

Health Insurance Exchanges: Long on options, short on time

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At a glance

In 2013, state exchanges will open for enrollment. Some states are prepared to establish their own exchanges, but many others will look to the federal government to run most—if not all—of their exchange functions. Understanding the nuances of the public and private exchange models and the new members will be critical for businesses to succeed in this new marketplace.

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every sale, purchase, and expense must be properly documented to ensure compliance with tax laws and to provide a clear audit trail. This includes keeping receipts, invoices, and bank statements in a secure and organized manner.

Next, the document outlines the various methods for tracking income and expenses. It suggests using spreadsheets or specialized accounting software to categorize and record financial data. Regularly reviewing these records allows for better financial management and helps in identifying areas where costs can be reduced.

The document also addresses the timing of income recognition and expense deduction. It explains how certain transactions may be deferred or accelerated for tax purposes, depending on the taxpayer's financial goals and the specific rules of the tax code. Consulting with a tax professional is recommended to navigate these complexities.

Finally, the document provides a checklist of key tax-related tasks to complete by the end of the year. This includes reconciling bank accounts, reviewing retirement contributions, and ensuring that all necessary forms are filed on time. Staying organized throughout the year makes the end-of-year tax preparation process much smoother.

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One year from now, 12 million Americans are expected to begin purchasing health insurance through newly-created marketplaces known as exchanges.¹ 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 1965.²

States have until November 16 to notify the Department of Health and Human Services on whether they plan to form their own distinct marketplaces or collaborate with the federal government to operate an exchange. Many are waiting for the November election results before deciding how to proceed. This wait-and-see stance leaves an increasingly short decision window, which in turn shortens the time available for implementation by states and insurers.

Thus far, 13 states and the District of Columbia have issued formal letters of intent to establish their own exchanges, but not all will be ready for enrollment by October 2013. The majority of the remaining 37 states will have the federal government directly involved in running their exchanges—eight states have already chosen to have a federally-facilitated exchange, while three have selected an approach that divides duties in a state/federal “partnership.”

Public exchanges will create an irreversible shift in the insurance market that will ultimately change the way medical care is sold in the US.

For the insurance industry, the new state-based exchanges represent a major business opportunity—an estimated \$205 billion in premiums by 2021.

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 seeking lower costs, greater transparency and convenience.

¹ CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.

² Kaiser Family Foundation, “Medicare: A Timeline of Key Developments,” Available at: <http://www.kff.org/medicare/medicaretimeline.cfm>; US Census Bureau, “Historical National Population Estimates, 1900 to 1999” US Census Bureau, “Projections of the Population and Components of Change for the United States: 2010 to 2050 (Constant Net Migration).”

An emerging customer base

“This is the largest open enrollment in our careers.”

Kim Jacobs, UPMC Health Plan

The 2010 healthcare reform law extends health insurance to approximately 30 million Americans through two major mechanisms—an expansion of the Medicaid program and the new exchanges.³

States face two major decisions this fall: whether to expand Medicaid and which type of exchange to create. Enrollment in the exchanges will vary depending on whether states expand their Medicaid coverage. The new exchange members will be a combination of the newly insured, those who are no longer covered through their employer 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 SHOP (Small Business Health Options Program).

PwC’s Health Research Institute (HRI) analysis based on projections by the Congressional Budget Office (CBO) shows that 40% of the expected individual exchange enrollees will come from five states—California, Texas, Florida, New York and Illinois.⁴

“This is the largest open enrollment in our careers,” said Kim Jacobs, vice president of product and innovation at UPMC Health Plan. Individual state exchange members in 2021 are projected to range from 100,000 in states such as Maine to 3.5 million in California.⁵

Qualified individuals with incomes that fall between 100% of the federal poverty level (FPL) and 400% FPL will receive financial assistance from the government to buy insurance—in the form of subsidies or reductions in cost sharing.⁶

The law originally required all states to expand Medicaid to 138% of FPL, or \$15,415 for an individual or \$31,809 for a family of four.^{7,8} But a landmark ruling by the Supreme Court in late June 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 may still purchase coverage in the exchanges, but they won’t receive subsidies.

³ CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.

⁴ HRI Analysis; US Census Bureau, Current Population Survey, March 2011 Supplement; CBO, “Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision,” July 2012.

⁵ CBO and PwC HRI analysis.

⁶ Subsidies are tax credits and cost-sharing assistance given to qualified individuals in families with incomes between 100% and 400% FPL to buy affordable insurance. The amount of the premiums that individuals/families will have to pay is determined on a scale that ranges from 2% to 9.5% of annual income. More information available at: <http://www.kff.org/healthreform/upload/7962-02.pdf>.

⁷ In this report, Medicaid eligibility in 2014 was defined as individuals with incomes of up to 138% of the federal poverty level. While Medicaid is being expanded to cover those with incomes of less than 133% FPL, income is calculated using modified adjusted gross income (MAGI), which includes a 5% income deduction and has the net effect of raising the income cap to 138% FPL.

⁸ Based on the 2012 HHS Federal Poverty Guidelines for 48 contiguous US states, <http://aspe.hhs.gov/poverty/12poverty.shtml>.

