

A STUDY OF AFFORDABLE CARE ACT COMPETITIVENESS IN NORTH CAROLINA

Mark A. Hall, Wake Forest University
with the assistance of Katherine Booth



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Section 1 – State Context

Basic facts about North Carolina are presented in the table below and the distribution of the state’s population is shown in the map that follows.^{1,2,3,4,5,6}

Table 1: Basic State Facts

North Carolina Snapshot	
Type of Exchange	Federally facilitated marketplace
Expansion of Medicaid	No
Number of Rating Areas	16
Number of Insurers	1 statewide, another in only one metro area
Net Change in Number of Insurers (2014-2017)	-1, but most metro areas have lost two
Premium Increase (2016, silver plans)	22 percent (44th best)
State Population and Rank (July 2015)	9,902,000 (9th)
State Median Household Income and Rank (2015)	\$50,797 (38th)
Salient Health Facts	19.2 percent of adults in North Carolina report fair or poor health status; in the bottom quarter of U.S. states.
Salient Health Policy Information	Fairly standard regulatory environment, neither notably strict nor notably lenient. Per capita health spending is below U.S. average. Prior to the Affordable Care Act, North Carolina had the sixth-highest rate of uninsured in the U.S.

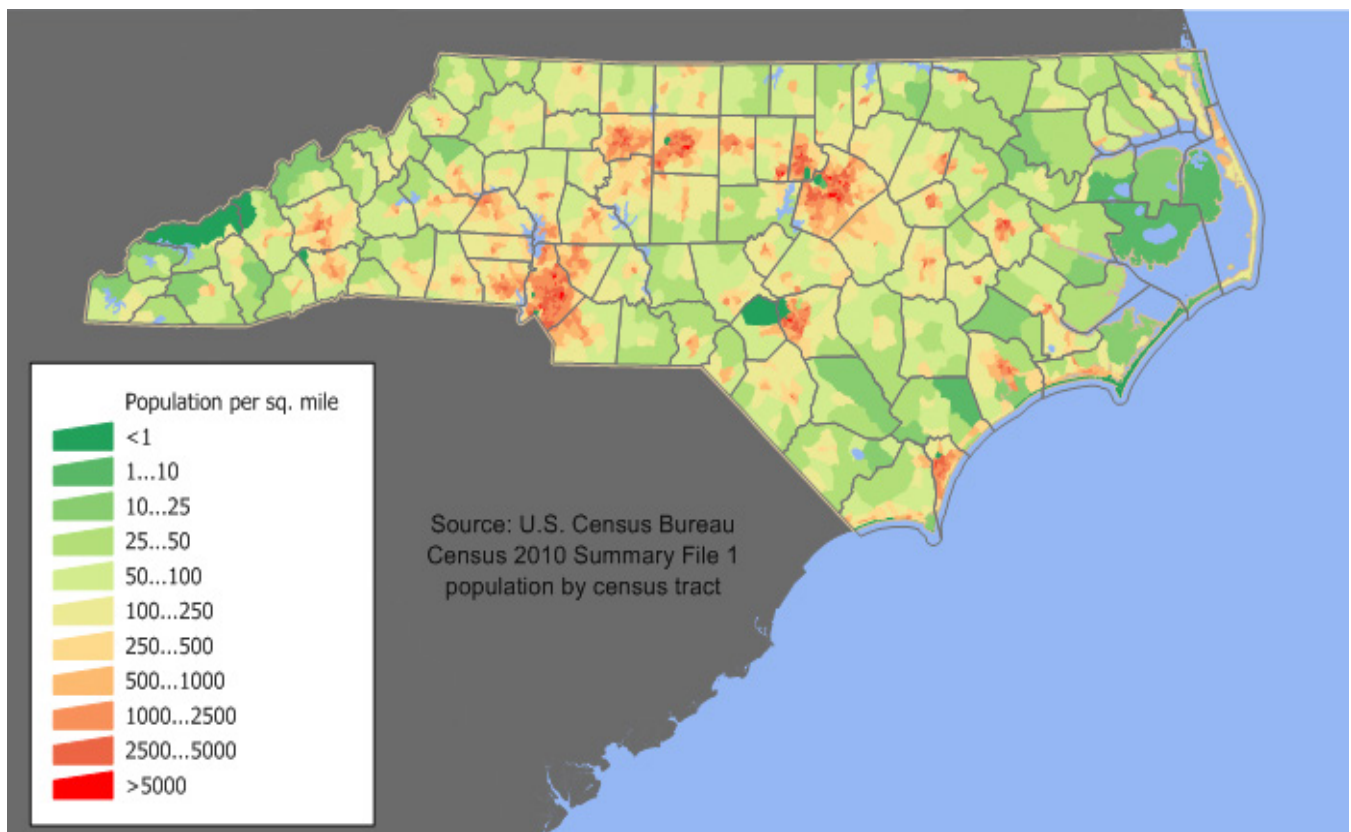
North Carolina is a populous state (10 million) with lower-than-average income (42nd nationally) and a historically high uninsurance rate (6th nationally). Thus, the state had a large number of potential new applicants eligible for subsidized coverage, and in fact has achieved the fourth-highest exchange enrollment in the country (approximately 600,000). North Carolina is also notable for being the second-largest state to have only one carrier statewide—Blue Cross and Blue Shield of North Carolina (Blue Cross).

