Health insurance exchanges:
A strategic perspective
Foreword

The Affordable Care Act (ACA) seeks to increase insurance coverage for 32 million uninsured individuals, including 24 million who are expected to obtain coverage through a health insurance exchange according to a Congressional Budget Office (CBO) projection. The number who might eventually obtain coverage through these exchanges may be up to 65 million if employers curtail employer-sponsored insurance (ESI) programs or larger numbers of individuals pursue coverage (Deloitte Center for Health Solutions projection, “Analysis of Insurance Coverage in 2020”). No one knows for sure how many will enroll through exchanges or when; nonetheless, the role state health insurance exchanges play is significant in the context of health reform.

Major strategic questions remain for key stakeholders:

• For states, can they set up and successfully operate an exchange by January 1, 2014? How will the exchange interact with the state’s strategy toward ESI and management of state health benefits coverage and Medicaid programs? Should a state consider allowing the federal government to operate the exchange in lieu of its development?

• For employers, will the state health insurance exchange offer an appropriate opportunity to discontinue traditional ESI and encourage employee purchasing through the exchange? How does such a consideration impact competition for its workforce?

• For health insurance plans, under what set of conditions will a plan choose to participate? What does the potential for decreased ESI mean for health plan strategy long-term?

• For providers, how does the growing influence of health insurance exchange in defining standards of care for the growing number of patients impact payments, operating margins, access to services, and quality expectations? Will exchanges pay providers at rates that result in margin erosion and program curtailment, or will an increased insurance market facilitated by exchanges reduce bad debt and access to timely clinical services by those currently uninsured?

• For consumers, those without insurance and those with coverage currently, will health insurance exchange facilitate access to affordable insurance plans that are easily compared and compliant with optimal health management?

The purpose of this brief is to inform key stakeholders about the current status of regulatory guidance about health insurance exchanges subsequent to a final rule anticipated later this fall.

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Overview of requirements
Section 1311 of ACA requires each state to establish an exchange to serve two markets by 2014: the individual market and the small group market (up to 100 employees). States intent on setting up their exchanges must demonstrate their capabilities specific to basic functions set forth in the proposed rule released July 11, 2011 including enrollee support services, oversight of health plans offered through the exchange (known as qualified health plans [QHPs]), operation of websites, and risk management. If the Secretary of the U.S. Department of Health and Human Services (HHS) determines that a state will not have an exchange operational by 2014, the Secretary of HHS must establish and operate the exchange in that state.

Anticipated coverage
According to the Deloitte Center for Health Solutions analysis, “The Impact of Health Reform on Health Insurance Coverage,” up to 65 million individuals may be covered through health insurance exchanges if employers elect to drop ESI after 2016, or if other market factors drive reduction of traditional coverage (Figure 1).

Figure 1: projected enrollment in millions (% of total) under scenarios A-D in year 2020

<table>
<thead>
<tr>
<th>Health insurance market segment</th>
<th>Scenario</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B1</td>
</tr>
<tr>
<td>ESI, excluding Small Business Health Options Program (SHOP)</td>
<td>128 (39%)</td>
<td>118 (36%)</td>
</tr>
<tr>
<td>SHOP</td>
<td>21 (6%)</td>
<td>19 (6%)</td>
</tr>
<tr>
<td>Individual, excluding health insurance exchanges</td>
<td>3 (1%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Health insurance exchanges</td>
<td>27 (8%)</td>
<td>35 (11%)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>51 (16%)</td>
<td>51 (16%)</td>
</tr>
<tr>
<td>Medicare</td>
<td>61 (19%)</td>
<td>61 (19%)</td>
</tr>
<tr>
<td>Uninsured</td>
<td>34 (11%)</td>
<td>38 (12%)</td>
</tr>
<tr>
<td>Total</td>
<td>327</td>
<td>327</td>
</tr>
<tr>
<td>% covered by commercial plans (group + individual)</td>
<td>54%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Source: Deloitte analysis, “The Impact of Health Reform on Health Insurance Coverage”

1 Not all numbers add due to rounding

Scenario A — “Intended results”: baseline
Scenario B — “Unintended results”: employers drop coverage
Scenario C — “Unintended results”: no individual penalty
Scenario D — “Unintended results”: delays/changes to original legislation

