

HEALTH INSURANCE EXCHANGES – POTENTIAL OPPORTUNITIES

*M. Orry Jacobs, Senior Advisor, BDC Advisors, LLC, and
Bill Eggbeer, Managing Director, BDC Advisors, LLC*

One of the major provisions of The Patient Protection and Affordability Care Act of 2010 (the Act) calls for the development of Health Insurance Exchanges to provide “...competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors.”¹

We believe that the Exchanges will have substantial implications for providers, and that the time for preparation is now. The Exchanges will require health systems to throw out their current contracting playbook, and develop a new payer strategy based on a market in which employers have a decreasing role in health purchasing decisions, and consumers bring their ruthless penchant for price slashing to our market.

There are three critical areas that providers must understand as we move into this new era of health care payment:

1. **The Basics:** The basics of the law, and how it will play out in the provider’s individual state. We provide some assistance here, in our appendix – *Health Insurance Exchanges 101*. If you are unfamiliar with the regulations we recommend that you begin with the appendix for a quick review of the basics.
2. **Implications for Providers:** Most importantly, providers need to understand that the Exchanges have real and knowable implications for their business. We present these in our first section.
3. **Unanswered Questions:** As Donald Rumsfeld so eloquently put it, in strategy “there are known knowns, known unknowns, and unknown unknowns.” While we cannot help with the latter, we can offer guidance on the “known unknowns” that you should be preparing for. We do this in the second section.

Implications for Providers

Despite the fact that there remain substantial unknowns about the implementation of the Exchanges, we do know enough to predict substantial implications for providers.

¹ This paper is based upon the preliminary regulations issued on 7/11/2011.

- **No More Clothes For The Emperor – More Transparent Than Ever Before**
Consumers will have much more data available about the health benefit plans offered through the Exchanges, and this data will include information about the quality of the providers. Imagine if your insurers took all of the data they have about your performance, and made it publicly available to everyone in your market. It is likely to go beyond even that scenario - providers will likely be required to provide more data to the Qualified Health Plans and the Qualified Health Plans will likely be making more data available about the providers in their networks.
- **The End of Not-for-Profit Status?**
While the Exchanges are not expected to provide universal coverage, the expectation is that hospitals will have substantially lower charity and bad debt expense. The first response to this will be a decrease in disproportionate share payments. However, politicians, on the lookout for means to increase revenues without raising taxes, are already examining the possibility of modifying the not for profit status of hospitals. The thinking goes: If hospitals are not providing charity care, then why are they not paying taxes?
- **The Exchanges Creating the “Walmart Effect”...**
For years providers have dreamed of cutting out the middleman (the insurers) and appealing directly to the patient (the consumer). This may have been an errant wish. When consumers do the buying, prices generally collapse (just take a look at what the combination of Southwest Airlines’ appeal to the non-business traveler (consumer) and the internet initially did to airline prices). Suppliers to Walmart need to have a laser focus on being the low cost leader – or they fail. While the middleman (the insurer) will remain, individual consumers will be making the buying decision for themselves. We expect that many will buy on the Exchange the same way they buy on Travelocity, Amazon, and at Walmart – largely based on price.
- **The “Walmart Effect” Will Cause a Shift In Payment Methodologies.**
The Exchanges create the ability for consumers to compare premiums on an “apples to apples” basis across similar benefit plans (e.g. silver, gold). In order to be competitive in this “Walmart “ environment the plans will then need to apply that downward pressure on unit payment rates to providers. There is no doubt that plans will be looking to new payment methodologies that will bring down prices more rapidly – including bundled payment, shared savings, and capitation. This may lead to payers and providers working more closely together to lower health care costs.
- **Low Prices and Narrow Geographies Will Lead to the Rise of Narrow Networks**
The minimum geographic area for a Qualified Health Plan generally specified in the draft regulations is a county. This should increase the potential to offer a narrow-network product at an attractive premium, particularly if the employers offering coverage through the Exchange allow many options for their employees. Rather than having employers select plans that have provider networks which cover a wide geographic area encompassing most of the homes of employees,

as they do currently, employees may be able to individually select a plan with providers in locations tailored to their needs. A health system or network offering a narrow network plan through a payer at an attractive price may be able to increase market share.

- **The End of the Cross Subsidy**

It is hard to imagine a future in which consumers are looking to buy the cheapest healthcare product, and being satisfied with a world in which their premiums subsidize care for Medicare and Medicaid patients. Health systems will need to find a way to make these programs profitable on their own.

