

Health Insurance Exchanges: Key Issues for State Implementation

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Introduction

Well-functioning Health Benefit Exchanges (Exchanges) may determine the success of federal health care reform in meeting its goals to improve access to health coverage, enhance the value of health insurance, and moderate the cost of health care. Across the country, state governments will play the pivotal role in operating the Exchanges, facilitating the expansion of Medicaid, and implementing market-altering changes to the rules governing commercial health insurance.

The American Health Benefits Exchange (for individuals) and the Small Business Health Options (SHOP) Exchange (for small employers) will serve as central points of access to commercial health insurance for millions of individuals and hundreds of thousands of small employers. In some states, enrollment in the Exchange may exceed the number of people currently covered by their Medicaid program.

By January 2014, individuals and small employers will be able to shop for insurance from a range of health plans offered through the Exchanges. Lower- and middle-income individuals earning up to four times the Federal Poverty Level (FPL) – more than \$88,000 for a family of four in calendar year 2010 – may be eligible for premium subsidies for commercial health plans. Small employers with lower-income workers that provide employer-sponsored insurance (ESI) may be eligible for premium subsidies for up to two years.

People who today cannot afford health insurance or are denied coverage due to poor health will soon be able to purchase insurance. In addition to premium subsidies, the health plans will limit point-of-service cost sharing (i.e., co-payments, co-insurance, deductibles) and cap members' out-of-pocket expenses.

Though the Patient Protection and Affordable Care Act (ACA) sets broad parameters for the Exchanges and federal regulations will provide further guidance, states are allowed some flexibility in

developing their own Exchange. As a result, they will need to make a number of key decisions.

This issue brief delves into some of the details of the health insurance Exchange, as defined by the ACA, and highlights a number of key issues for states to consider, including:

- Governance structure and administration;
- Key functions and responsibilities;
- Operation of the Exchange alongside the state's commercial health insurance markets;
- Rules governing carrier participation in the Exchange;
- Risk selection, inside and outside the Exchange;
- The interaction between the Exchange and the state's Medicaid and CHIP programs;
- The type and level of customer service that the Exchange will need to provide; and
- Whether states should establish their own Exchange or defer that responsibility to the federal government.

Although much remains to be determined with regard to the set up of the Exchanges, state officials will need to begin planning and establishing the infrastructure and the policies required for the successful implementation of health reform and the operation of state-based Exchanges. Figuring out how best to position the Exchange in 50 state health insurance markets and the District of Columbia will require an unprecedented amount of collaboration between states and the federal government, across state agencies, among stakeholders, and throughout the health insurance industry.

This brief provides policymakers and interested parties with a framework to help states plan for and establish state-based Exchanges. While this brief can help states develop a roadmap to implementation, they will need to actively monitor and

participate in the myriad policy and regulatory decisions to be issued by the federal government. As federal policies are established and regulations are promulgated, states will need to adapt and modify their plans in order to successfully establish their Exchange.

Whether to Establish a State-Based Exchange

An immediate decision for states is whether to establish their own Exchanges or to rely on the federal government to do so on their behalf. While deferring this responsibility to the federal government may seem appealing, there are pros and cons for states to consider. The value of establishing a state-based Exchange includes:

- Maintaining regulatory authority over a large share of the commercial health insurance market;
- Mitigating risk selection that may result from different rating and underwriting rules for insurance policies sold inside and outside the Exchange;
- Enabling greater coordination of benefits and eligibility rules across health coverage programs (e.g., Medicaid, CHIP and policies sold through the Exchange); and
- Promoting state health reform strategies and priorities through the Exchange.

On the other hand, there are risks for states that choose to establish their own Exchange, including:

- The challenge of creating a new program, particularly at a time when many states are struggling to balance their budgets;
- The requirement that the Exchange be self-sustaining by 2015; and
- The tension that will be created between keeping administrative fees low while satisfying the demands for high quality customer service.

To ensure that residents of every state have access to insurance through an Exchange, the law requires the secretary of the U.S. Department of Health and Human Services (HHS) to determine by January 2013 whether a state has taken actions necessary to implement an Exchange (i.e., adopt laws and regulations to establish the Exchange) and whether a state is likely to have an Exchange operating by January 1, 2014. For states that choose not to, or are unable to, establish their own Exchanges by that date, the federal government will establish and operate the Exchange within the state. This means that by early 2011 states will need to determine whether to establish a state-administered Exchanges. A number of factors will influence that decision, and the following sections highlight the major issues for states to consider.

Funding: A key issue for states will be the level of funding available from the federal government to support states in the planning and establishment of the Exchange. An initial allotment of funds – up to \$1 million for each state and the District of Columbia – to assist states with this effort was made available by federal HHS in September 2010. The federal government has indicated that additional funding in the form of implementation grants will become available in spring 2011. Unlike the initial planning grants, the implementation grants will be based on the specific needs of each state.

At a time when most states are unable to fund existing programs, it will be difficult for states to appropriate a significant amount of state revenues to establish their Exchange. An additional financial consideration is that federal funding is not available beyond December 2014, and the Exchange will need to establish a funding stream to support ongoing operations and become self-sustaining.

Policy Issues: Beyond financing the Exchange, there are a number of key policy issues to consider. First and foremost, health insurance regulation has largely been – and will continue to be – the

responsibility of state government. Given the central role the Exchange will play as a distribution network for commercial insurance, states may be loathe to relinquish any regulatory authority over what will likely be a sizeable share of the individual market, as well as a portion of the small group market.

Regulatory Issues: The law explicitly states that federal establishment of an Exchange will not preempt any state law “that does not prevent the application of the provisions” of the federal Exchange. However, in the event a state decides not to operate an Exchange, its authority to regulate insurance inside the Exchange would likely be compromised, potentially subjecting carriers to two sets of rules and reporting requirements for policies sold inside the Exchange (federal) and outside the Exchange (state).

More importantly, a federally administered Exchange that operates alongside a state-regulated health insurance market could lead to risk selection issues if the rating and/or underwriting rules are not the same. For example, if small employers purchasing coverage through the Exchange must meet participation requirements (i.e., percentage of employees that are covered by the policy) that differ from the participation requirements for small employers purchasing coverage outside the Exchange, carriers operating inside the Exchange may be advantaged or disadvantaged. In addition, the Exchange itself may be advantaged or disadvantaged vis-à-vis other distribution channels (i.e., policies purchased through brokers or direct from the carriers) if the rating and underwriting rules are not consistently applied.

Nonetheless, regardless of who runs the Exchange, rating rules, underwriting requirements and strategies to mitigate risk selection inside and outside the Exchange will need to be addressed. An Exchange administered by the federal government, operating alongside a state-regulated individual and small group market, will only increase the likelihood

of inconsistent rules between the two markets. That might then lead to one distribution channel (e.g., the Exchange) attracting less healthy individuals than the other, thereby driving up premiums due to adverse risk selection for health plans offered through the Exchange. A state-administered Exchange will likely be better positioned to align the rules and regulations across all distribution channels to avoid, or at least minimize, the potential for risk selection.

Promoting State Priorities: The Exchange can also be a powerful tool for states to help advance other health care priorities, such as payment reform, development of medical homes and accountable care organizations, promotion of consumer-directed health insurance, or the establishment of select or tiered network health plans. The combined volume of lives covered by the Exchange and state Medicaid programs, particularly after the Medicaid eligibility expansion to 133 percent FPL, will greatly enhance a state’s influence in the health care market. A federally-run Exchange may not align with a state’s health reform policies and priorities.

Competition and Transparency: Other issues for states to consider in deciding whether to establish an Exchange is the number of carriers operating in the market, the potential to increase carrier competition, and the ability to promote greater transparency about cost and quality. The dominance of a single insurer in some markets has been offered as a reason why an Exchange may not be appropriate for all states. With only one carrier operating in the market, there may be little that an Exchange can do to affect the health insurance market.

