

American Health Benefit Exchange

The Patient Protection and Affordable Care Act (“PPACA”) requires the creation of state-based health insurance exchanges for individuals and small businesses to purchase insurance.¹ These exchanges must be in operation by January 1, 2014.²

The creation of health insurance exchanges is a pillar of the new health care reform law — it’s estimated that by 2019, they will serve as a gateway for an estimated 29 million people to access coverage.³

Background

Exchanges are essentially organized insurance marketplaces, which, if they are designed and function well, could provide consumers with a “one-stop shop” to compare and purchase health insurance and enroll in public coverage programs, as well as use the power of a large risk pool to generate competition among health plans based on quality and cost.

The law creates two kinds of exchanges: American Health Benefit Exchanges for individuals and Small Business Health Options Program (“SHOP”) Exchanges for small business owners. While the federal government (primarily through the Department of Health and Human Services (“HHS”)) will set minimum standards, the new law delegates primary responsibility for governance and operation of the exchanges to the states. For example, states may merge the individual and SHOP exchanges, partner with other states to form regional exchanges, or form multiple exchanges within their state, so long as each one serves a geographically distinct area.⁴

However, if HHS finds that a state has elected not to run an exchange, or that its exchange won’t be operational by January 1, 2014, then HHS must operate the exchange or find a non-profit entity to do so.⁵

¹ PPACA § 1321(a)(1)(A).

² § 1311(b).

³ The Congressional Budget Office (CBO), “Cost estimate for amendment in the nature of a substitute for H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)”, Mar. 20, 2010, available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

⁴ § 1311(f).

⁵ § 1321(c).

Examples: Purchasing Insurance in Marketplace Today (2010)

Dennis is a 45-year-old children's performer, and a survivor of testicular cancer. His income ranges from \$30-\$40,000 per year. He's self-employed and needs to buy coverage in his state's individual insurance market. He does an internet search of health plans in his area, and sends in applications for 10 different policies. After waiting four weeks for any carriers to reply, Dennis receives 5 offers of coverage, four of whom impose a benefit limit with no coverage for any cancer treatment, and one of which imposes higher cost-sharing for prescription drugs and doctor's visits. All of them include a premium surcharge, averaging 70% of the base premium. Dennis decides he can't afford the coverage, so remains uninsured.

Paul, 58, and Sandy, 60, run a hog farm in Iowa. Sandy has diabetes that she's successfully managed with diet and medication. They just switched insurance companies on the advice of their insurance broker [the broker received a 30% commission from the new company]. Shortly after buying the policy, Paul's doctor told him he needed shoulder surgery. Three days after he was out of the hospital, the health plan rescinded his policy, leaving him on the hook for a \$10,000 bill. The company argued the shoulder injury was a "pre-existing condition" that Paul hadn't reported in the application. Paul and Sandy couldn't find other coverage in the private insurance market, so they now purchase through their state's high-risk pool. They pay \$1400 per month in premiums, yet still face a \$1000 deductible each year.

New Marketplaces for Insurance

Consumers and small business owners will be able to compare and purchase insurance plans in person, through the mail, phone or a web portal that contains comparative information about participating insurers, including eligibility, availability, covered benefits, premium rates, cost-sharing, provider networks, and critical financial information such as the amount plans spend to pay claims relative to administrative costs (also known as the "medical loss ratio").⁶ Consumers will be able to use an electronic calculator to determine their actual cost of coverage, taking into account any premium assistance they receive.⁷ The exchanges are also required to maintain a toll-free consumer assistance hotline and make information available in a culturally and linguistically appropriate manner.⁸

The legislation envisions that exchanges will be more than just clearinghouses that connect consumers with health plans. Rather, exchanges may offer only "qualified" health plans that meet requirements related to marketing and network adequacy, and offer at least a minimum essential benefits package.⁹

⁶ § 1103.

⁷ § 1311(d)(4)(G).

⁸ See §§ 1311(d)(4)(B), 1311(i)(3)(E) and § 1001, adding new PHSA §§ 2715(b)(2), and 2719(a)(1)(B).

⁹ § 1311(d)(2).

