

Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals

Timely Analysis of Immediate Health Policy Issues

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Summary

The focus on national health care reform has given rise to a number of proposals for revamping the health insurance marketplace so that all Americans would have affordable coverage. One option supported by President Obama, Senate Finance Committee Chairman Max Baucus and other health policy leaders involves the government establishing a public health insurance exchange to effectively organize an insurance market for those without coverage.

Their theory is that a national health insurance exchange would provide coordination and guidance to insurance markets to help them comply with consumer protections and compete in cost-efficient ways that would result in more Americans obtaining coverage.

Advocates of a public exchange say it could also help purchasers and insurers address some of the problems that currently exist in private health insurance markets, such as not enough risk spreading, discrimination, out of control costs, poor delivery of subsidies, troubles facilitating and ensuring enrollment, and underinsurance. These

fundamental challenges have long hindered the efficacy of our nation's health care system while contributing to the growing numbers of Americans who either have no insurance or insurance that is inadequate to meet their current and potential health care needs.

In this paper, researchers from the Urban Institute review some of the key problems facing purchasers of insurance—whether they be individuals or employers—and outline whether and how a public health insurance exchange might address them. The paper also highlights lessons that can be learned from the experience of prior efforts to create and operate exchanges, such as the Commonwealth Connector in Massachusetts.

The authors conclude a well-designed exchange can help bring about changes that can move the system toward many of the nation's most oft-stated health reform goals. Without an exchange, the authors assert that a patchwork of new agencies at the state and federal level—in addition to new roles for existing agencies—would be required to achieve similar reform objectives.

Introduction: What Is a Health Insurance Exchange?

In the national health care reform debate, President Obama has called for the establishment of a health insurance exchange, as has Senate Finance Committee Chairman Max Baucus. A health insurance exchange is a term to describe an organized marketplace for the purchase of health insurance.¹ In addition, a central feature of Massachusetts's state health care reform has been the creation of a "connector" to organize the marketplace for individual and small-group health insurance. The

Commonwealth Connector² has also been used to make health insurance affordable, adequate, understandable, and available to everyone regardless of health status, and to promote competition. Organizing the health insurance market in this way makes it possible for residents to comply with the state's new mandate that all adults have health insurance.

Private health insurance markets today are not very organized. Individuals and employers voluntarily participate as purchasers, but too often those who would like to buy coverage face barriers to doing so, including problems of affordability and discrimination

based on health status. Private health insurance companies and health maintenance organizations (HMOs) must obtain a license to sell coverage but otherwise generally have autonomy in their business decisions to enter or exit a market, as well as significant latitude in their marketing practices and product design. Health insurance policies are highly variable, and some leave policyholders underinsured. Market rules and consumer protections also vary widely across states and products and often are confusing. As a result, consumers face difficulty weighing options and understanding how coverage works. Using exchanges to provide



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structure and oversight to these markets has, however, been met with some resistance from the insurance industry.³

Key goals of health reform that expands coverage substantially and moves the nation toward universal coverage include

- ending discrimination based on health status and promoting sharing of health care risk,
- slowing the rate of health care inflation,
- subsidizing health insurance for low- and modest-income Americans to make it affordable,
- facilitating enrollment,
- ensuring meaningful coverage, and
- promoting transparency and accountability.

A health insurance exchange can be designed to assist in accomplishing these goals, but exchange design choices are critical in determining their outcomes. This paper reviews key problems that face individual and employer purchasers today and ways a health insurance exchange might be designed to address these problems. It also highlights lessons that can be learned from the experience of prior efforts to create and operate exchanges.

The Role of an Exchange in Risk Spreading

An important factor determining how successfully an exchange can provide a more organized marketplace will be whether new regulatory reforms are also adopted to achieve greater spreading of health care risk. Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. Research shows that the sickest 1 percent of the population accounts for nearly a quarter of all health care spending and the top 10 percent accounts for two-thirds of health care spending, while the healthiest half of the population accounts for only 3 percent of spending.⁴ Consequently, the financial gains to insurers able to enroll the best risks can be tremendous.