Despite having lower overall health care costs than national averages and group premiums near the national average, premiums for Affordable Care Act (ACA) nongroup coverage in North Carolina are the highest in the continental United States. These premiums vary, however, by as much as 30 percent across rating areas. Population density also varies a great deal across the state.

Under Republican leadership, North Carolina declined to run its own marketplace exchange. The state's insurance commissioner is popularly elected and therefore tends to have a somewhat populist orientation to consumer issues. The insurance department has been active in implementing the state's portions of the ACA's new market regulations.

The state also has refused so far to expand Medicaid. However, it is seeking a federal waiver to implement managed care for Medicaid statewide. Previously, the state's Medicaid was primarily fee-for-service (except for behavioral health).

Figure 1: Population of North Carolina



Source: Wikimedia Creative Commons, https://commons.wikimedia.org/wiki/File:North_Carolina_population_map.png

Section 2 – New Developments Entering the Fourth Open Enrollment Period

The most notable development for the 2017 open enrollment period (OE4) is the decision by two of the nation’s largest insurers—UnitedHealthcare and Aetna—to exit the marketplace exchange, both in North Carolina and in other states.

Previously, UnitedHealthcare had offered exchange coverage in three-quarters of the state’s counties, which included about 90 percent of its population, and Aetna had done so in more populous areas covering about a quarter of the counties, accounting for roughly half the state’s population.

With these two major departures from the market, Blue Cross and Blue Shield of North Carolina is the only option throughout most of the state, except in the Raleigh area, where Cigna has entered the exchange market for the first time. Blue Cross also considered whether it would withdraw from at least some counties, but announced recently that it would remain in all counties for an additional year—reserving, however, its option to reconsider that decision for future years.

An analysis by this same research team a year ago concluded that North Carolina’s individual market was reasonably competitive overall.⁷ Prior to the ACA, Blue Cross had a commanding market share in the individual market of 86 percent, and only one other insurer, Aetna (formerly called Coventry), had over 5 percent, making North Carolina’s individual market one of the most highly concentrated in the country.⁸ After the first three open enrollments, North Carolina’s individual market was noticeably less concentrated. Based on enrollment on and off the exchange, Blue Cross’s share of the individual market statewide dropped to 65 percent by early 2016. Aetna had 19 percent, and UnitedHealthcare had 16 percent.⁹

Obviously, this picture has changed considerably in less than a year.

