ISSUE BRIEF: SHOULD THE EXCHANGE NEGOTIATE WITH INSURERS OVER PREMIUMS, QUALITY, OR PAYMENT REFORMS?

THE RHODE ISLAND HEALTHCARE REFORM COMMISSION
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This Issue Brief provides background information on the issue, as well as stakeholder comments and recommendations. The Exchange Work Group convened meetings to present information, solicit feedback, and form preliminary recommendations. Participating stakeholders included representatives of small businesses, large businesses, consumer advocacy organizations, hospitals, physicians, health insurers, and health insurance brokers. This Issue Brief will be updated periodically to reflect any new information or additional stakeholder comments.

A critical issue in the design and function of the Exchange is whether it should aggregate the purchasing power of individuals and small businesses to leverage lower premiums (prices), higher quality, or payment reforms – and if so, how aggressively. Under Initial Guidance from the Department of Health and Human Services (HHS),[1] States have a range of options:

- The Exchange could function as an "active purchaser" – acting as many large employers do today on behalf of their employees, using leverage to bargain with insurers over premiums and/or quality.

- The Exchange could function as an "open marketplace" – a passive clearinghouse or "Travelocity" for health insurance that is open to all qualified insurers. In this model, the Exchange is merely a website that facilitates the purchase of insurance.

However, HHS has also made clear that the Exchange must have "the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers…"[2] The Affordable Care Act also requires the Exchange to take into account premium increases, and patterns of excessive increases, in determining whether to offer a plan.[3] Taken together, these requirements suggest that the Exchange cannot just accept any willing insurer.

Case Studies of Active Purchasing

Several case studies of Exchange-like models illustrate various degrees of active purchasing. An Exchange could simply offer all plans, or leverage lower premiums, higher quality, or payment reforms. If an Exchange engages in active purchasing, it could do so by negotiating with plans, imposing requirements, or conducting a competitive bidding process.

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[1] U.S. Department of Health and Human Services, Initial Guidance to States on Exchanges, available at: http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html.
[2] As required under Section 1311(e)(1) of the Affordable Care Act.
[3] Section 1311(e)(2) of the Affordable Care Act.

In **Utah**, the Utah Health Exchange serves 100 small employers with about 3,000 covered lives. The Exchange acts only as a market organizer; it is open to any willing insurer that meets minimal requirements (4 of the 6 major insurers participate). The Exchange does not negotiate on price, set minimum quality standards, or limit plan offerings. In 2010, consumers had a choice of 146 insurance products.

In **Massachusetts**, the Health Connector serves 176,000 subsidized individuals through a program called CommCare, and 38,000 unsubsidized individuals through a program called CommChoice. These are two separate and distinct markets that provide two very different models for an Exchange:

- **CommCare** actively seeks the lowest premiums possible through a competitive bidding process. First, the Connector sets a range for premium rates that would be actuarially justified. Within that range, the Connector then sets a rate ceiling below which insurers must bid. The Connector provides incentives for insurers to submit low bids by assigning some individuals to the lowest bidder. For example, individuals who do not select a plan have been auto-assigned to the lowest-cost plan. These incentives may increase insurers' motivation and leverage to negotiate lower provider rates and/or narrow their provider networks.

  CommCare also purchases based on quality, and seeks to promote payment reforms by requiring insurers to work on initiatives, including participation in pilot projects. In addition, CommCare actively seeks new competition, recruiting a new, out-of-state health plan called CeltiCare – the first market entrant in two decades. Because CeltiCare had a more limited provider network, it was lower cost, which increased competition and drove lower bids from other plans.

  Since CommCare's inception, premiums have increased less than 5 percent a year – compared to 8-10 percent in the commercial market. For fiscal year 2012, most insurers bid flat or lower rates compared to fiscal year 2011. Despite CommCare's aggressive active purchasing, *it has never turned away an insurer*, and offers all of the large and mid-sized HMOs in the state. This suggests that active purchasing can be effective without necessarily limiting the number of insurers. However, it is difficult to know whether Rhode Island's Exchange could achieve similar results, given differences in volume, demographics, markets, and plan designs.

