Price Leader: The California Health Benefit Exchange as a Driver of Low Premiums

Overview

With health insurance premiums increasing more rapidly than the rate of inflation, many Californians are unable to afford coverage and remain uninsured. Even many who now have health insurance worry that they may be unable to afford it in the future.[1] Respondents to a 2009 Commonwealth Fund survey indicated that 73% of people who tried to buy insurance on their own over the previous three years were prevented from doing so because premiums were too high.[2] Clearly, the cost of health insurance continues to pose a challenge to goals of expanding health insurance coverage.

One of the fundamental promises of health reform is to make health insurance more affordable and accessible for individuals and small businesses. When signing the Patient Protection and Affordable Care Act (ACA) into law, President Obama indicated that it was driven by "the core principle that everybody should have some basic security when it comes to their health care."[3] In many ways, the success of the California Health Benefit Exchange (CHBE) will be judged by its ability to fulfill this promise.

The creation of CHBE offers a unique opportunity to implement policies that emphasize affordability of health insurance. A price-leader Exchange focused on affordability would aim to drive down insurance premiums through selective contracting and through maintaining lean, efficient operations. Qualified health plans (QHPs) offered through this Exchange would be required to meet established quality standards, but the primary focus of a price-leader Exchange would be to offer plans with the lowest premium prices possible.

While some carriers may make different choices about which lines of business to participate in with new regulations taking effect in 2014, the lure of the large Exchange market is sure to result in keen interest from a number of carriers. Early estimates predict the Exchange will enroll approximately 2.5 million individuals.[4] With the exception of the few large, multi-state carriers, this expected enrollment is higher than the membership of the vast majority of health insurance carriers. The potential size of this market, coupled with California's diversity of carriers and provider networks (closed, broad, and limited) has strong potential to create the competitive market that would be essential for this model's success.[5]

This paper articulates key features envisioned for a price-leader Exchange model, and articulates how the Exchange would execute on this vision.

Values and Benefits

A price-leader Exchange would prioritize affordability and accessibility, aiming to put health insurance within reach of as many consumers as possible. This model would not preclude the possibility of plans pursuing delivery system change and other innovations. In fact, it would reward such plans if they achieved lower costs as a result of these efforts. But the focus of the price-leader model discussed in this paper (in contrast to a change-agent Exchange model, discussed in a companion paper) is on controlling premium prices, not on promoting a particular vision of long-term, system-wide transformation.

Similarly, the vision for a price-leader Exchange does not preclude CHBE from attending to other critical dimensions of health insurance, such as health care quality and service, both of which contribute significantly to achieving positive outcomes and consumer experiences, and which are necessary for CHBE to be successful. However, the price-leader Exchange would be driven by the recognition that price is a fundamental factor in whether people purchase insurance. It would focus first on offering low premiums in order to attract, enroll, and secure affordable access to care for as many Californians as possible, as soon as possible.

Prioritizing affordable premiums in the California Exchange would likely yield strategic and political benefits. Many constituents will judge the Exchange's ability to keep premiums low as an initial indicator of the organization's success. Further, because the start-up timeline for CHBE is very short, it would benefit from remaining committed to a single primary goal. Keeping a tight focus on this very tangible metric would assist with prioritizing resources and setting realistic expectations with stakeholders.

The vision of a price-leader Exchange described in this paper includes an achievable set of activities for the short-term, but could expand to include additional priorities in the future. For example, after the price-leader Exchange is implemented and functioning well, the CHBE Board could consider pursuing additional priorities, such as providing greater consumer options and support, or more actively promoting broader health system reform. (Models focusing on these priorities are outlined in the companion papers.)

Key Features and Operational Considerations

A price-leader Exchange would encourage low premiums by selecting health plans that offer the lowest price. It would use a variety of mechanisms, many of which would likely have greater success in highly competitive, non-rural, price-sensitive markets. These include:

- Limiting the number of carrier participants in order to achieve higher volume per carrier and an easier consumer shopping experience.

- Using negotiations with this limited set of carriers to drive down prices and achieve goals such as statewide coverage.

- Encouraging carriers to develop new plans solely for the Exchange, which may achieve lower price points through limited networks.

- Maintaining focus on minimizing administrative costs and creating automation and self-service capabilities wherever possible (while meeting all state and federal requirements for customer service).

- Focusing on carriers with lower premiums, where the price can be scaled and/or replicated.

