

FIVE-STATE STUDY OF ACA MARKETPLACE COMPETITION

A SUMMARY REPORT
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Acknowledgments

This report is the result of conversations between Alice Rivlin, Richard Nathan, and me in the fall of 2015. We had completed work on a report to the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (ASPE), examining the early indications of health insurance competition in several states. However, we were of the view that important changes were underway in the field. Under Alice Rivlin's leadership, we were able to develop a proposal that was funded by the Brookings Institution's Center for Health Policy. Timely field research was made possible because Richard Nathan of the Rockefeller Institute of Government had established the 40-state ACA Implementation Field Network.

The three of us, together with Mark Hall, the Turnage Professor of Law at Wake Forest University, and Micah Weinberg, President of the Economic Institute at the Bay Area Council in California, developed some guiding issues and questions to lead the discussions with insurers, providers, brokers, navigators, and regulators in our five states. The heavy lifting, of course, was undertaken by the state field researchers: Micah Weinberg in California; Patricia Born, Professor of Insurance at Florida State University in Florida; Megan Foster Friedman, Josh Fangmeier, Nancy Baum, and Marianne Udow-Phillips of the Center for Healthcare Research & Transformation in Michigan; Mark Hall in North Carolina; Tiffany Radcliff, Professor of Health Economics at Texas A&M University; and myself in Texas. Caitlin Brandt of Brookings managed the process and kept us on track. Cliff Foster at the Colorado Health Institute assisted with the editing of this report and the five field reports.

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Section 1 – Introduction

The health insurance marketplaces created by the Affordable Care Act (ACA) were intended to broaden health insurance coverage by making it relatively easy for the uninsured, armed with income-related federal subsidies, to choose health plans that met their needs from an array of competing options. The further hope was that competition among health plans on the exchanges would lead to lower costs and higher value for consumers, because inefficient, low-value plans would lose out in the competitive market place. This study sought to understand the diverse experience in five states under the ACA in order to gain insights for improving competition in the private health insurance industry and the implementation of the ACA.

In spring 2016, the insurance marketplaces had been operating for nearly three full years. There were numerous press stories of plans' decisions to enter or leave selected states or market areas within states and to narrow provider networks by including fewer choices among hospitals, medical specialists, and other providers. There were also beginning to be stories of insurer requests for significant premium increases. However, there was no clear understanding of how common these practices were, nor how and why practices differed across carriers, markets, and state regulatory settings.

This project used the ACA Implementation Research Network to conduct field research in California, Michigan, Florida, North Carolina, and Texas. In each state, expert field researchers engaged directly with marketplace stakeholders, including insurance carriers, provider groups, state regulators, and consumer engagement organizations, to identify and understand their various decisions. This focus included an effort to understand why carriers choose to enter or exit markets and the barriers they faced, how provider networks were built, and how state regulatory decisions affected decision-making. Ultimately, it sought to find where and why certain markets are successful and competitive and how less competitive markets might be improved.

The study of five states was not intended to provide statistically meaningful generalizations about the functioning of the marketplace exchanges. Rather, it was intended to accomplish two other objectives. First, the study was designed to generate hypotheses about the development and evolution of the exchanges that might be tested with “harder” data from all the exchanges. Second, it sought to describe the potentially idiosyncratic nature of the marketplaces in each of the five states. Political and economic circumstances may differ substantially across markets. Policymakers and market participants need to appreciate the nuances of different local settings if programs are to be successful. What works in Michigan may not work in Texas and vice versa. Field research of this sort can give researchers and policymakers insight into how idiosyncratic local factors matter in practice.

In brief, our five states had four years of experience in the open enrollment periods from 2014 through 2017. The states array themselves in a continuum of apparent success in enhancing and maintaining competition among insurers. California and Michigan appear to have had success in nurturing insurer competition, in at least the urban areas of their states. Florida, North Carolina, and Texas were less

successful. This divergence is recent, however. As recently as the 2015 and 2016 open enrollment periods, all of the states had what appeared to be promising, if not always robust, insurance competition. Large changes occurred in the run-up to the 2017 open enrollment period.

Four broad themes emerged from this study. *First, health insurance markets are local.* While there has been substantial attention on national carriers, their desire to merge, and their withdrawal from selected states or market areas, the field researchers consistently describe substantial differences that exist among the market areas they examined. Insurance markets are local largely because insurers rely on their ability to establish networks of providers to allow them to be priced competitively with other insurers. If they are unable to negotiate acceptable prices with local hospitals, physicians, and other providers, they are unable to compete. Thus, urban markets are different from rural ones. But urban markets differ as well. San Francisco is remarkably different from Los Angeles, as is Detroit different from Flint, and Miami different from Tampa.

Second, higher-than-expected claims costs have been the source of much of the turmoil in the health insurance marketplaces. In the first two years of the exchanges, insurers had very little information on the utilization experience they might expect from exchange enrollees. Many potential enrollees had not had coverage previously. The effects of the subsidies and the penalties on enrollment were unknown, and the extent and persistence of any pent-up demand for health services was also unknown. In retrospect, even insurers with large enrollment did not have reliable information on the likely claims experience. Medical claims turned out to be much greater than most plans envisioned. Many plans incurred losses. The risk-mitigation mechanisms in place proved inadequate to account for the magnitude of the resulting losses. Many plans withdrew from the exchanges, and many of the remainder raised their premiums substantially in the 2017 open enrollment period.

