

Three Strategies for Implementing a State Exchange

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Executive Summary

The Affordable Care Act asks states to set up insurance exchanges to “facilitate the purchase of qualified health plans.” The primary goal of an insurance exchange is to extend affordable health coverage to low-income households via Medicaid and federal premium tax credits. There are at least three key strategies to best connect low-income households with affordable coverage through a state-based exchange.

First, focus the exchange services on people who qualify for Medicaid and insurance affordability programs. A “focused exchange” will help guarantee that the people who need the exchange the most will receive the highest level of service. Asking the exchange to do more, especially in the early stages of operation, will only create competing priorities and distractions, which will diminish the quality of service an exchange offers to low-income households and, consequently, diminish the number of uninsured people who gain and maintain new coverage through the exchange. Also important, a focused exchange allows the rest of the insurance market to carry on without being subject to the exchange’s cumbersome regulations.

Second, establish a SHOP exchange to facilitate enrollment in the individual market, while maintaining the traditional small group market. The SHOP exchange presents one of the most challenging aspects of establishing a state-based exchange. Various provisions in the ACA may work together to undermine the viability of the traditional small group market and, thereby, undermine the viability of a SHOP exchange that depends on this market. Certain small employers will have incentives to abandon the small group market, shrinking the market and leaving higher, more expensive risks in the pool. In addition, there are practical challenges to enrolling individuals in the traditional small group market. To address these problems, SHOP exchanges should be established to facilitate enrollment in individual market health coverage, not small group market health coverage. The ACA allows states to merge both the individual and small group insurance market. In a merged market, small group coverage would functionally become individual market coverage and each market would merge into one risk pool. Merging the risk pools creates a larger pool, which reduces problems related to the size of the pool. Furthermore, this market should be more attractive to employers, which will help maintain the size and risk profile of the pool. Also, because it’s individual coverage, practical problems related to group coverage will disappear. To smooth the transition to a merged market, states should consider merging only a portion of the small group market.

Third, facilitate broad access to insurance affordability programs and high-quality consumer support services through private brokers and private exchanges. It will be important to guarantee that there are multiple avenues to buy health insurance with federal subsidies just as there are multiple avenues to buy nearly every other consumer product. Doing so offers two main benefits. First, it will increase the number of people with insurance coverage. More sales outlets for subsidized coverage and more people with a financial incentive to connect people with coverage will clearly increase the number of people with coverage. Second, it will increase the level of service offered by the public exchange. Just as any business needs competition to stay on its toes, a government-sponsored insurance exchange will need competition from private brokers and private exchanges to guarantee that it maintains a high level of service for consumers.

I. Introduction

The Patient Protection and Affordable Care Act (ACA) asks states to set up insurance exchanges to “facilitate the purchase of qualified health plans.” The federal government will step in and implement an exchange in states that fail to do so. The question over whether or not a state should implement an exchange is an incredibly important and difficult question for each state to answer. Not implementing an exchange hands the federal government more control over the state insurance market whereas implementing an exchange pushes the state further toward being just another arm of the federal government. Many states have decided to establish a state exchange and many other states are still weighing their options. For states that choose to establish an exchange, how should they go about building it?

Even for people who strongly oppose the ACA, this is an important question to consider if you happen to live in a state that chooses to establish an exchange. Once a decision to establish an exchange has been made, all parties and stakeholders who want to maintain a competitive and efficient insurance market must weigh in on how best to build an exchange.

The Obama administration claims that states retain substantial flexibility over their insurance markets under the ACA. However, the text of the ACA clearly reduces a state’s flexibility and authority. And the federal regulations that implement the ACA reduces flexibility and authority even more.

Any state that chooses to establish an exchange will benefit from gaining a maximum amount of flexibility to design an exchange to suit their own unique circumstances and goals. To that end, states should demand changes to the law to regain lost flexibility. Short of changing the law, states should demand maximum flexibility under the text of law, which would require rewriting certain regulations that are stricter than the law requires. And short of rewriting regulations, states should demand maximum flexibility under the regulations.

