ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:
Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

OVERVIEW

One of the key goals of the Affordable Care Act (ACA) is to make health insurance coverage more affordable and consumer-friendly by managing competition among health insurers through the creation of health insurance exchanges. In order to accomplish this, however, exchanges will first need to be attractive enough to insurers to participate. This paper explores state actions to encourage or require participation on exchanges, and preliminary responses from health insurers in six study states (Colorado, Maryland, New York, Oregon, Rhode Island, and Virginia) that are participating in the Robert Wood Johnson Foundation's State Health Reform Assistance Network and the related reform implementation monitoring and tracking project. The authors reviewed statutes, regulations and guidance across the six states and conducted interviews with 22 informants between March and April 2013. This paper provides an overview of the informants' perspectives on the extent to which insurers will participate and actively compete on exchanges in these states.

With the study states in the midst of a multi-month process of certifying insurers and reviewing rates, we will not know the final outcomes of these deliberations until mid- to late summer. While it is early, a number of observations can be made. First, it is clear that all six states are being very accommodating to insurers in a number of areas including network adequacy and service areas. Moreover, states have not been particularly aggressive in negotiations over premiums, rather deferring to the existing rate review process and letting the market determine rates.

Second, most states expect most commercial insurers to participate in the exchange. Rhode Island is an exception; two of the three commercial plans will not participate in the individual market, though they will participate in the Small Business Health Option Programs (SHOP). Most states expect some Medicaid-only insurers to participate in exchanges. In addition, many carriers offer both commercial and Medicaid plans, and many expect that the plans these carriers offer in exchanges are likely to be closer to Medicaid products. Four of the study states expect new consumer operated and oriented plans (CO-OPs) to offer coverage in the exchange, though there is skepticism about how competitive CO-OPs will be and how much market share they will achieve. There is also uncertainty about the presence and potential importance of multistate plans in each study state.

Third, it is expected that markets will be fairly competitive. While there is caution expressed by many insurers, the strong incentives to be the second-lowest cost plan is expected to lead to reasonably priced premiums, at least after the initial transition. Commercial carriers have the strong advantages of brand recognition and broad provider networks, but in general they are more expensive because of higher provider payment rates. It is expected that they

will have negotiate lower provider payment rates or have more limited networks than their commercial offerings. Medicaid plans will have the advantage of lower payment rates, though these are likely to be negotiated upward. The overall expectation is that the competition in exchanges will lead to provider payment rates somewhere between commercial and Medicaid rates, as well as more limited networks than in similar commercial markets.

Fourth, there is a great deal of uncertainty about how to set premiums. In part this reflects the many new requirements that carriers face, including the essential health benefits, actuarial value tiers, guaranteed issue, and rating rules, as well uncertainty about the health status of enrollees. Some plans will focus on avoiding losses, others will bid aggressively in order to gain market share. The expectation is that plans need to better understand the health characteristics of enrollees, as well as the effectiveness of risk corridors and risk adjustment mechanisms. Once they are assured, pricing is likely to become more aggressive.

Most states examined in this study are likely to have competitive exchange markets. This is seen in the initial premiums that we report for three of our states. Strong competition and reasonably priced plans are likely to be replicated in many states throughout the country. But there are also states where there is one dominant plan and little competition is expected. For the most part, the findings in this paper would not apply to these states. Our central conclusion is that there will be robust competition in many states and this will lead to reasonably priced premiums, with lower premiums for unsubsidized enrollees and lower subsidy costs to the federal government.

BACKGROUND

Much of the design of the Affordable Care Act has its roots in the theory of managed competition. Under the health reform law, health insurance exchanges will be established in every state to provide multiple coverage options to individuals and small groups through one organizing entity that sets uniform rules for participating health insurers and plans. The ACA also provides protections to insurers against adverse selection through three premium stabilization programs: risk adjustment, reinsurance and risk corridors.

The law does not, however, require health insurers to participate in exchanges, rather relying on market incentives. Most notably, the ACA limits the availability of premium tax credits (both for individuals and, beginning in 2014, small businesses) and individual cost-sharing subsidies to health plans purchased through exchanges.[1] Moreover, it ties the premium tax credits to the cost of the second-lowest cost silver plan offered in exchanges.[2] Assuming that individuals are price-conscious and seek to avoid having to pay additional amounts above the caps, insurers will presumably be encouraged to develop exchange products so they can compete to be the second-lowest cost plan offered in the market.

The law also allows states and the federal government to take additional steps to encourage or require insurer participation. In the federally facilitated exchanges, the Centers for Medicare & Medicaid Services (CMS) is using this authority to promote participation in FF-SHOP (federally facilitated Small Business Health Option Programs) exchanges. Recognizing that with the availability of tax credits, the individual exchange may be more attractive to insurers than the SHOP exchange, CMS will require insurers that have a greater than 20 percent share of the small group market in a state (or are members of an insurer group that has at least one member with greater than 20 percent market share) to participate in the FF-SHOP if they want to offer coverage in that state's individual exchange.[3] At their discretion, states may adopt similar requirements or other mechanisms to ensure a meaningful number of insurers participate and actively compete in their exchanges.

