Preparing for Health Reform: The Role of the Health Insurance Exchange

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Introduction

While the health reform debate continues in Washington, both the House and the Senate proposals include the establishment of health insurance exchanges to help facilitate the purchase of insurance for individuals and small employers. Although the bills differ in terms of the structure and number of exchanges—particularly whether to establish a single, national exchange or to support the creation of state and regional exchanges, as well as the larger policy issue regarding the creation of a public health insurance option to compete against commercial insurers—both proposals feature an insurance exchange as a central element of health reform.

Supporters of the exchange model view it as a way to organize the market, provide individuals and small employers with a central source of information, enable the comparability of benefit designs, administer public subsidies, facilitate the purchase of insurance through standardized enrollment processes, and improve competition among carriers. At its very core, an insurance exchange seeks to alter competition in the health insurance market from one based on avoiding risk to one based on price and quality.[1]

The success of Massachusetts's health reform law in covering upwards of 95 percent of all residents has convinced many people that an exchange, or in the parlance of Massachusetts, a "connector," is critical to expanding health coverage. However, whether—and how—an exchange can be instituted will vary from place to place, and its value will depend on the structure and role of the proposed exchange.

State-based exchanges, as opposed to a single national exchange, are the focus of this brief. Proponents of a national exchange argue that it would be better able to exercise bargaining power to reduce premiums and lower administrative costs. However, the establishment of a national exchange would likely require standardization of insurance rules across the states, which would bring with it a host of additional policy decisions, as well as various implementation and operational issues.

This Issue Brief provides readers with an overview of the potential role of a health insurance exchange, state-specific issues that should be considered before establishing an exchange, and the different ways in which an exchange might be structured and operated. Regardless of the outcome of national health reform, a number of states are contemplating creating a health insurance exchange as a way to improve the individual and small group markets.

In addition, this brief makes no assumptions regarding potential changes to individual and small group health insurance rules and regulations (e.g., guaranteed issue requirement, elimination of medical underwriting, no pre-existing condition exclusions or waiting periods, restrictions on allowable rating factors, limitations on rate bands, etc.). Nor does it assume either an individual mandate to purchase health insurance or an employer play-or-pay requirement regarding the offering of employer-sponsored insurance, both of which are major elements of the national health reform proposals.

Certainly, changes to the insurance rules could have a material effect on the availability and affordability of health insurance. An individual mandate and/or an employer play-or-pay requirement would alter the health insurance markets across all of the commercial segments (i.e., individual, small group and large group). However, these changes would impact states in different ways depending on each state's current insurance rules and regulations, the level of health coverage and rate of uninsured, and the extent to which employers are offering employer-sponsored insurance.

Nevertheless, the issues associated with establishing a health insurance exchange, and the groundwork that states can take in preparation for the possible development of an exchange, can be undertaken without regard to these or other changes that may occur as a result of federal health reform.

Developing a Baseline

The first step state policymakers should take in deciding whether to create an exchange is developing a thorough understanding of the existing sources of coverage, documenting the ways in which health insurance is obtained—for publicly-subsidized programs as well as commercial health insurance—and clearly delineating the problems or issues that an exchange is intended to address. By assembling a strong foundation of knowledge, policymakers can then decide whether, and how best, to structure an exchange that meets the needs of state residents and extends health coverage to the uninsured in the most efficient manner.

A comprehensive understanding of the state's current health insurance markets should include not only a thorough examination of the uninsured, but also an examination of the currently 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 any geographic/regional variations in the distribution of the uninsured;
- Family income;
- 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 publicly-subsidized health coverage programs.

This information is important and 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 public programs are reaching the intended target populations, and developing projections of the potential cost of expanding publicly-subsidized coverage. Detailed information on the uninsured can be used to target outreach and enrollment efforts for existing health coverage programs, to design new health insurance products and programs, and to better understand the population that could be served by an exchange.

