



June 30, 2022

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Idaho Section 1332 State Innovation Waiver

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to submit comments on Idaho's Section 1332 State Innovation Waiver.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting state health insurance marketplaces and the patients that they serve. We urge the Department of the Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that any changes to the healthcare system achieve coverage that is adequate, affordable and accessible for patients. A strong, robust marketplace is essential for people with serious, acute and chronic health conditions to access comprehensive coverage that includes all of the treatments and services that they need to stay healthy at an affordable cost. Our

organizations support Idaho's efforts to strengthen its marketplace by submitting this application to establish a reinsurance program, and we urge the Departments to approve the application.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high-cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14% in its first year.¹ More recently, a data brief released by the Center for Medicare and Medicaid Services showed that states with reinsurance waivers have experienced significantly lower individual market premiums than they would have otherwise and have seen gains in insurer participation.²

Idaho's proposal will create a reinsurance program starting for the 2023 plan year. This program is projected to reduce premiums by 7%. This would help patients with pre-existing conditions obtain affordable, comprehensive coverage. Our organizations believe the 1332 State Innovation Waiver will help stabilize the individual market in Idaho and protect patients and consumers. Our organizations support Idaho's state reinsurance proposal and urge the Departments to approve it.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

¹ American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

² Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO). State Innovation waivers: State-Based Reinsurance Programs. August 2021. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-Aug2021.pdf>.

JANUARY 2017

AN EVALUATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET AND IMPLICATIONS OF POTENTIAL CHANGES

American Academy of Actuaries
Individual and Small Group Markets
Committee



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The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Table of Contents

Executive Summary	1
SECTION 1	
What Is Necessary for a Sustainable Individual Health Insurance Market?	4
SECTION 2	
Assessment of Progress to Date	7
SECTION 3	
Addressing ACA Individual Market Challenges	20
Conclusion	36
Endnotes	39

Executive Summary

In this issue paper, the American Academy of Actuaries' Individual and Small Group Markets Committee examines experience in the Affordable Care Act (ACA) individual market. It outlines the conditions necessary for a sustainable individual health insurance market, examines whether these conditions are currently being met, and discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

What is necessary for a sustainable individual health insurance market?

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Slow spending growth and high quality of care.

How does the ACA individual market measure up to these conditions?

- Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected.
- For the most part, competing plans face the same rules; however, some rules might disadvantage insurers participating on the ACA marketplaces (or exchanges) compared to off the marketplaces.
- The uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.
- In recent years, health care spending has been growing relatively slowly compared with historical averages, but there are signs that growth rates are increasing.

What options have been proposed to improve the sustainability of the individual market?

Many options have been put forward to improve the sustainability of the individual market under the ACA. In addition, ACA replacement approaches have been proposed. The impact of any option or set of options depends on the specific details. This paper makes no recommendations and instead assesses the positive and negative implications of various options, including:

- **Stronger incentives to purchase coverage.** Strengthening the incentives to purchase coverage, through increased penalties for non-enrollment, increased premium subsidies, or a permanent reinsurance program, could help increase enrollment and improve the risk pool. Reducing the 90-day grace period and tightening special enrollment period (SEP) eligibility also have the potential to improve the risk pool by decreasing the potential for abuse of these protections.
- **Greater variation in premiums by age.** Widening premium variations by age could increase participation by young adults, but could result in higher uninsured rates among older adults and increased federal costs for premium subsidies, due to higher premiums for older adults.
- **Restructured premium subsidies.** Current premium subsidies are based on premium levels relative to income. The impact on enrollment, net premiums, and federal spending of basing premium subsidies instead on age or other factors depends on the amount of the subsidies relative to premiums.
- **Reduced regulatory uncertainty.** Releasing rules in a timely fashion would help reduce uncertainty for insurers. In addition, applying rules consistently among insurers is important to maintain a level playing field.
- **Allow insurance sales across state lines.** Allowing insurers to sell coverage across state lines, which states already have the ability to permit, could create an unlevel playing field and threaten the viability of insurance markets in states with more restrictive rules. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.
- **Enhanced state flexibility.** States could pursue approaches tailored to their specific situations through Section 1332 State Innovation Waivers or through other enhancements to state flexibility. Such efforts could include the pursuit of different enrollment incentives, subsidy structures, benefit coverage requirements, premium rating rules, etc.

An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes

Now that the individual market under the Affordable Care Act (ACA) is entering its fourth year of operation, experience is available from 2014–2016 that can be used to help assess the sustainability of the market over the longer term. In this paper, the American Academy of Actuaries' Individual and Small Group Markets Committee outlines the conditions necessary for the individual health insurance market to be sustainable over the long term and examines whether these conditions are currently being met. The paper then discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

SECTION 1

What Is Necessary for a Sustainable Individual Health Insurance Market?

This section outlines the conditions necessary for the sustainability of the individual health insurance market. In general, a financial security program is sustainable if it can be reasonably expected to be maintained over time without requiring significant curtailment or restructuring.¹ This determination involves considering whether all significant stakeholders accept the balance of benefits and costs and whether the program will achieve its goals over its time horizon. The ACA's goals include increasing access to affordable health insurance coverage, enhancing the quality of care, and addressing health spending growth.

With respect to the individual market, the conditions necessary for a sustainable market include achieving enrollment that is sufficient and balanced, a regulatory environment that is stable and facilitates fair competition, participation by health plans that is sufficient for market competition and consumer choice, and slow spending growth and high quality of care. These factors will affect premium affordability; in turn, premium affordability will affect enrollment numbers and risk pools. Subsequent sections of this paper will examine the extent to which the ACA individual market meets these conditions, including the feedback between enrollment and premiums.

Individual enrollment at sufficient levels and a balanced risk pool

Sufficient enrollment levels.

At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year. In states that fund health insurance marketplace operations through user fees, market-wide enrollment must be sufficient to generate adequate user fee revenues. At the insurer level, enrollment must be high enough to achieve stability and predictability of claims and to benefit from economies of scale, so that per-enrollee administrative costs are low relative to average claims.

A balanced risk pool.

Because the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs, typically referred to as adverse selection, can produce unsustainable upward premium spirals. Attracting healthier individuals (e.g., through the ACA individual mandate and premiums subsidies) is needed to keep premiums more affordable and stable.

A stable regulatory environment that facilitates fair and sufficient insurer competition

Consistent rules and regulations applied to competing health plans.

Health plans competing to enroll the same participants must operate under the same rules. If one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less-healthy individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Stable effective regulatory environment.

The rules and regulations governing the health insurance market need to be announced with sufficient lead time, relatively stable over time, and not overly burdensome in terms of costs or restrictions on innovation.

Reasonable expectation of earning a fair return.

Insurers operating in the ACA-compliant individual market rely on premium payments from enrollees, federal funding for premium tax credits and cost-sharing reduction subsidies, and risk-mitigation transfers. In total, these revenues must be adequate to cover claims and administrative costs. They must also provide a reasonable margin for contribution to reserves and surplus in order to meet solvency requirements and support ongoing business activities.

Sufficient health insurer participation and plan offerings

Sufficient number of participating health insurers.

Health insurance market competition can provide incentives for health plans to improve the efficiency of health care delivery, lower administrative costs, and provide products that are attractive to consumers. The optimal number of insurers likely differs by area and local market conditions (e.g., the number of eligible enrollees, the degree of provider concentration). Rural areas can support fewer insurers, for instance, due to low potential enrollment numbers and the presence of sole community providers.

Sufficient plan offerings.

The number and range of plan offerings must be sufficient to provide appropriate choice to consumers with respect to plan design features including a variety of out-of-pocket costs, provider networks, and plan type. This does not preclude requiring standardized plan designs. Offerings should not be so numerous that they impose an overwhelming burden on consumers that results in less-than-optimal choices.

Slow health spending growth and high quality of care

Reasonable health care costs and moderate health spending growth.

Long-term sustainability of the individual market requires containing the growth in health spending.

High quality of care.

There must be a focus not only on containing the growth in health care spending but also on improving health care quality, measured for instance based on health care outcomes.

SECTION 2

Assessment of Progress to Date

This section addresses each of the conditions for sustainability identified in Section 1 and assesses progress that has been made as well as challenges that remain to be addressed. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. For the most part, competing plans face the same rules. However, the uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and declined further in 2017.

Individual enrollment at sufficient levels and a balanced risk profile

Sufficient enrollment levels.

The number of individuals selecting marketplace plans during the annual open enrollment periods increased from 8.0 million in 2014 to 11.6 million in 2015, and to 12.7 million in 2016.² Enrollment numbers decline during the year, as individuals shift to other coverage sources (or to being uninsured) and insurers cancel coverage for consumers who don't pay their premiums. Offsetting part of this decline is enrollment during special enrollment periods (SEPs) for individuals who experience a qualifying event, such as a loss of coverage through a job. At the end of 2015, 8.8 million individuals had marketplace coverage, down from 11.6 million during the open enrollment period.³

Because of differences in populations and other factors, such as consumer outreach and enrollment systems, marketplace enrollment varies among the states. In 2016, the number of individuals with marketplace selections ranged from about 15,000 in Hawaii to 1.7 million in Florida.⁴ Hawaii had a state-based marketplace, but moved to using the federal marketplace because its low enrollment numbers were not enough to generate sufficient revenues to sustain marketplace operations.⁵ Other state-based marketplaces with relatively low enrollment numbers could be at similar risk. For instance, of the 13 remaining state-based marketplaces in 2016, three had fewer than 35,000 individuals with plan selections through the marketplaces during open enrollment (District of Columbia, Rhode Island, and Vermont).⁶

The ACA requires that insurers use a single risk pool when developing premiums. ACA-compliant off-marketplace plans are included as part of this single risk pool. In other words, insurers must pool all of their individual market enrollees together when setting the prices for their products. Therefore, premiums reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace. Although there are no official off-marketplace enrollment numbers, the Department of Health and Human Services (HHS) estimates that in 2016, about 7 million individuals enrolled in individual market coverage outside of the marketplace.⁷ The majority of these individuals are likely to have ACA-compliant coverage; the Kaiser Family Foundation estimates that in 2016, only 12 percent of all individual market plans are non-ACA-compliant (i.e., grandfathered and transitional plans).^{8,9} This suggests a total ACA-compliant individual market enrollment in 2016 of about 17-18 million.

Enrollment, both on the marketplace and in total, was lower than initially projected by the Congressional Budget Office (CBO) and others. In its May 2013 baseline estimates, CBO projected a total individual market enrollment in 2016 of about 37 million—22 million on the marketplace and about 15 million off marketplace.¹⁰ In updated estimates from its March 2016 baseline, CBO lowered its 2016 enrollment projection to 21 million—12 million on the marketplace and 9 million off.¹¹ One major reason for the downward adjustment is that more employers than projected are continuing to offer coverage, resulting in fewer individuals moving from employer coverage to coverage in the individual marketplace. Lower-than-expected enrollment also suggests that affordability remains a challenge—in 2015, 46 percent of uninsured adults said that they had tried to obtain coverage but it was too expensive.¹² In addition, the ACA's individual mandate may be too weak to provide sufficient enrollment incentives. Outreach efforts may be insufficient to raise consumer awareness of the mandate and availability of premium assistance.

Even with enrollment lower than expected, uninsured rates have declined under the ACA. For instance, the National Health Interview Survey reports that the share of individuals under age 65 who were uninsured at the time of the interview declined from 18.2 percent in 2010 to 10.4 percent during the first six months of 2016.¹³

Despite these coverage gains, about 27 million nonelderly people remain uninsured in 2016.¹⁴ Of these, the Kaiser Family Foundation estimates that 19 percent are eligible for a premium tax credit and 24 percent are eligible for Medicaid. These individuals may be unaware of their eligibility or, in the case of those eligible for premium subsidies, they may still find premiums unaffordable. Forty-seven percent of the uninsured are ineligible for premium assistance—20 percent due to their immigration status, 17 percent because they have an employer offer of coverage that is deemed affordable, and 11 percent because they have incomes that are too high. Another 10 percent of the uninsured would have been eligible for Medicaid if their state had expanded Medicaid coverage. Affordability may also be an issue for these groups. Notably, these are national estimates; percentages will vary among and within states.

A balanced risk pool.

A sustainable market requires not only enrollment at sufficient numbers, but also a balanced risk profile. That is, enrollment should not be skewed toward those with high health care costs; sustainability requires the enrollment of healthy individuals as well. The ACA includes several provisions that aim to reduce the potential adverse selection effects of allowing guaranteed access to coverage at standard premiums regardless of pre-existing health conditions. These provisions include providing premium and cost-sharing subsidies to lower the cost of coverage and imposing a financial penalty for individuals who remain uninsured. Each encourages even healthy individuals to obtain coverage. However, affordability issues and the weakness of the individual mandate could have disproportionately suppressed enrollment among individuals with low expected health care costs.

Lower-than-expected marketplace enrollment has been accompanied by concerns that the risk profile of enrollees was worse than many insurers expected.¹⁵ The average risk profile for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to reflect a larger share of healthy individuals enrolling, and therefore a more balanced risk profile. In contrast, lower participation rates will tend to reflect a less-healthy risk profile, and in turn higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll than those with lesser needs.

As expected, evidence from the 2014 open enrollment period suggests that less-healthy individuals were more apt to sign up first. For instance, early marketplace enrollees were more likely to be older and use more medications than later enrollees.¹⁶ Examinations of how the risk pool has been changing over time have yielded some mixed results. A Center for Consumer Information and Insurance Oversight (CCIIO) analysis of per-enrollee costs in 2014 and 2015 suggests that slower cost growth may have resulted from a broader and healthier risk pool and that states with stronger enrollment growth had greater improvements in their enrollee risk profiles.¹⁷ Similarly, an analysis of Covered California marketplace data found that the risk profile at the end of the open enrollment period improved from 2014 to 2015¹⁸ and nationwide estimates suggest an improvement from 2014 to 2015 in the share of marketplace enrollees self-reporting very good or excellent health status.¹⁹ In contrast, an analysis of the ACA risk adjustment program shows an increase in risk scores from 2014 to 2015.²⁰ Although this result suggests a deterioration of the risk pool, other factors could have played a role, such as increased diagnostic coding and better data submission to the Centers for Medicare & Medicaid Services (CMS). In addition, similar to the CCIIO analysis, the report finds that enrollment growth is correlated with an improvement in the risk profile when other factors such as a state's transition policy and Medicaid expansion decisions are controlled for.

