



Building a Better Health Care Marketplace

Building a Better Health Care Marketplace

U.S. PIRG Education Fund

Mike Russo, U.S. PIRG Education Fund
Melissa Cubria, TexPIRG Education Fund
Laura Etherton, OSPIRG Foundation
Brian Imus, Illinois PIRG Education Fund

June 2011

Acknowledgments

The authors bear responsibility for any factual errors. The views expressed in this report are those of the authors, and do not necessarily reflect the views of our funders.

Larry McNeely provided significant editorial, research, and drafting assistance.

The generous financial support of the Robert Wood Johnson Foundation, the California Wellness Foundation, and the Chicago Community Trust helped make this report possible.

With public debate around important issues often dominated by special interests pursuing their own narrow agendas, U.S. PIRG Education Fund offers an independent voice that works on behalf of the public interest. U.S. PIRG Education Fund, a 501(c)(3) organization, works to protect consumers and promote good government. We investigate problems, craft solutions, educate the public, and offer Americans meaningful opportunities for civic participation.

For more information about U.S. PIRG Education Fund or for additional copies of this report, please visit: <http://www.uspirg.org>.

© 2011 U.S. PIRG Education Fund.

Some Rights Reserved: U.S. PIRG Education Fund issues this report under a Creative Commons “some rights reserved” license. You are free to copy, distribute, or display the work for noncommercial purposes, with attribution. For more information about this Creative Commons license, visit: <http://creativecommons.org/licenses/by-nc-nd/2.5/>

Cover photo: Andre Blais / iStockphoto.com

Graphic Design: Harriet Eckstein Graphic Design

Table of Contents

Executive Summary	1
Introduction	4
I. Accountability and Transparency	8
II. The Power of Negotiation	11
III. Promoting Innovations in Cost and Quality	15
IV. Ensuring Stability	19
V. Designing a Consumer-Friendly Exchange	24
VI. Coordinating with Public Programs	28
Endnotes	32

Executive Summary

Consumers across the state know that the health insurance marketplace is broken. Insurers don't compete for their business, instead offering take-it-or-leave-it deals. Important information about coverage is buried in the fine print, making it hard to know what's really covered. Instead of working to lower costs and improve quality, too many insurers focus on covering healthy enrollees and dumping the sick. And costs are continuing their unsustainable rise. Nationally, the great majority of individual-market policyholders—77%—saw a premium increase from early 2009 to early 2010, with an average rate hike of 20%. Small businesses, too, pay 18% more for insurance than their larger competitors and have seen repeated double digit premium increases.

The creation of a new health insurance exchange offers our state the chance to build a better marketplace for health care. The exchange can help individuals and small businesses by increasing competition and improving choices in the state's insurance market. By providing better options and better information, and negotiating on behalf of its enrollees, the

exchange can level the playing field for consumers.

Success is not assured, however, as states confronting the task of setting up their exchange must grapple with important policy questions. This report is a blueprint for creating a strong, pro-consumer exchange that lives up to its promise of a better marketplace.

Accountability and Transparency

The exchange must be accountable to the public, and individual and small business consumers, not the special interests. The exchange's legislative mandate and mission statement should clearly state that the exchange is to be operated for the benefit of individuals, businesses and their employees, not the insurance and health care industries. It should be run and overseen by representatives drawn from the consumer and small business communities that the exchange is designed to serve, not insurers

or providers who could benefit financially from the exchange's decisions.

The Power of Negotiation

Just as any big business negotiates with insurers, using the bargaining power of its employees to push for lower premiums, so too a strong exchange must have the power to negotiate for better choices and lower costs. That means it must have the authority to exclude plans that fail to deliver robust consumer protections, quality care, and reasonable costs, particularly if the plan has a history of unreasonable rate increases. And because the bigger the exchange, the greater its negotiating power, the state should plan to open the exchange to employees of large businesses as soon as possible, and work to enroll as many eligible consumers as possible.

Promoting Innovations in Cost and Quality

Research and the experience of innovative providers across the country have identified game-changing strategies to hold down costs by providing higher-quality, coordinated care to patients: medical homes, chronic disease management, accountable care organizations, and bundled payments. The exchange, in its negotiations with insurers, can drive them to adopt these proven strategies. Once plans have initially agreed to adopt these reforms, the exchange must monitor their implementation, so that insurers disclose information on the impact which the reforms actually have on quality of care and coverage, cost, outcomes, and adherence to best practices. The exchange should provide a special "seal of approval" for the plans that do the best job at providing high quality care, and

provide consumers with easily understandable information about what these reforms mean and how consumers can best make use of them.

Ensuring Stability

If the exchange is not designed correctly, sicker enrollees can congregate within the exchange, with healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage which in turn sends premiums up again. Policymakers must prevent this dynamic from ruining the exchange's potential to improve consumer choices and hold down costs. They can require insurers to offer "mirror" versions of their products, on both the exchange and the market outside the exchange. The state should prohibit insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. And because a larger exchange will have more stability, states should conduct strong outreach and enrollment and widen the eligibility rules for the exchange.

Designing a Consumer-Friendly Exchange

The consumer experience is an important prerequisite for the exchange's success. Its web portal must be well-designed, ensuring that the language used is straightforward, avoiding jargon as much as possible and addressing the diverse language needs of enrollees. The exchange must also help those without high-speed internet to find coverage, providing a toll-free hotline and face to face assistance through its

Navigator program. It should take steps to help consumers make informed choices, by allowing them to make apples-to-apples comparisons of their options and making it easy to search for products that meet a consumer's particular needs. The exchange must safeguard consumers' privacy, by ensuring that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it.

Coordinating with Public Programs

The exchange will be only one piece of the state's larger health care landscape, which will continue to include public programs like Medicaid and the Children's Health Insurance Program (CHIP). Coordinating these various programs will require careful attention to issues of eligibility, enrollment, and transition, but will allow states to save money due to increased efficiency, and give consumers an easier experience getting their coverage. Whatever door a consumer enters through—applying to the exchange or a public program—they should quickly and easily receive the appropriate coverage. The state's system should obtain updated information from enrollees in both public programs and the exchange each year, and if the enrollee's eligibility has not changed, their coverage should be automatically renewed. If the enrollee instead becomes newly eligible for some other coverage source, the exchange should present the enrollee with their new choices, and automatically enroll them unless they opt out.

Also, the exchange has the opportunity to create ratings, comparison tools, standardized forms, and other services to

allow consumers to easily understand their coverage options when purchasing coverage through the exchange's web portal. Some of them might also be helpful for allowing public program beneficiaries to understand their coverage, so states may want to incorporate these aspects of the exchange's systems into those of their public programs. Similarly, exchanges should encourage private insurers to adopt reforms to how they pay for care that would reward high-quality, lower-cost care. The impact of these reforms will be heightened if similar reforms are also instituted in, and coordinated with, the public programs administered by the state.

Making Health Care Work for Small Businesses

The small businesses who will get coverage through the exchange will see important benefits. For smaller businesses, if one employee gets unexpectedly sick, premiums for the entire business can jump. The exchange can help mitigate this problem; by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of an impact on overall costs. And untangling the confusing array of plan options available to small businesses today can be a full time job by itself. By standardizing insurance products within tiers, and creating decision tools to allow for easy apples-to-apples comparisons, the exchange can allow even small businesses without much time or expertise to make choices that are right for them. But to make sure the exchange delivers value for small businesses, the exchange must provide for small business owners and their employees to have a voice in its decisions.

Introduction

In the year since the passage of the federal health reform law, the Patient Protection and Affordable Care Act (or ACA),¹ states across the U.S. have gotten to work implementing the new law's provisions and pursuing their own reforms—and the stakes could not be higher.

