COMMUNITY CATALYST

Exchanges:
Top Ten Priorities for Consumer Advocates

The Affordable Care Act (ACA) requires states to set up health insurance Exchanges to help individuals and small businesses access quality health insurance. Consumer advocates face seemingly infinite questions about the development of their state insurance Exchanges. Based on Community Catalyst's experience with Exchanges in Massachusetts, Utah, and other states, this list of priorities will begin to answer some of the many outstanding questions in order to help state advocates build strong Exchanges that help consumers' ability to access quality, affordable health insurance across the country.

1. **Decide Whether or Not Your State Should Operate an Exchange**
   The first question advocates must address is whether they want their state to operate an Exchange or encourage the state to defer to the federal government. For most states, it makes sense to operate an Exchange on the state level to retain accountability and align with state private insurance rules. However, for states with very hostile political environments, there is a risk that the government will not make the necessary efforts to create a strong Exchange. At this time little is known about the potential federal Exchange, so it is difficult to weigh the risks and benefits. Therefore, most states should now pursue the development of a state-run Exchange, and revisit the question of federal control once more is known.

2. **Ensure Consumer Participation in Governance**
   States face numerous questions about the governance of Exchanges – should Exchanges operate as an arm of state government, through quasi-governmental or contracted entities, or in regional collaboratives? The answer to those questions depends on the political environment in a state, but regardless, the more important concern is the makeup of the board that designs and oversees the Exchange. First, formalized and meaningful consumer representation in governance of the Exchange must be included. In addition, decision-makers in the Exchange should include other key stakeholders and beneficiaries such as labor and small business.

   A good model is the Massachusetts Exchange, which has been governed by an independent board that includes six citizens and four state officials representing the budget, Medicaid, insurance and state employee health insurance offices. Three of the citizen members are chosen for their expertise – an actuary, health economist, and benefits specialist – and three are chosen as representatives of primary stakeholders – consumers, labor, and small business. The diverse group provides balanced policy guidance to the Exchange.

In addition, the state should require all Exchange board meetings to comply with open meeting laws. Written agendas, information and data from the meetings should be available to the public. This improves transparency and oversight in all major Exchange decisions.

Finally, Exchange governance should exclude those with conflicts of interest due to a direct financial stake in the health system. This includes organizations and individuals representing hospitals, physicians, insurers, and brokers. Legislation that creates an Exchange in California has particularly strong conflict of interest language for Exchange board and staff. The Exchange is a marketplace for health insurance options and should be neutral. Those who would profit from enrollment should not govern the Exchange.

3. Give the Exchange the Authority to Act as an Active Purchaser

One of the goals of an Exchange is to provide consumers with health plan options that are affordable and high quality. To be able to meet this challenge, a state Exchange must have the authority to negotiate with health insurers based on quality, premiums, and other factors (and not just accept all plans, like Utah's Exchange). An Exchange should be able to limit participating health insurers based on price and quality of plans.

At a minimum, states should not require Exchanges to accept all eligible insurers without any negotiation or competitive process. Even in states where an active purchaser model may be challenging because of a lack of insurer competition, the Exchange should not be prevented from implementing such a model to benefit consumers when it becomes an option in the future. To increase the number of plans to select from in Massachusetts, the law requires insurers with at least 5,000 covered lives in the small employer market to bid on health plans in its Exchange. The Exchange then has the authority to select bidders based on standards of "quality and value" and has used this power in the past. However, it should be noted that while the ability to negotiate with health insurers is a valuable tool that can prevent substandard health insurers from participating in the Exchange, experience in Massachusetts suggests this policy is not a magic bullet to temper premium increases.

4. Require Qualified Health Plans to Meet High Standards

In addition to providing the option to negotiate with plans based on value, the ACA requires Exchanges to certify qualified health plans (QHPs). The ACA includes certain factors in certification, such as performance on quality measures – (Healthcare Effectiveness Data and Information Set (HEDIS) and, Consumer Assessment of Healthcare Providers and System (CAHPS) – as well as complaints and appeals processes and network adequacy. But state Exchanges can require additional measures for certification of QHPs offered through the Exchange – including payment incentives for high-quality care and reduction of hospital readmissions; delivery system reforms (e.g., patient management of their health conditions); and reductions in health care disparities and improvements in language access. In addition, qualified health plans should have to meet network adequacy standards that mandate the inclusion of essential community providers.

QHP standards can also be integrated with Medicaid. Health plans should be required to include Medicaid providers to facilitate continuity of care for families who may transition between Medicaid and the Exchange. In addition, states may consider allowing Medicaid

managed care plans to offer coverage for people through the Exchange, since many enrollees with low incomes will seek subsidies for insurance. Finally, Exchange plans could align with Medicaid payment methodologies that reduce cost and improve quality.

5. Guard Against Adverse Selection

Many have concerns that the Exchange will become a marketplace primarily for people with serious health conditions and, therefore, will be very expensive. The ACA takes a number of steps to reduce this possibility of adverse selection – insurers must use one pool for plans, the essential health benefits package must be offered in plans both inside and outside the Exchange, and risk-adjustment programs will help even out the differences between the markets inside and outside the Exchange.

However, these tools will not be sufficient if states do not apply the same basic private insurance standards to plans inside and outside the Exchange. In addition, states should not allow health plans outside of the Exchange to sell lower quality products or have more limited patient protections. Insurance plans should not use marketing practices or brokers to steer enrollees to particular plans inside or outside the Exchange.

