



# **Executive Summary: Policy Recommendations for Establishing a Health Insurance Exchange**

**December 1, 2010**

The Affordable Care Act of 2010 requires the state of Minnesota to provide residents access to a health insurance exchange by January 1, 2014. States are given latitude on the elements and design of an exchange while meeting minimum requirements. MAHU offers the following recommendations:

## **Minnesota should have its own Exchange.**

State-based exchanges are the only way for state policymakers to ensure that the unique interests of their constituents are being met and that unprecedented state-level policy control is not ceded to the federal government. Due to variations in state laws and needs, a regional exchange could wind up actually being more costly and difficult to administer than a separate state-based exchange.

## **Funding the Exchange.**

Funding the exchange should be through a user fee applied to those who choose to purchase their policy through the exchange.

## **The Exchange should require working with a Licensed Insurance Broker or Agent.**

Since agents are licensed to provide consumers with accurate information and advice about their health coverage options, exchange participation is a natural fit. Agents should be compensated for providing consumers with this service using fair market rates. In fact, all successful state-level private purchasing pools and exchanges have elected to utilize the services of agents for this reason. We also feel that Navigators must be required to hold a Minnesota health insurance license.

## **Two markets, but one Exchange.**

To save costs, increase efficiency and preserve the long-term health of the state's private insurance markets, MAHU recommends Minnesota create one public exchange where both individuals and small-business owners can access coverage options, but with **separate underlying infrastructures and risk pools**.

## **Exchange structure.**

MAHU feels Minnesota should strive for the simplest administrative structure possible. Minnesota should utilize both its existing regulatory authorities and the current private health insurance marketplace structure, which provides thousands of jobs in our state, with as little disruption as possible.

## **Exchange governance.**

We also feel a Board of Directors structure like the Minnesota Comprehensive Health Association (MCHA) would be appropriate as an overseeing body for the exchange.

## **Maintain a competitive market outside of the Exchange.**

Minnesota should preserve its health insurance market outside of the exchange and ensure that requirements for exchange-participating health plans should mirror state laws for plan options being marketed outside of the exchange; otherwise, adverse selection will be prevalent.

## **Limit participation in the exchange to just individual and small employer groups (2-50).**

Allowing employers with 51 or more employees will entice employers to drop coverage, placing more strain on our current market.

**Subsidy dollars need to be available inside and outside of the Exchange.**

To discourage adverse selection against the exchange pool, we recommend Minnesota explore options that would also allow individuals who elect to buy coverage in the traditional market to also be eligible for a subsidy either through a waiver or a state-funded effort. The Massachusetts Connector provides for this to help avoid adverse selection.

MAHU encourages government leaders and others who are required to create a state-based exchange to utilize the best aspects of the private health insurance market by using professionals that service the health insurance needs of millions of Minnesotans.

## Policy Recommendations for Establishing a Health Insurance Exchange

December 1, 2010

The establishment of health insurance exchanges is one of the most significant and far-reaching aspects of the private health insurance reforms contained in the federal Patient Protection and Affordable Care Act (PPACA). Required to be operational by January 1, 2014, exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' qualified health plans. The Exchanges will have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid and Children's Health Insurance Program (CHIP), as well as administering the premium and cost-sharing credits enacted under PPACA. The exchange will transform Minnesota's private health care marketplace for individuals and small businesses buying coverage.

The Minnesota Chapter (MAHU) of The National Association of Health Underwriters (NAHU), is the leading professional trade association for health insurance agents, brokers and consultants. Our members service the health insurance policies of hundreds of thousands of Minnesotans and work on a daily basis to help individuals and employers purchase, administer and utilize health insurance coverage. Consequently, we have a profound interest in the development of Minnesota's insurance exchange and feel that the decisions state policymakers will be making over the next few years regarding the design will be critical. MAHU is pleased to offer a number of central ideas for successful implementation based on our members' everyday real-world policy experiences working in the distribution system with individuals and businesses of all sizes.

