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Strategies to Stabilize the Affordable Care Act Marketplaces: Lessons from Medicare

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Georgetown University Center on Health Insurance Reforms

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Table of Contents

Introduction	4
Background.....	5
Stabilizing Insurance Markets: Lessons from Medicare.....	6
Market Competition and Plan Availability	6
<i>Financial Incentives</i>	6
<i>A Fallback Plan</i>	7
<i>Participation Requirements for Insurers</i>	7
<i>Regulatory Relief</i>	8
Premium Stability	8
<i>Risk Adjustment, Reinsurance, and Risk Sharing</i>	9
Maximizing and Sustaining Enrollment	10
<i>Outreach Campaigns and Consumer Assistance</i>	11
<i>Auto-Enrollment</i>	11
<i>Penalties for Failing to Enroll</i>	11
Conclusion	12
Acknowledgments	12

Introduction

The Affordable Care Act's (ACA) health insurance reforms have led to a dramatic decline in the number of uninsured people¹ and improved the overall quality of coverage for many.² At the same time, the health insurance marketplaces created by the law are still in flux. Drafters of the ACA envisioned that the early years of the insurance reforms and marketplaces would be a time of instability and crafted provisions designed to assuage insurers' concerns about the health risks of the marketplace population and the limits on their ability to control costs by denying coverage to people with pre-existing conditions.

However, while some insurers are doing well and expanding their presence on the ACA marketplaces, many of the private insurance companies upon which the success of the marketplaces depends have experienced losses.³ Some are reducing the scope of their marketplace participation, raising premium rates, or both, raising concerns among some about the long-term stability of the marketplaces.^{4,5}

Yet such instability and uncertainty are not exclusive to the ACA. These same issues have dogged other insurance markets, including programs where Medicare relies on private plans to deliver benefits. Medicare has two such programs – Medicare Advantage (MA), which offers beneficiaries the option of receiving their Medicare benefits through private plans, and Medicare Part D, which makes

a drug benefit available only through private plans. They contrast with the ACA marketplaces (Table 1) in various ways. They serve distinct populations and are financed differently. Medicare Advantage serves as an alternative to traditional Medicare, which remains available to everyone. In addition, unlike insurance for those under 65, once people enroll in Medicare, they remain in Medicare.

Fundamentally, however, both Medicare and the ACA marketplaces deliver a public benefit – subsidized insurance – through private companies. Both programs provide critical and life-saving benefits to consumers that depend on them. In doing so, the programs must effectively manage markets to encourage competition among insurers, improve consumer choices, and mitigate the risk of adverse selection.

In implementing and managing the Medicare Advantage and Part D programs, policymakers have used a range of approaches intended to guarantee the markets' viability and long-term success. These include policies and strategies to encourage participation by insurance companies, keep premiums stable, and enhance enrollment. In this paper, the authors consider whether any of these policies or strategies could also be used to help stabilize the ACA marketplaces, and if so, what the pros and cons of doing so would be.

Table 1. Marketplace, Medicare Advantage, and Part D Markets: Key Similarities and Differences

	ACA Marketplaces	Medicare Advantage	Medicare Part D
Population served	Primarily individuals under age 65 without access to government or employer-based coverage ^a	All Medicare beneficiaries (over 65 or with qualifying disabilities), but plans may not be available in all locations	All Medicare beneficiaries (over 65 or with qualifying disabilities)
Distribution mechanism	All offered by private insurers	All offered by private insurers; but traditional Medicare is an option for all	All offered by private insurers
Financing	Individual premiums, subsidized by federal income-based tax credits ^b	Individual premiums, subsidized by Medicare funds	Individual premiums, subsidized by Medicare funds ^c

^a Immigrants who are not lawfully present and incarcerated individuals are not eligible to enroll through the marketplaces.

^b Income-based cost-sharing subsidies are also available to lower deductibles and other out-of-pocket expenses.

^c Additional federal subsidies available based on income.

Background

In enacting the ACA, policymakers sought not only to reform the individual health insurance market to make it more accessible and affordable, but also to enhance its competitiveness. In particular, the law includes health insurance marketplaces or exchanges, which are designed to provide a level playing field upon which insurers can compete and reduce some of the marketing and distribution costs that have made it expensive for insurers to sell directly to consumers.

