

U.S. Health Reform—Monitoring and Impact

Insurers Remaining in Affordable Care Act Markets Prepare for Continued Uncertainty in 2018, 2019

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By Sabrina Corlette, Linda Blumberg, John Holahan,
Olivia Hoppe, Kevin Lucia, and Erik Wengle



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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

Although congressional efforts to repeal and replace the Affordable Care Act (ACA) did not succeed in 2017, the law continues to face an uncertain future. Absent legislative action, the Trump administration issued several policies in late 2017 rolling back some of the law's key provisions, and just before the end of the year, Congress successfully repealed the ACA's penalty for failing to maintain insurance coverage (the individual mandate). This repeal, coupled with federal administrative actions, has generated questions about the long-term availability of affordable health plan choices in the individual market.

In this brief, we examine insurers' participation and pricing decisions for the 2018 and 2019 plan years through structured interviews with 10 insurance companies participating in the individual market in 28 states and the District of Columbia. Key observations include the following:

- The anticipated rollback of the ACA's individual mandate led insurers to implement higher premiums in 2018 and will likely drive premiums even higher in 2019. However, insurers' views differed on the impact of repealing the individual mandate. Some felt it would ultimately lead to a collapse of the market and are considering further retrenchment; others felt confident that a market for highly subsidized, low-income consumers would continue.
- The midyear loss of the ACA's cost-sharing reduction (CSR) plan reimbursements drove 2018 premium increases ranging from 10 percent to 20 percent. However, several insurers credited state regulators with prompt action to help insulate consumers from premium hikes, noting

further that proposed federal legislation to restore cost-sharing reduction funding could result in significant disruption and sticker shock for consumers receiving premium tax credits.

- All insurers had concerns regarding an expansion of short-term and association health plans under the President's October 12, 2017 executive order. Insurers worry that an expansion of these plans could siphon healthy people away from the individual market, leaving a sicker, costlier population. Insurers indicated that a consequence of this would be higher premiums in the individual market. Further, although insurer respondents generally dislike these plans, many reported pressure to market them in order to retain healthy enrollees and remain competitive.
- Although the current administration has offered insurers greater flexibility in benefit design, few insurers reported taking advantage of it for 2018. Respondents stated that the flexibility came too late for them to significantly change their plan designs and that they did not want to add to the already considerable confusion among consumers about their marketplace coverage. For 2019, however, some insurers were open to greater benefit design changes.
- In areas where insurers had effective monopolies, premiums have generally been very high. This is driven in part by high provider prices, particularly in rural areas. Former Medicaid-only plans continue to have a pricing advantage over commercial insurers who tend to pay higher provider prices.

■ Insurers with narrow provider networks reported concerns about the potential exit of competing insurers, noting that their network providers lacked capacity to take an influx of new, often sicker enrollees. They further noted that unexpected insurer exits can produce considerable disruption, particularly if remaining insurers lack sufficient time or ability to readjust their pricing.

Most insurers in our study remain committed to participating in the individual market. But that commitment has been tested by the continued erosion of policies designed to

maintain the stability of the individual market, as well as shifts in federal policy that fail to account for the long regulatory and operational timeframes needed to bring an insurance product to market. Going forward, insurers will be closely watching how consumers respond to the lack of an individual mandate and the availability of new coverage options that do not have to comply with the ACA's protections for people with pre-existing conditions. A worsening of the risk pool will likely cause many insurers to reduce their market presence, will cause all insurers to raise their premiums, and may lead to more exits.

INTRODUCTION

Although congressional efforts to repeal and replace the Affordable Care Act (ACA) did not succeed in 2017, the law continues to face an uncertain future. Absent legislative action to repeal the law, the Trump Administration issued several policies in late 2017 to roll back some of its key provisions, and just before the end of the year, Congress successfully repealed the ACA's penalty for individuals who fail to maintain insurance coverage (the individual mandate). This repeal, coupled with federal administrative actions, has generated questions about the long-term availability of affordable health plan choices in the individual market.