In Massachusetts, detailed information on the uninsured was used to develop the health reform law, to establish the specific provisions of the various health insurance programs, and throughout implementation to target outreach efforts to particular groups of residents. The data used by Massachusetts policymakers included publicly available data (e.g., US Census Bureau's Current Population Survey, Massachusetts Department of Health Care Finance and Policy), as well as data prepared by researchers funded through the Blue Cross Blue Shield of Massachusetts Foundation's "Roadmap to Coverage" initiative.[2]

The Massachusetts data showed that a disproportionate percentage of young adults lacked health insurance and these data were subsequently used to persuade lawmakers to enact a legislative change that allowed commercial carriers to develop lower-cost "Young Adult Plans." These plans were allowed to offer slightly slimmer benefits than standard commercial insurance and were made available to individuals ages 18 to 26 who did not have access to subsidized coverage, either through an employer or through public programs.

The data were also used by the Connector to inform its marketing strategy, in particular the Connector's decision to partner with the Boston Red Sox as a way to reach men and young adults, two groups with higher than average rates of uninsurance. In addition, the data were used to estimate enrollment for the various publicly-subsidized health insurance programs, including programs that were in effect prior to health reform as well as the newly-established health insurance programs.

A second phase of the analysis should include a thorough review of the 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 an exchange model. In particular, states should carefully 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.

A number of states have established premium subsidy programs for lower-income individuals who work for small employers (e.g., Maryland's Health Insurance Partnership, Insure Oklahoma, and Massachusetts' Insurance Partnership). These programs subsidize the employee's share, and some programs also help subsidize the employer's share, of the premium for employer-sponsored insurance. It is important to understand how these programs might be impacted by the establishment of an exchange, particularly if the exchange provides premium subsidies to help lower-income individuals purchase insurance.

Not only will it be important to understand the eligibility rules for the various public programs, but it will also be critical to recognize how premium subsidies 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 would likely be targeted toward many of the same people. States will need to understand how the programs interact and structure the programs so that they are complementary. There may also be opportunities to consolidate or eliminate programs, as well as opportunities to streamline program administration.

The final step of the baseline analysis should include a thorough review of the commercially insured, in much the same way that the detailed 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:

- 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;
- Number of carriers operating in the market;
- 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

- 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. Policymakers will need to consider a number of issues in these market segments, including the rating rules and regulations; the extent to which these markets are functioning, what is working well, and what is not; the existence, operation and membership of high-risk pools; 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 information will be crucial in determining whether, how, and to what extent, an exchange might improve access to health insurance. For example, in many parts of the country there is little competition among health carriers. In these markets, what would be the role of an exchange? Are there barriers to entry that could be lowered or eliminated by the establishment of an exchange? Is it necessary to establish an exchange or can the market be improved through other means to encourage more competition among insurers?

In other states, commercial exchange-like entities may already be operating. In these markets, private-sector **intermediaries** may provide small groups and, in some instances, individual consumers with a central point of access to compare health benefits and select a health plan from among a number of insurers.

For example, the Connecticut Business and Industry Association operates the Health Connections program, which enables small employers (i.e., firms with 3 to 100 employees) to offer their employees a number of health plans and health insurers from which to choose. In Maryland, several third party administrators provide individuals and small employers with a central point of access to select from numerous health plans offered by a range of health carriers.

Policymakers also need to determine what is currently available in the market. In states with already functioning private sector exchange-like entities, policymakers will want to consider whether there are opportunities to leverage the infrastructure and capabilities of existing intermediaries to improve the functioning of the individual and small group markets.

Finally, a recognition and understanding of the role of health insurance brokers is essential. In most states, brokers play a central role in the purchase of health insurance, and their influence in the market should not be underestimated. However, brokers' involvement may vary from state to state, and their role may differ between the individual and small group markets.

For example, prior to health reform in Massachusetts, brokers played no role in the purchase of health insurance by individuals, but they were heavily involved in the purchase of health insurance by small employers. Understanding the role played by health insurance brokers—and how they may support an evolving individual and small group market—could prove crucial to the success of an exchange.