Obviously, different states will have different appetites for (1) directly challenging the law versus (2) challenging the regulations versus (3) demanding maximum flexibility within the regulations. It is essential that many states directly challenge the law and the regulations in order to fix fundamental flaws within the ACA. Nonetheless, some states will choose to establish an exchange without directly challenging the federal government. This report focuses on what those more compliant states should do to establish the best possible exchange.

The primary goal of an insurance exchange under the ACA is to connect low-income households with affordable health coverage. This report begins with a discussion of this goal and identifies four more objectives that should guide the development of an exchange. With this as a guide, the report then identifies three strategies states should put in place to build the best exchange possible under the current regulations. To do so, states will need to demand the maximum flexibility the regulations allow.

II. The primary goal and four more objectives

While variations on the insurance exchange concept have long been promoted as a tool to help improve insurance markets, the primary goal of state insurance exchanges established through the ACA is to extend affordable health coverage to low-income households. Indeed, exchange provisions in the ACA are written with a clear eye toward establishing a mechanism to connect low-income households to affordable health coverage, whether through subsidies for private health plans, new small business health plan options, streamlined enrollment in Medicaid, access to a state-sponsored basic health plan, or access to employer-sponsored plans.

Insurance exchanges focus primarily on connecting low-income households with tax credits. In 2014, exchanges will be the only place where low-income individuals and small businesses that employ low-income workers can access premium tax credits. The exchange is directed to certify qualified health plans (QHPs) to help guarantee people use tax credits to buy meaningful coverage that meets minimum standards. In addition, an exchange must establish a navigator program to support entities that provide information on the availability of tax credits and facilitate enrollment in QHPs through the exchange. Individuals cannot purchase QHPs in the exchange with tax advantaged dollars through a cafeteria plan, regardless of whether they receive tax credits or not.¹ Thus, the exchange appears to be established as a place for people to access a QHP with a tax credit that is separate from the insurance market where people can buy a health plan with cafeteria plan benefits.

An exchange also plays an important role in coordinating various ACA provisions intended to help low-income households. The ACA directs an exchange to determine whether people are eligible for Medicaid. Exchanges must grant exemptions from the individual mandate if there is no affordable coverage available in the exchange or from an employer. Exchanges must also help enforce the mandate on employers to provide health coverage. To the extent the ACA includes provisions aimed at improving the market—such as assigning quality ratings to QHPs and utilizing a standard format for comparing health benefits plan options—these provisions still appear to be aimed at improving the shopping experience for the primary users of the exchange, low-income households.

While exchanges might be focused on serving low-income households, many people no doubt hope exchanges will have a broader impact on the insurance market. As already noted, insurance exchanges have long been promoted as a tool to help improve insurance markets. In Minnesota, the Dayton administration highlights four problems with the insurance market that exchanges can help solve. Consumers don't have enough information to make smart purchasing decisions. Consumers are not engaged in the market. Most health plans are not portable from job to job, which leads to a lack of job mobility. And finally, there are too few sellers in the insurance market.

While there is substantial debate over whether exchanges, as provided for in the ACA, are the right tool to solve these problems, nearly everyone can agree the problems are real. Everyone should also agree that states should continue to work to solve these problems. As every state

¹ Patient Protection and Affordable Care Act of 2010 § 1515.

works to prepare for the full implementation of the ACA, these problems can be translated into four objectives to guide their work, whether they establish an exchange or not.

- First, make sure that consumers have the information they need to make smart health coverage purchases.
- Second, get consumers engaged in making decisions in the health care market.
- Third, broaden access to portable health plans that can move with people as both incomes and jobs change.
- Fourth, increase competition in the health insurance market.

Guided by these four objectives and the primary goal of extending affordable coverage to low-income households, this report outlines three key strategies to establish an exchange for those states that choose to do so.

III. Three strategies for establishing a state exchange

There are a multitude of decision points in developing a state-based exchange under the ACA. This report does not attempt to address every step in building an exchange. Instead, the report identifies three key strategies for establishing an exchange that best connects low-income households with affordable coverage. First, focus the exchange services on people who qualify for Medicaid and insurance affordability programs. Second, establish a SHOP exchange to facilitate enrollment in the individual market, while maintaining the traditional small group market. Third, facilitate broad access to Medicaid and insurance affordability programs through private brokers and private exchanges.

