ACA Implementation—Monitoring and Tracking

The Launch of the Affordable Care Act in Selected States:

Insurer Participation, Competition, and Premiums

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John Holahan and Rebecca Peters, The Urban Institute
Kevin Lucia, Georgetown University Health Policy Institute

Robert Wood Johnson Foundation

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, Illinois, 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. Cross-cutting reports and 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

This brief is one in a series examining what selected states are likely to accomplish in terms of implementing the Affordable Care Act (ACA): expanding health insurance coverage; providing outreach, education, and enrollment assistance; increasing competition in individual and small group insurance markets; reforming insurance market rules; and addressing issues related to provider supply constraints. In this series, we compare eight states: five that have chosen to aggressively participate in all aspects of the ACA; Colorado, Maryland, Minnesota, New York, and Oregon) and three that have taken only a limited or no participation approach (Alabama, Michigan, and Virginia). The focus of this brief is how states have encouraged insurer participation in the individual Marketplaces, the number and types of insurers participating, and the premiums that are available for silver plans in a number of markets in each state.

The study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides in-kind technical support to states to assist them with implementing the reform components each state has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. RWJF selected these states based on their governments' interest in exploring the options related to state involvement in ACA implementation. Some of these states pursued implementation aggressively, but in others varying degrees of political opposition to the law prevented full involvement. The result is that the variation in state commitment to health reform among the RWJF states reflects the same variation seen nationally.

Colorado, Maryland, Minnesota, New York, and Oregon have been actively pro-reform. They were quick to adopt the ACA, including engaging stakeholders and investing in consumer outreach and education. They contracted with information technology vendors to develop eligibility and enrollment systems, though Maryland and Oregon have not seen a smooth rollout of their websites. These states have created State-Based Marketplaces (SBMs) and have adopted the Medicaid expansion.

In the other three states—Alabama, Michigan, and Virginia—there has been strong opposition to ACA implementation, at least in some quarters. Because of their current circumstances (e.g., lower rates of employer-sponsored coverage and higher uninsurance rates), they have more to gain from health reform than do the other five states. All three rely on the federal government to develop and run their Marketplaces—Federally Facilitated Marketplaces (FFMs)—although Michigan and Virginia have taken on the Marketplace responsibilities associated with plan management. All rely on the federal website, but even as the website problems are resolved, these states still will have fewer resources to devote to outreach, education, and enrollment assistance.

OVERVIEW

One of the goals of the Health Insurance Marketplaces in the ACA is to increase the amount of price competition among health insurers. Under the health reform law, Marketplaces will be established in every state to provide multiple coverage options to individuals through one organizing entity that sets uniform rules for participating health insurers and plans. Although the ACA does not require health insurers to participate in individual Health Insurance Marketplaces, it allows states and the federal government to take additional steps to encourage insurer participation.

Much of the design of the ACA has its roots in the theory of managed competition. Most notably, the ACA limits the availability of premium tax credits and individual cost-sharing subsidies to health plans purchased through Marketplaces.[1] Moreover, it ties the premium tax credits to the cost of the second lowest cost silver plan offered in Marketplaces.[2] Assuming that individuals are price-conscious and seek to avoid paying additional amounts above the caps, insurers will have incentives to develop Marketplace products so they can compete to be the second-lowest cost plan offered in the market. In this section, we review the results of efforts to encourage insurer participation and the level of competition and premiums in individual Marketplaces in each of the eight study states.

State Action to Encourage Plan Participation

The ACA does not require health insurers to participate in individual Health Insurance Marketplaces, but rather relies on voluntary incentives. Some of the SBM states went further in requiring or encouraging participation in the Marketplaces. In addition, most of the study states implemented Marketplace standards that provided considerable flexibility to insurers in critical areas, such as service area requirements, network adequacy standards, and limitations on the number of plans offered.

State-Based Marketplaces

States that created State-Based Marketplaces often adopted regulatory mechanisms to require or encourage participation.[3] For example, Maryland required insurers to participate in the Marketplace if they met an aggregated revenue threshold.[4,5] Other states, including Colorado,[6] New York,[7] and Oregon,[8] instituted a waiting period for insurers that choose not to participate in the Marketplace in 2014—for example, insurers could have to wait two years before participating.

In addition, insurers were given considerable flexibility on a number of standards that could affect the decision to participate in the Marketplaces, including service area requirements and network adequacy standards (Figure 1).

Most states were concerned about ensuring sufficient insurer participation and consistently made efforts to avoid design features that insurers could perceive as causing market disruption or limiting competition, especially during the first years of implementation.[11] Although states could impose further standards, in general, the SBM states either adopted the federal minimum standards or implemented additional ones that also provided considerable flexibility to insurers (Figure 2).

For example, with regard to service area requirements, the SBM states are generally providing insurers with significant flexibility to decide in which regions of the state to offer coverage.[12] In Maryland, for example, the service area

Figure 1. Federal Minimum Standards That Apply to Qualified Health Plans (QHPs)

Network Adequacy Standards	QHPs must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay.[9]
Service Area Requirements	QHP's must maintain a service area that covers a minimum geographical area at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers; and the service area has been 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.[10]
Limit on Number of Plans or Plan Designs	Insurers may offer an unlimited number of plans through the Marketplace, however, QHPs must 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 must be offered by all participating insurers.

