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WHAT IS A HEALTHCARE INSURANCE EXCHANGE AND HOW DOES IT FIT IN U.S. HEALTHCARE REFORM?

Kathleen Sebelius, the new Secretary of Health and Human Services, told the House Ways and Means Committee in testimony presented on May 6, 2009, that a health insurance exchange ("Exchange"), if constructed correctly, could provide the basic format for providing health care to all Americans. So what is an Exchange, how does it work, and could it really transform health care in America?

Foremost, an Exchange is not just one thing. Think of a huge outdoor marketplace—sort of like the Pike Place Fish Market in Seattle—in which each of the vendors sells its wares to the public. The market (or Exchange) will have all its own rules, and the vendors (providers of health insurance) decide whether to set up shop there. In addition, the market may develop its own on-site shop at which it sells its own products. The market can decide which vendors will be included in the market, the types of products sold by the vendors, the size and content of the vendors' stands, the times the market is open, and the market can regulate methods used by the vendors to sell their products. In broad terms, federal Exchange may have a similar structure. Such an Exchange could potentially offer all the health insurance products an American would need at that one location.¹

The array of forms the Exchange can take, the products it can offer, and the level of federal regulation that may be applied are really awe-inspiring. As a starting point, the goals to be addressed by an Exchange may include the following:

1. **Transparency.** Provide transparency to purchasers of health insurance so that individuals or employers may make informed decisions regarding coverage and cost.
2. **Universal Enrollment or Access.** Ensure coverage for everyone. There should be no uninsured care after health care reform is implemented.
3. **Affordability.** Subsidize the cost of health insurance

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for low- and modest-income Americans so that everyone can afford health insurance.

4. Risk Spreading. Spread the risk so that even the sickest patients can be covered.
5. Cost Containment. Reduce health care costs through value-based purchasing and reduced administrative costs.
6. Portability. Maintain health coverage through job changes, periods of unemployment, and retirement.
7. Data Collection and Patient Interaction through Health Insurance IT. The Exchange could coordinate health care IT relative to electronic health records (EHR), data collection and data sharing, uniform interoperability formats and formulae, and web-based portals for patient connectivity.

An Exchange offers a vast range of alternatives for addressing each of these goals. For example, looking at a potential Exchange at the 10,000 foot level, would the Exchange include all health coverage for all Americans? Would the Exchange be limited to those in our society who currently have no coverage: the unemployed, employees of small employers, the working poor, people who are not eligible for Medicare or Medicaid? Would the Exchange be an option so that employers or individuals purchasing health insurance could purchase inside or outside the Exchange? Would the Exchange include Medicare and Medicaid as payors? If employers have policies for their employees currently, would those policies be included in the Exchange? How do self-funded employer plans fit within the Exchange? From the perspective of restraining administrative costs, maintaining transparency between plans, implementing consistent rules and regulations within the industry, and making plans available to all consumers without regard to pre-existing conditions, age, or physical limitations, it may make sense to keep as many health insurance options within the Exchange as possible.²

Each of the six goals identified includes different options and requires that additional decisions be made.

1. Transparency. The goal of transparency is that all purchasers of health insurance would be able to select their insurance product based on a rational comparison between plans. In addition to premiums and covered services, purchasers will want information regarding physicians and other healthcare providers, drug formularies, prompt claim payment history, customer service, and grievance and appeal processes. As we move to value-based purchasing, the Exchange should also be able to identify those plans, which pay for preventive care and which track provider quality care and adverse outcomes from its providers. There are a number

of studies that indicate dramatic differences in the cost of care which do not relate to the quality of care. In addition, purchasers should be able to compare premium dollars attributed to medical claim reimbursement versus administrative/overhead costs. The Exchange will need consistent information in a universally understood format.

2. Universal Enrollment or Access. The first goal of any health care reform is access to health care for all Americans. Access to health care requires two things: (a) reliable payment; and (b) available providers. Single-payor health coverage sponsored by the government is one way of addressing both of these goals. Senator Max Baucus of Montana, chairman of the Senate Finance Committee, has stated publicly that single-payor health care is not on the table. He has had vocal proponents of single-payor coverage escorted out of public meetings of the Finance Committee.

The Exchange will need to have a meaningful role in enrollment and access. The choices available to purchasers will need to be clear and understandable. There will need to be processes in place to bring everyone into the system.³ The Exchange will either need to enroll all eligible Americans and allow them to select their plans, or it will need a methodology for monitoring marketing and enrollment in all of the plans to be certain everyone is captured. There will need to be a system for following enrollees when they change plans, or are eligible for Medicare (if Medicare is outside the Exchange), leave a plan, divorce, or die. If enrollees become dissatisfied with their insurance plans because they deny claims, add costs, lose providers from their panel, or have insufficient providers for meaningful access to care, the Exchange will need to resolve those issues.

