

POLICY INSIGHTS

Private Health Insurance Exchanges *The Emerging Marketplace*

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Introduction

Markets have a way of asserting themselves, even under the worst of conditions. Even in the old Soviet Union, where private property was outlawed, a fairly vigorous black market evolved despite the secret police and the Gulags. When people have a need for a good or a service, someone will find a way to provide it for a mutually agreeable consideration.

So it is these days under the Obamacare regime. While the federal government is spending many billions of dollars to set up state-run monopoly exchanges, we are seeing the growth of “private health insurance exchanges” to do what no state monopoly is capable of.

These private exchanges come in many different models and sizes. The market hasn’t yet decided what the best approach might be, so there is a lot of experimentation. Some will fail, but others will succeed and usher in a new way of organizing the process of shopping for health insurance coverage.

But this process of experimentation illustrates how different the private sector is from governmental approaches. Private

Key Points:

- Employers are moving to Defined Contribution health benefits, as they did for retirement programs.
- Employers are using Health Reimbursement Accounts (HRAs) to make fixed annual contributions.
- Private health insurance exchanges are being created to help employees choose their own benefit programs.
- Private health insurance exchanges offer an array of benefits and costs.
- ACA exchanges are costly, will collect detailed personal data to share with the IRS, and should not be set up.
- Many different approaches are being used by businesses and insurers to create private insurance exchanges.
- It is not yet known which private exchange models will work best.
- But, unlike the state-funded federal exchanges in the Affordable Care Act, the private health insurance exchanges that work well will prosper and the ones that don’t will fail.

Employer-based insurance is an artifact of the wage and price controls of WWII.

exchanges will win or lose based on how well they perform. Governmental public exchanges will never be allowed to fail, no matter how incompetent or destructive they might be.

So, what exactly are we talking about here?

The Employer Based System

There is a long-standing hunger to fix a number of problems in health care. Many of these problems stem from the most common approach to providing health insurance coverage – employer-based insurance.

Many volumes have been written about how this system came about and how it has distorted the market for coverage. There isn't room in this paper for an extensive discussion, but in a nutshell, it is an artifact of the wage and price controls of World War II.

Employers were not allowed to attract workers by offering higher wages, so they began to offer health insurance coverage instead. This practice was reinforced in the late 1940s and early 1950s by the decision that the value of such coverage would not be considered income for tax purposes. It was “excluded” from income, which meant employees would not have to pay income taxes on the benefit and both employers and employees would be exempt from paying payroll taxes on it. Similar tax advantages were not provided to people who bought their own coverage.¹

As a result, securing coverage from an employer quickly became the most attractive means for buying health insurance. Today, approximately 160 million Americans get their health insurance through their employers. This is in contrast to a mere 10 million who buy their own coverage, according to the actuarial consulting firm Milliman.²

Because people get their coverage through their employers, they have very little awareness of what it costs or incentive to keep their costs down. Neither the providers nor the consumers of services have any interest in being cautious in their use of services. Employers, however, are very concerned about rising costs and have tried one thing after another, including “self-insuring” their benefits, emphasizing out-patient over in-patient treatment, moving to managed care, moving to discounted provider networks, and adding wellness programs. Some of this worked for a short time, but never very well.³

The Advent of Defined Contribution for Pensions

In recent years employers learned a lot from converting their old “defined benefit” retirement plans into “defined contribution” programs. Defined Benefits mean the employer guarantees a certain monthly income to its retirees. Obviously this is problematic. How can a company today guarantee a monthly pay-out twenty years into the future? The company can't know it will even be in business in twenty years, let alone know whether the gains on today's contributions will be adequate to cover the needs two decades hence.

The Employee Benefits Research Institute (EBRI) explains how new legislation enacted in 1978 opened up an alternative approach to defined benefit programs. It reports:

The Revenue Act of 1978 included a provision that became Internal Revenue Code (IRC) Sec. 401(k) (for which the plans are named), under which employees are not taxed on the portion of income they elect to receive as deferred compensation rather than as direct cash payments. The Revenue Act of 1978 added permanent

provisions to the IRC, sanctioning the use of salary reductions as a source of plan contributions. The law went into effect on Jan. 1, 1980. Regulations were issued in November of 1981.⁴

It took a couple of years for companies to see the potential of this new legislation. As recently as 1984, 82% of all medium and large establishments offered only Defined Benefits plans, but that changed dramatically in the next two decades, until by 2003 only 33% offered Defined Benefit plans and 51% offered Defined Contribution plans including 401(k) plans.⁵

Applying Defined Contribution to Health Benefits

Employers viewed the conversion to Defined Contribution retirement plans as a major success. They were no longer on the hook for unpredictable expenses far off into the future. They could make an annual contribution and be done with it. And employees benefited because their 401(k) plans were their own property and could go with them if they changed jobs. People began to have a sense of ownership and control, rather than passive dependency. Employers began to wonder if the same approach could be used in health care.

A paper published in 2000 looked at survey results from Cigna, PricewaterhouseCoopers, Booz-Allen & Hamilton, and KPMG, all showing a high level of interest from employers and employees in having employers make an annual contribution and employees being allowed to select their own health benefits program.⁶

This paper also found that the tax code allowed for such employer contributions on a tax-free basis, but that the Health Insurance Portability and Accountability Act (HIPAA) presented some major obstacles. In particular

HIPAA placed a red line between “group” and “individual” coverage, so that any employer contribution would prohibit the purchase of an individual insurance policy. The primary distinction is that group plans must be “guaranteed issue” with no denials of coverage or individual medical underwriting allowed. So, ironically, this “portability” law in fact prohibited portability.

