

Competition and Premium Costs in Single-Insurer Marketplaces: A Study of Five Rural States

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ABSTRACT

ISSUE: In 2017, five states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — had only one issuer participating in their health care marketplaces, limiting consumer choice and competition among insurers.

GOAL: Examine the history of participation in the individual market from 2010 (before the Affordable Care Act was enacted) to 2017, and analyze premium changes among marketplace plans.

METHODS: Robert Wood Johnson Foundation's HIX Compare, which provides national data on the marketplaces from 2014 to 2017.

FINDINGS AND CONCLUSIONS: In 2010, the individual insurance market was already concentrated in the five study states, with Blue Cross and Blue Shield (BCBS) plans covering the majority of enrollees. By 2015, with the marketplaces in full swing, more issuers were competing in the five states. But by 2016, co-ops were facing bankruptcy and left the marketplaces in these states; and in 2017, citing large financial losses, national issuers UnitedHealthcare, Aetna, and Humana also exited, leaving only a single BCBS plan in each state. Three of the five states experienced substantially higher annual premium increases than the national average. Policy options with bipartisan support, such as resuming cost-sharing reduction payments and reestablishing reinsurance and risk corridors, could help attract new or returning issuers to marketplaces in these states.

KEY TAKEAWAYS

- ▶ Five rural states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — had only one issuer participating in their health care marketplaces in 2017, which limited consumer choice and insurer competition.
- ▶ From 2014 to 2017, three of the five single-issuer states had much higher rates of annual premium increases than the federally facilitated marketplace average.
- ▶ Some states are implementing measures such as reinsurance programs to help stabilize their individual markets.

BACKGROUND

Uncertainty over the Trump administration's approach to the Affordable Care Act marketplaces and the repeal of the individual mandate penalties has increased fears of insurers exiting the marketplaces. This action would in turn create a lack of competition and, potentially, an increase in premiums because of adverse selection. In 2017, while some states had just one insurer participating, others had more than 10. Similarly, some states experienced large premium increases while others saw small increases and, in some cases, even decreases.

This issue brief examines the five states — Alabama, Alaska, Oklahoma, South Carolina, and Wyoming — that had only one insurer participating in the marketplaces in 2017. Understanding the experiences of competition and consumer choice in these states may help policymakers strengthen and improve the stability of markets going forward.¹ We look at the history of the individual market in these five largely rural states beginning in 2010, before the passage of the ACA, and then track the entry and exit of issuers from the marketplaces from 2014 to 2017. Our analysis also examines how premiums changed over this time period as the number of issuers declined.

FINDINGS

Marketplace Entries and Exits

In 2010, before the law was passed, the individual markets were relatively concentrated in the five study states. Blue Cross and Blue Shield (BCBS) plans held more than 50 percent of the market in each state; Blue Cross and Blue Shield of Alabama held an 86 percent market share.²

Assurant and HealthMarkets competed in the individual markets in four states (Exhibit 1), but both have since left the individual market nationwide.^{3,4}

When the marketplaces became operational in 2014, Alabama, Alaska, and Wyoming each had just two issuers participating (Exhibit 2). Four issuers competed in South Carolina (two were Blue Cross corporate entities) and six competed in Oklahoma.⁵ Newly established co-ops competed in Oklahoma, South Carolina, and Wyoming.⁶ These plans originated in the ACA's Consumer Operated

and Oriented Plan Program, intended to encourage the creation of qualified nonprofit health insurers to compete in the individual and small-group markets.

Co-ops had the largest 2014 enrollment in South Carolina and Wyoming (Consumers' Choice Health Plan and WINhealth Partners, respectively) and a Medicaid managed care plan, Moda Health, had the largest enrollment in Alaska (Exhibit 3). Two of these three plans also had the lowest premiums for silver plans, and Consumers' Choice was within a few dollars of the least expensive option. In 2015, Moda and Consumers' Choice retained the largest market shares in their states; WINhealth Partners held a 41 percent market share in Wyoming. In South Carolina and Wyoming, the co-op underpriced the BCBS plans by 13 percent and 15 percent, respectively. In Alaska in 2014, Moda underpriced BCBS by 10 percent. In Alabama and Oklahoma, BCBS was price-competitive with the other issuers that year, and retained a dominant market share.

