



Project for Health Insurance Exchange Education

How can states design a health insurance exchange that effectively holds down premiums?

The Project for Health Insurance Exchange Education (PHIXE) can help.

State policy-makers across the U.S. will soon decide what kind of health insurance exchange they want. In most states, the debate has centered on governance and accountability. These issues must be resolved to gain approval from the U.S. Department of Health and Human Services. But governance and accountability are not the only key issues.

As policy-makers and advocates in many states realize, it is equally important to create an exchange that holds down health insurance costs, while promoting health care quality.

So far, independent analysts have identified only one mechanism that will enable an exchange to lower health insurance premiums across the board: properly structured competition

The Congressional Budget Office has indicated that an exchange's pooling of a large number of insurance buyers, combined with subsidies for low-income buyers, could exert competitive pressure on health plans to constrain their prices. In an analysis of the potential effects of an exchange in Wisconsin, MIT Professor Jonathan Gruber estimates that this competition effect would lower premiums by 7.5%.

The Community Advocates Public Policy Institute recently launched PHIXE to assist states with designing exchanges—in particular, the SHOP exchange for small employers—that effectively uses competition to lower insurance premiums...potentially by more than 7.5%

PHIXE provides this educational service and technical assistance at no cost. We also help states ensure that their exchanges promote evidence-based addiction treatment, further holding down insurance premiums. Specifically, the project offers:

- Educational meetings with policy-makers and advocates about the ACA and exchanges;
- In-depth seminars to explain how exchanges can be designed to lower costs, promote quality, and improve addiction treatment;
- Technical assistance to states in designing effective exchanges.

For more information, please take a look at the enclosed materials. If you would like to discuss how we may be able to help, please contact me at (414) 270-2943 or DRiemerMil@yahoo.com, or Mike Bare at (414) 270-2976 or mbare@communityadvocates.net

Thank you,

David R. Riemer, Director



Project for Health Insurance Exchange Education

Who We Are

Community Advocates Public Policy Institute

Founded in 2008, the Community Advocates Public Policy Institute is a non-partisan organization that seeks to put into place policy changes to dramatically reduce poverty in Wisconsin. We also seek to ensure that low-income individuals can easily obtain high-quality health care, addiction treatment and mental health services.

Project for Health Insurance Exchange Education

The Project for Health Insurance Exchange Education (PHIXE), launched in 2011, seeks to harness the potential of state health insurance exchanges established by the *Affordable Care Act* (ACA) to maximize health insurance coverage, reduce costs and improve quality of care.

A central goal of the project is to educate state policymakers about how creating an exchange whose pool is 1) average in risk, 2) very large in size, and 3) incentivized to choose low-cost health plans is a powerful vehicle for enabling market forces to put strong and enduring pressure on health care insurers and providers to lower costs and enhance quality.

Another goal is to help policymakers understand how exchanges can improve addiction treatment.

The project offers:

- Educational meetings with advocates and policymakers about the ACA and exchanges in particular;
- In-depth seminars to explain how exchanges can be designed to lower costs and improve addiction treatment;
- Technical assistance to states in designing effective exchange.

David R. Riemer, Director, Community Advocates Public Policy Institute

David Riemer has nearly 35 years of experience in health care policy and administration.

After graduating from Harvard Law School in 1975, Riemer prepared Wisconsin's first Medicaid rule for the Administration of former Governor Patrick Lucey. As counsel to U.S. Senator Edward M. Kennedy's Subcommittee on Health and Scientific Research from 1978-81, he helped draft legislation dealing with prescription drug and mental health policy. Returning to

Wisconsin in 1983, Riemer worked for the Legislative Fiscal Bureau in assisting the Legislature to redesign the state employee health insurance plan, legalize HMOs and create a hospital rate-setting commission.

Riemer worked for several years with a Milwaukee insurance company on health care cost containment. From 1988 through 2001, as Budget Director, Administration Director and Chief of Staff for Milwaukee Mayor John Norquist, Riemer guided the city's effort to restructure its employee health insurance plan.