No one knows for sure how exchange enrollment will play out — there are simply too many variables that might influence participation including the effectiveness of the individual mandate in encouraging coverage, health cost inflation that might influence employer decisions, or delays in implementing ACA. Nonetheless, state participation in operating exchanges is required by 2014 with potential enrollment an unknown.
State role
As shown in Figure 2, exchanges aim to provide and enable consumer choice and affordability. The main functions of an exchange, laid out in ACA, include:
• Certifying, recertifying, and decertifying QHPs
• Assigning ratings to each QHPs on the basis of relative quality and price
• Providing consumer information on QHPs in a standardized format
• Creating an electronic calculator to allow consumers to assess the cost of coverage after application of any premium tax credits and cost-sharing reductions
• Operating a website and toll-free telephone hotline offering comparative information on QHPs and allowing consumers to apply for and purchase coverage if eligible
• Determining eligibility for the exchange, tax credits and cost-sharing reductions, and other public health coverage programs, and facilitating enrollment of eligible individuals in those programs
• Determining exemption from the individual mandate
• Establishing a Navigator program to assist consumers in making choices about their health care options

Health plan role
ACA outlined the several criteria plans must meet in order to be deemed a QHP. Figure 3 provides an overview of the requirements, as well as the requirements for the plan sales, distribution, and enrollment. (For additional health plan details, see Minimum requirements for health plan participation under the Summary of proposed rule section.) One key component that has yet to be defined is the minimum essential health benefit package. Per ACA Section 1302, the essential benefits must cover at least the following categories:
• Ambulatory patient services
• Emergency services
• Hospitalization
• Maternity and newborn care
• Mental health and substance use disorder services, including behavioral health treatment
• Prescription drugs
• Rehabilitative and habilitative services and devices
• Laboratory services
• Preventive and wellness services and chronic disease management
• Pediatric services, including oral and vision care

The Institute of Medicine (IOM) will make recommendations on what benefits should be required in QHPs in September; HHS will begin to collect public comments on the issue shortly thereafter.

Figure 2: exchanges offer standardized products following basic functions prescribed by HHS
• Online enrollment
• Rating/pricing
• Plan designs
• Quality and patient satisfaction ratings
• Children’s Health Insurance Program (CHIP)/Medicaid enrollment
• Electronic interfaces
• Subsidy administration
• Risk adjustment
• Coordination with Medicaid/CHIP

Health plan A
Health plan B
Health plan C
Health plan D
Health plan E
Figure 3: criteria for QHPs

<table>
<thead>
<tr>
<th>Product design</th>
<th>Pricing/underwriting</th>
<th>Sales and distribution</th>
<th>Enrollment and eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minimum essential benefits</td>
<td>• Guarantee issue and renewability</td>
<td>• Standard marketing requirements</td>
<td>• Standardized enrollment</td>
</tr>
<tr>
<td>• Actuarially equivalent benefit packages</td>
<td>• Limited underwriting</td>
<td>• Exchanges may determine role of agents and brokers</td>
<td>• Online, mail, phone, and in-person</td>
</tr>
<tr>
<td>– Bronze: 60%</td>
<td>– Geography</td>
<td>• Standard quality, price, and satisfaction ratings</td>
<td>• Subsidy eligibility management</td>
</tr>
<tr>
<td>– Silver: 70%</td>
<td>– Family status</td>
<td></td>
<td>• Coordination with Medicaid and Children’s Health Insurance Program (CHIP)</td>
</tr>
<tr>
<td>– Gold: 80%</td>
<td>– Age (3:1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Platinum: 90%</td>
<td>– Smoking (1.5:1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Catastrophic for under age 30</td>
<td>• No preexisting conditions exclusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Out-of-pocket limits</td>
<td>• Risk adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No annual or lifetime limits</td>
<td></td>
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</tr>
</tbody>
</table>

Four probable operating models

Four health insurance exchange operating models are likely to emerge, each with distinct characteristics (Figure 4).

Figure 4: potential exchange models

<table>
<thead>
<tr>
<th>Model</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Aggregator</td>
<td>Delivers bare-minimum capabilities to meet ACA requirements; enrollment transactions are passed to health plans’ websites. Impartial aggregator of information on health plan products and quality; provides structure to allow plan design and price comparisons.</td>
</tr>
<tr>
<td>Retail-oriented Exchange</td>
<td>Creates a retail shopping experience with robust service capabilities (e.g., the ability to shop by price or benefits needs). Offers a broad range of products varying in price and design, and provides education, outreach, and technical assistance for consumers and enrollment information and assistance.</td>
</tr>
<tr>
<td>Guided Exchange</td>
<td>Limits carriers through competitive selection process. Products may be standardized; more prescriptive mandates and regulatory oversight over market. Functions “owned” by exchange are minimal (e.g., basic tools and plan comparison information). Likely an interim model for states lacking the funds.</td>
</tr>
<tr>
<td>Market Curator</td>
<td>Creates a robust, end-to-end consumer experience from shopping to enrolling. Limits carriers through competitive selection process. Selects products that best fit customers, organizes them, and maintains product data files. Provides extensive member management services (e.g., initial enrollment and billing).</td>
</tr>
</tbody>
</table>
Existing state insurance exchanges

Two states — Utah and Massachusetts — have each developed and established an exchange. These two different models are frequently mentioned as prototypes (Figure 5).

