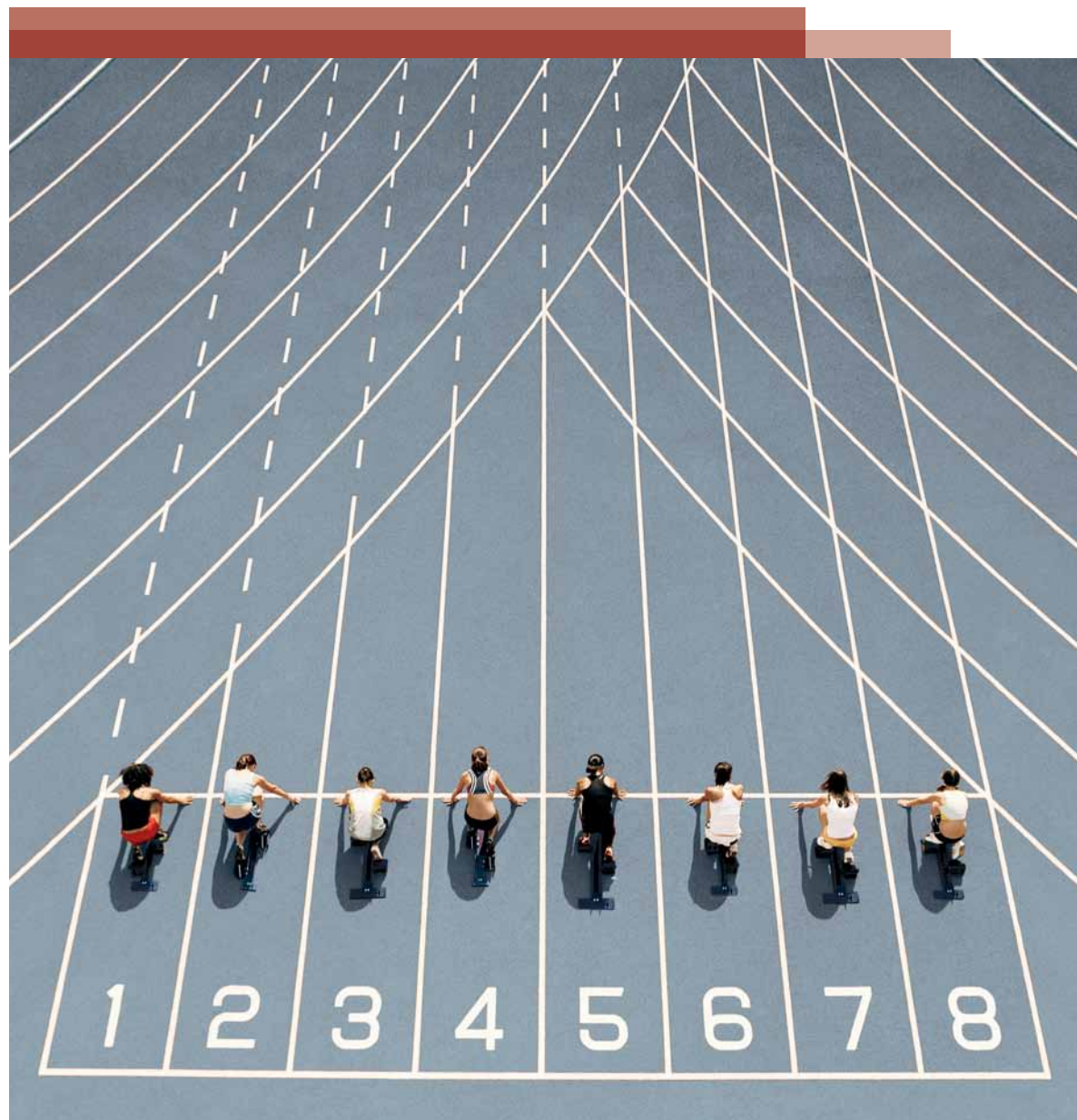


# ***Change the channel***

## Health insurance exchanges expand choice and competition

Health Research Institute

July 2011





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## ***Table of contents***

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### ***The heart of the matter*** **2**

***Insurers will compete head to head as health insurance exchanges open up consumer choice and a new \$60 billion market in 2014***

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### ***An in-depth discussion*** **6**

***The HIX channel will prompt insurers to know their individual customers, manage risk differently, and find new sales partners***

Health insurers covet exchange customers, but worry about risks 7

State exchanges will vary, and insurers must decide which ones to enter 13

Moving from risk selection to risk management 16

Identifying the new exchange consumers and what they prefer 18

Engaging the consumer 29

---

### ***What this means for your business*** **34**

***Health insurers need to prepare for market disruption, redefine the sales process, and prioritize population management***

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*The heart of the matter*

Insurers will compete head to head as health insurance exchanges open up consumer choice and a new \$60 billion market in 2014

In 2014, an estimated 12 million consumers will choose health insurers in a new, tightly regulated marketplace where choice will be king. That marketplace will encompass different state health insurance exchanges (HIXs) where health insurers compete for nearly \$60 billion in premiums. And that's just the start. By 2019, an estimated 28 million Americans will buy health insurance through this new online channel.<sup>1</sup> PwC estimates that by then, the HIXs will have grown to nearly \$200 billion in premium revenue. Insurers will compete head to head for individuals who will be required to buy their product but be able to comparison shop like never before.<sup>2</sup> This is a far cry from today's world,

where nearly all workers—except federal employees—have few choices of health plans. Choice tends to be even smaller still for those on the individual market, where nearly three-fourths are shut out because of cost, preexisting conditions, or insufficient coverage to fit their needs.<sup>3</sup>

More than half of insurance executives surveyed by PwC expect to see an increase in their individual business, and nearly half expect growth in their small group business. In the race for members, insurers must first understand these new customers. And they need to start now.

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1 Congressional Budget Office March 2011 baseline health insurance exchange estimates, <http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf>

2 Legal challenges to the individual mandate are on-going and expected to conclude prior to health exchange start dates, but this report assumes the mandate will be in effect.

3 Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi. "Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families," The Commonwealth Fund, July 2009.

## *Exchanges and insurers need to ramp up quickly to connect with the new exchange customers.*

### **Executive summary**

While the nation waits for states to declare whether they're going to develop their own health insurance exchanges or have the federal government do it for them, health insurers are debating their own decisions on how and where to play in the 2014 insurance marketplace. PwC's Health Research Institute (HRI) conducted research on health insurers' preparations and approaches to the upcoming exchange environment and surveyed consumers on their behaviors, preferences, and knowledge related to health insurance. In-depth interviews were conducted with 35 industry leaders including those representing health insurers, state governments, advocacy organizations, providers, and brokers. Although significant legal and design questions on health insurance exchanges (HIXs) remain, this report discusses key market and strategic considerations as state exchange models crystallize and insurers race to capture a piece of the 12-million membership pie in 2014.

### **Key findings**

- The health insurance exchanges, which will market policies to individuals and small groups, will be worth nearly \$60 billion in premium revenues in 2014, according to PwC estimates. By 2019, the exchange market will more than triple to nearly \$200 billion.
- Fifty-two percent (52%) of health insurance executives surveyed by HRI said their companies plan to compete for a slice of those revenues by participating in the exchanges. Nearly a third said they were undecided on whether to participate. The remainder said they do not plan to participate.
- The exchanges will create an array of new choices for customers in the individual and small group markets. Of those insurance executives who said they plan to compete in the exchanges, 37% said their companies are not in the individual market today and 20% are not in the small group market.
- The exchanges are scheduled to begin certifying plans around October 2012. While on average, insurance executives surveyed expect to be ready for exchange certification in 15 months, about 40% expect it will take 18 months, and about 20% expect it will take 24 to 36 months.

- As insurers approach 2014, adverse selection is their top concern, according to the HRI survey, followed by technology integration, such as payment or enrollment transactions.
- Insurers also are worried about how states will design the exchanges. Insurers are hoping states opt for an open marketplace. Only 10% of insurance executives surveyed favor an active purchaser model, in which states may select insurers based on their own criteria, such as excluding insurers believed to have excessive rates.
- Health insurers and the exchanges will face a huge consumer education challenge. For example, 87% of consumers in the individual exchanges are expected to be eligible for the government subsidies because of their incomes. However, in HRI's survey of consumers, 82% of people in that income group didn't know they would qualify for such subsidies.
- Consumers define quality through choice, and their preferences are expected to vary widely. The HRI survey found:
  - 37% of respondents with upper incomes (no subsidy) ranked benefits as the most important element when choosing a health plan; 43% of respondents with lower incomes (Medicaid eligible) ranked price as most important.
  - More than 60% of consumers said they should be rewarded (e.g. by gift cards or insurance discounts) for healthy behaviors, but nearly a third would give that up for a lower cost, according to the HRI survey.
- Forty-six percent (46%) of consumers say it would be easier to shop for insurance if they had someone to talk to at the insurance company; 43% would like a tool that estimates prices for common procedures.
- Insurance executives surveyed said their sales from brokers are expected to decrease by approximately 20% when the exchanges open; brokers who have established relationships will likely retain them during the early years of HIXs.
- Exchanges and insurers will need to ramp up quickly to connect with the new exchange customers. They will need to rely on a host of new partners, influencers, and channels. And maintaining those relationships will require new sales processes with influencers that include employers, providers, financial institutions, and retailers. Insurers will also need to move away from a reliance on risk selection to a focus on population risk management.

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*An in-depth discussion*

The HIX channel will prompt insurers to know their individual customers, manage risk differently, and find new sales partners

## Health insurers covet exchange customers, but worry about risk

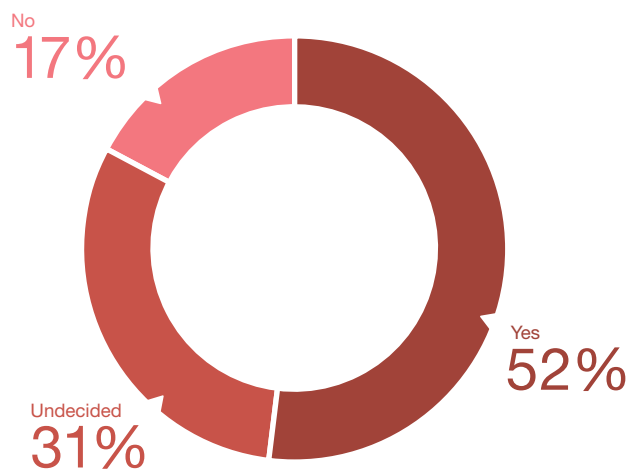
Among the most market-changing aspects in the Patient Protection and Affordable Care Act (PPACA) is the insertion of a new marketplace to buy health insurance subsidized by the government. The new marketplace is called an exchange, and the law requires two types of exchanges: American Health Benefit (AHB) Exchanges for individuals and Small Business Health Options Program (SHOP) Exchanges for small employers.

