NAIC Exchange Subgroup
Public Hearing
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Statement of Gary Claxton
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Good morning Commissioner Ario, Director McRaith, and members of the working group. Thank you for inviting me to speak today on the topic of health insurance exchanges. My name is Gary Claxton, and I am a Vice President at the Henry J. Kaiser Family Foundation, which is a non-profit, private operating foundation focusing on the major health care issues facing the U.S., as well as the U.S. role in global health policy.

Exchanges were a key part of the legislative response to widespread dissatisfaction with nongroup and small group health insurance markets. The Patient Protection and Affordable Care Act (ACA) transforms the nongroup insurance market, ensuring access to comprehensive coverage options, tightly regulating insurer rating and underwriting practices, and providing financial assistance so that low and moderate income families can participate. New standards for the small group market require policies to provide comprehensive benefits and eliminate pricing based on health. Exchanges play an integral role in these reforms by providing information to consumers and small group purchasers about the benefits, price and quality of plan choices, helping people understand and qualify for premium tax credits and cost sharing subsidies, and creating a transparent and fair market where insurers will have to compete on price and quality. It is worth noting that the legislation does not just create new standards for existing market actors, but establishes new institutions, exchanges, to mediate between consumers and health plans. Congress recognized that it could not fix the dysfunctional state of the current market without fundamentally changing the way that insurance is offered and delivered to nongroup and small group consumers.

ACA provides for states to set up exchanges, with a federal back-up if a state does not want to create an exchange or is unwilling to meet minimum standards (which have yet to be established). Because what exchanges essentially do is sell health insurance, state insurance commissioners will and should play a significant role in the design and implementation of state exchanges. As you and your state colleagues undertake this complex and challenging task, you will face a number of difficult policy choices and design issues, and the decisions that you make will affect how well exchanges are able to fulfill their many roles. I would like to discuss several of the more important design issues, with an emphasis on their implications for consumers.

SHOULD EXCHANGES BE ACTIVE PURCHASERS IN SELECTING HEALTH PLANS?

The basic function of an exchange is to array a set of health plan choices from which consumers can pick a plan that they like best. There are different ways to carry out this function, ranging from simply listing all the plans that meet some minimum standards to actively negotiating with plans to identify and select only those that are willing to provide something more – i.e., better performance or value – than their competitors. Generally, those who think that pure competition will produce the best results might prefer the listing approach, which allows any plan meeting minimum requirements to participate and lets buyers sort out the winners and losers. Those who are skeptical about how competitive markets will be, and those who believe that insurers will not invest sufficiently in quality or other system improvements without being pushed, might favor more active negotiations because they are unsure that competition alone will maximize long-term value for consumers.

There are some reasons to be skeptical about how competitive markets will be inside exchanges, although there is little doubt they will be more competitive under any reasonable organization than the nongroup market is today. One issue is that large, established carriers have resources and provider contracts that can make it difficult for new entrants and smaller players to offer price-competitive

products. Another issue is that individual consumers are often not educated insurance purchasers, and even with better information available through exchanges, their decisions on what products to buy may not always be guiding the market in the optimal directions. Most insurance purchasers, thankfully, do not have the opportunity to fully use their policies, and unless they have had serious acute and chronic conditions, they will not have gained an understanding of the how the cost sharing, network, and utilization management provisions of polices may work at times when they are most in need. Unaided, consumer decisions may overvalue policy provisions around more routine use and undervalue provisions that most affect the people with serious acute or chronic health care needs.

These concerns suggest that there may be value in permitting exchanges to actively negotiate with insurers seeking to participate. In markets with a few, dominant competitors for example, negotiation and the threat of exclusion may be necessary to get the lowest possible prices from insurers. Exchanges also are in a good position to identify and represent consumer preferences in areas where buyers have little experience. By communicating with consumers and surveying the experiences of all types of plan users, exchanges can identify unexpected traps and difficulties that consumers face and negotiate plan terms and arrangements that better protect consumers with differing health care needs.

In addition, competition alone may not encourage a sufficient level of investment in longer-term system improvements in areas such as quality and delivery system reform (it certainly has failed in these areas to date). Individual consumers are unlikely to know what type of system improvements are most needed or likely to be most effective, and may discount the importance of new arrangements with few immediate benefits but the potential to improve quality or reduce costs over the longer term. Exchanges can compensate by emphasizing reform approaches and pushing insurers to invest in system changes that could improve quality or produce longer-term reductions in costs.

While there are good arguments for exchanges to be active purchasers, there also are reasons for caution. Exchanges that are too prescriptive or that have too aggressive of an agenda for plans could hinder innovation or may overly limit choices of plans or plan arrangements. Exchanges also will be new, and it will take some time to identify what is working and not working and what types of arrangements and attributes seem to work best for different types of consumers with different needs. It may be wise for exchanges, even if they have authority to actively negotiate with plans, to start slowly and increase their involvement as the market unfolds and as they gain experience. Such a go-slow approach will likely frustrate some with an aggressive reform agenda or who want the lowest possible prices from day one, but it should enhance their credibility and effectiveness when they begin to push plans for better performance.

