Center for American Progress

THE ASSOCIATED PRESS/DAMIAN DOVARGANES

Toward an Effective Health Insurance Exchange

A Roadmap to Successful Health Care Reform

Maura Calsyn June 2012

Center for American Progress

Toward an Effective Health Insurance Exchange

A Roadmap to Successful Health Care Reform

Maura Calsyn June 2012

Contents

Introduction and summary

The central goal of the Affordable Care Act—to ensure that all Americans have access to quality health care—is a dramatic departure from the longstanding approach to health care in this country. The means of accomplishing this goal, however, are far from revolutionary. The legislation both preserves the private market for health care insurance and creates new, virtual marketplaces for uninsured individuals and small businesses to shop for health insurance products. These marketplaces—called exchanges—will provide both individuals and small businesses with one-stop, streamlined shopping for health insurance. When the exchanges are up and running, an estimated 20 million to 23 million Americans will use these markets to obtain health insurance.[1]

The exchanges will not replace existing health insurance markets. Thus, much of their success will depend on how well their design and operation account for the specific health care environments in which they will operate. States are currently responsible for regulating most health insurance, and state insurance markets vary greatly due to different legal requirements as well as differences in demographics and geography. Because of these differences, the Affordable Care Act intended the exchanges to be state run: The law gives states first crack at designing and implementing the exchanges within its broad requirements and offers funding to help states with these efforts.

If a state elects not to implement an exchange or is unable to have a functioning exchange ready by 2014, the health reform law requires the federal government to run the exchange on behalf of the state.[2] Four states—Arkansas, Louisiana, New Hampshire, and Maine—have announced that they will not pursue a state-run exchange. Additionally, it is likely that a federally facilitated exchange will also operate in many other states: Seventeen states have yet to begin exchange planning or implementation efforts and progress in other states has been very slow.[3] States may also choose a hybrid "partnership" exchange; taking day-to-day responsibility of plan management and customer assistance in a federally facilitated exchange.[4]

The design and implementation of the federally facilitated exchange presents a significant challenge requiring federal policymakers to coordinate closely with each state, taking into account the state's existing insurance market, specific health care needs, and political environment. But the federally facilitated exchange also offers an opportunity to advance reforms that help constrain health care costs and encourage the delivery of high-quality care. This paper suggests policies for the federally facilitated exchange to accomplish these goals, specifically:

- Creating state-specific advisory boards to advise federal policymakers about local health care environments

- Utilizing a variety of tools, including active purchasing, to reduce costs and encourage quality care

The federally facilitated exchange will be crucial to the success of the Affordable Care Act. The opportunity to design and implement an exchange that is consumer focused, offers high-value products, and fosters needed reform should not be squandered.

How the exchanges will work

For millions of uninsured Americans, these exchanges will be a gateway to health insurance coverage. The exchange will determine if an individual is eligible for Medicaid or the Children's Health Insurance Program, or CHIP, and if eligible, the exchange will enroll the person in that program.[5] If an individual does not qualify for one of those programs, she or he may then shop for and enroll in one of the exchange-selected private health insurance plans.[6]

The Affordable Care Act includes various levels of financial assistance in the form of premium tax credits and cost-sharing reductions for households with incomes of up to 400 percent of the federal poverty level—$43,320 for individuals and $88,200 for a family of four.[7] During the enrollment process the exchange will also determine if a person is eligible for this help.[8] Consumers will be able to compare health insurance plans based on quality and cost, using a web-based calculator that takes into account any financial assistance.[9]

Exchanges must provide a range of other customer-assistance services, including toll-free hotlines and websites, and engage in outreach and education efforts to encourage enrollment and ease this process.[10] Each exchange must also award grants to "navigators"—individuals and entities charged with helping consumers and employers learn about the exchange and enroll in qualified health plans—to support these efforts.[11]

Exchanges will also operate a Small Business Health Options Program, or SHOP.[12] Employers can select one or more qualified health plans for their employees, who will then choose from among those options.[13] Employers will also choose their level of contribution toward employees' coverage.[14] Similar to the individual exchange, employers and employees will be able to make side-by-side comparisons of qualified health plans and choose health plans based on cost and quality. The health care law also helps some small employers meet the cost of offering health insurance through a SHOP: Businesses with fewer than 25 full-time employees who earn average annual wages of less than $50,000 are eligible for a tax credit if they contribute at least 50 percent of the total premium cost.[15]

Because of their critical role in health care reform, the exchanges must run efficiently, provide consumer-friendly service, and promote access to quality, cost-effective care. Much of the success of these efforts will depend on the exchange's "plan management" role. Behind the scenes, the exchange will select which health plans may offer coverage in its market by certifying those plans as qualified health plans. The exchange will then manage those qualified health plans.

