

HEALTH INSURANCE EXCHANGES

Timely News and Strategic Insights on the Development and Operation of State Exchanges

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State Exchanges Are Key to Law, but True Reform May Hinge on Private Exchanges

As some state officials scramble to develop their exchanges and reach the milestones set by HHS, at least three groups are gearing up to launch national private insurance exchanges. And while the combination of private and state exchanges will mean new distribution channels for insurers, a shift among employers toward defined-contribution benefits could impact profitability for large health insurers.

On Sept. 20, WellPoint, Inc. joined with two large Blue Cross and Blue Shield plan operators to take a majority interest in Bloom Health, a small, Minnesota-based insurance exchange. The insurers, which will have equal stakes in the company, intend to use it as a platform to launch a nationwide private exchange. Meanwhile, consulting firm Aon Hewitt has developed its own private exchange platform for large employers, which it anticipates will be operational in time for the 2012 open-enrollment season — a full year before state-run exchanges are slated to begin their open enrollment.

"I think the secret story is...while everyone is focusing on state exchanges, the actual renaissance is going to happen in private exchanges," says Bryce Williams, CEO of Extend Health, a venture-backed California-based company that boasts the nation's largest private Medicare exchange. Extend Health has more than 150 employer clients, including 35 *FORTUNE* 1000 companies. Williams anticipates his defined-contribution retiree model will catch on for early retirees as well as some active employee groups.

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With Just 730 Days Until Open Enrollment... Can State Exchanges Really Be Ready?

State-run insurance exchanges are slated to launch their inaugural open-enrollment period on Oct. 1, 2013 — that's less than 24 months (17,520 hours) away. Given that just a dozen states have enacted legislation allowing them to move forward in developing the new entities, some industry observers contacted by *HEX* predict nothing short of a disaster. A few consultants who are working closely with states, however, say some exchanges could far exceed expectations on opening day.

"I think some states are going to hit it out of the ballpark," says Jon Kingsdale, Ph.D., managing director of Wakely Consulting Group and the former head of Massachusetts' pioneering Commonwealth Health Insurance Connector.

Based on recent meetings with executives in 20 state capitals, Sam Gibbs, president of eHealth Government Systems, says he's also optimistic based on the progress he's seen. "When you get below the political level and meet with the worker bees, they know they have to build something," he says, noting that the amount of work completed by states is all over the map.

But Neil Trautwein, vice president and employee benefits policy counsel at the National Retail Federation, is far less optimistic about enrollment success on Oct. 1, 2013. Based on the amount of progress most states have made, he predicts "confusion will rule the day.... Couple the exchange with major new market reforms, and a train wreck clearly lies ahead."

continued

And even if the states are ready for enrollment two years from now, potential enrollees might not be. Along with having to choose coverage, exchange participants will need to navigate through the unfamiliar Web portals and understand how the subsidies and tax credits work.

"My primary concern is that people won't know how to use or select the right product for themselves. This is especially true for those on Medicaid who haven't been in the marketplace like the others," says Larry Boress, president and CEO of Midwest Business Group on Health. Boress draws parallels to the first enrollment period for Medicare Part D, which also was complex in that enrollees had to match the drug benefit to the plans. "People needed good directions and education from many sources," he says.

Carl Doty, vice president and practice leader of consumer product strategy at Forrester Research, agrees and predicts that the first open-enrollment period will be chaotic for most states. Like Boress, Doty says consumers — particularly those who are unfamiliar with commercial health coverage — won't understand how to buy coverage that best meets their needs, and insurers haven't done much to simplify their plan designs or educate consumers. Moreover, the flood of new consumers into the market will "exacerbate" the already short supply of primary care physicians across the country.

"All of this will result in confusion and frustration among consumers. They will buy policies without understanding what they bought, which will lead to them incurring costs that they do not anticipate," Doty tells *HEX*. "And although they will have coverage, they will have difficulty finding primary care in a timely manner due to overflowing demand with insufficient supply. Even here in Massachusetts, five years after health reform passed, if you can find a primary care physician [who is] accepting new patients, it's likely that [a patient] has to wait 18 to 24 months to get an appointment."

Moreover, he expects that the flexibility states have in building their exchanges will translate to inconsistent rules regarding how subsidies work and which health plans are able to participate.

Doty says that while the reform law ultimately will accomplish its goal of reducing the nation's uninsured population beginning in 2014, he questions whether those people will be better off as a result.

It's 'Not Really That Complicated'

But Kingsdale insists "the basic exchange is not really that complicated," recalling his experience with the development of Massachusetts' insurance exchange. Kingsdale, who is consulting with states on the development of their exchanges, was hired to head the Connector Authority in June 2006 — one month after the state's reform law was enacted. Part of the exchange was operational before the end of the year and it was fully functional by July 1, 2007.

"Now, we didn't have the same political issues some states are facing. We didn't have to interface with a new federal data hub and we didn't have to meet federal standards or wait for federal interpretation" of the rules, he tells *HEX*. "But when we asked health plans to do the impossible — in terms of the timetable — they stepped to the line and did it...and when we contracted to develop our exchange website, it took months, not years."

But Kingsdale admits there are enormous differences between the early days of the Connector Authority and the challenge that states now face. "I don't want to suggest that this can be done in one year, but for states moving along now and making decisions, I think it's very doable between now and October 2013."

One of the biggest obstacles states face now is in completely restructuring their eligibility determination systems — a feat that Kingsdale says could take a state three or four years to accomplish. "In terms of the timeline, this is the most challenging piece of this."

