Open for business: Insurers prepare for new consumer market

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Health exchanges
Open for business

pwc

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Introduction

Implementation challenges, politics, and differing state responses to the Affordable Care Act foreshadow a turbulent beginning for new online insurance exchanges. Yet behind the turmoil, a new way of purchasing healthcare coverage is quickly refashioning the industry, with signs that non-traditional players are poised to gain.

For six decades, the majority of Americans have obtained health insurance through the workplace, usually selecting from very limited options. But with employers clamoring for cost savings and the final major elements of the Affordable Care Act (ACA) set to take effect in January, a sector that represents nearly one-fifth of the US economy is turning in a dramatically different direction.

Health insurance is going retail, fueled by online marketplaces that let individuals do the picking and choosing. Coupled with the emerging private exchange business, new government exchanges in 50 states and the District of Columbia are rapidly redefining how we purchase and consume healthcare. Bolstered by an individual mandate and large federal subsidies, the state exchanges will quickly expand the individual insurance market—albeit with an array of growing pains.

The allure of a flourishing individual market is attracting more than just the traditional commercial insurers. In the new health economy, established companies will go head-to-head with lesser-known players who bring a different set of skills and perspectives to the table. They include Medicaid managed care companies that understand how to reach low-income customers, plans owned by healthcare systems with hands-on patient experience, and agile insurance start-ups fueled by powerful data analytics. Companies from other industries—such as retailers and tax preparers—are simultaneously grabbing a piece of the action, challenging the traditional definition of the healthcare company.

Today's health sector views exchanges as an important opportunity. According to a survey of more than 100 health insurance executives by PwC's Health Research Institute (HRI), 69% said they planned to offer coverage on the state exchanges; though some are entering gingerly. All insurers—old and new— face significant challenges in the new marketplace. Technology woes and uncertainty around who will sign up for coverage top the list of concerns.

As the industry moves from wholesale to retail, the customer takes center stage. While most insurance executives expect consumers to select health plans based mainly on price, consumer experts interviewed by HRI say that other factors such as personalized communication, tangible rewards, and health management programs also will be crucial to attracting and retaining members—especially the coveted "young invincibles." Health companies should take cues from other industries such as retail and technology that are designed with the consumer at the heart.

The 2014 exchange landscape

At the start, the individual exchange may pale in comparison to the employer-based insurance market. Perhaps seven million Americans will shop on the individual exchanges in 2014, compared to 157 million people covered through the workplace.[1] However, the new market offers an intriguing opportunity for insurers to conduct early tests and position themselves in a changing landscape.

Who will participate and why

HRI's survey of more than 100 health insurance executives found that most insurers will offer coverage on the state exchanges. Yet the initial turnout will vary significantly. While every state will have at least one insurer, some will have far fewer than others. In Mississippi, for example, two companies will sell on the exchange in 2014, but 95% of the state's 82 counties will have just one to choose from.[2] By contrast, 16 insurers will sell coverage in New York.[3] Blues plans will compete in at least 36 states.[4]

For the 69% of insurers planning to offer some type of exchange coverage, staying competitive is a top priority. The HRI survey found that adding new members (63%) and maintaining existing members (61%) were extremely important factors in insurance company decisions to sell on the new exchanges, foreshadowing the rising significance of this business model (see Figure 1).

But for many, selling coverage on the exchanges goes beyond enrollment numbers. Health plans are also driven by a keen awareness of public perception and often a sense of social responsibility.

Over half (54%) of overall respondents and 63% of executives of non-profit companies said public perception was an extremely important decision factor. And many, when interviewed, expressed a sense of duty to serve their communities.

"Our company is committed to doing the right thing," said Susan Yeazel, divisional senior vice president of consumer markets at HCSC, the fourth-largest health insurer in the US which operates Blues plans in five states. In March, the company established a community-based education effort called Be Covered, which has more than 200 non-profit partners ranging from churches to food banks and civic organizations. The program has reached nearly two million uninsured consumers with printed and digital content and in-person education.

Yet even among participants, enthusiasm for the new markets varies considerably. Kaiser Permanente, for example, will offer exchange plans in the ten states it currently provides

Health insurance exchanges: a primer

The 2010 Affordable Care Act (ACA) established online health insurance marketplaces, better known as exchanges, to enable individuals and small businesses to shop for coverage. Exchanges and expansion of the joint federal-state Medicaid program are the two primary ways the law expands coverage.

Exchanges in fifty states and the District of Columbia are set to open on October 1, 2013, and coverage takes effect on January 1, 2014. The first open enrollment period runs until March 31, 2014. In future years, open enrollment will end on December 7.

Under the ACA, states were allowed to decide whether to run their own exchanges, or let the federal government take the reins. The federal government approved seventeen states and the District of Columbia to operate their own exchanges in the first year, while seven states will participate in an official partnership exchange. Utah will run its own small business exchange, while the federal government will run its individual exchange. The remaining states will default to the federally facilitated exchange.

The exchange market is expected to grow quickly, with approximately 22 million purchasing coverage on the individual exchanges by 2016. By 2023, an estimated 24 million will buy their healthcare on the individual exchanges.

**The individual and small business exchange markets together will account for $210 billion in premiums and 28 million members by 2023. Small business exchanges will account for an estimated 4 million individuals and $35 billion in premiums. HRI's analysis is based on data from the Kaiser Family Foundation and the CBO's May 2013 baseline insurance exchange estimates.*

individual coverage. Many large, national insurers are approaching the exchanges with caution, entering into markets they perceive as safe bets. Some of the largest national insurance carriers—such as Humana, Aetna and its subsidiary Coventry—are entering around twelve to fourteen markets in the first year.[5]

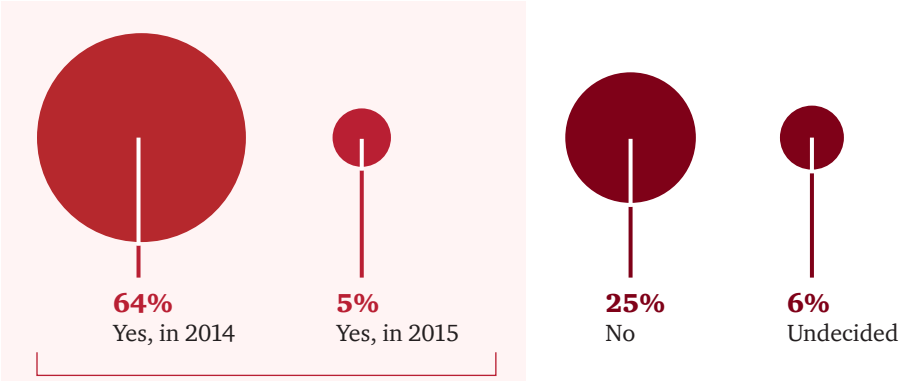
In HRI's survey, 10 of 18 executives at national health insurers said their companies won't offer exchange coverage in all the states they currently have business, compared to 30% of overall respondents.[6] Half of national insurance executives said they expect to enter additional states after 2014.