# **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

## **Minnesota Should Create and Operate its Own Exchange**

The first decision a state will need to make regarding an exchange is whether or not to establish an exchange at the state level in the first place. PPACA leaves implementation responsibility of exchanges for the small-group and individual markets primarily with the states.<sup>1</sup> However, exchanges are not optional. If a state fails to take the necessary steps to begin creating exchanges to serve one or both of these markets by January 1, 2013, the legislation requires the Department of Health and Human Services to create and operate exchange options for state residents instead.<sup>2</sup>



Assuming the PPACA remains unchanged, MAHU supports a State-based exchange as it is the only way for state policymakers to ensure that the unique interests of Minnesotans are being met. Furthermore, allowing for a federal fallback exchange for state residents and business owners would give the federal government unprecedented control over our state's private insurance market, but also our public health assistance programs like MNCare, Medicaid, GAMC and associated state-level expenses. The federal

government, not Minnesota, would establish enrollment/disenrollment and other plan function details normally under state control today.

Each state's population is different, with diverse needs and interests. Creating our own exchange will allow us the opportunity for variations and innovations to accommodate the specific needs of Minnesota residents. A Minnesota exchange will also provide residents with customized and timely consumer protections, patient advocacy and more effective customer service than a national exchange operated by federal regulators ever could.

A Minnesota exchange also will ensure that state officials have complete control over associated spending. PPACA does establish federal start-up grant funding for state-based exchanges, and requires

that each exchange must be self-sustaining by January 1, 2015<sup>3</sup> but there will be ongoing administrative costs, which will, in all likelihood, be borne by the state. If the state government retains control over its exchange's administration and design, it can make responsible choices about what type of exchange infrastructure best suits the state in terms of budget and the needs of its specific population. There are many different structural models for an exchange, some of which are much more costly for a

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

state than others. The two existing state-based exchanges, the Massachusetts Connector and the Utah Portal, bear this out. While the Massachusetts Connector has a staff of 50 employees and an annual budget of \$30 million, the Utah Portal is run by two individuals with an overall administrative budget of less than \$1 million.

If Minnesota elects not to create its own exchange and instead allows for a federal exchange to serve its residents, it also allows the federal government unprecedented control over state programs and spending. One of the stated functions of an exchange, according to PPACA, is informing individuals about their eligibility for Medicaid, CHIP or any applicable state benefits program and enrolling all persons found to be eligible. If a state creates its own exchange, then it retains control over its public health assistance programs, their eligibility rules and enforcement of those eligibility rules. However, if the federal fallback exchange mechanism is utilized, then federal regulators will assume control of determining eligibility and enrolling state residents in public assistance programs. With spending for Medicaid, MNCare, GAMC and other public health programs such an enormous part of Minnesota's state budget<sup>4</sup> it is hard to see how ceding unprecedented control over these programs to a federal entity would be financially sensible.

### **Inclusion of Health Insurance Agents and Brokers in State-Based Exchanges**

MAHU believes that exchanges should always include an option for participating individuals and businesses to contact a certified, state-licensed and independent agent/broker for assistance with their exchange-based coverage. PPACA specifically establishes that health insurance agents and brokers be allowed to enroll individuals and group plans in exchange-based products and assist with subsidies for eligible individuals.<sup>5</sup> Furthermore, independent agents and brokers should continue to be compensated for providing consumers with this service using fair market rates through the health insurance carriers with which they contract to do business. Minnesota should also consider offering agents and brokers financial remuneration for bringing individuals eligible for federal public health assistance programs, like Medicaid and MnCare, into the coverage system through the exchange, as has been tried in other states to improve coverage rates.

Health insurance agents and brokers work on a daily basis to help individuals and employers of all sizes purchase health insurance, use their coverage effectively and make sure they get the most out of the benefits they have purchased. They design benefit plans for the diverse needs of the public, explain coordination issues of public and private benefits to individuals/employees, explain how the interplay of existing federal and states law work, and solve

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

problems that may occur once coverage is in place. They also help employers of all sizes ensure compliance with state and federal laws and serve vital human resource functions for millions of American small businesses. They assist with claims and billing issues, which may include interacting with providers to correct coding issues. Their active assistance means that consumers' needs are addressed quickly, usually without the need to use the formal appeals process. Consumers' need for help in all of these areas will only increase as health reform is implemented.

