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Exchanges go live: Early trends in exchange dynamics

After three and a half years of forecasting, data is now emerging from the individual exchanges that can inform the likely impact of the Affordable Care Act.[1] The McKinsey Center for U.S. Health System Reform has developed a database covering more than 21,000 unique qualified health plans filed on the public exchanges in all 501 rating areas in the 50 states and District of Columbia.

This Intelligence Brief describes five trends emerging from the first few weeks of exchange data:

- The competitive landscape in the individual market has changed considerably, given the number of new entrants
- These new entrants are pricing competitively, but are not usually price leaders
- Premium levels vary considerably, both within and across markets
- Zero-net-premium products are widely available
- "Managed-care-like" designs are re-emerging, particularly among the new entrants

We based our analysis of each of these trends on data accessed directly from the public exchanges as of October 15th, 2013.[2] The situation remains dynamic, however, as there have been widely acknowledged challenges with the exchanges. Data releases are being refreshed regularly as the public exchanges resolve technical issues, and all analyses are contingent upon the accuracy of the information released. Accordingly, the trends described in this Intelligence Brief should be considered as directional indicators of how the public exchanges are likely unfolding, and not as conclusive proof of industry changes. Nonetheless, the trends can begin to inform both near-term and longer-term strategic actions.

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[1] This analysis focuses on individual-exchange products, because they are the only plans that enable income-eligible consumers to receive the federal premium and cost-sharing subsidies. Complete off-exchange filings may not be available in every state until the end of 2013, and thus they have not been included in the analysis.

[2] All data was obtained directly from the public exchanges over the first two weeks of October, by shopping directly on all exchanges as well as through datasets released by the federal exchange.

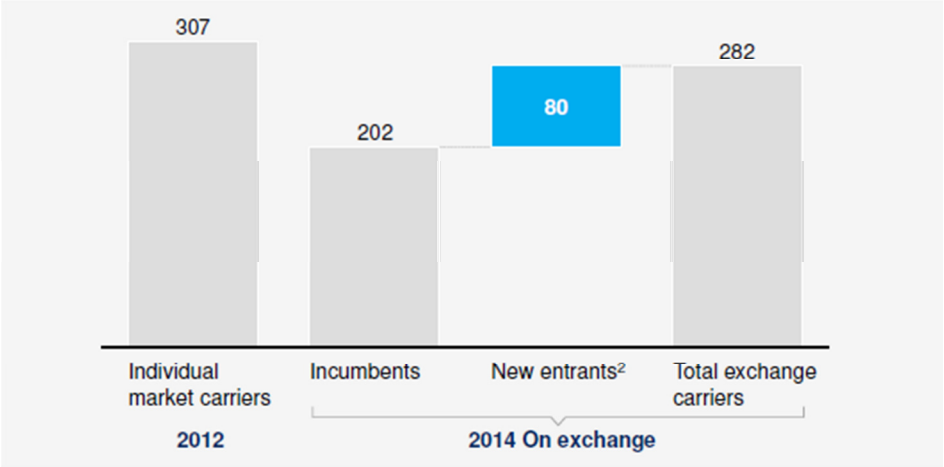
The competitive landscape in the individual market has changed considerably, given the number of new entrants

The competitor composition of the individual market has changed. Two-thirds of the "unique payors"[3] offering individual plans in 2012 have filed on the public exchanges in the same states. Yet 80 new entrants (defined as carriers participating in the individual market for the first time in a given state) have filed on those same exchanges *(Exhibit 1)*.

EXHIBIT 1

Composition of individual market, 2012 vs. 2014 on exchange

Change in total number of individual market carriers across the U.S.[1]



1 2012 and 2014 totals reflect counts of "unique carriers" within each state (e.g., national carrier playing in several states is counted in each state it plays in)
2 "New" entrant defined as carriers participating in the individual market for the first time in a specific state

