U.S. Health Reform—Monitoring and Impact

What Explains 2018's Marketplace Enrollment Rates?

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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**.

SUMMARY

In the months leading up to the 2018 open enrollment period for health insurance marketplaces, members of Congress made several efforts to repeal and replace the Affordable Care Act (ACA). Also, the federal government stopped reimbursing insurers for cost-sharing reductions (CSRs) for eligible marketplace enrollees with incomes below 250 percent of the federal poverty level (FPL); cut funding for enrollment assisters and marketplace advertising; and shortened the default open enrollment period for signing up for marketplace coverage. These developments could have caused large reductions in marketplace plan enrollment nationwide—yet that's not what happened. Fifteen states saw *higher* marketplace enrollment this year, but the remainder saw the expected enrollment declines.[1]

To understand the marketplace enrollment gains and losses observed in 2018 relative to 2017, the Urban Institute interviewed key stakeholders in Rhode Island, Washington, and New York, which saw marketplace enrollment increases, and in West Virginia and Louisiana, which saw enrollment drops. Interviewees from these states highlighted the following key factors influencing marketplace enrollment:

- **The relative prices of marketplace plans versus off-marketplace plans.** In several states, shifts in marketplace enrollment reflected the availability and affordability of marketplace plans relative to other coverage options. For example, some of the cheapest plans in Rhode Island were only available on-marketplace this year, which may have caused some people to switch from off-marketplace to on-marketplace plans. In Washington, insurers stopped offering many off-marketplace plans this year, which likely caused some consumers to shift to marketplace plans. In Louisiana, interviewees reported that many people kept grandmothered off-marketplace plans because premiums for these plans have grown at slower rates than marketplace premiums have.
- **The size of premium tax credits.** Rhode Island, Washington, and Louisiana maximized their premium tax credits by "silver-loading"—that is, directing insurers to only increase silver plan premiums to account for the cancelation of federal CSR payments. This practice increased the size of tax credits because credits are tied to the price of the second-lowest-cost silver plan in each area. The tax credit increase caused by silver-loading made gold and bronze plans significantly cheaper not only for consumers who qualified for cost-sharing reductions, but for all consumers who qualified for premium tax credits. Rhode Island and Washington saw enrollment gains this year, but Louisiana (which had limited advertising and a small enrollment assister presence) did not.
- **The amount of advertising.** Interviewees reported more insurer-sponsored advertising in states with at least two marketplace insurers competing statewide, and more state-funded marketplace advertising in states with their own state-based marketplaces. Among our five study states, those with high amounts of advertising all saw enrollment gains this year. (See Table 4 for a compilation of key outreach strategies used in the states profiled in this brief.)
- **The use of social media.** States with enrollment gains also reported increased or continued use of social media platforms to promote open enrollment or answer customer service questions. This may have led more young and healthy consumers to find out about coverage options and enroll in marketplace plans.

- **The tone of news coverage.** In the states that saw enrollment gains, government officials opposed attempts to repeal and replace the ACA and tried to combat consumer confusion by encouraging consumers to enroll in marketplace coverage. Interviewees in the other states said that ACA news coverage may have confused consumers about whether the law had been repealed, but they had mixed views about the impact of this confusion.
- **The length of states' open enrollment periods.** The study states with enrollment gains all had state-based marketplaces that opted for longer open enrollment periods than the shortened six-week period HealthCare.gov used this year. In New York, people who signed up after the first six weeks of open enrollment were mostly younger and healthier, helping improve insurers' risk pools.

INTRODUCTION

In the months leading up to the 2018 open enrollment period for health insurance marketplaces, Congress considered several proposals to repeal and replace the Affordable Care Act, and the federal government signaled that it might not reimburse insurers for cost-sharing reductions that insurers are required to provide to eligible marketplace enrollees with incomes below 250 percent of FPL. CSR payments to insurers were officially canceled in October 2017,[2] leading to heavily publicized insurance premium increases for many plans. In addition, the federal government cut its funding for in-person enrollment assisters by more than 40 percent,[3,4] cut its marketplace advertising by 90 percent,[5] and halved the default open enrollment period for signing up for marketplace coverage (from three months to six weeks: November 1 to December 15, 2017).[6]

These developments were expected to cause large reductions in marketplace plan enrollment nationwide—yet that's not what happened. Numerous states saw *higher* marketplace enrollment this year, although plenty of states did experience the expected enrollment declines (Table 1).

Nationally, the number of people selecting marketplace plans only decreased by 3.8 percent this year,[7,8] a smaller decline than many anticipated.

To understand the marketplace enrollment gains and losses observed in 2018 relative to 2017, the Urban Institute interviewed key stakeholders in five states that had high or low enrollment rates, were geographically diverse, and used different marketplace models. Of the five states, Rhode Island, Washington, and New York experienced enrollment increases in 2018, and West Virginia and Louisiana reported large decreases. In March 2018, we conducted 32 phone interviews with stakeholders including marketplace and other state officials, insurers, insurance brokers, enrollment assisters, hospital officials, federally qualified health center officials, and consumer advocates. We did not speak to all stakeholder types in all the states.

In this brief, we explain the different features of the five states, present cross-state findings, and discuss important factors in next year's open enrollment period.

