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# The Effects of Political Versus Actuarial Uncertainty on Insurance Market Stability



MARK A. HALL

*Market stabilization is a critical regulatory challenge for the private insurance component of the Affordable Care Act (ACA). Initially ACA market instability was due largely to the actuarial uncertainty associated with new market conditions for which good actuarial data were lacking. Then, in 2017, just as actuarial uncertainty was abating, political uncertainty came into play, reactivating and compounding actuarial uncertainty. Agreement is widespread that some stabilization measures are needed to improve the functioning of the ACA's market reforms. Based on documentary research at a national level and in-depth case studies in ten states, this study examines the role actuarial and political uncertainty have played in creating unstable market conditions and explores what measures state and federal lawmakers could take to improve market conditions.*

**Keywords:** Affordable Care Act, individual market, market stability

Market stabilization is a critical regulatory challenge for public policy officials under the private insurance component of the Affordable Care Act (ACA). Prior to the ACA, states had largely failed in their efforts to improve and reform their individual (nongroup) health insurance markets (see Monheit and Cantor 2004). Reform is inherently challenging given the dy-

namics of the individual market, which focus heavily on risk selection and segmentation rather than pooling risk and broadening coverage (see Hall 1995; Pauly and Herring 1999).

The ACA adopted a set of reforms aimed at correcting these market failings that worked well for the first two years, in 2014 and 2015, but in 2016 market conditions began to worsen sub-

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stantially (Hall and McCue 2016). Insurers exited the individual market, both on and off the subsidized exchanges, leaving many areas with only a single insurer, and threatening to leave some areas (mostly rural) with no insurer on the exchange. Also, most insurers bore significant losses in the individual market the first three years under the ACA, leading to substantial increases in premiums a couple of years in a row (Cox, Levitt, and Claxton 2017).

For a time, it appeared that rate increases in 2016 and 2017 would be enough to stabilize the market by returning insurers to profitability, which would bring future increases in line with normal medical cost trends. However, Congress's decision to repeal the individual mandate and the Trump administration's decision to halt "cost-sharing reduction" payments to insurers, along with other measures that were seen as destabilizing, created substantial new uncertainty for market conditions in 2018.

Moreover, this uncertainty continued. Although market volatility abated substantially in 2019, uncertainty persists due both to lack of clarity on the actual effects of the Trump administration's initial statutory and regulatory changes (such as the individual mandate repeal, which did not take effect until 2019), and to an additional set of regulatory changes that expand the availability of noncompliant plans sold outside of the ACA-regulated market. These uncertainties further complicate insurers' decisions about whether to remain in the individual market and how much to increase premiums. Although the market has not entered a "death spiral," some observers see that as a real possibility, at least for the unsubsidized part of the market in some states (CMS 2017; Barry-Jester 2017; Laszewski 2017).

Various efforts in Congress have failed to reform or replace the ACA, which leaves state lawmakers scrambling to identify feasible and viable approaches to stabilize and strengthen the individual market. These strategies seek to encourage more insurers to enter and remain in the market, to improve the risk pool by reducing adverse selection, and to create market conditions that moderate premium increases. States are also considering what measures they might want to take to more directly counteract federal regulatory changes viewed as poten-

tially destabilizing. For instance, states might adopt a replacement for the ACA's individual mandate, or decide to restrict plans that can be sold outside the ACA-compliant market.

Relevant experts widely agree that some stabilization measures are needed to improve the functioning of insurance market reforms. Medicare's private market programs (Medicare Advantage and Part D prescription drug coverage) include several permanent market stabilization features (Corlette and Hoadley 2016; Jost 2017a). Only one of the three mechanisms built into the ACA, however, is ongoing (risk adjustment); the other two have either expired (reinsurance) or were never fully implemented (risk corridors). Section 1332 of the ACA allows states to seek *innovation waivers* that provide federal financial support for alternate approaches to the ACA's central coverage provisions. Recent regulatory guidance explicitly invites states to use the Section 1332 waiver process as a way to obtain federal support for innovative market stabilization strategies such as reinsurance and risk pooling (CCIIO 2020; Jost 2017b). These developments give states far more opportunity than they previously had to design tailored approaches to market stabilization.

## APPROACH AND METHODOLOGY

This study is based on both an extensive documentary research at a national level and a series of in-depth case studies in ten states, using field researchers from the *ACA Implementation Research Network* developed by the Rockefeller Institute of Government and cosponsored by the Brookings Institution. These states, shown in table 1, were selected to represent the following range of market and regulatory conditions:

- have established their own reinsurance program (Alaska, Minnesota)
- are or were actively considering a reinsurance program (Colorado, Maine)
- faced the prospect of, but avoided, having one or more "bare" counties in their ACA exchange (Alaska, Iowa, Ohio, Nevada)
- have state-based exchanges and have expanded Medicaid (Colorado, Minnesota, Nevada)

**Table 1.** Key Characteristics of Study States

	Exchange Type	Medicaid Expansion	Average Gold Premium 2018
National			\$518
Alaska	Federal	Yes	778
Arizona	Federal	Yes	627
Colorado	State	Yes	501
Florida	Federal	No	489
Iowa	Federal	Yes	787
Maine	Federal	Not yet	636
Minnesota	State	Yes	458
Nevada	Hybrid	Yes	516
Ohio	Federal	Yes	420
Texas	Federal	No	435

Source: Author's tabulation based on Kaiser Family Foundation 2020.

default to the federal exchange and have not (yet) expanded Medicaid (Florida, Maine, Texas)

default to the federal exchange and have expanded Medicaid (Alaska, Arizona, Iowa, Ohio)

Each field researcher addressed the following questions (abbreviated), developed after an initial literature review and through consultation with the project's advisors:

How stable or unstable is the individual market, and what threats to stability (if any) exist? To what extent do instability problems or concerns vary among local markets?

What has driven price increases and insurer market participation the last couple of years?

What effect is uncertainty over the ACA's future and over current administrative policy having on market stability?

Does elimination of the individual mandate penalty affect market stability?

How did regulators and insurers deal with ceasing payments for cost-sharing reductions? What effect did this have on market rates and enrollment?

How helpful is reinsurance likely to be in improving market conditions?

What are the expected impacts of proposed federal rules that would make short-term plans, or other non-ACA-compliant plans, more available?

