McKinsey&Company

# Insights into the 2018 individual exchange market

November 30, 2017

# Insights into the 2018 individual exchange market

**Note:** This analysis reflects carrier participation, pricing, and plan type trends for the 2018 individual exchange open enrollment period. Findings are across 50 states and D.C.

## 1 Carrier participation

- Although there are fewer carriers in 2018 than 2017 (194 vs. 234), there are 8 new carriers/market entries in 2018.
- All consumers[1] will have access to at least 1 carrier in 2018. 26% of consumers will have access to 1 carrier, and 74% will have a choice of two or more carriers. Corresponding figures in the 2017 exchange market were 19% and 81%, respectively.
- Most carrier types filed to offer plans to a smaller share of consumers in 2018 than in 2017. National carriers filed to offer plans to 10% of consumers in 2018, compared with 26% in 2017, and Blues carriers filed to offer plans to 79% of consumers, compared with 93% in 2017.

## 2 Pricing

- The median gross premium (before subsidies) of the lowest-price silver plan will increase by 31% from 2017 to 2018, compared with 25% from 2016 to 2017. Prices in all other metal tiers will increase by a range of 12% to 18% from 2017 to 2018. Some premiums may have been affected by the regulatory decision to end cost-sharing reductions (CSRs).[2]
- A majority (62%) of subsidy-eligible consumers may see the net premium of the lowest-price silver plan in their county decline in 2018, compared with 48% in 2017.
- Among subsidy-eligible consumers, access to a plan with a net monthly premium of either $10 or less – or $75 or less – increased from 2017 to 2018 across bronze, silver, and gold metal tiers. 50% and 70% of subsidy-eligible consumers have access to bronze plan with a net monthly premium of $10 or less or $75 or less, respectively.

## 3 Plan options

- Among consumers with 1 carrier option in 2018, 37% will have at least 10 plans to choose from across bronze, silver, gold, and platinum metal tiers. Plan options increase as carrier choice increases.
- HMOs make up 49% of plans that are within 10% of the lowest-price plan in a given county in 2018, compared with 52% in 2017. Also, the median 2017 to 2018 change in the lowest-price silver plan premium is higher among HMO and EPO plans (34%) than PPO and POS plans (27%).

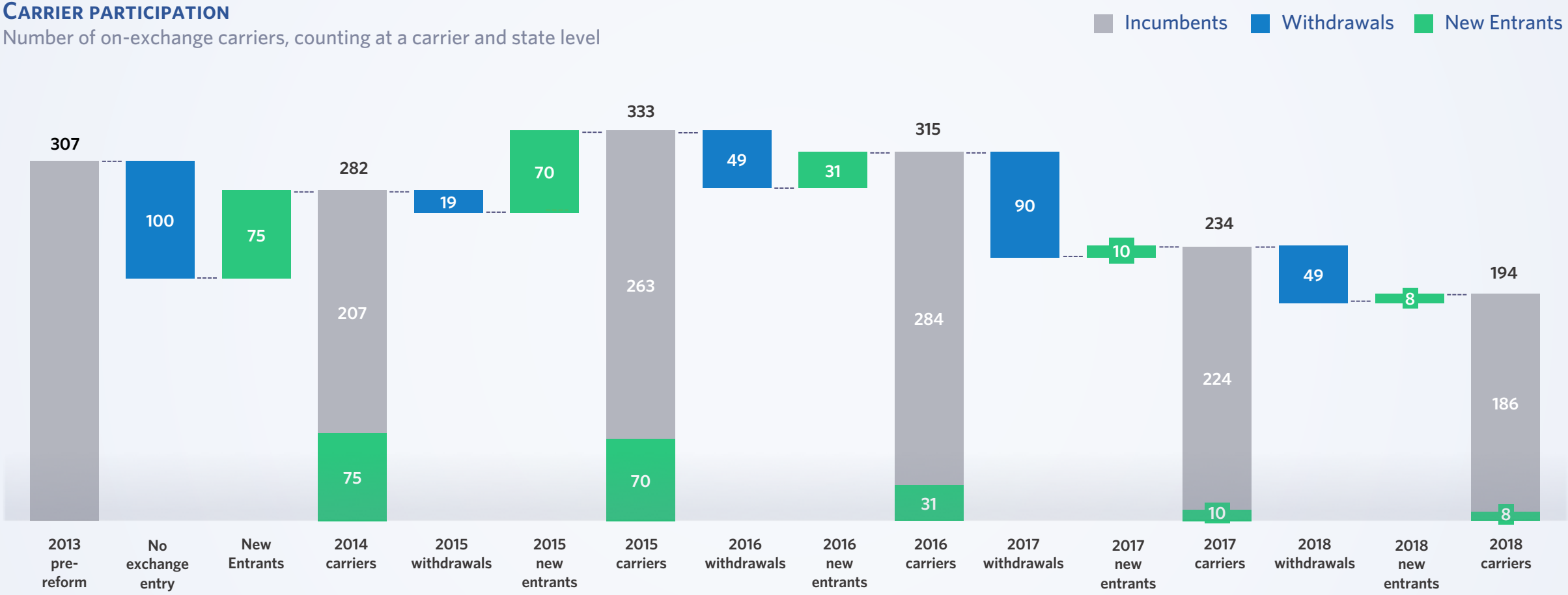
[1] Defined as the population eligible to purchase a qualified health plan (QHP).

[2] On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

# 1 Although there are fewer carriers in 2018 than 2017, there are 8 new carriers/market entries in 2018

## CARRIER PARTICIPATION

Number of on-exchange carriers, counting at a carrier and state level




**Note:** Carrier's participation status in a given year and state is defined as follows: Incumbent: A carrier that offered exchange plans during the prior year. For 2014 only, these are carriers that had individual market experience in 2013 in that given state. Withdrawal: A carrier that stopped participating on-exchange. For 2013 to 2014 withdrawals, these are carriers with individual experience in a given state that did not enter exchanges in 2014. New entrant: A carrier that did not participate on-exchange in the prior year but is joining exchanges for a given year and state. For 2014, these are carriers without individual experience in that state during 2013.