This benefit package will be defined in regulation, but must, at a minimum, include the following general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic disease management services
- Pediatric services, including oral and vision care¹⁰

The comprehensiveness of coverage in each plan will be standardized into four “tiers”: bronze, silver, gold and platinum, with bronze plans being the least generous and platinum being the most generous. All participating plans must offer at least a silver and a gold level option.¹¹

Outside of the exchange, not all plans need to be qualified, but individuals may only access the premium subsidies if they enroll in a qualified plan within the exchange.¹² In addition, exchanges are responsible for ensuring the plans meet minimum certification

criteria, and allowing them to participate only if doing so is “in the interests of” individuals and employers in the state.¹³ The exchanges must also encourage plans to compete based on the value of their services, by publicizing plan ratings based on quality, price and enrollee satisfaction.¹⁴

Exchanges will also perform important regulatory functions, determining who is eligible for premium subsidies, certifying individuals who are exempt from the new requirement to purchase health insurance, and sharing that information with the Internal Revenue Service. They will also verify whether employees are eligible for premium assistance through the exchanges because affordable employer-sponsored coverage is not available to them. Further, exchanges are required to help employers meet their obligations under the new law, by providing them with information on their employees’ enrollment in health plans through the exchange.¹⁵

Streamlining Enrollment

Exchanges must offer annual open enrollment periods as well as special enrollment periods for changes in circumstances (i.e., the birth of a child), and provide a standardized form that all exchange participants may use to enroll.¹⁶ And exchanges are empowered to de-certify any

¹⁰ § 1302(b).

¹¹ §§ 1301(a)(1)(C)(ii), 1302(d).

¹² § 1402.

¹³ §1311(e)(1).

¹⁴ § 1311(c).

¹⁵ § 1311(d)(4).

¹⁶ §§ 1311(c)(6), (c)(1)(F).

plans that use marketing techniques or benefit designs to discourage sicker individuals from enrolling.¹⁷ The exchanges are also responsible for identifying individuals who are eligible for Medicaid, CHIP, or any other available state or local public programs and enrolling them in the appropriate program.¹⁸

Further, the new law provides grants to consumer assistance programs and requires exchanges to fund “navigators,” organizations that can help inform the public about the availability of qualified coverage and financial assistance, and help enroll eligible individuals in the coverage that’s right for them.¹⁹

Using Transparency to Hold Plans Accountable

The legislation sets out new requirements for transparency and plan disclosure that will give consumers unprecedented access to information about benefits, cost-sharing, and plans’ business practices, as well as enhance regulators’ ability to identify and crack down on bad behavior.

For example, plans must provide a standardized summary of benefits to consumers that uses uniform definitions of insurance and medical terms, describes cost-sharing charges, and details exceptions and limitations on coverage, all in culturally and linguistically appropriate and easily understandable language.²⁰ Plans must also provide information to enrollees on the availability of in- and out-of-network providers.²¹ Further, plans must provide a “coverage facts label” that illustrates examples of an enrollee’s likely cost-sharing if they experience an illness, such as breast or prostate cancer.²²

For plans to be certified to participate in the exchanges, the new law also requires them to disclose information on certain business practices, such as claims payment policies and practices, financial disclosures, enrollment and disenrollment, the number of claims denied, rating practices, cost-sharing and payments for out-of-network coverage, enrollee rights and any other information required by HHS.²³

Addressing Quality and Cost

The health reform legislation envisions another role for the exchanges: driving improvements in the quality of care delivery and generating cost savings for consumers and businesses. PPACA includes a number of provisions to achieve this goal. To encourage quality improvement, plans must report to HHS and their enrollees on what programs they are implementing to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, promote prevention and wellness, and reduce health disparities. HHS will post these reports on the web portal.²⁴ Further, to participate in the exchange, plans must be accredited by an entity such as the National Committee for Quality Assurance (NCQA), which accredits

¹⁷ § 1311(c)(1)(A).

¹⁸ §§ 1311(d)(4)(F), 1413.

¹⁹ § 1001, adding PHSA § 2713, § 1311(i).

²⁰ *Ibid.*, adding PHSA § 2715.

²¹ § 1311(c)(1)(B).

²² § 1001, adding PHSA § 2715(b)(3)(F).

²³ § 1311(e)(3).

²⁴ §1311(g)(1).

health plans based on quality performance and patient experience. Other requirements for plans include: implementing provider payment strategies to improve quality and patient safety, requiring participating hospitals to implement patient safety systems and use discharge planning for patients, and including in their networks only those doctors and other providers who implement certain quality improvement mechanisms.²⁵

Efforts to use the exchanges to contain premium increases include requirements that plans post on the web information about premium increases and justifications for those increases, and providing exchanges with the ability to exclude plans who propose unjustified premium increases.²⁶ Policymakers also hope that the large insurance pools created by the exchanges will generate administrative efficiencies and sufficient purchasing clout for the exchanges to negotiate premium discounts with health plans.

