McKinsey Center for U.S. Health System Reform

Intelligence Brief

2015 OEP: Emerging trends in the individual exchanges

The 2015 open enrollment period (OEP) begins in about seven weeks. To develop a preliminary understanding of how it is likely to differ from last year's, we analyzed all available data from the state exchanges as of September 15, 2014. We began by collecting the carrier participation data released by 40 states and the District of Columbia; collectively, these localities contain nearly 80 percent of the population eligible for qualified health plans (QHP) in the United States. We then examined data from the 19 localities (18 states and D.C.) that released complete rate filings, which collectively contain 44 percent of the QHP-eligible population. (To simplify the discussion in this Intelligence Brief, we refer to the first group as "41 states" and the second group as "19 states.") For comparison with 2014 carriers and products, we used the comprehensive exchange offering database we developed during that OEP. Because detailed information about 2015 rate filings is currently available from only 19 states, many of our analyses focused on silver plans, the products purchased most often during the 2014 OEP.[1]

We elicited four key observations from our analyses:

- *Competition and choice are increasing.* In the 41 states releasing exchange participation carrier data, the number of health insurers increased by 26 percent between 2014 and 2015.[2] In the 19 states with complete filings, the number of products grew 66 percent, with most in the silver tier.
- *Gross premiums for most 2014 plans are likely to increase.* In the 19 states, proposed gross premiums are increasing for 65 percent of all exchange renewal products (plans offered in 2014 that were re-filed for 2015).[3] In 2015, therefore, enrollees could see a

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[1] Complete details about the specific states analyzed and our methodology can be found in the appendix.

[2] Our calculations are based on the number of carriers that offer plans in each state. For example, a national carrier that offered plans in 12 states in 2014 would be counted as 12 "unique payors" in that year. However, a carrier that offered 2014 exchange plans in 4 rating areas within 1 state is counted as a single entrant in that state.

[3] In the 19 states, 81 percent of all 2014 products were re-filed.

median increase of 4 percent when they receive their renewal notifications.[4] However, the actual increase they pay could be less than half that amount, given that many people will have the option of switching to a lower-price plan.

- *Price leadership volatility is high; in many rating areas, proposed 2015 premiums are lower than 2014 premiums.* Because price leadership is likely to turn over in 59 percent of the rating areas, over half of QHP-eligible individuals could have a new lowest-price carrier (either a higher-priced 2014 competitor that lowered prices substantially or an aggressively priced new entrant). Two-thirds of the rating areas with a less expensive lowest-price silver plan in 2015 have a new price leader.
- *The changes in net premiums for the subsidy-eligible are likely to vary significantly.* Net premiums (the cost of products after subsidies) for the lowest-price silver plans are likely to increase for 70 percent of subsidy-eligible individuals in the 19 states and decrease for 29 percent of that population (1 percent will see no change). The extent of the potential increases and decreases varies by market and income; individuals at the high end of subsidy eligibility (200 to 400 percent FPL[5]) are likely to see the highest increases.

A caveat: The rates released by the 19 states are the most recent information that is publicly available; however, they should be considered preliminary until exchanges go live on November 15th. For 7 of the 19 states (Colorado, Connecticut, District of Columbia, Indiana, Maryland, Oregon, Washington), the rates for 2015 have been approved but could still be modified before OEP. For the remaining 12 states, approved rates are not yet available. Furthermore, the rates to be released by the remaining 32 states could alter some of the trends just described. Once data from all states are available (after the 2015 OEP begins), we plan to publish a more detailed Intelligence Brief that will update our initial findings and contain more information about the catastrophic, bronze, gold, and platinum tiers. In the interim, we will regularly update our online, real-time 2015 rate filing tracker.

Competition and choice are increasing

In the 41 states releasing carrier exchange participation data, 57 new carriers[6] will be entering the 2015 exchanges. In contrast, only 5 carriers from 2014 have withdrawn. Accordingly, the number of carriers will increase 26 percent over 2014. Just over half of the new carriers participated on an exchange in another state in 2014 *(Exhibit 1)*. Twenty-three percent participated only in the off-exchange market in 2014; the remainder are new to individual health insurance.

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[4] Because of limitation in the available data, our calculations did not account for the fact that enrollees who aged a year between 2014 and 2015 will get a slightly different premium as they move up on the age curve. By analyzing the standard CMS age curve that applies to 45 of the 51 states, however, we were able to estimate that the average rate increase incurred for individuals ages 21 through 63 is 2.6% per year.