However, three confounding factors are worth considering. First, the availability of premium subsidies for millions of individuals across the country – including tens of thousands of people in states with relatively small populations – will alter the competitive landscape and should result

in new entrants, particularly in markets that have been dominated by one or two insurers. States should evaluate the potential to improve competition with the introduction of an Exchange and consider the role the Exchange may play in promoting greater transparency of health plan pricing, policies, and performance.

Second, the federal government's Office of Personnel Management (OPM) is responsible for contracting with insurers to offer at least two multi-state plans in each Exchange. These multi-state plans will need to be licensed in each state and meet the requirements of a "qualified health plan." As a result, states with limited carrier competition will likely be able to offer residents additional carriers to choose from.

Finally, the availability of federal funds to establish nonprofit, member-run health insurance plans (i.e., Consumer Operated and Oriented Plans, or CO-OPs) may provide an opportunity to improve competition in those markets that have limited carrier participation. By overseeing and operating an Exchange, a state will be able to ensure a level playing field for all carriers, including CO-OPs and new market entrants.

Establishing a state-administered Exchange will carry both risk and reward. A successful Exchange that efficiently and cost-effectively connects people with health insurance can be a powerful force for change in a state, but will take time and effort, with plenty of challenges along the way. State officials, as well as health insurers, consumers, advocates, employers, providers, brokers, and other stakeholders, are rightfully concerned about how this new entity will fit into their existing markets. Allowing the federal government to operate the Exchange is clearly an option for states to consider. But in making that decision, states will need to carefully weigh the advantages and disadvantages.

Regional, Statewide, or Multi-State Exchange

In addition to determining whether to establish a state-based Exchange or defer to the federal government, states have the option of operating a single Exchange that serves the entire state, multiple Exchanges serving different geographic areas within the state, or a multi-state Exchange that serves two or more states.

Given the administrative and operational responsibilities of the Exchange, it is difficult to envision a scenario in which establishing more than one Exchange in a single state would be an efficient use of resources. While it is quite likely that certain carriers may only be available in select regions of a state and the cost of health insurance within a state may vary from one region to another, a single state-wide Exchange's information technology, infrastructure, and customer service unit should be able to provide customers with information regarding the health carriers and health plans available in different regions of the state without the need to set up more than one Exchange. In addition, the administrative and quasi-regulatory responsibilities of the Exchange (e.g., processing eligibility, establishing interfaces with federal agencies, contracting with health insurers, evaluating and rating health plans, determining whether individuals are exempt from the individual mandate, etc.) make it difficult to envision the advantage of establishing more than one Exchange in a state.

This is not to suggest that some functions of the Exchange cannot, or should not, be delivered or administered on a regional basis. For example, outreach and education activities could be coordinated and administered regionally; or enrollment brokerage might be handled on a regional basis. These decisions may be affected by the size of the state and the manner by which health insurance is currently distributed in a state.

With regard to a multi-state Exchange, there may be efficiencies achieved by states joining together to establish and operate some of the back-office administrative functions of an Exchange. These could include processing enrollment, providing customer service, developing a website, and generating rates (i.e., monthly premiums for individuals and small groups seeking coverage through the Exchanges). Many of these functions will be similar, if not identical, across all Exchanges, and states may find value in jointly developing or purchasing these services.

However, because insurance regulations are administered at the state level, there are likely meaningful differences in insurance regulations across states that would need to be harmonized before states joined together to operate an integrated, multi-state Exchange. In the near term, it may be unlikely that states will establish a fully-integrated, multi-state Exchange. However, there may be opportunities to consolidate some of the functions of the Exchanges across two or more states.

Governance Structure, Administration, and Financing

For states that decide to run their own Exchange, the governance and administration of the Exchange are among the most important initial decisions, as these choices will have profound effects on the ability of the Exchange to successfully meet the health insurance needs of individuals and small employers. At its core, an Exchange is a distribution channel for commercial insurance. Under federal health reform, Exchanges are also conduits for premium subsidies and reduced cost sharing, thereby enabling individuals – and, to a lesser extent, small employers – to purchase insurance. The governance structure and administration of the

Exchanges should reflect this fundamental role and responsibility.

The governance structure and administration of the Exchange may determine, among other things:

- The management and extent to which the Exchange will be allowed to operate outside the confines of state government;
- The level of transparency and public accountability;
- The manner by which goods and services will be procured;
- Staffing levels and hiring procedures;
- The criteria that may be used to select health plans; and
- The intersection between publicly-subsidized coverage and non-subsidized commercial insurance.

Governance

The ACA provides states with latitude in establishing a governance structure for their Exchange. A state could operate the Exchange like any other state program and designate an executive agency to run the Exchange. Under this approach, a state's secretary of health and human services or commissioner of insurance, for example, might be responsible for oversight and management of the Exchange. An advisory board might be established to provide input and offer advice on Exchange policies and procedures, but the ultimate decision-making authority would rest with an executive branch agency.

An alternative approach, and the one recommended here, is for states to establish a governing body that is separate and apart from state agencies to serve as the policy-making body for the Exchange. A governing board responsible for setting policy and overseeing the operations of the Exchange can help establish the independence of the Exchange, provide greater continuity in the event of a change in administrations, and include individuals with relevant business and insurance expertise, as well as representatives from across the political spectrum.

Because the Exchange will need to be in-sync with the activities of a number of other state agencies – particularly a state's insurance regulator and its Medicaid agency – the Exchange's governing board might include state officials with expertise in those areas. An Exchange governing board might also benefit from the inclusion of an individual with commercial health insurance experience, as well as a consumer representative.

Board representation from organizations with experience in the individual and/or small group markets could also be useful, providing the governing board with insight into those markets and firsthand knowledge of the types of plans consumers have selected in the past and the way those markets operate. Because the individual and small group markets operate under different rules than the large group market, states would be well served to

include an individual with experience in those markets on the Exchange board.

As states draft legislation to establish the Exchange's governance structure, they will need to determine the roles and responsibilities of the board. A balance will need to be struck between the policy-setting responsibilities of the board and the administrative responsibilities of the Exchange staff. In general, the Exchange's governing authority might have responsibility for setting broad policy for the Exchange, approving major contracts, setting carrier selection criteria, and overseeing the activities of the Exchange staff. Restrictive processes that require board approval for all activities of the Exchange will not be conducive to effective and efficient operations. The Exchange will need to be adaptive and flexible in order to respond to an ever-changing marketplace, and an evolving set of federal rules and regulations.

Individuals and Groups Purchasing Through the Exchange

The availability of subsidized coverage for individuals and families with income up to 400 percent FPL will likely drive millions of people to purchase coverage through the Exchange. Small employers with lower-income workers may also be eligible for premium subsidies for insurance purchased via the Exchange. However, small employers' premium subsidies will be limited to two years in duration.

Though premium subsidies may induce tens of thousands of small employers to purchase health insurance through the Exchange, it is likely that individual purchasers will comprise the largest share of the Exchange's market. A further complicating factor with the Exchange is that group coverage purchased through the Exchange may require a shift from composite rating, the practice in most markets, to list-bill rating.

Under composite rating, a group's premiums for each rate basis type (i.e., individual, two-person, family) are based on the membership of the group as a whole. For each rate basis type, all members of the group are charged the same premium. In contrast, under list-bill rating, premiums for each member of the group will differ based on the member's age and the health plan selected.

This will add a level of complexity that may affect the Exchanges' ability to attract employers. In Massachusetts, administering the small employer program has proven challenging, and participation by small employers in the Massachusetts Connector, to date, is extremely limited.

Exchange administrators will need to simplify the shopping experience for employers, and their employees, in order to attract sufficient volume.

Administration

The law requires that the Exchange be administered by a governmental agency or non-profit entity established by the state, providing some flexibility for states to decide whether to house the Exchange within an existing governmental agency; in a new agency or quasi-public authority; or at a non-profit entity. The nature of the Exchange and its range of responsibilities may be best served by an entity that is accountable to the public yet separated – although certainly not immune – from executive and legislative influence.