SOURCE: McKinsey Exchange Offering Database

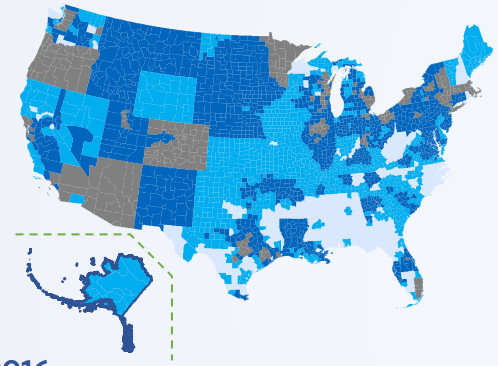
# 1 Carrier participation by county varies widely; 10 states will have 1 carrier in each county in 2018

## CARRIER PARTICIPATION

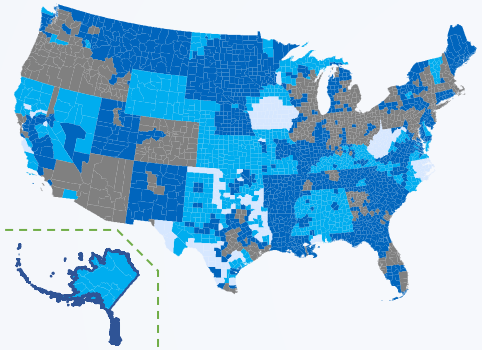
Number of carriers by county[1,2]

1 carrier | 2 carriers | 3-4 carriers | 5+ carriers

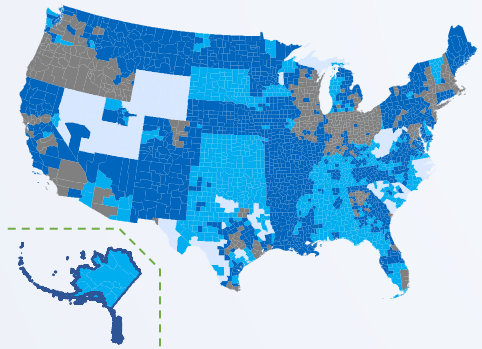
2014



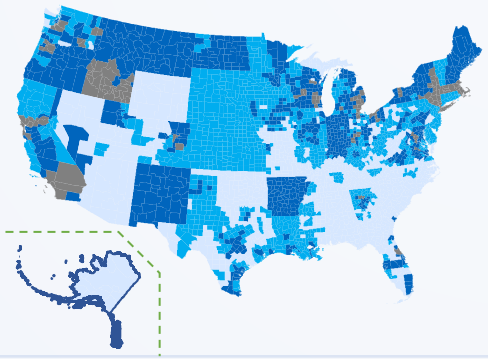
2015



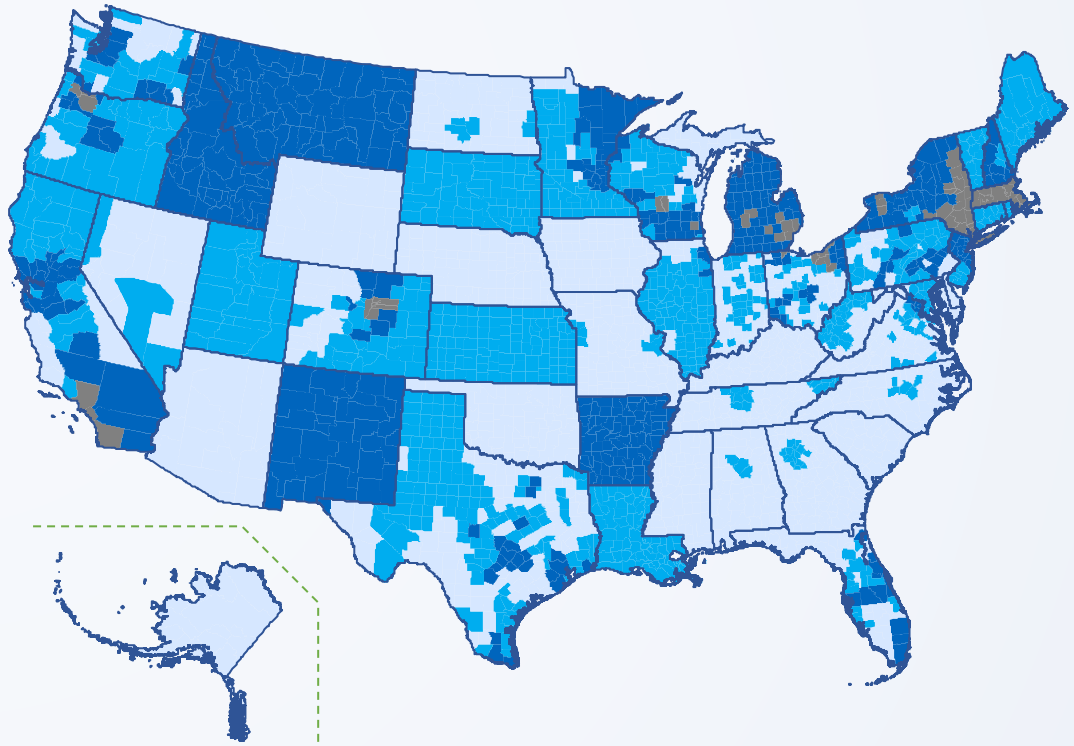
2016



2017



2018



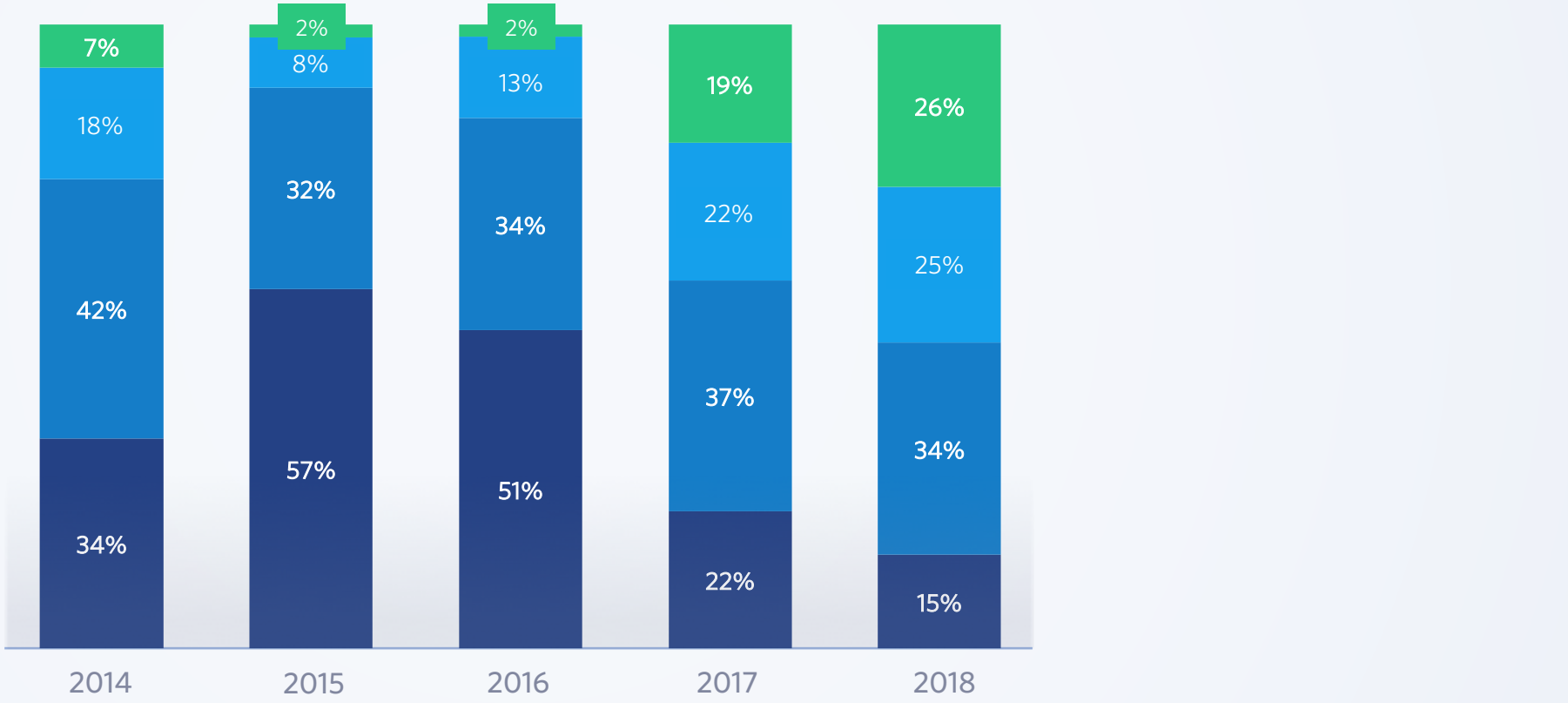
[1] Counting carriers that offer at least 1 silver plan at a parent company level.
[2] States with one carrier remaining in each county are Alaska, Arizona, Delaware, Iowa, Kentucky, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming. However, these states may have more than 1 carrier total participating in the state.