States are in the midst of plan certification. The exchange plan certification process involves multiple steps that take place over several months. For federally facilitated exchanges, the federal government established a timeline that required insurers to submit exchange plan applications between April 1 and May 3, 2013.[4] CMS will conduct a preliminary review of applications and report any deficiencies to insurers through the middle of June; insurers will subsequently have a brief window to make any revisions and resubmit their applications. CMS will review revised applications through the summer, with the goal of notifying all insurers of final certification decisions by September 4 and signing agreements with them over the following week.[5]

The federal government laid out a similar timeline for state partnership exchanges. Beginning around April 1, 2013, plan management partner states began accepting

health plan applications from insurers. These states will have until July 31 to complete their reviews and notify the federal government of their certification recommendations. CMS will then review state certification recommendations during August and follow the same timeline as the federally facilitated exchange for remaining activities.[6] In alignment with the federally facilitated exchange timeline after deadline extensions on both sides, the Bureau of Insurance in Virginia will require insurers to submit their filings by May 3 in order to be approved by the July deadline.[7]

Study states operating state-based exchanges generally began the certification process earlier than the federal government, in most cases in the winter of 2012–2013. Many of these states first required insurers to submit a non-binding notice of their intent to participate or, as in Colorado,[8] conducted "intent" discussions with carriers. Study states also typically set staggered deadlines for document submission over the course of the spring. New York, for instance, required insurers to submit their letter of interest by February 15, a participation proposal by April 15, rates and subscriber form on the same date (with extensions available until April 30th upon request), provider networks by April 30, and other plan management–related filings by May 15.[9] State-based exchange study states generally plan to complete their review and make final certification decisions by the end of July. Once rates were filed, four study states—Colorado, Maryland, Oregon, and Rhode Island—announced preliminary lists of insurers planning to participate in their exchange. Final agreements will generally not be signed until mid- to late summer; however, Maryland now has signed agreements for all its authorized carriers. New York indicated that it will not make anything public until the insurers have been certified by the Department of Health, the agency responsible for the exchange, which is scheduled to occur around July 15.

STATE ACTIONS TO ENCOURAGE PLAN PARTICIPATION

Some states are creating incentives for insurers to participate in exchanges. All four study states that are operating their own exchanges have adopted mechanisms to require or encourage participation in both their individual and SHOP markets. Maryland, for example, will require insurers to participate in the individual exchange if they meet an aggregate revenue threshold.[10] State informants indicated these requirements would likely impact five insurers in the state and would help ensure that the exchange would have statewide coverage. In addition, three study states—Colorado,[11] New York,[12] and Oregon[13]—have indicated that they intend to institute waiting periods for insurers that choose not to participate in the exchange in 2014. In Colorado's case, there is also a waiting period if insurers participate in the exchange and later voluntarily leave. Oregon has indicated that its prohibition includes restricting carriers who enter in only one market (either the individual or SHOP exchange) to only offer in that market until 2016.[14]

States are accommodating insurers on certain exchange standards. State officials consistently noted an effort to avoid design features that insurers could perceive as causing market disruption or limiting competition, especially during the first years of implementation. One state official in New York pointed out that the state needed to balance the concern of ensuring enough participation for insurers with other competing policy objectives during the development of exchange standards. An exchange official in Colorado similarly noted that up-front requirements beyond the federal baseline could be harmful; "It's already a big leap from where carriers are at." In particular, informants indicated that the study states are leaving considerable flexibility to insurers on a number of standards that are likely to have a significant impact on the decision to participate in the exchanges, including service area requirements, network adequacy standards, and limitations on the number and design of qualified health plans (QHPs). Exchanges are also largely deferring to the existing state rate review process rather than setting additional standards in this area.

With regard to service area requirements, the study states are generally providing insurers with significant flexibility to decide where, within the state, they will offer coverage. The federal minimum standard requires that a QHP's service area cover at least the geographic area of a county unless a smaller area is approved by the exchange as necessary, nondiscriminatory and in the best interest of consumers. Federal rules also require that service areas be established without regard to racial, ethnic, language or health-status-related factors, or other factors that exclude high-utilizing, high-cost or medically underserved populations.[15] The study states

are either adopting the federal standard, like Colorado, or implementing requirements that do not add significantly more protections than the federal minimum standard, at least for new entrants. For example, in Maryland, the service area of an existing insurer offering through the exchange must be consistent with its service area outside the exchange. A new insurer, like a CO-OP, may self-define its service area, as long as it covers at least an entire county and is established in a nondiscriminatory manner. Except for Rhode Island, no other study state is requiring an insurer to maintain a service area that covers the entire state or an entire rating region.

Given this approach, informants generally felt that service areas would resemble what they look like today. While insurance departments may look closely at insurers that are decreasing their service areas, they do not expect insurers to expand their service areas. In Oregon, for instance, officials reported that only one insurer has said it wants to expand from its current service area, with the goal of contracting with tribal communities. This means that some areas of a state may continue to be underserved, with only one or two, if any, insurers available on the exchange.