Key Issues for an Exchange

Having established a strong baseline of information and an understanding of how the state's health insurance market operates, policymakers will need to weigh various policy options in determining how an exchange might be structured to achieve the objective of extending health coverage to more residents; and how an exchange can help transform the individual and small group markets from competition based on avoiding risk into competition based on price and quality.

Defining the exchange's roles and responsibilities is essential to determining what type of administrative structure is most appropriate. While an exchange can take many different forms, there are three basic models to consider: (1) market organizer and distribution channel; (2) selective contracting agent; and (3) active purchaser.

Market organizer and distribution channel: under this model, 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 and purchase coverage; and serves as a broker of health insurance by handling premium billing and collection, as well as other administrative responsibilities on behalf of consumers and health carriers. Although not yet fully developed, the

Intermediaries — also known as third party administrators or general agents — provide administrative services, including processing enrollment, premium billing and collection, mid-year changes in enrollment or rate basis type, COBRA administration, and other administrative services. Unlike health insurance brokers, intermediaries do not sell insurance, although many intermediaries also have a brokerage business that does.

In the individual and small group markets, intermediaries handle a number of administrative functions that for large employers are usually handled by the health carrier or the employer's human resources staff. Intermediaries are typically paid by the health carrier through retention of a portion of the premium.

Utah Exchange (www.exchange.utah.gov) provides an example of this type of model.

Selective contracting agent: this model includes many of the same functions noted above, but also attempts to influence the market and enhance competition by contracting with a select group of carriers and offering a limited number of health plans. The exchange solicits health plans based on plan design parameters established by the administrators of the exchange. However, the exchange does not necessarily negotiate premiums with the health carriers, but provides an endorsement of the health plans that it chooses to offer. The Massachusetts Connector (www.mahealthconnector.org) uses a selective contracting approach for its commercial offerings (i.e., Commonwealth Choice).

Active purchaser: an exchange might also play a more active role in the market by establishing plan designs and purchasing health insurance much like a large employer procures health benefits on behalf of its employees. This model is predicated on the exchange covering a large group of members, comprised of a relatively healthy risk pool that enables insurers to offer competitively-priced plans. Many of the health purchasing cooperatives that were established in the 1990s, such as California's PacAdvantage (originally called the Health Insurance Plan of California) and the Texas Insurance Purchasing Alliance (TIPA), are examples of active purchaser models.

The approach taken—market organizer and distribution channel, selective contracting agent, or active purchaser—will dictate the administrative structure necessary to support the exchange. In particular, the more the exchange is actively involved in the market, the more likely the need to establish an entity with adequate staff to operate the exchange or to designate an existing agency to serve as the exchange administrator.

In addition to its impact on staffing levels, the exchange's roles and responsibilities will influence its governance structure. An exchange that supports the existing market, has no regulatory responsibilities, and does not actively participate in the selection of health plans likely will not require a significant governing authority to oversee its activities. However, if regulatory responsibilities are handed to the exchange, and if the exchange acts more like a purchaser of health plans, there may be greater demand for a more public governing body.

For example, the Massachusetts Connector Authority was given a number of regulatory responsibilities—e.g., establishing minimum creditable coverage standards for the individual mandate, approving the benefits and income-based premium schedules for subsidized health coverage, adopting an affordability schedule, and setting the penalties for not having health insurance. This led the state legislature to establish a public governing board for the Connector Authority, comprised of ex-officio public officials and individuals appointed by the governor and attorney general. In contrast, the Utah Exchange has no comparable regulatory authority, serves primarily as a market organizer and distribution channel, and is housed within the Governor's Office of Economic Development.