The federally facilitated exchange will carry out these functions in the states in which it operates, and it must meet the same requirements as the state-based exchanges.[16] These requirements are very broad and just as the states have flexibility in designing and implementing their exchanges, so do federal policymakers in the case of the federally facilitated exchange.

The Centers for Medicare & Medicaid Services, or CMS, the agency responsible for the design and implementation of the federally facilitated exchange, has published guidance on how it plans to operate the federally facilitated exchange. CMS will "seek to harmonize" exchange policies "with existing State programs and laws wherever possible."[17] It believes this approach will "promote the competitiveness of each [federally-facilitated exchange], minimize administrative burden for insurance issuers, and ensure consumer protections."[18] The guidance also discusses plan certification and other policy requirements and gives an implementation timeline for the federally facilitated exchange.

The role of exchanges in health care reform

For large groups the existing state insurance markets function reasonably well. These groups can usually purchase affordable, quality health care for two reasons: their size creates a stable risk pool in which premiums paid by healthy, lower-cost people subsidize the cost of insuring sicker, higher-cost people; and larger groups also have greater market power, allowing them to bargain with insurance companies on a more level playing field.

On the other hand, small groups and individuals purchasing health insurance directly from insurers are unable to spread risk and have little, if any, market power. As a result, the insurance sold in these markets can be prohibitively expensive.

Making this situation even worse is the difficultly of navigating the individual market. Individuals shopping for insurance find that the process is far from consumer-friendly—they must navigate a myriad of plan options and try to understand how different coverage limits, cost-sharing arrangements, and provider networks should affect their choice.

The exchanges will help solve these problems. They bring together a large and diverse group of health care purchasers and thereby create market power. Additionally, the exchanges will make the purchase of health insurance more consumer friendly, allowing side-by-side comparisons of plans and providing consumer assistance.

Exchanges, however, will only be successful if they include a sizable number of healthy individuals. Because the exchanges do not replace the existing health care markets, they must compete with plans offered in the existing insurance markets for this group. If the exchanges attract a disproportionate number of people in poor health, the average cost of insuring people in the exchange will rise, which in turn will raise premiums for everyone in the pool. If this "adverse selection" occurs, those in better health will be less willing to join the exchange or will leave if there are more reasonable options available in the outside markets, which in

turn will cause costs to rise even further—a scenario deemed the "death spiral." The Affordable Care Act tries to minimize this risk in a variety ways.

First, many healthy individuals without access to employer-sponsored insurance will have a financial incentive to stay in the exchange pool. The premium tax credits and cost-sharing reductions are only available when insurance is purchased through the exchanges.[19] Similarly, small employers may only claim the federal tax credit if they offer insurance to employees through the exchange.[20]

Second, many of the law's reforms apply both within and outside of the exchange, helping to level the playing field. For example, plans in both markets may no longer impose lifetime or annual dollar limits on coverage or include preexisting-condition exclusions.[21] Qualified health plans inside of the exchanges and new plans outside the exchanges must also cover the same essential health benefits.[22]

Third, the law includes three risk-sharing programs—risk adjustment, temporary reinsurance, and temporary risk corridors.[23] These programs will spread the financial risk borne by health insurance issuers and help keep premiums stable, especially during the first three years of the exchange.

These requirements greatly limit the ability of insurers to offer the types of plans outside of the exchange that attract the youngest, healthiest individuals—plans with very low premiums, high cost-sharing, and limits on coverage. They do not, however, fully eliminate the risk of adverse selection because there may still be differences between the markets. Because states are responsible for regulating the existing insurance markets, they can make additional changes to the nonexchange markets to eliminate remaining differences. Plans within the exchange, for example, may not use benefit design to discourage enrollment by individuals with significant health needs.[24] States could extend this prohibition to plans outside of the exchange.

Federal policymakers do not have the option of regulating the nonexchange markets to eliminate differences between the markets that may increase adverse selection. Instead, they must find other ways to further reduce this risk and encourage younger, healthier individuals to look for coverage inside the exchanges.

Recommendations for the federally facilitated exchange

One way for exchanges to compete with the outside market is to offer more "bang for the buck." Exchanges can accomplish this by providing a top-notch customer experience and selection of health plans that offer high-quality coverage at reasonable prices. This approach also furthers the broader goal of the Affordable Care Act of containing health care costs. Whether these efforts will be successful depends on federal policymakers developing detailed knowledge of customer needs by state and, even more important, a commitment to driving payment and quality reforms through active purchasing.

