
New Market Entrants: Growth and Diversification in U.S. Health Insurance

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Prepared by:
Avalere Health LLC

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The U.S. health insurance market has undergone a period of transformation in recent years. Driven in part by the Affordable Care Act (ACA), but also by technology and an emphasis on value-based care, new players have entered various insurance markets, offering new and diverse options to consumers. Importantly, new Internet-based platforms enable consumers to compare and access these choices, empowering individuals to make healthcare decisions that meet their needs.

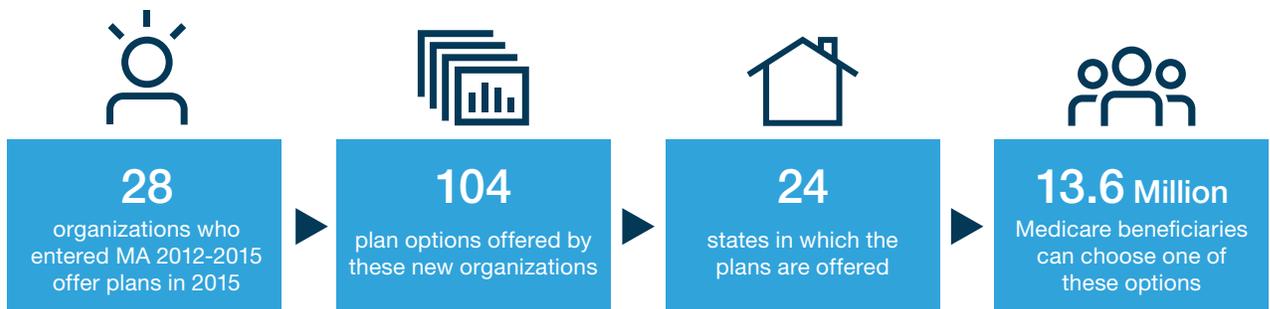
While acknowledging that some market participants have exited and will continue to exit over time, the following brief explores new entrants across insurance markets, including Medicare Advantage (MA), public exchanges, and employer-sponsored insurance. In addition, it considers how delivery system innovation and technology increase information flows and heighten competition in the insurance marketplace.

MEDICARE: NEW MA ENTRANTS AND FFS INNOVATION

With the aging of the baby boomers, Medicare enrollment is projected to grow from the current 54 million to 66 million by 2021.¹ MA enrollment is also projected to continue to grow as a percentage of overall Medicare enrollment, from 32 percent today to 38 percent in 2021.² Even as organizations enter the Medicare market to offer MA plans to the growing ranks of Medicare beneficiaries, policymakers are also rapidly driving payment and delivery innovations in traditional fee-for-service Medicare (FFS). Indeed, FFS reforms are making traditional Medicare increasingly similar to and competitive with MA.

New Entrants to MA

Twenty-eight parent organizations who entered the MA market between 2012 and 2015 still participate in the program today. Together, these new players offer 104 plan options, which are available to 13.6 million beneficiaries in 24 states.³



New MA entrants include established commercial plans as well as major health systems and provider groups that have become health plans. For example:

- **Commercial Plans:** The Health Care Service Corporation (HCSC), a Blue Cross Blue Shield Association licensee and the largest customer-owned health insurance company in the U.S. with more than 16 million members across markets, entered the MA market in 2013.⁴
- **Provider-Owned Plans:** 15 of the 28 new MA entrants are health systems, such as Universal Health Services, MedStar Health, Baylor Health System, and the Memorial Hermann Healthcare System, who have either established or acquired health plans to enter the MA market. **Figure 1** below lists each of the 15 new provider-sponsored MA entrants from 2012-2015.

Figure 1: New Provider-Sponsored MA Entrants, 2012-2015

Provider-Sponsored MA Parent Organizations	
Baylor Scott & White Holdings ⁵	MedStar Health, Inc.
Catholic Health Initiatives ⁶	Memorial Hermann Healthcare System
Catholic Health Partners ⁷	Mountain States Health Alliance
CHRISTUS Health	Piedmont WellStar Health Plans, Inc.
Community Hospital Foundation	Premier Health Partners
FirstHealth of the Carolinas, Inc.	Stanford Hospital and Clinics
Health Partners Plans, Inc.	Universal Health Services, Inc.
IJKG Opco LLC/Bayonne Medical Center	

