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McKinsey Center for U.S. Health System Reform

Intelligence Brief

Exchanges year 2: New findings and ongoing trends

The open enrollment period (OEP) for year 2 of the individual exchanges is officially under way, having begun on November 15th. To understand how the products being offered this year differ from those offered during the 2014 OEP, the McKinsey Center for U.S. Health System Reform expanded its database to include all of the 335 carriers[1] participating on the 2015 exchanges and all of the products they are offering there. This year, we were able to obtain data at a deeper level than we did last year (i.e., we were able to obtain 2014 and 2015 data for each county, not just each rating area). Thus, our database contains information on more than 223,000 ACA-compliant on-exchange products from both years, including premiums, benefit design, and network design. As a result, we were able to compare year-over-year carrier, product, and premium changes across the market as a whole. In addition, for each product offered in 2014 that was re-filed in 2015, we linked the data from both years so that we could understand the specific changes that 2014 exchange enrollees are seeing during the 2015 OEP.[2]

We elicited five key observations from our analyses:

- *Competition and choice are increasing nationwide.* In most counties, consumers shopping for coverage on the 2015 public exchanges have more carriers and more products from which to choose. Nationwide, the number of carriers participating on the exchanges has increased 19 percent since the 2014 OEP, and the number of products has increased 27 percent.

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[1] The carrier count represents the number of unique carriers offering products in at least one county within a state (not all carriers offer products in every county within a state). Carrier count is as it appears to consumers shopping on exchanges. Specifically, the count is the number of carriers that offer products in each state, i.e., a carrier that offers products in 3 states is counted 3 times, a carrier that offers products under 2 different carrier names in one state is counted 2 times, a carrier that offers one or more products in 1 state under 1 carrier name is counted only once.

[2] Complete details about our methodology can be found in the Appendix.

- *Gross premium prices are rising, especially for PPO and broad-network products.* Between the 2014 and 2015 OEPs, gross premiums of the lowest-price exchange products rose by a median of 6 percent across metal tiers.[3] Among the lowest-price 2014 exchange products re-filed for 2015, the median gross premium increase is 10 percent. Premiums for re-filed products built on health maintenance organizations (HMOs), narrowed networks, or both increased much less than did the premiums for products based on preferred provider organizations (PPOs) or broad networks.
- *Switching products would minimize or eliminate premium increases in many cases, but would not always lower overall costs.* We estimate close to three-quarters of 2014 exchange enrollees have access this year to a product that is within the same metal tier as the product they bought last year but priced below the 2015 premium of last year's plan. Often, however, the lower-premium products have higher deductibles.[4]
- *Net premiums for subsidy-eligible consumers have often risen.* Net premiums for the lowest-price silver products have increased for nearly three-quarters of those eligible for subsidies,[5] but in most cases the increases are less than 10 percent.
- *Recent and new entrants are often price leaders.* Just over half of new price leaders are either recent or new entrants (i.e., carriers that entered the individual exchange market in one or more states last year or this year). In many counties, there is a significant change in competitive price positions.

Competition and choice are increasing nationwide

Across the U.S., the number of carriers operating on the individual exchanges has increased 19 percent since the 2014 OEP (*Exhibit 1*). Seventy new carriers[6] entered the 2015 exchanges, and 17 withdrew.[7] Two-thirds of the new entrants are carriers that had offered individual products in 2013 but sat out the exchanges in their markets in 2014. One or more new carriers entered the exchanges in 59 percent of counties, which collectively contain 70 percent of the eligible population. In the other 41 percent of counties, there are no new carriers.

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[3] Median of the percentage change between the lowest-price 2014 product in each tier and the lowest-price 2015 product in the same tier in each county (calculated for all counties and all tiers).

[4] All products in a given metal tier should have a similar actuarial value, and thus the average consumers would be expected to pay should be similar. In addition to deductible, a range of other factors, including co-payments and the services to which the deductible is applied, influence the eventual amount a consumer must pay.

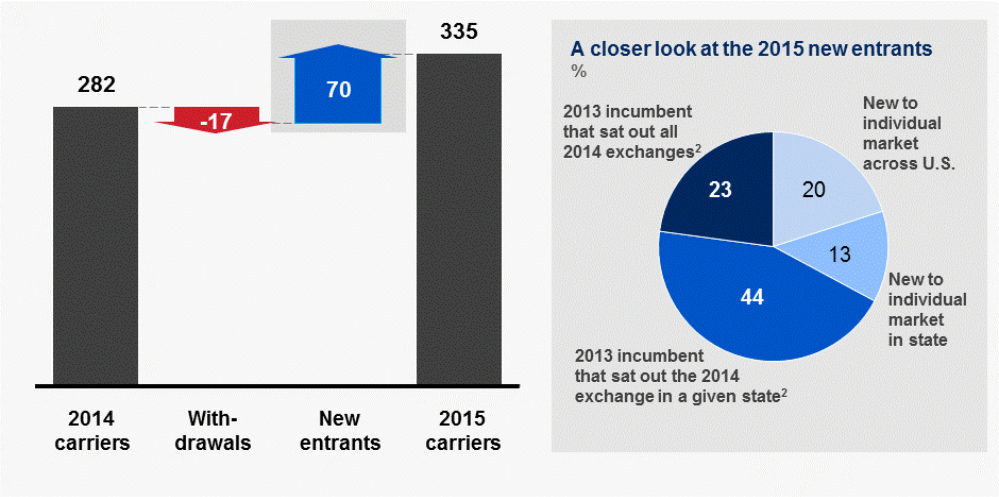
[5] Sixty-nine percent of the QHP-eligible population are eligible for subsidies; how many of these consumers will actually enroll is not yet known. Among 2014 exchange enrollees, 85 percent were determined to be eligible for subsidies. (ASPE Research Brief. "Health plan choice and premiums in the 2015 health insurance marketplace." December 2014.)

