Washington State Health Care Authority

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Health Benefits Exchange Project

First Draft for Comments and Discussion

Issue Brief #5: Keeping an Exchange Healthy: the Role of Participation and Sustainable Administrative Revenue

November 24, 2010

Summary

Keeping a Health Benefits Exchange healthy will depend largely upon participation and sustainable administrative funding. With many buyers and sellers competing efficiently, a market can flourish. Similarly, a larger number of enrollees and insurers in an Exchange can have salutatory effects:

- **Greater leverage**. If the Exchange includes a significant proportion of a State's population, it will have greater leverage to participate with other purchasers to increase the coverage of quality health care services and lower administrative costs. (see sidebar)
- **More stable risk**. The health risk of a larger member pool is likely to be less volatile, and to mirror the State population as a whole. An Exchange with these risk characteristics will be more inviting to insurers and health care providers.
- **Lower per person administration costs**. Both insurers and the Exchange itself can spread their fixed administrative costs over more members. Sustainable funding for an Exchange's administrative services will depend upon the goal of the Exchange, the number of exchanges in a state, and the risk and perceived equity of the funding source.

The 20 Percent Threshold

Identifying the key features of a successful Exchange, David Riemer and Alain Enthoven wrote:

"… the Exchange would need to act on behalf of a critical mass of people – at least 20 percent of the insured population that does not already receive Medicaid or Medicare. Only a pool of this size could attract serious bids from insurers. To amass such a large purchasing pool, Congress might need to require that all government employees, or all employers with fewer than 100 employees, join the pool."

The only public health plan we need
The New York Times; June 25, 2009

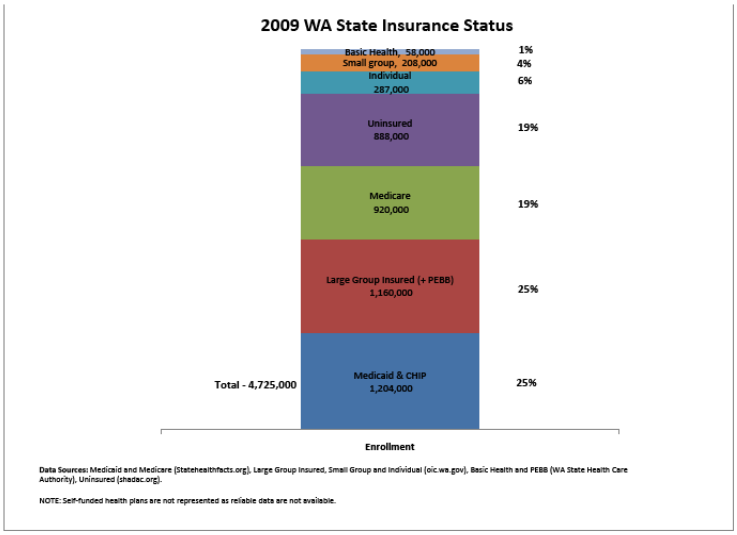
Background - Participation

Without adequate participation, an Exchange can fail. To increase participation, an Exchange might choose to:

1. **Aggressively Market its Services and Actively Engage Producers and Navigators**
2. **Expand the Definition of Small Employer from 1-50, to 1-100 Employees**
3. **Forego Adopting the Federal Basic Health Option**
4. **Merge the Individual and Small Group Risk Pools**
5. **Starting In 2017, Include Larger Employers and Public Employees**
6. **Join a Multi-State Exchange**

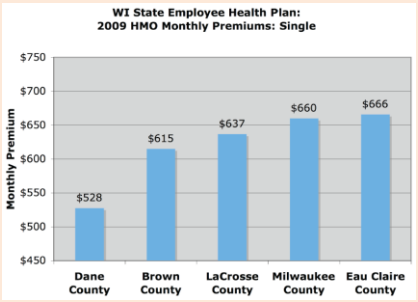
If a goal of the Washington Exchange is to help transform the State's health care, the Exchange may need to make such choices in order to attain a critical mass of active individuals, employers, and insurers. To retain those consumers, it will need to provide them with adequate choices and operate with high standards. Done right, achieving a critical mass of participates will likely be good for enrollees, the taxpayers who fund the Exchange's administrative services, and the state's health care delivery system.

