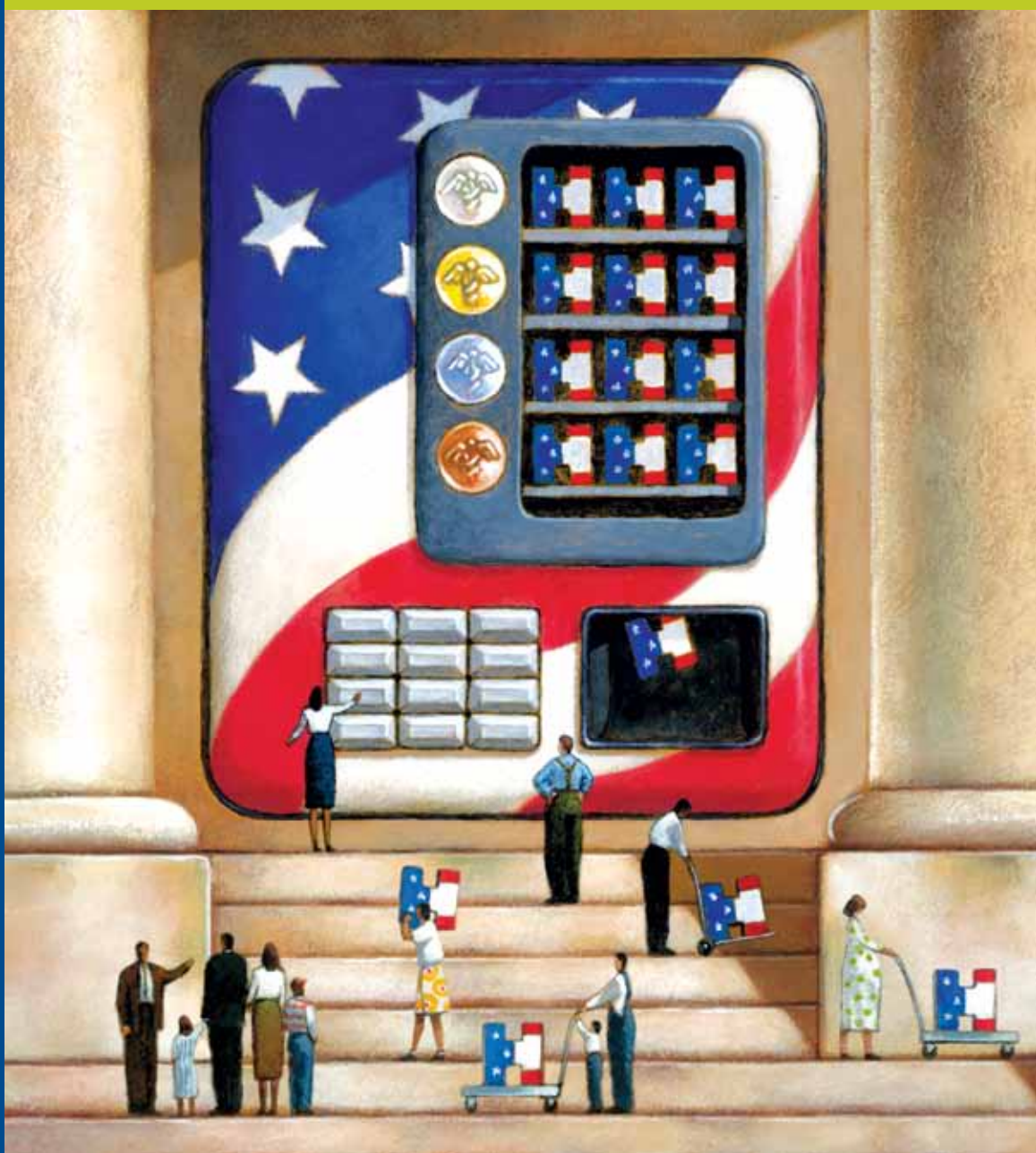
the inside track

Better benefits at work.

Health Insurance Exchanges
A marketplace for the future

- A pivotal role in the future of health care reform
- The potential to revolutionize the health insurance industry



The Health Insurance Exchanges mandated by health care reform will create an online marketplace where individuals and businesses can purchase health insurance coverage. Each exchange will act as a clearinghouse for insurance plans that are offered in a specific geographic area. The exchange model is designed to:

- Introduce managed retail competition into the marketplace to encourage better pricing and quality coverage
- Make coverage more affordable through rate oversight and subsidies
- Make it easy for individuals and small businesses to "comparison shop" for coverage
- Offer choices in standardized benefit plans and levels of coverage
- Require clear communication of plan descriptions and rates

The linchpin of reform

In many ways, the success of the Patient Protection and Affordable Care Act relies on the viability of the health insurance exchanges, which are mandated to take effect by 2014.

To understand why this is a critical linchpin to the complex national plan, consider the integral relationship between the two chief objectives of reform: providing health care coverage to millions of uninsured Americans and making that coverage affordable.

To accomplish this, the exchanges will pool together individuals and small businesses to give them greater buying power. Based on actuarial science, this concept is similar to the advantage large companies have when they contract for "group" insurance based on their greater risk pool. A large number of healthy people in a group is necessary to make the plan financially viable to offset the higher costs associated with high-risk individuals.

If the exchanges can produce a marketplace of markedly more affordable rates, they will help to make expanded coverage a reality.