Figure 2. Standards That Apply to QHPs in Select State-Based Marketplaces in 2014

State	Network Adequacy	Service Area Requirements	Limits on Number of QHPs or Plan Designs
Colorado	Federal standard, plus applying existing state managed care plan standards	Full county; exceptions allowed	No limit on number of QHPs; no requirement to offer standardized plans
Maryland	Federal standard	Service area must match outside market (existing insurers); full county (new insurers)	No more than four plans per metal tier per licensed entity; no requirement to offer standardized plans
Minnesota	Federal standard, plus applying existing state HMO standards	Full county; exceptions allowed	No limit on number of QHPs; no requirement to offer standardized plans
New York	Federal standard, plus applying existing state HMO standards	Service area must match outside market; exceptions allowed	No more than three nonstandardized plans per metal tier per service area; requirement to offer certain standardized plans
Oregon	Federal standard	Service area must match outside market; exceptions allowed	No more than three plans (one standard and two non-standard plans) per metal tier per service area with option to offer two additional innovative plans per metal tier per service area; requirement to offer certain standardized plans

of an existing insurer offering through the Marketplace must be consistent with its service area outside the Marketplace. Given this approach, informants generally felt that service areas would resemble what they looked like prior to the ACA.

The SBM states also provided insurers with significant flexibility in establishing their networks. Similar to service area rules, the SBM states either implemented the federal minimal standard, like Oregon, or adopted an existing state standard rather than setting new, more expansive standards.[13] For example, New York applied its existing HMO network adequacy standard to all QHPs (outside the Marketplace, it will continue to apply to only 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.

Three of the SBM states—Maryland, New York, and Oregon—placed standards that would limit the number of plans that insurers offer on the Marketplace and required them to offer certain standardized benefit designs.[14] However, these requirements still provided insurers with significant flexibility to offer an array of plans. For example, in New York and Oregon, insurers are required to offer a range of standardized plans and are also allowed to offer a limited number of nonstandardized plans: in New York, insurers are required to offer one standardized plan at each metal tier but are still permitted to offer a maximum of three nonstandardized plans at each tier; in Oregon, insurers are limited to three plans per metal tier other than platinum—one standardized plan and two nonstandardized plans—with the option of offering two additional “innovative” plans per tier in each service area.

Federally Facilitated Marketplaces

For 2014, the federal government chose not to implement incentives beyond those inherent in the ACA for federal facilitated individual Marketplaces (Figure 1). In addition, in developing standards for the FFMs, the federal government followed the federal minimal standards on the critical standards noted above, including service area requirements, network adequacy standards, and limits on the number of plans.

To the extent that a state was performing plan management functions on behalf of the FFM, such as in Michigan and Virginia, the law permitted the states to implement rules that were more stringent than the above standards. However, each of the three FFM study states, at least in these critical areas, generally defaulted to the federal standards or implemented an existing state standard that otherwise met the federal standard. Overall, these conditions have encouraged insurer participation in both SBM and FFM states.

INSURER PARTICIPATION

A significant number of insurers are participating in most Marketplaces in both SBM and FFM states. Participating insurers include many of the dominant existing commercial insurers and often new entrants to the commercial market, such as new nonprofit CO-OPs and Medicaid managed care plans.

SBM States

In the SBM study states, a significant number of insurers are participating in the Marketplaces. For example, 17 insurers in New York, 11 in Oregon, and 10 in Colorado were offering plans in at least some markets (Table 1).

In these states, many of the dominant insurers in the existing individual group market are participating in the individual Marketplace. Blue Cross or Anthem participate in almost all markets, though the products offered—Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO)—vary. An exception is in Oregon, where the largest insurer in the individual market, Regence Blue Cross Blue Shield, is not participating in the Marketplace, although Bridgespan—a subsidiary of Regence—is participating. In Colorado, Assurant and UnitedHealthcare, insurers with significant market share in the individual market, are not participating. Local and regional commercial insurers such as Moda, Lifespan, and Pacific Source in Oregon; Emblem and Oscar in New York; and Health Partners, Medica, and Preferred One in Minnesota are all major competitors in the Marketplaces.

With the exception of Minnesota, each of the study states will have a new entrant to the commercial market participating in the Marketplaces. In Colorado, New York, and Oregon, Medicaid MCOs are participating in the

Table 1. Insurers and Silver Plans by States and Number of Counties Served—SBM Study States

