The Heritage Foundation
LEADERSHIP FOR AMERICA

BACKGROUNDER

No. 2852 | NOVEMBER 12, 2013

Health Insurers' Decisions on Exchange Participation: Obamacare's Leading Indicators

Edmund F. Haislmaier

Abstract

How have health insurance companies responded to Obamacare? Insights into how Obamacare is likely to alter the health care system can be gleaned from analyzing insurer decisions to participate, or not participate, in the new exchanges. An analysis of the decisions shows that in the vast majority of states the Obamacare exchanges will offer less, not more, insurer competition than the state's current individual market. Obamacare's complicated, income-based design of premium and cost-sharing subsidies will result in the exchange market essentially offering something akin to Medicaid managed care for the middle class. The resulting picture is one that millions of Americans are likely to find unappealing.

In the run-up to the launch of the Obamacare[1] health insurance exchanges, attention increasingly focused on the premiums for the new coverage—specifically the degree to which they might be higher or lower than current premiums.[2]

Yet, changes in premiums tell only part of the story. Additional insights into how Obamacare is likely to alter the health care system can be gleaned from analyzing insurer decisions to participate, or not participate, in the new exchanges. Analyzing insurer exchange participation decisions in light of current insurance market data and other public information can yield important insights into how insurers expect the implementation of Obamacare to change America's health system.

Health insurers are the market actors with the strongest motivation to understand how Obamacare is likely to alter the decision

This paper, in its entirety, can be found at **http://report.heritage.org/bg2852**

Produced by the Center for Health Policy Studies

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Key Points

- Compared to the current individual health insurance market, insurer participation in the Obamacare exchanges represents a 29 percent net decrease in insurer competition nationwide.
- Obamacare's cost-sharing subsidies pay insurers to offer coverage to lower-income exchange enrollees with no deductibles and only nominal patient co-pays. As a result, Medicaid managed-care insurers are participating in the exchanges and many insurers are offering exchange plans with "narrow networks" that limit coverage to providers willing to accept low reimbursement.
- The insurers that decided to participate in the Obamacare exchanges are mainly a mix of Blue Cross carriers seeking to extend their market dominance, group-market carriers looking to retain enrollees when employers drop coverage, and Medicaid managed-care insurers expanding into a market they view as similar to their current business.
- The exchange market will essentially offer Medicaid managed care for the middle class.

making of the other players in the system—employers, individual consumers, and health care providers. Numerous provisions of Obamacare that will take effect in January 2014 will interact to reshape the health care market in significant ways. Because health insurers are either directly or indirectly affected by most of those changes, they have been forced to rethink their business plans.

Health insurers also have access to more comprehensive and granular data (from their own businesses) to feed into their assessments. Furthermore, they have had three years to analyze the data, map the interactions, and adjust their business plans in response to their expectations for the effects of Obamacare. Those factors all make insurer behavior a leading indicator for the likely path of future health system change under Obamacare.

It is possible to intuit some of the reasoning behind insurer decisions to participate, or not, in exchanges by examining state-level current market data and comparing it to state-level insurer exchange participation. Current market data offers a picture of each insurer's existing business focus, while exchange participation decisions can be presumed to reflect insurer expectations for Obamacare. Any patterns that emerge from such an analysis offer evidence of the extent to which insurer behavior is consistent, or inconsistent, with theoretical expectations.[3]

Divergent Expectations

In the three years since the enactment of Obamacare, there has been substantial disagreement between its supporters and opponents about the law's likely effects on health care markets. Until now, the two sides have supported their respective arguments with largely theoretical analyses. Now, with insurer-participation decisions finalized, and the exchanges open, it is possible to begin comparing the theories to reality. There are three broad areas in which the expectations of Obamacare's proponents and opponents differ:

1. **Increased vs. reduced insurer competition.** Proponents have argued that Obamacare's standardization of private health insurance and its creation of insurance exchanges offering easier consumer comparison shopping, along with substantial new premium subsidies, will stimulate greater competition among health insurers.

   In contrast, opponents have argued that Obamacare's product standardization and new insurer regulations, such as the "minimum loss ratio" regulation, are more likely to discourage insurer participation in the exchanges, induce smaller carriers to exit the market, raise barriers to market entry for new players, and limit the ability of existing carriers to expand beyond their current markets.[4]

2. **Coverage expansion vs. coverage substitution.** Proponents have argued that Obamacare will produce its intended effect of extending health insurance coverage to most of the currently uninsured population. They point to Obamacare's Medicaid expansion, new exchange coverage subsidies, and the individual mandate as factors that they believe will, collectively, produce a significant coverage expansion.

   In contrast, opponents have argued that any increase in coverage is likely to be much less than proponents forecast. They point to past experiences with expansions of Medicaid and the Children's Health Program (CHIP), in which a significant portion of the new enrollment was the product of the so-called crowd-out effect of individuals switching from private coverage to newly

1. Patient Protection and Affordable Care Act (PPACA) of 2010, Public Law 111-148.
2. For the most thorough analysis to date of premium changes, see Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4068, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.
3. All results reported in this *Backgrounder* that reference, or are otherwise based on, current market data, were derived by the author from insurance market data by state, carrier, and business segment, as reported in state insurance department regulatory filings, aggregated by the National Association of Insurance Commissioners (NAIC), and formatted into a comprehensive subscription data set by Mark Farrah Associates.
4. Edmund F. Haislmaier, "Health Care Consolidation and Competition After PPACA," testimony before the Subcommittee on Intellectual Property, Competition and the Internet, Committee on the Judiciary, U.S. House of Representatives, May 18, 2012, http://thf_media.s3.amazonaws.com/2013/pdf/Testimony-Insurance%20Consolidation.pdf.

available, and more generously subsidized, public coverage.[5] They argue that Obamacare's Medicaid expansion, new exchange coverage subsidies, and employer mandate are likely to produce similar shifts from private to public coverage. They also expect that Obamacare's new benefits and rating rules will make exchange plans more expensive (and thus, less attractive) to many of the uninsured (particularly younger and healthier) even after applying the new premium subsidies. Consequently, they expect the result to be a much lower net increase in coverage than supporters envision.

3. **Increased vs. reduced access to care.** Proponents have argued that Obamacare's coverage-expansion provisions will increase access to care. Opponents argue that, while access to care may improve for some of the newly insured, the increased costs and regulations imposed on private insurance are likely to result in less access to care for many others, particularly those who already have coverage. Opponents anticipate that insurers will respond to Obamacare's imposition of higher costs by excluding more providers from their networks and reducing provider reimbursement rates—resulting in more doctors who refuse to participate in their plans.

Of course, any definitive assessment of the accuracy of these contending expectations must await more complete data from real-world experience. For now, however, analyzing health-insurer-exchange-participation decisions at least indicates what those central players in the system expect, and thus, how the market is initially responding to Obamacare.

Determining Insurer Exchange Participation

The first measure for determining the extent of insurer exchange participation is the number of insurers offering coverage in each state's exchange. Since each participating insurer will be offering multiple plans, most of which are variations on the same basic design, the number of plans offered in each exchange has little significance. Indeed, the differences among the plans offered by each insurer will mostly consist of variations in the level of enrollee cost sharing, as Obamacare requires all exchange plans to offer standardized minimum benefits at prescribed levels of enrollee cost sharing. In fact, offering additional benefits above the required minimum risks making a plan more expensive and less competitive.

Also, the reported number of insurers participating in a state's exchange is sometimes misleading. That is because in some states an insurer may offer coverage through two or three of its subsidiaries—in which case, it is really one, not two or three, insurers participating in the exchange. For example, Illinois lists eight insurers as participating in its state exchange. However, the real number is five, because in Illinois Humana offers coverage through two subsidiaries, and Aetna offers coverage through three subsidiaries.[6] Conversely, a carrier operating in multiple states may elect to participate in the exchanges in some or all of those states. However, each state-level exchange participation by a multistate carrier is a separate business decision. That is because insurance market competition occurs at the state level, states differ in the structure of their insurance markets and insurance regulations, and under Obamacare the approval criteria for exchange participation can vary from state to state.

Consequently, counting the number of insurers that participate in each state at the parent-company level is the most appropriate methodology. Thus, in this analysis, participation in a state by two or more subsidiaries of the same carrier is counted as participation by the one (parent) company, while participation by the same parent company in more than one state exchange (whether through the same or different subsidiaries) is counted separately for each state. This methodology also omits carriers that will

5. For a discussion of the economic literature on the crowd-out effects of Medicaid and CHIP expansions, see Paul L. Winfree and Greg D'Angelo, "The New SCHIP Bill: The Senate Must Protect Private Coverage," Heritage Foundation *WebMemo* No. 2246, January 26, 2009, http://www.heritage.org/research/reports/2009/01/the-new-schip-bill-the-senate-must-protect-private-coverage.

6. In Illinois, Aetna is offering coverage through its subsidiaries Aetna Life Insurance Company, Coventry Health and Life Insurance Company, and Coventry Health Care of Illinois, Inc., while Humana is offering coverage through its subsidiaries Humana Health Plan, Inc., and Humana Insurance Company. The three other carriers are: Blue Cross Blue Shield of Illinois (a subsidiary of Health Care Service Corporation), Health Alliance (the trade name of the Carle Foundation), and the new Land of Lincoln Health Insurance CO-OP. News release, "Governor Quinn Announces Health Plan Rates Are 25 Percent Below HHS Estimates," Office of the Governor Pat Quinn, September 24, 2013, http://insurance.illinois.gov/newsrls/2013/09/QHPRates.pdf (accessed October 21, 2013).

be offering only dental insurance in the exchanges, as supplemental dental plans will only qualify for subsidies if purchased in conjunction with a major medical plan. Furthermore, simply purchasing a dental plan does not constitute compliance with Obamacare's individual mandate. Similarly, carriers that will only offer plans to small businesses in the separate Small Business Health Options Program (SHOP) exchanges are also excluded from this analysis, as those plans do not qualify for exchange subsidies.[7]

This methodology finds that the 51 exchanges in the states and the District of Columbia will have a total of 254 participating carriers, for an average of five carriers each.[8] New York will have the most, with 16 participating carriers, while New Hampshire and West Virginia will have the fewest, with only one carrier offering plans in each state's exchange. Table 1 summarizes the extent of insurer competition in the exchanges. As Table 1 also shows, there does not appear to be any correlation between the level of insurer participation and whether the state or the federal government operates the exchange. Rather, state-specific exchange participation seems to generally reflect current insurance-market-participation patterns in the various states.

