talking about Health Care Reform
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Understanding the Role of the "Exchange" or "Gateway"

Health reform proposals currently pending before Congress set up a new health insurance marketplace, or exchange, where individuals can shop for insurance. Within the exchange ("Exchange" in the House bill, "Gateway" in the Senate HELP bill), insurers would offer policies with comparable benefits and the government would set up Web sites where consumers could compare the offerings and enroll. The House and Senate exchanges share the following key features as well:

- Both provide a mechanism for providing subsidies to people with low or modest incomes.
- Premium payments and cost-sharing would vary with income on a sliding scale so that people with the lowest incomes would have the lowest health care costs.
- All plans would cover a list of comprehensive benefits.
- All plans would need to meet the same quality standards.
- Plans would share the burden of the highest-cost enrollees through a "risk-adjustment" mechanism. If seriously ill people gravitate to certain plans, these plans will not be left holding the bag—other participating insurers will share the costs. This will help prevent premiums from rising much faster in some plans than in others.

Who Would Use the Exchange to Shop for Health Insurance?

All current health reform proposals would allow individuals who do not have coverage through their employers to purchase coverage through an exchange. They would also allow small businesses to use the exchange plans to furnish coverage for their employees. In some proposals, large businesses could participate later on.

How an Exchange Could Help

- **Consumers would be able to readily compare their health plan choices**. Currently, only Colorado, Florida, and Texas have information on state insurance department Web sites that allows small employers to compare the premiums of available health insurance plans. Only Massachusetts (through a linked "Connector" Web site), New Jersey, and New York provide information to help individuals compare premium prices and shop for health insurance.[1] Very few states provide information about the quality of coverage and consumer satisfaction or easy-to-read information about consumer complaints.

- **Health plans would cover a standardized list of comprehensive benefits** so that consumers could make “apples to apples” comparisons. That is, people would be able to compare the costs of obtaining the same comprehensive benefits from different health insurers. A recent report explains that now, consumers encounter problems in making plan comparisons in part because there is such variation in plans: Two plans may vary drastically according to the benefits they provide, the extent of their networks, and the different amounts consumers would be required to pay in deductibles, copayments, and other cost-sharing.[2]
- **Comparative plan information could even include typical out-of-pocket costs** for treatment of common medical conditions.[3] Although this feature is not required by the legislation, it may be adopted in the final plans for the exchange. This would help consumers who have a tough time anticipating how much coverage and cost protection they might need if they become seriously ill.
- **The exchange would produce enrollment materials in various languages**, and it would also provide telephone assistance with enrollment in multiple languages.
- **The exchange would help people determine their options for obtaining insurance**, helping people who might be eligible to enroll in Medicaid, and helping those with incomes that are too high for Medicaid obtain premium subsidies in Exchange plans.
- **Health insurers would be required to disclose important information about costs, benefits, and the quality of their services**. Currently, consumers who are shopping for insurance lack access to full policy language, and even government regulators lack access to some information about licensed health plans.[4]
- **Insurers would have to market their plans fairly**, and the government would oversee this. For example, plans would not be allowed to selectively advertise to people who the plans believe are good risks and to discourage people who are sick from enrolling.
- **Health plans sold outside of the exchange would have to follow similar rules** to plans inside the exchange about how they price their products. This is important because, if there were fewer rules for health plans to follow outside of the exchange, health insurers might be tempted to steer most customers or the most profitable business outside of the exchange, undercutting the exchange’s ability to provide meaningful choices at a good price.[5]
- **Plans would be held accountable**. Under current exchange proposals, private plans and a publicly run plan would all compete in the exchange, and the government would subsidize premiums in all exchange plans for people with low and moderate incomes. If plans do not play by the rules, cover the care that they promised, and use adequate provider networks, they could face sanctions and be terminated from the exchange.

Issues to Watch

The following are issues that are not yet settled in the current health reform proposals, or for which the House and Senate have differing suggestions:

- **Will the government provide adequate premium subsidies to people in the exchange?** If premium subsidies do not cover enough people, or if they offer too little assistance to those people, middle-class as well as low-income families could suffer. Current bills propose to subsidize coverage on a sliding scale, with subsidies ending when incomes reach 400 percent of the federal poverty level, or $88,200 for a family of four. Even families at four times the poverty level have difficulty paying the average $13,000 annual premium for insurance plus the additional cost-sharing they are charged for health care.
- **Will limits on out-of-pocket spending be adequate?** Along with premium subsidies, families with modest incomes need protection against high cost-sharing. Current bills set limits on cost-sharing on a sliding scale based on income. After this limit is reached, there is no cost-sharing for care provided within the plan's network. It will be very important, especially for people with the lowest incomes, to have reasonable limits on cost-sharing so they can actually afford to get the health care they need.
- **How many plans should participate in the exchange?** Consumers find it easiest to compare a limited number of health plan choices. Studies show that too many choices (as is the case with Medicare Part D) can deter consumers from choosing the plan that best suits their needs and budgets.[6] Some national health reform proposals require that plans bid to become part of the exchange, and a limited number would receive contracts. Other versions propose that any plan that met standards would become part of the exchange.
- **What would control the costs of health plans?** As mentioned above, in some proposals, the government would negotiate prices with plans that want to sell policies in the exchange. Competitive bidding is one tool that the government can use to control the cost of insurance. Another tool that is part of health reform proposals is something called a "medical loss ratio," which limits the amount health plans can spend on administration, marketing, and profits (rather than on patient care).
- **What kind of public plan option will be in the exchange?** As of this writing, both bills that have been introduced in Congress include a public plan that would compete with private plans in the exchange. But we know amendments to these proposals will be debated as the bills move forward.
- **How will the exchange deal with employer plans?** Today, all employees in a business are usually charged the same premium regardless of their age. But the exchange will allow insurers to charge higher premiums to older people, who generally use more health services. If an employer decides to purchase coverage for his or her employees through the exchange, it is unclear if the older workers will continue to enjoy the same premiums as their younger colleagues, or if they will be subject to the age-based higher premiums permitted in the exchange.

- **Should exchanges be statewide or nationwide?** On one hand, a nationwide exchange is attractive because people would have access to the same coverage and the same protections no matter where they live, and there might be economies of scale in nationwide plans. On the other hand, states have the major responsibility of overseeing insurance now, and some states have established good consumer protections over the years, including requirements that insurers cover particular services. In all proposals now before Congress, states would continue to have a role in regulating and overseeing insurance company behavior, but the mix of state and federal responsibilities is still being discussed.

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[1] Families USA analysis of state insurance department Web sites, June and July, 2009.

[2] Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston, *Coverage When It Counts: How Much Protection Does Health Insurance Offer and How Can Consumers Know?* (Washington: Center for American Progress, May 2009).

[3] Ibid.

[4] Ibid.

[5] See, for example, Deborah Chollet, et al., *Health Insurance Exchange Study* (Washington: Mathematica Policy Research, 2008), and Elliot Wicks, *Building a National Insurance Exchange: Lessons from California* (Oakland: California Health Foundation, July 2009), available online at http://www.chcf.org/documents/insurance/BuildingANationalInsuranceExchange.pdf.

[6] Betty Tanius and Stacey Wood, "Aging and Choice: Applications to Medicare Part D," *Judgment and Decision Making* 4, no. 1 (February 2009): 92–101; Jonathan Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* (Washington: Kaiser Family Foundation, March 2009).

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