Study states have also shown a willingness to provide QHP issuers with flexibility in establishing their networks. The federal minimum standard for network adequacy requires QHPs to maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. In addition, essential community providers—providers that predominantly serve low-income, medically underserved individuals—must be covered at a level sufficient to ensure reasonable and timely access to these providers. Similar to service area rules, the study states either implemented the federal minimal standard, like Oregon, or adopted an existing state standard rather than setting new, more expansive standards. For example, New York applied its existing health maintenance organization (HMO) network adequacy standard to all QHPs (outside the exchange, it will continue to apply only to HMOs). However, according to informants, insurers can generally meet this standard by including one hospital (except in New York City and Long Island) and two providers of each specialty type in their network in each county.

Although the ACA does not place any limits on the number of plans that an insurer offers through exchange, it does require QHPs to comply with specific benefit designs standards, including coverage of "essential health benefits," cost-sharing limits, and standardized levels of coverage, often referred to as "precious metal tiers," of which the silver and gold levels of coverage are required to be offered by all exchange insurers. Although permissible under federal law, half the study states—Colorado, Rhode Island and Virginia—are not imposing any standards that would limit the number of plans that insurers offer on the exchange or require insurers to offer standardized benefit designs or market plans at every metal tier. Maryland is requiring insurers to offer plans at the bronze, silver and gold metal tiers but limiting the total number of plans to four per metal tier per licensed entity. However, because a single insurer may hold multiple licenses, a significant number of plans could still be available in the exchange overall. In New York and Oregon, insurers will need to offer a range of standardized plans but will also be able to offer a limited number of non-standardized plans: in New York, insurers are required to offer one standard plan at each metal tier but are still permitted to offer a maximum of three nonstandard plans at each level; in Oregon, insurers are limited to three plans per metal tier other than platinum—one standard plan and two nonstandard plans—with the option of offering two additional "innovative" plans per tier in each service area.

Such rules may impact how the number and diversity of plans on the exchange compares to the number and diversity of plans currently available. In New York, for example, an informant reported that the small group market today has approximately 15,000 plans (products), so the exchange will present a significant reduction in the number and differentiation of choices. On the other hand, New York has a very small individual market, so the exchange may provide more options than is currently available.

Finally, the exchanges in the study states will also largely defer to their existing state rate review processes rather than add another layer of review or negotiation by the exchange, although informants in Rhode Island reported that exchange representatives would take part in the insurance department's review. Informants generally indicated that state rate review processes are sufficient, noting that state regulators are under pressure to keep rates low. In addition, some informants expressed concern that a rate negotiation or competitive bidding process by the exchange would lead to higher rates outside the exchange, while they would prefer to see a level playing field.

INSURER PARTICIPATION

Many insurers are expected to participate on the exchanges. As noted above, states are in the midst of the plan certification process and final agreements will generally not be signed until mid- to late summer. However, informants in all the study states except Rhode Island reported that they expect a robust number of insurers to participate in the exchange, including existing commercial carriers and, in some states, new entrants to the commercial market such as new nonprofit CO-OPs and Medicaid MCOs. In addition, some state officials noted that they are expecting a Multi-State Plan (MSP), under contract with the Office of Personnel Management (OPM), to join the exchange.

Table 1: Expected Number and Type Of Health Insurers to Participate In Exchanges, as of June 2013

State	Total[a] # of Insurers (I), (S)	Prior "Pure" Medicaid Plan	CO-OP
Colorado[16]	10 (I), 6 (S)	1	1
Maryland[17]	6 (I), 6 (S)	0	1
Oregon[18]	11 (I), 9 (S)	2	2
Rhode Island[17]	2 (I), 3 (S)	1	0
Virginia[17]	9 (I), 6 (S)	0	0

a: Prior "Pure" Medicaid Plans and CO-OPs are a subset of the Total # of Insurers listed.

Commercial insurers. Respondents in the study states suggested that most commercial insurers, though not all, are indicating they are likely to participate. In New York, all the major commercial carriers have shown an interest in participating. These include Anthem/Empire, Excellus/Lifetime and Health Now. All of these are Blue Cross entities that operate in different parts of the state. Emblem, Aetna and United are also major players that are expected to participate, along with some new entrants.

As noted above, Maryland is requiring that insurers above a certain size in both individual and small group market participate in the Maryland Health Connection.[19] These plans are Aetna, CareFirst, Coventry, Kaiser and United Healthcare. CareFirst is the major insurer in the state in both individual and small group markets with 70 and 72 percent of the market, respectively; thus, it would have been difficult for CareFirst not to participate, even without the requirement. As noted above, the state assured that it would have competition in virtually all parts of the state by its participation requirement.

Colorado is expecting Anthem, Cigna, Humana, Kaiser and Rocky Mountain to participate together with some smaller insurers in the individual market, including a few new entrants. The state is expecting six insurers in the SHOP exchange. Kaiser and Anthem will be the main competitors in the Denver market. Rocky Mountain and Anthem will compete in western Colorado.

Oregon has received letters of interest from a large number of insurers, including most major insurers participating in the state. The Regence Blue Cross plan is the largest plan in the state but will not be participating. Rather, Bridgespan—a subsidiary of Regence—will be the plan offered in the exchange. The other major insurers participating in the exchange are Health Net, Kaiser, Moda Health, Pacific Source and Providence. All but Health Net will participate in the small group market as well as the individual market. Plans such as Providence and Bridgespan will be statewide while others will be in specific markets, predominantly Portland.