The risk corridor results for 2014 and 2015 also support assertions that enrollment was sicker than insurers expected; for many insurers, 2014 and 2015 premiums were too low relative to actual claims.²¹ Some of this understatement was likely due to the implementation of the transitional policy that allowed individuals to keep their prior non-ACA-compliant coverage. In states adopting the transition policy, ACA-compliant plans exhibited less favorable experience because lower-cost individuals were more likely to retain their prior policies. But even in many states that didn't allow for transition policies, insurers were more likely to receive risk corridor payments, suggesting that market average claim costs were higher than assumed in premium pricing.

Except for grandfathered plans, individuals will not be allowed to renew non-ACA-compliant plans beyond Dec. 31, 2017. In states that allowed transition policies, an influx of individuals from these plans to ACA-compliant plans could help improve the risk profile in 2018.

Risk profile concerns may have continued into 2016. The Kaiser Family Foundation estimated that during the 2016 open enrollment period, nationwide only 46 percent of the potential marketplace population selected a marketplace plan, ranging from a low of 22 percent in Iowa to a high of 74 percent in the District of Columbia.²² However, these figures understate total ACA-compliant enrollment to the extent that individuals enrolled off marketplace (notably, the District of Columbia does not offer plans off marketplace).

The availability of SEPs for individuals who encounter certain life events—such as losing health insurance coverage, moving, or getting married—also can affect average claim costs. Eligibility requirements for SEPs in the marketplaces have not been stringently enforced, thereby creating opportunities for individuals to delay enrollment until health care services are needed. On average, SEP enrollees have had higher claim costs and higher lapse rates than individuals enrolling during the open enrollment period.²³ The worse experience exhibited by SEP enrollees could be resulting from a combination of higher enrollment among SEP-eligible higher-cost individuals, lower enrollment among SEP-eligible low-cost individuals, and enrollment among higher-cost individuals who would not meet SEP eligibility criteria if validation were required. CCIIO is exploring additional verification requirements for individuals who purchase coverage on the marketplaces.

The availability of long premium payment grace periods for subsidized enrollees could also contribute to an unhealthy risk profile. Individuals who receive premium subsidies on the marketplace and have paid at least one month's premium are allowed a grace period of 90 days for future premium payments. States govern the grace period, typically 30 days, for individuals not receiving subsidies and those purchasing coverage off marketplace. Longer grace periods for on-marketplace plans can worsen the risk pool profile by allowing healthy people to pay premiums for nine months and be assured of 12 months of coverage if needed. In other words, individuals who develop health problems can retroactively pay premiums in order to maintain coverage; individuals who remain healthy can skip payments for the last three months of the year and simply enroll for the next year's coverage during the open enrollment period. The risk adjustment program does not mitigate lost revenue problems arising due to healthy people not paying a full year of premium. It's unclear the extent to which subsidized enrollees may be taking advantage of the extended grace period.

A recognition by insurers of worse-than-expected risk pool profiles in 2015 was likely a factor that contributed to 2017 premium increases. Insurers have more information now than they did last year regarding the risk profile of the enrollee population and used that information to adjust their 2017 assumptions accordingly.²⁴

A stable regulatory environment facilitating fair competition

Consistent rules and regulations applied to competing health plans.

A stable marketplace requires that rules be consistently applied to all competitors in order to prevent particular insurers from being inappropriately advantaged or disadvantaged. Inconsistent regulations distort the market, reducing competition and limiting consumer choices. Fair competition also requires rules to prevent insurers from gaming the system. These conditions are generally met under the ACA, but not completely.

The same issue and rating requirements apply to all individual market insurers in a state, regardless of whether coverage is offered on or off the state marketplace. However, many states decided to take up the federal option of allowing individuals to keep non-ACA-compliant coverage, which put ACA-compliant plans at a disadvantage with respect to enrolling healthier individuals. This transition policy expires at the end of 2017; beginning in 2018, individuals in these plans will need to purchase ACA-compliant coverage.

ACA-compliant plans on and off the marketplaces participate in the risk adjustment program. By transferring funds between insurers based on the relative risk of their plan participants, the risk adjustment program aims to reduce incentives for insurers to avoid enrolling people at risk of high health spending. An Academy analysis found that for the 2014 plan year, the risk adjustment program compressed the loss ratio differences among health plans—risk adjustment transfers increased average loss ratios among health plans with low loss ratios and reduced loss ratios for health plans with high loss ratios, indicating that the program generally worked as intended for the individual market.²⁵ Nevertheless, risk adjustment payments can be affected by diagnostic coding and operational issues, and risk adjustment transfers as a percent of premium are much more variable among smaller insurers, which can produce unexpected results.

Non-ACA-compliant plans are not part of the risk adjustment program. Therefore, the program cannot mitigate the differences in enrollment patterns between non-ACA-compliant plans, which are more attractive to healthy individuals, and ACA-compliant plans.

One example of rules that apply differently on and off marketplace is the length of the premium grace period. As noted above, a 90-day grace period is available for individuals receiving premium subsidies, whereas the grace period is typically 30 days for other enrollees, including those purchasing coverage off the marketplaces. This can create a minor advantage for insurers selling off marketplace only.

There are also some differences in how fees are levied among insurers. Marketplace user fees are collected to support marketplace operations. The fee is charged only on marketplace business, but insurers must spread the fee across its marketplace and off-marketplace business. Insurers that operate only off marketplace do not need to reflect the fee in their premiums.

Stable effective regulatory environment.

Uncertainty in the regulatory environment can impact premium adequacy and stability, and ultimately insurer solvency. ACA regulations put into place standardized and effective processes for premium rate development, actuarial value determinations, and rate review processes that contribute to relative stability in the year-by-year rate filing processes. However, certain regulatory and legislative changes have seriously undermined this stability, negatively affecting the risk pool profiles, premium adequacy, and insurer financial results. In addition, delays in the release of important information can negatively affect stability.

- **Allowing individuals to retain pre-ACA coverage.** The decision to allow individuals to retain pre-ACA coverage was not made until 2014 premiums were finalized. In states that allowed pre-ACA plans to be renewed, this decision resulted in the risk pool profiles of ACA-compliant coverage being worse than expected and contributed to premiums being low relative to actual claims.
- **Constraints on risk corridor payments.** Risk corridors were included in the ACA to mitigate the pricing risk in the early years of the program. Although originally not specified to be budget neutral, subsequent legislative and regulatory actions have limited risk corridor payments to those that can be paid through risk corridor collections. If there is a shortfall, risk corridor payments are made on a pro rata basis. Due to such a shortfall for the 2014 plan year, only 12.6 percent of risk corridor payments were made.²⁶ The failure to pay the full amounts led to financial difficulty for many plans, in particular many Consumer Operated and Oriented Plans (CO-Ops). For instance, the Kentucky Health Cooperative specifically cited the lack of full risk corridor payments as a reason for closure.²⁷ HHS has indicated that no funds will be available for 2015 risk corridor payments, as any 2015 risk corridor collections will be used toward remaining 2014 risk corridor payments.²⁸
- **Legal challenges to the ACA.** The steady flow of lawsuits has created additional costs and uncertainty. For instance, many states using the federal marketplace required dual premium submissions for the 2016 plan year because the Supreme Court had not yet

ruled on *King v. Burwell* (regarding the availability of premium subsidies) at the time premium filings had to be submitted for review. This required additional resources and expenses. Other cases are currently working their way through the courts. One that could have significant implications for premiums and insurer financial stability involves whether the administration has the legal authority to make cost-sharing reduction payments to health plans.²⁹

- **Timing of available risk adjustment information.** Because the risk adjustment program depends on the market-wide risk profile, there is uncertainty regarding the amount that insurers expect to pay or receive under the program. Risk adjustment results in 2014 and 2015 were much different than expected for some insurers, resulting in unexpected losses. This risk adjustment “shock” is another reason cited for causing solvency problems for CO-OPs and other smaller plans.³⁰ Because of the lag in reporting, final risk adjustment results for a given plan year are not released until the middle of the next year, after premiums have already been filed for the year after that. In recognition of this time lag, CCIIO has begun to release interim reports that provide summary risk adjustment information. This information is not available for all states and insurers using the reports must do so with caution because the final results can differ significantly from interim estimates.
- **Timing of final rules.** The rulemaking process is understandably long and involved. Nevertheless, the earlier that rules are finalized, the easier it is for insurers to meet deadlines for product and rate filings in May. The final rules applicable to 2018 premium filings were released in December, earlier than in prior years. This earlier release will reduce rulemaking uncertainty, especially if this timeframe is continued in future years.

Reasonable expectation of earning a fair return.

Like all businesses, insurers participating in the individual market have an obligation to protect their viability and solvency, requiring that they must earn a fair return that supports ongoing business activities. Premiums net any of other payments or receipts (e.g., through the risk adjustment and reinsurance programs) must be adequate to cover claims and all administrative costs, taxes, and fees, and still provide a margin for profit or contribution to reserves and surplus.

The ACA reforms implemented in 2014 significantly changed insurance market rules and increased business risks. The most fundamental of these risks is related to projecting claim costs. Insurers had very limited data available to estimate who would enroll in plans under the new rules and what their health spending would be. It was likely that the composition of the insured population would change dramatically due to the elimination of underwriting and the introduction of premium subsidies. The risk adjustment and transitional reinsurance programs also needed to be factored in, while the temporary risk corridor program could be viewed as providing a partial safety net for premium rate development uncertainty.

Even with all the known risks, issuers were further subject to circumstances that could not reasonably have been anticipated. As noted above, these include the ability for individuals in many states to continue non-ACA-compliant transitional coverage in 2014 and beyond, as well as the federal government's failure to make risk corridor payments in full.

In an analysis of 2014 experience, McKinsey & Company found much variation in financial performance among insurers, with about 40 percent of the market covered by insurers with positive margins; the aggregate post-tax margin in 2014 was -4.8 percent.³¹ The transition policy may have contributed to losses, as did insurer-specific factors, with CO-OPs and insurers offering preferred provider organization (PPO) plans and broad networks experiencing larger losses. Health maintenance organizations (HMOs), insurers with narrower networks, and Medicaid-based plans had more favorable experience, on average.

Once financial losses have been suffered, they cannot easily be recouped through future gains in the individual marketplace. Pricing margins can be limited by the rate review process and competitive pressures, which often puts downward pressure on rates, and health plans are not allowed to build in provisions to recoup past losses into premium rates.

Prior to the ACA, normal fluctuations in year-by-year margins could result in poorer-than-expected margins being offset by better-than-expected margins in subsequent years. The ACA's medical loss ratio (MLR) requirements limit the extent to which this can occur. These requirements stipulate that if claims plus quality improvement expenses fall below 80 percent of premium net of taxes and fees (in effect meaning that administrative costs and profit exceed 20 percent of premium), insurers may be required to return the difference to plan members.

Insurers and regulators now have more experience that can be used to develop and review future premiums. S&P Global Ratings recently forecast that insurer financial performance will improve, with smaller aggregate losses in 2016 than in 2015 and continued improvement in 2017 with more insurers becoming profitable.³²

Nevertheless, continuing uncertainty and ACA legal challenges mean that pricing and solvency challenges in the market remain. This has caused many issuers to question their ability to earn a fair return—resulting in some issuers withdrawing from existing markets and fewer issuers having an interest in entering new markets.

Sufficient health plan participation and plan offerings

Sufficient number of participating health insurers.

Although there is no definitive minimum number of health insurers that are needed to ensure a competitive marketplace, it is generally recognized that competition can be difficult with fewer than three insurers.³³ This threshold may be lower than in other markets due to consumers' ability to compare plans under the ACA.³⁴

The average number of ACA marketplace insurers per state increased from 5.0 in 2014 to 6.1 in 2015, and then declined to 5.7 in 2016.³⁵ Due to the failure of a number of small carriers, especially the CO-OPs, and market withdrawal announcements by some larger carriers (e.g., Aetna, Humana, UnitedHealth), the number of insurers is decreasing further in 2017. These averages mask tremendous variation among states. For instance, in 2017, five federal marketplace states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) have only one insurer. On the other end of the spectrum, Wisconsin has 15 insurers, Ohio has 11, and Texas has 10. Within states, the number of insurers offering coverage can vary by county, with rural counties having fewer participating insurers. Avalere estimates that in states using the federal marketplace, the average number of insurers per county has fallen from 5.3 in 2016 to 2.9 in 2017, and 21 percent of enrollees have only one participating insurer for 2017.³⁶

It was expected that insurer exits and entries would occur during the early years of the ACA as insurers adjust to the new market rules. Nevertheless, recent marketplace pullbacks, especially among some major insurers, raise a concern that the current ACA marketplace environment is not viable from a business perspective. (Notably, some of the insurers pulling back from offering marketplace coverage continue to offer ACA-compliant coverage outside of the marketplace.) A reduction in competition due to fewer participating insurers can reduce consumer options as well as impact premiums. The ability of insurers to effectively compete depends in large part on their ability to manage costs, which in turn reflects their ability to effectively negotiate with providers to lower utilization and costs (e.g., through narrower networks). Insurers with larger market shares in a particular area may have more leverage in provider contracting. (The dynamic may be different in rural areas with a limited number of providers—rural providers can have more negotiating power even if there is only one insurer.) On the other hand, having a more competitive market could provide insurers more incentives to negotiate aggressively and to pass along savings to consumers. Research based on 2014 and 2015 ACA premiums suggest that the addition of an additional competitor leads to lower premium increases, but the competitive effects shrink after two or three additional entrants.³⁷

Due in part to lower potential enrollment, rural areas can support fewer insurers, so it is not surprising that there are fewer participating insurers in rural counties and states. Nevertheless, having only one or even no participating insurers in some areas is a cause for concern.

Sufficient plan offerings.