Long before enactment of the ACA, many states and regions within states had highly concentrated health insurance markets.⁶ Rural residents in particular have long had limited choice among insurance providers.⁷ The ACA's efforts to inject greater competition into health insurance markets have encountered mixed success. Many markets, particularly urban ones, are competitive; about 10 percent of counties have six or more participating insurers in 2016. But over 30 percent of U.S. counties have only two insurers participating in the marketplace and 10 percent of counties have only one. Although disproportionately rural, these two sets of counties are estimated to represent about 32 percent of the population.⁸

The new marketplaces have faced challenges to their growth and stability, including strong political opposition from some policymakers, high-stakes constitutional challenges, problems with the functionality of information technology (IT) systems, the extended ability of certain health plans to remain exempt from the ACA's insurance reforms, and insufficient funding for consumer outreach and assistance. For these and other reasons, enrollment growth has been slower than originally projected. Additionally, many insurers have reported that they have attracted a sicker mix of enrollees than they had expected, leading to financial losses on their marketplace business.⁹ These losses have spurred some insurers to exit marketplaces; others have proposed significant premium rate increases for 2017.¹⁰

While similar issues have caused instability in other private marketplaces and in some cases led to their eventual demise, failure is unlikely for the ACA marketplaces.¹¹ The availability of federal subsidies and the requirement to maintain health insurance coverage both help ensure that the marketplaces will continue to attract enrollment and insulate most enrollees from year-to-year price fluctuations. However, there are legitimate

concerns that some consumers, particularly in certain long-underserved regions of the country, could lose access to subsidized coverage if all plans exited, or be faced with only limited or high-cost choices because of the lack of competition.

The ACA marketplaces are not the only insurance markets that have experienced periods of uncertainty and instability, particularly in their early years. Medicare has included a role for private plans in the mostly managed-care component now known as Medicare Advantage. The involvement of private plans has experienced cycles of plan exits, most recently in the late 1990s.¹² Between 1998 and 2002, the predecessor to today's MA program (called Medicare+Choice) faced insurers' decisions to terminate nearly half of the existing Medicare contracts.¹³ These terminations meant that between 300,000 and 1,000,000 enrollees annually could not stay in the plans they had selected. Terminations occurred disproportionately in rural counties where payment rates were lower. Total enrollment dropped between 1999 and 2003 from 6.4 million to 4.6 million.¹⁴ When Congress increased payment rates, the market stabilized and enrollment grew rapidly. In 2016, there were 17.2 million beneficiaries in Medicare Advantage.¹⁵

When lawmakers created the Medicare Part D prescription drug benefit in 2003, they drew on lessons learned from the Medicare Advantage program to develop policies and strategies to ensure that all beneficiaries would have access to a Part D plan, regardless of where they lived. At the time, there were widespread concerns that, because there was no history of a market for private standalone drug plans, few if any insurers would participate. Therefore, policy measures sought to encourage healthy competition in Part D.

Other public-sector programs, including the Federal Employees Health Benefit Program (FEHBP) and Medicaid managed-care programs in many states have experienced cycles of plan exits that have raised concerns among enrollees and policymakers (see text boxes).

In developing this paper, the authors reviewed Medicare Advantage, Part D and ACA marketplaces' statutory authority, implementing regulations, and published guidance for participating insurers. In addition, we hosted a structured discussion on May 17, 2016, among analysts and researchers with expertise in Medicare Advantage, Medicare Part D, and the

Instability in FEHBP

The Federal Employees Health Benefit Program (FEHBP) has experienced plan exits several times. In 1989, one of two large national insurers (Aetna) withdrew from FEHBP due primarily to adverse risk selection; the company found it was drawing a large share of high-risk and high-cost enrollees. In more recent years, several commercial insurers withdrew from a number of states (e.g., United Healthcare reduced its participation from 21 states in 1999 to 7 in 2010).¹⁶

To reduce such instability, the FEHBP program maintains contingency reserves to help the program's fee-for-service plans offset costs that are higher than expectations. The reserves are funded by a surcharge of up to 3 percent on plan premiums.¹⁷

