# The State of Exchanges
## A Review of Trends and Opportunities to Grow and Stabilize the Market

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**Avalere Health**
An Inovalon Company
1350 Connecticut Ave, NW
Washington, DC 20036

T | 202.207.1300
F | 202.467.4455

avalere.com

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## EXECUTIVE SUMMARY

Since their inception in 2014, exchanges have enrolled millions of consumers in health insurance, more than one-third of whom were previously uninsured.[1] Despite these accomplishments, exchanges face challenges that have driven issuer decisions to exit or scale back participation in the market and, overall, call into question the sustainability of the market. There are a range of potential solutions that may improve the long-term viability of exchanges. A combination of these and other policies may need to be considered by the executive branch, Congress, or states to ensure market stability into the future.

| | Risk Mitigation Programs | Enrollment Instability | Low Enrollment |
|---|---|---|---|
| Challenges | The risk adjustment program is not accurately or adequately compensating issuers for the risk of the population enrolled | There is significant churn in the market as individuals move in and out of exchange coverage throughout the year | Exchange enrollment is significantly lower than expected and, looking ahead, is unlikely to reach original projections<br>Those enrolled are older and less healthy than the population available to enroll |
| Potential Opportunities | Future changes to improve the accuracy of the model and simplify and amend the transfer formula may improve payment accuracy for issuers | Incentives to encourage continuous enrollment, alongside tightened special enrollment period (SEP) use and shorter grace periods, may help to mitigate turnover in the market | Reforms to strengthen penalties for not enrolling, make coverage more affordable, expand enrollment efforts, and improve the consumer experience could help to grow enrollment |

## INTRODUCTION

Since their inception, the health insurance exchanges created by the Affordable Care Act (ACA) have successfully enrolled millions of Americans. However, approaching the fourth open enrollment period, the exchange market faces ongoing, systemic challenges, which threaten the stability and sustainability of the market.

In examining these challenges, this paper summarizes enrollment, choice, and product design of 2016 exchange markets and identifies the key challenges facing the market that have driven issuer participation decisions for the 2017 plan year. Finally, the paper considers a range of potential policy options that could be combined to improve the sustainability of the exchange market into the future.

## OVERVIEW OF ENROLLMENT AND PRODUCT DESIGN

Despite lower than expected enrollment, exchanges have been successful to-date in enrolling and delivering choice of insurance to millions of consumers. While some of these trends are likely to shift into the future, as described later in this paper, the overview below provides a review of the exchange market in its first three years of operation (2014 to 2016).

### *Enrollment Has Grown but Falls Short of Expectations*

Exchanges have experienced modest enrollment growth each year, rising from 6.3 million enrollees in 2014, to 8.8 million in 2015, and 10.1 million enrollees projected in 2016.[2] [3] [4] However, enrollment continues to fall well short of expectations, and absent major policy changes, the market is unlikely to reach the size that was projected when the ACA was passed.

### *Premiums Through 2016 Have Been Relatively Stable*

Premium growth has been modest each year, increasing by 9 percent, on average, nationally in 2016.[5] These increases are approximately in line with pre-ACA individual market premiums increases, which rose between 8 percent and 12 percent each year from 2008 and 2011.[6] Early analysis of 2017 proposed rates in select states found premiums continue to vary widely by region, with average proposed premium changes for silver plans ranging from a 5 percent decrease in Rhode Island to a 19 percent increase in Virginia.[7] Overall, premiums are expected to grow more rapidly in 2017 than in previous years.[8] [9]

Notably, subsidies cap premiums for eligible consumers at a percentage of income based on the second-lowest cost silver plan available. As a result, exchange consumers can often limit their exposure to premium increases, especially if they are willing to switch plans. In 2016, approximately 85 percent of exchange enrollees received premium subsidies.[10]

### *Exchanges Offer Consumers Choice of Plan Options*

In 2016, consumers choose from a range of plan options offered by a variety of issuers across four metal levels. Specifically, an average consumer shopping on HealthCare.gov in 2016 had 50 plan options to choose from, including 3 catastrophic plans, 15 bronze plans, 19 silver plans, 11 gold plans, and 2 platinum plans.[11] Over time, this level of choice will be impacted by the number of issuers participating in the exchange market.

### *Plan Options Feature a Range of Benefit Designs*

Consumers choose among a range of distinct benefit designs across metal levels and within the same metal level. In particular, cost sharing, including deductibles and maximum out-of-pocket spending limits (MOOPs), varies greatly, providing consumers options based on their healthcare needs and preferences. For example, at the silver plan metal level, deductibles can range from $0 to $6,850 and MOOPs can range from $3,350 to $6,850.[12]

Looking ahead to 2017, the Centers for Medicare & Medicaid Services (CMS) established optional standardized benefit designs in the federally-facilitated exchange (FFE). While select state-based exchanges (SBEs) have previously adopted standardized plan designs, it remains unclear how many issuers may offer these plan designs in the FFE or how the introduction of standardized plans will impact the range of benefit design options available to consumers.

## KEY EXCHANGE MARKET CHALLENGES

Despite some success to date, the exchange market faces significant challenges in the future. In particular, lower-than-expected exchange enrollment, a costlier and less stable enrollee population, and inadequate risk mitigation programs are primary factors that could threaten the stability and sustainability of the market moving forward.

