Center for Health Policy at BROOKINGS

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Early Assessment of Competition in the Health Insurance Marketplace (HP-HAC-06)

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Executive Summary

This report, requested by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services (ASPE), analyzes competition in the Health Insurance Marketplaces created by the Affordable Care Act (ACA) in six states (Alaska, Florida, Kansas, North Carolina, Ohio, and Texas). The purpose of the study was to focus on a few states that had one or more potential indicators of "insufficient competition"—such as few insurers offering plans, low enrollment, high premiums, inadequately informed consumers, or sparsely populated rural areas—and try to understand how competition was working in these markets and what might be done to make it work better.

While the study collected quantitative data on each state's characteristics and insurance markets, the main emphasis was on gathering qualitative information and insights into how the state marketplaces were actually functioning in practice based on discussions with key informants. In each state, a field research team engaged in discussions with various stakeholders involved in the ACA marketplaces, including: insurance carriers, providers, administrators, navigators, and local health insurance experts. The field researchers, composed of health policy and public management experts knowledgeable about these states, were drawn from a larger network set up by the Rockefeller Institute of Government in collaboration the Brookings Institution to study the implementation of the ACA at the state level.

The report describes the findings for each selected state, discusses common themes across the states, and provides some potential remedies to improve competition. Following is a brief summary of why these states were chosen and what the field researchers found:

- Alaska was chosen because its vast size and sparse, isolated population posed obvious barriers to competition among insurers; only two insurance carriers serve the state; premiums are high; and enrollment is extremely low. The study team's discussions with the Alaska stakeholders emphasized the barriers to competition. These include high transportation costs due to lack of roads and other infrastructure in rural areas of the state. Limited numbers of providers also impede insurers' ability to negotiate prices. While having more insurers might lead to more vigorous competition, many stakeholders believed that the market was barely large enough to enable two carriers to operate profitably in the state. The Alaska Tribal Health System was described as underfunded and not a factor in limiting enrollment on the ACA marketplaces. The team emphasized problems of lack of consumer knowledge, confusion over insurance options, and difficulty of communicating with remote populations, many of whom do not speak English.
- Florida was chosen because the sixty-seven county-level rating areas provided a chance to study competition across areas within the state and because there is a wide variation in premiums across rating areas. Stakeholders agreed that the population of the market affected entry of insurers, with the most populous rating area studied, Miami, having fierce premium competition while the state's most rural rating area, Key West, had few insurers and providers available. Stakeholders strongly believed that the ability to negotiate prices with providers affected both premiums and insurer interest in entering the market. Navigators and other assistors played an important role in providing consumer assistance in an environment in which there was confusion and limited understanding of health insurance and the new law.

Despite low competition in some areas, Florida had the highest percent of eligible enrolled out of these six states, likely driven by the population centers.

- Kansas was chosen because it managed to attract four insurance companies in 2014 to compete in the marketplaces even though it is a mostly rural state (and technically there were only two insurers, with all four insurance companies being affiliated with Blue Cross Blue Shield (BCBS) or Coventry/Aetna). It had moderate levels of enrollment and low premiums compared to the national average. Stakeholders had differing views on the adequacy of competition. They had the lowest premiums among study states and attracted five insurance companies in year two, with BCBS having a forty percent market share statewide. United Healthcare and Humana also both operate in the state off the marketplaces, so some stakeholders seemed surprised that these companies had not entered the marketplace. Stakeholders also expect premiums to rise by thirty or forty percent in 2016.
- North Carolina was chosen because it had only a few insurers in the first year of the marketplaces, with only one in some counties, but experienced enrollment above the national average. Researchers found that competition improved after the first year of the marketplaces as a result of innovative approaches to competition, including narrow networks, tiered plan design, and risk-sharing agreements with providers. However, some rural areas are still relatively uncompetitive and have some of the highest premiums in the country, with premiums varying by as much as thirty percent across rating areas.
- Ohio was chosen because it experienced some of the highest premiums and lowest enrollment in the country even though they had among the largest number of insurers participating. Researchers concluded that the marketplaces were largely competitive, although there was low insurer participation and higher premiums in more rural, Appalachian parts of the state. The researchers believe that the rating areas could be restructured to better support these rural areas and provide lower premiums. Some stakeholders thought that the difficulty in negotiating affordable provider contracts contributed to high premiums. Stakeholders in the state also believe that competition suffered because of lack of a statewide enrollment and marketing effort.
- Texas was chosen because of the potential for a cross-rating area study, with the chosen rating areas having similar population but varying degrees of insurer participation. The three rating areas for study were found to have moderate levels of competition among BCBS and regional insurers. Regional insurers were able to negotiate better with providers and local health systems, leading BCBS to introduce a narrow network HMO. Premiums were also very similar across the rating areas for the lowest and second lowest silver plans, even though the number of insurers varied from two to six.

These six examples illustrate the diversity of state insurance market characteristics at the start of the implementation of the ACA and the difficulty of generalizing about the requirements for adequately competitive marketplaces. However, some common themes emerged. Across the six states, respondents consistently said consumers have difficulty understanding health insurance and purchasing and retaining marketplace coverage. State research teams also reported a lack of outreach initiatives, even though navigators and other assistors were considered to be useful. The ability of insurers to create effective, affordable provider networks was a key determinant to success in many states. State researchers also found that the population size and density was one of the main determinants of insurer participation. Researchers also found that enrollment was driven by premium costs. This may seem intuitive; however, it has major implications for insurers in terms of their role creating affordable provider networks and ensuring that consumers

know how premiums and tax credits work and are related to deductibles, co-insurance, and the composition of provider networks.