Figure 1. Projected exchange enrollment dependent on Medicaid expansion

Number of exchange enrollees and premium expenditures as determined by various state Medicaid expansion scenarios

	All states expand Medicaid to 138% FPL or above	Some states expand Medicaid to 138% FPL or above	No states expand Medicaid beyond current levels
2014	<ul style="list-style-type: none"> • 11 million enrollees • \$50 billion in premiums 	<ul style="list-style-type: none"> • 12 million enrollees • \$55 billion in premiums 	<ul style="list-style-type: none"> • 13 million enrollees • \$60 billion in premiums
2021	<ul style="list-style-type: none"> • 27 million enrollees • \$190 billion in premiums 	<ul style="list-style-type: none"> • 29 million enrollees • \$205 billion in premiums 	<ul style="list-style-type: none"> • 32 million enrollees • \$230 billion in premiums

Source: CBO and PwC HRI analysis

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 (See Figure 1).

HRI 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.⁹ They are mostly white, and about one in five speak another language at home (primarily Spanish) compared to the currently insured population, where one in eight speak another language at home. And roughly three-fourths (76%) of the exchange population will not hold a college degree, compared to nearly 60% of today's private insurance market.¹⁰

When the exchange population is combined with the ACA's new Medicaid beneficiaries, the result is a distinctly different customer base for the health sector (see *Who are the 30 million newly insured under the ACA?*). Serving a less educated, racially-diverse population that is more likely to cycle on and off government support will require creative outreach programs, more targeted products and stronger ongoing customer support.

Although almost 60 percent of adults entering the exchange market are employed full-time, nearly nine out of 10 will receive subsidies in 2014.¹¹ In the earlier years, more enrollees have lower incomes. For example, in 2014 about 60% will have incomes at or below 200% FPL (\$46,100 for a

⁹ CBO projections for exchange membership in 2021 are 25 million for the individual exchange and 4 million for the small group exchange.

¹⁰ A college degree is defined as a bachelors degree.

¹¹ CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012.

family of four). The number drops to 35% in 2021. Medicaid Managed Care organizations, which have experience addressing the unique needs of a lower income population, may be well-equipped to initially serve the market.

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

The exchange shoppers are unlikely to overwhelm the healthcare system or substantially drive up costs immediately after gaining coverage.¹² However, they will be less familiar with the insurance system; in 2014, approximately 75% of public exchange enrollees will be newly insured. Over time, outreach and education 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—and 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 sickest, costliest patients. Insurers are weighing several factors in developing their products.

“We need to find the right place on the shelf of the exchanges, public or private,” said UPMC Health Plan’s Jacobs. “We can do this by understanding what different consumers value. And we need to have a balanced population of the healthy and sick.”

Other factors besides price 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 HRI research has shown, almost half—47%—of consumers surveyed indicated a willingness to pay a higher price for additional insurance features such as dental or vision coverage.¹³

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

¹² Adults aged 18-64 represent about 83% of the newly insured.

¹³ PwC Health Research Institute, Change the channel: Health insurance exchanges expand choice and competition, July 2011.

A cautionary tale on meeting the needs of a new customer base

Are you feeling blue?

The story behind that seemingly simple question offers a cautionary tale for healthcare organizations looking to capture and serve the approximately 30 million newly insured customers enrolling in state insurance exchanges and Medicaid beginning next year.

At the San Francisco-based Chinese Community Health Plan, medical director Craig Reich, MD, knows firsthand that serving a unique patient population requires not only foreign language skills but a deep appreciation for cultural, educational and socioeconomic differences. When the federal government's Medicare Advantage Plan Stars survey asked members whether they were depressed—Are you feeling blue?—the American colloquialism didn't translate very well.

The vast majority of the health plan members only speak Chinese. And it became apparent the phrase wasn't translating clearly. Needless to say, the health plan, which serves 30,000 customers, has been scoring poorly on quality—which is made up of approximately half consumer experience scores and half health outcomes scores. Scoring low on the survey reduces bonus payments to Medicare Advantage plans.

“If our Star scores don't reflect high quality of care, we will eventually run out of money,” Reich said in an interview with HRI. “We won't be able to provide the culturally and linguistically competent benefits and care our community needs and is entitled to.”

Brian Cook, a spokesman for CMS, said the agency is studying ways to address language barriers. While the quality ratings and bonus payments are critical, Reich sees larger lessons for insurers and providers contemplating competing for the newly-insured population, which will have a distinctly different profile than today's market. For example, like the Chinese-speaking clientele Reich serves, 20% of consumers expected to shop on the individual exchanges do not speak English. Approximately 65% of exchange joiners won't have a college degree. The gap is even greater when adding in those patients expected to qualify for Medicaid.

“The needs of our members go well beyond health plan coverage,” said Reich. “Half of our member population physically comes into the center for customer service inquiries and our member services staff needs to be ready to handle life needs, such as questions on their telephone bill.”

The staff is all local, understands the community and can relate to cultural and language intricacies to get appropriate care for a member base that is predominantly on Medicare or Medicaid. The health plan is a subsidiary of Chinese Hospital and actively searches for physicians who can provide regular care in a way that fits their members.

Georges Benjamin, a physician and executive director of the American Public Health Association, said that the newly-insured population could pose a number of challenges—not the least of which is stability of providers. “In many cases these folks are cared for by someone right now,” he said. “Some of them are in a clinical practice even if that provider isn't currently getting compensated.”

