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How Insurers Competed in the Affordable Care Act's First Year

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Abstract Prior to the Affordable Care Act (ACA), most states' individual health insurance markets were dominated by one or two insurance carriers that had little incentive to compete by providing efficient services. Instead, they competed mainly by screening and selecting people based on their risk of incurring high medical costs. One of the ACA's goals is to encourage carriers to participate in the health insurance marketplaces and to shift the focus from competing based on risk selection to processes that increase consumer value, like improving efficiency of services and quality of care. Focusing on six states—Arkansas, California, Connecticut, Maryland, Montana, and Texas—this brief looks at how carriers are competing in the new marketplaces, namely through cost-sharing and composition of provider networks.

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BACKGROUND

Prior to the passage of the Affordable Care Act (ACA), most states' markets for individual health insurance were dominated by one or two carriers that competed primarily on how well they were able to screen and select people based on their risk of incurring medical claims. They had little incentive to compete by providing efficient services; instead, their focus was on reducing their risk of covering people who might have very high medical costs. Consequently, many people perceived likely to have high medical costs were uninsured, because carriers either rejected them or offered policies at excessively high premiums.

A principal goal of the ACA is to shift carriers' focus from risk selection to processes that increase consumer value, such as improving efficiency of services and quality of care. Carriers selling plans in the ACA marketplaces must accept all applicants and cover services for preexisting conditions. Further, the plans must cover the same minimum essential benefits and differ only in terms of actuarial value, which are identified by "metal" tier or level.[1] A risk-adjustment program requires carriers that enroll a healthier-than-average population to then compensate other carriers that

have less-healthy subscribers. In addition, premiums for individuals in the oldest age group cannot be more than three times the premiums for the youngest adult age group, and rating by gender and by how long a person has held a policy (durational rating) are prohibited.

Other researchers have documented the law's basic success in attracting more carriers to the individual marketplaces and making them more price-competitive.[2,3,4] But research so far has not delved deeper into how this success might vary among different marketplaces, whether insurers still continue to compete on risk selection, and what forms of price competition are emerging.

In late 2013 and early 2014, we studied six states—Arkansas, California, Connecticut, Maryland, Montana, and Texas—and conducted interviews with a variety of public and private sector policymakers, academic analysts, and consumer advocates. These states were selected to showcase different demographics, economic conditions, and insurance markets. California, Connecticut, and Maryland established their own marketplace exchanges; Arkansas and Montana are cooperating or partnering with the federal government; and Texas defaulted entirely to a federally facilitated marketplace.[5]

This issue brief summarizes what we observed in the six states. We describe the marketplaces' initial forms of competition and relate them to state-specific factors that might explain similarities or differences. Knowing more about carriers' initial competitive strategies provides a baseline for assessing changes in competitive strategies as the marketplaces mature.

HEALTH INSURANCE MARKETPLACES IN THE SIX STATES

Attracting Carriers

Before the ACA became law, most states had just one or two carriers that dominated the individual insurance market, even when a large number were licensed to sell policies in these markets.[6] As a result, states and the federal government were concerned about attracting carriers to the marketplaces and acted accordingly.[7] For example, although the ACA allows states to selectively contract with carriers, only California has so far opted to do so. In addition, the ACA created the Consumer Operated and Oriented Plan (CO-OP) program, which provided funding for new nonprofit insurance cooperatives. The co-ops are supposed to be managed with strong input from the people who enroll in the plans and will reinvest any profits as part of their efforts to offer affordable plans.

Efforts to increase the number of individual carriers are significant because the ACA's premium subsidies are benchmarked to the second-lowest premium of silver plans in each market. If only two carriers compete, one will have the second-lowest premium so there is little incentive for either to drive costs down to lower premiums. But key informants noted that when there are at least three carriers present, all the carriers—unless they are colluding—have an incentive to reduce costs. Each wants to have at least one bronze plan and one silver plan premium that are at or below the benchmark silver plan premium in the marketplace so they can increase their market share.