Recommendations to improve competition emerged from the state reports and consultations with the field researchers. One such mechanism was to encourage insurers to co-brand and risk-share with established health care provider systems as a way to obtain price concessions for their marketplace plans. It may also be useful to have navigator/assistor organizations provide culturally and linguistically sensitive, simple explanations of health insurance that also remind people of the need to have coverage to protect themselves and their families. Emphasis on available subsidies and rising penalties should also be stressed. Given the knowledge and experience of agent/brokers, it was also suggested that strategies should be devised to motivate them to service the marketplaces, such as providing them with larger fees or commissions for enrolling eligible participants. Because of the limited nature of this study and small sample, any of these remedies would need to be vetted more fully with stakeholders, and it would be helpful to more thoroughly review past experience with similar solutions.

I. Introduction

The goal of the Affordable Care Act (ACA), which became law in 2010, is to expand health insurance coverage to as many Americans as possible, thus drastically reducing the numbers of people who might not receive needed health care because they lack health insurance. Besides mandating that most uninsured individuals purchase insurance and most businesses cover their workers, the ACA made affordable health insurance available to uninsured Americans in two ways. First, it created marketplaces, where potential customers could choose among competing qualified health insurance plans offered by private insurance carriers. Federal subsidies, based on income, were available to help make the plans affordable to consumers. States could set up their own marketplaces or rely on the marketplace facilitated by the federal government. Second, the ACA offered generous federal matching to states that chose to expand their Medicaid programs to include all individuals and families with incomes up to 138 percent of the federal poverty line.

Setting up health insurance marketplaces was an enormous technological and operational challenge for states and the federal government. Operating in this new market environment was also challenging for insurance carriers. Many of their prospective new customers had not been covered by health insurance before the ACA's enactment and could be expected to have untreated conditions and little experience with the health care system. Even carriers that had been operating in the individual and small-group markets were unfamiliar with this population and were unsure where to set their premiums. For their part, many of the potential customers were buying health insurance for the first time and did not know what to look for or even how to interpret the terminology of insurance, such as "co-pays" and "deductibles." Thus, the implementation of the ACA was bound to be a huge learning experience for the federal government, the states, insurance carriers, the uninsured, and other stakeholders.

The marketplaces opened for business in October 2013. Since then, the combined effect of the marketplaces and Medicaid expansion has substantially increased health insurance coverage. Recent Census data indicate that approximately seven million more people had health insurance coverage in 2015 than in the previous year, with more than sixteen million people gaining

coverage since 2013; the proportion of the population without health insurance dropped from 13.3 in 2013 to 9.2 in 2015—a substantial break with prior trends. Nevertheless, with twenty-nine million people still uninsured, the ACA remains a work in progress. Implementation of major social programs, such as Medicare and Medicaid, always takes years of learning and adjustment. Meeting the ACA's goal of near-universal coverage of Americans by affordable health insurance will require additional time and resources, as well as continuing efforts to learn from the experience of implementation in order to improve the effectiveness of the Act.

Part of a serious strategy to learn from experience is to ferret out aspects of the ACA that may not be working as well as hoped, try to figure out what is happening, and consider what possible remedies might be. This study, requested by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS) represents such an effort. Its aim was to (1) identify states and areas within states where competition in the new marketplaces appeared to be "insufficient" and (2) interact with people involved in implementing the ACA on the ground, in order to find out how they perceived competition in their state insurance market, and what they thought might improve its competition and enhance outcomes.

In most parts of the country insurers competed vigorously to sign up those newly eligible for insurance subsidies under the ACA and the number of competing insurers increased between years one and two of ACA implementation. For example, a recent ASPE report (2015) on the effect of competition on premiums showed that within states using the federal marketplace, the percent of individuals who were eligible for Qualified Health Plans (QHP) and had access to at least three insurers increased to eighty-six percent in 2015, up from seventy percent in 2014. However, some states or sub-state areas had only one or two carriers offering plans or other indicators of "insufficient competition." ASPE identified six states (Alaska, Florida, Kansas, North Carolina, Ohio and Texas), which for different reasons raised concerns that competition in the marketplaces might be insufficient. ASPE asked the study team to try to understand the competitive situation in those marketplaces, why insufficient competition might be occurring, and what might be done about it.

The six states were not chosen randomly or thought to be representative of the larger universe of states. The assignment was not to draw generalizations across such a small number of states, although some strong common themes did emerge. The objective was to obtain insight into the particular conditions in the state that might be affecting competition in its marketplace. Statistical analysis of quantitative data would not serve the purpose. To gain insights into idiosyncratic situations, it was necessary to obtain qualitative and descriptive information from field researchers in the selected states familiar with the marketplaces and competitive situations in those states and sub-state areas. The field research was done by the state field-research network of health and public management experts brought together by the Rockefeller Institute of Government in partnership with the Brookings Institution. The Network, initiated in 2010, studies the implementation of the ACA across forty states. The lead author of this report is Michael Morrisey, Professor of Health Policy & Management at Texas A&M University, an expert on health insurance and member of the Network.