During this period, Riemer also helped to design Wisconsin's BadgerCare program, which Governor Tommy Thompson and the Legislature enacted in 1997. After obtaining a federal waiver in 1999, BadgerCare vastly expanded coverage to hundreds of thousands of the state's working families.

In 2003, as Budget Director for Wisconsin Governor Jim Doyle, Riemer helped redesign the state employee health plan to strengthen its incentive effects, significantly curbing state health care costs.

From 2004 through 2007, Riemer launched a statewide initiative, the Wisconsin Health Project, to build bipartisan consensus on comprehensive statewide health insurance reform. The resulting Wisconsin Health Plan, sponsored by State Representatives Curt Gielow (R) and Jon Richards (D), played a role in the State Senate's development of Healthy Wisconsin, included in the Senate version of the 2007-2009 budget.

Riemer currently directs the Community Advocates Public Policy Institute. In 2008, the Institute launched the Milwaukee Addiction Treatment Initiative, which helped enact state "parity" legislation for addiction and mental health treatment. In 2009, Riemer co-authored with Stanford Professor Alain Enthoven an op-ed in the *New York Times* on national health insurance reform (www.nytimes.com/2009/06/25/opinion/25enthoven.html). In 2010, he was appointed to the Wisconsin Legislative Council Special Committee on Healthcare Reform. Since 2010, Riemer has also been a member of the National Academy of Social Insurance Study Panel on State Health Exchanges.

David Riemer can be reached at (414) 270-2943 or DRiemerMil@yahoo.com.

Mike Bare, Research Director and Program Coordinator, Community Advocates Public Policy Institute

Mike Bare specializes in health care, disability, energy and housing research, and is an expert on the intersection of policy with politics and the legislative process. He is also a Program Evaluator of the Community Advocates Brighter Futures program, assists with the Milwaukee Tobacco Prevention and Control Program, manages the Institute's visiting speaker series, and is the Director of the Institute's Internship and Fellowship Program.

Bare previously worked as an aide to U.S. Senator Russ Feingold in his Washington, D.C. office, specializing on legislation relating to military and veterans' health and mental health services.

Bare holds a master's degree in political science from American University, where he was President of the Graduate Student Council and served on several University-wide committees. He has been a longtime volunteer for Special Olympics and other disability organizations, and also serves on the Board of Directors for the Down Syndrome Association of Wisconsin.

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Creating a SHOP Exchange that Holds Down Premiums

The best available evidence indicates that, in order for states to create a SHOP exchange for employers that actually works to hold down employers' health insurance premiums, the exchange must have a **participant pool with three features** that reinforce each other so strongly that they activate competitive market forces powerful enough to drive down health care costs:

1. The pool must be **average in risk**.
2. The pool must be **very large in size**—at least 20%, and preferably 30% or more of the state's population who are not enrolled in Medicaid and Medicare.
3. The pool's participants must have a clear, **strong economic incentive to choose low-cost health care plans**.

Only a SHOP exchange whose pool has **average risk**, a **very large size**, and participants with **strong incentives** to select the low-cost plan has the capacity (without a regulatory overlay) to unleash the kind of *intense and lasting market pressures* on health insurance companies that will induce them to *compete aggressively* to hold down their premiums by constraining the underlying cost of health care.

Why are the pool's **average risk**, **very large size**, and **strong incentives** so important? Because:

- If the exchange pool is average in risk, insurers will not be afraid to bid.
- If the exchange pool is very large in size, insurers have no economic choice but to submit a bid. They can't turn their backs on getting a slice of 20%, 30% or more of the non-Medicaid/non-Medicare market, however much they may dislike "multiple choice" arrangements. Too many customers, too much revenue, and too much profit are at stake.
- Finally, if participants in the exchange pool have a strong incentive to choose the low-cost plan, health care plans in turn have no economic alternative but to try to *be* the low-cost plan, or close to it. If they fail to submit a low bid, they will not only lose customers and revenue, but they are likely to end up with customers who are loyal to them because the customers are sick and do not want to change doctors, which (despite risk adjustment) will threaten the plans' profits.

