



Establishing a National Health Insurance Exchange

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Conference Report

Table of Contents

Session Title	Speaker(s)	Page
Key Themes		3
Case Study: Massachusetts' Commonwealth Health Insurance Connector	<p>Jon Kingsdale, Ph.D. <i>Executive Director, Commonwealth Health Insurance Connector</i></p> <p>Nancy Turnbull <i>Associate Dean for Educational Programs, Harvard School of Public Health</i></p>	4
Policy Considerations for a National Health Insurance Exchange	<p>Len M. Nichols, Ph.D. <i>Director, Health Policy Program, New America Foundation</i></p>	7
Addressing the Key Policy Considerations	<p>Murray N. Ross, Ph.D. (Moderator) <i>Vice President and Director, Kaiser Permanente Institute for Health Policy</i></p> <p>John Bertko, F.S.A., M.A.A.A. <i>Adjunct Staff, The RAND Corporation and Brookings Visiting Scholar</i></p> <p>Stuart M. Butler, Ph.D. <i>Vice President, Domestic and Economic Policy Studies, The Heritage Foundation</i></p> <p>Alissa Fox <i>Senior Vice President, Office of Policy and Representation, Blue Cross and Blue Shield Association</i></p> <p>Walt Francis <i>Expert in Advising Consumers on Health Plan Choices</i></p> <p>John McDonough, Dr.PH., M.P.A. <i>Senior Advisor to Senator Edward M. Kennedy, Senate HELP Committee</i></p>	9

The Health Industry Forum is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

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Key Themes

Overview

Establishing a national health insurance exchange—or system of state-level exchanges—is a critical element of health care reform. Through an exchange, small employers and individuals can access coverage through a program that offers administrative efficiencies and purchasing power comparable to large group programs. Although there is broad consensus that health insurance exchanges are needed, there is substantial disagreement about the scope of an exchange's activities, where it should be located, who should have access to it or be required to use it, and how it fits into the overall vision of health care reform. As the Massachusetts experience illustrates, an exchange is a critical mechanism for expanding health insurance coverage under a competitive multi-payer model. While central to insurance market reform, exchanges as envisioned in national health reform proposals are unlikely to significantly affect the rate of growth in health spending.

Context

On July 20, 2009, the Health Industry Forum brought together leading experts to debate policy considerations for establishing a national health insurance exchange.

Key Themes

- **Current small group and non-group/individual insurance markets aren't working.**

Participants agreed that while the large group insurance market works reasonably well, small group and individual markets are dysfunctional. The only way to drive comprehensive change is through federal legislation.

- **Most stakeholders support the concept of an exchange.**

The idea of an exchange that allows individuals and small employers to access coverage similar to that of a large group is generally supported by key stakeholders. This concept is also supported by the Congressional committees working on health care reform and by leaders in both parties.

- **The Massachusetts model is working well.**

Since Massachusetts has successfully achieved near universal coverage, policymakers working on national health insurance reforms have adopted many concepts from the state's program in their proposals. The Commonwealth Health Insurance Connector has been central to successfully implementing the state's coverage expansion. Among the key principles from Massachusetts that apply at the national level are:

- *Shared responsibility.* Mandates require all individuals and employers to get insurance or face a penalty. The individual mandate is included in both the Senate and House legislation; however, the employer mandate differs in each bill and is not supported by employers.

- *Insurance market reform.* Even before the 2006 health reforms passed, Massachusetts required guaranteed issue and renewal and adjusted community rating in the individual and small group markets. The 2006 law also merged the individual and small group markets.

- *Subsidized coverage.* In Massachusetts, about 60% of the newly insured received subsidized coverage. A key role of the Connector is to coordinate administration of the subsidies with Medicaid and other state agencies.

- *Risk adjustment.* Overseeing and ensuring that risk adjustment works is a key role of an exchange.

- *Consumer education.* The Connector provides extensive information to consumers, enabling them to learn about and compare plan options.