Virginia will have four of its major players participate. Anthem is the dominant carrier throughout the state; it has a large share of the individual markets—74.5 percent—and respondents indicated the company cannot afford to risk its market share by not participating. The national Anthem system's recent purchase of Amerigroup was done with the intent of having more capacity to deal with Medicaid, but it also gives Anthem a broader network of lower-cost providers to compete for exchange business. Anthem also has a Health Keepers product that it uses in the Medicaid market and will be using in the exchange market. CareFirst is also a dominant player in its part of the Northern Virginia market (Anthem and CareFirst do not compete in the same parts of the Northern Virginia market). In Northern Virginia, Aetna and the Inova hospital system have partnered to create Innovation Health Plan, which has filed to participate on the exchange. Informants reported that Aetna will be an important competitor in the most populated parts of the state, as will Kaiser in Northern Virginia.

Unlike in other states, only two insurers will be participating in the individual exchange in Rhode Island. Blue Cross, which is the dominant carrier serving the individual market today, will participate in the exchange. According to informants, it essentially has little choice. Tufts and United have decided not to participate in the individual exchange but will participate in the SHOP exchange. The Neighborhood Health Plan, a Medicaid plan, will provide some competition to Blue Cross.

Medicaid managed care plans. All states expect some Medicaid-only plans to compete in exchanges, and many expect them to be formidable competitors in the individual market. In addition, many insurers that offer both commercial and Medicaid plans are expected to offer something like their Medicaid product in the exchanges in most study states. Frequently, but not always, informants reported that Medicaid insurers are primarily interested in entering exchanges to maintain customers who switch back and forth between the commercial market and Medicaid, an occurrence known as "churning."

New York has a large number of prepaid health services plans (PHSP) that are Medicaid plans; plan representatives indicated that several PHSPs have an interest in coming into the individual exchange, including Fidelis, Healthfirst and MetroPlus. Doing so presents new challenges such as understanding risk, marketing, and developing capacity to serve more patients. Informants expected that Fidelis will be a strong competitor operating nearly statewide. The other PHSPs are expected to be strong competitors in New York City, though probably not dominant.

New York established provisions that eased the way for PHSPs to participate in the state exchange. First, they do not need a separate license to participate, though they have the same reserve requirements as commercial insurers. Second, the state also required that if participating commercial plans offer a product with out-of-network coverage outside the exchange, they must provide the same product inside the exchange. While out-of-network coverage expands access, it also increases costs. Because the PHSPs do not have an out-of-network option, this increases their chance to offer competitive premiums. Given that PHSPs have fairly broad networks, they seem able to offer attractive products at lower cost.

Medicaid-only plans are not participating in the exchange in Maryland. But two insurers that participate in both the Medicaid and commercial markets—Coventry and United—will be participating in the exchange. Informants reported that the two carriers will most likely offer some plans that more closely resemble their Medicaid products than their existing commercial products on the exchange.

Oregon expects to see several Medicaid plans participate in the exchange, including two community care organizations (CCOs). These plans are PacificSource Health Plans and Trillium Community Health Plan. All are local plans, serving particular regions in the state. To facilitate Medicaid insurers' exchange participation, officials in Oregon reported streamlining the process to transfer a Medicaid license to a commercial license.

In Colorado, informants reported that given the state's move to enroll Medicaid beneficiaries to regional community plans, there is little Medicaid managed care capacity remaining in the state. Without a Medicaid managed care plan presence in the Colorado, commercial insurers are not faced with significant competition from Medicaid plans, as in some other study states.

In Virginia, a major Medicaid plan—Virginia Premier—will not be offered in the exchange, but several commercial insurers offer Medicaid plans that may be made available. Virginia has not yet decided if the Medicaid expansion will be implemented; a decision to go forward could affect insurer decisions about products. Anthem will offer its Medicaid plan, Health Keepers, in the exchange throughout most of the state. In Northern Virginia, INTotal Health is an Inova-owned Medicaid MCO formerly known as Amerigroup Virginia. Inova is positioned to offer both commercial and Medicaid products through separate licenses—commercial through Innovation Health Plan (Aetna) and Medicaid through INTotal Health. In addition, Aetna has an arrangement with the Carillion hospital system in the Roanoke area and may offer this product on the exchange. Optima is a Medicaid plan connected to the Sentara hospital system that operates largely in the Tidewater area but is growing elsewhere in the state; it will participate in the exchange.

In Rhode Island, the Neighborhood Health Plan is planning to participate in the individual exchange. In addition to enrolling customers that churn between Medicaid and commercial coverage, informants reported that Neighborhood may be attractive to broader populations because of pricing advantages relative to Blue Cross, due to lower provider payment rates. Blue Cross's current high-cost population could keep premiums high, particularly if insurers do not believe risk adjustment will fully compensate.

In each state, informants reported little interest in the Medicaid entrants becoming bridge plans—plans designed to serve only those who transition in and out of Medicaid because of income fluctuations. As one respondent noted, entrants would have to get certified, develop networks, and meet all state requirements, but still be limited to a small market; "If they have to get through all the hoops to enter, they should just get in there and compete."