[6] Only 14 of the 70 new entrants are truly new to the individual insurance market. Forty of the new entrants participated in the 2014 OEP in some states but expanded into other states for 2015. The remaining 16 new entrants operated off-exchange in a given state but did not participate in that state's 2014 OEP.

[7] Seventeen is the number of withdrawals as it appears on the exchanges to consumers. Seven of the carriers had filed under two different legal-entity names in a given state during the 2014 OEP and then withdrew one of those names for 2015. (They stayed in the state under the other name.) As a result, the 17 withdrawals represent 10 unique carriers.

EXHIBIT 1

New carrier growth is driven in large part by re-entry of 2013 incumbents



1 Based on the number of carriers that offer plans in each state, i.e., carrier that offers plans in 3 states is counted 3 times, and a carrier that offers plans under 2 different carrier names in 1 state is counted 2 times
2 These carriers offered insurance in the off-exchange individual market prior to entering the exchange market in 2015.

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

With the exception of Blues carriers,[8] which were already available to 98 percent of exchange consumers in 2014, all carrier types increased their market presence in 2015 (*Exhibit 2*). National carriers[9] not participating in some or all of the 2014 exchanges are the most common type of new 2015 entrant and have the largest "footprint" expansion (i.e., increase in the number of consumers who can access their products on the exchanges).[10] Provider-based new entrants[11] have also expanded their footprint and remain the third most common carrier type after Blues and nationals.

8 Anthem is included in the category of Blues carriers. Because Anthem added a few new counties for the 2015 OEP, the Blues' market presence expanded slightly (from 97.7 percent in 2014 to 97.8 percent in 2015).

9 A commercial payor with a presence in more than 4 states that has filed on the exchanges (specifically, Assurant, Aetna/Coventry, Cigna, Humana, and UnitedHealthcare).

10 This expansion is primarily driven by UnitedHealthcare and Assurant, which expanded into 20 and 16 new markets, respectively.

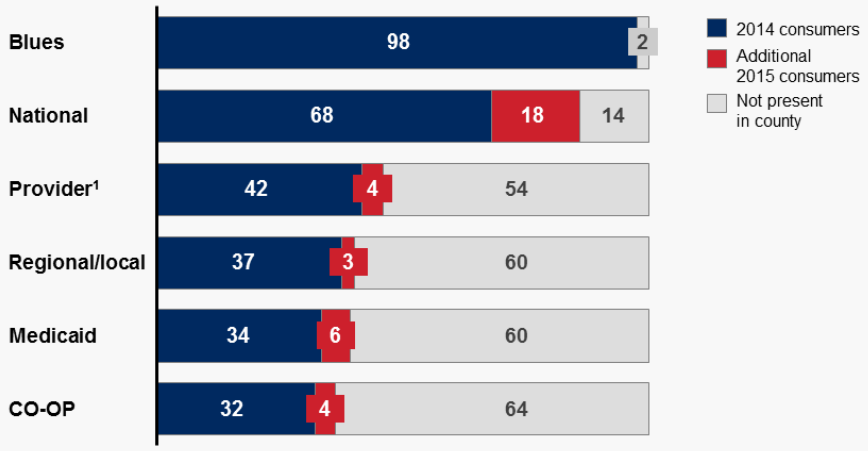
11 A carrier that also operates as a provider/health system. Note: Last year, we characterized provider-based entrants who also offered Medicaid as Medicaid entrants; however, this year we define these carriers as provider-based.

EXHIBIT 2

Many carriers have increased market penetration

Carrier types' market penetration across the U.S.

% of QHP-eligible consumers



1 Thirty percent of the provider-based new entrants also offer Medicaid products. If these new entrants are included with other Medicaid carriers, provider-based carriers expanded their footprint to 29% in 2015, from 22% in 2014