Insurer Name	Type of Products Offered	Number of Counties or County-Equivalents Where Insurer Is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)
Colorado (10 insurers statewide)			
Access Health Colorado	PPO	64 of 64	2
Anthem Blue Cross and Blue Shield	HMO	64 of 64	5
Cigna	PPO	6 of 64	5
Colorado Choice	HMO	30 of 64	5
Colorado HealthOP	EPO/PPO	64 of 64	2
Denver Health	HMO	3 of 64	2
Humana	HMO	12 of 64	2
Kaiser Permanente	HMO	23 of 64	3
Rocky Mountain Health Plans	HMO/PPO	64 of 64	12
UnitedHealthcare	EPO/PPO	48 of 64	2
Maryland (5 insurers statewide)			
All Savers/UnitedHealthcare	EPO	24 of 24	4
CareFirst Blue Choice	HMO/POS	24 of 24	3
CareFirst Blue Cross Blue Shield (MSP)	PPO	24 of 24	1
Evergreen	HMO/POS	24 of 24	4
Kaiser Permanente	HMO	24 of 24	3
Minnesota (5 insurers statewide)			
Blue Cross Blue Shield of Minnesota	PPO	87 of 87	2
HealthPartners	PPO	69 of 87	2
Medica	PPO	83 of 87	12
Preferred One	PPO	72 of 87	6
UCare	HMO	23 of 87	2

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Table 1. Insurers and Silver Plans by States and Number of Counties Served—SBM Study States *continued*

Insurer Name	Type of Products Offered	Number of Counties or County-Equivalents Where Insurer Is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)
New York (17 insurers statewide)[15]			
Affinity Health Plan	HMO	10 of 62	2
Blue Shield of New York*	EPO	20 of 62	4
CDPHP, Inc.	HMO	24 of 62	4
Emblem Health	HMO	10 of 62	1
Empire Blue Cross Blue Shield	HMO	28 of 62	3
Excellus Blue Cross Blue Shield	EPO	31 of 62	2
Fidelis Care	HMO	44 of 62	1
Healthfirst	HMO	6 of 62	1
Health Republic Insurance of New York	EPO	32 of 62	3
Independent Health	POS	8 of 62	3
MetroPlus Health Plan	HMO	4 of 62	2
MVP Health Care	HMO	47 of 62	4
Northshore LIJ	EPO	4 of 62	1
Oscar	EPO	9 of 62	3
Today's Options of New York	HMO	37 of 62	2
UnitedHealthcare	EPO	13 of 62	1
Univera	EPO	8 of 62	2
Oregon (11 insurers statewide)			
Atrio Health Plans	EPO/PPO	4 of 36	2
BridgeSpan	PPO	36 of 36	1
HealthNet	POS	3 of 36	3
Health Republic	EPO	36 of 36	3
Kaiser Permanente	HMO	9 of 36	3
LifeWise	PPO	36 of 36	3
Moda	PPO	36 of 36	5
Oregon's Health CO-OP	PPO	18 of 36	2
PacificSource	PPO	35 of 36	7
Providence	EPO	25 of 36	5
Trillium	PPO	8 of 36	1

Note: HMO is "Health Management Organization", PPO is "Preferred Provider Organization", POS is "Point of Service", EPO is "Exclusive Provider Organization"

**Blue Shield of New York includes Blue Cross Blue Shield of Western New York and Blue Shield of Eastern New York*

Marketplaces. In New York, these are having a significant effect in the market as we will discuss below. A number of the study states took action to facilitate these plans' participation in the Marketplaces. For example, in Oregon, officials reported streamlining the process to transfer Medicaid licenses to commercial licenses, in order to remove potential barriers to Medicaid MCOs participating in the Marketplace. In four of the study states—Colorado, Maryland, New York, and Oregon—CO-OPs are offering products in the Marketplaces. Informants in a number of the study states noted that, similar to the situation with Medicaid MCOs, states took action to encourage CO-OP participation in the Marketplaces.

FFM States

In two of the FFM study states, Michigan and Virginia, a robust number of insurers are participating in the Marketplaces (Table 2). For example, we find that 10 insurers in Michigan and 9 in

Table 2. Insurers and Silver Plans by States and Number of Counties Served—FFM Study States

Insurer Name	Type of Products Offered	Number of Counties or County-Equivalents Where Insurer Is Offering Plans	Number of Silver Plans Offered Statewide by Insurer (not including "child only" plans)
Alabama (2 insurers statewide)			
Blue Cross and Blue Shield of Alabama	PPO	67 of 67	2
Humana Insurance Company	PPO	3 of 67	1
Michigan (10 insurers statewide)			
Blue Care Network of Michigan	HMO	70 of 83	3
Blue Cross Blue Shield of Michigan (MSP)	PPO	83 of 83	2
Consumers Mutual Insurance of Michigan	PPO	47 of 83	2
HAP	HMO/PPO	23 of 83	2
Humana Medical Plan of Michigan, Inc.	HMO	3 of 83	1
McLaren Health Plan, Inc.	HMO	28 of 83	1
Meridian Choice	HMO	3 of 83	1
Molina Marketplace	HMO	3 of 83	1
Priority Health	HMO/PPO	70 of 83	8
Total Health Care USA, Inc.	HMO	4 of 83	1
Virginia (9 insurers statewide)			
Aetna	PPO	50 of 133	2
Anthem Blue Cross and Blue Shield	HMO	130 of 133	4
Anthem Health Plans of Virginia (MSP)	HMO	130 of 133	1
CareFirst Blue Choice, Inc.	HMO/POS	7 of 133	3
CareFirst Blue Cross Blue Shield (MSP)	PPO	7 of 133	1
CoventryOne	POS	26 of 133	6
Innovation Health Insurance Company	PPO	6 of 133	4
Kaiser Permanente	HMO	20 of 133	3
Optima Health	HMO	111 of 133	1

Virginia are offering plans in at least some markets. In Alabama, only two insurers are participating in the individual Marketplace, one of which is Blue Cross Blue Shield of Alabama (BCBSAL). However, BCBSAL has long maintained about 90 percent of this market and is participating in every county. The other insurer, Humana, is only offering products in three counties, including the Birmingham area. This arrangement reflects the reality in the existing individual market, where BCBSAL and Humana hold virtually the entire market.

