

Facing the Future

Setting up health insurance exchanges is one of the big, early tasks for lawmakers.



BY RACHEL BRAND

Ada May Roberts worried each year about renewing her health insurance. She feared being told the price had doubled or the insurance company would not renew her policy.

So every fall, the Massachusetts innkeeper spent hours with insurance salespeople, reading the fine print and filling out medical forms. Then she prayed she'd be covered.

All that changed three years ago. On the

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first day the Massachusetts Health Connector opened, Roberts typed her name, birthday and zip code into a website. In five minutes, she had a list of 22 plans—rated gold, silver or bronze. It took her only 10 minutes to buy health insurance. Since then, her rates have dropped \$300 a month, and she never fears being kicked off.

“I’m happy, happy, happy,” says the 59-year-old. “The weight of uncertainty has been lifted. Massachusetts got it right.”

Welcome to the future of health insurance. In three years, as many as 16 million people will buy inum through such online

trading posts, and the number will swell to 31 million by 2020. Insurers won’t be able to deny folks coverage because they are in poor health, and plans will be easy to compare.

But state lawmakers have lots to do before that day comes. They must decide whether to offer an exchange, who will run it, and how it will work with insurers.

Then they must launch the exchange into a fiscal environment that is anything but inviting. The overall cost of getting exchanges up and running is expected to be \$4.4 billion nationwide, although some federal funds will offset the cost.



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KANSAS INSURANCE COMMISSIONER

IT'S THE LAW

A core tenet of federal health care reform passed in March is this: The federal government wants more people to have health insurance.

So in 2014, the government will help 19 million people become insured for the first time. Some will qualify for subsidies, others for an expanded Medicaid program. This help is specifically for people who are unemployed, self-employed or work for companies that don't offer coverage.

At the same time, it will be against the law not to have health insurance, except in some

specific cases. People who flout the law will pay a penalty that varies by income.

Nobody knows how many people will use the carrots or respond to the sticks.

“Over time, we’ll build the expectation that it’s part of people’s personal responsibility to buy health insurance,” says Kansas Insurance Commissioner Sandy Praeger.

Regardless, exchanges will play a role. “If you are going to move into a world in which people buy insurance on their own,” says Jon Kingsdale, former commissioner of the Massachusetts Connector, “you need a vehicle to make it relatively easy for them to do so.”

ONLINE MARKETPLACE

Exchanges are designed to make it easy to shop for and buy insurance. They're often compared to airline ticket websites such as Expedia.com. But exchanges go further.

Imagine if Expedia.com gave shoppers information on the quality of flights—their on-time frequency, customer service ratings and the quality of the food. Exchanges will provide such qualitative information about health plans.

They also will not sell plans that fail to meet minimum quality standards and benefit packages set out by the federal government.

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UTAH HOUSE SPEAKER DAVE CLARK

They’ll make it easy for consumers to shop by grouping health plans into tiers—bronze, silver, gold and platinum—based on how much of the cost customers take on. Health care reform also requires insurers to justify annual price increases to the exchange board.

Finally, exchanges will be the portal through which people determine if they are eligible for Medicaid, federal subsidies or other programs, such as CHIP, the Children’s Health Insurance Program. That’s a daunting information technology challenge in the next three years for the existing state IT infrastructure.

“But this is an opportunity to take highly fragmented, at times very inefficient and cumbersome eligibility systems, and bring them into the 21st century,” says Kingsdale.