Consumers across America know that the health insurance marketplace is broken. Insurers don't compete for their business, instead offering take-it-or-leave-it deals. Important information about coverage is buried in the fine print, making it hard to know what's really covered. Instead of working to lower costs and improve quality, too many insurers focus on covering healthy enrollees and dumping the sick. And costs are continuing their unsustainable rise. Nationally, the great majority of individual-market policyholders—77%—saw a premium increase from early 2009 to early 2010, with an average rate hike of 20%.² Small businesses, too, pay 18% more for insurance than their larger competitors and have seen repeated double digit premium increases.³

The creation of a new health insurance exchange, authorized by the ACA, offers the states the chance to build a better marketplace for health care. The exchange can help individuals and small businesses by increasing competition and improving choices in the state's insurance market. By providing better options and better information, and negotiating on behalf of its enrollees, the exchange can level the playing field for consumers.

Success is not assured, however, because the exchange is both challenge and opportunity. Very few states currently run anything resembling an exchange, meaning they will very quickly have to develop their expertise. Additionally, the ACA leaves states substantial leeway to define critical aspects of the exchange, including who is eligible to buy coverage through it, how aggressively it will set standards and negotiate with insurers, and who will run it. Some of these choices will allow the state to improve on the law, but others could undermine the exchange's ability to deliver better choices and lower costs.

All told, state policymakers, including those eventually tasked with setting up and

running the exchange, will have to make a large number of critical decisions and implement them efficiently to ensure that the exchange is effective and up and running by 2014, when it will open for business.

Exchange Basics

It's long been true that large businesses get a better deal on health insurance than small businesses, because of the increased bargaining power they bring to the table. The same is true when it comes to individual health insurance, since a single consumer does not have much ability to negotiate. This lack of negotiating power also means there is less competition among insurers on these markets. Finally, costs are higher on

the individual market because of the lack of economies of scale: each plan contract must be individually sold and administered.

The ACA's solution to this problem is the exchange, a state-created competitive marketplace where individuals and small businesses can come together into a purchasing pool. If properly designed, the exchange will allow consumers to combine their bargaining power when buying private insurance. Its greater size will also help reduce administrative costs, since insurers will not need to process each individual coverage application.

But the exchange is more than just a purchasing pool. It can help to organize the health insurance marketplace, so that consumers will have more information

Spotlight on Small Business

While many Americans struggle with the rising costs and eroding quality of health care, the plight of small businesses stands out—lacking the advantages possessed by larger businesses, they face unique challenges. Without the bargaining power to negotiate with insurers for better rates, they often get a worse value for their health care dollars. Because smaller businesses often lack a human resources department, they are often left alone to negotiate an often-confusing insurance market. And because in many states insurers can refuse to cover individuals with pre-existing conditions, some would-be entrepreneurs never start up the small business of their dreams, because to do so could mean their family would go without health coverage.

In tandem with other reforms in the new federal health care law, states can design their exchange to help address all of these problems, giving small businesses and their employees access to a meaningful choice of higher-value, more affordable coverage options, and promoting the creation of new small businesses. Not only will this benefit the small businesses themselves, but the lower cost they pay for their coverage can have a significant positive impact on the state's economic health and job creation rates.⁴

Throughout this report, sidebars will highlight some of the benefits the exchange can have for small businesses, as well as focusing on policy issues specific to them.

about the pluses and minuses of different plans. Consumers will be able to use these easy-to-understand comparisons to make better choices, which will make insurers compete on cost and quality. And by negotiating with insurers and setting strong standards for consumer protection and quality improvement, the exchange can lower costs by driving reforms throughout the entire health care system.

To ensure that the exchange is stable, the state must take action to make sure it has a large risk pool of healthy as well as sick enrollees. And because the exchange will be one part of a larger health care landscape that includes other public programs, it will also be important to coordinate eligibility, enrollment, and other interactions. Finally, to succeed, it must be accountable to the public and the consumers it serves, and insulated from special interest influence.

What the ACA says about Exchanges

States have a large amount of flexibility to adapt the exchange to their particular goals and the state's market and policy environment, but the federal law does provide some important guidelines and requirements, including:

Timeline: Federal reform gives states the responsibility to establish exchanges for individuals and small businesses by 2014. If states do not establish an exchange by 2014, the federal government will establish one for them.⁵

Funding: States can apply for federal grants to help set up exchanges. By 2015, however, exchanges must be self-sustaining.⁶

Eligibility: Individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. States that currently define a small business as one with 50 or fewer employees may first open the exchange to these smaller businesses and then expand to businesses with up to 100 workers by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017. The state may run separate exchanges for individuals and businesses, or combine them.⁷

How consumers connect to the exchange: The federal government will make a template internet portal available to states.⁸ States are required to create a website to help consumers compare plans, and operate a toll-free hotline to answer questions.⁹

Helping consumers compare plans and sign up: The law directs the federal government to develop ranking systems on cost and quality, as well as an enrollee satisfaction survey tool, for states to use to help consumers compare plans in the exchange.¹⁰ It also requires states to use a standardized format to present health plan options, enroll applicants eligible for Medicaid or another public program into that program, and offer an electronic calculator to help consumers evaluate their expected premiums after any tax credits or other benefits are factored in.¹¹

Benefit package: The federal government will establish an essential health benefits package and levels of coverage, from bronze (the lowest level) to platinum (the highest), and a "catastrophic" plan only available to people under 30 or who are exempt from the requirement to have coverage.¹² States can require additional benefits, but must assume the cost for any subsidies for the additional benefits.¹³

Subsidies: Consumers who make too much to qualify for Medicaid but cannot afford coverage are eligible for sliding scale assistance to pay for premiums. These subsidies are only available on, and will be delivered through, the exchange.¹⁴

Criteria for health plans: The law directs the federal government to set criteria for an insurance plan to be a “qualified health plan” and allowed into the exchange. Criteria will include having sufficient choice of providers and implementing a quality improvement program. The law delegates the enforcement of the certification of qualified health plans to the state exchange.¹⁵ Aside from some narrow exceptions, states may develop and enforce additional criteria for qualified health plans, to better serve the interests of enrollees. For example, the state can empower the exchange to set additional quality standards, negotiate on costs, and engage in selective contracting. The exchange may also exclude plans with premium increases that are unjustified.¹⁶

Reinsurance and Risk Adjustment: The law directs states to establish a reinsurance mechanism by 2014, to protect insurers in the individual and small group markets from having to raise rates because too many of their enrollees are sicker than average. For similar reasons, it also provides for risk corridor and risk adjustment programs.¹⁷

Process: The law requires state exchanges to consult with a range of interests, including health care consumers, small businesses and the self-employed, and requires the exchange to be transparent regarding its costs.¹⁸

Outside of these fairly limited provisions, states can make their own decisions about what their exchange should look like and who should run it.

The States’ Next Steps

Across the country, states are beginning to grapple with their choices. To get an exchange up and running by 2014 will require states to take quick action—and some have already done so by passing exchange legislation. Several states have made key policy decisions and allowed the exchange to begin implementing them. Others have decided to set up the exchange’s governance, while leaving the definition of a specific business plan to the exchange board—or simply set up a study, which would be brought back to the legislature for further action next year.¹⁹ While these latter approaches may allow for more informed policy decisions, they may also threaten the state’s ability to meet the January 2014 deadline.

There is a last set of states that so far, have chosen to do nothing. Such a decision ill-serves consumers; in the absence of state action, the federal government will be obliged to create an exchange for the state, and a federally run exchange will likely not be as strong as one that is set up within the state, and is accountable to the public and consumers.

If a state wants to provide better coverage options to individuals and small businesses and begin lowering the cost of care, it must take quick action to create a pro-consumer exchange that lives up to the promise of a better marketplace for consumers. This report provides a blueprint for how to do exactly that, addressing key implementation issues with section-by-section recommendations.

I: Accountability and Transparency

The opportunity to create an exchange will allow the state to increase competition and improve choices in its insurance market. However, to fully realize this opportunity, the exchange must be accountable to the public, and the individual and small business consumers who will buy their coverage through it. In creating the exchange's structure and governance, the state must ensure that this important new entity is transparent in its operations, and fundamentally accountable to the public interest. By following the recommendations below, the states can ensure that their health insurance exchange reflects these principles.