Examples: Purchasing Insurance Through the Exchange (2014)

Dennis logs onto the web portal for the new exchange in his state. He enters some basic information about himself: age, zip code and income, and immediately learns that, based on his income from last year, he's eligible for a small premium tax credit. There are 16 plans available in his area, all of which must provide him coverage if he applies, and are forbidden from excluding cancer care from his covered benefits. He uses the website's interactive features to rank the plans based on highest patient satisfaction, and to see which plans include his oncologist in their networks. He also uses the electronic calculator to determine how much premium he will owe, as well as an estimate of his likely cost-sharing if his cancer returns. He finds a plan that suits his needs, and signs up immediately, using the online enrollment form. The government helps with his premiums, leaving him with monthly premium payments of \$260. If he needs extensive medical care for any reason during the year, he knows the maximum he'll pay out of pocket will be \$3,900.

Paul and Sandy don't have internet access at their farm, so they call the exchange's 1-800 number to learn about their insurance options and purchase a plan. They speak with an insurance counselor who inputs some basic information about them and discovers that there are three plans offering coverage in their area. They get instant quotes for all three plans, and two are within their price range. The counselor mails them information about the quality ratings, benefits, and provider networks for those two plans. Paul and Sandy compare the offerings, and choose the plan that has the lowest cost-sharing for Sandy's diabetes care. They're not eligible for premium credits because their income is too high, but their coverage, at \$1000 per month, is cheaper than what they had in the high risk pool, and comes with a deductible of only \$100.

²⁵ § 1311(c).

²⁶ § 1003, adding new § 2794(a) to Public Health Service Act.

Challenges in Exchange Design and Implementation

The concept of exchanges is not new. A number of states have experimented with exchanges — Massachusetts being a recent example that has demonstrated some success. However, the Massachusetts experience has been the exception and not the rule — most state experiments have been disappointing, largely because the exchanges have attracted sicker and more costly enrollees, or have been unable to attract sufficient numbers of people or plans to remain viable.²⁷ In fact, if not well-implemented and operated, exchanges could result in increased costs for consumers. To achieve a more rational, transparent market, competition based on value and not cherry-picking, and lower premiums overall, a number of challenges must be addressed:

Adverse Selection

Minimizing the potential for adverse selection is essential to the long term viability of exchanges. In past state experiments, exchanges have tended to attract sicker and more costly enrollees.²⁸ These sicker enrollees tend to drive premium prices higher, causing healthier individuals to seek coverage elsewhere, compounding the problem of increasing premium costs. In insurance terms, this is known as a “death spiral”.

Because the new law allows an insurance market to exist outside of the new exchanges, there is a high risk that health plans and employers will take advantage of the rules to “dump” people with high health costs into the exchange.

PPACA includes some provisions to try to mitigate this risk, but federal and state governments will likely need to implement additional protections. PPACA requires health plans to treat individuals in all of their plans (except for grandfathered plans) as part of a single risk pool, and must agree to charge the same premium rate for a plan they market both inside and outside the exchange.²⁹ However, these provisions would not affect health plans that operate exclusively outside the exchange, and plans are not required to offer the same products in and outside the exchange.

The new law also requires the use of risk adjustment, reinsurance, and risk corridors as tools to prevent adverse selection.³⁰ However, the success of these tools depends very much on how they are designed and implemented, and responsibility for this largely rests with the states. Very few states have experience with risk adjustment methodology, so these tools will need ongoing oversight and adjustment by the federal government to address market inequities.

²⁷ See M. Merlis, A Health Insurance Exchange: Prototypes and Design Issues, Issue Brief No. 832 (Washington D.C.: National Health Policy Forum, June 2009).

²⁸ Ibid.

²⁹ §§ 1312(c)(1), 1301(a)(1)(C)(iii).

³⁰ §§ 1341, 1342, 1343.

