

McKinsey Center for U.S. Health System Reform

Intelligence Brief



Exchanges three years in: Market variations and factors affecting performance

The third open enrollment period (OEP) for the public exchanges concluded in January. Many carriers—both early-OEP entrants and “wait-and-see” latecomers—believed this new market would achieve stability and sustainable margins in its third year. However, recent events—including carrier turnover (both entrances and exits), plan terminations, and pricing volatility—suggest the market is still in flux.

One reason for the flux is the variability of individual market¹ financial performance many carriers have disclosed publicly. For some carriers, significant losses are causing marked changes in enterprise-level capital, cost structures, and strategy. Early indications of 2015 performance suggest aggregate negative margins may have doubled; to date, however, only 86% of carriers have released preliminary data publicly.² We anticipate that our estimates will evolve as more information is released, such as final 3R results and rebates, as well as 2015 claim run-out and adjustments. Whether carriers’ performance in the individual market will improve in 2016 remains unclear.

Some carriers had positive margins in the 2014 and 2015 individual markets, however. Overall, 30% of the carriers (which together covered close to 40% of individual market enrollees) earned a profit in 2014. In 13 states more than half of the carriers were profitable, and in 45 states there was at least one profitable carrier in the market. Preliminary reports suggest close to one-quarter of carriers were profitable in the 2015 individual market as well. Careful analysis of all carriers’ performance reveals several factors associated with better results. These factors suggest that success in the individual market could require many carriers to develop fundamentally different business models.

Four key observations emerged from our analyses:

- The overall individual market suffered an aggregate loss of \$2.7 billion in 2014 (–5% post-tax margins), but performance varied widely among states and carriers.

¹ Throughout the paper, “individual market” refers to the entire individual market, both on and off exchange.

² Estimates are based on publicly available data (published by the National Association of Insurance Commissioners in its Supplemental Health Care Exhibit) for individual market business booked through year-end 2015; the estimate of 86% of carriers is weighted by enrollment; see methodology for further detail.

Exchanges three years in: Market variations and factors affecting performance

- Carriers earning a positive margin in 2014 appear to share several common factors, including narrowed networks and managed plan design.
- Early 2015 results suggest continued performance variability. Losses may have grown, but some carriers appear to have earned a profit.
- There is little risk of a market-wide “death spiral” given stabilizing subsidies.

INDIVIDUAL MARKET SUFFERED A LOSS, BUT PERFORMANCE VARIED WIDELY

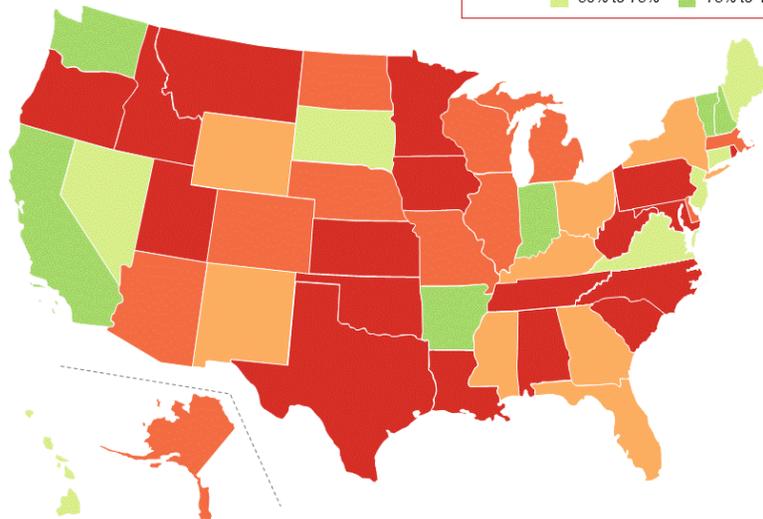
After risk adjustment, risk corridor, and reinsurance (3R) payments are factored in, the health insurance industry’s aggregate pre-tax margin in the 2014 individual market was -5.2% . The aggregate post-tax margin was -4.8% , amounting to a loss of \$2.7 billion nationwide.³ Deconstructing these results to consider a range of factors (e.g., geography, carrier type, plan design, and network) reveals wide variations in performance. Isolating these factors helps identify—and sometimes dismiss—potential contributors to performance.