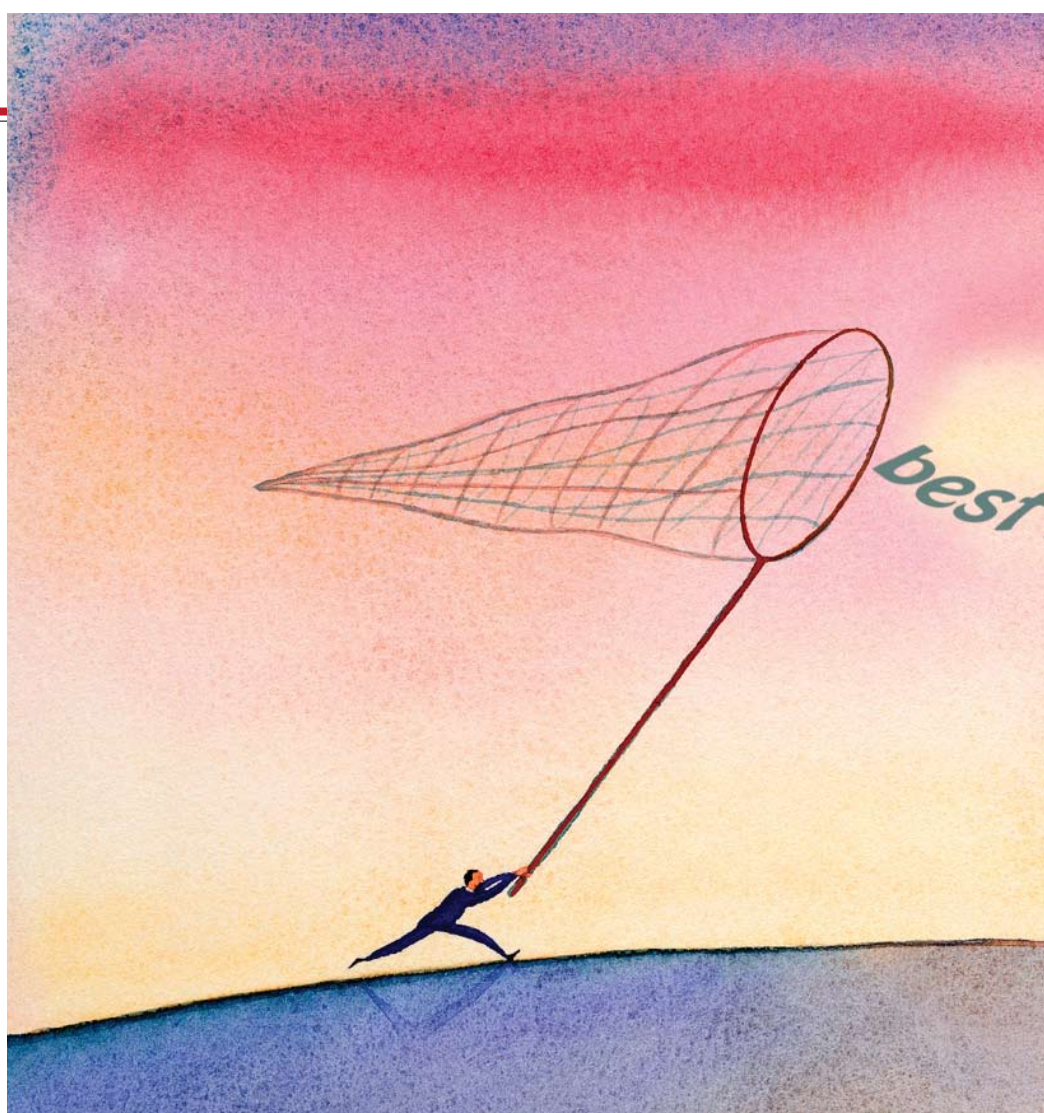
THE CLOCK IS TICKING

The timeline to set up exchanges is short—just three years. So state leaders considering exchanges—the alternative is to allow their citizens to use a federally established exchange—should pass authorizing legislation in 2011, experts say.

“If you have not already begun to implement, you are behind,” says Utah House Speaker Dave Clark. “A lot of folks are waiting on the political winds, but I would hope your legislative leaders would dig in and get started.”



HOUSE SPEAKER
DAVE CLARK
UTAH



Here are some key dates.

In September, many state leaders sent letters to the U.S. Department of Health and Human Services asking for \$1 million to fund planning for exchanges.

Within months, the federal government is expected to announce details of much larger developmental grants, possibly tens of millions of dollars, to pay for information systems and other exchange-related infrastructure.

By January 2013, states will have to show the U.S. Department of Health and Human Services they have a “functioning” exchange. If not, state residents will be steered to a federally established exchange.

Exchanges open in January 2014.

“By 2013, states should be well along with having a designated organization and the administrative systems in place,” says Richard Curtis, president of the Institute for Health Policy Solutions. He noted that even if exchanges are ready to go then, they will have to wait until complementary parts of health reform go into effect in 2014.

WHO’S LEADING?

Right now, only Massachusetts and Utah have functioning exchanges. Both will need changes to fit federal law.

Other states are taking first steps. This fall, Colorado legislators are holding public meetings on the exchanges. In Iowa and Kansas, executive agency heads are working through early implementation issues.

California lawmakers in September passed legislation to authorize work on the exchange, lay down guiding principles and set up a governing structure. At press time, Governor Arnold Schwarzenegger had not signed the bills.

All this preamble is needed, because once they dig in to writing legislation, lawmakers must make some important, potentially controversial, decisions.

First, who will be in charge of the exchange? The options include a state agency, an independent governmental entity or a non-profit.