In another move to engage carriers, most states declined to standardize benefit designs any more than the ACA required, thereby allowing carriers a wide variety of patient cost-sharing formulations (i.e., deductibles and copayments or coinsurance rates).[8] Among the six states studied, California, Connecticut and Maryland limited the number of plans carriers could offer at each of the metal levels. In Arkansas, Montana, and Texas, informants explained that standardization of

benefits was resisted, at least in part, in order to attract more carriers to the market. In these states, consumers confronted a relatively large choice of plans at each of the metal levels.[9] Across all the rating areas of the 36 federally facilitated marketplaces, the average number of available plans (not including catastrophic plans) was 53 in 2014.[10,11] This is far more than what is typically offered to people with employer-sponsored insurance and policy analysts are concerned that this could make selecting a health plan confusing.[12] However, carriers and policymakers did not know what combinations of cost-sharing and premiums would be most attractive to the uninsured, especially those younger or healthier. These consumer choices will determine which combinations are offered in future years.

Finally, states were allowed to determine the number of premium-rating areas and their boundaries. Although the marketplaces are often referred to as if they are statewide, the premium-rating areas, consisting of counties or metropolitan areas, are the de facto marketplaces in most states.[13] Among the six states studied, only Montana and Connecticut required carriers to offer plans in all rating areas in 2014. To increase their number of participating carriers, the other four states allowed carriers to choose where they would offer plans. As a result, in these states there are substantial differences in the numbers of carriers and plans available in each rating area.

Existing and New Market Entrants

Like most states, the six studied here have at least one carrier affiliated with Blue Cross–Blue Shield. In each case, that carrier had a large share of the state's total and individual market health insurance business prior to the ACA and has retained the largest share in each of the six states' marketplaces in 2014.

One reason Blues-affiliated carriers had a large first-year market share is that some of the biggest commercial carriers in the country—including Aetna, Cigna, and UnitedHealthcare—chose not to participate in the individual marketplaces in most of the study states.[14] By staying out for at least the initial year, they avoided uncertainties about how they might fare under the new market rules. This initial absence provided opportunities for new or less-established carriers to compete. Each of the six states had at least one new entrant to the individual market and some states had several.[15] There were three kinds of new entrants: co-ops (available in 23 states) Medicaid managed care plans, and smaller local or regional insurers that previously focused primarily on the group markets.

Connecticut, Maryland, and Montana have new co-ops. In Connecticut and Montana, the co-op was the critical third competitor needed to make the marketplace more price-competitive. Arkansas, Texas, and California have new entrants that previously provided managed care plans only to Medicaid beneficiaries or lower-income people in specific counties—for example, Chinese Community Health Plan and LA Care Health Plan in California. Connecticut and Texas had existing local or regional insurers in the group markets that saw the new marketplace as an opportunity to substantially expand their presence in the individual market. Many of these new entrants attracted substantial enrollment, especially when premiums were low.[16] Interviewees told us that new entrants made other carriers more competitive in setting premiums, a point confirmed by other reports.[17,18,19]

Carriers Competed on Value Rather Than Risk

The reform provisions of the ACA are intended to stop the practice of carriers selecting enrollees based on their likely use of costly health care. Instead, the ACA encourages carriers to compete in terms of how they provide value to consumers, where value is indicated by premium, expected out-of-pocket costs, and quality of providers. However, good information that consumers might use to compare quality of providers was scarce in the first year. Of the study states, California was the only one where even limited information about providers was available to people shopping for a plan in 2014.[20]

We detected no indication of any regulatory circumvention of the ACA's basic provisions of guaranteed issue, age-adjusted community rating, and standardized benefits and cost-sharing. The law's core requirements that prevent risk selection are being enforced in every state and carriers are complying.[21]

Key informants in each state commented that consumers appear to be price-sensitive and this is affecting the way carriers price plans. We observed that most insurance agents, despite some discontent, were constructively engaged with the ACA's market reforms. In the states studied, numerous agents had received training to sell individual insurance in the marketplaces. Many agents see this as a business opportunity and understand that their role has shifted from medical underwriting to consumer assistance.

HOW INSURERS COMPETE IN THE MARKETPLACES

Although competition in the marketplaces appears to have shifted from risk selection and toward consumer value, the marketplaces in the six states do not fit neatly into a single, well-defined pattern. Various demographic and regulatory factors explain many of the differences observed among and within the six study states.

Number of Plans and Products Offered

Exhibit 1 shows the number of plans being offered in the six states at each of the metal levels and indicates how many carriers are offering plans in each premium rating area. To see how people's choices depend on where they live, we have interactive maps of each state that show the total number of metal level plans offered and number of carriers offering plans in each county within each premium rating area.

