Health Insurance Exchanges and Managed Care Contracting: Building Sustainable Strategies

Idaho Hospital Association Annual Convention
Sun Valley, Idaho | October 6, 2014
Agenda

1. Health Insurance Exchange Overview
2. Public Exchanges
3. Private Exchanges
4. Contracting Strategy Implications
5. Questions and Discussion
Health Insurance Exchange Overview
Health Insurance Exchange Overview

- “Exchanges” are marketplaces for individuals and businesses to comparison shop and purchase healthcare coverage

- Seek to increase competition and consumer choice while providing benefit standardization and lower costs

- Public and private exchanges will co-exist in most markets

### Public: Individual
- Individual exchanges target uninsured and self-insured individuals
- SHOP exchanges target small employers early on
- Community-rated premiums with limited risk-adjustment
- Small business tax credits and individual subsidies are designed to make exchanges attractive

### Public: SHOP

### Private
- Private sector model for employer coverage
- Less regulated than public exchanges
- Support defined contribution models
- Various exchange models target different employer segments
2 Public Exchanges
Individual Public Exchange Enrollment – Where Are We Now?

**National Public Exchange Enrollment**  
*Millions*

- **April 2014**  
Picked a Plan: 8.0

- **August 2014**  
Paid Enrollees: 7.3

- **2014**  
Admin. Target: 7.1

- **57%** are previously uninsured based on June Kaiser survey, though significant variation is being seen by market.

- **28%** Age 18-34 enrollment was 28% of the total and short of the administration’s 39% target.

Failure to Launch – Small Business (“SHOP”) Exchange Is Off to a Rocky Start

Individuals Currently Enrolled in SHOP Exchanges

- California (Sept) 11,510
- Colorado (Aug) 2,470

- State exchanges have seen limited enrollment; no federal enrollment data available
- Online federal SHOP exchange was delayed until November 2014
- “Employee choice” delayed on federal exchanges until 2015 (18 states will opt out)
- Employers with up to 100 employees must be made eligible in 2016; states have option to include employers with more than 100 employees in 2017

Sources: Demko, P, Small business exchanges off to rocky start, Modern Healthcare, 12 July 2014; Jost T, SHOP Employee Choice State Opt-Outs and Navigator Grants, Health Affairs Blog, 10 June 2014; Connect for Health Colorado Marketplace Dashboard, 8/31/14; ACASignups.net.
Near to Medium Term Public Exchange “Dumping” Risk Will Be Greatest Among Small Businesses

WellPoint Already Experiencing Small Group Dumping

-12% 12% 2014 year-to-date decline in WellPoint small group membership

“The small group book...is seeing a few more leap [to the public exchanges] sooner than we had expected.”

Wayne DeVeydt
CFO, WellPoint
July 30, 2014

Large Employers Generally Committed To Coverage In Near Term, Uncertain About Long Term

95% 95% of large employers consider it “very important” to provide subsidized benefits to active full-time employees in “2015 and beyond”

25% Only 25% of large employers are “very confident” that health care benefits will be offered at their organization a decade from now

Note: Source for large employer data from Towers Watson, which surveyed employers with more than 1,000 employees.
Drivers That Could Impact Commercial Shift and Employer “Dumping” to Public Exchanges Will Vary Significantly by Market

