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Multi-state Health Insurance Exchanges[1]

Timely Analysis of Immediate Health Policy Issues
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Summary

Health insurance exchanges are a central component of the small group and individual health insurance market reforms in the Affordable Care Act (ACA). The ACA allows multiple states to jointly operate exchanges if they so choose. States might consider joining together to offer multi-state exchanges for four reasons. First, administrative economies of scale could be significant. Second, regional exchanges might make sense in large metropolitan areas that cross state boundaries. Third, states might establish multi-state exchanges to promote pooling across state lines. Fourth, multi-state exchanges could create the necessary critical mass of insured persons to establish stable risk pools by combining markets in small population states. However, multi-state exchanges are most likely to focus on shared administrative structures and efficiencies as opposed to risk-sharing. Cross-state risk-sharing would inevitably lead to one state population effectively subsidizing another and create a complex environment for policy decision-making.

The Affordable Care Act provides for the operation of health insurance exchanges by states. Health insurance exchanges are organized marketplaces for the purpose of providing coordination and guidance to insurers and helping them to comply with consumer protections and compete in cost-effective ways. In addition, exchanges will determine applicants' eligibility for subsidies and ensure efficient plan enrollment. They are likely to play a role in centralized marketing, risk adjustment and implementation of cost-containment strategies. Thus, exchanges will have a broad array of roles and a complex set of responsibilities. As such, some states, particularly smaller ones, may consider developing and operating an exchange jointly with another state or states. The law permits the establishment of multi-state exchanges at state discretion. This brief describes potential rationales for states to form multi-state exchanges and the issues raised by doing so.

Under the law, each state will establish and operate an exchange for individual health insurance coverage starting January 1, 2014. The exchange will not be an exclusive market for individual coverage; instead, individual policies could continue to be sold through the individual market outside the exchange. States will also establish Small Business Health Option Programs (SHOP exchanges) for small-group health insurance coverage. The SHOP exchange will not be an exclusive market either; instead, small businesses will have the choice to purchase small-group policies outside the exchange, to self-fund, or to not offer coverage at all. Although the exchanges will not constitute exclusive marketplaces, insurers will be required to pool risk regardless of where coverage is sold.[2] Specifically, insurers will be required to consider all of their individual policyholders (both in and out of the exchange) as members of a single risk pool. Likewise, insurers will be required to consider all of their small-group policyholders (in and out of the exchange) as members of a single risk pool. Risk adjustment guidelines will be developed by the U.S. Department of Health and Human Services and applied to all individual and small-group policies (other than grandfathered policies) sold within and outside exchanges. States will have the option of merging their individual and small-group markets and may opt to have one exchange to serve both.

Qualified individuals and small businesses could participate in the exchange. The law defines a small employer as a firm with up to 100 employees. States will have discretion to allow larger employers to participate in the exchange beginning in 2017. Exchange duties under the ACA will include the following:

- certifying, recertifying, decertifying and rating qualified health plans;
- maintaining a Web site through which individuals may obtain comparative information on available plans;
- providing information to consumers on health benefit plan options in a standardized format;
- providing eligibility information and enrollment assistance for Medicaid and children's health insurance plans (CHIP);

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- providing information to households on eligibility for subsidies to defray the costs associated with exchange plans and after-subsidy household costs of coverage;
- identifying and documenting appropriate households as being exempt from the new requirement to obtain coverage;
- establishing and maintaining a toll-free telephone hotline for providing consumer support; and
- transferring appropriate information to the Treasury Department.

States may choose to have their exchanges take on other responsibilities as well, for example, interacting with their state departments of insurance to support oversight of insurer compliance with market regulations. States will be allowed to establish subsidiary exchanges as long as each subsidiary operates in a geographically distinct area (for example, for northern and southern California). States can also establish regional or interstate exchanges with Secretarial approval.

Four rationales for establishing multi-state exchanges. States might consider joining together to offer regional or multi-state exchanges for four reasons. **First, administrative economies of scale could be significant.** Exchanges will need to develop subsidy administration and eligibility protocols, consumer ombudsman services, plan comparison materials and other new programs and functions in order to organize health insurance markets and make them operate more competitively. It might make sense, for example, for several small states to join together and undertake these tasks in common. Within multi-state exchanges, however, it would be important for each state's department of insurance to retain its regulatory jurisdiction and authority.