In Michigan, Blue Cross Blue Shield of Michigan, the largest plan in the existing individual market, is participating in the Marketplace and is offering a multistate plan statewide. However, UnitedHealthcare and Assurant, insurers that also maintain a smaller but significant share of the individual market today, are not participating. New entrants to the commercial market include Molina, a Medicaid HMO, and Consumers Mutual Insurance of Michigan, a nonprofit CO-OP. Blue Cross is offering its HMO product and Priority Health are each offering plans in 70 of 83 counties. Several insurers are offering all or almost all of their plans in the Detroit market; Humana, Molina, Meridian Choice, and Total Health Care USA. Meridian Choice is also offering products in several counties in the Kalamazoo area.

The Virginia Marketplace also features a robust list of participating insurers. These insurers include most of the major insurers in the existing individual market, with the notable exception of UnitedHealthcare. Anthem is offering its HMO product throughout the state, except in several counties in Northern Virginia where there would be direct competition with CareFirst. Optima Health is also competing in most of the state with the notable exception of Northern Virginia. Aetna is competing in about one-third of the state's markets, including Richmond and Roanoke, and is collaborating with the Inova hospital system to offer a plan in Northern Virginia.

INSURER COMPETITION AND PREMIUMS

In this section, we review insurer competition and the premiums that have resulted in selected Marketplaces in both the SBM and FFM states. We examined three different markets (four in New York and Virginia) within each state, typically the largest city or county, another major city or county, and a rural area. We focus on the premiums of the lowest cost plans bid by the three lowest cost insurers in each market.

In general, we find plans available in the individual Marketplaces in both the SBM and FFM states to be attractively priced. It can be difficult or misleading to make comparisons between plans offered in the new individual Marketplaces and plans that currently exist in the individual market, where there is great variation. In the existing individual market, premiums can be low for policies with limited benefits and/or because risk pools contain largely healthy people. People in these circumstances may see premiums increase, though many will receive subsidies that will keep their costs relatively low. Many other individuals may currently face high premiums or may be effectively unable to purchase coverage because of health status or age.[16] In tables 3 and 4 below, we compare the lowest cost silver plans to average pre-ACA premiums in the small employer market.

As discussed earlier, the ACA sets up strong incentives for insurers to bid aggressively in Health Insurance Marketplaces. The subsidies for those with incomes below 400 percent of the federal poverty level (FPL) are tied to the second-lowest cost plan in each area of a state. Individuals who choose to purchase a plan that is more expensive than the second-lowest cost silver plan, either a higher-cost silver plan or a gold or platinum plan, will be required to pay the full difference out-of-pocket. No subsidies are available for costs beyond the premium of the second-lowest cost silver plan. Because of this, insurers have incentives to price products competitively to achieve the second-lowest cost position.

The incentive to bid low has led to surprising outcomes across both the SBM and FFM study states, not only through relatively low premiums, but also which insurers offered the most competitive premiums. There are several instances in which Blue Cross–affiliated plans, including Anthem and CareFirst, are the lowest cost plans, sometimes with more limited networks than their commercial products. But more often, Blue Cross–affiliated plans are priced significantly above the second-lowest cost plans. UnitedHealthcare has declined to participate in many states' Marketplaces, and in most instances where they did participate, they submitted very high premiums (e.g., New York). Similarly, Aetna bid high in many Marketplaces where it participated, rendering itself uncompetitive in most markets.

There has been a significant presence of local commercial plans in the SBM study states such as Colorado, Minnesota, and Oregon, and many of these plans have offered competitively priced plans. Similarly, several local commercial plans are important participants in Michigan, an FFM state. Medicaid plans have also participated in several study states. Medicaid plans offered products at a variety of prices: they were the lowest cost bidder in several regions in New York, but were significantly costlier than the lowest cost offerings in many other states. Lastly, CO-OP plans exist in several states. They are the lowest bidder in some markets in New York, although there has been concern that they may not have sufficient capacity to provide care to a large number of individuals. The CO-OPs were among the highest-priced plans in Colorado, Michigan, and Oregon.

Tables 3 and 4 show the lowest cost insurers in three regions (four in New York and Virginia) in each of the study states. We also show the average pre-ACA premiums for nonelderly adults in small employer plans in these areas. As noted earlier, individual market premiums are not optimal for comparison, because information on benefit packages and risk pooling varies significantly. Small group premiums reflect many of the same issues seen in the individual market but to a somewhat lesser degree: high administrative costs, limited benefits, and high cost-sharing. Further, most states chose their most enrolled small group plans as the essential health benefits benchmark for the ACA-compliant nongroup and small group markets. In each case, the lowest cost silver plans are offered at premiums that are significantly below the cost of a pre-ACA small employer plan. This could reflect higher deductibles in silver plans.