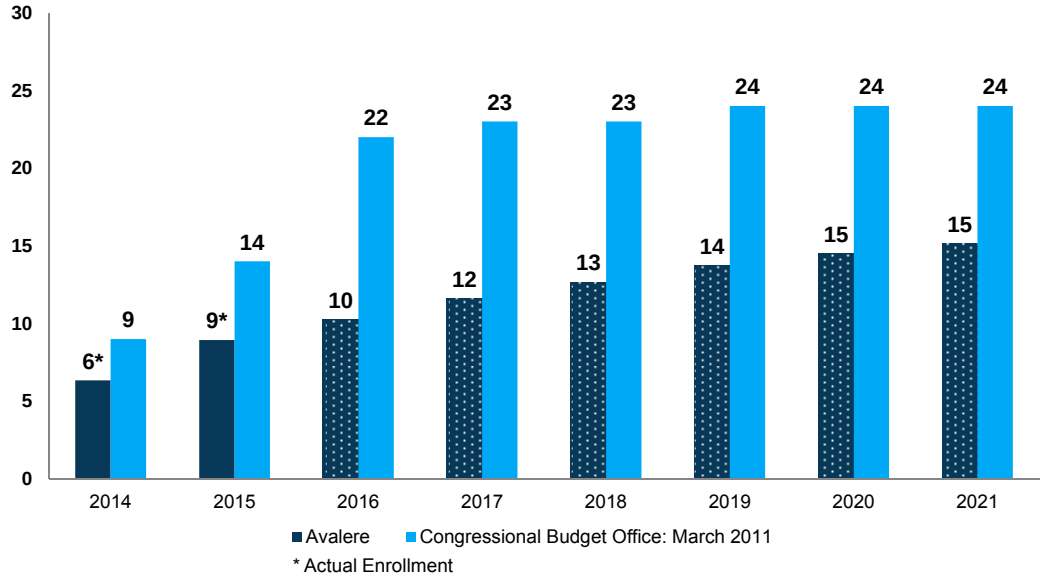
### Exchange Enrollment Is Lower than Projected

Since implementation in 2014, exchanges enrolled millions of Americans, but enrollment continues to fall well short of projections. Specifically, the Congressional Budget Office (CBO) projected in 2011 that exchanges would enroll 22 million individuals by 2016.[13] However, enrollment expectations have been continually downgraded, and year-end enrollment for 2016 is projected to be just over 10 million, or half of original projections.[14]

Looking ahead, expectations for future enrollment have also decreased over time, indicating the market is likely going to be much smaller than anticipated. Indeed, as shown

in Figure 1, CBO had projected the exchange market would grow to 24 million by 2021, but Avalere and others more recently estimate the market will reach its peak around 15 million consumers.

**Figure 1: Projected Exchange Enrollment, in Millions, 2014-2021**[15] [16]




Low enrollment is problematic for the sustainability of the exchange market for several reasons. First, low enrollment could pose financial challenges—fewer consumers purchasing coverage means fewer premiums on which to levy per member per month (PMPM) user fees. In addition, a small customer base makes the market less attractive to issuers. Most critical, however, is the impact of low enrollment on the risk pool. While it was expected that individuals with higher healthcare needs would be the first to sign-up for coverage, stakeholders assumed that as more people enrolled, better risk would enter the market and the risk pool would improve.[17] Lower enrollment means reduced opportunity for healthy people to enter the exchange market over time, leading to potentially unsustainable risk.

### *The Individual Mandate Penalty May Be Less Effective than Anticipated*

While the ACA established an individual mandate penalty for individuals who forgo purchasing insurance, the penalty may be too low to effectively attract enrollment. Particularly for middle-income, healthy individuals, the penalty remains low relative to the cost of coverage, even after accounting for premium subsidies, as shown in Figure 2.[18] For example, a 27-year-old earning approximately $24,000, or 200 percent of the federal poverty level (FPL), in 2016 would spend $1,523 on premiums annually for a low-cost silver plan, after accounting for premium subsidies.[19] However, if this individual does not buy insurance, he/she would pay just $695 in penalties—more than $800 less than if the individual had purchased coverage.

**Figure 2: Annual Premiums versus Individual Mandate Penalties for Individual Age 27, by Income as a Percent of the Federal Poverty Level (FPL)**

| | 27 Year Old | | | | |
|---|---|---|---|---|---|
| **Income as Percent of the Federal Poverty Level (FPL)** | **100%** | **200%** | **300%** | **400%** | **500%** |
| **Individual Mandate Penalty** | $ 695 | $ 695 | $ 891 | $ 1,188 | $ 1,485 |
| **Annual Premium for Average Second Lowest-Cost Silver Plan after Subsidies** | $ 241 | $ 1,523 | $ 2,880 | $ 2,880 | $ 2,880 |
| **Difference between Premium and Penalty** | **$ (454)** | **$ 828** | **$ 1,989** | **$ 1,692** | **$ 1,395** |

In the 2015 tax filing season (for calendar year 2014), 12.4 million taxpayers claimed healthcare coverage exemptions.[20] This indicates that more individuals claimed an exemption than enrolled in exchange coverage. Of those who claimed an exemption, only 46 percent indicated they had income below the tax filing threshold, which means more than half were granted exemptions for reasons other than income.[21]

The 7.9 million taxpayers who paid the penalty in 2015 reported a total of $1.6 billion in individual shared responsibility payments, which averaged $210.[22] However, most individuals do not make an active payment for the penalty, but instead the penalty is reconciled in their tax refund. Specifically, 82 percent of taxpayers who owed penalties still received a tax refund and therefore did not make an active payment back to the government. As a result, many taxpayers may not be aware or feel the impact of the penalty.

## The Exchange Population Has a Poorer Risk Profile than the Eligible Population

In addition to exchanges attracting and enrolling fewer individuals than projected, the population that has enrolled does not represent the population eligible to enroll, suggesting potential for adverse selection. In particular, the enrolled population is disproportionately older, lower-income, and in poorer health than the potential population. These trends have implications for the overall risk pool and threaten the stability of the market.