A Clear Pro-Consumer Mission

The exchange should be operated for the benefit of individuals, businesses and their employees, not insurance companies and providers. This charge should be included in the exchange's legislative mandate and mission, which could read as follows:

The exchange is established in the public interest, for the benefit of the people and businesses who obtain health insurance coverage for themselves, their families and their employees through the exchange now and in the future. It will empower consumers by giving them the information and tools they need to make sound insurance choices. The exchange works to improve health care quality and population health, control costs, and ensure access to affordable, quality, accountable care across the state.

Ensuring Accountability to the Public, Not the Special Interests

The exchange must have an organizational structure that makes it accountable to the public. That accountability can best be insured by creating the exchange as a strong, independent public agency, with a governing board. Allowing the exchange to be governed by a private non-profit organization runs the danger of making it unaccountable to the public or its representatives. At the same time, the exchange will

need to have some degree of independence from the state's government; it must have the ability to set its operating rules, recommend needed legislation, and negotiate on behalf of enrollees. Otherwise it will not have the agility and power it will need to be an effective advocate for consumers. Housing the exchange in an existing government agency could deny it this needed independence.

The governing body for the exchange should consist of representatives drawn from across the state's consumer and business communities. Persons who are or will become enrollees should be selected for service on the board, as well as organizations that represent them. Policy experts and those with detailed knowledge of insurance markets can also render important service. It may be appropriate for government officials, such as the state's Health and Human Services Secretary, to serve in an *ex officio* capacity, but such *ex officio* members should not be allowed to dominate the exchange board.

The people's elected representatives in the state legislature and statewide elected offices should have the responsibility of selecting members of the exchange board through gubernatorial and/or legislative appointment. But to prevent undue political influence, the removal of members should

only be possible in cases of misconduct or malfeasance. Direct election of exchange board members should be avoided, because the impact of special-interest spending could be determinative, privileging industry interests over those of the public in board member selection.

Strong Protections Against Conflicts of Interest

While the exchange will serve many functions, in large measure the most important is its role as a purchaser of insurance. For it to be effective at this task, it must be a zealous advocate for the interests of consumers, which means that it must be free of influence from the insurance industry, brokers, and providers. Consumers need the exchange to deliver high quality, affordable coverage—when it comes to negotiating for a better deal, their interests are at odds with those of the insurers. Because brokers are usually paid by insurers on commission for the policies they sell, they face a similar conflict of interest. So do providers, because pressure on insurers to lower costs might translate to cost pressure on providers. As a result, representatives of these industry interests should not serve on the exchange board.

Spotlight on Small Business

Small business owners, and their employees, should have a voice in the exchange's decisions. They should be consulted in any stakeholder committees or hearings, and representatives of small business should be included on the exchange's governing board, so that they can lend their expertise about what will work for them. Because small business owners and workers will sometimes have different perspectives, both voices should be represented.

Industry stakeholder groups, including insurers, providers, brokers, and others, should have opportunities for meaningful input into the exchange's decisions, especially those touching on technical or workability matters, and should be allowed to share their expertise. When industry representatives serve in an advisory capacity, strong conflict of interest requirements should be in place to ensure that they themselves—and other members of their industry—do not influence decisions that might financially benefit them. An exception to these provisions should, of course, be made for consumers who will financially benefit if the exchange is able to deliver lower costs and higher quality.

Robust Public Participation

Broad public input should be solicited and considered, both in the process of forming the exchange and in its ongoing operation, to ensure that the exchange is meeting the needs of consumers and accomplishing its mission. When setting rules and procedures, the exchange should provide opportunities for public comment, including open hearings and calls for written comments. Stakeholder groups should also be engaged throughout the exchange's decision-making process, including through formal advisory committees.

A similar process should be followed as a state's legislature considers how to create and structure its exchange. Efforts should be made to solicit feedback from consumers, including individual and small business enrollees, and the consumer advocates who represent them. In addition, because

in many states the exchange will serve populations with special health, cultural, and language needs, the exchange should take particular care to make sure that their decisions are informed by these perspectives as well.

Transparency of Budgets and Records

The public—and most importantly, enrollees—need to know that the exchange is working efficiently to promote their interests. The legislature and governor will also need to know the details of its operations, to inform their oversight and deliberations about possible further reforms. As result, transparency and public reporting are critical to allowing the exchange to build the trust it needs to do its job.

The exchange's yearly budget and details of its spending and revenue, including any contract agreements it reaches with insurers or outside vendors, should be made available to the public. Transcripts of hearings and other public proceedings should also be public and easily accessible. Transparency should be the rule across the exchange's activities and records. With that said, the exchange will also engage in negotiations with insurers, which will sometimes require some information to be kept confidential in order to protect the exchange's ability to drive a good bargain on behalf of consumers. Materials related to such negotiations should ordinarily not be open to public disclosure, except where the exchange board determines that disclosure would be in the interest of the public and of enrollees.

II: The Power of Negotiation

A well-made state exchange can help deliver lower costs for individuals and small businesses. Just as big businesses negotiate with insurers, using the bargaining power of their employees to push for lower premiums, so too can exchange enrollees benefit from a muscular exchange that negotiates on their behalf for better choices and lower costs.

But to live up to this potential, the exchange will need to do more than simply take all insurers who want to sell their products to its enrollees. It will have to take a close look at the benefits being offered, and the premiums and cost-sharing being charged, to assess whether they provide a good value.

The federal law requires the exchange to offer a health plan only if offering it is “in the interest of [enrollees].”²⁰ States should flesh out this vague injunction and require the exchange to negotiate with insurers to offer lower cost, higher quality coverage options for consumers. Similarly, the

exchange should monitor year over year premium increases to ensure enrollees continue to get a good deal. And because negotiating power and economies of scale depend on having a large pool of enrollees, the exchange should be made as large as possible.

States should have realistic expectations for what the exchange will be able to accomplish. In particular, its marketing leverage will likely vary from state to state, depending on the number of enrollees and the competitiveness of the market. In some states, the potential benefits of negotiation will be obvious, but they may seem more remote in others. Still, after 2014, the state’s insurance market will see substantial change, and the exchange will likely grow larger and larger over time. Thus, even if state policymakers believe that the exchange’s bargaining power will be initially limited, it should still be created with the power to negotiate so that it can use that power when circumstances change.

A Better Deal for Consumers

A strong exchange is a negotiating exchange. Empowering the exchange in this way will provide consumers and small businesses with an exchange that is not only a transparent and fair marketplace, but also a much-needed advocate standing up for their interests. With insurers competing with each other for access to enrollees, quality will increase and premiums will come down. A negotiating exchange will deliver concrete value for enrollees, with the potential to save consumers millions of dollars.

Some policymakers, as well as the insurance industry, have argued that the exchange should not negotiate for a better deal. Instead, they argue, plans should be allowed to set rates however they like, and be excluded from the exchange only for

flagrant misconduct. This “all willing sellers” model, however, while potentially increasing the number of choices consumers have, would also lead to higher premiums. A negotiating exchange, on the other hand, will need to consider both the affordability of premiums and the number of insurance options available to consumers, so it will be able to balance these concerns effectively.

A further reason to insist on a negotiating exchange is to safeguard taxpayer dollars. The new health reform law provides federal tax credits for Americans whose income could make it difficult to afford health insurance. These tax credits will be delivered through the exchange, and their cost will be pegged to prices on the exchange. As a result, an exchange that successfully negotiates for lower premiums will not only deliver savings to enrollees, but also create savings for all taxpayers.

Spotlight on Small Business

The experience of small businesses illustrates the importance of a negotiating exchange. While large businesses are currently able to leverage the bargaining power of a sizable number of employees, their smaller cousins find that they have little ability to negotiate. With less expertise and fewer potential customers, small businesses often face a market where insurers don’t need to compete for their business.

