HOW INSURERS ARE COMPETING UNDER THE AFFORDABLE CARE ACT[1]

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I. INTRODUCTION

Prior to the Affordable Care Act, insurance companies and health plans (which we refer to collectively as carriers) competed in the markets for individual and small-group insurance based primarily on how well they were able to screen and select people for their risk of incurring medical claims.[5] Carriers had much more to gain from avoiding (or charging more to) people who might have very high medical costs than by providing more efficient services.[6] [5a] A

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[5] Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, 19(2) HEALTH AFFAIRS 173, 177 (2000).

[6] "*47 Million and Counting: Why the Health Care Marketplace is Broken": Hearing Before the S. Comm. On Finance,* 110th Cong. 6 (2010) (statement of Mark A. Hall, Professor of Law and Public Health, Wake Forest University) *available at*

principal goal of the Affordable Care Act (ACA) is to improve conditions in the individual and small-group markets by shifting carriers' focus of competition from risk-selection to processes that increase consumer value, such as improving efficiency of services and quality of care.[7]

Key provisions of the ACA are intended to accomplish this fundamental shift in competitive focus: carriers must accept all applicants and cover them for pre-existing conditions;[8] premiums for individuals in the oldest age group cannot be more than three times the premiums for the youngest adult age group, and gender and durational rating are prohibited[9]; all plans sold in a state's individual and small-group marketplaces must cover the same minimum essential benefits and may differ only in terms of their actuarial value[10]; and a "risk adjustment" program requires carriers that enroll a healthier-than-average population to compensate those whose enrollees are sicker.[11] Finally, the ACA created insurance exchanges, known as "marketplaces," to help structure competition in the individual and small-group markets.[12]

Other researchers have documented the ACA's basic success in attracting more carriers to the individual marketplaces and making

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http://www.finance.senate.gov/imo/media/doc/061008MHTest.pdf.

[7] Tom Baker, *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*, 159 U. PENN. L. REV. 1577, 1585, 1613-4 (2011).

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §1201 124 Stat. 119, 154 (2010) (codified in 42 U.S.C . 300gg (2011)).

[9] *Id.* at *155*. Durational rating refers to a practice common in the pre-ACA individual and small-group markets in which carriers substantially raised premiums for people who remained after an initial year. *See* Mark A. Hall, *The Structure and Enforcement of Health Insurance Rating Reform*, 37 INQUIRY 376 (2001).

[10] *See* Patient Protection and Affordable Care Act, 42 U.S.C. §18022(d)(1) (2010)). The actuarial value is determined by the amount of cost-sharing the average person enrolling in each plan would be expected to pay. The ACA specifies the actuarial values (and associated metal names) of plans that can be offered in the marketplaces: 60 percent (bronze), 70 percent (silver), 80 percent (gold) and 90 percent (platinum). The health care services covered at each metal level are the same.*What the Actuarial Values in the Affordable Care Act Mean,* KAISER FAMILY FOUND. 2 (April 2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf.

[11] Patient Protection and Affordable Care Act, 42 U.S.C. §18063 (2010).

[12] 42 U.S.C. 18031 (2010).

them more price competitive.[13] However, research so far has not delved deeper into how this success might vary within and among different states, whether carriers still continue to compete to some extent based on risk selection, and what particular forms of price competition are emerging.

To gain a deeper perspective on how the ACA's market reforms have affected the nature of competition, we visited six states – Arkansas, California, Connecticut, Maryland, Montana, and Texas – and conducted interviews with a variety of public and private sector policymakers, academic analysts, and consumer advocates. We chose these six states because we wanted to examine states in different parts of the country that have different demographics, economic conditions, and insurance markets. Also, reflecting the diversity of marketplace governance,[14] three of our states (California, Connecticut, and Maryland) established their own marketplace exchanges, two are cooperating or partnering with the federal government (Arkansas and Montana), and one (Texas) defaulted entirely to a federally facilitated marketplace.

This article documents what we observed in the six states. We describe the initial forms of competition in the marketplaces and relate these competitive strategies to state-specific factors that might explain similarities or differences. Knowing more about carriers' initial competitive strategies makes it possible to document how competition may change as the reformed markets mature. The descriptions also provide an early indication of whether the policies

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[13] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, Health Insurance Marketplace Premiums for 2014 (2013), [hereinafter *Marketplace Premiums*] *available at* http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf; McKinsey Ctr. for U.S. Health Sys. Reform, *Exchanges Go Live: Early Trends in Exchange Dynamics*, MCKINSEY ON HEALTHCARE 2-3 (Oct. 2013), http://healthcare.mckinsey.com/sites/default/files/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.pdf.

[14] In 2014, sixteen states and the District of Columbia are managing their marketplaces, seven states are known as partnership states because the state and the federal government are jointly implementing the marketplaces, seven other states are federally managed but states carry out delegated functions such as plan management or marketing, and the remaining twenty states have federally facilitated marketplaces. Katie Keith & Kevin W. Lucia, Implementing the Affordable Care Act: The State of the States, COMMONWEALTH FUND 5 (Jan. 2014), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jan/1727_keith_implementing_aca_state_of_states.pdf.

embedded in the ACA are likely to have their intended result of forcing carriers to compete on the value of their products rather than on their ability to risk-select enrollees.

