backgrounder
The Iowa Policy Project

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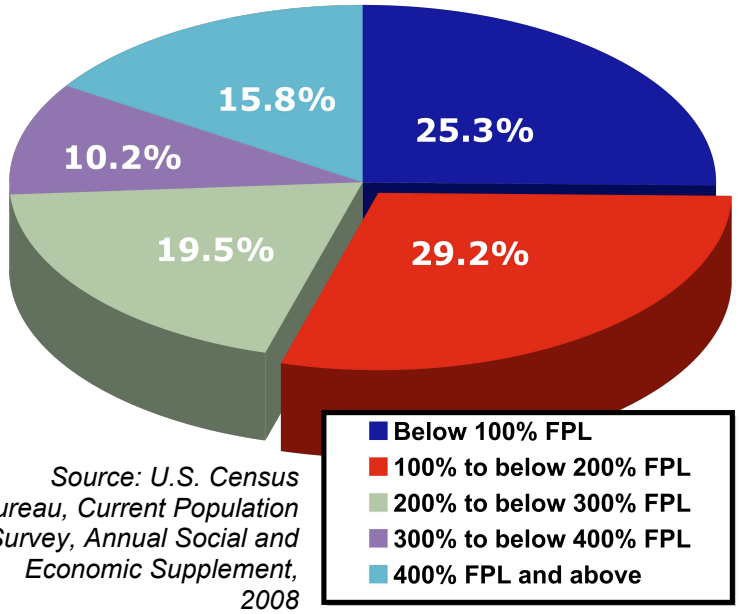
HEALTH INSURANCE EXCHANGES

Organizing the Insurance Market to Serve the Underserved

The largest income group lacking health insurance in the United States — nearly 30 percent of all uninsured Americans — earns between 100 percent and 200 percent of the federal poverty level (from $18,310 to $36,620 for a family of three).[1,2] An additional 9 million uninsured Americans, or 19.5 percent of the total uninsured population, earn between 200 percent and 300 percent of poverty (**Figure 1**). Clearly, lacking insurance is a problem that does not just affect the poor. As a result, solutions to this problem must utilize multiple policies. One of these policies is a health insurance exchange.

Health-insurance exchanges are a key component of health-reform proposals – both the House and Senate versions of health-reform legislation would create exchanges within specified geographical areas.[3,4] An exchange is a managed marketplace within a geographically defined area, in which many individuals can research and purchase insurance products. Insurance plans offered within the exchange meet certain criteria for benefits offered.[5] In most cases, exchanges would cover large geographical areas — usually a state. The purpose of an exchange is to make insurance more affordable and accessible to individuals, small groups and the uninsured.

Figure 1. Most Uninsured Earn Above Federal Poverty Level



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008

To achieve this goal, exchanges must be designed to increase risk pooling, eliminate risk-selection practices by insurers, require a minimum standard of benefits, and limit variation of plans offered within the exchange. In addition to creating a strong exchange, policymakers should also provide low- and moderate-income individuals and families with tax credits, so they can actually afford to purchase insurance coverage.

Risk Pooling — Individual buyers are at a distinct disadvantage to groups of buyers. When groups of people (such as a place of business) purchase insurance, the risk of major medical expenses is spread across a larger group, thus reducing the cost to insure them. Consumers purchasing insurance for themselves or their families, however, have a much smaller risk pool. Insurers often underwrite

insurance policies purchased by individuals and very small groups — that is, base premium prices on the health status and medical history of the individual purchaser.[6] This price variability often leads to adverse selection — when healthy and less healthy people fall into separate insurance arrangements, leading to higher premium prices for the less healthy group.[7]

An exchange can reduce the risk of insuring any one individual by grouping hundreds, or even thousands of people — an impossibility in the non-group private market.[8]

Limiting Risk Selection — Insurance companies function much like any other business – they seek to increase revenues and reduce costs. Less healthy individuals often pay much higher insurance premiums than healthy people, and may be excluded from insurance coverage altogether. Policymakers can implement market regulations to prevent extreme premium variability and exclusions. *Guaranteed issue* would require insurers to cover all applicants. *Modified community rating* would allow insurers to modify premium price only by a few approved factors, such as age and geographic location.