Who are the 30 million newly insured under the ACA?

Children who are uninsured all the way to seniors nearing Medicare age may not flood the healthcare system or substantially drive up costs soon after they obtain coverage under the Affordable Care Act. In fact an overwhelming majority, 88%, will be in relatively good health—data that suggests providers won't be immediately overburdened by the newly insured once coverage is offered to virtually every American.

But the profile of this incoming group of customers suggests distinct challenges for the health sector, as well as the patients themselves trying to navigate a raft of new regulations in today's fragmented system.

The newly insured will be a less educated, more diverse group. One in four will be black, Asian, Native American or multi-racial compared to 21% of the currently insured. And more than a quarter of the newly insured under the ACA—30%—will speak a language other than English. Today about 12% of the insured don't speak English as their primary language. (Both figures may include undocumented immigrants who will not be covered under the ACA.)

HRI analyzed two federal databases to draw a fuller portrait of the approximately 30 million uninsured Americans, under age 65, who stand to gain coverage under the law.

The analysis found that the majority of the newly covered in 2021 will enter the healthcare system relatively young, single and in good shape, though significantly less educated and more likely to be unemployed or underemployed than the current insured population. Many will cycle between Medicaid and the subsidized exchanges, a phenomenon known as churn. If all states participate in the Medicaid expansion, about 38% of individuals will move between the two categories four or more times over the next four years, according to one analysis.¹⁴

Over time, subtle differences in how the two groups compare may have a big impact on how patients are treated a decade from now. One of the most telling

factors can be found among the minority population projected to gain insurance.

Race and ethnicity often influence a patient's access to certain medical treatments. Fewer African Americans, for example, receive routine cancer screenings or procedures to treat heart disease compared to whites, according to data compiled by the Agency for Healthcare Research and Quality.¹⁵ If such statistics hold, then it is more likely that providers will treat potentially higher-acuity patients than they do now.

Other differences are more nuanced. The newly insured will be slightly older than those who are currently insured; they will be less likely to have a full time job, 42% compared to 59%. Not surprisingly, the new group earns less, with a median income of 166% of the federal poverty level compared to a median income of double that.

From an education standpoint, much of the emerging insured population will have to tackle a complex range of options and enrollment responsibilities without a college degree. Roughly 86% won't have a college degree compared to 63% of the currently insured population, HRI analysis found.¹⁶

Such income and education indicators paint a hazy future for providers. The ACA's coverage expansion means doctors and hospitals will have many more paying customers than now. But the new patient population is more likely to have difficulty with English and be unaccustomed to deciphering the vagaries of the health system. And although the new group reports feeling healthy, physicians suspect there will be a range of undetected medical issues to address.

"Even the initial health care assessment might be a problem for some of those patients and providers," said Georges Benjamin, a physician and executive director of the American Public Health Association. "Because they may not have seen a physician recently, they will require more hours of assessment and care."

¹⁴ Chris Fleming, "Frequent churning predicted between Medicaid and Exchanges," Health Affairs Blog, February 11, 2011; <http://healthaffairs.org/blog/2011/02/04/frequent-churning-predicted-between-medicaid-and-exchanges/>.

¹⁵ Agency for Healthcare Research and Quality, "Addressing Racial and Ethnic Disparities in Healthcare: Fact Sheet"; <http://www.ahrq.gov/research/disparit.htm>. Accessed September 2012.