Second, regional exchanges might also make sense in large metropolitan areas that cross state boundaries. Residents may reside in one jurisdiction but work and obtain health insurance in another. Today, in advance of health reform, insurers make adjustments in order to do business in such areas. For example, two Blue Cross Blue Shield (BCBS) plans operate in Kansas—Kansas BCBS and Kansas City BCBS. Kansas BCBS operates statewide except for the Kansas City metro area. Kansas City BCBS sells coverage only in the metro area and is licensed in both Kansas and Missouri. To the extent these two states have different rules governing health insurance, Kansas City BCBS follows the more stringent rule for all of its policies. In the context of health reform that provides for individual and employer mandates, it will be important to adopt structures that facilitate the purchase of coverage, making health insurance as affordable, efficient, and administratively simple as possible. For firms whose workers reside in different jurisdictions, regional exchanges could simplify coverage choices, the administration of subsidies, enforcement of mandates, and other key reform changes.

Third, states might establish multi-state exchanges to promote pooling across state lines. States jointly operating an exchange could choose to have insurers set identical prices for products sold in both states. However, whether risk pooling across state lines might occur would depend on the rating areas for health insurance that states establish. As discussed above, it seems unlikely that a lower-cost state would agree to pool risks and costs with a higher-cost state. Under the law, states will establish geographic rating areas for health insurance, subject to federal approval. Therefore, for example, even though Kansas and Missouri might decide to jointly operate a single exchange for their residents, if the cost of coverage across these two states is very dissimilar, they might decide to maintain distinct rating areas within the exchange for Kansas and Missouri and might even maintain substate rating areas.

Fourth, multi-state exchanges could create the necessary critical mass of insured persons to establish stable risk pools by combining markets in small population states. The minimum size for a credible risk pool is generally perceived to be about 100,000 lives. Thus, multi-state exchanges could be particularly useful for sparsely populated regions of the United States. Buettgens, Holahan and Carroll (2011) estimate the enrollment in state non-group health insurance exchanges under the ACA, based upon 2011 population estimates.[3] For example, they estimate enrollment in the non-group health insurance exchanges of Vermont, the District of Columbia, North Dakota, South Dakota, Wyoming, Alaska and Hawaii at 48,000, 49,000, 76,000, 82,000, 58,000, 61,000 and 64,000, respectively. Theoretically, at least, these states could participate in exchanges jointly with other states in order to establish more financially sound pools. However, obstacles could occur that would prevent cross-state exchanges from achieving such critical mass. For example, to operate in a multi-state exchange and operate everywhere within it, insurers would need to develop and maintain provider networks that reached broadly across the participating states. A Wyoming insurer may be unable to establish a robust provider network in Idaho, for example. In addition, introducing additional plans into small population areas could further fragment existing risk pools, particularly in the absence of effective risk adjustment.[4]

Risk adjustment—The ACA provides for risk adjustment. Even after medical underwriting is prohibited, risks might distribute unevenly across insurers, accidentally or as a result of consumer or insurer behavior that leads to adverse selection. Risk adjustment is a tool to even out maldistribution of risks across plans. For example, if one plan within an exchange enrolls a disproportionate share of the population with diabetes, a risk adjustment could be applied to take some premium revenue from other plans and transfer it to the plan with sicker enrollees. In this way, plans are not financially or competitively penalized for enrolling higher-need people and enrollees do not face higher premiums for choosing a plan that tends

to be more attractive to those with serious conditions.

The potential for adverse selection or risk selection increases if health insurance is sold in multiple markets—for example, both inside and outside an exchange. There may be incentives for insurers or agents to steer risk to one market or another (i.e., encourage purchasers who are less healthy to obtain coverage either inside the exchange or outside it) to gain a competitive advantage. Under the ACA, health insurance can be offered by insurers both inside and outside the exchange. However, carriers must pool the experience of coverage they sell both inside and outside the exchange and charge the same premium for a policy regardless of where it is offered. The law also provides for risk adjustment to be applied for all policies and carriers in the individual market, whether in or outside the exchange. A similar risk adjustment requirement applies to small-group coverage.