Establish state-specific advisory committees

The federally facilitated exchange should establish a separate advisory board for each state in which it will operate. The advisory boards should be the part of the stakeholder consultation process and a starting point for statewide outreach and education efforts. These boards will also provide valuable advice on state insurance markets and customer-assistance programs.

At almost every step in the design and implementation of the federally facilitated exchange, federal policymakers must consider the state environment in which the exchange will function. The Centers for Medicare & Medicaid Services has acknowledged this challenge and hopes to harmonize exchange policies with existing state programs wherever possible.[25] It also hopes that states that do not have a state-based exchange will choose to enter into a partnership exchange with the federal government and agree to run the day-to-day management or consumer assistance functions of the exchange. The Centers for Medicare & Medicaid Services designed the partnership options "to leverage traditional state rules, as well as help states that want to transition to a state-based exchange."[26]

Certainly, relying on existing state frameworks makes sense in many situations. If a state has a robust customer assistance infrastructure in place and is willing to

expand its role to include the federally facilitated exchange, it is smart to leverage those resources. Because health plans offered in the federally facilitated exchange must meet state licensure and solvency requirements and be in good standing with the state, it is much more efficient for the state to conduct that review.[27]

Even if a state decides to enter into a partnership exchange, federal policymakers must still consider the state's regulatory environment, the needs of its population, and any other state-specific issues that might impact exchange functions. Advisory boards will help fill in these blanks in a more thorough, methodical way than an ad hoc, fragmented stakeholder consultation process.

Advisory board membership

Advisory board members should represent each of the stakeholder groups recognized in the Affordable Care Act. All exchanges, including the federally facilitated exchange, must consult with:

- Educated health care consumers who are enrolled in qualified health plans
- Individuals and entities with experience in facilitating enrollment in health coverage
- Advocates for enrolling hard to reach populations
- Small businesses and self-employed individuals
- State Medicaid and CHIP agencies
- Federally recognized Native American tribes
- Public health experts
- Health care providers
- Large employers
- Health insurance issuers
- Agents and brokers[28]

For the federally facilitated exchange, this process must also "ensure that the needs of the states in which it operates are met."[29]

A number of states have formed advisory groups to ensure that state residents, exchange beneficiaries, and other relevant stakeholders have a voice as the exchange is implemented and administered. Two of the more robust examples include the District of Columbia and Vermont advisory committees. These two advisory boards include a mix of health care professionals; private health insurance consumers; Medicaid enrollees; disease-specific advocacy groups;

commercial and public-sector health plans; small-business owners; brokers; health care consumer interest advocacy groups; health care foundations; and exchange consumers.[30]

The federally facilitated exchange advisory boards should include a similar mix of experts with diverse backgrounds. At a minimum, the boards should include:

- A representative from each of the stakeholder groups listed in the Affordable Care Act and its regulations, including representatives of the state Medicaid and CHIP offices, if the state is willing to participate[31]
- A representative of the state insurance office, if the state is willing to participate
- Five additional consumers or consumer advocates

A representative from the Centers for Medicare & Medicaid Services from the relevant regional office would serve as a liaison to the board. Membership should reflect a state's geographic and demographic diversity. Further, its members should include a range of ages. Not only do the insurance needs of a 30-year-old differ from those of a 60-year-old, but outreach and educational efforts will likely vary between these groups as well.

This structure provides flexibility to address state-specific issues. If, for example, a particular demographic group is expected to comprise a large percentage of the exchange population or is traditionally underserved in the health care market, it is important to include a representative of that group. Similarly, if specific public health issues disproportionately drive insurance costs in the state, experts and advocates with knowledge of these issues should be advisory board members.

Areas of advisory board guidance

To make the most of their knowledge, federal policymakers should list specific areas of focus for the advisory board. First, the advisory board should help identify the exchange's target market, including vulnerable, underserved, and otherwise hard-to-reach groups in the state that the exchange will need to take special efforts to reach. Second, the advisory board should identify any barriers to enrollment that may exist for each of these groups. Using this information, the advisory board can then recommend specific education, outreach, enrollment,

and customer service efforts that will maximize participation in the exchange. At a minimum, the advisory boards should provide advice on the following:

- Navigator certification standards[32]
- Navigator training standards[33]
- Nonnavigator individuals and entities willing to assist in informal outreach efforts
- Ways to expand the stakeholder-consultation process
- Public-awareness campaigns, including media
- Opportunities to partner with popular local businesses, including at public events
- Marketing materials
- The number and types of plans offered on the exchange
- Face-to-face enrollment and consumer interaction
- Call center accessibility
- Website content

Advisory boards should also be charged with assisting federal policymakers in their review of the state's existing insurance and health care markets. The Centers for Medicare & Medicaid Services will have a sense of the expected market share and volume of the exchanges and the existing level of competition in the states' existing markets, but advisory board members will have a far more nuanced understanding of the state markets.

