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## Abstract

In response to regulatory changes at the federal level, states that run their own marketplaces have taken steps to stabilize their individual markets. In this comparison of state-based and federally-facilitated marketplaces from 2016-2018, we find that SBMs had slower premium increases (43% vs. 75%), and fewer carrier exits, than FFMs. The total population participating in FFMs declined by 10%, while the enrolled population in SBMs remained largely stable, increasing by 2%. We find that the performance of the ACA marketplaces varies by state and appears to cluster around marketplace types.

## Keywords

ACA marketplaces, insurance, premiums, enrollment

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## STATE-BASED MARKETPLACES OUTPERFORM FEDERALLY-FACILITATED MARKETPLACES

Jane M. Zhu, Daniel Polsky, Yuehan Zhang

In response to regulatory changes at the federal level, states that run their own marketplaces have taken steps to stabilize their individual markets. In this comparison of state-based and federally-facilitated marketplaces from 2016-2018, we find that SBMs had slower premium increases (43% vs. 75%), and fewer carrier exits, than FFM. The total population participating in FFMs declined by 10%, while the enrolled population in SBMs remained largely stable, increasing by 2%. We find that the performance of the ACA marketplaces varies by state and appears to cluster around marketplace types.

### INTRODUCTION

The Affordable Care Act established health insurance marketplaces where consumers can shop for a health plan and apply for federal subsidies. States had the option of developing and operating their own marketplaces, defaulting to a federally-facilitated marketplace (FFM), or operating in partnership with the federal government. State-based marketplaces (SBMs) retained authority over a range of marketplace functions, including selecting plans, developing quality or pricing guidelines, and conducting outreach. FFMs operated under rules established by the Department of Health and Human Services (HHS) and used the federal platform [healthcare.gov](http://healthcare.gov). Various state-federal partnership structures developed, in which states retained a range of marketplace functions but used the federal platform for enrollment. As of 2018, 16 states and the District of Columbia operate their own marketplaces, including five SBMs that use the federal platform.

In the face of carrier exits and rising premiums, uncertainty has swirled around the marketplaces. A recent [analysis](#) found an increase in issuer exits from 2016 to 2017, which were associated with rising premiums. In previous [briefs](#) we documented trends in provider network characteristics by state and plan and carrier types. In light of changing

federal rules around enrollment deadlines and consumer assistance, it is reasonable to question whether SBMs have been able to manage this uncertainty better than FFMs, given the leeway states have in adjusting to local market circumstances. For example, during the 2018 open enrollment period, nine SBMs [extended their enrollment periods](#) beyond the abbreviated federal deadline. A number of state-based marketplaces maintained funding for targeted outreach while federal outreach was scaled back. In this brief, we examine how different marketplace types fared from 2016 to 2018 and how these trends could matter to consumers, paying particular attention to changes in premiums, carrier and plan types.

### WHAT WE DID

We used plan-level data available from the [HIX Compare](#) dataset to obtain a list of qualified health plans sold in the ACA marketplaces in all 50 states and the District of Columbia from 2016 to 2018. There were 4,989 plans in 2016, 3,976 plans in 2017, and 2,802 plans in 2018. We identified carriers selling a qualified nongroup health plan in each of the 3,138 counties during this period. Unique insurers sharing a parent company or group affiliation were combined. We derived state-level plan enrollment data from the

Centers for Medicare & Medicaid Services' 2016-2018 ACA Marketplace health plan selections. Other key variables were linked from additional sources: we categorized State marketplace type from data reported by the [Kaiser Family Foundation](#) (Table 1), county metro status from the [Rural-Urban Continuum Codes](#), and median household income from the [SAIPE county estimates](#) for 2016. Issuer type was based on a set of decision rules, described in an [earlier brief](#).

**Table 1. Marketplace Definitions**

**State-based Marketplace (SBM):** States perform all Marketplace functions, and consumers enroll in coverage through state-maintained IT platforms. A number of states have adopted a State-based Marketplace-Federal Platform (SBM-FP), in which the state performs all Marketplace functions and consumers enroll through healthcare.gov. Both types are considered state-based marketplaces in our analysis.

