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New Research from EBRI:

Health Reform “Exchange” Plan Would Restructure Health Insurance Market, Has Big Implications for Current Employment-Based Benefits

WASHINGTON, DC—A key element being discussed as part of health reform—the creation of a health insurance exchange that would offer new forms of insurance pooling, combined with an individual mandate and guaranteed issue—would restructure the health insurance market and has major implications for the existing employment-based benefits system that provides the majority of Americans with health coverage, according to a study released today by the nonpartisan Employee Benefit Research Institute (EBRI).

The question of a health insurance connector/exchange and the various interdependent policy components has been central to the national health reform debate since the state of Massachusetts adopted that approach. The June *EBRI Issue Brief* examines issues related to managed competition and the use of a health insurance exchange for the purpose of addressing cost, quality, and access to health care services.

EBRI’s report is neutral on whether an exchange should or should not be formed, but instead lays out the various interdependent policy components that are essential for the success of such a program. It discusses issues that must be addressed when designing an exchange in order to reform the health insurance market and also examines state efforts at health reform that use an exchange. The full report, published in the June 2009 *EBRI Issue Brief*, is online at www.ebri.org

“For both employers and workers, the implications are enormous,” said EBRI’s Paul Fronstin, who co-authored the study with Murray Ross of the Kaiser Permanente Institute for Health Policy. “Will employers provide a fixed contribution for the purchase of insurance through an exchange? Would that be large enough to purchase coverage? Would it be flat or vary by workers’ health status, age, and/or marital status or the presence of children? Would it be taxed?” These remain open questions, he noted.

Fronstin notes that the large majority of Americans—about 62 percent of the U.S. population under age 65—currently are covered by an employment-based health plan. About 18 percent of

the working-age population depends on publicly subsidized health plans, 7 percent buy coverage individually, and 17 percent is uninsured.

Among the report's key points:

- ***Risk vs. price competition:*** The basic component of managed competition is the creation of sponsors that act as collective purchasing agents for groups of individuals. These sponsors would negotiate with insurers or health plans and offer exchange participants a menu of choices among different plans. Ultimately, the goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price.
- ***Adverse selection and affordability:*** Among the issues that need to be addressed if an exchange that uses managed competition has a realistic chance of reducing costs, improving quality, and expanding coverage: Everyone needs to be in the risk pool, with individuals required to purchase insurance or face significant financial consequences; effective risk adjustment is essential to eliminate risk selection as an insurance business model—forcing competition on costs and quality; the insurance benefit must be specific and clear—without standards governing cost sharing, covered services, and network coverage there is no way to assess whether a requirement to purchase or issue coverage has been met; and subsidies would be necessary for low-income individuals to purchase insurance.
- ***The public plan battle:*** The public plan option is shaping up to be one of the most contentious issues in the health reform debate. Proponents also believe that the creation of a public plan is necessary to drive private insurers toward true competition. Opponents view it as a step toward government-run health care and are wary of cost shifting from the public plan to private insurers.

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