This advice will be particularly important in states in which the political leadership or public remain hostile to health care reform. Outreach, education, and enrollment efforts will be extremely challenging in these states. There may be gaps in communication between the states and federal policymakers and the Centers for Medicare & Medicaid Services may not be able to rely on state officials for guidance. A formal and transparent advisory board with broad knowledge of the state's health care system and its specific needs can play an understudy role when a state's leadership is disengaged.

In these states the advisory boards can also help the federally facilitated exchange operate less like a distant bureaucracy and more like a hands-on, local enterprise. The advisory boards will help give the exchange a local presence. Board members will be a personal link between the state's consumers and small businesses and federal policymakers, and collectively they will offer suggestions for engaging a public that might be wary of the law.

To function more like a local business, the exchange must also have an on-the-ground presence in each state where it operates. The advisory board should recommend a navigator that can provide space that will function as a *de facto* exchange office for advisory board meetings and in-person enrollment. In larger states advisory boards might recommend more than one navigator so that offices can be located throughout the state. The Centers for Medicare & Medicaid Services liaison to the advisory board should also visit the offices regularly to see how the exchange is functioning. With these steps, the exchange should be better equipped to answer local concerns about health care reform and to modify its outreach, education, and enrollment strategies to reach local residents and businesses.

Use active purchasing and other tools to reduce costs, improve quality, and enhance consumers' experience

The federally facilitated exchange should implement policies, including active purchasing, that reduce costs, improve quality, and enhance the consumer experience. The exchange should use its market power to negotiate with health insurers and exclude plans that offer lower value to customers or that do not encourage cost and quality reforms. It should reward plans that offer more value to customers. Additionally, its structure should allow exchange customers to easily compare plan offerings.

Similar policies have helped to restrain costs and improve quality in both federal and state exchanges. The Federal Employee Health Benefits Program, or FEHBP, serves as the health care exchange for more than 8 million federal employees, retirees, and dependents, including members of Congress. FEHBP negotiates with plans based on both cost and quality, and over the past decade, it has held premium increases below the industry average.[34] The Massachusetts Commonwealth Health Insurance Connector—the state's exchange—uses competitive bidding to select plans based on quality and value. This proactive approach has helped to contain costs: premiums within the exchange's Commonwealth Care program have increased at much lower rates than those in the outside market.[35]

The following are specific recommendations to reduce costs, improve quality, and assist consumers. Many build on the successful FEHBP and Massachusetts policies. Because of differences in individual state markets, it may not be possible to implement each recommended policy in the same way in each state, but the exchange should strive to implement these recommendations.

Use competitive bidding to secure the best premium rates and to promote payment and delivery reform

For at least the first year of the federally facilitated exchange, the Centers for Medicare & Medicaid Services has adopted an open marketplace model.[36] During this period the exchange will act as a clearinghouse that is open to all qualified plans. CMS should transition to active purchasing, however, as soon as possible.

The federally facilitated exchange should set minimum quality standards, including measures of access to care for underserved populations, that health plans must meet in order to participate in the exchange. Plans meeting those standards would then compete with each other for exchange business based on cost.

The exchange should also require plans to incorporate payment or delivery reforms into their contracts with providers as a condition for competing for exchange business. Plans, for example, could implement value-based purchasing for hospitals and physicians under which they would reduce payments to providers with lower-quality ratings or reduce payments to hospitals with high rates of preventable readmissions.[37] Plans could also implement other pay-for-performance arrangements with providers.

Reward high-performing plans

The exchanges should provide bonus payments to the highest performing plans. The Centers for Medicare & Medicaid Services plans to fund the federally facilitated exchange through user fees from participating insurers.[38] The user fees should include an extra per-plan charge that is then redistributed to high-performing plans.

Federal policymakers should use the Affordable Care Act's Medicare Advantage bonus payment structure as a starting point for designing this award program. The law created substantial bonuses for Medicare Advantage plans that rated highest on a number of quality measures, including patient satisfaction.[39] Only qualified health plans with the highest quality scores should receive these payments, and if no plan scored at a high enough level, no payment would be made for that performance period. The exchange should further refine bonus payments to offer the largest bonuses to plans that not only meet stringent quality and patient satisfaction measures, but offer the best value to customers as well.