Approximately 17.6 million people obtain coverage through private health insurance plans offered in the individual market.¹ However, insurers participating in that market (both inside and outside the ACA's health insurance marketplaces) must decide annually whether to remain, what types of plans they will offer, and at what price they will offer them. These business decisions are highly dependent on federal and state policy decisions that may stabilize or destabilize the market. Although data suggest that insurers are entering 2018 on much sounder financial footing than in the early years of the ACA's marketplaces, several policies are in place this year that

threaten insurers' long-term participation in the marketplaces and the affordability of ACA coverage. Such policies include the repeal of the individual mandate penalty, the Trump Administration's decision to cut off insurers' reimbursements for the ACA's CSR plans, and the encouragement of alternative coverage options, such as short-term plans and association health plans (AHPs). At the same time, however, the Trump Administration has offered insurers greater flexibility over plan benefit design, which could lower premiums. Going forward, insurers must also consider the possibility of congressional efforts to repeal the ACA or, conversely, to stabilize it by restoring cost-sharing subsidies or instituting a reinsurance program.

Through structured interviews with a range of insurers participating in the ACA's marketplaces, this brief explores how insurers approached the 2018 plan year given considerable federal policy uncertainty as well as their strategies for 2019 and beyond. We find that federal policies have caused insurers to implement significant premium increases and offer fewer plan choices in 2018, and we predict even higher prices and potentially greater retrenchment of participation in 2019.

BACKGROUND AND APPROACH

A key goal of the ACA is to help consumers obtain affordable coverage through health insurance marketplaces, where private insurance companies compete on price and quality. Achieving this goal was premised on a three-part 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 required to maintain health insurance coverage or pay a penalty (the individual mandate). Third, to make that coverage more

affordable, low- and moderate-income consumers purchasing insurance 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 could cause insurers to leave the market or increase premiums to unaffordable levels.

These reforms, along with an expansion of the Medicaid program, were implemented in 2014 and have led to 20 million

people gaining coverage. In 2017, approximately 17.6 million people had individual market coverage through ACA-compliant health plans; 12.2 million of them enrolled through the ACA's marketplaces. For 2018, that number is projected to drop to approximately 9 million. Eighty-four percent of marketplace consumers receive premium tax credits, and 57 percent have deductibles and other cost-sharing reduced through federal subsidies. However, the marketplaces depend on private insurance companies to deliver these benefits, and many of these companies suffered financial losses in the first years of the law's implementation, leading some to rethink participation or leave the marketplace.

Several factors contributed to insurers' early dissatisfaction with the marketplaces, such as a sicker-than-expected population and high utilization of services, congressional action to defund a key risk-sharing program (the "risk corridor" program), and fierce price competition from low-cost carriers. The resulting shortfalls in revenue caused several insurers, including large national carriers UnitedHealthcare, Aetna, and Humana, to curtail their marketplace participation in 2017 and 2018.

Insurers remaining in the market in 2017 have used premium increases and various cost containment strategies to regain their financial footing, and early evidence suggests that most were either profitable or broke even. Just as the health insurance marketplaces began to stabilize, however, a new administration and Congress have changed federal policies and practices fundamental to the ACA's long-term sustainability. Before open enrollment began for 2018 coverage, the Trump Administration announced steep cuts to enrollment assistance and advertising programs, cut

the open enrollment period in half, and discontinued CSR reimbursements to insurers. In addition, an October 13, 2017, executive order called for the expansion of alternative coverage options, such as short-term plans and AHPs, which are not required to comply with most of the ACA's protections for people with pre-existing conditions.

These policy changes, previous financial struggles, and the continued threats of full ACA repeal by Congress led many insurers to leave the market, decrease their level of participation, or increase premiums significantly. Further, in December 2017, Congress passed the Tax Cuts and Jobs Act, which included the elimination of the individual mandate penalty (to take effect in 2019). As 2018 begins, insurers are assessing the impact of the individual mandate penalty repeal, proposed rules on AHPs and short-term plans, and legislation to restore CSRs and help insurers mitigate the risk of patients with significant health care costs through reinsurance.

To better understand how insurers participating on the ACA's health insurance marketplaces have responded to an uncertain policy environment, we reviewed available data about insurers' 2018 marketplace participation and premiums and conducted structured interviews with executives of 10 insurance companies participating in the individual market in 28 states and the District of Columbia. We asked insurers about participation and pricing decisions for the 2018 plan year as well as their longer-term marketplace strategies. 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 November 20, 2017, and January 23, 2018.