Third, there has been a substantial shift toward narrower insurer networks of providers. During the early 2000s, insurers responded to the backlash against managed care by moving away from relatively narrow panels of hospital and physician providers to broader panels. This was accomplished by offering preferred provider organizations (PPOs) that gave consumers many more provider options than did health maintenance organizations (HMOs). In the initial years of the ACA, many carriers offered PPOs in their exchange plans, field researchers report. PPOs are inherently less able to negotiate lower prices with health care providers, because the larger panels undercut the ability of insurers to trade higher patient volume for lower prices from providers. Moreover, the broader PPO networks allowed people with established relationships with specialists to keep their doctors. This had the effect of encouraging people with pre-existing conditions to disproportionately join PPOs. By the third year of the ACA, insurers reduced the number of PPO plans they offered and many switched to offering only HMOs. In Texas, it is reported that no insurer currently offers a PPO product in the individual market. This shift to narrower networks has the potential to allow insurers to negotiate lower prices with providers by assuring a greater volume of patients. Excluding some premier providers also potentially reduces the extent of adverse selection in a given plan by discouraging some patients with pre-existing conditions from enrolling in the plan.

Fourth, hospital and physician competition is essential to a robust and competitive insurer market. The field researchers report that premiums are higher and the number of insurers is lower in rural areas relative to urban ones. While part of this has to do with population size, it also has to do with the number of hospitals, physician groups, and health systems that are available in rural areas. When insurers had only a single hospital or health system with which to negotiate, insurers paid higher prices, the field researchers note. However, even in metropolitan areas, the availability of competing health systems was seen as essential to spurring insurer competition. While this was noted in nearly all the states, it was particularly clear in California. Large metropolitan areas in and around San Francisco had few health systems compared with the south and west of Los Angeles and, as a result, faced higher prices and had to charge much higher premiums, according to the researchers. As other state teams reported, if an insurer were unable to negotiate acceptable provider prices it would often forgo entering a market.

Section 2 – Background

The ACA was enacted in 2010 and imposed an individual mandate requiring all citizens and long-term legal residents to acquire health insurance. Most people continued to get insurance coverage through their employer. The Congressional Budget Office (CBO), however, estimated that some 8 million people would get coverage through the marketplaces in their first year of operation, 2014, and 21 million by 2016.¹ The mandate was to be enforced by a phased-in tax penalty of up to 2.5 percent of one's income. For those with low incomes, a subsidy in the form of an advanceable, refundable tax credit was provided that limited the cost of a policy on the exchange to no more than 2 percent to 9.5 percent of one's income, depending upon where one's income was relative to the federal poverty level (FPL). Critically important, insurers could not use the pre-existing conditions of individuals to determine their premiums in the marketplaces; only geographic location, age, and smoking status were relevant.

Individuals (and small businesses) could buy coverage through health insurance marketplaces, originally called health insurance exchanges. We will use the terms synonymously. Exchanges are state specific. Some 18 states established state-based exchanges, including California in our study.² Seven states established partnership exchanges, including Michigan in our study. These states undertook some of the functions of operating the exchanges and left some to the federal government. The majority of the states, 28, are federally-facilitated exchanges. These exchanges are essentially run by the federal government, although states had the option of undertaking some limited functions themselves.

The vast majority of the marketplaces were operated as “market facilitators” or clearinghouses. This means they certified that the plans offered on the exchanges covered the essential health benefits and met a few other qualifying conditions. They then facilitated a side-by-side comparison of the coverage, cost, and availability of services. California was the only “active purchaser” exchange. This means that the exchange imposed additional conditions on participation. Among other things, California negotiated the market areas in which insurers were allowed to offer coverage in the marketplace.

Each state established “rating areas” for plans offering coverage in their state. A given insurer offering a given plan in a rating area must charge the same premium to all people of the same age and smoking

status residing in that area. Rating areas are typically composed of counties. Florida designated each of its 67 counties as a unique rating area. Many states established contiguous counties as rating areas; North Carolina, for example, has 16 rating areas. Other states defined each metropolitan area as a rating area and all remaining rural counties as a single combined rating area; Texas followed this model. California used the contiguous county model, but split Los Angeles County into two rating areas, east and west. In general, an insurer is not required to offer a plan in all counties within the rating area. For example, Community Health Choice in the 11-county Houston rating area offers coverage only in Harris County. Thus, the number of insurers offering coverage may vary substantially across the counties within a single rating area as well as across a state.

To effectively offer an insurance plan in a given county, an insurer has to have an adequate panel of local hospitals, physicians, pharmacies and other providers to deliver care. These providers are typically called the insurer's "network." Since the 1980s and '90s, insurers have selectively contracted with providers. This means that they have negotiated prices for clinical services and, unlike earlier eras, not every provider gets a contract. The empirical evidence demonstrates that insurers essentially trade the promise of patient volume for lower prices from providers.³ If a community has fewer hospitals or fewer physicians, insurers tend to pay higher prices.⁴ The literature suggests that where providers are less competitive, insurers may have difficulty developing a network of providers at prices that will make their plans competitive. Moreover, long-established dominant insurers may have a network advantage, at least initially, because of long-standing pricing agreements with providers.

The state's political, regulatory, and cultural environment is part of the milieu that influences the potential success of the marketplaces. Political leaders in some states have been strongly supportive or opposed to the ACA. More supportive states, such as California and Michigan, have undertaken a host of small efforts to facilitate the functioning and success of an exchange. Other states, such as Texas and Florida, have been more oppositional. Both states imposed regulations making it more difficult to become navigators, for example. In the first two years of the exchanges, both states also declined to review premiums; Florida began reviewing rates for the 2016 enrollment period. Culture differences may have an impact as well. Navigators were said to be of major importance to the success of ACA enrollment in the Florida Cuban community, for example.⁵ The more populist health insurance commissioner in North Carolina has taken a more proactive consumer approach to ACA implementation than has the conservative legislature.