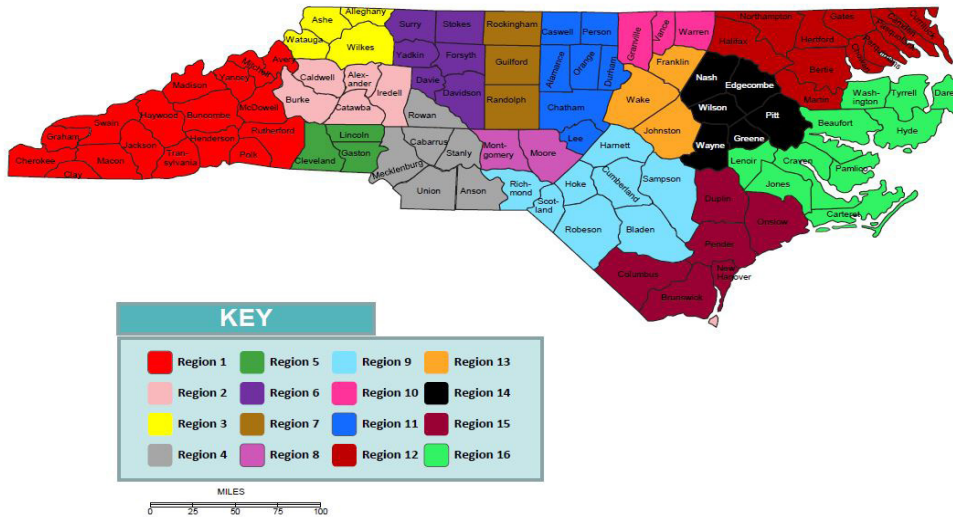
Section 3 – Selection of Study Locations

Below is a map of North Carolina’s 16 rating areas. This study addresses market conditions statewide, but with special focus on the eastern third (regions 12, 14, 15, and 16), the far west (region 1), and the Charlotte area (regions 4 and 5). The eastern third historically has had little competition among carriers; the western regions have seen some competition; and the Charlotte area has had significant competition.

Only Blue Cross has offered coverage statewide during all four ACA open enrollment periods. During the first open enrollment (OE1), Aetna offered coverage in the Charlotte area, along with other more populous areas mostly in the central part of the state. In the second open enrollment (OE2), Aetna

expanded somewhat to cover 39 of 100 counties that accounted for 64 percent of the state’s population. Included in this coverage was all of region 1 except for the five most western counties, but little or none of the east/southeast (9, 12, 14, 15, and 16).

Figure 2: North Carolina Rating Areas



Source: North Carolina Department of Insurance, North Carolina 2014 Rating Areas Accepted by CCIIO on 3/29/13, http://www.ncdoi.com/HealthCareReform/Documents/HealthCareReform/North_Carolina_Map_of_2014_Rating_Areas.pdf

During the second open enrollment, UnitedHealthcare entered the market, and in the third open enrollment UnitedHealthcare expanded to cover about three quarters of the state’s counties—all except those in the northeast, which have the least population.

Section 4 – Methodology

The selection and recruitment methods involved two steps. In addition to interviews, internet searches were conducted of major North Carolina newspapers and health policy websites for relevant information. First, contact lists were formed for each category of interview subjects. For insurers, regulators, providers, and state policy experts, this was done using existing connections and information, drawn from previous health policy research in North Carolina. For navigators and agents, contact lists were compiled from separate databases based on county and rating region.

People in these separate groups were contacted using a different approach for known contacts and new ones. For the former group, contacts were made on an individual basis, and positive responses were received from all ten contacts. For new contacts, a form email was sent that outlined the basic goal of the study as well as a detailed account of confidentiality procedures.

Of 28 such emails, 17 responded and agreed to participate. Overall, 27 interviews were conducted—four with insurers, five with navigators, six with agents/brokers, two with current or former regulators, seven with providers (both hospitals and physician groups), and three with state policy experts. Interviews lasted from 20 to 60 minutes, with most agent/navigator interviews lasting roughly 30 minutes and most interviews with regulators, insurers, and providers lasting longer.

Interviews were conducted by the author of this report, who took written notes. Interviews were based on an interview guide, but topics varied somewhat based on each source’s particular background and experience.

Section 5 – Findings and Analysis

5.1 INSURER PARTICIPATION

Sources gave a variety of explanations why North Carolina, despite the size of its enrollment, has failed to retain substantial competition on the ACA exchange.

First, no source blamed the state’s regulatory environment. Instead, several people noted that North Carolina regulators worked with carriers in a constructive and encouraging fashion to help facilitate marketplace success. In particular, there was general consensus that although the insurance department takes rate review seriously it has not refused to give insurers most of the rate increases they have sought because the increases have been, by and large, actuarially justified. Any concerns about regulatory burden were expressed mainly with regard to federal requirements, such as those for establishing qualified health plan status.

