CRA Insights: Health Care

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The health insurance exchange landscape

Background

A central feature of the Patient Protection and Affordable Care Act (ACA) is the establishment of exchanges to "offer Americans competition, choice, and clout" when purchasing health insurance.[1] These exchanges are intended to provide access to affordable health insurance coverage for individuals not covered by Medicaid or lower cost, employer-based insurance, i.e., individuals currently uninsured or covered by individual or small group insurance plans. The ACA requires that states establish an operational exchange by January 1, 2014, which can either be operated by the state or rely wholly or partially on the federal exchange.[2] In either case, the exchanges are expected to provide a forum for competition among insurers to provide plans that meet the criteria of access to insurance regardless of health status; partial standardization of plan design, including mandated coverage of certain "essential health benefits"; and pricing within regulated rate bands.

The ACA also mandates that, beginning in 2014, individuals not covered by employer-based plans, Medicare, Medicaid, or other suitable coverage must obtain individual coverage or pay a penalty. These individuals, along with many small groups,[3] are the target of the exchanges. Federal subsidies for those meeting certain income thresholds are intended to encourage the purchase of insurance through the exchanges. Beginning in 2016, employers with 100 or more employees may also purchase health insurance through an exchange.[4] The Congressional Budget Office (CBO) estimates that exchanges will serve seven million individuals in 2014 (the first year of operation), increase rapidly to 22 million by 2016, and stabilize between 24 and 25 million thereafter.[5]

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[1] "Affordable Insurance Exchanges: Choices, Competition and Clout for States," US Department of Health & Human Services, accessed June 11, 2013, http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html.

[2] 27 states are defaulting to the federal exchange; 17 will develop their own exchange and the remaining seven are partnering with the federal government. *See* Kaiser Family Foundation, "State Decisions for Creating Health Insurance Exchanges and Expanding Medicaid, as of May 28, 2013," accessed June 11, 2013, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17.

[3] Each state will have two exchange programs, one focused on individuals and the other focused on small employers (the Small Business Health Insurance Options Program or SHOP). While it was recently announced that the federally operated SHOP exchange will only offer one carrier in its initial year of operation, it is still anticipated that choice will be a compelling feature in future years.

[4] For additional details on the policies governing exchange establishment and operation, *see* National Institute for Health Care Reform, "Promoting Healthy Competition in Health Insurance Exchanges: Options and Tradeoffs," Policy Analysis No. 6, November 2011 or Bernadette Fernandez and Annie L. Mach, "Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)," Congressional Research Service, January 31, 2013.

[5] CBO, Health Insurance Exchanges: CBO's May 2013 Baseline, accessed June 11, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf. These estimates exclude small group enrollments, which the CBO predicts will add another two million enrollees in 2014 and three million in 2016.

Other recent estimates from the RAND Corporation and Truven Health Analytics are similar.[6] The number of eligible consumers as well as the percentage of those eligible who are actually expected to purchase insurance through the exchanges varies substantially across states. Using its Health Insurance Policy Simulation Model, the Urban Institute has estimated state-specific enrollment in the exchanges in the non-group exchanges.[7] The Urban Institute estimates that 8.9 percent of the non-elderly population will enroll nationwide, with statewide proportions ranging from 5.4 to 13.9 percent. Differences in income distributions (which affect eligibility for exchange subsidies), employer-based insurance eligibility, and Medicaid eligibility, among other factors, explain the variation across states.[8]

Exchanges are intended to promote competition among health insurers by balancing standardized benefit design and regulated pricing (to mitigate adverse selection and facilitate comparison shopping) with the flexibility to offer innovative products that could attract additional enrollees. Blue Cross Blue Shield plans, currently the largest providers of individual and small group plans in most states, are widely expected to participate in the exchanges.[9] At the same time, national insurance carriers have indicated that they will evaluate separately the opportunities each state provides.[10] Although there are many factors that will determine the ultimate competitiveness of each exchange, carriers currently offering small group and individual plans may be the likeliest initial entrants into the exchanges. Indeed, as we discuss below, early indications of the interest several states have received from insurance plans to participate in their state's exchange suggest that the number of applicants is correlated with the number of current small group carriers, though generally exceeds it.

