

THE HEALTH INDUSTRY FORUM

THE EVOLUTION OF STATE HEALTH INSURANCE EXCHANGES



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

Conference presentations and other background materials are available at www.healthforum.brandeis.edu.

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Key Themes

Overview

State health insurance exchanges are online marketplaces that provide consumers and small businesses a new way of purchasing health insurance. Exchanges present an opportunity for insurers to acquire new customers but with an expanded emphasis on price, the basis for competition will change.

States are beginning to design exchanges in anticipation of the Affordable Care Act's requirements. States have substantial flexibility in designing the exchange's governance, market rules, operations, financing, and more. As a result, each exchange will be different. States face challenges in developing the information systems necessary to operate exchanges. They must also devise strategies to educate the public. Most states will measure the success of their exchanges by the numbers of enrollees they attract.

While many states are proceeding with implementation, the future of healthcare reform remains uncertain. If Republicans win the White House and Congress in 2012, they plan to repeal the Affordable Care Act. But the meaning of "repeal" is unclear and as implementation proceeds, repeal becomes more difficult. Furthermore, many stakeholders support healthcare reform. If President Obama is reelected, the Democrats maintain 45 seats in the Senate, and the individual mandate is deemed constitutional, reform will proceed. But revisions to the law will still be necessary, including measures to expand states' flexibility.

Context

On July 13, 2011, the Health Industry Forum brought together a diverse group of stakeholders, including representatives from several states that are implementing health insurance exchanges, to illustrate a range of different approaches to key design principles, the progress currently underway, and implementation challenges. Participants also discussed the political landscape and assessed the future of healthcare reform and exchanges given possible outcomes of the 2012 election.

Key Themes

- **Health insurance exchanges are critical in providing individuals and small businesses with access to insurance.**

To reduce the number of people without health insurance, the Affordable Care Act (ACA) calls for states to create health insurance exchanges—essentially online stores for purchasing insurance. These exchanges will offer different levels of insurance products for individuals and small businesses from different insurers at different prices. They will provide pricing and benefits information and facilitate clear comparison of the options

available. Exchanges will also administer premium subsidies for eligible participants.

States must establish mechanisms for determining eligibility for subsidies as well as managing the distribution of subsidies. In addition, states must determine how public education and outreach will occur. They will need to establish a process for marketing and for enrolling subsidized and non-subsidized individuals. States can determine the scope of authority for their exchange. Some will design exchanges to be active purchasers that select health plans based on cost and quality, negotiate prices, and actively market plans and products in the exchange. Other states may select a model that principally provides information about health plan options.

- **Exchanges present both significant opportunities and important challenges for health insurers.**

Healthcare reform provides an opportunity for insurers to expand their markets. Exchanges provide insurers with increased access to the small business and individual markets—which poses both threats and opportunities for companies already focused on these markets. It will affect how insurers compete since pricing, consumer marketing, customer service, and local knowledge and expertise will be keys to success.

But with exchanges come other regulations that may increase administrative complexity and costs for health plans. Dealing with churn, risk adjustment, new competitors, and potentially rapid growth are all potential challenges related to exchanges.

- **Exchanges will vary on a state-by-state basis.**

Every state must make decisions about the governance of its exchange, the market rules, the operating model, the financial model, and much more. These decisions will be based on a state's market conditions, political climate, and vision of the governor. States will have differing perspectives on the role of the state as an aggressive procurer of health insurance, and will differ in how tightly exchanges are integrated with other programs, such as Medicaid.

The IT challenges for states are significant, as creating systems to determine eligibility and integrating information from existing state agencies (e.g., Medicaid, Revenue) is complex.

- **The 2012 election will have a significant impact on the future of exchanges and of healthcare reform.**

Republicans have vowed to repeal healthcare reform if they win the White House and enough seats in Congress in 2012. But they have not yet articulated what repeal means. Some participants believe that subsidies will be eliminated, which would stymie exchanges and healthcare reform. But others believe that subsidies would be maintained in some form, and implementation

of exchanges and other aspects of healthcare reform will be far enough along that per se repeal won't be possible.

If the Democrats fare well in the elections and the individual mandate is found to be constitutional, then healthcare reform will clearly be the law of the land and implementation will proceed. However, compromises and revisions will be necessary.

Lawmakers will need to deal with both federal budget issues and cost containment, and states will demand more flexibility. Other subjects such as insurer transparency, malpractice reform, and Medicaid expansion and rate review are some of the areas lawmakers may need to address further.