Risk spreading evens out the cost of health insurance, using revenue collected from premiums paid by people when they are healthy to pay the claims of people when they are sick. In so doing, risk spreading makes the cost of coverage more predictable for everyone and makes medical bills more affordable for people when they are sick. However, because of the powerful financial incentives for insurers to segregate risks rather than spread them, when permitted by state law, insurers will refuse to sell coverage to those with high expected costs, charge them higher premiums, or permanently exclude coverage for their pre-existing health conditions. These behaviors are observed in most private non-group health insurance markets today.⁵

Insurance market rules. Market regulations are required to prevent risk-selecting behavior by insurers. For example, guaranteed-issue requirements prohibit insurers from denying applicants based on health status or other risk characteristics; community-rating rules prohibit insurers from charging higher premiums, at issue and at renewal, based on health status or claims experience. Similarity in the design of benefit packages is also critical to risk spreading, otherwise policies offering more coverage will attract consumers who need more health care, segregating the risk pool.⁶

Currently states set rules to limit insurers' ability to risk select, and state insurance departments implement these rules, with some minimum standards established in federal law. Under reform, more uniform requirements for guaranteed issue and modified community rating are likely. Implementation of new health insurance market regulations could continue to be the responsibility of state insurance departments, federal regulatory agencies, or a cooperative effort of state and federal regulators. However, in an organized marketplace, the exchange can play other key roles to reinforce market rules and risk spreading.

In particular, the exchange can penalize or exclude from participation companies that violate insurance market regulations. The exchange can also establish market conduct rules to prevent evasion of insurance regulations through sales tactics and other informal means. For example, it can offer or require enrollment through a centralized place to prevent carriers from redlining (denying coverage to specified occupations or communities) or "street underwriting" (informally assessing the risk status of applicants and actively marketing only to the healthiest) or otherwise failing to enroll sicker consumers. These kinds of functions are carried out today by the Commonwealth Connector in Massachusetts.⁷

Even with market rules prohibiting risk selection, it is still possible for some insurers to end up with a disproportionate number of costly enrollees. Accordingly, another role for the exchange can be to provide for risk-adjustments to correct for uneven distribution of risks across health plans and ensure that health insurance premiums reflect the average cost of medical care as opposed to the mix of sick and healthy enrollees under any given plan. To date, policymakers have not been able to design very effective risk adjusters, in part due to lack of data about the relative cost of different health plan enrollees. However, the exchange could require insurers to provide such data and create more accurate risk adjusters. The more accurate the risk adjusters used, the greater the ability of an exchange to sustain a variety of insurance types, such as highly managed HMOs and less tightly managed preferred provider organizations (PPOs). Better risk adjusters would counteract criticism of past exchange experiences that they could not maintain such variety due to risk segmentation within them.⁸

Exclusive vs. competing markets. A central question is whether the exchange is the exclusive marketplace for health insurance. If consumers have the option of buying health insurance

either inside or outside the exchange, opportunities for risk selection reemerge. Decades of experience with health insurance purchasing cooperatives, association health plans, and other competing pooling arrangements demonstrate that it is far easier for insurers to achieve lower premiums by avoiding high risks or attracting low risks than by achieving efficiencies in the sale of insurance or the delivery of care.⁹

If the exchange is the exclusive marketplace for health insurance, opportunities for steering risks to alternative markets are eliminated. On the other hand, if insurers and purchasers can choose to participate in or outside the exchange, there will be a strong incentive to segregate risks.

To the extent a residual market outside the exchange is contemplated, care must be taken to ensure that identical rules apply to health insurance plans regardless of where they are sold to avoid adverse consequences due to risk selection. Rules concerning guaranteed issue, guaranteed renewability, and community rating must be the same inside and outside the exchange. For example, in the past, health insurance purchasing cooperatives (HIPCs) established in Texas and Iowa were required to use community rating while insurers outside of the HIPC were allowed to vary rates due to health status. The HIPCs soon experienced adverse selection as higher-than-average risks had an economic incentive to join the cooperative, while lower-than-average risks had an incentive to remain in the experience-rated traditional market, and HIPC rates soon became unaffordable.¹⁰ Comparable benefit packages must also be offered inside and outside the exchange; otherwise, sicker patients will gravitate toward the market where more comprehensive coverage is sold.