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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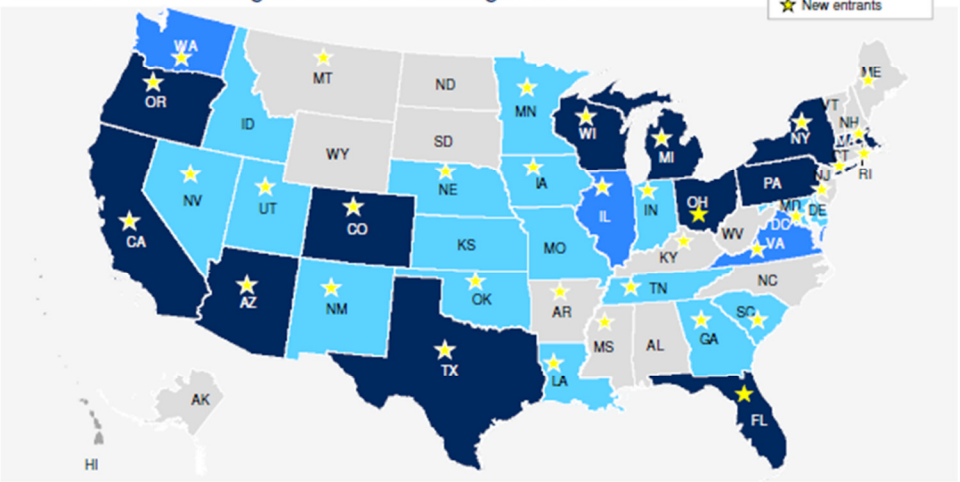
The intensity of post-reform competition varies greatly across the country. The number of carriers in any state offering products on the public exchanges is as low as 1 and as high as 17 *(Exhibit 2)*. Similar variability exists among the rating areas within a state; the number of carriers in individual rating areas ranges from 1 to 10.

[3] Our calculations are based on the number of carriers that offer plans in each state. As a result, a national carrier that offered plans in 12 states in 2012 would be counted as 12 "unique payors" in that year. In addition, a carrier that offers 2014 exchange plans in 4 rating areas in a state is counted as a single entrant in that state.

EXHIBIT 2

Exchange competitive intensity across the U.S.

Number of carriers filing on individual exchanges across the U.S.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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Nationwide, new entrants represent 28 percent of all carriers on the exchanges and 16 percent of all products offered. The new entrants include a range of organizations, as shown in *Exhibits 3-4*. Medicaid carriers (organizations previously providing plans to Medicaid enrollees and now offering commercial coverage on the exchanges) are the most common type of new entrant. However, consumer-operated and oriented plans (CO-OPs) are offering the most products of all new entrants in the market.

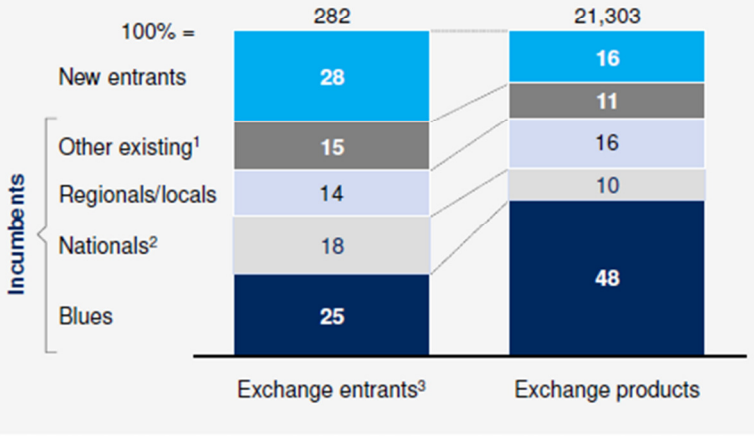
Among the incumbent payors, Blue Cross Blue Shield plans are the most active on the exchanges. They comprise 25 percent of all exchange participants and offer products in all but three states and all but five percent of the rating areas. National insurers[4] (i.e., Aetna/Coventry, Humana, Cigna, UnitedHealth) comprise 18 percent of all participants. They offer plans in 28 states and 38 percent of the rating areas. The different approaches taken by the Blues versus the national carriers are reflected in the number of products they are offering. Blues plans account for almost half of all exchange products, while national carriers account for less than 10 percent of all products.

[4] The term "national insurers" refers to all commercial health insurers that have a presence in more than four states and have filed on the exchanges. Anthem, HCSC, and Regence are excluded because they are classified as Blues plans.