Expected exchange enrollment by state

Figure 1 juxtaposes expected enrollment with the current number of small group carriers with at least a five percent share in each state.[11] The extent of demand is likely to affect insurance carrier interest in exchange participation. Areas with larger eligible populations are more likely to attract existing or new insurance plans to participate in the exchange, as any fixed costs of establishing and operating an exchange-approved plan can be spread over a larger number of enrollees. At the same time, the number of existing small group carriers in a state—which likely reflects not only current demand conditions in the small group market but also the costs imposed by the state's regulatory environment—may provide some guidance about the likely initial number of competitors in the state exchange. The map indicates that for those states with more than 750,000 anticipated enrollees, all

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[6] Carter C. Price and Christine Eibner, "For States that Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments," *Health Affairs*, vol. 32, no.6, 2013, pp. 1030-1036. Dennis Dunn, Gary Pickens and Beth Schneider, "Coverage Expansion Under the ACA: Challenges for Government, Health Plans, and Providers," Truven Health Analytics Inc., 2013.

[7] Matthew Buettgens, John Holahan and Caitlin Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," (Part of the series, A Timely Analysis of Immediate Health Policy Issues by the Urban Institute, Robert Wood Johnson Foundation, State Coverage Initiatives), March 2011. While these estimates were developed in 2011, the total estimate of 23.8 million is broadly consistent with the CBO's May 2013 projection of 22 million enrollees in 2016 and 24-26 million in the longer run.

[8] The Urban Institute simulation assumes full implementation of the ACA, including Medicaid expansion in every state.

[9] Indeed, Wellpoint has indicated it intends to participate in the exchanges in all 14 states in which it operates Blues plans. Alex Nussbaum, "UnitedHealth Steps Back from Obama Exchanges as Costs Rise," *Bloomberg Businessweek,* May 31, 2013.

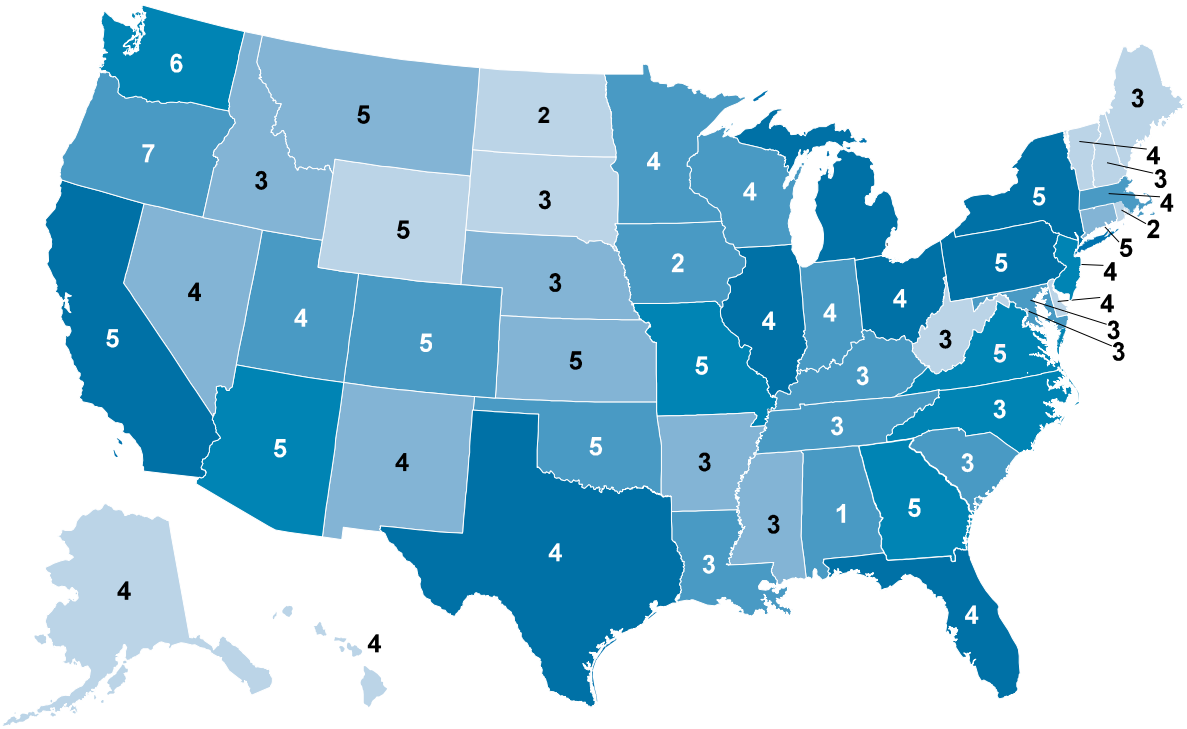
[10] UnitedHealthcare, for example, expects to enter 12 exchanges in the initial year, *see* Alex Nussbaum, "UnitedHealth Steps Back from Obama Exchanges as Costs Rise," *Bloomberg Businessweek,* May 31, 2013.

