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Health Insurance Exchange: The Importance of State Insurance Rules

Georgia Health Policy Center

J. Mack Robinson College of Business

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Georgia Health Policy Center,
Andrew Young School of Policy Studies and
Center for Health Services Research,
Institute of Health Administration
J. Mack Robinson College of Business
Georgia State University

Overview

Health Insurance Exchanges are entities that organize the market for health insurance by connecting small businesses and/or individuals into larger groups while facilitating the availability, choice, and purchase of private health insurance.[1] Exchanges have been around in some form for nearly two decades – as purchasing cooperatives, health alliances, and connectors – among states and private entities.[2] The long term sustainability of health insurance exchanges is dependent primarily on insurance rules that govern how plans are treated inside and outside of the exchange.

To be successful, exchanges must offer greater value than buyers can obtain outside the exchange. Exchanges, regardless of what they are called, vary in the combination of tools they have used to increase value. The tools which have been used historically to accomplish this are:

(1) Ensuring that rating rules are similar both inside and outside the exchange for both the individual and small group markets;

(2) Minimizing the risk that people with high cost medical needs will have a major impact on the group; and

(3) Reducing the administrative burden that small employers or individuals incur for selecting and managing their health insurance through group purchasing.

The Role of Rating Rules

Ensuring that the pricing of plans outside the exchange is based on a similar risk pool as those inside the exchange is the most powerful tool to reduce the cost of insurance in the long run. This tool will only work if insurance rules require plans to be priced so that small groups or individuals with lower cost medical needs cannot purchase insurance outside the exchange for a lower price. Similar products must be offered inside and outside the exchange, and similar prices must exist for individuals with both high and low medical needs. If small groups or individuals can find a lower price outside the exchange, they will leave the exchange and, gradually, those left in the exchange will be those with high cost medical needs. The exchange will no longer be able to sustainably offer greater value.

The Affordable Care Act (ACA) addresses part of this issue by requiring health plans to set their non-group and small-group premiums in advance, based on adjusted community rating, instead of evaluating and pricing the health risk of each purchaser separately. Age, family composition, tobacco use, and location are the main factors that can be considered in making adjustments to the fixed community rate.[3] The ACA requires that the same rules apply to plans offered both inside and outside the exchange. However, depending on their market and regulatory conditions, states will still have to determine, for example:

- 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.[4]

The Role of Risk

The success of state exchanges is also tied to risk selection. Pooling of risk is generally not successful when people with low medical needs can be enticed out of the pool. When this happens, the remaining population is comprised of less healthy individuals, often with high health care costs, which makes it difficult for an exchange to be financially viable in the long term. This skew in the covered population is called adverse selection. It is thought that this is what led to the failure of PAC Advantage plan in California, the Texas Insurance Purchasing Alliance, and Caroliance in North Carolina. In Florida, the state's high-risk pool closed in 1989, and many believe the cooperatives became the de facto high-risk pool, attracting more individuals with poor health.

In New York, Connecticut, and Massachusetts, insurers serving markets outside of the exchange are limited in determining premiums based on individual health risk; whereas, in Texas, North Carolina, and California, plans are allowed to vary rates based on risk. In states with community rating or other restrictions on premiums (for example, plans offered outside of the exchange being required to offer the same premiums as plans inside the exchange), adverse risk selection is less of an issue. Health Pass in New York operates under community rating and reports that in "In over the 12 years of operating, we have seen no evidence of significant systematic adverse selection."[5] In California, insurers are able to differentiate premium rates inside and outside the exchange; however, the insurers' ability to do so is limited to 10% below or above the standard rate. These provisions in the California law decrease the likelihood that large numbers of healthy individuals will be lured out of the exchange by significantly lower premiums.[6]

The Role of Group Purchasing

Small employers often face higher costs for providing health benefits than their larger counterparts because they are less able to spread risks, which results in unpredictable premiums. Exchanges attempt to level the playing field so that small businesses can offer competitive packages to their workforce, thus attracting equal talent to workers in the larger firms. When buying units are larger, the claims experience of the members is more predictable, and the pool may be more attractive to insurers.[7]

Group purchasing also has the potential to lower administrative costs. Individuals and small businesses spend a large amount of time, effort, and financial resources researching, negotiating, and administering health benefits. A well run exchange has the potential to be a one stop shop of information and access to a range of health insurance plans. The use of brokers in the exchange can also potentially minimize transaction costs for small employers. Many of the currently successful exchange models use brokers to further streamline the purchasing experience.