Source: Avalere analysis of Medicare Advantage enrollment files, 2011-2015

Traditional Medicare Payment and Delivery Reform

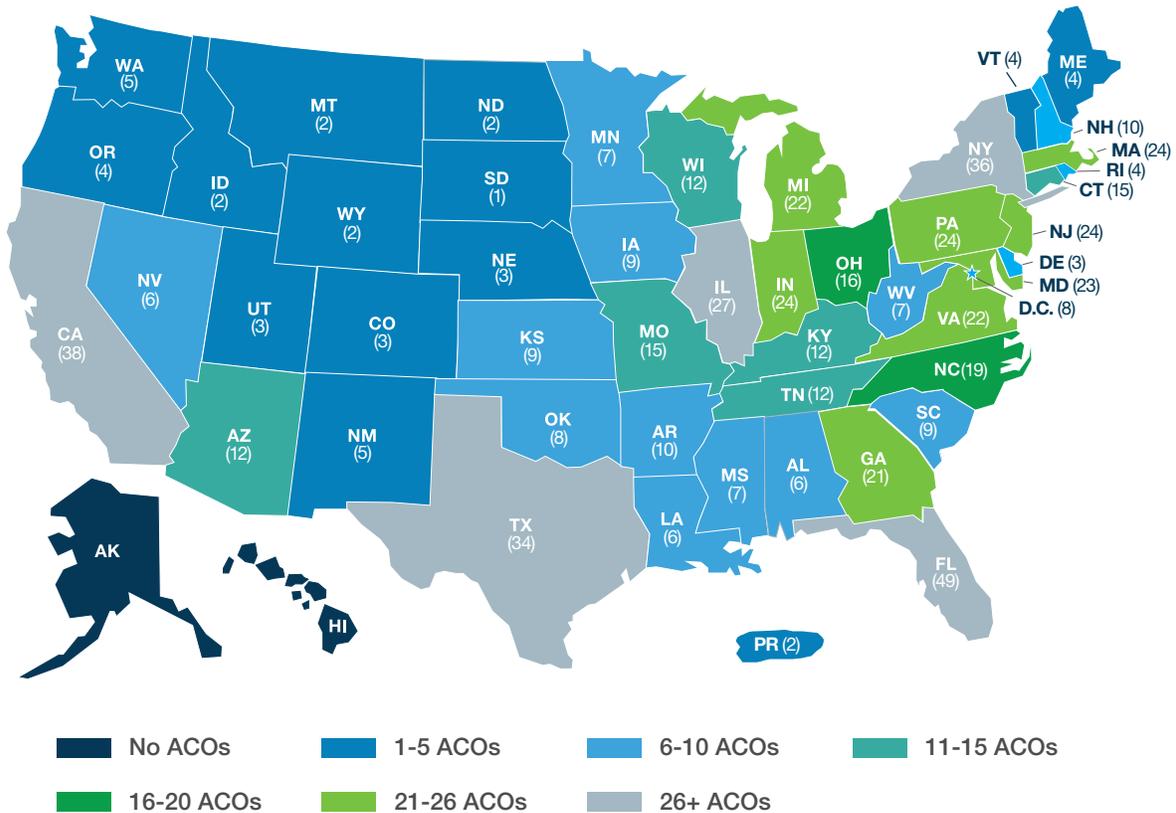
While Medicare beneficiaries in 2015 can choose from an average of 18 MA plan options, 68 percent of Medicare enrollees still choose to receive their Medicare benefits through traditional fee-for-service (FFS) Medicare.⁸ Indeed, the annual MA bidding and enrollment process, and the steady influx of new Medicare-eligible persons, require MA plans to compete with FFS to attract and retain members.

Since enactment of the ACA, policymakers have tested and instituted a number of reforms, such as accountable care organizations (ACOs) and incentive payments to primary care

physicians for coordinating care. In many areas throughout the country, these reforms are transforming FFS Medicare into a value-based program. As a result, many providers are testing some of the same care coordination and management features as MA plans.

As shown in **Figure 2** below, the Medicare ACO program, including the Medicare Shared Savings Program (MSSP) and the Pioneer ACO program, now includes 423 organizations that are responsible for the care of more than 7.9 million Medicare FFS beneficiaries.

Figure 2: Number of Medicare ACOs by State, 2015



Source: Avalere analysis; Data.CMS.gov, June 2015.

