

Improving the Health Insurance Exchange

SUMMARY

Both the House and Senate health reform proposals include a new type of health insurance “store” called the health insurance exchange. The role of the health insurance exchange is to encourage vibrant competition among health plans that results in high quality, understandable insurance options for consumers. This brief outlines some important differences between the House and Senate bills and highlights the provisions that will make the exchange as robust as possible.

The bottom line is that the final, merged bill should contain the best elements from both bills: (1) retain strong transparency provisions from the Senate proposal; (2) eliminate the option to sell non-group coverage outside the exchange, as is done in the House bill; and (3) enact the exchange at the national level, with an option for state-operated exchanges for states with the interest and capacity to do so.

What is a Health Insurance Exchange?

From the consumer’s perspective, a health insurance exchange is like a health insurance “store” – a place where individuals and small employers could choose from a variety of insurers offering high quality, understandable benefit plans. This store provides a single point of entry to the insurance market, making it easier to shop. The exchange would have reliable, easy-to-use information about each of the health plan options, making it easier to compare plans and choose the one that best matches your needs and preferences.

Features of a Good Exchange

In the absence of a robust public plan option, health insurance exchanges are potentially the best way to force insurers to compete on quality and price.¹ An effective exchange does this by having a large number of “shoppers” and providing easy-to-use information on health plan price, quality and benefits.

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First and foremost, a robust exchange must be the source of coverage for a significant portion of the population. The exchange must be large enough to attract participating insurers and must give those insurers enough patient volume that they can negotiate effectively with doctors and hospitals. Large size also helps ensure that the exchange has an average pool of both healthy and sick enrollees.²

How large is large? According to one study, an exchange should comprise at least 20 percent of the local non-Medicare, non-Medicaid insurance market.^{3,4} Even this threshold may be too low in our nation's smallest states, so the authors set a further threshold of at least 100,000 enrollees purchasing in the exchange. An important point of clarification: this threshold refers to enrollees who would be "pooled" together for insurance purposes, which can differ from the total number of enrollees purchasing in the exchange. For example, the House bill envisions a national exchange, yet it is likely that this exchange will sell state-based insurance products. Thus, the standard effectively applies to the number of persons who can be pooled together in the exchange. Under the Senate bill, individuals and small groups would be pooled separately (with a state option to pool them together). Hence, the effective standard is at least 100,000 individual purchasers and 100,000 small group purchasers in each state exchange.

Reliable, easy-to-use information about the policies sold in the exchange, when used by a large number of shoppers, could drive quality improvements and help control costs. For consumers to shop effectively, these benefit plans should be limited in number and standardized. If there are many different benefit plans, all offered at different prices, it becomes virtually impossible for consumers to make a rational choice – regardless of how good the comparative information is. As experience with Medicare Parts C and D has shown, too many choices means consumers often do not select the best plan for them, thereby providing little incentive for health plans to compete on price and quality.⁵

How Do The Two Bills Measure Up?

Both bills contain many similarities. For example, both bills make the exchange the only place where people can use the new "credits" for coverage you buy on your own.⁶ Additionally, both bills require individuals to have health insurance. Both bills require health plans participating in the exchange to adhere to a uniform set of federal standards, ensuring that a minimum level of coverage will be featured in all plans offered in the exchange and standardizing (somewhat) the amount of variation that plans can exhibit above that minimum.⁷ Together, these features provide a powerful incentive to purchase through the exchange.

While the exchanges can't regulate premiums directly, they can deny excessive premiums – an important protection for consumers. Both bills require the exchange to consider whether plans seeking to sell in the exchange have "excessive" premiums.

But the two bills differ in some very important ways (Table 1 on page 5). Our key concerns are:

Consumers Union recommends against the sale of individual (non-group) policies outside the exchange.

Consumers Union recommends a national exchange, with an option for states to create their own exchange.