Furthermore, a state could prohibit any of the most limited plans allowed on the market to be sold outside the Exchange by insurers that do not also sell the same plan for the same price inside the Exchange. This would prevent insurers not participating in the Exchange from trying to attract healthier people using low-benefit options. For example, in Massachusetts, the most limited plan available on the market is sold at the same rate inside and outside its Exchange.

Finally, financing the Exchange can also impact adverse selection. By requiring all insurers, not just those that participate, to pay an assessment to fund the Exchange, a state can distribute the costs and provide an incentive for insurers to join without increasing costs for insurers who do so.

6. Create Strong Private Insurance Rules

An Exchange is only as strong as the private insurance rules that surround it and the enforcement of these rules. Exchanges are built to ensure easy-to-understand private insurance options with strong consumer protections, therefore private insurance rules need to reflect those goals. States that allow the private insurance market outside the Exchange to operate under less stringent rules (beyond the issues of adverse selection) will undermine the success of the Exchange in reorganizing the market. For example, private insurance rules must require oversight and enforcement of fair treatment of people who purchase coverage — including the ACA limits on premium rating, guaranteed issue, and guaranteed renewability. If a state does not effectively enforce these rules (or does not provide the insurance regulator with the authority to do so), the Exchange will not be able to function properly.

7. Maximize Market Clout

An Exchange can only hold down insurer costs if it has market clout, so it needs to cover a significant share of people. It is important to broaden – not carve up – insurance markets to

provide Exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. States should not create regional Exchanges within one state, but rather maximize the largest pool of enrollees possible by running a single Exchange.

One way to increase market clout is to combine the individual and small group markets. For example, Massachusetts combined the markets in its Exchange for both individual and small group plans. The combined market has a stable risk pool, is an attractive business opportunity for major insurers in the state, and has stabilized premiums in the individual market. Alternatively, a state could run the entire private insurance market through the Exchange, but would need to create options for undocumented immigrants, who cannot purchase coverage through the Exchange. One alternative would be to require all insurers to offer a select class of products for people unable to access to coverage through the Exchange.

8. Create a Seamless Interface with Medicaid

The overall principle governing the coordination between the Exchange and Medicaid should be a "no wrong door" policy. No matter where a person initially applies, the state's eligibility and enrollment system should ensure they sign up for the appropriate program.

Massachusetts uses a single application form for health coverage. The state then determines if the applicant is eligible for Medicaid or the subsidized plan through the Exchange. The single application encompasses eligibility requirements for all programs and has limited the information needed from the applicant through matching electronic data from other state sources. The state's Office of Medicaid determines eligibility for both programs. The ability to create this type of sophisticated eligibility system depends on the state's investment in information systems. If a state does not have proper systems in place, a first step should be to seek funding to adopt such a system rapidly. States can now receive a 90% federal match for funds spent updating Medicaid eligibility systems, including work to coordinate with the Exchange.

Many people will move between Medicaid and CHIP and the Exchange plans as their incomes fluctuate. The Exchanges and Medicaid must develop systems that make it easy for people to retain their coverage during transitions. Massachusetts has found there is significant income fluctuation with certain categories of workers, such as seasonal workers. The state altered its application to reflect the unique challenges presented by these workers so people were not unnecessarily moved on and off coverage. Disenrolling and re-enrolling individuals creates a significant administrative burden, which the state should evaluate in creating enrollment systems. Also see the options for integrating Medicaid managed care plans with the Exchange outlined in Section 4.

9. Ensure Navigators can Provide Clear, Transparent Information to Consumers

One of the main goals of an Exchange is to provide easy-to-understand information about health plans that helps people make informed choices about their coverage. The ACA requires Navigators, a critical component of Exchanges, to be culturally and linguistically competent to help vulnerable populations understand their options and choose the most appropriate health plans. In addition, ACA restricts Navigators from receiving any financial benefit from enrolling consumers in health plans. To help with enrollment, Navigators should

build on the foundation of strong consumer assistance programs in states, especially those that partner with community-based organizations with experience working with the uninsured and vulnerable communities.

Navigators and outreach programs can also be very useful in gathering information about what is and isn't working on the ground in the Exchanges and health plans. States should set up an organized "feedback loop" where these entities can provide information to state policymakers to improve programs and ensure the information provided to consumers is practical.

10. Ensure Consumers Can Make Meaningful Comparisons between Health Plans

States should consider ways to make information and enrollment through the Exchange easy for consumers to understand. For example, creating standardized plans using criteria beyond actuarial value would allow apples-to-apples comparisons. Grouping health plans using actuarial values still allows for major differences in benefit limits and cost-sharing (even among plans in the same tier) and makes comparisons difficult for most people. In Massachusetts, the Exchange first used actuarial values to compare plans, and learned insurers could manipulate benefit design to confuse consumers. For instance, most consumers have difficultly translating the different cost implications between plans with a deductible versus co-insurance. Over the past four years, the Exchange has offered a variety of plans and sought to simplify the choices so consumers could understand the significance of the differences between them. Now Massachusetts defines standard benefit packages on which every insurer bids in each tier of coverage. Consumer focus groups have prompted many of these changes and proved invaluable in finding what was best for this market.