SOURCE: McKinsey Center for US Health System Reform

# 1 A majority of consumers continue to have carrier choice, though the percentage with access to fewer carriers has increased

**CONSUMER CHOICE OF CARRIERS**

% of consumers[1] seeing a given number of carriers in their county[2]



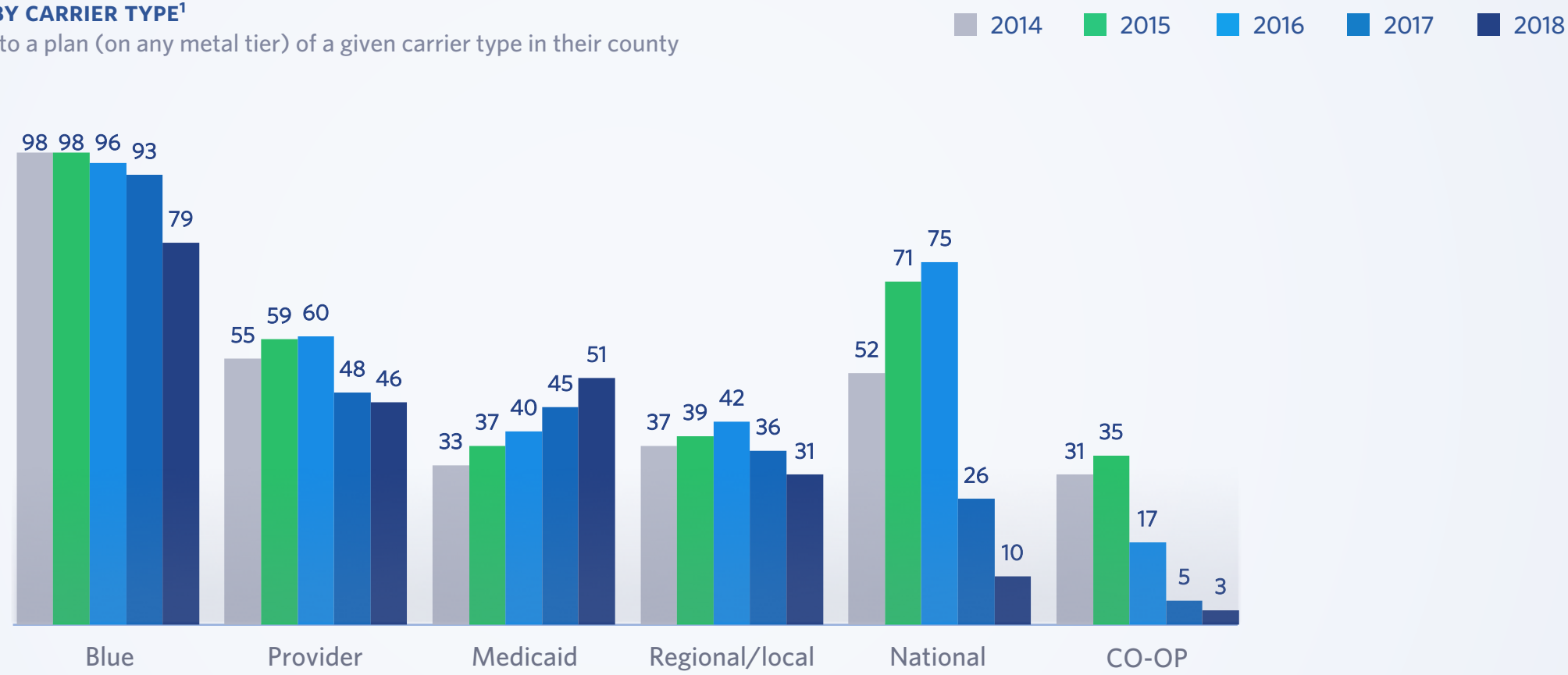

[1] Defined as the population eligible to purchase a qualified health plan (QHP).
[2] Counting carriers that offer at least 1 silver plan at a parent company level.

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT Model

# 1 Most carrier types filed to offer plans to a smaller share of exchange consumers in 2018 than in 2017

## EXCHANGE PARTICIPATION BY CARRIER TYPE[1]

% of consumers[2] with access to a plan (on any metal tier) of a given carrier type in their county




1 Blues: a Blue Cross Blue Shield payor (e.g., Anthem, HCSC); 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 on exchanges (e.g., Aetna, Cigna, UnitedHealthcare, Humana); Provider: 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.

2 Defined as the population eligible to purchase a qualified health plan (QHP).

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT model

# 2 Silver plan gross premiums (before subsidies) from 2017 to 2018 increased more than from 2016 to 2017, but increases on all other metal tiers are smaller

## GROSS PREMIUM CHANGE BY METAL TIER

Median % change in gross premium[1] (before subsidies) of the lowest-price plan, calculated at a county level