Looking ahead

The rule is open for public comment through September 28, 2011 and HHS expects feedback from all stakeholders. As noted in the next section, the Administration will address several exchange-related issues through upcoming rulemaking and guidance. More details are expected, yet states will likely continue to see the theme of flexibility throughout.

Figure 5: existing exchange prototypes

<table>
<thead>
<tr>
<th>Massachusetts Health Connector</th>
<th>Utah Health Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date started</strong></td>
<td><strong>Enrollees</strong></td>
</tr>
<tr>
<td>• October 2006 (Commonwealth Care)</td>
<td>Two separate single state exchanges:</td>
</tr>
<tr>
<td>• July 2007 (Commonwealth Choice: nongroup)</td>
<td>• Commonwealh Choice connects individuals earning above 300% federal poverty level (FPL) and small businesses (2-50 employees) to commercial insurance options — approximately 30,000 members in 2010</td>
</tr>
<tr>
<td>• February 2010 (Commonwealth Choice: small group)</td>
<td>• Commonwealth Choice connects eligible uninsured low income individuals to subsidized health options — approximately 160,000 members in 2010</td>
</tr>
<tr>
<td><strong>Scope and objectives</strong></td>
<td><strong>Governance</strong></td>
</tr>
<tr>
<td>• Improve consumer’s insurance shopping/buying experience</td>
<td>Semi-independent public entity (separate legal entity from Commonwealth governed by board with private and public sector representatives)</td>
</tr>
<tr>
<td>• Decrease administrative cost of buying insurance</td>
<td>Public agency housed in Governor’s Office of Economic Development</td>
</tr>
<tr>
<td>• Add price resistance to premium setting and insurer negotiations with providers</td>
<td>• Improve transparency with standard tiered plans</td>
</tr>
<tr>
<td>• Improve transparency with standard tiered plans</td>
<td>• Facilitate access to subsidy for those under 300% FPL</td>
</tr>
<tr>
<td>• Offer Internet-based portal that connects consumers to information needed to make an informed choice about their health insurance and facilitates enrollment</td>
<td>• Market organizer</td>
</tr>
<tr>
<td>• Offer employers access to defined contribution market</td>
<td>• Support employee premium aggregation</td>
</tr>
</tbody>
</table>

Summary of proposed rule

July 11, 2011, HHS published a proposed rule setting the minimum standards for health insurance exchanges. Comments will be accepted through September 28, 2011. Overall, the proposed rule is very similar to what is outlined in ACA. States have been afforded a high degree of flexibility in setting exchanges and have more time to demonstrate readiness. Below are key highlights of the proposed rule:

- **Federal requirements that states must meet to establish and operate an exchange:**
  - **Approval of a state exchange:** ACA requires the Secretary of HHS to determine whether a state exchange will be operational by January 1, 2014. Under the proposed approval process, states must submit an Exchange Plan demonstrating how the exchange will meet the minimum federal standards — HHS plans to issue a plan template. Each proposed exchange will undergo a readiness assessment carried out by the Centers for Medicare & Medicaid Services (CMS). The assessment will evaluate whether the exchange can perform its baseline functions and open for enrollment on October 1, 2013. Readiness assessment process may include meetings with state and exchange officials, conference calls, and on-site visits. HHS will issue additional guidance on the structure and schedule of the assessments. Significant changes to an Exchange Plan must receive written approval from HHS before they may be effective. HHS is considering using an approval process similar to that for State Plan Amendments. HHS will issue further guidance on this process. HHS may issue a conditional approval of a state exchange if it determines that it is likely to be fully operational by open enrollment; additional assessments would determine if the state is meeting required benchmarks. Any state without an operational exchange in 2014 may work with the federal government to continue developing its own exchange and to establish a state-based exchange in any subsequent year after a one-year transition period. States are also given the option to cease operations after 2014. The state must give HHS a one-year notice and collaborate on the development and execution of a transition plan.
  - **Governance:** when not run by an executive branch agency, an exchange should be administered by a formal, publicly-adopted operating charter or by-laws; hold regular public meetings; and offer opportunities for public comment on its policies and procedures. Governing board members should have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, or health policy issues related to the small group and individual markets and the uninsured. The voting majority cannot be made up of individuals licensed to sell health insurance. Exchanges should have procedures for disclosure of financial interest.

The small group exchange, SHOP, may have a separate board of governors, if the state ensures the SHOP will coordinate and share relevant information with the exchange. If a state chooses to merge its exchange and SHOP, it must ensure that the exchange has adequate resources to assist both individuals and small employers in the exchange.

