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A Health Insurance Exchange:
Prototypes and Design Issues

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OVERVIEW — *Many reform proposals call for the creation of one or more health insurance exchanges, intermediaries that can help individuals or small employers navigate the insurance market. An exchange might be public or private, national or local. It might serve simply as a clearinghouse for plan information or could play an active role in setting benefit packages, choosing high-quality plans, and negotiating premium rates. This paper begins with a summary of recent experience with insurance exchanges and similar systems. It then reviews basic issues in the design of an exchange.*

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Faced with a persistently large number of Americans lacking health insurance (45 million in 2007), policymakers are once again focusing on making coverage more affordable and accessible. Although some favor new or expanded public insurance programs, many proposals focus instead on providing tax credits or other subsidies that could help modest-income families or small-employer groups buy private insurance. A key problem for such proposals is that many people face nonfinancial barriers to obtaining coverage, especially in the individual or nongroup market.

In most states, insurers can refuse or restrict coverage for applicants with a history of medical problems or high costs, or they can charge these applicants higher premiums that could make coverage unaffordable, even with a subsidy. Insurers may compete on their ability to select the healthiest enrollees, rather than on efficiency or quality. Even healthy consumers may have difficulty choosing from among a large variety of plans with confusing differences in benefit packages and coverage rules. Finally, multiple insurers selling coverage directly to individuals and small groups have high marketing and other administrative costs.

For at least two decades, analysts have been proposing that some sort of government agency or independent entity should stand between insurance companies and insurance purchasers. The intermediary has had a variety of names over the years, such as "health alliance," "purchasing cooperative," and "connector." This paper will use the phrase "health insurance exchange," but the basic concept of an intermediary is more or less the same, regardless of the terminology.

An exchange might serve simply as a clearinghouse, informing individuals and/or employers of the health plan choices available to them and presenting standardized comparative information on benefits, premium rates, and perhaps quality and consumer satisfaction. In many proposals, however, an exchange would be more proactive. It would contract with some number of competing health plans, selected on the basis of price, quality, and other factors. It would set rules for participating insurers' underwriting and rating practices and would negotiate benefit packages (or it might enforce requirements set by

legislation or by a regulatory agency). Finally, it would manage enrollment and premium payment processes.

Proponents of this approach contend that an exchange could, at a minimum, simplify the process of finding and enrolling in a health plan and could promote greater competition by offering consumers a clear menu of plan choices. Some also suggest that an exchange could achieve economies of scale in administrative costs and, if it served a large population, might have enough bargaining power to negotiate lower premiums.

PROTOTYPES

Purchasing Cooperatives

There has long been interest in finding some way of giving smaller employers and individuals the purchasing power of large-employer groups. Specific trade or professional groups, such as the American Bar Association, have offered coverage to their members through contracts with health insurers. Other groups serve small employers across multiple industries. For example, the Council of Smaller Enterprises (COSE) in Cleveland, Ohio, has been offering health coverage since 1973. Currently, it serves 11,000 firms with 150,000 covered employees.[1] A similar private initiative is the Health Connections program of the Connecticut Business and Industry Association (CBIA), which has operated since 1995 and, in 2007, served 88,000 members in almost 5,800 companies.[2]

COSE offers a wide variety of plan designs, including a health maintenance organization (HMO), preferred provider organizations (PPOs), and high-deductible plans with a health savings account (HSA). However, since all the plans have always been provided by a single health insurer, Medical Mutual of Ohio (formerly Blue Cross), COSE is more like a portal to that insurer than a purchaser. The choice of plans is made by the employer; a firm has the option of making up to three plans available to its employees. CBIA offers fewer different plan designs, but multiple insurers offer each type of plan. In addition, each employee chooses from among all the available plans. The CBIA system thus comes much closer to the model contemplated by advocates of "managed competition," in which insurers compete to attract individual enrollees on the basis

of price and/or quality. However, CBIA is not exactly a purchaser, either. The participating plans offer the same rates that they offer to small employers purchasing outside the CBIA arrangement.

During the 1990s, a number of states promoted similar health insurance purchasing cooperatives (HIPCs) for small employers. Some were managed directly by government agencies, while others were independent entities authorized by state legislation. Although these programs enjoyed some initial successes—the largest, the Health Insurance Plan of California, served 7,430 groups with more than 140,000 enrollees in 1998—most have since failed.[3] Their enrollment was a tiny fraction of the market, insufficient to attract insurers or give them much negotiating power. One analysis of the three largest HIPCs found that they did not increase small-group enrollment in their states and did not reduce premiums.[4] In other cases, insurers competing outside the cooperative "cherry-picked" the healthiest groups, leaving the cooperatives with deteriorating pools of high-cost groups.[5] (PacAdvantage, the successor to the California HIPC, tried to address this problem in its final years by charging higher premiums to high-risk groups, as its outside competitors did. However, this measure was taken too late to prevent the pool from collapsing.)[6]

Massachusetts Connector

The Massachusetts Health Insurance Connector Authority was established as part of the state's sweeping 2006 health reform law, which included a mandate that nearly all individuals obtain health insurance coverage and that employers with 11 or more workers provide coverage or pay an assessment to the state. The Connector operates two separate insurance exchanges.

