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Creating an Effective Health Benefit Exchange: Key Issues for Virginia

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As Virginia begins to implement provisions of the new health reform law, creation of health benefit exchanges moves to the forefront of priorities. Governor Bob McDonnell and Secretary of Health and Human Resources Bill Hazel created the Virginia Health Reform Initiative in May 2010 and in August appointed its 24-member Advisory Council to look at how the state can best implement the new health law.

The new health reform law, the Affordable Care Act (ACA), outlined broad requirements for the state-based exchanges, and recent federal guidance has added some clarity on implementation. Further guidance and regulations are expected to be issued early in 2011.[1] Thus, a number of important choices remain in structuring and running a health insurance exchange that will work for all Virginians seeking health insurance coverage.

Where Does Virginia Stand?

States have been given significant discretion and independence in the design of their exchanges. Governor Bob McDonnell appointed the Virginia Health Reform Initiative and its 24-member Advisory Council to look at how our state can best implement the new health law.

In September 2010, Virginia was one of 48 states to receive a $1 million planning grant from the federal government to begin the process of creating an exchange. Further, the Advisory Council already has embraced the notion that Virginia should create its own exchange and not rely on the federal government to administer and set up the health benefit exchange for the state.

On December 20, 2010, the Council issued its report to Governor McDonnell, and outlined key principles Virginia should consider in creating its exchange.[2] While these principles and recommendations will help guide policymakers, there are still many specifics that remain to be addressed. Some of the important issues that Virginia policymakers must consider include:

- Choosing what entity will run the exchange;
- Reducing market segmentation;
- Protecting consumers;
- Using information technology and embracing transparency;
- Considering regional exchanges.

Overview

This issue brief addresses some of the options available to Virginia as it continues to consider the creation and implementation of the new health insurance marketplace. The state's success in creating a robust exchange with affordable options for consumers and a workable market for insurers relies on how Virginia chooses to structure the exchange and addresses these options.

While there may be a number of design decisions that could produce a successful and thriving exchange, a review of best practices in this field shows that the following principles are critical:

- Ensure that all key stakeholders have a voice, regardless of where the exchange is located;
- Provide affordable and comprehensive health insurance options for all Virginia consumers;
- Protect the rights of Virginia consumers and help them navigate the new exchange system;
- Develop and improve IT systems, including creation of a Web portal that is user-friendly and provides detailed information on price and quality.

Issue 1: Creating an Exchange Home

One of the initial choices facing Virginia is deciding who will run the exchange. Generally, there are three options a state could take: locate the exchange in an existing state agency; create a new government agency; or designate a non-profit or quasi-public entity to oversee the exchange.

Existing State Agency: From a structural standpoint, it could be enticing to locate exchange operations at the Department of Medical Assistance Services (DMAS), Virginia's Medicaid agency, or within the Bureau of Insurance, which currently regulates the insurance market in the state. These agencies are stable entities that currently manage aspects of the state's health care system. Each already is preparing for new roles and responsibilities under the exchange. Housing the exchange at DMAS could help create more integrated eligibility systems between the exchange, Medicaid and FAMIS (Virginia's children's health insurance program), as well as take advantage of the agency's established relationship with Virginia health plans. Adding the exchange to an already full (and expanding) portfolio, however, could strain the agency and adversely affect its core role.

Putting the exchange within the Bureau of Insurance could be problematic. The Bureau is already assuming new oversight and enforcement responsibilities under the new health care law on top of its current regulatory role. As the chief regulator of health care plans in the state, adding the administration of a health benefits exchange could compromise the primary role of the agency as a regulator.

Other states have taken the existing agency approach. In Utah, for example, the Governor's Office of Economic Development houses the existing exchange in that state.

New Government Agency: Creating a new governmental agency, likely within the Virginia Health and Human Resources Secretariat, would require integrated coordination with existing state agencies. Creating a new agency would also necessitate significant workforce upgrades and recruitment of technical expertise. Some states are considering this approach. For example, Maryland appears likely to recommend a new state agency as part of its implementation efforts.

Independent "Quasi-Governmental" Agency: Setting up an agency with independent authority could help to establish continuity in exchange operations, with a goal of avoiding undue influence from the political turnover that comes with changes in administrations. The Virginia Housing Development Authority, with organizational staff and a board of directors, could be used as a model. In addition, although increases in the state workforce would be needed, creating independence and possibly an alternate compensation structure could help in attracting technical staff from the private sector. Massachusetts has taken this approach in their existing exchange, and California has passed legislation to adopt this kind of an exchange structure.

