Structuring Health Exchanges

Gary L. Brace, FSA, MAAA
Rachel W. Killian, FSA, MAAA

This briefing paper identifies critical points that state governments need to address in regard to structuring their health exchanges, including whether to delegate governance to private or public entities, and the advantages and disadvantages of multiple exchanges within your state and/or regional exchanges in conjunction with neighboring states. It also briefly considers the potential for repeal of the PPACA.

- States should continue to develop a robust exchange mechanism. Although there is a possibility of repeal of all or parts of PPACA, continued forward progress is necessary to meet current implementation requirements.
- Governance of a state exchange can be delegated to a private entity, to a quasi-public entity, to a new or existing state agency or department, or to the federal government.
  - At one end of the spectrum is the private entity, which would enable greater flexibility and be subject to less political pressure. However, the state would have more difficulty coordinating with a private exchange, and would lose the opportunity to take advantage of any economies of scale with other insurance-related state entities.
  - At the other end of the spectrum, delegating development and governance of an exchange to the federal government would result in very little control by the state.
- Small states or ones with fewer insurance carrier options may want to consider the creation of a regional exchange.
  - This would increase the number of carriers in an exchange, thereby increasing the competition, creating a better cross-section of individuals, while spreading the administration costs.
  - Regional exchanges can present challenges of data coordination, especially with regard to Medicaid for multiple states.
- Some states may find it advantageous to create multiple exchanges within the state.
  - Participation in an exchange should be attractive to an insurance carrier.
  - An insurance company would *ideally* prefer an exchange that comprises individuals and small groups with similar healthcare purchasing needs, health status, and motivations.
  - The price level of products offered within a single exchange should anticipate a homogeneous group of individuals seeking insurance with the same underlying health status. The price of the product would then vary only by the age of the individual and the benefit design purchased.
  - Consequently, an exchange could be designed solely for the low-income, high-risk population (i.e., expansion of Medicaid and/or the risk pool). This population segment typically has a worse relative health status than a commercial insurance population.
- Exchanges, by law, need to be self-supporting. Carrier assessments and premium taxes could be used to fund the cost of an exchange. Carrier assessments would need to be consistent and predictable in order to ensure a stable revenue base. Exchanges with optional carrier participation may be at risk of not generating enough revenue to be self-supporting.

Gary L. Brace, FSA, MAAA, is a principal and consulting actuary with the Atlanta office of Milliman. Contact him at gary.brace@milliman.com.

Rachel W. Killian, FSA, MAAA, is an actuary with the Atlanta office of Milliman. Contact her at rachel.killian@milliman.com.

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