Table 1. Change in the Number of People Enrolled in Nongroup Marketplace Plans, 2017 to 2018

State	Platform	2017	2018	2017–2018 Percent Change
Alabama	FFM	178,414	170,211	-4.6%
Alaska	FFM	19,145	18,313	-4.3%
Arizona	FFM	196,291	165,758	-15.6%
Arkansas	SBM-FP	70,404	68,100	-3.3%
California	SBM	1,556,676	1,521,524	-2.3%
Colorado	SBM	161,568	161,764	0.1% ↑
Connecticut	SBM	111,542	114,134	2.3% ↑
Delaware	FFM	27,584	24,500	-11.2%
District of Columbia	SBM	21,248	19,289	-9.2%
Florida	FFM	1,760,025	1,715,227	-2.5%
Georgia	FFM	493,880	480,912	-2.6%

Table 1. Change in the Number of People Enrolled in Nongroup Marketplace Plans, 2017 to 2018 (continued)

State	Platform	2017	2018	2017–2018 Percent Change
Hawaii	FFM	18,938	19,799	4.5% ↑
Idaho	SBM	100,082	94,507	-5.6%
Illinois	FFM	356,403	334,979	-6.0%
Indiana	FFM	174,611	166,711	-4.5%
Iowa	FFM	51,573	53,217	3.2% ↑
Kansas	FFM	98,780	98,238	-0.5%
Kentucky	SBM-FP	81,155	89,569	10.4% ↑
Louisiana	FFM	**143,577**	**109,855**	**-23.5%**
Maine	FFM	79,407	75,809	-4.5%
Maryland	SBM	157,832	153,584	-2.7%
Massachusetts	SBM	266,664	267,260	0.2% ↑
Michigan	FFM	321,451	293,940	-8.6%
Minnesota	SBM	109,974	116,358	5.8% ↑
Mississippi	FFM	88,483	83,649	-5.5%
Missouri	FFM	244,382	243,382	-0.4%
Montana	FFM	52,473	47,699	-9.1%
Nebraska	FFM	84,371	88,213	4.6% ↑
Nevada	SBM-FP	89,061	91,003	2.2% ↑
New Hampshire	FFM	53,024	49,573	-6.5%
New Jersey	FFM	295,067	274,782	-6.9%
New Mexico	SBM-FP	54,653	49,792	-8.9%
New York	SBM	**242,880**	**253,102**	**4.2% ↑**
North Carolina	FFM	549,158	519,803	-5.3%
North Dakota	FFM	21,982	22,486	2.3% ↑
Ohio	FFM	238,843	230,127	-3.6%
Oklahoma	FFM	146,286	140,184	-4.2%
Oregon	SBM-FP	155,430	156,105	0.4% ↑
Pennsylvania	FFM	426,059	389,081	-8.7%
Rhode Island	SBM	**29,456**	**33,021**	**12.1% ↑**
South Carolina	FFM	230,211	215,983	-6.2%
South Dakota	FFM	29,622	29,652	0.1% ↑
Tennessee	FFM	234,125	228,646	-2.3%
Texas	FFM	1,227,290	1,126,838	-8.2%
Utah	FFM	197,187	194,118	-1.6%
Vermont	SBM	30,682	28,763	-6.3%
Virginia	FFM	410,726	400,015	-2.6%
Washington	SBM	**225,594**	**243,227**	**7.8% ↑**
West Virginia	FFM	**34,045**	**27,409**	**-19.5%**
Wisconsin	FFM	242,863	225,435	-7.2%
Wyoming	FFM	24,826	24,529	-1.2%
United States	N/A	12,216,003	11,750,175	-3.8%

SOURCE: CMS marketplace open enrollment period public use files for 2017 and 2018.

NOTES: SBM = state-based marketplace, meaning the state operates its own marketplace website and functions; SBM-FP = state-based marketplace–federal platform, meaning the state performs all marketplace functions but relies on the federally facilitated marketplace's plan selection website (HealthCare.gov); FFM = federally facilitated marketplace (HealthCare.gov), meaning that HHS performs all marketplace functions. The five states we studied are in bold. States with higher marketplace enrollment in 2018 than in 2017 are in green. New York's 4 percent increase in marketplace plan enrollment does not include the robust increase in the number of people enrolled in the state's relatively new Basic Health Program coverage, available for $0 or $20 per month for eligible people with incomes at or below 200 percent of FPL.

STATE PROFILES

Rhode Island

Rhode Island saw the largest increase in marketplace enrollment in the U.S. this year, with 12 percent more people selecting marketplace plans than in 2017. Premiums were relatively affordable, which likely drove enrollment in the state. Silver-loading ensured that tax credit–eligible consumers could receive large reductions in premiums, and made the lowest-priced gold plan cheaper than the state's silver benchmark plan. The premium for Rhode Island's lowest-priced silver plan increased by 18.3 percent from 2017 to 2018, a significantly smaller increase than the national average increase of 32 percent; meanwhile, the lowest gold plan premium *decreased* by 2.3 percent.[9]

Rhode Island's state-based marketplace extended open enrollment beyond the federal government's period by two weeks, until December 31, 2017, which respondents said helped drive high enrollment. The state marketplace also had a special enrollment period for people who started applications but were unable to finish them by the December 31 deadline, which allowed more people to enroll.

Interviewees described Rhode Island as a politically active state where consumers were paying careful attention to efforts to repeal the ACA, and many residents appeared anxious to enroll this plan year. Interviewees reported that Rhode Islanders were engaged on social media, especially Twitter, during the 2017 repeal-and-replace effort. Community groups and enrollment assisters also rallied against the repeal of the ACA, and these mobilization efforts later shifted toward getting people to sign up for health insurance during the open enrollment period. The state's marketplace and its insurers increased their social media presence and advertising during the enrollment period; respondents said that social media played a far greater role than traditional advertising methods this year.