Most sources pointed to the losses insurers have been suffering in the ACA exchange market as the primary reason for the lack of competition. No one attributed these losses to regulators’ refusal to approve requested rate increases, which have been in the range of 20 to 30 percent the past two years. Instead, insurers pointed to the difficulty in accurately projecting what claims costs would be for a newly created market. According to one interviewee, the large size of the state’s enrollment actually cuts against insurers’ eagerness to compete because, with a large market, “small misses [in price] equal large losses.”

One factor cited by some, but not most, sources is North Carolina’s failure so far to expand Medicaid. In prior research, failure to expand was cited as a factor favorable to market entry, because that means more people—those between 100-138 percent of the federal poverty level (FPL)—are eligible for highly subsidized private coverage. However, in the current round of interviews, some sources pointed to research indicating that states that did not expand Medicaid have experienced worse risk pools in their individual markets, because people near poverty have more unmet medical needs than average.

Most sources, however, felt that the current lack of competition in North Carolina is temporary. They

noted that North Carolina is distinctive in having most of its potential competition for Blue Cross currently coming from national insurers rather than from more local “homegrown” insurers that are committed to remaining in the state. UnitedHealthcare and Aetna appear to have made national decisions about their market exits, and no one pointed to any factors unique to North Carolina that led to their decisions to leave this state. Moreover, several sources felt that the vacuum created by the exit of UnitedHealthcare and Aetna will create an opportunity for other, smaller insurers to enter, if profitability improves in the individual market. Also, some sources noted that Aetna, in particular, has retained the option to re-enter the ACA exchange market by continuing to sell individual coverage in the nonexchange market.

Future market entry is made more likely by the fact that North Carolina is in the process of moving to managed care contracting for its Medicaid program. That process will take a couple of years, but it is expected to result in the entry of several newly licensed insurers to serve the existing Medicaid population. Several sources thought that it stands to reason that once a new insurer is licensed and capitalized to serve the Medicaid population, it would also consider entering the ACA exchange market. Also, they noted, Medicaid managed care companies are the types of insurers that have proven to be most successful in the ACA exchanges in other states.

A few sources were more skeptical about the possibility of new market entry. First, they noted the continuing unprofitability in the ACA exchange market. They also speculated that if new managed care carriers enter to serve the Medicaid population, their next likely target for market expansion would be Medicare Advantage, because of its greater profitability and the similarities in regulatory requirements and care management approaches.

5.2 NETWORK FORMATION

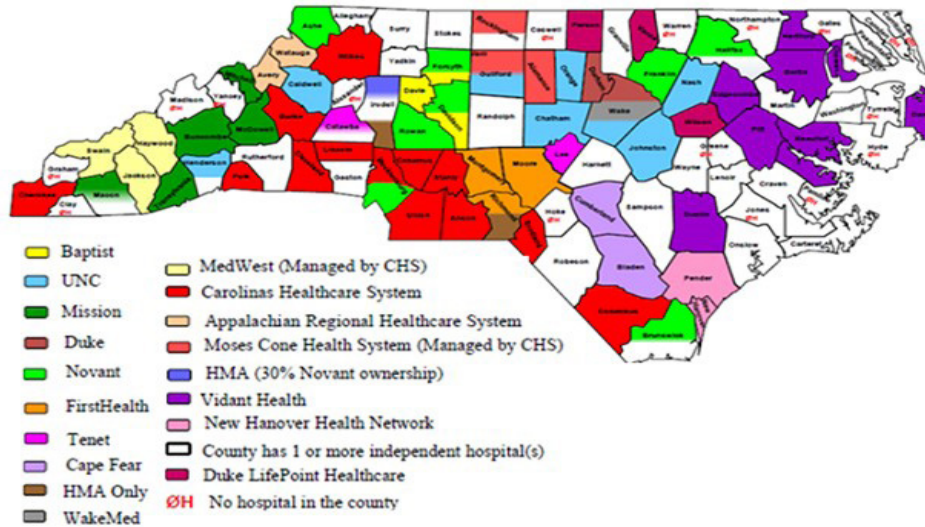
Sources consistently said that health insurers’ potential entry into the market and geographic coverage are driven by provider contracting. North Carolina is considered to have fairly consolidated provider markets, as shown in the map below.

