

More than 20 million individuals have gained health care coverage over the past several years. Yet, it is unclear whether these gains will be maintained given uncertainty in the individual health insurance market.

The American Hospital Association (AHA) urges Congress, the Administration and the states to take action to:

1. Stabilize and strengthen the Health Insurance Marketplaces; and
2. Provide coverage in instances of marketplace failure.

Stabilizing & Strengthening the Individual Health Insurance Marketplace

More than 10 million Americans rely on the Health Insurance Marketplaces for health coverage. While all marketplaces will have at least one plan selling in 2018, some markets are not yet stable, with volatility in health plan participation and double-digit premium increases. A number of factors have contributed to this instability. In some cases, demographic factors, such as a small population base and disproportionately unhealthy population, can make a market unattractive to health plans. The federal and state regulatory structure also plays a critical role. Uncertainty regarding federal payments for the cost-sharing reduction (CSR) subsidies led to both health plan exits and higher premiums for the plans sold in 2018. The repeal of the individual mandate in 2019 is expected to lead to additional plan exits and even higher premiums in the future. Other policy challenges include issues related to appropriate reimbursement, particularly as they relate to the reinsurance and risk-adjustment programs.

The AHA is committed to protecting this vital source of coverage, and we urge Congress, the Administration and states to take the following steps to stabilize the marketplaces and ensure coverage remains available in instances of marketplace failure.

- **Fund the Cost-sharing Reduction (CSRs) Subsidies.** The Administration's choice to stop funding for the mandatory cost-sharing subsidies has resulted in higher premiums as insurers recoup the value of the CSRs by increasing premiums. This policy particularly hurts individuals who do not receive subsidies and who bear the full cost of coverage. We urge Congress to fund this critical program, enabling insurers to reduce premiums.
- **Create a Federal Reinsurance Program.** Reinsurance is a proven way to protect plans from high-cost claims. The temporary reinsurance program that was in place for the initial three years of the marketplaces and the recent Alaska reinsurance program approved by the Administration demonstrate that such a program helps attract insurer participation and achieves affordable rates by spreading the costs of expensive claims. We urge Congress to reinstitute this program or a similar one. As an alternative, we encourage the Centers for Medicare & Medicaid Services (CMS) to continue working with states to develop and finance state-level reinsurance programs, such as Alaska's recently approved 1332 waiver.
- **Continue Evaluation and Refinement of the Risk-adjustment Program.** The risk-adjustment program is an important tool to ensure appropriate reimbursement for health plans. We are concerned, however, that the program may unintentionally harm smaller and newer insurers. Volatility in risk-adjustment payments disincentivizes these insurers from entering and staying in the individual and small group markets, therefore reducing consumer choice and competition. We encourage CMS to continue analysis of the risk adjustment model to determine if modifications are necessary to ensure fair treatment of insurers.