[5] Based on 2014 federal poverty level (FPL) guidelines; for a household of one, household income at 200 percent of FPL is $23K and at 400 percent of FPL is $47K.

[6] A 2015 new carrier (or "new entrant") is defined as a carrier that did not participate in a given state's exchange in 2014. However, it may have participated in other states' exchanges or offered off-exchange products in the given state.

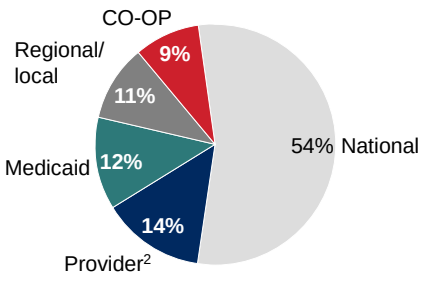
EXHIBIT 1

There is a range of new entrant types, with 57 new entrants across 41 states

100% = 57 carriers[1]

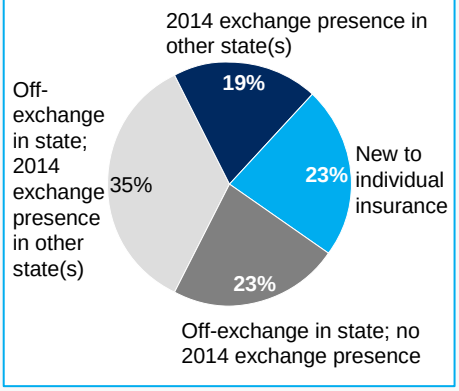
Over half are national carriers

Carrier type



Over half have 2014 exchange experience

Exchange experience



1 Based on the number of carriers that offer products in each state, i.e., a carrier that offers plans in 3 states counted 3 times
2 Includes provider-based entrants offering coverage in other lines of business

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 5, 2014 across 41 states with available information

National carriers are the most common type of new 2015 entrant, followed by provider-based health plans.[7] In addition, some Medicaid carriers that competed in 2014 are expanding into new exchanges, most often in Medicaid expansion states where the carrier already serves as a Medicaid managed care organization.

In the 19 states with complete filings, 153 carriers have proposed introducing 5,304 new products,[8] which would increase the total number of products on the exchanges by 66 percent *(Exhibit 2)*. In each rating area, the average number of products from which consumers will likely be able to choose is rising to 64, from 39. Existing carriers (2014 OEP participants that are offering products in 2015) are introducing 72 percent of the new plans. On average, these carriers are offering nearly twice as many products as the new entrants are offering in each rating area. Fourteen percent of the existing carriers are expanding into new rating areas in states where they participated in 2014—in some cases, doubling their addressable market. Provider-based plans (30 percent), Medicaid carriers (24 percent), and nationals (24 percent) are leading this form of expansion.

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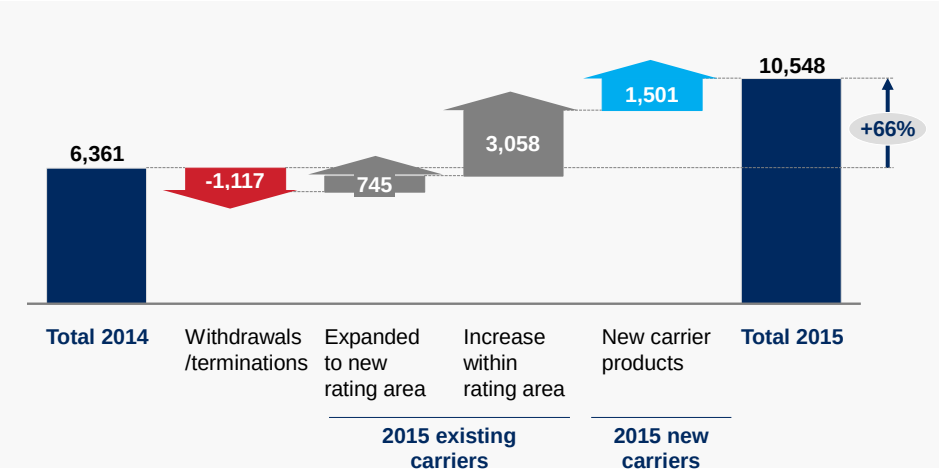
7 "Nationals" are commercial payors with a presence in more than 4 states. Provider-based products are being introduced by 3 providers that previously offered group commercial coverage, 3 that offered Medicaid products, 1 that offered Medicare plans, and 1 that offered individual insurance pre-reform.

