McKinsey Center for U.S. Health System Reform

Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?

INTRODUCTION

Health insurance carriers in every state have now filed their proposed product offerings for the public exchanges created by the Affordable Care Act (ACA). The full characterization of exchange offerings – including rates, products, networks, and formulary details – will not become transparent until October 1, 2013, when the exchanges go live. While the majority of rates are not set to be approved by the federal government until later in September, some states have begun to reveal rates, and almost all have released names of the carriers filing in their markets.

The McKinsey Center for U.S. Health System Reform has analyzed this emerging data for the individual-exchange market across 47 states and the District of Columbia.[1] Individual-exchange products are the only plans through which income-eligible consumers can receive the federal premium and cost-sharing subsidies.[2] The preliminary data in this analysis will undoubtedly continue to evolve before exchanges open, given federal approval of carriers is pending in all federally-facilitated and partnership states, and given recent examples such as Washington reversing its rejection of two carriers and several experienced carriers withdrawing from exchange markets. Following the release of all final rate filings, the Reform Center will be updating this analysis with a comprehensive report of the exchange landscape.

The analysis reveals four themes regarding the expected 2014 competitive landscape on the exchanges:

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[1] These numbers reflect on-exchange filings through September 12th, accessed from state Departments of Insurance (DOIs). See Table 1 for list of included states; (Texas and Missouri filings had yet to be revealed, and Massachusetts is not included, given less relevant with Connector in place.) Complete off-exchange filings may not be available in every state until the end of 2013, and therefore have not been included in this brief.

[2] Although this Intelligence Brief focuses exclusively on individual-market exchange products, the Reform Center is also analyzing off-exchange and small-group-market (SHOP) products. A different set of products, carriers, and price mix are expected to characterize the off-exchange individual market, since it may attract a higher-income population not eligible for the federal premium and cost-sharing subsidies.

- *Changes in the degree of choice offered to consumers on the exchanges will differ across states*; compared to today, half of states – over two-thirds of non-elderly uninsured – are likely to have roughly the same or more carrier choices, while the remaining half of states – close to one-third of non-elderly uninsured – can be expected to see a material decline in competitors based on carrier filings.[3]
- *The composition of individual-market participants is changing*, with close to one-third of incumbents foregoing exchange participation and many new entrants filing who could meaningfully alter the competitive dynamics.
- *Market disruption is probable given premium variations*, partially a function of lower new-entrant premium rates, though the extent and the sustainability of this potential disruption remain unclear.
- *A trend in managed care plan design – gatekeepers to manage referrals – is emerging*, especially among new entrants, likely as a way to achieve competitive price points.

HOW THE ACA EXCHANGES ARE CHANGING TODAY'S INDIVIDUAL MARKET

Changes in the degree of choice offered to consumers on the exchanges will differ across states. In 25 of the 48 markets analyzed – representing 68 percent of non-elderly uninsured – consumers can expect to see roughly the same (within +/- 15 percent) or more competitors from which to select coverage on exchanges relative to today (Table 1). Yet, in the remaining 23 states, consumers will likely face a material decline in competitors (defined as over 15 percent fewer carriers). This translates to about 32 percent of the non-elderly uninsured with a decline on average of two fewer carriers in their markets, or 43 percent less competition. Given not all carriers will offer statewide coverage, these trends will differ across local markets, as well.

Table 1: Individual market carrier landscape based on available exchange filings

States listed in order of 2011 non-elderly uninsured population

State	Exchange type[Δ]	2011 Non-elderly uninsured, 000s[†]	2012 Individual market participation[¶]	2014 On-exchange carriers filing[^]	2014 On-exchange new entrants
California	Active-purchaser	7,180	5	12	8
Florida	Federal	3,750	9	11	2
New York	Active-purchaser	2,558	10	16	8
Illinois	Partnership	1,857	7	6	1
Georgia	Federal	1,856	9	5	0
North Carolina	Federal	1,566	5	2	0

[3] 'Material decline' defined as greater than 15 percent. 'Roughly the same' defined as within +/- 15 percent. All estimates are based on state-level 2012 and 2014 exchange carrier totals. 2012 totals are based on carriers with at least 5 percent share, with adjustments where carriers below threshold have filed. Since not all carriers in 2012 or 2014 offer statewide coverage, the degree of choice on exchanges compared to today may differ by market within states.