Since it is the professional role of our members to provide consumers with accurate information about their health coverage options, exchange participation is a natural fit. In fact, all successful state-level private purchasing pools and exchanges have elected to utilize the services of agents and brokers for this reason. Those did not do so initially, like the Health Insurance Plan of California (HIPIC), which was the longest running state public purchasing pool to date (operational from 1993-2006), quickly found that the active participation of licensed agents and brokers was the key to the pool's enrollment success. The private market has years of experience in setting up exchange models, and with agents', brokers' and carriers' knowledge, exchanges will be able to minimize start-up costs. Agents and brokers can help an exchange anticipate consumer questions in advance and accelerate the program's start-up success. In addition, they will serve as a valuable resource to employers that operate in multiple states

and may be navigating overlapping and varying exchange rules. Employers with multiple state exposures have issues arranging coverage currently. Their need for professional assistance will only increase with the addition of exchange based coverage options.

However, to ensure that the advisors participating in the exchange are well-qualified and accountable to Minnesota consumer protection standards, it should be specified that all individuals and entities selling coverage or providing coverage option advice to consumers through any exchange should be subject to existing state insurance licensure and continuing education requirements, as well as all other applicable state-based regulations.<sup>6</sup> Trained and licensed advisors will help increase access and overall coverage rates by helping individuals determine what options were available and best-suited to their individual needs, and following existing state-based licensure and education requirements will ensure continued accountability and consumer protection.



# **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

## **Design and Structure of the Minnesota Exchange**

In designing the Minnesota Exchange, policymakers will need to make a multitude of structural decisions that will likely determine the exchange's success. One of the first key decisions a state will need to make is whether or not to create one exchange in the state or two. PPACA requires the establishment of an individual market exchange and also a Small Business Health Options Program exchange (SHOP exchange) to serve the small-employer market.<sup>8</sup> The new law also allows states to operate separate individual and small group exchanges, or to merge the two into a single exchange.<sup>9</sup> If a state elects to combine its exchanges, it will also have to decide whether or not to combine the underlying risk pools for each market or to keep those pools distinct.

To save costs, increase efficiency and preserve the long-term health of the state's private insurance markets, MAHU recommends the creation of one public exchange where both individuals and small-business owners can access coverage options, but with separate underlying infrastructures and risk pools.

From a consumer perspective, having just one exchange makes sense since it will be a single entity for the state to promote and individuals and business owners to access. Also, by combining the public aspects of the exchange for both markets, a state can avoid duplicating many administrative services like website management, risk adjustment and

advertising. One staff can serve the exchange for both markets, as can the same governing body.

However, for the exchange to be successful in the long term, it's just as important that, on the small-group back end, the state treat the exchange populations for the individual and small-group markets separately. PPACA requires insurers to pool all of their individual members in one risk pool and all of their small-employer group members in another, but the law also gives state exchanges the prerogative to combine risk pools.<sup>10</sup> Keeping participation pools distinct within the exchange is important for both the pooling of risk and for the administration of health insurance premium subsidies available to low-income individuals who purchase coverage through the exchange.

The idea of combining the individual and small-group risk pools might seem appealing; some believe it would make the entire exchange risk pool larger, theoretically reducing costs. It can be argued that individual consumers are relatively weak buyers of health coverage, as they are far more likely than a business owner to purchase health insurance coverage only in anticipation of needing to use the benefit.

This type of purchasing is known as adverse selection, which, if left unchecked, can cause price havoc to an insurance pool of risk. So, in theory, individual market consumers need the stability of the largest possible risk pool to mitigate their vulnerability.

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

However, PPACA already provides mechanisms that should ensure adequately sized risk pools for both markets, eliminating the need to combine them. The law includes both the requirement that all Americans must purchase qualified health insurance coverage in 2014, and employer responsibility requirements regarding the purchase of group coverage for those with more than 50 workers (including part-time employees on a pro-rata basis). Both of these provisions should, at least in theory, exponentially expand the number of people insured and the federal health insurance subsidies will ensure that they can pay for it.