8 Products are counted unique at the rating-area level. A new product is defined as a product that was not offered by a given carrier on the 2014 exchange in a given rating area. For example, if a new carrier offers one product in 4 additional rating areas, the plan would be counted as 4 new products, even though its benefits might be identical in all areas.

EXHIBIT 2

Exchange product choice is expanding in 2015

Product expansion from 2014 to 2015 across 19 states with complete filings
Number of individual exchange products[1]



1 Products counted unique at rating area level

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

Gross premiums for most 2014 plans are rising

To understand how premium levels may change in the 19 states with complete filings, we examined year-on-year pricing changes for all 2014 renewal products in any tier. Our analyses indicate that, based on submitted rates, gross premiums (the amounts charged by carriers) could increase for 65 percent of renewal products; the median price increase for this subset is 9 percent ($299 annually for a 40-year-old nonsmoker). For 28 percent of renewal products, rates could increase more than 10 percent. The overall median price increase for all renewal products is 4 percent. As the sidebar at right describes, however, calculations of medians alone do not accurately reflect the impact that price changes may have on consumers' pocketbooks.

The potential price changes vary by rating area. Memphis, for example, could see the median price of a premium rise by 15 percent. In contrast, the median premium price could decrease in Baltimore by 5 percent. In

How will 2014 enrollees be affected by premium changes?

Medians are often the best way to report on proposed gross premium changes, since they are not influenced by outliers. However, medians do not account for the fact that some 2014 plans enrolled many more members than other plans did. If the proposed rate changes are weighted to reflect the data currently available about last year's enrollment, the potential increase in the amount that 2014 exchange enrollees in all tiers could see with their renewal notifications rises from a 4-percent median to a 7-percent weighted average increase.

However, it is possible that many 2014 enrollees may switch plans due to the premium increases, given the strong preference consumers showed in the 2014 OEP for the lowest-price plans.[1] If, for example, every 2014 enrollee who bought last year's lowest-price plan purchased this year's lowest-price plan in the same tier, the weighted average gross-premium increase drops to 5 percent. Alternatively, if everyone facing an increase over 10 percent switches to the lowest-price plan in the same tier, the weighted average is only 3 percent.

1 According to a recent ASPE report, 64 percent of the 2014 enrollees in federally facilitated marketplaces chose either the lowest-price or second-lowest-price plan in their rating area. (ASPE Issue Brief. Health insurance marketplace: Summary enrollment report for the initial annual open enrollment period. May 1, 2014.)

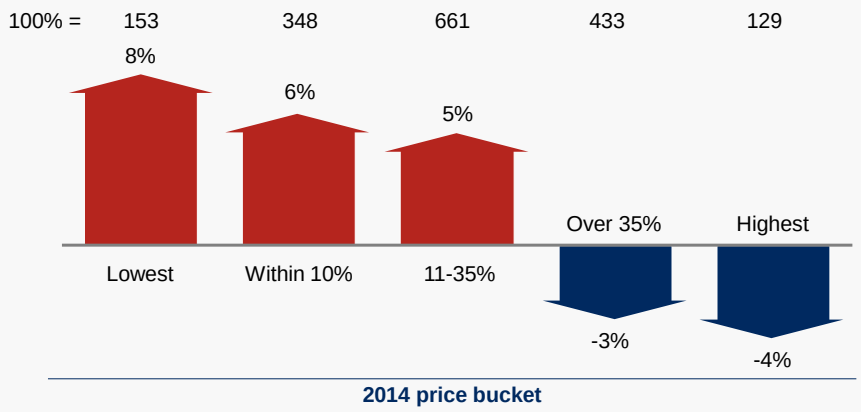
general, the states having lower-than-average 2014 prices are seeing the highest proposed increases in 2015 gross premiums.

Within the silver tier, the full range of proposed price changes runs from –35 percent to +36 percent. In most cases, the highest increases are being imposed on last year's lowest-price plans—a median increase of 8 percent, or $258 annually for a 40-year-old nonsmoker *(Exhibit 3)*. In contrast, the highest-price 2014 silver plans that have re-filed rates have a median premium decrease of 4 percent ($195 annually). As a result, premium price dispersion among renewal plans appears to be decreasing.