Commonwealth Care (CommCare) is a subsidized program offering for people with incomes below 300 percent of the federal poverty level (FPL)who do not have access to employer-sponsored coverage. Participants are assigned to a coverage level based on income. Those with incomes below 100 percent of the FPL have copayments only for prescription drugs and receive a dental benefit. Higher-income enrollees have copayments for all services, rising with income, and no dental coverage. Premium contributions are required for enrollees with incomes above 150 percent of the FPL. Within each coverage category, enrollees have a choice among four different carriers. Except for the lowest-income group, enrollees choosing a more costly carrier

pay half of the difference between their carrier's premium and that of the lowest-cost carrier. In its first years, CommCare was required to contract with the four organizations already serving the Medicaid (MassHealth) population. This gave the program limited bargaining power.[7] For the year beginning July 2009, the program has been opened to additional bidders, and bidding has been more competitive. Although premiums rose 9.4 percent between 2008 and 2009, those for the coming year have actually dropped slightly, and a fifth plan will be participating.[8]

Commonwealth Choice is an unsubsidized program offering a choice of six carriers and three benefit levels, plus special limited coverage plans for young adults, to people with incomes above 300 percent of the FPL

Commonwealth Choice (CommChoice) is an unsubsidized program offering a choice of six carriers and three benefit levels, Gold, Silver, and Bronze (plus special limited coverage plans for young adults), to people with incomes above the CommCare level. The three benefit levels are defined in terms of approximate actuarial value. Available plans within a level may have different specific benefits—some have a deductible, while others charge only copayments—and more or less restrictive provider networks.

Although people eligible for CommCare must enroll through the Connector, higher-income people can choose to enroll through CommChoice or buy non-exchange coverage on their own. The carriers who offer plans through the Connector offer the same plans at the same premium rates outside the Connector.[9] (They may also offer different benefit designs to non-Connector enrollees, and some other carriers sell individual and small-group coverage entirely outside the Connector.) Although the Connector functions more as a clearinghouse than as a purchaser, its authority to confer a seal of approval gives it some leverage in negotiating premiums and benefits. For the year beginning July 2008, average premium increases were 5.1 percent. (In comparison, large employers nationally reported an average increase of 6.0 percent for 2008.)[10]

Public Employer Plans

Large-employer group health plans frequently offer participants a choice from among multiple competing plans and perform many of the negotiating and coordinating functions envisioned for an ex-

change. In particular, two plans operated by public employers have often been suggested as models for a competitive system.

Federal Employees Health Benefits Program (FEHBP) — The FEHBP, administered by the federal Office of Personnel Management (OPM), may be the most widely cited example of an exchange-like system. Outside of Medicare, the FEHBP is the largest single purchaser of health insurance benefits in the United States, covering over 8 million federal employees, annuitants, and dependents.

FEHBP participants choose from among four different types of organizations: a Blue Cross/Blue Shield PPO plan, PPOs offered by employee organizations, HMOs, and high-deductible or consumer-directed health plans, which provide coverage in conjunction with a spending or savings account. (Many of these organizations offer two benefit levels, such as a "standard" and a "basic" plan.) Most of the PPOs operate nationally, while HMOs and the consumer-directed plans serve insurer-defined service areas. Each plan defines its own benefit package, subject to negotiation with OPM; OPM has not prescribed a minimum benefit package.

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Premium rates are set in two ways. The PPOs and some HMOs are experience-rated; premiums reflect actual expected costs for FEHBP enrollees, with a small profit allowance. Most HMOs are community-rated; they charge the FEHBP the same rates as other similar-sized large groups, with adjustments for population differences. For both employees and annuitants, the program makes a fixed contribution to plan premiums. This is set at the lesser of (i) 72 percent of the average premium for all plans, weighted by enrollment, or (ii) 75 percent of the premium.[11] Participants pay the remainder through payroll or annuity deduction. OPM sets aside 3 percent of all premium amounts paid to establish plan-specific reserve funds. These can be used in later years to cover losses, prevent sharp premium increases, or avoid benefit cuts. OPM negotiates premiums to some extent. It can question the actuarial assumptions used by a plan in developing its rate proposal, can ask for benefit changes to limit premium growth, and can agree with the plan on the extent to which the reserve funds will be built up or drawn down during the year.

OPM spent $27 million, less than one-tenth of 1 percent of total FEHBP spending, to administer the program in 2007.[12] However, OPM only negotiates and oversees carrier contracts and directly processes enrollment transactions for federal annuitants. The other functions of a large employer, such as processing new enrollments and enrollment changes and collecting and transmitting employee and employer premium contributions, are performed by the employing agencies. Costs for personnel operations are included in each agency's budget.[13] In addition to direct OPM and agency expenses, administrative costs for each participating carrier (such as for claims processing and care management) are included in that carrier's premiums. OPM estimated in 2003 that Blue Cross and the other national plans spent about 7 percent of premiums on administration.[14] This is slightly lower than the 8.6 percent administrative costs as a percent of premium equivalents reported by Blue Cross plans serving self-insured employers in 2006.[15] Administrative costs for the FEHBP HMOs are not publicly available but are likely to vary widely.