- **As the exchange concept is applied nationally, many critical questions must still be resolved.**

- *What is the long-term vision?* The current debate has focused on specifics and does not present a clear vision such as creating a mechanism for all individuals to have access to the benefits of large group purchasing.

- *Where will exchanges be located and who will run them?* National exchange models like the Federal Employees Health Benefit Program have worked well, but state-level exchanges could be more closely aligned with state insurance regulators and would likely generate more innovation. Bills being discussed in the House and Senate allow for state, regional, and federal exchanges, with differences in which option is presumed.

- *Who will use an exchange?* There is agreement that an exchange should include small employers and individuals but definitions differ. Current bills in Congress define "small" as 10 or 20 employees, which could be problematic for small firms with more than 20 workers.

- *When will exchanges commence?* The options being discussed in Congress call for an exchange in 2012 or 2013, partly to reduce costs associated with insurance subsidies.

- *What is grandfathered?* President Obama has said people can keep what they have. Decisions need to be made on what this means in terms of benefit design, rates, and transition periods.

- **The exchange concept is a critical component of health care reform, but payment and delivery system reforms are needed to drive meaningful cost control.**

Forum participants view exchanges as a necessary element of comprehensive health care reform. The Massachusetts Connector is an active purchaser for approximately 160,000 subsidized enrollees, and has achieved spending growth below the state average. However, its modest size affords it very limited impact on market-wide spending levels. More controversial payment and delivery system reforms are necessary to slow current rates of spending growth meaningfully.

Case Study: Massachusetts' Commonwealth Health Insurance Connector

Speaker: **Jon Kingsdale, Ph.D.**, Executive Director, Commonwealth Health Insurance Connector

Responder: **Nancy Turnbull**, Associate Dean for Educational Programs, Harvard School of Public Health

Overview

Landmark 2006 health care reform legislation in Massachusetts has led to coverage for 430,000 newly insured state residents. Presently 97.4% of the state's residents are insured, the highest rate in the country. There is much from the Massachusetts experience that can inform the national health care reform debate. Central to the success of implementing health reform has been a new health insurance exchange, the Massachusetts Connector Authority, which facilitates coverage efficiently for individuals and small businesses.

The Massachusetts Connector operates in a market that already has long-standing insurance market rules of the type being considered nationally. Within this context, there are many options for design of an insurance exchange. The Connector operates several distinct programs. For subsidized enrollees it serves as a purchasing cooperative that specifies benefits, oversees bidding and carrier selection, and administers subsidies. For non-subsidized enrollees it serves primarily as a distribution channel. The Connector must coordinate with other state agencies, work with insurers and brokers, and invest substantial resources in educating the public regarding available benefits. As Congressional leaders finalize proposals for health care reform, the Massachusetts Connector offers important lessons about key areas that must be addressed under a health insurance exchange.

Context

Dr. Kingsdale and Ms. Turnbull shared their perspectives on the process of implementing the Massachusetts Health Insurance Connector Authority, its successes, key challenges, and how the Massachusetts health reform experience can inform the national debate.

Key Takeaways (Kingsdale)

- **Massachusetts' health reform is a major success.**

Dr. Kingsdale shared data detailing some of the achievements of the Massachusetts Health Care Reform initiative:

- *97.4% of state residents are now insured.* In just two years since health reform was passed, almost 430,000 residents have become insured, reducing the uninsured rate to 2.6%, the lowest rate of any state.
- *43% of the newly insured are privately insured.* Health reform doesn't just bring more people into Medicaid; almost half of the newly insured enrolled through their employer plan.
- *Almost all taxpayers are complying.* The compliance rate among tax filers is 98.6%.

— *The cost trend has not been exacerbated.* Health insurance costs in Massachusetts were increasing 8-12% annually both before and after health reform. However, CommCare—the part of the program administered by the Connector, and an active purchaser—has seen a cost trend of just 4.7%.

"It turns out that enrolling everyone doesn't exacerbate cost issues."

— Jon Kingsdale

While the newly insured have not exacerbated cost trends, cost control has become a major priority in Massachusetts. A special state commission recently proposed major changes to health care reimbursement, shifting from fee for service to capitation—to help control costs and accelerate delivery system reform.

