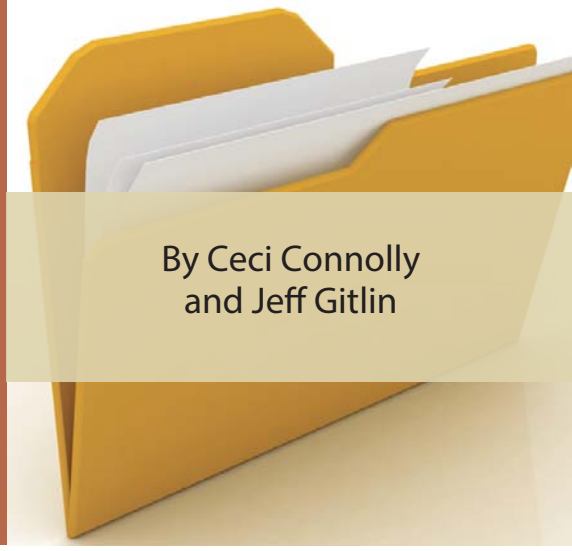
EXECUTIVE BRIEFING 1



By Ceci Connolly and Jeff Gitlin

Health Insurance Exchanges

This fall, 12 million Americans are expected to begin purchasing health insurance through newly created marketplaces known as exchanges. Federal subsidies will entice many would-be participants to the program that will offer coverage starting in 2014. By 2021, the size of the exchange market is projected to more than double, marking the single largest expansion of health coverage in this country since the creation of Medicare in 1965.

Health insurance exchanges — both public and private — will create an irreversible shift in the insurance market that ultimately will change the way medical care is sold in the United States. For the insurance industry, the new state-based exchanges represent a major business opportunity — an estimated $205 billion in premiums by 2021, according to analysis by PwC's Health Research Institute.

But thriving in this new market won't be easy. Insurers will continue their battle to keep a balance of healthy and sick members to limit adverse selection. Providers and insurers will face clear challenges in serving a new customer base with a demographic profile and health needs that differ from today's insured population in meaningful ways.

States will carry the responsibility to make consumers aware of new coverage and financial assistance options. Success will require a firm grasp on emerging public exchange models, a sophisticated understanding of the individuals who will be purchasing coverage and the skill to help consumers navigate an increasingly complex health system.

Private exchanges, already up and running in a handful of markets, may serve as innovation models in this new purchasing environment — targeting employers and consumers who are seeking lower costs, greater transparency and convenience.

There is much work to be done to understand and prepare for a new health care customer base before open enrollment begins in October.

EMERGING CUSTOMER BASE

The Affordable Care Act extends health insurance to 30 million Americans through two major mechanisms — an expansion of the Medicaid program and the new exchanges. The new exchange members will be a combination of the newly insured, those who are no longer covered through their employers and those who would have purchased insurance on their own in the individual market. The total exchange membership in 2021 is projected to reach 29 million — 25 million in the individual exchange and 4 million in the small group exchange, known as the Small Business Health Options Program, or SHOP.

The Health Research Institute analysis, based on projections by the Congressional Budget Office, shows that 40 percent of the expected individual exchange enrollees will come from five states: California, Texas, Florida, New York and Illinois. Individual state exchange members in 2021 are expected to range from 100,000 in states such as Maine to 3.5 million in California.

Qualified individuals with incomes that fall between 100 percent and 400 percent of the federal poverty level will receive financial assistance from the government to buy insurance — in the form of subsidies or reductions in cost-sharing.

The law originally required all states to expand Medicaid to 138 percent of FPL; that is, $15,415 for an individual or $31,809 for a family of four. But a ruling by the Supreme Court in June 2012 made the expansion optional, creating the likelihood of gaps in coverage.

States that do not expand Medicaid to the ACA threshold could leave a group of uninsured who fall between the state Medicaid level and the lower limit for exchange subsidies. Individuals outside of this range still may purchase coverage in the exchanges, but they won't receive subsidies.

