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Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison

Introduction

As various provisions of the Patient Protection and Affordable Care Act (ACA) take effect, states are deliberating the requirements and options that they face under the new law. Integral to implementing reforms under the ACA is the establishment of health insurance exchanges. Exchanges—government-regulated insurance marketplaces—are designed to increase access to and facilitate purchase of affordable health insurance for certain subpopulations, including individuals (nongroup market) and small businesses (small group market).

This issue brief presents key implementation and data considerations for states as they contemplate the creation and role of exchanges. In addition, this brief profiles four state exchanges—Massachusetts Health Connector, Utah Health Exchange, Connecticut Business and Industry Association (CBIA) Health Connections, and Washington Health Insurance Partnership (HIP)—launched under state health reform efforts that predated the ACA (Table 1, Page 7). Examples from these exchanges are highlighted throughout.[1]

Considerations for States

The ACA calls for the establishment of "American Health Benefit Exchanges" by January 2014 to sell health insurance to qualified individuals, including non-incarcerated U.S. citizens and legal immigrants without access to affordable employer coverage. The ACA also calls for the creation of "Small Business Health Options Program (SHOP) Exchanges," where businesses with up to 100 employees can obtain coverage for their workers.

The ACA Exchanges will offer individuals and small businesses a choice of health insurance carriers or insurers (both referred to as health plans in this brief) in a standardized way in order to make comparisons across coverage options easier. By offering a choice of qualified health plans, where plans compete on price and quality (instead of avoiding risk), and by facilitating comparison shopping for coverage, exchanges are intended to create an organized and fair market to attract and retain customers.

While the ACA outlines structural parameters for state exchanges and provides a minimum list of exchange functions (e.g., health plan certification and disclosure, operating a toll-free hotline and website, determining eligibility and facilitating enrollment for public programs, cost-sharing subsidies, and premium tax credits), several choices remain for states as they design and implement exchanges. For example, states need to decide how many exchanges to support, what role exchange(s) will play in the nongroup and small group markets, and how to make exchange(s) financially sustainable.

[1] See "Resources" section of this brief for several reference materials currently available to states.

States will seek sound data and analytic methods to drive decision-making about the exchanges. In addition, states will need sufficient quantitative and qualitative information to monitor and evaluate exchange implementation. Implementation and data-related issues for states to consider in their efforts to improve the nongroup and small group markets for health insurance under the ACA through Health Insurance exchanges are explored in detail below.

The newest health insurance exchange, ***Washington's Health Insurance Partnership (HIP)****, identifies monitoring and evaluation of HIP as one of its objectives. Washington State hopes to develop an evaluation template to ensure that data collection systems are in place for tracking the impact of HIP and future reform efforts.*

Exchange Scope and Objectives

States can go beyond ACA requirements and address additional state health policy priorities through the establishment of their exchanges; it will be important, though, for states to define a realistic scope and objectives.

The U. S. Department of Health and Human Services (DHHS) is supporting states as they engage in strategic and operational exchange planning by making available up to $1,000,000 per state through State Planning and Establishment Grants. Funds are available to help states frame the needs to be addressed through exchanges at baseline and over time and to model their exchanges accordingly. Grants also support modeling related to estimating the percent of individuals and businesses eligible for subsidies through exchanges, defining the small group market, merging nongroup and small group markets, and adjusting for risk selection.

Market Coverage and Structure

States have the option of creating separate exchanges for individuals and small businesses or of combining the nongroup and small group markets into a single exchange (generally, this will be feasible only if states choose to combine these markets outside the exchange as well). Alternatively, a state can allow the federal government to operate an exchange on the state's behalf. If states choose to establish their own exchange(s), these can be structured as single-state exchanges (similar to the examples in this brief), regional exchanges (which include more than one state), or subsidiary exchanges (which serve distinct geographic areas).

Separate exchanges for individuals and small businesses might allow states to better focus on the needs of the target group but could be more costly than a combined exchange. A combined exchange could support more consumer choice but might also create challenges if the risk profiles of nongroup and small group markets differ. Regional exchanges might be beneficial to smaller states by creating larger markets, enabling greater risk pooling, and allowing sharing of administrative costs across states; however, working across state lines could present regulatory and coordination challenges.

State decisions about defining and reaching target markets will be influenced by multiple variables including: demographic characteristics of the insured and uninsured populations; characteristics of the nongroup and small group markets for health insurance (such as the number of public and private plans, coverage levels, benefit sets, premiums, breadth of provider networks); the exclusivity of distribution channels; and projected health care costs.