<table>
<thead>
<tr>
<th>Driver</th>
<th>Influence Factors</th>
<th>Shift Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firm Size</td>
<td>Small firms are more likely to dump their employees to the exchange, particularly those with fewer than 50 employees</td>
<td>↑</td>
</tr>
<tr>
<td>Wages</td>
<td>Low-wage geographies will see more shift due to greater subsidy availability (and lower tax shield loss)</td>
<td></td>
</tr>
<tr>
<td>ACA Rate Increases</td>
<td>Many small employers seeing significant rate increases due to new ACA underwriting regulations</td>
<td>↑</td>
</tr>
<tr>
<td>Part-Time Workforce/Retirees/COBRA</td>
<td>Part-time employees and pre-65 retirees more apt to shift; employees on COBRA will often save by switching to an exchange plan</td>
<td></td>
</tr>
<tr>
<td>Exchange Plan Options and Premiums</td>
<td>Fewer plan options, higher premiums will delay uptake; favorable network contracts will lower premiums and increase likelihood of shift</td>
<td>↔</td>
</tr>
<tr>
<td>Timing</td>
<td>Uptake could initially be slow but increase over time once the market settles out, particularly if the “me too” effect takes hold</td>
<td>↔</td>
</tr>
<tr>
<td>Recruitment and Retention</td>
<td>Higher skilled/wage employers who prioritize recruitment and retention may not be willing to shift to public exchanges</td>
<td>↓</td>
</tr>
<tr>
<td>Early Renewals and Plan Cancellation “Fix”</td>
<td>Many employers renewed early to avoid ACA underwriting changes; Obama decision to allow non-ACA compliant policies also delays shift</td>
<td>↓</td>
</tr>
<tr>
<td>Penalties</td>
<td>Employer responsibility penalties a key deterrent for larger employers; fear among some that penalties could be increased in the future</td>
<td></td>
</tr>
</tbody>
</table>
As Expected, Most Public Exchange Enrollees Gravitated Toward Bronze and Silver Plans, and Roughly Half Chose Limited Networks

**National Plan Selection by Metal Level**

*Initial Enrollment Period¹*

- Bronze: 20%
- Cat. (2%): 5%
- Platinum: 9%
- Gold: 5%
- Silver: 65%

**National Plan Selection by Network Breadth**

*% Of Those with Access to Limited Network*

- Open Network: 44%
- Limited Network: 51%
- Don’t Know: 5%

Notes: (1) Includes additional special enrollment period activity through 19 April 2014. (2) Catastrophic plan.
Source: ASPE, Health Insurance Marketplace Enrollment Report, 1 May 2014; Commonwealth Fund ACA Tracking Survey, April – June 2014 (results for adults ages 19 – 64 who had the option to choose less expensive plan with fewer providers).
3 Private Exchanges
Private Exchanges – What Are They?

Private exchanges shift health care benefits from defined benefit to defined contribution, just as 401(k) plans replaced pension plans for retirement savings.

Private exchanges will support this market shift by offering a broader choice of plan and coverage options sponsored by a variety of organizations.

Select Private Exchange Sponsors

- Mercer
- Towers Watson
- Aon Hewitt
- bloom Health
- Buck Consultants
- Liaison
- UnitedHealthcare
- Aetna
- Cigna
- Blue Cross Blue Shield
Employer Surveys Suggest That a Material Shift to Private Exchanges Is Likely

Key Aspects of Private Exchanges Attractive to Employers

- Reduced administrative expense
- Improved predictability of health benefits expense
- Potential to save by reducing spending on over-insured employees
- New plan designs may lower employer costs over the long term
- Increased employee choice
- Accessing most favorable contracted rates across all geographies

Percentage of Employers Who Anticipate Moving to Private Exchanges Over the Next 3 to 5 Years

Aon Hewitt

33%

Private Exchange

“Our research — as well as other surveys — seems to indicate that over the next three to five years, 25% to 35% of employers will provide benefits through a private exchange.”

Steve Kreuger, Exchange Solutions Leader
Mercer

Early Private Exchange Adopters Include Household Names with Outsized Representation by the Retail and Restaurant Industries
Private Exchanges Experienced Strong Growth in 2014