TABLE 1

Insurer Exchange Participation

States listed in **bold** indicates state-run exchange.

Number of Participating Insurers	Number of States	States
16	1	**New York**
13	1	Wisconsin
12	1	**California**
11	3	Ohio, **Oregon**, Texas
10	1	**Colorado**
9	2	**Massachusetts**, Michigan
8	2	Arizona, Florida
7	2	Pennsylvania, **Washington**
6	1	Utah
5	5	Georgia, Illinois, **Minnesota, New Mexico**, Virginia
4	9	**Idaho**, Indiana, Iowa, Louisiana, **Maryland**, Nebraska, **Nevada**, Oklahoma, Tennessee
3	11	Arkansas, **Connecticut**, Kansas, **Kentucky**, Missouri, Montana. North Dakota, New Jersey, South Carolina, South Dakota, **District of Columbia**
2	10	Alabama, Alaska, Delaware, **Hawaii**, Maine, Mississippi, North Carolina, **Rhode Island, Vermont**, Wyoming
1	2	New Hampshire, West Virginia

Notes: All figures are at the parent company level (i.e., an insurer offering exchange coverage in a state through two or more subsidiaries is counted as one company).
Source: Author's calculations based on federal and state information on exchange participation.

B 2852 heritage.org

Assessing Obamacare's Effects on Insurer Competition

One measure for assessing the effect of the Obamacare exchanges on insurer competition is the number of new entrants in the market. Of the 254 insurers participating in the various exchanges, only 25 are new ones—and 23 of those are so-called CO-OP insurers funded by federal grants and loans under a program created by Obamacare.[9] It is highly uncertain how many of those CO-OPs will be successful over the long term, given that they were created more in response to government policy than to any unmet market demand and that, even if successfully launched, they will likely generate little surplus capital (due to Obamacare's restrictive minimum loss ratio regulations) needed to fund future expansion.[10]

7. There are six instances where a carrier will be offering coverage in a state's SHOP exchange, but not in its individual exchange—one each in: Connecticut, Iowa, Maryland, Michigan, Rhode Island, and the District of Columbia.
8. The list of exchange-participating insurers was compiled by the author. The source for the federally facilitated exchanges is data from HealthCare.gov, "Health Plan Information for Individuals and Families," https://www.healthcare.gov/health-plan-information (accessed October 16, 2013). Information for the state-run exchanges comes from either the state's exchange or its insurance department.
9. One more CO-OP, in Ohio, failed to become licensed in time to participate in the exchanges next year. See Carrie Ghose, "Obamacare-Backed Insurer Left Off Online Marketplace After Missing License Deadline," *Columbus Business First*, August 27, 2013, http://www.bizjournals.com/columbus/blog/2013/08/obamacare-backed-insurer-left-off.html?page=all (accessed October 22, 2013).
10. Edmund F. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, September 15, 2011, http://www.heritage.org/research/testimony/2011/12/effects-of-the-ppacas-minimum-loss-ratio-regulations.

The other two unsubsidized start-up insurers are both in New York. One is a regional plan sponsored by a local hospital system, the North Shore-Long Island Jewish Health System. This last insurer is the only one of the 25 new carriers with reasonable prospects for long-term success, as it is backed by an established local health system. As such, it seems to be following the same business strategy that a number of other local health systems throughout the country have successfully employed in the past.

Another measure for assessing the effects of the Obamacare exchanges on insurer competition is the number of existing carriers that are expanding into new markets. Nationally, there is only one instance of an established insurer expanding into a new market in response to Obamacare. That insurer is another carrier sponsored by a local health system, the Carle Foundation, which currently offers coverage (its Health Alliance plans) in Illinois and Iowa. In addition to offering coverage on the Illinois exchange, it will also offer coverage in Nebraska through that state's exchange.

It is, then, reasonable to conclude that Obamacare's provisions for expanding coverage by organizing state-based exchanges, subsidizing exchange coverage, and imposing an individual mandate to buy coverage, have so far had virtually no effect on inducing either the creation of new health insurers or the expansion of existing health insurers into new markets where they previously did not offer plans. Rather, the only significant increase in insurer competition will be as a result of direct government funding to create 23 new CO-OP insurers, for which there is high uncertainty about whether there will be sufficient market demand in the coming years.[11]

Yet another way to measure the effect of Obamacare on insurer competition is to compare, in each state, the number of carriers currently offering individual insurance to the number that will be offering coverage through the exchanges. That comparison is relevant because the plans offered in the exchanges will be for individual coverage. Also, the vast majority of exchange enrollees will likely qualify for new premium subsidies—theoretically making the exchanges an attractive source of coverage for consumers and a potential business opportunity for insurers.

In addition to the 25 new insurers, there are 36 instances in which an existing insurer not currently offering individual coverage in a state will offer such coverage through the state's exchange. However, that increase is offset by the fact that, in most cases, insurers whose principal line of business in a state is individual coverage have elected to not participate in the exchanges.

Table 2 compares, by state, the number of insurers participating in the exchange with the number of carriers that currently offer individual coverage. The data show that, despite 61 instances of new or existing carriers offering individual coverage for the first time through the exchanges, nationally there will still be 29 percent *less* insurer competition in the exchanges relative to the current market. Seven states will have the same level of competition in both markets, and five states will have more carriers offering exchange coverage than now offer individual coverage. In the remaining 38 states and the District of Columbia, fewer insurers will offer coverage in their exchanges relative to the number that currently offer individual-market coverage.[12]

Thus, in the vast majority of states, the Obamacare exchanges will offer less, not more, insurer competition than the state's current individual market.

Assessing Insurer Competition Within States

While state-level insurer participation is an important measure, it still overstates the actual level of competition that will occur in many states. That is because in most states, plans will be offered and priced on a local basis, and in many states few of the insurers participating in the state's exchange will offer plans in every county or region of the state.

For instance, the California exchange divided that state into 19 rating regions. In three of those regions (encompassing Los Angeles and San Diego)

11. Jay Hancock, "Rocky Opening Leaves Health Law's New Co-Ops Jittery," *Kaiser Health News*, October 15, 2013, http://capsules.kaiserhealthnews.org/index.php/2013/10/rocky-opening-leaves-health-laws-new-co-ops-jittery/ (accessed October 22, 2013).
12. The current individual market is much smaller than the other market segments. In this analysis, only carriers with 1,000 or more individual market enrollees in a state (as of the first quarter of 2013) are counted as currently offering such coverage. The assumption is that those carriers were likely still writing new individual policies as of 2012, while any carrier with fewer individual market enrollees was likely no longer writing new individual policies.

TABLE 2

Insurer Competition: Number of Insurers Offering Individual Coverage

State	In the Current Market	In the Exchange	Obamacare Effect on Competition
Alabama	4	2	-50%
Alaska	4	2	-50%
Arizona	11	8	-27%
Arkansas	7	3	-57%
California	12	12	0%
Colorado	14	10	-29%
Connecticut	7	3	-57%
Delaware	4	2	-50%
Florida	18	8	-56%
Georgia	11	5	-55%
Hawaii	2	2	0%
Idaho	5	4	-20%
Illinois	12	5	-58%
Indiana	11	4	-64%
Iowa	5	4	-20%
Kansas	9	3	-67%
Kentucky	6	3	-50%
Louisiana	8	4	-50%
Maine	4	2	-50%
Maryland	8	4	-50%
Massachusetts	8	9	13%
Michigan	14	9	-36%
Minnesota	6	5	-17%
Mississippi	5	2	-60%
Missouri	12	3	-75%
Montana	2	3	50%
Nebraska	4	4	0%
Nevada	5	4	-20%
New Hampshire	2	1	-50%
New Jersey	3	3	0%
New Mexico	3	5	67%
New York	10	16	60%
North Carolina	12	2	-83%
North Dakota	3	3	0%
Ohio	12	11	-8%
Oklahoma	8	4	-50%
Oregon	10	11	10%
Pennsylvania	14	7	-50%
Rhode Island	2	2	0%
South Carolina	9	3	-67%
South Dakota	4	3	-25%
Tennessee	10	4	-60%
Texas	18	11	-39%
Utah	9	6	-33%
Vermont	3	2	-33%
Virginia	10	5	-50%
Washington	7	7	0%
West Virginia	4	1	-75%
Wisconsin	15	13	-13%
Wyoming	5	2	-60%
District of Columbia	4	3	-25%
Total	**360**	**254**	-29%

Notes: All figures are at the parent company level (i.e., data for all subsidiaries of a company are aggregated under the one parent company). Since the current individual market is much smaller than the other market segments, current market figures are for carriers with 1,000 or more individual market enrollees in the applicable state, as of the most recent reporting period for which complete data are available (first quarter of 2013).
Sources: Author's calculations based on federal and state information on exchange participation and Mark Farrah Associates market data for current market participants.

there will be a choice of six carriers, while five other regions will have a choice of only three carriers.[13] Thus, while 12 carriers are participating in California's exchange, in any given region of the state, enrollees will have a choice of plans from only one-quarter to one-half that number. Indeed, only two of the 12 participating carriers are competing statewide in all rating regions.