Ohio	Federal	1,528	11	12	4
Pennsylvania	Federal	1,359	9	8	0
New Jersey	Federal	1,327	4	4	1
Arizona	Federal	1,157	7	5	1
Virginia	Federal	1,073	7	8	1
Washington	Clearinghouse	948	5	6	1
South Carolina	Federal	901	8	4	1
Louisiana	Federal	896	5	5	1
Tennessee	Federal	870	6	4	1
Mississippi	Federal	851	6	2	0
Indiana	Federal	801	9	4	1
Maryland	Clearinghouse	759	5	4	1
Colorado	Clearinghouse	710	9	10	3
Alabama	Federal	662	3	3	0
Oklahoma	Federal	635	6	4	1
Kentucky	State-run	624	2	3	1
Nevada	Clearinghouse	588	5	4	2
Oregon	Active-purchaser	565	8	11	4
Wisconsin	Federal	554	14	13	4
Arkansas	Partnership	504	5	4	0
Minnesota	Clearinghouse	493	6	5	1
New Mexico	State-run	411	4	5	2
Utah	Federal	393	5	6	2
Kansas	Federal	365	6	3	0
Connecticut	Clearinghouse	341	4	3	1
Iowa	Partnership	330	4	2	1
Michigan	Partnership	281	15	13	4
Idaho	Partnership	279	5	5	0
West Virginia	Partnership	256	5	1	0
Nebraska	Federal	230	4	4	2
Montana	Federal	177	4	3	1
New Hampshire	Partnership	147	2	1	0
Maine	Federal	127	2	2	1
Alaska	Federal	126	4	2	0
Rhode Island	Active-purchaser	121	1	2	1
South Dakota	Federal	104	6	3	0
Hawaii	Clearinghouse	99	2	2	0
Wyoming	Federal	97	7	2	0
Delaware	Partnership	94	5	2	0
North Dakota	Federal	74	5	3	0
D.C.	Clearinghouse	63	3	3	0
Vermont	Active-purchaser	55	2	2	0
TOTAL		40,737	280	244	63

Δ *Kaiser Family Foundation, "State Decisions for Creating Health Insurance Exchanges," with adjustment for Idaho's recent switch to partnership. Available online:http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.*

† *Census March Supplement to the Current Population*

¶ *Defined as carriers with at least 5 percent share in the 2012 individual market in a respective state, as defined by SNL Financial; adjustments were made for existing carriers filing in 2014 that were below the threshold*

The composition of the individual-market participants is changing. What is consistent across most states is the decline in number of incumbents. Close to one-third of today's individual-market carriers have chosen not to file on the exchanges, with incumbent participation declining in 40 of 48 markets analyzed.[4] This is despite the fact that some states have established market participation requirements for existing carriers, including waiting periods for future exchange participation for existing insurers choosing not to participate in 2014 (e.g., New York, Colorado, Oregon), as well as the forced exit of the private individual market for insurers not participating on exchanges (as Maryland has enforced). Potential factors contributing to this reluctance may include concerns about the ability to compete on exchanges, perceived financial viability of exchange markets, and the promise of alternative growth segments, such as private employer-based exchanges. In addition, some experienced carriers have withdrawn initially filed exchange products, citing reasons such as rate pressure from state regulators and uncertainties related to exchange implementation (recent examples include Connecticut, Maryland, New York, Georgia, North Carolina).

In contrast, new entrants are prevalent, having filed in 30 of the 48 markets analyzed. As new entrants make up 26 percent of all carriers filing (and at least half of all carriers in 7 states), the competitive dynamics change meaningfully. New entrants include a range of types, such as Medicaid carriers (managed care organizations historically providing services to Medicaid populations, but now offering commercial coverage on exchanges), Consumer Operated and Oriented Plans (CO-OPs), and provider-based plans. Although the variety of new entrants could change competitive dynamics, some of these carriers may lack experience with capabilities required in the individual market such as setting rates, managing risk, and meeting regulatory requirements.