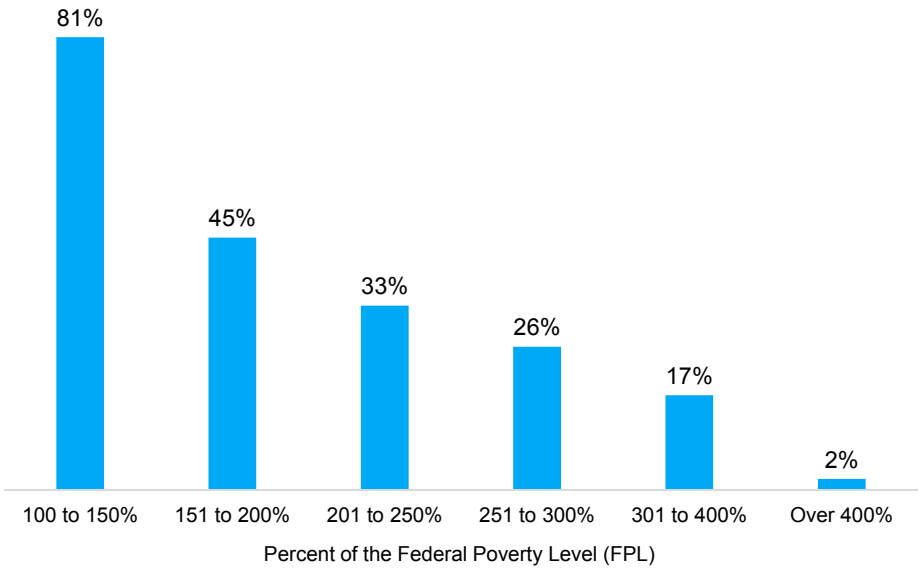
### *The Exchange-Enrolled Population Is Low-Income*

While exchanges were expected to enroll both subsidized and unsubsidized individuals, exchange enrollees are disproportionately low income, qualifying for premium subsidies as well as cost-sharing reductions. Specifically, in 2016, 85 percent (9.4 million) of individuals who enrolled in coverage received premium subsidies and 57 percent (6.4 million) of individuals accessed cost-sharing reductions.[23] At the same time, exchanges have

enrolled very few higher income individuals, as individuals with incomes over 400 percent of the FPL represent just two percent of the enrolled population.[24]

Analysis of participation rates by income among eligible individuals reveals a similar trend. As shown in Figure 3, exchange participation declines dramatically as incomes increase and subsidies decrease. Specifically, exchanges enrolled over 80 percent of eligible individuals with incomes below 150 percent of the FPL, but only two percent of eligible individuals with incomes above 400 percent of the FPL. In addition, less than one-quarter (17 percent) of potential exchange enrollees with incomes between 301 and 400 percent of the FPL selected coverage, even though many may be eligible for premium subsidies.[25]

**Figure 3: Percent of Potential Exchange Population Making Marketplace Plan Selections in 2016, by Income**

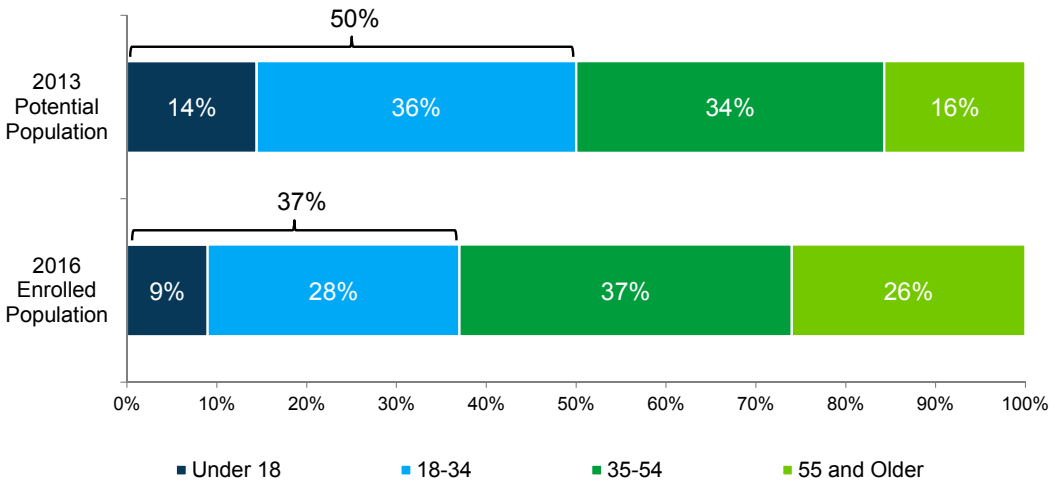



While this trend is not surprising given individuals with lower incomes have the greatest financial incentive to enroll in coverage, exchanges will need to better attract individuals across income levels to ensure the sustainability and stability of the market.

### *Exchange Enrollees Are Disproportionately Older*

Exchange enrollment has also skewed toward older individuals relative to the eligible population. Specifically, as shown in Figure 4 below, individuals 55 years and older comprise more than one-quarter (26 percent) of exchange enrollees, despite being just 16 percent of the eligible population. At the same time, while half (50 percent) of the potential exchange population was under the age of 35, only 37 percent of 2016 exchange enrollees are in that age bracket.[26]

## Figure 4: 2013 Potential Exchange Population and 2016 Enrolled Population, by Age




To ensure a balanced risk pool, exchanges will need to more successfully attract and retain younger individuals, often described as "young invincibles." Importantly, this focus on enrollment growth will likely need to come in parallel to reforms to the risk mitigation programs to ensure stability.

### *Exchange Enrollees Have Significant Healthcare Needs*

In addition to exchanges enrolling a greater share of lower income and older individuals, the exchange population is also in poorer health relative to the population in other markets. This trend has been identified and described by issuers and pharmacy benefit managers as an issue central to stability of exchanges and the outlook for the market.

