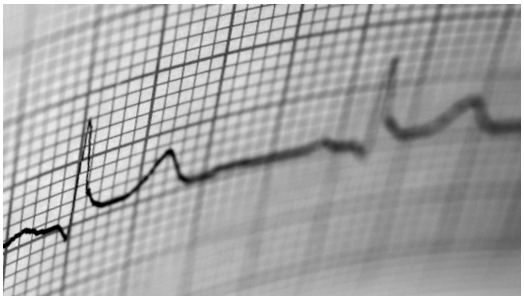
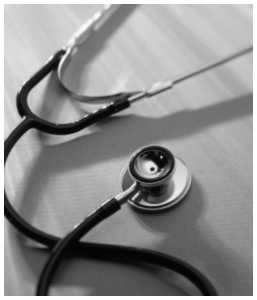
United Hospital Fund

# Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers



AN ISSUE BRIEF



**United Hospital Fund**

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# Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers

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# Foreword

New federal standards for health insurance coverage, coupled with ample state discretion to meet those standards, are central to the Affordable Care Act. Nowhere is the tension created by this federalist approach more evident than with requirements for the creation of new state health benefit exchanges, which are charged with renovating the insurance market for individuals and small businesses so that it is more efficient, is more affordable, and makes it easier for consumers to shop and compare coverage options based on value. Under federal guidance issued last summer, states must work to ensure that exchanges offer coverage "in the interest" of its customers.

Just how to attain that goal has engendered debates in state capitals across the nation, as state policymakers and stakeholders reargue the ACA's brief on the proper balance of regulation and market forces. This debate, with its roots in the managed competition theories that took hold in the 1970s, is often characterized by a continuum stretching between two poles: the passive market organizer approach or clearinghouse, and the active purchaser model.

This passive-active debate is the subject of this report, the fourth in a series of United Hospital Fund publications supported by the New York State Health Foundation examining issues associated with the creation of a New York Health Benefit Exchange. Past efforts discussed options for establishing the infrastructure and governance for a state exchange, integrating Medicaid with new subsidized commercial coverage, and options for altering core pooling mechanisms for individuals and small groups.

In *Passive/Active: Defining the Role for a Health Benefit Exchange in the Interest of New Yorkers*, co-authors Peter Newell and Robert L. Carey highlight options for New York through an analysis of key ACA provisions, relevant literature, and activities in other states, coloring an otherwise theoretical discussion with an informed snapshot of New York's insurance markets and regulatory framework. Their analysis sheds a great deal of light on fundamental decisions New York policymakers face in setting up New York's Exchange, and those decisions' consequences for consumers, health plans, and providers.

James R. Tallon, Jr.
*President*
*United Hospital Fund*

# Executive Summary

Health benefit exchanges are the centerpiece of the sweeping insurance reforms enacted by the Affordable Care Act (ACA). While Congress specified a destination for states—offering health plans "in the interests" of individuals and small businesses—it left broad discretion to states on how to get there.

Stepping into the breach, exchange theorists have created useful models for examining the roles an exchange could play in state insurance markets, ranging from a "passive market organizer" to an "active purchaser." The passive market organizer model, also known as the "clearinghouse," limits an exchange's role to ensuring compliance with federal standards and facilitating purchases with information on quality and new technology. Under the active purchaser model, an exchange would attempt to use its leverage—much like a large employer—to get the best prices through a competitive procurement, or to advance other goals.

Guidance to states from the U.S. Department of Health and Human Services (HHS) frames a similar set of state options, and outlines exchanges' duties and functions in two key areas: selecting the plans that can participate, and the products those plans can offer—a combination known as "qualified health plans." Three overarching issues emerge from the federal regulations: 1) participation in the exchange, while it could represent a good business opportunity for health plans, is voluntary; 2) while some potential enrollees will be drawn to the exchange by available subsidies, it is not an exclusive market; and 3) the size of the exchange market—which affects its market leverage—is unknown, and it could vary by hundreds of thousands of enrollees, depending on state policy decisions.

Two state exchanges predate the ACA and embody the range of possible approaches: Utah (a passive market organizer) and Massachusetts (an active purchaser). These two key exchanges are useful for New York to consider. Options for an exchange are best viewed, however, in light of New York's unique market landscape and regulatory framework.

Despite years of consolidation, New York overall falls within a group of states with lower market concentration, based on national surveys. New York's marketplace arguably lacks a true statewide insurer, includes three pioneering regional health maintenance organizations (HMOs), and is one of only two states with more than two Blue Cross Blue Shield (BCBS) plans. The resulting collection of regional markets, with nonprofit health plans prevalent upstate and for-profit plans dominant downstate, features a blend of three or four competing health plans of different types in each region, though there are areas of concentration in central New York, the Rochester area, and in the downstate small group market.

From a regulatory perspective, New York's prior approval law provides regulators with a strong set of tools to restrain rate increases. New York mandates HMO participation in the individual, small group, and Healthy NY markets, and it has a long history of benefit standardization. In addition to HMOs, nonprofit insurers, and commercial accident health insurers, New York licenses Prepaid Health Services Plans (PHSPs) serving public programs only. This segment includes provider-sponsored organizations, nonprofits, and national for-profit companies. PHSP participation in the Exchange is uncertain, but could significantly affect decisions in the New York City area, where most PHSP enrollment is located.

A passive market organizer model would be the simplest and least costly approach for New York's Exchange, and the quickest—a paramount concern, given the threshold requirements state exchanges must meet in order to avoid default participation in a federal exchange. At the same time, a passive market organizer exchange—and its customers—would have to live with health plans' decisions about product offerings. Health plans might offer an ideal, robust mix of prod-

ucts, or a skimpy menu reflecting a cautious approach to a new market and competitive pressures; the Exchange would have no say in the matter. In addition, this model cannot adapt to changing market conditions, or encourage broader health system reforms that in turn could improve New York's status as a high-cost state with middling quality and performance.

