

# Health Research Institute *Spotlight*



February 2016

## **Three years in, the ACA marketplace shows modest premium growth, fewer plan options and continued competition**

*With the individual exchanges expected to generate close to an additional \$50 billion in premium revenues cumulatively by 2025, there is opportunity for carriers to enter the market or expand their footprints.*

Three years after opening for business, the ACA marketplaces are beginning to settle. Despite headlines, premium growth for benchmark plans over the three years has been modest, and not out of line with the employer market, according to an analysis of premium data by PwC's Health Research Institute (HRI). Insurers are pruning their product portfolios in each metal tier, and getting rid of platinum plans altogether in some states.

Some churn in the marketplaces remains. In many states, the insurer offering the benchmark plan has changed from year to year, complicating choices for consumers. The benchmark plan was offered by the same insurer for all three years in just nine states. With real money left to capture in the market, there is still opportunity for carriers to enter, or to expand their current footprints. However, to do so successfully will require understanding this new landscape.

For this research, PwC's HRI analyzed three years of premium data from each state's most populous county and the District of Columbia, specifically looking at carrier participation and product offerings, benchmark premium growth and the impact of key dimensions – such as Medicaid expansion and number of carriers – on that premium growth.

### **Premium growth**

Benchmark premiums – those for the second-lowest-cost silver plans – have begun creeping up in year three on the exchanges. In 2016, more states experienced an increase in their benchmark premium in the most populous county than in 2015, and fewer saw decreases. There were 20 states in 2016 where the benchmark premium in the most populous county grew by double digits, according to HRI's analysis. In comparison, just five states experienced such increases in 2015. Eleven states did see decreases in the benchmark premium in 2016, but this is down from 25 states in 2015.

However, rate changes vary widely depending on individual states, geographic areas, companies, network types and enrollee demographics. Despite concerns about examples of significant rate hikes, overall national growth of these benchmark premiums over the three years has been modest and has largely mirrored increases in the employer market.



### **Minnesota**

*Finding the right price, and a cautionary tale about double-digit rate increases*

News of double-digit premium rate increases has attracted a lot of attention over the last two years. However, these increases are easily mischaracterized. Minnesota illustrates this well.

In the employer market, Minnesota historically falls near the middle of the pack. Its average employer premium for individual coverage ranked 25th in the country in 2014. But in that same year, its ACA benchmark premium was the lowest in the country, according to HRI analysis.

Since 2014, the benchmark premium rate in Minnesota's most populous county has increased by double digits each year

– 19% in 2015 and 29% in 2016. The state aimed too low in the first year of operation – the result of insurers being able to negotiate lower rates with providers as well as the state's more stringent rate review requirements.<sup>1</sup> Now insurers in the state are working to adjust premiums. With each year, the ACA markets are beginning to settle, better reflecting healthcare costs in each state.

Minnesota's story highlights the importance of looking beyond double-digit rate increases. Despite the dramatic premium increases the last two years, Minnesota had the second-lowest cost benchmark plan in the country in 2015. In 2016, it has the ninth lowest.

- Between 2014 and 2015, benchmark premiums in the most populous counties decreased by 0.2% on average, HRI found.
- Growth between 2015 and 2016 – at an average of about 4.2% – was higher than that between the first two years of operation.
- This means that over three years, benchmark premiums in the most

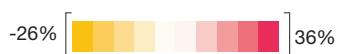
populous counties increased, on average, 4.0%. The median increase was 1.2%. This reflects a split in state experiences – a few have had significantly larger increases, pulling the average up.