By 2019, the Congressional Budget Office estimates:

- 24 million people will purchase coverage through the exchanges directly
- 5 million people will purchase exchange-based coverage through their employers

Initially there are three groups most likely to be impacted by the exchanges:

1. Potential enrollees, including:
   - Unemployed individuals
   - Self-employed workers
   - Employees at businesses that do not offer medical benefits
   - People previously denied coverage for pre-existing conditions
   - Retired workers not yet eligible for Medicare
   - Small companies unable to find affordable rates
2. Employers — The exchanges may ultimately influence the way employers of any size approach employee health benefits, and whether they continue to provide health coverage for active workers and retirees. There also will be an increased need for employee communications.
3. Brokers/agents — Their specific role has yet to be fully determined by the Department of Health and Human Services. However, they will continue to play a critical role by helping employers and employees to navigate the new landscape.

Preparing for the future

What are the factors that will determine whether the health care exchanges will be able to succeed in their pivotal role? This report details the legislative mandates that will shape the exchanges and the alliances that have preceded them. It also looks forward at the many developments yet to come, which may influence the future success — or failure — of the exchanges.

Comparison shopping for coverage

Health insurance exchanges will create a highly regulated market for health insurance coverage that will allow consumers to literally shop online for the plan and price that best fit their needs.

Will health insurance exchanges make it as easy to shop for health coverage as it is to browse online for a new pair of shoes? Not quite. However, the experience may feel somewhat like shopping for a computer, which allows consumers to compare defined elements and prices.

Similarly, health care insurance consumers will be able to compare plans online by their cost and features. The plans are categorized in four tier levels, from "Bronze" to "Platinum," and provide increasingly richer levels of coverage. Beginning in 2014, exchange-based plans will be available to individuals or to businesses with 100 or fewer employees. Initially, however, states can limit exchanges to employers with 50 or fewer employees.

Four tier levels of coverage

Plan level	Percent of average medical costs covered	Consumer cost-sharing*
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

** Consumer cost-sharing reflects, on average, the percentage of medical costs that the individual or employee will pay.*

The tiered levels of coverage from Bronze to Platinum work very much like auto insurance. When individuals choose an auto policy with a very low premium, it has a high deductible. They pay less up front, but have to pay a higher share of the cost if something happens and they need to make a claim.

Comparison shopping for coverage, continued

In order to be listed on the exchange, a health insurer must offer, at a minimum, coverage in the Silver and Gold levels. The plans with the highest level of cost-sharing, such as the Bronze and Silver plans, are designed to offer the lowest premiums.

Each of these four tier levels, as described on the previous page, will cover a package of comprehensive Essential Benefits yet to be fully determined by the Secretary of Health and Human Services (HHS). What varies from plan to plan is the level of cost-sharing, based on actuarial values. The general rule of thumb: the lower the premium, the higher the co-pays, deductibles and any other cost-sharing that the consumer will have to pay. Coverage at all tier levels must meet the minimum requirements of the Essential Benefits package.

Essential Benefits

The specific package of Essential Benefits has not yet been established by the Department of Health and Human Services, but the broad categories include:

- Preventive care
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse coverage
- Prescription drug coverage

Additional coverage options

In addition to these basic levels of coverage, the law allows for:

- Catastrophic "young invincibles" health coverage available to individuals under the age of 30
- Child-only health coverage
- Individual states to require benefits in addition to the Essential Benefits in an exchange plan. If they choose to do so:
  - When subsidies are used, the state must assume the cost by making payments to an individual enrolled in a Qualified Health Plan offered by the state; or by making payments directly to the Qualified Health Plan in which such individual is enrolled, on behalf of the individual. This is meant to defray the cost of any additional benefits.[1]

Qualified Health Plan

A Qualified Health Plan must:

- Meet certain criteria for certification issued or recognized by each exchange through which the plan is offered
- Provide the "Essential Benefits" package
- Be offered by an approved health insurer

- Exchanges must allow the offering of dental plans that provide limited scope dental benefits, either as stand-alone plans or in conjunction with a medical plan.
  - To qualify, the dental plan must provide the same children's oral health coverage required of all certified Qualified Health Plans.
  - If the stand-alone dental benefits plan that is offered provides coverage for pediatric dental benefits, then health plans offered in that exchange won't need to offer other dental coverage in order to be certified.

When is Bronze best?

The basic levels of coverage are designed to offer consumers a variety of choices that best fit their health and budget needs.

For example, healthy young adults with minimal health care needs may often choose the Bronze plan, which means they would pay, on average, 40% of the small number of medical bills they are likely to incur.

These young healthy adults may also choose to enroll in a so-called "young invincibles" plan designed specifically for young, healthy "twenty-somethings." (It is noteworthy that the plan is named for the group of under-30 activists who lobbied for its inclusion in the law.)

This catastrophic plan would feature relatively low premiums — projected to fall between $100 and $138 dollars per month — with a high deductible. It's meant to provide bare bones, affordable coverage to bring in young, healthy people to the risk pool, which will help keep premiums affordable across the board.

Selecting a richer, more expensive plan may make sense for older adults, or anyone with health or family medical history factors that could indicate the likelihood of higher usage. Although the Platinum plan would cost more in premiums, paying only 10% of covered medical expenses could represent an overall savings for the insured individual.

Some limitations

Individual purchasers can choose coverage from any of the tier levels. However, employee purchasers can choose coverage only within the tier level selected by their employer.

The supplemental safeguard

At any level of the coverage spectrum, employees can still be left vulnerable to catastrophic health events. For example, if a young, healthy individual with Bronze level coverage is seriously injured in an accident, paying 40% of the bills for trauma care could be financially devastating. A supplemental accident policy, purchased outside the exchange, could be an important fallback.