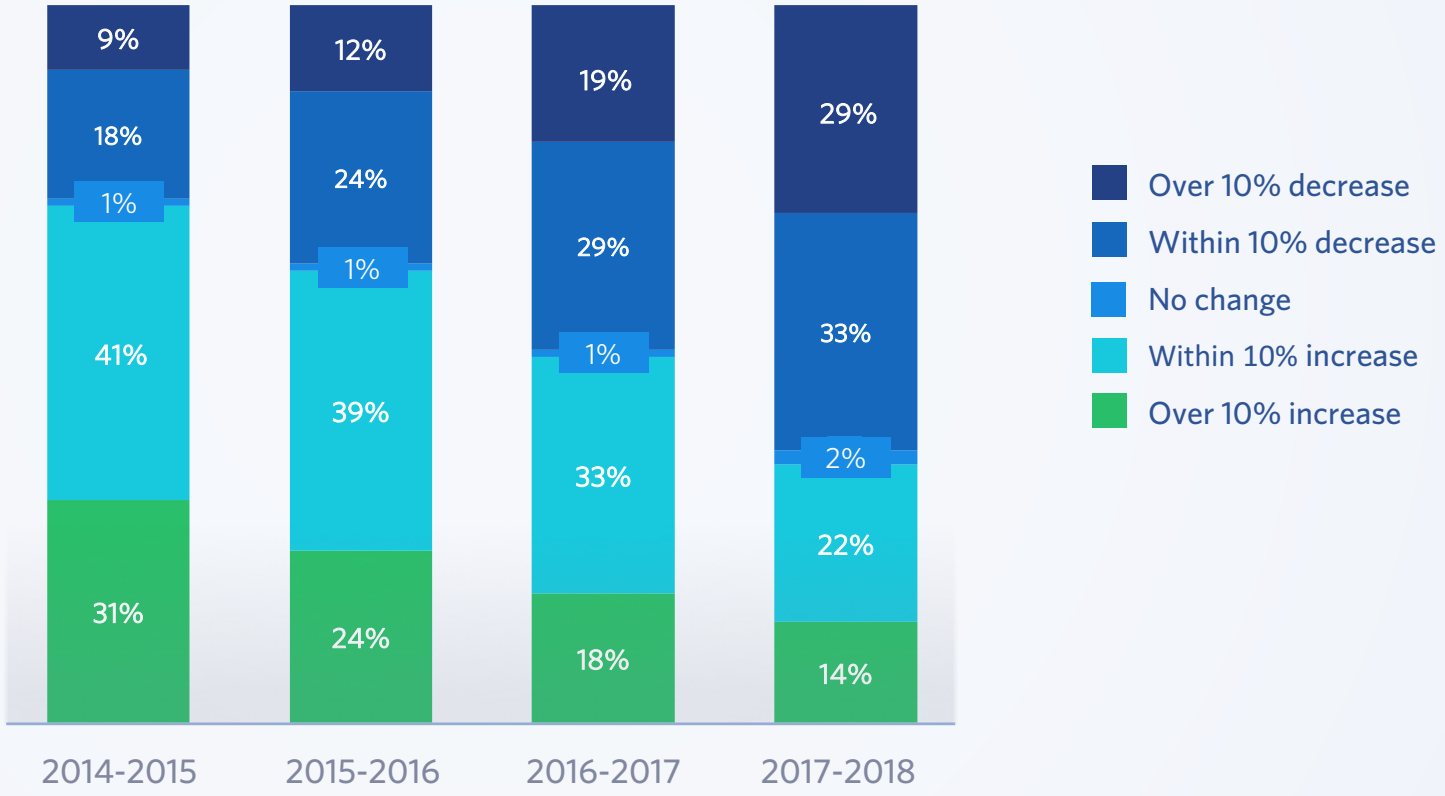

1 On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

SOURCE: McKinsey Center for US Health System Reform

# 2 A majority of subsidy-eligible consumers may see the net premium of the lowest-price silver plan in their county decline in 2018

## CHANGE IN SILVER NET PREMIUM FOR SUBSIDY-ELIGIBLE CONSUMERS

% of subsidy-eligible[1] consumers seeing a change in the net premium[2] (after subsidies) of the lowest-price silver plan in their county




[1] This includes only subsidy-eligible consumers (those with incomes below 400% of the federal poverty level), among consumers defined as eligible to purchase a qualified health plan (QHP). In cases where states change their eligibility requirements (e.g., via Medicaid expansion) we use the most recent set of eligibility determinations for all years (such that we are always comparing what a consistent population would observe).

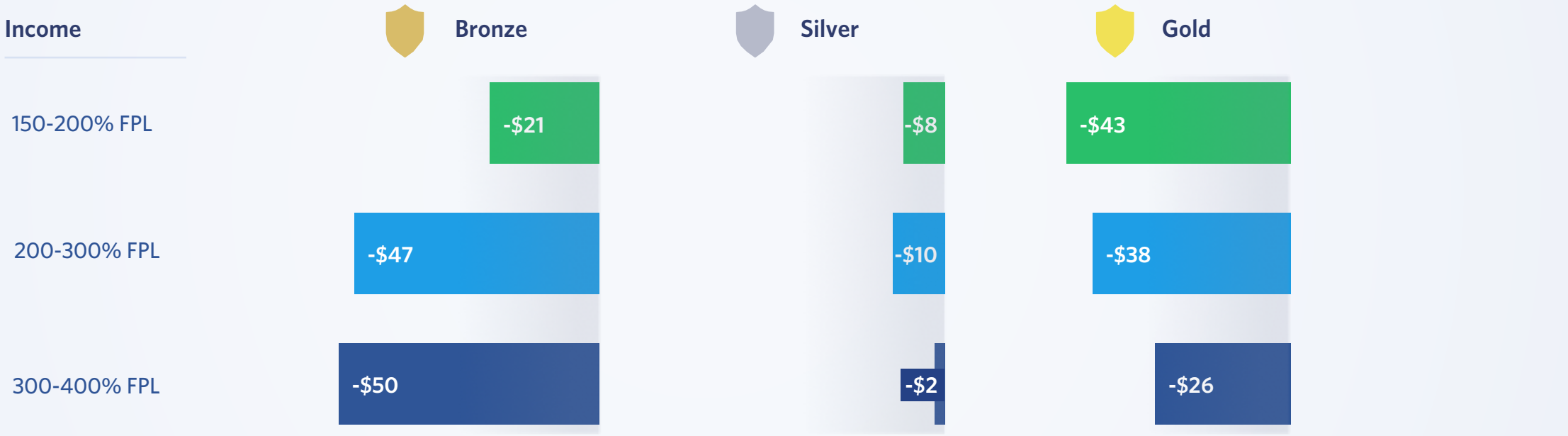
[2] On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT Model

# 2 Subsidy-eligible consumers may see a decline in net premium when selecting the lowest-price plan

## CHANGE IN NET PREMIUM BY METAL TIER AND INCOME 2017 TO 2018

Weighted average change ($) in net premium (after subsidies) of the lowest-price plan[1] by metal tier and percentage of federal poverty level (FPL) for subsidy-eligible consumers[2], calculated at a county level