In 2015, the number of issuers competing in each state changed little, but in 2016, participation declined (Exhibit 2). Co-ops went out of business in Oklahoma, South Carolina, and Wyoming. In most states throughout the country, co-ops lacked the capital to sustain financial losses from a sicker-than-expected enrollee population. Legislation passed by Congress required that the law's risk-corridor program (which was designed to help protect insurers against very large financial losses) be budget neutral. This left issuers with less than one-third of the funds they had expected to be available.⁷ In South Carolina, Coventry was acquired by Aetna.⁸ UnitedHealthcare entered the Oklahoma and South Carolina marketplaces.

In 2017, participation declined even further. National commercial issuers UnitedHealthcare, Aetna, and Humana exited the marketplaces in the study states (as well as in other states across the nation). Specifically, UnitedHealthcare left Alabama, Oklahoma, and South Carolina; Aetna exited from South Carolina; and Humana departed from Alabama. In Alaska, Moda Health left the marketplace after the state insurance department restricted its ability to sell insurance because of solvency concerns.⁹

Exhibit 1. Insurer Marketplace Participation in Five Study States, 2010–2017

State	2010*	2014	2015	2016	2017
Alabama	BCBS of Alabama	BCBS of Alabama	BCBS of Alabama	BCBS of Alabama	BCBS of Alabama
		Humana	Humana UnitedHealthcare	Humana UnitedHealthcare	
Alaska	Premera BCBS of Alaska	Premera BCBS of Alaska	Premera BCBS of Alaska	Premera BCBS of Alaska	Premera BCBS of Alaska
	UnitedHealthcare Assurant	Moda Health Plan	Moda Health Plan	Moda Health Plan	
	Aetna				
	HealthMarkets				
Oklahoma	BCBS of Oklahoma	BCBS of Oklahoma	BCBS of Oklahoma	BCBS of Oklahoma	BCBS of Oklahoma
	UnitedHealthcare Assurant	GlobalHealth	GlobalHealth	UnitedHealthcare	
		CommunityCare of Oklahoma	CommunityCare of Oklahoma		
		Coventry Health and Life			
		Coventry Health Care of Kansas			
	Aetna				
South Carolina	BCBS of South Carolina	BCBS of South Carolina	BCBS of South Carolina	BCBS of South Carolina	BCBS of South Carolina
	UnitedHealthcare Assurant	BlueChoice HealthPlan	BlueChoice HealthPlan	BlueChoice HealthPlan	
	BlueChoice HealthPlan	Consumers' Choice Health Plan	Consumers' Choice Health Plan	Aetna	
		Coventry Health Care of the Carolinas	Coventry Health Care of the Carolinas	UnitedHealthcare	
Wyoming	BCBS of Wyoming	BCBS of Wyoming	BCBS of Wyoming	BCBS of Wyoming	BCBS of Wyoming
	UnitedHealthcare Assurant	WINhealth Partners	WINhealth Partners		
	HealthMarkets				

* All state marketplaces included a number of miscellaneous legacy insurers in 2010 — we list only carriers with at least a 5 percent share of the market. Data: April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE); and Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Exhibit 2. Number of Participating Marketplace Insurers in Five Study States, 2014 to 2017

Year	Alabama	Alaska	Oklahoma	South Carolina	Wyoming	National average
2010 (pre-ACA)*	1	5	3	4	4	3.8
2014	2	2	6	4	2	7
2015	3	2	3	4	2	7
2016	3	2	2	4	1	7
2017	1	1	1	1	1	7