New York could pursue many goals through an active purchaser model exchange, including: reducing premiums through competitive procurements (a price leader approach); ensuring a broad range of choices in terms of actuarial value and provider networks; aiding consumer decision-making by reducing the complexity of the current market choices and making them more coherent and comparable; setting minimum standards to drive quality improvement; amplifying its market role and achieving other goals by adopting additional minimum standards shared by large public or private payers; or advancing longer-term goals consistent with ACA initiatives to improve population health, reform payment structures to reward quality, encourage the development of vertically integrated accountable care organizations, and improve primary care through patient-centered medical home models.

Each of these models has advantages and disadvantages. A price leader approach, for example, might not produce price discounts significantly greater than those approved under New York's prior approval process, but it could reduce consumers' choice of both health plans and providers, since some health plans might opt not to participate, and providers might not agree to join health plan networks for the reduced payment schedule that might result. Increased costs and complexity, larger differences between the exchange and non-exchange markets, and competitive advantages for health benefit arrangements not subject to the ACA or state requirements, are all possible drawbacks that could result from active purchaser models.

A policy discussion based on the passive market organizer versus active purchaser framework is useful, but has its limitations. Given New York's long history of regulatory intervention in health insurance markets, the public investment provided through the ACA, and well-documented shortcomings of New York's health system overall, a purely passive market organizer approach does not seem a likely direction for New York's Exchange. At the same time, while an Exchange with broad discretion to undertake active purchaser activities is attractive from an operational perspective, it requires politically difficult accommodations.

The challenge for New York policymakers, then, may be to chart a course somewhere in between the passive market organizer and active purchaser approaches, using two polestars: the clear intent of the ACA to promote informed, value-driven, and easily comparable consumer choices that improve quality and reduce costs; and a realistic understanding of New York's market characteristics and regulatory scheme. In many ways, this framework resembles the option HHS suggests of "implementation of selection criteria beyond minimum certification standards." Launching an exchange with an urgent mandate and the tools needed to create a broad but coherent set of product choices for consumers with diverse needs would put New York in a position to meet immediate deadlines, and would set the stage for the achievement of longer-term goals at the heart of the ACA.

## Acknowledgments

This report was supported by a grant from the New York State Health Foundation. Many individuals representing health plans, providers, government agencies, and business and consumer groups were interviewed for this report; all were generous with their time, candor, and insight. Miriam Aziz, a Research Assistant at the United Hospital Fund, made many significant contributions to this report.

## Introduction

Health benefit exchanges are the centerpiece of the Affordable Care Act's (ACA's) sweeping insurance reforms. But while the law sets a destination for state exchanges—"offering health plans in the interests" of individuals and small employers—it leaves states broad discretion on how to get there. Stepping into the breach, exchange theorists have created a useful typology (Carey 2010) for the space an exchange could occupy in state markets. With the "managed competition" theories serving as the wellspring (Enthoven 1993), and with reference to early experiments with "purchasing alliances" (Wicks et al. 2000; Yeagen et al. 1998; Wicks 2002), in which adverse selection problems are often the coda, analysts have laid out the merits of various exchange models, ranging from a "passive market organizer" to an "active purchaser."

Under the **passive market organizer** approach, also known as a "clearinghouse," any health plans meeting minimum ACA standards for insurers and products could participate; the exchange would act as an impartial source of information on health plans available in the market, providing the structure and tools that enable consumers to compare health plans and purchase coverage, and undertaking basic administrative functions for health plans and consumers. This model is often compared to the "Travelocity" travel planning business, and Utah's exchange, discussed below, is often associated with this type of operation.

Under the **active purchaser model**, the exchange would attempt to use its leverage—much as a large employer would—to get the best price through a competitive procurement, or attempt to influence the market by contracting with a select group of health plans or by setting health plan requirements that exceed the minimum standards of the ACA. Some observers have carved out a subset of less aggressive active purchaser activities and labeled them "selective contractor," of which the Massachusetts Connector, discussed in detail below, is often cited as an example. A series of papers advising California policymakers on the role of California's exchange, also discussed here, provides a thoughtful guide to different kinds of active purchaser activities an exchange could pursue (California HealthCare Foundation 2011a–d).

These models have their limitations, however, as their meanings are imprecise and they encompass a wide range of activities that often overlap. The passive market organizer theory, for example, probably underweights new duties in the market which are delegated to the exchange, and "active purchaser" and "selective contractor" could be viewed as synonyms. For simplicity's sake, we rely on the basic passive/active framework, but we will offer some refinements.

## Passive/Active

This passive versus active debate has played out across the country as states craft legislation to define the role of the exchange in their insurance markets. According to a recent survey, five states have opted for active purchaser exchanges, three have chosen passive market organizer or clearinghouse roles, and four more have either deferred the decision or left it to the board of the exchange to determine (Kaiser Family Foundation 2011a). Legislation adopted in California, the nation's first post-ACA exchange, is structured as an active purchaser and has received a good deal of attention.[1]

As New York policymakers grapple with defining the role for New York's Exchange, stakeholders have aligned in unsurprising camps, mostly reflecting the national discussion.[2] New York's leading trade association for health plans,

[1] Chapter 655, California Statutes of 2010, available at http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html; and Chapter 659, California Statutes of 2010, available at http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html (both accessed December 14, 2011).

[2] See the letters by the Blue Cross Blue Shield Association and America's Health Insurance Plans in response to the Honorable Kathleen Sebelius [Secretary of the Department of Health and Human Services], Request for Comments: Exchange-Related Provisions of Patient Protection and Affordable Care Act, October 4, 2010. See also Community Catalyst 2011.

for example, called for an exchange "without any rate approval responsibility or plans selection authority" so that "all plans that are licensed and authorized to provide health insurance should be permitted to participate in the Exchange."[3] In contrast, a leading consumer organization urged state policymakers to create an exchange that would "maximize value and consumer protections for New Yorkers by assuming the role of active purchaser... New York's Exchange should leverage its market share and utilize an aggressive bidding process, or actively negotiate with plans to ensure that consumers receive the highest value for their money."[4]

The New York State Business Council embraced a more limited role for the Exchange, calling for the inclusion of all insurers offering plans that meet minimum federal standards (Moree 2011). The National Federation of Independent Businesses, with an active charter member in New York, is a party to federal action seeking to overturn the law.[5] One small business group in New York, however, has urged an active purchaser role.[6]