- Discourage Noncompliant Health Plans.** The existence of non-ACA compliant health plans, such as transitional health plans, association health plans, and short-term limited duration health plans draws healthy individuals away from the marketplace risk pools, resulting in higher cost plans for those who remain. These types of plans do not need to include the consumer protections established under the ACA – such as prohibitions against medical underwriting and pre-existing condition exclusions, and the essential health benefit coverage – so are less expensive for healthy individuals than marketplace plans. However, these are the individuals who, if included, would help stabilize the marketplaces by reducing the cost of coverage, thus, making the marketplace more appealing to both consumers and insurers. For example, the Kaiser Family Foundation found that, in 2015, the average risk score of the marketplace population was significantly higher – 8 percent – in states that both allowed transitional health plans to continue and opted not to expand Medicaid, as compared to states that disallowed such plans and expanded Medicaid. We urge CMS to require that all individuals in noncompliant coverage transition to ACA-compliant coverage in 2019 and to more fully consider the implications to the marketplace risk pools before finalizing guidance on association health plans or short-term limited duration health plans. In addition, we encourage states to disallow the sale of transitional plans in their markets and regulate the sale of short-term health plans and, to the extent possible, association health plans.
- Expand Federal Outreach and Enrollment Efforts.** Enrollment in coverage is a multi-step process that includes awareness that coverage options exist, determination of eligibility for coverage and subsidies, and plan selection/enrollment. Currently, many consumers rely on navigators, agents and brokers, and other assisters to assess their coverage options and apply for coverage. Given the amount of uncertainty this year around the future of the marketplaces and the shortened open enrollment period, we urge CMS to devote more resources to federal outreach efforts and enrollment support.
- Support State-level Approaches to Marketplace Stabilization.** A number of states are exploring ways to stabilize their marketplaces, including through implementing state-level reinsurance programs (Alaska, Minnesota, Oklahoma, Oregon and Iowa), requiring or incentivizing insurers participating in the state’s Medicaid managed care program to also sell a minimum number of products on the marketplace (Nevada and New York), and enrolling Medicaid expansion populations in the marketplace to increase enrollment (Arkansas and New Hampshire). We are encouraged that CMS reiterated its support of states exploring innovative approaches in a March 2017 letter to governors. We urge the agency to prioritize review of state applications for innovative solutions and encourage it to develop templates for common approaches that will help reduce states’ burden associated with the application process.

Why This Matters

- Insurance coverage is critical to ensuring patient access to health care.** The uninsured are less likely to seek needed care and delays in accessing care can exacerbate medical conditions and further drive up the cost of treatment. The uninsured also are at greater risk of facing unforeseen medical bills, which can have significant negative financial and emotional implications.
- Uninsurance and underinsurance undermine efforts to improve population health.** Health insurance coverage facilitates patient access to preventive services, care coordination services, and other medical and social resources in the community.
- The Health Insurance Marketplaces are a major source of coverage for lower-income Americans.** More than 11 million consumers are enrolled in marketplace plans. The vast majority of enrollees do not have another source of affordable, comprehensive coverage.

- **Competition drives down premium rates and facilitates consumer choice.** Robust enrollment stimulates health plan competition based on quality and cost, which in turn attracts consumers to the market.

Providing Coverage in Instances of Marketplace Failure

Both the federal and state governments should develop alternative coverage options – or “fallback plans” – to ensure that individuals have access to coverage in instances of marketplace failure, meaning if no insurer were to offer coverage in a county or rating area of a state. Each option below varies in its level of complexity to implement, the stability challenges it can help address, and how it may impact hospitals and health systems. The AHA developed a [white paper](#) with Manatt Health that provides more details and analyses of each state-level option presented below.

- **Federal Fallback Plan Options.** The federal government operates several health insurance programs that have provider networks in every market (traditional fee-for-service Medicare and the Federal Employee Health Benefits Program or “FEHBP”) or nearly every market (Medicare Advantage). The federal government could permit individuals without coverage options to buy into a private plan sold through either the FEHBP or Medicare Advantage programs or allow for enrollment directly into fee-for-service Medicare. If pursued, we encourage Congress and the Administration to first evaluate using the FEHBP, given that the marketplace population more closely resembles the FEHBP population than the Medicare population. The government would need to modify program eligibility rules, as well as permit consumers to put the value of their ACA subsidies toward the cost of coverage.
- **State Fallback Plan Options.** States have several options to ensure coverage is available to consumers in the event of marketplace failure. In most instances, a state would need to seek a federal waiver to modify program rules, such as eligibility criteria and benefit packages, and direct the value of the ACA subsidies toward another source of coverage. The different options would be more or less appropriate for a specific state depending on the available resources and existing health system infrastructure, as well as the political and cultural environment.
 - **Buy-in Programs.** One option for certain states is to allow consumers to buy into an existing state level coverage program. For example, several states (Nevada and Hawaii) have explored allowing consumers to buy into the Medicaid program. Another option is to allow consumers to buy into the state employee health benefit program. States could allow consumers to use a variety of sources of funding to purchase this coverage, including their own funds, employer contributions and, if eligible, their marketplace subsidies.
 - **Leveraging Medicaid.** An option for certain states may be to apply for a federal waiver to expand Medicaid eligibility on a temporary or permanent basis to cover individuals living in bare counties.
 - **State Buy-in to D.C. Marketplace (or other State-based Marketplace).** Health plans selling in the D.C. marketplace are required to have a national provider network for their small group health plans in order to ensure that federal employees who enroll through the marketplace have access to coverage no matter where they live. It may be possible to leverage those health plans to also sell individual coverage through their networks in another state. In order to do this, the state with a bare market would contract with D.C.’s marketplace to offer individual products in those areas. States may find that another marketplace besides D.C.’s has insurers that also could provide coverage in their bare markets and may opt to contract with that state instead.