### 2014 Enrollment Among Select National Private Exchanges

<table>
<thead>
<tr>
<th>Exchange Operator</th>
<th># of 2014 Enrollees</th>
<th># of 2014 Employers</th>
<th># of Enrollees per Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>AON Hewitt</td>
<td>600,000</td>
<td>18</td>
<td>33,333</td>
</tr>
<tr>
<td>buck consultants</td>
<td>400,000</td>
<td>14</td>
<td>28,571</td>
</tr>
<tr>
<td>Liazon</td>
<td>100,000</td>
<td>2,400</td>
<td>42</td>
</tr>
<tr>
<td>Mercer</td>
<td>75,000</td>
<td>33</td>
<td>2,273</td>
</tr>
<tr>
<td>Towers Watson</td>
<td>46,500</td>
<td>3</td>
<td>15,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,221,500</strong></td>
<td><strong>2,468</strong></td>
<td><strong>495</strong></td>
</tr>
</tbody>
</table>

- Private exchange operators are quickly growing their enrollee bases and appealing to employers of all sizes
- Accenture estimates 2014 private exchange enrollment to be 3 million

Source: Company investor releases; Demko P, Accenture Puts Private Exchange Enrollment at 3 Million, Modern Healthcare, 12 June 2014.
## Drivers That Will Impact Commercial Shift to Private Exchanges Will Vary by Region

<table>
<thead>
<tr>
<th>Driver</th>
<th>Influence Factors</th>
<th>Shift Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Me Too” Effect</td>
<td>Secondary wave of “fast followers” will emerge if initial wave of employers demonstrates success</td>
<td></td>
</tr>
<tr>
<td>Rising Administrative Costs</td>
<td>Employers continue to look for ways to lower administrative expenses of employee benefits</td>
<td></td>
</tr>
<tr>
<td>Delivery Cost</td>
<td>Favorable insurer network contracts will increase plan participation and pressure on employers to shift</td>
<td>↑</td>
</tr>
<tr>
<td>Cadillac Tax</td>
<td>Some employers may use private exchanges to avoid the excise tax stipulated to begin in 2018</td>
<td></td>
</tr>
<tr>
<td>Presence in Multiple Markets</td>
<td>Ability to access plans that have the lowest contracted rates in each market appealing to jumbo employers</td>
<td></td>
</tr>
<tr>
<td>Exchange Plan Options and Premiums</td>
<td>Plan designs and premiums must be as good or better than current group coverage</td>
<td>←→</td>
</tr>
<tr>
<td>Paternalism</td>
<td>Employers can be paternalistic and resistant to significant changes in employee benefit design</td>
<td></td>
</tr>
<tr>
<td>Union and Public Sector</td>
<td>Collectively bargained cohorts and public sector employers typically are slower to change</td>
<td>↓</td>
</tr>
</tbody>
</table>

Similar to Public Exchanges, Private Exchanges Are Driving Higher Rates of High Deductible and Narrow Network Adoption

Percentage of Private Exchange Consumers Choosing HSA-Eligible Plan
2014 Survey of 8 Private Exchanges

42% to 67%

Percentage of Private Exchange Consumers Choosing Narrow Network
Liazon Private Exchange

48%

Chose Narrow Network

“Very few people spend other people’s money as carefully as they spend their own.”
Milton Friedman
Nobel Prize-Winning Economist

Medica Demonstrates The Ability of Private Exchanges to Drive Narrow Network and Value-Based Model Adoption

Open Network

- Minneapolis private exchange offers 5 network options (4 ACOs and 1 open network)
- >50% of enrollees chose ACO; those selecting open network pay $300 - $500 more per year
- >120 employers use the exchange; all year one employers renewed
- >93% of members report high satisfaction with exchange

ACO Options

4

Contracting Strategy Implications
Exchanges Will Accelerate Transition to Emerging Payment Models and Create New Strategic/Financial Challenges

### Implications

<table>
<thead>
<tr>
<th>Public Exchanges</th>
<th>Private Exchanges</th>
<th>Today’s Model</th>
<th>Emerging Models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access PPO</td>
<td>Expected to decline over time</td>
<td>Deployed in some markets</td>
<td>Expected to increase over time as narrow/tiered networks mature</td>
</tr>
<tr>
<td>High Deductible</td>
<td>Catastrophic and low actuarial value plans</td>
<td>Likely near-term model of choice</td>
<td>Common payer strategy absent regulatory/market restrictions</td>
</tr>
<tr>
<td>Narrow/Tiered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Implications**