A higher proportion of large, national, and for-profit companies said they plan to expand to other states after the first year. Exchange readiness and profitability were the primary reasons insurers decided not to initially participate in all markets.

Some insurance companies have decided late in the game to scale back the size and scope of their exchange efforts, limiting their risk in certain markets. After filing for 2014 rates, Aetna decided not to participate in several states—including New York, New Jersey, Ohio, Connecticut, Georgia, and Maryland.[7] Other insurers, including United, Humana, and Anthem Blue Cross, have also tempered their efforts.

Figure 1. Most health insurers will participate in the exchanges

Percentage of insurance executives who said their companies will offer exchange plans



Top reasons for participating

Ranked "extremely important" by insurers

- Adding new members (63%)
- Maintaining current members (61%)
- Public perception (54%)
- Competition is participating (54%)

Source: Health Research Institute 2013 insurance executive survey

Most large, well-established health insurers have already built strong business lines in other areas such as employer coverage and Medicare Advantage, so initial participation in every state exchange may not be a top priority.

Who will not participate and why

One third of health insurance companies don't plan to participate in exchanges or remain undecided, reflecting uncertainty about who will enroll and what their health status will be.

In the HRI survey, insurance executives cited profitability concerns, adverse selection, and understanding the preferences and behavior of newly-eligible customers as the most critical factors in the decision not to sell on the exchanges.

Adverse selection occurs when people only purchase coverage in anticipation of needing medical services, instead of as protection against unanticipated problems. Under the ACA, the traditional levers insurers use to control risk—underwriting and pre-existing condition exclusions—are no longer on the table.

While the ACA attempts to minimize the negative impacts through programs such as risk corridors (see next section) and community risk pooling, many insurers are concerned that the individual mandate may not be enough to convince healthy people to buy insurance—especially those not eligible for subsidies.

Small insurers are particularly vulnerable because they don't have as much capital to offset potential losses. They may also not have the resources to invest in a new line of business, or may be too specialized to compete against traditional insurers. A greater proportion of executives from small insurers—16 of 35—said their companies did not plan to participate on the exchanges, compared with just two of 29 executives from large insurers.[8]

The new exchange entrants

One fourth of companies that applied to sell coverage on the federal exchange in 2014 are entering the individual market for the first time.[9] The exchanges are the incubator of the health insurance market, sparking innovation by attracting new participants that bring expertise across a wide range of sectors.

For example, Medicaid managed care companies may have a competitive advantage with low-income beneficiaries. Insurers such as Molina Healthcare, which serves nearly 2 million members primarily in Medicaid managed care plans, are targeting a defined slice of the exchanges: the "churn" population. These individuals have incomes hovering around the eligibility threshold (138% of the federal poverty level, or $15,856 for an individual) and will move between Medicaid and the exchanges. About 38% of individuals are expected to move between Medicaid and the exchanges at least four or more times over the next four years.[10]

These companies' experience negotiating Medicaid rates with providers, creating tight networks, and managing members' social and medical needs could also give them an advantage in both price and member satisfaction. Low-income shoppers may also be more familiar with Medicaid managed care companies, giving those plans an edge through brand recognition.

Large hospital systems are entering the insurance business with their own health plans, blurring the traditional lines of the health industry. New York-based North Shore-LIJ Health System will sell insurance plans through its subsidiaries on and off the exchange.

The plans revolve around the system's own network of 16 hospitals, nearly 400 outpatient and ambulatory care centers, and thousands of care providers. Catholic Health Partners, a Cincinnati-based health system, will offer its own HealthSpan limited network products on the Ohio exchange in 2014.

Provider-owned health plans could do well in local markets in which they already have established reputations as high-quality caregivers, and where there are existing relationships between individuals and providers.

"Our power is that we are local," said Craig Hauben, North Shore-LIJ Care Connect Insurance Company's commercial product lead. "People say, 'I was born at NSLIJ' or 'she was treated at NSLIJ'. Our family connections with providers enable a level of trust and responsibility that a national insurer will never be able to achieve."

New insurance start-ups fueled by powerful data analytics could prove strong competitors in the exchanges. Oscar, an insurance start-up powered by venture capital, has hired experts from tech companies such as Microsoft, Tumblr, and gaming company Vostu Ltd.[11] The insurer is approved to sell plans in New York starting in 2014 and aims to provide a more interactive, user-friendly experience. It's investing in new technology that makes viewing bills and charges easy.

Members will be able to log into a personalized online account, type in their symptoms, click a button to speak directly with a doctor, and find in-person providers who are recommended by condition and cost.

Though untested, the hope is that as more people enter their health data into the company's systems, the technology will become smarter at providing real-time guidance to consumers (see Snapshot: a growing digital future for the exchanges).[12] It could, over time, create standards for evidence-based care—a significant return on investment.

Other types of companies beyond insurers are looking to capitalize on new opportunities that have come about because of the exchanges.

eHealthinsurance is one of several online brokers—including GetInsured, HealthCompare, and others—to partner with the Centers for Medicaid and Medicare Services (CMS) to sell health plans in states where the federal government will run all or part of the state's exchange. With over 1000 partners and affiliates and nearly 20 million visitors to its website in 2012, eHealthinsurance and other web brokers may be well positioned to find and enroll customers in markets if federal efforts fall short.

