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Active Purchasing for Health Insurance Exchanges: An Analysis of Options

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Executive Summary

State-based health insurance exchanges are a critical component of the Patient Protection and Affordable Care Act's (ACA) provisions to expand access to coverage to millions of Americans. In addition to being the gateway for people to purchase subsidized health insurance, exchanges are expected to help organize insurance markets and promote more effective competition among health plans. There is, however, disagreement among policy-makers over whether and how exchanges should be able to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices. Some policy-makers believe that the exchanges must be "active purchasers," empowered to selectively contract with carriers, set tougher participation criteria than the federal standards and/or negotiate price discounts in order to effectively serve consumers. Others believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans (a "Travelocity" approach).

In our research we found that active purchasing is not just one activity and it doesn't just involve determining whether plans should be in or out of an exchange. Rather, it can encompass a wide range of activities to leverage higher-quality, more affordable insurance for individuals and small businesses.

We also assess environmental factors in the states that would support – or undermine – the range of active purchasing activities in which an exchange may wish to engage. We conclude that even in states with the least hospitable environments for active purchasing efforts, there will be some important activities that the exchange leadership can undertake on behalf of enrollees. Selected findings include the following:

- The ACA requires states to authorize their exchanges to take on a number of activities that go beyond the role of a passive clearinghouse. At a minimum, each exchange must have the authority to exercise its own judgment of whether a health plan's participation is "in the interests of" consumers and employers in the exchange.
- The ACA permits exchanges to take on a wide range of activities to promote the availability of high-quality, affordable insurance products. These include, but are not limited to:
  - Setting additional certification criteria that reflect the state's goals for such things as population health, plan quality, access to providers, delivery system reform and transparency;

  - Using a selective contracting process to negotiate better prices and higher-quality from plans;
  - Managing product choices and setting parameters for cost-sharing;
  - Leveraging quality improvement and delivery system reforms by encouraging participating health plans to implement strategies to promote the delivery of better coordinated, more efficient health care services;
  - Aligning with other large purchasers in the state, such as large employer coalitions, the Medicaid agency and/or the state government employee benefits agency to send consistent purchasing signals to health insurance carriers and providers;
  - Recruiting new insurance carriers, particularly in states with highly concentrated insurance markets. Such an approach could also include providing technical assistance to regional, home-grown or Medicaid carriers to help them become exchange participants; and
  - Leveraging consumer decision-making through better information and web-based decision tools.
- There are environmental factors that could support – or undermine – active purchasing in the states. Each state will face a different calculus in whether and how to pursue active purchasing for its exchange, depending on such factors as market concentration, market rules, the number and health status of exchange enrollees and the exchange's ability to recruit and maintain a leadership and staff free from conflicts of interest and with the requisite expertise.
- Exchanges that sit in highly concentrated insurance markets are limited in how selective they can be, but they can pursue other strategies to improve value for enrollees. Exchanges need an appealing mix of health plan offerings to attract and sustain enrollment, particularly for small employers and unsubsidized individuals. While an exchange in a concentrated market may have limited leverage to negotiate price discounts, they could work to recruit new market entrants or encourage smaller carriers that may be able to expand market share through an exchange. They can also focus on promoting better consumer decision-making and encouraging competition based on value. The exchange could also collaborate with other large purchasers to align purchasing strategies.
- The size of the exchange impacts its ability to exercise leverage. Even though the exchange will be the exclusive source of coverage for most individuals eligible for federal premium and cost-sharing subsidies, in many states it will represent a relatively small share of the total commercial market. And small businesses and individuals will have alternative options in the outside market. In addition, states that establish Basic Health Plans may draw from the exchange a significant proportion of its subsidy-eligible enrollees. As a result, it is important not to overestimate the exchange's leverage to negotiate with carriers.
- The rules for the market outside the exchange are critical to successful active purchasing. If the exchange cannot capture a large enough share of the healthy participants in the commercial market, the whole notion of being an active purchaser is largely moot – it will not be able to attract a sufficient number of carriers with which to negotiate. The exchange will also need to worry about adverse selection among plans within the exchange. Officials involved in existing exchanges report that "carriers' confidence in risk adjustment is critical."
- Being an effective active purchaser requires resources, data-driven knowledge of the markets and the expertise to negotiate with carriers. Active purchasing cannot be done effectively without an infrastructure to do it. However, some states may face challenges assembling a board of directors with sufficient expertise that is also free from conflicts of interests. Others may find it similarly difficult to recruit and retain a staff that can perform the necessary duties. And maintaining the necessary personnel will require raising revenue, which in many cases will be accompanied by political pressure to demonstrate that the public investment is worth it.

- Negotiating price discounts from carriers will likely prove challenging for many exchanges. The fact that the exchange is not the sole distribution channel for insurance products could limit its leverage to negotiate prices with carriers. This is in part because the ACA requires that prices for the same products be the same inside and outside the exchange, meaning that any price discount negotiated by the exchange would have to be implemented in the outside market as well. For most carriers, the exchange won't be a big enough book of business to justify such across-the-board rate reductions. Most importantly, however, negotiating price discounts year-to-year with carriers does nothing to tackle the long-term problem for consumers and small businesses: the runaway growth in the costs of health care.
- Exchanges may have the greatest potential to improve value by incentivizing health plans and, in turn, providers to deliver higher-quality care, more efficiently. By consolidating individuals and small groups and potentially partnering with other large purchasers to align purchasing strategies, the exchange can encourage long-term delivery system reforms that can help improve the quality of care and mitigate the unsustainable trend in health care inflation.

Introduction

State-based health insurance exchanges are a critical component of the Patient Protection and Affordable Care Act's (ACA) provisions to expand access to coverage to millions of Americans. In addition to being the gateway for people to purchase subsidized health insurance, exchanges are expected to help organize insurance markets and promote more effective competition among health plans. There is, however, disagreement among policy-makers over whether and how exchanges should take on a more active role in promoting a reformed marketplace.

To be sustainable, exchanges will have to take on a minimum set of activities, not the least of which will be monitoring risk among plans within the exchange and closely tracking prices and products in the outside market. They will need to make sure the consumer shopping experience is as simple and streamlined as possible, including helping people enroll – and re-enroll – in the program most appropriate for them, whether it is Medicaid, CHIP, another state program or premium subsidies through the exchange. They'll need to run an effective Navigator program and work with insurance brokers and community groups to reach potential customers, educate them about their new rights and responsibilities under the law, sign them up for coverage and effectively respond to complaints. All of these activities suggest an exchange that is active in shaping the marketplace, rather than a passive conduit of information between buyers and sellers. However, these activities are just a necessary prerequisite for an exchange to be an active purchaser. As an active purchaser, an exchange not only needs to be a market organizer, it must be able and willing to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices.