- The Senate bill allows individual (non-group) policies to be sold outside the exchange. In our view, allowing outside sales is likely to undermine the effectiveness of the exchange by fragmenting the market. Outside sales allow insurers to structure their products to attract the healthiest enrollees, rather than spreading risks broadly and competing on price and quality. The provision is likely to confuse consumers who now have to shop in two market places to get the “best deal.”⁸ We note that the Senate bill requires insurers to pool together their non-group enrollees from inside and outside the exchange when they set their premium rates. However, nothing in the bill requires insurers to offer coverage in both venues. In other words, insurers could choose to only sell products outside the exchange – thereby circumventing the protective conditions. Consumers Union recommends: adopt the House approach which does not permit the sale of individual (non-group) policies outside the exchange.⁹
- Both bills permit the sale of small group coverage outside the exchange but only the Senate bill contains the requirement that insurers pool their enrollees from inside and outside the exchange when they set their premium rates. The Senate’s approach helps protect the exchange against “adverse selection” and Consumers Union recommends incorporating the Senate approach into final bill. We further suggest that this approach be strengthened by requiring insurers who wish to sell outside the exchange to sell the same plan within the exchange. If insurers are permitted to sell coverage only outside the exchange, they will find ways to draw off the lower-risk people, leaving the exchange with a disproportionate share of high-risk, costly enrollees. We also recommend that states be given the option of prohibiting outside-the-exchange sales. Finally, we recommend the legislation commission a GAO study that examines the costs and benefits of restricting small group coverage to sales within the exchange, as has been recommended by some analysts.¹⁰
- The Senate bill calls for exchanges to be state-based, with options for multi-state exchanges or multiple, sub-state exchanges.¹¹ In contrast, the House bill calls for a national exchange, with an option for states to create their own exchanges. Consumers Union recommends that the House approach be incorporated into final bill. A national health exchange will mean a uniform exchange structure, available to all Americans at the same time. Making state-based exchanges the starting point is likely to mean very uneven results for consumers, as demonstrated by our country’s experience with state-created HIPAA plans¹² and with state initiatives with respect to CHIP coverage.¹³ Indeed, several states are considering constitutional challenges to the final reform statute.¹⁴ States with the capacity and willingness to improve on the Federal model can do so under the House approach.
- The Senate bill calls for separate, state-based exchanges for small businesses and individuals.¹⁵ In contrast, the House bill puts individuals and small groups in a single exchange and pools them together for premium rating purposes. The Senate approach will mean greater administrative costs for our country as marketing, enrollment and other functions will be duplicated across both individual and small group exchanges, across 50 states and also

Consumers Union recommends: a study of exchange performance and exploration of other risk pooling approaches for our smallest states.

Consumers Union recommends incorporating additional benefits standardization into the final merged bill.

by insurers who will perform these functions as part of selling outside the exchange. To minimize this duplication and lower costs for consumers, we again recommend the House approach, but also urge that elimination of outside sales of small group coverage be studied as a future option.

- Under the proposed Senate rules, some of our nation’s smallest states (for example, the Dakotas, Montana, Delaware and Vermont) may have trouble establishing exchanges with a sufficient number of members. If small group enrollees are pooled separately from non-group and outside sales are permitted (as is done in the Senate bill), these exchanges will have an even more difficult time meeting the minimum size threshold for an effective exchange. Even with the larger pools created by the House, the small population in these states may not attract many competing insurers. Consumers Union recommends that the Secretary of HHS be directed to study the exchange performance and explore other approaches to creating large risk pools in these states.
- The Senate bill contains very strong provisions for the timely and accurate collection of health insurer data and a strong consumer bill of rights (for plans selling within the exchange). Consumers Union recommends: adopt these Senate provisions in the final merged bill.
- The bills are alike in that they use an “actuarial value” standard to define the plans that can be sold.¹⁶ Unfortunately, this actuarial value standard will provide insurers with ample room to design benefits in ways that attract or discourage particular types of enrollees, possibly resulting in adverse selection. Hence, it is critical that the bills also contain protections to guard against this outcome. Consumers Union recommends incorporating additional benefits standardization into the final merged bill. Of particular importance, the ban on annual benefit limits should prohibit annual benefit limits of all kinds, as is done in the House bill. Further, insurers should be required to have among their offerings, a standard plan which is identical in all respects, allowing consumers to truly compare their options on an apples-to-apples basis.