II. BACKGROUND

A. Carrier Participation

1. Actions to Attract Carriers

Before the ACA became law, most states had just one or two carriers that dominated the individual and small-group insurance markets – even when a large number of carriers were licensed to sell policies in these markets.[15] In response to this, concern about attracting carriers to the marketplaces drove many of the early actions taken by states and the federal government.[16] For example, although the ACA gives states the right to selectively contract with carriers, only California has opted to do so. Partly out of concern about potentially uncompetitive marketplaces, the ACA authorized the Federal Office of Personnel Management to administer two multi-state plans (MSPs) in every state.[17] In addition, the ACA created the Consumer Operated and Oriented Plan (CO-OP) program, which provided funds for establishing nonprofit insurance cooperatives in order to expand the number of carriers competing in the

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[15] *How Competitive Are State Insurance Markets?,* KAISER FAMILY FOUND. 7-8 (Oct. 2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf.

[16] Christine H. Monahan, Sarah J. Dash, Kevin W. Lucia, and Sabrina Corlette, *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces,* COMMONWEALTH FUND 4 (Dec. 2013), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2013/dec/1720_monahan_what_states_are_doing_simplify_rb.pdf.

[17] *The Multi-State Plan Program*, HEALTHAFFAIRS.ORG 1-3 (May 29, 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_116.pdf. The MSPs are to be phased in with only 60 percent of the states offering MSPs in 2014. For 2014, OPM signed a contract with just Blue Cross Blue Shield. Because there are already BCBS plans being offered in many of the marketplaces, it is not clear that the presence of a BCBS MSP will increase competition since there is no reason to expect the MSP to offer a lower premium. *See* Timothy Jost, *Implementing Health Reform: Congressional Coverage, Multi-State Plan Program, and ACA Litigation with a Twist*, HEALTH AFFAIRS BLOG, (Oct. 1, 2013) http://healthaffairs.org/blog/2013/10/01/implementing-health-reform-congressional-coverage-multi-state-plan-program-and-aca-litigation-with-a-twist/.

marketplaces.[18]

Efforts to increase the number of individual carriers are significant because the ACA's premium subsidies are determined by the second lowest premium of silver plans offered in each premium rating area of a state.[19] If only one or two carriers compete in a market, one or the other will have the second lowest premium for a silver plan; thus, there is little incentive for either of them to drive their costs down and get lower premiums. But many key informants noted that when a third carrier is present, all the carriers have an incentive to reduce their costs. Each wants to have at least one plan that is priced at or below the benchmark silver plan premium.

In yet another move to engage carriers, most states declined to standardize benefit designs more than the ACA required, thereby allowing carriers to use a wide variety of different forms of patient cost-sharing (such as deductibles and copayments, or coinsurance rates).[20] Among the six states we studied, California, Connecticut, and Maryland limited the number of different plans carriers could offer at each of the metal levels (bronze, silver, gold and platinum).[21] In the other states, informants explained that standardization of benefits was resisted, at least in part, in order to attract more carriers to the market.[22] In these states, consumers confronted a relatively large choice set of plans at each of the metal levels.[23] Across all rating areas of the thirty-six federally facilitated marketplaces listed in in 2014, the average number of available plans (not including catastrophic plans) was fifty three.[24] This is far more than what people with employer-

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[18] 42 U.S.C. § 1311 (2010).

[19] 42 U.S.C. § 1343 (2010).

[20] Monahan, *supra* note 16 at 5-6.

[21] *Id*. at 5

[22] *Id*.

[23] *Id*. This is despite the fact that each carrier has to pool all the enrollees of its various plans into a single risk pool to obtain compensation for any adverse selection. Thus, carriers can offer a large number of variations of cost-sharing to see what combination of premiums and cost-sharing consumers prefer, or what combination results in more efficient use of services. *Id.*

[24] *Marketplace Premiums, supra* note 13 at 2; GOVERNMENT ACCOUNTABILITY OFFICE, Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied (2014), *available at* http://www.gao.gov/products/GAO-14-657.

sponsored insurance are typically offered. Policy analysts are concerned that this much choice could make selecting a health plan confusing for consumers.[25] However, the large number of choices has to be seen in context because carriers and policymakers simply did not know what combinations of cost-sharing and premiums would be most attractive to the uninsured, especially those who are younger or healthy. They are letting consumer choices determine which combinations will be offered in future years.

Finally, in the federally facilitated and state-run marketplaces, the states were allowed to determine the number of premium-rating areas and their boundaries. Although the marketplaces are often referred to as if they are state-wide, the premium-rating areas, consisting of counties or metropolitan areas, are the *de facto* marketplaces in most states.[26] Among the six states we studied, only Montana and Connecticut require carriers to offer plans in all rating areas. The decision by the other four states to allow carriers to choose where they would offer plans was intended to increase the number of carriers. But as we show, this decision also means that there are substantial differences *within* states in the numbers of carriers and plans available to people.

2. New Entrants

Like most states, the six we studied have at least one carrier affiliated with BlueCross-BlueShield that possessed a large share of the state's total and individual-market health insurance business prior to the ACA. Given this, it is not surprising that the Blues-affiliated carriers retain the largest shares in each of the six states' marketplaces in 2014.

One reason a Blues-affiliated carrier in each state had a large first-year market share is that some of the biggest commercial carriers

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[25] Yaniv Hanoch, et al., *How Much Choice is too Much? The Case of the Medicare Prescription Drug Benefit*, 44(4) HEALTH SERVICES RESEARCH 1157 (2009).