- Because **CommChoice** serves unsubsidized individuals, who can easily buy insurance in the outside market, it does not have a "captive" consumer market. As a result, CommChoice does not have much leverage to negotiate price, and is pretty much a "price taker" from insurers. However, CommChoice does purchase based on quality: it awards a "Seal of Approval" to plans that offer good quality and value, and negotiates with insurers by issuing letters with proposed amendments to contracts. All participating insurers receive 4 stars or an "Excellent" rating from NCQA. Like CommCare, CommChoice also actively recruits new competition, helping a Medicaid managed care organization obtain a commercial license so that it could participate.

In between the Utah and Massachusetts models, the **Federal Employees Health Benefits Program** (FEHBP), which serves 8 million federal employees, retirees, and dependents, negotiates with plans based on both premiums and quality. To begin negotiations, the Office of Personnel Management issues an annual "call letter" that advises plans on policy initiatives (which can be fairly prescriptive) and asks plans to submit benefit and rate proposals.[4] OPM then reviews premiums based on costs, past experience, utilization, and inflation. Over the past decade, FEHBP has held premium increases below industry averages. Again, it is difficult to know whether Rhode Island's Exchange could achieve similar results, given differences in volume, demographics, markets, and plan designs.

Of course, Rhode Island is familiar with active purchasing, through **RIte Care**. Through its procurement process for Medicaid managed care plans, RIte Care seeks to leverage plan efficiencies to produce budget savings and quality health outcomes. For example, RIte Care encourages selective contracting to maximize the use of lower-cost community-based providers, and covers generic drugs first (with limited exceptions).

Key Considerations

In a highly concentrated insurance market such as Rhode Island's, the Exchange may have limited leverage to negotiate price discounts. Of course, this does not mean that the Exchange could not attempt to do so. Even if the Exchange is unable to negotiate price discounts, there may still be a role for it in ensuring that it offers high quality products and in promoting payment reforms. Furthermore, the Exchange could actively recruit new insurers or help smaller insurers expand market share. Finally, the Exchange could align purchasing strategies with Medicaid, a Basic Health Plan (if established), and/or the state employee health plan to maximize leverage.

To have enough purchasing power to be effective, the Exchange must have sufficient market share and volume. According to very rough and preliminary estimates, and assuming maximum participation, the Exchange would serve 113,000 individuals if it served everyone whose income exceeds 133 percent of poverty, or 77,000 individuals if the State establishes a Basic Health Plan for individuals whose income is between 133 and 200 percent of poverty. These estimates also indicate that 78,000 employees of small businesses could participate in the Exchange; this number would rise if small businesses with 51-100 employees could participate in the Exchange. Beyond these fundamental policy decisions, the volume of the Exchange will be affected by how attractive it is to small businesses and how well it competes with markets outside the Exchange.

[4] For example, the 2011 call letter includes the following policy initiatives (among many others):
- "We *encourage* you to submit proposals to implement pilot programs directed at managing patient care such as integrated healthcare systems."
- "We *expect* you to offer programs that promote health and wellness…This includes incentives for enrollees who complete a health risk assessment, are compliant with disease management programs, or who participate in wellness activities or treatment plans aimed at managing and improving health status."

As the examples of CommCare and CommChoice illustrate, an Exchange that has a large "captive" market will have more leverage. Subsidy-eligible individuals are "captive" because in order to claim their subsidies, they must buy insurance through the Exchange. According to national estimates by the nonpartisan Congressional Budget Office, 88 percent of Exchange enrollees will be subsidy-eligible in 2014, and 79 percent will be subsidy-eligible in 2019.[5] Therefore, even though the Exchange will serve unsubsidized individuals, a significant percentage of its enrollees will be "captive."

Active purchasing may require additional staff resources, market research, and technical expertise. These resources would translate into a larger operational budget, and could result in higher fees or assessments on insurers to support that budget – which insurers could pass on to consumers and small businesses in the form of higher premiums. Therefore, active purchasing would have to produce tangible savings to result in net premium reductions for consumers and small businesses.

Of course, at some point, if the Exchange is too selective in its active purchasing, it could unduly limit choices of plans and providers, competition among insurers, or innovation in benefit designs. In the small group market, limiting employer choice too much may drive employers away from the Exchange, which would undermine financial sustainability.

Preliminary Recommendations of the Work Group

At the outset, many stakeholders expressed that affordability and cost containment for small businesses should be a major goal of the Exchange. One stakeholder emphasized that an Exchange will do little unless care is managed and payment incentives, such as penalties for overuse of the emergency room, influence the behavior of insured individuals.

