Navigating
Health Insurance Exchanges
Key Questions and Implications for Providers
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Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>3</td>
</tr>
<tr>
<td>Implications of the Health Insurance Exchanges</td>
<td>4</td>
</tr>
<tr>
<td>Understanding the Exchanges</td>
<td>6</td>
</tr>
<tr>
<td>Key Questions for Health System Executives</td>
<td>8</td>
</tr>
<tr>
<td>1. Who are the potential health insurance exchange purchasers?</td>
<td>8</td>
</tr>
<tr>
<td>2. How will consumers learn about the exchanges and purchase coverage?</td>
<td>9</td>
</tr>
<tr>
<td>3. How do exchange plans differ from current plans on the individual market?</td>
<td>11</td>
</tr>
<tr>
<td>4. What subsidies are available on the exchanges?</td>
<td>15</td>
</tr>
<tr>
<td>5. How are exchanges and Medicaid expansion related?</td>
<td>17</td>
</tr>
<tr>
<td>6. How will newly covered patients utilize health care services?</td>
<td>19</td>
</tr>
<tr>
<td>7. What opportunities do insurers see in exchange participation?</td>
<td>20</td>
</tr>
<tr>
<td>8. How likely are employers to transfer employees onto exchanges?</td>
<td>22</td>
</tr>
</tbody>
</table>
Implications of the Health Insurance Exchanges

Capturing New Revenue Opportunities

1. By 2016, health insurance exchanges are expected to cover 24 million Americans, many of whom would otherwise not have had coverage; this will reduce the burden of bad debt and charity care for self-pay patients. (p. 8)

2. Although exchange-based health plans are likely to reimburse at lower rates than existing commercial plans, exchange-based plans are required to cover a wider range of services (mostly outpatient) than most commercial plans do, which could provide a volume boost in outpatient screenings, diagnostics, and preventive treatment. (p. 11-12)

3. Because exchange-based plans are required to cover many wellness and preventive services, with little or no patient obligation, health systems can be reimbursed for a broader array of services around maintaining population health. (p. 11-12)

4. Some states that currently offer Medicaid to individuals with incomes above 133% of the federal poverty level are considering limiting eligibility and effectively shifting some patients onto exchanges, which will reimburse at rates higher than those typically offered by Medicaid. (p. 17-18)

5. Widespread coverage expansion is likely to cause significant increases in wait times for primary care access; providers hoping to capture additional outpatient volume will need to heavily invest in expanded and alternative primary care access points for all patients. (p. 19)

Enrolling Eligible Patients

6. Fines for not purchasing insurance are always lower than premium costs, so providers and payers will need to actively market to relatively young and healthy purchasers the value of obtaining coverage. (p. 8-9)

7. Because penalties will be lower than expected out-of-pocket costs for many people, individuals with incomes between 100% and 400% of the federal poverty level and who expect high medical costs will be most likely to purchase insurance on the exchanges. (p. 13-15)

8. Regulations limit the ability of navigators and certified application counselors employed by providers to steer patients toward plans their health systems operate; providers offering plans must adhere to conflict of interest regulations. (p. 10)

9. Churning between Medicaid and exchanges will place a premium on verifying insurance and determining eligibility for Medicaid and exchange subsidies at the point of service. (p. 19)

10. Patients whose premium payments are delayed or who fail to properly report income fluctuations may become ineligible for subsidies; this could make premiums unaffordable and might cause these patients to drop their coverage. (p. 15)

11. The complexity of determining eligibility for exchange-based coverage and subsidies, and then enrolling in exchange-based plans, may disproportionately place the onus on providers for enrolling patients. (p. 9-11)
12. Some employers have indicated that they are considering restricting employees to part-time status to reduce the impact of penalties starting in 2015; providers may need to work with employers to present affordable alternatives to abdicating coverage. (p. 23-24)

Collecting the Full Patient Obligation

13. Providers may need to collect different amounts (even for the same service on a particular plan) for patients eligible for cost-sharing subsidies, increasing the complexity of billing and the necessity of accurately identifying patient obligations at the point of service. (p. 16)

14. Although bronze plans will have the lowest premiums, plans in the silver tier—the only tier in which cost-sharing subsidies are available—will provide lower out-of-pocket costs for high-cost patients eligible for subsidies (under 250% of the federal poverty level), significantly increasing the actuarial value of silver plans for these patients. (p. 16)

15. Consumers failing to pay premiums will maintain coverage for a 90-day grace period after their payment due date. Providers will only be reimbursed for services performed in the first 30 days of non-payment, putting them at risk for up to 60 days. (p. 14)

16. A significant number of purchasers under 30 will likely opt for catastrophic plans with deductibles equal to the out of pocket maximum, leading to a significant patient collection burden before the plan is responsible for coverage. (p. 13)

17. It is uncertain whether patients with exchange-based coverage are more likely to resemble commercial or self-pay populations in their willingness to pay their patient obligation, likely leading to widespread variance in collection success without a sustained provider focus on optimizing patient collections. (p. 19-20)

18. Providers that offer high-deductible plans on the exchanges have a financial incentive to provide care up to the point at which a patient’s deductible is met, but not beyond, suggesting that plans offered by integrated finance and delivery systems should contain a combination of high-deductible health plans with a strong care management component. (p. 12-13)

Preparing for Less Favorable Payer Reimbursement

19. Although the evidence of a significant shift is limited, the potential for large employers to transition employees onto exchanges is the largest margin threat to health systems that the exchanges present. (p. 22-23)

20. States that do not expand Medicaid will create a “doughnut hole” for low-income patients who are not eligible for Medicaid or exchange subsidies; providers will therefore need to continue existing charity care policies despite overall expansion in coverage. (p. 17-18)
Understanding the Exchanges

Health insurance exchanges are a central part of coverage expansion in the Affordable Care Act

A central component of health care coverage expansion envisioned in the Patient Protection and Affordable Care Act (ACA) is a system of state and federal health insurance exchanges. Along with the expansion of Medicaid, these exchanges—which the Department of Health and Human Services refers to as “marketplaces”—represent the single largest expansion of health insurance availability since the advent of Medicare and Medicaid in 1965. Slated for operation in 2014, these new sources of public funding for health insurance could extend health insurance to as many as 24 million Americans who otherwise would have gone without coverage, according to estimates from the Congressional Budget Office. Although the actual number of individuals who will gain coverage is subject to significant uncertainty, the likely increase will almost certainly expand access to health care services—preventive, routine, and acute—to millions of patients who otherwise would have foregone care.