To accomplish HHS's vision for a "no-wrong-door" enrollment system, exchanges will need to develop electronic interfaces that connect their own eligibility systems to a federal data hub that will link five federal entities

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(HEX 9/11, p. 1). Information supplied by applicants determined to be ineligible for Medicaid, for example, will be used to determine if they qualify for subsidies or tax credits.

“The technology on the back end will be the problem,” says Gibbs. But, he adds, CMS wants to use some pretty standard technologies, which could solve some interface problems.

And Gibbs says some states are considering having an outside entity manage the exchange. As an example, he points to the virtual health insurance marketplace Ceridian Exchange Systems LLC and eHealth Government Systems developed for Florida in 2010. While states are able to build informational websites, they typically don’t have experience in online sales, he notes.

If You Build It, Will They...Participate?

For health insurers, the biggest challenge might be in deciding whether to participate, and what will be required to compete effectively within an exchange. Insurers typically already rely on complex IT systems, which would need to be set up to interface with the exchange as well as with federal agencies.

And with no guidance yet on the essential benefit package, health insurers have their hands tied when it comes to developing qualified health plans that can be sold through an exchange.

While some state exchange executives already have issued marketing requests for proposals, the majority of them haven’t had time to give marketing much thought. But Kingsdale says that will need to change in 2012. By summer 2013, states will need to be ready to begin marketing their exchanges and educating consumers.

“You probably don’t want to do a lot of outreach six months before you open your doors. That would be a bit like spending all your campaign money too soon before the election.” In 2007, Massachusetts spent \$4 million in 12 months promoting its exchange. In addition, the Connector Authority conducted a whopping 338 town hall meetings during the first two years. At a national level, that would be the equivalent of 17,000, he says.

“If you build it, they won’t come...unless you build it and market it. That’s what we learned,” Gibbs quips. Moreover, the average citizen’s perception of exchanges has been distorted by politics. Exchanges, he says, will need to launch extensive marketing and communications efforts, which might include the use of agents and brokers, outreach from advocacy groups and town hall meetings.

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For HSA-Based Plans, Exchanges Could Become Incubator, or Killer

Health savings account (HSA)-based health insurance has become a mainstream product in small-group and individual markets. But there are no guarantees they will be available through state insurance exchanges. Depending on how HHS defines certain reform-law rules, the account-based plans could become a financial liability for health insurers. On the flip side, HSA-compatible high-deductible health plans (HDHPs), if offered as a Bronze-level product, could be among the most affordable and popular options on an exchange.

While congressional Democrats won’t eliminate HSAs through legislation, HHS could do it through regulatory fiat, says Whitney Johnson, an assistant professor of business law at St. Cloud State University in Minnesota and co-founder of HSA Resources, LLC, an HSA administrator. If HHS, for example, determines that HDHPs don’t fit its definition of a qualified health plan, insurers will stop selling them.

“If you want to get rid of something, you don’t make it illegal, you just don’t allow it to grow anymore,” says Paul Feldstein, a professor of health care management at the University of California in Irvine. “And that could happen with HSAs.”

The medical loss ratio (MLR) provision of the reform law also could keep HSAs from growing if it means HDHPs are no longer financially viable for health insurers. “MLRs look better if [the insurer] is paying for every office visit and the members pay a copayment,” explains Roy Ramthun, former health policy advisor to President George W. Bush and now president of HSA Consulting Services. “It’s safe to say that it’s going to be harder for HDHPs to meet the MLR requirements than for other types of plans. If HHS makes it very difficult for health plans to meet MLRs, then HDHPs are going to be the first health plans to go.” Ramthun co-wrote much of the early HSA guidance in 2004 while working at the Treasury Dept.

“I don’t think HSAs are going away,” adds Johnson, “but I am worried about them.”

HSAs Face Interpretation Hurdles

The reform law eliminated the ability to use HSA dollars to pay for over-the-counter drugs, and it boosted the penalty for early withdrawal from 10% to 20%. Here are three key interpretations of the law that will determine the fate of HSAs and exchanges:

♦ **First-dollar preventive benefits:** Although HDHPs are allowed to include some first-dollar coverage for preventive care, “the reform law mandates a lot of preventive care...and we keep getting new definitions of what is

preventive,” Johnson quips. If HHS’s definition of preventive care doesn’t jibe with the HDHP rules, then those products won’t be considered qualified health plans under the reform law.