- The increase compares favorably to employer premiums for single coverage, which have grown an average of 4.4% each year for the last five years.<sup>2</sup>

These findings echo an initial analysis conducted by HRI in 2014 which found that premiums for state-based exchange health plans were comparable to – and in some cases lower than – those being offered by employers.<sup>3</sup> The growth also falls well below the double-digit premium growth observed in the individual market prior to the ACA.<sup>4</sup>

#### Growth in ACA benchmark premiums in the most populous county

State	% Change 2014-15	% Change 2015-16
Alabama	2.6%	9.0%
Alaska	26.3%	31.4%
Arizona	-10.3%	17.2%
Arkansas	-2.4%	3.8%
California	-1.0%	-1.7%
Colorado	-15.8%	31.8%
Connecticut	-8.1%	1.1%
Delaware	4.0%	18.3%
District of Columbia	-0.3%	3.1%
Florida	1.8%	-4.5%
Georgia	2.0%	-0.5%
Hawaii	13.6%	25.9%
Idaho	-9.0%	30.2%
Illinois	1.7%	-8.3%
Indiana	-7.0%	-9.5%
Iowa	-6.9%	20.4%
Kansas	-11.8%	27.7%
Kentucky	3.2%	5.2%
Louisiana	22.9%	4.2%
Maine	-4.4%	1.0%
Maryland	5.8%	12.1%
Massachusetts	-6.5%	2.1%
Michigan	2.5%	-1.6%
Minnesota	18.5%	28.7%
Mississippi	-25.6%	-7.3%



State	% Change 2014-15	% Change 2015-16
Missouri	4.8%	3.9%
Montana	-6.6%	33.4%
Nebraska	-2.8%	18.6%
Nevada	-0.2%	9.9%
New Hampshire	-14.8%	5.7%
New Jersey	-2.0%	4.6%
New Mexico	-11.8%	8.6%
New York	2.0%	-0.9%
North Carolina	6.5%	25.2%
North Dakota	0.5%	11.5%
Ohio	-0.7%	-5.0%
Oklahoma	8.7%	34.8%
Oregon	5.9%	22.5%
Pennsylvania	-10.9%	3.2%
Rhode Island	-11.7%	1.3%
South Carolina	-4.4%	6.1%
South Dakota	-3.0%	20.5%
Tennessee	15.1%	25.3%
Texas	1.9%	2.4%
Utah	2.7%	13.4%
Vermont	5.7%	7.3%
Virginia	3.7%	0.6%
Washington	-9.7%	-10.4%
West Virginia	7.8%	18.1%
Wisconsin	5.6%	-2.1%
Wyoming	3.2%	4.7%

Source: PwC Health Research Institute analysis of publicly available ACA marketplace premium data

Churn in benchmark premiums has led to many changes in price leaders in each state. Insurers are refining premium pricing as they gain more information about who is buying coverage and which plans are being purchased. As they do, price leaders are changing. In both 2015 and 2016, the benchmark plan carrier in the most populous county changed in over 60% of states. Only nine states had the same carrier for the benchmark plan in all three years.

In addition, the class of carrier that is best able to compete on price – increasingly winning the benchmark premium – is shifting. In 2014, Blues plans held the title of benchmark plan carrier in the most populous county in 24 states.<sup>5</sup> By 2016, Blues plans were the benchmark carrier in just nine of the most populous counties.

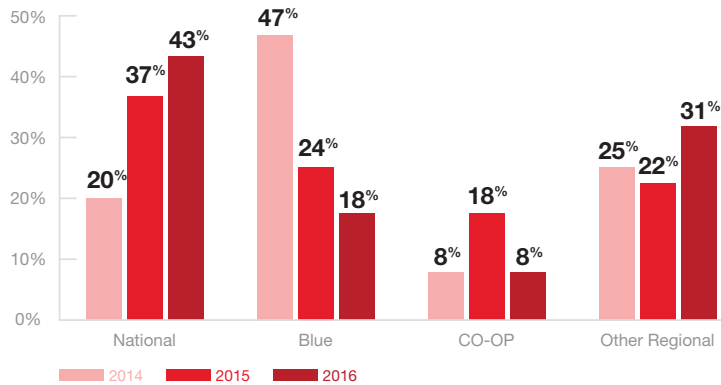
Meanwhile, national carriers and other regional players have gained traction.<sup>6</sup> CO-OPs are dropping out of the market. Provider-owned and Medicaid Managed Care plans also have gained ground. Twenty-seven percent of benchmark plans were provider-owned in 2016, up from 20% in 2014. Another 27% were offered by Medicaid Managed Care carriers, an increase from 10% in 2014.