States will regulate the exchanges—unless they choose to let the federal government do so for them—and they have the option to merge both exchanges into one.

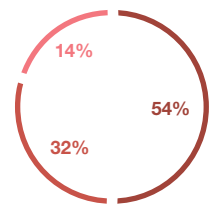
More than half (52%) of the 153 insurance executives surveyed by HRI said their organizations plan to participate in the exchanges, and nearly a third are undecided. (See Figure 1.) Slightly more intend to participate in individual exchanges. The top three drivers for participation in the exchanges are maintaining current members, adding new members, and public perception.

**Figure 1:** Health insurers' planned participation in the exchanges

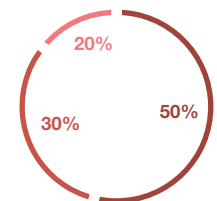
Overall participation in the exchanges



Individual exchange



Small business exchange



Source: PwC Health Research Institute Health Insurer Survey, 2011

**Figure 2:** Percent of insurance executives who expect an increase in net membership or net profit (among those who plan on participating in an exchange)



Source: PwC Health Research Institute Health Insurer Survey, 2011

The top two reasons some insurers don't plan to participate in health insurance exchanges are the ability to integrate technology (e.g. payment transactions) with the exchanges (34%) and the ability to charge enough to make a profit (23%). What will the rewards be? As shown in

Figure 2, health insurance executives surveyed by HRI said that while they expect to see membership gains, only 30% anticipate an increase in profits.

Yet, can insurers afford to stay out of these new exchanges? According to PwC estimates, the HIXs will generate nearly \$60 billion in premium dollars in 2014. By 2019, as more consumers and small businesses join the exchanges, the exchange market is expected to more than triple to nearly \$200 billion.

PwC based the market size of the exchanges on the Congressional Budget Office's (CBO) projected HIX membership (individual and small business) and the associated per capita premiums.<sup>4</sup> Specifically, the number of enrollees using the exchanges in 2014 is expected to be 12 million in 2014, but ramps up to 25 million in 2016 as the subsidies

<sup>4</sup> Per capita premium calculations are based on 2010 Kaiser Family Foundation small firm premiums of \$5,046 for single coverage and family coverage of \$13,250. The premiums were combined with the typical single and family proportions and divided by the number of people per plan to produce a small group per capita premium of \$4,200. A growth rate of 7% was applied to the 2010 per capita premium of \$4,200 to get approximately \$5,500 in 2014 and \$7,700 in 2019. Individual per capita premiums are estimated to be \$4,950 in 2014 and \$6,950 in 2019. The individual market per capita premiums are about 10% lower than small group premiums due to demographic differences in the two markets. These premiums were multiplied by the number of projected CBO enrollees in each market to generate the approximate market calculations of \$60 billion in 2014 and \$200 billion in 2019. These per capita premium numbers are roughly consistent with assumptions the CBO used in its March 2011 baseline health insurance exchange estimates. Premium revenues flowing through the exchanges could be larger or smaller than PwC estimates depending on factors such as individual mandate effectiveness and employer enrollment decisions.

become better known. The continued growth to 2019 can be attributed mostly to population growth.

The subsidies will provide powerful incentives to drive customers through the exchanges. Premium subsidies will be available to consumers with incomes of 138% to 400% of the federal poverty level (FPL).<sup>5,6</sup> Consumers above 400% FPL are able to purchase insurance, but are not eligible for subsidy assistance. The HIXs will be responsible for determining each consumer's eligibility and directing them to the appropriate programs. For instance, Medicaid and the Children's Health Insurance Program (CHIP) are separate programs from the individual exchange market, yet the exchange is responsible for determining a person's eligibility for these programs and streamlining their enrollment.

In addition, once the exchanges are operational, some small businesses will be able to receive tax credits of up to 50% of their contribution towards workers' insurance premium—but only if they use the exchanges.<sup>7</sup>

While some health insurers are in all three markets—individual, small group and Medicaid—most are not. As consumers' incomes fluctuate, their eligibility for Medicaid or a commercial plan in the individual HIX can also change. Consumers will experience less disruption if they can stay with the same health insurer as they change between these markets. Families with children who are CHIP eligible and adults who are not Medicaid eligible are inclined to select the same health insurance company to cover the entire family. More than half of all consumers surveyed (62% of Medicaid eligible, 51% of subsidy eligible, and 44% of

non-subsidy eligible consumers) said it's important to them to choose a health insurance company that offers both private commercial plans as well as Medicaid/CHIP plans. Health insurers interviewed speculated there would be an increased opportunity for partnerships and acquisitions to accelerate market presence.

The bidirectional business opportunity between Medicaid and commercial insurance opens the marketplace to new entrants. Thirty-seven percent (37%) of health insurance executives surveyed who said they currently are not in the individual market plan to participate in an individual exchange, and 20% plan to expand into the small group market.

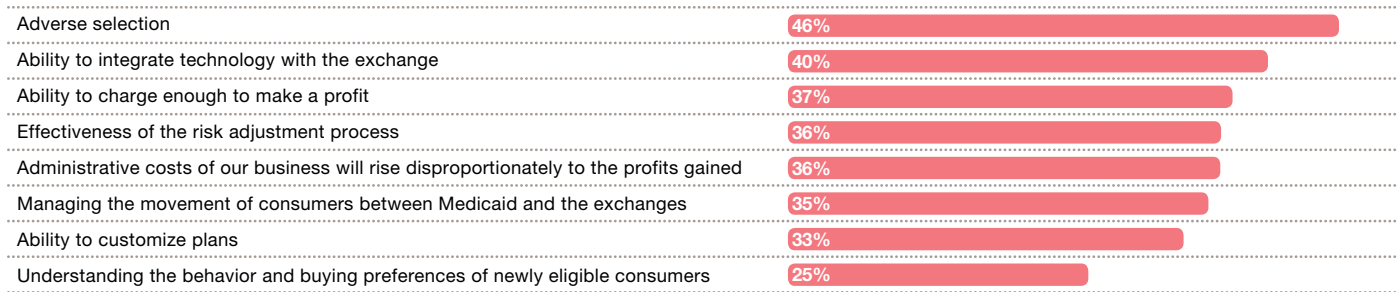
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5 In this report, Medicaid eligibility in 2014 was defined as individuals with incomes of up to 138% of the federal poverty level. While Medicaid is being expanded to cover those with incomes of less than 133% FPL, income is calculated using modified adjusted gross income (MAGI), which includes a 5% income deduction and has the net effect of raising the income cap to 138% FPL.

6 Patient Protection and Affordable Care Act, Sections 1401 and 1402.

7 Patient Protection and Affordable Care Act, Section 1421 Credit for employee health insurance expenses of small businesses.

**Figure 3: Insurers' concerns about participating in an exchange (among respondents who plan on participating in an exchange)\***



\*Respondents were able to select up to three answers

Source: PwC Health Research Institute Health Insurer Survey, 2011

***Top concern of insurers that will participate: adverse selection***

When the exchanges start operating in 2014, insurers will be required to accept all members regardless of health status. Not surprisingly, they're worried; 46% of health insurance executives whose organization will participate in an exchange say adverse selection is their primary concern. According to Bill Wehrle, vice president of health insurance exchanges at Kaiser Permanente, "Exchanges that do not have adequate mechanisms to balance the risk pool and effective mandates or incentives to drive individuals into the exchange could deter us from participating

in the exchange." Insurers' second concern is the ability to integrate technology (40%). (See Figure 3.) Steve Neeleman, MD, CEO of HealthEquity, a health savings account (HSA) and enrollment/claims administrator, said that's a valid concern that he saw when he was involved in the development of the Utah Health Exchange: "The participating insurers in Utah had to ramp up technology to be able to get information out to the insured and process payments. When it comes to payment, you have to have it all electronic because it's very inefficient to have checks mailed to insurers, brokers, and HSA companies."

## Insurers say they'll need on average 15 months to get ready

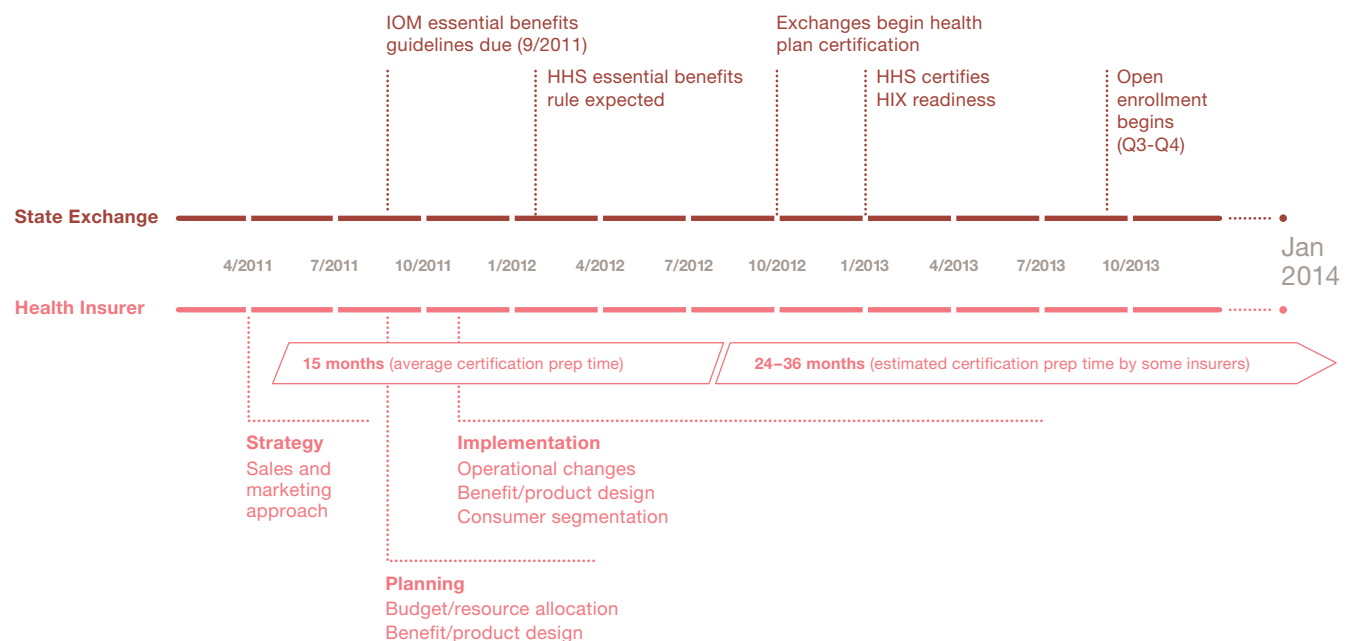
To ensure that consumers can start using the exchanges on Jan. 1, 2014, states and health insurers have much to do this year and the next. (See Figure 4.) The government has said consumers could start enrolling in the second half of 2013 for coverage that begins in 2014. It also expects the exchanges to need nine to 12 months to certify the health plans, which means health insurers must send their plans to the exchanges in late 2012.<sup>8</sup>

Among the tasks that lie ahead, market analysis, strategy completion, product development (including regulatory approval), and technology integration with the exchanges, are the most critical. Broker and sales process changes are among the top strategy discussions insurers will need to have. (See detailed discussion in *The future role of brokers* later in this report.) Insurers are in a balancing act of planning while waiting for more guidance from federal and state governments. While on average insurers expect to be ready for exchange certification in 15 months, about 40% expect it to

take at least 18 months, and about 20% expect preparation will take 24 to 36 months. For insurance executives who said their organizations plan to participate in the exchanges, 22% have their efforts on hold until there's more clarity on how the exchanges will operate. This could mean a late start and loss of market share.