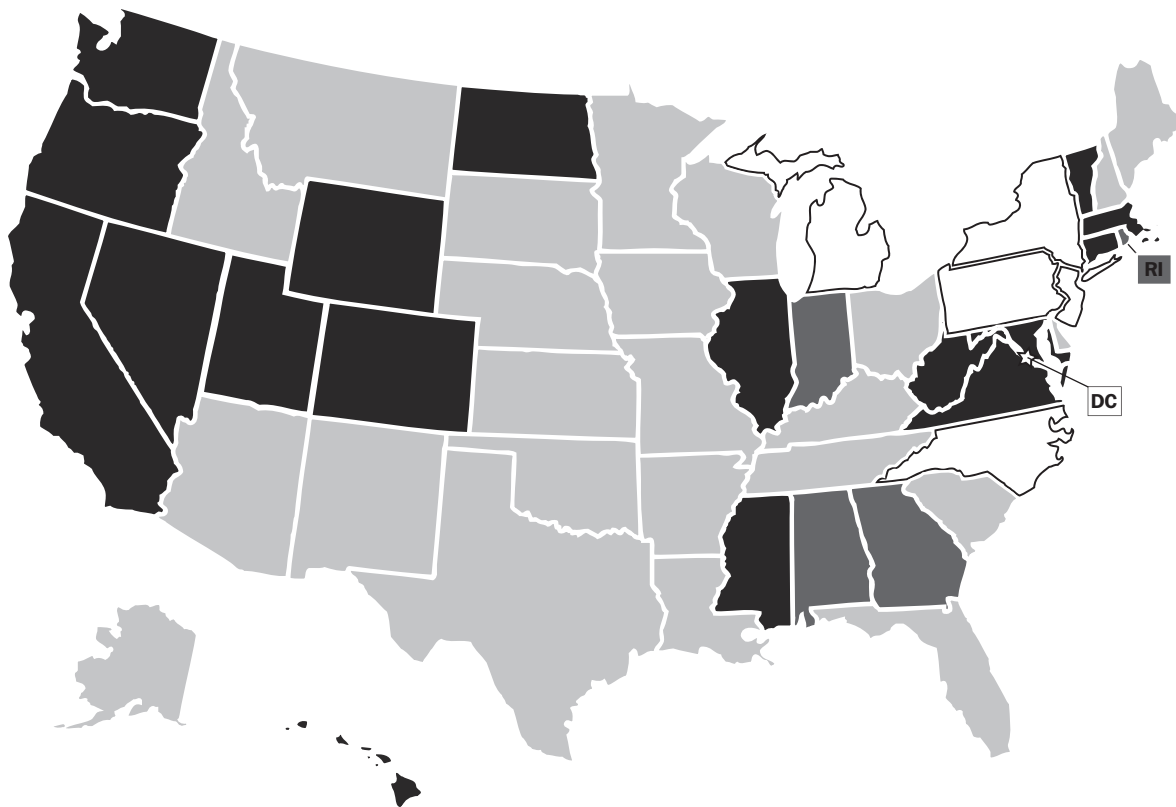
◆ **Annual deductibles:** Health plans offered through an exchange must have an annual deductible of no more than \$2,000 (\$4,000 for families). But many small employers offer health plans that have far higher deductibles. Forcing them to reduce the deductibles — through the Small Business Health Options Program (SHOP) exchange — would push premiums higher and make HSA-based plans less attractive. However, the maximum out-of-pocket limit for HDHPs (\$5,950 for single coverage and \$11,900 for families) is consistent with reform

law rules for qualified health plans. Moreover, it’s possible that the essential benefits package will ensure that insurers have to boost deductibles for all products to make them affordable. And that could mean more plans will be compatible with HSAs.

◆ **Actuarial value:** The reform law requires that health plans must pay at least 60% of the actuarial value of covered benefits. Actuarial value generally includes deductibles, copays and coinsurance. But HDHPs typically have lower actuarial values than do more traditional types of coverage because they don’t cover medical expenses until the annual deductible is met. To pay for those costs, enrollees can tap their HSA and use pretax dollars. However, it’s unclear whether HHS will count HSA contribu-

Progress of State Exchange Legislation

Rhode Island Gov. Lincoln Chafee (R) on Sept. 19 issued an executive order establishing the Rhode Island Health Benefits Exchange. Chafee also appointed the public members of the Exchange Board created in the executive order and named former U.S. Attorney Margaret “Meg” Curran as chair. Here’s a look at where other states stand in the development of their exchanges:



SOURCE: Compiled by AIS based on news reports and data from the National Conference of State Legislatures. October 2011

tions toward the actuarial value of the HDHP. Ramthun says the MLR rule could encourage health insurers to eliminate deductible-based plans in favor of coinsurance plans that cover 60% or 70% of all medical expenses. Such a strategy would make it easier for carriers to meet the MLR requirements because they would be paying more claims upfront rather than only after the deductible is met. "Whether to include HSA contributions as part of an HDHP's actuarial value is the key to whether [HSA-based plans] will exist on exchanges," says Robert Zirkelbach, a spokesperson for the trade group America's Health Insurance Plans (AHIP).

And even if HHS resolves all of those issues and allows HSA-based plans to be sold through exchanges, states might have other ideas, Ramthun notes. "The states could impose requirements under their exchanges that might make it more challenging for those plans to be offered."

Case in point: Massachusetts had to create an exemption for HSA-qualified plans after its reform law was enacted in 2006. The problem: The law required health plans to limit deductibles for prescription drug coverage to no more than \$250 a year, and limited annual deductibles to \$2,000 for family coverage (\$4,000 for families). Under federal rules, HSA-qualified HDHPs cannot include a separate drug benefit below the policy's deductible.

"There are lots of reasons why some carriers might find it too difficult to offer HSA-qualified plans through the exchanges," says Ramthun. "I'm not trying to provide them with excuses, but I can see how they might be used to justify not offering HSA-qualified plans.... On the other hand, this all has to be balanced against the unknown consumer demand for affordable premium plans and how far the income-based subsidies encourage people to enroll in them."

Exchanges Could Boost HSA Growth

Insurance exchanges could wind up being a giant incubator for the growth of account-based health plans, says John Young, senior vice president of consumerism at Cigna Corp. People buying their own coverage, he predicts, will gravitate to the low-premium plans.