Comparison shopping for coverage, continued

Until health care costs can be better controlled, supplemental coverage may be helpful even for Platinum level enrollees, especially those with little or no savings to fall back on. For example, if the 10% cost share of a cancer treatment bill is $10,000, this still could pose a major financial issue. A supplemental critical illness policy could help guard against this kind of financial threat.

These supplemental plans pay benefits directly to the insured individuals who can use them any way they choose, whether to pay medical bills or other expenses such as utilities or mortgage payments.

The online "clearinghouse" for coverage

On July 1, 2010, the Secretary of HHS launched a federal portal to provide consumers with basic information about plans available in their area. This federal portal — or website — will be the main gathering place for data until the exchanges are up and running. It will contain links to information for consumers and employers, so they can comparison shop the insurance coverage options available to them in their state.

Individuals can review and compare the plans offered, but pricing won't be available until October 2010. The government has opened the portal to the public at this time for two reasons:

- People who qualify for the Pre-Existing Condition Insurance Plans (PCIP) (also known as the high-risk pool) can access information about temporary coverage now through the portal. This is a temporary "bridge" form of coverage that won't be needed once the exchanges open in 2014.
- The government is also soliciting comments from the public on the portal itself, particularly looking for feedback on whether it is user friendly.

To view the federal portal, go online to **www.healthcare.gov.**

Pre-Existing Condition Insurance Plans (PCIP)

The PCIP is a transitional program until 2014, which will provide a new health coverage option for Americans who have been uninsured for at least six months, have been unable to get health coverage because of a health condition, and are U.S. citizens or otherwise legally residing in the United States.

Built-in consumer protection

How will individuals or small businesses know the plans offered through an exchange will provide fair and sufficient coverage?

Each plan offered by an insurer through an exchange must be certified as a "Qualified Health Plan" and provide coverage for Essential Benefits as defined by the Secretary of HHS.

The insurer must also:

- Agree to charge the same premium rate for each plan design offered regardless of how the plan is sold, whether through the exchange or not
- Be licensed and in good standing to offer coverage in each state
- Comply with regulations developed by the Secretary of HHS

The Secretary of HHS also will develop criteria that will be used to judge whether a plan meets a number of consumer-protection benchmarks. These will govern everything from marketing practices to the number and kind of health providers included in the plan, as well as clinical quality measures and claims practices.

Transparency is critical. Insurers will be required to provide clear information that explains to consumers exactly what each plan covers and what it costs.

Transparency mandates

Through the exchange portal, consumers will be able to review information about the performance rating of health insurance plans, including:

- The percent of policies that have been rescinded
- The percent of claims that are denied under individual market and small group market policies
- Data on rating and pricing
- The number of appeals and the judgments made

Portability also is an important element of exchange coverage. This feature is designed to make it simple for people to retain health insurance if they change jobs or lose a job.

Comparison shopping for coverage, continued

The broker role

Although some consumers may prefer to do their own one-stop online shopping, others, including many employers may prefer to rely on assistance from trusted advisors. The law allows brokers and agents to:

- Enroll individuals in any Qualified Health Plans in the individual or small business market offered through an exchange
- Assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an exchange (See section 3 of this report for tax credits and cost-sharing information.)

Brokers will continue to be key advisors for employers as they determine what choices to offer employees. They also will be instrumental in communicating changes to employers and employees.

Navigation assistance for consumer education

Each exchange is required to establish a "Navigator" program, which will award grants to Navigators who educate and enroll people or small businesses in exchange plans according to established criteria.

The money for these grants will come from the operational funds of the exchange, not from federal funds that a state can receive to establish the exchange.

Navigators will perform the following functions:

- Conduct public education activities to raise awareness of the availability of Qualified Health Plans
- Distribute fair and impartial information concerning enrollment in Qualified Health Plans and the availability of premium tax credits and cost-sharing reductions
- Facilitate enrollment in Qualified Health Plans
- Provide referrals for enrollees with grievances, complaints or questions to any applicable office of health insurance consumer assistance or health insurance ombudsman, or any other appropriate state agency
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange

A Navigator may not be a health insurance issuer, or anyone who receives any consideration (directly or indirectly) from any health insurance issuer for enrolling individuals or small businesses in exchange coverage.

To be eligible, a Navigator must demonstrate to an exchange that it has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers) or self-employed individuals likely to be qualified to enroll in a Qualified Health Plan.

Navigators may include, among others:

- Trade, industry and professional associations
- Commercial fishing industry organizations
- Ranching and farming organizations
- Community and consumer-focused nonprofit groups
- Chambers of commerce
- Unions
- Resource partners of the Small Business Administration
- Other licensed insurance agents, such as enrollers
- Other entities that are capable of carrying out Navigator duties

Navigators would be paid by the exchange. So far, the Secretary of HHS has not determined a compensation rate for Navigators.

The compensation rates in existing exchange plans vary by state. While Navigators are a new concept, the Utah exchange pays brokers $37 per subscriber per month, while the Massachusetts exchange pays $10 per subscriber per month.

Subscriber

For individual coverage, subscriber refers to the policy holder; and for employer-based coverage, it refers to the employee.

The Secretary of HHS will establish standards for Navigators, to make sure they are qualified and licensed (if appropriate) to engage in the prescribed Navigator activities and to avoid conflicts of interest.

Employer role

- For small businesses participating in the exchange, the employer selects the tier level of coverage to be made available to employees.
- Employers will choose a contribution amount towards this coverage.
- Employees will then be able to choose among the offerings available in that tier level within the exchange and pay for coverage with the dollars that the employer makes available.