Until a few years ago, Blue Cross included a “most favored nation” clause in its provider contracts. It required providers to give Blue Cross their best discount, but Blue Cross no longer does so and state law now forbids this. Providers in some parts of the state are still reluctant to give favorable discounts to Blue Cross competitors, several interview sources said. Sources also said that, considering the strong brand recognition that Blue Cross enjoys, it is not sufficient for competing carriers to simply match Blue Cross pricing; competitors need to offer prices that are lower to attract significant enrollment.

Aetna and UnitedHealthcare were able to achieve competitive provider contracts in two ways. Aetna partnered with major health systems in several metropolitan markets to offer cobranded plans, such as with Duke Medical Center in the Raleigh area or the Carolinas Healthcare System in Charlotte. UnitedHealthcare sought risk-sharing arrangements of different types with providers throughout the state, including some accountable care organizations (ACOs). Also, UnitedHealthcare offered only a closed-

network gatekeeper health maintenance organization (HMO) model in the individual market and no point-of-service or preferred provider organization (PPO) option. Cigna entered the Raleigh-area market for 2017 by offering a narrow network based on providers affiliated with the University of North Carolina.

Figure 3: Hospital Systems in North Carolina (multiple shadings indicate multiple systems)



Source: Blue Cross and Blue Shield of North Carolina, “Hospital Systems in North Carolina” (2014).

Blue Cross has also innovated with network models. It offers its standard, full-network PPO in over half the state. But, in several rating areas where Aetna and/or UnitedHealthcare had competed it offers two narrow network models: One that is based primarily on deeper fee-for-service discounting and the other that follows the cobranded health system model. In about half the state’s regions, Blue Cross also offers a tiered network, which is based on its broad network but which reduces patients’ cost-sharing for using providers that have more favorable pricing.

These network innovations are not restricted to the individual market—they are spilling over to other market segments. Blue Cross offers one of its two narrow network models in the group market, and Aetna likewise offers the cobranded networks it created for the individual market to its group purchasers.

Sources said that the reluctance of Blue Cross competitors to enter rating areas where Blue Cross is dominant is based on the unwillingness of providers to contract with Blue Cross competitors on favorable terms. The eastern part of the state was frequently noted as an area where Blue Cross has the market “locked up.” Some people attributed contractual unwillingness to providers’ market power, especially where area hospitals had formed systems and purchased most existing physician practices. One source, however, noted that provider consolidation sometimes facilitates innovative contracting, because networked systems are more aware of the need to create incentives that achieve clinical efficiencies.

Also, consolidated provider structures make contracting decisions more centrally. As a result, it is easier to form networks quickly compared with contracting separately with a large number of independent providers.

Providers offered several explanations about their willingness or ability to negotiate with carriers for lower rates. Representatives with several hospitals said they are willing to give significant discounts from their normal PPO rates. They realize it is necessary to offer competitively priced coverage and that having some coverage is financially much better than incurring uncompensated care. Some hospitals also see the strategic value of supporting market entry by competitors to Blue Cross, since otherwise they feel that Blue Cross dominates negotiations with providers.

Other hospitals, however, said they are not eager to receive patients with ACA coverage. They feel that these patients are likely to incur higher costs and be less stable in their source of insurance. Several hospital representatives noted that the ACA requires them to regard patients as having coverage for up to three months after the patient stops paying premiums. As a result, the hospital learns only retroactively that the insurer will not pay for the treatment.

When North Carolina insurers formed narrower or specialized networks for the exchange market, they did so in one of two ways. Some carriers used existing provider contracts to assemble an ACA product. For instance, sources said that UnitedHealthcare selected certain physicians from its broader networks to form the gatekeeping HMO product that it developed for the nongroup market—without having to negotiate new contracts with those physicians.

Other insurers, however, sought specific discounts or compensation arrangements with providers to form new networks. In doing so, they tended to work with established health systems that included both hospitals and a range of physicians. This facilitated meeting network adequacy requirements and took less time than negotiating with a larger number of smaller or separate providers.

This selective contracting caused frustration for some providers that were excluded. Some complained that they were willing to give substantial discounts to be included in these new networks, but the insurer was not willing to negotiate. One informed source confirmed that this is sometimes the case, because expanding the network would reduce discounts obtained from a larger health system. Also, one insurer noted that expanding new networks into more territory can take substantial effort, so insurers need to prioritize where to focus their energy and resources each year. Additional efforts in developing or expanding networks might not make the most sense for an insurer that is not sure it is going to remain in the market long term.