If multiple marketplaces exist, enrollment and disenrollment must also be monitored carefully to detect patterns that indicate risks are being steered from one insurance market to

another. Risk adjustments might also be needed to correct for selection bias of enrollment inside and outside the exchange. A state insurance department would ideally require similar data from non-exchange insurers that are required of exchange insurers to identify and address possible risk segmentations inside versus outside an exchange. Otherwise data on exchange enrollees could be compared with population averages as a proxy for measuring adverse selection into the exchange.

The Role of an Exchange in Cost Containment

For a given population and level of benefits, two factors determine the cost of health insurance coverage of a given level of comprehensiveness: (1) the underlying cost of providing health care services (price per unit of service and the level and intensity of services provided to a group of a given risk level), and (2) the administrative (non-health care) costs associated with providing the coverage.

Exchanges can attempt to lower the underlying cost of providing health care services by creating an environment more conducive to competition between health care plans, but such savings are theoretical at this point and dependent upon the design.

Competition to reduce underlying costs of providing care. Provider payment rates under private insurance are significantly higher in the United States than in other industrialized nations.¹¹ High provider payment rates may, in some instances, reflect high input costs (such as rent, cost of labor, benefits, etc.), but may also reflect a lack of competition in provider markets. For example, concentration in hospital markets has increased markedly since 1990, largely in response to greater consolidation in insurance markets and the increased market power of insurers and managed care plans.¹² There has also been an associated increase in alliances between hospital and physician groups. In addition, analyses suggest a high level of concentration

in insurance markets has diminished competitive pressures and enabled insurers to increase profits while passing health care cost increases to consumers.¹³ The lack of competitive pressures leads to higher prices and less cost-efficient practice patterns.

An exchange could create more competition among health insurers if it were given the authority to negotiate with health insurers over premiums. Insurers could also be excluded from participating in an exchange based upon premium price or growth. State departments of insurance do not negotiate prices with insurers; this would be a new function that the exchange would serve.

The exchange could also require all participating insurers to offer standardized or similar benefit packages, making it easier for consumers to compare prices for like policies. This would reinforce incentives for insurers to price premiums as competitively as possible. While standardization increases comparability of plans, increases risk sharing, and promotes greater competition, the tradeoff is that it reduces the number of insurance package choices available to consumers.

Employers buying coverage through the exchange could also be required to make fixed contributions to their workers' health insurance coverage regardless of plan chosen, providing them with an incentive to choose lower-cost plans. By benchmarking premium subsidies in the exchange to lower-priced plans (e.g., average of the lowest few bids, the median bid, etc.), enrollees would also have an incentive to choose lower-cost plans, and plans would have an incentive to keep premiums down in order to attract market share.

Providing a public plan option in the exchange could further enhance the competition among offerings.¹⁴ Such a public plan could be modeled after the traditional Medicare program and could pay providers based upon the evolving payments systems Medicare uses. Payment rates could be set at or above Medicare levels. Medicare payment

policies have been shown to reduce cost growth, especially for hospital and post-acute care services, relative to private insurers.¹⁵ Alternatively, a public plan might be modeled on self-funded health insurance plan options that most states today offer through their public employee health benefit programs. State personnel executives find such programs offer advantages, including the ability to develop new quality and cost-containment measures and realize long-term financial savings.¹⁶ A public plan with a potentially significant market share that controls provider payment rates could provide the competitive pressure to induce private insurers to be tougher negotiators with their own participating providers. The public plan might also be an innovator in the development of other cost-containment mechanisms (effective disease management, health information technology, etc.), which could lead private plans to adopt such approaches as well, which could generate additional long-term savings.

Reducing administrative costs of health insurance. Administrative costs of insurance are significant, yet not as influential on premiums as health care factors. According to the Congressional Budget Office, administrative costs of health insurance range from about 7 percent of premiums for the largest employer groups to about 30 percent of premiums for the smallest groups and individuals.¹⁷ While exchanges have some potential for creating efficiencies, it is important to realize that an insurer's administrative cost of covering 10,000 people individually through an exchange will be higher than those of providing insurance to one employer with 10,000 enrolled workers. The first case requires issuing 10,000 policies, whereas the latter requires only one policy. To the extent that health care reform shifts individuals from large group to individual policies, the system may experience some administrative cost increases. However, if the exchange primarily enrolls those who would otherwise have had small-group coverage or individual coverage, the difference in administrative costs might not be as significant.

