Community-Based Nonprofit Medicaid Plans and the New Health Insurance Exchanges: Opportunities and Challenges

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Introduction

Health insurance exchanges are a centerpiece of the Patient Protection and Affordable Care Act's (ACA) health insurance market reforms. In classic federalism style, the national reform provides some rules that will apply to all exchanges, but leaves much discretion to the states.

Among the many options states will need to address is how to treat local community-based, nonprofit, full-risk health plans. To date, the focus of these plans has been exclusively, or almost exclusively, on serving public programs—mainly Medicaid.[1] Under reform, Medicaid, Medicare, the Children's Health Insurance Program (CHIP), and other public programs will not be offered through the exchanges; instead, exchanges will enroll individuals and small groups who are not eligible for those public programs. Consequently, community-based plans that primarily serve those in public programs can continue to serve these populations without competing in an exchange. But a variety of program realities, plan needs, and public interest considerations may suggest a value to allowing—conceivably even encouraging—participation by these plans in the exchanges.

In this brief we explore several issues related to this policy option. Are community-based, nonprofit Medicaid plans (CNMPs) interested in participating in an exchange? What is the potential value or pitfalls related to that participation? Would CNMPs be able to compete on price and, in so doing, assist in the drive to lower health care costs? What might CNMPs want in an exchange environment? What might they advocate for as state legislatures establish exchanges?

A full exploration of these questions is beyond our scope here.[2] Rather, our goal is to place policy issues related to CNMPs on state agendas as they plan for exchange implementation, and to provide some insight into relevant policy questions for plans and states.

Overall, the CNMPs enroll 7–8 million individuals, or approximately seven percent of all Medicaid recipients, including some CHIP enrollees and some dual eligibles. (See box for more detail and information about these plans.) Because of their pivotal role in serving low-income populations, including the uninsured, and because substantial numbers of those that will be enrolled in the exchanges are likely to be low- or low-middle income individuals and families, the CNMPs may deserve special attention in exchange discussions. Complex interactions between state Medicaid programs and the exchanges also suggest the need to focus on the role of Medicaid-oriented plans.

Methods

In an effort to answer the questions outlined above, we interviewed CEOs and other leaders of 15 CNMPs in 12 states: New York (2), New Jersey, Colorado, Florida, Michigan, Texas, California (3), Rhode Island, Pennsylvania, Ohio, Massachusetts, and Oregon. In addition, we interviewed a selected group of national and state-based policy experts. While we made a particular effort to interview plan leaders from major population centers, the groups we met with in no way constitute a representative sampling. Moreover, the limited number

CNMPs and the Medicaid Managed Care Marketplace

As of June 2008, full-risk Medicaid managed care plans enrolled almost 22 million individuals, about half of all Medicaid recipients at that time and about 65 percent of all Medicaid enrollees in some form of managed care. (Later figures suggest that number is now closer to 24 million).[3] These full-risk Medicaid managed care plans can be divided into three broad types. First, there are multi-state health insurers that have Medicaid products in some states but primarily serve privately insured populations in the employer and/or individual marketplaces. Some of these insurers are for-profit, some nonprofit. According to the Association for Community Affiliated Plans (ACAP), the trade association of CNMPs, about 10 million individuals, (42 percent of full-risk Medicaid managed care recipients), are enrolled in these kinds of plans.

Second, there are private, largely for-profit plans that primarily serve Medicaid and other public programs. These are generally multi-state organizations. According to ACAP, about 7 million individuals (approximately 29 percent of full-risk Medicaid managed care recipients) are enrolled in these plans.

Third, there are the CNMPs that enroll an additional 7–8 million individuals in total, the great majority of whom are Medicaid recipients. This enrollment constitutes about 29–33 percent of the approximately 24 million individuals enrolled in full-risk Medicaid managed care.[4]

Almost all CNMPs are, by definition, local. Additionally, almost all operate in only one state and/or one geographic area within that state. They are all nonprofits or owned by nonprofit organizations. Most rely heavily on safety net delivery systems, especially community health centers, although most will contract with a wide array of medical groups and hospitals that serve the broader community.[5] Some are stand-alone plans; others are part of a larger health care system. Their mission statements generally reflect a commitment to serve low-income and vulnerable populations. Almost all are privately organized, many by provider organizations including hospitals that serve Medicaid and other public plan beneficiaries and the uninsured. A few, most notably California's Medi-Cal plans, are publicly owned.

According to ACAP, about 55–60 such plans are in existence today, 52 of which, located in 25 states, are represented by ACAP. The CNMPs vary widely in enrollment with the largest enrolling over 800,000 individuals and the majority in the 100,000–200,000 member range.[6]

of CNMP leaders we interviewed and the varying positions they expressed on different matters renders the findings, outlined below, preliminary and largely anecdotal.