TABLE 1 –HOUSE AND SENATE REFORM BILLS: HEALTH EXCHANGE PROVISIONS

Provision	House	Senate	How to Make it Better
Exchange Operation	National, with an option for a state waiver to set up their own exchange(s).	State-based, with a state option for regional or multi-state exchanges and a federal fallback if states do not create an exchange.	Adopt the House approach, lowering administrative costs and ensuring the law's provisions are implemented evenly for consumers across the nation.
Start Date	2013	2014	Adopt the earlier 2013 start date.
Who can purchase in the exchange?	Individuals (without an employer ¹⁷ or public coverage option) and firms up to size 100 (after time).		No changes.
Criteria for insurers to participate in Exchange	The Exchange "certifies" that plans are "qualified health plans" and comply with licensing, reporting and other established standards. Can deny participation to plans determined to have excessive premiums or terminate plans that do not comply with standards.	Exchanges "certify" that insurers comply with Federal standards with respect to a) marketing, b) sufficient choice of providers, c) networks include essential community providers, and d) have clinical quality accreditation, accurate and timely disclosure of various info. Exchanges can deny participation to plans with unreasonable premium increases.	Strengthen the bills by bringing in language which would make the exchange a "prudent purchaser." ¹⁸ In other words, allow the exchange to bargain with insurers to bring down premiums. ¹⁹
Provisions to guard against too few insurance choices?	Includes a new public plan option ²⁰ (available nationwide).	The Senate bill includes a provision for "multi-state" plans, regulated by OPM, but it is not clear if this will improve consumers' insurance choices. ²¹	Include the public plan from the House bill. In addition to adding a competitor in areas with few insurers, the presence of a public plan option should foster price and quality competition because the public plan would serve as a widely understood benchmark plan.
Must insurers offer the full range of permitted plan designs?	Insurers must offer the basic plan (70% Actuarial Value ²²). If insurers offer a basic plan, they may also offer the next tier, and so on.	Insurers must offer the middle two plan tiers (70% and 80% Actuarial Value). At their option they can also offer the other two plan designs.	The healthiest enrollees are likely to be attracted to the lowest cost – but least generous – plan designs. Thus, we recommend the Senate approach which ensures that insurers participate in the more comprehensive plans that appeal to less healthy enrollees, thus spreading risks more broadly.
What information will help consumers shop?	Insurers must use a standardized "disclosure" form to describe benefits so that consumers can compare plans on an "apples to apples" basis.	The Senate bill includes similar disclosure provisions but also includes the requirement that plans include an illustration of patient cost-sharing under common medical scenarios. The bill also provides for standardized plan quality information.	Adopt the stronger Senate provisions to help consumers shop.

TABLE 1 –HOUSE AND SENATE REFORM BILLS: HEALTH EXCHANGE PROVISIONS

(CONTINUED)

Provision	House	Senate	How to Make it Better
Can Individuals also purchase coverage outside the exchange?	No individual health plans may be sold outside the exchange, except grandfathered plans.	Individual health plans may be sold outside the exchange.	Exchanges are more effective if they are the exclusive market for coverage. CU recommends the House approach.
Can Small Groups also purchase coverage outside the exchange?	Yes	Yes	CU recommends a study of the pros and cons of eliminating outside-the-exchange small group sales, and that this option permitted on a state-by-state basis.
Are there provisions to ensure that "outside-the-exchange" enrollees are pooled with "inside-the-exchange" enrollees?	No. Result: insurers can charge lower premiums for small group coverage outside exchange, although the coverage must conform to the same rating rules and minimum benefit standards as coverage inside the exchange.	Yes. Insurers must pool together enrollees from inside and outside the exchange and charge both the same price.	To the extent that outside-the-exchange sales are permitted, CU recommends Senate approach. CU further recommends that insurers selling outside the exchange be required to offer the same plan inside the exchange, to prevent insurers from circumventing pooling rules.
Marketing Safeguards	Specifically prohibits "improper steering" of high-risk people into the exchange by insurers or employers.	HHS would develop a marketing standard that prohibits practices that discourage enrollment of individuals with high health needs.	CU recommends that both provisions be included in the final bill, with the penalty for violating these standards clearly specified. ²³