On the whole, there are no significant indications that the networks formed for the exchange market are too narrow. Most sources did not point to network adequacy problems, even if they tended to favor more explicit adequacy standards. One factor that mitigated concerns about adequacy is that most of the

narrow networks are in metropolitan areas where there are many providers to choose from. In addition, different health systems have affiliated with different insurers, so that consumers, if they are well informed, can usually find a network that has their preferred providers.

This differentiation among health systems in their plan affiliations has caused some problems, however, when subscribers switch plans to avoid substantial premium increases. As described more below, the more competitive nature of North Carolina's market in previous years meant that insurers would change places in relation to the benchmark premium on which subsidies are based. Thus, a particular network that is affordable in one year might become unaffordable in a subsequent year. Some navigators and agents complained that this caused people to switch plans without realizing they would be losing access to their preferred physician or hospital.

Consumer understanding of the consequences of switching plans was initially hampered, in part, by lack of easily accessible information about network composition. In addition, many enrollees had never had insurance and were unfamiliar with network rules and strictures. However, several interviewees noted that the marketplace's information technology has improved following the initial open enrollment periods. It is now easier than before for purchasers to determine whether their favored providers are included in a network.

5.3 PRICES AND ENROLLMENT

Despite having below average health care spending per capita and nationally average group premiums, premiums in the individual marketplace are among the highest in the country. Looking at the largest city in each state and comparing prices for the second-lowest-cost silver plan, the Kaiser Family Foundation reported that North Carolina had the fourth-highest premiums in the country in 2016.¹⁰ Statewide, North Carolina's average premiums in 2016 were the highest in the country after Alaska, the U.S. Department of Health and Human Services reported.¹¹ Prices varied among rating areas, however, by roughly 30 percent in 2016, when UnitedHealthcare and Aetna were in the market and by 20 percent in 2017 after they exited. Various sources thought these variations are attributable as much to provider pricing as they are to population health or utilization patterns.

In 2016, three out of the four highest-cost areas were concentrated in the rural coastal counties to the east (zones 12, 15, 16), where there are fewer providers. However, in 2017, more central rural areas emerged as the highest cost (zones 8, 9, 10, and 14). The lowest-cost areas were also mostly in the central part of the state in 2016 and 2017, including both rural areas and also some sizable cities, such as Raleigh, Greensboro, Fayetteville, and Wilmington, where there is greater density of both population and providers. In both 2016 and 2017, prices were intermediate in Charlotte (zone 4) and in mountainous counties to the west (zone 1).

For 2017, Blue Cross increased prices an average of 24 percent. This follows a 32 percent increase the prior year. The extent to which increases of those magnitudes were needed to break even or show a

small profit is not yet known, but in prior years (2015 and 2014) Blue Cross reported substantial losses from its marketplace plans.

Despite the relatively high marketplace premiums statewide, marketplace enrollment in North Carolina has been relatively successful. Roughly 600,000 people are now enrolled through the marketplace, the fourth most in the country. This represents an estimated 61 percent of potential purchasers, which is the fourth-highest proportion in the U.S. and third highest among states with a federally facilitated marketplace. About 90 percent of subscribers receive a premium subsidy, and almost two-thirds also receive cost-sharing reductions, which are among the higher such proportions in the U.S. Owing to the high proportion of enrollees who qualify for financial assistance, North Carolina has enrolled over half of the population that is potentially eligible for enrollment subsidies, which is fifth highest in the U.S.

The fact that most marketplace enrollees receive premium subsidies causes this market to function somewhat differently than others. Some enrollment assistors noted that pricing in their area became more competitive when UnitedHealthcare entered in the second year, though many existing subscribers saw substantial increases. This happened because UnitedHealthcare's lower price affected the subsidy that eligible consumers received for Blue Cross coverage. This subsidy is keyed to the second-lowest silver plan in the market, which initially was a Blue Cross plan. When UnitedHealthcare entered, either it or an Aetna plan became the second lowest, and so the available subsidy covered less of the premium for the broad-network Blue Cross plan than in the previous year.

Here is a scenario described by more than one source: A person initially enrolls in Blue Cross's broad network at a highly subsidized price. The enrollee switches in a subsequent year to another carrier after learning there would be a very large premium increase (because the subsidy was now based on a market entrant's plan). Then, the person learns that their preferred physician is not included in the chosen network.