The chosen state exchange model appears to affect both the change in number of competitors and the number of new entrants. States are either a state- or federal-run exchange model. Those states implementing their own exchanges (state-run) are using one

[4] Since incumbents are defined as carriers who had at least 5 percent share in the 2012 individual market in a specific state – with adjustments for existing carriers filing in 2014 that were below the threshold – the remaining carriers with less than 5 percent share in 2012 are not included in the estimates for incumbent participation. Many of these include carriers with closed books or with declining membership over recent years. Note the 2 states of FL and VA have the same number of existing carriers in 2012 and 2014 exchange, though did experience a decline in incumbent participation, with one existing carrier sitting out; this was netted out by another existing carrier introducing a new product under a separate legal entity.

of two approaches: clearinghouse models, in which any carrier that meets certain general criteria can offer products on the exchanges, or active-purchaser (AP) models, in which the state can deny participation to carriers failing to meet rate targets. Those states using federal-run exchanges have either defaulted completely to the federally-facilitated exchange parameters, or have opted for a state-partnership exchange, in which the state utilizes federal information technology but retains insurer-oversight and consumer-assistance responsibilities. Most (30 of 33) of the federal and state-partnership states analyzed experienced a decrease in carrier competition from 2012 to 2014. In comparison, in states with the most regulated model (AP), the level of competition is either constant or increasing, and in almost all of these, at least half of the competitors are new. This may reflect the fact that many AP states actively recruited participation from carriers and only thereafter approved final rates and products. For example, 33 carriers originally applied to offer coverage in California;[5] 12 were ultimately approved. Moreover, the state-run exchanges with local exchange boards and management (regardless of their decision to use an AP or clearinghouse model) may be perceived as easier to work with and more flexible than federal government, and therefore, may recruit a higher number of carriers.

In only some cases does the number of uninsured appear to correlate with the number of new entrants, where the market opportunity may be affecting business decisions by the carriers. Several states with the highest number of non-elderly uninsured – an indicator for potential market growth – have attracted a high number of new entrants (e.g., California, Florida, New York). However, a high number of uninsured is not always a predictor of new entrants. Some states with much lower number of uninsured (e.g., Oregon, Colorado) do have a high number of new entrants. (In these two cases, the exchange model selected may explain this growth.)

PRICING DYNAMICS IN THE ACA EXCHANGES

Market disruption seems probable given premium variations, partially a function of lower new-entrant premiums. Given the significance of the ACA reforms to the individual market, carriers, both existing and new, face uncertainty about how to set individual-market premiums in 2014. There are a number of new requirements, such as actuarial value tiers, standardized benefits, and new rating rules, as well as limited experience to inform expected utilization of new members. Additionally, the specific implications of risk adjustment, reinsurance, and risk corridors are not fully understood without actual experience. However, there appears to be an emerging trend of new entrants pricing lower; based on an analysis of premiums in the most populous rating areas of 8 states with available data, 66 percent of the new entrants priced below median premium levels in their respective markets (Exhibit 1). (Connecticut and Oregon were outliers in this regard; in both states, no new entrant priced below the median.)

A trend in managed care plan designs is emerging, especially among new entrants. Previous McKinsey research – based on exchange simulations from within the past year –