Consumers have choices with respect to their particular plans. The ACA provides for four metal levels, which reflect relative plan generosity, as well as a catastrophic plan available to young adults and individuals who qualify for a hardship exemption from the individual mandate. Insurers offering marketplace coverage must offer silver and gold metal plans, but are not required to offer the other metal levels. In most states, insurers have flexibility within metal levels to set particular benefit design and cost-sharing requirements. Some state marketplaces impose standardized plan options, but may allow non-standardized options as well. Standardized benefit options may help simplify consumer choices and facilitate plan comparisons,³⁸ but could also inhibit innovative plan designs. For the 2017 plan year, the federal marketplace is offering standardized benefit designs, called Simple Choice plans, on an optional basis. Insurers can also offer choices across additional plan dimensions, such as plan type (e.g., HMO, PPO), which can affect the level of care management, how broad or narrow the provider network is, and the availability of out-of-network benefits.

Over the first three years of the ACA, the average number of marketplace plans offered per county in federal marketplace states increased from 51 in 2014 to 55 in 2015, and then decreased to 48 in 2016; plan offerings per county is further decreasing to 30 in 2017.³⁹ Plan offerings and enrollment are concentrated in silver plans, which would be expected given that premium subsidies are based on silver plans and cost-sharing subsidies are available only for silver plans.

Forty-seven percent of 2017 federal marketplace plans are silver plans; 33 percent are bronze. On average, only one platinum plan is offered per county, and many areas have no platinum plan offerings at all. Enrollment has been even more concentrated; as of March 31, 2016, 70 percent of enrollment nationwide is in silver plans and 22 percent is in bronze.⁴⁰

The type of plans offered in the marketplaces has been changing, with a decline in less restrictive network PPO offerings. This shift may reflect consumers' willingness to forgo access to a broad set of providers and looser utilization management in return for lower premiums and cost sharing. Among silver plan offerings, PPO plans have declined from 52 percent of plan offerings in 2014 to 35 percent in 2016, and were expected to decline further in 2017, especially among competitively priced plans.⁴¹ Some areas have few or no PPO marketplace offerings.⁴² More restrictive network plans, such as HMOs and exclusive provider organizations (EPOs), are becoming a larger share of marketplace offerings. Low- and moderate-income consumers may be more open to narrower networks,⁴³ and Medicaid-based marketplace plans are particularly based on HMO and EPO plans.⁴⁴ Nevertheless, the high deductibles associated with lower-metal-level plans have generated concerns regarding high out-of-pocket costs.⁴⁵ On average, plan offerings are broader off marketplace, both in terms of plan type and metal tier,⁴⁶ but premium subsidies are not available for off-marketplace plans.

Insurers are shifting toward narrower provider networks in marketplace plans to lower premiums.⁴⁷ Health insurers negotiate provider payment rates and other network participation terms, such as those related to quality and sharing financial risk. Providers often accept lower payment rates in return for being included on a plan's network. Deep provider discounts have been negotiated in some cases, particularly when the health insurer is able to leverage rate negotiations between two competing health care systems.

Slow health spending growth and high quality of care

Because most premium dollars go toward paying medical claims, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires controlling health care costs. Medical spending trends for the individual market reflect those for the health system as a whole. In recent years, health spending has been growing relatively slowly compared with historical averages. Nevertheless, national health spending made up 17.8 percent of the economy in 2015.⁴⁸ Because health spending has been growing faster than the gross domestic product (GDP), this share is increasing.

There are signs that health spending growth rates are beginning to increase. Prescription drug spending growth has been particularly high recently, due to price increases and the introduction of high-cost specialty drugs. According to national health spending projections from the CMS Office of the Actuary, annual per capita spending growth for those with private health insurance will increase from 3.2 percent in 2014 to 4.9 percent from 2016 to 2019.⁴⁹ This higher growth rate remains lower than the 7.1 percent annual growth rate from 2007 to 2013, but exceeds projected annual per capita GDP growth by 1.0 percentage point. Growth in per capita health spending will directly result in premium increases.

Not only is national health spending high and growing, there is evidence that we are not spending our health care dollars wisely. For instance, the Institute of Medicine estimated that 10-30 percent of health spending is for unnecessary care or other system inefficiencies and that missed prevention opportunities also add to excess spending.⁵⁰ Although the medical care that people receive can vary dramatically across and within geographic regions, those variations are unrelated to health outcomes,⁵¹ also indicating inefficient spending. In addition, medical errors are now the third leading cause of death,⁵² raising quality concerns.

SECTION 3

Addressing ACA Individual Market Challenges

This section discusses the potential implications—both positive and negative—of several options that have been proposed to address the challenges in the individual market under the ACA. This section focuses on options to improve the risk pool profile, increase insurer participation, and improve the regulatory environment. Although the long-term sustainability of the individual market depends on containing health care spending, this is a health system-wide issue and not unique to the individual market. As such, an examination of payment and delivery system reform options is beyond the scope of this paper.

Options to Achieve Sufficient Enrollment Levels and a Balanced Risk Profile

One of the most popular elements of the ACA is that people with pre-existing health conditions cannot be denied health insurance coverage or charged more for that coverage. For this provision to work, however, healthy people must enroll at levels high enough to spread the costs of those who are sick. Otherwise, average costs, and therefore premiums, will rise. This section explores options related to approaches that aim to increase enrollment and attain a balanced risk profile.

Impose penalties for non-enrollment

One way of increasing enrollment is to penalize individuals who do not enroll. An individual mandate may be the best way of using penalties to increase enrollment, but only if it is effective and enforceable. Other options that impose penalties on individuals who initially forgo coverage but later enroll may provide some incentives to enroll when first eligible. However, their effect on the risk pool may come more from suppressing later enrollment or mitigating the costs of future adverse selection.

- **Individual mandate.** The ACA individual mandate penalty (\$695 or 2.5 percent of income, whichever is greater) may not be strong enough to encourage healthy consumers to enroll. For instance, an annual income of \$50,000 would result in a tax penalty of \$1,250, which is about half of the national average premium for a bronze plan.⁵³ A larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium.

Strengthening the mandate's enforcement could also increase its effectiveness. Currently, the mandate penalty is reported on the federal income tax form and is deducted from any tax refund. If no refund is owed, however, there are no consequences to the taxpayer if the penalty goes unpaid. Enforcing payment regardless of whether there is a tax refund would increase the mandate's effectiveness.

Increased outreach to ensure that consumers are aware of and understand the penalty as well as their coverage options and potential eligibility for premium subsidies would help increase the mandate's effectiveness, as would reducing allowed exemptions to the mandate.

- **Continuous coverage requirement/reduce access to coverage for late enrollees.** Another form of a late enrollment penalty would be to remove the pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period of time, such as 18 months. In other words, insurers would be allowed to underwrite individuals who do not enroll when first eligible or do not meet continuous coverage requirements. Individuals with pre-existing conditions could be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions.

If this type of approach were structured to allow insurers to offer preferred premiums to individuals who meet underwriting requirements, however, the marketplace would in effect return to a pre-ACA environment. Healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less healthy individuals would face higher premiums and potentially less generous or no coverage options. Similarly, if this approach moved away from requiring a single risk pool with risk adjustment among all plans, market fragmentation could occur and plans insuring higher-cost individuals would require higher premiums and could become less viable.

A continuous coverage requirement in effect imposes a one-time open enrollment period. Instead of having only a one-time open enrollment period, or annual open enrollment periods as under the ACA, an intermediate approach would be to offer open enrollment periods every two to five years.

- **Late enrollment premium penalty.** In addition to or instead of an individual mandate penalty, individuals who do not enroll in coverage when it is first available could be subjected to a premium surcharge if they later enroll. For instance, the Medicare program increases Part B and D premiums by 10 percent of premium for every 12 months that enrollment is delayed past the initial eligibility date. (Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums probably play a larger role.) The higher premium is paid for the lifetime of the enrollee. Such a penalty would be more challenging to implement under the ACA. It would be difficult to track an individual's eligibility and enrollment over time, especially when individuals change employers or move between different coverages. Communicating the nature of the penalty to consumers could also be difficult. In addition, as the penalty accumulates over time, premiums could become prohibitively expensive, potentially further suppressing subsequent enrollment, potentially more so among healthy individuals.

Provide enrollment incentives

In the ACA, the individual mandate is the stick and premium subsidies are the carrot used to encourage enrollment, especially among healthy individuals. Although much attention is focused on the enrollment experience among young adults, who on average have lower health care costs, enrolling low-cost individuals of all ages should be the goal. Enrolling healthy older adults can be even more advantageous than enrolling healthy younger adults, because of the higher premiums paid by older adults. Regardless of age, attracting low-cost individuals depends on whether they deem that the value of the health insurance available exceeds the premiums charged. Reducing premiums through premium subsidies, tax credits, or other means could increase the perceived value of insurance, even to healthy individuals. The impact of any change in subsidies on enrollment, premiums, and government spending would depend on the details of the approach.

- **Premium subsidies.** Premium subsidies for ACA coverage are based on income and the cost of the second-lowest silver tier plan, and are available for individuals with incomes up to 400 percent of the federal poverty level (FPL). Nevertheless, premium affordability appears to continue to be a problem. Premium subsidies could be increased, perhaps targeting different subsets of enrollees. One option would be to increase the premium subsidies for all individuals currently eligible for premium subsidies—those with incomes between 100 and 400 percent of FPL. This would help address the concern that premiums remain unaffordable for low- and moderate-income individuals. Another option would be to increase subsidies for a subset of individuals currently eligible for premium subsidies (e.g., individuals with incomes of 250–400 percent of FPL, younger adults, older adults) if affordability issues are seen as greater for those subgroups. A third approach would be to extend subsidies to individuals with incomes exceeding 400 percent of FPL, in recognition that even higher-income individuals can face affordability problems. By increasing subsidies, net premiums would decline, increasing the incentives for even healthy individuals to obtain coverage.

- **Restructured premium subsidies.** The ACA premium subsidy structure sets a cap on premiums as a share of income, and the cap increases with income as a share of FPL. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit, which can be used toward any plan in the marketplace. If the plan chosen costs less than the second-lowest silver tier plan (e.g., the lowest silver tier plan, a bronze tier plan), the enrollee will pay less than the premium cap. Because premiums for older adults are more expensive than premiums for younger adults, older adults will receive a higher premium subsidy than younger adults with the same income. Using that subsidy toward a lower-priced plan could result in an older adult paying a lower net premium than a younger adult with the same income. Conversely, if a higher-cost plan is chosen, older adults would pay a higher net premium than younger adults with the same income.

The subsidy structure could be changed so that subsidies vary by age, instead of or in addition to varying by income. For instance, subsidies could be targeted to increase enrollment among young adults. Regardless of how they are structured, subsidies need to be sufficient so that premiums are affordable, especially for low- and moderate-income households.

- **Reimbursement for high-risk enrollees.** The ACA includes a transitional reinsurance program that uses contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. To the extent that the group insurance market (including self-funded plans) has a healthier risk profile than the individual market, this mechanism in effect acts as a risk adjustment program between the individual and group markets. The program was in effect from 2014-2016 only. A permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums. For instance, during the reinsurance program's first year, the \$10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.⁵⁴ Such a program to pool high risks could be implemented at the state or federal level and could use the current funding mechanism or another. For instance, the state of Alaska recently established a comprehensive health insurance fund that will act like a reinsurance program, thereby lowering 2017 premium rate increases.

Modify insurance rules

Under the ACA, premiums cannot vary by health status, but are allowed to vary by age, up to a 3:1 ratio. The ACA also imposes rules regarding the comprehensiveness of coverage. These rules can affect average premiums and out-of-pocket costs. They also affect how premiums vary across individuals.

- **Wider premium variations by age.** Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent (\$70 per month), resulting in an increase in young adult enrollment.⁵⁵ However, premiums for 64-year-olds would increase by 29 percent (\$274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by \$11 billion in 2018 under the current ACA subsidy structure.
- **Increased access to catastrophic coverage or the addition of a lower tier “copper” plan.** Less generous coverage could be appealing to younger adults and healthy people of all ages more generally. The ACA offers a catastrophic plan option to adults under age 30 and older adults who have a hardship exemption from the individual mandate. However, individuals are not allowed to use premium tax credits toward catastrophic plans and the actuarial value of catastrophic plans is similar to bronze plans. As a result, current participation in catastrophic plans is quite low—less than 1 percent of marketplace enrollees.⁵⁶

Allowing broader access to catastrophic coverage with even lower actuarial values and allowing premium tax credits to be used toward this coverage could increase enrollment, especially among healthy individuals. Under current law, however, increased enrollment in catastrophic plans won’t affect premiums for the metal level plans—although catastrophic plans are part of the single risk pool, catastrophic plan premiums are allowed to be adjusted to reflect the expected impact of catastrophic plan eligibility. In addition, catastrophic plans are treated separately in the risk adjustment program.

Adding a copper tier plan, with an actuarial value lower than that of the bronze tier plans, could result in increased enrollment among young and healthy individuals.

However, the lower premiums associated with these plans mean that it would be more difficult to spread the risk of higher-cost enrollees in more generous plans. In addition, by their nature, both catastrophic plans and copper tier plans would have higher out-of-pocket cost-sharing requirements than other plans. This may be less of an issue for high-income individuals, but these types of plans are a less viable option for low- and perhaps even moderate-income individuals. (Individuals with incomes less than 250 percent FPL are eligible for cost sharing subsidies, but only if they purchase silver tier plans.)

- **Increased benefit design flexibility.** Designing benefit packages that would be more attractive to healthy enrollees could increase their participation. For instance, offering primary care visits or generic drugs with low copayments before the deductible could be a way to increase the value of benefits. Although insurers already have flexibility to vary plan designs within the actuarial value constraints, the HSA rules prohibit paying most non-preventive benefits prior to the deductible. Relaxing those rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits while also potentially reducing costs.

Make risk pools less susceptible to adverse selection

Even with provisions such as an individual mandate and premium subsidies that aim to reduce the adverse selection effects of prohibiting discrimination against individuals with pre-existing conditions, some degree of adverse selection will occur. In addition, many individuals enroll after the year begins, either later during the open enrollment period or during a special enrollment period. And many individuals drop coverage prior to the end of the year. Partial-year enrollment is not unexpected in the individual market, as individuals move between it and other sources of coverage, such as employer group coverage. Nevertheless, partial-year enrollment can be especially prone to adverse selection. Further mitigating adverse selection and encouraging full-year enrollment can improve the risk pool profile and market stability.