For example, Blue Cross Blue Shield plans indicated that 2014 and 2015 exchange enrollees have higher rates of certain conditions (i.e. coronary artery disease, hypertension, diabetes, depression, HIV, and Hepatitis C) than the plans' pre-ACA individual market enrollees. In addition, the exchange population used significantly more medical services and had significantly higher costs.[27]

In addition, pharmacy benefit manager Express Scripts indicates that 2014 exchange enrollees were nearly twice as likely to have $50,000 or more in annual medication costs compared to commercial members and were more non-adherent across a range of therapy classes.[28] In 2015, prescription drug spending grew faster in exchanges (14.6 percent) than in other markets, driven by spending on specialty drugs for HIV, Hepatitis C, oncology, multiple sclerosis, and inflammatory conditions.[29]

In addition to emphasizing the need for enrollment growth over time, the data above underscores the need to base the permanent risk adjustment program on data reflective of the unique health experiences of consumers in this market.

## Exchange Enrollment Lacks Continuity

### *Exchange Enrollees Churn Between Programs*

Relative to other markets, the exchange population is more likely to move between insurance plan options and insurance markets—sometimes referred to as "churn." Indeed, many exchange enrollees transition between being uninsured, having Medicaid coverage, employer-sponsored coverage, and/or switching among exchange plans. More than half (53 percent) of 2015 exchange enrollees did not have exchange coverage the year prior, and 29 percent of those who re-enrolled in the coverage chose a new plan for their second year of enrollment.[30] In addition, Avalere analysis of Inovalon's Medical Outcomes Research for Effectiveness and Economics Registry (MORE$^2$ Registry®) claims data finds that over 30 percent of enrollees in the individual market are enrolled for less than one year.[31]

This shift in sources of coverage presents challenges for issuers seeking to understand their population and effectively manage utilization and costs over time. For enrollees, this movement threatens continuous coverage and continuity of care (e.g., changes in formularies, provider networks).

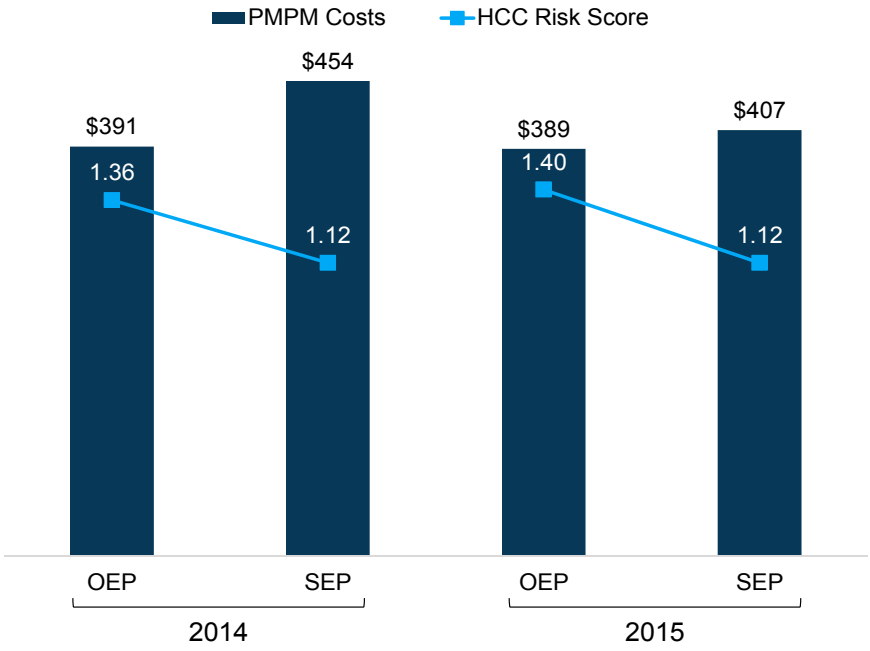
### *Individuals Enrolling Through SEPs Have Greater Healthcare Needs*

The ACA established an annual open enrollment period (OEP) to promote stability in the market, attracting enrollment at the same time each year to promote full-year enrollment and mitigate the potential for adverse selection (e.g., individuals signing up for coverage at any point when they need care and then dropping coverage). The ACA also allows for enrollment outside of the OEP, through special enrollment periods (SEPs), for some individuals experiencing life-altering events. However, since the implementation of exchanges, issuers have raised concerns about the extensive list of SEP qualifying events vulnerable to abuse.

SEP qualifying events include a range of scenarios, including loss of health coverage, changes in household size, changes in residence, changes in exchange eligibility or income, enrollment or plan errors, and other qualifying events.[32] These categories are broad and, as a result, enrollment through SEPs has been significant. Specifically, in the first half of 2015, approximately 940,000 individuals, or 15 percent of year-end federal exchange enrollment, enrolled in coverage on the federal exchange through a SEP.[33] [34]

Avalere analysis of Inovalon's MORE$^2$ Registry®, indicates that individuals who enrolled in coverage through SEPs in 2015 were enrolled for a shorter period of time (7.8 months for OEP enrollees vs. 3.6 months for SEP enrollees), used healthcare services (i.e. inpatient stays and emergency room visits) more frequently, and had 5 percent higher PMPM healthcare costs than those who enrolled through the annual OEP.[35] However, as shown in Figure 5, while PMPM costs are higher for SEP enrollees than OEP enrollees, their risk scores are as much as 20 percent lower on average.

**Figure 5: Average PMPM Healthcare Costs and Average Hierarchical Condition Categories (HCC) Risk Scores for OEP and SEP Enrollees, 2014 and 2015**




Risk scores represent a measure of predicted healthcare costs. This data suggests the shorter enrollment duration of individuals enrolling through SEPs may lead to risk scores that are not reflective of expected costs. As a result, SEP enrollment, when not appropriately regulated or accounted for in risk adjustment mechanisms, can have adverse implications for issuers.