Additionally, there is a requirement in PPACA that carriers must pool all of their individual coverage risks together,



regardless of whether the coverage was purchased through the exchange or not (excluding grandfathered plans), and there is a similar requirement for carriers regarding all small-group business.

Not requiring health insurance carriers to mix market types within their underlying exchange risk pools will also promote greater long-term health insurance market and exchange stability. State laws differ significantly between the group and individual markets, and actuarially these segments are quite different. Employer group health insurance participation expands and contracts with business

growth, whereas the size of individual or families can be more driven by a perception of an immediate need for coverage. Combining the individual and small-group market risk pools would likely cause adverse selection to the small-group pool, which would ultimately be much more costly to the exchange's participating consumers and health plans, and the insurance marketplace in general.

In the Massachusetts combination experience (which only encompasses a fraction of the state's small-group market), combining individuals and small

groups did not result in lower premiums. From 2007 to 2008, small-group premiums grew 5.8%, compared with 4.8% for

midsize and 5.4% for large groups, according to state figures.<sup>11</sup> Additionally, the American Academy of Actuaries cites in a recent issue brief that if a "guaranteed-issue individual market is merged with the existing small-group market, we would expect to see rates in the combined market to eventually increase overall... In fact, rates may increase very rapidly if employers and individuals realize that they can defer the purchase of insurance until there is a need for care."<sup>12</sup>

It is also important to note that all health insurance carriers currently keep these two pools of risk entirely distinct. Requiring them to combine these two

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

distinct blocks of business into one underlying risk pool could require significant infrastructure changes that would be both costly and time-consuming to implement and would certainly impact the price of premiums. Furthermore, it might reduce competition because some carriers may not find it profitable to remain in the individual and/or small-group markets.

Keeping the underlying individual and small-group exchange infrastructures separate is also important for effective subsidy administration. PPACA provides for subsidies for a number of different types of exchange purchasers: (1) individuals without access to qualified employer-sponsored coverage with family incomes between 100 % and 400% of the Federal Poverty Level; (2) low-income individuals whose employer-sponsored coverage fails to meet adequacy and/or affordability tests; and (3) qualified lower-income individuals who wish to opt out of their employer-sponsored coverage and utilize an “employee free choice” voucher to purchase coverage through an exchange. All of these categories of individuals need to purchase coverage through the individual market portion of the exchange; however, subsidies are not available to qualified group coverage beneficiaries, so keeping the two populations separate from an administrative perspective would be the most feasible course.

### **Regional Exchanges**

As an alternative or supplement to a state-based exchange, PPACA permits states to join together and

form regional exchanges. The idea of a regional exchange is appealing to many as a way of reducing state-level expenditures and associated administrative costs. However, MAHU believes it's also an idea that should be approached with caution. Unless flawlessly executed, due to variations in state laws and needs, a regional exchange could wind up actually being more costly and difficult to administer than separate state-based exchanges. Even contiguous states have very diverse populations and needs. Also, since the business of insurance has always been primarily regulated at the state level, each state insurance market has differing regulations, consumer protections and carrier participation. Resolving those legal differences in a way that is both consumer - friendly and administratively simple could prove to be extremely challenging.

### **Less is More - Keep the Exchange Structure Simple**

Once Minnesota decides it will create an exchange to meet the coverage needs of its individual and small-group market consumers, how the exchange will be structured, staffed and governed are the most important decisions that will need to be made. Generally, MAHU believes that a state-based exchange should strive for the simplest administrative structure possible, utilizing existing state regulatory authorities like the Department of Commerce for insurance regulation rather merely duplicating existing state government functions and services. In addition, we feel that a successful exchange model will utilize the current private health insurance marketplace

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

structure, which provides thousands of jobs in Minnesota, with as little disruption as possible. Utilizing these strategies of exchange design will be less costly to the taxpayers and grant consumers a greater degree of satisfaction and consistent protection.

*...MAHU believes that Minnesota should strive for the simplest administrative structure possible, utilizing existing state regulatory authorities...*

State-level exchanges are not a new concept. The exchange could be utilized as a means of connecting consumers with qualified and trained health insurance agents and brokers to provide them with guidance as well as subsidy enrollment and health insurance purchasing assistance. This function could be structured similarly to the Internet-based home sales portal operated by the National Association of Realtors, [www.realtor.com](http://www.realtor.com), which connects potential homebuyers with a state-licensed property listing agent.