CO-OPs. Four study states—Colorado, Maryland, New York and Oregon—are expecting new CO-OPs to offer coverage on the exchanges. Informants in Colorado and Oregon reported that state officials were working closely with their CO-OPs to ensure that these new entrants have everything in place, including the IT infrastructure, to offer coverage on the exchanges. Maryland chose to exempt CO-OPs from the state premium tax (which will also be used to fund the exchange in lieu of a QHP user fee) for five years. CO-OPs need to rent networks, but on what terms they can rent these networks and how broad the networks are will be a major determinant of their success. For example, in Oregon, the Health Republic Insurance Company (formerly Freelancers CO-OP) will rent the Providence's Health Services Network. Informants also expressed interest in how CO-OPs would balance competing pressures to set rates that allow them to maintain long-term solvency while also competing for market share.

Multi-State Plans. State officials in the study states are still waiting for more information from OPM with regard to Multi-State Plans. In general, state officials seem resigned to the fact that the MSP will not necessarily mean more competition, since the MSPs are expected to be national insurers that already have a presence in the states. Informants reported that they have hard time envisioning how, for example, a national Blue Cross Blue Shield plan could come into a state without essentially replicating the Blue Cross Blue Shield products within the state, assuming the MSP would have to use the Blue Cross network and provider payment rates.

EXCHANGE MARKETS LOOK TO BE FAIRLY COMPETITIVE

Most state respondents indicate that they expect the markets to be fairly competitive, which should lead to reasonably well-priced premiums, at least after the first year when much of the uncertainty has subsided. A major determinant of how insurer competition will affect premiums is the ability of insurers to negotiate with providers and their ability to create narrower networks that both meet network adequacy standards and at the same time allow them to offer an attractive product in the market.

As noted, several commercial insurers will participate in New York. Respondents believed that commercial plans will have serious competition from the larger PHSPs that will enter into the exchange market as well as possibly from the Health Republic Insurance Company (formerly Freelancers CO-OP). Some expect the Fidelis PHSP to be a significant force upstate. The PHSPs will also be strong in New York City; while they will not be dominant, they could force enough competition to bring down premiums by commercial players. Because they are Medicaid plans, they have lower provider payment rates and somewhat more limited networks than commercial plans. Informants were unsure how much they will have to expand their provider networks, if at all, to offer competitive plans in the exchange. In addition, while some informants thought that PHSPs will be able to take advantage of their Medicaid rates, others felt that providers may regard the rates that they currently give to PHSPs as being limited to government programs and that PHSPs will have to pay providers more for the commercial products they offer on the exchange.

Commercial plans are expected to face problems negotiating lower payment rates with providers to allow them to be competitive on the exchange. In upstate New York, consolidated hospital systems have considerable leverage over insurers. Downstate, insurers are large and are more likely to successfully negotiate with providers to give them lower rates for exchange products. Naturally, hospitals are pushing back. Respondents indicate that commercial insurers are concerned that PHSPs will negotiate rates with providers that are higher than Medicaid but still lower than what the commercial insurers can negotiate themselves, thus placing the commercial insurers at the disadvantage. But while Medicaid insurers are likely to have a pricing advantage, they do not have the brand recognition of large commercial insurers like Empire and United and will probably not be attractive to higher income people who will seek coverage through exchanges.

In New York, the upstate and downstate markets are very different. Downstate, the combination of strong commercial carries and several PHSPs, together with many different competing hospital systems, creates an environment for more aggressive negotiations over rates. These conditions generally do not exist upstate. Despite the fact that New York City is a far more expensive labor market, premiums may not end up being much different between upstate and downstate.

Informants indicated that it is somewhat hard to tell how competitive the Maryland market will be. CareFirst is a major player currently in the individual and small group markets, but if Coventry and United offer Medicaid-like products in the exchange, they may be competitive. How the CO-OP, as well as the possible MSP, will affect the competition is uncertain. Provider contracting in Maryland is a somewhat different issue than elsewhere because of the state's all-payer rate-setting system for hospitals under which rates for specific hospitals are set by the state and all insurers must reimburse hospitals at these predetermined rates. However, there is nothing limiting insurers from developing networks that include less expensive hospitals. In addition, it is expected that the larger insurers, such as CareFirst, can negotiate more aggressively with physicians on exchange products than others, giving them a pricing advantage.

Oregon seems to be a highly competitive market with the broad participation of many major insurers in the state, with the notable exception of Regence. Respondents believe the Portland area in particular will have considerable competition. The participation of Medicaid insurers and Bridgespan—which intends to offer plans with a small, low-cost network—could force considerable price competition in other Oregon markets. Specifically, informants reported an expectation that the larger insurers will develop narrower networks to keep their costs down, noting that narrow networks mean not only lower provider payment rates, but also creating a product that could be less attractive to a less healthy population. This is a way of achieving risk selection; how much risk corridors and risk adjustments will counteract this is unknown.

Colorado is also likely to be fairly competitive, with a large number of insurers participating, particularly in the Denver market. It is expected that insurers will offer more limited networks and may have lower provider payment rates than in their existing commercial products. It is not that insurers will negotiate better rates with particular providers, but, by establishing more limited networks of lower-paid providers, they will achieve the objective of lower priced products.