Appendix E: North Carolina State Memo

Submitted by

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1. State Context

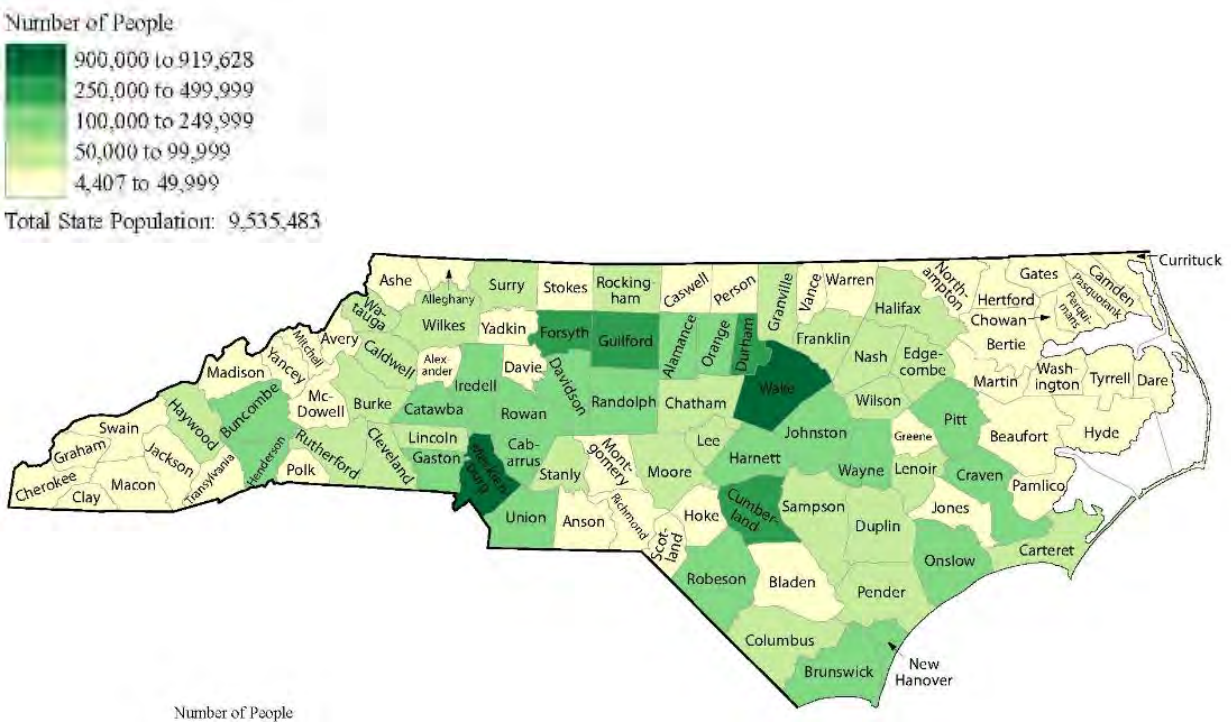
North Carolina merits study because it is the largest state in the country to have only one carrier statewide – Blue Cross and Blue Shield of North Carolina (Blue Cross). Basic facts about North Carolina are presented in Table E.1.1 and the distribution of the state's population is shown figure 1.1 in the map that follows.

Table E.1.1: Basic State Facts

Type of Exchange	Federally-facilitated marketplace (FFM)
Expansion of Medicaid	No
Number of Rating Areas	16
Number of Insurers	3
Net Change in Number of Insurers	Increased from 2 to 3 for 2015. A 4th has applied to enter for 2016.
State Population and Rank	9,638,800 million; rank: 10th in US
Median State Household Income and Rank	$44,254; rank: 42nd in US
Salient Health Facts (e.g. regions with concentrations of certain conditions, or with particularly concentrated poor health status)	Per capita health spending is below U.S. average; rank: 14th lowest in US. Sixth highest rate of uninsured in the US, in 2013.
Salient Health Policy Information (e.g. previous reform initiatives and relevant health insurance policies and requirements, notable insurance regulations)	Middle-of-the road small group market reforms. Moderately populist and elected insurance commissioner. Rate regulation is fairly lenient ("file and use"). Consolidated provider systems in much of the state.

North Carolina's insurance commissioner is elected rather than appointed. North Carolina was an early adopter of small group market reforms in the 1990s. Its version of these reforms was fairly centrist, allowing some, but only limited, rate variation based on health status. The individual market has had fairly standard regulation, with full risk-rating permitted. Until 2013, the state had a subsidized high-risk pool, which covered about 11,000 people. North Carolina reviews health insurers' rates for actuarial justification, but does not hold public hearings on rate requests. Any issues that arise during staff review tend to be handled in a non-adversarial fashion. Although the state refused to establish an exchange and is not involved with assisting the federal marketplace, its Department of Insurance actively reviews insurers' filings for compliance with ACA requirements for the insurance market generally.

Figure E. 1.1: Map of North Carolina[i]