Some health care providers have also argued for a more limited role for New York's Exchange. A major hospital trade association recently testified that "we do not believe the exchange should attempt to impose artificial affordability through price controls for insurers or providers, nor do we believe it should interfere in the business relationships between insurers and providers….We also believe it is important that the exchange not be invested with significant regulatory or policymaking responsibilities" in addition to the authority wielded by the departments of Financial Services and Health.[7]

In New York, the Cuomo Administration submitted program legislation[8] vesting the board of the Exchange with the authority to standardize benefit packages that would be available in the Exchange, and to "selectively contract" with health plans "so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service." In a subsequent amendment, the language was removed as part of a compromise effort aimed at reaching an agreement on establishing the basic infrastructure and governance and postponing decisions on more difficult issues, but that agreement proved elusive.[9]

Exchange models represent a broad range of activities along a continuum. In this paper, we outline the relevant ACA requirements for exchanges and provide some context for the ongoing debate about the models' benefits and drawbacks, based on activities in other states. We then ground the discussion by highlighting how two core exchange activities—selecting the health plans that will participate in the exchange and selecting the products available for purchase—are affected by unique features of New York's insurance market and regulatory framework. We conclude with a discussion of the policy options in the passive/active framework under the various exchange models.

[3] Paul F. Macielak [President and CEO of the Health Plan Association], letter to the Honorable Kathleen Sebelius [Secretary of the Department of Health and Human Services], Request for Comments: Exchange-Related Provisions of the Patient Protection and Affordable Care Act, October 4, 2010.

[4] Health Care for All New York (HCFANY). April 27, 2011. Testimony to the New York State Senate Standing Committee on Health and Standing Committee on Insurance regarding a New York State Health Insurance Exchange.

[5] In the Supreme Court of the United States, national Federation of Independent Business, Kaj Ahlburg, and Mary Brown v. Kathleen Sebelius, et al. On Petition For a Writ of Certiorari To The United States Court of Appeals for the Eleventh Circuit.

[6] Geyerhahn, B [director of special projects, Small Business Majority]. March 18, 2011. Statement on the record before the State Insurance Department on the health insurance exchange.

[7] Shure K [senior vice president of managed care and insurance expansion, Greater New York Hospital Association] May 18, 2011. Public forum on the establishment of a health insurance exchange in New York State: Testimony of the Greater New York Hospital Association.

[8] Governor's Program Bill #12 of 2011, Section 2, subdivision 7 of new Section 3984, Public Authorities Law. Available at http://www.governor.ny.gov/assets/documents/GPB12NEWYORKHEALTHBENEFITEXCHANGEBILL.pdf (accessed December 14, 2011).

[9] Governor's Program Bill #12R, A.8514 (Morelle)/S.5849 (Seward), introduced at the request of the Governor. Available at http://open.nysenate.gov/legislation/search?term=S5849. Passed Assembly June 23, 2011; recommitted to Senate Rules Committee, June 24, 2011.

## Exchange Duties under the ACA

The Affordable Care Act requires states to establish an American Health Benefit Exchange for individuals and a Small Business Health Options Program (SHOP) Exchange for employers with 1–100 employees, but it also gives states the discretion to combine the two exchanges, merge the individual and small group markets, and delay the integration of the 51–100 employee segment of the market until 2016 (Newell and Gorman 2011). Federally administered exchanges will be established in states that either opt not to create an exchange or fail to meet federal standards.

The leanest description of the minimum role an exchange must play in the market comes from early guidance offered to state governors by the U.S. Department of Health and Human Services (HHS).[10] The agency describes the Exchange as:

*"a mechanism for organizing the health insurance market place to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers."*

Within this general guidance, two sets of duties are described, "Exchange Functions" and "Oversight Responsibilities." Duties in the first category include certification, recertification, and decertification of plans; operating a toll-free hotline; maintaining a website with plan information; assigning price and quality ratings to plans; certifying those individuals exempt from personal responsibility provisions; administering cost-sharing and premium subsidies; and determining eligibility for public programs. Obligations in the second category require exchanges to apply regulatory standards developed by the secretary in five key areas: marketing; network adequacy, accreditation for performance measures, quality improvement and reporting, and uniform enrollment procedures. Certainly, the core function of the exchange is certifying that the health plans that wish to participate, and the products they offer, meet ACA standards.

Subsequent guidance by HHS[11] stresses the flexibility states have "to determine whether offering health plans is in the interest of individuals and employers." HHS invites state policymakers to consider four strategies, which can also be arrayed along the passive-active continuum:

- An "any qualified plan strategy," in which all plans that meet minimum certification requirements are admitted;
- A competitive bidding or selective contracting process;
- Negotiations with health insurance issuers on a case-by-case basis;
- Implementation of selection criteria beyond the minimum certification standards; or
- Some combination of these strategies.

Under the terminology of the ACA, which mirrors the structure of the Medicare Advantage Program, when exchanges certify qualified health plans (QHPs), they will be approving both the insurer or health maintenance organization (HMO) offering coverage (described as "issuers" in the ACA) and the benefit package offered by the insurer, with the two together described as the "health plan." For our purposes, we will examine the process for the approval of the insurer that wishes to offer coverage, as well as the benefit package.

[10] Kathleen Sebelius [Secretary of the Department of Health and Human Services], letter to Jane Cline [President of the National Association of Insurance Commissioners], Senator Richard Moore, and Governor Gregoire, Initial Guidance to States on Exchanges. November 18, 2010.

[11] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Proposed Rule. July 11, 2011. U.S. Department of Health and Human Services. 45 CFR Parts 155 and 156. Executive Summary available at http://federalregister.gov/a/2011-17610.

## Approving Health Plans for Participation in an Exchange

The proposed rule[12] outlines a series of minimum certification standards for exchanges to follow in reviewing the qualifications of health plans or issuers that want to participate in the exchange. Minimum certification standards require health plans to "be licensed and in good standing" to offer health insurance in New York, abide by ACA statutory and regulatory requirements, pay assessments required under the ACA, participate in the risk-adjustment mechanism, implement and report on quality improvement strategies (an important and often overlooked requirement), meet the accreditation standards in a variety of categories involving quality, customer satisfaction, and other areas, and offer products that comply with ACA standards.