Are there other measures the federal government has taken, or is considering, that could improve or worsen market stability?

Are there other measures that state officials are, or should be, considering to improve market stability?

In each state, seven to twelve interviews were conducted in mid-2018 with health insurers, regulators, insurance agents and navigators, health policy analysts, and consumer advocates, for a total of ninety interview subjects. Field researchers also collected relevant documentary information. This report is based on a synthesis of the field research and extensive information from national literature.

In formulating the research focus for this project, stability was conceptualized as consisting of three aspects: insurers remaining in the market, premiums not increasing greatly more than those in the large-group sector, and no steep or sustained declines in enrollment.

## FORMS OF UNCERTAINTY

It emerged from these interviews and literature review that a primary factor driving market stability is uncertainty over basic market rules. Such uncertainty takes one of two forms: the

financial effects of known changes in rules (actuarial uncertainty), and whether future adverse changes will occur (political uncertainty). Although actuarial uncertainty is always present, what has especially bedeviled ACA insurers is the political uncertainty over adverse changes in rules. Examples frequently mentioned were whether insurers will receive all of the payments that the ACA calls for, or whether core regulatory requirements will be enforced.

The ACA structure requires insurers to establish rates for the coming year well in advance so that rates can be reviewed prior to open enrollment. Further, rates cannot be changed during the year once they are set because the initial rates are the basis for determining enrollment subsidies. This makes rate calculations challenging enough in normal regulatory climates, but when regulatory policies start to become highly uncertain, and rules change “midstream” during a rating year, insurers can view their continued participation as untenable, especially when there is a lag between the policy change and data indicating its actual effects. Thus, one Texas insurer lamented, “Some warning and ability to build into our rates is critical to remain in business. Products are based on having information for pricing up front. There has to be a certain point where they say ‘pencils down’ and rates are in place. That would help everyone with more stability.”

Similarly, a Minnesota source explained that, given the ACA’s price competitive subsidy dynamic, “People who show up in any given year can change a lot year-over-year, and as a result, it’s hard to predict [the next year’s rates. Add to that] changing rules and programs and it becomes impossible.” This was echoed by two Maine insurance officials: “Political uncertainty is a problem because you have to lock in your rates early and then see what happens. . . . We deal with insurance risk. We don’t deal well with regulatory uncertainty. That’s not the kind of risk insurance was designed for.”

Political uncertainty featured especially prominently in the 2017 decision by Anthem Blue Cross to withdraw from, or not enter, the exchanges in a dozen of the fourteen states it serves. In Maine, one subject noted that Anthem withdrew there after years of being the

“carrier of last resort,” even though its exchange business had finally become profitable. This source felt that had the decision been purely local, Anthem might have remained in the market, but a national decision was made to withdraw from most exchanges, due to uncertainty in federal rules (2017a, 2017b):

There was so much [political] uncertainty and [I think] Anthem didn’t and doesn’t know what’s going to happen with the ACA from day to day. [Rumor has it] that if it had been entirely a local decision, Anthem might have stayed in for 2018. The market in Maine appeared to be stabilizing. But at the national level Anthem just felt: what part of the regulations are they going to go after next? [I assume] they couldn’t see staying in without knowing what the funding and regulations might be like on any particular day or month.

Likewise, a physician-led health maintenance organization (HMO) in Ohio left the market, explaining that “the uncertainty in Washington, D.C., around the future of the Affordable Care Act . . . and the associated volatility in the marketplace have led us to conclude that we cannot effectively plan and price affordable health insurance to sell on the exchange” (Gnau 2017). In Iowa, the CEO of an HMO commented that “it’s really truly amazing that we could have this much uncertainty at any given time. . . . It’s just very, very unique in my 36-year career” (Demko 2017).

Several subjects amplified that the Trump administration’s October 2017 decision to suddenly cancel payments to insurers for so-called cost-sharing reductions that require insurers to substantially reduce deductibles for lower-income subscribers. This abrupt change, made well after it was too late for insurers to adjust their 2017 rates and just a few days before their deadline to decide on 2018 participation, “had a concussive quality” and was the “straw that broke the camel’s back” because it “sent a clear signal” to insurers that they “cannot rely on the federal government to keep its [funding] commitments” in the future, especially after having refused previously to fund most of the risk corridor payments promised by the ACA between 2014 and 2016.

**Table 2.** Insurers Participating in the ACA Exchange Market

Location	2016	2017	2018	2019
National	5.6	4.3	3.5	4.0
Alaska	2	1	1	1
Arizona	8	2	2	5
Colorado	8	7	7	7
Florida	7	5	4	5
Iowa	4	4	1	2
Maine	3	3	2	3
Minnesota	4	4	4	4
Nevada	3	3	2	2
Ohio	14	10	8	9
Texas	16	10	8	8

Source: Author's tabulation based on Semanskee et al. 2017.

The destabilizing effect of political uncertainty was expressed frequently across the study states and was viewed as fundamental to whether the market can achieve stability in the future. Several sources in Texas, for instance, thought that destabilizing moves from the federal government have been sufficiently strong and illogical that it appears to them that the government might actually want greater presence of public insurance. A Texas insurance source remarked, “the [Trump] administration is doing all they can to destabilize the market. It just creates frustration and makes a Medicare for All solution more likely [because we] won't go back to where all these people are not getting insurance any more. A government option is more likely now than it was before Trump tried to destabilize it.”

In a Midwestern state, an insurer subject commented at length:

We unfortunately I think had a lot of withdrawals of political and personal trust from that bank over [the past year]. And some of that was political, some of it was necessary, some of it was not necessary. Where you had people of good faith trying to do the right thing and it was not—nobody could still trust each other. And I'm not talking about across the insurers, but state regulators, governor, legislative leaders, nobody could trust each other that at the end they could reach a stable conclusion. . . . And so there's a market dynamic going on [that] can't just be in one

state because you can't trust your local regulators will figure out a solution that doesn't screw you. Or you can't trust that the federal policy won't drop on you and all of a sudden your market position will go away.

