A STUDY OF AFFORDABLE CARE ACT COMPETITIVENESS IN TEXAS

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Section 1 – State Context

Basic facts about Texas are presented in the table below.[1,2,3,4,5]

Table 1: Basic State Facts

Texas Snapshot	
Type of Exchange	State Partnership
Expansion of Medicaid	Yes, with 1115 waiver
Number of Rating Areas	16
Number of Insurers in 2017	10
Net Change in Number of Insurers (2014-217)	-1
Premium Increase (2016, silver plans)	-9% (1st best)
State Population and Rank (July 2015)	27,434,400 (2nd)
State Median Household Income and Rank	$56,473 (26th)
Salient Health Facts	Despite a strong economy and high growth rates in both population and jobs, Texas has maintained the highest uninsured rate in the U.S. with 16 percent (over 4.3 million Texans) reported in the 2015 KFF.org state indicators. Under the Patient Protection and Affordable Care Act, the uninsured rate has decreased somewhat; it was 20 percent (5.4 million Texans) in 2013 (source: kff.org). For Texans remaining uninsured in 2016, 11 percent were Medicaid-eligible, 17 percent were tax credit-eligible, 56 percent were ineligible for financial assistance due to income, employer-sponsored insurance offer or citizenship, and 17 percent were in the Medicaid coverage gap. Other notable features of Texas health care markets: • The McAllen area (Hildago County) is often noted as an example of a location with high Medicare spending per capita. • The Houston metropolitan area is regarded as one of the most ethnically diverse in the nation.
Salient Health Policy Information	• State political leadership is majority Republican and Texas has been a strong “red” state in recent decades. State leaders have consistently opposed the Affordable Care Act and were on the forefront of state legal challenges to the health care law. Texas did not expand Medicaid, imposed additional requirements on navigators, and does not approve insurance rates for insurers wishing to participate in the exchange. • The state followed the federal default definition for exchange rating areas: metropolitan statistical areas plus a single rural area. • Texas followed the federal default on the definition of the benchmark health plan—the largest small business plan, by enrollment.

Individual health insurance policies are sold both on and off the exchange. Insurers offering coverage on the exchange are required by the Affordable Care Act (ACA) to offer at least some plans outside the exchange. However, insurers offering plans off the exchange are not required to offer coverage through the exchange. If an insurer in Texas withdraws from the individual market—that is, stops offering any policies—it may not re-enter the individual market for five years under ACA rules and Texas insurance regulations.

Blue Cross and Blue Shield (BCBS) in Texas is the largest insurer in the individual market and had an enrollment market share of 59 percent in the individual market in 2014. BCBS is a subsidiary of Health Care Services Corp. (HCSC) of Illinois. HCSC also has BCBS subsidiaries in New Mexico, Oklahoma, Montana, and Illinois. In addition, national carriers, including Aetna, Cigna, Humana, and UnitedHealthcare, provide coverage in the individual market. Regional insurers include Baylor Scott & White and FirstCare. Both Molina and Community Health Choice offer Medicaid managed care plans.

BCBS offers exchange-based coverage in all 254 counties in Texas and has done so in every year the exchange has been in place. Other carriers have been more selective, typically entering some, but not all, metropolitan rating areas and some, but not necessarily all, counties within these rating areas. A few insurers other than BCBS offer coverage in selected rural counties.

There was timid insurer participation in the health insurance marketplace in the Texas exchange during the first year it was in place. While 11 insurance carriers (henceforth insurers) participated, virtually all set premiums well above that of BCBS, with several respondents commenting that they did so to avoid high enrollment in the first year when they did not yet understand this new market or what to expect in the claims experience. In the second year, two new insurers entered exchange markets, UnitedHealthcare and Assurant Health. Other insurers expanded the number of counties where they offered within-exchange coverage. Several other plans lowered their premiums relative to BCBS. However, both UnitedHealthcare and Assurant announced midyear that they would not offer coverage in the exchange in 2016. BCBS announced losses of $400 million in the Texas individual market and decided to stop offering any preferred provider organization (PPO) plans through the individual market, both on and off the exchange. All other insurers followed suit, dropping PPO offerings for 2016.

Section 2 – New Developments Entering the Fourth Open Enrollment Period

The year leading up to the fourth open enrollment period was filled with dramatic changes in the Texas health insurance marketplace. National insurers Aetna and Cigna announced that they would exit the Texas exchange marketplace. In addition, the strong regional insurer Scott & White Health Plan also announced an exit from the exchange marketplace for 2017. BCBS announced that it would continue to offer health maintenance organization (HMO) plans, but would be requesting rate increases of 55 to 58 percent.

To our knowledge, none of the insurers leaving the exchange marketplace for 2017 have withdrawn from the off-exchange segment of the individual market. There is a view, held by some of the more significant insurers, that continuing to offer plans off the exchange provides an opportunity to quickly re-enter the exchange marketplace if economic factors or reforms to ACA requirements make their participation feasible.