Focusing on the premium rating areas is crucial to analyzing the forms of competition in the states' marketplaces because most states permit carriers to sell plans in just some premium rating areas rather than all of the state. California's 19 rating areas have between two and six carriers each. Arkansas and Maryland allowed some managed care organizations to sell only in the areas where they have provider networks. In Texas, which has 254 counties organized into 26 rating areas, there are even differences within premium rating areas; some counties have only one or two carriers offering plans while other counties in the same rating area have four or more.

The variation in the number of plans and carrier options available in different parts of the states is easily seen by examining the interactive maps. They show that Connecticut and Montana required that carriers offer the same plans in all rating areas. In contrast, there are substantial differences in choices depending on where a person lives in Arkansas, Texas, and California. Further, the interactive maps suggest that in the states that did not require carriers to offer the same choices

Exhibit 1. Range of Numbers of Health Plans by Metal Level by State Offered in 2014

State	Bronze	Silver	Gold	Platinum
Arkansas	4–14	3–11	3–13	0
California	6–9	3–9	3–8	3–8
Connecticut	8	4	4	0
Maryland	11	11–13	9–11	2
Montana	8	10	7	1
Texas	5–25	6–30	6–20	0–1

Arkansas has seven rating areas: three have three carriers, two have two carriers, and two have one carrier.
California has 19 pricing areas: six have three carriers (but three of these permit Kaiser to be in only specific subareas), four have four carriers, five have five carriers, three have six carriers; only Anthem BC of California and Blue Shield of California are in all 19 pricing areas.
Connecticut has eight rating areas: three carriers in each area; for silver and gold plans, only Anthem Blue Cross offers two plans.
Maryland has four rating areas.
Montana has four rating areas and each has all three carriers.
Texas has 26 rating areas: five have 2 carriers, nine have three carriers, three have four carriers; five have five carriers, one has six carriers, two have seven carriers, and one has 10 carriers.
Sources: http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/premiumdata/databook.aspx; and ValuePenguin data.

in all rating areas, choices differ based on the relative population size and per capita income in the premium rating area.

The types of products (i.e., HMO or PPO) offered are also important for assessing the extent of competition. When product choices are counted at the premium rating area level rather than aggregated to the state level, it is apparent that PPO and other non-HMO plans are more likely to be offered in areas that are more sparsely populated and have high numbers of poor and uninsured people (Appendix). Plans with limited provider networks are more likely to be PPO plans than HMO plans.

Finally, as other research shows, silver plan premiums are higher in rating areas with only one or two carriers.[22,23] We also observed this effect, and saw that the competition to produce the lowest-priced silver plan did not mean that the insurer with that plan had the lowest premiums across all the metal levels.

Different Competitive Strategies

The interactive maps and data show there are differences across the six states—and within four states—in how carriers are competing and the choices consumers have. In the six states studied here, carriers' use of two approaches—relying on patient cost-sharing or using limited provider networks—created three distinct competitive strategies used in the states' marketplaces. We observed four key state characteristics that aligned with the different competitive marketplace strategies.

Three Competitive Strategies in the Marketplaces

1. Carriers compete by offering many variations of cost-sharing, especially for the bronze and silver plans; there are no plans with narrow provider networks (e.g., Montana and Connecticut).

2. Carriers are restricted to offering a small number of plans at each metal level with very similar cost-sharing arrangements so carriers compete primarily based on their provider networks (e.g., California).

3. Carriers compete based both on provider networks and on variations in cost-sharing arrangements (e.g., Arkansas, Maryland, and Texas).

State Characteristics That Align with Different Competitive Strategies

- *Demographics:* the density and composition of the population, geographic distribution of health care providers, and the number of premium rating areas in the state.
- *Market structure:* the types of carriers and their market shares in the state's individual insurance markets before the ACA became law.
- *Regulatory approach:* the structure and type of regulatory oversight for different types of health plans, especially the composition of managed care networks and the oversight of HMOs versus conventional commercial insurers.
- *Attitudes about and history of reform:* how supportive and active state officials were in implementing the new marketplace and the state's history of health reform efforts.

