The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies

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Executive Summary

- Issuers and states faced considerable challenges in 2018 due to federal policy changes and uncertainty, including reduced carrier participation and the need to make premium work-arounds to address the removal of direct federal funding for the cost-sharing reduction ("CSR") program. For those receiving subsidies, their premium cost fell on average 3 percent in federally facilitated marketplace (FFM) states, while on average the premium for the lowest-cost Silver plan for those who did not receive subsidies increased 32 percent.
- Reductions to marketing and outreach for the federally facilitated marketplace began in the final week of open enrollment 2017 and have continued into the 2018 open-enrollment period. Total enrollment in the federally facilitated marketplace in 2018 closed with 8.7 million, down 9 percent from the 2016 level. To the extent a risk pool is shrinking, it is very likely to be getting "less healthy" and more expensive for all those insured, especially for the 6 million unsubsidized individuals who do not receive the Advanced Premium Tax Credit to offset the premium increases.
- The 2019 plan year has the potential to be just as uncertain and volatile as 2018 due to major policies changes that include (1) the removal of the individual mandate tax penalty, (2) the potential continuation of reduced marketing spending for the federal marketplace, and (3) implementation of association health plans and short-term, limited-duration plans.
- Statewide average premium increases in 2019, absent federal policies to stabilize these markets, could range from 15 to 30 percent — with some carriers in certain states having even higher rate increases, depending on state factors.
- Action on three federal policy options in early 2018 could significantly mitigate the potential 2019 rate increases, with reductions felt most directly by the 6 million consumers who purchase individual coverage without subsidies on-exchange or in the off-exchange Affordable Care Act-compliant market:
    1. Funding state-based invisible high-risk pools or reinsurance programs could produce an average rate reduction of 12 percent with a range of 9 to 16 percent depending on the state;
    2. Restoring marketing and outreach funding in the FFM in 2019 could reduce rates between 2 and 4 percent; and
    3. Reinstituting the health insurance tax "holiday" for 2019 could reduce rates between 1 to 3 percent.

Introduction

Issuers and states faced considerable challenges preparing for the 2018 plan year due to federal policy uncertainty. During the course of 2017, federal executive action shortened the open-enrollment period for the 2018 plan year, reduced the marketing and outreach budget for the 39 states in the federally facilitated marketplace by 90 percent, and ended cost-sharing reduction payments to issuers in October. The 2019 plan year has the potential to be just as uncertain and volatile, if not more so. Major policy changes for 2019 include setting the individual mandate tax penalty to zero for plan years 2019 and beyond, potential continuation of the minuscule marketing spending for the federal marketplace and the implementation of association health plans (AHPs) and short-term, limited-duration insurance plans, which could affect the market as early as 2019.

This document provides a brief summary of what occurred in 2018 and an overview of the potential impacts for 2019, along with a review of some of the major mitigating policies that could be adopted. We estimate that statewide average premium increases in 2019, absent federal policies to stabilize these markets, could range from 15.6 to 30.2 percent — with some carriers in certain states having even higher rates increases, depending on state factors. Given the continued uncertainty, while it appears most health plans participating in individual markets are themselves stable, a risk remains that parts of the nation could have no carriers interested in participating, or markets that now have two or three carriers could have only one carrier. We also estimate the impact of three federal policy options that could partially mitigate 2019 rate increases and promote carrier participation: reinsurance, increased marketing and outreach to promote enrollment in FFM states, and a reinstitution of the health insurance tax (HIT) holiday.

