



The Race to Open Enrollment: Critical Success Factors for Exchanges

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With less than 4 months until the start of open enrollment for health insurance exchanges, health plans, policymakers, and consumer groups are rushing to finalize plans for these new marketplaces. The stakes are high for the centerpiece of the Affordable Care Act's (ACA) coverage expansion. Avalere Health estimates that exchanges will enroll 8 million individuals and families in 2014, growing to 26 million in the next decade. Millions of chronically ill individuals who to date have had limited access to insurance, wait anxiously for coverage to begin on January 1. But, to create a successful market for the long-term, exchanges will need to attract healthier individuals with a range of plan options that are sold at competitive prices.

Key Factors to Achieving Success

Over the next few months, the viability of exchange markets will hinge on 3 critical success factors:

- Choice—the selection of health plans in each market
- Cost—competitive premiums for price-sensitive purchasers
- Consumer response—widespread awareness yielding robust and diverse exchange enrollment.

1. Choice: Selection of Health Plans in Each Market

We are already beginning to get a picture of health plan participation in exchange markets. A successful exchange will offer consumers a choice of health plans and product offerings across metal levels (ie, bronze, silver, gold). Blues plans and other regional carriers, which dominate the individual market today, will be prominent participants in almost all exchanges. These plans have the brand equity to gain new enrollment, but they must also work to keep their current customers who will newly qualify for exchange subsidies in 2014. States have a choice of operating model options with varying degrees of state responsibility for exchange functions (Figure 1).

The growth opportunity of exchange coverage is also expected to draw new plans into the market, although some carriers are making these investments cautiously. CIGNA, which today controls only 1% of the individual insurance market, plans to participate in 5 state exchanges—an effort to grow the business line in pursuit of new customers. Conversely, Aetna and UnitedHealthcare have both been selective about choosing which ex-

change markets to enter, and have been carefully considering the competitive landscapes, network designs, and the marketing challenges in each state. Early indications suggest that most exchanges will include relatively strong plan participation, including regional and national carriers and nonprofit or provider-sponsored plans.

Of the 15 states and the District of Columbia that have so far released details about insurer participation, almost all have a range of plan choices for consumers (Figure 2). Some small states in New England, such as Vermont, have fewer carriers participating. In Vermont, the BlueCross BlueShield of Vermont and MVP Health Care plans, which already dominate the individual market, will be the only carriers to sell in the exchange.

So, although concerns persist about the potential lack of products in some rural regions of the country, thus far, participation appears strong enough to guarantee most consumers meaningful choice among several plan options, with more competition occurring in large, urban markets.

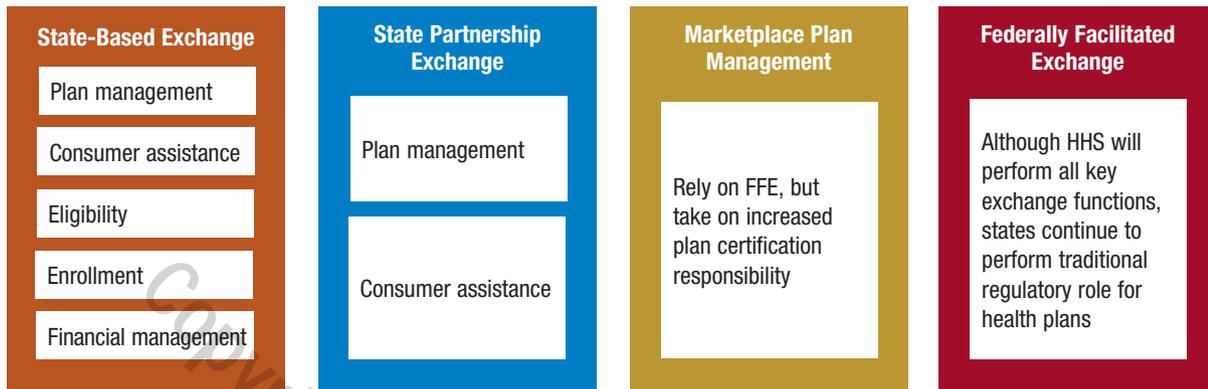
2. Cost: Competitive Premiums for Price-Sensitive Purchasers