Finally, states have choices with respect to Medicaid expansion under the ACA. Under the law, all states could expand their Medicaid program to cover individuals aged 19 to 64 with incomes below 138 percent of the federal poverty level and receive generous federal matching funds if they did so. However, failure to expand the state's program subjected a state to losing all of its federal Medicaid matching funds. The Supreme Court found this provision unconstitutional,⁶ and currently 19 states have chosen not to expand their program, including Florida, North Carolina, and Texas.⁷ In as much as there is overlap in eligibility for Medicaid and marketplace subsidies in the range of 100 to 138 percent of the FPL, decisions with respect to Medicaid expansion may affect enrollment and utilization in the exchanges. Also, states could opt whether to allow existing policyholders to retain their pre-ACA policies transitionally, as North Carolina did, or require them to switch to new, ACA-compliant coverage. Because current policyholders

had previously been medically underwritten, they constitute a healthier segment of the market, which some states allowed to remain outside of the ACA's new community-rated market.

This study was designed to explore in depth which of a variety of possible factors explain the varied success or limitations of the individual market during the ACA's first three years.

Section 3 – Methodology

This analysis was conducted by the ACA Implementation Research Network and included five states: California, Michigan, Florida, North Carolina, and Texas. These states were chosen both for the diversity of political/market settings and the strength of the field research teams available. In each state, local field researchers identified five rating areas, often composed of multiple counties that characterized the expected diversity of insurance competition that might be found in their state. The following listing provides a rationale for each state selected and identifies the counties or rating areas studied in each.

The order in which the states are presented here and going forward reflects our sense of the current success of insurer competition across the five states. Definitions of competition are never precise. Here, successful competition means that a relatively large number of insurers offer services and are able to negotiate for health care services with a relatively large number of hospitals, physicians, and other providers. It is important to appreciate, however, that the extent of competition differs widely within each state, and the rate of decline in insurer competition across the states has differed markedly as well.

- *California* is a large Western state that developed its own state-based exchange. It is a Democratic state that expanded Medicaid and has a history of innovative public and private efforts to change health insurance markets. Study sites were: the 22 rural Northern counties; San Francisco County; Contra Costa County northeast of San Francisco; the very populous southwest half of Los Angeles County; and the Inland Empire, the eastern region of Los Angeles County.
- *Michigan* is a large Midwestern state with Republican leadership that implemented a partnership exchange and expanded its Medicaid program in early 2014. The study sites included: Delta County in the Upper Peninsula; Genesee County, home of Flint; Kalamazoo County, a community with two hospitals; Kent County, which includes Grand Rapids and the largest health care market in the western portion of the state; and Wayne County, which includes Detroit and is the most populous county in Michigan.
- *Florida* is a large Southeastern state that was passively opposed to the ACA and did not expand Medicaid. Its choice of county-level rating areas potentially gave its insurers greater flexibility in locational decisions. In earlier field research, Florida was reported to have substantial exchange competition in the Miami area. The study sites included: Doral County in the northeast corner of the state; Gadsden County in the Panhandle, the only predominately African-American county in Florida; Hillsborough County (Tampa); and Miami-Dade County, the most populous area in the state.

- *North Carolina* is politically opposed to the ACA (for the most part), with large urban and rural market areas. Earlier fieldwork suggested that insurers were linking up with local provider systems to compete with a dominant Blue Cross and Blue Shield insurer. Study sites included the four rating areas that make up the eastern third of the state, characterized as historically having little insurer competition; one rating area in the far western region, characterized as having modest competition; and the Charlotte area, noted for substantial competition.
- *Texas*, the state with the second-largest population, has been actively opposed to the ACA. It did not expand Medicaid, it has a federally facilitated exchange, and its department of insurance plays no role with respect to the functioning of the law. However, from earlier field research, it has several metro areas with substantial insurance competition. Study sites included: the 11-county Houston rating area, characterized by substantial competition and a very diverse population; the five-county Austin area, reflecting substantial competition and potential political influence; the three-county Temple area, characterized by the presence of a large regional insurer; the single-county Midland area, noted for its remoteness in the west Texas oil region; and the single-county McAllen region, with unique issues due to its border location.

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 is 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.

In this analysis, the study team developed a series of discussion themes that focused on: insurer participation and withdrawal from the marketplaces, the structuring of provider networks, the state and federal regulatory environment, and any changes in the functioning of the marketplaces or the regulatory environment that would enhance insurer competition in the state. However, the themes were only intended to guide the discussions; the method of field research as undertaken by our network is to introduce the themes and allow the discussion to follow the responses of those interviewed, guided by the local knowledge of the field researchers.

In each state and study site, the field researchers conducted telephone or face-to-face interviews with representatives of health insurers, providers and provider systems, state insurance regulators, insurance brokers/agents, navigators, and others, such as media reporters or policy experts. The interviews ranged from 15 to 90 minutes. Each respondent was assured of anonymity, as were all organizations with the exception of the state insurance departments. Respondents were advised that they could decline to answer any questions.

Section 4 – State-by-State Summaries

This section provides an overview of the key findings from each of the five states in the study. However, there is much more in each of the state reports than can be summarized here. Of particular importance are the differences that were observed across rating areas in each state and the often-nuanced discussions of the reasons for many of the observations. None of this could be fully incorporated into this brief overview.

CALIFORNIA

Based on its ability to maintain a relatively large number of insurers in its largest metropolitan areas, California has the most successful marketplace of any examined in this report. Covered California, the state-based exchange, enrolled nearly 1.4 million people in the first open enrollment period, and the uninsured population declined from 17.2 to 8.1 percent. The number of people insured by the program, however, has largely plateaued at this level.