Customers should be able to easily find plans that offer the lowest-cost, highest quality or have the highest "Medical Loss Ratio"—the amount an insurance company spends on health care services and health care quality-improvement efforts.[40] The exchange should award a "Gold Star" or other special designation to those plans. And when individuals and small businesses search for plans on the exchange website, the exchange web portal should display these "Gold Star" plans first. Individuals and small businesses shopping for plans on the exchanges will then know quickly and easily which plans offer the highest value.

To further encourage plans to reduce costs and improve quality, the exchange should use its auto-enrollment mechanism to reward high-value plans. The Medicare Part D auto-enrollment policy enrolls beneficiaries only in low-cost plans.[41] The exchange should build on this model and maintain a list of plans that rank in the lowest quartile of cost but maintain above average quality ratings. When the exchange needs to automatically enroll an individual in a new plan, it should randomly assign the person to one of these high-value plans.

Policymakers should also consider other creative ways to use the market power of the federally facilitated exchange to assist plans in controlling costs.

Create a manageable choice for individuals and businesses

The exchange marketplace gives individuals and small businesses control over their health care costs, allowing consumers to select a plan that best meets their needs from a variety of options. The Affordable Care Act places broad restrictions on the benefits and costs of those plans, but plans still have significant flexibility in designing different insurance options.

First, all plans offered by the exchange must cover "essential health benefits"—specific categories of medical care such as emergency services and prescription drugs.[42] Second, the Affordable Care Act lists four levels of coverage based on their actuarial value that may generally be offered by insurance issuers.[43] The plan's actuarial value is based on the average percentage of total covered health care costs paid for by the plan.[44] The bronze-level plan must provide benefits equivalent to 60 percent of actuarial value, the silver-level is 70 percent, the gold-level is 80 percent, and the platinum-level is 90 percent.[45] The enrollee pays for the remainder through premiums, deductibles, co-payments, and co-insurance.

Within each of these tiers, plans could offer countless variations with different premiums, deductibles, co-payments, and co-insurance amounts. A plan with low premiums but high deductibles, co-payments, and co-insurance can have the same actuarial value as a plan with high premiums but very low deductibles, co-payments, and co-insurance. In addition, plans may expand on the list of essential health benefits.

Although choice is an essential feature of the exchanges, too many choices can also confuse consumers, making the process of shopping for insurance overwhelming, confusing, and frustrating. This "choice overload" can reduce customer satisfaction and lead to random, uninformed choices that may not reflect the individual's best interests or financial situation.[46]

Choice overload already impacts that health insurance market. In Medicare Part D, for example, consumers choose from an average of 33 plans and many times select prescription drug plans that do not meet their needs.[47] And in the Medicare Advantage context, the Centers for Medicare & Medicaid Services found that "the large number of MA [Medicare Advantage] plan options … has made it difficult and confusing for beneficiaries to distinguish between these plans and to choose the best option to meet their needs."[48]

A smaller number of health plan options also encourages consumers to focus on quality and cost. One expert has noted that "[c]hoice is optimized if it focuses the enrollee's attention on the salient features of the health plan."[49] By managing the number and type of insurance products the exchange offers, the exchange can focus consumer attention on price, cost-sharing requirements, and quality ratings.[50] This will also encourage competition, which in turn can lower costs.[51] Moreover, standardization may limit health insurers' ability to structure benefit and cost sharing for risk-selection purposes.[52] Evidence also suggests that older or less healthy plan members are less likely to change plans than younger, healthier enrollees.[53] For that reason, increasing plan choices may lead to adverse selection.[54]

The Massachusetts Commonwealth Health Insurance Connector offers real-world support for these findings. The Connector currently offers a limited number of standardized plans: insurers offer one gold product, two silver products, and three bronze products.[55] The design of the Connector has shifted over time. Originally, the exchange offered far more plans, but based on consumer feedback and focus groups the Connector limited its plan options.[56]

The federally facilitated exchange should follow this lead and standardize health insurance products by specifying plan designs and standardizing cost sharing. Because the exchange will operate in many different state insurance markets, federal policymakers should consider the existing market when setting requirements for plan design and cost-sharing. The requirements must be flexible enough to preserve consumer choice, yet narrow enough to avoid choice overload. The exchange should seek feedback from enrollees and modify the number of types of offerings available based on this information.

Structure the website and customer-assistance programs to help customers make informed choices

Regardless of how the exchange's structures its offerings, the website and customer-assistance programs will play a key role in facilitating informed consumer choice. The website must be user friendly and provide an appropriate level of cost and quality information, and navigators must be able to help consumers use these tools to select appropriate health plans.