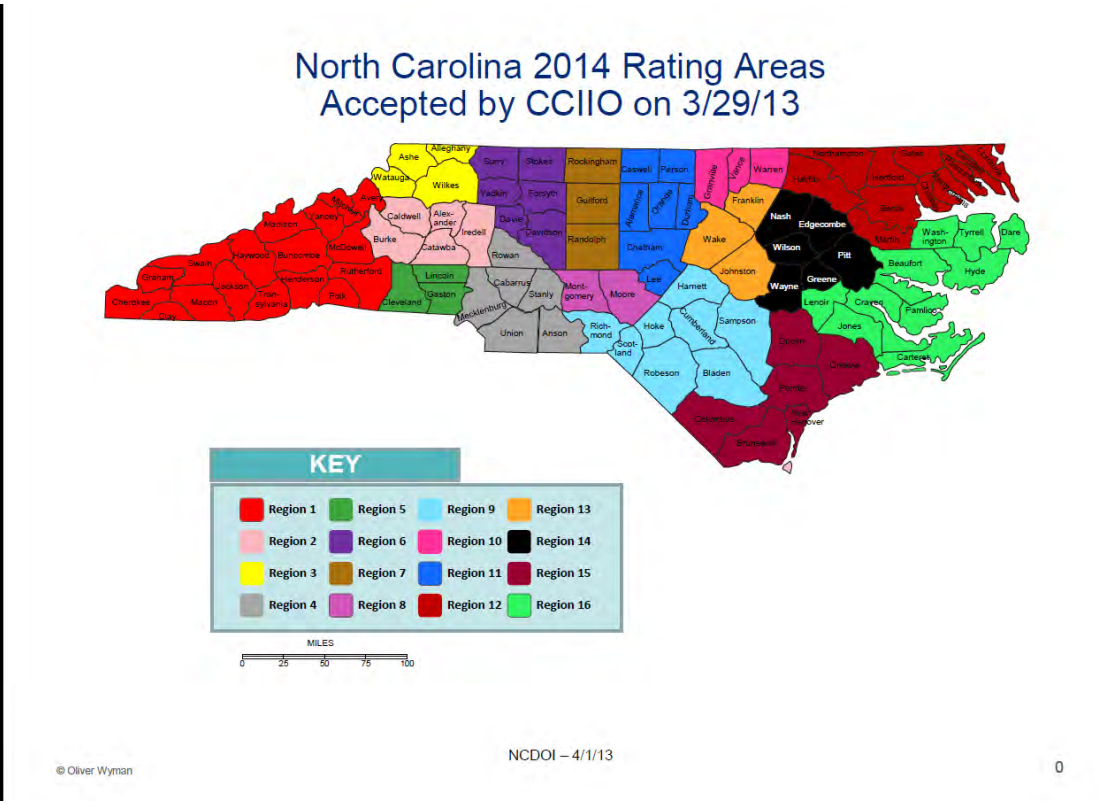
2. State Study Area and Rationale

The map below, Figure E. 2.1, shows North Carolina's 16 Rating Areas. This study addresses market conditions statewide, but with special focus on the eastern third (Rating Areas 12, 14, 15, and 16) and the far west (Rating Area 1). We give these areas special attention because they have fewer carriers competing and have notably consolidated provider systems.[ii]

Only Blue Cross offers coverage in the northeast corner – Rating Areas 15 and 16 – and in the two most eastern counties in Rating Area 14. Although these 23 counties account for almost a quarter of the state's 100 counties, they are thinly populated, accounting for less than 10 percent of the state's overall population.

In 2014, Blue Cross was the only carrier to offer coverage across all counties in Rating Area 1. Coventry offers coverage in 12 of these 17 counties, omitting the five that are furthest west. In 2015, United Healthcare entered most of the state, including all of Rating Area 1. It did not enter the northeast corner.

Figure E. 2.1: Rating Areas in North Carolina[iii]



3. Data Collection Methods

Selection and Recruitment Process

Our selection and recruitment methods involved two steps.[iv] We first formed contact lists for each category of discussant. For insurers, regulators, and state policy experts, we did so using existing connections and information, drawn from our previous health policy research in North Carolina. For navigators and agents, we compiled contact lists from separate databases based on county and rating area.[v]

We reached out to these separate groups, using a different approach for prior-known contacts and new ones. For the former group, we made contact on an individual basis, and received positive response from all contacts. For the latter group, we used a form email that outlined the basic goal of the study as well as a detailed account of our confidentiality procedures. This form was then sent to every potential navigator, and later agent. All told, we sent the email to around 20 navigators, and 30 agents. Out of all those contacted, we had four navigators respond, three of which followed through. We also had seven agents respond, four of which followed through.

Discussions

We conducted 17 discussions consisting of: 4 Insurers, 3 Navigators, 3 Regulators, 4 Agents/Brokers, and 3 State Policy Experts. Discussions lasted from 25 to 72 minutes, with most

agent/navigator discussions lasting roughly half an hour, and most discussions with regulators, insurers, and policy experts lasting close to an hour.

The four agents we spoke with had a collective experience in 10 counties: Pitt, Mecklenburg, Lee, Wake, Orange, Durham, Macon, Jackson, Swain, and Buncombe. Those counties are in five different rating areas, with the greatest number of counties represented in Rating Area 1 (in the far west), followed by Rating Area 11 (mid-state). The three navigators that we spoke with had collective experience in nine counties: Wake, Orange, Durham, Buncombe, Watauga, Avery, Madison, Burke, and McDowell. Those counties are in Rating Areas 1, 2, 11, and 13; two of the three navigators were primarily focused on Rating Area 1 (far west).

On the insurance side, we spoke with representatives from all three insurers present in North Carolina's marketplace, as well as one that did not enter the individual market. Of the three regulators we spoke with, one was a current regulator and two were former regulators active during or just prior to the first enrollment period. Of the three state policy experts we spoke with, one is in an academic space and two are involved with health access organizations. All are policy experts focused specifically on North Carolina.

The topics discussed with insurers, regulators, and policy experts were:

1) Why did various insurers enter, or not enter, the market, and choose to focus on some but not others parts of the market?

2) What kept other insurers out of the market, or kept market entrants from expanding?

3) How competitive is the market, and has market competition improved?

4) Would having more competition substantially reduce prices or improve choice?

5) Do the rating areas make sense; could they be improved? Should there be less freedom to pick and choose counties?