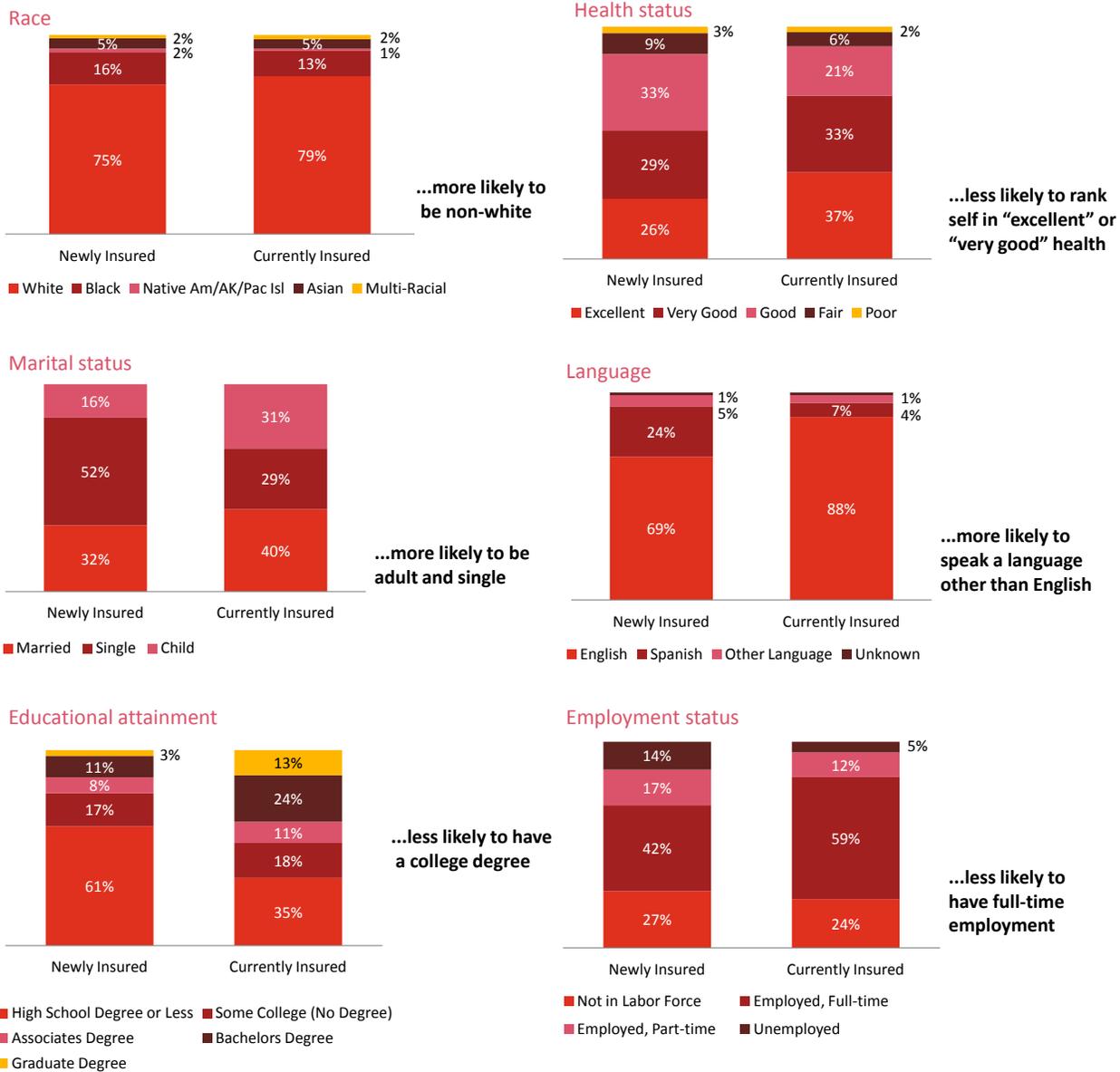
¹⁶ A college degree is defined as a bachelors degree.

Figure 2: Portrait of the newly insured

A comparison of individuals gaining coverage against those who already have coverage across several categories

Median age:
 Newly insured: 33
 Currently insured: 31

Median income:
 Newly insured: 166% FPL
 Currently insured: 333% FPL



Children account for a smaller portion of the newly insured than of the currently insured. This decreases the median age of the currently insured population. Limiting the population to adults ages 18 to 64 results in a median age among the newly insured of 38 and a median age of 42 among the currently insured population.

For more methodology information, see *About this research*.

Sources: HRI Analysis; US Census Bureau, Current Population Survey, March 2011 Supplement; Agency for Healthcare Research and Quality, 2009 Medical Expenditure Panel Survey; CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012.

The public and private faces of insurance exchanges

Under the ACA, states can run their own exchange, partner with the federal government or have the Department of Health and Human Services operate its federal exchange in the state. 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 are either 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.

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. (See Figure 4.)

Public exchanges

States that run their own exchanges will be responsible for setting eligibility standards, customer service, plan oversight and financial management.¹⁷ 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 CHIP.

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. Massachusetts, which currently has nine insurers in its exchange, is an example of an active purchaser.¹⁸ California, Oregon and Connecticut have indicated they will be active purchasers. Several other states, including Utah, Colorado and Hawaii, follow the passive purchaser model, which accepts all qualified health plans.

The customer service aspect cannot be ignored

States must set up websites, call centers and consumer outreach to enable widespread participation. States will also 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 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 the **federally-facilitated 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 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.

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 the store front, interacting with consumers and employers. “States that choose this option are ceding the more technical aspects of exchange activity to the federal government but can retain control of insurer oversight and consumer assistance,” said Joel Ario, managing director of Manatt Health Solutions and the former head of insurance exchange planning at HHS.

The federal government will run all functions except for plan management and certain elements of the customer service function. States can choose to run one, or both, of these functions.¹⁹

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 services function, they will lead all in-person customer assistance, while HHS will operate a call center and website.²⁰ The federal government will oversee eligibility, enrollment and financial management.

¹⁷ CMS presentation, “Exchanges: A Proposed New Federal-State Partnership;” State Exchange Grantee Meeting, September 19-20, 2011.

¹⁸ Massachusetts Health Connector Authority. Health Reform Facts and Figures, Summer 2012.

¹⁹ CMS. “Guidance on Federally-facilitated Exchanges,” May 16, 2012.

²⁰ CMS presentation, “Working Together to Implement Exchanges.” Health Insurance Exchange System-Wide Meeting, May 12-13, 2012.

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.²¹

State progress

State-run exchanges

Thirteen states—including New York, Vermont and Kentucky—and the District of Columbia have declared their intent to establish a state-based exchange. New York has moved forward rapidly since the governor signed an executive order in April 2012. The state has received more than \$183 million in grants—with about 75% spent on development of an IT system that will be fully integrated with the Medicaid program, and the remainder on exchange staff and exploratory analyses of models and the new population.²²

Danielle Holahan, director of policy and planning for New York's exchange, said that the state's biggest challenges to implementation have been the aggressive timeline and delayed federal guidance. The tight deadline however has helped jump start health data coordination activities in the state.