PPACA also attempts to keep a level playing field, among plans by requiring them, in and out of the exchange, to meet a number of market reform requirements, such as:

- Guaranteed issue and renewability of coverage.³¹
- Banning premium variation based on health status or gender, and limiting variation based on age (3:1), geography, family size, and tobacco use (1.5:1).³²
- Prohibiting pre-existing condition exclusions.³³
- Requiring plans in the individual and small group market to offer the minimum essential benefits package, as defined in PPACA.³⁴
- Banning lifetime and annual dollar limits on coverage of essential benefits.³⁵
- Requiring coverage of preventive health services without cost-sharing.³⁶
- Requiring plans to allow their members to participate in approved clinical trials relating to the prevention, detection, or treatment of cancer or other life-threatening diseases, and to cover the routine costs of trial participation.³⁷

Keeping the rules the same for plans inside and out of the exchanges is critical to discouraging them from using differences in the rules to game the system and divide the sick from the healthy. Unfortunately, plans with “grandfathered” status (i.e., those that were in existence prior to the law’s enactment) are exempt from many of these requirements, including, significantly, the new rating rules and the requirement to offer a minimum essential benefit package. Other plans, such as large-group or self-insured plans, are also exempt from many of these new rules. In addition, plans operating outside the exchange, that are not “qualified,” will not have to offer the essential benefit package or meet the same marketing and network adequacy requirements.

States can ensure the rules are the same by enacting conforming market protections in the state-regulated market outside the exchanges, but not all states will have the resources or ability to pass new laws or to enforce consumer protections and guard against adverse selection. PPACA allows the federal government to step in and operate an exchange if a state is unwilling to do so, but the legislation is silent on the federal government’s ability to step in if a state is failing to enforce the new market rules or pass the legislation necessary to prevent adverse selection. If not addressed, these market discrepancies could result in significant adverse selection against the exchange.

There is also risk of adverse selection within the health insurance exchanges, if sicker individuals and groups gravitate to certain plans because of their benefit structure, provider network, or

³¹ § 1201, adding PHSA §§ 2702, 2703.

³² Ibid., adding PHSA § 2701.

³³ Ibid., adding PHSA § 2705(a).

³⁴ Ibid., adding PHSA § 2707.

³⁵ § 1001, adding PHSA § 2711.

³⁶ Ibid., adding PHSA § 2713.

³⁷ § 1201, adding PHSA § 2709.

other factors. This has been a challenge for other insurance exchanges. For example, the federal Office of Personnel Management (OPM), which operates the Federal Employees Health Benefits Program (FEHBP), began in the 1980s to limit differences among participating plans to minimize the growth of adverse selection within its pool.³⁸

In addition to keeping the rules the same, the size of the risk pool in the exchange matters a great deal. One way exchanges can keep costs down for enrollees is to act like a large employer does in the marketplace — using the size of its risk pool to attract the best health plans and force them to compete based on quality and price. If the exchanges are unable to attract sufficient numbers of enrollees, they will have trouble negotiating the best rates, managing risk and reducing the impact of risk selection by insurers in the market.

Governance and Financing

The governance of the exchanges is also critical to their long-term viability. Yet PPACA is largely silent on the specifics of what sort of oversight body and staff leadership the exchanges must have. For example, it leaves the state to decide whether the operating entity will be a government agency such as the state insurance department or Medicaid agency, or a separate non-profit.³⁹ The law also says nothing about the size or composition of a governing board, such as whether patient advocates should have designated seats, or whether insurance company executives should be barred from participating (as they are in Massachusetts). The Administration will need to provide further detail on both of these issues in its guidance to states.

PPACA provides grants to states for planning and establishment of the exchanges.⁴⁰ However, by 2015, the exchanges must be able to sustain themselves financially. One likely scenario is that exchanges will charge a small assessment to participating health plans, but runs the risk that premiums would be higher inside than outside. How the state exchanges generate the revenue necessary to stay in business could have significant impact on important governance decisions, as well as the choice of plans and premium costs within the exchanges.

Conclusion

The new health insurance exchanges are critical to the success of health care reform. In order for cancer patients and their families to experience real changes in their ability to access, choose, and purchase comprehensive health insurance that meets their needs, policymakers at the national and state level must tackle critical challenges related to the design, implementation and governance of these new exchanges. These policymakers will need input from cancer advocates to ensure their decisions fully reflect the needs of patients and their families.

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³⁸ National Academy of Social Insurance (NASI), “Administrative Solutions in Health Reform,” Jul. 2009.

³⁹ § 1311(f).

⁴⁰ § 1311(a).