At the same time, small businesses lack the economies of scale enjoyed by large businesses—when they buy coverage, it may only be for a dozen employees. As a result, the administrative cost of securing coverage is proportionately higher for small businesses. Added together, these two factors mean that small businesses pay on average 18% more than large businesses do for comparable coverage.²²

To solve these problems through a strong exchange, the state must ensure that it is empowered to negotiate on behalf of its enrollees, and take advantage of economies of scale. To best leverage these benefits, states should strive to maximize the number of exchange enrollees. As discussed in the main text, states have the option of immediately allowing small businesses with up to 100 employees onto the exchange and eventually opening it to large employers as well. More enrollees mean greater economies of scale, and greater bargaining power.

The experience of Massachusetts confirms the importance of this feature of an exchange. Through its competitive bidding process, the state's exchange has kept the growth of premiums below 5%, which is half of the level experienced by all commercial health plans in Massachusetts. Because Massachusetts subsidizes the purchase of insurance through its exchange for low income residents, these steps are expected to save the state \$21 million in 2011.²¹

To give the exchange authority to negotiate, it must have the power to exclude low-value plans. The ability to say "no" is a prerequisite for any successful negotiation, and if the exchange is to deliver the maximum value for consumers and businesses, the state must explicitly give it the authority to exclude plans that fail to deliver robust consumer protections, quality care, and reasonable costs.

Stopping Excessive Premium Hikes

The exchange also has an important role to play in policing unreasonable rate increases. By pushing back against insurers with a history of significant rate hikes, the exchange can use its negotiating power to make premium increases more predictable and stable for consumers.

In many states, regulators review insurers' proposed rate increases to ensure that they are justified. The new law sets up a similar procedure at the federal level for states that do not currently review rates. In determining whether a premium increase is justified, regulators weigh some considerations that are similar to those the exchange should use in its negotiations, including whether the benefits offered are reasonable given the premium being

charged. However, rate review also looks to broader issues, including the impact of the rate increase on insurers' solvency and ability to pay future claims.

Because the exchange, unlike a regulator, is concerned first and foremost with the interests of consumers, rate review is no substitute for an exchange with the power to negotiate. But states should take steps to harmonize the exchange's negotiations with their regulatory rate review processes, increasing the exchange's effectiveness and efficiency.

First, the exchange should have the power to act on information from federal and state regulators, and exclude plans with a track record of unreasonable premium increases and no clear plan for bringing them under control. It should also take this information into account as it negotiates with plans. Second, the exchange should participate in the review of products sold in the exchange by providing comments on the reasonableness of the increase and its likely impact on consumers. The same standards should apply to insurance plans whether they are offered on or off the exchange, but the expertise of the exchange should be brought to bear on the plans sold in its marketplace.

Expanding Bargaining Power

The bigger the exchange, the greater its negotiating power. As more people get their coverage through the exchange, it will gain leverage with insurers eager for the business of those enrollees. And the larger it is, the greater its ability to achieve economies of scale to reduce administrative costs. As a result, a large exchange is a strong exchange.

Per the federal law, individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. The law allows states that currently define a small business as one with 50 or fewer employees to first open the exchange to these smaller businesses and then expand to businesses with up to 100 workers by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017.

Because the potential savings for consumers increase with the size of the exchange, the state should aim to maximize both eligibility and enrollment. The state should create a single, state-wide exchange, rather than splinter off its residents into separate regional exchanges depending on where they live, and it should operate a single exchange serving both individuals and small businesses.

It should also plan to open the exchange to employees of large businesses as soon as possible. However, expanding eligibility could create a risk of adverse selection and drive up premiums, for example if large employers with an older workforce flocked to the exchange, while those with younger, healthier workers stayed away (adverse selection is discussed in more detail in Section IV, below). The exchange should be charged with reporting to the legislature its recommendations on how to minimize these risks, so that it can adopt appropriate safeguards as it brings larger businesses onto the exchange.

In addition to opening eligibility to as many people as possible, the exchange should actively reach out to enroll people, because it will need to turn potential enrollees into actual ones, in order to increase its bargaining power.

The Basic Health Program Option

Under the new law, states have the option of creating a Basic Health Program. Under this arrangement, which is similar to existing Medicaid managed care plans, the state offers residents between 133% and 200% of the Federal Poverty Level access to a set of private plans, instead of offering them coverage through the exchange. The state negotiates with the insurers to secure the best possible rates for these enrollees, potentially reducing their cost sharing and providing coverage at a lower cost. States that choose this option may dedicate the federal dollars that this population would have received as tax credits in the exchanges to funding the program.

While this option may be attractive for many states, policymakers must be careful to consider the implications for the exchange if this population gets their coverage through a Basic Health Program instead. Because they would otherwise receive substantial subsidies, these are the potential enrollees most likely to purchase coverage through the exchange—without them, the exchange's bargaining power may be noticeably reduced.

III: Promoting Innovations in Cost and Quality

A health care exchange that pools its enrollees' bargaining power will help give consumers a better deal on their coverage, but it will need to do more to get the unsustainable rise in health care costs under control. That is because while consumers and businesses pay plenty in premiums and out-of-pocket costs, much of our health care spending does not yield the results that we really want—healthier people. Instead, as much as a third of all health care spending goes to treatments that at best are ineffective, and at worst can pose a danger to patient health.²³

The payment systems used by major insurers, both public and private, are one root of this problem. The widely used fee-for-service payment approach rewards providers for the number and complexity of tests and procedures that can be billed, not the quality of care provided or whether the patient gets healthy.

Fortunately, research and the experience of innovative providers across the country have charted a path toward medical care which can better rein in costs and improve patient's health. Primary care physicians

need to be able to work as a part of a team coordinating with a patient's other health professionals so that patients get all the care they need while avoiding unnecessary, duplicative, or harmful tests and procedures. And providers need easy access to updated medical records.

But providers will never achieve these wholesale changes in the delivery of care until payers change the way they pay for care. Insurers will need to move towards paying for quality and results, not volume. And the exchange, in its negotiations with insurers, can drive them to adopt these proven strategies, which will improve enrollees' health and lower overall health care costs.

Strategies to Achieve System Change

Medical Homes: This approach improves the quality of care and brings down costs by encouraging primary care physicians to work closely as a team with other specialists

and health professionals. A team of professionals, led by a doctor or nurse practitioner, is compensated for coordinating all of a patient's care, not just for the number of visits they have or tests they order. That team would have the time and resources needed to deliver the best care. By using electronic medical records, they would also help reduce medical errors and unnecessarily duplicative tests that can happen when one of a patient's doctors is unaware of what the others are doing. The burden of keeping track of tests, prescriptions and treatments will no longer fall solely on a sick patient. A nationwide system of medical homes could improve patient care and save up to \$194 billion over ten years.²⁴

Chronic Disease Management: Chronic disease management is a systematic approach that focuses on promoting a combination of behavior changes and clinical treatments to prevent chronic conditions from causing expensive health emergencies. For example, programs serving diabetes patients can closely monitor diet and other health indicators, to help the patient live a stable life rather than having to be rushed to the hospital for costly emergency surgery. While studies continue to evaluate these programs, research suggests that properly designed disease management programs can successfully reduce costs. Investments in chronic care management could lower costs by up to \$418 billion over the next decade.²⁵

Accountable Care Organizations: Best exemplified by high quality, low-cost providers like the Mayo Clinic, Intermountain Health in Utah, or Geisinger Health in Pennsylvania, Accountable Care Organizations (ACOs) integrate the care patients receive across the medical system. Rather than hospitals, physicians and other providers each being paid separately for individual treatments, under this model all three entities are all part of a single system

which shares the payment for the patient's entire course of treatment and is accountable for the health and outcomes of the patient. In many cases, this allows doctors to be paid by salary, rather than through piecework fee-for-service rates, and creates additional rewards for improving patient health and reducing unnecessary costs.