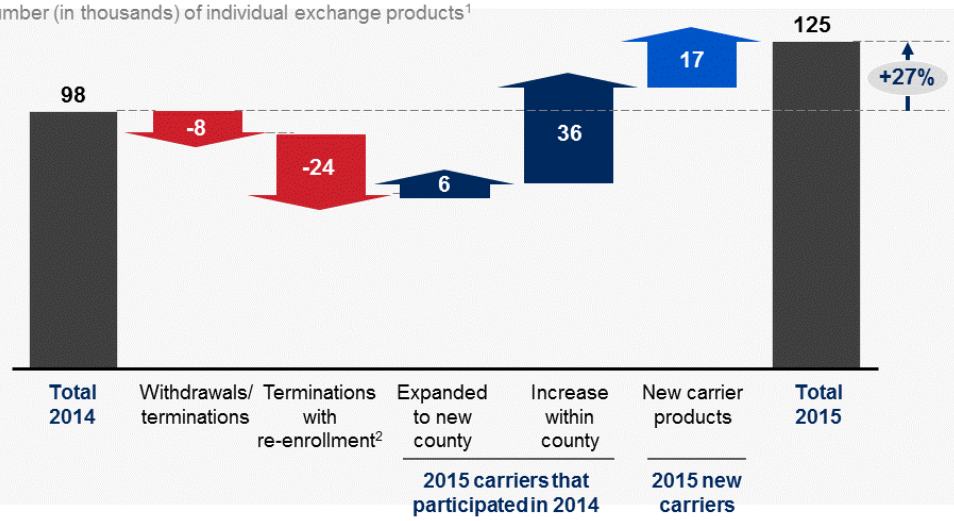
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

EXHIBIT 3

27% more products are being offered on the public exchanges this year

Product expansion from 2014 to 2015 across the U.S.

Number (in thousands) of individual exchange products[1]



1 Products counted as unique at the county level
2 Products that have a new designated 2015 plan into which enrollees will be auto-enrolled, as identified by the CMS Plan ID Crosswalk Public Use File

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Product choice for consumers has also increased—nationwide, there are 27 percent more products this year (*Exhibit 3*). New products were introduced in all metal tiers and at all price levels. In each county, anywhere between 6 and 160 products are being offered; the average is 40 (compared with 31 in the 2014 OEP).

Existing carriers (2014 OEP participants that are on the exchanges again in 2015) introduced 71 percent of the new products. On average, these carriers are offering nearly 1.7 times more products in each county than are the new entrants. Providers and consumer-operated-and-oriented plans (CO-OPs) had the highest rates of new product introductions.

Few patterns emerged among the carriers exiting the exchanges or among the products that were withdrawn. All carrier types terminated products, and none of them terminated an unusually high number of products. Furthermore, all carrier types introduced new products at rates that equaled or exceeded the number of products withdrawn.

Gross premium prices[12] are rising, especially for PPO and broad-network products

Between the 2014 and 2015 OEPs, gross premiums (the amount charged by carriers before subsidies are considered) rose by a median of 6 percent among the lowest-price exchange products in all metal tiers.[13] Among the lowest-price 2014 products re-filed for 2015, the median gross-premium increase is 10 percent.

Our estimates suggest that if all 2014 exchange enrollees (not just those who bought the lowest-price products) were to renew the product they purchased last year, 85 percent of them would have higher gross premiums this year (*Exhibit 4*). Gross premiums would decrease for 10 percent of these enrollees. The remaining 5 percent cannot renew their 2014 products because those products were withdrawn. If all of the exchange enrollees who could renew their 2014 products did so, the weighted-average gross-premium increase would be 9 percent.

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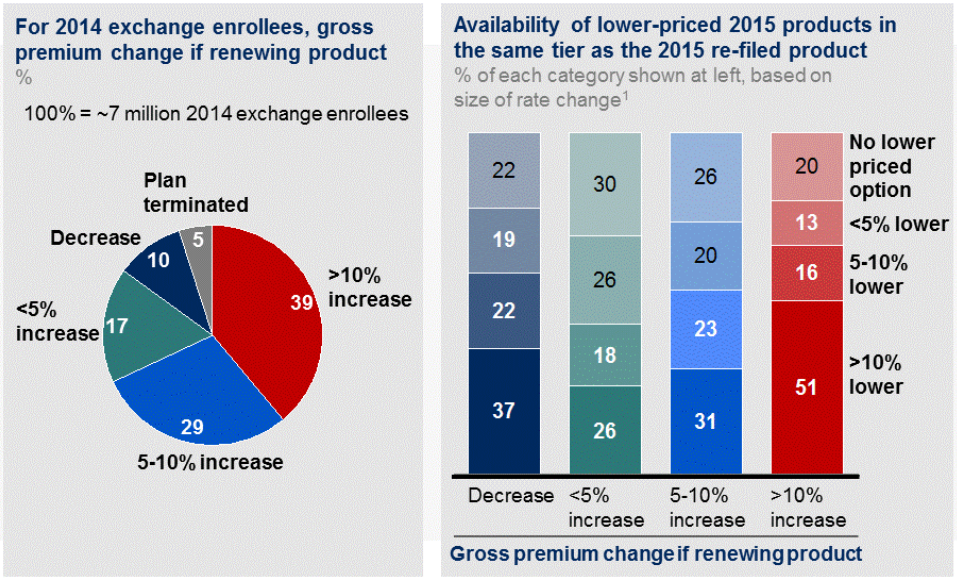
[12] Subsidies are only available for consumers with incomes under 400 percent FPL who are not eligible for Medicaid. These individuals do not face the full impact of the increases in gross premiums reported here. For consumers with incomes above 400 percent FPL, net premium equals gross premium. (See the next section. The Appendix describes the methods used to estimate the premium changes we report throughout this Intelligence Brief.)

