

ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:

Plan Participation in Health Insurance Exchanges: Implications for Competition and Choice

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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.

INTRODUCTION

Health insurance exchanges are intended to play many roles in health reform. One key role is increasing the amount of competition in the nongroup and small-group markets and thus increase consumer choices and reduce premiums. This brief focuses on how competition among insurance plans is likely to play out in 10 states: Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia. How the competition evolves will affect premiums and government subsidy costs. As we discuss, much depends on the number of insurers with significant market share and their ability to negotiate effectively with providers. The observations in this brief draw on the case studies, particularly our interviews with leading state officials, as well as health plan representatives and provider associations. They reflect information provided by respondents as well as, in some cases, our analysis of that information.

Two of the key provisions of the ACA are insurance market reforms and health insurance exchanges; together they should dramatically improve access to coverage in the nongroup and small-group markets. Insurance reforms such as guaranteed issue, prohibitions on medical underwriting, and risk adjustment will significantly reduce opportunities to avoid high-cost individuals. There will also be more people in the nongroup market due to subsidized coverage in the

health insurance exchanges. Administrative costs of coverage for the smallest employers are expected to be lower than prior to reform when insurance is purchased through exchanges. The exchanges will also provide more accessible information that will allow consumers to compare options based on price, cost sharing, networks, and quality, which will enhance competition.

Health insurance exchanges also build on the theory of managed, or organized, competition. Plan offerings must fit into actuarial value tiers, ranging from 60 percent (bronze), 70 percent (silver), 80 percent (gold), to 90 percent (platinum). This means, for example, that a bronze plan would cover 60 percent of the cost of covered benefits, on average, for a standard population. Plans participating in exchanges must offer products in the silver and gold tiers, and may offer bronze and platinum options. Premiums in the nongroup market will be subsidized by the federal government for individuals up to 400 percent of the federal poverty level (FPL) who do not have access to affordable employer-sponsored insurance. Subsidized individuals will have their out-of-pocket premium costs capped as percentage of income, as low as two percent for those with incomes between 133 and 150 percent of the FPL, with premium liabilities increasing as a percentage of income up to 9.5 percent of income for those with incomes of 300 to 400 percent of the FPL.¹ Thus, individual responsibilities are capped

for those eligible for subsidies, with the responsibilities increasing with income. The subsidies will be tied to the premium of the second lowest-cost silver plan in the area, and any individual choosing a more costly silver plan, or a gold or platinum plan, will pay the full marginal cost of the higher premium. This structure gives consumers choices of plans, but also incentives to make cost-conscious choices, and gives insurers incentives to compete to be one of the two lowest-cost plans.

This structured framework to encourage competition will affect choices for all enrollees, as well as premiums and government subsidy costs. The choices made by plans and individuals will also have substantial implications for the federal government, which will pay the full costs of premium subsidies—that is, the difference between the percentage of income at which an individual’s premium liability is capped and the premium of the second lowest-cost plan. Ironically, the federal government has a greater financial stake in the outcome of market competition than do the states, many of which will have either full or partial responsibility for the operation of the new exchanges. States still have the incentive to have exchanges operate efficiently, since the high-income unsubsidized population would be affected by higher premiums.

The case studies revealed that health insurance and provider markets are quite different across states. There is also considerable variation in these markets within states, particularly the larger ones. It is expected that all of the study states are likely to have one exchange, but larger states will have multiple geographic areas for pricing purposes (e.g., different geographic areas could have different plans competing and different premiums).

There could also be separate nongroup and Small Business Health Option Program (SHOP) exchanges with a joint administrative structure. Thus the level of competition and its implications for coverage decisions of consumers, premiums, and subsidy costs could differ significantly both across and within states.

In general, exchange premiums will depend on the actuarial value tier, but also benefit design, cost-sharing structure, the enrollment of individuals and families of different levels of medical need, and provider networks. They will also depend greatly on the leverage of commercial insurers with providers, particularly hospitals. Smaller plans that currently have a market presence because of good risk selection, but with little leverage with providers are unlikely to succeed in a more regulated and more organized market. It is also hard for new plans to successfully enter the market because of the difficulty in establishing provider networks. Plans with limited, but adequate networks that can negotiate lower provider payment rates than in today’s commercial market may be the most competitive.

At this point, it is difficult to foresee how the competition in each state will play out post-2014. Some insights can be garnered by examining current markets and how they appear to be changing in anticipation of full implementation of the reforms. We offer three alternative models of markets. The potential implications of Medicaid-managed care plans entering exchanges as competitors, a change that could happen in many states, are also discussed. In many states, the commercial and Medicaid-managed care markets are quite different; in other states commercial plans participate in Medicaid.