EXHIBIT 3

Lower priced 2014 products will see larger rate increases in 2015

2015 price increase of 2014 silver products across 19 states with complete filings
Median percentage increase across products by 2014 price position



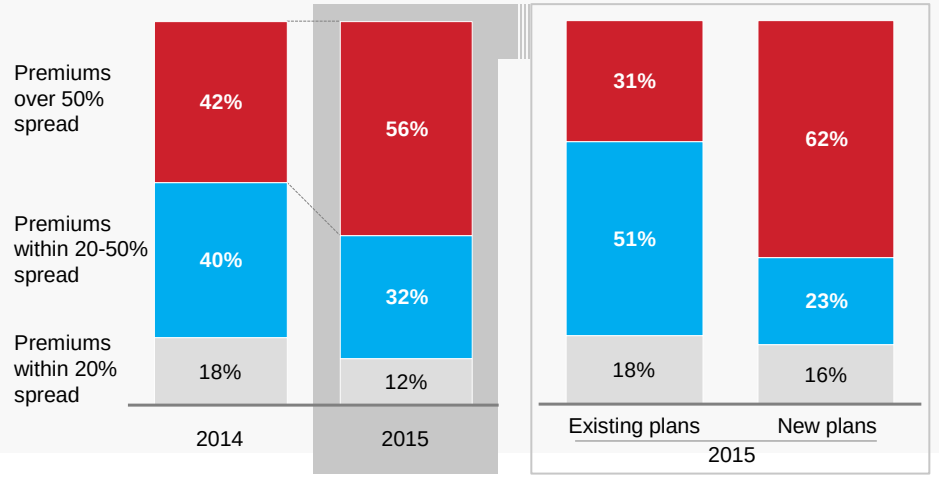
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

However, price dispersion is greater among new 2015 products (from both existing and new carriers) than it was among 2014 plans. Thus, consumers are likely to face a wider, rather than a narrower, range of prices this fall *(Exhibit 4)*.

EXHIBIT 4

Exchange price dispersion is increasing from 2014 to 2015

Silver-tier price variation[1] within rating area across 19 states with complete filings
QHP-eligible population, percent, 100% = 14.7M individuals



1 Price variation measured as % difference between lowest and highest exchange product for an individual within silver tier in each rating area

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

Price leadership volatility is high; many rating areas have lower premiums

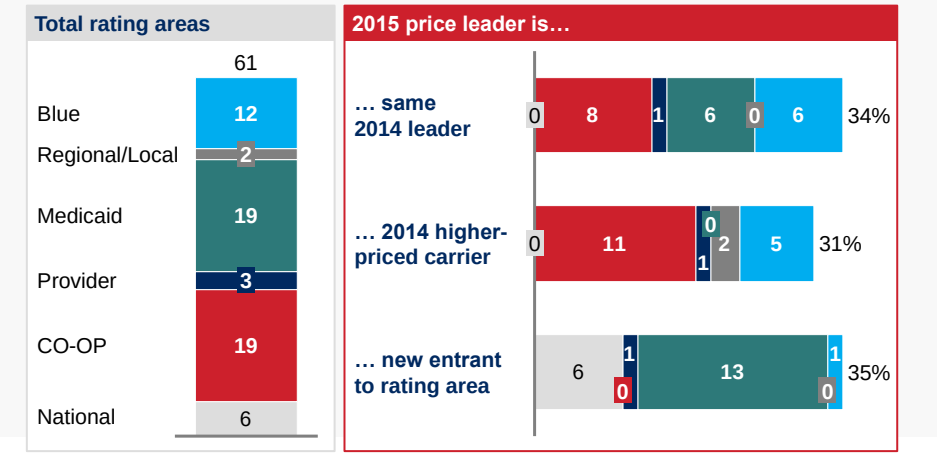
Competitive dynamics may lead to changes in price leadership in 59 percent of the rating areas in the 19 states. In 37 percent of the 165 rating areas, carriers have proposed introducing silver products less expensive than the lowest-price 2014 product *(Exhibit 5)*. (The median decrease is $179 annually for a 40-year-old nonsmoker.) In 9 percent of the rating areas, gross premiums for the lowest-price 2015 silver products could drop by more than 10 percent (median decrease is $531 annually). In 35 percent of the rating areas in which the lowest-price silver plan could decrease, a new carrier is likely to offer the new lowest-price product in 2015; in most of these rating areas, a Medicaid new entrant could capture the price leadership position. Another 31 percent of the time, a higher-priced 2014 competitor (most often, a CO-OP) has proposed decreasing its premiums to become the new price leader.