- **Regional or multiple exchanges:** an exchange may operate in two or more states, which do not need to be neighboring. States may also have more than one exchange if they do not overlap (e.g., a state could have an exchange in the northern as well as the southern part of the state). If a state chooses to separately operate its exchange and SHOP, the SHOP must encompass the same geographic area of the regional exchange.

- **Existing exchanges:** states with existing exchanges will work with HHS to identify any areas of non-compliance.

- **Minimum requirements for small employer participation:**
  - **Employer size:** until 2016, states can set the size of the small group market up to 50 or 100 employees. Starting in 2017, states can open the SHOP to employers with more than 100 employees.
  - **Structure of choices:** employers can choose the level of coverage they will offer (bronze, silver, gold, or platinum), define their contribution toward their employees’ coverage, and offer employees choices of multiple insurers and plans.

- **Minimum requirements for health plan participation:**
  - An exchange must certify a health plan before that plan can be sold through the exchange as a QHP. The exchange may adopt a variety of models for plan selection, from certifying any plans that meet minimum criteria to taking a more active role in selecting plans according to additional standards.
  - Exchanges may work with local health insurers on structuring QHP choices that are in the best interest of their enrollees. The rule gives exchanges flexibility on accreditation deadlines, allowing new and innovative health plans to sell through the exchange as they gain accreditation.
  - Exchanges, working with state insurance departments, may set the standards to ensure that consumers have a choice of health care providers within each QHP rather than proposing a national standard. Network adequacy and marketing standards would be set by states and exchanges.

- **Other exchange functions:**
  - **Enrollment:** an exchange must use a single streamlined application to determine eligibility and to collect information necessary for enrollment for: (1) QHPs, (2) premium tax credits, (3) cost-sharing reductions, and (4) Medicaid, CHIP, or the Basic Health Plan (BHP).
Navigator program: exchanges must award grant funds to public or private entities to serve as Navigators; duties include maintaining expertise in eligibility, enrollment, and program specifications and conducting public education activities to raise awareness of availability of QHPs. States must establish licensing or certification requirements and cannot support Navigators with federal funding.

Initial and annual open enrollment period: initial enrollment period — October 1, 2013 through February 28, 2014. Annual open enrollment period — October 15 through December 7 (57-day window); as an alternative, HHS is also considering November 1 through December 15 (45-day window). SHOPs will have a rolling open enrollment process to match the small group market outside the exchange. Employers can enter a SHOP at any time, while employees will only be able to enroll or change once a year, unless they meet special enrollment period requirements.

Payment of premiums: three options: (1) take no part in payment of premiums; (2) create an electronic “pass through” without directly retaining any payments; (3) establish process to collect premiums from enrollees and pay an aggregated sum to the QHP issuers. Regardless of the option the exchange chooses, it must always allow an individual to pay directly to the QHP issuer. Premium collection does not make the exchange liable for payment.

Items not addressed: the Administration will address several aspects of the exchange provision in separate rulemaking, including the following:
- The process for eligibility determinations for exchanges, premium tax credits, cost-sharing reductions, and other public programs, along with appeals for those determinations
- Standards related to ongoing federal oversight of exchanges and actions necessary to ensure their financial integrity (e.g., program integrity requirements)
- Benefit design standards for QHPs, including essential health benefits and calculations of actuarial value
- Quality data reporting requirements
- Standards outlining the exchange process for issuing certificates of exemption from the individual mandate

Stakeholder implications
Exchanges will have major implications for all stakeholders in the health care system, as well as employers (Figure 6).

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers</td>
<td>Reduces the burden of researching and contracting with plans; exchanges are intended to spread risk, lower premium costs, and expand coverage options</td>
</tr>
<tr>
<td>Small employers</td>
<td>In addition to consumer implications, small employers may be drawn to obtain coverage through SHOPs via premium tax credits</td>
</tr>
<tr>
<td>Larger employers</td>
<td>If state chooses to expand SHOP to employers with 100 or more employees (in 2017), may provide new coverage options with lower administrative costs</td>
</tr>
<tr>
<td>Health insurance companies</td>
<td>Expands market for health plans initially to individuals and small businesses; role of state a key variable (e.g., a state may function as an active contractor to reduce premium levels by negotiating directly with plans, instead of simply accepting plan bids that fall within pre-established parameters)</td>
</tr>
<tr>
<td>State Medicaid/CHIP</td>
<td>Streamlined applications may assist with enrollment, however income fluctuations may cause movement between Medicaid/CHIP and exchange coverage</td>
</tr>
<tr>
<td>Hospitals and physicians</td>
<td>ACA establishes network adequacy standards to ensure QHPs operate using provider networks that limit enrollment to individuals who live, work, or reside within their service areas; payments by QHPs might be lower than traditional commercial rates, reducing margins of providers</td>
</tr>
</tbody>
</table>
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