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Press Release

Milliman identifies key questions that will drive the creation of state healthcare insurance exchanges

New regulations provide some clarifications, leave many questions for states, health plans, and employers

Seattle – July 14, 2011 – Milliman, Inc., a premier global consulting and actuarial firm, today identified a series of considerations for states, health plans, and employers as they look toward the 2014 state exchange implementation deadline set forward in the Patient Protection and Affordable Care Act (PPACA) and reiterated in regulations issued by Health & Human Services on July 11.

"The exchange regulations provide clarification on some points while leaving many questions open," said Cathy Murphy-Barron, Milliman principal and consulting actuary. "The possibility that exchanges could serve a larger role in the rate review process introduces questions about interaction between state insurance departments and exchanges. Perhaps most importantly from an actuarial perspective, we are still awaiting regulations on essential benefits and other key aspects of pricing, which will be pivotal in dictating the design of plans in the exchange. So while we know more today than we did last week, there are still many unknowns and various questions for states, plans, and employers to consider as they plan for the exchange paradigm."

Some of the questions that still remain include:

- **How firm is the deadline?** Exchanges are supposed to be established by the open enrollment period that begins on October 1, 2013. However, the regulations indicate that some states could miss the 2013 deadline and then receive regular or conditional approval for an exchange in subsequent years.
- **How will essential benefit regulations shake out?** Many of the plan design and cost considerations that will influence the insurance policies sold through an exchange begin with the question of which benefits are offered and at what level. The exact nature of insurance policies sold through exchanges will remain vague until these regulations are introduced.
- **What rating role will be played by exchanges?** The exchange regulations suggest that exchanges may have a larger role in the rate review process, on top of a full review currently performed by state departments of insurance. Is there redundancy and, if so, how will that redundancy be reconciled? Yet another complexity involves methodologies used for rating individuals versus rating families. The discussion in the exchange regulations is not conclusive and leaves open a variety of different approaches that may allow flexibility or may just foment confusion.
- **What about smaller insurers?** The regulations indicate that health plans sold through the exchange can no longer determine their own geographic area, which introduces a new rating wrinkle. The same areas must be used within and outside of the exchanges. What should a

health plan do if a state introduces a geographic area that is larger than the area served by a health plan?

- **How will Federal exchanges operate?** The Federal government will create an exchange for any state that does not create its own exchange by the deadline, but the Federal exchange concept remains undefined. Who will pay for Federal exchanges? Will Federal exchanges need to be financially self-sufficient, as is the case with state-run exchanges?
- **What should we expect from Navigators?** Navigators are entities intended to help consumers make insurance purchasing decisions in the exchange. To date, little detail on Navigators exists. The regulations help by clarifying that Navigators must be in place by the exchange's first open enrollment period on October 1, 2013. The proposed rules now require that an exchange include two types of entities as Navigators. The proposed rules ensure that a community-based or consumer-focused group will fill one of these slots. Navigators will need to demonstrate an existing relationship to consumers before appointment. Brokers and agents may act as Navigators as long as they are not receiving compensation from a qualified health plan.
- **How will exchanges interact with CO-OPs?** PPACA allows for the creation of Consumer Operated and Oriented Plans (CO-OPs), but details of these plans are still unclear since CO-OP regulations are still pending. CO-OPs in theory will be sold on exchanges but they have some unique requirements; how will this interaction take place? For more on CO-OPs, see the briefing paper released earlier this week at http://bit.ly/oScnfj.
- **What does success look like?** The criteria for determining the success of an exchange are still unclear. Presumably there will be milestones for measuring such criteria, but these too are undefined. The regulations also do not get into quality measurement, though quality will likely feed success criteria; forthcoming regulations will pick up on the quality topic.

These details will have to come into focus before states can establish the proper exchange governance framework, before health plans can begin to establish their approach to rating, and before employers can make purchasing decisions. To add additional complexity, the answers to some of these questions may vary from one state to another or otherwise be influenced by local dynamics, including the existing regulatory environments in each state and geographic cost variation.

For more on Milliman's healthcare reform perspective, visit our reform library at www.milliman.com/hcr, our blog at www.healthcaretownhall.com, or follow us on Twitter at www.twitter.com/millimanhealth. If you are interested in receiving Milliman analysis directly, contact your Milliman healthcare consultant, register at onhealthcare@milliman.com, or call 646.473.3021.

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