Price leadership could also change in some rating areas where the premium of the lowest-price silver plan increases. In these rating areas, another carrier could offer a product with a premium below the cost of the least-expensive 2015 plan offered by last year's price leader.

EXHIBIT 5

Most lowest-price silver premium decreases are due to a new price leader

Rating areas where 2015 lowest-price silver is priced lower than 2014 lowest-priced silver
Number of rating areas by 2015 price leader, n = 61 rating areas across 19 states



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

The changes in price leadership appear to be having a dampening effect on premium increases. In the 59 percent of the rating areas that may have a new price leader, gross premiums for silver-tier products appear to be increasing more slowly than in rating areas where the 2014 leader is likely to remain in place (a median of 1 percent rather than 4 percent).

Changes in net premiums for the subsidy-eligible vary significantly

To understand how proposed premium changes affect affordability for subsidy-eligible individuals, we analyzed the likely change in net premium (the amount individuals have to pay after subsidies are considered) between the lowest-price silver plans in 2014 and 2015. Our calculations suggest that for 70 percent of those who are subsidy-eligible in the 19 states with complete filings, net premiums for these plans could rise; for this subset, the weighted average increase in annual net premiums is likely to be about $156. However, for 28 percent of all subsidy-eligible individuals, the increase in the lowest-price silver plan will likely be more than 10 percent.

Conversely, 29 percent of all subsidy-eligible individuals could see net premiums decline for the lowest-price silver plan; the weighted average decrease in annual net premiums for this group is likely to be $136. For 10 percent of all subsidy-eligible individuals, the decrease could exceed 10 percent. The remaining 1 percent of subsidy-eligible individuals will see no change. (A brief explanation of how we derived these estimates is given in the sidebar at the top of the next page. Greater detail appears in the appendix.)

These figures, like the changes in gross premiums, vary widely by market (the result of variations in pricing and competitive dynamics across rating areas). For example, almost all

subsidy-eligible individuals in Michigan are likely to see an increase in the net premium for the lowest-price silver plan from 2014 to 2015 (the weighted average increase is $271 annually). However, only 4 percent of subsidy-eligible individuals in New York are likely to see an increase—across the state, subsidy-eligible individuals are likely to see a weighted average decrease of $205 *(Exhibit 6).*

How will subsidy-eligible individuals be affected by changes in net premiums?

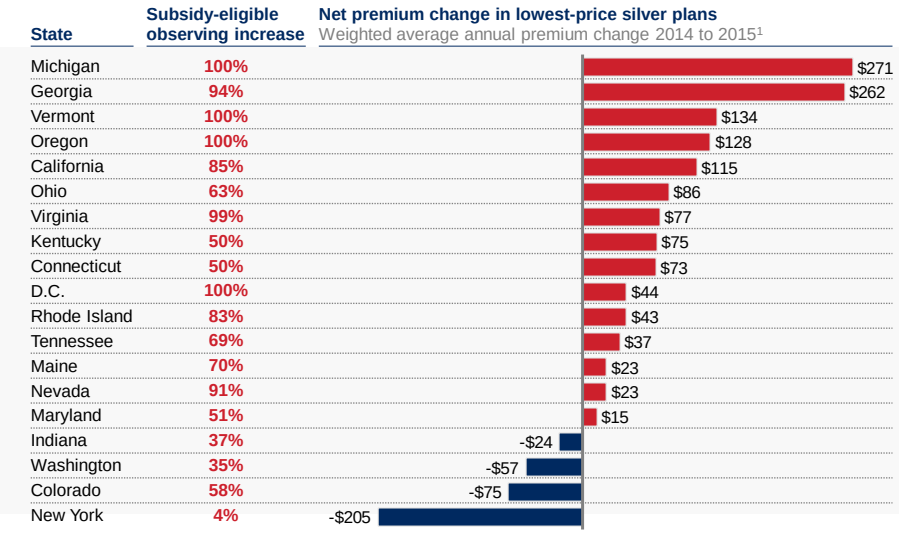
To understand the impact of premium changes on affordability for subsidy-eligible individuals, we separated out the three factors that determine the change in the amount of subsidies from 2014 to 2015: indexed definitions of the federal poverty level (FPL), indexed premium caps set by the Affordable Care Act, and the change in gross premium between 2014 and 2015 for the "anchor plan" (the second-lowest-price silver plan) in each rating area. Because subsidy levels are different for different groups, we used weighted averages rather than medians to estimate impact.