Health insurance exchanges represent the biggest change to the financing mechanism of health care delivery in a generation (the Medicaid expansion mostly builds on previously established programs). For patients that qualify, they offer a more-affordable set of health insurance options. For providers, this new reimbursement presents significant opportunities to improve performance against both margin and mission by providing a means for funding the care of otherwise indigent patients. But the challenges are equally large; the structure and operation of these exchanges are complex—and providers will need to seek every opportunity to ensure the patients they treat are covered in order to offset the cuts to Medicare reimbursement growth that will largely fund coverage expansion.

Exchanges allow insurance purchasers to review benefits, determine financial assistance eligibility, and estimate out-of-pocket expenses, while also providing transparency into quality performance and comparisons among similar plans. Eligible individuals may purchase coverage on one of the ACA-established American Health Benefit (AHB) exchanges, while small businesses may purchase coverage for their employees on the Small Business Health Options Program (SHOP) exchanges. Unlike private exchanges, these are run entirely by the state or federal government and offer financial assistance to eligible individuals.

All lawful residents living in the United States and not currently incarcerated are allowed to purchase on the exchanges, regardless of income, but 6 out of 7 people expected to do so will be eligible for subsidies provided by the federal government. Subsidies are determined based on income and are available to patients earning between 100% and 400% of the federal poverty level. Penalties may be levied on people who are required to file a federal tax return, but who do not receive employer-provided health benefits, participate in government-provided insurance programs, or enroll in a qualifying health plan.

As the exchanges were originally conceived in the ACA, each state was encouraged to design and operate its own exchange, with over $1 billion in federal funding available for exchange development. However, several states have defaulted to a federally operated exchange or partnered with the federal government to perform limited administrative tasks for the first year. As of this writing, 16 states and the District of Columbia have received approval to operate state-based exchanges (SBES), seven states will partner with the Department of

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2) Ibid.
As of this writing, 16 states will operate their own exchanges, 7 will partner with the federal government, and 27 will default to federal exchanges.

Each year, CMS will invite states with federally facilitated exchanges to transition to state-based exchanges.

SBEs run all aspects of the exchange except eligibility and risk corridor functions, while SPEs rely on the federal government for most administrative tasks and have more control over customer service and plan management duties. States have little input into FFE decisions, retaining only reinsurance capabilities and in some cases enrollment or customer service support. The Internal Revenue Service (IRS) has ruled that subsidies will be available to eligible individuals, regardless of the type of exchange their state pursues, though an ongoing legal challenge argues that, according to the letter of the ACA, these subsidies should only be available through state-run exchanges.

Each year, the Centers for Medicare and Medicaid Services (CMS) will solicit applications for SPEs and FFEs to transition into fully operational SBEs, as originally intended by the ACA. According to CMS, grants for establishing exchanges are expected to be available through 2014; beyond that point, states transitioning to state-run exchanges will likely be ineligible for federal grants. By 2015, current exchanges are expected to be self-sustaining through the use of fees from insurance companies that offer plans on the exchanges.

In addition to choosing to operate their own marketplaces, state-based exchanges may act as active purchasers or clearinghouses. Active purchasers have the opportunity to select Qualified Health Plans (QHPs) for their exchanges, negotiate premium levels, dictate quality metrics, and require plans to offer care coordination solutions. Six states chose to follow the active purchaser model, while the remaining 12 SBEs have thus far opted to act as

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4) Center for Consumer Information and Insurance Oversight, “Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges.”

clearinghouses. In the clearinghouse model, all QHPs may participate and set premium levels according to market conditions. All FFEs will operate as clearinghouses, as CMS will only verify that plans meet eligibility requirements and not select plans past those initial phases.

Key Questions for Health System Executives

1. Who are the potential health insurance exchange purchasers?

Eligibility for purchasing health insurance on exchanges is broad, as there are no strict minimum or maximum income requirements. To purchase coverage, a person must only be lawfully present in the United States and not incarcerated. The Congressional Budget Office estimates that 7 million Americans will purchase coverage on one of the AHB exchanges in 2014 and nearly 24 million will receive coverage through exchanges by 2016. Many of these purchasers are currently uninsured, while some currently purchase coverage in the individual market. Still others will be covered through exchange-based plans if the small businesses that employ them opt for coverage under the SHOP exchanges.

Understanding the Individual Mandate

A significant driver of exchange coverage is the ACA mandate requiring individuals to purchase health insurance. Any person not covered by employer-sponsored insurance or a government program, and who is able purchase insurance for less than 8% of his or her income, must purchase private health insurance coverage (unless other exemptions apply; see the following page). To verify coverage, insurance plans will send documentation to beneficiaries and to the IRS. When filing income taxes, the documentation must be attached to a taxpayer’s 1040 form, a process often compared to attaching a 1099 form to a tax return reporting interest or government assistance. Non-exempt individuals who do not have health insurance for three months or more in a given year face penalties.

Non-Compliance Penalties

Penalties for non-compliance vary with income and may be significant depending on the duration of non-compliance; penalties are pro-rated based on the length of the period without insurance. In 2014, the penalty is the greater of $95 or 1% of household income. The penalty increases in 2015 to $325 or 2% of household income, and again in 2016 to $695 or 2.5% of household income (whichever is greater). Each year, the penalty is capped at the cost of the cheapest bronze plan available on the exchange. As the graphic on the following page shows, the penalty assessed is often less expensive than purchasing coverage. A recent Gallup poll found that 25% of uninsured Americans are more likely to pay the fine than obtain health insurance. If young, healthy people choose to pay penalties rather than purchase insurance, then risk pools may be overwhelmed by older, less-healthy consumers.

9) Penalties for uninsured children under 18 are $47.50 in 2014, $162.50 in 2015, and $347.50 in 2016. The penalty for a family is capped at the cost of the lowest-cost bronze plan or three times the flat fee penalty—$695 in 2016 or later—whichever is greater.
In addition to non-compliance penalties, which will be far below the estimated premium cost of eligible plans for most individuals, restrictions on enforcement mechanisms will limit the government’s ability to compel the purchase of insurance. Traditional mechanisms for collecting taxes, such as tax liens, wage garnishment, and jail time, are prohibited when enforcing the health insurance mandate.\(^{11}\) Withholding refunds is the only substantive mechanism available to the IRS for penalty enforcement.

**Mandate Exemptions**

Mandate exemptions are granted to people in health care sharing ministries\(^ {12}\), Native Americans, undocumented immigrants, incarcerated people, and those with financial hardships, as determined by the Department of Health and Human Services (HHS). Members of certain faiths may be exempted from the insurance mandate if their religious beliefs conflict with insurance enrollment. Additionally, people whose income falls below the threshold for filing federal taxes ($10,000 in 2013) or whose least-expensive option exceeds 8% of income are exempt from penalties.

