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Chapter 5: Laying the Foundation for State-Based Exchanges

Health insurance exchanges (exchanges) were a huge topic of conversation in states in 2010. The Patient Protection and Affordable Care Act (ACA) requires the development of an entity—called an exchange—that would integrate many elements of health reform. The exchanges will be the public face of health reform, offering a new marketplace for health insurance and health information. They will also be charged with developing the seamless integration of multiple programs and data sources in order to determine who is eligible for which programs and subsidies and to help them enroll. The ACA gives each state the option to develop, implement, and run their own exchange; if a state chooses not to do so, the federal government will run one for that state.

As states begin to discuss how they might set up an exchange, a range of issues arise. These include adverse selection, cost containment, quality of care, transparency in the price and quality of health care services, the ongoing role of brokers and agents, and the playing field on which insurance plans will compete for business. The list quickly becomes long and overwhelming. While opinions vary on how much an exchange can and should accomplish, it is certain that states have many important policy and operational decisions ahead of them. State policymakers will not only need to decide *what* the exchange should achieve, but also *how* the goals can be achieved.

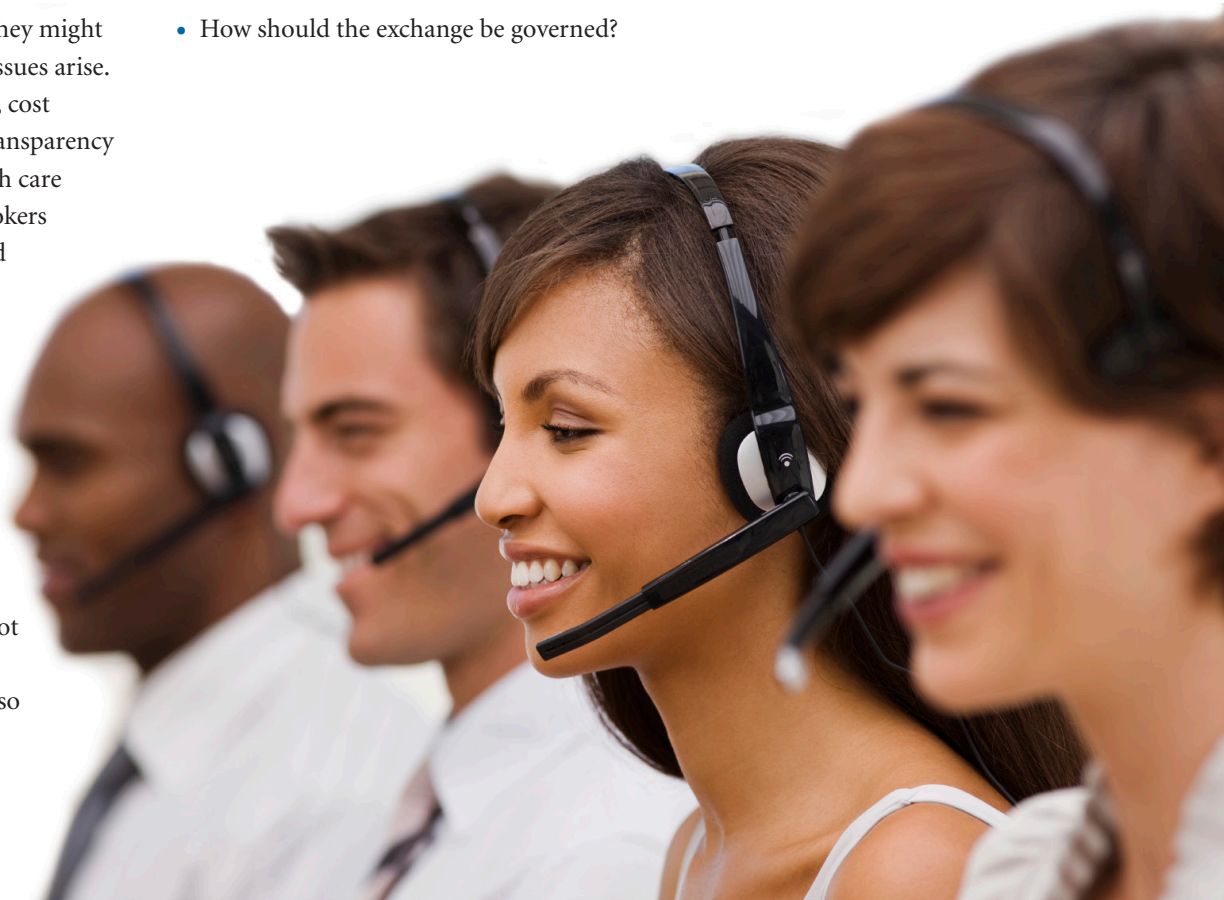
There are many excellent resources on policy issues related to exchanges. State Coverage Initiatives has set up an exchange website[1] that compiles our issue briefs and webinars, as well as reports, studies, and other working documents from states, research institutions, and from the federal government. Several other reputable organizations have done the same. This report does not go in-depth on every issue related to exchanges. It summarizes the exchange-related work of states in 2010, offers in-depth information about the two existing state-run exchanges in Massachusetts and Utah, and addresses some of the first-order policy choices states need to make including:

- Whether or not to have a state-based exchange?
- How should the exchange be governed?
- What types of data do states need to gather as they seek to make policy choices that will work in their health care markets?

Finally, this report offers a list of tactics (or lessons learned) for states as they move forward with exchange planning and implementation.