HOW INVOLVED SHOULD EXCHANGES BE IN ENFORCING HEALTH INSURANCE MARKET STANDARDS?

ACA charges exchanges with certifying the health plans that they will offer to consumers. Because of this selection role, it is possible, and maybe even likely, that consumers and policy makers will start to look to exchanges to also ensure that the plans and products that are selected comply with insurance market reforms and other legal requirements. With exchanges focused entirely on health insurance and already charged with collecting information from plans and reviewing their behavior, there is some logic to extending their reach to general oversight of health plan conduct in the markets they work in, particularly if there is dissatisfaction with existing regulatory performance. For example, ACA already requires insurers to provide justifications for rate increases to exchanges and for exchanges to consider these in certification; it would be a relatively small step to consolidate rate review entirely in the exchange. Further, the ability to include or exclude plans from exchanges could prove to be a more potent sanction against plan misconduct than the fines and other administrative remedies typically used by insurance departments to enforce insurance standards.

Despite the appeal of telling the new guy to fix all of the problems in these markets, there are some good reasons for exchanges to stay away from regulatory functions. One is that acting as a regulator would tremendously complicate the already difficult task of getting exchanges up and running by 2014. Regulation takes more and different personnel than selecting plans and organizing plan choices, and establishing new agencies that could do both tasks well would be a herculean feat within the time allowed. Another is that regulating involves a somewhat different focus and mindset than what some people would want to see from exchanges. Regulators focus on plan compliance with legal standards, and they are expected to be neutral arbiters when there are disputes over whether standards are met. Exchanges, in contrast, might be expected to try to push participating insurers toward delivering higher value for consumers, which is hardly a neutral stance. Organizations without a clear focus and mandate are not likely to be effective, and ones with conflicting foci are even less likely to succeed.

Even if exchanges do not take on formal regulatory functions, they may want to have explicit policies dealing with certification of health plans with a history of serious regulatory violations. At the least, they should consider providing to consumers the history of complaints and regulatory actions for each plan offered through the exchange. Beyond that, the question is whether a history of bad practice should disqualify a plan (permanently or for some period) from participating in this new marketplace.

HOW MUCH INTERACTION IS NEEDED BETWEEN STATE MEDICAID PROGRAMS AND EXCHANGES?

State Medicaid programs are greatly expanded under ACA, but they largely remain separate from the new insurance standards and subsidized coverage provided through exchanges. Generally, people with incomes below certain amounts are eligible for subsidized Medicaid coverage while people with higher incomes (up to 400% of poverty and without access to employer provided or other coverage) may

receive subsidized coverage through exchanges. ACA requires exchanges to inform applicants about the availability of Medicaid coverage and, in reviewing applications for enrollment, to enroll individuals in a state's Medicaid program if the exchange determines the individual would be eligible. Beyond this screening function, however, ACA does not address how exchanges should interact with Medicaid. The statute treats most people as eligible for, or enrolled in, one program or the other at any given time.

People are not static, however, and many will move back and forth between exchange-participating health plans and Medicaid coverage as their incomes and circumstances change. With millions of new, low-income enrollees in both Medicaid and exchange coverage, the number of transitions back and forth between Medicaid and private coverage will be much, much larger than we see today. To assure smooth transitions and maintain continuity of coverage, close coordination and ongoing communication between eligibility and enrollment personnel in both programs will be essential. Ideally, the programs would work together to develop materials for these transitioning people, explaining the implications and options involved with moving one direction or the other.

While transitions present the most compelling need for coordination, there are other areas where exchanges and Medicaid programs could work together to serve enrollees better. One area is outreach. Medicaid and CHIP programs have made giant strides in some states in identifying and enrolling eligible people who had been previously uninsured. Exchanges should learn from these experiences as they reach out to low-income populations that are not used to thinking about private health plans and commercial coverage. Given the overlap of potential clients, ideally Medicaid programs and exchanges would coordinate some of their outreach programs, with the goal of finding uninsured people and enrolling them where they are eligible.

Another area where exchanges could learn from Medicaid is in plan contracting, particularly for standards relating to service access and quality. The millions of low-income enrollees expected to enroll in exchange coverage present somewhat different challenges than the people who now buy nongroup coverage. People with low incomes face additional access barriers (such as language, location and transportation) and may have different health needs (such as poorer access to sources of healthy food). Exchanges may want to consider some of the standards and benchmarks developed by Medicaid programs for Medicaid managed care plans when contracting with exchange plans and reviewing their performance. These are populations that will be new to the commercial market but well-known by Medicaid and CHIP programs. Hopefully exchanges can learn from their experiences.

Thank you again for the opportunity to testify on this important issue. Exchanges have the potential to transform the nongroup and small group markets by informing consumers and focusing plan competition on providing lower prices and better value. States have an opportunity to achieve this potential if they keep exchanges focused on their primary purpose – creating a transparent and fair market with informed consumers. Getting exchanges up and running by 2014 will be big challenge for states. We look forward to working with you as you take on this important challenge.

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