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Consideration of Early Creation and Operation of a Health Benefit Exchange

Minnesota Department of Health
Minnesota Department of Commerce
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Introduction

Under the federal Patient Protection and Affordable Care Act (PPACA) enacted in March of 2010, new mechanisms for comparing, purchasing and obtaining health care coverage are created called Health Benefit Exchanges ("Exchange"). The federal law requires that an Exchange be operational in each state on January 1, 2014. By January 1, 2013, a state must have created an Exchange at a state, multi-state, or regional level and have taken the necessary steps to have that Exchange operational by January 1, 2014 or the U.S. Department of Health and Human Services (HHS) will establish one on a state's behalf.[1] Full federal funding is available to states for the implementation of an Exchange that complies with the requirements specified in law and the rules promulgated by HHS.[2]

An Exchange is an organized competitive marketplace to facilitate the comparison, choice, and purchase of health care coverage for individuals and employees of small businesses and potentially larger businesses in later years.[3] Through an Exchange, individuals and employees are provided comparable information on costs, benefits, provider networks, services, quality, and consumer satisfaction for an array of coverage options, and they use this information to enroll in the health benefit plan that best fits their personal and family needs. Exchanges will also be the mechanism by which consumers receive financial assistance for health care coverage either through Medicaid eligibility or federal premium and cost-sharing subsidies starting in 2014.

The 2010 Minnesota Legislature directed the Departments of Health, Commerce, and Human Services to analyze the advantages and disadvantages of creating and operating an Exchange prior to the federal January 1, 2014 deadline.[4] It is important to distinguish between the creation and operation of an Exchange. If a state does not want HHS to establish an Exchange on their behalf, a state must act before January 1, 2013 to create an Exchange with the structure, governance, and authority to take the necessary actions to make an Exchange operational by January 1, 2014. This report describes the advantages and disadvantages of operating an Exchange prior to 2014 if Minnesota decides to create an Exchange prior to January 1, 2013.[5]

This report concludes that the disadvantages of operating an Exchange prior to 2014 outweigh the advantages. Early operation would likely require state expenditures for the development of short-term infrastructure, may not satisfy federal requirements, could confuse consumers, and could divert time and resources from efforts to comply with federal Exchange provisions by 2014. It is also unlikely that the work necessary to establish an Exchange could realistically be completed in a timeframe significantly earlier than 2014, especially given the lack of sufficient guidance from HHS to date.

[1] U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, "Initial Guidance to States on Exchanges," November 18, 2010.
[2] See section 1311 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010.
[3] In 2014, individuals and small employers are eligible to participate in an Exchange. Starting in 2017, larger employers with more than 100 employees may be eligible to participate in an Exchange at the discretion of a state. See section 1312 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010.
[4] 2010 Minnesota Special Session Law, Chapter 1, Article 22, Section 5, Subdivision 2.
[5] This report assumes that the functions of an Exchange would be tested prior to starting operations, so testing is not considered an early operation of an Exchange.

This report makes two specific recommendations regarding the early operation of the primary functions of an Exchange:

- **Recommendation #1:** Given the challenges created by existing health insurance market rules and the 2014 federal implementation date of other health reforms that interact with an Exchange, early operation prior to 2014 is not recommended for the choice, enrollment, and purchase of private market coverage by individual consumers and employees of small businesses through an Exchange.

- **Recommendation #2:** Given the changing Medicaid eligibility rules and the challenges of developing the technical capacity before 2014, early operation of Medicaid eligibility and enrollment functionality through an Exchange prior to 2014 is not recommended.