Governance is crucial because an exchange

plan for me

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CALIFORNIA SENATOR ELAINE ALQUIST

behaves like a business, selling insurance, and a government—determining eligibility. It’s e-commerce meets social services.

“Who runs it will determine the direction and flavor,” says Kingsdale.

Existing state agencies might flavor the exchange with their own spices. Massachusetts’ exchange is run in an independent agency governed by a nine-member board. California’s proposed exchange would be run by an independent agency governed by a five-person board of health insurance experts, appointed by the governor’s office and the



SENATOR
ELAINE ALQUIST
CALIFORNIA

Legislature. To avoid conflicts of interest, there would be no doctors or insurers on the board.

“We want people with knowledge of the health care marketplace to be on the board because the exchange is, in effect, selling insurance,” says California Senator Elaine Alquist.

“We chose a small board because we want it to be able to reach consensus quickly and easily. Additionally, because the exchange will be competing in the private insurance market, it will need to make decisions quickly,” she says, “but it is still important to have public hearings and to be accessible and accountable to the public.”

Utah, by contrast, runs its exchange through the state Office of Consumer Health Services. Other states, such as Kansas and Colorado, are looking at using existing state agencies.

Colorado Senator Betty Boyd says she’s “not sure I see another department being created in these fiscal times.”

PICK AND CHOOSE?

One of the most controversial decisions legislators will need to make is whether an exchange can pick or, in legislative language, “selectively contract,” with health plans.

Go back to the Expedia.com example. Imagine if it could pick a handful of airlines to work with and lock out the rest in the interest of negotiating a better deal for consumers.

Some say that would promote competition, others say the opposite.

Although federal law says exchanges can’t dictate price to health insurers, states can go beyond minimum federal requirements on health plans in the best interest of consumers, says Curtis of the Institute for Health Policy Solutions.

“An exchange can say, ‘Look, here are our criteria, and we want to see your competitive bids across the board,’ ” Curtis says. “This introduces two levels of competition, both to



SENATOR
BETTY BOYD
COLORADO

get into the exchange and among plans within the exchange.”

California’s legislation would let the exchange selectively contract with health plans, a provision California health plans strongly oppose.

“The governor’s signature on these bills would harm Californians’ access to health insurance,” John Graham of the Pacific Research Institute wrote in a recent newspaper article. “Limited choice means higher costs.”

California policy experts took this approach because they think it will allow them to get the best value for consumers.

“As a bulk purchaser, the exchange will have significant market clout in the individual market, and it should seek to get a good deal on price and on improving quality,” says California’s Alquist. “Part of the way we do this is by picking plans on the basis of value and quality compared to their competitors.”

Kingsdale, who consulted on California’s legislation, points out that “while there are no guarantees in life, using discretion in the service of bringing down price and creating value is a good thing.”

Other legislators feel selective contracting could stymie market competition, or even shut down some plans.

Selective contracting “becomes a real problem if a state decides the only way individuals and small groups can purchase is through this state exchange,” says Praeger of Kansas. “Then the ability to deny some plans access might put them out of business.”

Utah’s Clark says his state doesn’t plan to allow selective contracting. “The [reform] legislation requires the insurance companies to justify premium increases. We have not found the need to interject ourselves into that.”

BALANCING THE MARKETS

Finally, legislators must set up exchanges in ways that don’t attract all only sicker patients, while healthier people buy insurance

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on the open market. In insurance language, that’s called “adverse selection,” or a death spiral.

“This is a big issue,” says Joan Henneberry, Colorado’s Medicaid director. “It has to do with making sure the rules of engagement are the same in both markets.

“If you require all sorts of bells and whistles inside the exchange and nothing outside, you could have a market outside offering plans that are a lot less expensive with lighter benefits,” she says. “The risk is all the people who really need insurance are going to buy it inside the exchange.”

The risk of adverse selection is also built into the exchange by design. People receiv-



SENATOR
JACK HATCH
IOWA

ing subsidies or government-paid health care must buy through the exchange, while wealthier people won’t have to. (There’s no requirement that individuals buy insurance through the exchange, just that they buy insurance.)

Iowa Senator Jack Hatch says his state may force all plans that sell individual and small group insurance to go through Iowa’s exchange. “I believe that if a plan doesn’t want to sell on the exchange, then they can’t sell insurance in Iowa.”

Since California’s proposed plan will not take all comers, the legislation set up rules to protect the exchange. Any plan that sells in the exchange must sell all product categories—platinum to bronze—and sell the same products outside it. No carrier, for example, will be able to sell a catastrophic plan outside the exchange only.