In the New York exchange, plans will be offered at the county and New York City borough level. While 16 carriers are participating in New York's exchange, the greatest competition will occur in four of the five New York City boroughs and Nassau County on Long Island, with nine carriers offering plans in each of those jurisdictions. In contrast, five New York counties have only two competing carriers, and 11 counties have only three. None of the 16 carriers participating in New York's exchange is offering coverage on a statewide basis.[14]

Furthermore, the largest states are not the only ones that will experience more limited local competition. For instance, Wisconsin is the state with the second-highest number of insurers participating in its exchange (13 carriers), but as in New York, none of them is offering coverage statewide. At the county level, actual competition in Wisconsin will consist of less than half the total number of participating insurers. The most competition will be six insurers—but that will only be the case in four Wisconsin counties. Eleven counties will have five competing insurers, 10 counties will have four competing insurers, 17 counties will have three competing insurers, another 17 will have two competing insurers, and the remaining 13 counties will have only one insurer offering exchange coverage. Thus, in 42 percent of Wisconsin's 72 counties, enrollees will be able to obtain exchange coverage from only one or two insurers.[15]

Similarly, while four insurers are participating in Iowa's exchange, three will offer plans in 14 of the state's 99 counties. The other 85 counties will have only two competing insurers each.[16] Indiana also has four insurers in its exchange, but all four will offer plans in only 6 of that state's 92 counties. Thirty Indiana counties will have only one insurer offering exchange coverage, and another 35 counties will have only two insurers.

In Arkansas, while three insurers are participating in the exchange, in 24 of the state's 75 counties (nearly one-third) only one carrier will offer coverage. In Mississippi, two carriers are offering coverage in the exchange, but they will compete directly in only five counties—the four counties that encompass Jackson and its surrounding area, and a fifth county that is a suburb of Memphis, Tennessee. In the other 77 Mississippi counties, the exchange will offer coverage from only one of the two carriers.[17]

Other states also have similar patterns of less insurer competition at the local level, particularly in more rural areas. In fact, only four states have *both* an above-average level of insurer participation in the exchange (six or more carriers), *and* a choice of plans in every region of the state from at least half the participating carriers, as shown in Table 3. Yet, those are states that already have more competitive markets, as evidenced by that fact that in no case does an insurer in any of the four states currently have even a 50 percent market share in a state's individual or employer-group market.

Assessing Insurer Participation Decisions

Each insurer decision to participate, or not participate, in a given state's exchange is the product of a variety of factors and considerations. While much of the thinking behind those decisions is not public, an examination of current insurance market data and other public information provides some insights into how insurer decisions reflect carrier expectations for Obamacare's market effects.

The private health insurance market can be divided into six basic business segments, or product "lines," each with different business characteristics:

13. Covered California, "Health Insurance Companies for 2014," September 2013, https://www.coveredca.com/PDFs/English/booklets/CC-health-plans-booklet-rev2.pdf (accessed October 22, 2013).
14. NY State of Health, "Health Plans by Counties and Boroughs," http://healthbenefitexchange.ny.gov/sites/default/files/Health%20Plans%20by%20County.pdf (accessed October 22, 2013).
15. Healthcare.gov, "Health Plan Information for Individuals and Families."
16. Ibid.
17. Ibid.

(1) individual coverage; (2) employer group coverage; (3) administrative services only (ASO) for self-insured employers; (4) Medicaid managed care; (5) Medicare Advantage plans; and (6) various "supplemental" coverage products, such as dental plans, vision care plans, Medicare supplemental policies, and prescription drug plans.

Some insurers concentrate on offering products in only one or two market segments, while others have a broader business portfolio, offering products in most or all segments. Thus, an insurer's principal business segment in a state is an important reference point for understanding that insurer's decision to participate, or not, in the state's exchange.

For instance, it is not surprising that carriers whose principal current business consists of offering Medicare Advantage plans will generally not participate in the exchanges, since the exchanges are designed to offer individual major medical coverage to the non-elderly. Nor is it surprising that insurers whose principal business is offering supplemental coverage plans will also generally not participate in the exchanges—other than those offering stand-alone dental plans, which, as previously noted, are not relevant to an analysis of insurer exchange participation.

That leaves four health insurance business segments where it is possible to look for patterns in insurer exchange-participation decisions that might give indications of carrier expectations for the effects of Obamacare.

The Individual Market. Because of the highly favorable tax treatment given to employer-sponsored insurance, individual coverage has long been a small subset (less than 10 percent) of the total private health insurance market. Such coverage is typically purchased by those without access to an employer-sponsored plan, such as the self-employed. However, Obamacare could potentially expand the individual market significantly, as the new exchange coverage will consist of individual plans accompanied by new federal subsidies for enrollees with incomes between 100 percent and 400 percent of the federal poverty level (FPL).

TABLE 3

States with Insurer Exchange Participation Above the National Average and Coverage Offered in Every Region of the State by at Least Half the Participating Insurers

State	Insurers Participating in Exchange	Insurer Competition at Rating Region Level	
		Maximum	*Minimum*
Colorado	10	9	5
Massachusetts	9	9	5
Oregon	11	10	9
Utah	6	6	4

Source: Author's calculations based on federal and state exchange participation information.

B 2852 heritage.org

However, in the exchange market there is almost a complete lack of participation by insurers whose principal business in a state is individual coverage. There are only three instances of such carriers deciding to participate in a state's exchange, and in all three cases the carrier's principal business in most other states is not individual-market coverage.[18]

Employer Group Coverage Market. This segment consists of insurers focused mainly on selling traditional employer-group policies. Their customers are typically small to medium-size employers, each with anywhere from a few employees to several hundred. In contrast to individual-market insurers, a large share of the carriers whose principal current business consists of offering employer-group market plans have elected to participate in the exchanges. For this category of insurers there are, nationally, 84 instances of carriers electing to participate in the exchange, versus 46 instances of carriers declining to participate—a participation rate of 65 percent to 35 percent. Thus, carriers whose principal business is employer-group coverage are effectively betting on the Obamacare exchanges by a ratio of two to one.

18. Centene, primarily a Medicaid managed care insurer, is participating in the exchange in Arkansas, where its only current business is through a subsidiary in the individual market. Humana operates in all states, with Medicare Advantage plans accounting for the largest share of its total enrollment. Humana is participating in the exchanges in 14 states and in two of them, Colorado and Utah, its largest business segment in the state happens to be the individual market.

Employer Self-Insured Market. While smaller employers tend to purchase so-called fully insured group coverage from an insurer, larger employers tend to "self-insure" their employee health plans—meaning that the employer, not the insurer, bears most of the risk for the plan's cost. However, self-insured plans almost always contract with an insurer, or another third-party administrator (TPA), to administer the benefits and process the claims. Insurers refer to contracts of this kind as administrative services only (ASO). Among the group of insurers whose principal business consists of ASO contracts with self-insured plans, there are, nationally, 78 instances of carriers participating in the exchange, versus 127 instances of carriers declining to participate—38 percent participation versus 62 percent nonparticipation.

However, there is an important caveat. This group includes 41 Blue Cross and Blue Shield insurers. Relative to their peers, there are other factors likely at play in Blue Cross participation decisions, such as the fact that many of them also have the largest share of the individual market in their state.

Thus, in order to form a more precise picture it is necessary to further divide the category of insurers whose principal business is ASO for self-insured employers into two subgroups. Doing so shows that for the subset consisting of Blue Cross carriers, 39 (95 percent) are participating in the exchanges, while two are not. In contrast, for the subset consisting of non–Blue Cross carriers, in only 39 instances (24 percent) are they participating in the exchanges, while in 125 instances (76 percent) they are not—a *nonparticipation* ratio of three to one.

Medicaid Managed-Care Market. During the past two decades there has been significant growth in states contracting with private insurers to deliver benefits to Medicaid enrollees, particularly non-elderly, non-disabled enrollees. The growth has been in both the number of states adopting this approach and the number of enrollees covered by "Medicaid managed care."[19] Among insurers whose principal business in a state is Medicaid managed care, nationwide there are 50 instances of carriers electing to participate in the exchanges, versus 103 instances of carriers declining to participate—33 percent participation versus 67 percent nonparticipation.

What Insurer Participation Decisions Indicate

There are five distinct patterns that emerge from this analysis. Each of those patterns offers evidence of the extent to which insurer behavior is consistent, or inconsistent, with theoretical expectations.

Pattern #1: Overwhelming participation by Blue Cross and Blue Shield carriers. Of the 62 Blue Cross and Blue Shield licensees in the U.S., all but three will participate in the exchanges.[20] This pattern is likely explained by the fact that Blue Cross carriers tend to occupy a unique competitive position in their local markets. Unlike its competitors that typically focus on one (or sometimes, two) market segments, a Blue Cross carrier is often the dominant insurer in two (or more) market segments in its state.

Consequently, the exchange participation decision of a Blue Cross carrier likely involves other considerations—such as whether it already has a dominant position in the individual market (as many do), or higher "brand awareness" among consumers—that might give it an advantage over other carriers in an exchange. For those Blue Cross carriers that are still nonprofits, there is the added consideration that tax law requires them to justify their nonprofit status by demonstrating a "community benefit." So, participating in the exchanges might help them make the case that they offer a community benefit, even though they largely operate the way their for-profit competitors do.

In sum, this pattern suggests that Blue Cross carriers view the exchanges as another market segment in which they can further leverage their existing local market dominance.

