health insurance exchanges bring potential opportunities

One of the major provisions of the Affordable Care Act (ACA) calls for the development of health insurance exchanges to provide “…competitive market-places for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors.” With the recent decision by the U.S. Supreme Court to uphold the constitutionality of the ACA, implementation of the health insurance exchanges will proceed. States have the option of developing their own exchanges or having the federal government provide one for them.

Given that the exchanges could have substantial implications for providers, the time to prepare for them is now. The exchanges will require health systems to modify their current contracting playbook and include a new payer strategy based on a market in which employers have a decreasing role in healthcare purchasing decisions and in which consumers have a bias toward shopping for lower-cost health plans.

Implications for Providers
Although many important questions about the details of exchange implementation remain unanswered, the strategic implications for healthcare providers are clear. Exchanges will have a profound impact on the healthcare marketplace, with implications for the role of consumers in decision making, payer mix, prices, margins, and even, potentially, the phenomenon of the “tax-exempt” provider sector.

Unprecedented transparency. Consumers will have much more data available about the health benefits that plans offer through the exchanges, and these 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.

a. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, Federal Register, March 27, 2012.
(QHPs)—that is, the health plans that are certified to offer insurance through an exchange. And the QHPs will, in turn, likely publicize these data, too, regarding providers in their networks.

**The “Walmart Effect.”** For years, healthcare providers have dreamed of cutting out the middlemen (the insurers) and appealing directly to the patients (the consumers). This may have been an errant wish. With the exchanges, although the insurer will remain, individual consumers will make the buying decision for themselves. And when consumers do the buying, there’s likely to be downward pressure on price, because many will buy on the exchanges the same way they buy on Travelocity and Amazon, and at Walmart—largely based on price. Consider Walmart, in particular: Suppliers to Walmart need to have a laser focus on being the low-cost leader—or they fail.

This “Walmart Effect” also will likely result in new payment methodologies. The exchanges will allow consumers to compare premiums on an “apples-to-apples” basis across similar benefit plans (e.g., silver, gold). To be competitive in such an environment, the plans will then need to apply that downward pressure on unit payment rates to providers. They will likely continue to look to new payment methodologies—such as bundled payment, shared savings, and capitation—that will bring down prices more rapidly. This trend could have the beneficial effect of encouraging payers and providers to work more closely together to lower healthcare costs.

**Low prices and narrow geographies will lead to a rise in narrow networks.** The minimum geographic area for a QHP generally specified in the final regulations is a county. Allowing for such a narrow geographic area should increase the potential for plans to offer narrow-network products at attractive premiums, particularly if the employers offering coverage through the exchange allow many options for their employees. Instead of the current approach in which employers select plans with provider networks that cover a wide geographic area encompassing most of the homes of employees, employees may be able to select their own individual plans, 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 who are looking to buy the cheapest healthcare product will be satisfied with paying premiums that have been adjusted to subsidize care for Medicare and Medicaid patients. Health systems will need to find a way to operate profitably under these government programs on their own.

**The possible end of not-for-profit status.** Although the exchanges are not expected to provide universal coverage, the expectation is that hospitals will have substantially lower charity and bad-debt expense. This change will initially prompt a decrease in disproportionate share payments. The next step is likely to be a challenge to the very existence of the not-for-profit status of hospitals, given that politicians, already on the lookout for ways to increase revenues without raising taxes, are already contemplating this issue. With declines in charity care and bad debt, the question will be, If hospitals are not providing charity care, then why are they not paying taxes?

**Unanswered Questions**

There is still great uncertainty about how health insurance exchanges will function, but it is reasonable to speculate about the possibilities and their implications.

**How will the forms of exchanges differ from state to state?** As of the date of publication of this article, the status of exchanges in states around the country was as follows:

- Fifteen states and the District of Columbia had exchanges in place.
- Sixteen states were studying options.
- Three states were planning for partnership exchanges.
- Eight states said they would not establish exchanges.
- The remainder had not shown significant activity.

b. Kaiser Family Foundation, “State Action Toward Creating Health Insurance Exchanges, as of September 27, 2012,” statehealthfacts.kff.org (search on "health insurance exchanges").
Given the flexibility provided to the states in the final regulations, healthcare providers will find it important to monitor—and possibly influence—the specific forms exchanges will take in their states.

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 many decisions that have not yet been made. 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. Various survey results and analyses predict the range of employers dropping coverage to be from 2 to 30 percent, with the Congressional Budget Office (CBO) predicting 7 percent, although the higher percentages have not been seen in Massachusetts. If a significant percentage of employers were to drop coverage, would Congress 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? The rate will likely affect how much strength a hospital or health system has in negotiating rates with the QHP payers.

Will exchanges expand to include Medicaid or larger employers? The law allows states to offer QHPs to larger groups through exchanges beginning in 2017. If this timeline goes as planned, the population acquiring coverage through exchanges could grow significantly. The final 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 the Children’s Health Insurance program, which could significantly increase the number of insured individuals.

Will the information on cost and quality to be made readily available through the exchanges influence consumers’ choice of plans and providers? The exchanges are required to make considerable data available online relating to cost, quality, and consumer satisfaction. Although a recent survey found that fewer than three in 10 Americans look online for data on physician quality, and that fewer than one in five look online for data on physician costs, the numbers appear to be growing. The transparent cost and quality information will likely have some impact on consumer purchasing decisions, but the size of this impact, particularly on consumer satisfaction, remains to be seen.

Action Steps
Given that the impact of the health insurance exchanges is likely to be profound, it is definitely not too early to begin preparing for them. Finance leaders should take, or ensure that their organizations are taking, the following action steps.

Monitor state developments. Finance leaders should closely monitor efforts to develop exchanges in their states. A staff member should be assigned to track legislative proposals and actions, and development of related regulations. In any state that declines to sponsor an exchange, monitoring should be focused on federal efforts to develop and implement an exchange in the state.

Prepare for increased transparency. Finance leaders should keep informed of quality, cost, and patient satisfaction metrics that their states plan to make available in 2014 on their exchange websites. They should advocate for their organizations to take aggressive action now to improve performance in those metrics, as it frequently takes time for actions to translate into improved scores.

Consider the impact in financial planning. Given that the advent of exchanges will likely lead to a decrease in the uninsured and an increase in Medicaid roles, and that small group and individual enrollment will likely shift from traditional commercial plans to

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c. 2011 Survey of Health Care Consumers in the United States: Key Findings, Strategic Implications, The Deloitte Center for Health Solutions.
Exchanges at rates substantially lower than today’s commercial rates, finance leaders should ensure that long-range financial plans account for likely declines in bad debt and charity, changes in payer mix, declines in payment rates, shifts in utilization rates, and reductions in disproportionate share funding.

**Consider developing a narrow network product.** Finance leaders should set up discussions with managed care companies about offering narrow network products that may appeal to employees and individuals in the organization’s local area. They should seek perspectives from local employers that are likely to consider participating in an exchange as to the characteristics that are most important to them in selecting plans from which their employees can choose.

**Carefully monitor employer and consumer choices.** Finance leaders should pay attention to the plans that employers and consumers select among those offered by exchanges. They should advocate for their organizations to conduct focus groups or surveys to learn which factors are driving these decisions. This information should be incorporated into the organization’s strategic planning.

**Attentiveness Is Key to Remaining Competitive**

Exchanges could significantly alter the healthcare landscape. It will be important to pay significant attention to their development, and then monitor how they impact the marketplace. As always, the challenge will be how to turn this change into a competitive advantage.

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