EXHIBIT 3

Carrier type breakdown by exchange entrants and products

2014 individual exchange entrants and products by carrier type across the U.S.
Number of entrants and products, percent



1 Includes existing Medicaid and provider-based carriers currently offering individual insurance in the state where they have filed on exchange
2 Aetna / Coventry, Humana, Cigna, United
3 Reflects count of "unique carriers" within each state

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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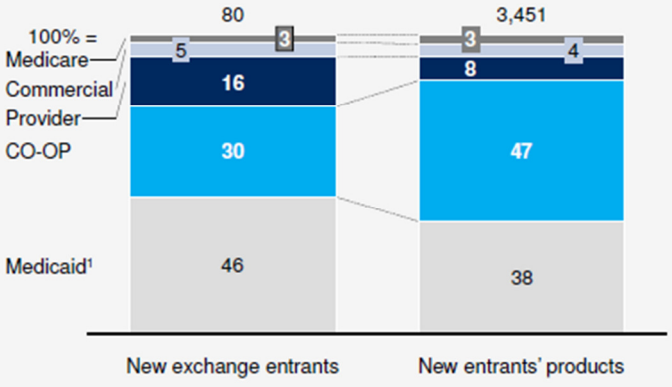
EXHIBIT 4

New entrant-specific breakdown by exchange entrants and products

2014 individual exchange new entrants and products by carrier type across the U.S.
Number of new entrants and products, percent



1 Includes provider-based Medicaid plans

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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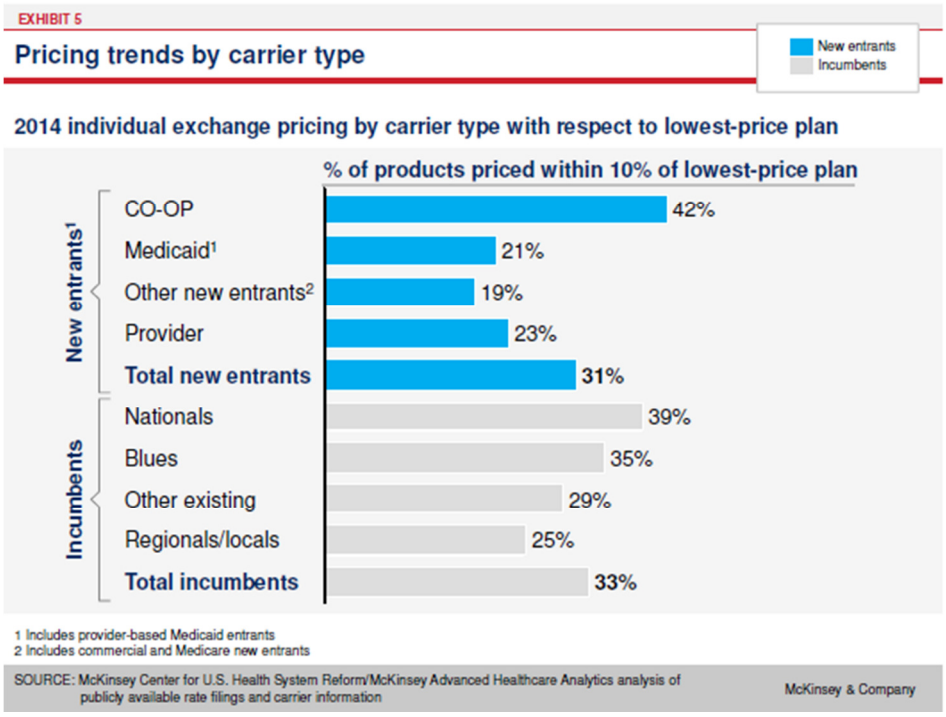
New entrants are pricing competitively, but are not usually price leaders

Across the country, about half the new entrants' plans are priced below the median in their respective markets.[5] Furthermore, 31 percent of the new entrants' plans are within 10 percent of the lowest-price plan (the price range our research suggests most consumers are willing to consider[6]). The new entrants' rates are consistent with incumbents' rates, with 47 percent of incumbents' plans priced below the median and 33 percent within 10 percent of the lowest-price plan *(Exhibit 5)*. However, incumbents are more likely to be price leaders. Even in rating areas where new entrants are present, incumbents are offering 66 percent of the lowest-price products in each metal tier.