Employers sought guidance from the IRS to clarify what was allowed, so in 2002 the Service issued a Notice (2002-45) and Revenue Ruling (2002-41) creating what it termed a “Health Reimbursement Arrangement” (HRA).⁷ These rulings were a new way of interpreting Sections 105 and 106 of the Internal Revenue Code, which authorize employer spending on health services.

Essentially, employers may take such spending as a business deduction without adding the funds to the employee’s income. Such money may be deducted only when it is actually spent, not when it is promised. The IRS said employers may allocate an amount of money for employees to spend in the future, but this allocation is only “notional” (there is no actual money in an account) and the employer may deduct it only when it is in fact spent on a health care service.

HRAs allow employers to contribute to an employee’s health care expenses (including premiums) without restriction by creating a Health Reimbursement Account, which is tax-free but may be used solely for health care expenses. Unspent funds may roll over and build-up over time, but always remain the property of the employer until used.

There is no restriction on the amount of money, and there is no requirement that there be any kind of insurance policy to accompany

There is interest in employees being allowed to select their own health benefits program.

Exchanges allow individual choice by employees with insurance products that meet HIPAA regulations.

the account. Thus, HRAs may be for any amount of money and they may go along with any kind of insurance programs – or none at all. An employer may simply make an HRA available instead of providing insurance.

Importantly, employers may also set up Section 125 plans such as a “premium conversion plan” or “flexible spending account” to enable employees to supplement the employer’s HRA contribution with their own funds on a tax-free basis.⁸

These HRAs are an ideal way for employers to help pay for a worker’s health insurance policy, except the HIPAA rules still apply. Because it is employer money, any coverage purchased with it would be considered “group” coverage instead of “individual” coverage. If employers were going to take this approach they needed some mechanism to combine individual choice by employees with insurance products that met the HIPAA regulations, that is, guaranteed issue of individually-owned health insurance. This mechanism is what we think of today as a “Health Insurance Exchange.”

Models of Public Exchanges

There is a vast variety of ways such a mechanism could be set up. Let’s look first at governmental versions of the idea:

- Probably the earliest iteration was Alain Enthoven’s idea for “Managed Competition.”⁹ This was the basis for President Clinton’s health reform proposals. It goes far beyond just being a market place for existing health insurance products. It envisions a new form of insurance company to oversee all health care delivery. Indeed, the purpose of Managed Competition seemed to be to control doctors and end any form of independent practice

or fee-for-service medicine. Enthoven is quite explicit in saying that “free choice of doctor by the patient (and) free choice of prescription by the doctor,” are evils that should be done away with.¹⁰

- A model that has been greatly admired by the Heritage Foundation since at least 1990, is the Federal Employees Health Benefits Program (FEHBP).¹¹ FEHBP offers a very wide variety of private insurance plans federal workers may choose from. But the program is not really “portable” since taking a job outside of federal employment ends participation.

- The Heritage Foundation’s ideas helped spawn Governor Romney’s health insurance exchange in Massachusetts — the “Connector.” This went well beyond the FEHBP’s simple market place, however. It added another level of regulation on top of the insurance regulations already in place. The Board of the Connector dictates what benefits are offered and what premiums are allowed.¹²

- Of course, the Affordable Care Act took the RomneyCare Connector even further. The ACA Exchanges will define with precision what “essential benefits” must be covered in ten different areas of service (ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and so on). They also distribute income-based subsidies and refer applicants to other programs such as Medicaid. So they will collect detailed personal information on income, job status, and what other employer-based coverage might be available for each applicant.¹³

These federal exchanges will be required to collect and pass this information on to

the IRS. These and other requirements go well beyond anything being done by the Connector in Massachusetts, yet the operating costs of the Connector in 2009 was \$26 million for vendors and \$3.4 million for employee compensation.¹⁴ We can expect the new federal exchanges to cost considerably more.

We don't yet know what all the specific requirements will be in the federal exchanges. *The New York Times* reports that only 13 states have declared they will set up their own exchanges, leaving the federal government to set up exchanges in the remaining 37 states, but at this writing there is no information available about what the federal government will require. It is all being done behind closed doors.¹⁵

Even the relatively simple task of enrolling in the health plan of one's choosing has become massively complex in these exchanges. Eleven states and the federal government have created a consortium, "Enroll UX 2014" to offer "a scenario-based Design Reference Prototype and a detailed Design Specifications Manual for an online health insurance portal that will make it easier for people to understand the coverage they may be eligible for and will support their enrollment decision-making."¹⁶

Interestingly, the Department of Health and Human Services has decided that these exchanges may not do such a great job of marketing, so it has already issued regulations allowing private exchanges to market ACA-qualified health plans on their web sites in addition to whatever marketing the federal exchanges themselves do.¹⁷

The impact of the federal exchanges could be significant. A report from PwC states, "Public exchanges will create an irreversible shift in the

insurance market that will ultimately change the way medical care is sold in the US."¹⁸

The Citizens' Council for Health Freedom has established a dedicated web site to keep track of the ever-evolving federal health insurance exchange developments at: <http://www.cchfreedom.org/issue.php/26>

All of these approaches are created and defined by politicians. They rely on laws, regulations, and bureaucracies to be implemented. They are all coercive, and like laws everywhere, are very difficult to change once written into law. Further, they would all create interested parties who will quickly become invested in preserving the systems intact or risk losing their investments.

Perhaps more importantly, they all assume that a vastly complex, expensive, and essential industry can best be managed by smart people sitting around a table in Washington, DC or Boston, Mass. They all feature a childish conceit that an elite group of experts is better able to make health coverage decisions than the patients who are personally involved.

