. In most of the study states, insurance regulators echoed insurers' concerns; one state regulator said that all the insurers that announced their withdrawal from his state's marketplace blamed "federal instability."

State regulators and insurers mentioned specific policy issues that have affected their decisions of whether and how much to participate in the individual market. Insurers agreed almost unanimously that the primary issue influencing their decisions has been the Trump administration's threat to cut off future CSR payments. Their concern has proven well placed: President Trump decided in October 2017 to terminate these payments.

Insurers also raised concerns that the individual mandate would not be enforced in 2018. State regulators concurred; one said that worry over enforcement of the individual mandate was "dampening" insurer participation for 2018.

Concerns about federal uncertainty persist even for the insurers that decided to fill bare markets. One insurer respondent said his company's executives are "just terrified that the feds are going to pull the rug out from underneath them in the middle of the plan year." Another insurer that decided to participate in what would have been a bare county released a letter saying that they are pricing in the downside risks of the "potential negative effects of federal legislative and/or regulatory changes."[9]

The legacy of past federal policy shifts and financial losses

Insurers' decisions about 2018 marketplace participation are informed by their experience in previous years. For most, that experience has been rocky. Many saw significant financial losses in the individual market between 2014 and 2016, although there was some improvement in 2016.[10] Some of these losses can be traced to federal policy actions during the program's early years, including the initial failed rollout of the federal marketplace in late 2013, the unexpected decision to allow renewal of non-ACA-compliant plans (also called "transitional" or "grandmothered" plans), and unanticipated failures to fund the federal risk-sharing (risk corridor) program. Insurers' tolerance for federal policy instability and uncertainty has already been considerably tested.

Insurers and regulators alike noted that financial losses from earlier years "couldn't be sustained," and some did not foresee significant improvements in the marketplace risk pool as they evaluated their 2018 marketplace participation. One state regulator said his insurers had expected that after a "rough couple of years," things would "settle down," but the market "is not panning out the way they thought," so they are now leaving or reducing their presence in the individual market. Insurers also noted that simply raising premiums would not sufficiently protect them from future financial risk. One said that although rates have risen a lot, "we've seen the same thing happen in the average claim that comes into our door that needs to be paid." Some of these insurers may have been willing to risk continued financial uncertainty in their marketplace business if they had greater confidence in a government partner committed to its long-term sustainability.

Business Dynamics Guided Insurer Decisions to Cover Bare Counties

Insurers' decisions to continue or expand participation in certain counties were driven by many factors, but ultimately the decision must align with a company's business strategy. Different insurers have different business strategies for the individual market, often informed by the company's culture and tolerance for risk, experience with the market and government programs such as Medicaid managed care, ties to the local community, and for-profit or nonprofit status. For example, for-profit national companies participating in multiple states

(Aetna, Anthem, Humana, and UnitedHealth) have been the most likely to exit the marketplaces; others, such as the previously Medicaid-only company Centene, have doubled down.

That said, respondents identified three factors that drove participation decisions for all insurers: access to a provider network at reasonable cost, the risk pool within the relevant rating area (and the insurer's ability to price for that risk), and the actions of competing insurers. But these factors differ across states and even across regions within a given state. In 2017, state regulators were often instrumental in encouraging insurers to expand to a new service area or maintain participation.

Access to affordable provider systems

All the insurers said that building and maintaining a provider network at an affordable cost was a challenge in the at-risk counties. Many of these areas are rural and/or have few hospitals, physicians, and other health professionals. In other areas, leading providers may be unwilling to negotiate with particular insurers. Hospital systems or physician groups in these areas may have a monopoly or the market power to demand high reimbursement rates. This can make it challenging, particularly for an insurer without existing provider relationships, to offer individual market plans in these communities. As one national insurer put it, "We are always looking at growth from the standpoint of … would we do well with provider networks … would there be enough competition [among providers]?" He added, "I can't stress enough the importance of the provider network" in driving the company's decision to offer plans in an area. Similarly, insurers in one study state told regulators early on that filling the at-risk counties was entirely contingent on their ability to "work things out" with the local providers.