Funding and Operating an Exchange

Even if the exchange is set up as a "simple" market organizer and distribution channel—as opposed to an active purchaser of health insurance—the services provided by the exchange may require an initial investment of resources as well as an ongoing stream of revenue to fund operations. The level of upfront investment will depend, in part, on the types of services currently being provided in the market and the extent to which existing services may be leveraged and utilized by the exchange.

An exchange that is responsible for structuring the market, providing consumers with an ability to compare health plans, generating premium quotes, and enrolling individuals and/or groups in coverage will require information technology infrastructure and customer service staff. Whether the infrastructure and personnel are built or bought—i.e., established and operated by the administrator of the exchange or outsourced to a third party—there will be significant back-office infrastructure needed to operate the exchange.

In addition to assisting consumers with initial health plan selection and enrollment responsibilities, a fully-functioning exchange will need to provide ongoing account management and maintenance (e.g., monthly premium billing and collection, processing changes in coverage status, delinquent payment notification, renewals, etc.). The exchange administrator will need to establish—or work with an entity that has already established—electronic data interchanges with the health carriers in order to generate quotes, process enrollments, and handle myriad administrative responsibilities.

If the exchange is also responsible for administering public subsidies to help lower-income individuals purchase insurance, the exchange will need to establish an eligibility determination process or utilize an existing means of screening applicants for subsidized health coverage (e.g., the state's Medicaid agency). The costs associated with determining eligibility for subsidized coverage—as well as handling eligibility redetermination processes and administering program integrity measures—may also need to be factored into the cost of operating the exchange.

The amount of capital needed to set up an exchange will depend on the availability and capabilities of existing commercial intermediaries, as well as the ability of public agencies to process eligibility applications for premium subsidies—and the extent to which these resources are leveraged. Regardless, funding ongoing operations will require either an annual

appropriation, retaining a portion of the premium for coverage obtained through the exchange, or possibly a combination of the two.

The Massachusetts Connector received an upfront appropriation of $25 million, with ongoing operations funded through retention of a portion of the premiums for subsidized and unsubsidized health coverage purchased through the Connector. In the private sector, intermediaries and health insurance brokers are typically paid through retention of a portion of the premiums paid by enrollees. The fees retained by these administrative entities typically range from 3 to 5 percent of premiums.

Building or Renting Administrative Functions

In a number of states, private sector intermediaries provide administrative services on behalf of health insurers and consumers. These entities typically operate in the individual and small group markets. Often working in concert with health insurance brokers, the intermediaries generate premium quotes, process enrollments, bill, collect and remit premiums, and provide a range of post-enrollment administrative functions. In essence, these intermediaries take over account management functions that are otherwise handled by a health carrier and/or the benefits management office of mid-sized and large employers.

In those states with private intermediaries, public exchange administrators 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 existing intermediaries, not least of which are the infrastructure and the data interchanges that these companies have established with the health carriers. This will be particularly relevant for exchanges that intend to offer a variety of health plans from a number of carriers. It is worth noting that despite different approaches to the exchange model, the Massachusetts Connector and the Utah Exchange use private sector intermediaries to administer their commercial insurance offerings.

The exchange administrator may need to decide whether to contract with one intermediary or utilize the services of multiple intermediaries. This decision will depend, in part, on the role of the exchange and the capabilities of the private intermediaries. Massachusetts contracts with one intermediary for its commercial insurance offering and a separate intermediary for its subsidized insurance program; Utah offers a number of intermediaries from which small employers may purchase commercial insurance.

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

Premium Subsidies and the Role of the Exchange

The health reform proposals being considered by Congress empower the exchange with administering a premium subsidy program to help lower-income individuals purchase insurance. How the subsidized insurance program is designed will affect the structure and operation of the exchange. There are two basic options with regard to a premium subsidy program: establish a separate Medicaid-like health plan with enrollment limited to individuals eligible for subsidized coverage; or provide premium subsidies to help individuals purchase health coverage in the commercial market.