How Will Health Insurance Exchanges Affect Health Plans' Business Models

Speaker: **Jon Kingsdale, Ph.D.**, *Managing Director, Wakely Consulting Group*
 Respondents: **Jerry Fleming, M.B.A.**, *Sr. VP and National Health Plan Manager, CA, Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals*
Marla Pantano, *Senior Actuary, Aetna Health Care Reform Project Management Office*

Overview

State insurance exchanges offer health plans a challenging new channel to sell insurance in the difficult-to-access small group and individual markets. This presents a significant opportunity that requires new models for competing effectively. The enhanced transparency that accompanies participation in an exchange will force plans to compete based on price, brand, service, quality, and consumer experience. While eager about the opportunities presented by exchanges, health plans are concerned about added regulation, increased costs, customer churn, the accuracy of risk adjustment, and preserving the individual mandate (or having a viable alternative).

enrollment, billing and collections, as well as marketing and selling insurance through the exchange.

"We are a retailer selling insurance . . . an exchange is an electronic insurance store."
— Jon Kingsdale

The Massachusetts Health Connector's website (<https://www.mahealthconnector.org/portal/site/connector/>) offers Gold, Silver, and Bronze plans and provides consumers with purchasing options depending on how much they wish to spend. After consumers enter basic information, like their birth date and zip code, they see information on different plan options along with the prices, allowing for fast, easy comparison shopping.

Context

Jon Kingsdale, who oversaw the creation of Massachusetts' health insurance exchange—implemented just 12 months after state health reform legislation was passed—described the primary functions of an exchange and shared his thoughts on how exchanges will affect competition among health plans. Representatives from Aetna and Kaiser then shared their perspectives and concerns.

Exchanges will evolve very differently state by state.

Every state's approach to creating an exchange will be different. Key dimensions of the different exchange models are:

- *The aggressiveness of the exchange's procurement process.* At one end of the continuum, the exchange would operate purely as a clearinghouse that provides purchasers with information, similar to Expedia. On the other end of the continuum, states may adopt more aggressive purchasing practices such as including only plans that meet specific price and quality criteria.
- *The degree of integration with other insurance programs.* Integrating the exchange with Medicaid, public employee insurance programs, and/or private purchasing coalitions provide expanded opportunities to promote payment reform or bargain for lower prices, but these strategies may also face political and technical hurdles. Oregon, for example, would like to create an exchange that is highly coordinated with other purchasers, while other states will have little integration.

Key Takeaways (Kingsdale)

Health insurance exchanges are essentially stores where consumers can learn about and purchase health insurance, with five primary functions:

1. *Determine eligibility and subsidy levels.* States are concerned that determining eligibility under new rules and data sources will be difficult. In Massachusetts, the exchange outsourced eligibility determination to Medicaid.
2. *Lead public education and outreach.* Since exchanges are a new concept and insurance is a "grudge" buy, it is essential to engage in outreach to educate the public about what they are and the need for coverage.
3. *Enroll subsidized and unsubsidized enrollees.* Some stakeholders argue that an exchange should just serve subsidized enrollees. But from a mission, scale, and risk-adjustment perspective, enrolling both subsidized and unsubsidized individuals is an important consideration.
4. *Specify plan designs and cost sharing.* Like any retailer, exchanges must determine the products they want to put on their shelves, which they do by specifying plan designs. Currently, Massachusetts' two exchanges (operated by the "Commonwealth Health Connector") sell coverage from nine different insurers that provide a range of choices in benefits, product design, and cost.
5. *Select, contract with, and sell health plans.* This involves evaluating health plans, managing processes related to

Exchanges will change how health plans compete.

- *More transparency and price sensitivity.* While health plans are excited about the growth of the insured market, with 32 million more individuals receiving health insurance, there will be a great deal of pressure on premiums driven by MLR (medical loss ratio) regulations and increased price transparency. Price transparency appeals to consumers and may lead to increased price sensitivity. In Massachusetts, 56% of consumers in the exchange selected the Bronze option and 40% of consumers purchased lower-priced plans within this option. Outside of the exchange, Blue Cross Blue Shield of Massachusetts has a market share of 58%, but for purchases through the exchange, with more pricing information and price-sensitive consumers, BCBSMA's market share is just 24%.
- *New emphasis on risk adjustment and care management.* The federal government will risk adjust health plan premium

payments, unless a state wants to assume this role. With risk adjustment, plans will be more comfortable enrolling sick people and then will have the opportunity to utilize care management programs to improve both quality and cost of services.

- New focus on consumers.* Most plans have expertise in marketing to and servicing groups but far less experience marketing directly to consumers. Nevertheless succeeding through an exchange requires plans to focus specifically on marketing to individuals whose concerns and decision making may vary from employers.
- Emphasis on state-by-state markets and local competition.* Because exchanges will be state-based, competition will take place at the state and local level. Based on specific market dynamics new health plans may enter the market with new products—for example, local provider-sponsored offerings.