Bundled Payments: This innovation replaces itemized fee-for-service payments with a single, bundled payment for all treatments, tests, and procedures a patient receives for a given condition. Hospitals, physicians, and other providers who have treated a patient are together reimbursed by a set amount for every patient admitted with a particular diagnosis (which can be adjusted upwards if the patient is especially high-risk and likely to require more extensive treatments). The providers share the payment, so that they are rewarded for delivering high-quality, effective care that ensures the patient will not be quickly readmitted for the same complaint. Properly structured bundled payments can generate enormous savings of up to \$182 billion over ten years.²⁶

The Path to Lower Costs and Higher Quality

These innovative approaches to delivery system reform can result in improved patient care and lower costs. In Medicare, the Affordable Care Act phases in these reforms over the next several years.²⁷ But if these changes are to extend beyond that single program, so that all consumers can receive their benefit, state policymakers should use their exchanges to drive insurers to adopt these reforms.

As discussed in Section II, above, states must act to ensure that the exchange have

the authority to negotiate with plans and set high standards that insurers will need to meet in order to participate in the exchange. While these tools can simply serve as a device to bargain down premium costs over the short term, the possibilities are much broader. Exchanges can also use that authority to accelerate system change that will bring down costs over the medium- to long-term.

The exchange should have a variety of mechanisms at its disposal in accomplishing these goals. If the exchange requires plans to submit competitive bids to participate, the extent and quality of cost-saving reforms should be a required element of every insurer's bid. For example, insurers participating in the exchange could be required to pay providers via bundled payments where appropriate, or reimburse primary care doctors for leading a medical home team.

In the same way that exchanges can negotiate lower premiums as a condition of entry onto the exchange, the exchange should use its bargaining power to push plans to aggressively implement these reforms. Indeed, if the exchange sets strong standards, it can help insurers who are already pursuing similar initiatives, by giving them more leverage with providers who might resist such reforms.

To give any real advantage to the exchange in these negotiations and help bring all health plans up to the level of the highest-performing ones, the exchange must have the ability to say no and to exclude those plans that refuse to take steps to lower costs and improve quality for consumers. It is for this reason that the "all-willing sellers" model for the exchange, often advocated by insurers and other industry interests, is simply inadequate. If a state exchange must accept all comers, it has given up the advantage

it needs to insist that plans adopt these critically important system reforms.

Translating Policy into Results

The exchange's efforts cannot stop once plans have agreed to incorporate these reforms. The exchange must demand strong performance from insurers, and evaluate whether these new policies are accomplishing their goals.

State exchanges should have the authority and resources to monitor plans' compliance with their commitments. Insurers should be required to disclose information on the impact of the reforms they have adopted on quality of care and coverage, cost, outcomes, adherence to best practices and other appropriate information, to allow the exchange to evaluate the effectiveness of their programs. And the exchange should consider this information when considering the plans' participation in the exchange in the future.

Empowering the Consumer

The last ingredient needed for an exchange that delivers lower costs and higher quality is a strong role for the individual consumer. The Affordable Care Act requires exchanges to provide a website where consumers can compare and shop for the plan that is right for them, and requires that it provide some level of price and quality information. But states should go further.

Exchanges should provide easily understandable information about what delivery reforms like medical homes, accountable care organizations, and chronic disease

management mean and how consumers can best make use of them. States should also consider providing a special “seal of approval” that would be visible on the exchange website for those plans that do the best job of promoting high-quality and low-cost care. Policymakers should insist that more detailed metrics evaluating the quality of care and coverage, outcomes, adherence to best practices and other appropriate information be available to consumers through the exchange website. Finally, consumers should be able to access this information easily and understandably as they choose their coverage.

Towards a Coordinated Strategy on Costs and Quality

The exchange will not be the only active purchaser of medical care in the state. Other payers, such as large employers, public employee plans, the state Medicaid plan and union trusts, will likely also be developing their own initiatives to reform how they pay for care. By working together and aligning these programs, states can drive positive change in the health care market even more effectively, so that providers are not subjected to a variety of uncoordinated reform initiatives. Exchanges can play a strong leadership role in convening these multi-payer initiatives and making them effective. States should consider building into their exchange mechanisms allowing it to coordinate with other large purchasers to drive positive change in the marketplace.

IV: Ensuring Stability

The idea of creating health insurance purchasing pools, like those called for in the Affordable Care Act, is not a new one. In the past, many states have experimented with creating such pools, and their experience has shown that mechanisms like the exchange can succeed at improving choice and holding down costs. But experience has also shown that success is not automatic. In some states, the pools have been failures, forced to close their doors by upwardly-spiraling premiums and downwardly-spiraling enrollment.²⁸ In designing their exchange, states must take care to avoid past mistakes and create a stable marketplace for individuals and small businesses.

The past failures can often be traced to a single dynamic. Sicker enrollees congregated within the purchasing pools, with healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage and secure less expensive coverage on their own, which in turn sends premiums within the pool up again. This phenomenon, called adverse selection, can lead to a vicious cycle

that only ends with the destruction of the purchasing pool.

If a state decides to allow insurers to sell their products to individuals and small groups without going through the exchange, as most appear to be planning, the fundamental challenge is to ensure that the exchange does not become a dumping-ground for less-healthy patients, with healthier enrollees purchasing coverage outside of it. This is critical both to protect consumers and to instill confidence in insurers—if they are worried that adverse selection might undermine the exchange, they will be significantly less likely to participate.

Fortunately, the ACA guards against the worst risks of adverse selection by preventing insurers both on and off the exchange from directly discriminating against the sick, and it also contains specific provisions aimed at balancing risk on and off the exchange. But to complement these ACA policies, states should adopt additional measures to ensure that adverse selection does not undermine the viability of their insurance market.

Baseline Protections in the ACA

The Affordable Care Act contains important provisions to avoid adverse selection on state exchanges. Per the federal law, enrollees who purchase a product that is sold both inside and outside the exchange must be in the same risk pool, and insurers must charge the same premium in both cases. The same minimum benefit standards will apply across the entire insurance market as well, limiting insurers' ability to scoop up the healthy by offering low-cost, low-benefit plans. Tax credits will be available to some consumers who purchase coverage on the exchange, making it an attractive option for both sick and healthy. Most importantly, whether an insurer is doing business on the exchange or off, they may not deny coverage to people based on pre-existing conditions, and the ACA's rating rules, which allow insurers to vary premiums based only on age, geography and tobacco use, must apply identically inside and outside the exchange.

Further, all insurers will participate in a series of programs aimed at reducing the impact of differences in enrollee health. These programs (variously labeled reinsurance, risk adjustment, and risk corridors) mean that insurers who cover more sick people face less of a financial disadvantage than they otherwise would. The programs will apply both on and off the exchange, but by increasing the overall stability of insurers' risk pools, they will help reduce the incentive for insurers to segregate healthy enrollees off the exchange.

However, these protections, as important as they are, will not by themselves fully prevent the risk of adverse selection. For example, while healthy and sick enrollees must be charged identical premiums, the same is not true for young and old enrollees—the ACA imposes some limits, but

insurers can still set lower premiums for the young, who tend to be more profitable. As a result, insurers will still have the ability to structure and market their plans to attract younger, less expensive enrollees to their non-exchange offerings.

Further, risk adjustment programs will likely be most effective in equalizing risk across insurers within the exchange—reducing the impact of health differentials across the state's entire health care market will be more challenging. As a result, many insurers may push to keep their non-exchange risk pool as healthy as possible.

States should compensate by incorporating the ACA's protections into their own law. For example, states can create their own supplemental reinsurance programs if the federal one proves insufficient. Further, to the greatest possible extent, states should make sure that identical rating rules apply to their entire insurance market, both on and off the exchange—not only will this help protect against adverse selection, it will also minimize disruption for consumers who move in and out of the exchange. The remainder of this section outlines additional steps states should take to guard against adverse selection.

