

# Insurance Exchange Marketplace: Implications for Emergency Medicine Practice

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The Patient Protection and Affordable Care Act of 2010 requires states to establish healthcare insurance exchanges by 2014 to facilitate the purchase of qualified health plans. States are required to establish exchanges for small businesses and individuals. A federally operated exchange will be established, and states failing to participate in any other exchanges will be mandated to join the federal exchange. Policymakers and health economists believe that exchanges will improve healthcare at lower cost by promoting competition among insurers and by reducing burdensome transaction costs. Consumers will no longer be isolated from monthly insurance premium costs. Exchanges will increase the number of patients insured with more cost-conscious managed care and high-deductible plans. These insurance plan models have historically undervalued emergency medical services, while also underinsuring patients and limiting their healthcare system access to the emergency department. This paradoxically increases demand for emergency services while decreasing supply. The continual devaluation of emergency medical services by insurance payers will result in inadequate distribution of resources to emergency care, resulting in further emergency department closures, increases in emergency department crowding, and the demise of acute care services provided to families and communities. [West J Emerg Med. 2011;00(0):000–000.]

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Insurance exchanges have for a long time been involved in healthcare reform discussions. The Clinton Health Security Act of 1993, the Massachusetts Health Connector of 2006, and the most recent Patient Protection and Affordable Care Act of 2010 all established insurance exchanges. The intent of an insurance exchange is to benefit consumers by reducing barriers to the purchase of health insurance. In its most simple form, a healthcare insurance exchange is a marketplace where insurers come to provide their goods for sale. Policymakers and health economists believe that exchanges will improve healthcare at lower cost by promoting competition among insurers and by reducing burdensome transaction costs. Where exchanges can differ is in their capacity to regulate the insurers who sell goods in the marketplace.

Federal legislation requires each state to start or join an exchange by January 1, 2014. States are permitted to begin their own state-run insurance exchange or may join to form regional exchanges. A federally operated exchange will be

established, and states failing to participate in any other exchanges will be mandated to join the federal exchange. Insurance exchanges established by states must include 1 for individuals and 1 for small businesses (these can be combined). The exchange is to be Web based, with participating insurance plans available in 4 tiers from the least comprehensive coverage, “bronze,” to the most comprehensive, “platinum.” Insurance premiums for these standardized insurance plans are to be equivalent in price in and outside the exchanges. In addition, the state-run exchanges can exclude insurers from the exchanges on the basis of cost and quality value.<sup>1</sup>

The federal government defers to state legislatures in structuring these insurance exchanges. The exchanges have a range of potential responsibilities to be established by state legislation: providing standardized information about all products offered, developing risk-adjustment mechanisms, and overseeing health plans’ practices with respect to benefit and design.<sup>2</sup> What body or organization will govern the exchange?

The establishment of a board of directors to organize and govern the insurance exchange and the board's selection process will be proscribed by state legislation. The board will be responsible for enforcing insurers' establishment of premiums based on a community rating as dictated by federal legislation. Adjustments to the fixed community rate can only be made on the basis of age, family composition, tobacco use, and location. The board will also be responsible for establishing a risk-adjustment system pursuant to which insurers providing coverage to unhealthier patient populations receive additional reimbursement.<sup>1</sup>

California recently adopted legislation to establish a state insurance exchange as described in California Health Benefit Exchange.<sup>3</sup> This legislation establishes the California Health Benefit Exchange as an independent public entity governed by an executive board consisting of 5 members: 2 appointed by the governor, 1 by the Senate Committee on Rules, and 1 by the Speaker of the Assembly and the Secretary of California Health and Human Services or his designee. Licensure and regulation of healthcare service plans remains in the scope of the Department of Managed Health Care and the Department of Insurance.<sup>3</sup> The board will not be a third regulating body that controls insurance premiums. The executive board has the power to select insurance providers permitted to participate in the Web-based exchange at the recommendation of the Department of Insurance and the Department of Managed Health Care.<sup>4</sup>

How will the development of insurance exchanges affect emergency medicine? This question is difficult to answer because the exchanges can have a broad range of functions, not all of which are clearly defined at this time. A better question for the immediate time is, how have managed care and high-deductible plans affected emergency services' reimbursement? Managed care has reduced physician reimbursement while not containing costs.<sup>5</sup> This occurs by managed care plans shifting sicker patients into fee-for-service plans, placing an unfair burden on the resources of these insurance pools.<sup>5</sup> High-deductible plans of people with limited means place them in a state of being underinsured, resulting in their delaying or foregoing necessary care.