**State-Partnership Marketplace (SPM):** States manage plans, but HHS performs all remaining Marketplace functions. Consumers enroll through healthcare.gov.

**Federally-facilitated Marketplace (FFM):** HHS performs all Marketplace functions, and consumers enroll through healthcare.gov.

Source: [Kaiser Family Foundation](#)

For premiums, we used the second-lowest Silver plan for a 27-year-old in a given county, which is the basis for federal subsidies to low- and middle-income enrollees. For comparison, we also examined monthly premiums for the lowest Bronze plan, given changes to cost-sharing reduction payments that affected Silver plans. All county-level analyses were weighted by the county population.

To assess the trends in premiums over time, we estimated percentage change in premiums in 2017 and 2018 compared to a baseline in 2016. We focused our analysis on FFM, SBM, and SPM, and our definition of state-based marketplaces included state-based marketplaces with federal platforms (SBM-FP). We do not report results in this brief for two states that switched marketplace types between 2016 and 2018 (Hawaii switched from an SBM-FP to an FFM, while Arkansas switched from an SPM to an SBM-FP).

## WHAT WE FOUND

**Exhibit 1a** describes marketplace characteristics across states in 2018. Our results include 27 states with FFMs, 16 states with SBMs, and six states with SPMs. Two states switched marketplace types (not shown). States with FFMs had, on average, a higher percentage of non-metro counties and lower median household income compared to states with

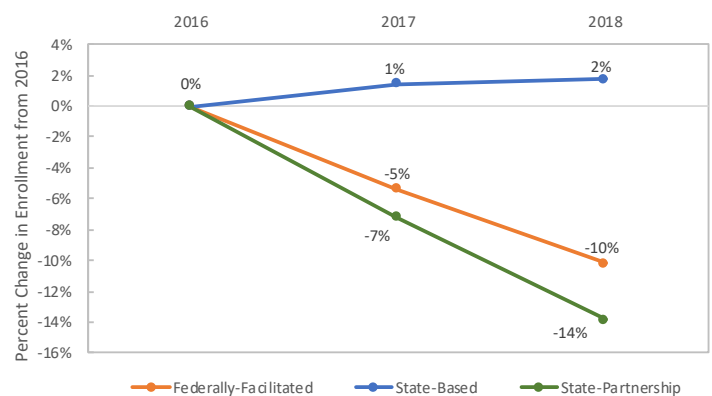
SBMs. Between 2016 and 2018, the total population participating in FFMs declined from 8.3 to 7.5 million (-10%) (**Exhibit 1b**). The enrolled population in SBMs remained largely stable, increasing from 3.3 to 3.4 million (2%), while the total population enrolled in SPMs declined 14% from 9.1 to 7.8 million.

**Exhibit 1a. Description of Marketplaces, by State-Level Characteristics**

	Federally-facilitated marketplaces (n=27)	State-based marketplaces* (n=16)	State-partnership marketplaces (n=6)
States	AK, AL, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NC, ND, NE, NJ, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WY	CA, CO, CT, DC, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, VT, WA	DE, IA, IL, MI, NH, WV
Total Population	177,382,896	111,345,320	29,982,494
Total enrollment in 2018	7,485,656	3,403,360	783,618
Median household income, \$	55,398	62,852	57,673
Percent of non-metro counties	62.7%	47.5%	56.7%

\* State-based marketplaces includes four states using federal platforms: KY, NM, NV, OR; data for HI and AR (switchers) not shown.

**Exhibit 1b. Average Percentage Change in Enrollment in 2017 and 2018 from 2016, by Marketplace Type**



\*Percentage change is calculated with 2016 as the baseline.

Overall, plan types did not change substantially between 2016 and 2018, though there was a slight increase in the proportion of EPOs and a slight decrease in the proportion of PPOs (**Exhibit 2**). Across all marketplace types, the majority of plans were HMOs in 2018 (57% of plans in FFM vs. 52% of plans in SBMs). In FFM, the relative proportion of EPOs grew from 11% to 19% during this time. In SBMs, the relative proportion of EPO plans grew from 15% to 18%. The share of PPO plans in both FFM and SBMs declined slightly from 2016 to 2018.