6) How much have BCBS competitors made inroads into BCBS's market share, and why does BCBS retain such large market shares in various parts of the state?

7) How narrow are provider networks, and how much do they differ among carriers or market segments?

8) What barriers exist to provider contracting by BCBS competitors? Do "most favored nation" clauses still have an impact?

9) How much variety is there in the plans being offered?

10) Why are rates going up so much? Does this indicate lack of competition?

11) Does state regulation deter market entry or expansion?

12) Could North Carolina do anything to help encourage more competition?

The topics discussed with agents and navigators were:

1) How long have you worked as a [navigator/agent]? What are the geographic regions you have served/worked in? Where do you have the most experience?

2) [For Agents] Roughly what percentage of your work focuses on non-group health insurance?

3) How has the market changed in your geographic area(s) since 2013 with regard to competition among non-group insurance carriers?

    a) Number of Carriers?

    b) Variety of Plan types?

    c) Rates?

4) In your region(s), did United enter the market for the second open enrollment?

    a) If so, what effects do you think this had?

    b) If not, why do you think United did not enter?

5) [For agents]: In your regions, are there any active small group carriers that have left, or not entered, the non-group market? If so, why do you think they have stayed out?

6) Are provider networks narrower for the non-group than the group market?

    a) How much narrower (for hospitals, specialists)?

    b) [If there is more than one non-group carrier]: how much do the non-group provider networks differ between Blue Cross and the other carrier(s)?

7) Have consumers complained about any of the following in the non-group marketplace?

    a) Provider networks?

    b) Variety of plans?

    c) Cost?

8) Is cost proving to be an outright barrier to enrollment?

9) Which carrier has the best price or value? Has that changed between year 1 and 2?

10) Would consumers benefit from having more competition among non-group carriers?

    a) Would prices and options be pretty much the same if we had one or two more carriers?

11) Are there any state laws or regulations that discourage more carriers from being in the non-group market, or that keep this market from being more competitive?

12) Do you think there is anything North Carolina could do to make the non-group market more competitive?

4. Findings of Marketplace Conditions

Insurer Participation and Regulatory Environment

In 2014 only Blue Cross Blue Shield of North Carolina (Blue Cross) participated statewide. Coventry, now owned by Aetna, participated in 39 counties covering 64 percent of the state's population. United Healthcare entered the marketplace in 2015, covering most of the state except for the large northeast corner (consisting of two and a half Rating Areas with 23 counties, but less than 10 percent of the state's population). Humana has applied to enter the marketplace for 2016, but in more populous urban centers in the central part of the state (e.g. Raleigh, Charlotte, Greensboro).

An additional carrier, FirstHealth, initially applied in 2013 to enter the market in a few counties, but withdrew its application after concluding that it was unlikely to gain sufficient enrollment to justify the effort. FirstHealth is an HMO based in the Pinehurst/Southern Pines area and owned by a smaller hospital system outside the major population centers. It had not planned to expand beyond its narrow market territory.

Prior to the ACA, Blue Cross had a commanding 86 percent market share in the individual market. Only one other insurer, Coventry, had over 5 percent, making North Carolina's individual market one of the most highly concentrated in the country.[vi] After two years of market expansion and reform, North Carolina's individual market is now noticeably less concentrated. Based on enrollment on and off the exchange, Blue Cross' share of the individual market statewide has dropped to 65 percent. Coventry has 19 percent, and United has 16 percent.[vii]

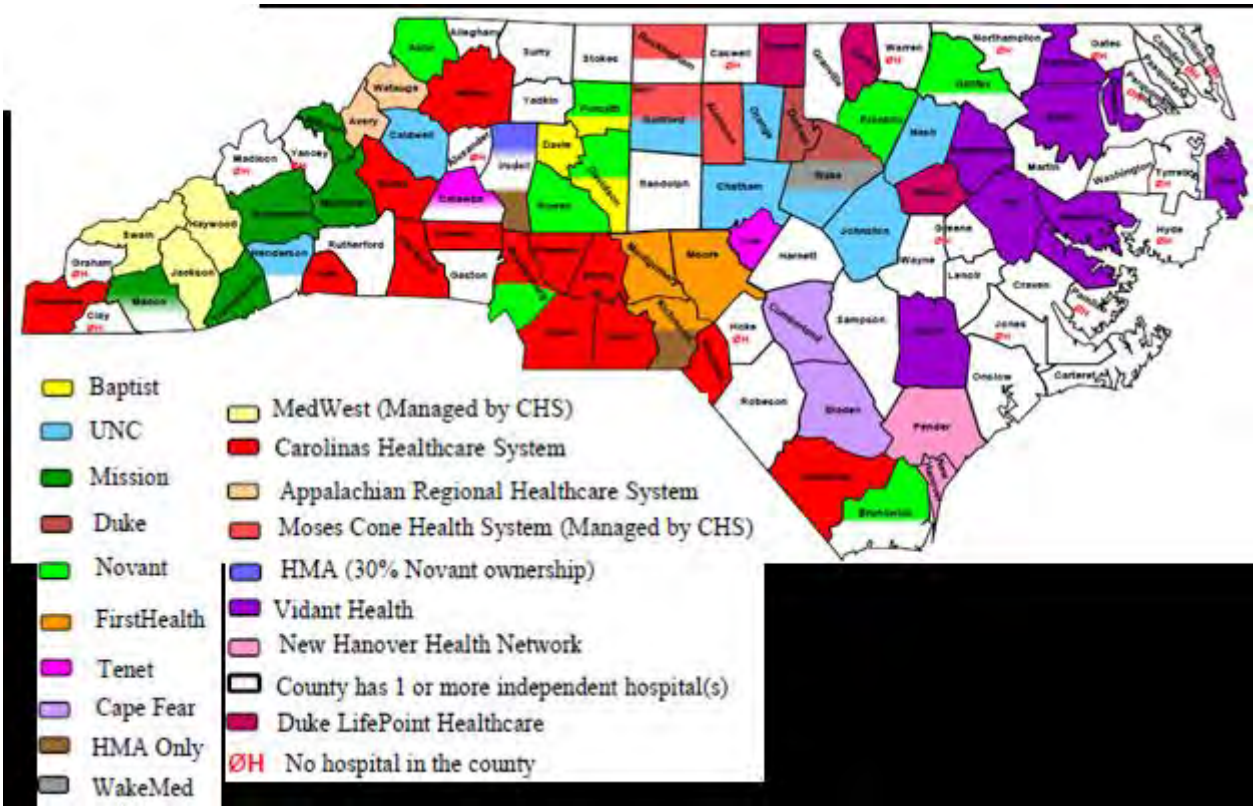
We were told that the following factors encouraged Blue Cross competitors to enter the market. First, North Carolina is a populous state with lower-than-average income, and thus it offered a large number of potential new enrollees. Contributing to the potential market size is the fact that North Carolina has not expanded Medicaid. Non-expansion increases the number of people eligible for highly-subsidized coverage since it brings those who are between 100-133 percent of poverty into the marketplace. The strength of outreach and enrollment efforts by public interest groups was also noted as a positive feature. Additionally, the initial market entrants already had a presence in the group markets, reducing the cost of entering the individual market. Humana, the newest entrant, had previously scaled back in the group market, but has been strong in the Medicare Advantage individual market.