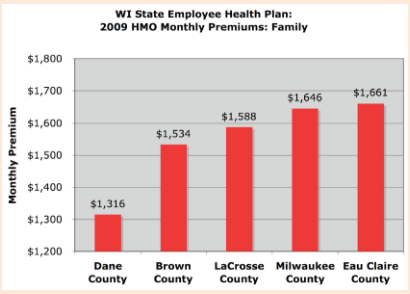
The chart below gives the participation of Washingtonians in the State's health insurance options in 2009.



In Dane, Participation Matters

Since 1983, the Wisconsin State Employee Health Plan has provided an Exchange for about 80,000 state employees in most of the state's 72 counties. But one county stands out: In Dane County, even though Plan benefits are the same as for all other counties, the cost is dramatically lower:





The reason? In Dane, the Exchange covers more than 20 percent of the total insured population, thus giving it market clout. In other counties the percentage is much lower. Participation matters.

Some say the Dane county Exchange has a positive impact on health care quality, also because of its size.

Source: Riemer, D. (2009). *Effective health insurance Exchanges: the Dane county, Wisconsin, model*. Presentation to the Institute of Medicine Roundtable on Evidence-Based Medicine, July 2009.

These five categories will likely contribute participants to a Washington State Exchange:

- the uninsured
- the current basic health plan
- people currently insured in individual plans
- people currently insured in small group plans
- association health plans (counted among large group enrollees)

The first four categories represent about 27 percent of the total state population, and about 40 percent of the population not covered by Medicare or Medicaid. Thus, it may appear that the Washington Exchange will easily exceed the 20 percent threshold for healthy Exchange participation advocated by Riemer and Enthoven (in Washington, about 1 million people). (see sidebar) However, it is not so simple: some individuals will likely receive coverage from the current Medicaid program or the expanded Medicaid provisions under the Patient Protection and Affordable Care Act (ACA). Some will not want to leave their current individual, small-group, or assocation health plan. And, some people will opt out of the mandated coverage requirement altogether.

Thus, it may be important for the Exchange to expand its source of participants beyond these five categories. The ACA provides several ways for an Exchange to expand its participation:

1. **Aggressively Market Exchange Services, and Actively Engage Producers and Navigators**. The ACA provides opportunities, but does not require an Exchange to actively market its services. Massachusetts, however, found that encouraging a high proportion of eligible people to join its Exchange required intensive marketing. In an attempt to achieve similar results, an Exchange can establish a Navigator program.[1] Through outreach and education programs, Navigators will engage entities such as trade, industry, and professional associations, to raise public awareness about the Exchange, and to facilitate enrollment in the Exchange. Since the grants for outreach and education programs will come from Exchange operating funds, not from federal grants, each Exchange must decide how intensively it will pursue Navigators programs. Facilitating participation in an Exchange could depend upon how to reach enrollees with the best mix of services and teamwork between Navigators and producers.
2. **Expand the Definition of the Small Employer Market.** Starting in 2014, a state can expand the definition of its small employer market from employers with 1–50 employees to employers with 1-100 employees. In 2016, a state must expand the definition of the small group market to be employers with 1-100 employees.[2]
3. **Forego Adopting the Federal Basic Health Option.** The ACA permits each State to establish a federal Basic Health option that is similar to the current Washington

[1] PPACA § 1311(d)(4)(K) and § 1311(i)

[2] PPACA § 1304(b)

Basic Health plan (and is in fact modeled on the Washington plan).[3] However, such a plan would be outside the Exchange and would decrease the number of potential Exchange participants.