1. Focus the exchange on Medicaid and insurance affordability programs

The exchange should be a “focused exchange” that focuses primarily on connecting people with Medicaid and public insurance affordability programs. This will help guarantee that the people who need the exchange the most will receive the highest level of service. Asking the exchange to do more, especially in the early stages of operation, will only create competing priorities and distractions, which will diminish the quality of service an exchange offers to low-income households and, consequently, diminish the number of uninsured people who gain and maintain new coverage through the exchange.

The fact is, the strategies that best meet the first three objectives will likely be a bit different for low-income households. For instance, to meet the first objective—*informed consumers*—low-income households will need to take more care in understanding out-of-pocket costs, how to manage out-of-pocket costs and where to find help if they have trouble affording these costs. Also, finding information such as which providers are on a bus line will also be more important to low-income households. On the second objective—*consumers engaged in making decisions*—people eligible for cost-sharing reductions will have plans with higher actuarial values than most and, therefore, less exposure to out-of-pocket costs. But they will also be more sensitive to the costs they are responsible to pay. This is a very different dynamic and will

demand different strategies to help them become engaged consumers. Finally, there will also be differences in the context of insurance coverage portability. How the ACA's cost sharing reductions will work is still unknown, but what is known is that the minimum actuarial value of the plan will change as incomes rise. How to assure people have portable plans as their incomes rise through the various stages of subsidized coverage and then into nonsubsidized coverage presents a unique challenge to covering low-income households.

Understanding the different needs of low-income households, it is clear these households will require an exchange to implement unique strategies to be successful and to maximize its capacity to reduce the ranks of the uninsured. Focusing the exchange exclusively on people who qualify for Medicaid and insurance affordability programs will help guarantee the exchange focuses on these strategies.

There are two additional benefits to this strategy. First, it reduces the possibility of adverse selection related problems. Adverse selection happens when a health plan or health plan market attracts people with higher risks and, as a result, become more costly than other plans or markets. The risk of adverse selection is already diminished for the exchange because the risk pool for the exchange and the outside market must be the same. The risk of adverse selection will be even less if the only people using the exchange are people who use the exchange to connect with insurance affordability programs. That's because people will select QHPs in the exchange because it is the only way to gain access to federal tax credits and cost-sharing subsidies, not because of the plan design. Similarly, large employers avoid adverse selection in their health plans because people select the employer primarily to get a job, not to get a particular health plan.

Second, the rest of the insurance market retains access to the high quality information they need to make smart health coverage decisions, which helps further the first objective. Buying health insurance with all its various components and moving parts is difficult. Many people do struggle to acquire and then process all the information necessary to make a smart decision on their own. Fortunately, people are not left alone. To make smart health coverage decisions, people and businesses rely on insurance brokers just as they rely on financial planners to make smart retirement investments. Brokers provide an extremely valuable service that solves the mismatch in information between consumers and health plans.

Many people are looking to the exchange to provide the same service as brokers and to possibly replace brokers. A government-sponsored exchange that attempts to squarely compete with brokers serving the entire market puts consumers at risk. There is no reason to think a government-sponsored exchange will serve consumers as well as brokers or private exchanges. Consumers will be at risk if an exchange is given an unfair advantage over brokers, which may be a government-sponsored exchange's only way to compete. With an unfair advantage, an exchange could undercut brokers, drive them out of the market, and leave consumers with less information and less effective representation when buying and using a health plan. This can largely be avoided if an exchange focused on people eligible for Medicaid and insurance affordability programs and left a robust market for everyone else outside the exchange.

a. How to establish a focused Exchange

How can a state focus the exchange on low-income households in accord with current law and regulations? There are two possible avenues to establish a focused Exchange. First, a state may rely on its authority to license health plans. Second, an exchange may make use of its authority to certify QHPs that are available through the Exchange.