Models of Private Exchanges

While enormous amounts of money and effort have been expended on these pie-in-the-sky fantasies, in the real world real employers have been working with real insurance companies on better ways to finance the health care needs of real patients. Time would be well spent in studying these efforts for what is and is not working well and in looking for ways to remove obstacles and refine the products so they can work better for more people.

The private exchanges may be grouped into three categories:¹⁹ Those started by employer business groups, those started by insurance

37 States will not set up federal exchanges, leaving the federal government to set up exchanges in those states.

Connecticut Business and Industry Association's exchange, started in 1995, may be the first private exchange.

companies, and those started by independent entrepreneurs. We'll take them in turn.

The Business Group Exchanges

Business group exchanges have a clear advantage in that the founding organizations already have trusted relationships with employers. They exist to make life easier for business owners, but their relationship with employees and health plans may or may not be as positive. They typically will ensure portability for employees, but only when the employee moves between participating employers and health plans. Some examples:

CBIA Health Connections

Started in 1995, this may be the first of the private exchanges.²⁰ It was founded by the Connecticut Business and Industry Association and was estimated to cover 75,000 people, or one-fifth of the small employer market in Connecticut, in 2010. At the time it offered 48 different plans by four different carriers. Spokesman Ken Comeau told a group in California that CBIA itself designs the plans that are offered so they can be standardized.²¹

However, since the Affordable Care Act was passed, two of the carriers, Cigna and Health Net, decided to stop offering coverage through the program, leaving only ConnectiCare and Oxford as participating health plans.²² The program continues to offer a wide variety of plan designs, including Health Savings Accounts (HSA)s and it will also provide administration services to an employer's HRA program.²³

HealthPass

Another early effort is HealthPass in downstate New York. This company was begun in 1999 to enable small employers to offer

Defined Contributions to workers who then choose the benefits program that is best for their own families.²⁴ It currently insures some 3,300 small employers with 30,000 employees and dependents.²⁵ Unlike its Connecticut neighbor it also offers dental, vision, life, and disability coverage. On medical coverage it offers products from Health Insurance Plan of New York and the Oxford Health Plan.

HealthPass recently commissioned a survey of small businesses in its area²⁶ and found, among other things, that:

- 76% think the business climate in New York State is on the wrong track.
- 27% think their own business is doing well.
- 54% who don't provide coverage would like to.
- 56% of those who do provide coverage think they spend too much time on it.
- 52% would prefer a private exchange while 28% would prefer a public exchange.

NFP Health Services Administrators²⁷

This Massachusetts-based firm is a variation on the theme. It began in 1969 as the Massachusetts Business Association and functions very much like other business associations, using its leverage to secure favorable rates from insurers. It offers coverage from some seven different health plans in Massachusetts, Rhode Island and New Hampshire. It currently claims to be an "exchange," but does not appear to offer the essential services associated with other exchanges – the ability of employers to make fixed contributions, of employees to choose

from an array of benefit options, administration of an HRA or Section 125 account to enable tax-free premium payments from employees, and portability between plans. This raises a cautionary note: the term “exchange” is very popular in today’s environment, but it may not mean the same thing to everyone who uses it.

Insurer-Sponsored Exchanges

Insurer-sponsored exchanges also have an existing client base. It should be relatively easy to move current small employer clients into an exchange-type mechanism and allow individual employees a wider choice of health plan design. However, the portability issue (the ability of a consumer to keep the same coverage as they move between jobs) is more limited than with business-sponsored exchanges. The new employer would have to be covered by the same insurer as the old one. Plus, if there are problems with the insurer (such as with claims processing or customer service support), these exchanges offer no remedy. Examples include:

Blue Cross Blue Shield of Kansas City²⁸

The Blue KC Exchange is being offered to some 6,000 small businesses with 2 – 99 employees and 80,000 individual customers at their next renewals. It allows employers to make a fixed contribution and employees to choose from ten different products with a monthly employee-only premium ranging from \$31.21 to \$266.27. The employee contribution can be tax-free through a payroll deduction program. All of the usual BCBS services (such as on-line support, nurse hotlines, provider directories) are available, and job-changing employees can retain their coverage provided the new employer also participates in this program. This is a very simple and attractive approach, though it involves only the one insurer.²⁹

Highmark

Highmark is the Blue Cross plan for Western Pennsylvania. It announced late in 2011 that it would offer an exchange to employers with 10 – 99 employees beginning on January 1, 2012. Employees will have a choice of seven health plans and two vision/dental plans. At this writing information about premiums and benefits was not available.^{30 31}

Blue Choice

This plan was just announced recently, on April 30, 2012.³² A press release announced that Blue Cross and Blue Shield of Minnesota will be working with eHealth Technology to offer a new “Blue Choice” defined contribution option. There is not yet much information available about what will be offered, but the release says there will be a three-year price guarantee included.

WellPoint³³

WellPoint is teaming up with Chicago-based Health Care Service Corp (which runs Blue plans in Texas, Illinois, New Mexico, and Oklahoma) and Blue Cross Blue Shield of Michigan to offer an exchange program in all 50 states by next year. The combined companies acquired an existing exchange, Minneapolis-based Bloom Health, which currently offers a menu of health plans to 20,000 workers at 50 companies. The consortium intends to compete directly with state-run federal exchanges when (and if) they come on-line in 2014. Bloom’s current customers tend to be in the mid-market with 100 to 1,000 employees. It is not clear whether the arrangement will be expanded to small employers, though it would have to be if it intends to compete with state-run exchanges.

Independent Exchanges

These independent companies are all

The popular term “exchange” may not mean the same thing to everyone who uses it.