The illustrative graphic below shows penalties for individuals at several income levels. In this case, the freelance writer with $11,000 in annual income would be exempt assuming no plan is available for less than 8% of his or her income.

### Noncompliance Penalties for Illustrative Uninsured Individuals

<table>
<thead>
<tr>
<th>Income</th>
<th>Freelance Writer</th>
<th>Community Organizer</th>
<th>Real Estate Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$11,000</td>
<td>2014: $0</td>
<td>2014: $250</td>
<td>2014: $1,900</td>
</tr>
<tr>
<td></td>
<td>2015: $0</td>
<td>2015: $500</td>
<td>2015: $3,800</td>
</tr>
<tr>
<td></td>
<td>2016: $0</td>
<td>2016: $695</td>
<td>2016: $4,750</td>
</tr>
</tbody>
</table>

**2. How will consumers learn about the exchanges and purchase coverage?**

With millions of Americans eligible for exchange plans and open enrollment underway, raising awareness about exchanges is the most important factor to successful enrollment. Efforts to raise awareness include media campaigns, in-person events, and door-to-door canvassing in certain states. Early indications show that most Americans eligible for exchange-based subsidies are unaware that they qualify; according to a recent poll conducted by the Commonwealth Fund in September, only 32% of uninsured Americans are even aware of the health insurance marketplaces.\(^ {13}\)

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11) Mark Koba, "When It Comes to Health-Care Reform, the IRS Rules," May 6, 2013, CNBC.
12) Health care sharing ministries are not-for-profit organizations whose members share similar ethical and religious beliefs and agree to share health care costs.
California launched a $250 million marketing campaign over two years, comprising exchange-run media campaigns and grants to community organizations. Other state-based exchanges have found creative ways to advertise, such as exchange-branded coffee cups in Oregon, sunscreen on beaches in Connecticut, and minor league baseball advertisements in Washington.14

Health insurance companies have also announced significant marketing initiatives, such as a recent campaign launched by Blue Cross Blue Shield of Texas called “Be Covered Texas”.15 Be Covered Texas is partnering with over 100 community-based organizations to reach uninsured Texans. Complementing insurance product marketing, providers have a role in raising awareness for both Medicaid eligibility and exchange participation. Trinity Health, for example, is planning to provide counselors for patients applying for Medicaid and exchange plans at most of its hospitals, along with computer kiosks at selected sites. Additionally, they will continue to use community health workers to promote coverage at sporting events and community venues.16 Other health systems are incorporating awareness campaigns into quarterly patient communications and marketing materials.

Exchange coverage may be purchased through an online marketplace, over the phone, through in-person registration, and through traditional insurance brokers. Each enrollment path is connected to the “no wrong door” system, which ensures that no matter the method through which an individual applies, he or she is screened for eligibility in all government programs, as well as for exchange financial assistance.

### Key Channels for Exchange Enrollment

The most popular channel, through which 80% of enrollees are expected to purchase insurance, is the online marketplace designed by HHS.17 The online system guides enrollees through a series of questions to determine eligibility for financial assistance and government programs, then provides a list of plans along with the subsidized premiums and estimated cost-sharing. With the launch of exchanges, HHS opened a call center and online live chat function for people to learn about the eligibility process, receive answers to specific questions while navigating the online marketplace, and apply for coverage.

Navigators will also enroll people at community centers and events. All navigators will be paid through CMS grants for the first year of employment, then are expected to receive funding through fees that insurance companies pay to offer plans on the exchanges. After an application process, CMS allocated over $67 million to 105 organizations to serve as navigators for 2013-2014, including nine health care providers. Their duties include raising awareness of exchanges among community members, helping people determine eligibility for health insurance assistance, and guiding them through the enrollment process. While assisting consumers with plan selection, navigators must offer fair, accurate, and impartial information on health plans. Additionally, they must disclose all conflicts of interest to both the marketplace and consumers, while not recommending any plan over another.

Providers not selected as navigators may apply to CMS to be certified application counselor (CAC) organizations. As a CAC organization, the provider trains staff members designated to assist consumers enroll in health insurance exchange plans and ensures all

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15) BlueCross BlueShield of Texas, “Blue Cross and Blue Shield of Texas Launches “Be Covered Texas” Campaign to Raise Awareness of Individual Health Insurance Enrollment Options.”
staff comply with established privacy laws. Providers may pay for these positions from their general budgets, non-CMS grants, or Medicaid funding.\(^\text{18}\)

Finally, traditional **health insurance brokers** will play a role in exchange enrollment. In calculating the medical loss ratio, however, the ACA classifies broker commissions with administrative costs and overhead rather than with medical expenses, effectively requiring that commissions be paid out of an insurer’s profits; this may limit the attractiveness of brokers to insurers.\(^\text{19}\)

**Mechanics of Exchange Plan Enrollment**

Over the summer, health plans worked with CMS to address plan deficiencies, negotiate network adequacy requirements, and meet regulatory requirements to achieve Qualified Health Plan (QHP) status. On October 1, open enrollment began in most marketplaces and will last until March 31, 2014. Consumers wishing for coverage to begin on January 1, 2014 must pay their first premiums by December 15, 2013. Moving forward, registration must be completed by the 15\(^{th}\) of the month for coverage to begin the following month. Any coverage purchased after the 15\(^{th}\) of the month will begin the month after next. For example, a plan purchased on January 17, 2014 will begin coverage on March 1, 2014.

After the initial open enrollment period, eligible individuals may only enroll or switch plans due to triggering events. These events include losing minimum coverage, change in family status or citizenship, income fluctuation affecting cost-sharing/premium assistance, and permanent relocation that offers access to new QHPs. People may only switch plans within the same metallic level (bronze, silver, gold, or platinum; see page 12) they originally purchased, a precaution in place to prevent switching to a plan with a higher actuarial value before a significant medical procedure or purchasing a lower value plan after such an event.\(^\text{20}\)

**Application and Enrollment Timeline**

<table>
<thead>
<tr>
<th>December 15</th>
<th>March 31</th>
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<tbody>
<tr>
<td>Enrolled patients must pay first premium</td>
<td>Open enrollment ends for all plans</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>October 1</th>
<th>January 1, 2014</th>
<th>January 1, 2015</th>
</tr>
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<tbody>
<tr>
<td>Open enrollment begins for all plans</td>
<td>Coverage begins for newly-insured patients</td>
<td>Employer mandate takes effect</td>
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</table>

**3. How do exchange plans differ from current plans on the individual market?**

Although health insurance exchange plans are fundamentally similar to plans on the existing individual insurance market, exchange plans differ from current individual market offerings in three ways: health benefits they must offer, actuarial value calculations dictating plan design, and pricing bands to which they must adhere.