In the discussion of policy options, the views expressed, unless otherwise indicated, are those of the author. No effort is made here to provide authoritative answers. Rather, the hope is to raise and define the questions and options that plans and policymakers will need to address.

Interest and Assets

Some CNMP leaders believe that Medicaid expansions under the new federal law will be great enough to enable them to increase membership considerably, and that the potential gain in competing for the larger pool of individual and small group exchange consumers might not be worth the organizational effort, costs, or risks involved.[7]

However, the great majority of plan leaders expressed moderate to great interest in competing in health exchanges. At a minimum, according to some, they will need to be in the exchange just to protect what they already have. As individuals move in and out of Medicaid, plans serving both the Medicaid and exchange populations will have greater capacity to retain their members. Consequently, plans not in both Medicaid and the exchange could be at a competitive disadvantage. Similar circumstances could arise with CHIP, as parents of CHIP-eligible children who receive care through the exchange seek to enroll their children in the same plan in which they are enrolled. For these reasons, participation in an exchange seems advisable to many Medicaid-focused plans.

Most leaders interviewed, however, saw participation in an exchange as a way to support their mission as well as a means to plan stability or growth. It is unlikely that many of these plans long for competition with commercial health plans. But the subsidized populations, especially those in the lower-income ranges who will access insurance through the exchange, are viewed by these plans as their natural constituency. Most CNMP leaders believe they represent the kinds of plans best suited to serve that constituency.

Community, networks, continuity, and choice

The most obvious and frequently asserted benefits of including CNMPs in an exchange are related to the concepts of community, provider networks, continuity, and, to a lesser extent, choice. These benefits are viewed as accruing both to the plans themselves and to the communities they serve.

Most plan leaders emphasized their experience—as well as that of their providers—with and commitment to serving low-income, underserved, and culturally diverse populations. As one suggested, they speak the language of the community, literally and figuratively. While they usually recognize the limits of their "brand" beyond that community, they believe it to be strong within that community, which, they emphasize, includes provider organizations. They pride themselves on viewing providers as partners; indeed, in many cases, the providers own the plan. In addition, these partners are tied to the community served and are better prepared to address its unique cultural, economic, and medical challenges.

Continuity refers to a variety of presumed benefits of CNMP participation in exchanges. Most obviously, participation of Medicaid plans in an exchange would enable individuals moving in and out of Medicaid or other public programs to stay in the same plan while doing so. This should prove of value to states, as well as to plans, because these transitions should be much smoother if the Medicaid plans are in the exchange. Continuity also has a family component. Family members may be eligible for different public plans or subsidies in the individual or small group marketplace. Without plans serving the public programs participating in an exchange, many families are likely to find themselves members of several different plans.

Finally, although most did not emphasize this, CNMPs would provide exchanges with a healthy dose of choice. Some of the plan leaders interviewed admitted a preference for a more regulated, single-payer type system. But given the government's policy decision to rely at least as heavily on competition as on regulation in seeking reform goals, CNMPs, which are built on serving different communities under different health care system circumstances, provide an obvious asset in expanding consumer choice. Clearly, CNMPs, as a group, are more distinct from commercial plans than commercial plans are from each other (with the possible exception of Kaiser or other highly integrated plans).

More questionable is whether or not CNMPs can provide a higher quality of care to populations they may serve in an exchange. Some plan leaders and policy analysts suggested that the continuity benefits of CNMP exchange participation, as outlined above, would have value in terms of quality improvement. For example, individuals would be able to stay in one system, thus making provider relationships easier to maintain. Moreover, especially as more commercial plans have moved from an emphasis on managed care to broader networks and maximum choice, it is the best of the Medicaid managed care plans that may have the greater capacity to improve quality via disease management programs, increased focus on care of the chronically ill, and other activities associated with accountable care organizations incentivized under reform. As one CEO suggested, when it comes to plan involvement in membership access to care, commercial insurance has moved toward an emphasis on wide provider choice and away from plan involvement and guidance. Medicaid plans, he argued, are better equipped to serve their members

beyond the payment of claims and the provision of a provider.

This view, according to some plan leaders and their ACAP representatives, is supported by positive Healthcare Effectiveness Data and Information Set (HEDIS) scores and other indicators of quality and consumer satisfaction in much of Medicaid managed care. According to internal reviews conducted by ACAP, 22 ACAP member plans that submitted 2008 data to the National Committee for Quality Assurance had a higher average HEDIS score than non-ACAP plans on most measures. [8]

Overall, CNMP leaders seemed confident that their plans could provide a quality of care that is as high or higher than other Medicaid plans. However, they pointed to several barriers to high quality care in the Medicaid program. Many noted low reimbursement rates, pressures to see large numbers of patients in short time frames and, above all, difficulty in providing adequate access to specialty care.

