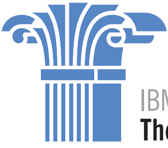


IMPLEMENTATION BRIEF 3

Implementation of the Affordable Care Act of 2010

Preparing for Health Insurance Exchanges: Benefits, Challenges, and Responsibilities for the Federal Government and the States

Jack Meyer
Professor
Schools of Public Policy and Public Health
University of Maryland

UNIVERSITY OF
MARYLAND
School of Public Policy

The Patient Protection and Affordable Health Care Act was signed into law in March 2010. Shortly after the passage of the bill, the University of Maryland School of Public Policy and the IBM Center for the Business of Government came together to create a Blog on the IBM Center's website to address implementation issues surrounding the new law.

The Making Health Care Work Blog focused on the central challenge of the new law: How will the nation implement the massive bill of over 2700 pages? The Blog discussed how the nation can make health care reform work, as well as the challenge of designing important new tools needed for government. While news coverage focuses on the politics of health care reform in Washington, the Blog went beneath the rhetoric to share the difficult details of what state and federal officials have to do to make sure that the law works on the ground.

From analysis to "Q and As" with top officials, the Making Health Care Work Blog remains a source of valuable information about Medicaid expansion, health insurance exchanges, and other top challenges in the implementation of health reform.

Review the discussion at:
www.businessofgovernment.org/blogs/making-health-care-reform-work

Now that health reform has been enacted, people have begun working on the details of implementing the new law. The University of Maryland School of Public Policy and the IBM Center for The Business of Government are collaborating to offer a unique voice on the major implementation issues surrounding health care reform. The implementation brief series is based on two key premises:

- The battle over the passage of health reform was just the prelude to even bigger implementation battles to come.
- Making health reform work is the next great frontier, and we all have a vested interest in understanding the complicated process of turning legislation into a national program that is implemented in a way that works for all.

Jonathan D. Breul

Donald F. Kettl

This implementation brief, *Preparing for Health Insurance Exchanges: Benefits, Challenges, and Responsibilities for the Federal Government and the States,* is the third in a series of reports exploring some of the most formidable and important challenges facing states and the federal government as they implement the Affordable Care Act. These exchanges, which will offer a wide choice of private health plans and sliding scale federal premium subsidies for millions of Americans, are scheduled to launch in 2014.

Previous implementation briefs in the series examined the following:

- *Implementation Brief 1* focused on innovative approaches to enrolling people newly eligible for Medicaid.
- *Implementation Brief 2* described promising strategies for meeting the medical needs of the newly eligible once they are enrolled.

This report, *Implementation Brief 3*, examines the key features of health insurance exchanges and the main challenges in setting them up and making them operational. *Brief 3* concludes with action steps that states can take, some with the assistance of the federal government, to address these challenges.

As with the previous two implementation briefs, this series seeks to contribute to the discussion about the Affordable Care Act's implementation. As always, we welcome your comments and look forward to a lively discussion.

Jonathan D. Breul
Executive Director
IBM Center for The Business of Government
jonathan.d.breul@us.ibm.com

Donald F. Kettl
Dean, School of Public Policy
University of Maryland
kettl@umd.edu

What are Health Insurance Exchanges?

By enrolling in health insurance exchanges, millions of Americans could experience—many for the first time—a wide choice of health plans, transparent information on prices and quality of care, and financial help in obtaining coverage. Exchanges are a key component of the Patient Protection and Affordable Care Act (ACA) passed in March 2010. They hold the promise of creating a broad-based "farmers market" where consumers can select from an array of private health insurance plans, irrespective of their current health conditions.

Existing models of exchange-like organizations are the Federal Employee Health Benefit Plan (FEHBP) and the California Public Employees Retirement System (CalPERS), which offers 1.6 million employees and retirees of California state government and state universities a choice of private plans. Over the past two decades, a number of business coalitions around the country have also formed exchange-like organizations for their employees.

As a result of ACA's health insurance reforms, consumers cannot be turned down or charged more money because of their health conditions. Also, an essential benefits package now being designed as part of ACA would ensure comprehensive health care coverage for enrollees. The law also calls for premium coverage scaled to household income and limits on out-of-pocket expenses. Thus, exchanges hold the potential to create an organized, transparent marketplace through which individuals, families, and small businesses can readily access affordable, quality coverage.