The bottom line: an exchange whose pool is **average in risk**, **very large in size**, and composed of participants who have a **strong incentive to join the low-cost plan** will cause *market forces* to induce health care plans to seek a *competitive* advantage by submitting low premium bids, which they can

ultimately sustain only if they in turn hold down health care costs by making the delivery of health care itself more efficient.

10 Policy Measures

There are at least 10 specific measures that state policy-makers can take to create a SHOP exchange whose pool has **average risk**, a **very large size**, and **strong incentives to select low-cost plans**.

To promote the pool's **average risk**, policy-makers could ensure that the SHOP exchange attracts a good cross-section of risk (and doesn't distort the distribution of risk among the different benefit levels) by enrolling in the SHOP exchange only those employers that agree to:

1. Cover a high percentage (e.g., 75% or more) of their *full*-time employees;
2. Cover a high percentage (e.g., 75% or more) of their *part*-time employees—if they decide to provide coverage for *part*-time employees;
3. Cover a high percentage (e.g., 75% or more) of spouses, partners, and dependent children—if they choose to provide coverage for spouses, partners, or dependent children; and
4. Place all covered groups within the *same* benefit level (Bronze, Silver, Gold or Platinum) that the employer has designated.

NOTE: These measures are primarily designed to stabilize the SHOP exchange pool's risk profile by ensuring that employers who've placed their employees in the pool do not face "adverse selection" from other employers who dump a few unhealthy employees into the pool while covering the healthy majority of their workers elsewhere. These risk stabilization measures will also increase the size of the SHOP exchange pool.

To promote an exchange pool that's **very large in size**, policy-makers could take several measures to increase the number of employers that use the SHOP exchange to cover their employees:

5. Require the SHOP exchange to serve small employers with 1-100 full-time employees for its first two years (in addition to 2016 and beyond);
6. Permit the SHOP exchange to serve employers of *any* size beginning on January 1, 2017 (at which point opening up the SHOP exchange to larger employers is first allowed);
7. Require that all governments within the state (i.e., state government, counties, cities, villages, towns, school districts, etc.) —if they voluntarily elect to provide their employees with health insurance—must use the SHOP exchange as the exclusive vehicle for providing their employees with health insurance:
 - A. During the years prior to January 1, 2017, when the SHOP exchange is not available under the ACA to either private or governmental employers with over 100 full-time employees, the state entity that runs the SHOP exchange would have to *temporarily* operate a separate but parallel exchange for governmental employers only—one that is fully coordinated with the SHOP exchange, and demands the same premium bids from health care plans, but is legally distinct;
 - B. Beginning on January 1, 2017, the SHOP exchange would be expanded to absorb all governmental employers, and the separate but parallel exchange for larger governments would terminate.

NOTE: Under this policy, governments would be free to decide whether to provide health insurance in the first place, and, if so, whether to go with the Bronze, Silver, Gold, or Platinum level of coverage.

8. Require that certain government contractors or grantees—should they voluntarily elect to provide their employees with health insurance—must use the SHOP Exchange as the exclusive vehicle for providing their employees with health insurance.

NOTE: This would be limited to contractors and grantees that rely on state programs as a primary source of income, i.e., nursing homes, hospitals, transportation contractors, etc. The ACA prohibits states from formally requiring their contractors or grantees to use the Exchange, but it may be legally possible for a state to condition its contracts and grants on use of the Exchange.

Since this policy would apply to all contractors and grantees that receive a specified high level of taxpayer funding, it would limit adverse selection. There would be some risk of adverse selection, however, because contractors and grantees would be free to decide whether to provide health insurance in the first place, and, if so, whether to select the Bronze, Silver, Gold, or Platinum level of coverage.

