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BUILDING A CONSUMER-ORIENTED
HEALTH INSURANCE EXCHANGE:
KEY ISSUES

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Building a Consumer-Oriented Health Insurance Exchange: Key Issues

As states develop insurance exchanges, their decisions have profound implications for consumers. This report covers three main areas where consumers intersect with the exchange. First are ways consumers participate in exchange governance, such as directly serving on exchange governing boards. Second is consumer input into exchange policy and implementation decisions, and the various avenues states are using to gather this input, such as workgroups, town hall meeting participation, and surveys. Third is the early planning for the consumer-serving functions of the exchange, such as navigator programs and the web portal.

http://nashp.org/sites/default/files/Building_a_Consumer_Oriented_Exchange_final.pdf



Health Insurance Exchange Rules Highlight 'State Flexibility'

TOPICS: INSURANCE, MARKETPLACE, HEALTH REFORM, STATES

MAR 12, 2012

The Department of Health and Human Services today released many of the rules for health insurance exchanges, which include specifics about state functions and responsibilities.

Kaiser Health News has a copy of the health exchanges rule from the Federal Register, as well as the regulatory impact analysis.

The Associated Press: Feds Release Health Overhaul Blueprint For States

Tackling a huge logistical challenge, the Obama administration Monday released an ambitious blueprint for states to match up uninsured Americans with coverage that's right for them under the health care overhaul law. The long-awaited regulation, released as the Supreme Court prepares to hear a challenge to the law, stresses state and federal flexibility (Alonso-Zaldivar, 3/12).

Modern Healthcare: HHS Issues Final Rule On Health Insurance Exchanges

The final rule outlined the minimum standards states must meet in establishing and operating their exchanges, such as individual and employer eligibility for enrollment. The rule also outlines minimum standards that health insurers must meet to participate in an exchange and the standards employers must meet to participate in the exchange. The regulation aims to offer states "substantial discretion" in both the design and operation of their exchanges, according to the rule (Daly, 3/12).

National Journal: HHS Releases Exchange Regulations

[HHS] laid out the [state's] functions: Certifying "qualified health plans"; operating a website for comparing plans; running a toll-free hot line for consumer support; providing grants to "Navigators" for consumer assistance; determining eligibility of consumers for enrollment in qualified health plans; and helping them enroll. States must build their insurance markets essentially from scratch and have been clamoring for the rules of the road before they invested heavily in infrastructure (Fox, 3/12).

Politico Pro: Exchange Rule Keeps Disputed Provisions

Insurers, for example, wanted HHS to prevent exchanges from imposing requirements on plans in the exchanges beyond what is included in the health care reform law. States could use this power to create "active exchanges" that negotiate on behalf of consumers. ... But HHS disappointed consumer advocates by not reducing the number of insurers that will be allowed to sit on the board of the exchange. Up to half of a board can represent insurers under the new rules (Millman and Feder, 3/12).

The Hill: States Get 'Substantial Flexibility' In Running Health Law Exchanges

The final rules also offer each state more time to set up its exchange. The law requires states to "demonstrate complete readiness" by Jan. 1, 2013, in order to guarantee they'll be operational 12 months later. If states that don't meet the deadline, a federal exchange will take over (Pecquet, 3/12).

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Affordable Insurance Exchanges: Choices, Competition and Clout for States

On March 12, 2012, the U.S. Department of Health and Human Services (HHS) published a final rule on Affordable Health Insurance Exchanges, which combines policies from two Notices of Proposed Rulemaking (NPRMs) published last summer. One rule, published on July 15, 2011, outlined a proposed framework to enable states to build Affordable Insurance Exchanges (Exchanges), which are new state-based competitive marketplaces created under the Affordable Care Act. A second NPRM, published on August 17, 2011, outlined proposed standards for eligibility for enrollment in qualified health plans through the Exchange and insurance affordability programs, including premium tax credits.