Day-to-day activities of the Exchange will need to be carried out by a professional staff that can effectively implement and operate a health insurance marketplace, help consumers make informed choices, and provide a level playing field for insurers to compete. Given the amount of work that will be required to set up and operate the Exchange and the inherently commercial nature of the Exchange, placing the day-to-day operations of the Exchange within an existing state agency should be carefully evaluated before a state opts for this choice.

Three existing state agencies may be generally considered as “natural homes” for the Exchange: 1) insurance departments; 2) Medicaid agencies; and 3) state employees’ health benefits administrators. In addition, Utah currently houses its Exchange in the governor’s office of economic development. There are pros and cons to each of these agencies serving as Exchange administrators.

Although state insurance departments obviously have expertise with commercial insurance, they may be an unlikely Exchange administrator in light of their regulatory authority, their oversight of the insurance markets, and their lack of experience operating an insurance program. A state Medicaid agency clearly has experience operating publicly subsidized health coverage programs, but little if any experience with commercial insurance. Though a state employees’ health benefits administrator understands

commercial insurance and has experience operating a health insurance program for employees, the individual and small group markets are materially different from large group, employer-sponsored insurance.

Finally, a state’s economic development agency, given its role in promoting policies to improve the business climate in a state, certainly understands the financial burden that health insurance premiums can place on businesses and is keenly aware of the importance of a healthy workforce. However, economic development agencies are generally not in the business of operating a commercial insurance program and are not set up to administer premium subsidies, process eligibility for lower-income individuals, administer requests for exemptions from the individual mandate to maintain health coverage, nor handle many of the other provisions of the federal health care reform law.

This is not to suggest that any of those state agencies, or other state agencies, is incapable of developing the administrative apparatus to handle the myriad responsibilities of an Exchange under the federal health care reform law. However, existing priorities of state agencies may not allow senior managers to devote the necessary time and attention to the establishment and operation of an Exchange.

The high-profile nature of the Exchange and its wide range of responsibilities suggest that the administration of an Exchange might best be placed in the hands of a new agency, a quasi-public authority, or a nonprofit entity established for the express purpose of operating the Exchange. The recommended approach is to designate or create an entity that is solely devoted to the establishment and operation of the Exchange, overseen by a governing body responsible for setting policies and procedures.

In determining how – and where – the Exchange should be administered, states will need to consider whether state procurement rules apply to the Exchange or whether the Exchange will be given greater latitude to procure goods and services; what will be

the conflict of interest and public disclosure requirements for the board and the Exchange staff; whether the employees of the Exchange will be subject to civil service rules and state compensation levels; as well as, in some states, whether employees will be unionized.

Overall, a key consideration is the ability of the Exchange, wherever it is housed, to be adaptive and capable of developing new programs and modifying those programs as circumstances change. States with long procurement cycles, stringent hiring practices, and/or rigid work rules will need to carefully consider these and other management issues in deciding where to place the administration of the Exchange. An Exchange will need to respond to changing market conditions, the evolving preferences of consumers, and the ongoing development and issuance of federal guidelines regarding the administration and operation of the Exchange.

Financing

While federal grants will be available from late 2010 through 2014 to support the planning, establishment and initial operations of the Exchange, federal grants cannot be renewed beyond December 31, 2014 (one year after the Exchange is operating), and the Exchange will need to be self-financed in 2015 and beyond. In much the same way that insurance brokers are paid from the policyholders’ premiums, the Exchange will likely need to generate operating revenues through retention of a portion of the premiums or through direct payments from the participating carriers.

The financing required to operate the Exchange will depend on a number of factors, including, but not limited to:

- The ability of the Exchange to leverage existing infrastructure for its operations;
- The manner by which eligibility for premium subsidies will be processed;
- The need to establish interfaces between the Exchange and health insurers for functions such as rate development, transfer of enrollment information, and eligibility for premium subsidies;

- Whether the Exchange will handle premium billing, collection and reconciliation;
- The extent of outreach and marketing undertaken by the Exchange;
- The development and maintenance of a website that is capable of providing decision-support tools used by consumers to evaluate their health insurance options;
- Whether brokers will be paid from Exchange revenues or by the carriers;
- The amount of consumer support that will be provided by the Exchange versus the insurance carriers; and
- The level and type of reporting required by the federal government.

How these and other issues are handled, along with an estimate of the number of people served by the Exchange, will determine the revenues needed to support the operations of the Exchange. There will be tension between keeping administrative fees as low as possible and providing consumers with high quality service. To achieve economies of scale and minimize per-member cost, the Exchange will likely need to spend money to attract and retain consumers by offering value-added services. Achieving a balance between those two competing – although not mutually exclusive – factors, will be an ongoing challenge faced by the Exchange.

Developing a Strategic Plan

Having established a governance structure and administrator for the Exchange, a critical step will be the development of a strategic plan and timeline for implementation.¹ The strategic plan will identify the services that need to be in place, along with a roadmap to get there, to meet the January 2014 deadline.

A key ingredient in the development of the strategic plan will be a thorough understanding of the current market,

including documenting the potential population to be served by the Exchange. Assembling a strong foundation of knowledge and data will enable the Exchange board, staff, and state policymakers to structure an Exchange that best meets the state's needs.²

A comprehensive understanding of a state's current health insurance market should include not only an examination of the uninsured, but also an examination of the insured, recognizing that people move in and out of health coverage, as well as across different types of coverage (i.e., public and private), throughout the year.

The analysis of the uninsured should include:

- Estimates of the total number of people who lack health coverage;
- Demographic information (i.e., age, gender, marital status, race/ethnicity), as well as geographic/regional variations;
- Family income status;
- Employment, including a breakdown of the uninsured who are employed based on the size of their employer (i.e., number of employees), and whether they are offered employer-sponsored insurance; and
- Eligibility for existing publicly subsidized health coverage programs.

This information is useful for a number of reasons, not least of which is the value in helping to quantify the number of people who do not have access to health coverage, determining how effectively current programs are reaching their target populations, and developing projections of the potential pool of people who may be covered through the Exchange. Detailed information on the uninsured can also be used to target outreach and enrollment efforts for existing health coverage programs and the expansion of Medicaid.

A second phase of the analysis should include a review of existing publicly subsidized health insurance programs, including the penetration (i.e., take-up

rates) of the different programs, the distribution methods (i.e., outreach and enrollment) for each program, and a review of how existing programs may complement or compete with coverage that will be offered through the Exchange.

The final phase of the baseline analysis should include a review of the commercially insured, in much the same way that the examination of the uninsured was undertaken. For many states, detailed information on the insured population may not be as readily available as information on the uninsured. For some of the metrics noted below, it may be necessary to piece together information from a variety of sources (e.g., state insurance agencies, commercial health plans, private researchers), or states may need to sponsor new research to obtain this information.

The review of the insured population should include the following:

- A demographic profile of the insured across each of the major market segments (i.e., individual, small group, large group);
- Geographic/regional variations in the coverage rate of the commercially insured;
- The number of carriers operating in the market;
- A breakdown by size of employers that offer insurance;
- Types of insurance provided by employers (i.e., benefit design, cost sharing arrangements);
- Premiums and the percentage paid by employees and employers;
- Employees' take-up rate of employer-sponsored insurance by size of employer; and
- The manner by which individuals obtain coverage (e.g., directly from carriers, through a broker, using an intermediary, etc.).

Particular attention should be paid to the individual and small group markets. The Exchange and state policymakers will need

to consider a number of issues in these market segments, including:

- The current rating rules and regulations;
- The extent to which these markets are well-functioning (i.e., competitive and providing meaningful coverage);
- The number of carriers and types of health plans available;
- The manner by which commercial insurance is distributed (e.g., the role of insurance brokers, intermediaries, carriers, third-party administrators, etc.); and
- The sources and types of information available to individual and small group purchasers.

This baseline information will help on a number of fronts, particularly with regard to key policy decisions that will need to be made to effectively shift the individual and small group markets from one in which insurers “compete” by avoiding risk through the use of medical underwriting to a market in which insurers compete based on price and quality.

Currently, most states allow insurers in the individual and small group markets to set premiums based on the health status of applicants and to raise premiums if individuals or small group members become ill. Furthermore, in most states insurers are not required to accept all applicants in the individual market (i.e., no guaranteed issue requirement).