Massachusetts adopted the former model. The Connector's subsidized health plan, Commonwealth Care, is available to adult residents of Massachusetts with incomes at or below 300 percent of the Federal Poverty Level (FPL) who do not have access to other types of subsidized health coverage (e.g., Medicaid, Medicare, employer-sponsored insurance, etc.).[3] This program is separate and distinct from commercial insurance offered through the Connector.

The Connector establishes the benefits schedules (i.e., services covered, point-of-service cost sharing) and negotiates rates with the health carriers that choose to participate in the subsidized insurance plan. Individuals eligible for subsidized coverage are then able to choose coverage from the participating carriers. The services covered and the point-of-service cost sharing are the same for each plan type,[4] although the monthly premium paid by the enrollee may vary depending on the rate negotiated between the health carrier and the Connector. In addition to potential differences in monthly premiums, the major difference across the carriers is the provider network (i.e., which physicians and hospitals are included in the network).

The latter approach is the one that is most commonly discussed as part of national health reform. Under this model, public funds would be made available to subsidize the premiums for lower-income individuals wishing to purchase health insurance in the commercial market.

One advantage of using public funds to subsidize premiums in the commercial market is that an individual would be able to maintain his or health plan when their income grows and they are no longer eligible for a subsidy. In contrast, under the Massachusetts Connector's Commonwealth Care program, once someone becomes ineligible for publicly-subsidized coverage they lose their health insurance and must purchase a new policy in the commercial market.

Nonetheless, an exchange that provides subsidies for commercial insurance will have a number of decisions to make in determining how best to structure the program. For example, will the subsidy be

available only for a select group of plans or for all commercial plans sold through the exchange? Will the subsidy be set as a fixed dollar amount based on the lowest cost plan available or will the subsidy be set as a percentage of the premium? Will there be a pre-determined open enrollment period or will enrollment occur on a rolling basis? Policymakers will need to grapple with these and many other policy and administrative issues.

Outreach and Enrollment

Instituting an aggressive and pro-active outreach and enrollment campaign will be critical to generating sufficient enrollment in the health plans offered through the exchange, which in turn will largely determine the sustainability and success of the exchange. This will be true for publicly-subsidized health coverage, as well as unsubsidized health insurance.

The fact that millions of Americans are eligible—but not enrolled—in (free) Medicaid coverage is an indication of the challenge that states will face in signing up people for coverage through the exchange, particularly for people who will be charged a monthly premium. While an individual mandate will certainly affect the take-up rate, policymakers must recognize that people will need information on the health insurance options available and their responsibility to obtain and maintain health coverage.

The Massachusetts experience is helpful in this regard. After health reform was enacted, the state undertook a multi-pronged outreach, education, and enrollment effort, utilizing state employees, community-based advocacy organizations, hospitals, community health centers, paid media, and public-service announcements, as well as pro bono private sector advertisements. As noted previously, a major part of the Connector's marketing strategy included promotional activities and paid advertisements during Boston Red Sox games, in an effort to reach young adults and men, two groups that were disproportionately uninsured. In addition, to jump-start enrollment in Commonwealth Care, tens of thousands of individuals who had been receiving care through the state's free care pool were automatically enrolled in this new publicly-subsidized health coverage program.

However, even with a multi-million dollar outreach effort, Commonwealth Care enrollees who are charged a premium for health insurance are more likely to be older than enrollees who are provided free health insurance. As of November 2009—three years since the program's inception—over 43 percent of Commonwealth Care enrollees in the highest income category (i.e., 200 percent to 300 percent FPL) are age 50 or older, compared to 26 percent of enrollees in the lowest income category (i.e., 150 percent FPL or less). Conversely, only 11 percent of enrollees in the highest income category are 19–26 years old, while this age group comprised over one-third of enrollees in the lowest income category.