Market Factors and 2018 Enrollment

The prospects for the 2019 individual market are directly affected by the premiums, and in turn, new enrollment and renewal in the individual market for 2018. The individual market is composed of the on-exchange market (which is about 85 percent subsidized) and the off-exchange market (which is entirely unsubsidized). The individual market includes roughly 6 million Americans who are unsubsidized and bear the full brunt of premium increases (see the *Six Million Americans Impacted Most Directly by Premium Increases* starting on page 8). These are the people who benefit most from policies that foster better enrollment with an improved risk mix. In state-based marketplaces and the FFM, over 8 million Americans receive subsidies and are largely shielded from the effect of premium increases by increased federal subsidies. The data below on enrollment reflects only the on-exchange enrollment, and only the data from the federally facilitated marketplace, since in some states operating state-based marketplaces — such as California — open enrollment for 2018 does not close until Jan. 31, 2018. Off-exchange enrollment is not readily available because no single agency is tasked with compiling these numbers for all states in a systematic and timely fashion.

The factors that likely contributed to changes in enrollment and rates for 2018 include:

1. Changes in products and their pricing to address the removal of direct cost-sharing reduction (CSR) funding contributed to lower premiums for most individuals receiving subsidies: Most states across the nation implemented a “consumer-centric work-around” to allow health plans to fund the required CSR subsidy program by loading the costs on Silver or on-exchange Silver products only. There were many implications of this policy, but for the majority of states including those in the FFM, net premiums remained the same or decreased for subsidized enrollees, while unsubsidized individuals could avoid net premium increases due to how health plans funded the required CSR program. For the states in the FFM, this meant

that on average net premiums for the benchmark Silver plans were about 3 percent lower in 2018 than they were in 2017.[1] In a few states, unsubsidized individuals may have faced a "CSR surcharge" in addition to the other reasons for premium increases if their state did not provide an off-exchange option without an additional premium increase for the CSR.

2. **Reduction in FFM Marketing for Plan Years 2017 and 2018:** Reduced marketing and outreach spending by the FFM actually began in the final week of open enrollment for 2017 when the Trump administration pulled $5 million in planned paid advertising.[2] Before this decision, total cumulative 2017 plan selections for the week of Jan. 1 to14, 2017, was outpacing the prior year.[3] Given this trend, projections were that the final week of enrollment would match or even surpass the over 680,000 plan selections that were made in the final week of the open enrollment for 2016.[4] What actually occurred was that the final week's enrollment report for Jan. 15 to 31, 2017, showed only 376,260 plan selections – an estimated drop of over 300,000 enrollees.[5] In the end, total 2017 plan selections decreased by a little over 420,000, down 5 percent from 2016 (see Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018). The federal government continued the policy of reduced marketing spending for the FFM states for the 2018 open-enrollment period with a 90 percent decrease for FFM states, leaving just $10 million for 39 states, as well as a reduction in support for Navigators doing outreach from $63 to $37 million.[6] (See the next section for continued discussion of the impact on sign-ups for 2018.) We estimate the potential range of 2019 premium impacts of these administration decisions will result in the risk mix in the individual markets to continue to get less healthy and more expensive.

3. **Shortened Open-Enrollment Period:** The open-enrollment period for FFM states — and some state-based marketplaces — was cut in half for plan year 2018. Taken together with the reduction in marketing for the 2018 plan year, the likely impact in many states will be a reduction in the number of healthy new sign-ups.

Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018

Total Plan Selections	2015	2016	2017	2018
Federal Marketplace	8,838,291	9,625,982	9,201,805	8,743,642
Covered California	1,412,200	1,575,340	1,556,676	*

* Please note final 2018 plan selection data for Covered California will not be available until after Jan. 31, 2018

[1] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE). "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange." (Oct. 30, 2017) https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf. See Table 6 on page 10, comparing change in net premiums after APTC. A recent Covered California analysis also found that the net monthly premiums for enrollees who receive financial help are on average 10 percent lower than what new and renewing consumers paid last year (https://coveredcanews.blogspot.com/2017/12/covered-california-looks-ahead-to-2019.html).

[2] Politico. "With less fanfare, Obamacare sign-ups roll to a finish." (Jan. 31, 2017). https://www.politico.com/story/2017/01/obamacare-health-care-signup-234459.