In response to issuer concerns regarding the lack of regulation, CMS began to take steps to reduce access to SEPs.[36] Specifically, CMS has removed a number of SEP qualifying events that it determined are no longer necessary or due to concerns of inappropriate use.[37] [38] Furthermore, CMS has provided additional detail around the documentation beneficiaries must submit in order to verify SEP eligibility.[39]

Looking ahead, CMS is likely to pursue additional action around SEPs. In particular, while CMS did not propose any new changes in the 2018 Notice of Benefit and Payment Parameters (NBPP) proposed rule, it seeks comment on how to balance appropriate access via SEPs with concerns regarding risk pool impact.[40] In addition, CMS recently released a Frequently Asked Questions (FAQ) document regarding verification of SEPs and requests comment on the design of a pilot program to evaluate the impact of pre-enrollment verification of SEP eligibility and curb potential abuse of SEPs.[41]

### *Grace Periods May Allow for Inappropriate Continuous Coverage*

To help individuals maintain continuous coverage throughout the year, the ACA established grace periods. Grace periods allow for subsidized individuals, after paying the first month's premium, to continue to be enrolled in their exchange plan for 90 days after failing to make a premium payment. The issuer is required to pay claims for the first month of the grace period; however, providers are generally at risk when providing services to an exchange enrollee during the second and third months of a grace period. The grace period provision may be particularly prone to abuse, as it can allow individuals to pay nine months of premiums and maintain coverage for twelve months, enrolling again in coverage during the next OEP. As a result, issuers and providers have suggested that CMS shorten the 90-day grace period to 30 days.[42] [43]

### *Third Party Payments May Expose the Risk Pool to Adverse Selection*

CMS has been clear that health plans are required to accept third party payments from certain government health programs (i.e. Ryan White); however, it has discouraged plans from accepting third party cost sharing and premiums assistance from other entities such as hospitals and other providers.[44] [45] Nevertheless, CMS and others have highlighted the potential negative impact of current third party assistance on the exchange risk pool.[46] To address this potential concern, CMS recently released a Request for Information (RFI) to explore further the potential ramifications of third party premium payment outside of these programs on the exchange market.[47]

## The ACA's Risk Mitigation Programs Are Inadequate

### *Risk Adjustment Is Not Adequately Accounting for Expected Healthcare Costs*

The ACA established three risk mitigation programs (the "3Rs") to encourage issuer participation, mitigate risk in the new market, and appropriately compensate issuers for the financial costs of their enrollees. Two of the three programs, reinsurance and risk corridors, were designed as temporary programs for the 2014, 2015, and 2016 plan years.

Reinsurance, which seeks to limit issuer losses for high-cost individuals, is estimated to have been effective in lowering 2014 plan premiums by approximately 10 percent.[48] However, the risk corridors program, which was intended to transfer funds from plans that have higher-than-projected gains to plans with lower-than-expected gains, has been significantly underfunded, reducing its effectiveness. In 2014, this program paid only 12.6 percent of total corridor payments due. CMS' recent announcement that 2015 collections will exclusively be applied to outstanding 2014 payments suggests the program will continue to be largely ineffective for 2015 and 2016.[49] Many issuers, particularly the ACA's Consumer Operated and Oriented Plan (CO-OPs), have cited insufficient risk corridor payments as a factor driving their exits.

Unlike risk corridors and reinsurance, the risk adjustment program is permanent and is therefore a primary focus of potential improvement in the exchange market. Risk adjustment establishes transfer payments so that plans with lower-cost enrollees subsidize those plans with higher-cost enrollees. Plans receive a higher payment for sicker enrollees with costlier care, and make payments to other plans if they enroll a larger share of healthier enrollees. The exchange risk adjustment program is "zero sum" in that plans with higher risk scores receive payments from plans with lower risk scores. These payments or charges are generally announced six months after the conclusion of the plan year, potentially surprising some plans with a risk adjustment "bill." Indeed, CMS' announcement of owed risk adjustment payments for 2015 immediately contributed to the closure of Connecticut CO-OP HealthyCT and Oregon Health CO-OP.[50] [51] In addition, Maryland CO-OP Evergreen Health filed suit in federal court over the risk adjustment program.[52]

The risk adjustment program has a number of weaknesses identified by issuers and stakeholders as a key concern adding to instability in the market. At its core, the risk model has several limitations, described in a previous Avalere analysis and CMS white paper, which increase the likelihood of inaccuracy in calculating risk score and transfer payments.[53] [54] In the recently released NBPP for the 2018 plan year, CMS proposed a number of specific changes to the risk model to address some of these challenges. [55] Specific weaknesses of the current risk adjustment program include:

- **Data Sample:** The large group employer population dataset that CMS used to estimate the model does not closely mirror the currently-enrolled individual and small group commercial population. Due to this mismatch, the risk model may not properly estimate costs for the exchange population.