STATE WORK ON EXCHANGES IN 2010

The general work of states on exchanges was driven in part by the federal funding opportunities and requirements. On July 29, 2010, the Department of Health and Human Services (HHS) issued a Funding Opportunity Announcement (FOA) that



Timeline for Exchange Implementation in 2010

March 23:	The ACA is signed into law by President Obama.
July 29:	HHS issues a Funding Opportunity Announcement (FOA) that made $1 million available to every state for Exchange Planning and Establishment Grants.
September 1:	Exchange Planning and Establishment Grants applications due.
September 30:	HHS announces that $49 million was made available to 48 states and the District of Columbia for exchange planning.
September 30:	California becomes the first state in the nation (after the passage of the ACA) to enact exchange authorizing legislation.
October 4:	The deadline for comments on the proposed guidance for exchanges due to HHS.
October 29:	HHS announces a competitive grant program for "innovator states."
November 8:	HHS issues initial guidance on the IT expectations for exchanges.
November 8:	HHS announces that a 90 percent match will be available (once the rule becomes final) to develop new eligibility and enrollment systems and a 75 percent match for system improvements.
December 22:	Innovator grant applications due.

made $1 million available to every state (the funding was non-competitive) for Exchange Planning and Establishment Grants. The grant proposals were due September 1 and funding was announced on September 30; HHS announced that $49 million was made available to 48 states and the District of Columbia.[2] While a number of states had already begun discussions, once the grants were awarded to states, they began their planning efforts in earnest. Many states spent the fall developing requests for proposals (RFPs) for consultants and other experts to help them with their data collection and planning efforts.

States also spent time and resources preparing responses to the federal government in order to meet an October 4 deadline for comments on the proposed guidance for exchanges.

On October 29, HHS announced a competitive grant program for "innovator states." The funds are designed to help leading states make quick advancements in information technology that can then be shared with the rest of the states. On November 8, the Centers for Medicare & Medicaid Services (CMS) announced a notice in the Federal Register that proposes an increase in federal matching funds to states for designing and developing new information technology (IT) systems needed to support Medicaid eligibility systems that will interface with state insurance exchanges.[3] Once the rule becomes final, CMS will pay 90 percent of those costs rather than the previous 50 percent. In addition, they will pay 75 percent of costs for maintenance and operations of existing systems. In order to obtain these higher matching rates, the new IT systems will need to meet certain standards.

Many states also are preparing for the 2011 legislative session, hoping to get authorizing legislation passed to establish an exchange and set up a governance structure.

According to HHS, the state exchange planning grant applications requested funding for the following broad areas:

- Assessing current IT systems and infrastructure and determining new requirements;
- Developing partnerships with relevant stakeholders to gain public input into the exchange planning process;
- Planning for consumer call centers to answer reform-related questions from their residents;
- Determining what state statutory and administrative changes are needed, including changes that may be necessary to set up the governance structure, facilitate health plan contracting, consumer outreach, etc;
- Hiring key staff and determining ongoing staffing needs;
- Planning the coordination of eligibility and enrollment systems across Medicaid, CHIP, and the exchanges; and
- Developing performance metrics, milestones, and an ongoing evaluation process.[4]

In addition to performing the functions above, many states have already begun to collect the data they will need to inform decision-making. (**See the box titled "Data States Will Need for Exchange Decision-Making"** for more detail about the types of information states will need.)

The fact that the vast majority of states applied for the exchange planning grant funds can be taken as a positive sign of interest from the states. However, applying for the initial grant does not guarantee that states will ultimately choose to host an exchange (rather than letting the federal

Data States Will Need for Exchange Decision-Making

States will make many important decisions about the future of their health insurance markets over the next few years. They will need good data to make informed decisions. Some states will choose to collect and analyze those data on their own, while others will contract with consultants for the needed analytical work. Most states will combine these two strategies. Even when states work with outside firms, they will need to have clear sense of their own goals and the policy choices they need data to inform.

First, states will need to collect economic and demographic data—including information about the income distribution within their state and how individuals are currently getting health coverage. The ACA will cause people to move between coverage types and into the new subsidy programs; states will need to be able to predict this with some accuracy. They may also be interested in particular populations, like those who live in rural areas, minority groups, at-risk populations, and others.

Second, states will need to gain actuarial knowledge about their market. What benefits do current insurance products being sold in the state actually cover and what are typical cost-sharing arrangements? Are the uninsured in the state likely to be younger and healthier or older and sicker? What impact will any new rules likely have on premiums? Actuarial information will help state policymakers plan for premium changes and to guard against adverse selection in their exchange design.

Third, states will need to collect financial information so they can begin to develop a budget for the exchange. While a state has many options for funding their exchange, the model used in Massachusetts is a premium surcharge, which means that the revenue of the exchange is driven by the number of people enrolled in the exchange. As more people enroll, the funding that comes into the exchange will increase and there will be more people over which the expenses of an exchange can be spread. Some of the tasks of the exchange required under the ACA include:

- Providing for a toll-free telephone hotline;
- Developing a system for eligibility determination, verification, and enrollment;
- Certifying, recertifying, and decertifying health plans as qualified health plans (QHPs);
- Establishing a tier system for plans (based on actuarial value as required by the ACA) and any other rating mechanisms;
- Maintaining an internet website through which enrollees and prospective enrollees of QHPs may obtain standardized comparative information on those plans; and
- Making available an electronic calculator to determine the cost of health coverage after the application of any premium tax credit and cost-sharing reductions.

The goals, revenue, and expenses of an exchange are all inter-related. Finding the right balance will be especially important for states after 2015 when they will be responsible for funding the ongoing operations of the exchange. Ambitious goals will likely mean that the exchange has more expenses. Scaling back the goals could reduce the expense, but it may also reduce enrollment levels or customer satisfaction which could negatively impact revenue.

Finally, states will want to gain a sense of the impact of the ACA on their budgets. States will need to do an accounting of current state programs to see if any of them overlap with the federal legislation. Some states programs may be duplicative and funding could be re-programmed to supplement federal funds. In some cases, states may want to look at the resources that are currently allocated to covering uncompensated care and care for those without insurance. Some of that funding also could be re-allocated. Of course, states will also be asking questions about potential cost savings outside of the context of exchanges, as the budgets in all states are extremely tight. [5]

For more information on the data issues facing states, see "Health Insurance Exchanges: How Economic and Financial Modeling Can Support State Implementation," published by State Coverage Initiatives.[6]

government do it). The two states that did not apply for funding were Minnesota and Alaska. Each cited their opposition to the federal legislation as the reason they did not apply for the funding.