To be successful in exchanges, health plans will have to be priced competitively, excel at direct-to-consumer marketing, optimize risk adjustment, and utilize care management effectively. Plans will have to pick their states carefully as each exchange and local market will be different.

Health plans may consider three alternative strategies outside of exchanges: 1) focus on developing national level products like large group ASO offerings; 2) pursue an anti-exchange strategy, for example, by developing a small-group strategy that markets against exchanges as the domain of government bureaucrats; or 3) continue with a traditional strategy of non-group risk selection.

Key Takeaways (Pantano)

Marla Pantano summarized Aetna's perspective on exchanges, including challenges and concerns that must be addressed.

- **Aetna sees a set of design principles that are critical for building a sustainable exchange marketplace.**

Under the Affordable Care Act, exchanges are a primary mechanism for creating access to affordable health plan choices. In addition to supporting state flexibility, Aetna advocates the following design principles for exchanges:

- Strong, viable marketplaces on and off the exchange.* Aetna believes there is value in providing consumers with different ways to shop for insurance. Some people may want to purchase directly from health plans, or through a broker or agent. Other individuals will be attracted to purchasing through an exchange.

"We believe there should be markets on and off the exchange that are strong and viable."

— Marla Pantano

- Market-oriented principles.* One principle is to have an open market where any plan could offer products through or outside of an exchange. Other important principles are transparency and flexibility, including the flexibility for plans to offer a range of different products, with different benefits, at different prices.

- Avoid duplication of existing regulatory functions.* Having similar regulatory functions, like rate review, at both the federal and state levels could be extremely cumbersome.
- Ensure a well-balanced risk pool.* The ACA's individual mandate is necessary to make sure that risk pools are well balanced. If the individual mandate is struck down by the courts, other mechanisms would need to be put in place to ensure well-balanced risk pools.
- Administrative simplicity.* There is potential for exchanges to increase complexity and add costs. With this in mind, Aetna wants exchanges to be designed to ensure administrative simplicity. This includes creating standard ways for exchanges to communicate with health plans.

- **While Aetna supports exchanges, there are concerns and challenges.**

- New taxes.* Several new taxes including direct fees on health insurers have been added to help pay for healthcare reform.
- Increased costs.* Parts of the health reform legislation will increase health insurance premiums. Specifically, decisions on benefit design and actuarial value have the potential to dramatically increase the cost of health insurance when they go into effect in 2014. These are counter to the goal of making healthcare more affordable.
- Risk management mechanisms.* Mr. Kingsdale said that many states will rely on the federal government for risk adjustment. The federal government risk adjusts payments to Medicare Advantage plans using a method which is quite sophisticated and requires a great deal of information. The same mechanism may not work as well in the individual marketplace where people change coverage more frequently.

Key Takeaways (Fleming)

Jerry Fleming described Kaiser's perspective on what is important for exchanges to succeed, as well as the opportunities and challenges for Kaiser.

- **The success of an exchange requires appropriate policy decisions at multiple levels.**

- The market in which an exchange operates needs to work.* If there is a weak individual mandate then the insurance market won't be stable and won't work.
- An exchange has to have conditions that make it an effective competitor.* If an exchange sees itself as a social institution, it won't work; it must have an entrepreneurial attitude. Competing effectively means giving consumers choices and achieving high levels of participation.
- An exchange must be a change agent.* If the market works and the exchange is an effective competitor, it will earn the right to become a change agent.

Other general issues that must be addressed for exchanges to succeed include:

- Risk adjustment.* Mr. Fleming agreed with Ms. Pantano that risk adjustment for this commercial market is different than for the Medicare market.

- *Minimal product variation.* To minimize confusion and enable price comparisons there should be minimal variation in the products offered through an exchange.
- *Minimizing risk selection.* Health plans should not be able to implement risk selection strategies that succeed outside of the exchange market. Because a carrier could use product variation and risk selection outside of the exchange, Kaiser believes that states should impose limits on such strategies.
- *Quality measurement.* Kaiser thinks quality measurement is important and positive quality results should translate into financial benefits for plans.
- *Minimizing barriers to entry.* For an exchange to provide choices and promote competition, it should be very conscious of the plans it offers and should pay attention to minimizing the barriers to entry.

▪ **Kaiser sees exchanges as a big opportunity to penetrate new markets, but also sees significant challenges.**

- *The basis for competition favors Kaiser.* Mr. Fleming agreed with Mr. Kingsdale's views on how health plans will compete in an exchange: based on price, brand, quality, care management, service, and consumer marketing on a very local basis.