Realtor.com is an excellent example of the portal approach to accessing a service that Minnesota might want to investigate. On the site, private companies compete and list homes for sale in one place in a standardized format. But [Realtor.com](http://Realtor.com) does not regulate the types of properties that can be listed, nor does it regulate the prices that sellers charge consumers. The

real estate market is also a good example of how multiple, competing portals or exchanges can be used to serve consumers, which is allowed under PPACA. While [Realtor.com](http://Realtor.com) is a nationwide service, it does not preclude individual and regional realty companies like Edina Realty and Coldwell Banker from operating their own portals to assist homebuyers.

Funding for the exchange should be done by a user fee for those who purchase their coverage through the exchange.

To make sure Minnesota's model for our exchange is sound we recommend working on the structure of our exchange carefully with input from all interested parties. Our suggested date for implementation is January 1<sup>st</sup>, 2014.

### **Maintain Two Separate Markets and a Level Playing Field between Them—Keep State Requirements the Same Inside and Outside the Exchange**

Another key issue Minnesota will need to address is how the rules governing exchanges will mesh with existing and varying state coverage protections. In an effort to maintain consumer and employer choices, and to ensure insurance options are available in the event the exchanges do not prove viable, Congress specifically provided that individual and group health insurance markets are to exist outside of the exchanges.<sup>13</sup> The law also permits consumers to go outside the exchange, without penalty, if they find less

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

expensive coverage there.<sup>14</sup> PPACA also provides for “grandfathered” plans to exist outside the exchange.<sup>15</sup>

Despite these protections for health insurance markets to exist independent of the exchange, it has come to our attention that some state policymakers see little need for preserving outside individual and small-group health insurance markets. MAHU feels that any action to limit coverage options outside of the exchange would be a serious mistake that could deprive health insurance consumers of innovative and potentially more affordable health coverage options.

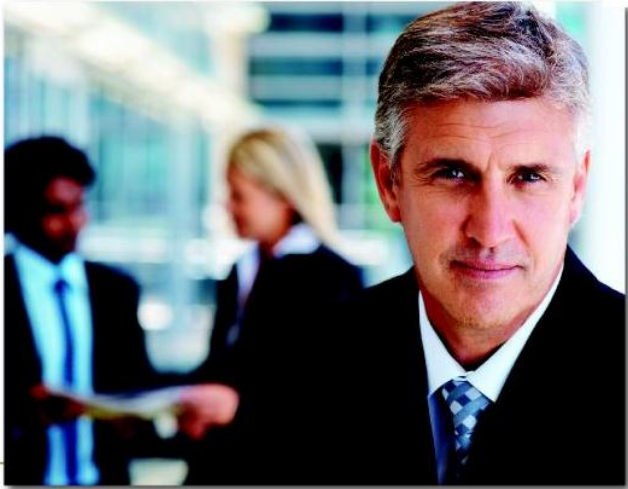
Exchanges may prove to be so popular with consumers that they may eventually subsume either the individual health insurance market or small-group market, or both. However, if that happens, it should be a natural market process, not a forced one. Exchanges are bound to encounter some hurdles as they are implemented. It would be imprudent to eliminate consumer choice and an outside marketplace in a time of such great marketplace change.

To make sure that both the exchange and an independent private market coexist in Minnesota peacefully, requirements for exchange-participating health plans should mirror state laws for plan options being marketed outside of the exchange; otherwise, adverse selection will be rampant. National experience with purchasing pools of all kinds shows

that pools that operate at the state level that also fairly compete with plans outside the pool are the least disruptive to the market. We strongly urge Minnesota not to create laws that are less restrictive inside the exchange, as that will merely attract more undesirable risks to the pool and cause short-term damage to the conventional private market. Laws that are more restrictive for exchange participating plans than the outside market will discourage health plan participation within the exchange. It’s critical that the exchange be structured in such a way that it does not damage or eliminate the traditional private insurance marketplace, and the best way to do that is keeping the playing field level. If the exchange totally replaces other private-market options, there may be no other vehicle for coverage if the exchange ultimately fails for any reason.<sup>16</sup>

PPACA establishes that rules regarding the issuance of health insurance coverage and health insurance rating methodologies will be the same for the individual and fully insured small-group markets, regardless if coverage is purchased through the exchange or through the traditional private market. These rules will go a long way toward ensuring even competition in the state. However, several other areas of market regulation may be different for exchange purchasers versus traditional market purchasers unless Minnesota makes efforts to account for these variances.