<sup>8</sup> Comments made by Henry Chao, chief information officer of the Office of Consumer Information and Insurance Oversight, during a Dec. 14, 2010 conference call in response to questions from state officials. Reported by Inside Health Policy, Jan. 19, 2011.

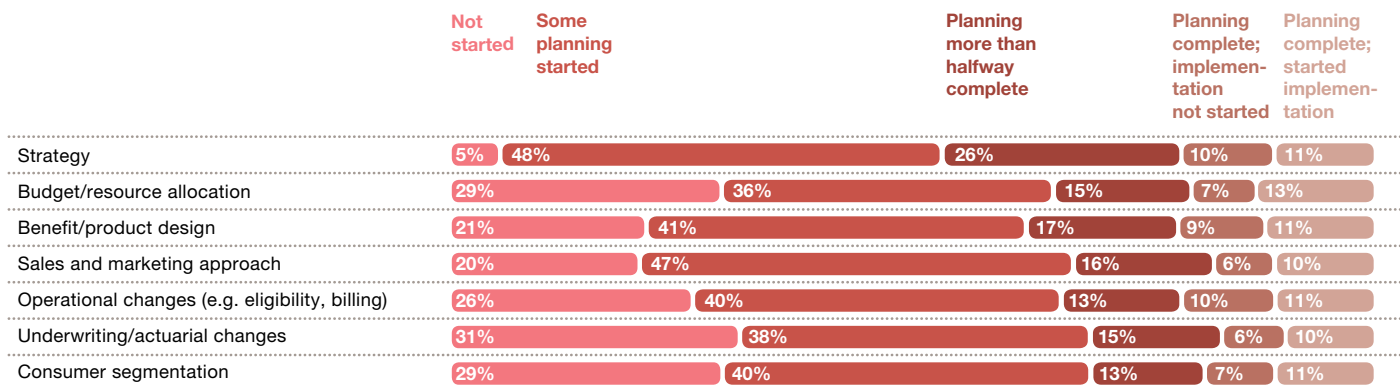
**Figure 4: Insurer planning activities and health insurance exchange milestones**



HHS = U.S. Department of Health and Human Services  
IOM = Institute of Medicine

Sources: PwC interviews, IOM, OCIO

**Figure 5: Health insurers' progress in preparing for health insurance exchanges**



Source: PwC Health Research Institute Health Insurer Survey, 2011

The primary responsibility for exchange planning falls in many places in an insurer's organization, from strategy and healthcare reform to operations, product development, and government affairs. Finance, sales and marketing, and compliance were cited by surveyed insurers as key areas with secondary responsibility. Of insurance

executives who said their organization will participate in an exchange, ninety-five percent (95%) said their strategy planning is underway or complete, but one in four has not started allocating budget or planning any operational changes. (See Figure 5.)

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## ***State exchanges will vary, and insurers must decide which ones to enter***

The health reform law provides guidelines for the health insurance exchanges, but states have flexibility in implementation. That flexibility will translate into dozens of variations across the nation, which could make some exchanges profitable for some insurers but not for others. As one insurer interviewed noted, the membership is enticing, but the financial viability may be a barrier to enter certain markets.

### ***Insurers prefer open exchange to active purchaser***

Each state can decide how it operates its exchange. One end of the spectrum is the open marketplace model, in which any plans that meet the state and federal criteria can participate. The other end is the active purchaser model, in which the exchange selects which plans can compete for members and establishes a bidding process. Health plans will face different flavors of those models from state to state. “California as an active purchaser will establish plan participation standards that could operate very differently than Massachusetts has as an active

purchaser,” said Kim Belshe, a long-time California health policy leader and board member of the California Health Benefit Exchange. “Our goal is to selectively contract with plans to increase value for members, in terms of improved quality, access, and price.”

As states define their exchange models, insurers have to figure out why the states chose a particular model. For example, Nora Leibowitz, development director at Oregon’s Health Insurance Exchange, said, “Our exchange will be evaluating health insurers on issues such as what they are doing to promote medical homes, and we will take this into consideration in the health plan ratings.” Leibowitz added: “The exchange will be a good venue for health plans to showcase their work in these areas.” Interviews with several state exchange planning leaders showed that they see the exchanges as a way of tailoring the goals of coverage in the state. For example, Figure 6 describes how if a state prizes certain goals, it could take actions to achieve them.

*10% of health insurance executives surveyed prefer the active purchaser model.*

Health insurers are used to a competitive bidding process in the large group market, but not as much in the individual and small group markets. Not surprisingly, only 10% of health insurance executives surveyed by HRI preferred the active purchaser model. Forty-four percent (44%) of respondents prefer an open marketplace model, with 46% either preferring a model somewhere between an open marketplace and active purchaser or having no preference. Insurers are worried that without some criteria, the exchanges could spark a race to the floor. “While we prefer an open marketplace, we want the exchange to have high standards for certifying health plans. There is the potential for new companies to come into the market with low prices, but not necessarily the quality,” said Jim Reed, senior vice president of marketing and sales at Excellus Blue Cross Blue Shield in New York.

**States have flexibility to set actuarial levels, benefit levels**

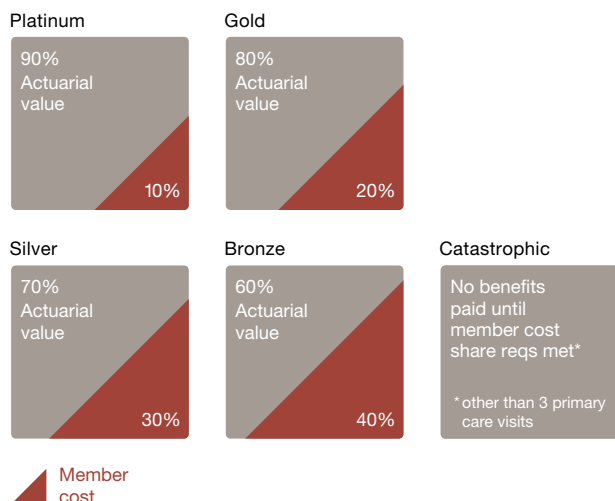
The health reform law says health plans in the exchanges must cover a minimum level of services, described as the “essential health benefits” package. The U.S. Department of Health and Human Services (HHS) is still defining all of the essential benefits, but the law says the benefits will reflect those offered by a typical employer and must include such services as maternity care, mental health, and substance abuse treatment.<sup>9</sup> However, state exchanges can require health insurers to go above and beyond what HHS defines as essential benefits. And health insurers can choose to provide more benefits than what are required.

<sup>9</sup> Patient Protection and Affordable Care Act, Section 1302(a) Essential Health Benefits Package.

**Figure 6: State exchange goals and corresponding actions**

Goal	Possible exchange actions to achieve the goal
Lower costs	<ul style="list-style-type: none"> <li>• Give a higher quality ranking or “seal of approval” for health insurers that demonstrate they are working with providers and effectively lowering medical costs</li> <li>• Bar health insurers believed to have made excessive rate hikes</li> </ul>
Enhance value-add products	<ul style="list-style-type: none"> <li>• Develop quality benchmarks and offer plans only from health insurers that meet the quality standards</li> <li>• Offer subsidies for small employers that provide plans with wellness incentives</li> </ul>
Improve consumer education	<ul style="list-style-type: none"> <li>• Provide tools for consumers to compare the out-of-pocket costs of certain procedures across plans</li> <li>• Require oversight and coordination of health insurers’ marketing materials and consumer/member outreach</li> <li>• Standardize quality and value ratings</li> </ul>

**Figure 7: Health benefits coverage level and associated actuarial value**



Source: Patient Protection and Affordable Care Act, Section 1302(d) Levels of Coverage

Consumers will be able to select from five levels of coverage, four of which will carry an actuarial value. (See Figure 7.) Each state will conduct its own actuarial analysis. The actuarial value weighs the percentage of the value of benefits provided. For instance, a bronze plan with a 60% actuarial value means the member would be responsible for 40% of the costs of all covered benefits. That 40% would include deductibles, copayments, and coinsurance.

The fifth coverage type is a catastrophic plan, but it will be offered only in limited cases. It, too, must cover the essential benefits but does not pay any benefits (except for three primary care visits) until the member has met a deductible or cost sharing requirement. The only consumers who can purchase catastrophic plans are those in the individual market, under 30 years of age, or exempt from the individual mandate because of a hardship or because affordable coverage is not available.<sup>10</sup>

According to PwC’s consumer survey, the ideal number of health plans to choose from when purchasing online is four, but that does not mean choice should be limited. In HIXs where the benefits are not strictly defined and allow some flexibility, health insurers can create multiple products. Wisconsin’s Department of Health Services project manager Craig Steele describes his state’s HIX challenge: “Wisconsin insurers will continue to have the opportunity to tailor plans to consumer preferences. The challenge for the exchange is to provide the appropriate education and present the plan information in such a way that allows consumers and employees to make an informed choice.”

A 2011 Kaiser Family Foundation (KFF) study explored possible plan designs that might fit the actuarial values for each of the four metallic benefit categories. The study found cost sharing could vary widely even though the plans ultimately have the same actuarial equivalency. How HHS and the state exchanges will assess the actuarial values has yet to be announced, but based on the KFF study, the more lenient an exchange’s valuation process, the more that cost sharing could vary among the plans.<sup>11</sup>

10 Patient Protection and Affordable Care Act, Section 1302(e) Catastrophic Plan.

11 Kaiser Family Foundation, What the Actuarial Values in the Affordable Care Act Mean, April 2011.

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## ***Moving from risk selection to risk management***

Ultimately, health insurers will need to manage the risk they receive rather than rely on choosing the risk they will manage. “We hope health insurers are deliberate about stepping out of the box and thinking about how to best structure plans versus just minimizing risk,” said Seema Verma, Indiana’s healthcare reform lead.