This is a big deal for consumers – particularly those receiving subsidies – as it means many will have to change carriers in order to minimize or eliminate premium increases. Yet, more than half of enrollees stayed with their 2014 plans when enrolling for 2015. Consumers were more likely to switch when their premiums increased substantially.<sup>7</sup>

### Products for sale

Beyond adjusting plan premiums, insurers are rethinking their exchange product portfolios. The average number of product offerings in each metal tier decreased between 2015 and 2016. The decline in plans in 2016 is largely due to carriers offering fewer options, not market exits. While some states did see fewer insurers selling plans in the most populous county, far more had a decline

Percentage of benchmark plan carriers by carrier type



*Blues plans have been the benchmark carrier in progressively fewer states each year.*

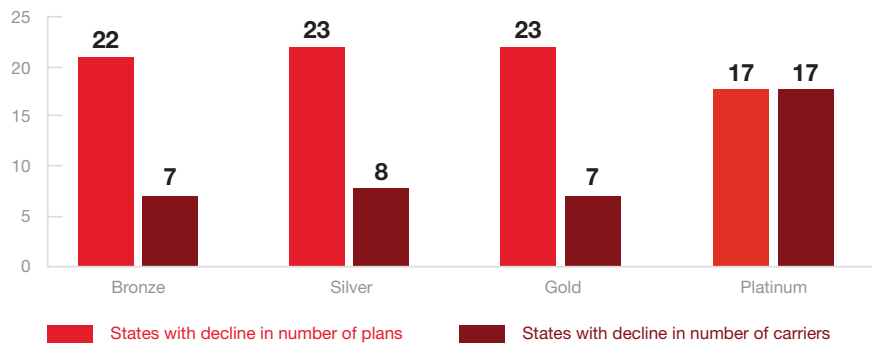
Source: PwC Health Research Institute analysis of publicly available ACA marketplace premium data

in the number of plans being offered. With consumer purchasing trends in-hand, insurers may be starting to weed out underperforming products.

For instance, HRI found that some carriers are moving away from platinum plans altogether. Many state exchanges that once offered platinum plans no

longer do, and others have fewer options. Over the previous three years, platinum products have struggled to attract enrollees, over 80% of whom receive subsidies tied to silver plans.<sup>8</sup> In the 35 states that used HealthCare.gov in all three years, 10 states exited the platinum plan market between 2014 and 2016. In 2016, just 16 states offered these plans.

States with a decrease in the number of plans, carriers in the most populous county in 2016, by metal tier



Source: PwC Health Research Institute analysis of publicly available ACA marketplace premium data. Bronze, gold and platinum data only for states using HealthCare.gov.

Number of states where the most populous county had...

	0 Platinum plans	1-2 Platinum plans	3-5 Platinum plans	6-9 Platinum plans	10 or more Platinum plans
2014	12	14	4	3	2
2015	13	8	9	3	2
2016	19	11	2	3	0

Source: PwC Health Research Institute analysis of publicly available ACA marketplace premium data

## Implications

Three years in, the dynamics of the ACA health insurance marketplace are shifting. Insurers are tweaking their offerings as they become more knowledgeable about who they are insuring, what the competitive landscape looks like and how to navigate a more tightly-regulated market. With the individual exchanges expected to generate close to an additional \$50 billion in premium revenues by 2025, there is still opportunity for carriers to enter the market, or to expand their current footprints. However as they do, they must adjust their approaches, taking into consideration the following dimensions to account for this new landscape.