- **Risk of Share Loss**: Limited Threat
- **Price Pressure**: Limited Threat
- **Bad Debt**: Significant Threat
- **Use Rate Pressure**: Limited Threat
## Strategic Dynamics Will Vary by Market

<table>
<thead>
<tr>
<th>Driver</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Price Levels</td>
<td>Higher prices relative to Medicare create more “room” for undercutting and amplify the potential for material financial impacts</td>
</tr>
<tr>
<td>Capacity Utilization</td>
<td>Narrow/tiered networks less impactful if capacity constraints preclude meaningful steerage; some spare capacity needed for tiered/narrow networks to be effective</td>
</tr>
<tr>
<td>Urban vs. Rural</td>
<td>Competition is required for narrow/tiered contracts to be practical/effective; rural markets with sole community providers will be less dynamic</td>
</tr>
<tr>
<td>Employer Dynamics</td>
<td>Wage levels, employer size distribution, and other characteristics will lead employers to make different decisions across markets</td>
</tr>
<tr>
<td>Consumer Willingness to Give Up Choice</td>
<td>The price discount required to give up choice will vary by market, leading to different tradeoffs between price and volume</td>
</tr>
</tbody>
</table>
The Shift to “Retail” Is Giving Consumers a Greater Role in Decisions at Two Levels – Health Plans and Health Services

Understanding the consumer “path to purchase” becomes critical in a retail environment

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Narrow</strong></td>
<td>• Which Providers?</td>
</tr>
<tr>
<td></td>
<td>• Which Services?</td>
</tr>
<tr>
<td><strong>Open</strong></td>
<td></td>
</tr>
</tbody>
</table>

- Health Plans
  - Narrow
  - Open

- Health Services
  - Which Providers?
  - Which Services?
Developing a Service-Level Consumerism Strategy Has Become a Planning Imperative

- Growth in high deductible plans has prompted payers and employers to develop price transparency tools revealing cost and quality data to members.
- Providers in competitive markets are at risk of revenue and market share erosion as payers and patients become aware of reimbursement variance.
- The commercial services at risk (e.g., imaging, lab, and OP surgery) are critical financial contributors at most hospitals.
- Developing a pricing and broader retail strategy to address this risk has become a key planning imperative.

Select Companies Offering Transparency Tools

![Select Companies Offering Transparency Tools](image)
Key Considerations for Exchange Narrow Network Participation

**Direct Financial Impact**
- **Volume** - What is the volume “in play” to be gained or lost?
  - Available market capacity
  - Market share
  - Emergent vs. elective volumes
  - Degree of exclusivity
  - Likely plan enrollment
- **Rates** - What is the level of discounting required?

**Other Considerations**
- **Spillover effect** onto employer plan rates and benefit decisions
- What is the **lockout risk** to not participating?
- Will the **ability to negotiate different terms/discounts** change in the future?
- Are payers having **rate-only discussions** that ignore value-based investments?
- How does the exchange contract **fit within the broader managed care strategy**?
Private Exchanges Will Be a Key Delivery Channel for Value-Based Care – The Aetna National Private Exchange of ACOs Example

“We’ll create…a national ACO chain where we have private exchanges on the front of ACOs that can address large employer populations in specific markets – potentially disrupting the national account business by making their purchases more local.”

Mark Bertolini
CEO, Aetna

Note: ACO private exchange network map above is illustrative
Coordinated Networks of High-Value Providers Offer the Potential to Improve Upon Current Narrow Network Shortcomings

Current Narrow Networks

Narrow Network 1.0

- Current narrow networks are often a fragmented, random assortment of providers willing to take the lowest bid
- Creates potential care continuity problems and consumer frustration/confusion regarding which providers are in network

ACO/CIN or IDN

Narrow Network 2.0

- Networks assembled by providers via ACO/CIN or IDN offer potential for improvement
- If executed correctly, care will be better coordinated and confusion/uncertainty regarding provider participation will be mitigated

“Consumers should choose a health system, not a health plan.”