— *High satisfaction.* Those participating in the Connector give it good marks, and the overall satisfaction ratings for Massachusetts health reform range from 69 to 75%. These are great results for a program's first few years.

But the numbers don't tell the human story. People who now have coverage have been able to seek care when they otherwise would not have. Some individuals have received diagnoses and treatments that have saved their lives.

- **Key elements of Massachusetts' health reform are now central to the national policy debate.**

- *Shared responsibility.* Massachusetts reforms were passed based on the principal that reform requires commitments and contributions from individuals, government, and employers.
 - **Individuals.** In Massachusetts, adults are mandated to purchase insurance, if they can afford it; in their annual state tax filings, they indicate whether they had insurance or were exempt for financial (or religious) reasons.
 - **Government.** The government is responsible for providing premium assistance to those who are at or below the 300% federal poverty level and lack access to other subsidized coverage, such as employer-sponsored insurance, Medicare or Medicaid.
 - **Employers.** Employers with eleven or more employees must make a fair and reasonable contribution toward coverage or pay an assessment.
- *Insurance market reform.* Many of the key elements of insurance market reform under debate were already in place in Massachusetts prior to its 2006 health reform legislation. These include guaranteed issue and renewal, and adjusted community rating. Defining Minimum Creditable Coverage, another key national policy issue, has proven challenging in Massachusetts.

In the national discussion there is talk of “grandfathering” all existing policies—i.e. if you like it you can keep it—including benefits packages and rates. Massachusetts did not do this because grandfathering would result in a continuation of plans with benefits that fall below the minimum requirements. For example, Massachusetts’ Minimum Creditable Coverage includes prescription drugs. This was controversial because some wanted to continue purchasing lower-cost plans without drug coverage.

—*Insurance exchanges.* The term “exchange” is used widely but means different things to different people. Based on the Massachusetts model, an exchange would include the following functions:

- Subsidizing coverage for the low-income uninsured. Government pays a portion of the cost of the health insurance premium based on income level.
- Offering coverage to targeted market segments, such as individuals buying directly and small groups. The individual market was the starting point in Massachusetts.
- Specifying a defined set of plan designs at each of three different actuarial levels with a set of rules and coverage tiers for unsubsidized coverage.
- Selecting and contracting with health plans. Just creating an exchange isn’t adequate. The goal is to attract quality health plans that give consumers choices that will keep them well and cover them when they are sick.
- Educating consumers and selling health plans. Educating uninsured consumers requires significant outreach and marketing. To address this need, the Massachusetts Health Connector leads an ongoing public information campaign to inform residents and businesses, and to help consumers understand the pros and cons of different plans and what best fits their needs.

The congressional committees drafting health reform legislation all envision some form of an exchange. One of the major tensions is whether primary responsibility will be placed with the federal or state governments.

—*Senate Health, Education, Labor, and Pensions (HELP)* has proposed grants to establish state exchanges with a federal fallback if a state doesn’t act.

—*Senate Finance* initially proposed a national exchange but has shifted towards a policy of state exchanges. The exchanges that it envisions would be web-based information portals (health insurance “Yellow Pages”) versus active negotiators and purchasers of health care.

—*House (3 different) Committees.* These committees envision a national exchange, with the ability for states to opt out. A new independent agency like the Social Service Administration would run the national exchange, which would focus on qualifying people for subsidies along with regulating insurance.

