

## **Final Report submitted to ASPE by RAND and the Brookings Institution**

### **Early Assessment of Competition in the Health Insurance Marketplace (HP-HAC-06)**

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## Executive Summary

This report, requested by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (ASPE), analyzes competition in the Health Insurance Marketplaces created by the Affordable Care Act (ACA) in six states (Alaska, Florida, Kansas, North Carolina, Ohio, and Texas). The purpose of the study was to focus on a few states that had one or more potential indicators of “insufficient competition”—such as few insurers offering plans, low enrollment, high premiums, inadequately informed consumers, or sparsely populated rural areas—and try to understand how competition was working in these markets and what might be done to make it work better.

While the study collected quantitative data on each state’s characteristics and insurance markets, the main emphasis was on gathering qualitative information and insights into how the state marketplaces were actually functioning in practice based on discussions with key informants. In each state, a field research team engaged in discussions with various stakeholders involved in the ACA marketplaces, including: insurance carriers, providers, administrators, navigators, and local health insurance experts. The field researchers, composed of health policy and public management experts knowledgeable about these states, were drawn from a larger network set up by the Rockefeller Institute of Government in collaboration the Brookings Institution to study the implementation of the ACA at the state level.

The report describes the findings for each selected state, discusses common themes across the states, and provides some potential remedies to improve competition. Following is a brief summary of why these states were chosen and what the field researchers found:

- Alaska was chosen because its vast size and sparse, isolated population posed obvious barriers to competition among insurers; only two insurance carriers serve the state; premiums are high; and enrollment is extremely low. The study team’s discussions with the Alaska stakeholders emphasized the barriers to competition. These include high transportation costs due to lack of roads and other infrastructure in rural areas of the state. Limited numbers of providers also impede insurers’ ability to negotiate prices. While having more insurers might lead to more vigorous competition, many stakeholders believed that the market was barely large enough to enable two carriers to operate profitably in the state. The Alaska Tribal Health System was described as underfunded and not a factor in limiting enrollment on the ACA marketplaces. The team emphasized problems of lack of consumer knowledge, confusion over insurance options, and difficulty of communicating with remote populations, many of whom do not speak English.
- Florida was chosen because the sixty-seven county-level rating areas provided a chance to study competition across areas within the state and because there is a wide variation in premiums across rating areas. Stakeholders agreed that the population of the market affected entry of insurers, with the most populous rating area studied, Miami, having fierce premium competition while the state’s most rural rating area, Key West, had few insurers and providers available. Stakeholders strongly believed that the ability to negotiate prices with providers affected both premiums and insurer interest in entering the market. Navigators and other assistants played an important role in providing consumer assistance in an environment in which there was confusion and limited understanding of health insurance and the new law.

Despite low competition in some areas, Florida had the highest percent of eligible enrolled out of these six states, likely driven by the population centers.

- Kansas was chosen because it managed to attract four insurance companies in 2014 to compete in the marketplaces even though it is a mostly rural state (and technically there were only two insurers, with all four insurance companies being affiliated with Blue Cross Blue Shield (BCBS) or Coventry/Aetna). It had moderate levels of enrollment and low premiums compared to the national average. Stakeholders had differing views on the adequacy of competition. They had the lowest premiums among study states and attracted five insurance companies in year two, with BCBS having a forty percent market share statewide. United Healthcare and Humana also both operate in the state off the marketplaces, so some stakeholders seemed surprised that these companies had not entered the marketplace. Stakeholders also expect premiums to rise by thirty or forty percent in 2016.
- North Carolina was chosen because it had only a few insurers in the first year of the marketplaces, with only one in some counties, but experienced enrollment above the national average. Researchers found that competition improved after the first year of the marketplaces as a result of innovative approaches to competition, including narrow networks, tiered plan design, and risk-sharing agreements with providers. However, some rural areas are still relatively uncompetitive and have some of the highest premiums in the country, with premiums varying by as much as thirty percent across rating areas.
- Ohio was chosen because it experienced some of the highest premiums and lowest enrollment in the country even though they had among the largest number of insurers participating. Researchers concluded that the marketplaces were largely competitive, although there was low insurer participation and higher premiums in more rural, Appalachian parts of the state. The researchers believe that the rating areas could be restructured to better support these rural areas and provide lower premiums. Some stakeholders thought that the difficulty in negotiating affordable provider contracts contributed to high premiums. Stakeholders in the state also believe that competition suffered because of lack of a statewide enrollment and marketing effort.
- Texas was chosen because of the potential for a cross-rating area study, with the chosen rating areas having similar population but varying degrees of insurer participation. The three rating areas for study were found to have moderate levels of competition among BCBS and regional insurers. Regional insurers were able to negotiate better with providers and local health systems, leading BCBS to introduce a narrow network HMO. Premiums were also very similar across the rating areas for the lowest and second lowest silver plans, even though the number of insurers varied from two to six.

These six examples illustrate the diversity of state insurance market characteristics at the start of the implementation of the ACA and the difficulty of generalizing about the requirements for adequately competitive marketplaces. However, some common themes emerged. Across the six states, respondents consistently said consumers have difficulty understanding health insurance and purchasing and retaining marketplace coverage. State research teams also reported a lack of outreach initiatives, even though navigators and other assistors were considered to be useful. The ability of insurers to create effective, affordable provider networks was a key determinant to success in many states. State researchers also found that the population size and density was one of the main determinants of insurer participation. Researchers also found that enrollment was driven by premium costs. This may seem intuitive; however, it has major implications for insurers in terms of their role creating affordable provider networks and ensuring that consumers

know how premiums and tax credits work and are related to deductibles, co-insurance, and the composition of provider networks.

Recommendations to improve competition emerged from the state reports and consultations with the field researchers. One such mechanism was to encourage insurers to co-brand and risk-share with established health care provider systems as a way to obtain price concessions for their marketplace plans. It may also be useful to have navigator/assistor organizations provide culturally and linguistically sensitive, simple explanations of health insurance that also remind people of the need to have coverage to protect themselves and their families. Emphasis on available subsidies and rising penalties should also be stressed. Given the knowledge and experience of agent/brokers, it was also suggested that strategies should be devised to motivate them to service the marketplaces, such as providing them with larger fees or commissions for enrolling eligible participants. Because of the limited nature of this study and small sample, any of these remedies would need to be vetted more fully with stakeholders, and it would be helpful to more thoroughly review past experience with similar solutions.

## **I. Introduction**

The goal of the Affordable Care Act (ACA), which became law in 2010, is to expand health insurance coverage to as many Americans as possible, thus drastically reducing the numbers of people who might not receive needed health care because they lack health insurance. Besides mandating that most uninsured individuals purchase insurance and most businesses cover their workers, the ACA made affordable health insurance available to uninsured Americans in two ways. First, it created marketplaces, where potential customers could choose among competing qualified health insurance plans offered by private insurance carriers. Federal subsidies, based on income, were available to help make the plans affordable to consumers. States could set up their own marketplaces or rely on the marketplace facilitated by the federal government. Second, the ACA offered generous federal matching to states that chose to expand their Medicaid programs to include all individuals and families with incomes up to 138 percent of the federal poverty line.

Setting up health insurance marketplaces was an enormous technological and operational challenge for states and the federal government. Operating in this new market environment was also challenging for insurance carriers. Many of their prospective new customers had not been covered by health insurance before the ACA's enactment and could be expected to have untreated conditions and little experience with the health care system. Even carriers that had been operating in the individual and small-group markets were unfamiliar with this population and were unsure where to set their premiums. For their part, many of the potential customers were buying health insurance for the first time and did not know what to look for or even how to interpret the terminology of insurance, such as "co-pays" and "deductibles." Thus, the implementation of the ACA was bound to be a huge learning experience for the federal government, the states, insurance carriers, the uninsured, and other stakeholders.

The marketplaces opened for business in October 2013. Since then, the combined effect of the marketplaces and Medicaid expansion has substantially increased health insurance coverage. Recent Census data indicate that approximately seven million more people had health insurance coverage in 2015 than in the previous year, with more than sixteen million people gaining

coverage since 2013; the proportion of the population without health insurance dropped from 13.3 in 2013 to 9.2 in 2015—a substantial break with prior trends. Nevertheless, with twenty-nine million people still uninsured, the ACA remains a work in progress. Implementation of major social programs, such as Medicare and Medicaid, always takes years of learning and adjustment. Meeting the ACA’s goal of near-universal coverage of Americans by affordable health insurance will require additional time and resources, as well as continuing efforts to learn from the experience of implementation in order to improve the effectiveness of the Act.

Part of a serious strategy to learn from experience is to ferret out aspects of the ACA that may not be working as well as hoped, try to figure out what is happening, and consider what possible remedies might be. This study, requested by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS) represents such an effort. Its aim was to (1) identify states and areas within states where competition in the new marketplaces appeared to be “insufficient” and (2) interact with people involved in implementing the ACA on the ground, in order to find out how they perceived competition in their state insurance market, and what they thought might improve its competition and enhance outcomes.

In most parts of the country insurers competed vigorously to sign up those newly eligible for insurance subsidies under the ACA and the number of competing insurers increased between years one and two of ACA implementation. For example, a recent ASPE report (2015) on the effect of competition on premiums showed that within states using the federal marketplace, the percent of individuals who were eligible for Qualified Health Plans (QHP) and had access to at least three insurers increased to eighty-six percent in 2015, up from seventy percent in 2014. However, some states or sub-state areas had only one or two carriers offering plans or other indicators of “insufficient competition.” ASPE identified six states (Alaska, Florida, Kansas, North Carolina, Ohio and Texas), which for different reasons raised concerns that competition in the marketplaces might be insufficient. ASPE asked the study team to try to understand the competitive situation in those marketplaces, why insufficient competition might be occurring, and what might be done about it.

The six states were not chosen randomly or thought to be representative of the larger universe of states. The assignment was not to draw generalizations across such a small number of states, although some strong common themes did emerge. The objective was to obtain insight into the particular conditions in the state that might be affecting competition in its marketplace. Statistical analysis of quantitative data would not serve the purpose. To gain insights into idiosyncratic situations, it was necessary to obtain qualitative and descriptive information from field researchers in the selected states familiar with the marketplaces and competitive situations in those states and sub-state areas. The field research was done by the state field-research network of health and public management experts brought together by the Rockefeller Institute of Government in partnership with the Brookings Institution. The Network, initiated in 2010, studies the implementation of the ACA across forty states. The lead author of this report is Michael Morrissey, Professor of Health Policy & Management at Texas A&M University, an expert on health insurance and member of the Network.

## Indicators of Insufficient Competition

Before enactment of the ACA, the individual health insurance market (sometimes called the non-group market) was quite small. It served about 7 percent of individuals under age 65, predominantly the self-employed, workers in small businesses, and people in transition between employers. State insurance regulation of the individual market varied greatly, as did the number of insurers offering coverage in the state. Many states, especially sparsely populated rural states, had few carriers offering policies in the individual market.<sup>1</sup> Potential customers seeking coverage in the individual market often encountered high premiums, denial of coverage because of preexisting health conditions or previous claims, and great difficulty finding clear information about plan coverage that would enable them to compare insurer offerings. The ACA was designed to make the individual insurance market more accessible, transparent and affordable to the uninsured, and by bringing more potential customers into the market armed with federal subsidies, to make it more attractive to insurers.

In general, the ACA has improved competition in the individual insurance market. Potential customers have turned to the individual market as federal subsidies made plans more affordable, and the larger market has attracted more carriers. According to ASPE estimates, more than four out of five people eligible to purchase a qualified health plan live in rating areas with three to eleven issuers in the Marketplace, and more issuers has been associated with lower premiums.<sup>2</sup> Not surprisingly, however, some rural states and rating areas with sparse populations have attracted few issuers. Dispersed insurer markets, especially in rural areas, have also impeded competition in the Medicare Advantage program.

While robust competition appears to be the norm in the post-ACA individual insurance market, this study focused on some places where competition was thought to be “insufficient.” Since there is no clear definition of insufficient competition that can be applied uniformly across the six states—it depends on the characteristics of the state or area-- we relied on multiple indicators identified through a literature review, available in Appendix A. In a highly competitive marketplace, one would have expected (or hoped) to find multiple insurers competing vigorously with each other on the basis of price and attractiveness of benefits and well-informed consumers choosing plans most suited to their needs. However, the six states were thought to fall short of this ideal in various ways, with each exhibiting one or more of the following indicators:

- Too Few Insurers

Some states or areas within states had too few insurers to ensure vigorous price competition. This may be because insurers did not have enough experience with the newly insured and did not know how to price their product, because they fear losing money in a sparsely settled area with few customers, because they fear the ACA may be gutted or repealed, or because of the high fixed costs associated with entering a particular new market.

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<sup>1</sup> J. Abraham and P Karaca-Mandic, “Regulating the Medical Loss Ratio: Implications for the Individual Market,” *The American Journal of Managed Care*, 2011; 17(3), 211-218.

<sup>2</sup> B. Biles, G. Casillas, and S. Guterman, “Competition Among Medicare’s Private Health Plans: Does It Really Exist?” *Commonwealth Fund Issue Brief*, 2015. Accessed September 29, 2015, [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/aug/1832\\_biles\\_competition\\_medicare\\_private\\_plans\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf).

- High Premiums

Others had high premiums compared to the national average. Premiums may be high because one or two dominant insurers have enough market power to keep them high. Insurers may perceive high health needs or pent up demand for care from the previously uninsured. Health care costs may be high in the area, because providers have market power..

- Low Enrollment

Consumers may choose not to enroll for many reasons: high prices relative to their perceived need for health insurance, poorly designed websites, lack of health insurance literacy, etc. Insurers are less likely to enter a market in following years if enrollment was low from the beginning. Even a larger number of insurers vigorously competing may have limited success signing up customers if the population or state officials are unsupportive of the program.

- Consumer Lack of Information, Inadequate Consumer Assistance, or Unsupportive Political Environment

Potential customers, especially those who have not had insurance before, may perceive they do not need it. They may be confused by the terminology technology of an electronic marketplace for health insurance. Additionally, they may be used to seeking care in an emergency facility and unfamiliar with alternatives. They may be exposed to negative views of the ACA.

- Rural Markets and Poorly Designed Rating Areas

Rural areas may lack sufficient populations to support vigorous insurance competition. In addition, rating areas may be drawn in such a way that it is hard to market insurance products to potential customers because the rating area includes populations with markedly different providers and prices, or widely differing health care demand.

*Why these were these states chosen?*

- Alaska was chosen because it had only two participating insurers, low population density, very low enrollment, and isolated settings likely prevent more insurers from participating. Its premiums are extremely high compared to the national average and increased between year one and two.
- North Carolina also had very few insurers the first year (with only one in some counties). The number of carriers and premiums both increased in 2015, although the premium increases were minimal. However, North Carolina also experienced some of the highest enrollment in the country, enrolling 45 percent of the potential enrollee population.
- Florida was chosen because the county-level rating area structure provided a natural research environment to study competition across areas within the same state. To get a comprehensive perspective, we looked at both a rural and metropolitan area, as well as one with a particularly small market.
- A similar cross-rating area approach was taken in Texas, where we looked at three rating areas with similar populations but different numbers of participating insurers, in an attempt to draw conclusions on why insurers decided to participate in some Marketplaces, but not others.



- Ohio was chosen because its premiums were still high and enrollment was among the lowest in the country even though it had among the highest number of participating insurers in the country.
- Finally, the study includes Kansas--a notably rural state that attracted three insurers, had relatively stable premium prices, and moderate levels of enrollment (close to the national average). We chose to analyze the state as a whole, since its insurance market is evenly distributed across all of its rating areas.

Given the fact that the ACA is new, complicated and controversial, and that insurance is a complex product, it was not surprising that consumers were often wary and confused and lacked information and understanding of what the ACA offered and how to engage with it. This situation was not unique to these six states, but was clearly a common theme in all of them. Other themes that emerged across these states included the importance of population size and density, the extent to which premiums drive enrollment, and the importance to insurers of establishing provider network at acceptable prices. The six states all had state government leadership that opposed the enactment of the ACA and were not disposed to facilitate its implementation. Illustrating this opposition, all states used the Federally-Facilitated Marketplace (FFM) rather than a state-based one. Similarly, only Ohio initially expanded Medicaid, although Alaska did so in the summer of 2015.

When potential remedies for insufficient competition were discussed, the state reports stressed improving education for consumers and increasing information transparency of key features of the plans. Agents, brokers, and navigators were also very important in the enrollment and education process. However, many agents and brokers expressed frustration with the amount of compensation and the constrained timeline for enrollment, and navigators have serious concerns about underfunding in the future. Higher fees for brokers and agents and continued funding or aid for navigators from the private sector or other federal programs could help alleviate these concerns and continue to increase enrollment over time, improving competition. As consumers learn more about health insurance, they can make better choices, and plans will have to compete on benefits and the strength of their networks. Another potential remedy that was mentioned was to encourage insurers to co-brand and risk-share with established health care providers systems as a way to obtain price concessions for their marketplace plans.

This report begins with a brief review of the extant empirical literature on health insurance markets, focusing on indicators of potential inadequate insurer competition. The key components of this analysis, however, are a series of investigations by local field research teams on the ground in each state. Section III summarizes the methodology used to conduct these field studies. Section IV provides some basic facts and comparisons across the states. Sections V through X summarize the findings of each of the state teams: Alaska, Florida, Kansas, North Carolina, Ohio, and Texas. Section XI draws generalized conclusions across the six state studies and highlights important differences, and Section XII reports suggestions for improving competition that emerged from the field studies.

## II. Methodology for the Field Research

Field research is an approach to addressing important policy questions by utilizing the knowledge and opinions of informed local experts and stakeholders. It is at its best when describing nuanced situations and circumstances that are heavily influenced by context. As such, it is particularly well suited to examining questions of the implementation of policy. It describes what's happening and offers insight into why events are unfolding as they are. It also serves as a method to identify topics and areas for further study.

The six state-based field research teams in the ACA Implementation Network are knowledgeable about the political and health care environments in their states and know many of the stakeholders in local health policy environment. Their approach is to engage in discussions of a focused but open-ended nature designed to obtain insight into what is happening and why and to allow a cross-calibration of the observations of stakeholders with differing vantage points.

In this analysis the Brookings team in consultation with RAND and staff of ASPE developed a series of discussion themes that focused on: the extent of insurer competition in the state and in selected state insurance rating areas, whether additional insurers would meaningfully enhance competition and lower premiums, why insurer participation in the marketplaces looked the way it did, what factors determined participation, what problems had been experienced in the first two years of the insurance marketplaces, and what sort of changes might enhance competition.

The indicators of potentially limited competition were drawn from the literature review: too few insurers, high premiums, low enrollment, rural markets and poorly designed rating areas. The literature review can be found in Appendix A.

Each team of field researchers used these indicators to identify and justify the geographic rating areas on which they focused. Their choices were influenced by their sense of where the interesting and important competitive insights would be found. Brookings, RAND and ASPE approved these choices based on the presence of indicators of insufficient competition. The research teams in Alaska and Kansas each chose to examine their state as a whole, given their low insurer participation and relatively small number of rating areas. The field researchers in North Carolina focused on rural areas of the state that heretofore had few insurers offering coverage. The field researchers in Florida chose to contrast and compare a large urban rating area (Miami) with a moderately sized market (Tallahassee) and a sparsely populated area (the Keys) that saw varied premium levels. The Ohio research team selected three rating areas with widely ranging populations as a result of the State's rating area design, and that had relatively high premiums as compared to the rest of the state. Finally, the Texas team chose to contrast three moderately sized urban rating areas with differing numbers of insurers operating in their marketplaces. As a result, comparisons across the states provide a wide set of insights into many different competitive situations.

The field researchers discussed the themes with a wide range of stakeholders: insurance agents/brokers, navigators, insurers, hospitals/physicians, regulators, and policy experts. In states other than Alaska, the number of discussions ranged from 11 to 20, depending upon the state. Most state teams had some difficulty in reaching one type of respondent or another,

typically insurers or health care providers, however the issues related to this difficulty tended to be ameliorated by more extended discussions with other stakeholders such as agents/brokers or regulators.

The discussions with stakeholders took place in the month of June 2015. In five states these discussions were held face-to-face or in phone conversations of 20 to 90 minutes in duration. In Alaska the field researchers used a series of three focus groups to discuss the themes, with seven participants in total. These were not structured by representation but by the availability of the participants. In all instances the participants were told that they would not be identified by name, that they could refuse to participate in any portion of the discussion, and that the field researchers were not interested in the position of their organizations, but rather their insights as knowledgeable experts in the area. The protocol was reviewed by the RAND Institutional Review Board (IRB) and judged to be exempt.

The discussions were augmented with publically available documents known to the field researchers or provided by some of the stakeholders.

Throughout the project the Brookings team interacted with the field researchers to answer any questions the researchers had about protocols or the study, and to seek clarification of draft findings. A kickoff conference call was held with all research teams where the project was described and draft themes discussed. Dr. Nathan contacted each team separately to answer questions they may have had and to see if there were problems arising in the contacts. Draft state reports were reviewed in early July by the project team at Brookings with additional reviews by staff at RAND and ASPE. Questions were returned to each team and final state reports were received in mid-July. It is important to note that many of the final report's conclusions and suggestions for fixing insufficient competition are derived from stakeholder and field researcher feedback, gleaned through the state reports and conference calls. Because our report focused on a limited number of states and markets, the findings are not broadly generalizable to marketplaces in other states and rating areas.

**Table 1: Basic State Facts**

	<b>Alaska</b>	<b>Florida</b>	<b>Kansas</b>	<b>North Carolina</b>	<b>Ohio</b>	<b>Texas</b>	<b>National</b>
<b>State Population and Rank (2013)<sup>3</sup></b>	700,000 (48 <sup>th</sup> )	19,400,000 (4 <sup>th</sup> )	2,800,000 (34 <sup>th</sup> )	9,600,000 (10 <sup>th</sup> )	11,500,000 (7 <sup>th</sup> )	26,400,000 (2 <sup>nd</sup> )	313,400,000
<b>Median Household Income and Rank (2011-2013)<sup>4</sup></b>	\$61,749 (7 <sup>th</sup> )	\$47,106 (39 <sup>th</sup> )	\$49,804 (32 <sup>nd</sup> )	\$44,254 (42 <sup>nd</sup> )	\$46,672 (40 <sup>th</sup> )	\$51,752 (27 <sup>th</sup> )	\$52,047
<b>Overall Health Ranking, 2014<sup>5</sup></b>	26 <sup>th</sup>	32 <sup>nd</sup>	27 <sup>th</sup>	37 <sup>th</sup>	40 <sup>th</sup>	31 <sup>st</sup>	NA
<b>Expansion of Medicaid</b>	Expansion announced July 2015	No	No	No	Yes	No	NA
<b>Type of Marketplace</b>	Partnership	Federally-facilitated Marketplace	Federally-facilitated Marketplace	Federally-facilitated Marketplace	Federally-facilitated Marketplace	Federally Facilitated Marketplace	NA
<b>Number of Rating Areas</b>	3	67 counties	7	16	17	25 MSAs + rural	NA
<b>Number of Marketplace Insurers in 2015</b>	2	14	5	3	16	11	On average, 6
<b>Net Change in Number of Insurers, 2014-2015</b>	0	Increased from 11 to 14 for 2015	Increased from 4 to 5 for 2015	Increased from 2 to 3 for 2015	Increased from 11 to 16 for 2015	Increased from 8 to 11 for 2015	On average, increased from 5 to 6
<b>2<sup>nd</sup> Lowest Silver Premium, 27 Year Old Non-Smoker 2014, 2015, &amp; Percent Change<sup>6</sup></b>	\$349 \$449 28.7%	\$217 \$231 6.5%	\$196 \$187 - 4.6%	\$244 \$262 7.4%	\$216 \$220 1.9%	\$203 \$210 3.4%	\$218 \$222 1.8%
<b>Percent of Potential Enrollees in Marketplaces, 2014, 2015, &amp; Percent Change in number enrolled<sup>7</sup></b>	15.4% 22.3% 50.3%	39.3% 52.5% 33.7%	23.3% 34.6% 48.9%	32.6% 41.9% 28.6%	16.1% 20.2% 21.7%	23.8% 30.8% 28.5%	28.0% 35.4% 24.1%

<sup>3</sup> “Total Number of Residents,” Kaiser Family Foundation estimates based on the Census Bureau's *March 2014 Current Population Survey (CPS: Annual Social and Economic Supplement)*, accessed July 28, 2015, <http://kff.org/other/state-indicator/total-residents/>.

<sup>4</sup> “Median Annual Household Income,” Kaiser Family Foundation data from the U.S. Census Bureau, *Current Population Survey, 2011 -2013 Annual Social and Economic Supplements. Two-Year-Average Median Household Income by State: 2010 to 2013*, accessed July 28, 2015, <http://kff.org/other/state-indicator/median-annual-income/>.

<sup>5</sup> “2014 Annual Report,” UnitedHealth Foundation, accessed July 28, 2015, <http://www.americashealthrankings.org/reports/annual>.

<sup>6</sup> “Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace,” ASPE, last modified July 8, 2015, <http://aspe.hhs.gov/health/reports/2015/premiumreport/healthpremium2015.pdf>.

<sup>7</sup> “Marketplace Enrollment as a Share of the Potential Marketplace Population,” data and data estimates from the Kaiser Family Foundation, accessed July 28, 2015, <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/> and <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2014/>. Note that percent change is the change in the number of persons covered in 2015 relative to 2014.

### III. Overview of the States

#### State Variation

The states included in this study are diverse. Texas and Florida are among the states with the largest population in the country, while Alaska is among the smallest. Nonetheless, all the states, except Alaska, have household incomes below the median of all the states, and all had overall health rankings below the median in 2014. See Table 1 on the previous page.

The states are largely similar in their approach to broad issues of implementing the ACA. Only Ohio initially expanded its Medicaid program, although Alaska did so in mid-2015. All of the states use the FFM, although Alaska does so in a partnership model. However, the six states differ in how they approached the creation of marketplace rating areas. Four used collections of contiguous counties, while Florida established separate rating areas for each of the sixty-seven counties in the state and Texas has separate MSA rating areas plus one additional area for all non-metropolitan counties. The number of carriers operating in the state marketplaces ranges from two in Alaska to sixteen in Ohio. Five of the states have seen net increases in the number of marketplace carriers, while none have seen reductions.

There was substantial variation in the proportion of the eligible populations that signed up for coverage through the marketplaces in the first year. This ranged from fifteen and sixteen percent in Alaska and Ohio, respectively, to thirty-three and thirty-nine percent in North Carolina and Florida. All the states saw increases in the proportion of covered eligible populations of twenty-two to fifty percent.

There is also substantial variation across the study states in the statewide average second lowest cost silver plan premium for a twenty-seven-year-old non-smoker. Alaska's premium in 2015 was 240 percent higher than that of Kansas. The state specific reports identify variation across their rating areas.

The states could generally be regarded as politically opposed to the ACA because most elected neither to facilitate state-based marketplaces nor to expand Medicaid. However, this opposition has waxed and waned in some states over time. Often, state policy and practice has been to ignore the implementation of the law rather than actively oppose it. In some cases, states were initially supportive of the ACA, but may have shifted their support due to changes in state leadership. For example, Kansas' state government voiced no opposition to the ACA when it was initially debated.

#### Rating Areas

- Alaska  
Alaska has three rating areas. The entire state was the focus of study due to its small population, the presence of only two carriers, high health care costs across the state, and the low numbers of providers.

- **Florida**  
Florida has sixty-seven rating areas, one for each county. Three areas were selected for study: Dade County (Miami) because of its large diverse urban population with a large number of participating carriers; Leon County (Tallahassee) because it is a small urban market with few providers and few insurers; and Monroe County (Key West) because it is a small somewhat isolated county with very high premiums but with proximity to the large Miami market.
- **Kansas**  
Kansas has seven rating areas comprised of contiguous counties. The entire state was the focus because all but one of the rating areas had a similar number of plan offerings. Kansas is interesting because there were a fair number of insurers for the rurality of the state and premiums were slightly below the national average, but they experienced moderate to low enrollment.
- **North Carolina**  
North Carolina has sixteen rating areas comprised of contiguous counties. The study team examined five rating areas, the four in the eastern third of the state (areas 12, 14, 15 and 16) and area 1 in the far west region of the state. The counties in these rating areas are sparsely populated relative to the rest of the state and marketplace coverage was dominated by a single carrier in 2014.
- **Ohio**  
Ohio has seventeen rating areas comprised of contiguous counties. The study team selected the four rating areas in the southeastern third of the state. Two were selected because they had high premiums and few insurers (rating areas 16 and 17), one because of its diverse urban and rural mix with high premiums (area 10) and one because it had only a small decrease in the number of uninsured (area 9).
- **Texas**  
Texas has twenty-five MSA rating areas and an additional rural area. The study team focused on three areas: Waco (area 24), Bryan-College Station (area 6), and Laredo (area 12) because each of the moderate sized metro areas had similar population size but six, four, and two insurers, respectively, operating in the marketplaces.

The next sections highlight salient findings of the state studies. The detailed state reports with findings and conclusions can be found in Appendices B through G.

## IV. Alaska

Alaska has the largest area of any state in the union but with a statewide population smaller than Dayton, OH. While it has three MSAs, one-third of the population lives in rural and remote parts of the state. It is unique in that the majority of the state is not connected by roads. Eighty percent of Alaska Native villages, for example, are reportedly not linked by a road system. The salient issue in Alaskan health is that populations are small and far-flung, not easily reached by conventional transportation systems, and without many health care providers. There are only twenty-three hospitals in Alaska, thirteen of which are designated as Critical Access Hospitals, which have special payment rules designed for small remote facilities. Refer to Appendix B for the full report of the Alaska State Memo.

The Alaska marketplace is served by two insurers, one headquartered in Seattle, WA and the other in Portland, OR. The participants in the Alaska focus groups generally agreed that two insurers were probably sufficient for the population. The regulators in Alaska were viewed as working to help carriers function in the state and trying to attract additional insurers – or at least keep the current two from leaving the state. Thus, they were not viewed as imposing undue restrictions.

The limited and dispersed population base means that there are few accessible hospitals, specialists or other health care providers for much of the population. As a result, discussants believe that it is extremely difficult for an insurer to negotiate over price the way they might in other markets. In addition, the dearth of population centers and substantial transportation issues mean that health care prices are high and entail costs not as frequently encountered elsewhere. Air-ambulance service, for example, is not uncommon for medical emergencies; these costs range from \$23,000 to \$100,000 depending upon distance.

The Indian Health Service provides care for Alaska Native and American Indian people in the state through the Alaska Tribal Health System. Approximately twenty percent of the state's population has rights of access. However, this program is widely viewed as under-funded and suffering from many of the same health care resource limitations found in the state generally. Thus, it is not believed to be a major factor in limiting enrollment in the marketplaces, in which all Alaska Native and American Indian people are eligible to participate.

The discussants believe that there continues to be substantial confusion over the ACA and health insurance generally. In addition to concerns about a wide and confusing array of plan offerings and misunderstanding of insurance terms such as deductibles and coinsurance, large numbers of people in Alaska lack email addresses and many do not speak English. Respondents note that 99 different languages are spoken in the Anchorage School District. Discussions also noted that political opposition to the ACA in the state added to misgivings. The Alaska state government was initially opposed to the law, as evidenced by its initial decision neither to get involved in developing a state-based health insurance marketplace nor to expand Medicaid. However, since a new governor was elected in 2014, the state has become more supportive, opting to take-up the ACA's Medicaid expansion in 2015. Alaska does have a "211 Program," a statewide phone

number with an accompanying website that connect residents to a many related social services and navigators, in-person assisters and organizations that provide assistance with enrollment.

Some discussants observed that in some cases assister roles were not well defined and in others that they were too narrowly defined so they did not have sufficient time to establish trust with potential enrollees and were allowed not to make recommendations. In addition, there was confusion about the role of navigators and in--person assisters and the broader outreach efforts of “Enroll America,” a nonprofit organization of health care enrollment coalitions.

### *Summary*

Alaska faces a number of significant barriers to more robust competition that are particular to the state. Alaska faces uniquely burdensome transportation barriers and costs, as one-third of its population lives in remote areas and many lack roads connecting to other communities. Limited numbers of providers impede insurers’ abilities to negotiate competitive prices. As a result, having two insurers participating in the marketplace was concluded to be reasonable given Alaska’s unique circumstances. Like other state teams, however, the Alaska research team’s analysis noted significant consumer confusion and lack of awareness of insurance product characteristics.



## V. Florida

Florida has a large, growing and diverse population. The study team focused on three local areas within the state: the urban, multicultural Miami rating area; the smaller and more homogeneous Tallahassee market in the Panhandle; and Key West, the more rural and geographically dispersed rating area south of Miami. Refer to Appendix C for the full report of the Florida State Memo.

Insurer participation was described as robust throughout the state entering the 2000s. However, the state imposed caps on the rate of increase in premiums in the early 2000s, which led many carriers to leave. Some have returned now that rates have been allowed to increase. Regulators are regarded as taking a hands-off approach and have chosen not to make regulatory changes during the first years of the ACA.

The decision to participate in the marketplace rating areas was described by insurers as depending in large part on their existing experience in that area. Only BCBS (Florida Blue) offered coverage in every county in the marketplace in 2014. Aetna and UnitedHealthcare were active throughout the state for commercial coverage but only entered the marketplace in selected counties. A second factor said to drive insurer participation was Medicaid experience. Some regional and provider-associated plans appear to have entered the marketplace as a defensive move to keep their Medicaid enrollees if they churn between Medicaid and the marketplace. Carriers with a large book of business in the small group and individual markets were also thought to participate so as to keep subscribers who were drawn to the marketplaces due to the subsidies.

Miami was described as having a robust insurance market. While the products are similar, the plans differ substantially with respect to the breadth of network providers. Premium competition was regarded as fierce, with some carriers pricing aggressively and others withdrawing from the market because they could not negotiate competitive provider prices, or their provider network was overwhelmed with unanticipated enrollment. The field researchers found that some of this activity was spurred by navigators and assistors who worked with specific minority populations and others linked with providers.

The Tallahassee market was characterized as much less competitive. The consensus is that it is difficult for insurers to negotiate acceptable prices with providers. There are two principal hospitals in the market area and these providers rely on fee-for-service payments rather than disproportionate share payments to cover charity care. This ‘cost shifting’ argument is that their charity care obligations, paid from the surpluses in private sector pricing, limited their ability to offer more competitive prices to private sector insurers. In addition, independent specialists are struggling to remain autonomous in the face of higher costs of billing, collections, employment practices, and compliance with patient privacy and electronic medical record expectations. Many are becoming hospital employees to avoid these hassles. Navigators and assistors appear to have not played a meaningful role.

Discussants noted that the Key West rating area “has about as much competition” as one might expect due to a relatively small population, the need to have providers on many of the individual

keys, and the relatively few providers available. Its premiums were over \$100 per month higher than in metro Miami.

In addition to narrow network considerations in marketing health plans, respondents noted that the carriers emphasized silver and gold products rather than bronze plans. They indicated that these plans were more appealing to hospitals because silver and gold plans suggested that the enrollees were more likely to be able to pay their deductibles and copays.

There is considerable confusion about the nature of coverage and eligibility particularly among the Cuban and early retiree populations. Navigators and assistors appear to have played a big role in Miami, but less so elsewhere. At the same time agents and brokers are said to be leaving the health insurance market; they believe that marketplace consumers are uninformed about health insurance and as a result they have to provide too much information. Moreover, they viewed it as too difficult to make a living in just the three-month open-enrollment window in the marketplace. Even with these barriers, Florida managed to enroll the highest percentage of their eligible population out of the study states.

### *Summary*

The Florida analysis suggested several generalizations about marketplace competition in the rating areas studied. First, the population size of the market appears to matter a lot in terms of the strength of competition among plans. Second, robust competition appears to depend upon the ability to negotiate acceptable prices with providers; a lack of providers inhibits this ability. Third, navigators and assistors can play an important role in providing information, however, while the role of navigator/assistsors is increasing, that of agents and brokers was said to be declining.

## VI. Kansas

Kansas has a population of three million people in 105 counties. Half are designated as rural or frontier counties. Three health insurers share the majority of the individual and small group markets in the state. Blue Cross Blue Shield (BCBS) of Kansas offers coverage in 103 of the counties, Coventry (a subsidiary of Aetna) offers bronze, silver, and gold plans in all 105 counties. BCBS offers coverage in the two populous counties along the Missouri border. Refer to Appendix D for the full report of the Kansas State Memo.

There were divergent views as to the competitiveness of the Kansas insurance marketplaces. Hospital officials and broker/agents believed competition was limited. They noted that BCBS of Kansas had a forty percent market share statewide and a much higher share in rural areas. They noted that this dominance allowed BCBS to negotiate low payment rates to providers. However, insurers and regulators argued that there was sufficient competition. Given the small Kansas population it was unrealistic to expect many more carriers to enter the state, and existing premiums were not excessive, ranging from \$194 to \$220 for a twenty-seven year old individual. The rates in Kansas were the lowest of any in the six states studied. The informants also noted that premiums were expected to increase by thirty to forty percent in plan year 2016.