One outcome from increased competition has been the development of narrow network plans consisting of providers willing to accept lower payment rates for health insurance Marketplace products. In previous work, respondents indicated that some plans felt pressure to negotiate lower provider payment rates and use narrower networks in their commercial products to be competitive. This has led to lower premiums, but the adequacy of these networks could become problematic.

In the discussion below, we summarize key patterns in each study state, starting first with the SBM states, and then following with observations from the FFM states.

State-Based Marketplaces

In each of the SBM study states, market competition has resulted in reasonably priced premiums in the new Marketplaces. Among these five states, the premiums for the lowest cost insurers are in Minnesota, followed closely by Maryland and Oregon (Table 3). New York's rates are not easily comparable because of the state's full community rating. In general, there is no consistent pattern in premium pricing across regions within a state, with the exception of Colorado and New York, where premiums are often much higher in rural than in urban markets. In all five states, premiums of the lowest cost plans in each market are well below premiums in the small employer market. This could reflect differences in cost sharing and benefit packages but also almost certainly reflects the effects of enhanced market competition.

In Colorado, Humana and Kaiser Permanente along with a new CO-OP plan, Colorado HealthOP, offered the lowest cost plans in Denver. The largest insurer in the state, Anthem, along with other large carriers such as Rocky Mountain Health Plan and Cigna, offered plans in Denver with premiums substantially above those of Kaiser or Humana. Denver Health, a Medicaid plan, also offered plans at a lower cost than Anthem.

Surprisingly, premiums outside of Denver are more expensive than in Denver. The Grand Junction market is dominated by the Rocky Mountain Health Plan, which offered several plans with lower premiums than Anthem and two other insurers. Similarly, in rural San Juan County, Rocky Mountain Health Plan offered the lowest-premium plan. Anthem, UnitedHealthcare, and Access Health Colorado also participated but offered plans with substantially higher premiums.

In Maryland, premiums are lower than in Colorado. In Baltimore, CareFirst offered the lowest-priced products. The next-lowest-premium plans were offered by Blue Cross's multistate plan and Kaiser Permanente. The same pattern emerges in the Washington, DC, metropolitan area and in western Maryland. The lowest cost Kaiser Permanente health plan premium was slightly costlier than the Blue Cross products, but was still competitively priced. UnitedHealthcare, and the state CO-OP, Evergreen, had the highest premiums throughout the state. Aetna originally submitted a bid to participate in the state's Marketplace but chose to withdraw its bid before the Marketplace's opening.

Several local commercial insurers are participating in the Minnesota Marketplace, including Preferred One, Health Partners, and Medica. In each of the three study regions—Minneapolis, Duluth, and Red Lake County—Preferred One offered the lowest cost. Health Partners offered plans that were only slightly more expensive than Preferred One in each of these markets. Blue Cross Blue Shield of Minnesota offered plans whose premiums were higher in each region. Medica, another large commercial plan in the state, offered several plans but had the highest premiums.

In New York, there was substantial competition in Manhattan, Syracuse, Nassau County (Long Island), and rural Hamilton County. In Manhattan, Metro Plus Health Plan, a Medicaid plan, offered the lowest cost product. The second-lowest cost plan was offered by Health Republic, a CO-OP plan, followed by Oscar, a new commercial plan. Other Medicaid plans—Health First, Affinity Health Plan, and especially Fidelis—also offered competitive premiums. Empire Blue Cross Blue Shield offered plans with significantly higher premiums than plans offered by Metro Plus, Emblem, or Fidelis. Health Republic, the state's CO-OP, offered a low-cost plan, but many have expressed concerns about its provider capacity. In Nassau County, Fidelis Care was the lowest cost plan, followed closely by Health Republic and Empire Blue Cross Blue Shield. In Syracuse, the two lowest cost plans were Health Republic and Fidelis Care. The Excellus Blue Cross Blue Shield plan, the largest commercial plan in the region, was substantially more expensive. In rural Allegany County, Fidelis offered the lowest cost product by a significant margin, and offerings from Blue Cross and Univera were nearly $100 (per month) more expensive.

Insurers in Oregon offered several plans with very low premiums. In Portland, the second-lowest cost plan was Moda Health. Several insurers offered plans with premiums within 15 percent of Moda Health's lowest cost plan. A large number of local or regional health plans participated in the market. Individuals living in Portland could choose from plans from Moda Health, Health Net, Health Republic, Pacific Source, Kaiser Permanente, Lifewise, Providence, Bridgespan, and Oregon's Health CO-OP. Kaiser Permanente was not among the lowest cost options in any of the Oregon regions we studied, despite its significant market presence. Oregon's Health CO-OP offered some of the highest-priced products in both Portland and Eugene. Regence Blue Cross Blue Shield offered a plan, Bridgespan, that has a narrower network than its commercial product, but its premiums were significantly above those of Moda Health, Health Net, and Pacific Source health plans.