- **Modify the open enrollment period.** Shortening the open enrollment period or ending it prior to January 1 would increase the confirmed enrollment in January. As a comparison, the 2017 open enrollment period runs from November 1 to January 31 for ACA plans, but only from October 15 to December 7 for Medicare. Having an ACA open enrollment as short as that for Medicare might not be currently feasible—more time may be needed for outreach and enrollment efforts. In addition, individuals may need until December to know what their financial situation for the next year will be (e.g., whether they get a raise can affect enrollment decisions). Nevertheless, an enrollment period that ends prior to January 1 could reduce the potential for adverse selection, thus improving the average risk profile. In addition, it would help insurers understand their enrollee population sooner, direct members into care management programs earlier, provide more time to send welcome materials to enrollees, and better ensure enrollees access to insurance benefits closer to January 1.
- **Reduce the 90-day grace period.** Individuals receiving premium subsidies are allowed a 90-day grace period for premium payment. This can enable enrollees to select against the market by paying premiums retrospectively only if they use services during that time; those who don't use services can let their coverage lapse. This can destabilize the market and increase average costs per enrollee. Reducing the grace period so that it is the same as that for individuals not receiving subsidies, typically 30 days, could keep enrollees participating regardless of need, and for a longer duration. Concerns regarding premium affordability could be addressed through other mechanisms, such as increased or restructured premium subsidies.
- **Tighten SEP eligibility and enrollment verification.** Recent changes by CMS to eliminate some SEP categories and tighten the eligibility requirements for certain SEPs have been reported to have resulted in a 15 percent decline in SEP enrollment.⁵⁷ CMS has also announced plans to test procedures that would verify SEP eligibility.⁵⁸ Further limiting SEP eligibility and tightening enforcement could reduce any abuses of SEP eligibility that might be occurring. Although potentially difficult to implement, an additional option is to prohibit SEP enrollees from choosing richer plans than their prior coverage. Any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible, otherwise the consequence could be to reduce participation among healthy SEP eligibles, thus worsening the risk pool. Because higher claim costs among SEP enrollees likely reflects not only abuse of SEP eligibility, but also higher enrollment among high-cost SEP eligibles, consideration

should be made to increase outreach regarding SEP eligibility and the individual mandate (e.g., notices to employees losing group coverage). Doing so could reduce adverse selection by increasing participation among low-cost SEP eligibles. Nevertheless, late-year SEP enrollment among healthy eligibles could be low because deductibles aren't prorated.

- **Limit third-party premium and cost-sharing payments.** Adverse selection can occur when third parties pay an individual's insurance premiums and cost sharing, as these payments are more typically made on behalf of individuals with high health care needs. Payments from certain third parties may be appropriate. For instance, CMS requires insurers to accept third-party payments from federal, state, and local programs. However, it is less appropriate for providers who will receive payments for their services to be making payments on behalf of enrollees. CCIIO has expressed concerns that provider organizations could be steering Medicaid and Medicare patients to marketplace plans in order to obtain higher reimbursement rates.⁵⁹ Dialysis providers in particular appear to be benefiting from such steerage, even if it is not the best coverage option for patients. To address this issue, CMS issued rules to improve dialysis facility disclosure requirements and transparency around third-party premium payments.
- **Establish high-risk pools.** Rather than directly increasing the participation of healthy individuals, high-risk pools could be established to remove high-cost enrollees from the risk pool, reducing premiums for the remaining enrollment. If the issue and rating requirements were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average standard premiums would be lower but high-risk individuals could have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.⁶⁰ Substantial funding would be required for high-risk pools to be sustainable. In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums. As discussed above, an alternative is to use funding that would have been directed to external high-risk pools toward a program that reimburses plans the costs of high-risk enrollees.

Increase sources of potential individual market enrollment

Another approach to increasing enrollment in the individual market is expanding eligibility to other groups:

- **Incorporate Medicaid expansion population into the individual market.** The ACA expanded Medicaid eligibility to 138 percent of the FPL. Arkansas and New Hampshire received federal waivers to expand Medicaid by purchasing marketplace coverage for newly Medicaid-eligible adults; the Arkansas waiver began in 2014 and the New Hampshire waiver began in 2016. Iowa had implemented a similar program but subsequently terminated it when the remaining marketplace insurer would no longer accept Medicaid enrollees. Other states could pursue the approach of using Medicaid funds to purchase marketplace coverage. Incorporating the Medicaid expansion population into the individual market would increase marketplace enrollment, potentially increasing marketplace stability. But the impact on the risk profile and resulting premiums is unclear—having a lower income is often associated with having poorer health. In 2015, Arkansas had the highest average risk score in the individual market (but closer to the average risk score in the small group market), perhaps reflecting in part the Medicaid waiver. In addition, there is evidence that marketplace premiums are lower on average in states that expanded Medicaid compared to those that have not.⁶¹ These findings suggest that expanding traditional Medicaid could improve marketplace risk profiles, although marketplace enrollment would decline.
- **Merge the individual and small group markets.** Merging the individual and small group markets into a single risk pool would increase the size of the risk pool. Whether it would lead to greater market stability and lower premiums, at least compared to the individual market, would depend on the relative size and risk of the individual market compared to the small group market. For instance, if a state's small group market is relatively large and lower risk than its individual market, the small group market would more easily absorb the individual market, lowering premiums for those previously in the individual market without substantially increasing premiums for those previously in the small group market. In contrast, if the small group market in a state is relatively small compared to the individual market, merging the markets could increase small group premiums without a significant reduction in individual market premiums. Other factors that could impact outcomes are whether merged market premiums would be allowed to vary between individuals and groups and the extent to which a self-funding option is available for small groups with lower expected health care spending. Adverse

selection against the ACA market could occur if low-cost small groups pursue self-funding options. Currently, self-funding is relatively infrequent among small groups. Of establishments with fewer than 100 workers that offer health insurance, 14.2 percent offered a self-funded plan in 2015, up from 13.4 percent in 2014.⁶² Nevertheless, to limit additional adverse selection, rules might need to be considered to discourage further self-funding among small groups.

- **Remove option for adult children up to age 26 to remain on a parent's insurance plan.** The ACA allows adult children to remain on a parent's plan up to age 26. This likely suppresses young adult enrollment in the individual market. Eliminating that provision could increase young adult enrollment in the individual market, but could also lead to an increase in uninsured rates among young adults. The potential impact on the individual market risk pool profile depends on the extent of adverse selection among younger adults, with healthy young adults opting to forgo coverage.

Increasing Insurer Participation and Improving the Regulatory Environment

Options to level the playing field

It is important for competing plans to operate under the same rules. For the most part, the ACA applies the same rules to all plans in the individual market. However, there are some instances in which plans are treated differently. Options to address these inconsistencies include:

- **Reduce the grace period for subsidized enrollees.** As noted above, reducing the grace period for subsidized enrollees could improve the risk pool profile. It would also increase consistency between individuals with premium subsidies and those without, including those purchasing coverage off the marketplace.
- **Consistent SEP enforcement mechanisms.** Stricter SEP enforcement mechanisms have the potential to improve the risk profile. In addition, more consistent SEP verification processes between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

- **Modifying marketplace fee assessments.** Marketplace fees should be assessed in a manner that does not disadvantage insurers participating in the marketplace. Currently, marketplace fees are assessed only on insurers selling coverage on the marketplace, but these insurers are required to spread the fee to both their on- and off-marketplace enrollees. Insurers selling off marketplace only avoid these fees. Potential solutions include allowing insurers to vary their administrative charges for on-marketplace and off-marketplace members, with the marketplace business being charged the entire marketplace fee. Another option would be to charge the marketplace fee to all insurers operating in the market, even those operating exclusively off marketplace. This would spread the costs of the marketplace over a broader base and allow the charge to be a lower percentage of premium. Even off-marketplace-only insurers benefit from marketplace functions that increase enrollment, because they can improve the overall market's risk profile.

Prohibit off-marketplace plans

Another option that would create a level playing field is to require all insurers and plans to be offered only through the marketplace. This would prevent insurers from choosing to market only off marketplace to avoid some of the fees and additional marketplace rules and may help with some risk selection problems to the extent that risk adjustment does not fully compensate for risk differences between on- and off-marketplace plans. In general, a wider array of insurance plans is available off the marketplace than on the marketplace. Prohibiting off-marketplace plans could potentially increase the options available to enrollees receiving premium subsidies. On the other hand, insurers may choose to continue offering only the narrower set of on-marketplace options, thus reducing plan choice among individuals previously purchasing off-marketplace plans. Also, some insurers may decide not to participate in the market at all.

Continue to improve the risk adjustment program

The risk adjustment program should fairly compensate insurers for the risk of their enrollees so that insurers do not have incentives to avoid any particular type of potential enrollee. CCIIO has indicated plans to modify the risk adjustment program so that it better reflects differences in the underlying risk among participating insurers. These modifications include the incorporation of prescription drug data, the incorporation of preventive services, and better accounting for partial-year enrollees. In addition, CCIIO will begin using data collected from the ACA-compliant individual and small group markets for purposes of calculating risk scores and making risk adjustment transfers to also calibrate the

model. This will improve the model's accuracy for these markets compared to the current calibration method that uses experience from large employer plans. CCIIO is also exploring the incorporation of a high-risk enrollee pool to improve risk adjustment for extremely high-cost enrollees. The risk adjustment program should continue to be monitored. If experience suggests that the risk model systematically over- or under-compensates for certain enrollee subgroups, the model should be revised as appropriate. Except under exceptional circumstances, changes should be made on a prospective basis only. In addition, CCIIO should continue to provide and improve interim reports to help reduce uncertainty for insurers.

Conduct effective rate review

A sustainable insurance market requires that premiums be adequate but not excessive. Although much focus is often given to ensuring that rates are not too high, it is equally important that rates not be approved if they are too low. Low rates may help an insurer attract a large membership, but rates that are too low have numerous adverse consequences, including:

- **Higher risk of insurer insolvency.** Insurer insolvencies not only cause coverage disruption for enrollees, but the cost can be borne by other insurers through state guaranty funds or special assessments that increase premiums.
- **Inadequate premium subsidies.** If premium subsidies are based on the second-lowest silver tier plan with a premium that is set too low, those subsidies will be insufficient to purchase a more adequately priced plan.
- **Insufficient risk adjustment transfers.** The risk adjustment program bases transfers on market average premiums. If those averages are understated due to an insurer having rates that are too low, the risk adjustment transfers will be too low to adequately adjust for risk profile differences among insurers.

Another issue with the rate review process is the availability of insurer premiums and pricing assumptions to competing insurers. The ACA requires rate filing transparency and an opportunity to allow for consumer feedback, although the level of detail required varies by state. Because there are multiple rate filing rounds, this transparency means that rates could be publically available, even before they are approved. As a result, insurers would be able to mimic another's pricing strategy, sometimes referred to as shadow pricing. In other words, premiums can go up or down relative to initially filed rates for reasons other than the adequacy of rates. This further emphasizes the need for an effective rate review that considers not only whether premiums are excessive, but also whether they are inadequate.

Allow insurance sales across state lines

Under this option, insurers licensed to sell insurance in any particular state would be allowed to sell insurance under that state's rules in other states. The intention is to spur more competition, which could increase consumer choice, lower premiums, and improve services. For instance, an insurer could choose to follow the rules of a state with less restrictive benefit requirements in order to offer lower-cost coverage in another state. Although states currently have the ability to permit the sale of insurance across state lines, few have done so to date and no out-of-state insurers have entered the market in those states.⁶³

Health insurance is licensed and regulated primarily by state authority. Prior to the ACA, the rules regarding insurance issue, premium rating, and benefit requirements varied considerably by state. The ACA narrowed state differences in these rules by imposing more standardized requirements. Premium rate review and approvals continue to be conducted primarily at the state level, as are other consumer protections such as network adequacy requirements.

Allowing insurance licensed in one state to be sold in another would raise concerns regarding how insurers would set up local provider networks and how consumer protections would be enforced. In addition, with many of the rules currently harmonized across states, there is less ability for insurers to take advantage of differences in rules in order to lower premiums by avoiding certain requirements.

If the ACA issue, rating, and benefit requirements were relaxed and the state variation in rules returned, there would be more opportunity for insurers to take advantage of these differences. However, this could create an unlevel playing field, with plans in a single market competing under different market rules. Less-healthy individuals would purchase plans licensed in states with stricter regulations (e.g., guaranteed issue, community rating, comprehensive benefit requirements), and healthier people would purchase plans licensed in states with looser regulations. Such a result could lead to healthier people benefiting from less-expensive insurance, but those who are older and have more health issues would face higher premiums. Premiums for the plans licensed in states with stricter regulations would increase accordingly. Such a situation could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.

Include a public plan option

In order to increase plan availability and consumer choice, a public plan option could be offered as a marketplace competitor. This could be structured as a fallback option in areas with no or few participating insurers or could be offered more broadly. In order to compete on a comparable basis with private plans, a public plan would need to follow the same rules as those governing private plans and set premiums that are self-supporting. These rules could include the establishment of a premium stabilization fund that would function similarly to private plan surplus and cover any unexpected differences between plan expenditures and premiums, rather than relying on general government funds.

A public plan could provide consumers with an additional option, especially in areas with no or few other participating insurers. Nevertheless, a public plan would face the same underlying issues as private plans, such as low enrollment and sole community providers, which make it difficult for insurers to cover costs and earn a reasonable return. A public plan could potentially support lower premiums than traditional health plans, especially if such plans are able to use the federal government's clout with providers to negotiate payment rates at, or somewhat above, Medicare rates. Such an approach could lead to a more affordable coverage option, but would create an unlevel playing field relative to other competing private plans. If a public plan can achieve much lower provider payment rates than other plans, thereby allowing it to offer lower premiums, the effect could be to eliminate competition, making the public plan the sole option. In addition, there could be concerns regarding health care access if providers opt to not participate at the lower payment rates.

A variant of the public plan option is to allow older adults, (e.g., 50 or 55 and older), to buy into Medicare. There are many design considerations involved, such as whether the benefits would be structured similarly to current Medicare benefits, how the premium would be determined, and whether subsidies would be available. A Medicare buy-in could have a large impact on the individual marketplace. In 2016, 26 percent of individuals enrolling during the open enrollment period were age 55–64.⁶⁴ If a large portion of these individuals were to move to a Medicare buy-in, it could lower average premiums in the individual market. However, by reducing the size of the individual market pools, the financing of the marketplaces and the predictability of experience could be affected.