DOMINANT INSURER—MANY HOSPITAL SYSTEMS

There are a few states among the 10 studied which have a single dominant insurer, but where there are a large number of distinct hospital systems. Two prominent examples are Michigan and Alabama. Maryland has some of the same characteristics. In Michigan, Blue Cross Blue Shield (BCBS) has an extremely large market share, about 80 percent of the insured population; including self-insured plans. The state has a number of strong hospital systems. Respondents indicated that historically, BCBS has been relatively accommodating in its rate negotiations with hospitals, knowing it can pass

on higher costs to groups and individuals. Recently, BCBS has been sued over allegations that it had agreed to pay hospitals somewhat better as long as other competing insurers are charged even more.² BCBS certainly has the market power to drive hard bargains with hospitals, but seems to have chosen not to do so. Smaller insurers may be able to offer plans at lower premiums with limited networks by selective contracting with a limited set of providers, but this does not seem likely to occur. Participation by some Medicaid plans could be more likely, but without serious competition

from other strong plans under reform, it is difficult to see incentives for BCBS to offer lower cost/leaner network products within the exchange. Its premiums and subsidy costs are likely to be relatively high compared to a truly competitive market, despite its substantial insurer market power unless new lower-cost carriers enter the market.

Alabama is another state with a very dominant BCBS plan, with more than an 85 percent market share in the individual and small-group markets. Other insurers, such as United and Humana, have some presence in the state, but their market share is very small. Respondents indicated that United and Humana have had difficulty negotiating favorable reimbursement agreements with providers and building networks, given BCBS' market power. There are three or four hospital systems that dominate metropolitan markets. It is unlikely that the insurance market will become more competitive with the introduction of a health insurance exchange. While BCBS essentially operates as a single-payer system in the state, respondents do not believe they have used this market power to bring down provider payment rates. Clearly,

they have the market strength to dominate the exchange and offer low-cost products to exchange enrollees. However, there will not be sufficient incentives to use that strength unless plan competition increases.

Maryland is another state with a strong CareFirst BCBS plan and multiple hospital systems. The unique feature in Maryland, however, is the presence of the Maryland Health Services Cost Review Commission. The Commission sets hospital rates for all payers, public and private, thus, even a dominant payer like CareFirst cannot use its market leverage in negotiations with hospitals, nor can it set rates at arbitrarily high levels and simply pass those costs onto consumers. CareFirst attributes its competitive advantage to being a nonprofit competing with for-profit plans. It fully expects to compete in the exchange, and it is hard to anticipate an effective challenger in the current commercial market. Kaiser has a significant presence in Maryland and could be competitive. And, as will be discussed below, a possible threat to CareFirst's market dominance could come from one of the state's Medicaid-managed care plans.

MANY INSURERS—DOMINANT HOSPITAL

The second model is one where the insurance market has many insurers, but a single dominant hospital or hospital system. In these markets, it is very difficult for insurers to negotiate hospital payment rates, meaning that premiums are high and are likely to remain high under reform.³ Examples of such markets include Northern Virginia, where the INOVA hospital system has

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substantial market power. Respondents indicated that even Anthem and CareFirst⁴, the dominant insurers in Virginia, have difficulty dealing with INOVA. Insurers such as Kaiser, Aetna, and United that have smaller market shares in Northern Virginia have even more difficulty negotiating with INOVA.

In Rhode Island, there are two dominant hospital systems—seven of the state's 11 hospitals are in these two systems. No one can realistically sell an insurance

product in the state without these two systems participating. Having little leverage with providers, carriers are unlikely to be able to compete aggressively on price post-reform either. Excluding the high-cost hospitals is not viewed as an option. Rhode Island has three major plans—Blue Cross Blue Shield of Rhode Island, Tufts and United. All have a significant market presence, and all are likely to participate in the exchange. Most respondents did not see an advantage of attempting to get more plans to compete in the state, because more plans with little leverage against providers would have little effect on premiums. However, the state health insurance department has authority to review provider payment rates as part of the state's rate review process, and this authority provides a potential avenue for constraining cost and premium growth.

A similar market is seen in upstate New York, where there are many commercial plans but one "must-have" hospital system in most of the upstate areas. Little change is anticipated as a result of reform's full implementation. Limited hospital options in small town and rural areas of most states also inhibit carrier negotiating leverage. As such, premiums and subsidy costs per person are anticipated to be relatively high in these areas, all else held constant.