Here's how a focused exchange may be established through state health plan licensure authority. All health plans—including multi-State and CO-OP plans—sold through an exchange must be licensed by the state.² A state may therefore impose requirements on all plans sold through the exchange so long as the requirements are not inconsistent with the requirements of the ACA.³ To date, nothing in federal law or regulation specifically requires unsubsidized health plans to be sold through an Exchange. To the contrary, federal law and regulations continue to “encourage State flexibility within the boundaries of the law.”⁴ Without any specific provision that requires an Exchange to offer unsubsidized QHPs, there should be no barrier to a state requiring health plans to sell only subsidized plans through a state exchange.

While nothing in the letter of the law presents an obstacle to establishing a focused exchange in this way, there is at least one possible inconsistency in the regulations. The regulations require the exchange to allow applicants to apply for a QHP without applying for financial assistance.⁵ The agency comments on the rule explain: “We believe it is important to preserve the option for an applicant to bypass the examination of his or her household income and other information that may result in a lengthier eligibility process, and allow him or her to enroll directly in a QHP without financial assistance if he or she so chooses.”⁶ Thus, the rule appears to envision an exchange where people can access QHPs with and without financial assistance. While the rules might envision an exchange with subsidized and unsubsidized QHPs, nothing in the rules require it. Without a direct requirement, state flexibility should be honored.

The second possible avenue—QHP certification—may provide an alternative to establish a focused Exchange through the authority of the Exchange versus the authority of the state legislature. A state Exchange may clearly establish additional certification criteria using its broad discretion to certify only those plans that are “in the interests of qualified individuals and qualified employers.”⁷ Specifically, an Exchange could require a health plan to be funded, in

² Patient Protection and Affordable Care Act of 2010 § Sec 1334 (b)(2).

³ Patient Protection and Affordable Care Act of 2010 § Sec. 1321 (d).

⁴ Federal Register Vol. 76, No. 136, p. 41867 (July 15, 2011).

⁵ Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act, 45 C.F.R. § 155.310 (b).

⁶ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Federal Register, Vol. 77, No. 59, p. 18355 (March 27, 2012).

⁷ Patient Protection and Affordable Care Act of 2010 § 1311 (e)(1)(B) allows states to add certification requirements that exceed the minimum requirements established by the Secretary. It provides: “An Exchange may certify a health plan as a qualified health plan if . . . the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State.” The ACA outlines three factors on which an exchange cannot exclude a health plan, which implies that exchanges have broad authority to exclude health plans on other grounds. The proposed and final rule grants this authority. The explanation of the proposed rule states: “An Exchange may also implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interests of the qualified individuals and employers.” Patient

part, by federal premium tax credits in order to be certified as a QHP. In this way, the only products available in the Exchange will be products that are funded in part through tax credits and, as a result, only those people who qualify for and use tax credits would access health plans through the Exchange.⁸

This additional certification criterion should satisfy the “interest” test. As already discussed, a focused exchange can focus on meeting the needs of people who qualify for Medicaid and federal insurance affordability programs and, as a result, provide a higher level of service. Clearly, this is in their interest. Avoiding adverse selection is also in everyone’s interest.

The QHP certification approach involves the same inconsistency with federal regulations as the state licensure approach. And similarly, this should not be a problem so long as the federal government honors their promise of flexibility.

However, there may be a more substantial obstacle to establishing a focused exchange through QHP certification. The ACA requires the Office of Personnel Management (OPM) to contract with health insurance issuers to offer at least two multi-State health plans through each state exchange. The ACA also establishes the Consumer Operated and Oriented Plan (CO-OP) Program to foster the development of qualified nonprofit health insurance issuers. The ACA “deems” multi-State plans and CO-OP plans to be qualified health plans.⁹ Because the ACA deems these plans to be QHPs, DHS does “not believe these plans can be excluded from participation, including in [state] Exchanges that adopt selective certification approaches.”¹⁰ If true, then people without financial assistance could enroll in multi-State plans and CO-OP plans through a state exchange. To get around this obstacle, an exchange would likely need to negotiate with OPM to apply the state’s more selective certification rules to multi-State plans and CO-OP plans.