Attracting and serving members

Most plan leaders also seem to believe that the same policy case that is made for including CNMPs in an exchange can be made in the marketplace to attract new enrollees, especially among lower-income populations. Nonprofit status, a solid brand in some communities, local community-focused orientation, and networks of providers who have served the Medicaid and CHIP programs would provide attractive marketing features.[9] Additionally, some leaders pointed to ties to academic medical centers that provide both an assurance of high quality and access to advanced technology, and perhaps the appeal, suggested by one leader of a hospital-based plan, that "we probably trained your doctor." Others emphasized provider-owned status, networks as broad as those maintained by commercial plans, and high quality or consumer satisfaction ratings as positive selling points.

Another asset of Medicaid plans in general, and CNMPs in particular, might be their experience and relative comfort level in working with government. As one state insurance commissioner suggested, whereas commercial plans want government to serve as "a referee at best," Medicaid-based plans are accustomed to a public-private partnership, and a heavily regulated one at that. Many Medicaid plans have developed sound working relationships with government when it comes to issues such as those that will need to be addressed as exchanges are created and implemented. This being the case, it is likely that CNMPs will be very comfortable with the exchange format and the significant dose of regulation it is likely to entail.

Competing on Price and Lowering Costs

Of all the questions asked, the one about the capacity for CNMPs to lower costs drew the most varied responses. Some plan leaders emphasized their "more integrated networks" as a source of lower costs. Others noted that their nonprofit status or a culture of service over profit enabled them to keep salaries and other administrative costs lower than those of commercial plans. They are more "lean and mean" one suggested. They do not have high-cost real estate and compensation levels are lower than in commercial plans.

But most leaders, especially those who appeared to have thought about it the most, were unsure on this question. The answer, they suggested, would hinge largely on whether or not their Medicaid providers would continue to accept the lower rates paid by Medicaid plans as the Medicaid population expands. It would also depend on whether or not the Medicaid plans could compete with commercial plans in payment rates for non-Medicaid physicians should the plan compete to serve privately insured, higher income populations. Most believed that both sets of providers would demand higher compensation; how much more would be the question. Certainly, with smaller enrollments, CNMPs would be at a disadvantage in bargaining with the non-Medicaid providers. If forced to pay the same as commercial plans, let alone more, community-based plans would be hard pressed to produce lower premiums. As one CEO suggested, "If we are lower cost, it is not because we are more efficient; it is because we pay less and it is not clear this will last."

Wariness of competition on price

Some CNMP leaders, probably with good reason, are wary of price competition on a level playing field. Servicing higher income populations will likely require larger networks in these communities and less reliance on clinics. Such demands are likely to increase costs. Moreover, with larger numbers and more clout in the marketplace, commercial plans may be better able to drive down provider payments and better equipped to confront growing provider consolidation. In addition, if CNMPs choose to compete aggressively for the subsidized populations, they might need to withstand or absorb losses in months or even years of aggressive price competition.

Moreover, CNMP leaders point out that even the perceived advantage of paying providers less may be a chimera. Larger commercial plans pay no more, and sometimes less, than CNMPs for Medicaid populations, only paying more for commercial market populations. What may make Medicaid plans less expensive is not that they pay less for some providers, but that they rely more, overall, on lower-cost providers. That, in the end, is really their pricing advantage. In an exchange, therefore, their challenge might be to encourage middle-income enrollees to accept a lower-cost network.

Plan leaders seemed to differ on the value of being provider-led and owned. Leaders of provider-owned plans usually expressed

the view that their strong alliance with providers would help them hold down costs. The providers in the plan would, presumably, see the competitive value in lower costs and would work collaboratively to achieve this goal. By contrast, leaders of non-provider led plans tended to see provider leadership as a roadblock or "constraint" in the effort to lower costs. Bargaining power with providers can decline, they asserted, when providers own the plan.

Finally, one somewhat contrarian viewpoint emphasized that many community-based plans may not be "tough enough" for real price competition. Will they drop providers when necessary, especially those who may be tied to the provider institution that owns the plan? In the commercial market place, this CEO argues, it is about price; you need to squeeze and push providers. You cannot be too friendly or too financially connected to them.

Benefits and mission preservation; a potential challenge to lower costs

One cost challenge on which CNMP leaders do not seem to have focused yet, may lie in the concept of a low-cost plan and the means to achieve that status. Exchange consumers are likely to be highly cost conscious, seeking lower cost plans. If they are able to pay providers less, CNMPs may find their costs-per-service to be lower than those of competing commercial plans. But the Medicaid benefit they typically offer is a broad one—platinum or better according to the structure of ACA's benefit design levels. To be attractive to cost conscious exchange consumers, CNMPs may need to offer the lower-cost benefit options—silver and bronze. To do so, CNMPs will almost certainly have to apply substantial copayments and, even more significantly, substantial deductibles. This would create a new billing and accounting challenge, one that may feel awkward for mission-driven plans focused on low-income and vulnerable populations.