[26] Texas, for example, has 26 rating areas for its 254 counties with 25 of the rating areas having one or a few counties that comprise metropolitan areas, but the 26th rating area consists of 187 counties. Ct'r for Consumer Information & Insurance Oversight, *Texas Geographic Rating Areas: Includig State Specific Geographic Divisions*, CMS.GOV (last visited May 30, 2015) http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/tx-gra.html.–

in the country – in particular, Aetna, Cigna and United Healthcare – chose not to participate in the individual marketplaces in most of our study states in 2014.[27] By staying out for at least the initial year, they sought to avoid the risk of insuring potentially high-cost individuals. This initial absence provided opportunities, however, for new or less established carriers to compete in the marketplaces. As a result, each of the six states had at least one new entrant to the individual market, and some states had several new entrants.[28] There were three kinds of new entrants: COOPs, Medicaid managed care plans, and smaller local or regional carriers that previously focused primarily on the group markets.[29]

Of the six states we studied, Connecticut, Maryland and Montana are among the twenty-three nationally that have new COOPs. In Connecticut and Montana, the COOP constituted the critical third competitor needed to make the marketplace more price competitive. Arkansas, Texas, and California have new entrants that previously provided managed care plans only to Medicaid beneficiaries or to lower-income people in specific counties (e.g., the Chinese Community Health Plan and the LA Care Health Plan in California). In Connecticut and Texas, existing local or regional carriers in the group market saw the new marketplace as an opportunity to substantially expand their presence in the individual market. Many of these new entrants attracted substantial enrollment, especially when their premiums were low.[30] Some interviewees

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[27] CNN, (Sept. 10, 2013) http://money.cnn.com/2013/09/10/news/economy/obamacare-insurers/; However, they are offering plans in many of the states' marketplaces for 2015. Nat'l Conf. of State Legislatures, NCSL.ORG (March 2015), http://www.ncsl.org/Portals/1/Documents/Health/Health_Insurance_Exchanges_State_Profiles.pdf.

[28] Jerry Avorn, *Part "D" for "Defective" – The Medicare Drug-Benefit Chaos*, 354 NEW ENG. J. MED. 1339, 1340-41 (2006).

[29] *McKinsey*, supra note 13 at 3.

[30] Id. at 5 (noted that among new entrants, COOPs offered 37 percent of the lowest-price plans in the 22 states where they were competing in 2014); *Over 400,000 People Now Enrolled in CO-OP Health Insurance Plans*, NATIONAL ALLIANCE OF STATE HEALTH CO-OPS (NASHCO) (2014), *available at* http://nashco.org/over-400000-people-now-enrolled-in-co-op-health-insurance-plans/ (The National Alliance of State Health COOPs (NASHCO) released first-year enrollment figures from the 23 COOPs showing that more than 400,000 people (5 percent of all marketplace enrollees) enrolled with a COOP).

confirmed what others have reported[31] – that the presence of new entrants made other carriers set their premiums more competitively.

B. Basic Marketplace Metrics

Table 1 shows the number of plans offered at each of the metal levels for each of the six states we studied and indicates how many carriers offered plans in each premium rating area of each state in the first year of the marketplaces (2014). To demonstrate how people's choices depended on where they live, Table 2 shows the total number of plans offered with different organizational structures (explained more below) within each premium rating area.

The premium rating areas are a key factor in considering the forms of competition in the states' marketplaces because most states permit carriers to sell plans only in some parts of the state. The number of carriers in each of California's nineteen rating regions varied between two and six in 2014. Arkansas and Maryland allowed some managed care organizations to sell only in those areas where they had provider networks.[32] In Texas, which has twenty-six rating areas, at least one rating area and some counties within other rating areas had only one or two carriers offering plans.

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[31] Burke, *infra* note 34; Dafny, *infra* note 34; McKinsey, *supra* note 13.

[32] http://marylandhbe.com/wp-content/uploads/2012/12/Carrier-Reference-Manual_Rel1_0_Oct2012.pdf at 11.

Table 1: Number of Health Plans by Metal Level, 2014[33]

State	*Bronze*	*Silver*	*Gold*	*Platinum*
Arkansas	3-14	2-11	2-13	0
California	6-9	3-9	3-8	3-8
Connecticut	8	4	4	0
Maryland	11	11-13	9-11	2
Montana	7	8	5	1
Texas*	8-31	8-37	7-27	0-2

* Texas numbers include multi-state plans; other states do not include multi-state plans.

AR had seven rating areas: three had three carriers, two had two carriers, and two had one carrier.

CA had nineteen rating areas: six had three carriers (but three of these permited Kaiser to be in only specific sub-areas), four had four carriers, five had five carriers, three had six carriers; only Anthem BC of CA and BS of CA were in all nineteen pricing areas.

CT had eight rating areas: three carriers in each area; for silver and gold plans, only Anthem BC offered two 2 plans.

MT had four rating areas and each had all three carriers.

TX had twenty-six rating areas: five had two carriers, nine have three carriers, three have four carriers; five have five carriers, one had six carriers, two had seven carriers, and one has ten carriers.

[33] U.S. Dept. of Health and Human Svcs, *Health Insurance Marketplace Premiums for 2014 Databook*, (Sept. 25, 2013), http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.