In 59 percent of the rating areas in the 19 states analyzed, the 2015 anchor plan's price is rising; in 41 percent, it is declining. The change in the anchor plan's premium relative to change between 2014 and 2015 in the cost of the lowest-price silver plan[1] 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 plan among subsidy-eligible individuals. Only one-third of the net premium changes are driven by changes in the other two factors.

1 Subsidy-eligible individuals face higher net premiums for the lowest-price silver plan when the rise in the anchor plan's cost is less than the gross premium increase for the lowest-cost plan, or when the decrease in the anchor plan's cost is greater than the decrease in gross premium for the lowest-cost plan.

EXHIBIT 6

Change in net premium for subsidy-eligible varies widely across markets



1 Based on a weighted average net-premium across all subsidy eligible individuals; accounts for age, family size, income, and geography

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

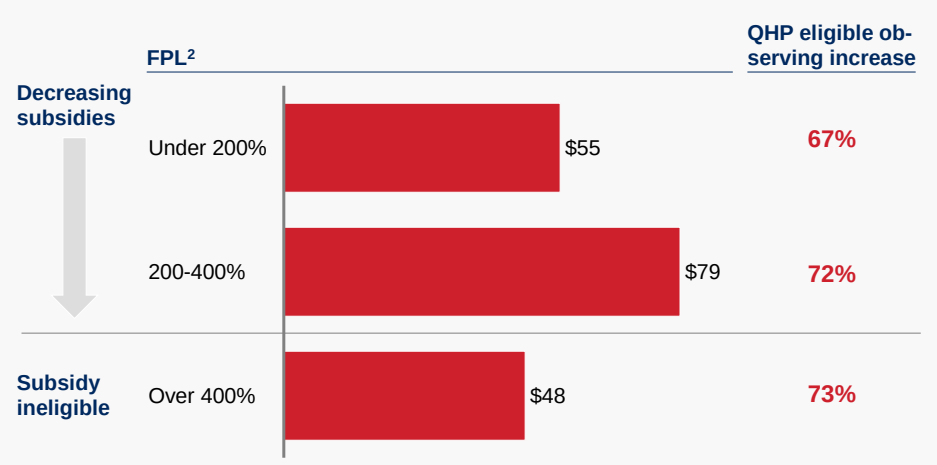
Individuals at the high end of subsidy eligibility (200 to 400 percent of FPL) are likely to be most exposed to increases in net premiums for the lowest-price silver plans. Individuals with

incomes below 200 percent FPL are largely protected from these increases (they hit their premium cap even if they buy the lowest-cost plan, and thus their subsidy absorbs the entire premium cap). In contrast, those with incomes above 400 percent FPL have already been paying full gross premiums and thus face only the percentage increases in those premiums. However, most individuals in the middle income bands do not hit their premium cap if they buy the lowest-price plan, and thus they must bear the premium change in its entirety. Our analyses suggest that the weighted average increase in annual net premiums per member for the lowest-price silver plan is likely to be about $55 when income is less than 200 percent FPL and $48 when income is above 400 percent FPL—but for those in the middle, the annual increase is likely to be about $79 *(Exhibit 7)*.

EXHIBIT 7

Those at high end of subsidy eligibility are most exposed to price increases

Net premium change in lowest-price silver plans across 19 states
Weighted average annual premium change 2014 to 2015 by FPL[1]



1 Based on a weighted average net-premium across all subsidy eligible individuals; accounts for age, family size, income, and geography
2 Based on 2014 FPL guidelines: For a household of one 100% FPL is $12k, 200% is $23K, 400% FPL is $47K

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 19 states with complete filings

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The emerging trends presented in this Intelligence Brief help to inform expected changes in the competitive landscape on the 2015 exchanges, which open in approximately seven weeks. 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, based on 19 states with complete filings and 41 states with carrier exchange participation data. Additional data will better inform the extent to which the exchange landscape is evolving.

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The authors would like to thank Brock Mark, Brendan Murphy, and Paolo Singer 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 and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of comprehensive 2014 individual exchange offerings as well as what has actually been filed to date on the individual exchanges for 2015. Once final 2015 exchange offering data is available for all states (after the 2015 OEP begins), the database will be further updated.

Additional Reform Center/MAHA tools can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across product types and actuarial value tiers by consumer characteristics, exchange network trends, and predictions of market share based on filings and consumer-predicted dynamics, benefit designs across carrier types and metal tiers, and more. Specific analyses are available upon request from the Reform Center/MAHA team; we look forward to helping our clients achieve success in the post-ACA market through the use of data-driven analysis on specific market trends.