Barriers and Liabilities

The potential value of CNMPs competing in exchanges is clear. But the barriers to being able to do so effectively are equally apparent. In seeking to compete in exchanges, many CNMPs would face a variety of challenges including limited experience with the rules and realities of commercial products and marketing; limitations of having low market share; lack of name recognition beyond their low-income and uninsured constituencies; concerns of middle-income consumers that they are a "Medicaid" or "poor person's" plan; and conflicts with their mission.

Challenges of the commercial marketplace

Most CNMPs deal almost exclusively with public programs. Most have limited, if any, experience in offering varieties of benefits packages, copayments, deductibles (including variants of these by income level) and other features of commercial insurance products in today's markets or those products under the ACA. They have functioned in highly regulated, defined-benefit programs. Clearly, the pricing of benefits—which is not an issue in Medicaid because the rates paid to plans are generally set through negotiations with the government—will be a challenge, especially in a multiple product environment. Few of the CNMPs have much experience pricing premiums for individuals or, especially, small groups. Leaders of even the largest of these plans generally acknowledge that they "will need help here. We will have to build or buy it." For larger plans, this may not be too difficult. But for smaller plans, increased costs of "building or buying" new expertise could be considerable. Pricing errors that yield premiums that are too high or too low will each have negative consequences, ranging from limited new enrollment to threats of insolvency. Reflecting this concern, one CEO of an East Coast CNMP reported, "We had a commercial product for awhile. It did not do well. We mispriced it." Commercial plans, of course, may face some of the same challenges in the new marketplace; but they have more experience with new products and more capacity to weather a pricing error.

Interestingly, as one CEO of a large plan suggested, one of the places where CNMPs might find needed expertise is large commercial plans that may choose not to compete in exchanges directly, but might do so indirectly through surrogates. Under this scenario, alliances, even mergers, of CNMPs and commercial insurers may prove intriguing to some.

In most cases, the experience of community-based plans with marketing, enrollment, and eligibility is generally limited to public programs. Depending on the extent to which an exchange assumes some of these functions, that inexperience could be anything from limiting to debilitating. On the one extreme, exchanges may perform considerable enrollment, eligibility, and information-providing functions, thus easing the administrative and competitive burdens of smaller plans to reach and service potential enrollees. Should exchanges, by contrast, choose to require participating plans to perform those functions, CNMPs might face steep learning curves.

Risk selection and market segmentation

Of even more concern to many CNMP leaders is the market segmentation, risk selection, and underwriting advantages of commercial competitors. Certainly the rules of reform in the ACA offer some consolation. Requirements (guaranteed issue) that plans accept all applicants, in and out of the exchange, will reduce the capacity of all plans to avoid enrolling higher risk individuals. The individual mandate will also ease risk-based concerns, keeping all in the pool and bringing in more of the healthy. The offering of subsidies only in the exchange should reduce "gaming," in which plans entice lower risk populations and employers to sign up outside of the exchange. Requirements that some reform provisions apply in and out of the exchanges will

also help. Improvement in risk adjustment methodologies can also be expected, reducing the impact of adverse selection, should it occur. These new rules are substantial barriers to market segmentation practices or, as one spokesperson for CNMPs noted, they provide a foundation of "big bricks."

But sophisticated plan leaders understand that there is virtually no way to control all the potential of experienced commercial competitors to "game the system," avoid higher risks, or segment markets. At least one analyst, while noting the multiple reforms aimed at limiting adverse selection and risk segmentation, pointed out a number of means by which these efforts could still fail.[10] Even the best risk adjustment strategies, as one CEO noted, will prove imperfect, and will always "lag the market." Given the small margins of error within which community-based plans operate, any small loss due to risk-oriented games or mistakes will be costly.

As some suggest, CNMPs might improve their capacity to engage in such activities themselves, or at least learn to protect themselves from the effects of market segmentation efforts of commercial competitors. But this, they emphasize, is not what their mission is about. As one CEO of a large CNMP plan said, "My board gets upset when our medical loss ratio goes too low. Why, they ask, are we not giving out the money for providers or more services to members?"

Such concerns lead many in the CNMP community to think about strong exchanges—as regulators or purchasers—that would use rules or services to keep the competitive playing field as level as possible.

Reputation, finance, and mission

Reputation, image, stigma, and matters of branding also raise concerns. Many CNMP leaders recognize that their reputation as a "Medicaid" or "poor people's" or "safety net" plan will render efforts to appeal to higher income groups in the exchange more daunting. "We are downtown and not in the suburbs," one noted. Overcoming this challenge might require, among other things, broader networks, the inclusion of higher cost hospitals and more specialists in those networks, and more outreach into the suburbs. Such pursuits would be challenges to both cost structure and mission.