Geographic analysis exposes considerable differences in 2014 carrier performance *across* states (*Exhibit 1*). In six states, more than 75% of carriers had positive individual market margins. California and Washington posted the strongest results (95% of carriers with positive margins). By contrast, in 18 states, fewer than 5% of the carriers had positive margins. Yet, only six states had no carriers reporting positive margins in 2014.

EXHIBIT 1

Variation in carrier financial performance across states

% of carriers within each state that had positive 2014 post-3R post-tax individual market margins



Note: Percentage of carriers within each state that had positive 2014 post-3R, post-tax individual market margins, weighted by individual market enrollment. Methodology is described more fully in the Appendix.

SOURCE: McKinsey Payor Financial Database

Data as of 04.28.2016

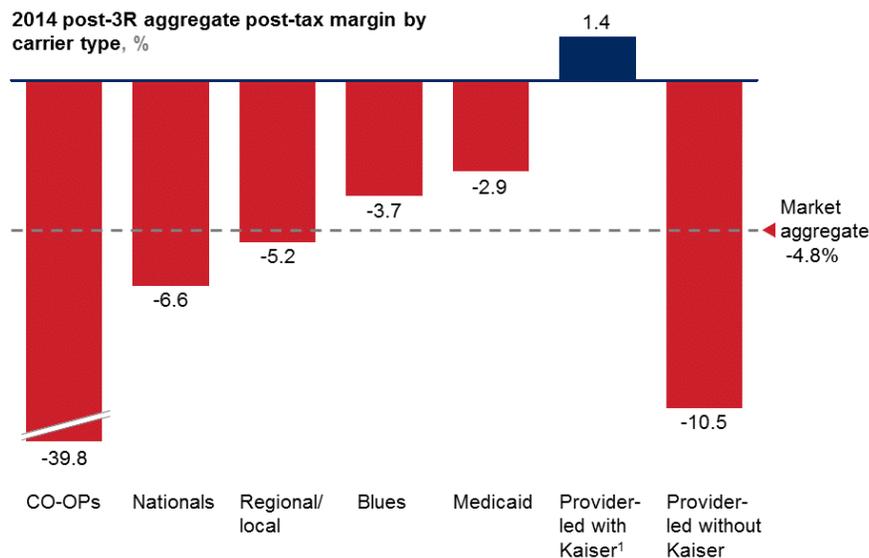
³ Several regulatory changes made after carriers filed 2014 premiums (e.g., extension of transitional plans, change in expected risk corridor payments) may have contributed to the losses.

A handful of regulatory and competitive factors appear to have contributed to the geographic differences, including the allowance of transitional policies (i.e., transitional plans, which had an unfavorable impact), enrollment trends (more is better), and silver-plan price dispersion (less is better). However, the statistical significance for each of these associations is relatively weak.⁴ Furthermore, the variation in carrier-level performance *within* each state suggests that carrier-specific factors likely also influenced results.

These carrier-specific factors shaping carrier profitability include carrier type, benefit design, and network breadth. The variations in 2014 individual market margins *across* carrier type were wide (*Exhibit 2*). CO-OPs (Consumer Operated and Oriented Plans) were the most unprofitable. Provider-led health plans were the only carrier type to earn a positive post-3R aggregate post-tax margin in 2014, but this result largely reflected the performance of Kaiser Permanente, the most profitable carrier in the 2014 individual market. Almost equally wide was the difference in performance *within* carrier types (*Exhibit 3*). For example, there was more than a 40-percentage-point margin spread between the highest- and lowest-performing Blue carriers and a 65-percentage-point spread for provider-led plans.

EXHIBIT 2

Carrier margins in the 2014 individual market, by carrier type



¹ Kaiser comprises 55% of all provider-led plan enrollment.

Note: The methodology used in this analysis is described in the Appendix.