Starting in 2014, one-stop marketplaces called Exchanges will be operational, enabling consumers and small businesses to choose a quality, affordable private health insurance plan that fits their health needs. Exchanges will offer health insurance options that meet consumer-friendly standards; facilitate consumer assistance, shopping for and enrollment in a private health insurance plan; and coordinate eligibility for premium tax credits and other affordability programs that ensure health insurance is affordable for all Americans. Through Exchanges, the public will have the same kinds of insurance choices as members of Congress.

Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs.

The final rule released today offers a framework to assist states in setting up Affordable Insurance Exchanges. The framework preserves and, in some cases, expands the significant flexibility in the proposed rules that enables states to build an Exchange that works for their residents. For example, the final rule allows states to decide whether their Exchange should be operated by a non-profit organization or a public agency, how to select plans to participate, and whether to partner with HHS for some key functions. The final rule also offers significant additional flexibility regarding the eligibility determination process. It also makes it easier for small businesses to get coverage through the Small Business Health Options Program (SHOP), strengthens consumer protections, and keeps it simple for health plans interested in participating in Exchanges.

The final rule builds on over two years' work with states, small businesses, consumers and health insurance plans. The Administration examined models of Exchanges; held numerous meetings with stakeholders; and consulted closely with state leaders, consumer advocates, employers and insurers. Before the proposed and final rule was issued, HHS published a Request for Comment (the RFC) on August 3, 2010 on a number of policy issues addressed in the rules. In response to the proposed rules, HHS received approximately 24,780 comments from the public. The commenters represented a wide variety of stakeholders, including but not limited to states, tribes, tribal organizations, health plans, consumer groups, healthcare providers, industry experts, and members of the public. In the final rule, we have responded to comments submitted in response to the Exchange establishment and eligibility proposed rules and the RFC, where relevant. In addition to those comments received formally, HHS also

engaged in listening sessions with a wide range of stakeholders across the country after the proposed rules were released. This public input was also integral to the development of the final rule policy.

The Exchange final rule includes standards for:

- The establishment and operation of an Exchange
- Health insurance plans that participate in an Exchange
- Determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs
- Enrollment in health plans through Exchanges
- Employer eligibility for and participation in the Small Business Health Options Program (SHOP)

This final rule is the latest in an ongoing series of steps to help states develop Exchanges. As of February 22, 2012, 49 states and the District of Columbia have received Exchange Planning grants, while 33 states and the District of Columbia have received Exchange Establishment grants. HHS is continuing to provide technical assistance to states, including technical consultations, monthly user groups, working groups on core functions, and conferences.

Public Comment

The comment period for the proposed rules ended October 31, 2011. HHS received approximately 24,780 comments on both proposed rules that informed the final rule policies. Several provisions in the final rule, which are being issued as interim final, are open to further public comment. This includes the new flexibility for the eligibility process.

Establishment of Exchanges

The final rule outlines the standards for a state to establish an Exchange while prioritizing state flexibility in numerous ways. For example, each state can structure its Exchange in its own way: as a non-profit entity established by the state, as an independent public agency, or as part of an existing state agency. In addition, a state can choose to operate its Exchange in partnership with other states through a regional Exchange or it can operate multiple Exchanges that cover distinct areas within the state. Any combination of these options can be approved. Exchanges that are run by independent agencies or non-profits must have governance principles, include consumer representation, and that ensure freedom from conflicts of interest and promote ethical and financial disclosure standards.

Exchanges will perform a variety of functions, including:

- Certifying health plans as "qualified health plans" to be offered in the Exchange
- Operating a website to facilitate comparisons among qualified health plans for consumers
- Operating a toll-free hotline for consumer support, providing grant funding to entities called "Navigators" for consumer assistance, and conducting outreach and education to consumers regarding Exchanges
- Determining eligibility of consumers for enrollment in qualified health plans and for insurance affordability programs (premium tax credits, Medicaid, CHIP and the Basic Health Plan)
- Facilitating enrollment of consumers in qualified health plans

States have substantial flexibility in determining how to perform these functions. The final rule simplifies the process for states' Blueprints for Exchanges to be approved and updated; empowers states

to determine a role for agents and brokers – including the use of on-line brokers; and removes processing of appeals from minimum Exchange functions.

