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**“States Have Good Reason to Implement
Health Insurance Exchanges”**
(By Doug Anderson¹; March, 2011)

The Patient Protection and Affordable Care Act calls for the creation of health insurance exchanges to be operational in every state by January 1, 2014.² A health insurance exchange is a marketplace where consumers and small businesses can shop for, select, and enroll in private health insurance. Exchanges also help low-income people obtain federal subsidies to pay for private insurance and enroll in public programs such as Medicaid.

In order for a state to establish an exchange by 2014, it must begin implementation soon. To assist states, HHS has made federal funding available for full implementation.³ To receive federal funding, a state must show that it will meet HHS benchmarks and deadlines.⁴ If a state elects not to create an exchange, or if HHS determines that a state is not making the necessary progress, HHS will establish an exchange in that state.⁵

While some states have moved quickly to implement exchanges, other states have been slow to act because of opposition to the new law. Recently, 21 state Governors wrote to HHS Secretary Kathleen Sebelius saying the new law “should be repealed by Congress if the courts do not strike it down first.”⁶ Recognizing the law may not be repealed or struck down, the Governors asked HHS for flexibility in operating exchanges and

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² The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1311(b) (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152 (2010), is referred to herein as the “Affordable Care Act.”

³ U.S. Department of Health and Human Services, New Announcement for State Planning and Establishment Grants for the Affordable Care Act’s Exchanges, Funding Opportunity No. IE-HBE-10-001, CFDA 93.525 (July 29, 2010); U.S. Department of Health and Human Services, New Announcement for Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Funding Opportunity No. ___, CFDA 93.525 (January 2, 2011).

⁴ Affordable Care Act, §1311(a)(4)(A) (2010).

⁵ Affordable Care Act, §1321(c)(1) (2010).

⁶ Letter from 21 State Governors to HHS Secretary Kathleen Sebelius (February 7, 2011).

waivers as to provisions of the law. Since this correspondence, President Obama and HHS have expressed willingness to give states flexibility, but they are unwilling to support changes that undermine the goal of providing affordable coverage to more Americans. Thus, with no assurance that the new law will be overturned or amended, states are left to decide whether they should move forward with an exchange or let the federal government do so.

Although many states and their Governors have legitimate concerns about the new law, if it remains in effect, states should establish their own exchanges if they want to control the way the federal law is implemented. Many critical decisions about how exchanges will work have not been made, and states that establish exchanges can make or influence those decisions. A state that operates an exchange can implement the law in ways that preserve the strengths of local insurance markets, whereas a state that decides not to operate an exchange will have less influence over market participants, products and forces.

The following are some important reasons why states should implement their own exchanges rather than depend on the federal government do so.

1. A state based exchange can preserve competition among insurers whereas a federal exchange may not do so.

Many states have health insurance markets with a variety of carriers competing for business, including national, regional, and locally-owned carriers. Each of these types of carriers can provide quality coverage at competitive prices within the communities they serve. In states with competitive markets and a variety of carriers competing for business, federal implementation of an exchange can undermine competition and threaten affordable coverage.

The Affordable Care Act gives flexibility to states to address competitive issues within exchanges. States can choose whether to limit the number of carriers selling coverage in an exchange, or not. As explained in guidance issued by HHS in the Fall of 2010:

States have a range of options for how the Exchange operates from an “active purchaser” model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an “open marketplace” model, in which the

Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings.⁷

Whether the “active purchaser” or “open marketplace” approach is most appropriate for a particular state may depend on the characteristics of the insurance market in a state. In some states, including those with strong competition, an “open market” approach may be appropriate because it can: (1) foster healthy competition among carriers; (2) allow regional and local carriers to participate; (3) allow for a variety of products to be offered to consumers; and (4) keep carriers from withdrawing from the market by not limiting participation to a few carriers.

