HealthScape Advisors

A CONVEY COMPANY

The ACA Market, a Decade In With a Promising Future for the Adaptable Health Plan

Summary

At one point, the Affordable Care Act (ACA) market was the "new kid on the block" and every health plan wanted in. Shortly after its debut, plans faced financial and competitive challenges. The uncertainty of this market rapidly became evident in plan responses. Constantly changing regulations, uncertainty around population risk, aggressive pricing, and heightened competition required plans to constantly adapt. Some plans exited the market, others stayed in and pursued expansion, and in the middle were plans that watched from the sidelines. After nearly a decade since its launch in 2014, the ACA market reached near record enrollment with over 16 million enrollees during 2023 open enrollment, a 13% increase from 2022. This growth can be attributed to subsidy expansion and favorable regulatory changes which have inspired confidence and played a stabilizing role for health plans in an increasingly dynamic market.

However, capitalizing on this growth will require health plans to stay agile, comprehensively engage partners, and adapt their strategic, financial and operating plans while mitigating risk. This is increasingly important in the wake of incremental legislation impacting 2024 open enrollment.

This Executive Brief highlights two trends driving growth and stability and outlines five key changes from previous rulings that will require plans to take a broader, holistic approach to enterprise strategy and near term go-to-market planning.

TREND 1

Expansion of subsidies have brought greater stability to the market

The expansion of subsidies has had a stabilizing effect on market participation. Subsidy expansion has increased the affordability of marketplace plans as three in every four enrollees now qualify for subsidies, the highest number of people qualifying for subsidies in ACA market history. In fact, the recently passed Inflation Reduction Act (IRA) ensures that the subsidies enacted under the American Rescue Plan Act (ARPA) of 2021 continue without interruption through 2025. These expanded subsidies have helped reduce premium payments and out- of-pocket burden for consumers across various income and age levels.

PREMIUMS REDUCED TO NEARLY

$0

FOR THE BENCHMARK SILVER PLAN

Consumers with incomes up to 150% of federal poverty level (FPL) can have their premiums reduced to nearly $0 for the benchmark silver plan

OLDER CONSUMERS: PREMIUM PAYMENTS CAPPED AT NO MORE THAN

8.5%

OF HOUSEHOLD INCOME

Older consumers (50 and older) whose premiums are age-adjusted in most states and could easily cost three times more than a young adult on the same policy, will now have their premium payments capped at no more than 8.5% of household income

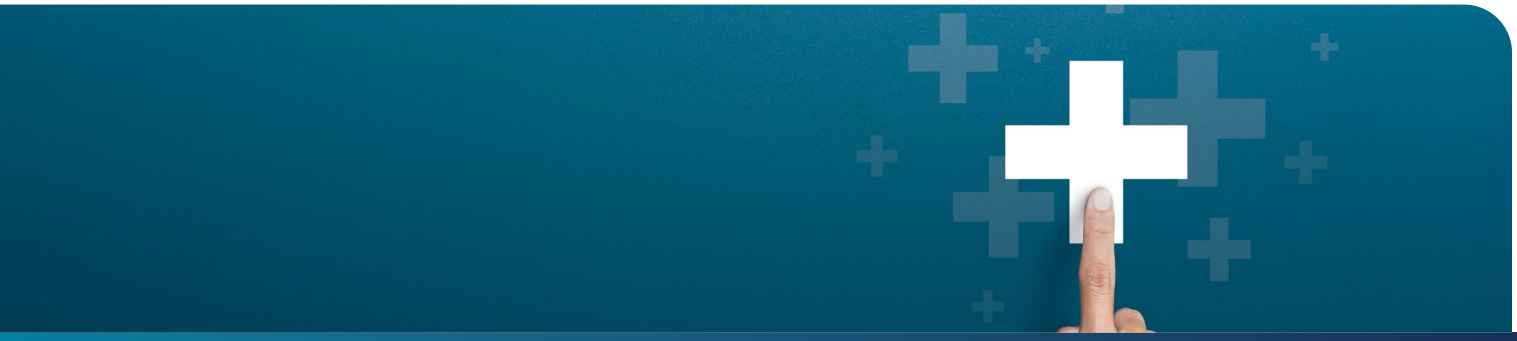
THOSE EARNING OVER

400%

OF THE FPL NOW QUALIFY FOR SUBSIDIES

Those earning over 400% of the FPL now qualify for subsidies to reduce premium payment and premiums are now capped at no more than 8.5% of their household income, broadening the potential market for new enrollees

