

Health Insurance Exchanges

ACTION NEEDED:

Congress needs to carefully weigh the pros and cons of any “exchange” proposal concerning access to health insurance.

INFORMATIONAL POINTS:

NAHU recognizes the need for greater opportunities to enroll individuals in health insurance coverage. In particular, the issue of individuals who are eligible for programs like Medicaid and CHIP but are not actually enrolling needs to be addressed. There is also the perception that uninsured individuals need a centralized place to access coverage options, connect with qualified professionals and make choices based on their individual needs and budgets.

If Congress does decide to create national standards for exchange(s), it is critical that these entities be structured in such a way so as to not damage or eliminate the traditional private insurance marketplace. If pools totally replace other private-market options, there may be no other vehicle for coverage if the pools fail.

Exchanges should be state-based to accommodate for the varying needs of our diverse population.

Exchanges should always include an option to contact a certified, state-licensed agent/broker for assistance. It should be specified that all individuals and entities selling through any exchange should be subject to existing state-licensure and continuing education requirements and all other applicable state-based regulations.

Agent and brokers who would like to participate in selling and servicing products through an exchange should be required to complete an annual exam-based certification process that addresses both private coverage options and public assistance and subsidy-eligible options to ensure that they are familiar with all coverage choices available to consumers. Trained advisors would help increase access and overall coverage rates by helping individuals determine what options were available and best suited to their individual needs.

Exchanges should be web-based “portals” rather than purchasing pools and/or regulatory bodies that also sells private coverage or offers a public program option.

While purchasing pools may provide more health plan options for individuals to choose from, history shows that they do not reduce health insurance costs. The most successful state purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable.

The portal model is the best way to provide consumers with easier access to coverage options without disrupting the existing private insurance market. The Web-based portal for home sales www.realtor.com, which presents property listing information in a standardized format but also connects a potential homebuyer with the state-licensed property listing agent, is a good example of how this could work. Private companies compete and list homes for sale in one place, in a standardized format. But Realtor.com does not regulate the types of properties that can be listed, nor does it regulate the prices that sellers charge consumers.

The real estate market is also a good example of how multiple, competing portals can be used to serve consumers. While Realtor.com is a nationwide service, it does not preclude individual and regional realty companies like Weichert and Coldwell Banker from operating their own portals to assist homebuyers.

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Another structural issue Congress will need to address is how exchanges will mesh with existing and varying state coverage rules and consumer protections. Plan rating rules and other requirements should mirror state laws outside the exchanges, otherwise adverse selection will be rampant. National experience with purchasing pools of all kinds shows that pools that operate at the state-level that also fairly compete with plans outside the pool are the least disruptive to the market.

Under no circumstances should rating laws be different inside the exchange or outside the exchange, as any difference between the marketplaces will cause selection against the exchange. National purchasing pool experience shows that when the playing field is unlevel adverse selection occurs and plans drop out of the pool. So far, risk adjusters have been inadequate to combat this problem.

Greater stability will be realized by not mixing market types (i.e., not combining individuals purchasing coverage independently with small businesses or other group coverage). State laws differ significantly between the group and individual markets and, actuarially, these segments are quite different. Combining them would cause adverse selection to the exchange.

Although including the self-employed in an exchange is an attractive idea, it should be done cautiously as it can cause the same problems as combining individual and small-employer markets. If both small groups and the self-employed are eligible for participation, extra restrictions should be made on the self-employed to control entry into the pool and to ensure the existence of a business.

One function of the Massachusetts connector is to administer the state's subsidized coverage program, Commonwealth Care. If exchanges are utilized as a means of national subsidy administration, such subsidies should be broad-based and available to eligible individuals and businesses both in and outside the connector, as is allowed in Massachusetts.

If subsidies are available only inside the exchange, crowd-out from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the pool can also result in higher-than-expected costs for those in the pool and an apparent larger number of uninsured than actually exist.

Depending how exchanges are structured, there may be legal issues too. Under the Massachusetts connector model, all policies are individual policies, regardless of whether they are sold to individuals independently or they are purchased through a small employer. Thus, they could cause individuals who currently have traditional group coverage to lose existing federal consumer protections that were established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and only apply to traditional small-group policies.

Depending on structure, we also see potential conflicts with the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Budget Reconciliation Act of 1985 (COBRA). Like HIPAA, these laws serve essential functions to protect consumers, and NAHU does not want to see these protections diminished.