Key features of these exchanges are:

- A broad choice of private health plans organized into four levels, ranging from the least comprehensive coverage (bronze) to the most comprehensive (platinum). A catastrophic coverage plan must be offered to those under age 30 or those who lack access to affordable insurance.[1]
- The opportunity for private, nonprofit organizations to form insurance cooperatives (co-ops), which are effectively consumer-owned. Such co-ops do not yet exist but efforts are underway to build them.
- Eligibility for federally financed premium subsidies and limits on out-of-pocket health spending for those with incomes up to four times the federal poverty line, or about $88,000 a year for a family of four.
- Exchanges are based at the state level. States may operate one exchange for individuals and one for small firms, or set up one consolidated exchange. States can also band together to establish regional exchanges.
- Exchanges must be operational in January 2014.
- Eligibility is restricted to U.S. citizens and legal immigrants.
- The federal government will set up an exchange for states that cannot demonstrate in January 2013 that they will be ready for launch a year later.

What is at Stake?

For decades, millions of Americans have fallen into the chasm between the ability to afford private health insurance and eligibility for public programs. Many working families and individuals with moderate incomes have been uninsured because they:

- Work for an employer that does not offer health coverage
- Are not eligible for their company plan because they work part-time or just started the job, or
- Cannot afford their share of the premium

Too young for Medicare, above the line for Medicaid, and unable to afford job-based coverage, many of these working families are uninsured, while others have coverage but are struggling to keep up with the bills for premiums and out-of-pocket health expenses.

As noted above, exchanges would operate in the context of an array of new insurance reforms, meaning an end to pre-existing condition exclusions, to charging higher rates for people in poor health, and to imposing annual and lifetime limits on benefits. As a result of these and other insurance reforms, insurers would be forced to compete mostly on the basis of cost and quality, not by cherry-picking the healthiest consumers. This would be a major transformation of the American health care system. It would bring relief to small firms struggling with the high cost of health insurance premiums.

But with this great promise also come formidable challenges. We now have the first set of blueprints for the construction of exchanges. But these blueprints need to be filled in with more detail, and then construction must begin. Like any construction project, building exchanges will face barriers related to ensuring a firm foundation, obtaining a qualified workforce, and coordinating the work of many subcontractors.

States will face a number of important challenges in preparing for the operation of their exchanges. Below are the some of the key action steps that states, as well as the federal government in some instances, will face as they implement exchanges.

ACTION STEP 1: Obtain Enhanced Federal Matching Funds for Exchange Planning and Implementation

The federal government will provide full funding for exchange development and implementation activities. Some 48 states have already received $1 million each in exchange planning grants. Alaska and Minnesota did not apply for these grants, and recently, Florida returned its grant to the federal government. In addition, seven states were awarded much larger amounts of funding after submitting proposals to the U.S. Department of Health and Human Services (HHS) presenting innovative exchange plans. Oklahoma, which received the largest award, recently announced that it was returning the funding. Subsequent opportunities for federal support will be made available to states.

The federal government is also making funding and technical assistance available for health information technology related to exchange development and screening and enrollment. States should take advantage of this federal support as they gear up to develop and operate exchanges.

ACTION STEP 2: Make Critical Early Design Choices

States will need to make important early design decisions about exchanges:

- Whether to participate in ACA, including its major features such as exchanges and Medicaid expansion
- Whether to build their own exchanges or let the federal government create exchanges for them
    - The federal government will be designing an insurance exchange for those states that do not participate or submit proposals that the federal government believes do not comply with ACA.
    - At the present time, it seems likely that most states will build their own exchanges rather than let the federal government step in during 2013 and use its own model.
- Whether to join with neighboring states in a regional exchange
    - This might make more sense for small states that could have trouble obtaining a critical mass of patients and plans and who would benefit from linking with surrounding states.
    - States might consider forming a regional exchange for their small employers (50 or fewer workers) while forming their own exchange for individuals. In smaller states, many individuals live in one state and work in another.

- Whether to combine the two types of exchanges called for by ACA (one for individuals and one for small firms) or to make the small firm option a kind of separate module under the overall rubric of the exchange for individuals
- How to govern the exchanges
  - Most states seem headed toward setting up a quasi-independent organization with more flexibility than state agencies have regarding employee compensation and contracting.
- Whether to start with a very basic model of exchanges, limiting roles and functions to those required by ACA, or create a more comprehensive model
  - A key decision here is whether to make exchanges simply "market organizers," with all health plans meeting ACA requirements automatically accepted, or a more "active purchaser," which would set cost and quality specifications and retain the right to exclude health plans that do not meet them.
  - Exchanges might choose to confine their responsibilities to establishing a web portal and related functions and enrolling applicants in the right program. This would be a very basic exchange, one that takes on only the roles explicitly required under ACA. This is the kind of model that has been operational in Utah, except that the Utah model pre-dates ACA and does not involve premium subsidies.
  - Exchanges could become active and organized purchasers of health coverage, as has occurred in Massachusetts. In this case, states would establish cost and quality goals and retain the right to exclude health plans that do not meet these goals.
- Whether to take on additional functions of an active purchaser which could include
  - Developing quality metrics that health plans must report, and implementing rewards/penalties based on performance
  - Conducting education and outreach to serve vulnerable populations
  - Promoting the formation of integrated health care delivery systems that engage in some risk-sharing and accountability for quality improvement
  - Facilitating the formation of "patient-centered medical homes," featuring comprehensive primary and preventive care and effective chronic care management[2]