Beyond our study states, other researchers have documented similar explanations from insurers across the country (Aaron et al. 2017; CBPP 2017; U.S. Congress 2017). For instance, a field interview study similar to this one reported that insurers are “just terrified that the feds are going to pull the rug out from underneath them in the middle of the plan year” (Lucia et al. 2017). Further, the CEO of CareFirst, the Blue Cross plan that covers Maryland, Virginia, and the District of Columbia, observed that “Continuing actions on the part of the administration to systematically undermine the market and make it almost impossible to carry out the mission” of serving the individual market (Cunningham 2018).

### Insurer Participation

This extraordinary degree of political uncertainty has undoubtedly contributed to insurers' reluctance to enter or remain in the ACA's individual market. Moreover, local market conditions have made insurer participation far more challenging in some states than in others, as shown in table 2.

Nationally, looking at the Marketplace exchanges, insurer participation dropped by almost 40 percent between 2016 and 2018 (HHS



2017; Haislmaier 2018; Semanskee et al. 2017; see also Abraham 2020). Eight states had only a single insurer in 2018 (Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming), up from five in 2017, and rural areas in many states had only a single insurer. Among federal exchange states, single-insurer areas accounted for 29 percent of enrollees in 2018, up from 20 percent in 2017 and 2 percent in 2016 (Weinberg and Haase 2017; HHS 2017).

In 2019, however, insurer participation saw a notable uptick. No state saw any insurers withdraw or retrench for 2019, and eighteen had a new insurer (or two) enter (or reenter) (Abelson 2018; Mathews 2018).

That pattern is also seen in our study states. In both 2017 and 2018, six of the ten states saw declines, but only three had declines both years, and declines were noticeably smaller for 2018 than for 2017, with the exception of Iowa. Further, insurer participation increased for 2019 in half of these states.

Iowa is a good case study in the initial market tumult. The state initially had half a dozen insurers, but its consumer-operated health plan (co-op) failed, and Aetna and United withdrew as part of nationwide corporate decisions. A Wisconsin-based HMO was in one corner of the state for a while, but then withdrew due to losses and regulatory uncertainties. This left Medica and Wellmark Blue Cross. Initially, Wellmark remained out of the Iowa market but as other insurers withdrew, it decided to enter for 2017. It then left the Iowa market for 2018, however, in the face of substantial losses, along with tumult in the market after Republican efforts to repeal the ACA and cancel cost-sharing payments, which left only Medica for 2018.

The situation in Iowa has improved, however. Wellmark reentered the market for 2019, noting that legislative and regulatory uncertainty has “dissipated just enough that we think we’re able to step back in,” as long as “there aren’t any significant changes to the ACA” (Ramm 2018). Informed speculation also suggests that Wellmark’s reentry decision was tied to the state’s decision to allow it to start selling non-ACA-compliant coverage through

the Farm Bureau. Some are concerned, though, that Wellmark’s reentry and its embrace of the non-ACA-compliant market could cause Medica to retract.

Signs of potential market improvement were evident in some other states. In Maine, Anthem Blue Cross withdrew from the exchange for 2018 but continued to keep a toe in the off-exchange market in a remote corner of the state, which allowed it to reenter the market fully in 2019 (due to the state implementing its proposed reinsurance program). In Ohio, Anthem Blue Cross withdrew both on and off the exchange for 2018, but kept its off-exchange presence in just a single county, which allowed it to reenter for 2019.

Elsewhere, although significant market entries were not anticipated, market participants and observers felt that insurer participation was not likely to substantially worsen, as things now appear, because the major market contraction had already happened in 2016. For instance, Texas now has eight insurers, down from fourteen in 2015, and only Blue Cross is statewide, but the major exodus was after 2016, in response to sustained losses. For 2018 and 2019, although Humana and a Nevada-based insurer (Prominence) left the Texas market, Centene entered and Oscar expanded its geographic territory, so the level of competition remained approximately the same as in 2017, the number of single-insurer counties having increased only 5 percent. Texas sources thought that substantial additional retractions or exits were unlikely because insurers are now profitable and enrollment remains sizable; in fact, some sources thought that insurers that previously left might consider reentering the exchange market.

### Covering Bare Counties

A significant indication that the ACA marketplace is not on the precipice of collapse is that no areas had no insurers for the 2018 and 2019 open enrollments. For a time in 2017, it appeared that as many as eight states might be facing such “bare” counties, but they all were able to secure full market coverage, using techniques like the following from our study states (for more, see Lucia et al. 2017).

In several study states (including Colorado, Maine, Minnesota, and Ohio), insurers and informed observers credited “cooperative,” “flexible,” “proactive,” and “problem-solving” state regulators with helping keep insurers in the market and convince them to cover additional counties. Minnesota subjects in particular emphasized that insurers there “have largely stayed put through thick and thin” because the collective “desire to make the individual market stable [and] accessible [so that] everyone else gets insurance” is strong. As one observer remarked, “the individual market is a little bit of a labor of love and sort of a commitment to the state [by insurers] as much as it is sound business.”

The most frequently mentioned form of regulatory flexibility was the ability in most states to either file two sets of rates, or to quickly revise previous rate filings, to account for the Trump administration’s abrupt decision (discussed earlier) to stop funding cost-sharing subsidies. In Iowa, for instance, several sources noted that insurers were nervous about being in a market where cost-sharing payments were being used as a political bargaining chip, but Medica, now the state’s only insurer, decided not to withdraw after the insurance department allowed it to file contingency (backup) rates. In contrast, Medica’s exit from North Dakota was attributed to its not being allowed either to file alternative rates or to build into its rate structure the possibility of losing cost-sharing funding.

Reinsurance or other forms of risk-spreading did not emerge as a strong potential driver of insurer participation. Reinsurance can play an important role in stabilizing insurance rates, but we saw little or no indication that it has been key to an insurer’s decision to enter or leave a market altogether. Experience is still new with reinsurance, however, so its impact is not yet fully known. Also, it is quite possible that reinsurance could help participating insurers expand to cover more of a state they are in, even if it does not affect decisions to leave or stay out altogether. Reinsurance can make insurers more comfortable with entering underserved areas because it directly addresses concerns about the greater difficulty in establishing

actuarially sound rates in less populous areas or in areas where an insurer lacks data to project local medical costs.