In 2014, insurers must comply with a whole new set of rules regardless of whether they compete in the exchanges. These rules will alter the way they calculate risk.

Health insurers are not permitted to:

- Deny coverage or charge different premiums based on a person’s health or claim history.
- Charge premiums that are more than three times higher than the lowest premium, based on age, for the same product and geography.
- Spend less than 80% of premium dollars on medical expenses for the individual and small group markets. If they do, they’ll have to pay a rebate to members.

Health insurers are permitted to:

- Charge different rates based on geography, number of persons covered (e.g. single, family), age, and tobacco use. However, there are limitations on the premium variation for age and tobacco use.
- Charge a smoker 1.5 times the premium of a non-smoker.

### ***States must address adverse selection and risk adjustment***

Health insurers’ top concern about adverse selection is not unfounded. To sustain the exchange’s success, the exchange will need to balance the risk both inside and outside the exchange. “In the 1990s, California established a health insurance exchange that failed due to adverse selection and ultimately had to shut down because it was not sustainable,” said Belshe, “California policymakers provided the exchange with additional mechanisms to prevent this from occurring with the California health benefit exchange, such as the authority to standardize benefits.”

Beginning in 2014, an estimated 240,000 individuals in current high risk pools are expected to transition to the individual market and enter the exchanges.<sup>12</sup> While this is a small percentage of those using the exchanges, the concern remains that the exchanges will become the new high risk pools.

To alleviate the impact of adverse selection, the health reform law establishes a risk adjustment process along with two temporary risk management programs: reinsurance and risk corridor. Those programs will be in place from 2014 through 2016 while the market adjusts to the shift in members and substantiates the risk adjustment process.

- **Risk adjustment.** At its simplest level, an exchange will charge a fee to health insurers whose members have lower than average risk scores (including enrollees in all plans inside and outside the exchange). Those fees would be paid to health insurers whose members have above average risk scores.<sup>13</sup>
- **Reinsurance.** Health insurers (including third party administrators on behalf of self-insured plans) will collectively pay \$25 billion over the three-year period for reinsurance. States may collect more to cover the administrative costs. Insurers with high-risk individuals and/or large claim expenses will receive payments from the reinsurance entity based on a pre-defined list of high risk conditions.<sup>14</sup>
- **Risk corridor.** This will be based on the Medicare Part D risk corridor and is similar to the risk adjustment. Health insurers with costs (minus administrative costs) of less than 97% will be assessed a fee, and those with costs that exceed 103% will receive extra payments.<sup>15</sup>

### ***Understanding risk adjustment in the HIX market***

Regardless of whether they plan to participate in the exchanges, health insurers need to thoroughly understand the risk adjustment process and calculation, since they will still be required to participate in risk adjustment. Different risk adjustment models are in use today such as DxCG's Hierarchical Condition Categories for Medicare Advantage and the Chronic Illness and Disability Payment System used by many state Medicaid programs. The commercial market also uses various risk adjustment methods to measure quality and efficiency and determine provider payments. These existing models can have varying impacts on health insurers. Health insurers may be able to influence the exchanges in the risk adjustment process by providing feedback to state exchanges. Once the process has been defined for

the exchanges, it could determine how health insurers prepare for the market shifts and their own market positioning.

### ***Insurers must excel in managing the risk received***

The backbone of managing risk rests with each insurer's care management capabilities. A successful care management methodology facilitates better management of chronic illnesses, improved collaboration with providers, reduced medical errors, and increased consumer engagement to improve patient compliance with treatments and reduce costly care. According to HealthEquity's Dr. Neeleman, "My goal for the future is to have disease specific plans. You are going to be more efficient at managing care when you are doing it every day rather than once a week."

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12 Estimate based on 221,813 people enrolled in 34 state high risk pools as of December 31, 2010. <http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7&sort=a&gsa=2> and 18,313 enrollees in the federal high risk pool at the end of March 31, 2011. <http://www.healthcare.gov/news/factsheets/pcip05062011a.html>

13 Patient Protection and Affordable Care Act, Section 1343 Risk Adjustment.

14 Patient Protection and Affordable Care Act, Section 1341 Transitional Reinsurance Programs for Individual and Small Group Markets in Each State.

15 Patient Protection and Affordable Care Act, Section 1342 Establishment of Risk Corridors for Plans in Individual and Small Group Markets.

## Identifying the new exchange consumers and what they prefer

### New requirements usher in new customers

With implementation of the health reform requirements, such as guaranteed coverage, government subsidies and the individual mandate, a new group of customers will join the ranks of the insured: nearly 28 million are expected to be using the individual and small group health insurance exchanges by 2019. (See Figure 8.) The individual market will make up the majority of these enrollees with more than three quarters of the projected membership in 2014 and nearly 90% in 2016 and 2019.

California, Florida, Georgia, and Texas are hotbeds of market fluctuation. Those four states account for nearly 30% of the entire U.S. population, and more than 8% of their residents are expected to purchase insurance through the exchanges.<sup>16, 17</sup> (See Figure 9.) However, for states to achieve their projected HIX enrollments, they need to educate and attract consumers and small businesses. As eHealthInsurance.com discovered after its launch, a large amount of work is involved in attracting members. “Just because you build the exchange doesn’t mean members will come. You have to go get the members,” said Sam Gibbs, president of government systems at eHealth.

<sup>16</sup> U.S. population figures based on 2010 Census, <http://2010.census.gov/2010census/popmap/>

<sup>17</sup> PwC analysis and CBO.

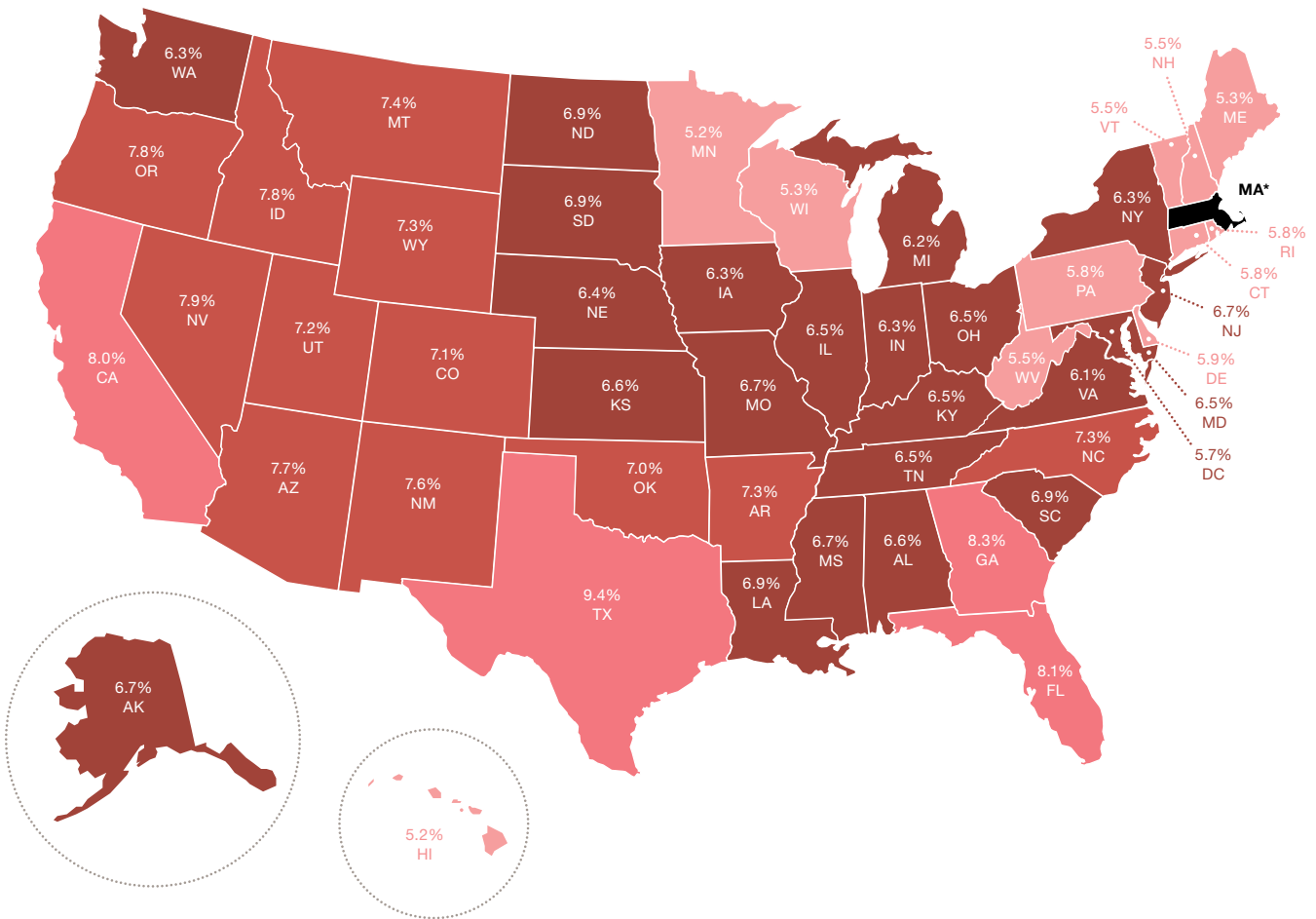
**Figure 8: Estimates of health insurance exchange membership**

Individual exchange	2014	2016	2019
Predicted membership	9 million	22 million	24 million
Subsidy eligible	87%	82%	83%
Non-subsidy eligible	13%	18%	17%
Small business exchange	2014	2016	2019
Predicted membership	3 million	3 million	4 million

Source: CBO March 2011 baseline health insurance exchange estimates, projected membership rounded to the nearest million

**Figure 9: Projected enrollment in the individual exchanges in 2019 (as a percentage of state population)**

■ 5–5.9%  
 ■ 6–6.9%  
 ■ 7–7.9%  
 ■ 8–10%



\*MA implemented an exchange in 2006 and enrollment is expected to continue with little anticipated change as a result of PPACA.

Sources: PwC analysis, CBO

*“The (health insurance) industry is moving from wholesale to retail.”*

Jeffrey Troutman,  
PNC Healthcare

Consumers and small businesses lack knowledge about exchanges. In PwC’s consumer survey, 56% of consumers didn’t know the definition of a health insurance exchange, and 82% of subsidy eligible respondents did not know they would qualify for financial assistance. According to the CBO, 87% of consumers in the individual exchanges in 2014 are expected to be eligible for the government subsidies. “One of the first hires the exchanges should make is a communications director because consumer education is key and needs to start early,” said Andrea Routh, executive director of consumer advocacy group Missouri Health Advocacy Alliance. According to Routh, “Organizations such as consumer advocacy, business groups and government agencies are starting to educate the public about the exchanges. As the states make decisions and establish the exchanges, they will improve the communication by partnering with these organizations to get the word out.”