SOME STATES AHEAD OF THE CURVE

While the work of the majority of states was driven by the federal deadlines and availability of funding, a few states were ahead of the curve in their exchange planning. For the most part, states that acted quickly: 1) had governors who generally supported the ACA; and 2) had done some previous work related to exchanges (or at least related to reform of the small group market).

Wisconsin. Wisconsin Governor Jim Doyle was a vocal proponent of health reform during the federal debate. In Wisconsin, he had already done considerable work to reduce uninsurance by expanding and simplifying coverage for children and families and offering new coverage options to childless adults. As a next phase of reform, the Doyle administration was considering options to improve the individual and small group insurance markets in the state. They hired a consultant to model options for a Wisconsin-based exchange. Ultimately, they did not pursue those reforms because Wisconsin did not have the resources for the level of subsidies that were eventually included in the federal reform.

Nevertheless, the prior effort in Wisconsin laid the groundwork for quick consideration of exchanges in a few important ways. First, there was already a growing consensus among officials in state government that the current insurance market was broken and needed serious overhaul. They had already identified many of the problems and possible solutions that could be applied to their market. Second, during previous coverage expansions, Wisconsin had begun to innovate by simplifying and improving their public program eligibility determination and enrollment structure. Their approach has been a model for other states around the country.[7] They are likely to build on that technology infrastructure to establish the web portal and back-end functionality of an exchange. Finally, Wisconsin has been experimenting with reforms throughout their health care system that could ultimately inform the work of the exchange. These include value-based purchasing strategies in their Medicaid program, a public-private

all-payer claims database that has goals for increasing transparency and quality reporting, and other cost-containment initiatives spurred by the recession in the state.

Building on that foundation, state officials in Wisconsin developed a white paper that outlines the main issues and policy questions Wisconsin will face.[8] It lays out recommendations for a governance and funding structure. It offers suggestions for how to make enrollment simple for consumers. It talks about how the state will work with the other groups in the Wisconsin Health Information Organization (WHIO) to improve payment and purchasing strategies.

Governor Doyle did not seek re-election and Scott Walker was elected governor in November. On November 10, 2010, Governor-elect Walker wrote a letter to the secretary of the Wisconsin Department of Administration that stated, "As you are no doubt aware, I have pledged that one of my first acts as governor will be to authorize the attorney general to join other states in suing the federal government to opt-out of the new federal health care law. Even as the lawsuit is considered by our judicial system, it is clear that the federal law will affect Wisconsin's management of our Medical Assistance programs. I ask that the Doyle administration temporarily freeze any new implementation of the federal health care law, including the establishment of exchanges, until after January 3."[9] Based on this statement and others by the governor-elect, it is likely that Wisconsin will change course in respect to its plans to implement an exchange.

The example of Wisconsin brings to light a challenge that many states face. There were 37 governor's races around the country in 2010. As a result, state officials did not know if their planning was laying the groundwork for future reform efforts or if it would be rejected by the incoming administration. Some state officials sought to preserve their efforts by broadening the conversation to include those who will outlast the administration—the public and other stakeholders. Other states delayed investing significant time in planning, preferring to leave the heavy lifting to the new administration. Still others spent their time gathering information and setting up a decision-making process while delaying major decisions until the political situation became clearer.

West Virginia. West Virginia is another example of a state with a head start on thinking about an exchange. They planned to set up an exchange prior to the passage of the ACA and received funding from the Health Resources and Services Administration under the State Health Access Program (SHAP) for that purpose. Using that funding (which is a five-year grant that started in 2009), West Virginia hopes to have an exchange functioning well before the federal deadline of 2014. West Virginia will issue requests for proposals and sign contracts through fall 2010 and spring 2011 to accomplish the following tasks:

- Conduct an insurance market survey;
- Craft an economic and actuarial assessment model;
- Create a planning and assessment model;
- Develop a business plan;
- Build an education and outreach plan;
- Assess their technology needs and develop a strategy for solving technical problems; and
- Facilitate all of the work listed above.

The planned West Virginia exchange will determine whether individuals are eligible for any state or federal assistance programs, and will enable individuals to comparison shop among available private insurance plans. The planning and stakeholder engagement process could also identify other objectives for the exchange.[10]

West Virginia has set up a process for gathering stakeholder input to help inform the structure of the West Virginia exchange. On November 15, the state issued a request for public comment that calls for that input. In addition, they have planned public meetings throughout the state from November 2010 through January 2011. The purpose of these meetings is to

> "inform the public about what is in the Affordable Care Act (ACA) concerning the exchange; educate the public about what the OIC [Office of the Insurance Commissioner] has accomplished to date on exchange planning; outline critical areas where stakeholder input is needed; receive stakeholder input and gather public ideas on the exchange; and, from the information gathered in these meetings and prior, develop community of interest policy groups to further develop exchange plans."[11]

While the planning work of state officials in West Virginia is ongoing as of the close of 2010, that state is also facing a change in leadership. West Virginia Governor Joe Manchin III launched an ultimately successful bid for the state's U.S. Senate seat in the middle of his second term as governor. As a result, the President of the West Virginia State Senate, Earl Ray Tomblin, a Democrat like Manchin, will become governor. Another election for governor will be held in 2011.

PLANNING FOR EXCHANGE AUTHORIZATION LEGISLATION

States have begun to consider whether they should seek legislation during the upcoming 2011 legislative session to authorize and establish an exchange. Many states will seek to pass basic legislation that sets up a governance structure (as California has already – see below) to handle incoming data (likely generated with planning grant funds), make recommendations and decisions based on that information, and ensure all of the

major functions of the exchange are carried out. That legislation would not decide major policy and operational questions; rather, it would determine who will be responsible for these decisions, whether that is a board, a nonprofit, or an existing agency or cabinet official.