[3] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 1-14, 2017. (Jan. 18, 2017). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-18.html.

[4] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 24, 2016 - Feb 1, 2016. (Feb 4, 2016). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html.

[5] Centers for Medicaid and Medicare Services. Biweekly Enrollment Snapshot for Jan 15-31, 2017. (Feb 3, 2017). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-03.html)

[6] Centers for Medicaid and Medicare Services (Aug. 31, 2017) "CMS Announcement of ACA Navigator Program and Promotion for Upcoming Open Enrollment." https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also the CMS fact sheet: http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

Early Market Impacts for 2018

Early signs of the 2018 market impact of federal policy changes and uncertainty include changes in carrier participation in 2018 and premium increases for Patient Protection and Affordable Care Act-compliant plans around the nation. Carrier participation and premium increases are important not only for understanding what happened in 2018 but also because they may foreshadow what could occur in 2019. With continued policy and rate uncertainty, the two major actions that carriers could take for 2019 are to (1) decline to continue participating (potentially resulting in more "one plan" counties or even leading to "bare counties"), or (2) raise premiums to accommodate the anticipated cost of covering their on- and off-exchange individual market risk pools.

- **Carrier Participation:** Although no counties were left without an issuer in 2018, data compiled by the Kaiser Family Foundation show that the percent of enrollees with only one issuer to choose rose from 21 percent in 2017 to 26 percent in 2018.[7] These data also show that the average number of plans per state dropped from 4.3 to 3.5 between 2017 and 2018, and the number of states with only one issuer rose from 5 in 2017 to 8 in 2018. (See the Kaiser Family Foundation for additional county-level issuer participation data and maps: http://kaiserf.am/2DHyocF.)

- **Premium Increases:** A Kaiser Family Foundation analysis shows that issuers added cost-sharing reduction surcharges ranging from 7 to 38 percent to 2018 premiums.[8] Independent of the cost-sharing reduction surcharge, statewide premium increases averaged 32 percent for the lowest-cost Silver plans.[9] Uncertainty about enforcement of the individual mandate, enrollment projections related to the shorter enrollment period and the anticipated drop in marketing and other factors likely also contributed to rate increases above the expected medical trend increase. While subsidized enrollees will generally see their 2018 tax credit increase, more than offsetting the premium increase, unsubsidized consumers both on- and off-exchange will bear the full weight of those premium increases. The effect on enrollment for those not receiving subsidies is not clear at this point, but what is certain is that to the extent there is a drop in coverage due to higher premiums, it will result in a worsening of the risk pool and higher premiums for the entire market in future years.

  Average premium increases in 2018 for key products are higher in states with only one carrier, which is an important consideration for 2019. Among states with more than one issuer in 2018, the average premium increase from 2017 to 2018 for the second-lowest-cost Silver plan for a 27-year-old was 36 percent compared to 44 percent in regions with one issuer.[10] Among states with more than one issuer in 2018, the average premium increase from 2017 to 2018 for the lowest-cost Bronze plan for a 27-year-old was 21 percent compared to 29 percent in states with one issuer.[11]

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[7] Kaiser Family Foundation. "Issuer Participation on ACA Marketplaces, 2014-2018." (Nov. 10, 2017.) https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.

[8] Kaiser Family Foundation. "How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums." (Oct. 27, 2017) https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

[9] Kaiser Family Foundation. "How Premiums Are Changing In 2018." (Nov. 29, 2017) https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/.

[10] These rates include the "CSR surcharge" that resulted in increased premium tax credits, meaning the net premium went down for many subsidy eligible individuals.