Silver-Loading of CSR Payments Yielded Generous Subsidies for Marketplace Plans

All respondents said that the state's silver-loading of CSR payments made a huge difference in the number of people who enrolled in marketplace coverage. Silver-loading refers to insurers adding their estimated costs of providing CSRs to eligible enrollees fully into their silver-tier premiums. Most states' insurance regulators instructed insurers to account for these costs in their silver marketplace premiums, as Rhode Island's regulators did. But some directed insurers to incorporate the costs in both silver marketplace and nonmarketplace premiums, and others instructed insurers to spread them more broadly across all tiers of coverage.[10]

Adding the costs of CSRs into silver marketplace premiums alone maximizes the size of advanced premium tax credits available to people with incomes up to 400 percent of FPL because the size of the credit is linked to the premium for the second-lowest-cost silver marketplace plan offered in a consumer's geographic area (the "benchmark" plan). The higher the silver premium, the larger the tax credits available.[11] Thus, silver-loading in Rhode Island made many plans—namely, gold and bronze plans—affordable for consumers eligible for premium tax credits.

Because uninsurance is already low in Rhode Island (around 4 percent),[12] many respondents suspected that much of the increase in marketplace enrollment came from people switching from off-marketplace plans into marketplace plans. Some of the cheapest marketplace plans are not available off-marketplace, so people with incomes above 400 percent of FPL may have switched to marketplace coverage to enroll in these cheaper plans.

Increased Social Media Presence and ACA Mobilization Efforts Raised Awareness

Respondents said that social media were important in generating marketplace enrollment, reflecting a deliberate change in the state marketplace's marketing strategies. The marketplace began advertising earlier than in past years to boost early enrollment and alert consumers to the shorter enrollment period. The state's marketplace and its insurers significantly reduced, if not eliminated, their television advertising in favor of targeted social media advertising, which interviewees believed was better suited to reaching young and healthy Rhode Islanders who might not otherwise enroll in coverage.

Interviewees noted that national news coverage of congressional attempts to repeal and replace the ACA also functioned as advertising, increasing awareness of the marketplace.

Navigators Accepted Appointments

Rhode Island created new tools for enrollment assisters and consumers this year. For example, the state worked with navigators to create a simple scheduling system that allowed consumers to make appointments to receive enrollment assistance. In past enrollment periods, long in-person wait times may have deterred consumers who had trouble taking time away from work or other responsibilities. The ability to set appointments also encouraged consumers to enroll earlier, slightly alleviating the rush at the end of the enrollment period.

Glitch-Free System Ensured a Smooth Marketplace Enrollment Experience

Before the 2018 open enrollment period, the state made significant improvements to the marketplace's IT platform. In 2016, the state rolled out a new centralized computer system that facilitated enrollment in marketplace plans, Medicaid coverage, and all other publicly funded assistance programs (including TANF and SNAP) and was intended to improve administrative performance and efficiency. However, this system had some software glitches, which created a backlog of thousands of cases in the new system, delaying eligibility determinations and enrollment in programs. The state fixed these technical problems for this year's enrollment period, which may have helped more people sign up for marketplace coverage.

Washington

In Washington, marketplace plan enrollment increased 8 percent in 2018. The state's marketplace has robust insurer participation, with seven insurers offering products for 2018. At the same time, presubsidy health insurance premiums increased substantially in the state. The average lowest-priced silver premium in Washington rose by 37 percent, while the average lowest-priced gold premium increased by 25 percent.[9] Tax credit–eligible people with incomes up to 400 percent of FPL could obtain larger premium tax credits to absorb these larger premiums if they chose a plan with a premium at or below the second-lowest-priced silver premium. However, people with incomes above 400 percent of FPL faced substantially higher premiums without financial support.

Despite steeply rising premiums at all metal tiers, Washington's marketplace premiums remained low compared with those of other states (see Table 3), and the state saw the third-largest increase in marketplace enrollment of any state this year. Interviewees offered several explanations for these enrollment gains.

Elimination of Off-Marketplace Plans Drove Many Consumers to the Marketplace

By far the most common explanation given for higher marketplace enrollment this year was that insurers in many counties stopped offering off-marketplace products. Many people who were enrolled in these plans likely turned to the state's marketplace for a new plan. Marketplace staff capitalized on this market shift by boosting outreach in areas where many off-marketplace plans were being discontinued. Increased social media presence, targeted ad campaigns, and enrollment assisters encouraged people in these areas to use the state's marketplace website to shop for a new plan.

There were other notable market shifts this year. In general, insurers offered fewer products in fewer counties. When rates and plans were approved for 2018, two Washington counties were left with no marketplace offerings. The state's insurance commissioner and insurers worked together to prevent "bare" counties, but several interviewees said that insurers were finding it increasingly difficult to offer products in certain areas. Many insurers also stopped offering bronze products in certain counties, and residents there had to upgrade to more expensive plans with lower cost-sharing. Interviewees attributed this trend of fewer plan offerings to general uncertainty about the fate of the ACA at the federal level.

Silver-Loading Absorbed High Premium Increases

As in Rhode Island, marketplace silver-loading generated larger premium tax credits in Washington state. As in Rhode Island, this practice made some gold plans cheaper than some silver plans in certain areas.

