Center for Mississippi Health Policy

Issue Brief

Building a Health Insurance Exchange in Mississippi

March 2011

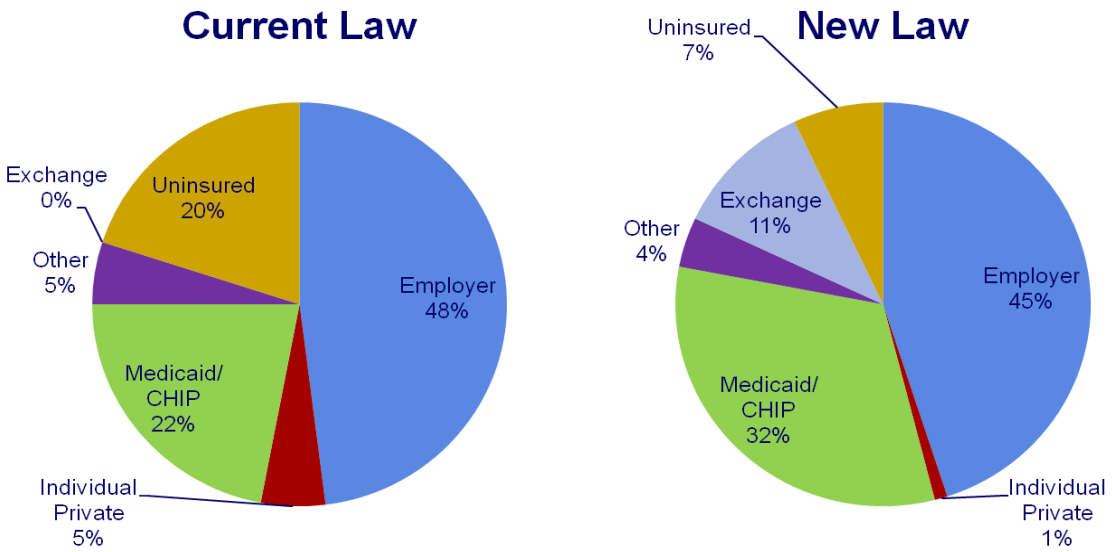
What Is a Health Insurance Exchange?

A key provision in the Patient Protection and Affordable Care Act (PPACA), the federal health care reform legislation, is the implementation of a nationwide system of Health Insurance Exchanges. The United States Department of Health and Human Services (DHHS) defines an exchange as "a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality."[1]

The intent expressed in the law is for the Exchange to be a "one-stop shop" for families and businesses to find health insurance plans suitable to their needs, including determining eligibility for Medicaid, the Children's Health Insurance Program (CHIP), or financial subsidies. The Exchange will also provide small businesses with an avenue for offering health insurance to their employees. The basic concept of the Health Insurance Exchange is to increase competition among health insurance companies by offering individuals and small businesses an array of standardized health insurance products from which to choose. Because subsidies, in the form of premium tax credits, will be provided to qualifying individuals for insurance purchased through the Exchange, uninsured persons should have greater access to affordable health insurance coverage.

Projections developed by economists at the Georgia Health Policy Center of changes in coverage likely to occur after full implementation of PPACA show that approximately 275,000 Mississippians (11 percent of non-elderly persons) are expected to enroll in coverage through an Exchange.

Figure 1. Sources of Coverage Before and After Full Implementation for Non-elderly Population



Source: *An Overview of Health Reform*. Center for Mississippi Health Policy and Georgia Health Policy Center, September 2010. Available at www.mshealthpolicy.com.

Governance Options for States

A state may establish its own Exchange or may join with other states to create a regional Exchange. States must notify the Secretary of DHHS by 2012 if they elect to operate their own Exchange.[2] If a state does not set up its own Exchange, the federal government will assume that responsibility either directly or through an agreement with a nonprofit entity.[3] The federal law provides states with a certain amount of flexibility, and in planning to operate an Exchange, states will have several decisions to make about which options will be implemented.