Under federal health care reform, medical underwriting will no longer be allowed in the individual and small group markets. In 2014, health insurance policies in these markets will be guaranteed issue using a modified community rating system to set premiums. Rates will still vary, primarily based on the age of the applicant; however, the health status of individual applicants will not be a factor in the development of premiums.

These changes in the rating rules will mean that individuals and small employers who are currently unable to purchase insurance

or who are effectively priced out of the market due to health status may be able to purchase coverage. On the other hand, it will also mean that individuals and small employers who have coverage today may see their premiums adversely affected by the addition to the risk pool of people who had previously been denied coverage due to their medical conditions.

The law recognizes that in most states these changes to the individual and small group market rules will result in risk selection problems for insurers. To mitigate this impact, the health care reform law includes three mechanisms to address risk selection and provide some financial protection for insurers:

- Transitional reinsurance program for the individual market in each state;
- Risk corridors in the individual and small group markets; and
- Risk adjustment to transfer funds among health plans that offer coverage in the individual and small group markets based on the relative health status of their enrollees.

While these provisions of the health care reform law are designed to address the risk selection problems that may result from the switch to a guaranteed issue, modified community rating system, the data and information collected as part of the background research effort can be used to develop actuarial and economic models to help policymakers as they grapple with a number of key questions, including:

- How will changes to the rating and underwriting requirements in the individual and small group markets affect premiums for people currently covered?
- What might be the cost of coverage for the policies within each benefit tier offered through the Exchange (Platinum, Gold, Silver, Bronze, and Catastrophic)?
- How many people will receive coverage through the Exchange and what will be their demographic profile?

- How many people are susceptible to switching their source of coverage (e.g., from employer-sponsored insurance to an individual product offered in the Exchange or to other publicly subsidized coverage)?
- Should the individual and small group markets be merged, and, if so, what might be the impact on coverage and premiums in each market?
- Will the inclusion of groups of 51–100 employees have a positive or negative effect on the risk pool, and how will premiums be affected?
- Should groups of more than 50 employees be prohibited from purchasing coverage in the small group market during the first two years of the Exchange?

The analysis from this research effort will be helpful to the Exchange, as well as beneficial to state policymakers and regulators who will be implementing changes to the state’s individual and small group markets. Using the information from each phase of the analysis will help with the development of a strategic plan for the Exchange, which can be used to determine:

- How the Exchange will interact with the state’s Medicaid/CHIP program and how the Exchange will fit into other publicly subsidized health coverage programs;
- The Exchange’s business plan and financial model to become self-sustaining;
- The targeted outreach and marketing efforts that will be necessary to attract a broad and diverse risk pool;
- The role of the Exchange in the commercial health insurance market, and whether the Exchange will be proactive in encouraging carriers to develop and offer innovative plan designs; and
- Whether, and how, the Exchange will be used to support broader policy initiatives such as payment reform, service delivery reform, or other health care and health insurance reforms a state may be pursuing.

The strategic plan may also establish whether the Exchange will be an active or passive player in the market. The level of market involvement will depend on state policymakers' interest in using the Exchange to buttress broader policy initiatives, and whether they see the Exchange as a market "maker" or a market "taker." The Exchange may be an agent of change or it may play a more limited role as a basic distribution channel for commercial insurance and premium subsidies for low and moderate income individuals and families.

An important challenge for policymakers and governing boards of the Exchanges will be to develop a strategic plan that recognizes and reflects what is happening in the market and seeks to align the goals and objectives of the Exchange with each state's health reform priorities. While policymakers must make certain that the essential "blocking and tackling" functions of an Exchange are not undermined by focusing too much attention on larger policy matters, states should also recognize the opportunity that the Exchange presents in supporting broader health care and health insurance reform activities.

Engaging Stakeholders: The success of each state's Exchange in meeting the needs of its residents will be enhanced if a broad cross-section of stakeholders is engaged and actively participating in the planning and development of the Exchange. States will need to engage stakeholders in meaningful and substantive discussions about how best to design and implement an Exchange that will complement – and hopefully improve – the state's health insurance market and its health care system. Meaningful engagement will require reaching out to a wide range of individuals and groups, including business associations, small employers, consumer advocates, insurers, hospital executives, physicians, union members, small employers, brokers, legislators, and other interested parties.

Some states have already started this process by establishing work groups comprised of public officials and private sector representatives, holding public forums,

developing health care reform websites, and initiating an outreach and education plan. The ongoing involvement of a broad cross-section of individuals and groups who may directly benefit from the operations of the Exchange will help states design an Exchange that reflects their needs and desires. Engaging people in the planning efforts can also serve as an effective way to disseminate information about health care reform, in general, and the Exchange, in particular.

Key Functions and Responsibilities of the Exchange

The Exchange is a market organizer, distribution channel for commercial insurance, conduit for premium subsidies and reduced cost-sharing, and enforcement arm for compliance with the individual mandate. At its core, the Exchange must attract and retain customers by offering quality health insurance plans offered by qualified health insurers. Thus, it must process transactions effectively and efficiently; provide members with information to make informed decisions; establish a streamlined eligibility and enrollment process; and administer a process to enable individuals to apply for waivers from the health insurance mandate.

These can be viewed as four distinct and separate responsibilities – determining eligibility, carrier and plan selection, enrollment, and enforcement. Each is discussed below.

Determining Eligibility

Federal law expects states to use a:

“single, streamlined form that: may be used [by individuals] to apply for all applicable state health subsidy programs, within the state; may be filed online, in person, by mail, or by telephone; may be filed with an Exchange or with state officials operating one of the other applicable state health subsidy programs; and is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable state health subsidy programs.”³

States are expected to establish a single portal – potentially feeding into a single eligibility engine – that will be used to determine eligibility for Medicaid, CHIP, the Exchange, and other state health insurance programs. In many states with separate Medicaid and CHIP programs that operate under different eligibility rules and that process applications through different eligibility engines, establishing a single portal/single eligibility engine may require a significant upgrade to existing eligibility systems or the development of a new eligibility system to process applications and determine eligibility.

The vision for the Exchange, and other public health coverage programs, is that an individual will be able to provide a limited amount of information and find out whether he/she is eligible under any of the health coverage programs available in the state. The elimination of the asset test for most Medicaid recipients and no asset test for premium subsidies through the Exchange will certainly reduce the amount of information that states will need to collect to determine eligibility.⁴

However, eligibility for coverage and premium subsidies through the Exchange will be predicated on whether the applicant has access to employer-sponsored insurance (ESI), whether the ESI meets actuarial standards and provides “minimum essential benefits,” and whether the employee's share of the premium as a percentage of his/her income is above or below a certain percentage of his/her income (see Appendix for more information on subsidy determination). In addition, only legal residents will be allowed to purchase coverage through the Exchange, regardless of their eligibility for premium subsidies.

The federal government will be issuing regulations regarding the single portal eligibility system and the standard eligibility form. However, states will need to start planning for the development of a system that can process applications and determine eligibility for all health coverage programs. Additionally, a mechanism

to capture and store eligibility and enrollment information for all public subsidy programs will be needed to minimize the potential for individuals to be covered by multiple programs simultaneously.

Minimum Essential Benefits: Federal law requires that Exchanges offer only “qualified” health insurance plans that provide coverage for “minimum essential benefits.” What “qualified” and “minimum essential benefits” mean will be determined by the secretary of HHS. However, a state may require plans to cover benefits beyond the minimums established by the federal government, but the cost of those additional benefits must be borne by the state. This may mean that states with mandated benefits that are not considered “minimum essential benefits” will be responsible for paying, on behalf of enrollees receiving premium subsidies through the Exchange, for the additional premium amount associated with the cost of those benefits.

In addition to the potential cost to states with mandates or requirements that go beyond the federal government’s “minimum essential benefits,” the administrative challenge of adjusting premiums and paying health carriers separately for the cost of those additional benefits could be a significant administrative and operational burden. States will need to review carefully the federal regulations that establish “minimum essential benefits” and compare those benefits to their list of mandates and benefit requirements.