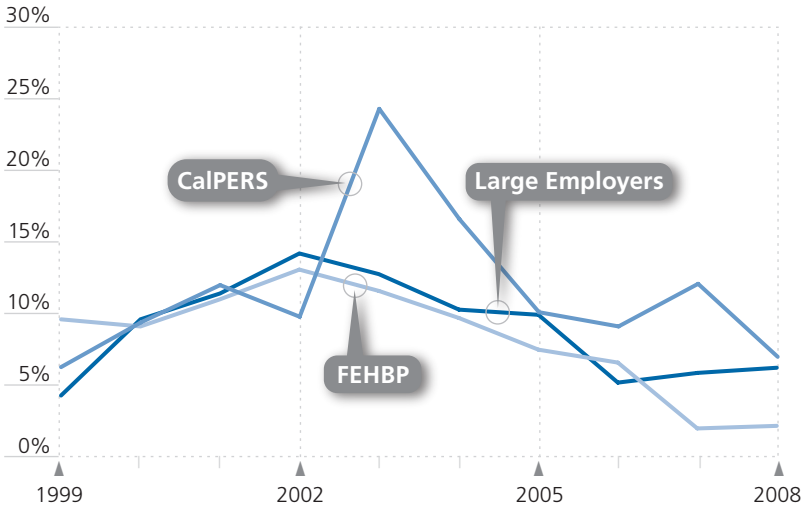
California Public Employees' Retirement System (CalPERS) — CalPERS is another commonly cited model of an exchange-like system. It administers health benefits for 1.3 million workers and retirees, including state employees and those of 1,100 local agencies that have chosen to participate.[16] CalPERS offers a choice among several contracting HMOs, all offering standard benefits, and two self-insured PPO options. An independent board negotiates benefits and premium rates. (The State of Wisconsin Group Health Insurance Program operates in much the same way, negotiating premiums with multiple plans for a standardized package and providing optional coverage to local governments.)[17]

CalPERS administers health benefits for 1.3 million workers and retirees.

An important difference between the FEHBP and CalPERS is that the FEHBP serves only a "captive" population. Participants are unlikely to seek coverage in the outside market, because they would have to forgo the government premium contribution. CalPERS, on the other hand, faces some degree of competition, because local governments can choose to use CalPERS or find coverage in the group market. (One result is that CalPERS has been compelled to negotiate separate premium rates for different regions, because uniform statewide rates were noncompetitive in some areas, and groups were drifting away.)

Like other large-employer plans, the FEHBP and CalPERS experienced high premium growth in the early years of this decade and

FIGURE 1: Annual Percent Growth in Premiums for FEHBP, CalPERS, and Large Employers (200+ workers)**, 1999–2008**



Note: CalPERS figures are for active workers only. FEHBP figures include annuitants, as may some of the figures reported by large employers in the Kaiser/HRET surveys.

Source: For FEHBP and CalPERS, 1999-2007: U.S. Government Accountability Office (GAO), Federal Employees Health Benefits Program: Premiums Continue to Rise, but Rate of Growth Has Recently Slowed, GAO-07-873T, Washington, DC, May 2007; For FEHBP, 2008: Office of Personnel Management, "OPM Holds Average FEHB Premium Increase to about Two Percent for Second Year," press release, September, 13, 2007; For CalPERS, 2008: Facts at a Glance: Health, 2008; For large employers: Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), Employer Health Benefits: Annual Survey, 1999–2008.

slower growth more recently. As Figure 1 shows, the FEHBP has done slightly better than other large employers. During the ten years from 1999 to 2008, FEHBP average premiums rose 8.0 percent per year; those of other large employers, 8.7 percent. The comparison for some years may be slightly misleading, because OPM has periodically drawn on reserve funds to hold down premium increases. CalPERS had a spike in premiums early in this decade and responded by increasing cost-sharing and dropping some high-priced plans.[18] If the 24 percent increase in 2003 were omitted, CalPERS average increases over the ten years would be about the same as for other large employers.

One factor in recent FEHBP experience is worth noting in the context of the exchange concept. FEHBP enrollees have been moving from more costly to less costly plans. If all FEHBP enrollees in 2002 had stayed in the same plan through 2007, premium increases over the five-year period would have averaged 8.9 percent a year. Enrollee shifts reduced this figure to 7.7 percent a year, suggesting that plan competition in a structured arrangement can make some difference.[19] Whether the shift has been to more efficient plans or to plans with less extensive benefits is unclear. However, analysis by the Government Accountability Office indicates that, for enrollees staying within the same plans, benefit reductions have reduced premium growth.[20] Similar trends have also occurred in other large-employer plans.

Medicare Advantage

Under the Medicare Advantage (MA) program, Medicare beneficiaries may choose between original Medicare (the basic fee-for-service program) and various types of private plans, including HMOs,

PPOs, and private fee-for-service plans. Nearly 10 million beneficiaries—over one-fifth of the Medicare population—were enrolled in MA plans as of November 2008.[21] MA plans usually provide better benefits than the original Medicare program at a lower cost to beneficiaries than other sources of supplemental coverage, such as the individual Medigap policies sold by private insurers. However, many plans are able to finance these extra benefits only because Medicare is paying them much more than it would have spent to cover the same beneficiaries on a fee-for-service basis. Because of the payment issues, discussions of competitive models rarely allude to the MA program. Still, some features of the program's operations may shed light on design decisions for exchange programs.

DESIGN ISSUES

Different health reform proposals call for an exchange operating at the state, regional, or national level. Some would have the exchange operated directly by a government agency, such as OPM at the federal level or some state agency, while others contemplate some independent organization that might possibly receive public funding but be insulated to some extent from the political process. These choices are key to designing an exchange and will be considered at the end of this section. Regardless of an exchange's geographic scope or organizational structure, however, some basic issues would need to be addressed.

