



ACA REQUIREMENT: HEALTH INSURANCE MARKETPLACE OVERVIEW- PART 1

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Executive Summary

The world of eCommerce continues its rapid expansion in almost every geography and business line with the notable exception of health insurance. Numerous attempts over the past 20 years have not resulted in much traction. These various less-than-successful ideas have culminated in health insurance marketplaces (HIMs, previously referred to as health insurance exchanges) required under the Patient Protection and Accountable Care Act (ACA).

HIMs are an exciting, complex, new piece of the healthcare industry intended to allow consumers to leverage technology advances to simplify the purchase of health insurance. They represent one of the most significant consumer choice changes in healthcare in decades and are expected to play a role in redefining the industry for decades to come. Along with the design and introduction of these marketplaces, consumers who have had limited or inconsistent access to health insurance options in recent years will be confronted with new options and products. Additionally, as a result of the ACA individual mandate which requires all Americans to have health insurance or face a tax penalty, multitudes of new consumers will be utilizing the HIMs. The introduction of these “new” consumers into the healthcare system will also result in changes for health insurers and providers and will initiate a series of ripples that are expected to reverberate through other parts of the industry for years as services are adapted to meet the needs of the changing population.

In general, the historical (and still current) challenges to reaching success with HIMs include:

- Most Americans get their third-party health coverage through the government (Medicare and Medicaid) or their employer. This reduces the national addressable market size for HIMs to about 20 percent of the population.
- The industry is regulated at the state level, which fragments the total market into 50 smaller markets. This affects the economics and return on investment of any one solution.
- The purchasing process for health insurance is complex and does not lend itself well to a typical consumer model, let alone an online experience.
- Varied and changing regulatory issues (both state and federal) make maintenance costs high.

The purpose of this paper is to provide an introduction to health insurance marketplaces and the unique privacy and security challenges they face. The paper will explore the history of HIMs, the impact of the ACA on their evolution and anticipated adoption rate, and the difference among types of HIMs. Finally, we will consider the regulatory environment in which the marketplaces are expected to operate over the next few years and the implications of that environment for implementation of privacy and security solutions. Subsequent study between group authors will address the privacy and security issues that will be part of these new marketplaces.

Introduction

A key principle of the Patient Protection and Accountable Care Act (ACA) is to extend health insurance coverage to millions of Americansⁱ. Many ideas on how to accomplish this goal were considered but the primary non-Medicaid effort to expand coverage was designed under Section 1311(b) Act with the establishment of Health Insurance Marketplaces (HIMs), previously referred to as Health Insurance Exchanges (HIEs or HIXs). HIMs were identified as a “mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.”ⁱⁱ

Following the June 2012 United States Supreme Court decision to uphold the individual mandate,ⁱⁱⁱ the US Department of Health & Human Services (HHS) quickly moved to grant funding to states to support the design and development of state-run HIMs^{iv}. HIMs must begin enrolling consumers in October 2013 and be fully operational no later than January 1, 2014.

To achieve the goals of the ACA, HIMs will offer millions of Americans numerous affordable, quality health insurance products and the ability to compare them. The goals of these marketplaces will be to increase competition in the health insurance market, improve price and quality transparency, and reduce costs for consumers.

What is the purpose of Health Insurance Marketplaces?

Prior to passage of the ACA, individuals with pre-existing conditions had a difficult time finding affordable individual health insurance. Furthermore, the small group market was unable to achieve the cost efficiency and economies of scale that were attainable by larger groups. These challenges contributed to the number of individuals without private health insurance coverage. HIMs purports to address and improve these inefficiencies by prohibiting discrimination based on pre-existing conditions in the individual market and allowing small groups the opportunity to pool risk and purchasing power to lower costs and improve quality.

The ACA requires that each state make a determination to either set up their own state-run HIM or allow the federal government to operate a HIM in that state. Simply put, a state must decide whether to build their own exchange and exercise control and accountability for how it functions, or allow the federal government to operate it for them.

Finally, these changes do not exist in a vacuum but as part of a larger societal movement toward more transparency and online user friendliness. With the advent of Facebook, LinkedIn, and other social media tools, consumers’ expectations of online media and ease of use have risen exponentially. Therefore, HIMs must not only create an easy user experience, but also guarantee that personal user and health care information are safeguarded during the process. As such, we will discuss privacy and security aspects of HIMs that must be accounted for, not only by law but as a matter of management.

Historical Perspective – Commerce and the Digital Age

It has been less than 20 years since the advent of interactive digital media and electronic commerce, and in the last five years, there has been a surge of growth in both the volume of transactions and

the dollar value of the goods and services being transacted. Since 2007, the dollar amount of retail e-commerce transactions has increased from \$122.7 billion to \$161.5 billion today.^v Even though that period includes the deep recession of the early 2000s, transactions have experienced a compound annual growth rate (CAGR) of 7.1 percent. Electronic banking services have increased alongside, with the number of households with electronic banking accounts increasing from 63 million to 79 million.^{vi}

While suppliers of physical goods and financial assets have developed electronic distribution channels that rival or even surpass the traditional distribution channels, health insurance has only recently joined the shift to what have become known as electronic exchanges or marketplaces. Although there is no office source to confirm it, some industry experts place the total number of people that have ever purchased their health insurance through a multi-carrier marketplace web site at less than 18 million.