- **Payment for High Cost Enrollees:** The current model may not accurately compensate plans for high-cost enrollees. To address this problem, CMS proposes in the 2018 NBPP to reintroduce an element of reinsurance by covering 60 percent of claims above $2 million for any enrollee from a separate pool of funds. The pool, which will be funded by a percent-of-premium assessment on issuers, will aggregate costs across states. However, such proposal may have limited impact due to the high attachment point of $2 million. Analyses suggest that a $2 million attachment point is too high to materially improve the conditions for plans with high-cost enrollees.[56]

- **Adjustment for Partial Year Enrollment:** The model does not account for higher than expected costs for partial year enrollees, a concern that issuers have raised as contributing to financial losses. In the 2018 NBPP, CMS proposes to include in the 2017 risk model partial year enrollment duration (ED) factors. The ED factors will incrementally increase the risk score of an enrollee who is covered for less than one year. CMS is also proposing to incorporate ED factors into the 2018 model.[57]

- **Ability to Predict Costs for Healthy Individuals:** CMS also indicated it is considering a range of approaches to recalibrate the risk models to better predict risk for healthier subpopulations. While issuers report not enough money is being transferred to plans for high-cost individuals, analyses also indicate that too much money is being transferred away from healthier enrollees. Specifically, issuers are incurring losses on individuals who are not assigned any Hierarchical Condition Categories (HCCs) in the risk adjustment model. For example, issuers face a loss ratio of 126 percent for individuals without any HCCs, but just 69 percent for individuals with five HCCs.[58] Anthem reported in its 2016 second quarter earnings that risk adjustment "over-charges for healthy and over-reimburses for certain moderately unhealthy disease states."[59]

- **Disease Selection:** The model currently relies upon the diseases and conditions used in the Medicare risk adjustment model, which may not be appropriate for the individual and small group market. Perhaps as a result, only approximately 20 percent of the enrollees from the large group population used to estimate the model have at least one HCC.[60] This disease selection could be a contributing factor to the issue described above—namely that risk scores are too low for the healthy individuals because a very small percentage of enrollees have at least one HCC.

- **Prescription Drug Data**: Currently, the model does not include available prescription drug information to determine diseases and assign severity, yet the model is designed to predict medical and drug costs. In the 2018 NBPP, CMS proposes to include prescription drug data in the 2018 risk adjustment model. In this model, prescription drug use would provide an additional source to indicate a disease and would indicate the relative severity of an enrollee's condition for the purposes of calculating the risk score. CMS added 12 Prescription Drug Categories (RXCs) to the risk model and developed RXC-HCC pairs.

  However, CMS' proposal to include prescription drug data lacks clarity regarding which drugs will be included in each RXC. As a result, CMS could intend to include all drugs within a class or only particular drugs. These approaches would have varying implications for the risk adjustment model and, depending on how it is implemented, may be unlikely improve model accuracy.

### *Challenges Associated with the Transfer Formula*

In addition to reforms to make the risk adjustment model more accurate, there are additional considerations related to the transfer formula used to calculate plan payments.

- **Lack of Predictability of Transfer Payments:** The unpredictability of the risk adjustment program poses significant challenges for issuers. Plans may struggle

to predict their risk adjustment receipts or payment responsibilities throughout the year and, as a result, plans may owe a significant and unexpected amount. For example, the difference between expected and actual 2015 risk adjustment payments for a number of CO-OPs exceeded $10 million, or over 10 percent of their revenue.[61]

- **Effect of Including Administrative Expenses in Transfer Payment:** The calculation of the risk adjustment transfer payment may not appropriately incentivize efficiency. Specifically, the transfer payment is calculated as a percent of the average premium in the market, and the average premium incorporates administrative costs. As a result, more efficient plans with lower administrative costs may be subsidizing less efficient plans.

- **Zero Sum Transfer Formula:** The zero sum nature of the transfer formula may be insufficient to cover the aggregate risk in the market, given the smaller size and greater health needs of the enrolled population as compared to the potential population. Currently, the risk adjustment program is zero sum, meaning that there are "winners" and "losers" in the program. While incrementally more healthy people may exacerbate the current inaccuracy of the model in predicting enrollee costs without HCCs, low enrollment may hinder the ability of the current zero sum formulation to be effective.

## ISSUER PARTICIPATION

As issuers have gained experience in the market and developed a clearer understanding of the population, many have expressed broad concerns about the financial sustainability of offering exchange coverage. In particular, many of the challenges mentioned above are driving issuers' decisions regarding future participation in the market.

Ahead of the 2017 plan year, several large national and regional issuers have indicated they will significantly scale back or no longer participate in the exchange market because of unsustainable financial losses. In addition to CO-OPs and large national issuers exiting the market for 2017, there are also a range of local and regional issuers that are exiting or scaling back participation. In particular, LifeWise (Oregon), WellCare (Kentucky, New York), and Scott & White Health (Texas), among others, have announced they are exiting select states. [62] [63] [64] [65] Harken Health, a subsidiary of United, intended to expand its current exchange participation beyond Illinois and Georgia to offer coverage in Florida in 2017, but recently announced it will exit all exchange markets for 2017. In addition to issuers exiting entire states, some issuers (e.g., BlueCross BlueShield of Tennessee and Premera Blue Cross in Washington) will also decrease participation within existing states in 2017. [66] [67]

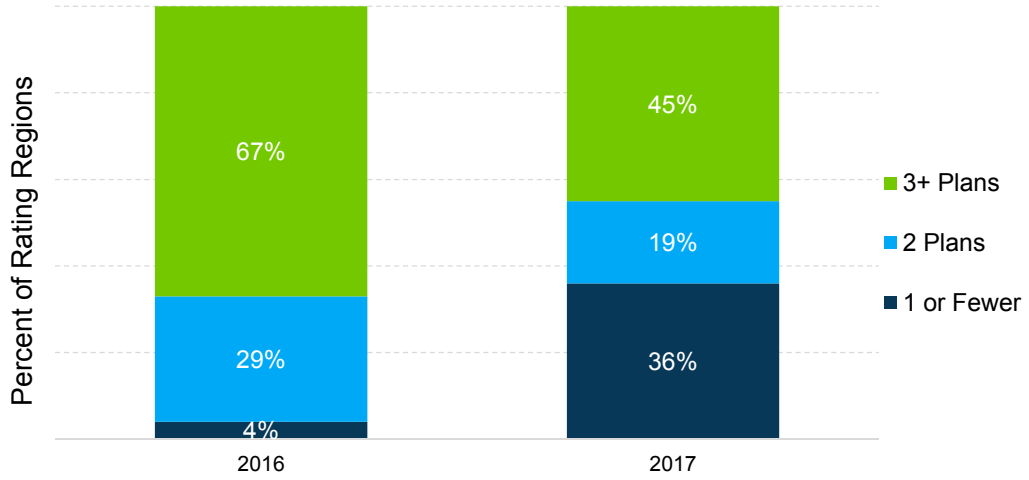
Figure 6, below, displays the announced changes in exchange participation and the financial losses as described by notable exchange exits: United, Humana, Aetna, and the CO-OPs.