Some states are making a political calculation as to whether 2011 is the right year to bring exchange legislation before their legislature. States are only just starting to spend their planning grant funds and much of the data that they expect to collect will not become available for several months. If the legislature is skeptical about the ACA and hesitant to implement an exchange, there may be more wisdom in waiting until 2012 when new governors and legislators have had more time to review pertinent state-based data that will be generated and consider all of the relevant issues.

Whether or not states elect to enact legislation in 2011, they do need to be aware that doing very little through the course of 2011 is a risky strategy, given the number of tasks that must be accomplished before January 1, 2013, when the federal government will certify whether or not a state will be ready to implement an exchange in 2014. For a full report on a suggested timeline for exchange implementation, see the SCI publication, *Health Benefit Exchanges: An Implementation Timeline for State Policymakers*.[12]

California Becomes First State in the Country to Authorize an Exchange Post-ACA

On September 30, 2010, California became the first state in the country to enact authorizing legislation for an exchange after the passage of the ACA. Like the other leading states, California had already spent significant time considering the possible role of an exchange in that state. In the case of California, this option was extensively discussed during their 2007-08 comprehensive health care reform debate.[13]

Table 1: **Should a State Run Its Own Exchange?**[14]

Pros	Cons
Allows a state to maximize its own goals.	Requires the allocation of staff resources and expertise.
Makes it easier to coordinate with state agencies.	Could carry more risk at the state level, both financially and politically.
Maintains maximum state regulatory authority over the market.	A federal exchange would allow for a consistent approach across states (or across those that do not host their own exchange).
More responsive to state stakeholders and the public; better positioned to engage in a dialogue with key state-based groups.	For small states, there might be questions related to economies of scale—will the exchange have enough people to justify the expenses of setting it up?
Better positioned to address adverse selection because policies inside and outside of the exchange can be aligned.	Susceptible to political changes at state level.
Better positioned to quickly modify the exchange based on changes in the state's market.	
Better positioned to build on a state's existing core competencies.	
Prevents the exchange from being susceptible to political changes at federal level.	
More control over how brokers and agents are treated under the exchange.	
A national definition of "qualified health plans" with no state-level modifications may not serve the needs or interests of local plans.	
Better positioned to understand the demographic and geographic issues that should inform network adequacy standards.	

The California legislation—Senate Bill 900 and Assembly Bill 1602—was designed to authorize the state to enforce the insurance market reform provisions of the ACA and to establish a health insurance exchange. The legislation stipulates that the exchange is to be governed by an independent, five-member board. This board will be charged with making a majority of the operational decisions for the exchange. Two of the members were appointed by the governor (in the case of this legislation, Governor Schwarzenegger had two days to make appointments between the enactment of the law and his final day in office) and another member will be the secretary of health and human services appointed by the incoming governor. The remaining two members will be appointed by the legislature, specifically the Senate Rules Committee and the assembly speaker, who will each get to appoint one member. The new law gives the board latitude to determine participation requirements, premium schedules, rates paid to plans, and cost-sharing provisions for qualified health plans.

Due to previous experience in California with adverse selection in an exchange (then called a purchasing pool), state officials were particularly concerned with setting up safeguards against that possibility. For that

Table 2: **Governance Models for State-based Exchanges**

Existing State Agency	
Strengths	Weaknesses
Builds off existing infrastructure thus curbing infrastructure costs.	Civil service and procurement rules could pose challenges (this could be addressed with legislation to exclude the exchange from certain rules).
Most accountable model to state policymakers and the public.	A risk of conflict of interest could arise, particularly for the insurance department which is charged with regulating all insurance.
Better positioned to work with constituent state agencies.	More susceptible to changes in political environment.
Better positioned to carry out public policies of governor's office.	The work of the exchange could get lost in the priorities of an existing agency.
Better positioned to work with federal regulatory agencies.	Diverse representation of a board could bring in multiple perspectives; this could be lost in an agency unless an advisory or governing board was also appointed.
Eliminates duplication of health insurance regulatory functions (if placed within the state insurance department).	Could carry stigma as a governmental agency.
Better positioned to mitigate risk of adverse selection, which is the number one threat to exchange success, because policies could be more easily aligned with insurance market regulations.	
Independent Quasi-Governmental Agency	
Strengths	Weaknesses
Most flexibility with hiring and procurement.	Less accountable to state policymakers/public.
Better positioned to insulate exchange from political environment.	Would have to create completely new infrastructure and cover resulting costs. (Note: this could be mitigated if the agency contracted with existing public and private entities for core exchange functions).
Less impacted by arguments of conflict of interest in facilitating purchase of coverage and regulating market.	Potential for duplicative regulatory functions for licensure, certification, market conduct, and enforcement.
This is an entirely new organization which could create its own culture and hire staff suited for achieving its goals.	Not as well-positioned to work with the essential state agencies (Note: this could be somewhat mitigated if existing state agency heads serve on the governing board).
Carries less of the stigma of being a government agency.	Because the exchange will be governed by an entity that is not accountable to the governor, it will be more difficult to align policies between the exchange and the larger insurance market, possibly leading to problems with adverse selection either into or out of the exchange.
A diverse board could ensure that multiple perspectives and areas of expertise are represented.	Does not have an existing structure for working with federal agencies.

Source: These strengths and weaknesses are taken from the lists compiled by West Virginia,[15] Maine,[16] Tennessee and other states.

reason, the legislation also requires all plans that offer coverage inside the exchange to offer a product at all five benefit levels. In addition, whatever products a plan sells inside the exchange must also be sold outside the exchange.[17]

NAIC Model Legislation

In order to help states develop authorizing legislation, a group of state health insurance commissioners drafted model exchange legislation under the auspices of the National Association of Insurance Commissioners (NAIC); it is available on their website.[18] The ACA charged the NAIC with helping the secretary of HHS develop regulations related to exchanges.