There are a number of reasons why the purchase of health insurance, compared to other consumer purchases, has been slow to transition away from traditional distribution channels, including the typical annual calendar of enrollment. The number of lives covered under employer-provided policies has left many lives outside of the immediately addressable market for electronic distribution.^{vii} Compounding the problem of a smaller addressable market has been the fact that health insurance is largely regulated through state law, regulation and oversight mechanisms, which has complicated all facets of converting the sales and enrollment processes to electronic channels.^{viii}

Beyond distribution issues, the industry has grappled with devising ways to display, compare and explain health insurance in ways that fit into the conventions of electronic commerce and are understandable by consumers. While these conventions have been wildly successful with more easily commoditized products like books, electronics, and travel, more complex products, such as health insurance, have not seen as rapid a transition to electronic commerce.

Given these difficulties, it is not surprising that the components of a working health insurance marketplace that have been assembled over the last 15 years have arisen separately through efforts in both the public and private sector.^{ix} The assembly of these components into the framework prescribed by the ACA has required a re-thinking not only of electronic distribution of personal health information, but a re-formulation of how to configure the components of health insurance as well as reconsideration of how to comply with existing insurance laws at state and federal levels.^x

History's Impact on Current Activities

The rise of electronic marketplaces has been a topic of academic research for more than two decades, with early research published in the 1990s (Konsynski, Venkrataman, others). A key observation within this research is how electronic marketplaces may create new business value that impacts both internal and external operations and inevitably, strategic position within a value chain.^{xi} Using this research we can apply empirical research in other segments and roughly predict potential outcomes within the healthcare market as HIMs come into vogue.

An example of potential market response is a large healthcare provider which, realizing the emerging possibility of new health plans coming into its marketplace via a HIM, created its own health plan using branding that the local market is already familiar with (leveraging their existing

market presence) and ensuring that it will be listed in the HIM as of January 1, 2014, alongside the other options. The healthcare provider has shifted its position, some would say dramatically, from simply responding to external health plans (along with the revenue implications that that represents) to proactively managing the health risk of the indigent patient population. Moreover, the provider is doing this within the context of creating an accountable care organization within its community—a large and growing metropolitan area.

Without HIMs, it is unlikely that conceptualization and execution of this plan would have occurred. The HIM, an electronic marketplace construct, provides (at a minimum) a new form of consumer engagement empowered by federal regulation that offers new possibilities for defining how health plans, providers, and other healthcare stakeholders engage markets to offer services and/or improve business value. Notably, it is highly likely that the entire process of "consumer engagement" will involve intense scrutiny and development over the next three to five years in healthcare; inclusive of the appropriate use of technology for payment, health information and more. HIMs may be central to this emerging dynamic in healthcare.

By applying academic research on electronic marketplaces as a basis for potential strategic direction of HIM implementation and growth, we may suggest that the initial phase will be marked by localized experimentation (HIM adaptation and structural iterations in the marketplace that yield various outcomes ranging from failed to successful), operational assimilation that may result in reduction of operational costs for health plans and others, (for example, online engagement of the consumer may result in expedited enrollment and/or approval by health plans) to enterprise shift within a healthcare network that redefines the value paradigm (as is the case with the example of the large healthcare group provided above).

Failed Marketplaces

Much has been written about existing state-sponsored marketplaces, but little research exists regarding failed attempts by states to establish such mechanisms and what we might learn from these experiences. One such example is the Health Insurance Plan of California (HIPC), which operated from 1993 to 2006. The post-mortem analysis indicates that there were several factors leading to the slow demise of HIPC: the lack of incentives for health plans to participate in HIPC as it was a voluntary association; the lack of engagement with insurance brokers, who were largely shut out of the process; a lack of understanding of the dimensions of comparing one type of product against another (e.g., comparing the benefits of a preferred provider organization against those of a health maintenance organization or fee-for-service plan); and a worsening adverse selection problem as time went on (note: "adverse selection" refers to a situation where only those individuals who expect to use their benefits purchase coverage; to keep insurance affordable, health insurance companies need a balance of enrollees who will use their benefits and those who will not. This allows the financial risk of paying for health care to be spread across a broader group of individuals, keeping the cost of coverage lower for everyone participating in the plan). While efforts were made to correct these failings (including a privatization and re-branding as the Pacific Health Advantage ("PacAdvantage"), the early alienation of brokers compounded with increasing adverse selection eventually led to HIPC/PacAdvantage's demise in 2006. Drafters of the ACA were aware of the challenges faced by HIPC/PacAdvantage and took them into consideration in structuring the plans, risk corridors and comparative benchmarks as well as carving out a role for brokers and agents in the new ACA marketplaces^{xii}.