***Washington**'s **HIP** requires small employers with low-income workers to purchase insurance through the exchange if they want to offer their low-income employees a state subsidy.*

*A **Utah** needs assessment found that the state was below the national average for businesses with 50 or fewer employees offering health insurance coverage, and this finding informed Utah's decision to set up an exchange that initially targeted small businesses with 2 to 50 employees.*

*The State of **Massachusetts** operates two statewide Health Insurance Exchanges: **Commonwealth Care** is a separate exchange for subsidy-eligible individuals; **Commonwealth Choice** is a combined exchange for small group and unsubsidized nongroup health insurance. Subsidy-eligible individuals are distribution channel for subsidized coverage; Commonwealth Choice, on the other hand, is one alternative for its target market to access commercial health insurance products.*

Governance

Exchanges may be operated by a federal agency (if states cede control over exchange design and implementation), by a state government or quasi-public agency, or by a private and most likely nonprofit entity.

Of the four models profiled in this brief, the Connecticut Business and Industry Association (CBIA) Health Connections exchange is the only exchange operated by a non-public entity. Some advantages of private exchanges include: operational flexibility and adaptability; the ability to pay more for experienced staff; opportunities for strong relationships with private health plans, businesses and brokers; and insulation from political influence. It might be harder, however, for private entities to coordinate with government agencies or to access needed data unless required by law.

*The **Connecticut Business and Industry Association's Health Connections Exchange** reduces the administrative burden for small employers by offering them full-service human resources services, which has been particularly successful in the less than 25 employee small group market.*

Exchange Role in Plan Selection

States can implement exchange functions related to health plan selection and participation with varying degrees of involvement in the market. For example, a state can limit the exchange to the role of market organizer, serving as impartial information source that lists and compares all qualified health plans. Alternatively, a state can make the exchange an active purchaser, by using a bidding process, by applying restrictive certification and reporting requirements, and/or by negotiating with plans to identify and select high performers.

Exchanges cannot function without the participation of health insurance plans. In light of this, states must decide whether plan participation in exchanges will be voluntary or mandatory and determine the role they want exchanges to play along the continuum of market organizer to active purchaser. On the one hand, if a state serves as a market organizer, acting as a clearinghouse for qualified health plans, this would maximize plan choices for consumers. On the other hand, if a state serves as an active purchaser, determining which plans qualify for exchange status, the state might have greater potential to influence health care costs and quality. However, this could reduce consumer choice if plans choose not to participate in the exchange or if the exchange drops plans.

DHHS will establish minimum certification requirements for plans that participate in exchanges under the ACA. Examples of the types of information plans must provide to exchanges or the public include: quality measures for health plan performance; claims payment policies and practices; periodic financial disclosures; and data on enrollment, disenrollment, denied claims and rating practices. When acting as active purchasers, exchanges have the opportunity to impose stricter requirements, but if they do so they must also set up the infrastructure for heightened compliance.

The role of exchanges in plan selection may evolve over time. Monitoring of data can inform this decision, including but not limited to plan participation in exchanges, number and distribution of individuals and employers purchasing insurance through exchanges, premiums offered in exchanges, and enrollee satisfaction with exchanges. States may wish to include in their legislation requirements for ongoing monitoring and reporting on exchanges and for comparisons of exchange performance to the broader market for health insurance outside of the exchange.

Washington *and* ***Utah*** *assume the role of market organizer in their health insurance exchanges.*

Both the ***Massachusetts Health Connector Commonwealth Choice*** *(the combined exchange) and* ***CBIA Health Connections Health Insurance Exchange*** *operate closer to the definition of active purchaser: They limit the number of plans participating in their exchanges (through benefit design parameters, for example) to promote competition and reduce potential confusion from having too many marketplace options.*

Benefit Options

By design, exchanges offer consumers structured health insurance benefit options that are transparent and comparable across health plan, premium, benefit package, cost-sharing arrangement, and provider network.

The ACA requires that qualified health plans offer a minimum benefit package (to be defined by DHHS) at specified coverage levels. Much like Massachusetts Health Connector's Commonwealth Choice, levels of coverage are based on "actuarial value"—that is, the average level of medical costs covered by health plans: the bronze-level provides benefits equal to 60 percent of the actuarial value of plan benefits (the lowest cost option), the silver level covers 70 percent of the actuarial value, the gold level covers 80 percent, and the platinum level covers 90 percent. Participating plans must offer at least one silver level and one gold level option in exchanges. Within each level or tier, states can determine the desired combinations of essential benefits and cost-sharing arrangements they want qualified health plans to offer customers. It appears that ACA restricts employees of small businesses to a choice of options at only one tier, selected by the employer.