Tax preparers such as Jackson-Hewitt and H&R Block will use their experience with the federal tax system to educate individuals about the ACA's personal financial implications. H&R Block is teaming up with technology firm GoHealth to help customers determine their subsidy eligibility and enroll in health insurance. Jackson-Hewitt is partnering with web broker GetInsured, and is offering assistance to consumers on healthcare options regardless of their eligibility category under the ACA.

Brian Haile, senior vice president of health policy at Jackson-Hewitt, underscored the value of reaching healthcare consumers when they are engaged in the tax process. "We have to link with a program that people are already willing to complete," he said. "The notion that people will take 45 minutes out of their day to do this is unrealistic," referring to the process of applying for coverage and subsidies. "You need to build onto a process that people have material incentive to complete."

Creative partnerships are flourishing. The Blue Cross Blue Shield Association, which represents 37 Blues plans across the US, is teaming up with Walgreens to reach shoppers across the retailer's more than 8,000 US stores (see Figure 2). The partnership should boost enrollment in Blues plans and the number of Walgreens customers shopping with insurance coverage.

Figure 2. The new exchange participants

Exchange participation is not just reserved for commercial insurers. New players, some from other industries such as retail and technology, are carving out space in the individual exchange market.

Provider-owned plans	• North Shore-Long Island Jewish and Catholic Health Partners offering products based on their own hospital and provider networks
Medicaid managed care plans	• Molina Healthcare expanding from Medicaid managed care into public exchanges • NY-based Fidelis Care to offer coverage on state's exchange
Insurance start-ups	• Venture capital-funded Oscar aims to enhance customer experience using big data and transparency
Consumer Operated and Oriented Plans (CO-OPs)	• CoOpportunity Health serving exchange customers in NE and IA, also offering solutions to employers • Minuteman Health, CO-OP sponsored by Vanguard Health Systems and Tufts Medical Center, offering plans on MA Connector
Web brokers	• eHealth—along with other web brokers such as GetInsured, HealthCompare—signed deal with CMS to sell exchange products in federal exchange states
Retailers	• Blue Cross Blue Shield Association and Walgreens teaming up to educate customers about exchanges, both in stores and online
Tax preparers	• Jackson Hewitt and H&R Block educating consumers on health reform and selling services that estimate subsidies and penalties
Technology companies	• HIT company Eligible selling a program interface to insurers to handle customer claims eligibility questions • Eliza Corporation developed solutions for insurers to guide members at key points, from exchange transition to targeted outreach during the year
Non-health insurers	• Prudential, MetLife, and Aflac selling supplemental plans that provide cash direct to policy holders for accident or illness
Government service providers	• MAXIMUS provides administrative services to state exchanges such as CA and NY; also supports Medicaid, Medicare, other government health programs • Virginia-based Serco will help process exchange applications for federal exchange

Source: PwC Health Research Institute

What to watch for

1. **Struggling new entrants.** New health insurers will face three main challenges: dealing with the normal growing pains of an organization, learning how to operate effectively as an insurer, and managing the needs of a largely unknown population. Many first-timers will rely on outside companies and partnerships to help run the insurance operation, potentially posing big oversight challenges in areas such as enrollment and customer service.
2. **Quiet standouts.** Innovators could initially go unnoticed as they build their businesses and customer credibility, but could eventually capture the market with their new approaches to familiar problems.
3. **Non-participants opting in.** Companies without an exchange strategy may decide to jump into the market in 2015—in states where new entrants are allowed—after they gain a better understanding of the new population and observe the successes of their competitors first-hand.
4. **Increased collaboration.** Companies will increasingly seek out partnerships that allow them to reach and engage exchange customers in new ways. Insurers are already partnering with pharmacy retailers and technology companies, but new collaborations could conceivably stretch into areas such as the food, fitness, and entertainment industries.
5. **Carryover into the broader health insurance market.** Employers and traditional insurers may apply lessons from the new exchanges. For example, if narrower networks lower premiums without causing significant member blowback, employers will revisit this once-unpopular strategy.

Operational challenges

Insurers participating on the exchanges face significant operational challenges. They not only need internal systems and processes capable of handling high volume, but must also be able to link to federal and state eligibility, enrollment, and plan management systems.

The challenge of building exchange infrastructure—including the massive federal data hub— from scratch in just over three years has been compounded by regulatory and implementation delays as well as dwindling federal funds. The many intersection points between the industry and government, from eligibility and enrollment to subsidy payments and beyond, offer many opportunities for breakdown.

Insurers

Of the insurance executives surveyed by HRI whose companies were participating on the exchanges, 63% said technology integration and 61% said coordination of subsidies were major barriers to implementation (see Figure 3).

For many national insurers that expect to operate in several states, readiness varies by region: each regional subsidiary may have its own IT systems that need to connect with the exchanges.

Companies are putting most of their short-term energy and resources into technical exchange readiness but may be neglecting other less apparent, yet still critical elements. A minority of respondents said understanding newly eligible customers (34%) and organizational culture (13%) were major barriers to implementation.

Only 57% said they were in the advanced stage of customer segmentation, or dividing customers into discrete groups that share similar characteristics. This suggests that many insurance companies need to shift gears quickly to focus on their consumer strategies.

State and federal exchanges

Exchange capabilities and readiness vary widely. On one end of the spectrum are states such as New York, which had established a website, staffed its call centers, and conducted

Figure 3. Insurance executives see technology integration as the biggest barrier to exchange implementation*

63%	61%	51%	46%	41%	34%	13%
Technology integration	Coordination of subsidies	Adverse selection	Profitability	Managing churn	Understanding newly-eligible consumers	Organizational culture

*Of those participating in exchanges.
Source: Health Research Institute 2013 insurance executive survey

real-time testing with the federal data hub as of late July 2013.

"Everyone likes to focus on what will go wrong, but we have consistently met our deadlines," said Danielle Holahan, deputy director of the New York Health Benefit Exchange. "We're pretty proud of where we are and where we're going."