"There are activities we've started, like an all-payer database that we're committed to and will continue regardless of the ACA's fate," said state insurance commissioner Nirav Shah, MD.

In 2011, Vermont passed a law that puts it on a course to establish a single-payer healthcare system by 2017. Its exchange will help smooth

that transition, and retain most major functionality including enrollment, eligibility and consumer education. "The biggest difference will be turning off the connection to carriers," said exchange deputy commissioner Lindsey Tucker. "But in terms of the system components, the infrastructure will remain the same."

State officials in Kentucky fully intend to have its state exchange up and running by the January 2014 HHS operational deadline. "Developing the exchange has given us the opportunity to take a hard look at the benefits for all populations including Medicaid, small group and the uninsured," said Audrey Haynes, secretary of the cabinet for Health and Family Services. "We've been watching every dollar to see how it fits in with short and long term goals."

State/Federal partnership

Three states—Arkansas, Illinois and Delaware—have announced that they will pursue state/federal partnership exchanges. (See Figure 3.) Arkansas has been moving toward a partnership exchange since late 2011, and has made notable progress to build out its capabilities around plan oversight and customer service.²³ The state created a steering committee to provide oversight, and has received nearly \$9 million in grants to design and connect Medicaid and exchange enrollment, develop consumer assistance programs and build out the state's plan management functions.²⁴

Federally-facilitated exchange

Eight states have indicated that they do not intend to develop a state-based exchange, and consequently will

turn over the program to the federal government. For example, in July 2012, Texas Governor Rick Perry announced that his state would not establish an exchange. The state received \$1 million in planning grants, but has since returned all but \$100,000.²⁵

Undecided

Many states remain undecided. Tennessee, for example, has announced it is awaiting the outcome of the November elections. In the meantime, the governor has directed state officials to conduct exchange "contingency" planning, even though the state lacks formal legislative authority to establish one. If the ACA remains intact, the state will either aggressively set up a state-based exchange or participate in the FFE.

"One of our biggest concerns is to reduce confusion for families that have multiple health plans and

- **Reinsurance program:** attempts to offset individual high-cost outliers from 2014 – 2016. All health insurers, and third-party administrators on behalf of self-insured group health plans, will make contributions based upon percentage of premium to support payments to insurers that cover high risk individuals.
- **Risk corridor program:** run by federal government and focuses on accurate rate setting and creates a way for insurers and the federal government to share risk.
- **Risk adjustment program:** permanent program run by federal government, which aims to neutralize the effect of risk differences among health plans.²⁶

For more information, see HRI's brief on *Health Insurance Exchange Final Rules: Moving ahead to 2014*

²¹ Ibid.

²² Kaiser Family Foundation State Exchange Profiles. Available at: <http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx>.

²³ Ibid.

²⁴ HHS. Creating a New Competitive Marketplace: Affordable Insurance Exchanges. <http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a>.

²⁵ Kaiser Family Foundation State Exchange Profiles. Available at: <http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx>.

²⁶ Ibid.

Figure 3: A snapshot of public exchanges

These nine states have announced that they will follow a particular exchange model

State-run exchange	State/Federal partnership exchange	Federally-facilitated exchange
<p>Vermont Grant funding: \$158.9M* Medicaid Expansion: Working and Jobless 150% FPL</p> <ul style="list-style-type: none"> Enacted in 2011 as part of law to establish a single-payer system Exchange falls under state's Medicaid office Investing significant resources to design and build a new IT infrastructure State plans to keep current Medicaid levels 	<p>Delaware Grant funding: \$4.4M Medicaid Expansion: Working 110% FPL, Jobless 100% FPL</p> <ul style="list-style-type: none"> In July 2012, governor announced state would pursue partnership exchange Has conducted initial assessments, including IT gap and essential health benefits analyses Leaning toward full Medicaid expansion 	<p>Florida Grant funding: \$1.0M (returned) Medicaid Expansion: None</p> <ul style="list-style-type: none"> In July 2012, governor announced that Florida would not implement a state exchange Moving forward to create a new marketplace for small businesses called the Florida Health Choices Corporation Not likely to expand Medicaid
<p>Kentucky Grant funding: \$66.6M Medicaid Expansion: None</p> <ul style="list-style-type: none"> Established in 2012 by executive order Executive director has been appointed Exchange will be governed by an advisory board Held public forums on state exchange Leaning toward full Medicaid expansion 	<p>Illinois Grant funding: \$39.0M Medicaid Expansion: None</p> <ul style="list-style-type: none"> In July 2012, governor indicated state would pursue partnership model Plans to move toward a state-based exchange by 2015 Passed exchange legislation, conducted initial analysis, and began IT development Undecided on Medicaid expansion 	<p>Alaska Grant funding: \$0 M Medicaid Expansion: None</p> <ul style="list-style-type: none"> In July 2012, governor announced that Alaska would not create a state exchange Only state in nation that did not apply for exchange planning grant Evaluating options and financial impact for a state-funded exchange Not likely to expand Medicaid
<p>New York Grant funding: \$183.2M Medicaid Expansion: Working and Jobless 100% FPL</p> <ul style="list-style-type: none"> Established in 2012 by executive order Several stakeholder analyses conducted on exchange design Moving forward with plans for integrated IT infrastructure Leaning toward full Medicaid expansion 	<p>Arkansas Grant funding: \$8.9M Medicaid Expansion: None</p> <ul style="list-style-type: none"> In December 2011, governor endorsed partnership model concept Has released exchange framework Leaning toward full Medicaid expansion 	<p>Texas Grant funding: \$1.0M, (\$0.9 returned) Medicaid Expansion: None</p> <ul style="list-style-type: none"> In July 2012, governor announced that Texas would not establish an exchange Prior to announcement, state had used federal funds to identify subcontractors for preliminary analysis/planning Not likely to expand Medicaid
<p>13 states and the District of Columbia have declared to HHS that they will create state run exchanges. These states have received 76% of federal grant funding. Most of the money is being used to develop an IT infrastructure, with the remainder focused on staffing, consulting and stakeholder engagement.</p>	<p>3 states have announced that they are planning for a partnership exchange. These states have received 3% of federal grant funding. Money is being used to define business and information system requirements and develop operational plans.</p>	<p>8 states have announced that they will not create state exchanges so will be governed by the FFP. These states have received approximately 2% of federal grant funding. Money is being used to study current markets and structures.</p>

