# Insurance Exchange Options

## Key Issues

Two critical and complex issues in the design of an insurance exchange:

1. What are its roles and functions?
2. Who may (or must) purchase through the exchange?

## Issue 1: Possible Functions and Roles of an Exchange

An insurance exchange can play a variety of roles. We can select from this "menu" to produce a range of options. The options range from a relatively narrow role, with a limited set of functions, to a broader role, with a longer list of functions. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

### 1. Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.
- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.

- Ensure provision of post-enrollment customer services, e.g., provide or coordinate with brokers and carriers to provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, etc.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

**2. Benchmarking and Standards**

- All of the functions above, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- Establish the role, functions and appropriate compensation for health insurance agents and brokers servicing the exchange and its customers.
- Innovate by contracting for complete packages of products and services from the carriers, or by allowing the exchange to contract separately for benefits or services that might better achieve benchmark performance.

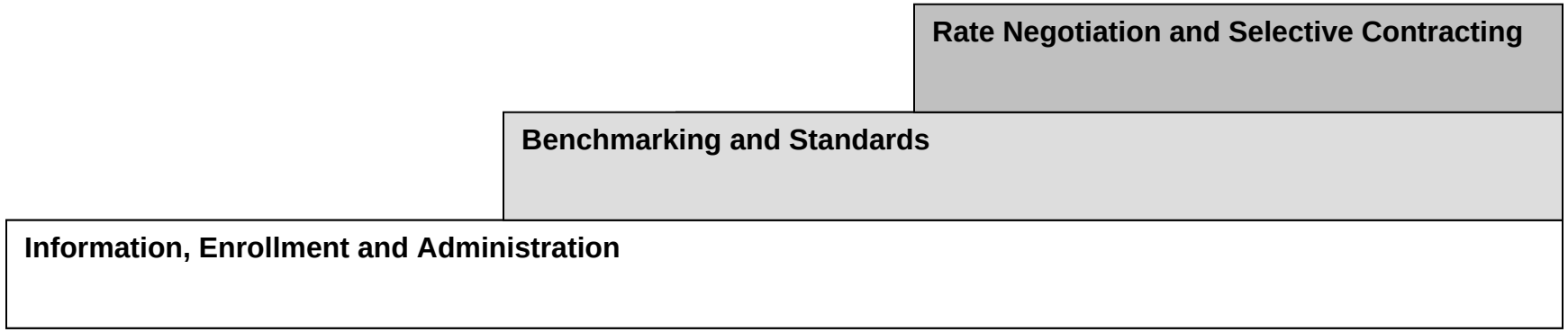
All carriers that meet the benchmark standards could participate in the exchange.

Note: this category should be viewed as a continuum, depending on how the performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

**3. Rate Negotiation and Selective Contracting**

- All of the functions above, plus:
- Solicit bids or price proposals.

- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.




To evaluate this range of options, it is useful to articulate the goals of an exchange. The following is an initial list of possible goals:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions, and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.

- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

[See additional possible goals below in discussion of Issue 2.]

**Issue 2: Who must or may purchase through the exchange?**

The design of an insurance exchange is affected by the number and characteristics of the participants. There are three categories of participants that would potentially benefit the most by using an exchange:

A. Individuals – subsidized

B. Individuals – non-subsidized
C. Employees who use Sec.125 contributions from a non-offering employer or are not eligible for coverage
D. Small employer groups and their employees. (Note: this could be phased in, e.g., begin with groups with 2-10 employees, expand to all groups up to 25 employees, and then later expand to all groups up to 50 employees.)

For each of these categories, participation in the exchange could be required or voluntary. Requiring the use of the exchange seems most compelling for the first category. The pros and cons of voluntary or required participation for the other groups are discussed below.

Note: it is possible to consider adding other populations to the exchange beyond these options. For example, it would be possible to open the exchange to medium and large employers and their employees on a voluntary basis. Required use of the exchange for these groups would not be possible, however, due to the ERISA exemption for self-insured employer groups.)
Note 2: there are also some sub-categories that may warrant different policies. For example, there are people who work for employers offering coverage, but they are not eligible for coverage – for example, part-time workers. Should they be required to use the exchange, as those who work for a non-offering employer are? This will require further analysis and discussion.

In evaluating who should be included, three other goals should be considered:

- **Minimize the disruption** for current (mostly non-subsidized) consumers in the individual market.
- **Encourage participation of carriers** in the individual market generally, regardless of the presence and role of an exchange.
- Make it easy for consumers to move between subsidized and non-subsidized individual coverage, as well as between individual and small group coverage, i.e., **"seamlessness"**.
- Facilitate the task of **managing risk selection** to avoid an adverse risk spiral in any market segment.

