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Fact Sheet: Marketplace Stability

More than 10 million Americans have purchased health coverage through the Health Insurance Marketplaces authorized by the Affordable Care Act (ACA). However, the marketplaces in many states are not yet stable, with a number of insurers opting to discontinue coverage from one year to the next. If no plans are available in a market, consumers will lose access to the federal premium subsidies and cost-sharing reductions (CSRs) that make coverage more affordable.

A number of factors have contributed to the instability of the marketplaces. Most recently, uncertainty regarding continued federal payments for the CSRs has led a number of insurers to reconsider their marketplace participation in 2018, and may contribute to significantly higher premium rates in 2018 for plans that are sold on the marketplaces. Other factors contributing to marketplace instability include the expiration of the temporary reinsurance program in 2016; lower enrollment among younger, healthier consumers; inaccurate pricing by insurers in the early years of the marketplaces; and inadequate reimbursement as a result of issues related to the risk-adjustment program.

Both Congress and the Administration should pursue policy and operational changes to make the marketplaces more attractive to both consumers and insurers. Without such changes, insurers may continue to exit the marketplaces, leaving some consumers without affordable coverage options and increasing costs for those who remain.

AHA Position

Both Congress and the Administration should take actions to stabilize the insurance markets.

Needed congressional actions:

- Fund the cost-sharing reductions
- Reinstitute and fund a federal reinsurance program
- Authorize a federal "fallback" plan in the event of marketplace failure, such as allowing consumers to buy into the Federal Employees Health Benefits Program (FEHBP)

Needed Administrative Actions:

- Enforce the individual mandate
- Refine the risk-adjustment program to better account for enrollee costs
- Enhance outreach and enrollment activities
- Fully phase out transitional health plans
- Support the development of state-level solutions, such as wrap-around reinsurance programs and fallback plans in the event of marketplace failure

Why?

- **The Health Insurance Marketplaces are a major source of coverage for lower-income Americans.** More than 10 million consumers are enrolled in marketplace plans. The vast majority of enrollees do not have another source of affordable coverage, or an alternative to receive assistance with their premiums and/or cost-sharing.

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- **Insurance coverage is critical to ensuring patient access to health care. The uninsured are less likely to seek needed care.** 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.
- **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.

Key Facts

- **The vast majority of marketplace enrollees receive financial help for their premiums or cost-sharing.** In 2017, 83 percent of marketplace enrollees received help in paying for their premiums through advanced premium tax credits; 58 percent of enrollees also received CSRs.[1]
- **Consumer choice among plans varies significantly by market.** In 2017, 32 percent of counties had three or more participating insurers, 36 percent of counties had two participating insurers, and 32 percent of counties had only one participating insurer. However, the counties with more plan choice also are more populated, and, as a result, 57 percent of consumers in 2017 had three or more insurers offering plans in their markets.[2]
- **Insurer participation in 2018 will not be known until early October.** Despite several high-profile insurer exits from a number of counties in 2018, the full scope of both exits and new entrants will not be known until contracts are finalized near the end of September.
- **Plan premiums – and annual changes in plan premiums – also vary significantly by market.** In 2017, monthly premiums ranged from $243 in Washington to $927 in Alaska.[3] The change in premiums from 2016 to 2017 varied considerably by market, from -4 percent in Indianapolis to +145 percent in Phoenix.[4]
- **States play a significant role in marketplace stabilization.** State insurance regulators have significant responsibility for the plans sold in their states and have a number of levers they may use to help stabilize the marketplaces. One of the most critical functions of state regulators is premium rate review and approval. Some states also are exploring state-level marketplace stabilization programs. For example, the Centers for Medicare & Medicaid Services has approved a jointly state and federally funded reinsurance program in Alaska.

For more information on AHA's recommendations to improve marketplace stability, please visit *www.aha.org/marketplace-stability*.

1. *Centers for Medicare & Medicaid Services, "Health Insurance Marketplaces 2017 Open Enrollment Period: Final enrollment report: November 1, 2016 – January 31, 2017," March 15, 2017.*
2. *Kaiser Family Foundation, "Analysis of Insurer Participation in 2017 Marketplaces," accessed August 7, 2017.*
3. *Kaiser Family Foundation, "Marketplace Average Benchmark Premiums," accessed August 7, 2017.*
4. *Kaiser Family Foundation, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces;" October 24, 2016*