Eligibility

An exchange could be open to all individuals, to all small-employer groups, and/or to specific populations, such as self-employed individuals or early retirees. All of the HIPCs were designed to serve small employers. In contrast, the Massachusetts Connector enrolls individuals, although some may pay their premiums with pretax dollars set aside by their employers through a section 125, "cafeteria plan" arrangement. (The Connector now has a pilot program under which small employers may contract with the Connector directly.)

Perhaps the key issue in setting eligibility rules is the extent to which the exchange would replace or compete with existing sources of coverage. Under some proposals, the exchange is intended to be the main route to coverage for its target population. This approach

would maximize the exchange's ability to negotiate premiums, structure the market, and influence the performance of the health care system. More commonly, proponents of an exchange assume that it would operate within the existing market. So, for example, an exchange offering a choice of insurance plans to individuals would compete with non-exchange plans selling coverage to the same target population.

An exchange operating in this way would need to balance two different concerns. On the one hand, it would need to attract a large and diverse population to encourage insurer participation and to avoid becoming the coverage source of last resort, serving only people who could not find coverage on more favorable terms elsewhere. On the other hand, if the exchange were to prove highly competitive because of lower administrative costs or other advantages, there might be calls to narrow its target population in order to minimize disruption of the existing market or to prevent the exchange from gaining too much market power.

There are a number of options for restricting access to an exchange. An exchange serving individuals could be closed to people who have access to an employer group plan. This would require some way of verifying current or past coverage or access to coverage. Another way of narrowing enrollment would be to make the exchange available only to people who qualified for a tax credit or other subsidy. This would minimize disruption of the private nongroup market, because current buyers of nongroup coverage tend to have higher incomes than the uninsured and would be less likely to qualify for subsidies.[22] Although this approach would be satisfying to nongroup carriers, it could also mean that higher-income people with health problems, who might have difficulty obtaining nongroup coverage today, might still be left without access to coverage.

Most proposals for an exchange serving employers have some upper limit on firm size, such as 50 or 100 workers. One reason is a perception that larger groups have no difficulty obtaining coverage in the existing market. But there is another possible reason for excluding them: large-employer groups tend to pay lower premiums than small groups for comparable coverage, because of smaller administrative costs. It is uncertain that an exchange could reduce these costs enough to be attractive to most large employers. If not, the only large employers that would seek coverage through the exchange

might tend to be those with higher-cost enrollees, thereby driving up average costs for the whole pool.

Competition with Carriers Outside the Exchange

Nongroup insurers in most states are allowed to refuse coverage to high-risk individuals, limit coverage for any "preexisting condition" the purchaser has at the time coverage takes effect, and charge higher premium rates to older purchasers or those with a history of high costs or medical problems. Federal law prohibits small-group insurers from excluding any firm or employee within a firm but leaves rate regulation to states; many states allow higher rates for high-risk groups. (For a fuller discussion of this issue, see the NHPF background paper, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform"; available at www.nhpf.org/library/background-papers/BP_Underwriting_04-13-05.pdf.)

Most proposals for an exchange would require participating insurers to accept every applicant in the target population and would limit the insurer's ability to vary premium rates according to health risk. These provisions are hardly avoidable, given that a fundamental rationale for an exchange is to make insurance available to people who are having trouble finding it. However, requiring exchange plans to operate under these restrictions would place them at a huge disadvantage if non-exchange plans could continue to operate under current state rules. They could refuse high-risk applicants and offer better rates than the exchange plans for low-risk ones. In time, the exchange could fall into a "death spiral," serving a dwindling pool of high-risk enrollees with very high premium rates.

Many proposals would avoid this problem by requiring non-exchange plans to conform to the same rules that govern plans within the exchange. If the exchange plans were required to guarantee issue and faced strict limits on rate variation, so would the non-exchange plans. Although this would largely solve the selection concern, the rules that might be applied to nongroup insurers are still being debated. The insurance industry, for example, contends that guaranteed issue would be workable only if it were accompanied by an individual mandate to buy coverage, an issue on which a consensus has not yet been reached. For this reason, it may be worth examining other approaches to the problem of selection in an unregulated market.

Allow exchange plans to adopt some restrictions — At a minimum, the plans could be made available only during a limited annual open enrollment period. This restriction would prevent people from waiting until they were sick to seek coverage. (An individual mandate, a requirement that every person obtain insurance, would also prevent this delay but would not protect the exchange from drawing a disproportionate number of costly applicants.) The plans could also be allowed to adopt preexisting condition exclusions or to vary rates to some limited extent by health risk. In effect, the exchange would protect itself by mimicking the existing market, at the price of defeating one of its own main objectives. Many of the state-level HIPCs for small employers eventually found themselves forced to take this route. The Cleveland COSE, which serves both small firms with two or more employees and self-employed "groups of one," follows the state's small-group rules for the two-or-more class but follows the individual market rules for the groups of one, using underwriting to screen out high-risk applicants. An intermediate option would be to allow plans to start out operating under the current rules in their area and then gradually transition toward open enrollment and more uniform rating. This might allow exchange plans to develop a base of healthy enrollees and hope to retain them (perhaps simply by inertia) as a mix of sicker enrollees began to join.

