Healthcare
BUSINESS STRATEGY™

ACA Driving the Need for Health Plan Membership by County

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As health insurance moves to a direct-to-consumer model, identifying where consumers are located and what health plan options are available in local markets is essential. The Affordable Care Act (ACA) is reshaping the industry and setting standards to ensure that consumers have coverage options in all geographies of every state in the U.S. Companies participating in the Marketplace (Exchanges) are using county market share and penetration rates to identify underinsured opportunities for Medicaid and Commercial market expansion. Accountable Care Organizations (ACOs) and the new Consumer Operated and Owned Plans (CO-OPs), which typically offer coverage in a specified area within a state, also have need for local marketplace data. In a nutshell, the industry as a whole needs more granular health plan enrollment data at county and zip code levels where available to effectively leap to the next generation of health coverage.

Today's data-driven world is propelling the use of data in business planning. No surprise, health plans and vendor stakeholders alike are relying more heavily on data to accurately analyze markets and make better business decisions. And better decisions result in greater operational efficiencies, cost reductions and overall reduced risk for insurers and contractors. This Business Strategy report looks at why geographic granularity is essential when analyzing health plan enrollment data and what metrics are currently available at the county-level.

Health Plan Enrollment and the Need for Geographic Granularity

The ACA introduced a number of policies and procedures that depend on demographic and geographic assessments. For instance, ACA regulations require states to establish geographic rating areas (GRA) to be used in premium calculations for individual and small group health insurance marketplaces. While states could establish a single state-wide rating area, only five states have done so: Delaware, Hawaii, New Hampshire, Rhode Island and Vermont. Of the 45 states that are using GRA for rating, three quarters are using county combinations to make up the rating areas. The remaining states are using various combinations of 3-Digit zip codes and MSAs+1 (metropolitan statistical areas - plus one area to capture those areas of the state not included in an MSA) methodologies to determine the regions.[i] Health plans competing in these GRAs will undoubtedly need to know their market share within the specific regions, especially when rating decisions are made for the next open enrollment period.

Geographic rating regions will also factor into the state risk adjustment programs for individual and small group health plans. The ACA requires that non-grandfathered individual and small group health plans, inside and outside of the Exchanges, operate in state-based risk adjustment programs effective January 1, 2014. States could either elect to establish and operate their own risk adjustment program, which needed the approval of the Department of Health & Human Services (HHS), or allow the Federal Government to operate a risk adjustment program on a State's behalf. All of the states, except for Massachusetts, have elected to operate under the federal risk adjustment program. Through the program, a plan's risk profile is evaluated against that of other plans offered within that plan's state and within that plan's market.[ii] Local market enrollment is an important factor for predictive models health plans are building in response to the ACA State risk adjustment programs.

The Affordable Care Act also called for the establishment and funding of the Consumer Operated and Oriented Plan (CO-OP) Program, to create qualified nonprofit health insurance issuers that offer competitive health plans in the individual and small group markets. Many of these CO-Ops are expected to participate in local areas within a state, until they are able to build state-wide provider networks. These new plans and other regional health plans have a need for county-level enrollment and financial data to benchmark how they are doing against the competition.

Health care has always been provided at the local market level. Despite telemedicine initiatives and medical tourism schemes, health care providers are local and most hospitals primarily serve people within a certain radius of their location. Many of these providers are forming Accountable Care Organizations (ACOs) to serve Medicare, Medicaid and/or Commercial populations. ACOs are often at the center of limited network health plan products and many resemble the early health maintenance organizations. To ensure success of the ACO, providers of care need to understand the size of the population and the health plan competition in the local area to gauge provider panel sizes. The rise of ACOs and limited network products are also driving the need for local marketplace data.

As Exchanges roll out, plans are using county market share, penetration, and demographics to identify underinsured markets and targets for Medicaid and Commercial market expansion. Health plans want to build market penetration and presence in select, targeted markets they deem to be less risky based on many factors (such as costs, health status, and competition). With the shift from employer-sponsored to direct consumer purchases, plans are much more engaged in market segmentation analysis. They want local market demographics and market share carved out as granularly as it can be delivered, e.g. individual, small group, Medicaid (by types of program). Data-driven marketing approaches, that entail connecting and analyzing large volumes of data and then tailoring strategies to what's relevant for key customer groups, are essential as the health insurance industry evolves to a consumer model. As health plans strive to keep marketing and administrative costs low they are using data to identify where to spend advertising and marketing budgets, deploy sales forces and beef up broker contacts.

While the ACA is primarily behind the demand for county-level enrollment data, there are many additional industry applications for this level of detail. Pharmaceutical companies use county market share figures to anticipate volume and negotiate contracts and pricing with health plans. The same applies for other types of vendors that need to gauge usage or volume of service/ product needed in order to contract with health plans.

County Demographics and Enrollment Data

Understanding what data is available at a smaller geographic region is critically important for insurance carriers, vendors and other stakeholders. According to The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program, which produces estimates for all counties and states by detailed demographic and income groups on a sub-state-level, there is significant variation of health insurance coverage. For example, the county to county level rate of people under the age of 65 that have insurance coverage ranges from 54% to 96.9% across the U.S. According to the most recent SAHIE report, released in August 2013 with data from 2011, the county-level uninsured rates ranged from a low of 3.1% in Norfolk County, Massachusetts to a high of 46% in Aleutians East Borough, Alaska. The counties with the highest rates of uninsured are concentrated mostly in the southern and western regions of the U.S. particularly in south Florida, southern Georgia, southwest Arkansas, Texas, northwest New Mexico, southern Colorado, Montana, Idaho, southwest Nevada, and Alaska.[iii] A low percentage insured means opportunity for health insurance carriers to gain membership. The SAHIE data is particularly useful when identifying where potential program participants live.