Online Insurance Brokers

Given the predominance of new enrollments (vs. renewals) by insurance brokers, it should come as no surprise that the first electronic health insurance comparison and enrollment web sites were online versions of a broker's offering^{xiii}. Beginning in 1997, the early lead-generation web sites, which supplied brokers with information from interested consumers, had new online competition. On a few new web sites, individual insurance products for multiple carriers were compared according to their premium costs after some rudimentary health and demographic information was collected. Data provided by the consumer was examined by underwriters employed by the carrier before the online broker reached back out to the consumer for final enrollment steps or rejection based on an actuarial assessment of the consumer's eligibility. For these first online brokers, the state laws almost always required paper applications with "wet" signatures for a valid enrollment to take place. Further, because of the state-by-state licensing of brokers, it took nearly six years for the largest online brokers to be truly nationwide in their marketing reach.^{xiv}

Many of the larger Field Marketing Organizations (FMOs), companies contracted with health insurance carriers to provide outsourced sales and marketing employees, have been working to set up private marketplace capabilities either on their own or as a private-label exchange co-branded with an association or large corporation. In doing so, they have run into a number of hurdles, most notably that these private marketplaces are voluntary and so don't necessarily have comprehensive market coverage. This lack of comprehensive carrier display has been documented to foster the impression that consumers are being "steered" to a broker's preference, rather than the "best" plan for a prospective member.^{xv} Also, the recent traction of private marketplaces is driven by the ACA requirement that health insurance carriers not deny an individual coverage based on pre-existing conditions, reducing the underwriting issues faced by current marketplaces.

Medicare Modernization Act of 2003: Part D

While the online brokers slowly grew as a share of the individual insurance market, the Bush Administration's efforts to create a drug benefit for Medicare beneficiaries set the stage for the most rapid change. The capabilities of electronic distribution of private health insurance products increased dramatically as did the collection and analysis of personal health information. This also led to expedited efforts to resolve technical and policy issues that had previously restricted the industry's adoption of electronic commerce.

Primarily known for the Part D drug benefit, the Medicaid Managed Care Act (MMA) also boosted Part C and Medicare Advantage plans, both of which were provided to beneficiaries through private insurers but administered by the Centers for Medicare and Medicaid Services (CMS). MMA stipulated that beneficiaries would be able to compare not only the premiums of Part D coverage between carriers, but also the out-of-pocket costs of the underlying medications supplied under each plan, something that had never been done for a federal health program.^{xvi} MMA allowed for an interim benefit with drug discount cards where the out-of-pocket cost of medicines was compared using software developed by DRX, a small software company. DRX also helped devise the legal framework for electronic enrollment and attestation. This framework allowed for that capability to be added when enrollment volumes threatened to sink the program under a mountain of paper.^{xvii}

In late 2005, the enrollment infrastructure for the Medicare.gov Plan Finder was turned on and in the initial enrollment period for Calendar 2006 more than 6 million beneficiaries chose to enroll electronically in Part D plans.^{xviii} It was the largest enrollment effort of its kind ever experienced.

Plans were displayed in a multiple-carrier display and the Plan Finder provided estimated annualized out-of-pocket costs. MMA provided the scale and resources necessary to demonstrate how to standardize benefits across hundreds of carriers and more than 5,000 plans with nationwide reach.^{xix} Despite its success, however, two elements remained unresolved: (1) the competing regulatory schemes between the state Insurance Commissions and CMS; and (2) the need to verify income and assets for subsidy qualifications.

With the first issue, it was eventually resolved that the states would have oversight of the brokers and agents licensed by each state to sell insurance, while CMS would have oversight authority of the carriers issuing coverage as described by the MMA. There remained some friction until stricter marketing guidelines for Medicare carriers were enacted in 2008 that better defined the regulatory oversight powers of CMS and required carriers to monitor the activities of contracted sales agents and brokers, closing a gap in oversight between the states and CMS.^{xx}

The second issue of verifying income and assets was a difficult one as MMA did not specify how CMS would receive this information from the Social Security Agency or the Internal Revenue Service. This made any verification process difficult to accomplish. Multiple technical corrections were included in the 2008 Medicare Improvements for Patients and Providers Act (MIPPA). This cleared the way for the agencies to exchange information necessary to determine subsidy eligibility.^{xxi}

To date, the Plan Finder has enrolled more than half of all consumers who have used an electronic marketplace to enroll in a Medicare plan.^{xxii}