Allow subsidies to be used only for exchange coverage — Some proposals would allow a tax credit or other subsidy to be applied only to premiums for a plan within the exchange.[23] This is the model for the CommCare segment of the Massachusetts Connector. By reducing premiums for exchange plans, a restrictive subsidy could offset the price effects of adverse selection and help the plans compete with non-exchange coverage. Of course, this option would be unappealing to non-exchange carriers. Moreover, it could undercut the claim, in many exchange proposals, that everyone would be free to keep his or her existing coverage.

Require non-exchange insurers to compensate exchange plans for accepting excess risk — Aside from any premium subsidy, funds could be channeled to exchange plans in several ways to help compensate them for accepting high-risk applicants. One might follow the approach used in some states to fund their high-risk pools for the medically uninsurable: non-exchange insurers who turned away sick applicants could be assessed to help cover the costs of including these applicants in an exchange plan. A more elaborate system would be

to adopt a risk-adjustment scheme that shifted revenues among both exchange and non-exchange plans, based on some measure of the health status or expected need of their enrolled populations.

Any of these options involves striking a difficult balance between helping the exchange plans compete with the non-exchange market and giving them so great an advantage that non-exchange carriers might disappear from the target market segment. This basic issue is considered at the conclusion of this paper.

Insurer Participation

An exchange would need to attract enough insurers to offer participants a meaningful choice among plans. If it succeeded in this goal, it might face the reverse problem: too many plans seeking entry. A proliferation of options could be confusing to consumers, complicate exchange administration, and reduce opportunities to leverage plan purchasing power and economies of scale.

Assuring an adequate choice of plans — At a minimum, an exchange would need to address the potential for adverse selection. Even so, some insurers might be hesitant to participate, because they would be entering a new market presenting uncertain risks. One solution might be some form of transitional risk-sharing. Under the Massachusetts CommCare program, the Connector shares half the losses if a plan's costs are more than 5 percent above its premium revenues; the Connector shares in profits if the plan's costs are less than 95 percent of revenues. (The Medicare Part D prescription drug program has a similar risk-sharing arrangement.) Only one of the four plans had losses large enough to trigger the risk-sharing in 2007.[24] CommCare also has an individual stop-loss system; plans pay 1.25 percent of premiums into a pool and are compensated when costs for any individual member exceed $150,000.

Even if plans' concerns about financial risk were addressed, some observers contend that plans already operating in the small-group or individual market might have little incentive to offer coverage through an exchange. Why would insurers help an exchange meet its enrollment goals if the result would be to give the exchange greater bargaining power? In addition, insurers might not necessarily prefer head-to-head price competition on a standardized benefit.[25] Insurers' calculations about the benefits of joining an exchange

might differ if the exchange had a captive population that could not be reached in any other way or if the exchange were a widely publicized component of a comprehensive health reform program, as was the case in Massachusetts.

If an exchange sought to serve a broad area, such as a whole region or even the entire nation, it would face the further problem of assuring adequate choice in rural or other underserved areas. (Even in Massachusetts, only two of the six CommChoice insurers are available statewide.) Although the FEHBP makes multiple choices available throughout the country, it can do so only because of the nationwide Blue Cross Blue Shield and employee association PPOs. In 2008, eight states had only one HMO competing with the PPO plans, and one state (Wyoming) had no HMO at all.[26] Participants everywhere do have a choice among at least Blue Cross and the four national association plans, some of which have different optional benefit levels. However, because all these plans are PPOs that impose penalties for use of out-of-network care, this choice may not be meaningful in a given geographic area unless all of the available plans have adequate provider networks there. As might be expected, Blue Cross has the most comprehensive network. The other national plans develop their own networks or contract with existing networks (for example, CIGNA). Especially in isolated areas, the number and accessibility of participating providers can vary considerably among plans.

If an exchange sought to serve a broad area, such as a whole region or even the entire nation, it would face the problem of assuring adequate choice in rural or other underserved areas.

Some proposals would include a publicly administered health plan as one of the options available under the exchange. (In some proposals that include both concepts, it is unclear whether the proposed public plan would operate within or in competition with the exchange.) A full discussion of the public plan option, which has emerged as one of the most contentious issues in the health reform debate, is beyond the scope of this paper. One concern is that including a public plan would discourage participation by private plans—which must, however efficient they are, make some profit—and that the exchange could then devolve into a public program. But some people contend that a public alternative could serve as a useful benchmark to encourage greater efficiencies by private carriers.[27]

Limiting participation — If an exchange were the principal avenue to coverage for a substantial population, it might wish to limit the

number of participating carriers. The FEHBP, while it is open to any HMO that wishes to participate and meets specified standards, is closed to any new PPO plan; only Blue Cross and the employee associations may offer these plans. At the other extreme, Medicare Advantage must contract with any new entrant that meets regulatory requirements. As a result, beneficiaries in Miami were expected to choose from among 107 different health plan options offered by 35 different contractors as of May 2009.

