November 18, 2012

# Insurers Face Array of Variables in Weighing Health Exchange Participation

**Competition in exchanges differs from the norm.**

As health insurance exchanges began to operate on Oct. 1, it has become apparent that carriers' participation varies greatly across different geographies. While some states – such as California, Oregon, Michigan and Pennsylvania – have more than 10 insurance companies offering exchange products, many states have only two or three carriers participating, and some have only one.

The exchange products and rules differ from traditional health insurance market practices, and insurance companies have carefully evaluated their participation in the exchange marketplace, particularly in states that have not had a guaranteed issue requirement for individual policies. Insurance carriers usually evaluated significant factors in conjunction with their financial flexibility and willingness to absorb the financial losses – should the exchange products, especially at first, prove to be unprofitable – to decide whether or not to participate. Such factors included the:

- Competitive landscape in the state;
- Carrier's market share;
- Strength of the network and provider discounts;
- Weight and role of individual products in the company's overall portfolio; and
- State's economic and regulatory climate.

## Competition Redefined

Competition on the exchange market is viewed somewhat differently from the traditional approach. It is widely expected that significant numbers of individuals with poor health and no prior coverage may sign up in the beginning. Therefore, as the only carrier in the market, especially in a state with no prior guaranteed issue, a company is subject to possible adverse selection. A larger number of insurance players on the exchange reduces the chance of adverse selection for any particular carrier, and therefore may be viewed positively. In the states where some exchange carriers are new entrants – whether out-of-state insurance companies using the opportunity to break into the market, or newly founded health cooperatives – the established health insurance players face competitors offering limited network lower priced products that can appeal to a healthier population. Established carriers such as Blue Cross Blue Shield plans, with high name recognition and a reputation for rich products and high-touch service, can become a choice of sicker populations.

Insurance companies that have large membership and significant market share in the state have an advantage in terms of strong provider networks and discounts. However, while in traditional health insurance, the network's reach often is viewed as a critical competitive advantage, the exchange products have driven a number of carriers – including Blue Cross Blue Shield plans that generally have the largest share of providers participating – toward narrow or high-performance networks. By limiting the

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exchange products to narrow networks, where providers deliver lower cost and higher quality care, carriers increase their ability to control claims costs and offer products at lower premiums than for broad network products. Furthermore, the narrow network mitigates the risk of adverse selection based on reputation for wide access and rich services. Since insurance companies have a choice to offer exchange products only in certain counties, their decision to participate with the exchanges usually is tied to the availability of an efficient provider cost structure in every locality.

New carriers also are entering the marketplace in 2014. The Patient Protection and Affordable Care Act (PPACA) included a provision for funding a loan program to create customer-driven, nonprofit health insurers called Consumer Operated and Oriented Plans, or CO-OPs. As a result, 24 CO-OPs received approval for low-interest loans to fund required capital levels and commence operations. In January 2013, as part of the fiscal cliff agreement, the availability of funding for additional CO-OPs ceased. Of the 24 CO-OPs, 22 are set to operate on health insurance exchanges in 2014. One Ohio-based CO-OP missed the deadline to have its application approved, and as a result is to offer products outside the exchange in 2014 and on the exchange in 2015. The other CO-OP, in Vermont, was dissolved after the Centers for Medicare & Medicaid Services terminated its loan agreement.

A.M. Best believes that in general, the decision whether or not to participate in the public exchange, in and of itself, is not a rating factor. For companies that elect not to participate, A.M. Best will consider their market share in the individual market and the potential impact to operating performance from the loss of membership, as well as the potential impact to earnings. For companies that opt to offer coverage on a public exchange, A.M. Best will monitor these carriers' levels of risk-adjusted capitalization and their ability to remain adequately capitalized with the additional enrollment.

### Calculating the Risks

Some companies with long-term market presence, high name recognition and reputations for rich products decided to mitigate the risk of adverse selection by establishing and offering only nonbranded products on the exchanges. In such cases, carriers still have an advantage of deeper discounts and effective operations due to a large nonexchange membership; however, they face the inconvenience and expense of marketing the new brand.

The size and role of individual and small-group products in the overall product portfolio is another deciding factor for carriers choosing whether or not to participate in the exchange market. Insurers focused on large and midsize accounts may choose not to participate in the exchanges in 2014 and possibly re-evaluate their decisions in future years. Carriers that already have sizable individual membership, especially in states where the individual market historically has been strong, are likely to continue their commitment to individual members by offering exchange products. There are some exceptions in which insurers with large individual blocks of business have decided not to participate in the exchanges and have been intentionally reducing their exposure to individual membership since PPACA first was adopted. These carriers usually had sustained significant operating losses with guaranteed-issue individual products in prior years and were trying to avoid similar results in the future.