Consumer Choice

A price-leader Exchange would exercise its authority under state law to engage in selective contracting and would limit participation to carriers with the lowest prices. By offering fewer carrier options, participating carriers could expect to have access to a greater percentage of the Exchange population. Expectations of higher membership could boost carriers' willingness to to accept a lower price point in the Exchange.

While federal law imposes a new structure on the types of plans the Exchange may offer, it still allows for some variation, primarily in the area of cost sharing. California law explicitly gives CHBE authority to further standardize these levels by being more prescriptive about how the actuarial value is achieved.[6] Although allowing cost-sharing variation within a given level could encourage carriers to develop innovative products for the Exchange, greater standardization could go further in achieving price containment goals.

Establishing uniform benefit designs allows consumers to accurately compare prices across products, making price variation for the same coverage more visible. When benefits are not standard, it is difficult for consumers to determine the cause of price differences between products; the price point could be driven by breadth of coverage, cost of the networks, size of the negotiated provider discounts, administrative efficiency, population health management, size of margins, or other variables. Without standardization, consumers may mistakenly assume that a higher premium represents more comprehensive coverage.

By way of reference, the Massachusetts Connector (Massachusetts' health reform program implemented in 2006) initially allowed significant cost-sharing variability within a single benefit level. However, feedback from consumers indicated preference for a simpler shopping experience with fewer options. So, over time, the Connector fixed benefit designs and reduced the number of plans.[7]

Product Standardization: The Massachusetts Experience

The Massachusetts Health Connector's unsubsidized insurance exchange ("Commonwealth Choice") began with little more product standardization than required by the ACA, but soon found that consumers wanted more choice of carriers and fewer, less confusing benefit design options to better enable comparison shopping. Without product standardization, many shoppers wrongly assumed that the lower-priced but actuarially equivalent benefit plans offered less coverage, and that the higher price was a proxy for coverage or quality. This had the opposite of its intended effect, driving consumers toward higher premiums thinking that they were getting more value, when they may have actually been choosing to pay more for an equivalent product. To address this problem, Connector eventually moved to standardize around nine popular plan designs across three actuarial tiers (plus catastrophic coverage for young adults), based on the plan designs that were selling well in the exchange.

Customer Service Issues

A price-leader Exchange's service functions would focus on minimizing operating costs through lean administration, and on maximizing opportunities for automation and self-service by consumers. With lower operating costs, carrier assessments would not need to be as high, which, in turn, would allow selected carriers to offer products at a lower price point.

This is not to say that the price-leader model would provide bare-bones customer service or that it would consider service to be unimportant. This Exchange model would fulfill all of the requirements of customer service as defined by federal and state legislation, including developing the roles of "navigators" to assist consumers, as well as meeting all language and accessibility requirements. The baseline requirements of the price-leader Exchange could include evening and weekend hours for live customer support, workers embedded within the community, and other service requirements that may be necessary for the Exchange to meaningfully support its prospective and current members. Self-help tools would assist consumers with support they could manage on their own before seeking a more advanced tier of service.

However, as an exchange focused primarily on price, *additional* service functions emphasized in a more service-oriented model (such as the service-center model described in a companion paper) would not be as high of a priority. For example, a price-leader Exchange would likely not offer a 24-hour support line, and its online support tools would likely not include tools that would be offered under a service-center Exchange model, such as applications that would enable consumers to model their out-of-pocket expenses in a range of different products based upon their known health status.

Because federal funding could be available to support the development of the Exchange before it is required to be self-sufficient in 2015, the price-leader model would focus on front-loading customer service development costs to the greatest extent possible.

It would be important for the self-service capabilities of a price-leader Exchange to allow consumers to make purchases directly. Broker fees have historically represented a significant portion of premiums, comprising as much as 20% of annual premiums for new individual-purchased policies. More recently, broker fees have been on a downward trend due to medical loss ratio requirements in ACA, but they still remain a significant portion of revenue.[8, 9] The price-leader strategy would not explicilty eliminate brokers, but would strive to minimize costs wherever possible throughout the distribution chain.

Managing Eligibility and Enrollment

In its goal of providing quality service through the most efficient means possible, a price-leader CHBE would invest in automated and self-service tools to improve both access to coverage and overall system efficiency. Easy-to-understand information and educational tools such as web-based videos and tutorials would help customers be as autonomous as possible when navigating eligibility and enrollment. A price-leader Exchange would also establish concise and integrated tools to maximize the efficiency of phone and in-person support functions. Similar to other potential Exchange models, and as required by federal law, eligibility for a price-leader Exchange would be integrated with other public programs.