Yet even among states that began the exchange planning and development process early, delays are cropping up. Oregon announced that it would postpone direct consumer online enrollment until later in October 2013. Other states such as Connecticut and Nevada are postponing non-critical functions such as the ability for enrollees to update their coverage and virtual website assistants until the exchanges are up and running.[13]

Many are concerned about federal exchange readiness. The Government Accountability Office (GAO) published a report in June 2013 indicating that major technical components of the federal exchange could be delayed, and slightly postponed insurer contract signings spark questions about future delays.[14]

The '3Rs'

The uncertainty of doing business in the new exchange world could be significantly reduced by risk protections in the ACA. The '3Rs'—risk adjustment, risk corridors, and reinsurance—were established to stabilize premiums.

Risk adjustment requires health plans to set rates based on average risk pools in the individual and group markets. Reinsurance is designed to protect insurers against specific high-cost members. Risk corridors shield health plans from the effects of inaccurately estimating the cost of their exchange enrollees by limiting profits and losses.

"The three programs were very helpful for us when we were setting our pricing," said Lisa Rubino, senior vice president of Medicare, Duals and the Marketplaces at Molina Healthcare, in an interview with HRI.

Yet some expressed concerns over the operational readiness of the three programs. "Like everything else in this environment, [the programs] are partially built and partially tested," noted one insurance executive.

Investing in manual backup processes

With concerns about system readiness, exchanges, insurers and the federal government are turning to manual backup processes.

CMS signed a contract with Reston, Virginia-based Serco to run a mailroom that will process enrollment applications, a third of which are expected to be paper.[15] The one-year contract has the potential to extend to five years, with a total value of $1.25 billion.[16] Some states have worked with contractors to increase staffing for paper enrollment processing. Insurer HCSC has updated its business systems and processes so it can adapt to changes in member volume and system activity during the open enrollment period.

Preparing for exchange customers

How much will price matter?

A full 94% of insurer participants think price will be an extremely important factor for exchange consumers, according to the HRI survey. And they are acting accordingly. In Oregon, for instance, two insurers revised their initial premium rates after seeing competitors' rates. Similar rate revisions have occurred in the District of Columbia, Maryland, and other states.

Ninety-one percent of participating insurers think consumers will care most about premiums, with total out-of-pocket costs (64%) coming in a distant second. However, less visible elements such as cost-sharing can ratchet up total price considerably.

Exchange consumers, many of whom have never purchased insurance before, may struggle to understand the vagaries of health insurance pricing—and later, the cost at the point of care.

In a study of Massachusetts exchange plan enrollees, Harvard researchers found that 45% of survey respondents inaccurately estimated their out-of-pocket costs at the time of enrollment.[17] Other studies have shown that consumers have a poor understanding of cost-sharing mechanisms such as co-insurance and deductibles.[18]

Insurers could see individuals drop coverage after the first year if they selected low-priced plans that didn't include their current providers, or if they unexpectedly receive a large bill from a provider asking them to pay the difference not covered by their insurance company. While brokers and government-funded navigators and assisters will help guide consumers through the plan selection and enrollment process, it will also be up to health plans to ensure that consumers have access to simple, effective cost comparison and educational tools.

Exchange plan pricing varies by state and individual. Factors such as essential health benefits, insurer competition, and changes to the insured pool will impact premiums. Millions of exchange customers will shop with federal subsidies—meaning that the sticker price will seem lower than the current cost of coverage. A Kaiser Family Foundation study estimated that almost half who bought their own insurance prior to the exchanges will be eligible for tax credits to offset the cost of exchange premiums.[19]

The emerging customer base

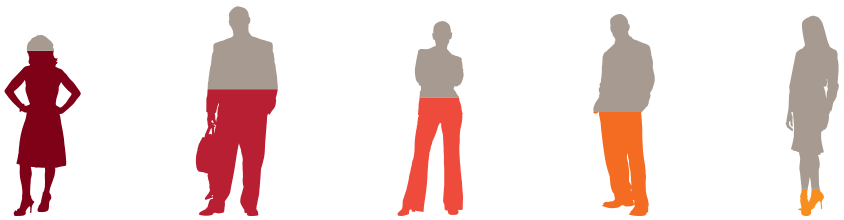
Seven million customers may enroll in individual exchange plans through the end of March 2014, with an additional 17 million joining over the next decade.

According to HRI analysis, the exchange population will have a median age of 33 and a median income around 189% of the Federal Poverty Level, about $21,700 for a single adult. Only 35% are married, 81% percent do not hold a college degree, and nearly one-in-four speak a primary language other than English. Ninety-one percent report they are in relatively good health.

Source: PwC Health Research Institute analysis for year 2014: CBO Baseline ACA Projections, May 2013; Current Population Survey, March 2012 release; 2010 Medical Expenditure Panel Survey.

Figure 4. Insurers weigh in on price*

Percent of executives who believe the following price elements will be most important to consumers



91% Premium

64% Total out-of-pocket cost

60% Deductible

50% Office visit co-pay

10% Co-insurance

94% think price will be extremely important to consumers

*Of those participating in exchanges.
Source: Health Research Institute 2013 insurance executive survey

Snaphot: exchange premium rate changes in 2014

Illustrative premiums before and after exchange implementation

HRI compared 2013 rates for six hypothetical individuals to 2014 reported rates. Pricing in 2014 varied as much as $437 between the youngest and oldest buyers but in the majority of illustrations were lower; pricing also varied by income level and state.

Figure A. Change in premium costs, 2013-2014*

		Subsidized			Unsubsidized		
		Age: 25 **Salary: $23k** Plan: Silver Smoker: No	**Age: 40** **Salary: $23k** Plan: Silver Smoker: No	**Age: 45** **Salary: $30k** Plan: Silver Smoker: No	**Age: 25** **Salary: $46k** Plan: Silver Smoker: No	**Age: 40** **Salary: $64k** Plan: Silver Smoker: Yes	**Age: 60** **Salary: $46k** Plan: Silver Smoker: No
CA	PPO	-34%	-52%	-32%	2%	-9%	-11%
	HMO	-26%	-42%	-20%	9%	0%	33%
CO		-15%	-26%	-3%	20%	4%	19%
OR		-9%	-41%	-17%	23%	14%	-5%
VT		-71%	-71%	-50%	2%	2%	2%

*Changes in California premiums vary substantially depending on whether plans are provided through PPOs or HMOs. Because of the large market share of HMOs in California, and the difference in results, we have reported those figures separately. While HMOs also have a large presence in other states, the results for HMOs and PPOs are similar.

