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Health Insurance Exchanges: Public Mandate and Private Opportunity



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The Patient Protection and Affordable Care Act (more commonly known as the “Affordable Care Act” or “ACA”) mandated the creation of state-based health insurance marketplaces, since dubbed “Affordable Insurance Exchanges,” which will allow individuals and small groups to research, compare, and enroll in health plans. Like many aspects of the Affordable Care Act, the exchange concept has been subject to political squabbling and uncertainty, due in part to the ongoing presidential campaign process. However, the pace of exchange development, and interest from private companies that intend to compete with the public exchanges, has begun to accelerate.

Background

State-based health exchanges must be created in each state no later than Oct. 1, 2013, the beginning of the mandated public open enrollment period. Insurance coverage under the plans offered through the exchanges will become effective on Jan. 1, 2014. In states that opt not to create their own exchanges, the federal government will be required to implement “federally facilitated exchanges.”

States that intend to establish and operate their own exchanges, either alone or in partnership with the U.S. Department of Health and Human Services (HHS), must notify HHS of their intentions by Nov. 16, 2012. Thirteen states and the District of Columbia have done so as of Oct. 5, 2012. In states that do not do so, HHS will operate federal exchanges. Currently, 16 million people in the U.S. are uninsured, and the Congressional Budget Office has estimated that more than 20 million people will buy coverage through the state exchanges by 2016.

HHS has awarded more than $1 billion in federal grants to be applied toward the establishment of exchanges. Thus far, 49 states and the District of Columbia have received initial Exchange Planning Grants, and 34 states and D.C. have received Exchange Establishment Grants. A few states have also received Early Innovator Grants to develop model Exchange IT systems. States that have not yet applied for grants may continue to do so through 2014.

Not all states will be ready to operate their own exchanges by the Jan. 1, 2014 deadline. Some states delayed taking any action while waiting for the Supreme Court to rule on the constitutionality of the ACA, which it finally did in June, and now will probably not have sufficient time to establish the necessary infrastructure for an exchange even if they want to. Other states, notably including Florida and Texas, have rejected exchanges entirely and may be waiting until after the presidential election before taking any action. Some states have even returned federal grant money that they received.

Currently, only two states, Massachusetts and Utah, operate their own exchanges. The Health Connector, an independent Massachusetts state agency that operates much like the exchanges contemplated by the Affordable Care Act, was created in 2006. The online “Commonwealth Choice” marketplace allows residents of the state to compare plans from all major insurers, and the “Commonwealth Care” program offers a variety of low-or-no-cost health insurance for those who qualify. Today, 98 percent of Massachusetts residents have health insurance.

The Utah Health Exchange, targeted toward small businesses and employer groups, opened for employer enrollment in 2009. The Exchange allows employees to compare health plans and select the one that works best for their individual needs and circumstances. A limited number of larger employers also participate in the Exchange through a pilot program.

In order to participate in an exchange under the Affordable Care Act, an insurance plan must be certified as a qualified health plan

(QHP). The ACA sets forth coverage, premium, marketing and operational requirements for QHPs. It remains to be seen whether states will make the same requirements applicable to plans that choose not to participate in the exchanges.

Private Exchanges: An Opportunity for Growth

Politicians, the media, and much of the public are closely following the development of the public exchanges and the many ongoing intrastate debates on whether to establish a state exchange or a federally facilitated exchange. However, many insurers and other private stakeholders are currently assessing the advantages and disadvantages of creating a private health insurance exchange (or "private exchange").

It is likely that private exchanges will fill in certain gaps left by the public exchanges.

While the insurance plans offered by insurers through public exchanges will be governed by the ACA, insurers in private exchanges may have additional flexibility to tailor their products and services to employers and individuals (so long as they meet the same basic criteria as any company offering insurance, including compliance with state insurance department regulations where required). Private exchanges may also offer insurers the opportunity to develop new markets and create competitive pricing structures for consumers. As a result, it is likely that private exchanges will fill in certain gaps left by the public exchanges.

For example, private exchanges could include different tiers of benefit coverage, additional products such as dental and life insurance, or even non-insurance products. Private exchanges may also be able to distinguish themselves by the level of service or administrative support they offer. Two potential models for private exchanges are:

- Single-Carrier Exchange: A single-carrier exchange is an exchange developed and promoted by one insurer for a specific group such as an employer. Employers that choose this route would likely remain involved in the negotiation and design of the plan. The exchange could include three to five different health insurance products and would likely provide a high level of administrative support to members.

- Multi-Carrier Exchange: In contrast, a multi-carrier exchange would be developed and promoted by third-party intermediaries (brokers or benefit consultants) and would offer numerous products across several insurers.

Caveat Emptor?

Regardless of the model, it appears that private exchanges will create opportunities for insurers to preserve their group purchasing power by driving more consumers to their products. At the same time, exchanges will lower the bar for new entrants, since the overhead costs of operating in a private exchange presumably will be lower than maintaining a traditional sales force. This may result in increased numbers of insurers and plans, overall, suggesting that consumers will need to become savvier purchasers to ensure that the plan they choose best meets their needs.