Independent exchanges include the company often cited as a model for what an exchange could be.

over the place when it comes to sponsorship and business models. In some cases they are existing brokers trying to expand their services and customer bases, in others they are information technology companies with no health insurance marketing experience. Some are focused on the small group market, others on large groups, and still others on retiree health benefits. Some examples:

eHealthInsurance³⁴

Founded in 1997, eHealthinsurance offers comparison shopping in all fifty states. It started with an emphasis on individual (non-group) coverage and expanded to small group, Medicare supplement, and other products such as vision and dental. It offers plans from 180 different insurers. People may shop for coverage by entering their zip code and seeing the differences in coverage and cost in their area without ever speaking to an agent. Applications for coverage may be submitted on-line. The company claims to have insured three million people and is often cited as a model for what an exchange could be.

BenefitMall³⁵

BenefitMall describes itself as the leading general agency in the country, representing 15,000 independent brokers in eleven states. It provides coverage to 2 million people in 175,000 groups. It offers an “exchange” web site,³⁶ which seems to be mostly a lead generator for its brokers and agents.

Choice Administrators³⁷

Choice Administrators has been operating an exchange, CaliforniaChoice, since 1996 in California. It features small and mid-sized (up to 199 employees) group coverage and

individual employee choice through a defined contribution program. It serves some 10,000 employers and over 150,000 individual members. For small groups, it offers coverage through five different health plans and over 30 pricing options. The mid-sized exchange includes two carriers and 11 different plan designs. It is also offering to be the exchange for states looking to set up programs to comply with the Affordable Care Act.

Liazon Corporation³⁸

Liazon was founded in 2007 and is offering exchange services to small and midsize companies through its Bright Choices web site. It has offices in New York City, Buffalo, and Waltham, Massachusetts and serves about 2,000 company clients in 23 states. It was recently featured in an article in the *Augusta, Georgia Chronicle*.³⁹

ConnectedHealth⁴⁰

ConnectedHealth is a start-up company founded by the people who began Subimo, an on-line comparison of physician and hospital services and prices that was acquired by WebMD a few years ago. It’s not clear what its business model will be. Certainly it has the expertise to offer outstanding on-line consumer support, but there is little information about how it will serve employers and carriers in this area.

Towers Watson -- Extend⁴¹

The benefits consulting firm Towers Watson very recently acquired Extend Health, Inc. for \$435 million.⁴² This is a very interesting development. Extend runs an exchange for Medicare Advantage and Medicare Supplemental programs for those employers

who cover retiree health benefits. According to an article in *InformationWeek*, Extend currently serves some three dozen Fortune 500 companies with over 200,000 retirees. Commentators see this as an effort by Towers to get into an exchange relationship with large companies for their regular workforce.⁴³

Other Developments

Tower Watson is only one of several benefits consulting firms trying to get into the exchange business. Others include Aon Hewitt, which is investing \$75 million to start an exchange. *Employee Benefit News* recently reported that Aon will be offering its exchange services to 90,000 employees of Sears and 45,000 employees of Darden starting January 1, 2013.⁴⁴ Buck consultants, which is part of Xerox, is also developing an exchange.⁴⁵

What is the Role of the Agent/Broker in an Exchange?

The answer to this question depends on whether we are looking at public or private exchanges. In public exchanges the answer is minimal heading to none.

The attitude of advocates of public exchanges is that brokers are middlemen who add no value to the system. If they feel greedy physicians are the source of high costs and need to be controlled, they also feel that agents and brokers are just leeches on the system. The primary point of having an exchange is to eliminate the costs associated with commissioned sales. Now, for political reasons they may allow some modest referral fees at least until they get their “navigators” up and running. These navigators are envisioned as a type of community organizer. An advocacy group, Community Catalyst, published a short paper that describes it well,⁴⁶ It says:

According to the ACA, Navigators may be community and consumer-focused non-profit groups; trade, industry, professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration (SBA); licensed insurance agents and brokers; and other entities capable of carrying out the required duties.

However, who is selected to be a navigator is constrained. The paper recommends the following:

Navigators must:

- Have adequate training on the Exchange, Medicaid and other public programs and the private insurance market in the state.
- Be able to explain eligibility, benefits, cost-sharing, and appeals processes to consumers.
- Be trusted by the community to provide appropriate, clear and correct information.
- Be free from conflicts of interest, including payments and incentives from insurers or industry.
- Act in the interest of the consumer as their client, not the insurer.
- Be able to provide information to individuals and families in a way that can be understood, in a culturally sensitive manner, for those with low-proficiency English, and people with disabilities who have special communication needs.
- Be able to effectively serve low-income, disadvantaged, and hard-to-reach populations.
- Be able to help people understand

Aon Hewitt is investing \$75 million to start a private exchange, soon to be offered to 90,000 Sears employees.

The real potential for private exchanges comes from markets that will not be involved in the ACA exchanges.

how premium tax credits work, and their potential financial impact.

- Adequately represent a diverse set of organizations and entities throughout a state in order to effectively serve the large number of people who will be eligible for insurance through the Exchange.

Private exchanges will feel no such constraints. If a broker or agent can help make the system work better they will be welcomed to participate, though compensation will likely be lower than traditional commissions.

Discussion

Clearly there is something very big going on here.

An article in *Bloomberg/BusinessWeek* described it as a \$4 billion market, but that was describing only the potential of selling coverage through the ACA exchanges. The real potential for private exchanges comes from the mid- and large-group markets that will not be involved in the state-based federal ACA exchanges.⁴⁷

A recent survey of 6,579 employers by J.D. Powers found that nearly half are poised to switch to Defined Contributions and private health insurance exchanges. An article in *Employee Benefits News* says, “Almost half of respondents (47%) say they “definitely will” or “probably will” switch to a defined contribution model within a private exchange, allowing employees to select the coverage that best fits their needs.”⁴⁸

The passage of the Affordable Care Act has certainly added to this interest in at least two ways:

1. It has generated a huge amount of attention to the concept. Businesses are looking at the requirements of the law and

thinking about how clumsy it is and how much better it could be in private hands.

