American Hospital Association®

# Marketplace Stability & Fallback Options

**Throughout 2017, Congress has debated repeal and replace (or repair) of the Affordable Care Act (ACA). While flawed, the ACA has expanded coverage to more than 20 million individuals.** Yet, it is unclear whether these gains will be maintained given uncertainty in the 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. Most recently, uncertainty regarding federal payments for the cost-sharing reduction subsidies has led to both health plan exits and higher premiums for the plans that will be sold. Other policy challenges include issues related to appropriate reimbursement, particularly as they relate to the reinsurance and risk-adjustment programs, and uncertainty regarding enforcement of the individual mandate.

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.** Without a congressional appropriation for the CSRs, insurers are at risk of shouldering approximately $7 billion to $9 billion annually in unreimbursed costs should the Administration stop these payments. Without this funding, health plans likely would either exit the marketplaces – reducing consumer coverage options – or significantly increase premium rates to cover these costs – potentially making coverage unaffordable for consumers who do not receive subsidies. The Congressional Budget Office (CBO) estimates that failure to fund the CSRs would result in the cost of silver plan premiums increasing an average of 20 percent for 2018.
- **Enforce the Individual Mandate.** Without the individual mandate or another mechanism to incentivize enrollment, millions of individuals may opt not to enroll in coverage. The most likely consumers to forgo coverage are the healthiest individuals, who expect to have minimal health care needs. Without these healthier individuals in the market, rates will rise as the risk pools worsen and there are fewer individuals to share in health care costs. Indeed, insurers already are proposing higher rates as a result of uncertainty around whether the individual mandate will be enforced. Covered California, California's marketplace, estimated that failure to enforce the mandate could result in premium increases of more than 28 percent and a loss of coverage for 350,000 Californians.
- **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.
- **Fully Phase Out Transitional Health Plans.** Since the marketplaces have been in operation, the federal government has allowed states to permit insurers to continue selling plans that do not comply with the ACA to those individuals continuously enrolled in such products. Many states have chosen to phase out these plans. However, those that have not phased out these plans have less healthy risk pools because healthier individuals continue to buy coverage outside of the marketplace risk pool. These are exactly 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. 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 these plans to continue and opted not to expand Medicaid, as compared to states that disallowed such plans and expanded Medicaid.[1] We urge CMS to require that all individuals in non-compliant coverage be transitioned to ACA-compliant coverage in 2018. States also may act unilaterally to disallow the sale of such plans in their markets.
- **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.

## *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 is developing a white paper with Manatt Health for release this fall that will provide 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.

1. *No states disallowed transitional plans but expanded Medicaid.*