There are a variety of Medicare ACO structures, ranging from networks of individual physicians to physician groups to hospital/physician partnerships. In general, ACOs focus on care coordination, engaging patients in their own health, and rewarding participating providers for improved quality of care, cost-efficiency, or patient outcomes, much like MA plans. Twenty-two ACOs caring for 660,000 Medicare beneficiaries currently bear two-sided financial risk, further blurring the lines between FFS Medicare and MA.⁹ Moreover, the Pioneer ACO model and the Next Generation ACO model allow beneficiaries to affirmatively

connect themselves or “choose” an ACO.¹⁰ The Next Generation ACO model will even allow ACOs to provide financial rewards to beneficiaries for engagement with ACO-participating providers.¹¹

This trend toward innovation in the FFS sector is expected to continue. In January 2015, the Department of Health and Human Services (HHS) announced a goal of tying 50 percent of FFS Medicare payments to quality or value through alternative payment models, such as ACOs, by the end of 2018.¹² As a result of these and other reforms, FFS will continue to enhance its ability to coordinate care for beneficiaries, while allowing patients free choice of providers. Over time, as these innovations drive cost savings and quality improvement, FFS may become an even stronger competitor to MA.

COMMERCIAL MARKET: NEW MARKETS AND NEW PARTICIPANTS

The commercial insurance market experienced significant change following the implementation of the ACA, including the introduction of new insurance exchanges. Meanwhile, providers continue to capitalize on integrated delivery systems to become health insurance plans and offer direct-to-consumer provider networks. As a result, group and non-group managed care markets are experiencing a series of new market entrants delivering a variety of choice to consumers.

New Entrants in a Transformed Individual Market

By introducing health insurance exchanges and instituting insurance market reforms, the ACA created a new, consumer-oriented insurance market where individuals and small businesses can shop and compare insurance products. As a result of the ACA and these new market dynamics, competition has entered the marketplace and continues to grow in size.

- **Start-Ups:** The new exchange marketplaces have attracted new insurers, such as Oscar, a tech savvy start-up that raised \$295 million in venture capital from Goldman Sachs and others. Leasing a provider network from MagnaCare, a third-party administrator (TPA) that administers health plans for self-insured employers in New York and New Jersey, Oscar offered coverage on the New York exchange in 2014 and 2015. Recently, Oscar has announced that it will expand into California in 2016.¹³ Zoom+ is another example of a new, innovative insurance option. Specifically, the company began by establishing a series of walk-in clinics throughout Portland, offering a subscription-based model and a range of consumer-oriented features. Zoom+ will offer insurance plans on the Oregon exchange in 2016.¹⁴

- **Traditional Medicaid MCOs:** The introduction of the ACA exchanges has also led traditional Medicaid managed care organization (MMCO) plans, including Centene and Molina,¹⁵ to enter the individual market. With the expected churn between Medicaid and exchanges for low-income individuals, the MMCOs have seen an opportunity to improve continuity of care by participating in both markets in a state. Centene offers coverage on 11 state exchanges in 2015, while Molina participates in 9 state marketplaces. Other MMCOs like HealthNet and WellCare each offer coverage on two state exchanges.¹⁶
- **CO-OPs:** The ACA financed the creation of Consumer Oriented and Operated Plans (CO-OPs) to compete in the transformed individual market. To facilitate launch of these new entities, CMS awarded loans totaling \$2.4 billion for the 23 CO-OP plans that began offering health insurance in 23 states in 2014.¹⁷ While 2 CO-OPs have since left the market, and a third will not participate in 2016, 20 CO-OPs will continue to participate in state exchanges next year. In the first quarter of 2015, CO-OPs counted 870,000 individuals as enrollees, up from 478,000 in the fourth quarter of 2014 and 291,000 in the first quarter of 2014. According to ratings agency A.M. Best, most CO-OPs have reported favorable operating cash flows early in 2015.¹⁸
- **Multi-State Plans:** ACA also created the Multi-State Plan (MSP) program to provide additional choice for consumers in the individual market. The program is run by the Office of Personnel Management (OPM), with whom plans can contract to participate. To date, a combination of 2 MSP plans are offered in 35 states and DC. One MSP is offered by a coalition of Blue Cross Blue Shield plans and another is offered by a group of CO-OPs. Together, the MSPs have more than 370,000 enrollees.¹⁹

Providers Becoming Payers

As discussed above, healthcare providers such as hospitals and physician groups are establishing health plans and forming ACOs to participate in the changing Medicare market. They are also forming ACOs and establishing health plans to compete in the commercial insurance market. A June 2013 survey of 100 hospitals found that 34 percent already had a health plan, and another 21 percent intended to launch a plan by 2018.²⁰