SHOULD A STATE RUN ITS OWN EXCHANGE?

Many states will quickly and easily decide to operate their own exchange. For others, the question of whether or not the state should take on this role could be a difficult one. States with small populations may wonder if the fixed costs of setting up an exchange can be recouped if only a limited number of people ultimately use it. Other states may be skeptical about the potential value of an exchange and prefer to let the federal government take the lead. Others may be stymied by limited staff capacity and expertise in this area.

One challenge for states that are debating whether or not they should attempt to operate an exchange is that they may need to make this decision in the absence of full information. It is currently not known, for example, how exactly the federal fall-back option would operate. States do not know how the federal government would fund the ongoing operation of a federally-led exchange. In addition, states have been given planning grant funds to collect data on their insurance market, expected demand for the services of the exchange, and other issues that could inform the decision of

whether it is feasible for a state to operate its own exchange. States that do not make that decision early risk falling behind in the planning process, but some may feel they do not yet have enough information to help them make the appropriate choice for them.

Table 1 lays out some issues related to whether a state should run its own exchange.

Whether a state's leaders support federal reform or not, it is clear that they will have more influence over the final impact of the ACA if they engage and seek to put their own unique stamp on reform. Strong coordination between those regulating the markets inside and outside the exchange needs to occur – most commentators have strongly recommended that states apply exactly the same rules in both markets – and this can be best accomplished when both markets are run at the state level.

GOVERNANCE AND ADMINISTRATION

For states that elect to establish an exchange, the next major question they face is how should it be governed? Three major options are available to states: 1) an independent, quasi-public board; 2) a state agency; or 3) a nonprofit. If a state agency is charged with governing the exchange, they could utilize an advisory board or a governing board. Multiple options for which state agency should get the job of governance also exist; options include: 1) the state health department or Medicaid agency; 2) the insurance department; 3) an overarching purchasing agency (in states where that exists); 4) the agency responsible for the state employees health plan; or 5) other options including a state budget agency or governor's office.

Related to governance is the question of how the exchange will be administered. For example, it is feasible that an exchange could be governed by an independent board, but that they would contract with the state Medicaid agency for the eligibility and enrollment functions. Likewise, a board could use the purchasing expertise of the state employees health plan staff to execute and monitor contracts with private plans. If the state elects to utilize a state agency to govern the exchange, they could adopt special hiring and procurement rules so that the public entity could operate in a manner more akin to a private entity or independent agency.

All states will be assessing their current capacity, including the strengths and weaknesses of existing agencies and the services that are available in the private market. A key to keeping costs low is to avoid duplicating existing expertise and functional tasks and to leverage aspects of the private market that are working well.

Many states—including Maine, Maryland, West Virginia, Wisconsin, and others—have already drafted "strengths and weaknesses" lists for various governance models. Table 2 shows some of the key considerations related to two of the most common governance models being proposed. The option of having a completely independent nonprofit entity run the exchange has not gained major traction with states. Most states want the exchange to have some public accountability that can be gained through public appointments or ex officio appointments to the governing board of key state officials. In addition, nonprofit governance raises several tax issues that states may be hesitant to tackle.[20]

Exchange Board Composition

For states that elect to use advisory and governing boards, the composition of those groups will be critical. States should consider several factors:

- **Size**. A governing board that goes above seven to nine people will quickly become unwieldy. In fact, California only appointed five members to their board. At the same time, states may want to make sure various types of expertise are represented, which could lead to pressure for a larger board.
- **State agency staff**. Because the exchange will need to be in-sync with the activities of a number of other state agencies—particularly a state's insurance regulator and its Medicaid agency—the exchange's governing board might include state officials ex-officio with expertise in those areas.
- **Commercial health plan experience**. Board representation from organizations with experience in the individual and/or small group markets could also be useful, providing the governing board with insight into those markets and firsthand knowledge of the types of plans consumers have selected in the past and the way those markets operate. Because the individual and small group markets operate under different rules than the large group market, states would be well served to include an individual with experience in those markets on the exchange board
- **Consumer representative**. The consumer perspective will be critical as the board plans outreach campaigns, sets up its website, and determines which plans will be available through the exchange.
- **Representation**. While it will be tempting to include a "representative" from all of the major stakeholder groups, it may be more advisable to seek people with the right expertise rather than those who come representing a certain interest group. In fact, it may be preferable to specifically require that individuals leave their advocacy hat at the door and seek to make decisions that are in the public interest.
- **Conflict of Interest**. States will want to consider compensation and conflict of interest rules. California put in place strong conflict of interest provisions, including some that prevent members from serving on the board of or staff to a health insurer or provider. Board members in that state will receive no compensation. For more details, see California Senate Bill 900 (2010).[19]

Getting the role of the board right will be important as well. Restrictive processes that require board approval for all activities of the exchange will not be conducive to effective and efficient operations. The exchange will need to be adaptive and flexible in order to respond to an ever-changing marketplace and an evolving set of federal rules and regulations.

Clearly, states have many issues to consider as they make their governance/administrative decisions. While West Virginia is strongly considering placing their exchange in their insurance department, other experts have advocated that states establish an independent agency. Timothy Stoltzfus Jost recommends an independent agency because, if placed within the insurance agency, health plan selection by an exchange would be "inconsistent with the impartiality that must be shown by an insurance commissioner"[21] in the agency's job of regulating all plans. He asserts that a Medicaid agency serves a fairly different population than the exchange would. An independent agency could be exempted from some state administrative rules and could develop a culture and a set of policies consistent with its unique role.

The Maryland Health Care Reform Coordinating Council has recommended that the legislature set up an independent public board to make initial decisions related to the exchange. They are leaving open the possibility that that board could recommend a different governance structure in future years.

