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Health Care After the Supreme Court Decision: Establishing and Operating State Exchanges

By Chris Rivard
Partner
Moss Adams LLP

By Karl Rebay
Director
Moss Adams LLP

By Barbara Letts
Senior Manager
Moss Adams LLP

The Supreme Court has ruled on the Affordable Care Act and, although it upheld its constitutionality, it opened the door to giving states more flexibility on the expansion of Medicaid. Consequently, a large number of states appear to be opting out of the expansion program, potentially leaving an estimated three million people uninsured who would have been covered before the ruling, according to the Congressional Budget Office. Participation is no longer a requirement, and states no longer risk losing all their federal funding for Medicaid if they don't participate.

States are now turning their focus to exchanges—health insurance marketplaces in which people who lack affordable coverage through an employer will be able to shop for policies. Anyone can use the exchanges to gain the benefits of comparative insurance shopping, but most customers are expected to be individuals and families with incomes between 133 and 400 percent of the federal poverty level. This segment will be eligible for federal tax subsidies to make insurance affordable.

The Affordable Care Act states that individuals must be able to buy insurance through the new state exchanges by January 1, 2014. But the states must demonstrate to the Department of Health and Human Services by January 1, 2013, that the exchanges will be operational in 2014. If this can't be demonstrated by the deadline, the federal government will establish and op-

erate the exchanges for the states.

So far 10 states and the District of Columbia have enacted legislation to establish state-based exchanges, and three states have established an exchange by executive order. Massachusetts and Utah passed laws in favor of exchanges prior to the enactment of the Affordable Care Act in March 2010. That's a total of 15 states in the "yes" column right now.

To round out the field, three additional states are planning for the establishment of exchanges, a host of others are studying their options, two have decided not to create state-run exchanges, and 15 have exhibited no significant activity or engagement in this area.

The federal government has given the states approximately $1 billion in research, planning, and technology grants to help establish exchanges. Though many are using the funds for that purpose, some have chosen to return them. Nonetheless, the Obama administration is eager to see well-designed and well-run exchanges created around the country, so it's willing to provide additional financing sources that can be used even after the original start-up deadline.

With or without federal funds, establishing a state exchange is complex and challenging—and challenges exist even for those states and insurers that have already invested significant time and money in this endeavor. Among other things, governance and certification procedures must be established; standards for competing plans must be set; new information technologies must be put in place; and small-business health options must be developed and agreed on.

States establishing exchanges also have a number of important questions to ask as well as decisions to make. For instance:

- Will they require health plans to compete on price, list insurance options on an exchange Web site, or ask insurers to place bids?

- Will they have consumer representation on their boards? Who will sit on the boards?

- Will the state allocate funds for the exchange? What if there aren't enough fees collected from participating health plans?

- Will insurance brokers be included in the exchanges?

- Will there be "navigators" who will help educate consumers about the exchanges?

One of the central issues for states is determining how selective an exchange should be. One that involves a limited number of enrollees may have a harder time bargaining with insurers. And an exchange that accepts virtually everybody may help provide reasonable choice for customers.

That said, exchanges must be prepared to confront the consequences of adverse selection, which take hold when there is a disproportionate enrollment of high-risk, high-cost individuals. Indeed, adverse selection can lead to rising premiums and an exodus of lower-risk people and employers, who can take advantage of more affordable options elsewhere. This, in turn, creates a high-risk pool—and even higher premiums.

Despite the challenges of establishing an effective and efficient exchange, the states have been granted a good deal of flexibility by the federal government in this process. For example, they can run an exchange through an existing agency or through a newly created not-for-profit entity. They have the option to open an exchange to all insurers or limit the number of health plans available. They can decide what kind of role agents and brokers can have in selling health plans through an exchange. And they can allow larger employers to participate in an exchange if that makes sense.

Of course, the biggest choice for states is whether their exchange is established and operated by the state itself or by the federal government. In a state-based exchange, the state operates all activities, but it may use the federal government for determining premium tax credits and cost-sharing reductions, exemptions, and risk adjustment and reinsurance programs.

It's unclear, on the other hand, what an exchange that's facilitated by the federal government will really look like. The law says the federal government can operate an exchange either directly or through an agreement with a not-for-profit entity. And the state can decide if it wants to offer a reinsurance program or Medicaid and CHIP eligibility assessment or determination. Another wrinkle here is that an exchange facilitated by the federal government will remain unfunded until people begin

purchasing insurance through it.

There are other downsides to having the federal government operate a state exchange:

- There would most likely be fewer health plan offerings for consumers
- Insurers would have to deal with two levels of government
- The federal government would have to get involved with Medicaid eligibility determinations
- The state would have limited influence over policy and the consumer experience

There is a third option, though. In August 2011 HHS proposed an exchange model that would revolve around a partnership between the federal government and states. This state partnership approach would tailor the exchanges to local needs and market conditions, and it would allow a transition to take place so that the states could eventually run their own exchanges. The state would operate the plan management and provide consumer assistance under this model, but it could use the federal government for a reinsurance program and Medicaid and CHIP eligibility assessment or determination.

States aren't the only ones with questions about exchanges right now. Consumers, for example, may know that exchanges will provide a range of health plans with varying levels of benefits, but they don't know how much plans will actually cost through the exchanges. Another consumer uncertainty: What happens if employers buy health care through the exchanges?

Obviously, many critical details and fundamental specifics still need to be worked out before the exchanges become a reality for our nation. As a result, the next year promises to be intense and fast changing for the entire health care industry. But, in the end, this intricate and sweeping effort should prove worthwhile and beneficial.

Chris Rivard is the national leader of the Health Care practice at Moss Adams. He works with a wide variety of health care entities, specializing in financial statement preparation, development of accounting systems, reviews of procedures and internal controls, and preparation of feasibility studies as prerequisites for capital financing. He can be reached at (509) 834-2456 or chris.rivard@mossadams.com.

Karl Rebay has worked and consulted in health care for 19 years. He leverages his deep expertise in strategic business planning and provider operations—including successfully operating under capitation, turnarounds, feasibility studies, development of capitation models, and negotiation and analysis of managed care contracts—to help organizations strengthen their operations. He can be reached at (949) 623-4193 or karl.rebay@mossadams.com.

Barbara Letts is an experienced health care consultant in the areas of bundled payments and strategic financial planning for private physician practices, medical groups, medical foundations, ambulatory clinics, critical access hospitals, county hospitals, children's hospitals, academic medical centers, and large health care systems. She can be reached at (949) 623-4182 or barb.letts@mossadams.com.

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