2. It has broken the historical connection between employers and the direct provision of health insurance benefits. The law essentially gives employer permission (and incentives) to drop coverage in favor of allowing workers to participate in an exchange program. All employers must do is pay a modest fee (penalty) to send their workers to the exchange.

Consequently large numbers of employers are considering getting out of the health benefits business. A December 2011 paper by Grace-Marie Turner of the Galen Institute puts it this way:

“McKinsey & Company surveyed 1,300 employers across industries, geographies, and employer sizes, and concluded that the Patient Protection and Affordable Care Act (PPACA) will lead to a “radical restructuring” of job-based health coverage. McKinsey found that 45 to 50 percent of employers say they will definitely or probably pursue alternatives to employer-sponsored health insurance in the years after it takes effect in 2014. One-third of employers say they “will definitely or probably drop coverage after 2014.” Among employers who knew most about the new health law, half said they were likely to drop coverage.”⁴⁹

The benefits consulting firm Booz and Company also surveyed a number of employers and found that half would “gravitate to multiple-carrier exchanges, while less than 30 percent prefer a single carrier exchange.”^{50 51}

This study also identified issues for employers, health plans, and entrepreneurs to consider when designing or deciding to

participate in a private exchange. Much of this involves the need to educate employers and employees about defined contribution, the need for employers to determine how such a switch will hurt or help their ability to attract talented employees, the need for a simple and robust web site experience and real-time administrative support, the concern about transaction fees and brand identity. Underlying all this are concerns about evolving tax law and regulations.

Very significant companies are investing very large amounts of money to capture a share of this new business model. And it is an entirely new way of organizing the health care financing system. It is transitioning from a system in which the employer selects the benefit plan and allows employees to participate in it, to a system in which the employer makes funds available for employees to buy and “own” the coverage of their choosing.

This solves many important problems in our current system:

- Employer costs will be fixed and controllable. An employer will be able to contribute only what it can afford.
- Employees will be able to choose their plan design, the one that works best for their own family.
- Coverage will eventually be portable, so employees can keep the same coverage as they change jobs, or lose their job altogether.
- Unlike individual coverage today, the employee contribution may be tax free through using a Section 125 payroll deduction.
- Two-income families may be able to use contributions from different employers

to purchase a single plan for the whole family.

Importantly, this movement predates the Affordable Care Act and is growing independently of anything the ACA is doing. Yes, the ACA is having some influence. It has increased awareness of the concept of exchanges and some of the vendors hope to get a share of the ACA federal exchange business – if it ever happens.

But the most serious players in this space are acting independently of the ACA. They are addressing the very large employer market, often beginning with retiree health benefits as a way of establishing a presence.

Other business models are focused on the small group or individual markets. These have also been created independently of the ACA, but may benefit if the ACA exchanges go into effect.

Perhaps the most interesting here is the Wellpoint/Bloom effort, which intends to compete directly against state-run ACA exchanges in all fifty states.

Is this plausible? Absolutely. The state-run exchanges, if they ever happen, will be primarily political entities focused on regulating and controlling participating insurers. They will spend their time defining with precision how much of each kind of service must be covered and how much will be paid by the insurer and how much by the patient. They will, for instance, decide how many visits to a psychiatric counselor must be covered and what the co-pay will be for the patient.⁵² Any health plan not complying will be stricken from the available choices for the consumer.

Wellpoint/Bloom will presumably not micromanage the participants, but allow

State-run exchanges will be political entities focused on controlling insurers.

With or without ACA exchanges, employers will no longer be doing business the way they have in the past.

customers to choose what coverage works best for their own family. Wellpoint/Bloom will invest its energy in on-line customer service to make the shopping experience enjoyable and to support customers throughout the health care system. These kinds of services are eminently “scalable” so it will be easy to offer the same services in all fifty states rather than creating separate systems in Kansas, Nebraska, and Iowa.

It is entirely possible that state-based ACA exchanges will be created but be so clumsy and hard to use that no one participates in them. But with or without ACA exchanges the future is clear. Employers will no longer be doing business the way they have in the past. They will be moving decisively to a Defined Contribution approach to health benefits, just as they did with pension benefits in the past. Private Health Insurance Exchanges are the essential facilitator in this transformation.

Policy Considerations

First, it must be said that all this activity is attempting to create a rational market within a massively dysfunctional environment. Over the course of 75 years, the United States has created a mountain of tax policies, insurance regulations, and targeted public programs that are irrational and supremely difficult to even understand, let alone navigate. The recent Affordable Care Act has only added to the complexity.

Still, to the extent the private exchanges are attempting to move health insurance to a system of individual choice and ownership and allow employers to concentrate on their core business rather than being quasi-welfare agencies, the efforts should be applauded and encouraged.

How can this trend be encouraged? What

obstacles should be removed to facilitate the development? What should be under consideration for Congress or state legislatures?

Tax Law. The current treatment of insurance premiums for tax purposes is far and away the most difficult issue in encouraging individual ownership and portability. Employer-sponsored coverage is completely free of all taxes, while individually-owned coverage may be purchased only with after-tax dollars. At a minimum, tax law should be neutral on how coverage is bought. Whether it is bought and paid for by an employer or bought and paid for by an employee should make no difference whatsoever on taxes. It might all be considered taxable, it might all be considered tax-exempt, or it might all be in between, with a cap on the tax advantage.