Table 3. Monthly Premiums for the Lowest Cost Silver Plan (Before Subsidies) for the Three Lowest Cost Insurers in Selected Regions—SBM Study States

State	Location	Insurer	Premium: 27-year-old	Premium: 50-year-old
CO	*Statewide*	*Pre-ACA Statewide Average*	*$440.50*	
	Denver	Kaiser Permanente	$208.52	$357.77
		Humana	$212.96	$365.36
		Colorado HealthOP	$232.10	$398.23
	Mesa (contains Grand Junction)	Rocky Mountain Health Plan*	$242.62	$416.27
		Anthem BCBS	$305.41	$524.01
		Colorado HealthOP	$346.88	$595.16
	San Juan County (rural)	Rocky Mountain Health Plan*	$286.22	$487.77
		Anthem BCBS	$330.52	$563.27
		Colorado HealthOP	$364.22	$620.70
MD	*Statewide*	*Pre-ACA Statewide Average*	*$451.50*	
	Baltimore	CareFirst Blue Choice*	$187.00	$319.00
		CareFirst BCBS (MSP)	$197.00	$335.00
		Kaiser Permanente	$221.27	$377.11
	Washington, D.C., Metro Area	CareFirst Blue Choice*	$174.00	$297.00
		CareFirst BCBS (MSP)	$183.00	$312.00
		Kaiser Permanente	$221.28	$377.11
	Western Maryland (rural)	CareFirst Blue Choice*	$172.00	$294.00
		CareFirst BCBS (MSP)	$181.00	$309.00
		Kaiser Permanente	$221.28	$377.11
MN	*Statewide*	*Pre-ACA Statewide Average*	*$445.83*	
	Duluth	PreferredOne*	$169.69	$289.18
		HealthPartners	$174.48	$297.35
		UCare	$191.31	$326.03
	Minneapolis	PreferredOne*	$126.21	$215.09
		HealthPartners	$135.99	$231.75
		Blue Cross Blue Shield of Minnesota	$150.72	$285.95
	Red Lake County (rural)	PreferredOne*	$140.18	$238.89
		HealthPartners	$154.77	$263.76
		Blue Cross Blue Shield of Minnesota	$164.48	$312.05
NY	*Statewide*	*Pre-ACA Statewide Average*	*$525.33*	
	Allegany County (rural)	Fidelis Care	$338.11	$338.11
		Blue Shield of Western New York	$425.88	$425.88
		Univera	$430.05	$430.05
	Nassau County	Fidelis Care	$360.00	$360.00
		Health Republic	$365.28	$365.28
		Empire Blue Cross	$384.34	$384.34
	New York County (contains Manhattan)	MetroPlus Health Plan	$359.26	$359.26
		Health Republic	$365.28	$365.28
		Oscar	$384.72	$384.72
	Onondaga County (contains Syracuse)	Health Republic*	$285.65	$285.65
		Fidelis Care	$341.34	$341.34
		MVP	$397.43	$397.43

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Table 3. Monthly Premiums for the Lowest Cost Silver Plan (Before Subsidies) for the Three Lowest Cost Insurers in Selected Regions—SBM Study States *continued*

State	Location	Insurer	Premium: 27-year-old	Premium: 50-year-old
OR	*Statewide*	*Pre-ACA Statewide Average*	*$430.83*	
	Eugene	Moda Health*	$175.00	$298.00
		Pacific Source Health Plans	$193.00	$330.00
		LifeWise	$208.00	$355.00
	Portland	Moda Health*	$159.00	$270.00
		HealthNet	$176.00	$300.00
		Providence	$192.00	$327.00
	Spray County (rural)	Moda Health*	$175.00	$298.00
		Health Republic	$190.00	$323.00
		LifeWise	$208.00	$355.00

*Note: *Issuer offered the two lowest-cost plans in the area noted*

***New York has full community rating and thus rates do not vary by age*

Source for Pre-ACA averages: MEPS (2012) Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State: Less than 50 Employees http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf

In each of the other Oregon markets we examined, the lowest cost plan was Moda Health. In Eugene, Pacific Source was a major competitor of Moda, as were Lifewise and Providence. Bridgespan, Oregon's Health CO-OP, and Trillium were the most expensive plans in Eugene. In rural Spray County, Moda Health was the lowest cost plan followed by Health Republic (one of two CO-OPs in Oregon), Lifewise, Providence (Medicaid), Pacific Source, and Bridgespan.

Federally Facilitated Marketplaces

We generally find premiums for adults in the markets of the FFM states, including Alabama, Michigan, and Virginia, to also be moderate (Table 4), well below premiums for individual workers in the small business group market prior to ACA implementation. The amount of insurance market competition varies across as well as within the three study states. In each of these markets, Blue Cross–affiliated plans (including Anthem) are often the lowest cost plans. Often UnitedHealthcare, which has a presence in all three states, did not bid or bid at relatively high rates that were essentially uncompetitive.

In Alabama, premium rates were relatively low, well below premiums in the small employer market. Blue Cross Blue Shield Alabama is the dominant carrier throughout the state (Table 2) and is offering plans statewide. Humana is participating in Birmingham and submitted a slightly lower bid in that market than did BCBSAL. Given its market power and few competitors, it is surprising that BCBSAL premiums are so low. This fact could reflect BCBSAL's strong bargaining power vis-à-vis providers.