Since being created as part of a Medicare reform law in late 2003, HSA-based coverage has become a mainstream insurance product. At least 6.3 million accounts, holding nearly \$12 billion in assets, have been opened nationwide, according to data released in August by Devenir, LLC, an independent investment advisory firm. OptumHealth, a subsidiary of UnitedHealth Group, has the biggest share of the HSA pie with \$1.33 billion in assets. In January, AHIP estimated that 11.4 million lives were enrolled in an HSA-compatible plan. With so many

people now covered by the plans, and billions held in their accounts, HHS could face consumer backlash if it tampers with HSAs.

There might even be a place for financial institutions within the exchanges, where participants could find an HDHP as well as an HSA administrator, says Dennis Triplett, CEO of Healthcare Services at UMB Bank, an HSA administrator. "If you can choose a health plan via an online portal, couldn't you do the same with HSA administrators?" he asks.

Editor's note: Johnson recently published a report — "The Impact of Health Reform on HSAs" — in the trade journal *Benefits Quarterly*. To download a copy, visit <http://tinyurl.com/3wjwyr1>.

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Good News for Small Carriers: Exchanges Could 'Dilute' Brand

Behemoth health plan operators have advantages over their small competitors in almost every way. But insurance exchanges could change that.

"One of the advantages and unique elements of insurance exchanges is they tend to dilute brand," according to Kevin Counihan, former chief marketing officer for Massachusetts' Commonwealth Health Insurance Connector Authority. "If you are a health plan that has 70% market share, you tend not to love exchanges because you have never had to compete in that kind of transparent marketplace before. The smaller plans love it...and it makes them want to be a bit more aggressive." Counihan, now president of CHOICE Administrators Exchange Services, an developer of insurance exchanges, offered his thoughts during a Sept. 29 conference on insurance exchanges. The two-day conference, sponsored by World Congress, was held just outside of Washington, D.C.

The reform law requires HHS to develop a rating system for health policies offered through the exchanges. The ratings are likely to be based on premium costs, payment policies and practices, enrollment and disenrollment levels, claim-denial rates, financial soundness of the company, medical loss ratios and member satisfaction surveys. In the eyes of consumers, ratings might trump brand recognition.

Moreover, using the Internet as a distribution point will give participating carriers the same access to potential new customers. And that could make it easier for some of the smaller insurers to break into new markets,

adds Sam Gibbs, president of eHealth Government Systems. "At least initially...there will be a level playing field," he tells *HEX*.

"I think [insurance exchanges] could help smaller carriers compete" with larger ones, adds Enrique Martinez-Vidal, a vice president at AcademyHealth and director of the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program, which works with state policy leaders to develop strategies to improve insurance coverage. Through a website, insurance exchanges will let consumers compare standardized coverage options. That might help small carriers overcome some of the marketing strength that many of the big carriers have outside of the exchange, he says.

Case in point: Martin Watson, CEO of California-based SeeChange Health, expects his company to be ready to participate in six state exchanges by 2014. Martin left UnitedHealth Group's product-development division in 2009 to launch a value-based insurance model aimed at small employers in several large markets in California. SeeChange expanded statewide on Oct. 1.

"We already administer and support all of the benefit designs required under the reform law...I think we're very well positioned for the exchange model," Watson tells *HEX*. "We're very excited about the exchange model and moving into that space." Martin's company is licensed to sell coverage in 25 states; it expects to expand into Colorado by the first quarter of 2012 and intends to have a presence in six states by 2014.

Disproportionate Enrollment in Mass.

The creation of insurance exchanges in Massachusetts in 2006 led to disproportionate enrollment increases for the smaller carriers. Neighborhood Health Plan (NHP) says its enrollment has nearly doubled to about 230,000 — largely due to the state's reform law. The company offers Medicaid and subsidized coverage through the Connector as well as unsubsidized commercial group and individual products inside (i.e., Commonwealth Choice) and outside of it.

The exchange "definitely helped us to compete and expand coverage to similar populations as those we have been serving for over 25 years. It also helped us diversify product offerings," says Carla Bettano, vice president of business development. While the company still has just a tiny fraction (1.5%) of the state's overall commercial market, it has the largest market share (35%) of the unsubsidized enrollment offered through the exchange. "Our overhead tends to be low and we are very cost-effective," she tells *HEX*.

"They still don't have huge enrollment numbers, but they did very well within the Connector against the state's three largest insurers," says Rosemarie Day, the

founding deputy director and chief operating officer of the Connector Authority, who now heads her own consulting firm.

Unlike NHP, Network Health was strictly a Medicaid managed care company prior to the state's reform law. While the insurer still doesn't sell commercial coverage, the state's exchanges opened the door to a new market — individuals and families with annual incomes below 300% of the federal poverty level (FPL).

"We had tremendous growth in membership once the Connector introduced the subsidized product for previously uninsured adults," says Debbie Gordon, Network Health's chief marketing officer. "I think it created a new avenue to attract members and it created a new segment [of the population] that was eligible for our product."

Yes, Size Does Matter

Scale will ultimately dictate price, and that is a key advantage for large carriers. So if small insurers aren't able to compete on price, they might be able to set themselves apart on quality, suggests Mark Lutes, an attorney in the Health Care and Life Sciences practice at Epstein Becker & Green. "I don't think that small is inherently beautiful. On the other hand, if you're a small player, you need to create a better mousetrap in terms of care management," he tells *HEX*.