[11] ASPE Research Brief. "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange." (Oct. 30, 2017) https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

- **Enrollment Changes for the Federally Facilitated Marketplace:** Overall, enrollment in the states served by the FFM for 2018 was 8.7 million, including both renewing individuals and those newly signing up for coverage (see Table 1. Annual Enrollment: FFM and Covered California — 2015 to 2018), which reflects a decrease of 5 percent from 2017. Given the fact that reduced marketing and outreach spending began in the final week of open enrollment for 2017, it may be more appropriate to compare open enrollment performance for 2018 to the 2016 open-enrollment period. Over the past three years — from 2016 to 2018 — the number of sign-ups in states served by the FFM declined by 882,340 (a 9 percent decline). Importantly, however, this count does not include changes in the off-exchange individual market, which is likely to have even greater declines because those unsubsidized individuals do not have the Advanced Premium Tax Credit to offset the premium increases. In contrast, in California, on-exchange enrollment has remained stable during this three-year period. Covered California's relative stability comes in the context of the fact that there is substantial churn in the individual market, with about 40 percent of enrollees leaving Covered California each year, the vast majority of whom get coverage elsewhere.

  One of the lessons of the past five years is that the individual market is characterized by "churn" — many people come and go from the individual market due to changes in life circumstance (e.g., getting or losing job-based coverage, moving, aging into Medicare). Another lesson that is fundamental to maintaining a stable risk pool and keeping premiums low is that while constant net growth is not necessary to maintain a stable risk mix, to the extent a risk pool is shrinking, it is very likely to be getting "less healthy" and more expensive for all those insured.

Potential 2019 Premium Impacts of Known Risk Factors and Uncertainty

As the regional variation in carrier participation and premium increases in 2018 shows, health care is local and what will happen in terms of carrier participation, rates and enrollment varies considerably on a state-by-state basis. Factors that affect state-specific circumstances include whether the state is supported by the FFM (and its decisions on marketing) or by a state-based marketplace (SBM) making independent investments in marketing, the state insurance-regulatory environment and what that means for potential products or policies that siphon risk out of the individual market, and other market factors. The 2019 premium impact of several policies are estimated and discussed below. All impacts are summarized in Table 2: 2019 Premium Driver Estimates and Mitigation Options.

1. **Elimination of the Individual Mandate Penalty:** The Tax Cuts and Jobs Act eliminated the individual mandate penalty, effective January 2019. In November 2017, the Congressional Budget Office estimated that elimination of the individual mandate could drive a rate increase of 10 percent on average.[12] The impact within each state will vary based on a variety of factors, including the health of the state's risk pool, carrier competition and the strength of marketing and outreach efforts. Considering these factors, we would expect variation across states with a low impact of 8 percent and a high impact of 13 percent depending on state-specific factors.

[12] Congressional Budget Office. "Repealing the Individual Health Insurance Mandate: An Updated Estimate." (November 2017.) https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

2. **Premium Increases Caused by Enrollment Reductions and Deteriorating Risk Pool (Marketing and Other Factors) in Federally Facilitated Marketplace States:** Even in the face of net premium reductions for the majority of consumers who receive premium subsidies, the FFM states in the 2018 plan year had 5 percent fewer new sign-ups compared to 2017 and a reduction of 9 percent compared to FFM enrollment in 2016 (see Table 1). The individuals who did sign up were likely less healthy on average than new enrollees in 2017. Some of the decline in enrollment is attributable to the federal decisions to reduce marketing — both at the end of the open-enrollment period for plan year 2017 and for the recently completed enrollment period. Using an assumption that the individuals who — for whatever reason — were not persuaded to sign up are on average 25 percent less costly than the average enrollee, we estimate that premiums in FFM states will increase by about 1.3 percent in 2019 due to the decreased marketing for the 2018 plan year.[13] The dollar value of this 1.3 percent premium load is about $1 billion nationally, which contrasts to the $90 million "savings" attributed to reducing marketing spending.[14] The impact in any given FFM state may vary depending on the existing risk pool in that state and the change in enrollment between 2017 and 2018. We believe states with relatively unhealthy risk pools and lower 2018 enrollment compared to 2017 could see as much as a 6.3 percent rate increase in 2019 attributable to the marketing reduction and other factors that resulted in decreases in net enrollment for plan year 2018. On the other hand, states with higher enrollment in 2018 — including some SBM states — may see a slight downward pressure of up to 2.3 percent of their 2019 rates.