In the case of multi-state exchanges that share risks across state lines (i.e., are not merely set up to take advantage of administrative economies of scale), the opportunity for selection dynamics increases, based on the factors discussed previously. If rules and required plan features within a multi-state exchange varied at all from those governing plans operating outside the exchange in even one state, significant adverse selection could occur, possibly raising costs for all enrollees across the participating states in a multi-state exchange. While the law provides for the implementation of a risk adjustment mechanism across exchange and non-exchange plans, there is no practical experience with such a strategy, and it would be difficult under the most uniform of circumstances. For example, there is no available data today to assess the extent to which the Massachusetts Connector is adversely selected against relative to Massachusetts plans that do not participate in the Connector.

Effective risk adjustment is important in the context of exchanges generally but would be critical for cross-state exchanges. While significant advances have been made in the development of risk adjustment technology (the DxCG model is used in multiple states already[5]), access to sufficient data can be a constraint. The more claims or utilization information carriers provide, the better the risk adjustment software can assess the relative risk of enrollees. However, shortcomings in data collection can hinder the effectiveness of risk adjustment. In California, for example, many managed care plans do not collect detailed outpatient or prescription drug data as a matter of course. Insurers also vary in the specificity of data they collect—for example, some may collect the first three digits of a diagnosis code for a patient while others may collect four or five digits of the code. Getting insurers to collect and report uniform claims and diagnosis data for risk adjustment purposes will require investing resources and time.

Many decisions must be made to implement risk adjustment successfully. For example, will adjustments be made prospectively based on the characteristics of enrollees at the beginning of the plan year, retrospectively based upon utilization during the past year or based on some combination? What types of health conditions will be used as a basis for risk adjustment, and how will they be weighted relative to each other in calculating the adjustment? All risk adjustors do not come up with the same answers, making these decisions carry significant financial implications for different plans. Within a multi-state exchange, states would need to agree on these choices as well as what to do in circumstances when insurers opt out of the exchange. For example, insurers being assessed under risk adjustment due to enrolling a healthier than average risk pool could decide to leave the exchange to avoid paying. How would this be handled? Performing risk adjustment without standardized health plans across the boundaries of the purchasing pool would also be difficult.

Political and administrative issues involving multi-state exchanges—In addition, multi-state exchanges would tend to dilute the policy-making locus to a level not politically accountable. For example, state A might seek to limit the exchange options to three carriers (e.g., in order to exclude high-priced options or those that have not hit particular quality targets), while state B could oppose this approach. Or, in the course of certifying exchange-eligible plans and insurers, if consumer complaints (for example, involving network adequacy) arise against a carrier in one state but not in another, the multi-state exchange would have to weigh whether to decertify the plan despite the fact that residents of one state may be happy with it. These disagreements could cause conflicts between member states of the same exchange. Thus, decisions that improve the functioning of the market become more difficult with a multi-state exchange.

In summary, exchange policy will be a constant balancing act between spreading risk, maintaining insurer participation, and, in the case of multi-state exchanges, ensuring that competing interests of different states are handled satisfactorily. As a result, of the fact that cross-state risk-sharing would lead to one state's population effectively subsidizing another state's population and create a complex environment for decision-making, multi-state exchanges are likely to focus on shared administrative structures and efficiencies as opposed to risk-sharing.

Endnotes

1 This brief was adapted from a longer report by Linda Blumberg and Karen Pollitz, "Cross-State Risk Pooling under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bills," (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412124.

2 Self-funded plans will not be pooled with fully insured plans, however.

3 Matthew Buettgens, John Holahan, Caitlin Carroll, "Health Reform across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," (Washington, DC: The Urban Institute, 2011), http://www.urban.org/url.cfm?ID=412310.

4 Plus, having many plans within an exchange can seem attractive from a choice perspective but can also make purchasing pools significantly less flexible. Getting 25 health plans to do something uniformly takes a great deal of work and planning. Insurers are much better at developing quickly implemented strategies to avoid bad risks than an exchange with many plans can be at preventing risk segmentation. In addition, to the extent that multi-state exchanges or enlarged markets increase the number of plans offered, the task of administering and regulating the market can be more difficult.

5 DxCG is one of the commercially available claims-based risk assessment tools. A recent study analyzed the relative predictive accuracy of these tools: see Ross Winkelman and Syed Mehmud, "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment," (Society of Actuaries, 2007), http://soa.org/files/pdf/risk-assessmentc.pdf.

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