* All state marketplaces included a number of miscellaneous legacy insurers in 2010 – we list only carriers with at least a 5 percent share of the market. Data: April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE); and Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Exhibit 3. Market Share and Silver Plan Premiums in Five Study States, 2014 and 2015

State	Insurer	2014 market share	2015 market share	2014 premium, silver plan	2015 premium, silver plan
Alabama	BCBS of Alabama	95.2%	75.7%	\$253	\$274
	Humana	4.8%	5.2%	\$254	\$263
	UnitedHealthcare	—	19.1%	—	\$278
Alaska	Premiera BCBS of Alaska	42.1%	27.2%	\$456	\$620
	Moda Health Plan	57.9%	72.8%	\$410	\$518
Oklahoma	BCBS of Oklahoma	90.0%	97.5%	\$245	\$258
	GlobalHealth	3.7%	1.1%	\$250	\$289
	CommunityCare of Oklahoma	0.4%	1.2%	\$343	\$315
	Coventry Health and Life	0.0%	—	\$306	—
	Coventry Health Care of Kansas	5.7%	—	\$234	—
	Aetna	0.3%	—	\$350	—
South Carolina	BCBS of South Carolina	22.2%	19.2%	\$322	\$308
	BlueChoice HealthPlan	5.4%	23.1%	\$317	\$302
	Consumers' Choice Health Plan	52.1%	42.4%	\$280	\$285
	Coventry Health Care of the Carolinas	20.3%	15.1%	\$276	\$295
Wyoming	BCBS of Wyoming	24.0%	59.2%	\$489	\$457
	WINhealth Partners	76.0%	40.8%	\$417	\$453

Note: Premium prices are for individual coverage for a 40-year-old nonsmoking adult.

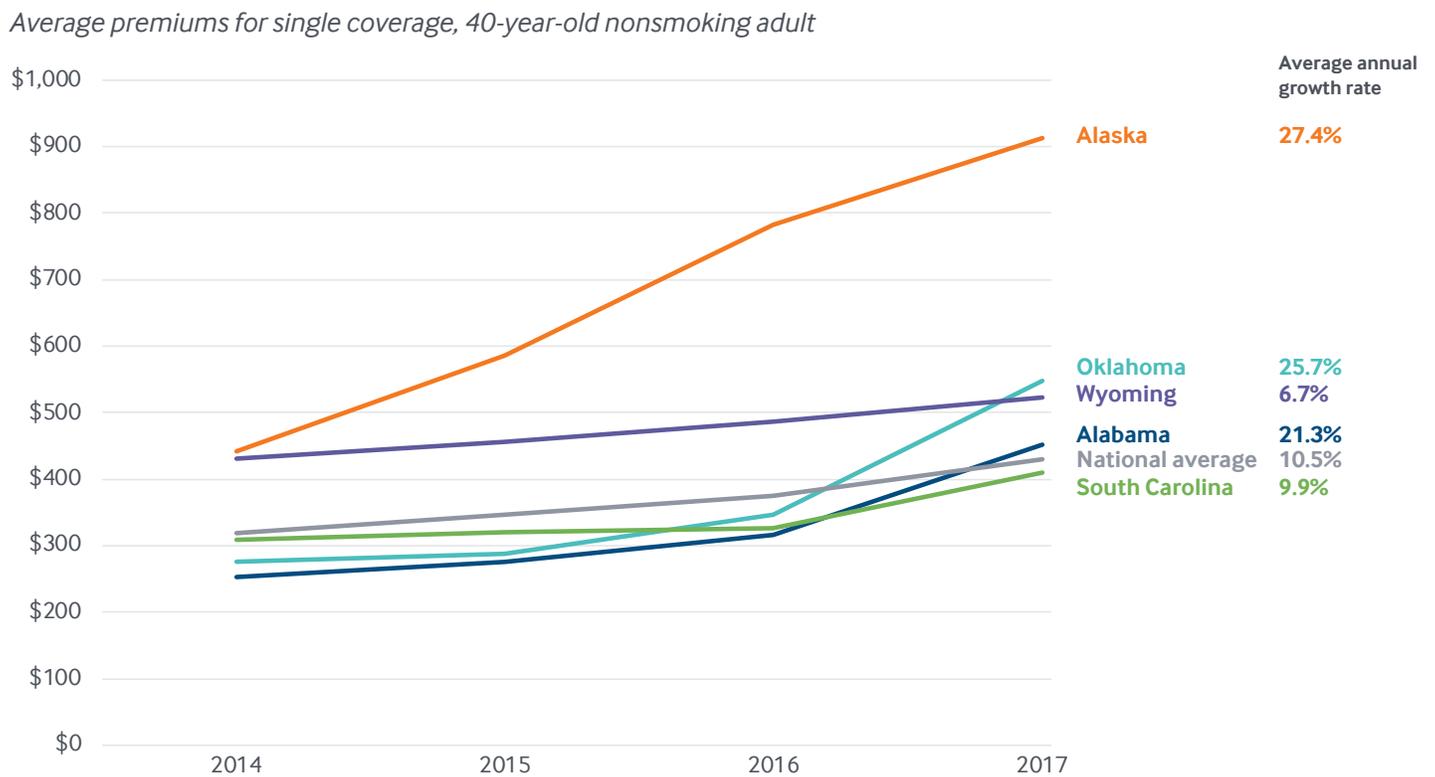
Data: Center for Consumer Information and Insurance Oversight, *Issuer Level Enrollment Data, 2014 and 2015* (CCIIO, n.d.); and Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