MANY INSURERS—MANY HOSPITALS

In some states, there are many insurers and many hospitals or hospital systems. Colorado is an example of this type of situation. The state has small critical access hospitals in rural areas, but a few very strong hospital systems in the Denver and “front range” area. There are four major plans—Kaiser, United Healthcare, Anthem Blue Cross and Rocky Mountain Health Plan—that each have significant market share. The fact that they all have significant market share means that none has considerable leverage over the hospital systems. Kaiser is in a somewhat stronger position in this respect as it manages its own provider network. Each of the state’s insurers could potentially profit under reform from

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developing a more limited network option with lower provider payment rates and, as a result, lower premiums. Tiered network products—plans that allow enrollees to have access to high-cost providers if they pay all or most of the marginal cost—are also possible. We do not have evidence at this time as to whether plans are considering this approach, but the presence of several strong insurers and several provider systems make it possible for the ACA incentives to spur stronger price competition in the small-group and nongroup markets. The lower income subsidized individuals in exchanges will likely be quite price sensitive, making such products available.

Oregon is another example of a market where there is one significant hospital system alongside many

independent hospitals, several of which are vital to a strong network. At the same time, there are a number of insurers with significant, but not overwhelming market share. These include Regence BCBS with 27 percent of the market, Kaiser Permanente with 28 percent, and Providence with 11 percent. Respondents in Oregon generally believe that the competition in the state’s insurance markets has placed carriers at a disadvantage relative to providers, many of which are “must-have” hospitals for carriers’ networks. For one insurer to emerge post-reform with a particular competitive advantage, it would have to develop a product with limited or tiered networks and lower premiums. Such a change in the market dynamic likely would lead to similar responses from competitors if consumers are drawn to the lower-price plan despite its exclusion of at least some flagship hospitals.

Minnesota is a special case. It has many large insurers, but also many hospital systems. The latter include the Mayo Clinic, Allina Health System Hospitals and Clinics, Essentia Health System and Sanford Health. All have several hospitals and clinics, largely in Minneapolis and Saint Paul, but they also have a presence in the rest of the state. The Sanford system is strong in rural and small towns. At the same time there are three large health plans—BCBS, Medica and Health Partners—and each has about one-quarter to one-third of the market. No plans have any particular market leverage. Minnesota is likely to have relatively low-cost options in the exchange, because of the balanced competition in both the carrier and provider sectors, and it is already a low-cost state. Respondents suggest that the fact that all of the hospital systems are nonprofit, as are all insurers, is another contributor to their low-cost state profile. Additionally, there is a state requirement that all plans serve the Medicaid market.

MEDICAID AS A COMPETITOR

Strong Medicaid-managed care plans could enter into the commercial insurance market in virtually any state to compete with current dominant carriers. However, the transition into the commercial market would not be an easy one for Medicaid plans. The commercial market

operates quite differently than does the public program environment, requiring different benefit packages, cost-sharing designs and marketing to a very different population. It has different licensure rules and processes, and more reserves are required than Medicaid plans

typically hold. Commercial plans also have broader provider networks than Medicaid plans, and expanding their networks will usually require paying at least somewhat higher provider payment rates.

One area where Medicaid plans could emerge as strong competitors with commercial plans is in New York City (NYC). Currently, several prepaid health services plans (PHSPs) with about 70 percent of Medicaid lives operate in NYC. The PHSPs are hospital- and clinic-sponsored. They have broad networks and typically contract with most local hospitals. In New York, unlike other states, it is not difficult for Medicaid plans to convert their existing licenses to health maintenance organization (HMO) licenses, and some already have reasonably high levels of reserves. They pay hospitals better than Medicaid fee-for-service, but still less than do commercial plans. Most hospitals in NYC participate in the Medicaid market simply because Medicaid covers such a large part of the population. While commercial plans will participate in New York exchanges, it is likely that some PHSPs will also enter the small-group or nongroup markets in order to compete with them. Many informants in the state believe that PHSPs could be very competitive, particularly in the nongroup exchange. They would be likely to pay hospitals and doctors somewhat more than they do under Medicaid, however. If PHSPs come in as strong competitors, commercial plans will probably have to develop different products with more limited networks that permit lower average provider payment rates. If some of the PHSPs compete effectively in the exchange downstate and cause commercial insurers to develop new products to grow market share, the intense competition could result in significant downward pressure on premiums and subsidies in the NYC area, all else being equal.