FINDINGS

For the most part, the insurers remaining in the ACA's marketplaces today are committed to long-term participation if they can be assured of a more stable policy environment. Several feel they have adjusted their pricing sufficiently to protect themselves from the lack of the individual mandate penalty and other policy changes that will likely affect their 2018 finances. However, their decisions on whether and where to participate and how to set plan premiums in 2019 will depend on several emerging issues, such as the potential for expanded sales of short-term plans and AHPs and federal ACA-related legislation, as well as on the decisions of competing plans that could affect their market share and exposure to risk. Although insurers generally appreciated the Trump Administration's efforts to provide them with

greater flexibility over plan benefit design, few have yet taken advantage of it.

Insurers had differing views about repeal of the individual mandate

Most of our interviews were completed before Congress eliminated the individual mandate penalty in the Tax Cuts and Jobs Act of 2017. Throughout 2017, however, insurers were uncertain as to whether the administration would relax enforcement of the mandate or whether legislation would eliminate it completely and, if either were to occur, the timetable on which such a policy change would be made. Insurers widely considered the individual mandate to be a linchpin that maintained diverse health care risk pools in an environment of guaranteed issue, modified community

rating, and coverage standards. Every representative interviewed reported that his or her company had considered the implications of losing the mandate when setting 2018 premiums and were currently doing the same for 2019 premiums.

Insurer representatives were united in their strong view that the individual insurance market would be better off and premiums would be lower if the individual mandate penalty was maintained and enforced. Respondents differed somewhat, however, in how large of a premium effect they felt the mandate has had. Insurers that thought the individual mandate affected premiums estimated that it affected them by eight percent or more (compared with the 10 percent effect estimated by the Congressional Budget Office). Some sources felt that elimination of the individual mandate and the resulting loss of healthy enrollees would ultimately collapse the market. One insurer that reduced its service area for 2017 indicated that the expectation that the individual mandate would be eliminated through repeal efforts was a significant factor in its decision to retrench. Others indicated that the Tax Cuts and Jobs Act's elimination of the individual mandate penalty would be significant as they re-evaluate the nature of their continued participation.

Several sources indicated that the importance of the individual mandate for market stability and premiums was inextricably entwined with other policy changes being made, such as increased flexibility for the sales of short-term plans and AHPs. Multiple sources felt that the combination of these changes would likely lead to a continuing market for highly subsidized insurance coverage for the low-income, but an unsubsidized market for the middle class that would be unaffordable to all but a very few, and dominated by people with serious health problems. Insurers also thought the interaction effects among the policies could be significant and increase premiums more than each policy change might individually. Insurers predominantly enrolling low-income people with substantial federal subsidies felt that they could continue to serve this population, but many felt that coverage could decline substantially (particularly in the individual market outside the exchanges, where most unsubsidized people purchase coverage). Insurers with lower shares of subsidized enrollees suggested they may need to exit the markets if the mandate were repealed.

Although insurers must submit proposed premium rates for state regulatory review many months before they are implemented, some insurers, based on the probability the individual mandate would be eliminated or its enforcement decreased, built into their 2018 rates an assumption that the risk pool would be sicker. Other insurers tried and were prohibited from doing so by state regulators, and others were

not specific about whether their proposed 2018 premiums included such an assumption. As a result, 2019 premiums are likely to differ significantly in how they adjust for the repeal of the mandate.

All sources felt that repeal of the mandate (which occurred after the interviews) would require them to reassess their premiums and possibly their market participation for the 2019 plan year. Some hoped that particular states would implement their own individual mandates (though their expectations of this happening were low), and others felt that an adequately funded reinsurance program could significantly offset the damage of losing the mandate. One source thought the confusion caused by the administration's comments led many consumers to believe the individual mandate had already been repealed, so they expected consumer behavior had already changed for the 2018 plan year (i.e., fewer healthy people enrolled).

Most insurers are able to adjust to the loss of CSRs; restoring them could be disruptive

Just three weeks before the start of open enrollment for 2018 coverage, the President announced the federal government would stop reimbursing insurance companies for the CSR plans they are required to offer through the ACA's marketplaces. Marketplace enrollees with income between 100 and 250 percent of the federal poverty level who purchase a silver-level plan are eligible for reduced deductibles, co-payments, and coinsurance. Although the administration's decision did not change the requirement that insurers offer these lower cost-sharing plans to eligible individuals, it eliminated the funding insurers receive to compensate them, a loss projected to be \$8 billion in 2018 alone. Although insurers had been required to finalize their 2018 premium rates in August, most were able to work with state and federal insurance regulators to adjust those rates and protect themselves from CSR-related losses.