### Maintaining Profitability

Despite these successful uses of persuasion and regulatory flexibility, observers and participants noted that insurer participation and market coverage is precarious, “on really thin ice,” unless insurers are able to make a profit in the exchange market. Prior to the 2018 regulatory upheavals, insurers were becoming profitable, some handsomely so. Just as sustained losses through 2016 were the main reason that insurers left the market then, many subjects noted the ability to now turn a profit as why insurers are now entering, or remaining in, these markets. Insurers now in the market are willing to adapt to almost any of a range of market rules, as long as the rules are clear and stable, so that they can rate for them accurately.

Several sources noted the continued likelihood of profits as why bare counties are unlikely to become widespread: given the ACA’s built-in subsidy structure, insurers that face no competition can basically “print money” as long as cooperative regulators allow them to set their premiums high enough to cover anticipated costs and a reasonable margin. Other analysts, however, note that even monopoly status does not guarantee insurer participation (Lucia et al. 2017). Making a profit, or avoiding substantial losses, depends on accurately forecasting medical expenses. Doing so is difficult in thinly populated areas, where even just one patient can cause pricing to be inadequate.

To end on a positive note, insurers in many of the study states thought that ordinary actuarial uncertainty is not destabilizing under the ACA. Therefore, many subjects thought that, “absent the distractions” of changes in federal regulatory policy, participation in the ACA market could stabilize and more insurers might re-enter. That the ACA’s subsidy structure makes that portion of the market “hard to kill” is key (Abelson 2018). As a Maine health policy expert explained, “The subsidy structure saves everything. As long as we continue to have robust enough subsidies and subsidized people, the insurers will stay pretty solvent.”



**Table 3.** ACA Exchange Rate Increases

	2017	2018	2019
National	25	27	−1
Federal exchanges	28	30	−1
State exchanges	17	22	0

*Source:* CMS and state exchange data reported by Kaiser Family Foundation (2020) and Charles Gaba (2018a).  
*Note:* Numbers in percentages.

The Congressional Budget Office endorses this view, explaining in 2018 that

the marketplaces are stable in most areas in large part because most enrollees purchasing subsidized health insurance there are insulated from increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere. (CBO 2018)

However, the CBO also warned that

substantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers’ decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country. (2018)

Confirming this assessment, an insurer in Maine said that “if it were not for the prospects of association and short-term plans, those things we are facing in 2019, we are at a relatively stable place.” A Minnesota insurer spoke similarly: “the premiums are [finally] covering the medical bills, the only question is, can we just stop changing the rules? And then if we could [reduce] premiums it will all kind of stabilize over time.” As an Ohio regulator put it,

“just not making changes for a while” would be the best thing to improve stability.

**PREMIUM RATES**

In 2017 and 2018, insurance prices in the individual market increased at substantial double-digit rates across the country, as well as in most of our study states, resulting in combined increases mostly in the 50 to 60 percent range over two years (table 3). Rates leveled off for 2019, however.

Most subjects who commented on steep rate increases attributed those in 2017 to insurers “catching up” with the underlying level of medical claims ACA enrollees were generating. For instance, in 2014 and 2015, Minnesota had the lowest rates in the country, which sources attributed to “grossly underrated” prices that were “totally out of whack with reality.” This level of underpricing meant that Minnesota insurers were hurt especially badly by the federal government’s failure to fund most of the “risk corridor” payments called for by the ACA. After Minnesota insurers began to develop a more accurate measure of their full medical claims, they increased their rates for 2016 an average of about 40 percent, which was among the highest increases in the country that year, and a second round of even steeper increases was needed for 2017 to further catch up with actual costs. More than catching up, however, Minnesota insurers appear to have overshot and thus have reduced their rates significantly (by about 7 percent in 2018 and a further 15 to 20 percent for 2019).

Until 2017, Arizona also had among the lowest rates in the country, due to its “fierce price-cutting” dynamic. But, for 2017, after a “mass exodus” of most insurers, the two that remained had extremely large rate increases of

about 50 to 75 percent—the steepest in the country that year by far. Since then, however, rates have decreased about 10 percent. Similar, but less extreme, patterns were noted in several other states.

### Achieving Profitability

Following these earlier rounds of steep increases, observers in most of the study states thought that the market had become profitable by the second half of 2017. These impressions are confirmed by national analysts, which consistently report that the individual market became profitable in 2017 (Fritchen and Giesa 2018; Fiedler 2017; S&P Global 2018; Cox, Semanskee, and Levitt 2018). Indeed, the individual market now appears to be substantially more profitable than it was before the ACA. The Trump administration's Council of Economic Advisers released an extensive report on "The Profitability of Health Insurance Companies" that explained in detail:

While insurers initially incurred losses in the ACA marketplaces as they adjusted to new regulations and a relatively unhealthy risk pool, insurers are now profiting on the [individual market], with higher premiums that are largely covered by federal premium subsidies. . . . Health insurance companies initially struggled to make a profit in the post-ACA individual and small group markets. Insurers were unsure how to price insurance with the new ACA requirements such as, guaranteed-issue, modified community rating, and an expansive minimum essential benefits requirement. They underpriced their products relative to their enrollees' health risks. Many insurers left the market altogether. But the remaining insurers, despite the expiration over a year ago (2016) of the reinsurance and risk corridors programs which were meant to financially protect insurers, have started to make higher profits again. (White House 2018)

The White House report continues by documenting that "the gap between individual market premiums and claims payments was much higher in 2017 than pre-ACA. . . . Gross profit margins (premiums less claims) have increased

as the small number of remaining companies gained experience with the . . . risk pool" (2018).

More than simply achieving profitability, recent rate increases substantially overshot their cost targets in two study states (Minnesota and Alaska), resulting in substantial rate decreases or even refunds.

### Pricing for Uncertainty

Despite the profitability most insurers achieved by 2017, steep price increases continued into 2018 for several reasons. One was insurers' ordinary actuarial uncertainty over the extent to which their 2017 pricing had in fact achieved profitability. Rates for 2018 needed to be filed by mid-2017 to allow time for review and revision before open enrollment in November. At that point in the year, however, insurers did not yet have a full picture of how accurate their prior year's pricing was because claims tend to be higher in the fourth quarter once more patients have met their deductibles.