Potential competitors include Humana and UnitedHealthcare, which operate in the state but not on the marketplace. New entrants were thought to be cautious, allowing established carriers to enroll the sickest people and to deal with any pent-up demand. Nevertheless, there were expectations that UnitedHealthcare would enter the market.

Kansas' discussants indicated that consumer shopping was based mainly on price rather than provider networks. Some informants noted that some consumers changed plans in 2015 because they were not satisfied with consumer service; they consistently said that price and excellent customer service was key to being successful in the Kansas marketplace.

The discussants generally believed that health insurance products were complicated and that many consumers were confused. Agents/brokers were seen as reluctant to devote time to selling in the individual market. In part this had to do with the complexity of the products, but it also related to BCBS selling exclusively through its own network of agents.

### *Summary*

As of the time of the field research Kansas had the lowest premium rates of the states studied in this project and had five insurers participating on the marketplace, yet BCBS of Kansas had a forty percent market share statewide and larger market share in some rural areas and premiums were expected to increase by thirty to forty percent in plan year 2016. Like other states, the Kansas research team noted that consumers' understanding of insurance products is limited.

## VII. North Carolina

Prior to the ACA, BCBS had a commanding share of the North Carolina individual market with an eighty-six percent market share. Of the other insurers in the market only Coventry, now owned by Aetna, had over a five percent share. However, the market has changed substantially in the last two years. Refer to Appendix E for the full report of the North Carolina State Memo.

Most discussants consider the market as a whole to be competitive, and there are several signs of healthy competition overall. Although BCBS remains the only statewide carrier, it now only has a sixty-five percent market share. Coventry competes with it in the more populous urban markets, and a new carrier has entered the market each of the two years of the ACA. Discussants expect one of these to expand to cover most or all of the state as it further develops its provider networks.

Discussants attribute much of this success to the innovation exhibited by the new insurer entrants. North Carolina is a populous state with lower-than-average income, and thus a large number of potential new applicants eligible for subsidized coverage. The decision not to expand Medicaid was also seen as enhancing the appeal of the state to insurers, because it increases the potential market size. New entrants were able to capitalize on this opportunity by linking their insurance products with well-known state health care providers. One of the carriers has co-branded its insurance products with existing major health systems, taking advantage of their name recognition. Another has entered into risk-sharing agreements with providers throughout the state. BCBS was also innovative in its approach. In areas where it was competing with other carriers it introduced two new networks; one a narrow network PPO and the other a tiered-network in which subscribers pay differential copays or coinsurance rates depending upon the cost of the provider they use.

Sources consistently said that health insurers' market entry and geographic coverage was driven by provider contracting. If a new entrant couldn't obtain provider prices ten percent lower than BCBS it was thought to be unable to overcome the BCBS name recognition and network. Until recently, BCBS had "most favored nation" clauses in its provider contracts, and discussants believe that providers in some parts of the state have reservations about providing discounts to non-BCBS insurers. Provider contracting in the areas that BCBS had "locked up" was described by some discussants as an unwillingness of providers to offer acceptable prices either because of the presence of few providers or because providers had formed systems and purchased physician practices.

Relatively uncompetitive areas remain in the state. These comprise a small portion of the state's population and are clustered in the far west and in the northeastern most regions of the state. There is some sense, however, that the spread of competition in the rest of the state will have spillover effects even here.

Despite the increase in competition, premiums in North Carolina are among the highest in the nation. The premiums, however, vary by as much as thirty percent across rating areas. Most of

the discussants attribute these differences to provider pricing rather than population health or utilization patterns.

Many of the discussants saw the strength of outreach and enrollment efforts of public interest groups as an important element in the increased enrollment observed in the state. However, this facet was not a focus of the North Carolina report findings.

### *Summary*

The North Carolina research team found that, within the selected rating areas, competition has grown since the implementation of the ACA marketplaces. In larger metropolitan areas, some insurers are experimenting with innovative approaches to competition, including narrow networks, tiered plan design, and risk-sharing agreements with providers. However, uncompetitive areas remain---particularly in areas with small populations---and premiums are still among the highest in the country. Discussants noted that insurers' market entry and geographic coverage was driven by the ability to contract with providers for rates at least ten percent below those of BCBS.

## VIII. Ohio

Ohio was the only study state to have expanded its Medicaid program. However, it was still a FFM, and like the other study states, did not have a coordinated statewide outreach program. Refer to Appendix F for the full report of the Ohio State Memo.

The study team concluded that the Ohio health insurance markets appear to be competitive. They do find that the number of carriers in the rating areas was negatively associated with premiums. Rating areas with eleven or more insurers had the lowest premiums while those with only five or six had the highest. There are many insurers present in the marketplace throughout the state with somewhat fewer offering plans in the Appalachian region.

Discussants indicate that insurers have been cautious about entering markets, targeting larger population areas, but wary of enrolling sicker-than-average populations. Indeed, there was a sense among some insurers that they didn't understand and feared the potential utilization experience of the new market enrollees and were reluctant to aggressively compete for this population.

The study did suggest that provider prices may be an issue in negotiating contracts and the level of ultimate premiums, but this was not a focus of the Ohio report.

Discussants indicated that consumers were very confused about health insurance and the ACA. They noted that there was no statewide marketing effort to enroll people and no coordinated efforts at outreach. There was also a sense among respondents that the number of plan options may have been excessive and therefore confusing. Consumers were focused almost entirely on the premium. They were said to not appreciate the value of the coverage nor the advantage offered by the subsidies.

The field researchers noted that the interaction of the definition of the rating areas and the carrier freedom to only offer plans in selected counties in a rating area could lead to higher premiums in some instances. This can occur when the second lowest silver plan in the rating area is not offered in selected counties within that rating area. Consumers in those counties would then be required to select a more costly silver plan, the lowest cost silver plan.

Finally, the field researchers suggested that the rating areas could perhaps be better structured in Ohio. Based on their analysis of premiums across Ohio rating areas, and the literature review finding concerning relatively homogeneous rating areas, they concluded that the MSA plus single rural rating area may better enhance competition.

### *Summary*

Selected rating areas in Ohio were found to be largely competitive. The research team found that greater numbers of insurers participating on the marketplaces were associated with lower premiums; however they noted that fewer insurers offered plans in rural Appalachian areas. The team also noted that provider prices may be an issue in negotiating contracts and ultimately on

premium levels. Akin to other states, Ohio found a broad lack of consumer knowledge of health insurance products to be a barrier to Marketplace enrollment.

## IX. Texas

The individual health insurance market in Texas is dominated by BCBS. Its enrollment-based market share increased from fifty-five percent in 2010 to fifty-nine percent in 2014. There were sixty-four non-group insurers in Texas in 2014, and eleven insurers that offered coverage in the marketplace in at least some counties. BCBS is the only carrier to offer marketplace coverage in every county. However, BCBS is publicly reported to have incurred losses of twenty percent in its Texas individual insurance business.<sup>8</sup> Refer to Appendix G for the full report of the Texas State Memo.

Insurer competition is provided by regional and national carriers but the number of carriers varies substantially by the population in the county. Both regional and national insurers are regarded as having put premium pressure on BCBS in local markets. National carriers are present throughout the metropolitan areas of the state, offering ACA-compliant policies off the marketplace. Three new carriers did enter the Texas marketplace in 2015, two only in selected counties, with AssurantHealth entering all the metropolitan counties. Agents regarded Assurant's insurance offerings as high priced products that attracted little attention. In June Assurant announced that it would exit the health insurance market nationally.

Regional carriers are typically associated with local health systems. This association tends to limit their geographic reach but reportedly also allows them to obtain favorable provider prices. National carriers are limited by their ability to establish effective networks of providers. As one insurer representative reported, the ability to compete depended almost entirely on the ability to establish viable and price competitive networks.

Within the three moderate sized rating areas studies, competition was described as "moderate" by the research team. Regional insurers were seen as forcing BCBS to price more aggressively than they would otherwise. The regional carriers may have negotiated lower prices with their local providers that allowed them to set lower premiums. BCBS introduced a narrow network HMO to compete. National insurers are present off the marketplace, so there is a possibility that these potential entrants limit the ability of marketplace carriers to set higher prices. Premiums of the lowest and second lowest Silver plans in the three rating areas did not differ meaningfully even though the number of carriers varied from two to six across the three rating areas.

Observers suggested that low enrollment was due to confusion about the nature of coverage, lack of marketing and outreach, the unwillingness of agents/brokers to devote time to a three-month open enrollment period, and little assistance from navigators/assistsors. The lack of assistance from navigators may be linked to state legislation that required additional training for navigators in Texas.

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<sup>8</sup> D. Mangan, "Big Proposed Obamacare Rate Hike in Texas Follows Big Loss," CBS News, June 3, 2015, accessed July 20, 2015, <http://www.cnbc.com/2015/06/03/big-proposed-obamacare-rate-hike-in-texas-reflects-big-loss-.html>.



### *Summary*

In the three rating areas selected for study, competition was described as moderate among BCBS and regional insurers. Selected rating areas had between two and six participating carriers. Regional insurers, while geographically limited, were seen as better able to negotiate provider prices than were national carriers. This competition was seen as prompting BCBS to introduce a narrow network HMO. As with other states, it was noted that consumer confusion negatively impacted enrollment.

## **X. Common Themes**

Though states vary widely, and this is surely true of those studied here six general themes emerge from the findings for the states studied. While the states differ widely and each state has its own a somewhat different focus based upon the characteristics of the state and its health insurance markets, nonetheless, there are common themes, emphasized in one or two states, but echoed in the reports of many of the others. There are also findings that were uniquely experienced in one state that may be useful in enhancing competition and enrollment in others.

### **Population Size and Density Matters**

The size of the local insurance market is an important determinant of insurer participation. A large population offers the potential for more covered lives. In addition, a large population suggests that there are more providers with which insurers can negotiate for acceptable prices and greater economies for public or private outreach and enrollment efforts conducted by navigators/assistsors or by providers and philanthropic groups.

Alaska is the outlier, a geographically massive state has a population of less than 800,000 people. Transportation is a big challenge.. Still, the research team reported that respondents are convinced that two insurers are adequate to serve the population. Indeed, the state's insurer regulators have to work to keep even the two. Moreover, the state's sparse population results in there being few service providers, hence adding difficulty negotiating prices. The result is prices much higher than in the lower forty-eight.

The field researchers in Alaska were not alone in finding that sparse markets make it hard to support numbers of insurers. Kansas researchers reported that with BCBS of Kansas as the dominant insurer throughout rural areas, they doubt that a high level of competition can be achieved. This is borne out in observations fir the Appalachian region of Ohio, the northeast and far west regions of North Carolina, and the Keys in Florida.

### **Enrollment in Marketplace Plans is Driven by Low Premiums**

Throughout the states, where there was evidence of competition, navigators, assistors, brokers and insurers all said enrollment at the time of the field observations was driven by premiums.

It was generally observed, and this is to be expected and has been commented on by others, greater presence of insurers can lead to lower prices, especially for premiums at the time of the field observations. Field researchers in Ohio reported this and researchers in Texas noted that in moderate-sized markets with regional carriers, BCBS of Texas was under pressure" to offer lower premiums. In the same vein, field, researchers in Florida reported that in the Miami market competition was "robust" and insurers priced aggressively to attract enrollees.

Still, insurers in competitive markets have to be concerned about their costs. As discussed below, provider pricing in the rating areas we studied are key for insurers in terms of their being able to negotiate for and offer lower-priced plans.

As noted earlier, consumer understanding is key – and not easy. Consumers were found to have a lot to learn about the nature of insurance products and how premiums are related to their available tax credits, deductibles, co-insurance, and network providers under the Affordable Care Act. If they are just choosing plans based on premiums, they might not be choosing plans that truly meet their needs most efficiently if they do not understand the trade-offs between different plan benefits.

Field reports from Florida, Kansas, Ohio, and Texas suggested some insurers, particularly national insurers, have been cautious about entering the marketplaces. This, too, has been noted frequently. Some respondents of our suggested these carriers may have been waiting to enter ACA marketplaces until consumers with chronic conditions and pent-up demand had selected plans. Even with tax credits available to low income consumers, many of the remaining uninsured who were eligible still did not choose to enroll in marketplace plans. This is a big challenge we observed at the local level that has been commented on increasingly during the period we have been assembling our findings.

### **Establishing Networks of Providers at Acceptable Prices is Key to Insurer Success**

With the exception of the Alaska team, the field researchers found that establishing a price competitive network of providers was essential to being able to compete in the local markets. In this respect, and as noted in the ASPE study cited earlier, there is evidence of healthy competition in many of the ACA marketplaces studies, though that does not translate necessarily into broad participation on the part of ACA eligible marketplace participants. Reports from researchers in Texas, Kansas, Ohio, Florida, and North Carolina provide examples of why healthy marketplace competition matters commenting on the inability of insurers to negotiate on pricing when there were only one or two hospital providers (or provider networks) in the community. In some cases, they mentioned a decline in the numbers of hospitals due to closure or consolidation. Field researchers in Kansas, particularly, noted that the presence of a dominant insurer with a well-established network made it difficult for other carriers to obtain price concessions from local providers.

North Carolina's situation is particularly instructive because it highlights innovation that new entrants used to establish a market presence. Insurers there indicated that they could not compete with the dominant well-known and well-regarded insurer unless they could negotiate prices that were 10 percent lower than that received by the dominant carrier. Other state field reports, while not as precise, suggest that insurers didn't enter local markets or were not competitive on premium if they could not negotiate acceptable provider prices.

In North Carolina, two new carriers entered the market and the share of the dominant insurer declined. Discussants reported that the new carriers entered into co-branding arrangements with health care systems and risk-sharing agreements with local providers to be able to compete locally. These arrangements appeared to allow them to achieve price concessions from providers that allowed the issuers to challenge the dominant carrier. This finding is consistent with reports from Texas that regional insurers, linked to local provider networks, were able to successfully compete with the dominant insurer there. The presumption of one respondent is that the local providers granted substantial price breaks to the regional carrier.

A second way to obtain price concessions from providers is to establish narrow networks. With this approach insurers emphasize the negotiated inclusion of relatively lower-cost hospitals and other providers in their panel of providers. Both for North Carolina and Texas, field researchers said local Blue Cross Blue Shield plans responded to competitive challenges by offering managed-care plans with narrowed networks. Others noted this development more obliquely. The Kansas report, for example, noted that the creation of a new BCBS subsidiary offering of an HMO product was initiated as an effort to be more competitive. Researchers were not able to provide estimates of the extent to which such networks excluded higher-cost providers, but taking a close look at the local level this is what appeared to be happening in these ACA marketplaces. A closer look would be needed to try to estimate the effects of such competitive strategies.

### **Health Insurance is a Complicated Product**

All of the six individual-state reports noted the difficulty consumers had in understanding health insurance and deciding on the insurance coverage and specific Qualified Health Plans (QHPs). There were several facets to this. There were substantial problems, especially in the first open-enrollment period (OEP)-1, that confused and frustrated consumers; thankfully, many of these issues were resolved going forward.. Still, problems remain of cancelled policies and difficulty navigators, assisters and brokers have had interfacing with *Healthcare.gov*, especially on income determination.. Field reports for Kansas, Ohio, Alaska, and Texas also mentioned publicity, namely, political opposition and press reports as denigrating the ACA and making consumers fearful and uneasy about coming forward. Reports, however, suggest that these were individual politicians and commentators rather than explicit actions of state governments.

It was frequently noted that, consumers were confused about how insurance works and how the law works and terms like deductibles, coinsurance, and networks. Organizations sponsoring navigators and in-person assistors as well as insurance agents and brokers told field researchers that consumers, in specific, had trouble understanding the relative value of the metals levels of QHPs (i.e. the value of silver coverage relative to bronze), who don't understand the value of subsidies (both tax credit and cost-sharing reeducation) and as a result focused on variations in monthly premiums. Some respondents noted selecting a low premium plan in the first year necessitated switching to another plan in year two because of the re-basing of the second lowest cost Silver plan which raised their premium. Others issues underlying consumer confusion, and this has been noticed increasingly, is the necessity to switch plans noted as a result of discovering that their preferred providers were not in-network.

The confusion is not limited to those who have not had insurance coverage in the past. Many who have had employer-sponsored coverage were found to be equally at a loss; they have had no experience choosing plans. Employers did it for them. In fact, in some places it was reported that a high number of plan options added to this consumer confusion, however, none of the respondents regarded this as a reason to limit the number of plans offered.

## **Lack of Outreach and Navigator/Assistor Efforts Often Played a Key Role**

Most of the state reports commented on the need for additional and stronger organized outreach to encourage enrollment and to explain the mandate for coverage and the nature of coverage and the benefits available under the law. In effect, the need for coordinated was found to be more prevalent in states with federal-administered exchanges (FFM). Increased state outreach could attract consumers, and navigators/assisors in many states were found to be critical in helping beneficiaries make more informed choices. Another issue we noted and has been commented upon by others is the lack of both the amount and continuity of financial support for consumer education and assistance for enrollment and retention. Several state reports, including Ohio, credited civic groups and the press for fulfilling this educational function. .

There were places that are exceptions to the points just made. The Florida report, for example, highlights the success of navigators and assisors in the Miami-area marketplace enrolling people for the first time (with much of this population having a language other than English as their primary language), by providing services like telephone support and insurance literacy seminars. This it was suggested spurred insurer competition by helping people differentiate among plans and actually enroll.

A subtheme associated with enrollment was found in state reports on brokers/agents. There were concerns raised in four of the study states (Florida, Kansas, Ohio and Texas) that agents were not in a position to function in ACA marketplaces. One respondent noted that health insurance has become a three-month part-time enterprise referring to the ACA annual open-enrollment periods. As a result, it was said that agents only can jump in and out of this market and had limited incentives to become knowledgeable about the products in the individual market. Mostly, they can receive commissions, but typically not a high or even moderate industry level.

## **State Regulatory or Rating Area Concerns**

None of the state respondents reported evidence of significant state regulatory concerns. Most found the state agencies competent in facilitating the functioning of their state insurance markets. Researchers in Texas and Ohio briefly noted that the state imposed additional limitations on navigators, and the Kansas report suggested that state approval of plan offerings could be swifter.

In general, the discussion respondents reported no problems with the rating areas. Most had considered alternatives and/or discussed the proposed areas with the industry. The Ohio research team suggested that their rating areas might be improved by moving to the MSA +1.<sup>9</sup> This was based upon observed higher premiums in less homogeneous rating areas. The regulators in Texas suggested that expanding the age-premium corridor from three to one to five to one would encourage more young people to obtain coverage.

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<sup>9</sup> MSA +1 structure has rating areas divided by Metropolitan Statistical Areas, plus the remainder of the state in one additional rating area.

## **XI. Learning from Experience**

Potential remedies for insufficient competition were drawn from state researchers' insights, the literature review, and discussion among the Brookings team and with RAND and ASPE staff. All of the ideas discussed here would need to be vetted more fully on account of the limited the sample and observation time period for this study.

The toughest problem is how to encourage more insurers to compete in sparsely settled rural areas. The North Carolina report suggested that the growth in competition that they observed in most of the state could spill over into the more rural markets as carriers solidified their provider networks. Ohio researchers also mentioned the potential of restructuring the rating areas into an MSA + 1 structure, although there was not consensus from the researchers or the literature on how much heterogeneity is appropriate for grouped counties.

It may be useful to highlight apparent successes to encourage local and regional insurers and health systems to capitalize on the comparative advantages they may have. The experience of new entrants in North Carolina together with the success of regional carriers in Texas suggests that one mechanism to enhance competition is for insurers to co-brand and risk-share with well-established health care systems. The key to this success appears to be price concessions that these health care systems granted in marketplace for profits from the plan offerings. However, the research teams did not explicitly establish this linkage.

Consistently the field reports showed consumers are confused and in need of help. The example of Medicare Part D suggests consumers may come around to understanding the options and selection plans that are best for them. They have been aided by a well-functioning, state-specific software system that helps them identify their prescription drug use and enables them to select plans consistent with that use. Translating this success into the individual ACA health insurance marketplaces is a big challenge. It would require similarly transparent access of information on characteristics of health insurance plans while individuals are shopping.

While there has already been improvements made to [healthcare.gov](http://healthcare.gov), it still needs to be made more consumer friendly. Consumers should be able to easily filter, search, and compare plans across different dimensions, including annual estimated care costs, updated provider directories, indicators of network narrowness, and plan quality. Successful private sector experiences could be assessed. In addition, the potential displayed by navigators/assistsors suggests that this program could be expanded or new and more innovative programs developed under a pilot program. Alaska's "211 Program" may serve as a model in this regard. This statewide phone number and the accompanying website connect residents to a multitude of social services, such as navigators and other organizations who provide assistance with enrollment. If navigator funding is phased out, support from other federal programs, such as the Indian Health Service, may be an option. The program is currently underfunded, but has already established cultural competency communicating with vulnerable populations.

Indeed, given the lack of knowledge among both the uninsured and those who previously had insurance, it may be very useful to have navigator/assistor organizations focus on “health insurance 101” programs that are linguistically and culturally sensitive, and linked to a media campaign that reminds people of the need to have coverage to protect themselves and their families. Emphasis on available subsidies and rising penalties should also be stressed. Such programs would seek to translate insurance concepts, identify why one type of coverage may provide much more value even if it costs a bit more, and help people see the value of subsidies that may be available to them.

Given the knowledge and experience of agent/brokers, it may be appropriate to consider ways to motivate them to service the marketplace markets. Agents and brokers have a depth of knowledge about the nature of insurance and the relative value of alternative products. They know how to communicate these complicated products to consumers and they are already dispersed throughout urban and suburban areas and small towns. Many specialize in serving minority populations. However, many also reported being disinclined to service the marketplace market because of low compensation and the large time commitment associated with marketplace clients.

One straightforward approach to increase enrollments is to substantially raise the fees or commissions given to agents/brokers for enrolling subscribers. Such an expansion could be across the board. It could also focus on provisions of special enrollment regulations, which may allow increases in commissions in targeted areas that have marketplace enrollments that are below some threshold. Alternatively, or in addition, higher commissions might be established for a two or three year period in the expectation that after that time, like in Medicare Part D, consumers have developed enough familiarity with the products that they can make reasonably knowledgeable decisions on their own.

August 18<sup>th</sup>, 2015, Brookings and RAND briefed Richard Frank, ASPE staff, and other HHS staff members on the conduct and findings of this study in a discussion of potential remedies, including but not limited to those discussed in the report. Potential remedies included federal and state level interventions. Some actions the federal government might be able to take are: better funding and training for navigators, more engagement of brokers, renewed health insurance education efforts for consumers, spreading industry awareness of the North Carolina vertical integration success, and holding conferences with State Based Marketplaces to review lessons learned from FFMs. States could also engage in many of these activities; for example, funding navigators and in-person assisters and reducing limits on their participation in enrollment assistance. State governments and insurance regulators could also consider whether any changes in rating areas could enhance competition and whether any state actions or regulations were inhibiting carriers from entering the marketplaces or residents from enrolling.

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## Appendix A: Literature Review

### I. Introduction

The Affordable Care Act (ACA) created health insurance marketplaces to provide consumers with a choice of competing health insurance plans that met the coverage criteria specified in the law. The hope was that competition among plans would result in consumers being able to choose from plans that offered at least adequate benefits and provider networks at reasonable prices. Consumers would be eligible for subsidies to make the plans more affordable.

These marketplaces have had varied success across the country. According to Gunja and Gee's market entrant report for The Assistant Secretary for Planning and Evaluations' (ASPE) office (2014), some states have attracted substantial numbers of insurers. For instance, states like Florida, Michigan, and Arizona, each had at least ten insurers the first enrollment year. Others, like New Hampshire, West Virginia, Alabama, Alaska, Maine, Mississippi, North Carolina, and Wyoming had two or fewer insurers in the state, and many of these insurers did not offer their plans statewide, leaving some rating areas with only one insurer. The percent of population enrolled also varied widely after the second open-enrollment period according to Kaiser Family Foundation (2015), with 70 percent of the population eligible for marketplace plans enrolled in Vermont, compared to South Dakota and Iowa on the opposite end, with 21 percent and 20 percent enrolled respectively. This study is focused on identifying markets where competition has been weak, uncovering the reasons for insufficient competition, and identifying possible federal and state remedies.

Because the ACA is so new—there have only been two open enrollment periods—there are few scholarly articles dealing with competition in the ACA markets themselves. There is, however, relevant literature in the private individual insurance markets, employee-sponsored insurance, and Medicare Advantage markets.

We first define a market with insufficient competition and explain how the ACA was crafted to prevent it, along with some literature on the level of success of these initiatives in the first years. We found in our scan of the literature that there are consistent features that may indicate insufficient competition and struggling markets: a small number of insurers, high premiums, low enrollment, predominantly rural markets, and poorly designed market areas. We then review some causes and effects of these indicators, provide some potential solutions for improving competition, and highlight some examples of competition from other markets, specifically hospital competition.

### II. Methods

First, we used literature based on recommendations from Michael Morrissey, the Co-Technical Task Leader on this project, who has background knowledge and experience in insurance markets and written a textbook on health insurance (2014).

We then used snowball methodology, adding relevant papers cited by the first group of papers recommended by Michael Morrissey. Relevant articles were identified through the titles listed in the references and through our reading of the first group of recommended articles. We did not find many additional relevant articles.

We then used GreyLit.org for grey literature, and then searched Google Scholar to fill in any gaps that we may have missed in the first pass. This section of the search covered the time period 2010-present. Our search strings were as follows:

1.1.1 Health insurance and individual market

1.1.2 1.1.1 and competition

1.1.3 1.1.1 and regulation

1.1.4 1.1.1 and networks or provider contract

1.1.5 1.1.1 and enrollment

1.1.6 1.1.1 and premiums

1.1.7 1.1.1 and market failure or death spiral

1.1.8 1.1.1 and remedies or best practices

1.1.9 1.1.1 and market power

1.1.10 1.1.1 and rural

2.1.1 Affordable Care Act and health insurance

2.1.2 2.1.1 and competition

2.1.3 2.1.1 and regulation

2.1.4 2.1.1 and networks or provider contract

2.1.5 2.1.1 and enrollment and exchange

2.1.6 2.1.1 and premiums

2.1.7 2.1.1 and market failure or death spiral

2.1.8 2.1.1 and remedies or best practices

2.1.9 2.1.1 and market power

2.1.10 2.1.1 and rural

### **III. Defining a Health Insurance Market with Insufficient Competition**

In a successful market—the kind described in economics texts—consumers are able to buy quality products from sellers that have sufficient competition so as to not allow them to raise their prices above marginal costs. Consumers benefit from this competition, as they are able to buy better quality products at lower prices than they would if competition proved insufficient. Before the passage of the ACA, individual insurance markets in the United States bore little resemblance to this textbook picture. Insurers in many states were allowed to engage in medical underwriting and often denied coverage to persons with “pre-existing conditions,” refused to renew policies for people who had high expenditures, and imposed life-time limits on health spending. As a result, many people who depended on the individual health insurance market often found that they could only buy inadequate insurance that was not beneficial when they got sick. People with serious illnesses or multiple chronic conditions faced extremely high premiums or could not buy insurance at any price.

The insurance market reforms in the ACA changed the nature of health insurance competition. These rules were enacted to encourage insurers to compete on price and quality: enforcing an individual mandate and providing subsidies for people between 100 and 400 percent of the federal poverty level (FPL), removing the ability for insurers to engage in medical underwriting in the marketplaces, and enforcing minimum standards in terms of benefits and other aspects of the insurance plans. The exchanges or marketplaces created under the ACA enable consumers to access information about the plans available to them, including networks and premiums. They can compare the relative value of plans on websites and choose those that appear to them to offer the highest quality and lowest cost.

As Chandra et al (2011) outline, there is disagreement about the consequences of the individual mandate and whether the mandate is even a necessary part of the reform. Supporters of the mandate believe that, because the ACA removed the ability for insurers to engage in medical underwriting and did not allow insurers to charge different premiums to people with different health statuses, premiums would become too high for healthy people without the mandate requiring many people to enroll.

In an effort to better judge whether or not the individual mandate would be successful at increasing the proportion of healthier enrollees across the US, Chandra et al turned to the Massachusetts health care reform as an example, looking at the age, health status and health care costs of residents on the marketplaces between 150 and 300 percent FPL, before and after the mandate. What they found was that enrollees who signed up before the mandate were on average four years older, 50 percent more likely to be chronically ill, and had about 45 percent higher average monthly health care spending. Research conducted by the Society of Actuaries (2013) predicted that states with the smallest amount of regulation of medical underwriting practices before the ACA would have the largest increase in premium prices. Before, healthy people were able to have very low premium prices, making it more likely for large groups of healthier people to enroll, but leaving the sickest priced out of the market. In fact, the state they predicted would have the highest premium increase was Ohio, one of the six study states being focused on particularly because of the high premiums and low enrollment realized there. According to McDonough et al (2006) Massachusetts had one of the most restrictive medical underwriting policies in the country before their health reform, which holds with the results from the Society of Actuaries study – they predicted Massachusetts would have among the lowest premium increases in the entire country.

It is the responsibility of the marketplaces to act as a gateway for plan information and enrollment for consumers. As Morrissey (2014) explains, most states act as market facilitators, meaning that the state accepts all plans that meet minimum requirements, and acts as a source of information for consumers with the intention of helping consumers understand the difference between the options and to help them choose the plan that best meets their needs. This incentivizes plans to compete against each other on quality, additional benefits beyond the essential, provider network size, prices, etc.

Unfortunately, ensuring that consumers have access to a range of plans with an essential minimum of benefits does not guarantee that markets will function well-enough to ensure that

customers will have adequate choices and will be able to purchase good quality insurance; and even with the new rules, insurers have to find ways to maximize their profits to be incentivized to stay in the market. Insufficient competition can stem from many factors.

- There may be too few insurers to ensure vigorous price competition. This may be because insurers do not have enough experience with the newly insured and do not know how to price their product, because they fear losing money in a sparsely settled area with few customers, because they fear the ACA may be gutted or repealed, or because of the high fixed costs associated with entering a particular new market. If there are only one or two insurers, they may overtly or tacitly collude to keep premiums high.
- Consumers may choose not to enroll for many reasons: high prices relative to their perceived need for health insurance, poorly designed websites, lack of health insurance literacy, etc. Insurers are less likely to enter a market in following years if enrollment was low from the beginning.
- Even a larger number of insurers vigorously competing may have limited success signing up customers if the population or state officials are unsupportive and unfriendly to the program.
- Rating areas may be badly drawn so that it is hard to market insurance products to potential customers because the rating area includes populations with markedly different providers and prices, or widely differing health care demand.

The point of this field research project is to explore conditions in a variety of markets in six states to discover which markets are not giving consumers adequate choices at affordable prices and enrolling substantial fractions of the eligible populations. Below, we summarize the literature on potential indicators for markets that could have sub-optimal performance.

#### **IV. Potential Indicators of Insufficient Competition**

##### **Low Number of Insurers and High Premiums**

Evidence from the private and Medicare markets suggest that more insurers in the ACA's health insurance marketplaces will correlate with lower health insurance premiums. According to a review by Gaynor et al (2014), the majority of research on U.S. insurance markets finds that a greater number of insurers in the market and lower premium prices are linked. Furthermore, economic theory predicts that all else equal, as the number of competitors increases, prices should decrease.

The private health insurance market tends to be concentrated and several studies suggest that this concentration contributes to higher premiums. Dafny (2010) studies the relationship between the number of health insurance companies in a given market and the premiums offered by the insurers. Using data from a private benefits company that included many employers and thousands of workers, Dafny shows that insurers charge more profitable firms higher premiums –

clear evidence of imperfect competition – but the amount of price discrimination declines as the number of insurers in the market increases.

A follow-up study by Dafny et al (2012) exploiting changes to the local insurance market structure in Texas, driven by the 1999 merger of Aetna and Prudential, confirms that the concentration of the insurance industry directly affects premiums. This study uses the Larger Employer Health Insurance Dataset (LEHID) – longitudinal data on all the health plans offered between 1998 and 2006 by over 800 employers in 139 different geographical markets, representing over 10 million beneficiaries in each year of the sample. As Aetna and Prudential offered plans in all 139 markets Dafny et al use this nationwide merger to study the relationship between premium growth and increases in local market concentration, as measured by the commonly used Herfindahl-Hirschmann Index (HHI). They indeed find that the merger caused large and varying increases in HHI throughout local markets, which consequently led to a total premium increase of about 7 percentage points by 2007. However, this study has various limitations. For example, the analysis is only based on one merger, and the sample is mainly made up of large, multisite firms, meaning that the results might not be generalizable to all types of markets, such as the individual and small group. Moreover, this study's results do not take into account the effects of the significant amount of consolidation that has happened across, as opposed to within, markets.

A similar study by Guardado, Emmons & Kane (2013), which analyzes Nevada's market concentration due to a merger between UnitedHealth Group and Sierra Health Services, also finds a significant, positive association between the merger and premium increases. When comparing metropolitan areas affected by the merger (study markets) to areas that were not affected (control markets), results showed that compared to the control market, the study market plans experienced 13.7 percent higher premiums – a much larger increase than in the Dafny et al (2012) study. According to Guardado, Emmons & Kane, the reasons for these much larger results could be due to several reasons. First, Guardado, Emmons & Kane use entirely different data, they merged two datasets: (1) BenefitPoint Health Plan Database from between 2004 and 2009, which offered information on the characteristics of plans sold to employers during that time; (2) and HealthLeaders-InterStudy (HLIS) Managed Market Surveyors, over the same time period, from which they calculated plan market shares and concentration levels, as measured by HHI. Second, Dafny et al (2012) focus their study on large employers, whereas Guardado, Emmons & Kane's analyses mainly focus on small employers, which might have less price negotiating power with insurers.

Dranove et al (2003) also find a relationship exists between the number of insurers in the private market and premiums. This study uses 1997 HMO data from the Interstudy database – which contains data collected by state regulatory agencies to generate a census of HMOs in the US – to explore how differences in HMO types influence local market competition. Instead of using the HHI index to measure local market concentration; this study uses a combination of a theoretical model posed by Bresnahan and Reiss (1991) and an empirical model developed by Mazzeo (2002) to study the nature of competition in HMO markets. When examining HMOs operating in a series of local markets, Dranove et al found that local HMOs and HMOs with a national geographic scope do not compete, because they serve different market segments. But premiums

decline significantly when more insurers of the same type (local or national) enter the market and begin to compete.

In the Medicare market, the same relationship between the premiums and the number of competitors holds. Maestas et al (2009) examines price variation in the Medigap market by drawing from two merged datasets: the Weiss Ratings, Inc., which provides a snapshot of premiums provided in 2004 by approximately 91 percent of all insurers operating across the nation; and an administrative regulatory database from the National Association of Insurance Commissioners (NAIC), which holds total premiums, beneficiaries, and claims for each plan offered by an insurer in each state. This study finds that there was a positive relationship between prices and the market share of the two largest firms.

Two papers by Lustig (2009) and Town and Liu (2003) study the Medicare+Choice (now Medicare Advantage) market and show that there is a relationship between consumer welfare losses and the number of health insurance firms serving the market. To measure welfare losses to consumers resulting from imperfect competition in privatized Medicare, Lustig (2009) combines data from multiple sources between 2000 and 2003. One of the findings of this study is that there are substantial welfare losses in markets with low insurer competition, or ‘monopoly markets’. Town and Liu (2003) use data between 1993 and 2000 from five CMS penetration files (including the SCP files); AARP Medigap policy Plan F premium data; and the Area Resource File to estimate the welfare that Medicare beneficiaries receive from the Medicare+Choice program. They find that the relationship between consumer welfare and the number of plans in a county is positive, and that most of the welfare increase is due to increased premium competition.

Duggan et al (2014) find similar results in a study analyzing how the quality of Medicare Advantage coverage varies with the generosity of plan reimbursement. To do this, they leverage policy-induced variation in the generosity of MA plan reimbursement given that reimbursement levels are set according to each county’s per-capita FFS spending levels. Their findings suggest that in markets with a small number of insurers, insurer profits are higher and the value of the benefits supplied by the insurers is lower than in areas with a large number of insurers.

Dafny et al (2014) provide some preliminary evidence that the ACA’s marketplaces are imperfectly competitive, just like the private and Medicare Advantage markets. Using data on the plans available in the federally facilitated marketplaces (FFMs), along with estimates of market shares for plans participating in the marketplaces, Dafny et al exploit an exogenous decision by United Healthcare to not enter any of the health insurance marketplaces, to estimate the effect that additional insurers would have had on the health insurance exchange premiums. They find that if all the insurers active in the commercial market had participated in the health insurance exchanges then the second-lowest-cost silver premium would have been 11.1 percent lower.

### **Interactions with another Market - Provider Concentration and High Premiums**

A more recent trend in the literature also points to the importance of health care provider market power – especially of large hospitals and physician groups – in driving higher premiums.