## Selecting Products to Be Sold in an Exchange

A second important role of the exchange is making sure that the products submitted by compliant health plans meet other standards in the ACA. HHS is responsible, with advice from the U.S. Department of Labor and the Institute of Medicine (IOM), for fleshing out the "essential health benefits" that are outlined in ten broad categories in the ACA and will apply to both individual and small group policies in the exchange (IOM 2011). Most of these categories—hospital, ambulatory, maternity, emergency, preventive care, and lab tests—are already required in New York. Requirements on coverage for a second group of the categories—mental health and substance abuse treatment (including behavioral health treatment), prescription drugs, and rehabilitative and habilitative services and devices—differ between individual and small group coverage; they are often covered but subject to benefit limitations. The final categories, pediatric vision and dental coverage, are not required in commercial coverage, though they are often valued employee benefits and are included in public coverage. The recent IOM report suggested a direction for resolving some of the inconsistencies between individual and group coverage by embracing a "small group plus" approach to the standard; the HHS guidance is highly anticipated. States must pay the cost of benefits not required under the regulation;[13] they also have the option of applying for a waiver of the requirements for an actuarially equivalent benefit package.[14]

In addition to these core benefit requirements, exchanges must vet health plans' compliance with benefit requirements based on three other tests: actuarial value, out-of-pocket maximums for in-network care, and deductible limits. Income-based premium and cost-sharing subsidies will help make coverage more affordable for lower-income individuals,[15] and small businesses that employ low-wage workers may be able to recoup some of their premium expenses.[16]

**Actuarial Value.** The ACA establishes five allowable benefit levels for products based on their actuarial value: 90 percent for platinum plans; 80 percent for gold; 70 percent for silver; and 60 percent for bronze.[17] A fifth category, catastrophic, is only available to individual purchasers under age 30 or individuals of any age who are granted an exemption from individual responsibility requirements. The actuarial value

[12] U.S. Department of Health and Human Services, Proposed Rule, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans," July 15, 2011, page 41923.

[13] Affordable Care Act, Section 1331(d)(3)(B).

[14] Affordable Care Act, Section 1332.

[15] Affordable Care Act, Sections 1401 and 1402.

[16] Affordable Care Act, Section 1421.

[17] Affordable Care Act, Section 1302(d)(1).

of this benefit package is based on Internal Revenue Service (IRS) rules for health plans that are compliant with health savings account (HSA) requirements. The ACA requires participating health plans to offer at least one gold and one silver level product.

**Out-of-Pocket Maximums.** Benefit packages sold through the exchange must limit the total amount of each member's costs for in-network services.[18] The cost-sharing limits are based on annual maximums that apply to HSA-eligible plans, $5,950 for individuals and $11,900 for families, with subsidies that will reduce this expense for lower-income individuals on a sliding scale.

**Annual Deductibles in the Group Market.** Deductibles for small group purchasers are capped at $2,000 for individuals and $4,000 for families. Since individual purchasers are not subject to this deductible limit, they will be eligible to purchase a broader range of HSA-eligible products with deductible limits capped only by the IRS limits.

## Three Overarching Issues

Three overarching issues that emerge from this review of general ACA provisions are worth highlighting, before turning to a discussion of New York insurance market characteristics that will color the options policymakers face in determining the role of the Exchange:

1. *Participation in the exchange for health plans is voluntary.* Subsidies and tax credits for individuals and small businesses, along with personal responsibility requirements for individuals, will create attractive new business opportunities for health plans, but most health plans (except, arguably, HMOs; see below) are not required to offer coverage through the exchange.[19]

2. *The exchange is not an exclusive market.* Although New York policymakers will study the idea of making its Exchange the exclusive market for individuals and small groups,[20] at the outset it is likely that the Exchange will function as a second distribution channel for coverage. While it may be the first stop for individuals and small groups eligible for tax subsidies, early take-up of small business tax credits similar to those to be offered though the Exchange has been smaller than projected,[21] and both groups of consumers will have other choices in the market. This places a premium on an exchange design that provides value to purchasers through the quality of the consumer shopping experience.

3. *The size and composition of the exchange market is not known with certainty.* A number of variables—state policy decisions, pending federal guidance, and the behavioral responses of individuals, businesses, and health plans to the menu of incentives and penalties in the ACA—could cause significant swings in the population of covered lives seeking to enroll in coverage through the Exchange. Decisions by New York policymakers, for example, on whether to adopt the Basic Health Program,[22] and the timing of adding employer groups with 51-100 employees, could add or subtract hundreds of thousands of covered lives to the enrolled population in the Exchange (Newell and Gorman 2011).

[18] Affordable Care Act, Section 1302(c)(1).

[19] Affordable Care Act, Sections 1401, 1402, 1421, and 1302.

[20] New York Assembly bill A.8514 of 2011, Section 3988.

[21] Treasury Inspector General for Tax Administration. September 19, 2011. Affordable Care Act: efforts to implement the small business health care tax credit were mostly successful, but some improvements are needed. Available at http://www.treasury.gov/tigta/auditreports/2011reports/201140103fr.pdf (accessed November 21, 2011).

[22] Affordable Care Act, Section 1311.

## The New York Landscape

As federal regulators have noted, "[h]ow an exchange elects to implement the 'interest' determination may vary based upon a number of factors, including the size and risk profile of the exchange's potential enrollees, concentration of the health insurance market in the area served by the exchange, and the applicable state insurance rules. Each exchange will likely need to assess these factors in selecting an approach that will promote value and quality for its enrollees."[23] Many observers have also noted the importance of examining "environmental factors" in the local landscape as a first step in evaluating the proper role of an exchange (Corlette and Volk 2011; Jost 2011). Before turning to an evaluation of how passive and active strategies can be applied to the selection of plans and products, there are some unique features of New York State's market that warrant examination.

