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# Insurance Exchanges Under Health Reform: Six Design Issues For The States

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**ABSTRACT** The Patient Protection and Affordable Care Act depends on new, state-based exchanges to make health insurance readily available to certain segments of the population. One such segment is the lower-income uninsured, who can qualify for subsidized coverage only through an exchange. Other segments are unsubsidized individuals and small employers, who may choose to buy coverage inside or outside of an exchange. Although the law provides some guidance in structuring these new exchanges, it leaves many key decisions to the states. Successfully implementing exchanges will require public-private partnerships, expertise in insurance operations and marketing, and a series of strategic decisions. We review the half-dozen most important design issues.

**T**he Patient Protection and Affordable Care Act of 2010 creates state-based exchanges and relies on them to make health insurance readily available to segments of their populations. Support for the concept during the debate on health reform stemmed in part from the ability of exchanges to meet different goals—including transparency of prices and benefits in the health insurance market and affording new mechanisms for regulating insurance products. It was also widely acknowledged that an existing state exchange, the Commonwealth Health Insurance Connector Authority, has played a central role in achieving near-universal coverage in Massachusetts.<sup>1</sup>

The new national health reform law calls for state or regional exchanges to be established by 1 January 2014. Regional exchanges can be multistate or within part of a state. States choosing not to establish exchanges will be able to rely on a federally operated exchange. The law further stipulates that the exchanges be created along the following lines:

(1) There must be either two separate exchanges—one for individuals (whether or not they receive federal subsidies) and one for small

businesses—or one consolidated exchange covering both individuals and small groups in each state or region. (2) The ability to purchase insurance through the exchanges will be restricted to U.S. citizens and to legal immigrants who are not incarcerated. (3) Health insurance plans will be available on four benefit tiers or levels—from the lowest, or “bronze,” level up to the highest, or “platinum.” There must also be a catastrophic plan for those who are under age thirty or who lack access to affordable insurance. (4) Premiums will be set according to adjusted community rating of risk in and outside the exchanges for the nongroup and small-group markets. (5) Exchanges may contract selectively with health plans that are determined to be of high value, based on cost and quality.

These parameters nonetheless leave considerable discretion to the states in how they structure plan offerings and facilitate comparison shopping. For example, will a given exchange select health plans through negotiations or competitive bidding, or both, or will it showcase all qualified and licensed carriers? Will the exchange allow each carrier to define patient cost sharing within a benefit tier, or will it specify coinsurance, copayments, and deductibles? We identify

six key issues that states will face as they develop health insurance exchanges.

## Key Design Issues

**ORGANIZATION AND GOVERNANCE** How should an exchange be organized and governed? Generally speaking, publicly sponsored exchanges will organize markets to help relatively “weak” buyers by enhancing individual choice and streamlining the distribution of insurance. The rationale for government sponsorship is to improve the dynamics found in the private market. However, political involvement raises concerns that an exchange may use the rules to disadvantage private insurers or discriminate unfairly among carriers. Presumably, governance should aim to address these concerns.

If an exchange is to process commercial transactions and attract customers, it should be insulated from political influence and must have access to the business expertise it needs. If it is to achieve policy objectives through tax-financed subsidies and some degree of regulation, it also must be publicly accountable.

This combination of requirements suggests the model of a semi-independent government authority, managed outside the civil service pay structure. The authority would be governed by a board of directors that has relevant expertise; represents a broad political spectrum; is appointed by elected officials; and is held accountable for the stewardship of public funds. This approach would be an obvious choice in the case of a regional exchange, which, as a semi-independent authority, could be governed by appointees from participating states.

**RATING RULES** What are the rating “rules of the game” within which insurers must function? The Patient Protection and Affordable Care Act requires health plans to set their nongroup and small-group premiums in advance, based on adjusted community rating. Instead of evaluating and pricing the health risk of each purchaser separately—requiring the enrollee’s medical history, for example, to predict use and cost of medical services—community rating generates a premium that can be quoted instantly for all qualified purchasers.