Joseph Zubretsky
Senior Executive Vice President, Aetna
Provider-Assembled Networks Should Offer Easy Access to High-Value Providers with Appropriate Geographic Footprint

- Goal for providers is to assemble a network that
  1. employers/exchanges will include as an option
  2. consumers will choose
  3. meets network adequacy standards
- Employers will generally prefer to work with fewer/broader networks for direct contracts
- Exchanges make the inclusion of multiple networks more feasible, and consumers on exchanges will choose based on the network characteristics of local providers convenient to them

Source: ACO Business News; ‘Medica Private Exchange ACO Enrollment Exceeds Expectations’; February 2014; Volume 5, Number 2
It is important to consider exchange dynamics in the context of wholesale employer strategies to develop a comprehensive plan.

**Wholesale:**
“House Money, House Rules”

**Limited Networks**
- Direct Contract
- Narrow Network

**Service-Level Consumerism**
- High Deductible
- Reference Price
- Centers of Excellence

**Shift Risk to Providers**
- FFS
- P4P
- Bundled Payment
- Shared Savings
- Shared Risk
- Full Risk

**Retail:**
Shift Plan Choice to Consumers

**Shift to Exchanges**
- Public Exchange
- Private Exchange
Summary Implications

- Exchanges will catalyze the shift of purchasing healthcare benefits from the wholesale to the retail channel
- This channel shift will change the behavioral economics of plan purchasing decisions and increase the prevalence of high deductible and limited network plans
- By increasing the prevalence of high deductible plans, exchanges will also accelerate the development of a retail mindset among consumers shopping for individual health care services
- Value-based reimbursement will increase over the long term as pricing and cost pressures grow; private exchanges will be a key distribution channel for value-based models
- Competing on value and improving cost structure are the only viable long-term options for continued growth
- Providers should develop exchange and service-level consumerism plans focusing on the “path to purchase” within the context of their broader managed care strategy
Questions and Discussion
Appendix
Rising Penalties Will Increase Public Exchange Enrollment by the Uninsured Over Time

The penalty for not obtaining coverage will be the **greater** of a flat dollar amount or a percentage of income unless certain exemptions are met.  

1) Penalty applied to income above income tax filing threshold (roughly $10,000 for individuals and $20K for families in 2012).  
2) Flat dollar penalty is indexed to inflation after 2016.  
3) Some individuals may be exempt from penalties based on religion, citizenship, income, time noninsured, access to affordable coverage, etc.  

“The Three Rs” Will Provide (Some) Financial Protection to Insurers Participating in the Public Exchange

<table>
<thead>
<tr>
<th>What</th>
<th>Risk Adjustment</th>
<th>Reinsurance</th>
<th>Risk Corridors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Redistributes funds from plans with lower risk enrollees to plans with higher risk enrollees</td>
<td>Provides payment to plans that enroll higher cost individuals</td>
<td>Limits losses and gains beyond an allowable range</td>
</tr>
<tr>
<td>How</td>
<td>Individual risk scores are averaged to determine plan risk score. Plans with lower risk will make payments to plans with higher risk.</td>
<td>If an enrollee’s costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap).</td>
<td>HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims.</td>
</tr>
<tr>
<td>When</td>
<td>2014 onward (permanent)</td>
<td>Temporary for 3 years 2014-2016</td>
<td>Temporary for 3 years 2014-2016</td>
</tr>
</tbody>
</table>

- Adverse selection, risk selection and premium volatility could be unintended consequences of the guaranteed issue and community rating aspects of the ACA
- The ACA’s **risk adjustment**, **reinsurance**, and **risk corridor** programs are designed to work together to mitigate the potential effects of adverse selection and risk selection, particularly during the early years when penalties are low
# Small Business Exchange Eligibility by Business Size Will Expand Over Time

