

MAKING EXCHANGES WORK IN HEALTH-CARE REFORM

Exchanges are essential for successful health reform. A competitive market of exchanges and cost-conscious consumers can give health plans and providers powerful incentives to innovate to reduce the cost of health care while improving quality. This competition and choice would complement the incentives for economical choice in the excise tax on high-cost health plans. The Congress has found it very difficult to use other tools, including regulation, to achieve better health care at lower cost. Anything short of real competition would be far less successful in the truly essential task of “bending the cost curve” downward.

There are four distinct steps on the continuum from failure to success for the exchange system:

Failure: The exchanges are initially populated disproportionately with bad risks, or the system is structured such that the exchanges attract disproportionately bad risks over time, or both. Fearing adverse selection, private health insurers either do not enter the exchange in the first place, or exit it. Either the exchange system collapses of its own weight, or it comes to be dominated by a public plan that is captive to fee-for-service medicine and fails to innovate.

Survival: Under this scenario, the exchange system lives to *fight* another day. It avoids adverse selection and so does not collapse outright, but it is organized in such a way that its highest level of accomplishment is to serve its clients with the kind of inflationary, generally mediocre-quality fee-for-service coverage that employers provide to employees today. It does not attract major new entries into this market or investment in significant quality-improving, cost-reducing innovations. It would require *another legislative battle* when the political system next recognizes the need for action and again summons the courage to address health care. It would also require a new consciousness-raising campaign to explain why insurance exchanges hold the key to success, because the limited exchange system envisioned in this scenario would not demonstrate its own potential merit.

Successful but limited: Like successful exchange-type systems today, such as the Federal Employees Health Benefits Plan and CalPERS, the exchange system might provide good-quality care and a measure of internal competition and innovation, but might not achieve the necessary size and pervasiveness to move the entire market. Under this scenario, there is some measure of practice improvement among the participants within the exchange. People migrate to more-efficient plans that deliver higher value for money over time, if they can keep the savings. But gradually the inefficiency in private medicine at large drags exchange costs along in an upward climb, as providers in the exchange shadow-price the inefficient private sector.

Driving value system-wide: The best conceivable outcome under the current political circumstances would be an exchange whose participant pool (1) is representative of the overall population in terms of risk, (2) includes at least 20 to 25 percent of the non-Medicaid/non-Medicare population, and (3) has clear incentives to select the lowest-cost “reference” plan because participants must pay out-of-pocket (on an after-tax basis) for the *extra* cost of any other insurance plan. Such an exchange would have the structure, size, and incentives needed to exert considerable leverage on the entire private-medicine cost curve.¹ Private insurers and providers need to compete on both price and quality to succeed within such an exchange, and as they do so their innovations flow naturally to the coverage and care that they provide to other private payers – in a way that is much more direct than the currently hoped-for flow from Medicare regulations to private medicine.² For exchanges to be truly successful in changing the financing and delivery system, insurers and providers must be persuaded that competition will become the main form of business. If this were to happen, there would be natural pressure for the exchanges to expand and to cover additional groups over time, and they might well become the dominant form of health-insurance coverage.

CED has proposed an even better end state for the current reform, in which the exchanges provide coverage for essentially the entire working-age population.³ Over time, people could begin to carry their preferred coverage with them as they change jobs and eventually retire, gradually replacing fee-for-service medicine with cost-conscious consumer choice among competing, and therefore more-efficient, private insurance plans and delivery systems. The current political process appears unlikely to accept this outcome today, but it should be the goal for reform going forward.

POLICY STEPS

The discussion below explains first what the exchange system would need merely to survive. Then, it presents ideas for the further steps that would be needed for the system to succeed in greater measure. Though this step-by-step perspective is helpful, it is possible to put in place on day one an exchange system that goes far beyond mere

¹ The best known example is the Wisconsin State Employee Health Plan as it operates in Dane County, an exchange that has consistently obtained lower health-insurance premiums and high health-care quality from the area’s competing HMOs.

² The motivation behind the current bill’s regulatory approach to achieving savings in Medicare is in effect to mandate efficiency through governmental direction of the practice of medicine. This approach may be superior to simple reimbursement reductions to achieve short-term Medicare savings. However, lost provider revenue rather than efficient practices could well be shifted to private medicine, unless a competitive market, such as would be created by an effective exchange system, gave private medicine a reason to seek out its own efficiencies. In sum, market incentives are a far superior way to motivate health-insurance companies and health-care providers to reduce costs and improve quality for the under-65 population.

³ *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System*, http://www.ced.org/images/library/reports/health_care/report_healthcare07.pdf.

survival to reduce costs and improve quality – both for participants inside the exchange and, because of the incentives the exchange creates, for those obtaining insurance on the outside. The only thing lacking in the current environment is political will.