State Marketplaces - Massachusetts Connector and Utah

In 2006, Massachusetts and Utah both established state marketplaces using two different approaches. Massachusetts created the Connector to establish standard benefit packages and provide oversight for the carriers selling these plans. In addition, state insurance law was changed to eliminate restrictions on pre-existing conditions, negating the need to screen consumers for pre-existing conditions during the enrollment process. The Connector had substantial resources devoted to monitoring the implementation of the program and providing compliance rules for the participating plans.^{xxiii}

On the other end of the spectrum, Utah's marketplace provided the electronic marketplace infrastructure with no new regulations. The plan benefits are not standardized to the extent seen in Massachusetts and the underwriting requirements remain unchanged from before the exchange. In many ways the Utah marketplace differs little from some of the private solutions being offered by online brokers.^{xxiv}

In the new state marketplaces being developed under ACA, it is clear that most, if not all of the technical innovations pioneered by the online brokers and by the Medicare.gov Plan Finder are being adopted or enhanced. Moreover, there was a concerted effort to study the shortcomings in prior attempts at establishing marketplaces and devise policy frameworks that would provide the flexibility to adapt to unknowns as they arose. In addition, the ACA modeled its HIMs requirements on the more comprehensive regulatory and compliance model of the Massachusetts Connector. It remains to be seen whether the policy solutions for eligibility verification and state-federal joint oversight are up to the task ahead, but at least the issues have been surfaced and planned for.

As envisioned, the ACA marketplaces were intended to be overseen and operated by state Departments of Insurance. Under the “base case,” the federal government would allocate planning and development dollars in order to establish a policy and regulatory framework for the states’ operations by 2012, followed by the establishment and demonstration of a state’s technology platform by early 2013. States also have the option to work with other states in establishing “regional” marketplaces, something that might be attractive for smaller states. If a state expresses its intent to establish a State-run marketplace but is unable to do so by the established deadline, CMS will provide the necessary technology or oversight for carriers wishing to enroll members through the HIM. Beyond the aforementioned regulatory and technology operations, the marketplaces will serve as the mechanism to apportion income-based subsidies to lower-income consumers. This is the most untried aspect of the marketplace and much of the policy activity to date has been around income verification and interactions with other federal agencies, such as with the Internal Revenue Service and the Department of the Treasury.

Going Forward

Regulatory Oversight

Regulatory oversight incorporates many components. Standards are utilized to assist in achieving interoperability among state and federal health programs and with providers and community organizations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided transaction rules, but it did not address the need for consistent standards in implementing these rules, nor did it address the electronic exchange of information between state and federal agencies. Section 1561 of the ACA requires the Department of Health & Human Services (HHS) to coordinate with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee to develop recommendations for the electronic sharing of information between state and federal agencies.

Section 1104 of the ACA requires the adoption of a single set of operating rules for each HIPAA Transaction; Section 1561 of the ACA calls for the development of interoperable and secure standards and protocols for enrollment. States are encouraged to use the National Information Exchange Model (NIEM) and unified forms to facilitate enrollment and a common means for data exchange. ^{xxv}

HIPAA’s Security and Privacy rules specify the rules that HIPAA covered entities and business associates must follow. Should state laws and/or specific program requirements impose additional restrictions in sharing sensitive health information, this must be taken into account. Also, information systems containing tax return information must comply with the taxpayer privacy and safeguards requirements of Section 6103 of the Internal Revenue Code.

Through the capabilities of shopping online for healthcare coverage, marketplaces will collect data from consumers on the front end and need to exchange data from other systems on the back end, creating privacy and security challenges. Identification and authentication of users, protecting health information and other data such as demographic information for eligibility verification provides an ideal setup for financial identity theft, medical identity theft and insurance fraud and other threats. Therefore, HIMs must have a Notice of Privacy Practices and strict enforcement of privacy and security policies within the exchanges.

Technological Advancements

The U.S. Department of Health & Human Services (HHS) offered \$49 million in grant funding given to 48 states and the District of Columbia to fund assessing current information technology systems and infrastructure and determining new requirements. Coordination of eligibility and enrollment systems across existing programs and the exchanges will be an integral piece.

As new state marketplaces are beginning to emerge, technical innovations developed and utilized by online brokers and Medicare.gov Plan Finder are being enhanced. PricewaterhouseCooper's (PwC) Health Research Institute (HRI) published its annual list of the [*Top Health Industry Issues for 2013*](#). According to PwC US, the pace of technical innovations within healthcare is certain to quicken in 2013 with the effects of technology, consumerism, budgetary pressures and the ACA converging on a sector that represents nearly one-fifth of the economy.