Whether and how state exchanges should be active purchasers have been focal points of debate as states consider legislation to establish exchanges under the ACA. Many believe that the exchange must be empowered to selectively contract with carriers, set tougher participation criteria than the federal standards and/or negotiate price discounts in order to effectively serve consumers. Other stakeholders believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans (the "Travelocity" approach).

Through a review of primary and secondary source materials and interviews with officials currently or formerly responsible for running purchasing exchanges or groups that service individuals, employees and small businesses, we assess existing efforts to provide value-oriented products to subscribers. We conclude that active purchasing is not just one activity. Rather, it can encompass a wide range of activities to leverage higher-quality, more affordable health insurance for individuals and small businesses.

From our review of existing exchanges and augmented by interviews with national health policy experts, we discuss environmental factors in the states that would support – or undermine – the range of active purchasing activities in which an exchange may wish to engage. All of the active purchasing activities we identify will not work in all states. By the same token, even in states that have the least conducive environments for active purchasing efforts, there will be some important activities the exchange leadership can undertake to deliver better quality, affordable products to their enrollees. The findings in the paper are the authors' alone and should not be attributed to any individuals or groups with whom we consulted.

What it Means to be an Active Purchaser

The notion of a market sponsor that is also an active purchaser has a long history, with roots in the concept of managed competition. As articulated in 1993 by Alain Enthoven, managed competition involves "intelligent, active collective purchasing agents" acting on behalf of enrollees and "connotes the ability to use judgment to achieve goals…to be able to negotiate." And it uses "rules for competition…to reward…those health plans that do the best job of improving quality, cutting cost and satisfying patients."[1]

Health insurance exchanges build on Enthoven's vision. They could be empowered to act on behalf of consumers and small business owners in a number of ways that would drive value. In its initial guidance to states about insurance exchanges, the Department of Health and Human Services (HHS) has interpreted the law to allow a state to empower its exchange to be an active purchaser, "using market leverage and the tools of managed competition to negotiate product offerings with insurers," much like a large employer would. And while HHS notes that a state can operate its exchange as a "clearinghouse that is open to all qualified insurers," the law sets boundaries on how open that clearinghouse can be.[2]

Minimum Requirements Under the ACA

Whether or not a state chooses to empower its exchange to be an active purchaser, the ACA requires exchanges to take on a number of activities that go well beyond the role of a passive clearinghouse. For example, exchanges cannot take "any willing plan." To participate, plans must not only provide the federally prescribed essential benefits package[3] and offer products that meet minimum cost-sharing and actuarial value standards, they must satisfy a set of certification criteria. These criteria include, for example:

- **Marketing standards.** Plans cannot use marketing or benefit design to discourage sicker people from enrolling.
- **Network adequacy.** Plans must provide a sufficient choice of providers and notify consumers about the availability of in-network and out-of-network providers. Plans must also include within their networks essential community providers that serve low-income, medically underserved individuals.
- **Accreditation.** Plans must be accredited based on clinical quality measures and patient experience ratings, including their performance on consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals and other factors.
- **Quality improvement.** Plans must implement a quality improvement strategy that includes implementing quality reporting, case management, care coordination, prevention of hospital readmissions, activities to improve patient safety and activities to reduce health disparities.
- **Standardization.** Plans must use a uniform enrollment form and standardized format for summarizing the benefits in their products.
- **Transparency.** Plans must provide to enrollees and prospective enrollees information on their performance on quality metrics. They must also report to HHS their performance on pediatric quality measures.[4]

In addition to these criteria, the exchange must determine that each plan's participation is "in the interests of" consumers and employers in the exchange.[5] This federal standard is subjective and the leadership of state exchanges could implement it in a myriad of ways. But at a minimum, it means that if the exchange leadership decides a plan's participation is not in the interests of consumers and business owners, it can reject it. And presumably, no state legislature could take away the exchange's ability to make that kind of subjective judgment without falling out of compliance with the ACA. Indeed, HHS's January 2011 Funding Opportunity Announcement (FOA) for exchange planning and implementation makes clear that, to be certified as compliant (and avoid a federally established exchange), exchanges must have "the capacity and authority to take all actions necessary to meet Federal standards, *including the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers*"[6] (emphasis added).

Similarly, while the ACA does not mandate that exchanges engage in price negotiations with carriers, it encourages exchanges to monitor rates inside and outside the exchange. At a minimum, all exchanges must review plans' requested premium increases before they go into effect and take the information they receive in that process into consideration when deciding whether to accept or reject a plan in the exchange.[7] The law also requires exchanges to take into account any recommendations from the state department of insurance (DOI) on whether to exclude a health plan because of a "pattern or practice of excessive or unjustified rate increases."[8] The ACA also sets some limits on exchanges' ability to regulate the market. It prohibits exchanges from excluding a health plan through "the imposition of premium price controls."[9] The law does not define what a "premium price control" is, but presumably it means that

the exchange cannot dictate the price a plan can charge for a particular package of benefits.

Once plans are selected to participate, the ACA supports the exchange continuing to take an active role in managing the products it offers. For example, exchanges must assign each product with a rating based on relative quality and price.[10] HHS is tasked with developing the rating methodology and the exchange must post each rating on its web portal, along with information on the level of enrollee satisfaction in each health plan.[11] The exchange must also display on its web portal health plans' product offerings within prescribed benefit levels, based on actuarial value (i.e. Bronze, Silver, Gold and Platinum).[12] For most states, this implies that the exchange will have to exert some effort to make sure issuers are actually in compliance with the actuarial value standard. For example, the exchange may want to ensure that a plan claiming a Silver level designation actually has the requisite combination of benefits and cost-sharing to achieve the required 70% actuarial value.[13]

In addition, because the ACA empowers exchanges to re-certify and de-certify qualified health plans, the exchange will need to monitor the plans' marketing standards, network adequacy requirements and other certification criteria on an ongoing basis to ensure that they are living up to their obligations.[14] The law assists exchanges in this role by requiring qualified health plans to submit to the exchange, HHS and the state's DOI an array of business practice data, including data on rating practices, claims payment policies and practices, enrollment and disenrollment, denied claims and cost-sharing for out-of-network care. Plans must also submit "periodic financial disclosures" to the exchange.[15] HHS will presumably issue regulations with guidance to states on the depth and scope of data that plans will need to make available, but exchanges will be able to make use of such disclosures to assess plans' fitness to remain in the exchange on an ongoing basis.

Active Purchasing: A Wide Range of Activities

The federal law sets a floor, but state exchanges that wish to take on the role of active purchaser can take on a much wider array of activities to try to promote access to more affordable, higher-quality insurance products for consumers and small businesses. The broad wording of the ACA's provision requiring exchanges to consider "the interests of" participating individuals and employers gives them considerable discretion to decide what activities to pursue, within the context of local market conditions, stakeholder interests and its resources and capacity.