[13] Median of the percentage change between the lowest-price 2014 product in each tier and the lowest-price 2015 product in the same tier in each county (calculated for all counties and all tiers).

EXHIBIT 4

Most enrollees face higher renewal premiums but have cheaper options



1 Consumers whose plans were terminated are excluded

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Across metal tiers, the price changes range from a decrease of 48 percent to an increase of 88 percent. In most cases, the highest increases are found on last year's lowest-price products—for example, a median increase of 8 percent for the lowest-price silver products (equal to a $20 monthly increase for a 40-year-old nonsmoker). In contrast, the highest-price 2014 silver products re-filed for 2015 have a median premium increase of just 2 percent ($7 monthly for that same person). Accordingly, premium price dispersion among re-filed products is decreasing.

Nevertheless, price dispersion is considerably larger among 2015 products (from both existing and new carriers) than it was in 2014. The net result is that consumers are facing an overall wider, rather than a narrower, band of premiums among all 2015 products. For about half of all consumers this year, the price differential between the least and most expensive products within the same metal tier in a given county is greater than 50 percent. However, the gap between the lowest- and second-lowest-price silver plans has narrowed.

HMO products experienced much smaller year-over-year median gross premium increases than PPO products did (*Exhibit 5*). Similarly, products configured around narrowed networks had smaller rate increases than broader-network products did.[14] We found the lowest median

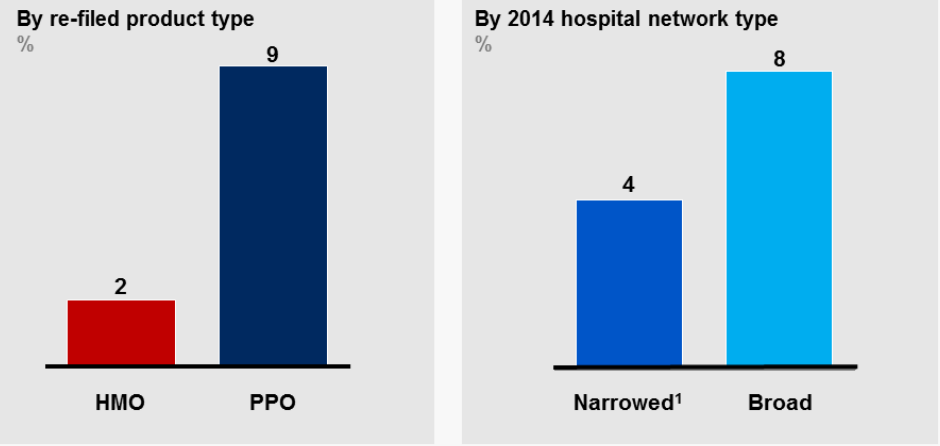
[14] Narrow networks cover 31 to 70 percent of the hospitals in their markets. Ultra-narrow networks cover 30 percent or less of those hospitals. Tiered networks group hospitals based on differences in co-payments. (For information on how network breadth correlated with 2014 product pricing, see the Intelligence Brief, McKinsey Center for U.S. Health System Reform. "Hospital networks: Updated national view of configurations on the exchanges." June 2014.)

gross premium increases in HMO products configured around narrowed networks (1 percent, compared with a 10-percent increase for PPO products configured around broad networks).

EXHIBIT 5

HMOs and narrowed networks had the lowest premium increases

Median premium increases among re-filed 2014 products



1 Includes narrow, ultra-narrow, and tiered networks

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Our analysis also showed that HMO products now comprise a greater percentage of all lowest-price products, as well as of all products priced within 10 percent of those products. For example, 47 percent of the lowest-price silver products in 2015 are HMOs, compared with 32 percent last year. We are in the midst of conducting a detailed analysis of the relationship between the network breadth of 2015 products and their pricing; results will be reported in an upcoming Intelligence Brief.

Switching products would minimize or eliminate premium increases in many cases, but would not always lower overall costs

We estimate that close to three-quarters of 2014 exchange enrollees have access this year to a product that is within the same metal tier as the product they bought last year but priced below the 2015 premium of last year's plan. For about 55 percent, the gross premium decrease is likely to be more than 5 percent; for close to 40 percent, the decrease could be above 10 percent *(see Exhibit 4)*.

Premium differences of this magnitude may induce some consumers to switch to new products. However, individuals need to evaluate this carefully because a decrease in premium price will not always result in a decrease in an individual's out-of-pocket costs. For some 2014 enrollees who have a lower-premium option this year, the lower-premium 2015 product has a deductible higher than the one associated with renewing their 2014 product. However, a range of other factors, including co-payments and the services to which the deductible is applied, influence the eventual amount a consumer must pay. Furthermore, all products in a given metal tier should have a similar actuarial value, and thus the average consumers would be expected to pay should be similar.

Presently, we cannot predict how many consumers will switch to a new product to lower their premiums. Our research suggests that premium increases of 10 percent or higher may induce consumers to shop for a new product.[15] A switch to a product with a lower premium may not always be cost-minimizing, as it will depend on any change in benefit design of the new lower-premium product, as well as the specific types and amounts of services utilized. The extent to which individuals fully understand this trade-off is unclear.