Affordable Care Act provides that a state’s plan to operate an Exchange must be approved by HHS no later than January 1, 2013. However, the final rule allows for conditional approval if the state is advanced in its preparation but cannot demonstrate complete readiness by January 1, 2013. The final rule also allows states that are not ready for 2014 to apply to operate the Exchange for 2015 or any subsequent year. HHS will continue working with states to support their progress, including through new funding opportunities. New funding will be available for all Exchange models through a final award date no later than December 31, 2014. The budget and project period for Level One Exchange Establishment Grants is up to one year from the date of award and for Level Two Exchange Establishment Grants is up to three years from the date of award.

Qualified Health Plans

Health plans offered through the Exchange must be certified as “qualified health plans”. Qualified health plans will provide high-quality coverage like that of a typical employer plan. To be certified by the Exchange, health plans must meet minimum standards that are primarily defined in the law. The final rule gives Exchanges the flexibility to establish additional standards for health plans offered in their Exchanges. For example, Exchanges have flexibility on the:

- **Number and Type of Health Plan Choices:** The final rule allows Exchanges to work with health insurers on structuring qualified health plan choices that are in the best interest of their customers. This could mean that the Exchange allows any health plan meeting the standards to participate or that the Exchange creates a competitive process for health plans to gain access to customers on the Exchange.
- **Standards for Health Plans:** The final rule allows Exchanges, working with state insurance departments, to set specific standards to ensure that each qualified health plan gives consumers access to a variety of providers within a reasonable amount of time. Exchanges will also establish marketing standards to make sure that qualified health plans do not market plans in a way that discriminates against people with illnesses. It also gives Exchanges flexibility to set the timeframes in which health issuers need to become accredited for their quality performance (if they are not already), allowing consumers access to new and innovative health plans through the Exchange as they gain accreditation. And it amends the grace period policy to ensure that qualified health plans can provide seamless coverage without being left paying all the bills.

Eligibility

The Exchange final rule establishes a streamlined, coordinated, and web-based system through which an individual may apply for and receive a determination of eligibility for enrollment in a qualified health plan through the Exchange and for insurance affordability programs. This means that no matter how an application is submitted or which program receives the application, an individual will use the same application and receive a consistent eligibility determination, without the need to submit information to multiple programs. This consumer-focused approach will facilitate the enrollment of millions of Americans into affordable, high quality coverage while minimizing the administrative burden on states, individuals, and health plans.

- **Eligibility Determinations:** The final rule outlines standards and processes for Exchanges to consider whether consumers are eligible for all available programs using a single, streamlined

application, meaning that consumers do not have to guess what programs they are eligible. Consumers will be able to easily notify the Exchange of any changes that might affect their eligibility, including marriage, divorce or a job change. The final rule also ensures that Exchanges will make it easy for consumers to keep their coverage year to year through a simple eligibility redetermination process.

- **Simple Verification of Data:** To reduce paperwork and red tape for consumers, the final rule directs Exchanges to rely on existing electronic sources of data to the maximum extent possible to verify relevant information, with high levels of privacy and security protection for consumers. For the majority of applicants, an automated electronic data matching process should eliminate the need for paper documentation.
- **Coordinating across Programs:** The final rule ensures that Exchanges will coordinate with Medicaid, CHIP, and the Basic Health Program, where applicable, to ensure that an applicant experiences a seamless eligibility and enrollment process regardless of where he or she submits an application.
- **New Options for States:** In response to comments, the final rule provides two ways for Exchanges to interact with Medicaid agencies when making eligibility determinations: Exchanges, following state-established Medicaid rules, can conduct eligibility determinations for Medicaid and for advance payment of premium tax credits; or the Exchange will make the preliminary eligibility assessment and turn it over to the state Medicaid agency, if applicable, for final determination, within certain parameters. In addition, a state-based Exchange may determine eligibility for advance payments of the premium tax credit and cost-sharing reductions or it could be approved if HHS makes determinations for these functions. These approaches continue the commitment to facilitating enrollment in the appropriate insurance affordability program without delay.