Please contact reformcenter@mckinsey.com with any inquiries.

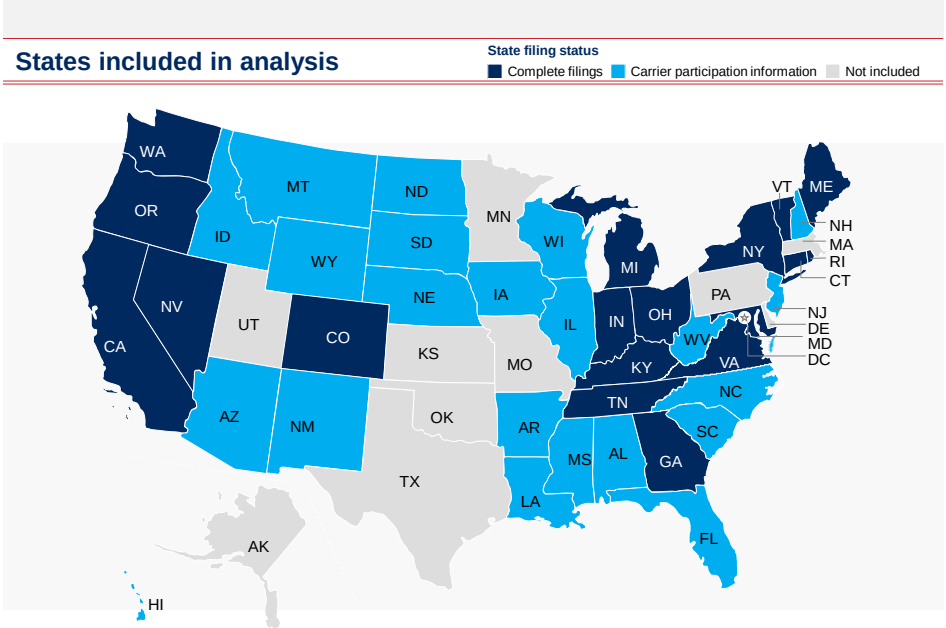
Methodology

Data sources:

The major analyses in this Intelligence Brief are based on the two types of data that were publicly available as of September 15th:

2015 exchange rate filings: Publicly available complete 2015 individual market exchange filings released by the Departments of Insurance in 19 states. These filings include on-exchange carriers and rate tables. They are the most recent information that is publicly available, yet are preliminary until exchanges go live on November 15. For 7 of the 19 states (Colorado, Connecticut, District of Columbia, Indiana, Maryland, Oregon, Washington), the rates for 2015 have been approved but could still be modified before OEP. For the remaining 12 states (California, Georgia, Kentucky, Maine, Michigan, Nevada, New York, Ohio, Rhode Island, Tennessee, Virginia, Vermont), approved rates are not yet available.

2015 exchange carrier participation data: Additional information available from 22 states (making a total of 41) about individual exchange carrier participation for all carriers filing on the 2015 exchanges. We obtained this information through a variety of sources, including Departments of Insurance, carrier websites, and press releases with carrier or DOI citations. The additional states are Alabama, Arkansas, Arizona, Florida, Hawaii, Iowa, Idaho, Illinois, Louisiana, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, South Carolina, South Dakota, Wisconsin, West Virginia, and Wyoming.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of September 15, 2014 across 41 states with available information

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2014 exchange offerings database: A county-level database of all products offered on 2014 exchanges across all 501 rating areas in the United States. This includes premiums, carriers, cost-sharing details, plan type design, and network design across all metal tiers.

McKinsey Predictive Agent-based Coverage Tool (MPACT): A granular and dynamic behavioral simulation model that projects the impact of health reform over time on the coverage decisions of consumers, payers and employers. It provides specific projections of lives in each health insurance business line at a granular county level, merging county- and state-level sources from Census, Small Area Health Insurance Estimates (SAHIE), and American Community Survey (ACS).

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 represents the number of unique carriers offering products in at least one rating area within a state. (Not all carriers offer products in every rating area within a state.) The carriers were then divided into two groups: those that had offered products on the 2014 exchanges and re-filed those products for 2015 and those that were offering products on the exchanges for the first time in 2015.