<table>
<thead>
<tr>
<th># of Employees</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 50</td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
</tr>
<tr>
<td>51 – 100</td>
<td>State Option</td>
<td>State Option</td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
</tr>
<tr>
<td>&gt; 100</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>State Option</td>
<td>State Option</td>
</tr>
</tbody>
</table>

- **Mandatory**: Eligibility is required.
- **State Option**: States have the option to offer this.
- **No Eligibility**: States do not have this option.

States have the option to open their SHOP exchanges to large employers in 2017.
Large Employers Are Losing Confidence In Their Ability to Offer Health Benefits Over The Long Term

% of Employers That Are Very Confident That Health Benefits Will Be Offered At Their Organization a Decade From Now

### High Deductibles Create Significant Patient Cost-Sharing for Most Silver and Bronze Plans

#### Standardized Deductible Levels by Plan

**California Health Exchange**

<table>
<thead>
<tr>
<th>Plan Tier</th>
<th>Subsidized Cost-Sharing</th>
<th>Unsubsidized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Silver</td>
<td></td>
</tr>
<tr>
<td>Incomes Eligible (FPL)</td>
<td>&lt; 150% FPL</td>
<td>150% - 200% FPL</td>
</tr>
<tr>
<td></td>
<td>&lt; $17,235</td>
<td>$17,235 - $22,980</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0¹</td>
<td>$500¹</td>
</tr>
</tbody>
</table>

**Note:**
1) Hospital care not subject to deductible.
2) Medical deductible.
3) Deductible for medical and drugs. Income eligibility ranges are for individuals.

CMS Tightening Network Adequacy Rules in 2015

Percentage of Essential Community Providers\(^1\)
Required to Be Included in Network

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Network Adequacy Review

- In 2014 CMS largely relied on plan accreditation and state review
- In 2015 CMS will collect/review plan provider lists under a “reasonable access” standard
- Goal to ensure provider access without “unreasonable delay”
- Will develop “time and distance” standards for future rulemaking

Note (1): Essential community providers include safety net hospitals, FQHCs, Ryan White HIV/AIDS providers, family planning providers, and Indian Health providers.

“\(\text{It’s a substantial change. It’s much more specific, and it’s going to involve a lot more direct federal oversight.}\)”

Karen Pollitz
Kaiser Family Foundation

© 2014 Kaufman, Hall & Associates, Inc. All rights reserved.
### Post Subsidy Exchange Plan Price

**Maximum Premium as a Percentage of Income for Second-Lowest Cost Silver Plan**

*Individual*

<table>
<thead>
<tr>
<th>Income as % of FPL(^1)</th>
<th>&lt;133(^2)</th>
<th>133%</th>
<th>150%</th>
<th>200%</th>
<th>250%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium $</strong></td>
<td>$230</td>
<td>$458</td>
<td>$689</td>
<td>$1,448</td>
<td>$2,312</td>
<td>$3,275</td>
<td>$4,366</td>
</tr>
<tr>
<td><strong>Income $</strong></td>
<td>$11,490</td>
<td>$15,282</td>
<td>$17,235</td>
<td>$22,980</td>
<td>$28,725</td>
<td>$34,470</td>
<td>$45,960</td>
</tr>
</tbody>
</table>

Note: 1) 2013 FPL for 48 Contiguous States and the District of Columbia: $11,490 for an Individual, and $23,550 for a family of 4. 2) 100% of the FPL was used to represent the Premium $ and Income $ for the <133% range.