For more information about employer responsibilities, see the Unum report "The price of reform: Funding America's health care reform package."

The workings of an exchange

A health insurance exchange acts as a clearinghouse for qualified health insurance plans that are offered in a geographic area.

It is designed to operate with a larger risk pool of people of all ages and states of health compared to the smaller risk pool of traditional small group or individual insurance. The government has established a few important guidelines to make sure insurers stay within this new model:

Individual plan	Small business
Rates and actuarial assessments cannot be based on the people enrolled in that plan only.	Rates and actuarial assessments cannot be based on the people enrolled in that small business plan only.
One large risk pool will include all people enrolled in health plans offered by the insurer in the individual market in that state.	One large risk pool will include all people enrolled in health plans offered by the insurer in the small business market in that state.
• Includes people with this coverage purchased outside of the exchange. • People in "grandfathered" plans do not have to be included in this large risk pool.	
A state may merge the individual and small group insurance markets if it determines this to be appropriate.	

The basic functions of an exchange

Each exchange will be responsible for five major functions:

Certification — Each exchange must certify health plans as Qualified Health Plans permitted to be sold through an exchange, as discussed on page 6 of this report.

Information — Each exchange must provide information about the Qualified Health Plans offered through the exchange. This includes:

- Maintaining a website that discloses standardized comparative information on the plans
- Providing an assistance hotline
- Assigning a rating for each plan's relative quality using criteria to be established by the Secretary of HHS
- Establishing a "Navigator" program to provide grants to organizations that educate the public about the services of an exchange (Navigator programs are discussed on pages 10–11 of this report.)

Eligibility — Each exchange must inform individuals of the eligibility requirements for public health programs such as Medicaid, the Children's Health Insurance Program (CHIP) and any applicable state or local public programs, and provide a way to enroll eligible individuals in those programs.

Implementation — Each exchange must provide certifications and reports that help implement the other provisions of the law. This includes granting certifications for individuals who are exempt from the health reform requirement to maintain coverage.

Enrollment, education & service functions — In addition to the online portal that will be used for enrollment, each exchange must offer the following:

- Open enrollment — Each exchange must provide an initial open enrollment period, annual open enrollment periods, and special enrollment periods under certain circumstances. These must all comply with regulations to be issued by the Secretary of HHS.
- Rating system — The Secretary of HHS will develop a system for rating Qualified Health Plans offered through an exchange on the basis of relative quality and price. These ratings must be publicly displayed on an Internet portal established by the Secretary of HHS.
- Enrollee satisfaction system — The Secretary of HHS must develop an enrollee satisfaction survey system to evaluate consumer satisfaction with the Qualified Health Plans offered through the exchanges. This will apply only to plans with more than 500 enrollees in the previous year.
- Cost calculator — Exchanges must provide an electronic calculator to help determine the actual cost of coverage (after any tax credits and cost-sharing reductions).

The workings of an exchange, continued

An evolving concept

The idea of a health exchange is not new. Starting in the 1990s, a handful of states, including Texas and California, implemented exchange programs known as "alliances." These plans failed largely because there were no regulations in place to stop insurers from outside the alliances from "cherry-picking" the healthiest individuals from the alliance population. This left a high-risk, high-cost, medically needy population. Without enough healthy people paying into the plans, they became insolvent.[2]

There are several states that have exchanges in place. For this report we have focused on two states: Massachusetts, which calls its system a "Health Connector," and Utah.

This chart shows how these existing health exchanges compare with one another and to the proposed national program.

	Massachusetts Health Connector	Utah Health Exchange	PPACA Provisions
Established	Launched in 2006	Launched in 2009	Launched in every state by January 1, 2014
Individual vs. small group	• Targeted individuals & small businesses (combined pool) • Re-launched to small businesses in 2009	• Small businesses (2–50 employees) • Large group pilot in 2011; all businesses in 2012 • Fall 2010: individuals can access coverage via a link on the exchange	• States must offer exchanges for individuals and small businesses • States can choose to offer to these groups separately or both in one exchange
Governance of exchange	Independent government agency • 45 dedicated employees • 10 member board	• Delegated to 2 employees within governor's office • Functions contracted to private companies	• Exchange must be a governmental agency or non-profit • May contract with "eligible entities" to perform the functions of the exchange
Enrollees	• 400,000+ people	• 433 people insured* • 500 employers on waiting list	TBD
Individual mandate	Yes	No	Yes
Subsidies for low income individuals	Yes	No	Yes

**The Utah Health Exchange opened for a "Limited Launch" for small employer groups (2–50 employees) on August 19, 2009. In less than eight business days 136 businesses representing 2,333 employees signed up. Of those 136 businesses, 99 qualified as a small employer group and were eligible to continue the enrollment process. Because of the 75% participation requirement, a number of these cases did not qualify for Exchange coverage and as of January 1, 2010, 433 employees and family members had secured group health insurance via the Utah Health Exchange. Information from the Utah Exchange Portal, cited July 2010.*