[1] On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

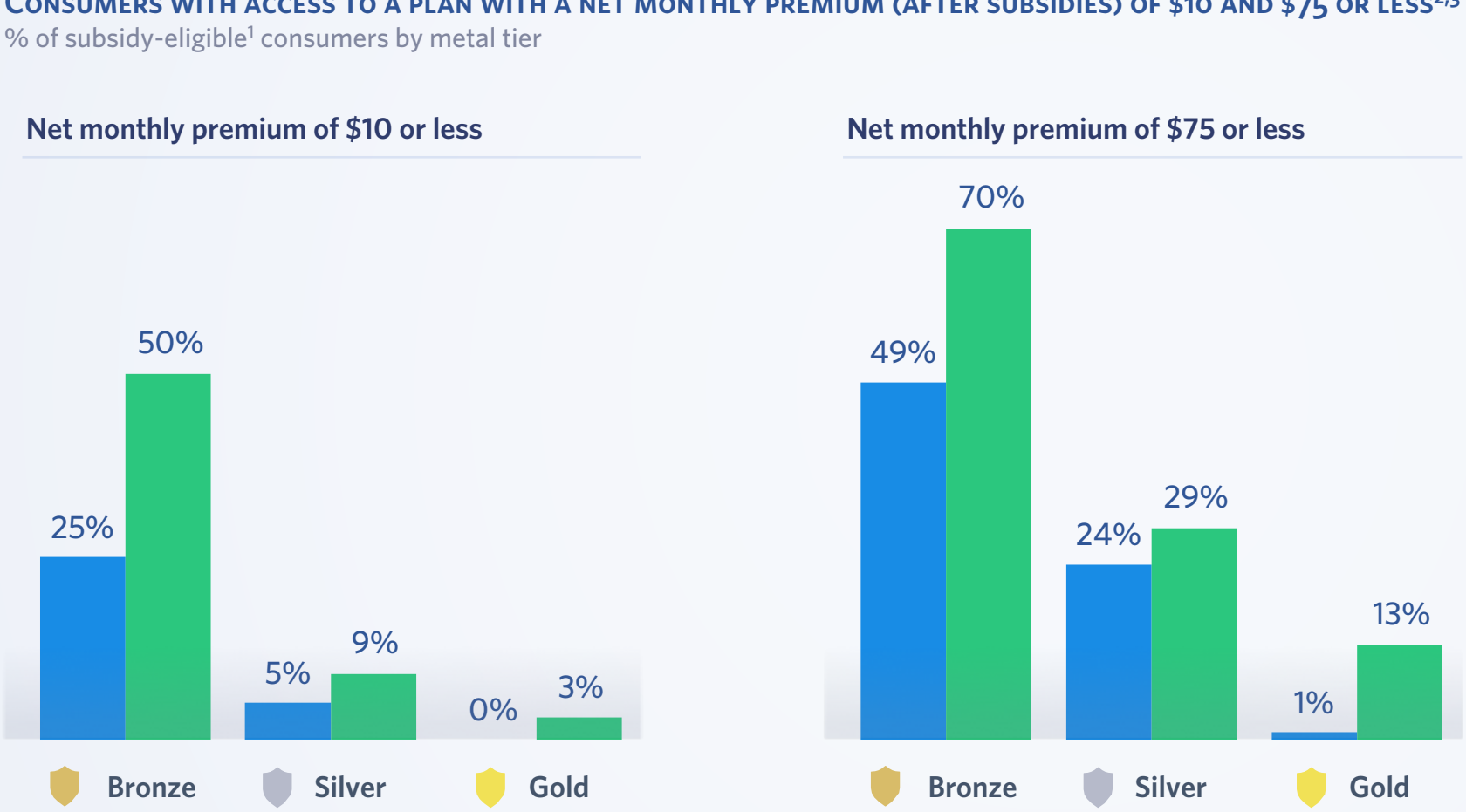
[2] This includes only subsidy-eligible consumers (those with incomes below 400% of the federal poverty level), among consumers defined as eligible to purchase a qualified health plan (QHP). In cases where states change their eligibility requirements (e.g., via Medicaid expansion) we use the most recent set of eligibility determinations for all years (such that we are always comparing what a consistent population would observe).

SOURCE: McKinsey Exchange Offering Database

# 2 Access to a plan with a net monthly premium of either $10 or less – or $75 or less – increased from 2017 to 2018

## CONSUMERS WITH ACCESS TO A PLAN WITH A NET MONTHLY PREMIUM (AFTER SUBSIDIES) OF $10 AND $75 OR LESS[2,3]

% of subsidy-eligible[1] consumers by metal tier




[1] This includes only subsidy-eligible consumers (those with incomes below 400% of the federal poverty level), among consumers defined as eligible to purchase a qualified health plan (QHP). In cases where states change their eligibility requirements (e.g., via Medicaid expansion) we use the most recent set of eligibility determinations for all years (such that we are always comparing what a consistent population would observe).

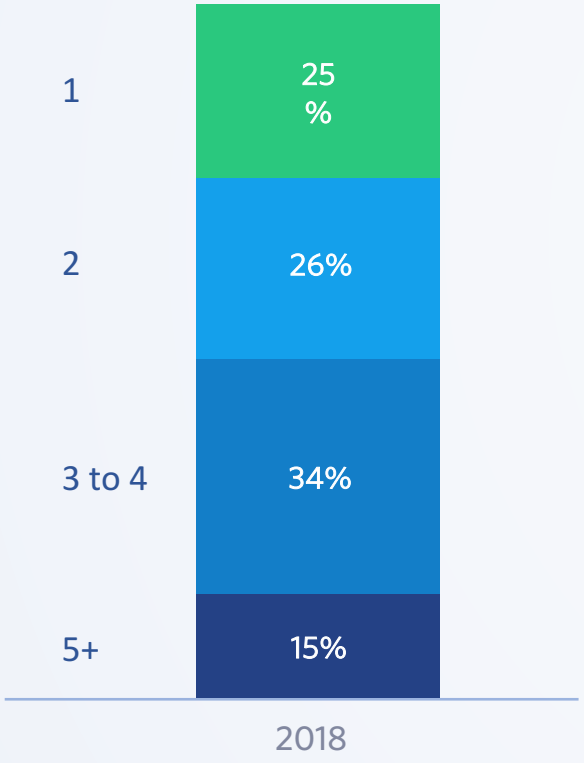
[2] $10 and $75 benchmarks are illustrative of potential reductions in net premium as a result of advanced premium tax credits and consumers selecting the lowest price option in a given metal tier.