Moreover, sources explained that, in states with several competing insurers, insurers face actuarial uncertainty each year about whether their risk pool will change substantially from the previous year, due to an inherent volatility in enrollment. This volatility is caused in part by the ACA's subsidy structure, which is set to the second lowest priced silver plan. As competing insurers adjust their prices, the reference plan can change each year, causing highly price-sensitive subscribers to seek out less costly options. A Texas actuary explained that this structure leads to "fierce price-cutting" as insurers attempt to gain, maintain, or regain market share each year. Not only can large numbers of subscribers change plans each year, but insurers that underpriced in the previous year will need steep increases the following year to avoid large losses, causing many of their new enrollees to switch again. This pricing dynamic can cause a "lot of churn" in enrollment, as much as 40 percent turnover (according to the Texas actuary), which "is terribly unsettling" to actuaries because they lack data to estimate the claims for their new pool of enrollees. Not knowing for sure, actuaries tend to price more conservatively, meaning with an additional rate cushion.

For these reasons, until year-to-year changes

in pricing and market participation become more stable, some observers felt that insurers would continue to price conservatively, meaning add a cushion on top of the trend in expected medical expenses. Some subjects contrasted this element of instability in the ACA market with the much more stable enrollment patterns under Medicare, where people remain enrolled for the duration of their life and make enrollment changes infrequently.

### Political Uncertainty

Although several subjects discussed these aspects of actuarial uncertainty, the type of uncertainty mentioned far more frequently was the political uncertainty that burst on the scene in 2017. As previously noted, this uncertainty has affected insurers' decisions to enter or leave the market. For insurers that remain in the market, political uncertainty also affects their pricing decisions. For 2018, we heard that political uncertainty following the 2016 elections affected pricing decisions much more strongly than did actuarial uncertainty, which is confirmed by additional examples collected from insurers in other states (CBPP 2017; U.S. Congress 2017). The Blue Cross plan in Tennessee, for example, explained that, in deciding to reenter a part of the state it previously had exited, it had to increase 2018 rates more than expected, because, "given the potential negative effects of federal legislative and/or regulatory changes, we believe it will be necessary to price in those downside risks, even at the prospect of a higher-than-average margin for the short term, or until stability can be achieved" (BCBS-TN 2017). Tennessee's commissioner of insurance commented that, "until the insurers know the rules of the road, it's that instability, that uncertainty, the insurers hate the most. They are going to price for that" (Fletcher 2017).

Overall, one national observer (Charles Gaba) calculated that, for 2018, the Trump administration's "sabotage" of the ACA accounted for over half (17 percentage points) of the average rate increase of 28 percent (Gaba 2018a, 2018b). According to his credible calculation, regulatory uncertainty and change accounted for 50 percent more of insurers' rate increases than the increase in underlying medical costs.

The American Academy of Actuaries also

stresses the timing difficulty that regulatory change presents (2017). Even if insurers know the full extent of regulatory change in advance, it takes more than a year to have enough real-world data to gauge the effects of changes in a complex market environment. Given that rates need to be filed about six months in advance and cannot be changed for a year once they take effect, a full two years is usually needed to correctly adjust prices for regulatory change. Thus, if significant change occurs regularly, insurers will repeatedly struggle to achieve a stable and predictable pricing pattern. As an Ohio insurer explained, the specifics of any particular regulatory change are often not as important as simply the uncertainty created by ongoing regulatory change, stating that "not knowing what to expect" is the bigger problem for "an industry that likes certainty."

### Hope for the Future

Obviously, continuing rate increases are not sustainable at the levels experienced the past few years, and many subjects saw the pattern as an ominous sign of the market's instability. Others, however, felt more optimistic because pricing in the individual market has, for the most part, reached a sustainable level and therefore, absent additional adverse regulatory changes, future increases should be moderated, more or less in line with the trend in medical costs. According to a Maine insurer, "If you put the whole market together, I don't think the whole market was terrible before the uncertainty and federal changes [in 2017]. There was not a tremendous amount of underfunding [going into 2018] so we should have been pricing for trend at that point."

Elsewhere, a good number of insurers and analysts thought that "the worst may be over," as one Colorado source put it. In Texas, for instance, several informants thought that the exchange market was "settling down" because insurers were able to increase rates enough to catch up with initial adverse selection: "It used to be stressful, but now we're used to it. . . . It's steady. . . . The [initial] risk pool [proved] expensive, but [it's] work[ing] okay" now.

These statements were made, however, before the 2019 federal regulatory changes that greatly expanded the ability to purchase non-

**Table 4.** Changes in ACA-Compliant Enrollment

	2019 Exchange Enrollment	2018 Exchange Enrollment	2017 Exchange Enrollment	2017 Unsubsidized Enrollment
National	-3.8	+4.6	+0.5	-20
Federal exchanges	-3.7	+3.2	+0.3	-27
State exchanges	0	+5.8	+4.9	-12

Source: Centers for Medicare and Medicaid Services 2017, 2018, and 2019.

Note: All numbers in percentages.

complying plans outside the ACA market. Thus, although insurers in many states held rates steady for 2019, ongoing developments could prompt insurers to increase future rate requests.

### ENROLLMENT

Nationally, 11.4 million people enrolled in the Marketplace exchanges during open enrollment for 2019, down from 11.8 million in 2018 and 12.2 million in 2017 (CMS 2019). Three years of 3 to 4 percent declines brought 2019 exchange enrollment to about the level it had been in 2015. However, because more 2018 enrollees followed through with their first month's premium than in previous years, actual "effectuated" enrollment by February 2018 was 4 percent higher (10.6 million) than in February 2017, the highest February level so far (CMS 2018).<sup>1</sup>

Based on this relative stability in enrollment (table 4), most interview subjects viewed recent open enrollments as a success that left them "pleasantly surprised," considering "all of the [political and regulatory] turmoil" that has affected the ACA in the past year. Nationally, CMS Director Seema Verma declared that 2018 was the "most cost effective and successful open enrollment to date!" (CMS 2019).<sup>2</sup> Among our study states, even where enrollment appeared

to dip agreement was widespread that any decline was "less than we feared" or expected.