Carriers will need to have strong provider contracts to compete with bigger players based on price. "It will be very tough to break into a market where the other carriers have contracts with all of the key providers," Martinez-Vidal adds. Lower overhead or streamlined administrative services might help small carriers reduce coverage costs.

Some carriers that sell products through eHealth's Web portal are more nimble and better at working in an online environment than others, says spokesperson Nate Purpura. "The insurers that work closely with our carrier relations team to examine what's working and what consumers are buying...and then quickly adjust their products to fit those trends tend to have more success." Smaller carriers are often nimble enough to make changes quickly and take advantage of market trends. Larger organizations, by contrast, might take six months to change a pricing point, Gibbs adds.

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Private Exchanges May ‘Bloom’

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“Employers that have already seen how well a Medicare exchange can work are going to consider deploying it...maybe not across their entire worker population, but they might consider it for their early retirees because it will be more efficient than their group plan,” he tells *HEX*. “The number of lives that move through private exchanges is going to exceed the public side, in our opinion.” Some industry observers contend that enrollment in state-operated exchanges will be limited to subsidy-eligible individuals and small employers.

The investment in Bloom will allow the Blues plan operators to offer their clients a number of health plans options, which may or may not have a defined-contribution element, and could either be insured or administrative services only (ASO), says Steve Zaharuk, senior vice president at Moodys. “I don’t think this is intended to compete with the health care reform exchanges or is a tactic to prevent conversion to ASO. However, it does present an alternative to an employer that may be considering dropping health insurance for their employees once the public exchanges are operational,” he tells *HEX*.

Aon Hewitt’s insurance exchange, which is expected to begin enrolling members next fall, will use a multi-carrier platform and target employers with at least 1,000 employees, says Ken Sperling, who is heading up the company’s exchange efforts. He tells *HEX* that the shift

to a defined-contribution model will take time and likely will be led by a handful of early adopters beginning in 2013. He says the movement will be similar to the slow but steady adoption of account-based consumer-directed health plans in the early part of the decade. Sperling left Hewitt in 2005 to become senior vice president of national accounts at Cigna HealthCare. He rejoined Hewitt Aon in 2009.

Along with participating in multi-carrier exchanges, some insurers also might build their own “single-carrier exchanges,” which will allow employees to choose from a variety of coverage options — at various prices — within that insurer’s portfolio. He says it makes sense for insurers to build single-carrier exchange capabilities to help retain employers that want to move to a defined-contribution model.

The market for private exchanges, however, will depend on how the state exchanges are structured and how they interact with the outside insurance market, says Shawn Nowicki, director of health policy at the Northeast Business Group on Health (NEBGH), which is the parent company of HealthPass New York, a non-profit insurance exchange that targets small employers.

Private exchanges such as Aon Hewitt’s are likely to be popular among large employers and health insurers, says Nowicki. And large employers can deliver a large and relatively balanced risk pool for insurers.

“I think it would be wise for carriers to participate in a private exchange before the state exchanges are opera-

Patient-Centered Medical Homes: Results From Two Major Health Plans

- What were the goals of the two different Blues plan models?
- What are the factors that, in each case, led to improved care in the primary care setting?
- What specific steps were taken by each health plan to implement the model?
- What changes in their normal care management protocols did physicians have to make?
- What new communications/orientation with patients were required to launch the new efforts?
- What new information technology investments and strategies were needed to build effective insurer-provider partnerships?
- Most importantly, what results were achieved by each health plan, and how might those lead to further collaboration among health partners?

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tional...to at least take a critical look at that model and to get some experience," he tells *HEX*.

Nowicki says it's too early to tell how Health Pass will fit in once New York's insurance exchange becomes operational. More than 4,000 New York employers (about 32,000 lives) offer coverage through Health Pass, which was created in 1999 after then Mayor Rudolph Giuliani (R) awarded a \$1 million grant to the New York Business

Group on Health (now NEBGH). About 45% of those employers didn't previously offer coverage.

Mark Lutes, an attorney with the law firm Epstein Becker and Green, says there is room for both private and state-run insurance exchanges. While public exchanges "will compete on a risk-pool perspective and on a service perspective with private exchanges, I don't think one is going to steal or undercut the other."

Reporter's Notebook

In September, the development of insurance exchanges was a red-hot topic for conferences in and around Washington, D.C. Here's a look at a few comments made during sessions at some of those meetings:

"When I joined the [Commonwealth Health Insurance Connector Authority] in '06, my first thought was, 'Who is going to want to buy insurance through the state?' I realized later that the state is viewed as a trusted advisor, and people didn't trust the plans. Insurance is complicated, it's confusing and people tend to think someone is ripping them off. The smart exchanges are going to build on that [level of trust] and establish a means to leverage it to their advantage."

— **Kevin Counihan**, president of CHOICE Administrators Exchange Services and former chief marketing officer at the Connector Authority at *World Congress' 2nd Annual Health Care Reform Congress on Health Insurance Exchanges*, Sept. 19

"Our goal is not to say, 'It's better than it was before.' Our goal is not to say, 'It's pretty good for government work.' Our goal is not to say, 'It's pretty good for Medicaid.' We set a goal for ourselves that we really wanted a 21st Century customer experience...an experience that people feel good about."

— **Penny Thompson**, deputy director for the CMS Center for Medicaid, CHIP and Survey and Certification, at *AHIP's Preparing for Exchanges Conference*, Sept. 16

"The initial launch [of exchanges] is critical. It may not be possible for exchanges to have every bell and whistle that they'll ultimately have...It's more important that the launch happen successfully and cleanly than have every bell and whistle."