In Exhibit 2, we illustrate each state's unique combination of these characteristics. Distinguishing between characteristics that do not change quickly, such as population size, and characteristics that a governor or legislature could adjust is important for states that want to alter initial competitive strategies.

State Characteristics Related to Competitive Strategies

With observations of only six states, it is impossible to say that particular characteristics are demonstrably more important than others in explaining the type of competition in specific marketplaces. Nevertheless, this analysis provides a starting point for examining competition in other states and a reference point for any future analysis of all 50 states.

Demographics. The six states' populations in 2013 ranged from just over 1 million in Montana to more than 38 million in California. But as the maps clearly show, these totals mask the extent to which the populations are clustered around certain cities or counties while other areas are quite sparsely populated. Under the ACA, states were able to decide the number of premium rating areas they would have and their boundaries. Some states worked to create rating areas with roughly equal numbers of people but other states did not. The rating area boundaries follow county lines in most states, with areas consisting of more than one county. There are generally far fewer physicians and hospitals in rural areas so carriers have limited bargaining power for negotiating lower reimbursement rates or establishing exclusive provider networks in these areas. As a result, the premium rating areas have a direct influence on carriers' options for how they might compete in a state or in specific parts of a state.

In some states or regions, we observed that carriers differentiated their plan offerings primarily in terms of patient cost-sharing (e.g., Montana) or by offering PPO plans with a combination of greater cost-sharing and restrictions on providers (e.g., rural counties in California and Texas). Carriers that rely primarily on limited provider networks are either not offering their products in sparsely populated areas or they are not competing in the state marketplace at all.[24]

Market structure. Arkansas, Connecticut, Maryland, and Montana each had a dominant carrier (i.e., Blue Cross Blue Shield) in their individual insurance markets before the marketplaces were established. In addition, Arkansas, Connecticut, and Maryland had managed care plans with

Exhibit 2. Key Characteristics Across Study States

State	Demographics (2014)	Market structure	Regulatory approach	Attitudes about and history of reform
Arkansas	Population: 3 million; 56% of population in urban and suburban areas	Three carriers are competing; five of seven areas have two or three carriers offering plans. Prior to ACA the largest insurer had 78% of individual-market enrollees.	"Any willing provider" requirement for managed care plans (i.e., plans have to accept any provider who wants to be in their provider network)	Mixed views about reform; partnership state; innovative private Medicaid option
California	Population: 38.8 million; 95% of population in cities and suburban areas	Two to six carriers are competing in areas. Prior to ACA, four carriers had more than 5% of individual market enrollees; the largest had 48% of enrollees. Providers competitive in many urban areas, but less so in rural areas.	Active purchaser exchange; divides regulatory authority between managed care and indemnity plans	Long history of reform efforts; prior experience with failed insurance exchange
Connecticut	Population: 3.6 million; 88% of population in urban and suburban areas	Three carriers are competing in each area. Prior to ACA, the two largest carriers in individual market had 40% and 30% of enrollees. One of these chose not to compete in 2014. Some areas have dominant hospitals.	Strong network adequacy rules	Strongly supports reform
Maryland	Population: 6 million; 87% of population in urban and suburban areas	Six carriers competing but not in all areas. Prior to ACA, only two carriers offered plans in individual insurance market, largest had 72% of enrollees.	Tradition of strong regulation (e.g., hospital rates have been regulated since 1971)	Strongly supports reform
Montana	Population: 1 million; 56% of population in urban and suburban areas; one city with more than 100,000, two other cities with populations between 50,000 and 100,000	Three carriers competing in all areas. Prior to ACA, two carriers had 34% and 36% of individual insurance market enrollees and MT BCBS had 60% of large-group insurance market. Only two cities have two hospitals.	Active Department of Insurance	"Silent" partnership state (i.e., state conducts plan management activities to support certification of qualified health plans in the federally facilitated marketplace)
Texas	Population: 27 million; 85% of population in urban and suburban areas	Carriers and providers competitive in urban areas, less so in rural areas. Prior to ACA, five carriers each had more than 5% of individual insurance market enrollees; largest had 59% of enrollees.	Tradition of fairly light regulation	Hostile to reform

Source: Authors' analysis; and for individual insurance market in "Market Structure": Kaiser Family Foundation, State Health Facts, http://kff.org/state-category/health-insurance-managed-care/insurance-market-competitiveness/.

smaller market shares. Arkansas and Maryland did not require these carriers to compete in rating areas where they lacked provider networks. In contrast, Connecticut required carriers to compete across the state; the one HMO offering plans in the marketplace is in all eight rating areas. Montana does not have any carriers offering managed care plans in the state.