The group of individuals expected to use the exchanges includes people for whom insurance is too expensive today, who are healthy enough that they don’t feel they need insurance, or who will move from an existing form of insurance to one provided through the exchange. “Many of the newly insured have not had a medical

home and are not used to an insurance product,” said Sandy Praeger, Kansas insurance commissioner and co-chair of the National Association of Insurance Commissioners’ exchanges subgroup. “The goal of the exchange is to do more than just provide them with a piece of paper that says they are insured—it’s educating them about how to use their healthcare so they get the appropriate care.”

Being competitive in the new environment will require a new view of customers. Jeffrey Troutman, executive vice president of PNC Healthcare, a division of PNC Bank, N.A., sees a fundamental shift: “The industry is moving from wholesale to retail, and the need to make every interaction simple and user-friendly will drive much of the success for health insurers,” he said. The direct-to-consumer sales process changes the customer mix insurers are used to. Small employers will also be joining the exchange, making up nearly 4 million of the total exchange membership in 2019.

55

75%

The average number of months those who are currently uninsured have been without insurance.

The percentage of people who cite affordability as the reason.

Source: PwC Health Research Institute Consumer Survey, 2011

According to PwC analysis of CBO projections, nearly all (97%) of the individual exchange customers in 2014 are expected to be those who were previously uninsured. The remaining 3% are expected to be those who previously had purchased individual coverage. PwC's consumer survey found out the following about the uninsured:

- 76% said they can't afford health insurance.
- 55 months is the average amount of time they have been uninsured.
- 55% are more likely to buy health insurance because of the government subsidies.
- Nearly 40% agree they are more likely to buy health insurance because of the individual mandate and associated penalty.

Affordability is expected to change for this population in 2014 when the government takes two steps: establishes a national floor for Medicaid eligibility and provides government premium assistance for middle-income Americans. Previously, states set their own standards for Medicaid eligibility; some states were stingy so as to limit spending, and others were generous. But in 2014, Americans whose incomes fall below 138% of FPL will qualify for Medicaid.

Americans with incomes of 138% to 400% of FPL will be eligible for premium subsidies to buy private insurance through the exchanges.

As the number of newly insured consumers grows, it will shift how consumers approach their health-care and how insurers address their customers' needs. "Individuals tend to have more social services needs as they move from higher income to lower income levels," said Janet Grant, executive vice president, external affairs and corporate compliance officer at CareSource, the largest Medicaid managed care plan in Ohio. "It is very difficult for Medicaid participants to focus on prevention and wellness activities when they're dealing with bigger social issues such as transportation or housing."

18 CBO's analysis of the major health care legislation enacted in March 2010, <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>

## *Understanding consumers' purchasing behaviors for their insurance and medical care is a continual process.*

### ***One size doesn't fit all***

With this shift toward a retail focus, it will be more important than ever for insurers to know who their customers are so they can meet their needs and build lasting relationships. So, who are these customers? As Figure 10 shows, their preferences vary based on their backgrounds, demographics, and genders.

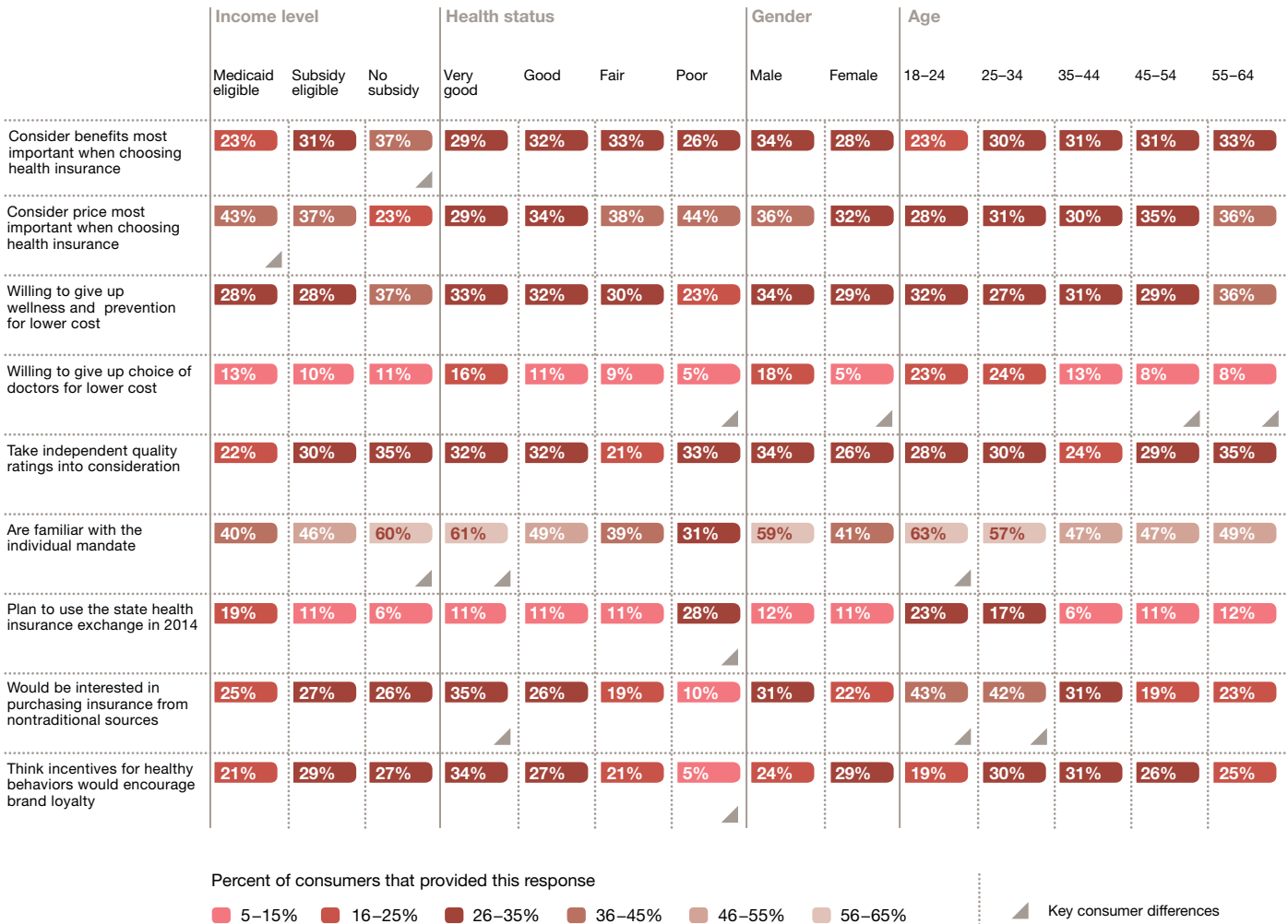
For example, surveyed consumers who are younger and healthier are more open to purchasing health insurance from nontraditional sources, such as a retail store. This is also the group that is less likely to consider price as most important. Younger consumers, consumers with higher incomes, and consumers in very good health are the most familiar with the individual mandate. Most consumers would be loyal to a health insurance company that offers incentives for healthy behaviors—except for the young and those in the poorest health.

Independent quality ratings are important to a quarter to a third of those consumers; those at higher income levels are more likely to consider independent ratings when judging the quality of a health insurance plan.

Younger consumers (aged 18 to 34 years) are three times as likely as consumers over 45 to be willing to give up their choice of doctor for a lower health insurance cost.

Understanding consumers' purchasing behaviors for their insurance and medical care is a continual process that enables health insurers to better manage the services they offer. New York health insurer EmblemHealth is aware of the importance of knowing its consumers. "We are placing increased focus on our data analytics and reporting," said Jeff Grahling, EmblemHealth's vice president of business development and health care reform. "This enables us to look at consumer behaviors and develop programs to meet the different populations. We are already seeing positive improvement from our pilot programs and are evaluating how to scale the programs to other populations."

**Figure 10: Consumer snapshot of preferences and knowledge**



Source: PwC Health Research Institute Consumer Survey, 2011

## ***How the Massachusetts exchange led some plans to narrow hospital networks***

In 2006, when the Massachusetts health insurance exchange was established, the initial goals were to expand coverage to some 650,000 uninsured residents and to improve the level of benefits provided in the marketplace.<sup>20</sup> To accomplish those goals, Massachusetts established a number of features similar to those in PPACA, such as:

- Subsidies offered to individuals with incomes of up to 300% FPL
- An individual mandate for nearly all Massachusetts residents
- A minimum level of benefits (called minimum credible coverage)
- A health insurance exchange (Health Connector) for consumers and small businesses

While Massachusetts now has the lowest uninsured rate (2%) in the nation, critics have pointed out that the reforms have done little to curb spending.<sup>21</sup> Massachusetts continues to outpace the national expenditure on healthcare.<sup>22</sup>

In 2010, the state's Division of Health Care Finance and Policy delivered its analysis of Massachusetts' healthcare spending and highlighted the recommendation for health insurers to create products that direct members to quality, lower cost providers. The Massachusetts' active purchaser exchange model gives it the authority to direct the annual competitive bidding process. In the most recent round, the state focused its attention on reducing costs for Commonwealth Care, the subsidized product for individuals with incomes of 300% FPL or less.

One plan, Network Health, responded by excluding high-cost hospitals from their provider networks. In addition to Network Health's limited provider network, the Commonwealth Care program also includes CeltiCare Health Plan, an existing low cost, limited network option. Both Network Health and CeltiCare now have the status as the "lowest cost health plans." Achieving this status allows the

health insurers to compete for certain new Commonwealth Care membership not available to the other health insurers.

That approach is expected to have a marketplace impact beyond just costs. Boston Medical Center HealthNet Plan (BMCHP), which currently has the largest share of members in Commonwealth Care, chose not to reduce its networks. "This is the biggest challenge we have faced and know it may cause some members to move toward the lower cost insurers," said BMCHP's chief financial officer Scott O'Gorman.

Some advocacy groups have concerns that narrowing networks will affect patients' access to care or, as O'Gorman noted, "create a two-tiered system that separates the slightly higher income Commonwealth Care members from Medicaid members and other patients. For the premium paying Commonwealth Care members to get the lowest rates, they end up going to networks that are less robust than the Medicaid market."

Parkland Health & Hospital System in Dallas is encouraged about the uninsured receiving coverage through the exchanges, but is concerned about the access challenges it saw in Massachusetts. According to Parkland CEO Dr. Ron Anderson, "If the products created for the exchanges are just an extension of Medicaid and do not have adequate coverage of private physicians, the Medicaid providers will be unable to support the influx of patients. You will end up with members who have insurance coverage, but cannot get the care needed."

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20 Kaiser Family Foundation, Massachusetts Health Care Reform: Three Years Later, September 2009.