IT’S COMPLICATED

If setting up a health insurance exchange sounds complex, that’s because it is. Each answer leads to more questions.

“It’s like Jell-O,” says Praeger. “You push down somewhere, and it pops up somewhere else.”

Fortunately, legislators can tap the expertise of colleagues in Massachusetts and Utah.

The National Association of Insurance Commissioners is working closely with the U.S. Department of Health and Human Services on exchange issues. The insurance commissioners organization and the National Academy of Social Insurance, a nonprofit devoted to the role of social insurance in promoting economic security, are each writing model legislation.

“Building this thing will be a mammoth task,” says Iowa’s Hatch. “But remember, it doesn’t have to answer every question. It just has to provide a pathway for a consumer to make a decision about health insurance.”

CHECK OUT an interview with the former head of the Massachusetts health insurance exchange and find more information on how states are implementing health care reform at www.ncsl.org/magazine.

Forecast for States on Medicaid Expansion

The federal health reform law is expected to add about 16 million people to the Medicaid rolls. How will states fare under the expansion?

The answer depends on many factors: a state's current Medicaid eligibility levels, the number of poor and uninsured people, forthcoming federal regulations, how the economy is doing and even who you ask.

A few things are clear. The federal law prohibits states from reducing their Medicaid eligibility levels in place on March 23, 2010, until 2014. That's when health insurance exchanges must be operating and state Medicaid programs must begin covering people with family incomes up to 133 percent of the federal poverty guidelines (\$29,326 for a family of four in 2010). The federal government will cover the lion's share of the medical costs for the newly eligible people, beginning with 100 percent for the first three years (2014-2016) and phasing down to 90 percent in 2020 and beyond. The federal share—referred to as federal medical assistance percentages or FMAP—is also called the federal matching rate.

Although states already are required to cover pregnant women and children in families with incomes up to 133 percent of the poverty level, their coverage of parents of children enrolled in Medicaid or the Children's Health Insurance Program varies greatly. Typically, childless adults do not qualify for Medicaid no matter how poor they are, unless they are disabled or old. A few states have covered some childless adults for some services, either through a federal Medicaid waiver or by using only state money.

This wide variation in current eligibility criteria will most affect how individual states fare financially under the new law. For example, 12 states—Alabama, Kansas, Louisiana, Mississippi, Missouri, New Hampshire, North Carolina, Pennsylvania, Texas, Utah, Virginia and West Virginia—currently provide full benefits for parents with incomes that fall somewhere below 50 percent of the poverty level. Under health care reform, a greater proportion of poor people in those states will qualify for Medicaid and the enhanced federal match.



On the high end of current Medicaid coverage for parents, 18 states—Arkansas, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Vermont and Wisconsin—and the District of Columbia already cover at least some parents with incomes at or even above the 133 percent level. These states will not capture the higher federal match for such parents when the required expansion kicks in. In all states, the higher FMAP will apply only to newly eligible people, and not to the hundreds of thousands who currently qualify but are not enrolled.

For states that already cover some childless adults under Medicaid up to at least the poverty level (referred to as “expansion states”), at least some will get a break with a gradually increasing FMAP rate for those qualifying adults, to reach the 90 percent level by 2020. The secretary of the Department of Health and Human Services will determine which states will qualify for the enhanced match for covering childless adults. The most likely candidates include Arizona, Delaware, Hawaii, Maine, Massachusetts, New York and Vermont, according to the Henry J. Kaiser Family Foundation.

In addition to the money states must pony up to meet their eventual 10 percent match for expanded Medicaid enrollment—that occurs in 2020—state policymakers worry about several other expenses. Those include cover-

ing new enrollees who already qualified for Medicaid, but who were not enrolled. This is referred to as the “woodwork effect” since people will be coming out of the woodwork to sign up for coverage once the individual mandate for coverage kicks in.

There also are administrative costs for enrolling thousands of new people, for which the federal government pays only 50 percent; new computer systems to integrate Medicaid with the new health insurance exchanges; and higher reimbursement rates for primary care providers, required under the federal law for two years, to be covered by the federal government. Although not required, states will feel pressure to maintain those higher rates once the feds pull back.

Some experts assert states will actually come out ahead financially with the Medicaid expansions. They point to a significant decrease in spending for the uninsured; the ability to shift some people with higher incomes from Medicaid to insurance exchanges with federal subsidies; an enhanced federal match for the Children's Health Insurance Program beginning in 2016; and greater flexibility to integrate funding and services for people who qualify for both Medicaid and Medicare. Time will tell.

Martha King, NCSL

CHECK OUT the latest on state implementation of federal health reform at NCSL's health portal.