[3] On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

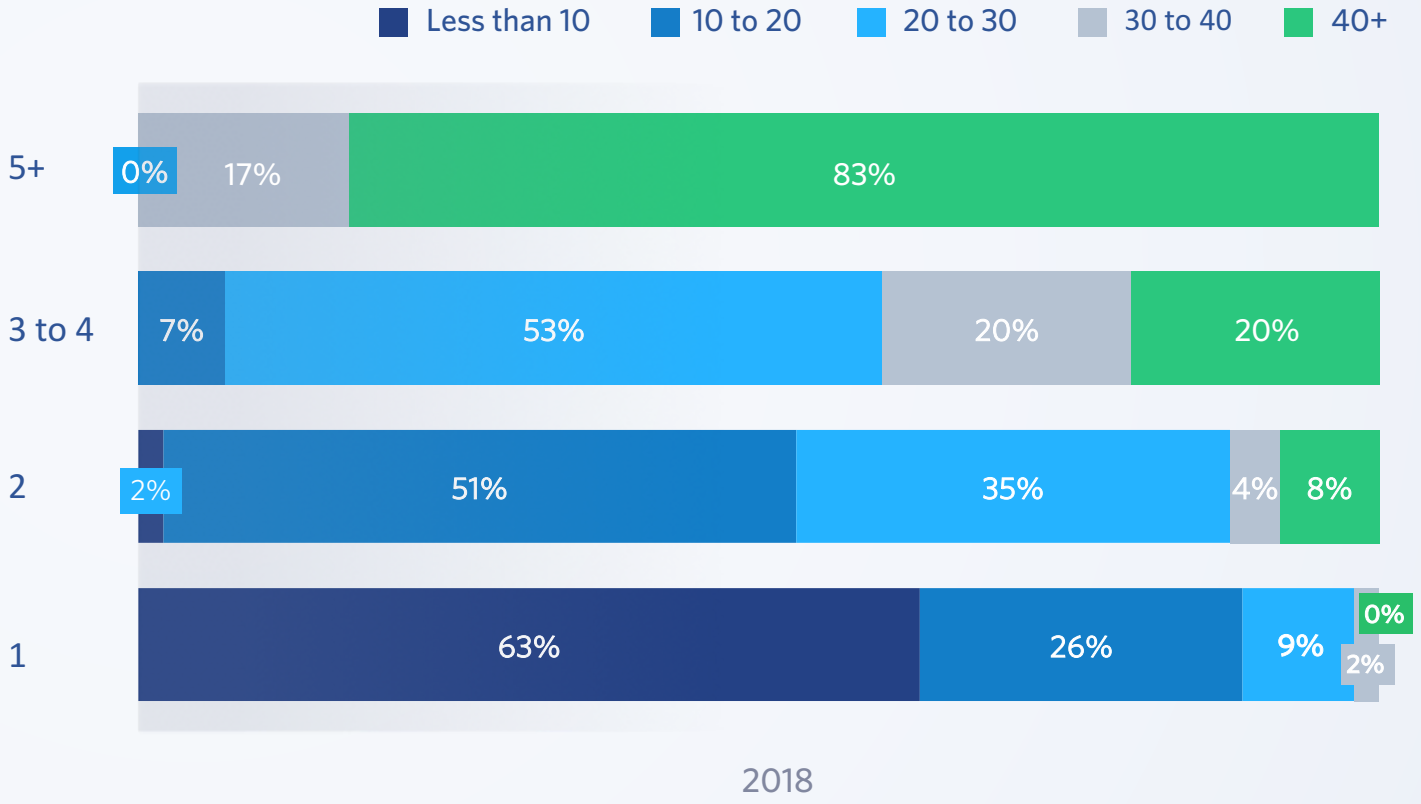
SOURCE: McKinsey Exchange Offering Database, McKinsey MPACT model

# 3 Consumers' access to plan options increases as access to carriers increases

**Breakdown of consumers (%) by access to number of carriers in their county, 2018**
% of consumers[1], number of carriers[2]




**Breakdown of consumers[1] (%) by access to number of products within each number of carriers[2] category, 2018**
% of consumers[1], number of products[3], number of carriers[2]



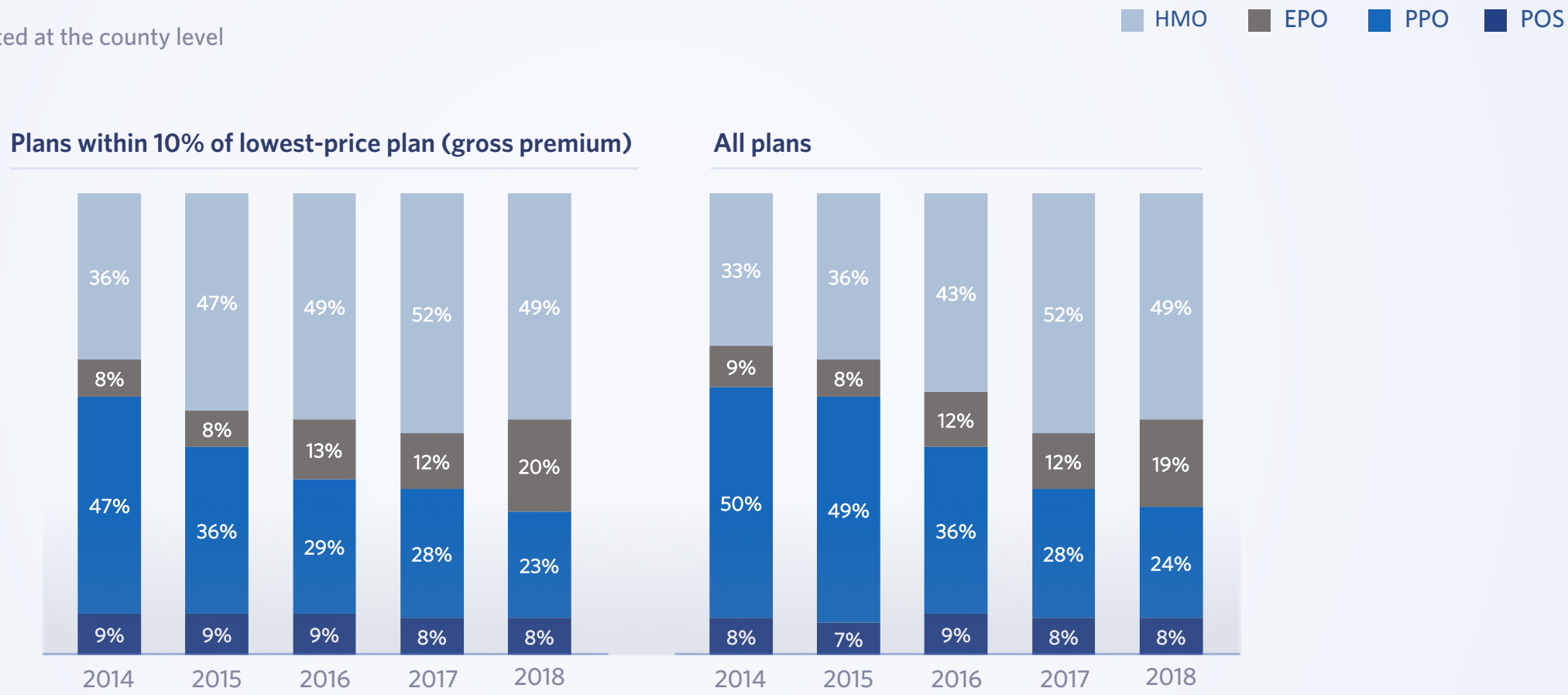

[1] Defined as the population eligible to purchase a qualified health plan (QHP).
[2] Counting carriers at a parent company level.
[3] Includes bronze, silver, gold, and platinum metal tiers.