3. **Impact of FFM and SBM Open Enrollment 2019 Marketing Decisions:** A continued policy of not using collected health plan user fees to promote enrollment for the 2019 plan year will likely result in lower enrollment, a worse risk mix and carriers that will price for this expectation with further increased premiums. While we note that issuers' load for lack of marketing will vary, we use an estimate of 2.6 percent, which builds on prior work on the impact of marketing on enrollment and risk mix.[15]

   According to research commissioned by Covered California, some of the impacts to reduced marketing and outreach investments for 2018 may have been offset by substantial increases in media coverage generated by proposals to repeal and replace the Affordable Care Act and administration decisions regarding open enrollment 2018. During Oct. 1, 2017, through Dec. 15, 2017, the topics of "enrollment" and "enrollment period" were more frequently mentioned in news articles, increasing by 53 and 125 percent, respectively, when compared to the same period last year. Past research by Covered California has documented that both news coverage and paid advertising prompt action by consumers.[16] This increased

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[13] Covered California. "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets." (September 2017.) http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf. See page 21 for a discussion of the relationship between marketing, individuals' health status and enrollment.

[14] This number was derived as follows: The 2016 actual aggregate individual market gross premiums of $49 billion was inflated by 48 percent, which was the average rate change reported by ASPE for the lowest-cost marketplace plan between the 2016 and 2018 plan years (see Table 4, page 8). This calculated to $72 billion, which was then inflated by a 7 percent medical trend to equal $78 billion. We then multiplied 1.3 percent by $78 billion. This method is a conservative estimate as we modeled it based on the rate change for the lowest-cost plan.

[15] Covered California (2017). "Marketing Matters Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets." (September 2017) http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

[16] NORC (2015) "Final Report: Covered California – Overview of Main Findings from the Third California Affordable Care Act Consumer Tracking Survey. (October 22, 2015) http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf

coverage of the shorter deadline and enrollment opportunities may have partially offset the absence of national or broadcast TV advertising for healthcare.gov, but it is unlikely to continue in 2019.

4. **Association Health Plans and Short-Term, Limited-Duration Plans:** Assuming that federal regulations are finalized in time for the 2019 plan year, we estimate that Association Health Plans (AHPs) and short-term plans will result in a modest premium increase for 2019. Assuming that the individuals who leave will be 25 percent less costly than the average enrollees in the common risk pool, we estimate that AHPs and short-term plans together will increase rates between 0.3 and 1.3 percent in Affordable Care Act-compliant plans.

5. **Medical Trend:** We assume an increase in medical costs of 7 percent based on current national averages.

While actual impacts at the issuer level could vary significantly depending on state factors and policy decisions made in 2018, we estimate that the addition of the factors listed above to the expected cost of medical inflation could produce 2019 average statewide premium increases between 15.6 and 30.2 percent. We would also expect that multiple states would be at risk for having the remaining carriers exit as well as a continued increase in both the number of states or parts of states with only one issuer and the number of individuals with only one issuer from which to choose. Given the fact that areas served by only one carrier generally face higher premiums, it is likely that in many parts of the nation these estimates understate the impacts that will be felt by consumers.