Across markets, Blues plans are the most common price leaders, offering 42 percent of all lowest-price products across the U.S. While national insurers are competing in fewer markets (38 percent of rating areas covering slightly more than half of non-elderly uninsured[7]), they are more competitive in those states, offering the lowest-price product 56 percent of the time. Among new entrants, CO-OPs have emerged as price leaders, offering 37 percent of lowest-price products in the 22 states where CO-OPs are present.

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[5] This percentage is lower than the 66 percent we reported in our September Intelligence Brief, as the September estimate was based on available data of plans filed in only eight states.

[6] In our exchange simulations, we observed the lowest priced products and products priced within 10-15% of the lowest-price product netting a considerable share of lives, especially in lower metal tiers. However, strong brands were still able to offset the price advantage and retain strong share in many geographies.

[7] Non-elderly uninsured defined as those over 100 percent FPL in non-Medicaid expansion states and over 138 percent FPL in Medicaid expansion states.

Although these pricing trends are relevant at a cross-market level, plan pricing varies significantly across rating areas, as we discuss below. In one-fourth of the largest cities with new entrants, a majority of the new entrants' products—100 percent in Los Angeles, 86 percent in Milwaukee, and 67 percent in Indianapolis, for example—are priced within 10 percent of the lowest-price product.

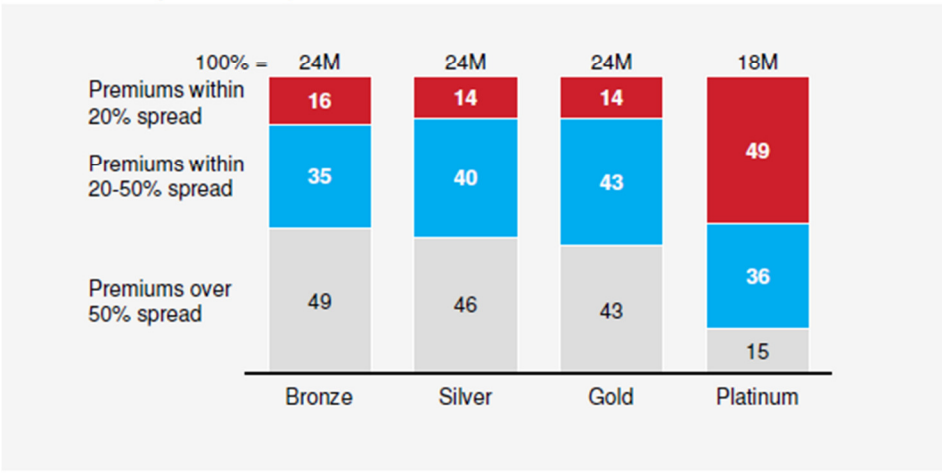
Premium levels vary considerably, both within and across markets

In most rating areas, large variations in pricing are present within and across metal tiers. Close to half of all non-elderly uninsured individuals[7] are offered premiums in their rating areas that vary by over 50 percent within a single tier across bronze, silver, and gold, and close to one-fifth of uninsured are seeing this type of variation in platinum *(Exhibit 6)*. There may be several potential factors contributing to these pricing differences within a given rating area, including degree of network narrowing, different costs of care, and different assumptions about risk pool (i.e., morbidity of expected membership and impact of risk adjustors/re-insurance). Of these, narrow networks likely represent the largest sustainable price-lowering action carriers are taking in 2014.

EXHIBIT 6

Price variation within rating area and metal tier

Price variation[1] within rating area and tier on 2014 individual exchanges across the U.S.
Total non-elderly uninsured[2], percent



1 Price variation measured as difference between lowest and highest exchange product for a 40-year old single within each tier in each rating area
2 Includes uninsured between ages 18-64 who are over 138% FPL in Medicaid expansion states and over 100% FPL in non-Medicaid expansion states