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**



Mandated insurance benefit requirements could vary significantly between the two marketplaces. PPACA requires that exchange-based plans include coverage of essential benefits and, while the framework of what those benefits will be are included in the statute, the specific details will be determined through a yet-to-be-issued federal regulation. PPACA also acknowledges that all states have their own laws on the books specifying mandatory coverage requirements for both individual and small-group plans, and that aspects of these requirements may be more stringent than the federal mandated essential benefits. If this is the case, the state is given the option of whether or not to extend its existing mandated benefit laws to the exchange population. If Minnesota elects to do so, however, it is responsible for bearing the cost of providing these additional mandated benefits to people receiving subsidized coverage through the exchange. In other words, no federal subsidy dollars may go to pay for additional state-level mandated benefits. Accordingly, each state

will need to carefully evaluate its mandated benefit requirements. If the Minnesota elects not to apply any of its specific mandated benefit requirements to the exchange population but still requires the traditional market to abide by those mandates, it could cause great harm to that market. Premiums in the traditional market would need to be proportionately higher than exchange premiums to account for the costs of the additional mandate benefits. Furthermore, individuals and groups who anticipated a need for those specific benefits would be perversely incited to buy traditional coverage versus the exchange-based products. The resulting adverse selection could cause premiums to spiral and the eventual demise of the traditional market. A better course of action would be to either adopt the federal standards both inside and outside of the exchange, or apply the mandated benefit standard evenly across all markets.

Another concern is product availability and participation requirements both inside and outside the exchange. Federal law limits exchange products to Platinum, Gold, Silver and Bronze plan designs. Furthermore, deductibles will be strictly limited, in effect barring high-deductible plans from the exchanges. Given the wide scope of services covered under PPACA's rules and the benefit levels mandate for the various plan designs, it's hard to see how affordability will be maintained for individual market consumers. Effort should be made to offer, within the existing guidelines, affordable choices for those consumers who wish to bear reasonable risk in

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

providing for their health security. In the absence of such options, Minnesota may find that only those individuals eligible for subsidized coverage may elect to participate in the exchanges.

However, on the employer side, if Minnesota is not careful regarding participation requirements for employer groups, there may be an uneven attraction of employer groups to the exchange-based marketplace. Currently, in the small-group market, many states and virtually all health insurance carriers require some degree of minimum employee participation in order to offer a group health insurance plan. These requirements are what prohibit many smaller employers from offering multiple benefit options to their employees, particularly from multiple insurance carriers. However, unless the state makes provisions otherwise, an exchange may allow multiple carriers to offer multiple products to the employees of a single employer—a feat that may not be able to be duplicated outside of the exchange unless the state addresses participation requirements.

A final aspect of the law that may create an unlevel playing field is the availability of subsidies for individual market purchasers. PPACA provides that the low-income tax credits for individual market purchasers are only available to those purchasing coverage inside the exchange, thereby strongly incenting such purchasers to buy an exchange-based coverage product. To discourage adverse selection in this manner against the exchange pool, we recommend Minnesota explore options that would also allow individuals who elect to buy coverage in the

traditional market to also be eligible for a subsidy, either through a waiver or a state-funded effort. The Massachusetts Connector provides for the use of subsidy dollars in both the traditional private and exchange-based markets for this very reason.

### **Focus on the Small Groups—Participation in the Exchange**

Another variable PPACA forces state-based exchanges to address is the size of the employer-sponsored health insurance plans that will be allowed to purchase coverage through an exchange. And there are multiple decisions a state will have to make in this regard. Before 2016, states will have the option to define “small employers” either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be



## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

defined as those with 100 or fewer employees in all states. MAHU supports leaving the definition of small employer at 50 or fewer employees.