21 Division of Health Care Finance and Policy, Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys, December 2010. [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mhis\\_report\\_12-2010.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mhis_report_12-2010.pdf)

22 Division of Health Care Finance and Policy, Massachusetts Health Care Cost Trends 2010 Final Report. [http://www.mass.gov/Eeohhs2/docs/dhcfp/cost\\_trend\\_docs/final\\_report\\_docs/health\\_care\\_cost\\_trends\\_2010\\_final\\_report.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/final_report_docs/health_care_cost_trends_2010_final_report.pdf)

The percent of respondents not willing to pay a higher price for any additional health insurance feature

53%

Source: PwC Health Research Institute Consumer Survey, 2011

### Brands may become neutralized in the exchanges

Consumers surveyed by PwC said that benefits and price are the two most important elements in their decision to choose a particular health insurance plan, followed by provider network and coverage area. A company being well known was the least influential attribute. Kevin Counihan, the former chief marketing officer from the Commonwealth Health Insurance Connector Authority, said he’s seen this unfold over the past five years of Massachusetts health reform: “The exchange neutralizes brand recognition and forces health plans to compete on price, provider network, and value.”

But, consumer preferences vary with income. Thirty-seven (37%) percent of respondents with upper incomes (no subsidy) ranked benefits as most important and 23% ranked price

as most important, while 43% of those with lower incomes (Medicaid eligible) ranked price as most important and 23% ranked benefits as most important. (See Figure 11.) Regardless of income, price is an important factor, and consumers are not inclined to pay more to get more. Over half (53%) of respondents are not willing to pay a higher price for any additional health insurance feature, such as dental coverage, choice of doctors, or vision coverage.

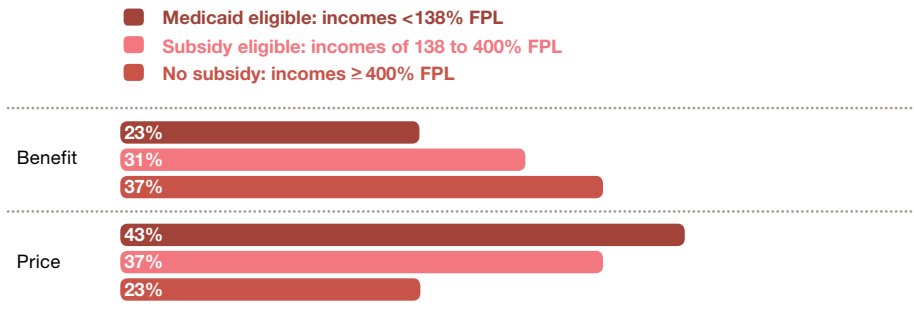
### Consumers say high quality plans have the right benefits and providers

Consumers’ perceptions of high quality health plans are driven by plans that have the covered benefits they are interested in and that include their preferred doctors and hospitals. (See Figure 12.) Neighborhood Health Plan (NHP), a health insurer with only 2% of the commercial market

in Massachusetts, has attained more than 35% of the unsubsidized market share in the Massachusetts insurance exchange, the Commonwealth Health Connector. While several factors contributed to NHP’s success with Commonwealth Choice, the state’s unsubsidized HIX, the company attributes much of its success to its price and its provider network.

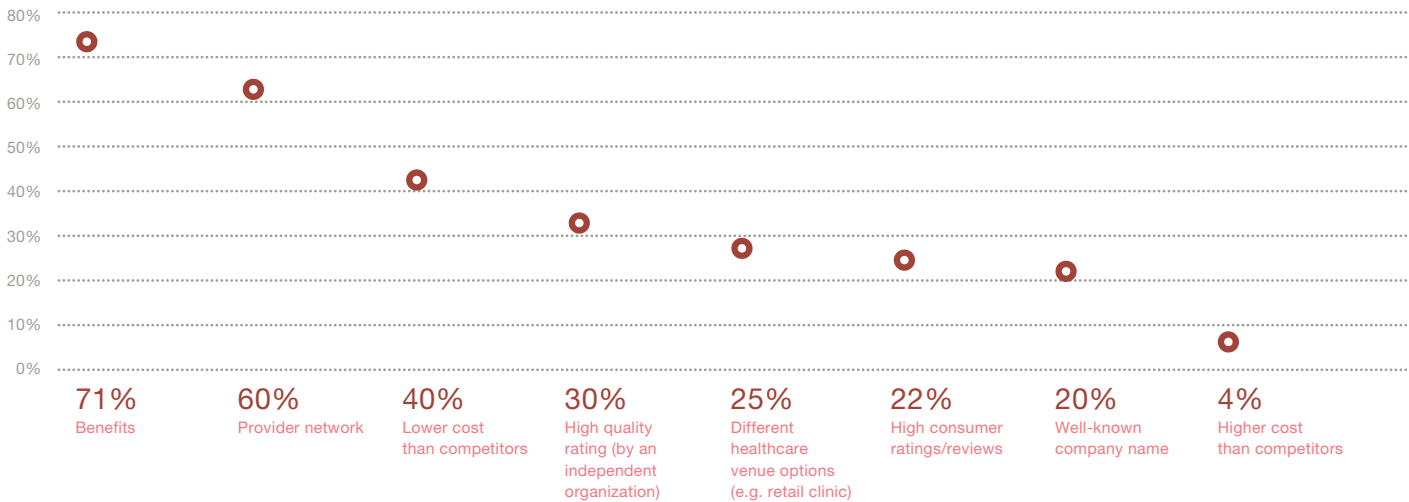
“We are priced competitively and even though we are not always the lowest cost, we have seen our total commercial membership (inside and outside of the Connector) double in the past five years,” said Carla Bettano, vice president of business development at NHP. “While our provider network is still relatively small in comparison to our competitors, we have expanded thoughtfully and more often demonstrate upwards of 80% overlap with providers for most of our small groups that had previously been insured by one of our competitors,” added Bernadette Di Re, NHP’s senior director of sales and membership. (See Massachusetts sidebar, page 24, for additional information on recent changes and implications for provider networks.)

Figure 11: Ranking of benefits or price as number one factor in insurance purchasing (based on income eligibility status)



Source: PwC Health Research Institute Consumer Survey, 2011

**Figure 12: Top characteristics that consumers look at to determine whether a health plan is of quality**



Source: PwC Health Research Institute Consumer Survey, 2011

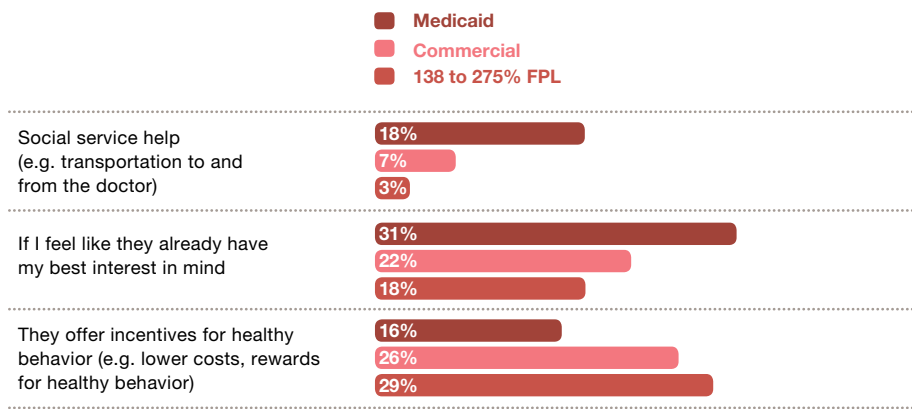
While the top characteristics for determining quality are the same for all income groups, consumers with higher incomes are 50% more likely to consider the independent quality rating of a health insurance company than are those with lower incomes.

Margaret O’Kane, president of the National Committee for Quality Assurance, which accredits and rates health plans, suggests health plans may want to use auto insurers as a potential model to endear members. “Auto insurers focus on the consumer, act as a partner with the consumer, and work toward the end goal of

helping to prevent accidents, keeping premiums low, and improving safety,” O’Kane said. “There is an art to making the member understand you are helping them and not standing between them and the care they need. It is not simple or easy but health insurers need to build that relationship with the consumer.”

According to the PwC survey, loyalty drivers vary by income. (See Figure 13.) Current Medicaid recipients gravitate toward insurance companies they feel have their best interests in mind (31%). They are six times more likely than commercial consumers

**Figure 13:** Characteristics that influence consumers to be loyal to a particular health insurance company (by current health insurance type and income)



Source: PwC Health Research Institute Consumer Survey, 2011

to prefer companies that offer social service help. Consumers with middle incomes (<275% FPL) responded similarly and are more than twice as likely as those with higher incomes to prefer health insurers that provide social service help.

These attitudes could benefit the plans that already provide Medicaid managed care and know their populations. For example, Steve O’Dell, senior vice president of Molina Healthcare, a predominantly Medicaid health insurer serving 16 states, knows that some members will move into and out of Medicaid as their incomes change. “We have seen consumers up to 275% FPL exhibit similar behaviors as and have similar characteristics to the Medicaid population. We will likely participate in the individual exchanges so we can continue to serve the financially vulnerable population and provide continuity of care for those that move between Medicaid and commercial insurance.”

### **Customer relationships ease adoption of online insurance purchasing**

Online purchasing will add another element to the insurance buying experience. Internet sales of music more than doubled in a five-year span in the early to late 2000s. Overall electronic shopping sales increased 26 times in the span of a decade from \$4 million to \$107 billion.<sup>19</sup> The retail industries created an experience that was supported, convenient, and easy to understand and use.

If health insurance purchasing evolves similarly to the retail experience, the relationship between insurers and their individual customers will make a huge shift. So far, consumers have little experience buying insurance online. (See Figure 14.) Consumers surveyed were six times more likely to have downloaded music on the Internet than to have bought health insurance. They were nine times more likely to have bought airline tickets.

<sup>19</sup> U.S. Census Bureau, <http://www.census.gov/econ/estats/>

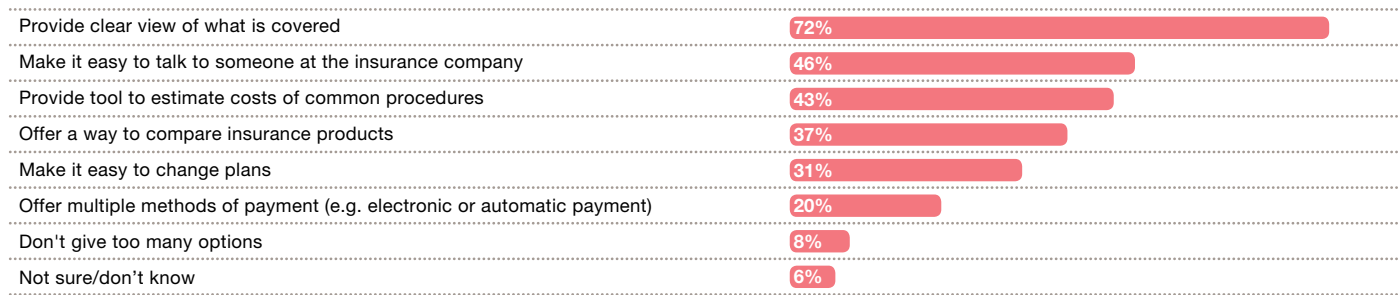
Consumers with lower incomes have the added challenge of being less experienced with online purchasing; 33% of individuals surveyed with incomes of less than 138% FPL said they have never purchased on the Internet the items shown in Figure 14.