Exchanges could lead to administrative cost savings in several ways, however. First, a significant share of small-group and individual-policy administrative costs are attributable to marketing expenses. For example, commercial insurers typically pay agent commissions of 15 to 20 percent of the first year's premium for newly issued individual market policies, and up to 10 percent of the first year's premium for small-group policies, with Blue Cross Blue Shield plans often paying lower commission rates.¹⁸ Sale of coverage through agents could continue under a health insurance exchange—small groups and individuals rely heavily upon agents for advice about coverage, and earlier attempts to organize markets through purchasing pools did not eliminate agent participation.¹⁹ However, in a more organized health insurance marketplace with greater consumer protections and improved information materials, marketing costs could be reduced. For coverage sold through the Massachusetts Commonwealth Connector, for example, broker commissions range from approximately 1.3 to 3.3 percent of annual premiums, which is lower than they were prior to reform.²⁰

The exchange would also reduce administrative costs due to lower churning across insurance plans. Individuals who purchase their coverage through an exchange would not have to change insurance coverage when changing jobs. Employers could make their insurance contributions to the exchange, allowing workers to remain enrolled in a given plan regardless of their employment status. Currently, small employers in states without community rating have a tendency to change insurers when they receive substantial rate increases, also contributing to churning. Broad-based risk spreading within an exchange would drastically reduce year-to-year variation in premiums and its consequent churning across insurers.

Having a single exchange available for purchasers in a given geographic area will also serve to minimize churning,

as individuals and employers would not be moving across markets in search of lower premiums—the competition would all be concentrated within the single exchange market. To the extent coverage is stabilized, insurers would have greater incentives to invest in benefits and services that can improve health and reduce costs in the long run. Churning blunts such incentives today because the benefits of health care investments in today's enrollees may be realized by a different insurer.

Having a public plan option available in the exchange would provide a lower administrative cost option to enrollees and would likely pressure private plans to hold down their administrative expenses to remain competitive. Multiple studies conclude that administrative costs in public plans are lower than those in private plans.²¹ One study, in particular, finds that public-program administrative costs, even after adjusting for the health care risk of the covered population, are lower than private-plan administrative costs.²² That study estimates that using a representative segment of the nonelderly population, a public plan's administrative costs would be roughly 6 to 8 percent, a significant savings compared with private plans.

Finally, an exchange can require detailed reporting and disclosure of administrative costs by insurers. Transparency can reinforce competitive pressure to hold down administrative costs.

The Role of an Exchange in Delivering Health Insurance Subsidies

The cost of delivering subsidies in a non-organized health insurance market can be substantial, depending upon the approach for doing so. For example, evidence from the Health Coverage Tax Credit (HCTC) which pays non-means-tested premium subsidies for some 16,000 trade-displaced workers indicates that roughly 34 percent of total spending on that program is attributable to the costs of administering the subsidy.²³ As a result of the many transactions that

are required to coordinate eligibility determination and to determine and make appropriate payments to hundreds of different health plans—processes that span multiple agencies under this program—the HCTC has proven to be a very expensive program for delivering health insurance premium subsidies. The administrative process has also had the undesired effect of making program enrollment difficult and time-consuming for potential enrollees, contributing to low participation rates.

To administer subsidies, the exchange would need to collect information about individuals' ability to pay, for example, from their most recent tax return and current pay stubs. Because a change in health insurance status tends to coincide with a significant change in income, the exchange would also need to provide ways for people to document or attest to recent changes in ability to pay.

Centralizing the subsidy determination and the process by which subsidy payments are made to insurers into a single agency, such as an exchange, would be a much more efficient approach to administration compared to the HCTC experience. One-stop shopping streamlines the process for consumers. In Massachusetts, for example, residents fill out a single, common application for assistance; once their needs and ability to pay are evaluated, those qualifying for assistance are directed to Medicaid or to the subsidized private health insurance plans offered through the Connector, as appropriate. In addition, providing exchanges with the authority to standardize plans, limit the number of vendors, and reduce the number of transactions (e.g., by batching subsidy payments to carriers with less frequent reconciliations) would all serve to lower administrative costs and make the market function more effectively.

