



Health Insurance Exchanges: Viability and Influence on Private Markets

by Tracy Johnson, Ph.D., Health Policy Solutions and Rebecca Kellenberg, MPP, Health Management Associates

Introduction

The Patient Protection and Affordable Care Act (hereafter, ACA or "federal reform") establishes two types of insurance exchanges -- one for the individual market (American Health Benefit Exchange) and one for the small group market (Small Business Health Options Program, or SHOP) -- to serve as one-stop-shopping markets for a range of subsidized and unsubsidized coverage options. These two exchanges may operate as separate entities or be merged and administered as one exchange, and large groups with more than 100 employees may be added in 2017. States may also decide to join a regional or interstate exchange or to establish subsidiary exchanges that serve distinct geographic areas. Exchanges can be either a government entity or a non-profit organization designated by the state. States that fail to establish exchanges by 2014 will participate in a national multi-state exchange.

Each exchange will be required to offer "qualified" health plans that fall into benefit tiers based on actuarial value:

- Platinum (90% actuarial value; covers 90% of the benefit costs of the plan)
- Gold (80% actuarial value; covers 80% of the benefit costs of the plan)
- Silver (70% actuarial value; covers 70% of the benefit costs of the plan)
- Bronze (60% actuarial value; covers 60% of the benefit costs of the plan)
- Catastrophic (High Deductible Health Plans - HDHP) that are limited to individual market enrollees with certain characteristics
- Two federally-defined, multi-state plans

This brief focuses on the purchasing functions of a health benefit insurance exchange as outlined in federal reform and their implications for Colorado's private markets inside and outside the exchange(s). State options and key decision points are identified.

How will exchanges change the existing size and array of health insurance markets in Colorado?

Exchanges represent new purchasing option(s) and do not replace existing markets. Because federal tax credits to purchase private coverage are redeemable only through exchanges, many if not most of the 300,000 uninsured Coloradans who will qualify for subsidized coverage are expected to purchase it through the exchange. However, higher-income uninsured individuals as well as those who currently obtain coverage through other markets may also choose to purchase insurance through exchanges. Actual exchange enrollment and movement between the exchange and existing markets will be influenced by forthcoming federal rules as well as state implementation decisions that affect user-friendliness, health plan options, and prices.

What is required to have a viable exchange?

In order for exchanges to live up to their promise of one-stop-shopping, Colorado must make strategic decisions to optimize the size and composition of the exchange risk pool as well as ensure an attractive range of plan choices. Colorado will also have to decide on the scope of the exchange's regulatory and purchasing authority which will affect the tools it has at its disposal to manage risk pools and plan participation.

- **Volume Matters: Issues to consider in optimizing the size of the exchange(s)**

The number and health characteristics of Coloradans purchasing coverage through exchange(s) is referred to as the exchange "risk pool." In general, larger pools offer more stability over time and lower prices through economies of scale and greater health plan negotiating power with providers. Large pools are also more likely to have large numbers of healthy, low-cost individuals who can offset the costs of those needing more health care services. According to The Commonwealth Fund, a minimum pool size of 100,000 participants is desirable.

Attending to exchange risk pool size and composition is especially important for a less populous state like Colorado, although several federal provisions should help. For example, since premium subsidies for individuals may only be redeemed through the exchange, many if not most of the estimated 300,000 qualifying Coloradans likely will purchase through the exchange. To ensure that exchanges do not further divide risk pools (segment risk), insurers may not price products differently according to whether they are offered through the exchange or outside it.

Colorado's risk pool size will be determined first by its decisions to pursue regional, state-wide or multi-state exchange administration and secondly by its decision on whether or not to merge individual and small group markets eligible to purchase health coverage through the exchange. However, mergers inevitably create winners (e.g., current high-cost groups) and losers (current low-cost groups) and engender other trade-offs to be carefully weighed.

- **Composition Matters: Issues to consider regarding adverse selection**

In an insurance context, adverse selection refers to the disproportionate enrollment of high-risk, high-cost individuals, and it can occur at the health plan level (e.g., certain plans enroll more costly individuals than others) and/or at market-level (e.g., the exchange or group market enrolls riskier individuals than the non-group market or vice versa). One of the primary reasons for the new federal requirement that individuals must purchase minimum health coverage is to increase the number of healthy people participating in insurance markets. This provision was intended to offset the requirement that insurers accept all-comers, including those with pre-existing health conditions. The extent to which the individual mandate achieves its policy intent will have an important effect on risk profiles across markets. Because adverse selection is unlikely to be completely eliminated, risk adjustment mechanisms that aim to offset its effects will be equally important.

While federal policy aims to protect exchanges from adverse selection by reconciling policy across markets -- e.g., standardizing rating factors, benefits and other insurance market rules -- some incentives to "market shop" will continue to exist. Colorado and other states will have to decide whether the remaining differences in rules inside and outside the exchanges -- especially those that drive differences in plan options and price -- serve a valid market purpose or whether further standardization is desirable.

- **Purchasing Choices: Issues to consider in optimizing the plan participation**

One of the functions of the exchange is to certify that health plans meet minimum standards, according to four defined benefit tiers and other state/federal rules, such as requiring that exchange health plans: be accredited, justify any premium increases, contract with essential community providers and outreach/enrollment navigators, and meet standards re: marketing, provider networks and quality/safety performance.