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ENDNOTES

- ¹ While Consumers Union endorses a public plan option, as of this writing it appears likely this provision will be dropped from the final bill.
- ² While both the Senate and the House bill feature risk adjustment, risk adjustment methodologies are imperfect and will not result in the same benefits as a large risk pool featuring an average mix of healthy and unhealthy enrollees.
- ³ Enthoven, Alain, Kramer, William, Riemer, David, Minarik, Joseph. *Health Reform Needs Better Insurance Exchanges*, Committee for Economic Development, December 16, 2009.
- ⁴ The experience of CalPERS, California's public employee retirement system with over a million enrollees, reinforces the finding that both size and market share matter. CalPERS was very effective at driving cost and quality in the early-mid 1990s. However, in 2003 CalPERS' costs represent less than 3 percent of the total health expenditures in California. A round of insurer consolidations and hospital system consolidations resulted in market dominance by a handful of hospital systems in most of California, and CalPERS lost much of its bargaining power. Despite having 440,000 members covered by Kaiser (the insurer with the largest share in the program), this total represented less than 6.5 percent of all Kaiser California members.
<http://www.calstrs.com/about%20calstrs/Teachers%20Retirement%20Board/agendas/bod0503pdf/bs0507.pdf>
- ⁵ See Consumers Union, *Simplifying Health Insurance Choices*, June 2009.
- ⁶ The Senate bill also restricts the small business tax credits to coverage purchased through the exchange. The House bill does not include this restriction.
- ⁷ In addition, health plans offered through the exchange would have to abide by state laws that govern the marketing and sale of health insurance, as long as those laws are at least as protective as the federal rules.
- ⁸ Approximately 45% of consumers who purchase on their own after reform will not qualify for subsidies according to estimates from the Congressional Budget Office. These consumers would have an incentive to examine the choices in both markets.
- ⁹ Except for grandfathered plans.
- ¹⁰ For example, Enthoven et al. op cit.; Timothy Jost, *Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues*, The Commonwealth Fund, December 2009; and Elliot Wicks, *The Insurance Exchange In Health Reform: Essential Characteristics*, October 14th, 2009, Health Affairs Blog.
- ¹¹ If the Senate state-based approach is adopted, it becomes even more critical that the bill provide a strong federal "fallback" in the event state implementation is too weak or features insufficient enrollment.
- ¹² The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required states to provide a coverage option that compiles with the law's group-to-individual portability provision, among other things. By Fall 1997, three states had failed to enact at least some HIPAA protections. Faced with these defaults, the resources initially allocated to HCFA (now CMS) to implement HIPAA quickly proved inadequate. K Pollitz, N Tapay, E Hadley, and J Specht. "Early Experience With 'New Federalism' In Health Insurance Regulation," *Health Affairs*, July/August 2000, Vol 19, Issue 4, 7-22.
- ¹³ The 1997 enactment of SCHIP gave states \$40 billion over 10 years to provide health coverage for uninsured children in families that earn too much to qualify for Medicaid but not enough to afford private insurance. The SCHIP funding formula gave states three years to spend their initial annual allocations. At the end of those three years, any unspent state funds were taken back. While most states moved quickly to design and implement expanded health coverage for children, several states lagged behind and had to return funds. In FY 2003, a point of relative maturity in SCHIP, ten states had spending more than twice as high as their federal allotment for that year, while five states spent less than half their allotment in that year. Genevieve Kenney and Debbie I. Chang. "The State Children's Health Insurance Program: Successes, Shortcomings, And Challenges," *Health Affairs*, Volume 23, Number 5 September /October 2004.
- ¹⁴ David D. Kirkpatrick. "Health Lobby Takes Fight to the States," *The New York Times*, December 28, 2009. <http://www.nytimes.com/2009/12/29/health/policy/29lobby.html>
- ¹⁵ States are given the option of creating a combined exchange.
- ¹⁶ See Consumers Union, *What will an "Actuarial Value" Standard Mean for Consumers?*, December 2009.

- ¹⁷ Employees with access to employer coverage are normally prohibited from using tax credits to purchase coverage in the exchange but there are exceptions. The “manager’s amendment” to the Senate bill includes a “free choice voucher”. This provision requires employers who offer coverage to permit certain employees to take their employer contribution into the exchange to purchase coverage. (Employees with access to employer coverage are normally prohibited from purchasing in the exchange, unless their employer is a small firm that offers exchange coverage.) To be eligible for this voucher, employees must fall into a “gap”: their contribution to employer coverage must exceed 8% of their income (thus freeing them from the individual mandate) but be less than 9.8% of income (if greater, they would be eligible for premium subsidies in the exchange). An employee who uses a voucher is not eligible for a premium tax credit. The CBO estimates that a very small number of enrollees will meet the terms of the free choice voucher--about 100,000 nationwide (December 19 2009 Letter From CBO to Harry Reid on Managers Amendment).
- ¹⁸ The bill drafted by the Senate’s Health, Education, Labor, and Pensions (HELP) Committee included such language.
- ¹⁹ Experiments with insurance exchanges at the state level suggest that any exchange cannot be strong negotiator with health plans unless it is the exclusive source of coverage for the people it represents. Hence, the non-exclusive approach used by the Senate is a cause for concern. Elliot Wicks. *The Insurance Exchange In Health Reform: Essential Characteristics*, Health Affairs Blog, October 14th, 2009. <http://healthaffairs.org/blog/2009/10/14/the-insurance-exchange-in-health-reform-essential-characteristics/>
- ²⁰ See Consumers Union, *The Public Plan: A New Type of Competitor*, September 2009.
- ²¹ In their analysis, the CBO concludes: “Whether insurers would be interested in offering such plans is unclear, and establishing a nationwide plan comprising only nonprofit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.” December 19 2009 Letter From CBO to Harry Reid on Managers Amendment.
- ²² See Consumers Union, *What will an “Actuarial Value” Standard Mean for Consumers?*, December 2009.
- ²³ If the Senate approach prevails, allowing the purchase of coverage outside the exchange, it will be even more critical to protect against inappropriate marketing practices. Experience with the exchanges at the state level suggests that insurers will find many subtle and not-so-subtle ways to steer higher-risk people to the exchange.