Insurers in our study reported premium rate increases of 10 percent to 20 percent as a result of lost CSRs. The amount of increase varied by insurer; insurers with a high proportion of CSR-eligible enrollees reported higher premium effects than those with fewer CSR-eligible enrollees. Interview respondents also noted that the abrupt termination of CSR funding was extremely disruptive, requiring significant internal efforts to recalculate premium rates and adjust plan benefit designs as well as external efforts to educate state regulators about the impact of the change and premium increase strategies that would limit adverse effects for consumers. In fact, one insurer noted that continued threats (ultimately realized) to discontinue CSRs were of far greater concern to company executives than repeated congressional efforts to repeal the ACA. Another representative reported

that the time and resources devoted to the issue were “really disruptive, in terms of systems, in terms of working with vendors, I mean the whole nine yards.”

Other insurers noted that the working relationship with state departments of insurance, many of which review and approve premium rates, was “really critical.” Some state departments of insurance saw the threat early on and required insurers to file two sets of rates, one assuming CSR reimbursements would be paid in 2018 and one assuming they would not. Several insurers noted that they worked closely with state departments of insurance during this time, and many urged regulators to provide clear direction to all participating insurance carriers about whether a CSR-related premium increase would be allowed and how it should be allocated. “We wanted regulators to instruct us on what to do because that evens the playing field,” one company representative told us.

Insurers also commented on the effect of the CSR-related premium increase on consumers’ buying power. Because most states allowed or required insurers to concentrate the premium hike on silver-level marketplace plans, eligible consumers’ premium tax credit subsidies were commensurately increased. As a result, premiums for many gold-level plans were close to or even lower than those for silver-level plans, and many consumers were able to purchase bronze-level plans with a \$0 premium. Although open enrollment had not yet closed at the time of our interviews, some insurers anticipated that enrollees not eligible for large cost-sharing reductions would shift from silver-level to gold- and bronze-level plans. Early data from a handful of the state-based marketplaces suggest that this shift did, in fact, occur.

Several insurers were concerned about proposed federal legislation to restore CSR funding. They noted that many consumers are now “getting a good deal,” thanks to higher premium tax credits, and that restoring CSRs would cause considerable confusion during the 2019 open enrollment season and lead to sticker shock for consumers who had switched to gold- or bronze-level plans this year. Restoring CSRs “is not helpful at all,” said one representative.

Marketplace insurers are concerned about the expansion of short-term plans and AHPs but face competitive pressures to sell them

The October 2017 executive order to expand access to short-term plans and AHPs would allow insurers to market insurance products that do not have to comply with many of the ACA’s consumer protections (see box). Proposed administration rules implementing this order were published early in 2018.

Short-Term & Association Health Plans

Short-term plans: A health plan designed to fill temporary gaps in coverage. Generally, short-term plans are only available to consumers who can pass medical underwriting, and they provide minimal financial protection for those who become sick or injured. In a recent analysis, short-term policies regularly excluded coverage for pre-existing conditions as well as entire categories of key benefits, including mental health and substance-use services, maternity care, and prescription drugs. Currently, federal rules limit short-term plans to three months and they are not renewable. New rules to implement the executive order are expected to lengthen the duration of these policies, perhaps for as long as 364 days.

Association health plans: Before the ACA, millions of individuals and small employers bought health insurance through associations, such as professional or trade associations. Under current federal law, health insurance sold through an association to individuals is subject to the rules that apply to the individual market. However, new proposed federal rules would allow association health plans to be treated as large-group plans and sold to certain individuals, such as sole proprietors and people who are self-employed, without having to comply with many of the ACA consumer protections that apply to the individual market, such as essential health benefits or rating limits based on age and gender.

The executive order immediately raised questions among insurers about how these non-ACA-compliant policies might affect the individual market and whether competing insurers would aggressively market such coverage options. By the time the executive order was published, insurers had largely made their participation decisions and set rates for the marketplaces in 2018. Insurers recognized, however, that an increase in the availability of policies lacking ACA protections would likely shift healthy individuals away from ACA-compliant plans. A few insurers further speculated that ACA-compliant plans on the individual market would become largely populated by subsidy-eligible individuals; healthier unsubsidized people would gravitate towards these alternative options (if they signed up for coverage at all).

One insurer expected it would need to raise premiums as a result of the executive order but would not speculate to what degree until they saw the final regulations. Another insurer made clear that the availability of these alternative coverage options, especially combined with the loss of the individual

mandate, would affect its decision to continue participating in the marketplace in 2019.