**Figure 14:** Consumers’ experience with purchasing on the Internet

Long-term care insurance	2%
Medical/health insurance	5%
Life insurance	5%
Car insurance	17%
None of those	19%
Downloaded music	31%
Airline tickets	45%
Hotel rooms	46%
Books	52%
Clothing	53%

Source: PwC Health Research Institute Consumer Survey, 2011

**Figure 15: Top things health insurers can do to make insurance purchasing more user-friendly**



Source: PwC Health Research Institute Consumer Survey, 2011

Insurers can help with this transition. When asked how, three-fourths of consumers said insurers could be clear about what they're selling. (See Figure 15.) Insurers also could help with customer experience and satisfaction by making it easier to compare insurance products. Commercial members are especially interested in this tool and are almost twice as likely as Medicaid members to prefer such functionality. Commercial members are also a third more likely to want a tool that estimates the costs of common procedures. State health exchanges can see such tools at work now. "Our website's most used features are those that help consumers choose a plan that meets their needs, compare plans side-by-side, and check whether a doctor is included in their network," said Bill Hanis, vice president of technology at eHealth.

Consumers' other online experiences will affect their expectations about the exchanges. "Consumers' expectations of purchasing products and being serviced online have been heightened. How they purchase other items shape their expectations of purchasing health insurance online. An example is completing the transaction in real-time, being approved, and receiving a temporary ID card quickly," said Dennis Bolin, chief financial officer of Health Plan Alliance, an association of provider-owned and independent health plans.

## Engaging the consumer

When selling through the exchanges, health plans will have to educate consumers and build plan awareness through a new array of touchpoints. (See Figure 16.) Influencers—such as brokers, navigators, and exchange employees—will affect which plans gain market share.

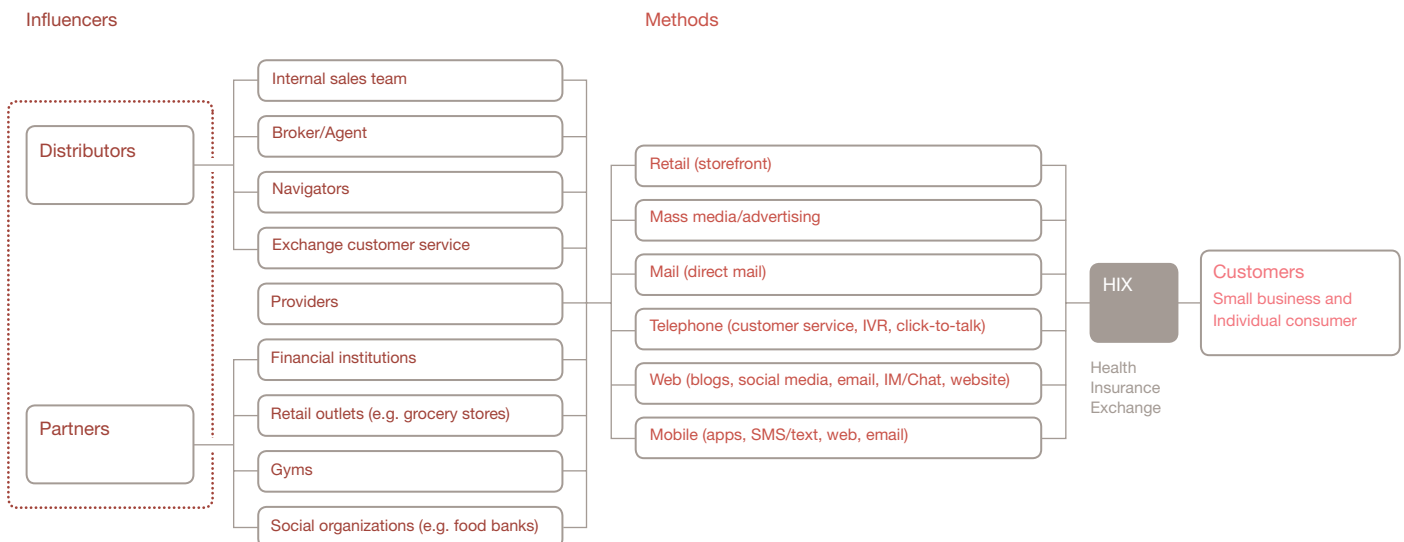
Some health plans already have experience in selling retail products to discrete markets; Medicare Advantage and Medicaid managed care plans are examples. But health plans will need to expand their retail expertise and learn how to connect with and

serve other consumers. Pennsylvania-based insurer Highmark has taken steps in that direction, operating six Highmark Direct retail stores and opening two more in the summer of 2011. Since opening its first store in March 2009, Highmark Direct has had more than 63,000 visitors and enrolled thousands of consumers.<sup>20</sup>

HRI's consumer survey showed that this retail concept could become popular: 26% of consumers surveyed said they are interested in purchasing health insurance from a nontraditional insurance company, such as a retail store, while 37% of consumers said they do not have a preference.

<sup>20</sup> Highmark press release, [https://www.highmark.com/hmk2/about/newsroom/2011/pr042511\\_vid.shtml](https://www.highmark.com/hmk2/about/newsroom/2011/pr042511_vid.shtml)

Figure 16: Consumer touchpoints during their insurance buying experience



*“Health plans are used to a business to business marketing approach. It’s entirely different when marketing to consumers, and health plans are challenged by this shift.”*

Dennis Bolin, Health Plan Alliance

A well-known brand name was seen by consumers surveyed as the least influential factor when purchasing health insurance. But, as the individual market becomes increasingly competitive, health insurers will need to distinguish themselves by creating meaningful touchpoints with members. Partnerships with outside industries, such as bundling complementary products with insurance or financial institutions, are one way in which plans may choose to market products. Other ways include connecting with consumers through hospitals, clinics, food banks, grocery stores, gyms, and retail outlets. Being present in places people frequent will help insurers establish their brand outside the exchanges. Costco already has an avenue for small businesses to purchase health insurance in California, Oregon, Hawaii and Washington. Costco also offers individual family insurance through a national carrier.

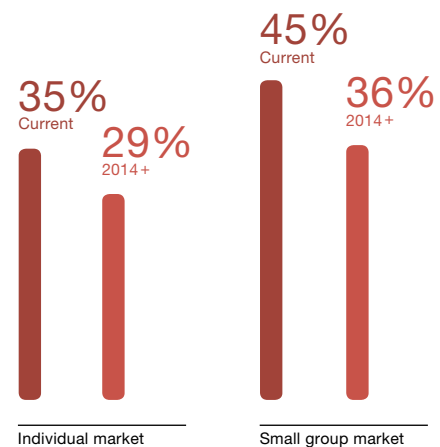
### ***The future role of brokers***

The need for brokers does not go away in 2014, but the functions brokers perform will evolve over time. Brokers will not be negotiating premiums for HIX related business, but at least initially they are expected to continue playing key roles in educating and influencing customers. Health insurance is a complex purchase, and until an exchange

enables customers to easily compare plans, provides the right decision tools, and streamlines the enrollment process, there will continue to be a demand for brokers who provide those services. According to Mila Kofman, Maine’s former insurance superintendent, “There will be a larger demand for informed agents to assist the influx of consumers purchasing insurance. Both brokers and navigators will be needed to help consumers and businesses compare their options and understand what they are purchasing.”

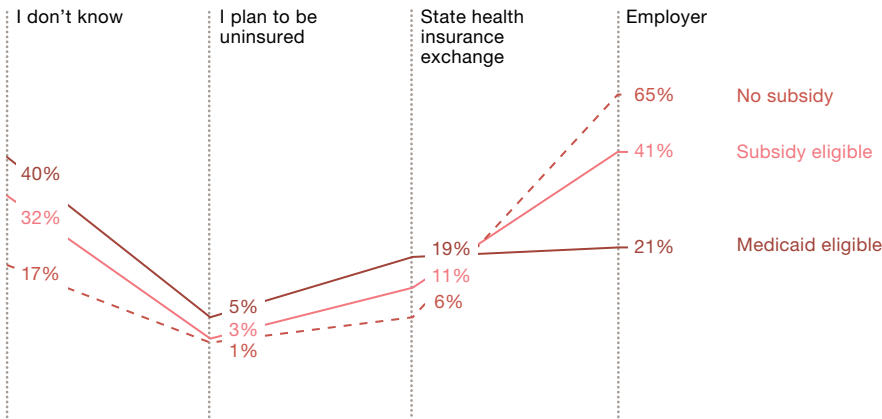
The PwC survey found that health insurers that plan to participate in the exchanges expect broker-generated business to decline by around 20% in each market. (See Figure 17.)

**Figure 17:** Percent of business health insurers say is now generated through brokers and what they expect in 2014



Source: PwC Health Research Institute Health Insurer Survey, 2011

**Figure 18: Where consumers think they'll obtain coverage in 2014**



Source: PwC Health Research Institute Consumer Survey, 2011

For small businesses, brokers are seen as the front door to the exchanges. Jeffrey Hogan, north-east regional manager of Rogers Benefit Group reflected, “As we saw in Massachusetts, if brokers are not engaged or incentivized to participate in the exchanges, small business participation will be lacking.” While the presence of brokers is expected to slightly decline, brokers have strong support for continuing to educate and guide consumers and businesses in health insurance selections. According to Terry Gardiner, vice president of policy and strategy at Small Business Majority, a small business advocacy group, “Over 80% of small businesses have a trusted

relationship with a broker and will rely on them to determine where to purchase their health insurance.” What is unclear is how exchanges will create a level playing field and avoid conflicts of interest inside and outside the exchange. As exchanges define the rules of engagement, health insurers and brokers alike will have to evaluate their current operations and the ways they position themselves and their relationships post-2014.