Table 2: Number of Counties in Which Texas Insurers Offered Coverage on the Exchange, by Year [6]

Insurer (Insurance Carrier)	Number of Counties Covered			
	2014	2015	2016	2017
Aetna	49	49	49	---
All Savers	---	---	30	---
Allegian Choice	---	6	7	---
Ambetter from Superior Health	12	20	---	---
Assurant Health	---	77	---	---
Blue Cross Blue Shield	254	254	254	254
Celtic Insurance*	---	---	20	32
CHRISTUS Health	---	---	22	25
Cigna	37	37	12	---
Community First Health	3	3	5	---
Community Health Choice	9	9	10	10
FirstCare Health	108	108	108	95
Humana	20	20	22	10
Molina Marketplace	9	9	9	9
Oscar Insurance	---	---	4	1
Prominence HealthFirst	---	---	11	11
Scott & White	51	57	58	---
Sendero Health	8	8	8	8
UnitedHealthcare	---	22	---	---

Note: Celtic began offering the Ambetter plans in 2016.

Table 2 above shows the insurers offering coverage in each of the first four open enrollment periods and the number of counties in which they offered coverage in each year. The number of insurers offering coverage on the Texas health insurance marketplace ranged from a high of 16 in 2016 to a low of ten in 2017. However, it is important to note that many insurance carriers are only present in a handful of counties. Indeed, six of the insurers are present in 11 or fewer counties.

Section 3 – Selection of Study Locations

This report focuses on five rating areas in Texas: Houston, Austin, Temple, Midland, and McAllen. With the exception of Midland and McAllen, all of these are multiple-county metropolitan areas.

HOUSTON

The Houston metro area, rating area 10, is comprised of ten counties: Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, San Jacinto, and Waller. The metro area had a 2013 population of 6.3 million, of which nearly 70 percent reside in Harris County. The metro area is one of the most diverse in the nation; 37.3 percent of the population is white, 16.7 percent African-American, and 37.1 percent Hispanic. This rating area was selected because of its large and diverse population; the presence of large tertiary health centers such as the Texas Medical Center; a large safety net hospital system Harris Health; and the presence of Medicaid managed care insurers, Community Health Choice and Molina.

AUSTIN

The Austin metro area, rating area 3, is comprised of five counties: Bastrop, Caldwell, Hays, Travis, and Williamson. The metro area had a 2013 population of nearly 1.9 million people, of which nearly 60 percent live in Travis County and another 24 percent live in Williamson County. Nearly 53 percent of the metro population is white and 33 percent is Hispanic. Austin is the state capital and was included because earlier fieldwork in Florida suggested that the political influences in a state capital might affect the local health insurance market.

TEMPLE

The Temple metro area, rating area 11, is comprised of three counties: Bell, Coryell, and Lampasas. It had a 2013 metro population of 424,000, of which 53 percent is white, 21 percent is Hispanic, and 18 percent is African-American. Over 77 percent of the population resides in Bell County. Temple was selected because it is the home of the Scott & White Health Plan, a central-Texas insurer with a long-established HMO model of care delivery. Earlier fieldwork suggested that Scott & White Health Plan could be a meaningful competitor to BCBS in Central Texas.

MIDLAND

Midland, rating area 16, is located in the West Texas county of Midland. It is one of the very few single-county rating areas in Texas. It had a 2013 population of approximately 158,000. Fifty percent of the population is white and nearly 40 percent is Hispanic. Midland is in the heart of the Texas “oil patch” and is subject to the economic booms and recessions associated with fluctuating petroleum industry conditions. Midland has one general hospital. While it is contiguous to the Odessa metro area, local informants indicated that there is little health care competition between the metro areas. Midland was selected because of its location as a small metropolitan area in an otherwise rural portion of the state and because it has a single hospital provider.

MCALLEN

The McAllen metro area, rating area 15, is located in South Texas on the Mexican border across from the city of Reynosa. The McAllen area is comprised of 818,000 people, all of whom reside in Hidalgo County. The metropolitan area is over 90 percent Hispanic and less than 8 percent white. McAllen was selected because of its large Hispanic population and because earlier fieldwork suggested that communities along the border have unique challenges with the exchange.

Section 4 – Methodology

This study largely draws on interviews with key informants in the selected rating areas. We selected informants in positions to comment on the functioning of the exchange and health insurance markets statewide and occasionally to comment from a national perspective, with particular attention to events in Texas. These interviews are supplemented with quantitative data drawn from four years of plan characteristics and premiums provided by the Centers for Medicare & Medicaid Services (CMS) through its HealthCare.gov website.

The interviewees consisted of representatives of three insurance carriers, five hospital providers (including hospital systems), four insurance brokers/agents, one media reporter, and four representatives of the Texas Department of Insurance (TDI). All but the TDI interviews were conducted by telephone; face-to-face interviews were conducted with TDI staff.

Potential experts were initially identified using publicly available lists of hospitals, insurers, and agents. The lists of most types of respondents were not extensive, but we identified subsets of respondents with particular characteristics (e.g., brokers who included the ACA as a specialty, hospitals that are part of larger health care systems, accountable care organizations, etc.). Once selected, potential respondents were contacted by phone or email, with interviews generally conducted subsequently. All participants were told that their participation was voluntary and they were free to not answer any questions. All respondents were assured that their names would not be used, and with one exception they were assured that the name of their organization would also not be used. The exception was the TDI. We indicated that the name of the organization could not be masked. Interviews with providers and brokers/agents typically lasted less than 45 minutes. Interviews with insurers and hospital leaders lasted approximately one hour, and the TDI interview lasted 90 minutes.