Pattern #2: Virtually no participation by individual market–focused carriers. Despite the fact that the exchanges will offer individual coverage, and that most enrollees will receive a federal premium subsidy, there is virtually no

19. For a concise discussion of the types and distribution of state Medicaid managed care programs, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid Managed Care: Key Data, Trends, and Issues," *Policy Brief*, February 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf (accessed October 23, 2013).

20. The only ones not participating in the exchanges are Blue Cross and Blue Shield of Mississippi, and Wellmark, the parent company of the Blue Cross and Blue Shield licensees in Iowa and South Dakota.

participation in the exchanges by insurers whose principal current business in a state consists of offering individual-market coverage. Indeed, there is *no* national carrier with an individual-market focus offering coverage in *any* of the exchanges.[21]

The most likely explanation is that carriers specializing in individual-market coverage tend to be relatively small, and that most individual policies are currently purchased from larger insurers—such as Blue Cross and Blue Shield carriers—that also have a large presence in other segments of the market.

A closely related factor is the considerable uncertainty that all insurers have about the expected risk profile of the exchange market, particularly the greater probability of higher-than-expected claims costs. Small carriers are less able than large ones to absorb substantial unanticipated losses. Obamacare's minimum loss ratio regulations also preclude insurers from increasing premiums in future years by enough to recoup any initial losses.[22] Thus, the only safe way for a small insurer to enter a market as uncertain as the new exchanges would be to "rate defensively"—meaning to start off charging premiums that reflect their actuaries' worst-case scenarios. However, since such higher premiums would make their plans less competitive, they might decide it is not worth the effort.

Whatever their reasons, it is quite clear that this group of carriers overwhelmingly concluded that the Obamacare exchanges are *not* an attractive business opportunity.

Pattern #3: Significant participation by employer group market–focused carriers. As noted, this group of insurers has elected to participate in the exchanges by a ratio of two to one. The most plausible explanation for this pattern is that carriers focused on this market segment anticipate significant erosion in employer-group coverage, as their customers—particularly smaller employers—are induced by Obamacare to drop their group plans and send their workers to the exchanges. Indeed, many workers in smaller firms would actually be financially better off if their employers dropped group coverage, as they would receive more generous subsidies for coverage through the exchanges.

It is also reasonable to infer from this behavior pattern that two-thirds of these carriers likely believe that offering coverage in the exchanges will give them an opportunity to retain at least some of their present enrollees when employers drop their current group plans in response to Obamacare.

This pattern is confirmed by the behavior of the largest carrier in this category, Kaiser Permanente, which operates in eight states and the District of Columbia. Seventy-six percent of Kaiser's total current enrollment comes from employer group plans, and Kaiser has elected to participate in the exchanges everywhere it operates.

Another confirming data point is the fact that of the 36 insurers that will be participating in the exchanges despite not currently offering individual coverage, 11 are carriers whose principal current business is employer-group coverage.

In sum, the behavior of this group of insurers appears to offer market confirmation of the expectation among Obamacare opponents that a significant number of employers (particularly smaller ones) are likely to drop their current group coverage plans in the coming years.

Pattern #4: Relatively little participation by carriers focused on providing administrative services to self-insured employer plans. In nearly two-thirds of cases the carriers in this group have opted not to participate in the exchanges. As noted, when the Blue Cross carriers are excluded, the nonparticipation rate for this group rises to three-quarters.

Most significant is that this group includes three of the four major insurers that operate nationally in all 50 states and the District of Columbia—Aetna, United, and Cigna. The exchange participation decisions of all three carriers strongly confirm this pattern. Nationally, 61 percent of Aetna's total business is ASO for employer self-insured plans, and Aetna will participate in only 16 of the exchanges.[23] For United, 54 percent of its total business is in this market segment, and it will participate in four exchanges.[24] In Cigna's

21. The two largest individual market–focused carriers operating nationwide are Sun Life Assurance Company and Assurant. Neither carrier is offering major medical exchange coverage in any state. All of Sun Life's major medical business is in the individual market, as is 79 percent of Assurant's business (the remaining 21 percent is employer-group coverage). Both carriers also offer free-standing dental plans.
22. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations."
23. Aetna also participates in SHOP, but not in the individual exchange in Maryland.
24. United also participates in SHOP, but not in the individual exchanges in Connecticut, Michigan, Rhode Island, and the District of Columbia.

case, this coverage category accounts for 84 percent of its total business, and Cigna will offer exchange coverage in only five states.

The most likely explanation for this pattern is that insurers expect enrollment in the employer self-insured market segment to remain relatively stable under Obamacare. That expectation seems reasonable on several grounds. First, self-insured employers tend to be large—or very large—employers and as such would be subject to Obamacare's employer mandate penalties if they dropped coverage. Second, many workers in self-insured firms have family incomes that are too high to qualify for exchange coverage subsidies in the absence of an employer plan. Third, self-insured plans are exempt from Obamacare's requirement to cover a minimum set of "essential benefits," which means that they retain significant leeway to control future cost growth by making adjustments to their benefit designs.

Indeed, with respect to the last point, it is quite plausible that Obamacare will produce an *expansion* of the self-insured market segment—at the expense of the "fully insured" employer group–coverage segment. While Obamacare imposes the minimum essential benefit requirements only on insurance policies sold in the individual and small group markets, it also includes a provision that expands the definition of "small group" from 50 workers to 100 workers, starting in 2017. Thus, it would not be surprising if, faced with the onset of that costly mandate, in future years more medium-sized employers shift the coverage they now offer their workers from fully insured to self-insured plans.

Pattern #5: Notable participation by carriers focused on Medicaid managed care. At first glance, the two-to-one nonparticipation ratio among this group does not seem surprising. Another key component of Obamacare is the expansion of Medicaid to millions of low-income, able-bodied adults. Despite the Supreme Court ruling that Congress could not force states to expand Medicaid, the Congressional Budget Office projects that Obamacare will still add 9 million individuals to Medicaid in 2014.[25] Thus, it would be understandable if insurers whose principal business is Medicaid managed care decided to stick with what they know best, and took a pass on participating in the exchanges.

However, that explanation raises the intriguing question of why one-third of this group *did* elect to participate in the exchanges. One likely explanation is that because the incomes of many individuals fluctuate above and below the threshold for Medicaid eligibility, Medicaid managed-care insurers that participate in the exchanges will be better positioned to retain those enrollees in their plans. In those cases, the principal change would simply be the source of the government subsidies paying for the coverage. The other possibility is that this subgroup of carriers actually views offering exchange coverage as an attractive business opportunity in its own right.

This participation pattern is essentially the same for states that are, and are not, adopting the Medicaid expansion. That, too, is understandable, as insurers had to make their exchange participation decisions last spring, at a time when many states were still debating whether to adopt the Medicaid expansion.

Among insurers whose principal business in a state is Medicaid managed care, one-third are participating in the exchanges. Those carriers account for 50 (20 percent) of the 254 exchange participating carriers nationwide. If other insurers who also have Medicaid managed-care business—but for whom it is not their principal business—are included, the figure rises to 108 carriers, 43 percent of the 254 exchange participating insurers. Furthermore, of the 36 insurers that will participate in exchanges despite not currently offering individual coverage, 22 are carriers whose principal current business is Medicaid managed care.

However, 14 states do not have Medicaid managed care and, hence, have no carriers currently offering such coverage. Table 4 shows that, among the 36 states and the District of Columbia that operate part of their Medicaid programs through managed-care plans, nearly half (49.5 percent) of the carriers participating in their exchanges operate Medicaid managed-care plans in the state. Indeed, in 28 instances Medicaid managed-care accounts for *over 90 percent* of the carrier's current business in the state. Table

25. Congressional Budget Office, "Table 1: May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf (accessed October 23, 2013).

4 also shows that 31 states will have at least one insurer with Medicaid managed-care business in the state offering coverage on the exchange, and that in 18 states half or more of the insurers in the state's exchange currently have Medicaid managed-care business. Indeed, in six states Medicaid managed care is the *principal* current business of half or more of *all* exchange carriers—six of the 11 in Texas, three of the five in New Mexico, two of the four in Indiana, and one of the two each in Delaware, Mississippi, and Rhode Island.

Clearly, a number of carriers offering Medicaid managed care view the exchanges as a business opportunity. However, digging deeper into the data reveals distinctly different responses to Obamacare by the four biggest multi-state carriers in this category—Molina, Wellcare, Centene, and WellPoint:

- **Molina.** Just under 90 percent of Molina's total business consists of Medicaid managed care, and Molina is offering exchange coverage in nine of the 10 states where it currently operates. The exception is Louisiana, which is the only state where Molina's Medicaid business is not "at risk"—meaning that the company contracts with the state to manage the coverage of some Medicaid enrollees, but does not assume the risk for the cost of their coverage.

- **Wellcare.** In contrast to Molina's "all-in" position, Wellcare is "all-out" when it comes to the exchanges. Medicaid managed care accounts for 77 percent of Wellcare's total enrollment nationwide, but it is not participating in the exchanges in any of the six states where it offers that coverage. In fact, Wellcare is not participating in *any* exchange in *any* state—making it the only major multi-state health insurer of any kind to entirely avoid the exchanges.

- **Centene.** The approach taken by Centene is closer to that of Molina. Ninety percent of Centene's total enrollment comes from the Medicaid managed-care plans that it operates in 14 states. In seven of those states, Centene is offering exchange coverage, and those seven states collectively account for 75 percent of Centene's total Medicaid managed-care enrollment. Centene is also offering exchange coverage in two other states where it does not have Medicaid managed-care business. One is Massachusetts, where Centene already offers coverage through that state's existing Health Insurance Connector—which is being transitioned into an Obamacare exchange. The other is Arkansas, which does not currently have Medicaid managed care. In both states, Centene is offering exchange plans through its Celtic Insurance Company subsidiary, a small, individual market–focused insurer that it acquired in 2008.

