2017 exchange market: Plan type trends

Findings across 50 states and DC

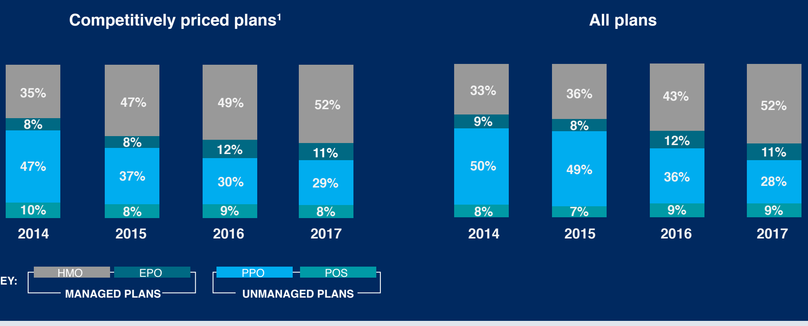
As of 11.03.2016

PLAN OFFERINGS

MARKET VIEW
Change in plan type distribution

HMOs continue to increase in proportion, while PPOs continue to decline

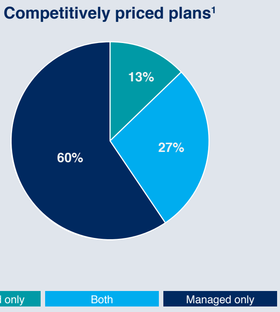
Plan offerings by plan type and year (includes plans across all metal tiers)

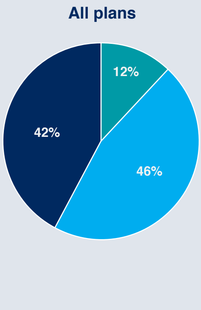


CONSUMER VIEW
Degree of access to plan types

While more than half of consumers have access to an unmanaged plan in 2017, only 40% have access to one at a competitive price[1]

QHP-eligible population with access to managed and/or unmanaged plans in 2017



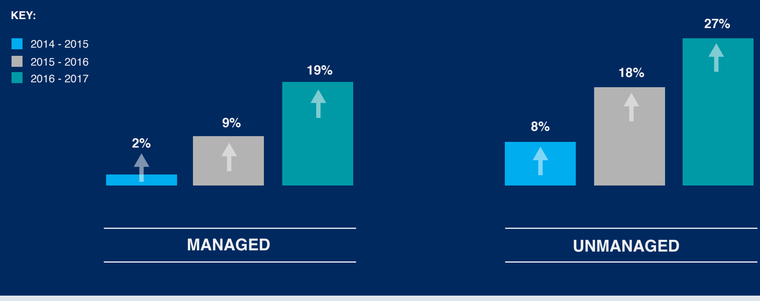


KEY: Unmanaged only | Both | Managed only

MARKET VIEW
Premium change by plan type

Price increases of unmanaged plans surpassed those of managed plans every year

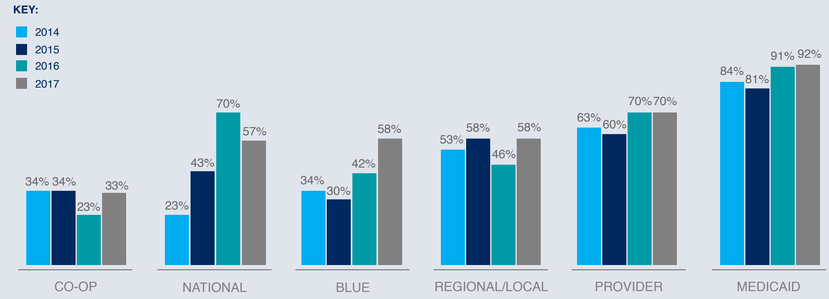
Median increase in lowest-price silver gross premium (before subsidies) by plan type



CARRIER VIEW
Change in plan type distribution by carrier type[2]

All carrier types increased their proportion of managed plans in 2017, except nationals

Plan offerings that are managed, by carrier type[2] and across years



METHODOLOGY

The above findings are based on publicly available 2014 - 2017 individual exchange premiums and plan offerings from state and federal exchange websites compiled within the McKinsey Exchange Offering Database. Plan types reported here were taken directly from exchange websites and Summary of Benefits and Coverage (SBC) documents. Independent assessment of plan types was not part of the analysis presented in this document.

Plan types are defined as follows:

- HMO (managed plan): a health maintenance organization is a plan typically centered around a primary care physician who acts as gatekeeper to other services and referrals; it usually provides no coverage for out-of-network services, except in emergency or urgent care situations.
- EPO (managed plan): an exclusive provider organization is a plan similar to an HMO. It usually 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.
- PPO (unmanaged plan): a preferred provider organization is a plan that typically allows members to see physicians and get services that are not part of a network, but out-of-network services often require a higher copayment.
- POS (unmanaged plan): a point-of-service plan is hybrid of an HMO and a PPO; it is an open-access model that may assign members to a primary care physician and usually provides partial coverage for out-of-network services.

† Competitively priced plans are defined as being priced within 10% of the lowest price plan in the same metal tier and county
‡ Blues: a Blue Cross Blue Shield payor; includes Anthem, HCSC, Regence ; Consumer-operated-and-oriented plan (CO-OP): a recipient of federal CO-OP grant funding that was not a commercial payor before 2014 ; Medicaid: a carrier that offered only Medicaid insurance in the past; includes Molina and Centene, along with regional/local Medicaid carriers ; National: a commercial payor with a presence in more than four states that has filed on exchanges (specifically, Aetna/Coventry, Assurant, Cigna, Humana, UnitedHealthcare) ; Provider-based: a carrier that also operates as a provider/health system ; Regional/local: a commercial payor with a presence in four or fewer states (most often, just one state) that has filed on the exchanges