As plans have gained experience and matured in the ACA business, we have seen premiums right-size nationally to offset healthcare inflation and higher utilization of care, and appropriately price to cover medical costs while maintaining consumer affordability. Due to the nature of how subsidies are set, even when premiums increase, subsidized enrollee premium payments may not be impacted, and therefore, the health plan's growth may not be affected. As seen in 2023, after four years of almost no premium changes, premiums increased on average by 4% for the benchmark silver plan and the overall market grew 13%.



TREND 2

ACA market remains dynamic and competitive, with predominant players being Blues, Nationals and Medicaid plans

Relative stabilization has allowed plans to contemplate and pursue reentry and/or expansion of their ACA footprint. Plan participation jumped nearly 70% from 2018 to 2023. While the last five years have been marked by 157 plan entries and 35 exits, the last decade signals a shift in the types of plans that enter, exit and/or reenter the exchange.

At the onset, Blues and Nationals dominated the market in 2014, with nearly 75% market share. In 2023, while Blues and Nationals are still major players with ~45% combined share, Insuretech, Provider-Sponsored Plans, and Regional players have increased participation, with the greatest increase with Medicaid players. We continue to see more volatility with Insuretechs marked by 20 market exits in 2023. As an example, Bright Health is exiting all states in which it sold ACA plans. This volatility is expected to continue given recent news that Oscar Health will be exiting California in 2024 while Friday Health Plans will be shutting down its operations nationwide.

Unsurprisingly, as consumers tend to fluctuate between Medicaid and ACA eligibility, we have seen Medicaid players capture greater share over time by leveraging established infrastructure and cost containment strategies utilized in managing the Medicaid population to also serve ACA populations. Nationals, Blues and regional plans are uniquely positioned to recapture share if they can harness the opportunity to acquire and retain members with strategies that cross all lines of business, including enrollees who are now eligible for employer sponsored coverage.

Key regulatory changes may impact health plan readiness and go-to-market plans for 2024

Viability and growth in a dynamic and competitive market will require health plans to consider five notable changes from recent rulings in broader enterprise strategies and go-to-market planning for 2024. While not comprehensive, these are the ones that rose to the top in HealthScape's analysis:

1. **Medicaid Eligibility Redeterminations** have begun with announcement of new permanent special enrollment periods
2. **The "Family Glitch"** is fixed with opportunity to expand family coverage and help consumers who were not aware of the policy change in 2023
3. **New standardized plan requirements** and limits on non-standard plans, including changes to automatic re-enrollment hierarchy
4. **New network adequacy** requirements increase access to care for consumers
5. **The expansion of the Assister role** to include enrollment to reduce barriers to access coverage

1 Medicaid eligibility redeterminations restarted, with announcement of new permanent special enrollment periods

At the height of the pandemic, the federal government halted the process of disenrolling members from Medicaid to maintain coverage. Beginning April 1, 2023, all Medicaid enrollees are required to reapply for the program in a process called Medicaid eligibility redeterminations. It is estimated that 5 to 14 million people will lose coverage in the unwinding of this provision. Depending on the state and the availability of eligibility information, disenrolled individuals will have three primary options to maintain health insurance coverage:

1. Auto-enroll in the lowest-cost silver ACA plan (e.g., California) or otherwise turn to the ACA market
2. Transition to employer sponsored insurance (ESI)
3. Qualify for a "Basic Health Program" in select states (e.g., Minnesota, New York) that allows for continuation of essential health benefits coverage at an affordable price due to Section 1331 of the Affordable Care Act

Historically, disenrollees largely remain uninsured due to barriers from moving from Medicaid to other programs, which is a key concern for regulators, states, and health plans. To increase awareness and enrollment, CMS has issued guidance allowing states to collaborate with MCOs to update enrollee contact information, as well as partner with health plans and community organizations. Furthermore, to help mitigate coverage gaps and allow for a more seamless transition to marketplace coverage, CMS ruled in April 2023 that federal and state-based exchanges are allowed to establish permanent special enrollment periods, allowing people being disenrolled from Medicaid to enroll in an exchange plan 60 days before and 90 days after losing coverage.