Unlike many other states, the number of insurers offering coverage through the marketplace has remained relatively high at 11. Only UnitedHealthcare has withdrawn from the state's exchange, and respondents believe that it was not a major player. However, in 2016, some insurers were reporting losses for the first time in this segment of the market. This is particularly true of Blue Shield of California, one of the largest insurers in Covered California.

Respondents attribute much of the success and stability of the California marketplace to the active purchaser model that California adopted for its exchange. Covered California imposes additional conditions on participation in the exchange and negotiates somewhat aggressively with insurers over premiums. In addition, it has an active navigator program that is viewed as helping to enroll many people from 100 to 200 percent of the federal poverty level. Covered California is also seen as helping insurers negotiate prices with health systems.

There are substantial differences in the number of insurers and in premiums across the five rating areas examined. Competition is regarded as robust in the populous southeastern Los Angeles rating area. The lowest-priced silver plan unsubsidized monthly premium for a 40-year-old nonsmoker was \$256. Eastern Los Angeles County, the Inland Empire, had identical premiums and somewhat fewer insurers. Premiums for the lowest-priced silver plan were substantially higher in the 22-county rural Northern California rating area and the San Francisco (\$407) and Contra Costa (\$402) rating areas.

Respondents in the state attribute the differences in premiums to differences in the availability of health care systems, hospitals, and physician groups. In the two Los Angeles rating areas, there are a relatively large number of distinct systems and other providers. Insurers have been able to negotiate much lower prices in these markets. These lower prices are reflected in the lower premiums on the exchange. In contrast, in the Bay Area and in Northern California there are many fewer providers (only two health systems in the entire Northern California region). This lack of provider competition is said to keep prices and, therefore, premiums high.

Unlike the other states studied, there was much less discussion of adverse selection in the California market. This appears to have changed in the southwestern Los Angeles rating area in 2016. The insurance market included Medicaid managed care-type plans, HMOs and EPOs (Exclusive Provider Organizations), and PPOs. In the first years, the premiums differed by perhaps \$50 across plan types for a 40-year-old. However, the PPOs, with their broader networks of providers, found that they were attracting enrollees with significant health problems, resulting in losses. Their premiums increased substantially while the Medicaid managed care-type plans maintained and even lowered their premiums. In 2017, the difference in the lowest-priced silver plans between the Medicaid-type and the PPOs was \$167.

MICHIGAN

Respondents in Michigan regard the marketplace as generally successful over the first three years. Michigan has a partnership exchange that uses the [HealthCare.gov](https://www.healthcare.gov) web portal, but performs many of the exchange functions at the state level. The state also implemented Medicaid expansion in 2014 through a 1115 waiver.

The Michigan marketplace began in 2014 with 13 insurers and expanded to 16 carriers in 2015. Two left the exchange in 2016 and four more did so in 2017. The remaining 10 carriers are dominated by Blue Cross Blue Shield of Michigan (BCBSM) and its HMO affiliate, Blue Care Network. The remaining insurers are largely regional carriers within the state. There is substantial variation in the number of insurers across the five rating areas examined by the study team. Wayne County (Detroit) and Genesee County (Flint) have nine and eight insurers, respectively, in the exchange. Delta County in the Upper Peninsula has only two carriers—BCBSM and its HMO affiliate.

Respondents attribute the relative strength of the marketplace to the presence of regional insurers rather than national carriers. Moreover, BCBSM has historically been the insurer of last resort in the Michigan individual market and, as such, has had limitations placed on it by enabling legislation that are not faced by other insurers. BCBSM, however, faced losses in the individual market even before the ACA. The state also has a long history with Medicaid managed care, and this tradition may be a factor in the success of Medicaid managed care-type insurers in the state.

The state's marketplace insurance plans have undergone an evolution over the first four open enrollment periods. More important than the exit of several insurers has been the shift from PPO broad-network plans to much narrower HMO offerings. In the 2017 open enrollment period, only BCBSM continues to offer PPOs. This movement has been driven by an effort to control utilization and negotiate better provider prices. One respondent indicated that the individual market is different from the group market in that employers are interested in broad networks that can accommodate their heterogeneous workforce. In contrast, people in the individual market are only interested in whether their own providers are present. This view may be leading to greater development of more narrow local networks. There was a view among respondents that the narrow network phenomenon was still quite new in Michigan and had not yet had a major impact on competition.

Respondents also indicated that insurers had expected a healthier population of enrollees than they actually achieved. This realization has led to both the movement away from PPOs to improve risk selection and recent increases in premiums.

The least-costly silver premium in 2017 ranged from a low of \$233 per month for a 40-year-old in Wayne County to \$397 for a similar individual in Delta County. As in California, the study team attributed these higher premiums in rural areas to the availability of health systems and insurers. Delta County has very few providers while Detroit, Flint, and Grand Rapids have many.

FLORIDA

Respondents in Florida see the state marketplace as being largely successful but with substantial differences across the rating areas. These are largely attributed to population density more than the availability of providers per se. Navigators appear to have played a major role in many parts of the state, despite legislation making navigator licensure more difficult. A substantial number of insurers entered the market, but three major insurers have withdrawn from the exchange since 2015, citing an inability to turn a profit due to an inability to adequately deal with the sicker population that enrolled.

Florida's marketplaces have had strong enrollment despite Florida being an oppositional state with respect to the ACA. It did not expand its Medicaid program and it opted for a federally facilitated exchange. In 2013, it passed legislation requiring background checks for navigators and banning navigators from public health facilities. However, in 2015, it re-established regulatory authority for the insurance commissioner to review rates and it enacted legislation in 2016 banning balance billing when a patient uses an in-network facility and does not have the ability to choose participating providers.