# Salary Threshold for FPL Multiples

<table>
<thead>
<tr>
<th>Family Size</th>
<th>% of FPL</th>
<th>100%</th>
<th>≤ 133%&lt;sup&gt;1&lt;/sup&gt;</th>
<th>133%-150%&lt;sup&gt;1&lt;/sup&gt;</th>
<th>150%-200%&lt;sup&gt;1&lt;/sup&gt;</th>
<th>200%-250%&lt;sup&gt;1&lt;/sup&gt;</th>
<th>250%-300%&lt;sup&gt;1&lt;/sup&gt;</th>
<th>300%-400%&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>$11,490</td>
<td>$15,282</td>
<td>$17,235</td>
<td>$22,980</td>
<td>$28,725</td>
<td>$34,470</td>
<td>$45,960</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>$15,510</td>
<td>$20,628</td>
<td>$23,265</td>
<td>$31,020</td>
<td>$38,775</td>
<td>$46,530</td>
<td>$62,040</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>$23,550</td>
<td>$31,322</td>
<td>$35,325</td>
<td>$47,100</td>
<td>$58,875</td>
<td>$70,650</td>
<td>$94,200</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>$31,590</td>
<td>$42,015</td>
<td>$47,385</td>
<td>$63,180</td>
<td>$78,975</td>
<td>$94,770</td>
<td>$126,360</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>$39,630</td>
<td>$52,708</td>
<td>$59,445</td>
<td>$79,260</td>
<td>$99,075</td>
<td>$118,890</td>
<td>$158,520</td>
</tr>
</tbody>
</table>

Note: 1) The upper bound from each income range was used to calculate the corresponding Salary Benchmark. 
Private Exchanges – How Do They Work?

- Each stakeholder has a defined role in the exchange
- The exchange becomes the central hub connecting stakeholders
- Employees gain greater choice and control

**Employer**
- Contracts with Private Exchange Sponsor for coverage
- Determines plan offerings
- Provides defined contribution
- Eliminates administrative role
- Facilitates transition to exchange

**Private Exchange**
- Contracts with insurance providers
- Single or multi carrier models
- Provides decision and enrollment support to employees
- Facilitates employer subsidy

**Employee**
- Receives employer’s subsidy via limited spending account
- Selects coverage through the exchange
- Seeks care through contracted providers
- Exchange provides defined contribution/ enrollment support

**Insurer**
- Develops insurance products to offer in private exchange
- Fully insured or self funded (ASO) products
- Bills employee full cost of coverage
- Provides customer service to employees

**Provider**
- Hospitals and physicians contract directly with insurers
- May have different reimbursement fees and methodologies
- Standard patient billing and collection process
Two Types of Private Exchanges: Single Carrier vs. Multi-Carrier

**Single Carrier Private Exchange**

![Single Carrier Private Exchange Diagram]

**Multi-Carrier Private Exchange**

![Multi-Carrier Private Exchange Diagram]
Survey Data Indicate Receptivity to Private Exchanges Among Employees

Source: Accenture: “Are You Ready? Private Health Insurance Exchanges Are Looming,” June 2013, based on March 2013 online survey of 2,000 consumers between the ages of 18 to 64.
Private Exchange Offerings Are Increasingly Attractive to Employers

**% Of Employers That Believe Private Health Insurance Exchanges Provide A Viable Alternative To Employer-Sponsored Coverage For Active Full-Time Employees**

- **2014**: 33%
- **2015**: 67%

**Top Three Factors That Would Cause Employers to Seriously Consider A Private Exchange For Active Full-Time Employees**

- Evidence that private exchanges can deliver greater value than our current self-management model: 74% (2014), 71% (2015)
- The actions of larger companies in our industry: 47% (2014), 56% (2015)
- Inability to stay below the excise tax using our current approach: 36% (2014), 34% (2015)
- Desire to reduce spending on health care benefits within our total rewards mix: 6% (2014), 11% (2015)
- Ability to provide additional health care plans choices to employees: 32% (2014), 40% (2015)
- Potential reduction in internal health benefits administration activities, staff or cost: 22% (2014), 33% (2015)
- Use of a transition to a private exchange to support direct-to-consumer platform or potential longer-term exit of health plan sponsorship: 11% (2014), 17% (2015)
- Other: 5% (2013), 4% (2014)