Financial matters of capital and reserves also raise concerns. Should participation in the exchange lead to a significant influx of new members, would CNMPs have the reserves to support that expansion? Will CNMPs and their affiliated clinics have adequate access to capital should that be required in a more competitive marketplace? The greater financial strength of commercial competitors is also of concern. Those plans can afford short-term losses while building market share in new markets. They can more easily shift resources from community to community and product to product, and they have more flexibility to exit markets when they prove unprofitable. Community-based plans are community-based; there is nowhere to go and often no product or market that can be abandoned.

Finally, there is the matter of mission itself. As noted above, views of mission may drive community-based plans towards the exchange and the populations it will serve. But some see significant challenge here as well. Efforts to compete for populations at 300-400 percent of poverty might, as noted above, require broader networks and higher costs associated with those networks in higher-income communities, changes in public relations and branding, and other requirements that might undermine a mission to serve more vulnerable populations. As one CEO implied, his plan may want or need to be the health care equivalent of a Walmart; trying to be Macy's at the same time might prove threatening to those who really need Walmart.

Of course, such mission conflict, as one CEO pointed out, will work both ways. Plans that once serviced mostly employer-based populations will find themselves competing in an exchange serving lower-income populations with different service requirements. "They, too, will need to adjust."

What Do CNMPs Want in Exchanges?

Many of the CNMP leaders we spoke with acknowledged that they had not yet given much thought to the structure and rules of the new exchanges, including the central question of whether the exchange should function as a "passive price-taker" on the one extreme, or an "aggressive market restructurer" on the other. Still, after reviewing their assets and liabilities in the new marketplace, most seemed to move logically to a modest level of consensus on what CNMPs would want from an exchange.

Assurance of a level playing field

Reflecting their greatest concerns, most CNMP leaders envision an exchange that will, at minimum, provide their plan with protection against the underwriting and risk-selection challenges of the private insurance marketplace. To this end, most recognize the value to their plans of exchanges that assume responsibility for enrollment and eligibility, that aggressively pursue risk adjustment strategies, and that—with the help of state regulators as required—limit the capacity of brokers or insurers to steer individuals or groups to in or out of the exchange choices. Some even suggest that the exchange or other state regulators may need to provide protection against predatory pricing. Overall, a number of plan leaders view such "leveling the playing field" activities as the most important function of the exchange. However, most of their analysis focused only the principle of a level playing field; few had thought through the specific proposals that exchanges might employ to achieve this goal.

Still, while they may lean towards establishment of an exchange with considerable authority and responsibility, some have concerns. One CEO feared that too many rules to level the playing field might render the exchange too cumbersome. Another suggested it would detract from the real need of plans to learn how to compete. Still another, in California, expressed a specific concern

about the requirement in that state's pending legislation, that exchange plans be accredited. "That's an expensive and time-consuming process," he noted.

Other options and preferences

Some plan leaders also expressed interest in other policy choices that might assist them as new competitors in new markets. Adjustment in solvency standards is of interest to some. Rules or legislation that might improve access to private capital or public funding is another, especially capital for information technology. Also mentioned was some capacity to limit new enrollment lest a large new enrollment undermine capacity to meet a reserve requirement. Rules regarding service areas are another obvious issue for community-based plans, although most have not yet reached this level of focus. To the extent that exchanges require plans to maintain wide—even statewide—service areas, community-based plans would be seriously disadvantaged. Most would be unable to compete under these circumstances, unless they considered such cumbersome strategies as joint ventures with similar plans.

On the critical matter of whether the exchange should allow all licensed plans to compete, select some plans and exclude others, or fall somewhere in between, there is not yet a clear consensus among the plan leaders with whom we spoke. Most common, perhaps, is the view that exchange rules clearly allowing community-based plans to compete may be adequate. Plans might certainly appreciate a legislative directive that they have value and exchanges should seek to include them in exchange competitions. But those who have thought through this issue seem content with an absence of an exclusion provision and support for a level playing field.

Other concerns or interests included a provision that might enable plans based in children's hospitals, which serve only children, to continue that practice. And several plan leaders voiced uneasiness with how the new state high-risk pools required under reform, established in late summer of 2010 and set to expire on January 1, 2014, will be folded into the exchanges. Clearly, any plan—especially a small community-based plan—that received a disproportionate share of high-risk individuals and was not adequately compensated for serving it, would be greatly disadvantaged.

Finally, a few plan leaders expressed interest in the cooperative option adopted in the federal reform. But this attraction seemed to be less about the cooperative as a health plan structure and more about the capacity to seek the $6 billion available to support the establishment of cooperatives. Given that the ACA focuses more on the governance structure of a cooperative and less on how it might deliver care, one California analyst has suggested that community-based plans might look into the option of forming a cooperative—individually or collectively—and then have the cooperative contract out much of the insurance and care delivery functions to community-based plans.