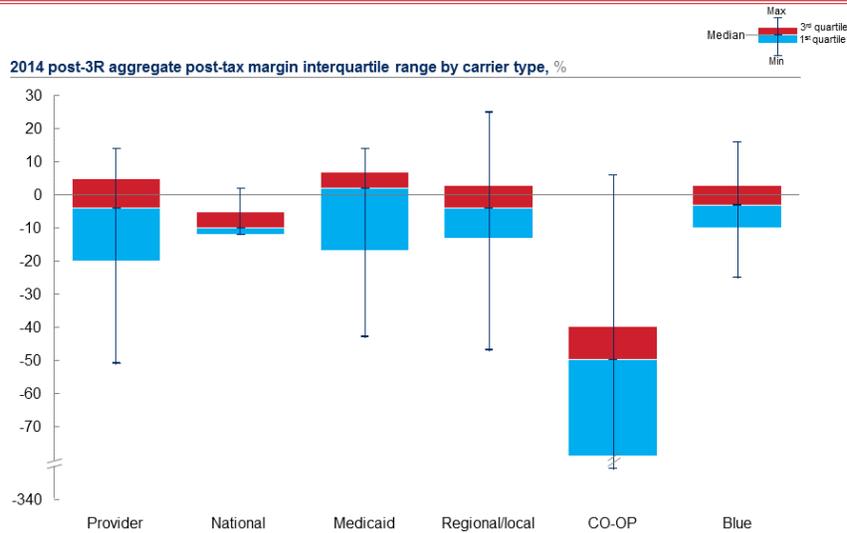
SOURCE: McKinsey Payor Financial Database

Data as of 04.28.2016

⁴ As measured by R-squared values. Analysis was based on carrier margins weighted by QHP enrollment, limited to carriers with over 1,000 QHP lives.

EXHIBIT 3

Carrier margins in the 2014 individual market, by carrier type and quartile



Note: The methodology used in this analysis is described in the Appendix.

SOURCE: McKinsey Payor Financial Database

Data as of 04.28.2016

SOME FACTORS ARE ASSOCIATED MORE CLOSELY WITH CARRIER FINANCIAL PERFORMANCE

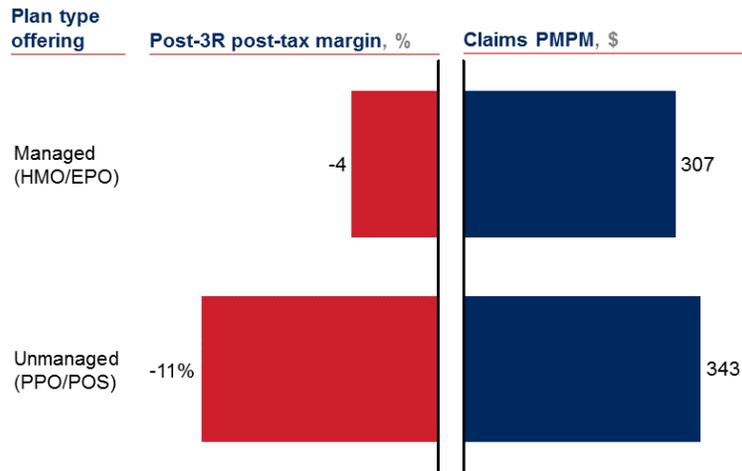
At the individual carrier level, results varied as well. While most carriers had negative margins after accounting for the 3Rs, approximately 30% of carriers achieved a positive margin in 2014.⁵ At the plan level, patterns emerge around performance differences. In the aggregate, plans based on health maintenance organizations (HMOs) had lower losses than plans based on preferred provider organizations (PPOs), consistent with their ability to enable more tightly managed benefits and care (*Exhibit 4*). In both 2015 and 2016, the premium increases for HMO plans were roughly half those of PPO plans, which suggests the initial results carriers experienced in the individual market were more favorable for the HMO plans.⁶

⁵ McKinsey on Healthcare Infographic. 2014 individual market post-3R financial performance. February 2016. (healthcare.mckinsey.com/2014-individual-market-post-3r-financial-performance)

⁶ McKinsey on Healthcare Infographic. 2016 exchange market remains in flux: plan type trends. December 2015. (healthcare.mckinsey.com/2016-exchange-market-remains-flux-plan-type-trends)

EXHIBIT 4

2014 individual market financial metrics by exchange plan type



HMO, health maintenance organization; EPO, exclusive provider organization; PPO, preferred provider organization, POS, point of service.

Note: The methodology used in this analysis is described in the Appendix.