Participants were asked a series of questions that followed a semi-structured interview format. The Brookings Institution research team initially developed these questions. However, local field researchers reviewed and modified the questions, as needed, to reflect any unique elements of the Texas environment or respondent type.

Discussions with insurers focused on decisions to enter or exit the Texas market overall or specific markets within Texas. They were specifically asked about the elements of the Texas exchange over time that most surprised them. These conversations naturally evolved into discussions of enrollment and pricing experience and the interplay of enrollment, utilization, and the risk adjustment process. Questions were also asked about provider networks and the role of federal and state regulation in the functioning of the exchanges.

Discussions with providers focused much more on their inclusion or exclusion from insurer networks, the effects of changes in insurer participation on them and their market, and the nature of competition among providers in their area. They were also asked about surprises over the first three years and, in selected cases, were asked about outreach to enhance enrollment.

Brokers and agents were asked about their experience with the health insurance marketplace. More generally, brokers/agents were asked about their views on the functioning of the exchange, the enrollment experience of their individual market clients, and the potential for competition in the local insurance market. These informants also commented on the availability of plans on and off the exchange.

Interviewees with the TDI were asked about the availability of data on the Texas insurance markets and the exchange. They were also asked a series of questions about their involvement with insurance regulation and concerns raised by carriers about the operations and future of the exchange. They were asked about surprises that emerged in the Texas insurance market over the first three years of the exchanges. They were also able to confirm or challenge observations that we had obtained from other sources.

Finally, we conducted one interview with a media reporter with expertise in Texas health business. This interview was wide-ranging and focused primarily on surprises, the reported and anticipated effects of insurer exits, the roles of predominantly Medicaid insurers in offering exchange plans, and concerns over network adequacy and balance billing.

Section 5 – Findings and Analysis

The relatively rapid devolution of competition in each site studied in Texas reflects both common and unique features of each area. Tables 3 and 4 show the trend in the number of insurers and selected average premiums for a 27-year-old nonsmoker in the largest county in each of the selected rating areas. The findings are discussed in the context of each study sites.

Table 3: Number of Plans and Representative Lowest-Priced Silver Plan Monthly Premiums by Study Area, 2014-2017 [7]

City		2014	2015	2016	2017
Houston (Area 10)	Highest-Lowest Premium	$281	$354	$308	$353
	Lowest Premium	$195	$203	$207	$232
	BCBS Premium	$195	$205	$239	$353
	Community Health Choice Premium	$281	$203	$214	$255
	Number of Insurers	**5**	**8**	**7**	**3**
Austin (Area 3)	Highest-Lowest Premium	$243	$318	$277	$372
	Lowest Premium	$169	$188	$188	$238
	BCBS Premium	$204	$214	$254	$372
	Number of Insurers	**7**	**9**	**8**	**3**
Temple (Area 11)	Highest-Lowest Premium	$242	$297	$300	$345
	Lowest Premium	$178	$205	$202	$334
	BCBS Premium	$178	$206	$228	$340
	Scott & White Premium	$242	$205	$238	--
	Number of Insurers	**5**	**6**	**5**	**3**
Midland (Area 16)	Highest-Lowest Premium	$221	$303	$240	$348
	Lowest Premium	$185	$196	$227	$335
	BCBS Premium	$185	$196	$227	$335
	Number of Insurers	**2**	**3**	**2**	**2**
McAllen (Area 15)	Highest-Lowest Premium	$281	$308	$239	$307
	Lowest Premium	$153	$161	$159	$174
	BCBS Premium	$155	$168	$195	$307
	Molina Health Premium	$281	$254	$217	$209
	Number of Insurers	**3**	**7**	**7**	**4**

HOUSTON

The Houston rating area includes over six million people. In the 2015 and 2016 open enrollment (OE) periods, there appears to have been substantial competition. In Harris County, the largest county in the rating area, eight insurers offered plans in 2015 and seven in 2016 (see Table 3). The premium for the lowest-priced silver plan stayed very stable, increasing only $12 over three years and reflected changes

in the identity of the lowest-priced plan. The narrowing of the range of premiums across insurers' plans between the lowest-cost and highest-lowest-cost (i.e., the most expensive lowest-cost) silver plan also suggests that insurers were following a competitive strategy. However, in 2017 this competition largely collapsed. Four insurers left the market, leaving only BCBS and two Medicaid managed care insurers, Community Health Choice and Molina Health. BCBS, the largest insurer, raised its premiums 47.7 percent.

Interviews with insurers, regulators and the media identified the difficulties faced by most insurers. In the first two years, carriers had no first-hand experience with the ACA population upon which to base premiums. Most set premiums "timidly" and what turned out to be above the BCBS rates. Most saw very low enrollment. In the second year, three new carriers entered the Houston market. Established carriers lowered their premiums relative to BCBS's first-year premium. This was said to reflect a view at the time that there had been pent-up demand for care, and that subsequent higher penalties would spur enrollment of healthier individuals. One new entrant, Assurant Health, set its premiums well above others (and subsequently exited the market midway through the year). The Assurant Health plan was the "highest-lowest" Houston premium in 2015.