Table 2: Types of Health Plans by State Premium Rating Area, 2014

State & Rating Area Number	Point of Service (POS)	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	Exclusive Provider Organization (EPO)
Arkansas				
1	8	25	0	0
2	5	7	0	0
3	9	26	0	0
4	5-9	7-26	0	0
5	0	7	0	0
6	0	7	0	0
7	5	23	0	0
California				
1	0	12	5	0
2	0	10	10	0
3	0	10	13	0
4	0	5	14	5
5	0	10	12	0
6	0	10	5	0
7	0	14	12	0
8	0	14	9	0
9	0	14	0	0
10	0	14	5	0
11	0	10	8	0
12	0	10	5	0
13	0	10	5	0
14	0	10	5	0
15	0	6	19	5
16	0	5	20	5
17	0	10	15	0
18	0	5	11	5

State & Rating Area Number	Point of Service (POS)	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	Exclusive Provider Organization (EPO)
19	0	5	24	5
Connecticut				
1	0	16	0	0
2	0	16	0	0
3	0	16	0	0
4	0	16	0	0
5	0	16	0	0
6	0	16	0	0
7	0	16	0	0
8	0	16	0	0
Maryland				
1	9	2	18	6
2	9	2	14	6
3	8	2	15	6
4	8	2	15	6
Montana				
1	4	17	0	0
2	4	17	0	0
3	4	17	0	0
4	4	17	0	0
Texas				
1	0	6	11	0
2	0	11	11	0
3	0	11	11	0
4	0	11	11	0
5	0	11	11	0
6	0	11	11	0
7	0	11	11	0

State & Rating Area Number	Point of Service (POS)	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	Exclusive Provider Organization (EPO)
8	0	6 - 8	28	0
9	0	35	11	0
10	0	23	9-14	0
11	0	23	9	0
12	0	23	9	0
13	0	23	9	0
14	0	23	9	0
15	0	23	9	0
16	0	23	9	0
17	0	23	9	0
18	0	23	9	0
19	0	23	9	0
20	0	23	9	0
21	0	23	9	0
22	0	23	9	0
23	0	23	9	0
24	0	23	9	0
25	0	23	9	0
26	0	17-23	6-18	0

The tables show that Connecticut and Montana require that carriers offer the same plans in all rating areas of the state, whereas there are substantial differences in choices in Arkansas, Texas and California depending on where an individual lives. The types of plans with different organizational structures (for example, HMO or PPO) being offered are also important for assessing the extent of competition in each of the six states. When these different product choices are counted at the premium rating area level, rather than aggregated to the state level, it is apparent that PPO and other non-HMO plans are more likely to be offered in areas that are more

sparsely populated and have high numbers of poor and uninsured people. This is an important finding because the plans with limited provider networks are more likely to be organizationally structured as PPO plans than HMO plans for reasons we discuss below.

Finally, as other research shows, silver plan premiums are lower in rating areas with more carriers than in rating areas with only one or two carriers.[34] We also observed this effect, and we observed that competition to have the lowest-priced silver plan did not consistently result in the lowest-priced silver carrier being the carrier with the lowest premiums across all the metal levels.

C. Six Marketplace Synopses

These statistics only partially describe how competition in the marketplaces developed in their initial year. They do not encompass the market and regulatory characteristics of each state that are essential for understanding why differences exist among the states, which is the focus of the remainder of this report. Here, we introduce each of the six state marketplaces.

California has the most managed marketplace among the six states. Only it engages in selective contracting with participating carriers, and its plan designs are more standardized than in the other states. Texas is at the opposite end of the range. It declined to establish an exchange, and its insurance regulators are forbidden from assisting with ACA regulation or implementation.

Connecticut created its own marketplace and Montana is a quasi-partnership state jointly running its marketplace with the federal government. The two states have a number of marketplace similarities. Both have only three carriers (including a very strong BlueCross BlueShield and a new COOP in each state) competing statewide in their marketplaces.[35] Neither state used selective

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[34] Amy Burke et al., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace*, ASPE Research Brief, Jun. 18, 2014, http://www.aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf; Leemore Dafny et al., *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces*, NBER Working Paper No. 20140, May 2014, http://www.nber.org/papers/w20140.pdf.

[35] Montana has 5 BCBS multi-state plans (one bronze, two silver, and two gold) but those are managed by BCBSMT. Connecticut does not have multi-state plans available in its marketplace in 2014.

contracting, and both states used rate review to push carriers to reduce their initial rate bids.

However, the similarities of Connecticut and Montana's marketplaces end there. Montana has far more plan choices available to its residents than does Connecticut, and the magnitude of deductibles available in Montana is almost double that in Connecticut. Montana does not require carriers to offer a platinum plan and only the Montana COOP offers one. Connecticut requires carriers to offer at least one silver and one gold plan but it does not require carriers to offer a platinum plan – and none do. It also limits the number of plans carriers may offer at each metal level to four.

Maryland's Health Connection, like Connecticut, limits carriers to no more than four plan designs at each metal level, and requires carriers to offer at least one plan in each of the bronze, silver and gold metal levels. Maryland differs from the other five states by requiring carriers with market shares above specified dollar thresholds in the state's individual and small-group health insurance markets to participate in its marketplace.[36]

Arkansas, as a partnership state, jointly administers its marketplace with the federal government. The individual marketplace in Arkansas is perhaps more complicated than those in the other five states because Arkansas received federal approval to enroll newly-eligible Medicaid recipients in the marketplace plans. Medicaid beneficiaries who do not choose a health plan are auto-enrolled according to an algorithm that assigns larger numbers of people to the plans with the lowest market shares.