According to a recent National Academy of Social Insurance (2015) report, some providers are able to get significantly higher private payment rates due to differences in negotiating power. For example, providers can have higher market power and demand higher prices in less populated geographic areas, where there is constrained access to care as well as by offering unique or specialized services not offered by other local providers. This report also highlights that many studies have found a relationship between hospital consolidation and increases in price. A study of six major California markets by Berenson, Ginsburg and Kemper (2010) suggests that this relationship exists. This study analyzes qualitative data gathered from the Center for Studying Health System Change between October and December 2008 to assess regional variations in the affordability, access and quality of care. This data was collected through 300 semi-structured interviews with various relevant stakeholders, such as providers, health plans and employers. Results found that provider consolidation has given them greater bargaining power over health plans, which has caused an increase in premiums. An empirical study by Haas-Wilson and Garmon (2011) further supports the notion that provider market power drives higher premiums. This study examined how the merger of two hospitals in the northern suburbs of Chicago – Evanston and Vista Health – impacted what commercial insurers paid for inpatient hospital services. They analyzed changes in prices in the two merged hospitals after the merger and compared them to control hospitals, while also controlling for factors that change over time and between hospitals such as patient case-mix. Haas-Wilson and Garmon found that hospital price increases were larger post-merger in the merged hospital, when compared to the control hospitals. These results suggest that, as a result of the merger, the hospital grew market power and was able to negotiate higher prices with private payers.

Recent research on the effects of provider consolidation on prices suggests that the relationship between market concentration and insurance premiums is more ambiguous than set out in the previous section. That is, in markets where providers are concentrated, insurer consolidation could result in stronger leverage to negotiate lower prices with providers, which would create savings that can be passed on to beneficiaries in the form of lower premiums (Guardado, Emmons & Kane 2013). For example, a study by Melnick, Shen and Wu (2011) found that hospitals in highly concentrated insurer markets have lower prices; however, in markets where hospitals are consolidated, hospitals have higher prices. Melnick, Shen and Wu therefore suggest that hospital prices are dependent on the relative market concentration of both insurers and hospitals. A recent study by Trish and Herring (2015) supports the idea that the relationship between market concentration and premiums is dependent on various market factors. When analyzing levels of concentration in both local insurer and hospital markets, as measured by HHI, Trish and Herring found that: (1) in markets with higher levels of insurer concentration compared to contracts with employers, premiums were higher; (2) in markets with higher levels of insurer concentration compared to hospitals, premiums were lower; and (3) in markets with higher levels of hospital concentration, premiums were higher.

The literature on insurer concentration listed above consistently shows that increasing the number of insurers in the market lowers premiums for consumers, although there was no definitive answer on what a ‘correct’ number of insurers would be. But adding provider concentration to the mix makes the outcomes more ambiguous. Targeting rating areas with lower numbers of insurers (many have only one or two) for study could help illuminate this



relationship between insurers and provider networks, and the effect it has on prices for consumers.

### **Low Enrollment**

Another key indicator of struggling markets is low enrollment. Low enrollment can indicate that premiums are too high, which incentivizes healthier individuals to pay a penalty rather than to enroll in health insurance. Premiums have long been found to have a statistically significant effect on consumer plan choice and enrollment in health insurance markets, regardless of the program or sector, with different types of consumers exhibiting different levels of price sensitivity. One place to look for evidence is Massachusetts, which has had a marketplace since 2006, and thus there is more available, in-depth published research. Ericson and Starc (2013) found that on the Massachusetts Health Connector, younger individuals were more than twice as price sensitive as older individuals. People below 300 percent of the federal poverty level were also found to be very price sensitive, with Chan and Gruber (2010) finding a \$10 increase in price leading to an 8-16 percent decrease in the probability of choosing a plan. For people newly enrolling in health insurance, they also found that there was a large statistical difference in price sensitivity by health status – healthier people were much more price sensitive than sicker people.

Some evidence from the first years of the ACA marketplaces has supported the evidence that younger, poorer, and sicker consumers are particularly price sensitive, and that financial barriers and high premiums discouraged these subsets of the uninsured populations from enrolling. In a survey completed after the first open enrollment, Zuckerman et al (2014) used Urban Institute's Health Reform Monitoring Survey (HRMS) and found that 71.8 percent of the respondents that remained uninsured did so because of financial barriers. Their sample includes uninsured adults (nonelderly, ages 18-64) who were uninsured for some or all of the 12 months prior to the June 2014 survey. At the time of the survey, 57 percent of these adults remained uninsured and 43 percent had insurance coverage. The insured adults include (1) adults who used the marketplaces to obtain coverage through Medicaid or a qualified health plan and (2) adults who had been uninsured during the year but obtained coverage outside the marketplaces (for example, from their employer, Medicaid, or directly from an insurer). Thus, not all the insured necessarily sought information on health plans through the marketplaces, and many may not be enrolled in a marketplace plan. Those who received insurance obtained coverage through Medicaid, a qualified health plan available via the marketplace, or their employer. DiJulio et al (2014) report that Kaiser Family Foundation's California Longitudinal Panel Survey found that 34 percent of respondents stated that cost remained a barrier to obtaining coverage.

While price plays an important factor, there are additional psychological and behavioral barriers. If there are too many choices and the website is too confusing to navigate, people are more likely to make irrational decisions, or avoid enrolling in the first place. Frank and Lamiraud (2009) conducted consumer choice research on the Swiss market for health insurance, which is similar to the ACA's marketplaces, and discovered that consumers were less likely to make rational decisions when there were too many choices displayed. One positive note from their study is that consumers who used agents paid lower premiums than those making the decision on their own. Perceived time constraints can also be a barrier to enrollment, and there is some evidence from the ACA that this was an issue for people attempting to enroll. In the same survey cited above

(Zuckerman et al 2014), 20.1 percent of those still uninsured after the first enrollment period listed time and technical barriers as a reason for not enrolling. The Kaiser Family Foundation's Longitudinal Panel Survey (Dijulio et al 2014) also found that 36 percent who remain uninsured cited as their primary barrier to enrollment cost in addition to difficulty completing the enrollment process.

### **Rural Markets and Poorly Designed Market Structure**

Differences between rural and urban markets have long been an issue in health insurance, as rural populations are likely to be older and have higher rates of poverty. Holmes and Ricketts (2003) found that rural residents under the age of 65 were more likely to be uninsured than urban residents, and these differences hold true nationwide and within states. Lenardson et al (2009) found similar results and noted that rural workers were less likely to work for companies that provided health insurance and were responsible for finding insurance through other means. They also found that uninsurance rates increased the farther removed the counties were from population centers.

We know from previous research from the Medicare Advantage program that heterogeneity between rural and urban areas and age mix affect competition and market outcomes. Medicare Advantage operates on markets at the county level, and Frakt et al (2012) found that insurers tend to enter urban counties more frequently than rural areas, increasing competition. Abraham et al (1999) found that when looking at HMO participation in the Medicare risk market, the payment rate in the county was one of the main factors in deciding whether to participate. The likelihood of an HMO participating in a market also decreased as the percentage of people over 75 increased, perhaps showing an inclination towards HMOs choosing to participate in markets with younger Medicare populations. This suggests that already low-cost rural areas with older populations may not provide enough incentive for insurers to participate when they stand alone.

A study of the first year's performance of the marketplaces found that rurality continues to impact premiums and insurer participation among and within states. Polsky et al (2014) looked at the impact of rurality at the county level, defining rural counties as those with below 50,000 people, instead of using density as a population measure. They looked at insurer participation and premiums of silver plans for 50 year old individuals in the first year of the marketplaces, and did not find higher premiums across all rural counties; but they did find that rural counties in states that also had many urban counties had lower premiums and more competition than counties with statewide rural populations. In addition, states with over 50 percent of their population living in rural areas had half as many insurers, fewer plan types, and higher premiums than states with less than 5 percent of their population in rural areas. These findings suggest that states with large rural populations continue to face barriers.

Because the ACA aimed to change the nature of competition by creating rating areas for which insurers are required to assign a uniform premium, Barker et al (2015) evaluated the changes in health insurance marketplaces from 2014 to 2015 and the resulting impacts on premiums and insurer participation among rural rating areas (instead of at the county level). They looked at all 50 states plus the District of Columbia, and found that 64 percent of rating areas with fewer than 50 persons per square mile gained at least one insurer in that time period; however, they found

significant differences among rural states. When comparing five rural states with the lowest increase in second lowest cost silver plan premiums to the five rural states with the highest increase in premiums, they found on average .17 new insurers participating in lowest premium increase states and .5 fewer insurers participating on average for highest premium increase. Highlighting notable differences among these groups, Barker et al noted that rural states with the lowest increase were comparatively smaller and had higher normalized average premiums in 2014 than those with the highest increase. While rural rating areas did not see uniform impacts on insurer participation and premiums, these findings suggest that high increases in premiums within rating areas are related to declines in insurer participation.

Under the ACA, states could create their insurance exchange rating areas with some flexibility, following basic guidelines – the rating areas must be based on counties, three-digit zip codes, Metropolitan Statistical Areas (MSAs), or a combination of these. In particular, the MSA+1 design divides all metropolitan areas and their surrounding areas into rating areas, and then combines the remaining rural counties into one large rating area. As seen in Table A.1 (CMS 2013), some states, like Florida, used individual counties as rating areas, and some states, like Texas, used metropolitan statistical areas and grouped all the rest of the rural counties together in one large rural rating area.

**Table A.1. Market Areas of the Six States in our Assessment of Insufficient Competition Project**

State	Geographic Rating Division	Number of Rating Areas
Alaska	3-Digit Zip Codes	3
Florida	Individual Counties	67
Kansas	Groups of Counties	7
North Carolina	Groups of Counties	16
Ohio	Groups of Counties	17
Texas	MSA +1	26

Barker et al (2014) have done research on the differences in premiums by insurance rating area in the first year of ACA health insurance marketplaces. After controlling for distinguishing factors, they found differences in premiums by population density of rating areas for both federally-facilitated (FFM) and state-based (SBM) marketplaces. They found that premiums were inversely associated with population density for single, 27 year old non-smokers. The average adjusted premium for rating areas with population density below 100 per square mile were as follows: MSA+1 style states at \$241.73, individual counties at \$258.86, and for all other methods, \$269.18. Barker et al found that the design associated with the lowest premiums was one that allots rating areas to each MSA and lumps all other non-MSA, or rural, counties together.

Dickstein et al (2015) conducted quantitative research on the effects of rating area definition on premiums and the number of insurers in FFM states. They defined small and rural markets as those with populations smaller than 37,000 individuals, and with fewer than 40% of the population living in urban areas. They found that states that combined small counties with neighboring urban areas into a single rating area had higher numbers of insurers and lower annual premiums. However, they note that too much heterogeneity within a rating area (e.g. in terms of the urban and rural mix) may increase the fixed costs and may negatively impact insurer participation or increase premiums. As a result, while Barker et al (2014) note that MSA+1 designs were associated with the lowest premiums, Dickstein et al (2015) found contiguous inclusion of rural counties in MSA rating areas can increase the number of insurers and lower premiums provided that there is not too much heterogeneity within the grouping.

All of these studies focused on premium costs and insurer participation. None looked at provider network adequacy or differences in benefit generosity, highlighting an information gap and issue with the scarcity of literature looking beyond price and number of insurers.

## **V. Current Best Practices and Potential Solutions**

### **Restructuring Rating Areas**

In their policy brief after a committee meeting on the pricing of insurance plans and premiums for rural populations, the National Advisory Committee on Rural Health and Human Services (2014) also agreed with the studies in the previous section, that in low-density areas, the MSAs+1 design had lower than average premiums, while states that had rating areas that were individual counties had higher premiums. One possible solution for states may be to create MSA type structures, and for states to avoid creating rating areas that are only small and rural. Geographically small rating areas with low population density can result in lower competition.

### **Removing Barriers for Competitors to Enter the Market**

Facilitating new providers and insurers to enter the market is another possible strategy to improve competition. First, health care providers often face barriers to entry due to state professional licensing standards and scope of practice laws, which outline their legal professional roles. Industry professionals often develop these standards with their own economic interest and are often opposed to broadening the roles of other providers. Moreover, the system itself is fraught with the complexities of various state, local, and federal regulations, which hamper the revising of licensure and scope of practice regulations (Safreit 2011). The result is stringent state-based licensure and scope of practice standards for certain health care providers such as nurse practitioners and physician assistants that restrict them from practicing independently without the supervision of a physician (Lathrop & Hodnicki 2014). However, research has shown that stricter licensure and scope of practice laws lead to higher prices, diminished consumer choice in providers, and a reduced supply of primary care physicians. State licensure regulations also hamper the entry of retail clinics and urgent care centers, which have emerged as lower-cost options to physician offices and emergency departments with equal quality of care (NASI 2015). However, many states licensure boards impose physician supervision, which increases the cost of the model.

Suggestions to improve the licensure and scope of practice landscape, so that it doesn't obstruct provider market entry and competition, have included: (1) allowing the participation of other professionals on the boards, such as social sciences and health services experts, to ensure that appropriate regulations are developed and enforced; (2) charging the Federal Trade Commission (FTC) with monitoring proposed state regulations for anti-competitive provisions; and (3) creating national, more uniform, educational preparation, licensure, and scope of practice regulations for each health care profession. (NASI 2015; Safreit 2011)

## **VI. Conclusion**

The ACA has provided a template for massive experimentation with regulated competition through the marketplaces. Since there have only been two open enrollment periods, the evidence base around market reforms in order to improve health insurance access and coverage for consumers in some of the struggling markets across the country will continue to grow and provides time to make changes moving forward. While there is no empirically definitive definition of a market with insufficient competition, one can heuristically be defined as one in which premiums exceed marginal costs. Based on a review of the literature, potential markers of

insufficient competition are an inadequate number of insurance carriers, high premiums, low take-up rates, and a market that is unable to support multiple carriers. More insurers in a market typically correlate with lower premiums, but the increased market power of providers and hospitals creates complicated relationships and mixed outcomes that need further study. Different consumer populations have also been shown to have different levels of price sensitivity, and varying psychological and behavioral reasons for choosing to enroll or not enroll in health insurance. Finally, the research surrounding market structure consistently highlights the challenges of incentivizing insurers to participate in rural areas, but shows the potential for restructuring markets in a way that encourages insurer participation and improves choice for consumers.

Many states are only experiencing one or a few of these factors, and more research is needed to understand the complicated relationship between all these moving pieces. Throughout the course of this study, we expect to learn more about what features are critical to ensure that healthy marketplace competition can occur.

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## Appendix B: Alaska State Memo

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## 1. State Context

**Table B.1.1: Basic State Facts**

Type of Exchange	FFM, SBM, Partnership
Expansion of Medicaid	Governor Walker announced his intention to “unilaterally” expand Medicaid on July 16, 2015.
Number of rating areas	3
Number of insurers	2
Net change in number of insurers	0
State Population and Rank	699,900; 48 <sup>th</sup> in US
Median State Household Income and Rank	\$61,749; 7 <sup>th</sup> in US
Salient Health Facts (e.g. Regions with concentrations of certain conditions, or with particularly concentrated poor health status)	32% of state lives in rural or remote parts of AK, with limited access to health care
Salient Health Policy Information (e.g. Previous reform initiatives and relevant health-insurance policies and requirements, notable insurance regulations)	Patient Centered Medical Home Pilot Project; Emergency Department Super Utilizer Project; Extensive use of Telemedicine; Medicaid Expansion

Alaska covers a large geographic area – two and a half times the size of Texas and approximately one-fifth the size of the contiguous forty-eight states – and comprises a variety of diverse climates and land formations including deserts, plains, swamps, forests, glaciers, ice fields, fjords, river systems, volcanoes, thousands of islands and six major mountain ranges.

There are only a few urban areas in Alaska, with the largest being Anchorage. The Anchorage Metropolitan Area, which includes both the municipality of Anchorage and the Matanuska-Susitna Borough (Mat Su), has a population of 398,612, just over half of the state population of 735,601. The other two major urban areas are Fairbanks and Juneau. Thirty-two percent of the state’s population lives in rural and remote parts of the state. Table B.1.2 summarizes selected social determinants of health in both urban and rural Alaska.

Alaska is unique for the US in that the majority of the state is not connected by roads. The road system and rail belt tie together population centers, but a large proportion of the population lives in smaller villages spread throughout parts of the state that can only be reached from Anchorage or the contiguous forty-eight states by air or water. According to the Indian Health Service, eighty percent of Alaskan Native villages are not linked by a road system. Large items such as furniture and building materials, as well as bulk fuel shipments, can only be delivered to many coastal and river communities by barge during summer months.

**Table B.1.2 Social Determinants of Health, Rural and Urban Alaska<sup>i</sup>**

	Urban Alaska	Rural Alaska	Rural United States	National Average
<b>Poverty rate</b>	8.2%	13.9%	18.5%	15.8%
<b>Less than high school education</b>	7.4%	10.3	16.2%	14.0%
<b>Unemployment rate</b>	5.6%	8.5%	6.4%	6.1%

There are more than 200 federally recognized Alaska Native tribes located in tribal villages throughout the state. There is also one small reservation, the Annette Islands Reserve in Metlakatla in Southeast Alaska.

The Indian Health Service (IHS) is responsible for providing health care to Alaska Native and American Indian people in the state. In general, this care is provided through the Alaska Tribal Health System (ATHS) whose services are supported at least in part by IHS. The ATHS is a statewide voluntary affiliation of more than thirty tribal organizations providing health services to Alaska Native and American Indian people. The entire tribal health system serves approximately 143,000 Alaska Native people (approximately 19.4% of the state population) and provides comprehensive service across the entire continuum of care.

The ACA provides expanded options for Alaska Natives and American Indians:

- Continue to use IHS, tribal, and/or urban Indian health programs; and/or
- Enroll in a qualified health plan (QHP) through the Marketplace; and/or
- Access coverage through Medicare, Medicaid, and the Children's Health Insurance Program.

If IHS recipients choose to enroll in a QHP through the Health Insurance Marketplace plan, they may qualify for special benefits and protections offered to Alaska Natives and American Indians. When a Medicaid recipient who is also an IHS beneficiary receives Medicaid-covered services from a tribal health facility, the federal Medicaid match is 100 percent.

In addition to the Alaska Native Medical Center in Anchorage, which is the statewide referral hospital for the tribal health system, there are forty-four tribal health centers, 160 Community Health Aide clinics and five tribal residential substance abuse treatment centers. Community

Health Aides receive four sessions of training, each three to four weeks long. In addition to Community Health Aides, the tribal system also provides care through Behavioral Health Aides and Dental Health Aide Therapists.

Overall, there are twenty-three hospitals in Alaska, seventeen of which are located in rural areas. Thirteen hospitals across the state have been identified as Critical Access Hospitals. Despite the numerous tribal health care facilities spread across the state, about half of the Alaska Native residents in the state reside in communities that are isolated from regional hospitals and health centers by long distances and geographic barriers. The IHS spends more per capita to provide medical and community health care services in Alaska than it does in any of the contiguous forty-eight states.

Residents of non-tribal rural communities are often even more isolated from health care and social service programs. In many non-tribal villages, there may be no health care or other services available without traveling to the regional hub or an urban center. In these communities, the primary source of local health care may be traveling public health nurses. Because most rural Alaskan communities are not accessible by road, they can only be reached by boat, snow machine or small aircraft. In the event of medical emergency, an air-ambulance (either helicopter or airplane) is the timeliest option for transport to a regional hub. The costs for an air-ambulance range from \$23,000 to \$100,000 depending on the distance and means of transport.

Another one of the big challenges in Alaska is recruiting and retaining health care providers, especially behavioral health providers. In 2012-2013, it was estimated that 4.3 percent of the state's adults had a serious behavioral health disorder, above the national average of 4.1 percent, and only 35.9 percent of adults with any mental illness received treatment, below the national average of 41 percent.<sup>ii</sup> High treatment needs, combined with few in-state residential treatment beds, led to high levels of out-of-state Residential Psychiatric Treatment Center (RPTC) placements. In 2004, there were over 700 children in out-of-state RPTC placements. That same year, the state Department of Health and Social Services, the Alaska Mental Health Trust Authority, state planning boards, families, tribes, and other stakeholders started an initiative to reduce the number of out-of-state placements and by 2010, the number of out-of-state youth placements dropped to 89 (although by 2012 it had risen slightly to 117). More recent numbers of out-of-state placements are difficult to find, but this remains an ongoing challenge in the state.

Another important need in the state is local alcohol and substance abuse treatment programs. Often individuals need to leave the home community to access substance abuse services, but when they return after treatment they do not have the support available to help them remain sober.

## **2. State Study Area and Rationale**

We focused on the entire state because there is little variation amongst or between rating areas. The entire state experienced the three main indicators of insufficient competition - high premiums, low insurer participation, and low enrollment.

### **3. Data Collection Methods**

#### *Participant Identified/Recruitment*

Study participants were identified by the Alaska team from the small sample of stakeholders in the individual health insurance marketplace in the state of Alaska. They were contacted by Dean Hogan via email and phone, and invited to participate in a group discussion to get their perspective on the following:

- The nature of competition in Alaska's individual health insurance marketplace;
- The relationships between insurer participation and premiums and enrollment rates;
- Other factors that may be affecting competition in the individual health insurance marketplace.

#### *Study Participants*

Seven experts chose to participate in the study. They included one representative each of the following categories of experts: insurance broker, regulator, insurer, hospital executive, navigator, provider association, and health policy expert.

#### *Data Collection Process*

Qualitative data were collected in three small group discussions that allowed participants to engage one another in responding to discussion questions. The first group discussion consisted of the broker and the health policy expert, the second of the regulator and the insurer, and the third of the hospital executive, navigator, and provider association representative. Dr. Driscoll facilitated the discussion using a semi-structured discussion guide consisting of structured questions and unstructured probes to follow-up on new or emergent themes.

Discussion questions were asked about three overarching domains or topical areas related to the individual health insurance marketplace: level of competition, enrollment, and costs. All questions were open-ended, and invited participants' opinions and possible remedies related to the marketplace currently and in the future.

#### *Analytic Process*

Discussion data were collected in the form of hand-written notes and in audio-tape which were transcribed for in-depth analysis. Thematic analysis of the discussion notes allowed for the top-line findings described in this report.

### **4. Findings of Marketplace Conditions**

#### *Insurer Participation*

Most discussants agreed that two insurers; Moda Health and Premiera/BCBS are probably sufficient for the Alaska population. The health policy expert and the regulator felt that one additional insurer would be advantageous particularly if one of the current insurers leaves.

Without that third insurer there would be a monopoly if one left. Regarding the amount of carriers needed in Alaska, the insurance regulator said, “we will have enough carriers when the rates stabilize.”

The relationship between insurers and insurance regulators in Alaska is unique, and more collaborative than in many states in regards to establishing rates. This can best be described as a deliberative process whereby carriers submit data and information to the regulator but the “right” rate is established through discussion, consultation and/or clarification. As the insurance regulator stated, “the state approves the rates – it doesn’t set the rates.” The regulator has also on occasion suggested the carrier increase their proposed rates out of concern the carrier might not be financially viable to continue to conduct business in the state (thus reducing competition).

#### *Interactions with another market*

There is limited interaction with another provider market due to geographic isolation in Alaska, with the exception of the Anchorage and Mat Su markets. Many Mat Su residents still drive to Anchorage for care. Providers are concentrated for the most part in Anchorage. Discussants agreed that a lack of provider competition within and between markets results in increased costs and subsequently higher insurance premiums.

#### *Is pricing driven by competition in the health insurance marketplace or by the risk pool?*

This issue came up in several group discussions. In other words, if we had more insurers would the price for a policy decline, or does it have to do more with who is in the pool? Alaska has a fairly high number of people with health issues that increase risk and subsequently higher cost. The risks include both adverse health outcomes associated with behavioral health problems, as well as geographic isolation which necessitates high costs for transportation. This leads to the emergency department super-utilizer phenomenon.

#### *Low enrollment in the marketplace*

Discussants spoke about how low enrollment might be driven by, or result from, the following factors: many potential enrollees were not technologically savvy (many did not have an email address before the initial enrollment period); the number of plans (in 2015, there were 30 plan options in Anchorage) was overwhelming and confusing even with navigation assistance; language created a barrier for many immigrants (there are 99 different languages spoken in the Anchorage School District alone); some enrollees had a cognitive impairment; and premiums were very high for those who did not benefit from a subsidy (roughly ten percent of enrollees). The average premium for the second-lowest cost silver plans for twenty-seven year olds, before tax credits, was \$349 in 2014 (national average of \$218), and this number increased by twenty-eight percent to \$449 in 2015 (national average of \$222).<sup>iii</sup>

The federal exchange rollout of 2014 also negatively impacted the numbers. Among individual consumers, it is believed that the marketplace is viewed as government intrusion (not generally accepted or approved by individuals who feel their personal information will be used for purposes other than what was intended) where the prevailing view is that “Obamacare” is socialized medicine. The previous state government administration was passively opposed, and at times actively opposed, to the ACA and subsequently the establishment of the marketplace.

In October 2013, DHSS Commissioner Bill Streur said the state was taking its time choosing whether to expand Medicaid<sup>iv</sup> for fear of burdening future generations with “a stupid decision.” Streur has said the state was examining a proposal by Arkansas to buy insurance plans using Medicaid expansion funds,<sup>v</sup> which would cover low-income patients without expanding Medicaid itself. A month later, then Governor Parnell publically rejected Medicaid expansion on cost grounds, calling the proposal in its current state a “hot mess.”<sup>vi</sup> Characterizing himself as “responsible for all Alaskans,” Parnell said he was unwilling to attach the state's citizens to what he characterized as a “failing Obamacare system.”

*“Federal dollars are enticing but not free,” Parnell said.*

At that time, Senate Majority Leader John Coghill (R-Anchorage) said he approved of Parnell's decision.

*“Considering the failure of the Affordable Care Act, the Governor is wise to refuse Medicaid expansion at this time,” Coghill said. “It’s a matter of dollars and cents –America can’t afford it. They don’t have the money to pay for this and they’ll take it from future generations.”*

On July 16, 2015 current Alaska Governor Bill Walker sent a letter to the Alaska Legislative Budget and Audit Committee (LB&A Committee), a committee of the Alaska State Legislature, giving members the required forty-five day notice of his intention to accept additional federal and Mental Health Trust Authority money to expand Medicaid in Alaska.

In a prepared statement and subsequent press conference, Governor Walker said, “thousands of Alaskans and more than 150 organizations including chambers of Commerce, hospitals and local governments have been waiting long enough for Medicaid expansion. It’s time to expand Medicaid so thousands of our friends, coworkers, neighbors and family members don’t have to make the choice between health care and bankruptcy.”

In response to Governor Walker’s request, the LB&A Committee can do one of three things within the forty-five day period: recommend that the state accept the federal and Mental Health Trust Authority money as outlined in the Governor’s letter; recommend the state not accept the money; or provide no response. Additionally, during the forty-five day period, the legislature could call itself into a special session to address Medicaid expansion.

The Governor suggested in public statements since July 16, 2015 that he intended to accept these monies regardless of the legislature’s decision.<sup>vii</sup> In August, the legislative council sued the governor in an attempt to block the expansion, but the judge ruled in the governor’s favor, and Medicaid was expanded on September 1, 2015.<sup>viii</sup>

*The role of navigators was not clearly defined or too narrowly defined*

According to the policy expert, insurance carrier, and provider, the navigators did not have the time or opportunity to develop a trusting relationship with a potential enrollee, thus increasing the likelihood that the person would enroll and be confident about their decision. Navigators were also cautioned against being a broker or agent and making a recommendation regarding the “best plan”. Walking this fine line between these two competing perspectives made it difficult for navigators to effectively do their jobs. Another important factor was the creation of “Enroll



Alaska,” an arm of a for-profit benefits group designed to proactively conduct outreach and engage prospective enrollees. This may have caused some role confusion for the navigators.

#### *Rural markets and poorly designed market structure*

According to the CMS Effectuated Enrollment snapshot Alaska has a total enrollment of 18,320 and a (subsidized) APTC enrollment of 16,583 (90.5 percent). The number of prospective participants in the marketplace varied, but Kaiser estimated the number of potential marketplace enrollees in 2014 to be approximately 84,000.<sup>ix</sup>

Many state residents are Alaska Native (seventeen percent of the population) or military, also employed with the state or large organizations offering group insurance. Although the Indian Health Service (IHS) is an important funder of services for Alaska Native people, it does not adequately cover the true costs of care – thus necessitating the importance of signing people up for Medicaid and health insurance through the marketplace.

In most areas of Alaska (particularly the rural or frontier regions) there is usually only one health care provider. Without provider competition, there has been limited managed care penetration in Alaska. There are no HMOs, PPOs or ACOs per se. There are some managed care strategies, such as limiting the kind and amount of care driven by diagnosis. There are a limited number of provider networks, primarily for primary care practitioners. Specialists for the most part have not chosen to join these networks nor are they being forced to join these networks. They appear to be taking a “wait and see” approach. Additionally, the Alaska Native population has little knowledge or ability to work within the primary care environment, relying on emergency departments for their health care. For those in a hub community or a rural community, the only option is the Alaska Native health clinic.

### **5. Analysis of Marketplace Conditions in Selected Sites**

The costs associated with health care in the state are rising for a number of reasons:

1. Risk profile (diabetes, heart disease, cancer, substance abuse)
2. Geographic distribution and isolation
3. Clinical network structure not well integrated
4. Costs of technology (gamma knife)

It is too early to see if and how the marketplace can bend the curve, but these rising costs will make it difficult for more carriers to enter the marketplace.

Alaska did not experience enrollee attrition from 2014 to 2015. In fact, according to the Kaiser Family Foundation website there was a sixty-five percent increase in enrollees from one year to the next (12,890 in 2014 to 21,260 in 2015). In spite of this increase there is some concern the number may decrease in 2016 due to individuals opting for the tax penalty rather than paying the premiums and cost sharing.

## **6. Potential Remedies and Other Considerations for Enhancing Marketplace Competition**

1. Improve recruitment through branding and integration of navigators with partners like insurers, community health centers and hospitals. The navigator specifically mentioned co-locating a navigator at a local hospital, resulting in several enrollees signing up for coverage while they were in the hospital seeking care. The navigator also suggested increasing the use of Alaska 211. Alaska 211 is a one stop resource for connecting individuals and families to a wide variety of vital resources in the community (such as emergency food and shelter, disability services, counseling, senior services, etc.). Their website encourages visitors to use the site for access to information about the Health Insurance Marketplace in Alaska including questions about 2015 coverage. They also offer free ACA education and assistance sessions.
2. Invest in improving the population's health through preventive health services. Healthier people will drive down costs over time.
3. Bring all relevant stakeholders to the table, including payers, regulators, insurers and providers. Because of the fragmented nature of the Alaskan health insurance landscape, any effort to reduce health care costs should incorporate the viewpoints of Alaska's diverse stakeholder groups (which include Alaska Native tribal leaders). Higher health care costs equal higher insurance premiums, which lead to fewer people signing up for health insurance. The current fee for service system does little to reduce costs, but it is unclear what types of payment and health care model reforms would even be possible to implement in Alaska. Stakeholder conversations can bring to light some of these answers.
4. Consider whether the marketplace model even works in a state with a small, geographically dispersed population, with the fastest growing senior population, with limited provider and insurer competition and the third highest per capita health care expenditures in the nation.<sup>x</sup>

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- <sup>ix</sup> Kaiser State Health Facts, “Marketplace enrollment as a share of the potential marketplace population, April 2014,” accessed September 25, 2015, <http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2014/>
- <sup>x</sup> Kaiser State Health Facts, “Health care expenditures per capita by state of residence,” 2009, accessed September 25, 2015, <http://kff.org/other/state-indicator/health-spending-per-capita/>

## Appendix C: Florida State Memo

### Submitted by

Patricia Born

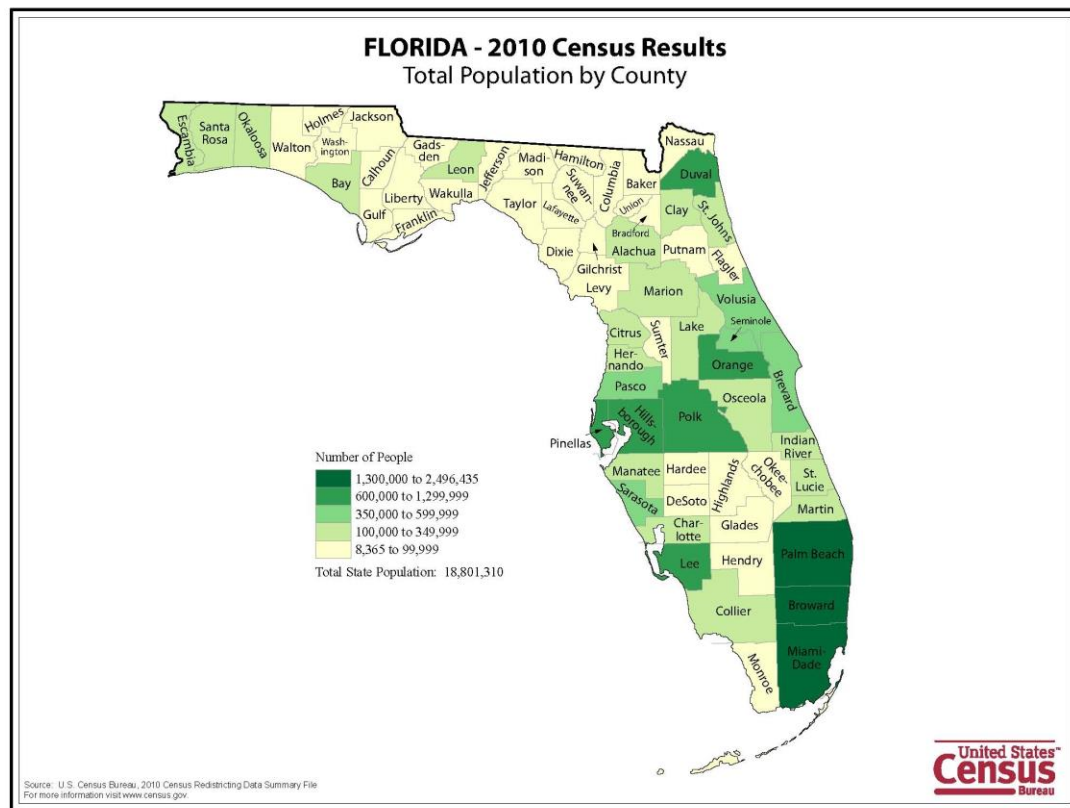
### 1. State Context

With a population of 19.9 million, Florida ranks third in the U.S. in size. It merits study for several reasons. Most importantly, the population is very diverse in terms of race and ethnicity, age, and income levels. This diversity may present challenges for the state in providing solutions to meet the specific needs of these groups. It also has the most rating areas, at 67. Basic facts about Florida are presented in Table C.1.1 and the population density is shown in Figure C.1.1 in the map that follows.