▪ **The Massachusetts Health Connector’s experience can help inform key elements of designing a national exchange model.**

Dr. Kingsdale outlined seven design issues that exchanges must consider:

1. *Governance.* The Massachusetts Health Connector is a semi-independent public agency with a diverse board which holds public meetings. This structure is working well.
2. *Coordination with other agencies.* One of an exchange’s key roles is to coordinate with a host of state agencies, including Medicaid, the Division of Insurance, the Department of Revenue, and Health and Human Services. Reform involves change for other state agencies as well so, for example, the Connector works with Revenue on the interpretation, tax enforcement, and appeals of the individual mandate, and with Insurance on the regulation of new insurance offerings.
3. *Premium rating in the exchange.* The Massachusetts Connector acts as both a wholesale purchaser of subsidized insurance and a retail distribution channel, offering commercial insurance products to uninsured individuals. This requires that the Connector act as a purchaser, a negotiator of rates (based on ACR), and a risk manager.
4. *Risk adjustment.* To “channel” competition among health plans away from “skimming” off the healthy members and toward offering efficiency, high quality, etc., premiums are based on the acuity (health) of the covered lives. Initially, the Connector used reinsurance and age, gender, and geography to predict acuity, but it has now added an explicit adjustment for the health of each enrollee, based on their claims history.
5. *Benefit specification.* Specifying benefits involves market research to ensure that the Connector offers plans that consumers want. Now that the Connector has experience, it can see which plans and benefit designs consumers are signing up for. Plans have been standardized for easy comparison, based on (a) what people want to buy, and (b) innovative designs that the Connector encourages.
6. *Carrier bidding and selection.* A key role of the Connector is encouraging and managing competition through regular bidding cycles in which it sets forth desired objectives and encourages existing and new competitors to compete. The criteria for selecting plans are completely transparent. The Connector is focused on building long-term relationships with health plans, and wants them to view the Connector as a profitable business segment, where they can earn 1-2% margins.
7. *Administrative functions.* Enrolling consumers into health plans through an exchange requires significant outreach and marketing. It also involves eligibility determination, subsidy administration, billing for enrollee premium shares, customer service (the Connector fields 50,000 calls per month), and appeals.

Dr. Kingsdale sees the value of exchanges as: representing and protecting enrollees; acting as a prudent purchaser; providing

consumer choice and managed competition; and creating economies of scale to distribute insurance efficiently to individual consumers and small groups.

Key Takeaways (Turnbull)

Ms. Turnbull was appointed to the Connector Board by the Massachusetts Attorney General as a representative of consumer interests. She agreed with most of Dr. Kingsdale's comments and offered additional thoughts on the Connector's success.

Like Dr. Kingsdale, she supports the Connector's governance structure, including the diverse board with multiple consumer representatives. The transparency of board deliberations brings integrity to the process.

- **The success of the Massachusetts Health Connector is built on a history of reform and a few specific factors.**

Ms. Turnbull sees the Connector as building on twenty years of health insurance reform in Massachusetts. Previous reforms, many of which were legislatively difficult, built a foundation for the Connector and created preconditions. These include requiring insurers to rate products for self-employed individuals and small groups in the same rating pool, thereby giving individuals better rates. States that lack the same history may find it more difficult to create exchanges.

Ms. Turnbull doesn't believe that the Connector could be successful without other policies that were part of the 2006 reforms, including:

—*Expansion of publicly subsidized coverage.* Of the newly insured in Massachusetts, 60% have been covered through public subsidies, either from Medicaid or Commonwealth Care. The ability of the Connector to start with the existing Medicaid plans allowed it to get up and running quickly.

"The Connector without public subsidies would not be as effective."

— Nancy Turnbull

—*An individual mandate.* The individual mandate has been effective in requiring individuals to secure coverage. About one-third of the newly insured have gotten coverage through employer plans; people appear to have joined plans they were already eligible for but hadn't joined. About 10% (approximately 45,000 individuals) of the newly insured have purchased private, non-subsidized coverage and about half of those (22,000 individuals) sought coverage through the Connector.

- **There would be benefits to having the Connector be the sole mechanism for purchasing small group and individual policies.**

Today, the Connector is one of many ways in which small groups and individuals can purchase health insurance. Ms. Turnbull suggested that making the Connector the exclusive purchaser of small group and individual policies would create far more purchasing clout, create a larger risk pool, decrease administrative costs, encourage greater innovation in plan design

for these segments, and increase value. It would also permit risk adjustment across plans, which is occurring with the subsidized plans for which the Connector is the exclusive purchasing entity.