A middle option is to allow the exchange to select plans through some form of competitive bidding or negotiation. CalPERS has in the past dropped plans that failed to hold their premium increases to target levels.[28] The Massachusetts CommChoice program issued a request for proposals for its initial year of coverage; ten carriers responded, and six were approved, using an elaborate scoring system to grade the proposals. Criteria included premium and cost-sharing levels; desired "features," such as wellness programs or a high-performance network; marketing strategy; and broad geographic coverage.[29] A system of this kind may necessarily involve some degree of subjective evaluation by exchange staff. This subjectivity might be more acceptable for a program like CommChoice, which serves a very small market segment, than it would be for an exchange expected to serve a large population. A larger program might be obliged to develop a more rigid system, using only cost or other objective measures, possibly at the price of discouraging innovation and accelerating the current trend toward consolidation in the health insurance industry. (Paradoxically, a decision by the exchange to limit the number of competing plans could give each of the plans greater negotiating power.)

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Benefit Packages

An exchange could allow participating insurers to offer any benefit package they chose. It could set some minimum benefit standards but allow insurers to offer more comprehensive plans, or it could require all insurers to offer the same standardized plan. (An alternative to full standardization would be to allow insurers to offer "actuarially equivalent" benefits, that is, different benefit packages shown to be of equal value to a typical member of the target population.)

The FEHBP is at one extreme, with no prescribed minimum benefit package.[30] OPM from time to time specifies particular benefit changes it wants from all plans, for example, mental health parity or added preventive services. It also has a strong review process for benefit proposals and has moved, since the 1980s, to eliminate a few plans with substandard coverage and to narrow differences among the remaining plans. Still, plans develop their own benefit packages; they may impose different levels of cost-sharing, have different annual out-of-pocket limits, and differ in the extent of their coverage of ancillary services such as prescription drugs and dental and vision care. This amount of variation may make it difficult for participants to compare plan values. In addition, it has been alleged in the past that some plans manipulated their benefits to attract low-risk enrollees or discourage high-risk enrollees. Similar opportunities might exist in an exchange if benefits were not standardized.

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The Medicare Advantage program has a specified minimum, the benefits under original Medicare, but allows plans to design their own supplemental benefits. These benefits must have a minimum actuarial value (set for each plan as part of the bidding and rate-setting process), and the Centers for Medicare and Medicaid Services (CMS) may reject benefit designs likely to result in risk selection. Still, the benefit choices can be very complex, especially in areas served by a large number of plans.

The Massachusetts Connector offers three different levels of benefits; within a given level, competing plans have different specific features but roughly the same actuarial value. Similarly, President Clinton's 1993 health care proposal would have had a standardized benefit package to be offered by all insurers participating in the proposed health alliances; consumers would have been allowed to select from among three different possible levels of cost sharing. However, insurers would also have been permitted to offer separate supplemental plans, covering excluded services such as cosmetic surgery or paying some of the enrollees' cost sharing, so long as the plans were offered uniformly to all enrollees in the basic coverage.

Whatever the basic benefit standard (or set of standards), there is also the question of whether carriers could offer more comprehensive plans. In the classic managed competition model, all insurers offer the same package. This approach allows consumers to make easy

price comparisons, without having to guess about how well different plans would protect them under different possible scenarios of their future needs. It also reduces the likelihood that healthier people will be attracted to certain plans, for example, because they are willing to accept a higher deductible than people with greater expected costs. On the other hand, many proponents of competition among insurers believe that people should have the option of picking the package that best suits their own needs and preferences. One option is to require plans to quote a premium for the basic coverage and a separate premium for any additional benefits, the approach proposed in the 1993 Clinton plan.[31] Some people have suggested that a considerable number of different plans might be acceptable, so long as variation was on a limited number of clear parameters (such as deductible and percentage rate for coinsurance) and the plans had no "fine print" differences consumers would have difficulty in evaluating.[32]

Finally, as in the case of guaranteed issue and rating restrictions, there is the question of whether plans operating outside the exchange should be subject to the same benefit rules as exchange plans. If not, the possibility exists that non-exchange plans would offer benefit packages designed to appeal to healthier applicants. Although uniform benefit requirements could prevent this tactic, some people would object to this further restriction on consumer choice.

Risk Adjustment

In addition to the general problem of exchange plans attracting high-risk applicants is the likelihood that plans within the exchange will have different risk profiles. Price competition among plans can be distorted if healthier or lower-cost participants are in some plans and sicker, higher-cost participants are in others. Plan premium differences may then reflect, not the plans' relative efficiency, but rather the characteristics of their enrolled populations.

The problem of "biased selection" has arisen in both public and private arrangements that offer a choice among health plans. Several studies of the FEHBP in the 1980s, including one by the Congressional Research Service, found evidence of selection problems and consequent distortions of premium competition.[33] Some more recent studies found little evidence of biased selection among active workers.[34] At a minimum, however, it is clear that the FEHBP practice of using a uniform premium for active workers and annuitants makes the plans

with a higher proportion of annuitants more costly than other plans, regardless of relative efficiency.

Medicare has had a similar problem. Enrollees in Medicare Advantage plans are healthier than beneficiaries remaining in original Medicare; within the MA program, those choosing private fee-for-service plans are healthier than those choosing HMOs.[35] Medicare has responded by using a risk-adjustment system. Enrollee characteristics that may predict future costs and utilization are compared across plans, and the program then pays the plans with low-risk populations less than those with high-risk populations. The adjustments are invisible to consumers: the rates they see when making plan choices are rates for a "typical" participant. This minimizes the need for plans with high-risk populations to charge higher premiums. Medicaid managed care programs and a few employer group purchasing programs, such as the California HIPC and Minnesota's Buyers Health Care Action Group, have also adopted some form of risk adjustment.