	Massachusetts Health Connector	Utah Health Exchange	PPACA Provisions
Operating cost	Fiscal Year 2009: $40 million	Fiscal Year 2009: $600,000	The Secretary of HHS will offer grants to states. Exchanges must be self-sustaining by 2015. These grants have been established (see page 21 and 23 for more information)
Broker comp	$10 per subscriber per month	$37 per subscriber per month	TBD • The Secretary of HHS will issue determination on Broker/Agent role in enrollment process
Carriers participating in the exchange	• Individual: 7 carriers (includes BCBS Mass, Tufts Health Plan, and Harvard Pilgrim) • Small Business: 3 carriers	• Limited launch: 3 major carriers • Second iteration: 5 major carriers (representing 95% market)	TBD • Government will contract for at least two multi-state plans to be offered through each exchange** • The Secretary of HHS will establish a program for health co-ops to form and offer plans through an exchange
Plan requirements	An issuer must offer at least: • One plan at each tier level of benefits (Bronze, Silver, Gold) • Must make plans available outside the exchange at same price	An issuer must offer at least: • One federally qualified high-deductible plan at the lowest qualifying deductible, with out-of-pocket maximum of 3X deductible • May offer other plans	• Certified as a Qualified Health Plan • Issuer must offer at least a Gold and a Silver plan in order to participate in the exchange
Employer contribution	• Employer selects the coverage tier; workers may only purchase coverage in that tier • Employer must pay at least 50% toward premium and establish a base amount	• Defined contribution • Must achieve 75% enrollment to participate in the exchange	Employer selects the coverage tier; employees may purchase coverage in this tier only†

***Insurers offering multi-state plans would need to make them available in at least 60% of states in the first year, and increase the number of states incrementally over three years, after which the plans would have to be available in all states.*

†Employer responsibilities are discussed in detail in the Unum report "The price of reform: Funding America's health care reform package."

The workings of an exchange, continued

The **Massachusetts Health Connector** plan began in 2006. It was specifically designed to expand health insurance coverage in the state with the belief that coverage expansion was initially more critical than cost control. The plan covers more than 400,000 people, and its subsidies for low-wage earners have increased health care utilization. However, Massachusetts has discovered that the health care system is not equipped to keep up with these new demands. And according to published reports, state regulators have exercised their power to limit new competitors to the health marketplace, yet prices have continued to rise. As a result, coverage is available, but unaffordable for many individuals and businesses.[3]

In **Utah**, the piloted free-market exchange set up for small businesses is still in its experimental stage. According to reports, hundreds of small employers are on a waiting list for the 2011 enrollment season.

The Utah exchange offers a choice of more than 60 health plans, but the premiums were estimated to be up to 130% more expensive than what some companies were already paying. While Utah law had limited premium increases for traditional renewing plans, these protections were not extended to employers moving to the exchange. However, this disincentive to move to the exchange was eliminated as of February 2010, when state legislators approved a law designed to reform the exchange and mend some of its problems.[4]

Fostering competition with nonprofit co-op programs

Since healthy competition is an essential element of a successful exchange, the Secretary of HHS will establish programs designed to avoid some of the pitfalls of the early initiatives. By requiring a plan offering for each state, the Secretary of HHS is ensuring there are coverage options for all Americans.

The law calls for the development of a **co-op program**, which will be designed to foster the creation of tax-exempt nonprofit insurers. These insurers would be able to offer Qualified Health Plans in both the individual and small business market.

Additionally, the Secretary of HHS will create a **Basic Health Program**, which will allow states to contract with insurers and networks of health care providers. Together, they would offer Standard Health Plans to low-income individuals who are not eligible for Medicaid.

There is a "level playing field" provision in the law that keeps private insurers from having to meet any requirements that are not also imposed on Qualified Health Plans offered under the co-op program or multi-state Qualified Health Plans.

Health Care Choice Compacts

One provision of the law calls for "Health Care Choice Compacts," which allow two or more states to enter into an agreement permitting the offering of one or more Qualified Health Plans in the individual market in those states. Health Care Choice Compacts won't take effect before January 1, 2016. The regulations for creating these compacts have not yet been designed, but will be released by the Secretary of HHS by 2013.

The exchanges of tomorrow

How many Health Insurance Exchanges will there be? That won't be known for some time. The law allows for any state to create its own exchange, which would be administered by either a government agency or a nonprofit organization.

Will states decide to create their own exchanges? During the hotly debated evolution of the health care reform act, the states argued strongly against a national plan, which would have the federal government overseeing all exchanges.

Although several states have filed lawsuits or passed legislation in efforts to override aspects of health care reform, many states have already begun determining how their exchanges will be set up.[5]

The law allows states to contract with private, nonprofit entities to operate the exchanges. If a state fails to create an exchange, or the exchange does not meet the law's minimum standards, the federal government would then create an exchange for that state. The deadline for certification of a state-based exchange is January 1, 2013.

If the response to the Pre-Existing Condition Insurance Plans (PCIP) opportunity is any indication, states may choose to participate. So far, the majority of states plus the District of Columbia have elected to operate their own PCIP program.

Coverage outside the exchange

It's important to note that the law allows insurers to sell health insurance outside of the exchanges. However, it does require that any coverage sold inside and outside of the exchanges be priced the same.

States may also develop multiple state exchanges (when there is a larger geographic area with diverse or disparate populations needing coverage) or multi-state, regional exchanges, which could add states incrementally during the first few years.

It's too early to predict how many states will actually have their own working exchange by 2014 or work with other states to provide exchanges, rather than allowing the federal government to provide their exchange by default.

The workings of an exchange, continued

The potential impact on retiree health benefits

When the health insurance exchanges become operational in 2014, people who retire before age 65 will have access to competitive plan choices, and they cannot be turned away or offered higher rates due to pre-existing conditions.

According to Towers Watson, this will be an important development, because it may accelerate the number of employers choosing to end sponsorship of retiree health programs.[6]

In fact, a survey of employers reveals that:[7]

- 77% of employers believe that health care reform will reduce the number of large organizations offering employer-sponsored retiree medical benefits.
- 43% of employers that currently offer retiree medical plans said they plan to reduce or eliminate them.
- 55% of employers who are likely to be subject to the "Cadillac" tax on expensive health plans say they are likely to eliminate or reduce retiree medical programs.