The consumers in exchanges will most likely be sensitive to price. Without the benefit of employer contributions to offset their premiums, enrollees will be driven to the lowest-cost plans, especially plans in the bronze and silver metal levels. Although most enrollees will receive premium subsidies, these subsidies will be tied to the second-lowest-cost silver plan, and consumers will still be motivated to reduce their portion of the cost. As such, keeping premiums as low as possible in this market will be essential for health plans to drive enrollment.

Health plans face a difficult proposition in pricing products for this new market. The age and health status of likely enrollees in the exchanges remain uncertain, and individuals with the greatest health needs are the most motivated to enroll in the early years of the program. Relative to prices in today's individual market, the exchange premiums will be higher as a result of a range of new benefit requirements, rating rules, and higher-risk enrollees entering the market. Health plans need to strike a careful balance between fiscally responsible pricing that accounts for the risk profile of the anticipated exchange enrollees and competitive premiums that drive enrollment.

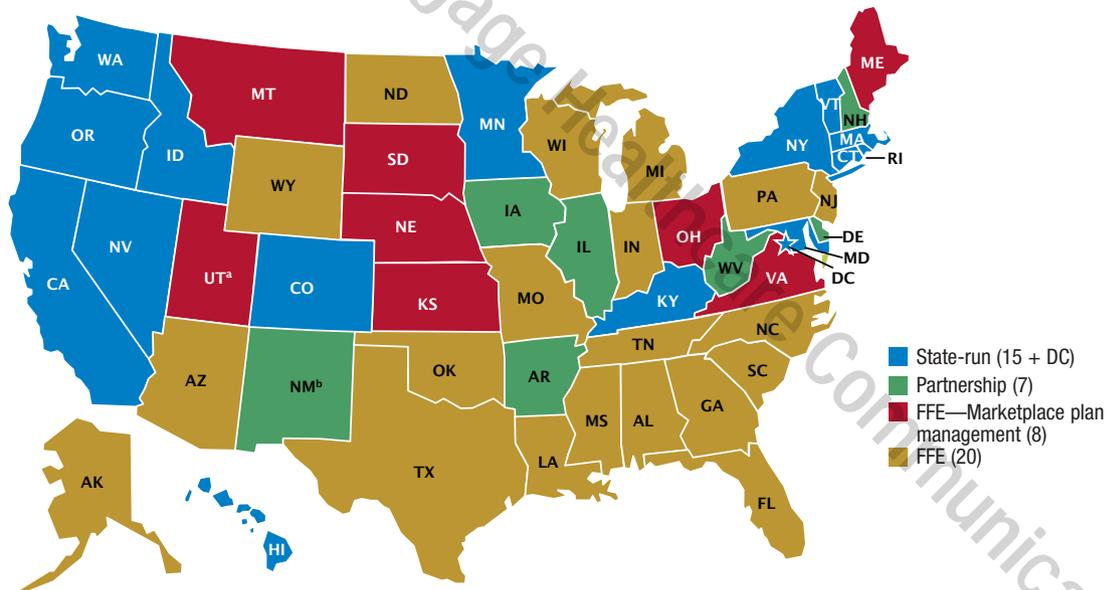
Figure 1 State Operating Model Options for Exchange Functions

Decision deadlines have passed for the 2014 plan year. Next opportunity for states to change models is the 2015 plan year—state plans or blueprint due November 2013.



FFE indicates federally facilitated exchange; HHS, Department of Health and Human Services. Copyright © Avalere Health, LLC. Used with permission.

Figure 2 Insurance Exchange Operational Model



As of May 21, 2013, 16 states and Washington, DC, will run exchanges in 2014, 6 states are pursuing partnership, and others are relying on the FFE.