In contrast, California and Texas had other carriers besides BCBS with substantial shares of the individual market before the ACA. Cigna, UnitedHealthcare, and Aetna offered PPO plans in the individual markets of these two states before 2014, but chose not to sell plans in Covered California in 2014, and although Cigna and Aetna sold plans in some areas of Texas in 2014, UnitedHealthcare did not. California and Texas also had strong regional HMOs (e.g., Kaiser

Permanente in California, Scott and White in Texas) which chose to offer plans in some areas in 2014. California also has several Medicaid managed care plans and provider groups that have long focused on providing care to underserved and uninsured people.

The carriers in Arkansas, Connecticut, Maryland, and Montana continued to offer the same types of products that their residents had been used to purchasing in the individual and small-group markets before the ACA. Competition in Arkansas and Maryland reflects a combination of strategies while competition in Connecticut and Montana primarily focuses on cost-sharing differences. In some urban parts of California and Texas where there were large numbers of uninsured people, some carriers' plans require enrollees to obtain care from a limited set of providers.[25] Most of the competition in California's rating areas is in terms of provider networks while carriers in Texas's rating areas use a mix of strategies. The carriers in the marketplaces are not straying too far from what they offer outside the marketplaces.

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

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

Texas, for instance, has a mix of HMOs, PPOs, and EPOs that is based partly on differences in existing state regulations of each type of managed care plan. Texas has stricter regulation of network adequacy for HMOs than for conventional insurance, with specific limits regarding how far a person must travel to reach a primary care provider or a hospital emergency room. Accordingly, the HMO plans offered in the premium rating areas are concentrated in urban areas where they constitute a majority of the marketplace products. In Texas' more rural rating areas, the majority of products offered are PPOs. Similarly, the mix of HMO, PPO, and EPO plans in California is driven by different provider markets and the varying ways California regulates these plan types.[26]

In Connecticut, existing regulatory policy discouraged carriers from offering different provider networks in different plans or market segments because of concerns about creating consumer confusion. Carriers must use networks that are "substantially similar" to those they offer in the large-group market, which is defined as including 85 percent of the same providers.[27] Not surprisingly, Connecticut required carriers to offer the same plans in all areas of the state. Montana, where only two cities have more than one hospital, also required carriers to offer the same plans in all areas of the state. In Arkansas, sources said that a state regulation limiting how much insurers can penalize patients for going out of network made it difficult to create plans with limited provider networks.[28]

Attitudes about and history of reform. The extent to which a state was actively involved in setting up its marketplace influenced its competitive strategies, as did the state's history of health reform. Among the six states studied, California and Texas are at the bookends of the spectrum of reform efforts and involvement in setting up a marketplace. Texas chose not to run its own marketplace and the state's Department of Insurance has essentially stayed out of the marketplace operations.

The board of Covered California—California's state marketplace—used selective contracting authority to require carriers to compete for approval to sell in each of the 19 rating areas in

the state. Although the Covered California board did not use its selective contracting authority to exclude qualified carriers, it defined more specifically than other states what qualifications were necessary for a carrier to participate. Moreover, the fact that California could use its authority to reject any bids on the basis of proposed rates encouraged some carriers to offer plans with narrow provider networks. Several sources told us that the decision to use selective contracting grew out of the state's history of managed competition in the California Public Employees' Retirement System—also known as CalPERS, the state's public employee program for pension and health benefits—and in the Health Insurance Plan of California for small employers, as well as California's approach to regulating managed care plans since 1975.[29] This helps explain California's limits on the plan designs that carriers can offer at each metal level. This, in turn, explains why competition in most of California's rating areas is focused on provider networks.

Maryland chose not to conduct selective contracting but required marketplace participation by all insurers that had pre-ACA health insurance market shares above $10 million in the individual market and above $20 million in the small-group market. The result is that competition among carriers exhibits a mix of cost-containment approaches.