**Summary of Options**

Assumption: There will be reforms to the individual market, e.g., guaranteed Issue and elimination of current high risk pool, with a new mechanism to address the costs for high risk individuals. All of this assumes there will be an individual mandate. I would reverse columns B and C or just have the 125 discussion as a separate item

| | | **Categories of Enrollees Potentially Entering Exchange** | | | |
|---|---|---|---|---|---|
| | | A. Individuals – subsidized (required) | B. Employees who use Sec.125 contributions from a non-offering employer or are not eligible for coverage | C. Individuals – non-subsidized (voluntary or required) | D. Small employer groups and their employees (voluntary or required) |
| **Exchange Functions** | Tier 1: Information, Enrollment & Administration | **1A** | **1B (vol)**<br>**1B (req)** | **1C (vol)**<br>**1C (req)** | **1D (vol)**<br>**1D (req)** |
| | Tier 2: Benchmarking and Standards | **2A** | **2B (vol)**<br>**2B (req)** | **2C (vol)**<br>**2C (req)** | **2D (vol)**<br>**2D(req)** |
| | Tier 3: Rate Negotiation & Selective Contracting | **3A** | **3B (vol)**<br>**3B (req)** | **3C (vol)**<br>**3C (req)** | **3D (vol)**<br>**3D (req)** |

Discussion

The goals of **Consumer Shopping, Enrollment, Payment Processing,** and **Customer Service** would be met in all options. Expanding the size of the exchange (i.e., including categories B and C) would offer these benefits to more people.

> *Implications and related issues* – many of these services are currently provided by insurance brokers and agents. If we develop an exchange, it will be important to consider an appropriate role, appointment process and payment structure for brokers and agents. For example, within the exchange it may be appropriate for brokers to be appointed and paid by the exchange rather than by carriers. This could limit the number of participating brokers/agents, and the payment structure might be based on something other than a percentage of premium.

There is a range of issues that emerge when looking at the potential advantages and disadvantages of including groups other than subsidy users in the exchange. (This can be viewed as moving across the columns of the matrix to include non-subsidized individuals and small groups.)

1. What are the benefits or disadvantages of **increasing the *size*** of the exchange? Potential advantages include:
   - A larger pool would spread any fixed administrative costs over a larger base, thereby reducing the cost for each participant. This benefit is significant as the pool expands to a certain level [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
   - A larger pool would spread the risk more broadly, provide more stability for the pool over time, and potentially lessen the danger of an adverse risk spiral. As with spreading fixed administrative costs, the benefit of this is significant up to a certain level [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
   - *If* the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, a larger exchange could have more influence in the market – especially if the exchange worked closely with other large public and private purchasers. This would also depend on the role that the exchange chooses, especially if it set high performance benchmarks for carrier participation in the exchange (i.e., the "upper" end of Tier 2 functions). If the exchange were relatively small – i.e., subsidized

individuals (category 1) only, which would be approximately 100,000 people – some carriers might choose to not participate rather than try to meet the standards. If the exchange were larger, however, those carriers might try to meet the performance benchmarks rather than abandon this market segment. At its largest (i.e., including the entire combined individual and small group markets), the exchange would include approximately 700,000 people [*caution: very rough estimate],* which would be just under 20% of the total market (3.7 million). As noted above, its influence on Lowering Costs and Improving Quality could be enhanced if it worked with other public and private employers/purchasers to use consistent measures, performance standards and purchasing practices.

On the downside, including more categories of people in the exchange could create implementation challenges. Even if the eventual goal is to create a large exchange, it may be prudent to phase in the various categories gradually to maximize the likelihood of successful implementation.

2. What are the advantages and disadvantages of **voluntary vs. mandatory** participation for non-subsidized individuals and small groups? On one hand, a voluntary arrangement has intrinsic appeal. It allows the exchange to prove its value as consumers "vote with their feet", choosing to join or not to join the exchange. It also means the current individual market remains intact and requires benefits and pricing structures in and outside of the exchange to be the same to minimize selection. However, the biggest concern regarding voluntary participation is **risk selection**, i.e., the possibility that high-risk individuals or groups would join the exchange, while low-risk individuals or groups remain outside the exchange. This would lead to an adverse selection spiral within the exchange; historically, this has occurred frequently with exchanges in other states.