Allowing consumers a choice between the individual market and a Medicare buy-in could create opportunities for adverse selection for both markets, depending on the plan generosity and premium differences between the two options. For instance, because Medicare does not cap out-of-pocket costs, individuals with high expected health care costs could be more likely to opt for individual market coverage rather than Medicare. This selection against the individual market would at least partially offset any premium reductions resulting from a younger average enrollment age.

Offering a Medicare buy-in option would also have implications for employer coverage. Employers are concerned about health care costs for workers and covered retirees in the very age group that a Medicare buy-in program would target. Their support for early retiree coverage has already diminished in the past 25 years. A Medicare buy-in option could be seen as a potential replacement for remaining early retiree coverage, depending on benefit and premium levels. If federal premium subsidies are available for Medicare buy-in coverage, such a shift would increase the costs of federal premium subsidies.

CONCLUSION

To be sustainable, the individual market under the ACA requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings. Experience from the first three years of the ACA varies, with the markets in some states faring relatively well. More typically however, the results thus far indicate the need for improvement along most of these measures.

Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has generally been lower than expected and enrollees have been sicker than expected. Both of these factors have contributed to substantial premium increases in many, but not all, states. For the most part, competing plans face the same rules; however, some rules might be disadvantaging insurers participating in the marketplaces compared to off the marketplaces. The uncertain and changing regulatory environment, including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments, contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.

Many options have been put forward to improve the short- and long-term sustainability of the individual market, either through changes to the ACA or by replacing the ACA with a different approach. If as part of this a goal is to provide coverage to people with pre-existing conditions at standard premiums, it is vital to enroll enough healthy people to spread the costs of those who are sick. The ACA's individual mandate, annual open enrollment period, and premium subsidies aim to achieve a balanced risk profile. Increased penalties for non-enrollment could help improve the risk profile, as could improving premium affordability, for instance through increased premium subsidies or additional funding for high-risk enrollees. Weakening the incentives for participation, however, could further exacerbate adverse selection issues and lead to higher premiums and more uninsured.

Achieving a balanced enrollee risk profile, along with providing consistent rules in a timely fashion to insurers, could lead to a more stable and sustainable market. Insurer participation could increase as a result, leading to more consumer choice.

Individual market experience varies by state. The ACA's section 1332 waivers could be used by states to pursue different approaches to improving the individual market. These approaches could reflect the particular situations of each state.

Finally, it's important not to overlook the need for a continued focus on controlling health care spending. Most premium dollars go toward paying medical claims. Therefore, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires keeping health spending in check. Moderating health spending growth is a key to the sustainability of not only the individual market, but also the health care system as a whole.

Endnotes

1. American Academy of Actuaries, [*Sustainability in American Financial Security Programs*](#). June 2015.
2. Department of Health and Human Services, ASPE Issue Briefs, [*Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*](#), May 1, 2014; [*Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*](#), March 10, 2015; [*Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*](#), March 11, 2016. Figures reflect pre-effectuated enrollment—that is, the selection of a plan, with or without the first premium being paid. The open enrollment period for 2014 ran from October 1, 2013–March 31, 2014; enrollment figures cited also include additional special enrollment period activity through April 19, 2014. The open enrollment period for 2015 ran from November 15, 2014–February 15, 2015; enrollment figures cited also include additional special enrollment period activity through February 22, 2015. The open enrollment period for 2016 ran from November 1, 2015–February 1, 2016.
3. CMS, [*December 31, 2015 Effectuated Enrollment Snapshot*](#), March 11, 2016.
4. Department of Health and Human Services, ASPE Issue Brief, [*Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*](#), March 11, 2016.
5. Governor David Y. Ige, “[*News Release: State to Assist with Transition of Private Non-Profit Hawai'i Health Connector Operations*](#).” June 5, 2015.
6. Department of Health and Human Services, ASPE Issue Brief, [*Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*](#), March 11, 2016.
7. HHS, [*ASPE Data Point: About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies*](#). October 4, 2016.
8. Grandfathered plans are those already in effect when the ACA was passed in March 2010. Those plans are allowed to be renewed indefinitely as long as they do not undergo substantial changes. Transition plans are those purchased after March 2010, but prior to the ACA's marketplace requirements that went into effect in January 2014. A federal decision was made in the fall of 2013 that gave states the option to permit non-ACA-compliant coverage renewals into 2014. This was later extended to allow coverage renewals of non-ACA-compliant coverage through 2017. A majority of states opted to allow for transitional plans. See Kevin Lucia, Sabrina Corlette, and Ashley Williams, “[*The Extended “Fix” for Canceled Health Insurance Policies: Latest State Action*](#),” The Commonwealth Fund, November 21, 2014.
9. Liz Hamel, et al., [*Survey of Non-Group Health Insurance Enrollees, Wave 3*](#). Kaiser Family Foundation, May 20, 2016.
10. Congressional Budget Office, [*The Budget and Economic Outlook: 2014-2024*](#). February 2014. The CBO 2013 baseline does not include a separate line item for off-marketplace individual market enrollment estimates. However, the baseline estimates indicate that in 2016, 24 million nonelderly individuals would be enrolled in off-marketplace non-group and other coverage, where “other” includes Medicare. According to CMS, nearly 9 million nonelderly individuals were enrolled in Medicare in 2013. Depending on whether “other” coverage includes additional coverage categories, this suggests an estimated off-marketplace non-group enrollment upwards of 15 million in 2016.
11. Congressional Budget Office, [*Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*](#), March 2016.

12. Kaiser Family Foundation, [Key Facts about the Uninsured Population](#), September 2016.
13. Emily P. Zammitti, et al., [Health Insurance Coverage: Early Release Estimates from the National Health Interview Survey, January-June 2016](#). Centers for Disease Control and Prevention, November 2016.
14. Congressional Budget Office, [Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026](#), March 2016.
15. Greg Ip, “[The Unstable Economics in Obama’s Health Law](#),” *Wall Street Journal*, August 17, 2016.
16. Julie M. Donohue, et al., “[Early Marketplace Enrollees Were Older and Used More Medication Than Later Enrollees; Marketplaces Pooled Risk](#).” *Health Affairs* 34(6): 1049-1055, June 2015.
17. CCIIO, [Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool](#), August 11, 2016.
18. Zachary Goldman, John Bertko, and Jim Watkins, “[Health Risk Continues to Improve in Covered California](#),” *Health Affairs Blog*, October 26, 2015.
19. Stacey McMorrow, et al., “[Marketplaces Helped Drive Coverage Gains in 2015; Affordability Problems Remained](#).” *Health Affairs* 35 (10): 1810-1815, October 2016.
20. Rebecca Owen, [An Examination of Relative Risk in the ACA Individual Market](#), Society of Actuaries, August 2016.
21. CCIIO, [Risk Corridors Payment and Charge Amounts for Benefit Year 2014](#), November 19, 2015. CCIIO, [Risk Corridors Payment and Charge Amounts for Benefit Year 2015](#), November 18, 2016.
22. Kaiser Family Foundation, “[Marketplace Plan Selections as a Share of the Potential Marketplace Population: Timeframe November 1, 2015-February 1, 2016](#),” accessed on August 29, 2016.
23. Chris Carlson and Kurt Giesa, [Special Enrollment Periods and the Non-Group, ACA-Compliant Market](#), Oliver Wyman, February 24, 2016.
24. American Academy of Actuaries, [Drivers of 2017 Health Insurance Premium Changes](#), May 2016.
25. American Academy of Actuaries, [Insights on the ACA Risk Adjustment Program](#), April 2016.
26. CCIIO, [Risk Corridor Payment and Charge Amounts for Benefit Year 2014](#), November 19, 2015.
27. Bob Herman, “[Kentucky Co-Op Blames Inadequate Risk Corridor Funding for Closure](#),” *Modern Healthcare* October 12, 2015.
28. CCIIO, [Risk Corridors Payment and Charge Amounts for Benefit Year 2015](#), November 18, 2016.
29. Under the ACA, health insurers are required to provide cost-sharing reductions to eligible enrollees and the federal government is to reimburse insurers for these reductions. At issue in *House v. Burwell* is whether a congressional appropriation is required to make such reimbursements. If the courts ultimately rule that an appropriation is required and none is made, insurers would need to increase premiums for all plan enrollees in order to fund the cost-sharing reductions. Otherwise, financial losses could occur, potentially threatening insurer solvency. The uncertainty of whether any required appropriations would be made would itself create uncertainty and instability for insurers and premiums, potentially leading to insurers withdrawing from the market.
30. See for example, State of Connecticut Insurance Department, “[Insurance Department Places HealthyCT Under Order of Supervision](#).” July 5, 2016.
31. McKinsey; [Exchanges three years in: Market variations and factors affecting performance](#), May 13, 2016.

32. S&P Global Ratings, *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer*. December 22, 2016.
33. Cynthia Cox, Gary Claxton, and Larry Levit, [Analysis of Insurer Participation in 2016 Marketplaces](#), Kaiser Family Foundation, November 2015.
34. Paul Jacobs, Jessica Banthin, and Samuel Trachtman, “[Insurer Competition in Federally Run Marketplaces is Associated with Lower Premiums](#),” *Health Affairs* 34:12 (2027-2035), December 2015.
35. Cynthia Cox et al., [2017 Premium Changes and Insurer Participation in the Affordable Care Act’s Health Insurance Marketplaces](#), Kaiser Family Foundation, November 1, 2016.
36. Caroline F. Pearson, [2017 Open Enrollment Preview](#), Avalere, October 25, 2016.
37. Paul Jacobs, Jessica Banthin, and Samuel Trachtman, “[Insurer Competition in Federally Run Marketplaces is Associated with Lower Premiums](#),” *Health Affairs*, December 2015.
38. Too many health insurance plan choices can lead to suboptimal consumer decision making. Research suggests that 10 to 15 options can result in a sufficient range of choices and manageable decision making. See Consumers Union, [The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making](#), November 2012.
39. ASPE, [Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace](#), October 31, 2015; ASPE, [Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace](#), October 24, 2016.
40. CMS, [March 31, 2016 Effectuated Enrollment Snapshot](#), June 30, 2016.
41. McKinsey Center for U.S. Health System Reform, “[2016 Exchange Market Remains in Flux: Plan Type Trends](#).” December 2015.
42. Katherine Hempstead, [Burnt Offerings? PPOs Decline in Marketplace Plans](#), Robert Wood Johnson Foundation Issue Brief, November 3, 2015.
43. California HealthCare Foundation, [Designing Coverage: Uninsured Californians Weigh the Options](#), June 2007.
44. McKinsey Center for U.S. Health System Reform, [2016 Exchange Market Remains in Flux: Plan Type Trends](#), December 2015. McKinsey Center for U.S. Health Reform, [2017 Exchange Market: Plan Type Trends](#), as of November 3, 2016.
45. Robert Pear, “[Many Say High Deductibles Make Their Health Law Insurance All but Useless](#),” *New York Times*, November 14, 2015.
46. Harris Meyer, “[New Data Expose Mysterious World of Off-Exchange Health Plans](#),” *Modern Healthcare*, October 24, 2016.
47. Daniel Polsky, Zuleyha Cidav, and Ashley Swanson, “[Marketplace Plans with Narrow Physician Networks Feature Lower Monthly Premiums than Plans with Larger Networks](#).” *Health Affairs* 35 (10): 1842-1848, October 2016.
48. Anne B. Martin, et al., “[National Health Spending: Faster Growth in 2015 As Coverage Expands and Utilization Increases](#),” *Health Affairs* published online December 2, 2016.
49. Sean P. Keehan, et al., “[National Health Expenditure Projections, 2015–25: Economy, Prices, And Aging Expected To Shape Spending and Enrollment](#),” *Health Affairs* 35(8):1522-1531. August 2016.
50. Institute of Medicine, [Best Care at Lower Cost: The Path to Continuously Learning Health Care in America](#), September 6, 2012.
51. Institute of Medicine, [Variation in Health Care Spending: Target Decision Making, Not Geography](#), July 24, 2013.
52. Martin A. Makary and Michael Daniel, “[Medical Error—The Third Leading Cause of Death in the US](#)” *BMJ* May 3, 2016.

53. Internal Revenue Service, “[Individual Shared Responsibility Provision—Reporting and Calculating the Payment](#).” Accessed on October 31, 2016.
54. American Academy of Actuaries, [Drivers of 2015 Premium Changes](#), June 2014.
55. Evan Saltzman and Christine Eibner, “[Insuring Younger Adults through the ACA’s Marketplaces: Options to Expand Enrollment](#),” Commonwealth Fund blog post and [technical appendix](#), December 16, 2016.
56. CMS, [March 31, 2016 Effectuated Enrollment Snapshot](#). June 30, 2016.
57. CCIIO, “[Frequently Asked Questions Regarding Verification of Special Enrollment Periods](#),” September 6, 2016.
58. CCIIO, “[Pre-Enrollment Verification for Special Enrollment Periods](#),” December 12, 2016.
59. CMS, “[Promoting Transparency and Appropriate Coverage for Dialysis Patients](#),” CMS Fact Sheet, December 12, 2016.
60. Congressional Research Service, “Health Insurance: State High Risk Pools,” 2011.
61. Aditi P. Sen and Thomas DeLeire, [The Effect of Medicaid Expansion on Marketplace Premiums](#), Department of Health and Human Services, ASPE Issue Brief, September 6, 2016.
62. Employee Benefit Research Institute, [Self-Insured Health Plans: Recent Trends by Firm Size, 1996-2015](#), July 2016.
63. Sabrina Corlette, et al., [Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage](#), The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, October 2012.
64. Department of Health and Human Services, ASPE Issue Brief, [Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report](#), March 11, 2016.