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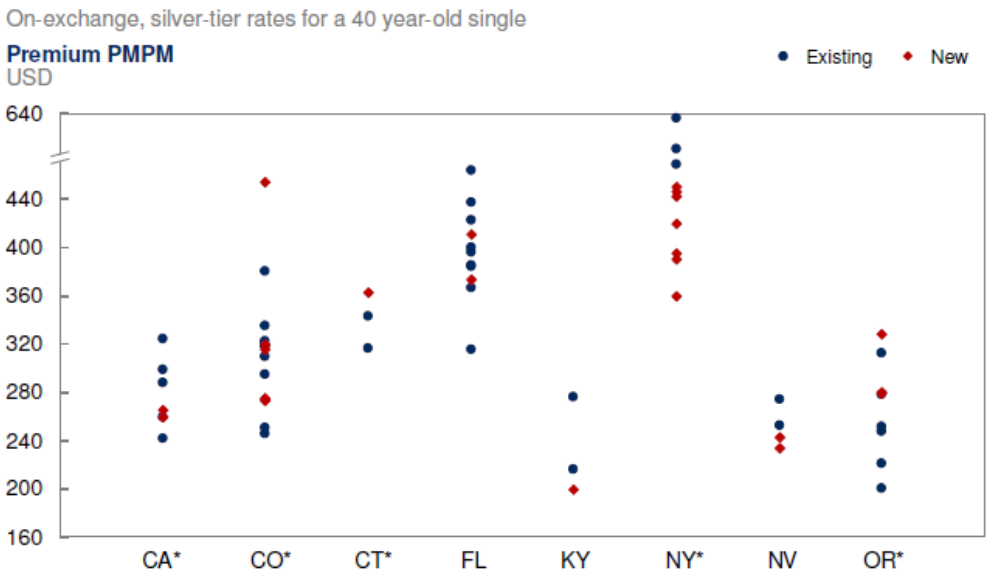
[5] "Bloomberg: California One of 2 States to Force Health Insurer Bids." Available online: http://www.bloomberg.com/news/2013-03-13/california-one-of-2-states-to-force-health-insurer-bids.html.

has indicated that consumers are willing to trade off narrower provider access for lower monthly premiums or out-of-pocket costs. Consistent with the new entrant pricing trends above, new entrants are designing products with managed care characteristics likely as a way to achieve more competitive prices. In 14 states, plan type information about the exchange products that will be offered was available for analysis: 78 percent of products offered by new market entrants have restrictive characteristics (HMO or EPO), compared with 42 percent of products offered by incumbents. Incumbent products being filed on exchanges seem to be reflecting the PPO products more common today. Potential reasons may be that existing carriers need to both retain and acquire members and have existing provider relationships to manage. More broadly in the post-reform landscape, across new and existing entrants alike there is a broader shift toward managed care characteristics. Even many PPOs are emerging as lower cost and more restrictively managed. While this approach is designed to meet market demands, it is not yet known how satisfied consumers will be with these network designs over the long term.

EXHIBIT 1

Exhibit 1. 2014 Individual-market on-exchange filed prices by new and existing carriers



* States with approved rates; remainder of states reflect submitted filings only, pending final approval

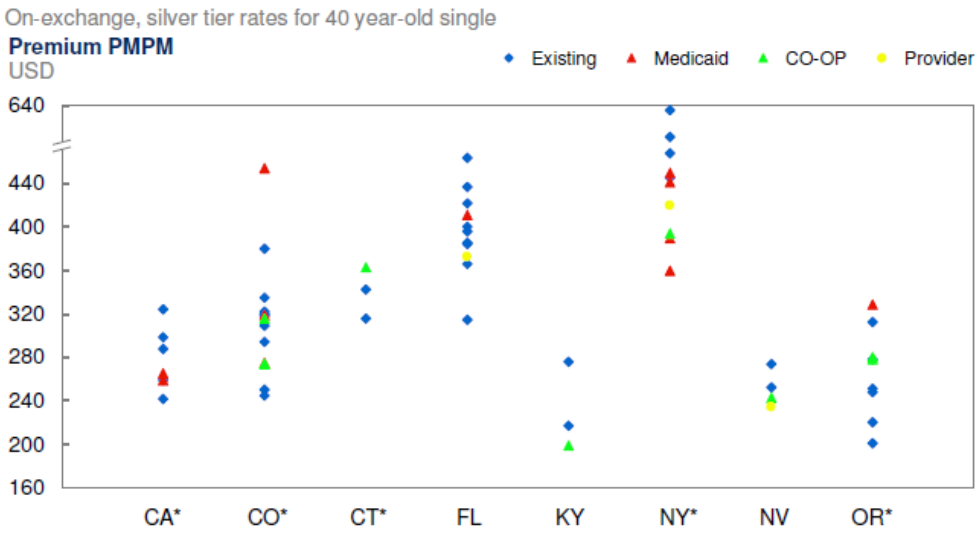
Source: Pricing data from 8 markets with both new and existing entrants. Each state's rates reflect prices from the state's most populous rating area, with the exception of Florida, for which the numbers are state-wide averages