2. Establish a SHOP exchange to facilitate enrollment in the individual market, while maintaining the traditional small group market

The ACA requires states or the federal government to establish a Small Business Health Options Program (SHOP) Exchange “to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State.”¹¹ The SHOP exchange presents one of the most challenging aspects of establishing a state-based exchange. For many states, the best way to meet these challenges, at least in the short term, will be to establish a SHOP exchange to facilitate enrollment in the

Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule, Federal Register Vol. 76, No. 136, p. 41891 (July 15, 2011). The final rule affirms this “broad discretion to certify health plans.” Federal Register Vol. 77, No. 59, p. 18405 (March 27,2012).

⁸ A state must limit the products available in the exchange because the law does not appear give states the authority to add additional eligibility requirements. States can control what’s sold, because a state cannot appear to control who buys. To enhance portability, people should be able to maintain a QHP after they no longer qualify for tax credits.

⁹ Patient Protection and Affordable Care Act of 2010 §§ 1301 (a)(2) and 1322 (c)(5)

¹⁰ Federal Register Vol. 77, No. 59, p. 18406 (March 27,2012).

¹¹ Patient Protection and Affordable Care Act of 2010 § 1311 (b)(1)(B).

individual market, while maintaining the traditional small group market. This will require the state to merge a portion of the small group market with the individual market.

a. Challenges to building a SHOP exchange

There are a number of difficult challenges to establishing a SHOP exchange. The main challenges center on how specific provisions in the ACA may work together to undermine the viability of the traditional small group market and, thereby, undermine the viability of a SHOP exchange established to facilitate enrollment in the small group market. Additional challenges revolve around the limited value of the small business tax credits and the difficulty of shoehorning employee choice into a group insurance market setting that is not presently designed to offer choice.

i. ACA provisions undermine the small group market

University of Minnesota Law School professors Amy Monahan and Daniel Schwarcz outlined in a recent paper how “interweaving provisions embedded within the Affordable Care Act create strong incentives that, starting in 2014, will tend to undermine [the small group health insurance] market.”¹² Here’s how Monahan and Schwarcz describe the ACA’s approach to reforming the small group market.

On one hand, the ACA subjects the small group market to many of the same new insurance rules that it applies to the individual market, including requiring the provision of “essential health benefits,” limiting permissible medical underwriting to age and smoking status, and instituting minimum medical loss ratios. It also requires the establishment of SHOP exchanges to help organize the small group market, just as it does in the individual market. On the other hand, though, the ACA preserves small employers’ freedom not to offer coverage, provides more limited new subsidies to support SHOP exchanges than it provides for individual exchanges, and leaves small employers free to “self-insure” in order to avoid many of the regulatory requirements that they would otherwise face. [Citations omitted.]

The small group market, according to Monahan and Schwarcz, will be subject to “substantial instability” due to three incentives embedded within this approach. First, small employers with low-income employees will be encouraged to not provide coverage because their employees will be better off with federal premium and cost-sharing support in the exchange. Second, small employers with a mix of low- and high-income employees will be encouraged to offer unaffordable coverage to low-income employees so that they can take advantage of federal support in the exchange, while preserving employer-provided coverage for higher income employees. And third, small employers with low-risk employees will have a strong incentive to “self-insure” and leave the small group market.

¹² Amy Monahan and Daniel Schwarcz, Saving Small Employer Health Insurance, Minnesota Legal Studies Research paper No. 12-36 (Aug. 29, 2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2138200.

Each of these incentives leads to two major problems.

- First, the pool of people covered by the small group market will shrink. When small employers either decide to not offer coverage or offer unaffordable coverage, employees without access to affordable coverage will either remain uninsured or access coverage through the individual market insurance exchange. Either way, those people are no longer in the small group market. Any company that chooses to self-insure will also remove their employees from the market. The small group market is already a small insurance pool and making the market even smaller will reduce efficiencies of scale and make the market less attractive to insurers.
- Second, the people left in the pool are likely to be higher risks, which will make the pool much more expensive to insure. Employers with low-risk employees can leave the pool because they may find more affordable coverage by self-insuring. Without a balance of low and high risks, insurance premiums for everyone in the pool may become unaffordable.