To promote a SHOP exchange pool whose participants have a **clear and strong economic incentive to select low-cost health care plans**, at whichever benefit level (Bronze, Silver, Gold or Platinum) the employer has chosen, policy-makers could:

9. Ensure that the SHOP exchange only enrolls employers that agree to contribute—on behalf of their workers, or on behalf of their workers’ spouses, partners, or dependent children—a flat dollar amount that *does not exceed the lowest dollar premium bid* at whichever benefit level (Bronze, Silver, Gold or Platinum) the employer has chosen; and
10. Permit the SHOP exchange to enable employers to contribute *more* than a flat dollar equivalent to the premium bid by the lowest-bidding plan *only if*:
 - A. The health care plan for which more is contributed is an integrated delivery system, at least 75% (or some other high percentage) of whose primary care doctors have an exclusive economic relationship with the plan; and
 - B. The total amount contributed by the employer does not exceed 110% (or a similar percentage) of the premium bid by the lowest-bidding plan.

NOTE: In general, it is essential that the participants in the SHOP exchange have a clear and strong economic interest to join the low-cost plan at the benefit level (Bronze, Silver, Gold or Platinum) chosen by their employer, which can be achieved by obliging them to pay out-of-pocket for the full extra cost of selecting a more expensive plan at that benefit level. There is, however, one possible exception to this. It may be appropriate for SHOP exchange participants to face no extra cost (thus, no disincentive) if they choose to enroll in an integrated delivery system whose primary care doctors almost all work for the integrated delivery system and the integrated delivery system is only “slightly” more expensive. Avoiding a disincentive to choose such an integrated delivery system may make sense because there’s evidence that, in the long run, integrated delivery systems staffed by highly-invested primary care providers are more effective in reducing the error, waste, and inefficiency that typically characterize the provision of health care, and thus have the capacity to lower costs “the right way” by making health care much more efficient.



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Project for Health Insurance Exchange Education

Ensuring that Exchanges Improve Addiction Treatment

As part of creating a health insurance exchange that's effective in holding down costs and improving health care quality in general, state policy-makers will want to pay particular attention to how their state's exchange can improve addiction treatment and mental health services. The more a state exchange promotes early identification and effective treatment of these serious, chronic, but often ignored and stigmatized illnesses, the more the exchange can accomplish its overall goals of constraining costs and strengthening health care quality. Addiction treatment advocates and state policy-makers should consider these five steps:

1. Adopt Smart Transition Procedures for Released Prisoners

The *simplest, fastest and least expensive* step that a state exchange can take to improve addiction treatment is to require that, **prior to release, all prisoners in the prison health system must enter the exchange** and (as appropriate) sign up for either Medicaid or exchange-based coverage, to take effect immediately upon release.

The administrator of the exchange, working with the state's Medicaid agency and the state's Department of Corrections, should ensure that prisoners approaching release have used the exchange portal, chosen a health care plan, selected a primary care doctor and scheduled an immediate post-release appointment with the doctor. This will eliminate gaps in their coverage, and enable them to receive ongoing health care—typically involving treatment for addiction, and potentially co-occurring mental illnesses, which often require maintenance of a regimen of prescription drugs.

States can prevent crimes, spare innocent people from death and injury, reduce recidivism and avoid taxpayer costs by establishing efficient transition procedures within their prisons to promote this continuity of care. The cost to states will typically be nil, because the federal government will pick up most (if not all) Medicaid costs, and tax credits provided through the exchange are federal. The subsidies offered through the exchanges are also borne by the federal government. The administrative burden on the states will also be minimal.

2. Create a Sound Relationship between Medicaid and the Exchange

The *Affordable Care Act* allows states to limit (over time) their Medicaid programs to low-income individuals whose incomes don't exceed 133% of the poverty line. Low-income individuals whose incomes fall between 133% and 400% of the poverty line (and who are not covered by an employer, Medicare, or any other government program) would typically obtain a subsidy to buy a private health care plan, providing the same "essential health benefits" that Medicaid provides, through the state's exchange.