In other states, an “active purchasing” approach may be chosen in order to (1) leverage the exchange’s purchasing power; (2) compel carriers to bid on exchange business with their best products and price; and (3) promote the development of innovative products focused on improved quality. It should be noted, however, that in a competitive market with a variety of carriers, an “active purchasing” model can cause market disruption. It can give carriers selected for the exchange increased market share across all markets and thus a competitive advantage that can extend to business outside of the exchange. An active purchasing model can therefore change market dynamics which could have adverse effects on consumers.

Regardless of whether a state prefers the open marketplace or active purchasing model, if a state elects not to establish an exchange, it cannot control how an exchange will deal with competitive issues. This is concerning because HHS has not indicated how it will approach competition within an exchange. For example, if HHS contracts with a limited number of national carriers to participate in federal exchanges, regional and local carriers could be excluded and placed at a competitive disadvantage in the markets they serve. Limiting participation could also lead to consolidation of carriers, which has tended to be bad for consumers.

2. States are better able to address adverse selection.

“Adverse selection” occurs when people in poor health buy a particular health insurance plan more often than people in good health. Since people in poor health tend to have higher health care expenditures, this causes premium rates for all consumers in the plan to go up. When rates increase, people in good health are more likely to drop coverage or change plans. This can cause even more people in good health to drop coverage. When

⁷ U.S. Department of Health and Human Services, Initial Guidance to States on Exchanges (Nov.18, 2010), http://www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html.

this happens, “adverse selection” becomes a cycle that builds from year to year to create an insurance pool with only high risk individuals, causing insurance to be unaffordable.

Many insurance regulators and experts have legitimate concerns that the Affordable Care Act may cause adverse selection in the individual and small group markets. The following requirements of the Affordable Care Act cause some of the concern:

- Insurers must offer coverage to any person who applies. This may allow people to wait until they are sick to buy coverage.
- Although people are required to buy insurance if they can afford to do so under the new law, the income tax penalty for not doing so may not be large enough to get young and healthy people to buy coverage.⁸
- Insurers cannot impose “pre-existing condition exclusions” on enrollees, encouraging unhealthy people to wait to buy coverage.
- Insurers may not charge higher premium rates to people in poor health.
- Insurers may sell different coverage outside of an exchange. This may cause some insurers to design products for sale outside the exchange to attract healthy consumers and avoid unhealthy ones.

While the Affordable Care Act has a number of provisions designed to fight adverse selection, such as the individual and employer responsibility requirements, there are still opportunities for adverse selection to occur. States are in the best position to combat adverse selection and may take action to prevent it. In this regard, states can:

- Design risk adjustment and transitional reinsurance programs to ensure risks are fairly distributed to all insurers in the market;
- Develop market rules to apply equally to products sold inside and outside an exchange;
- Require insurers to offer the same product inside and outside of an exchange;
- Merge the individual and small group markets;
- Monitor companies to make sure risk adjustment and pooling is working effectively and as expected;
- Ensure that exchanges are attracting large pools of diverse risk, so that enrollees with different risk characteristics are all well represented; and
- Ensure that a variety of carriers are offering coverage.

⁸ The penalty is \$95 per year in 2014, rising to \$695 per year in 2016. See, Affordable Care Act, §§1501 and 10106(b)(3) (2010), as amended.

If a state chooses not to implement an exchange, it may not be able to effectively address adverse selection and rising premium rates within its insurance markets.

3. A state can coordinate its exchange with its Medicaid and SCHIP programs to achieve cost savings.

The Affordable Care Act provides that all Americans with incomes under 133% of the Federal Poverty Limit will be eligible for Medicaid coverage.⁹ In addition, exchanges must screen all applicants for Medicaid eligibility and, if applicants are found to be eligible, enroll them in coverage.¹⁰

Currently, eligibility and enrollment in Medicaid differs from state to state. In some states, the application and enrollment process is disjointed, complex, and costly. For example, some states require people to apply in person at county offices. Mail-in and online enrollment is not permitted. Eligibility criteria can be complex, with intricate asset tests and disregards, and required documentation. Sometimes, eligibility and application requirements differ depending upon the type coverage. Computer systems can also be outdated. In fact, some states have separate systems for eligibility and claims processing, which complicates the accuracy of coverage and reimbursement.