SOURCE: McKinsey Center for U.S. Health System Reform Exchange and Network Offerings Database, McKinsey Payor Financial Database, McKinsey Predictive Agent-based Coverage Tool

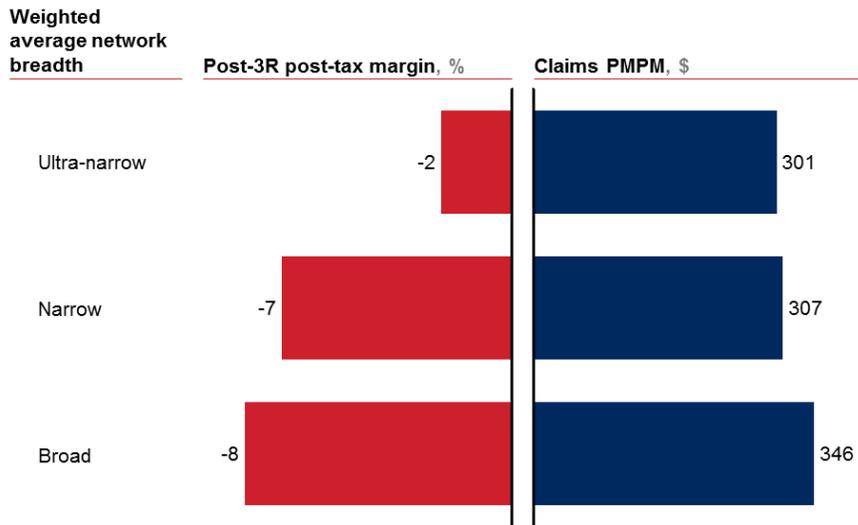
Data as of 04.28.2016

Similarly, plans with narrowed (narrow or ultra-narrow) hospital networks had better aggregate margins and lower claims in 2014 than broad-network plans did, likely resulting in part from unit-cost advantages (*Exhibit 5*). Plans with narrowed networks also had lower median premium increases than broad plans did in both 2015 and 2016. In addition, the pricing spread between the two plan types has continued to expand—the difference in median premiums between narrowed- and broad-network silver plans from the same carrier increased from 16% in 2014 to 22% in 2016.⁷ The combination of the improving relative pricing of narrowed networks and their superior financial performance suggests that they may be emerging as one sustainable element of exchange plan design.

⁷ Coe E, Bello J, Lamb J. Hospital networks: Perspectives from year 3 of the exchanges. March 2016. (healthcare.mckinsey.com/hospital-networks-perspective-three-years-exchanges)

EXHIBIT 5

2014 individual market financial metrics by exchange network type



PMPM, per member per month.

Note: The methodology used in this analysis is described in the Appendix.

SOURCE: McKinsey Center for U.S. Health System Reform Exchange and Network Offerings Database, McKinsey Payor Financial Database, McKinsey Predictive Agent-based Coverage Tool

Data as of 04.28.2016

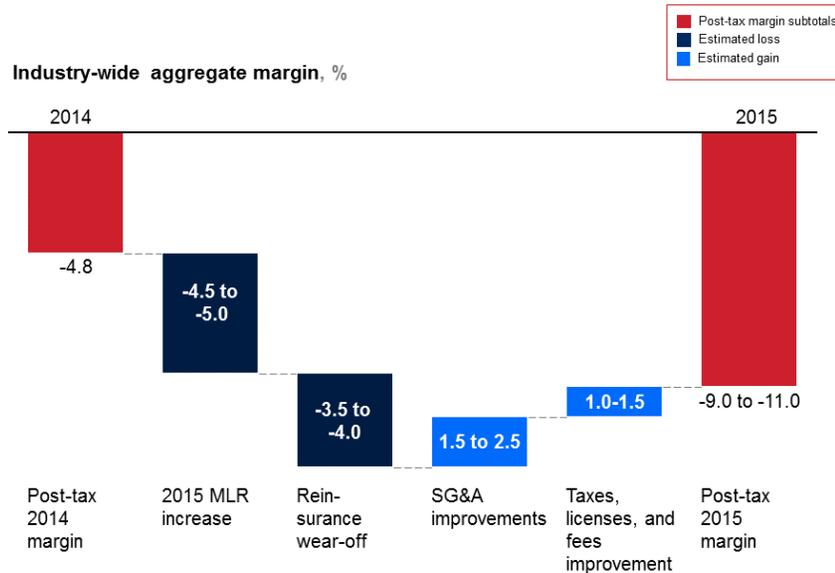
EARLY 2015 RESULTS SUGGEST CONTINUED VARIABILITY IN CARRIER PERFORMANCE

Our initial perspective, based on emerging financial results reported for 2015, is that aggregate losses in the individual market may have doubled from 2014, with post-tax margins between -9% to -11% (*Exhibit 6*). The larger losses are most likely the result of two primary factors: higher year-over-year medical loss ratios (MLRs) (around 4.5% to 5% margin reduction) and lower reinsurance payments (another 3.5% to 4% margin reduction).