Private exchanges may cause more potential problems for public exchanges than mere competition, particularly if the states allow insurers to offer different products in the public and private exchanges and do not ensure that regulations for the different exchanges are consistent.

If healthier people have the ability to enroll in more favorable plans offered through private exchanges while people who are in poorer health and have higher health expenses must obtain coverage through the state exchanges ("adverse selection"), the cost of coverage through the plans offered in the state exchanges will be higher than for the plans offered in the private exchanges. This would drive up costs both for those purchasing coverage through the state exchanges, and for the federal government to the extent that it is required to provide premium subsidies to low-income consumers. Higher costs would eventually create higher premiums, further depressing participation in the state exchanges and perhaps jeopardizing their survival.

Lessons Learned From Other Industries

To educate and address insurance purchasers, the public sector will look to the private sector for innovative solutions, and perhaps the most important lesson to be learned is that one size does not fit all when it comes to health care. Private insurers with a well-established brand have the ability to take advantage of this opportunity. By setting up its own private exchange, an insurer may exclusively market its own services in addition to continuing to participate in the states' public exchanges. That does not mean, however, that these single-company exchanges will only offer one product. Much like Hilton has more than 10 different hotel brands, ranging from budget to luxury, a single private insurer would have the ability to target employer groups of different sizes and various segments of the population with a variety of products and price points.

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Search engines may also create a secondary market for both the private and public exchanges. These "exchanges of exchanges" would allow insurers to reach a larger target audience who may not have shopped at a particular insurer's individual exchange. Search engines, however, also have the potential to increase margin compression, resulting in lower profits per product for payors.

For example, in the airline industry, aggregators like Orbitz and Kayak have developed software that scans individual companies' websites to offer the lowest

possible price to the consumer. Similarly, in the automobile insurance industry, companies like Esurance, an Allstate subsidiary, provide insurance quotes from a wide range of auto insurers. While loyal customers may still go directly to one company's website for all their airline or auto insurance needs, increasingly more individuals and companies are using search engines to locate the best price. The same may occur with health insurance, and companies that create a single exchange or enter multiple-carrier exchanges should consider this possibility in their overall marketing strategy.

First Movers in the Market and Trends

Some companies have already entered the private exchange market. On the single-carrier side, Bloom Health, a Minnesota-based private exchange startup, has focused on selling to employers and working with them to address the rising cost of their employees' health care.

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Two of the largest insurers in the country have backed this approach: WellPoint, the largest insurer based on enrollment, and Health Care Services Corp., the largest consumer-owned health insurer, recently purchased a controlling interest in Bloom Health. Bloom Health attempts to define and control health benefits spending through a “defined contribution” approach, which it feels gives employees more flexibility to tailor their health benefits to meet their needs. This approach allows businesses to offer a company health care insurance package while, in theory, minimizing its insurance costs.

On the multi-carrier side, eHealthInsurance provides a wide array of options that can be filtered based on company, monthly costs, deductibles, and coinsurance. Like the Massachusetts Health Connector, these multi-carrier exchanges have had more success signing up individuals than employer groups. Although the simplicity of their websites makes it simple for anyone to shop for insurance, multi-carrier exchanges will need to develop a more robust employer consultation component, at least initially, to capture a larger portion of the insurance business from small and medium-sized companies.

The most significant trend appears to be a shift from the traditional defined benefit plan—common among employers—to defined contribution plans, like the approach used by Bloom Health. Although according to a 2011 Kaiser Foundation survey, 94 percent of companies with 50 or more employees still provided health insurance, a recent report published by the consulting firm McKinsey & Co. estimated that as many as one-third of employers may stop using an employer-sponsored model. This shift would likely mirror a similar trend by employers to contribute to employees' 401(k) retirement plans rather than invest in a company-wide pension program. The benefit to employers of the defined contribution health plan is that employers have a set payment amount and fewer administrative costs. Employees also gain the benefit of choosing their own plan based on their needs and the amount they are willing to spend. This approach requires insurers in a private exchange to provide education and support to companies who will need to understand the legal and tax implications of moving to this fixed contribution system.

In addition, some large retailers of consumer goods may enter the health insurance market. Walmart, Kmart, and several national pharmacy chains are already going beyond merely filling prescriptions by incorporating one-stop health clinics into their stores. Selling insurance would appear to be a natural extension of their current relationship with consumers. These large retailers might have an advantage over other companies due to their trusted brand recognition and large marketing budgets.

Conclusion

Although only two states currently operate their own exchanges, all 50 states will have an exchange by 2014. In addition, private exchanges will be filling in the gaps and competing side-by-side with the public exchanges. Private exchanges offer an opportunity for growth for private insurers, and an opportunity for market disruption by established companies in other industries that can rely on their marketing power and brand strength.