Two advancements that will have a direct impact on the industry, both within and outside of HIMs, are direct connectivity and the increased proliferation of mobile applications. Although not suitable for all organizations, those who use them tout the convenience of being able to collect and share information in real-time. Mobile applications and direct connectivity are now commonly seen for payment purposes in all aspects of our lives, including health care. Point of Service (POS) systems with direct connectivity to health care insurers now provide eligibility, co-pay and other detailed information regarding coverage that in the past a person could receive only by making a phone call, sending a fax, or waiting for a response to a written inquiry. Because of the amount of time that might pass between the time of the initial inquiry and the time the response was provided there was a risk that the information provided in the response was often no longer accurate by the time it reached the person making the inquiry. Direct payment opportunities provided by direct connectivity and mobile applications mitigate this concern, but they also create unique challenges regarding privacy and security.

In an electronic environment, communication moves from a one-to-one exchange of information to an environment of one-to-many. This not only changes the dynamics and implications of a security breach, it also poses greater risk for identity theft. Prior to electronic exchange of health information, a security breach would put a single record at risk for a single individual; in an electronic environment, entire databases of records can be accessed with the click of a button, and the information can be widely distributed with just another click. The relative ease and anonymity with which information may be accessed and distributed in an electronic environment makes cyberspace an attractive target for identity thieves, including those associated with international criminal organizations. These threats and the importance we as a nation place on personal privacy make it imperative that the HIMs infrastructures being erected at the state and federal levels incorporate the most advanced identity management tools available to them. Fortunately, cutting edge identity management tools are among much of the technological advancement the industry has experienced over the last few years.

Best in class identity management solutions are now available that offer real-time access to vast and diverse data sources. Such solutions go beyond the traditional credit bureau, standard demographic, and traditional "hot" lists to confirm an individual's identity. These solutions use publicly available data to create a more comprehensive view of an individual, information that is then used to generate questions that only the individual the information pertains to would know the answers to. Examples of the types of questions that might be asked to confirm an individual's identity using these solutions might include, "Which of these three cars did you own in 1997?"

“Which of these three phone numbers is associated with the following address?” or “When is the last date you shared an address with this individual?”

Verification of this kind requires strong data linking capabilities. Data linking is the key to turning raw data into relevant information for a particular transaction. In a best in class identity management solutions data linking capabilities are accompanied by data analytic capabilities that allow the system to detect patterns of behavior, such as suspicious patterns of identity authentication attempt failures that might suggest fraudulent activity. Data analytics are also used to score the risk associated with a particular transaction. The score is then delivered to the operating system where configured rules and thresholds determine whether the score indicates an individual’s efforts to confirm their identity should be accepted, rejected, or additional information obtained.

Finally, best in class identity management tools allow users to choose from among a variety of ways to confirm their identity, such as:

- verifying something they have (i.e., a cell phone);
- something they know (i.e., a password or knowledge-based questions mentioned previously); or
- something they are (i.e., a voice print or location).

They can provide identity management solutions simultaneously across a variety of channels and all types of devices, and support the use of emerging platform architectures.

Best in class identity management solutions will allow HIMs to establish a trusted environment in which consumers can feel confident their personal health information is being handled in a secure manner.

HIMs also will be impacted by the work of the National Strategy for Trusted Identities in Cyberspace (NSTIC). Launched by the Obama administration in April 2011, NSTIC is a White House initiative for government entities to work with the private sector, advocacy groups, and others to address identity security in all online environments. The strategy calls for "the development of interoperable technology standards and policies—an 'Identity Ecosystem'—where individuals, organizations, and underlying infrastructure—such as routers and servers—can be authoritatively authenticated. Also referred to as "federated identity management," this is an open system where individuals are able to access online services from multiple companies using a single user name and password (credential). The credential will have been established by one of the participating companies in the system. The benefits to consumers and businesses include protecting them from identity theft and fraud, while still allowing the Internet to be used as a platform to "support innovation and a thriving marketplace of products and ideas."^{xxvi} We will discuss the efforts of this group in greater detail in the second paper of this two-part series, scheduled for release in July 2013.

Services Associated with Public & Private Market Places

Health Insurance Marketplaces... Not Created Equal

Those new to the industry or unfamiliar with the history of health insurance marketplaces might assume that if you’ve seen one HIM you’ve seen them all. In fact, there are a variety of models with

substantial differences among them. These differences go beyond governance structure—Is the marketplace private? State-run? Federal? This includes the types of coverage provided, the structure of plan benefit designs, sources of revenue and individuals served. In this section we will discuss the services provided by the various health insurance marketplace models.

Private Health Insurance Marketplaces

Private health insurance marketplaces have been in existence since at least the early 2000s. They were created as a “one stop shop” for those purchasing commercial health insurance – a place where consumers can compare a variety of major medical and supplemental health insurance products through electronic means, access decision support tools that will help them determine which product or combination of products will best meet their needs, and enroll in and pay for those products. Serving the individual and group markets, including both self-insured and fully-insured employer groups, private health insurance marketplaces are generally operated by brokers or health insurance companies themselves, and frequently offer online banking services to facilitate premium payments.