— **John Arensmeyer**, CEO, Small Business Majority at the *Health Care Reform Congress on Health Insurance Exchanges*, Sept. 19

"Not a single state — Republican or Democrat — is satisfied with the flow of information coming from

HHS. The message over and over again was that the longer HHS waits to issue and finalize regulations, the greater flexibility they'll have to allow states on a number of key issues."

— **Attendee** (who asked not to be identified) commenting on a closed-door meeting on exchanges sponsored by the National Governors Association, Sept. 8

"There could be opportunities for collaboration between the federal government and the states... There have been talks about shared business functions that could be developed by the federal government and shared with states...It seems that HHS is trying to be responsive to what it's hearing from the states."

— **Sarah Lueck**, senior policy analyst, Center on Budget and Policy Priorities, at the *Health Care Reform Congress on Health Insurance Exchanges*, Sept. 19.

"Generally, when consumers are dissatisfied with an insurance purchase, it's the health plan that takes the heat."

— **Larry Altman**, vice president of corporate marketing and communications, Horizon Blue Cross Blue Shield, in a comment to federal officials speaking at *AHIP's Preparing for Exchanges Conference*, Sept. 16

"I think it would be very difficult to not participate in the exchange. The market outside the exchanges may very well cease to exist, and so I think that if you want to stay in business, this kind of forces you to."

— **Emily Henehan Murry**, policy advisor in the Office of House Majority Whip Kevin McCarthy (R-Calif.), at the *Health Care Reform Congress on Health Insurance Exchanges*, Sept. 19.

For health plans, defined-contribution plans might be more profitable than ASO accounts. But there also are risks, and it's too soon to tell how the model will stack up against ASOs or more traditional fully insured products, says Matthew Coffina, a health care analyst at Morningstar, Inc.

Unlike ASOs, defined-contribution plans are fully insured and are believed to carry a higher margin per member. But they also require "significant regulatory capital and come with the risk of higher-than-expected medical costs," Coffina explains. The trend toward insurance exchanges is more negative than positive for WellPoint, says Coffina, who suggests that the investment in Bloom is likely an attempt to not be left behind.

"When employers purchase a single plan for all of their employees, they want broad provider access to keep everyone happy. If the insurance-purchase decision moves down to the individual level, individuals may be willing to forego broad provider access in [favor of] lower costs at the providers they use the most," Coffina explains. "That should make smaller regional health plans — and perhaps in the future large hospital systems offering self-contained plans — more effective competitors to WellPoint."

Defined Contribution Could Control Rates

For employers, Sperling says a multi-carrier exchange will contain rate hikes by creating competition among participating insurers. Most employers, he explains, will set annual contribution increases to an amount that parallels wage increases, about 2% to 3% — well below medical inflation. But he contends the competition created by the exchanges will help slow medical premium growth.

"You are not increasing your subsidy at 3% while health care costs are going up 8%, you're increasing the subsidy at 3% while health care costs are going up at 3%. So that's not cost shifting, it's allowing people to choose various levels of coverage in a competitive market," he explains. "We are trying to bring significant critical mass to the table so that all of the insurance companies we contact see an opportunity...in that we have enough volume to create a competitive dynamic," Sperling says. The exchange will incorporate a risk-adjustment mechanism so that a carrier that takes an abnormally high risk is compensated appropriately.

"One of the goals of reform is to preserve the employer-sponsored system. Private exchanges do that. This is not an exit strategy for employers, it's a vehicle to drive efficiency into the market and keeps employers in the game," says Sperling.

Williams agrees and says employers "are not going to cut and run. But they are going to want to be involved

in the process, and they are going to want to see results that show they are getting something more efficient and less costly than what they had with their group plan."

Once the individual market becomes more stable, the Aon Hewitt exchange will make individual contracts available. And that will allow insurance coverage to be portable after an employee terminates employment. "That's an idea that, from a policy perspective, we've been chasing for decades. While the employee doesn't continue to get the subsidy when they leave, they do get to keep their coverage."

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HHS Seeks Partnerships With States

HHS appears to be taking steps to coax more states to develop a health insurance exchange. On Sept. 19, the department offered up several ways in which the states could partner with the federal government to create these marketplaces. States under these proposed partnership models could choose one of three options:

◆ **State plan management:** States would use their current expertise to tailor health plan choices for their state's exchange, collecting and analyzing plan information and performing plan monitoring and oversight. HHS would coordinate with the state regarding plan oversight, including consumer complaints and issues with enrollment reconciliation.

◆ **State consumer assistance:** Under this option, states would oversee in-person consumer assistance, manage the Navigator program, which helps provide direct assistance helping people sign up for insurance, and conduct outreach and education. HHS would operate more centralized consumer assistance functions, including call-center operations, consumer website management and written correspondence with consumers to support eligibility and enrollment.

◆ **Both plan management and consumer assistance:** States would perform both of these functions. The guidance tries to lay out clear options for states about roles they can play and the roles feds are allowed to play," so states can figure out what options may work best for them.

STATE PROFILE: Vermont**For Vermont, Exchange Is First Step Toward Single-Payer System**

As envisioned by the reform law, state insurance exchanges will be a place where insurers compete for members based on price and quality. But Vermont doesn't anticipate having more than two participants — likely Blue Cross and Blue Shield of Vermont and Schenectady, N.Y.-based MVP Health Care, Inc. — and sees the exchanges as a stepping stone toward a single-payer system.