However, as the premiums for the 2017 open enrollment period were being developed, insurers began to have their own data on claims experience and discovered that their experience was much worse than they anticipated. One insurer said it knew that morbidity experience would be worse than standard; this insurer estimated 135 percent of standard experience. It turned out to be closer to 170 percent. One insurer commented that churning was substantial in this segment of the market, saying "some 20 to 25 percent of our enrollment was after the open-enrollment period, and these people tended to have quick claims." Press reports said this adverse selection was common among the non-Medicaid insurers.

A second factor mentioned by one insurer and the brokers was the rapid shift from PPO to HMO plans in Texas. That prompted a number of unhealthy individuals with existing providers to switch plans to keep their physicians. This adverse selection substantially raises the claims experience of the last plans to give up PPO options.

A third key factor was the operation of the risk adjustment mechanisms put in place with the ACA. "When we set our premiums relatively high, we got a high-morbidity enrolled population; we lost money," one insurer said. "When we lowered our premiums to attract a healthier population, we made money, but then lost it and more when the risk adjustment bill arrived six-months later." The risk adjustment model is revenue neutral. Insurers with relatively healthy enrollees are assessed a fee. Those with relatively unhealthy enrollees receive revenue from those fees. Insurers that withdrew indicated they couldn't make money with higher premiums because of adverse selection and they couldn't make money with lower premiums due to risk adjustment, so they withdrew from the market. The regulators we interviewed essentially confirmed this view.

In contrast, insurers that specialize in Medicaid managed care populations appear to do well in the ACA environment. One of them said that enrollment "exceeded our wildest dreams." Unlike private insurers, their utilization experience is low, as evidenced by having to pay large risk adjustment fees. One of these insurers indicated that the premium problems they had "were all BCBS's fault." BCBS allegedly set its premiums too low in the first year and many other insurers just followed them, assuming BCBS knew what it was doing.

It is unclear what accounts for the differential performance of the Medicaid insurers. Some attribute the experience to enrolling a population that is comfortable with the set of largely safety net providers in these networks. Others argue that the low prices that safety net providers accept makes the model viable. It is also unclear whether this approach can be realistically expanded in Houston. One observer suggested that one Medicaid plan is only looking to maintain its current enrollment, while the other is aggressively seeking to expand.

It is widely reported that the Medicaid managed care plans only have safety net providers. However, one such carrier in Houston indicated that it has contracts with many of the local top-tier hospitals and uses them regularly. Providers we interviewed confirmed that this relationship is continuing in the 2017 open enrollment period. One premier hospital indicated that while it doesn't have contracts with any marketplace insurers, it accepts patients from these plans on a case-by-case basis (e.g., through "spot" contracts) if there is nowhere else they can get needed care.

In terms of outreach, there is very little activity among navigators in Texas. While there are public service announcements sponsored by many civic organizations, the safety net providers are doing the most. For example, Harris Health, the safety net hospital in Houston, holds enrollment fairs and contacts its clients to be sure they understand and enroll in the ACA. Harris Health is reported to have lowered its eligibility for charity care to 150 percent of the federal poverty level to encourage people to enroll in the marketplace.

AUSTIN

The Austin experience is very similar to Houston's with respect to the decline in the number of insurers offering coverage and the trends in premiums (see Table 3). Travis County, the most populous county in the Austin rating area, had as many as nine and eight insurers in 2015 and 2016, respectively. As in Houston, Assurant Health entered the market in 2015 with the highest-lowest silver premiums and withdrew midyear. Like Houston, there was an exodus of five insurers from the Austin market in the lead-up to the 2017 open enrollment period. Unlike Houston, however, there is no Medicaid managed care plan available in Austin; instead BCBS, Celtic, and Sendero are available.

We had speculated that Austin, as the state capital, would fare better with insurance competition because political considerations could mitigate some economic factors. We found no evidence to support this.

Table 4: Percent Change in Monthly Premium Cost for Silver Plan for 27-Year-Old Nonsmoker by Study Area, 2014-2017 [8]

City		Percent Change 14-15	Percent Change 15-16	Percent Change 16-17	Percent Change 14-17
Houston (Area 10)	Highest-Lowest Premium	26.0%	-13.0%	14.6%	25.6%
	Lowest Premium	4.1%	0.0%	12.1%	19.0%
	BCBS Premium	5.1%	16.6%	47.7%	86.0%
	Community Health Choice Premium	-27.8%	5.4%	19.2%	-9.3%
Austin (Area 3)	Highest-Lowest Premium	30.8%	-12.9%	34.3%	53.1%
	Lowest Premium	11.2%	0.0%	26.6%	40.8%
	BCBS Premium	4.9%	40.0%	46.5%	82.4%
Temple (Area 11)	Highest-Lowest Premium	22.7%	1.0%	15.0%	42.6%
	Lowest Premium	15.2%	-1.0%	65.3%	87.6%
	BCBS Premium	15.7%	10.7%	49.1%	91.0%
	Scott & White Premium	-15.3%	16.1%	--	--
Midland (Area 16)	Highest-Lowest Premium	37.1%	-20.8%	45.0%	57.5%
	Lowest Premium	5.9%	15.8%	47.6%	81.1%
	BCBS Premium	5.9%	15.8%	47.6%	81.1%
McAllen (Area 15)	Highest-Lowest Premium	9.6%	-22.4%	28.5%	9.3%
	Lowest Premium	5.2%	16.1%	9.4%	13.7%
	BCBS Premium	8.4%	16.1%	57.4%	98.1%
	Molina Health Premium	-9.6%	-14.6%	-3.7%	-25.6%