Benefit Levels: Health plans offered through the Exchange will be available in five benefit levels: Platinum, Gold, Silver, Bronze, and Catastrophic. The benefit levels will vary based on “actuarial value,” which is a summary measure of the amount of medical claims that would be paid by the health plan as a percentage of the total medical claims incurred for a standard population. In essence, the different benefit levels will have different amounts of point-of-service cost sharing.

Platinum plans will cover 90 percent of the cost of care. This means that a member enrolled in a Platinum level plan would, on average, pay ten percent of the cost of care through co-payments, co-insurance and/or other types of cost sharing. The actual amount of cost sharing will vary for each member, based on their use of services and supplies.

A health plan with an actuarial value of 90 percent has relatively modest cost sharing. For example, the Platinum plans might have no upfront deductible; office visit co-payments of \$20; inpatient hospitalization co-payments of \$250 per admission; outpatient surgery co-payments of \$50 per procedure; and prescription drug co-payments of \$10/\$25/\$50 for generic, preferred brand-name, and non-preferred brand-name drugs, respectively.

Gold plans will cover 80 percent, Silver plans will cover 70 percent, and Bronze plans will cover 60 percent. Catastrophic plans, which are limited to individuals younger than 30 or people who are exempt from the insurance mandate due to affordability or other hardship, will be high deductible health plans (HDHPs).⁵

Point-of-Service Cost Sharing: A key decision for the Exchange will be the extent to which benefits are standardized (e.g., cost sharing, types of plans – HMO, PPO, Indemnity) within each benefit level. The federal law provides some flexibility with regard to the plans offered and the cost sharing, within the parameters of actuarial value set by the ACA and “minimum essential benefits” to be set by the secretary of HHS.

On the one hand, dictating the specifics regarding the amounts and types of cost sharing for each service within each benefit level might help focus consumers’ decision making on the comparison of premiums, differences in provider networks (i.e., hospitals and physicians), quality of service, and reputation of the carrier. On the other hand, this approach may result in less creativity in the market and reduce a consumer’s ability to trade

off one type of cost sharing (e.g., an upfront deductible, lower cost sharing after the deductible) for other types of cost sharing (e.g., no upfront deductible, higher co-payments) within the same benefit level.

While standardizing benefits may be desirable from the perspective of helping consumers navigate what can be a confusing process, being overly prescriptive and micromanaging the product design within the Exchange may result in products that are out of sync with the market and may stifle innovation. The depth and breadth by which benefits are standardized will be an important decision for state policymakers and the Exchange.

Basic Health Program: The health reform law provides states with an option to create a “Basic Health Program” for individuals with income between 133 and 200 percent FPL, in lieu of their receiving coverage through the Exchange. This Basic Health Program must offer, at a minimum, the same level of benefits and limits on cost-sharing that individuals would have received had they purchased a Platinum level plan (for individuals with income up to 150 percent FPL) or a Gold level plan (for individuals with income between 150 and 200 percent FPL). However, the monthly member premium for the Basic Health Program cannot exceed the monthly premium that the eligible individual would have been required to pay if he/she had enrolled in the second lowest cost Silver level plan available through the Exchange.

States opting for the Basic Health Program will be required to establish a competitive procurement process, including negotiating premiums and cost sharing with the health insurers; and, “to the maximum extent feasible,” states will need to make available multiple health plans to eligible individuals covered under the Basic Health Program.

This provision of the law provides states with an option to develop and offer a Medicaid-like health benefit for

Table 1: Out-of-Pocket Limits by Income in the Exchange

Income Category	Reduction in Out-of-Pocket Limit Relative to HSA/HDHP Maximum	Out-of-Pocket Limit (based on 2010 HSA/HDHP Maximum)	Actuarial Value of Silver Plan
Up to 150% FPL	Reduced by two-thirds	\$1,963/\$3,927	94%
150.1 – 200% FPL	Reduced by two-thirds	\$1,963/\$3,927	87%
200.1 – 250% FPL	Reduced by one-half	\$2,975/\$5,950	73%
250.1 – 300% FPL	Reduced by one-half	\$2,975/\$5,950	70%
300.1 – 400% FPL	Reduced by one-third	\$3,986/\$7,973	70%
Above 400% FPL	No reduction	\$5,950/\$11,900	70%

individuals with income between 133 and 200 percent FPL. The benefits available under a Basic Health Program would be richer (i.e., lower point-of-service cost sharing) than Silver level coverage available through the Exchange, while premiums could be no greater than those charged for Silver level coverage.

States would receive 95 percent of the value of tax credits and cost sharing reductions that would have been provided to individuals to purchase the second lowest cost Silver level coverage through the Exchange. These funds, combined with the member's share of the premium, would be used to pay health insurers for the Basic Health Program.

This option may be attractive to those states that had previously expanded their Medicaid programs beyond the federal minimums and/or developed other publicly subsidized programs for individuals with income above 133 percent FPL. In addition, states may wish to use this option to smooth out the differences between Medicaid benefits, which generally have very limited cost sharing and no monthly premiums, and the benefits and cost sharing requirements under the Exchange.

However, states will need to consider not only whether they may be able to offer individuals in this income category a richer health benefit package for less, but the potential impact to the commercial insurance market that may result from separating those individuals from the rest of the risk pool. Individuals eligible for the Basic Health Program will not be eligible for premium subsidies and reduced cost sharing through the Exchange.

It is likely that individuals with income between 133 percent and 200 percent FPL will constitute a sizeable proportion of the uninsured who will be eligible for premium subsidies for commercial insurance through the Exchange. Roughly 25 to 30 percent of the uninsured in every state have income between 100 percent and 200 percent FPL.⁶ Removing that group from the individual commercial market and separating them from the Exchange may have a number of consequences, including:

- Negatively affecting premiums in the individual market by splitting off a large group of people – quite possibly younger and healthier than the broader uninsured population – who would otherwise enroll in coverage through the Exchange;
- Reducing the number of people covered through the Exchange, thereby making it less attractive for commercial insurers to participate;
- Limiting the Exchange's ability to promote other health reform priorities; and
- Affecting the ability of the Exchange to achieve economies of scale, which may increase the per-member administrative costs of the Exchange.

Perhaps the most significant factor for states to consider before deciding to establish a Basic Health Program relates to the reduced cost sharing and increased actuarial value of Silver level plans for individuals with income at or below 400 percent FPL. As discussed below, this provision of the ACA will minimize the effective cost of coverage (i.e., premiums and point-of-service cost sharing) for lower income individuals.

The ACA requires plans sold through the Exchange to limit out-of-pocket expenditures to the maximum allowed under the federal rules pertaining to high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). The current out-of-pocket maximum for an HSA-qualified HDHP is \$5,950 (individual) and \$11,900 (family).

However, federal law provides cost-sharing subsidies that will further reduce the out-of-pocket expenses for individuals at or below 400 percent FPL. These cost-sharing subsidies will effectively increase the value of the Silver level plan, particularly for individuals with income at or below 200 percent FPL. Table 1 displays the subsidies that will be provided to individuals purchasing Silver level coverage through the Exchange.

These cost-sharing subsidies and increases in the actuarial valuation of Silver level plans for individuals with income at or below 200 percent FPL may address the concerns expressed by some with regard to the potential out-of-pocket costs for lower-income individuals who purchase coverage through the Exchange, and may obviate the need to establish a Basic Health Program for these individuals.

Carrier and Plan Selection

Because the Exchange will offer low and moderate income individuals federally funded premium subsidies and reduced cost-sharing, the Exchange will likely attract tens of thousands of individuals, and in some states millions of people. This market power makes it incumbent upon the Exchange to establish a fair and transparent process in the selection of health carriers and health plans.

Federal law requires the Exchange to offer “qualified” health plans, and the Exchange will need to establish a selection process and evaluation criteria to solicit “qualified” plans from health carriers. Exchanges will have three ways in which they can approach this responsibility: 1) as a market organizer/distribution channel; 2) as a selective contracting agent; or 3) as an active purchaser.