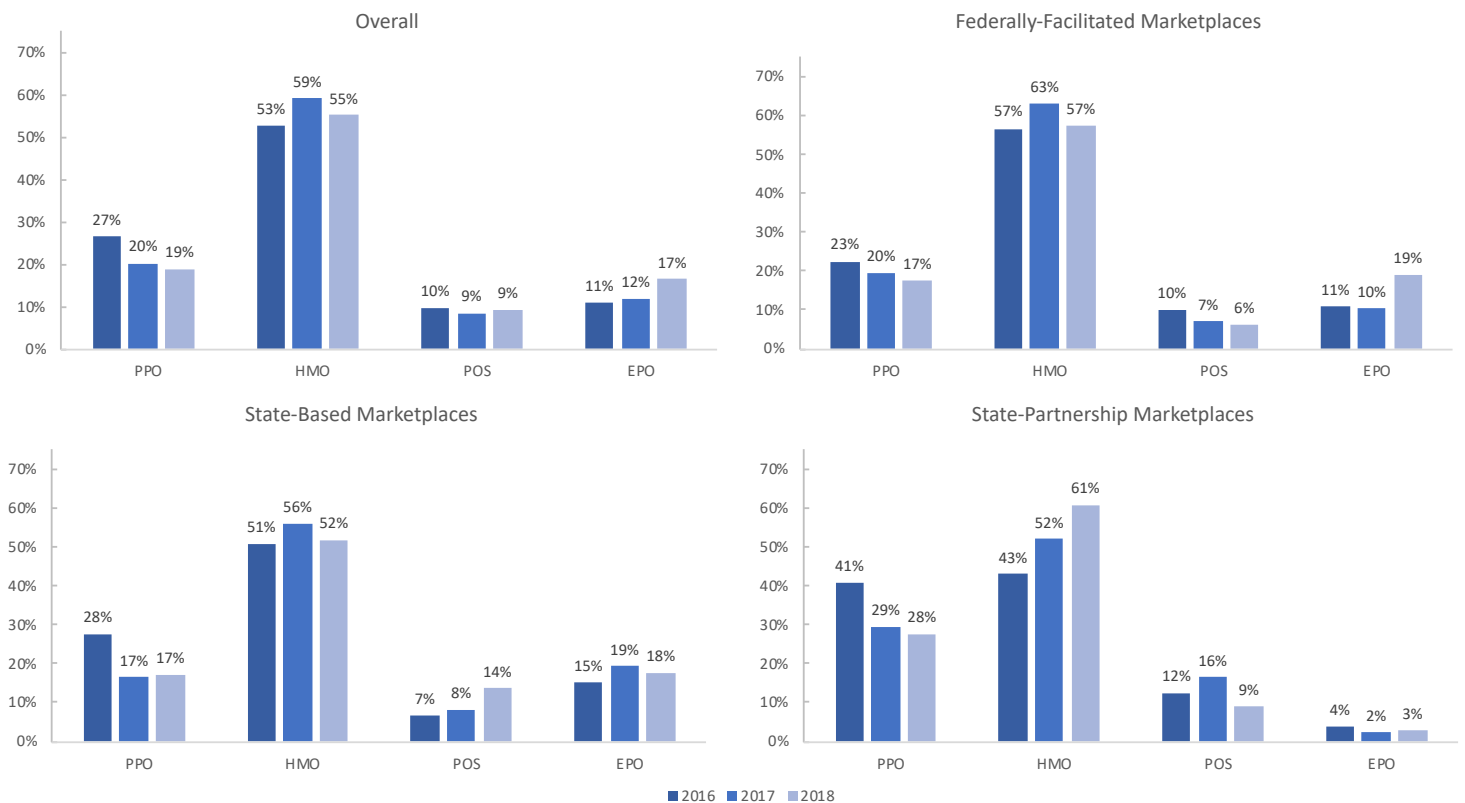
**Exhibit 3** shows that in 2016, FFM had a higher proportion of national carriers (32%) and a lower proportion of regional/local carriers (12%), compared to SBMs (15% national and 20% regional/local). The proportion of national carriers dropped significantly between 2016 to 2018 (overall, from 25% to 3%), while the proportion of Blues, Medicaid, regional/local, and provider-based carriers increased or remained largely stable across different marketplace types. Results for CO-OPs were not shown.