The governance structure and administration of the exchange may determine, among other things:

- The management and extent to which the exchange will be allowed to operate outside the confines of state government;
- The level of transparency and public accountability;
- The manner by which goods and services will be procured;
- Staffing levels and hiring procedures;
- The criteria that may be used to select health plans; and
- The intersection between publicly-subsidized coverage and non-subsidized commercial insurance.[22]

However a state decides to govern their exchange, it will be critical that it is a nimble organization, able to react to the environment and learn from its mistakes. The work of the exchange will be new and states will need to learn as they go. They need a structure in place that allows them to operate – in some ways – more like a private-sector market participant than like a traditional government agency.[22]

CONCLUSION

Exchanges were a hot topic among states in 2010; they were discussed in their own right and as a centerpiece or organizing principle for overall state reform efforts. While all the health-related state agencies will have tasks related to the ACA, it is likely that the exchange planning process and, ultimately, the governing board and staff for the exchange will be a locus for discussing each state's reform goals and strategies.

Exchange planning was impacted by many of the larger trends discussed in this report, including the capacity challenges states are facing due to budget difficulties and the significant turn-over in state leadership (particularly governors). Once the political instability of 2010 has settled down, it is likely that most states will use 2011 to lay the groundwork for exchange planning and implementation.

Comparing the Small Group Component of the Massachusetts and Utah Exchanges

The existing state-based exchanges in Massachusetts and Utah have been characterized by many observers as representing the opposing ends of the political spectrum, with the Massachusetts Health Connector cast as the liberal, big government approach and the Utah model as the competition-oriented, conservative model. In fact, each state relies on the power of competition; they just have differing views on how to promote and enable consumer choice. While the programs have taken different approaches, much can be learned from each. In addition, each will need to adapt under the provisions of the Patient Protection and Affordable Care Act (ACA).

While the vast majority of the Massachusetts' Health Connector's resources are directed to implementing the individual subsidies and the state's individual mandate (because enrollment in its subsidized coverage program is currently much larger than in its unsubsidized program), the focus of this overview will be on the small group (i.e., the insurance market for small employers) component of their program. This will be compared with the Utah approach to this same market. Each will be examined in light of the requirements of the Small Business Health Options Program (SHOP) that passed as a part of the ACA.

TWO APPROACHES TO COMPETITION

The Utah Health Exchange was established to promote consumer choice in the small group market. In the Utah market outside the exchange (and in small group markets in most states), employers choose a health plan for their employees. However, the employer may not know the premium, cost-sharing, and benefit trade-offs that each individual employee might prefer. The Utah Health Exchange was set up to facilitate the ability of an employer to provide a defined contribution toward the overall premium and then allow its employees to choose a plan. Employees pay their share based on the additional cost (over and above what the employer is paying) of their chosen plan. The plans from which an employee is able to choose look very similar to the plans available outside of the exchange; the benefit designs are not standardized.

In 2010, the Massachusetts Health Connector launched a new small business product called Business Express. Similar to how individuals can access information and enroll through the Connector, Business Express enables employers to choose a specific health plan product for all their employees using the Health Connector's Web-based portal; employees then enroll in the product the employer has chosen. The Health Connector organizes its benefit plans tiers (Gold, Silver and Bronze) and each insurer offering coverage must meet basic benefit design specifications. The concept is that employers, like individuals, are more empowered to choose the coverage that best suits their needs if they have a venue where they can transparently view a reasonably representative sampling of health insurance options across a spectrum of standardized benefit designs and compare the prices of similarly designed plans—an "apples to apples" comparison.

Prior to Business Express, the Health Connector offered a different small group plan on a pilot basis that did allow some employee choice. It required that an employer choose a benefit tier and then employees could choose from various plans within the tier. Ultimately, they suspended that model for new business because it was perceived as more complicated to administer both for the Health Connector and for the small employer. It remains available for renewals of existing accounts. A major lesson learned was that employers want a plan that is *affordable* and *simple* to administer and explain to their employees.

The ACA requires that a state's small business exchange, at a minimum, gives employers the option of the employee choice model. It also requires the Health Connector's innovation of offering benefit tiers, though states will have significant flexibility in how many plans will be allowed in each tier. States could maximize the strengths of each state's model by allowing employee choice and then standardizing key benefit design options to ensure that plans are competing transparently on quality and price.

The details of how Utah makes the employee choice mechanism work could be particularly instructive to other states. Here are the steps that occur when an employer comes to the Exchange:

- An employer comes to the Exchange to express interest in purchasing a plan (this can be done through the employer's usual broker if that broker is certified to sell on the Exchange.)
- Information about the risk profile of each employee is provided to the Exchange.
- Two of the four plans in the Exchange assess the risk profile of the small employer's group, given the health history of all the employees. If these two plans calculate similar risk factors, all four plans agree to use the average risk factor. If the risk factors are significantly different, a third plan generates a deciding opinion.
- The employer decides on the amount of defined contribution for each employee.
- The employees each shop for a plan, using the amount the employer has elected to contribute for them, along with their own contributions. Premiums vary by the plan type or carrier selected but not by individual risk.

- Once each employee has selected a plan, the Exchange accepts a lump sum payment that includes the total premium from the employer and employees. On the back end, the Exchange risk adjusts the amount sent to each plan so that the plans with the higher-cost employees get a larger percentage of the overall premium.

FACILITATING GOOD CHOICES

The current insurance market is mostly opaque to both individuals and employers. This has required the use of brokers, who receive a commission from the insurance carrier. Utah required the use of brokers in their Health Exchange in 2010, though it will be optional in 2011. "The brokers provide a valuable service to many small businesses, and we believe that many employers will continue to want that human connection," says Patty Conner, the Director of the Utah Health Exchange. The use of a broker is optional in Massachusetts' Business Express. Further, the Health Connector has negotiated a small savings for "mini-group" employers, reducing the monthly administrative fee from $25 per month to $10 per month. As a result, these "mini-group" employers could save more than $300 annually by purchasing through the Health Connector. In Business Express, 92 percent of small businesses currently use a broker. Except for the small savings for mini-groups, the premium for the small employer is the same whether they use a broker or not.