SOURCE: McKinsey Exchange Offering Database, McKinsey MPACT model

# 3 HMO and EPO plans continue to have increase in proportion, but PPO and POS plans decline

## PLAN TYPE DISTRIBUTION

% of plan offerings[1], calculated at the county level



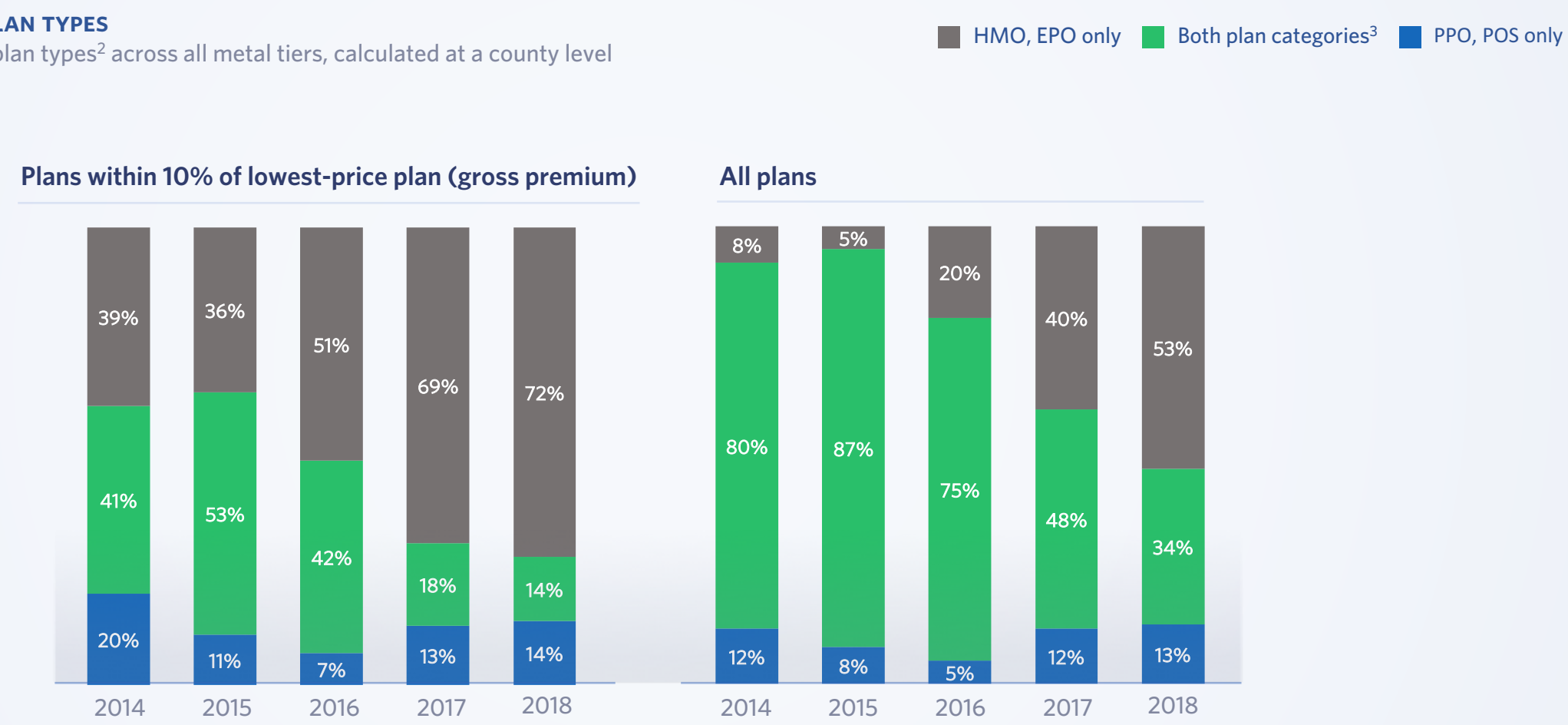

[1] Does not include catastrophic plans.

SOURCE: McKinsey Center for US Health System Reform

# 3 Consumers continue to have fewer lower-priced PPO and POS options

## CONSUMER ACCESS TO PLAN TYPES

% of consumer[1] access to plan types[2] across all metal tiers, calculated at a county level



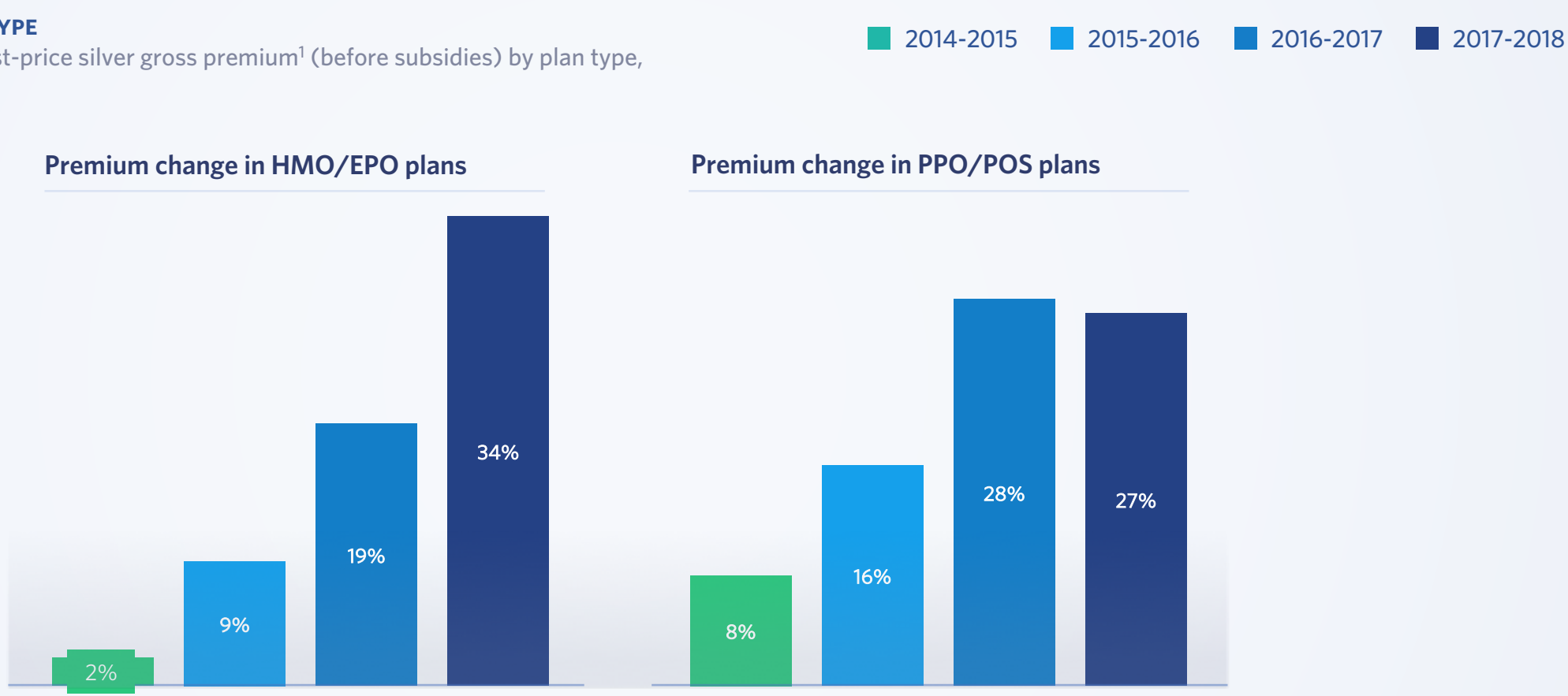

[1] Defined as the population eligible to purchase a qualified health plan (QHP).
[2] Does not include catastrophic plans.
[3] Defined as at least 1 PPO or POS plan and at least 1 HMO or EPO plan.