Some respondents noted that insurers with an existing network, particularly one used for a state's Medicaid managed care program, have a built-in advantage. For example, one insurer's existing relationship with Medicaid providers likely made it easier for it to decide to fill some of that state's at-risk counties. An insurance executive said, "We were pleased to leverage our Medicaid position," observing that doing so allowed the company to "come up with a reimbursement scheme that worked well." However, the insurer acknowledged that the tactic has a limited shelf life because providers increasingly balk at accepting Medicaid-level reimbursement for marketplace enrollees. In other cases, insurers and providers may have relationships through large-group business or through relationships in neighboring counties.

Some insurers develop tightly managed, closed provider networks as part of their long-term strategy for the individual market. Unfortunately, this strategy is often not viable in counties with limited provider competition, leading insurers to decline to offer coverage there. For example, one insurer is pursuing "accountable health networks" (AHNs) for their plans, in which groups of providers coordinate patient care and take on some downside risk for patient outcomes. "We feel like AHNs are the future," the executive said. However, he noted that these products are simply not viable in more rural parts of the state.

Pricing for risk in low-density areas

Insurers generally agreed that after assessing the viability of the provider network, the second biggest challenge they face is evaluating and pricing for the health risk of the population being served. In low-population counties, this can be particularly challenging. For example, Ohio's rural Paulding County, the last county in the state to be covered by an insurer for 2018, currently has 334 marketplace enrollees.[11] Just one very expensive patient can upend an insurer's pricing strategy in a state or region with a small overall risk pool, even after accounting for risk adjustment. Moreover, in a state with a single insurer, that insurer's premiums must incorporate the full costs of a patient, without any outside risk-stabilization funding.

Insurer respondents indicated that they were more likely to agree to serve an at-risk region if they already had knowledge of the local demographics and claims patterns. For example, one national insurer said they were more likely to participate in an area if they already had a Medicaid plan operational there, giving them insights into the local "risk profile."

But knowledge of the local risk pool can also discourage insurer participation. For example, regulators in one state speculated that a national insurer's effort to limit its service areas to certain counties was an attempt to avoid specific patients they knew to have extremely high costs. Some insurers cited the end of the ACA's reinsurance payments in 2016 as an important factor in opting out, especially because they considered risk adjustment insufficient to correct for high-cost patients. Reinsurance payments would have helped to mitigate this concern, if they had not sunset.

Even insurers with a monopoly in an area may be reluctant to commit to participating, if they believe they cannot accurately price for the uncertainty they face. An added challenge is that insurers were required to finalize their premium rates well before the 2018 plan year. Once consumers start shopping for plans based on those rates, state and federal laws bar insurers from changing them, even in the face of new data about the nature of the risk pool or unexpected federal policy decisions that result in deterioration of the risk pool. For example,

regulators in one state believe that, leading up to the 2017 plan year, the rate review time frame "dictated by [federal regulators]" did not give insurers enough time to adjust their rates to account for emerging data about the marketplace risk pool. This led to insurers "pulling back in significant ways."

Strategic adjustments to the actions of competing insurers

Insurers must develop business strategies for a market with an eye toward the competition. In some cases, a large, dominant commercial insurer must consider the effects of a low-cost Medicaid plan expanding its presence and eroding the insurer's market share. A small regional insurer must consider the impact of a larger competitor exiting the market, including changes to its risk pool and its capacity to serve an unexpectedly large number of enrollees. For example, Optima, a small regional insurer in Virginia, decided to expand to additional counties in 2018, expecting that Anthem, the large Blue Cross Blue Shield plan, would maintain its presence. When, over the summer of 2017, Anthem announced that it would pull out of those counties in 2018, Optima concluded that it too had to exit, leaving those counties temporarily bare for 2018.[12] One factor driving Optima's decision was its limited capacity to absorb all of Anthem's enrollees. Ultimately, Anthem decided to re-enter the Virginia market.