Another case is in Virginia. Anthem is the dominant insurer in the state with a large market share in all

insurance markets in which it operates (CareFirst is the BCBS plan operating in a substantial portion of Northern Virginia), and is likely to participate in the exchange. Its significant market share allows it to negotiate effectively with most providers. But Anthem could face competition from insurers owned by or aligned with hospital systems. Virginia Premier, the Medicaid-managed care product of the Virginia Commonwealth University system (while based in the Richmond area), could compete for covered lives in several parts of the state. The Virginia Premier plan has a broad provider network and pays slightly better than Medicaid fee-for-service rates, although it would have to pay somewhat higher rates to be able to offer its network to a broader population. If Virginia Premier chooses to offer exchange plans in the areas in which they have provider networks, they could offer serious competition to Anthem.

The Optima health system, connected to the Sentara hospital system, has a major presence in the Tidewater area and competes in both Medicaid and commercial markets. Because it owns several hospitals, it has an advantage in its market. In the Roanoke area, the Carilion system controls most of the hospitals in that part of the state. It has aligned with Aetna to market its own insurance plan and currently participates primarily in Medicaid, but it is expected to grow to be a strong competitor with Anthem in the commercial marketplace. If it offers a product in the Virginia exchange, the Carilion/Aetna partnership could be a low-cost plan, particularly in the Roanoke area. Anthem, in response, has developed a more limited network product with lower provider payment rates (Health Keepers) and will remain a formidable competitor. Competitive dynamics within Virginia will be interesting to watch. The competition to be the second lowest-cost plan could be intense in particular regions of the state.

CONCLUSION

We conclude that insurance competition within exchanges is likely to differ both across and within states. In some areas where there is a dominant insurer, there should be leverage with providers despite the lack of insurer competition. But often these dominant insurers are not willing to use their market clout to drive hard bargains with hospitals. Whether they will do so in the new exchange environments will be a function

of whether other plans are able to enter the markets to actively compete with them. It is difficult for new commercial insurers to enter markets in this way, since being competitive on price requires that a carrier be able to negotiate effectively with providers for in-network payment rates that are lower or similar to the current dominant carrier. Without substantial market share, negotiations for competitive provider rates are usually not

possible. In these markets, competition and choice are likely to remain limited, and premiums and subsidy costs are likely to be higher than in more competitive areas.

In markets with many insurers and a dominant hospital, attracting plan enrollees generally requires the inclusion of the hospital system in the network. Due to the hospital's relative power in negotiations, it is difficult for plans to negotiate effectively for lower provider payment rates, and thus plans generally find it infeasible to offer low-cost insurance products for a given set of benefits and cost-sharing requirements. Thus, it is difficult to see low-cost plans emerging to compete within exchanges. While there is more choice of plans, competition is effectively limited.

In markets where there are many insurers and many hospitals, outcomes remain hard to predict, but the potential for greater competition on price will be enhanced by the managed competition structure inherent in the ACA. One or more insurers may attempt to offer more limited networks with lower payment rates, or alternatively tiered network products, in an attempt to obtain a position as one of the two lowest-cost plans in

an area, giving them a competitive advantage within an exchange.

The other opportunity for highly competitive insurance markets to develop seems likely to occur when Medicaid-managed care plans enter commercial markets with more limited provider networks than the existing commercial plans, where the providers are willing to accept somewhat lower payment rates for limited populations. In our study states, such a scenario is most likely to occur in New York City and in parts of Virginia, although there is a possibility that such a dynamic could emerge in Colorado, Maryland, Oregon and perhaps elsewhere. Still, Medicaid plans face difficult issues in making this type of transition—marketing to a higher-income population than usual, designing benefit packages consistent with the commercial market, assuring adequacy of reserves, and building broader provider networks. If competition with Medicaid plans materializes, commercial plans are likely to respond by developing their own limited networks with lower provider payment rates. Such a competitive dynamic would lead to lower premiums and government subsidy costs.

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ENDNOTES

1. Individuals with incomes below 250 percent of FPL are also eligible for cost-sharing subsidies.
2. Pear R. 2010. "U.S. Sues Michigan Blue Cross Over Pricing." *New York Times*, <http://www.nytimes.com/2010/10/19/business/19insure.html>. While the DOJ case against BCBSM continues, another case (*City of Pontiac vs. Blue Cross Blue Shield of Michigan*) was decided in BCBSM's favor just after our site visit, when a U.S. District Court dismissed the antitrust action.
3. The evidence on this is reviewed in an excellent summary: Vogt WB, Town R. 2005. "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Research Synthesis Report No. 9. Princeton, NJ: The Robert Wood Johnson Foundation.
4. Anthem and CareFirst are former BlueCross-BlueShield plans that have different market areas in Northern Virginia.