Trends in Premiums

The average annual premium increases from 2014 to 2017 in three of five study states substantially outpaced the national average (Exhibit 4). Alabama averaged 21 percent annual increases, and Alaska and Oklahoma had 27 percent and 26 percent increases, respectively. The average annual premium increase nationwide was

11 percent. Wyoming was the sole single-issuer state with annual premium increase growth (7%) below the national average, while South Carolina was nearly the same as the national average. Premium increases were particularly large from 2016 to 2017 in Alabama (43%) and Oklahoma (58%).¹⁰ In these two states, BCBS controlled overwhelming shares of the market for all study years.

Exhibit 4. Average Statewide Marketplace Premiums for Silver Plans in Five Study States, 2014 to 2017



Note: All premium figures weighted by population of the geographic rating area in which the plan is sold.
 Data: Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017).

CONCLUSIONS AND NEXT STEPS

The five study states, which were all left with a single issuer by 2017, experienced similar cycles from 2014 to 2017. In 2010, before passage of the ACA, the individual insurance market was already concentrated in all five states. By 2014, two insurers, Assurant and HealthMarkets, which each had a presence in four states, left the health insurance business. In 2015, participation held steady in four of the five states. In 2016, co-ops, facing bankruptcy, left the marketplaces in these states. In 2017, citing large financial losses, large national issuers UnitedHealthcare, Aetna, and Humana exited these marketplaces. Despite the withdrawal of these three large insurers, a 2017 report from Standard & Poor's observed trends toward stabilization in the individual health insurance market, but noted that these markets still need more time to mature.¹¹

From 2014 to 2017, three of the five single-issuer states experienced substantially higher rates of annual premium increases than the federally facilitated marketplace average. The other two states had rates comparable to the nationwide figure. Limited competition was a likely factor behind the higher premium increases.^{12,13} In addition, the elimination of many lower-cost options, with co-ops exiting the market, also contributed to larger premium increases. Moreover, none of these states opted to expand Medicaid, so they may have experienced adverse selection as individuals with incomes between 100 percent and 138 percent of poverty enrolled in the marketplaces. States that did not expand Medicaid had marketplace premiums that were 7 percent higher than states that did.¹⁴ Generally speaking, lower-income people have poorer health status than moderate- and high-income people.¹⁵