**Table C.1.1 Basic Facts**

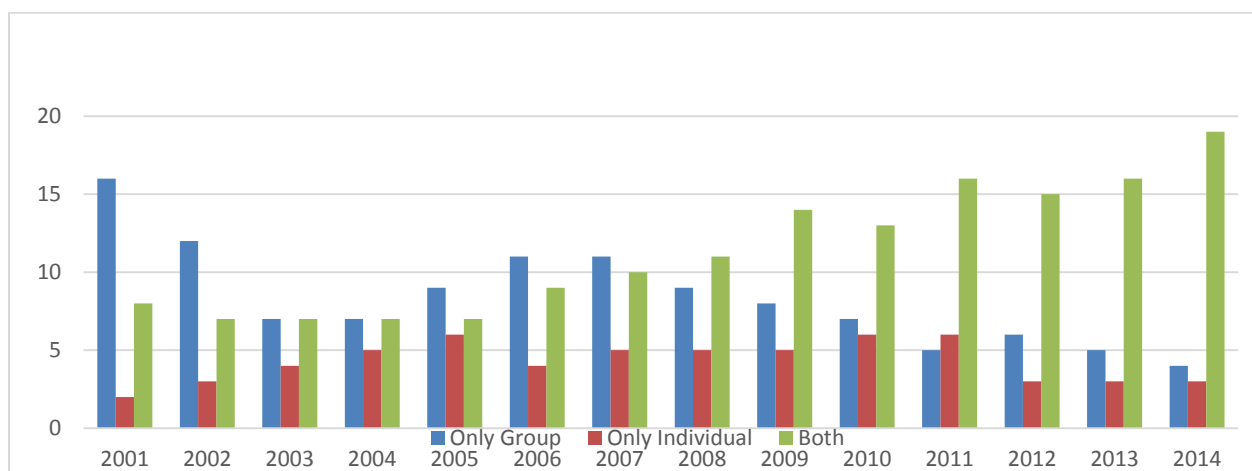
<b>Demographic Characteristics</b>	
Race	Race: 59% White, 22% Hispanic, and 15% Black
Ethnicity	Population foreign-born: 19%; 91% are U.S. citizens. English as a second language: 28% of the population.
Age	Population over 65: 18% of total
Median State Household Income and Rank <sup>i</sup>	\$47,106. Rank 39 <sup>th</sup> in US (2011-2013)
Percent in Poverty and Rank <sup>ii</sup>	16.5%; Rank 35 <sup>th</sup> highest poverty rate in US (2014)
Percent Uninsured and Rank <sup>iii</sup>	19%; Rank 2 <sup>nd</sup> highest in US (tied with Arizona) (2013)
State Population and Rank <sup>iv</sup>	19,379,400. Rank 4 <sup>th</sup> in US (2013)
<b>Political Climate and Insurance Regulatory System</b>	
Governor	Rick Scott, Republican, first elected 2010, reelected 2014.
Legislative party control	House and Senate: Republican, since 1996.
Insurance Commissioner	Kevin McCarty, Appointed in 2003.
<b>Health Insurance Climate</b>	
Percent of Private Sector Establishments that Offer Health Insurance	42.7% vs. 49.9% overall US
Health Spending per Capita <sup>v</sup>	\$7,156; 18 <sup>th</sup> highest in US (2009)
Medicaid Spending per Capita <sup>vi</sup>	\$4,434; 48 <sup>th</sup> in US (2011)
Population Health Ranking <sup>vii</sup>	32 <sup>nd</sup> out of 50 (2014)
Other Salient Health Policy Information	Florida has 52 health insurance mandates.
<b>Basic Exchange Characteristics</b>	
Type of exchange	Federally-facilitated marketplace (FFM)
Enrollees in the exchange	983,775 (2014); 1.6 million (2015)
Expansion of Medicaid	No
Number of rating areas	67 (rating area = county)
Premiums	Increase from 2014 to 2015: 7% on average

**Figure C.1.1 Population Density in Florida, 2010<sup>viii</sup>**



The number of health insurers participating in the Florida market has changed significantly over the past 14 years. Figure C.1.2 illustrates the number of insurers writing group coverage, individual coverage, or both by year, for the period 2001-2014.

**Figure C.1.2 Number of Commercial Health Insurers Operating in Florida, 2001-2014<sup>ix</sup>**



The figure shows two notable trends. First, the figure illustrates a decline in the number of insurers participating in the early 2000s. Efforts by the state regulator to control rising health insurance premiums involved capping premium increases which led to a number of insurer exits. Restrictions on premium rate increases were subsequently relaxed, and beginning in 2007, the figure shows an increasing number of commercial insurers participating in the individual market.

Florida was the lead plaintiff in a lawsuit in 2012 that sought to declare part of the ACA unconstitutional. At that time, Governor Rick Scott also announced that Florida would not attempt to implement a state-based exchange. Previously, the state had attempted to establish its own version of an online health insurance marketplace, called Florida Health Choices. It had 49 enrollees in 2014 and in 2015 currently has 80 paying customers. These customers do not qualify for any subsidies. Despite resistance to the ACA, the experience in Florida has been remarkable. Enrollment in the first year was 983,775, and grew to 1.6 million in the second year (2015). Over 90 percent of the enrollees received financial assistance. Table C.1.2 presents additional statistics for the enrollees in the first year.

**Table C.1.2 Florida Exchange Enrollment Characteristics, 2014<sup>x</sup>**

<b>By Gender: Number % of Total</b>	<b>By Financial Assistance Status: Number, % of Total</b>
Female 538,130 - 55%	With Financial Assistance 893,655 - 91%
Male 445,349 - 45%	Without Financial Assistance 90,120 - 9%
Subtotal With Known Data 983,479 - 100%	Subtotal With Known Data 983,775 - 100%
<b>By Age: Number % of Total</b>	<b>By Metal Level: Number % of Total</b>
Age < 18 43,226 - 4%	Bronze 128,632 - 13%
Age 18-25 123,363 - 13%	Silver 722,696 73%
Age 26-34 142,662 - 15%	Gold 54,694 - 6%
Age 35-44 179,028 - 18%	Platinum 67,212 - 7%
Age 45-54 248,623 - 25%	Catastrophic 15,102 - 2%
Age 55-64 240,028 - 24%	Subtotal With Known Data 983,775 - 100%
Age ≥65 6,844 1%	
Subtotal With Known Data 983,774 100%	

For the 2014 plan year, Floridians had a range of ACA-compliant plan options available at all metal levels both on and off the Federal Exchange. While 11 insurers participated in the marketplace, availability was constrained in smaller, rural counties. In 21 of the total 67 counties, only one insurer participated in the exchange, offering between 7 and 31 different plans. Insurer offerings of PPACA-compliant plans off the Exchange (1,522) were nearly five times as many as offerings of on-Exchange plans (352).<sup>xi</sup> In 21 counties, only one company offered a PPACA-compliant health insurance plan; across all 67 counties, a minimum of six plans were available in the individual market and 38 in the small group market. Table C.1.3 lists the licensed insurers participating in the FFM for the 2014 and 2015 plan years.

**Table C.1.3. Licensed Insurers Participating in the Florida FFM<sup>xii</sup>**

<b>2014 Plan Year (11)</b>	<b>2015 Plan Year (14)</b>
Aetna Life Insurance Company	Aetna Life Insurance Company
Blue Cross Blue Shield Of Florida	Blue Cross Blue Shield of Florida
Cigna Health And Life Insurance Company	Cigna Health And Life Insurance Company
Coventry Health Care Of Florida	Coventry Health Care of Florida
Florida Health Care Plan, Inc.	Florida Health Care Plan, Inc.
Health First Insurance Company PPO	Health First Health Plans
Health Options, Inc.	Health First Insurance Company
Humana Medical Plan, Inc.	Health Options, Inc.
Molina Healthcare of Florida, Inc.	Humana Medical Plan, Inc.
Preferred Medical Plan	Molina Healthcare of Florida, Inc.
Sunshine State Health Plan, Inc.	Preferred Medical Plan
	Sunshine State Health Plan, Inc.
	Time Insurance Company
	UnitedHealthcare of Florida
No. of Health Insurers in FL operating off-exchange only: 13	No. of Health Insurers in FL operating off-exchange only: 12

## 2. State Study Area and Rationale

The first rating area chosen for this assessment is Leon County, located in the Panhandle of the state and bordering Georgia. The second two areas are Miami-Dade County and Monroe County. These two areas cover the tip of the Florida peninsula. Figure C.2.1 presents the 67 rating areas (counties) in Florida.

**Figure C.2.1 Map of Rating Areas (Counties) in Florida<sup>xiii</sup>**



When Florida chose to let the federal government operate a health insurance exchange in the state, the Florida Office of Insurance Regulation opted to use counties as rating areas. There are 67 counties, and hence 67 rating areas in the state. For this project we collected some state-wide information and more specific information collected from stakeholders in three rating areas: Leon County, Miami-Dade County, and Monroe County.



Justifications for selecting these areas follow:

- **Leon County.** Leon County was selected because it is a small market. It has 281,845 residents; 186,411 (66%) live in Tallahassee. Tallahassee is the largest city in Leon County, and provides a good representation of a small market in Florida. The state capital, Tallahassee's resident population includes a large proportion of government workers including legislators, who have an interest in accessing quality health care services. The population also includes a large proportion of college students who have insurance coverage through their parents' plans.

The population of Leon County has a median age of 29 and the median household income is \$46,369. Population density is 421.8 persons/sq. mile. Fifty-nine percent of the population is white, non-Hispanic and 29.9 percent is black, non-Hispanic. The remaining population (8.5) is Hispanic, Latino or Asian. Approximately 10% of Leon County residents are supported by Medicaid.

- **Miami-Dade County.** Miami-Dade County has 2.66 million residents; 417,650 (16%) live in Miami.

This rating area currently ties two other counties (Broward and Palm Beach) for having the most plans participating compared to all other Florida counties except for two with an equal number of plans participating (37). The area has a diverse demographic profile based on incomes, ethnicity, age, and includes many retirees but also many young professionals or recent graduates who are no longer covered by their parents and will be forced to look into enrolling in an ACA plan.

The population of Miami-Dade has a median age of 38 and the median household (family) income is \$40,260. The population of downtown Miami has been growing and is continuing to grow, increasing 68 percent from 2000 to 2010, and an additional 21 percent between 2010 and 2014 (estimated). Currently, more than 50 percent of the downtown Miami population is now between 20 and 44 years old.<sup>xiv</sup> In 2004, only 22 percent of the county's adult population had at least a bachelor's degree. Approximately 19% of Miami-Dade County residents are supported by Medicaid.

- **Monroe County.** Monroe County has approximately 73,090 residents; 24,649 (34%) live in Key West.

This area was chosen because it is adjacent to Miami-Dade County, but differs significantly from Miami-Dade in terms of participation by insurers (3) and the number of plans offered (10). It is also significantly more "rural", in that the population density is 19.6/sq. mile compared to 1,315/sq. mile in Miami-Dade. Further, health care premiums on the FFM for Florida Keys residents are the highest in the state. The average premium for a 40 year old is nearly \$100 more than the premium paid in the neighboring Miami-Dade County (\$450 vs. \$358 in 2015).

The population of Key West has a median age of 41 and the median household (family) income is \$57,246. Roughly 17% of Key West's population consists of long term residents that have lived in their homes for more than 5 years, while 23% of Key West's population have moved in the last year. Approximately 8.5% of Monroe County residents are supported by Medicaid.

### 3. Data Collection Methods

#### Selection and Recruitment Process

Information for this report contains information collected from experts representing the various stakeholders in the health insurance marketplace.<sup>xv</sup> Most of the experts we had discussions with were identified through conversations with health policy contacts across the state and through contacts at state associations of health plans, providers, and agents. Additional experts were identified through internet searches and conversations with experts already identified. Contact lists for each category of expert and for each rating area were then formed.

Experts in all categories were contacted either by phone call or email, depending on the familiarity of the individual. For the latter group, a form email was sent that outlined the basic goal of the study and provided details on our confidentiality procedures. One contact declined to participate due to confidentiality concerns. All discussions were conducted by phone in June 2015.

#### Discussions

16 discussions were conducted. Table C.3.1 summarizes the experts we held discussions with, by category, and describes the general experience of these experts in the rating areas studied. Discussions lasted from 20 to 90 minutes.

**Table C.3.1 Florida Expert Participants**

Category	Number of Participants	Collective Areas of Experience
Regulators	2	Statewide
Policy Expert	1	Statewide
Agents/Brokers	4	Leon, Miami-Dade, Monroe, Broward
Navigators	2	Statewide
Insurers	5	Statewide
Providers	2	Leon, Miami-Dade, Monroe
TOTAL	16	

Of the insurers, three of the five representatives were from insurers with significant participation in the exchange (i.e., statewide or nearly statewide). One representative was from a plan that does not participate at all, and one represented an insurer that participates in only a few select rating areas.

The topic areas covered with insurers, regulators, and policy experts were:

- 1) Factors driving insurer participation in the commercial market
- 2) Competitiveness in the commercial market
- 3) Factors driving insurer participation in the exchanges
- 4) Competitiveness in the exchanges
- 5) Strategies for maintaining competitiveness [insurers]
- 6) Rate filings on and off the exchange
- 7) Establishment of provider networks for exchange products
- 8) Role of state regulator in the operation/monitoring of exchange activities
- 9) Consumer complaints regarding the exchange (costs, accessibility, etc.)

The topics areas covered with agents, navigators, and providers were:

- 1) Choice of insurance products available on and off the exchange
- 2) Notable changes in insurance market structure
- 3) Provider network scope and accessibility
- 4) Consumer complaints regarding the exchange (costs, accessibility, etc.)
- 5) Impact of state laws or regulations on exchange performance
- 6) Strategies for maintaining competitiveness [agents, providers]

## **4. Findings of Marketplace Conditions**

### *Insurer Participation and Regulatory Environment*

As noted in Section 1, the Florida health insurance market in the early 2000s was vibrant, with many insurers (20+), which included many regional carriers. According to the brokers, a period of rate suppression in the early-mid 2000s started driving plans out of the state. Over time, plans reentered the market as they were allowed to charge more adequate rates. The regulators now seem to take a hands-off approach; the regulators did not have any current initiatives in the works for increasing the insurer presence in the state. Rather, the regulators agreed it was important to refrain from making any significant changes to Florida insurance regulations at this time, given the tumult of changes insurers are facing with the ACA.

According to the insurer experts, their decision to participate in the exchange in any particular rating area has largely depended on their existing coverage in that area. Before the implementation of the exchange, few insurers were operating statewide for their commercial business. When the exchange went online in 2014, only one insurer, Blue Cross and Blue Shield of Florida (Florida Blue), offered a plan in every rating area. The next two largest commercial players – Aetna and UnitedHealthcare – were active across the state for their commercial business, but joined the exchange only in select rating areas. Florida Blue was the only insurer participating in Leon County in the first year. When UnitedHealthcare joined in 2015, they offered plans with a narrow network.

Another important factor driving insurer participation is the extent to which they participate in Medicaid. The largest Medicaid plans in the state, Staywell Healthplan (WellCare), Amerigroup Florida, and Prestige Health, do not participate on the exchange. Nonetheless, one broker in Monroe County suggested that some plans providing Medicaid coverage (e.g., Sunshine State,

Molina and Humana) may have joined the exchange as a defensive move, so that they can maintain enrollments as the enrollees make the transition back and forth from Medicaid. Insurers with a large book of business in the small group and individual markets had a similarly strong incentive to participate, e.g., to transition employees from small groups to the exchange. BCBS-FL has the largest share of the individual market in Florida, followed by Humana and Coventry. These plans all have a large presence in the exchange.

Florida exchange consumers have a choice of plans in every rating area, but there is significantly more choice in the more populated areas. In 2015, there are at least two insurers participating in every rating area, offering between 7 and 31 plans. Table C.4.1 shows the market shares of the top insurers in five rating areas: the two areas in which the top insurer has the highest and lowest market shares, and the three selected for further study. These data indicate substantial variation in competitiveness across the state, but also confirm that while no insurer operates as a monopoly in any rating area, some counties are dominated by one insurer (e.g., Gulf County).

**Table C.4.1 Market Share of Top Insurer in Highest, Lowest, and Selected Rating Areas in Florida<sup>xvi</sup>**

Rating Area	County Name	Number of Issuers	Largest Market Share
FL017	Flagler	6	33.62%
FL043	Miami-Dade	9	47.88%
FL044	Monroe	3	49.23%
FL036	Leon	3	56.33%
FL022	Gulf	3	90.91%

The insurer experts explained that they have made active choices to participate in the market in a specific way. For example, they may not price attractively for the bronze market – they actively chose not to go after this – rather they go after silver and platinum members. The experts agreed that this is a strategy that helps in provider negotiations: providers are more willing to deal with plans that have lower cost sharing because it suggests a higher certainty of payment. Florida Blue, for example, is known for being more expensive. Currently >70% of their exchange business is in silver plans, 10-15% in platinum, and a small percentage in gold. The insurer representatives agreed that populations with lower cost sharing are also more attractive to hospitals – lower cost sharing means less potential bad debt.

#### *Interactions with provider market*

Insurer sources indicated that one of the most important factors driving their participation in the exchange is their ability to provide a cost-effective network of providers to their enrollees.

Existing plans have generally hung their exchange products off their existing networks. In some cases insurers have introduced narrow networks, i.e., networks of providers that have been tailored to reduce limit access to particular providers. The insurer representatives indicated that they have not generally expanded their networks unless necessary. However, they continue to have conversations with other systems.

There is a much larger concentration of hospitals in Miami-Dade County (approximately thirty-seven), compared to the relatively more sparse concentrations in Leon and Monroe Counties (five and four respectively).<sup>xvii</sup>

According to the insurers and physicians we talked to, the Florida health care market is characterized by significant consolidation among health care providers. They note that incentives to consolidate to achieve economies of scale have existed for some time now, and that the ACA provided yet another set of reasons for physicians and hospitals to form larger networks. One new concern stems from the uncertainty of coverage for exchange enrollees, e.g., a patient appears to have coverage for a specific service or provider; but then the services are provided, and then it appears there was no coverage.

### *Prices and enrollment*

Another important challenge cited by the insurers stems from the demographics of the rating area. First, there must be an adequate number of eligible individuals. Insurer representatives expressed the challenge in developing rates for each county in Florida for both their on- and off-exchange business. They need to have favorable costs relative to other competitors in order to operate in an area. The carrier's biggest challenge of going on the exchange is estimating its risk. Estimating this risk was easier for the larger carriers that were already operating statewide. Smaller carriers have less experience to draw from, putting them at a disadvantage when it comes to establishing rates, not only for rating areas in which they have never operated, but also for areas in which they may have more limited experience compared to the large plans. Thus, some smaller carriers have recently merged. Some of these carriers have continued using the original plan name (e.g., Coventry Health is now owned by Aetna), and enrollees in those plans now have access to a much larger network of providers.

**Table C.4.2 Comparison of Exchange Experience, 2013-2014**

<b>Exchange Experience - Comparison</b>	<b>Leon</b>	<b>Miami-Dade</b>	<b>Monroe</b>
Enrollment <sup>xviii</sup>	10,983	392,231	6,844
Percentage Point Drop in Uninsured 2013-2014 <sup>xix</sup>	5%	9%	9%
2015 Average Premium for 27 year old – Silver Plan <sup>xx</sup>	280.49	293.97	369.76

The insurers we talked to are competing to get products onto the exchange at a good price, but some plans have either underestimated, or have purposely been overly competitive with rates to pick up market share. The standardization of plans leads exchange consumers to make insurance choices almost solely based on price. This, in turn, has made plans very cautious about letting rate information out, according to the insurance and experts and regulators. They agreed that success of the exchange requires plans to attract an adequate number of enrollees, but one consequence of pricing too low is getting flooded with enrollees. Preferred Medical Plan in South Florida received more than double the number of enrollees they were expecting, and has

recently stopped accepting any new applications, since their network of providers was overwhelmed.<sup>xxi</sup>

Plans in Florida filed for rate approvals on May 15. Table C.4.3 shows that plans who have filed rate changes are seeking double-digit increases for 2016. No new plans have filed to participate on the exchange for 2016; it is not yet clear if existing participants are planning to expand into new rating areas for new yet. It is not likely that rates will settle any time soon – plans have really just have one full year on which to base experience.

One of the navigators noted that a law blocks the insurance commissioner’s office from activities that would protect consumers, especially as it comes to reviewing rates. This law includes language that requires insurers who increase rates to itemize how various parts of the ACA are responsible for the rate increase: “The dollar amount of the premium which is attributable to the impact of guaranteed issuance of coverage. This estimate must include, but is not required to itemize, the impact of the requirement that rates be based on factors unrelated to health status, how the individual coverage mandate and subsidies provided in the health insurance exchange established in this state pursuant to PPACA affect the impact of guaranteed issuance of coverage, and estimated reinsurance credits.” [Florida Law Ch. 2013-101, Section 647.410]

**Table 4.3 Requested Rate Changes in Florida, May 2015<sup>xxii</sup>**

<b>Company Name</b>	<b>Product Name</b>	<b>Requested Rate Increase</b>
Aetna Health Inc.	Aetna HMO – Individual – 18628FL007	17.78%
	Aetna HMO – Individual – 18628FL011	17.50%
	Aetna HMO- On Exchange– Individual – 18628FL012	21.22%
Cigna Health and Life Insurance Company	FL_IND_Local Plus – Individual – 48121FL002	12.82%
Coventry Health Care of Florida, Inc.	CoventryOne Carelink Exchange HMO – Individual – 57451FL007	16.06%
	CoventryOne Carelink HMO – Individual – 57451FL009	15.30%
	CoventryOne HMO – Individual – 57451FL010	18.12%
Preferred Medical Plan, Inc.	Exchange Plans – Individual – 51398FL065	14.50%
UnitedHealthcare Life Insurance Company	2015 Off Exchange – Individual – 17341FL017	31.28%
UnitedHealthcare of FL, Inc.	Compass – Individual – 68398FL003	18.19%

\* Note: all increases were submitted between 5/5/2015 - 5/27/15 for a 1/1/2016 effective date

The Leon County health insurance market is dominated by Blue Cross and Blue Shield of Florida (Florida Blue) and Capital Health Plan, a locally-based HMO affiliate of BCBS-FL.<sup>xxiii</sup> These plans dominate the group market and face/respond to a variety of influences including the large base of state government employees and additional political influence from the Florida legislature, given their location. Although legislators will generally purchase an insurance product in their home districts, the regulators we talked to suggested that the legislature puts some pressure on the quality of health services in Tallahassee. Tallahassee is also home for many

students who are covered on their parents' plans, and thus using services in Tallahassee, but not necessarily seeking coverage from area plans. A broker operating in Leon County indicated that once the government employees and students are accounted for, there is not much activity in Leon County on the individual side, and thus expects demand in the area for exchange coverage is low.

CHP is not currently participating in the exchange and has no plans to participate in 2016. The insurance experts and brokers indicated that CHP has very strong ties to the provider community, and hence might be able to provide coverage on the exchange at a competitive price. The other major insurer in the rating area, Florida Blue, has participated in the exchange in all rating areas for 2014 and 2015, and plans to continue in 2016. They were the only plan in some counties initially, so there was no competition in those markets. In some markets, this put pressure on providers to take Florida Blue Contracts. The insurance executives confirmed that in Monroe and Leon Counties, if providers did not take ACA business, they lost all of their (off-exchange) Florida Blue contracts.

Insurers currently participating on the exchange in Leon County, and number of products are shown in Table C.4.4. The table suggests there is a variety of plan types, not only with different cost sharing levels (metal types), but different network provisions. Assurant offered a range of PPO plans, but has announced that it will not participate in the exchange in 2016.

**Table C.4.4 Insurers Participating in Leon County and Number of Products, 2015<sup>xxiv</sup>**

<b>Carrier</b>	<b>Bronze</b>	<b>Silver</b>	<b>Gold</b>	<b>Platinum</b>
Assurant	2 - PPO	2 - PPO	1 - PPO	1 - PPO
UnitedHealthcare	2 - HMO	2 - HMO	2 - HMO	1 - HMO
Florida Blue	1 - EPO 1 - HMO	3 - EPO	1 - EPO	3 - EPO

Florida Blue contracts with 60,000 providers across the state, and operates HMOs that the experts suggested look more like PPOs (referred to as EPOs). The insurer cut its exchange product portfolio in half since 2014 because some plans offered initially did not pick up an adequate number of enrollees.

The insurance experts noted that, on average, the Blue Options plans provided by Florida Blue are priced \$50 more than the plans offered by UnitedHealthcare. However, Florida Blue did not lose many people during renewals. The insurance experts confirmed that Florida Blue prices on anticipated margin: their strategy is to never price below cost, so they tend to get undercut. The number of competitors does not drive plan's pricing. Rather, pricing depends on competition in the provider networks (hospital system, PCPs, specialists). The plan maintains three provider networks and lets provider behavior drive costs, i.e., if a consumer wants provider choice they

pay more. There are two main hospitals in Leon County: Tallahassee Memorial Hospital and UHC Capital Regional Medical Center.

Providers indicate that there is little to no negotiating with health insurers in Tallahassee. Capital Health Plan, which does not participate in the exchange, has half of the market. Providers join their network out of necessity.

In 2014, Florida Blue was the only plan in Florida panhandle participating in the exchange. In 2015, both UnitedHealthcare & Assurant entered. As noted above, Assurant has already announced that it will be out of the exchange for 2016. Florida Blue requires exclusive agreement with brokers but only for individual products. UnitedHealthcare and Humana (off-exchange) don't require exclusive agreements. Florida Blue generally compensates health providers at a lower rate than CHP, and continues to have a hard time getting a foothold in Tallahassee. According to the experts, Aetna, Cigna, Humana have been unable to get into the Tallahassee market because they have never had a network in the area.

The UnitedHealthcare plans in Leon County are HMOs with a very limited choice of providers. However, the plans picked up a significant number of enrollees in 2015 because they were cheaper than Florida Blue. The brokers and navigators indicated that many enrollees who signed up with UnitedHealthcare were not happy with the limited network. These consumers may have been deceived by the generally huge network that UnitedHealthcare maintains for their off-exchange products. The Florida Blue exchange plans, i.e., Blue Options, offer the same provider network as the Florida Blue off-exchange products.

There are two main hospitals in the county. Tallahassee Memorial Hospital is the fourth largest employer in the area, and Capital Regional Medical Center is the 11th largest. The insurance experts and brokers noted that hospitals prefer to rely less on disproportionate share revenue and county special tax assessments and more on FFS rates or gain-share/percent of premium risk deals that ACA plans might provide. Both hospitals have put more physicians on the payroll. The physicians we talked to suggested that their colleagues have been willing to take employment because they have become tired of running a practice and handling complicated billings, the collections, and employment practices. Compliance with mandates relating to patient privacy and electronic records became expensive. The hospital can give them a place to practice, without having to run a business.

Consolidation of providers in Tallahassee has been specialty dependent. For example, oncologists in Tallahassee joined FL Cancer, and urologists joined a statewide group made up of 1000s of urologists. These providers may have better bargaining power, but some prefer to keep their autonomy. The physicians have so far avoided major consolidation, but noted that their contracts with CHP are the main source of business, and they are currently happy with their arrangements. Florida Blue does not pay as much, but the physicians did not report any problems with their arrangements either. One broker mentioned that UnitedHealthcare is having difficulty providing more than a narrow network in the County and that it is likely they have had trouble negotiating with the area hospitals and health care providers.

Independent practices are struggling to maintain their autonomy and remain participating in the plans' networks. Some providers in Leon County are part of a specialty co-operative that can



assist them in negotiating some practice issues, such as health benefits for their own employees. However, they are legally restrained from using this organization for getting better reimbursements from plans.

The enrollment experience in Miami-Dade has been phenomenal. Over 750,000 consumers joined the exchange in the first year. These enrollees have access to a large number of providers and several large hospitals. The county was the first area in Florida to establish an accountable care organization (ACO), formed by the state's largest health insurer, the county's most prosperous hospital system and an oncology group of 38 doctors practicing at 17 locations.

Miami-Dade County is characterized by a large population and a large number of plans from which to choose from. Note that although the product sets are rather uniform across insurers, underlying networks are dramatically different from carrier to carrier. Insurers currently participating on the exchange in Miami-Dade County, and number of products, are shown below in Table C.4.5.

**Table C.4.5 Insurers Participating in Miami-Dade County and Number of Products<sup>xxv</sup>**

<b>Carrier</b>	<b>Bronze</b>	<b>Silver</b>	<b>Gold</b>	<b>Platinum</b>
Ambetter from Sunshine Health	12 - HMO	15 - HMO	6 - HMO	
Assurant Health	2 - PPO	2 - PPO	1 - PPO	1 - PPO
Cigna Healthcare	2 - PPO	5 - PPO	2 - PPO	
Coventry Health	2 - HMO	2 - HMO	1 - HMO	
Florida Blue	4 - EPO	6 - EPO	2 - EPO	6 - EPO
Florida Blue HMO	2 - HMO	3 - HMO	1 - HMO	2 - HMO
Humana Medical Plan	2 - HMO	1 - HMO	1 - HMO	1 - HMO
Molina Marketplace	1 - HMO	4 - HMO	1 - HMO	

The plans in Miami-Dade County have a large number of providers with which to negotiate, and many of these are quite large. For example, Baptist Health Care is a network of providers that operates 7 hospitals in Miami-Dade and Monroe counties. Large networks such as this can make collaborative agreements with one plan, resulting in some smaller plans getting bullied out. AvMed---which participates in the exchange in several other counties and provided coverage in the Miami-Dade exchange in 2014---chose to discontinue participation in this market due to its smaller size, although insurance executives confirmed that it is doing well off exchange with individual and group policies.

Preferred Medical Plan, which has historically developed a strong clinic-based network, has stopped accepting exchange enrollees in Miami-Dade County. They severely undercut the rates to get market share and, consequently, their delivery system was overwhelmed. Molina also priced aggressively low to compete with Preferred.

Two factors affect the competitiveness of the market in Monroe County. First, the County has a small provider network. Monroe County has three main hospital groups, which are located at significant distances from each other along the keys. The geographic dispersion of this small population generally requires that a plan negotiate participation from all three hospitals in order to guarantee coverage for enrollees across the rating area. In addition to the small provider network, health insurance plans are staying out of Monroe County simply due to the size of the county. The population is too small to support a large presence of insurers. Therefore, it is almost impossible to offer an HMO plan. Currently, three carriers participate in the Monroe County exchange and offer the plans shown in Table C.4.6.

**Table 4.6 Plans Offered in Monroe County, by Plan<sup>xxvi</sup>**

<b>Carrier</b>	<b>Bronze</b>	<b>Silver</b>	<b>Gold</b>	<b>Platinum</b>
Assurant	2 - PPO	2 - PPO	1 - PPO	1 – PPO
Cigna Healthcare	2 - PPO	5 - PPO	2 – PPO	
Florida Blue	2 - EPO	3 - EPO	1 - EPO	3 - EPO

Premiums for exchange coverage in Monroe County are much higher than the other rating areas assessed above. The brokers indicated that this is largely due to the scarcity of the providers and hospitals. They also noted that the county has an unusually large population of drinkers and smokers. It is notable that other health insurers are doing commercial business in the county, but they have stayed off the exchange. In our discussions, these insurers indicated that it was largely because it is not where they want to put their marketing power, given the small return (in terms of attracting enrollment).

## **5. Analysis of Marketplace Conditions in Selected Sites**

Florida has more enrollees in its exchange than any other state, with 1.6 million enrolled. A majority of these enrollees – 1.28 million – receive subsidies. Insurer participation statewide is good, but competition varies significantly across rating areas. In some areas, only two insurers participate and one insurer dominates the market. Initial experience suggests that insurers did not price adequately and therefore will remain in the exchanges only if they can increase rates: five insurers operating in the Florida health insurance market have requested rate double-digit increases ranging from 14.5% to 31.3% for 2016.

Given the demographic makeup of the populations, exchange enrollment in Leon County is not expected to be as high as in other more populated counties in Florida. A representative physician

practicing in Tallahassee sees approximately 45-50% CHP, 15-20% BCBS, then Medicaid, and then exchange patients.

Tallahassee doctors have noted that patients with exchange coverage are seeking less care, and they are getting asked more frequently if they can provide a discount on their services. This is due to a larger number of enrollees with high deductibles, who either can't afford to, or don't want to pay for services out of pocket. More generally, getting insurance is not equal to getting care. Doctors also note that several free clinics that were set up in Leon County have historically been underutilized.

Miami-Dade county experienced dramatic enrollment when the exchange first opened in 2014, with a large population getting insurance for the first time. The year two growth was similarly impressive. Many of these enrollees accessed the marketplace with the help of a navigator. There are several organizations in the Miami-Dade area that provide navigator services which include telephone support for applicants and insurance literacy seminars.

At the same time, the brokers indicated that independent health insurance agents are practically gone from this market. Most agents and brokers have consolidated. Success in this market now requires that they make a year's business in the 3 months of open enrollment. Brokers report earning only one-third of what they were making previously in selling health insurance in the small group and individual markets. Professional brokers have been replaced by part time brokers who spend the rest of the year on other work. Brokers who are heavily involved in other lines of business have not seen as much of a hit on their income, in some cases because in addition to helping to transition employees to the exchange, they write other coverages for their small group clients.

Enrollment in Monroe County exchange is low, but that is not surprising given the size of the population. Brokers selling health insurance in Monroe County are generally diversified, providing other coverages to small businesses. Thus, broker attrition rate due to the implementation of ACA has been very low. As in other areas, brokers are forced to provide more education to their clients about how the health insurance market works, including explaining how subsidization and/or penalties work. Migration of clients from small group plans to the exchange is income driven, and many times a customer that is eligible for a subsidy on the exchange will forego this opportunity to stay out of "Obamacare."

The navigators pointed to several operational challenges as well. For many consumers, e.g., the Cuban population in South Florida, this is the first time they've been offered health insurance. Navigators have spent a lot of time on education throughout the state. One foundation reported that 44 percent of the people they helped to enroll spoke a language other than English as their primary language.

Florida has a large elderly population including early retirees in the late fifties and early sixties, who are not yet eligible for Medicare. Early retirees can buy insurance on the exchange, but complain that it is still too expensive, and they are often not eligible for the subsidies because their incomes are too high. On the other hand, older people who are eligible *are* getting a bigger subsidy than younger people. It is not surprising, then, that the average age in the exchange is higher than predicted.

The uniform rating concept may be especially problematic. Risk adjustment across counties should be a zero-sum game, but one of the health insurance experts was concerned that the risk scores will not correlate with actual costs, and it is not clear yet how much adjustment will occur from county to county. Plans need to pick a target population to design right network/services, and these populations vary significantly across counties.

## **6. Possible Remedies to Enhance Marketplace Competition**

The discussants did not have any specific suggestions for enhancing marketplace competition. Competition in Miami-Dade County – one of the largest counties in the state – is robust, and enrollment has been remarkable. To date, the navigators in Florida have received much of the credit for Florida’s exchange experience, and they continue to innovate. The navigators were positive about the workings of the exchange in Florida – especially in Miami-Dade and the Tampa area – and noted that they were still forming collaborations with community groups across the state. They confirmed that they have seen less activity in Leon and Monroe Counties, and suggested it might be due to the smaller populations in those areas.<sup>xxvii</sup> The navigators at University of South Florida, recipients of one of the federal grants to support navigators, have developed a unique approach to providing assistance across the state. Specifically, they have generated a “heat map” to show, by zip code, outreach and enrollment activities.

The regulators note that there are no problematic rating areas in the state, but some plans are experiencing more problems than the others.<sup>xxviii</sup> Problems with implementation have been resolved, but ongoing program problems include documents getting lost. Renewals were also a problem last fall, as consumers were not prepared for the additional paperwork. Since Florida has not expanded Medicaid, there are a significant number of people in the “gap”. The Kaiser Foundation reported that 18% of those in the coverage gap (nationally) reside in Florida. One Florida navigator admitted that two-thirds of the people she worked with did not qualify for the exchange subsidies because they were below the lower limit. All she could do was qualify them for a tax exemption.

As noted previously, many of the discussants commented on the regulatory uncertainty which discourages health insurance carriers from participating in the exchange. This regulatory uncertainty hurts the small plans the most because they can’t prepare for all possible scenarios. It also has a further consequence of encouraging health providers to consolidate to achieve greater negotiating power. Meanwhile, Florida regulations pertaining to health insurance have not changed for a while. Insurance experts and the brokers agreed that the state mandated benefits should be reviewed, as they exceed the federally mandated benefits, and are adding to the overall cost of the plans. Most discussants also agreed that while expanding Medicaid will cause an additional disruption in the market, they would support this for the benefit of the individuals now in the “gap.” As plans get more experienced with the population in the exchange, all of the stakeholders concurred that the number of participating plans and enrollment would increase.