The other states neither required nor restricted participation by carriers. Instead, they accepted all qualified carriers that chose to participate.[30] However, these states were far from passive in their dealing with carriers. Connecticut and Maryland required carriers to offer standardized benefit designs and limited the number of nonstandard products carriers may offer. In contrast, Arkansas and Montana, despite having only three carriers each, have a very large number of plans available.

Although the ACA does not require states to regulate the premiums of plans offered in the marketplaces, all the states except Texas chose to actively review carriers' proposed 2014 rates as a way to encourage low premiums. As part of their review, insurance regulators or marketplace officials questioned some of the assumptions carriers used in developing their proposed rates. This resulted in substantial reductions of 10 percent to 20 percent by one or more carriers. In Connecticut and Montana, at least two carriers reevaluated their proposed rates; in Arkansas and California, some voluntary rate revision occurred even before proposed rates became public because officials quietly advised higher-priced carriers to reevaluate their initial filings.

This dynamic caused the marketplaces to be highly price-competitive, at least for the bronze and silver plans. However, it was critical to this dynamic that there were at least three competing carriers in most of the premium rating areas in each of the six states. (There were exceptions in rural parts of California, Arkansas, and Texas).

CONCLUSIONS

Our study of six states' experiences during the first year of the ACA marketplaces shows that when carriers are not allowed to compete by risk-selecting who they insure, they shifted to competing with different patient cost-sharing requirements and the composition of provider networks. But these competitive strategies are not the same across the country. Carriers compete differently in different states and rating areas, and the choices people have depend on where they live. The four factors we identified provide a framework for understanding the differences in competitive strategies among the marketplaces. But the fact that varying competitive strategies characterize different regions within a state raises a concern about carriers' potential ability to avoid covering people

who may have higher risks of costly medical conditions. If states and the federal government do not implement a statewide risk-adjustment mechanism, then the goal of shifting competition away from risk selection may be jeopardized.

This study also provides a reference point for identifying changes in the forms of future competition, as it reflects only the initial year of the ACA marketplaces. The ACA reforms will surely stimulate continuing adaptations by carriers, providers, and policymakers, and we expect the competitive strategies in the marketplaces to evolve as consumers and carriers gain more experience with marketplace competition.

Notes

[1] The actuarial value is determined by the share of medical costs that a plan would pay for the average person enrolling in each plan. (So the share a person would expect to pay is the difference between 100 percent and what the plan pays.) The ACA specifies the actuarial values (and associated metal names) of plans that can be offered in the marketplaces: 60 percent (bronze), 70 percent (silver), 80 percent (gold) and 90 percent (platinum). The health care services covered at each metal level are the same.

[2] S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, June 2014).

[3] McKinsey Center for U.S. Health System Reform, "Exchanges Go Live: Early Trends in Exchange Dynamics," Oct. 2013, available at http://healthcare.mckinsey.com/sites/default/files/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.pdf.

[4] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace Premiums for 2014" (Washington, D.C.: HHS, ASPE, Sept 25, 2013), available at http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

[5] In 2014, 16 states and the District of Columbia managed their marketplaces, seven states were partnership states because the state and the federal government are jointly implementing the marketplaces, seven other states were quasi-partnership states because they have received approval from HHS to conduct plan management activities to support the certification of qualified health plans, and the remaining 20 states had federally facilitated marketplaces. See K. Keith and K.W. Lucia, *Implementing the Affordable Care Act: The State of the States* (New York: The Commonwealth Fund, Jan. 2014).

[6] Kaiser Family Foundation, "How Competitive Are State Insurance Markets?" Focus on Health Reform Issue Brief (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2011), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf.

[7] C. H. Monahan, S. J. Dash, K. W. Lucia et al., *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013).

[8] Ibid.

[9] This is despite the fact that each carrier has to pool all the enrollees of its various plans into a common risk pool to obtain compensation for any adverse selection. Thus, carriers can offer a large number of variations of cost-sharing to see what combination of premiums and cost-sharing consumers prefer.

[10] HHS, ASPE, "Health Insurance Marketplace Premiums for 2014," 2013.

[11] U.S. Government Accountability Office, 2014. "Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied" (Washington, D.C.: GAO, Sept. 2014), available at http://www.gao.gov/products/GAO-14-657.

[12] Y. Hanoch, T. Rice, J. Cummings et al., 2009. "How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit," *Health Services Research,* Aug. 2009 44(4):1157–68.