"When we look at this new environment for the exchange, we see quite an opportunity for Kaiser Permanente and plans like Kaiser Permanente . . . it's pretty easy for us to be differentiated because we differentiate on the things people care about."

— Jerry Fleming

- *Exchanges provide access to new market segments.* Historically it has been difficult for Kaiser to penetrate the small group market and the individual market. But the exchange is a new distribution channel that provides access to these segments. Kaiser is optimistic about its ability to grow its business in these segments.

Despite Kaiser's optimism, it sees issues related to exchanges. Among them:

- *The regulatory environment.* Kaiser is concerned about rate review and price regulation. Regulators may look at Kaiser's reserves and want them used to reduce rates, yet since

Kaiser also runs a delivery system; its strong balance sheet is used for investments in hospitals, clinics, and technology.

- *Benefit range.* As an integrated system, Kaiser finds it difficult to deal with high-deductible plans.
- *Rapid growth.* Kaiser is set up to deal with annual growth in the health care services it delivers of 2–4%; its smaller regions can comfortably grow around 6%. But Kaiser is not structured to grow at rates of up to 15%, as this requires tremendous amounts of capital investment. However, exchanges could result in that level of growth.
- *Churn.* There is uncertainty about the stability of the exchange population and what the rate of churn will be.

Participant Discussion

- **Role of brokers.** While many small employers have outsourced aspects of HR to brokers, the role of brokers in a non-group market with exchanges isn't clear. Unless brokers are able to lock in their role through legislation, they may be forced or choose to retreat from the market. (An analogy is that attendants used to pump everyone's gas, but now people pump their own gas in most states.)
- **Prices of insurance premiums.** Ms. Pantano is concerned that having a floor of 60% of actuarial value for products offered through the exchange will increase premiums, as will the maximum three-to-one rate bands. Mr. Fleming believes there must be state oversight of the relative pricing of different plan tiers (e.g., bronze, silver, etc.) offered through exchanges.
- **Anti-exchange strategies.** As long as risk pools are balanced both in and off exchanges, participants see it as unlikely that plans will choose to stay out of the exchanges.
- **Tiered networks.** Ms. Pantano believes there is an opportunity to offer products with different types of networks (ranging from narrow to open), at different prices. Mr. Fleming believes it is more important for health plans to select delivery systems that can perform well than to alter benefit design, and Mr. Kingsdale said that once-a-year enrollment, with different prices for different networks, is more effective than narrower networks with high co-pays for going outside the network.

Evolving State Exchange Models and Potential Impacts on Local Insurance Markets

Moderator: **Murray N. Ross, Ph.D.**, Vice President and Director, Kaiser Permanente Institute for Health Policy
 Panel: **Jennifer Kent**, Principal, Health Management Associates and Former Deputy Legislative Secretary, Office of Governor Arnold Schwarzenegger
Joshua Sharfstein, M.D., Maryland Secretary of Health and Mental Hygiene
Anya Rader Wallack, Ph.D., Special Assistant to Vermont's Governor Peter Shumlin for Health Care Reform

Overview

The evolution of health insurance exchanges will be different in every state, based on the health insurance market, the political climate, and the vision of state leaders. There will be different governance structures, operating models, and different funding mechanisms. But in general, states view exchanges as an important vehicle for improving access to health insurance for the individual and small group markets. State's generally share a goal of enrolling as many people as possible in the targeted population segments. They face similar challenges: determining operational rules for the exchange; creating an integrated IT system linked to Medicaid's eligibility system; determining the role for brokers and agents; and deciding the extent to which the exchange will actively work to control premium growth. While the challenges associated with implementing exchanges are significant, states are optimistic about their potential.

Context

Representatives from Maryland, California, and Vermont described how these states are thinking about exchanges, the progress they are making, and the challenges they have encountered.

Key Takeaways (Maryland)

Dr. Joshua Sharfstein, Maryland Secretary of Health and Mental Hygiene, described the progress to date in implementing an exchange, and important issues that still need to be addressed.

As background, Maryland's individual health insurance market does not require guaranteed issue and so premiums are relatively low. There is also a high-risk pool for individuals, with about 20,000 people. The small group market has guaranteed issue and is community rated. There are three very active third-party administrators in the small group market.

- **Maryland sees an exchange as a way to improve access and help control costs.**

A Maryland healthcare reform taskforce concluded that the ACA will result in coverage for about 350,000 people who were previously uninsured. For the first ten years this will be positive for the state budget, generating around \$800 million in savings. Longer term, savings must come through delivery system improvements.