Open enrollment was not viewed as successful everywhere, however. Observers in several states thought that enrollment had suffered in the wake of recent federal actions to halve the open enrollment period and greatly reduce advertising and support for navigators.<sup>3</sup>

Some states, such as Florida, saw a substantial increase in enrollment. Subjects there attributed this success in 2018 in part to the boost from the substantial free media coverage generated by ongoing political controversies over congressional attempts to repeal and replace the ACA and administration efforts to weaken ACA funding and enforcement. Although some subjects thought that the controversy confused people and thus interfered with enrollment, others noted that their states worked especially hard ("busted our butts") to counter the confusion and to use the general controversy to stimulate more interest in enrollment.

Nationally, Ogilvy (a large advertising firm) reports that media coverage of enrollment, enrollment period, and deadline in an ACA-related context increased by 53 percent, 125 percent, and 129 percent, respectively, over the prior year (Ogilvy 2018). In Minnesota, an exchange official estimated that its "earned" (unpaid) media was valued at \$6.5 million, four

1. CMS reports only a 3 percent enrollment increase, but that appears to be based on older enrollment numbers for 2017. The updated 2017 numbers in CMS's report indicate a 4.6 percent increase.

2. Seema Verma (@SeemaCMS), "11.8 million consumers enrolled for 2018 Exchange coverage nationwide," Twitter, April 3, 2018, <https://twitter.com/seemacms/status/981250136344088576> (accessed January 29, 2020).

3. For the 2018 open enrollment, CMS reduced its national marketing budget by 90 percent, from \$100 million to \$10 million, and cut funding for navigators by 42 percent, from \$63 million to \$37 million.

times its paid media budget. Elsewhere, people commented that all the “media hoopla” and the shorter deadline caused people to “scramble” to renew or enroll. A few observers expressed concern, though, about what might happen in future years when the media “frenzy” dies down.

### State-Based Exchanges

Enrollment has been stronger in the seventeen states that operate their own marketplace exchanges than in the thirty-four that default to the federal exchange. This is likely because states with their own exchanges are more committed, in various ways, to making the ACA work.

Sources in Colorado and Nevada for instance, attributed much of their success in “insulating” the market from recent federal policies to their ability to commit substantial funds to marketing and outreach in order to offset the “drastic” cuts that “slashed” and “gutted” federal funds for these purposes. Some sources also emphasized the need for state-based marketing to offset the Trump administration’s “messaging” and “narrative that intentionally feeds uncertainty [about the status of the ACA] and that undercuts the work that we were trying to accomplish” of informing people about the continued availability of highly subsidized coverage. A Minnesota source, for example, emphasized that there is “just a negative narrative out there that is I think just so damaging to consumer confidence.”

In North Carolina, which uses the federal exchange, actuaries for the largest health plan attributed a portion of their 2018 premium increase to “consistent messaging from Federal policymakers stating their intent to abolish the ACA coverage mandates, [which we believe] will embolden many healthier individuals to drop coverage” (BCBS-NC 2017). Similarly, the Blue Cross plan in Florida said that “one of the first messages we knew we had to [convey during] open enrollment is, ‘the ACA is still here.’ [W]e did not assume that people knew that, and they didn’t. They assumed that the President had

ended it. . . . So, it’s a very confused marketplace” (Brookings Institution 2018).

Supporting the benefits of positive messaging, a study from California reports that marketing efforts by its state-based exchange have resulted in a much stronger capture (79 percent versus 64 percent) of the subsidy-eligible population than in federal exchange states, which has produced a risk pool in California that is 20 percent healthier than in federal exchange states (Lee et al. 2017). One attraction of investing in marketing and outreach is that the positive returns potentially compound each year (until market saturation) because these efforts can both attract new enrollees and help keep existing ones. Thus the California analysis estimates that increased marketing in other states could lower premiums nationally by 2 to 3 percent each of the next two years (Covered California 2018).

In addition to having their own marketing budget, the two state-based exchanges in this study that operate their own enrollment platforms (Colorado and Minnesota) also attributed their relative success to their ability to extend open enrollment for several weeks beyond the federal window, which was only half the length of the previous year. Others, however, felt that shorter open enrollment was not necessarily a major disadvantage. The shorter enrollment period is, they noted, similar to that used in Medicare (for Part D coverage and Medicare Advantage plans), and that six weeks is enough time once people have become used to the open enrollment process because people (who by nature tend to procrastinate) are motivated by a deadline, especially if they “know they need insurance.”

Despite the split views on the need for longer open enrollment, most agreed that state-based exchanges give states more control over measures that can maximize enrollment.<sup>4</sup> Minnesota, for instance, at the last minute added an extra “special enrollment” week onto the end of its 2016 and 2017 open enrollment period to allow residents to take advantage of a just-enacted rebate for unsubsidized subscribers. A

4. For instance, as an exchange official in Rhode Island remarked, “We could extend our open-enrollment period, control our marketing budget and nimbly mitigate the impact of the loss of cost-sharing subsidies [to insurers], which led to a very successful open enrollment” (Appleby 2018; see also Giovannelli and Curran 2018).



preference for a state-run exchange was also heard in Nevada, whose exchange currently contracts to use the federal HealthCare.gov platform. There, officials were frustrated both by the shortened open enrollment and by their sense that CMS was not flexible enough in its service hours and maintenance downtime to accommodate the large Nevada workforce (in gaming and entertainment) that has atypical work schedules. For this and other reasons, Nevada recently appropriated funds to launch its own web platform by 2020. Similarly, Minnesota's Democratic governor vetoed a Republican-led bill in May 2017 that would have required the state to move to the federal exchange, citing the recent successes of their state-based exchange.

One additional factor that has affected enrollment is political viewpoint. All else being equal, enrollment nationally has been lower in areas with more Republican voters, ostensibly due to more negative attitudes about the ACA (Lerman, Sadin, and Trachtman 2017). Among our study states, sources in Alaska and Iowa especially noted that vocal opposition to the ACA by current or former public officials had dampened enrollment, even by people eligible for substantial subsidies. Owing to this lower take-up, national research shows that the risk pool is less healthy in Republican leaning areas, producing higher premiums in those areas in 2017 (Trachtman 2018). Interestingly, this partisan relationship did not exist in insurers' initial pricing decisions for 2014, but emerged subsequently.

Further indication that supportive attitudes and regulatory measures improve the ACA risk pool comes from the rate increase data presented in table 3 and documented elsewhere (Hall and McCue 2018), which show that, although rate increases were very steep, over the previous two years they were 5 to 10 percentage points lower in states operating their own exchanges than in those that default to the federal exchange.