3. Affordability. The Exchange could monitor sources and uses of subsidized insurance premiums. With multiple agencies administering multiple plans for various populations and multiple governmental programs, each designed to address a particular hole in the system (such as disproportionate share payments to hospitals which serve uninsured and low income patients), there are multiple sources of funds which could be made available to subsidize premiums for some segment of the American population. One priority of the Exchange could be to ferret out these sources of funds, shake them loose through regulatory or statutory programs, and redirect those funds to supporting the Exchange program.

The other side of affordability is understanding which people will need to have their health care insurance subsidized in whole or in part; how to determine appropriate levels of income to qualify for subsidization; and tracking methods for following changes in eligibility throughout the course of the

individual's life. In addition, it may be helpful to track which plans attract more subsidized premiums compared to the services they offer, the cost of those services, and the outcomes they experience. One aspect of health care reform which is gaining increased interest is disparity in outcomes. People who get the same treatments have different outcomes, sometimes based on ethnicity, race or other factors which need to be understood. Standardized methods for identifying appropriate groups to subsidize, incorporating tracking tools, and implementing meaningful data collection can best be accomplished by an Exchange.

4. Risk Spreading. Americans are a melting pot of young people and old people, healthy people and sick people, active people and couch potatoes, healthy eaters and fried food fanatics, women bearing children, people with chronic illnesses, rich people and poor people, people who live where access to health care is plentiful and people who live in rural areas where one must travel a long way to see a doctor. If the Exchange is to provide options for all of them, it needs to be able to account for those differences by spreading the risk among all of the participants.

The choices in this category will drive cost. If one insurer provides greater services and more drugs, it is likely to attract enrollees with greater health costs. For example, a young healthy person may not review the drug formulary if he or she does not use prescription drugs. A person with chronic disease will have to select that option which covers all or a greater amount of his or her drug requirements. Is it best to factor the higher costs of care to all insurers in the Exchange, or should all insurers be required to cover all risks in all markets? Should the Exchange collect the premiums and distribute them by enrollment in the various plans? If that were the case, could the Exchange institute risk adjustments which would pay insurance plans with sicker enrollees a risk-adjusted premium? Is it appropriate that sicker people should pay higher premiums? If the insurance Exchange is predicated on everyone having insurance, would healthy people be underwriting the cost of care to sick people? Isn't that how insurance works?

Risk selection is one of the reasons an Exchange may be a viable option for health care reform if universal access to care is a driving goal. In the current market, insurance companies compete for business by targeting the healthiest populations and target marketing those groups. Their claims are low because their enrollees are, for the most part, healthy. They may institute a second layer of insurance to cover catastrophic cases. That leaves the sickest individuals on government plans or uninsured if they do not qualify for Medicare or

Medicaid. Uninsured people do not contribute premiums either because they are financially unable to do so or they think that they are young and healthy enough not to require health insurance. That drives up premiums for everyone because the cost of their care is a factor in provider costs which then translates into premium costs for the insured population.

The Exchange will have a critical role to play in (a) setting the services to be offered by each health plan participant; (b) identifying ways to spread the risk across all plans and all regions; (c) either administering enrollment for all plans or identifying a means of overseeing the enrollment, marketing plans and processes of each of the insurance plans to minimize risk selection; and (d) monitoring access to services provided by each of the plans.

5. Cost Containment. One goal of health reform generally is to reduce health care costs through value based purchasing and reduce the administrative costs of providing that care. The Exchange will be tasked with oversight of the various clinical benchmarks incorporated by each of the plans OR with standardizing benchmarks for all plans to use in their physician and provider contracts OR some combination thereof. It may be that the initial benchmarks applicable to all plans would be those adopted by the Medicare program for heart disease and diabetes. Then, once the benchmarks are in place, the Exchange would track compliance by the various plans and, as part of the transparency objective, make that information available to consumers. In addition, the Exchange would want to track compliance with the benchmarks with outcomes in some measurable way. Once again, those outcomes would be part of the transparency initiative.

Another cost saving measure will be to identify and eliminate those costs currently in the system which are no longer necessary if all people are insured. For example, if everyone has insurance, chasing uninsured patients for payment will be eliminated. Co-pay and deductible amounts will still require collection activity, but that should be a dramatically smaller number. What would be the effect if there were no more need for safety net providers? All providers would be paid by insured individuals. Are there not savings which inure to the benefit of the total population which can be redirected toward cost containment measures in health care? While not the subject of this article and arguably not within the imprimatur of the Exchange, favorable tax treatment to entities or agencies who serve the poor may become less important if all providers are paid through an insurance plan.

Reduced administrative costs are the other

component of cost containment. The Exchange could have broad power with respect to only admitting plans with identifiable and reasonable administrative components. On the other hand, administrative costs of the various plans within the Exchange could be market driven through transparency of those costs in Exchange-provided comparisons made available to consumers. The total costs of administering the program must, of course, include the cost of administering the Exchange. How powerful the Exchange is will determine how much it will cost to run it. If it has the hands-off approach adopted by some state Medicaid agencies which have outsourced their programs to private insurers, the costs associated with operating the Exchange could be relatively small. However, if the Exchange is to collect premiums, oversee enrollment, monitor payments to insurance plans, operate the subsidies for low income individuals and families, provide data for the industry related to services and outcomes, and take on all of the other programs which will be made clearer as the Exchange is rolled out, the cost of the Exchange itself will have to be a factor in any clear analysis of cost containment. That cost will need to be assessed against the costs of a national health care plan in which insurance companies operate independently.