Employers who provide health insurance benefits to their employees through a defined contribution plan—an arrangement whereby an employer provides its employees with a set dollar amount with which to purchase the health insurance coverage of his/her choice—may find private health insurance market places particularly attractive. Offering a defined contribution plan through a private health insurance market place allows the employee to choose from among the plans offered by the exchange while providing him access to decision support tools that will help him determine the level of coverage most appropriate for his circumstance.

A young, single male employee who wears glasses may choose to purchase a less expensive medical benefits plan and use the remainder of his defined contribution to purchase vision coverage. A married employee with young children, on the other hand, may choose to purchase medical and dental coverage. Because they operate as a private, independent business, private health insurance market places allow a great deal of flexibility to both the health insurance companies who choose to offer products through them and the consumers and employer groups who choose to purchase coverage from them.

State-Run Health Insurance Marketplaces

Throughout the years different states have attempted to establish their own health insurance marketplaces. The most successful of these, the Massachusetts Connector, was used as the model for the American Health Benefits Exchanges required under the ACA.

The Massachusetts Connector was established in 2006 as a public-private partnership intended to assist individuals and small employers in purchasing affordable health insurance in the state of Massachusetts. The goal was for the Connector to promote administrative ease, eliminate paperwork, offer portability, and pre-tax treatment of premiums for employees of small employers who might not otherwise offer health insurance benefits, and standardize the choice of plans available in the market place. The state provided \$25 million in start-up funds, with the understanding that once established the exchange would become self-supporting. The Connector is governed by a 10-member board of individuals from the private and public sector appointed by the Governor or Attorney General, and offers both subsidized and non-subsidized health insurance plans.

Unlike private health insurance marketplaces, where rules of eligibility and benefit designs are determined by the individual health insurance carriers who participate in the exchange or by employer groups offering their employees coverage through the exchange, health insurance carriers who participate in the Massachusetts Connector must follow eligibility rules and benefit guidelines established by the Connector Board. For subsidized plans, the Board determines the specific benefit packages to be offered and premium contributions for individuals with incomes between 150 and 300 percent of the federal poverty guidelines. These plans are intended for purchase by individuals who were previously uninsured or underinsured and ineligible for other types of subsidized coverage, such as Medicaid. Non-subsidized plans must meet quality and value standards established by the Board and fall within one of three levels of benefit packages, each offering a richer set of benefits at a higher cost than the plan in the tier below it.

Under Massachusetts law, small employers with 11 or more full-time employees who do not wish to offer health insurance benefits directly to their employees may establish a Section 125 Plan that allows both full- and part-time employees to purchase health insurance coverage through the Connector using pre-tax dollars. Small employers who offer health insurance benefits directly to their employees may also take advantage of the non-subsidized plan offerings of the Connector. In this case, the employer chooses which Connector health plan will be offered to its employees and pays 50 percent of the employee's premium.

Like the private health insurance marketplaces, the Connector facilitates electronic enrollment in the plans it offers, and provides billing and customer support. However, it does not offer the decision-making tools found in the private exchanges.

The Massachusetts Connector was created as part of an overall health insurance reform bill passed by the state in 2006. As a result, the duties of the Connector go beyond those typically associated with an exchange. For example, the Connector shares medical risk with Medicare Managed Care Organizations (MMCOs) that participate in their product offerings. The Connector also manages the State's stop-loss pool. If a participating MMCO incurs medical expenses for a Connector enrollee that are more than five percent above the total capitation rate the MMCO is receiving for that individual, the Connector will pay half of the costs that are over and above the capitated rate. Conversely, if medical costs incurred by a participating MMCO are between 50 percent and 95 percent of the capitated amount received, the Connector shares in the savings. If the annual medical costs for a particular individual exceed \$150,000, the Connector pays the additional costs out of the state's stop-loss pool.

Although the Massachusetts Connector was used as a model for exchanges created under the ACA, the health insurance marketplaces created under the ACA are not an exact replica of the Connector.

- First, state health insurance marketplaces established under the ACA must be government or non-profit entities; they cannot be a private-public partnership such as the Connector.
- The marketplaces must be approved by the HHS.
- Finally, they will have significantly more responsibilities than the Connector, and must coordinate with many more state and federal agencies in executing their duties.

45 CFR§155.200 outlines the functions of a public exchange. A partial list of responsibilities includes:

- determining benefits to be included in products offered through the exchange;
- establishing open enrollment periods;

- certifying as a Qualified Health Plan (QHP) those commercial carriers who wish to participate in the Exchange and meet certification requirements;
- evaluating quality improvement strategies employed by QHPs;
- overseeing implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures and data reporting;
- operating of a toll-free call center to provide customer support;
- creating and maintaining a web site that provides standardized comparative information on each plan offered through the exchange, including premium, summary of benefits, and cost-sharing requirements for each plan, provider directories, results of enrollee satisfaction surveys, quality ratings assigned to participating commercial health insurance carriers, medical loss ratio information reported to HHS by participating commercial health insurance carriers, and information about dollars lost to fraud, waste, and abuse;
- determining applicant's eligibility for Medicaid or other subsidized health insurance, and the level of subsidy authorized by the ACA (eligibility determination includes evaluating an individual's residency, income, personal assets; and citizenship);
- tracking and reporting of information to HHS for individuals whose employer does not provide minimum essential health insurance benefits as required by the ACA, or who provides these benefits at a rate that does not meet affordability standards as dictated by the ACA; and
- establishing and managing a Navigator program that includes all of the elements outlined in §155.210 of the regulation.