- **Provider-Owned Plans:** Plans owned by providers and integrated health systems have a significant presence serving consumers in both the ACA exchange market and the group market. There are approximately 100 provider-owned health plans in the U.S. in 2015.²¹ At least 37 provider-sponsored health plans, including the Indiana University Health Plan in Indiana, the McLaren Health Plan in Michigan, and the University of Pittsburgh Medical Center (UPMC) Plan in Pennsylvania, offer coverage on a total of 21 state exchanges in 2015.²² As an additional example, Ascension

Health, the nation's largest nonprofit health system with 131 hospitals and 1,900 sites of care in 24 states, acquired the U.S. Health and Life Insurance Company in December 2014 to offer coverage options to self-insured employers in those states where it operates hospitals.²³

- **Direct-to-Consumer Providers:** Risk-bearing providers are also targeting the group market with “direct-to-employee” options that reserve a limited role, if any, for traditional insurers. Boeing, for example, contracted with the Providence-Swedish Health Alliance and the University of Washington Medicine Accountable Care Network to offer a new integrated provider network option to 30,000 Puget Sound employees. Based on its initial success, Boeing recently announced that new direct contracts with provider systems in Missouri and South Carolina will enable it to offer innovative options in 2016 to an additional 19,000 employees.²⁴

This new provider competition leverages efforts to integrate care and experience bearing risk to offer new choices to consumers. Moreover, when combined, the options above play a significant role in exchange markets across the country, as shown in **Figure 3**, and stand to deliver additional choice to the broader commercial market over time.

Figure 3: Participation by New Entrants in 10 States with Highest Exchange Enrollment, 2015

State	CO-OP	Multi-State Plan	Medicaid MCO	Provider-Owned Plan
California		X	X	X
Florida			X	X
Georgia		X	X	X
Illinois	X	X	X	
Michigan	X	X	X	X
New York	X	X	X	X
North Carolina		X		
Pennsylvania		X		X
Texas		X	X	X
Virginia		X		X

Source: Avalere State Reform Insights, August 2015

TOOLS TO FACILITATE CONSUMER DECISION-MAKING

To complement the new players entering the marketplace, the development and growth of Internet-based health insurance exchanges promotes access to more choices and facilitates informed consumer plan selection. Through online marketplaces, consumers are able to view and compare available plan options side by side, regardless of whether a plan has a significant marketing budget. The online marketplaces have the potential to include intelligent decision support to ensure consumers have necessary information to pick a plan that meets their individual needs. These capabilities are changing the way people choose health insurance, and have the potential to create a new level of retail-focused competition in the market.

Public Exchanges

The ACA-established public health insurance exchanges serve as online portals where consumers can shop for health insurance in their own states. Public health insurance exchanges are built to enhance competition and consumer plan selection. Plans sold on the exchanges are marketed as one of four metal levels (bronze, silver, gold, platinum), which correspond to the actuarial value of the plan. As a result, the metal levels are an intuitive way for consumers to understand the relative value of each plan.



The current online portals boast varying strengths and features to aid in consumer shopping and decision-making. While all exchange websites allow consumers to sort, filter, and view available plan options in desired ways, some exchanges include more advanced consumer shopping tools. To help consumers understand expected costs under the various plan options, the California exchange features an out-of-pocket cost calculator, while the Idaho website calculates average expenses under each plan. Colorado and Connecticut feature interactive online assisters to help consumers navigate the exchanges. For consumers looking to see if their drugs are covered, Colorado offers a robust formulary search tool. A number of additional states offer provider search tools to help patients determine if their providers are included in the network of each plan.²⁵

Through state and federal exchanges, qualifying consumers can also access premium tax credits, or subsidies, to make insurance more affordable. The exchange websites contain tools where consumers can input their annual income and receive an estimated subsidy amount, which is then applied to the premiums of available plans on the exchange. Understanding the real premium cost after the subsidy helps consumers better estimate cost responsibility under each plan. The exchange websites also serve as portals of information on the ACA, health insurance basics, and eligibility for exchange coverage, and can point consumers to appropriate state-specific resources.