- **WellPoint.** Perhaps the most interesting response among these four is WellPoint's. It operates Blue Cross plans in 14 states and will participate in the exchanges in all of those states. However, last year WellPoint acquired AmeriGroup—a Medicaid managed-care insurer operating in 12 states. In the states where AmeriGroup operates, but where Wellpoint does *not* have a Blue Cross subsidiary, the company will *not* participate in the exchanges. Thus, WellPoint has essentially responded to the exchanges as a Blue Cross carrier. The company apparently views its acquisition of AmeriGroup as a play on the Medicaid expansion—not as a way to leverage broader participation in the exchanges.

Effects of Obamacare's Cost-Sharing Subsidies on Exchange Coverage

One major feature of Obamacare that has received relatively little attention is the law's cost-sharing subsidies for lower-income exchange enrollees. Yet, understanding how those subsidies operate—and how they interact with the other provisions of Obamacare—goes a long way toward explaining not only why Medicaid managed-care insurers are participating in the exchanges, but also why many insurers are offering exchange plans with "narrow networks" that limit coverage to certain providers.

Obamacare provides both premium subsidies and cost-sharing subsidies for exchange coverage, and both sets of subsidies vary based on enrollee income.

Most of the attention has so far focused on the premium subsidies for exchange enrollees with family incomes between 100 percent and 400 percent of the FPL. Those premium subsidies are calculated at enrollment based on the individual's family income and with reference to the second-lowest-cost Silver plan that is offered in the

enrollee's location.[26] For example, if it is determined—by applying the statutory formula to the enrollee's income—that an enrollee will be responsible for paying $100 a month for coverage, and if the reference plan (second-lowest-cost Silver plan) costs $250 a month, that enrollee's subsidy will then be set at $150 a month.

Once the enrollee's premium subsidy is calculated, he can apply that amount to the purchase of any available exchange plan in the Bronze, Silver, Gold, or Platinum coverage levels, with responsibility for paying the difference (if any) between the subsidy amount and the total premium. So, to continue the foregoing example, if the enrollee picks a more expensive plan, say, one costing $300 a month, he would have to pay $150 a month for coverage ($300 premium minus $150 subsidy). If instead the enrollee picks a less costly plan, say, one with a $200 a month premium, he would only have to pay $50 a month for coverage ($200 premium minus $150 subsidy).

However, the cost-sharing subsidies work very differently. To start with, they only apply to Silver plans—so an enrollee *must* buy a Silver plan to benefit from the cost-sharing subsidies. Second, the cost-sharing subsidies are paid directly to the insurer, without the enrollee knowing the amount. All that the enrollee knows is that the deductibles and co-payments that come with *his* coverage are less than the plan's standard amounts. For example, if the plan's deductible is $2,000 but an enrollee's income qualifies for cost-sharing subsidies that pay the insurer to lower his deductible to $500, the enrollee will be told that, for *him*, the deductible is $500. The plan's premium, and the premium subsidy that the enrollee receives, remain the same. Thus, for the same premium, the enrollee will be getting the plan with lower cost-sharing requirements.

Of course, that makes the actual cost of the plan to the insurer (for that enrollee) more expensive than the stated premium, but the federal government pays the insurer the additional cost-sharing subsidy to cover the difference.

Thus, different individuals can purchase the same plan for the same nominal premium, while, based on their different incomes, ending up with different deductible and co-pay levels for their coverage. Table 5 illustrates how this will work. The third row in the table shows the effect of the premium subsidies. An enrollee with an income of 400 percent of the FPL will be responsible for paying $364 a month for the reference plan (the second-lowest-cost Silver plan), while an enrollee with an income of 100 percent of the FPL has to only pay $19 a month for the same coverage. The federal government pays the difference (if any) between those amounts and the plan's premium to the insurer as a premium subsidy.

The next 14 rows in Table 5 show how the plan's various cost-sharing provisions will also be adjusted based on enrollee income. Thus, an enrollee with an income of 400 percent of the FPL will have a $2,000 deductible and be charged a $45 co-pay for each doctor visit, while an enrollee at 100 percent of the FPL will have no deductible and be charged only $3 for each doctor visit—even though both enrollees bought *the same plan*.

Those adjustments, of course, increase the real cost of the coverage for the second enrollee, but the nominal premium remains the same. Instead, the federal government pays the insurer a *second* set of subsidies (the cost-sharing subsidies) to cover the difference between the real and nominal premium that results from the requirement that the insurer reduce the plan's deductibles and co-pays for lower-income enrollees. The result is that lower-income enrollees will pay very little in either premiums or out-of-pocket expenses for their coverage, while Obamacare's complicated subsidy scheme will reimburse insurers for the extra cost of those features.

However, this design creates a problem for insurers. A substantial share of their exchange enrollees are likely to be on the lower end of the income scale. That is because lower-income individuals are not only more likely to be uninsured and seeking coverage, but will also find exchange coverage more attractive, as they will be able to buy plans with very low co-pays and heavily subsidized premiums.

26. Obamacare standardizes health insurance plans based on the concept of "actuarial value." A plan's actuarial value is the average share of total expenses for the covered benefits that the plan pays. So, an actuarial value of 70 percent means that the plan, on average, pays 70 percent of the total expense for the covered benefits. The enrollee is responsible for paying the remaining costs, according to the plan's schedule of deductibles and co-pays. The four plan categories specified in Obamacare are: Bronze (60 percent actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial value), and Platinum (90 percent actuarial value). See Public Law 111–148 §1302(d).

TABLE 4

Insurers with Medicaid Managed-Care Business

The table below lists the 36 states and the District of Columbia that provide some Medicaid coverage through Medicaid managed care (MMC) and the number of MMC insurers that chose to participate in their exchanges. About half of the participating insurers in these states conduct MMC business in their states, and about one-quarter have MMC as their principal business.

	NUMBER OF PARTICIPATING INSURERS IN EXCHANGE			
State	**Total**	*... doing* some business *in MMC*	*... with MMC as* principal business	*... with MMC accounting for* more than 90 percent of business
Arizona	8	2	2	2
California	12	8	5	5
Colorado	10	2	1	
Connecticut	3			
Delaware	2	1	1	
Florida	8	5	3	2
Georgia	5	2	1	1
Hawaii	2	2		
Illinois	5	1		
Indiana	4	3	2	2
Iowa	4			
Kansas	3			
Kentucky	3	1		
Louisiana	4			
Maryland	4	2		
Massachusetts	9	5	2	
Michigan	9	6	4	2
Minnesota	5	4	1	
Mississippi	2	1	1	1
Missouri	3	1		
Nebraska	4	1	1	
Nevada	4	2		
New Mexico	5	4	3	1
New York	16	11	4	4
Ohio	11	5	4	3
Oregon	11	3	1	1
Pennsylvania	7	5	1	
Rhode Island	2	1	1	1
South Carolina	3	1		
Tennessee	4	1		
Texas	11	10	6	1
Utah	6	2	1	
Virginia	5	3	1	
Washington	7	3	3	2
West Virginia	1			
Wisconsin	13	10	1	
District of Columbia	3			
Totals	**218**	**108**	**50**	**28**

Note: Connecticut, Iowa, Kansas, Louisiana, and West Virginia appear on this list because they have insurers that provide MMC, but none of the insurers in those states currently offering MMC will be participating in the state exchanges.
Source: Author's calculations based on federal and state information on exchange participation and Mark Farrah Associates data on current enrollment by carrier, state, and market segment.

B 2852 heritage.org

TABLE 5

Sliding Scale Benefits (Single Person)

Percent of FPL	100%–150%	150%–200%	200%–250%	250%–400%
Annual Income	$11,490–$17,235	$17,235–$22,980	$22,980–$28,725	$28,725–$45,960
Consumer Portion of Premium for Silver Plans (balance paid by federal subsidy)	$228–$684/year ($19–$57/month)	$684–$1,452/year ($57–$121/month)	$1,452–$2,316/year ($121–$193/month)	$2,316–$4,368/year ($193–$364/month)
Deductible	None	$500	$1,500 medical deductible	$2,000 medical deductible
Preventative Care Co-pay	No cost	No cost	No cost	No cost for 1 annual visit
Primary Care Visit Co-pay	$3	$15	$40	$45
Specialty Care Visit Co-pay	$5	$20	$50	$65
Urgent Care Visit Co-pay	$6	$30	$80	$90
Lab Testing Co-pay	$3	$15	$40	$45
X-Ray Co-pay	$5	$20	$50	$65
Generic Medication Co-pay	$3	$5	$20	$25
Emergency Room Co-pay (waived if admitted)	$25	$75	$250	$250
Emergency Medical Transportation Co-pay	$25	$75	$250	$250
Hospital Care and Outpatient Surgery	10%	15%	20% of the plan's negotiated rate	20% of the plan's negotiated rate
Drug Deductible	None	$50, then pay the co-pay amount	$250, then pay the co-pay amount	$250, then pay the co-pay amount
Preferred Brand Co-pay After Drug Deductible	$5	$15	$30	$50
Maximum Out-of-Pocket	$2,250	$2,250	$5,200	$6,350
Actuarial Value	94%	87%	73%	70%

Source: Covered California, "2014 Sliding Scale Benefits: Single Person," http://www.coveredca.com/PDFs/English/CoveredCA_HealthPlanBenefitsSummary.pdf (accessed September 23, 2013).

B 2852 heritage.org

The problem is that insurers know that the very low co-pays charged to lower-income enrollees will have virtually no effect on their demand for health care services. Thus, the only way that insurers will be able to control plan costs is by limiting coverage to a smaller number of providers willing to accept low reimbursement in return for a high volume of patients.