Instability in Medicaid Managed Care

Various state Medicaid managed-care programs have faced actual or threatened plan exits. In the late 1990s, nearly one in five commercial plans participating in Medicaid programs across the country exited,¹⁸ and programs in at least 15 states have faced exits in more recent years. States have adjusted payment rates to prevent or limit the exit of Medicaid plans. In 2008, Florida's Medicaid agency notified plans participating in a Medicaid reform pilot program that rate cuts would average 3 percent instead of the 5 percent previously scheduled. Within days, two of three exiting insurers announced they would stay in the program.¹⁹ In addition, most states apply risk adjustment to the capitation rates used in contracts with managed-care organizations. About half also have risk-sharing arrangements such as reinsurance or risk corridors.²⁰

ACA marketplaces. This report reflects the policies and strategies discussed during that meeting, as well as targeted one-on-one interviews with additional

experts. However, the findings and views expressed in this report are the authors' own, and should not be attributed to any individuals with whom we consulted.

Stabilizing Insurance Markets: Lessons from Medicare

In this section, we explore policies and strategies in three areas. First, we consider measures that seek to strengthen market competition by encouraging insurers to participate in markets. Second, we look at measures intended to maintain premium stability for insurers participating in a market. Last, we consider measures designed to maximize and sustain enrollment in the programs. For each option, we review provisions in MA and Part D and discuss lessons for marketplaces.

Market Competition and Plan Availability

A key metric of marketplace success is the participation of insurance companies. Competition among insurers helps keep prices low and can provide expanded choices for consumers. Economists have posited that having a minimum of three companies participating is critical to robust competition.²¹ This section explores strategies, such as financial incentives, fallback plans, insurer participation requirements, and regulatory relief, that policymakers and administrators have used to try to encourage and sustain the participation of private insurers in Medicare, and seeks to assess whether and how these strategies might work for the ACA marketplaces.

Financial Incentives

In the wake of high-profile market exits in the Medicare Advantage program, policymakers were able to entice insurers back into the program by increasing payment rates. The Medicare Modernization Act (MMA) of 2003 changed the method Medicare uses to pay plans to a system in which plans bid against a benchmark price that varies geographically. Overall, the new system led to payments to plans that were approximately 10 percent higher relative to local fee-for-service (FFS) costs from about 2006 to 2010.²²

These changes, together with other changes described below, led many insurers to re-enter markets they had departed and brought other insurers into the program. Whereas 31 percent of Medicare beneficiaries had no private plan option available in 2000, by 2006, nearly every Medicare beneficiary had access to at least one MA plan. Enrollment more than doubled from 2005 to 2010.²³

Congress made further adjustments to MA payments in 2010, with the goal of coming closer to financial neutrality, in other words, paying plans no more than 100 percent of Medicare's FFS costs. This led to forecasts of reduced plan availability and enrollment. But enrollment has continued to grow. In 2016, 31 percent of Medicare

beneficiaries were enrolled in MA plans, up from 12 percent in 2003.²⁴ And plan availability has dropped only modestly. In 2016, 99 percent of Medicare beneficiaries have access to an MA plan.²⁵ Enrollment is less than 5 percent in only two states: Alaska and Wyoming. However, there remain 145 counties in 14 states without any MA insurer.

Straightforward overpayments (i.e., paying private plans more than their costs) are less feasible for ACA marketplace insurers than in MA, in part because the two programs are financed in different ways: MA plans bid against a statutory benchmark that is based in part on Medicare's FFS costs in the same geographic area, and federal payments are made to the plans based on a comparison of the plan's bid to the statutory benchmark. Insurers participating in the ACA marketplaces have no statutory benchmark; they must set premium rates based on assumptions about the health risks of their enrollees, their future utilization of health services, and the cost of reimbursing providers. While marketplace plans receive federal payments, those payments are income-based premium tax credits assigned to eligible enrollees, not to the plan itself.

To address concerns about insurer participation in the ACA markets, Congress could however enact a schedule of more generous tax credits and cost-sharing reductions to defray the cost of marketplace qualified health plans for enrollees. Doing so would enhance the value of those plans for consumers, and would likely entice more people to enroll and maintain coverage, including those who are relatively healthy. This, in turn, would likely encourage more insurers to participate in the marketplaces.

