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Strong Demand Expected for Marketplace Open Enrollment, Despite Administration Actions

By Tara Straw, Sarah Lueck, Shelby Gonzales, and Halley Cloud

On November 1, HealthCare.gov and most state-based marketplaces will begin the Affordable Care Act (ACA)'s sixth open enrollment period, with consumers signing up for 2019 coverage. This open enrollment launches at a time when two major federal policy changes undermining the marketplace take full effect. The first of these is the 2017 tax law's repeal of the penalty related to the ACA's individual mandate (the requirement that most people get health insurance or pay a fee). The second is new Trump Administration rules designed to promote short-term health plans and association health plans, which don't meet ACA benefit standards or include the ACA's protections for people with pre-existing health conditions. Both changes will likely raise premiums and reduce marketplace enrollment.

Nevertheless, the marketplaces have proven resilient in the face of Trump Administration actions that depress enrollment and will likely remain so in the coming year, for several reasons. Surveys show that the large majority of marketplace consumers are satisfied with their coverage, and they'll have even more insurer and plan choices in 2019. Most marketplace consumers are protected from rate increases by offsetting increases in their premium tax credits and, as in 2018, many will find good bargains among the more generous plans.

Administration Actions Will Depress Enrollment

After persistent efforts by congressional Republicans and the Trump Administration in 2017 to repeal the ACA, nearly 1 million fewer people signed up for marketplace plans in 2018 (11.8 million) than at the peak in 2016, the final year of the Obama Administration (12.7 million).¹ More recent Trump Administration actions threaten enrollment once again this year by causing premiums to rise, reducing assistance to consumers, and creating confusion among consumers.

¹ Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report," April 3, 2018, <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report>.

Administration Actions Push Up 2019 Premiums

Premiums in 2019 are higher than they otherwise would be, due to a series of Trump Administration actions. During the last two years, the Administration threatened to end cost-sharing reduction payments to insurers and then did so, proposed rule changes expanding substandard health plans that operate outside the ACA marketplaces and then finalized them, backed multiple attempts in Congress to repeal the ACA, and fostered a general atmosphere of uncertainty about whether and how it would enforce key provisions of the law.² Late in 2017, Congress passed legislation that eliminated the mandate penalty in 2019, as discussed below, though in some cases insurers raised their 2018 premiums in anticipation of that change or out of concern the Administration would weaken enforcement.³

Each of these actions exerted upward pressure on premiums in the individual market. Premiums in 2019 for silver “benchmark” plans are 16 percent higher on average as a result of the repeal of the mandate penalty, the loss of cost-sharing reduction payments, and the expansion of substandard plans, the Kaiser Family Foundation estimates.⁴ So while average premiums for these plans will fall 2 percent in 2019 in the 39 states that utilize HealthCare.gov, as the Centers for Medicare & Medicaid Services (CMS) reported,⁵ premiums should actually be falling more. Moreover, evidence indicates that flat or falling premiums reflect some insurers having set their 2018 premiums too high as they attempted to deal with sudden Administration policy shifts, especially the end of cost-sharing reduction payments in October 2017.⁶

It’s good news that many consumers live in areas that will see little to no premium growth in 2019. However, while tax credits shield the large majority of marketplace consumers from premium increases, as discussed below, that is not the case for people with middle to high incomes. For people who must pay the full cost on their own, high premiums could discourage them from enrolling.

² See “Sabotage Watch: Tracking Efforts to Undermine the ACA,” Center on Budget and Policy Priorities, updated September 12, 2018, <https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca>.

³ Rabah Kamal *et al.*, “An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges,” Kaiser Family Foundation, August 10, 2017, <https://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>.

⁴ Rabah Kamal *et al.*, “How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums,” Kaiser Family Foundation, October 26, 2018, <https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/>.

⁵ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “2019 Health Plan Choice and Premiums in HealthCare.gov States,” October 26, 2018, <https://aspe.hhs.gov/system/files/pdf/260041/2019LandscapeBrief.pdf>.