State lawmakers proposed moving to a single-payer system in 2017, but Vermont could act more quickly if granted a federal waiver. The single-payer system, dubbed Green Mountain Care, will use a common mechanism to administer all commercial, government and state employee health plans.

"Yes, the exchanges are a stepping stone for us... but they're a very necessary step because of the structure the reform law provides in terms of benefit packages," Vermont Insurance Commissioner David Kimbell tells *HEX*. "The only reason we can move in this direction is because we only have three [commercial] carriers now... and they insure about half of our residents," says Kimbell. "If there were 15 carriers here, our vision might be more problematic."

State lawmakers have determined that Vermont's exchange will be an active purchaser, which will determine which health plans participate and contract directly with them.

Both the Vermont Blues plan and MVP intend to offer coverage through the exchange, but Cigna Corp., which doesn't participate in the state's individual or small-group markets, indicated that it wouldn't decide until final rules have been issued, according to interviews conducted by the consulting firm Bailit Health Purchasing, LLC, which is working with the state.

Vermont's Medicare, Medicaid and Commercial Enrollment	Lives Covered
Blue Cross and Blue Shield of Vermont	142,413
Cigna Corp.	92,194
MVP Health Care, Inc.	40,000
Medicaid	109,353
Medicare	95,182
TRICARE	13,917
Uninsured	47,460
Total State Population	621,270

SOURCE: Vermont Dept. of Insurance/Bailit Health Purchasing, LLC

"What we hope to create is an exchange that allows us to bring some administrative streamlining into our private insurance world...and also build the functionality that will allow it to align conveniently with our process for enrolling people into Medicaid," explains Mark Larson, commissioner of the Dept. of Vermont Health Access, which oversees the state's public health programs. "People will come to the exchange to sign up for either a private or public health care program. That will help us build the functionality we need to then transition to Green Mountain Care." Larson was appointed commissioner by Gov. Peter Shumlin (D) in July. He resigned from the state legislature Aug. 16 and began his new career the next day. His department will house both the exchange and Green Mountain Care. A deputy commissioner will be appointed to operate the exchange.

Market Outside Exchange Is Unlikely

Larson says one of the most pressing questions from health insurers is whether there will be a market outside of the exchange. But with a total state population of just over 620,000, having an outside market might make it impossible for the exchange to be self-sustaining by 2015, as required by the reform law.

"Our initial position was that it probably wouldn't make sense having a market outside, given that products offered inside the exchange must be priced the same as those sold outside of it," says Robin Lunge, the state's director of health care reform. "With such a small population...I'm not sure we can split up the risk pool."

Lunge, who previously was an attorney at the Vermont Dept. of Banking, Insurance, Securities, and Health Care Administration, was appointed by Shumlin last June.

The governor has indicated that he doesn't want coverage offered outside of the exchange so that the exchange can have the deepest risk pool possible. Even if the exchange enrolled all of the state's residents, "that's not enough to satisfy most actuaries," adds Kimbell.

The state is working with consultants on a study that will weigh the impact of having a market outside of the exchange. It will report its findings to the legislature in January.

STATE PROFILE: Vermont

Larson says his office also is trying to determine whether “small employers” will be defined as fewer than 50 employees or fewer than 100. And Lunge says she has been meeting with small business owners in the state to determine how best to structure the Small Business Health Options Program (SHOP) exchange.

While MVP and the Vermont Blues plans are expected to participate in the insurance exchange, it’s unclear if both plans will have a role to play once the state moves to a single-payer system. A significant issue for MVP is whether Vermont intends to eliminate the commercial insurance market.

If it does, there wouldn’t be any role left for MVP in the state, Frank Fanshawe, vice president, corporate affairs of MVP, told *HEX*’s sister publication, *Health Reform Week*, in April. By contrast, Leigh Tofferi, a spokesperson for the Vermont Blues plan, has been quoted as saying, “If there’s a single-payer system, we’d like to be the single payer.”

Subsidized Coverage Isn’t New to Vermonters

Thanks to a federal block grant, Vermont has one of the most generous Medicaid programs in the nation and is able to offer some form of coverage to residents with incomes up to 300% of the federal poverty level. About 109,000 lives are enrolled in that program, and another 10,000 are covered through Catamount Health, a state-subsidized insurance option for Vermonters who don’t have access to employer-sponsored coverage.

That program is similar in concept to the subsidized coverage that will be available through exchanges. People now enrolled in Catamount likely will be transferred into exchange-based coverage. “For those people, the exchange will seem very familiar because they are used to getting a state subsidy,” says Lunge. A mere 4,000 lives have coverage through Vermont’s individual market.

Kimbell says the state is working with CMS to determine a way for Medicare funds to flow through the exchange along with Medicaid dollars. That, he tells *HEX*, will make the risk pool, and the money flowing through the exchange, “much more robust.”

Larson admits that technology might be the biggest challenge. “We are trying to build it so the technology used in our exchange reinforces the technology of our Medicaid management system and together they provide the capacity to do universal health care down the road,” he explains.

Like most states, Larson is very interested on how the reform law will be impacted by the Supreme Court and future Congresses and presidential administrations. “We’re investing a lot of time and money in moving forward, and relying on the federal government to be a partner in that process,” he says.

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Gov. Shumlin Appoints Green Mountain Care Board

Last month, Vermont Gov. Peter Shumlin (D) announced members of the five-person Green Mountain Care Board, which will oversee the state’s move to a single-payer system and be involved in the development of the exchange.