With UnitedHealthcare and Aetna exiting the market, the opposite will happen for many subscribers. Those who kept Blue Cross plans with broader networks will see a price drop, because their subsidy will now be keyed only to Blue Cross's premiums, which will now be the second lowest in most locations (except the Raleigh area, where Cigna is entering and its pricing is similar to, or below, that of Blue Cross). Consumers who dropped their broader network Blue Cross plan may now be able to afford switching back. Ironically, then, the loss of competition will have some immediate consumer benefits, at least in the short term, since most subscribers receive premium subsidies, and those subsidies will now be set to the plans that previously had covered the majority of the market.

5.4 REASONS FOR HIGHER PRICES

One possible reason for higher premiums is that North Carolina allowed people to keep and renew their noncomplying policies. Those policies are medically underwritten, so grandfathered subscribers tend to be relatively healthier. Additionally, those policies are not community rated, so their prices remain

more favorable for younger subscribers. To some extent, then, this “continuation” policy may have kept a healthier population out of the community-rated market. According to one actuarial estimate, almost a third of North Carolina’s nongroup enrollment was in transitional policies in 2014—sixth highest in the country.¹² The government estimated that, in 2015, North Carolina had 138,000 people with individual coverage purchased outside the exchange who could have qualified for premium subsidies—fourth highest in the country.¹³

Another possible explanation for higher prices in North Carolina is the state’s decision not to expand Medicaid. As a result, the exchange market includes people whose income is 100-138 percent of the FPL, who would otherwise be eligible only for Medicaid. On average, such people tend to have more serious health problems. Therefore, premiums in nonexpansion states have been estimated to be 7 percent higher, on average.¹⁴

North Carolina is one of 22 states that, as of 2015, both allowed transitional policies and had not expanded Medicaid. Analyzing both factors, the Kaiser Family Foundation reported that the “risk score” for North Carolina’s enrolled population that year (which calculates expected health care costs based on demographics and diagnoses) was 8 percent higher than the national average and 12 percent higher than states that both expanded Medicaid and prohibited transitional plans.¹⁵

Finally, some short-term policies that do not purport to be ACA-compliant were being sold in the state. Because these policies are not subject to the health care law, they can be medically underwritten and can exclude pre-existing conditions, which allows them to be priced much less expensively for healthier people. Views differed on the extent that short-term policies were being sold, with some sources believing that they are not a significant part of the market, but others noting that marketing had increased, at least until a recent federal regulatory change.

Views were split on whether these state policies account for a major component of current market prices. Most people thought that not expanding Medicaid has caused rates to be somewhat higher, but only some sources thought that allowing existing subscribers to maintain transitional coverage affects rates. Those who have more direct access to relevant data felt that permitting transitional policies is only a minor factor, especially now that the ACA market reforms are in their fourth year, due to steady attrition among previous subscribers. Also, several sources noted that the significance of short-term policies will diminish following a recent federal ruling that limits these to a maximum of three months.

Adverse selection is another factor that might increase rates. Several sources felt that the nongroup market has an unusually high number of people who sign up for insurance in order to receive expensive treatment and then drop coverage once treatment is no longer needed. Hospital sources, in particular, expressed frustration that they sometimes start treating patients for elective procedures who have recently signed up for coverage but then drop it after treatment is complete (or sometimes even during the course of treatment). Other sources said they had not seen this to any notable extent. However, at

least two multihospital systems in the state make extra efforts to enroll patients or potential patients, and one of these hospital systems makes arrangements to waive deductibles and reimburse premiums if patients maintain their coverage. Premiums in the rating area where the latter hospital system is located are among the highest in the state.

A final reason for higher premiums cited by several sources is simply the extent of unmet health care needs in the state. North Carolina ranks in the bottom 20 percent of states in terms of overall health indicators and spending on public health. Also, prior to the ACA, North Carolina had a higher uninsured rate than the national average. Thus, several observers and market participants noted that it is natural that people who were most eager to sign up did so because they needed treatment. They added that enrolling as a means to obtain treatment is perfectly appropriate as long as people maintain their coverage.