There is a general lack of consistent pricing advantage among the types of new entrants (Exhibit 2). While the majority of new entrants are pricing below the median, there is underlying variation within each type of entrant across markets. Medicaid entrants and CO-OPs are both the lowest-priced entrant in at least one market and the highest-priced entrant in another. Provider-based plans are an exception, pricing below the median in both markets where they have filed. This varied pricing pattern suggests that, so far, there

may be inconsistent advantage across geographic regions based solely on carrier structure. The following sections outline some of the potential advantages and challenges of the three main types of new entrants.

EXHIBIT 2

Exhibit 2. 2014 Individual-market on-exchange filed prices by new entrant carrier type



* States with approved rates; remainder of states reflect submitted filings only, pending final approval

Note: New-entrant competitor types defined as follows: *Existing:* offers individual insurance in the respective state's individual market today, based on 2012 SNL data; *Medicaid:* offers Medicaid insurance today but not in individual market (includes provider-owned entrants who are in the Medicaid market today); *CO-OP:* recipient of CO-OP grant funding and not prior commercial carrier; *Provider:* operates as a provider/health system today but not in individual or Medicaid markets (includes providers not offering any insurance today, as well as providers offering only Group or Medicare)

Source: Pricing data from 8 markets with both new and existing entrants. Each state's rates reflect prices from the state's most populous rating area, with the exception of Florida, for which the numbers are state-wide averages

Medicaid Carriers

Medicaid carriers expanding into the commercial segment with standard exchange offerings are the most common type of new individual-market entrant, comprising 40 percent of new entrants across the markets analyzed. They are also perhaps the most closely watched type of new entrant. Some Medicaid carriers seem positioned to be among the lowest cost carriers. In New York City, for example, Medicaid entrants are the two lowest-priced products on the market; in Los Angeles, both Medicaid entrants are priced below the median. However, other Medicaid carriers have priced highly. In Portland, Oregon, for example, a Medicaid carrier is the highest priced carrier on the exchange, and that is only after another Medicaid carrier withdrew from the market because its rates were 35 percent higher than what the state would approve.[6] A Medicaid

6 "Portland Area Approved Rate Examples." Available online: http://www.oregonhealthrates.org/files/app_portland_individual.pdf.

entrant is also the highest-priced carrier in Denver. Several underlying factors could be at play. The lower-priced Medicaid carriers may be able to use relationships with their existing provider networks as a starting point for contract negotiations. The higher prices of carriers may be influenced by higher market-risk assumptions based on member experience or by less experience with rate-setting. As more premium data emerge, further analysis of Medicaid entrants' pricing trends, underlying assumptions, and operating models will better inform expected competitive impact.

Consumer Operated and Oriented Plans (CO-OPs)

As an alternative to the "public option" during health reform deliberations, the ACA established CO-OPs as not-for-profit health benefits carriers. The federal government dedicated a pool of start-up and solvency funding, with a total of $2 billion awarded in loans to CO-OPs in 24 states,[7] comprising 37 percent of new entrants across the markets analyzed. Emerging data show that most CO-OPs are pricing lower, and often the lowest. For example, in Kentucky, a CO-OP is the lowest-cost entrant, and CO-OPs in Colorado, Nevada, and New York all filed plans below the median premium. Yet, not all CO-OPs have priced so competitively. Connecticut's CO-OP, for example, came in 15 percent higher than the next-closest carrier.