The end result, one representative noted, would be a market in which “if you’re healthy you can buy an underwritten [short-term plan or AHP], but if you’re not, the ACA compliant-plan for unsubsidized coverage will just be unaffordable.” Another insurer echoed this viewpoint, suggesting that over time the individual market “will look like a high-risk pool.”

However, insurers noted that this potential outcome might depend on how states regulate these coverage options. In theory, states could limit the availability of these products to protect the individual market risk pool. One West Coast insurer appeared confident that regulators in its state would make it difficult to sell short-term policies if federal rules are relaxed.

At the same time, insurer respondents noted that to remain competitive, they may ultimately market short-term plans or AHPs in order to maintain market share. However, that pressure was not felt universally. Some former Medicaid-only plans dismissed the possibility of selling to individuals outside of the ACA-compliant individual market, largely because they are focused on heavily subsidized marketplace enrollees. For example, one of these insurers concluded that short-term policies are “not the right thing for this organization,” because they are targeted to people who make too much money for ACA subsidies. On the other hand, traditional commercial carriers reported that they are going to track the market closely and potentially market these coverage options. One large commercial insurer, otherwise committed to participating in the marketplace, shared that “we don’t have a desire to offer [short-term plans and AHPs] but we have to look at it.” Another noted that “if you cannot beat them, then you might have to join them.”

Few insurers took advantage of new benefit design flexibility

The administration took several actions to expand insurers’ flexibility to design plan benefits for the 2018 plan year. Under the ACA, insurers must offer plans at up to four levels of coverage: bronze, silver, gold, and platinum. Each level reflects the value of coverage: bronze is the least generous (with an actuarial value of 60 percent) and platinum is the most generous (with an actuarial value of 90 percent). Silver plans must have an actuarial value of 70 percent and gold plans 80 percent.

The administration issued rules early in 2017 allowing insurers to vary their plans’ actuarial values more than before. However, insurer respondents indicated that they made no or very minor benefit design changes in preparation for the

2018 plan year. Several noted that the new rules were released too late in the plan design process for them to make changes, but they might affect 2019 plan designs. Other insurers noted that given an uncertain policy environment and the resulting premium increases, they wanted to make as few benefit design changes as possible to minimize the disruption for their customers. One insurer noted, “Double-digit increases hit consumers hard. [We decided], let’s keep benefits stable as possible and minimize rate increases....” Another insurer reduced the number of plans it offered, saying “We smoothed down the offering...it’s a lot less confusing for consumers.”

During the interviews, a handful of insurers indicated that they had made minor changes for the 2018 plan year. Some insurers mentioned they made changes to their formularies and networks. One noted a change from a five-tier formulary to a six-tier one, but noted, “We want to make sure premiums are as affordable as possible. Cost of product is concerning, especially for the unsubsidized population.”

In addition to policy uncertainty, provider payment rates and network design changes affect affordability

In general, insurers confirmed that their 2018 premiums reflect the health status of their enrollees as well as trends in underlying medical care costs. However, they noted that premiums have also been affected by considerable policy uncertainty. As a result, insurers that may have previously set a low price to compete for market share are hesitating to do so now. The more aggressive pricing by former Medicaid-only plans suggests that they may be the exception. Rather, the prevailing sentiment among insurers is to set premiums high enough to prevent losses even if that means owing rebates because of the ACA’s medical loss ratio standard.

In some markets, insurer monopolies have developed and very high premiums have resulted. Some respondents noted that in such cases it is difficult for them to enter such markets and stimulate competition because the existing insurers have established relationships and favorable contracts with providers. In many cases, particularly in rural markets, there are not enough providers to enable insurers to negotiate modest rates or to develop narrow-network products. As one insurer put it, “A lot of rural counties have monopoly providers, [while] we need to reach network adequacy [standards]. They’ll want higher rates...sometimes you just have to pay it.”

The uncertainty described above along with monopoly conditions in many markets have led to premium increases on and off the marketplaces. Most of those enrolled in the marketplaces are protected from higher premiums by subsidies, but those buying off the marketplace are not protected. As a result, insurers projected slight declines in enrollment for subsidized individuals and larger declines among unsubsidized

individuals. Although most insurers were interviewed before the end of open enrollment, one insurer had already observed a decline in its off-marketplace enrollment.