   The problem of risk selection can be mitigated – at least to some degree – by the following:

   - Application of the same insurance regulations (e.g., guaranteed issue, rating, benefit design, etc.) inside and outside the exchange. [Note: the rating methodology would need to be the same, but the rates themselves would not have to be identical, e.g., there might be different administrative loading factors inside and outside of the exchange.]
   - Use of a risk adjustment mechanism between the two segments (in the exchange vs. outside of the exchange) [*Is this feasible? How would it work?]*

- Establishment of eligibility and participation rules for small groups in the exchange.

The question remains: would these steps be sufficient to minimize the risk of adverse selection in a voluntary arrangement?

Regarding non-subsidized individuals (Category C above), it appears – on balance – that voluntary participation would not be preferable. Allowing individuals to choose whether or not to use the exchange does have the advantages discussed above, but there are a few significant disadvantages. These include:

- If participation is voluntary, the potential for risk selection is likely to be significant. This potential could be mitigated to some degree, but not entirely, by requiring the same rates and benefit designs inside and outside the exchange and by using a risk adjustment mechanism.
- If an individual market exists outside the exchange, insurers' administrative and marketing expenses would remain the same or potentially increase if they were to participate in both.
- If participation is voluntary, there may be no advantage for carriers to participate in both, especially if the exchange assumes Tier 2 functions (Benchmarking & Standards), insurers may choose not to participate in the exchange. This would be especially likely if the benchmarks for participation are high.
    - Participating in the exchange would require extra effort on the part of carriers to meet the standards. This would seem unnecessary as long as their plans can still be offered outside the exchange. In this situation, insurers who choose to participate in the exchange might feel vulnerable to non-exchange insurers pursuing risk selection strategies.

Requiring individuals to use the exchange would eliminate the danger of risk selection between the two markets (inside and outside the exchange). It would also simplify the entrance process for consumers and reduce carriers' marketing costs. The disadvantages of requiring individuals to use the exchange include:

- If the exchange assumes Tier 2 functions, some insurers might not be able to meet the standards or would choose to exit the market. To the extent this occurred, current enrollees would have to switch to a different insurer.

- While marketing costs may decline, the cost of administering the exchange would likely offset that reduction to some degree.
- Self- and non-employed individuals would not benefit as greatly from the administrative efficiencies provided by the exchange as others would, such as small employer groups. The burdens of enrolling more than one person, billing employees, making plan payments, etc. do not exist for self- and non-employed individuals, but those efficiencies would be great for small employer groups.
- If there is no alternative to using the exchange, it will be necessary for the exchange to offer superior service in order to minimize the complaints that are likely to accompany this scenario.

3. There are several other implications of including more people in the exchange. As more categories are included, it would make it easier for people who shift from subsidized to unsubsidized or individual to group coverage, i.e., the goal of **seamlessness** would be met. On the other hand, including more categories might be **more disruptive** for people who currently have individual or small group coverage, especially if the carrier and benefit options within the exchange were different from their current coverage.

What are the pros and cons of having the exchange exercise a **broader range of functions**? (This can be viewed as moving down the rows of the matrix to include Benchmarking & Standards and Rate Negotiation/Selective Contracting.)

*If* the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, some would argue that a broader role for the exchange would help to achieve them. This depends, however, on what one believes about which approach is most effective.

- Some believe that a “consumer-driven” approach is sufficient; consumers who are price-sensitive and have access to transparent information on cost and quality will choose the carriers (and their affiliated provider networks) that offer the best value.

- Others believe that consumers acting alone cannot move the market and that an "agent" (e.g., a large employer, public purchaser, or an exchange) is needed to establish benchmarks and comparable benefit packages. In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market. (Note: this would be strengthened by a "defined contribution"-type formula for subsidized individuals, rather than the "percent of premium" arrangement under the current FHIAP program.)
- Finally, some believe that the competitive model (implicit in both of the above approaches) is not effective due to the special nature of the health care market. As a result, it would be necessary for the exchange to negotiate rates and selectively contract with carriers.

Note: the preceding discussion also applies to the goal of **Maximizing the Value of State-funded Subsidies**.

Other implications of a broader role for the exchange:

- **Carrier Participation** would be encouraged due to streamlined marketing/enrollment and risk adjustment functions, but it might be discouraged if the purchasing standards (in level 2) were considered too stringent or if rate negotiation (in level 3) led to rates that were considered too low. This would have a corresponding effect on **Consumer Choice.**