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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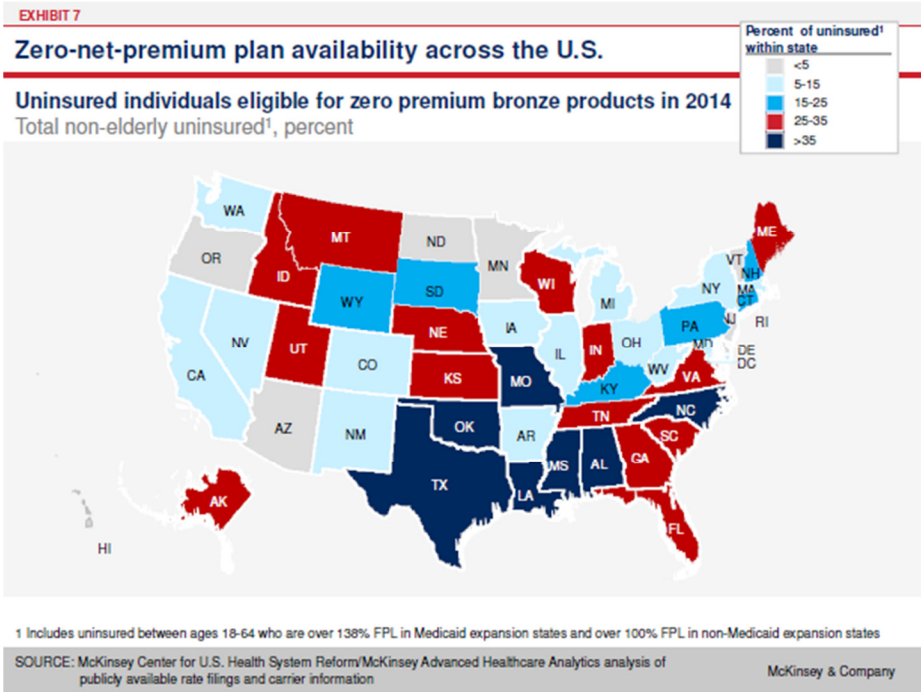
There appears to be some correlation between pricing and metal tier. In almost all rating areas, the lowest-price product in one tier is less expensive than the lowest-price product in the tier above it. However, there is often considerable overlap within single rating areas in the range of prices offered in each tier and across tiers. As a result, a 40-year-old single person can buy a bronze, silver, or gold plan for the same price in 43 percent of rating areas. Similarly, in 20 percent of the rating areas offering a platinum product, a 40-year-old can purchase a bronze, silver, gold, or platinum plan at the same price. In Phoenix,

Arizona, for example, a 40-year-old who is willing to spend $249 per month could find at least one product at that price in each metal tier.

The variation in pricing across rating areas is also considerable. Among bronze plans, for example, the least-expensive product for a 40-year-old single person is $115 per month in Minnesota but $403 in Colorado (this Colorado product actually costs more than the least-expensive platinum plans in almost 80 percent of the rating areas offering platinum products). Although underlying differences in the cost of care across markets may explain part of the variation in premium levels across markets, they unlikely explain all of it. Considerably more data—and a full multivariate analysis—will be required to isolate the specific independent variables affecting the pricing dispersion across markets.[8]