As a result, exchange enrollment in the SHOP and individual exchanges may range from a low of 11 million in 2014 to a high of 32 million in 2021.

IMAGE FROM SHUTTERSTOCK

The Health Research Institute analysis of demographic data for exchange members indicates that the 25 million people slated to receive individual coverage have a median age of 33 and report being in relatively good health. They are mostly white, and about one in five speak another language at home (primarily Spanish) compared with the currently insured population, where one in eight speak another language at home. Roughly three-fourths of the exchange population will not hold a college degree, compared with nearly 60 percent of today's private insurance market.

Although almost 60 percent of adults entering the exchange market are employed full-time, nearly nine out of 10 will receive subsidies in 2014. In the earlier years, more enrollees have lower incomes. For example, in 2014 about 60 percent will have incomes at or below 200 percent FPL ($46,100 for a family of four). The number drops to 35 percent in 2021. Medicaid managed care organizations, which have experience addressing the unique needs of a lower-income population, may be well-equipped to serve the market initially.

In the latter years, the average income of exchange participants rises slightly as higher-income individuals join exchanges. For example, in 2014, the Health Research Institute estimates that 16 percent of the individual exchange population will have incomes above 300 percent FPL. The portion rises to 35 percent in 2021.

The exchange shoppers are unlikely to overwhelm the health care system or substantially drive up costs immediately after gaining coverage. However, they will be less familiar with the insurance system; in 2014, approximately 75 percent of public exchange enrollees will be newly insured. Over time, outreach and educational efforts by states and insurers will need to match the changing needs of exchange members as they transition from newly insured to more sophisticated customers.

PRICING AND COMPETITION

Consumers care about price and, with all else being equal, price will win. That's where health plans will start competing on the exchanges. Insurance companies must determine how to price at the different levels of plans laid out in the ACA — bronze, silver, gold and platinum — each having cost-sharing percentages. Some plans will price low to attract new customers, while some may price higher to join the game without initially attracting only the most ill, costliest patients. Insurers are weighing several factors in developing their products.

Other factors will fuel competition as exchanges become more established. While the ability to differentiate products may vary depending on the health exchange and the knowledge of the consumer, a subset of higher-priced plans with a better-fitting provider network could beat out some lower-priced plans. As previous Health Research Institute research has shown, almost half — 47 percent — of consumers surveyed indicated a willingness to pay a higher price for additional insurance features such as dental or vision coverage.

Even more important to consumers is the quality of insurance coverage. Consumers cited benefits and provider network as the top two aspects that define quality. Lower costs came in third.

PUBLIC AND PRIVATE FACES

Under the ACA, a state can run its own exchange, partner with the federal government or have Health & Human Services operate its federal exchange. While all three models follow a common basic framework, each will vary in operational structure and oversight, and carry different implications for insurers, providers and employers.

The concept of an insurance marketplace is not entirely new. Today, private purchasing exchanges run by insurers or third parties offer a banquet of options to employers and individual consumers. These exchanges either are run by a single health insurer or an independent private company that brings in multiple carriers in a private purchasing marketplace. In addition to multiple health plans, consumers can choose from other products such as property and life insurance or discounts on wellness products. The variation in private exchanges makes it difficult to quantify the exact number.

THE EXCHANGE SHOPPERS ARE UNLIKELY TO OVERWHELM THE HEALTH CARE SYSTEM OR SUBSTANTIALLY DRIVE UP COSTS IMMEDIATELY AFTER GAINING COVERAGE.

Private exchanges are in many ways the precursor to the public exchanges envisioned in the ACA. And in the future, private exchanges will create an alternative both for employers and for individuals who do not qualify for government-subsidized insurance.

Public exchanges

States can set up their own exchanges, form a partnership with the federal government to run an exchange or opt out entirely, in which case the federal government will run the exchange.