What should Virginia do?
Whatever the ultimate decision, the state should try to keep the exchange immune from the changes in administrations and other political turnover that is common in Virginia due to its one-term governorship. Continuity will be essential to building the public trust and support of the new insurance options and requirements under a health benefit exchange.

Additionally, exchange governance should avoid conflicts of interest. Any governance board or advisory panel created by the state should draw from experts in health insurance, health economics, consumer groups, and the private sector. However, industry groups that could directly benefit financially from the exchange should not be part of governing the exchange. The recent misuse of state funds by the Virginia Tobacco Indemnity and Community Revitalization commission provides an important reminder to create and enforce strong rules in exchange governance.

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Issue 2: Insurance Market Issues

In addition to deciding exchange governance, policymakers must consider many insurance market issues in creating a successful health benefit exchange marketplace.

Reducing Adverse Selection

While the exchanges are intended to provide more affordable coverage options than are currently available in the individual and small group markets, those markets would continue to remain in place. This raises significant concerns about adverse selection.

Adverse selection would occur if healthier people enroll in plans offered through the outside markets, while less healthy people disproportionately enroll in the exchanges. The long-term viability of the exchanges is predicated on the exchanges having a balanced risk pool of younger/healthier and older/less healthy enrollees. Otherwise, premiums in the exchange would rise, reducing participation, and, ultimately, threatening the success of the exchanges. Adverse selection was one of the primary reasons why some exchange-like pools that states established in the past have failed.

States can take a number of steps to reduce the risk of adverse selection. These include:

Create Same Rules Inside and Outside the Exchange: If insurers who are allowed to participate in the exchange must play by different and more stringent rules than those that are not offering plans in the exchange, the non-exchange plans will likely be able to attract a healthier group of enrollees. This will cause an increase in prices in exchange plans relative to those sold outside of the exchange and give some insurers a competitive advantage. Virginia should require that all insurers face the same marketing, quality and transparency rules

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(those required of Qualified Health Plans offered through the exchanges), regardless of the insurance market.

Standardizing Coverage Offerings: Under the new law, within the exchange, insurers can only offer the less comprehensive "bronze" plans, which would be most attractive to healthier individuals, if they also offer "silver" and "gold" Plans. Virginia should require that insurers outside of the exchange follow those same rules in order to prevent some firms from only offering less comprehensive plans. Conversely, plans in the exchange should be required to include the mandated benefits that plans outside the exchange must include. The state should also explore requiring that health plans offer the same coverage options inside and outside of the exchange

Effective enforcement of One-Risk Pool: One of the ways the Affordable Care Act tries to limit adverse selection is requiring insurers to use one risk pool for all their plans, whether they are sold in the exchange or the non-exchange individual market.[3]

Which Insurers Can Participate?

Virginia policymakers must also decide how many insurance plans can be offered in the exchange. The state could choose to let most or all qualifying plans into the exchange. This model would provide a more open market without regulation on price and quality.

Or, Virginia could act like a large employer, by negotiating with the plans to ensure that certain price and quality standards are met for plans that want to offer insurance within the exchange. This option could make insurance more affordable and comprehensive. In addition, limiting the number of plans to a reasonable range of offerings would prevent overwhelming the consumer with too many options that make choosing a plan more difficult, which was a problem for many seniors in the early years of the Medicare Part D prescription drug program.

Small Business Exchanges

In addition to individuals that cannot access health insurance through their employers, small businesses with up to 50 employees will have the opportunity to access a health benefit exchange beginning in 2014. The Small Business Health Options Program (SHOP) will attempt to improve the small group market for health insurance. In Virginia, less than 40 percent of businesses with 50 or fewer employees offered health insurance in 2009.

States are given the option of creating separate exchanges or having a single exchange that would run both the individual and SHOP exchange (the state could have one access point for both individuals and small businesses, but still maintain separate oversight and risk pools). States will need to decide which option will provide the best marketplace for both the consumer and participating small businesses. Initially, states will also need to determine whether to keep the 50-employee threshold or allow businesses with up to 100 employees to participate. Beginning in 2016, all states will be required to open the SHOP exchange to businesses with up to 100 employees, with the option of adding larger employers in 2017.

What Should Virginia Do?

Adverse selection: Without question, Virginia policymakers should work to limit adverse selection. Preventing segmentation

of the market will help to keep insurance affordable on average, especially for those that need it the most.