In Virginia, there are many strong insurers, many of which have arrangements with hospitals systems—Optima and Sentara, Aetna and Carillion, Aetna and Inova—which provide the potential to negotiate rates to develop lower-priced products for exchange competition. Anthem's market power allows it to negotiate effectively. Kaiser is already an integrated network but suffers from its inability to negotiate with Inova and DC-area hospitals. All the insurers other than Anthem face the difficulty in maintaining large networks while paying less than commercial rates. Many believe that exchange networks are more likely to look like narrower Medicaid networks than traditional commercial networks but with higher provider payment rates.

Aetna has also purchased Coventry and could be competitive in areas where Coventry had a major presence, particularly Richmond and Roanoke. In the Richmond area, Anthem is a fairly dominant carrier, though it is recently getting competition from an alliance between Optima and Sentara. In the Tidewater area, Anthem is also widely considered the strongest player, but the Optima-Sentara alliance could offer a lower-cost exchange product and provide fairly strong competition. In the Roanoke area, the Aetna-Carillion system alliance could also participate in the exchange. How well it can compete against Anthem is unknown. Little competition is expected in rural parts of the state where Anthem is by far the strongest competitor.

In Rhode Island, the strength of competition is uncertain. Blue Cross could face serious competition from the Neighborhood Health Plan. Blue Cross has a large number of high-risk enrollees from years of being the insurer of last resort and has high provider payment rates. The Neighborhood Health Plan may benefit from lower provider payment rates and fewer existing high-risk enrollees. Again, the risk adjustment system may be sufficiently effective in spreading risk.

In Rhode Island provider contracting is a major issue. There are two strong hospital systems that offer different product lines (a general hospital and the others providing maternal and child health services). None of the Rhode Island insurance plans have much success in negotiating with these two dominant hospital systems. Because of the effect this has on premium increases, the insurance commissioner reviews insurer-provider contracts as a part of the state rate review process. Blue Cross pays more because it is expected that they pay enough to cover hospital losses as a fiduciary responsibility. Blue Cross is attempting to negotiate better rates with hospitals for its exchange products, as are Tufts and United,

though it is not clear whether they are being successful. The Neighborhood Health Plan historically has been a Medicaid plan and has paid lower rates. It will most likely have to develop different contracts with providers to get them to participate in Neighborhood's exchange product.

PRICING STRATEGIES COULD VARY SIGNIFICANTLY IN THE FIRST YEAR

How insurers will price their plans is a subject of great uncertainty. Concerns about massive increases in rates have proliferated. Clearly, some insurers will price high to avoid adverse selection, but they then could end up with very few takers. Others may price low to gain market share. Narrower network plans should be able to price low relative to other insurers.

In several states, insurers seem to be legitimately conflicted. They face a lot of new requirements—such as essential health benefits, actuarial value tiers, guaranteed issue, and rating rules—along with uncertainty about the composition of the enrollee population, making pricing very confusing. Insurers also vary considerably in the amount of confidence they have in the risk corridor and risk adjustment systems, which are intended to protect them against serious losses. While insurers in general tend to be worried about pricing correctly to avoid losing money, they recognize that it could be hard to compete with Medicaid or commercial insurers offering essentially a Medicaid product. The commercial insurers have brand recognition and a lot of experience with marketing commercial products that Medicaid insurers do not have, but it will still be difficult to compete if their prices are too high.

Many Blue plans face the problem of having a large number of high-risk individuals now, being the insurer of last resort in some states. Informants speculated that they are likely to retain most of these high risks. In states without significant market competition, like Rhode Island, the Blues will likely have higher premiums, all else being equal. In other states, the Blues will have to price more aggressively or lose a lot of their current market share.

There is a general consensus that the first year will be somewhat chaotic. There is fear about adverse selection in the first year, though most believe that eventually there will be a good mix of risks. Many think that some insurers will price relatively high to have a presence in the market but not necessarily build up market share, while pricing more aggressively in the second year as they gain more familiarity with the market. In Oregon, on the other hand, informants reported that most insurers will be pricing to get market share, trusting that the risk corridor and risk adjustment programs will prevent large losses.

Some state regulators will play a role (New York and Rhode Island) in moderating premiums if they regard them as too high. New York officials expressed concern that insurers will price too high, given their current experience with the individual market, and indicated that they will put pressure on insurers through the state rate review process. Rhode Island officials also expressed the belief that Blue Cross could price high given that it expects to retain many of the bad risks it currently covers, and the state indicated that they may lower premiums to make the marketplace more competitive.

Being the second-lowest cost plan is not a primary goal in year one. Much of the design of exchanges has its roots in the theory of managed competition. Premium tax credits are tied to the cost of the second-lowest cost silver plan in each area. Individuals enrolling in a more expensive plan would face all the additional cost at the margin. Thus, there should be considerable competition to be the second-lowest cost plan, because individuals wishing to pay no more than the statutory percentage of income would gravitate toward this plan or a lower-cost alternative.

Despite these incentives, state officials and insurers reported a lack of focus on being the second-lowest cost plan. Some believe that consumers would self-select based on a number of factors, with price an important but not the only consideration. For example, Rhode Island respondents indicated that in the current market, individuals often choose plans that have higher premiums than other choices because they have lower deductibles and less cost-sharing. Thus, insurers wanted to develop products that can be competitive but at the same time cover their costs. Whether or not they are the second-lowest cost plan, they cannot afford to lose money. In particular, informants stressed that the major for-profit plans have limited tolerance for losses and are more risk adverse, while some nonprofit plans could probably absorb more risks, at least in the short term. PHSPs and other Medicaid plans may get better rates from providers,

but they have fewer reserves and, thus, they also cannot afford losses, even in the short term.