Enhanced Marketing Efforts Included Increased Social Media and Targeted Outreach

While the federal government cut funding for marketplace advertising, Washington maintained its state marketing budget. This year, the state operated six physical storefronts where people could enroll in coverage, more than the two storefronts available last year. Interviewees reported that these physical storefronts were popular and consistently busy. The marketplace also increased its digital presence this year through a series of how-to videos posted on Facebook and Twitter and through several "full-page takeovers"—large pop-up advertisements that would appear on popular websites (e.g., yahoo.com, seattletimes.com) before a user could access the content. Marketplace staff worked to improve search engine optimization so that ads for the marketplace would appear when consumers searched for information about health insurance in the state. These efforts took place statewide but focused on "geo-targeted" areas where many people were losing their previous insurance options. Marketplace staff believed that this increased digital presence and the new storefronts drove traffic to the marketplace's website and ultimately increased enrollment.

Organizations throughout the state also targeted certain vulnerable populations for marketplace outreach and enrollment assistance. For example, enrollment assisters increased their presence in Hispanic, Cantonese, and Russian communities where uninsurance rates were higher than the state average.

Finally, the marketplace rolled out a new tool called the Smart Planfinder, which helped potential enrollees filter their search for their personal prescriptions, preferred providers, and predicted number of doctor's visits for the year.

A State Official Encouraged Marketplace Enrollment

Washington state's insurance commissioner issued several press releases about the negative impact for consumers of the federal government's decision to stop reimbursements for CSRs.[13] The commissioner was vocal about the issue on social media and traditional media, and he encouraged people to enroll in marketplace coverage, despite rising premiums for unsubsidized people.

New York

In New York, marketplace enrollment increased 4 percent from 2017 to 2018. Premiums for the lowest-cost silver and gold plans in 2018 increased 10.3 and 10.5 percent, respectively—increases that were well below those observed nationally.[9] New York also saw large enrollment gains for its Basic Health Program (BHP), which launched in 2016 and is available to people with incomes up to 200 percent of FPL who would otherwise be eligible for marketplace subsidies. BHP premium contributions are $20 or less per month. Meanwhile, enrollment in off-marketplace plans decreased in 2018, likely because of increases in unsubsidized premiums.

New York is one of only two states with a BHP.[14] Because residents can enroll in Medicaid or BHP plans, fewer marketplace enrollees in the state qualify for CSRs; CSRs are only available to premium tax credit–eligible people with incomes up to 250 percent of FPL who purchase silver-level coverage in the marketplaces. After the federal government stopped reimbursing insurers directly for CSRs, New York's 12 insurers increased marketplace premiums only nominally, because only marketplace enrollees with incomes between 200 and 250 percent of FPL qualified for CSRs, and the CSRs for this group were relatively modest (providing 73 percent actuarial value coverage instead of 70 percent).[10] Thus, New York's marketplace was much less affected than other states by the federal government's decision to stop paying for CSRs. But New York's state government was much more affected: It lost nearly $1 billion in funding for BHP plans because its BHP payment was based in part on CSR payments the enrollees would otherwise receive through the marketplaces.[15]

Interviewees said that vocal support from the governor and the mayor of New York City for marketplace coverage helped increase enrollment. Amid federal efforts to repeal and replace the ACA, both leaders publicly encouraged people to enroll in marketplace coverage and funded marketplace advertising and enrollment activities. Some interviewees thought the threat to marketplace coverage and these leaders' responses caused some consumers to keep or seek out marketplace coverage.

Marketplace Messaging Touted Affordability and Cleared Up Confusion

New York's marketplace issued press releases clarifying that *after factoring in premium tax credits,* marketplace premiums would be the same or lower than those in 2017 for many New Yorkers. State press releases also stated that BHP plans were available to lower-income consumers for $20 a month or less[16] and that bronze plans were available for free for many enrollees in dozens of counties this year.[17] These messages focused on the affordability of coverage because price is a top consideration for consumers.

New York's marketplace also tried to clear up confusion caused by news stories about efforts to repeal and replace the ACA, explicitly stated that it was "open for business," and clarified that the individual mandate was still in effect for 2018. Marketplace advertising emphasized the large number of people who obtain insurance through the state's online portal, which offers marketplace plans as well as Medicaid and BHP plans. The state's "4 Million Reasons to Enroll" campaign emphasized the wide range of people who sign up for coverage. Interviewees found this campaign memorable and effective.

Local Support for Marketplace Coverage Combated Federal Threats

Interviewees cited the governor's outspoken support of the marketplace in the face of repeal-and-replace efforts in Washington, D.C. The governor participated in rallies, issued press releases, and funded a robust advertising and enrollment assistance campaign. These actions showed that the state was invested in maintaining its marketplace and the enrollment gains achieved in recent years. The mayor of New York City also funded the city's own ad campaign and navigators, which interviewees said helped promote enrollment.

Some interviewees thought that congressional efforts to repeal and replace the ACA may have encouraged some consumers to enroll in coverage while it was still available, pushing enrollment higher than it might otherwise have been. News coverage of repeal-and-replace efforts also kept health insurance top of mind for consumers.

New York Continued to Use Successful Enrollment Strategies

Interviewees felt that New York succeeded in increasing enrollment largely because it maintained the robust effort of past years. New York's marketplace funded advertising campaigns and navigators at previous levels ($7 million and $27 million, respectively) and continued to purchase online banner and pop-up ads (which have been particularly

successful) and print ads in certain ethnic publications. The state's marketplace sent 1.2 million personalized emails to people who had created marketplace accounts to remind them to enroll in 2018 coverage, and marketplace representatives participated in nearly 470 events this year.[18]

New York's marketplace maintained its three-month open enrollment period instead of condensing it to six weeks to align with HealthCare.gov's shortened enrollment period. Interviewees said that this longer open enrollment period helped encourage marketplace enrollment. It also likely helped improve insurers' risk pools: New York state officials have found that people who enroll in coverage after the first six weeks of open enrollment tend to be younger and buy lower-tier plans. Early enrollees tend to pick higher-tier plans, suggesting that they are sicker and plan to use more health care services.