Responsibilities of an Exchange

The primary responsibilities of an Exchange under PPACA are to facilitate the comparison, choice, enrollment, and purchase of health care coverage.[6] Specifically, an Exchange must:

- Certify and determine which insurers and benefit plans are qualified for participation;
- Operate a toll-free telephone hotline and website for providing information on health care coverage options to current and prospective enrollees;
- Provide comparative information on health insurers and benefit plan options in a standardized format, including ratings for price, quality, and enrollee satisfaction;
- Set up open enrollment and special enrollment periods to start in 2013 for 2014 enrollment;
- Determine eligibility for individual and employer premium and cost-sharing subsidies;
- Make available an electronic calculator to determine the actual cost of coverage after any premium and cost-sharing subsidies have been applied;
- Facilitate enrollment using a uniform enrollment form;
- Determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP) and facilitate enrollment;
- Grant certifications for individuals exempt from the individual coverage requirement and transfer to the U.S. Internal Revenue Service (IRS) and HHS information on individuals eligible for subsidies, exempt from coverage requirement, and no longer enrolled in coverage;
- Notify employers when employees are eligible for individual subsidies for calculation of any employer responsibility payments;
- Use an electronic interchange to share information with state and federal agencies; and
- Establish a "Navigator" program for entities to assist consumers by providing information, helping with enrollment, and addressing questions and grievances.

[6] See sections 1311, 1411, 1413, 2201, and 10104 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010.

Interaction of an Exchange with Other 2014 Health Reforms

This section of the report describes the relationships between the primary functions of an Exchange and other reforms that take effect in 2014 under PPACA. The advantages and disadvantages of operating an Exchange prior to 2014 are directly related to the relationship of Exchange functions to other federal health reforms implemented in 2014.

Private Market Choice, Enrollment, and Purchase

An Exchange is designed to foster a more competitive marketplace by addressing some of the barriers to competition in the health care market. Some of the key components of a competitive market are that consumers have access to transparent information to choose between goods and services, are personally responsible for their purchasing choices, and are able to change or maintain their purchasing decisions. In the health care market, consumers often lack sufficient information to make well-informed decisions and are generally not responsible for the choice or cost of their health benefit plan because they receive coverage through an employer.

Through an Exchange, individuals and employees are provided access to comparable information on costs, benefits, provider networks, services, quality, and consumer satisfaction for an array of health care coverage options. Consumers instead of employers use this information to choose, change, or maintain the health benefit plan that best fits their personal and family needs. For small businesses, the employer establishes a "defined contribution" towards the cost of coverage and employees pay the difference between this financial contribution and the cost of the health benefit plan of their choosing.

Under various federal laws including HIPAA and ERISA, employers are limited in their ability to provide a defined contribution towards individual coverage in markets like Minnesota that do not have guarantee issue and community rating. Defined contribution arrangements, where employers contribute towards but do not select a specific health insurer or individual health benefit plan, are likely considered group health plans that are prohibited from restricting access to or varying premiums for health insurance based on health status.[7] To address this issue and allow choice of health benefit plans regardless of health status for all individuals and employees, the federal law requires health insurers to accept all applicants (guarantee issue) and vary premium pricing only by age, geography, family size, and tobacco use (community rating) instead of health status (medical underwriting).[8]

When guarantee issue and community rating are introduced in a market without incentives for all individuals to have health care coverage consistently, it creates an incentive for consumers to delay purchase of health care coverage until they are sick (consumer adverse selection). This market incentive leads to an insurance risk pool with sicker individuals and higher premiums for the entire market, and this pattern worsens over time as fewer people purchase coverage and premiums continue to rapidly increase (death spiral). To address this issue, the federal law seeks to incent all individuals to

[7] See Mathematica Policy Research, "Final Report: (Minnesota) Health Insurance Exchange Study," Submitted to the Minnesota Department of Health, March 27, 2008.
[8] See sections 1201, 1252, 1255, and 10103 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010.

purchase coverage through the provision of premium and cost-sharing subsidies and a requirement for individuals to have health care coverage starting in 2014.[9]

Guarantee issue and community rating environments can also create undesirable incentives for health insurers. In this type of market, premiums do not fully reflect the relative costs of healthy and sick individuals and thus, insurers have a financial incentive to compete for healthy individuals (insurer adverse selection) rather than compete on efficiency, quality, and value. Starting in 2014, risk adjustment, reinsurance, and risk corridor provisions in the federal law seek to address this issue by adjusting payments to insurers offering health benefit plans inside and outside an Exchange based on differences in the risk characteristics or health status of enrollees.[10]