Aetna has indicated it expects to participate in 14 exchanges in 2014, *see* Dina Overland, "Aetna Taking 'Measured' Approach to Exchanges as Earnings Fall 4%," *FierceHealthPayer*, May 1, 2013, and Cigna will participate in five, *see* Caroline Humer, "Cigna Plans to Sell Health Insurance in Five Public Exchanges," *Reuters,* May 6, 2013.

[11] The distribution of individual insurance carriers is substantively similar. While service areas may include less than an entire state, many insurance carriers operate statewide. The most notable exceptions are states with multiple Blue Cross Blue Shield plans with non-overlapping territories.

but Michigan have at least four sizeable small group carriers. Interestingly, some low demand areas have as many as five carriers currently, and most have at least three.

Figure 1: Expected exchange enrollment and number of small group insurers by state[12]



Expected enrollment per small group carrier and rate review

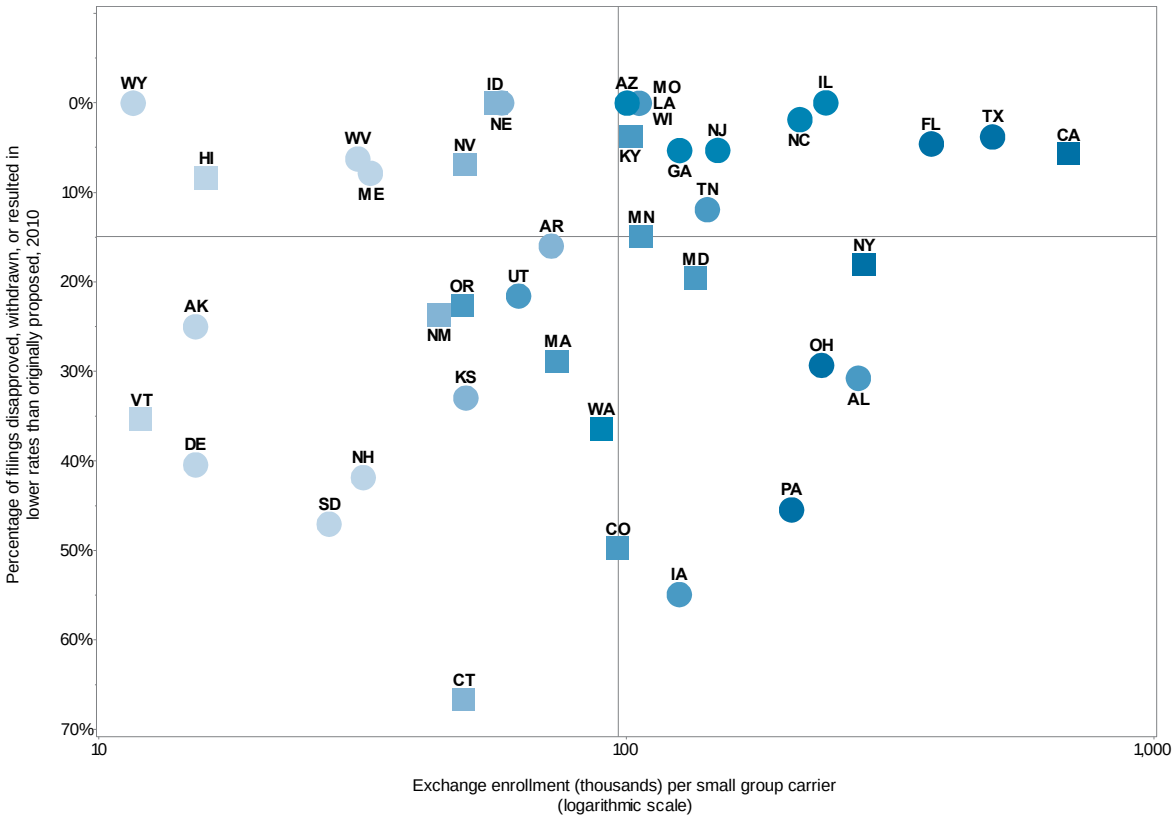
Rate regulation of small group plans in each state may also affect the willingness of health plans to offer plans through the exchanges. Conversely, states with more expected enrollees per existing small group carrier may be viewed as more attractive to enter, all else equal. Figure 2 juxtaposes the percentage of filings that are denied in each state with expected exchange enrollment per existing small group carrier in the state. The color of the marker for each state indicates total expected exchange enrollment, while squares denote state-run exchanges and circles denote federal or partnership exchanges.

[12] Matthew Buettgens, John Holahan and Caitlin Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," Table 3: Coverage in the Non-Group Exchanges, (Part of the series, A Timely Analysis of Immediate Health Policy Issues by the Urban Institute, Robert Wood Johnson Foundation, State Coverage Initiatives), March 2011.