Insurance participation: In terms of participation, Virginia should work to ensure that the plans that participate in the exchange offer quality insurance at the best price for consumers and businesses. Active negotiation, just as large employers do every year, would ensure that consumers have access to affordable coverage options and could produce significant moderation in premium increases. However, even if policymakers pursue a more passive approach, Virginia could still ensure a reasonable premium price structure by authorizing the Bureau of Insurance to conduct vigorous rate reviews.

SHOP exchange: In order to target the SHOP exchange to businesses that most need the assistance, Virginia should limit participation to firms with fewer than 50 employees at the outset. These businesses are most likely to be unable to afford coverage. Further, only a minority of these firms currently even offer coverage to their workers. Conversely, approximately 98 percent of Virginia businesses with more than 50 employees currently offer health coverage.

Issue 3: Consumer Protections and The Navigator Program

As in most states, the current individual market for health insurance in Virginia has performed poorly in protecting the consumer. Coverage has often been unaffordable and could often be discontinued with little or no warning. Only about 350,000 Virginians, or about 5 percent of the population, obtain coverage in the individual market. Others, especially those considered high-risk or with pre-existing conditions, can face a pre-existing condition exclusion or an exorbitant premium cost.[4]

Consumer Protections & Health Reform

Some of the inherent problems of the individual market were addressed in the new health law. Beginning in September 2010 for children, and in 2014 for adults, insurers can no longer discriminate based on pre-existing conditions. Once the exchange begins, insurers will not be able to differentiate rates based on health status. Variations will be allowed for age (no more than 3:1), tobacco use (no more than 15:1) and geographic regions. Exchange rules also will require that at least two plans in the exchange pay between 70 to 80 percent of the full value of the total benefits provided in the plan.[5]

The practice of retroactively canceling a policy for an application or other non-fraudulent mistake, known as "recission," has been outlawed by the new law. Annual spending caps have been eliminated and lifetime spending caps are being phased out by 2014. Additionally, beginning in 2011, health plans will be required to use between 80 and 85 percent of the premium on health care expenses, and not administrative costs.[6] Consumers will receive a rebate if the insurer does not meet this requirement.

It will be vital for the Virginia Bureau of Insurance to enforce these new consumer protections, both for those getting coverage within and outside of the exchange. Consumers should have the confidence that the health plans offered are providing quality and comprehensive coverage, meeting the standards and rules set under the law. The Bureau is preparing legislation for the 2011 General Assembly to grant the bureau the authority to conduct oversight and enforcement for health reform provisions. Virginia policymakers should also provide them with the resources, including staffing, to carry out this function.

Consumer Assistance Programs

Consumers will need help accessing available coverage and enrolling in the correct program in the new exchange marketplace. All states are required to create and manage consumer assistance services, including a Navigator program. The Navigator will give grants to nonprofits and other organizations that commit to providing public education about enrollment in the program.

In addition to the Navigator program, states will need to create a toll-free hotline to offer help to individuals and families with questions about the exchange and the healthcare options available to them. Since 2006, as part of their health reform, Massachusetts has operated a successful help line run through a nonprofit organization.

What should Virginia do?

Virginia should create robust consumer

assistance programs, including a Navigator program to provide funding to nonprofit organizations and other community organizations to help Virginians make informed insurance choices. Help also should be given to those with language or other cultural barriers. These Virginians have historically had the most trouble accessing the health insurance system and experience the highest rates of uninsurance in the Commonwealth. Virginia has already received an $830,000 grant to expand consumer assistance and conduct outreach. Additional funding for consumer assistance will be necessary for the Navigator, help line and other consumer activities to be useful to Virginians.

Although additional federal guidance may be needed, Virginia ultimately could look to the Covering Kids and Families program that helped enroll children in FAMIS, funded by the nonprofit Robert Wood Johnson Foundation and run through the Virginia Health Care Foundation, as a potential model.

Issue 4: Information Technology

A Web portal for consumers to access the health coverage in the exchange is expected to include price, quality and other information to help consumers make informed choices about their health insurance. The Web exchange will help determine which tax credits individuals are eligible for and which program they should be enrolled in depending on income (Medicaid, FAMIS or the exchange). Secretary Hazel has publicly stated his hope that Virginia can create an innovative and useful Web presence that will help simplify enrollment and eligibility determinations.

But the task is daunting, since most states will have to significantly upgrade their technology in advance of 2014, both in creating the Web-based exchange resources and improving their Medicaid systems. Several opportunities are available to help, however. First, the federal Department of Health and Human Services will be producing a template for states to use in designing their exchange Web sites. In addition, the federal government is offering up to five fully federally-funded "Early Innovator" grants to states or regional collaborations that have achievable IT models, primarily concentrated on eligibility and enrollment systems, which can be transferred to all states looking to improve their technology. States receiving these grants will be required to share their IT innovations and infrastructure with all states looking for help. All states will also be able to apply for further federally funded exchange planning grants starting next year.