Survival

The bare minimum task to ensure that the exchange system survives is to avoid adverse selection. This is not a simple task, because the behavior of consumers, employers, providers and insurers is not easily predictable. However, there are certain steps that should help to prevent risk selection against the exchange:

Government should prohibit the use of health status to adjust individual and small group premiums, and limit adjustments based on other factors. The Senate bill does this.⁴

Pricing rules should apply equally to the entire individual and small-group market, not just the exchange.⁵ The Senate bill requires this.⁶

Individual and small-group premiums must be based on the experience of an insurer's combined pools inside and outside the exchange. The Senate bill requires this.⁷

Insurance regulations generally (including requirements of guaranteed issue, guaranteed renewal, and prohibition of exclusion of pre-existing conditions mandated in the current reform) should apply to the entire individual and small-group market, not just to the exchange. The Senate bill requires this.⁸

There should be at least some form of standardized benefits package. The Senate bill specifies this.⁹

Consumers need information, presented useably, on prices and quality measures of insurance options. The Senate bill requires this.¹⁰

Government must oversee insurer marketing practices to prohibit tactics that would manipulate low- and high-risk persons either to participate in the exchange or to obtain coverage from insurers outside of the exchange. The Senate bill prohibits the use of the

⁴ Section 2704 (under Sec. 1201 Amendment).

⁵ This assumes the approach of the current Senate bill, which allows private individual and small-group markets outside the exchange. See the discussion below questioning this approach.

⁶ Sections 1301 and 2704 (under Sec. 1201 Amendment).

⁷ Section 1312.

⁸ Sections 2702, 2703, 2704, and 2705 (under Sec. 1201 Amendment).

⁹ Section 1301 and 1302.

¹⁰ Sections 1311 and 2201.

benefits package to manipulate risks,¹¹ but there appears to be no provision addressing this issue more broadly. The House bill contains a broader prohibition of “improper steering” of high-risk people into the exchange,¹² which should be included in the Senate bill.

Insurers must be required to provide adequate networks of providers for the treatment of expensive conditions, lest they build and manipulate a reputation for providing adequate care only for healthy people. Regional exchanges or regional branches of a national exchange should be charged with enforcing this because local market knowledge is required. The Senate bill partially addresses this issue through a provision relating to the choice of providers.¹³

Finally, risk adjustment must increase payments to insurers who enroll more costly people, both inside and outside the exchange. The Senate bill provides this.¹⁴

Thus, in terms of direct regulation of risk selection, the House bill’s language regarding “improper steering” of high risks should be added, and additional attention should be paid to the provision regarding the adequacy of provider networks to care for high-cost people.

There is still a significant risk of adverse selection into the exchanges despite these best efforts to anticipate and prevent it. The Senate bill does provide for a process to monitor the exchanges,¹⁵ but **the scope of the GAO study mandated in this effort should be expanded to include the analysis of adverse selection. In addition, the Secretary should be given authority to take regulatory steps as needed to address problems of adverse selection.**

Regulatory safeguards alone, however, would not ensure the survival of the exchanges. More importantly, such safeguards will not ensure that exchanges acquire the **combination** of average risk, large size, and proper incentive structure that they **must** have in order hold down the growth of health insurance premiums, improve quality, and transform the health-care system.

Average Risk and Large Size: To guarantee that each exchange has average risk and large size, each exchange needs a minimum number **and** a minimum percentage of enrollees in each county, region, state, or multi-state area it serves, drawn from an approximately random selection of the overall population.

¹¹ Section 1311.

¹² Section 414 of H.R. 3962.

¹³ Section 1311.

¹⁴ Section 1343.

¹⁵ Section 1313.

The Senate bill is not certain to achieve the necessary minimum exchange size in either absolute or percentage terms. The default territory of each exchange is a single state.¹⁶ A state, however, is not necessarily the best-sized risk pool for health insurance. A few of the largest states may be too large and diverse to constitute only one risk pool.¹⁷ The least populous states may well be too small, and those instances probably present the greater risk, given that only a fraction of the population is in the exchange. In particular, relatively rural states with widely dispersed populations might be the most in need of the exchanges for coverage, but also would be the least attractive markets for insurance companies. Considering that the Senate bill also allows private individual and small-group markets to operate alongside the exchanges, and exchanges to be divided between the individual and small-group markets,¹⁸ the potential populations of the exchanges could be subdivided and reduced in size considerably.