Examples of Active Purchasing

- Additional certification criteria
- Selective contracting
- Negotiation on price/quality
- Limiting the number of products
- Setting standards for cost-sharing
- Piloting new delivery system and reimbursement strategies
- Aligning with other state purchasers (i.e., Medicaid, state employee plans)
- Recruiting and assisting new market entrants
- Use of web-based decision tools to drive value-oriented decisions by consumers

Additional Certification Criteria

While the ACA lays out minimum federal standards for participation in the exchanges, states have considerable flexibility to add to those standards with criteria that reflect the state's goals for such things as population health, plan quality, access to providers, delivery system reform and transparency. For example, the exchange could require participating plans to engage in specific efforts to promote interoperable health IT in clinical settings, implement strategies to ensure continuity of care for individuals whose income changes cause them to gain or lose eligibility for public programs or coordinate with state public health officials on emerging public health challenges.[16] However, because additional certification criteria could add to plans' costs and are not required of plans in the outside market, the exchange will need to be mindful of any effect on premiums in the exchange.

Exchanges could also require participating plans to provide benefits in addition to those required by federal

law in the essential benefits package. Such additional benefits could reflect existing state benefit mandates that were not included in the federal package; or they could be added over time in response to emerging consumer needs, scientific advancement and changes in the evidence base. However, such benefits could add to the premium, and the ACA requires states to defray any premium costs above those associated with the federally defined essential benefit package.[17]

Selective Contracting and Price Negotiation

Many stakeholders and advocates view the ability of the exchange to selectively contract with health insurance carriers to be the lynchpin of active purchasing. In a competitive health insurance marketplace, with multiple plans seeking access to exchange enrollees, the authority to limit the number of plans could give an exchange leverage to negotiate better prices and quality.

To the extent an exchange is able to selectively contract with health plans, the process would involve two steps: first, an initial certification that a plan is eligible to participate in the exchange because it meets the necessary ACA criteria, as well as any additional criteria the exchange may impose. Second, certified plans would be allowed to bid for exchange business and plans would be chosen based on their bids. That bidding could take place through a formal "Request for Proposals" (RFP) process in which the lowest bidders would win. It might also involve less formal negotiations between the exchange and carriers.

Case Studies of Active Purchasing – On the Ground Efforts to Promote Value in Insurance Coverage

With the exception of large employer-purchasers like California Public Employees' Retirement System (CalPERS), and the Massachusetts Connector Authority, we were unable to find many examples of existing insurance exchanges that take on the activities that connote active purchasing. And those that do engage in these activities have unique characteristics and environments that make their efforts more feasible. CalPERS, for example, has a largely "captive" population of state government employers. The Massachusetts Connector was created in a relatively competitive insurance market, with a foundation of market rules that ensured a level playing field. It also created a separate marketplace for subsidized individuals and, at least initially, limited access to that market to Medicaid Managed Care Organizations (MCOs). In this paper we include short case studies of existing "exchanges," each of which falls along a continuum of what it means to be an active purchaser.

Massachusetts' Connector Authority

The Connector began enrolling individuals in 2006, just months after enactment of the law that created the exchange. The Connector is administered by a quasi-public agency and operates two exchanges: Commonwealth Care (CommCare) as the marketplace for individuals eligible for subsidies and Commonwealth Choice (CommChoice) as the marketplace for unsubsidized individuals and small businesses. The Connector covers 220,000 individuals, of which 40,000 are individuals in CommChoice and 4,500 are enrolled through small business.[22]

The Massachusetts Connector has been able to use selective contracting in CommCare, largely because it serves a captive population: subsidies for those under 300 percent of the federal poverty level (FPL) are only available through CommCare. It has structured the bidding and enrollment process to encourage the lowest-possible bids, resulting in an annual rate of increase in premiums of under 5 percent – about half the rate of growth in commercial health insurance.[23] With CommCare, noted a former official, "We have the same tools any large employer has."[24] In addition, when CommCare opened to new plans, the Connector worked hard to recruit a national carrier, Centene, to offer coverage with tighter provider networks in both CommCare and CommChoice. Because Centene's product offerings (called Celticare) had a lower cost structure, the Connector leveraged those to garner lower bids from the original participating plans.[25]

While CommChoice's population is not "captive," in that unsubsidized individuals and small businesses have similar products available to them in the outside market, the Connector has undertaken active purchasing functions in CommChoice. However, its efforts to push plans on its quality and efficiency goals must be balanced with the need to offer an attractive and affordable mix of plan offerings. Carriers must gain the Connector "Seal of Approval" to participate and the Connector staff has used market research to require plans to limit the number of products offered and standardize cost sharing. However, like the other exchanges examined in this report, the Connector does not negotiate on price, since it has limited leverage to do so. As one board member put it: "With CommChoice we're largely just a price taker."[26] However, the Connector has effectively used the standardization of benefits and "guarantee" of quality products to drive consumer shopping that is based primarily on value.[27]

Large employers that engage in active purchasing, such as the California Public Employees' Retirement System (CalPERS), use the contracting process extensively to extract the best possible value from participating plans. For example, CalPERS incorporates into their contracts metrics to assess their plans' financial performance and customer service and actively encourages their plans to implement delivery system and care management reforms that will improve outcomes and reduce health care costs.[18] CalPERS also reserves the right to audit plans' calculations of rates. As Priya Mathur, Chair of the CalPERS Health Committee noted, "We do that because we want the best rate possible and because we don't feel we can just accept what their black box process says their rate should be."[19]

Non-employer based exchanges that offer possible models of selective contracting include the Massachusetts Connector and the law creating the California exchange, which requires the exchange board to selectively contract with carriers "so as to provide health care coverage choices that offer the optimal combination of choice, value, quality and service."[20]

Since its first year of operation in 2007, the Massachusetts Connector has used its authority to select participating plans to obtain premium discounts from carriers. In its subsidized market, Commonwealth Care, officials report that the average annual rate of increase in premiums per covered person has been held under 5% – about half the rate of growth in commercial health insurance. Although it also selectively contracts in its unsubsidized market, the Connector has had less leverage with carriers because it is not the sole distribution channel for insurance products. Coupled with the fact that rates for the same products have to be the same in the Connector and the outside markets, the Connector is simply not big enough to demand big price discounts in the unsubsidized market.[21]

Managing Product Choices and Setting Parameters for Cost Sharing

An active purchaser exchange might not only manage the number and quality of participating carriers, but also manage the number and type of products they offer. For states with concentrated insurance markets, it may be more desirable to allow all qualified carriers to participate but limit their product offerings. As noted above, the ACA requires plans to offer products with at least the essential benefits package at specified actuarial value levels (Bronze, Silver, Gold and Platinum); it does not require any further standardization of cost-sharing. Thus, participating carriers could offer potentially hundreds of products at each actuarial value, with different permutations of cost-sharing and additional benefits.