In 2016, most counties had at least four carriers. As shown in **Exhibit 4**, among states with FFM, 58% of counties had four or more carriers; 24% had 3 carriers; 15% had two carriers, and just 2% had a single carrier.

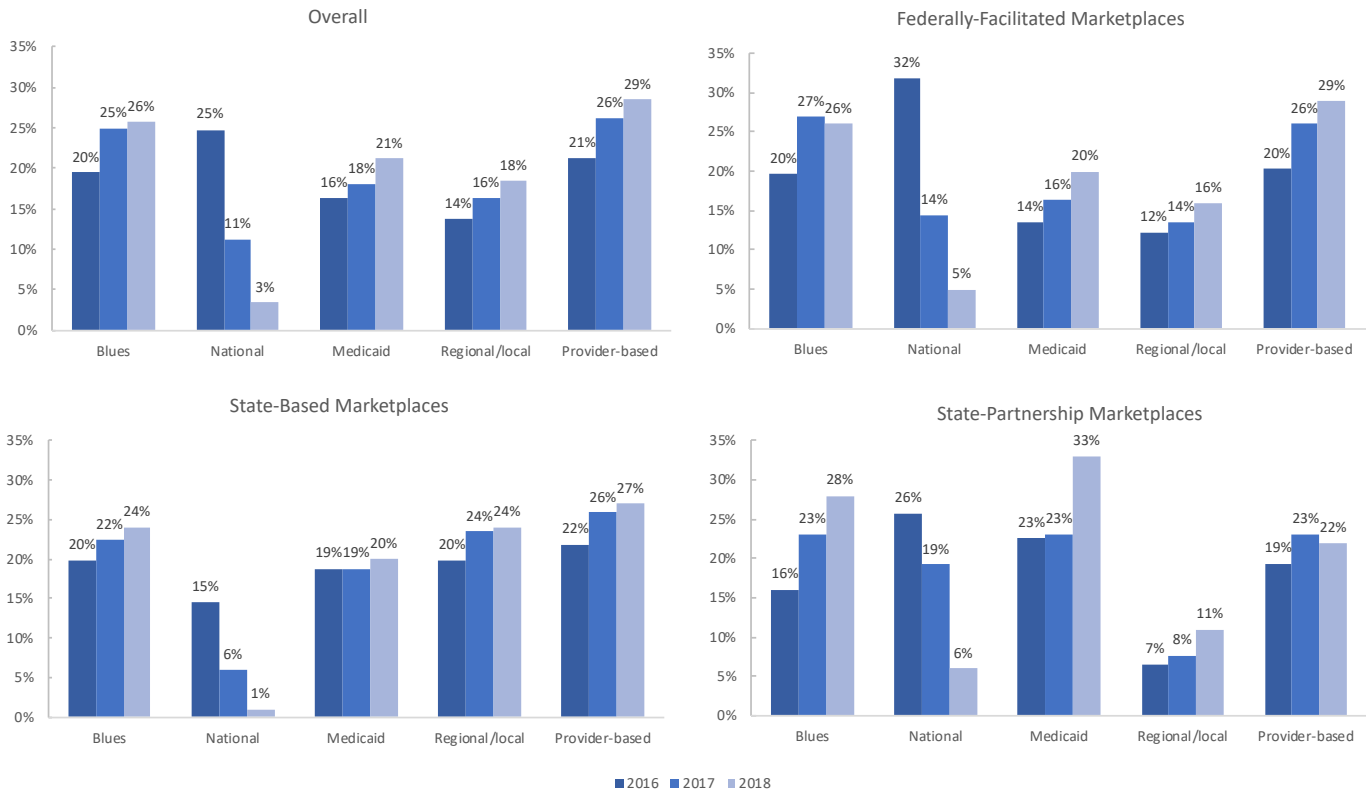
In 2018, 40% of FFM counties had a single carrier, and the proportion of counties with at least 4 carriers had declined to less than 10%. SPMs faced similar, though less pronounced, declines in carrier count at the county level. In comparison, SBMs retained four or more carriers in 59% of counties in 2018, down from 80% of counties in 2016. Non-metro counties were more likely to face fewer carriers than metro counties in 2016, and experience greater reductions in the number of carriers (see online [Appendix](#)).