⁶ See Rachel Fehr, Cynthia Cox, and Larry Levitt, “Individual Insurance Market Performance in Mid-2018,” Kaiser Family Foundation, October 5, 2018, <https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2018/> and Matthew Fiedler, “How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?” USC-Brookings Schaeffer Initiative for Health Policy, August 2018, <https://www.brookings.edu/wp-content/uploads/2018/08/Individual-Market-Premium-Outlook-20191.pdf>.

Expansion of Substandard Health Plans Puts Consumers and Market Stability at Risk

In 2019, federal rule changes are expected to boost the number of people enrolled in short-term health plans and association health plans (AHPs). These types of health coverage do not meet ACA benefit standards or include the ACA's pre-existing condition protections, yet under the new federal rules, short-term plans and AHPs could become widespread alternatives to ACA plans in states that allow this to occur.

As of October 2, short-term plans can last up to one year and be extended, instead of being limited to three months as under prior rules. And AHPs, which are health plans that trade and professional groups offer to their members, can now be formed more easily and offered to self-employed individuals (and small businesses), even though they don't have to meet ACA standards that otherwise apply to coverage offered to individuals and small businesses. Neither AHPs nor short-term plans must meet the ACA's essential health benefits requirements, so they can leave out or sharply limit coverage for mental health care, prescription drugs, or substance use disorder treatment. AHPs can charge people higher rates based on characteristics such as gender, age, and occupation (though not health status). Short-term plans *can* deny coverage and charge higher rates based on health status; they also can impose dollar limits on the benefits they will pay out during the coverage period and broadly exclude coverage related to a person's pre-existing conditions.

Some consumers who would have enrolled in ACA marketplace plans could instead be lured to short-term plans or AHPs, particularly if they expect to be healthy or do not realize that the coverage is far less comprehensive than marketplace coverage. Companies offering short-term plans typically market them aggressively; in some cases they are explicitly targeting the ACA open enrollment period for a marketing push, even though there is no deadline to sign up for these plans.⁷ This will likely increase consumers' confusion.

The looming expansion of substandard plans raises two major concerns. The first is that some consumers will enroll in a substandard plan and then get sick or injured, leaving them with high out-of-pocket costs or difficulty accessing coverage of needed services. The second is that the proliferation of such plans will cause the traditional insurance risk pool to deteriorate by siphoning off healthier enrollees, which would threaten the market's stability over time and leave individuals — specifically, those ineligible for premium tax credits — paying significantly higher premiums. The Urban Institute estimated that the federal expansion of short-term plans, combined with elimination of the individual mandate penalty, would increase premiums for ACA plans by 18.3 percent and leave 9 million fewer people with minimum essential coverage.⁸

⁷ Sarah Lueck, "Key Flaws of Short-Term Health Plans Pose Risks to Consumers," Center on Budget and Policy Priorities, September 20, 2018, <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

⁸ Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018, https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

Repeal of Individual Mandate Will Raise Premiums and Depress Enrollment

The coming open enrollment period will be the first since the 2017 tax law repealed the individual mandate penalty. In 2019 alone, eliminating the penalty will lower Medicaid enrollment by 1 million people and nongroup insurance enrollment (on and off the marketplace) by 3 million, while raising the number of uninsured by 4 million, the Congressional Budget Office (CBO) estimates.⁹ In one survey of adults with insurance coverage, 5 percent overall said they would drop their coverage in 2019 due to repeal of the penalty, while 9 percent of people in the individual market said they wouldn't re-enroll.¹⁰

The individual mandate was intended to keep healthy people in the marketplace to maintain a stable risk pool. Without this nudge to enroll, premiums will rise. CBO estimated that premiums will be 10 percent higher in 2019 than they would be absent the change, as fewer healthy people will enroll in the regulated nongroup market and sicker people will remain.¹¹ *Nearly 8 in 10* insurers surveyed said they increased 2019 rates due to repeal of the penalty, by an average of 5 percent.¹² This follows double-digit premium hikes in 2018 driven by concerns about non-enforcement of the mandate and the other regulatory uncertainty fueled by the Trump Administration's year-long ACA repeal effort.¹³

Outreach Cuts Will Mean Less Assistance and Lower Enrollment

The Administration has sharply cut marketplace outreach and enrollment assistance, making it less likely that new consumers will learn about the coverage and financial assistance available to them. Outreach and marketing have shrunk to \$10 million, a 90 percent cut since 2016, despite continued evidence that advertising yields enrollment gains.¹⁴ (See Figure 1.) For purposes of comparison,

⁹ Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018, <https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf>.