### Figure 6: Exchange Issuer Participation and Financial Losses

| Issuer | Exchange Participation | | Financial Losses |
|---|---|---|---|
| | 2016 | 2017 | |
| **United**<br>*"The smaller overall market size and shorter-term higher risk profile within this market segment continue to suggest we cannot broadly serve it on an effective and sustained basis."*[68] | 1,855 counties across 34 states[69] | 3 states—Nevada, New York, and Virginia[70] | United experienced losses of **$475 million** on the exchanges in 2015 and expects to lose over **$600 million** in 2016.[71] |
| **Humana**<br>*"Humana anticipates proposing a number of changes to retain a viable product for individual consumers, where feasible, and address persistent risk selection challenges."*[72] | 1,351 counties across 19 states | 156 counties across 11 states[73] | Humana expects losses for 2016 individual commercial plans, including exchanges, to **total $337 million**.[74] |
| **Aetna**<br>*"This population dynamic, coupled with the current inadequate risk adjustment mechanism, results in substantial upward pressure on premiums and creates significant sustainability concerns."*[75] | 778 counties across 15 states | 242 counties across 4 states—Delaware, Iowa, Nebraska and Virginia[76] | Aetna's losses have totaled more than **$430 million** for individual products since January 2014.[77]<br><br>Aetna expects 2016 losses to exceed **$300 million**.[78] |
| **CO-OPs**<br>*"Between reduced congressional appropriations and disappointments with respect to risk adjustment or risk corridors, it's a lot for any startup to overcome."*[79] | 23 CO-OPs were established under the ACA and offered coverage in 2014<br><br>As of October 2016, 6 CO-OPs remain in operation, and it remains unclear how many will continue to participate in 2017[80] | | CO-OPs originally received $2.4 billion in federal funding. The 16 closed CO-OPs received **$1.7 billion**.[81]<br><br>Most remaining CO-OPs are incurring losses—4 CO-OPs lost a combined **$46.5 million** in the first half of 2016.[82] |

Importantly, Avalere analysis of issuer decisions indicates that consumer choice may decrease substantially for 2017. As shown in Figure 7, nearly 36 percent of exchange market rating regions may have only one participating issuer offering plans in 2017.[83] Similar analyses from other experts underscore these findings. McKinsey predicts that at least 12 percent of consumers will have access to just one issuer in 2016, up from 2 percent in 2015, and Kaiser Family Foundation finds that 31 percent of counties may have just one issuer in 2016.[84] [85]

**Figure 7: Issuer Participation in Exchange Rating Regions, 50 States & DC**




Carrier participation decisions are likely to evolve up until open enrollment begins on November 1. For example, since the Avalere analysis described in Figure 7 was released, Blue Cross and Blue Shield of Nebraska, Indiana University Health Plan (Indiana), and Oscar (New Jersey), among other issuers, have announced plans to exit select state exchanges for 2017.[86] [87] While select issuers have also announced intent to enter into new states or regions, 2017 participation is expected to be substantially lower than 2016 overall.

## POLICY OPTIONS TO ADDRESS KEY MARKET CHALLENGES

Given the current state of the exchanges heading into the 2017 plan year, there are potential changes that may help stabilize the market into the future. A number of these solutions have been discussed by stakeholders and/or explored by CMS to date.

### Improve Risk Mitigation Programs

There are several opportunities to improve the risk adjustment program, including amending proposed changes and introducing new and more fundamental changes. Combined, these changes could improve the accuracy and predictability of the model and, as a result, promote stability in the market.

### Increase Accuracy of Risk Model

- **Improve Disease Selection:** Reconsider coverage criteria for the diseases included in the model, as the same conditions used for the Medicare model development may not be appropriate for the individual and small group commercial population.
- **Align Data Sample:** Recalibrate the model based on individual and small group commercial enrollees, rather than the current MarketScan database.
- **Improve Proposed Inclusion of Drug Data:** Restructure how prescription drugs are included in the model to mitigate the potential for adverse implications. In particular, each RXC should be an accurate predictor of healthcare spending. This goal may be accomplished by adding subcategories of drugs within each RXC or by selecting a more homogenous set of drugs.

### Improve New Reinsurance Element

- **Reduce Reinsurance Attachment Point:** Examine the impact of lowering the attachment point from the proposed $2 million to $1 million, $500,000, or $100,000.[88]

### Amend and Simplify Transfer Formula

- **Create a New Transfer Formula:** Create a system where plans are paid based on the risk of their population, regardless of how that risk compares to other plans' customers to help insurers better predict their risk transfer payments and alleviate concerns stemming from the zero sum nature of the model. This approach might require dedicated funding for the risk adjustment program overall, similar to the Medicare Advantage program.
- **Exclude Administrative Costs from Transfer Formula:** Remove administrative costs from the transfer payment calculation to mitigate the variation in issuers' efficiency.

## Encourage Enrollment Stability

Encouraging enrollees to continue to stay enrolled in their plan for a longer period of time may also help stabilize the market and mitigate concerns related to adverse selection. Specifically, verifying that enrollees are eligible to enroll and creating incentives for individuals to remain enrolled throughout the year will promote a more stable and predictable market.