Similarly, the maps in **Exhibit 5** visually compare trends in county-level carrier count for FFM vs. SBMs. From 2016 to 2018, states with FFM saw an increase in the number of counties facing just one carrier (in red) and a decrease in the number of counties with at least 4 carriers (in darker blue). Nebraska, for example, had at least 4 carriers in nearly all counties in 2016; by 2018, carrier exits left all counties with just one carrier. For SBMs, this trend was less pronounced, with most states retaining two or more carriers at the county level. States that experienced a reduction in carrier count in a majority of counties included Nevada, Colorado, California, Oregon, Washington, Maryland, and Kentucky.

**Exhibit 2. Distribution of Plans: Overall and by Marketplace Type, 2016 – 2018**



**Exhibit 3. Distribution of Carriers: Overall and by Marketplace Type, 2016 – 2018**



**Exhibit 4. Distribution of County-Level Carrier Count: Overall and by Marketplace Type, 2016–2018**

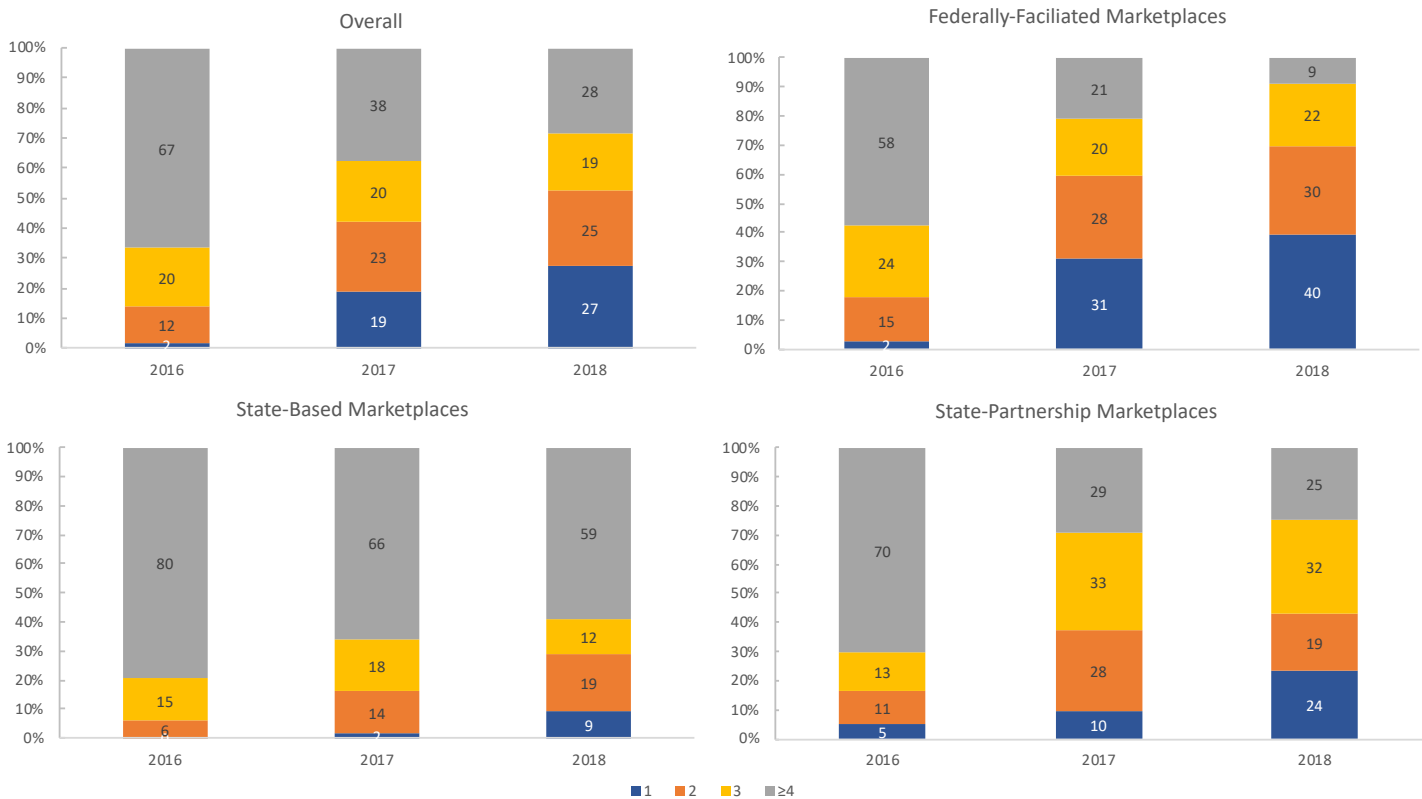
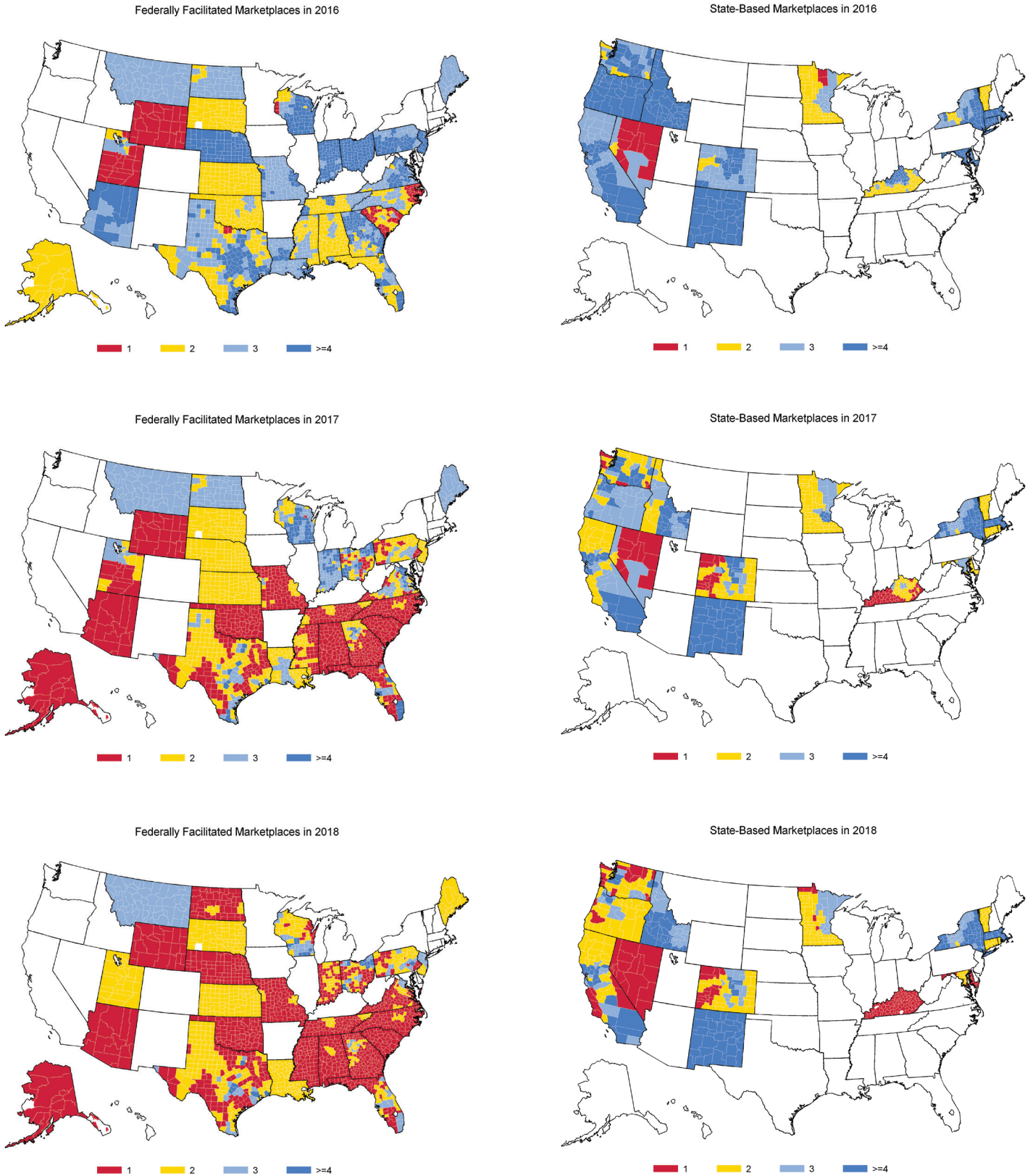