There is also considerable concern over risk. If plans price aggressively to be the second-lowest cost plan, they can end up with a lot of bad risks. While risk corridors and risk adjustments could deal with this issue, there is considerable uncertainty about how well this would work. There is also concern about how many people would enroll in exchange coverage given that insurance may still be unaffordable even with premium assistance, particularly for individuals and families earning between 250 and 400 percent of the federal poverty level who qualify for less generous tax credits. With low enrollment, the average enrollee is likely to be sicker and more costly than the population as a whole. To the extent there are concerns about adverse selection and the effectiveness of the risk corridor and risk adjustment systems, insurers will be naturally skittish.

Informants repeatedly said that the premiums in the first year will not be the premiums expected on an ongoing basis, describing the exchanges as a new world. Being the second-lowest cost plan in the subsidized market is not anything that insurers have any experience with, and they may adjust their tactics when they become more familiar with the market and see how other insurers set premiums.

PREMIUM RATE FILINGS INDICATE VARIANCE BETWEEN PLANS IN THE INDIVIDUAL EXCHANGE

At the time of writing, three study states—Colorado, Oregon and Rhode Island—had publicly released premium rate filings for carriers participating on and off the exchange. These rates must still undergo analysis and approval by each state's insurance department and, thus, cannot be considered final. Furthermore, for a variety of reasons, rate information was not available for every plan in the three states that had released this data. Despite these limitations, the rate filings represent an early opportunity to view how insurers decided to price their plans, potentially illuminating some of the strategies discussed above.

For Colorado and Oregon, the premium rates in Table 2 represent the monthly individual premium for a silver plan for a 40-year-old nonsmoker residing in the state's capital. For insurers who do not offer products in the state's capital, another county has been selected and is noted in the table. In Oregon, these sample rates are for the standard silver plan have been calculated and are summarized on the state's Rate Review website. Sample rates for non-standard plans in Oregon were not available at the time of writing.[20] In Colorado, the rates were calculated using formulas provided by each insurer in the rate filings. Insurers are not required to offer a standard plan in Colorado; the rates listed here represent the most inexpensive and most expensive silver plan.[21] In Rhode Island, the rates cited represent a base rate—in this case, the price for the standard plan for a 21-year old for a given insurer in a given market. These rates were obtained from Rhode Island's Rate Review website.[22] In all three states, the figures listed are the prices before a premium tax credit has been applied. Actual costs for consumers who qualify for premium assistance would be lower, all other location, age and smoking-status factors held constant.

Because different types of data were available for each state, "apples to apples" comparisons cannot be made across states with the information provided below. In Colorado, especially, where the rates below do not correspond to a standard plan, there is likely some degree of variation in benefits which may drive some of the difference in price.

Based on this initial sampling of rates, some surprising patterns have emerged. Most rates seem fairly reasonable, especially in Oregon. Rhode Island's seem somewhat higher, reflecting the limited competition and difficulty plans have in negotiating with providers.

It is interesting to note that, within the samples reviewed, Medicaid plans have not provided the lowest cost offerings of these states. CO-OP plans have relatively low rates, in the states where this information was available, but in no state was it the lowest rate. Additionally, Blue Cross/Blue Shield products are not the highest priced in any state; in fact, they are the currently the lowest priced product in Rhode Island.

Within the states, presented rates vary significantly. For example, in Oregon, the price difference between the

Table 2: Sample Premium Rates for QHPs in Three States, as of May 30, 2013

State	Plan Name	Premium Rate ($)
Colorado[a] (Rates for highest and lowest cost silver plans; 40-year-old nonsmoker in Denver MSA)	All Savers Insurance Company (United)[b]	412-425
	Cigna Health & Life Insurance Company	318-357
	Colorado Choice Health Plans	288-300
	Colorado Health Insurance Cooperative	394-453
	HMO Colorado Inc. (Anthem)	320-355
	Humana Health Plan Inc.	412-418
	Kaiser Foundation Health Plan of Colorado	245-261
	New Health Ventures Inc.	454
	Rocky Mountain HMO	311-383
Oregon (Rates for 40-year-old nonsmoker in Multnomah County)	ATRIO Health Plans[c]	371
	BridgeSpan Health Company	288
	Health Net Health Plan of Oregon	221
	Health Republic Insurance Company	299
	Kaiser Foundation Health Plan of the Northwest	291
	LifeWise Health Plan of Oregon	252
	Moda Health Plan Inc.[d]	225
	Oregon's Health Co-Op	278
	PacificSource Health Plans	257
	Providence Health Plan[e]	342
	Trillium Community Health Plans, Inc.	486
Rhode Island (Rates for 21-year-old, EHB base rate)	Blue Cross Blue Shield of Rhode Island	331
	Neighborhood Health Plan of Rhode Island	345

a In Colorado, Denver Health Medical Plan will offer products on the state-based exchange, although sample premium rate information was not available for them at the time of writing.

b All Savers will not offer a product in Denver County; the rates cited are for Pueblo County.