[13] Texas, for example, has 26 rating areas for its 254 counties, with 25 of the rating areas having one or a few counties that comprise metropolitan areas, but the 26th rating area consists of 187 counties.

[14] However, they are offering plans in many of the states' marketplaces for 2015.

[15] An October 2013 report by McKinsey counted 282 carriers in all the states' marketplaces. The 282 carriers consist of 80 new entrants (primarily carriers that prior to the ACA offered managed care plans Medicaid enrollees plus the 24 co-ops) and 202 carriers that have been selling coverage in the states' individual insurance markets. The 202 "incumbents" are only two-thirds of the 307 carriers that have been selling plans in states' individual markets, however. See http://healthcare.mckinsey.com/sites/default/files/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.pdf.

[16] The McKinsey report noted that among new entrants, co-ops offered 37 percent of the lowest-price plans in the 22 states where they were competing in 2014. See http://healthcare.mckinsey.com/sites/default/files/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.pdf. The National Alliance of State Health CO-OPs released first-year enrollment figures from the 23 co-ops showing that more than 400,000 people (5% of all marketplace enrollees) enrolled with a co-op (National Alliance of State Health CO-OPs, "Over 400,000 People Now Enrolled in CO-OP Health Insurance Plans," April 24, 2014, available at http://nashco.org/over-400000-people-now-enrolled-in-co-op-health-insurance-plans/).

[17] McKinsey Center, "Exchanges Go Live," 2013.

[18] HHS, ASPE, "Health Insurance Marketplace Premiums for 2014," 2013.

[19] L. Dafny, J. Gruber, and C. Ody, "More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," NBER Working Paper 20140 (Washington, D.C.: National Bureau of Economic Research, May 2014), available at http://www.nber.org/papers/w20140.pdf.

[20] S. J. Dash, S. Corlette, and A. Thomas, *Implementing the Affordable Care Act: State Action on Quality Improvement in State-Based Marketplaces* (New York: The Commonwealth Fund, July 2014).

[21] J. Giovannelli, K. W. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market* (New York: The Commonwealth Fund, July 2014).

[22] Dafny, Gruber, and Ody, "More Insurers Lower Premiums," 2014.

[23] A. Burke, A. Misra, and S. Sheingold, "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014" (Washington, D.C.: HHS ASPE, June 18, 2014), http://www.aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

[24] In Texas, for example, rating area 3 consists of five counties surrounding and including the city of Austin, and has a total population of about 1.7 million people. Seven carriers offering 80 different plans (50 HMO and 30 PPO plans) are competing there. By contrast, rating area 12 consists of just Webb County, the sixth largest geographic county in the state, with a population of 260,000. Area 12 has only two carriers offering 20 different plans, 18 of which are BCBS plans (12 PPO plans and eight HMO plans); Molina, the other carrier, offers just HMO plans—one each at the silver and gold actuarial levels.

The age distribution of the population in rating areas also interacts with population density of areas. For example, the lowest-priced silver plans have the same premiums in both Texas rating areas 3 and 12, but the lowest premiums for the bronze, second-lowest silver, and gold plans are lower in Webb County (area 12) than they are in Austin (area 3). Thus, even though Webb County has fewer choices of carriers and plans, because its population is relatively young, people face lower premiums than do people in the Austin area.

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

[26] California regulates HMOs through its Department of Managed Health Care (DMHC), whereas its Department of Insurance (DOI) regulates all other forms of insurance, except for Blue Cross and Blue Shield, which has the option to submit PPO products to either regulation agency. Prior to the ACA, the DOI regulated most managed care plans sold to individuals while the DMHC regulated most plans sold to groups. Yet almost all of the carriers in Covered California opted for regulatory reasons to file their individual market products with the DMHC. This means that most plans are HMOs, except for those sold by Anthem Blue Cross and by Blue Shield of California, which also sell PPOs.

[27] Because lower-premium plans with limited provider networks have gained traction among employers in the past two years, the Access Health Connecticut board decided to allow carriers to offer nonstandard plans with limited provider networks. None chose to do so in 2014, in part because a carrier's lowest-price silver plan must be a standard plan.