An informal exchange advisory group was created shortly after the state received its planning grant. About 50 stakeholders participate. A formal Exchange Board is slated to be up and running in July 2012, says Vermont Director of Health Care Reform Robin Lunge.

Members of the Green Mountain Board are:

- ◆ **Anya Rader Wallack, Ph.D.:** Wallack, who will chair the group, has served as Shumlin’s Special Assistant for Health Reform since January. She once served as interim president of the Blue Cross Blue Shield of Massachusetts Foundation.
- ◆ **Al Gobeille:** Gobeille is a restaurant owner, a board member of the Visiting Nurse Association and a member of the state of Vermont’s payment reform advisory committee.
- ◆ **Karen Hein, M.D.:** Hein is immediate past president of the William T. Grant Foundation, which funds research to improve the lives of adolescents throughout the U.S. Previously she served as executive officer of the Institute of Medicine.
- ◆ **Cornelius Hogan:** Hogan has worked for the past 10 years as an international consultant, and previously he served as secretary of human services under Govs. Dean and Richard Snelling. Hogan is a well-known single payer advocate who has authored several books on Vermont health reform.
- ◆ **Allan Ramsay, M.D.:** Ramsay is a family physician who served as medical director for an HMO in rural Colorado and served in the National Health Service Corps.

SOURCE: Office of the Governor, September 2011.

EXCHANGE BRIEFS

◆ **HHS said Sept. 27 it has extended the comment period on the proposed exchange-related guidance that it issued July 15** (*HEX 8/11, p. 1*).

Comments now must be submitted by Oct. 31 — almost a month later than the original deadline. The proposed regulation, which offered broad guidance on how states should set up their exchanges, was issued along with companion guidance related to reinsurance and risk adjustment. The extension of the official comment period follows a “robust outreach campaign,” aimed at generating feedback, Steve Larson, director of the Center for Consumer Information and Insurance Oversight, said in a blog posting. The revised comment-period deadline aligns with the end of the comment period for proposed exchange-related rules that were issued on Aug. 17 (*HEX 9/11, p. 1*). Comments can be submitted to Regulations.gov. Read Larson’s blog at <http://tinyurl.com/42jc8j7>.

◆ **A nine-member advisory panel, formed early this year, has presented its recommended insurance exchange legislation to Maine’s Insurance and Financial Services Committee** — a legislative committee — the Associated Press reported Sept. 26. The group’s report details how the state should authorize the exchange to certify participating health plans, determine eligibility of individuals to participate and maintain toll-free hot lines and other services to help people purchase coverage, according to AP. Some state Democrats, however, worry that the plan doesn’t do enough to represent consumer interests.

◆ **Despite objections from members of her own political party, Arizona’s Republican Gov. Jan Brewer is seeking \$29.8 million in federal funding to build the state’s insurance exchange**, AP reported Oct. 4. Despite the request, Brewer’s office said the state intends to continue to challenge the constitutionality of the reform law. Arizona on Sept. 28 joined a coalition of 26 states that petitioned the U.S. Supreme Court to review the 11th Circuit Court’s decision that upheld the constitutionality of the reform law. The Goldwater Institute, a right-leaning Phoenix-based think tank, is launching a separate legal challenge to the reform law and has urged states to refuse to implement exchanges. Visit Brewer’s office at www.azgovernor.gov.

◆ **Nebraska Gov. Dave Heineman (R) wants his state’s lawmakers to hold off on passing legisla-**

tion authorizing the development of an insurance exchange until the Supreme Court rules on the reform law’s constitutionality, *The Omaha World-Herald* reported Oct. 4. However, he indicated that lawmakers also must be ready to move forward so that the federal government doesn’t wind up operating the exchange if the law isn’t overturned. While the legislature’s regular session ends in April, Heineman said he would call a special session if needed to pass exchange legislation. On Sept. 30, the state applied for a second federal grant to support exchange planning efforts, the newspaper reported. For more information, visit www.governor.nebraska.gov.

◆ **Oregon’s state Senate in September confirmed the members of the Oregon Health Insurance Exchange Board**. The board will oversee the development of the state’s exchange and will submit a formal business plan for the exchange no later than Feb. 1, 2012, for approval by the legislature. Liz Baxter, executive director of We Can Do Better, a non-profit organization focused on improving health care and health outcomes, will chair the board, according to a prepared statement issued Sept. 22 by Gov. John Kitzhaber (D). Visit governor.oregon.gov.

◆ **Limited information from the feds about insurance exchanges, including costs, could keep Republican state senators in New York from voting to approve the creation of an exchange this year**, according to an Oct. 6 article in *The Capitol*, a biweekly newspaper that covers New York politics. The lawmakers, according to the newspaper, were dismayed that HHS officials who spoke at a recent Manhattan conference “couldn’t answer basic questions about the program.” The state’s Democratic-controlled Assembly passed an exchange bill over the summer, but the GOP-led Senate has refused to take it up. New York already has received \$38.7 million in federal grants to help set up the exchange. If an state insurance exchange is created in New York, it will be overseen by a new agency. On Oct. 3, the state combined existing banking and insurance departments to create the Dept. of Financial Services. Along with overseeing insurance companies, banks and credit unions, the new agency will regulate and possibly run the state’s insurance exchange, according to *The Business Review* newspaper. DFS will have about 1,500 employees. For more information about the new department, visit www.dfs.ny.gov.

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