Many experts believe there are considerable advantages to greater benefit standardization. Research has shown that too much choice among health insurance products can be confusing to consumers and lead them to purchase products that do not best meet their needs.[28] In Massachusetts, focus groups of consumers enrolled in coverage through the Connector indicated that the degree of product choice initially offered was overwhelming.[29] In the Medicare Advantage (MA) program, which provides private coverage to Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) has noted that in many areas the plethora of plan options has resulted in beneficiary confusion and difficulty in choosing a plan that meets their needs.[30] In 2012, CMS will approve only Medicare D plans that are "substantially different from those currently on the market by the same insurer."[31]

Limiting the number of available benefit designs can also narrow carriers' ability to use benefit design to select favorable risk. Research has shown that plans can use flexibility to adjust cost-sharing for certain services to attract the healthiest enrollees and deter sicker ones. For example, in Medicare Advantage, some plans imposed higher co-payment charges for days in the hospital and costly treatments like chemotherapy than in traditional Medicare.[32] CMS became concerned about the resulting adverse selection and has moved to standardize cost-sharing.[33]

For both reasons – to help consumers make better choices more easily and to limit carriers' opportunities for risk selection – the Massachusetts Connector has limited carriers to offering only a certain number of products at each benefit level (three at the Bronze level, two at the Silver level and one at the Gold level). It has also moved to standardize deductibles and co-payments for certain clinical services.[34] HealthPass New York's exchange actively structures benefits,[35] as does Washington's new Health Insurance Partnership (HIP), a federally subsidized small business exchange.[36]

Washington Health Insurance Partnership

The Washington state Health Insurance Partnership (HIP) opened to enrollment in January, providing subsidized coverage options to small, low-wage firms. The program targets small firms (up to 50 employees) where half the employees earn less than 200 percent of the federal poverty level (FPL) and the firm does not offer coverage. These firms either cannot afford to contribute the share of premium required in the small group market (between 75 and 100 percent) or their low-wage employees cannot afford their share of the premium.[39] HIP allows employers to contribute as little as 40 percent of the premium and subsidizes between 60 and 90 percent of the worker's share based on household income. Currently, small firms use a broker to select and enroll in a plan, but the law requires HIP to allow employees to choose their coverage beginning in 2013.

The program is administered by the state agency that also administers the state employee and Basic Health Plan (BHP) offerings. By law, the HIP Board selects products offered in the small group market that fit within four categories: comprehensive, mid-range, a Health Savings Account (HSA) eligible high-deductible plan and a catastrophic plan. The board has engaged in some standardization of benefits by defining the deductibles that correspond to those four levels of coverage. After some debate, the board decided to include a catastrophic plan option (with deductibles of $5,000) to give employers that previously did not offer health insurance a low-cost option; however, no enrollees have chosen this plan to date. Plan administrators speculate this is because employers are able to choose more comprehensive coverage for their workers because of the employee subsidy and the reduced contribution requirement for employers. HIP intends to monitor enrollment in each of its plan levels to better understand the products to which employers are gravitating.[40]

HIP views itself as an "organizer" because they are required by statute to choose products already available in the small group market. However, they do carry out one of the key activities of active purchasing: the board has a selection process for participating carriers that asks the carriers to submit appropriate products for the target population with benefit values calculated against a benchmark plan (the state's self-funded health plan). The plans were then ordered according to the four categories, from comprehensive to catastrophic, based on the actuarial value of each plan. The goal was to establish groups or "tiers" of plans in each category and to minimize the amount of variation in the actuarial value within each category.[41]

HIP officials believe the program will be successful because of a number of factors. First, they largely serve a captive audience, since the employee subsidies and reduced employer contribution rate are limited to products sold by HIP. Second, HIP credits the first year's limited enrollment and the uniformity of market rules governing plans operating inside and outside as key to the program's partnership with carriers willing to participate.[42] HIP may take on a more active role as enrollment grows, including instituting a requirement that carriers offer products in all four tiers. And the HIP board has created a risk adjustment subcommittee to consider implementing risk adjustment when "employee choice" is implemented in 2013.

Currently, 52 individuals are enrolled through 14 small businesses. Enrollment is limited by available federal funding, which was originally expected to last for three years and allow for up to 4,000 subsidized lives. However, the FY2010 federal budget put in jeopardy future funding for the program after August 31, 2011. Program administrators are awaiting further word on the status of future funding.

However, exchanges should approach benefit standardization with some caution. Setting cost-sharing parameters up front could meet resistance from carriers who may have to create whole new products, rather than offer existing ones. The exchange will also want to ensure that a more limited array of products is in line with – and keeps up with – consumer preferences. For example, the Massachusetts Connector did not require greater standardization until it had clear evidence of consumer demand for a narrower set of products as well as data on the products to which consumers were gravitating.[37] In addition, to the extent an exchange promotes standardized benefit designs, it will need to be sensitive to the impact on potential innovations that could benefit consumers and promote value, such as "value based" cost-sharing ("VBID") or provider tiering based on quality and efficiency.[38]

Leveraging Quality Improvement and Delivery System Reforms

Many policy experts and administrators of employer and government purchasing programs believe that the long-term benefits of health insurance exchanges lie not in their ability to negotiate rates with health plans in the short-term, but rather to help align incentives among purchasers and payers to encourage long-term, systemic changes in the way health care is paid for and delivered.[43] As Priya Mathur of CalPERS noted, "Just negotiating on price with an insurance company is not sufficient. Active purchasing is an opportunity to get at what's underlying

the trend. You have to get down to the provider and the member level."[44]

While some large employers have acted to drive delivery system and payment reforms at the provider level through their contracts with health plans, individual and small group purchasers have been absent from those efforts because they haven't had the infrastructure, capacity or market leverage to participate. At the same time, many insurance markets are experiencing a wave of consolidation among hospital and physician groups, giving those groups greater leverage to raise prices.[45] As a result, some health plans may actually welcome an exchange that is active in this area. An official with one health plan put it this way: "For those of us who are negotiating with providers, we might like to see an exchange putting requirements on plans that give us leverage in those negotiations."[46]

For example, CalPERS is moving to implement initiatives with its participating health plans that will drive delivery system reform at the provider level. It recently announced the results of a pilot to develop Affordable Care Organizations (ACOs) in partnership with one of its participating health plans, Blue Shield of California. Launched in January 2010, CalPERS reports the program is showing positive health outcomes (i.e., reduced hospital readmissions) and has generated an estimated $15.5 million in cost savings.[47]

The grocery chain Safeway, a self-insured purchaser, is also working to lower its costs and improve health outcomes. For example, while the company imposes no cost-sharing for colonoscopies in order to encourage at-risk employees to undergo the screening, they discovered that providers were charging widely disparate rates for the same exact procedure, with no discernable difference in quality. In the San Francisco Bay Area alone, the cost of a colonoscopy ranged from $880 to $8,650. Safeway now uses "reference pricing" for colonoscopy and other services, letting employees know that it would pay up to $1,500 for the procedure; employees who go to higher-priced providers must pay the difference.[48] The goal of the program is to change consumer behavior by encouraging employees to obtain preventive services from lower-cost providers. It may also have the effect of encouraging providers to charge prices for their services that are more in line with their costs.