State health insurance marketplaces established under the ACA must be self-sufficient and are prohibited from using federal funds to finance any of their required functions. Under the ACA, HHS will establish a federal health insurance marketplace to perform the functions required of a state health insurance marketplace for those states that choose not to implement their own exchange. States had until February 15, 2013, to demonstrate their intent and readiness to operate a state-level exchange. They had the option to operate one exchange for their entire state, participate in regional exchanges with states that share their borders, or enter into a state-federal partnership. All exchanges must be fully operational by January 1, 2014.

It is uncertain whether these various models of health insurance marketplaces will be able to co-exist over an extended period of time, or whether those mandated under the ACA will eventually lead to the extinction of the private exchanges. What is certain is that regardless of whether an exchange is public, private, or a combination of the two, or whether it is operated by the state or federal government, all health insurance marketplaces must deal with the same privacy and security concerns.

Privacy & Security/Identity Management Issues

Identity must be defined to provide directives for privacy and security. In the broadest of terms, identity may be identified as related to an organization, a person, or an inanimate object such as a computer. Parameters for privacy and security must then be developed based on the type of entity. Based on the scope of the parameters set, identifying properties will be gathered based on a select set of constructs.

Privacy, security, and usability issues abound in identity management based on limitations encountered in existing systems for identity management. Since identity management includes

technologies for the creation, management, and use of digital identities, remote usage must be managed by a process that provides access, but identifies users of that access. Interpretations of the concepts of identity management are as varied as the stakeholders involved and programs developed to establish secure, reliable services while protecting the individual's information that must be collected to obtain secure access.

Support of a wide breadth of systems, web portals, and web applications can present unknown difficulties and challenges with interfacing with those products and systems. Since multiple industry stakeholders are engaged, approaches in identity management may differ due to the type of stakeholder (e.g., healthcare, government entities, banks, health plans). User perspectives have also weighed on future development of the simplicity of access, while ensuring greater security of information. With the explosion of social networks, security breaches for those sites is well publicized and demands the attention of approaches to security while keeping in mind the privacy of user. Identity management systems also manage various types of access. For example, on-line banking protocols are as stringent as healthcare access requirements. Both parties are relying on authentication to ensure the authorized individual has access to information.

Conclusion

Although not a new concept in healthcare, the health insurance marketplaces mandated by the ACA are just different enough from those previously introduced in the private sector to create major shifts in not only in how health insurance coverage is accessed and paid for in the United States for years to come. The breadth and depth of responsibilities assigned HIMs under the ACA will require vendors to expedite continued technological advancements to support the myriad functions a marketplace is expected to perform.

Chief among concerns addressed by state and federal officials will be the development of a trusted environment, without which these latest attempts at electronic commerce in the health insurance industry are doomed to fail. With less than eight months remaining before government HIMs are expected to begin enrolling consumers, it behooves those responsible for implementing the HIMs to consider how other industries, such as banking and finance, have responded to similar privacy and security concerns generated by electronic commerce. They should employ state of the art identity management tools to apply lessons learned from these other industries and ensure they are providing the greatest level of privacy and security protection available to the consumers required to health insurance use their services to comply with the new government mandate that every US citizen have coverage.

This paper is one of a two-part series. Our follow up paper will provide a more in-depth discussion of the privacy and security challenges faced by HIMs and explore the applicability of solutions implemented by other industries faced with similar electronic commerce concerns. In the meantime, HIMs must begin enrolling consumers in October 2013 and expected to be fully operational no later than January 1, 2014.

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The purpose of the Privacy and Security Task Force is to support banks and other institutions serving the financial services industry in complying with health care privacy and security standards, including but not limited to HIPAA and HITECH regulations. More information is available online via our [Medical Banking & Financial Systems Committee](#) website. If you are interested in working with the Privacy & Security Task Force, please contact BCS Program Manager, Ebony Morgan at emorgan@himss.org.

About HIMSS

HIMSS is a cause-based; not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 52 years ago, HIMSS and its related organizations are headquartered in Chicago with additional offices in the United States, Europe and Asia. HIMSS represents nearly 50,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 570 corporate members and more than 225 not-for-profit partner organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, research initiatives, and media vehicles designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care. To learn more about HIMSS and to find out how to join us and our members in advancing our cause, please visit our website at www.himss.org.