State-based regulatory barriers were not reported by any of our discussants as a significant impediment to market entry or expansion. No discussant expressed the view that North Carolina is a hostile regulatory environment, and several discussants noted that North Carolina regulators worked with carriers in a constructive and encouraging fashion to help facilitate marketplace success. Any concerns about regulatory burden were expressed mainly with regard to federal requirements, such as those for establishing qualified health plan status.

Interactions with Provider Market

Discussants consistently said that health insurers' market entry and geographic coverage is driven by provider contracting. North Carolina is considered to have fairly consolidated provider markets, as shown in the map below (Figure E.4.1).

Figure E.4.1: Hospital Systems in North Carolina[viii]



Notes: Multiple shadings in a county indicate a split between two or three systems. Only counties shaded white have one or more independent hospitals.

Until a few years ago, Blue Cross included a "most favored nation" clause in its provider contracts. Although they no longer do so (and state law now forbids this), many discussants said that providers in some parts of the state remain reluctant to give favorable discounts to Blue Cross competitors. Discussants also said that, considering the strong brand recognition that Blue Cross enjoys, it is not sufficient for competing carriers to simply match Blue Cross pricing; competitors need to offer prices that are at least 10 percent lower to attract significant enrollment. Indeed, in most of the markets where Blue Cross faces competition, its competitors offer lower-priced plans.[ix]

Coventry and United have been able to achieve competitive provider contracts in two ways. Coventry has partnered with major health systems in several metropolitan markets to offer co-branded plans, such as with Duke Medical Center in the Raleigh area or the Carolinas Healthcare System in Charlotte. United has sought out risk-sharing arrangements of different types with providers throughout the state, including some Accountable Care Organizations (ACOs). Also, United offers only a closed-network gatekeeper HMO model in the individual market, and no point-of-service or PPO option.

Blue Cross has also innovated with network models. It offers its standard, full-network PPO throughout the state, but in many rating areas – especially those where Coventry and/or United

compete – it also offers two other network models: a narrower network based on deeper fee-for-service discounting; and a tiered network, based on its broad network but which reduces patients' cost-sharing for using providers that have more favorable pricing.

These network innovations are not restricted to the individual market; they are spilling over to other market segments. Blue Cross so far has not offered its narrow networks in the group market, but Blue Cross does offer its tiered networks to groups, and Coventry and United offer their narrower ACO and HMO networks in both group and individual markets. In addition, synergies were noted between the individual marketplace and the Medicare Advantage market. United uses its risk-sharing networks for Medicare Advantage products as well. And, discussants speculated that Humana is using its strength in the Medicare Advantage market to enter the individual marketplace.

Repeatedly, discussants said that the reluctance of Blue Cross competitors to enter Rating Areas where Blue Cross is dominant is based on the willingness of providers to contract with the competitors on favorable terms. The eastern part of the state was frequently noted as an area where Blue Cross has the market "locked up." Some discussants attributed this contractual unwillingness to providers' market power, both existing naturally due to few providers in the area, but also where area hospitals had formed systems and purchased most existing physician practices. One discussant, however, noted that provider consolidation sometimes facilitates openness to alternative contracting arrangements because networked systems have greater awareness of the need to create incentive structures that achieve clinical efficiencies. Also, these consolidated provider structures make contracting decisions more centrally, and therefore networks form quicker than contracting separately with a large number of independent providers.

Consistent with this account, several discussants noted that United Healthcare has recently formed a business relationship with the largest hospital and physician network in eastern North Carolina, and there is speculation that United will soon enter those rating areas. If so, North Carolina would have two providers that are virtually statewide and two others (Coventry at present, and Humana now entering) in the major population centers (as well as in some more rural areas).