Different insurers have different business strategies. Some seek monopoly power. Others prefer that at least one other competitor shares the risk. For example, one state regulator said it was easier to convince an insurer to enter new counties only if it would be the sole insurer there. But an insurer respondent in another state said that a condition of its agreement to enter an at-risk county was that another insurer must enter as well. His company didn't "want to be the last insurer in the county," he said.

Insurers also look to the behavior of peers for clues about the viability of a market. Regulators in one state found that the departure of several large national companies from the ACA's marketplaces "was concerning for the other companies participating." The large national companies often have access to data analytics and Washington lobbyists that the smaller insurers do not. Their exits worried local insurers, who wondered if "maybe [the national insurers] are going the right way." One regional insurer told us, "Those [national] guys know their markets and have lots of experience. Them leaving is enough to make anyone nervous."

State Actions Were Critical in Preventing Bare Markets in 2018

The threat of bare counties was unlikely to resolve itself without action from both insurers and state regulators. Even where insurers could make a business case for serving potentially bare counties, they needed help from regulators to ensure that they would not be surprised by regulatory changes that exposed them to financial loss. In some cases, this meant a specific state legislative or regulatory action, such as adding a reinsurance program through a Section 1332 waiver or allowing insurers to file higher rates in anticipation that CSRs would not be paid. In other cases, this meant an unspoken expectation that agreeing to fill a bare county would lead to a more favorable regulatory stance on other issues important to the insurer, such as network adequacy or geographic rating areas.

States' relationships with insurers

State officials and insurers agreed that good longstanding relationships between regulators and the industry were an important foundation for the negotiations over filling bare counties. These types of relationships often ensure that insurers give serious consideration to a request that they expand to or remain in a given county, even if it is not part of their 2018 strategy for marketplace participation. That said, relationships alone were not sufficient; the decision to enter or stay in a county often hinged on other business considerations or regulatory concessions from state or federal officials.

For example, Nevada's governor called the CEO of Centene when the state was facing 14 bare counties.[13] Although that one telephone call did not immediately fix the situation, it started a series of discussions between state and Centene officials over several months that led the company to extend marketplace participation statewide.

In another state facing bare counties, a regulator reported, "We've had great relationships with the industry regardless of administration. This made things easier … for the [insurance commissioner] to pick up the phone and call CEOs… With every company we reached out to, they were willing to have the conversation, and it progressed from there." In another state, a regulator noted that the department of insurance "appealed to [insurers] with a corporate responsibility argument." Another insurer from that state suggested that the company's response was "about being a good steward in our state … not because we thought we could make [the situation] work financially… We have a close relationship with the regulator; it's just something we felt like we could do."

Versions of these conversations were reported in several of the states where we conducted interviews. Respondents typically emphasized how relationships could provide this starting point. Connections among insurers, insurance departments, governor's offices, and legislators varied, but often stemmed from an existing relationship history. No single formula worked everywhere.

State regulatory levers

Although the ACA set a minimum floor of insurance standards and consumer protections in federal law, states continue to be the primary regulator of health insurance. In general, regulators in the study states were willing to explore or, in some cases, use their authority to resolve or mitigate the regulatory concerns of insurers that were considering maintaining or expanding into less competitive counties.

As noted above, one of insurers' primary concerns in expanding coverage into a new service area is network capacity, including the ability to maintain a network of providers that meet federal and state network adequacy standards. In at least a few study states, state regulators worked with insurers to resolve ongoing concerns related to meeting the network adequacy standards. As an insurer in one state contemplated expanding into a new county, state regulators worked closely with federal regulators to ensure that the insurer's provider network would be found to meet the network adequacy standards for participating health plans. In this county, the network hospital contracted by the insurer as the primary site for serving county enrollees would be in a bordering state—an atypical approach for meeting network adequacy standards in that state.