The development of standardized products offered within the exchange can also be used as an efficient mechanism for subsidizing cost-sharing for the modest-income population. For example, a small number of plans with equivalent benefits but varying levels

of cost sharing could be designed, similar to the approach taken with the Massachusetts CommonwealthCare program. People with the lowest incomes could be made eligible for subsidized coverage with the lowest level of cost sharing, those with somewhat higher incomes could be made eligible for subsidized coverage with somewhat higher cost sharing, etc. This approach allows for far less cumbersome administration of out-of-pocket subsidies than reimbursement of cost sharing on a claim-by-claim basis.

The Role of an Exchange in Facilitating and Ensuring Enrollment

Creating an environment in which voluntary health insurance enrollment is made as easy as possible is a critical component of comprehensive reform. Health reform may provide for an individual mandate to obtain health insurance. Assuming such a mandate is implemented, if compliance with the law is made affordable and barrier-free for individuals and families, then enforcement should be necessary for only a small share of the population. Even without an individual mandate, simplifying enrollment will be valuable in helping to promote higher coverage rates. An exchange could provide a central location for individuals and employers to obtain reliable information about coverage options, premiums, subsidies, and enrollment processes. It would also facilitate enrollment of individuals and firms if all related administrative tasks—choosing plans, determining subsidies, making payments—occurred at one locale with well-trained assistance available. Some have criticized exchanges as being duplicative of insurers in terms of administrative functions.²⁴ While most exchange functions described here would constitute new roles that are not part of existing insurer activities, the enrollment area is one in which it will be important to carefully coordinate responsibilities in order to ensure that the most efficient entity performs specific tasks.

In addition to enrollment, insurance retention is a very important issue

in ensuring continuous coverage for the population. This issue has been highlighted in public insurance participation²⁵ and is evidenced by the large number of insurance transitions in the private sector as well. On average, 2 million people lose their coverage every month.²⁶ Coverage may be lost due to job status changes, aging of dependents, divorce, etc. An exchange that tracks insurance enrollment and disenrollment and retains information on a variety of subsidized and unsubsidized insurance options can help individuals navigate these situational changes without experiencing gaps in insurance coverage.

The Role of an Exchange in Ensuring Meaningful Coverage

Another key goal of health reform is to ensure that people have coverage that will actually pay their medical bills and secure them access to needed medical care. The exchange can promote this goal by ensuring that only policies that meet minimum coverage standards may be offered. In addition to ensuring coverage adequacy, minimum coverage standards will reinforce risk spreading. For example, if all policies must cover the same set of benefits, consumers will be less likely to gravitate toward policies based on their risk status. By contrast, for example, if only some policies in a market include prescription drug coverage, all other things equal, patients with expensive pharmaceutical needs, such as people with diabetes, multiple sclerosis, and cancer, will be more likely to cluster in those policies.

Defining what constitutes “meaningful” coverage will inevitably entail controversy. The more health insurance covers, the more it costs. Political tradeoffs are likely. For example, minimum coverage standards in effect during the first year of health reform in Massachusetts permitted the sale of less expensive policies that did not cover prescription drugs, making it cheaper for residents to comply with the mandate to buy health insurance. Certain policies for young adults also capped covered benefits at \$50,000 per year.

By the second year, minimum coverage standards were increased to include prescription drug coverage, although the “young adult” plans with benefits caps and no drug coverage are still allowed. Far less generous coverage standards are required by the state of Florida under a new program to make affordable health insurance policies available to all state residents. Some “CoverFlorida” policies do not cover any hospital or emergency room care, for example.

An exchange might provide for a common set of services that all plans must cover, but permit some variation across policies based on the level of cost sharing (i.e., deductibles and copayments) that can be applied. Even greater variation might be applied through the use of benefit caps, as described above in the case of the Massachusetts reforms. Depending on what coverage standard is adopted, health reform may achieve universal coverage but problems of underinsurance may persist.²⁷ A report on the Massachusetts health reform effort, for example, found the problem of underinsurance in that state, though diminished, has not yet been entirely resolved.²⁸

Determination of what constitutes adequate coverage may be delegated to the exchange or some other independent body in order to remove this decision from the more political legislative arena and to permit modifications and updates. For example, one congressional proposal delegates to the Institute of Medicine the job of determining medically necessary benefits that all health insurance must cover.²⁹ In Massachusetts, the legislature assigned to the Commonwealth Connector the task of designing minimum coverage standards for health insurance policies. The Connector established initial minimum creditable coverage (MCC) standards in 2007 and has updated them annually since. Under national reform, adequate coverage should be defined at the federal level, regardless if it is done by the exchange or another agency or organization.