Under the new federal rules, age, family composition, tobacco use, and location are the main factors to be considered in making adjustments to the fixed community rate. A purchaser will thus be able to generate rate comparisons for any level of benefits simply by providing his or her date of birth, household size, and ZIP code. These rating rules make it possible to automate insurance pricing and facilitate comparison shopping in an exchange.

However, the range of premiums under these rating rules allows less variation than is actuarially justified and, therefore, implies some cross-subsidization. Although subsidizing sicker individuals sounds desirable—after all, that’s what group insurance does—it also opens opportunities for carriers to take advantage of, or be unfairly disadvantaged by, risk selection.

The new federal law applies these rating rules to the individual and small-group markets both in and outside of the exchange. If similar marketing and rating rules did not apply outside of the exchange, insurers, brokers, and buyers could seek ways to exploit the discrepancies. For example, consider what would happen if premium rates were allowed to vary more outside the exchange than in it, or if much less generous plans were sold only outside the exchange. In these instances, higher-risk individuals would purchase through the exchanges, since their premiums would be constrained, whereas lower-risk purchasers would gravitate to other markets, where they could buy less coverage or pay lower premiums.

Even when the rating rules are the same, however, insurers may use subtle marketing and product design features to drive positive risk selection. This in turn raises critical questions about how to level the playing field in and outside of the exchange. These include whether and how states should require health plans to participate in the exchange; whether actual rating practices and the range of benefits offered in and outside of the exchange must be comparable; how healthy is the pool of uninsured people who are likely to enroll through an exchange, compared to those who are currently insured; and whether existing grandfathered health plans will be able to find ways to shed their adverse risks to the new exchange.

Clearly, these questions will need to be addressed state by state, depending on each state’s particular market and regulatory conditions. For example, consider state A with many competing health plans and state B with just two dominant carriers. State A’s exchange can be selective and not offer all licensed carriers, without adversely affecting the risk profile of any single carrier. State B’s exchange runs a greater risk of adversely affecting its only other carrier, if one is in the exchange and the other is out. Which carrier in state B would enjoy favorable risk selection is not obvious, but the real risk of hurting the only other carrier has serious policy and equity ramifications.

**ADJUSTING PREMIUMS FOR RISK SELECTION** How can premium revenues be adjusted for risk selection among participating carriers? Risk selection is closely linked to premium rating

and underwriting rules. The new rules for adjusted community rating do not fully mitigate risk selection because they compress rates for the young and old—specifically, rates for the elderly can be only three times as high as those for the young. Moreover, even less compressed rates would not fully account for selection. For example, one insurer with a better brand or broader network of physicians may attract sicker enrollees than another carrier, even within the same age distribution.

Comparison shopping through an exchange is expected to drive increased competition among plans on administrative efficiency, customer service, provider reimbursement rates, care management, and clinical networks. Premium differences among plans must reflect these variables, rather than enrollees' health status. Risk adjustment is a tool that measures the burden (or risk) of ill health covered by competing insurers and then “adjusts” for it by providing additional payments to insurers with a higher risk burden and assessing fees on those insurers with lower risk.

However, putting a risk-adjustment system in place will require making several key determinations. First, is risk selection among plans significant, beyond what is already accounted for under the allowed rating rules? Second, is the corrective adjustment practical? Third, would it substantially equalize risk? Comparative risk calculation for health plans requires submission and analysis of their claims data. Transfer payments among the plans requires running their premiums through a central distribution point, or imposing a premium assessment on all competing plans, which is then redistributed to compensate for risk selection. Risk adjustment must apply across the entire class or segment of insured people subject to the applicable rating rules.

The health reform law calls for risk adjustment in the individual and small-group markets but leaves this function to the states. The states will come to understand that since this function moves dollars from one competing health insurance plan to another, the myriad technical questions of how risk adjustment is done, not to mention who does it, will be closely watched and hotly debated.

Fortunately, there is plenty of evidence that these functions can be performed effectively. The Centers for Medicare and Medicaid Services (CMS) has been managing a comprehensive risk-adjustment process for Medicare Advantage since 2004—collecting encounter data, calculating risk scores, and adjusting plans' payments. The Health Connector in Massachusetts adjusts risk and revenues among its Commonwealth

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Care plans (which are government-subsidized for lower-income individuals), using a variant of the same Diagnostic Cost Groups (DxCg) software that the CMS uses. A number of for-profit and nonprofit organizations, including university research departments, also have the capability to provide risk-adjustment services if an exchange wishes to contract for them.