[28] The regulation requires HMOs to let patients obtain care from non-network providers under terms that limit patients' cost-sharing to no more than 25 percent more than what they would have paid for network care, on average. This prevented QualChoice, an HMO operating in five of the seven rating areas of the state, from offering a closed-panel network in the marketplace. Instead it offers a limited network product in the two most populous rating areas as well as a product with the larger network it normally offers to groups. QualChoice's limited network product has a premium that is competitive with BCBS; its larger network product is 10 percent to 15 percent more expensive than the BCBS products. Arkansas' "any-willing-provider" law was not cited as a regulatory barrier because it protects only providers who are willing to accept carriers' discounted payment rates.

[29] The Pacific Business Group on Health (PBGH) took over the Health Insurance Plan of California (HIPC) in 1998, which was renamed the Pacific Health Advantage or PacAdvantage. The HIPC-PacAdvantage was quite similar to the structure of the ACA marketplaces. It operated for a total of 13 years, ending in 2006 because of adverse selection that it could not reverse. In mid-2011, the PBGH issued a report with five lessons for Covered California, the first one of which was that there should be a "meaningful but not unlimited number of choices" of products offered. The chairman of PBGH's Board, Paul Fearer, is a member of the Board of Covered California.

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

Appendix. Types of Health Plans by Premium Rating Area-Region by State

State & Rating Area Number	Types of Health Plans			
	POS	PPO	HMO	EPO
Arkansas				
Rating Area 1	12	29	0	0
Rating Area 2	6	11	0	0
Rating Area 3	12	29	0	0
Rating Area 4	6–12	11–29	0	0
Rating Area 5	0	11	0	0
Rating Area 6	0	11	0	0
Rating Area 7	6	29	0	0
California				
Rating Area 1	0	12	6	0
Rating Area 2	0	12	6	0
Rating Area 3	0	12	15	0
Rating Area 4	0	6	17	6
Rating Area 5	0	12	14	0
Rating Area 6	0	12	11	0
Rating Area 7	0	12	14	0
Rating Area 8	0	12	11	0
Rating Area 9	0	12	6	0
Rating Area 10	0	12	6	0
Rating Area 11	0	12	9	0
Rating Area 12	0	12	11	0
Rating Area 13	0	12	6	0
Rating Area 14	0	12	6	0
Rating Area 15	0	6	22	6
Rating Area 16	0	6	22	6
Rating Area 17	0	12	17	0
Rating Area 18	0	6	12	6
Rating Area 19	0	6	27	6
Connecticut				
Rating Area 1	0	16	0	0
Rating Area 2	0	16	0	0
Rating Area 3	0	16	0	0
Rating Area 4	0	16	0	0
Rating Area 5	0	16	0	0
Rating Area 6	0	16	0	0
Rating Area 7	0	16	0	0
Rating Area 8	0	16	0	0

Appendix *(continued)*

State & Rating Area Number	Types of Health Plans			
	POS	PPO	HMO	EPO
Maryland				
Rating Area 1	9	4	18	6
Rating Area 2	9	4	14	6
Rating Area 3	9	4	14	6
Rating Area 4	8	4	15	6
Montana				
Rating Area 1	4	25	0	0
Rating Area 2	4	25	0	0
Rating Area 3	4	25	0	0
Rating Area 4	4	25	0	0
Texas				
Rating Area 1	0	12	11	0
Rating Area 2	0	12	11	0
Rating Area 3	0	19–30	44–50	0
Rating Area 4	0	19	12–17	0
Rating Area 5	0	12	35	0
Rating Area 6	0	12–18	19	0
Rating Area 7	0	12	12	0
Rating Area 8	0	12–30	6–14	0
Rating Area 9	0	12	35	0
Rating Area 10	0	25	6–17	0
Rating Area 11	0	19	19–46	0
Rating Area 12	0	12	8	0
Rating Area 13	0	12	6	0
Rating Area 14	0	12	11	0
Rating Area 15	0	12	8	0
Rating Area 16	0	12	11	0
Rating Area 17	0	12	11	0
Rating Area 18	0	12	14	0
Rating Area 19	0	19	6–42	0
Rating Area 20	0	23	6	0
Rating Area 21	0	12	6	0
Rating Area 22	0	12	6	0
Rating Area 23	0	12	6	0
Rating Area 24	0	19	52	0
Rating Area 25	0	12	6	0
Rating Area 26 (177 counties)	0	12–23	6–55	0

Data Source: Value Penguin data.

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