A Fallback Plan

Although exits of Medicare managed-care plans in the late 1990s and early 2000s caused much hand-wringing left some geographic areas without any plan, beneficiaries who lost their plan could, and often did, move back to the traditional Medicare program relatively seamlessly. However, in crafting the Medicare Part D program, policymakers recognized that no such natural fallback existed. Because private insurers would be the sole route through which beneficiaries would obtain prescription drug benefits, policymakers feared that no plans would bid and wanted to ensure that Part D plans would be available to beneficiaries in all parts of the country. The MMA included a fallback plan, whereby an insurer or benefits administrator would offer the benefit but not operate as a risk-bearing entity. The fallback would be implemented in any region where there was not at least one standalone drug plan and at least two drug plans in total (including those offered as part of MA plans). In reality, many plans entered

the Part D market and there has never been the need to invoke the fallback plan.

During debate over the ACA, lawmakers considered – but ultimately rejected – proposals to create a national public option plan. As designed, the public option would have been a government-run, risk-bearing plan that would operate alongside and compete with private insurers in all regions of the country.²⁶ It is not clear whether policymakers also considered a public option plan as a Part D-style fallback plan, but doing so could help ensure adequate choice for consumers, particularly those living in areas without enough participating insurers. Specifically, an ACA-style fallback plan could be triggered when an insurer's exit leaves a county with few or potentially no competing insurance companies.²⁷ With such a fallback plan, the federal government would bear the risk and set premiums, and likely contract with a third party administrator to manage a provider network and adjudicate claims. One option would be to use FEHBP's national service benefit plan (operated by Blue Cross Blue Shield) as the structure for a fallback while keeping the risk pool separate from participating federal employees. This approach would at least have an existing structure with a provider network and other administrative mechanisms. Another approach would be to leverage the Medicare program's infrastructure, such as its fiscal intermediaries and provider reimbursement rates, to quickly build a public option fallback. Regardless of the approach, the design of a fallback plan would need to address issues such as identifying provider networks, assessing the impact on competition, and maintaining incentives for other carriers to enter down the road.

Participation Requirements for Insurers

In the wake of the market exits by Medicare managed-care plans in the late 1990s, policymakers expanded the types of plans available to beneficiaries. In addition to local health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which were already part of the program, Congress added (1) private fee-for-service (PFFS) plans, which offered Medicare beneficiaries unrestricted access to all providers;²⁸ (2) PPO demonstration plans, which were encouraged with higher payments and reduced administrative requirements;²⁹ and (3) regional PPOs, which were required to serve an entire region (generally one or more states), given more flexibility in meeting network access requirements, and offered certain financial protections. New plan types helped increase plan availability in rural areas and other underserved areas, and regional PPOs continue to account for about 2 percent of MA enrollment (new rules

requiring PFFS plans to have provider networks have reduced enrollment substantially).³⁰

In the private individual insurance market, some states have initiated efforts to expand the geographic availability of insurers. For example, Florida has required a large national insurer, as a condition of approving that company's merger with another insurer, to expand its offering on the marketplace to five additional counties by 2018, and to develop a plan to expand to additional underserved counties by 2020.³¹ Arizona law requires insurers selling PPO plans to offer them statewide, both inside and outside the marketplace.³² However, such requirements can backfire; several insurers on Arizona's marketplace are no longer offering PPOs, instead switching to HMOs, in part to avoid the statewide requirement.³³

State and federal policymakers have also attempted to create incentives for insurers to participate or remain in the commercial non-group market. In all states, insurers are barred from re-entering the individual insurance market for five years if they discontinue selling in that market.³⁴ Several state-run marketplaces have adopted formal participation requirements, including requiring insurers with a certain share of the individual market to participate, establishing waiting periods for entry for insurers who failed to participate in 2014, and in the District of Columbia and Vermont, requiring all individual policies to be sold through the new ACA-created marketplace.³⁵ Such requirements, however, could reduce or delay competition for a longer-than-desired period of time.