To better understand the sustainability of these entrants, external constraints should be considered. CO-OPs face capital requirements as well as start-up cost pressures, operating model constraints, and broader competitive challenges. The Health and Human Services Inspector General recently reviewed 16 of the 24 CO-OP loan recipients and found that 11 seemed to have start-up funding costs exceeding the loans provided by CMS, and all 16 had limited private monetary support.[8] These findings suggest real risk around near-term viability and raise questions about whether CO-OPs can build the necessary capabilities to be sustainable exchange participants. A better understanding of CO-OP operating models and leadership/talent structures will help clarify whether the more competitively priced CO-OPs pose a competitive threat, or will remain niche players at best.

Provider Plans

Provider plans comprise 26 percent of new entrants across states analyzed.[9] One factor affecting this participation may be that the exchanges represent a low-risk opportunity to

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[7] "CMS: New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers." Available online: http://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[8] "HHS IG: The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance with Federal Requirements, and Continued Oversight is Needed." Available online: http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.

[9] This includes 10 percent of new provider entrants that offer Medicaid today and that are include in the estimated 42 percent of Medicaid entrants. Note the remaining 8 percent of new entrants outside Medicaid, CO-OP and provider have current presence in non-Individual commercial or Medicare today.

utilize excess hospital capacity and protect against carriers' utilization management tools, which often leads to volume reductions. There is a range of types of providers entering exchanges. The majority offer some type of non-individual insurance today, such as Medicaid, Medicare, or group. Yet, there are also examples of new provider entrants to the insurance space, such as a major New York health system creating its own health insurance entity to participate on the exchange. Provider-based plans partnering with experienced commercial insurers – an approach that draws upon their complementary core strengths – may be well-positioned to price competitively and remain sustainable over the long term. In the states analyzed, the provider entrants new to insurance are among the lowest priced. As more data on provider entrants become available, a closer analysis of these models will help inform the degree of sustainable structural advantage.

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The emerging trends presented in this Intelligence Brief help to inform the expected competitive landscape on exchanges, which open in approximately two weeks. Carrier participation data analyzed across the 47 states and District of Columbia indicate that changes in the degree of choice on exchanges will differ across markets; yet, almost all will see a decline in number of incumbents, and majority will see a greater choice of types of carriers. The high number of new entrants on exchanges may meaningfully alter the competitive dynamics. While price variation exists across all carrier types, available data indicate a trend of lower-priced new entrants with higher rates of managed care characteristics. Additional data will better inform the extent to which competitive dynamics are altered and the expected sustainability of the new emerging landscape.

– Erica Coe, Erin Haigh, Jim Oatman

Appendix

Forthcoming analyses

Network and formulary details for plans: While very limited network and formulary details of filed products are publicly available today, that information is scheduled to become transparent when exchanges go live on October 1, 2013. The Reform Center is planning a detailed analysis of underlying provider configurations to inform how products offered in 2014 may be shifting from what is currently available.

Plan design / cost-sharing details: Details of degree of consumer cost-sharing vs. payor will be available with full form filings come October 1, 2013. The Reform Center will analyze these design trends across tiers, in light of additional cost-sharing subsidies for silver tier, to inform shifts in consumer responsibility.

Multi-state plans: The Office of Personnel Management (OPM) is currently reviewing multi-state plans offering coverage on the exchanges. Once that information is available publicly, the Reform Center will analyze the design and price position of these products.

Off-exchange individual-market plans: While premium and cost-sharing subsidies are only available in on-exchange plans, many individuals will continue to receive coverage through the off-exchange individual market. This segment may attract those who wish to continue their current coverage with a "grandfathered" health plan as well as higher-income individuals ineligible for federal subsidies.

Small-group-market plans: Although the focus of this Intelligence Brief is exclusively the on-exchange individual market, the Reform Center is also analyzing carriers and products available in the small group market (SHOP exchanges).