The Massachusetts Health Connector provides comparative information directly to the consumer, reducing the need for a broker in the selection of coverage (although the broker may provide a range of other services that have value to the small employer). This type of comparative information will also be required by the ACA. The Utah Health Exchange is currently developing a mechanism to provide additional comparative information about health plans and providers using data from their all-payer claims database and other sources.

As states and the federal government consider the information technology solutions that will power the exchanges under ACA, additional search options and techniques currently utilized in Utah and Massachusetts will be worth considering. The Utah Health Exchange allows employees searching for a plan to know if that plan's network includes a preferred doctor, clinic, or hospital. The Massachusetts Health Connector has a provider search function for its subsidized coverage program and will soon implement one for its unsubsidized coverage program. In the future, exchange search engines could also include quality information about plans and providers. A search question could ask consumers which elements of a plan are most important to them: for example, low premiums; minimal cost-sharing; high quality rating; whether the plan's network includes a certain doctor; or whether the plan does a good job serving those with a particular chronic condition.

One element of choice is having a diversity of plans that offer different types of network options. This diversity was an important issue in Massachusetts, which generally has very high health care costs and also has a few providers who (because of their dominance in the Boston market) receive payments that are much higher than the average market rate. In order to promote limited networks, the Health Connector helped attract a new health insurer, CeltiCare, into the state's market. CeltiCare is a limited network option that is available at a lower price.

The Health Connector offers all of the state's seven major health plans. The Utah Health Exchange offers plans from four of the state's five major insurers in the small group market.

The choice model of the two exchanges is based on different theories on the type of environment that promotes good consumer decision-making. The Health Connector staff, based on focus groups and interviews with consumers, believes that consumers make the best choices when their options are simplified and somewhat constrained. They believe that consumers are best able to focus on the important differences between plans when key benefit design features and other specifications are standardized. For those shoppers who want a simplified, streamlined shopping experience, the Health Connector seeks to offer enough choice that consumers can make a meaningful decision, but not so much choice that they become overwhelmed or that important differences between the plans are hidden. The Utah Health Exchange is based on the idea that the market should decide the number and types of options available to consumers; the role of the Exchange is to facilitate competition and choice.[24]

INITIAL RESULTS

During 2010, the Utah Health Exchange completed a pilot phase and currently its service is available to all small employers seeking effective dates in 2011. The pilot phase enrollment includes 11 employee groups comprising 116 individuals. Early enrollment was limited in order to keep the development of the Exchange manageable. In addition, the Utah exchange had initial problems with health plans offering premiums that were significantly different from those being offered in the outside market. As a result, the state enacted legislation in 2010 to require the health plans to have a single risk pool for their products both inside and outside the exchange. Policymakers observed the importance of keeping a level playing field inside and outside the Exchange.

In the first few months of operation, Business Express has enrolled more than 5,500 members (a small number of these members are hold-overs from the previous small group plan). Their 2010 progress report includes a quote from one Massachusetts business owner who lays out many of the benefits that are available to small employers:

> "When our existing health plan provider announced a 23 percent increase in our health insurance rates, we wanted to explore our options. Business Express made it very easy for us to perform a side-by-side comparison of each of the health plans offered. Benefits are standardized on the website so you can really compare apples to apples to make the best choice. It saved us time, allowing us to get back to our business. . . But perhaps the best part of all is that our company and our employees saved a combined $9,300 compared to what we would have spent if we simply continued on with a very similar plan from another insurer."[25]

One interesting result of the Health Connector model (across individuals and small groups) is that it has led to some changes in consumer choices of plans. They are tending to choose smaller, lower-cost plans over the larger plans with higher name recognition, larger networks, and higher prices.

Evaluating the potential of employee choice based on the Utah model is more difficult. The small number of enrollees from the pilot program makes it unlikely that health plan behavior—in pricing and network and benefit design—has been impacted. There is hope among those in Utah and those who designed the federal SHOP model that the widespread ability of individual employees to choose plans could ultimately have a powerful effect on the market, making it more responsive to consumer demands. This remains to be seen.

ADMINISTRATIVE COSTS

Much has been made of the amount that the Health Connector spends on administration (about $30 million) versus what the Utah Health Exchange spends ($650,000), but a simple comparison of these numbers hides the larger reality of the goals and achievements of each model. The Connector provides coverage for 220,000 Massachusetts residents through the subsidized Commonwealth Care and unsubsidized Commonwealth Choice programs and determines the rules to implement the state's individual mandate. In addition, they invest in communications and outreach to educate Massachusetts residents about the requirements under the law and educate them about the coverage available through the Connector. The Utah Health Exchange uses its $650,000 annual allotment from the state to manage contracts and operations and to conduct policy planning for the state. In addition, they charge a $6 per employee per month fee that goes directly to the contractors for their role in operating the system. As stated above, 116 people are currently enrolled in the exchange in Utah. In addition, the Utah Health Exchange relies on brokers to facilitate employer and employee choice. That expense is exogenous to the state's cost to administer the Utah Health Exchange.[26]

LESSONS LEARNED

Both programs have learned important lessons during their first years of implementation that could be relevant to other states. Norman Thurston, Health Policy and Reform Initiatives Coordinator for the Utah Department of Health, shared the following insights:

- Involve stakeholders early and make sure insurers are heavily invested in the decisions and plans.
- Look for solutions that already exist in the private sector.
- Start with something concrete (it helped Utah to begin with a pilot).
- Make it a level playing field; keep the rules inside and outside the Exchange as similar as possible.[27]

Glen Shor, executive director of the Massachusetts Connector, notes:

- It is wise to pilot an experimental new product.
- For many small employers, less is more. Many prefer a shopping experience that is streamlined, simple, and facilitates informed comparisons among their options.
- The Health Connector hired staff that had both public and private sector experience. This diverse knowledge helps them serve their mission.
- Nurture relationships with providers, plans, advocacy groups, and legislators.
- Massachusetts benefited from having tight deadlines – it focused the work and kept reform efforts on track.
- Do not underestimate the power of a healthy, functioning market.[28]

CONCLUSION

Under the ACA, every state will need to develop a SHOP exchange (or defer to the federal government to run one in their state). In the first two years of this exchange, very small businesses with low-income employees will be eligible for tax credits within the exchange. After 2016, those credits will no longer be available. At that time, it will be important for these exchanges to show they can provide value to small employers as they look for a simple, cost-effective product.