The exchange will be the way in which many newly covered Maryland residents will get insurance. Maryland's exchange is a public corporation with nine board members as defined in law enacted 4-12-11. The state legislature assigned six studies to the board to be conducted in the next year, on topics such as the recommended operating model, the insurance model, the

financial model, and more. The board is expected to make recommendations to the state legislature.

"What we're trying to do with exchanges is address cost issues in a way that's good for health."
— Joshua Sharfstein

The exchange became active on June 1, 2011; it has a procurement policy, and is in the process of hiring an executive director and staff.

- **In creating the exchange in Maryland, several issues must be dealt with.**

- Keeping the individual and small group markets separate.* Because the small group market has been community rated and the individual market has not been, combining them would be disruptive. So, Maryland is likely to initially keep them separate.
- Involving brokers.* Because brokers understand cost and how to sell products, Maryland thinks it is important to keep them involved under an exchange.
- Focusing on the navigator function.* Maryland realizes that the ease of use and the communications around the navigator function that are designed to address the individual needs of consumers are critically important.
- Conducting rate review.* It is important that rate review be done well. Maryland has hired experts with technical competence to help figure out how to best do rate review.
- Implementing IT and eligibility.* Maryland has a legacy eligibility system. It sees major IT challenges associated with implementing a new eligibility system and integrating all of the pieces that are necessary for the exchange to work.

Key Takeaways (California)

Jennifer Kent, who worked on health policy issues in California under Governor Schwarzenegger for seven years, provided an insider's account of the process to establish California's exchange.

- **To create an exchange, Governor Schwarzenegger took advantage of the political climate in California.**

After previously failed attempts to reform healthcare in California, in his last session as governor, Mr. Schwarzenegger largely embraced federal healthcare reform and sought to shape it in California. His public support for the federal legislation involved negotiating a multi-billion dollar 1115 Medicaid waiver.

Democrats in California were willing to work with Mr. Schwarzenegger to create a health insurance exchange because

they feared the potential that a new governor could block the state from implementing healthcare reform.

Once the governor and the Democrats agreed to create an exchange, the governor's only requirement was that the exchange must be involved in negotiating the best prices for the purchasers of health insurance. All of the other details were left to the governor's aides, including Ms. Kent.

▪ **As every state must do, California wrestled with decisions about the governance, operations, and funding of its exchange.**

California's governor delegated decisions about the exchange's governance and other details to a "home-grown health squad" of aides and experts. This team focused on the following areas:

—*Governance structure and funding mechanisms.* The team felt that the exchange had to be a government entity to ensure transparency and accountability. Within government, they felt that an independent board would be more flexible, dynamic, and responsive to market conditions than another government agency. They preferred a smaller board and settled on a board with five members. The board members are selected based on having diverse experiences, as opposed to representing specific groups, like consumers, labor, or the healthcare industry. Board terms are staggered, members are not paid, and they must adhere to standard conflict of interest provisions.

The exchange is funded by primarily assessments on insurers; and will not receive support from the state's general fund. All assessments must be approved by a two-thirds vote of the legislature. To limit the bureaucracy, the exchange's operating surplus is limited to a one-year reserve.

—*Market rules.* In creating the exchange, it was important to establish rules to protect the exchange and ensure it could compete on a level playing field with the non-exchange market. The new rules require that health plans that participate in the exchange have to sell the same products at the same prices outside the exchange, and they must offer every coverage level in all tiers. Catastrophic-only coverage (the lowest cost option) is only available through the exchange.

—*Selective contracting.* The exchange has the ability to certify and decertify qualified health plans, can standardize products, and can add other plan requirements. The exchange does not have to contract with plans that don't meet the established criteria. Because the California law requires that the exchange provide the optimal combination of price, value, quality, and choice, the inclusion criteria are likely to include quality measures.

—*Administrative and operational flexibility.* The exchange is exempted from many of the state's procurement rules. There is still a competitive process, but the level of bureaucracy will be reduced.

—*Topics tabled until a later date.* Among the topics that have not yet been dealt with are the benefits package, the role of agents and brokers, and decisions about whether to merge the individual and small group markets.

As in Maryland, integrating the information systems that are necessary to operate the exchange is a significant challenge. California expects 3–4 million people to purchase through the exchange. The state has three Medicaid eligibility systems that feed data into a 30-year-old legacy system.

Key Takeaways (Vermont)

Anya Rader Wallack, special assistant to the Governor of Vermont, explained how the situation in Vermont differs from other states.