The majority (around 60%) of carriers that filed financial results publicly (as of April 28, 2016) reported a higher MLR in 2015 than in 2014. A subset of carriers (close to one-quarter) did report positive margins in 2015, but there is some turnover between the two years in terms of which carriers generated a positive margin. As mentioned above, our preliminary estimates of 2015 carrier financial performance as well as the size of the aggregate 2015 losses are likely to evolve as we gain insight into additional factors.

EXHIBIT 6

Margin changes in the individual market



Note: The methodology used in this analysis is described in the Appendix.

SOURCE: McKinsey Center for U.S. Health System Reform exchange and network offerings database, McKinsey Payor Financial Database, McKinsey Predictive Agent-based Coverage Tool

Data as of 04.28.2016

THERE IS LITTLE RISK OF A MARKET-WIDE SPIRAL GIVEN STABILIZING SUBSIDIES

The individual market has little risk of entering a classic insurance “death spiral” as long as the federal government continues to offer subsidies to those with incomes below 400% of the federal poverty level. Given the unique regulatory conditions of this market, the key determinants of its stability are not the traditional factors (risk and cost of care for this segment), but rather the ongoing subsidy payments.

The majority of enrollees currently in the individual market—an estimated 69% of those in the market, both on and off the exchanges⁸—qualify for subsidies, which cap their premium contributions to a percentage of income⁹ (*Exhibit 7*). Our modeling work suggests this mechanism acts as a powerful market stabilizer, making coverage affordable for a broad segment of the individual market regardless of premium increases (albeit at a higher rate of government spending). Similarly, the cost-sharing subsidies offered to many enrollees help stabilize the market but increase government spending. In addition, our modeling suggests that the percentage of enrollees eligible for both types of subsidy will likely rise. Thus, under the

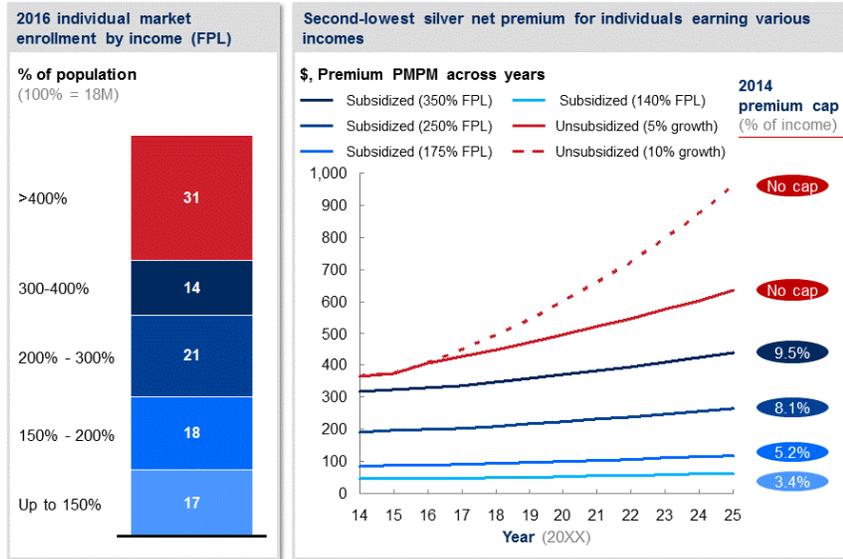
⁸ The overall individual market income distribution was based on McKinsey internal modeling estimates, given the limited data available for off-exchange enrollees. Among on-exchange enrollees specifically, a higher portion are subsidy-eligible; ASPE reported that 83% of 2016 enrollees are receiving subsidies in its March 11, 2016 report, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (<https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>).

⁹ The premium cap is determined independent of premiums and premium increases; as a result, subsidized individuals will not experience premium rate increases tied to those filed by carriers.

current design of subsidized and mandated coverage, there will likely continue to be a large, viable individual market.

EXHIBIT 7

Impact of premium increases by enrollee income level



FPL, federal poverty level; PMPM, per member per month.