Considerations for Plans

Medicaid eligibility redeterminations are likely to spur further growth in the ACA market. Health plans that offer Medicaid and ACA coverage can leverage Medicaid eligibility redeterminations as a growth lever and partnership opportunity across lines of business. While redeterminations are an opportunity, they also pose a significant risk for plans that are not priced correctly for a potential influx of higher risk members. Plans should:

- Ensure there is a detailed tracking system of impacted members, their eligibility and coverage options.
- Design an end-to-end experience and outreach campaign for each member cohort to streamline and simplify transitions, engaging community and MCO partners.
- For plans with value-based or risk-sharing provider contracts, collaborate with providers to form outreach strategies to capture former Medicaid members and transition them to an ACA plan at any point before, during or after open enrollment. Providers can support care management and risk adjustment activities and assist patients with understanding their benefits and the importance of regular check-ups.
- Consider the health status and health insurance literacy of each member cohort to present an accurate comparison between Medicaid and ACA plan benefits to improve engagement, reduce member abrasion and decrease gaps in coverage and care delays during the transition.
- Evaluate plans' financial position and pricing strategy to determine whether the plan derives greatest benefit from either capturing auto-enrolled members through low cost silver plans or pursuing alternative member retention strategies.

2 “Family Glitch” is fixed, with opportunity to help consumers who were not aware of the policy change

Prior to 2023, the “family glitch” deemed an estimated 5 million people ineligible for marketplace subsidies for having “affordable” employer-based coverage (including through a family member’s job). When the affordability of an employer-sponsored plan was determined, it was based on the cost for the employee, excluding spouse and dependents (affordability threshold is less than 9.12% of household income in 2023). To access coverage, families would either pay more for employer family coverage or pay full price for the ACA market, spending up to and over 25% of their household income without access to subsidies. The ruling to fix the glitch was announced prior to 2023 Open Enrollment and allows family members who do not have access to “affordable” job-based coverage to buy health insurance through the marketplace and qualify for premium tax credits.

Considerations for Plans

It is unclear how many families took advantage of marketplace subsidies in 2023 Open Enrollment given its effective date. A potential gap in communication between plans and enrollees creates tremendous opportunity for health plans to educate families now and leading up to 2024 Open Enrollment. Plans should:

- Identify beneficiaries, their subsidy eligibility and coverage options (either via employer or marketplace exchanges) to be well positioned for outreach efforts
- Evaluate if it may be more beneficial for some small employers to stop subsidizing family coverage and more fully fund employee health costs or salaries, especially if family members can receive subsidized coverage in the ACA market at a lower cost
- Partner with brokers / navigators / employers to develop marketing campaigns directly targeting (1) families with individuals that were not previously enrolled in an ACA plan, (2) families that may not have sufficient coverage and (3) families that are newly eligible for subsidies

3 New standardized plan requirements and limits on non-standard plans, including changes to automatic plan re-enrollment hierarchy

In 2023, consumers were presented with an average of 113.7 plan options, largely attributable to the influx of competitors and their ever-expanding product portfolio. CMS passed a ruling to limit the number of non-standardized plans insurers could offer in a region to four in 2024 and two in 2025. Limited optionality aims to simplify and avoid overwhelming consumers in an increasingly complex system.

The ruling also requires health plans to offer standardized plans in every rating area offering non-standardized plans. The agency estimates the cap will decrease the average number of plan options for consumers from 113.7 in 2023 to 90.5 in 2024.

Lastly, in its latest ruling, CMS finalized changes allowing exchanges to modify their automatic re-enrollment hierarchies. Instead of health plans automatically re-enrolling enrollees into the same product (i.e., passive renewal), enrollees eligible for cost-sharing reductions (CSRs) and those enrolled in a Bronze-level plan will be automatically re-enrolled in a Silver-level plan (with CSRs). This re-enrollment will be within the same provider network if the premium is the same or lower than the Bronze plan after applying the advance premium tax credit. This Bronze to Silver Crosswalk will largely benefit enrollees with incomes under 150% FPL.