III. EMERGING FORMS OF COMPETITION

A. Competition Focused on Value of Products Rather than Risk-Selection

As noted in the Introduction, the ACA's insurance reform provisions are intended to improve competition in the individual and

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[36] Any insurer with a market share of more than $10 million in the individual market (and $20 million in the small-group market) has to participate; Louise Norris, *Maryland health insurance exchange/marketplace*, HEALTHINSURANCE.ORG (May 1, 2015), http://www.healthinsurance.org/maryland-state-health-insurance-exchange/.

small-group markets by facilitating comparison shopping and by ending carriers' ability to select enrollees based on their likely use of costly health care. We in fact observed a high level of price competitiveness in each state,[37] and we detected no indication of any serious regulatory circumvention of the ACA's basic provisions of guaranteed issue, age-adjusted community rating, and standardized benefits and cost sharing. The law's core requirements that prevent risk-selection are being enforced in every state,[38] and carriers are complying.

The ACA encourages carriers to compete based on the value they bring to consumers. The expectation is that people will choose a plan that provides them with the best value based on the premium, expected out-of-pocket costs, and quality of providers associated with the plan. Key informants in each state commented on how price sensitive consumers are in the new marketplaces and how competition appears to be affecting carrier pricing of plans. However, the absence of good information needed to compare quality of providers became an issue during the first year of the marketplaces. California is the only one of our study states where even limited measures of quality were available to people shopping for a plan in 2014.[39]

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[37] *See* One notable exception is that, in Arkansas, the carrier that specializes in Medicaid managed care (Novasys, d.b.a. Ambetter Health) had marketplace rates that were substantially higher than those of the other two carriers. David Ramsey, *New Marketplace rule will impact all insurance carriers, not just Ambetter*, Arkansas Times, April 17, 2014, http:www.arktimes.com//ArkansasBlog/archives/2014/04/17/rule-requiring-plans-covering-only-essential-health-benefits-will-impact-all-carriers-not-just-ambetter. Sources speculated that Novasys adopted this pricing strategy because it counted on receiving guaranteed Medicaid enrollees through auto-assignment, realizing that the state will pay the full premium for them. Another explanation for its higher rates, however, is that only Novasys's plans also included dental benefits, which are Medicaid-covered benefits.

[38] Justin Giovannelli et al., *Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market*, 1758 THE COMMONWEALTH FUND, no. 15 (July 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1758_giovannelli_implementing_aca_state_reform_individual_market_rb.pdf.

[39] Sarah J. Dash, et al., *Implementing the Affordable Care Act: State Action on Quality Improvement in State-Based Marketplaces*, 1763 THE COMMONWEALTH FUND, no. 18 (July 2014), www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1763_dash_implementing_aca_state_action_quality_improvement_rb_v2.pdf.

We also observed that most insurance agents, despite some discontent, were constructively engaged with the ACA's market reforms. In the states we studied, numerous agents had received training to sell individual insurance in the new marketplaces. Many agents see a business opportunity in this market segment and understand that their role has shifted from dealing with the medical underwriting process to assisting consumers with choosing a health plan.

Despite the overall compliance with ending risk-selection, we observed some cause for concern.[40] The unexpected presence of a number of plans with narrow provider networks raises the concern that such plans could be unattractive to people with complex health concerns but very attractive to healthy people. The types of plans that are being offered in the marketplaces are predominantly managed care plans, with some options offering quite restrictive or narrow provider networks.[41] In some cases, the plans involve very restrictive provider networks and enrollees generally cannot obtain care from a provider who is not affiliated with the network.[42]

Narrow provider networks offer a mechanism for carriers to control enrollee health care spending. However, the narrow provider

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[40] In addition to the points noted in text, we also observed some temporary measures to select more favorable risks, during the ACA's transition period. In the final months of 2013, some carriers in several of the six states (most notably Arkansas) marketed 364-day policies that would commence on December 31, 2013, to people who wanted premiums that were medically underwritten. *See* Sabrina Corlette, *Health Plans Get Creative Skirting the ACA*, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE (Sept. 4, 2013), http://ccf.georgetown.edu/all/health-plans-get-creative-skirting-the-aca/. Similarly, some carriers encouraged healthier groups to renew existing policies before the January 1, 2014 start date of the new law, in order to keep their lower rates in effect for another year. Jeffrey Young, *Aetna Seeks to Avoid Obamacare Rules Next Year*, HUFFINGTON POST (April 4, 2013), http://www.huffingtonpost.com/2013/04/04/aetna-obamacare_n_3009589.html. Some of these strategies are short-lived because transitional plans will be phased out fairly soon. Short term plans merit continued attention, however, because they continue to be outside of the ACA's market reforms. *Transitional reinsurance program results in significant new costs for group health plans*, 35 FYI, no. 93 (Dec. 6, 2012.

[41] M.P. McQueen, *A different kind of Medicaid Expansion*, MODERN HEALTHCARE (July 27, 2013), http://www.modernhealthcare.com/article/20130727/MAGAZINE/307279991.

[42] Scott Gottlieb, *The President's Health Care Law Does Not Equal Health Care Access*, AMERICAN ENTERPRISE INSTITUTE, docs.house.gov/meetings/IF/IF14/20140612/102332/HHRG-113-IF14-Wstate-GottliebS-20140612.pdf (testimony from hearing before U.S. House of Representatives Energy & Commerce Committee, Subcommittee on Health).

networks also may be more attractive to low-risk people. Also, others have noted that some carriers are using their lists of covered or preferred drugs to discourage enrollment by patients with higher cost health conditions.[43] Nevertheless, the general consensus among the informed sources we interviewed is that potential risk-selection concerns are not likely to be market-destabilizing. They expect that the ACA risk adjustment process, mentioned earlier, which takes effect in 2015, will counteract any incentives for carriers to pursue such strategies.