The importance of attracting a large and diverse risk pool, comprised of a broad mix of individuals with varying health care needs, will largely determine whether an exchange can effectively function and be sustainable. The history—and the ultimate demise—of the insurance cooperatives and health purchasing alliances that sprang up in the early and mid-1990s provides ample evidence of the dangers of not attracting and retaining a large and diverse risk pool.[5]

While outreach and enrollment will be crucial for the success of the subsidized insurance program, the exchange will also need to attract a significant share of the unsubsidized individual and small group market. In order for a commercial, non-subsidized health insurance exchange to survive, it will need to attract enough volume to create administrative efficiencies and be "risk neutral" in terms of the overall health status of the individuals and small groups purchasing coverage through the exchange.

The exchange, or an entity aligned with the exchange, will need to undertake both a broad public information campaign and a targeted marketing strategy to create awareness and generate customers. This will require a significant, sustained, and multi-pronged approach.

The Risk of Adverse Selection

A well-organized and multi-faceted outreach and enrollment initiative will be necessary to inform individuals and to enroll a large and broad mix of people in the exchange. The success of this effort will have ramifications for the sustainability of the program due to the impact that the health status of the population covered may have on the premiums of policies purchased through the exchange.

Publicly-subsidized insurance often faces little "competition," in that most people eligible for public health insurance programs do not usually have alternative sources of coverage. And while people in good health may not sign up for publicly-subsidized coverage until they think they "need it," even if it is free, commercial insurers face an even greater challenge attracting enough healthy people to offset and spread the cost of members with significant health care needs. This is particularly true in the individual market.

Pro-active outreach and enrollment—along with an individual mandate—should help attract a large number of people to the subsidized insurance program available through the exchange. However, the commercial (non-subsidized) health insurance made available through the exchange may be competing for customers against other established distribution channels (e.g., carriers, health insurance brokers, Web-based brokers, intermediaries).

If the exchange becomes the sole source of coverage for individual and small group purchasers—as some have suggested—and there are no alternative distribution channels, adverse selection becomes less of

a concern. However, if people can obtain health insurance from other distribution channels, the exchange will need to establish policies and procedures that minimize adverse selection.

One way to mitigate the risk of adverse selection would be to require health insurers to combine all of their individual and small group members into a single risk pool for the purpose of establishing premiums. This is the approach taken in Massachusetts. An individual who purchases a health plan through the Connector is quoted a premium that is based on each health carrier's individual and small group book of business, including individual and small group members who purchase coverage outside of the Connector. The carriers do not establish separate risk pools for each distribution channel.

An alternative—or complementary—approach would be for states to establish a risk adjustment mechanism that would help protect health plans that cover a disproportionate share of high-cost people by shifting funds from health plans that cover a greater percentage of low-cost people. While not easily accomplished, risk adjustment can help minimize the carriers' inclination to control costs by avoiding older and/or sicker individuals; and can help minimize carriers' financial exposure, particularly for smaller carriers who might not have a book of business large enough to offset a large share of high-cost enrollees.

As noted in the preceding section, many of the 1990's versions of health purchasing cooperatives failed because they attracted relatively poor risk and competed against insurers and other distribution channels that were able to offer consumers lower priced health plans. That experience—although not identical to the exchange models being considered today—offers a few cautionary lessons with regard to mitigating adverse selection: (1) rating rules should be applied consistently inside and outside the exchange; (2) carriers' underwriting rules should not vary significantly across distribution channels; and (3) brokers play a key role in the marketplace and can influence both the volume and the types of people who purchase coverage through the exchange.

The Role of Health Insurance Brokers

Although health insurance brokers' level of involvement in the individual and small group markets may vary from state to state, they generally play an influential and critical role in the distribution of health insurance across the country. Brokers serve as the de facto benefits office 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. As noted above, small group brokers in many markets often use intermediaries to provide back-office support before, during, and after enrollment. The intermediaries perform administrative functions that are typically handled by large employers' human resources office and/or by the health carriers.