Negotiated provider rates affect insurers' ability to compete

Insurers reported that negotiated provider rates are a big factor in premium prices and growth. Provider rates explain much of the variation across markets for a given carrier as well as variation across carriers, and respondents indicated provider payment rates differed considerably. In most markets, Medicaid pays the lowest provider rates while commercial insurers pay the highest. Medicare reimbursement rates tend to be somewhere in between Medicaid and commercial rates.

Marketplace insurers whose business is largely commercial generally pay commercial rates; in some cases, they have been able to negotiate discounts for the marketplace population, but these rates are still not as low as those for Medicaid.

Former Medicaid-only plans, on the other hand, report they are paying their providers at or above Medicaid rates. As one put it, "Our marketplace product is like a 'Medicaid Plus' product." These insurers report that providers are pushing back on Medicaid rates, but there is no indication that rates approach commercial or even Medicare levels. The former Medicaid-only plans participating in our study reported no intentions to exit or retract their service areas. In fact, national Medicaid insurers such as Centene seem to be expanding their footprint.²³

Additionally, insurers report that plans with out-of-network coverage ("PPO" products) tend to be more attractive to sicker individuals. Even with the promise of payments under ACA's risk adjustment program, these products have proven harder

for insurers to sustain. Some respondents indicated that they are simply not viable.

Actions of competitors could drive marketplace participation decisions

Insurers that offer narrow-network plans do not necessarily welcome the exit of competing insurers, even though it would add to their market share. First, they often do not have enough provider capacity to absorb a departing company's enrollees. Second, the insurers that exit have tended to be those with broader networks that are attractive to sicker individuals. The receiving company may face challenges accurately pricing for a new, unknown set of health risks. Third, because insurers must set premium rates for the next plan year many months in advance, the unexpected departure of a competitor with large market share late in the year can cause havoc. At best, it leads to considerable disruption as the insurer and state regulators scramble to adjust premium rates to accurately reflect the influx of new and potentially sicker enrollees. At worst, it could mean premium rates that are inadequate to reflect the new enrollee risk, resulting in financial loss or insolvency for the remaining insurer.

In sum, marketplace competition varies across markets but is evolving. Broader network commercial plans, or PPOs, are finding it more difficult to survive, particularly in non-rural areas. Provider payment rates are higher, and broader networks are attractive to less-healthy individuals. In 2018, 52 percent of U.S. counties are covered by a single insurer.²⁴ In such a monopoly situation, a commercial insurer can survive. But in other markets, competition is pushing insurers to offer exclusively narrow-network plans with lower provider payment rates. These narrow-network plans can in turn make it more challenging for insurers to absorb enrollees from a competitor who decides to exit the market.

CONCLUSION

Most insurers in our study remain committed to offering coverage in the individual market, including through the ACA's marketplaces. But that commitment has been tested by the continued erosion of policies designed to maintain stability in the insurance pools. In a series of structured interviews with 10 insurers participating in the marketplaces in 28 states, we discuss how insurers responded to policy changes in 2017, including the (1) repeal of the individual mandate, (2) ultimately realized threats to cut off CSR payments, (3) promotion of short-term plans and AHPs, and (4) increased flexibility for benefit design. We further examine how these policy changes as well as pressures from competing marketplace insurers are likely to affect the availability, price, and quality of coverage options in 2019 and beyond.

In general, insurers are confident that given greater certainty about the direction of federal policy, they can continue to offer marketplace coverage and set premiums that accurately reflect their risk. However, they note that several of the policy actions discussed have led to significant insurer retrenchment and premium increases and will likely contribute to even higher premiums in 2019. Going forward, insurers will be watching closely how consumers respond to the lack of an individual mandate and the availability of new coverage options; a worsening of the marketplace risk pool will likely cause many insurers to reduce their market presence, will cause all to increase premiums, and may lead to more exits.

ENDNOTES

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About the Authors and Acknowledgements

Sabrina Corlette and Kevin Lucia are Research Professors at Georgetown University's Center on Health Insurance Reforms (CHIR). Linda Blumberg and John Holahan are Institute Fellows in the Urban Institute's Health Policy Center, Olivia Hoppe is a Research Associate at CHIR, and Erik Wengle is a research analyst in the Urban Institute's Health Policy Center. The authors thank Caroline Elmendorf for her research support, Michael Marazzi for copyediting, as well as the many sources who took the time to discuss these issues with us.

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