References

- ⁱ Congressional Research Service. "PPACA: A Brief Overview of the Law, Implementation and Legal Challenges." March 2, 2011. <http://www.nationalaglawcenter.org/assets/crs/R41664.pdf>
- ⁱⁱ Initial Guidance to States on Exchanges. <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges/html>
- ⁱⁱⁱ <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>
- ^{iv} To avoid confusion with "Health Information Exchanges" or HIEs, HIMSS has adopted the term "Health Insurance Marketplaces" or HIMs to refer to Health Insurance Exchanges.
- ^v February 26, 2012 ComScore E-commerce quarterly retail tracking report.
- ^{vi} 2011 Fiserv Consumer Trends Survey, Figure 2: Household usage of online banking. <http://www.fiserv.com/documents/en/resources/rp-2011-fiserv-consumer-trends-survey.pdf?rdeResponseMimetype=application/force-download>
- ^{vii} U.S. Bureau of Labor Statistics Current Population Survey, Annual Social and Economic Supplement; Share of the under-65 population with employer-sponsored health insurance, 2000–10
- ^{viii} Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change; Mila Kofman, J.D. and Karen Pollitz, M.P.P.; Health Policy Institute, Georgetown University; April 2006
- ^{ix} Enthoven, Alain C. (1988). Theory and practice of managed competition in health care finance. Amsterdam and New York: North-Holland; Enthoven, Alain C. (1993). "The history and principles of managed competition". Health Affairs 12 (Supplement 1): 24–48;
- ^x Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change; Mila Kofman, J.D. and Karen Pollitz, M.P.P.; Health Policy Institute, Georgetown University; April 2006
- ^{xi} Beyond Business Process Redesign: Redefining Baxter's Business Network. Short & Venkatraman. Sloan Management Review. 1992
- ^{xii} Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience; May 1998; Jill M. Yegian, Ph.D., Thomas C. Buchmueller, Ph.D., James C. Robinson, Ph.D., Ann F. Monroe
- ^{xiii} Purchasing Health Insurance Online; California Healthcare Foundation. December 2002. <http://www.ehealthinsurance.com/content/expertcenterNew/OnlineInsuranceFullReport.pdf>
- ^{xiv} eHealthInsurance Inc 10-K 2006
- ^{xv} Consumers Union. How Consumers Shop for Health Insurance: Lessons for Exchange Designers. Quincy, Lynn. December 12, 2011. <http://mn.gov/hix/images/MR-CU-Presentation.pdf>
- ^{xvi} Medicare Payment Advisory Commission (MEDPAC). Report to the Congress: Medicare Payment Policy, March 2011 Chapter 13, page 319. http://medpac.gov/documents/Mar11_EntireReport.pdf
- ^{xvii} New York Times. Medicare to Provide Comparisons of Most Prescription Prices. Pear, Robert. April 11, 2004. <http://www.nytimes.com/2004/04/11/politics/12MEDIC.html>
- ^{xviii} New York Times. Tips and Tools for people with Medicare. CMS.gov. July 27 2011
- ^{xix} Department of Health and Human Services. Office of Inspector General. Audits of Medicare Prescription Drug Plan Sponsors. December 2011. <https://oig.hhs.gov/oei/reports/oei-03-09-00330.pdf>
- ^{xx} Medicare Advantage and Prescription Drug Benefit Programs: Final Marketing Provisions; 42 CFR Parts 422 and 423 Medicare Program. Final Rule September 2008. <http://govpulse.us/entries/2008/09/18/E8-21674/medicare-program-medicare-advantage-and-prescription-drug-benefit-programs-final-marketing-provision>
- ^{xxi} Medicare Advantage/Part D Contract and Enrollment Data; CMS.gov 2005-2012. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html?redirect=/MCRAdvPartDENrolData/MCESR/list.asp>
- ^{xxii} Computer Sciences Corporation. The Massachusetts Health Connector: Lessons Learned from the Builders of the Health Insurance Exchange. DeBor, Greg and Turisco, Fran. http://assets1.csc.com/health_services/downloads/CSC_Massachusetts_Health_Connector_Lessons_Learned.pdf
- ^{xxiii} Georgetown Health Policy Institute. The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned. Corlette, Sabrina, Alker, Joan, Touschner, Joe, Volk, JoAnn. <http://ihcrp.georgetown.edu/pdfs/Mass%20Utah%20Exchanges%20Lessons%20Learned.pdf>
- ^{xxiv} Office of Legislative Research and General Counsel. Utah Health Insurance Exchange; Types of Entities; Prepared for the Health System Reform Task Force. October 19, 2011.
- ^{xxv} HIT.gov. <http://www.healthit.gov/policy-researchers-implementers/health-it-rules-regulations>
- ^{xxvi} National Strategy for Trusted Identities in Cyberspace. <http://www.nist.gov/nstic/about-nstic.html> (02/21/2013).