Economic factors such as average income and job growth in the state, as well as regulatory issues, such as rate review mechanism and Medicaid expansion, are other important considerations for participating in exchanges. Lower income translates into a larger

subsidy-eligible population, therefore increasing the number of individuals likely to purchase policies through the exchanges. In addition, businesses in lower income states may be more likely to send their employees to the exchanges because of the available subsidies. Under these circumstances, single-state carriers may want to establish their position on the exchange market since there is a possibility of gradual transition from group to individual coverage via exchanges. The decisions of many states not to expand Medicaid have influenced the dynamics of participation in the exchanges, since significant numbers of low-income people in these states will not be eligible for government subsidies.

Individuals who qualify for Medicaid can shift in and out of the program as their employment status or income changes. Those who no longer qualify for Medicaid may be highly subsidized in an exchange environment, particularly in states that have expanded eligibility for Medicaid. By offering coverage on the exchange, a health insurer may be able to retain highly subsidized individuals who are no longer eligible for Medicaid. As a result, some of the insurance companies that participate and specialize in Medicaid managed care, such as Centene Corp. and Molina Healthcare Inc., are offering products in the health insurance exchanges in selected markets.

Health insurance companies are weighing their financial flexibility against business and economic uncertainties of the exchange products. Overall, the industry has enjoyed several years of strong margins, combined with modest premium growth, leading to stronger levels of risk-based capital. In addition, its ability to issue debt at historically low rates and access bank lines of credit provides opportunities for additional capital if needed. However, while some carriers are willing to expand into exchanges at the expense of lower future capitalization, others are focused on preserving capital and are avoiding participation in products that are likely to incur operational losses in the near term.

As open enrollment proceeds, A.M. Best will monitor health insurers' market positions, both on and off the exchanges, for impacts on companies' operations as well as their operating performance and risk-adjusted capitalization. Of interest will be any negative impacts from the additional membership and potential trends that may develop.

## Strategic Considerations

For publicly traded national health insurers, profit opportunities largely drive their decisions to participate or not in exchanges. Geographic diversification of these carriers allows for greater flexibility to choose to participate in exchange markets, based on existing membership and opportunities for better discounts from providers in a given state. In some cases, carriers' plans to bid on state Medicaid programs may foster participation in exchanges even in markets where they currently have relatively little business.

For Blue Cross Blue Shield plans and nonprofit carriers, their organizational mission and historical role as insurers serving all market segments are important considerations, along with profitability. The majority of Blue Cross Blue Shield plans are participating in the individual exchanges. For these companies, it was a matter of developing the right products at a lower cost. However, it should be noted that a few Blue Cross Blue Shield plans have elected not to participate in exchanges, at least in 2014, while others have elected to participate under a different company that is not a Blue Cross Blue Shield-branded entity. For these companies, the decision may have been based on their concern over adverse selection, and that a limited number of existing competitors in the pre-exchange market could result in even fewer competitors in an exchange environment.

During the past several years, many health insurance companies changed their operations and service models to ease the transition into consumer-driven markets, including exchanges. These changes include, among others:

- Increased flexibility in information systems;
- Enhanced automated services;
- Better medical management of chronic conditions;
- Quality-based reimbursement to providers; and
- Rewards for wellness.

On the exchange market, the ability to deliver care at a lower cost is likely to become a major competitive advantage. In addition, enterprise risk management (ERM) programs may become important to carriers' success in the exchange market. Companies with mature ERM programs have established the process to view organizational risks in aggregate and are better able to balance overall risk. Since participation in new exchange products may increase operational risks, a mature ERM program may help to offset it in part by reducing risks in other areas.

It is widely anticipated that the number of individuals buying exchange products in 2014 will be lower than initial estimates following PPACA's passage. However, the first year will provide important training for participating insurance carriers that may face operational issues and financial losses due to the influx of new members. The companies that chose not to participate may benefit by avoiding initial pitfalls, but they could lose significant market share, especially in the individual segment. Furthermore, A.M. Best believes some companies – those electing to either not participate or limit the number of exchanges they will participate in next year – are waiting to see what happens in the first year or two. These carriers may elect to join in later years, such as 2015 or 2016. While these companies may lose out on initial enrollment, the individual market can be highly price sensitive, and based on premiums, they still may be able to gain enrollment.

## Conclusion

Overall, health insurers' earnings have been strong over the past few years and have enabled many companies, particularly nonprofits, to build capital. This should enable those taking part in exchanges to absorb the additional premiums and withstand lower margins or potential losses, should they occur through adverse selection, and still remain adequately capitalized for their business risks. However, A.M. Best has some concerns that newly established entities may not have the financial wherewithal to absorb large volumes of business, initial start-up costs and/or a period of sustained losses without seeking support from other sources.

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SR-2013-B-492