Blue Cross of Florida (Florida Blue) had an individual market share of 60 percent in 2013. This dropped to less than 41 percent by 2015, largely due to the entry or growth of Aetna (formerly Coventry), Humana, and Molina. However, between 2015 and the 2016 open enrollment period three major carriers left the exchange: Aetna, UnitedHealthcare, and Cigna. The withdrawal of insurers is related to the enrollment of higher-cost subscribers. Florida provides medical loss ratio data by insurer in the individual market. Aetna reported that 99 percent of premiums went to claims costs in 2015; UnitedHealthcare and Cigna reported 108 and 256 percent, respectively. The carriers also noted that the risk-adjustment process was inadequate and sometimes harmful to their ability to turn a profit.

The decline in the number of insurers had differential effects across the five rating areas studied. Miami went from nine carriers in 2014 to five in 2017. Hillsborough (Tampa) went from six to five, and Duval (Jacksonville) continued to have four carriers offering exchange coverage through the period. However, rural Gadsden (in the Panhandle) lost a carrier and now has only one; Orange County (in the middle of the state) went from five to only Florida Blue and its HMO affiliate.

Throughout Florida, it appears that navigators have been active and successful in enrolling people into plans. The organizations, led by the University of South Florida, cooperate throughout the state and appear to have overcome many of the problems in reaching people, even in rural areas. The navigators

report that the bigger problems in 2016 were dealing with shifts in available coverage due to withdrawals and in helping people deal with changes in the networks of providers. While other respondents were concerned about the decline in availability of insurers, navigators were less concerned and thought the requisite reduction in the number of plan offerings was a good thing because it made choice easier.

The analysts conclude that large insurers with established relationships and Medicaid managed care-type providers appear to have comparative advantages in providing coverage through the exchange. The study noted a shift toward HMOs from PPOs and the ability to contract with providers, but these issues did not appear to be paramount in Florida.

NORTH CAROLINA

The North Carolina experience has turned significantly in the last year. The state has a federally facilitated exchange and did not expand Medicaid. However, it is currently negotiating for a waiver to implement Medicaid managed care statewide.

Prior to the ACA, the state's individual insurance market was dominated by Blue Cross Blue Shield of North Carolina (BCBS), which had an 86 percent market share. Aetna and UnitedHealthcare became major competitors in the first three years of the exchange. By 2016, the BCBS market share had declined to 65 percent, and Aetna and UnitedHealthcare had market shares of 19 percent and 16 percent, respectively. UnitedHealthcare was available in some 75 percent of the counties in the state and to 90 percent of the state's population. Aetna was in 25 percent of the counties, with approximately 50 percent of the population. During this time, Aetna had developed partnerships with major health care providers and had cobranded products with the Duke Medical Center in the Raleigh area and the Charlotte-based Carolinas Healthcare System, among others. UnitedHealthcare had entered into risk-sharing agreements with a number of organizations throughout the state, including some accountable care organizations. BCBS also innovated, using a tiered network of providers differentiated by price.

However, both Aetna and UnitedHealthcare withdrew from the North Carolina individual marketplace prior to the 2017 open enrollment period. Three reasons were given for the departures. First, the plans had difficulty in projecting claims costs, and the ensuing losses were substantial. Second, some respondents indicated that the failure to expand Medicaid resulted in a group of people from 100 to 138 percent of the federal poverty level who entered the exchange and had higher claims experience. Third, some observers thought that Aetna's departure was a nation-wide decision, in reaction to the federal government's refusal of permission to merge with Humana. No one attributed the departure to state regulatory impediments.

There was a common, but not unanimous, view that the reduction in competition in North Carolina was temporary, at least prior to the election. The view held that the withdrawal of the large national insurers provided an opportunity for local insurers and providers to develop tailored products that would compete with BCBS. In addition, many held the view that the development of Medicaid managed care in the state would spur participation by Medicaid managed care-type insurers, and these organizations could also compete with BCBS.

After the first year of the ACA, insurers in the state appear to have aggressively used selective contracting to develop narrow networks to compete with the dominant BCBS insurer. UnitedHealthcare, for example, offered only a narrow panel HMO with gatekeeper on the exchanges, and Cigna, selling only in Raleigh in 2017, offers a narrow network around providers affiliated with the University of North Carolina. BCBS offers its standard PPO plans in much of the state, but developed new narrow network plans in many of the rating areas where Aetna and UnitedHealthcare competed with it.

Despite the emergence of narrower networks in some areas, North Carolina had some of the highest marketplace premiums in the country. Many respondents attributed this to the ability of health care providers and systems with market power to maintain high health services prices in areas where there is not substantial provider competition. Others suggested that the state's decision to allow transitional policies kept people with low utilization out of the exchange. Others attributed the high premiums to the poor health status of many in the state.

TEXAS

The Texas marketplace has unraveled rather dramatically in many areas. In 2015 and early 2016 there were 14 and 16 insurers, respectively, offering coverage in the Texas marketplace. By the 2017 open enrollment period, there were only 10 insurers, and six of these offered plans in 11 or fewer of Texas's 254 counties. Even major metro areas, such as Houston and Austin, had only three insurers offering coverage in the marketplace.

In 2014, BCBS, the dominant insurer in the state, offered PPO and HMO plans in every county in the state. Other insurers were described as timid in offering plans in selected counties and at premiums generally well above those of BCBS. After the first year's experience of low enrollment and substantial premium sensitivity among enrollees, existing insurers expanded their offerings, and two new insurers, UnitedHealthcare and Assurant, entered the market in 2015. Both exited the marketplace by 2016. Nonetheless, in the 2015-2016 period the individual insurance market in Texas was viewed as competitive, at least in the large and moderately sized metro areas. Many rural counties had two and sometimes three insurers offering coverage, but some were served only by BCBS.