Potential 2019 Premium Stabilization Actions

Plan year 2019 has the potential for significant rate increases. Federal policy action in early 2018 could significantly mitigate the potential 2019 rate increases estimated above. Funding state-based invisible high-risk pools or reinsurance programs at a nominal level of $15 billion (which would be a $5 billion cost to the federal budget after Advanced Premium Tax Credit offsets) in 2019, and the same amount in 2020 — if not made permanent — could produce an average rate reduction of 12 percent with a range of 9 to 16 percent depending on the state. Reinsurance would also likely have the effect of fostering health plan participation.[17] A restoration of marketing and outreach funding in the FFM in 2019 could lead issuers to reduce rates between 2 and 4 percent, because of their understanding that the enhanced marketing would increase the proportion of healthy individuals who will sign up for coverage. Federal spending to promote enrollment using the health plan user fee would likely have a distinctly positive return on investment. Support for marketing could be either done through national marketing and promotion sponsored by the U.S. Department of Health and Human Services (HHS), using the assessment on health plans collected for that purpose, or the same funds could be distributed to states or other local entities to promote enrollment in FFM states. And finally, an additional 1 to 3 percent rate reduction — depending on the issuer — could be achieved by reinstituting the health insurance tax holiday for 2019. These reductions would be felt most directly by the 5 to 6 million consumers who purchase individual coverage without subsidies on-exchange or in the off-exchange Affordable Care Act-compliant market.

[17] For a description of potential ways to structure financial support for state-based invisible high-risk pools or reinsurance, see "Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance." http://hbex.coveredca.com/data-research/library/CoveredCA_Reducing_Premiums_1-10-18.pdf.

Conclusion

Going into 2017, the individual insurance markets were largely stabilizing in terms of enrollment and issuer profitability.[18] Yet the 2018 rate increases were significantly above medical cost, and the prospects of another year of such increases raises the stakes for policies that foster a strong individual market. Year-to-year policy actions or market uncertainty leads to both wide variation in premium impacts and carrier decisions that the market is not worth the risk. Both of these choices have negative consequences for enrollees, particularly those who do not qualify for premium subsidies. Policymakers now have a short window of time to enact stabilization measures, some of which we have described above, that could mitigate a significant share of the 2019 premium increase and may keep issuers in the individual market that would otherwise exit in the current environment.[19]

The Six Million Americans Impacted Most Directly by Premium Increases

The individual (or "nongroup") market is composed of approximately 15 million Americans.[20] Roughly 6 million individual market enrollees who do not receive subsidies are directly affected by premium rate increases. The vast majority of these individuals (approximately 75 percent) obtain insurance in the off-exchange individual market. This means they purchase directly from health plans, but they are still purchasing Affordable Care Act-compliant policies and they are all part of the "common risk pool" that serves as the basis for health plans' pricing.

The median household income estimated in the 2016 National Health Interview Survey for off-exchange consumers was approximately $75,000, compared to a median income of $66,000 for those aged 19 to 64 (regardless of coverage).[21] For many of these consumers, double-digit premium increases could lead them to drop coverage. The off-exchange market does have a somewhat higher proportion of high-income individuals – with 10 percent having an estimated household income of $200,000 or more, compared to

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[18] Kaiser Family Foundation. "Individual Insurance Market Performance in Late 2017." (Jan. 4, 2018.) https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-late-2017. S&P Global Ratings. "The U.S. ACA Individual Market Showed Progress in 2016 But Still Needs Time to Mature." (April 7, 2017.) https://www.spglobal.com/our-insights/The-US-ACA-Individual-Market-Showed-Progress-In-2016-But-Still-Needs-Time-To-Mature.html.

[19] We note that this estimate does not take into account the potential premium impacts of restoration of direct funding for cost-sharing reductions. In particular, unsubsidized enrollees in states that did not take mitigating actions by encouraging the CSR premium increases to be loaded on the Silver plans could see a significant rate reduction in 2019. But for most consumers in most states, the restoration of direct funding of cost-sharing reductions would likely have little, if any, impact (depending onstate and carrier pricing to protect consumers).