### Unsubsidized Enrollment

Field interviews revealed an entirely different story about enrollment by individuals who are not eligible for an advance premium tax credit (APTC) subsidy. This story is somewhat more

difficult to tell, however, because we lack clear and consistent data about off-exchange enrollment, where much (but not all) unsubsidized enrollment occurs. Most difficult to measure is enrollment in non-ACA-compliant plans, such as those that have been grandfathered from before March 2010, or grandmothered from before January 2014. Nevertheless, data are available for ACA-compliant plans sold to unsubsidized (non-APTC) purchasers, either on or off the exchanges. For that population, table 4 shows a notable decline in 2017, when ACA premiums began to spike; a subsequent report shows a further decline of 33 percent in 2018 (Semanskee, Cox, and Levitt 2018), resulting in a two-year exodus of roughly half the market. The unsubsidized decline was substantially greater in some states than others. As table 4 shows, states that defaulted to the federal exchange did twice as badly in 2017 (-27 percent) as those operating their own exchanges (-12 percent).

In our study states, key informants reported variously that enrollment declines among unsubsidized people were "disturbing," "surprising," or reflecting a "precipitous" "exodus." A number of observers feared that this portion of the market was becoming a virtual "high-risk pool," meaning that, for the most part, only people who remain will have expensive health conditions.

These concerns were heard both in states with more successful and less successful open enrollment on their exchanges. For instance, in Minnesota, although exchange enrollment has increased substantially, unsubsidized ACA enrollment dropped 53 percent in 2017, and the individual market overall (including non-ACA plans) has declined from 309,000 in 2015 to 166,000 in 2017, and further still in 2018. This decline was reported to be most notable in rural areas, where the proportion of the population with individual coverage has dropped by more than half in the past few years.

A similar pattern has occurred in Iowa, which has had an especially strong off-exchange market. In earlier years, Iowa had substantially more unsubsidized than subsidized subscribers in ACA plans, but, by 2017, unsubsidized subscribers constituted only 42 percent of the ACA market, meaning that Iowa's unsubsidized



enrollment dropped by almost half. Similar, or even more severe, trends were noted in Alaska, Arizona, and Texas, but in half the study states (Colorado, Florida, Maine, Nevada, Ohio), unsubsidized enrollment held fairly steady or declined only moderately through 2017. However, in several of those states, subjects feared that the additional steep rate increases for 2018 drove away more people who do not qualify for subsidies.

Sharply increasing premiums accentuate the difference between those who do and do not qualify for subsidies. The ACA's subsidy structure cushions the impact that premium increases have for those who qualify for a subsidy because the ACA caps the cost of the second lowest silver plan in each rating region to 9.7 percent of household income. Subsidies cease, however, for people above 400 percent of the federal poverty line (which, in the continental United States, equates to almost \$50,000 for a single person or \$100,000 for a family of four). If people earn even a dollar more than the 400 percent ceiling, they receive no subsidy—a phenomenon known as the “subsidy cliff” (Norris 2016).

When the ACA exchange first started, the subsidy cliff was not nearly as dramatic as it is now because premiums were substantially lower. Scenarios vary based on a person's age and family size, but, in general, in 2014 and 2015, people would typically pay the same or a similar amount for insurance whether they were just below and just above the 400 percent subsidy ceiling. Once insurance premiums started to increase steeply, in 2016, the subsidy cliff became much more pronounced, and especially so following premium increases in 2017 and 2018. Now, earning more than the subsidy ceiling can cause someone to pay several thousand dollars more for their insurance.<sup>5</sup> Insurer Medica, for instance, provided the following example for young parents with two children.<sup>6</sup> If a family's income is \$98,000, their insurance

premium for silver coverage is capped at \$9,500 a year, but if family income is \$101,000, there is no cap and the insurance premium increases to \$27,000 a year (paid after taxes).

Steep premium increases would likely produce reduced enrollment even without the subsidy cliff, but the cliff creates an even greater divide in how rate increases affect enrollment, because only people who receive subsidies are sheltered from the brunt of premium increases. Indeed, the ACA's subsidy structure can end up actually reducing the net cost for some plans as the sticker price increases, since the subsidy is based on a particular reference plan (the second lowest silver), which may end up increasing more than other plans. This auto-adjusting subsidy feature “insulates” most of the exchange market from price increases, but people above 400 percent of poverty remain fully exposed to those increases. Thus, only they are likely to find that premium increases make coverage substantially less affordable.

Accordingly, many observers noted that the individual market has “bifurcated” into essentially two submarkets: subsidized (through the exchanges), and unsubsidized (mostly off-exchange). The subsidized portion was seen by most informants as remarkably “resilient,” “surprisingly robust” (see Abelson 2018). But, those who are ineligible for subsidies are “SOL” [s\*\*\* out of luck] because that part of the market “is going to be terrible” and there is “no help on the horizon” for them.

### Expanding Premium Subsidies

The most obvious measure to address the subsidy cliff is simply to expand subsidies to people who continue to face unaffordable premiums—especially those above 400 percent of the poverty level. Reinsurance helps that segment of the population only indirectly, by reducing premiums across the board. Reinsurance is also indirect in that it reimburses insurers' claims costs after they have set their premiums, with

5. This cliff effect is made even more challenging by the fact that some people will not know for certain whether they are above or below the ceiling until they file their taxes several months following open enrollment—at which point, if they have incorrectly enrolled in subsidized coverage because they underestimated their taxable income, they may learn that their insurance costs several thousand dollars more than they first thought.

6. Iowa Insurance Division, “Medica Insurance Company, 2018 ACA Compliant Individual Rate Filing Observations,” <https://iid.iowa.gov/documents/iid-medica-rate-filing-observations-2018> (accessed January 29, 2020).

the hope that this will help to keep premiums lower, but reinsurance offers no guarantee that all of its funding will accrue to the benefit of consumers in the form of lower premiums. Some of this funding might instead go toward increasing insurers' profits.