In terms of the competiveness of its markets, over 30 different commercial health insurance licensees—Article 44 HMOs, Article 43 nonprofit insurers, and Article 42 life, accident, and health insurers—participated in New York's commercial insurance market in 2009 (Newell and Baumgarten 2011). New York typically ranks above average among states in terms of the competitiveness of its insurance markets.[24] Arguably, New York lacks a single statewide insurer.[25] One of the reasons for this is that New York is one of only two states with three or more BCBS plans; 45 states (including the territory of Puerto Rico and the District of Columbia) have a single plan.[26]

Normally, less concentrated markets lend themselves to more active exchange functions. But many of the individual licensees operating in New York are part of affiliated organizations or large holding company structures, and, first and foremost, New York State is a combination of regional markets with varying degrees of concentration. Excellus BlueCross BlueShield, for example, enjoys significant market share in both the Rochester and Syracuse regions.[27] Large, multistate commercial health plans, such as United HealthCare and Aetna, have had limited success penetrating upstate markets. Nonprofit plans, except for EmblemHealth, have a limited presence in New York City and its suburban counties.

Upstate, many regions feature a smaller but desirable mix of plans, including at least one incumbent BCBS plan and one or more of New York's pioneering, physician-based regional HMOs: Independent Health Association, headquartered in Buffalo, Schenectady-based MVP Healthcare, and Albany's Capital District Physicians Health Plan. The Hudson Valley is something of a tidewater region, in which for-profit

[23] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Proposed Rule. July 11, 2011. U.S. Department of Health and Human Services. 45 CFR Parts 155 and 156. Preamble available at http://federalregister.gov/a/2011-17610 (accessed December 14, 2011).

[24] According to a Kaiser Family Foundation study (2011b), New York was one of only five states in which the largest insurer for individual coverage had a market share of less than 35 percent. Similar results were found for the small group market. New York ranked above the median for the number of health plans with more than a 5 percent small group market share, below the median for states based on the health plans with the largest small group market share, and also below the median in terms of its score on the Herfindahl-Hirschman Index, a formula used to measure market concentration for antitrust purposes.

[25] Most health plans no longer aggressively market indemnity coverage, which can be issued statewide under an Article 43 or Article 42 license, although BCBS plans in New York must operate within designated service areas. EmblemHealth administers New York's Pre-existing Condition Insurance Program (the NY Bridge Plan) statewide, but it contracted with a vendor to fill gaps in its provider network. United Healthcare operates a statewide outpatient network for the Empire Plan component of the New York State Health Insurance Program, but Empire BCBS administers the hospital benefit, in cooperation with other BCBS plans in New York and in other states. Although BCBS plans commonly enroll multistate employers or employers with workers who have multiple worksites in different regions, they rely on service agreements with other BCBS plans for care delivered outside of their operational territories.

[26] BlueCross BlueShield Association. About the BlueCross and BlueShield Companies. Available at http://www.bcbs.com/about-the-companies/ (accessed November 22, 2011).

[27] In 2009, Excellus BCBS had a 53 percent market share of comprehensive group coverage in the Syracuse region, and a 67 percent market share in the Rochester region (Table 12 in Newell and Baumgarten 2011).

plans operating in the tristate area compete with these regional HMOs gradually reaching south. In the New York City area, three national for-profit insurers (United/Oxford, Empire BCBS, and Aetna) compete with the lone nonprofit remaining in the metropolitan area (EmblemHealth, the HIP/GHI plan) and a small HMO (Atlantis). United's Oxford subsidiary, however, has significant market share in the small group market in the downstate area (Figure 7 in Newell and Baumgarten 2011).

New York's Prepaid Health Services Plans (PHSPs), a fourth category of licensing in New York, are another factor to be considered. Serving only the public insurance market, this vibrant group includes national for-profit companies, local nonprofits, and hospital-sponsored plans that compete alongside HMOs and Article 43 nonprofit insurers active in both public and private markets. FidelisCare has become one of the largest insurers in the state, and it is active in nearly all markets (Table 13 in Newell and Baumgarten 2011). New York City's public program market is without question the most competitive market in the state (Table 13 in Newell and Baumgarten 2011). Though PHSPs face some operational, regulatory, and practical challenges to enrolling both individual and small group commercial members through the Exchange, many of these plans are weighing this option.[28] Should a significant number of New York City PHSPs seek to participate in the Exchange, the metropolitan region would become the only one in the state where the Exchange faces a surfeit of willing health plans (Tables 12 and 13 in Newell and Baumgarten 2011).

[28] PHSPs have little experience with the small group market, or with agents and brokers, and may lack some of the information technology required in this market. Current New York statutory provisions and regulatory interpretations restrict the amount of commercial business they are allowed to write. Largely due to cost concerns, most PHSPs have not undertaken the accreditation procedures that are required of health plans that wish to participate in the exchange.

## New York's Regulatory Framework

There are also a number of elements to be considered in terms of New York's regulation of health plans and insurance markets. Since 1992, health plans have been prohibited from basing rates on health status, gender, occupation, or age of individuals and small group members in New York, a system similar to the reforms adopted in the ACA, which allows some rate differentials based on age and tobacco use. While the ACA authorizes a state to establish a single, statewide rating territory, current law in New York allows health plans to develop an overall community rate based on the claims experience and costs for enrollees in a type of product (e.g., HMO or PPO), with variations based on a county or group of counties, reflecting cost differences across counties. These rates in turn must be reviewed and approved by the State Department of Financial Services (DFS) under New York's Prior Approval law, one of the most robust statutes in the nation.[29] New York enacted a series of consumer protections beginning in 1996, many of which are incorporated in the ACA.

In terms of product offerings, the New York market features a considerable degree of standardization. Benefits and cost-sharing are set in statute for the standardized direct pay market for individual HMO products and the Healthy NY program,[30] for individuals and small groups. New York typically ranks high among states in terms of benefits that must be included in contracts for individuals and small groups, or at least made available to them for purchase. And finally, New York regulators at the DFS and Department of Health (DOH) enjoy fairly broad discretion in terms of product offerings.[31]

Two elements of New York HMO regulation in particular may come into play. State regulations discourage the use of deep cost-sharing in HMO products (Table 1 in Newell and Baumgarten 2009), which might make it difficult for health plans to field HMO products in the lower-tier actuarial value categories (e.g., catastrophic, bronze, and silver levels). At the same time, provisions from New York's original Community Rating law[32] require HMOs to enroll individuals and small employer group members. Since the ACA targets individuals and small groups—with and without subsidies or tax credits—this suggests that New York's Exchange will start with the participation of all the state's HMOs, although health plans could surrender their HMO licenses and operate through Article 42 or Article 43 licenses.