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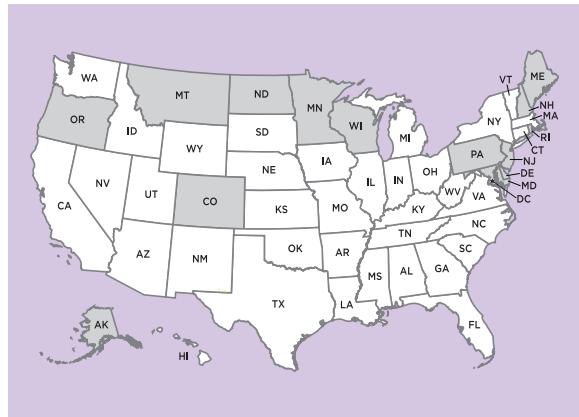
CCIO DATA BRIEF SERIES

State Innovation Waivers: State-Based Reinsurance Programs

AUGUST 2021

BACKGROUND

Section 1332 of the Affordable Care Act (ACA) permits states to apply for waivers from certain ACA requirements to pursue innovative and individualized state strategies that provide their residents with access to affordable, quality health care, subject to approval by the Department of Health and Human Services (HHS) and the Department of the Treasury (collectively, the Departments). In order for a section 1332 waiver to be approved, the Departments must determine that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as without the waiver; will provide coverage to at least a comparable number of residents as without the waiver; and will not increase the federal deficit. States were first able to apply for section 1332 waivers beginning on January 1, 2017, and to date, the Departments have app



As of Plan Year (PY) 2021, 14 states with approved section 1332 waivers operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.ⁱ

The data presented below provide an overview of the state-based reinsurance programs implemented as of PY 2021 under currently approved section 1332 waivers (referred to throughout this report as section 1332 state-based reinsurance waivers), including relevant information about premiums, issuer participation, plan offerings, and enrollment.ⁱⁱ

CURRENTLY APPROVED SECTION 1332 STATE-BASED REINSURANCE WAIVERS

Funding Sources and Program Design Elements

Tables 1 and 2 summarize state funding sources and programmatic elements for currently operating section 1332 state-based reinsurance waivers.ⁱⁱⁱ Through section 1332 waivers, states have designed and implemented different reinsurance models, including: a claims cost-based model, where issuers are reimbursed for a portion of the costs of enrollees whose claims exceed an attachment point (CO, DE, MD, MN, MT, ND, NH, NJ, OR, PA, RI, WI); a conditions-based model, where insurers are reimbursed for costs of individuals with one or more of pre-determined high-cost conditions (AK); or a hybrid conditions and claims cost-based model (ME).

ⁱ State-based reinsurance programs are distinct from the temporary federal reinsurance program that was effective for the 2014 through 2016 benefit years, the latter having been established via section 1341 of the ACA. The goal of the ACA's temporary reinsurance program was to stabilize individual market premiums during the early years of the federal market reforms that took effect beginning in 2014.

ⁱⁱ The information contained in this report does not reflect the American Rescue Plan Act of 2021, or other factors that may have led the states to update their PY 2021 parameters since submitting rate filings for the 2021 plan year (e.g., the Departments' 2021 pass-through estimates).

ⁱⁱⁱ State legislation authorizing states' funding sources are listed in the endnotes.

TABLE 1
State Funding Sources for Section 1332 State-Based Reinsurance Waivers

State	First Year of Operation Under a Waiver	State Funding Sources ^{iv}
Alaska	2018	Alaska funds the state portion of its section 1332 state-based reinsurance waiver through a separate fund called the Alaska Comprehensive Health Insurance Fund. This fund is established within Alaska's general fund and financed by the state's premium tax that applies to all lines of insurance (not just health insurers) in Alaska. ¹ Premium tax rates vary from 0.75% to 6% depending on insurer type.
Colorado	2020	Colorado funds the state portion of its section 1332 state-based reinsurance waiver through the Colorado Health Insurance Affordability Enterprise (Enterprise). The Enterprise was established under Colorado Senate Bill 20-215 in June 2020. ² The main source of funding for the Enterprise is drawn from a fee on health insurers who would otherwise be subject to the now repealed federal Health Insurance Provider Fee under Section 9010 of the ACA. For PYs 2022 and 2023 only, Colorado will administer a special assessment on hospitals. A portion of the state's health insurance premium tax revenue will also go to the Enterprise. Money from the state's general fund is available for section 1332 state-based reinsurance waiver administration only.
Delaware	2020	Delaware funds the state portion of its section 1332 state-based reinsurance waiver through an assessment on carriers and any person or entity subject to state regulation that provides either 1) products that would otherwise be subject to the federal Health Insurance Providers Fee under Section 9010 of the ACA; or 2) products subject to a state assessment. The state assessment is 2.75% of premium annually in years that the Health Insurance Providers Fee is waived, and 1% of premium annually in years that the Health Insurance Providers Fee is assessed. ³
Maine	2019	Maine funds the state portion of its section 1332 state-based reinsurance waiver through 1) a market-wide assessment (\$4 per member/per month), and 2) a ceding premium equal to 90% of premiums received from consumers for all policies ceded, whether on a mandatory or discretionary basis. ⁴
Maryland	2019	In PY 2019, Maryland funded the state portion of its section 1332 state-based reinsurance waiver through a 2.75% state assessment on certain health insurance carriers. ⁵ The assessment equals the amount carriers otherwise would have been subject to under the now-repealed federal Health Insurance Providers Fee of Section 9010 of the ACA. Maryland extended and reduced the assessment to 1% for PYs 2020-2023. ⁶
Minnesota	2018	Minnesota funds the state portion of its section 1332 state-based reinsurance waiver through its general fund and a portion of past accumulations of the state's 2% provider tax, which applies to hospitals and other providers. ⁷
Montana	2020	Montana funds the state portion of its section 1332 state-based reinsurance waiver through a 1.2% annual state assessment on major medical health insurance premiums. ⁸
New Hampshire	2021	New Hampshire funds the state portion of its section 1332 state-based reinsurance waiver through a premium assessment of 0.6% of the previous year's second lowest cost silver plan without waiver rate across all licensed health insurance issuers in the state's individual and group health insurance markets with some exceptions. ^{9,10}
New Jersey	2019	New Jersey funds the state portion of its section 1332 state-based reinsurance waiver from revenue raised by shared responsibility payments per the state individual mandate, ¹¹ and if necessary, the state general fund.
North Dakota	2020	North Dakota funds the state portion of its section 1332 state-based reinsurance waiver through a state assessment on insurers writing in the small and large group health insurance markets. North Dakota allows insurers to deduct the assessment from the state premium tax. ¹² The PY 2020 assessment on the insurers was approximately \$22M. Assessments were suspended in the third quarter of PY 2020 and the suspension is expected to continue through PY 2021.
Oregon	2018	For PYs 2018 through 2019, Oregon funded the state portion of its section 1332 state-based reinsurance waiver through a phased-in 1.5% state premium assessment levied on major medical premiums and, for PY 2018 only, Oregon also used excess fund balances held in two state programs, the Oregon Health Insurance Marketplace (OHIM) fund and the Oregon Medical Insurance Pool (OMIP) account. ¹³ Starting in PY 2020, Oregon made two changes to the assessments: 1) increased the premium assessment to 2%, and 2) expanded the assessment to apply to premiums derived from "insurance described in ORS 742.065" (stop loss insurance). ^{14,15}
Pennsylvania	2021	Pennsylvania funds the state portion of its section 1332 state-based reinsurance waiver through a portion of a user fee that is 3.0% of premiums and assessed on issuers participating in the Pennsylvania Health Insurance Exchange and other available state sources. This fee only affects individual market issuers, as there are currently no participating SHOP issuers. ¹⁶
Rhode Island	2020	Rhode Island funds the state portion of its section 1332 state-based reinsurance waiver through a state appropriation for the Health Insurance Market Integrity Fund to support operation and administration of the program, and from penalties collected from the state individual mandate. ^{17,18}
Wisconsin	2019	Wisconsin funds the state portion of its section 1332 state-based reinsurance waiver through state general purpose revenue (GPR), which consists of general taxes, miscellaneous receipts, and revenues collected by the state. The state is able to appropriate GPR for the Wisconsin Healthcare Stability Plan (WIHSP) through a sum sufficient appropriation. ¹⁹

^{iv} Unless otherwise indicated, the state funding sources presented reflect all active years to date of a given state's reinsurance program.

TABLE 2
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters
Alaska	Conditions Based	<p>Total Amount of Reinsurance Payments^v Planned*/Paid: \$60M*/\$60M (2018) \$69M* (2020) \$64.1M*/\$64.1M (2019) \$80M* (2021)</p> <p>Eligibility: For 2018 and 2019, Alaska covered all the costs of claims for one or more of 33 conditions specified in state regulation. For 2020 and 2021, Alaska expanded coverage to include an additional HCC condition to address severe COVID-19 cases.</p> <p>Cap: None, but for claims above \$1M the program pays net of amounts covered by the federal risk adjustment program high-cost risk pool (2018-2021).</p>
Colorado	Claims Cost Based	<p>Total Amount of Reinsurance Payments Planned*: \$250M* (2020) \$262M* (2021) Colorado's program specifies a three-tier structure for coinsurance rates, with targeted reduction in claim costs by rating area.</p> <p>Attachment point: \$30,000 (2020/2021) Coinurance rate: Average 60% (2020) Average 55% (2021) Cap: \$400,000 (2020/2021)</p> <p>Tiers:</p> <ul style="list-style-type: none"> • Tier 1 (Rating Areas 1, 2, 3 for Boulder, Colorado Springs, Denver): Claim costs are to be reduced by between 15% and 20%; • Tier 2 (Rating Areas 4, 6, 7, 8 for Fort Collins, Greeley, Pueblo, Eastern Plains, central southern part of state): Claim costs are to be reduced by between 20% and 25%; • Tier 3 (Rating Areas 5 and 9 for Grand Junction, Mountain Areas, Western Slope, western half of state): Claim costs are to be reduced by between 30% and 35%.
Delaware	Claims Cost Based	<p>Total Amount of Reinsurance Payments Planned*: \$26.9M* (2020) \$39.3M* (2021)</p> <p>Attachment point: \$65,000 (2020/2021) Coinurance rate: 75% (2020) 80% (2021) Cap: \$215,000 (2020) \$335,000 (2021)</p>
Maine	Hybrid (Attachment Point/Conditions Based)	<p>Total Amount of Reinsurance Payments Planned*/Paid: \$89.7M*/\$90.5M (2019) \$86M* (2021) \$81.8M* (2020)</p> <p>Eligibility: There are two types of ceding to the Maine Guaranteed Access Reinsurance Association (MGARA) for reinsurance benefits: 1) all policies covering individuals with one of eight listed high-risk health conditions are required to be ceded, and 2) any other policies may be ceded at the carrier's discretion.</p> <p>Attachment point: \$47,000 (2019) \$65,000 (2020/2021) Coinurance rate:</p> <ul style="list-style-type: none"> • 90% for \$47,000-\$77,000 (2019); \$65,000-\$95,000 (2020/2021) • 100% for >\$77,000 (2019); >\$95,000 (2020/2021) and a percentage of claims above \$1M, which are not partially covered by the high-cost risk pool under the federal risk adjustment program (2019-2021) <p>Cap: None, but for claims above \$1M the program pays net of amounts covered by the federal risk adjustment program high-cost risk pool (2019-2021)</p>

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Maryland	Claims Cost Based	Total Amount of Reinsurance Payments Planned*/Paid: \$462M*/\$352.8M (2019) \$400M* (2020) Attachment point: \$20,000 (2019-2021)	Coinsurance rate: 80% (2019-2021)	Cap: \$250,000 (2019-2021)
Minnesota	Claims Cost Based	Total Amount of Reinsurance Payments Planned*/Paid: Up to \$271M** (2018/2019) \$136.1M (2018) \$149.7M (2019) Attachment point: \$50,000 (2018-2021)	Coinsurance rate: 80% (2018-2021)	Cap: \$250,000 (2018-2021)
Montana	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$32.9M* (2020) \$39.5M* (2021) Attachment point: \$40,000 (2020/2021)	Coinsurance rate: 60% (2020/2021)	Cap: \$101,750 (2020/2021)
New Hampshire	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$45.5M* (2021) Attachment point: \$60,000 (2021)	Coinsurance rate: 74% (2021)	Cap: \$400,000 (2021)
New Jersey	Claims Cost Based	Total Amount of Reinsurance Payments Planned*/Paid: \$295M*/\$267.7M (2019) \$320M* (2020) Attachment point: \$40,000 (2019/2020) \$35,000 (2021)	Coinsurance rate: 60% (2019/2020) 50% (2021)	Cap: \$215,000 (2019/2020) \$245,000 (2021)
North Dakota	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$47.3M* (2020) \$24.7M* (2021) Attachment point: \$100,000 (2020/2021)	Coinsurance rate: 75% (2020/2021)	Cap: \$1M (2020/2021)
Oregon	Claims Cost Based	Total Amount of Reinsurance Payments Planned*/Paid: \$90M*/\$90M (2018) \$95.4M*/\$94.5M (2019) Attachment point: \$95,000 (2018) \$90,000 (2019/2020) \$83,000 (2021)	Coinsurance rate: 59.2% (2018) 50% (2019-2021)	Cap: \$1M (2018-2021)
Pennsylvania	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$133.9M* (2021) Attachment point: \$60,000 (2021)	Coinsurance rate: 60% (2021)	Cap: \$100,000 (2021)

TABLE 2, cont.
Program Design Elements of Section 1332 State-Based Reinsurance Waiver

State	Type of Reinsurance Program	Program Parameters		
Rhode Island	Claims Cost Based	Total Amount of Reinsurance Payments Planned*: \$14.7M* (2020) \$19.3M* (2021) Attachment point: \$40,000 (2020) \$30,000 (2021) Coinurance rate: 50% (2020) 50% (2021) Cap: \$97,000 (2020) \$72,000 (2021)		
Wisconsin	Claims Cost Based	Total Amount of Reinsurance Payments Planned*/Paid: \$200M*/\$174.3M (2019) \$200M* (2020/2021) Attachment point: \$50,000 (2019) \$40,000 (2020/2021) Coinurance rate: 50% (2019/2020) 48% (2021) Cap: \$250,000 (2019) \$175,000 (2020/2021)		

^v In Table 2 for **Total Amount of Reinsurance Payments**, values marked with one asterisk (*) indicate the total planned cost of the reinsurance payments for eligible claims, which is the state's estimated total reinsurance reimbursements for a given reporting year for eligible claims expected to be incurred in the individual market.

Values marked with two asterisks (**), in the case of Minnesota, indicate the maximum program size (\$271M) for PYs 2018 and 2019, such that the actual program size will fully cover reimbursements to carriers for 80% of the costs between \$50,000 and \$250,000 for individual claims. However, there is general agreement between the state's model and carriers' models that an approximate 20% reduction in premiums is the result of the state's program parameters (i.e., attachment point, coinsurance rate, and cap), which are the most relevant information the carriers need and use to develop rates.