Finally, the federal government will pay for the vast majority of the costs of making IT upgrades in Medicaid. Federal reimbursements to states for upgrading their Medicaid eligibility systems will be increased to 90 percent (up from 50 percent in Virginia), with a reimbursement rate of 75 percent for maintenance and operations, if the state achieves certain performance standards. This increased federal support will provide key resources for upgrades, many of which were needed even before health reform was enacted.

What should Virginia do?

Virginia's policymakers, especially Secretary Hazel and the Health Reform Initiative, have committed themselves to developing leading IT systems and a user-friendly Web presence for the exchange. Although Virginia ultimately chose not to apply for an "Early Innovator" grant, the state should actively seek to use the exchange models developed elsewhere. Drawing on these ideas will help defray the costs and ensure that Virginia creates an exchange with real value to the consumer seeking health coverage.

The Commonwealth should also take advantage of the significantly increased federal Medicaid matching funds needed to upgrade our current systems to meet the overall needs of health reform as we move toward 2014.

Finally, Virginia will need to begin to identify funding streams to finance exchange operations. State-based exchanges will need to be financed by the states beginning in 2015. Before then, Virginia should fulfill exchange planning requirements and actively pursue any additional grant opportunities. Grant awards in 2011 will be contingent on the state meeting certain planning milestones.

While there are many options for the state, the funding should be sustainable and sufficient to adequately meet the operational needs of the exchange and ensure that

consumers have viable and affordable insurance options.

Issue 5: Regional Health Exchanges

The Affordable Care Act gives states the option to create a regional exchange between states. For Virginia, the most compelling possibilities might be between Virginia, Maryland, and Washington, D.C., or Northern Virginia, D.C. and suburban Maryland. Already groups in each of the three jurisdictions have begun discussions on whether such an exchange would be feasible. The Virginia Health Reform Initiative is participating in these meetings to determine whether such an approach could be advantageous for the state.

A regional exchange, especially in the National Capital Region, would be attractive for a number of reasons. Certainly, creating a larger exchange between the three jurisdictions would provide a bigger marketplace with greater participation numbers. Such a marketplace could potentially attract insurers into the market if they believed it offered a profitable pool of enrollees. The large risk pool would provide a mix of healthy and less healthy individuals, and it would be attractive to the local mobile workforce.

However, a regional exchange would face several obstacles, including the complexity in licensing and establishing a uniform regulatory authority. Rules would also need to be aligned in the exchange plans. This could produce administrative problems for insurers, which may have to comply with several different sets of regulations if the rules for plans outside the exchange are different than the rules for exchange plans. In addition, each jurisdiction might develop different rules for coordination with Medicaid and other insurance options. Such additional complexity might cause insurers to avoid the regional exchange.

What should Virginia do?

Virginia should continue to participate in the discussions with Maryland and Washington, D.C. If rules and regulations can be coordinated between the jurisdictions, a regional exchange (either between the entire states or just in the National Capital Region) could be an effective way to share exchange operating costs and reduce the administrative burden on Virginia.

Conclusion

Creation of a health benefit exchange will be one of the most important aspects of health reform implementation. Virginia should carefully consider these and other critical issues, with input from consumer groups and businesses, to create an exchange that will provide quality and affordable health insurance options for Virginians.

Endnotes

1 For additional introductory information on health insurance exchanges, see The Commonwealth Institute issue brief, "Understanding the Health Reform Law: What are Health Insurance Exchanges?," August 2010.

2 Report of the Virginia Health Reform Initiative Advicory Council, December 20, 2010. Accessed at: http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf

3 For additional discussion on adverse selection, see Lueck, Sarah. "States Should Structure Insurance Exchanges to Minimize Adverse Selection," Center on Budget and Policy Priorities (Washington, D.C.), August 17, 2010.

4 Ault, Alicia. "Uninsured, You're Not Alone," *Washington Post,* October 16, 2007.

5 Plans in the exchange can be Bronze (60 percent actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial value), and Platinum (90 percent actuarial value). Participating insurers will be required to offer at least one silver and gold plan in the exchange. In addition, all insurers sold by participating insurers, whether offered inside or outside of the exchange, must meet the minimum Bronze level.

6 Plans sold in the individual or small group market (and likely in the exchange beginning in 2014) will be subject to the 80 percent threshold; large group health insurance will be required to spend 85 percent of premiums on health care.

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