In another state, network adequacy rules require insurers to meet specific quantitative standards—that is, limits on the time and distance consumers must travel to see a provider. State insurance regulators recognized that these standards may be challenging to meet, especially for insurers considering selling in rural, potentially bare counties. But regulators were willing to be creative and, at a minimum, explore ideas such as the use of telemedicine to meet state network adequacy standards or to allow longer distances and travel times between patients and providers. But ultimately this approach was not needed because the insurer who covered these rural counties was able to partner with a local network of providers.

Regulators also leveraged their authority to review and approve proposed premium rates. In several study states, regulators used their authority over the review of rates to encourage insurers to maintain or expand coverage in the states. For example, in one state, regulators allowed insurers to revise their rates after reviewing competitors' rates. Discussions with one state insurance regulator suggested that this practice prompted at least one insurer to raise their premiums in 2017, but was critical to "keep them in [the marketplace]." The continued participation of this insurer in 2017 became important in 2018, when the state was facing the possibility of limited plan participation in multiple counties. One state official also pointed out that rate review authority allowed the state to require a new marketplace insurer to increase their proposed rates to avoid underpricing, so that the insurer's efforts to compete in 2018 would not compromise their long-term solvency.

Regulators found ways to address another insurance company concern: insurers' limited ability to assess and manage risk. For example, an insurer in one state appreciated that state regulators collected and shared claims data from all insurers. This information allowed the insurer to make a more informed decision about its marketplace premiums, and contributed to the insurer's decision to remain. In another state, officials worked with federal regulators to allow insurers to discontinue offering gold plans on the marketplace, despite the ACA's statutory requirement that they do so. Gold plans have lower cost-sharing than silver plans and tend to generate higher costs for the insurer.

In some study states, regulators encouraged insurers to assume in their rate filings that they would not be reimbursed for CSR payments in 2018. Although this meant larger premium increases for many consumers (with tax credits that might help some consumers offset the increases), it gave insurers more confidence to participate in the market by protecting them from major financial losses. Conversely, Medica's exit from North Dakota's marketplace has been attributed to the company's inability to get approval for higher rates to accommodate the potential suspension of CSR payments.[14] After the president pledged to terminate CSR payments in October, some states and insurers took immediate action to raise premiums where initial filings did not account for this possibility.[15]

State commitments to future policies to stabilize the marketplace

In some study states, regulators' commitment to broader or longer-term regulatory efforts to stabilize the individual marketplace was important in convincing insurers to maintain or expand marketplace participation. In two study states, officials tried to use the ACA's innovation waivers, also known as Section 1332 waivers, to allow states to propose alternative approaches to replace or supplement the ACA's marketplace and some private insurance provisions. For example, the Oklahoma state legislature created and provided seed funding for a state-based reinsurance program; the continuation and financing of the program was contingent on the approval of a federal Section 1332 waiver application for 2018. Oklahoma is also contemplating a broader plan that by 2019 would shift the state away from some core ACA insurance reforms such as the income-based premium tax credits and a minimum essential benefits package.

State officials noted that BCBS-OK, the only plan still participating in the Oklahoma marketplace, has never threatened to leave. But they recognize that this insurer has

suffered significant financial losses and, at some point, "it would be time for [BCBS-OK] to walk away too." To prevent this, state officials worked closely with BCBS-OK and other stakeholders to ensure that their market stabilization plan under a 1332 waiver addressed stakeholder concerns and increased participation in the marketplace. On September 29, the state withdrew the waiver application after failing to receive a timely approval from federal officials.[16]

Iowa officials also submitted a 1332 waiver application to allow the creation of a reinsurance program, limit plan offerings to a single standardized silver-tier plan, and replace the ACA's premium and cost-sharing subsidies with a state premium credit. However, unlike Oklahoma, Iowa billed its waiver application as a "stopgap" measure. As the state faced the possibility of limited plan participation in its marketplace for 2018, it developed this approach in part to entice a statewide insurer back into the marketplace. This effort was at least partially successful because that insurer agreed to re-enter the marketplace if the federal government had approved the waiver application. However, after being notified that the state would not receive sufficient federal funds if the waiver was approved, Iowa withdrew the waiver application on October 23.[17]

In another state, an insurer that expanded coverage into a potentially bare market did so in part because the state regulator agreed to re-evaluate the state's geographic rating areas, an important industry concern. One state official noted that "it was a sign of good faith on the state's part to our intent to stabilize the market moving forward."