For example, a study of Medicare Part D's reinsurance program concluded that only about half of its reinsurance payments flow through to benefit consumers in the form of reduced premiums or better benefits; the rest is retained by insurers, and in less competitive markets, they retain more than 80 percent of the reinsurance benefit (Cabral, Geruso, and Mahoney 2017). Similarly, under the ACA, various estimates indicate that reinsurance appears to be a decidedly expensive way to increase the number of people purchasing insurance. Milliman's analysis for Maine's reinsurance proposal, for instance, estimated that its proposed \$55 million in reinsurance funding would reduce the number of uninsured by only roughly one thousand, which equates to \$55,000 per additionally insured person (Ely et al. 2018). Relative inefficiency is also reflected in a report by RAND, which analyzes various scenarios for improving the individual market. RAND's analysis suggests that, for the levels of funding they specified, expanding subsidies could cost half as much per new enrollee as funding reinsurance (Liu and Eibner 2018).

Therefore, some interview subjects questioned whether reinsurance is the best use of funds for market stabilization. Prior to adopting reinsurance for 2018, Minnesota in fact used \$500 million of state funding in 2017 to rebate 25 percent of the premium to individual market subscribers who did not receive subsidies in order to offset a portion of the massive rate increases that year. Unfortunately, the appropriation was not authorized until the end of open enrollment and thus it came as a pleasant surprise to those who had already enrolled, rather than being available earlier as an inducement for more people to enroll. Accordingly, observers thought that this was "a complete lost opportunity" or questioned whether it "makes sense" to "pour so much money into serving a small population of the market."

Nevertheless, several Minnesota subjects thought that a direct consumer subsidy is an alternative worth considering for the future. Unlike reinsurance, one source noted that the rebate is "something people understand and don't have to reinterpret." Another noted that "at least you know that it's offsetting directly versus thinking that the health plans are spending those resources effectively." Others thought that the reinsurance program that Minnesota instituted following the one-year rebate was "just flushing money down the toilet," by giving it to insurers without accountability for how it is used. One source commented that reinsurance is "hugely expensive for the number of people that are in the individual market," and another commented "I've never seen a larger waste of taxpayer dollars in my time."

However, even if expanding direct subsidies were preferred to reinsurance, direct subsidies would be much less effective than reinsurance in capitalizing on federal funds (via a Section 1332 waiver). Extending subsidies to people above 400 percent of poverty might reduce overall premium costs some, by bringing healthier people into the market, but the effect on marketwide premiums is much more attenuated for targeted subsidies than for marketwide reinsurance. Therefore, although targeted subsidies may be more effective in inducing more people to enter the market, this approach is less effective in reducing premium subsidies for existing subscribers, which is the key to using a 1332 waiver proposal under the ACA to secure supplemental federal support for market stabilization. Thus, in the absence of additional federal legislation, it appears that states would have to fund almost all of targeted subsidies on their own.

## CONCLUSION

The ACA's individual market is in generally the same shape now that it was at the end of 2016. Prices are high and insurer participation is down, but these conditions are not fundamentally worse than they were at the end of the Obama administration. For a variety of reasons, the ACA's core market has withstood remarkably well the various body blows it absorbed during 2017 and 2018, including repeal of the individual mandate and halting payments to

insurers for reduced cost sharing by low-income subscribers.

Two elements are key to the market's resilience. The first is the ACA's subsidy structure, which keeps insurance affordable for the majority of current subscribers, regardless of unsubsidized market prices. The second is the willingness of state regulators to give insurers the rate increases they need to regain and maintain profitability. Especially important was the flexibility in most states to allow insurers to adjust their rates for 2018 in a way that protected most higher-income subscribers from the brunt of premium increases needed to make up for lost cost-sharing payments. The prospects for continued enrollment of a sizable number of subsidized and profitable subscribers has kept insurers from abandoning the market.

Much more troubled, however, is the unsubsidized portion of the ACA's individual market. Although insurers also continue to serve this market segment, steep price increases have been needed to achieve profitability and to counteract regulatory disruption, which is driving more unsubsidized people out of the market.

Also troubling is that, although stability is not fundamentally worse now than in the ACA's early years, neither have conditions improved markedly, in most states. Absent the regulatory changes and political uncertainty that emerged in 2017, it appears that the ACA's individual market could have achieved a good deal more stability than it has. Especially troubling for insurers is that, when recent changes have been made, insurers often were given no opportunity to adjust their pricing before the changes took effect. This unpredictability caused some insurers to leave or avoid the market, and causes those who remain to increase prices more than they otherwise need to in order to have more cushion for the unknown.

Nevertheless, several measures hold some promise for improving the market, though each has limits. Reinsurance, partly funded by a Section 1332 waiver, can lower premiums roughly 10 to 20 percent and encourage insurers to enter or remain in more sparsely populated areas. However, reinsurance is seen as only a stopgap measure whose benefits are limited.

Rather than (or in addition to) reinsuring insurers, directly targeting funds to unsubsidized subscribers holds more promise for larger reductions in their premiums and thus greater increases in coverage. However, supplemental federal funding is not available for expanding subsidies, so the strategy would need to be funded entirely by states.

Increased availability of coverage options outside the ACA-regulated market presents both a threat to stability, and a potential opportunity for a compromise improvement. The threat arises from allowing parallel markets to form that segment people according to their health status and medical needs. To avoid that, and to protect ACA markets that are working reasonably well, some states may want to limit these non-ACA-compliant options. However, in states where the ACA market is beyond repair for unsubsidized people, offering them a less expensive non-ACA option may be the least-worst path forward. Doing that is not likely to substantially harm those who remain eligible for subsidies. But unsubsidized people with existing health problems would be rendered worse off. That damage might be mitigated, however, by devising creative ways to target subsidies to those who now need them the most, perhaps by assessing the growing noncompliant portion of the market.

Beyond these more creative approaches, a variety of more obvious measures could help stave off market deterioration. Investing in marketing and enrollment assistance can improve the risk pool, as can replacing the individual mandate with an alternative incentive for enrollment. Also, giving insurers some flexibility to adjust their rates midyear can increase their confidence in remaining in the market and being more parsimonious in setting their initial rates.

The measures currently available to states are unlikely, however, to improve the individual market to the extent needed without substantial additional funding. Although the ACA market is likely to survive in its basic current form, the future health of the market—especially for unsubsidized people—depends on the willingness and ability of state and federal lawmakers to muster the political determination to make substantial improvements.

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