This may be compounded by the fact that a temporary government subsidy for businesses offering early retiree health benefits will expire in 2013 if funds are not exhausted earlier.

The question of affordability

A major determinant of exchange success is whether the program can ensure that health care coverage is affordable to people of all incomes.

Since the issue of affordability has been a pain point for initiatives in the past, the health care reform law includes several important measures to address this issue. Each of the following begins in 2014 when the exchanges are in operation, unless otherwise noted:

Subsidies for exchange participants — Subsidies will be available for individuals and families with incomes equal to 133% to 400% of the federal poverty guidelines. To put that in perspective, the federal poverty level in effect for 2010 is $22,050 for a family of four. Based on that rate, the high end income level for any subsidy eligibility would be $88,200 for a family of four.

The subsidies will be implemented as refundable and "advanceable" tax credits. These are upfront cash payments that enrollees can use toward premiums. The amount of the subsidy is determined by:

- income (using a sliding scale)
- cost (based on the second-lowest priced "Silver tier level" plan available through the exchange)

The subsidies are seen as a critical element to the success of the exchanges. They are expected to draw in a large customer base to jump-start the program. Then, the availability of choice and competitive rates is designed to persuade people to remain in the exchanges.

For the most part, federal subsidies will not be available to people with access to health coverage through an employer except in these circumstances:

- If an employer's health plan does not cover, on average, 60% of an individual's cost; or
- If an employee's share of the employer premium exceeds 9.5% of his or her income

In either case, the employee is eligible to enroll in an exchange plan and receive premium and cost-sharing subsidies.

The question of affordability, continued

Cost-sharing subsidies — The law also provides for reduced cost-sharing for families with incomes at or below 250% of the federal poverty guidelines. These families are eligible to enroll in health plans that require the insurer, on average, to pay a larger share of covered expenses.

Reduced out-of-pocket limits — The law places a cap on out-of-pocket spending for everyone, regardless of income. This is designed to help people avoid bankruptcy due to exorbitant medical expenses. People with incomes at or below 400% of the federal poverty level will have a lower cap on out-of-pocket expenses than the general population.

The limits will be tied directly to the out-of-pocket limits that apply to high-deductible plans that are used with Health Savings Accounts (HSAs). Since the HSA limits are adjusted each year to reflect inflation in premiums, it's not yet possible to accurately predict what those limits will be in 2014. For 2011, the figures are:

Single	$5,950
Family	$11,900

Free choice vouchers — If an employer offers a Qualified Health Plan under an eligible employer-sponsored plan and pays any portion of the cost of that plan, it must also offer the alternative of a "free choice voucher" to employees who meet these criteria:

- Their required contributions to the plan would be between 8% and 9.8% of their household income (adjusted by the Secretary of Labor after 2014 to reflect rates of premium growth).
- Their household income is not greater than 400% of the poverty line.
- They choose not to participate in a health plan offered by the employer.

These vouchers are equal to the portion of the cost the employer would have paid for the company plan at its highest level of coverage. The employee can use the voucher to obtain coverage on an exchange and keep any balance of funds that remain.

The voucher amount is not included in the employee's income. For the employer, the amount of the voucher generally would be treated as deductible employee compensation.

The Secretary of HHS will issue rules that prescribe the method by which household income is calculated.

State grants for creating exchanges — The federal government will provide grants to states for establishing exchanges. Grants will be renewed for states that have made sufficient progress toward establishing an exchange, but no grants will be made after January 1, 2015. After this date, exchanges must be self-sustaining. For more details on grants see page 23.

Loans/grants for co-op programs — By July 2013, the federal government will provide loans or grants for co-op programs to nonprofit, member-run corporations that offer Qualified Health Plans. To qualify, these corporations cannot be affiliated with existing insurers and cannot be sponsored by state or local governments. These new insurers will be required to use any profits generated by the plans to lower premiums or improve benefits. They must comply with all state requirements for insurers of Qualified Health Plans.

No penalties for cancellation — An exchange, or a Qualified Health Plan offered through an exchange, may not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for another Essential Benefits plan.

Employer considerations

Beginning March 1, 2013, employers that are covered under the Fair Labor Standards Act will be required to notify each current employee and new employees at the time of hiring:

- About the existence of the exchanges and the services they provide
- That, if the employer's share of the total allowed cost of benefits under its plan is less than 60%, the employee might be eligible for a tax credit and a cost-sharing reduction if the employee purchases coverage through an exchange
- That, if an employee purchases coverage through an exchange without a free choice voucher from the employer, the employee may lose any employer contribution for health benefits and any related tax advantage

Oversight and enforcement

While the Secretary of HHS will determine many of the guidelines and regulations for the operation of exchanges, the day-to-day governance of the program will be left to the exchanges themselves, and the states which provide them.

Each exchange must be operated by a government agency (state or federal) or by a nonprofit agency. The law allows states to contract with "eligible entities" to perform the functions of the exchange.

Each exchange will be responsible for inspecting the policies offered by insurers to make sure they meet the government's standards for Qualified Health Plans and that the coverage is in the best interest of buyers.

In addition, each exchange will be charged with risk adjustment, to make sure the insurers are competing on level ground, which will foster healthy competition within the marketplace.

An eye on premiums

The exchanges cannot set premiums. However, they will oversee requests for premium increases and can prohibit an insurer from participating if the increases are determined not to be justified.