One of the first decisions a state must make is the organizational structure for the Exchange. State Exchanges may be constituted as a nonprofit body or a governmental agency. They may be governed by a board or placed directly under an agency head or the governor. If states place an Exchange within an existing government agency, an Exchange could benefit from procedures and administrative systems that are already in place, possibly making the development of an Exchange easier and faster. If established within an Insurance Department, the operations of the Exchange will need to be separated from the regulatory functions of the Department.

A nonprofit structure may allow for more flexibility because a nonprofit entity would not be subject to the same laws and regulations governing the operations of public agencies, such as personnel and procurement rules. This flexibility could facilitate the establishment of the Exchange within the short time frame provided, but may also reduce transparency and accountability.

If a governing board is created, the State will need to determine the appropriate composition of its membership, balancing consumer, business, provider, and insurance industry interests. If the board includes members who may be impacted financially by decisions of the board, provisions will need to be made to address potential conflicts of interest. Regardless of the governance structure chosen, states will have considerable work to accomplish in creating an Exchange and ensuring that it works cooperatively with the state agencies responsible for other functions under health care reform, particularly Insurance and Medicaid.

Types of Exchanges

Federal law allows for two types of Exchanges: the Small Business Health Options Program (SHOP) and the American Health Benefit Exchange. The SHOP exchanges are intended to help small business owners provide health insurance for employees and the American Health Benefit Exchange is intended to provide health insurance for individuals. Small businesses are defined as those with one to 100 workers, but states can elect to limit small business participation to employers with 50 or fewer employees in 2014.[4] In 2017, states will be able to expand access to the Exchange for businesses with more than 100 employees.

States have flexibility in how many Exchanges will be established. More specifically, they have the option to merge both types of exchanges, form regional exchanges with other states, or form multiple exchanges within their own state.

Tax Credits and Subsidies

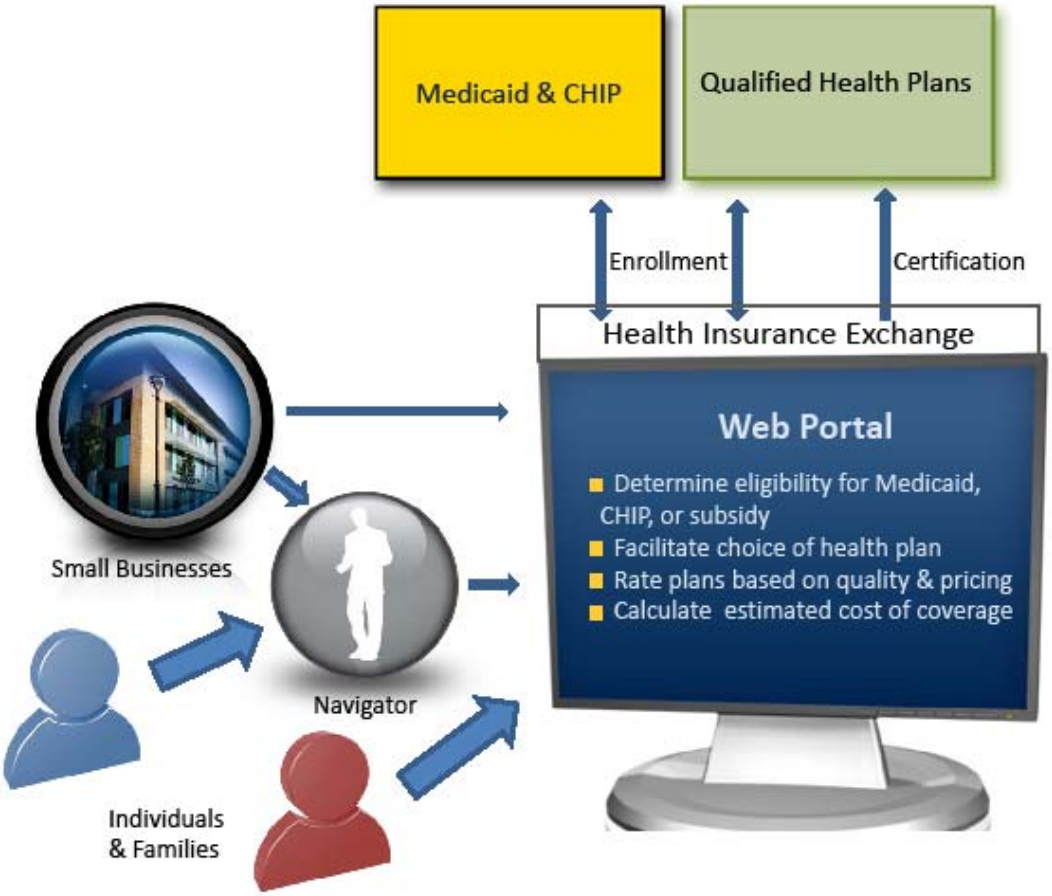
Both the SHOP and the American Health Benefit Exchange provide tax benefits to certain businesses and individuals that qualify. The Center for Mississippi Health Policy, in collaboration with the Georgia Health Policy Center, has developed a “Small Business Health Reform Calculator” to assist small employers in estimating current tax credits for which they may be eligible. The Calculator can be found on the Center’s web site at http://www.mshealthpolicy.com/smallbusinesscalculator.htm.