B. Different Competitive Strategies

Although competition in the marketplaces appears to have shifted away from risk selection and toward consumer value, the marketplaces in the six states do not fit neatly into a single well-defined pattern. Tables 1 and 2 clearly show that there are differences across the six states and inside four of the states in how carriers are competing and the choices consumers are facing. This is not totally surprising since under the ACA the states – even those with federally facilitated marketplaces – made many of the decisions about marketplace rules. Indeed, closer examination reveals that various demographic and regulatory factors explain many of the differences among the insurance markets in our six study states.

The nature of competition can be categorized by the extent to which carriers rely on patient cost-sharing or limited provider networks to achieve lower premiums. In the six states we studied, carriers' use of these approaches created three distinct competitive strategies that characterize the states' marketplaces (see Table 3). Four principal characteristics of states appear to be associated with one or the other of the three competitive strategies that characterize the states' marketplaces (see Table 4).

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[43] Kimberly Leonard, *Insurance Companies Find Obamacare Loopholes*, U.S. NEWS (Sept. 23, 2014), http://www.usnews.com/news/articles/2014/09/23/insurance-companies-find-obamacare-loopholes; Michelle Andrews, *Some Plans Skew Drug Benefits to Drive Away Patients, Advocates Warn*, KAISER HEALTH NEWS, (July 8, 2014), http://kaiserhealthnews.org/news/some-plans-skew-drug-benefits-to-drive-away-patients-warn/; *See,* Douglas Jacobs & Benjamin Sommers, *Using Drugs to Discriminate: Adverse Selection in the Insurance Marketplace*, 372 NEW ENG. J. MED. 399, 400 (2015).

Table 3: Three Competitive Strategies in Marketplaces
Carriers compete by offering many different variations of cost-sharing, especially for the bronze and silver metal plans, and there are no plans with narrow provider networks. E.g., Montana and Connecticut.
Carriers are restricted to offering a small number of plans at each metal level and the plans have very similar cost-sharing arrangements so the carriers compete primarily in terms their provider networks. E.g., California.
Carriers compete based both on provider networks and on variations in cost-sharing arrangements. E.g., Arkansas, Maryland, and Texas.

Table 4: Characteristics Associated With Differences in Competition in Marketplaces
The geographic spread and demographic composition of the population and geographic distribution of health care providers, and whether there are a small or large number of different premium rating areas in the state.
The types of carriers and market shares in the state's individual insurance markets before the ACA became law.
The structure and content of regulatory oversight for different types of health plans, especially the composition of managed care networks and the oversight of HMOs versus conventional commercial carriers.
How supportive and active state officials were in implementing the new marketplace and the state's history of health reform efforts.

Every state has a unique combination of characteristics that describe it. Nonetheless, by identifying differences in these characteristics and noting when some are grouped together, a framework emerges that suggests why different competitive strategies exist in the six states' marketplaces. Distinguishing between characteristics that do not change quickly, such as the size of the state's population and characteristics that a governor or legislature could adjust, is important for states that want to influence the competitive strategies that develop in their marketplaces.

It would be disingenuous to suggest with observations in only six states' that particular characteristics are more important or have quantitatively different causal effects than others on the type of

competition in the marketplaces. Instead, our analysis is qualitative and descriptive, with the goal of fostering a more systematic analysis of the competitive strategies emerging in all the states' marketplaces.

***(1) Demographic factors**.*

The six states' populations in 2012 ranged from just over 1 million (Montana) to more than 38 million (California). But these totals mask the extent to which the populations are clustered around some cities or counties while other areas of the state are quite sparsely populated. How many premium rating areas the states could have and what their boundaries are was a decision the federal government left to the states.[44] Some states worked to create rating areas with roughly equal numbers of people while other states did not. The rating area boundaries follow county lines in most states, with areas consisting of more than one county. There are generally far fewer physicians and hospitals in rural areas, so carriers have limited bargaining power for negotiating lower reimbursement rates or establishing exclusive provider networks in these areas. As a result, the rating area boundaries have a direct influence on carriers' options for how they might compete in a state and in specific regions of a state.

In some states or regions of states, we observed that carriers differentiated their plan offerings primarily in terms of patient cost-sharing (e.g., Montana) or by offering PPO plans with a combination of greater cost-sharing and restrictions on providers (e.g., rural counties in California and Texas). Carriers that rely on limited provider networks are either not offering their products in the sparsely populated areas of the six states or they are not competing in the state marketplace at all. In Texas, for example, rating area 3 consists of five counties surrounding and including the city of Austin, and has a total population of about 1.7 million people. Seven carriers offering eighty different plans (fifty HMO and thirty PPO plans) are competing there. By contrast, rating area 12 consists of just Webb County, the sixth largest geographic county in the state, with a population of 260,000. That area has only two carriers offering

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[44] CENTER FOR MEDICARE & MEDICAID SERVICES, MARKET RATING REFORMS; STATE SPECIFIC GEOGRAPHIC RATING AREAS (last updated May 28, 2014), http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html.

twenty different plans, eighteen of which are BCBS plans (twelve PPO plans and six HMO plans); Molina, the other carrier, offers just HMO plans - one each at the silver and gold actuarial levels.