States may consider whether their exchange could act as catalysts for quality improvement and delivery system change in the market just as purchasers like CalPERS and Safeway do. The ACA plants seeds for this by requiring exchange plans to report to HHS and their enrollees about their programs to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, promote prevention and wellness and reduce health disparities.[49] Further, to participate in the exchange, plans must be accredited by an entity such as the National Committee for Quality Assurance (NCQA), which accredits health plans based on quality performance and patient experience. Other requirements for participating plans include: implementing provider payment strategies to improve quality and patient safety, requiring participating hospitals to implement patient safety systems and use discharge planning for patients and including in their networks only those doctors and other providers who implement certain quality improvement mechanisms.[50]

An exchange could aggregate the purchasing power of individuals and small groups to encourage more coordinated and efficient care. Building on the example of purchasers such as CalPERS and Safeway, exchanges might encourage plans to implement new reimbursement strategies and value-oriented benefit designs to improve health outcomes and perhaps also reduce the long-term trend in health care costs. Such initiatives might best evolve as part of a long-term strategy, in cooperation with other purchasers and with input from providers and consumers.

Alignment with Other State Purchasers

Policy experts have expressed the concern that, as envisioned under the ACA, exchanges may not have a sufficient proportion of the commercial insurance market to leverage change in the behavior of plans or providers.[54] An exchange might gain sufficient leverage in a number of ways, such as aligning purchasing strategies with large employer coalitions, state government employee benefit agencies and/or state Medicaid and CHIP programs. Such an effort does not mean combining risk pools, but rather it would require the exchange leadership to coordinate purchasing initiatives with these entities so that all are sending consistent signals to carriers and providers.

For example, many purchasers are interested in promoting "medical homes," primary care physician practices that agree to take on accountability for the full range of patients' health needs, usually for a fixed per-member per-month payment. There is evidence that medical homes have the potential to improve patient care while reducing spending.[55] However, many physician practice groups are reluctant to undertake the necessary IT and workforce investments required to achieve a medical home designation if only a small percentage of their patient population would be enrolled. To the extent large purchasers in the state all require carriers to implement medical homes, this could greatly expand the number of patients involved, encouraging primary care physician groups to form medical homes and specialists to cooperate with medical home protocols. Similarly, many providers complain about the plethora of carriers' "pay for performance" (P4P) programs, each with a different set of quality measures and different payment structure. If all carriers were essentially implementing the P4P programs with aligned measures and types of incentives, providers might be more likely to participate.

Recruiting New Market Entrants

Exchanges that sit in concentrated insurance markets, where one or two carriers dominate the individual and small group markets, may find an active purchasing role more challenging. While the ACA attempts to encourage new competition through the creation of multi-state insurance plans[56] and health insurance cooperatives,[57] these programs have yet to be developed and it is too soon to assess whether they will be successful. In a highly concentrated market, an exchange might work to recruit new carriers to the state or assist home-grown regional carriers or Medicaid plans to meet requirements for offering products through the exchange. Such efforts could involve technical assistance or using a request for proposals (RFP) process to entice new entrants. In states with high-quality regional carriers with integrated or local networks, exchanges need to be careful about requirements that might inadvertently prevent them from participating. For example, a requirement that participating carriers offer coverage state-wide could limit competition without offsetting advantages.[58]

The Massachusetts Connector worked in 2009 (for FY2010) to recruit Centene, a national for-profit carrier, to enter the state and offer products in both the subsidized and unsubsidized markets. It was the first major new market entrant in the state in decades.[59] In subsequent rounds of contracting, Centene's low premiums encouraged other carriers to compete on price. The Connector also worked with a Medicaid managed care organization (MCO) to obtain a commercial license, enabling it to become the eighth plan offering the Commonwealth Choice product.[60]

California Public Employees' Retirement System (CalPERS)

CalPERS is the second largest public purchaser of coverage in the nation after the federal government. Administered by the state of California, it purchases health benefits for more than 1,100 local and government agencies and school employers. It offers three health maintenance organization (HMO) products offered through two carriers and three self-funded preferred provider organization (PPO) products.[51]

CalPERS views itself as an employer purchaser, aligning with other employer purchasing groups and functions like an active purchaser exchange. CalPERS uses purchasing on behalf of 1.3 million beneficiaries to drive better value from the plans with which it contracts. The board decided in 2002 to modify the contracting process to strengthen its purchasing clout. In that year, the board moved from an "any willing plan" process to multi-year, performance-based contracts with carriers.[52] The number of carriers was narrowed in order to concentrate CalPERS purchasing power "at a time when providers in California were consolidating their power."[53] The remaining carriers each got a bigger share of the total enrollment and had greater incentive to partner with CalPERS on value based purchasing. The contracting process now incorporates performance metrics – both financial and customer service – as well as auditing in their contracts with insurers. Their purchasing approach is to "actively manage the trend" in health care costs, with contract terms that vary by plan depending on the goals they're pursuing with the plan. For example, they have partnered with participating plans to do disease management and pilot an ACO.

Participating employers are set in statute and have the option to purchase coverage outside of CalPERS. However, the population enrolled in CalPERS is relatively stable and largely captive. In response to some groups leaving to take "teaser rates" from plans operating in the outside market, CalPERS instituted a five-year-lock out period on any employer that leaves CalPERS, which has substantially reduced the number of employers leaving CalPERS.

Leveraging Consumer Decision-Making

Active purchasing also involves changing consumer behavior. Exchanges will have new transparency rules and web portals to help consumers make more informed and value-based comparisons of health plan products.

The notion of "plan chooser software" is not new; it has been used for years by large employers and on-line brokers such as ehealthinsurance.com and has been implemented in both the Utah and Massachusetts exchanges. What is more innovative is the idea that such software can be used strategically to empower consumers to make more value-oriented decisions. As one expert noted, most consumers shop for plans based on only two dimensions: price and provider.[61] These two dimensions tell consumers very little about plan benefits, customer service or provider quality, limiting their ability to choose plans that align with all of their needs.

Many exchange planners are thinking about ways to use the web to guide consumers in new ways, "designing for the future, not where consumers are now."[62] The ACA encourages exchanges to use their websites to provide an unprecedented amount of information to consumers about health insurance products, such as a standardized summary of benefit form, proposed or approved premium increases, actuarial value, the medical loss ratio (MLR) and performance based on price and quality. Exchanges might provide this information with graphics, simplified language and navigation to allow consumers to prioritize according to their preferences and make informed choices.