Exhibit 5. Federally-Facilitated Marketplaces vs. State-based Marketplaces: Carrier Count by County, 2016 – 2018

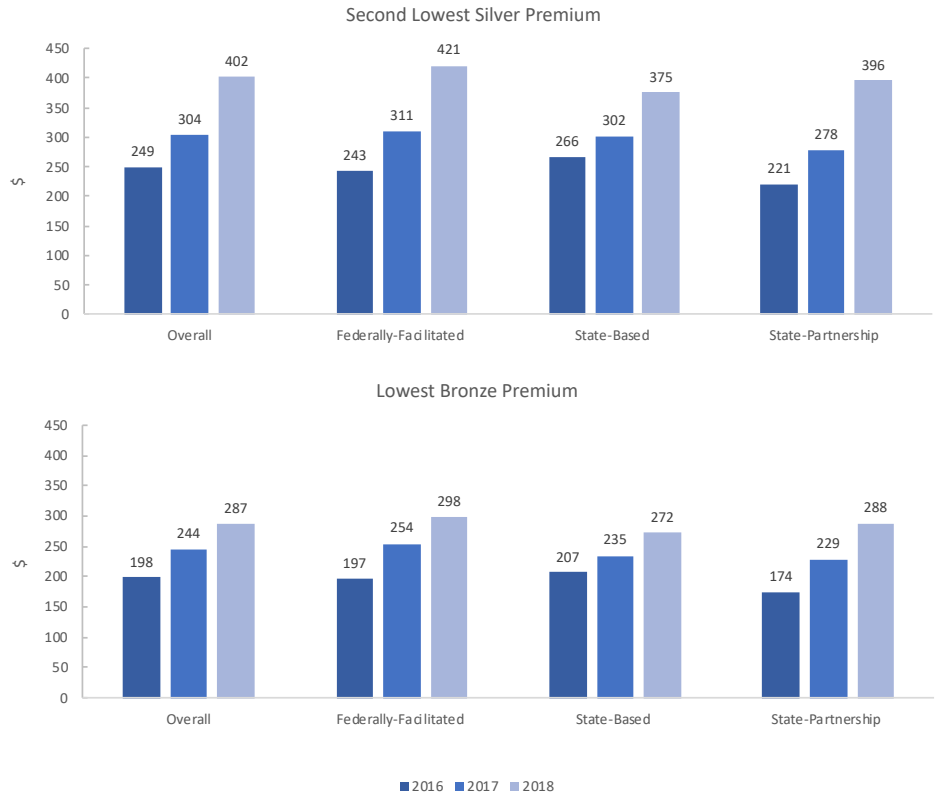


Overall, average premiums for second-lowest silver plans rose from \$249 in 2016 to \$402 in 2018, an increase of 61% (**Exhibit 6a**). In FFMs, the average premium for a second lowest silver plan was \$243 in 2016, increasing to \$311 in 2017 and \$421 in 2018. Premiums for second-lowest silver plans in SBMs, in comparison, rose from \$266 to \$375 during this period. Lowest bronze plans experienced smaller increases in premiums, which were comparable across marketplace types. Premiums rose faster in FFMs than in SBMs, and for silver plans compared to bronze plans (**Exhibit 6b**). On average, premiums for second-lowest silver plans increased by 75% from 2016 to 2018 in FFMs.