Matters of Public Policy

A full discussion of policy implications and options is beyond our scope here. But there can be little question that whether focused on the narrow question of CNMPs competing in exchanges or the broader issues inherent in the exchange construct, the policy challenges are complex, potentially significant, and unavoidable.

Value and challenge

Judged simply on the criteria of potential value, there is much to be said for the participation of CNMPs in exchanges. The potential benefits include continuity of care, a proven capacity to address the needs of vulnerable and low-income populations, and the potential to lower costs and increase choice. Indeed, it is hard to imagine a reasonable basis for the exclusion of these plans.[11] The more critical question for states will be what policy steps, if any, should be taken to encourage or facilitate that participation? The range of options is wide, including issues of risk adjustment, solvency, service areas, benefit structures, rules relating to sales in and out of the exchange, and even efforts to create or incentivize the creation of community-based plans where they do not now exist. In lobbying efforts, most community-based plans will want a level playing field in most respects; but they may want or need some exceptions in other respects.

Challenges to the participation of CNMPs plans may be as formidable as the case for their participation is strong. Operational, financial, marketing, risk selection, benefits and even mission-based challenges loom large. Given the compelling potential value of community-based plan participation and the potential challenges to their doing so, opportunity and uncertainty abound, for plans, states and the health care system. The combination of opportunity and challenge is likely to shine a bright light on public policy options.

In establishing exchanges, or even in deciding not to do so, states can be expected to weigh the pros and cons of various trade-offs. At one end of the continuum, some states will likely take multiple steps to enable, even encourage, the participation of community-based plans. At the other end, some states may render that participation difficult and unlikely. Between those two extremes lay multiple public policy landing places. But, in either case, the making of these policy decisions will be unavoidable.

Strategic choices for CNMPs

Beyond the matter of community-based plans, it is striking that the fundamental policy questions surrounding the exchanges are not much different than they were in the early 1990's when the Clinton administration's plan adopted the concept. Issues of who governs the exchange, who is in and who is out, whether it is a price-taker or an aggressive purchaser, and how far the exchange

should go in leveling the playing field have not changed much in 15 years. One difference today is the extent to which national reform left exchange-related decisions to the states. There is no one answer or solution to these questions. Here, almost certainly, American federalism will work its varied will.

Overall, CNMPs face hard choices. Exchanges may provide them a real opportunity to compete, better serve a somewhat broader but still familiar constituency, and grow. But many are also likely to confront legitimate questions about mission and capacity to compete in a very different market. There may be many policies in place to reduce levels of risk and uncertainty but some level of uncertainty seems inevitable, and adjustments will take time.

Many CNMPs can be expected to enter exchanges and compete aggressively. Others may view the risks as too great or their capacity to appeal to consumers beyond their Medicaid base as too limited. Those plans may choose not to enter the exchange. One strategic compromise for CNMPs might be to participate in exchanges, but—in terms of appeals for members and competitive positioning—stick close to the populations they currently serve and other low-income populations. If that type of plan appeals to higher-income individuals accessing care through the exchange, fine. If not, the plan might still experience growth via additional members in Medicaid and perhaps other public programs while avoiding many of the risks and uncertainties of changing their current business plan to appeal to and compete for higher-income populations.

The numbers, rough as they may be, offer some guidance to CNMPs. Beginning in 2013, it is expected that by 2019 Medicaid expansion will increase the number of beneficiaries by between 15.9 and 22.8 million, according to one recent analysis.[12] Assuming the distribution of these new members into managed care organizations is similar to current circumstances, CNMPs may gain at least 4 million to as many as 6–8 million members, especially if more of the disabled Medicaid population is moved into managed care. Such an increase would represent a near doubling of membership for the CNMPs.

By contrast, the Congressional Budget Office estimates that about 24 million Americans will access their care through exchanges.[13] The exchange pool, clearly, is much larger than the Medicaid expansion

Key Provisions in California's Exchange Legislation

The California legislation that created an exchange, signed by the Governor Arnold Schwarzenegger on September 30, 2010, leaves the selection of competing plans to the governing body of the exchange. The legislation clearly indicates that the state's Medi-Cal plans are eligible to compete in exchanges. But as the exchange board can select participating plans (including limiting the numbers of plans), no plan—Medi-Cal or others—are guaranteed participation.

The legislation does, however, contain a provision allowing the exchange board to work with the regulators of CHIP (Healthy Families Program in California) and Medi-Cal to achieve the goal of continuity of care as individuals move in and out of public plans. Specifically, the legislation empowers the exchange to provide individuals "the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange."[16]

The legislation also grants the exchange the right to coordinate with state and local government agencies overseeing public programs to ensure eligibility for and enrollment in public programs and the exchange as individuals transition between the two.[17] In all likelihood, one of the easiest means of achieving these goals is to facilitate the participation of Medi-Cal plans in the exchange.