Minimum Standard of Benefits and Limited Variation of Plans Offered — For consumers to make informed choices, they must be able to understand what they are purchasing. Requiring insurers to offer a plan that provides a baseline of specified benefits gives consumers confidence that they will have coverage for what they need. Limiting the variation of plans offered within the exchange further allows consumers to make an informed decision, and also prevents adverse selection.[9]

Tax Credits for Low- and Moderate-income Individuals and Families — Alone, exchanges address problems of availability but not affordability. As a result, policymakers should also provide low- and moderate-income individuals and families with tax credits, so they can actually afford to purchase insurance coverage. A 2006 poll showed that more than half of the uninsured could not afford insurance.[10] Census data reveal that more than one-third of the U.S. uninsured were employed full time for the preceding year, and more than two-thirds of the uninsured had been employed (either full or part time) for at least part of the year.[11] As mentioned above, nearly one-third of the uninsured — or some 13 million Americans — earn between 100 percent and 200 percent of poverty. An additional 8.9 million Americans earn between 200 percent and 300 percent of poverty.[12] Massachusetts implemented an insurance exchange in 2006, providing subsidies to low- and moderate-income individuals and families up to 300 percent of poverty.[13,14] Since the implementation of the exchange and subsidy program, uninsurance is down to a nationwide low of 2.6 percent, with a 45 percent decrease in the number of low-income uninsured adults.[15,16]

The design of health insurance exchanges is essential to the success of the health reform proposals. Allowing multiple exchanges to operate within a state or region would undermine the risk-pooling advantages of creating an exchange, and would only complicate insurance choices for consumers.[17] Moreover, making participation within the exchange optional and allowing a less-regulated, parallel insurance market would likely segregate the market, and lead to many of the risk selection and adverse selection problems that exist in our current system.[18]

If designed properly, insurance exchanges can expand insurance coverage and provide consumers with affordable options.

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[1] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (2008).
[2] U.S. Department of Health and Human Services, The 2009 HHS Poverty Guidelines (January 2009).
[3] House Tri-Committee Health Reform Discussion Draft, Section-by-Section Analysis (June 30, 2009).
[4] Senate Health, Education, Labor and Pensions Committee, "Affordable Health Choices Act" (June 9, 2009).
[5] Linda J. Blumberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Markets to Promote Health Reform Goals," *Urban Institute* (April 2009).

[6] Family Foundation, "How Private Health Insurance Works: A Primer" (April 2008).
[7] Sarah Lueck, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," *Center on Budget and Policy Priorities* (March 31, 2009).
[8] Blumberg and Pollitz, op. cit.
[9] Lueck, op. cit.
[10] John Graves and Sharon K. Long, "Why Do People Lack Health Insurance?" *The Urban Institute* (May 2006).
[11] U.S. Census Bureau, op. cit.
[12] Ibid.
[13] John Holahan and Linda Blumberg, "Massachusetts Health Care Reform: A Look at the Issues," *Health Affairs* (August 2008).
[14] Massachusetts Commonwealth Connector, "Health Reform Facts and Figures" (June 2009).
[15] Massachusetts Commonwealth Connector, Health Care Reform: Overview (accessed July 9, 2009).
[16] Massachusetts Commonwealth Connector, "Health Reform Facts and Figures" (June 2009).
[17] Sarah Lueck, "Allowing Multiple insurance Exchanges In a Single Area Would Make It Harder to Obtain Affordable, Good-Quality Coverage," *Center on Budget and Policy Priorities* (July 8, 2009).
[18] Blumberg and Pollitz, op. cit.

The Iowa Policy Project

Formed in 2001, the Iowa Policy Project is a nonpartisan, nonprofit organization based in Mount Vernon, with its principal office at 20 E. Market Street, Iowa City, IA 52245.

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