

Small Business Prescription for National Healthcare Reform

Design of a Health Insurance Exchange

Many experts and advocacy groups have proposed a health insurance exchange—also known as a “connector,” “insurance pool” or “gateway”—as an important element of comprehensive reform. A health insurance exchange is usually defined as a managed marketplace in which individuals and employees of small businesses can choose among a variety of health plans. Small Business Majority supports the inclusion of a well-designed health insurance exchange in comprehensive healthcare reform legislation as an important means of improving the availability and affordability of health insurance for small businesses and the self-employed.

What problems would a health insurance exchange address?

An insurance exchange is intended to address many of the problems that individuals and small businesses face in the current health insurance market, in particular:

- **Costs.** The smallest businesses pay, on average, 18% more than very large employers for similar health benefit plans.¹ This is due to (1) higher selling and administrative costs for insurers in the small group segment, (2) the lack of purchasing power of small businesses, and (3) the lack of consumer choice to drive price competition among insurers. According to a recent study, insurers’ administrative costs for individuals may be as high as 40.9% of claims costs, compared to 4.5% for very large groups. Similarly, the administrative costs for small groups (<50 employees) may range from 21.8% to 35.8%—much higher than for large groups.²
- **Choice.** In some parts of the US, small employers and sole proprietors have a limited choice of health plans due to dominant market positions of some insurers. In addition, health insurers usually don’t allow small employers to offer competing plans, due to high administrative costs and concerns about adverse selection; as a result, the employer is forced to accept a one-size-fits-all plan for her/his employees. The fact that the employees of these small businesses don’t have the opportunity to choose the health plan that is best for them reduces employee satisfaction and can make it difficult to hire and retain the best people. The lack of choice for employees also means that there is no effective competition among insurers at the consumer level in most small groups.
- **Convenience.** Small business owners are busy people, focused on making their business successful, and they don't have time to search out and negotiate for the best health insurance coverage for their employees. The costs of health benefits are so high, however, and the rates and coverage details are so confusing, that small businesses are forced to spend enormous amounts of time exploring options and administering their health plans. Time is money, and this burden is a real economic cost to small businesses.

¹ J. Gabel et al., Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down, *Health Affairs*, May/June 2006.

² Estimates by The Lewin Group for The Commonwealth Fund published in *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: Commonwealth Fund, Feb. 2009).

A well-designed exchange will:

- Reduce the extra premium paid by small businesses, and reduce the volatility (year-to-year changes) in health premiums, by pooling small business buying power and gaining economies of scale;
- Offer people choices of multiple insurers, providers and delivery systems, and—by allowing portability of health coverage—reduce employee recruitment barriers;
- Help people shop for insurance and make it easy for them to compare options by providing individuals and employees with clear and comparable information regarding insurers, provider networks and benefit plan options available to them;
- Greatly reduce the burden on small business owners of administering health benefits;
- Drive innovation and improvements in affordability, quality and customer service resulting from healthy competition among both insurers and providers.

In order for an exchange to be successful, it must also be financially sustainable over the long run. A particular problem that has plagued many exchanges in the past is **adverse selection**.³ If the exchange is not designed properly, there is a danger that the risk profile of the exchange participants is higher than that of the rest of the market, i.e., high-cost people are selectively enrolled in the exchange. As a result, the premiums charged in the exchange are higher than normal, which leads to a spiral of rising premiums as lower-cost people opt out of the exchange.⁴

A health insurance exchange in the context of comprehensive reform

The success of a health insurance exchange depends both on its design **and** the other elements of comprehensive reform. For the purposes of this paper, it is assumed that the following elements that have appeared in various Congressional proposals will be part of a comprehensive reform proposal:

- **Insurance reform**, including
 - Guaranteed availability of coverage (no medical screening)
 - No exclusion of coverage for preexisting health conditions
 - Health insurance rating rules that prohibit adjustments for health status or claims experience
- A requirement that **everyone have health insurance** for a minimum defined set of **affordable health benefits**—with a provision that financial assistance be offered to people who can't afford the cost of coverage
- **Tax equity for the self-employed** that allows the full deduction of health insurance premiums for the purposes of their income tax and self-employment tax
- **Financing based on the principle of shared responsibility**—potentially including an expectation that all employers offer or pay for health insurance, accompanied by any or all of the following: a sliding scale payment formula based on payroll or number of employees, a tax credit to help small businesses that can't afford to offer coverage, a phase-in period for startup companies, and an exemption for the very smallest businesses

³ Elliot K. Wicks, Mark A. Hall and Jack A. Meyer, *Barriers to Small-Group Purchasing Cooperatives*, Economic and Social Research Institute, March 2000.

⁴ Rick Curtis and Ed Neuschler, "What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs," Institute for Health Policy Solutions, Washington, DC, May 2009.

Proposed Design and Rationale

A variety of health insurance exchange designs could effectively address these problems, but the issues are very complex and the design elements must be carefully crafted for the exchange to create healthy competition in the insurance market and drive down costs.