Exchanges can take the comparative display of information further by giving a special designation (i.e., "Top Value" or "Exchange Select") to plans that submit the lowest-price bids, have consistently high MLRs, and/or score high on quality and customer satisfaction metrics. They might additionally program the plan chooser software so that these plans are the first that appear when consumers conduct a search.[63]

The Massachusetts Connector has effectively used the web to guide consumers to plans with lower cost structures. Because plan offerings are standardized and each has received the Connector's approval, consumers are able to make apples-to-apples comparisons and choose lower-priced plans with confidence that they are still getting a quality product. As a result, plans with lower cost structures (i.e., with tighter networks and/or lower marketing budgets) have a greater market share in Commonwealth Choice than they do in the outside market.[64] At the same time, the Connector continues to offer plans with wider networks for consumers that prefer less restricted access to providers.

Factors that Could Support – or Undermine – Active Purchasing in the States

States' decisions about whether and how to pursue an active purchasing strategy for their exchange will hinge on a wide range of factors and each state will face a different calculus, depending on such environmental factors as market concentration, market rules, the number and risk profile of exchange enrollees and the exchange's ability to develop and maintain leadership and staff with the requisite expertise.

States that decide to pursue active purchasing may do so in any number of ways. Some may conclude that direct "price negotiation" with carriers will not work well in their markets, but will build a web portal that allows apples-to-apples comparisons and strongly encourages consumers to select plans that offer the best value. Some states may decide that the best thing they can do to promote competition is to recruit new market entrants or provide technical assistance to help home-grown, regional plans participate in the exchange. Others may conclude that the best way to make insurance coverage more affordable in the long term is to partner with participating health plans to drive delivery system reform at the provider level. Other states might have a political leadership that rejects any effort to organize or reform their insurance markets. Below we discuss a range of environmental factors that could either support or undermine the exchange's success as an active purchaser.

Connecticut Business and Industry Association

The Connecticut Business and Industry Association (CBIA) sponsors Health Connections, which began in 1995 with the goal of providing its member small businesses (3 to 100 employees) with one place to shop among a choice of health plans. Employees choose their own plan (an "employee choice" model) and enroll in coverage with the help of a broker. Enrollment to date is 6,000 businesses covering 85,000 lives.

CBIA does not engage in what might be traditionally considered "active purchasing." However, it plays an active role in selecting products to offer in the exchange. According to CBIA officials, exchange staff actively monitor what consumers are buying and work with brokers to identify attractive products. Sometimes those products are already available in the small group market and sometimes they ask carriers to develop new products for CBIA. Recently, two carriers pulled out of the small group market, leaving just two carriers participating in CBIA's exchange. A concentrated market, a CBIA official said, presents a challenge for any exchange because it means the exchange's "attractiveness…is minimized."[65] In other words, as a market organizer, an exchange operating in a concentrated market will be hampered because there are fewer options to organize.

However, CBIA's leadership believes it continues to provide an appealing alternative for small businesses, for two primary reasons. First, employers can make a defined contribution to their employees' coverage and their employees can choose among the health plan options (the "employee choice" model). Those employees choosing more expensive coverage must pay the difference.[66]

Second, CBIA provides a full suite of services to small employers that don't have their own human resources department. For example, CBIA provides member businesses with other insurance products (e.g., long-term disability and life insurance) and administration of COBRA coverage, Section 125 plans, Health Reimbursement Accounts and Health Savings Accounts. This feature gives the exchange an advantage when competing with the outside small group market.

Market Concentration

Nearly all health insurance markets in the U.S. are highly concentrated; in 48 percent of metropolitan statistical areas, just one insurer holds at least half of the market.[67] In general, that large insurer (as well as its closest competitor) will be a "must have" plan in the state exchange, if the exchange is to attract unsubsidized individuals and small businesses. For some states, these large carriers may be the only ones with networks that reach statewide. Equally important, at least initially, is that consumers and small business owners see these brand name plans when they shop for coverage. If an exchange fails to attract a sufficient mix of insurance products that consumers want to buy, it could stumble out of the gate, failing to attract sufficient enrollment.

Nothing in the ACA requires plans to participate in the exchanges and plans will make pragmatic business decisions about whether to participate. Many health insurance carriers may dislike the head-to-head nature of competition in an exchange and prefer instead to use traditional distribution channels for their products. As Elliot Wicks noted in a 2002 brief for the Commonwealth Fund:

> *Health plans have often been hostile to the purchasing co-op model for several reasons. First, they are understandably wary of the model because it gives their customers bargaining clout. Second, they do not like the individual-choice feature of co-ops because it provides enrollees with a ready way of switching to a different health plan during every open enrollment period. Third, they believe that their chances of getting and keeping all of the employees in an employer group – which brings in more revenue and helps spread risk – are much better when they market to that group outside of the purchasing co-op.*[68]

Past efforts to operate exchanges have largely failed because plans chose not to participate or, in some cases, actively worked to undermine the exchange.[69] However, the ACA's market reforms that go into effect in 2014, including the responsibility to purchase insurance, the elimination of health status underwriting and premium subsidies will create a very different competitive environment than has existed in the past. As a result, some carriers may see opportunities to expand their market shares within a structure of individual choice, and exchanges should seek to partner constructively with these carriers.

If an exchange wishes to contract selectively with plans or negotiate with them on price and quality, it needs to attract a reasonable mix of carriers with products that consumers and small business owners want to buy. If the exchange sits in a market that is highly concentrated, this approach to active purchasing will likely be unsuccessful. An

exchange in this environment may want to approach active purchasing as a long-term strategy. As Professor Timothy S. Jost of Washington and Lee University School of Law notes in an interview for the Commonwealth Fund, "Exchanges may want to start out as less selective and gradually move toward a more active purchasing model."[70]

In addition, an exchange in a concentrated market can work to recruit new market entrants or provide encouragement to smaller carriers that might be able to expand market share within the exchange. If it can't be a successful price negotiator, it can focus its efforts to promote better consumer decision-making and encourage competition based on price and quality. It can also collaborate with other large purchasers in the market such as employer coalitions, the state Medicaid agency and the state government employee plan to align purchasing strategies and send consistent signals regarding quality improvement and delivery system reform to carriers and providers.

Size and Risk Profile of The Exchange

The larger the exchange becomes, the more likely it can exercise leverage in the marketplace. Even though it will be the exclusive source of coverage for individuals eligible for federal premium and cost-sharing subsidies and will therefore constitute a large share of the individual market, in most states, exchanges will have a relatively small share of the total commercial market (including employer coverage). As one expert noted, in many ways an exchange that actively purchases on behalf of its enrollees would play the same role a large employer plays in soliciting bids to provide coverage to its workers.[71] Yet a growing number of large employers feel that they have little real leverage in an increasingly concentrated insurance market.[72] And the individuals and small businesses that the exchange may wish to serve will have alternative options in the outside market.