[29] New York Insurance Law, Section 3231, available at http://www.dfs.ny.gov/insurance/health/prior_app/3231_prior_app_laws.pdf (accessed December 1, 2011).

[30] New York Insurance Law, Sections 4321, 4322, 4321-a, 4322-a.

[31] For example, New York Public Health Law Section 4403(5) sets standards for the Health Commissioner's review of HMO networks; New York Insurance Law Section 3217 authorizes the superintendent to set minimum standards for health insurance.

[32] New York Public Health Law Section 4406 places HMO contracts under the supervision of the Superintendent of Insurance, and requires that the contracts be "issued to any individual and dependent of such individual and any group of fifty or fewer employees or members, exclusive of spouses and dependents or any employee or member of the group, including dependents, applying for such contract at any time throughout the year." Limited exceptions apply for HMOs serving only public program enrollees.

# Passive versus Active in New York

## Passive Market Organizer

Under a passive market organizer approach, New York's Exchange would simply evaluate health plans for compliance with minimum federal standards for issuers and the products they offer, rather than attempting to exert additional influence over the market. The Exchange could defer to, or contract with, state regulators to handle rate review and approval, marketing standards, network adequacy requirements, health insurer accreditation, and other regulatory responsibilities. All insurers wishing to participate on the Exchange would be required to offer QHPs that satisfy the minimum federally defined certification criteria.

Proponents of the passive marketplace model cite the system's lower level of administration costs, and praise the market-driven process as a way to determine the benefits and options that would be available for consumers (Howard 2011). With a more limited review process, and a reliance on existing state agencies, the passive marketplace model would lessen staffing and contracting demands on the new Exchange, and it would be the fastest model to set up—an important advantage, with the first open enrollment period less than two years away. Proponents also see this approach as avoiding the pitfalls in the perceived overregulation of health insurance markets in New York (Howard 2011), and they have a preference for harnessing free-market forces and competition to drive down prices for consumers. This more laissez-faire approach would certainly be warmly embraced by the state's insurers, whose participation is essential.

But it is important to realize that even a passive market organizer exchange model would involve certification requirements that go beyond making sure that health plans are compliant with all *current* regulatory standards for insurers, Article 43 corporations and HMOs; the ACA adds requirements that do not currently apply to New York insurers, or apply to only certain kinds of licensees. For example, as required by the ACA, the Exchange must ensure that health plans do not "employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."[33] To cite another example, currently only HMOs and PHSPs participating in the commercial and Medicaid Managed Care markets undergo network adequacy reviews; commercial participating provider and exclusive provider organization platforms (PPOs and EPOs, respectively) are not currently subject to such determinations, although they are ranked based on the quality of networks and performance by state regulators.[34] Yet the Exchange is charged with "ensuring a sufficient choice of providers" for individuals and small group members selecting products… and providing "information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers."[35] Finally, the Exchange must monitor health plans' implementation of "quality improvement strategy or strategies" that involve a "payment structure that provides increased reimbursement or other incentives" for a wide range of quality improvement efforts, including chronic disease management, care coordination, the prevention of hospital readmissions, improved patient safety and error reductions, wellness and health promotion activities, and the reduction of health care disparities through a variety of means. Federal guidelines are expected on these standards.[36]

[33] Affordable Care Act, Section 1311(c)(1)(A).

[34] New York State Department of Health QARR system. See, for example, http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/northeast/ppo/ (accessed December 14, 2011).

[35] Affordable Care Act, Section 1311(c)(1)(B).

[36] Affordable Care Act, Section 1311(g).

At its root, the passive market organizer model can involve two acts of delegation: the exchange delegates to state agencies its regulatory responsibilities, and delegates to health plans the determination of what products to offer in the marketplace. An information technology system programmed in passive market mode, however, might blow a fuse trying to ease comparisons among the myriad of products in the current individual and small group markets in New York.

Past research by the Fund has shown the complexity and variation in plan design and cost-sharing.[37] Research into current commercial product offerings indicates numerous and often minor variation among products. Excellus BCBS, for example, a health plan that has absorbed other BCBS plans over its many years of operation and that operates in a large service area, introduced a new rider in 2009 to accommodate an increase in COBRA benefits; the rider applied to over 200 products. Recent filings by Excellus due to policy changes required by the ACA applied to over 125 PPO product offerings and a handful of EPO products.[38]

While federal benefit standards and actuarial levels will bring a degree of standardization to the post-exchange market, there is a nearly limitless combination of co-payments, deductibles, and coinsurance features that health plans can use to "hit the numbers," depending on the product. Plans in the market today can include separate in-network and out-of-network deductibles; separate in-network and out-of-network coinsurance, with different limits; and multiple co-payment options for primary care visits, specialist visits, inpatient care, ambulatory surgery, emergency room visits, ambulance coverage, prescription drugs, dialysis, inpatient and outpatient substance abuse services and rehabilitation, and inpatient and outpatient mental health care. For products with out-of-network benefits, health plans use different schedules to calculate the reimbursement consumers will receive. While the uniform Summary of Coverage being developed by HHS to assist consumers in understanding different benefits is an important first step,[39] it is ill-equipped to translate all the variations in cost-sharing present in the market today. Health plans also use various means to calculate premiums on the most fundamental component—family size.[40]

It is a safe bet, however, that health plans will not likely make all the products they currently offer available on the Exchange. Empire BCBS made a significant course correction in its small group line recently, withdrawing a number of popular products, and state regulators noted in interviews that many other health plans were narrowing their product offerings. However, even within the narrower group of products offered through the Exchange, significant variation will exist.