26 states have not announced their intentions.

* Grant funding includes \$36m in early innovator money received as part of the New England States Collaborative for Insurance Exchange.

Sources: Kaiser Family Foundation, HealthCare.gov, interviews with Vermont, Kentucky, and New York state exchange officials.

individual eligibility changes,” said Brian Haile, exchange director. Tennessee is considering a “bridge” option which would allow families to stay on the same insurer with the same card regardless of whether they have Medicaid, CHIP or subsidies and regardless of eligibility changes. In a state where all Medicaid and CHIP beneficiaries are in managed care, Tennessee believes, if structured correctly, it can fold in exchange consumers to reduce potential confusion over coverage.

Private exchanges

Private exchanges run by insurers, retailers or another third party, offer three other types of exchanges.

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.

In 2011, Minnesota-based insurer Medica partnered with Bloom Health, a company that offers online shopping with in-person customer support to produce a private exchange. The My Plan by Medica exchange now serves more than 50 employers and 15,000 people. It is built on a business model that allows employers to tailor their Medica plan designs and overlay them with different provider networks to bring more plan options to their employees.²⁷

“There’s a huge latent demand for employers that want a cost solution while keeping their employees happy,”

Abir Sen, CEO of Bloom Health, said, explaining the growth of the firm. “Our goal is to better manage costs while providing a better experience.”

Humana is another insurer that’s been working on its private exchange for the past year with a strong focus on the customer experience, using a data gathering system to create a user experience that mirrors that of retail shopping.

“We believe the new retail purchasing environment requires a deep understanding of consumer preferences,” said vice president of market and business segment operations Lois Gargotto, who is leading Humana’s private exchange development. “Our personal profile tool collects data directly from the consumer during enrollment so that we can offer customized product bundles with intelligent messaging for the consumer.”

The retailer-run model encompasses companies outside of the health industry that sell their own insurance products, cobranded 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 generic.

Insurers are also considering how to build consumer-facing private exchanges that highlight their products as well as direct members to the public exchanges if they are subsidy eligible. 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 the purchasing experience is lead by familiar companies.

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 non-profit. Large brokers and benefit firms are two examples.

California based CHOICE Administrators has been in the private exchange business since the early 1990s and focuses on small employers with less than 100 employees.

“In an exchange, employees spend money differently than employers think,” said Ron Goldstein, president and CEO of CHOICE Administrators. “Individuals often buy up when they understand their choices.” Choices can currently include services such as vision, chiropractic service or more coverage for family members. “We’ve relied heavily on the broker network to educate the individuals and as more choice is introduced into the system, we’ll need the brokers to continue to play that educator role,” he added.

Another dimension of the private exchange model is the way that choice is brought to the customers—through money and benefits. In the defined contribution model, employers give specific dollar amounts on behalf of their employees to purchase coverage, with any remaining contributions available for additional coverage and/or other health expenses. In the defined benefits approach, employees choose from a variety of benefit options based on a budget set by the employer.

²⁷ Conversation with Abir Sen, CEO of Bloom Health, August 30, 2012.

Figure 4: Anatomy of an exchange

Two categories of exchanges will exist: public and private. On the public side, there are state-run, state-federal partnership and federally-facilitated exchanges. On the private side, insurers, third parties and retailers operate exchanges. Public exchanges perform five core functions. Mechanisms to neutralize risk for insurers and the government are either managed by the state or other agencies. Each public exchange must connect to a federal data hub and state Medicaid and CHIP programs.