ACTION STEP 3: Create Regulatory Oversight

Both the federal government and the states must create regulatory oversight functions related to exchanges. Both levels of government will be charged with reviewing and reporting on insurance company rate increases. The Center for Consumer Information and Insurance Oversight (CCIIO) in the Centers for Medicare and Medicaid Services (CMS) provides this oversight for the federal government. States will conduct oversight and review of insurance premiums and other aspects of exchange operations through their insurance departments. This includes determining whether health plans are in compliance with limits on "medical loss ratios," which require that at least 80

percent of premium revenues (from consumers obtaining coverage on their own or through small firms) are devoted to paying health care claims or improving quality. For people obtaining health coverage through large employers, the minimum figure is 85 percent.

This rate review will undoubtedly become controversial. There is a long history of states regulating insurance, but most of that regulation is limited to requiring insurers to hold adequate reserves, establishing certain mandated benefits, and so on. The new steps, however, involve both states and the federal government in a review of rate increases, which will presumably lead to attempts to block these rate increases if they are not deemed justifiable. Proponents will say that the government is acting in the consumers' best interest, while opponents are likely to charge that the government is engaging in price controls.

ACTION STEP 4: States Should Develop Effective Relationships with Federal Agencies

States face a daunting challenge of gathering and synthesizing data from a number of different sources, and developing effective interfaces both across different state agencies and with federal agencies. To determine eligibility for Medicaid, for example, states need to ascertain a person's income according to a new formula called the Modified Adjusted Gross Income, also known as MAGI. This takes the household's gross income and disregards 5 percent, so that in effect, households with a gross income up to 138 percent of the federal poverty line (FPL) will be eligible for Medicaid—the net income limit, then, is 133 percent of the FPL. In applying this MAGI, however, states must ensure that no child is disadvantaged by its use. For example, suppose a state were already covering children in Medicaid up to 150 percent of the FPL (e.g., New York). This state may not exclude children in households with incomes between 133–150 percent of the FPL.

Household income will also be used to determine the size of the federal subsidy for which an exchange applicant is eligible. People with incomes just above the Medicaid eligibility level (e.g., 140–150 percent of the FPL) would receive a federal subsidy that would cover most of the premium. People with incomes near the top of the range (e.g., $80,000 a year for a family of four) would receive a subsidy covering a much smaller proportion of the premium.

Exchange managers will work with the Internal Revenue Service (IRS) to ascertain the exact amount of the previous year's income for each household, and then obtain the subsidy from the IRS in the form of a refundable tax credit. States may want to use their own data from work force agencies or tax files to update the household's income figure during the year. Next, they must obtain the household's contribution—for example, if the federal government covers 60 percent of the premium, the household would be responsible for 40 percent. The two payments would be bundled and sent to the health plan that the applicant selects. This is a complex process, with the potential for problems and delays. If the federal payment is late in arriving, the applicant may have to wait for coverage or front the full premium and be reimbursed (a hardship for many).

The state must also determine whether the insured person is a United States citizen or a legal immigrant. This will likely require working closely with the Social Security Administration (SSA).

ACTION STEP 5: States Must Set Up a Web Portal Where Health Plans Can be Compared

With the assistance of the federal government, states must enable consumers to make apples-to-apples comparisons among competing health plans. Consumers will need to know each plan's premium, the breadth of its network of physicians, hospitals, and other health care providers, and the benefit levels in the four benefit tiers noted above. States will also assign ratings to health plans based on "relative quality and cost," according to criteria developed by the Secretary of Health and Human Services. This information must be displayed in a way that facilitates user-friendly, side-by-side comparison of plans.