Approximately 10 million consumers effectuated coverage through either the federal exchange or a state-based exchange as of mid-2015.²⁶ Avalere estimates more than 20 million consumers will be enrolled in exchanges by 2018.^{27, 28}

Private Exchanges

Meanwhile, private exchanges continue to emerge as a mechanism for employers to deliver increased choice to their employees, while controlling costs. Specifically, private exchanges are online portals where consumers can choose from insurance options offered by one or more carriers. Private exchanges are typically administered by a third-party company, rather than an employer, and often facilitate a defined contribution approach to premiums.

Looking ahead, participation in private exchanges by employers is expected to grow. Specifically, Accenture projects 40 million private exchange enrollees by 2018.²⁹ In particular, many employers are even more actively considering moving their retirees to private exchanges, with 24 percent planning to move their retirees into a private exchange by 2016.³⁰

Private exchanges offer employers one mechanism to deliver increased choice to employees—both in terms of the number of carriers and benefit designs offered. Indeed, single-carrier exchanges continue to be popular in the marketplace, despite delivering only one participating insurance carrier.³¹

Private exchanges are offered and administered by a range of third-party companies, including benefit consultants (e.g., Aon Hewitt, Towers Watson), carriers (e.g., Aetna), and other technology vendors (e.g., Liazon).

Technological Advances Delivering Choice to Consumers

Emerging technology is changing traditional healthcare and insurance market dynamics and helping to facilitate more informed decision-making with more choices in the market. Among the many rising companies in this space, Collective Health, Stride Health, EmployerDirect, and PicWell offer innovative solutions to help businesses self-insure and aid consumers in forecasting healthcare costs and selecting appropriate plans.³²

Facilitating Choice in the Employer Market

- Collective Health is one example of a technology start-up facilitating choice in the employer market. Specifically, Collective Health works with employers to build custom health insurance plan offerings for employees. Typically only large employers seek to establish self-funded plans, but Collective Health uses advanced data analyses of claims history to make it possible for smaller employers to forgo using a health insurance carrier and to benefit from the self-funded model. Each employer can create health insurance plans customized to the expected needs of its own employees.³³
- EmployerDirect is a healthcare management company that helps self-funded employers provide value-based healthcare benefits to employees by partnering with providers to bundle payments. One of EmployerDirect's main products, SurgeryPlus, negotiates bundled payments for surgical procedures with high-quality physicians. EmployerDirect also offers care coordination assistance, including helping covered employees select a provider and schedule a procedure.³⁴

Helping Consumers Make Informed Choices

- Stride Health is another example of how data is driving better consumer decision-making as choices increase. Stride serves as a personal and customized recommendation engine for consumers shopping for health insurance. Specifically, Stride seeks to minimize consumer confusion and to simplify and streamline the process of plan selection. Indeed, Stride works individually with consumers to select the appropriate plan by forecasting healthcare spending based on expected utilization under the plans. While public exchanges have enrollment assistance, they do not have cost forecasting abilities and there are often significant wait times to speak to an assister directly. Consumers using Stride average just 12 to 15 minutes to complete the plan recommendation and enrollment process.³⁵
- Picwell utilizes predictive analytics to help consumers choose health insurance plans. Picwell has aggregated public and private data on healthcare utilization, lifestyle and behavior, financial information, and demographics, which it uses to generate scores to help individual consumers choose a plan.³⁶ Aon Hewitt currently offers Picwell's services through Aon's Retiree Health Exchange.³⁷

Over time, these evolving technologies combined with new market entrants and more diverse consumer choice in the marketplace may further empower consumers to drive competition and innovation.

LOOKING AHEAD

Looking ahead, this period of transformation in healthcare payment and delivery will continue. As providers gain experience bearing risk and develop better care delivery models, they will continue to compete with traditional health plans for enrollment, whether in Medicare or the commercial market. Meanwhile, the early success of Oscar and others is likely to encourage new start-up insurance models that rely on technology to engage the consumer. While some players will naturally exit the market over the coming years, current innovation is likely to spur continued growth and deliver new diversity of choice to consumers in the future.

ENDNOTES

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- 3 Avalere analysis of 2015 MA Landscape File and June 2015 MA Enrollment File. New MA entrants are parent organizations who did not contract with Medicare in 2011 but who did contract in either 2012, 2013, 2014, or 2015 and who remain under contract in 2015. Analysis does not count PACE, Cost, or Duals-Demo plans as MA plans.
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- 7 Catholic Health Partners entered MA by acquiring Kaiser's business in OH.
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Contact Us

Avalere Health

1350 Connecticut Ave, NW Suite 900
Washington, DC 20036
202.207.1300 | Fax 202.467.4455
avalere.com