Participant Discussion

- **Policy too.** The Connector is more than a distribution mechanism for insurance. It also plays an important role in most aspects of health care reform policy. For example, the state legislature delegated decisions about "Minimum Creditable Coverage" and premium "affordability" to the Health Connector's board.
- **Exemptions.** Individuals in Massachusetts who cannot purchase "affordable" coverage—according to the Connector's progressive schedule of what households at increasing income levels can afford to pay for Minimum Creditable Coverage—are exempt from the individual mandate. About 75,000 individuals were exempt in the mandate's first year (2007).
- **Appeals.** The Connector has appeal processes for various programs, including tax-filers' appeals of the individual mandate, but the number of appeals has been less than was anticipated. For calendar year 2007, there were only about 2,200 tax payer appeals of the mandate, out of nearly four million filers. The Connector's appeals unit budget was about \$2.5 million, but only spent approximately \$250,000. One reason for the low number of appeals may be that the initial tax penalty for not purchasing insurance was low, at just \$219. As the penalty increases the number of appeals may increase.
- **Non-enrollees.** Not a tremendous amount is known about the 2.6% of state residents who are still not covered; however, these non-enrollees tend to skew towards young, male, single, Hispanic, and low-income residents. Reflecting on previous focus groups with the uninsured who earn too much to qualify for subsidies, Dr. Kingsdale commented that many of them disdain insurance, some even calling it a rip-off. They are cynical about insurance, doctors, and hospitals and have a "young immortal" outlook with little concern for injury or chronic diseases.
- **Auto enroll.** One participant suggested that instead of requiring individuals to enroll in an exchange, an alternative approach could be to automatically enroll everyone who lacks insurance. To avoid being part of an exchange, individuals would have to opt out.

Policy Considerations for a National Health Insurance Exchange

Speaker: **Len M. Nichols, Ph.D.**, Director, Health Policy Program, New America Foundation

Overview

At the federal level, there is a great deal of interest in, and momentum for, establishing health insurance exchange(s). Exchanges are part of the discussion in the Senate and House committees that are working on health care reform. These committees recognize that the current health insurance market doesn't work for the small group and non-group segments. The goal is to provide all Americans with the advantages of large group health insurance.

There remain many details to be worked through regarding where exchanges will be organized and who will run them; who must and who may participate; what exchanges will do; when they will begin; what the role of employers will be; and how exchanges will affect the business model of insurers.

While Congress has not yet resolved many aspects of exchanges, what is known is that the final legislative outcome will be far from perfect, implementation will take time and will occur in phases, and the cost will be significant. To guide the hard decisions that policymakers must make, a clearer long-term vision is needed.

Context

Following the discussion of the Massachusetts Health Insurance Connector, Dr. Nichols outlined the key considerations for a national health insurance exchange. He focused on the why, where, who, what, and when of exchanges.

Key Takeaways

- **Why: Exchanges are needed to enable all Americans to have access to the advantages of large group purchasing.**

Currently, the only insurance market that is working is the large group market. Non-group market underwriting is increasingly unacceptable and the small group market is failing small employers. Small employers face faster premium growth, high loads, explicit or de facto underwriting, and moribund competition—and the situation isn't getting any better.

"The small group market is failing small employers."

— Len M. Nichols

Establishing an exchange enables all Americans to have access to the advantages of large group purchasing.

- **Where: The Senate and House have different views of where exchanges will be organized, but both allow for national and state exchanges.**

The House presumes a national exchange, but would allow states to petition to operate their own exchange. Under the House bill, an entity currently being referred to as the "Health Choices Administration" would run a national exchange. States could

apply to run their own exchanges as long as they can do so consistent with federal rules.

The Senate HELP Committee (Health, Education, Labor, and Pensions) starts with the presumption that exchanges will be organized by states. HELP supports sub-state exchanges (for example, multiple exchanges could exist within California), and multi-state exchanges, where states can join together to form a regional exchange. HELP calls for a federal fallback for states that are unable to administer an exchange. HELP would allow states to decide whether an exchange was run by the government, by a non-profit entity, or by a quasi-independent entity.