▪ **The insurance situation, delivery system, and vision for the exchange are quite different in Vermont, where the long-term goal is a single-payer system.**

Vermont has only three private health insurers, and only two of them offer small group coverage, with BlueCross BlueShield having the bulk of the business. New insurers aren't likely to enter the market. Vermont has passed insurance reform, community rating, and guaranteed issue for both the small group and non-group markets. Also, the small group and individual markets are essentially merged. Vermont has a long history of Medicaid expansion, and almost half of the state's population is on Medicare, Medicaid, or both. The state's Medicaid expansion provides subsidized private coverage with eligibility administered by Medicaid. Vermont has no real "managed care" or selective contracting with providers.

The state has 14 hospitals and just one tertiary care center, all of which have fairly exclusive service areas. The delivery system for Medicaid and the commercial market are essentially the same.

From a policy perspective, Vermont's current situation is also unique; the governor recently proposed moving the state to a single-payer system or getting as close to a single-payer system as possible.

"We see the exchange as being a foundation for moving the state to a single-payer system."

— Anya Rader Wallack

Vermont has passed legislation that authorizes the state's exchange. This legislation focuses on cost control and gives a new regulatory board the ability to set rates, implement payment reforms, and control provider costs in every imaginable way.

Vermont's exchange was placed in the state's Agency for Human Services, the Department of Vermont Health Access. This made sense operationally since the exchange needs to work closely with Medicaid. The exchange is overseen not by a board, but by a deputy commissioner. Detailed planning is now underway for the exchange, with the idea that it will provide much of the administrative infrastructure for the single-payer system.

▪ **In keeping with its vision for healthcare, Vermont's exchange as outlined in its new law will be unique.**

- All small group and non-group (individual) coverage will be sold through the exchange.
- It will be tightly integrated with Medicaid and the Agency for Human Services responsible for eligibility determination.

- It may be used to administer coverage for public employees.
- It will serve as a vehicle for administrative simplification. Vermont is trying to use federal funds to create new administrative infrastructure that will simplify the administration of Medicaid and the exchange.
- Vermont eventually intends to request a waiver from the federal government to convert the exchange into a publicly financed single payer.

Ms. Wallack is concerned about the ability to marry a social program with the exchange's private market function, and is concerned that payers could game the system if the exchange does not serve most of the private market. She also is concerned that the resources provided by the federal government are not being used to make the states more capable in sustaining their efforts.

Participant Discussion

- **Defining success.** The panelists envision a successful exchange as one where the eligibility system works and the exchange is able to enroll large numbers of people. Failure would be a system that fails to attract consumers.
- **Guidance from the feds.** Participants were asked where they need guidance from the federal government. The main requests were for information about the essential benefits, and information about eligibility, which is necessary to design IT systems.
- **Keeping prices down.** A principle for Maryland's exchange is competition, with the belief that competition will keep prices down. Since Vermont aspires to a single-payer system it envisions that prices will be held in check through regulation.
- **Reapplying IT solutions.** Since developing integrated IT solutions is such an enormous challenge, the panelists were asked if their states might consider adopting solutions developed by another state. Ms. Kent thought that there would be some resistance from the Medicaid program, but she believes that those responsible for the exchange's IT systems would be open to adopting solutions from other states. Dr. Sharfstein believes that it might be less risky for a state to purchase an off-the-shelf solution which it can then configure, as opposed to creating its own IT solution. Dr. Wallack believes that it makes sense to implement a proven IT solution, but said that Vermont will be inclined to create its own system.

Is Compromise Possible in the Political Battle over Health Reform?

Speaker: **Len M. Nichols, Ph.D.**, Professor, George Mason University

Respondents: **Joseph Antos, Ph.D.**, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute for Public Policy Research

Karen Ignagni, M.B.A., President and CEO, America's Health Insurance Plans

Overview

The panelists agreed that political compromise is impossible in the short term. The future of healthcare reform and exchanges depends on what happens in the 2012 election. If the Republicans win, healthcare reform and exchanges could be repealed, though it is not clear what repeal means. It is possible even in a Republican administration with a Republican Congress that exchanges, subsidies, and other aspects of healthcare reform would remain in place. Whatever the direction, stakeholders must acknowledge that some aspects of healthcare reform need to be revised, states need to be granted far greater flexibility, and Congress needs a laser-like focus on cost containment.

Context

Professor Nichols was asked what compromises would need to occur for health insurance exchanges to have a chance at working.

Key Takeaways (Nichols)

- **Compromise prior to the 2012 election is impossible. It is possible after the election, under certain conditions.**

Professor Nichols sees no chance of political compromise on healthcare reform prior to the 2012 election. If Obama loses the election, healthcare reform is likely to be repealed by the Republicans, though it is not clear what this means, or what if anything would replace the Affordable Care Act (ACA).