Notes: Premiums are for a 27-year-old nonsmoker purchasing a silver plan without a subsidy. Premiums are drawn from the largest county, by population, in the rating area. Multiple insurers may each offer several silver plans in a county. Of the silver plans offered by each insurer, the "highest-lowest" is the most expensive of the lowest-priced silver plans available.

TEMPLE

Temple is located in Central Texas and has a population of about 424,000. We included Temple in our study because it is the home of Scott & White Health Plan, a well-regarded regional and largely HMO insurer. Baylor Scott & White is also a system of health care providers who provide care throughout the state, but with a concentration in Dallas. The Scott & White system merged with Baylor in 2013. The insurer retained the Scott & White name.

Bell County, the largest county in the Temple rating area, had fewer insurers than Houston or Austin. For its size, however, it appears to have had a dynamic insurance market with six insurers in 2015 and five

in 2016. The decline in 2016 reflects the departure of Assurant Health and Ambetter, but the single-year entry of Celtic (see Table 3).

In the first years, it appeared that Scott & White did compete somewhat aggressively with BCBS. Its premium was the highest-lowest in the first year of the exchange. It then became the lowest-priced silver plan in 2015, and raised its lowest-priced premium by 16 percent in 2016. It then withdrew from the Temple marketplace and all other exchange markets in Texas for the 2017 enrollment year. Its experience is said to be similar with that reported in Houston. That is, at higher premiums it attracted high-morbidity subscribers and at lower premiums it made tentative profits that were more than lost as a result of risk adjustment fees.

Like other private carriers in the state, Scott & White has remained in the off-marketplace individual market. The view of both insurers and regulators is that withdrawing from the individual market entirely means that an insurer may not re-enter the market for five years. The view seems to be that a modest presence in the ACA-compliant off-exchange market allows insurers to hedge their bets. If the ACA environment improves, they can quickly re-enter. The implication of this strategy is that off-exchange products are likely to be priced rather high to minimize losses.

MIDLAND

The experience of the Midland market is different than that experience in the larger Texas metro areas. Midland is in the West Texas oil patch. As seen in Table 3, Midland has never had more than three insurers, and two remain in the 2017 open enrollment period—BCBS and FirstCare. Both of these insurers increased premiums 45 percent or more for 2017.

In Midland, there was limited insurer competition in the individual market both before and after the implementation of the ACA exchange marketplace. Brokers and providers unanimously reported that the market for policies was characterized by a large number of small employers that tended to seek out and offer their workers relatively generous small-group health plans. BCBS has consistently been the dominant insurer in both the employer and individual markets.

In recent years of falling oil prices, there has been an increase in the unemployment rate and a persistent rate of 18 to 20 percent of residents without insurance. The geographic isolation of Midland, described by one respondent as a “quick four hour drive” to the nearest large metropolitan area for tertiary care, has resulted in an exchange marketplace for this rating area that includes a choice of local providers that broadly overlaps with the choices available to all insured groups in the market. In other words, providers that tended to participate as PPO providers in 2013 individual plans have continued to participate as providers in the HMO plans offered for enrollment in 2016 and 2017. There has not been a substantial narrowing of the provider network in Midland, as the market was already self-contained with a single hospital that participates in all offered exchange plans. Travel to distant metropolitan areas for routine

care is not feasible for residents of this market, but respondents reported that tertiary care for cancer and other serious illnesses is why some patients would seek out larger networks in choosing health plans.

Insurers indicated that the ability to identify willing provider-partners is key to the decision to enter a local market: if an insurer couldn't get acceptable prices that allowed it to have the first- or second-largest market share, it almost wasn't worth entering the area.

MCALLEN

McAllen is in South Texas on the Mexican border. As seen in Table 3, its experience is very similar to Houston and Austin in the sense that seven insurers offered plans in 2015 and 2016, but only four do so in the 2017 open enrollment period. This includes Molina Health, which has reduced its Hidalgo county premium in every year of operation. In contrast, the four-year increase in premiums for BCBS in the McAllen rating area was the largest of any of our five study sites.

Insurance through the exchange marketplace in McAllen has met with challenges similar to those of other border communities in Texas. Notably, with larger cities in nearby Mexico, residents can cross the border to purchase a broad array of health care services that are less expensive than the offerings in Texas. The number of hospitals in McAllen is relatively large for the population and includes facilities owned by several national for-profit chains.