4. **Merge the Individual and Small Group Risk Pools.** PPACA permits the Exchange to merge the individual and small group risk pools.[4] Depending on the impact of such a merger (a topic currently being studied) this action could increase the number of Exchange participants.
5. **Starting In 2017, Include Larger Employers and Public Employees.** PPACA allows a state to include large employers in its Exchange, starting January 1, 2017.[5] As Riemer and Enthoven suggest, the state may also elect to include public employees in the Exchange, just as the ACA requires members of Congress to join an Exchange.
6. **Join a Multi-State Exchange.** The ACA allows a state to join other states in forming a regional Exchange.[6] Although such an action would increase the absolute number of participants in an Exchange, it is an open question whether it would help to increase Exchange participation as a percentage of the region's population not covered by Medicaid or Medicare.
7. **Offer Consumer Operated and Oriented Plans (CO-OP) and Multi-State Plans.** Both types of plan can be offered as qualified health plans in an Exchange. The federal government must offer at least two multi-state plans in each state.[7] Although member-run health insurance issuers can establish CO-OP plans, as specified by the ACA, states are not obligated to offer a CO-OP through an Exchange.[8] To the extent that either plan is cost-competitive or offers a unique form of coverage, states could encourage additional participation through an Exchange.

Key Considerations – Participation

As Washington State deliberates on the options that could increase participation in an Exchange, it should consider several key factors:

- **Trade-offs**. Although each of the options may help to increase participation, each may also have undesirable consequences. For example, foregoing a federal Basic Health plan may increase participation in an Exchange, but it also precludes additional flexibility in covering the state's population that lies between 133 percent and 200 percent of the Federal Poverty Level.
- **Choice and high standards**. Whether or not an Exchange makes any of the above choices to expand its participation, it should ensure that consumers are offered an adequate number of plan choices (perhaps by requiring each participating insurer to offer a plan in each level of an Exchange) and to operate with high standards for

[3] PPACA § 1331
[4] PPACA § 1312(c)(3)
[5] PPACA § 1312(f)(2)(B)
[6] PPACA § 1311(f)(1)
[7] PPACA § 1334
[8] PPACA § 1322

efficiency and customer service. For example, the ACA's risk adjustment methods will need to be accurately and impartially implemented in away that attracts insurers.

- **Measurement of results**. It is important that the state establish a process to measure two Exchange participation metrics: the absolute number of participants and the percentage of the total population not covered by Medicaid or Medicare.

Background – Administrative Revenue

How an Exchange's administrative costs will be funded is also an important matter. Federal grant funds will pay for the development of a state-based Exchange to be implemented January 1, 2014. Each Exchange, however, will need to have a sustainable source of administrative revenue beginning January 1, 2015.

A state-based Exchange will provide numerous services such as:

- Certify and select qualified health plans, and designate the level of coverage for those plans.
- Provide information on health plan benefits in a standard format.
- Inform the public on the performance of qualified health plans, including information on relative price and quality of those plans.
- Determine the eligibility and provide premium and reduced cost-sharing subsidies.
- Coordinate eligibility and enrollment with state Medicaid programs and a federal basic health option (if selected by Washington State.)
- Provide customer service through a web portal and call center.
- Support the implementation of the individual mandate for coverage.
- Contract with Navigators to raise awareness of the availability of qualified health plans. Navigators will also provide culturally appropriate information about those plans; make referrals, answer questions, and solve problems; and facilitate enrollment in qualified health plans.

No organization has administered an Exchange on the scale anticipated by national health reform. The experiences of programs in Washington and other states, however, do provide us with a glimpse into the administrative expenses we can expect from an Exchange.

Massachusetts Connector

The *Massachusetts Connector* provides a model for some key elements of an Exchange by facilitating subsidized and non-subsidized coverage and by supporting the implementation of the Commonwealth's individual mandate. The Connector received an initial appropriation of $25 million to fund its start-up costs and operating expenses. The Connector now must generate its own revenue to sustain its operations after the start-up funds were exhausted.

The Connector offers subsidized plans through Commonwealth Care, and low-cost, nonsubsidized plans through Commonwealth Choice. The Connector is statutorily authorized to attach an administrative fee on health plans offered through either program. The fee is based on a percentage of the capitation payments for Commonwealth Care and the monthly premium for Commonwealth Choice plans. In fiscal year 2008, the administrative fee for both programs was 4.5%. Both fees have been reduced over time as premiums and enrollment in both programs has increased (see sidebar). The Connector had a significant operating loss in its first full fiscal year. This was due to the need to hire staff, procure outside assistance, and launch programs – all while building initial enrollment.

