ISSUE BRIEF: SHOULD THE EXCHANGE OFFER MANAGEABLE AND MEANINGFUL CHOICES OF HEALTH PLANS?

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.

An Exchange can use active purchasing to negotiate not only lower premiums, higher quality, or payment reforms, but also to manage the number and type of insurance products that it offers. Therefore, a critical issue for the design and function of the Exchange is whether it should allow the maximum choice possible, or create a manageable menu for consumers and small businesses.

The Affordable Care Act requires coverage of "essential health benefits" – specific items and services, such as mental health services or prescription drugs.[1] The Act also specifies the levels of coverage that plans can provide.[2] These levels are measured by actuarial value, or the percentage of an enrollee's total health care costs paid for by the plan, on average. For example, on average, a Silver plan would pay for 70 percent of an enrollee's costs, with the enrollee contributing the remaining 30 percent of costs (through a deductible, coinsurance, and/or copayments at the point of service).

Aside from these requirements, the Affordable Care Act does not further prescribe benefit or cost-sharing designs. Plans may cover benefits that are in addition to the "essential health benefits." There are also an infinite number of combinations of deductibles, coinsurance, or copayments that could yield a given actuarial value. For example, a low deductible and high coinsurance could produce the same actuarial value as a high deductible and low coinsurance. Various combinations of additional benefits and cost-sharing designs could result in significant variation and an extensive choice of products.

However, a growing body of evidence suggests that more choice is not always better and could lead to "choice overload." In particular, studies indicate that people are more likely to make a choice – and be satisfied with their choice – when they face a more limited set

[1] Section 1302(b) of the Affordable Care Act.
[2] Section 1302(d) of the Affordable Care Act. The levels of coverage are Bronze, Silver, Gold, and Platinum, which on average pay for 60, 70, 80, and 90 percent of costs, respectively.

of choices.[3] For example, research on 401(k) retirement savings plans has found that as the number of fund options increases, employee participation falls.[4]

In the health insurance context, there is evidence that too much choice can lead to poor decision-making. In Medicare Part D, consumers frequently choose prescription drug plans that provide less risk protection at higher cost.[5] In Medicare Advantage, CMS recently found that "the large number of MA plan options…has made it difficult and confusing for beneficiaries to distinguish between these plans and to choose the best option to meet their needs."[6]

By standardizing health insurance products – specifying plan designs – the Exchange could make comparisons easier. This could both improve consumer decision-making and enhance competition, which could improve quality and lower premiums.[7] Standardization could also limit insurers' ability to use plan design to select risk. As Jon Kingsdale has observed: "One objective of reform is to narrow the opportunity for insurers to compete mainly on risk selection. If you can narrow that opportunity, you can focus insurers on value as a business strategy."[8] Finally, much in the same way that managing 401(k) options increases employee participation, managing plan offerings could increase participation in the Exchange and the overall coverage rate.

Standardization is not without risks. It could result in products that are not in line with consumer preferences. Therefore, the Exchange would have to conduct market research carefully and review its offerings frequently. Also, if too restrictive, standardization could stifle innovation that promotes value. For example, "value-based insurance design" – which provides for lower cost-sharing for cost-effective services – would be incompatible with standardized products that do not allow such variation.

Case Study: Massachusetts Commonwealth Health Insurance Connector

When it first started, the Connector allowed unlimited variation at each level of actuarial value, but consumer focus groups indicated that the choices were too confusing. As a result, the Connector standardized its products, using market surveys to specify cost-sharing designs. Today, insurers can offer only one Gold product, two Silver products,

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[3] Sheena S. Iyengar and Mark R. Lepper, *When Choice is Demotivating: Can One Desire Too Much of a Good Thing?*, Journal of Personality and Social Psychology, Vol. 69, No. 6 (2000), pp. 995-1006.
[4] Sheena Sethi-Iyengar, Gur Huberman and Wei Jiang, "How Much Choice Is Too Much? Contributions to 401(k) Retirement Plans," in *Pension Design and Structure: New Lessons from Behavioral Finance*, Oxford University Press, July 2004.
[5] Jason Abaluck and Jonathan Gruber, *Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice*, American Economic Review, Vol. 101, No. 3, May 2011.
[6] Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 4, 2011, p. 122.
[7] The nonpartisan Congressional Budget Office concludes that Exchanges can enhance competition and reduce premiums by allowing consumers to compare standardized products. CBO, *An Analysis of Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009.
[8] Sabrina Corlette, Joan Alker, Joe Touschner, and JoAnn Volk, *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned*, Georgetown University Health Policy Institute.

and three Bronze products. Most recently, in response to feedback from consumers and insurers, the Connector eliminated one of the three Silver products and loosened its specifications to allow variation in cost-sharing for some categories of services.[9]

Preliminary Recommendations of the Work Group

Recommendation: The Exchange should have authority to standardize products to provide manageable – but still meaningful – choices.

A significant majority of stakeholders supported this recommendation. For example, California's exchange legislation includes the following provision: "The board shall have the authority to standardize products to be offered through the Exchange."

One stakeholder commented that FEHBP provides far too many choices, making it difficult to compare apples to apples. From a consumer perspective, having to process too much information, especially with no insurance background, can consume too much time and be overwhelming. This stakeholder also raised the issue of which terms could be used for searches through the Exchange's portal, such as whether consumers can search for products that cover disease management programs.

Another stakeholder commented that the model of the Utah Health Exchange, with over 100 plan offerings, does not help the public shop for insurance better. In the view of this stakeholder, a "big mall" exchange would be counterproductive, and too confusing for consumers.

Another stakeholder argued that standardization can limit risk selection, which is an important goal for both individuals and small businesses. Allowing consumers to customize products that are standardized to some extent is pretty much the status quo, and could result in risk selection.

Another stakeholder questioned what harm could possibly result from simply giving the Exchange *authority* to standardize plans. Still another argued for an Exchange that has the capacity for growth, and that has tools to develop flexibly over time, given that it is difficult to determine now what the ideal balance should be in the future.

Other Stakeholder Views

One stakeholder suggested that as long as Navigators help consumers find the right products for them, there is no need for standardization. Another stakeholder responded that even where consumer assistance is available, evidence indicates that consumers can make poor choices.

Another stakeholder noted that in the direct pay market in Rhode Island, there are 5 products, but people are always asking for additional products – so policymakers should learn from this experience. Still another noted that Rhode Island is already a small market

[9] Board of the Commonwealth Health Insurance Connector Authority, Minutes, January 13, 2011.

without a plethora of options, arguing that policymakers should be careful about setting up the Exchange too narrowly. In particular, the Exchange should consider offering variation on services like care coordination and chronic disease management.

Another stakeholder argued that the whole objective of the federal law is to foster and promote competition, and that it is important to differentiate between what different employers want. For example, an employer with all of its employees in Rhode Island may want a closed network based in Rhode Island, whereas an employer with offices in several states may want a wide open network. Employers may also want to make choices to drive employee behavior, such as driving them away from the ER and toward wellness programs.