This neutrality would enable employers to decide whether it makes business sense to provide coverage directly, to contribute to employee’s premiums, or to not bother with it at all. Many employers will fall into each of these categories, as determined by their own resources, expertise and values – not arbitrary tax code distinctions.

Insurance Regulation. Insurance regulations are a mess. Each state has its own, sometimes very different regulations for commercial insurance companies, Blue Cross Blue Shield plans, and HMOs. There are different laws for the individual, small group, and large group markets. On top of that are federal laws and regulations that may apply according to group size or whether an employer meets certain other criteria. One law alone, ERISA (the Employee Retirement and Income Security Act of 1974) is so confusing and contentious that the U.S. Supreme Court has issued rulings on it on an almost annual basis since it was enacted.⁵³

Once again, the Affordable Care Act has done nothing to simplify or clarify the existing mess. Rather it has added yet more confusion, complexity, and litigation on a regulatory system that is already overburdened.

We need a concentrated effort to understand, clarify, and simplify the rules of the road for health insurance, and indeed all forms of insurance in the United States. Admittedly these issues raise a host of thorny philosophical questions about state versus federal authority. For most of our history insurance was not considered commerce, so it was exempt from any federal role. But the failure of our leadership to address these issues at all has created a morass of conflicting, sometimes contradictory, laws and regulations that are a dead weight on the whole U.S. economy.

Other Issues. Short of these massive, epic topics there are a few immediate things that might be done to clarify the environment for private exchanges.

First, the states should drop the idea of creating public exchanges, with or without federal involvement. Public exchanges add nothing to efficient marketing of health insurance. Every state already has comprehensive insurance regulatory agencies that are perfectly able to oversee the practices of insurance companies. Every state also has a distribution network of insurance agents and brokers that is expert at providing consumers with access to available products. These systems will get even better with the advent of private exchanges, and public exchanges can only get in the way of needed innovation.

Another key concern is the treatment of HRAs for purchasing individual coverage. It is not clear that employer contributions necessarily mean that the coverage has to be

considered group, rather than individual. Some state insurance departments have interpreted it that way, others have taken the opposite view. The law is not clear, but late in the Clinton administration (in November, 2000), the Health Care Financing Administration (HCFA) — the former name of today’s Centers for Medicare and Medicaid Services (CMS) — issued a last minute regulation on HIPAA that supported that interpretation.⁵⁴

Perhaps surprisingly the Bush administration never addressed it, but presumably a future administration could issue a contrary regulation, or the states could challenge the current regulation. It could also be argued that the IRS guidance on HRAs superceded this HCFA interpretation. Overturning that requirement would greatly simplify and expand the choices available to employees.

The other initiative that might be helpful would be for states to relax their existing small group requirements on mandated benefits and rating restrictions., especially to the extent they exceed the requirements of the ACA. These restrictions are usually much tighter than the rules on individual coverage because legislatures felt they were protecting employees from the short-sighted decisions of employers. But if employees are choosing their own benefits programs, this “protection” would be inappropriate.

While not as important as federal tax law, the states could take the initiative to exempt individual premiums from state income taxes. This could help more people afford to buy their own coverage even when the employer contribution is limited.

Conclusion

With or without the Affordable Care

States should drop the idea of creating public exchanges, with or without federal involvement.

Relying on employers for something as essential as health or retirement coverage simply doesn't work very well anymore.

Act, change is in the air and long overdue. As with so many things about the American economy and the American government, the path we have been on for the past 50 years is unsustainable, bureaucratic, unaccountable, unresponsive to the needs of consumers, of questionable quality, and far too expensive.

Employers are responding by finding ways to make “consumer empowerment” a reality in their own sphere of influence. This is good for both employers and employees.

Employers want to focus on their business needs without acting as social welfare agencies for their workers. The old model of lifetime employment with a single company is long gone. Today's employers need to be flexible and efficient to prosper in a global economy.

Employee attitudes are changing, too. People want to have more control over their own lives. They are likely to have many jobs over the course of a lifetime, live in many places, and possibly have many different living arrangements. Relying on an employer for something as essential as health or retirement coverage simply doesn't work very well anymore.

Workers are demanding choice and individual ownership of their health benefits as they are in every other aspect of their lives. Defined contribution of benefits by the employer, and personal choice and ownership of health coverage is the latest iteration of this demand for autonomy.

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Endnotes

- ¹ Victoria Craig, “Federal Tax Policy: Its Effect on Health Care Costs, Coverage and the Uninsured,” Council for Affordable Health Insurance, October 1992.
- ² <http://publications.milliman.com/publications/health-published/pdfs/health-insurance-market-10-31-11.pdf>.
- ³ Greg Scandlen, “100 Years of Market Distortions,” <http://tullerinsurance.com/EnvNewsFall03.pdf>.
- ⁴ History of 401(k) Plans: An Update, EBRI, February, 2005. <http://www.ebri.org/pdf/publicationsfacts/0205fact.a.pdf>.
- ⁵ EBRI Databook on Employee Benefits, Chapter 10, May, 2011. <http://ebri.org/publications/books/index.cfm?fa=databook>.
- ⁶ Greg Scandlen, “Defined Contribution Health Insurance,” National Center for Policy Analysis Policy Backgrounder No. 154, October 26, 2000. <http://www.ncpa.org/pdfs/bg154.pdf>.
- ⁷ Gordon-Feinblatt, attorneys. <http://www.gfrlaw.com/pubs/GordonPubDetail.aspx?xpST=PubDetail&pub=536>.
- ⁸ See “What is a Section 125 Cafeteria Plan?” at <http://www.fchp.org/employers/general-plan-information/cafeteria-plans.aspx>.
- ⁹ Alain Enthoven, “The History and Principles of Managed Competition,” Health Affairs, Supplement, 1993. http://content.healthaffairs.org/content/12/suppl_1/24.full.pdf.
- ¹⁰ Ibid.
- ¹¹ Heritage has been promoting this model since at least 1990. There is no one definitive publication to illustrate this support. A search for “FEHBP” on the Heritage web site turns up 345 separate reports extolling FEHBP. See <http://www.heritage.org/search?query=FEHBP>.
- ¹² Michael Tanner, “No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work,” Cato Institute, June 6, 2006. <http://www.cato.org/publications/briefing-paper/no-miracle-massachusetts-why-governor-romneys-health-care-reform-wont-work>.
- ¹³ Rita Numerof, “What's Wrong With Health Insurance Exchanges...” Galen Institute, May 2012. <http://www.prweb.com/releases/2012/5/prweb9562587.htm>.
- ¹⁴ Twila Brase, “State Health Insurance Exchanges Will Impose federal Control,” Citizens' Council on Health Freedom, May 2011. <http://www.cchfreedom.org/files/>