¹⁰ Sara R. Collins *et al.*, "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-Mar. 2018," *To the Point*, Commonwealth Fund, May 1, 2018, https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse?redirect_source=/~/media/b404ef047f9e4858b22305756550caf0.ashx.

¹¹ Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028."

¹² Beth Fritchen and Kurt Giesa, "Oliver Wyman Survey: The Affordable Care Act's Stabilization," Oliver Wyman, June 20, 2018, https://health.oliverwyman.com/2018/06/aca_survey.html.

¹³ For a general discussion, see Kurt Giesa, "Analysis: Market Uncertainty Driving ACA Rate Increases," Oliver Wyman, June 4, 2017, https://health.oliverwyman.com/2017/06/analysis_market_unc.html. An example of insurers' aggressive response to the loss of the mandate in their 2018 rates occurred in Pennsylvania, where UPMC received state approval for a rate increase of 41.15 percent, or more than five times the expected growth in medical costs (7.01 percent). See <https://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Documents/2018%20ACA/UPMC%20HO%20-%20IND%20-%202018%20Rate%20Decision%20Summary%20Final.pdf>.

¹⁴ Ariel Cohen, "CMS Not Increasing ACA Marketing and Outreach Budget for 2019," *Inside Health Policy*, September 21, 2018, <https://insidehealthpolicy.com/daily-news/cms-not-increasing-aca-marketing-and-outreach-budget-2019>. See, for example, Sarah E. Gollust *et al.*, "TV Advertising Volumes Were Associated with Insurance Marketplace Shopping and Enrollment in 2014," *Health Affairs*, June 2018, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1507>.

California’s state-based marketplace, which has made a concerted effort to invest in outreach and enrollment assistance, will spend \$6.5 million on its statewide navigator program and \$45 million on paid advertising.¹⁵

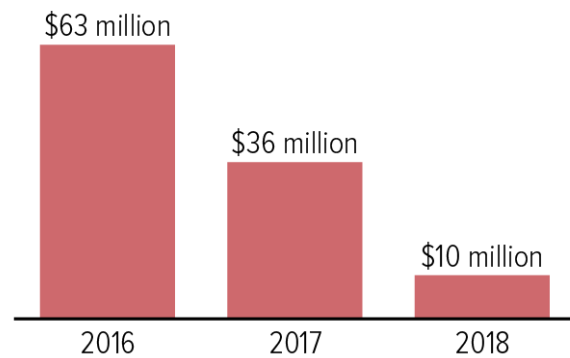
Similarly, CMS has cut funding for enrollment help by navigator programs by more than 80 percent since 2016, leaving only \$10 million to spread across 34 states, despite an ongoing need for in-person assistance.¹⁶ (Navigator programs raise awareness about the marketplace, help people apply for federal subsidies, provide impartial information about plan options, and help consumers with issues such as filing appeals and submitting eligibility documentation.) In Florida, five groups received nearly \$6.6 million in navigator funding last year to enroll 1.7 million people, the most in any state; this year a single group will receive only \$1.25 million to serve the entire state. In Texas, navigator coverage will fall far short of the previous, near statewide coverage, with no funded navigators in San Antonio, Dallas, Fort Worth, Austin, Corpus Christi, Waco, or the entire Texas Panhandle. Three states — Iowa, Montana, and New Hampshire — will have no navigator at all.