In 2015, BCBS also announced that it had incurred operating losses of \$400 million in the Texas individual market. It withdrew all of its PPO plans, offering only HMOs. Several other insurers did so as well. In 2016, Aetna, Cigna, and an important regional insurer Scott & White announced they were withdrawing from the exchange for 2017.

Respondents indicated the withdrawals were spurred by operating losses resulting from much higher than anticipated claims experience. One insurer indicated that it had anticipated that claims experience would be 35 percent higher than standard, but what they saw was 70 percent higher. The risk-adjustment process was also identified as a problem. One insurer indicated that it obtained an operating profit in the individual market only to lose it and more when the risk-adjustment bill arrived six months later. Insurance regulators confirmed the importance of both of these factors. A third reason, expressed by some, was that the refusal to expand Medicaid had resulted in the exchange carriers facing a more morbid population.

Regardless of the reasons, premiums increased dramatically in the 2017 open enrollment period. BCBS premium increases for 2017, for example, ranged from 46.5 percent to 57.4 percent across the five rating areas studied, while other insurer premium increases were not as dramatic. There was nearly general agreement among respondents that the state's exchange was at risk of entering a death spiral.

Many respondents expressed surprise at how quickly exchange offerings shifted from PPOs to narrower network HMOs. One commentator noted that this was particularly unexpected among "middle-class and upper-middle-class families" who always thought they had good insurance but were now struggling with finding new providers and having restrictions on their access to specific hospitals and specialists.

Two bright spots were identified in the Texas market. First, while insurers exited the exchange, they continued to offer plans in the ACA-compliant off-exchange market. If they totally abandoned the individual market, they would not be allowed to return for five years. Thus, many brokers and insurers viewed this development as suggesting that insurers were hedging their bets about future improvements in the economic or political environment. Second, Medicaid managed care-type insurers have been extraordinarily successful in Texas. As one said, "We exceeded our wildest dreams." Respondents were uncertain as to why these plans were successful. Some attributed it to an enrollment cohort that was comfortable and experienced with the largely safety net providers and utilization controls used by these plans. Others suggested it was the Medicaid-level payments that these networks of providers were willing to accept. Respondents were similarly divided over whether these models could be expanded to a broader population.

Section 5 – Testable Hypotheses

A careful reading of the five state studies yields a series of common themes. As is clear, each of the states has a somewhat unique experience, but there appears to be a continuum of experience, often overlapping, sometimes disparate. With only five states, it is dangerous to suggest that there are general conclusions that can be drawn. Rather, we suggest that these five states offer a set of hypotheses about the experience of the marketplaces that can be tested with insights from other states and from empirical data as they becomes available.⁸

Nine hypotheses emerge. In many cases, they reflect the more or less common experience of the five states. In other instances, they emerge because of the differences seen across the states and our collective sense of why these differences may exist.

HEALTH INSURANCE MARKETS ARE LOCAL

In each of our five states, the nature of insurer competition differed, sometimes dramatically across the state. The ability of an insurer to offer a competitively priced insurance plan depends upon the prices that it can negotiate with hospitals, physicians, pharmacies, and other providers in the community. Essentially, insurers trade higher patient volumes for lower health services prices.

Over at least the initial years of the exchanges, there were more insurers in metro areas like Detroit, Los Angeles, and Miami than there were in places like the Upper Peninsula of Michigan, Northern California, or the Panhandle of Florida, the field researchers reported. Moreover, all of the states found that insurers typically did not offer coverage in every county in the state. (Obvious exceptions were the dominant insurers in Texas and North Carolina, which offered coverage in all counties in their respective states.) This phenomenon was explained by the ability of an insurer to establish a network of local providers; having a network in Detroit was irrelevant to having one in the Upper Peninsula.

One implication of this is that competition in the sense of having several insurers each providing plans in an area is unlikely to be the case everywhere in a state. In some areas, population density is simply inadequate to support more than a single carrier. However, in large and medium sized markets such competition can be expected.

A second and key implication of this is that the extent of competition among local hospitals, physician groups, and health systems more generally appears to be essential to competition among insurers. Analysts in California noted that the range of premiums for similar policies for a 40-year-old varied by \$150 per month from low-cost Los Angeles to high-cost Northern California. This was attributed to a lack of competition among health systems in the north and substantial competition in Los Angeles. Similarly, respondents in Michigan attributed high premiums in the Upper Peninsula compared with low premiums in Detroit and Flint to the lack of competing providers in the north. Similar reports came from comparisons of the Florida Panhandle and Miami and Midland in West Texas compared with Austin and Houston.

Thus, a second hypothesis emerges: Maintaining and enhancing competition among local hospitals, physicians, and other providers may be a precondition to competition among insurers.

CLAIMS COSTS SUBSTANTIALLY EXCEEDED INSURERS' EXPECTATIONS

It seems clear that insurers generally underestimated the claims costs of the individuals who would enroll in the exchanges, particularly in the first years of the ACA, when they had little data on the new cohorts of potential enrollees. The best evidence of this comes from Florida where medical loss ratio data by insurer showed that many carriers had claims expenses that were very near the size of the premiums they collected. Some had claims that were 50 percent to over 100 percent greater than their premiums. Insurers and regulators in Texas observed that they had little meaningful data on which to base initial premiums for a population that they had not insured previously. Data drawn from existing experience or from publicly available sources were unable to predict enrollment and utilization as it actually occurred. Moreover, it appears to have taken more than two years for many carriers to have sufficient creditable data to draw meaningful conclusions about their experience.

The underestimates are the result of perhaps a sicker overall pool of potential enrollees as well as those with chronic conditions or other health maladies disproportionately choosing to enroll.

The main testable question that arises from this study is whether the recent large premium increases will stabilize the market through a “one-time correction” or whether claims cost problems will continue to

plague the market.⁹ If the latter, then solutions will have to be found to compensate insurers for covering those expected to have higher utilization.