States that run their own exchanges will be responsible for setting eligibility standards, customer service, plan oversight and financial management. The complex eligibility process will require use of a combination of data

provided by the enrollee and federal databases to identify who is eligible for enrollment and subsidies, as well as for Medicaid and the Children's Health Insurance Program.

States must also decide if they will be "active purchasers," selecting which plans may compete in the marketplace, or "passive purchasers" by allowing an open marketplace.

The pressure is on the states to assist consumers in choosing coverage and determining eligibility in the new exchange marketplaces. States must set up websites, call centers and consumer outreach to encourage broad participation. States also will have the power to determine which health plans qualify to participate in their exchange and, to a certain extent, they will monitor the benefits offered and rates charged.

States also have the option of running their own risk-adjustment and reinsurance programs — designed to insulate insurers from high-cost individuals. The federal government will administer the risk-corridor program, which limits the variation in gains and losses by health plans that participate in the exchange.

In **state-federal partnerships**, states will split oversight duties with HHS, although the term "partnership" may not necessarily mean a 50-50 division of labor. The state in this model is more of a storefront, interacting with consumers and employers.

The federal government will run all functions except plan management and certain elements of the customer service function. States can choose to run one or both of these functions.

If states choose to oversee plan management, they will be responsible for certification, recertification and decertification of qualified health plans, data collection and insurer oversight. If they choose to run the customer service function, they will lead all in-person customer assistance, while HHS will operate a call center and website. The federal government will oversee eligibility, enrollment and financial management.

In the partnership model, states may administer their own reinsurance program. The federal government will operate the risk-corridor program and the permanent risk-adjustment program.

If the state opts out and the **federal government** facilitates the exchange, HHS will oversee all five major exchange functions: enrollment, eligibility, customer service, plan management and financial management. Guidance issued by the administration in May 2012 follows four principles: providing consumers access to quality insurance in a seamless manner; parity in insurance markets inside and outside the exchange; continuity with state policies; and collaboration with many stakeholders.

Private exchanges

Private exchanges offer three other types of insurance marketplaces:

1. In the **insurer-run model**, individual insurers or groups of insurers operate exchanges that are designed to showcase plan choices. The insurer may partner with employers to customize plan options.

2. The **retailer-run model** encompasses companies outside of the health industry that sell their own insurance products, co-branded products and "buy-up" packages, or bundles, of additional products and services such as health and wellness products. These products would be customized for the retailer or market.

Insurers also are considering how to build consumer-oriented private exchanges that highlight their products and direct members to the public exchanges if they are eligible for subsidies. The concept of merchandising will be brought to the forefront, including cross-selling other products, upselling and suggestive selling. Personalization will be another important aspect of retail exchanges.

The retail marketplace is still in development, but consumers can expect to see a focus on convenience as nontraditional health care players get involved.

3. In the **third-party-run model**, an external administrator links consumers to a variety of plan choices across multiple insurers, and may be either for-profit or nonprofit. Large brokers and benefit firms are two examples.

Another dimension of the private exchange model is the way customers are offered a range of options — through money and benefits. In the defined-contribution model, employers give specific dollar amounts on behalf of their employees to purchase coverage, with the option of employees' contributing more for additional coverage and other health expenses. In the defined-benefits approach, employees choose from a variety of benefit options based on a budget set by the employer.

INDUSTRY IMPLICATIONS

Within the first seven years of operation, state insurance exchanges are projected to translate into a $205 billion market opportunity for the health sector. Companies that want to capture the new business must develop a clear understanding of these future customers and how to forge long-lasting relationships with them.

Providers

Providers should prepare for an increased number of patients who may arrive for their first checkups in years, some with undetected illnesses and a pent-up need for care. Insurers, in the new outcomes-based environment, will put pressure on providers to deliver value over volume. Hospitals and physician groups must move to improve information management, demonstrate quality and implement care coordination.

Enrollment in exchanges could speed up such new expectations among patients as more online capabilities, improved transparency and an increased focus on customer experience.