Regulatory Relief

Medicare used regulatory relief as one incentive to bring new plan types into Medicare Advantage. Regional PPOs are allowed to meet network adequacy requirements with less robust networks of contracted providers by reimbursing non-contracted providers at Medicare FFS rates. If they do so, they must limit beneficiaries' cost-sharing liability to in-network levels and are barred from requiring prior authorization for those out-of-network services. All MA plans have the ability to rely on paying traditional Medicare rates to some providers that remain outside their networks, a negotiating advantage lacking in the ACA marketplaces. A regional PPO can also simplify coverage requirements because it can take a local coverage determination made by the Centers for Medicare & Medicaid Services (CMS) and apply it uniformly across its region, rather than using different coverage requirements in different parts of the region.³⁶

The federal government, or states, could entice insurers to enter new markets by offering them regulatory relief.

Some types of regulatory relief require legislation, but others, such as some of those taken in MA, can be accomplished through regulations or sub-regulatory policy initiatives.

For example, one of the largest barriers to an insurer entering a new market or region is the cost of building a provider network. Insurers face a chicken-and-egg dilemma: they must build sufficient membership to negotiate competitive rates with providers, but they must also show state regulators that they have an adequate network of providers before they are allowed to market their plan to potential members. Accomplishing this in an area that has few or highly concentrated provider systems is difficult. To lower that initial barrier to market entry, state or federal regulators could offer insurers a longer-term path to meeting network adequacy requirements, while still ensuring that enrollees can access needed services. In other words, states could give insurers the opportunity to meet minimum standards such as provider-to-enrollee ratios, wait times, or maximum time and distance over a specified number of years, such as three years. Insurers would still be required to ensure that enrollees can receive the services promised under the plan, for example, by guaranteeing access to out-of-network providers with in-network cost sharing and no balance billing. Under these terms, a phased-in approach to network adequacy regulation could allow them to build membership and be in a better negotiating position with providers.

Premium Stability

The laws creating the Medicare Advantage and Part D programs and the ACA's insurance reforms include provisions designed to ensure that premiums remain stable, both during the initial years of implementation and over the long term. These provisions protect against both adverse selection, which occurs because those who are most in need of health care are more likely to enroll in insurance or certain plan designs than healthier individuals, and risk selection, which occurs when insurers use strategies to discourage enrollment by people with health care needs. The programs include risk adjustment, reinsurance, and risk corridors – often referred to as the 3Rs (Table 2). Generally speaking, risk adjustment compensates insurers with enrollees who are sicker than their competitors. Reinsurance helps those that have attracted enrollees with catastrophic medical expenses, while risk corridors help provide a buffer for insurers that have inadequately priced their plans. The types of risk mitigation programs and their duration vary between Medicare and the ACA.

Table 2. Comparing Risk Mitigation Programs: Marketplaces and Medicare

	ACA Marketplaces	Medicare Advantage	Medicare Part D
Risk Adjustment			
Duration	Permanent	Permanent	Permanent
Structure	Plans make or receive risk transfer payments, based on their enrollees' age, sex, and health conditions. Funds are transferred on a budget-neutral basis from plans with lower-risk enrollees to plans with higher-risk enrollees.	Federal payments to plans are adjusted for an enrollee's risk measure based on factors that include age, sex, and prior health conditions.	Federal payments to plans are adjusted for an enrollee's risk measure based on factors that include age, sex, and prior health conditions.
Reinsurance			
Duration	Expires after 2016	No Program	Permanent
Structure	Funds transferred from a reinsurance pool (collected from all health insurers and self-funded health plans in individual and group markets) to individual market insurers to help offset a portion of plan costs for high risk enrollees.	N/A	Plans receive federal reinsurance payments to cover 80% of any beneficiary's drug claim costs above a specified threshold. Payments are incorporated into federal subsidies to plan bids and are effectively a transfer across plans.
Risk sharing; Risk corridors			
Duration	Expires after 2016	Temporary risk sharing fund established for regional PPOs in 2006-7; now expired.	Permanent
Structure	The government reimburses a share of loss beyond a certain percentage; similarly, plan pays the government a share of gains beyond the same percentage. In 2014 Congress limited payments so that total payouts could not exceed the amount received from plans.	N/A	The government reimburses a share of loss beyond a certain percentage; similarly, plan pays the government a share of gains beyond the same percentage.