Compounding the harm of the funding cuts, the Administration abandoned the practice of awarding multiyear grants, which was meant to promote continuity and expertise among navigator organizations, instead announcing single-year funding only seven weeks before open enrollment.¹⁷ This left little time for awardees to set their budgets and hire and train enrollment workers, or for qualified applicants denied grants to replace that funding with money from other sources.

FIGURE 1

Trump Administration Has Cut Navigator Funding by Over 80 Percent Since 2016

Funding for programs using federal marketplace



Source: Centers for Medicare & Medicaid Services (CMS)

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¹⁵ Covered California, “Fiscal Year 2018-2019 Budget,” June 15, 2018, https://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2018-19_Budget-6-15-18.pdf.

¹⁶ Karen Pollitz, Jennifer Tolbert, and Maria Diaz, “Data Note: Further Reductions in Navigator Funding for Federal Marketplace States,” Kaiser Family Foundation, September 24, 2018, <https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>. See also Halley Cloud, “In Latest ACA Sabotage, Administration Nearly Eliminates Marketplace Enrollment Assistance Funds,” Center on Budget and Policy Priorities, July 13, 2018, <https://www.cbpp.org/blog/in-latest-aca-sabotage-administration-nearly-eliminates-marketplace-enrollment-assistance-funds>.

¹⁷ Centers for Medicare & Medicaid Services, “Grants Awarded for the Federally-Facilitated Exchange Navigator Program,” September 12, 2018, <https://www.cms.gov/newsroom/press-releases/grants-awarded-federally-facilitated-exchange-navigator-program>.

Proposed “Public Charge” Changes Could Raise Immigrants’ Fears

The Administration recently proposed a rule that could frighten families that include immigrants from obtaining marketplace coverage for which they are eligible. If finalized, the Department of Homeland Security rule would make it much harder for many immigrants lawfully in the country to remain here and for many seeking legal entry to come. The rule directs immigration officials to reject applications from individuals who seek lawful permanent resident status, or seek to enter the United States, if they have received — or are judged likely to receive in the future — any of an extensive array of benefits tied to need, including Medicaid. Although receipt of marketplace subsidies is not one of the benefits that would lead to rejection of an immigration application, the proposed requirements are complex and confusing. Many families that include immigrants may be afraid to apply for marketplace subsidies, given the Administration’s harsh stance on immigration and the significant media attention that the proposed changes have received. (Consumers who apply for marketplace subsidies must also be screened for Medicaid eligibility; this link between the application processes for the two programs could cause further fear and confusion.)

The proposed public charge rule is far from becoming final, and it specifies that changes related to benefit use in the immigration process would not begin until 60 days after the rule is finalized. This should provide some reassurance to families seeking to enroll in health coverage. Still, many people will likely be deterred, fearing that enrolling in health coverage could prevent them from realizing their families’ immigration-related goals.

Efforts to Undermine ACA Have Created Consumer Confusion

Some people who need health coverage likely doubt the ACA is still law. A Government Accountability Office (GAO) report documenting the factors that likely affected 2018 enrollment cited consumer confusion about whether the ACA had been repealed and whether coverage was still available.¹⁸ After Congress’s year-long effort to repeal the law in 2017, President Trump continued the repeal rhetoric this year, saying in the State of the Union that “[w]e repealed the core of disastrous Obamacare”¹⁹ and stating as recently as May that “[e]ssentially, we are getting rid of Obamacare.”²⁰

Compounding consumer uneasiness, the Administration announced in June that it won’t defend the ACA against a court challenge by 20 Republican-led states that seeks to invalidate the entire law.²¹ In particular, the Justice Department asked the court to strike down two critical consumer

¹⁸ U.S. Government Accountability Office, “Health Insurance Exchanges: HHS Should Enhance its Management of Open Enrollment Performance,” July 2018, <https://www.gao.gov/assets/700/693362.pdf>.

¹⁹ Amy Goldstein, “Trump’s claim that ‘core of the disastrous Obamacare’ is gone,” *Washington Post*, January 30, 2018, https://www.washingtonpost.com/politics/2018/live-updates/trump-white-house/fact-checking-and-analysis-of-trumps-state-of-the-union-2018-address/trumps-claim-that-core-of-the-disastrous-obamacare-is-gone/?utm_term=.daaa4904aa52.