Medicaid Eligibility and Enrollment

Medicaid eligibility for non-elderly and non-disabled populations will be based on a modified adjusted gross income methodology from federal income tax law in 2014 instead of the current methodology that is based on various income and asset test calculations. Medicaid eligibility will also be expanded to cover all non-elderly and non-disabled individuals under 133 percent of the federal poverty level in 2014, including adults without dependent children. [11] States may expand Medicaid eligibility for adults up to 133 percent of the federal poverty level prior to 2014. If a state expands eligibility prior to 2014, the calculation of eligibility for the expansion population could be based on the new modified adjusted gross income methodology or the existing income eligibility methodology without the asset test calculation. However, eligibility determination for non-expansion populations will follow existing Medicaid eligibility rules based on income and assets until 2014. In 2014, an Exchange is required to enroll all non-elderly and non-disabled individuals found to be eligible for Medicaid based on the new modified adjusted gross income eligibility rules.

One application form is to be used for Medicaid, CHIP, and subsidies through an Exchange. According to recent guidance from HHS, individuals seeking coverage should have the same experience whether or not they are subsidy eligible and whether or not they apply through the Exchange or the Medicaid agency.[12] For most people, eligibility and enrollment through the Exchange or Medicaid agency is expected to happen in real time. Some people may experience discrepancies between available and submitted sources of information and for these individuals, a timely, but not necessarily a real time response will be required. Other individuals may seek a specific determination by Medicaid (because of disability, for example), that may require more information and processing time. The federal law envisions a fully integrated eligibility determination system in 2014.

[9] See sections 1401, 1402, and 1501 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010, and modified by sections 1001 and 1002 of the Health Care and Education Reconciliation Act, Public Law 111-152 enacted on March 30, 2010.
[10] See sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010.
[11] See sections 2001, 2002, and 10201 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010, and modified by section 1004 of the Health Care and Education Reconciliation Act, Public Law 111-152 enacted on March 30, 2010.
[12] U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, "Guidance for Exchange and Medicaid Information Technology (IT) Systems: Version 1.0," November 3, 2010.

Recommendations

This section of the report describes the advantages and disadvantages of operating an Exchange prior to 2014. Recommendations regarding early operation of an Exchange prior to 2014 are based on the relationship of the primary functions of an Exchange to other related federal health reforms described above that become effective in 2014.

Private Market Considerations and Recommendations

Full operation of the private market Exchange functions related to choice, enrollment, and purchase of health care coverage for individual consumers and employees of small businesses prior to 2014 would require the implementation of additional insurance market reforms inside and outside an Exchange. Minnesota could implement guarantee issue and community rating prior to 2014, but the implementation of these insurance market reforms should be paired with risk adjustment mechanisms and provisions to incent healthy individuals to purchase health care coverage in order to mitigate adverse selection by consumers and insurers.

There are several disadvantages of early implementation of guarantee issue, community rating, risk adjustment, and provisions including subsidies and coverage requirements to encourage all individuals to purchase coverage. Implementation of these provisions prior to 2014 would likely require state expenditures for subsidies, since federal subsidies will not be available until 2014. It is also likely that state expenditures would be needed for the development of short-term infrastructure for the enforcement of provisions, such as an individual coverage requirement, to incent all individuals to purchase coverage. Given that a federal enforcement infrastructure will be operated by the IRS starting in 2014, there would be no need for similar infrastructure at a state level after 2014 and therefore, it is unlikely that federal funds could be used for the development of this short-term infrastructure. This approach is not recommended because it would divert time and resources from efforts to comply with federal Exchange requirements by 2014.

Minnesota could also consider creating an Exchange under existing insurance market rules without guarantee issue and community rating that complies with various existing federal laws including HIPAA and ERISA. Under this approach there is a chance of adverse selection, and the early implementation of an Exchange without guarantee issue and community rating would require the establishment of functionality that would likely not comply with federal requirements starting in 2014. With this approach, Minnesota would need to establish insurer underwriting, pricing, and risk sharing mechanisms similar to those developed by the Utah Exchange to account for employee premium and renewal pricing based on health status. When Utah started its launch of the Exchange it experienced an unequal distribution of risk between the Exchange and the outside market (adverse selection) as a result of different rules for insurers inside and outside the Exchange. [13] In addition to the potential for adverse selection, this approach would likely require state expenditures for the development of short-term infrastructure and would thus divert time and resources from implementation of federal provisions required in 2014.