For the six hypothetical individuals, HRI found the two primary drivers of pricing to be:

Income - HRI compared two hypothetical 25 year-old male non-smokers who bought the same silver plan. The only difference? Income. The lower-income customer saw his out-of-pocket premium cost drop by at least 9%, while the higher-income customer saw his go up in every state. That's because the federal government is picking up 52% of the premium for the lower-income customer in the form of subsidies.

Age - The ACA typically reduces premiums more for those who are older and potentially increases premiums for those who are younger. The 25-year-old below making $46,000 a year will pay between 2% and 23% more for a silver plan in 2014. Conversely, the 60 year-old may pay less for a plan in two of four states. However, HRI's analysis showed that in some states, HMOs may actually be widening their age rating, meaning they are charging comparatively more for older buyers than they did before.

Methodology

To complete this analysis, HRI compared 2013 plans sold on ehealthinsurance.com that were similar to new 2014 silver exchange plans. A silver plan has an actuarial value of 70%, meaning that the plan will pay for 70% of health expenses, while the member will pay 30%. 2013 plans with similar deductibles, co-pays, and catastrophic limits to 2014 silver plans were considered equivalent. Because of the many changes in regulations between 2013 and 2014, the plans may not be fully comparable.

Silver-tier plans were considered to illustrate the savings for low income individuals because of subsidies, and states were chosen based on a cross-sampling of publically available data. Subsidies were calculated based on the second-lowest priced silver plan.

Final rates as of September 12, 2013.

Key findings

Figure B. Tobacco Adjustments

	Pre ACA	Post ACA
CA	Yes	No
CO	Yes	Yes
OR	No	Yes
VT	No	No

Patterns vary widely by state

Variation across states is seen because:

- ***State exchanges can either be clearinghouse exchanges or active purchasers.*** Those states that are active purchasers negotiate rates and health plan features directly with insurers, bringing down premiums and reducing costs. Conversely, states with clearinghouse exchanges allow any qualified plan to join their exchange.
- ***States have different rating rules.*** Some states like Vermont do not allow insurers to adjust price for smoking status or age. Other states, like California, allowed insurers to adjust for tobacco prior to the ACA but not after (see Figure B).
- ***Some states have more participants than others.*** While California, Colorado, and Oregon have over ten insurers on their exchanges, Vermont has just two; competition also influences pricing.

Premium price influencers

Guaranteed coverage

Previously, insurers could reject individuals who were considered high risk and more expensive to cover, a practice that the ACA prohibits. Coverage is now guaranteed, which tends to increase premiums in states that did not have community rating in 2013.

Competition

State exchanges force insurers to compete against one another on premiums. Subsidies are based on the second lowest cost silver plan, so insurers will price around it.

Pricing band limits

In 2013, states decided how much insurers could adjust for age, gender, health status, and tobacco use. Now insurers may only charge up to three times more for age and 1.5 times for smoking. In states that did not have community rating in 2013, this tends to increase rates for 25 year olds and reduce rates for 60 year olds. Health status is not a pricing factor.

Low-income subsidies

The ACA provides subsidies to people earning between 100% and 400% of poverty (see Figure 3). About 86% of exchange participants will be eligible for subsidies next year.[1]

Insured pool changes

Subsidies may help entice healthy low-income people to buy coverage through the exchanges, which could drive down overall risk for insurers and lower premiums.

New products

Exchange plans will be available in five new 'tiers': Catastrophic, Bronze, Silver, Gold, and Platinum. The tiers are based on the percentage of healthcare expenses that an insurer will pay.

1 Congressional Budget Office estimates

Minimum essential benefits

In 2013, the cheapest plans had minimal benefits. The ACA requires minimum coverage for all plans, raising the cost for the lowest-cost plans.

Medical cost trend

Premiums would still rise in 2014 as they have in prior years, due to factors such as provider prices and utilization of services that are not directly related to the ACA.

State management

Some states will aggressively manage premiums in their exchanges, while others will essentially let the market self-regulate. States that manage enrollment may enforce rules that only allow lower premium plans to participate.

Changes in network design

As a strategy to decreases costs, insurers offering Preferred Provider Organization (PPO) plans are narrowing the number of doctors in their networks and may also exclude high-cost hospitals and/or providers.

Figure C. Subsidy range for a single individual
(% of premium paid for by govt)

%FPL	Salary ($)	Age		
		25	40	60
100-138%	11,490-15,856	92%*	94%*	97%*
138%	15,856	83%	86%	94%
150%	17,235	77%	82%	92%
200%	22,980	52%	62%	82%
300%	34,470	0%	15%	60%
400%	45,960	0%	0%	50%
>400%	>45,960	0%	0%	0%

*Subsidies for individuals between 100-138% FPL are only available to individuals in states that are not expanding Medicaid. Percentages shown represent 100% FPL income level. 138% FPL accounts for a 5% income disregard.

Brand will be critical

In the new exchange markets in which product and pricing are similar, customers will likely go for the recognizable brand, as they do in other sectors. "If I go to Best Buy to buy a TV, price will come into consideration, but brand will also be an important factor," said David Braza, chief actuary at Premera Blue Cross. "If I don't recognize a brand, I won't buy a product. It will be a combination of pricing and brand—making sure people know who you are."

Acting early and having a clear marketing strategy could pay off later as customers associate the concept with a brand. "If someone asks for a tissue, they ask for a Kleenex. If someone asks for something to be copied, they ask for it to be Xeroxed. There's a certain value to being a first mover," said one insurer.

Understanding the young invincibles

Enrolling a diverse mix of exchange customers will be important for health insurers to balance their financial risks. Attracting and retaining the presumably healthier "young invincibles" will be important for the industry to help offset the costs of older, likely less healthy members.

Yet it is a bit of a catch-22: while young, healthy people are needed to hold down premiums across the board, they have less incentive than the rest of the population to purchase health insurance.