Consumers should be able to compare plans based on out-of-pocket costs. The website's calculator and plan-comparison functions should allow consumers to review and compare each plan's estimated total out-of-pocket costs. When researching plan options, consumers should be able to enter their age, family size, ages of dependents, and self-reported health status, and the estimate should reflect these specifics. The Medicare Part D website already calculates costs for different plans based on beneficiaries' prescription drugs. The exchange website should build on this model.[57]

The website should also allow consumers to select common conditions or illnesses to estimate how ongoing treatment may impact their costs. The costs of an individual with young children, for example, may differ from the costs of an individual with children in their twenties. Likewise, two individuals with self-reported "fair" health status might have different health care needs depending on what illness or condition they may have. Advisory board members should help policymakers determine if there are any state-specific factors such as geography that may drive costs and therefore should also be included.

Consumers also need to know what providers are in each plan's networks. The exchange website should include a tool that allows individuals to search for plans

with networks that include their doctors. The website should also have a tool to compare the breadth of provider networks and how these differences may impact a consumer's out-of-network costs. This information will be particularly useful to rural residents, whose plan selection may be driven in large part by the availability of local providers. Moreover, consumers should also have access to quality information about the plan's providers. The provider director for each plan should include provider quality information.

The website will include the results of enrollee-satisfaction surveys.[58] The Small Business Health Options Program exchange should also solicit feedback from employers and make that information available to employers. To be of real assistance to consumers, the exchange should display these results broken down by utilization and patient condition.

The experiences of patients who have large medical expenses are extremely relevant in determining a plan's quality.[59] If all patients' experiences are aggregated without breaking out the opinions of sicker, higher-utilization patients, a plan may appear to have high consumer satisfaction, but in reality it may just have a very high number of healthy patients.[60] Similarly, when individuals are selecting between qualified health plans they should be able to see how enrollees with similar health needs believe the plans function.[61]

Because the website will ask for customer-specific information during this process, the exchange has the responsibility of protecting this personal health information. Likewise, when individuals self-report health status as part of their customer-satisfaction surveys, the exchanges must protect this information.

Design the SHOP exchange to protect older employees and minimize adverse selection

The SHOP exchange gives small businesses an opportunity to offer health care coverage by qualified health plans to their employees. But an unintended consequence of the SHOP exchange could be that some older employees will pay higher premiums than they do currently in the small group market.

Today, health plans usually set premiums for businesses based on the average health status and age of the entire group. Businesses with older, less healthy employees generally pay more for health insurance than businesses with younger,

healthier employees. Within each of these employee groups, all employees generally have the same cost-sharing obligations regardless of their health status or age.

The health care reform legislation potentially changes this group treatment. The law gives employers a range of options in selecting plans for their employees. An employer might decide that its employees could choose between all plans offered on the SHOP exchange, it could select a metal level (gold, silver, bronze) and employees would then choose between plans at that level, or it could select one or more specific plans for their employees.[62]

If individual employees select different health care plans insurers will no longer be able to set group-based premiums. Instead, insurers will charge a separate premium for each employee that is enrolled in their plan. And because insurers can adjust premiums based on an enrollee's age—up to three times the amount for a younger employee—older individuals could pay up to three times the amount as their youngest colleagues.[63]

The federally-facilitated SHOP exchange should structure employer premium contributions so that this "rate shock" does not occur. Employers should pay a percentage of the average premium for a selected "reference plan." This approach is based on the successful Connecticut Business and Industry Association Health Connections program.[64] First, the employer selects a qualified health plan that will be the "reference plan." The exchange then sets a uniform premium for each employee in the reference plan, and the employer sets its contribution as a percentage of the average premium. Any employee that chose the reference plan would pay the same premium.

Employers could also allow employees to select a different qualified health plan. If employees chose those plans, they would be responsible for the difference in premiums between the reference plan and the selected plan. If the employee chose a less expensive plan, she or he would save on premiums. This approach also provides financial certainty to employers—they will know their contribution amount before employees select their plan.

During the first years of its operation, the SHOP exchange should also limit employers' choice across metal levels (gold, silver, bronze) to minimize adverse selection. If employers gave their employees an unlimited choice in plans, younger, healthier individuals might gravitate to lower metal levels, leaving a disproportionate share of older, less healthy individuals in the reference plan.

Once the SHOP exchange is operating and has a sufficiently large number of employers shopping for coverage to spread out the risk, these restrictions could slowly be removed.

Conclusion

Exchanges will play a key role in the success of the Affordable Care Act. Active purchasing, as part of the exchange design, offers an opportunity to build consumer-focused marketplaces that offer high-value products. The exchanges also have "the opportunity … to fundamentally change the dynamic of negotiation of contracts on the commercial side—between commercial payers and providers."[65] This opportunity should not be wasted. The federally facilitated exchange should encourage payment and delivery system reform in the private health care market.