## References and Endnotes for Appendix C

- <sup>i</sup> Kaiser Family Foundation, “State Health Facts –Florida: Categories and Indicators,” estimates based on the United States Census Bureau, accessed September 24, 2015, <http://kff.org/statedata/>.
- <sup>ii</sup> United States Census Bureau, “Florida – 2014 Poverty Status in the Past 12 Months by Sex by Age,” accessed September 24, 2015, [http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_14\\_1YR\\_B17001&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_B17001&prodType=table).
- <sup>iii</sup> Kaiser Family Foundation, “State Health Facts –Florida: Categories and Indicators,” estimates based on the United States Census Bureau, accessed September 24, 2015, <http://kff.org/statedata/>.
- <sup>iv</sup> Ibid.
- <sup>v</sup> Ibid.
- <sup>vi</sup> Ibid.
- <sup>vii</sup> UnitedHealthcare Foundation, “America’s Health Rankings,” 2014, accessed July 20, 2014, <http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas%20Health%20Rankings%202014%20Edition.pdf>.
- <sup>viii</sup> United States Census Bureau, “Florida – 2010 Census Results, Total Population by County,” accessed July 20, 2015, <https://www.census.gov/2010census/news/releases/operations/cb11-cn95.html>.
- <sup>ix</sup> Data obtained from insurers’ annual statutory filings, National Association of Insurance Commissioners, 2014.
- <sup>x</sup> ASPE/HHE Health Enrollment reports.
- <sup>xi</sup> Florida Office of Insurance Regulation, “Annual Report, 2014,” accessed July 20, 2015, <http://www.floir.com/siteDocuments/2014AnnualReport.pdf>.
- <sup>xii</sup> Healthcare.gov, “Health and dental plan datasets for researchers and issuers,” accessed July 20, 2015, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.
- <sup>xiii</sup> Geology.com, “Florida County Map with County Seat Cities,” Geology.com, accessed July 21, 2015, <http://geology.com/county-map/florida.shtml>.
- <sup>xiv</sup> M. Disare, “For young professionals in Miami, it’s a hard road to travel around town,” Miami-Herald, July 20, 2014, accessed July 20, 2015, <http://www.miamiherald.com/news/local/community/miami-dade/article1976301.html>.
- <sup>xv</sup> The information collected via discussions was corroborated and enhanced with additional information obtained through internet searches of major Florida newspapers and health policy websites for relevant information.
- <sup>xvi</sup> The market share data were provided by ASPE, June 29, 2015.
- <sup>xvii</sup> Florida Hospital Association, “Hospital Directory,” FHA, accessed July 27, 2015, <http://www.fha.org/reports-and-resources/hospital-directory.aspx>.
- <sup>xviii</sup> Enroll America, “Marketplace Enrollment Maps,” accessed July 20, 2015, <https://www.enrollamerica.org/research-maps/maps/marketplace-enrollment-maps/>.
- <sup>xix</sup> Enroll America, “Changes in Uninsured Rates by County,” accessed July 20, 2015, <https://www.enrollamerica.org/research-maps/maps/changes-in-uninsured-rates-by-county/>.
- <sup>xx</sup> Researcher analysis of data from Healthcare.gov, “2015 Health plan information for individuals and families,” accessed July 20, 2015, <https://www.healthcare.gov/health-plan-information-2015/>.
- <sup>xxi</sup> In June 2015, Molina Healthcare of Florida, Inc., entered into a definitive agreement to acquire certain assets of Preferred Providers’ Medicaid business in Florida.
- <sup>xxii</sup> HealthCare.gov, “Rate Review,” accessed July 21, 2015, <https://ratereview.healthcare.gov/#search>.
- <sup>xxiii</sup> CHP has an affiliation agreement with Blue Cross and Blue Shield of Florida, Inc. which gives BCBSF majority control of the corporate membership of CHP. The affiliation agreement provides that CHP may receive administrative services from BCBSF and commits BCBSF to loan CHP operating funds, if necessary.
- <sup>xxiv</sup> HealthCare.gov, “See 2015 health insurance plans and prices,” accessed July 21, 2015, <https://www.healthcare.gov/see-plans/>.
- <sup>xxv</sup> HealthCare.gov, “See 2015 health insurance plans and prices,” accessed July 21, 2015, <https://www.healthcare.gov/see-plans/>.

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<sup>xxvi</sup> HealthCare.gov, “See 2015 health insurance plans and prices,” accessed July 21, 2015, <https://www.healthcare.gov/see-plans/>.

<sup>xxvii</sup> While not required in the ACA, Florida state law requires fingerprinting and background checks for anyone who wants to serve as a navigator. The navigators suggested that this poses a challenge for rural areas that may have difficulty performing fingerprinting and background checks because the costs may be prohibitive.

<sup>xxviii</sup> Florida has an odd set up in that consumer services (complaints) is in the Department of Financial Services, while the state’s Office of Insurance Regulation is responsible for regulating the activities of insurers in the state. The two divisions reportedly communicate frequently, but this division could delay action when problems arise.

## Appendix D: Kansa State Memo

### Submitted by

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### 1. State Context

#### *About Kansas*

With a population of 2.9 million, over half of Kansas' 105 counties are designated as rural or frontier and only 16 have urban or semi-urban status.<sup>i</sup>

Most of the population identifies as non-Hispanic White (greater than 77 percent). Hispanics are the largest minority with about 11 percent of Kansans identifying as Hispanic or Latino, followed by approximately six percent identifying as African American. Slightly less than 90 percent of Kansas adults age 25 and older have a high school degree or higher, and approximately 30 percent have a bachelor's degree or higher. Kansas is performing slightly better than the nation in these measures, as the national averages are at 86 and 29 percent, respectively. Fourteen percent of the Kansas population lives in poverty, compared to approximately 16 percent nationwide.<sup>ii</sup>

Currently, Kansas ranks near the middle of the country (27th) in terms of overall health, according to the 2014 America's Health Rankings, presented by the United Health Foundation. In terms of children in poverty, cardiovascular deaths, diabetes, infant mortality and premature death, Kansas ranks near the middle. Additionally, Kansas ranks 35th in terms of primary care physician-to-population ratio.<sup>iii</sup>

In general, counties in Southeast Kansas (e.g., Montgomery, Labette, Neosho) have consistently struggled economically and have poorer health than other parts of the state. Additionally, some counties in Western Kansas also experience poorer health (e.g., Finney, Ford, Hamilton). According to the 2015 County Health Rankings, these counties rank lower in health outcomes (premature death, poor or fair health, poor physical and mental health days and low birthweight) and factors (rates of smoking and obesity, percentage of uninsured, availability of physicians and mental health providers, low high school graduation rates and income inequality, and air pollution and housing problems).<sup>iv</sup>

Generally, the more populous and prosperous north-eastern and south-central regions of the state tend to have lower uninsured rates than the more rural, western areas. However, more than half (52.5 percent) of uninsured Kansans younger than age 65 live in one of the five largest counties (Douglas, Johnson, Sedgwick, Shawnee or Wyandotte).<sup>v</sup>

See Table D.1.1, below, for key facts about Kansas and its Federally Facilitated marketplace (FFM).

**Table D.1.1: Basic State Facts**

Type of Exchange	Federally-facilitated marketplace (FFM)
Expansion of Medicaid	No
Number of rating areas	7
Number of FFM insurers for 2015 plan year	5
Net change in number of insurers for 2015	Increased from 4 to 5 for 2015
State Population and Rank <sup>vi</sup>	2,840,600; Rank: 34 <sup>th</sup> in US
Median State Household Income and Rank <sup>vii</sup>	\$49,804; Rank: 32 <sup>nd</sup> in US
Salient Health Facts (e.g. Regions with concentrations of certain conditions, or with particularly concentrated poor health status)	<p>America's Health Ranking: 27th in overall health compared to other states</p> <p>Percent uninsured in Kansas (2013): 12.3%</p> <p>Percent Kansans in Poverty (2013): 14.0%</p> <p>County Health Rankings: Southeast Kansas counties consistently rank worse than other parts of the state due to health outcomes (e.g., premature death, poor or fair health, poor mental health days) and health factors (e.g., smoking, adult obesity, access to healthy foods, physical inactivity).</p>
Salient Health Policy Information (e.g. Previous reform initiatives and relevant health-insurance policies and requirements, notable insurance regulations)	Although Kansas is technically a “file and use” state, K.S.A. 40-2215 authorizes the Kansas Insurance Department to review and approve policy forms and premium rates for health insurance plans marketed in the State before they are available for sale to consumers.

### *The Kansas health insurance market*

Governor Sam Brownback has been an opponent of the Affordable Care Act (ACA) since before its passage, voting against it as a U.S. senator, and has continued in his opposition since



becoming Governor of Kansas in 2010. As a result, Kansas has a federally facilitated marketplace (FFM) and has not expanded its Medicaid program as called for in the ACA, which has created an “eligibility gap” for Kansans who earn too little to qualify for premium tax credits and too much to qualify for Medicaid. According to Kansas Health Institute (KHI) estimates, there are approximately 182,000 Kansans in the eligibility gap, and all are age 19–64. While 43.0 percent of Kansans in the eligibility gap have no health insurance, the remaining 57.0 percent are currently insured. However, if Medicaid is expanded, some in the eligibility gap who are insured may choose to switch to Medicaid.

The Kansas Insurance Department (KID) provides plan management services for the FFM but the state is not an official FFM “partner” with the federal government. In Kansas, the insurance commissioner is an independently elected statewide official and is not appointed by the governor. Former insurance commissioner Sandy Praeger, a moderate Republican who retired from office in January 2015, worked collaboratively with former Kansas governor Kathleen Sebelius (Democrat) on various health reform issues, and supported implementation of the ACA. During Praeger’s time at KID with Brownback as governor, she was central to the state’s discussions and decisions about the implementation of the ACA and the operation of the marketplace.

In November 2014, Kansas elected Ken Selzer (Republican) as its new insurance commissioner. During the campaign, Selzer indicated that he favored more competition in the Kansas insurance market, stating, “More competition in difficult lines of insurance will benefit all Kansans. We will work hard to make the Kansas regulatory environment more beneficial to consumers, protecting them where needed and encouraging companies to build their business in Kansas.”<sup>viii</sup> Like Governor Brownback, Commissioner Selzer is critical of the ACA and opposes Medicaid expansion.

Three health insurers share a majority of the individual and small group markets in Kansas - Blue Cross Blue Shield of Kansas (BCBS Kansas), Coventry/Aetna and Blue Cross Blue Shield of Kansas City (BCBS Kansas City).<sup>ix</sup> BCBS Kansas operates in 103 Kansas counties and BCBS Kansas City covers the remaining two along the Kansas/Missouri border. A number of other insurers, including UnitedHealthcare and Humana, also operate in the state.

BCBS Kansas is the predominant insurer in the Kansas FFM, followed by Coventry (a subsidiary of Aetna) and BCBS Kansas City. Please see Section 4 for detailed findings and analysis related to the Kansas FFM.

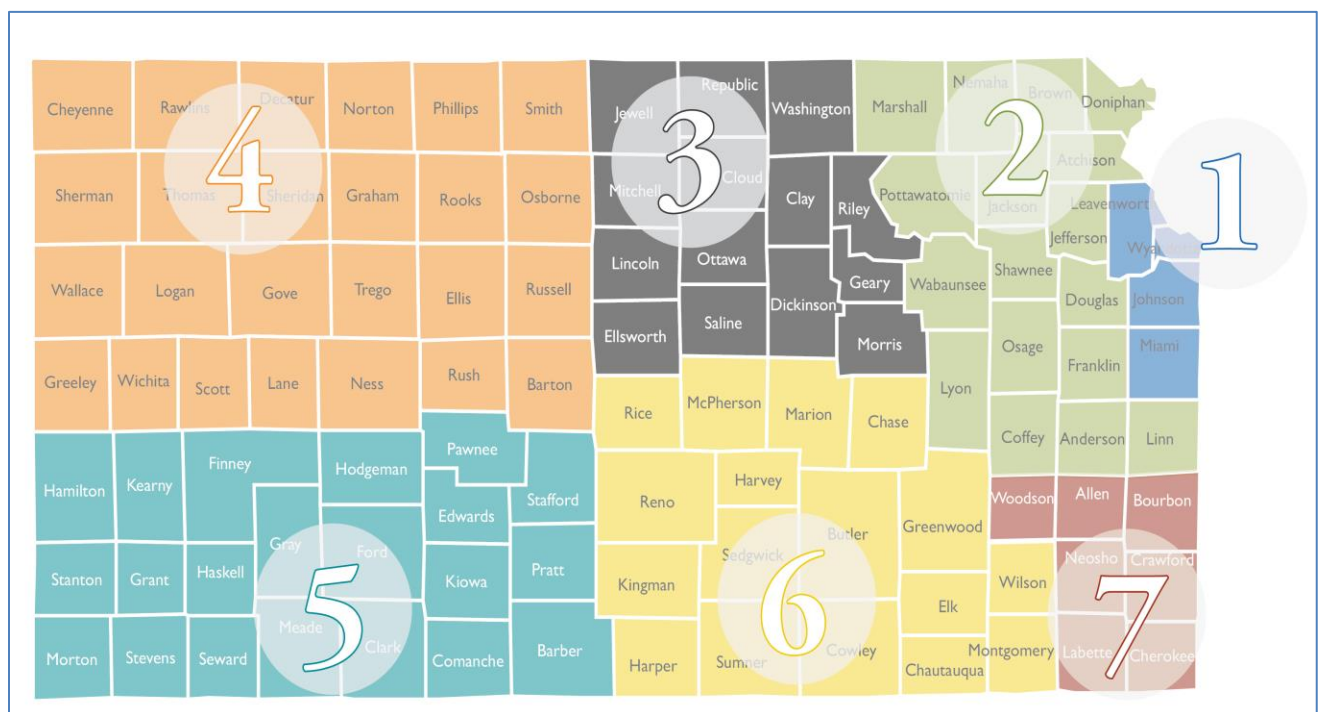
## 2. State Study Area and Rationale

Kansas' 105 counties are divided into seven rating areas, and individuals and families in all seven areas have 24-34 health plans to choose from. The two insurers offering coverage in Johnson and Wyandotte counties<sup>10</sup>, BCBS Kansas City and Coventry Health and Life, did not offer platinum or catastrophic plans for the 2015 plan year. The vast majority of plans offered in Kansas are Preferred Provider Organization (PPOs) plans. A limited number of Point of Service (POS) and Health Maintenance Organization (HMO) plans are available.

Although plan choice in the Kansas City metro area differs slightly from the rest of the state, the number and distribution of metal level plans offered are consistent across rating areas. Every county in Kansas has at least 24 plans available for individuals and families to purchase, with a minimum of two different insurers offering coverage in each county. Thus, the Kansas team decided to study the state as a whole, while recognizing there are differences in choice within the Kansas City rating area.<sup>x</sup>

Please see the map below for the location of rating areas in Kansas.

### Kansas Rating Areas



<sup>10</sup> These two counties cover the state's second largest metropolitan area; Johnson County has the highest per capita income in the state.

**Table D.2.1: Rationale for Selecting the State of Kansas**

<b>Rating Areas:</b>	<b>Rationale</b>
The state of Kansas as a whole	Plan offerings are consistent across rating areas, both in number of plans and benefit levels, with the exception of Rating Area 1 where no Platinum or Catastrophic plans are offered.

### **3. Data Collection Methods**

During June 2015 the Kansas state team conducted 11 key informant discussions with health insurance experts, including insurers, former regulators, health policy experts, hospitals, agents/brokers, and navigators. Key informants were selected to ensure inclusion of diverse viewpoints. For example, the team selected agents and brokers who sell plans on the marketplace and those who do not. Rural and urban hospitals were also selected in order to capture a range of perspectives. The Kansas team also accessed expert information by drawing upon past and present partnerships and collaboration.

Discussions were conducted by 2-3 team members in person and in some cases, over the phone, as some of the key informants were located a considerable distance from KHI's location in Topeka, Kansas. Discussions lasted on average one hour, but ranged from about 45-90 minutes long. The discussions were semi-structured in nature, meaning that the team asked a standard set of questions, but they were tailored to informants through follow-up or clarification questions as necessary. The discussion protocols were also tailored to each type of informant in order to capitalize on specific expertise of each sector.

All discussions were voluntary and confidential. Key informants were given the opportunity to skip questions or sections of the discussion, but none did so. Every discussion followed the same general structure, which is outlined below:

1. Key informants were given an informed consent which outlined the discussion protocols and included a confidentiality agreement and consent to record the discussion.
2. The discussion leader provided the informants with background information on the project and answered any questions before beginning the discussion.
3. A set of standard questions was asked according to expert type (i.e. one set for insurers, regulators, and so on). More detailed questions were asked of participants based on their specific expertise.
4. General question topics covered are presented by expert type in Table 3.1, page 7.

### *Analysis*

Key informant discussions were kept confidential and access was limited to the staff involved in the discussion process. To ensure confidentiality, all discussion records were kept in a secure project folder. During discussions, one team member asked questions while the others took notes. Following each discussion, the Kansas team discussed their perceptions and combined notes to ensure consistency in results. To analyze the information, the Kansas team used inductive coding to identify common themes in discussion responses. The team also used recordings to verify accuracy of the information presented. The analysis presented in this report has been prepared in the aggregate according to expert type in order to maintain the confidentiality of the participants.

Please see Table D.3.1 for details regarding the overall sample of key informants.

**Table D.3.1: Kansas Key Informants**

<b>Expert Type</b>	<b>Number Recruited/ Attempted</b>	<b>Number of Participants</b>	<b>Description of Informants</b>	<b>Topic Areas Discussed</b>
Insurer	5	1	Operates on and off the Kansas FFM	General perceptions of competition in the Kansas health insurance market; service area; market share; customer relations and enrollment; provider networks; potential challenges and solutions to competition
Regulator	5	2	Former high level officials with the Kansas Insurance Department	General perceptions of competition in the Kansas health insurance market; overall Kansas insurance market and marketplace; customer relations and enrollment; provider networks; regulation in the Kansas insurance market; potential challenges and solutions to competition
Health Policy Expert	1	1	Expert with significant health policy background and experience who has educated consumers across the state.	General perceptions of competition in the Kansas health insurance market; customer relations and enrollment; regulation in the Kansas insurance market; potential challenges and solutions to competition
Hospital	3	3	Rural and urban providers in different areas of the state.	General perceptions of competition in the Kansas health insurance market; service area; market share; customer relations and enrollment; provider networks; relationship with insurers
Agent/Broker	3	3	A mix of those who sell insurance on and off the Kansas FFM. All sell insurance throughout the state.	General perceptions of competition in the Kansas health insurance market; service area; experience in the Kansas insurance market; customer relations and enrollment; provider networks; regulation in the Kansas insurance market
Navigator	1	1	Director of organization that has been the recipient of a federal navigator grant for the past two years and has engaged in marketplace enrollment assistance, education and outreach for the Kansas FFM.	General perceptions of competition in the Kansas health insurance market; service area; provider networks; customer relations and enrollment

## 4. Findings and Analysis of Marketplace Conditions

### *Insurer Participation and Competition in the Kansas FFM*

Although there are technically five insurance companies offering health plans on the Kansas marketplace for 2015, Kansas only has two insurers. Three of the insurance companies are Blue Cross Blue Shield companies and two are Coventry/Aetna companies. Kansans were able to choose from 82 plans— 64 for individuals and families and 18 for small businesses offered by BCBS Kansas, Coventry Health Care of Kansas, Coventry Health and Life Insurance, BCBS Kansas City, and BlueCross BlueShield Kansas Solutions, Inc. (a subsidiary of BCBS Kansas and a new insurer for 2015).<sup>xi</sup> Please see Table D.4.1 for a description of available plans by metal tier. The former insurance regulators noted they believe the creation of this new BCBS company, which offers HMO products, may have been a response to competitively priced products offered by Coventry Health Care of Kansas in 2014.

**Table D.4.1: Plans Available in the Kansas Marketplace, 2015 Plan Year<sup>11</sup>**

Individuals and Families	Total Number of Plans	Plan Type	Number of Plans
	64	Bronze	20
		Silver	29
		Gold	11
		Platinum	2
		Catastrophic	2
Small Businesses	18	Bronze	6
		Silver	7
		Gold	5

As noted in the literature review, a small number of insurers in a marketplace may be an indicator of insufficient competition. However, Kansas experts were mixed on whether they believed the Kansas FFM was or was not sufficiently competitive.

Hospital officials and agents/brokers believed that competition was limited, as BCBS Kansas has more than 40 percent of the market share in the overall Kansas health insurance market and a majority of the market share in the marketplace. In Kansas, the company is even more dominant in some of the rural parts of the state. One hospital representative noted that BCBS Kansas holds such a large percentage of the rural market share that competition is nearly non-existent in those areas. In addition, the company's dominance makes it difficult for rural providers to negotiate reimbursement rates and the limited competition in the hospital's area impacts its ability to achieve a higher rating on its bonds.

However, others believe there is sufficient competition in the marketplace because, although there are few insurers, there is plenty of choice in terms of plans and benefit packages available to consumers, and competition is fierce between the companies offering coverage on the marketplace. A representative from an insurer selling on the Kansas FFM stated that premiums

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<sup>11</sup> Source: KHI analysis of 2015 marketplace data provided by the Kansas Insurance Department

in Kansas are competitive compared to other states, if not better, even though there are only a few carriers. The former insurance regulators reiterated this point, explaining that because the population is small, it drives the number of carriers. They stated that in the Kansas marketplace there are good choices and a number of plans and it may not matter how many insurance companies are there. They believe that as long as consumers have access to health care at an affordable premium, the market is successful.

All informants noted that consumers shopping on the marketplace choose their plans based mainly on price rather than provider networks or other factors. During the 2014 open enrollment period insurance regulators were concerned that one company aggressively priced their products to increase their market share. Informants stated that although many customers initially chose lower-priced plans, some consumers were not satisfied with customer service and switched to different coverage during the 2015 open enrollment period. Informants consistently stated that being competitive on price and providing excellent customer service is key to being successful in the Kansas marketplace.

As mentioned above, consumers usually chose their coverage based on price over other factors like provider networks and benefit packages. Table D.4.2 shows the 2015 average premiums by plan type for a 27-year-old Kansan.<sup>xii</sup> On average, premiums for plans on the marketplace changed very little between 2014 and 2015 (the average premium across all plans increased 0.1 percent).<sup>xiii</sup>

**Table D.4.2: Average Premiums for a Single Person, Age 27, by Rating Area, 2015 Plan Year<sup>12</sup>**

Rating Area	Average Premium (Kansan, Age 27)	Total Average Premium (Kansan, Age 27)
1	\$206.09	\$203.80
2	\$200.00	
3	\$198.65	
4	\$219.60	
5	\$210.51	
6	\$194.33	
7	\$197.40	

Most informants noted that for the 2016 plan year, insurers have submitted rate filings for premium increases of 30-40 percent. Since approved rate increases may ultimately be lower than these filed rates, it is not yet clear how they will impact enrollment or consumer satisfaction with both the insurers and the marketplace.

Informants also stated that for Plan Year 2016, UnitedHealthcare is expected to offer insurance plans on the Kansas FFM. They speculate that the company may have postponed entering the Kansas marketplace to allow other companies to assume the risk of previously uninsured customers with pent-up demand for high-cost services who likely purchased coverage during the first two years of marketplace operation.

<sup>12</sup> Note: See map above for information about rating areas in Kansas.

All informants agreed that BCBS Kansas' dominant position in the Kansas market is due to the company's name recognition, quality plans with broad provider networks and excellent customer service. Informants repeatedly stated that in order for any company to increase its market share in Kansas, it would need to provide competitively priced, high quality products and as good or better customer service than BCBS Kansas. In particular, in the rural parts of the state where there are a limited number of health care providers, any new insurer attempting to enter the Kansas market will likely encounter difficulty entering into favorable reimbursement contracts with providers if the insurer, with little or no market share, is unable to assure the providers that they will have a substantial number of potential patients.

### *Enrollment in the Kansas FFM*

For Plan Year 2014, there were an estimated 298,000 potential marketplace enrollees in Kansas, but only 57,013 (19.1 percent) selected a plan. Despite the conservative political environment in Kansas, enrollment grew significantly for 2015 to 96,197 enrollees. Of the total number of those that enrolled, approximately half were new consumers.<sup>xiv</sup>

Informants stated they believe the Kansas marketplace is performing well in terms of enrollment. Former insurance regulators attributed this success, in part, to Insureks.org, a public website KID created in fall 2013 to help Kansans become more informed about the options available to them on the marketplace. Informants stated that with the difficult rollout of healthcare.gov in 2014, KID's website was very popular with consumers, navigators and agents who were seeking information about plans and rates and attempting to determine tax credit eligibility. During 2015 open enrollment the website was primarily used by navigators and agents, who found it to be a helpful and easy-to-use resource when assisting consumers with reviewing plans and choosing insurance coverage before they went to healthcare.gov to enroll.

Although enrollment increased significantly from 2014 to 2015, there are still a large number of uninsured Kansans who have not enrolled. Many of these individuals are likely to be eligible for premium tax credits. The most cited reason for failure to enroll was that shopping for health insurance is extremely complicated, even for those who have had it in the past. Several informants noted that consumers who may have previously obtained health insurance through their employers were not used to having a choice of health plans, benefits or provider networks and were not adequately prepared to make these choices if they moved to individual coverage offered through the marketplace. Individuals who have never been insured were completely unprepared and lack the knowledge to make informed decisions when faced with a large number of health plan choices with complex benefit and cost-sharing structures.

Agents who previously sold coverage through the marketplace indicated they are no longer willing to do so because the complexity and time required to assist consumers far outweighs the financial rewards of selling plans on the marketplace. As a result of the ACA's medical loss ratio requirements, many insurance companies have reduced the commissions they previously paid to agents who sold their products. In addition, it is also important to note that BCBS Kansas does not contract with independent agents and brokers, so they receive no commission when customers select a BCBS Kansas plan.

A health policy expert stated that choosing from 20 to 30 plans is overwhelming and harmful for consumers. This informant suggested it would be better for consumers if there was more



regulation to control the number of plans and to ensure meaningful differences between the plans offered on the marketplace.

Informants identified these and other potential barriers to enrollment:

- Lack of health insurance literacy and resulting confusion when shopping on the marketplace;
- Younger Kansans believe they are healthy and would rather pay the penalty for not having health insurance than pay for premiums;
- Even with tax subsidies, some Kansans determine that health insurance premiums are not affordable for their families;
- Some Kansans are philosophically or politically opposed to the ACA and do not want to participate in the marketplace; and
- Hospitals in Kansas do not require patients to have health insurance and continue to provide services to the uninsured.

#### *Provider networks*

Prior to 2014, most insurers operating in Kansas were offering health plans with broad provider networks throughout the state. However, beginning in 2014, the first year of marketplace operation, Kansas insurance regulators began to see the use of narrow networks in some marketplace plans.

Most informants noted that while some plans on the Kansas marketplace offer narrow provider networks, there are also an abundance of plans with broad networks. However, they also believe narrow networks are a concern in Kansas and agreed that since most consumers who purchase coverage on the marketplace do so based on price, this often results in confusion and concern when they subsequently realize providers they have used or wish to use are not “in-network” for the plan they purchased. In order to address this issue, they repeatedly called for more education and outreach by insurance companies and those who assist consumers to help them understand how provider networks play a role in their coverage.

Consumer advocates and health care providers are most concerned about the use of narrow provider networks to control costs for marketplace plans. In 2014, Kansas news organizations reported that in Johnson and Wyandotte Counties, BCBS Kansas City offered several plans with narrow provider networks — including just seven of the area hospitals in their networks, rather than the nineteen area hospitals typically covered by this insurer. Coventry Health and Life’s network did not include one or more hospitals operated by a major hospital system in the Kansas City metropolitan area.<sup>xv</sup>

The state’s largest insurer, BCBS Kansas, has broad provider networks for the majority of its products but its new subsidiary, BlueCross BlueShield Kansas Solutions, offered products for 2015 with a network that includes only providers located within the 103 counties served by BCBS Kansas. This limited network provides no benefits if insureds seek services from providers located outside of the 103 county area, which includes the state’s academic medical

center and providers located in states adjacent to the Kansas border. As a result of this new entrant into the Kansas marketplace the cost of the second-lowest-cost silver (benchmark) plan decreased in some parts of the state, which resulted in a reduction in the premium tax credit for individuals purchasing those plans.

In 2014, Coventry Health Care of Kansas offered POS plans in 23 Kansas counties, which generally had more restrictive provider networks than PPO plans. In the counties where they were offered, these plans had the lowest premiums of all available plans.<sup>xvi</sup>

It will be important to examine how many enrollees select plans with limited provider networks and to assess whether they are well-received by consumers. At this time, it is unclear whether data on the number of enrollees by plan type are available.

### *Regulatory framework in Kansas*

In order to offer plans in the Kansas FFM, insurers must comply with the same regulatory requirements applicable to doing business in the broader Kansas health insurance market. The former insurance regulators explained that all companies must file their health plan policy forms and rates, advertising and communication materials and strategy, along with required explanatory and justification documentation, with KID before the plans can be marketed in the state. From the date of filing, KID has at least 30 days to review and approve the submitted rates and forms. However, this review period often extends beyond 30 days if KID staff have questions about the filing and insurers are asked to submit additional documentation or clarification of documentation already submitted. The informants stated that under Kansas law, proposed premium rates increases can only be denied if they are unreasonable, excessive or unfairly discriminatory and the denial has to be based on sound actuarial science. Insurers doing business in Kansas are familiar with KID's regulatory process and do not market and sell their plans until the rates and forms are officially approved by KID. The former regulators stated that historically, KID's overall goal has been to ensure that Kansans have access to good quality products with adequate but reasonable premiums.

Since Kansas has a federal marketplace, informants did not identify or suggest any potential state-based policy or regulatory changes that could be made to increase competition in the marketplace. In general, agents and brokers were satisfied with the regulatory framework in Kansas, but mentioned it can be cumbersome for insurers to gain approval for some types of products. For example, agents noted that the requirement for advance approval of rates and forms process seems to take longer in Kansas than in other states. However, they also acknowledged that the Kansas process has consistently ensured the availability of quality products offered by strong, reliable insurers.

In March 2014, KID announced that it would allow Kansas insurers to take advantage of the extended federal transitional policy announced by the Obama Administration. Under this policy insurers could continue to renew certain individual and small group non-grandfathered plans with policy years beginning on or before October 1, 2016. The former regulators stated that most of the major insurers in the state took advantage of the federal transitional policy and made this option available to their enrollees, particularly in the small group market. Agent/broker informants indicated that many small employers, particularly those with young or healthier

employees, elected to renew their non-grandfathered plans and therefore did not join the risk pool of enrollees in ACA compliant plans.

As stated above, insurers have submitted rate filings for premium increases of 30-40 percent for the 2016 plan year. The former regulators stated these increases were expected and predictable. Premium rates for 2014 and 2015 were developed by insurers based on their best estimates of the number and type of enrollees who would purchase coverage beginning in 2014, and the claims expenses they would incur for this unknown population. In the absence of real data, insurers attempted to set premium rates to cover estimated costs, but also competitively priced their plans to appeal to potential new enrollees.

For 2014, insurer informants reported that a significant number of Kansans who enrolled in coverage through the marketplace were older and less healthy than the general population. The insurers also found that in many cases, these new enrollees had significant, previously unmet health care needs for which they sought care during 2014. In addition, since the individual mandate tax penalty for failing to purchase coverage was relatively low for 2014, younger, healthier individuals elected to stay out of the insurance market.<sup>xvii</sup>

When preparing their rate filings for the 2016 plan year which were submitted in May 2015, the insurers had at least one full year of enrollment and claims experience with this new population of enrollees that they could use to establish and justify premium rates for 2016. The KID staff responsible for review and approval of insurer rate filings will be instrumental in determining whether the enrollment and claims expenses experienced by Kansas insurers during the first year of the marketplace support the premium rates proposed by the companies.

The former insurance regulators stated that for 2017 and beyond, they anticipate that premium rates will level out over time as pent-up demand for high cost services is fulfilled and younger, healthier individuals enter the market as the tax penalty increases each year. For states like Kansas where insurance regulators are statutorily charged with ensuring that insurers use premium rates that are adequate, but reasonable, the companies will look for appropriate ways to manage costs and stabilize rates.

## **5. Potential Remedies to Enhance Marketplace Competition**

### *Insurer participation*

While agent/broker and hospital informants expressed concerns about the low number of insurers operating in the Kansas marketplace, and the overall Kansas health insurance market, they were unable to identify any specific regulatory changes that could be made to increase the number of insurers operating in the market. Informants freely acknowledge that Blue Cross Blue Shield Kansas' dominance in the market is the result of the company's long-standing reputation for offering high quality health plans, with broad provider networks, and excellent customer service. All informants agreed that companies attempting to increase their market share or to enter the Kansas market would have to offer high quality, competitively priced products and also consistently provide as good or better customer service than BCBS Kansas. Given the company's well established place in the market and its ability to enter into provider contracts with very favorable terms, due to its large market share, this is likely a significant deterrent to new companies entering the market and offering plans in the marketplace.

One former insurance department official noted that premium rates in Kansas are very reasonable as compared to many other markets. Those rates are attributable, in part, to the competitive provider contracts that some companies operating in Kansas are able to secure because they control significant shares of the insured market and are able to offer providers access to large numbers of insured patients. The former official suggested that if the number of Kansas insureds was spread more thinly among a greater number of insurers, they might not be able to negotiate those competitive provider contracts, which would negatively impact costs and premiums.

#### *Consider simplifying the regulatory approval process*

Agents and brokers indicated they have heard from insurers operating in the state that KID's approval process for policy forms and premium rates can take longer than what is experienced in other states. While informants suggested that greater efficiencies or changes in KID's approval process might be helpful, they also stated the existing process has consistently yielded good quality products they are proud and confident to offer to their customers.

## **6. Conclusion**

There are a number of factors that contribute to whether or not a health insurance marketplace is considered to be competitive, including: insurer participation, enrollment, provider networks and a state's regulatory framework.

When assessing competition in the Kansas marketplace, informants identified challenges with narrow provider networks and a somewhat lengthy regulatory approval process. Additionally, Kansas has a small number of insurers operating in the marketplace, and the literature review found that this could be an indicator of "insufficient competition". However, the information obtained by the Kansas team suggests that this definition may not be an appropriate characterization of the market in a less populated state like Kansas. Informants were in agreement that the addition of new insurers offering coverage on the marketplace would be welcomed, but also noted that the companies currently offering coverage on the marketplace are providing Kansans with a wide variety and number of quality health plan choices. Moreover, according to the former insurance regulators and health policy informants, new insurers entering the Kansas marketplace may, in fact, create more complication and confusion for consumers, and not necessarily result in more competitive premium rates or improved product choices.

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- <sup>xii</sup> Researcher analysis of data from Healthcare.gov, “2015 Health plan information for individuals and families,” accessed July 20, 2015, <https://www.healthcare.gov/health-plan-information-2015/>.
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- <sup>xvi</sup> Ibid. (2014). Kansas Health Institute.
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## Appendix E: North Carolina State Memo

### Submitted by

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### 1. State Context

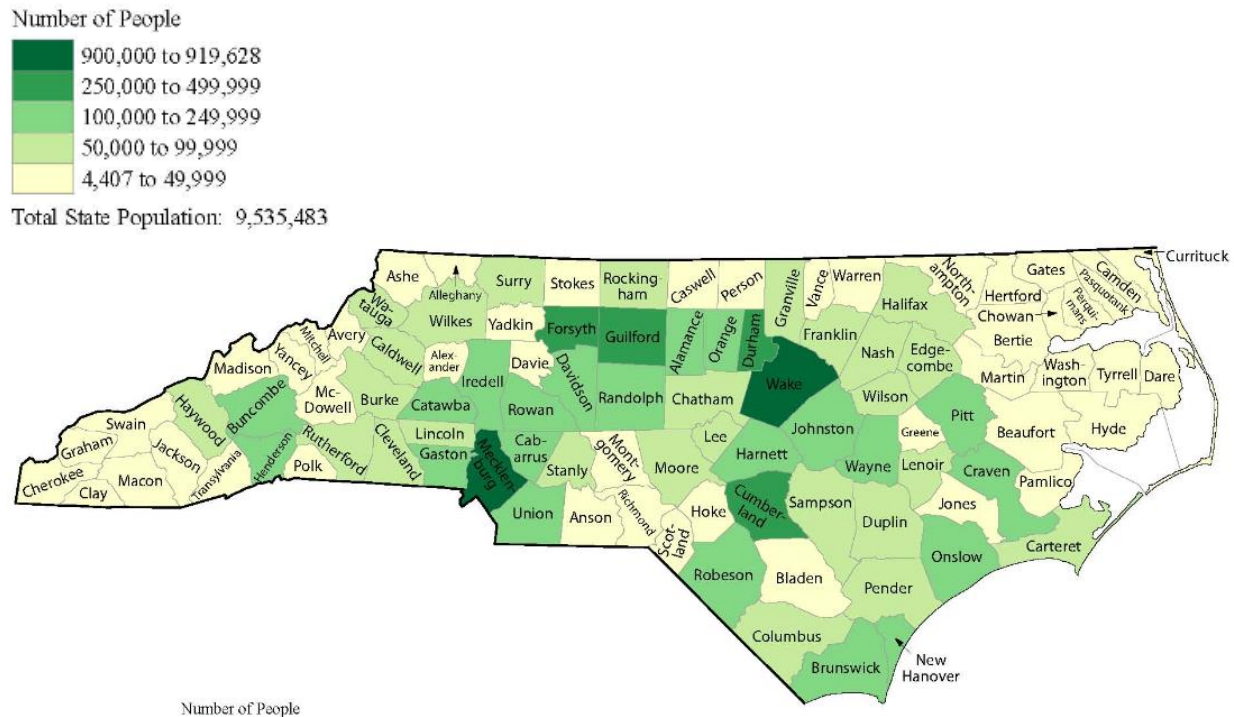
North Carolina merits study because it is the largest state in the country to have only one carrier statewide – Blue Cross and Blue Shield of North Carolina (Blue Cross). Basic facts about North Carolina are presented in Table E.1.1 and the distribution of the state’s population is shown figure 1.1 in the map that follows.

**Table E.1.1: Basic State Facts**

Type of Exchange	Federally-facilitated marketplace (FFM)
Expansion of Medicaid	No
Number of Rating Areas	16
Number of Insurers	3
Net Change in Number of Insurers	Increased from 2 to 3 for 2015. A 4 <sup>th</sup> has applied to enter for 2016.
State Population and Rank	9,638,800 million; rank: 10 <sup>th</sup> in US
Median State Household Income and Rank	\$44,254; rank: 42 <sup>nd</sup> in US
Salient Health Facts (e.g. regions with concentrations of certain conditions, or with particularly concentrated poor health status)	Per capita health spending is below U.S. average; rank: 14 <sup>th</sup> lowest in US. Sixth highest rate of uninsured in the US, in 2013.
Salient Health Policy Information (e.g. previous reform initiatives and relevant health insurance policies and requirements, notable insurance regulations)	Middle-of-the road small group market reforms. Moderately populist and elected insurance commissioner. Rate regulation is fairly lenient (“file and use”). Consolidated provider systems in much of the state.