Who are the coveted "young invincibles"? In 2014, the administration is targeting a group of 2.7 million adults between the ages of 18 to 35. According to White House Advisor David Simas, this group will be mostly male (57%), free of chronic conditions (96%), non-white (52%), and will reside primarily in three states—California, Florida, and Texas.[20]

Although many uninsured young adults may go without coverage in the first few years of the ACA, that will likely change. For many young people, following the law and avoiding a penalty could prove strong motivators to purchase insurance.

Case Study

When WellPoint chose an exchange marketing strategy, it decided to go big. The insurer, which owns and operates Blues plans in 14 states, signed a deal with Spanish-language television network Univision to reach viewers in California, New York, Colorado, and Georgia.

WellPoint joins two other Blues plans as the exclusive sponsors of the network's "Salud es Vida" campaign, which translates to Health is Life. The campaign is designed to educate its audience on the benefits of preventive care, healthy living, access to care, and treatment of specific diseases such as diabetes and asthma through ads and a special Univision-branded website that will let customers browse exchange options and even directly enroll through the plan sponsors' websites.

The targeted approach could pay off for WellPoint. As of 2011, 31%—or about 15 million—of the nation's Hispanic population were uninsured. Of those, 38% had incomes between 138% and 400% of the federal poverty level (between $15,856 and $45,960 for a single individual), meaning that many will qualify for exchange subsidies. And nearly half of the US Hispanic population is under the age of 26, a critical target group for insurers.

The Univision partnership reflects the importance of reaching certain ethnic groups that have had relatively little exposure to insurance. Because health insurance is a highly individualized product, cultural and demographic targeting could prove instrumental to success.

Sources: Kaiser Family Foundation analysis of the Hispanic population. April 2013. Gold,J. "Univision Obamacare Deal Could Put WellPoint, Blues Ahead of Competitors." Kaiser Health News. August 2, 2013.

The penalty for lacking insurance in 2014 is the greater of $95 or 1% of income, increasing to $695 or 2.5% of income by 2016. Many young adults will also likely qualify for subsidies: according to one analysis, of the estimated 15.7 million young adults aged 19 to 29 who were uninsured in 2012 and 2013, 80% will be eligible for insurance exchange subsidies or Medicaid.[21]

Although many young people are likely to take up coverage, they may opt for high-deductible "catastrophic" plans with lower premiums that will only be available to those under 30. Unsubsidized insurance will be more expensive for middle- and higher-income young people than it was in the past, due to factors such as age rating restrictions and essential health benefit requirements. Premium subsidies, however, are available only for the metal tier plans, making them a more likely choice for low-income young adults (see Snapshot: exchange premium rate changes in 2014).

Although the millenials may have incentive to purchase insurance, this new crop of buyers will likely demand more from their health insurers than passive financial protection: they will want products that are geared to what they value most.

Figure 5. What young invincibles value

Products with positive associations

For many young invincibles, health insurance is still seen as fixing a problem—one that does not directly impact them. "It isn't that millenials aren't invested in their health," said Rose Manning of Continuum, a design consultancy firm. "They are flossers who grew up not littering, who exercise and generally try to stay positive. Health insurance doesn't feel like the same thing." Health insurers need to tap into the "maintain or improve" mindset by emphasizing wellness over medical care.

Tangible rewards

Tangible rewards offer a visible way to mark progress, which could be especially important for young people who expect an immediate return on their investments. Examples of tangible rewards include free teeth whitening in exchange for regular dental check-ups or discounts on healthy foods. The HumanaVitality program allows consumers to earn "Vitality bucks" for healthy behaviors such as regular exercise and shop for items like digital cameras on its website.

Social networks

Virtual social networks are highly valuable to the young, technologically-savvy crowd. In the era of Facebook, Twitter, and Instagram, connecting instantly with friends and like-minded individuals has become increasingly important. Nearly 90% of 18-to-24 year olds surveyed by HRI said they would use social media to engage in health-related activities. Insurers can use social media to cultivate relationships with consumers by answering questions, providing timely feedback, and connecting them with providers and others in the healthcare community.

Personalized communications

"Young people want to feel like they have someone on the inside who is helping them navigate and pull strings," said Sean Brennan of Continuum. Carefully crafting the customer experience to minimize perceived bureaucracy is key, and insurers should look to other industries such as retail for guidance. Also important is a relevant message: men, for instance, rank financial security as an important motivator for purchasing insurance, while women are more attuned to issues such as family planning. Targeting 'trusted advisors'—in most cases, parents—can be a valuable strategy as well.

Source: PwC Health Research Institute

Snapshot: a growing digital future for the exchanges

The country's seismic shift toward a more digitized way of life has not overlooked the health industry. Examples abound in areas such as digitized health records, widespread e-prescribing, and rising clinician-patient communication via email and text.[1] Insurers need a digital strategy that supports all facets of the health insurance exchanges—from education and enrollment to customer service and retention.

Digital is just one way to reach the newly-insured and should be integrated into a broader plan for connecting to potential and existing customers. "We're designing all customer touch points—whether sales kiosks, retail locations, our system navigators in the community, or digital advertising—to link back to KP.org for mobile and desktop users," said Niki Aberle, senior director of marketing for Kaiser Permanente's Northwest Region. "Our product is health and care delivery, and our insurance offerings are the channel to help people access that. By guiding customers to KP.org, we're making it as easy as possible to conveniently access our care and services—when, where, and how they want."

Going forward HRI research shows insurers should place their digital bets on two key areas:

1. Use of mobile technologies to attract and retain exchange customers
2. Use of technologies to analyze data whenever and wherever an exchange shopper makes contact with the insurer and turn it into actionable information for insurers

How mobile fits into the exchange equation

Being able to interact with customers while they are on the go means insurers have one more way to broaden access to their services while simultaneously mitigating the insurer's financial risk. Offering mobile apps to exchange customers will make it easier for them to manage their accounts—determine subsidy eligibility, check claims, find in-network providers, estimate out-of-pocket costs, make payments—and gain easy access to medical information and health management tools.

Consumers' appetite for mobile health apps is growing. While HRI consumer research showed that 13% of consumers had healthcare, wellness, or medical applications on their mobile devices in 2012, new estimates by Research and Markets show 50% of consumers will have these apps by 2017.[2] With the large influx of newly insured into the market through the exchanges, demand for mobile tools will rise.

eHealthinsurance, a private online marketplace that has been in business since 1997 has begun to invest heavily in mobile programming in anticipation of a surge of new exchange customers. The company will connect into the federally facilitated exchanges and display subsidy eligible health plans on its website.