These goals are fully compatible. This paper recommends an active, hands-on approach by federal policymakers. And while it may not be possible to implement each of our recommendations and suggestions immediately, together they present a roadmap for successful health care reform.

About the author

Maura Calsyn is the Associate Director of Health Policy at the Center for American Progress. Prior to joining the Center, Maura was an attorney with the Department of Health and Human Services' Office of the General Counsel. During her time there she served as the Department's lead attorney for several Medicare programs and advised the Department on implementation of the Affordable Care Act. Before joining the Office of the General Counsel, Maura worked as a health care attorney at two international law firms. Maura's interest in health policy and law began when she worked as a health care legislative assistant for Rep. Anna Eshoo (D-CA) before attending law school. Maura is a graduate of Hamilton College and Harvard Law School.

Endnotes

1 Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act" (2012).

2 Patient Protection and Affordable Care Act, Public Law 111-148, Section 1321(c), 111th Congress, (2010).

3 Center on Budget and Policy Priorities, "Status of State Health Insurance Exchange Implementation" (2012), available at http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf.

4 Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges" (2012), available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

5 Patient Protection and Affordable Care Act § 1413; 45 C.F.R. §155.345. There are two alternative approaches for eligibility determinations by the federally-facilitated exchange. First, the exchange determines Medicaid and CHIP eligibility and electronically transmit the determination to the state Medicaid and CHIP agency. That agency will accept the exchange's determination and enroll the person in Medicaid or CHIP. Second, the exchange assesses Medicaid and CHIP eligibility, but the state makes the final decision. The state then notifies the exchange if they decide the individual is ineligible for Medicaid and CHIP. Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges."

6 Patient Protection and Affordable Care Act §§ 1312(a)(1) and 10104(i)(1).

7 Internal Revenue Code § 36B (added by Patient Protection and Affordable Care Act § 1401 and amended by Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 111th Congress, (2010)); Patient Protection and Affordable Care Act § 1402 (as amended by Health Care and Education Reconciliation Act of 2010) and § 1412.

8 Patient Protection and Affordable Care Act § 1412; 45 C.F.R. § 155.320.

9 45 C.F.R. § 155.205(b)(6).

10 Patient Protection and Affordable Care Act § 1311(d)(4); 45 C.F.R. § 155.205.

11 Patient Protection and Affordable Care Act §§ 1311(i) and 10104(h); 45 C.F.R. § 155.210.

12 Patient Protection and Affordable Care Act § 1311(b)(1)(B).

13 Patient Protection and Affordable Care Act §§ 1312(a)(2), 1312(f)(2)(A), and 10104(i); 45 C.F.R. § 155.705(b).

14 45 C.F.R. § 155.725(c)(2).

15 Internal Revenue Code § 45R (added by Patient Protection and Affordable Care Act § 1421).

16 Patient Protection and Affordable Care Act § 1321(c); 45 C.F.R. § 155.130.

17 Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges."

18 Ibid.

19 Internal Revenue Code § 36B (added by Patient Protection and Affordable Care Act § 1401 and amended by the Health Care and Education Reconciliation Act of 2010); Patient Protection and Affordable Care Act § 1402 (amended by the Health Care and Education Reconciliation Act of 2010).

20 Internal Revenue Code § 45R (added by Patient Protection and Affordable Care Act § 1421).

21 Public Health Service Act § 2704 (added by Patient Protection and Affordable Care Act § 1201); Public Health Service Act § 2711 (added by Patient Protection and Affordable Care Act § 10101(a)); Internal Revenue Code § 9815(a)(1) (added by the Patient Protection and Affordable Care Act § 1563(f)); Employee Retirement Income Security Act § 715(a)(1) (added by the Patient Protection and Affordable Care Act § 1563(e)).

22 Public Health Service Act § 2707 (added by Patient Protection and Affordable Care Act § 1201); Patient Protection and Affordable Care Act §§ 1301(a)(1)(B) and 1302(b).

23 Patient Protection and Affordable Care Act §§ 1341, 1342, 1343, and 10104(r).

24 Patient Protection and Affordable Care Act § 1311(c)(1)(A).

25 Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges."

26 Ibid.

27 Patient Protection and Affordable Care Act § 1301(a)(1)(C).

28 Patient Protection and Affordable Care Act §§ 1311(d)(6) and 10104(e)(2); 45 C.F.R. §§ 155.105(f) and 155.130.

29 77 Fed. Reg. 18310 ,18326 (March 27, 2012) (final rule).