Beginning in 2014, Mississippians with incomes between 133 percent and 400 percent of the Federal Poverty Level may be eligible for subsidies for the purchase of coverage within the Health Insurance Exchange. Of the estimated 275,000 individuals projected to purchase coverage through the exchange in 2014, about 229,000 should be eligible for subsidized coverage. Economists estimate the subsidies for these individuals will be worth approximately $912 million in 2014, all to be funded by the federal government. These estimates could change, however, once rules are established regarding enrollment, benefits, and coverage requirements.

Functions of an Exchange

Section 1311(d)(4) of the PPACA requires all Exchanges to perform certain minimum functions:

- Certify, recertify and decertify health insurance plans as "qualified health plans" to be offered through the Exchange,
- Operate a toll-free hotline for consumer assistance,
- Maintain a website providing standardized comparative information on health plans,
- Assign price and quality ratings to plans,
- Present plan benefit options in a standardized format,
- Provide information on Medicaid and CHIP, determine eligibility for applicants, and enroll eligible individuals in these programs,
- Provide an electronic calculator to allow applicants to determine the actual cost of coverage, taking into account premium tax credits and cost sharing reductions for which they are eligible,
- Certify individuals who may be exempt from the individual responsibility requirement,
- Provide information to the Treasury Department and to employers on certain employees who are eligible for premium tax credits, and
- Establish a Navigator program that provides grants to entities to conduct outreach and education, as well as assist consumers in enrolling in qualified health plans through the Exchange.



Performance of these activities will require implementation of the technology needed for individuals and employers to access comparative information on health plans; determine eligibility for Medicaid, CHIP, or subsidies; estimate costs of coverage, premium tax credits, and cost sharing reductions; and enroll in the appropriate coverage. The Exchange will need to interface electronically with federal and state agencies necessary to determine eligibility for public coverage or subsidies and grant certifications of insurance coverage or exemptions.

Essential Health Benefits

All plans in the Exchange will be required to offer at a minimum certain "Essential Health Benefits" that include the following:

- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services,
- Prescription drugs,
- Preventive and wellness services,
- Chronic disease management, and
- Pediatric services (including pediatric oral and vision care).

PPACA gives the Secretary of DHHS the authority to define specifically what these Essential Health Benefits will include. DHHS reports that the agency is currently working with the Institute of Medicine (IOM) to develop these specifications.