In an organized marketplace, minimum health coverage standards must be

enforced. The exchange can support enforcement by certifying that policies offered meet coverage standards. This task may be accomplished in cooperation with the state insurance department, which may review and certify policies. Such cooperation would allow enforcement beyond policies offered within the exchange. Additional minimum requirements for health plan provider networks, prompt claims payment standards, and appeal and grievance procedures, as well as other conditions of participation may also be required to ensure that promised coverage is delivered. Other entities may be involved in enforcement, as well. In Massachusetts, all residents must have coverage that meets MCC standards, regardless of whether they purchase through the Connector. Residents must file with their tax return certification of coverage under a plan that meets MCC standards, and the Department of Revenue assesses a penalty on those who do not comply.

Whatever standard for minimum coverage may be adopted, the exchange can monitor the impact of coverage standards. Measurements of uncompensated care, medical debt, and other indications of underinsurance can be developed and implemented, with findings reported periodically. The exchange may adjust minimum coverage standards in response to these measures.

The Role of an Exchange in Promoting Health Insurance Transparency

Transparency is critical in a competitive market where consumers have choices. If competition is to promote efficiency and cost savings, consumers must be able to distinguish plan features that affect costs, understand tradeoffs, and weigh choices in an informed manner.

Currently, consumer information about health insurance can be quite limited. For example, consumers contemplating coverage choices typically only have health plan summaries available. The full policy contract usually is not delivered until after the policy

is purchased. Important coverage features, such as the health plan provider network or the names of drugs covered under the health plan formulary, also may not be available to prospective enrollees. For medically underwritten policies—those for which premiums vary across enrollees as a function of their health status—the price of coverage also might not be apparent until the time of purchase. Even consumers who believe they are healthy may be surprised by premium surcharges imposed on the basis of relatively non-serious health conditions such as seasonal allergies.³⁰ Premium increases at renewal may also be unexpectedly dramatic for consumers who make claims if they are covered under “experience rated” policies,³¹ or for consumers who remain covered for a number of years under “durational rated” policies.³² It can also be hard for consumers to know in advance whether a health insurance policy will pay claims promptly or provide good customer service.

One important task of the exchange is to provide more and better information about health insurance than consumers have available today. The Commonwealth Connector, for example, groups health insurance plans into three categories by actuarial value—gold, silver, and bronze—to make it easier for consumers to compare across options. In addition, the Connector web site and brochures make plan comparison documents available that highlight differences in key plan features such as deductibles, co-pays, and benefit limits.³³ Detailed plan comparison documents are also prepared for participants in the Federal Employees Health Benefits Program,³⁴ California public employees and retirees,³⁵ and senior citizens purchasing Medicare supplemental policies or HMOs,³⁶ among others.

The exchange can delve deeper into health plan coverage features and offer information tools to help consumers determine which plan networks include their doctor or which plan formularies cover their prescription drugs. For

example, an on-line “formulary finder” allows seniors to identify which Medicare Part D plans cover their prescription drugs and what levels of cost sharing apply. This information is juxtaposed with monthly premium data so consumers can compare total costs they might face under different Part D plans.³⁷ While an agency or agencies outside an exchange could play such a role, this is not common today and would require collection and processing of a great deal of information from insurance plans. Such a task would be easiest for a central clearinghouse, like an exchange, that is already interacting with plans, is familiar with plan details, and is involved with facilitating individuals’ enrollment in coverage.

In addition to comprehensive and understandable plan benefit comparison tools, the exchange should also make available information about how different plans perform on measures such as prompt payment of claims, customer service, breadth and quality of plan provider networks, and outcomes of grievance and appeals processes. Information of this type would be particularly hard for consumers to gather on their own, and is available now in only a fragmented way for some plans in the form of consumer satisfaction surveys and health plan report cards.³⁸ The exchange can also require disclosure of other important data by health plans and then verify, analyze, and publish findings to help consumers understand and evaluate differences in health plan performance. For example, in Washington State, the Office of the Insurance Commissioner (OIC) makes available a Health Carrier Information Comparison tool to give consumers information on the efficiency of health insurers. The tool provides information about carrier loss ratios,³⁹ profit margins and other characteristics to help consumers see how much of their premium dollars are spent on medical claims vs. administrative costs.⁴⁰ The New Jersey Insurance Department makes health insurance policy contract language available online.⁴¹ Organizing the health insurance marketplace so that these kinds of information are readily

and routinely available to all consumers would be another important role of an exchange. To the extent coverage is sold outside of an exchange, state insurance departments might also play a role in collecting and summarizing information on non-exchange plans. However, implementing uniform information standards for all coverage across states would require federal involvement.