- **Implement a Basic Health Plan (BHP).** Federal law allows states to access 95 percent of the value of the marketplace premium tax credits and cost-sharing subsidies to provide alternative coverage to eligible individuals through a state health program. Under current law, states may establish a BHP for individuals with incomes up to 200 percent of poverty who do not qualify for Medicaid. To date, two states (New York and Minnesota) have implemented a “Basic Health Plan.” States with bare counties or volatile markets may implement a BHP as an alternative to marketplace coverage and seek federal approval to increase the eligibility level above 200 percent of poverty to cover marketplace consumers who otherwise would not be able to access their subsidies.
- **New State Insurance Product.** States could design a new insurance product to be offered on the individual market, potentially working with existing Medicaid managed care plans to develop and sell the product. States would not necessarily need federal approval as the new health plan could be designed to meet the ACA requirements and be sold on the marketplace.
- **High-risk Pool.** If a state has a high-risk pool, it could use that infrastructure to provide coverage to marketplace consumers in bare counties. However, states are unlikely to benefit from establishing a high-risk pool solely to address bare counties given the complexity and cost associated with operating them.

Key Marketplace Facts

- **Marketplace enrollment remained relatively stable in 2018, despite the uncertainty leading up to open enrollment.** Overall enrollment only dropped 3.7 percent since 2017,¹ despite the shorter enrollment period in many states and the significant decline in outreach and enrollment supports. Enrollment varied greatly by state, with states in control of their own outreach and enrollment supports generally faring better than those relying on the federal government.
- **The vast majority of marketplace enrollees receive financial help for their premiums.** In 2017, 83 percent of marketplace enrollees received help in paying for their premiums through advanced premium tax credits.²
- **Consumer choice among plans varies significantly by market.** During the 2018 open enrollment period, 18 percent of counties had three or more participating insurers, 30 percent of counties had two participating insurers, and 52 percent of counties had only one participating insurer. However, the counties with more plan choice also are more populated, and, as a result, 48 percent of consumers in 2018 had three or more insurers offering plans in their markets.³
- **Plan premiums – and annual changes in plan premiums – also vary significantly by market.** In 2018, average monthly benchmark premiums ranged from \$311 in Rhode Island to \$865 in Wyoming. The change in premiums from 2017 to 2018 varied considerably, from -22 percent in Alaska to +88 percent in Iowa.⁴

1. Kaiser Family Foundation, “Change in Marketplace Enrollment 2017-2018” <https://www.kff.org/health-reform/state-indicator/change-in-marketplace-enrollment-2017-2018/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Percent%20Change,%202017-2018%22,%22sort%22:%22asc%22%7D>

2. Centers for Medicare & Medicaid Services, “Health Insurance Marketplaces 2017 Open Enrollment Period: Final enrollment report: November 1, 2016 – January 31, 2017,” March 15, 2017.

3. Kaiser Family Foundation, “Insurer Participation on the ACA Marketplaces, 2014-2018” <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>

4. Kaiser Family Foundation, “Marketplace Average Benchmark Premiums, 2014-2018” <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>