As an example, the ACCESS Internet portal, which is used in Wisconsin to support eligibility and enrollment functions for a range of government programs, created efficiencies that resulted in reduced costs and better public perception. ACCESS reduced processing time from 45 minutes to 25 minutes per application, thus lowering processing costs. It also reduced error rates, which have a significant impact on the efficiency of processing as well on how the public perceives the quality of the program.[10]

Automated enrollment would require online integration with carriers including a web interface that would share data between carriers and the Exchange. In the price-leader model, the considerable resources required for developing these integrated systems would be mitigated because CHBE's selective contracting would focus on a smaller set of carriers. In addition, to the degree that Exchange enrollment assumed a greater share of carriers' overall business, they could also experience economies of scale and operational savings. These factors could help lower carriers' rates for Exchange products.

A price-leader model would aim to minimize administrative layers involved in enrollment through the Exchange, which could mean a diminished or changed role for intermediaries such as insurance brokers and community eligibility workers. It could be that the Exchange would

negotiate more exclusivity or different compensation structures with brokers who achieve performance objectives. Such efforts would bring significant controversy that would need to be worked through with the relevant constituents.

Carrier Procurement Issues

The price-leader strategy would differ most from other models in its approach to the procurement of carriers. The board would establish threshold quality, service, technology, network, and other requirements that any carrier must meet in order to participate in the Exchange. The Exchange would require participating carriers to demonstrate their performance against these standards in a transparent way through public reporting tools. Among the many factors for the Exchange to consider when selecting participating carriers (such as financial stability, customer satisfaction, and network reliability), the most highly weighted criteria for selection would be price.

The board would define specific benefit design features, such as a uniform cost-sharing structure at each actuarial value level. The board would also need to provide clarification wherever the federal definition of "essential health benefits" allows for some variation. Bidding carriers would supply bids specific to these benefit designs, simplifying comparison of prices and scoring of competitive proposals.

Because some lower-priced carriers in California are smaller plans, and many, such as Managed Medi-Cal plans, have not historically offered individual products, the Exchange could take steps to assist low-priced plans expand to new lines of business or new geographic areas. This could mean that the Exchange would perform particular operational functions that smaller carriers may not have developed, or that may be inefficient for these carriers to offer due to limited scale. The Exchange could also provide assistance to carriers that wish to expand services into individual and/or small group lines of business in order to participate in the Exchange.

Carriers will be concerned about risk selection, especially during the first few years of the Exchange when the market is turbulent and new risk adjustment approaches are untested. For instance, carriers may be concerned that the first enrollees in the Exchange will be previously uninsured people with pent-up demand—especially individuals with pre-existing conditions who were unable to purchase health insurance before the requirement of guaranteed issue. CHBE could mitigate carrier risk selection fears in a number of ways. For instance, offering the potential of greater volume by limiting the number of carriers should provide participating carriers with a more balanced risk pool. The Exchange could also negotiate multi-year contracts, which could spread risk over time. To defend against opportunistic carriers that might choose to wait out initial turbulence, CHBE could consider a contracting rule that precludes admitting new carriers for a proscribed period.

A price-leader CHBE could also encourage carriers to offer narrow-network options. Most health plans now—especially commercial carriers—have very broad networks that typically include almost all non-Kaiser providers, including some high-cost providers and hospitals. The result is that consumers can typically access virtually the same network through different carrier options. Encouraging carriers to offer limited network plans that exclude access to some higher-cost facilities could realize significant premium savings. While the savings associated with narrow networks vary depending upon how the network change is implemented, plans have been able to offer price reduction as high as 25% by offering HMOs with limited networks.[11] CHBE could also encourage carriers to rely on low-cost regional provider networks where this tactic could generate notable premium savings.

It should be noted, however, that limited networks can also come with some additional risk. Limited networks are smaller and consequently could have less capacity in certain regions. For instance, a limited network product with one hospital could have less inpatient capacity than a network that includes six hospitals. Depending upon the size and structure of these limited networks, CHBE could be required to contract with more of them to provide sufficient access. Limited networks can also create confusion for consumers who are used to a more open-network model. And finally, limited networks could represent obstacles to continuity of care as members migrate among Medi-Cal, Exchange qualified health plans, and other commercial products on the Exchange that all have distinct networks with little overlap.