How to utilize brokers and how they fit into the outreach and enrollment program for the exchange will be one of the more important decisions made by exchange administrators. California's experience in this regard is illuminating. The Health Insurance Plan of California (HIPC) attempted to minimize the role of brokers by setting its broker commissions below the prevailing small group rates and allowing employers to avoid paying commissions altogether by purchasing coverage directly from the HIPC.

As a result, brokers reacted by not promoting the HIPC as an option for small employers—which severely impacted enrollment—and plan administrators discovered that servicing the small groups without brokers was more costly than they expected. The HIPC reversed course, adjusted their broker fees so that they were comparable to those paid in the small group market, and eliminated the financial incentive offered to small employers who purchased coverage directly from the HIPC.[6]

The key lesson from California's experience, as well as the experience of other purchasing cooperatives across the country, is to recognize that brokers play a prominent and important role among small employers. They often have long-standing and trusting relationships with their clients, and they 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—will prove invaluable to exchange administrators.

The Exchange in the Context of the Current Market

As suggested in the first few sections of this Issue Brief, understanding the current health insurance market will be critical to designing an effective exchange that addresses gaps in coverage and improves the health insurance market. These gaps may be similar across many parts of the country, but market conditions will vary and may be quite different in each state. Much like the "first do no harm" maxim that medical students are taught, policymakers must be mindful of how the exchange will fit into the current market and how it can operate most efficiently and effectively.

With regard to the exchange's subsidized health insurance program: how will the premium subsidies and eligibility rules be structured so as to reach the target population and avoid crowd out? Can existing public subsidy programs be administered by, and/or consolidated within, the exchange? Is it possible and optimal to utilize existing infrastructure and/or state agencies to handle the

eligibility determination process for those newly eligible for premium assistance?

Within the commercial market, the focus of the exchange should be on complementing —not simply replicating —existing functionality and capabilities. Is there a central point, or points, of access for information that allows consumers to compare health insurers and health plans? What types of information may be lacking and can be filled by the exchange? How can the exchange drive administrative efficiencies and help streamline the enrollment process? How will the exchange interact with the state's health insurance regulator?

Conclusion

While it is likely that the federal health reform law will set guidelines for the operation of state-based exchanges, there will be a host of state-specific policy and administrative decisions that will need to be made in order to effectively and efficiently implement an exchange. These decisions will influence whether the exchange can help meet the objective of increasing access to affordable health insurance for individuals and small businesses. Setting the rules for health insurers to participate, providing consumers with relevant and useful information to make informed decisions, streamlining administrative processes, and shifting the insurance market from a competition based on avoiding risk into a competition based on price and quality will take time.

In establishing an exchange, policymakers must be mindful of the particular market conditions that exist in their own state. They will need to engage a broad cross-section of stakeholders—some with competing interests—in order to craft a program that improves the delivery of health insurance.

In some ways the exchange has become a sort of Rorschach test, with people making very different predictions—and having different expectations—about its value and how it can help transform the health insurance market…or not. While an exchange can be a useful vehicle for delivering health insurance and improving competition, major changes to the health insurance markets, and any attempt to lower the cost of health care, will require much more fundamental and substantial health care restructuring than anything an exchange might provide.

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Endnotes

1 Fronstin, P. and M. Ross. "Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider," Employee Benefit Research Institute, Issue Brief 330, June 2009.

2 For additional information, see http://www.census.gov/hhes/www/hlthins/hlthins.html, www.mass.gov/dhcfp, and http://bluecrossfoundation.org/Policy-and-Research/Roadmap-to-Coverage.aspx.

3 Children of parents eligible for Commonwealth Care are typically covered by the state's Medicaid program.

4 The Commonwealth Care program has three "plan types," with different premiums and co-payment schedules, based on the income category of the enrollee. The plan type for higher-income enrollees charges higher co-payments than the plan type available to lower-income enrollees.

5 For a comprehensive review of the experience of these health purchasing cooperatives, see Wicks, E. et al. "Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers," Economic and Social Research Institute, March 2000.

6 Ibid.