Prices and enrollment

Despite having below-average health care spending per capita, insurance premiums in the North Carolina marketplace are higher than national averages. Looking at the largest city in each state and comparing prices for the second-lowest cost silver plan, the Kaiser Family Foundation reports that North Carolina has the 7th highest premiums in the country.[x] Prices vary across the state, by roughly thirty percent among Rating Areas.[xi] Various discussants agreed that these variations are attributable largely to provider costs, suggesting that most of this cost difference was attributable to provider pricing rather than population health or utilization patterns – but we did not explore that distinction in detail. Although a detailed analysis has not been performed, there does not appear to be a consistent pattern between population density and premium cost. Charlotte is the highest priced rating area, but Greensboro, a medium-sized city, is among the lowest. Various rural areas appear at different points in the state's pricing spread.

One reason noted for higher premiums is that North Carolina allowed people to keep and renew their noncomplying policies. Because those policies are medically underwritten, these

subscribers tend to be relatively healthier. Those policies are also not community rated, meaning their prices can remain more favorable for younger subscribers. To some extent, then, this "continuation" policy has kept a healthier population (numbering roughly 200,000) out of the community-rated market. However, we did not obtain any actuarial estimate of the impact of this phenomenon.

Despite the relatively high marketplace premiums statewide, marketplace enrollment in North Carolina has been relatively successful. Almost a half million are now enrolled through the marketplace, the fourth most in the country. This represents an estimated 45 percent of the potential purchasers, which is the 7th highest proportion in the US and fourth highest among FFM states. Over 90 percent of subscribers receive a premium subsidy (third highest in the US) and 65 percent receive cost-sharing reductions (fifth highest in the US). Owing to the high proportion of enrollees who qualify for financial assistance, North Carolina has enrolled about two-thirds of the population that is eligible for subsidies (fourth highest in the US). Enrollment was strong in both years, with about half of current enrollees being newly enrolled in 2015.

The fact that most marketplace enrollees receive premium subsidies causes this market to function somewhat differently than others. Some discussants noted that, when United entered in the second year, although pricing in their area became more competitive, many existing subscribers saw substantial increases. This happened because United's lower price reduced the subsidy that subscribers receive for Blue Cross coverage. This subsidy is keyed to the second-lowest Silver plan in the market, initially was a Blue Cross plan. When the United plan entered, either itself or a Coventry plan became the second-lowest. Thus the available subsidy covered less of the premium for the broad-network Blue Cross plan than in the previous year.

A scenario described by more than one discussant is as follows: a person initially enrolls in Blue Cross's broad network at a highly subsidized price, then switches in year 2 to another carrier after learning that there would be a very large premium increase (because the subsidy was now based on a market entrant's plan), but then learns that their preferred physician was not included in the chosen network. Subscribers' understanding of the consequences of switching plans was hampered by lack of easily accessible information about network composition. Additionally, many enrollees had never had insurance before and were unfamiliar with network rules and structures. Several discussants felt that the marketplace's information technology needs to be improved in order for consumers to make truly informed and accurate choices.

5. Analysis of Marketplace Conditions

Overall, it appears incorrect to characterize North Carolina's individual insurance market one of insufficient competition. Most discussants consider the market to be competitive, and there are several signs of healthy competition overall. Although Blue Cross remains the only statewide carrier, Coventry competes with it in the more populous urban markets, and a new carrier has entered the market each of the two years running (first United, then Humana). Moreover, it is likely that United will expand to cover most or all of the state as it further develops its provider networks. Even if some areas remain less competitive, strong competition in the state's core population centers should have spill-over benefits for pricing in rural areas. Because the ACA requires each carrier to treat the entire state as a single risk pool, carriers' price differences between more and less competitive rating areas should be based only on actuarially-demonstrated differences in health care costs rather than on differences in market power.

In addition to choice of several carriers, the individual market in North Carolina offers a choice of distinct types of networks. Blue Cross and Coventry each offer more than one type of PPO or point-of-service network structure – full, tiered, limited – and United offers yet another option – a closed gatekeeper network HMO. Thus people have both a choice of carriers and, within two of the carriers, different types of networks. There is also a range of choices in patient cost-sharing designs. Accordingly, few discussants seriously complained of insufficient choice; some noted that adding more choice could produce consumer confusion.

The North Carolina market was also described as being "price competitive." Although its premiums are above the national average and have increased by double digits each of the two years, the presence of Coventry and the entry of United have caused the market to be more price competitive.[xii] Blue Cross remains the market leader, but United and Coventry often offer lower-priced options. Accordingly, Blue Cross has lost substantial market share compared to its position prior to reform.

Some parts of the state remain uncompetitive, with either no choice other than Blue Cross, or with Blue Cross competitors unable to offer lower prices. However, these areas (clustered in the far west and northeast corners of the state, with rural pockets elsewhere) account for a small fraction of the state's population. Barriers to increased competition in these areas were consistently attributed to the inability of other insurers to secure favorable network contracts with local providers. A few discussants also believed that the small size and poorer health of the potential risk pool in these rural areas was a factor deterring market expansion.

In part, difficulty negotiating competitive provider networks was attributed to provider consolidation or the small size of the provider community in rural areas. It was also attributed to the lingering effects of a history of Blue Cross using "most-favored nation" clauses. However, United is reported to have reached an agreement with the major health system in the far eastern part of the state. In its other rating areas, it is seeking to develop alternative networks using value-based incentives and risk sharing payment methods rather than discounted fee-for-service.