Compounding these problems is the fact that states will need to expand their small group market to include employers with up to 100 employees by 2016. Most states define a small employer as an employer with up to 50 employees. When the definition of small group expands, the entire group will largely be subject to the same rules, but there will be one key difference: Employers with more than 50 employees will be subject to the employer mandate to offer coverage and employers with 50 or fewer employees will not. This will heighten the possibility of adverse selection. When the mandate kicks in, employers with high-risk employees that currently do not offer coverage will be forced to enter the insurance market, raising the pool's risk profile and, thereby, raising premiums. Higher premiums will make self-insuring more attractive to some employers and pull even more low-risk employers out of the group market.

ii. Small business tax credits

Another major challenge to the SHOP exchange is the limited value of the small business tax credits available through the SHOP exchange. Only a small number of employers actually qualify for the full tax credit. The credit begins to phase out when a small business employs more than ten employees or pays more than \$25,000 in average annual wages. Employers with more than 25 employees or more than \$50,000 in average annual wages do not qualify. Most limiting, the tax credit is only available for a two-year period. When the tax credit expires after two years, small businesses will experience a large spike in health care costs if they intend to maintain the same coverage.

iii. Challenges to offering choice in the group market

There are a few other challenges related to certain design features. First, to offer a choice of health plans a SHOP exchange must likely work within a defined contribution model where employers provide employees a defined dollar amount to apply toward the premium of the health insurance plan they choose. However, the group insurance market is not currently structured to provide choice to employees and it will be an administrative challenge for an exchange to provide a new structure in the context of the current group market. In particular, it is uncertain

how to effectively underwrite employers in a group market where their employees can be covered by different insurers. Second, and related to the first, the regulations require exchanges to aggregate premiums from multiple insurers into one bill for employers and to collect payment on these bills from employers. Finally, portability is a key objective, but it is not clear how a group health plan could be portable from job to job.

b. Designing a SHOP exchange

In light of these challenges—and always keeping in mind the primary goal and key objectives of an exchange—how should a state design their SHOP exchange? Again, various provisions in the ACA will likely result in two main problems: the small group pool will shrink and those left in the pool will be higher (and more expensive) risks. But these aren't the only problems. The small group market has long struggled due to a lack of choice, competition, and portability. New options in the small group market and a well-designed SHOP exchange may be able to address many of these problems.

One design element is key to addressing each of these problems: Establish a SHOP exchange to facilitate enrollment in the individual market. The ACA allows states to merge the individual market and the small group market. In a merged market, small group coverage would functionally become individual market coverage and each market would merge into one risk pool. After markets are merged, a SHOP exchange can be established to facilitate enrollment in individual market health coverage, not traditional small group market health coverage.

Merging markets is not without risks. A move to merge the entire individual market with the small group market could pose quite a shock to the insurance market and to the small employers that rely on this market. It's hard to know exactly how a merger would impact premiums, but any change that dramatic could lead to some dramatic premium increases for certain employers. Overnight, brokers that serve the small group market would need to change their entire business model to focus on serving individuals. Other unintended consequences are certainly possible. Therefore, states will want to implement strategies to smooth any transition.

One way to lessen the shock to the insurance market is to merge only a portion of the small group market—the portion of the market providing employers with a defined contribution health plan—and keep the traditional small group market that provides defined benefit health plans. While small employers will continue to be able to choose between defined contribution and defined benefit health plans outside the SHOP exchange, the SHOP exchange should be designed to offer only defined contribution health plans.

What is the legal basis for a partial merger? Currently, most people presume there are only two merger options: Don't merge or merge the entire small group market with the individual market. But based on the text of the ACA, a partial merger should be permissible. According to Sec 1312 (c)(3) of the ACA, "A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate." There are no further details on how states should go about merging markets. However, this text makes two things clear:

lawmakers did not want to lock in the current structure of the small group market and lawmakers did not want to eliminate the states' role in structuring their small group market.