c ATRIO will not offer a product in Multnomah County; the rates cited are for Polk County.

d Moda Health was formerly known as ODS Health.

e The rates for Providence represent original rate submissions; this insurer proposed new rates at a later date

lowest cost sample plan and the highest cost sample plan exceeds $250 per month for an individual. In a sense, insurers were "blindly" submitting rates, since other insurers' rates remained private until the final deadline had passed. After the rates became publicly available and insurers noted the amount of variation, Providence Health Plan proposed lower premiums than their original submissions.[23] FamilyCare Health Plans, a Portland-based nonprofit, reversed their decision to offer products on the individual exchange when the Oregon Insurance Division cut their proposed rates by nearly half.[24]

Although some insurers' rates were not publicly available for this initial analysis, it is clear that there will be significant variation in premium rates for QHPs in exchanges. What is less clear, perhaps, is whether and how much they will change when there is an opportunity to re-bid.

CONCLUSIONS

While it is still early in the process, a number of observations can be made. The study states have clearly made strong efforts to encourage insurers to participate in exchanges and develop competitive markets. They have been accommodating on the numbers of plans insurers can offer, service areas, and network adequacy rules. Most states have not been aggressive in negotiations over premiums. Most states expect all or most commercial insurers to participate in the exchange. An exception is Rhode Island where two of the three major commercial plans will not participate in the individual market though they will participate in the SHOP.

Four of the six states expect some Medicaid-only insurers to compete in exchanges. In addition, many carriers offer both commercial and Medicaid plans and may offer something closer to their Medicaid product in the study states. Competition from Medicaid-only plans is likely to be particularly strong in New York and Rhode Island; in other states, the Medicaid products of commercial plans are likely to strongly influence competition in the market. Four of the study states—Colorado, Maryland, New York, and Oregon are expecting new CO-OPs to offer coverage in the exchange. There is uncertainty as to how competitive CO-OPs will be and what market share they will achieve; much depends on their ability to establish broad networks at low cost. Finally, all states expect that there may be one or more multistate plans operating in their states.

Because of the significant participation of insurers, most state respondents expect markets to be fairly competitive. In general, the structure of the exchange market with built-in pressure to be the second-lowest cost plan is expected to lead to reasonably well priced premiums, at least by the second or third year. Commercial carriers have the advantages of brand names and broad provider networks but are more expensive because of higher provider rates. There is considerable belief that they will either negotiate better rates or have more limited networks than their commercial offerings. Medicaid plans participating in the exchanges will have the advantage of low provider payment rates, but these are likely to be negotiated upward as providers resist accepting lower Medicaid rates for a commercial product. Thus, competition in the market seems likely to lead to provider payment rates somewhere between commercial and Medicaid rates, as well as more limited networks than seen in the commercial marketplace.

The pricing of plans is a matter of great uncertainty. Carriers face many new requirements, including essential health benefits, actuarial value tiers, guaranteed issue, and rating rules, as well as uncertainty about characteristics of enrollees. Many plans indicate that they will set premiums cautiously to avoid losses. Those who price too cautiously could achieve protection against the costs associated with bad risks but have few enrollees. Others recognize the need to price more aggressively in order to gain market share. Most believe that the first year will be somewhat chaotic. When there is a better understanding of the health characteristics of enrollees and the ability of risk corridors and risk adjustment to protect plans against risk, pricing will become substantially more aggressive.

The evidence on rates from three of our states supports the information we collected from respondents. The premium filings indicate surprisingly low premiums from several carriers in all three states. The variation in rates indicates that some insurers have been cautious, others more aggressive. Respondents generally believed that there will be much less uncertainty as time goes on and that market competition will increase after the first year.

We caution that the states in our study may not be representative of the nation. While many other states are likely to create competitive markets similar to the states we studied, e.g., California has recently released

information that they will contract with 13 plans and that their premiums were surprisingly low.[25] But there are many other states in the nation where there is a dominant Blue Cross plan and little competition expected from new entrants or Medicaid plans. Thus, the findings in this paper would not apply. Based on our discussions with individuals in the six states, we believe that exchanges in many states will have robust competition that will lead to reasonably priced premiums with benefits that will accrue to both beneficiaries and the federal government.

About the Authors and Acknowledgements

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The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

ENDNOTES

1. ACA § § 1401, 1402. and 1421.
2. ACA § 1401(a) adding new § 36B(b)(3)(B) to the Internal Revenue Code.
3. 45 C.F.R. § 156.200(g).
4. Initially, applications were due by April 30, 2013, but HHS provided a brief extension in light of technical problems.
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10. MD Code, Insurance, § 15-1303(b) and MD Code, Insurance, § 15-1204.1. An exception to this rule is provided if the only individual plan that insurer offers in the state is a student health plan.
11. 2012 Annual Report to the Colorado General Assembly and Governor, p. 7. January 15, 2013.
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13. Cover Oregon, Request for Application, Qualified Health Plans. Revised Nov. 30, 2012.
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19. This minimum threshold is $20 million in annual premium revenues for the small group market and $10 million in the individual market. See http://marylandhbe.com/wp-content/uploads/2012/10/Maryland_Health_Benefit_Exchange_Act_of_2012_Senate_Bill_238_House_Bill_443.pdf.
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