Beyond collecting data to help consumers make informed choices between insurance plans, an exchange could be responsible for collecting data to ensure that subsidy dollars are being spent on plans that are operating efficiently. This effort could include collecting key data on loss ratios, the health care risk profile of enrolled populations, and the use of health care services by enrollees. Such data could also be used for monitoring and enforcing federal standards, performing risk adjustment, and for developing a data base that could assist in designing system reforms that could increase the efficiency of service delivery.

The Role of an Exchange in Promoting Health Insurance Accountability

Transparency in health insurance is also key to accountability. If a goal of health reform is to foster competition based on efficiency, one job of the exchange must be to gather information to ensure this is the case. It should be able to determine, for example, whether two low bids submitted by competing carriers reflect similar levels of efficiency or vastly different performance on prompt payment of claims. Transparency and disclosure of information to the exchange is necessary to

- monitor compliance with an individual mandate by consumers,
- monitor compliance by insurers with market reforms,
- contract with plans on the basis of efficiency, and
- determine the need for risk adjustments.

Accomplishment of these goals will require disclosure of verifiable data on a variety of key factors, including

- marketing and enrollment practices by carriers, with detail by policy and by demographics and health status of applicants and enrollees;
- enrollment and disenrollment data, with detail by policy and by demographics and health status of enrollees and for people who renew or disenroll from coverage;
- premiums charged when policies are issued and renewed, with detail by policy and by demographics and health status of enrollees;
- detail of benefits and cost sharing under each policy;
- information on provider participation and fee schedules;
- loss ratio data, including detail on administrative costs by type of expense;
- claims payment practices and history, with detail for claims submitted, paid, delayed, and denied by patient type and type of service; and
- data on diagnoses and use of services for risk adjustment.

Through its transparency and disclosure requirements, an organized health insurance marketplace also will be much better able to verify compliance with rules that promote risk spreading. A coordinated effort with state departments of insurance would benefit those continuing to purchase coverage outside of an exchange.

Other Issues Regarding a Health Insurance Exchange

In considering the role and potential of a health insurance exchange, other important questions include who would buy coverage in an exchange, how would the exchange operate in relationship to existing agencies with jurisdiction over health insurance (in particular, state insurance departments) and who would operate an exchange—the federal government or states? Answers to these questions will depend

on broader health care reform policy and political decisions.

Who participates? Under health care reform, it is possible that all private insurance would be purchased through an exchange. Alternatively, an exchange might be established to replace only those segments of today's private health insurance markets that would benefit most from tighter organization. Larger exchanges might generate more political backlash from those who oppose new and bigger government agencies or from insurance companies and agents who might not favor the higher level of oversight an exchange could bring to the market. Arguably, the individual market and the group market for the smallest firms (for example, with fewer than 10 employees) experience the most difficulties today. The individual market is characterized by aggressive medical underwriting and risk segmentation, bare bones policies, and high rates of turnover. It is the market in which adverse selection concerns are the greatest. People buying on their own also lack assistance that might otherwise be provided by a human resources department. In the small-group market, the smallest firms are least likely to offer coverage today and tend to be more vulnerable to insurer underwriting and pricing practices designed to deter adverse selection. The smallest firms also tend to lack the resources to hire human resources experts.⁴²

If the exchange is limited to only individuals and small employers, a question arises as to whether employees of large firms would be eligible to seek subsidized coverage in the exchange. Such individuals might be allowed to obtain subsidized coverage through the exchange if that would make them better off relative to what their job-based health plan covers and costs. However, permitting this would also increase the cost of the subsidy program overall, displacing a greater amount of private spending. Alternatively, if a priority of

reform is to enhance choice of plans, all individuals might be offered the option of obtaining coverage through the exchange, including employees who are also offered job-based coverage. As noted earlier, however, when individuals can choose to buy coverage in or out of the exchange, risk selection issues arise. At a minimum, risk selection would need to be closely monitored in such a context, and risk adjustments could be used to correct for significant selection problems.