Examples

The chart on the next page illustrates the range of exchanges or exchange-like entities that have been implemented since 1993 and some of the factors which define them. All of the entities, except for the Massachusetts Connector and the Florida cooperatives sought to reduce administrative and purchasing costs for small groups by bringing buyers together. The Massachusetts Connector was designed for individuals, and the Florida cooperatives were set up as clearinghouses to provide information on plans and prices (Florida law prohibited its cooperatives from negotiating rates).

Name	State	Status	Number of Businesses	Number of Lives		Year Implemented	Factors
California Choice	CA	Active	10,000	160,000		1996	• Defined contribution plan: Employer subsidizes employee a set amount, giving each employee control over plan choice • Health rating allowed in the market outside of the exchange • Brokers included
Connector	MA	Active	N/A	200,000		2006	• Consists of two plans: *Care,* a subsidized plan for low-income individuals and *Choice,* an unsubsidized plan for individuals and small businesses. • Individual mandate • No health rating in the market outside of the exchange
Healthpass	NYC	Active	4,000	35,000		1999	• No health rating in the market outside of the exchange • Plans marketed solely through brokers • Acts as an information clearinghouse for employers • Selects participating plans • Plays role in structuring benefit options
Health Connections	CT	Active	20% of market	75,000		1995	• No health rating in the market outside of the exchange • Brokers included • Acts as an information clearinghouse for employers • Selects participating plans • Plays role in structuring benefit options
Healthy New York	NY	Active	15,347	160,000		2001	• No health rating in the market outside of the exchange • Maintains affordability throughout state – reinsurance at 90% for claims above $5,000 and the benefits offered are limited
Utah Health Exchange	UT	Active	1,000	2,880		2009	• Small group limited launch for employers <50 employees • Of the 99 eligible initial volunteering employers, 19 dropped out during application process; by end of first year, 11 employers remained
Florida Health Purchasing Alliance	FL	Inactive	Unknown	98,000		1993	• Ceased 2000 • State prohibition on cooperative's negotiating rates - must accept all plans • Lower commissions for brokers • Looked promising early on, but over time only able to attract smallest employers and unable to maintain enrollment
PAC Advantage	CA	Inactive	6,000	116,000		1993	• Ceased 2006 • Health rating allowed in market outside of the exchange • Brokers excluded • After a promising start, these factors began to inhibit the necessary rate of uptake, causing premium rates to rise
Texas Insurance Purchasing Alliance	TX	Inactive	1,000	13,000		1993	• Ceased 1999 • Health rating allowed in the market outside of the exchange • At its peak, only covered 1,000 firms/13,000 individuals
Caroliance	NC	Inactive	1,020	3,310		1995	• Ceased 2001 • Health rating allowed in the market outside of the exchange • Lack of brokers • Not allowed to negotiate over quoted premium rates • Enrollment too small to attract insurers

Conclusion

The Affordable Care Act requires that an insurance plan offered outside the exchange have the same premiums as that plan offered inside the exchange. However, insurance plans not offered in the exchange may be priced according to state law. As a result, small changes in plan design or benefit levels could still attract those with better risk to plans only offered outside of the exchange. How states choose to amend their insurance rules to account for this will perhaps play the most important role in whether or not an exchange is successful.

Two other factors needed for a successful exchange are minimizing risk for the pool and reducing administrative burden through group purchasing. These mechanisms decrease costs and add to the value of exchanges for small groups and individuals; however, the long term sustainability of health insurance exchanges will be dependent on state insurance rules that govern how plans are treated inside and outside of the exchange.

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Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University
14 Marietta Street, NW, Suite 221
Atlanta, GA 30303
www.gsu.edu/ghpc

Center for Health Services Research
Institute of Health Administration
J. Mack Robinson College of Business
Georgia State University
PO Box 3989
Atlanta, GA 30302
http://robinson.gsu.edu