This explains why many participating insurers—including ones that do not currently operate Medicaid managed-care plans—are offering narrow network plans on the exchanges. For instance, California Blue Shield has no Medicaid managed-care business, but the plans it offers on the California exchange restrict enrollees to about half the number of providers in its regular network for non-exchange plans.[27] In New Hampshire the only carrier offering coverage on the state's exchange is Anthem (a subsidiary of WellPoint). Because New Hampshire is a state that does not contract with managed-care plans for Medicaid, Anthem has no Medicaid managed-care business in the state. Yet for its New Hampshire exchange plans, Anthem includes only 16 of the state's 26 hospitals in its network.[28] Indeed,

27. Chad Terhune, "Insurers Limiting Doctors, Hospitals in Health Insurance Market," *Los Angeles Times*, September 14, 2013, http://www.latimes.com/business/la-fi-insure-doctor-networks-20130915,0,2814725.story (accessed October 23, 2013).
28. Ben Leubsdorf, "Anthem Takes Heat from N.H. Senators Over Limited Provider Network for Marketplace Plans," *Concord Monitor*, September 19, 2013, http://www.concordmonitor.com/news/work/business/8491779-95/anthem-takes-heat-from-nh-senators-over-limited-provider-network-for-marketplace-plans (accessed October 23, 2013).

insurers throughout the country are responding in much the same way.[29]

Given the parameters set by Obamacare, narrow network plans are less the product of a desire to keep premiums low, or improve quality, but rather of the need to control costs in a market where the insurer cannot rely on standard levels of cost sharing to encourage patients to be judicious consumers of medical services. Put simply, when the government pays insurers to lower cost sharing to the point that some patients are charged less than the price of a sandwich for a visit to the doctor, and calling an ambulance could be cheaper than calling a taxi, insurers know that their only recourse is to limit their plans to covering a smaller group of low-cost providers.

It should, therefore, not be surprising that a number of insurers with Medicaid managed-care business saw in Obamacare's exchange subsidy design an end result that looks a lot like Medicaid managed care—and thus, decided to offer coverage on the exchanges. It is a business model that they already know how to successfully implement. Indeed, Molina's CEO was recently quoted in the *Miami Herald* explaining that "Medicaid is essentially an individual market for low-income patients … and Medicaid has premiums that are paid for by the state. The reason we went after the exchange is we feel there are a lot of similarities."[30]

Even though insurers can adjust for the inability to use cost sharing to influence patient behavior by offering narrow network plans, that response creates another problem—one for which they do not have a solution. The new problem is that while relying on a limited network of providers accommodates lower-income enrollees who face only nominal cost sharing, it also makes the plan much less attractive to higher-income enrollees.

For instance, in San Diego, the premium for the second-lowest-cost Silver plan for a 40-year-old is $308 a month. Consider two 40-year-old enrollees living in San Diego; one with an income at 150 percent of the poverty level ($17,235 a year), and the other with twice that income at 300 percent of the poverty level ($34,470 a year). The first enrollee pays $57 a month for that plan, with the federal government paying the remaining $251 in a premium subsidy. Table 5 shows that the government also pays the insurer a cost-sharing subsidy to lower the insured's deductible to zero, and his physician co-pays to $3 and $5.

The second enrollee pays $273 a month for the same plan, with the federal government paying only a $35 a month premium subsidy. Furthermore, the second enrollee does not qualify for reduced co-pay amounts. Table 5 shows that his deductible is $2,000 and that his physician co-pays are $45 and $65. If the plan only pays for visits to a limited network of providers, that might be an acceptable trade-off for the first enrollee, but is likely to be an unattractive proposition for the second one—who is paying much more in premiums, has a substantial deductible, and is charged higher co-pays for each visit. Thus, the second enrollee is much less likely to buy the coverage.

Because Obamacare's cost-sharing subsidy design essentially forces insurers to adopt more limited provider networks for at least the Silver-plan level of exchange coverage, those plans will be less attractive to enrollees with incomes between 250 percent and 400 percent of the FPL—as they do not benefit from reduced cost sharing and also get much less in premium subsidies. That could result in enrollees in the bottom half of the exchange income scale (100 percent to 200 percent of the FPL) clustering in Silver plans while those in the upper half of the exchange income scale (200 percent to 400 percent of the FPL) gravitate toward Bronze-level plans that cover more providers and offer lower premiums, but impose higher deductibles and more cost sharing. Indeed, for those with incomes between 300 percent and 400 percent of the FPL, the premium subsidies offered for exchange coverage are so small that many might decide to instead seek coverage elsewhere.

29. Robert Pear, "Lower Health Insurance Premiums to Come at Cost of Fewer Choices," *The New York Times*, September 22, 2013, http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=1&_r=3&hp& (accessed October 23, 2013), and Anna Wilde Mathews, "Many Health Insurers to Limit Choices of Doctors, Hospitals," The *Wall Street Journal*, August 14, 2013.

30. Daniel Chang, "Obamacare Plans for South Florida Vary Widely in Prices, Value," *Miami Herald*, October 5, 2013, http://www.miamiherald.com/2013/10/05/3672251/obamacare-plans-for-south-florida.html (accessed October 23, 2013).

Conclusion

The patterns that emerge from this analysis of insurer exchange participation decisions offer the first indications of what the Obamacare exchange market is likely to look like.

When compared with the divergent expectations of Obamacare supporters and opponents, the evidence is more consistent with the expectations of opponents than with those of supporters. Specifically:

- With respect to insurer competition, by any measure Obamacare has produced no more than negligible increases in competition—and in only a handful of states. Furthermore, when compared to the current individual market, the Obamacare exchanges actually represent a significant (29 percent) net *decrease* in insurer competition nationwide. Those results strongly confirm the expectations of Obamacare's opponents.

- On the question of coverage expansion versus coverage substitution, a definitive answer must still await data on actual enrollment during the coming months. That said, the insurer participation patterns revealed by this analysis suggest that, at a minimum, there is an expectation among insurers that Obamacare will produce measurable coverage substitution effects resulting from employers dropping their current plans in response to Obamacare. In particular, the exchange participation decisions of insurers whose principal current business is employer-group coverage are at least consistent with the views of Obamacare opponents on this question.

- When it comes to the question of whether Obamacare will result in increased or decreased access to care, this analysis finds two patterns that confirm Obamacare opponents' expectations for reduced access. The first is the participation in the exchanges by a significant number of carriers with current Medicaid managed-care business—particularly the subset for which Medicaid managed care is their main, or even exclusive, current business. The second is the fact that those insurers, along with others—including ones that do not currently have any Medicaid managed-care business—are offering exchange plans that cover only narrow networks of providers.

For the vast majority of states, the exchanges will offer less insurer competition than the state's current individual market. Most of the insurers whose principal business is employer-group coverage appear to expect significant erosion in that coverage segment due to Obamacare inducing employers to drop their current group plans. Given that the distribution of exchange enrollees will likely be skewed toward the lower end of the 100 percent to 400 percent of FPL income range (and thus, eligible for reduced cost sharing), participating insurers are offering exchange plans with limited provider networks and a significant number of Medicaid managed-care plans opted to join the exchanges.

The insurers who have elected to participate in the exchanges are mainly a mix of Blue Cross carriers seeking to extend their current market dominance, group-market carriers seeking to retain enrollees when employers drop coverage, and Medicaid managed-care insurers expanding into a market that they view as very similar to their current business.

In fact, Obamacare's complicated, income-based design of premium and cost-sharing subsidies will result in the exchange market essentially offering something like Medicaid managed-care for the middle class.

The resulting picture is one that millions of Americans are likely to find unappealing. It is yet another reason why Congress should simply scrap the entire—ill-conceived—law and replace it with simpler and better solutions.

*—**Edmund F. Haislmaier** is Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation.*

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 1 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Alabama	Blue Cross and Blue Shield of Alabama	Blue Cross and Blue Shield of Alabama	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Alaska	Moda Health	Moda Health	Self-Insured Employers (ASO)
	Premera Blue Cross	Premera Blue Cross Blue Shield of Alaska	Employer Group Insurance
Arizona	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	Blue Cross Blue Shield of Arizona, Inc.	Blue Cross Blue Shield of Arizona, Inc.	Self-Insured Employers (ASO)
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Compass Cooperative Health Plan, Inc.	Meritus Health Partners, Meritus Mutual Health Partners	N/A—New Insurer, CO-OP
	Health Net, Inc.	Health Net Life Insurance Company, Health Net of Arizona	Employer Group Insurance
	Humana, Inc.	Humana Health Plan, Inc.	Medicare Advantage
	IASIS Healthcare	Health Choice Insurance Co.	Medicaid Managed Care
	University of Arizona Health Network	University of Arizona Health Plans	Medicaid Managed Care
Arkansas	Arkansas Blue Cross Blue Shield	Arkansas Blue Cross Blue Shield	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter of Arkansas	Individual Insurance
	QualChoice of Arkansas, Inc.	QualChoice Health Insurance	Self-Insured Employers (ASO)
California	Alameda Alliance for Health	Alameda Alliance for Health	Medicaid Managed Care
	Blue Shield of California	Blue Shield of California	Employer Group Insurance
	Chinese Community Health Plan	Chinese Community Health Plan	Medicare Advantage
	Contra Costa Health Services	Contra Costa Health Plan	Medicaid Managed Care
	Health Net, Inc.	Health Net	Employer Group Insurance
	Kaiser Permanente	Kaiser Pemanente	Employer Group Insurance
	L.A. Care Health Plan	L.A. Care Health Plan	Medicaid Managed Care
	Molina Healthcare, Inc.	Molina Healthcare	Medicaid Managed Care
	Sharp HealthCare	Sharp Health Plan	Employer Group Insurance
	Valley Health Plan	Valley Health Plan	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross of CA	Self-Insured Employers (ASO)
	Western Health Advantage	Western Health Advantage	Employer Group Insurance
Colorado	Access Health Colorado	New Health Ventures Access Health	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna	Self-Insured Employers (ASO)
	Colorado Choice Health Plans	Colorado Choice Plans	Self-Insured Employers (ASO)
	Colorado Health Insurance Cooperative, Inc.	Colorado Health Insurance Cooperative	N/A—New Insurer, CO-OP
	Denver Health Medical Plan, Inc.	Denver Health Medical Plan	Employer Group Insurance
	Humana, Inc.	Humana Health Plan, Inc.	Individual Insurance
	Kaiser Permanente	Kaiser Foundation Health Plan of CO	Employer Group Insurance
	Rocky Mountain Health Plans	Rocky Mountain View, Rocky Mountain Mesa County Exclusive	Self-Insured Employers (ASO)
	UnitedHealth Group	All Savers Insurance Co.	Self-Insured Employers (ASO)
	WellPoint, Inc.	HMO Colorado, Inc.	Self-Insured Employers (ASO)
Connecticut	EmblemHealth	ConnectiCare	Employer Group Insurance
	HealthyCT, Inc.	HealthyCT	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Blue Cross Blue Shield	Self-Insured Employers (ASO)
Delaware	Aetna, Inc.	CoventryOne	Medicaid Managed Care
	Highmark Health Services	Highmark Blue Cross Blue Shield Delaware	Self-Insured Employers (ASO)