[20] It is difficult to obtain administrative data about the entire individual market. For this analysis, we estimate the size of the market based on 2016 enrollment data based on Centers for Medicaid and Medicare Services (CMS) data releases. The reports suggest that in 2016 there were roughly 14.3 million enrollees in the single risk pool, which does not include enrollees in Massachusetts or Vermont, or the individual market enrollees in plans that are not part of the single risk pool (e.g. "grandfathered" plans). CMS reports that approximately 10 million were enrolled on-exchange, with about 8.4 million receiving tax credits. For total single risk pool size and average monthly enrollment, see Centers for Medicaid and Medicare Services, Center for Consumer Information and Insurance Oversight (2017). "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year." (June 30, 2017): https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf. For on-exchange and tax credit average monthly enrollment for 2016, see Centers for Medicaid and Medicare Services (2017). "Effectuated Enrollment Snapshot." (June 12, 2017): https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

[21] National Health Interview Survey (NHIS) 2016, using Lynn A. Blewett, Julia A. Rivera Drew, Risa Griffin, Miram L. King, and Kari C. W. Williams. IPUMS Health Surveys: National Health Interview Survey, Version 6.2. Minneapolis: University of Minnesota, 2016. http://doi.org/10.18128/D070.V6.2. Datasets available at http://www.nhis.ipums.org. Due to high rates of missing data for income in the NHIS, for this analysis we relied on the NHIS imputed income point estimates, and all analyses were restricted to ages 19 to 64 (inclusive). See Division of Health Interview Statistic, National Center for Health Statistics (2016). "Multiple Imputation of Family Income and Personal Earnings in the National Health Interview Survey: Methods and Examples." Available at: https://www.cdc.gov/nchs/data/nhis/tecdoc15.pdf.

6 percent of all individuals regardless of coverage source – however, these are a distinct minority of those getting insurance in the individual market.

An independent review that compared off-exchange enrollees to their Marketplace counterparts in 2015 found that while off-exchange enrollees' age distributions were not meaningfully different, the off-exchange are more likely to be:

1. middle or upper-middle class;
2. college graduates;
3. male;
4. white;
5. citizens; and
6. in better self-reported health status.[22]

[22] Goddeeris, John, Stacey McMorrow and Genevieve Kenney. 2017. "Off-Marketplace Enrollment Remains An Important Part of Health Insurance Under the ACA." Health Affairs. 36(8): 1489-1494.

Table 2. 2019 Premium Driver Estimates and Mitigation Options

PREMIUM-INCREASE DRIVERS
Estimates reflect potential state average increases; some states and individual carriers could be higher or lower. Premium estimates reflect gross premiums; for those receiving subsidies, premium increases would likely be far less.

	Low	Medium	High
Premium Drivers on Top of Medical Trend	**8.6%**	**14.7%**	**23.2%**
Individual Mandate Premium Impact	8%	10%	13%
2018 Enrollment Change Premium Impact	-2.3%	1.3%	6.3%
2019 Ongoing Marketing Reduction Premium Impact	2.6%*	2.6%	2.6%
Short-Term and Association Health Plans	0.3%	0.8%	1.3%
Medical Trend	**7.0%**	**7.0%**	**7.0%**
Total Potential 2019 State-Level Premium Rate Increase	**15.6%**	**21.7%**	**30.2%**

OPTIONS TO MITIGATE PREMIUM INCREASES
Estimates reflect the range of how each stabilizing policy would affect states based on their circumstances. The effect on premium in some states for individual carriers could be greater.

	Low	Medium	High
Reinsurance (see Covered California reinsurance analysis)	**-9%**	**-12%**	**-16%**
Gross reinsurance funding level (billions)	$12	$12	$12
Net federal cost of reinsurance	$5	$5	$5
Enhance Marketing and Outreach	**0.0%**	**-2.3%**	**-4.2%**
Health Insurance Tax Holiday	**-1.0%**	**-2.0%**	**-3.0%**

* State-based marketplaces (SBMs) that continue outreach and marketing to promote enrollment for 2019 will likely mitigate this additional premium increase driver.

This policy report is the product of the plan management and policy staff of Covered California, led by Chief Actuary John Bertko and informed by review by outside academic and policy experts. For questions, please contact Vishaal Pegany at vishaal.pegany@covered.ca.gov.