**RANGE OF BENEFIT OPTIONS** How many and what kinds of benefit options should an exchange offer? An exchange's role in facilitating comparison shopping for coverage begins with the display and comparison of premiums, benefit levels, and health care provider networks. Consumers want an entity they trust to offer high-value plans and help them choose. But how many choices to offer, and of what kind, are matters of judgment and consumer preference.

Among the choices exchanges have to make are, first, how many insurance carriers should be allowed to offer health plans to consumers; and, second, whether to specify uniform benefits on each tier or to allow actuarial equivalence among different plan designs. There are several dangers to be avoided in making these decisions. Too much choice may confuse consumers and lead to adverse selection. On the other hand, too little choice may conflict with consumers' preferences and stifle innovation in the design of insurance policies and benefits.

On the questions of whether or not to specify uniform benefits, both the private Connecticut Business and Industry Association's Health Connections<sup>2</sup> exchange and the public Massachusetts Health Connector<sup>3</sup> have found a happy medium over time. They have, in fact, standardized benefits according to the types of policies that are most popular with consumers—and have found that this approach actually improves consumers' ability to comparison shop, even though it limits their choices somewhat.

In a small-business exchange, allowing individuals to choose among a number of carriers and policy designs can be tricky, because group insurance is designed as a pooling mechanism. To minimize risk selection, the Patient Protec-

tion and Affordable Care Act restricts employees of small businesses to a choice of carriers at only one benefit tier (bronze, silver, gold, or platinum), chosen by the employer. (In the individual exchange, each participant can choose a benefit tier and an insurer offering that tier of coverage.) Otherwise, the sicker employees would tend to buy up—meaning the gold or platinum benefit tiers—while healthy employees buy down—meaning bronze or silver tiers. The result would be higher premiums overall in the small-employer exchange.

**BIDDING TO PROVIDE BENEFIT PACKAGES** How should carriers bid to provide the benefit packages and be selected to offer coverage through an exchange? Effective markets depend on robust competition among sellers. An exchange cannot achieve its policy objectives if carriers don't participate in it. The level of carrier participation in exchanges may be influenced in several ways: by forcing them to participate through laws; by excluding competing channels of product distribution; by aggressive marketing efforts on the part of the exchange; by subsidizing the insurance purchases of eligible buyers; and by buyers' and sellers' perceptions of fairness, value, and efficiency.<sup>4</sup>

Assuming robust interest among insurers in participating, an exchange can be selective in choosing which plans to offer customers. In doing so, it must balance various concerns. These include the need to offer consumers broad access to a choice of providers, to achieve breadth of geographic coverage, and to offer continuity, so that consumers can pick a plan and stay with it over time if they choose to do so. On the other hand, limiting the number of participating plans may give the exchange more bargaining power in negotiating rates and other details with insurers. These are likely to be dynamic issues that will change over time.

The bidding process and selection criteria incorporate a host of discretionary judgments. One consideration is which types of plan designs the various nongroup, small-group, or other target customer segments desire. Another is determining how to select plans based on value, when plans are free to adjust premiums over time for coverage offered through or outside the exchange as enrollment evolves and claim trends develop. Still another is how to adjust benefit designs in response to changing market conditions, without disrupting existing coverage. Exchanges must also decide how much risk selection among plans is tolerable, without undermining the ability of plans to compete on value; and how to help insurers adjust to the business risks of selling through exchanges, so that they will price their products at levels that consumers

will find attractive.

**PROTECTING THE PUBLIC** How can an exchange create administrative efficiencies and protect the public? The opportunity offered through exchanges to reduce administrative costs and add transparency to health insurance is substantial. Today, in the absence of exchanges, the nongroup and small-group markets offer a bewildering array of benefit choices and create hurdles to purchasing coverage. Most small employers use brokers to navigate this complex variability, and individuals in many states depend on brokers to find a carrier that will accept them. The carriers, in turn, structure their broker compensation programs to attract and retain good business.