A “large employer” will be an employer that had an average of at least 101 employees the preceding calendar year and at least one employee on the first day of the plan year. Initially, these employers will not be eligible to participate in the exchange, although PPACA allows the state the option of expanding the exchange to serve as a potential coverage option for larger groups beginning January 1, 2017.<sup>17</sup> MAHU recommends against Minnesota allowing larger employer groups to utilize the exchange as a purchasing mechanism. Current state-based exchange models in Utah and Massachusetts are only providing coverage options to the small-employer market; while both exchanges are still in their infancy, both have struggled to attract group participation. While it seems logical that adding larger groups would increase the numbers of pool participants, in reality these groups would have a negative impact on the pool due to the nature of those likely to apply for coverage.

PPACA establishes that mid-market fully insured plans (those with more than 100 employees) and self-funded employer group plans that purchase coverage outside of the exchange will be allowed to continue to use experience rating in determining their annual group health insurance premiums. This rating methodology, which uses the group’s actual de-identified claims data over a three-year period to shape highly accurate premium rates, is what allows

most larger employer group health plans to obtain the health insurance coverage price advantages they receive today. However, if Minnesota allows larger groups to participate in the exchange, those groups would be subject to the same modified community rating requirements as participating small groups and individuals. As stated previously, having different insurance market requirements for the same market for exchange participating groups and non-exchange participating groups will only lead to adverse selection — one of the main contributing factors to the demise of previous state-based purchasing pools. In this specific case, only the large groups with years of poor claims experience would financially benefit from exchange participation, and could consequently drag down the entire exchange’s pool of risk.

Finally, the employer-based system is the cornerstone of our nation’s health insurance coverage. For the majority of Americans under the age of 65, employer-sponsored health insurance is a dependable, reliable and cost-effective method for attaining high-quality health insurance coverage. Employers use health insurance benefits as a means of attracting and keeping quality employees. Group purchasing power helps employers obtain preferential pricing and provide employees benefits that are generally much more extensive than what is available to consumers spending a similar amount in the individual market. Administrative costs are also lower because coverage is provided to many individuals through a single transaction with one

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

employer. There is great flexibility with employer-sponsored plans as well, as employers can pick and choose among new benefit, payment and organizational innovations and can implement new programs and halt unsuccessful ones relatively quickly. There are also many advantages for employees, including but not limited to generous employer subsidies, tax advantages and the ease of the workplace-enrollment process.

Large employers that elect to allow their employees to purchase exchange-based coverage will be denying their employees many of the advantages of traditional large-group health insurance coverage. Furthermore, once a large employer ceases to provide traditional coverage and turns to the exchange, it becomes much easier for that large employer to elect to cease to provide employee benefits altogether and instead pay the corresponding fine. Since the employees will be accustomed to purchasing their coverage somewhat independently through the exchange anyway, and since the employer responsibility requirement fine for many employers may actually be less expensive than their exchange-based health insurance premiums, it is not unreasonable to assume many large employers might abandon the provision of health insurance to their workers. The intent of PPACA was certainly not to incent larger employers from getting out providing health benefits to their employees, but MAHU is extremely concerned that, by allowing large employer groups to participate in

state-based exchanges, that could be the unintended consequence.

### **Utilize Existing State-Based Institutions for Risk Adjustment**

Once Minnesota's exchange becomes operational, PPACA includes three risk-adjustment programs—two transitional and one permanent—designed to help transition health insurance markets to the new reforms.<sup>18</sup>

If plans outside the exchange attract a significantly healthier population than plans within the exchange, the former group will need to compensate the latter. The first risk-adjustment program, a permanent one to be administered by the states,<sup>19</sup> covers health plans inside and outside the exchange, but not self-insured or grandfathered plans. In this program, the state will assess plans and insurers with low-risk enrollees and make payments to plans and insurers with high-risk enrollees. Second, the bill includes a transitional reinsurance program to be implemented for 36 months (from 2014 to 2016) by the states under contracts with private reinsurers.<sup>20</sup> Finally during the 2014-2016 period, a risk-corridor program also will be available for qualified health plans in the individual and small-group market.<sup>21</sup>