The likely reason for limited details is that the ACA expects states to work out the details on their own. Indeed, the language of the ACA expects states to continue operating as the primary regulators of insurance. So long as states regulations don't "prevent the application of the provisions" of the ACA, Sec. 1321 (d) commands "no interference with state regulatory authority." Because nothing about a partial merger interferes with any other provision of the ACA, it is reasonable to conclude that the ACA intends to continue giving states broad flexibility over how they structure their insurance markets, including over how they merge the individual and small group market if they choose to do so.¹³

Whether a state should merge the entire market or just a portion of the market will depend on the characteristics of the individual and small group markets in each state. The size of the small group market, stability of the small group market, and the likely impact on premiums for both individuals and small employers will be key determinants.

c. Benefits of a merged market

Whether a state chooses to merge the full or only a portion of small group market with the individual market, there are a number of possible benefits to this approach. If states opt for a full merger, a defined contribution plan would then be the only insurance option for small employers. A partial merger will help develop and strengthen defined contribution health plan options for all small employers (both inside and outside the SHOP Exchange) without eliminating the traditional small group plan options that so many small businesses depend on today. While employers can offer a defined contribution health plan today, there has long been uncertainty over how state and federal laws regulate these arrangements. The process of merging the markets provides an opportunity to clarify the law, which should make defined contribution health plans more attractive.

A full merger would create a larger risk pool, which should avoid most problems related to the size of the risk pool. One risk pool will also help mitigate any problems that might arise from employers not offering coverage or offering only unaffordable coverage for low-income employees. Unless the employer self-insures, low-income employees who get coverage on their own will still be in the same pool as employees covered by their employer.

On the other hand, a partial merger offers employers the benefit of choice between markets. If employers are given a choice, the traditional small group market may shrink and eventually

¹³ A partial merger also reflects the current regulatory framework of the individual and small group market. In addition to the individual market and the small group market, there is, even today, a third category that blends the two markets. When an employer decides to offer a defined contribution health plan, federal regulatory guidance and case law provides that individual market insurance policies may also be governed by small group market rules, depending on how the employer administers the defined contribution plan. A partial merger provides an opportunity to clarify this rather murky regulatory arrangement. This approach also agrees with federal regulations that apply certain small group market rules in the ACA to individual plans sold in a merged market. Exchange Establishment Standards and Other Related Standards under the Affordable Care Act, 45 C.F.R. § 155.705.

disappear if a large number of small employers choose a defined contribution approach. But the benefit here is that the small group market still has a chance to prove its worth. The small group market may prove to be competitive and survive. But even if the small group market fails to compete, the demise of the market will happen over time, providing a smoother transition.

A merged market can also help counter the incentive for small employers to self-insure by offering a more attractive option than self-insuring. A well designed defined contribution health plan may be very attractive to small employers. Compared to self-insuring, there will be less administrative complexity and no risk. Furthermore, a defined contribution health plan may help solve many of the long-standing problems with the traditional small group market.

- Through a defined contribution, people would own their own individual health plan that they can take with them from job to job. Portability solved.
- People would be able to choose from a wide variety of individual health plans. Choice solved.
- More choice would also lead to a more competitive insurance market because, without the employer acting as an intermediary, insurers would need to pay more attention to the demands of the individual consumer. This might not solve the competition problem, but it clearly helps.
- Finally, because the employee takes more charge of choosing their health plan, the employer is freed from a human resources job it neither wanted nor did well.

In sum, states should be free to merge only a portion of their small group market with the individual market because the ACA continues to give states broad authority to regulate and structure their insurance markets. For many states, a partial merger will help develop defined contribution health plan options for small employers without eliminating the traditional small group plan options that so many small businesses depend on today.

3. Facilitate broad access to subsidized health plans through brokers and private exchanges

An exchange as most people view it intends to be a new government-sponsored marketplace for health insurance. The comparison isn't perfect, but it's fairly accurate to say an exchange aims to be a Travelocity, Expedia or Orbitz for buying health insurance. It will be important to guarantee that there are multiple avenues to buy health insurance with federal subsidies just as there are multiple avenues to buy airline tickets and nearly every other consumer product. Doing so offers two main benefits.