Under the “market organizer/distribution channel” model, the Exchange would establish threshold criteria and offer all health carriers and all health plans that meet the criteria. The Exchange acts as an impartial source of information on health plans that are available in the market; provides structure to the market to enable consumers to compare health plans based on relative actuarial value; administers premium subsidies; and serves as a broker of health insurance.

In the “selective contracting agent” model, the Exchange plays a more active role. The Exchange may attempt to exert its influence in the market and enhance competition by contracting with a limited number of carriers offering a select group of health plans, or by requiring that health carriers and health plans meet certain cost and/or quality metrics. The Exchange might solicit plans based on plan design parameters or preferred plan types or, depending on the number of carriers operating in the state, the Exchange might offer only the four or five lowest-priced carriers, for example.

The Exchange, under the “active purchaser” model, establishes plan designs and purchases health insurance on behalf of its members, much like a large employer establishes and purchases health benefits on behalf of its employees. This model is predicated on the Exchange covering a large and broad risk pool that enables carriers to offer competitively-priced plans. Initially, it may be difficult to envision the Exchange as a true “active purchaser,” in large part because the carriers will be required to establish premiums based on numerous unknown factors (e.g., the number of

people purchasing coverage through the Exchange, health status of enrollees, demographic characteristics, etc.).

Given the Exchange’s role in the market and the availability of premium subsidies for low and moderate income individuals, carriers offered through the Exchange will likely have exclusive access to a sizeable population. This heightens the responsibility of the Exchange to establish a fair and open health carrier and health plan selection process, regardless of the decision to be a market organizer/distribution channel, selective contracting agent, or active purchaser.

Enrollment

Setting up a mechanism by which individuals and small employers can select a health plan and enroll in coverage is a primary purpose for the Exchange. How this is handled and by whom will be important decisions.

Individuals will be allowed to choose any health plan offered by the Exchange, while employees of small employers that purchase coverage through the Exchange may be limited to a level or tier of plans selected by their employer. For example, an employer that selects a Silver level plan might limit his/her employees to select only from among the carriers and plans available in the Silver level. These employees would not be able to “buy up” to Gold or Platinum level plans, nor would the employees be allowed to “buy down” to Bronze level plans.

The ability of employees to “buy up” or “buy down” and the manner by which this selection process is structured will be of particular interest and concern to the health insurers whose products are offered through the Exchange. In almost all small group markets, carriers do not allow employers to offer their employees more than one, or possibly two, health plans from which to choose. More importantly, carriers typically do not allow another carrier’s plans to be offered to a small employer.

These carrier underwriting rules are used to minimize risk selection. Placing all employees in one benefit plan eliminates

the chance that individual employees will choose a plan based on their health status and/or the health care needs of family members. Although it does not address risk selection that may occur at the employer level (i.e., an employer may select a plan based on his/her health care needs), it does address risk selection at the individual employee level.

However, restricting employees’ health plan choices runs counter to what many people consider the central purpose and value of the Exchange for small employers; that is, allowing employees to choose the health insurance that best meets their needs. Some of the risk selection problems will be addressed by the establishment of risk corridors and the risk adjustment mechanism that will apply in the small group market. Nonetheless, Exchange administrators and state policymakers will want to carefully monitor the coverage choices of small employers’ employees that purchase coverage through the Exchange, particularly if these employees are allowed to select from any of the four coverage tiers available in the small group market (i.e., Platinum, Gold, Silver, Bronze).

Under the Exchange, employees may select from health plans with benefits that range from 60 percent actuarial value (Bronze plans) to 90 percent actuarial value (Platinum plans), and premiums will vary across the four tiers by 50 percent or more. The structure of the employee choice model will affect the extent to which older and/or sicker employees may select more comprehensive coverage (i.e., higher premiums and lower cost sharing), while younger, healthier employees opt for less comprehensive and less expensive policies. Balancing the value of consumer choice against the potential for risk segmentation and the impact that risk segmentation may have on the market will need to be evaluated in establishing the underwriting rules and plan choices available to employees purchasing coverage through the Exchange.

While employees of small employers may have limitations placed on their health plan options, individuals will be able

Table 2: Jones Family Income and Premium Share

Mr. and Mrs. Jones and their two children	
Modified Adjusted Gross Income	\$55,125
Federal Poverty Level	250%
Family Share of Premium	8.05%
Family Monthly Premium	\$370

to choose from all of the plans and all of the levels of coverage (i.e., Platinum, Gold, Silver, Bronze) offered through the Exchange. Moreover, individuals younger than 30 and those exempt from the individual mandate will be able to select a Catastrophic or high deductible health plan (HDHP).

For individuals at or below 400 percent FPL, the premium subsidy for the individual consumer is based on the cost of the second lowest priced Silver level plan. Individuals opting for a different plan may pay more or less premium, depending on their plan choice. The federal government will be providing a “defined contribution” that an individual may then take with him/her to shop for insurance. Tables 2 and 3 show a simplified example of how this might work.

The Jones family is eligible for a subsidy, based on their income of \$55,125 for a family of four. If they select the second lowest priced Silver level plan, their share of the monthly premium would be \$370. Or, they could take their federal subsidy and select a plan with lower out-of-pocket costs and higher premiums (i.e., Platinum or Gold level plans); a different Silver level plan with comparable out-of-pocket costs but lower or higher premiums; or a Bronze level plan that has higher out-of-pocket costs but lower monthly premiums. As Table 3 below shows, the federal

government’s share of the premium is fixed, regardless of the Jones family’s choice.

Individuals will likely have a number of carriers and plans from which to choose. However, reduced cost sharing for lower-income individuals (i.e., those with income at or below 400 percent FPL) will only apply if the individual selects a Silver level plan. This provision of the law will likely limit the number of subsidy-eligible consumers who decide to purchase a Gold or Platinum level plan. (See the “Basic Health Program” section of this report for a fuller discussion of the cost sharing reductions and increases in actuarial valuation of Silver level plans available to individuals with income at or below 400 percent FPL).

Premium Billing and Collection: The Exchange could be structured to serve primarily as a conduit, providing people with information about their health plan choices, calculating health plan premiums – including the subsidy levels that may be available – and sending consumers to the health carriers to complete enrollment. The carriers would be responsible for enrolling the individuals, handling premium billing and collection, and providing customer service.

Under this scenario, the health carrier would be provided information from the Exchange with regard to the premium

subsidy available to the individual. The carrier would need to coordinate with the federal government to collect any advanced tax credits and then bill the member for his/her share of the premium.

While the Exchange will serve as a single point of access for health coverage, federal law dictates that health insurers, and not the Exchange, will be responsible for billing and collecting premiums, as well as coordinating with the federal government for the advance payment of tax credits for subsidy-eligible individuals. Given the number of carriers and health plans that may be offered through the Exchange and the volume of subsidy-eligible individuals purchasing coverage, the complexity of each health carrier coordinating the billing process and aggregating premiums for hundreds of thousands of individuals with different subsidy levels may add significantly to the operational responsibilities of health carriers participating in the Exchange and may undermine the goal of reducing administrative costs.

The “Free Choice Vouchers” program may add another layer of complexity. Under this provision of the law, employees who are offered employer-sponsored insurance but whose share of the premium exceeds eight percent of their income may be eligible to use their employer’s premium contribution to offset the cost of insurance purchased through the Exchange. In contrast to other provisions of the law, the Exchange is responsible for collecting the employer’s share of the premium and applying this payment to the premium of the health plan in which the employee is enrolled.

Table 3: Jones Family Premium Amount by Plan Level

Plan Tier	Total Monthly Premium	Federal Subsidy Amount	Jones’ Premium Amount
Platinum	\$1,800	\$1,030	\$770
Gold	\$1,600	\$1,030	\$570
Silver (most expensive)	\$1,430	\$1,030	\$400
Silver (second-lowest cost)	\$1,400	\$1,030	\$370
Silver (lowest cost)	\$1,380	\$1,030	\$350
Bronze	\$1,200	\$1,030	\$170

For employers, the need for the Exchange to administer premium billing, collection, and remittance will be particularly crucial. Under the Exchange SHOP model, employees will be able to choose coverage from a number of carriers, depending on how the small employer program is structured. If the health plans are responsible for premium billing and collection, an employer purchasing coverage through the Exchange would need to pay multiple health carriers for his/her employees, and would need to establish contractual relationships with the different carriers selected by his/her employees.