Finally, no notable regulatory barriers to healthy competition were noted with regard to state *insurance* regulation. (We did not inquire about *provider* regulation.) The limited regulatory concerns expressed were related mainly to federal rules, with a few discussants stating that streamlining the process for carriers to become qualified health plans could be especially helpful to smaller carriers that might consider entering the market. Smaller carriers conceivably could emerge, for instance, if one or more of the existing provider networks decided to form an insurance company.

6. Possible Remedies for Enhancing Marketplace Competition

We received no consistent, concrete, and noteworthy suggestions for enhancing market competition, save for the aforementioned point to streamline the federal approval process. Other suggestions made were either vague (e.g. increase enrollment), or idiosyncratic and unrealistic (e.g. repeal Obamacare). A number of discussants simply said that they could not think of any good, constructive ideas to make the market more competitive than it already is.

This reflects the observations that, for the most part, the individual market in North Carolina appears to be fairly competitive already, with no significant regulatory barriers to entry or expansion. Some discussants also questioned how helpful it would be to have more insurers competing. First, if new insurers are not able to secure substantially greater discounts from providers, it is not clear how they might be expected to offer substantially lower prices. Second, the very ability to secure substantial discounts might be reduced if insurers' market power were spread too thin.

We inquired in particular about whether North Carolina's design of its rating areas deterred market entry or expansion. Currently, North Carolina allows insurers to select service areas county by county, meaning that they may enter part but not all of a rating area. Overall, discussants thought that the rating areas were well considered. No discussant thought it would be a good idea to require insurers to cover the entire state in order to enter the market; all agreed that such a policy would discourage market entry. One possibility we did not explore in depth was requiring insurers that want to enter the individual market to offer coverage in the counties in which they also sell group coverage.

Views were more divided on whether it might be a good idea to require insurers to cover an entire rating area. Some discussants complained that insurers are permitted to "cherry pick" within rating areas, by covering only one or a few counties. However, the majority of discussants felt that requiring full coverage of an entire rating area might cause an insurer to refrain from attempting to "gain a toehold" in a region where it is not yet fully established.

References and Endnotes for Appendix E

[i] United States Census Bureau, "North Carolina – 2010 Census Results, Total Population By County," http://www.census.gov/2010census/news/pdf/cb11cn61_nc_totalpop_2010map.pdf

[ii] For a detailed description in the western region, see Randall R. Bovbjerg & Robert A. Berenson, "Certificates of Public Advantage: Can They Address Provider Market Power?," *Urban Institute* (February 2015), http://www.urban.org/research/publication/certificates-public-advantage/view/full_report.

[iii] North Carolina Department of Insurance, "North Carolina 2014 Rating Areas Accepted by CCIIO on 3/29/13," http://www.ncdoi.com/HealthCareReform/Documents/HealthCareReform/North_Carolina_Map_of_2014_Rating_Areas.pdf

[iv] In addition to discussions, we conducted internet searches of major North Carolina newspapers and health policy websites for relevant information.

[v] For the navigators we assembled a list of the navigator organizations and their individual members operating in the 50 least populous counties in North Carolina, see "Find Local Help," HealthCare.gov, accessed July 1, 2015, https://localhelp.healthcare.gov/; "Navigator Grant Recipients," CMS, accessed July 1, 2015, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013.pdf; "Navigator Grant Recipients for States with a Federally-Facilitated or State Partnership Marketplace," CMS, accessed July 1, 2015, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-09-08-2014.pdf; "Health Care Navigators," Legal Aid of North Carolina, accessed July 1, 2015, https://www.legalaidnc.org/public/learn/projects/health-care-navigators/default.aspx. For agents we made use of the National Association of Health Underwriters' database, sorting by county and ACA certification.

[vi] Kaiser Family Foundation, "Individual Insurance Market Competition," accessed July 1, 2015, http://kff.org/other/state-indicator/individual-insurance-market-competition/.

[vii] These figures are from a knowledgeable discussant, derived from carriers' recent rate filings. They are broadly consistent with CCIIO data reflecting marketplace-only enrollment, although the CCIIO data suggest somewhat greater market share for Blue Cross of about 70 percent statewide.

[viii] Blue Cross and Blue Shield of North Carolina, "Hospital Systems in North Carolina" (2014).

[ix] S. Sekhar, "A State-Based marketplace in North Carolina," (prepared for the North Carolina Justice Center, 2014), http://dukespace.lib.duke.edu/dspace/bitstream/handle/10161/8614/MP%205-2-14.pdf.

[x] Kaiser Family Foundation, "Monthly Silver Premiums for a 40 year Old Non-Smoker Making $30,000/Year," accessed July 1, 2015, http://kff.org/other/state-indicator/monthly-silver-premiums-for-a-40-year-old-non-smoker-making-30000year/.

[xi] Murawski, J. and D. Raynor, "In NC, Health Insurance Rates Vary Widely, Depending on Where You Live," *Raleigh News & Observer*, December 6, 2014, http://www.newsobserver.com/news/business/personal-finance/article10185707.html; Rose Hoban, "North Carolina Insurance Rates a Mixed Bag," *North Carolina Health News*, September 27, 2013, http://www.northcarolinahealthnews.org/2013/09/27/north-carolina-insurance-rates-amixed-bag/.

[xii] Blumberg, L.J., J. Holahan, and E. Wengle, "Marketplace Price Competition in 2014 and 2015: Does Insurer Type Matter in Early Performance?," *Urban Institute* (June 2015) (see Appendix A-7, p. 29), http://www.urban.org/research/publication/marketplace-price-competition-2014-and-2015-does-insurer-type-matter-early-performance .