Leveraging of the Medicaid program

Starting in 2012, Nevada Medicaid required all insurers participating in its Medicaid managed care program to offer at least one gold and one silver plan on the Nevada marketplace.[18] Anthem (AmeriGroup) and UnitedHealth (Health Plan of Nevada) participated in both programs in 2016. For 2017, this requirement was eliminated as Medicaid opted to expand the number of MCO options to four in a new round of competitive bidding. Instead, if they agreed to participate in the marketplace, MCO applicants received bonus points that increased their chances of being selected as Medicaid contractors. Four companies were selected for MCO contracts: Anthem (AmeriGroup), UnitedHealth (Health Plan of Nevada), Centene (SilverSummit), and Aetna. Despite the bidding incentive, Anthem withdrew from the marketplace because participation was no longer a requirement, but both Centene and Aetna initially agreed to enter Nevada's marketplace for 2018. Ultimately, Aetna withdrew from both programs after it received only minimal Medicaid enrollment and before its marketplace participation ever began.

The Medicaid incentive appears to have been an enticement to keep UnitedHealth in the Nevada marketplace even while it reduced its participation nationally. The company also remained in New York's marketplace after the Medicaid agency added a requirement prohibiting companies that exited the state's marketplace from retaining a Medicaid MCO contract. Nevada officials believe their Medicaid policy was a significant incentive for Centene to enter the marketplace. However, because Medicaid MCO contracts are only used in the more urban counties, the incentive system did not directly affect the company's decision to cover rural counties. Aetna's exit from the marketplace and Medicaid in Nevada for 2018 suggests that a Medicaid incentive may not be as successful in enticing insurers that do not have a large Medicaid presence.

Nevada is considering expanding Medicaid MCO contracting statewide, so the bonus points may continue to be important in the future. State officials also noted that their legislature may consider reinstituting marketplace participation as a requirement for Medicaid MCOs, rather than just adding bonus points to insurers' Medicaid bids.

States and Insurers Seek Long-Term Solutions to Market Stability

There is strong consensus among state regulators and insurers in the study states that the solutions used to prevent bare counties in 2018, varied as they were, are temporary and unsustainable without long-term federal action. Efforts discussed in this paper, including at least one state's proposed reinsurance program, are effectively a patch for 2018. For example, one state official, citing conversations with insurers stepping into bare counties, said, "All of them were very clear that this was a one-year commitment to do what they're doing. So, when we get to spring of next year, all bets are off." Insurers echoed this sentiment, pointing out problems with relying on short-term fixes. One respondent in Iowa said that the state's "stopgap" waiver request for 2018 highlighted the challenges of transitioning to a new system in time for open enrollment. Across all states, regulators and insurers stressed the immediate need for funding of CSR payments and federal enforcement of the individual mandate.

States have expressed confidence that over the long term, they can aid market stabilization through state innovation waivers, although recent federal activity on several waivers (or lack thereof) may send a different signal. States said that federal changes to the process would make waivers a more viable option. Many study states mentioned the 1332 waiver and the need for federal legislative action to address administrative barriers to the process of applying and receiving approval for the waiver. Some felt the review took too long; one state official said of CMS, "We hope they won't wait until October

31… We don't have 180 days for them to review this." An insurer expanded on this barrier, explaining the challenges of implementing a 1332 waiver program on a rushed timeline because of late or pending approvals. The insurer cited the need to appoint boards, establish the program, contract with vendors, explain to consumers what the changes meant for them before open enrollment, and run a new state-level program before the start of the new plan year in January 2018.