North Carolina’s insurance commissioner is elected rather than appointed. North Carolina was an early adopter of small group market reforms in the 1990s. Its version of these reforms was fairly centrist, allowing some, but only limited, rate variation based on health status. The individual market has had fairly standard regulation, with full risk-rating permitted. Until 2013, the state had a subsidized high-risk pool, which covered about 11,000 people. North Carolina reviews health insurers’ rates for actuarial justification, but does not hold public hearings on rate requests. Any issues that arise during staff review tend to be handled in a non-adversarial fashion. Although the state refused to establish an exchange and is not involved with assisting the federal marketplace, its Department of Insurance actively reviews insurers’ filings for compliance with ACA requirements for the insurance market generally.

**Figure E. 1.1: Map of North Carolina<sup>i</sup>**



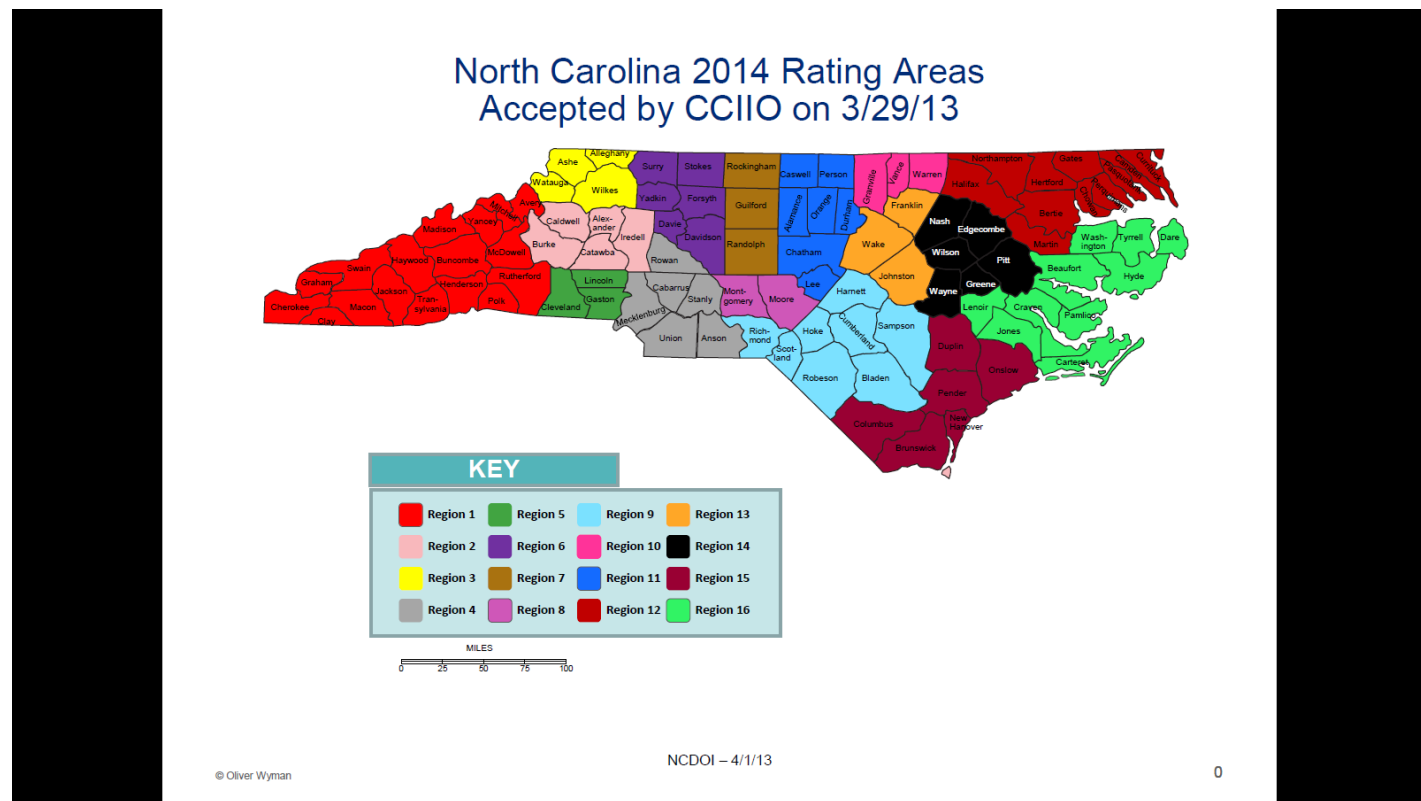
## 2. State Study Area and Rationale

The map below, Figure E. 2.1, shows North Carolina's 16 Rating Areas. This study addresses market conditions statewide, but with special focus on the eastern third (Rating Areas 12, 14, 15, and 16) and the far west (Rating Area 1). We give these areas special attention because they have fewer carriers competing and have notably consolidated provider systems.<sup>ii</sup>

Only Blue Cross offers coverage in the northeast corner – Rating Areas 15 and 16 – and in the two most eastern counties in Rating Area 14. Although these 23 counties account for almost a quarter of the state's 100 counties, they are thinly populated, accounting for less than 10 percent of the state's overall population.

In 2014, Blue Cross was the only carrier to offer coverage across all counties in Rating Area 1. Coventry offers coverage in 12 of these 17 counties, omitting the five that are furthest west. In 2015, United Healthcare entered most of the state, including all of Rating Area 1. It did not enter the northeast corner.

**Figure E. 2.1: Rating Areas in North Carolina<sup>iii</sup>**



### 3. Data Collection Methods

#### *Selection and Recruitment Process*

Our selection and recruitment methods involved two steps.<sup>iv</sup> We first formed contact lists for each category of discussant. For insurers, regulators, and state policy experts, we did so using existing connections and information, drawn from our previous health policy research in North Carolina. For navigators and agents, we compiled contact lists from separate databases based on county and rating area.<sup>v</sup>

We reached out to these separate groups, using a different approach for prior-known contacts and new ones. For the former group, we made contact on an individual basis, and received positive response from all contacts. For the latter group, we used a form email that outlined the basic goal of the study as well as a detailed account of our confidentiality procedures. This form was then sent to every potential navigator, and later agent. All told, we sent the email to around 20 navigators, and 30 agents. Out of all those contacted, we had four navigators respond, three of which followed through. We also had seven agents respond, four of which followed through.

#### *Discussions*

We conducted 17 discussions consisting of: 4 Insurers, 3 Navigators, 3 Regulators, 4 Agents/Brokers, and 3 State Policy Experts. Discussions lasted from 25 to 72 minutes, with most



agent/navigator discussions lasting roughly half an hour, and most discussions with regulators, insurers, and policy experts lasting close to an hour.

The four agents we spoke with had a collective experience in 10 counties: Pitt, Mecklenburg, Lee, Wake, Orange, Durham, Macon, Jackson, Swain, and Buncombe. Those counties are in five different rating areas, with the greatest number of counties represented in Rating Area 1 (in the far west), followed by Rating Area 11 (mid-state). The three navigators that we spoke with had collective experience in nine counties: Wake, Orange, Durham, Buncombe, Watauga, Avery, Madison, Burke, and McDowell. Those counties are in Rating Areas 1, 2, 11, and 13; two of the three navigators were primarily focused on Rating Area 1 (far west).

On the insurance side, we spoke with representatives from all three insurers present in North Carolina's marketplace, as well as one that did not enter the individual market. Of the three regulators we spoke with, one was a current regulator and two were former regulators active during or just prior to the first enrollment period. Of the three state policy experts we spoke with, one is in an academic space and two are involved with health access organizations. All are policy experts focused specifically on North Carolina.

The topics discussed with insurers, regulators, and policy experts were:

- 1) Why did various insurers enter, or not enter, the market, and choose to focus on some but not others parts of the market?
- 2) What kept other insurers out of the market, or kept market entrants from expanding?
- 3) How competitive is the market, and has market competition improved?
- 4) Would having more competition substantially reduce prices or improve choice?
- 5) Do the rating areas make sense; could they be improved? Should there be less freedom to pick and choose counties?
- 6) How much have BCBS competitors made inroads into BCBS's market share, and why does BCBS retain such large market shares in various parts of the state?
- 7) How narrow are provider networks, and how much do they differ among carriers or market segments?
- 8) What barriers exist to provider contracting by BCBS competitors? Do "most favored nation" clauses still have an impact?
- 9) How much variety is there in the plans being offered?
- 10) Why are rates going up so much? Does this indicate lack of competition?
- 11) Does state regulation deter market entry or expansion?
- 12) Could North Carolina do anything to help encourage more competition?

The topics discussed with agents and navigators were:

- 1) How long have you worked as a [navigator/agent]? What are the geographic regions you have served/worked in? Where do you have the most experience?
- 2) [For Agents] Roughly what percentage of your work focuses on non-group health insurance?
- 3) How has the market changed in your geographic area(s) since 2013 with regard to competition among non-group insurance carriers?
  - a) Number of Carriers?
  - b) Variety of Plan types?
  - c) Rates?
- 4) In your region(s), did United enter the market for the second open enrollment?
  - a) If so, what effects do you think this had?
  - b) If not, why do you think United did not enter?
- 5) [For agents]: In your regions, are there any active small group carriers that have left, or not entered, the non-group market? If so, why do you think they have stayed out?
- 6) Are provider networks narrower for the non-group than the group market?
  - a) How much narrower (for hospitals, specialists)?
  - b) [If there is more than one non-group carrier]: how much do the non-group provider networks differ between Blue Cross and the other carrier(s)?
- 7) Have consumers complained about any of the following in the non-group marketplace?
  - a) Provider networks?
  - b) Variety of plans?
  - c) Cost?
- 8) Is cost proving to be an outright barrier to enrollment?
- 9) Which carrier has the best price or value? Has that changed between year 1 and 2?
- 10) Would consumers benefit from having more competition among non-group carriers?
  - a) Would prices and options be pretty much the same if we had one or two more carriers?
- 11) Are there any state laws or regulations that discourage more carriers from being in the non-group market, or that keep this market from being more competitive?
- 12) Do you think there is anything North Carolina could do to make the non-group market more competitive?

## 4. Findings of Marketplace Conditions

### *Insurer Participation and Regulatory Environment*

In 2014 only Blue Cross Blue Shield of North Carolina (Blue Cross) participated statewide. Coventry, now owned by Aetna, participated in 39 counties covering 64 percent of the state's population. United Healthcare entered the marketplace in 2015, covering most of the state except for the large northeast corner (consisting of two and a half Rating Areas with 23 counties, but less than 10 percent of the state's population). Humana has applied to enter the marketplace for 2016, but in more populous urban centers in the central part of the state (e.g. Raleigh, Charlotte, Greensboro).

An additional carrier, FirstHealth, initially applied in 2013 to enter the market in a few counties, but withdrew its application after concluding that it was unlikely to gain sufficient enrollment to justify the effort. FirstHealth is an HMO based in the Pinehurst/Southern Pines area and owned by a smaller hospital system outside the major population centers. It had not planned to expand beyond its narrow market territory.

Prior to the ACA, Blue Cross had a commanding 86 percent market share in the individual market. Only one other insurer, Coventry, had over 5 percent, making North Carolina's individual market one of the most highly concentrated in the country.<sup>vi</sup> After two years of market expansion and reform, North Carolina's individual market is now noticeably less concentrated. Based on enrollment on and off the exchange, Blue Cross' share of the individual market statewide has dropped to 65 percent. Coventry has 19 percent, and United has 16 percent.<sup>vii</sup>

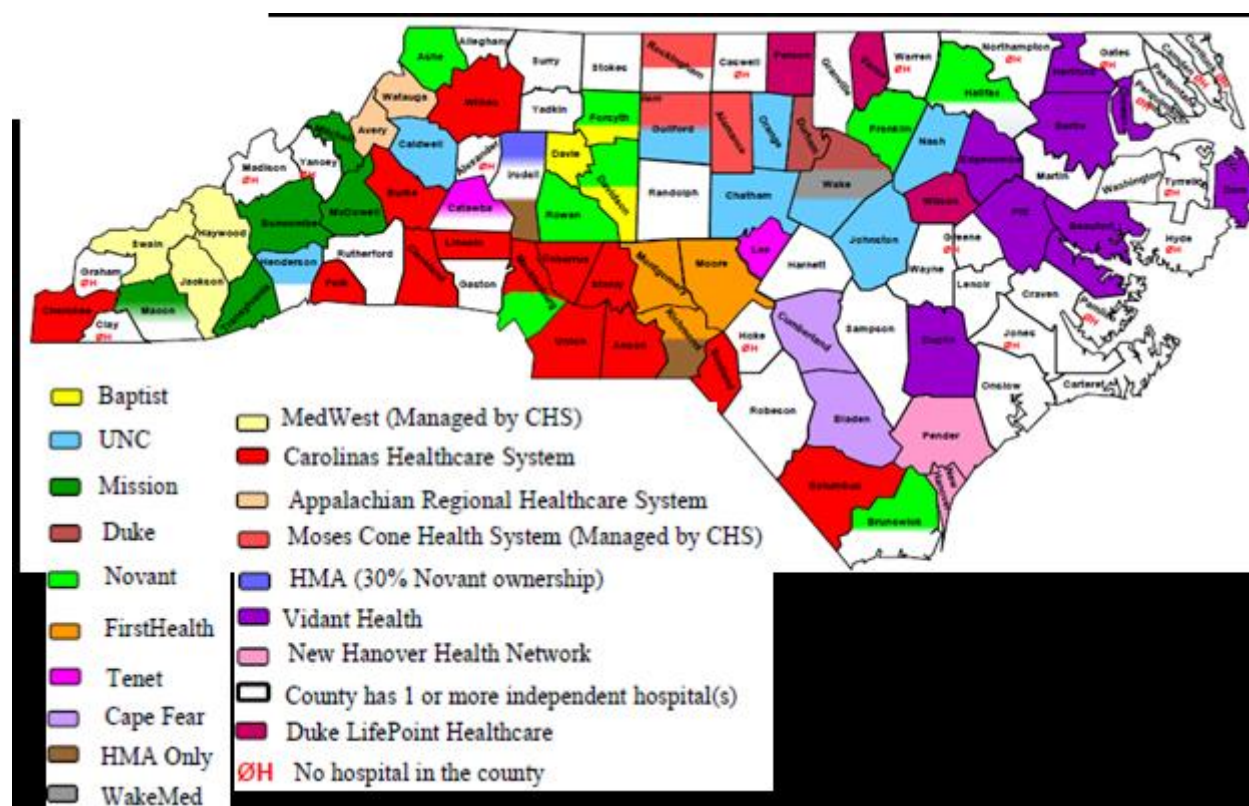
We were told that the following factors encouraged Blue Cross competitors to enter the market. First, North Carolina is a populous state with lower-than-average income, and thus it offered a large number of potential new enrollees. Contributing to the potential market size is the fact that North Carolina has not expanded Medicaid. Non-expansion increases the number of people eligible for highly-subsidized coverage since it brings those who are between 100-133 percent of poverty into the marketplace. The strength of outreach and enrollment efforts by public interest groups was also noted as a positive feature. Additionally, the initial market entrants already had a presence in the group markets, reducing the cost of entering the individual market. Humana, the newest entrant, had previously scaled back in the group market, but has been strong in the Medicare Advantage individual market.

State-based regulatory barriers were not reported by any of our discussants as a significant impediment to market entry or expansion. No discussant expressed the view that North Carolina is a hostile regulatory environment, and several discussants noted that North Carolina regulators worked with carriers in a constructive and encouraging fashion to help facilitate marketplace success. Any concerns about regulatory burden were expressed mainly with regard to federal requirements, such as those for establishing qualified health plan status.

### *Interactions with Provider Market*

Discussants consistently said that health insurers' market entry and geographic coverage is driven by provider contracting. North Carolina is considered to have fairly consolidated provider markets, as shown in the map below (Figure E.4.1).

Figure E.4.1: Hospital Systems in North Carolina<sup>viii</sup>



Notes: Multiple shadings in a county indicate a split between two or three systems. Only counties shaded white have one or more independent hospitals.

Until a few years ago, Blue Cross included a “most favored nation” clause in its provider contracts. Although they no longer do so (and state law now forbids this), many discussants said that providers in some parts of the state remain reluctant to give favorable discounts to Blue Cross competitors. Discussants also said that, considering the strong brand recognition that Blue Cross enjoys, it is not sufficient for competing carriers to simply match Blue Cross pricing; competitors need to offer prices that are at least 10 percent lower to attract significant enrollment. Indeed, in most of the markets where Blue Cross faces competition, its competitors offer lower-priced plans.<sup>ix</sup>

Coventry and United have been able to achieve competitive provider contracts in two ways. Coventry has partnered with major health systems in several metropolitan markets to offer co-branded plans, such as with Duke Medical Center in the Raleigh area or the Carolinas Healthcare System in Charlotte. United has sought out risk-sharing arrangements of different types with providers throughout the state, including some Accountable Care Organizations (ACOs). Also, United offers only a closed-network gatekeeper HMO model in the individual market, and no point-of-service or PPO option.

Blue Cross has also innovated with network models. It offers its standard, full-network PPO throughout the state, but in many rating areas – especially those where Coventry and/or United

compete – it also offers two other network models: a narrower network based on deeper fee-for-service discounting; and a tiered network, based on its broad network but which reduces patients’ cost-sharing for using providers that have more favorable pricing.

These network innovations are not restricted to the individual market; they are spilling over to other market segments. Blue Cross so far has not offered its narrow networks in the group market, but Blue Cross does offer its tiered networks to groups, and Coventry and United offer their narrower ACO and HMO networks in both group and individual markets. In addition, synergies were noted between the individual marketplace and the Medicare Advantage market. United uses its risk-sharing networks for Medicare Advantage products as well. And, discussants speculated that Humana is using its strength in the Medicare Advantage market to enter the individual marketplace.

Repeatedly, discussants said that the reluctance of Blue Cross competitors to enter Rating Areas where Blue Cross is dominant is based on the willingness of providers to contract with the competitors on favorable terms. The eastern part of the state was frequently noted as an area where Blue Cross has the market “locked up.” Some discussants attributed this contractual unwillingness to providers’ market power, both existing naturally due to few providers in the area, but also where area hospitals had formed systems and purchased most existing physician practices. One discussant, however, noted that provider consolidation sometimes facilitates openness to alternative contracting arrangements because networked systems have greater awareness of the need to create incentive structures that achieve clinical efficiencies. Also, these consolidated provider structures make contracting decisions more centrally, and therefore networks form quicker than contracting separately with a large number of independent providers.

Consistent with this account, several discussants noted that United Healthcare has recently formed a business relationship with the largest hospital and physician network in eastern North Carolina, and there is speculation that United will soon enter those rating areas. If so, North Carolina would have two providers that are virtually statewide and two others (Coventry at present, and Humana now entering) in the major population centers (as well as in some more rural areas).

### *Prices and enrollment*

Despite having below-average health care spending per capita, insurance premiums in the North Carolina marketplace are higher than national averages. Looking at the largest city in each state and comparing prices for the second-lowest cost silver plan, the Kaiser Family Foundation reports that North Carolina has the 7th highest premiums in the country.<sup>x</sup> Prices vary across the state, by roughly thirty percent among Rating Areas.<sup>xi</sup> Various discussants agreed that these variations are attributable largely to provider costs, suggesting that most of this cost difference was attributable to provider pricing rather than population health or utilization patterns – but we did not explore that distinction in detail. Although a detailed analysis has not been performed, there does not appear to be a consistent pattern between population density and premium cost. Charlotte is the highest priced rating area, but Greensboro, a medium-sized city, is among the lowest. Various rural areas appear at different points in the state’s pricing spread.

One reason noted for higher premiums is that North Carolina allowed people to keep and renew their noncomplying policies. Because those policies are medically underwritten, these

subscribers tend to be relatively healthier. Those policies are also not community rated, meaning their prices can remain more favorable for younger subscribers. To some extent, then, this “continuation” policy has kept a healthier population (numbering roughly 200,000) out of the community-rated market. However, we did not obtain any actuarial estimate of the impact of this phenomenon.

Despite the relatively high marketplace premiums statewide, marketplace enrollment in North Carolina has been relatively successful. Almost a half million are now enrolled through the marketplace, the fourth most in the country. This represents an estimated 45 percent of the potential purchasers, which is the 7<sup>th</sup> highest proportion in the US and fourth highest among FFM states. Over 90 percent of subscribers receive a premium subsidy (third highest in the US) and 65 percent receive cost-sharing reductions (fifth highest in the US). Owing to the high proportion of enrollees who qualify for financial assistance, North Carolina has enrolled about two-thirds of the population that is eligible for subsidies (fourth highest in the US). Enrollment was strong in both years, with about half of current enrollees being newly enrolled in 2015.

The fact that most marketplace enrollees receive premium subsidies causes this market to function somewhat differently than others. Some discussants noted that, when United entered in the second year, although pricing in their area became more competitive, many existing subscribers saw substantial increases. This happened because United’s lower price reduced the subsidy that subscribers receive for Blue Cross coverage. This subsidy is keyed to the second-lowest Silver plan in the market, initially was a Blue Cross plan. When the United plan entered, either itself or a Coventry plan became the second-lowest. Thus the available subsidy covered less of the premium for the broad-network Blue Cross plan than in the previous year.

A scenario described by more than one discussant is as follows: a person initially enrolls in Blue Cross’s broad network at a highly subsidized price, then switches in year 2 to another carrier after learning that there would be a very large premium increase (because the subsidy was now based on a market entrant’s plan), but then learns that their preferred physician was not included in the chosen network. Subscribers’ understanding of the consequences of switching plans was hampered by lack of easily accessible information about network composition. Additionally, many enrollees had never had insurance before and were unfamiliar with network rules and structures. Several discussants felt that the marketplace’s information technology needs to be improved in order for consumers to make truly informed and accurate choices.

## **5. Analysis of Marketplace Conditions**

Overall, it appears incorrect to characterize North Carolina’s individual insurance market one of insufficient competition. Most discussants consider the market to be competitive, and there are several signs of healthy competition overall. Although Blue Cross remains the only statewide carrier, Coventry competes with it in the more populous urban markets, and a new carrier has entered the market each of the two years running (first United, then Humana). Moreover, it is likely that United will expand to cover most or all of the state as it further develops its provider networks. Even if some areas remain less competitive, strong competition in the state’s core population centers should have spill-over benefits for pricing in rural areas. Because the ACA requires each carrier to treat the entire state as a single risk pool, carriers’ price differences between more and less competitive rating areas should be based only on actuarially-demonstrated differences in health care costs rather than on differences in market power.

In addition to choice of several carriers, the individual market in North Carolina offers a choice of distinct types of networks. Blue Cross and Coventry each offer more than one type of PPO or point-of-service network structure – full, tiered, limited – and United offers yet another option – a closed gatekeeper network HMO. Thus people have both a choice of carriers and, within two of the carriers, different types of networks. There is also a range of choices in patient cost-sharing designs. Accordingly, few discussants seriously complained of insufficient choice; some noted that adding more choice could produce consumer confusion.

The North Carolina market was also described as being “price competitive.” Although its premiums are above the national average and have increased by double digits each of the two years, the presence of Coventry and the entry of United have caused the market to be more price competitive.<sup>xii</sup> Blue Cross remains the market leader, but United and Coventry often offer lower-priced options. Accordingly, Blue Cross has lost substantial market share compared to its position prior to reform.

Some parts of the state remain uncompetitive, with either no choice other than Blue Cross, or with Blue Cross competitors unable to offer lower prices. However, these areas (clustered in the far west and northeast corners of the state, with rural pockets elsewhere) account for a small fraction of the state’s population. Barriers to increased competition in these areas were consistently attributed to the inability of other insurers to secure favorable network contracts with local providers. A few discussants also believed that the small size and poorer health of the potential risk pool in these rural areas was a factor deterring market expansion.

In part, difficulty negotiating competitive provider networks was attributed to provider consolidation or the small size of the provider community in rural areas. It was also attributed to the lingering effects of a history of Blue Cross using “most-favored nation” clauses. However, United is reported to have reached an agreement with the major health system in the far eastern part of the state. In its other rating areas, it is seeking to develop alternative networks using value-based incentives and risk sharing payment methods rather than discounted fee-for-service.

Finally, no notable regulatory barriers to healthy competition were noted with regard to state *insurance* regulation. (We did not inquire about *provider* regulation.) The limited regulatory concerns expressed were related mainly to federal rules, with a few discussants stating that streamlining the process for carriers to become qualified health plans could be especially helpful to smaller carriers that might consider entering the market. Smaller carriers conceivably could emerge, for instance, if one or more of the existing provider networks decided to form an insurance company.

## **6. Possible Remedies for Enhancing Marketplace Competition**

We received no consistent, concrete, and noteworthy suggestions for enhancing market competition, save for the aforementioned point to streamline the federal approval process. Other suggestions made were either vague (e.g. increase enrollment), or idiosyncratic and unrealistic (e.g. repeal Obamacare). A number of discussants simply said that they could not think of any good, constructive ideas to make the market more competitive than it already is.

This reflects the observations that, for the most part, the individual market in North Carolina appears to be fairly competitive already, with no significant regulatory barriers to entry or expansion. Some discussants also questioned how helpful it would be to have more insurers competing. First, if new insurers are not able to secure substantially greater discounts from providers, it is not clear how they might be expected to offer substantially lower prices. Second, the very ability to secure substantial discounts might be reduced if insurers' market power were spread too thin.

We inquired in particular about whether North Carolina's design of its rating areas deterred market entry or expansion. Currently, North Carolina allows insurers to select service areas county by county, meaning that they may enter part but not all of a rating area. Overall, discussants thought that the rating areas were well considered. No discussant thought it would be a good idea to require insurers to cover the entire state in order to enter the market; all agreed that such a policy would discourage market entry. One possibility we did not explore in depth was requiring insurers that want to enter the individual market to offer coverage in the counties in which they also sell group coverage.

Views were more divided on whether it might be a good idea to require insurers to cover an entire rating area. Some discussants complained that insurers are permitted to "cherry pick" within rating areas, by covering only one or a few counties. However, the majority of discussants felt that requiring full coverage of an entire rating area might cause an insurer to refrain from attempting to "gain a toehold" in a region where it is not yet fully established.



## References and Endnotes for Appendix E

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- <sup>ii</sup> For a detailed description in the western region, see Randall R. Bovbjerg & Robert A. Berenson, “Certificates of Public Advantage: Can They Address Provider Market Power?,” *Urban Institute* (February 2015), [http://www.urban.org/research/publication/certificates-public-advantage/view/full\\_report](http://www.urban.org/research/publication/certificates-public-advantage/view/full_report).
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- <sup>iv</sup> In addition to discussions, we conducted internet searches of major North Carolina newspapers and health policy websites for relevant information.
- <sup>v</sup> For the navigators we assembled a list of the navigator organizations and their individual members operating in the 50 least populous counties in North Carolina, see “Find Local Help,” HealthCare.gov, accessed July 1, 2015, <https://localhelp.healthcare.gov/>; “Navigator Grant Recipients,” CMS, accessed July 1, 2015, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013.pdf>; “Navigator Grant Recipients for States with a Federally-Facilitated or State Partnership Marketplace,” CMS, accessed July 1, 2015, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-09-08-2014.pdf>; “Health Care Navigators,” Legal Aid of North Carolina, accessed July 1, 2015, <https://www.legalaidnc.org/public/learn/projects/health-care-navigators/default.aspx>. For agents we made use of the National Association of Health Underwriters’ database, sorting by county and ACA certification.
- <sup>vi</sup> Kaiser Family Foundation, “Individual Insurance Market Competition,” accessed July 1, 2015, <http://kff.org/other/state-indicator/individual-insurance-market-competition/>.
- <sup>vii</sup> These figures are from a knowledgeable discussant, derived from carriers’ recent rate filings. They are broadly consistent with CCIIO data reflecting marketplace-only enrollment, although the CCIIO data suggest somewhat greater market share for Blue Cross of about 70 percent statewide.
- <sup>viii</sup> Blue Cross and Blue Shield of North Carolina, “Hospital Systems in North Carolina” (2014).
- <sup>ix</sup> S. Sekhar, “A State-Based marketplace in North Carolina,” (prepared for the North Carolina Justice Center, 2014), <http://dukespace.lib.duke.edu/dspace/bitstream/handle/10161/8614/MP%205-2-14.pdf>.
- <sup>x</sup> Kaiser Family Foundation, “Monthly Silver Premiums for a 40 year Old Non-Smoker Making \$30,000/Year,” accessed July 1, 2015, <http://kff.org/other/state-indicator/monthly-silver-premiums-for-a-40-year-old-non-smoker-making-30000year/>.
- <sup>xi</sup> Murawski, J. and D. Raynor, “In NC, Health Insurance Rates Vary Widely, Depending on Where You Live,” *Raleigh News & Observer*, December 6, 2014, <http://www.newsobserver.com/news/business/personal-finance/article10185707.html>; Rose Hoban, “North Carolina Insurance Rates a Mixed Bag,” *North Carolina Health News*, September 27, 2013, <http://www.northcarolinahealthnews.org/2013/09/27/north-carolina-insurance-rates-amixed-bag/>.
- <sup>xii</sup> Blumberg, L.J., J. Holahan, and E. Wengle, “Marketplace Price Competition in 2014 and 2015: Does Insurer Type Matter in Early Performance?,” *Urban Institute* (June 2015) (see Appendix A-7, p. 29), <http://www.urban.org/research/publication/marketplace-price-competition-2014-and-2015-does-insurer-type-matter-early-performance>.

## Appendix F: Ohio State Memo

### Submitted by

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### 1. State Context

In the most recent open-enrollment period, Ohio had sixteen insurers offering plans on its federally-facilitated marketplace (FFM) exchange. Ohio expanded Medicaid in October 2013, with coverage beginning in January 2014. Overall, Ohio's health is among the worst in the U.S. and its healthcare spending is among the highest, ranking 40<sup>th</sup> worst on both measures.<sup>i</sup> Within Ohio, Appalachian counties score particularly poorly in health, health care, and socioeconomic measures.

**Table F.1.1. Basic State Facts**

Type of Exchange	Federally-facilitated marketplace (FFM)
Expansion of Medicaid	Yes
Number of rating areas	17
Number of insurers	16
Net change in number of insurers	5
State Population and Rank	11,477,300; 7 <sup>th</sup> in US
Median State Income and Rank	\$46,672; 40 <sup>th</sup> in US
Salient Health Facts (e.g. Regions with concentrations of certain conditions, or with particularly concentrated poor health status)	<ul style="list-style-type: none"><li>• Ohio's overall population health is among the worst in the nation, ranking 40<sup>th</sup> out of all states.</li><li>• Ohio also ranks 40<sup>th</sup> worst for healthcare costs, spending more than most states on healthcare.</li><li>• Within Ohio, Appalachian counties (including selected Ratings Areas 10, 16, 17) rank in the bottom half, and often the bottom quartile, for health outcomes, quality of life, clinical care, and social and economic factors.</li></ul>
Salient Health Policy Information (e.g. Previous reform initiatives and relevant health-insurance policies and requirements, notable insurance regulations)	<ul style="list-style-type: none"><li>• State-level regulation is perceived as appropriate and not overly burdensome on insurance companies.</li><li>• Perception that the Ohio Department of Insurance (ODI) is pro-consumer. For example, an administrative rule currently under consideration intends to increase network transparency for consumers purchasing exchange plans.</li></ul>

### *Ohio's marketplace*

Prior to 2014, the average monthly premium in the individual market in Ohio was \$222, the 17<sup>th</sup> lowest in the country, below the national average of \$235.<sup>ii</sup> Ohio did not have stringent market controls (no guaranteed issue or community rating, for example) prior to implementation of the Affordable Care Act (ACA) market reforms.

During the 2015 open enrollment period, Ohio's average monthly premium in the individual market was \$389.<sup>iii</sup> While twelve states had the same or higher premiums than Ohio before Advance Premium Tax Credits (APTC) were applied, only one state, New Jersey, had higher premiums after APTC were applied. Ohio's post-APTC average premium in 2015 was \$145.

Ohio is divided into seventeen rating areas across eighty-eight counties. Rating areas were drawn based on county lines. During the 2015 open enrollment period, there were sixteen insurers participating in the FFM for Ohio. The number of carriers (insurers) participating in Ohio's FFM varied by rating area, from a high of 12 to a low of 5. The participating insurers in Ohio's FFM for 2015 are shown in Table F.2.1.

**Table F.2.1. Participating Insurers in Ohio FFM in 2015**

- |                          |                      |
|--------------------------|----------------------|
| • Aetna                  | • Humana             |
| • Ambetter (Buckeye)     | • InHealth (co-op)   |
| • Anthem                 | • Med Mutual         |
| • Assurant               | • Molina Marketplace |
| • AultCare               | • Paramount Ins.     |
| • CareSource             | • Premier            |
| • Health Span            | • SummaCare          |
| • Health Span Integrated | • UnitedHealthcare   |

Three of these insurers are operating in only two rating areas.

Within rating areas, some counties had fewer carriers than others. This difference was usually small, one to two carriers across counties within the same rating area, but higher variation across counties, by as many as five to six carriers, was also observed within a few rating areas. Number of plans offered across Ohio counties varied from sixteen to sixty-five; the average was twenty-four plans per county.

### *Ohio's enrollment*

Currently, Ohio marketplace effectuated enrollment represents only about 20% of the estimated potential market size for marketplace coverage.<sup>iv</sup> Compared to all other states and the District of Columbia, Ohio ranks 47<sup>th</sup> in percent of estimated potential market enrolled.

Ohio expanded Medicaid in October 2013, with coverage beginning in January 2014. By December 2014, more than 500,000 Ohioans had coverage through the new eligibility category.

Enrollment quickly outpaced state administration estimates and assisters frequently reported helping more Medicaid-eligible consumers than marketplace-eligible.

Ohio enrollment in the FFM has occurred at a slower rate. During the initial open enrollment period, 154,000 Ohioans selected a marketplace plan. During the second open enrollment period, 234,000 Ohioans selected a marketplace plan. Ohio's effectuated enrollment as of March 31, 2015, is 188,867.

According to recent Gallup-Healthways data, Ohio experienced a decrease in percent uninsured between 2014 and 2015 from 13.9% to 10.5%. New coverage options as a result of the ACA, including both Healthcare.gov and Medicaid expansion, likely contributed to the increase of Ohioans with health insurance.

#### *Ohio's consumer assistance*

In August 2013, five Ohio organizations initially were awarded federal navigator grants for the first open enrollment period. However, subsequent state legislation established additional state regulations for navigator organizations. In particular, a specific provision in the state law prohibits any "entity that is receiving financial compensation, including monetary and in-kind compensation, gifts, or grants, on or after October 1, 2013, from an insurer offering a qualified health benefit plan through an exchange operation in this state" from acting as a navigator.<sup>v</sup>

As medical providers, two initial navigator grant awardees, Cincinnati Children's Hospital Medical Center and Clermont Recovery Center, receive payment from health insurers and, as a result of Ohio's state law, were unable to participate in the navigator program. As a result, Ohio's final navigator grant amount totaled about \$3 million, distributed across three organizations. The Ohio Association of Foodbanks was the largest recipient, with an award of \$2 million. Helping Hands Community Outreach Center received \$231,000 and Neighborhood Health Association received \$753,000.<sup>vi</sup>

For the second open enrollment period, three organizations were awarded navigator funding, totaling about \$2.6 million. The Ohio Association of Foodbanks was again the largest recipient, with an award of \$2.2 million. Midwest Asian Health Association received \$149,000 and HRS/Erase, Inc. received \$275,000.<sup>vii</sup>

To achieve statewide reach, the Ohio Association of Foodbanks operated as a navigator consortium during both enrollment periods. They partnered with other organizations throughout the state, in addition to providing consumer assistance in Ohio counties without a navigator presence.

Because Ohio opted to operate as a federally-facilitated marketplace state, there is no state-led initiative to coordinate outreach, enrollment and consumer assistance. To help fill this void, the Ohio Network for Health Coverage and Enrollment (ONCE) was formed in 2013. After the first open enrollment period, ONCE convened stakeholders and identified the creation of a statewide communications campaign to raise awareness about new coverage options as a top priority. Funding for the campaign came from the Ohio Association of Foodbank's navigator award and additional resource development efforts. The effort had a final budget of approximately \$325,000. The campaign was branded, "Are you covered, Ohio?" and included collateral materials, original website and logo, and radio and TV advertisements.

## Ohio's health

The overall health of Ohio's population is among the worst in the nation, ranking 40<sup>th</sup> out of all states and D.C.<sup>viii</sup> Ohio particularly struggles with adult smoking and secondhand smoke exposure, adult diabetes, and infant mortality. Ohio also ranks 40<sup>th</sup> for healthcare costs, spending more than most states on healthcare. According to the Health Policy Institute of Ohio's *Health Value Dashboard*, the state also struggles in the areas of public health and prevention, social and economic environment, and physical environment.