- First, it will increase the number of people with insurance coverage. More sales outlets for subsidized coverage and more people with a financial incentive to connect people with coverage will clearly increase the number of people with coverage.
- Second, it will increase the level of service offered by the public exchange. There is no guarantee that a government-sponsored exchange will serve consumers well. Just as any business needs competition to stay on its toes, a government-sponsored insurance

exchange will need competition from private brokers and private exchanges to guarantee that it maintains a high level of service for consumers.

Clearly, more people with health coverage who receive a high level of service from brokers, private exchanges, or public exchanges advances all four of the objectives aimed at improving - the insurance market. Consumers will be both more informed and more engaged. More people covered means more people with portable health plans and a more competitive market because there will be a larger market to compete over.

Ideally, consumers will be able to access subsidized coverage through brokers and private exchanges seamlessly, without needing to jump through too many additional hoops. To the consumer, enrolling in subsidized coverage should be just like enrolling in any other type of coverage, except for the added layer of needing to apply for the tax credit. The public exchange will need to be built to facilitate this consumer experience.

a. How to permit brokers and private exchanges to enroll people in subsidized QHPs

Federal regulations allow states to permit brokers to “enroll qualified individuals in a QHP in *a manner that constitutes* enrollment through the Exchange.”¹⁴ Enrollment through a broker will constitute enrollment through an Exchange, so long as brokers follow certain rules and use certain components (or tools) of the exchange in the enrollment process. In particular, brokers must use the Exchange’s online application to determine eligibility for Medicaid and insurance affordability programs.¹⁵ Also, brokers must register with the exchange and receive “training in the range of QHP options and insurance affordability programs.”¹⁶ In this manner, private brokers and private exchanges can enroll individuals in federally subsidized QHPs outside of the state-based exchange marketplace and use their own tools to inform, guide and engage consumers.

To make the application process easy for consumers, States should develop a web app that brokers can integrate into their own web sites to interface with the backend functions of the eligibility verification and enrollment application on the exchange web site. States should also consider developing a separate web portal to the eligibility verification and enrollment application for brokers that do not use a web site for enrollment.

¹⁴ Exchange Establishment Standards and Other Related Standards under the Affordable Care Act, 45 C.F.R. § 155.220.

¹⁵ Writing for the HealthAffairs Blog, Cindy Gillespie suggests that brokers must also use their own private web portal. See Cindy Gillespie, “Little-Noted Provision On Agents And Brokers Could Mean Big Changes For Exchanges,” HealthAffairs Blog, June 8, 2012, at <http://healthaffairs.org/blog/2012/06/08/little-noted-provision-on-agents-and-brokers-could-mean-big-changes-for-exchanges/>. However, the regulations do not specifically require brokers to use their own web site. Rather, the regulations add certain requirements “[w]hen an Internet Web site of the agent or broker is used.” Thus, these requirements only kick in if a broker uses their own website. A state should be free to offer a special online enrollment application for brokers who do not have their own website.

¹⁶ Exchange Establishment Standards and Other Related Standards under the Affordable Care Act, 45 C.F.R. § 155.220 (d)(2).

IV. Conclusion

Federal approval will be required to implement these strategies. While these strategies aim to comply with federal regulations, they are likely to meet challenges from federal regulators because they do not fall in line with the standard approaches under consideration in most states. If challenged, states should push back and demand that the Obama administration honor its promise of flexibility in establishing state-based exchanges. Guaranteeing a true measure of flexibility is essential to protecting state insurance markets and to enhancing access to affordable coverage for low-income citizens.

This report has focused on strategies that should comply with federal regulations. However, as explained earlier, in order to fix fundamental flaws in the ACA it will be essential for other states to directly challenge the law and regulations. To *best* protect and enhance state insurance markets, states must win back flexibility and authority from the federal government in order to implement approaches that would currently violate federal law and regulations. With that said, this report offers what may be considered a second or third best approach, but it is nonetheless the position that many states find themselves in today.