Data considerations for states as they make decisions about exchange benefit options include the need to track the types of benefit options purchased by customers within each available tier. To the extent that plans offer the same benefit options to consumers outside of health insurance exchanges, it will be important to compare enrollment inside and outside of the exchange. States may wish to collect data from all health plans doing business in the state on the types of benefit options being purchased by individuals and small employers, in order to monitor and understand differences between the exchange and non-exchange markets.

The State of Utah offers a different approach to benefit options, supporting a defined contribution option through its exchange. Small businesses can offer employees a tax-free contribution toward their purchase of health insurance through the ***Utah Health Insurance Exchange****; employees are free to choose the coverage they prefer and can afford among a variety of benefit options offered by qualified health plans.*

Funding

As mentioned above, funding for exchange planning and initial operations is available from DHHS until January 2015, when state exchanges must be self-sustaining. Through financial and actuarial analyses, states can determine whether exchange operations will be an ongoing charge on the public sector (as in Utah and Washington) and/or whether the exchange will require other means of revenue generation. For example, exchanges could assess plans (e.g., Massachusetts collects a portion of premiums for products sold through the exchange), employers (e.g., Connecticut charges dues), or individuals.

Rating; Adjusting for Risk Selection

As it stands, the ACA allows both nongroup and small group health insurance markets to continue to exist outside of exchanges. The ACA, however, takes several steps to prevent a common problem seen with previous attempts to set up voluntary health insurance purchasing pools: adverse selection—that is, the tendency for high-risk individuals to buy health insurance and low-risk individuals to defer purchase of health insurance resulting in an inability to attract healthy enrollees.

The first strategy by which the ACA reduces the likelihood of adverse selection is by imposing premium rating restrictions on health plans, whereby individual and small group premiums must be based on an adjusted community rate. Additionally, rating rules apply both within and outside of exchanges to maintain consistency in the markets, similar to the Massachusetts, Connecticut, and Washington models. The rating rules for options sold in those states are the same as for those products sold outside of the exchanges.

Other strategies by which the ACA limits the potential for adverse selection against exchanges include: enacting an individual mandate, providing a catastrophic coverage option in the exchange for individuals up to age 30 (similar to the Young Adult Plan in Massachusetts), limiting the distribution of subsidies and tax credits to exchange-based coverage (as is the case in Massachusetts and Washington), and mandating risk-adjustment mechanisms.

States could further protect exchanges from adverse selection by adopting laws that limit how qualified health plans function outside of exchanges. States may also introduce or amend legislation related to reinsurance and risk adjustment within exchanges and to the data needed to support these mechanisms.

Under the ACA, states are responsible for administering a risk adjustment system for non-grandfathered plans in the nongroup and small group markets. The criteria and methods for this system will be established by DHHS, and the mechanism will apply to plans sold both inside and outside the exchange. States will need to establish sophisticated data collection and analysis functions in order to carry out this responsibility.

*Limited participation in the **Utah Health Exchange** in its first year of operation exposed premium rating issues (in the form of large differences between premiums for options offered within and outside of the exchange); in response, the state passed legislation requiring premium rating rules to be the same for products offered across different markets in the state.*

Existing Models for Comparison

Of the four models profiled in Table 1, the Massachusetts Health Connector most closely aligns with the new federal law. The States of Massachusetts, Utah and Washington, as well as Connecticut and the CBIA specifically, are in the process of determining how their exchanges will be impacted by ACA.

Conclusion

Exchanges called for under the ACA are expected to organize and expand the nongroup and small group markets for health insurance by offering consumers easy to understand and comparable coverage options. As states consider exchange scope, design, implementation, management, and evaluation that best meet the needs of customers under the law, they have viable models in Massachusetts, Utah, Connecticut, and Washington for reference. States also have the opportunity, at the exchange design stage, to create the data infrastructure needed to support program implementation and revision as well as to meet the information demands of state and federal policy makers.