Ohio has thirty-two Appalachian counties (including Ratings Areas 10, 16, 17). Generally, Ohio's Appalachian counties rank in the bottom half, and often the bottom quartile, for health outcomes, quality of life, clinical care, and social and economic factors.<sup>ix</sup> The population tends to be older than the state average<sup>x</sup> and have higher percentages of the population living in poverty.<sup>xi</sup> Appalachian counties also tend to have higher-than-average rates of negative health behaviors, such as adult smoking, obesity, and teen births.<sup>xii</sup>

Among all chosen rating areas, twenty-seven of thirty-two counties have patient-to-provider (PCP) ratios that are markedly higher than the state average of 1336:1.<sup>xiii</sup> In some Appalachian counties, the ratio is up to eleven times larger than the state average.

This poor state of health was a theme among stakeholders participating in discussions for this project (see Section 3), hereafter referred to as "discussants," who noted that Ohio is "not that healthy of a state," with concentrations of particularly poor health in certain areas of the state. Insurer and provider discussants noted that the type of consumer taking up exchange coverage "reflects the average [poor] health of the population."

## 2. State Study Area and Rationale

The field research team at the Health Policy Institute of Ohio (HPIO) selected the rating areas found in Table F.2.1 for analysis as a part of the ASPE-funded *Assessment of Markets with Insufficient Competition*.

**Table F.2.1. Rationale for Rating Area Selection**

Rating Area	Rationale
9	Seven MSA and three micropolitan counties; certain counties experienced a considerably lower drop in uninsured compared to other counties in the state
10	Diverse population size among counties; highest premiums in the state
16	Diverse population size among counties; high premiums and a lower number of issuers compared to other counties
17	High premiums and a lower number of issuers compared to other counties

**Rating area 9** (Logan, Fayette, Madison, Knox, Pickaway, Licking, Union, Fairfield, Franklin, Delaware counties): This rating area has seven MSA counties (including one with a large city, Columbus, the state's capital) and three micropolitan counties. Nine insurers participated in this rating area. Average premiums were not as high as those in the other study areas, but were still in the third quartile of the highest premiums in the state. Two counties within the rating area (Union and Delaware) experienced a considerably lower drop in uninsured compared to other counties in the state, although both had a relatively low uninsured rate prior to 2014.

**Rating area 10** (Vinton, Gallia, Scioto, Lawrence, Pike, Jackson, Ross counties): This rating area is diverse in terms of population size, with one MSA county, four micropolitan counties, and two non-metro counties. Seven insurers participated in this rating area. The area had the highest premiums of anywhere else in the state compared to the rest of the state.

**Rating area 16** (Harrison, Noble, Perry, Guernsey, Tuscarawas, Morgan, Monroe, Coshocton, Muskingum, Belmont, Jefferson counties): This rating area is diverse in terms of population size, with three MSA counties, four micropolitan counties, and four non-metro counties. Seven insurers participated in this rating area. All counties within the rating area had high premiums and a lower number of issuers (ranked in the bottom two quartiles) compared to other counties in the state.

**Rating area 17** (Meigs, Hocking, Athens, Washington counties) – This rating area has one MSA county, two micropolitan counties, and one non-metro county. Six insurers participated in this rating area and it had very high premiums.

Additional data relevant to the selected rating areas:

- **Two of the four selected rating areas have the highest average premiums in the state** for both twenty-seven and forty year-old consumers.
- Combined population in the study counties is about **a quarter of the state's population**.
- According to an Enroll America analysis, the average state take-up rate for FFM coverage is 30%. **All but three of the selected counties for this analysis have take-up rates below the state average** and Franklin County's rate (where Columbus is located) is only slightly above (30.23%).
- In the latest U.S. census, thirty of the thirty-two counties had **rural densities** (percent of population living in a rural area) **higher than the state average** (22.1%).
- Twenty-two of the thirty-two counties (69%) listed above are in **Appalachia, an area of the state that experiences significant health and cost challenges**, detailed above.

### 3. Data Collection Methods

#### *Selection/recruitment process*

Health Policy Institute of Ohio (HPIO) frequently engages multi-stakeholder groups and fosters relationships across health and policy sectors to inform its work. HPIO leveraged those relationships for the purposes of this project, reaching out to its stakeholder network both to recruit discussants and ask for suggested discussants.

Outreach began on June 3<sup>rd</sup> and continued through June 16<sup>th</sup>. Selected discussants were contacted individually by email by HPIO's president, Amy Rohling McGee. Contact efforts, including the addition of further potential discussants, continued until at least two discussants of each expert type were confirmed. Number of experts recruited and participating is detailed in Table F.3.1.

**Table F.3.1. Experts recruited and participating**

Expert type	Discussants selected for recruitment	Number participating in discussions	Average length of discussion
Regulators	2	2	36 minutes
Insurers	6	5	44 minutes
Brokers/Agents	2	2	38 minutes
Navigators	4	2	41 minutes
Hospitals	5	2	21 minutes
Physicians/Physician Groups	5	2	34 minutes
State Public Policy Experts	5	3	36 minutes
<b>Total</b>	<b>29</b>	<b>18</b>	<b>37 minutes</b>

Overall, eighteen experts representing all expert types participated in discussions, which were conducted between June 8<sup>th</sup> and June 29<sup>th</sup>, and averaged thirty-seven minutes in length. The highest participation rates were among insurers, regulators, and brokers.

#### *Topics covered*

Topics covered with all experts included discussions of:

- The nature of competition in Ohio’s individual health insurance marketplace, including levels of insurer and provider competition, as well as competition for consumers.
- The relationships between enrollment rates and insurer participation, premiums, and provider networks.
- Other factors that discussants believe may be affecting competition and enrollment in the individual health insurance marketplace.

Topics related to discussants’ fields of experience and expertise were also explored. For example:

- **Regulation-sector experts** were asked about the regulatory climate in Ohio as well as potential improvements to insurance law/regulation, and about consumer complaints they have fielded since the exchange opened.
- **Insurers** were asked about their decision-making process when choosing whether to offer plans in the exchange and in certain areas, as well as for their impressions of the insurance regulatory climate in Ohio.
- **Physicians/physician groups** and **hospitals** were asked about what trends they have seen in terms of coverage in their patient population.
- **Brokers/agents** and **navigators** were asked about their experience with subsidy eligible and non-eligible consumers, and the relationship between brokers and navigators and how that may have impacted consumer outreach and enrollment.

#### *Secondary data*

In addition, the HPIO field research team collected and analyzed secondary data from a variety of sources to inform their analysis. This included data on enrollment and take-up rates, health status and behaviors, demographic characteristics, and provider concentration. See Appendix F.1 for secondary data spreadsheet on the selected study rating areas.

## 4. Findings of Marketplace Conditions

### *Insurer participation*

During the 2014 open enrollment period there were twelve issuers participating in the federally facilitated marketplace for Ohio. For the 2015 open enrollment period, one issuer exited the market and five new issuers entered the market, resulting in a total of sixteen issuers. Only one other state has as many issuers offering exchange plans, with a national average of seven issuers across states.<sup>xiv</sup> See Section 2 for participating insurers for 2015.

Discussants offered a variety of reasons for choosing to participate on the exchange in Ohio. The most common responses were that the insurance company was already doing business in the state (“we decided that in every state we did business in, we’d participate on the exchanges”) and the opportunity for “future growth” in the new market. Stakeholders who participated in this study did not speculate as to why one of the insurers who participated in the 2014 open enrollment period did not participate in 2015.

Insurer participation ranges from five to twelve in each of the state’s seventeen rating areas. Three of these insurers are operating in only two rating areas.

The counties within the rating areas selected for this study have varying numbers of carriers:

Rating Area 9 – The ten counties (seven MSA and three micropolitan) in this rating area have between four and eight carriers, offering a range of sixteen to twenty-six plans.

Rating Area 10 – The seven counties (one MSA, four micropolitan, and two non-metro) in this rating area have between five and six carriers, offering a range of eighteen to nineteen plans.

Rating Area 16 – The eleven counties (three MSA, four micropolitan, and four non-metro) in this rating area have between four and five carriers, offering a range of sixteen to thirty-six plans.

Rating Area 17 – The four counties (one MSA, two micropolitan, and one non-metro) in this rating area have between four and six carriers, offering a range of four to six plans.

The rating area with the highest number of metro areas, Rating Area 9, also had the highest number of carriers.

**Table F.4.1. Census statistical areas and carriers by rating area, Ohio**

Rating Area	Number of metropolitan areas	Number of micropolitan areas	Number of non-metro areas	Number of carriers, 2015
9	7	3	0	9
10	1	4	2	7
16	3	4	4	7
17	1	2	1	6



Our analysis found that there is a correlation between the number of carriers in a rating area and the average premiums. Statewide, rating areas with eleven or more carriers saw the lowest premiums, with an average premium for \$269 a twenty-seven year-old. Rating areas with only five or six carriers saw the highest premiums, averaging \$301 (see Table F.4.2).

**Table F.4.2. Census statistical areas and carriers by rating area, Ohio**

<b>Number of issuers</b>	<b>Average premium (27-year-old)</b>	<b>Average deductible</b>	<b>Take-up rate</b>
5-6	\$301.17	\$2,654.06	21.98%
7-8	\$293.42	\$2,664.76	19.80%
9-10	\$273.54	\$2,729.50	29.76%
11+	\$269.36	\$2,835.02	34.87%

The rating areas selected for this study generally reflect this trend (see Table 4.3). Rating Area 9 has the highest number of issuers and had the lowest average premium at \$287.27. Rating Area 17 has the lowest number of issuers and the second highest premium at \$330.65 (\$0.75 less expensive than Rating Area 10, which had 7 carriers).

However, deductibles were higher in areas with more carriers. Rating areas with eleven or more carriers had an average deductible of \$2,835. Rating areas with five or six carriers had an average deductible of \$2,654 (see Table F.4.2).

The rating areas selected for this study reflect this trend. Rating Area 9 has the highest number of issuers and had the highest average deductible. Rating Area 17 has the lowest number of issuers and had the lowest average deductible (see Table F.4.3).

**Table F.4.3. Census statistical areas and carriers by rating area, Ohio**

<b>Rating Area</b>	<b>Number of carriers</b>	<b>Average premium (27 year-old)</b>	<b>Average deductible</b>
9	9	\$287.27	\$2,741.86
10	7	\$331.40	\$2,691.73
16	7	\$294.42	\$2,658.58
17	6	\$330.65	\$2,667.94

Our analysis also shows a general correlation between a rating area's take-up rate and the number of carriers. Rating areas with eleven to twelve issuers had a higher take-up rate than the state average and higher than areas with only five to six issuers (see Table 4.2).

#### *Interactions with another market – provider concentration and high premiums*

Twelve Ohio counties have no hospitals located within their border; half of these counties are in the selected rating areas. Another fifteen counties in the selected rating areas have only one hospital in the county.

In twenty-seven of the thirty-two counties in the study area, the resident-to-primary care physician (PCP) ratio is higher than the state average of 1336:1. In Rating Areas 10, 16, and 17, the PCP ratio is more than twice as high as the state average, meaning that there are half as many (or fewer) primary care providers available per area resident. Two counties in the study area have PCP ratios ten times the state average, making them the highest ratios in the state: Morgan County at 14911:1 and Vinton County at 13239:1.

**Table F. 4.4. Hospitals and PCP ratios in selected rating areas, Ohio<sup>xv</sup>**

Rating area	Total number of hospitals	Number of counties without a hospital	Average PCP ratio	Number of carriers	Average premium (27-year-old)
9	25	0 (of 11)	1970:1	9	\$287.27
10	7	1 (of 7)	3688:1	7	\$331.40
16	12	4 (of 10)	4183:1	7	\$294.42
17	4	1 (of 4)	2613:1	6	\$330.65
<b>Ohio</b>	<b>187</b>	<b>12</b>	<b>1336:1</b>	<b>16</b>	<b>\$283.28</b>

As seen in Table F.4.4, areas with fewer hospitals and fewer primary care physicians per resident tend to have higher premiums and a lower number of marketplace carriers.

Medicare reimbursements per enrollee were above the state average in Rating Areas 10 and 17. Rates may be higher in areas where there is no competition among hospital providers. Medicare reimbursements in most of the counties with no in-county hospital were below the state average. When there is no hospital nearby, people may defer care completely, therefore resulting in lower costs.

#### *Low enrollment*

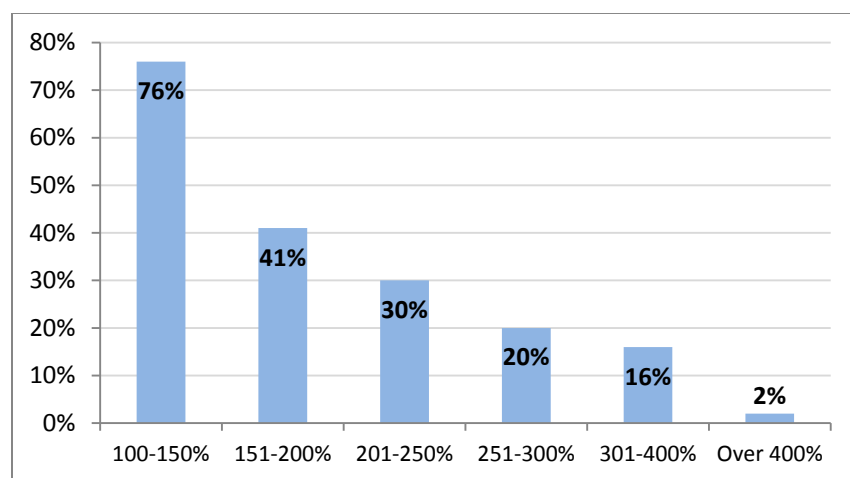
According to an Enroll America analysis, the average take-up rate for marketplace coverage in Ohio was 30%. Across the state, take-up rate varied from 10.1% to 39.5%. All but three of the selected counties for this analysis have take-up rates below 30% and Franklin County's rate (where Columbus is located) is only slightly above the average (30.23%).

Representatives of all stakeholder groups participating in discussions commented that low enrollment is due in large part to high premiums and lack of affordability. Even with financial assistance, the cost sharing requirements are too high for many. Those who have assisted people with finding coverage stated that the tax penalties are too low to incentivize people to purchase coverage.

Within the selected rating areas, 65% of the counties have poverty rates that are higher than the state average<sup>xvi</sup> and 75% have median household income that is less than the state average of \$48,138.<sup>xvii</sup> In addition, Ohio has a higher than average number of people who fall in the 200-399% FPL range, who are eligible for lower APTC and therefore face higher effective premiums than those in lower FPL ranges. Among all states and DC, Ohio has the 11<sup>th</sup> highest percent of population falling into that group (33.1%).<sup>xviii</sup> Ohio is one of only thirteen states where the highest percent of population falls in the 200-399% category. According to analysis done for CMS by Avalere Consulting, across the U.S., eligible individuals falling in the 200-399%

category were significantly less likely to enroll in exchange plans, compared to those in the 100-150% and 151-200% range<sup>xix</sup> (see Table F.4.5).

**Table F.4.5. Percent of eligible individuals enrolled in exchange plans, by income (percent FPL), United States<sup>xx</sup>**



As mentioned above, take-up rate was also directly related number of carriers in a rating area, with higher take-up rates in areas with more carriers.

#### *Rural markets and poorly designed market structure*

Ohio has eighty-eight counties, grouped into seventeen insurance rating areas.<sup>xxi</sup> Thirty-eight of Ohio's counties have metropolitan statistical areas (with a core urban population of 50,000 or more), thirty-three counties have micropolitan statistical areas (with a core urban population of 10,000 to no more than 50,000), and seventeen counties are non-metropolitan areas (with a core urban population of less than 10,000). All seventeen insurance rating areas in Ohio include either at least one metropolitan statistical area or one micropolitan statistical area.<sup>xxii</sup> Nine of the rating areas include at least one non-metropolitan area.

Seven rating areas (41%) have high census statistical area heterogeneity, meaning they include at least one of each type of census statistical area (i.e. at least one metropolitan area, one micropolitan area and one non-metropolitan area). On average, these rating areas have higher premiums and a lower marketplace take-up rate than other rating areas (see Table F.4.6). Two rating areas in the state (11.8%) are homogenous, including only metropolitan statistical areas. These two rating areas have, on average, considerably lower premiums than the rest of the state, higher carrier participation, and higher take-up rates. Three of the four rating areas selected for further analysis in this study have a high level of census statistical area heterogeneity (Rating Areas 10, 16, 17).

**Table F. 4.6. Comparison of marketplace characteristics based on health insurance rating area heterogeneity, Ohio 2015**

Census statistical area heterogeneity	Number of rating areas	Avg. premium (27-year-old)	Avg. number of carriers	Avg. take-up rate
<b>High</b> (Includes all three types of census statistical areas: metropolitan, micropolitan, non-metropolitan)(Rating Areas 1, 2, 3, 5, 10, 16, 17)	7	\$295.17	8	24.3%
<b>Medium</b> (Two types of census statistical areas: either metropolitan and micropolitan OR micropolitan and non-metropolitan)(Rating Areas 6, 7, 8, 9, 11, 12, 13, 14)	8	\$278.81	8	26.9%
<b>Low</b> (Metropolitan area only)(Rating Areas 4, 15)	2	\$259.53	11	33.6%

Thirty-two of Ohio's counties are in Appalachia.<sup>xxiii</sup> Appalachian counties in Ohio tend to have greater healthcare access issues and poorer health than urban counties in the state.<sup>xxiv</sup> In addition, Appalachian adults smoke more than adults in metropolitan, suburban or rural, non-Appalachian counties.<sup>xxv</sup> This is particularly significant given that tobacco use is one of the four factors insurers can use to vary an individual's premiums, which means there is some possibility that premiums were disproportionately affected in these rating areas (further analysis would be required). Insurers on the marketplace can charge an individual who smokes a premium up to 50% higher than a premium for an individual who does not smoke.

Ohio's Appalachian counties are disbursed across eight of Ohio's insurance rating areas. Four of Ohio's rating areas are comprised of only Appalachian counties. Three of these four rating areas, (rating areas 10, 16 and 17) were selected for further analysis through this study. Notably, the four insurance rating areas comprised of only Appalachian counties have, on average, lower carrier participation, higher premiums, and a lower marketplace take-up rate than other rating areas in the state (see Table F.4.7).

**Table F. 4.7. Variance in marketplace characteristics across rating areas with Appalachian and non-Appalachian counties, Ohio 2015**

Census statistical area heterogeneity	Number of rating areas	Avg. premium (27-year-old)	Avg. number of carriers	Avg. take-up rate
<b>Rating areas with only Appalachian counties</b> (Rating Areas 10, 13, 16, 17)	4	\$306.80	7	24.7%
<b>Rating areas with only non-Appalachian counties</b> (Rating Areas 1, 2, 3, 4, 6, 7, 8, 9, 12)	9	\$278.77	9	27.7%
<b>Rating areas with a mix of Appalachian and non-Appalachian counties</b> (Rating Areas 5, 11, 14, 15)	4	\$269.90	10	26.2%

## 5. Analysis of Marketplace Conditions in Selected Sites

### *Competition*

Ohio's individual insurance market is considered relatively competitive. Based on the Herfindahl-Hirschman Index (HHI), Ohio ranks in the top 25% of states for how evenly market share is distributed across insurers. In 2010, Ohio's HHI score was 2,519. In 2013, Ohio's HHI score was 2,623, well below the national average of 3,888.<sup>xxvi</sup>

Largest market share varied across the selected rating areas. Rating Area 9 had the largest single market share in Ohio at 51.8%; Rating Area 10 had the lowest in Ohio at 24.3%. While we were not able to ascertain market share for specific carriers in the rating areas studied, discussants mentioned that Anthem, Aetna, Medical Mutual of Ohio, and CareSource were the major carriers in the selected rating areas.

**Table F. 5.1. Largest market share by a single carrier<sup>xxvii</sup>**

Rating Area	Largest market share
9	51.8%
17	38.5%
16	29.7%
10	24.3%

While many insurers opted to offer plans on the exchange in Ohio, particularly in metropolitan areas, it's uncertain how vigorously they pursued attracting new consumers. During discussions with insurers there was a sense of cautiousness during initial enrollment periods while much was still unknown about the type of consumer seeking exchange coverage, the cost of care, provider participation, and other factors.

One insurer stated that "insurers targeted enrollment efforts in areas where they could be competitive price-wise," in particular in the areas of the state with higher population density.

Several insurers shared similar strategies, indicating that they targeted metropolitan areas with higher population density to increase enrollment in their exchange offerings, as compared to more rural or lower density areas.

An insurer commented about urban areas, “there are more uninsured and more opportunities there.” HPIO’s data analysis reflects this trend, showing that rating areas with four or more metropolitan areas had the highest number of carriers.

Insurers also targeted enrollment efforts in areas they felt they could be competitive price-wise. One insurer commented, “we always want to be the lowest or second-lowest premium. That was our strategy.”

A theme that emerged from discussions with insurers was that the number of choices may have been overwhelming from a consumer perspective and made choosing a carrier and plan complex. One insurer remarked, “I think some of it may be the consumer is just getting bombarded by the eleven competitors, and don’t know what to buy, so they don’t buy.” Two discussants remarked that while choice is good, too much choice may overwhelm a consumer. On the face these plans may have seemed similar, so selecting the plan with the right “fit” for a consumer may have been difficult.

One discussant commented on whether insurers actively marketed exchange plans to previously uninsured people:

*The root of competition is, ‘Do I want this population of patients?’ Initially, I can’t say that payers want this population of patients. They tend to be looking for care, and they have chronic diseases. There’s only competition when there’s a prize, and there was no prize, except having your name in the market.*

### *Regulation*

Ohio is a FFM state, but the Ohio Department of Insurance (ODI) performs plan management activities. ODI oversees the certification of health plans; collects, reviews, and approves plan rate and benefit information; and oversees plan compliance, consumer complaints and issuer decertification.

The general impression among discussants was that the level of regulation in the state has not changed significantly since implementing the ACA. A discussant with expertise in Ohio’s regulatory environment remarked “all the rules that Ohio already had in place are still in place.” Several discussants mentioned that the most noticeable regulatory change has been adjustments in timelines for rate filings, but ODI’s involvement has been relatively unchanged otherwise.

A theme among insurer discussants was that the level of regulation from the state has been appropriate and not overly burdensome on insurance companies. One insurer commented, “the regulatory environment in Ohio I would say has been fair. ODI has done a good job trying to put information and expectations out there, create a level playing field with respect to how the filings should happen.”

Several insurers also described ODI as being pro-consumer. Notably, ODI has proposed an administrative rule to increase network transparency for consumers purchasing plans on the

exchange. The proposed rule requires health insurance companies to maintain provider directories that include an explanation of how out-of-network costs are calculated and up-to-date information about providers, including contact information and whether the provider is accepting new patients.

However, most discussants also commented that the political beliefs of key statewide elected officials influences insurance market regulation and Ohioans' perceptions of the ACA. In 2011, the state's lieutenant governor, who also serves as the director of ODI, stated in a press release:

*Unfortunately, while being sold as healthcare “reform,” this new law serves only to trap individuals and employers in the same dysfunctional cycle in which they have been participating for years, but now with even higher premiums and a severely damaged insurance market in Ohio. As your Lt. Governor and Insurance Director, I will do everything I can to protect Ohio’s citizens and job creators from this catastrophic law.*<sup>xxviii</sup>

Several insurers commented on the effects of politics on enrollment, particularly the negative view of the ACA on the part of the lieutenant governor. One discussant remarked, “our Department of Insurance unfortunately has a viewpoint. That is clearly a reason for low enrollment as well.” However, some also observed that this attitude has shifted in recent months. One discussant said, “there is a less resistant attitude now, second plan year of the exchange, versus the early rancor and pandering and politicking of the ACA.”

#### *Consumer awareness and outreach*

As described in Section 4, marketplace take-up rates varied across health insurance rating areas, ranging from 10.1% to 39.5%, with a state-wide take-up rate of 30.1%. As a point of reference, there are twenty-three states that have a total of 40% or more of their eligible population enrolled in the marketplace. Sixteen of these twenty-three also have federally-facilitated marketplaces.<sup>xxix</sup>

There are many factors that may contribute to both low take-up rates and variation in take-up rates across Ohio's rating areas. Three prevailing themes focused on consumer awareness and outreach emerged from the stakeholder discussions that may highlight some of the issues around Ohio's poor enrollment performance.

1. Consumers lack understanding of the value/benefit design of health insurance coverage on the marketplace.
2. Lack of consumer awareness regarding the ACA mandate to purchase health insurance coverage and the ability to purchase subsidized coverage for eligible individuals through the marketplace.
3. Ohio's political climate and consumer perceptions of the Affordable Care Act (ACA).

Fifteen of the eighteen participating discussants indicated that consumers lack understanding of the value/benefit design of health insurance coverage on the marketplace. One of the frustrations expressed by discussants was that consumers were focused solely on the plan rate (or premium) rather than on plan benefits. As a result, consumers were swayed away from purchasing marketplace coverage because they viewed their plan premium cost as being too high. One broker stated, “I know the actual cost of these [plans], but people don't understand what health

care costs...If you're healthy, you've never had the experience." When asked whether consumers took advantage of subsidies, the response was, "no, they don't understand the value of the subsidies."

Other discussants suggested that the issue stemmed from much of the eligible marketplace population in Ohio being first generation health insurance purchasers. According to discussants, these first generation purchasers experience great difficulty going online and choosing what is "a very complex product." Another broker hypothesized that "what's deterring enrollment on the exchange is the population that would be most helped is the population that's most computer illiterate." This discussant went on to say, "I can hardly get people to download an app, much less go online and choose a complicated plan. They're first generation buyers. Our industry is a dinosaur. We still use paper and fax machines."

Eight of the eighteen discussants suggested that low and varying take-up rates across rating areas was due to lack of awareness regarding both the ACA mandate to purchase health insurance coverage and the ability to purchase subsidized coverage for eligible individuals through the marketplace. Specifically, discussants attributed low enrollment to weak consumer outreach efforts. This was thought to be particularly true of the more rural and Appalachian regions of the state. Given that rating areas comprised of only Appalachian counties had lower carrier participation and enrollment rates than other rating areas (see Table 4.7), this hypothesis garners greater validity.

Ohio's navigator award for the second open enrollment period was \$2.6 million.<sup>xxx</sup> When compared to the number of uninsured residents, the state received the fourth lowest amount of navigator funding compared to other FFM states. Ohio received about \$1.73 in navigator funding per uninsured resident, compared to \$9.78 per uninsured for the highest-funded FFM state.<sup>xxxi</sup> Additionally, analysis conducted after the first open enrollment period showed that state-based marketplace states had a larger amount of consumer assistance funding per eligible uninsured, likely due in part to the fact that federally-facilitated marketplace states do not have access to in-person assistance funding.<sup>xxxii</sup>

However, the correlation between navigator funding and marketplace take-up rate is not clear. North Carolina received the second lowest amount of navigator funding per uninsured resident, yet had the fourth highest marketplace take-up rate among partnership and FFM states. At the same time, South Dakota had the highest amount of navigator funding per uninsured resident, yet had the lowest marketplace take-up rate among partnership and FFM states. Consequently, while funding may contribute to higher take-up rates across states, it does not appear to be the driving factor behind marketplace enrollment numbers.

Discussants spoke of the lack of statewide marketing campaigns, as well as a lack of billboards and radio ads targeting non-metropolitan regions of the state. A number of discussants focused on the need for localized public relations campaigns "tailored to local community needs." This, in conjunction with insurers focusing on targeted metropolitan areas throughout the state, may have contributed to lower enrollment rates in the non-metropolitan areas. One discussant commented that in metropolitan areas, consumer outreach and enrollment efforts could be targeted more towards large non-Hispanic immigrant populations. The discussant noted that while Franklin County does not have a large Hispanic population, it does have large African and



Asian immigrant populations for whom communication materials should be tailored. Notably, one of Ohio's navigator grantees in 2015 is specifically targeting Ohio's Asian population.

While ONCE took steps to raise awareness of new coverage options through a coordinated marketing effort, the campaign experienced challenges with funding and a compressed time frame to fully operationalize the initiative.<sup>xxxiii</sup>

Finally, ten of the eighteen discussants indicated that consumer enrollment and variation across rating areas may have been driven by political climate and consumer perceptions related to the ACA. Multiple discussants stated that consumers were swayed away from purchasing insurance through the exchange as a result of statements made by politicians and general anti-Obamacare sentiments in the state.

As one discussant indicated, "we have a state that has chosen to not support the ACA and not encourage people to enroll." Another discussant commented that the media has been spreading the message that "government [is] taking over your health care." The discussant also commented that "this misperception...has been playing out through legislators and everyone around the state." Despite this, there is optimism that enrollment will increase as individuals "begin to know someone who has...coverage and when the experience of the coverage contrasts with the negative hype that's been in the public domain for so long."

#### *Rural markets and poorly designed market structure*

There are two patterns that emerge in the structure and design of rating areas in Ohio. The first pattern relates to the distribution of census statistical areas across rating areas. As indicated in Section 4, rating areas with a high level of heterogeneity (i.e. one of each type of census statistical area) have, on average, higher premiums and lower take-up rates than other rating areas. As rating areas decrease in heterogeneity, premiums decrease and take-up rates increase. This pattern holds true if the rating area is comprised of only metropolitan areas. However, given that Ohio has no rating areas comprised of only non-metropolitan areas and only micropolitan areas, it is unclear if this pattern would hold true if a rating area were homogenously rural.

There is evidence that too much heterogeneity within a rating area may lead to lower carrier participation and higher premiums.<sup>xxxiv</sup> At the same time, research on differences in premiums by insurance rating area structure found that states that grouped together metropolitan statistical areas into various rating areas and grouped all other non-metropolitan areas together (or rural counties) into one rating area experienced lower premiums than other states (referred to as the MSA+1 design).<sup>xxxv</sup> This suggests that the high-level of heterogeneity across Ohio's rating areas may be a contributor to the state's overall higher premiums. The high premiums experienced in various regions of Ohio may also be a significant contributor to the low take-up rates in those regions.

Further analysis of Ohio's rating areas also indicated an interesting phenomenon in regards to the distribution of Appalachian counties across rating areas. Rating areas structured to include a mix of Appalachian and non-Appalachian counties experienced lower premiums and higher carrier participation than rating areas including only Appalachian counties or non-Appalachian counties. It is possible that combining Appalachian and non-Appalachian counties into one rating area may have decreased fixed costs for carriers and resulted in slightly lower premiums for

consumers. However, this finding, coupled with the discussion above regarding distribution of census statistical areas across rating areas, suggests that there is a delicate balance between some heterogeneity across rating areas that can lead to spreading of fixed costs and lower premiums to too much heterogeneity within a rating area that can increase fixed costs and increase premiums.

It is also important to note that although the premium in rating areas including only non-Appalachian counties was higher than the rating areas including both Appalachian and non-Appalachian counties, the take-up rate in these rating areas (with only non-Appalachian counties) was higher. The difference in take-up rates between these rating areas therefore cannot be attributed solely to carrier participation or premium level. The difference may be attributed to another factor, such as a higher level of consumer awareness regarding ACA requirements and more targeted enrollment efforts and engagement of consumers in non-Appalachian versus Appalachian regions of the state.

#### *Provider competition and exchange plan participation*

One theme that emerged from the discussions was that some providers have been reticent about participating in the networks of exchange plans. An insurer commented that “providers have looked at this exchange opportunity with a fair bit of skepticism.” Another insurer stated that those who accept Medicaid are more likely to be comfortable accepting exchange plans.

On the other hand, one primary care provider indicated that “the payers just used our same contracts that we had for commercial. They essentially wouldn’t see a difference. Physicians might not even know. We just had to notify our offices because the plans are named differently”. When asked about why some physicians implicitly state that they are not accepting exchange plans, the discussant responded that “it might be that the rates for exchange aren’t as good for physicians as they are [for] commercial, so [they] might just be making the decision based on reimbursement”.

One provider mentioned that in rural areas it seems that some providers have not been asked to participate in exchange plans: “They [insurers] have a small number of providers that results in people having to drive sixty, seventy, eighty miles to get coverage within the network. Then they come back and they wonder why nobody here locally is participating. They put the blame on the local hospitals and physicians because we’re not part of that coverage. They are unaware that you have to be asked to participate in the coverage and we have to be willing to provide the service at what’s being paid. A lot of people don’t understand that.”

Exploring the relationship between hospital competition and premiums further, an insurer reflected that, “if you’re the only hospital in four counties, then you can kind of dictate the reimbursement rates.” A recent *Columbus Dispatch* article focused on an orthopedic surgeon, Dr. Brian Cohen, at Adena Health System (in Chillicothe, located in Rating Area 10) that was listed as one of the highest-paid physicians at a not-for-profit healthcare system nationally by Modern Healthcare. Dr. Cohen’s compensation was \$2.9 million in 2012. In order to attract quality surgeons to rural areas, providers may need to compensate at a higher rate. This in turn may increase the negotiated rate for certain procedures.

While some marketplace insurers that created “narrow networks” for some or all of their plans, the issue did not arise as a major concern during the course of the discussions. Discussants

reflected that the cost of premiums was the primary factor that consumers used in making plan selections, while accessibility of a particular provider was second, if it was on the consumer's radar. However, ODI stated that one of the reasons for drafting the network transparency rule described in Section 5 was a noted increase in the number of consumer complaints received regarding difficulty in obtaining accurate network information from insurers.

Another insurer stated the belief that health system consolidation is a barrier to enrollment and access and affects premium prices. We did not examine the extent of hospital consolidation with physician practices for this study.

#### *Other factors contributing to low enrollment*

##### ***Premiums and affordability***

As noted in Section 4, representatives across expert types noted that low enrollment is largely due to high premiums and lack of affordability. In addition to higher premiums in certain regions and a higher portion of population in the 200-399% FPL group, one discussant offered the hypothesis that ample insurer competition may have driven down the cost of the second-lowest-cost silver plan, therefore lowering the amount of APTC offered to Ohioans. This would have reduced overall affordability for subsidy-eligible potential consumers, even those looking at lower cost (bronze) plans.

Another explanation for low enrollment could be that Ohio experienced more rate shock than other states.<sup>xxxvi</sup> Because Ohio's insurance market was lightly regulated prior to the ACA, the percentage increase in premiums ended up being relatively high because of essential benefits, out-of-pocket limits, etc. Even with APTC, some younger or healthier people may have experienced increased rates and those with limited incomes may be particularly sensitive to those rates.<sup>xxxvii</sup>

Another discussant noted that Ohio's tobacco surcharge may be higher than other states. While insurers may vary premium rates by up to 50% based on tobacco use, the discussant's impression was that insurers may be pricing premiums higher for tobacco users in Ohio relative to other states. A 2014 study examining thirty-five states and the District of Columbia confirms this impression; Ohio was one of only eight states with median surcharges at or above 25% for exchange plans.<sup>xxxviii</sup> Given the high prevalence of tobacco use among Ohioans, the higher tobacco surcharge could contribute to higher than average marketplace premiums in Ohio, deterring marketplace enrollment. Further analysis would be needed to verify whether this is the case.

##### ***Brokers and agents***

Brokers and agents have a strong presence in Ohio. Their role in Ohio's FFM may not be unique to other states; however, there were several themes that arose through discussions related to brokers and agents that are important to highlight when examining the performance of Ohio's FFM.

There have been concerted efforts to increase the coordination of marketplace consumer outreach, assistance and enrollment efforts in Ohio among brokers, agents and navigators. However, many discussants indicated that there is room to improve the relationship. Specifically,

several discussants indicated that there was some confusion initially on how brokers and agents and navigators could work together, and what was and was not permissible by law. One broker stated, “early on, the way the law [ACA] was rolled out, there was some uncertainty whether brokers could work with navigators. So it created a lot of dissension and maybe misunderstanding about how each party worked and how we could work together.” The broker went on to indicate that the issue was “the feds creating that perception early on.”

The confusion impacted how effectively brokers/agents and navigators worked together for the initial open enrollment, however several discussants indicated that steps are being taken on the part of navigators and brokers and agents in Ohio to bridge and better coordinate their consumer outreach and enrollment efforts.

When asked about navigators, one broker remarked, “I like them because I don’t want to deal with the people who are highly subsidized or who don’t have insurance. It takes too much time for what you’re getting paid. You’d make more money working at McDonalds then trying to help someone get insurance who’s just getting involved for the first time.” Another broker indicated that only one-third of Ohio’s brokers and agents actually sell plans on the marketplace. Discussants also indicated that brokers and agents were likely to direct an individual to the individual marketplace only if they qualified for financial assistance. One discussant stated, “it’s my belief that if a person is not eligible for subsidies, why give them another layer of bureaucracy [by sending them to the FFM], since there’s no real value if they’re not eligible for subsidies.”