California law requires CHBE to provide coverage statewide. However, the law does not require carriers to service any given geography. It can be difficult to arrange for coverage, particularly managed care in sparsely populated, rural areas. In these regions, there may be limited carrier and provider competition, and thus less ability to negotiate prices. The ACA requires the federal government to contract with two national carriers who would provide insurance in multiple states, and within every region of the state. These options could provide Exchange-based coverage in areas where the Exchange would otherwise struggle to attract carriers. CHBE may also want to consider requiring carriers to participate in the Exchange in all counties for which they are licensed. This could provide additional coverage options by state-wide carriers in difficult-to-cover areas, and could also prevent these plans from participating only in regions where they are especially profitable—although the strategy would probably add some premium cost to the lowest-cost, most competitive regions of the state.

California Agency Experience in Carrier Selection

Other California state agencies have experience in negotiating with health insurers, focusing on premium reduction and other goals. These experiences reflect both successes and failures in the ability to control premiums, which can be valuable history for the Exchange to draw upon when establishing its own contracting strategy. Consulting with these and other purchasers, each representing different perspectives on procurement, could provide CHBE valuable insights, context, and background as it prepares to negotiate with health insurers.

The state **Managed Risk Medical Insurance Board (MRMIB)** selects and negotiates premiums with managed care carriers for its Healthy Families Program. MRMIB also operated an unsubsidized exchange for small employers (50 or fewer employees) during the 1990s that had more than 147,000 enrollees when it was transitioned to administration by a private non-profit entity, the Pacific Business Group on Health. MRMIB has chosen to contract with numerous carriers, both commercial and MediCal, and has maintained this wide choice over time.

CalPERS selects and negotiates premium prices with managed care carriers for over 1.3 million enrollees. CalPERS contracts exclusively with commercial carriers (including one carrier that administers CalPERS' self-insured plans) and has elected to reduce the number over time in an effort to address rate and quality issues.

Integration with Public Programs

Both federal and state laws related to the Exchange acknowledge the likelihood that people may move between subsidized coverage through the Exchange and the Medicaid/Healthy Families programs when their family income changes. The goal to provide some continuity in insurance coverage and provider access during these changes has implications for both eligibility policy and carrier contracting strategies.

Providing continuity of coverage for those moving between the Exchange's products and other public programs is a worthy goal. To support this goal, a price-leader Exchange would be especially interested in working with managed Medi-Cal plans to the extent that those plans could offer lower-cost options in the individual and small group marketplaces on the Exchange. The added benefits in terms of continuity of care would be a welcome outcome. However, the price-leader Exchange might be willing to accept some limitations in provider continuity for those migrating between coverage options if that were necessary in order to realize significant cost savings through a strategy of contracting with narrow network plans. The price-leader CHBE might seek to coordinate with Medi-Cal to develop strategies to minimize the impact of this disruption.

Metrics for Success

The success of a price-leader Exchange would be measured by its ability to offer plans with lower premiums and lower annual premium increases when benchmarked against national and state standards. **(**Because carriers participating in the Exchange are required by federal law to price identical products at the same level inside and outside of the Exchange, the Exchange cannot expect to offer lower prices than plans offered by carriers that participate in the broader individual and small group markets. However, some carriers may choose to participate and offer lower priced plans only in the Exchange.)

A price-leader Exchange would also be judged by metrics that are common to all models such as customer enrollment, retention rates, the ability to meet service and quality standards, and customer satisfaction levels.[12]

To maintain the focus on keeping premium prices low, CHBE could establish standardized public reporting of premiums for participating plans. By comparing prices and price increases against state and federal benchmarks, the Exchange's progress toward its primary goal would be concrete and visible.

Risks and Unintended Consequences

If the price-leader Exchange is implemented and succeeds, it has the potential to have a meaningful, market-wide impact on making health care coverage more affordable and accessible. In addition, by offering viable alternatives to customers, it could drive more acceptance of limited networks by customers, potentially driving down overall market costs. However, there are a number of risks and unintended consequences that could result from prioritizing premium price over all other variables.

It will be difficult for the Exchange to anticipate all of the consumer behaviors and carrier practices that could impact risk selection. Carriers not chosen to participate in the Exchange could seek to undermine the Exchange in an attempt to preserve and optimize their own business. Despite many policy levers in federal and state law intended to protect the Exchange from adverse selection, CHBE may be unable to assure a fair balance of risk inside and outside of the Exchange.