file/Policy_Insights-Insurance_Exchange.pdf.

¹⁵ Robert Pear, “U.S. Officials Brace for Huge Task of Operating Health Exchanges.” *New York Times*, August 4, 2012. http://www.nytimes.com/2012/08/05/us/us-officials-brace-for-huge-task-of-running-health-exchanges.html?_r=3&pagewanted=all.

¹⁶ Enroll UX 2014 web site -- <http://www.ux2014.org/>.

¹⁷ Cindy Gillespie, “Little-Noted Provision On Agents And Brokers Could Mean Big Changes For Exchanges,” *Health Affairs Blog*, June 8, 2012. <http://healthaffairs.org/blog/2012/06/08/little-noted-provision-on-agents-and-brokers-could-mean-big-changes-for-exchanges/>.

¹⁸ “Health Insurance Exchanges: Long on Options, Short on Time,” PwC, October 2012.

¹⁹ A paper published by the Liazon Corporation uses a different method of categorizing private exchanges. It focuses on the target markets rather than the sponsorship. So, it has three categories: 1. Group Market, 2. Individual in Group Clothing, and 3. Individual Market. See Alan Cohen and Christopher Condeluci, “Private Health Insurance Exchanges: What Are They and What Makes The Successful?” http://www.liazon.com/news-room/whitepapers/Private_Exchange_White_Paper.pdf.

²⁰ Brian Schilling, “Purchasing High Performance Health Exchanges,” *Commonwealth Fund*, April 30, 2010. <http://www.commonwealthfund.org/Newsletters/Purchasing-High-Performance/2010/April-30-2010/Case-Studies/Health-Exchanges-Choice-Without-Hassle-and-the-Heart-of-Reform.aspx>.

²¹ Ken Comeau, *CBIA Health Connections*, March 1, 2012, http://www.californiahealthbenefitadvisers.com/blog/2012/03/ken_comeau_cbia_health_connect.html.

²² Matthew Sturdevant, “CIGNA Won’t Offer Small-Group Plans Through the CBIA in 2011.” *Hartford Courant*, October 28, 2010. <http://blogs.courant.com/connecticut-insurance/2010/10/cigna-wont-offer-smallgroup-pl.html>.

²³ *CBIA* web site at <http://www.cbia.com/ieb/er/medical/hc2/default.htm>.

²⁴ *HealthPass* -- <http://www.healthpass.com/about-healthpass.html>.

²⁵ Mark Kessler, “Lessons to be Learned by a Successful Exchange,” February 24, 2012. http://www.californiahealthbenefitadvisers.com/blog/2012/02/healthpass_ny_lessons_learned.html.

²⁶ *HealthPass* Press Release, December 5, 2011. http://www.healthpass.com/assets/files/News%20and%20Information/HealthPass_Employer_Survey_Release_Final.pdf.

²⁷ *NFP Health Services Administrators*. <http://nfphealth.com/>.

²⁸ *Blue KC Exchange* web site. <http://www.bluekcxchange.com/>.

²⁹ Diane Stafford, “Private Insurance Exchange Introduced By Blue Cross Blue Shield of Kansas City,” *Kansas City Star*, November 16, 2011. <http://www.insurancenewsnet.com/article.aspx?id=299619&type=newswires>.

³⁰ *Highmark* press release, November 15, 2011. <https://www.highmark.com/hmk2/about/newsroom/2011/pr111511.shtml>.

³¹ Holly White, “Highmark Partners to Launch Health Insurance Exchange,” *Central Penn Business Journal*, November 15, 2011. <http://www.centralpennbusiness.com/article/20111115/CPBJ01/111119879/Highmark-partners-to-launch-private-health-insurance-exchange>.

³² *eHealth* press release, April 30, 2012. <http://finance.yahoo.com/news/ehealth-technology-tapped-power-private-130000879.html>.

³³ Pat Wechsler, “WellPoint to Vie With State-Run Health Markets,” *Bloomberg News*, September 20, 2011. <http://www.bloomberg.com/news/print/2011-09-20/wellpoint-buys-health-exchange-to-compete-with-state-run-insurance-markets.html>.

³⁴ *eHealthinsurance* web site at <http://www.ehealthinsurance.com/>.

³⁵ *BenefitMall* web site at <http://www.benefitmall.com/Our-Company>.

³⁶ *BenefitsMall Exchange* site at <https://benefitmall.inshealth.com/ehi/Alliance?allid=ben28687&agentid=157972>.

³⁷ *Choice Administrators* web site at <http://choiceadminexchanges.com/>.