Net premiums for many subsidy-eligible consumers will rise

To understand how premium changes affect affordability, we analyzed the change in net premium (the amount individuals have to pay after subsidies) between the lowest-price silver products in 2014 and 2015. Our calculations suggest that 73 percent of all QHP-eligible consumers—including 71 percent of those eligible for subsidies—appear to be subject to a net premium increase (*Exhibit 6)*. For 38 percent of subsidy-eligible consumers, the increase is less than 10 percent (a weighted average of $7 per member per month) (*Exhibit 7*). For 33 percent of the subsidy-eligible, the increase is over 10 percent (a weighted average of $22 PMPM). In contrast, 28 percent of subsidy-eligible consumers appear to have a decrease in net premiums; 10 percent are seeing a decrease greater than 10 percent (a weighted average of $18 PMPM).[16]

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[15] In our recent consumer survey ("On the Eve of Open Enrollment 2015"), 70 percent of consumers reported that they would consider switching products if the premium for their 2014 plan rose by 10 percent or more; some were sensitive to as low as a 5-percent difference. In the 2014 OEP, however, strong brands were able to offset the price advantage and retain strong share in many geographies.

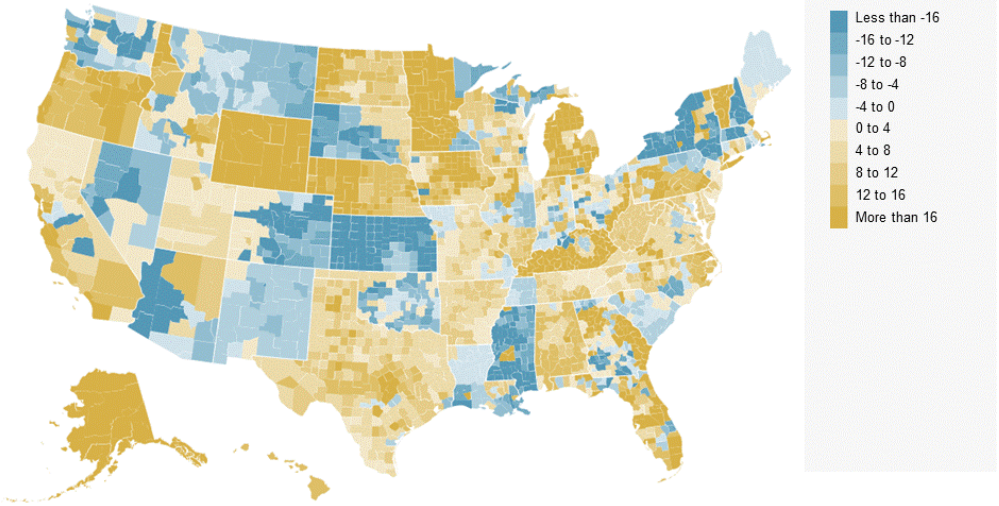
[16] For 1 percent of subsidy-eligible consumers, net premiums remained the same between 2014 and 2015.

EXHIBIT 6

Net premiums are often rising, but increases are low for most consumers

Net premium change between 2014 lowest-price silver and 2015 lowest-price silver

$ PMPM premium change for all QHP-eligible consumers



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

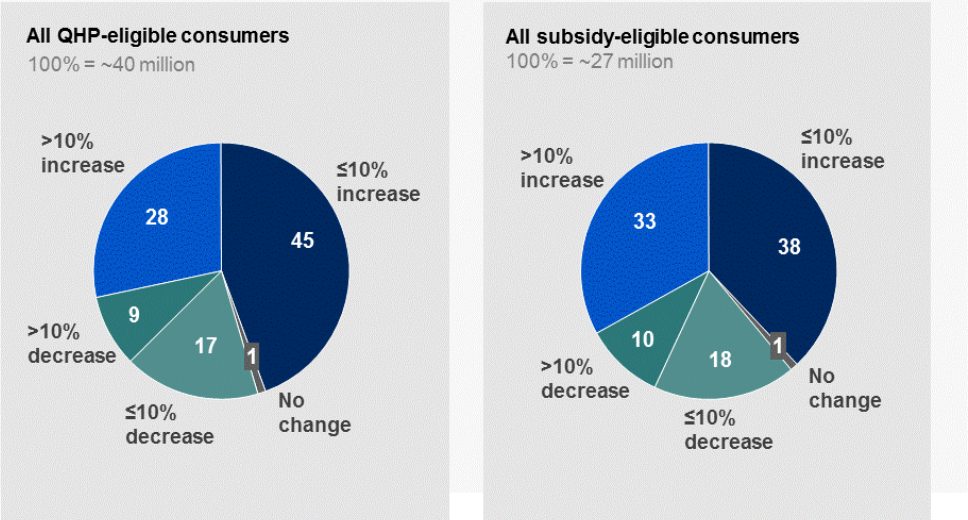
Nationwide, the relative increase in net premiums for the lowest-price silver products decreases as income levels rise (it is a weighted average of 15 percent for those with incomes below 200 percent of the federal poverty level (FPL), 5 percent for those with incomes between 200 and 400 percent FPL, and 3 percent for those with incomes above 400 percent FPL). In absolute terms, the reverse is true (it is a weighted average of $6 PMPM for those with incomes below 200 percent FPL vs. $9 PMPM for those with incomes above 400 percent FPL). Early exchange filings, which we analyzed in our September 2014 Intelligence Brief,[17] suggested that individuals at the high end of subsidy eligibility (200 to 400 percent FPL) might be disproportionately affected by net premium increases. This finding did not persist when we looked at the full set of exchange filings, largely because of differences among the states in the magnitude of the weighted-average net premium increases. Those increases are highest in Alaska and Michigan and lowest in Arizona and New Hampshire.