Meanwhile, in the individual market, the cost of marketing and enrollment is excessive. In some areas, brokers earn monthly commissions of 10 percent or more on nongroup premiums. The Commonwealth Fund estimates that the percentage of private premiums that goes for administrative purposes averages 41 percent for individual and 29 percent for small-group coverage.<sup>5</sup> Many of the functions associated with sales, enrollment, premium billing, and collections could be streamlined through a combination of manual rating and economies of scale. Manual rates are the standard actuarial rates for the "average insured population" that are not adjusted for health status, tobacco use, or other factors. Some economies of scale will come from enrollment in only four benefit tiers (plus a catastrophic plan), not spread among the literally thousands of benefit designs available today. Additional savings will come from spreading the cost of developing a state-of-the-art Web site for insurance shopping across hundreds of thousands or even millions of users. Electronic enrollment and payment will also reduce costs: For example, the cost of processing a paper check may be approximately \$10, while an electronic funds transfer typically costs about \$0.25.

The exchanges are charged by the federal health reform law with standardizing and automating these processes. With sufficient scale, they can greatly reduce administrative costs. For example, the CMS provides a fairly easy-to-use Web site that allows seniors to choose among many Part D prescription drug plan options with minimal sales and distribution costs. The Health Connector in Massachusetts serves some 200,000 enrollees and supports many other functions as well, with an administrative budget equal to 3 percent of total premiums (based on personal communication from the Commonwealth Health Insurance Connector Authority, regarding the proposed fiscal year 2011 budget).<sup>6</sup>

Exchanges can also add quality metrics, cost

calculators, “physician finders,” and other tools to help shoppers. They can go even further and promote understanding of health reform, healthy lifestyles, and patient advocacy. At some point, however, too much information—like too much choice—crowds out basic functionality; advocacy competes with sales; and both drive up administrative costs. Exchanges have to set priorities among competing objectives.

Unfortunately, one role conflict is built into the new law. In one of many compromises, the law prohibits exchanges from selling even private, unsubsidized insurance to undocumented immigrants. The paperwork burden that will be involved in policing exchanges to weed out any undocumented immigrants could create exactly the kind of intrusiveness that will drive unsubsidized customers to seek coverage elsewhere. Absent an administratively convenient solution, this could keep state-based exchanges from reaching the scale needed to realize possible efficiencies.

### Conclusion

Running a government-sponsored exchange parallel to conventional distribution channels for insurance presents a unique challenge. Exchange operators will need an entrepreneurial vision, including marketing and business acumen. At the same time, they must demonstrate prudence and trustworthiness in safeguarding public funds.

Well-run exchanges can aggregate buying power, realize administrative efficiencies, and improve consumers’ shopping experience, thereby helping fulfill the individual and employer mandates in the Patient Protection and Affordable Care Act. The new health reform law

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also requires exchanges to play a role in determining eligibility for low-income subsidies. And exchanges will have to operate within the constraints of public procurement procedures, transparency in government, and, ultimately, voters’ expectations.

If an exchange does not attract and serve customers well, it cannot achieve its mission. At the same time, no matter how scrupulously mission-driven and well-managed they are, public exchanges will raise fears of unfair competition among commercial interests. If an exchange succeeds “too well,” then it can expect responses from both the market and politicians. Carriers and conventional distributors that view exchanges as a business threat may react by offering new services, efficiencies, or other competitive responses, or they may try political means to diminish the threat. If exchanges can overcome these hurdles, however, they will be a critical force in spreading coverage and stabilizing health insurance markets in the challenging years to come. ■

Elements of this paper have been adapted from another paper by the authors, distributed at the Health Industry Forum, in Washington, D.C., 20 July 2009.