### **Where consumers plan to purchase insurance**

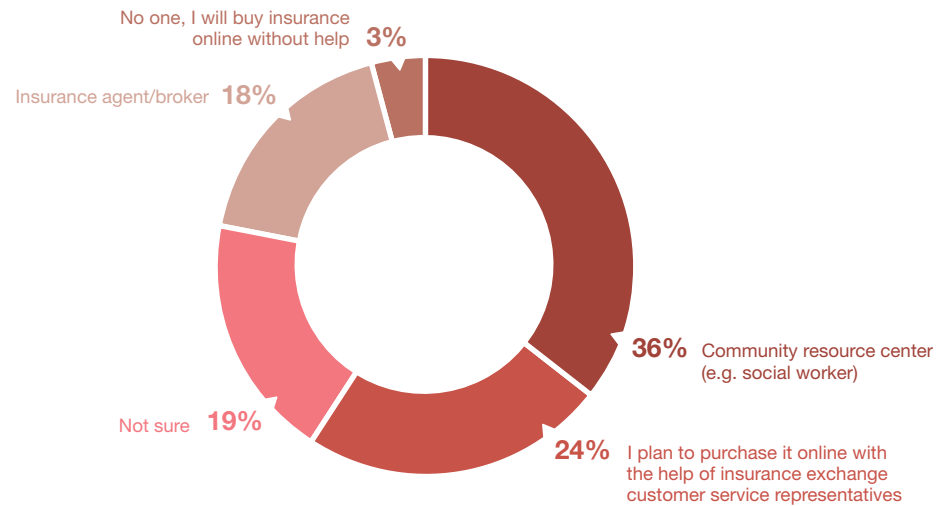
PwC’s consumer survey found that in 2014, more than 40% of consumers plan to rely on their employers for

insurance. Eleven percent (11%) expect to purchase insurance through the state health insurance exchanges. And nearly one-third of respondents do not know where they will purchase insurance. States that create a small business exchange with an employee choice model will enable health insurers to market directly to individuals of small groups. “Allowing employers to put in a set contribution and have employees purchase a plan through the exchange gives employees a choice that isn’t often available today. It also opens up a new channel for marketing products to small business employees,” said Small Business Majority’s Gardiner.

Among the Medicaid and subsidy eligible individuals, about 40% of subsidy eligible and 20% of Medicaid eligible consumers plan to purchase insurance through employers. Six percent of non-subsidy eligible consumers expect to purchase their insurance through state health insurance exchanges. (See Figure 18.)

*Trusted relationships will be an advantage in the new retail insurance environment.*

**Figure 19:** Consumers were asked: Who will you work with to buy health insurance through the exchange?



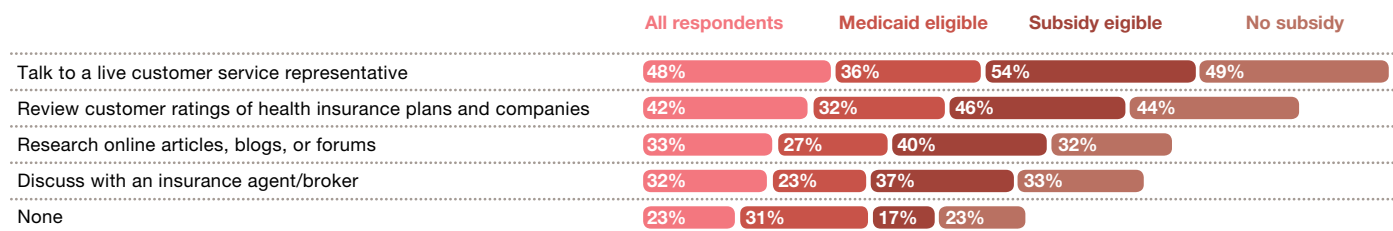
Source: PwC Health Research Institute Consumer Survey, 2011

### ***Who will influence consumers?***

Of the 11% of consumers who said they will purchase insurance through state-based exchanges, few respondents expect to purchase their insurance online without any help. Consumers say they are twice as likely to work with a community resource such as a social worker than an insurance agent or broker to help them make their purchase, and 24% of consumers plan to purchase insurance with the help of exchange customer service representatives. (See Figure 19.)

Trusted relationships will be an advantage in the new retail insurance environment. Brokers, insurance agents, providers and community resource centers have established connections with individuals and small businesses. "We are in a position to help individuals migrate to a better form of insurance," said Ron Anderson, MD, CEO of Parkland Health & Hospital System, one of the largest public hospitals in the nation. Exchanges will need to provide further guidance on the role of navigators and brokers.

**Figure 20: Support needed before purchasing health insurance over the Internet\***



\*Respondents were able to select more than one answer

Source: PwC Health Research Institute Consumer Survey, 2011

Since exchanges are fundamentally online marketplaces, the network of navigators and brokers will be the primary source of face-to-face contact with customers who need help in understanding their options and determining which plans best meet their needs. “There are vast differences in cultures which require different methods of communication,” said Routh of the Missouri Health Advocacy Alliance. As exchanges and health insurers develop those networks, it’s important to understand the different populations and the strengths navigators and brokers bring to the table in serving those populations. According to Routh, “Brokers have insurance expertise while community groups have relationships and experience overcoming barriers to enrollment and servicing these members. Partnerships between these two types of organizations will be the foundation for effective outreach.”

Consumers have little experience in purchasing health insurance online and will be looking for support before they feel comfortable buying insurance over the Internet. PwC’s survey found consumers largely want to talk with customer service representatives or insurance brokers and review peer feedback and online forums. (See Figure 20.)

As insurers are further removed from these influencers and have less control over the information being relayed on their behalf, it becomes increasingly important that they post easy to understand material online for consumers to access. They also should educate the various outlets with similar material so a consistent message is provided.

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*What this means for your business*

Health insurers need to prepare for market disruption, redefine the sales process, and prioritize population management

### ***Prepare for market disruption***

Because health insurance exchanges have never before been implemented nationally, the market could see a paradoxical future. The exchanges could lead to either market consolidation or expanded competition.

**Market consolidation:** Some insurers have started exiting markets, citing worries about guaranteed issue and new medical loss ratio (MLR) requirements. Because states have so much flexibility in designing their exchanges, insurers may find some states more profitable markets than others. In addition, some insurers with complementary products and services may join forces. And while HIXs present the opportunity for health insurers to enter new markets, the prospect may prove too expensive to undertake without partnering with one another.

**Expanded competition:** Health insurance exchanges create new territory for nontraditional health insurance companies to enter the insurance market. With only 36% of the consumers surveyed opposed to purchasing health insurance from nontraditional insurance companies, this presents an attractive market for new entrants. These players can come in the form of new health insurers or of partnerships between existing insurers and retailers or financial institutions. Companies that have the capital, market presence, and superior consumer interaction and service experience are well positioned to tap into this market.

### ***Redefine the sales process***

Brokers and internal sales teams are health insurers' primary mechanisms for attracting and retaining customers in today's individual and small group markets. Brokers have direct incentives to sell for insurers, but with HIX membership, that model shifts in 2014. Compensation becomes the responsibility of the exchange, taking away health insurers' ability to influence brokers through financial incentives. Insurers will need to find new ways to influence the influencers by demonstrating how their products benefit consumers and by making it easy for brokers, navigators, and providers to understand their plans. Investing in relationships with those who have frequent touchpoints with consumers is critical for understanding what drives plan selection, for attracting customers, and for establishing a solid position in the market.

Virtual touchpoints and such channels as social media and mobile applications could play big roles in influencing the sales process. Connecting with populations that rely on those technologies for their social interactions could create more engagement opportunities and help reduce insurers' administrative and medical costs.

## **Prioritize population management**

The individual market is financially challenging. To improve their chances, health insurers should consider the following actions:

### **1 Establish superior data tracking and analytics**

Health insurers need to maintain accurate data to feed the exchange's risk adjustment process. Such input will help exchanges determine the appropriate compensation for insurers that enroll a disproportionately sicker population and balance the risk.

Data analytics also represent a key factor in effective case management. Health insurers can better deploy nurses and case managers if they understand which members are at greater risk and who will benefit from various interventions.

Because data modeling can be complex and costly, health insurers need to thoroughly understand how the data will be used and work backwards to determine which elements to track and how. It will be important that health insurers work with their providers to maintain accurate health status profiles for their enrollees. Some simple examples are the tracking of members with chronic conditions such as diabetes and ensuring that the records submitted for risk adjustment purposes continue to report the condition year over year.

Because risk assessment systems typically look at only one year of claims data, that information will be lost if the member does not receive any services during the year or if the provider does not record the member's condition on the claims record. Studies have shown that in the absence of a concerted effort to maintain the documentation of high-cost cases, there is a marked drop off in individual risk scores for members with chronic conditions. The conversion from ICD-9 to ICD-10 also adds complexity, because the risk models currently in use in the U.S. use ICD-9.

### **2 Predict the new risk**

In addition to the already insured, health insurers need to understand the prevalent illnesses of the uninsured and of those in high-risk pools. Consider developing customized products for chronic diseases. Creating products that function like centers of excellence enable health insurers to market plans and attract members with medical care they are well versed in managing. Health insurers that can manage care at a rate lower than the average that is used in the risk adjustment model can still profit from attracting a sicker than average population while providing quality services and products for members. Attracting select populations also enables health insurers to better predict the risk that will be received and enables those insurers to better price premiums and better manage MLR thresholds.

### **3 Embrace care management**

Insurers should invest in disease management efforts and develop innovative ways to help members take better control of their healthcare and make educated decisions. Suggested practices include:

- Sharpening the care management focus on clinical software solutions and data analytics
- Investing in wellness and prevention programs to encourage healthier lifestyles and reduce chronic illnesses
- Investing in clinics to lower the use of more costly, emergency departments
- Placing nurses in clinics to work with patients in discussing treatment plans and directing their care
- Evaluating pre-authorizations and working with consumers and providers to discuss lower cost, high quality alternative care facilities for routine services such as lab work and scans

*The health insurance exchanges stand to shift current market forces and controls. Health insurers and consumers alike can benefit from those shifts if health insurers understand the new risks and consumer needs.*

## About this research

*Change the channel* represents the most in-depth research to date on health insurance exchanges by PwC's Health Research Institute (HRI). HRI conducted 35 in-depth interviews with thought leaders and executives representing health insurers, departments of insurance, state exchanges, advocacy organizations, and independent quality organizations. In addition, in spring 2011 HRI commissioned surveys of 1,000 consumers (balanced by age, sex, geography, income, and insurance status) and 153 health insurance executives regarding their preferences and expectations around health insurance exchanges.

In this report, Medicaid eligibility in 2014 was defined as individuals with incomes of up to 138% of the federal poverty level (FPL). While Medicaid is being expanded to cover those with incomes of less than 133% FPL, income is calculated using modified adjusted gross income (MAGI), which includes a 5% income deduction and has the net effect of raising the income cap to 138% FPL.

## About PwC

PwC firms provide industry-focused assurance, tax and advisory services to enhance value for their clients. More than 161,000 people in over 150 countries in firms across the PwC network share their thinking, experience, and solutions to develop fresh perspectives and practical advice. See [www.pwc.com](http://www.pwc.com) for more information.

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## PwC Health Research Institute

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