***(2) Market structure before the ACA*.**

Arkansas, Connecticut, Maryland and Montana each had a dominant carrier (BCBS) in their individual insurance market before the states' marketplaces were established. In addition, Arkansas, Connecticut and Maryland had managed care plans that did not have large market shares before the ACA became law. Arkansas and Maryland did not require these carriers to compete in rating areas where they do not have provider networks. In contrast, Connecticut required carriers to compete across the state and its HMO is offering plans in all eight rating areas. Montana does not have any carriers offering HMO plans in the state.

In contrast, California and Texas had other carriers besides BCBS with substantial shares of the individual market before the ACA. In particular, national carriers such as Cigna, UnitedHealth and Aetna offered PPOs in California and Texas. California and Texas also had strong regional HMOs (e.g., Kaiser Permanente in California, Scott and White in Texas). California also has several Medicaid managed care plans and provider groups (such as the Chinese Community Health Plan in San Francisco and northern San Mateo County) that have long-focused on providing care to under-served and uninsured people.

The carriers in Arkansas, Connecticut, Maryland and Montana continued to offer substantially the same types of products that people in each state had been used to purchasing in the individual and small-group markets before the ACA. Competition in Arkansas and Maryland reflects a combination of strategies while competition in Connecticut and Montana primarily focuses on cost-sharing differences. By contrast, in some urban parts of California and Texas, where there were large numbers of uninsured people, some carriers' plans require enrollees to obtain care only from a limited set of providers.[45] Most of California's rating areas exhibit competition

[45] The shift to restricted provider networks caught many policymakers and analysts by surprise but the commercial market in both states (and others as well) had already been moving to one where carriers were offering products with narrow provider networks at lower premiums than their standard products.

based primarily on provider networks while Texas's rating areas have more of a mix of strategies. Thus, the carriers in the marketplaces are not straying too far from what they were offering before the ACA.

(3) ***Existing regulatory structures***.

States' existing regulatory structures also influenced the forms of marketplace competition that initially emerged. Especially relevant is how states regulate HMOs and other managed care networks. One key issue is whether states require carriers to include most providers in their networks, or whether they permit limited networks.

Many states regulate HMOs differently than PPOs, with a strong focus on HMO network adequacy and quality. Some states allow non-HMOs to sell closed network products, known as exclusive provider organizations (EPOs).[46] Depending on the state and how a carrier is incorporated, a carrier might be restricted in the types of provider networks it can offer or it might be able to apply to a different state regulatory agency in order to offer the type of product it prefers.[47]

Texas, for instance, has a mix of HMOs and PPOs that is based in part on differences in existing regulations. Texas has stricter regulation of network adequacy for HMOs than for conventional insurance, with specific standards limiting how far a person has to travel to reach a primary care provider or a hospital emergency room. Accordingly, the HMO plans offered in the marketplace are concentrated in urban areas, where they constitute a majority of the products offered in the marketplaces. In the more rural rating areas of Texas, a majority of products offered are PPOs. Similarly, the mix of HMOs, PPOs, and EPO plans seen in California is driven both by different provider markets and by the different ways in which California regulates these plan types.[48]

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[46] Bonita Briscoe, *Understanding Health Plan Types: Whats in a Name?,* U.S. BUREAU OF LABOR STATISTICS, (Jan. 2015), http://www.bls.gov/opub/btn/volume-4/understanding_health_plan_types.htm.

[47] *Id*.

[48] California regulates HMOs through its Department of Managed Health Care (DMHC), whereas its Department of Insurance (DOI) regulates all other forms of insurance, except for Blue Cross and Blue Shield, which has the option to submit PPO products to either regulation agency. *See* CAL. HEALTH & SAFETY CODE § 1340 et seq. Prior to the ACA, the DOI regulated most managed care plans sold to individuals while the DMHC regulated most

In Connecticut, existing Department of Insurance regulatory policy discouraged carriers from offering different provider networks in different plans or market segments because of concerns about creating consumer confusion. Carriers must use networks that are "substantially similar" to those they offer in the large group market, defined as including eighty five percent of the same providers.[49] Not surprisingly, therefore, Connecticut (and Montana as well) required carriers to offer the same plans in all areas of the state. In Arkansas, some sources said that a state regulation limiting how much carriers can penalize patients for going out of network made it difficult to create plans that have limited provider networks.[50]

The different regulatory structures in each state have a direct bearing on the numbers of HMO and PPO plans available in each premium rating area of each state (as shown in Table 2). The competitive strategies that typify the different premium rating areas are affected by whether regulations allow a carrier to offer PPO plans with limited provider networks.

(4) ***Proactive implementation of the ACA's reform and state history of reform efforts.***

The extent to which a state was actively involved in setting up its marketplace clearly affected the competitive strategies observed in the state.States' health reform histories also informed the particular

plans sold to groups. Yet almost all of the carriers in Covered California opted, for regulatory reasons, to file their individual market products with the DMHC. This means that most plans are HMOs, except for those sold by Anthem Blue Cross and by Blue Shield of California, which also sell PPOs.

[49] Because lower-premium plans with limited provider networks have gained traction among employers in the last two years, Connecticut's exchange board decided to allow carriers to offer "non-standard" plans with limited provider networks. None chose to do so, in part because a carrier's lowest price silver plan must be a standard plan.