Zero-net-premium products are widely available

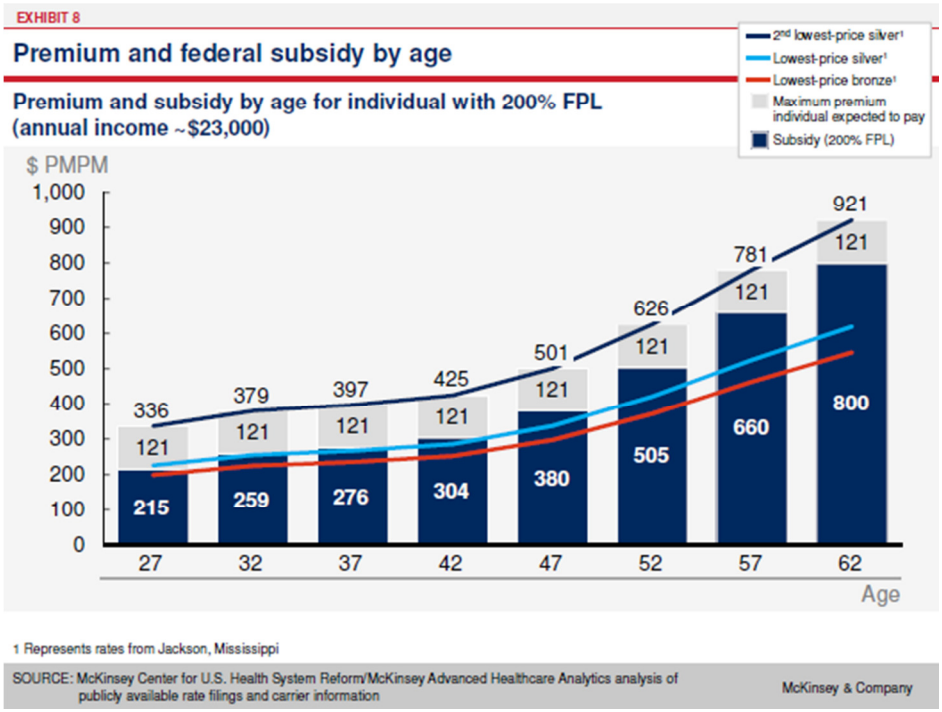
Across the U.S., 6 to 7 million people may be eligible for a zero-net-premium bronze plan and ~1 million may be eligible for a zero-net-premium silver plan. This estimate includes uninsured as well as currently individually insured, with uninsured comprising the majority (~85 percent) *(Exhibit 7)*. In a zero-net-premium plan, the federal premium subsidy covers the entire premium (many people still face co-payments for services delivered). The subsidy amount is calculated as the difference in the price of the second-lowest silver plan in that rating area and the "maximum premium" the person is expected to pay. This maximum is a function of the person's income and family size. Persons with income up to 400 percent of the federal poverty level are eligible for a subsidy.



[8] McKinsey Reform Center plans to conduct and publish this multivariate analysis later this year.

To illustrate, consider a 42 year old single female living in Jackson, Mississippi earning $23,000 a year (200 percent of the federal poverty level). For her income level, the maximum premium she is expected to pay is 6.3 percent of her income, or $121 a month. Because the second-lowest silver plan available in her rating area is $425, the federal premium subsidy for her is $304. If she chooses to buy the lowest-price bronze product (priced at $236), the "net premium" for her is zero because it is priced below her subsidy.

While the premium increases directly with a person's age, higher premium products increase at a greater rate as age increases *(Exhibit 8)*.[9] Accordingly, older people are eligible for larger subsidies than are younger people, increasing the likelihood that they can obtain a zero-net-premium product. Similarly, people with lower incomes are more likely to be eligible for zero-net-premium products, because subsidy levels increase as income decreases.



The number of zero-net-premium products a person has available to them depends on his/her subsidy amount, the number of plans priced below the second-lowest silver plan in his/her rating area, and the differences in price among those plans. The greater the price differential between the second-lowest silver plan and either the lowest silver or lowest bronze plan, the more likely it is that the person can find one or more zero-net-premium products. Because premium levels vary widely across rating areas, the availability of zero-net-premium products also varies widely. For example, our research suggests that about 40