From an employer's perspective, the prospect of dealing with multiple insurers will greatly diminish the value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for his/her employees' health coverage, by not centralizing the premium billing and other administrative functions within the Exchange, the employer would need to deal with various carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks that are now handled through one health carrier or through a broker.

In light of those administrative challenges, the Exchange may be the more appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other mid-year administrative tasks, such as changes in enrollment, COBRA notification, etc. In some states, health carriers already utilize intermediaries or third-party administrators to handle virtually all of these administrative tasks for individuals and small groups.

States may have an opportunity to influence the federal government's approach and subsequent rulemaking on the issue of whether the health insurers or the Exchanges could or should bill and collect premiums. At the very least, the responsibility for premium billing and collection, as well

as the larger challenge of coordinating premium subsidies with the federal government, should be an optional service that the Exchange could facilitate if there are administrative efficiencies to be achieved.

Enforcement of the Individual Mandate

The Exchange is also responsible for establishing a process to determine whether an individual is exempt from the "individual responsibility penalty" (i.e., individual mandate) based on affordability or hardship. Information on each individual that is issued a certificate of exemption from the Exchange must be transferred to the secretary of the Treasury. Setting up a means by which individuals will be able to request an exemption from the mandate will be another core responsibility of the Exchange.

Outreach and the Role of "Navigators" and Brokers

Instituting an aggressive outreach and education campaign will be critical to generating sufficient enrollment in the health plans offered through the Exchange, which in turn will determine the ultimate success of the Exchange. The fact that millions of Americans are eligible but not enrolled in (free) Medicaid coverage may be an indication of the challenge that states will face in enrolling people for coverage through the Exchange.

The availability of premium subsidies and reduced cost sharing for health plans purchased through the Exchange will undoubtedly provide the Exchange with a significant advantage over other commercial insurance distribution channels. However, Exchange administrators and governing boards must recognize that people will need information on their health insurance options, their responsibility to obtain and maintain health coverage pursuant to the individual mandate, and the subsidized health insurance that may be available to them.

If the Exchange is to attract sufficient volume, it will need to undertake a multi-pronged outreach, education, and enrollment campaign. Such an effort might include Exchange employees, state employees working for social service agencies, schools-based promotional activities, community-based advocacy organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, paid media, and public service announcements.

It is important to recognize that the vast majority of Americans have never purchased health insurance on their own. People either obtain insurance through their employer (perhaps choosing from among a limited number of plans) or they receive publicly subsidized coverage from Medicaid or Medicare. It is likely that most people will go their entire lives without actually purchasing commercial health insurance. Under the Exchange, tens of millions of new "customers" will be responsible for purchasing health insurance, many of whom will be doing this for the first time. These new customers will need help wading through their options.

Navigators

Recognizing this need for consumer-based information and assistance, the health reform law requires the Exchange to establish an outreach and enrollment program that provides grants to Navigators that are responsible for apprising people of their health coverage options and helping individuals enroll in a health plan or in other publicly subsidized health coverage programs. Navigators are entities such as trade, industry, and professional associations; chambers of commerce; unions; community based non-profit groups; and other groups that have established, or can readily establish, relationships with employers, employees, consumers, or self-employed individuals.

Navigators will be responsible for conducting public education activities to raise awareness of the availability of qualified health plans through the

Exchange; distributing “fair and impartial” information concerning enrollment and the availability of premium subsidies and cost-sharing reductions; facilitating enrollment in qualified health plans; referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and providing information in a culturally and linguistically appropriate manner.

The secretary of HHS is responsible for establishing standards for the Navigators. However, federal law prohibits health insurers from serving as Navigators and prohibits Navigators from receiving direct or indirect payments in connection with the enrollment of an individual or an employee in a qualified health plan. The latter exclusion may preclude brokers from serving as Navigators.

The Exchange will need to establish a selection process for awarding grants to Navigators. Many states already use community-based groups to help with outreach and enrollment for Medicaid, CHIP, and other public assistance programs. It is likely that those groups will be prime candidates to become Navigators. However, the Exchange will want to expand beyond those groups, given the need to reach people who normally are not eligible for public assistance programs (i.e., individuals and families with income up to 400 percent FPL).

Brokers

In light of the possible exclusion of health insurance brokers from serving as Navigators, the Exchange will need to determine how best to use brokers to facilitate enrollment and assist consumers. Although health insurance brokers’ level of involvement in the individual and small group markets varies from state to state, they play an influential role in the distribution of health insurance across the country. Brokers serve as the de facto benefits offices for many small businesses, providing firms with a range of services, including assistance with health insurance, disability coverage, life insurance, and other ancillary lines of coverage. Business owners rely on brokers to sort through their health

insurance options, provide health plan recommendations at the time of renewal, and serve as their agents throughout the year in dealings with insurers.

In determining the role that brokers may play in the operation of the Exchange, a number of key issues/questions are worth considering:

- What is the current role of brokers in the individual and small group markets? In some states, brokers may be heavily involved in the small group market but much less active in the individual market.
- What types of services do brokers provide for their clients, beyond the annual health plan selection process?
- How are brokers compensated? Traditionally, brokers receive a percentage of the monthly premium. However, in some markets this traditional compensation model is changing to a flat dollar amount, unrelated to the amount of the monthly premium.
- Do brokers receive additional compensation – sometimes referred to as retention bonuses or overrides – for meeting targets for renewing business with a carrier? How might those payments factor into any Exchange-based payment model for brokers?
- Should brokers fees be transparent and paid separate and apart from the premium? The Exchange will likely want to coordinate this type of change in disclosure and payment with the rest of the commercial market to ensure a level playing field across the various distribution channels.

How to utilize brokers and how they fit into the Exchange’s outreach and enrollment program is one of the more important decisions to be made by the Exchange. Brokers play a prominent role in the market, particularly for small employers. They often have longstanding and trusting relationships with their clients and provide information at the ground level about health insurance options. Determining how best to leverage the expertise of health insurance brokers and to make an

effort to include them in the outreach and enrollment program may prove invaluable to the ultimate success of the Exchange.

Measure Current Capacity and Existing Infrastructure

The level of upfront investment and ongoing funding to support the Exchange will depend, in part, on the types of services currently being provided in the market and the extent to which existing infrastructure and resources may be leveraged and utilized by the Exchange. Regardless of whether the infrastructure and other resource needs are built or bought (i.e., established and operated by the Exchange or outsourced to a third party), there will be significant back-office infrastructure needed to set up the Exchange and service consumers.

As noted earlier, the process by which people will be determined eligible for subsidized coverage, as well as eligibility redetermination processes and program integrity measures, is an integral part of the Exchange’s operations. The availability and capabilities of existing public agency infrastructure and resources to process applications for premium subsidies and the extent to which the infrastructure and resources may be leveraged by the Exchange will be important to evaluate early on in the planning process.

In addition to determining eligibility for premium subsidies and assisting consumers with initial health plan selection and enrollment, the Exchange may also need to provide ongoing account management and maintenance (e.g., monthly premium billing and collection, changes in coverage status, delinquent payment notification, renewals, etc.). The Exchange will need to establish, or work with an entity that has already established, electronic data interchanges with the health carriers in order to generate monthly premiums, process enrollments, and handle myriad administrative responsibilities.

Private sector intermediaries already provide those types of administrative services on behalf of health insurers and

consumers in a number of states. These entities typically operate in the individual and small group markets. Working in concert with health insurance brokers and health carriers, the intermediaries generate premium quotes; process enrollments; bill, collect, and remit premiums; and provide a range of post-enrollment administrative functions. Essentially, intermediaries take over account management functions that are otherwise handled by a health carrier and/or the benefits management office of midsized and large employers.