		Public exchanges		
		State run	State/Federal partnership	Federally-Facilitated Exchange (FFE)
		State is responsible for oversight and execution of five core functions	Federal government oversees some functions; states have choice of two core functions for administration	Federal government is responsible for overseeing all 5 core functions
Five core functions	Eligibility • Applications • Information verification • Coordination: Medicare/CHIP • Redeterminations and appeals	●	●	●
	Enrollment • Enrollment • Payments	●	●	●
	Customer service • Consumer support • Education/outreach • Navigator function • Call center • Website	●	● ○	●
	Plan management • Plan selection (active v. passive) • Plan rate, benefit analysis • Monitoring and oversight of insurers • Data collection/analysis	●	●	●
	Financial management • User fees • Support of risk adjustment, reinsurance, risk corridor programs • Financial integrity	●	●	●
Risk Management	Risk adjustment • Protects health plans in individual and small group markets from adverse selection • Both inside and outside exchange • State-run exchanges may operate	●	●	●
	Reinsurance • Operates from 2014-2016 (possibly to 2018) • Protects issuers from high-cost members • States have option for self- or HHS administration	●	●	●
	Risk corridors • Will limit variation in gains/losses by QHPs • Intended to stabilize market • Operates from 2014-2016 • Administered by HHS	●	●	●
External links	Link into federal data hub (APTC/CSR) • Link to federal data hub to help determine Advance Premium Tax Credit, Cost Sharing Reduction • Federal data hub links to DHS, SSA and IRS	●	●	●
	Link to State Medicaid/CHIP Program • Eligibility data for Medicaid/CHIP is transmitted to state Medicaid office for enrollment	●	● △	● △

Private exchanges		
Insurer	Third party	Retail
<ul style="list-style-type: none"> • Run by insurer(s) • Promotes group plans from that carrier • Allows employee to select from several options, provides comparison tools and support • Less ability to control pricing 	<ul style="list-style-type: none"> • Run by a third party such as a vendor or benefits company • Multiple insurers participate • Potential incentive to keep pricing lower (not as much as government run exchanges) 	<ul style="list-style-type: none"> • Run by retail company • Promotes selection of retail health products, including insurance and other products • Partner with insurers to create in store distribution channels
<p>May use either of the following approaches if exchange is employer focused v. an individual exchange</p>		
<p>Defined Contribution Employer provides set amount of money on behalf of employee. Employee chooses plan via exchange and uses remainder to pay for expenses or additional insurance. <i>Target: Employers seeking to maintain coverage but control costs.</i></p>		
<p>Defined Benefit Exchange presents a range of plan options for employees to select from. Employer shares cost with employees, but does not use defined contribution. Exchange may work with employer to customize products. <i>Target: Employers satisfied with status quo that wish to provide employees with better decision-making tools.</i></p>		

- State function
- State or Federal function
- Federal function
- States can choose to run consumer assistance functions, including education and outreach as well as a navigator program.
- State chooses if HHS will determine enrollment eligibility or provide data for state decision. OPM administers multi-state plans.

Sources: Center for Consumer Information and Insurance Oversight, Robert Wood Johnson Foundation, PwC Health Research Institute Analysis, 2012.

Health 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.²⁸ After states make people aware of the fact that subsidized insurance exists, companies that want to capture the new business must develop a clear understanding of these future customers and how to forge longer-lasting relationships with them.

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.

“Larger insurers may have an advantage over smaller insurers in turning a profit under the small margins,” said Joel Ario, managing director of Manatt Health Solutions and the former head of insurance exchange planning at HHS. “Large-scale acquisitions are a likely outcome.” However, in some markets, where there are fewer players, regional insurers and accountable care organizations that know their customer base and can be competitive on price and benefits could provide tough competition to the larger companies.

The pace of state exchange planning also poses challenges for insurance companies that are evaluating which markets to enter or exit. The timeline to begin qualifying health plans begins in October but no state is ready. High-progress states such as California and

New York hope to begin health plan certification in early 2013. 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 15-20% 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% for the first few years as part of the so-called risk corridor function, a temporary program that limits gains and losses by insurers operating 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.²⁹

In addition to public exchanges, insurers continue to eye opportunities in the private exchange world, including with small businesses.

²⁸ CBO and PwC HRI analysis.

²⁹ Kaiser Family Foundation, Focus on Health Reform: Explaining Health Care Reform, February 2012 and Robert Wood Johnson Foundation, Health Affairs: Health Policy Brief, August 30, 2012.

“Once the exchanges are established, expect to see provider organizations developing products to compete with insurers on all lines of business.”

Stephen Jackson, health industry investor

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 potentially also manage risk. Winners will likely find a way to communicate with consumers in a manner that non-healthcare professionals can understand.

Providers

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

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

Providers will also 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 reevaluating their reimbursement and billing structures.

Provider-owned health plans and ACOs could be well positioned. “Once the exchanges are established, expect to see provider organizations developing products to compete with insurers on all lines of business,” said health industry investor Stephen Jackson. “They will be able to offer lower-cost products with the advantage of local name recognition/reputation and insurers could become the backroom for these organizations.”

Employers

Employers of every size and shape are contemplating the role of exchanges in the future—and whether they 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.³⁰ Employers eliminating coverage would likely face increased

³⁰ Kaiser Family Foundation: The penalty is \$2,000 annually times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.

pressure to raise wages. Numerous tax benefits from offering health benefits would also be lost if a firm decides to drop coverage. And, employees view healthcare as a valuable benefit—one that can give businesses a competitive edge.

The decision to drop insurance coverage is most likely to 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 2013, employers will be required to notify employees about the new exchanges, providing detailed information on services offered and subsidy eligibility.³¹ The business must also clarify that it will not provide a contribution toward coverage if the employee enrolls in an exchange plan.

Pharmaceuticals and life sciences

As newly-insured consumers gain access to healthcare services and products, pharmaceutical and life sciences companies will gain new customers. However, manufacturers will have to expand and diversify market access strategies as health exchanges are implemented and evolve in order

to gain financial rewards from the expansion in health coverage.