Mark Farrah Associates' (MFA's) County Health Coverage product uses the SAHIE data as the basis for establishing credible enrollment estimates by health plan. Health plan membership by county is updated on a quarterly basis using a multi-faceted methodology with data insights from many sources. In addition to insights from health plans themselves, enrollment estimates in County Health Coverage are further honed by analyzing enrollment reports from state insurance departments, health plan service areas and provider network density. Let's take a look at how an analyst might apply data to identify opportunity. A SAHIE report published by the

U.S. Census Bureau showed that uninsured rates in the Miami, Florida metropolitan area are higher than rates in central and northern Florida.[iv] By combining SAHIE observations with MFA data observations, an analyst might conclude the Miami-Dade area, with nearly 744,000 uninsured people, affords ample opportunity for Humana, the 5th ranked carrier in the market, or Avmed, the 6th ranked carrier, to gain membership without necessarily taking members from Blue Cross Blue Shield of Florida, UnitedHealthcare or Aetna -- the top carriers by market share in the county. In fact, all plans in the market could realize growth if most of the uninsured obtain coverage.

Medicare enrollment data at a county level is provided by the Centers for Medicare and Medicaid Services (CMS) and is available through Mark Farrah Associates' Medicare Business Online (MBO) product and in County Health Coverage. While county-level data through the CMS website is not very user friendly, MBO makes it easy to analyze the wealth of information available at the sub-state level for health plans selling into the Medicare market.

Medicaid enrollment data at the county level is primarily supplied by individual states on a county level basis through State supplemental insurance reports and through annual CMS reports. It is interesting to note that the need for states to report Medicaid enrollment to regulators drove the need for state-based enrollment reports, and the state's need for county-level data drove the creation of the federal SAHIE program. The expansion of Medicaid as part of ACA Reform may in turn provide impetus for more comprehensive county-level enrollment reporting going forward.

Health plans are making important decisions about investments in products and markets, charting a course to thrive in the evolving healthcare market. They are keeping a close eye on the success of the individual and small group marketplaces and Medicaid expansion initiatives and applying demographics and competitive insights to define and support business strategy. Coming up with a successful business strategy is not an easy feat for health insurers. Demographics of insured and uninsured populations and competitor assessments to size up opportunity in local, target markets are key factors. County-level data is also being used for predictive models and other business analysis tools to assess profitability under various scenarios.

It is difficult to imagine with the breadth of state-level enrollment and other financial data available to us today, that just seven years ago, some regulators and health plan analysts questioned the need and interest in state-specific health insurance data. State-level data is now routinely used in state discussions about health policy, coverage options, and on the impact of state budget decisions and in health plan market assessments. Just a few years ago, policymakers and health plan executives were asking for more specific information about the characteristics of state populations and where dollars would be spent for programs such as Medicaid expansion. Today, worried about much of the same things, these same people are asking for enrollment data on a sub-state/county level. Reasonable estimates are the best the industry has to work with today. But perhaps we can look forward to expanded county-level enrollment reporting in the near future.

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[i] CMS Center for Consumer Information and Oversight, Market Rating Reforms, State-specific Geographic Rating Areas: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html

[ii] Federal Register/Vol. 78, No. 47/ Monday, March 11, 2013/ Rules and Regulations: http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04904.pdf

[iii] Small Area Health Insurance Estimates (SAHIE) 2011 Highlights by U.S. Census Bureau, Social, Economic and Housing Statistics Division (SEHSD)/Small Area Estimates Branch (SAEB) Issued August 2013 , page 7 and 12 http://www.census.gov/did/www/sahie/data/2011/SAHIE_Highlights_2011.pdf

[iv] Small Area Health Insurance Estimates (SAHIE) 2011 Highlights by U.S. Census Bureau, Social, Economic and Housing Statistics Division (SEHSD)/Small Area Estimates Branch (SAEB) Issued August 2013 , page 9 http://www.census.gov/did/www/sahie/data/2011/SAHIE_Highlights_2011.pdf

About County Health Coverage

County Health Coverage™ provides reliable estimates of health insurance market share at the county level. MFA integrates information from highly relevant sources including state insurance regulators, provider network data, health plan service areas and Medicare market penetration data. Product Features include Company market share by County, Company and State; Private Risk, Private ASO, Managed Medicaid, Medicare Advantage, and PDP segments; Product type breakdowns for HMO, PPO, POS and Indemnity Insured population demographics and Medicare eligible by county; Web interface with easy-to-use dropdown filters and download to Excel. To learn more see County Health Coverage™ (/products/County-Health-Coverage.aspx)

About Mark Farrah Associates (MFA)

Mark Farrah Associates (MFA) is a leading data aggregator and publisher providing health plan market data and analysis tools for the healthcare industry. We are a licensed redistributor of NAIC data. MFA's Health Coverage Portal™ includes both risk-based and administrative services only membership and detailed financial data by plan, parent, state, region and nationally. Committed to simplifying analysis of health insurance business, our products include Health Coverage Portal™, County Health Coverage™, Health Insurer Insights™, Medicare Business Online™, Medicare Benefits Analyzer™, and Health Plans USA™.

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