Exchange product offerings: To understand how consumers' choice of products is changing, we compared the number of exchange products offered in 2014 and 2015. To look at product offerings from the consumer's perspective, we counted two otherwise identical plans offered by the same parent company as separate plans if they are being sold under two different

names. "Total across state" was calculated by determining the total number of plans (in all metals tiers) in each rating area and then adding those numbers together. "Plans offered compared to 2014" represents the difference between the total number of 2015 exchange plans offered in a given state and all 2014 exchange plans offered in that same state; plans were counted uniquely at a rating-area level (i.e., each plan in each rating area counts as one).

Gross premium change for 2014 exchange plans: To understand the gross premium changes affecting 2014 exchange plans, we calculated the average change for all 2014 exchange plans that were re-filed in 2015. (As a result, these rate changes do not indicate overall pricing in the 2015 market, because they exclude new exchange entrants' plans as well as new exchange plans filed by existing carriers.) To do this, we started with the full set of 2014 exchange plans across the 165 rating areas with complete 2015 filings available. For each plan, we identified whether it was terminated (as indicated in the rate filing), withdrawn from the market (if the carrier withdrew), or re-filed in 2015. We matched 2014 products with their 2015 equivalent product by HIOS ID or other key identifying product feature. Once all of the 2014 exchange plans that were re-filed were matched with their 2015 exchange offering, we calculated the increase or decrease in pricing for each plan and then averaged the changes across all plans.

We focused many of our analyses of gross premiums on exchange silver products for three reasons. First, 65 percent of all exchange enrollees bought silver plans. 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. To understand gross premium changes in the lowest-price silver plans between 2014 and 2015, we looked at all 2014 lowest-price silver exchange plans and compared them to all filed 2015 lowest-price silver plans across the 165 rating areas with complete 2015 filings available. For 2015, the total includes new entrants' plans and new plans filed by existing carriers.

Next, we calculated the weighted-average gross premium changes for 2014 exchange plans as a way to better understand the premium changes that 2014 exchange enrollees would face. First, we established the distribution of 2014 exchange enrollment at a rating-area level by price position within metal tier across ages. To do this, we used HHS-reported state-level exchange enrollment by metal tier and age within tier, and national enrollment by price position within tier (lowest, second-lowest, all others). We assumed that the age distribution within tier and the price position distribution remained constant at a rating-area level. We used McKinsey's MPACT model (based on public sources: Census, ACS, SAHIE) to estimate age distribution at a rating-area level. For the distribution of price position for plans above second-lowest, we assumed a geometric distribution across remaining plans.

Then, we combined this 2014 exchange enrollment distribution at a plan level with actual 2014 exchange products that were filed again in 2015 across our 19 states. To estimate premiums, we assumed that each exchange enrollees 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 plan. Then, we calculated the weighted-average rate increases at a percent and nominal level for each of the 19 states and at the overall cross-19-state level.

Net premium change for subsidy-eligible individuals: To understand the net premium changes that subsidy-eligible individuals will face, we calculated the weighted average change in net premiums between 2014 and 2015 for the lowest-price silver plan in each rating area. We assumed that subsidy eligibility will be re-determined for all individuals in 2015. 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 2014 and 2015 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 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 2014 and 2015 net premiums to calculate weighted-average rate changes for the 19 states individually and collectively.

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 rating area, the interactions between the 2014 to 2015 changes in the cost of the second-lowest-price silver plan (the anchor plan against which subsidies are set) and the lowest-price silver plan.

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 4 states that has filed on the exchanges (specifically, UnitedHealth, Cigna, Humana, and Aetna/Coventry)
- Provider-based: a carrier that also operates as a provider/health system
- Regional/local: a commercial payor with a presence in 4 or fewer states (most often, just one state) that has filed on the exchanges

Obtaining previous Intelligence Briefs

Previous Intelligence Briefs on exchange dynamics can be obtained online at: healthcare.mckinsey.com/reform

- "Hospital networks: Updated national view of configurations on the exchanges" (June 2014)
- "Individual market: Insights into consumer behavior at the end of open enrollment" (May 2014)
- "2015 Medicare Advantage rates: Perspectives for payors" (April 2014)
- "Individual market enrollment: Updated view" (March 2014)
- "Exchange product benefit design: Consumer responsibility and value consciousness" (February 2014)
- "Individual market enrollment: Early assessments and observations" (January 2014)
- "Hospital networks: Configurations on the exchanges and their impact on premiums" (December 2013)
- "Exchanges go live: Early trends in exchange dynamics" (October 2013)
- "Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?" (September 2013)

September 2014