### Dimensions that make a difference

Dimension	Potential impact <sup>9</sup>
<b>Exchange type</b>	Federally-facilitated exchanges had higher average benchmark premiums and higher average growth in benchmark premiums all three years.
<b>Medicaid expansion</b>	States that expanded Medicaid had lower average benchmark premiums and lower average growth in benchmark premiums all three years.
<b>Number of carriers</b>	States that had a greater number of carriers had lower average benchmark premiums all three years.
<b>Achieved enrollment</b>	States that had a “high” level of enrollment in 2014 had lower average growth in enrollment in 2015.
<b>Narrow networks</b>	States with lots of narrow networks in 2014 had lower average benchmark premiums and lower average growth in benchmark premiums all three years.
<b>Exchange management strategy</b>	States that have implemented an “active purchasing” management strategy had lower average growth in benchmark premiums all three years. <sup>10</sup>

Source: PwC Health Research Institute analysis of publicly available ACA marketplace premium data

- **Be cognizant of what’s selling** and selective with product offerings. Variation across the market is decreasing.
- **Know where you’re selling.** Where a company does business matters. Markets with more carriers tend to have greater downward pressure on premiums. In states that have expanded Medicaid, hospitals have a lower indigent care load and premiums tend to be more attractive to enrollees.
- **Narrower networks help keep premiums down.** But be aware that proposed regulations could place limits on just how narrow they can be, which could mean even higher premiums.<sup>11</sup>
- **Look at states with lower enrollment in the past.** These may be areas of greater opportunity in the future as there is still “low hanging fruit” to be captured.
- **Advertise opportunities to save.** Many consumers are not shopping around for the best deals from year to year. With increased advertising of lower premiums and potential savings, carriers may be able to convince consumers to make the effort to swap their plans.<sup>12</sup>

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## Endnotes

1. Jordan Rau, "The 10 Least Expensive Health Insurance Markets in the US," Kaiser Health News, February 13, 2014, <http://khn.org/news/10-least-expensive-health-insurance-markets-in-us/>.
2. PwC Health Research Institute analysis of 2015 Kaiser Family Foundation Employer Health Benefits Survey, September 22, 2015, <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>.
3. PwC Health Research Institute, "Health insurance premiums: comparing ACA exchange rates to the employer-based market," 2014, <https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pwc-hri-health-insurance-premium.pdf>.
4. Jonathan Gruber, "Growth and variability in health plan premiums in the individual insurance market before the Affordable Care Act," The Commonwealth Fund, June 2014, [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1750\\_gruber\\_growth\\_variability\\_hlt\\_plan\\_premiums\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jun/1750_gruber_growth_variability_hlt_plan_premiums_ib_v2.pdf).
5. For the purposes of this analysis, "Blues plans" refers to any of the member companies of the Blue Cross and Blue Shield System: <http://www.bcbs.com/about-the-companies/>.
6. The pronounced shift between Blues plans and national carriers as the dominant carrier type of the second-lowest-cost silver plans is in part due to the way in which carriers have been classified. Kaiser Permanente – classified as a national carrier for the purposes of this analysis – has been the benchmark plan carrier in an increasing number of states over the years. Anthem Blue Cross and Blue Shield – classified as a Blue plan – has been the benchmark plan carrier in a decreasing number of states over the years.
7. Thomas DeLeire and Caryn Marks, "Consumer decisions regarding health plan choices in the 2014 and 2015 marketplaces," HHS Office of the Assistant Secretary for Planning and Evaluation, October 28, 2015, [http://aspe.hhs.gov/sites/default/files/pdf/134556/Consumer\\_decisions\\_10282015.pdf](http://aspe.hhs.gov/sites/default/files/pdf/134556/Consumer_decisions_10282015.pdf).
8. US Department of Health and Human Services, Centers for Medicare & Medicaid Services, "June 30, 2015 Effectuated Enrollment Snapshot," September 8, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>.
9. Premiums were adjusted using Medical Expenditure Panel Survey (MEPS) data to account for the overall cost of healthcare in each state and better isolate the impact of each dimension.
10. States that are active purchasers directly negotiate premiums, provider networks, and number of plans and benefits sold in the marketplace.
11. PwC Health Research Institute, "CMS proposed rule sets minimum network adequacy standards," HRI regulatory center weekly newsletter, November 30, 2015, <https://www.pwc.com/us/en/health-industries/health-research-institute/weekly-regulatory-legislative-news/week-of-11-30-2015.html#section1>.
12. Turnover in the carrier of the benchmark premium is an important consideration for consumers in the marketplaces, especially those who qualify for subsidies. Premium tax credits are tied to the second-lowest-cost silver plan. Consumers who qualify for these subsidies face the full difference in premium between the benchmark plan and more expensive plans if they don't opt to switch to the benchmark plan for that year. For example, suppose a subsidized enrollee chooses the second-lowest-cost silver plan in 2015 with a \$200 premium. The enrollee receives a subsidy of \$180, bringing her net premium cost in 2015 down to \$20. In 2016, what was the second-lowest-cost silver plan in 2015 increases its premiums to \$250, an increase of 25%. Another carrier now offers the second-lowest-cost silver plan, at a 2016 premium of \$200. With premium tax credits tied to the second-lowest-cost silver plan, the enrollee still receives a subsidy of \$180. If she keeps the same plan in 2016, she will face a net premium of \$70, an increase of 250%. The enrollee could achieve a 0% change in net premiums if she switched to the benchmark plan.

