

OPTIONS FOR ADDRESSING COUNTIES THAT HAVE NO INDIVIDUAL MARKET QUALIFIED HEALTH PLAN FOR 2018

The potential of having counties with no carrier serving the individual exchange market in 2018 appears very high if there is not substantive activity to help stabilize the market. There are no “good” options for addressing what would be a “bare county.” By far the best option is to prevent a county from having no carrier in the first place by adopting a package of stabilization policies that would assure full nationwide coverage. Those policies would likely include for 2018 and 2019: (1) full on-going federal funding of Cost Sharing Reduction Subsidies; (2) enforcement of existing individual mandate until a comparable policy is in place; and (3) Risk Stabilization funding for 2018 and 2019. To affect health plan decisions for 2018 these policies need to be in place and credible by May 2017 at the latest.

The options that follow, in the event there remain bare counties, also need fast implementation as health plans would need to be contacted by July of 2017 in order to be able to offer coverage in January 2018. These options are provided in summary form followed by major issues with regard to their implementation. For all of these potential solutions, there needs to be developed a standard definition of “underserved” county. Issues related to definition of underserved counties include:

- Is the definition prospectively for counties that have only 1 or 2 carriers as of 2017, or counties that are known to have 0 carriers after an initial bid process?
- There will be huge implementation challenges if the policy is targeted based on filling gaps at the “last minute.”
- Definitions based on counties with one or two carriers may not help in some circumstances (e.g., where three carriers all pull out of a county), depending on the date selected to determine “underserved” areas.

1. Forgive the health insurer tax (HIT) on a proportional basis for carriers that enter or stay in “underserved” counties.

Issues:

- Could help for 2018, but only if it’s implemented soon.
- May require legislation, though there might be ways to do through executive action.
- Some tax reductions could go to insurers who would otherwise participate regardless.
- May not help in some circumstances (e.g., where three carriers all pull out of a county), depending on the date selected.
- Need to develop formula so the tax reduction of the HIT is proportional to the county/counties or enrollment served by the carrier so there is no “windfall” tax benefit for a carrier.
- The formula would need to consider making the HIT forgiveness for not only the individual business, but also for a carrier’s other lines of business in a state, such as Medicare, employer and Medicaid.

2. Waive penalty for non-covered individuals living in counties with no plans offered.

Issues:

- Relatively simple to administer for 2018.
- Does not address issue of providing coverage to individuals wanting coverage.

- 3. Provide targeted risk stabilization resources/reinsurance to a carrier that serves an underserved region.** An insurer that enters or stays in a county where there are zero carriers or just one carrier as of a certain date would be eligible for this funding.

Issues:

- Could be scaled up or down more easily than the health insurer tax holiday.
- Would allow participating carriers to reduce individual market premiums thus reducing federal spending on premium tax credits.
- Not very costly if the number of enrollees in bare counties is small, particularly given the reduction in federal spending on premium tax credits, which means that the federal cost of providing reinsurance is about 1/3 of the nominal reinsurance funding amount given the substantial reduction in APTC and the direct reduction in federal spending.
- Could help for 2018, but only if it's implemented soon and would require an appropriation.
- Could potentially be done on the state level through a 1332 waiver with federal pass-through funding, but the timing would be virtually impossible for 2018. In addition, state funding would be a significant challenge for many states even if a substantial amount of that funding were repaid by the federal government because of savings generated from reduced federal premium tax credit payments.
- Some reinsurance funds could go to insurers who would otherwise participate regardless.

- 4. Allow consumers to “buy in” to the state Medicaid program in regions that have no QHP.**

Issues:

- Very difficult if not impossible to implement for 2018.
- Since this would require state action, it would not necessarily be a common national solution.
- Potentially easier to implement than a requirement that Medicaid managed care plans participate in the individual market, particularly in rural counties.
- Could serve as an incentive to encourage carriers to participate in the marketplaces.
- State Medicaid programs would need to set a premium for the buy-in, which would require federal rules and oversight to avoid either a “windfall” in revenues or funding that is insufficient to cover states’ costs. This could also put states at risk for premiums that are too low.
- Nearly all state Medicaid programs use actuarial consultants, so their ability to set rates should not be a technical impediment.
- Medicaid programs would need to establish plan designs for the buy-in (potentially with cost-sharing reductions as well). The federal standard plan designs could be used, which is likely preferred for administrative simplicity.
- It may be very difficult to work out federal payment issues to states of APTC amounts in the absence of a “second lowest” silver plan for benchmarking.
- The network capacity of Medicaid providers is uncertain.
- There would need to be a decision on whether to require consumers to be in Medicaid managed care plans or participate in Medicaid fee-for-service.