The more complex risk-adjustment systems use extensive patient-specific information, accepting the trade-off between precision and the cost of collecting data.

Some risk-adjustment systems are fairly primitive; for example, they may use only the age and sex of enrollees, although there can be considerable cost variation within an age or sex class. More sophisticated systems, like the one developed for Medicare Advantage plans, use data on enrollees' past diagnoses or conditions and/or their utilization of specific services, such as prescription drugs. Because people's conditions and need for services change over time, none of these systems can perfectly measure the level of risk presented by different plans' populations. They may serve their purpose if they discourage plans from seeking to enroll low-risk populations (for example, by manipulating their benefit packages or using targeted marketing) and if they work well enough to prevent ongoing major distortions in pricing.

The more complex systems use extensive patient-specific information, accepting the trade-off between precision and the cost of collecting data. In addition to the added cost, a system requiring data on past diagnoses and utilization would not be workable in the early years of a new exchange—and might never be workable if participants tended to shift in and out of the exchange system. It is possible to develop retrospective risk adjustment, under which data on enrollees are collected

during each year and the plans are compensated at the end of the year if they turn out to have enrolled a high-risk population. However, this approach could make it very difficult for carriers to make financial plans and might limit exchange participation to those with more substantial capital reserves.

If exchange plans were in competition with plans operating outside the exchange, it might seem logical to extend risk adjustment to all plans in or out of the exchange that served a given population. This would require that all plans supply data. In addition, some degree of benefit standardization would be needed, because it would be difficult to design a risk-adjustment system for plans with different benefit packages. Once non-exchange plans had been subjected to the degree of regulation needed to make risk adjustment work, it is not clear why they would find it beneficial to remain outside the exchange.

Geographic Scope

The various prototypes for an exchange have operated in a single metropolitan area (Cleveland's COSE), across an entire state (the Massachusetts Connector and CalPERS), and nationally (FEHBP). Most current discussion focuses on either a state-level or national exchange. Each has possible advantages. State-level exchanges might be better equipped to deal with local differences in the health insurance marketplace or health delivery systems. A national exchange might benefit from some economies of scale and could also have greater bargaining power. In addition, it might promote greater continuity of coverage, because people who moved to a new state would not have to change exchanges (although they might have to change insurance plans within the exchange.)

A national exchange would need to address at least two major issues. The first relates to benefits. Every state has laws requiring health insurers to cover specific types of health services (for example, mental health care or contraceptives), to pay for services rendered by specific providers (such as chiropractors), and/or to include certain individuals (such as adopted children) in family coverage. These laws apply only to policies sold by licensed insurers. (Employers who choose to self insure—that is, to cover their workers' expenses directly, instead of buying an insurance policy—are exempt from state mandates under the Employee Retirement Income Security Act of 1974, or ERISA).

If insurers participating in a national exchange were required to comply with state mandates, the exchange would not be able to establish a uniform benefit package, and administration would be complicated. To avoid this problem, the authorizing law for the FEHBP exempts contracts for coverage of federal employees from state benefit rules.[36] A law authorizing a national exchange could create a similar exemption, subjecting participating insurers only to whatever benefit requirements were adopted by the exchange. However, state mandates often are enacted in response to pressure from provider organization or patient advocacy groups. Preemption might merely shift the locus of lobbying efforts from state legislatures to the exchange administrators or to Congress.

A national exchange could allow all plans, whether national or local, to set prices locally.

A second key issue for a national exchange would be pricing. What is the fairest way of accounting for regional variations in health spending? Under the FEHBP, the national plans charge one rate nationwide, while the HMOs charge rates that reflect local prices. The Blue Cross standard plan is more expensive than the three HMOs available in Atlanta; it is less expensive than any HMO available in New Jersey. In the FEHBP context, the potential for distortion in competition is reduced because enrollees receive a government contribution: the differences in the net premiums paid by enrollees for different plans are not as large as the gross premium differences. The same might be true for exchange participants receiving some form of premium subsidy. But participants with incomes too high for the subsidy would see the full premium difference. Moreover, the potential distortion in competition among plans within an exchange could be exacerbated if the exchange plans were competing with non-exchange plans that were all locally priced. CalPERS faced this problem, because local governments could buy coverage either through the program or in the outside market. Statewide CalPERS premiums were uncompetitive in southern California, and the program was forced to adopt regional pricing.

Similarly, a national exchange could allow all plans, whether national or local, to set prices locally. While this might seem fairer, it could also create a hardship for people in high-cost areas who were eligible for a low-income premium subsidy. The subsidy might be enough to buy generous coverage in some areas and not others. One solution, adopted under the low-income subsidy component of the Medicare Part D prescription drug program, is to provide different maximum subsidies in different areas, based on local premium levels.

Governance

An exchange could be a government agency, an entirely independent private organization, or some form of mixed public-private entity. At one extreme, the FEHBP is operated by an ordinary executive branch agency, the OPM. Other exchange-like programs, such as Cleveland's COSE and the Connecticut CBIA program, are wholly private. Some HIPCs are private but operate under special state authorization legislation that may waive some rules, such as mandated benefit laws, or may allow insurers to contract with a small-employer exchange on terms different from those they offer to other small groups. These laws may create one exchange or allow for multiple competing exchanges; in Texas, for example, 57 group purchasing cooperatives and coalitions were certified by the state as of March 2008.[37]

An exchange could be a government agency, an entirely independent private organization, or some form of mixed public-private entity.