\(^{18}\) Centers for Medicare and Medicaid Services, “Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace”

\(^{19}\) Centers for Medicare and Medicaid Services, “Helping Consumers Apply & Enroll Through the Marketplace.”

Every non-grandfathered plan offered on or off the health insurance exchanges must cover services from 10 categories of essential health benefits (EHBs), listed in the table below. The average health plan on the individual market today covers only three-quarters of these benefits, and only 49% of current plans cover all of the EHBs mandated for exchange-based plans.

Additionally, several preventive services are now covered with no copay for new exchange-based plans. Twenty-two preventive services are covered for women, 27 are covered for children, and 15 listed in the table below are covered for all adults; some restrictions apply based on age, health risk, and other factors.

### New Requirements for Essential and Preventive Services

<table>
<thead>
<tr>
<th>Essential Health Benefits</th>
<th>Preventive Services Covered for All Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ambulatory patient services</td>
<td>1. Abdominal Aortic Aneurysm screening</td>
</tr>
<tr>
<td>2. Emergency services</td>
<td>2. Alcohol misuse screening and counseling</td>
</tr>
<tr>
<td>3. Hospitalization</td>
<td>3. Aspirin use</td>
</tr>
<tr>
<td>5. Mental health and substance use disorder services, including behavioral health treatment</td>
<td>5. Cholesterol screening</td>
</tr>
<tr>
<td>6. Prescription drugs</td>
<td>6. Colorectal cancer screening</td>
</tr>
<tr>
<td>7. Rehabilitative and habilitative services and devices</td>
<td>7. Depression screening</td>
</tr>
<tr>
<td>8. Laboratory services</td>
<td>8. Type Two diabetes screening</td>
</tr>
<tr>
<td>9. Preventive and wellness services and chronic disease management</td>
<td>9. Diet counseling</td>
</tr>
<tr>
<td>10. Pediatric services, including oral and vision care</td>
<td>10. HIV screening</td>
</tr>
<tr>
<td></td>
<td>11. Immunization vaccines</td>
</tr>
<tr>
<td></td>
<td>12. Obesity screening and counseling</td>
</tr>
<tr>
<td></td>
<td>13. Sexually Transmitted Infection prevention counseling</td>
</tr>
<tr>
<td></td>
<td>14. Tobacco screening and cessation</td>
</tr>
<tr>
<td></td>
<td>15. Syphilis screening</td>
</tr>
</tbody>
</table>

### Tiers of Exchange-Based Coverage

Health insurance plans offered on the exchanges fit into four categories—bronze, silver, gold, and platinum. Each insurer participating in the exchanges must offer at least two plans, one at the silver level and one at the gold level.

The tiers of exchange-based coverage differ in the actuarial value of services covered, ranging from coverage of 60% of actuarial value at the bronze level to 90% of actuarial value for platinum plans; patients are responsible for paying the remaining cost of services. HHS will provide a uniform measure of actuarial value, based on an average population, to ensure parity across plans.

Within a given tier, plans can vary in how the patient’s portion of expected expenses is covered. For example, some plans may opt for higher premiums with low copays, deductibles, and coinsurance, while others may have lower premiums but higher deductibles.

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21) Plans offered before March 23, 2010 are “grandfathered” and not required to offer EHBs. However, plans that reduce benefits, raise coinsurance charges or deductibles, add annual dollar limits for claims, or reduce employer contribution by more than 5% lose grandfathered status.

and coinsurance. The graph on the following page displays the actuarial values associated with each metallic level, along with the consumer's out-of-pocket share.

Additionally, exchanges may include plans offering only catastrophic coverage, but only to individual purchasers under 30 or to those who would be exempt from the individual mandate because premiums for other plans would exceed 8% of their income.23

### Actuarial Value and Expected Patient Payment for Exchange-Based Plans

*Percentage of Cost Covered, Excluding Catastrophic Coverage Plans*

<table>
<thead>
<tr>
<th>Metallic Level</th>
<th>Actuarial Value</th>
<th>Out-of-Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Platinum</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**New Pricing Regulations**

Starting in 2014, insurers may not deny health insurance coverage due to pre-existing conditions (a practice known as “guaranteed issue”). Similarly, insurers may no longer price products differently based on many factors they consider today: health status, gender, industry, or length of time enrolled in plan (a practice known as “community rating”); this will effectively end most of the practices of underwriting.

The pricing bands still permitted—age, tobacco use, and geography—are restricted. Age bands will be limited to 3:1, from today’s more-typical 5:1, meaning that the oldest person in a plan may now be charged only three times more than the youngest person.24 Smokers may be charged 1.5 times more than non-smokers, although some exchanges have chosen not to enforce that pricing band, arguing that smoking is a “pre-existing medical condition.”25 Insurers are also permitted to vary pricing by geography; enrollees in high-cost regions may be charged more for coverage than those in low-cost areas. HHS provided the number of regions permitted to each state and allowed state governments to either divide their states up in those areas by March 31st or default to federal region delineation.

The ACA allows premiums to be adjusted by up to 30% based on an individual’s participation in wellness programs, so long as wellness incentives are not “subterfuge for discriminating on the basis of a health factor.”26


24) Federal Register, "Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule."


26) Federal Register, "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans.”
Finally, new regulations governing reimbursement may increase the risk of non-payment from plans to providers. Consumers maintain valid health insurance coverage for a 90-day grace period without premium payment, but health insurance companies are only required to reimburse providers for services rendered in the first 30 days of non-payment. While the intention of this rule was to ensure care continuity for patients, any services provided to a patient in the last 60 days of the 90-day period may not be reimbursed by the plan and must be collected directly from patients. CMS encourages issuers to notify providers of patients at-risk of defaulting on their premiums after the initial 30-day period, but no requirements for that communication currently exist.