However, if Obama is reelected, if the Democrats hold at least 45 Senate seats or regain control of the House, and if the Supreme Court rules that the individual mandate is constitutional, then the ACA will be accepted (begrudgingly by many) as the law of the land. Then after the election, a serious, pragmatic conversation will occur on how to improve the ACA.

Many groups favor this scenario, because they want healthcare reform to work. Health plans want it to work and fear that if reform "blows up," the eventual result will be a single-payer system. Hospitals want reform to work and fear that if it is repealed and Medicaid budgets are slashed, the impact on uncompensated care would be disastrous. Large employers want healthcare reform to work, and want even more done to address costs. Providers want it to work, and want tools to help change the delivery system so they can deliver better care. Even many moderate Republicans want reform to work to make the healthcare system more viable over the long term.

- **If compromise occurs, it would involve giving states more flexibility.**

If conditions lead to a serious conversation on how to revise the ACA, it is important to focus on signaling that business as usual is over because the country can't afford it. It will be necessary for Democrats to acknowledge that there are legitimate criticisms of

the ACA, and for the Obama administration to give Republican governors more flexibility to make changes. Being flexible is necessary so that the system is not seen as "Obamacare" but is a system that is developed and ultimately owned at the local level by Republicans as well as Democrats.

"If Obama wins, if the Senate is still close, and if the Supreme Court says it's the law, you've got to make it work. The notion of amending [ACA] will suddenly be a good idea . . . the real issue will be, where do states need flexibility?"

— Len M. Nichols

Flexibility is required on the essential benefits package, along with a transition period to slowly adjust to any changes in the actuarial value. Flexibility is also needed to provide states the ability to decide whom to enroll in the exchange and whom to provide subsidies to, which may include people not officially in poverty who cannot afford insurance.

Also on the table are budgetary compromises or "failsafes" that would condition coverage expansion and subsidy growth on achieving savings; compromises on the IPAB (or a comparable entity) to impose transparency requirements on insurers; and compromises on malpractice reform, which is needed for physician buy-in and to get physicians to practice differently.

Key Takeaways (Antos)

Dr. Antos responded to Professor Nichols and shared his thoughts on what compromise might look like.

- **It is not clear what "repeal" would mean under Republican control.**

It seems that Democrats have their heels dug in on preserving "reform," though it is not clear what they are focused on preserving. Like Professor Nichols, Dr. Antos believes that Democrats have to be open to making changes.

At the same time, Republicans are advocating "repeal," yet they have not articulated what this means and how they would replace the ACA. After a law has been in place for several years, it is very difficult to repeal its effects, which is a reality that Republicans must deal with if they win. Whatever changes Republicans wish to make, there would have to be a reasonable transition rather than an abrupt course reversal.

"Repeal means to replace it with something else . . . if you repeal something you have to ask what is it that you want to work? That is a tough question."

— Joseph Antos

While the terms "reform" and "repeal" aren't certain, there are some unavoidable facts that must be dealt with:

- *There remain gigantic debt and deficit problems that will limit what policymakers can do for the foreseeable future.*
- *Despite the criticisms of the ACA, alternative reforms will start from there.* Changes made by health plans, providers, and employers as a result of ACA will form the backdrop for future reform.
- *The private sector needs more flexibility.* While Professor Nichols emphasized giving states more flexibility, Dr. Antos said that it is the private sector that needs more flexibility.

Also, Dr. Antos argued that trying to mix social goals with private market functions won't work. In doing so, private enterprises won't produce what they are intended to produce and the social goals won't be achieved. Social goals and private enterprise should be separated.

Key Takeaways (Ignagni)

• **Health reform has sustainability problems because it didn't solve the key problem of cost containment.**

During the reform debate, policymakers were driven by three incorrect assumptions:

1. Access expansion and cost containment cannot be done simultaneously.
2. Health reform equals insurance reform.
3. The cost problem is too hard to fix.

The reality is that healthcare costs are crushing the economy. Small businesses and individuals can't afford healthcare. Because healthcare costs drive insurance costs, the cost of insurance has risen and is unaffordable for many. People are purchasing high-deductible health coverage because this is the only coverage they can afford.

The cost problem for small businesses and individuals will worsen under healthcare reform. There is already a massive tax on health insurance premiums for small businesses, averaging 3%. Under the ACA, the ratio between what is charged to older and younger people must be no greater than 3 to 1, compared with ratios today of 5 to 1 or 7 to 1. The result is that everyone under 30 years old will see their premiums rise dramatically. This will be a huge problem.

Another assumption is that health reform legislation will reform the market for health insurance, but the market can't be reformed unless everyone in the market is covered. The experience in Massachusetts has shown that unless everyone is enrolled, the system won't work. For the insurance market to work, a risk pool needs to be appropriately funded.