Some of these problems can be addressed by a state if it chooses to implement an exchange. Federal funding is available to create new IT systems to determine eligibility and enroll people in Medicaid coverage. These new systems can complement, and in some cases replace, antiquated Medicaid systems currently in use. Updated IT systems which focused on the Medicaid medical benefit can increase efficiencies, allow for better data extraction and analysis, and allow states to better implement health care quality improvement strategies. Since Medicaid programs are operated by states, these efficiencies are best achieved if states participate.

States also can align Medicaid coverage with private insurance coverage to achieve savings. Under the Affordable Care Act, HHS will develop an “essential health benefits package” similar to large employer coverage.¹¹ States can tailor Medicaid coverage to be comparable to “essential health benefits” such that citizens can access comparable benefits at all income levels. Developing Medicaid coverage to be comparable to essential health benefits will ease the transition of consumers from Medicaid to private insurance, or vice versa, when incomes change. States are more likely to achieve these efficiencies if they help to design the benefit offered in an exchange.

⁹ Affordable Care Act, §2001 (2010).

¹⁰ Affordable Care Act, §1311(d)(4)(F) (2010).

¹¹ Affordable Care Act, §1302 (2010).

States also have the opportunity to develop “basic health programs” to provide coverage to citizens between 133% and 200% of the Federal Poverty Limit.¹² A “basic health program” allows eligible individuals to purchase a state created health plan rather than purchase coverage directly from a private insurer. Federal funding is available for “basic health programs” equal to 95% of the premium tax subsidy a subscriber would have received if they had enrolled in private coverage.¹³ States can achieve savings because the federal funding for basic health programs may fully cover the cost of the program, and possibly more. States that don’t participate in federal reform cannot take advantage of these savings.

4. States that establish exchanges can align exchange standards with state initiatives to improve health care quality and reduce costs.

Many states are pursuing initiatives to improve health care quality. For instance, states have undertaken initiatives to establish patient centered medical homes, reduce avoidable hospital readmissions, encourage the formation of accountable care organizations, and modernize health care provider payment systems. Although there are common approaches to improving health care quality, states often take different approaches. One reason why states take different approaches is that the quality of health care differs from state to state and region to region.¹⁴ Thus, to effectively implement health care quality improvements, states must develop priorities and strategies tailored to the circumstances of the state.

States can establish exchanges aligned with the priorities and strategies of state quality improvement initiatives. Exchanges are places where consumers shop for, select and purchase health insurance. Health insurance plays a critical role in health care quality because insurance pays providers for the services they rendered. The current system of reimbursement – fee-for-service – pays providers for volume and units of care regardless of the quality of care. States are working with carriers to develop ways in which to pay providers to reward them for positive health outcomes and effective care.

Through exchanges, states can establish standards, ratings or rewards for plans aligned with the quality improvement. For example, a state with a patient centered medical home initiative can publicize health plans within an exchange that support medical homes and the patients that use them. In similar ways, an exchange can encourage carriers to

¹² Affordable Care Act, §1331 (2010).

¹³ Affordable Care Act, §1331(d)(3) (2010).

¹⁴ See, *Dartmouth Atlas of Healthcare*, the Center for Evaluative Clinical Sciences, Dartmouth Medical School (1998), <http://www.dartmouthatlas.org/downloads/atlas/98Atlas.pdf>.

address preventable adverse medical events, support accountable care organizations, and reform provider payment systems to reward quality. Notably, since different states take different approaches to quality improvement, states are best suited to operate exchanges in ways that are aligned with quality initiatives.