**Impact on Individual Market Premiums**

Analysts expected essential health benefits that plans are now required to offer and tighter restrictions on pricing bands to place significant upward pressure on premium prices in the individual market. However, 94% of premiums reported in the 36 federally-facilitated and state partnership exchanges were lower than Congressional Budget Office estimates of $392/month, with 39% of premiums greater than 20% below estimates. Among 48 states reporting exchange rates, the average lowest-cost silver plan is $310 before subsidies, while the lowest cost bronze plan is $249.\(^{27}\) State-based exchanges saw similarly encouraging results, as monthly premiums on the Covered California marketplace ranged from $220-$254, compared to Milliman’s projection of $450 per month.\(^{28}\)

The graphs below display weighted averages for monthly premiums for a 27-year-old adult with a $30,000 annual income. In both Florida and Mississippi, the purchaser receives a subsidy pegged to both the second-lowest-cost silver plan and income, as outlined on the following page. Since plans offered in Tennessee are below the purchaser’s maximum premium contribution, no subsidy is provided for coverage purchase.

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**Weighted Average Monthly Premiums for 27 Year-Old Purchaser**

* $30,000 Annual Income in Three States

**Florida**

- Bronze: $193
- Silver: $247
- Gold: $301

**Tennessee**

- Bronze: $157
- Silver: $159
- Gold: $254

**Mississippi**

- Bronze: $248
- Silver: $267
- Gold: $359

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Many healthy, younger consumers, however, may see their premiums increase. Premium credits and cost-sharing subsidies (discussed on the following page) are likely to mitigate some increases. In a recent report, the Urban Institute found that about two-thirds of newly covered young adults between ages 21 and 27 will receive Medicaid or exchange-based subsidies. Of those remaining, two-thirds are covered through their parents’ employer-sponsored insurance, but one-third is susceptible to significant increases in premiums.29

4. What subsidies are available on the exchanges?

Exchange purchasers may be eligible for premium and/or cost-sharing subsidies, two mechanisms by which total out-of-pocket costs are reduced for low-income individuals. Additionally, small businesses that purchase on SHOP exchanges can in some cases receive tax credits for purchasing on the exchanges during their first two years of operation.

While the ACA contains no rule prohibiting providers from paying patient premiums for health insurance exchange coverage, CMS has not issued explicit guidance on the implications of this practice. Those providers considering contributing wholly or partially to a patient’s premium obligation should consider three factors before offering assistance. First, organizations should review anti-kickback regulations that prohibit hospitals from steering patients to their own facilities. Any offer to pay a patient’s premium must include all plans on the exchange, not only those which have contracted with the contributing provider’s network. Second, unlike Medicaid enrollment, exchange coverage is not retroactive and begins on the first of the following month if a patient registers before the 15th of the month and the month after next if a patient enrolls after the 15th of a given month. Finally, patient deductibles and copays will be significant for those not on cost-sharing plans, so the onus of collecting patient obligations will still be on the provider. Further, unpaid deductibles often cannot be written off as charity care and would be classified as bad debt.

Premium Credits

Premium credits vary depending on a purchaser’s household income and the cost of the plans available on the exchange. Credits are available at the beginning of the year, whether or not an individual owes taxes, and are paid directly to the insurer. The subsidy is calculated by subtracting the individual’s maximum allowed premium (a variable percentage of income) from the cost of the second-cheapest plan in the silver tier. The subsidy is the same regardless of the tier in which someone chooses to enroll; the difference in premiums between plans for a given individual must be covered out of pocket by the enrollee. For example, an enrollee could purchase a bronze plan at a lower out-of-pocket expense.

A purchaser with a household income of $22,340, for example, is required to pay 6.3% of annual income toward the second-lowest cost silver plan. If that plan costs $3,500, then he or she is required to pay $1,407 and would receive a $2,093 tax credit. The table on page 17 shows premiums as a percentage of income, maximum annual individual premiums, and maximum out-of-pocket caps with cost sharing available to exchange enrollees.

Cost-Sharing Subsidies

Cost-sharing subsidies are available to individuals with incomes below 250% of the federal poverty level (FPL) who choose silver-level plans; cost-sharing subsidies are not available to enrollees in plans in other tiers. For patients who are eligible for the greatest cost-sharing subsidies, these plans have an estimated actuarial value of up to 94%. The subsidies limit maximum out-of-pocket expenses based on income, made up by per-member, per-month payments from CMS directly to QHPs. Patients pay the same premiums as consumers without cost-sharing eligibility, but patient obligations are designed differently. For example, plans with cost-sharing subsidies require lower copays and deductibles, relieving the patient’s out-of-pocket obligation but increasing the importance of premium payments. Out-of-pocket maximums for patient obligations, previously based on Health Savings Account legal limits, have been delayed until 2015. This change was required due to group plans administering benefits through multiple benefits managers, but may cause patients to pay more for prescription drugs and high-cost procedures.

Eligibility for exchange subsidies will be determined at the beginning of the enrollment process through the “no wrong door” system that screens enrollees for eligibility in both government programs and exchange subsidies. Enrollees will use income estimates based on 2012 tax returns and in most cases, the exchange will verify an applicant's income against IRS, Social Security Administration, and Equifax data. If the applicant's income does not match government records, then supplementary documentation or an explanation will be requested. But, for the first year of eligibility, CMS has provided state-based exchanges "temporarily expanded discretion" to accept personal attestations of income in certain enrollment cases.

During the year, consumers will be required to report income fluctuations to verify eligibility and adjust subsidies accordingly. Failure to report income fluctuations might result in the individual having to pay back subsidies when filing taxes, or the loss of coverage through automatic disenrollment if the IRS reports a different income than the enrollee states. Patient obligations for paying back premium subsidies at the end of 2014 are capped in cooperation with a consumer’s income. For example, a consumer with an income below 200% FPL would pay back a maximum of $300 regardless of overpaid subsidy, while someone with a household income of 450% FPL would be required to repay up to $1,750 to the IRS.

Subsidy eligibility is also dependent on household income, whereas affordable employer-sponsored insurance is measured by an individual’s income – an intricacy referred to as the "family glitch”. Employees offered individual coverage with premiums below 9.5% of individual income are therefore precluded from receiving subsidies for health insurance exchanges. The glitch may affect up to 500,000 children who are ineligible for subsidies because at least one parent has access to affordable employer-sponsored coverage.