Insurers continued to fund robust ad campaigns involving print media, social media, online ads, billboards, and community outreach and events. One insurer we interviewed explained that "what may work in one area doesn't necessarily work in other areas," so they customized their advertising approach geographically based on past experience. Several interviewees mentioned the "cheeky" New York City subway ad campaign by startup insurer Oscar. Insurers also continued to employ many certified application counselors to help enroll people in coverage, and several thousand insurance brokers operate in the state. Of over 9,000 certified enrollment assisters in New York, only about 500 are publicly funded navigators.[19] Navigators reported no change in their efforts this year compared with last year.

West Virginia

Unlike Rhode Island, Washington, and New York, West Virginia saw a decrease in marketplace enrollment (19.5 percent) from 2017 to 2018. West Virginia uses a "partnership" marketplace model: Residents can shop for and enroll in health insurance plans through HealthCare.gov, but the state manages the plans sold on the marketplace. Also, over a third of West Virginia's nonelderly population is now enrolled in Medicaid (Table 2) since the state expanded the program under the ACA.

At the time of our interviews, respondents said they were awaiting final enrollment numbers for West Virginia, but they suspected that dips in marketplace enrollment this year could be attributable to higher premiums statewide (despite subsidies capping the maximum required payment for a person with income under 400 percent of FPL). West Virginia did not silver-load, so premium tax credits were not maximized for enrollees as they were in many other states. The average premium of the lowest-priced silver plan in West Virginia increased by 16.9 percent over last year, and the average lowest-priced gold plan premium increased by 24.3 percent. These premium increases were lower than in many other states, likely because premiums in West Virginia were already higher than those in many other states (see Table 3).

Table 2. Share of Nonelderly People with Different Types of Insurance in Five States, 2018

	Total Nonelderly Population	Share of total nonelderly population					
		Employer-Sponsored Insurance	Medicaid/CHIP	Subsidized Nongroup Insurance	Unsubsidized Nongroup Insurance	Other (Including Medicare)	Uninsured
Louisiana	3,871,000	47.9%	34.5%	2.2%	2.5%	3.5%	9.3%
New York	16,649,000	54.1%	28.9%	5.6%	2.0%	1.9%	7.5%
Rhode Island	869,000	53.5%	32.8%	2.9%	3.0%	2.6%	5.3%
Washington	6,077,000	55.7%	27.4%	2.1%	2.8%	3.9%	8.2%
West Virginia	1,455,000	51.5%	34.9%	1.4%	1.3%	5.0%	5.8%
United States	273,498,000	54.4%	25.3%	3.3%	2.9%	3.1%	10.9%

SOURCE: Urban Institute analysis using HIPSM 2018.[20] Coverage estimates simulated for 2018.

NOTES: States with higher marketplace enrollment in 2018 than in 2017 are in green. Subsidized nongroup insurance includes marketplace plans purchased with advanced premium tax credits. Unsubsidized nongroup insurance includes marketplace plans purchased without advanced premium tax credits and off-marketplace plans. New York's Basic Health Program, known as the Essential Plan, is included in the subsidized nongroup insurance column.

Table 3. Average Lowest-Cost Silver and Gold Marketplace Premiums in Five States

State	Lowest-Cost Silver Premium	Lowest-Cost Gold Premium	Marketplace Enrollment from 2017 to 2018
Rhode Island	$287	$300	↑
Washington	$326	$399	↑
Louisiana	$455	$562	↓
New York	$484	$571	↑
West Virginia	$514	$686	↓
United States	**$444**	**$518**	

Source: Holahan J, Blumberg LJ, Wengle E. *Changes in Marketplace Premiums, 2017 to 2018*. Washington: Urban Institute; 2018. https://www.urban.org/sites/default/files/publication/97371/changes_in_marketplace_premiums_2017_to_2018_0.pdf.

Average premium increases in West Virginia obscure significant regional variation. Only one insurer, Highmark Blue Cross Blue Shield, offers plans statewide, and it had significantly higher premiums this year than last year. The state's other insurer, CareSource, had more modest premium increases (and narrower provider networks) but was only available in 32 of the state's 55 counties. CareSource is relatively new to West Virginia, having entered the state in 2016, and continues to build its network and attract new enrollees. Interviewees said that off-marketplace activity is scant in West Virginia, and none thought that nonmarketplace enrollment changed significantly this year.

Federal cuts to advertising also likely depressed marketplace enrollment. Interviewees reported that many residents were confused about whether the individual mandate remained in effect, and there was little marketplace advertising to set the record straight. Interviewees also reported an uptick in consumers buying short-term policies and accident insurance with limited benefits—only to find that these non-ACA-compliant plans would not satisfy the individual mandate. (These plans are health status–rated, not guaranteed-issue, and they do not meet the ACA's benefit and cost-sharing standards.) Some of these consumers felt they had been misled, filed complaints with the state, and got refunds. Finally, the six-week open enrollment period was the shortest ever in West Virginia, and some prospective enrollees were surprised to learn that they had missed the deadline when they attempted to enroll in late December.

Adding the Cost of CSRs to All Metal Tiers Caused Premium Increases for Most Enrollees

While most states added CSR costs only to silver marketplace plans,[10] West Virginia's insurance commissioner instructed insurers to spread the cost of CSRs across all plans at all metal tiers, both on and off the marketplace. This made premium subsidies in West Virginia smaller than they otherwise would have been, and unsubsidized consumers faced higher premiums because of CSR-related adjustments no matter which level of coverage they wanted. As a result, some unsubsidized West Virginians likely did not purchase coverage.