Enrollment

Once determined eligible, the integrated enrollment system of the Exchange will use a streamlined, simple system to ensure that eligible Americans successfully enroll in the health coverage that best fits their needs. The enrollment process outlined in the final rule will be geared toward consumers and will use websites and toll-free call centers, among other tools, to help people enroll in coverage. Exchanges will enable consumers to learn about the varieties of coverage provided in the market so that they can make informed choices about the coverage available on the Exchange. Exchanges have options to improve the performance of this system through the design of their website. Exchanges may also decide whether to use the single application that will be made available or design one on their own that is comparable. Like the eligibility process, the final rule ensures that the enrollment process meets high standards regarding the privacy and security of personal information.

The final rule also provides standards for Exchanges to build partnerships with and award grants to entities known as “Navigators” who will reach out to employers and employees, consumers, and self-employed individuals to:

- Conduct public education activities to raise awareness about qualified health plans
- Distribute fair and impartial information about enrollment in qualified health plans, premium tax credits, and cost-sharing reductions
- Assist consumers in selecting qualified health plans
- Provide referrals to an applicable consumer assistance program or ombudsman in the case of grievances, complaints, or questions regarding health plans or coverage
- Provide information in a manner that is culturally and linguistically appropriate

Exchanges will award grants to Navigators. The final rule directs states to choose at least two Navigator organizations, one of which must be a community or consumer-focused non-profit organization.

Small Business Health Options Program (SHOP)

Beginning in 2014, Exchanges will operate a Small Business Health Options Program (SHOP). The SHOP will provide small employers with new ways to offer employee health coverage, better information, easier administration, and access to tax credits that make coverage more affordable.

As described in the final rule, the SHOP will allow employers to choose the level of coverage they will offer and offer the employees choices of all qualified health plans within that level of coverage. This allows employees a choice among plans and can select the one that best fits their needs and their budget. Employers can offer coverage from multiple insurers, just like larger companies and government employee plans, but get a single bill and write a single check. SHOP Exchanges can also allow employers to select a single plan to offer its employee, like is typically done today. And the final rule allows minimum participation rules to be met through coverage in any SHOP plan, not a single one.

Exchanges will decide how a SHOP is structured. Specifically, the final rule provides flexibility with regard to:

- **Size of small businesses that can participate in SHOP:** States can set the size of the small group market at either 1 to 50 or 1 to 100 employees until 2016. In 2016, employers with between 1 and 100 employees can participate in a SHOP. And, starting in 2017, states have the option to let businesses with more than 100 employees buy large group coverage through the SHOP.
- **Structure of choices for small businesses:** Exchanges can choose to offer employers additional ways to provide coverage, including allowing their employees to choose any plan in all levels of coverage or a traditional “employer choice” offer of a single plan.

Starting in 2014, small employers purchasing coverage through SHOP may be eligible for a tax credit of up to 50% of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than \$50,000, offer all full time employees coverage, and pay at least 50% of the premium.

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findings brief

key findings

- Retail clinic use for those with acute conditions increased tenfold from 2007-2009.
- Living close to a retail clinic is one of the strongest predictors of use. Young, healthy, higher-income individuals who live nearby are more likely to visit a clinic than the general population.
- Use of retail clinics was not higher in communities with a shortage of physicians.

Trends in Retail Clinic Use Among the Commercially Insured

New delivery models have been studied and encouraged over the past few years in an attempt to find inventive ways to improve health care and curtail costs. One interesting model can often be found in one's nearest pharmacy, grocery store, or "big box" retailer. Retail clinics, such as CVS's Minute Clinics or Walgreen's TakeCare Clinics, deliver health care that is often less expensive and is available on a drop-in basis as well as in the evening and on weekends. Retail clinics tend to treat a subset of the ailments for which one typically goes to a physician's office; "just ten complaints account for more than 90 percent of all retail clinic visits."¹ These same 10 complaints account for 13 percent of adult primary care physicians visits and 12 percent of visits to the emergency department.