How does an exchange relate to other agencies? Many key functions of an exchange are likely to be new, not now undertaken (or undertaken very extensively) by existing government agencies—for example, negotiating with health plans, establishing minimum coverage standards, subsidizing health insurance premiums, providing plan comparison tools, and facilitating enrollment. It seems unlikely that an exchange would also be designed to replicate or replace other functions now carried out by other agencies. In particular, an exchange probably would not take over the regulation of health insurance. State insurance departments would continue to license health insurers, oversee solvency, and enforce health insurance regulations, such as guaranteed-issue requirements, subject to federal minimum standards. However, as noted earlier, the exchange could reinforce certain requirements by excluding noncompliant carriers from participation. The exchange can also heighten the level of oversight and transparency of certain health insurance practices.

Is the exchange operated by the federal government or states?

Assuming national health care reform, the exchange would be established under federal law and responsibility for operating it would ultimately reside with the federal government. In addition, if subsidies in the exchange were financed federally, the federal government would likely retain this

function, as well. CBO has suggested that states have less incentive to control costs when administering federal subsidies.⁴³ On the other hand, because local factors influence many aspects of health care and health insurance markets, states might be given the opportunity to establish and administer an exchange subject to federal guidelines. Whether states would want to take on this responsibility is an open question. A state might want to administer the exchange in order to provide even more protection for its residents than federal law provides—for example, to require policies to cover more than national minimum benefit standards specify. However, affording states this level of flexibility might also affect the overall cost of health reform, in this example, by increasing the cost of subsidizing health insurance premiums.

Conclusion

A health insurance exchange makes it possible to organize health insurance markets more efficiently and effectively than takes place today for the many reasons outlined here. Because so many different problems must be addressed in the insurance marketplace in order for all Americans to have meaningful and affordable coverage, an entity like an exchange is needed to coordinate tasks and guide markets to comply with consumer protections and compete in cost-efficient ways. An exchange is not a panacea for all that ails the U.S. health care system, but, carefully designed, it can be a vehicle that facilitates and monitors the movement of the system toward achievement of many national health care reform goals. Without an exchange, a patchwork of new agencies and new roles for existing agencies at the federal and state levels would be required to achieve reform objectives, and in so doing, uniformity and efficiency of administration of the necessary tasks would be compromised.

Notes

- 1 In addition to “exchange,” other terms have been used to describe this concept of an organized marketplace, including “connector,” “alliance,” “purchasing pool,” and “purchasing cooperative.”
- 2 Hereafter referred to simply as the Connector.
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- 31 Experience rated policies are those with premiums set as a function of the particular group’s past health service use.
- 32 Durational rating applies premium surcharges at renewal based on tenure of the policyholder. Durational rating prompts those policyholders who are still healthy enough to pass medical underwriting to apply for new coverage at new issue rates. Policyholders who have gotten sick, however, are stranded in their current coverage. Siphoning off healthy policyholders raises the average experience of the in-force coverage, causing rates to rise dramatically at renewal. See, for example, “On Their Own,” *Consumer Reports*, January 2008. <http://www.consumerreports.org/health/insurance/health-care-on-your-own-1-08/overview/health-care-on-your-own-ov.htm>. Although the policy featured in this story was subject to rating bands, which are supposed to limit how much more sick people must pay than healthy people for the same policy, such limits are not effective if insurers can separate healthy and sick consumers into different policies.
- 33 See <http://www.mahealthconnector.org>.
- 34 See <http://opm.gov/insure/health/planinfo/index.asp>.
- 35 See <http://calpers2009.chooser2.pbgh.org/>.
- 36 See <http://www.medicare.gov>.
- 37 See <http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>.
- 38 See, for example, FEHBP plan comparison information provided by a nonprofit consumer group called Consumer Checkbook, at <http://www.checkbook.org/newhig2/AboutGuide.cfm>. See also “Consumer Guide to HMOs in New York” at http://www.ins.state.ny.us/consumer/cg_hmo2008.pdf.
- 39 The share of premiums paid out to cover benefit claims.
- 40 See <https://fortress.wa.gov/oic/hcis/public/comparisonhome.aspx>.
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