While choice in markets has long been viewed as an ideal that promotes competition and empowers consumers, a growing body of literature over the last decade has introduced evidence of the deleterious effects of "choice overload." Research on a wide range of topics—the Swiss health insurance market (Frank and Lamiraud 2009), 401(k) offerings by employers (Rice et al. 2009; Abaluck and Gruber 2011), the Medicare Part D program (Iyengar et al. 2003), and the purchase of jams and chocolates (Iyengar and Lepper 2000)—has found that too much choice can be "demotivating." The study of the Swiss market—which, to be fair, featured in

[37] See page 51, "Selected Health Coverage Options for 'Jack Unlimited,'" in Newell and Baumgarten 2009. See also Newell and Gorman 2010.

[38] New York State Department of Financial Services response to United Hospital Fund FOIL request. November 2011. Rate Manual for Excellus Health Plans, Inc. Available at http://www.healthcare.gov/news/factsheets/2011/08/labels08172011b.pdf (accessed December 14, 2011).

[39] U.S. Department of Health and Human Services. 45 CFR Part 147. Summary of Benefits of Coverage and the Uniform Glossary.

[40] See, for example, DFS listing of premium rates for standard individual plans, November 2011, New York County, for different ways health plans set premium based on family size. Available at http://www.dfs.ny.gov/insurance/hmorates/pdf/New_York.pdf (accessed December 14, 2011).

some parts of the nation more than 30 insurers vying for business—found that "very large choice sets are likely to reduce the effectiveness of consumer decision-making. This weakens the relationship between enrollment and price and may result in larger markups by health insurers, who are less likely to offer price concessions when consumer decision is not price-driven. Our findings suggest that simplifying health plan decision-making by reducing the size of the choice set might result in more price competition among insurers, and benefit consumers."

On the fundamental matter of the choices individuals shopping in the Exchange will have—critical to a distribution channel that faces competition for customers—the passive approach might result in a skimpy menu reflecting a cautious approach to an uncertain market, or a bloated assortment of products with minor but confusing differences in cost-sharing components that are difficult to compare, or an ideal mix between these extremes. Some might question the faith in market forces that the passive marketplace model represents, given New York's reputation as a high-cost state, with only middling quality and value for purchasers (McCarthy et al. 2009), in a nation that lags behind most of the rest of the world (OECD 2011). The size of the ACA's investment in New York also raises the question of whether a business-as-usual approach is desirable, or a reasonable expectation.[41]

[41] According to Buettgens et al. 2011, if the provisions of the ACA are fully implemented in 2011, New York is estimated to receive a total of $1,771,056,00 in federal premium subsidies and $256,071,000 total in federal cost-sharing subsidies in the nonelderly, nongroup exchanges, totaling over $2 billion. These figures are based on state estimates of the number of nonelderly covered in the exchanges and estimates on the distribution of exchange coverage by income group. The majority of those below 400 percent of FPL will receive exchange subsidies. This share is the result of several factors, including the availability of employer-sponsored insurance coverage and the distribution of income in the state.

## Utah's Exchange as a Passive Market Organizer

The Utah Health Exchange, which was established in 2008 and is currently not compliant with the exchange requirements of the ACA, is often cited as a passive market organizer model. Over 120 different products are offered by three insurers,[a] and employees of small employers that utilize the Utah Exchange can select from among a wide range of health plans. Choices include HMO and PPO plans, HSA-qualified plans, and health plans with modest cost-sharing and low annual deductibles (e.g., $250 for individuals and $500 for families); as well as health plans with the maximum deductible allowed under current IRS rules for HSA-qualified plans ($5,950 for individuals and $11,900 for families). Insurers participating in the Utah Exchange also offer health plans with select provider networks and broad provider networks, allowing employees to choose from an assortment of health plans.

In contrast to the exchange requirements under the ACA, the Utah Health Exchange does not group health plans based on their actuarial value, individuals are not eligible to purchase coverage, and premium subsidies are not available. Utah's Exchange was originally intended to fill a niche in the group market by allowing small employers to provide their employees with a defined contribution option. Employers provide their employees with a fixed contribution and employees enroll in a health plan that best meets their needs. It "is designed to connect consumers to the information they need to make informed health care choices, and in the case of health insurance, to execute that choice electronically."[b]

Through August 2011, Utah reported that 165 groups and approximately 4,200 members (i.e., employees, spouses, and dependents) were insured through the Exchange. These 4,200 members were spread across 95 different health plans.[c] The wide dispersion of employees across a broad range of health plans offered by these three carriers suggests that consumers will take advantage of the employee choice model when offered the opportunity.

[a] Regence Blue Cross Blue Shield of Utah, Select Health, and United Healthcare currently participate on Utah's Health Exchange. Humana had also participated but withdrew in October 2011.

[b] Information accessed on September 6, 2011, from Utah Health Exchange website, (www.exchange.utah.gov).

[c] Author's interview of Utah Exchange officials.

## Active Purchaser

Under the active purchaser model, New York's Exchange could pursue a wide range of strategies it perceives as in the interest of its customers. These could range from an aggressive procurement that awards a contract to the bidder with the lowest price, to more modest strategies that set standards for participating health plans beyond the federal minimums in a number of areas. Following is a discussion of some options that could be pursued.

**Price Leader.** The option that first comes to mind for an active purchaser is a "price leader" model (California HealthCare Foundation 2011b), and it has undeniable appeal to individuals, workers, and small employer groups who have struggled to absorb premium increases that have far outstripped wages and general inflation (Schoen et al. 2011; Exhibit 1 in Kaiser and HREF 2011a). This divergence has led to reduced coverage rates for individuals and small groups, and higher premium contributions and cost-sharing for workers (Exhibit A, Kaiser and HRET 2011b). While New York's commitment to public programs has offset declines in commercial coverage (United Hospital Fund and Urban Institute September 2011), it is straining the budgets of both state and local governments. In the vision of its proponents, an active purchaser Exchange could reverse this trend by using its market power to get the "little guys" (individuals and small businesses) the same deal as the "big guys" (large private employers, state Medicaid programs, and state and federal employee health benefit programs). But the possible gains of this approach—lower premiums and higher offer and take-up rates for small employers and their workers—must be viewed in light of the difference between an exchange and these other entities, New York's market and regulatory scheme, and the natural consequences for consumers and providers, as market leverage rolls downhill.