Risk Adjustment, Reinsurance, and Risk Sharing

Medicare Advantage uses risk adjustment, but does not have risk corridors or public reinsurance (with some exceptions). Insurers can buy private reinsurance if they choose. Research showed that MA plans were enrolling beneficiaries who were healthier on average than those in traditional Medicare, leading policymakers to expand risk adjustment beyond geographic and demographic factors to avoid Medicare overpayments. Risk adjustment based on actual diagnostic information to capture health status was phased in starting in 2000.

Although there is no across-the-board use of risk corridors or federal reinsurance in Medicare Advantage, Congress authorized risk corridors for the regional PPOs during their first two years (2006 and 2007) to encourage plan entry. Congress also authorized a regional stabilization fund for the first seven years of regional PPOs. The

fund was available to raise payments for the first plans to serve all regions of the country, the first plans to serve a particular region, or in cases where additional payments might discourage a plan from departing a region.³⁷

Congress, in creating Part D, employed all of the 3Rs (risk adjustment, reinsurance, and risk sharing) and opted to make them permanent.³⁸ The motivation for this aggressive approach was because they were creating a new market and sought to encourage insurers to participate. Although some have questioned both the scope and permanent nature of these programs for Part D, on balance they have helped the program operate as intended and helped keep the market – and prices – stable.

Lawmakers crafting the ACA authorized a permanent risk adjustment program, but the risk corridor and reinsurance programs were authorized for just three years. Policymakers expected that, by the fourth year of

enrollment, there would be a balanced mix of healthy and sick enrollees, insurers would have better data upon which to price their plans, and the marketplaces would be relatively stable.

However, a congressional budget agreement late in 2014 disabled the ACA's risk corridor program, the existence of which had encouraged some insurers to price their plans more aggressively than they might have otherwise. Long after insurers' pricing decisions had been made, the budget deal dramatically limited the funds available to compensate them for significant losses.³⁹

In addition, there is considerable evidence that the individual insurance market and the marketplaces have not stabilized as quickly as lawmakers might have predicted. Insurers have reported that enrollees have higher-than-expected health care costs, including many with catastrophically high medical bills.⁴⁰

To better ensure the long-term stability of the ACA marketplaces, policymakers could reconsider the structure and duration of the 3Rs. As in Medicare Part D, both the risk corridor and the reinsurance programs could be made permanent. However, extending the risk corridor program might not improve marketplace stability dramatically. The primary rationale for the risk corridor program is to buffer insurers from significant mispricing, a real risk when insurers know little about the population they will be serving or their health needs. But three years in, insurers should have more comprehensive data about their costs and be able to price plans more accurately. On the other hand, a risk corridor program could be viewed as protection against costs that cannot be anticipated, such as a flu epidemic in certain communities, an unexpected contagion such as the Zika virus, or a new treatment such as drugs for hepatitis C.

Extending the ACA's reinsurance program and its mechanism of financing would more likely have a stabilizing influence. The program could be authorized permanently, as it is in Medicare Part D, or for a set period of time, with authority for CMS to continue it if needed.⁴¹ While insurers can always buy private reinsurance, those costs are likely to be passed on in the form of higher individual market premiums. Funds for the reinsurance pool would need to be, as they are currently, collected from individual market insurers, group market insurers, and self-funded plans. This broad base of funding could further be calibrated based on the health risk in the large group market relative to the individual market. To the extent the risk pools improve in the individual market, then payment transfers from the group market would decline. An ancillary benefit is that the improved risk pool would

help keep premiums more affordable, thus reducing federal outlays for the premium tax credits.

One state has stepped in with a state-based reinsurance program, just as the federal program is set to expire. Responding to concerns about the small size and risk profile of its individual market, Alaska has enacted reinsurance for individual market plans, scheduled to start in 2017. It will be financed through payments from individual market, group market, and stop-loss (reinsurance) insurers.⁴²

Maximizing and Sustaining Enrollment

Programs such as the ACA marketplaces and the MA and Part D programs have three primary enrollment challenges. First, they must enroll the largest possible share of eligible individuals into the program. Second, they must keep those individuals enrolled in the face of changes in life situations and financial resources. Third, they must manage a significant amount of natural – and beneficial – enrollment volatility. Market-based programs work best when enrollees reexamine their choices on a regular basis – both to ensure they are in a plan that best fits their needs and to exercise price discipline among competing insurers.