It is not yet clear where the Senate Finance Committee will come out, but Dr. Nichols' best guess is along the lines of HELP's presumption of state-run exchanges.

- **Who: Legislators have not yet resolved who will be in exchanges or what is a "small" business.**

Important questions that must be addressed are:

— *Who must be in exchanges?* According to HELP, no one must be in an exchange; anyone can opt out. The House would require that individuals and small groups be in an exchange.

— *Who may be in exchanges?* HELP and the House would both allow individuals and small groups to be in exchanges.

— *Who may keep what they have now?* President Obama's statement "You can keep what you've got if you like it" has been accepted by the House and the Senate as gospel. As a result, everyone is grandfathered everywhere. In addition, HELP would allow individual and small group markets to continue to exist (as is the case in Massachusetts), but with conformed insurance market rules. The House requires rule congruence in the entire group market by 2017.

— *How small is small?* This is an extremely important question. Both chambers of Congress favor a phased approach where "small" is initially defined as 10 or 20 employees, and possibly increased at a later date. The problem is that employers with 21 employees would not be deemed "small" and would not be able to participate in an exchange. Options exist in the pending bills for larger employers to opt in later.

"Some see in these provisions precious little relief for larger small firms who are not happy with their status quo."

— Len M. Nichols

- **What: Those in the health care debate envision many specifics for what exchanges could do, but an overall vision is lacking.**

Dr. Nichols accepts that there is no such thing as a perfect bill or a perfect exchange. He also accepts that exchanges will evolve in phases. However, deciding exactly what an exchange should do should be based on a long-term vision, which he sees as lacking.

Government leaders need to articulate a clear vision so that the near-term steps are consistent with the long-term vision.

Among the tasks performed by exchanges:

- *Administering qualified health plans' participation in the exchange.*
- *Overseeing insurer marketing and conduct.*
- *Monitoring/enforcing competition.*
- *Keeping track of monetary flows.*
- *Overseeing and ensuring that risk adjustment works.*
- *Aiding in the enforcement of purchase mandates.*
- *Ensuring compliance with benefit offering rules and requirements.*
- *Managing choices.* For HELP this includes managing choices with SCHIP; for the House it means managing choices from Medicaid (after 3 years).

The Massachusetts Health Connector currently plays two key roles. It "offers" insurance and information and it "purchases" insurance, which involves negotiating, selecting, and purchasing. Currently most federal policymakers only envision exchanges in the "offering" role. While in Massachusetts the Connector is working to address health care costs, controlling costs is not part of the exchange conversation at the federal level. The Massachusetts legislature is attempting to address cost savings through separate efforts focused on topics such as Medicare payment reform.

▪ **When: The House and Senate envision exchanges starting in 2012 or 2013, with intermediate measures.**

HELP envisions exchanges beginning in 2012; in the House bill its exchange starts in 2013. These delays are to push back when spending begins. However, because this is such a critical piece of health care reform, it seems hard to imagine that implementation would be pushed back until after the next presidential election.

There are interim or intermediate measures that members of HELP have discussed. HELP calls for a tax credit for smaller, lower-wage employers under certain conditions, and both HELP and the House envision reinsurance for retiree health plans.

▪ **There are additional issues that must be addressed, such as whether to change health insurers' business model.**

It is possible to create a robust market for small employers and individuals. But doing so could have significant implications for the business model of health insurers. A decision to fundamentally alter the business model of insurers should be based on an overriding vision. Dr. Nichols supports a vision of providing the advantages of large group purchasing to small groups and individuals. In doing so, insurers will be forced to change their business model from risk selection to helping provide value and health to customers.

Other issues to address include the size and scope of exchanges, age ratings, transition issues, and the role of employers. Congress has not paid enough attention in the current debate to employer issues. Among the areas requiring further discussion

are: pay or play; employer tax credits; and employee versus employer choice. For example, do employers pick an actuarial tier and then employees pick within the tier?