### NOTES

- 1 Senate Finance Committee. Expanding health care coverage: proposals to provide affordable coverage to all Americans. Washington (DC): Senate Finance Committee; 2009 May 14. p. 4–7.
- 2 Connecticut Business and Industry Association [home page on the Internet]. Available from: <http://www.cbia.com/home.php>
- 3 Commonwealth Health Insurance Connector Authority [home page on the Internet]. Available from: <http://www.mahealthconnector.org>

- 4 For example, carriers insuring 5,000 or more lives in the small-group market are required by law to seek the Health Connector’s seal of approval. The availability of public subsidies for low-income, uninsured people through the Connector effectively means that health plans cannot reach this segment of the market through other distribution channels. Switzerland and the Netherlands simply exclude the use of any channel other than the official government exchange.

- 5 Davis K, Schoen C. Testimony: putting the U.S. health system on a path to high performance. New York (NY): Commonwealth Fund Commission on a High Performance Health System; 2009 Feb. Chart 14.
- 6 The proposed budget fiscal year 2011 budget supports additional (non-exchange) functions, such as policy making, appeals of the requirement that individuals buy coverage, and public education about health reform.

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Jon Kingsdale is an independent consultant and the immediate past executive director of the Commonwealth Health Insurance Connector Authority. In that capacity, he led the effort to develop and implement Massachusetts' two health insurance exchanges for small groups and individuals, following passage of that state's health reform legislation in 2006. He also helped develop key elements of the health care financing policy in the state.

Before taking the helm of the Connector Authority, Kingsdale was a senior executive at Tufts Health Plans in Massachusetts, where he was responsible for strategic planning, product development, public affairs, and government relations. He led major product initiatives such as the development of various new health maintenance organization (HMO) benefits for the group market (including tiered-network HMO and point-of-service plans), New England's largest Medicare+Choice HMO, and consumer-directed health plans. He also held executive positions in strategic planning and reimbursement at Blue Cross Blue Shield of Massachusetts.

Kingsdale received a doctorate in economic history from the University of Michigan. He has taught at the Harvard School of Public Health, where he also conducted research on hospital finances, as well as at the Boston

University School of Public Health.

Kingsdale believes that the effort to implement new health insurance exchanges will be the "toughest policy to implement since the Civil Rights Act." The federal government not only must properly implement the exchanges, he says, but also must continue to "sell" the idea to the public as well as the states, insurers, providers, and consumer advocates. Despite this, he expects that the exchanges will gain broad acceptance in due time. He notes that there has been long-standing bipartisan support for the notion of exchanges.



**John Bertko** is a Brookings Institution visiting scholar.

John Bertko is an independent consultant focused on health insurance; is a visiting scholar at the Brookings Institution; and is an adjunct staff member at the RAND Corporation, based in Santa Monica, California. He is the retired chief actuary of Humana Inc., where he managed the corporate actuarial group and directed work by actuarial staff for Humana's major business units, including Medicare Advantage and consumer-driven health care products. He currently serves on the panel of health advisers for the Congressional Budget Office and recently completed a six-year term on the Medicare Payment Advisory Commission (MedPAC). He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Bertko has worked with a number of groups on the subject of

insurance exchanges, including the Health Insurance Plan for California (HIPIC) in the 1990s, the Federal Employees Health Benefits (FEHB) exchange-like mechanism for federal employees, and the Part D exchange in Medicare. He says that exchanges will ultimately serve an integral role in improving the public's health care choices. He draws a parallel with the travel industry: It used to be that individuals had to work with a travel agent to schedule a trip, which often limited their choices, he says. Now, Bertko says, with an online marketplace or exchange of travel options, it is easier for consumers to make better choices—not only because they have a wider array of options, but also because the process of choosing one is greatly simplified. "This is a good free-market kind of mechanism" that the public will ultimately endorse, he says.

Like his coauthor Kingsdale, Bertko sees a number of challenges facing the federal government. He argues that administrative requirements must be developed and that staffing must include people who can both provide necessary oversight and run the exchanges themselves. There also will need to be proper administration of federal subsidies to make sure that funds are used effectively. Additionally, the federal government must establish consistent rules to prevent the insurance industry from "gaming the system" by trying to enroll mostly healthy people through subtle marketing and "creative" plan designs. Bertko believes that the solution lies in risk adjustment, through which the exchange would provide additional payments to insurers with a higher risk burden and offsetting reductions to those with less risk.