Proliferation of Limited-Benefit Plans Lowered Enrollment in ACA-Compliant Plans

Interviewees reported that consumers were misled by plans with limited benefits that were not ACA-compliant. These plans, including short-term policies and accident insurance, are marketed directly to consumers online. Some websites use ACA-like language even though the plans do not meet the requirements of the ACA, and consumers who purchase them can be subject to the IRS penalty for not having health insurance. This had been happening in West Virginia for several years, but the problem appeared to get worse in 2018. Companies offering short-term, limited-benefit plans aggressively marketed these products and seemed to be gaining enrollment. Some consumers who bought these plans and complained to the state got refunds and can now enroll in ACA-compliant coverage through a special enrollment period. But interviewees were concerned that many others who were misled either had not yet noticed or did not file an official complaint.

The Shortened Enrollment Period Caused Some West Virginians to Miss Open Enrollment

West Virginia's open enrollment period was shorter than ever, ending on December 15, 2017, for coverage beginning January 1, 2018. Interviewees believed that this shortened enrollment period depressed enrollment, and some cited consumers calling the state to ask why they could not enroll in late December as they had in past years.

Confusion May Have Caused Some Consumers to Forgo Coverage

Federal efforts to repeal and replace the ACA may have had a major impact on enrollment in West Virginia. Interviewees reported that call centers heard from many state residents panicked about whether their insurance would become unaffordable or disappear, confused about whether they were required to purchase insurance this year, and uncertain about whether the ACA was still in effect. In the past, federal advertising helped limit misinformation and encourage enrollment, but federal cuts to advertising this year likely caused confusion about insurance options. Interviewees said that rural residents may have been disproportionately affected by cuts to federally funded TV and radio ads about open enrollment because many do not have regular internet access.

A Collaborative Health Care Community Worked Together to Encourage Enrollment

Despite these challenges, West Virginia stakeholders united to get state residents covered. An association of federally qualified health centers conducted monthly calls with navigators, application assisters, and the state's insurance commissioner to help strengthen the network of people and organizations working to increase enrollment. Interviewees described a collegial and collaborative environment where providers, insurers, state government officials, and consumer advocates worked together to support enrollment, especially in the state's most vulnerable communities. For example, health centers and enrollment assisters across the state partnered to hold enrollment events at libraries and shared information about marketplace coverage on Facebook and Twitter. The Primary Care Association purchased a new tool from Enroll America that helped connect consumers with application counselors in their area. Interviewees thought that these efforts to increase enrollment had value, even though enrollment was down overall.

Louisiana

In Louisiana, 23.5 percent fewer people enrolled in marketplace plans this year compared with last year. Meanwhile, state enrollment in Medicaid (which was expanded under the ACA in mid-2016) continued to grow. Interviewees said this was the main reason marketplace enrollment decreased in Louisiana this year: People with incomes between 100 and 138 percent of FPL who were previously insured through marketplace plans shifted to Medicaid coverage. This shift may have been caused in part by the recent exit of a marketplace insurer, which forced tens of thousands of previously insured people to look for a new insurance plan; Medicaid coverage may have looked more attractive than marketplace coverage to some of these people.

Interviewees also noted that grandmothered plans (non-ACA compliant plans purchased and held continuously since before 2014) remain common in Louisiana. These plans seem to have had smaller premium increases this year, so enrollees may be holding onto them instead of opting for more comprehensive, modified-community-rated marketplace plans.

Price was a major driver of marketplace enrollment decisions. Interviewees cited a state press release highlighting an 18.5 percent increase in the average marketplace premium[21]—but not the much smaller increases or even decreases consumers faced if they qualified for premium tax credits.[7,8] In fact, premiums for the lowest-cost silver and gold plans increased less in Louisiana (12.9 percent and 8.3 percent, respectively) than in many other states. Interviewees said that last year's premium increases were also high (at 27 percent[22]). Many interviewees believed that the large perceived increase in premiums drove away some consumers, especially young and healthy people who may have less need for health care.

Few enrollment assisters and minimal advertising of the open enrollment period may also have depressed marketplace enrollment.

The number of insurers offering marketplace plans in Louisiana has steadily decreased in recent years. Only two still offer marketplace coverage, and only one operates statewide.

New Availability of Medicaid Was Well Publicized

Louisiana's mid-2016 expansion of Medicaid eligibility to low-income childless adults was well publicized and brought over 250,000 enrollees into that program in its first month. Expansion-population Medicaid enrollment has continued to grow since then and is now nearing 500,000.[23] These enrollment increases may be driven by the redirection of people seeking marketplace plans into Medicaid coverage if they are eligible; this was not previously the case. One interviewee said that, despite the steady increase in Medicaid enrollment, the number of nonenrolled Medicaid-eligible people in Louisiana is still much higher than the national average, suggesting that more people could shift from other coverage into Medicaid in the future.

Advertising Was Minimal

A few interviewees thought that the reduction in federally funded marketplace advertising—especially online ads targeted at young and healthy consumers—hurt enrollment numbers. Some reported that the state government had funded advertising campaigns around Medicaid expansion, especially last year, but not around marketplace open enrollment. Interviewees said that insurers advertised throughout the year but did not increase their ad buys around the open enrollment period.