Another potential issue is that focusing exclusively on carrier costs could lead to preference toward Medi-Cal managed care plans. At least in some geographic areas, such a preference could result in low-premium plans that establish a very low subsidy level when matched against California’s commercial market plans. This could result in fewer plan choices or in additional costs for those who qualify for subsidies. Further, because managed Medi-Cal plans often use networks that include community clinics and other providers that primarily serve low-income

populations, the public might perceive CHBE as positioned outside of mainstream health care and coverage. This could bring with it the stigma of being a government charity program.

Furthermore, health care system costs are less driven by carrier costs and more by the costs of the providers themselves. Relying solely on a strategy that puts pressure on health carriers rather than a strategy that directly addresses the costs of health care may be insufficient to accomplish lower price targets over the long term. Purchasers in California's self-insured and large group markets have increasingly turned to strategies that focus on these provider interventions (for example, the Pay for Performance initiative, and efforts to encourage accountable care-type organizations) as a means to control costs.

Even if CHBE succeeds in controlling premiums through its procurement approach, providers and carriers could attempt to achieve a lower price point by shifting costs to other purchasers, including self-insured large and mid-sized group purchasers. While this tactic may be favorable to the Exchange, it may not not have a positive impact on the California marketplace as a whole. As such, CHBE should take steps to ensure that lower costs are not short-term attempts to purchase market share or cost-shifting to other purchasers, but reflect true product-line costs.

While CHBE may conclude that it can best achieve its goals by selecting a few long-term partners, it could discover that carriers that have agreed to participate in good faith would find that doing so is not sustainable, or that contract provisions they have agreed to are not viable from a business perspective. It will be challenging for carriers to perfectly assess long-term business interests in the new market environment of 2014. Despite all the best intentions, it is possible that carriers would need to alter their relationship with the Exchange, which could result in market disruption.

By excluding carriers from the Exchange marketplace, the Exchange itself could be more vulnerable to the risk-segmentation strategies of carriers operating solely outside of its boundaries. External carriers will have to sell products with essential benefits, and pool risks across all their individual-market enrollees (and, separately, across all their small-group market enrollees), as required by federal law. Nevertheless, they will still be able to develop products that vary considerably with respect to cost sharing and provider networks, thus creating different products aimed at consumers with higher or lower health care needs.

Given the safeguards provided by the insurance rule changes of federal law, this is not as serious a concern as it would be in the absence of those changes, but vigilance would still be required. CHBE could mitigate this dynamic somewhat by using its state-law authority to standardize some or all cost-sharing configurations within the Exchange—a decision that would trigger a related state-law requirement for carriers operating outside the Exchange to sell at least one standardized product at each benefit level. CHBE would also want to participate vigorously in the development and monitoring of the risk adjustment process.

Another risk associated with the price-leader Exchange's approach is that excluding higher-cost carriers may make it more difficult for CHBE to ensure continuity of coverage for enrollees. Commercial carriers—other than the closed network Kaiser Health Plan—tend to have considerable overlap in provider networks. If, in order to maximize cost-efficiency, CHBE chooses to contract only where there is not a high degree of carrier overlap, it would have to transition enrollees to other providers when it loses a carrier in a service area. Being forced to change providers can erode consumer satisfaction and therefore result in gaps in care that could impact consumer health.

Finally, any cost-reduction strategy that redefines the relationship with brokers carries significant risk. Brokers who believe the Exchange to be a threat to their livelihood could actively work against the Exchange by, for example, communicating doubts about CHBE performance to consumers or by referring higher-risk consumers to the Exchange.

Conclusion

Given the uncertainties about the new insurance market that will come into existence in 2014, use of the selective contracting approach associated with the price-leader Exchange as described in this paper is not without risk. However, it is an approach that could be implemented relatively quickly and, by emphasizing affordability, it offers a realistic prospect of making insurance coverage more accessible to Californians. Establishing a new business entity that could immediately serve millions of people is a tall order for the Exchange. Maintaining a narrow focus with a specific goal that is most closely aligned with the immediate needs of the public could give CHBE a good chance of success.

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Notes

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[12] See companion paper on operations, "Competing Demands: Operational Imperatives for the California Health Benefit Exchange" for a description of the suggested standard set of metrics.