Part of this problem appears to have arisen because those with chronic conditions or those who had been in state high-risk pools joined the marketplaces. However, several states—Florida, North Carolina, and Texas particularly— noted that generous special enrollment rules allowed many people to delay enrollment until they needed to use health services. North Carolina researchers also reported that the decision to allow transitional policies at the start of the ACA implementation helped keep otherwise healthy people from joining the exchange. Sources in Michigan and North Carolina noted that some people appeared to game the system, enrolling for coverage, receiving care, and then effectively disenrolling by not paying premiums.

MOUNTING LOSSES STEMMING FROM HIGH UTILIZATION CAN OVERWHELM COMPETITIVE EFFORTS

In four of the five states, we observed the withdrawal of multiple insurers. In each case, this was attributed to business losses stemming from high utilization. In Texas and North Carolina, the results were striking; rating areas that had five to nine insurers suddenly had three. In Michigan, six of the 16 insurers offering coverage on the exchange withdrew, two prior to the 2016 open enrollment period and four prior to the 2017 period. In Florida, three national carriers all but left the state. Even California reported the departure of one national insurer.

It appears that, at least in populous metropolitan areas, insurers did compete for business and innovated to be successful. North Carolina noted that one national carrier cobranded some insurance products with well-known health care providers, and another entered into risk-sharing agreements with a number of provider organizations with the intent of competing with the dominant insurer in the state. Yet, these insurers left the exchange, in part, because the utilization experience was worse than expected. They also left due to decisions made at a national level, which some observers felt were driven in part by legal or political factors, such as the Department of Justice’s antitrust review of Aetna’s and Humana’s proposed merger. Similarly, in Texas after the first year many insurers reduced their premiums relative to Blue Cross in order to compete for market share. However, in these and other cases carriers that appeared to be competing in the middle years of the exchange left the market being unwilling to sustain the losses they had been incurring.

This suggests that health insurance markets can be competitive, at least in more populated areas, if the adverse selection problem can be mitigated.

RISK MITIGATION MECHANISMS MAY HAVE BEEN INADEQUATE

The ACA provided for an ongoing risk-adjustment mechanism that essentially transferred premium dollars from insurers with lower utilization experience to those with greater utilization. In addition, the law had transitional programs that paid insurers for particularly high-cost cases and provided a risk corridor by which large gains or losses would be minimized.

Respondents in Florida and Texas indicated that these processes were inadequate. One interpretation of these reports is that the funding for the risk-program was inadequate because the entire pool of those enrolling was much sicker than anticipated. In addition, or alternatively, the permanent and temporary risk mitigation mechanisms may have been inadequate to compensate insurers for the subset of really high cost individuals who joined some plans.

This suggests that if society does not want to allow insurers to charge differential premiums for people with differing levels of anticipated utilization, then some other mechanisms such as subsidized reinsurance and a more generous risk-adjustment mechanism are necessary to compensate insurers for the cost of high utilizers.

A SHIFT TO NARROWER NETWORKS IS WELL UNDERWAY

A smaller network of providers allows an insurer to channel patients to fewer providers and, as a result, negotiate lower prices from them. In addition, the exclusion of high-profile premium hospitals may dissuade consumers with health problems from selecting a plan that does not include their specialists and hospitals.

Across all five of our states, insurers have begun to offer narrow networks in their exchange plans and sometimes in all their individual market plans. Michigan reported that all the insurers other than BCBSM now offer only HMOs and reportedly had done so to improve risk selection and risk management. Similarly, in North Carolina many of the national carriers offered only HMOs or established networks around a limited set of providers. However, several of those limited networks were built around leading hospital systems such as Duke that are known to be more expensive. Interestingly, BCBS in North Carolina continues to offer PPO plans in much of the state but only HMO products in rating areas where they are competing with other carriers. In Texas there are no PPO plans offered in the individual market.

These events suggest that there will be a continued movement toward plans offering narrow networks of providers. These efforts may control costs and limit premium increases. However, brokers and policy experts in some states expressed concern that consumers were just beginning to understand the importance of networks and the implications for access were not yet realized. Among testable questions are whether network development is focused on higher-value providers or whether this is being done to either restrict access to high-need patients or dissuade them from enrolling in the plan.

OUTREACH TO CONSUMERS MAY BE CRITICAL TO ENROLLMENT

Insurance is a complicated product with often unfamiliar terms. Earlier work by the ACA Implementation Field Network found that people were confused and often ignored important coverage details while searching for the lowest premium. The field research this year suggests that consumers are beginning to be aware of the importance of factors like the size of the deductible and the meaning of copays. While these problems continue to arise, there are new challenges with the nature of provider networks and the meaning of balance billing. Moreover, respondents indicate that consumers continue to have difficulty with simply enrolling or re-enrolling as plan availability changes.

Of the five states studied, Florida appears to have made the most extensive use of navigators, with a statewide network of organizations that sought to provide information and encourage enrollment. Indeed, Florida has enrolled the highest proportion of eligible enrollees. In California and North Carolina, respondents also view the active navigator programs as an important reason why enrollment is high relative to other states. Other states had much less to say about navigators. However, hospitals, particularly safety net providers, have some incentive to enroll people to reduce their charity care load. One such provider in Texas described successful enrollment fairs and outreach to current and former patients encouraging and helping them to re-enroll. They also lowered the income level of eligibility for charity care to encourage people to enroll.

However, many states relayed concerns about the ability of brokers and agents to assist clients. Unlike navigators, brokers/agents have a deeper understanding of the insurance market and often have established relationships with insurers. Many indicated that brokers/agents had little involvement in the exchanges. Respondents in North Carolina indicated that as insurers saw the impact of adverse selection on the claims experience they reduced commissions to brokers/agents in an effort to reduce enrollment by high-morbidity individuals during special enrollment periods outside of open enrollment.