A persistent challenge in the McAllen market, along with others in Texas, is that many residents who would be eligible for premium subsidies through the exchange nonetheless choose to remain uninsured. Others delay enrollment until there is a health issue that necessitates purchasing coverage, but may discontinue premium payments once their condition is resolved. As a result, providers have had a challenge in accepting these plans without being assured of payment. Respondents reported that insurers that have been most successful in the exchange markets under these conditions have followed a model that emulates that of the Medicaid managed care plans to contain costs. This model includes educating enrollees about which providers are in the care network and helping patients find the best care to address routine needs. Because many enrollees in the McAllen area were newly insured, part of the education included helping them find a medical home other than emergency rooms.

While the McAllen rating area has a large number of providers, competition was not viewed by respondents as a strength in the implementation of the ACA exchange market enrollment, since health care costs there tend to be relatively high. McAllen is often cited as an example of a place where per beneficiary Medicare costs are higher than the national average. Some underlying population characteristics, including diabetes prevalence, a high proportion of manual laborers, and a relatively large population of recent immigrants to the United States all contribute to these higher-cost conditions. One respondent said there is potential to help improve the overall population health by having more residents access preventive health services and screening exams. Another noted that the overall payer mix has not changed since implementation of the individual insurance mandate. The same provider indicated that the exchange market is "closer to the Medicaid space" than the commercial market in McAllen. Another respondent said the experience in

the exchange market has been positive, as it has helped highlight the problem of uncompensated care and bad debt for hospitals.

Section 6 – Outcomes of Competition

The competitiveness of marketplace offerings in Texas was very promising in the large- and medium-sized metropolitan areas during 2015 and 2016. Even in the rural areas there were selected increases in the number of insurers offering coverage. All this changed in the 2017 open enrollment period. Several significant insurers left the exchange. These included Scott & White, Aetna, and Cigna. This dramatically reduced the number of insurers offering coverage in even the largest metropolitan areas. As we noted above, Houston and Austin have gone from eight and nine insurers, respectively, in 2015 to only three in 2017. In rural areas, BCBS continues to offer coverage in every county, but it is much more likely to be the only insurer doing so.

There is a widely held perception that the Texas individual market is in a premium death spiral resulting from premiums that were too low and nonenrollment penalties that were not high enough. Respondents anticipate that claims experience will continue to outstrip premiums, leading more insurers to exit the market and the remaining insurers enrolling the sickest subscribers from the withdrawn plans. “You can’t get around the economics,” one respondent said. “You can’t spend more than you take in and expect it to be a success.” While most respondents would not hazard a guess, those who did thought there was a 50/50 chance that BCBS would withdraw in 2018. An alternative view held by one respondent was that Texas seems more like New York or Pennsylvania than states where BCBS had withdrawn. In this view, the large metro populations (separated by large empty spaces) would keep BCBS in the Texas exchange.

From a price perspective, premiums have increased dramatically in 2017. BCBS continues to be the largest insurer in the state. In our five rating areas, the BCBS premium for its lowest-priced silver plan increased 46.5 percent (in Austin) and 57.4 percent (in McAllen).

Outside of the usual realm of competition within the qualified plans market, brokers pointed out that some individuals are finding “gray area” alternatives to avoid IRS penalties associated with the individual insurance mandate. None of the brokers with whom we spoke sold these plans, citing ethical concerns in marketing them as “insurance.” They described the plan types as either “faith-based” or “minimum-benefit” and noted that consumers who buy them may not realize the difference between these plans and plans that offer real protection from financial risk. Their sense was that consumers purchase these type of arrangements with the mistaken understanding that they are less expensive ways to avoid IRS penalties and offer real protection from costly health services. As such, there is a segment of under-informed consumers who would view these plans as competitive with the exchange marketplace.

Several respondents also noted that some problems inherent in the individual market are being addressed by plans that offer more aggressive education to consumers regarding use of emergency rooms, primary

care providers, and “hotlines” for questions about how to use plan benefits. One respondent said that such educational initiatives are well-aligned with the HMO model of gatekeepers, in which consumers are required to have an initial point-of-care to determine the best setting or provider for a particular health concern. Another respondent suggested that narrower networks of HMOs in Texas are likely the first step in aligning the incentives of the insurers with those of providers for managing costs.

There are two brighter spots in this environment. First, insurers that have withdrawn from the marketplace in Texas have, for the most part, remained in the ACA-compliant off-exchange segment of the individual market. If they were to fully withdraw from the individual market, under Texas law and ACA policy they would be barred from participating in the marketplace for five years. Respondents indicated that they were hedging their bets concerning the future political and economic environment around the ACA. Keeping plans in the off-exchange niche allows these insurers to quickly jump back into the exchange if circumstances permitted. While the odds are that these insurers will ultimately withdraw, this strategy suggests that they have not yet abandoned the marketplace and could be enticed to re-enter with appropriate policy actions to repair some of the incentives that have resulted in adverse selection.

The second bright spot is the Medicaid managed care insurers. Respondents indicate that these insurers have thrived in the post-ACA environment. The lowest-priced silver plans for both Molina Health and Community Health Choice were lower in 2017 than in any prior year in study sites where they offered coverage. It isn’t clear what this portends for the future, however.