The insurance exchange will change how insurance is purchased. In the current employer system, consumers of insurance are separated from the cost of premiums. The purpose of an insurance exchange is to increase transparency to make the cost of insurance obvious and to reduce the transaction costs on the healthcare system. With consumers for the first time confronted with the cost of "purchasing" insurance and a plethora of options, what will be the outcome? In Massachusetts, the Health Connector (the statewide insurance exchange) has performed market research of customer preferences and now sells lower-priced, less well-known health plans than conventional market channels.<sup>6</sup>

It should be noted, however, that the insurance market in

California is considerably different from that of Massachusetts. The California insurance market is an oligopoly, making penetration by competitors difficult. Fifty-eight percent of the entire California market is controlled by 2 entities, Kaiser and WellPoint Inc. Lack of meaningful competition is even more evident in individual regions within California.<sup>7</sup>

Proponents of insurance exchanges believe that the increased transparency will lead to further competition, resulting in technologic innovation and higher quality of care provided at a lower cost. Jon Kingsdale, PhD, the founding Executive Director of the Commonwealth Health Insurance Connector Authority in Massachusetts and current consultant to the State of California in the implementation of the insurance exchange, in a recent publication offers some insight into recent innovations in the Massachusetts insurance market spurred by its insurance exchange.<sup>6</sup> Dr Kingsdale points out that, in the current system, an employer selects 1 health plan to provide care to all its employees. Only 1 health plan is selected in order to save on the administrative costs of having to deal and interact with multiple health plans. This 1 plan must provide a broad range of services and providers that will allow the employer's large group of employees, all with ranging demands, to be satisfied with the care provided. Insurers then have less bargaining power because they must be all-inclusive to keep their large group of insureds satisfied, and this results in rising insurance premiums. Dr Kingsdale asserts that an exchange counters this by allowing each employee to choose among a large group of health plans to find a less encompassing plan that will satisfy his or her individual demands. How will the Emergency Medical Treatment and Active Labor Act providers be able to negotiate fair value for their services in these market conditions?<sup>7</sup>

Insurance exchanges will reshape the insurance marketplace and impact the value attributed to emergency medical services. Many details have yet to be finalized in defining this marketplace, but with the ever-increasing pressure by health reform pundits to shift from a hospital-centered care structure to a preventive outpatient clinical structure, there is significant potential for emergency medical services to be falsely deflated in value.

The following is a noninclusive list of questions still to be answered; now is the time, as emergency care providers, to help find answers to these questions so that healthcare reform results in realistic improved care for our patients.

1. Will patients, by their own choice, pick higher-deductible plans that make emergency visits less affordable because of greater out-of-pocket payment?
2. Will more patients choose managed care options resulting in restricted access to providers and emergency departments?
3. Will patients demand knowledge of emergency department services costs while being treated in the emergency

department, with concern for greater out-of-pocket payment? Will this result in greater medical legal exposure?

4. Will the effect of the cost of medical malpractice on medical insurance premiums become more obvious to insurance consumers?

5. What is the value of 24-hour emergency services care to a community?

The last question is the most significant in demonstrating the true societal impact on emergency care services. What is the value of 24-hour emergency services care to a community? California recently passed a law that allows for selective contracting by California Health Benefits Exchange, meaning that the Exchange will be empowered to restrict insurers from participating. The certification process will involve the establishment of formal scoring criteria by which to compare and contrast insurance plans, similar to those used by Medi-Cal, the Department of Managed Health Care, and Pacific Business Group. How emergency medical services are qualified by these formal scoring criteria should be done with the input of emergency physicians and with the consideration of the value to society of having 24-hour emergency services care available to our communities.<sup>8-12</sup>

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