Table 1. Examples of Existing State Health Insurance Exchanges

Exchange Title	Massachusetts Health Connector	Utah Health Exchange	Connecticut Business and Industry Association (CBIA) Health Connections	Washington Health Insurance Partnership (HIP)
Initiation Month and Year (Pilot or Full Launch)	October 2006 (Commonwealth Care) and July 2007 (Commonwealth Choice - nongroup); February 2010 (Commonwealth Choice - small group)	August 2009 (small group); April 2010 (large group pilot 50+)	January 1995	September 2010 (enrollment begins) January 2011 (coverage begins)
Scope and Objectives	• Improve consumer's insurance shopping/buying experience • Decrease administrative cost of buying insurance • Add price resistance to premium setting and insurer negotiations with providers • Improve transparency with standard tiered plans • Facilitate access to subsidy for those under 300% FPL	• Offer Internet-based portal that connects consumers to information needed to make an informed choice about their health insurance and facilitates enrollment • Promotes greater employee choice, transparency and value • Offers employers access to defined contribution market • Supports employee premium aggregation	• Provide choices of group health insurance to employees of small businesses • Provide full service Human Resources and other benefits	• Improve access to employer-sponsored coverage through private health insurance system • Achieve health risk that emulates a conventional employer-group • Increase small employer offer and employee coverage rates • Provide access to managed health care services • Offer health plan choice geared toward managing the full cost of coverage and encouraging take-up, retention and sustainability of coverage • Pilot a quantitative/qualitative program evaluation
Market Coverage, Structure and Current Enrollment	Two separate single state exchanges: 1) Commonwealth Care connects eligible uninsured low income individuals to subsidized health options --approx. 160,000 members in 2010; 2) Commonwealth Choice	Single state exchange targeting small employers (2-50) and large employers (50+) -- 433 members in 2010	Single state exchange targeting small employers (3-100) -- 75,000 members in 2010	Single state exchange targeting small employers (2 – 50) if they do not currently offer health insurance coverage to their employees, if at least 50% of their employees are at or below 200% FPL, and if they agree to

Exchange Title	Massachusetts Health Connector	Utah Health Exchange	Connecticut Business and Industry Association (CBIA) Health Connections	Washington Health Insurance Partnership (HIP)
	connects individuals (earning above 300% FPL) and small businesses (2 – 50) to commercial insurance options --approx. 30,000 members in 2010			establish a Section 125 plan. Sliding scale premium subsidies are available to employees of low-income families (at or below 200% FPL)
Governance	Semi-independent public entity (separate legal entity from Commonwealth governed by board with private and public sector representatives)	Public agency housed in Governor's Office of Economic Development	Private not-for-profit entity (run out of for-profit)	Public agency administered by the Washington State Health Care Authority (which also administers a low cost coverage program, health insurance for low income individuals, a drug plan and the State's employee benefit plan)
Exchange Role in Plan Selection	Active purchaser for Care. Between market organizer and active purchaser for Choice -private plans have received the Connector's "Seal of Approval" to offer a range of benefits options	Market organizer	Between market organizer and active purchaser	Market organizer. Collaboration with health plans and brokers. According to state statute, HIP must try to include health plans that maximize the quality of care provided and result in improved health outcomes
Benefit Options	Care: 5 plans, 3 plan types according to income with different benefits and cost sharing arrangements. Choice: 6 plans; 7 options. 3 plan types (gold, silver, bronze) plus young adult plan based on actuarial value. Business Express (employer contribution) and Voluntary Plan (Section 125). Employers choose plans and options	3 plans and 66 plan options	2 suites of coverage (one more comprehensive than the other). Within each suite, 4 plans with 38 options (varying levels of cost sharing). Businesses must contribute 50% of premium for lowest cost plan in suite. Standard packages for most popular policies	Plans (TBD); options will range in price. Businesses will be required to pay at least 40% of employees' monthly premiums (relatively low minimum contribution rate)

Exchange Title	Massachusetts Health Connector	Utah Health Exchange	Connecticut Business and Industry Association (CBIA) Health Connections	Washington Health Insurance Partnership (HIP)
	within a plan type. Standard packages for most popular policies			
Initial and Ongoing Funding	Initial $25 million appropriation; self-sustaining through retention of a portion of premium collected on the subsidized and non subsidized products sold	Initial $600,000 appropriation; annual appropriation and technology fees	Initial and ongoing funding outside of the public sector (no public funding); membership dues from employers	Initial appropriation funding fell through; now funded on a federal DHHS HRSA State Health Access Program (SHAP) grant
Rating; Adjusting for Risk Selection	Care – Premium subsidies available only through the Exchange. Capitation model with aggregate risk-sharing program and stop loss reinsurance pool. Employs predictive modeling to minimize practice of risk selection by insurers (draws from model used by DHHS' Centers for Medicare and Medicaid Services). Choice - Rating factors are the same inside and outside of the Exchange. Requires insurers to combine all individual and small group members into a single risk pool to establish premiums	March 2010 law clarified rating rules requiring insurers to use same risk rating practices in both the defined contribution and defined benefit markets. Risk Adjuster Board assures that risk is spread across insurers. Because employees can select among a variety of options, there is a possibility that some insurers have a higher proportion of sicker, more-costly individuals enrolled. Utah's reinsurance system is designed and managed by the insurers, who have agreed to subsidize those with sicker policy holders	Same rating and eligibility rules inside as outside in the parallel private market and benefit floor	Premium rating factors are the same (small group adjusted community rates) inside and outside of the Exchange. No specific mechanisms to address risk selection; expects initial enrollment to be approximately 800 subsidized individuals, which most likely will not impact small group risk pool

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