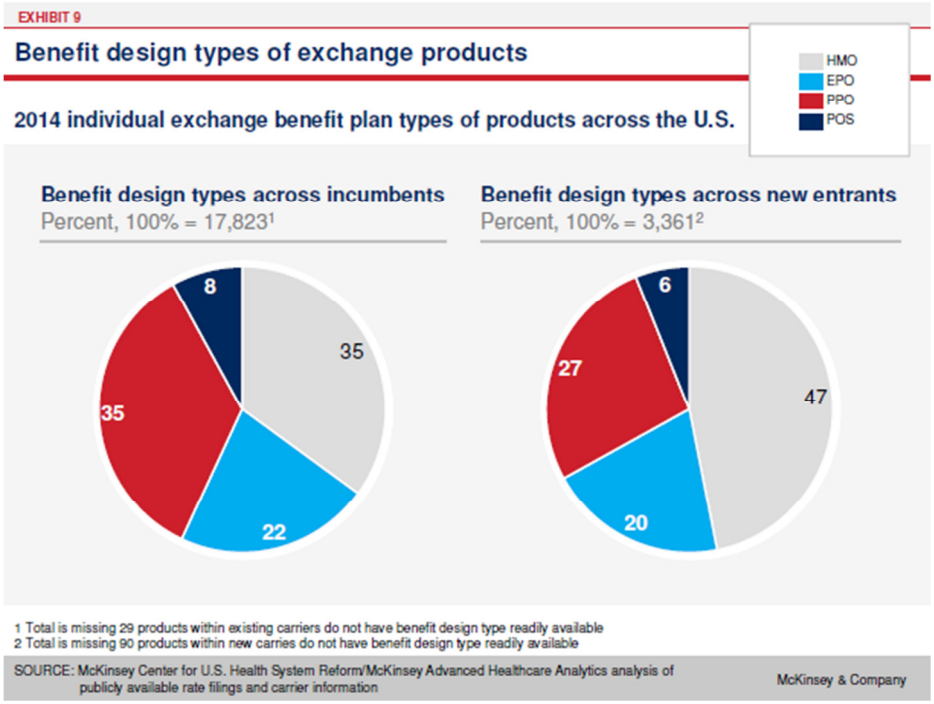
[9] As age increases, higher priced products increase at the same rate as lower priced products, according to the HHS standard age curve for 2014 individual market premiums (except in NY and VT). However, while the rate of increase is the same, the absolute dollar difference is different, resulting in higher subsidies for higher-priced products, since subsidies are calculated by a flat dollar amount regardless of age.

percent of the non-elderly uninsured[7] in Missouri are eligible for zero-net-premium bronze plans, compared to only 2 percent of the uninsured in New Jersey.

It is not yet known how many of those eligible for zero-net-premium bronze plans will opt to buy a bronze plan rather than a silver plan, especially since almost all of these individuals would be eligible for a cost-sharing subsidy[10] if they bought a silver plan.[11] At present, zero-net-premium silver plans are available to ~1 million individuals, where eligible individuals can obtain a plan requiring no premiums yet containing cost-sharing subsidies, resulting in limited out-of-pocket costs.

"Managed-care-like" designs are re-emerging, particularly among the new entrants

A more diverse set of benefit designs is emerging. Close to 60 percent of all exchange products incorporate "managed-care-like" benefit designs, in the form of either health maintenance organizations (HMOs) or exclusive provider organizations (EPOs). New entrants offer these products more often than incumbents, with 67 percent of new entrants' plans HMOs or EPOs, compared with 57 percent of incumbents' plans (*Exhibit 9)*. Of new entrants, Medicaid entrants almost exclusively offer "managed-care-like" plans, with close to 90 percent of products structured as HMOs. CO-OPs and provider-based entrants are each offering ~50 percent HMOs or EPOs.



10 Cost-sharing subsidies offset an individual's total out-of-pocket spending incurred when using health services (outside of their monthly premiums), including co-payments, co-insurance, and deductibles.

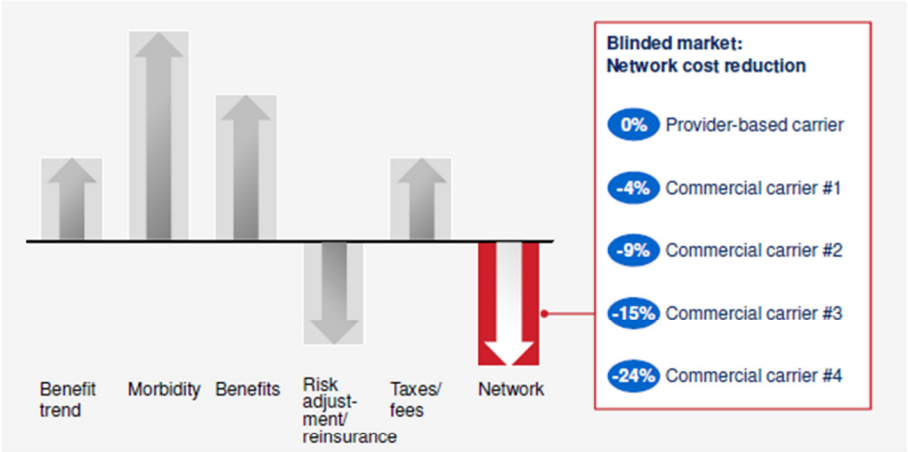
11 Individuals earning up to $28,725 a year (250 percent of the federal poverty level) are eligible for cost-sharing subsidies, but only if they buy a silver plan.