According to one experienced navigator, one reason people drop coverage or that healthier people don't enroll stems from the paperwork burden that the federal government requires to document eligibility. Sometimes documents or explanations had to be sent in several times to complete enrollment or avoid disenrollment, the navigator said. People who do not have a pressing need for treatment are more likely to fail to complete an enrollment process that they find to be frustrating or cumbersome.

To counter adverse selection, North Carolina insurers ceased paying any agent commissions in 2016 following the end of open enrollment, reasoning there is more adverse selection among people who sign up during special enrollment. Blue Cross reinstated commissions for the 2017 open enrollment, but the commission percentage is lower than it has been in past years, causing several brokers who were interviewed to complain that they cannot continue serving this market segment.

Section 6 – Summary and Conclusions

Although North Carolina currently has one of the least competitive exchange marketplaces in the country, it is not obvious that most consumers are suffering as a result. Relatively high premiums are offset for most purchasers by premium subsidies. Moreover, these higher premiums are not obviously due to lack of competition among insurers. Insurers so far have posted losses rather than profits from the ACA's nongroup market. Thus, higher prices are being driven mainly by underlying health care costs. Those costs result both from provider pricing and from the health needs of people who are enrolling.

More serious health problems are attributable, in part, to the general population health in North Carolina and, in part, to state policies that have resulted in a worse risk pool for the exchange market (not expanding Medicaid, and keeping transitional plans). A worse risk pool also might be due to enrollment efforts that target people with the greatest health care needs.

The difficulty in negotiating competitive provider networks is attributable both to provider consolidation

and simply to the small size of the provider community in rural areas. It is for this reason that a number of interview sources enthusiastically supported the idea of a “public option.”

Others, though, were somewhat skeptical or more reserved about a public option, noting that a lot depends on what exactly a public option is and how it would function. Notably, however, outright opposition to the idea was heard only infrequently, indicating general recognition of the fact that, in some parts of the state, a more competitive insurance market may not be feasible.

One factor that mitigates the current lack of competition among insurers is the extent of *potential* competition, at least in more populous areas. Although Blue Cross remains the dominant carrier, increased competition is inevitable, many sources said. No barriers to market entry were noted beyond the usual regulatory requirements to establish financial solvency. Aetna remains poised to re-enter the exchange market if it chooses to do so in the future, and UnitedHealthcare might be able to re-enter through a subsidiary, even if the parent company is excluded for five years. In addition, the state’s recent adoption of managed care contracting for Medicaid is expected to bring in several new carriers that also could enter the nongroup market.

Despite lacking a choice of carriers, the individual market in North Carolina offers a choice of distinct types of networks. In response to Aetna’s earlier formation of ACO-type networks built around prestige hospital systems and to UnitedHealthcare’s earlier embrace of a gatekeeping HMO platform, Blue Cross now offers several types of PPO structures—full, tiered, and limited. Blue Cross also offers a range of choices in patient cost-sharing designs. And, the network innovations that Blue Cross and its previous competitors developed for the nongroup market are also being offered in the group market. Thus, there is evidence of spillover benefits to the employer market from competition in the exchange market.

Finally, significant concerns about network adequacy were not voiced frequently. Instead, concerns were related mainly to helping consumers understand the network consequences of their choices and the need to obtain accurate information about which providers are and are not in a particular networks.

Overall, the following conclusions can be drawn from this study:

- Vigorous competition among insurers initially emerged in markets where the population density and differentiation among providers could support competing networks.
- Vigorous insurer competition may not be achievable in parts of the state that are more rural or where providers have consolidated.
- The sharp drop-off of insurer competition in 2017 is not due to factors in the North Carolina regulatory environment, but instead due to across-the-board decisions by national insurers.

- There is a good possibility that, if profitability is restored in the nongroup market, more insurers will enter (or re-enter) the North Carolina market.
- There are some indications that adverse selection among enrollees has contributed to premiums being higher in North Carolina than elsewhere in the country.

Based on these observations, the following steps could be considered for increasing competition and making premiums more affordable:

- Create a public option in areas where insurer competition is less feasible.
- Take steps to increase competition among providers, especially outside the largest urban areas.
- Change or modify policies that might contribute to adverse selection among enrollees.

Endnotes

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8. Kaiser Family Foundation, “Individual Insurance Market Competition: 2014,” accessed Nov. 18, 2016, <http://kff.org/other/state-indicator/individual-insurance-market-competition/>
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