One set of respondents suggests that the success of those insurers is a result of the population they serve. They believe these enrollees understand the narrow networks of largely safety net providers and the utilization controls that are imposed, and that other populations will not be as accepting of these restrictions. Another set of respondents argues that the Medicaid managed care plans will not be able to expand their capacity to accommodate larger enrollment. Indeed, in Houston it is reported that one Medicaid insurer is aggressively seeking to expand enrollment, while the other is focusing only on retaining its current enrollment. A third set of respondents, albeit a smaller one, holds that people will adjust to the new reality of the safety net networks of these insurers. The argument is that both perceptions will change, and that consumers with individual insurance plans may not have much choice.

We have no hard data on the enrollment by insurer, much less by income levels of those who do enroll. It is, of course, widely known that the vast majority of people who obtain coverage thorough the marketplace receive a subsidy. That said, respondents had two relevant observations.

First, a Houston respondent indicated that the biggest surprise over the first three years of the exchange in Texas occurred in 2016. People in the middle class and upper middle class who had perhaps purchased similar coverage prior to the ACA were generally surprised at the elimination of PPO offerings. “They had always considered themselves to have had good coverage,” the respondent said. “Now those who used care were discovering that their doctors or hospitals were no longer in the network.” This was viewed

as unsettling, but it was unclear what it suggested for the future. A related issue is the burden people face with having to change plans yearly, particularly when it means forming a new medical home and getting their new providers to know what the old providers did. There was a sense that people with prior insurance experience and established relationships with community providers who purchased policies through the exchanges were getting "beaten down."

The second observation had to do with off-exchange plans. These plans are much more likely to be purchased by higher-income people who are ineligible for exchange subsidies. One insurer believed this market niche would experience the death spiral. In the exchange, people are largely buffered from the full premium increase by subsidies tied to their incomes, not to premiums. The view was that the off-exchange market, not the marketplace products, would collapse due to cycles of adverse selection.

A related observation concerns the small group market. Many employers that had purchased relatively generous plans are having difficulty finding plans with a similar level of benefits for their workers. Several respondents in the Midland and Houston markets noted this. Midland, in particular, was described as an oil town where smaller firms with strong financial resources typically purchase generous small group health plans. However, respondents in that market suggested that fewer insurers are offering quotes for the small group market since the ACA was implemented.

There no longer appears to be actively competitive individual insurance markets in Texas. The fundamental problem is that of adverse selection. More unhealthy people have enrolled in the Texas marketplace than had been anticipated by policymakers and insurers. Competition is largely irrelevant until this problem is dealt with.

In our interviews with insurers and regulators, we asked what sort of policy changes they would recommend to deal with adverse selection. They responded with their own insights and what they had heard from industry colleagues or sources:

- Fix the risk adjustment mechanism. Currently, the process is a zero-sum game. Fees collected from insurers with lower claims were transferred to those with higher claims.

  However, the funds were inadequate to cover the losses incurred by those with high-morbidity subscribers. Moreover, one could further deal with the problem by reintroducing the reinsurance program that allowed insurers to be compensated for cases that were above some threshold. One interviewee argued that the risk adjustment mechanism could be more nationally based rather that state based, following the Medicare advantage model.

- Expand the age band allowed for assessing premiums. The current one-to-three range is too narrow. One insurer said it enrolls many more older people that anticipated. More

younger people could be attracted to plans if premiums for them were lower.

- Reduce the ability of people to enroll outside of the open enrollment period. One insurer argued that 20 to 25 percent of their exchange enrollment occurred outside the open enrollment period and that these individuals were "quick claims," meaning that many of them almost immediately submitted medical claims. However, another insurer argued that changing waiver provisions would be "lipstick on a pig" and wouldn't have much impact on their experience.

Providers and brokers in all Texas markets offered a list of problems that could be addressed if/when ACA reform is implemented, including: The 90-day provision in which enrollees can receive services without paying their premiums, IRS penalties that are too low, little or no penalty for individuals who drop coverage once their health care needs are met, and the "bump" in utilization that results when new enrollees are essentially testing their benefits without adequate education or resources to understand their plan designs or networks. It seems that the Medicaid-like plans understand these types of issues and address them more proactively than commercial carriers that are accustomed to other market segments.

Section 7 – Analysis

Discussions with a variety of providers, brokers, and other stakeholders in Texas, along with careful review of the markets included in our more-detailed study, has resulted in several key lessons learned regarding the ACA exchange market, competition, and possible avenues to improve competition. These include:

1. Competition in the Texas exchange cannot occur until the adverse selection problem is addressed.

2. Enrollment of individuals without previous insurance coverage is considerably riskier for carriers than anticipated. The initial strategy that considered the risk pool as similar to other markets resulted in lower-than-needed premiums and greater-than-anticipated utilization in the first two plan years.

3. Insurers were expected to determine premiums for the second year well before they understood the claims experience from the first year. The inherent risk selection problems from the first year were not yet fully understood. This resulted in what appeared to be an increase in competition in a well-functioning market, but soon was revealed to be a highly segmented market in which the average enrollee paid premiums for seven months (i.e., long enough to address their own health concerns and then drop out). The availability of PPO plans, therefore, shifted to an all-HMO market, and plans announced their intention of leaving the exchange market by the middle of the third year.

4. Off-exchange plans have remained active in Texas, signaling optimism that problems in the current individual insurance markets can be addressed, pending policy changes and sustained positive economic conditions in the state.