One legislative provision might prove problematic for Medicaid-oriented plans. All plans participating in an exchange are required to offer at least one product in each of the levels of coverage outlined in the ACA. This provision certainly has value in terms of minimizing risk selection gaming. It may protect Medicaid plans accustomed to offering generous benefit packages from other plans that might choose to seek healthier enrollees by offering more modest benefit plans. However, as noted earlier in this report, it may prove difficult for CNMPs and other Medicaid-oriented plans to offer multiple products featuring alternative benefits.

According to several staff individuals involved in the California legislation, the most controversial issue before policymakers was that of selective contracting: should the exchange accept all plans that meet the criteria for participation; or, should it have the power to limit (select) the number of participating plans? This should come as no surprise to anyone familiar with the history of exchange-type purchasing agencies. Since first proposed by Alain Enthoven and others over 30 years ago,[18] the question of limiting participation or accepting all competitors has been contentious, with those more partial to market-oriented approaches favoring the take-all-comers approach and those more open to stronger regulatory approaches favoring the selection option.

California policymakers, rejecting the objections of some insurers, chose to allow the exchange to select competing plans. But whatever the merits of that choice, it is likely that this issue will also be controversial in other states.

pool. But for CNMPs, the competition for individuals in the exchange could be much stiffer, much less familiar, and much riskier. Under these circumstances, a cautious strategy of continuing a focus on Medicaid and other public programs while, if allowed under exchange rules, beginning to offer options to the individual and small employer populations in the exchange may prove attractive.

Long term, an additional question may face CNMP leaders and states. As opportunities to enroll larger numbers of individuals by opening the exchange to employers with over 100 employees—beginning in 2017—then policy objectives of CNMPs might clash.[14] Many CNMPs may wish to see growth in the numbers of individuals served by exchanges. But the right of many larger employers to be in or out of the exchange will greatly increase the overall risks of adverse selection and risk segmentation. Ideologically, we might expect many CNMPs to favor a larger purchasing pool; risk-wise, they may need to be wary.

Administrative capacity and related matters

Whichever direction states lean, establishing and implementing an exchange system may be a difficult, "devil in the details" task. Most reports from Massachusetts suggest this to have been the case, whatever one's view of the success or lack thereof in that experience. Policymakers in California, which in October became the first state to approve ACA-required exchange legislation,[15] have had somewhat similar experiences. (See box for summary of California exchange legislation.) Challenges facing California have been eased somewhat by its experience in the legislature's 2007–2008 reform effort in which exchanges were to have played a major role. That effort provided an already highly experienced and skilled legislative staff additional exposure to exchange-related issues. Even the political challenges were rendered less difficult in 2010 for the majority Democrats because Republicans decided to abstain from participation, perhaps hoping that reform overall will be repealed or that the ultimate blame for the presumed failure of reform will fall squarely on the Democrats. Still, key legislative staffers found some of the policy trade-offs complex, and willingly admit that California's legislation leaves other difficult issues to the exchange itself, as was the case in Massachusetts.

Thus, the matter of reform capacity may extend beyond community-based plans to the states themselves, a point emphasized by more than a few plan leaders. Most of those we spoke with report that their states have done little to date, at least legislatively, and some express concerns about the capacity to do so, especially when the political dimension is added to the equation. Some plan representatives noted concerns that state policymakers opposed to reform might have little interest in establishing effective exchanges and might have more interest in the overall failure of reform. In what may be a foreshadowing of such politics, several CNMP leaders noted that electoral politics were already playing a role in exchange discussions, with discussions relating to exchanges hinging on perceptions of who might be governor in 2011. Additionally, it should be acknowledged, as Timothy Stoltzfus Jost has summarized, that "while a few state-level exchanges have been quite successful, many others have failed."[19] Without question, the exchange policies outlined in the ACA indicate that federal policymakers learned much from those failures and have attempted to address them. But, as Yost concludes, "Congress has built its reform of private health insurance markets largely on what has to date been an experiment with decidedly mixed results."[20]

The fact that exchanges need to be up and running by 2014 and, therefore, in place and near operational capacity in 2013, means that legislation to establish them will, almost certainly, need to be approved in 2011-12 legislative sessions. This may prove a tight timetable for many states.

On the other hand, concerns that states lack the capacity or will to implement exchanges may be overstated. Reports from those engaged in state health association activities indicate that in many states discussions involving policymakers and stakeholders around exchange issues are, in fact, taking place in earnest, even if not yet around legislative vehicles. Moreover, the ACA provides for substantial funding to support state exchange activities, and multiple foundations, associations and government agencies are holding discussions on how best to provide additional support, training, and expertise for state efforts. And, as one state policy analyst noted, many states already have some experience in exchange-type arrangements, through their public employee health benefits programs, high-risk pools, or Medicaid.