Levels of Coverage in an Exchange

An Exchange must offer four levels of coverage (bronze, silver, gold, and platinum) that vary based on the percentage of benefits provided by the plan. Coverage levels range from 60% to 90% of the full actuarial value of plan benefits. This scale is designed to allow individuals to balance cost and coverage in selecting a plan that meets their needs, as plans with higher levels of coverage will cost more. Additionally, a catastrophic plan can be offered to individuals up to age 30 or to individuals whose premiums exceed 8 percent of their income. This latter plan will only be available in the individual market. In order for an insurance plan to be certified as a qualified health plan in the Exchange, it must offer at least one plan at the Silver level and one plan at the Gold level.[5]

Figure 2. Exchange Benefit Levels

Plan Level	Percentage of Benefits Provided by the Plan (based on full actuarial value of benefits)
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Navigators

Many Mississippians will need assistance in determining their eligibility under the various health coverage options and in selecting the health plan that is most appropriate for themselves and their families. To address this situation, PPACA mandates that an Exchange include a program where "Navigators" are responsible for outreach, education, and enrollment.[6] Exchanges will provide grants to eligible entities to provide these services. Funding for the Navigator program must come from operational funds of the Exchange and not from the federal grants provided to states to establish the Exchange.[7]

DHHS will define national standards for Navigators and provide a process for ensuring that they are qualified. Navigators can be entities such as trade, industry, and professional associations; chambers of commerce; community based non-profit groups; and other organizations that have established, or can readily establish relationships with employers, employees, consumers, or self-employed individuals who are likely to seek health coverage through the Exchange.[8] Navigators cannot be a health insurance company and may not receive payment from a health insurance company, either directly or indirectly, related to the enrollment of individuals or employees in a qualified health plan.[9]

The federal health care reform law lists the following specific responsibilities of Navigators:

- Conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange,
- Distributing "fair and impartial" information concerning enrollment and the availability of premium subsidies and cost-sharing reductions,
- Facilitating enrollment in qualified health plans,
- Referring individuals to the appropriate agency or agencies if they have questions, complaints, or grievances, and
- Providing information in a culturally and linguistically appropriate manner.

The Role of Agents and Brokers

Insurance agents and brokers (often referred to collectively as "producers") can serve as Navigators, but they cannot receive compensation from insurance plans for services provided as Navigators. Agents and brokers have historically assisted consumers and small businesses with the process of selecting and enrolling in health insurance plans. They have typically been compensated based on a commission that is a percentage of the premiums paid by the policyholder. Such commissions average approximately six to eight percent, but may vary depending on the product and/or geographic region, and are often higher for initial enrollments.[10]

The restrictions against Navigators being paid by health insurance plans for enrollment could possibly limit the participation of producers as Navigators. Two other factors may further reduce their role: the website that must be established by the Exchange to simplify the process of selecting and enrolling in health insurance plans and the limit on the administrative costs for health insurance plans. The latter requirement creates an incentive for insurers to reduce administrative costs, including producers' commissions.[11]

Nonetheless, purchasing health insurance is likely to be a confusing process for many, and the legislation recognizes the knowledge and expertise of producers that could contribute to their function as Navigators. Balance may be found in modifying the manner in which producers are paid so that payment is based on services rendered and not contingent on which plan is selected.[12] There is also a potential risk that producers may be faced with incentives to move their clients to insurers that are outside of the Exchange.[13] This could become more of an issue if states limit or regulate commissions inside but not outside the exchange.

The states' role in licensing producers is not changed by PPACA. Therefore, the possible challenges for states will be in making decisions concerning regulations of the responsibilities of producers in the Exchanges, the types of services provided by producers, and their compensation.