Eliminating Steering

One way that less-healthy people can wind up in the exchange is if insurers or brokers put them there. While the Affordable Care Act limits the ability of insurers to make greater profits from the healthy than the sick, as discussed above many insurers might still wish to keep their non-exchange risk-pool as healthy as possible.

To guard against this possibility, states should protect the exchange by prohibiting

insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. This prohibition should be policed via the state insurance regulator, as well as the licensing authority for brokers.

Products Available On and Off the Exchange

If certain kinds of products are primarily available either on the exchange or, conversely, off of it, consumers who want those kinds of products will be drawn to that marketplace. That means that if products that appeal most to healthy consumers are primarily available outside the exchange, or if products that sicker consumers will want to buy are primarily available on the exchange, this could create a risk of adverse selection.

A state can reduce this risk by requiring insurers to offer “mirror” versions of all their products, such that they sell identical exchange and non-exchange versions. That way, consumers will have access to a broad array of benefit choices in both marketplaces, preventing the restriction of options that can lead to adverse selection. Additionally, since, as discussed above, the federal law requires that identical products use the same risk pool and charge the same premium both inside and outside the exchange, this would greatly reduce the risk of undermining the exchange.

If that approach is not possible, states could ensure that at least some products are available both inside and outside the exchange. The federal law already requires that exchange-participating insurers offer both at least one silver and one gold product inside of the exchange, so one place to start would be requiring insurers to offer those products outside the exchange as well.

Spotlight on Small Business

The problems posed by a pool of enrollees that doesn't spread risk aren't confined just to the exchange—many small businesses have experienced these issues as well. In most states, insurers currently set their prices based on the average age or health of a small business' employees. This means that businesses with healthier or younger workforces pay lower premiums, while those with older or sicker employees pay more. It also means that for smaller businesses, if one employee gets unexpectedly sick or ages into a new bracket, premiums for the entire business can jump. With the cost of health care already prone to double-digit rises, these unexpected rate shocks make it hard for small businesses to maintain stable coverage.

The exchange and related reforms can help mitigate this problem in two ways. First, by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of a proportional impact on overall costs. Further, because the new reform law will prevent insurers from varying their prices based on the health of enrollees starting in 2014, and limit variation based on age, the risk of premium spikes will be much reduced.

States could go further and require insurers to offer more than one product at those silver and gold levels, or they may insist that plans also offer a product at the highest-benefit platinum tier. Further, states could require insurers who offer catastrophic coverage plans outside the exchange to offer identical plans on the exchange as well—since enrollees of these plans are most likely to be young and healthy, they pose the greatest adverse selection risks.

In developing the precise requirements, the state should closely examine the products currently being offered on its health insurance market, with a goal of ensuring that consumers both on and off the exchange have a robust set of choices between products with varying degrees of comprehensiveness.

Increasing Exchange Eligibility and Enrollment

The risk of adverse selection is closely tied to the total number of the exchange’s

enrollees—if the exchange is large, it will take a much greater imbalance in enrollees’ health status to create an adverse selection problem. Put simply, a larger exchange has a greater “buffer” to protect against adverse selection. This means that outreach and enrollment efforts will themselves help the exchange’s stability. Further, increased outreach may be needed to reach healthier consumers, since in many cases those with health problems are most alert and receptive to new information about coverage options.

There are, of course, many other benefits to having a large exchange—it increases the negotiating power of the exchange, as discussed above, and also helps more of a state’s residents enjoy the benefits of the exchange. The fact that this approach also helps to better guard the exchange against adverse selection means that the state has a further reason to widen the eligibility rules for the exchange (for example, by including larger businesses, so long as the state is careful to open eligibility in a way that does not itself pose an adverse selection risk), and put a strong effort into outreach and enrollment programs.

The Basic Health Program Option

As discussed earlier in this report, the Basic Health Program provides an alternate way that states can choose to cover those between 133% and 200% of the Federal Poverty Limit. Taking these potential enrollees out the exchange’s risk pool could potentially make it more difficult to ensure that the exchange is stable. One cause of this is the simple fact that the Basic Health Program will reduce the raw number of exchange enrollees. However, it is also the case that these consumers are likely to be among the healthiest of exchange’s enrollees, because they receive the most generous subsidies, meaning that both healthy and sick will be likely to purchase coverage. To protect against the potential danger of adverse selection, state policymakers may wish to create reinsurance and risk adjustment mechanisms that link the respective risk pools of the Basic Health Program and the exchange.

Feedback and Monitoring

In addition to adopting the above policies, the state should closely monitor changes in the insurance market once the exchange is up and running, for imbalances in risk, premium spikes, or changes in the types of products available on and off the exchange. This task could be taken on by the exchange itself, the state insurance

department, or some other entity. Regardless, whoever studies the market's stability should regularly make recommendations to the state on any action that is needed to maintain the viability of the exchange, and the appropriate body—whether the legislature, an agency, or the exchange itself—should take swift action to protect consumers by mitigating the problem.

V: Designing a Consumer-Friendly Exchange

Even if the state ensures that its exchange is fair and effective, if it is not easy to use and trusted by consumers, eligible enrollees won't materialize. And if consumers lack the ability to understand their options and make informed decisions, the power of the exchange to drive competition and quality will be undermined.

The exchange is a store where consumers can buy health insurance products—and anyone who's worked retail knows that the consumer experience is critical. For all the attention that must be paid to getting the behind-the-scenes aspects of the exchange to work, the front end is just as important. When a consumer goes to the exchange to buy coverage, will it be a simple, easy process, or will they get frustrated by needless red tape? Will they be able to entrust their personal financial information to the exchange? Will the exchange help them pick coverage that's right for their family? The answers to these questions cannot be taken for granted.

Simple, Streamlined, and Accessible

Many consumers will buy their coverage through the exchange's web portal. States have significant leeway to design that portal, but they must take care to ensure that it is as simple and consumer-friendly as possible. One necessary step will be to clearly label consumers' options, so that they can easily understand what they need to do to sign up for coverage. Another will be to ensure that the portal can analyze the information provided by the consumer and tailor the options it presents accordingly—for example, catastrophic plans should not be presented to those who are not eligible for them.

The exchange must be accessible to all potential enrollees, including those who lack broadband-speed internet connections. For some, the web portal will be the best way for them to buy coverage, but others will need different, equally clear pathways to enrollment, such as the toll-free hotline required by the ACA, or the Navigator program, which will allow the exchange to provide in-person community outreach.

The same amount of care, streamlining and simplification that go into the website should go into the materials and process used by the other access points—hotlines and Navigators. To the greatest possible extent, all three access points should use application processes and materials that are identical, so that consumers who sign up for coverage over the phone can then easily renew online, for example.

However consumers access the exchange, the information it provides must be designed with an eye towards the needs of those who will ultimately be using it. This means ensuring that the language used is straightforward and descriptive, avoiding jargon as much as possible. The state should audit the Flesch Reading Ease and Flesch-Kincaid scores of the various materials and web content being used, to ensure that they are comprehensible to ordinary enrollees—this is especially important because many exchange enrollees will be buying coverage for the first time, making them even less familiar with health coverage terms of art than the ordinary layperson.

Similarly, the state must assess the diverse language and cultural needs of potential enrollees and lay out a plan to meet them—simply offering a Spanish version of the web portal, for example, is a good start but will likely not be enough to guarantee that all consumers are able to use the exchange effectively. A good rule of thumb is that all materials should be translated into any language spoken by at least 5% of potential enrollees, and provision should be made for enrollees speaking other languages that fall below this threshold.

Getting all of these usability details right won't be easy. In addition to setting a strong plan, the exchange must also engage in testing and run focus groups, to make

sure that consumers can easily navigate its various systems. Engaging a broad range of stakeholders in this testing process—including communities with specific language, cultural, and health needs—will help ensure that the exchange has a smooth start-up in 2014.