Considerations for Plans

Health plan success will be contingent on streamlining and curating a targeted and competitive product strategy. Members in a Bronze plan mapped to $0 premium Silver-level plans (with CSRs) is an advantage for health plans who are in the Medicaid market and already have the infrastructure in place to manage these members. Health plans that serve broader populations across income levels, will need to create a product portfolio that attracts the right members and the right risk to their products, leveraging opportunities like the family glitch. At the highest level, plans will need to:

- Assess the competitive landscape and their overall product strategy to attract and retain targeted populations
- Evaluate the impact of the member mix shift on portfolio margin, risk adjustment, pricing and retention
- Revisit open enrollment renewal plans, identify impacted members, update crosswalk plan options and strategies to retain and migrate members, and operationalize key changes
- Develop a cohesive and robust member engagement and communication strategy with personalized guidance for members on the changes, alternatives and benefits, including education for direct sales, broker and customer service teams
- Leverage provider partnerships as hospitals and clinics can drive consumer decisions if they understand the impact of this change

4 New network adequacy requirements increase access to care for consumers

CMS established two new essential community provider categories—mental health facilities and substance use treatment centers—to increase access to behavioral health care.

Exchange plans will be required to contract with at least 35% of available essential community providers (ECPs) in their service area. The final rule also extends the 35% requirement to Federally Qualified Health Centers (FQHCs) and family planning providers. These changes, in conjunction with other expanded network adequacy requirements increase provider choice, advance health equity and expand access to care for consumers with low incomes, complex or chronic health care conditions, as well as those residing in underserved areas.

Considerations for Plans

It should be no surprise of CMS and state regulators' intent to create more seamless transitions between Medicaid and the ACA marketplace. Plans have likely anticipated changes to their networks and many plans, particularly those serving the Medicaid population, may already have existing contracts and networks to leverage to meet the new adequacy requirements. In response to the ruling, plans should:

- Assess existing network adequacy gaps
- Identify potential provider and community partners and review opportunities to improve unit cost position and value-based performance (e.g., high/low value providers, specialty spend, partnerships with risk-bearing entities).
- Considering social determinants of health, leverage partnerships with prominent community-based organizations (CBOs) that may already be serving members and identify opportunities to improve members' continuity of care and health outcomes
- Deploy personalized campaigns to educate members with increased access to care in their local area after operationalizing the new network

5 Assister role expanded to include enrollment to reduce barriers to access coverage

Prior to 2023, Assisters / Navigators were utilized to perform personal outreach and education to potential members but were prohibited from providing enrollment assistance during the first contact. This created a gap in potential enrollees accessing coverage due to barriers (e.g., lack of transportation, childcare) to enroll in-person outside of their home.

Assisters / Navigators will now be permitted to perform door-to-door enrollment assistance, removing the previous barriers, and ensuring potential enrollees receive the sufficient coverage. This structure allows for real-time education on plan offerings and mechanisms of the marketplace. The ease of enrollment provides a positive foundation for those entering the marketplace as consumers and sets the stage for strong member engagement through the plan term.

Considerations for Plans

These specific regulatory changes can be both lengthy and confusing for many, and Assisters / Navigators will play a critical role as trusted experts guiding families on how to navigate the system, contextualize their options and how to close the loop on door-to-door enrollment. It will be necessary for plans to:

- Work with these Assisters to design an optimal engagement strategy with the various communities
- Supply Assisters / Navigators with the necessary education and resources so they are aware of available options for enrollees
- Establish a targeted approach to Assister / Navigator training that prioritizes simplicity throughout for both the Assister and potential enrollee

The Case for Agility, Adaptability and Comprehensive Engagement

The ACA market has often been synonymous with volatility, uncertainty and complexity. Despite the constantly evolving regulations and competitive landscape, the ACA market is here to stay. Health plans must stay agile, adapt and comprehensively engage internal and external stakeholders in support of its members. Health plans that embrace the short- and long-term opportunities afforded by this business, while mitigating risks, will be most favorable to sustainably win in the marketplace.

HEALTHSCAPE CAN HELP

HealthScape works with a variety of health plans to help health plans launch products, optimize their performance and execute on sustainable growth strategies in the ACA market. Please reach out to Kristin Mullany, Matt Krizmanich and Tej Shah for additional information.

The authors would like to thank Courtney Good and Kiamya Philson for their support and contributions to this article.

HIGHLIGHT

Kristin Mullany
Principal
kmullany@healthscape.com

Matt Krizmanich
Managing Director
mkrizmanich@healthscape.com

Tej Shah
Managing Director
tshah@healthscape.com