It is critical for state policymakers to structure the complex relationship between Medicaid and the state's exchange so that **low-income individuals do not fall through the cracks** as changes in their income and family structure (e.g., divorce, marriage, new child, a child leaves home, etc.) cause them to gain or lose Medicaid eligibility. For low-income individuals with an addiction to alcohol or other drugs, or who have a co-occurring mental illness, a particular concern is to **maintain continuity of care**—to be able to stay with the addiction treatment and mental health providers with whom they have established a positive, productive relationship.

3. Structure the Exchange to *Inherently* Lower Costs and Improve Quality

The best available evidence suggests that if a state exchange is structured so that its risk pool is (1) average in risk, (2) very large in size (e.g., over 25% of the non-Medicaid/non-Medicare market), (3) composed of participants who have a strong economic incentive to choose a low-cost, high-quality health care plan, the exchange will exert strong and enduring pressure on the health insurance market that *inherently* drives health insurers and providers to lower costs and improve quality of care.

The Project for Health Insurance Exchange Education (PHIXE) has outlined, in a separate document, 10 specific measures that state policymakers can take to create a SHOP exchange whose pool has average risk, a very large size and strong incentives to select low-cost plans.

A SHOP exchange that is structured to *inherently* lower costs and improve quality will also tend to improve addiction treatment. Addiction and frequently co-occurring mental illness are serious, chronic illnesses whose neglect by a health care plan will raise the plan's costs and diminish its quality in numerous ways—e.g., more auto accidents, more strokes and heart attacks, higher risk of STDs and STIs, etc. The more powerful a SHOP exchange's structure is (due to the pool's average risk, large size and strong incentives) in rewarding through the market those health care plans that are efficient in delivering low-cost, high-quality health care, the more the exchange will be likely to reward health care plans that do a better job in early identification, accurate diagnosis, and effective treatment of addiction and co-occurring mental illness.

4. Improve Quality of Qualified Health Plans

The *Affordable Care Act* requires states to certify and rate “qualified health plans.” One opportunity for advocates and state-policy makers to improve addiction treatment is to **ensure that the certification and rating criteria relate to addiction treatment.**

The *Affordable Care Act* allows states to require that “qualified health plans” cover treatment beyond what's prescribed in the “essential health benefits” package, creating an opportunity for policymakers to **include quality addiction treatment in the expanded benefits package.** One strategy would be to have the exchange assess how well each health care plan has done in adhering to the addiction-based rating criteria established by the National Quality Forum.

Markets must provide consumers with objective information to function successfully. For a state exchange to help make the health insurance market work better, it would be a logical step to provide consumers with a wide range of information about how well health care plans have done in the past with early identification, accurate diagnosis, and effective treatment of addiction. **The exchange portal, telephone assistance, and navigators could all be required to provide up to date information to consumers about the quality of each plan's addiction treatment coverage.**

5. Rethink the Interaction between Insurance and Stand-Alone Treatment Programs

A final issue is what role, in a world of near-universal insurance coverage, should be performed by stand-alone addiction treatment programs?

Once the ACA takes effect, and virtually every American has health insurance that provides coverage for addiction as well as mental illness (and on a “parity basis”), the role of categorical SAMSHA, state, and county-funded programs for addiction treatment will have to be reexamined.

Particularly if groups like the Coalition for Whole Health are successful in persuading the U.S. Department of Health Services to define addiction and mental health treatment to mean both outpatient and inpatient programs, what will be left—outside of the realm of health insurance—for categorical addiction and mental health programs to do?

Advocates for improved addiction treatment, as well as state policy-makers, **need to think through this question very carefully** for their particular states, and **develop in advance a set of policies they want to see implemented.** Otherwise, budget pressures at the federal, state, and county levels could result in a rapid phasing-out of government-funded categorical programs, potentially causing

many persons in need of addiction treatment to (once again) fall through big holes in the addiction treatment safety net.