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 2 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Florida	Aetna, Inc.	Aetna, CoventryOne	Self-Insured Employers (ASO)
	Blue Cross Blue Shield Florida	Florida Blue, Florida Blue HMO, Florida Health Care Plans	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter from Sunshine Health	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Health First	Health First Insurance, Inc.	Medicare Advantage
	Humana, Inc.	Humana Medical Plan, Inc.	Medicare Advantage
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Preferred Medical Plan, Inc.	Preferred Medical Plan	Medicaid Managed Care
Georgia	Alliant Health Plans	Alliant Health Plans	Employer Group Insurance
	Centene Corporation	Ambetter from Peach State Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Insurance Company, Humana Employers Health Plan of Georgia, Inc.	Employer Group Insurance
	Kaiser Permanente	Kaiser Foundation Health Plan of Georgia	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Hawaii	Hawaii Medical Service Association	Hawaii Medical Service Association	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente Hawaii	Employer Group Insurance
Idaho	Blue Cross of Idaho Health Service, Inc.	Blue Cross of Idaho	Employer Group Insurance
	Cambia Health Solutions, Inc.	BridgeSpan Health Company	Employer Group Insurance
	Intermountain Healthcare	SelectHealth, Inc.	Medicare Advantage
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance
Illinois	Aetna, Inc.	Aetna, Coventry Health Care	Self-Insured Employers (ASO)
	Health Care Service Corporation	Blue Cross Blue Shield of Illinois	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Insurance Company, Humana Health Plan, Inc.	Employer Group Insurance
	Land of Lincoln Mutual Health Insurance Company	Land of Lincoln Mutual Health Insurance Co.	N/A—New Insurer, CO-OP
	The Carle Foundation	Health Alliance Medical Plans	Employer Group Insurance
Indiana	Centene Corporation	Ambetter from MHS	Medicaid Managed Care
	MDwise	MDwise	Medicaid Managed Care
	Physicians Health Plan of Northern Indiana, Inc.	Physicians Health Plan	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Iowa	Aetna, Inc.	Coventry Health Care of Iowa Inc.	Self-Insured Employers (ASO)
	Avera Health Plans	Avera Health Plans	Employer Group Insurance
	CoOportunity Health	CoOportunity Health	N/A—New Insurer, CO-OP
	Gundersen Health Plan, Inc.	Gundersen Health Plan, Inc.	Employer Group Insurance
Kansas	Aetna, Inc.	Coventry Health and Life, Coventry Health Care of Kansas, Inc.	Employer Group Insurance
	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas, Inc	Employer Group Insurance
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City	Self-Insured Employers (ASO)
Kentucky	Humana, Inc.	Humana Health Plan, Inc.	Self-Insured Employers (ASO)
	Kentucky Health Cooperative, Inc.	Kentucky Health Cooperative, Inc.	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Health Plans of Kentucky, Inc.	Self-Insured Employers (ASO)

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 3 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Louisiana	Humana, Inc.	Humana Health Benefit Plan of Louisiana, Inc.	Medicare Advantage
	Louisiana Health Cooperative, Inc.	Louisiana Health Cooperative	N/A—New Insurer, CO-OP
	Louisiana Health Service & Indemnity Company	Blue Cross Blue Shield Louisiana, HMO Louisiana, Inc.	Self-Insured Employers (ASO)
	Vantage Health Plan, Inc.	AAA Vantage Health Plan	Employer Group Insurance
Maine	Maine Community Health Options	Maine Community Health Options	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Employer Group Insurance
Maryland	CareFirst Blue Cross Blue Shield	CareFirst of Maryland, Inc., CareFirst BlueChoice, Inc., GHMSI	Self-Insured Employers (ASO)
	Evergreen Health Cooperative, Inc.	Evergreen Health	N/A—New Insurer, CO-OP
	Kaiser Permanente	Kaiser Foundation	Employer Group Insurance
	UnitedHealth Group	All Savers Insurance	Self-Insured Employers (ASO)
Massachusetts	Baystate Health	Health New England	Employer Group Insurance
	Blue Cross Blue Shield of Massachusetts	Blue Cross Blue Shield of Massachusetts	Self-Insured Employers (ASO)
	Boston Medical Center Health Plan, Inc.	Boston Medical Center HealthNet Plan	Medicaid Managed Care
	Centene Corporation	Ambetter from CeltiCare	Employer Group Insurance
	Fallon Community Health Plan	Fallon Community Health Plan	Employer Group Insurance
	Harvard Pilgrim Health Care, Inc.	Harvard Pilgrim Health Care	Self-Insured Employers (ASO)
	Minuteman Health, Inc.	Minuteman Health	N/A—New Insurer, CO-OP
	Partners HealthCare System, Inc.	Neighborhood Health Plan	Medicaid Managed Care
	Tufts Health Plan	Tufts Health Plan, Network Health	Self-Insured Employers (ASO)
Michigan	Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan, Blue Care Network of Michigan	Self-Insured Employers (ASO)
	Caidan Enterprises, Inc.	Meridian Choice	Medicaid Managed Care
	Consumers Mutual Insurance of Michigan	Consumers Mutual Insurance of Michigan	N/A—New Insurer, CO-OP
	Henry Ford Health System	HAP	Employer Group Insurance
	Humana, Inc.	Humana Medical Plan of Michigan Inc.	Medicare Advantage
	McLaren Health Care	McLaren Health Plan, Inc.	Medicaid Managed Care
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Spectrum Health	Priority Health	Employer Group Insurance
	Total Health Care	Total Health Care USA, Inc.	Medicaid Managed Care
Minnesota	Blue Cross and Blue Shield of Minnesota	Blue Cross and Blue Shield of Minnesota	Self-Insured Employers (ASO)
	HealthPartners	HealthPartners	Employer Group Insurance
	Medica Holding Company	Medica	Employer Group Insurance
	PreferredOne Community Health Plan	PreferredOne Insurance Company	Self-Insured Employers (ASO)
	UCare Health, Inc.	UCare Minnesota	Medicaid Managed Care
Mississippi	Centene Corporation	Ambetter from Magnolia Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Missouri	Aetna, Inc.	Coventry Health Care, Coventry Health and Life	Self-Insured Employers (ASO)
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Employer Group Insurance
Montana	Blue Cross and Blue Shield of Montana	Blue Cross and Blue Shield of Montana	Self-Insured Employers (ASO)
	Montana Health CO-OP	Montana Health CO-OP	N/A—New Insurer, CO-OP
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 4 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Nebraska	Aetna, Inc.	Coventry Health Care of Nebraska Inc.	Medicaid Managed Care
	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Nebraska	Self-Insured Employers (ASO)
	CoOportunity Health	CoOportunity Health	N/A—New Insurer, CO-OP
	The Carle Foundation	Health Alliance-Alegent Creighton Health Partner	N/A—New to State
Nevada	Nevada Health CO-OP	Nevada Health CO-OP	N/A—New Insurer, CO-OP
	Saint Mary's Health Plans	St. Mary's	Employer Group Insurance
	UnitedHealth Group	Health Plan of Nevada	Self-Insured Employers (ASO)
	WellPoint, Inc.	Anthem	Self-Insured Employers (ASO)
New Hampshire	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
New Jersey	Freelancers Consumer Operated And Oriented Program Of New Jersey, Inc.	Health Republic Insurance of New Jersey	N/A—New Insurer, CO-OP
	Horizon Blue Cross Blue Shield of New Jersey	Horizon Blue Cross Blue Shield of New Jersey	Self-Insured Employers (ASO)
	Independence Blue Cross	AmeriHealth New Jersey	Employer Group Insurance
New Mexico	Ardent Health Services	Lovelace Health System	Medicaid Managed Care
	Health Care Service Corporation	Blue Cross and Blue Shield of New Mexico	Self-Insured Employers (ASO)
	Molina Healthcare, Inc.	Molina Healthcare of New Mexico	Medicaid Managed Care
	New Mexico Health Connections	New Mexico Health Connections	N/A—New Insurer, CO-OP
	Presbyterian Healthcare Services	Presbyterian Health Plan	Medicaid Managed Care
New York	Affinity Health Plan	Affinity Health Plan	Medicaid Managed Care
	CDPHP	CDPHP	Employer Group Insurance
	EmblemHealth	EmblemHealth	Employer Group Insurance
	Freelancers Health Service Corporation, Inc.	Health Republic	N/A—New Insurer, CO-OP
	Healthfirst	Healthfirst	Medicaid Managed Care
	HealthNow New York, Inc.	Blue Shield of Northeastern NY, Blue Cross Blue Shield of Western NY	Employer Group Insurance
	Independent Health Association, Inc.	Independent Health	Employer Group Insurance
	MetroPlus Health Plan, Inc.	MetroPlus Health Plan	Medicaid Managed Care
	MVP Health Care	MVP	Employer Group Insurance
	North Shore LIJNorth Shore-LIJ CareConnect Insurance Company, Inc.	North Shore LIJ	N/A—New Insurer
	Oscar Insurance Corporation	Oscar	N/A—New Insurer
	The Lifetime Healthcare Companies	Excellus Blue Cross Blue Shield, Univera	Employer Group Insurance
	The New York State Catholic Health Plan, Inc.	Fidelis Care	Medicaid Managed Care
	UnitedHealth Group	United	Self-Insured Employers (ASO)
	Universal American Corp.	Today's Options	Medicare Advantage
	WellPoint, Inc.	Empire Blue Cross	Self-Insured Employers (ASO)
North Carolina	Aetna, Inc.	CoventryOne	Self-Insured Employers (ASO)
	Blue Cross and Blue Shield of North Carolina	Blue Cross and Blue Shield of North Carolina	Self-Insured Employers (ASO)
North Dakota	Medica Holding Company	Medica	Employer Group Insurance
	Noridian Mutual Insurance Company	Blue Cross Blue Shield of North Dakota	Employer Group Insurance
	Sanford Health	Sanford Health Plan	Self-Insured Employers (ASO)