In fact, states will have to create an electronic calculator that will estimate health plan costs. ACA facilitates this through a series of insurance market reforms. To describe a very complicated set of reforms as simply as possible: ACA stipulates that when the law is fully phased in, insurers will only be able to "rate" consumers based on their age (and then subject to a restriction that the oldest applicants cannot be charged more than three times the premium of the youngest); family status; tobacco use; and location within the state. Insurers will no longer be able to rate premiums based on the applicant's health status, nor use pre-existing condition restrictions. And they will not be able to charge women more than they do men.

As a result, applicants could simply enter their age, family status (e.g., single, married, number of dependent children), and their zip code, and the calculator would tell them what the premium would be for, say, a bronze plan, or a gold plan. The web portal could also provide other useful consumer information on the plans. This includes helping people determine if a particular physician is included (just as consumers evaluating Medicare Part D insurance plans can check to see if a certain prescription drug they are using is on that plan's formulary, or list of preferred drugs that it will reimburse).

A complementary effort involves the establishment of a toll-free hotline and a customer service call center. These centers must be staffed by people with the knowledge to assist consumers themselves or direct them to experts who can do so.

Another important and related task is to set up a navigator system that will help consumers to select a health plan, know their health coverage, and understand how best to use the health care system. States can make grants to facilitate outreach and education to vulnerable populations. A challenge for states is to provide a variety of options without overwhelming consumers.

ACA requires states to establish an integrated eligibility determination system. The law requires the use of a single application form for all programs available online, in person, by mail, or by phone. There must be an integrated eligibility determination for all state health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP). States must also establish a standardized enrollment form.

ACTION STEP 6: States Must Build a Mechanism for Risk Adjustment of Premiums

Risk selection occurs when one insurer attracts a group of consumers who are more costly to serve than those enrolled with another insurer. Risk selection will be greatly reduced by insurance market reforms under ACA, but it will not be eliminated. Although plans may not deny coverage to sicker people, or price them out of affordable health coverage, they may compete in other ways. Insurers with a "better brand" or broader network of physicians may attract patients with more complex health needs, even within the same gender and age brackets. Moreover, plans will differ on administrative efficiencies, customer service, provider reimbursement rates, care management, and clinical networks. Premium differences among plans should reflect these differences. Risk adjustment 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 insurers with lower risk profiles.[3]

According to Kingsdale and Bertko, implementing a risk adjustment system will require several determinations. States will need to assess whether there is, in fact, considerable risk selection remaining after the insurance market reforms are implemented; whether the corrective adjustment is practical; and whether it would substantially equalize risk. These determinations will require submission and analysis of insurers' claims or "encounter" data and developing a mechanism for running premiums through a central distribution point, or imposing a premium assessment on all plans that would then be redistributed to adjust for risk selection.[4] This is both technically difficult and politically tricky as the plans have so much at stake and there will appear to be winners and losers even though the effort is aimed at leveling the playing field.

ACTION STEP 7: States Must Ensure Financial Sustainability

Under ACA, states are required to make their exchanges financially self-sustaining by 2015. The federal government is providing substantial resources and technical assistance at the front end, but is not responsible for operating costs over time. As noted by Sonier and Holland, "… exchanges will be faced with a classic start-up issue: incurring significant expenses while dealing with an uncertain revenue stream. This balance will be especially acute in the early stages, as enrollment may ramp up less slowly than estimated while at the same time the 'burn rate' on cash has already been committed. Therefore, while solid budgeting discipline, strong vendor negotiation, and expense management should be a core competency, exchanges will also need to develop additional expertise and data sources for revenue forecasting."[5]

Exchanges are likely to generate much of the revenue required for self-sufficiency through premium assessments. It is likely that such assessments will be passed through, in whole or in part, to consumers. Revenue forecasts will therefore need to estimate both the projected trend in premiums and the number of people likely to enroll in the exchanges. This will require a model that accounts for a number of different "flows" and switches as consumers determine where they

would best be served. In addition to people moving from being uninsured to participating in the exchanges, others will leave the individual market for exchange coverage while some small firms will participate in the exchange, moving their workers from the small-group private market to the exchange.

Yet, there may also be some flows in the other direction. Some people may shift from public coverage to employer coverage or individually purchased coverage. Capturing all of these shifts in coverage status will require sophisticated modeling, and many states are likely to need microsimulation modeling, which accounts for all of these different shifts in insurance status, the costs and benefits of reform, and how those costs and benefits are distributed.[6]

Insurance exchanges are at the heart of health care reform. These exchanges hold the promise of offering millions of moderate-income Americans a choice of affordable health plans. States and the federal government face many challenges in implementing the exchanges. Key decisions about governance, enrollment, calculating and directing subsidies, and insurance regulation are looming. The federal government is helping states through grants and technical assistance. States would benefit from a clearinghouse of best practices and a dissemination and transfer of promising approaches as they work toward start-up in 2014.