State legislative calendars also act as a barrier to 1332 waivers and state innovation. The federal government requires states to pass legislation giving them authority to submit a waiver, and some state officials noted that they could not pursue a 1332 waiver for 2018 because their state legislature was not in session this year.

DISCUSSION

In the second half of 2016 and early 2017, emerging data suggested that the individual marketplaces were becoming more stable. However, federal uncertainties, specifically around CSR reimbursement and enforcement of the individual mandate, led insurers to re-evaluate the risks and benefits of continued market participation in 2018. This ultimately created the threat of bare markets in several states before the fifth open enrollment period.

Our interviews with insurance regulators and insurers in six states provide insight into the approaches, opportunities, and limitations of state insurance regulators and marketplace officials seeking to prevent bare counties and resulting losses of insurance coverage. The specific remedies varied from state to state but were consistently informed by the considerations of insurers who ultimately made the decision to expand their offerings into these counties.

For states, addressing bare counties often began with senior insurance regulators or political leaders reaching out to insurers with which they had an existing relationship. To complete the deal, insurers were made comfortable with the business case for participation and were given assurances about regulatory issues, in the form of specific financial help through reinsurance funding or more informal promises that issues such as state rate review, plan, or network requirements would not be obstacles.

Although the threat of bare counties for plan year 2018 was averted as of September 27, when contracts were signed, the risk continues as stakeholders respond to the president's decision in October to stop CSR plan reimbursements. State insurance regulators and insurers have stated that the brokered solutions that served this year's marketplace are not likely to be lasting. Without greater certainty about federal policymaking, states will once again face the risk of bare counties—and consumers the loss of coverage—in 2019 and beyond.

APPENDIX

Study State Summaries[19]

Iowa. In 2016 and 2017, Iowa's state-partnership marketplace maintained four participating insurers, some operating statewide and some in selected regions of the state (by contrast, there was only one insurer on the exchange in 2015). There was some volatility in insurer participation, however, with UnitedHealth exiting after 2016 and Wellmark Blue Cross Blue Shield entering the market in 2017. In 2017, 13 of 99 counties were covered by a single insurer (Medica). Aetna, Gunderson, and Wellmark have all left the exchange for 2018. Gunderson only participated in five counties in 2017 and had few enrollees, while Aetna (formerly operating as Coventry) had the most enrollees in the Iowa marketplace. Wellmark, which had entered the marketplace in 2017 after offering only off-exchange coverage in previous years, also announced its departure for 2018. As described in this report, Wellmark had expressed willingness to re-enter the marketplace for 2018 if Iowa had received its 1332 waiver.

Nevada. From 2014 through 2017, the Nevada state-run marketplace saw robust participation, with at least three insurers each year. In 2017, the three participating insurers were Anthem Blue Cross Blue Shield, Prominence, and UnitedHealth (operating as Health Plan of Nevada). Anthem offered both an HMO and a PPO product, so by some counts there were four options. Anthem was the only insurer in 11 rural counties in 2017. For 2018, two insurers, Aetna and Centene (operating as SilverSummit), announced their intention to enter the Nevada marketplace, creating the possibility of five insurers. As described in this report, these entries resulted at least partially from state incentives in Medicaid managed-care bidding. But by late summer 2017, the situation had changed significantly. Anthem and Prominence both announced their intent to withdraw from the Nevada marketplace, although Anthem had initially said it would remain with a reduced market area of just three urban counties. Aetna withdrew after seeing minimal enrollment under its new Medicaid managed-care contract. This left just two insurers (Centene and UnitedHealth) and coverage in only three urban counties. These three counties contain the bulk of Nevada's population, but 14 rural counties were at risk of having no insurer. This was prevented with the announcement in August that Centene (SilverSummit) would enter the marketplace in the 14 rural counties.