Thus, increases in enrollment may depend critically on the ability of consumers to understand the insurance products and make informed decisions.

INSURERS MAY BE WAITING IN THE WINGS

While all the state studies reported a decline in the number of insurers, and precipitous declines in two of the states, there were expressions of some optimism in the reports of the three hardest hit states. This had to do with the continued presence of insurers in the off-exchange portion of the individual market and views that the departure of national insurers provided an opening for local insurers to provide coverage.

In Texas, insurers indicated that they were continuing to offer plans in the off-exchange market. If they were to leave the individual market entirely, they were banned from returning for five years. Thus, they expected to offer plans at relatively high premiums to limit enrollment but to hedge their bets so they could re-enter the exchange market should economic or political conditions improve. In North Carolina, many respondents viewed the decline in the number of insurers as temporary. There were two reasons for this. First, it provided an opportunity for providers to form narrow local networks to provide coverage in their communities. Second, the anticipated arrival of Medicaid managed care, through a 1115 waiver, was expected to lead to the entry of Medicaid managed care-type insurers that had apparently been successful in other states. Similarly, respondents in Michigan indicated that the exit of national insurers was less of a real concern because the strong state tradition of Medicaid managed care would lead to expansions of these organizations and potentially the creation of new ones.

Thus, the local and regional insurers may grow in the place of departing national insurers. More cautiously, improvements in the approaches to adverse selection may lead to a rapid improvement in the competitive environment.

MEDICAID MANAGED CARE-TYPE INSURERS MAY BE THE FUTURE OF THE MARKETPLACES

In contrast to the experience of Blue Cross and commercial insurers, Medicaid managed care-type insurers, such as Molina Health, WellCare in Florida, Community Health Choice in Texas, among others, appear to have thrived in the ACA marketplace environment. Medicaid managed care-type insurers have traditionally provided a network of health care providers to people with Medicaid coverage in a state. With the advent of the ACA, many of these insurers expanded into the exchanges to offer coverage to people who had been former clients but whose incomes made them no longer eligible for Medicaid.

These plans have often been new to the market, as in several cases in Florida, or have existed prior to the ACA, providing coverage to the nondisabled, nonelderly components of the Medicaid population. These organizations contract with a relatively narrow network of providers, often including safety net hospitals and federally qualified health centers. The providers often accept Medicaid levels of payment, and consumers are said to be subject to sometimes relatively stringent utilization management strategies. These plans appear to have used these networks and expertise to shift into the exchange market initially to continue to provide coverage to people whose incomes transitioned them from Medicaid to exchange subsidies.

It is unclear whether this model can be generalized to a broader population, and the views of respondents within the states is mixed. It is conceivable that these plans will be major players, and perhaps the dominant players, on the exchanges.

MEDICAID EXPANSION AND CANCELLATION OF TRANSITIONAL POLICIES MAY HAVE AIDED THE MARKETPLACE

California and Michigan expanded their Medicaid program under the ACA. Neither of the field reports in these states suggested that the expansion was important in the functioning of the exchanges. However, some respondents in Florida, North Carolina, and Texas suggested that one key reason for concern in their states was the absence of Medicaid expansion. Some North Carolina sources also thought that the continuation of transitional policies worsened the ACA's risk pool.

The suggestion in these states was that a Medicaid expansion would have enrolled a number of people with chronic health conditions in the Medicaid program and not left them to the exchanges. People eligible for Medicaid must have income below 138 percent of the federal poverty level. However, the ACA allows those with incomes above 100 percent of the FPL to purchase heavily subsidized coverage through the marketplace. A second, and perhaps somewhat inconsistent argument, is that an expanded Medicaid program would have brought more modest-income families to the exchanges and many of these relatively healthy people would have enrolled in the exchanges, lessening the adverse selection concerns.

Thus, a testable hypothesis is that states that expanded Medicaid and/or cancelled transitional policies had less adverse selection in the marketplace and less dramatic withdrawals from the marketplace by insurers.

Section 6 – Priority Future Field Research

As efforts to repeal and replace the ACA move forward and as replacement models are implemented, better knowledge about the validity of our hypotheses are critical to the success of these new efforts. Not all of these hypotheses are best tested with field research. Some are best examined with quantitative data and statistical methods. Because of the local nature of health insurance markets, we view three topics as particularly benefiting from the kind of on-the-ground local investigation that is the hallmark of field research.

First, as the current system is repealed and as new mechanisms are put in place, how does insurer competition fare? Do carriers re-enter selected markets? Do they wait for the uncertainty to clear before entering markets? If they are able to offer an array of plan types, how does this affect enrollment? To what extent are differentiated plans attractive to differing populations? How do risk pools function and how does their presence affect more traditional plans? What effect does greater ease of cross-state insurance provision have on insurer competition more generally? How do future changes in the Medicaid program affect competition? How do the experiences differ across market areas and state political environments?

Second, one key reason that insurance markets are local is that insurer success depends upon the ability to form networks of providers that offer health services at acceptable prices. To what extent do provider concentration and further consolidation continue to limit the extent of insurer competition? Does the elimination of accountable care organizations enhance competition? Do local providers cobrand with insurers to compete against larger, more dominant carriers?

Finally, what is the future of narrow networks? Do these smaller arrangements of providers continue to proliferate? Is there a new wave of backlash against limitations on choice? Do narrower networks nonetheless provide meaningful access to tertiary providers on selected bases? Are current niche insurers such as Medicaid managed care plans able to use their unique networks to enlarge their enrollment?

There is much to do and little time to do it.

Endnotes

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