30) Center for Consumer Information and Insurance Oversight, “HHS Notice of Benefit and Payment Parameters for 2014.”
34) Kelly Kennedy, “ ‘Family glitch’ in health law could be painful,” USA Today, September 23 2013.
### Premiums and Out-of-Pocket Costs for Individuals Eligible for Subsidies

<table>
<thead>
<tr>
<th>FPL Income</th>
<th>Premium as Percent of Income</th>
<th>Income for Individual</th>
<th>Maximum Annual Individual Premium (Silver Plan)</th>
<th>Maximum Out-of-Pocket Cap with Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-133%</td>
<td>2% of income</td>
<td>&lt;$14,856</td>
<td>$297</td>
<td>$1,964</td>
</tr>
<tr>
<td>133-150%</td>
<td>3-4% of income</td>
<td>$14,856-$16,755</td>
<td>$445-$670</td>
<td>$1,964</td>
</tr>
<tr>
<td>150-200%</td>
<td>4-6.3% of income</td>
<td>$16,755-$22,340</td>
<td>$670-$1,407</td>
<td>$2,975</td>
</tr>
<tr>
<td>200-250%</td>
<td>6.3-8.05% of income</td>
<td>$22,340-$27,925</td>
<td>$1,407-$2,247</td>
<td>$2,975</td>
</tr>
<tr>
<td>250-300%</td>
<td>8.05%-9.5% of income</td>
<td>$27,925-$33,510</td>
<td>$2,247-$3,183</td>
<td>$2,975</td>
</tr>
<tr>
<td>300-400%</td>
<td>9.5% of income</td>
<td>$33,510-$44,680</td>
<td>$3,183-$4,244</td>
<td>$3,987</td>
</tr>
</tbody>
</table>

### Small Business Tax Credits

Small businesses choosing to purchase coverage in the SHOP exchange may also qualify for tax credits during the first two years of exchange coverage. Currently, small businesses are eligible for tax credits up to 35% of the company's employee contribution if the company has fewer than 25 full-time employees, has an average annual employee wage of less than $50,000, and provides at least 50% of the employee's health insurance costs. Starting in 2014, that tax credit increases to 50% of the employer's contribution toward an employee's health insurance coverage. Many benefit analysts fear that the short two-year period for 50% tax credits will lead to the SHOP exchange phasing out after 2016, as small businesses will revert to lower tax credits. Evidence in Massachusetts points to very low enrollment in the current small business exchange; only about 4,700 employees currently receive coverage through the Massachusetts vehicle.\(^\text{35}\)

### 5. How are exchanges and Medicaid expansion related?

As originally envisioned in the Affordable Care Act, Medicaid expansion would cover patients with incomes up to 133% of the FPL, with exchange subsidies covering patients whose incomes fall above this level and below 400% of the FPL. But the Supreme Court’s 2012 ruling, allowing states to forego expanding Medicaid eligibility without penalty, has complicated the interplay between Medicaid and exchanges. As of this writing, 22 states have opted not to expand Medicaid coverage or are leaning against expansion.\(^\text{36}\)

In states that do expand Medicaid, individuals with incomes between 100% and 133% of FPL will not be allowed to purchase insurance on the exchanges, but they will be eligible for Medicaid. States that do not expand Medicaid eligibility will offer subsidies for exchange-

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\(^{36}\) Advisory Board Company, "Where each state stands on ACA's Medicaid expansion," available at: [www.advisory.com/MedicaidMap](http://www.advisory.com/MedicaidMap).
Based coverage for individuals above 100% (rather than 133%) of the FPL, but there will be a “doughnut hole” for people whose income is below 100% of FPL and above the income cutoff for Medicaid eligibility.

The decision not to expand Medicaid eligibility is particularly problematic for hospitals and health systems heavily reliant on Disproportionate Share Hospital (DSH) payments; in 2014, $500 million in DSH payment cuts were supposed to be offset by increased Medicaid enrollment. In September, CMS released its methodology for correlating funding cuts with the number of uninsured residents in a state and hospital reliance on DSH payments. While President Obama attempted to delay the DSH payment cuts until 2015, CMS had no legal avenue for doing so without additional legislation. In response to hospital reactions, CMS modified the rule in October to align payments with hospital operating schedules, understanding that many financial reporting periods span more than one year.37

Using Medicaid Funds for Exchange Enrollment

Governors in several states, including Arkansas, Florida, Ohio, Louisiana, and Maine, have expressed interest in allowing Medicaid-eligible consumers to purchase health insurance on the exchanges with federal Medicaid funding.38 Arkansas Governor Mike Beebe presented the proposal to HHS Secretary Kathleen Sebelius, who approved it in late September at an estimated cost of $1.1 billion.

HHS previously issued guidance outlining how such an agreement would operate, including, most notably, that cost-sharing mechanisms currently in place for Medicaid patients (e.g., very low copays), must continue to exist in exchange plans. Similarly, HHS will not permit the state to place residents under 100% FPL on Medicaid and provide exchange subsidies to those with incomes of 100-133% FPL because, as HHS noted, “partial expansion is not an option.”39 Finally, such an arrangement must not cost more than the agency would have paid under a traditional Medicaid expansion.

37) Centers for Medicare & Medicaid Services, "Medicare Program; FY 2014 Inpatient Prospective Payment Systems: Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments."
However, several states in which Medicaid covers individuals with incomes above 133% of the federal poverty level, are considering limiting Medicaid eligibility so that more people can receive federally subsidized, exchange-based coverage.\(^{40}\)

### Increased Likelihood of Churning

Income reporting requirements, introduction of premiums to previously uninsured patients, and changing qualifications escalate the likelihood of “churning” for newly covered people—moving between exchange subsidies, Medicaid, and ineligibility within a single enrollment year. According to a Health Affairs analysis, 50% of people initially eligible for Medicaid or exchange subsidies will churn during 2014.\(^ {41}\) Churning presents particular challenges to providers, as a patient’s network coverage may change with insurance and it is difficult to recoup care management investments when patients move in and out of the system. This creates a problem with patient collections as well, as patients are likely to see their obligations vary from one visit to the next depending on their coverage.

### 6. How will newly covered patients utilize health care services?

To understand how newly covered patients will utilize health care services, it is helpful to understand the profile of these patients. Census data reveals that these patients will be, unsurprisingly, younger and lower-income than currently insured patients. A Kaiser Family Foundation study found that the average age of expected exchange enrollees is 35, while their median income is 235% of FPL.\(^ {42}\) Exchange patients are also expected to have limited familiarity with the health care system and be more likely to utilize care in emergency departments or urgent care centers, given current care patterns. Care navigators will be especially helpful for patients in this population, who are disproportionately unlikely to have current primary care providers.

Unmanaged chronic conditions are also likely to be present in exchange patients because many of these patients previously could not afford care. Investing in chronic disease management and early diagnoses can benefit exchange patients during their initial interactions with a provider. Many of these chronic health conditions are related to minimal education about preventive and elective care; as a result, preventive services (which are generally covered with limited out-of-pocket patient expense for exchange-based plans) can be valuable as part of a population health strategy for these patients. Explaining elective services can also benefit those patients willing to spend money for out-of-pocket care, but who had previously been hesitant to purchase insurance.