The reality is that the cost of an exchange and insuring the insured will be significant. The starting point should be to decide what we as a country want to do, based on a clear vision, and then to decide how we are going to pay for it.

Participant Discussion

- **Steps and phases.** The participants agree that implementing exchanges is a long-term undertaking that will occur in phases. However, other than pushing back spending, there is no legitimate reason why exchanges need to be delayed until 2012 or 2013. A functioning system for Medicare Part D, which is more complicated than an exchange, was operational within 2.5 years. In Massachusetts, tens of thousands of individuals received coverage within ten weeks of legislation being passed.
- **Tier selection.** Allowing individuals and small groups to select tiered plans (such as gold, silver, and bronze) may require increased prices for all tiers. Sick people disproportionately select the highest level of coverage (gold) while healthy people select the lowest coverage level (bronze). John Berko commented that the risk adjustment is pretty good for the higher risk pool but is not as good for the lower risk pool. The result is that prices need to rise by 2-3% for all tiers. Dr. Nichols views a 2-3% price increase as a small price to pay to make small business happy by providing exchanges and flexibility around tiers.
- **The young and healthy.** If young, healthy people have their own risk pool, the risks and costs of coverage are low. But if they are made part of a larger pool, the cost of their coverage increases. Under an exchange, this group would likely be forced to pay more; they lack the political clout to prevent this. Walt Francis explained that federal employees are all part of one pool, regardless of age, but younger people pay only about 80% of what older people pay.
- **Redistribution of spending.** While there is much discussion and debate about the incremental cost of health care reform, perhaps more important is how to reallocate and redistribute overall health care spending.

Addressing the Key Policy Considerations

Moderator: **Murray N. Ross, Ph.D.**, Vice President and Director, Kaiser Permanente Institute for Health Policy
 Panel: **John Bertko, F.S.A., M.A.A.A.**, Adjunct Staff, The RAND Corporation and Brookings Visiting Scholar
Stuart M. Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, The Heritage Foundation
Alissa Fox, Senior Vice President, Office of Policy and Representation, Blue Cross and Blue Shield Association
Walt Francis, Expert in Advising Consumers on Health Plan Choices
John McDonough, Dr.PH., M.P.A., Senior Advisor to Senator Edward M. Kennedy, Senate HELP Committee

Overview

Many panelists agreed that a health insurance exchange could have a critical role in national health insurance reform. The debate is now around specific issues such as where an exchange should reside (at a federal or state level), what should be grandfathered, and the transition process. Many panelists also agreed that while exchanges are extremely important for fostering competition in insurance markets, changes in delivery system organization will require new kinds of payment models.

Context

Panelists shared their perspectives on exchanges and the role an exchange can play in health care reform. Massachusetts was referenced as a model being considered in the current legislation; however, the political process may yield a different design even though many see the Massachusetts model as one of the effective ways to provide health insurance coverage to the uninsured.

Key Takeaways

- **There is no consensus about whether exchanges should be state-based or national.**

Dr. Butler and Ms. Fox favor state-based exchanges under a framework, goals, and rules set by the federal government. They believe a national exchange would be hierarchical, bureaucratic, and confusing for consumers. It would duplicate functions already performed at the state level.

"A federal exchange would be costly, complex, and confusing."
 — Alissa Fox

Because states set insurance regulations and deal with insurer solvency, the states are the best places for exchanges. In addition, having multiple state-based exchanges would lead to greater experimentation.

"We want states to experiment and figure it out over time."
 — Stuart M. Butler

Ms. Fox and Dr. Butler also emphasized the need for shared responsibility. Ms. Fox said that insurers would support guaranteed issue in the individual market, but only if accompanied by an individual mandate to ensure a risk pool that included both healthy and sick people. Dr. Butler believes

a new kind of shared responsibility is needed. What has existed has been shared responsibility between individuals and employers; what is needed is a sharing of responsibility between individuals and society.

Countering the state-based argument, Mr. Francis stated that the federal government already operates three exchanges—for Medicare Advantage, Medicare Part D, and the Federal Employees Health Benefits Program (FEHB), and these exchanges work well. (Mr. Bertko concurred that the exchange created for Medicare Part D, Plan Finder, is working well.)