More importantly, 48 states and the District of Columbia applied for and received the federal government financial support for exchange development offered in the ACA. Whatever their reservations were, virtually all the states, even those with Republican governors or Republican-dominated legislatures have made at least a small indication that they are ready to move ahead with consideration of exchange development. The federal government may also be expected to help (especially given its interest in success) by crafting regulations on such matters as Medicaid enrollment and eligibility, certification of health plans, risk adjustment, etc., all of which might ease organizational or regulatory burdens on the states. Finally, the fact that the federal government will itself need to be ready to assume exchange activity in 2014 suggests that it will have to work through multiple exchange issues. As one state policy leader concluded, "The states won't be alone on this; it won't be Massachusetts."

The combination of opportunity and challenge suggests the need for a heavy investment in policy assistance to the states over the next two years. Intensive training in "Exchange 101"—focused on workable options—should be a "must" for key state policymakers. And reform supporters and policymakers—especially governors—need to recognize that how the seemingly dreary task of implementation is performed may be critical to success of the overall goals.

About the Author

Walter Zelman, Ph.D., is chair of the Department of Health Science at California State University, Los Angeles. In addition to his present and past academic roles, he has served as a public interest lobbyist, a candidate for public office, a special assistant to a California insurance commissioner, a Clinton White House health care advisor, and a president of a California state health care trade association. He has published numerous articles on health care and California politics and two books on health care market change and health policy.

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Endnotes

1 Included in this definition are plans that are both Medicaid-focused and community based. Not included are commercial plans that focus on Medicaid and commercial plans that serve some Medicaid beneficiaries while focusing on other populations.

2 Those interested in more detailed discussions of exchange issues might review Jost, T. S. "*Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues*." The Commonwealth Fund, December 2009, and Dorn, S., *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*. State Coverage Initiatives, July 2010.

3 Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Managed Care: Key Data, Trends, and Issues," February 2010. A September 2010 Kaiser Commission report indicates an increase in overall Medicaid enrollment of about 10 percent by December 2009. "Medicaid Enrollment: December 2009 Data Snapshot," September 2010.

4 The estimates provided here are a bit imprecise given that enrollee numbers for some these many plans include CHIP recipients and dual eligibles. ACAP supplied information citing Centers for Medicare & Medicaid Services data. ACAP and Kaiser Commission on Medicaid Facts, September, 2010.

5 These plans are sometimes referred to as safety net plans. However, that title may be inappropriate as many draw on a wider array of providers.

6 Information supplied by ACAP representatives and taken from ACAP Web site, www.communityplans.net.

7 This trade off will be explored in more detail later in the paper.

8 ACAP representatives emphasize that this data has significant limitations. It does not include all ACAP plans and is based on averages. It has not been published or peer-reviewed.

9 It will be interesting to see the impact of the ACA's requirement that all plans in the exchange contract with Federally Qualified Health Centers. Conceivably, as commercial plans develop relationships with clinics, a competitive advantage of the CNMPs could be reduced.

10 Jost, T. S. "Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues." The Commonwealth Fund, December 2009.

11 In California, Anthem Blue Cross argued that because Congress had rejected a public plan, California's public Medicaid plans should be barred from competing in the exchange. Undated Anthem Blue Cross letter on SB 900, submitted to State Senate Health Committee, Sacramento, California. The California Hospital Association expressed concerns that some of the Medicaid plans might gain excessive market leverage. In an interview with State Senate Health Committee staff member, October 7, 2010, Sacramento, CA, an insurer trade association argued that Medicaid plans should not be allowed to "use surplus revenues from those programs to capitalize participation in the Exchange." Undated statement of principles issued by the Association of California Health and Life Insurance Companies, Sacramento, CA. None of these arguments appear to have had much influence on legislators supporting the exchange legislation.

12 Holahan, J. And I. Headen. "Medicaid Coverage and Spending in Health Reform," Urban Institute, May 2010.

13 Dorn, S. *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*. State Coverage Initiatives, July 2010.

14 Under the ACA, states may decide to limit access to the exchange to firms with 50 or fewer full-time employees. In 2016, firms of up to 100 full-time employees may have access to the exchange. In 2017, exchanges states may decide to allow larger firms access to the exchange. Taken from Dorn, Ibid., p. 7.

15 This legislation was approved on strict party lines, with Democrats supporting and Republicans opposing. Governor Arnold Schwarzenegger signed the legislation.

16 Assembly Bill 1602 (Perez), Section 8, 2009-2010 California state legislative session.

17 Ibid., Section 7

18 See, for example, A.C. Enthoven, "Consumer Choice Health Plan: A National Health Insurance Proposal Based on Regulated Competition in the Private Sector," *The New England Journal of Medicine* (23 and 30 March 1978): 650-658 and 709-720.

19 Jost, op cit., p. 2

20 Ibid.