Values without any asterisks indicate the total actual amount paid out by the state for reinsurance payments in the individual market for a given reporting year where known. The final total amount paid out by the state for a given reporting year is typically available in the following PY. Furthermore, the total actual amount does not include the expected operational costs associated with running the state-based reinsurance program.

The average premium reduction rates in the with waiver scenario compared to the without waiver scenario for a given PY (as seen in Table 3) reflect the total planned cost of the reinsurance payments for eligible claims. Note that the total planned costs for PYs 2020 and 2021 do not yet reflect potential cost changes due to COVID-19 or the American Rescue Plan Act of 2021. States may update their program budgets and payment parameters as more claims and enrollment data are received.

Premiums

Table 3 presents the actual impact of the section 1332 state-based reinsurance waiver on statewide average premiums each year of the waiver's operation compared to the estimated impact on statewide average premiums in the first year of the waiver (i.e., as estimated in the original state waiver application). From PYs 2018 to 2021, states that have implemented section 1332 state-based reinsurance waivers for the individual market have reduced statewide average second-lowest-cost silver plan premiums by a range of 3.75% to 41.17% relative to premiums absent the waiver, as shown in Table 3.

TABLE 3
Statewide Average Premium Impact of Section 1332 State-Based Reinsurance Waivers^{vi}

State	First Year of Operation Under a Waiver	Estimated Statewide Average Premium Reduction in First Year of Waiver ^{vii}	Actual Statewide Premium Reduction from Waiver Compared to No Waiver ^{viii}			
			2018	2019	2020	2021
Alaska	2018	Up to a 20% reduction	30.18%	33.95%	37.12%	41.17%
Minnesota	2018	Up to a 20% reduction	16.78%	20.16%	21.29%	21.31%
Oregon	2018	Up to a 7.5% reduction	7.15%	6.71%	8.00%	8.05%
Maine	2019	Up to a 9% reduction		13.86%	7.24%	9.11%
Maryland	2019	Up to a 30% reduction		39.63%	35.83%	34.0%
New Jersey	2019	Up to a 15% reduction		15.49%	16.93%	16.02%
Wisconsin	2019	Up to an 11% reduction		9.92%	11.04%	13.04%
Colorado	2020	Up to a 16% reduction			22.44%	18.47%
Delaware	2020	Up to a 20% reduction ^{ix}			13.78%	15.80%
Montana	2020	Up to an 8% reduction			8.89%	9.38%
North Dakota	2020	Up to a 20% reduction			20.03%	12.14%
Rhode Island	2020	Up to a 5.9% reduction			3.75%	6.40%
Pennsylvania	2021	Up to a 4.6% reduction				4.92%
New Hampshire	2021	Up to a 16% reduction				13.90%
Overall State Average Premium Reduction Among States with Approved Section 1332 State-Based Reinsurance Waivers^x			12.73%	17.84%	17.65%	14.13%

^{vi} The statewide average premium is an average of premiums among rating areas in the state, with each rating area given an equal weight. Enrollment data by rating area are unavailable.

^{vii} The estimated statewide average premium reduction for the first year of the waiver is provided by each state as part of its waiver application.

^{viii} The actual statewide average premium reductions are calculated using per person per month premium information submitted by each state for pass-through calculations pertaining to each year of the approved waiver. Consistent with the specific terms and conditions of its waiver, each state provides to the Departments: (1) the final second lowest cost silver plan (SLCSP) rates for a representative individual (e.g., a 21-year-old nonsmoker) in each rating area with the approved waiver; and (2) the state's estimate of what the final SLCSP rates for a representative individual in each rating area would have been absent approval of the waiver for each year of the approved waiver.

^{ix} Delaware estimated a 13%-20% average premium reduction, depending on the level of funding expected to be available for each plan year, plus any additional assumed morbidity improvement, as explained in its application.

^x Overall average premium reduction uses 2018 risk adjustment premium to weight each state's premium reduction and estimate an overall premium reduction across states with approved section 1332 state-based reinsurance waivers.

Issuer Participation

Table 4 shows changes in individual market Exchange issuer participation among states with section 1332 state-based reinsurance waivers. Figures 1 and 2 illustrate the change in individual market Exchange issuer participation in these states comparing PYs 2017 (before any reinsurance waivers were operational)^{xii} and 2021 on national maps. Table 5 presents a summary of the percentage of enrollees with access to 1, 2, or 3+ individual market Exchange issuers in states with operational section 1332 state-based reinsurance waivers, compared to the percentage of individual market Exchange enrollees in all states across the U.S.

TABLE 4
Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xiii}

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Alaska	2018	1	1	1	2 [^] Re-entry: Moda	2
Minnesota	2018	4	4	4	4	5 [^] Entry: Quartz Health Solutions
Oregon	2018	6	5 Exit: ATRIO Health Plans	5	5	6 [^] Entry: Cambia Health Solutions (additional HIOS ID)
Maine	2019	3	2 Exit: Anthem	3 [^] Re-entry: Anthem	3	3
Maryland ^{xiv}	2019	3	2 Exit: Cigna	2	2	3 [^] Re-entry: UnitedHealth Group
New Jersey	2019	3	4 [^] Entry: Mulberry Health (Oscar)	4	4	4
Wisconsin	2019	15	11 Exits: Anthem, Franciscan Health Solutions, Gundersen Health System, Molina Healthcare	12 [^] Re-entry: Molina	13 [^] Re-entry: WPS Health Plan, Inc.	14 [^] Re-entry: Anthem
Colorado	2020	7	7	7	8 [^] Entry: Oscar Health	8
Delaware	2020	3	1 Exits: Aetna (two separate HIOS IDs)	1	1	1
Montana	2020	3	3	3	3	3
North Dakota	2020	3	2 Exit: Medica	3 [^] Re-entry: Medica	3	3
Rhode Island	2020	2	2	2	2	2

TABLE 4, cont.
Individual Market Issuer Exchange Participation in States with
Section 1332 State-Based Reinsurance Waivers^{xii}

State	First Year of Operation Under a Waiver	On-Exchange, Individual Market Issuer Participation ^{xiii}				
		2017	2018	2019	2020	2021
Pennsylvania	2021	8	9 [^] Entry: Highmark (additional HIOS ID)	11 [^] Entry: Centene Re-entry: Geisinger Health (additional HIOS ID)	12 [^] Entry: Mulberry Health (Oscar)	12
New Hampshire	2021	4	3 Exit: Minuteman Health	3	3	3

TABLE 5
Percent of Enrollees with Access to 1, 2, 3+ Individual Market Exchange Issuers,
Compared to Overall U.S.^{xv}

Section 1332 State-Based Reinsurance Waiver States	1 Issuer		2 Issuers		3+ Issuers	
	2020	2021	2020	2021	2020	2021
	4%	3%	14%	9%	82%	88%
Overall U.S.	9%	3%	18%	15%	73%	82%

^{xii} Note that Alaska began operating a state reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xiii} For states with a Federally-facilitated Exchange (FFE), CMS issuer counts are based upon the number of unique Health Insurance Oversight System (HIOS) IDs. Issuers represent the organization within an insurance company that is responsible for insurance offerings in a given state. Registering an entity as an Issuer within HIOS will generate a unique Issuer ID. FFE 2021 data reflected in this table are point in time as of October 2, 2020. State-Based Exchange (SBE) 2021 data reflected in this table are self-reported from the Exchanges to CMS. These data are point in time as of October 30, 2020 for the following 1332 waiver states: Colorado, Maryland, Minnesota, New Jersey, and Rhode Island, and August 30, 2020 for Pennsylvania. Note that New Jersey and Pennsylvania transitioned from FFEs to SBEs in PY 2021. Issuers offering partial county coverage are considered participating in a county and are included in the total number of issuers in a county. Issuers that partially cover counties do not cover every zip code in the county.

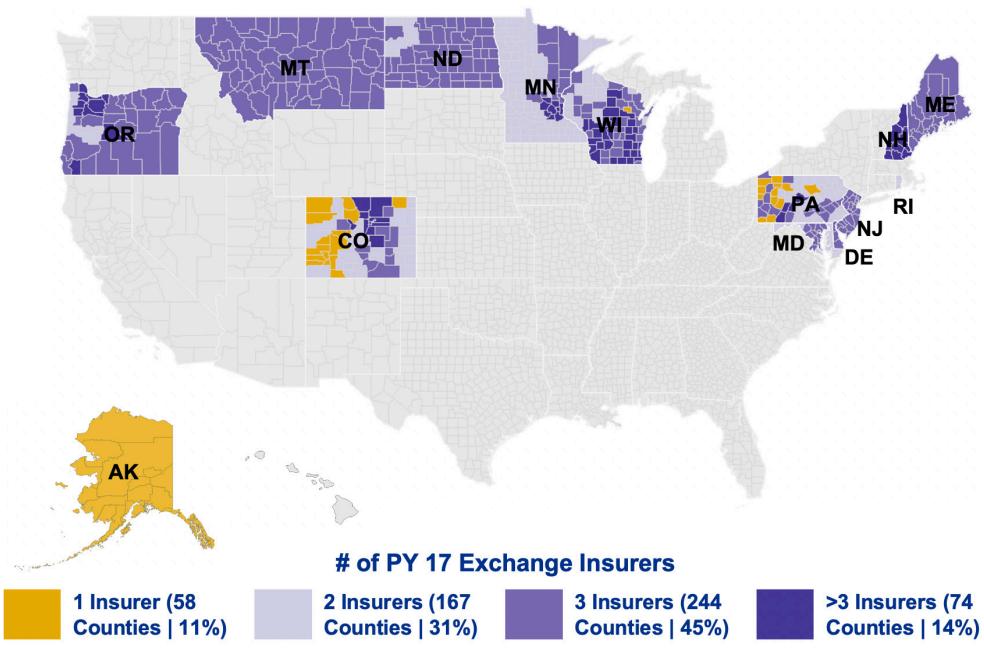
^{xiv} ^Denotes a new issuer participating (entry or re-entry) in the individual market from the previous year.

^{xv} To ensure that the total counts of issuers within a state or county are consistent with SBE reporting BlueChoice (HIOS 28137), CFMI (HIOS 45532), and GHMSI (HIOS 94084) in Maryland have been aggregated to the parent company level (CareFirst BlueCross BlueShield).

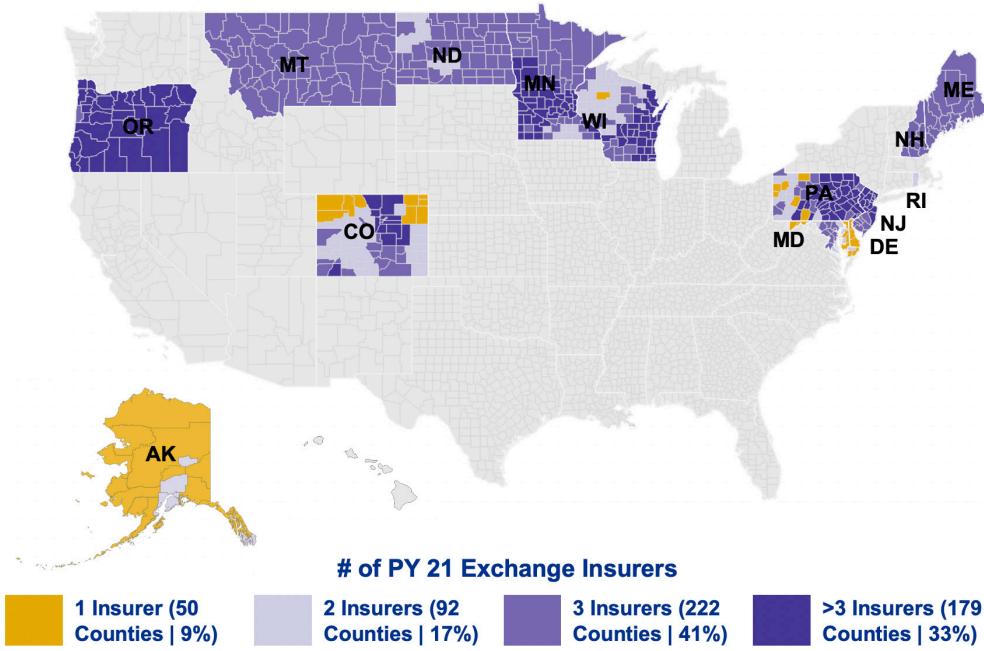
^{xvi} Methodology note for Table 5: The number of issuers in each county was counted and weighted by the county enrollment. That weighted issuer count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate national trends, Los Angeles County, California has two rating areas where issuers could possibly participate on the State's Exchange in the individual market. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for purposes of these calculations.

FIGURES 1 and 2
**Individual Market Issuer Participation on the Exchanges in States with
 Section 1332 State-Based Reinsurance Waivers^{xvi}**

2017



2021



^{xvi} For illustrative purposes, PY 2017 is provided as a comparison year to PY 2021 because section 1332 waivers were not yet operational in PY 2017, and the first waivers went into effect in PY 2018. Note that for some states, issuers exited the state's individual marketplace prior to the state's implementation of a section 1332 state-based reinsurance waiver, and some states' waivers began operating as recently as PY 2021. For each state's first year of operation and issuer count across PYs 2017 through 2021, please refer to Table 4 above.

Plan Offerings

Table 6 shows the average number of qualified health plans (QHPs) by metal level per county, weighted by enrollment in states with section 1332 state-based reinsurance waivers. Table 7 summarizes the average number of QHPs weighted by enrollment available in states with section 1332 state-based reinsurance waivers, compared to the average number of QHPs available in all states across the U.S.