²⁰ See, for example, Michael Ollove, “Health Insurance Premiums Are Stabilizing, Despite GOP Attacks,” Stateline, August 16, 2018, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/16/health-insurance-premiums-are-stabilizing-despite-gop-attacks>.

²¹ Letter from the Office of the Attorney General, Department of Justice, to Speaker of the House of Representatives Paul Ryan, June 7, 2018, <https://www.justice.gov/file/1069806/download>.

protections: the provision that bars insurers from denying coverage to people with pre-existing conditions (guaranteed issue) and the prohibition on charging higher premiums to people because of their health status (community rating).

The insurance landscape for 2019 will also leave consumers confused. As noted, a flood of new plans with substandard benefits will be marketed alongside more comprehensive plans during marketplace open enrollment. At the same time, there will be fewer impartial, trained experts to explain the differences and little time to do it: once again, open enrollment for states using HealthCare.gov will be only 45 days long (ending on December 15), shorter than in many states with a state-based marketplace.²²

The shorter open enrollment period will leave consumers with fewer opportunities to hear about HealthCare.gov and less time to visit, shop for plans, and get questions answered. It will also deny them the option of waiting out the holiday season and signing up for coverage in January. Low- and moderate-income families experience especially high financial stress in December, which may discourage them from enrolling in coverage at that time of year, a study by Harvard and Vanderbilt researchers found.²³

Consumer Demand for Coverage Expected to Stay Strong

Despite the headwinds described above, marketplace coverage will remain attractive to consumers, for several reasons.

Most Marketplace Consumers Are Satisfied With Their Coverage

The starting point for open enrollment sign-ups is the roughly 10 million current marketplace consumers.²⁴ More than 80 percent of marketplace enrollees were satisfied with their coverage in 2017, similar to previous years, surveys show.²⁵ (See Figure 2.) Despite repeal of the individual

²² Six of the 12 states that operate their own enrollment platform (California, Colorado, District of Columbia, Massachusetts, Minnesota, and New York) extend their open enrollment period beyond the federal minimum. For a list of open enrollment deadlines in state-based marketplaces, see Louise Norris, “What’s the Deadline to get Coverage during Obamacare’s Open Enrollment Period?” [healthinsurance.org](https://www.healthinsurance.org/faqs/what-are-the-deadlines-for-obamacares-open-enrollment-period/), October 10, 2018, <https://www.healthinsurance.org/faqs/what-are-the-deadlines-for-obamacares-open-enrollment-period/>.

²³ Katherine Swartz and John Graves, “Shifting the Open Enrollment Period for ACA Marketplace Could Increase Enrollment and Improve Plan Choices,” *Health Affairs*, July 2014, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0007>.

²⁴ Centers for Medicare & Medicaid Services, “Early 2018 Effectuated Enrollment Snapshot,” July 2, 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>.

²⁵ Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, “Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March-June 2017,” Commonwealth Fund, September 2017, <https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand>.

mandate penalty, 90 percent of individual market enrollees (on and off marketplace) plan to re-enroll for 2019.²⁶

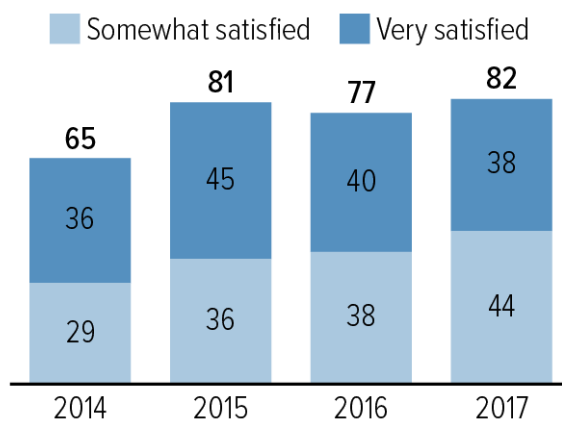
Re-enrollment isn't appropriate for all consumers; some obtain job-based coverage, experience income changes that make them eligible for Medicaid, or otherwise find a new source of coverage. Nonetheless, in previous years, high satisfaction rates among marketplace consumers have translated into high re-enrollment rates. Last year, for example, nearly 5.5 million consumers came back to HealthCare.gov or their state marketplace and actively selected a plan, in addition to the nearly 2.9 million who were re-enrolled automatically.²⁷ Returning consumers made up 73 percent of all 2018 enrollment.