Administrative Fees
Commonwealth Care
and
Commonwealth Choice

Year	Commonwealth Care	Commonwealth Choice
FY07	5%	See note
FY08	4.5%	4.5%
FY09	4.0%	4.5%
FY10	3.75%	4.5%
FY11	3.2%	3.5%

Note: Commonwealth Choice did not generate revenue until fiscal year 2008.

Third-party administrative expenses for premium billing and customer service for both Commonwealth Care and Commonwealth Choice account for roughly $20 million of the Connector's $30 million fiscal year 2010 annual budget. Communications, information technology support, and consulting services account for another $5 million in annual administrative expenses.

Washington State Basic Health Plan

Washington State has administered the *Basic Health Plan* for over two decades. It determines eligibility for subsidized coverage for a standardized health plan offered through negotiated contracts with private managed care organizations. Basic Health's administrative ratio as a percentage of total funding for FY09—11 is 3.98% and the average administrative cost per member per month is $8.83 based on total program and administrative funding of about $350 million for the biennium. Basic Health is a customer service organization, represented by an administrative budget, predominantly spent on staff and information technology services.

Utah Exchange and the Health Insurance Partnership

Recent experience from the *Utah Exchange* and *Washington State Health Insurance Partnership (HIP)* provides us with information on start-up costs. Utah received $500,000 in start-up costs and Utah's annual operating expenses for the Exchange are also roughly $500,000.

Since the authorization of HIP in July, 2007, state funds of roughly $1.2 million were spent on start-up activities before the program was delayed in January, 2009 due to budget cuts. The largest sources of expenditures were for Policy staff and consulting services, supporting HIP Board policy decisions and administrative development of sliding-scale premium schedules and third-party administrator contracts.

Spending of roughly $600,000, for policy staff and consulting services, was needed to prepare HIP to offer coverage under a federal grant starting on January 1, 2011. Throughout 2010, federal funds for program development primarily supported the selection of small group health plans, the necessary revisions and testing of the third-party administrator's computer system, and outreach and marketing to small employers.

Key Considerations – Administrative Revenue

The federal government is responsible for funding the development efforts -- such as information technology systems needed to operate an Exchange. Each state, however, must pay for administering an Exchange and Washington State should consider multiple options for generating sustainable administrative revenue for an Exchange.

Options for Sustainable Administrative Revenue

The Legislature should direct a Development Board to recommend sustainable options for administrative funding of an Exchange. At a minimum, the Board should consider these options:

1. **Revenue from Products Associated with Unhealthy Lifestyles**
2. **Targeted Income Tax**
3. **Surcharge or Administrative Fee on Individual or Small Group Qualified Health Plans Offered Through an Exchange**
4. **Surcharge on All Health Plans**
5. **Provider Fees**
6. **General Revenues**
7. **Blended Funding**

1. Revenue from Products Associated with Unhealthy Lifestyles

Candy, soda, tobacco, and alcohol are products typically targeted when discussions turn to assessing fees on products associated with unhealthy lifestyles. These revenue sources can be appealing because they are deemed to contribute to unhealthy lifestyles that are associated with the utilization of health care services. A tax on these products is targeted to the users of the products. Generating such targeted revenues does not recognize that programs like an Exchange, by serving a significant portion of our state, are valuable to all Washingtonians and likely serve each Washingtonian or a family member at some time throughout a resident's life.

Taxes were recently increased on candy, soda, and bottled water to fund health care programs and those taxes were reversed by referendum.

2. Targeted Income Tax

To pursue this option, Washington State would have to establish an income tax, likely targeting high-income earners. Similar to option 1, the income tax would target specific individuals for a program that serves a significant portion of state residents.

A targeted income tax on high-income earners was recently considered in Washington State and defeated by initiative.

3. Surcharge or Administrative Fee on Individual or Small Group Qualified Health Plans Offered Through an Exchange

Operations of the Massachusetts Connector are funded by an administrative fee and HIP has the authority to fund its operations with a surcharge on plan premiums. (HIP, however, is currently funded by a federal grant.) This revenue source can be appealing because it applies to the products offered through an Exchange and is paid by those who directly receive value from the coverage offered through the Exchange.