TABLE 6
Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
AK	2018	All	5	5	7.7	8.3	0	2.7	0.6	3.3
		Bronze	2	2	3.4	3.6	0	1.4	0.2	1.6
		Silver	2	2	2.7	2.8	0	0.7	0.1	0.8
		Gold	1	1	1.7	1.8	0	0.7	0.1	0.8
		Platinum	0	0	0	0	0	0	0	0
CO	2020	All	N/A	39	47.2	60.8	N/A	8.2	13.6	N/A
		Bronze	N/A	14.6	17.8	24.1	N/A	3.2	6.3	N/A
		Silver	N/A	15.7	20.2	25.6	N/A	4.5	5.4	N/A
		Gold	N/A	8.7	9.2	11.1	N/A	0.5	1.9	N/A
		Platinum	N/A	0	0	0	N/A	0	0	N/A
DE	2020	All	6	7	8	11	1	1	3	5
		Bronze	2	2	3	3	0	1	0	1
		Silver	3	3	2	3	0	-1	1	0
		Gold	1	1	2	3	0	1	1	2
		Platinum	0	1	1	2	1	0	1	2
MD	2019	All	15.5	13.6	16.6	25.4	-1.9	3	8.8	9.9
		Bronze	4.6	3.7	5.7	8.3	-0.9	2	2.6	3.7
		Silver	5.4	4.5	4.5	8.1	-0.9	0	3.6	2.7
		Gold	4.6	4.5	5.5	8.2	-0.1	1	2.7	3.6
		Platinum	0.9	0.8	0.8	0.9	-0.1	0	0.1	0
ME	2019	All	15.2	25.5	29.2	31	10.3	3.7	1.8	15.8
		Bronze	6	10	12	13	4	2	1	7
		Silver	7.2	12.5	14.2	14.2	5.3	1.7	0	7
		Gold	2	3	3	3.7	1	0	0.7	1.7
		Platinum	0	0	0	0	0	0	0	0
MN	2018	All	N/A	N/A	28.1	44.7	N/A	N/A	16.6	N/A
		Bronze	N/A	N/A	12.5	17.6	N/A	N/A	5.1	N/A
		Silver	N/A	N/A	10.2	18.5	N/A	N/A	8.3	N/A
		Gold	N/A	N/A	5.3	8.5	N/A	N/A	3.2	N/A
		Platinum	N/A	N/A	0	0	N/A	N/A	0	N/A

TABLE 6, cont.
Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
MT	2020	All	15.8	17.8	20.9	20.9	2	3.1	0	5.1
		Bronze	7.5	8.5	9.3	9.3	1	0.8	0	1.8
		Silver	4.7	5.7	7.3	7.3	1	1.6	0	2.6
		Gold	3.7	3.7	4.3	4.3	0	0.6	0	0.6
		Platinum	0	0	0	0	0	0	0	0
ND	2020	All	8.2	20.6	20.7	21.9	12.4	0.1	1.2	13.7
		Bronze	2.6	9.3	9.3	9.9	6.7	0	0.6	7.3
		Silver	3.2	7	7.1	6.9	3.8	0.1	-0.2	3.7
		Gold	2.3	4.3	4.3	5.1	2	0	0.8	2.8
		Platinum	0	0	0	0	0	0	0	0
NH	2021	All	13.7	14.8	23.4	32.4	1.1	8.6	9	18.7
		Bronze	3	4	9.8	10.8	1	5.8	1	7.8
		Silver	7.9	7.9	10.7	16.6	0	2.8	5.9	8.7
		Gold	2.9	2.9	2.9	4.9	0	0	2	2
		Platinum	0	0	0	0	0	0	0	0
NJ	2019	All	18.6	19.4	20.4	23.4	0.8	1	3	4.8
		Bronze	4.5	4.5	4.5	6.6	0	0	2.1	2.1
		Silver	10.3	10.3	11.3	12.2	0	1	0.9	1.9
		Gold	3.8	4.6	4.6	4.7	0.8	0	0.1	0.9
		Platinum	0	0	0	0	0	0	0	0
OR	2018	All	20.5	25.5	30.4	49.1	5	4.9	18.7	28.6
		Bronze	7	9.8	12.1	20.3	2.8	2.3	8.2	13.3
		Silver	7.2	8.6	10.1	16.3	1.4	1.5	6.2	9.1
		Gold	6.2	7.1	8.2	12.5	0.9	1.1	4.3	6.3
		Platinum	0	0	0	0	0	0	0	0
PA	2021	All	13.5	16.1	26.3	34.7	2.6	10.2	8.4	21.2
		Bronze	3	3.9	8.3	10.5	0.9	4.4	2.2	7.5
		Silver	5.4	6.7	10.7	15.1	1.3	4	4.4	9.7
		Gold	3.7	4	6.5	9	0.3	2.5	2.5	5.3
		Platinum	1.4	1.4	0.7	0	0	-0.7	-0.7	-1.4

TABLE 6, cont.
Average Number of QHPs per County Weighted by Enrollment in States with
Section 1332 State-Based Reinsurance Waivers^{xvii}

State	First Year of Operation Under a Waiver	Metal Level	PY18	PY19	PY20	PY21	PY18-PY19 Change (count)	PY19-PY20 Change (count)	PY20-PY21 Change (count)	PY18-PY21 Change (count)
RI	2020	All	18	18	19	20	0	1	1	2
		Bronze	4	4	4	4	0	0	0	0
		Silver	7	7	7	7	0	0	0	0
		Gold	7	7	7	7	0	0	0	0
		Platinum	0	0	1	2	0	1	1	2
WI	2019	All	31.2	27.6	35.4	49.7	-3.6	7.8	14.3	18.5
		Bronze	9.4	9.2	12.8	19.9	-0.2	3.6	7.1	10.5
		Silver	12.6	11.3	13.8	18.8	-1.3	2.5	5	6.2
		Gold	8.2	6.6	8.3	10.5	-1.6	1.7	2.2	2.3
		Platinum	1.1	0.5	0.5	0.5	-0.6	0	0	-0.6

TABLE 7
Average Number of QHPs Weighted by Enrollment Available in States with Section 1332 State-Based Reinsurance Waivers Compared to Overall U.S.^{xviii}

Section 1332 State-Based Reinsurance Waiver States	Bronze		Silver		Gold		Platinum		TOTAL	
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
	10.0	13.2	11.3	15.0	6.3	8.2	0.2	0.2	27.8	36.6
Overall U.S.	12.3	19.3	15.0	22.9	7.0	9.1	2.2	2.3	36.6	53.6

^{xvii} Methodology note for Table 6: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Data only reflects states with operational section 1332 state-based reinsurance waivers for that year, with some exceptions where state data was unavailable. Data are only available going back to 2018, and data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019, so their values are set to N/A for those years). Highlighted cells indicate years when a state's section 1332 state-based reinsurance waiver is operational.

^{xviii} Methodology note for Table 7: The number of plans in each county and metal level was counted and weighted by the county enrollment. That weighted plan count was then divided by the total enrollment. Because data for SBE states are not available for all years (i.e., data are not available for Colorado for 2018 and not available for Minnesota for 2018 and 2019), only PYs 2020 and 2021 are shown, which account for all states with operational section 1332 state-based reinsurance waivers for those particular years. To calculate the national trends, Los Angeles County, California has two ratings areas where issuers could possibly offer a different number of plans. Since Los Angeles County has a very large number of enrollees, the two rating areas in the county are treated as separated counties for the purposes of these calculations.

Enrollment

Table 8 displays individual market enrollment both on and off-Exchange for states that began implementing section 1332 state-based reinsurance waivers in PYs 2018 and 2019.

TABLE 8
Individual Health Insurance Market Subsidized^{xxix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment
Alaska ^{xxi}	2018	Total	17,596	15,898	16,761	16,533
		Percent Change ^{xxii}		-10%	+5%	-1%
		Subsidized	14,065	13,442	14,125	13,254
		Percent Change		-4%	+5%	-6%
		Unsubsidized	3,531	2,456	2,636	3,279
		Percent Change		-30%	+7%	24%
Minnesota	2018	Total	240,312	155,471	148,943	150,950
		Percent Change		-35%	-4%	1%
		Subsidized	42,631	61,932	62,832	59,219
		Percent Change		+45%	+1%	-6%
		Unsubsidized	197,681	92,539	86,111	91,731
		Percent Change		-53%	-7%	7%
Oregon	2018	Total	224,670	210,384	190,899	177,715
		Percent Change		-6%	-9%	-7%
		Subsidized	87,436	95,919	98,489	95,106
		Percent Change		+10%	+3%	-3%
		Unsubsidized	137,234	114,465	92,410	82,609
		Percent Change		-17%	-19%	-11%
Maine	2019	Total	82,158	77,897	72,801	67,260
		Percent Change		-5%	-7%	-8%
		Subsidized	63,402	57,984	57,883	52,589
		Percent Change		-9%	-0.2%	-9%
		Unsubsidized	18,756	19,913	14,918	14,671
		Percent Change		6%	-25%	-2%
Maryland	2019	Total	255,560	227,207	193,227	191,824
		Percent Change		-11%	-15%	-1%
		Subsidized	95,084	98,261	110,632	114,189
		Percent Change		3%	13%	3%
		Unsubsidized	160,476	128,946	82,595	77,635
		Percent Change		-20%	-36%	-6%

TABLE 8, cont.
Individual Health Insurance Market Subsidized^{xxix} and Unsubsidized Average Monthly Enrollment for Select States with Section 1332 State-Based Reinsurance Waivers, Compared to Overall U.S.^{xx}

State	First Year of Operation Under a Waiver	Individual Market Enrollment	2016 Individual Market Average Monthly Enrollment	2017 Individual Market Average Monthly Enrollment	2018 Individual Market Average Monthly Enrollment	2019 Individual Market Average Monthly Enrollment	
New Jersey	2019	Total	336,605	342,903	312,923	303,808	
		Percent Change		2%	-9%	-3%	
		Subsidized	186,444	185,258	178,312	162,892	
		Percent Change		-1%	-4%	-9%	
		Unsubsidized	150,161	157,645	134,611	140,916	
		Percent Change		5%	-15%	5%	
Wisconsin	2019	Total	246,712	299,302	206,934	197,421	
		Percent Change		-7%	-10%	-5%	
		Subsidized	174,641	166,310	164,999	157,413	
		Percent Change		-5%	-1%	-5%	
		Unsubsidized	72,071	62,992	41,935	40,008	
		Percent Change		-13%	-33%	-5%	
Total U.S. ^{xxiii}		Total	14,517,542	13,018,351	12,128,447	11,718,848	
		Percent Change		-10%	-7%	-3%	
		Subsidized	8,248,839	8,025,959	8,356,247	8,272,321	
		Percent Change		-3%	+4%	-1%	
		Unsubsidized	6,268,703	4,992,392	3,772,200	3,446,527	
		Percent Change		-20%	-24%	-9%	

^{xxix}Subsidized and unsubsidized in terms of eligibility for Advance Payments of the Premium Tax Credit (APTC).

^{xx} Enrollment data for 2016, 2017, 2018, and 2019 sourced from: Trends in Subsidized and Unsubsidized Enrollment October 9, 2020. Data includes average monthly enrollment in the ACA individual market (on and off-Exchange), and does not include enrollment in grandfathered or transitional (“grandmothered”) plans. Available online at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf>.

^{xxi} Alaska began operating its reinsurance program in 2017, prior to the first year of its approved section 1332 state-based reinsurance waiver.

^{xxii} Percent changes in enrollment are for 2016 to 2017, 2017 to 2018, and 2018 to 2019.

^{xxiii} Total U.S. enrollment excludes data on plans from Massachusetts and Vermont, because both states have merged their individual and small group markets.

TABLE 1 ENDNOTES:
Legislation Authorizing State Funding Sources for States
with Section 1332 State-Based Reinsurance Waivers

Alaska

¹SB 165 was signed into law on June 29, 2018. (Chapter 46 SLA 18). Available online at
<http://www.akleg.gov/basis/Bill/Detail/30?Root=SB%20165>

Colorado

²SB20-215 was signed into law on June 30, 2020. Available online at
https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf

Delaware

³HB 193 was signed into law on June 20, 2019. Available online at <http://legis.delaware.gov/BillDetail/47632>

Maine

⁴SP 221 LD 659 was signed into law on June 2, 2017. Available online at
<https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0221&item=3&snum=128>

Maryland

⁵SB 387 was signed into law on April 10, 2018. Available online at
https://www.marylandhbe.com/wp-content/uploads/2018/04/Ch_38_sb0387E.pdf

⁶HB 258 was signed into law on May 25, 2019. Available online at
http://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_597_hb0258t.pdf

Minnesota

⁷HF No.5 was signed into law on April 3, 2017. Available online at
https://www.revisor.mn.gov/bills/text.php?number=HF5&version=0&session=ls90&session_year=2017&session_number=0&type=ccr&format=pdf

Montana

⁸SB 125 was signed into law on April 30, 2019. Available online at
<https://leg.mt.gov/bills/2019/BillPdf/SB0125.pdf>

New Hampshire

⁹HB 4 (Chartered Law 346 of 2019) was signed into law on October 2, 2019. Available online at
http://gencourt.state.nh.us/bill_status/billText.aspx?id=1336&txtFormat=html&sy=2019

¹⁰RSA 404-G:3. Available online at <http://www.gencourt.state.nh.us/rsa/html/xxxvii/404-g/404-g-mrg.htm>

New Jersey

¹¹A3380 was signed into law on May 30, 2018. Available online at
https://www.njleg.state.nj.us/2018/Bills/A3500/3380_R1.PDF

North Dakota

¹²HB 1106 was signed into law on April 18, 2019. Available online at
<https://www.legis.nd.gov/assembly/66-2019/documents/19-8068-05000.pdf>

Oregon

¹³HB 2391 was signed into law on July 5, 2017. Available online at
<https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/HB2391>

¹⁴Oregon Revised Statutes, 743B.800 (2019). Available online at
https://www.oregonlegislature.gov/bills_laws/ors/ors743b.html

¹⁵HB 2010 was signed into law on March 13, 2019. Available online at
<https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB2010/Enrolled>

Pennsylvania

¹⁶ Act 42 was signed into law on July 2, 2019. Available online at

<https://www.insurance.pa.gov/Documents/Act%2042%20Codified.pdf>

Rhode Island

¹⁷ S 2934 was signed into law on July 3, 2018. Available online at

<http://webserver.rilin.state.ri.us/BillText/BillText18/SenateText18/S2934A.pdf>

¹⁸ H 8351 was signed into law on July 3, 2018. Available online at

<http://webserver.rilin.state.ri.us/BillText/BillText18/HouseText18/H8351.pdf>

Wisconsin

¹⁹ 2017 Wisconsin Act 138 was signed into law on February 27, 2018. Available online at

<https://docs.legis.wisconsin.gov/2017/related/acts/138>