30 The Henry J. Kaiser Family Foundation, "State Exchange Profiles: District of Columbia" (2012), available at http://healthreform.kff.org/state-exchange-profiles/washington-dc.aspx.

31 Patient Protection and Affordable Care Act § 1311(d)(6); 45 C.F.R. § 155.130.

32 Patient Protection and Affordable Care Act § 1311(i)(4); 45 C.F.R. § 155.210(b)(1).

33 Patient Protection and Affordable Care Act § 1311(i)(4); 45 C.F.R. § 155.210(b)(2).

34 "Office of Personnel Management: Frequently Asked Questions," available at http://www.opm.gov/faqs/QA.aspx?fid=fd635746-de0a-4dd7-997d-b5706a0fd8d2&pid=ca706517-97d8-44b5-a8eb-9fda13fc41ef; U.S. Government Accountability Office, "Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed and Varies among Participating Plans" (2007).

35 Commonwealth Health Insurance Connector Authority and Executive Office of Health and Human Services, "The Top Ten Facts About Massachusetts Health Care Reform" (2011), available at https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2011/Week%20Beginning%20March%2006/10%2520FACTS%2520POSTER.pdf.

36 Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges."

37 As models, the exchange can look to the value based purchasing program and the hospital readmission reduction program for Medicare. Social Security Act §§ 1886(o) and (q) (added by the Patient Protection and Affordable Care Act §§ 3001 and 3025).

38 Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, "General Guidance on Federally-facilitated Exchanges."

39 Social Security Act § 1853(o) (added by Health Care and Education Reconciliation Act of § 1102(c)(3)).

40 Public Health Service Act § 2718 (added by Patient Protection and Affordable Care Act §§ 1001 and 10101(f))

41 42 C.F.R. § 423.34(d).

42 Patient Protection and Affordable Care Act § 1302(b)(1).

43 Ibid., § 1302(d)(1)

44 Ibid., § 1302(d)(2)

45 Ibid., § 1302(d)(1)

46 Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues" (Washington: Commonwealth Fund, 2010); The Rhode Island Healthcare Reform Commission, "Issue Brief: Should the Exchange Offer Manageable and Meaningful Choices of Health Plans" (2011), available at http://www.statecoverage.org/files/RI_issue_brief_no._2_-_standardizing_health_plans.pdf.; Rosemarie Day and Pamela Nadash, "New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans," *Health Affairs* 31 (5) (2012): 986.

47 Day and Nadash, "New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans"; Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice in the Medicare Part D Program," *American Economic Review* 101 (4) (2011): 1180-1210.

48 Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part d Payment Policies and Final Call Letter," April 4, 2011, p. 122; Day and Nadash, "New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans."

49 Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues."

50 Ibid.

51 Congressional Budget Office, "An Analysis of Premiums Under the Patient Protection and Affordable Care Act" (2009).

52 Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues."

53 Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues," (Washington: Commonwealth Fund, 2010).

54 Ibid.

55 Commonwealth Health Insurance Connector Authority, Request for Response: Health Benefit Plans Seal of Approval (Jan. 14, 2011). Health Connector Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 2011.

56 Day and Nadash,"New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans."

57 "Medicare Plan Finder," available at https://www.medicare.gov/find-a-plan/questions/home.aspx?Language=English.

58 Patient Protection and Affordable Care Act § 1311(c)(4); 45 C.F.R. § 155.205(b) .

59 Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues."

60 Ibid.

61 Ibid.

62 Patient Protection and Affordable Care Act §§1312(a)(2) and 1312(f)(2)(A); 45 C.F.R. §§ 155.705(b)(2) and (3).

63 Public Health Service Act § 2701 (added by Patient Protection and Affordable Care Act § 1201); Patient Protection and Affordable Care Act § 1301(a)(4).

64 Jolene Chou and others, "Examining a Defined Contribution Strategy in the SHOP Exchange," (Rutgers Center for State Health Policy, 2011); "About CBIA Health Connections," available at http://www.cbia.com/ieb/er/AboutHC.php.

65 Comment by Richard J. Gilfillan, Director, Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services, during "Obamacare at Work: Innovations to Deliver Better Care at Lower Cost," hosted by the Center for American Progress, May 22, 2012, available at http://www.americanprogress.org/events/2012/05/lowercost.html.

The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just, and free America that ensures opportunity for all. We believe that Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect these values. We work to find progressive and pragmatic solutions to significant domestic and international problems and develop policy proposals that foster a government that is "of the people, by the people, and for the people."

Center for American Progress

1333 H STREET, NW, 10TH FLOOR, WASHINGTON, DC 20005 • TEL: 202-682-1611 • FAX: 202-682-1867 • WWW.AMERICANPROGRESS.ORG