Over the long term, it will be critical for the marketplaces to expand enrollment to include healthier and younger consumers and to maintain that level of enrollment over time. Enrollment in the health insurance marketplaces at the end of the 2016 enrollment season was approximately 12.7 million, more than 8 million fewer than Congressional budget forecasters originally projected.⁴³ An estimated 16 million people are eligible but not enrolled in either Medicaid or marketplace coverage.⁴⁴

In addition, the individual market, including the ACA marketplaces, experiences a lot of natural “churn,” where enrollees cycle in and out of different forms of coverage. A majority of marketplace enrollees are enrolled in their plan for just one year or less.⁴⁵ Many enrollees experience income and life changes that make them eligible for other coverage, such as Medicare, Medicaid, or an employer-sponsored plan. Others may initially enroll but struggle to maintain premium payments over the course of the year or become frustrated because of cost barriers to obtaining health services.⁴⁶ Marketplace consumers have shown themselves to be extremely price sensitive, with a high proportion of them using the annual open enrollment season to shop for lower premium plans. This high level of enrollment volatility requires the marketplaces to invest in long-term strategies to boost and retain enrollment, beyond the initial public outreach campaigns deployed at launch.

Medicare has used several strategies to encourage and maintain enrollment, including educational campaigns and consumer outreach and assistance, auto-enrollment of some enrollees that do not proactively select a plan, and financial penalties for enrollees who do not enroll at their first opportunity to do so.

Outreach Campaigns and Consumer Assistance

In launching Medicare Part D in 2006, the Administration initiated a nationwide publicity campaign six months prior to the official start date, including mass media advertising, public events featuring senior Administration and congressional officials, and a Medicare bus tour. Efforts included a targeted outreach campaign to educate low-income beneficiaries about “extra help” through a Low-Income Subsidy (LIS).⁴⁷ The federal government further supports State Health Insurance Assistance Programs (SHIPs), located at area agencies on aging, to provide counseling for Medicare beneficiaries seeking help for decisions about Medicare Advantage, Part D, or supplemental insurance (Medigap). It continues to support these resources and engages in media outreach annually during the Medicare open enrollment period. Medicare has also been active in addressing abusive marketing practices by participating private plans, such as attempts to inappropriately steer beneficiaries into certain plans.

While officials in 2013 and 2014 conducted a national campaign to educate people about the new ACA marketplaces, they faced considerable headwinds, such as widespread misinformation about the law, ongoing legal challenges, a polarized political atmosphere, and congressional rejection of the Administration’s requests for additional implementation funds. Funding to support the ACA’s in-person assisters, or Navigators, has been limited and is declining. Moreover, insurance companies have been reducing or eliminating broker commissions for enrollment into the marketplaces. Yet there is mounting evidence that in-person assistance is critical to helping people through the complicated eligibility and plan selection process.⁴⁸

To grow and maintain enrollment in the ACA marketplaces, an ongoing and sustained commitment to outreach and in-person assistance is needed. As officials did with the launch of Part D, the ACA marketplaces must invest in both broad and targeted outreach campaigns to eligible uninsured, as well as in-person assistance for consumers, particularly for hard-to-reach populations and those eligible for financial assistance.

Auto-Enrollment

Generally, Medicare Part A (which covers care in hospitals and other facilities) is automatic for eligible individuals, while Part B (which covers care by physicians and other health professionals) is optional, but is treated as the default choice for most eligible individuals. Enrollment in Medicare Part D or in a Part D plan, however, is not the default choice in most cases. The exception is that beneficiaries who receive the LIS will be assigned automatically to a Part D plan if they do not select one on their own. These individuals are randomly assigned to one of the plans in their region which are available to them at no premium. Under certain circumstances, these subsidized enrollees are reassigned randomly to a new plan.⁴⁹ The use of random assignment rather than some type of beneficiary-centered assignment was seen as a way (especially in the program’s first year) to guarantee that all eligible plans would receive an equal number of subsidized enrollees. It thus creates an incentive for insurers to enter or stay in Part D and to bid low.