Adverse Selection

People who expect to use health care services generally seek more comprehensive coverage and are generally willing to pay higher prices for coverage than people who don't anticipate needing as much health care. Adverse selection occurs when a health plan enrolls a disproportionate number of the people who are at risk of using more health care services and are more costly. Adverse selection can cause a health plan to enter a "death spiral" where the higher costs lead to higher premiums, which only those with the greater need for coverage are willing to pay. The higher premiums cause lower risk individuals to seek coverage elsewhere, thus raising premiums further. The cycle repeats until the premium costs exceed the budget of even the neediest individuals, and the plan collapses.

Health care reform legislation does not eliminate existing insurance markets, and the differences between the markets inside and outside of the Exchanges could potentially lead to adverse selection. An example scenario is if a highly disproportionate number of individuals with poorer health and higher health costs enroll in insurance plans in an Exchange, while individuals who are healthier and have lower health costs enroll outside of the Exchange. This situation would make health insurance coverage in the Exchange cost more than equivalent health coverage outside the Exchange, thereby increasing costs for consumers and businesses purchasing through the Exchange, as well as for the government.

PPACA includes provisions designed to minimize adverse selection, including premium subsides, risk adjustment, and reinsurance:

- Individuals receiving federal premium subsidies, which will include individuals of all risk levels, can purchase health insurance only within the Exchange. Lower risk individuals cannot move out of the exchange and still receive premium subsidies.
- PPACA also provides for a transitional reinsurance program to stabilize the individual markets from 2014 through 2016. Health plans will make payments to a state reinsurance entity that will make payments to health plans that cover high risk individuals in the individual market.
- The law's risk-adjustment provision is designed to compensate health insurance plans that enroll sicker, higher cost individuals. The state will assess a charge on plans with less than average risk and make payments to plans with greater than average risk.

States will have the flexibility to provide additional strategies inside and outside the Exchange to help prevent adverse selection. Some options states may consider in addressing adverse selection include the following:[14]

- Require that all insurers in the Exchange offer all four tiers of coverage,
- Standardize benefit packages for plans inside the Exchange to allow for easier comparison,
- Require plans outside the Exchange to offer a standardized benefit package at each of the four tiers,
- Restrict sale of "catastrophic" insurance plans to within the Exchange, and
- Require that all individual and/or small group policies in the state be sold only through the Exchange.

Plan Selection

States have options regarding the manner in which health plans will be selected for participation in the Exchange. States may choose to allow any qualified health plan that meets state-established criteria to be offered through the Exchange. Alternatively, states may want qualified health plans to compete for participation and only select a limited number of plans that offer the best price and quality. The first model provides the most choice to consumers, and plans compete at this level. The latter model is generally designed to drive quality improvement and price reduction.

Funding

The Patient Protection and Affordable Care Act authorized State Planning and Establishment Grants to help States plan and create Health Insurance Exchanges. States have multiple opportunities to apply for resources for implementing Exchanges. Forty-eight states (including Mississippi) and the District of Columbia were each awarded Planning Grants of $1 million dollars in 2010.[15] The purpose of these grants is to provide states with the resources needed to perform the necessary research in planning how their states will operate an Exchange.

The next cycle of grants available for states will be for Established Grants that were announced by DHHS in January 2011. This grant program does not have a fixed limit on grant awards. The amount of money provided to states will be based on the state's implementation plan and the amount of progress the state has made in creating an Exchange.[16]

It is important to note that the federal grants available to states for establishing Exchanges end in 2014. Beginning Jan 1, 2015, Exchanges must be self-sustaining. It is expected that Exchanges will be funded on an ongoing basis by fees charged to participating plans.[17]

For More Information

The Center for Mississippi Health Policy has collaborated with the Georgia Health Policy Center at Georgia State University to produce a series of issue briefs that describe the contents of the Patient Protection and Affordable Care Act and project the potential impact in Mississippi. More detail on the implications for businesses and individuals is available in the issue briefs, "Health Reform Implications for Employers" and "An Overview of Health Reform," which can be found on the Center's website at www.mshealthpolicy.com.

Endnotes

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[17] Carey, R. op. cit.

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