An insurer proposing an increase will submit the information and the exchange will consider whether it falls under patterns or practices that constitute excessive or unjustified premium increases.

The exchange must also take into account any excess of premium growth outside the exchange as compared to the rate of premium growth of plans within it, including information reported by the states.

In the years prior to the establishment of exchanges, the Secretary of HHS will conduct a broader premium rate review process. One outcome of this review will be that states provide information about trends in premium increases and make recommendations to the state exchange about whether particular insurers should be excluded from participation in the exchange. This also will be based on whether the insurers show a pattern or practice of excessive or unjustified premium increases.

Congress has appropriated $250 million in grants to states to help them improve the health insurance rate review and reporting process. Grants will be available over the next four years, with the first cycle of grant money to be awarded in 2010. According to the invitation to apply for funding, sent out by the Secretary of HHS, the states must use these grant funds to support the following specific activities:

- **Develop or enhance rate review activities:** States will be required to use grant funds to either develop or enhance their current capacity to review and, to the extent permitted by state law, approve or deny rate increases in the individual and group markets. States that do not currently review rate filings will need to demonstrate in their application how they plan to develop a process to conduct meaningful rate reviews or otherwise enhance their oversight over insurers' rating practices, including plans to share rate data with the Secretary of HHS.
- **Reporting to the Secretary of HHS on rate increase patterns:** States will be required to provide the Secretary of HHS with information about rate trends in health insurance coverage as well as meet other reporting guidelines as outlined in this grant announcement. To the extent that states do not currently have the capacity to report this data, they may utilize grant funds to develop procedures and/or the infrastructure to enable them to report in the future.

Disclosures required by health insurers

Health insurers wishing to offer coverage through an exchange will need to disclose information regarding the way they do business. This information must be written in plain language, and submitted to:

- The Secretary of HHS
- The applicable state insurance commissioner
- The exchange in which the plan is offered (if applicable)
- The public

These disclosures include:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to any out-of-network coverage
- Information on enrollee and participant rights
- Other information as determined to be appropriate by the Secretary of HHS

Oversight and enforcement, continued

In addition, plans offered through an exchange must include information on cost-sharing. This information must be available, at a minimum, to individuals through an Internet website and by other means for individuals without access to the Internet.

Overseeing quality-improvement incentives

The Secretary of HHS will develop guidelines for a pricing structure that rewards incentives for improved quality in health care. Once these guidelines are developed, the exchanges will oversee the required reporting by Qualified Health Plans.

This required reporting will include data on:

- Quality reporting, effective case management, care coordination, chronic disease management and medication and care compliance initiatives designed to improve health outcomes
- Comprehensive programs for hospital discharge including patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional, designed to prevent hospital readmission
- Use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage to improve patient safety and reduce medical errors
- Wellness and health promotion activities
- Use of language services and community outreach to reduce health and health care disparities

Going forward: Guidance to watch for

These important elements have yet to be finalized:

- Definition of Essential Benefits
- Details on the role of brokers/agents in enrollment
- Determinations relating to open enrollment periods
- Secretary of Labor's definition of "typical coverage provided by an employer"
- Health Care Choice Compacts

A history-making role for today's employers

If the health insurance exchange initiative is successful, 2017 will usher in a landmark era for U.S. employers.

This is the period when the exchanges may be opened up to businesses with more than 100 employees. At that point, even very large employers could opt for exchange coverage. In fact, a pilot program this year in Utah is designed to test the processes of the exchange with a few large employers.[8]

Hanging in the balance will be a highly compelling question: What will happen to group health coverage as we know it today? There are three potential scenarios, each hinging on a distinct economic advantage:

Scenario 1

Group health plans would continue, primarily retained as a differentiator for drawing critical-skills talent and due to their favorable tax treatment.

Group plans allow employers to deduct the amount they pay for their employees' health insurance premiums, and workers do not include that funding or their contributions as part of their taxable income.

This scenario also relies on the continuation of a trend, namely: workers' preference to have their employer involved in choosing health insurance coverage, rather than sorting through options on their own. Employer-sponsored health plans of the future could be different from those offered today, however, as they are influenced by market changes that occur through the exchanges and other elements of the PPACA.

Scenario #2

Employers may allow employees to select coverage through the exchange and make contributions toward this coverage.

This scenario could give employees more choice and give employers some cost stability. Eventually, this could be an option for employers of any size.

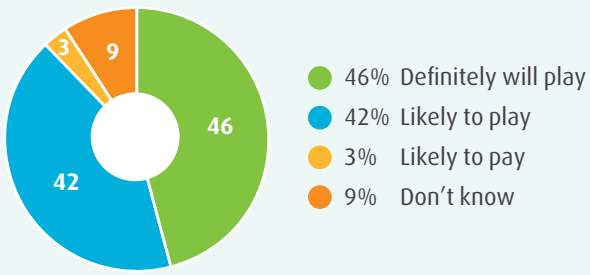
A history making role for today's employers, continued

Scenario #3

Employers may choose to pay the penalty for not sponsoring a health plan and leave their employees to select coverage through an exchange. The average employer-sponsored health insurance premium for 2010 was more than $10,000 per employee per year.[9] By comparison, the penalty for not providing coverage is $2,000 per employee per year.