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 5 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Ohio	Aetna, Inc.	HealthAmericaOne	Self-Insured Employers (ASO)
	CareSource	CareSource	Medicaid Managed Care
	Catholic Health Partners	HealthSpan, Kaiser Foundation Health Plan of Ohio	Employer Group Insurance
	Centene Corporation	Ambetter from Buckeye Community Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Health Plan of Ohio, Inc.	Medicare Advantage
	McKinley Life Insurance Company	AultCare	Employer Group Insurance
	Medical Mutual of Ohio	MedMutual	Self-Insured Employers (ASO)
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Summa Health System	SummaCare	Employer Group Insurance
	Vanguard Health Ventures, Inc.	Paramount Insurance Company	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Oklahoma	Aetna, Inc.	Aetna, Coventry Health and Life, Coventry Health Care of Kansas, Inc.	Self-Insured Employers (ASO)
	CommunityCare, Inc.	CommunityCare HMO	Employer Group Insurance
	GlobalHealth, Inc.	GlobalHealth	Employer Group Insurance
	Health Care Service Corporation	Blue Cross Blue Shield of Oklahoma	Employer Group Insurance
Oregon	Atrio Health Plans, Inc.	Atrio Health Plans	Medicare Advantage
	Cambia Health Solutions, Inc.	BridgeSpan	Employer Group Insurance
	Freelancers Consumer Operated And Oriented Program Of Oregon, Inc.	Health Republic Insurance Oregon COOP	N/A—New Insurer, CO-OP
	Health Net, Inc.	Health Net	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Moda Health	Moda Health	Self-Insured Employers (ASO)
	Oregon's Health CO-OP	Oregon's Health CO-OP	N/A—New Insurer, CO-OP
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance
	Premera Blue Cross	LifeWise Health Plan of Oregon	Employer Group Insurance
	Providence Health & Services	Providence Health Plan	Self-Insured Employers (ASO)
	Trillium Community Health Plan, Inc.	Trillium	Medicaid Managed Care
Pennsylvania	University of Pittsburgh Medical Center	UPMC Health Plan	Medicaid Managed Care
	Aetna, Inc.	Aetna, HealthAmericaOne	Self-Insured Employers (ASO)
	Capital BlueCross	Capital Blue Cross, Keystone Health Plan Central	Self-Insured Employers (ASO)
	Geisinger Health Plan	Geisinger Health Plans	Employer Group Insurance
	Highmark Health Services	Highmark Health Insurance Company, Highmark Health Services	Self-Insured Employers (ASO)
	Hospital Service Association Of Northeastern Pennsylvania	Blue Cross of Northeastern Pennsylvania	Self-Insured Employers (ASO)
	Independence Blue Cross	Independence Blue Cross	Self-Insured Employers (ASO)
Rhode Island	Blue Cross & Blue Shield of Rhode Island	Blue Cross Blue Shield of Rhode Island	Self-Insured Employers (ASO)
	Neighborhood Health Plan	Neighborhood Health Plan of RI	Medicaid Managed Care
South Carolina	Aetna, Inc.	CoventryOne	Self-Insured Employers (ASO)
	BlueCross BlueShield of South Carolina	Blue Cross Blue Shield of South Carolina, BlueChoice HealthPlan	Employer Group Insurance
	Consumer's Choice Health Insurance Company	Consumers' Choice Health Plan	N/A—New Insurer, CO-OP
South Dakota	Avera Health Plans	Avera Health Plans	Self-Insured Employers (ASO)
	Sanford Health	Sanford Health Plan	Self-Insured Employers (ASO)
	South Dakota State Medical Holding Company, Inc.	DakotaCare	Employer Group Insurance

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 6 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Tennessee	Blue Cross Blue Shield of Tennessee	Blue Cross Blue Shield of Tennessee	Self-Insured Employers (ASO)
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Community Health Alliance Mutual Insurance Company	Community Health Alliance	N/A—New Insurer, CO-OP
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Texas	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter from Superior Health Plan	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Community Health Choice, Inc.	Community Health Choice	Medicaid Managed Care
	Health Care Service Corporation	Blue Cross Blue Shield of Texas	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Health Plan of Texas, Inc.	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Texas	Medicaid Managed Care
	Scott & White Health Plan and Insurance Company	Scott & White Health Plan	Employer Group Insurance
	Sendero Health Plans, Inc.	Sendero Health Plans	Medicaid Managed Care
	SHA, LLC	Firstcare Health Plans	Medicaid Managed Care
	University Health System	CommunityFirst	Medicaid Managed Care
Utah	Aetna, Inc.	Altius Health Plans	Employer Group Insurance
	Arches Mutual Insurance Company	Arches Health Plan	N/A—New Insurer, CO-OP
	Cambia Health Solutions, Inc.	BridgeSpan Health Company	Employer Group Insurance
	Humana, Inc.	Humana Medical Plan of Utah, Inc.	Individual Insurance
	Intermountain Healthcare	SelectHealth	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Utah Marketplace	Medicaid Managed Care
Vermont	Blue Cross Blue Shield of Vermont	Blue Cross Blue Shield of Vermont	Employer Group Insurance
	MVP Health Care	MVP Health Care	Employer Group Insurance
Virginia	Aetna, Inc.	Aetna, CoventryOne, Innovation Health Insurance Company	Self-Insured Employers (ASO)
	CareFirst Blue Cross Blue Shield	CareFirst Blue Cross Blue Shield, CareFirst BlueChoice, Inc.	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Sentara Healthcare, Inc.	Optima Health	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield, Anthem Health Plans of Virginia	Self-Insured Employers (ASO)
Washington	Cambia Health Solutions, Inc.	BridgeSpan	Employer Group Insurance
	Centene Corporation	Coordinated Care	Medicaid Managed Care
	Community Health Network of Washington	Community Health Plan of Washington	Medicaid Managed Care
	Group Health Cooperative	Group Health	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Premera Blue Cross	Premera Blue Cross, Lifewise Health Plan of Washington	Self-Insured Employers (ASO)
West Virginia	Highmark Health Services	Highmark Blue Cross Blue Shield West Virginia	Self-Insured Employers (ASO)

ASO — Administrative Services Only

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 7 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Wisconsin	Common Ground Healthcare Cooperative	Common Ground Healthcare Cooperative	N/A—New Insurer, CO-OP
	Dean Health Systems, Inc.	Dean Health Plan	Employer Group Insurance
	Group Health Cooperative of South Central Wisconsin	Group Health Cooperative-SCW	Employer Group Insurance
	Gundersen Health Plan, Inc.	Gundersen Health Plan, Inc.	Self-Insured Employers (ASO)
	Health Tradition Health Plan	Health Tradition Health Plan	Employer Group Insurance
	Medica Holding Company	Medica	Employer Group Insurance
	Mercy Health System Corporation	MercyCare Health Plans	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Wisconsin	Medicaid Managed Care
	Physicians Plus Insurance Corporation.	Physicians Plus Insurance Corporation	Employer Group Insurance
	Security Health Plan of Wisconsin, Inc.	Security Health Plan of Wisconsin, Inc.	Employer Group Insurance
	University Health Care, Inc.	Unity Health Insurance	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
	Wisconsin Physicians Service Insurance Corporation	Arise Health Plan	Self-Insured Employers (ASO)
Wyoming	Blue Cross Blue Shield of Wyoming	Blue Cross Blue Shield of Wyoming	Self-Insured Employers (ASO)
	WINhealth Partners	WINhealth Partners	Employer Group Insurance
District of Columbia	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	CareFirst Blue Cross Blue Shield	CareFirst	Self-Insured Employers (ASO)
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance

ASO — Administrative Services Only

Source: Data compiled by the author. The source for the federally facilitated exchanges is data from HealthCare.gov, "Health Plan Information for Individuals and Families," https://www.healthcare.gov/health-plan-information (accessed October 16, 2013). Information for the state-run exchanges comes from either the state's exchange or its insurance department. Ownership of subsidiaries and trade names was verified using state insurance department filings.

B 2852 heritage.org