³⁸ *Liazon* web site at <http://www.liazon.com/>.

³⁹ “Augusta Company to Offer Private Health Insurance Exchange,” *Augusta Chronicle*, October 2, 2012. <http://m.chronicle.augusta.com/news/health/2012-10-02/company-offer-private-health-insurance-exchange-augusta>.

⁴⁰ *ConnectedHealth* web site at <http://www.connectedhealth.com/>.

⁴¹ *Extend Health* web site at <https://www.extendhealth.com/>.

⁴² Marian Kolbasuk McGee, “Towers Watson to Acquire Extend Health,” *InformationWeek*, May 15, 2012. <http://www.informationweek.com/news/healthcare/admin-systems/240000349?queryText=Towers%20Watson>.

⁴³ Tory Wolff, “Towers Watson’s bold move in private

insurance exchanges: leapfrog Aon and leave Mercer’s alliance compromised,” Healthcare Recon Blog, May 22, 2012. <http://blog.reconstrategy.com/2012/05/towers-watsons-bold-move-in-private.html>.

⁴⁴ “Two Major Employers Embrace Private Health Insurance Exchange,” Health Data Management, September 27, 2012. <http://www.healthdatamanagement.com/news/employers-benefits-private-health-insurance-exchanges-45019-1.html>.

⁴⁵ Tory Wolff, *ibid*.

⁴⁶ “Navigators: Guiding People Through the Exchange,” Community Catalyst, June 2011. http://www.google.com/url?sa=t&rct=j&q=health%20insurance%20exchange%20navigators&source=web&cd=1&ved=0CFoQFjAA&url=http%3A%2F%2Fwww.communitycatalyst.org%2Fdoc_store%2Fpublications%2FNavigators_June_2011.pdf&ei=i-Q0ULauC6Lz0gHnnICgAg&usg=AFQjCNH3J8CjTinFOLhrOixyN0b8CvJQxw&cad=rja.

⁴⁷ Alex Nussbaum, “EHealth-Led Exchanges Eye \$4 Billion Market in Health Law,” Bloomberg/BusinessWeek, April 16, 2012. <http://www.businessweek.com/printer/articles/45508?type=bloomberg>.

⁴⁸ Marli D. Riggs, “J.D. Power: Nearly half of employers will switch to private health care exchange model,” Employee Benefit News, June 19, 2012. <http://ebn.benefitnews.com/news/jdpower-health-plans-private-exchanges-2725494-1.html>.

⁴⁹ Grace-Marie Turner, “A Radical Restructuring of Health Insurance,” Galen Institute, December 2011. <http://www.galen.org/topics/a-radical-restructuring-of-health-insurance/>.

⁵⁰ Ashkay Kapur, et. al., “The Emergence of Private Health Insurance Exchanges,” Booz & Company, 2012. <http://www.google.com/url?sa=t&rct=j&q=booz%20%26%20company%20ashish%20kaura&source=web&cd=2&sqi>

[=2&ved=0CEYQFjAB&url=http%3A%2F%2Fwww.booz.com%2Fmedia%2Fuploads%2FBoozCo-Emergence-Private-Health-Insurance-Exchanges.pdf&ei=Xx4lUKBn0cfQAFzDgdAP&usg=AFQjCNGXtkv4UVWc2hRltqGmEimrLBzJlQ&cad=rja](http://www.booz.com%2Fmedia%2Fuploads%2FBoozCo-Emergence-Private-Health-Insurance-Exchanges.pdf&ei=Xx4lUKBn0cfQAFzDgdAP&usg=AFQjCNGXtkv4UVWc2hRltqGmEimrLBzJlQ&cad=rja).

⁵¹ Margaret Dick Tocknell, “Health Insurance Exchanges Put Defined Benefits to the Test,” HealthLeaders, May 23, 2012. <http://www.healthleadersmedia.com/content/HEP-280464/Health-Insurance-Exchanges-Put-Defined-Benefits-to-the-Test>.

⁵² At this writing, HHS appears to require the states follow the benefits structure laid out in a “benchmark” plan currently available within the state, but it also appears that states will have some latitude in choosing and refining the benchmark design. See “Essential Health Benefits,” Health Affairs Policy Brief, April 25, 2012. http://www.google.com/url?sa=t&rct=j&q=essential%20benefits%20package%20aca&source=web&cd=6&ved=0CEsQFjAF&url=http%3A%2F%2Fhealthaffairs.org%2Fhealthpolicybriefs%2Fbrief_pdfs%2Fhealthpolicybrief_68.pdf&ei=SVUIUMPcl-i70AGLhIDACA&usg=AFQjCNEM2qldMEAuqmcod1rOKZryMhCjxA&cad=rja.

⁵³ Greg Scandlen, “Legislative Malpractice: Misdiagnosing Patients’ Rights,” Cato Institute, Briefing Paper No. 57, April 2000. <http://www.cato.org/publications/briefing-paper/legislative-malpractice-misdiagnosing-patients-rights>.

⁵⁴ Program Memorandum to Insurance Commissioners, Health Care Financing Administration, November, 2000. <http://www.google.com/url?sa=t&rct=j&q=hcf%20hipaa%20employer%202000&source=web&cd=8&sqi=2&ved=0CFYQFjAH&url=https%3A%2F%2Fwww.cms.gov%2FRegulations-and-Guidance%2FHealth-Insurance-Reform%2FHealthInsReformforConsume%2Fdownloads%2FHIPAA-00-06.pdf&ei=YX4qUlVnFrDk6QHlZIG4DQ&usg=AFQjCNEwZOI5BwfSqJaJWSqr5DPr33QAA&cad=rja>.