## About this research

PwC's Health Research Institute performed an analysis of publicly available ACA marketplace premium data for the most populous county in each state for 2014, 2015 and 2016. Data for states using HealthCare.gov was downloaded as of November 19, 2015. For states implementing their own state-based exchanges, analysis was limited to silver plan premium data. Any analysis of other metal tiers is based solely on data from those states using HealthCare.gov. This research looked at individual coverage, specifically for a 40 year-old, non-smoker. Medical Expenditure Panel Survey (MEPS) 2014 data were used to adjust premiums to account for the overall cost of healthcare in each state. Unless otherwise indicated, all reported results have been weighted by state population.

## About the PwC Health Research Institute

PwC's Health Research Institute (HRI) provides new intelligence, perspectives and analysis on trends affecting all health related industries. The Health Research Institute helps executive decision makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

## Acknowledgments

### Sandra Hunt

Principal, US Client  
Service Global Human  
Resource Services

### Jack Rodgers, PhD

Managing Director,  
Health Policy Economics

### Kristen Bernie

Manager, Health Policy  
Economics

## Health Research Institute

### Kelly Barnes

US Health Industries and Global Health  
Industries Consulting Leader  
kelly.a.barnes@pwc.com

### Benjamin Isgur

Director  
benjamin.isgur@pwc.com

### Trine Tsouderos

Director  
trine.k.tsouderos@pwc.com

### Benjamin Comer

Senior Manager  
benjamin.comer@pwc.com

### Matthew DoBias

Senior Manager, Regulatory  
matthew.r.dobias@pwc.com

### Alexander Gaffney

Senior Manager, Regulatory  
alexander.r.gaffney@pwc.com

### Sarah Haflett

Senior Manager  
sarah.e.haflett@pwc.com

### Laura McLaughlin

Senior Manager  
laura.r.mclaughlin@pwc.com

### Marianne DeWitt

Research Analyst  
marianne.t.dewitt@pwc.com

### David Wong

Research Analyst  
david.wong@pwc.com

## For a deeper conversation about how this topic may impact your business, please contact:

### Kelly Barnes

US Health Industries and Global Health  
Industries Consulting Leader  
(214) 754 5172  
kelly.a.barnes@pwc.com

### Benjamin Isgur

Director  
(214) 754 5091  
benjamin.isgur@pwc.com

### Trine Tsouderos

Director  
(312) 241 3824  
trine.k.tsouderos@pwc.com

### Sandra Hunt

Principal, US Client Service Global  
Human Resource Services  
(415) 498 5365  
sandra.s.hunt@pwc.com

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