Finally, cost is likely to be the most important factor to exchange patients, especially in 2014, when reported quality measures are incomplete or inconsistent. Many exchange plans have high deductibles and even those with lower patient obligations due to cost-sharing subsidies will require some contributions for care. Newly covered patients are likely to shop around only if it is easy to compare services and transparent prices are promoted. Health systems with robust ambulatory infrastructures and low-cost imaging centers hold special advantages among these patients.


\(^{42}\) Kaiser Family Foundation, “A Profile of Health Insurance Exchange Enrollees;” March 1, 2011.
Massachusetts offers the best case study for projecting care utilization, using the state’s experience after its Connector exchange launched in 2006. Primary care utilization increased by 6% in the state, while emergency room utilization decreased 5%. Coverage expansion reduced preventable admissions, length of stay, and the number of outpatient visits occurring in the emergency room.43

For hospitals with inpatient capacity constraints, and especially for those whose primary care physicians are near their panel size limits, an uptick in utilization among newly insured patients may present challenges. In some cases patients may experience long wait times in the hospital or delays in scheduling outpatient visits; as a result, providers may be unable to capture new volumes. If increased utilization does materialize, many providers will need to invest in expanded outpatient and primary care capacity.

7. **What opportunities do insurers see in exchange participation?**

New health insurance shoppers equipped with billions of dollars in financial assistance from the federal government provide a remarkably attractive market opportunity for health insurance companies. Insurers showing the most interest in exchanges are those with experience in the individual market. Several Blue Cross Blue Shield plans, along with provider-sponsored and independent firms, see an opportunity to market plans locally and design networks around potential enrollees. Narrow network products have proven to be popular offerings, as Blue Shield of California exchange plans will include only 36% of providers included in its current statewide physician network.44

Within the 36 federally-facilitated or state partnership exchanges, consumers have an average of 53 QHP options offered by eight different issuers. Over 95% of consumers have access to two or more health insurance companies, as participation varies by service area.45 Across the board, insurance companies not traditionally offering health products, such as Aflac and Geico, did not express the interest that some had expected, though.

With the introduction of guaranteed issue, renewal requirements, and more restrictive pricing bands, many insurers have expressed concerns about adverse selection, as healthy people may abstain from purchasing coverage and the pool could comprise mostly unhealthy patients. Along with sicker patients, introducing previously uninsured consumers to coverage may incite a spike in health care utilization, particularly for high-cost services for which cost was a prohibiting factor. Limiting premium increases depends on enrolling a healthy insurance population, but to protect insurers from an unpredictable risk pool, exchanges offer three new mechanisms—risk adjustment, reinsurance, and a risk corridor—which, taken together, are designed to protect insurers from enrolling disproportionately high-risk populations, paying for outlier costs, and losing significant amounts of money due to higher-than-expected claims.46

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45) Department of Health & Human Services, "Health Insurance Marketplace Premiums for 2014."
Risk Adjustment

Risk adjustment provisions protect insurers with exchange-based plans from high costs due to enrollment by an unusually costly population. Exchanges will transfer a portion of payments from plans with healthier populations to those with disproportionately unhealthy or elderly enrollees. This is a permanent program that can be administered by either a state-based exchange or HHS. Guidelines for calculating risk scores are presented by HHS, but insurance companies report their own risk scores in order to avoid providing personal health information to the government.47

Currently, health plan guidelines calculate risk scores using age, sex, diagnosis factors, geographic rating area, and excess utilization. Given the score’s calculation, a plan with a high number of statistically unhealthy enrollees that manages its patients well can receive significant payments as a reward for enrolling high-risk patients.

Reinsurance

Because of the uncertainty around participation and risk pools in the exchanges, many conventional reinsurers may be reluctant to reinsure exchange-based plans. The ACA includes a temporary reinsurance program, administered by HHS, that is designed to offer reinsurance plans similar to those in the private market through 2016, at which point commercial reinsurers are expected to offer products for exchange plans.

Under the HHS reinsurance program, all health plans must pay $5.25 per member, per month to HHS or $63 per year in reinsurance premiums. HHS will then pay reinsurance claims of 80% to health plans for their enrollees with annual costs of $60,000 to $250,000. The program is expected to administer $10 billion in reinsurance payments in 2014, but there is no mechanism to return reinsurance premiums to insurers if a plan does not benefit from the program.48

Risk Corridor

A risk corridor, which will go into effect in 2014 and expire in 2016, is the final premium-stabilizing mechanism and the most difficult to calculate in advance. Each QHP must set a target amount for claims payments—premiums collected less administrative costs. If allowable costs vary by 3% or more, the QHP will receive money from or pay money to HHS. The program is not a one-sided risk transfer; rather, it is in effect a reverse shared savings program.

If costs are greater than 3% above the target amount, HHS pays the QHP 50% of the difference, while HHS pays 80% of costs greater than 8% above the target. Conversely, if a QHP spends less than 97% of its target amount, it must pay HHS 50% of the difference, or 80% of the difference for costs below 92%. Plans with spending within 3% of the target amount (between 97% and 103%), will neither receive nor pay any portion of the variance from target spending. Plans will still lose money if premiums are priced too low and enrollees utilize many services, but the temporary risk corridor regulation minimizes the amount gained or lost.

48) Department of Health & Human Services, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2014.”
Transparency and Information Sharing Requirements

Exchanges also present new platforms for insurers to communicate quality and transparent pricing information to consumers. Participating insurers must disclose claims payment policies, denied claims, cost-sharing, and rating practices on the exchange. Additionally, exchanges have the right to examine all premium increases and assign a rating to health plans based upon benefit quality. These provisions add an unprecedented level of scrutiny on insurers, demanding greater accountability for changes in benefit plan design and enrollee premiums. Insurers must maximize the opportunities presented by these new regulations to attract quality-conscious consumers.

8. How likely are employers to transfer employees onto exchanges?

Many health system executives view—and advocates of the ACA have promoted—the health insurance exchanges as a boon to providers. Previously uninsured or underinsured patients now have the opportunity to purchase comprehensive health insurance with government assistance and collective buying power.

But if employers were to drop coverage and shift employees to exchanges, hospitals and health systems would likely experience significant margin erosion. Many providers have accepted discounted commercial rates in exchange plan negotiations, but reimbursement reductions vary by market. Tenet Healthcare announced that it will receive a 10% reduction off current commercial rates with tiered and narrow networks for Blue Cross Blue Shield plans on the exchanges. Additional Advisory Board interviews have revealed a wide range of rates, from near-Medicaid rates to current commercial reimbursements. Both lower rates and narrow networks for enrollees in exchange-based plans could hurt providers, accustomed today to cross-subsidization through commercial rates for employer-sponsored insurance and broader provider choice offered to a company.