Unanswered Questions

There is still a great deal of uncertainty about how Health Insurance Exchanges will function.

- **What form will an Exchange(s) take in your State(s)?** – Two States (Massachusetts and Utah) already have exchanges, 11 states enacted legislation to establish an Exchange, 6 states are pursuing an Exchange through administrative channels, 2 states have said they won't establish an Exchange, and the rest are in various stages of consideration.² Given the flexibility provided in the draft regulations to the States, it will be important to monitor (and possibly influence) the specific form an Exchange will take in your State. (see The Commonwealth Fund Blog for the Exchange status in your State).
- **Who will participate in the Exchanges and how big will they be? Will employers and/or individuals drop coverage and pay the penalties?** – The size of the Exchanges will depend on decisions by many people that have not yet been made. Will the mandate for individuals to buy health insurance withstand the current court challenges? If so, will individuals buy insurance policies in the Exchanges or opt out by paying the fine (\$95 in 2014, \$325 in 2015, and \$695 or a percentage of taxable income in 2016)? Similarly, there is much speculation as to the number of employers that will stop providing health insurance to their employees and pay the \$2,000 penalty per employee. While this has so far not been the case in Massachusetts, various survey results and analyses predict the range of employers dropping coverage to be from 2-30%, with the Congressional Budget Office predicting 7%. If a significant percentage of employers drop coverage, will Congress choose to increase the penalty in an effort to discourage employers from dropping coverage? Decisions on either the individual mandate or the small employers' choices will ultimately determine how many people purchase their insurance through an Exchange.
- **How will providers be paid?** – What rates will providers be paid by the payers offering the QHPs? Will the rates be typical commercial rates, Medicaid rates, or something in between? How much strength does your Hospital/System/Network have in negotiating rates with the QHP payers?

² The Commonwealth Fund Blog, "State Health Insurance Exchange Legislation: A Progress Report, September 12, 2011

- **Will Exchanges expand to include Medicaid or larger employers?** – The regulations allow States to offer QHPs through Exchanges beginning in 2017. If so, the population acquiring coverage through an Exchange could grow significantly. The draft regulations require that individuals be able to apply for enrollment through an Exchange and receive a determination for eligibility for advance payment of premium tax credit, cost-sharing reduction, Medicaid, or CHIP. This could significantly increase the number of insured individuals.
- **Will the information on cost and quality made readily available through the Exchanges result in consumers altering their choice of plans and providers?** – A great deal of data relating to cost, quality, and consumer satisfaction is required to be made available online by the Exchange. While less than 30% of the population currently report that they look online for data on physician quality and less than 20% for data on physician costs³ the percentages appear to be growing. While transparent cost and quality information will likely have some impact on consumer purchasing decisions, the degree to which this will occur and the relative influence of cost versus quality versus consumer satisfaction data is unclear.

Conclusion

Given both the flexibility available to the states in structuring their Exchange(s) and the unknowns discussed above, it will be important for providers to closely monitor the developments in their own state(s) and future regulations to be issued. In addition, it may be useful to begin dialogues now with payers to discuss how one might best collaborate in developing QHPs for the provider's service area. As always, the question is how to turn this significant change into a competitive advantage!

³ 2011 Survey of Health Care Consumers in the United States: Key Findings, Strategic Implications, The Deloitte Center for Health Solutions

APPENDIX: Health Insurance Exchanges 101

It is hoped that provisions to expand Medicaid coverage and provide subsidies in the form of tax credits for families earning up to 400% of the Federal poverty level, together with the Exchanges, will significantly reduce the number of US citizens who are uninsured (currently more than 43 million). "Up to 30 million people are expected to enroll in a health plan through their state exchange by 2020, either on their own or through their employer."⁴ The Congressional Budget Office estimates that 95% of the population will have health insurance coverage by 2016, as a result of the Act.

States can establish two types of Exchanges:

1. American Health Benefit Exchange for the individual market
2. Small Business Health Options Program (SHOP) for the small business market

A State can combine the two types into one Exchange. States can also cooperate to form multi-State Exchanges, or decide not to establish an Exchange and the Federal government will step in and provide one. The Exchanges must be administered by a governmental agency or a non-profit agency, must be in operation by 1/1/2014, and must be financially self-sustaining by 1/1/2015. Applications for establishing an Exchange are to be submitted to HHS by 1/1/2013, although all of the required elements do not have to be operational by that date.