- Small Business Majority believes the design should include the following elements:
1. The health insurance exchange should be **large**. This will enable it to provide help to more of the individuals and workers in small businesses who will benefit the most from an exchange. Other advantages of increasing the size of the exchange include:
 - A larger pool will **spread any fixed administrative costs** over a larger base, thereby reducing the cost for each participant.
 - A larger pool will **spread the risk more broadly**, provide more stability for the pool over time, and lessen the danger of an adverse risk spiral.
 - Participation by more categories (e.g., employees of small businesses as well as the self-employed) will also make it easier for people who move between categories, e.g., it will **make it “seamless” for workers** who leave a job and start their own business.
 - A larger exchange could have more **influence in the market**—especially if the exchange works closely with other large public and private employers to use consistent purchasing strategies.
 - A larger exchange will **attract insurers** who will see this segment as a good market opportunity and will develop competitive products.

Finding ways to achieve a large exchange, however, is a challenge. From one perspective, the idea of a purely voluntary system has considerable appeal; many think it would be preferable for individuals and small employers to choose whether or not to participate in an exchange. Voluntary participation, however, might not enable it to achieve a critical mass and achieve the objectives listed above. In addition, voluntary participation may create a problem of adverse selection. In order to achieve adequate size, others have advocated that all individuals and small employers should be required to use the exchange. This would ensure (1) sufficient size, (2) a balanced risk pool, and (3) that everyone in these segments is treated equally. Since there are significant problems with either of these approaches, some have suggested that only certain categories should be required to use the exchange, and financial incentives should be used to encourage use of the exchange by other categories.

Specific policy proposal:

- *The exchange will become the only option for individuals (non-employees) and employees of “micro-groups” (ten or fewer employees).*
- *For employees of other small groups (11-50), there will be a dual marketplace, i.e., these groups will have the option of purchasing through the exchange or outside.*

Note: In the long run, the exchange should also be available to larger groups (51+), but this will require changes in insurance regulations and/or other mechanisms to avoid the adverse selection problem.
- *Financial assistance (i.e., premium subsidies) will only be available for those who participate in the exchange.*

Note: Other potential incentives—e.g., allowing the use of small employer tax credits only for employers who choose to have their employees participate in the exchange, or allowing employees who work for employers with fewer than 50 employees to be able to exclude the value of their employer-paid health benefits from taxable income only if they

participate in the exchange—would not be necessary to achieve sufficient size of the exchange.

Note: The number and variety of insurers in small towns and rural areas may not be sufficient to offer adequate choice to participants in the exchange. Since many of the benefits of an exchange are the result of healthy competition among insurance plans, it may be necessary to introduce a public health plan option in certain areas. A public option should operate on a level playing field with the private plans; the public plan would not have the authority to set provider rates and would have no special advantages over private plans.

2. To ensure that the exchange is **financially sustainable** for the long run, it is important to avoid the problem of adverse selection, i.e., the risk profile of the exchange participants should not be higher than the rest of the market. This is essential in order to avoid the potential “death spiral” described above. In theory, this problem could be avoided if participation in the exchange were mandatory for everyone. Since this is probably unrealistic and would cause severe disruption—at least for groups above a certain size—any design that includes voluntary participation must include mechanisms to minimize the risk of an adverse selection spiral.

Specific policy proposal:

- *The same insurance regulations (e.g., guaranteed issue, rating, benefit design, etc.) will apply inside and outside the exchange.*
 - *Insurers must set their premiums based on the entire pool of the combined markets (inside and outside the exchange).*
 - *Insurers inside an exchange will be prohibited from advantaging their comparable non-exchange products in any way—e.g., through the use of different broker commissions, marketing, application processes, etc.*
 - *If an insurer participates in the small group markets outside of the exchange, it must also participate inside the exchange.*
 - *The employer must choose one option for the entire group, i.e., the employer may not send only selected employees to the exchange.*
 - *It also may be necessary to use a “risk equalization” mechanism between the two segments (within the exchange vs. outside of the exchange).*
3. Within the exchange, it is also necessary to **protect insurers from adverse selection**. In any insurance market, there is a danger that high-cost people will tend to be concentrated in a particular insurer’s plan, driving up premiums and creating an adverse selection spiral for that insurer.

Specific policy proposal:

- *A risk equalization mechanism will be established by the governing body to compensate insurers who enroll members with predicted costs that are higher than average. This will be financed by payments from insurers who enroll members with predicted costs that are lower than average.*
- *The governing body will define three or four standardized benefit plans to be offered to participants in the exchange. All insurers must offer all of these benefit plans within the exchange.*
- *Premiums must be based on the actuarial differences between the benefit plan options rather than the experience of the separate pools.*

- *Employees and their dependents may join the exchange or change benefit plans only during an annual open enrollment period or as a result of a qualifying event (e.g., birth of a child).*
4. The health insurance exchange should have a **strong role**. This will enable the exchange to exert its market power to drive innovation and improvements in affordability, quality and customer service resulting from healthy competition among both insurers and providers. Its role should not be limited to information and decision support (an “insurance mart”); it should also provide enrollment and administrative functions that will benefit individuals and small businesses. In addition, it should be an “active and prudent purchaser”—similar to the role played by many large employers—with the authority to determine which insurers will be offered, based on their ability to meet coverage and quality standards, and to negotiate with those insurers to ensure the lowest possible premiums for participants.