Additionally, high satisfaction rates mean that as the ACA marketplaces mature, a growing number of people have prior, often positive marketplace experience. They may be more likely to return to the marketplace as “new” consumers if their circumstances change again.

FIGURE 2

Most Marketplace Consumers Are Satisfied with Their Coverage

Share of adult marketplace enrollees



Note: Consumers in the Affordable Care Act (ACA) marketplace

Source: Commonwealth Fund ACA Tracking Surveys

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Insurer Participation Will Increase

In recent years, some insurers reduced participation in ACA marketplaces or left them entirely due to financial losses and the unpredictable policy environment. But in 2019, some insurers are newly entering the marketplaces, others that left in 2016 and 2017 are returning, and existing insurers are expanding the areas they serve. According to CMS, 23 more insurers will offer plans in 2019 than did so during the last open enrollment period, and only five states are expected to have a single insurer offering marketplace coverage, down from eight states in 2018.²⁸ This will increase some consumers' array of plan choices (on average, consumers will have 26 plans to choose from, up from 25 in 2018), which could help them find a plan with features — such as a provider network and deductible level — that meet their needs. Greater competition among insurers also could help reduce premiums for people who don't qualify for subsidies.

²⁶ Ashley Kirzinger *et al.*, “Kaiser Health Tracking Poll – March 2018: Non-Group Enrollees,” Kaiser Family Foundation, April 3, 2018, <https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/>.

²⁷ Centers for Medicare & Medicaid Services, “Health Insurance Exchanges 2018 Open Enrollment Period Final Report.”

²⁸ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “2019 Health Plan Choice and Premiums in HealthCare.gov States.”

In addition, if participating insurers ramp up their marketing activities and enrollment assistance, this could boost awareness about marketplace plan options, ACA subsidies, and the benefits of adequate coverage.

Most Marketplace Consumers Are Protected From Rate Increases

Under the ACA, marketplace consumers with incomes below 400 percent of the poverty level (about \$100,000 for a family of four) can purchase silver benchmark coverage for no more than a specified fraction of their income, regardless of sticker price premiums. This fully shields them from premium increases. For example, a family of four with income of \$50,000 is guaranteed the option to purchase benchmark coverage for no more than about 6.5 percent of their income, or about \$270 per month. When sticker prices increase, the family's premium remains the same, with their premium tax credit adjusting to make up the difference. In 2018, while sticker price premiums for benchmark coverage increased by an average of 37 percent in HealthCare.gov states,²⁹ average net monthly premiums for the more than 85 percent of consumers qualifying for subsidies *fell* from \$106 to \$89.³⁰ (See Figure 3.)

The large majority of both current and potential marketplace enrollees are eligible for a premium tax credit. Eighty-seven percent of 2018 marketplace enrollees qualified for a credit.³¹ Likewise, the Urban Institute estimates that one-quarter of the remaining uninsured (about 7.5 million of the 30 million uninsured) are potentially eligible for a credit because their incomes are below 400 percent of the poverty level.³² The Department of Health and Human Services (HHS) and independent analysts estimate that a substantial majority of individual market consumers who purchase off-marketplace could qualify for a credit if they switched to marketplace coverage.³³

²⁹ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," October 30, 2017, https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

³⁰ Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report"; Centers for Medicare & Medicaid Services, "Health Insurance Marketplaces 2017 Open Enrollment Period Final Open Enrollment Report," March 15, 2017, <https://www.cms.gov/newsroom/fact-sheets/health-insurance-marketplaces-2017-open-enrollment-period-final-enrollment-report-november-1-2016>.