Additional background on the underlying research

The analysis supporting this Intelligence Brief is informed by a new McKinsey Health Systems and Services practice asset that has been developed jointly by the Center for U.S. Health System Reform and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of what has actually been filed – more than 150,000 pages of detailed data so far – for plan year 2014. The Reform Center/MAHA tool can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across plan types and actuarial value tiers by consumer characteristics, predictions of market share based on filings and consumer-predicted dynamics, and more. Specific analysis is available upon request from the Reform Center/MAHA team, and we look forward to working to make our clients successful in the post-ACA market with data-driven analysis on specific market trends.

Following the release of the final rate filings across the United States, the Reform Center plans to analyze them and then release a comprehensive report, which will expand the

scope of states analyzed as well as additional analysis on plan design, networks, formularies, and pricing sustainability.

Please reach out to reformcenter@mckinsey.com with any inquiries.

Methodology

Observations included in this brief will continue to be developed as more information is publicly released. Data received at time of publication are preliminary based on "submitted" filings and releases by respective state departments, and should neither suggest any overall national trend nor represent final filings even within any given State. Each of the analyzed premiums and carrier counts is potentially dynamic and may change before plans are open for enrollment on October 1st.

Analyses were based on publicly available filings as of September 12th across 47 states and the District of Columbia; and, for those states where full filings were not available, analysis was based on published rate summaries. (Texas and Missouri filings had yet to be released, and Massachusetts was not included.) This filing information includes premium rates for some states and certain underlying assumptions by the filing carriers (e.g., MLR, anticipated change in morbidity pool, profit margins). The publicly available filings data was not independently validated by McKinsey. Complete off-exchange filings may not be available in every state until the end of 2013 and have not been included in this brief.

For analysis of change in the number of carriers in the current individual market compared to the on-exchange individual market, the analysis used state-level 2012 and 2014 exchange carrier totals. 2012 totals are based on carriers with at least 5 percent share in a respective state's individual market, according to SNL Financial data. Carriers that were below the five percent threshold in 2012 but filed in 2014 were also included in our 2012 count. 2014 totals are based on all carriers filing on exchanges. The percentage difference between 2012 and 2014 on-exchange carrier counts was calculated defining 'material change' as greater than 15 percent and 'roughly the same' as under 15 percent. Finally, since not all carriers in 2012 or 2014 offer statewide coverage, the degree of choice on exchanges compared to today may differ by market within states.

For pricing analysis, premiums were analyzed across the 8 markets where data was available for all carriers and there was a combination of new and existing entrants. With the exception of Florida (where data represents state-wide averages across age and geography), each state's displayed rates reflect prices from the state's most populous rating area for a 40-year old single non-tobacco user selecting a silver on-exchange plan. In the 6 states (California, Colorado, Connecticut, California, Nevada, and Oregon) where detailed rate filings were available, the premiums shown represent the lowest on-exchange individual market silver tier premium for each carrier. For Florida and New York, the premiums shown are the summary results of standard silver tier plans as published by each state's Department of Insurance. The data used for this pricing analysis may not be exhaustive as some filings have not been publicly released yet.

Please email reformcenter@mckinsey.com for any additional clarification.

Glossary of health care terms

Consumer Operated and Oriented Plan (CO-OP) – a new entrant that is a recipient of federal CO-OP grant funding and is not a prior commercial carrier

Existing entrant – an insurance carrier that offers individual insurance in the respective state's individual market today, based on 2012 SNL Financial data

EPO – an exclusive provider organization is a plan model that is similar to an HMO. It provides no coverage for any services delivered by out-of-network providers or facilities except in emergency or urgent care situations; however, it generally does not require members to use a primary care physician for in-network referrals

Gatekeeper – an approach that limits access to healthcare services in some way (e.g., by requiring referrals through a primary care provider)

HMO – a health maintenance organization is a plan model centered around a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent care situations

Medicaid entrant – a new entrant that offers Medicaid insurance today but is not in the individual market

PMPM – per member per month

PPO – a preferred provider organization is a plan model that allows members to see doctors and get services that are not part of a network, but out-of-network services require a higher copayment

Provider entrant – a new entrant that operates as a provider/health system today

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