According to HRI's insurance executive survey, 70% of insurance executives believe the ease of finding information on a mobile device will be important to customers. But exactly half of those same executives are not confident their companies will have mobile capabilities in place by the time enrollment begins.

What to consider:

- ***Skilled mobile programmers have yet to gravitate to healthcare.*** Insurers are struggling to find staff specializing in mobile and web programming to meet the demands of consumers who want flexibility, transparency, and tools to use when shopping for insurance online.[3] Insurers may want to partner with another company to breathe life into their mobile strategies.

  In 2012 Aetna created CarePass, a collaborative technology that brings together 25 of Aetna's mobile health partners.[4] The applications on CarePass have been downloaded more than 100 million times. "We realized that a 164 year old health plan was never going to create the most innovative technology or mobile solutions, but we could create a platform to connect the latest and greatest apps for consumers," said Martha Wofford, vice president and head of CarePass at Aetna.

  Consumers can connect multiple mobile apps and select devices to CarePass, set and track goals, and access health data in one place. Aetna members can also connect information from their personal health record to create a broader picture of their health. "This is a way for all the ships to rise," said Wofford. "It helps app companies gain distribution and helps consumers and members find solutions that are convenient, connected and personalized."

  Aetna tested CarePass first with consumers, not its members. "The industry typically tries to push something out and we don't get great uptake," said Wofford. "For this, we are taking something that's already working in the market and layering in the insurance as opposed to starting inside out."

  Aetna had a similar strategy with iTriage—the only mobile health app it owns. While any consumer can use iTriage to search for a doctor, Aetna members can go a step further and find a doctor that is in-network, for example.

- ***Mobile might be the only access point for some customers.*** "I was in a rural southern state where roughly 35% of people don't have high-speed internet in their home but the vast majority of them have internet access on their phone," said Sam Gibbs, senior vice president of sales at eHealth.

  According to a HRI consumer survey, people who live in a rural area are as likely as their urban counterparts to have a smartphone. They are also are more likely to have used their smartphone for a health reason such as communicating with a physician or nurse via email or text.

- ***Mobile technologies should be as flexible as possible.*** Insurers should determine what level of mobile options they want to provide on Day 1 and have plans for expanding. Different levels of mobility return different levels of value for the insurer and the consumer (see Figure A).

1. PwC Health Research Institute. "Top health industry issues of 2013."
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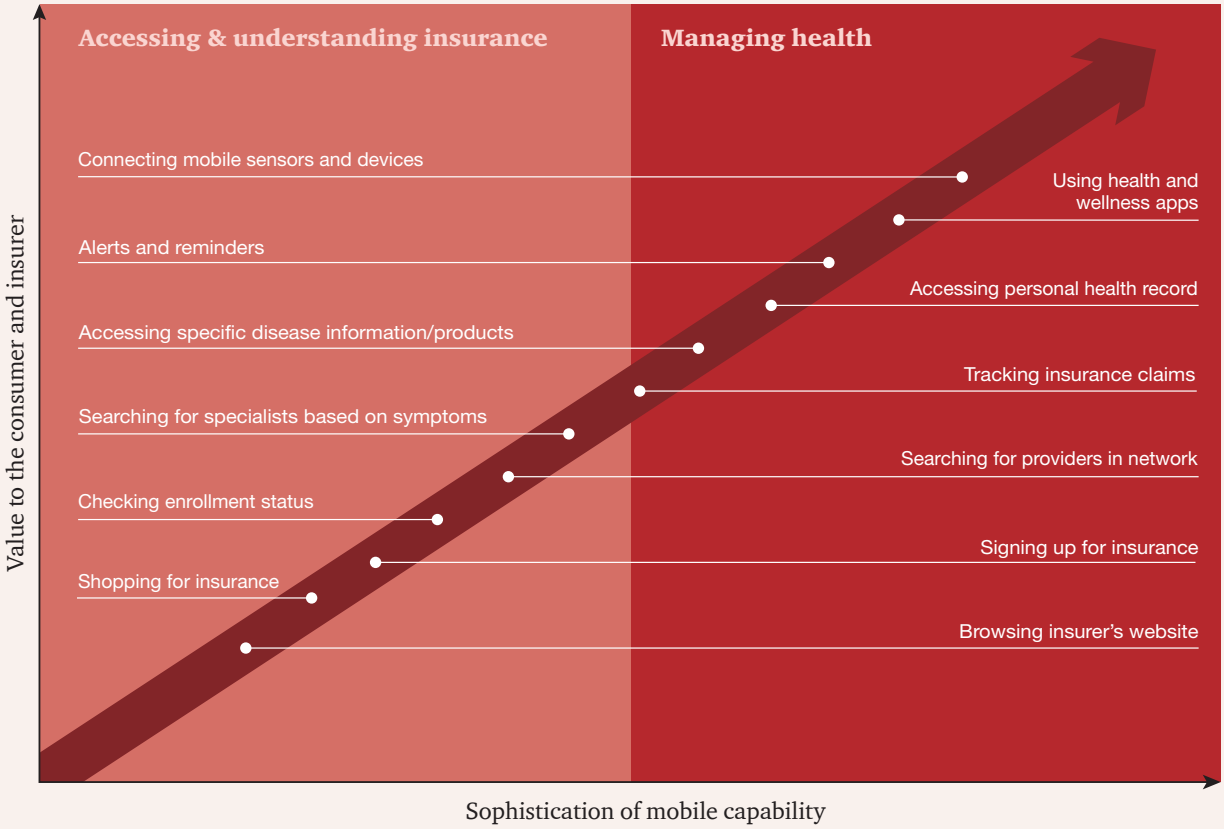
Figure A. How mobile capabilities can deliver value for exchange customers and help retain them



Source: PwC Health Research Institute

How analytics fit into the exchange equation

There are at least two main objectives for analytics in the exchange world: analytics for operational readiness on Day 1, and analytics that lend insights into member behavior and create better feedback loops that help them modify and change behaviors to improve health. Insurers must have strategies for both.