Fewer Enrollment Assisters Operated in Louisiana This Year

Louisiana insurers generally do not employ certified application counselors. Instead, they rely on insurance brokers and state navigators to enroll people in marketplace coverage. After federal cuts to navigator funding, the state reportedly employed only five or six people as navigators—a "sad situation," according to one insurer. Some insurance agencies that previously hired seasonal workers to help enroll people in marketplace coverage did not do so this year, which may also have affected enrollment. Interviewees said that enrollment assisters at federally qualified health centers primarily enrolled patients in Medicaid coverage, but hospitals did not usually have enrollment assisters on site.

Repeal-and-Replace Efforts Caused Consumer Confusion but May Not Have Been the Main Drivers of Marketplace Enrollment

Congressional efforts to repeal and replace the ACA caused widespread consumer confusion about where the law stood. Most interviewees said this may have discouraged some consumers from enrolling in coverage. But interviewees had mixed views about whether the federal government's signaling that it might not enforce the individual mandate had any impact on consumer decisions. Interviewees also had mixed views about whether the administration's decision to shorten the HealthCare.gov open enrollment period reduced enrollment; some interviewees thought that it had a small impact at most.

CROSS-STATE FINDINGS

Most interviewees saw price as the main driver of consumer decision-making and marketplace enrollment. They said that **consumers were drawn to the type of insurance that offered the lowest premiums**. In Louisiana, where marketplace enrollment decreased, the expansion of Medicaid to people with incomes up to 138 percent of FPL attracted some enrollees previously insured through marketplace plans. In Rhode Island, on-marketplace plans were cheaper than off-marketplace plans, which may partly explain the state's enrollment gains. But in Louisiana, many people who still had grandmothered pre-ACA plans kept them because they had smaller premium increases than marketplace plans this year. In Washington state, which saw enrollment gains, many people likely shifted into marketplace plans after insurers stopped selling many off-marketplace plans. In West Virginia, some interviewees reported that more people bought low-cost, non-ACA-compliant plans, which do not meet the ACA's individual mandate. See Table 2 for the distribution of coverage in the five states.

Marketplace premiums were more affordable in some states than in others. A recent Urban Institute analysis found that the lowest-priced silver premium in Rhode Island, which saw enrollment gains this year, was only $287 per month for a 40-year-old nonsmoker—about half the price of the analogous plan in West Virginia ($514), which saw enrollment losses. See Table 3 for the average lowest silver and gold premiums in each of the five study states.

But affordability is not just about premiums. Many people with incomes up to 400 percent of FPL qualify for advanced premium tax credits to help them pay for marketplace coverage. In Rhode Island, Washington, and Louisiana, **insurance regulators maximized premium tax credits for consumers by instructing insurers to silver-load the expected costs associated with cost-sharing reductions**.[10] This decision had an impact on federal spending. According to the Congressional Budget Office, the silver-loading approach will increase federal deficits by $194 billion through 2026.[24] The larger tax credits in these three states made bronze plans available to some subsidized consumers for free, and gold plans more affordable. Rhode Island and Washington saw marketplace enrollment gains this year, but Louisiana did not—perhaps because its insurance commissioner mentioned only the large increase in *presubsidized* premiums in a press release about open enrollment; this may have dissuaded some consumers from shopping for coverage. Louisiana also had few enrollment assisters to spread the word about the generosity of this year's premium tax credits. Meanwhile, West Virginia did not silver-load and experienced enrollment losses. New York's marketplace premiums were relatively unaffected by the elimination of CSR payments because its Basic Health Program lowered enrollment in CSR plans. But the New York state government took a financial hit because the federal government decreased payments to the Basic Health Program when it stopped reimbursing insurers for CSRs.

Interviewees said that advertising by insurers and marketplaces influenced enrollment this year. Some **insurers mounted robust advertising campaigns** in Rhode Island, New York, and Washington, which had at least two marketplace insurers operating statewide and saw enrollment gains this year. Interviewees in the other two states reported less insurer advertising and noted that the federal government almost eliminated funding for marketplace advertising. Rhode Island, New York, and Washington funded their own marketplace ad campaigns using state funds, but Louisiana and West Virginia did not.

News coverage may also have influenced some consumers' enrollment decisions. In New York, Washington, and Rhode Island, **state officials publicly opposed attempts to repeal and replace the ACA and encouraged consumers to enroll in coverage.** But in West Virginia and Louisiana, interviewees said that news coverage of attempts to repeal and replace the ACA may have caused consumer confusion about the fate of the law, although they disagreed about whether this had a big impact.

In Rhode Island and Washington, interviewees reported an **increase in the use of social media to promote open enrollment,** which may have helped more young and healthy consumers find out about coverage options and enroll in coverage. New York continued to use social media, among other approaches. See Table 4 for outreach strategies recommended by interviewees in the states profiled in this brief.

Of the five states in this analysis, the states with enrollment gains had **state-based marketplaces that opted for longer open enrollment periods** than the shortened six-week HealthCare.gov period. (This trend is also seen nationally: Table 1 shows that nearly every state with its own state-based marketplace saw enrollment gains this year, and every state that relied on HealthCare.gov saw enrollment losses.) In New York, people who sign up after the first six weeks tend to be younger and healthier, helping improve insurers' risk pools and lower premiums; but in West Virginia, some consumers were confused about the new enrollment period and missed the deadline. Interviewees in Louisiana were skeptical about the impact of the length of open enrollment.

The three states with enrollment gains in our study also **rolled out new tools to make it easier for consumers to select marketplace plans this year** (although these tools were usually not thought to be the primary drivers of marketplace enrollment trends). Rhode Island introduced a scheduling system that allowed consumers to make appointments with enrollment assisters, reducing in-person wait times. Washington and New York launched new online tools to help consumers pick plans that met their customized needs (e.g., that covered their specific prescriptions or providers).