Empowering Consumer Choice

A well-designed exchange holds the promise of harnessing consumer choice to make the insurance marketplace more competitive. However, if consumers don't understand their options and aren't easily able to determine what coverage is right for them, this promise will be substantially weakened—and unfortunately, this is exactly what consumers currently face on the insurance market. To get past this confusing status quo and provide a consumer-friendly shopping experience, the exchange must do five things:

First, it must help consumers make apples to apples comparisons of plans. The five standardized tiers set out by the ACA will help with this, as consumers will be able to compare products that have roughly similar levels of coverage, but that will not be the extent of a state's power to improve the consumer experience. The exchange should also consider further standardizing its offerings, to reduce unnecessary variation and allow for better comparison-shopping. Finally, the exchange should make it easy for a consumer to compare the important aspects of two different coverage options at a glance, so they can focus in on important differences as they narrow down the list of options.

Second, the exchange should make it easy to find products that meet a consumer's

needs. The consumer should be able to prioritize different criteria, such as whether they care more about price, specific categories of benefits, location and breadth of provider networks, customer service, quality of care, history of premium increases, and so on—and then run a customized search to find plans that meet those particular needs.

Third, the exchange should develop ratings and rankings to allow consumers to understand the strengths and weaknesses of their coverage options. These could include one to five star ratings for particular aspects of coverage, such as those discussed above, as well as a “seal of approval” for high-performing plans. These ratings should be incorporated into the comparison and search tools discussed above.

Fourth, one of the most important pieces of information a consumer must have when choosing their coverage is whether their current doctor or other provider is included in the insurer’s network. There should be easy-to-use search tools integrated into the exchange web portal to allow consumers to know whether changing their coverage will also mean changing their doctor.

Fifth, the exchange must clearly explain the cost of each product, beyond just the monthly premium. Products with high deductibles and coinsurance may lead to consumers paying significant amounts through cost-sharing, and those impacts could be less visible. As a result, the exchange should list, in addition to the monthly premium, the expected yearly cost-sharing under the

Spotlight on Small Business

Currently, small businesses wishing to purchase coverage for their employees face a dizzying array of choices, with insurers offering benefit packages that appear only slightly different from each other, but whose surface similarities can mask substantial variation in covered benefits. Untangling these subtleties, and determining which plans are a good fit for the particular health needs of a business’ employees, can be a full time job by itself. But most small businesses can’t afford a dedicated health benefits manager to perform these tasks.

The steps outlined in the main text will make this task much easier for small business owners. Further, a small business will be able to allow its employees to choose whatever plan they like, rather than the current system, where the business is often forced to rely on a one-size-fits-all approach. And because the exchange will employ Navigators to perform outreach and help enrollees understand their choices, small businesses will have built-in support and advice.

It will be important that the exchange offer a single application for employees to use, regardless of what plan they choose; that it allow the business to make a single premium payment, without forcing it to engage in complicated allocations; and for businesses that qualify for the ACA’s new small business tax credits, they should be able to easily see how those credits will reduce the premiums they will pay.

product for a patient with low, average, and high health needs, to allow for a more informed evaluation of consumer options. Similarly, because some exchange enrollees will receive tax credits to offset the cost of their premiums, a calculator including these savings should be incorporated into the buying process, so that consumers will know what they will actually have to pay. Only by detailing all these aspects of the plan can consumers get an accurate picture of their costs, and choose the plan that is right for their budget and health needs.

Privacy Protections

The exchange will have access to sensitive consumer information, including financial and medical information. If consumers are not confident that the exchange will keep their personal data safe, they will be hesitant to enter the exchange or give it the information needed to make accurate eligibility and enrollment decisions. Building consumer confidence in the privacy and security of their personal information therefore must be a priority for the exchange.

The exchange must develop and implement a plan to ensure that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it, for example in order to make eligibility determinations or process payments. Under no circumstances should the exchange sell personal data, or share it with others for commercial use. Consumers should be able to easily access all of the data the exchange has about them, and make corrections to erroneous information. Protections must be adopted to prevent data breaches or unauthorized access. And in the event that such breaches do occur, the exchange must speedily inform consumers and take strong action to minimize the harm.

The exchange should clearly disclose these protections, so that consumers know that the exchange takes its responsibility to their personal data seriously. Similarly, in order to build trust, whenever the exchange asks for personal information, it should make clear exactly why that information is needed.

Consumer Assistance

Even the best designed exchange will not function perfectly in all cases. Individual consumers will need help in determining their eligibility and picking coverage. They also should have a place to register complaints and suggestions. Consumer assistance programs should be developed in tandem with outreach and Navigator programs, with coordination to ensure that they are all consumer-friendly and give the same information. Language access and cultural competency will be a critical component of successful programs.

Some states already have a state insurance ombudsperson or insurance consumer protection section within an agency, or may partner with separate nonprofit groups to serve this function. The ACA provides funding and technical assistance to such programs, and states may want to use these funds to integrate these existing programs into the exchange as it is developed.

Feedback from these avenues of consumer assistance should be gathered, analyzed, and fed back to the exchange's policymakers, so operations can be analyzed and improved to eliminate common problems. Consumer satisfaction is the ultimate test of the exchange's success; their experiences will be the best barometer for determining what needs to be done to meet the goal of providing affordable, quality, accessible coverage.

VI: Coordinating with Public Programs

While the exchange represents a significant new opportunity to improve the quality and affordability of health insurance, it is only one piece of the state's larger health care landscape. Public programs, including Medicaid and the Children's Health Insurance Program (CHIP), will continue to play a significant role, and the way they interact with the exchange will be important to the success of both.

Medicaid, in particular, will see its eligibility significantly increased in 2014, the same year the state exchange will open its doors. Many of those who apply for Medicaid will not be eligible for that program, but could qualify for tax credits to buy coverage on the exchange—and vice versa, as some of those who enter the exchange might also be eligible for a public program. Further, over time consumers might move from one to the other as their income fluctuates. States that carefully address these eligibility, enrollment, and transition challenges will save money due to increased efficiency, and consumers will have an easier experience getting their coverage. Those that do not will run the risk

of burying the promise of health reform in confusion and red tape.

Beyond these coverage issues, the state can also take action to integrate its public programs with the exchange to achieve greater effectiveness. Some of the consumer tools that the exchange will develop could be used in public programs as well to improve the consumer experience, and aligning the quality-improving, cost-lowering policies pursued by the exchange and public programs will similarly increase the effectiveness of both.

Eligibility and Enrollment

One of the most important functions that the exchange will serve is to help qualifying consumers get access to affordability tax credits to help them pay for their coverage. However, some of those who try to buy coverage through the exchange will inevitably be eligible instead for a public program, such as Medicaid or CHIP. Then, when families actually apply, the

picture could be even more complex, as different family members might be eligible for different sources of coverage.

In order to meet these challenges, the exchange must make it simple for consumers to enroll in the program that is appropriate for them. This means it must coordinate its eligibility systems with those of the state's public programs, to catch whether an applicant for coverage is eligible for one of them instead. If so, the exchange should forward the application to the relevant agency, which can then process the paperwork and enroll the applicant, without requiring the applicant to submit duplicate forms or visit another office.

Similarly, states should make sure that if a consumer applies for a public program such as Medicaid, but does not qualify, he or she is immediately connected to the exchange. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage, and to the extent possible, the state should employ a single eligibility and enrollment system.

At every step, as the state develops its eligibility and enrollment system, it must strive to create a simplified, streamlined process that avoids red tape and efficiently gathers the information it needs, both from applicants and from existing data sources—for example, a state could allow applicants to enter their social security numbers to allow the application system to access their age, income information contained in their tax returns, participation in other public programs, or other needed information.

Creating this streamlined no-wrong-door enrollment system will be important to ensuring that consumers are able to easily sign up for coverage. Not only will this benefit those consumers, it will also be important for ensuring that the exchange has

a stable risk pool—the larger the number of enrollees, the more stable the exchange will be, and the applicants most likely to be turned off by a complex application process will be those who are healthy and least in need of coverage. Further, states will need to both create new eligibility and enrollment systems for the exchange, and update their existing Medicaid systems to account for new eligibility changes in the federal reform law. They should take the opportunity to integrate these systems, rather than creating two parallel but separate systems.