The evidence suggesting employers are likely to move their employees onto exchanges—either by dropping private coverage or by purchasing plans on the small business exchange—is mixed. In Massachusetts, the number of employers offering health insurance increased after the state’s Connector exchange launched, likely because the insurance mandate made job-seekers more interested in a position that offered health coverage.50

But in the months after the Affordable Care Act was passed, some large companies have indicated that offering health insurance benefits is becoming cost-prohibitive. Companies with low-wage employees are the most likely to shift employees to exchanges, because health benefits have historically been more important for attracting and retaining high-wage employees. Because regulations against discriminatory pricing prohibit companies from offering greater contributions or more generous plans to higher-wage employees than lower-wage workers, an employer would have to pay higher-wage workers even higher salaries and allow them to purchase insurance with post-tax income.51 Employers violating nondiscrimination rules will be subject to fines of $100 per day per discriminated employee. Further guidance from CMS on nondiscriminatory pricing is expected this summer.52

The evidence that employers will move their employees onto exchanges is mixed

52) Many questions remain regarding the interaction between grandfathered plans and new coverage options, as well as the rule’s application to full and part-time employees.
Exchange “dumping” will vary by market, but academic estimates range from a nearly 22.3% shift from employer-sponsored insurance (ESI) to exchanges, to a positive effect of 8.7% (moving more individuals onto ESI). The Congressional Budget Office projects that in 2022, 4 million fewer Americans will have ESI as a result of the ACA.  

Many employers are reluctant to be the first to move, as the perceived negative backlash could damage a firm’s reputation. However, after the first movers shift their employees to exchanges, a domino effect could occur, with other employers deploying similar tactics. Smaller companies are more likely to shift employees than larger firms; as a recent poll found, only 5% of employers with 1,000 or more employees are somewhat or very likely to direct full-time employees to exchanges with a financial subsidy in the next five years.

**Employer-Sponsored Insurance Already on the Decline**

Regardless of exchange movement, trends over the last 10 years show declines in employer-sponsored insurance. A report from the Robert Wood Johnson Foundation found that the proportion of employers offering health insurance decreased from 69% in 1999 to 60% in 2010, while the average employee’s contribution doubled during that time, to $3,842 for a family of four.

Although many employers have yet to determine their strategy for responding to exchanges, Advisory Board research has found wide variation, with some employers expecting to abdicate coverage for their employees and other employers taking an activist approach designed to promote mutually beneficial coverage and wellness options.

On the abdication side, some employers have already shifted employees to a private exchange, withdrawn coverage completely, or designed a health savings account that permits a defined contribution. Over the past several months, companies such as Walgreen, IBM, and Time Warner announced plans to provide defined contributions to employees to purchase coverage on private exchanges. In other cases, employers may reduce premium costs by reducing the actuarial value of the plans they offer, perhaps to the 60% level that the ACA defines as the “minimum value” of acceptable coverage. Conversely, activist employers are working with systems to reduce health care costs and design mutually beneficial products to offer employees. Most employers fall between these two extremes and are waiting for providers and insurers to approach them with innovative ideas and options to reduce costs.

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New Employer Regulations

Originally slated for 2014 implementation, employers with 50 or more full time employees or full-time equivalents will now be required to offer affordable health insurance to employees in 2015, offering a “minimum value” of coverage (an actuarial value of at least 60%).\(^{57}\) In a rule referred to as “pay or play,” employers must pay a penalty of $2,000 per full-time employee, above 30 full-time employees or full-time equivalents, if any employee purchases coverage on an exchange with premium subsidies.\(^{58}\) A separate unaffordability penalty of $3,000 per employee may also be imposed on an employer if the least-expensive plan offered exceeds 9.5% of an employee’s household income, or does not meet the 60% actuarial value threshold set by the bronze-level exchange plans.\(^{59}\) If an employer offers coverage to 95% or more of employees, it avoids the first penalty, but no threshold allows an employer to avoid the “unaffordability” penalty. The unaffordability penalty can be no greater than what an employer would pay under the “pay or play” regulation. Note that penalties only apply to employers whose employees obtain coverage on the exchanges; there is no employer penalty if an employee is eligible for Medicaid coverage in lieu of employer-sponsored insurance.

Beyond capping employees at 49 to avoid triggering employer penalties, some employers are reducing employee hours to fewer than 30 per week to avoid paying additional per-employee penalties. Other companies are evaluating moving employees among franchises, ensuring that they do not work more than 29 hours at any one facility. Finally, some regional employers have proposed banding together and sharing employees among multiple industries. For example, an employee could work 20 hours at a restaurant and 20 hours at a grocery store, while requiring neither to provide coverage.\(^{60}\)

\(^{57}\) Full-time employee for this regulation means 30 hours per week or 130 hours per month. Full-time equivalents include part-time employees: for example, two employees, each working 15 hours per week, equal one full-time equivalent.

\(^{58}\) Department of Health and Human Services, “Health Insurance Basics: Large Business.”


SHOP Exchange

A major feature of the ACA intended to help small businesses provide affordable coverage is the Small Business Health Options Program (SHOP) exchange. Lawmakers intended for the SHOP exchange to give businesses with fewer than 50 employees (expanded to 100 in certain SBEs) the opportunity to pool together employees and act as a large entity when purchasing insurance. As a result, small business employees would reap the benefits afforded to large employers when approaching health insurance negotiations. Each employer would provide its employees with set amounts to purchase the coverage that best fit his or her situation on the SHOP exchange. Rather than being confined to one plan from one insurance company, employees would enjoy a large selection of plans just like those purchasers in the individual market. Added to this benefit is a two-year tax credit for employers of low-income Americans.

In April 2013, however, HHS delayed the employee choice aspect until 2015 for federally-facilitated SHOP exchanges, citing “operational challenges.” Rather than employees choosing from several plans in 2014 as purchasers on the individual market will have the opportunity to do, an employer will offer one SHOP plan to its employees, with the option only to purchase or decline that plan. State exchanges are free to delay the employee choice feature, as the federal government has done, or to continue plans to offer small business employees full choices through the exchanges. For employees, the delay means they may be more likely to purchase coverage from the individual exchanges. If employers are not satisfied with the one choice offered through the SHOP exchanges, then they can offer off-exchange coverage to employees or move them into defined-contribution models, such as private exchanges.