The minimum functions that an Exchange must fulfill are:

- Implement procedures for certification/recertification of health plans as qualified health plans (QHPs)
- Provide for the operation of a toll-free telephone hotline (call center) to respond to requests for assistance and a Navigator program to help prospective enrollees make enrollment decisions and facilitate the enrollment process
- Maintain a website for obtaining standardized comparative information on such plans
- Assign a rating (quality and cost) for each qualified health plan
- Use a standardized format for presenting health benefits plan options
- Inform individuals of Medicaid eligibility requirements
- Establish and make available electronically a calculator to determine the actual cost of coverage after any premium credit

Each managed care organization applying to have one or more QHPs in an Exchange must be accredited by an accrediting entity recognized by HHS with the accreditation covering the following categories:

- Clinical quality measures, such as HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access

⁴ The Commonwealth Fund Blog, "State Health Insurance Exchange Legislation: A Progress Report", June 16, 2011

- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

There are four categories of health benefit plans which QHPs may offer: bronze, silver, gold, and platinum. They correspond to 60%, 70%, 80%, and 90% of the actuarial value of benefits provided under the health benefit plan, respectively. The HHS Secretary will specify a minimum set of health benefits (essential benefit package) that must be included, and they must be equal to the benefits provided under a typical employer plan. Each QHP is required to offer at least a silver and gold plan.

The minimum criteria for certification as a QHP issuer/QHP are:

- Offering the essential benefit package
- Adhering to cost-sharing limits
- Being licensed to offer health insurance
- Compliance with quality standards established in the law and regulations
- Non-discrimination as defined in the law and regulations

Exchanges must consider premium rates and trends in the certification process.

Exchanges are given significant flexibility on how inclusive they need to be in certifying QHPs for participation in the Exchange. They may:

- Accept all QHPs that meet the minimum required standards
- Limit participation to those QHPs that score highest on a set of criteria established by the Exchange
- Employ case by case negotiation with managed care organizations to decide which QHPs to list in the Exchange.

Therefore, some states will have an open market that includes any QHP meeting the minimum requirements, while other states may select a small number of QHPs to participate in the Exchange.

For individuals, the Act provides for expansion of Medicaid eligibility through increasing the minimum income threshold to 133% of the Federal poverty level for anyone under age 65 (currently many state Medicaid plans do not cover childless couples at all) and also through offering tax credits to those earning up to 400% of the Federal poverty level. According to *The Wall Street Journal* (7/12/2011), tax credits would be as follows for a 40 year old with spouse and 2 children and total premium of \$12,130:

% of Poverty	Enrollee Out-of-Pocket Cost	Subsidy
400% (\$93,700)	\$8,901	\$ 3,229
300% (\$70,275)	6,676	5,454
200% (\$46,850)	2,952	9,179
150% (\$35,137)	1,405	10,725

The second type of Exchange, the Small Business Health Options Program (SHOP), is designed to offer small employers affordable health insurance for their employees. Small employers are defined as having 1–100 employees. States have the option of limiting the designation of small employer to those having 1-50 employees until 2016. Beginning in 2017, states will have the option to allow SHOPs to offer QHPs in the large group market. An employer who participates is required to offer coverage in a QHP, at a minimum, to all full-time employees.

The regulations provide Exchanges with significant flexibility as to how wide a range of plan options it can offer to employers. Exchanges can allow employers to:

- Have employees choose from any QHP offered in the SHOP at any level of coverage
- Select specific levels from which an employee may choose a QHP, e.g. choose from any gold or silver plan
- Select specific QHPs from different levels of coverage from which an employee may choose a QHP
- Select a single QHP to offer employees

The Exchange is required to be able to provide a single bill to an employer and collect a single payment, even if multiple QHPs are involved, and the Exchange is then required to distribute the payments to the appropriate QHP issuers.

The Act and draft regulations contain a number of provisions to minimize the issue of adverse selection and mitigate risk to QHP issuers (more detail will be offered in a subsequent BDC Advisors paper). One of these provisions requires a QHP issuer to

charge the same premium rate without regard to whether the plan is offered through an Exchange, or it is offered directly from the issuer or through a broker. A QHP issuer must offer QHPs that cover each of the following groups:

- Individuals
- 2 adult families
- 1 adult families with child(ren)
- All other families

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For more information, contact M. Orry Jacobs, Senior Advisor,
BDC Advisors, LLC at 216.470.3352, or orry.jacobs@bdcadvisors.com, or
Bill Eggbeer, Managing Director, BDC Advisors, LLC
at 410.544.7402 or bill.eggbeer@bdcadvisors.com.