Transitions and Renewals

Year after year, exchange enrollees will need to renew their coverage. If their income increases and they no longer are eligible for subsidies, they likely will continue to purchase coverage through the exchange—but if their income decreases, they will become eligible for Medicaid rather than subsidized exchange coverage, and if they go to work for an employer that offers job-based coverage, they will likely exit the exchange. Similarly, Medicaid enrollees whose incomes increase will become newly eligible for coverage through the exchange. And those who turn 65 will become eligible for Medicare. Managing these transitions will be critical to ensuring that the state's exchange remains stable over time.

Ideally, the state's system will obtain updated information from enrollees in both public programs and the exchange each year (either directly from enrollees, or via tax returns or other data sources). Based on this information, if the enrollee's eligibility has not changed, their coverage should be automatically renewed after giving the enrollee a chance to opt out. If the

enrollee instead becomes newly eligible for some other source of coverage, the exchange should present the enrollee with their new choices—however, even if the enrollee does not specifically take action, the exchange or Medicaid should automatically enroll them.

Only if the enrollee specifically opts out of coverage should they exit the system—otherwise consumers may fall through the cracks, leaving them without coverage and potentially in violation of the federal law’s individual coverage requirement. Differences in the timing of eligibility determinations and the commencement of coverage mean that the state must pay careful attention to realize this goal of seamless coverage and renewal.

Navigators and Outreach

Experience with existing public programs has clearly shown that simply giving consumers new coverage options is not enough to guarantee that they will exercise them—if members of the public do not understand how they can access those options,

they will not take advantage of them. As discussed above, broad enrollment will not only help the beneficiaries affected, but also increase the stability of the exchange’s risk pool, giving the state another reason to prioritize enrolling eligible consumers in the exchange.

Simply posting information on a state website and running a few public service announcements will not be enough to drive the necessary enrollment. Specific outreach efforts will be needed. However, it will be difficult for the state to reliably target those who will be eligible for coverage through the exchange without also targeting those who will be eligible for coverage through an expanded Medicaid program or some other public program. In order to maximize its investment in outreach, then, the state should ensure that its efforts inform members of the public about the exchange as well as about other public programs.

One particular area where states should take into account the role of public programs is in deciding how to run its Navigator program, through which the exchange will contract with individuals and organizations to reach out to particular communities to provide information and help

The Basic Health Program Option

States that opt to create a Basic Health Program will have to make an additional effort to coordinate its enrollment with both Medicaid and the exchange. Enrollees below 133% of the Federal Poverty Limit would be in Medicaid, those between 133% and 200% would enroll in the Basic Health Program, with those above 200% purchasing coverage from the exchange; thus, most enrollees would either move from Medicaid to the Basic Health Program, or vice versa, or from the Basic Health Program to the exchange, or vice versa. However, there will certainly be cases where enrollees “skip” the Basic Health Program, due to large swings in their income. States must make sure that all three systems are prepared for all the possible transitions. Similarly, Navigators should be educated and provide information about the Basic Health Program in states where the option exists.

eligible consumers enroll in the exchange. In many states, insurance brokers or agents have pushed to be the primary or even the sole providers of Navigator services. But while many brokers possess significant expertise about private coverage, and have deep relationships with some small businesses, in many states they may not have the required knowledge about public programs, or the language or cultural skills needed to perform effective outreach to underserved communities.

As a result, in designing their outreach efforts, states should make sure that they have all their bases covered—in some communities, brokers can be an effective information source, but a strong Navigator program should also include a wider array of organizations, particularly those with longstanding ties to underserved communities and constituencies.

Leveraging Consumer Tools and Aligning Incentives for Quality and Lower Costs

As discussed above, the exchange has the opportunity to create ratings, comparison tools, standardized forms, and

other services to allow consumers to easily understand their coverage options when purchasing coverage through the exchange's web portal. While most of these tools will be developed with an eye towards private individual and small group private coverage, some of them might also be helpful for allowing public program beneficiaries to understand their coverage. This will especially be the case in states that have a significant number of Medicaid managed care plans, since in those states, enrollees will similarly have to assess which of their options is the best choice for them. As a result, states may want to incorporate these aspects of the exchange's systems into those of their public programs, as well as pursuing the enrollment and eligibility integration discussed above.

Finally, as discussed above, one of the key policy innovations exchanges should pursue is encouraging private insurers to adopt payment reforms that would reward high-quality, lower-cost care. The impact of these reforms will be heightened if similar reforms are also instituted in the public programs administered by the state, so that providers don't face a confusing, contradictory array of different payment systems. State employee benefit plans could also be incorporated into this effort.

Endnotes

- 1 H.R. 3590, the Patient Protection and Affordable Care Act of 2010 (hereafter “ACA”).
- 2 Julie Appleby and Jaelyn Schiff, *New Survey: Consumers Who Buy Their Own Health Insurance Report Big Rate Increase Requests*, Kaiser Health News, June 21, 2010, at <http://www.kaiserhealthnews.org/Stories/2010/June/21/Consumers-Who-Buy-Their-Own-Health-Insurance-Report-Big-Rate-Increase-Requests.aspx>.
- 3 Council of Economic Advisers, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees*, July 25, 2009, at <http://www.whitehouse.gov/administration/eop/cea/Health-Care-Reform-and-Small-Businesses>.
- 4 Jonathan Gruber for Small Business Majority, *The Economic Impact of Healthcare Reform on Small Businesses*, June 2009, at <http://www.smallbusinessmajority.org/small-business-research/economic-research.php>.
- 5 ACA § 1311(b), § 1321(c).
- 6 ACA § 1311(a), (d)(5).
- 7 ACA § 1311(b)(2), § 1312(f)(2).
- 8 ACA § 1311(c)(5).
- 9 ACA § 1311(c)(5), (d)(4).
- 10 ACA § 1311(c)(3), (c)(4).
- 11 ACA § 1311(d)(4).
- 12 ACA § 1302(e).
- 13 ACA § 1311(d)(3).
- 14 ACA § 1401, § 1402.
- 15 ACA § 1311(c)(1), (d).
- 16 ACA § 1311(e).
- 17 ACA § 1341, § 1342, § 1343.
- 18 ACA § 1311(d)(6), (7).
- 19 For example, California passed legislation in 2010 creating its exchange, which has since begun conducting meetings and preparing its business plan (the California exchange’s website, at <http://www.healthexchange.ca.gov>, contains information on its meetings and activities). By way of contrast, recently-passed bills in Maryland and Oregon will require state-created exchanges to bring their business plans back to their respective legislatures for approval. See Maryland SB 182, Oregon SB 99. Representing a third, even slower approach, the Illinois legislature has set up a study committee to make recommendations on creating an exchange. Illinois HB 1577.
- 20 ACA, § 1311(e).
- 21 Massachusetts Connector, *Report to Massachusetts Legislature on Implementation of Health Care Reform, FY 10*, November 2010, at <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf>.
- 22 *Economic Effects of Health Care Reform*.
- 23 See Statement of Peter R. Orszag, Director, Congressional Budget Office, *Opportunities to Increase Efficiency in Health Care*, Health Reform Summit of the Committee on Finance, United States Senate, June 16, 2008, at <http://www.cbo.gov/ftpdocs/93xx/doc9384/06-16-HealthSummit.pdf>.
- 24 U.S. PIRG Education Fund, *The Three Trillion Dollar Question*, August 2009, at <http://cdn.publicinterestnetwork.org/assets/2NNG6HYLrHJ46vODIsH5eg/USP-costs-report-final-7-28.pdf>.
- 25 *Id.*
- 26 The Commonwealth Fund, *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, June 2009, at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Finding-Resources-for-Health-Reform.aspx>.
- 27 See ACA, Title III.
- 28 See Timothy Stoltzfus Jost for the Commonwealth Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, July 2010, at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>.