In states with private intermediaries, the Exchange will need to decide whether, and how best, to leverage the capabilities of these businesses. There will likely be significant advantages to contracting with one or more intermediaries, particularly with regard to the infrastructure and the data exchanges that these companies have already established with health carriers.

The decision of whether and how best to utilize the services of private sector intermediaries will be affected by the capabilities of these businesses. Exchange administrators will need to determine which services can be handled internally, which should be outsourced, and which intermediaries may be best equipped to provide the administrative services required.

Review Existing Public Subsidy Programs to Identify Opportunities for Consolidation, Elimination, and Administrative Efficiencies

Federal health reform should be viewed as an opportunity for states to review their existing publicly subsidized health insurance programs, with an eye toward examining whether and how existing programs may fit into the changing marketplace given the availability of premium subsidies through the Exchange.

In particular, states should review public programs that provide premium subsidies for lower income individuals who work for small employers; programs that are designed to assist people who are recently unemployed (e.g., COBRA premium subsidy programs); and other programs geared toward helping working adults obtain coverage.

For example, a number of states have established premium subsidy programs for lower income individuals who work for small employers. These programs subsidize the employee's share of the premium for employer-sponsored insurance, and some programs subsidize the employer's share, as well. It is important to understand how these programs will be impacted by federal health reform and the establishment of an Exchange. While states may want to continue to encourage and support the offer of health insurance by small employers, the availability of premium subsidies for lower income individuals through the Exchange may allow states to eliminate or modify their existing programs.

In addition, not only will it be important to understand the eligibility rules for the various public subsidy programs, but it will be critical to recognize how premium subsidies and benefits (e.g., what's covered and the cost sharing requirements) for similarly-situated individuals might compare across these programs. For example, programs that subsidize employer-sponsored insurance offered by small employers will need to be matched against an Exchange-based program that provides subsidies for the purchase of individual insurance, as these programs will likely target many of the same people. States need to understand how the various programs interact and may need to restructure the programs so that they are complementary.

There may also be opportunities to consolidate, restructure, and/or streamline program administration. Given the requirement that states are expected to

establish single portals through which eligibility for all public subsidy programs will be determined, states may have an added incentive to limit the number of programs offered.

The Road Ahead

State governments will need to make a number of key decisions in the coming months to establish the proper foundation upon which to build an effective and efficient health insurance Exchange. And, while the federal health care reform law sets parameters within which the Exchanges will need to operate, the law also provides some flexibility to allow states to develop Exchanges that best meet the needs of their residents and employers.

The successful development and operation of the Exchanges will likely determine whether the federal health care reform law can achieve its goals of improving access to health coverage, enhancing the value of health insurance, and moderating the cost of health care. Across the country, state governments will play the pivotal role in operating these Exchanges.

Certainly, an immediate and significant challenge for most states will be the development of a single, streamlined eligibility process to determine eligibility for Medicaid, CHIP, the Exchange, and other state health insurance programs. For many states, establishing a single eligibility engine will either require an upgrade to existing eligibility systems or the development of a new eligibility system. Given the time and resources required to plan, design and develop eligibility systems, states will need to begin work on this requirement immediately in order to meet the January 2014 effective date.

Setting the rules for health insurers to participate in the Exchange, providing consumers with relevant and useful information to help them make informed decisions, streamlining administrative processes, and shifting the insurance market from one based on avoiding risk to one based on price and quality will require

collaboration between states and the federal government, across state agencies, among stakeholders, and throughout the health insurance industry.

The Exchange can play an important role in effectively and efficiently delivering health insurance and improving competition in the market. It can also become an important part of a broader effort to improve the health insurance and health care systems. Whether, and to what extent, that happens will depend on state policymakers' willingness to use the Exchange as a vehicle for change.

About the Author

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Prior to joining PCG, Mr. Carey was director of planning and development for the Commonwealth Health Insurance Connector Authority, an independent authority established to implement the 2006 Massachusetts Health Care Reform Law. In this role, Mr. Carey helped design and

implement new health insurance programs, including publicly subsidized and commercial health benefit plans, as well as health insurance financing arrangements. Mr. Carey was also responsible for coordinating activities across state agencies to implement the numerous components of the Massachusetts health reform law.

Prior to his work at the Connector Authority, Mr. Carey served as director of policy and program management at the Massachusetts Group Insurance Commission, the state agency responsible for providing health and welfare benefits to more than 325,000 state and local employees, retirees, and dependents. His work experience includes senior research and policy positions with non-governmental research organizations, government oversight boards, and senior policy positions with the U.S. Congress.

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Endnotes

- 1 For more information on developing a timeline, see "Health Benefit Exchanges: An Implementation Timeline for State Policymakers," Patrick Holland and Jon Kingsdale, State Coverage Initiatives, July 2010.
- 2 For a more detailed discussion of background research that should be compiled, see "Preparing for Health Reform: The Role of the Health Insurance Exchange," Robert Carey, State Coverage Initiatives, January 2010.
- 3 Section 1413 of the Patient Protection and Affordable Care Act.
- 4 It should be noted that there is ongoing concern that states may need to maintain two eligibility systems for their Medicaid program. The ACA specifies that a state cannot get an enhanced federal match for a person who was eligible under pre-ACA eligibility categories. Depending on how the Department of Health and Human Services decides to address this issue, states may need to show that a new enrollee was not eligible under old rules before they enroll them in Medicaid at the new eligibility levels and get enhanced match.
- 5 A high-deductible health plan (HDHP) offered through the Exchange must cover all of the essential health benefits, as determined by the secretary of HHS, but may have a larger up-front deductible than the \$2,000 (individual coverage) and \$4,000 (family coverage) limits established in the health reform law. In 2010, HDHPs could have deductibles of \$5,950 (individual) and \$11,900 (family).
- 6 "Critical Issues in Health Reform - State Characteristics," American Academy of Actuaries, November 2009. www.actuary.org/pdf/health/state_characteristics_nov09.pdf, accessed on September 2, 2010.

Appendix

Unlike most Medicaid and CHIP programs, the subsidy amount for insurance purchased through the Exchange will be set as a percentage of an individual’s or family’s modified adjusted gross income. The amount that the family must pay is set according to their income as a percent of the federal poverty level (FPL). Under this methodology, two families with similar FPL percentages may pay different premiums for the same coverage. The example below shows two families, both at 250 percent FPL, and demonstrates how their monthly

premiums would differ under the Exchange.

The ACA sets the applicant’s premium as a percentage of income depending on the applicant’s FPL level. Additionally, federal law dictates that the applicant’s premium will be set on a sliding scale and “in a linear manner.” That means the eligibility process will need to determine the applicant’s income, the applicant’s FPL percentage, the percentage of income required for health insurance that corresponds to that FPL, and the applicant’s corresponding dollar share of the premium.

The table below shows the premium percentages for each FPL level, as detailed in the law. Depending on how the federal government interprets the requirement that the members’ share of the premium be set in a “linear manner,” there may be as many as 167 different premium percentages that will need to be calculated for applicants with income between 133 percent and 300 percent FPL. For income over 300 percent FPL, the premiums will be set at 9.5 percent of income. States will need to pay close attention to the regulations that will be forthcoming on this issue.

FPL Level	2009 Single	Premium as Percent of Income	Annual	Monthly
Up to 133%	\$14,844	2%	\$297	\$24.75
133%	\$14,845	3%	\$445	\$37.11
150%	\$16,742	4%	\$670	\$55.81
200%	\$22,322	6.3%	\$1,406	\$117.19
250%	\$27,902	8.05%	\$2,246	\$187.18
300%	\$33,483	9.5%	\$3,181	\$265.07
350%	\$39,063	9.5%	\$3,711	\$309.25
400%	\$44,644	9.5%	\$4,241	\$353.43

	The Jones Family	The Smith Family
Number of family members	4	6
Modified adjusted gross income (AGI)	\$55,125	\$73,825
Modified AGI as % of income	250%	250%
Family’s share of premium as % of family income	8.05%	8.05%
Family’s share of monthly premium	\$370	\$495