Specific policy proposal:

The exchange will have the responsibility and authority for the following functions:

- *Information and decision support*
 - *Create a central clearinghouse for information about health plan and insurance product choices.*
 - *Design decision support tools and provide transparent information on cost, quality and service to people who are purchasing health insurance.*
 - *Enrollment and administration*
 - *Manage enrollment process with efficient, user-friendly tools.*
 - *Offer customer services to enrollees, e.g., handling questions regarding coverage and complaints about insurers.*
 - *Determine eligibility for government financial assistance.*
 - *Provide a mechanism to collect and aggregate premium contributions from multiple sources (individual, employer(s), government subsidies).*
 - *Administer a risk equalization mechanism to protect insurers who enroll high-risk members.*
 - *Benchmarking and standards*
 - *Establish standardized or comparable benefits offered by insurers to clarify and simplify the consumer choice process and minimize risk selection.*
 - *Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes*

Note: All carriers that meet the benchmark standards may participate in the exchange.
5. The design of the exchange must also include elements that define the **structure, governance, financing and state role** in the administration of the exchange.

Specific policy proposal:

- *The structure for the exchange will be modeled on the Federal Employee Health Benefits Plan (FEHBP) and similar health benefit plans managed by large private employers. For each county or zip code in the US, the exchange will determine which qualified health insurance plans are available, based on their licensure, provider network and other standards. This information will be made available to participants in the exchange, thus creating virtual local exchanges.*

- *A national administrator operating under the authority of the secretary of the Department of Health & Human Services will oversee the exchange. States will have the option of managing state-level exchanges under common national rules.*
 - *An independent Health Insurance Exchange Board will be established to monitor the implementation of the program and to make recommendations to the national or state administrator concerning improvements in the program. The board will consist primarily of individuals and small employers, who are expected to be the primary participants in the exchange.*
 - *States will continue to have the responsibility and authority for licensure and oversight of insurance companies (e.g., financial solvency, marketing rules, consumer protections, etc.) operating within their boundaries.*
 - *State regulations regarding rating and benefits in the individual and small group markets will be superseded by new federal legislation.*
 - *The administrative costs of the exchange will be financed by a reasonable fee charged to insurers in the individual and small group markets. Startup expenses will be financed by the federal government.*
6. The **transition** to the new system and structure must be managed to minimize rate shocks and other disruptions. States currently have a wide variety of insurance regulations (rating, benefit design, medical screening, etc.), resulting in very different markets in different states. In addition, the insurance regulations for individuals and small groups within a state are usually different. (For example, most states allow medical screening and age rating in the individual market but not in the group market.) In these states, applying the same insurance rules—in effect, merging the individual and small group markets in the exchange—would create major disruptions. Some kind of transitioning makes sense, but small businesses and individuals face serious problems now, and they need relief as soon as possible.

Specific policy proposal:

- *The creation of the exchange for individuals and employees of “micro-groups” (10 or fewer employees) will take effect within one year of enactment of the legislation. Participation by others (employees of larger groups (11-50)) will be available one year later.*
Note: Participation by larger groups (51+) will be considered in future years, but this will require changes in insurance regulations and/or other mechanisms to avoid the adverse selection problem.
- *People with current health coverage in the individual and small group market may keep their current plans for two years after this legislation is enacted.*
- *New rating rules within the exchange will be phased in over two years, e.g., gradually compressing the rate bands to reduce the differences in premiums between young and old enrollees.*
- *The secretary may grant time-limited exceptions to the implementation schedule in cases of individual hardship, such as lack of affordable health plan options for low-income people (below 150% of federal poverty guidelines) or to avoid a forced change of health plans during the course of treatment for a serious acute health condition.*

Summary and Conclusion

Small Business Majority believes that a health insurance exchange is an important element of comprehensive reform. A well-designed exchange will address many of the problems that individuals and small businesses face in the current system, especially costs, choice and convenience. In order to accomplish these goals, the exchange should

- Be reasonably large;
- Contain structural elements that will ensure long-term sustainability;
- Protect insurers from adverse selection;
- Exert a strong role as an active and prudent purchaser;
- Be administered nationally, with an option for state-level administration; and
- Manage the transition to avoid serious disruptions.

A well-designed health insurance exchange will

- Reduce the extra premium paid by small businesses, and reduce the volatility in health premiums;
- Offer people choices of multiple insurers, providers and delivery systems;
- Help people shop for insurance and make it easy for them to compare options;
- Greatly reduce the burden on small business owners of administering health benefits; and
- Drive innovation and improvements in affordability, quality and customer service resulting from healthy competition among both insurers and providers.