Recommendation: The Exchange should have authority to aggregate the purchasing power of individuals and small businesses to leverage lower premiums.

A significant majority of stakeholders supported this recommendation. Note that under this recommendation, the Exchange would simply have the authority to *attempt* to secure price discounts; it may decline to exercise that authority, or fail in its attempt. One stakeholder noted that the more successful the Exchange is, the more leverage it will have to negotiate lower prices – and that brokers have a role to play in increasing participation in the Exchange.

Recommendation: The Exchange should have authority to aggregate the purchasing power of individuals and small businesses to leverage higher quality products and payment reforms.

A significant majority of stakeholders supported this recommendation. Some stakeholders who did not support this recommendation do support active purchasing based on quality, but were concerned that "payment reform" is too broad and undefined.

[5] Congressional Budget Office, Final Cost Estimate, March 20, 2010.

The Work Group may further specify and define the types of payment reform that the Exchange should have authority to promote.

One stakeholder supported a model in which the Exchange would set quality standards in advance, and then certify all plans that meet those standards. Under this model, consumers would know that they are choosing among high quality products, and would better understand their choices. This model might allow for more innovation, and be more effective in delivering choice, than more aggressive active purchasing. In the view of this stakeholder, this model is better suited for the commercial market, because consumers are not "captive" to that market, and will have a choice to purchase insurance outside of the Exchange.

Two stakeholders, in supporting the most aggressive active purchasing possible, argued that unless the Exchange is strong enough to incentivize movement away from fee-for-service, the State will not be able to contain costs. Another stakeholder, in supporting active purchasing based on quality, argued that the focus should be on moving away from fee-for-service and rewarding healthy behavior, such as incentivizing the use of primary care and generic drugs.

Recommendation: Models for Active Purchasing to Leverage Lower Premiums, Higher Quality, and Payment Reforms

The Work Group considered two models of Exchanges that seek to leverage lower premiums, higher quality, and payment reforms:

- In one model, the Exchange has authority to negotiate based on premiums, quality, and implementation of payment reforms, while ensuring adequate choice. This is similar to the FEHBP model discussed above. California enacted this model in its Exchange legislation: in selectively contracting for plans, "the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."

- In the other model, the Exchange negotiates based on quality and implementation of payment reforms, and secures price discounts by setting a ceiling for premiums, and soliciting bids below the ceiling. This is similar to the CommCare and RIte Care models.

A significant majority of stakeholders supported one of these two models. *Of those stakeholders who supported one of these two models*, a majority supported the more aggressive model that is similar to RIte Care. One stakeholder, in supporting the more aggressive model, reasoned that public dollars are at stake.

Recommendation: The Exchange should align purchasing strategies with Medicaid and CHIP, a Basic Health Plan (if established), and the state employee health plan.

A significant majority of stakeholders supported this recommendation. The stated rationale is that if the volume of the Exchange is limited, this strategy is a way to build more leverage to drive reform. One stakeholder noted that, unlike FEHBP, which serves millions of federal employees, Rhode Island's Exchange will be small, and should therefore align with Medicaid as an active purchaser. Another stakeholder noted that reforms are already underway, and must be integrated with the Exchange's strategies, because providers are already confronted with too many different reforms.

For example, suppose that one payer implements a pay-for-performance (P4P) initiative. That one payer may not have enough patients by itself to influence providers and reform the delivery of care. Or, if multiple payers do implement P4P programs, they may use different quality measures and different payment incentives. But if programs are aligned across all payers, providers receive consistent signals, more patients are involved, and providers have more incentive to provide higher quality care.

The extent to which the Exchange can help reform the payment and delivery system is unclear. The Exchange is not by itself a panacea for containing costs, but it may present an opportunity to aggregate the purchasing power of all payers to drive system change over the long term.

Other Stakeholder Views

A few stakeholders supported the model of the Utah Health Exchange. One of these stakeholders valued its focus on freedom and flexibility, including flexibility for small business owners to change their coverage based on current business conditions. Another expressed that active purchasing is not helpful in getting the Exchange up and running, which should be the main priority. In the view of this stakeholder, payment reforms are already underway, and will be in place by 2014. However, movement away from fee-for-service is challenging, and will have to be done slowly and carefully.