It is helpful to think about the potential population for a state exchange in three categories:

- **Subsidy-eligible individuals and families.** These individuals, with incomes up to 400 percent of FPL, can access federal premium and cost-sharing subsidies only through the exchange. This population represents a greater proportion of the market in some states than others. For example, 76 percent of Mississippi residents have incomes below 400 percent of FPL compared to 52 percent in Connecticut.[73] This will largely be a "captive population" (with possible exceptions discussed below) that many health plans might be eager to serve.
- **Self-pay individuals and families.** Individuals with incomes over 400 percent of FPL may sign up for coverage through insurance exchanges, but they are not eligible for subsidies. The exchange will need to provide an adequate mix of affordable plan choices to incentivize them to participate.
- **Small businesses.** Small businesses with up to 50 employees are eligible to enroll through an exchange, with a state option to expand their small group market to up to 100 employees. Beginning in 2017, states can allow large employers to participate. Eligible small businesses (with no more than 25 employees and average wages under $50,000) can access premium tax credits through the exchange for two years. This may give some employers a modest, temporary incentive to purchase through exchanges. However, as it will with self-pay individuals, the exchange will need to demonstrate that it can add value to the options currently available in the outside small group market.

For subsidy-eligible individuals, those at the higher end of the income scale will not necessarily be a captive population for the exchange. The generosity of the federal subsidies drops off considerably between 250-400% of poverty (see Table 1). Depending on how states regulate their non-group markets outside the exchange, these individuals might find products outside the exchange that are more affordable to them, even though they would lose access to subsidies.

Table 1. Maximum Nongroup Premiums Based on Income

Income	Maximum Household Premium Payment
Up to 133% of poverty	2% of income
133-150% of poverty	3-4% of income
150-200% of poverty	4-6.3% of income
200-250% of poverty	6.3-8.05% of income
250-300% of poverty	8.05-9.5% of income
350-400% of poverty	9.5% of income

A state's decision to establish a "Basic Health Plan" (BHP) for the lowest-income individuals eligible for subsidies in the exchange could also reduce enrollment

in the exchange and impact its ability to be an active purchaser. Authorized under the ACA and pitched to states as a "more affordable alternative to health insurance Exchanges," the BHP program gives the states the option to enroll low-income individuals between 133-200 percent of FPL in a Medicaid-like plan.[74] If a state establishes a BHP, the federal government would provide 95 percent of the premium subsidy that it would have spent on those individuals if they were enrolled in the exchange. If states leverage Medicaid provider discounts for the BHP program, they will likely be able to set premiums lower than exchange premiums and roll the extra federal subsidy into a richer benefit package or higher provider rates. One estimate indicates that states could access an extra $1,000 per enrollee if they establish a BHP instead of enrolling low-income individuals in the exchange.[75]

However, BHPs could pull a significant percentage of what would otherwise be a "captive" population for state insurance exchanges. The Urban Institute has estimated that, in an average state, a BHP would reduce the percentage of the population enrolled in the average exchange from 16 to 14 percent of all residents.[76] While this is a small total reduction, the BHP would significantly lower the number of "captive" individuals in the exchange – i.e., those eligible for substantial federal premium and cost-sharing subsidies. As noted in the chart above, once an individual approaches the 250 percent FPL threshold, the generosity of his or her subsidy diminishes considerably. This makes it more likely, in a state that allows a looser regulatory environment outside the exchange, that young and healthy individuals at the higher end of the income range will find a cheaper product in the outside market. However, while the BHP may result in the exchange having a smaller proportion of the commercial market than it might have otherwise, the exchange could increase its market leverage by aligning purchasing strategies with the BHP. And states may have greater financial incentives to pursue cost management in the BHP than they would in an exchange because they will be able to retain any savings that result.

Market Rules

The insurance rules for the individual and small group markets outside of the exchange will have a critical impact on the ability to be an active purchaser.

The primary challenge – and responsibility – of the exchange is to protect itself against adverse selection. As Professor Jost notes, "The single most important reason why some exchanges have not succeeded in the past is that they became the victims of adverse selection – they were unable to capture a large enough share of the healthy participants in the insurance market."[77] Indeed, if its survival is at stake, the whole notion of an exchange being an active purchaser is largely moot – it will not be able to attract a sufficient number of plans with which to selectively contract or negotiate. Existing exchanges that have to compete with an outside market, such as HealthPass New York, CBIA and the Massachusetts Connector, identify the equality of the inside/outside market rules as essential to their sustainability.[78]

For states establishing exchanges under the ACA, the law allows for small but potentially meaningful differences in the market rules. For example, all plans in the exchange must meet certain network adequacy standards. If a state allows plans in the outside market to operate with less robust networks, those plans could sell their products more cheaply and attract healthier enrollees than exchange plans with equivalent benefits. Similarly, exchange plans are forbidden from using marketing practices that discourage higher-risk people from enrolling. If the state allows plans in the outside market to use marketing strategies that discourage sicker people, it could result in adverse selection against the exchange. States will need to use their licensing and regulatory authority to ensure a level playing field on these and other market rules if they want a successful and sustainable exchange.

Exchanges also need to worry about adverse selection among plans within the exchange. According to Bill Kramer, an executive with the Pacific Business Group on Health (which operated California's failed small business exchange, PacAdvantage): "Insurance companies are obsessed with avoiding bad risk." One lesson from PacAdvantage is that "if plans felt they were being selected against, they bailed out."[79] This is for good reason: as soon as a carrier starts to take on sicker enrollees than its peers, the resulting higher claims (and thus, premiums) can trigger an adverse selection "spiral" that often cannot be reversed. Officials involved with existing exchanges such as HealthPass New York and

HealthPass New York

HealthPass began in 1999 with $1 million in seed money from the Mayor's office and the goal of giving small business greater access to coverage and stemming the tide of working uninsured. Sponsored by the Northeast Business Group on Health, HealthPass allows employees of participating employers to choose their own plan with a defined contribution from their employer. Almost half of the employers who buy coverage through HealthPass had no prior insurance and about one-fourth of the employees were previously uninsured.[83] Enrollment has been growing. HealthPass covers 4,000 employers with 17,000 employees, for a total of 33,000 covered lives.