[50] The regulation requires HMOs to let patients obtain care from non-network providers under terms that limit patients' cost-sharing to no more than twenty-five percent more than what they would have paid for network care, on average. This prevented QualChoice, an HMO operating in five of the seven rating areas of the state, from offering a closed-panel network in the marketplace. Instead it offers a limited network product in the two most populous rating areas as well as a product with the larger network it normally offers to groups. QualChoice's limited network product has a premium that is competitive with BCBS; its larger network product is ten to fifteen percent more expensive than the BCBS products. Interestingly, Arkansas' "any-willing-provider" law was not cited as a regulatory barrier, because it protects only providers who are willing to accept carriers' discounted payment rates.

policies adopted by the states for their marketplaces. Among the six states we studied, California and Texas "bookend" the spectrum of reform efforts and state involvement in setting up their marketplaces. Texas steadfastly refused to run its own marketplace and the state's Department of Insurance has essentially stayed out of the marketplace operations.

The board running Covered California used its selective contracting authority to require carriers to compete for approval to sell in each of the nineteen rating areas in the state. Because it was clear that the Covered California board would favor lower-premium carriers, these carriers submitted bids to provide limited provider network PPO and EPO plans with lower premiums in some of the rating regions. Although the Covered California board used its selective contracting authority to exclude only a few carriers, it defined more specifically than other states what qualifications are necessary for a carrier to participate.

Several people told us that the decision to use selective contracting grew out of the state's history of managed competition in CalPERS (its large public employee program for pension and health benefits) and the Health Insurance Plan of California (HIPC) for small employers, as well as California's approach to regulating managed care plans since 1975.[51] This history also helps explain California's limits on the plan designs that carriers can offer at each metal level, which in turn is a major reason why competition in most of California's rating areas is focused on provider networks.

Maryland chose not to conduct selective contracting but it required marketplace participation by all carriers that had pre-ACA health insurance market shares above $10 million in the individual

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[51] The Pacific Business Group on Health (PBGH) took over the Health Insurance Plan of California (HIPC) in 1998, which was renamed the Pacific Health Advantage or PacAdvantage. The HIPC-PacAdvantage was quite similar to the structure of the ACA marketplaces. It operated for a total of thirteen years, ending in 2006 due to adverse selection that it could not reverse. David Gorn, *Lessons Learned From PacAdvantage Failure*, CALIFORNIA HEALTHLINE, (Aug. 4, 2011), http://www.californiahealthline.org/capitol-desk/2011/8/report-beware-of-adverse-selection; Micah Weinberg and Bill Kramer, *Building Successful SHOP Exchanges: Lessons from the California Experience*, PACIFIC BUSINESS GROUP ON HEALTH (2011), http://www.pbgh.org/storage/documents/PBGH_SHOP_05.pdf.

market (and above $20 million in the small-group market).[52] The result is that competition among carriers exhibits a mix of cost-containment approaches.

The four other states we studied neither required, nor restricted, participation by carriers. Instead, they accepted all qualified carriers that chose to participate.[53] However, these states were far from passive in dealing with carriers. Connecticut and Maryland required carriers to offer standardized benefit designs, and limited the number of non-standard products carriers may offer. In contrast, Arkansas and Montana, despite having only three carriers competing in each state, have a very large number of plans available. Tables 1 and 2 showing the different numbers of carriers and plans offered in each state's rating areas reflect these different levels of state interaction with the marketplace implementation and histories of reform efforts.

Finally, all of the states except Texas actively reviewed carriers' proposed rates as a way to pressure carriers to offer premiums that were as low as feasible. As part of their review, insurance regulators or marketplace officials questioned at least some of the assumptions that carriers used in developing their proposed rates, resulting in substantial reductions (in the range of 10-20 percent) by one or more carriers. In Connecticut and Montana, at least two carriers re-evaluated their proposed rates; and in Arkansas and California, some voluntary rate revision occurred even before proposed rates became public because officials quietly advised higher-priced carriers to re-evaluate their initial filings.

This rate filing and review dynamic caused the marketplaces to be highly price-competitive, at least for the bronze and silver plans. One key to this dynamic is that in most of the premium rating areas in each of the six states there were at least three competing carriers. (the exceptions are some rural areas of California, Arkansas, and Texas). As a result, carriers were at some risk of being above the favored positions of having the lowest or second lowest-priced silver plan.

[52] Norris, *supra* note 36.

[53] Connecticut and Maryland, however, have legislative authority to use selective contracting in the future, if their boards decide to do so.

IV. CONCLUSIONS

When carriers selling individual insurance are no longer allowed to compete with mechanisms that allow them to risk-select individuals they insure, how do they choose to compete instead? Our study of six states' experiences during the first year of the ACA marketplaces shows that carriers are competing to reduce premiums by focusing on patient cost-sharing and on the composition of provider networks. But the competitive strategies that mark the type of competition occurring in the marketplaces are not the same across the country. The types of choices people have depend on where they live – and how carriers compete depends on which rating area and state one examines. Thus, there is some basis for concern that carriers have the potential to choose geographic areas or tailor their provider network to reduce coverage of people who may have higher risks of costly medical conditions.

The four factors we identified from our six-state study provide a framework for understanding why there are different competitive strategies among the marketplaces. Our study also provides a reference point for identifying changes in the forms of competition that will occur in the future. The picture of competition in the six states' marketplaces in 2014 reflects only the initial year of the ACA marketplaces. Indeed, the mere fact that more carriers are in the marketplaces across the country in 2015 will alter the competition. A set of reforms as fundamental as those in the ACA will surely stimulate continuing adaptations by carriers, providers and policymakers. We expect the competitive strategies in the marketplaces to evolve as consumers and carriers gain more experience with the marketplace competition.