5. Require Medicaid managed care plans to participate in underserved counties.

Issues:

- Very difficult if not impossible to implement for 2018.
- Since this would require state action, it would not necessarily be a common national solution.
- Plans may not have networks or capacity in the relevant counties, especially rural ones.
- It is difficult to coerce a plan into participating. It could simply set a very high premium to discourage enrollment.

6. Require Medicare Advantage plans to participate in underserved counties.

Issues:

- Very difficult if not impossible to implement for 2018.
- Plans may not have networks or capacity in the relevant counties, especially rural ones.
- It is difficult to coerce a plan into participating. It could simply set a very high premium.
- The networks of providers may not be aligned with needs of younger-marketplace enrollees.
- Very likely to have strong health plan opposition.

7. Allow QHP-eligible individuals in bare counties to buy into state employee plans using tax credits.

Issues:

- Very difficult if not impossible to implement for 2018.
- Since this would require state action, it would not necessarily be a common national solution.
- Some specific state employee plans may not have networks or capacity in more rural counties, but state employee systems generally cover people in all parts of the state through some plan.
- Requires plans to set a premium for the buy-in, which would presumably be negotiated between the state and the plans. Many state employee plans are self-insured, and it is unclear who would bear risk in that case.
- Plans would need to establish plan designs for the buy-in (potentially with cost-sharing reductions as well). The federal standard plan designs could be used, which is likely preferred for administrative simplicity.
- Most state employee plans have historically broad networks and rich benefits making those designs more expensive than the coverage offered in market places. Hence, either substantial network re-contracting or benefit redesign may be needed or the cost of this coverage may be far higher than that offered through marketplaces.

8. Allow QHP-eligible individuals in bare counties to buy into FEHB.

Issues:

- Very difficult, if not impossible, to implement for 2018.
- Does not require individual states to act, so could be implemented nationally.
- FEHB should be able to cover anywhere.
- Requires plans to set a premium for the buy-in, which could involve negotiations between the US Office of Personnel Management, Health and Human Services and the plans. It may be difficult to get plans to propose competitive premiums for business they're not looking to attract.
- Plans would need to establish plan designs for the buy-in (potentially with cost-sharing reductions as well). The federal standard plan designs could be used, which is likely preferred for administrative simplicity.
- Most FEHB have historically broad networks and rich benefits making those designs more expensive than the coverage offered in market places. Hence, either substantial network re-contracting or benefit redesign may be needed or the cost of this coverage may be far higher than that offered through marketplaces.

9. Allow QHP-eligible individuals in bare counties to buy into TRICARE.

Issues:

- Would be difficult to implement in 2018 (but implementation could be speeded up through inter-agency cooperation with the Department of Defense and Health and Human Services).
- TRICARE uses three national carriers, so relatively few plans to work with.
- Because military personnel are stationed throughout the country, all counties could be covered.
- Could serve as an incentive to encourage carriers to participate in the marketplaces.
- TRICARE's contracts (based on cost-plus) would require some renegotiation, but this happens every year. There would need to be plan designs and premiums for marketplace enrollees.

10. Allow tax credits to be used for off-marketplace plans in counties that have zero plans.

Issues:

- Could be implemented relatively quickly, but for 2018 implementation would probably require tax credit available with credit payable at tax filing rather than advanced.
- There may be no ACA-compliant plans participating off-marketplace. Even where plans are currently participating off-marketplace, they may be only willing to do that because they can control their enrollment – such as through special enrollment policies, doing targeted marketing and limiting enrollment. If those plans were required to comply with additional rules and take more enrollees they may be unwilling to continue their participation.
- In the absence of cost-sharing reductions, this would not work well for low-income people. Two options could address the absence of cost-sharing reduction products:
 - Off-marketplace plans could be required to provide cost-sharing reductions, but then you've simply recreated the existing marketplace and plans are unlikely to stay in the market.
 - Expand the dollar amount of the tax credit by the value of the Cost-Sharing Reduction subsidies.
- If tax credits are extended to short-term or grand mothered plans, it opens the door to medical underwriting and an unbalanced risk pool as those individuals would not be part of a common risk pool for the entire state.

11. Create a public plan fallback.

Issues:

- Impossible to implement for 2018.
- Ensures a plan is available everywhere.
- Was formally part of Part D, but never needed given the broad private plan participation.
- Very complex implementation issues: would require some kind of contract (e.g., with an intermediary), development of a network, provider payment rates, and premiums.
- Would require capital to ensure the plan is solvent (or a federal guarantee).
- Likely to have very strong political opposition.