"Managed-care-like" features are widely believed to be a way to hold down costs and thus permit payors to offer lower premiums. Our analysis of exchange plan benefit designs shows some correlation with premium levels: HMO and EPO plans represent 69 percent of all lowest-price products in markets where offered. In addition, of all product offerings within each benefit design type, HMO and EPO plans have 34 percent of products priced within 10 percent of the lowest-price plan, compared with 31 percent of all PPO and POS plans. This latter trend reveals that beyond the more traditional "managed-care-like" benefit designs, even less restrictive designs are beginning to impose some restrictions as a way to keep premiums low.

Analysis of more data about the provider networks affiliated with each exchange offering and benefit design type will reveal further trends regarding how payors have utilized network design to achieve lower rates. The actuarial assumptions behind insurers' 2014 exchange filings are beginning to show the degree to which network has been used as a cost-reduction lever. For example, in one rating area, some payors optimized their networks to reduce premiums by as much as 24 percent *(Exhibit 10)*. We need to obtain a deeper understanding of the trade-offs consumers face—such as how they choose among "managed-care-like" features, network breadth, and price, and how willing they are to make trade-offs among these features.[12] Although more restrictive features appear to be a way to meet consumer demand for low price points, it is yet unclear how consumers will actually respond to these features over the long term.

EXHIBIT10

Factors affecting 2014 individual market premium development



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information

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[12] McKinsey Reform Center plans to conduct and publish an analysis of exchange network trends in November.

The early trends presented in this Intelligence Brief provide an emerging view of the competitive landscape unfolding on the public exchanges across the United States. However, these trends are directional indicators only. Given the dynamic nature of the exchanges and the data emerging from them, we need to conduct additional analysis to better understand the extent to which competitive dynamics are changing. The Reform Center is continuing to analyze all product offerings across the country to develop a comprehensive perspective on exchange dynamics; we will release additional results publicly in the form of white papers over the coming months.

— Ananya Banerjee, Erica Coe, and Jim Oatman

Appendix

Additional background on the underlying research

The analysis supporting this Intelligence Brief is informed by a new McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of what has actually been filed on the exchanges—over 21,000 qualified health plans—for plan year 2014. The Reform Center/MAHA tool can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across plan types and actuarial value tiers by consumer characteristics, predictions of market share based on filings and consumer-predicted dynamics, and more. Specific analyses are available upon request from the Reform Center/MAHA team; we look forward to helping our clients achieve success in the post-ACA market through the use of data-driven analysis on specific market trends.

Please contact reformcenter@mckinsey.com with any inquiries.

To access the Reform Center's September Intelligence Brief, "Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?," go to: www.mckinsey.com/client_service/healthcare_systems_and_services/latest_thinking

Glossary of health care terms

Consumer-operated and oriented plan (CO-OP) – a new entrant that is a recipient of federal CO-OP grant funding and is not a prior commercial carrier

EPO – an exclusive provider organization is a plan model that is similar to an HMO. It provides no coverage for any services delivered by out-of-network providers or facilities except in emergency or urgent care situations; however, it generally does not require members to use a primary care physician for in-network referrals

Existing entrant – also referred to as incumbent, an insurance carrier that offered individual insurance in the respective state's individual market for plan year 2013, based on 2012 SNL data

Gatekeeper – an approach that limits access to healthcare services in some way (e.g., by requiring referrals through a primary care provider)

HMO – a health maintenance organization is a plan model centered around a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent-care situations

Medicaid new entrant – a new entrant that offered only Medicaid insurance in the past

PMPM – per member per month

PPO – a preferred provider organization is a plan model that allows members to see doctors and get services that are not part of a network, but out-of-network services require a higher copayment

POS – a point-of-service plan is hybrid of an HMO model and a PPO model; it is an open-access plan model that assigns members a primary care physician and provides partial coverage for out-of-network services

Provider entrant – a new entrant that operates as a provider/health system today

October 2013