"The federal government operates three national health care exchanges that are performing most of the tasks discussed [at this Forum] . . . and all of them are working quite well."
 — Walt Francis

These exchanges have plan competition, benefit design flexibility, low administrative costs, good consumer information systems, and high consumer satisfaction. Mr. Francis acknowledged that these exchanges don't deal with state-level insurance regulation issues, and that state-level exchanges are more likely to spark innovation and new ideas.

- **Exchanges can contribute to "bending the cost curve" but controlling costs would require delivery system reform.**

In general, panelists and participants saw value in the concept of an exchange, but viewed exchanges as having only a limited impact on costs. Mr. Bertko offered two ways that exchanges can impact costs:

—*By lowering administrative costs.* By making comparative information easily accessible, the expense of agents, with commissions as high as 20-30%, can be significantly reduced. Renewal commissions are quite a bit lower, but many non-group enrollees have the coverage for only a short while (e.g., between jobs).

—*By fostering competition.* The exchange offered as part of Medicare Part D has helped control drug costs by fostering competition between plans. The power of exchanges can also be seen through FEHB, which has outperformed Medicare in keeping costs down, even though Medicare can set prices.

Participants from private plans said they are working to control costs and improve quality. What is needed is a change in the Medicare payment model away from paying for volume

through fee for service. Changing the Medicare payment model is an important step that will impact the cost curve.

Such comments prompted participants to observe that the policy debate taking place is mainly focused on insurance reform; not on comprehensive health care reform.

"Insurance reform won't change delivery."
 — John Bertko

Reforming health care requires changing the payment system and the delivery system, which is not being talked about.

"We are talking about health insurance reform, which is necessary but not sufficient. The heavy lifting, which is not being talked about, is around delivery system reform . . . we have to move away from unrestrained fee for service; it will bankrupt the country."
 — Participant

The action that is needed is moving from fee for service to some form of global payment. This would drive delivery system changes.

The problem is that as politically difficult as exchanges are, changing the payment system and altering the delivery system are even more difficult because it means paying providers differently and in some instances paying them less. Some participants view starting with a long-term vision and proceeding with exchanges as a good first step.

steps. Some participants suggested not grandfathering benefits and rates forever, but having multi-year transitional phases.

- **Employers' role.** Dr. Butler suggested a different role for employers. Instead of designing and paying for coverage, employers should facilitate the coverage process, nudge the various stakeholders, and let individuals make decisions. This is analogous to the role employers have in retirement benefits.
- **Spending limits.** Dr. Butler commented that the theory behind legislation is often that micro changes will ultimately bring about the desired macro results, such as controlling costs. He sees this as unlikely. Instead, he believes there is a need for large-scale, macro action, which would limit the budget on tax-funded health programs and tax subsidies, especially tax exclusions. This would force hard choices.

Participant Discussion

- **Off the table.** Despite the endorsement of economists, the concept of tax caps appears to be off the table. The idea was to tax wealthy individuals who have "Cadillac coverage." However, many firms with high-priced insurance don't have Cadillac policies; their higher premiums are due to having an older workforce. Also, higher-income states in the Northeast have more expensive—but not necessarily Cadillac—coverage. This attempt to get wealthy people to pay more sounded appealing, but is complex, impractical, and now off the table.

Another idea that is off the table is a \$.10 soda tax. A soda tax could generate significant revenue, change consumer behavior, and help address obesity. But, this idea is off the table in both the Senate and the House.

- **Grandfathering vs. transitioning.** Ms. Fox favors grandfathering because keeping groups separate would mitigate premium spikes. Mr. Bertko doesn't see an issue in allowing small employers to keep their current benefit designs, but grandfathering rating requirements and rating levels would add complexity.

The panelists and Forum participants recognized that implementing exchanges would be a gradual process that must take place in phases. Jon Kingsdale described the need for a long-term vision that is implemented through a series of