[17] McKinsey Center for U.S. Health System Reform. "2015 OEP: Emerging trends on the individual exchanges." September 2014.

EXHIBIT 7

Most enrollees face higher renewal premiums but have cheaper options

Net premium change in lowest-price silver products from 2014 to 2015



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

The changes in net premiums for the lowest-price silver products also vary by market type. In general, urban markets are seeing close to twice the weighted-average net premium increases than rural markets. Markets in which CO-OPs are the predominant carrier type are seeing less than one-third the increases of other markets.

To fully understand the impact of premium increases on low-income consumers, we also estimated the number of consumers having access to zero-net-premium products. We found a 10-percent decrease in the number of persons with access to zero-net-premium bronze products (from 6.0 million in 2014 to 5.4 million in 2015). Most (95 percent) of the consumers having access to zero-net-premium bronze products have incomes below 250 percent FPL, qualifying them for cost-sharing subsidies should they select a silver product. The number of people with access to zero-net premium silver product decreased from about 912,000 in 2014 to just over 420,000 in 2015.

Recent and new entrants are often price leaders

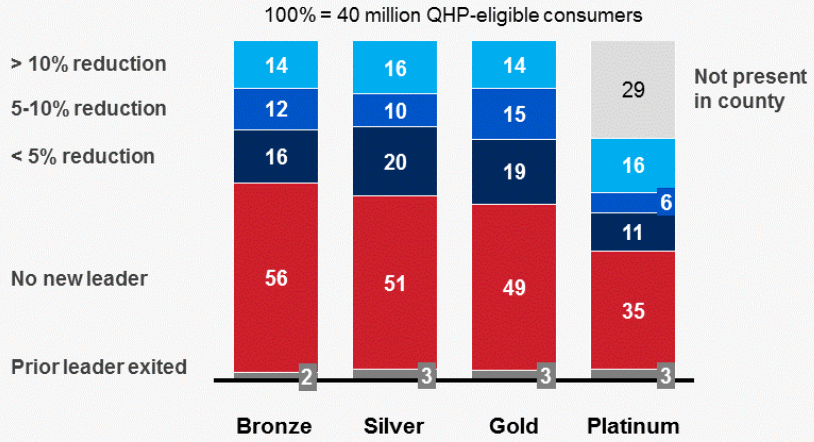
Price leaders (the carriers offering the lowest-premium product in each metal tier) are changing in at least one tier in 77 percent of counties across the U.S. Within the silver tier, there is a new price leader in 45 percent of counties, which together contain 49 percent of the consumers shopping on the 2015 exchanges (*Exhibit 8*). Over half of these new silver-tier price leaders entered the individual market within the past year: 32 percent were new to the overall individual market in their states in 2014, and another 26 percent are new entrants to the exchanges in one or more states in 2015.

EXHIBIT 8

One-third of QHP-eligible consumers have a new price leader in 2015

Change in price leadership

% of QHP-eligible consumers seeing a change in price leadership by the size of the price differential[1]



1 2015 price leader compared to 2014 price leader's 2015 rate

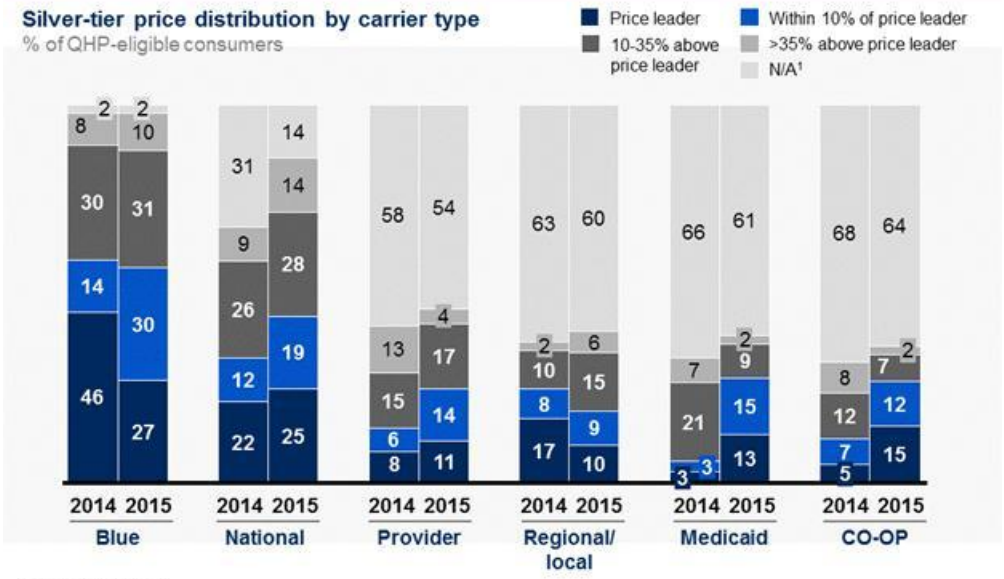
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Frequently, the new price leaders undercut the 2014 price leaders by a significant amount. For 16 percent of all consumers shopping on the 2015 exchanges, the new lowest-premium silver product is priced more than 10 percent below the 2015 premium of last year's silver-tier price leader. For 17 percent of consumers, the price of the 2015 lowest-premium silver product is below that of last year's lowest-premium silver product.