This surcharge is not a broad source of revenue. It would not apply to self-funded health plans or even to all health insurance plans. It is worth noting that Washington State health insurers now pay a state health insurance premium tax, most of the high risk pool assessment, and the ACA applies an annual fee on health insurers beginning in 2014.

Targeted options will necessitate estimating which portion of Exchange operations should be funded. It is difficult to justify, for example, surcharges on qualified health plans funding the entire information technology system that would determine eligibility for Medicaid, CHIP, a federal basic health option, and an Exchange.

4. Surcharge or Administrative Fee on all Health Plans

Exchanges will be instrumental in achieving near universal coverage and so become a valuable organization for all forms of health insurance coverage. This surcharge or fee, consequently, would appeal to those who believe all forms of health plan coverage, irrespective of public or private payment, should fund the administration of an Exchange. If applied to only private health insurance plans, then this fee would be similar to the state's high risk pool assessment, except for exemptions for public coverage and proportional assessments to stop-loss carriers and the Uniform Medical Plan. It is instructive that the transitional reinsurance program directed by the ACA to re-insure the Individual Market beginning in 2014 is funded by an assessment on all fully-insured and self-funded private health plans.

5. Provider Fees

These fees are favored by those who believe that the broadest possible fee should be imposed throughout the health care system. These fees are difficult to collect across all clinicians, however, and in the case of high risk pools, are commonly assessed upon hospitals.

6. General Revenues

Those who support general revenues believe an Exchange offers value to every Washingtonian and that revenues should be generated from the broadest possible population base. Increasing general revenues for an Exchange or any other activity usually necessitates a strong justification. Another option is not to increase general revenues and have administrative funds for an Exchange compete among all other general revenues for funding.

7. Blended Funding

Typically, blended funding combines some form of targeted and broad revenue sources. Typically, appropriating general revenues, as experienced by the state's high risk pool, is difficult to justify after targeted surcharges or fees have been assessed.

Suggested Criteria for Evaluation

The Board should evaluate the funding sources against many criteria, including these:

- The goal or perceived value of an Exchange;
- The number of Exchanges implemented in the state;
- The relative risk of the each funding source; and
- The equity of establishing targeted or broad revenue sources.

Goals and Perceived Value of an Exchange

Whether an Exchange is a market organizer or an active purchaser will impact administrative costs. If a state chooses to implement a market organizer, then minimal administrative costs will be expected. A state that chooses to implement a selective purchaser will likely assume the responsibility of demonstrating the value of performing additional administrative activities.

An Exchange will also need to decide whether to serve as the aggregator of private and public contributions toward the total premium transferred to insurers. Basic Health performs this aggregating service and the HIP will aggregate the employer contribution, employee contribution, and federal subsidy. An Exchange can likely aggregate multiple premium contributions more efficiently than spreading the responsibility to each insurer; adding to the administrative costs of an Exchange.

The Number of *Exchanges* Implemented in the State

Multiple or "subsidiary" Exchanges can serve distinct geographic areas of a state. If Washington State decides to develop and implement subsidiary Exchanges, there will likely be increased scrutiny not to duplicate services and administrative capability such as information technology and customer service staff.

The Relative Risk of Each Funding Source

Every option carries some risk. Relatively large fixed expenses, needed to support early enrollment growth, can be estimated and adequately funded by a general fund appropriation. A relatively large initial administrative appropriation -- usually needed to fund fixed costs -- can also appear excessive, when compared to early enrollment figures, and jeopardize the credibility of the program. Targeted assessments, on the other hand, could underfund start-up costs if collection begins with enrollment. A general appropriation also has the potential to fall short of providing administrative capacity for better-than-expected enrollment growth. Assessments, conversely, can provide more flexible funding for scaling the size of an Exchange.

The Equity of Establishing Targeted or Broad Revenue Sources

Each administrative funding option will be evaluated on equity. Targeted funding options appeal to those who believe that revenue should be generated from activities that are closely associated with health care utilization, or that revenues should be generated from taxes or fees on the products delivered through an Exchange. Broad funding options will appeal to those who believe that an Exchange provides value to the entire state as well as its participants.

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