³¹ Centers for Medicare & Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot."

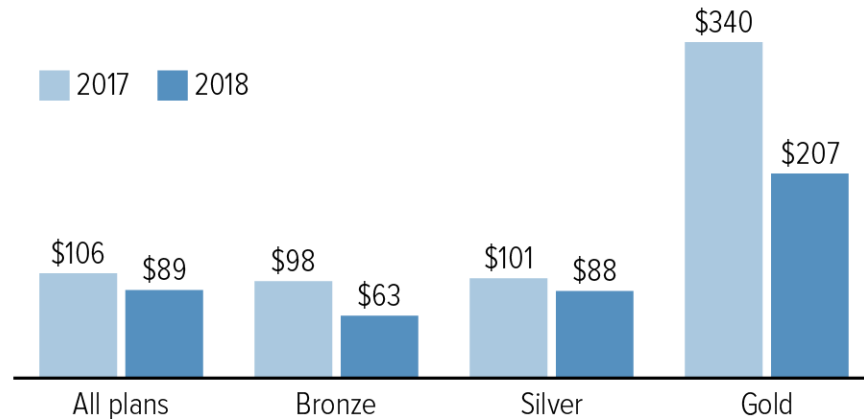
³² Linda J. Blumberg *et al.*, "Characteristics of the Remaining Uninsured: An Update," Urban Institute, July 2018, https://www.urban.org/research/publication/characteristics-remaining-uninsured-update/view/full_report.

³³ Department of Health and Human Services, Assistance Secretary for Planning and Evaluation, "About 2.5 Million People Who Currently Buy Off-Marketplace May Be Eligible for ACA Subsidies," October 4, 2016, <https://aspe.hhs.gov/system/files/pdf/208306/OffMarketplaceSubsidyeligible.pdf>. In addition, McKinsey analysts estimated that about 70 percent of consumers across the entire individual market have incomes below 400 percent of the poverty level. McKinsey Center for U.S. Health Reform, "Exchanges three years in: Market variations and factors affecting performance," May 2016, <https://healthcare.mckinsey.com/exchanges-three-years-market-variations-and-factors-affecting-performance>.

FIGURE 3

Cost of Marketplace Coverage Fell in 2018 After Counting Premium Tax Credits

Average monthly premium costs for HealthCare.gov enrollees



Note: Average premiums, after accounting for monthly advance premium tax credits, are the per-person premium amounts, weighted by HealthCare.gov plan enrollment during the open enrollment period for 2017 and 2018. Data reflect marketplace enrollment in the 39 states using HealthCare.gov as of January 31, 2017 (for 2017) and December 23, 2017 (for 2018).

Source: Government Accountability Office analysis of Department of Health and Human Services data

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Many Consumers Can Afford More Generous Plans

Many consumers eligible for a premium tax credit will be able to find good bargains for 2019 coverage, similar to 2018. A large share of last year’s premium increases resulted from the Trump Administration’s decision to stop cost-sharing reduction payments, which reimburse insurers for the cost-sharing assistance the ACA requires them to provide to lower-income enrollees. This assistance is available only to consumers who enroll in marketplace silver plans, so insurers in most states raised premiums for silver plans but *not* for bronze, gold, or platinum plans to account for the loss of those payments. (This practice was referred to as “silver loading.”)³⁴

Consumers’ premium tax credits rise to match increases in silver plan premiums, regardless of whether they purchase a silver plan or a different coverage tier. As a result, enrollees in 2018 coverage had a larger credit to apply to a marketplace plan; many found particularly good bargains among gold plans (which have higher premiums but significantly lower deductibles) and bronze plans (which have hefty deductibles but modest premiums), where the 2018 premium increases were much smaller than among silver plans. In 2018, the lowest-cost gold plan cost less than the lowest-

³⁴ David Anderson *et al.*, “Implications of CMS Mandating a Broad Load of CSR Costs,” *Health Affairs* blog, May 15, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180511.621080/full/>.