States will have considerable flexibility in defining the requirements that participating plans must follow when designing their benefit structure and formularies. Current federal guidance stipulates only that exchange plans must offer at least one drug per class.³² Depending on the type of benchmark plan selected by states, manufacturers will be confronted with a spectrum of pharmacy benefit structures ranging from restrictive formularies to a comprehensive benefit similar to that offered through the Federal Employee Health Benefits Program (FEHBP).

Manufacturers will have to account for state-level variation in developing strategies around market access. Drug companies can initially draw upon their experience and resources devoted to other managed markets such as Medicaid. Over time, qualified health plan participation rules may impose additional requirements such as evidence that demonstrates superiority to medications and devices already covered in a therapeutic category.

If more states choose to adopt the FEHBP open formulary design as a default, this could be a boon for branded drug manufacturers looking for continuity and maximum pharmaceutical coverage. On the other hand, more limited formularies would further drive usage of generic medications.

³¹ IRS, <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>.

³² The Kaiser Family Foundation: Health Reform Source. “Private Insurance Benefits and Cost-Sharing Under the ACA,” February 28 2012.

The long-term outlook

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

Yet the 2010 law is neither the first nor the last word on the future of exchanges. Even if a future Congress and administration scale back or repeal the law, exchanges remain a hot prospect, as evidenced by the private sector entering this new market.

While states may establish their exchanges as passive “open markets,” they are likely to shift to the active purchaser approach as they gain enrollees, plan participants and

ultimately buying power over the long run.³³ Investors such as Jackson view 2014 as the start of a major new trend in the US health system—away from employers managing coverage to a robust, open marketplace.

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 MLR 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.

³³ Interview with Joel Ario, managing director of Manatt Health Solutions and the former head of insurance exchange planning at HHS, September 10, 2012.

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Kelly Barnes
Partner
Health Industries Leader
kelly.a.barnes@us.pwc.com
(214) 754 5172

David Chin, MD
Principal (retired)
david.chin@us.pwc.com
(617) 530 4381

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312 7910

Sandy Lutz
Managing Editor
sandy.lutz@us.pwc.com
(214) 754 5434

Benjamin Isgur
Director
benjamin.isgur@us.pwc.com
(214) 754 5091

Serena Foong
Senior Manager
serena.h.foong@us.pwc.com
(617) 530 6209

Caitlin Sweany
Senior Manager
HRI Regulatory Desk
caitlin.sweany@us.pwc.com
(510) 506 8972

Matthew DoBias
Senior Manager
HRI Regulatory Desk
matthew.r.dobias@us.pwc.com
(202) 312 7946

Bobby Clark
Senior Manager
HRI Regulatory Desk
robert.j.clark@us.pwc.com
(202) 312 7947

Sarah Haflett
Manager, Health IT Research
sarah.e.haflett@us.pwc.com
(267) 330 1654

Christopher Khoury
Senior Manager
christopher.m.khoury@us.pwc.com
(202) 312 7954

Advisory team

Jeffrey Gitlin
Principal
jeffrey.gitlin@us.pwc.com
(860) 241 7056

Sandra Hunt
Principal
sandra.s.hunt@us.pwc.com
(415) 498 5365

Jack Rodgers
Managing Director
jack.rodgers@us.pwc.com
(202) 414 1646

Stacy Sachen
Principal
stacy.sachen@us.pwc.com
(801) 537 5238

Kristen Soderberg
Manager
kristen.a.soderberg@us.pwc.com
(202) 346 5143

Mike Thompson
Principal
michael.thompson@us.pwc.com
(646) 471 0720

John Utz
Manager
john.t.utz@us.pwc.com
(860) 241 7448

Health Industries marketing

Todd Hall
Director
todd.w.hall@us.pwc.com
(617) 530 4185

Nadia Leather
Director
nadia.m.leather@us.pwc.com
(646) 471 7536

About this research

The HRI analysis utilizes a combination of data from the Current Population Survey, Medical Expenditure Panel Survey and Congressional Budget Office publications. It reflects the previously insured, newly insured populations and projected health insurance exchange members up through the age of 64. The data assumes full implementation of the ACA in 2021. For educational attainment and work force status, the analysis is restricted to adults, ages 25-64, and ages 18-64, respectively. HRI's research also included interviews with 15 health industry and government leaders.

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Darin Gordon Director and Deputy Commissioner TennCare, Department of Finance and Administration State of Tennessee	Lindsey Tucker Deputy Commissioner Health Benefits Exchange Division Department of Vermont Health Access
Brian Haile Director Tennessee Insurance Exchange Planning Initiative State of Tennessee	
Audrey Haynes Secretary Cabinet for Health and Family Services State of Kentucky	
Danielle Holahan Director of Policy and Planning New York State Health Benefit Exchange	

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about how this subject
may affect your business,
please contact:***

Jeffrey Gitlin
Principal
jeffrey.gitlin@us.pwc.com
(860) 241 7056

Sandra Hunt
Principal
sandra.s.hunt@us.pwc.com
(415) 498 5365

Stacy Sachen
Principal
stacy.sachen@us.pwc.com
(801) 537 5238

Ceci Connolly
HRI Managing Director
ceci.connolly@us.pwc.com
(202) 312 7910