ENDNOTES

1 The SCI health reform web page that highlights state, federal, and research work on exchanges can be found at: www.statecoverage.org/health-reform-resources/119/110.

2 Alaska and Minnesota did not apply for an exchange planning grant.

3 Department of Health and Human Services. (2010, November 3) "HHS announces new federal support for states to develop and upgrade Medicaid IT systems and systems for enrollment in state exchanges." Retrieved January 10, 2011, from www.hhs.gov/news/press/2010pres/11/20101103a.html.

4 Department of Health and Human Services. *Health Insurance Exchanges: State Planning and Establishment Grants.* Retrieved December 23, 2010, from www.hhs.gov/ociio/initiative/grant_award_faq.html.

5 Sonier, J. and P. Holland. (2010, November). *Health Insurance Exchanges – How Economic and Financial Modeling Can Support State Implementation.* State Coverage Initiatives. Retrieved December 23, 2010, from www.statecoverage.org/node/2697.

6 Ibid.

7 To learn more about Wisconsin's eligibility and enrollment reforms in their BadgerCare Plus program, see "Profiles in Coverage: Wisconsin's BadgerCare Plus (BCP) Program." Retrieved December 23, 2010, from www.statecoverage.org/node/1751.

8 Wisconsin Office of Health Care Reform. (2010, December). *Wisconsin Health Insurance Exchange: A 2010 Report – A Starting Point.* Available at www.statecoverage.org/node/2788.

9 Letter to Wisconsin Department of Administration Secretary Daniel Schoof from Governor-Elect Scott Walker on November 10, 2010. Retrieved December 23, 2010, from www.wrn.com/wp-content/uploads/2010/11/111110walkerletter1.pdf.

10 Williams, W. (2010, June 10). "W.Va. to Launch Health Insurance Exchange." *The State Journal.* Retrieved December 23, 2010, from www.statejournal.com/story.cfm?func=viewstory&storyid=81151.

11 West Virginia Department of Insurance. *Health Insurance Exchange Stakeholder Engagement Strategy.* Retrieved December 23, 2010, from www.wvinsurance.gov/LinkClick.aspx?fileticket=lmWbuhSTDJA%3d&tabid=480&mid=1202.

12 Holland, P. and J. Kingsdale. (2010, July). *Health Benefit Exchanges: An Implementation Timeline for State Policy Makers.* State Coverage Initiatives. Retrieved December 23, 2010, from www.statecoverage.org/node/2444.

13 To learn more about the California effort to enact comprehensive reform, see Zelman, W. (2009, June). *Swimming Upstream: The Hard Politics of Health Reform in California.* State Coverage Initiatives. Retrieved December 23, 2010, from www.statecoverage.org/node/1814.

14 This list relies heavily on the work done by the West Virginia Department of Insurance. Their exchange website can be found at: www.wvinsurance.gov/Default.aspx?alias=www.wvinsurance.gov/healthcareexchange. Retrieved December 23, 2010.

15 Ibid.

16 Lishko, A. (2010, September). *Health Care Reform: Exchange Options Discussion, Based on deliberations of the steering committee on health reform.* [PowerPoint slides]. Retrieved December 23, 2010, from www.statereforum.org/images/Docs/exchanges/maineexchangeoptions_draft_4.pdf.

17 For more information, see the staff summary of Assembly Bill 1602 at www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_cfa_20100419_093901_asm_comm.html. Retrieved December 23, 2010.

18 The NAIC model exchange legislation is available at: www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf. Retrieved December 23, 2010.

19 California Senate Bill 900. Retrieved December 23, 2010, from http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100819_amended_asm_v92.html.

20 For more information on tax issues related to nonprofit governance of exchanges, see www.statecoverage.org/node/2787.

21 Jost, T.S. (2010, September). *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues.* The Commonwealth Fund Retrieved November 15, 2011, from www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

22 Carey, R. (2010, September). *Health Care Exchanges: Key Issues for State Implementation.* State Coverage Initiatives. Retrieved December 23, 2010, from www.statecoverage.org/node/2630.

23 Ibid.

24 These statements are based on interviews with program leaders and the information available on their websites. For more information about the Massachusetts Health Connector, visit www.mahealthconnector.org/portal/site/connector/. To learn more about the Utah Health Exchange, see www.exchange.utah.gov/.

25 The Commonwealth Health Insurance Connector Authority. (2010, November). *Massachusetts Health Care Reform 2010 Progress Report.* Retrieved January 18, 2011, from www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/Connector%2520Progress%2520Report%252010.pdf.

26 For the most part, the Massachusetts Health Connector maintains the prevailing role of brokers in its health care market. Brokers had not typically been active in the individual market there and, thus, they are not used in the individual market portion of the Connector's business. This heightened the need for strong comparative information to be available on the Connector's website. Brokers have a stronger role in the small group market and this largely has been maintained through Business Express.

27 Based on phone interview and email correspondence with Norman Thurston, Health Policy and Reform Initiatives Coordinator, Utah Department of Health, October-December 2010.

28 Based on phone interview and email correspondence with Glen Shor, Executive Director of the Massachusetts Connector, October-December 2010.

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