Two of the broker discussants had even stronger views when it came to the Small Business Health Options Program (SHOP) Marketplace. One remarked, “I don’t do small group through the exchange. I think they’re better served outside of the exchange in the small group market. You have more options off exchange in the small group market. You have fewer carriers for small group on the exchange. Again it comes down to bureaucracy...there isn’t any real value if I’m giving them another step or another person to deal with.”

## **6. Possible Remedies to address issues in the examined markets**

### *Restructure rating areas*

Ohio has structured its rating areas based on county lines, often grouping together urban and more rural regions of the state into one rating area. A recent study of rating areas conducted by Dickstein *et al.* (2015) found that states that combined areas of low population density with surrounding urban areas into a single rating area had higher carrier participation and lower annual premiums than other states. However, researchers also found that too much heterogeneity (i.e. high rural and urban mix) could lead to low carrier participation and higher premiums. Conversely, a study by Barker *et al.* (2014) indicates that states structuring their rating areas through a MSA+1 design, grouping metropolitan and non-metropolitan (or rural) regions of the state into separate rating areas, have, on average, lower premiums than other states.<sup>xxxix</sup>

Seven of Ohio’s seventeen rating areas include one of each type of census statistical area – metropolitan, micropolitan and non-metropolitan. These seven rating areas are more heterogeneous than the remaining nine rating areas in the state and have the highest premiums and lowest marketplace take-up rates relative to other rating areas in the state (see Table 4.6). As

homogeneity within a rating area in Ohio increased, average premium amounts appeared to decrease and take-up rates appeared to increase.

It's also important to note that the methodology of using the second lowest cost silver plan (SLCSP) as the basis for calculating premium tax credits does not seem to be advantageous for some Ohioans given how rating areas are structured. As mentioned in the analysis, Ohio's average premiums after tax credits are higher than all states except one. While a competitive market may drive down the cost of the SLCSP in a rating area, it's possible that the SLCSP may not be offered in the entire rating area, especially in rating areas that are more heterogeneous or include both urban and rural populations. Therefore, the second lowest silver plan may not always be available to a person for purchase, if a carrier does not offer the second lowest silver plan in all parts of the rating area. Consequently, people in these heterogeneous rating areas may experience high premiums, yet may not receive a tax credit sufficient to offset these higher premiums.

Given these findings, Ohio should consider restructuring its rating areas based on the MSA+1 design. It appears that Ohio's rating areas could be too heterogeneous – resulting in higher fixed costs and premiums across the state. By restructuring its rating areas based on a MSA+1 design, Ohio could potentially lower premiums and increase marketplace take-up rates and overall enrollment.

#### *Encourage provider price and quality transparency*

Another way to enhance insurance marketplace competition would be to encourage greater price and quality transparency among providers. With provider charges available in the public domain, providers are more likely to be motivated to continuously improve, competing with others on the basis of quality, price and service. Likewise, purchasers, armed with price and quality data, may structure contracts, payments and benefits in a way that encourages the purchase of health care services and health care coverage with the highest value. Finally, consumers can make informed decisions, selecting carriers who contract with providers who provide the highest quality care at the best value for their dollar. Taken together, greater price and quality transparency may lead to lower insurance premiums.

#### *Incentivize consumer outreach, education, and enrollment efforts targeting rural regions and special populations*

Low consumer awareness about marketplace coverage options and limited outreach efforts across the state emerged as prevailing themes from stakeholder discussions. Discussants from all sectors noted challenges including a lack of understanding of the requirement and value of purchasing health insurance coverage, low health insurance literacy and understanding of benefit plan design, and negative perceptions of the ACA more generally.

As a FFM state, there is no state-led initiative to coordinate outreach, enrollment, and consumer assistance in Ohio. The navigator program is the primary source of federal funding for consumer assistance, and Ohio received less funding per uninsured than most other FFM states. This limited the reach of assisters across the state, particularly in rural areas. Additionally, much of the outreach during the first open enrollment period focused on Medicaid expansion, which resulted in less emphasis on marketplace coverage. Consumers' initial distrust of the ACA was

encouraged by the critical views of state policymakers and created additional challenges for assisters.

In light of these challenges, increased outreach, education, and enrollment efforts are necessary for future enrollment periods. Increased funding would allow additional capacity and reach for assisters to work across the state. Our findings suggest that targeting or incentivizing efforts towards rural areas and minority groups would help to increase enrollment of those populations, while allowing continued work in more urban areas. Assisters should also acknowledge that they may need to spend additional time combating anti-ACA sentiment and consumers may need additional “touches” before they are ready to enroll. Coordinated mass media campaigns may help positively change perceptions in the community.

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## Appendix F-1: Secondary Data for Ohio State Memo

**Table F-1.1 HPIO analysis of Enroll America marketplace data**

Rating Area	County		2013 Total Uninsured	2013 Uninsured <138%	2013 Uninsured >138	Plans Purchased thru 2/22/15	Take Up Rate	Est. Remaining Uninsured 2015 >138%
			353,670	152,335	201,335	52,936	30.11%	148,399
9	Delaware County	0.72%	9,383	2,743	6,640	3,523	53.06%	3,117
9	Fairfield County	1.00%	13,127	4,680	8,447	2,511	29.73%	5,936
9	Fayette County	0.33%	4,319	2,109	2,210	368	16.65%	1,842
9	Franklin County	11.86%	155,503	70,295	85,208	25,761	30.23%	59,447
9	Knox County	0.68%	8,973	3,663	5,310	1,119	21.07%	4,191
9	Licking County	1.37%	17,986	6,385	11,601	2,733	23.56%	8,868
9	Logan County	0.49%	6,448	3,086	3,362	429	12.76%	2,933
9	Madison County	0.36%	4,664	1,724	2,940	612	20.82%	2,328
9	Pickaway County	0.38%	5,027	1,836	3,191	678	21.25%	2,513
9	Union County	0.33%	4,306	1,378	2,928	715	24.42%	2,213
10	Gallia County	0.34%	4,468	1,802	2,666	348	13.05%	2,318
10	Jackson County	0.35%	4,623	2,655	1,968	454	23.07%	1,514
10	Lawrence County	0.60%	7,875	3,169	4,706	803	17.06%	3,903
10	Pike County	0.31%	4,065	1,800	2,265	397	17.53%	1,868
10	Ross County	0.71%	9,334	5,002	4,332	1,126	25.99%	3,206
10	Scioto County	0.85%	11,191	4,728	6,463	874	13.52%	5,589
10	Vinton County	0.14%	1,805	549	1,256	80	6.37%	1,176
16	Belmont County	0.55%	7,255	3,043	4,212	1,076	25.55%	3,136
16	Coshocton County	0.44%	5,799	2,594	3,205	710	22.15%	2,495
16	Guernsey County	0.42%	5,531	2,594	2,937	495	16.85%	2,442
16	Harrison County	0.14%	1,779	806	973	93	9.56%	880
16	Jefferson County	0.57%	7,506	3,122	4,384	1,273	29.04%	3,111
16	Monroe County	0.13%	1,720	909	811	172	21.21%	639
16	Morgan County	0.15%	2,013	953	1,060	222	20.94%	838
16	Muskingum County	0.77%	10,067	4,002	6,065	1,366	22.52%	4,699
16	Noble County	0.12%	1,548	718	830	113	13.61%	717
16	Perry County	0.38%	4,936	2,188	2,748	461	16.78%	2,287
16	Tuscarawas County	0.89%	11,642	4,959	6,683	1,375	20.57%	5,308
17	Athens County	0.51%	6,686	2,957	3,729	947	25.40%	2,782
17	Hocking County	0.28%	3,626	1,302	2,324	537	23.11%	1,787
17	Meigs County	0.27%	3,563	1,544	2,019	220	10.90%	1,799
17	Washington County	0.53%	6,902	3,040	3,862	1,345	34.83%	2,517
		24.92%						

**Table F-1.2 County Health Rankings - rank**

Rating Area	County	Health outcomes rank (of 88)	Quality of life rank (of 88)	Health factors rank (of 88)	Clinical care rank (of 88)	Social and economic factors rank (of 88)	Physical environment rank (of 88)
9	Delaware County	1	3	1	1	1	55
9	Fairfield County	15	21	13	7	13	56
9	Fayette County	80	83	60	64	49	7
9	Franklin County	52	62	46	19	60	53
9	Knox County	37	6	34	53	29	35
9	Licking County	31	33	32	21	31	47
9	Logan County	40	26	29	17	36	15
9	Madison County	45	35	39	41	39	67
9	Pickaway County	57	67	49	60	42	75
9	Union County	5	14	7	15	6	37
10	Gallia County	84	80	66	42	72	13
10	Jackson County	83	82	84	81	80	60
10	Lawrence County	88	88	70	71	63	16
10	Pike County	85	84	88	78	88	86
10	Ross County	81	86	72	29	76	22
10	Scioto County	86	87	86	72	83	39
10	Vinton County	73	77	83	82	85	49
16	Belmont County	60	70	52	73	46	43
16	Coshocton County	44	48	61	74	59	40
16	Guernsey County	58	55	75	80	64	52
16	Harrison County	76	68	74	87	50	88
16	Jefferson County	82	73	76	77	66	65
16	Monroe County	47	58	67	83	70	34
16	Morgan County	61	76	77	85	82	25
16	Muskingum County	66	61	63	55	74	62
16	Noble County	25	42	69	76	61	69
16	Perry County	51	45	71	65	68	74
16	Tuscarawas County	30	34	45	63	33	57
17	Athens County	59	50	53	47	56	27
17	Hocking County	53	47	48	51	53	38
17	Meigs County	79	81	87	79	84	23
17	Washington County	33	41	28	46	34	19

**Table F-1.3 County Health Rankings - measure**

Rating Area	County	Adult smoking rate	Uninsured rate (under 65)	Population age: % below 18	Population age: % 65 and older	Median household income	Medicare reimbursements per enrollee (price adjusted)	Could not see a doctor due to cost	PCP Ratio
		2006-2012	2012			2013		2006-2012	2012
9	Delaware County	12%	7%	27.9%	11.1%	\$89,016	\$9,513.00	4%	827:1
9	Fairfield County	20%	11%	24.8%	14.0%	\$56,697	\$10,682.00	13%	1676:1
9	Fayette County	31%	14%	23.8%	16.2%	\$40,031	\$10,553.00	26%	2888:1
9	Franklin County	20%	15%	23.7%	10.6%	\$51,456	\$10,046.00	13%	1037:1
9	Knox County	21%	14%	23.3%	16.0%	\$47,053	\$10,297.00	11%	2529:1
9	Licking County	23%	13%	23.9%	14.8%	\$54,909	\$9,461.00	13%	2327:1
9	Logan County	22%	14%	24.3%	16.2%	\$50,077	\$8,928.00	-	1819:1
9	Madison County	25%	12%	21.4%	13.7%	\$54,039	\$9,920.00	23%	1957:1
9	Pickaway County	21%	13%	22.4%	14.3%	\$52,666	\$11,147.00	13%	2350:1
9	Union County	19%	10%	26.0%	11.0%	\$68,650	\$10,581.00	5%	2292:1
10	Gallia County	31%	15%	23.0%	16.9%	\$39,447	\$10,443.00	18%	960:1
10	Jackson County	27%	14%	24.0%	15.4%	\$37,823	\$10,876.00	16%	2746:1
10	Lawrence County	26%	14%	22.7%	16.7%	\$41,137	\$11,157.00	21%	2142:1
10	Pike County	26%	14%	24.0%	15.8%	\$41,092	\$12,210.00	15%	3560:1
10	Ross County	33%	13%	22.0%	14.6%	\$42,730	\$11,419.00	14%	1461:1
10	Scioto County	34%	15%	22.1%	16.3%	\$36,682	\$13,246.00	26%	1706:1
10	Vinton County	21%	15%	23.0%	15.1%	\$37,842	\$9,843.00	12%	13239:1
16	Belmont County	22%	14%	19.2%	18.5%	\$39,264	\$10,767.00	18%	2177:1
16	Coshocton County	21%	15%	23.5%	17.5%	\$39,496	\$10,129.00	18%	2627:1
16	Guernsey County	30%	15%	22.9%	17.2%	\$39,760	\$9,959.00	11%	1991:1
16	Harrison County	34%	14%	20.9%	19.4%	\$40,343	\$11,301.00	11%	1964:1
16	Jefferson County	29%	14%	19.6%	19.2%	\$38,074	\$12,186.00	15%	2442:1
16	Monroe County	-	14%	20.9%	21.1%	\$41,000	\$9,889.00	-	7275:1
16	Morgan County	22%	16%	22.1%	18.8%	\$36,057	\$9,698.00	20%	14911:1
16	Muskingum County	23%	14%	23.6%	16.4%	\$40,399	\$9,789.00	13%	1563:1
16	Noble County	-	15%	18.6%	23.0%	\$42,425	\$10,225.00	-	4860:1

16	Perry County	25%	15%	24.7%	14.5%	\$41,586	\$10,337.00	14%	4002:1
16	Tuscarawas County	22%	15%	23.0%	17.6%	\$44,121	\$9,623.00	14%	2200:1
17	Athens County	30%	16%	15.2%	11.0%	\$35,783	\$9,904	18%	1128:1
17	Hocking County	25%	15%	23.4%	16.6%	\$42,376	\$10,906.00	13%	2091:1
17	Meigs County	40%	16%	22.3%	17.1%	\$40,023	\$10,868.00	-	5898:1
17	Washington County	20%	13%	20.1%	18.7%	\$41,236	\$10,569.00	13%	1336:1
		OH: 21%	OH: 14%	OH: 22.9%	OH: 15.1%	OH: \$48,138	OH: \$10, 365	OH: 13%	OH: 1336:1

**Table F-1.4 ODH Hospital Registration, Quick Strike Analysis, Census Bureau and Ohio Poverty Report 2015**

Rating Area	County	# of hospitals (does not include LTAC, PSYCH, REHAB)	# of tax-exempt hospitals that include county in defined service area	Rural density (percent population living in rural area, 2010 census)	% population in poverty
		ODH Hospital Registration	Quick Strike Analysis	Census Bureau	Ohio Poverty Report 2015
9	Delaware County	1	1	19.3%	4.9%
9	Fairfield County	2	2	34.7%	11.9%
9	Fayette County	1	0	47.8%	20.1%
9	Franklin County	14	12	1.4%	18.1%
9	Knox County	1	1	55.7%	14.2%
9	Licking County	2	1	35.5%	12.0%
9	Logan County	1	2	56.9%	15.9%
9	Madison County	1	1	48.5%	11.0%
9	Pickaway County	1	0	49.9%	13.3%
9	Union County	1	1	50.0%	7.8%
10	Gallia County	1	2	81.4%	17.7%
10	Jackson County	1	3	64.6%	24.6%
10	Lawrence County	1	2	45.9%	18.3%
10	Pike County	1	2	74.2%	23.5%
10	Ross County	1	1	58.7%	19.7%
10	Scioto County	2	2	54.3%	23.3%
10	Vinton County	0	0	100.0%	20.6%
16	Belmont County	3	3	54.7%	14.6%
16	Coshocton County	1	3	61.5%	16.9%
16	Guernsey County	1	5	61.4%	20.3%
16	Harrison County	1	3	84.1%	18.4%
16	Jefferson County	2	2	40.0%	16.6%
16	Monroe County	0	1	97.7%	19.0%
16	Morgan County	0	2	81.5%	20.2%
16	Muskingum County	2	2	47.0%	18.1%
16	Noble County	0	3	62.5%	15.2%
16	Perry County	0	2	75.2%	19.6%
16	Tuscarawas County	2	6	41.6%	14.6%
17	Athens County	1	2	43.2%	31.7%
17	Hocking County	1	1	70.8%	15.9%
17	Meigs County	0	2	81.3%	21.9%
17	Washington County	2	2	56.6%	15.3%
				OH: 22.1%	OH: 15.8%

**Table F-1.4 Averages by Rating Area**

<b>Rating Area</b>	<b>Avg PCP by rating area</b>	<b>Total hosp by rating area</b>	<b>Avg # of hosp per area</b>	<b># counties w/o hospital</b>
9	1970:1	25	2.5	0
10	3688:1	7	1	1
16	4183:1	12	1.1	4
17	2613:1	4	1	1

## Appendix G: Texas State Memo

### Submitted by

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### 1.State Context

Texas is the second largest state in the nation. It has a large Hispanic population and health status characteristics that largely mirror the U.S. as a whole. Blue Cross Blue Shield of Texas (BCBS) has long been the dominant insurer in the individual and small group market in Texas although a number of other carriers are active in the state. Table G.1.1 provides some basic background on the State.

**Table G.1.1: Basic State Facts**

Type of Exchange	Federally Facilitated Marketplace (FFM)
Expansion of Medicaid	No
Number of rating areas	26 (25 MSAs and 1 all rural)
Number of insurers	64 non-group insurers; 11 exchange insurers
Net change in number of insurers	Increased from 8 to 11 exchange insurers for 2015
State Population and Rank	26,422,500; Rank: 2 <sup>nd</sup> in US
Median State Household Income and Rank	\$51,752; Rank: 27 <sup>th</sup> in US
Salient Health Facts (e.g., Regions with concentrations of certain conditions, or with particularly concentrated poor health status)	Leading causes of death in Texas mirror the U.S. South and West Texas have substantially poorer health on most state measures.
Salient Health Policy Information (e.g., Previous reform initiatives and relevant health-insurance policies and requirements, notable insurance regulations)	Texas requires navigators to be licensed after undergoing 30 hours of training. Texas has network adequacy regulations that the Texas Department of Insurance considers ahead of the curve. Otherwise the Department of Insurance is uninvolved in the Exchanges.

Texas government and policy has been actively opposed to the implementation of the Patient Protection and Affordable Care Act (ACA).<sup>i</sup> The state chose not to expand its Medicaid program and uses a federally facilitated marketplace. The state's Department of Insurance is not involved in any aspect of the operation of the exchanges except that it licenses and regulates health insurers generally. In 2013, CMS notified state insurers that, if there was no state-legislated enforcement authority, the federal agency would assume insurance enforcement authority and review premium increases. Also in 2013, the state enacted legislation requiring insurance navigators to be licensed and undergo an additional 20 hours of training beyond the federal requirements.<sup>ii</sup>



In 2013, the Current Population Survey (CPS) estimated that nearly 16 million people in Texas were aged 19 to 64. Approximately 54 percent had employer-sponsored health insurance coverage and another 6 percent had other private coverage, notably non-group purchased plans. Medicaid provided coverage to approximately 8 percent of this group and 28 percent were uninsured. This implies that 4,491,300 working-age Texans reported they lacked health insurance coverage in 2013.<sup>iii</sup> The number and percentage of uninsured in the state have been fairly stable between 2010 and 2013.

Recent data from an online survey by the Baker Institute at Rice University suggests that the number of uninsured in Texas has decreased substantially in the last year. The study researchers reported that between September 2014 and March 2015, the percentage of working age Texas adults without health insurance coverage declined from 24.6 percent to 16.9 percent.<sup>iv</sup> The survey results indicate that much of the increase was from increased purchase of non-group plans. The percentage of respondents with non-group private plans increased from 10.3 percent in September of 2013 to 17.7 percent in March of 2015. This survey is not without its limitations, however. Of particular note, the survey was internet-based and had a completion rate of approximately 5 percent each quarter.

These findings are consistent with data on the ACA. The ACA had its first open enrollment period between September 1, 2013 and March 31, 2014. This enrollment period was fraught with technical difficulties for federal-default insurance exchanges like Texas as well as for the state-based exchanges. In this first year of operation Texas saw enrollment of 745,339. Some of the exchange enrollees, of course, had lost private coverage, but others were newly covered. Texas did allow insurers to renew non-compliant plans in the first year of the ACA. In the second enrollment period, November 15, 2014 through February 15, 2015 exchange enrollment in Texas was 1,251,270, an increase of 68 percent. This increase of over 500,000 in Texas was only exceeded by California and Florida.<sup>v</sup> The Kaiser Family Foundation estimated that the percentage of potentially eligible enrollees in Texas increased from 24 percent to 32 percent between the two open enrollment periods, an increase of 32 percent.<sup>vi</sup>

## **2. State Study Area and Rationale**

Texas has 25 MSA-defined rating areas, with each including 1 to 12 counties and a single additional rating area composed of the remaining 194 rural counties. During the initial open enrollment period, 11 carriers were offering coverage in one or more counties; and 14 carriers offered coverage in the second enrollment period. During the second open enrollment period all counties had at least two carriers offering coverage. Blue Cross Blue Shield of Texas (BCBS) is the only carrier to offer an exchange plan in every county.

We selected three Texas MSAs for this study (See Table G.2.1): Laredo, Bryan-College Station, and Waco. They will be studied comparatively. Each metro area has an approximate population of 240,000 but had two, four, and six exchange carriers, respectively in the initial year of the exchange. This approach allows us to examine market level differences that may begin to explain the substantial differences in carrier participation in three self-contained rating areas with essentially equal populations.

**Table G.2.1: Rationale for Rating Area Selection**

<b>Rating Area</b>	<b>Rationale</b>
Laredo (rating area 12) Webb County	Laredo has an approximate population of 250,000 people on the Mexican border. Laredo's exchange is served by two carriers: BCBS and AssurantHealth. In 2014, it had exchange enrollment of 5,903 and 10,980 in 2015. In 2015 the second lowest-cost Silver plan for a 27-year old non-smoker was \$194.50 per month. Median household income in 2014 was \$35,974 and the uninsured rate for those aged 18 to 64 was 49 percent.
Bryan-College Station (rating area 6) Brazos, Burleson and Robertson Counties	Bryan-College Station (BCS) has a metro population of approximately 230,000 people. It is in the central section of the state and is the home to one of the largest public universities in the state. All three counties are served by three common carriers: BCBS, AssurantHealth, and Baylor/Scott & White. However, Brazos is also served by Cigna, and Robertson by FirstCare. In 2014, the MSA had exchange enrollment of 3,077 and 5,867 in 2015. The second lowest-cost Silver plan for a 27-year old non-smoker was \$205.24. Median income across the three counties ranged from \$39,771 to \$43,561. The uninsured rate ranged from 28 to 32 percent.
Waco (rating area 24) McLennan County	Waco has an approximate population of 230,000 people. Waco is approximately 100 miles south of the Dallas-Forth Worth MSA and 100 miles north of the Austin MSA. Waco is home to a large private university. It is served by six carriers: BCBS, FirstCare, AssurantHealth, Humana, Baylor/Scott & White, and AmBetter. In 2014, Waco had exchange enrollment of 3,733 and 7,138 in 2015. The second lowest-cost Silver plan for a 27 year-old non-smoker was \$200.02. The median income was \$40,855 and the uninsured rate among adults was 29 percent.

### 3. Data Collection Methods

This analysis relies on two general data sources. The first is a series of discussions conducted over the phone and in person. The second consists of publically available state specific reports prepared by various organizations. Table G.3.1 reports the number of discussions undertaken by type of expert.

**Table G.3.1: Number of Discussions Conducted by Expert Type**

Agents	3
Navigators	2
Insurers	1
Hospitals	3
Physicians	0
Regulators	5
Policy Experts	1

Contacts with experts generally resulted from direct emails or phone calls to known experts. In some cases the initial phone calls resulted in referrals to other parties whom the initial respondent considered better able to address the questions.

E-mail contacts of hospitals, regulators, and insurers included a set of potential questions and an assurance that: participation was voluntary; that no names of individuals would be disclosed; and that the study team was requesting information based on their personal view of the market. They were not asked to speak for their organization. Phone discussions with agents, navigators, and policy experts included the same assurances.

Discussions with regulators, agents, navigators, and policy experts began with a question about their sense of the extent of competition in Texas and in their local market (if appropriate). This was followed by questions addressing how one would know the extent of competition, what factors mattered in competing in the insurance market, whether two additional carriers would likely enhance competition in the market. This led to discussions of problems experienced and their sense of what future competition would look like. However, the discussions varied considerably depending upon the nature of the initial questions.

For the hospitals, questions generally followed the same line of inquiry but also asked explicitly about the effects of the ACA on their organizations, and their experience interacting with the carriers in the exchange

#### **4. Findings and Analysis of Marketplace Conditions**

The Texas Department of Insurance (TDI) provided enormous assistance in improving our understanding the nature of the market in Texas. TDI conducted its own recent analysis of the market (completed in June 2015), shared this document with the study team, and had more direct discussions related to the project issues and reactions to comments obtained from other stakeholders.

TDI's report indicated that there were 93 insurers in the non-group market reporting that they had collected premiums in the Texas in 2010. This number declined to 67 in 2012 and to 64 in 2014.<sup>vii</sup> The decline largely resulted from the exit of carriers who offered limited option plans that were not compatible with the ACA. Over this period, 46 carriers left the market and 28 new carriers entered. Many of these had not been active in the state. Not surprisingly, these changes had virtually no impact on market shares; the combined premium-based market share of those exiting was 5.0 percent and 1.65 percent for those entering. Over the period, the top carrier, Blue Cross Blue Shield of Texas (BCBS) had a premium-based market share that increased from 54 percent in 2010 to 68 percent in 2014. Based on enrollment, the BCBS market share increased over the same period from 55 to 59 percent. Over this five-year period, statewide individual enrollment was fairly stable at approximately 730,000 covered lives until 2014 when it doubled to 1,467,240 covered lives.

One insurance agent noted, however, that BCBS had lost \$400 million in its Texas individual market last year. Regulators confirmed this. Press reports indicate that this was a 20 percent loss on ACA compliant plans.<sup>viii</sup> It is not clear whether the loss was a result of a strategic intent to maintain and expand its market share by underpricing products, or a misjudgment of the claims costs of its new enrollees, or some combination of both.

### *The health insurance exchange in Texas*

Most of the national carriers are licensed to provide coverage in every Texas county. However, to date, they only participate in selected MSA rating areas and sometimes only in selected counties within these rating areas. This suggests that there is substantial potential for new entry into the Texas exchanges. The website HealthPocket demonstrates as much. For each of our study rating areas it provides links to each of the plans offered on the exchange as well as other “ACA compliant” plans that are offered but not eligible for a subsidy, that is, offered off the exchange.<sup>ix</sup>

The number of health insurance carriers in the federal exchanges in Texas expanded between its first and second year of operation. A 2014 case study of the Texas market conducted by the University of Texas-Austin Lyndon B. Johnson School of Public Affairs found that there were 11 health insurance carriers participating in the federal-default Texas exchange. BCBS provided coverage in all 254 counties, with FirstCare offering coverage in 108 counties, and Scott & White and Aetna providing coverage in 51 and 49 counties, respectively. The other seven carriers offered coverage in many fewer counties, typically in selected regions in the state.<sup>x</sup>

In the second year, there were 13 carriers offering exchange coverage in Texas. The new entrants were AssurantHealth, United HealthCare, and WelcomeHealth. No plans exited.

A common view seems to be that the market is dominated by BCBS and that it gets “pushed” to offer lower premiums by a number of small and regional insurers. An insurer representative suggested that the smaller regional insurers were often tied to a particular health care system. This limited their geographic reach but may have given them a local premium advantage over BCBS or national carriers in as much as these systems may have given larger discounts to their own insurance products. The large national insurers, while present in some rating areas, were not always significant exchange players in the moderately sized urban markets we focused on. The insurer representative indicated, “Texas was tricky.” The view was that the ability to compete in Texas depended almost entirely on establishing viable and price competitive networks. This was difficult given BCBS’ large market share and long established relationship with providers together with the price concessions he suspected that health systems gave their own plans. He noted that while they were successful in establishing an insurance product in one metropolitan market, they could never get the network together to duplicate that success in other Texas metros.

AssurantHealth was the most notable entrant in as much as it provided exchange plans in all 25 of the MSA rating areas. This appears to have been part of a national corporate strategy to more aggressively participate in the exchanges. Agents in Texas suggested that AssurantHealth was moving from a strategy of offering supplemental and limited coverage plans to offering fully ACA-compliant plans. In June 2015 it announced with would withdraw from the health insurance field at the end of the year.<sup>xi</sup> In our analysis of premiums in the three rating areas of study, AssurantHealth typically offered generous plans at some of the highest premiums in those areas.

### *Competition in the three rating areas*

Views from respondents were mixed on how competitive the exchange markets were in our three rating areas. All respondents noted that the plans did very little marketing of their exchange products in contrast to the marketing that goes on during large-group open enrollment periods. Some thought the carriers had set their premiums high across the board to limit enrollment during the first few uncertain years of the ACA. This seems inconsistent with the losses reported for BCBS. Other respondents, as noted above, maintained that the small regional insurers tended to put pressure on BCBS.

Table G.4.1 reports the Silver premiums for a 27-year old non-smoker in each of our three rating areas. We report the lowest and second lowest premiums, and the highest premium together with the carrier offering that plan. In addition, we report the exchange market share of the (unnamed) carrier with the greatest share in the rating area.<sup>xii</sup>

**Table G.4.1 Premiums for Least and Most Costly Silver Plans by Rating Area**

<b>Rating Area (#)</b>	<b>Least Cost Silver</b>	<b>2<sup>nd</sup> Least Costly Silver</b>	<b>Highest Cost Silver</b>	<b>Number of Carriers</b>	<b>Market Share of (unnamed) Largest Carrier</b>
Laredo (12)	\$186.80 BCBS	\$194.50 BCBS	\$261.67 Molina	3	99.2%
Bryan-College Station (6)	\$205.24 Scott & White	\$207.12 FirstCare	\$383.84 Assurant	5	68.4%
Waco (24)	\$186.17 Humana	\$198.77 AmBetter	\$285.82 Aetna	7	38.3%

The data generally support the view that BCBS does not always have the lowest or the second lowest Silver premium; a regional insurer such as Scott & White or FirstCare was often lower. However, even though Aetna offers the highest cost plan in Waco, Humana, another national carrier, has the lowest cost plan. Apparently, there is no simple relationship between the number of carriers offering a plan on the exchange and the premiums of the lowest and 2<sup>nd</sup> lowest cost plans in these moderately sized urban markets. The data do suggest, however, that a larger number of carriers in the market is associated with a smaller market share of the largest carrier.

However, the Laredo market suggests how complicated understanding health market competition may be. Laredo is located on the Texas-Mexico border. It is known for having some of the worst health status indicators in the state. This alone might suggest that plans may be reluctant to service this rating area relative to some others. It does have the fewest carriers offering coverage in any MSA rating area. Nonetheless, its premiums are essentially as low as in Waco where the number of carriers offering coverage is more than twice as great. The key to this market appears to be the role played by health care providers in nearby Nuevo Laredo, Mexico. People routinely cross the border for health care services. Paraphrasing one respondent: There is one urologist in Laredo; there are seven in Nuevo Laredo. Those seven urologists in Mexico have lower prices and the currency exchange rate for U.S. dollars is favorable, making cash payments an affordable option. This makes a low premium bronze plan with a \$6,000 deductible less attractive for uninsured residents of Laredo. That respondent also suggested that when the dominate carrier in the area has an established relationship with local providers it is difficult for new entrants to negotiate provider prices that can give them a competitive edge.

It is unclear the extent to which Texas insurers newly offered narrow network plans. BCBS did introduce a new HMO product in 2013-14 that was described as having only a relatively few participating physicians. Discussants speculated that this was done to compete with the smaller regional carriers. However, in both Waco and Bryan-College Station existing regional insurers offer closed panel HMOs for some time, so in some sense narrow networks already existed in these rating areas. Additionally, in late July BCBS of Texas announced that it will eliminate its PPO product in the Texas individual market and will only offer the HMO plan with its smaller networks. This was reportedly done in response to the \$400 million in losses last year and as an alternative to raising premiums as dramatically as would have been necessary.<sup>xiii</sup>

Thus, the insurer market in Texas, both statewide and in the three rating areas, is dominated by BCBS. Discussants believe that additional insurers would result in somewhat lower premiums and that, in the three rating areas, at least, regional insurers are able to challenge BCBS on premiums. There appears to be little to distinguish the premiums in the three rating areas. The lower cost plans are generally fairly comparable. As we noted earlier, it is also the case that there are often several carriers offering off-exchange products in the same markets and it is conceivable that these markets are contestable in the sense that the off-exchange products limit the premiums that on-exchange plans can charge. Less conceptually, these carriers may only be waiting for better information on the implicit risk profile of potential enrollees before entering these rating areas. However, as we note in the next section, access to providers at favorable prices is a key issue.

#### *Providers and insurers*

Agents and health care providers generally believe that low premiums drive enrollment (see below). This may be due to the size of the networks and the prices that carriers have negotiated with insurers.

Regulators and agents also view consolidation in the number of Texas free-standing hospitals over the last 15 years to have hindered the ability of insurers to negotiate prices as effectively as they once did. While an insurer may be interested in entering one of the markets, it has to have a cost advantage to be competitive. When there were only one or two systems of providers in a moderately sized market, it was difficult to negotiate a meaningfully lower price, or even a price comparable to that of BCBS or to that of the regional insurer. One agent maintained that BCBS had negotiated substantially lower prices than other carriers but still only set premiums on a par with other insurers who did not get nearly as low prices. (This is, of course is inconsistent with the BCBS losses reported earlier.)

Some smaller hospitals have indicated that they have not been included in some plan networks and other hospitals indicated that they are in some plans but not others. All of the hospitals we spoke with were reluctant to discuss why they were not in these networks.

In general there seemed to be a strong view among our respondents that consolidation of the hospital industry has reduced the ability of insurers to negotiate lower prices. Many commented on the national press reports of potential mergers in the health insurance industry.<sup>xiv</sup> Some see the consolidation as a natural response to the loss of bargaining power that has affected insurers vis-à-vis hospitals. Many also fear that increased insurer concentration will undermine the ability of the regional insurers to compete in the federal exchange marketplace.

### *Consumers, enrollment and information*

Respondents generally hold that enrollment in the insurance exchange in Texas has been driven by price. Consumers are said to have limited understanding of the nature of insurance coverage or the meaning of deductibles, coinsurance and copays. They certainly don't understand issues of in- and out-of-network providers. Thus, they are driven to the lowest cost plans based on a fear of penalties for non-enrollment.

Agents report that there was tremendous confusion and frustration in the first year of the ACA in Texas, but that this had settled down substantially in the second year. However, they and the navigators indicated substantial misunderstanding, confusion and fear associated with participating in the exchanges. The negative press and Texas political opposition attendant to the exchanges in the first year and continuing to some extent into the second year is also said to be a major factor.

Regulators say they have heard few complaints and certainly fewer in year two. However, they also stated, "Everyone knows that we have nothing to do with the exchanges [so we don't field many complaints]". Agents indicated that the largest set of complaints now relate to errors in coverage and mistaken cancellations. They indicated that even prior to the exchanges, carriers would mistakenly drop coverage for an individual or sometimes doubly enrollment. Sometimes there were billing errors. This now happens in the exchange plans as well. However, they indicated that it is much more difficult to interact with the exchange than it was with individual carriers. "As an agent I used to be able to call a carrier and resolve a billing or coverage issue. With the exchange the client has to be present and there seems to be no easy way to resolve issues." In addition, agents indicated that the narrow open-enrollment period made it difficult for them to stay up to date on health insurance issues and to justify a time-investment for a small market segment.

All pointed out that there was little marketing or outreach in Texas. This may partially reflect plans not wanting to devote many resources to minor markets. However, it undoubtedly also reflects the lack of navigators in the state. Texas requires licensure and the regulators indicated that there were approximately 500 navigators in the state compared to 525,000 health insurance agents. Some of the hospital respondents indicated that they implemented their own outreach programs in an effort to reduce the number of uninsured that they treat.

## **5. Possible Remedies to Enhance Marketplace Competition**

Respondents in Texas had few possible remedies to offer to enhance marketplace competition.

### *Increase consumer knowledge, marketing and outreach*

Virtually all respondents indicated that most uninsured Texans had little understanding of health insurance products or the tradeoffs between a complex system of premiums, deductibles, network composition, and other components of choices for plan enrollment in the exchange. The learning curve going from uninsured to insured was perceived to be very steep.

Navigators argued for more navigators and greater funding, particularly outside of the largest metropolitan areas.

Agents suggested that the open enrollment window could be longer to allow more opportunity to educate consumers and to familiarize them with potentially unfamiliar health insurance terms.

*Monitor and address antitrust issues with provider concentration*

Regulators and agents believe that the consolidation of hospitals and other providers along with a perceived statewide dominance by BCBS has reduced the ability of less well established insurers to negotiate lower prices.

There is related concern about the impending consolidation of insurers nationally.

*Rating issues*

Regulators were generally of the view that the geographic rating areas, as defined, were adequate for Texas. This was attributed to consultation with the industry before the areas were set. Most insurers apparently also considered the areas as “about right.”

However, Texas insurance regulators were concerned that the ACA age corridor of a 1 to 3 range in premiums from youngest to oldest was too narrow and resulted in premiums that were much too high to be reasonably borne by young people. They suggested that a possible remedy to enhance enrollment would be to expand the corridor to 1 to 5.



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