The individual and small-group exchanges should be consolidated into a single exchange, and the minimum size of the risk pool included in the combined exchange should be increased as much as possible. As a very rough rule of thumb, a stable risk pool for health insurance should include at least 100,000 lives in each exchange's territory.¹⁹ An even larger size would be preferable from the point of view of economies of scale in administration of multiple plans and overall market impact. **The Secretary of Health and Human Services²⁰ should be empowered, if an exchange appears to be well below that size, to consolidate counties, regions, or states to achieve the 100,000 threshold.** The designation of the boundaries of the various exchanges should be subject to some discretion and creativity on the part of the Secretary. If the Secretary finds that a sparsely populated state cannot avoid having an insufficiently large exchange population, he or she should be given the discretion to combine that state with a nearby state (or portion thereof) to create a single, adequately sized exchange. This would make the exchange system as a whole more stable and likely to survive.

***Minimum Percentage:* To safeguard further against adverse selection, and above all to ensure that exchanges are powerful enough to induce private health insurance companies to submit competitive bids, each exchange should have a minimum participant pool of at least 20 to 25 percent of the non-Medicaid/non-Medicare**

¹⁶ The bill does allow states to combine to form "regional exchanges" by combining with other states, or "subsidiary exchanges" within states (Sec. 1311, p. 145).

¹⁷ The California state employee health-insurance system, CalPERS, chose to subdivide its exchange-like pool into five geographical zones to allow premiums to reflect the different cost levels in those zones.

¹⁸ Section 1311.

¹⁹ The choice of this number begs several important questions. How many plans would serve each exchange? Although bare survival might require only one, a larger exchange population might support several competing plans to better effect. But pushing in the other direction, would plans in the exchange cover other persons as well – outside of the exchange, or in other exchanges? Might such reach of the plans allow each exchange to be smaller while still allowing competition and sound risk pooling?

²⁰ The Secretary is given authority over the organization of the exchanges in the current Senate bill (Section 1311).

population in its coverage area. Especially in the larger states, the minimum exchange size of 100,000 lives noted above will be a tiny fraction of the total population of the exchange's territory. In the large states, an exchange will thus be exposed to a substantial risk of adverse selection should it reach the 100,000 threshold by attracting a disproportionately unhealthy group. A "percent of population" test is essential to reduce this risk, and also to guarantee that the risk pool is seen by private health insurers as big enough to justify their competing for it. In other words, the risk pool must be seen as offering so many lives, and so much premium revenue, that the private insurers must bid aggressively. The successful experience of the Wisconsin State Employee Health Plan in Dane County points to 20 to 25 percent of the non-Medicaid/non-Medicare population as the minimum share of each exchange's risk pool in the territory it serves.

Specific Amendments Needed to Guarantee Average Risk and Large Size:

The following amendments are needed to guarantee that each exchange has the average risk and large size necessary to induce private health insurance companies to submit competitive bids:

- (1) Combine the individual and small-group exchanges;**
- (2) Require that all uninsured individuals (if not eligible for Medicaid, Medicare, or another existing federal program) must use the exchange.**
- (3) Require that all employers with fewer than 100 employees must use the exchange.**

These amendments would result in a system of exchanges that, all told, should meet the 100,000 minimum in almost every state (with the Secretary having the authority to combine sparsely populated states to reach the 100,000 threshold) **and** meet the 20 to 25 percent of population test in each county, region, state, or multi-state territory served by an exchange.

No Restriction on Number of Plans: The exchange system could work well regardless of whether the number of health insurance plans allowed to bid is limited or is unlimited.

Once the individual and small-group markets are combined in a single exchange, however, there is no reason to limit artificially the number of health insurers who may bid. Furthermore, to the extent that all (or most) of the uninsured—and all (or most) of the employees of smaller firms—are included in the exchange risk pool, it would be unfair to private health insurers to limit the number who may bid.

Therefore, the bill should set appropriate standards of quality and soundness for insurer participation in the exchanges, and allow all qualifying insurers to participate.

The continuation of private individual and small-group markets outside of the exchanges follows from a decision to allow the exchanges to choose a limited number of plans that

would be offered to their members, on the basis of quality. There is some reason for this decision, which is to limit the number of choices to avoid customer confusion, and to manage quality. With the exchange allowed to restrict insurer access, and with the private market discontinued, individual and small-group insurers that were not selected for inclusion in the exchange would in effect be legislated out of business. However, fragmenting the risk pool in this way will cause more harm than this selection process will cause good. Instead, there should be global appropriate minimum standards of quality and soundness for participation in the exchanges, all insurers able and willing to meet the standards should be allowed to participate, and with this step one exchange (at whatever geographical level) should be created to serve all individual and small-group customers. This would at one stroke substantially increase the sizes of the exchange populations, and increase stability and reduce the danger of adverse risk selection. Having too few options in the exchange is more of a risk than having too many. However, some consumers would find a long list of alternative insurance options to be confusing or intimidating, even if that long list provided those consumers with better options. To mitigate this potential information overload, the exchange should make the same kind of effort at development of “plan-chooser software” that was made for the introduction of Medicare Part D, and should pursue any possible empowerment of employers and community and other non-profit organizations to provide help and guidance to consumers.