Private Exchange Activity Is Occurring Across a Range of Employer Sizes and Industries

Liazon Forges Partnerships with National Brokers

Mercer Announces 2014 Private Exchange Participants

Walgreens Joins AON Hewitt Private Exchange

BAN/USI have 150 U.S. offices; Liazon exchange includes 2,400 employers

33 mostly midsize companies across range of industries will enroll 75K employees

160K Walgreens employees were enrolled in 2014; total AON 2014 enrollment is 600K

Note: 600K AON enrollees includes employees and dependents across 18 employers, an increase of 15 employers vs. the 3 employers enrolled in 2013.
Private Exchanges Are Driving Significant Increases in High Deductible Plan Adoption

% Electing HSA-Qualified Plans in 2014

By Private Exchange Operator

- In 2014, multiple private exchanges were surveyed regarding enrollee plan choice
- Survey found significant levels of high deductible plan adoption in most exchanges

ACA Penalties for Employers Not Offering Affordable Coverage

Start here.

Does the employer have at least 50 full-time equivalent employees?

No

Penalties do not apply to small employers.

Yes

Did at least one employee receive a premium tax credit or cost sharing subsidy in an Exchange?

No

The employer must pay a penalty for not offering coverage.

Yes

If the employer has 25 or fewer employees and average wage up to $56,000, it may be eligible for a health insurance tax credit.

Yes

The penalty is $2,000 annually times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.

No

The employer must pay a penalty for not offering affordable coverage.

Does the employer offer coverage to its workers?

No

Employees can choose to buy coverage in an Exchange and receive a premium tax credit.

Yes

The penalty is $1,000 annually for each full-time employee receiving a tax credit, up to a maximum of $2,000 times the number of full-time employees minus 30. The penalty is increased each year by the growth in insurance premiums.

Does the insurance pay for at least 60% of covered health care expenses for a typical population?

No

The employer must pay a penalty for not offering affordable coverage.

Yes

Those employees can choose to buy coverage in an Exchange and receive a premium tax credit.

Other employees have to pay more than 9.5% of family income for the employer coverage?

No

There is no penalty payment required of the employer since it offers affordable coverage.

Yes

The employer must pay a penalty for not offering affordable coverage.
Kaufman Hall Services at a Glance
Qualifications, Assumptions and Limiting Conditions (v.12.08.06):
This Report is not intended for general circulation or publication, nor is it to be used, reproduced, quoted or distributed for any purpose other than those that may be set forth herein without the prior written consent of Kaufman, Hall & Associates, Inc. (“Kaufman Hall”).

All information, analysis and conclusions contained in this Report are provided “as-is/where-is” and “with all faults and defects”. Information furnished by others, upon which all or portions of this report are based, is believed to reliable but has not been verified by Kaufman Hall. No warranty is given as to the accuracy of such information. Public information and industry and statistical data, including without limitation, data are from sources Kaufman Hall deems to be reliable; however, neither Kaufman Hall nor any third party sourced make any representation or warranty to you, whether express or implied, or arising by trade usage, course of dealing, or otherwise. This disclaimer includes, without limitation, any implied warranties of merchantability or fitness for a particular purpose (whether in respect of the data or the accuracy, timeliness or completeness of any information or conclusions contained in or obtained from, through, or in connection with this report), any warranties of non-infringement or any implied indemnities.

The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. In particular, actual results could be impacted by future events which cannot be predicted or controlled, including, without limitation, changes in business strategies, the development of future products and services, changes in market and industry conditions, the outcome of contingencies, changes in management, changes in law or regulations. Kaufman Hall accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. All decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the client.

In no event will Kaufman Hall or any third party sourced by Kaufman Hall be liable to you for damages of any type arising out of the delivery or use of this Report or any of the data contained herein, whether known or unknown, foreseeable or unforeseeable.