Through their role in certifying health plans, exchange(s) will play a central role in selecting the health plans available for purchase. At a minimum, exchange(s) are required to ensure that qualified health plans comply with federal benefit minimums and other requirements. However, states may impose additional rules on qualified plans for exchange participation, although they have to pay for any additional required benefits. State decisions around exchanges' purchasing and regulatory authority likely will influence the number and types of plans seeking to participate as much as previously discussed factors such as exchange risk pool size and composition.

States have some flexibility in deciding how active a purchasing/regulatory role they wish to play. At one end of the purchasing continuum, Colorado exchanges could function as "market organizers", encouraging broad participation by health plans, keeping certification requirements to federal minimums, and focusing on transparency of information. At the other end of the spectrum, exchanges could operate as "active purchasers", further standardizing benefit options and engaging in selective contracting to achieve specific market/policy goals, for example, ensuring that qualified plans meet specified price and quality standards and have experience serving low- and middle-income Coloradans who will qualify for subsidies. Depending on final federal regulations, states could even choose to empower exchanges to negotiate rates with qualified health plans. The scope of exchange regulatory influence likely has implications for governance, broker roles, and markets inside and outside the exchange.

What influence will exchanges have on existing private markets?

While exchanges are intended to rationalize rather than replace existing markets, the continued viability of non-group and small group markets outside of the exchange will depend on the same factors that affect exchange viability: risk pool size and composition as well as health plan willingness to participate. The effectiveness of insurance market reforms and other ACA provisions, such as the individual mandate, may be as or more important to private market viability than mere exchange presence.

While subsidized coverage will exist only within the exchange, "grandfathered" plans will exist exclusively outside it. The real question will be - where do individuals and small businesses prefer to purchase unsubsidized, non-grandfathered coverage? In theory, such coverage could be obtained inside or outside the exchange, with a shared risk pool for rating purposes. In Massachusetts, for example, more than half of the unsubsidized non-group market continues to seek coverage outside of the exchange. Ultimately, whether the Colorado exchange(s) exist in parallel to current non-group and small group markets or eventually absorb them will depend on operational decisions that affect exchanges' user-friendliness as well as policy decisions that affect the range of options available to unsubsidized individuals and small businesses through each market option.

State Decisions/Policy Options:

While the ACA has provided a federal framework for the development of state health insurance exchanges, Colorado will confront a number of policy and operational decisions that will affect exchange viability and existing markets. Colorado may consider the following options when determining the optimal exchange structure:

Risk Pool Decisions	Regulatory/Purchasing Decisions
<ul style="list-style-type: none">• Establish a state exchange or defer to HHS?• Establish a regional vs. state-wide vs. multi-state exchanges?• Establish a separate individual and small group exchange or combined exchange?<ul style="list-style-type: none">○ States may administer the two groups jointly or separately○ States may merge the two risk pools or keep them separate• Limit small group market to <50 eligible employees prior to 2016 or expand to <100?• Incentivize brokers to steer enrollment to exchange?	<ul style="list-style-type: none">• Implement core exchange functions only or add additional functions?• Implement federal minimums for certification or further standardize benefit options?• Require and fund benefits beyond required “essential health benefits?”• Implement “open” or “selective” contracting with carriers and health plans?• Review rate change justifications only or negotiate rates with plans?

Sources:

- Carey R. Preparing for Health Reform: The Role of the Health Insurance Exchange. State Coverage Initiatives. January 2010.
- Curtis R. What Health Insurance Exchanges and Choice Pools Can and Can't Do About Risks and Costs. Institute for Health Policy Solutions. Revised May 2009.
- Explaining Health Care Reform: Questions about Health Insurance Exchanges. Kaiser Family Foundation. April 2010.
- Focus on Health Reform: A Summary of New Health Reform Law. Kaiser Family Foundation. April 21, 2010.
- Department of Health Care Policy and Financing Impact of State and National Reform. Medicaid Expansion Population Caseload. Health Care Policy and Financing - Budget Division. April 12, 2010.
- In Brief: Key Decisions for State Establishing a Health Insurance Exchange. McKenna Long & Aldridge. 2010.
- Jost TS. Health Insurance Exchanges and the Affordable Care Act. The Commonwealth Fund. 2010.
- Lischko A. Drawing Lessons: Different Results from State Health Insurance Exchanges. Pioneer Institute for Public Policy. 2010.
- Lischko A. Health Insurance Connectors & Exchanges: A Primer for State Officials. State Coverage Initiatives. Sept. 2007.
- Patient Protection and Affordable Care Act (PPACA), enacted March 23, 2010.
- Patient Protection and Affordable Health Care Act of 2010: Health Insurance Exchanges. National Association of Insurance Commissioners. Updated 4/20/2010.
- Patient Protection and Affordable Health Care Act of 2010: Health Insurance Market Reforms. National Association of Insurance Commissioners Updated 4/20/2010.

Author Contact Information:

Tracy Johnson, Ph.D.
Principal
Health Policy Solutions
31377 Tamarisk Lane
Evergreen, CO 80439
phone: (303) 674-5634
email: TLJ6805@aol.com

Rebecca Kellenberg, MPP
Health Policy Consultant
Health Management Associates
120 N. Washington Square, Suite 705
Lansing, MI 48933
phone: (517) 482-9236
mobile: (406) 529-9825
email: rebecca.kellenberg@gmail.com