Table 4. Marketplace Outreach Strategies in the Study States

✓ Geographically target advertising at counties where a large share of people will lose their existing coverage (e.g., if insurers are ending off-marketplace plans)
✓ When promoting marketplace coverage, emphasize how affordable *post*subsidy premiums are[25]
✓ Use social media (e.g., how-to videos on Facebook and Twitter) and online advertising (e.g., full-page takeover ads that launch before a user can access online content, Pandora online radio ads) to reach young and healthy consumers, who can improve insurers' risk pools
✓ Use print ads in local ethnic publications to reach communities with historically high uninsurance rates
✓ Operate storefronts where consumers can enroll in coverage face-to-face
✓ Give consumers the option to schedule an appointment with an enrollment assister to reduce wait times
✓ Issue state press releases that explicitly encourage consumers to enroll in marketplace coverage
✓ Encourage marketplaces to send multiple rounds of automated emails to people who previously set up marketplace accounts, reminding them to re-enroll in coverage for the new year
✓ Foster collaboration and coordination among enrollment assisters, marketplace staff, and other stakeholders (e.g., through monthly conference calls) to share best practices for increasing enrollment

LOOKING FORWARD

Despite a tumultuous policy landscape in Washington, D.C., nationwide enrollment in marketplace coverage did not change drastically from 2017 to 2018. Total enrollment dropped by only 3.8 percent, from approximately 12.2 million people to 11.8 million. In this brief, we described the different factors that likely led to increases and decreases in enrollment in five states, according to key stakeholders we interviewed. In the 2019 open enrollment period, other factors will affect insurers' pricing of premiums and decisions to stay in the market, and consumers' decisions about whether to sign up for coverage.

Perhaps the greatest threat to marketplace plans is the federal government's proposal to allow less comprehensive, short-term insurance policies to extend to up to 364 days (instead of the current 90 days).[26,27] Because these plans are expected to be much cheaper than ACA plans, they would likely draw many young and healthy enrollees away from marketplace coverage, leaving sicker and costlier enrollees in marketplace plans and driving up marketplace premiums. Insurers are largely united in their opposition to extending short-term plans to 364 days and have asked the Centers for Medicare & Medicaid Services (CMS) to limit the duration of such plans to three or six months.[28] Insurers have also asked CMS not to make any changes to the duration of these plans until 2020. Urban Institute researchers estimate that if short-term plans are extended to 364 days, the number of people with minimum-essential-coverage plans will decrease by an estimated 2.6 million in 2019. They also estimate that premiums for ACA-compliant nongroup plans will increase by an average of 18.3 percent because of increased enrollment in short-term plans and the elimination of the individual mandate penalties.[29]

Another factor likely to reduce marketplace enrollment next year is the federal government's decision to no longer require marketplaces to have at least two navigator entities and to no longer require navigator entities to maintain a physical presence in their service area.[30] Interviewees reported that navigators are critical in helping consumers understand the complex and changing health insurance landscape and in limiting the spread of misinformation. Reducing access to navigators would impose another coverage barrier on consumers already overwhelmed by plan selection.

The repeal of the ACA's individual mandate (included in the 2017 Tax Cuts and Jobs Act) will also take effect in 2019.[31] The impact of this policy will differ across states. Some interviewees did not expect the repeal to have a major impact because many consumers want to purchase insurance, whether it is required or not. A recent Kaiser Family Foundation poll found that nine out of ten people would purchase insurance even in the absence of a mandate.[32] But some interviewees worried that the elimination of the mandate would cause healthier individuals to forgo insurance, yielding a sicker marketplace population and higher premiums. For example, New York has a large unsubsidized population (over 40 percent of marketplace enrollees in 2017),[33] and interviewees in the state thought that some healthy, unsubsidized people might not purchase insurance once the mandate is no longer in effect.

Several interviewees worried that the individual mandate's repeal would feed into general consumer and insurer uncertainty in the coming year. The Kaiser poll found widespread confusion among Americans, with only a fifth aware that the ACA's individual mandate was still in effect for 2018 but had been repealed for 2019.[32] Some states, including Rhode Island and Washington, are considering instituting their own individual mandates to keep healthier people in their risk pools,[34] but the elimination of the national mandate is likely to reduce the number of young and healthy people who enroll in coverage in other states. Currently, only Massachusetts has a state-specific individual mandate in effect.

Overall uncertainty about the fate of the marketplaces will continue to grow, as efforts to scale back (or bolster) ACA provisions are considered at the federal and state levels. According to a recent Kaiser poll, more than half of Americans think that the ACA marketplaces are "collapsing."[32] But some states are proactively taking steps to protect market stability in the face of changing regulations. For example, interviewees in Louisiana and Washington described efforts to introduce reinsurance programs that could reduce premiums in the individual market and thus increase enrollment. Reinsurance allows plans to receive partial reimbursement from the state for expensive medical claims, allowing insurers to set lower premiums.[35] As states prepare for 2019, they must decide whether and how to continue to bolster the marketplaces, despite federal efforts to limit the ACA's reach.

ENDNOTES

1. In this paper, we use "marketplace enrollment" as a shorthand for marketplace plan selection. Publicly available data identify the number of people who used a marketplace to select a health insurance plan. Once an individual has selected a plan, they need to provide additional information to the insurance company and begin paying premiums to complete their enrollment process. The number of individuals who had completed the marketplace enrollment process was generally not publicly available at the time of writing.
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