If employers do decide to opt out of group coverage, the exchanges could theoretically become the predominant delivery method for health insurance. A survey by Towers Watson indicates that the vast majority of employers are likely to play — by offering at least the minimum "Essential Benefits Package" mandated by the law — rather than pay.[10]

Likelihood that organization will play or pay†



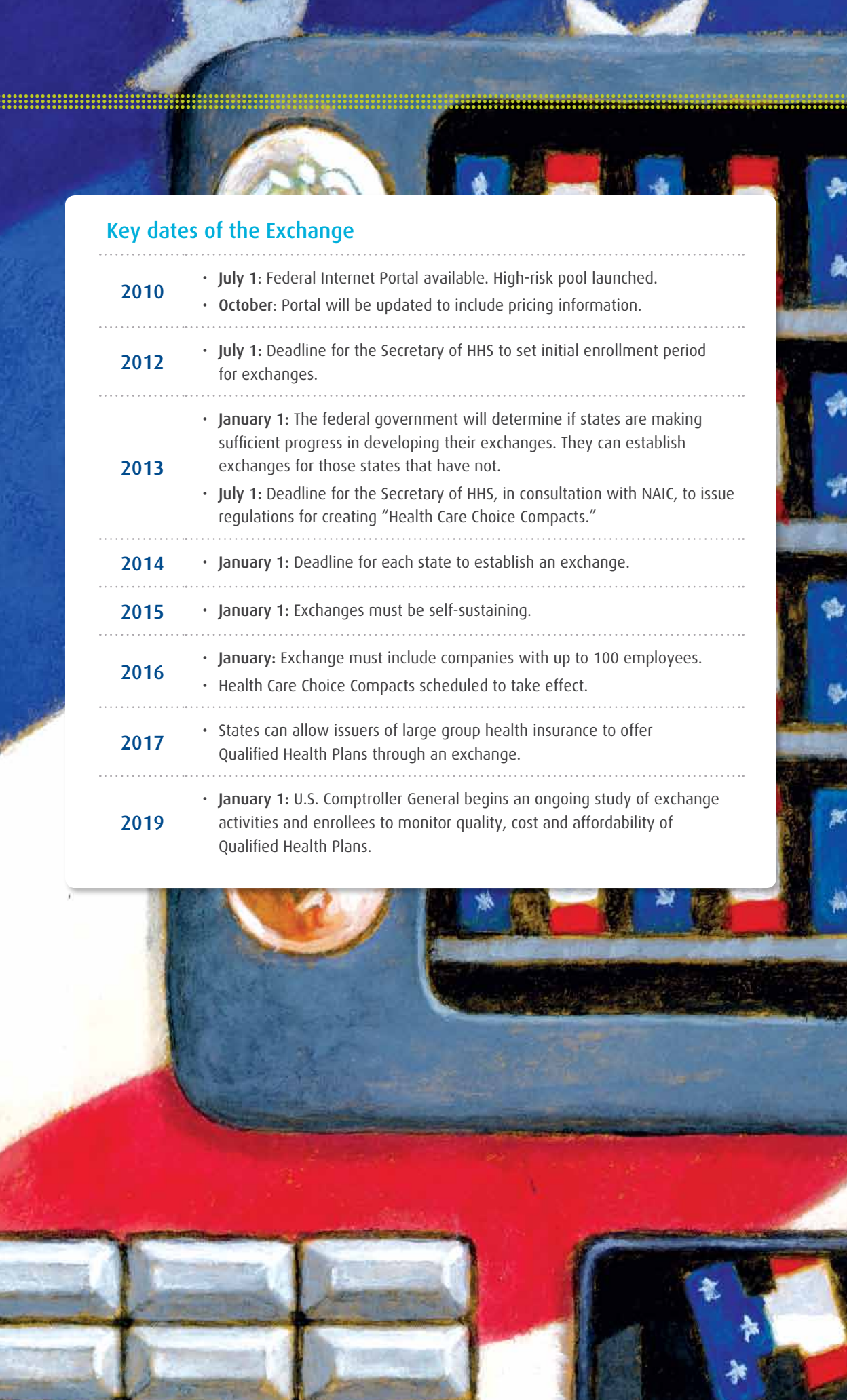
†From towerswatson.com, May 2010

The final litmus test

Regardless of which scenario holds true — or if the results wind up somewhere in between — the ultimate test of the effectiveness of the health exchanges will come down to two critical factors:

- Will they expand coverage to millions of Americans?
- Will that coverage be affordable?

With so many variable factors still to be decided by the government and no reliable way to predict consumer response, it will be several years before anyone can accurately assess this new marketplace of the future.



Key dates of the Exchange

2010	• **July 1**: Federal Internet Portal available. High-risk pool launched. • **October**: Portal will be updated to include pricing information.
2012	• **July 1:** Deadline for the Secretary of HHS to set initial enrollment period for exchanges.
2013	• **January 1:** The federal government will determine if states are making sufficient progress in developing their exchanges. They can establish exchanges for those states that have not. • **July 1:** Deadline for the Secretary of HHS, in consultation with NAIC, to issue regulations for creating "Health Care Choice Compacts."
2014	• **January 1:** Deadline for each state to establish an exchange.
2015	• **January 1:** Exchanges must be self-sustaining.
2016	• **January:** Exchange must include companies with up to 100 employees. • Health Care Choice Compacts scheduled to take effect.
2017	• States can allow issuers of large group health insurance to offer Qualified Health Plans through an exchange.
2019	• **January 1:** U.S. Comptroller General begins an ongoing study of exchange activities and enrollees to monitor quality, cost and affordability of Qualified Health Plans.

As the Health Insurance Exchanges evolve, you can count on Unum to provide analysis and information on this new benefits marketplace. We will continue to assess the impact of health care reform on your business and the benefits industry.

For information on Unum's products and services contact your broker or local Unum representative.

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