[13] See Heritage Foundation, "Consumer Power: 5 Lessons from Utah's Heath Care Reform," Web Backgrounder #2453, Published August 19, 2010. In response to adverse selection concerns, Utah enacted provisions to help mitigate the problem, but did not implement guarantee issue and community rating as will be required starting in 2014. Utah is currently monitoring the market impact and the potential for continued adverse selection.

Recommendation #1: Given the challenges created by existing health insurance market rules and the 2014 federal implementation date of other health reforms that interact with an Exchange, early operation prior to 2014 is not recommended for the choice, enrollment, and purchase of private market coverage by individual consumers and employees of small businesses through an Exchange.

Medicaid Considerations and Recommendations

Given that Medicaid eligibility rules in 2014 will be different than what will exist prior to 2014, early operation of eligibility determination and enrollment functions through an Exchange would require the creation of the technical capacity and functionality to perform automated Medicaid eligibility and enrollment using existing Medicaid eligibility rules. Although there are advantages to creating and operating an automated eligibility and enrollment system to help consumers get coverage, it is unlikely that this technology could realistically be implemented earlier than 2014. The disadvantage of this effort is that attempting to develop an automated eligibility system for operation prior to 2014 based on existing eligibility rules would require time and resources for the development of short-term technical capacity that would not be applicable after 2014. Thus, this approach is not recommended as it would divert time and resources from significant efforts that will be needed to create an automated real time eligibility and enrollment system based on the new Medicaid eligibility rules effective in 2014.

Although not equivalent to an automated process, the Department of Human Services (DHS) is in the process of developing an online consumer application based on existing Medicaid eligibility rules for implementation in 2011. An Exchange could direct consumers to this online application prior to 2014.

If Minnesota adopts an early expansion of Medicaid for adults under 133 percent of the federal poverty level prior to 2014, the new eligibility rules could potentially apply to this population but they would not apply to non-expansion populations eligible for Medicaid prior to 2014. The state could consider creating the technical capacity for the Exchange to use the new Medicaid eligibility rules to perform eligibility determination and enrollment for this expansion population of adults without dependent children prior to 2014. However, it is unlikely that this technology could be implemented significantly earlier than 2014, especially given the lack of sufficient guidance from HHS to date. The advantage of this approach, if it could be achieved prior to 2014, is that the technology developed prior to 2014 could be used after 2014 and expanded to the rest of the non-elderly and non-disabled Medicaid population. The disadvantage of this approach is that it could create confusion for consumers if there are multiple Medicaid eligibility and enrollment processes. The Exchange could create a seamless interface for the consumer for both sets of eligibility rules, but technology development needs for this interface may not be compatible with work needed for 2014 and thus, could divert time and resources away from provisions required in 2014.

Recommendation #2: Given the changing Medicaid eligibility rules and the challenges of developing the technical capacity before 2014, early operation of Medicaid eligibility and enrollment functionality through an Exchange prior to 2014 is not recommended.

Summary

The 2010 Minnesota Legislature directed the Departments of Health, Commerce, and Human Services to analyze the advantages and disadvantages of creating and operating an Exchange prior to 2014. If a state does not want HHS to establish an Exchange on their behalf, a state must act before January 1, 2013 to create an Exchange with the structure, governance, and authority to take the necessary actions to make an Exchange operational by January 1, 2014.

If Minnesota decides to create an Exchange prior to 2013, the disadvantages of operating that Exchange prior to 2014 outweigh the advantages. The primary functions of an Exchange related to facilitating the choice, enrollment, and purchase of private market coverage, and conducting Medicaid eligibility and enrollment should not be implemented prior to 2014. Early implementation of these functions would likely require state expenditures for the development of short-term infrastructure, may not satisfy the 2014 federal requirements, may confuse consumers, and could divert time and resources from efforts to comply with federal Exchange requirements by 2014. It is also unlikely that the work necessary to establish an Exchange could realistically be completed in a timeframe significantly earlier than 2014, especially given the lack of sufficient guidance from HHS to date.