In Michigan, individual premiums were also well below those in the small group market: Blue Cross Blue Shield was the first- or second-lowest cost plan in two of the three areas we examined, Ann Arbor and Keweenaw County. But BCBS was not the second-lowest cost plan in Detroit (Table 4). Both Humana and Total Healthcare USA (a small local plan) offered silver plans at lower premiums than did BCBS in that area. Other local commercial plans such as Health Alliance Plan (HAP), McLaren, and Priority Health also offered plans in the Detroit area but at significantly higher premiums. A major national Medicaid plan, Molina, also offered a plan in Detroit but at a premium well above those of Humana, Total Healthcare, or BCBS. The Consumers Mutual Insurance of Michigan, the state's CO-OP plan, had the highest bid in Detroit, as well as in Ann Arbor and Keweenaw County. Presumably, the CO-OP plan was unable to develop a provider network at favorable rates.

The competition to BCBS in Detroit is somewhat surprising but encouraging. However, the two lowest cost plans in Detroit do not appear to have bid in most other areas in the state. In Ann Arbor, the lowest cost plans were offered by BCBS. There were several other bidders, including Priority Health and HAP, but premiums were considerably higher than for the BlueCross HMO products. In rural Keweenaw County, BlueCross had no competition besides the CO-OP, and premiums were much higher than in the urban areas.

In Virginia, either Anthem or CareFirst is the dominant carrier in most parts of the state. Anthem offered the second-lowest cost plans in Richmond, Roanoke, and Highland County. Optima Health, a commercial and

Table 4. Monthly Premiums for the Lowest Cost Silver Plan (before subsidies) for the Three Lowest Cost Insurers in Selected Regions—FFM Study States

State	Location	Insurer	Premium: 27-year-old	Premium: 50-year-old
AL	*Statewide*	*Pre-ACA Statewide Average*	*$439.08*	
	Greene County (rural)	Blue Cross and Blue Shield of Alabama*	$183.78	$313.20
		-	-	-
		-	-	-
	Jefferson County (contains Birmingham)	Humana	$209.16	$356.46
		Blue Cross and Blue Shield of Alabama	$211.24	$360.00
		-	-	-
	Montgomery County	Blue Cross and Blue Shield of Alabama*	$198.57	$338.40
		-	-	-
		-	-	-
MI	*Statewide*	*Pre-ACA Statewide Average*	*$464.17*	
	Washtenaw County (contains Ann Arbor)	Blue Care Network of Michigan* (HMO)	$198.76	$338.73
		Blue Cross Blue Shield of Michigan (PPO)	$255.04	$434.64
		Priority Health	$256.99	$437.96
	Wayne County (contains Detroit)	Humana Medical Plan of Michigan, Inc.	$156.16	$266.14
		Total Health Care USA, Inc.	$183.75	$313.14
		Blue Care Network of Michigan	$198.76	$338.73
	Keweenaw County (rural)	Blue Cross Blue Shield of Michigan*	$274.02	$466.99
		Consumers Mutual Choice of Michigan	$337.08	$574.44
		-	-	-
VA	*Statewide*	*Pre-ACA Statewide Average*	*$449.92*	
	Fairfax City (Washington, D.C., area)	Innovation Health Insurance Company	$213.00	$362.00
		CareFirst Blue Choice	$222.97	$379.99
		Kaiser Permanente	$225.54	$383.55
	Highland County (rural)	Anthem BCBS*	$226.91	$386.70
		Anthem Health Plans of Virginia (MSP)	$241.55	$411.66
		Optima Health	$262.09	$446.66
	Richmond City	CoventryOne	$188.26	$320.84
		Anthem BCBS	$207.51	$353.65
		Anthem Health Plans of Virginia (MSP)	$220.90	$376.45
	Roanoke City	Optima Health	$221.34	$377.21
		Anthem BCBS	$234.62	$399.83
		Anthem Health Plans of Virginia (MSP)	$249.75	$425.62

*Note: *Insurer offered the two lowest cost plans in the area noted. MSP is multi-state plan*

Source for Pre-ACA averages: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2012 Medical Expenditure Panel Survey—Insurance Component. Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: Less than 50 employees http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf

Medicaid plan connected with the Sentara Hospital System, provided the only competition to Anthem in Highland County. In Richmond, Anthem faced competition from Optima, Aetna, and Coventry, but still offered the second-lowest cost plan. In Roanoke, Optima premiums were below those of Anthem, but Anthem maintained the position as the second-lowest cost plan. It should be noted that Anthem offered its HMO product—Health Keepers—in the Marketplace. Thus, the competition in most of Virginia was essentially between the HMO product of Optima and the HMO product of Anthem.