By deepening their understanding of customers—or more specifically, segmenting, profiling and trending data—insurers can develop personalized messages and offer specific resources or products based on online searches. This type of refinement enables insurers to anticipate not only members' needs, but the needs of potential customers of similar demographics and behaviors. It also should help project patient profitability and revenue for different exchange populations.

What to consider:

- ***Insurers can guide through analytics.*** According to a recent HRI survey, 64% of consumers value products that match their needs and preferences. One insurer is investing in technology that will allow it to monitor potential customers or existing members as they peruse the website and make real-time adjustments to help guide them to relevant information. For example, if a member is looking for information on diabetes, the site might suggest providers or nutritionists in the member's network or a mobile app. The same insurer is even testing technology that would allow a call representative to securely take control of a prospective customer's computer to guide the purchasing process.

  Blue Shield of California is investing in analytic technologies that connect data from all of its digital touch points with consumers and members. "We want to get a comprehensive view of what's going on so that we can test and learn, test and learn," said Jessica McCarthy, vice president for marketing and client experience at Blue Shield of California. "And as the market settles, we'll settle out with an advantage because we'll have all this data." The insurer decreased spending on television advertising from 80% to 44% of its marketing budget and redirected it to social media, online radio, mobile, and digital video.

- ***Insurers can expand and manage access through analytics.*** Analytics can provide real-time guidance on how to communicate with the newly-insured population. One insurer is developing the ability to analyze the personalities, preferences, or lifestyles—an approach known as psychographic profiling—of different exchange subgroups that would give the company insight into both demographics and behaviors.

Investing in the future

Attract new customers with competitive pricing

Consumers will be shopping on price and health plans should redouble efforts to improve value.

Many insurers are designing exchange plans that have limited or "narrow" networks of hospitals, physicians, and specialty providers. By excluding high-cost and/or low-performing providers, health plans can reduce premiums.

Plans should also revisit care management strategies such as pre-authorization requirements and prescription drug price tiers. These approaches can reduce costs but require good customer communication and education to ensure satisfaction.

Invest in retention and population health management

Attracting a new member can be more expensive than keeping one, so insurers need to invest big in retention strategies. Similarly, well-designed population health management programs can control costs while improving satisfaction.

Engaging members immediately when they join—and assessing their potential risk—is imperative. Eliza Corporation, a health engagement management company, works with insurers to build health risk assessments into the member welcome and translate those responses into a vulnerability score. These assessments allow insurers to get customers enrolled in targeted medical and prescription drug management programs before a major incident arises. Members also receive timed, tailored outreach via phone, mail, text, email, and other channels.

Some insurers, such as Premera Blue Cross, already use these techniques. Premera's members have access to personalized web pages with health risk assessments and electronic health records that can be shared with doctors, pharmacists, and other caregivers, as well as other features such as personalized communications.

Design around the customer

Health plans should focus on the customer in every aspect of product design and service delivery—or risk losing members to more consumer-friendly competitors. "Too often it's about what the member can do for the health plan, versus what the health plan can do for the member," said Marc Jeffreys, senior vice president of consumer markets at Eliza Corporation.

Insurers should create a variety of ways for customers to shop for coverage and easily access plan benefits and cost information, including in-person, online and via mobile.

They should design customer service communication channels that minimize bureaucracy and meet different social and cultural needs. Finally, they should gather customer feedback through various means such as social media, phone surveys, and text message—and develop strategies to translate that feedback into meaningful performance improvement.

Insurers should create a variety of ways for customers to shop for coverage and easily access plan benefits and cost information.

Figure 6. Measuring success in the exchanges

		Questions	Success measures
Customer experience (external)	Beginning	• How much do I know about potential customers? • How am I reaching them? • Am I growing my business? • Am I attracting a successful enrollee mix?	• Membership growth • Increase in per-member profits
	Middle	• How happy are my customers? • How good am I at identifying at-risk members and preventing adverse events? • How easy is it for members to access price, cost, and quality data? • How do I measure feedback? • How is feedback translated into performance improvement?	• High exchange quality and consumer satisfaction scores • High and/or increasing member retention rates • Low and/or declining rate of preventable adverse events • Increase in per-member profits
	End	• Why are members leaving? • What is the return rate? • Am I collecting exit data? • How am I using exit data to improve the member experience?	• Members purchase new product under same company (i.e., Medicaid plan) • Low and/or declining attrition rates
Operational (internal)		• Are IT systems able to connect with state, federal exchanges? • Do I have an effective exchange compliance program that covers privacy and security, reporting, communications, and operations requirements? • Do I have strong data analytics and mobile strategies?	• Ability to send and receive compliant data transactions with state and federal parties • State and HIPAA-compliant privacy and security programs • Compliant data reporting and member communication • Uptick in member use of mobile technology

Source: PwC Health Research Institute

Conclusion

State health insurance exchanges—buttressed by the growth of private exchanges—represent a major shift in the way individual consumers purchase healthcare. Backed by the force of federal and state laws, the marketplaces will draw an estimated 24 million customers by 2023 and attract not just traditional commercial insurers, but also new players capable of infusing the industry with fresh thinking and jolting some historic industry powerhouses.

To secure their legacy in the new market, insurers should move swiftly and strategically. They should think beyond initial implementation challenges and focus on building a meaningful customer experience, with a sharp eye on cost reduction for members. Understanding and engaging customers in ways that personally resonate, while keeping apace in a price-competitive environment, will be the foundations for success in the new exchange frontier.

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About this research

The research for this report included in-depth interviews with 21 insurance executives, consumer experts, and health policy leaders. HRI also commissioned a telephone survey of 101 executives from commercial insurers, provider-owned health insurers, Medicaid managed care insurers, third party administrators, and consumer operated and oriented plans. A total of 77 self-identified local or regional insurance executives were surveyed, along with 24 national insurance executives. In most cases, insurers offering coverage in multiple states were counted as one larger entity. The survey defined 'small' insurers as those with under 100,000 covered lives, 'medium' as between 100,000 and 1,000,000 covered lives, and 'large' as over 1,000,000 covered lives.

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