SOURCE: McKinsey Center for US Health System Reform, McKinsey MPACT model

# 3 From 2017 to 2018, the percentage premium increases for PPO and POS plans did not exceed those of HMO and EPO plans

## PREMIUM CHANGE BY PLAN TYPE

Median % increase in the lowest-price silver gross premium[1] (before subsidies) by plan type, calculated at a county level



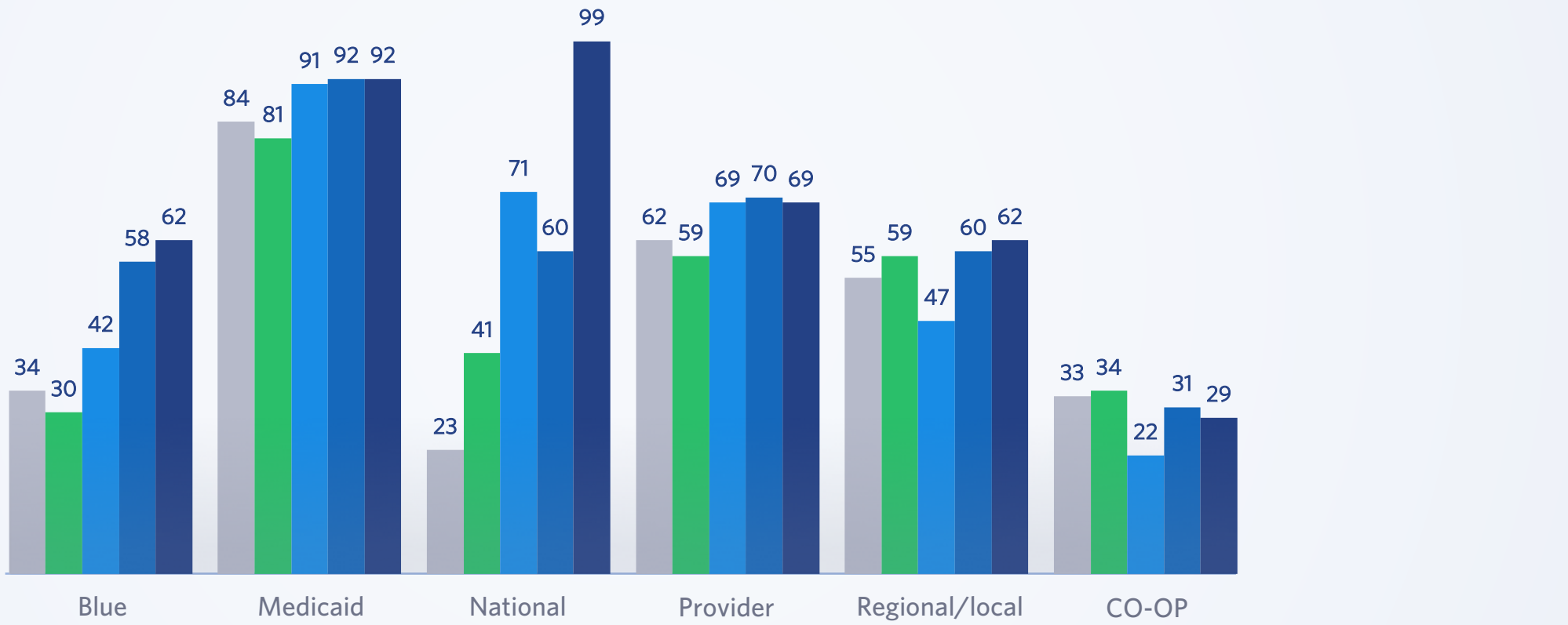

1 On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.

SOURCE: McKinsey Center for US Health System Reform

# 3 Over time, most carrier types have increased the proportion of their offerings that are HMO or EPO plans

**PLAN TYPE DISTRIBUTION BY CARRIER TYPE[1]**

% of plan offerings that are HMO or EPO plans[2]




1 Blues: a Blue Cross Blue Shield payor (e.g., Anthem, HCSC); 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 on exchanges (e.g., Aetna, Cigna, UnitedHealthcare, Humana); Provider: 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.

2 Does not include catastrophic plans.

SOURCE: McKinsey Center for US Health System Reform

# Methodology

**Overarching methodology:** Findings in this document are based on publicly available information. 2014 through 2018 rates come from the McKinsey Exchange Offering Database, which includes county and plan level information from publicly available rate filings and healthcare.gov. The qualified health plan (QHP)-eligible population is estimated using McKinsey's MPACT model, based on public sources (e.g., US Census, American Community Survey), defined as individual market-eligible/enrolled or uninsured, and eligible for Medicaid but uninsured.

**Pricing[1]:** 2014 through 2017 pricing information is based on publicly available approved rates, and 2018 information is based on healthcare.gov as well as state-based exchanges. All analyses are at the county level. This report does not include off-exchange pricing data. To understand the net premium changes that subsidy-eligible individuals will face, we calculated the weighted average change in net premiums between 2017 and 2018 for the lowest-price silver plan in each rating area. First, we established a distribution of subsidy-eligible individuals (at a household level) in each rating area, using McKinsey's MPACT model (based on public sources: Census Bureau, ACS, SAHIE). Next, we combined this population distribution with data about 2017 and 2018 lowest-price silver plan 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 maximum premium (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 plan to calculate the net premium of the lowest-price silver plan. Finally, we used the 2017 and 2018 net premiums to calculate weighted-average rate changes for 50 states and D.C. individually and collectively.

**Carrier participation:** To calculate the counts of carrier participation, we analyzed the number of unique carrier names that are offering plans on-exchange. In the case where a single parent company offers plans under multiple carrier names, we count each carrier separately. To calculate the consumer view of carrier participation, we analyzed the number of unique parent companies that are offering plans on-exchange, to be reflective of what a consumer perceives.

**Plan types:** Plan types reported here were taken directly from carrier rate filings and Summary of Benefits and Coverage (SBC) documents. Independent assessment of plan types was not part of the analysis presented in this document. Plan types are defined as follows:

- HMO: a health maintenance organization is a plan typically centered around a primary care physician who acts as gatekeeper to other services and referrals; it usually provides no coverage for out-of-network services, except in emergency or urgent care situations
- EPO: an exclusive provider organization is a plan similar to an HMO. It usually provides no coverage for any services delivered by out-of-network providers or facilities except in emergency or urgent-care situations; however, it generally does not require members to use a primary care physician for in-network referrals
- PPO: a preferred provider organization is a plan that typically allows members to see physicians and get services that are not part of a network, but out-of-network services often require a higher copayment
- POS (unmanaged plan): a point-of-service plan is hybrid of an HMO and a PPO; it is an open-access model that may assign members to a primary care physician and usually provides partial coverage for out-of-network services

1 On October 12, 2017, the Trump administration announced that it would not make cost-sharing reduction (CSR) payments to carriers. Most states instructed carriers to account for the loss of CSR funding in the 2018 plan year. However, the approaches vary -- for example, many states required carriers to load additional premium increases onto silver tier plans, while others asked insurers to spread additional premium increases across all metal tiers. Thus, there is variation in premium trends across states and metal tiers.