Moreover, all of the technical and policy implementation decisions assessed in this *Implementation Brief* are playing out against a backdrop of an intense political and legal battle over the national health care reform legislation. Litigation challenging the individual mandate and other features of ACA is working its way through the federal court system. Governors of some states have frozen all work on the implementation of the federal law pending the outcome of this litigation, while other governors have threatened to pull out of Medicaid rather than expand it to follow the law. Still other governors are moving ahead to implement ACA at a rapid pace. Finally, the American public is clearly divided over health care reform.

The purpose of this *Implementation Brief* and others in this series is to focus on the key challenges involved in implementing the law. While very much aware of the controversy surrounding this issue around the nation, we seek to inform the debate by highlighting the major challenges and offering a series of action steps and promising approaches to addressing these challenges in a nonpartisan way.

1. Jon Kingsdale and John Bertko. “Insurance Exchanges Under Health Reform: Six Design Issues for The States.” *Health Affairs,* June 2010. 29:6:1158-1163.
2. Exchange and Insurance Markets Workgroup. “Report to the Health Care Reform Coordinating Council.” State of Maryland. October 31, 2010.
3. Kingsdale and Bertko. Supra. 1160.
4. Kingsdale and Bertko. Supra. 1160.
5. Julie Sonier and Patrick Holland. “Health Insurance Exchanges—How Economic and Financial Modeling Can Support State Implementation.” *AcademyHealth Member Update.* November 2010. p. 5.
6. Sonier and Holland. Supra. p. 3.

Jack Meyer, Ph.D., is a professor in the Schools of Public Policy and Public Health at the University of Maryland. Dr. Meyer is also a Principal in the Washington, D.C. office of Health Management Associates. Meyer was the founder and president of the Economic and Social Research Institute.

Dr. Meyer's current research interests include assessments of the new national health reform legislation, analyzing state and local government reforms to improve the health-care delivery system and cover the uninsured, and identifying promising approaches to care management for people with chronic illness.

Dr. Meyer's recent publications include "Expanding Health Coverage in the District of Columbia: D.C.'s Shift From Providing Services to Subsidizing Individuals and its Continuing Challenges in Promoting Health," prepared for the Brookings Institution and the Rockefeller Foundation; "The Impact of Federal Stimulus Funding on Health Spending in Florida: Accomplishments and Challenges," published by the Collins Center for Public Policy; "County and City Health Departments: The Need for Sustainable Funding and the Potential Effects of Health Care Reform on Their Operations," published by the Robert Wood Johnson Foundation; and "Chronic Disease Management: Evidence of Predictable Savings," published by Health Management Associates.

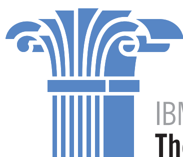
Key Contact Information

Jack Meyer
Professor, Schools of Public Policy and Public Health
Maryland School of Public Policy
University of Maryland
2101 Van Munching Hall
College Park, MD 20742
(202) 785-3669, ext 762

JMeyer@healthmanagement.com

Acknowledgments

The author would like to thank Mark Abramson at the IBM Center for The Business of Government for his valuable comments and suggestions.



IBM Center for
The Business of Government

About the IBM Center for The Business of Government

The IBM Center for The Business of Government connects public management research with practice. Since 1998, we have helped public sector executives improve the effectiveness of government with practical ideas and original thinking. We sponsor independent research by top minds in academe and the nonprofit sector, and we create opportunities for dialogue on a broad range of public management topics.

For additional information, contact:

Jonathan D. Breul
Executive Director
IBM Center for The Business of Government
600 14th Street, N.W.
Second Floor
Washington, D.C. 20005
(202) 551-9342
e-mail: businessofgovernment@us.ibm.com
website: www.businessofgovernment.org

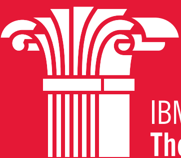
UNIVERSITY OF
MARYLAND
School of Public Policy

About the University of Maryland School of Public Policy

The School of Public Policy at the University of Maryland, College Park, provides graduate and post-graduate studies in a comprehensive range of domestic and international policy areas. Situated near the nation's capital, the school affords access for students and faculty to the broad spectrum of governmental and nongovernmental agencies that formulate and implement policies affecting the economy, the environment, welfare, children and families, and international relations.

For additional information, contact:

Maryland School of Public Policy
University of Maryland
2101 Van Munching Hall
College Park, MD 20742
(301) 405-6330



IBM Center for
The Business of Government