Note: The methodology used in this analysis is described in the Appendix.

SOURCE: McKinsey Center for U.S. Health System Reform, ASPE, McKinsey Predictive Agent-based Coverage Tool

Data as of 04.28.2016



As the above findings illustrate, the individual market faces continued challenges. Yet, there are real variations in market and carrier performance revealing opportunities for differentiated results. There are also specific actions carriers can take to improve near-term performance on the public exchanges and position their businesses for longer-term sustainability. To succeed, however, many carriers may have to develop a fundamentally different business model—the commercial segment model is not viable for the public exchanges. Carriers will also have to remain nimble to adjust rapidly to the market’s evolution.

The findings in this Intelligence Brief provide a perspective on the evolution of the individual market. The information is based on publicly reported data as of April 28, 2016.

—Erica Coe; Patrick Finn; Martina Miskufova; Jim Oatman, FSA; and Kris Weber

The authors would like to acknowledge Brock Mark and Brendan Murphy for their contributions to this Intelligence Brief.

Appendix

METHODOLOGY

The entity financial performance information given in all exhibits is based on information in McKinsey's Payor Financial Database. The performance metrics include adjustments made to reflect October and November 2015 3R announcements from the Centers for Medicare & Medicaid Services (CMS).¹⁰

Additional data sources used for specific exhibits are mentioned below.

Exhibit 1

The percentage of carriers with positive margins in each state was measured by the portion of National Association of Insurance Commissioner (NAIC) groups that had 2014 post-3R individual market margins greater than zero, weighted by the number of 2014 individual covered lives of each insurer in the given state.

Exhibit 2

Carriers' post-3R aggregate post-tax margins were calculated by dividing total gains and losses in the market by total premiums. This approach takes into account the respective enrollment of each carrier through premium totals.

Exhibit 3

Each carrier's performance was aggregated at the national level using the NAIC group name (i.e., as defined above). Only NAIC groups with more than 1,000 individual lives in 2014 were included. Quartile ranges for each carrier type were taken using a traditional interquartile range (minimum, 25th percentile, median, 75th percentile, maximum).

Exhibit 4

Only entities with exchange plans that had more than 1,000 qualified health plan (QHP) enrollees in 2014 were included. Entities were placed in categories (managed, unmanaged) determined by the plan type (as reported on the exchanges or the plan's summary of benefits and coverage, informed by the McKinsey Exchange Offering Database) of the lowest-price silver plan offered by each entity to the majority of the QHP-eligible population within its

¹⁰ Including its September 17, 2015, "Summary report on transitional reinsurance payments and permanent risk adjustments transfers for the 2014 benefit year" (www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf) and its November 19, 2015, memo on "Risk corridors payment and charge amounts for benefit year 2014" (www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf).

footprint. If 50% or more of an entity's footprint saw an HMO/EPO as the lowest-price silver plan available from the entity, the entity was classified as managed; otherwise, the entity was classified as unmanaged. County-level QHP-eligible population estimates are based on the McKinsey MPACT model. All entities reporting to the California Department of Managed Health Care were classified as managed, regardless of plan type status. The financial metrics for all entities in each plan type category were then weighted by the entity's 2014 QHP enrollment (obtained from CMS Medical Loss Ratio (MLR) reports¹¹) to obtain the aggregate performance of each category.

Exhibit 5

Only entities with exchange plans that had more than 1,000 QHP enrollees in 2014 were included. Entities were placed in categories (ultra-narrow, narrow, broad) determined by the weighted average hospital network breadth of that entity, which was based on the breadth (expressed as a percentage: the number of in-network hospitals in rating area divided by the total number of hospitals in rating area) of lowest-price silver plan offered by that entity in each county, weighted by the QHP-eligible population in that county. Network detail is informed by the McKinsey Exchange Offering Database. County-level QHP-eligible population estimates are based on the McKinsey MPACT model. The entities were then placed into categories (broad, if the weighted average network breadth was more than 70%; narrow, 30% to 70%; ultra-narrow, less than 30%). Tiered networks were assigned to a category based on the breadth of their first tier. The financial metrics for all entities in each network breadth category were then weighted by the entity's 2014 QHP enrollment (obtained from CMS MLR reports) to obtain the aggregate performance of each category.