In the Northern Virginia market, there is considerably more competition. The rates in Northern Virginia were very low compared to small employer premiums. CareFirst, the BCBS plan in the Washington, DC, area, offers coverage in parts of Northern Virginia, and the remaining areas are covered by Anthem. The two carriers do not compete in the same geographic area. There are two other important competitors in Northern Virginia. The Innovation Health Insurance Company is a plan developed by Aetna and the Inova Hospital System. They tended to have very competitive rates and were often the lowest cost plan in several cities in Northern Virginia. This is presumably because other insurers could not negotiate payment rates as favorable as Innovation would pay hospitals in the Inova system. In most of the Northern Virginia markets—Alexandria, Arlington, and Fairfax—the Anthem or CareFirst product was the second-lowest cost plan but the Innovation product was often less expensive. Kaiser Permanente was also very competitive in Northern Virginia; it was the second-lowest cost plan in many areas, and was very close to the second-lowest cost plan in others.

In the various areas we investigated in these three FFM states, premiums were fairly low, similar to those observed in SBM states where states played a more active role in trying to stimulate competition. The presence of Anthem as the dominant insurer did not result in high premiums. This was particularly surprising in Alabama, given the insurer's market power. The threat of competition in several markets in Michigan seems to have kept the rates low, though premiums in rural parts of Michigan were quite high, reflecting the fact that BCBS clearly had no competition. In several markets in Virginia, Anthem BCBS had strong competition from Optima, a commercial and Medicaid plan connected to a large hospital system. Anthem offered its HMO product, one with a limited network and somewhat lower provider fees. As a result, Anthem was very competitive in all markets. In Northern Virginia the competition between the Anthem or CareFirst plans, the Aetna/Inova plan, and Kaiser Permanente served to keep rates at moderate levels.

CONCLUSION

One of the goals of the health insurance Marketplaces in the Affordable Care Act is to increase the amount of price competition among health insurers. However, the ACA does not require health insurers to participate in individual health insurance Marketplaces, but rather relies on voluntary incentives. Although a number of SBM states have adopted mechanisms beyond these incentives to encourage or require insurer participation, in general, states and the federal government implemented Marketplace standards that provide insurers considerable flexibility in the critical areas of service area requirements, network adequacy, and limitations on the number of plans offered.

This flexibility, paired with strong incentives to compete for market share, appears to have encouraged insurers to participate in the Marketplace in robust numbers in both SBM states and FFM states. In all study states except Alabama, a significant number of insurers are offering products in at least some areas of the state. These insurers generally include many of the important existing commercial insurers and also, in most states, new entrants to the commercial market, such as new nonprofit CO-OPs and Medicaid managed-care organizations. As a result, competitive Marketplaces exist in each of the study states, again with the exception of Alabama. We provide data on the lowest cost silver plans, because subsidies are tied to the second-lowest cost plans in each market. The considerable competition seen between insurers to offer one of the lowest cost plans has ostensibly resulted in reasonable premiums for most individuals purchasing insurance in the nongroup Marketplaces in the majority of markets in all eight study states. Low premiums can reflect deductibles as well as limited or tiered networks.

There was considerable diversity in which insurers emerged as the most competitive across states. There is no indication that market competition is affected by whether the Marketplace is facilitated by state or federal government. Blue Cross plans, which include Anthem and CareFirst and have a significant presence in a majority of study states, offered the lowest cost plans in some markets, but not others. In some states, local commercial plans presented

the lowest cost offerings. Medicaid managed-care plans entered the commercial market for the first time in several states, and had the lowest cost premiums in some markets, but among the highest in others. CO-OPs had a presence in some states, but offered the lowest cost options in only some markets.

ENDNOTES

1. ACA § § 1401, 1402., and 1421.
2. ACA § 1401(a) adding new § 36B(b)(3)(B) to the Internal Revenue Code.
3. Holahan, J., R. Peters, K. Lucia, and C. Monahan. "Cross Cutting Issues: Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States." Robert Wood Johnson Foundation. 2013.
4. MD Code, Insurance, § 15-1303(b).
5. An exception to this rule is provided if the only individual plan that the insurer offers in the state is a student health plan.
6. 2012 Annual Report to the Colorado General Assembly and Governor. January 15, 2013, p. 7.
7. New York State Department of Health, Office of the New York Health Benefit Exchange. *Invitation to Participate in the New York Health Benefit Exchange*. January 31, 2013, p. 6.
8. Cover Oregon. *Request for Application, Qualified Health Plans*. Revised November 30, 2012. p. 6.
9. 45 C.F.R. § 156.230.
10. 45 C.F.R. § 155.1055.
11. Holahan et al., 2013.
12. Holahan et al., 2013, p. 4.
13. Holahan et al., 2013, p. 5.
14. Holahan et al., 2013, p. 5.
15. Some materials have cited 16 insurers in New York instead of 17; Empire and Excellus are members of the same holding company.
16. For example, in a state like New York with guaranteed issue and community rating but without subsidies or a mandate, premiums in the individual markets have been relatively high, reflecting the health status of the limited number of people who purchase. In New York, premiums under reform would be expected to fall dramatically, and the premium data presented here illustrate this case.

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About the Authors and Acknowledgements

John Holahan is an Institute fellow and Rebecca Peters is a research associate at the Urban Institute. Kevin Lucia is a senior research fellow at the Center on Health Insurance Reforms at Georgetown University. This study was funded by the Robert Wood Johnson Foundation.

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