In the ACA marketplaces in 2016, approximately 36 percent of marketplace enrollees were passively renewed into their same or a similar plan, meaning they did not return to the marketplace during the open enrollment period to actively shop for a plan.⁵⁰ CMS has proposed that the federal marketplace might switch certain enrollees into a low-cost plan during the annual renewal process, rather than passively renewing their current plan. These individuals would retain the right to select a different plan. As envisioned, this would occur only if an enrollee’s plan premium was slated to increase by a specified percentage, such as 5 or 10 percent, and the enrollee had previously opted in to being re-enrolled by default into a lower-cost plan.⁵¹ While the Administration has not finalized this proposal, it could be revisited as a way to entice a new insurer to enter the marketplace in a state or county, for example, by promising that insurer that it would get a certain proportion of such default enrollees.

Penalties for Failing to Enroll

Medicare-eligible individuals who fail to enroll in Medicare Part B when they first become eligible face a late enrollment penalty unless they qualify for an exception, such as having coverage as an active employee from an employer or spouse’s employer. The penalty, which applies for life, adds a 10 percent increase to the standard Part B premium for every 12-month period that the person was eligible for Part B, but did not take it. Part D has a similar late enrollment penalty which adds 1 percent to the premium for every month for which the person was eligible but not enrolled. There is some evidence that

Medicare beneficiaries were aware of the Part D penalty during the initial enrollment period in 2005-2006 (even if they did not understand how it worked) and that it was a factor in encouraging them to enroll in Part D.⁵²

The ACA does not impose late enrollment penalties on people who do not enroll in coverage at their first opportunity. Those that do not maintain a minimum level of coverage either through the marketplace, an employer, or other source, face an annual tax penalty. However, insurers have argued that the tax penalty is weak and provides an insufficient incentive for people to enroll.⁵³ Because the full amount of the tax penalty is only first levied during the 2016 tax filing season (in early 2017), it may be too soon to judge whether it provides a sufficient incentive for those lacking coverage to seek it.

Further, imposing a late enrollment penalty in the ACA context is significantly more complicated than it is for Medicare beneficiaries. In particular, once someone becomes eligible for Medicare they do not lose that eligibility. When they enroll, they tend to stay enrolled. That is far from the case with the ACA marketplace enrollees. Those with subsidized coverage are likely to cycle in and out of eligibility over the course of their lifetime, dependent on income changes, household changes, and access to other forms of coverage, such as Medicaid or employer-based plans. Tracking whether someone has enrolled in a marketplace plan in a timely fashion is much more of a challenge.

Conclusion

The history of health insurance markets teaches us that, without certain safeguards and incentives, there are likely to be periods of instability and uncertainty, particularly in the early years of a program. Other public programs have experienced a history of new market entry followed by retrenchment, as private plans tested out the new programs. Challenges for policymakers can include encouraging plan entry, maintaining robust competition among insurers particularly in historically underserved areas, ensuring price stability and discouraging risk selection, and building and sustaining enrollment. But in most cases, these challenges were addressed so that programs weathered the period of instability.

The Medicare Advantage and Part D markets can provide policymakers and administrators with lessons and strategies that can be applied to the ACA marketplaces. While the Medicare markets are very different than the ACA markets, both in terms of the population served and financing mechanisms, both deliver a critical benefit – health

coverage – through private market mechanisms. And in both cases, a combination of financing, risk stabilization, and enrollment outreach strategies are critical to long-term stability. The challenges for the ACA marketplaces are probably greater than those in Medicare because they lack the stabilizing influence of the traditional Medicare program and have a less stable enrollment base.

In this paper we outline policies used in the Medicare Advantage and Part D programs, as appropriate, to manage markets and ensure their long-term sustainability. No one policy discussed above provides a “silver bullet” solution for the ACA markets, and all would require some modification to account for the unique characteristics of the health insurance marketplaces. But these policies, on their own or in combination with others, could help private insurers compete more effectively in the ACA marketplaces and provide enrollees in all regions with adequate access to affordable plan choices.

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