5. Providers uniformly noted that the individual market is not a large portion of their business, but that they are pleased to participate in these plans to the extent they:

    (a) alleviate the problems of uncompensated care,

    (b) promote preventive health services and routine care to reduce downstream negative health consequences of not having insurance, and

    (c) meet the contracted payment rates needed for these lines of business.

    Most indicated that they did not affirmatively choose to participate in particular plans, but that insurers could build plans that included or excluded them.

6. Respondents from two large health care systems and one large university-based medical center said they considered the ACA exchange marketplace plans an important piece of their mission to improve population health and reach within their communities. They added that "spot agreements" with insurers are feasible whenever the needs of a particular patient do not fall neatly within an existing plan participation agreement, since routine network inclusion of subspecialty providers might have otherwise only been feasible for plans that were classified as platinum or gold.

7. Smaller markets noted fewer impacts of the conversion from PPO to HMO plans in terms of provider choice. This was somewhat surprising. The explanation was that markets with fewer providers were already "narrow networks." In essence, the insurers had no choice regarding which providers to keep "in network" if they elected to offer plans in that rating area or county. While provider choice was not narrowed, some respondents indicated that specific physician groups declined both Medicare participation and participation in any HMO-like plan.

8. Providers who track payer mix have noticed an increase in the uninsured proportion of their business since 2014. One respondent indicated that this is related to three factors:

    (a) Some really sick people without insurance enrolled and then dropped out after a year or two.

(b) The unemployment rate rises as oil prices fall.

(c) People with exchange insurance are struggling to pay their deductible. Subsidies help with premiums, but the $6,000 out-of-pocket is hard for individuals with limited resources to handle.

9. Providers also noted that insurers have recognized that the ACA individual coverage market includes a very price-sensitive group. Plans that are succeeding are offering the lowest-cost options possible and are trying to minimize out-of-network "leakage" by enrollees, because that would result in greater out-of-pocket expenses. As a result, insurers have tended to contract with large provider groups and networks that include most large facilities in a given market. Thus, competition in those provider markets has remained robust.

10. Respondents pointed out that an "adequate" network has not been well-defined. Consumers may desire to join a plan that includes all providers they see or intend to see, but don't realize the cost implications associated with increased choice. Insurers may construct a network that has select providers to keep premiums lower and consider it "adequate," since it may help with care coordination and reduce patient uncertainty about which providers they can access with their plan.

Respondents had thoughtful insights and suggestions for tweaking the marketplace in Texas:

> "Health care exchanges may evolve to look more like Medicaid HMO plans in the future—already seeing it as the workable model here in Texas. There may also be a public option in the future that includes a model that resembles the Medicare advantage plan offerings, in which case more of the big commercial insurers may re-enter these markets, especially if the financial incentives are similar to the MA plans. This would be particularly helpful in the small markets/rural areas in getting plans for those with subsidies available. (BCBS is the only plan in a lot of these counties now)."

> "Federal government pricing of premiums and payments would help stabilize the market and hopefully the very sick individuals will be able to get needed services. In the first ACA exchange year, big plans had more expenditures on transplant services alone than they collected in premiums. Clearly, there were lots of unmet needs that were being addressed by new enrollees who could not get insurance before the ACA was implemented. A public option, which was not included in the initial implementation, may become an option in the future."

> "Better risk adjustment methodologies are needed."

> "Penalties for not enrolling should be much higher. Healthy individuals will not shoulder these huge premium increases every year without a strong incentive to do so, and enrolling them is the only way to make things work."

Section 8 – Post-Election Comments

It is not yet clear what the election of Donald Trump will mean for the federally facilitated individual exchange marketplace in Texas. The elected leaders of Texas have remained opposed to the ACA since its implementation, while many providers we interviewed had a more favorable opinion of the impact of the ACA on access to care and reductions in uncompensated care. A straight-out repeal of the ACA would probably result in a number of insurers re-entering the state's individual insurance market, typically offering medically underwritten plans much as they did before the ACA. The elimination of subsidies and, perhaps, the marketplace would reduce the number of people insured in the individual market to a level analogous to the proportion insured pre-ACA. There would be little impact on the Medicaid population, because Texas did not expand its Medicaid program.

However, there is no suggestion that the ACA will simply be repealed. Most political sources speak of repeal and replace. The impact on Texas clearly depends upon the details of the replacement. The key to a thriving individual insurance market is a mechanism to deal with adverse selection and affordability. Trump has indicated that the prohibition on the use of pre-existing conditions to set premiums should continue. This could be accommodated with a high-risk pool, for example, that separates high utilizers from others. People in these pools could be provided a higher subsidy. Under that scenario, if the replacement legislation eliminates the individual mandate and the requirement that all plans offer the essential benefits, it is likely that carriers will begin to offer an additional selection of plans with fewer benefits and much lower premiums. These will be attractive to healthier individuals who are very sensitive to premiums, but would be unattractive to less-healthy people who remain outside the high-risk pools.

The new administration has been less clear on plans to deal with a replacement for the Medicaid expansion under the ACA. It is likely, however, that the Republican leaders in Texas would be more willing to accept a plan that gives each state greater flexibility in establishing eligibility, determining the nature of covered services, and paying providers.

Endnotes

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