Kaiser Family Foundation, "Focus on Health Reform: How Competitive are State Insurance Markets?," Table 2: Small Group Insurance Market Competition 2010, October 2011, accessed June 11, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf.

California Department of Insurance, Health Insurance and ASO Health Covered Lives Report, Small Group Health Plan Data, December 31, 2012, accessed June 11, 2013, http://www.insurance.ca.gov/0100-consumers/0020-health-related/upload/AB1083SMALLGROUP.pdf.

Figure 2: Expected enrollment per small group carrier and rate review by state[13]



The graph is divided into quadrants according to the median values for each measure. States in the upper right quadrant are those with the fewest rate denials and the largest number of expected enrollees per existing small group carrier. These states may be the most attractive to enter to the extent that these measures indicate the burden of regulatory oversight and the extent of demand for each historic competitor. Conversely, those states in the lower left quadrant have smaller expected demand per small group carrier and more stringent regulation, and may represent less attractive exchange opportunities for carriers. In general, most of the states that, based on these metrics, appear most attractive for exchange participation (those in the upper right quadrant), expect large total numbers of exchange enrollees (as indicated by darker blue shading) and will rely on the federally operated exchange (indicated by a circle marker). Conversely, those states that appear least attractive have small expected enrollment (as indicated by gray shading) or plan to operate their own exchange (indicated by a square marker).

[13] United States Government Accountability Office, "Private Health Insurance: State Oversight of Premium Rates," Table 3, July 2011, accessed June 11, 2013, http://www.gao.gov/new.items/d11701.pdf.

Matthew Buettgens, John Holahan and Caitlin Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," Table 3: Coverage in the Non-Group Exchanges, (Part of the series, A Timely Analysis of Immediate Health Policy Issues by the Urban Institute, Robert Wood Johnson Foundation, State Coverage Initiatives), March 2011.

Kaiser Family Foundation, State Health Facts, "State Decision For Creating Health Insurance Exchanges," May 28, 2013, accessed June 11, 2013, http://kff.org/health-reform/state-indicator/health-insurance-exchanges/.

States with a federally facilitated exchange may generally attract greater entry for at least three reasons. First, those states that have opted to operate their own exchange rather than relying on federal assistance appear to be more likely to deny rates. Second, with the exception of California and New York, most states that plan to operate their own exchanges can expect smaller enrollments per existing carrier. Finally, the federally facilitated exchange has indicated that it will accept all "qualified health plans" that are interested in participating, whereas some of the states may use additional selection criteria.

Early reports are recently available from several states regarding health plan interest in exchange participation. Comparing the number of health plans that will participate in each state's exchange with the existing number of small group carriers shows an increase relative to current small group participation in the three upper right hand quadrant states for which information is available. California is expected to have 13 exchange participants, relative to eight existing small group carriers, while Florida will support seven independent exchange participants relative to four small group carriers at present, and Georgia has attracted six exchange players, relative to five existing small group carriers. Conversely, both Vermont and New Hampshire, located in the least favorable lower left quadrant, anticipate a decline in participation, with Vermont going from four to two and New Hampshire from three to only a single exchange participant. Finally, a few puzzles have emerged. Oregon, in the lower left quadrant, expects 12 exchange participants, relative to five small group carriers, while Washington expects nine exchange participants relative to six carriers now, and Colorado anticipates 11 relative to six existing small group carriers. These three states all have above average penetration rates for Medicare Advantage health plans and perhaps would-be exchange participants believe that this relatively greater appetite for "managed" products in the Medicare population implies a generally greater willingness to enroll in the types of highly managed plans likely to be offered through exchanges.

Market outlook for insurers

The establishment of exchanges through the ACA presents health insurers with an opportunity to enroll 25 million people who previously lacked health insurance or obtained health insurance through higher priced small group plans. These exchanges have the potential to spur competition among insurers by making purchasing decisions easier for consumers and providing opportunities to expand enrollment or enter into new markets. States such as Illinois, Florida, Texas, and California—with large numbers of consumers expected to enroll in plans offered through exchanges and relatively less regulatory oversight—may be particularly attractive for entrants, while states such as Connecticut, South Dakota, or New Hampshire—with relatively few enrollees expected and relatively more aggressive regulators—may see fewer new insurance carriers offering plans through exchanges.

CRA's Health Care consulting

CRA's health care consultants are well-versed in all of the changes that public and private sector health reform initiatives are causing in the marketplace and how they affect payors, providers, and consumers. We have researched, published, taught, and consulted on health care matters involving antitrust, mergers, damages, class certification, and valuation for more than 20 years. Our experts combine superior analytics with deep and detailed institutional knowledge of health care in the United States to provide advice, analyses, and expert testimony for law firms, professional associations, government agencies, and other clients.

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