### Increase Market Integrity Oversight

- **Tighten SEP Use:** Further reduce the number of SEP qualifying events and/or heighten verification and documentation requirements, beyond what CMS has already proposed. Importantly, changes to SEP rules will need to balance market stability with access to coverage.
- **Shorten Grace Periods:** Reduce the 90-day grace period to, for example, 30 days. Alternatively, place additional enrollment restrictions and/or penalties on

beneficiaries who lose coverage because of non-payment of premium in one year and seek coverage in the following plan year.

- **Increase Transparency of Third Party Payments:** Promote transparency and issuer identification of third party payments from providers that may result in individuals who are eligible for Medicare or Medicaid enrolling in exchange coverage.

### Incentivize Enrollment Stability

- **Create Incentives to Retain Coverage**: Introduce incentives for longer-term, continuous enrollment, such as:
  - *Multi-Year Contracting:* Give issuers the ability to offer plans on a multi-year basis and to provide premium discounts to members who commit to plan membership over multiple years.
  - *Benefit Design Incentives:* Change benefit designs to reward loyal members (e.g., deductibles that decrease as tenure in a plan increases).

## Grow and Diversify Exchange Enrollment

In addition to changes that improve the exchange risk adjustment mechanisms and establish a more stable risk pool, opportunities to grow enrollment are likely to add stability to the market overall.

### Strengthen Penalties for Not Enrolling

- **Increase Individual Mandate Penalty:** Increase the individual mandate penalty amount for future years to make the tradeoff between purchasing insurance or paying the penalty less attractive for those forgoing insurance.
- **Strengthen Regulation of Mandate:** The Internal Revenue Service (IRS) could more strictly regulate mandate penalty exemptions to ensure each individual granted an exemption is qualified. Alternatively, Congress could grant the IRS authority to collect individual mandate penalties as it typically would for owed taxes.
- **Create Late Enrollment Penalty:** Exchanges could institute new penalties for late enrollment in order to further incent enrollment in the current plan year. Individuals who forgo signing up for insurance in prior years would be required to pay an additional amount when signing up for coverage in the future. The late penalty could be similar to the penalty that currently exists under the Part D program, which is added on to beneficiaries' monthly premiums. For example, if structured similar of the Part D program, a 50 year-old individual who is not eligible for subsidies and forgoes enrolling in coverage for 10 months would pay, approximately, an additional $50 per month added to the total premium for the duration of his/her exchange enrollment.

Alternatively, a late enrollment penalty could be implemented in the form of reduced coverage for the initial months of enrollment. For example, following late enrollment, an individual may only receive coverage for preventive services and emergency room visits for a specified period of time.

- **Tie Coverage to Public Program Participation:** Make health insurance a condition of other public programs, such as obtaining a driver's license. For example, in order to obtain a driver's license, an individual would be required provide evidence of continuous health insurance coverage.

### Increase Subsidies to Promote Premium Affordability

- **Restructure Subsidy Allocation:** As an alternative to increasing subsidy amounts overall, reduce subsidies for individuals between 300% FPL and 400% FPL in order to increase subsidies for individuals at lower income levels.

### Expand Enrollment Efforts

- **Increase Funding for Enrollment Efforts:** As more states continue to rely on the federal platform, additional funding for federal exchange education and enrollment assistance could help grow enrollment. Exchanges may reinvest in enrollment and outreach efforts to promote awareness of available coverage options and financial assistance, as well as in enrollment assistance to facilitate the enrollment process. Notably, presidential candidate Hillary Clinton has proposed to invest $500 million per year in "an aggressive enrollment campaign" to grow exchange enrollment.[89]

### Improve the Consumer Experience

- **Enhance Consumer Tools:** Consumers may benefit from more understandable consumer shopping tools, including user-friendly searchable formularies, provider networks, and out-of-pocket cost tools. These tools may help individuals choose the right coverage for their unique care needs and preferences, which may result in enrollees remaining in the plan longer. Notably, in 2014, approximately one-third of exchange enrollees with chronic conditions had to switch providers because they were not in-network and over one-fourth of enrollees switched their medication, making the case for increased consumer education and tools that increase transparency in plan selection.[90]
- **Streamline the Enrollment Process:** Enhancing and streamlining the processes for individuals to enroll through brokers and other qualified third parties could help grow enrollment. Third-party websites have long facilitated enrollment for shoppers in the individual market, and now bring strong decision support tools that are easily accessible to consumers. Initiatives to make it easier for brokers to enroll consumers directly and/or mitigate the back-and-forth interaction with exchange platforms could streamline the enrollment process.

### Attract "Young Invincibles"

- **Adjust Age Rating**: Modify the current age rating band from 3:1 to 5:1. Changing the age rating bands would lower premiums for younger individuals and raise premiums for older consumers.

- **Offer New Plan Options:** Provide lower cost plan options, such as a copper plan (50 percent actuarial value), to attract younger and healthier enrollees. Copper level plans would feature lower premiums, in exchange for higher cost sharing.[91] Alternatively, design new plan options that include additional benefits (e.g., vision) or first-dollar coverage for commonly used services. CMS suggests that consumers prefer plans that cover and pay for services before the deductible is reached.[92]

## LOOKING AHEAD / CONCLUSIONS

Despite moderate enrollment success to date, the exchange market faces significant uncertainty approaching the fourth open enrollment period. Lower-than-expected enrollment, instability in coverage, and inadequate risk mitigation programs are top concerns driving issuer decisions to limit participation in the market. While carrier participation is expected to decrease in 2017, opportunity exists for the next administration and/or Congress to stabilize the exchange market through a combination of potential policy solutions.

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# Contact Us

**Avalere Health**
An Inovalon Company
1350 Connecticut Ave, NW
Washington, DC 20036
202.207.1300 | Fax 202.467.4455
**avalere**.com