In a HCFO-funded study, researchers led by Ateev Mehrotra, M.D., and J. Scott Ashwood examined how retail clinics are used, what types of patients are likely to utilize their ser-

vices, and whether a shortage of primary care in a community was associated with greater retail clinic use. The study showed a "striking increase in retail clinic use between 2007 and 2009," suggesting that "convenience is the strongest predictor of retail clinic use." Furthermore, the study did not find an association between the use of retail clinics and availability of other forms of primary care. The results of this study, building on the prior work of retail clinics, were published in the November 2011 issue of the *American Journal of Managed Care*.²

Methods

The researchers used claims and enrollment data provided by Aetna for 13.3 million enrollees in 22 markets with retail clinics from 2007-2009. They focused on 11 acute conditions that are most commonly seen in retail clinics, including ailments such as upper respiratory infections, influenza, and bronchitis. The Aetna data included information



Robert Wood Johnson Foundation

Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

on over 300,000 enrollees who had visited a retail clinic at least once. From this data, the researchers excluded those over 65 years of age because they were likely to have coverage from Medicare, and also excluded those who lived more than 20 miles away from a retail clinic. Controlling for health status, the analysis focused on likely predictors of retail clinic use, including sex, age, distance to retail clinic, health status, income level, and access to primary care physicians.

Increasing Use

The results of the study showed that retail clinic use increased tenfold among those seeking care for acute conditions between 2007 and 2009. When the retail clinics entered markets in 2007, less than one in 1,000 enrollees visited a retail clinic. By December of 2009, that number had grown to almost six out of every 1,000 enrollees seeking acute care at retail clinics. This percentage of use continued to increase even after the rapid growth in the number of retail clinics slowed.

Primary User Demographics

Not surprisingly, convenience drives individuals to retail clinics. This study found that retail clinics are more likely to be used by young, healthy, high-income enrollees who live nearby than by the general population. Enrollees who lived less than one mile from a retail clinic were 7.5 percent more likely to visit a clinic than enrollees who lived more than 10 miles away. Similarly, adults ages 18 to 44 were more likely to visit a retail clinic than those in other age groups, and enrollees from zip codes with higher median household incomes were more likely to use a retail clinic than those from a low-income zip code.

Is Retail Clinic Use Driven by a Shortage of Primary Care?

Another hypothesis explored by the researchers was whether people who lived in a community with a shortage of physicians were more likely to use a retail clinic. This idea was not supported in their results. Instead, they found an equal utilization rate in federally designated Health Professional Shortage Areas and other areas.

Limitations and Future Directions

Although this study looked exclusively at retail clinic use by those with commercial insurance, additional work is needed to explore the impact of utilization by the uninsured. One issue not explored in this study was whether people went to a retail clinic as a substitute for their normal physician's office, or if they would have stayed home and not sought medical care otherwise. If the growth in retail clinic visits "represents substitution for other sources of care, then the increase in retail clinic use could lead to lower costs," says Mehrotra. If clinics are frequented by those who would have otherwise remained at home, this model increases overall health care costs. The researchers recommended future work to determine if visits to retail clinics represent new utilization of health care or if these visits are replacing trips to physician's offices altogether.

Conclusion

At the time of this study, the construction of new retail clinics seemed to plateau with the slow economy. However, recent reports show a new resurgence in their growth. Retail clinics had flat growth in 2009, and rose only 3 percent in 2010, but jumped to 11.2 percent in 2011.³ With the increase, more retail centers and "big box" stores are considering the advantages of offering

health care in addition to their usual commodities. In late 2011, a leaked document from Walmart revealed its ambitions to "become the nation's largest provider of primary health care services," although the company has since backed away from those goals and is now simply leasing space in its stores to local health care providers.⁴ With their increasing prevalence, retail clinics are likely to continue presenting health systems researchers and policymakers with interesting questions on how innovative health care delivery models can affect quality and cost in the United States.

For More Information

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Endnotes

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