Another faulty assumption is that having a mandated medical loss ratio (MLR) will lead to cost containment. It won't. Health plans' profits are at best 4% and often are less than 1%. The MLR regulations will actually cause some insurers to exit some markets, a process that has already begun.

The true cost problem in America is not a utilization problem; it is a problem with unit costs. The focus on controlling costs must address unit costs.

"We have to have a discussion about what we are going to do about unit costs. Yes, that's hard because my cost containment is somebody else's revenue reduction."

— Karen Ignagni

One avenue to address cost containment is to have the discussion at the state level, where it may be possible to make more progress.

Participant Discussion

- **Disclosure of rate increases.** In the future, health plans will have to disclose the components of rate increases. This will show everyone that the cost problem is driven by providers, and not health plans. It will also show the huge variation in what providers charge for the same services, especially in markets where there has been significant provider consolidation.

- **Cost containment.** The IPAB is supposed to regulate the private market, but its future is uncertain. Dr. Antos believes that the place to start is by changing how Medicare pays. The concept of a fixed subsidy to allow consumers to purchase their insurance through an exchange sounds to Dr. Antos like a reasonable principle, but the transition hasn't been figured out.

Ms. Ignagni believes we are approaching a time when employers are not going to pay an increase over some specified amount. If the general rate of inflation is 2%, it is simply unreasonable for healthcare costs to constantly grow at 10% or 12%. Employers will turn to insurers with a fixed amount of money and ask what they can buy for that amount. Additional costs will be shifted to individuals, who will demand cost containment. Currently, commercial insurers are creating a range of new products, with different types of networks (from narrow to open) at different prices. Providers underfunded by Medicare and Medicaid have been able to shift costs and therefore have had little incentive to contain costs. But the coming changes will force providers to become more efficient.

- **Unit costs and bundled payment.** Since the cost problem is a unit cost problem, Professor Nichols sees two potential solutions: 1) price regulation, which Vermont is testing, but which the rest of the country doesn't want; and 2) bundled prices on much larger units of care. The idea is to take thousands of CPT codes and reduce them down to a handful of bundled prices that pay one lump sum to a provider to care for an entire episode. However, Ms. Ignagni is concerned that while bundled payments make sense as a way to address unit cost, the country is on the wrong path with ICD-10, as hundreds of thousands of new codes are being created, which is inconsistent and not necessary with bundled payment.

- **Lack of price elasticity.** One participant argued that as Medicaid and Medicare payment declines, providers can just raise their prices to other payers. In general, when providers do so they don't lose any volume. There is very little price elasticity because the customer doesn't pay the bill. Perhaps exchanges can begin to change that, because the prices in the delivery system can be translated to individuals. Ms. Ignagni said this is happening in Massachusetts. Consumers can select different

types of networks, with different degrees of openness and different quality ratings at different prices.

- **Medicare as catalyst.** Professor Nichols argued that since it is by far the largest purchaser of healthcare and in many markets, the only buyer large enough to get provider attention, Medicare must lead the transformation of the payment system.

"No one can go there [to bundled payment] unless Medicare drives it. Medicare has got to go first."

— Len M. Nichols

Ms. Ignagni said that she used to believe that Medicare had to go first, but she no longer believes this is true. In fact, the private sector is leading transformation. Proof of this is that ACOs have emerged across the country, well in advance of passage of healthcare reform and the ACO regulations.

- **Medicaid rates.** We are underpaying Medicaid providers in practically every market. In Professor Nichols' view, the country must have an adult conversation about what Medicaid providers are paid.
- **Potential delays.** Regardless of who wins the next presidential election, it is possible that the dates for different phases of implementing healthcare reform could be changed. States that are ready to go forward could do so, but states that are behind might be granted more flexibility.

- **Demanding information.** One of the important roles that only the government can perform is to demand that different players in the healthcare system reveal certain information. In fact, some dominant hospital systems put clauses into contracts that prohibit the disclosing of data. The government can, should, and, in many places, will change this.
- **Disclosure requirement.** Ms. Ignagni suggested that there should be a disclosure requirement for any hospital charging a certain amount over the Medicare rate (perhaps 20% or 30%) to a commercial client that can be monitored to track cost-shifting.
- **The future of subsidies and exchanges.** Professor Nichols believes that if the Republicans win the White House in 2012, subsidies would disappear, which would shut down exchanges and derail healthcare reform. Dr. Antos isn't so sure. He believes that even if there is a Republican president and Republican control of Congress, there will still be some form of insurance subsidy, though the name will change. Ms. Ignagni believes that exchanges and subsidies are here to stay.

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