6. Portability. Another benefit of an Exchange is to maintain health coverage through job changes, periods of unemployment, divorce, and retirement. Through an Exchange, it would be possible for an individual to sign up for an insurance plan on day one and, so long as it continued to meet his or her needs and if it is a national plan, continue with that same plan throughout his or her life, regardless of geographic location, employment status, age, health, or marital status. This objective raises a number of unique challenges. First, health insurance is governed by state law. Each insurer must be licensed in the state or states in which it provides coverage. While there are national health insurance companies, there are also a whole host of insurers who operate regionally or on a state level. The Exchange would need to have a methodology to address movement between those insurers as purchasers require a change. In addition, even if the Exchange requires a floor of basic covered services for all insurance plans, there may be variations in coverage among the various plans. The Exchange's enrollment and transparency programs can address a consumer's questions in making changes if those programs are fully operational. Another issue which requires resolution is what happens when an employee who is happy with his current insurer leaves that employer to work for an employer which has a different sponsored plan or even a self-funded plan. Portability would presume that the employee could retain his or her old insurance. Market forces may dictate that the employee must factor insurance

coverage into any employment changes. As more and more of the costs are borne by the employee, this becomes a much bigger factor.

7. Health Insurance IT. All of the Exchange objectives discussed so far will require health insurance IT to support the goals and implement the solutions. The Exchange is really the driving force behind standardizing forms and formats so that (a) the quality of care can be tracked and improved over the whole spectrum of patients and health care plans; (b) transparency between plans and providers within plans can be tracked and made available to consumers; (c) enrollment may be implemented and tracked throughout one's life; (d) affordability can be tracked and updated as an individual's financial circumstances change; (e) risk spreading can be tracked and dealt with appropriately; (f) cost containment clearly must be measured through HIT; and (g) HIT is required so that your records follow you when you change plans and so that the Exchange will know what plan you are in and when you change plans. HIT is not an objective or an end. It is merely a means for the Exchange and all of the plans within the Exchange to communicate with each other and with the consumers. Consumers need to know about the care they are receiving; the state of their health; the cost of the care; how much they are personally responsible for paying; preventive measures they should consider; new treatments which may be available to them. HIT is the means. Interoperability between various HIT formats will be key. The Exchange can facilitate the ability of the various information sources to communicate with each other and with consumers. There would likely be a sort of Health Information 2.0 in which a patient/consumer could communicate directly with care givers or test takers regarding their health and appropriate next steps.

Of course, the last question for this article is whether the Exchange should include a public product; that is, perhaps one of the insurance products offered generally is a product available to all individuals which is underwritten by the federal government, like the Medicare program. It would have a co-pay and deductible component, like all of Medicare, and a premium component like Medicare Part B. Some private insurers are wary of introducing a public product because, if it is available to everyone, the private insurers are fearful that it would drive the premiums down for everyone. Some people want to make a public product available only in rural areas or areas where there are only two or less private plans available. Some would limit the public plan only to the poor or very sick so that the public plan would support the safety net hospitals and physicians who currently provide the health care to uninsured individuals.

There are arguments on all sides of this issue. If a public plan were available to everyone, arguably the premiums for all insurance would be reduced because it would promote competition. As the public plan would be subject to the same transparency rules as the private plans, their costs, including costs of providing health care, would be available to everyone. This may assist private plans in contracting with their health care providers. If the public plan were subsidized through methods other than or in addition to subsidized premiums from its enrollees, that could also be made apparent by the Exchange to taxpayers, purchasers and private plans alike. The purpose of the public plan would need to be crystal clear: (a) is it a bare bones plan which provides only basic services at a low cost? (b) is it a subsidized plan meant to cover the sickest in the population? (c) is it a plan to fill the gaps in rural or other underserved areas of the country? (d) is it meant to compete head-to-head with the private plans, offering competitive rates, competitive services, or value-added services? If (d) is the answer, is that really the role of government?

¹ The templates most often cited for a federal Exchange are the Massachusetts Commonwealth Connector program, the California program for public employees and retirees, and the Federal Employees Health Benefit Program.

² A primary exception may be federally funded plans such as Medicare and Medicaid as they have the added Stark, fraud and abuse, and Federal False Claims Act regulatory prohibitions which would not necessarily apply to private insurers. The question of including/not including the Medicare and Medicaid programs in the National Health Insurance Exchange is left for another article.

³This has been a tremendous obstacle for Medicaid and the SCHIP program for the states as there are many of our citizens who either do not understand the program, are wary of any government program, or who just think it does not apply to them.

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