HealthPass representatives say the program is a microcosm of the outside marketplace, acting as an organizer that selects certain products for offer within the exchange. The program offers between 20 and 30 benefit options across four categories of products: in network providers only, in- and out-of-network provider options, a "cost-sharing" plan (i.e., more cost-sharing for most services other than preventive services) and HSA-eligible high deductible plans. For the first 18 months the program operated, they used standardized plans based on co-payment amount, but carriers said they couldn't sustain that model and wanted to offer products based on what they thought would sell. In response, HealthPass moved to the current four groupings of coverage.[84] Program representatives note the products they offer have lower MLRs than those offered in the outside market, suggesting the exchange is attracting employees with relatively lower claims costs. This, in turn, has made their exchange more attractive as a distribution channel for the carriers.

HealthPass, like CBIA, must compete with the outside small group market for business and so concentrates on providing as many support services as possible – many of those same services offered by CBIA – in order to relieve employers of the burden of administering the program and not disadvantage them in the labor market when competing with large employers that offer services and benefits beyond health coverage.[85]

the Massachusetts Connector indicated that "carriers' confidence in risk adjustment is critical."[80]

The ACA gives the states some tools to boost such confidence, through requirements that they implement a risk adjustment program among carriers and a temporary reinsurance program. If the exchange can demonstrate to carriers that it has an average risk profile that mirrors the rest of the market and is effectively managing risk among its product offerings, carriers may say, "I can't *not* bid on this business."[81] Officials with HealthPass New York's exchange attribute their success in attracting carriers in large part to the health of its population relative to the outside market.[82]

State Resources

Being an active purchaser can be resource-intensive. To do it well requires sitting down with plans, one-on-one, early and often to discuss goals, priorities, requirements and areas of mutual interest. It requires staff time, market research and ongoing outreach to stakeholders. It requires a staff and leadership with the knowledge and expertise to go toe-to-toe with the carriers. It requires careful monitoring of consumer demands and managing a portfolio of products to meet consumers' needs.

For some states, assembling a board of directors with sufficient expertise that is also free from conflicts of interest could be a challenge. It may be similarly difficult to recruit, develop and retain a director and staff that can perform the necessary duties. For states that choose to house their exchange within the executive branch or require the exchange to meet the same personnel and procurement standards as state government agencies, pay scales and civil service rules may hinder their ability to attract individuals with the requisite experience. States that house their exchange in a non-profit outside the government structure could face challenges coordinating with other state agencies on purchasing strategies. Other states simply might not want to operate an exchange that requires a large operating budget.

One thing is clear: active purchasing cannot be done effectively without an infrastructure to do it. Those with on-the-ground experience with purchasing groups consistently emphasize the need to have a dedicated staff focused on the responsibilities of being an active purchaser. For example, when one large purchaser moved to standardize benefits offered to its employees, the chair of its benefits committee found that plans would try to skirt the new requirements in their policy's "fine print." He emphasized, "You have to stay on top of these things."[86]

Exchanges that do have the necessary personnel will require an adequate operating budget. Many states are considering an assessment on carriers or subscribers to support their exchange.[87] These assessments will add to the costs of insurance. As a result, exchanges will likely

come under political pressure to demonstrate that they are effectively managing the market and moderating premium increases. They will need to prove that the public investment in them is worth it.

Impact of Environment On One Form of Active Purchasing: Price Negotiation

Using the exchange to negotiate price discounts from carriers is an appealing concept, but will be challenging for many states to execute. And some may not want to – with only federal dollars at risk, some states may not want to pursue active purchasing at all.

But even for states that do wish to negotiate on price, the fact that the exchange is not the sole distribution channel for insurance products marketed to self-pay individuals and small employers could limit its leverage to negotiate prices with carriers. Because the ACA requires that prices for the same products be the same inside and outside the exchange, any price discount the exchange negotiates with a carrier will have to apply to that product market-wide. While the exchange might have a large population, for most carriers it won't be a large enough book of business to justify also discounting their rates in the outside market. The Massachusetts Connector has encountered this problem with its unsubsidized exchange (Commonwealth Choice), whose roughly 40,000 enrollees (about half the individual market) represent a small book of business for participating carriers. As a result, the Connector has had little leverage to garner price reductions from plans. "With CommChoice we're largely just a price taker," one Connector board member told us.[88]

That said, because the media and political spotlight will be on exchanges, particularly in the early years, a state may want to use its bully pulpit to encourage lower bids. For example, when carriers in Massachusetts submitted initial bids to the Connector in 2007, the Governor asked them to "sharpen their pencils," and they returned with lower bids – although they achieved those lower bids largely by raising the cost-sharing in their benefit design.[89]

In any event, such efforts to push prices lower must honestly take into account plans' underlying costs and need for solvency. If they don't, plans will need to increase premiums by an even greater amount in the next bidding cycle or shift more costs to consumers.

Health policy experts on the NASI study panel on exchanges flag another challenge of price negotiation: the ability of plans to change their rates during the course of the year.[90] In other words, a negotiated rate, to go into effect when people sign up during the next year's open enrollment period, could be meaningless if carriers can adjust their rates monthly or quarterly outside of open enrollment. And if the exchange negotiates a rate guarantee throughout the year, but the state doesn't impose the same requirement on plans in the outside market, plans bidding for exchange business would be placed at a disadvantage.[91]

But perhaps most importantly, simply negotiating premium discounts with plans year-to-year does nothing to tackle the long-term problem for consumers and small businesses: the runaway growth in the costs of health care. This is where an insurance exchange might have a dramatic impact. By consolidating individuals and small groups and potentially partnering with other large purchasers (i.e., state government employee purchasers, Medicaid and self-insured employers in the state) to align purchasing strategies, the exchange can incentivize health plans and, in turn, providers to deliver higher-quality care, more efficiently.

Concluding Comments

Our analysis gives rise to several findings. First, all states will have to empower their exchanges to take on a minimal level of "active purchasing" in order to meet the ACA's requirements. At a minimum, they must have discretion to exclude a plan if it is not in the interest of enrollees.

Second, active purchasing is not just one activity but rather connotes a range of activities that involve an ability and willingness to act on behalf of individual and small group buyers and set rules for competition that encourage higher-quality, efficiency and consumer satisfaction.

Third, the most aggressive conception of active purchasing – the notion that an exchange will selectively contract with and negotiate price discounts with carriers – will face environmental and operational challenges in

many states. These may include heavily concentrated markets, inadequate size relative to the outside market, adverse selection, and a lack of the necessary infrastructure to take on the job. Exchanges can be effective in negotiating high-quality, lower-cost coverage, but it requires health plans that want to participate, a sufficient number of healthy enrollees, a regulatory environment that provides a level playing field and a leadership and staff with expertise and market savvy.

Finally, exchanges may have the greatest potential to improve value by incentivizing health plans and, in turn, providers to deliver higher-quality care, more efficiently. By consolidating individuals and small groups, potentially partnering with other large purchasers to align purchasing strategies and encouraging value-oriented consumer shopping, the exchange can encourage long-term delivery system reforms that can help improve quality and tackle the long-term challenge of unsustainable health care costs.

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