Providers also will face an uncertain payment landscape and new payer mix. Enrollment in the exchanges and increased participation in Medicaid will shift the balance of

insurers — and providers should seek to capitalize on this change by re-evaluating their reimbursement and billing structures.

Insurers

Uppermost on the minds of many insurers are the issues of pricing and risk selection. Insurers will be focused on finding the sweet spot in product pricing and managing the influx of enrollees profitably.

The pace of state exchange planning also has posed challenges for insurance companies that are evaluating which markets to enter or exit. California, considered a high-progress state in health insurance exchange development, required insurers to submit bids to enter its public exchange in late January and is reviewing applications. Participation in all 50 public exchange markets may not be realistic — or worthwhile — for all but a few players. Insurer participation will depend on how each state exchange is run, the parameters that are set around a qualified health plan and the structure of essential health benefits, including how similar those standards are across states.

Plans will compete head-to-head in the exchanges and against plans operating outside of the exchanges. Increased competition and pricing transparency will put further pressure on insurers to control costs while maintaining benefits and quality. As the insurance exchange population becomes more demanding, plans will need more than price to entice new members or retain existing ones.

If insurers decide to compete on an exchange they must keep a careful eye on administrative costs. Plans must already keep these costs below 15 to 20 percent of premiums under the ACA's medical loss-ratio requirements. Even if the company does well, it will be required to relinquish a portion of profits above 3 percent for the first few years as part of the so-called risk-corridor function, a temporary program that limits gains and losses by insurers that operate in the exchange. And while there are controls in place to limit plan loss and liability from high-cost members, there are no guarantees of long-term profitability.

In the private exchange world, insurers may work to create their own single-carrier exchanges or choose to participate in broader third-party exchange networks. As the environment shifts to a direct-to-consumer market, segmentation will be an important means to offer differentiated products to consumers and also potentially manage risk. Winners likely will find ways to communicate with consumers in a manner that non-health care professionals can understand.

Employers

Employers of every size and shape are contemplating the role of exchanges in the future — and whether they may offer a viable alternative to employer-sponsored coverage. While the ACA's $2,000 per full-time employee penalty for dropping coverage may seem small relative to the cost of providing health insurance, it masks a more complex picture. Employers eliminating coverage likely would face increased pressure to raise wages. Numerous tax benefits from offering health coverage also would be lost if a firm decides to drop coverage. And, employees view health care as a valuable benefit — one that can give businesses a competitive edge.

The decision to drop coverage most likely will be considered by firms with high concentrations of lower-wage workers who will qualify for federal subsidies through the individual exchange markets if affordable health benefits are not provided. More broadly speaking, private exchanges offer a new alternative for employers to move toward a defined-contribution approach that caps costs while facilitating access to a wider array of benefits.

Starting in March, employers will be required to notify employees about the new exchanges, providing detailed information on services offered and subsidy eligibility. The business must also clarify that it will not provide a contribution toward coverage if the employee enrolls in an exchange plan.

LONG-TERM OUTLOOK

Generous purchasing subsidies built into the ACA provide a large and rapid cash injection into the burgeoning health insurance exchange market.

Insurance exchanges have the potential to revolutionize the health insurance market by shifting the focus to the individual and prompting the sellers of insurance to think in a more retail-oriented manner. There will be a push for clarity in products and their value, convenience for buyers and competitive prices.

While states may establish their exchanges as passive "open markets," some may shift to the active purchaser approach as they gain enrollees, plan participants and, ultimately, buying power over the long run.

Ongoing cost concerns will continue to spur change, both in the form of commercial innovation and more traditional government pressure. Under the ACA, regulators already have medical loss-ratio limits on premiums and the power to review rate increases. In addition, states may follow Massachusetts in implementing all-payer pricing systems for providers.

Private, employer-focused exchanges have much to gain in this process. Unbound by public exchange requirements, private exchanges will have the flexibility to experiment with different approaches — and adapt rapidly to meet consumer demands. They may lead the way in the quality of customer experience. **T**

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