Fallback: If the requirement that uninsured individuals and small employers must use the exchange is not politically acceptable, then at least there should be a rebuttable presumption that such individuals must buy their coverage through the exchange, unless they act affirmatively to opt out of the exchange. It is possible that low-risk individuals could choose to opt out disproportionately, but it is equally possible that high-risk individuals would opt out disproportionately. In any event, requiring an opt-out decision would be better than the current state of the bill, under which choice is totally voluntary²¹ and as a result each exchange pool faces a serious risk of both insufficient enrollment and adverse selection.

From Survival to System-Wide Value

Proper Incentives: A fully successful exchange requires not only a risk pool that is average in risk and large in size, but also the *right incentives* for private health insurers to trigger the market forces that will drive insurance companies – and through them health care providers – to reduce cost and improve quality (primarily by driving out the error, waste, and inefficiency that infuse our health care system). Average risk and large size will induce health insurance companies to compete and submit bids. But only if the exchange confronts insurers with the proper incentives are they sure to submit *competitive* bids – that is, low premiums that reflect the best efforts to control cost while maintaining quality – and then go about the business of justifying their premium

²¹ Section 1312.

bids by working with HMOs, doctors, clinics, and hospitals to reduce the underlying cost of health care.

Only one incentive has exerted this sort of downward pressure on health insurance premiums in an exchange pool that is average in risk and large in size. **That incentive is that exchange participants have a strong economic reason to select lower-cost plans (at any benefit level) because those consumers alone, with their own money, unaided by government subsidy or employer subsidy, must pay for all or virtually all of the extra cost of higher-priced plans (at the same benefit level).** This has been the incentive used by the Federal Employees Health Benefits Plan, and by CalPERS for state employees. It has certainly been the incentive used for over 25 years by the Wisconsin State Employee Health Plan. This incentive instantly triggers a corresponding incentive on the part of health insurance companies to hold down their premiums (compared to what they otherwise would have bid) and to improve the quality of their plans, so that they can attract exchange enrollees and premium dollars by charging enrollees little or nothing out-of-pocket to join their particular insurance plans, **and** by offering high-quality health care.

Specific Amendments Needed to Create the Proper Incentives:

The following amendments are needed to guarantee that participants in well-structured exchanges, i.e., with average risk and large size, *also* have a strong incentive to select low-cost, high-quality health insurance plans:

(1) Require that, if an exchange participant chooses a plan whose premium costs more than the “reference plan,” the participant must pay the entire extra amount with out-of-pocket, after-tax dollars;

(2) Prohibit employers (of any firm size) from contributing to their employees’ health insurance any amount greater than the cost of the “reference plan.”²²

Fallback: If the full scope of this provision is not politically acceptable, then it can be softened by:

- Allowing exchange participants to use ***before-tax*** dollars (i.e., with a tax deduction or exclusion) to pay the extra cost of joining a health insurance plan whose premium exceeds that of the “reference” plan.

- Allowing employers to provide an additional subsidy to their employees who choose or who are offered a benefit package with an actuarial value that is richer than the 70 percent value of the “reference plan,” *provided* that the firm’s further contribution is limited to *lowest-cost* version of the richer benefit package.

- Possibly combining these two provisions.

²² Employers certainly should be free to increase the salaries of all their employees to help them pay for insurance. But this recommendation holds that they should **not** be allowed to increase the salaries of only those employees who chose specific, more-expensive insurance policies – because that would encourage their employees to purchase more-expensive, less-efficient coverage.

This fallback weakens—but does not eliminate—the incentive of exchange participants to select lower-cost plans, and would be acceptable as part of the compromise process.

These steps are important to getting the exchanges off to a healthy start, and in fact especially helpful in the beginning of the process. The more persons who are allowed or directed into the exchange, the more the sheer size of the populations will solve some of the problems of adverse selection. However, if the exchanges are not allowed to set off on a sound footing, the entire concept is likely to be discredited, and it would be less likely that policy ultimately will move toward competition, choice and efficiency.

As the exchange system takes hold, firms of greater and greater size – up to 250 employees, up to 500 employees, and ultimately up to firms of any size – should be allowed to join. Even without an expansion of this magnitude, the exchanges – *if* designed as recommended above – will reduce the growth of health insurance premiums and improve quality. But Congress ultimately must take the lid off the growth of the exchange system if exchanges are to pull the rest of the private market, and the American health care system itself, towards greater efficiency. States already are permitted to provide for the entrance of larger firms into the exchange beginning in 2017.²³ That date should be accelerated.

²³ Section 1312.

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