Ohio. In every year from 2014 to 2017, Ohio had at least 10 insurers participating in its federally facilitated marketplace. In many markets across the state, participation will remain robust in 2018. Although Anthem and Humana are exiting the marketplace for 2018, eight insurers will continue to participate. But Anthem had been the only statewide insurer. This left 20 counties (out of 88 counties in the state) where no insurers expressed an intention to offer plans. At the end of July, the state announced that five insurers had agreed to step in to cover 19 of the 20 bare counties: Buckeye Health Plan (offered by Centene), CareSource, Medical Mutual, Molina, and Paramount Health Care. In late August, CareSource agreed to cover the remaining bare county (Paulding County). All but one of these 20 counties will be served by a single insurer in 2018.

Oklahoma. Insurer participation in Oklahoma's federally facilitated marketplace has declined each year from four insurers in 2014 to just a single insurer in 2017. UnitedHealth exited at the end of 2016, leaving Blue Cross Blue Shield of Oklahoma (BCBS-OK) as the only insurer in 2017. The impact of this shift was minimal because BCBS-OK had the bulk of enrollment. Early in 2017, Oklahoma's insurance commissioner warned that the state could lose its last insurer, although BCBS-OK responded to media inquiries that no decision had been made. This was the context for state legislative action and the development of a Section 1332 waiver application, notably including a state reinsurance program (as described in this report). By June, BCBS-OK had indicated its intent to continue in the Oklahoma marketplace for 2018. On September 29, the state withdrew the waiver application after failing to get a timely approval.

Tennessee. Tennessee's federally facilitated marketplace has included at least three insurers since its first year in 2014. Participation fell from four insurers in 2016 to three in 2017; the exit of UnitedHealth from the program for 2017 left Blue Cross Blue Shield of Tennessee (BCBST), Cigna, and Humana. Although BCBST, the largest insurer, remained in the program, it exited from the state's metropolitan areas (Knoxville, Memphis, and Nashville). Because BCBST and UnitedHealth had been the only statewide participants in 2016, 73 of the state's 95 counties had only a single insurer in 2017. Humana's decision to withdraw nationally from all marketplace participation in 2018 took it out of Tennessee, but Oscar Health entered the Tennessee marketplace for the greater Nashville area. For a few months in early 2017, it appeared that the Knoxville area would have no insurers for 2018. But BCBST agreed to re-enter the marketplace for that region. Nevertheless, 78 of the state's 95 counties will have only a single insurer.

Washington. From 2014 to 2017, Washington's state-based marketplace has seen robust competition with at least six participating insurers each year. In 2017, six insurers

participated; if multiple product lines from three of these are counted, there were nine product lines on the marketplace. Community Health Plan of Washington opted to exit for 2018, but it had covered fewer than 100 enrollees. The Cambia Group withdrew both of its marketplace products (Bridgespan and Regence Blue Shield). This left four participating insurers with six product lines, some with reduced service areas. The result was several counties with a single insurer and two potentially bare counties (Grays Harbor and Klickitat). In June, the insurance commissioner announced solutions. Premera Blue Cross elected to enter Grays Harbor County, and two insurers (Bridgespan/Cambia and Molina) agreed to serve Klickitat County. Bridgespan became Cambia's only on-exchange offering in the state.

Other states. Four states not included in this study were also at risk of having bare counties for 2018. *Indiana* almost had four bare counties after exits by Anthem and MDWise and a reduction in CareSource's service area. CareSource revised its filing to stay in two counties and expand into another. Centene picked up the last bare county and joined CareSource in two of the other three. In *Missouri*, Centene elected to enter 40 counties, including the 25 that were on the verge of having no insurers after withdrawals by other companies. *Virginia* faced the exits of multiple insurers for 2018, including late exits by Anthem and Optima Health Plan that left 63 bare counties and independent cities. Optima then agreed to re-enter five of these; shortly thereafter Anthem reversed its exit, meaning that all the bare counties would have coverage. In *Wisconsin*, the marketplace experienced exits by Anthem and Molina, leaving Menominee County as the one county with no insurer. Security Health Plan stepped in to cover that county.

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19. These summaries are derived from media reports, state legislative and administrative actions, our interviews, and the extensive background information available on healthinsurance.org.

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