Exhibit 6

2014 Post-tax margins were calculated based on data from the MLR reports and other documents released by CMS using this formula: premiums – (claims + 3R adjustments + SG&A expenses + state and federal taxes, licenses, fees, federal ACA assessments).

To calculate the *2015 MLR increase*, we used NAIC's 2015 year-end Premium, Enrollment, and Utilization Exhibits, which includes information from 86% of the carriers in the individual market. (This calculation excludes any California carriers filing with the California Department of Managed Health Care, and carriers who had not yet submitted 2015 data at the time of NAIC's report.) We assumed that these non-reporting carriers experienced 2015 MLR changes similar to those reported in the NAIC Exhibits. To determine *2015 reinsurance wear-off*, we began by dividing \$7.7 billion (the amount CMS has said would be paid in reinsurance for 2015) by \$71.4 billion (our projection for 2015 total premium revenue). The result was then subtracted from the 2014 reinsurance payments (expressed as a percentage of premiums). By combining these figures, we were able to estimate 2015 post-tax margins. We expect that our 2015 estimates will evolve as more information is released, including final 3R results and rebates, as well as 2015 claim run-out

¹¹ www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

and adjustments. (Claim run-out refers to the period of time after the plan year has ended during which claims can still be submitted for reimbursement, thus altering total booked claims as calculated at the end of the plan year.)

Exhibit 7

To estimate the year-end 2016 individual market composition by income level, we leveraged the 2016 OEP enrollment report released by the Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE) for all marketplace enrollees.¹² We also used estimates from our MPACT coverage model for the remainder of the individual market (off-exchange ACA and non-ACA enrollees). (See below for description of MPACT model.) To map projected growth in the net premiums for the second-lowest silver plans, we first estimated how much the premium cap is likely to be indexed annually. The premium cap is derived from two factors: the rate of income growth (based on National Health Expenditure Data 2014 projections) and the rate of premium growth for the commercial group market (based on the Congressional Budget Office's estimate of 5.3% from its March 2016 report). Second, we estimated the growth in the federal poverty guidelines as set by CMS based on past year-over-year federal poverty level changes.

MCKINSEY DATABASES

Exchange Offerings Database

The Exchange Offerings Database offers a granular view of all individual exchange products across the country offered in 2014 through 2016, as well as pre-reform benchmarks. It includes details, such as premiums, benefit design, and network design, on more than 340,000 county-level ACA-compliant exchange plans.

Specifically, the database includes:

- Data for all 3,143 counties in the U.S.
- Carrier and pricing details for all new entrants and incumbents (including 315 carriers participating on the 2016 exchanges)
- Hospital network data, including more than 2,000 unique exchange networks in 2014 and over 2,500 such networks in both 2015 and 2016, as well as network participation data for all acute care hospitals in the U.S. (over 4,500), including 373 health systems
- Cost-sharing benefit design details for all products; drug formulary data for select markets
- Pre-reform (2013) comparison data for incumbents' market presence and offering

¹² ASPE Issue Brief. Health insurance marketplaces 2016 open enrollment period: Final enrollment report. March 11, 2016. (aspe.hhs.gov/pdf-report/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report)

McKinsey Predictive Agent-based Coverage Tool (MPACT)

MPACT is a micro-simulation model that uses a comprehensive set of inputs and a distinctive approach to modeling consumer and employer behavior to project how health insurance coverage may be changing post-reform. MPACT contains 300 million “agents” representing all residents of the United States. Each agent is characterized by his or her county of residence, type of insurance coverage, and eight demographic variables. Over the course of the micro-simulation, agents in each geo-demographic segment make health insurance purchasing decisions depending on their eligibility, prior purchasing behavior, demographics (including health risk status), subsidy eligibility, and penalty impact, among other factors.

Payor Financial Database (PFD)

The PFD aggregates and verifies information from SNL Financial, the NAIC, and other public sources to create a consolidated set of P&L data by carrier, by state, by line of business. At present, data is available for the individual, small-group-, and large-group-risk markets; breakdowns for Medicaid, Medicare Advantage, and Medicare Supplemental will be available soon. The PFD includes granular data for the most recent six years (2010–15). The data is validated and adjusted to account for reporting and other errors, as well as to ensure comparability. Outputs include covered lives, premiums, claims, expenses, and profits. Claims are subcategorized to allow detailed comparison of granular expense categories (e.g., five separate components of expenses incurred for improving healthcare quality).

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