Other exchanges or similar programs fall somewhere between public and private status. In Massachusetts, the Connector Authority is an "independent public entity" with a ten-member board, of whom four are state officials and the rest are appointed by the governor or attorney general.[38] The CalPERS Board has a similar mix of public officials and appointed members, plus some members who are elected by CalPERS enrollees.[39] A mixed public-private authority can be structured in many ways. At the federal level are boards and administrations with varying degrees of autonomy from executive oversight, government corporations such as Amtrak, and government-sponsored enterprises such as the Corporation for Public Broadcasting.

There is no firm typology of government organizations, nor can they be arranged along a single continuum with poles labeled public and private. Instead, organizations vary along multiple dimensions of flexibility or autonomy, each potentially important in the design of an exchange. A number of questions could be asked in order to explore these dimensions:

- Does an organization have to comply with general rules for government agencies, such as civil service laws or standard procurement procedures?

Some people would suggest that personnel rules could prevent an exchange from rapidly building a skilled staff, while strict contracting procedures might limit its ability to negotiate with insurers. However valid these concerns, it is common for government agencies to

be exempted from specific requirements. For example, various advisory bodies are subject to neither civil service nor procurement rules. Specific rules aside, one important difference between a public and private exchange might be that a public program would have to provide some degree of due process. A private exchange might admit or exclude health insurers more or less arbitrarily, while a public one must have uniform requirements applied objectively.

- To what extent is an organization subject to executive review or federal oversight?

Some of the functions that might be performed by an exchange, such as processing enrollment applications and collecting premiums, are more or less mechanical. Others might involve a greater degree of subjective judgment. An exchange might be called upon to specify a minimum benefit package. It might have to approve a risk-adjustment system that would redistribute revenues among insurers. In Massachusetts, the Connector decides how much families at different income levels can afford to pay for health insurance. (This decision in turn determines which families will be subject to the individual coverage mandate.)

It might be argued that an exchange would be better able to make difficult and potentially controversial decisions if it were independent and shielded as much as possible from the political process. Another possible viewpoint is that decisions of this kind, involving as they often do the distribution of financial burdens and rewards, are inherently political. Whether an exchange is public or private, it is going to have to find some way of balancing the competing interests of consumers, insurers, providers, and (if public premium subsidies are involved) taxpayers.

- Must an organization seek annual appropriations, or does it have its own dedicated funding stream?

Prototypes for an exchange, whether public or private, commonly meet their operating costs through an assessment on premiums. This is the case for both semi-independent organizations like the Massachusetts Connector and for government agencies like OPM and to some extent CMS, which funds beneficiary education programs through health plan user fees. An organization with dedicated funding may be less subject to detailed legislative oversight; a possible trade-off for this independence is that elected officials would be less engaged and less committed to the organization's success.

CONCLUSION

Many of the design issues that would need to be resolved in developing a health insurance exchange revolve around a central question: how would the exchange fit into the existing health insurance marketplace? In the 1993 Clinton plan, the local health alliances were intended to be the basic gateway to coverage for nearly all individuals and small-employer groups. Only larger-employer plans were to be allowed to operate outside the alliance structure. This was one of the basic reasons for the vehement opposition to the plan by the private insurance industry. Although some larger insurers that were already deeply invested in managed care believed that they could function within the proposed system, smaller insurers whose profits depended on skillful selection of healthy applicants would have been forced out of business.

Most of the current proposals instead contemplate an exchange that would compete side-by-side with non-exchange insurers. These insurers would be selling coverage to the same population, individual and/or small-group, targeted by the exchange. As was suggested earlier, if non-exchange insurers continued to offer coverage at favorable rates to the healthiest applicants (or manipulated benefit packages to attract these applicants), the exchange could degenerate into a high-risk pool, dependent on government subsidies to serve a small population of older and sicker clients. On the other hand, measures that might help protect the exchange by restricting the activities of non-exchange insurers could make it very difficult for those insurers to compete in the same market. Perhaps some could operate more efficiently or offer higher quality than the exchange plans, although there are also concerns that some would continue to find ways of attracting healthier enrollees.

What would it mean if an exchange were to wind up as the only game in town for the segment of the population it served? The basic premise of an exchange, that structured competition among insurance carriers can reduce costs, may require that the exchange contract with a limited number of carriers, so that each can have a large enough enrollment and sufficient market power to bring changes in the way health care is delivered and organized.

Provider groups would likely be concerned if an exchange were to accelerate the trend toward concentration in the insurance industry, strengthening a few insurers' bargaining power. On the other hand,

some people think that further consolidation might be desirable, if it reduced duplicative administrative systems and enhanced insurers' ability to pursue initiatives such as pay-for-performance or bundled payment systems, care coordination and wellness programs, large investments in health information technology, and development of integrated systems. Others suggest that an exchange could actually reduce consolidation, for example, by making it possible for new, community-based plans to compete on a more equal footing with established insurers.

An exchange serving a large share of the nonelderly population could emerge as a force for driving fundamental change in the way insurers operate and, in turn, the way health care is organized and delivered. If this occurs, however, it will be necessary to develop a governance structure that can maintain the flexibility to innovate while assuring accountability to the providers, insurers, and consumers the exchange would need to serve.

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