As a cautionary note, in the same way that “active purchasing” may cause consolidation of the market by limiting the number of carriers that can participate in an exchange, implementation of quality initiatives through an exchange can have similar results. If an exchange establishes minimum standards that only a few carriers can meet, other carriers will be excluded even if they are making good progress toward the quality standards. Care must be taken to set standards, ratings and rewards that strike a balance between desired quality improvements, on the one hand, and competitive markets, product choice, and reasonable price, on the other hand. Since health care is delivered locally and insurance markets differ from state to state, states are best suited to operate exchanges in ways that support quality improvements.

5. States can involve insurance agents in exchanges whereas the federal government may not do so.

Insurance agents can play an important role in helping individuals and business shop for, understand and enroll in coverage. They interface with insurers, analyze plan options, consult as to benefit and contribution arrangements, make recommendations as to tax-deferred savings accounts, and provide advocacy during the insurance claim process.¹⁵ It is unclear, however, whether insurance agents will have a role in coverage sold through an exchange.

The Affordable Care Act does require that each exchange have a “navigator program” with funding for individuals and organizations to educate the public, distribute information and facilitate enrollment in exchange products.¹⁶ Navigators may be insurance agents but they are not required to be. Notably, the law provides that a “navigator” cannot receive compensation from an insurer related to enrollment in a qualified plan, which would preclude the current system for compensating agents.¹⁷

With regard to exchanges implemented by the federal government, no assurance has been given that insurance agents will have a role to play. Only if a state chooses to implement

¹⁵ See, National Association of Insurance Commissioners, Resolution to Protect the Ability of Licensed Insurance Professionals to Continue to Serve the Public, adopted by the NAIC Joint Executive (EX) Committee/Plenary (Aug. 8, 2010); http://www.naic.org/documents/index_health_reform_resolution_protect_insurance_professionals%20.pdf.

¹⁶ Affordable Care Act, §1311(i)(3) (2010).

¹⁷ Affordable Care Act, §1311(i)(4)(A)(ii) (2010).

an exchange can it partner with insurance agents to include them in the new system. If a state decides not to participate in an exchange, there is no guarantee that insurance agents will be allowed to participate. A federal exchange with centralized operations could result in local insurance agents losing their jobs and being replaced by centralized call centers in distant states.

6. States can coordinate exchange operations with insurance department oversight.

It will be important that exchanges and state insurance departments coordinate their activities. Under the new law, they will both regulate the same insurance companies and product offerings. For example, with regard to the benefit plans, insurance departments will review policy forms for compliance with state and federal law, while exchanges will certify plans as meeting federal standards. With regard to rates, insurance departments will make sure rates are actuarially justified and comply with the law, while exchanges will require carriers to justify premium rate increases and may exclude plans if rates are too high. As to consumer assistance, insurance departments will help consumers resolve complaints against insurers, while exchanges will help consumers select and enroll in coverage. And, as to solvency, insurance departments will ensure carriers have income streams and reserves necessary to pay claims, while exchanges may require insurers to justify rate increases which could impact solvency.

These activities must be coordinated so there is no duplication of effort, dual regulation, or conflicting positions being taken. Exchanges and insurance departments should coordinate their policy and rate review activities so that rates are reviewed once without contradictory rulings or guidance. Consumer assistance programs should be coordinated with no overlapping responsibilities. And, review of rate increases by exchanges must be coordinated with department solvency oversight to make sure rates being charged are adequate for future solvency. A state that chooses to implement an exchange can make sure exchange activities are coordinated with the insurance department oversight.

Conclusion

Some states have legitimate concerns that the Affordable Care Act will raise premium rates and cause some individual and businesses to lose coverage. However, states would be wise to establish exchanges on their own terms. While the federal government may do a good job at implementing federal exchanges, insurance markets differ from state to state, and states are better able to implement solutions tailored to their markets. States can achieve the best outcomes in implementing the Affordable Care Act if they are involved in establishing their own exchanges.