The carrier types capturing the greatest increase in silver-tier price-leadership positions in 2015 are CO-OPs and Medicaid (*Exhibit 9*). In contrast, the Blues and regional/local carriers are most frequently ceding price-leadership positions. Nevertheless, the Blues remain price leaders for 27 percent of 2015 consumers, a larger percentage than any other carrier type.

EXHIBIT 9

Many consumers are finding new price leaders



1 Not present in county

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

The changes in price-leadership positions are having a dampening effect on overall premium increases. In the counties with a new price leader in the silver tier, gross premiums for the lowest-price silver products increased at a lower rate than in counties where the 2014 price leader remained unchanged (a median of 1 percent compared with 7 percent). Counties in which CO-OPs were the new price leader experienced a median rate decrease of 1 percent.

□ □ □

The emerging trends presented in this Intelligence Brief help to inform changes in the competitive landscape on the 2015 exchanges as compared to 2014 exchanges. Data on the changes in competitors, product offerings, and prices provide insight into potential implications for market volatility, product affordability, member retention, and overall market growth. However, the findings in this Intelligence Brief are directional indicators only. As the 2015 OEP progresses, we will continue to analyze trends across both offerings (including exchange network detail) and consumer behavior.

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The authors would like to thank Brock Mark and Brendan Murphy for their support.

Appendix

Additional background on the underlying research

The analyses supporting this Intelligence Brief are informed by a McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform (the Reform Center) and McKinsey Advanced Healthcare Analytics (MAHA). This tool offers a real-time view of comprehensive 2014 and 2015 individual exchange offerings.

Additional Reform Center/MAHA tools can compare a range of topics, including a) individual and small-group rates and filings, b) pre- to post-ACA trends, c) pricing across product types by consumer characteristics, d) exchange network trends, e) predictions of market share (based on rates, filings, and consumer-predicted dynamics), and f) benefit designs across carrier types and metal tiers.

Please contact reformcenter@mckinsey.com with any inquiries.

Methodology

Data sources and analyses:

The major analyses in this Intelligence Brief are based on publicly available information about exchange product offerings.

2014 and 2015 exchange offerings database: We developed a county-level database of all products offered in all metal tiers on the 2014 and 2015 individual exchanges across the United States. It includes details about premiums, carriers, cost-sharing provisions, product type design, and network design.

McKinsey Predictive Agent-based Coverage Tool (MPACT): This model provides specific county-level demographic details about the QHP-eligible population in 2014. These details are attained by merging county- and state-level data from the U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Centers for Medicare and Medicaid Services (CMS), and Health and Human Services (HHS). They have been reconciled with publicly reported enrollment information to date for 2014 (i.e., exchange enrollment, Medicaid enrollment). This granular and dynamic behavioral simulation model also has details about all other lines of insurance business and projects these details forward to show the impact of health reform over time on the coverage decisions of consumers, payors, and employers. However, for the purposes of this Intel Brief, we are not using the projection aspect of this model, just the 2014 baseline information.

Approach to analyses:

Carrier exchange participation: To understand how carrier participation is changing competitive dynamics on the exchanges, we compared the number of carriers competing on the exchanges in 2014 and 2015. The carrier count is based on what consumers see when they shop on the exchanges; thus, it represents the number of unique carriers offering products in at least one county within a state (not all carriers offer products in every county

within a state). Specifically, the count is the number of carriers that offer products in each state, i.e., a carrier that offers products in 3 states is counted 3 times, a carrier that offers products under 2 different carrier names in one state is counted 2 times, a carrier that offers one or more products in 1 state under 1 carrier name is counted only once.

Exchange product offerings: To understand how consumers' choice of products is changing, we compared the number of exchange products offered in 2014 and 2015. Products were counted uniquely at a county-area level (i.e., each product in each county area counts as one). To look at product offerings from the consumer's perspective, we counted two otherwise identical products offered by the same parent company as separate products if they are sold under two different names.

Gross premium changes in the market as a whole: To understand gross premium changes in the market as a whole, we compared the lowest-price products in each tier at the county level between 2014 and 2015. We calculated the percentage change between each 2014 and 2015 lowest-price product by tier and calculated a median of all percentage changes.