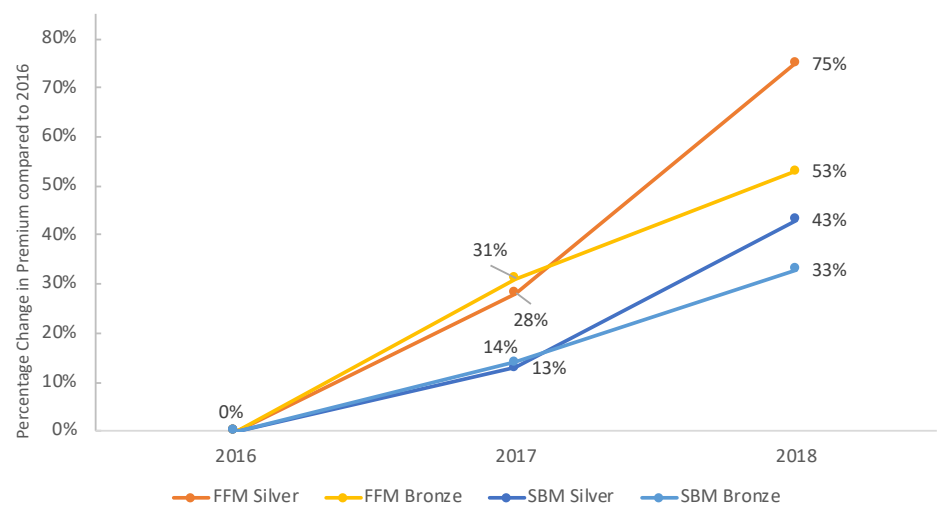
Finally, because SBMs and SBM-FPs may feature some differences in marketplace functions (for instance, SBM-FPs could not extend enrollment deadlines while SBMs could), we also examined variation between these two types of state-based marketplaces. While results are not shown in this brief, SBMs saw greater carrier participation, and fewer carrier exits, compared to SBM-FPs. Premiums also rose at slower rates in SBMs.

Premiums rose faster in FFMs than in SBMs, and for silver plans compared to bronze plans.

**Exhibit 6a. Average Premiums (Second-Lowest Silver and Lowest Bronze) from 2016-2018, Overall and by Marketplace Type**



**Exhibit 6b. Average Percentage Change in Premiums (Second-Lowest Silver and Lowest Bronze) in 2017 and 2018 from 2016, Overall and by Marketplace Type**





## WHAT IT MEANS

We find that the performance of the ACA marketplaces varies by state and appears to cluster around marketplace types. Compared to FFM, SBMs have been less vulnerable to issuer exits and premium increases, suggesting that SBMs may have different sensitivities to common health insurance marketplace problems like low enrollment and adverse selection.

These findings are consistent with a recent analysis by [Hall & McCue](#), which found that plan premiums, projected claims, and overhead were much higher in FFMs than SBMs in 2018. They note that these trends have existed since the marketplaces began, but differences were greater in 2018 than for the previous two years.

The mechanisms for these differential trends are unclear. For one, variation in state policy decisions may have considerable impact on market outcomes. A report from the [Robert Wood Johnson Foundation](#) identified a number of policies – such as the sale of limited coverage plans, the availability of transitional or “grandmothered” individual market products, and the non-expansion of Medicaid – as decisions that could destabilize the risk pool for ACA marketplace plans. There may also be state-dependent structural factors, including rurality, that could affect differential performance across marketplaces. [The National Academy for State Health Policy](#) has pointed out a number of steps that states have taken to drive stable markets, including working with issuers to ensure choice, and developing new tools and methods to attract healthier enrollees. Future evaluation should focus on the regulatory and operational features of SBMs that may contribute to these findings.

The performance of ACA marketplaces varies by state and appears to cluster around marketplace types. Compared to FFM, SBMs have been less vulnerable to issuer exits and premium increases, suggesting that SBMs may have different sensitivities to common health insurance marketplace problems like low enrollment and adverse selection.

## ABOUT LDI

Since 1967, the Leonard Davis Institute of Health Economics (LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation’s health and health care. Originally founded to bridge the gap between scholars in business (Wharton) and medicine at the University of Pennsylvania, LDI now connects all of Penn’s schools and the Children’s Hospital of Philadelphia through its more than 250 Senior Fellows.

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