The transitional reinsurance program is likely to prove very important for smoothing the introduction of the exchange, which is likely to pick up most of the participants in the federal preexisting condition insurance plan (PCIP) when it terminates

## **POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE**

at the end of 2014. States may also terminate their own high-risk pool programs and companies may terminate or cut back on early retirement coverage as the exchanges become available. Because individual mandate penalties do not fully phase in until 2017, unhealthy individuals will likely be over-represented in the exchanges for the first few years. The reinsurance program will help to ease this transition. The permanent risk-adjustment program also will be important, as it should deter risk selection against the various markets on a long-term basis.<sup>22</sup> As with exchanges generally, Minnesota has the option of not creating a risk-adjustment mechanism and instead subjecting itself and health

insurance consumers in the state to federal fallback enforcement through the Department of Health and Human Services. However, MAHU strongly recommends Minnesota elect to develop its own risk-adjustment system. All of the same control and consumer-protection reasons that apply to the creation of state-based exchanges generally apply to the risk-adjustment provisions as well, and financing should not be a consideration for Minnesota, as the reinsurance payment funds stem directly from the health insurance carriers. Furthermore, MAHU believes MCHA could easily be converted for the purpose of risk-adjustment administration at little to no cost to the Minnesota.

# POLICY RECOMMENDATIONS FOR ESTABLISHING A HEALTH INSURANCE EXCHANGE

## Conclusion

As an association of benefit professionals whose members service the health insurance needs of hundreds of thousands of Minnesotans, it is our goal to create a state-based health insurance exchange that will effectively meet the coverage needs of individuals and small-business owners who choose to participate in it and will also utilize the incomparable services of health insurance agents and brokers. Our members look forward to continuing our service as champions of health insurance consumers, and to serving as resources for federal and state policymakers in the exchange development process.

## ENDNOTES

1 § 1311(b)(1).

2 § 1321(c).

3 § 1311(a)(4)(B).

4 Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Molly O'Malley-Watts and Caryn Marks. "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession." Kaiser Commission on Medicaid and the Uninsured, September 2009.

5 § 1312(e).

6 § 1311(j) of the PPACA calls for exchanges to contract with "Navigators" — organizations and entities (including licensed health insurance agents and brokers) whose purpose is to help inform the public about the availability of qualified health plans and financial assistance, as well as to help enroll individuals into qualified health plans. § 1311(j)(4) also requires the HHS Secretary establish standards for Navigators to ensure that they are qualified, and licensed if appropriate, to engage in Navigator activities.

7 § 1311(f)(2).

8 § 1311(b)(1)(B).

9 § 1311(b)(2).

10 § 1312(c).

11 Jeremy Smerd, "Insurance Exchanges: Promise Dampened by Politics?" Crain's New York Business, May 9, 2010. <http://www.craigslist.com/article/20100509/SMALLBIZ/305099999>

12 American Academy of Actuaries, "Critical Issues in Health Reform: Merging the Small Group and Individual Markets," September, 2009, pg. 5.

13 § 1312(d).

14 § 1312(d)(1), (3) and (4).

15 1251(a).

16 Although most of the insurance reforms imposed by PPACA apply both within and outside the exchange, one notable exception which will create an uneven playing field and could well contribute to adverse selection against conventional insurance markets is that premium-assistance credits and cost-sharing reductions payments will be accessible only to individuals enrolled in health plans through the exchanges (§ 36B(b)(2) of the Internal Revenue Code, added by PPACA §1401 and § 1402(b)(1)).

17 § 1312(f)(2).

18 M. Hall, "Three Types of Reinsurance Created by Federal Health Reform," Health Affairs, 2010 29(6):1168-72.

19 § 1343.

20 § 1341.

21 § 1342.

22 T. Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, July 2010, p. 6.

23 The 35 states with existing high-risk pools are: Alabama (portability only), Alaska, Arkansas, California, Colorado, Connecticut, Florida (closed for new enrollees), Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Tennessee, Utah, Washington, West Virginia, Wisconsin and Wyoming.