cost silver plan in nearly 500 counties nationwide, and more than half of people who were uninsured and eligible for marketplace coverage could have obtained a bronze plan for *zero* net premium.³⁵

For consumers eligible for premium tax credits, silver loading will result in similarly good deals for bronze and gold plans in 2019, despite a 3 percent drop in the average monthly tax credit.³⁶ Overall, HHS estimates that 79 percent of HealthCare.gov consumers can find a 2019 plan with a premium of less than \$75 per month after tax credits.³⁷ (See Figure 4.) Gold plans are also more affordable. For example, a 40-year-old consumer with income of \$30,000 in Des Moines, Iowa, can choose a bronze plan with a \$6,200 deductible at zero net premium, or for a premium of less than \$7 per month, enroll in a gold plan with a \$750 deductible.

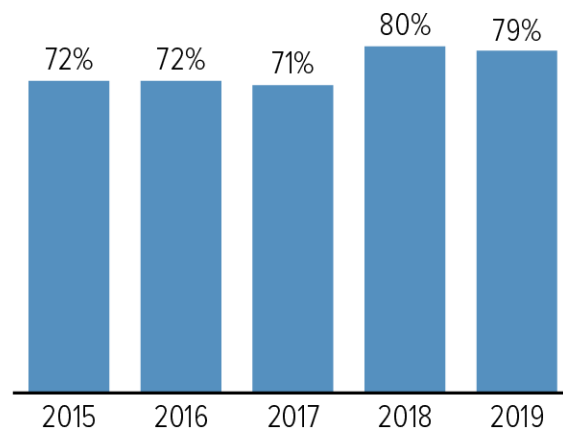
In addition to creating bargains among gold and bronze plans, higher silver prices made more families eligible for premium tax credits (since eligibility is based on benchmark premiums as a specified share of household income). As a result, in 2018, enrollment among people with income between 301 and 400 percent of poverty was up 10 percent in states that use HealthCare.gov.³⁸ With premiums relatively unchanged in many areas, the same trend should continue for 2019.

Even consumers who are ineligible for premium tax credits might benefit. More than half of unsubsidized consumers enroll in bronze or gold plans,³⁹ and because premium increases will be smaller for those tiers than for silver plans, unsubsidized consumers may find better deals than they expect in those tiers. (Most will still face significantly higher premiums than they would have if not for the Administration’s actions, however.) In some parts of the country, gold plans will cost

FIGURE 4

79% of HealthCare.gov Consumers Can Enroll in a 2018 Plan for Less Than \$75 Per Month

Share of consumers who can buy a plan for less than \$75 per month, after accounting for tax credits



Source: Department of Health and Human Services

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³⁵ Ashley Semanskee, Gary Claxton, and Larry Levitt, “How Premiums are Changing in 2018,” Kaiser Family Foundation, November 29, 2017, <https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/>.

³⁶ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “2019 Health Plan Choice and Premiums in HealthCare.gov States.”

³⁷ *Ibid.*

³⁸ Andrew Sprung and David Anderson, “Mining the Silver Lode,” *Health Affairs* blog, September 7, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.186647/full/>.

³⁹ Ashley Semanskee, Gary Claxton, and Larry Levitt, “How Premiums are Changing in 2018,” Kaiser Family Foundation, November 29, 2017, <https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/>.

consumers about the same as, or less than, silver plans, allowing unsubsidized consumers to reduce their premium *and* lower their deductible by switching from silver to gold. Likewise, bronze plans may offer a better deal than silver plans: while they still have higher deductibles, the premium discount they offer is substantial, as it was in 2018. The lowest-premium plan costs 29 percent less than the benchmark silver plan in 2019 on average across HealthCare.gov states — identical to last year.⁴⁰

⁴⁰ Centers for Medicare & Medicaid Services, “Average Monthly Premiums for Second-Lowest Cost Silver Plan and Lowest Cost Plan for States Using the HealthCare.gov Platform, 2016-2019,” data as of September 28, 2018, <https://www.cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019.pdf>.