We focused many of our analyses on exchange silver products for three reasons. First, 65 percent of all exchange enrollees bought silver products in the 2014 OEP. Second, all carriers are required to offer a silver product to compete on the exchanges. Third, the silver tier is the only tier for which income-eligible consumers can receive both federal premium and cost-sharing subsidies.

Gross premium change for 2014 exchange enrollees: To understand the specific changes that 2014 exchange enrollees are seeing during the 2015 OEP, we linked data for all 2014 products that were re-filed in 2015. To do this, we started with the full set of 2014 exchange products across all counties. For each product, we identified whether it was terminated, withdrawn from the market (if the carrier withdrew), or re-filed in 2015. For states using the Federally Facilitated Marketplace (FFM), we referenced the CMS "Plan ID Crosswalk Public Use File" released in November 2014 to identify both terminated products for which consumers are auto-enrolled into a new product and terminated products that do not include auto-enrollment. For the state-based marketplaces (SBMs), we defined terminated products as any 2014 product that did not have an equivalent 2015 product, based on matching HIOS ID or other key identifying product features.

Using this linked data, we then calculated the weighted-average gross premium changes for re-filed 2014 exchange products to understand the changes that 2014 exchange enrollees would face if they were to re-enroll in the same plan. First, we established the distribution of 2014 exchange enrollment at a county level by price position within metal tier across ages. To do this, we used HHS-reported enrollment, specifically zip-code level enrollment for FFM states and state-level enrollment for SBM states, both as of April 19, 2014 (end of the 2014 OEP), since more recent granular market-level enrollment figures have not yet been released. We then leveraged our McKinsey MPACT model (based on public sources such as CMS, HHS, Census, ACS, and SAHIE) to inform current exchange enrollment since the April-released numbers. We then determined enrollment by price position within tier (lowest,

second-lowest, all others), based on HHS-reported national enrollment by price position.[18] We assumed that the price position distribution remained constant at a national level. We used McKinsey's MPACT model (reconciled with HHS-reported enrollment demographics) to determine age distribution at a county level. For the distribution of price positions for products above second-lowest, we assumed a geometric distribution across the remaining products.

Then, we combined this 2014 exchange enrollment distribution at a product level with actual 2014 exchange products that were filed again in 2015. To estimate premiums, we assumed that each exchange enrollee purchased an individual policy, as contract size was not reported. We used the median age factor for each age bucket, and then calculated rates for each year and rate changes for every product. Then, we calculated the weighted-average rate changes across the U.S.

Net premium change for QHP-eligible individuals: To understand the net premium changes that QHP-eligible individuals will face, we calculated the population weighted-average change in net premiums between 2014 and 2015 for the lowest-price silver product in each county. We assumed that subsidy eligibility will be re-determined for all individuals in 2015. First, we established a distribution of QHP-eligible individuals (at a household level) in each county, using McKinsey's MPACT model. Next, we combined this population distribution with data about 2014 and 2015 lowest-price silver product net premiums, calculating per-member-per-year net premiums at a household level. To estimate net premiums, we used income level and household size to determine the relative premium cap for each household unit. Then, we calculated the second-lowest-price silver premium based on the median age for each age bucket combined with household size to determine the relative subsidy, and applied that to the lowest-price silver product to calculate the net premium of the lowest-price silver product. Finally, we used the 2014 and 2015 net premiums to calculate weighted-average rate changes.

Using this net premium calculation to understand how premium price changes affect affordability for subsidy-eligible individuals after subsidies are applied, we analyzed, in each county, the interactions between the 2014 to 2015 changes in the price of the second-lowest-price silver product (the benchmark product against which subsidies are set) and the lowest-price silver product.[19]

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[18] ASPE Research Brief. "Premium, affordability, competition, and choice in the health insurance marketplace, 2014." June 2014.

[19] The change in the benchmark plan's premium relative to change between 2014 and 2015 in the price of the lowest-price silver product has the greatest impact on affordability for subsidy-eligible individuals (specifically, whether they will see an increase or decrease in their net 2015 premium for the lowest-price silver plan). Our calculations show this change accounts for about two-thirds of the differences in net 2015 premiums for the lowest-price silver product among subsidy-eligible individuals. Only one-third of the net premium changes are driven by changes in the indexed definitions of the federal poverty level and the indexed premium caps set by the Affordable Care Act.

Classifications for carriers

The criteria we used to classify payors are summarized below.

- Blues: a Blue Cross Blue Shield payor; includes Anthem, HCSC, Regence
- Consumer-operated-and-oriented plan (CO-OP): a recipient of federal CO-OP grant funding that was not a commercial payor before 2014
- Medicaid: a carrier that offered only Medicaid insurance in the past; includes Molina and Centene, along with regional/local Medicaid carriers
- National: a commercial payor with a presence in more than four states that has filed on exchanges (specifically, Aetna/Coventry, Assurant, Cigna, Humana, UnitedHealthcare)
- Provider-based: a carrier that also operates as a provider/health system
- Regional/local: a commercial payor with a presence in four or fewer states (most often, just one state) that has filed on the exchanges

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