^aIn addition to the marketplace plan management model for its individual exchange, Utah will rely on its existing small group exchange as its SHOP.

^bAlthough New Mexico will operate a partnership for its individual exchange, the state will run its own SHOP.

FFE indicates federally facilitated exchange; SHOP, small business health option program.

Source: Avalere State Reform Insights, May 21, 2013. Copyright © Avalere Health, LLC. Used with permission.

One of the ways that plans will keep premiums down is by relying on narrow networks of providers with whom they can negotiate lower payment rates. Although most health plans enforce physician networks today, exchanges may feature a greater use of limited hospital and pharmacy networks to drive enrollees toward lower-cost providers. Such strategies have been a major thrust of the Massachusetts exchange efforts used to limit premium increases in its market.

Over the next several months, the government will launch a marketing campaign about the exchanges and will rely on navigators. Health plans, consumer advocates, providers, and other healthcare stakeholders will play a crucial role in raising awareness about exchanges, particularly for people with low healthcare needs.

A second strategy that plans are expected to use to manage costs is to control access to prescription drugs. Minimum formulary coverage will vary greatly by state, based on the essential health benefit (EHB) rules. Although plans in 21 states are required to include more than 95% of drugs on their formularies, plans in Colorado and Utah must cover only 55% of drugs. Furthermore, the EHB rules give broad plan flexibility to manage access to drugs using prior authorization, formulary tiers, and increased cost-sharing for nonpreferred and specialty drugs. Given the limits on benefit design included in the ACA, plans will be aggressive in using narrow networks, formulary management, and other tools at their disposal to be price competitive in exchange markets.

3. Consumer Response: Widespread Awareness Yielding Diverse Exchange Enrollment

In the early years of exchanges, the highest-risk consumers will enroll faster than lower-risk individuals. Reinsurance and risk corridor programs will temporarily help insulate plans from some of the adverse selection that is sure to occur. However, long-term market stability will depend on drawing younger and healthier enrollees into exchanges via premium subsidies, the individual mandate, and the availability of catastrophic plans for young adults. The faster these healthy individ-

uals enroll, the more functional exchanges will become.

Nonetheless, in a March 2013 poll by the Kaiser Family Foundation, 77% of the respondents reported that they had heard little or nothing at all about their state's exchange, and 57% of the respondents stated that they did not have enough information about how the ACA would impact them personally.¹

Furthermore, although individual mandate penalties will raise awareness of the requirement to maintain health insurance coverage, the initial penalties are low, and taxpayers may not realize that they are subject to the penalty until April 2015 (after the end of the 2014 open enrollment period). Clearly, state and federal governments and private stakeholders face a daunting challenge to educate the public about their new coverage options and about how exchanges will impact them.

Exchange Navigators

Over the next several months, the government will launch a marketing campaign about the exchanges and will rely on navigators. Navigators will be hired to educate individuals about exchanges and to facilitate their subsidy application and plan selection process. But, limited funding—the federal government has awarded \$54 million in grants for navigators and has awarded an \$8 million contract for marketing—could stymie widespread outreach efforts. Instead, health plans, consumer advocates, providers, and other healthcare stakeholders will play a crucial role in raising awareness about exchanges, particularly for people with low healthcare needs.

Conclusion

Exchanges are positioned to be the most important tool for achieving the insurance coverage goals set forth in the ACA, and success of the law depends on the viability of these new markets. Exchanges have the potential to extend coverage to millions of people who today cannot access health insurance in the dysfunctional individual market. As we anticipate the impact of exchanges in 2014 and beyond, success will depend on plan choice, competitive cost, and diverse consumers. ■

Author Disclosure Statement

Ms Pearson has no conflicts of interest to report.

Reference

1. Kaiser Health Tracking Poll: March 2013. March 20, 2013. <http://kff.org/health-reform/poll-finding/march-2013-tracking-poll/>. Accessed May 23, 2013.