Historically, competition among issuers in the five single-issuer states — and in rural states generally — has been limited. In these states, marketplace enrollees have less choice, and, in many cases, the approximately 20 percent of enrollees who are not eligible for premium tax credits have higher premium costs. But the experience and policies of other states offer insights and ideas that could help. For example, Minnesota recently enacted its own

reinsurance program, and state officials and issuers there have stated that premiums for 2018 are 20 percent lower as a result.¹⁶ Federal programs to reestablish risk corridors, or reimburse issuers for previous losses under the program, could also reduce premiums and make market entry more appealing.¹⁷ And resuming cost-sharing reduction payments to issuers also could help to encourage participation and foster lower premiums.¹⁸ Many of these proposals have bipartisan support in Congress.¹⁹

The measures Congress legislated to ensure issuer participation in the Medicare Part D prescription drug program could be extended to the marketplaces, as some have also suggested.²⁰ Under such a plan, if no issuers participate in a county, the U.S. Department of Health and Human Services would contract with an issuer to administer a plan. Alternatively, the two largest insurers participating in the Federal Employees Health Benefits (FEHB) Program in the county could be required to offer a silver plan. This participation would be a requirement for the plans to be included in the FEHB Program.²¹ Insurers regard FEHB as providing high value, given the program's very large enrollment; in fact, every U.S. county has at least one participating plan.

In 2017 and 2018, the Trump administration and Congress took a number of actions to scale back the ACA that could also potentially affect the stability of the marketplaces. These include: 1) repealing the individual mandate penalties, which is projected to increase the number of uninsured Americans by 13 million by 2027; 2) ending funding for cost-sharing reduction payments; and 3) proposing new rules that would increase the proliferation of association health plans and short-term insurance policies that do not meet many ACA requirements, such as essential health benefits.²² The effect of these changes on issuer participation and premiums likely will be the focus of future research. Measures to increase choice and market competition, or to reduce premiums, will require legislative or administrative changes, or both. States also could take steps — as Alaska, Minnesota, and Oregon have done — to establish reinsurance programs to stabilize the individual market.^{23,24}

HOW WE CONDUCTED THIS STUDY

Our primary data source is the Robert Wood Johnson Foundation's HIX Compare, which provides national data on the marketplaces from 2014 to 2017.^a Data elements include premiums, deductibles, and out-of-pocket limits. A second database used in the study is the April 2011 National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) that provides names of issuers offering coverage in each state in 2010 in the individual market. Lastly, we used the Center for Consumer Information and Insurance Oversight (CCIIO) Issuer Level Enrollment Data for 2014 and 2015.

In our analysis of trends from 2014 to 2017, readers should be aware that these calculations are heavily dependent on the premiums and cost-sharing requirements of the remaining issuer in 2017. In all five states this issuer is the local Blue Cross Blue Shield plan.

The HIX Compare dataset presents premium information for single enrollees at age 27 and age 50 and for family enrollees with adults at age 30. In order to present consistent estimates by age group, all premium figures were scaled to reflect 40-year-old adults, using both federal and state-specific age-rating ratios.^b

We use weighting to present estimates to provide a more accurate picture of the market as a whole. Using simple averages would treat all premium changes equally, even if they occur among plans that have low enrollment or are offered in areas with low population. We chose to weight premium and cost-sharing figures by the population of the rating area in which the plan is sold. The CCIIO has released plan-level enrollment data in states with federally facilitated marketplaces for 2014 and 2015, but since these data were not available for all plan years, we did not use them to calculate premium or cost-sharing figures. We did use them, however, to calculate market share information in 2014 and 2015.

^a Robert Wood Johnson Foundation, *HIX Compare 2014–2017 Datasets* (RWJF, April 26, 2017). Data from the state-based marketplaces had not yet been made public when this issue brief was written.

^b Center for Consumer Information and Insurance Oversight, *Market Rating Reforms: State-Specific Age Curve Variations* (CCIIO, Aug. 9, 2013, updated May 2, 2017).

NOTES

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