Unlike a large employer, the Exchange is not a purchaser of insurance, but instead a facilitator or distribution channel. The Exchange is neither a risk-bearing entity nor a separate risk pool, and neither its size nor its risk profile is known. Unlike Medicaid or a large employer, each health plan that participates in the Exchange must, to calculate individual rates, pool its Exchange and non-Exchange members; the same requirement is in place for small group rates. It must also be taken into account that the small group market typically generates higher claims experience (Gorman et al. 2006) than large groups, as well as higher administrative expenses (it is less costly to administer one group of 500 employees than 100 groups of five employees).

The ACA preamble cites Medicaid procurements as example of active purchaser models for states to pursue. Massachusetts's CommCare program is perhaps the best example of an active purchaser procurement (see sidebar). New York's Medicaid Managed Care program, except for select populations, however, has not engaged in a typical active purchaser procurement since 1995, and that process was not without some rough patches (Sparer et al. 1999). Enrollment in Medicaid is still voluntary in 11 predominantly rural counties with more limited managed care organization penetration. While New York has successfully implemented a regional, risk-adjusted rate-setting system for Medicaid Managed Care, that structure may not translate easily to a commercial procurement by the Exchange.

A price leader active purchaser model for New York's Exchange would involve some practical and logistical considerations that, though not insurmountable, are complex. Without statewide insurers, New York would have to undertake procurements in multiple regional markets, perhaps choosing from among the five different regional approaches state regulators use today for various purposes.[42] Even after regions are established,

[42] State regulators and commissions have relied on different regional alignments for different purposes. The New York State Department of Health divides New York into nine regions for Medicaid Managed Care rate setting, eight regions for Health Care Reform Act (HCRA) assessments, and six regions for the eQARR reports on Managed Care Plan performance. The Commission on Health Care Facilities in the 21st Century divided New York relied on six regions for their report, *A Plan to Stabilize and Strengthen New York's Health Care System* (2006). The state Department of Financial Services uses seven regions for the Regulation 146 risk-adjustment mechanism. The Proposed New York Exchange legislation includes regional advisory boards in five regions.

aggregating a reasonable number of bidders would not be simple, because many plans participate in some but not all counties in a region.

Due to ACA and New York requirements, a price leader approach would create a binary system of setting premiums based on a procurement, and regular, prior-approved community rates. Since health plans offering a product in and out of the Exchange must charge the same premium, a successful bidder would have to either accept a presumably lower premium than they would have received for their enrollees outside of the Exchange, or withdraw the product from the non-Exchange market.

The larger issue, however, concerns the expectation that a price leader approach would drive significant discounts for individuals and small groups beyond the rates established under New York's current rate-setting system. In an ongoing summary of decisions on rate applications,[43] the DFS reports significant reductions in the premiums sought by health plans for community-rated products. In November, the Cuomo Administration announced[44] that 11 health plans would refund over $114 million to a half million policyholders because of minimum loss ratio violations—the minimum amount of each premium dollar a plan must spend on medical claims—and DFS recently moved to make the details of health plans' rate increase applications public.[45]

A successful price leader procurement would

[43] New York State Department of Financial Services reports significant reductions in the premium increases sought by many health plans; report available at http://www.dfs.ny.gov/insurance/health/prior_app/prior_app.htm (accessed December 14, 2011).

[44] Press release. November 9, 2011. Governor Andrew M. Cuomo. Available at http://www.dfs.ny.gov/about/press/pr1111091.htm (accessed December 14, 2011).

[45] For health plan rate filing details, see New York Department of Financial Services website, available at http://www.dfs.ny.gov/insurance/health/prior_app/prior_app.htm (accessed December 14, 2011).

### Massachusetts's CommCare as an Active Purchaser

CommCare, the publicly subsidized health coverage program available to Massachusetts adults with income up to 300 percent of the federal poverty level (FPL), is perhaps the most relevant example of an exchange-like program that utilizes an active purchaser model. The Connector establishes the plan designs and cost-sharing requirements, and issues a solicitation for health plans that wish to participate in the CommCare program.

When CommCare was originally established in 2006, participation was limited to four Medicaid managed care organizations (MCOs) that were under contract with the state's Medicaid agency, MassHealth. This statutory restriction applied to the first three years of the program, after which the Connector was allowed to contract with other carriers. Since 2009, one additional insurer, Celticare, responded to the request for proposals and is now participating in CommCare.

Through the active purchaser model, the Connector has successfully controlled costs and limited premium increases. Initially, the Connector negotiated rates with the MCOs. However, since 2008, the Connector has established a target monthly premium each year, and the MCOs submit rates at or below this target premium. Setting premiums on an annual basis is a powerful way to control costs, but the Connector has other arrows in its quiver too: an auto-assignment policy and a member premium payment policy.

Under the Connector's auto-assignment policy, enrollees who are not charged a monthly premium (i.e., those with an income at or below 150 percent FPL, or "zero premium" enrollees) are automatically assigned to the MCO with the lowest premium if they have not selected a health plan during the 60-day enrollment period. This policy serves as a powerful incentive for carriers to submit aggressive premiums, in part because the risk profile of members who are auto-assigned is favorable compared to members who actively choose a health plan.

In late 2006 and 2007, when CommCare was first rolled out and tens of thousands of people were being enrolled in the program, over 50 percent of "zero premium" enrollees did not choose an MCO and were automatically assigned to the MCO with

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the lowest premium. By November 2007, roughly 30 percent of "zero premium" CommCare enrollees were being auto-assigned.[a] The auto assignment rate is now below 10 percent.

The premium payment policy requires members who wish to enroll in a health plan with higher premiums to pay the difference in cost between the lowest-cost premium and the premium of the health plan in which they wish to enroll. Members who are willing to pay more for the same level of benefits are more likely to have known health care needs and an established relationship with providers in the higher-cost health plans' network. As a result, there are likely to be risk selection issues associated with members who enroll in the higher-cost health plans.

These two policies have helped drive down the cost of coverage in the CommCare program. However, there are significant differences between Massachusetts's subsidized health coverage program and the subsidized health insurance that will be available through the Exchange.

First, premium subsidies through the CommCare program are significantly more generous than the subsidies that will be available through the Exchange (see table). Roughly half of all CommCare members do not pay any monthly premium,[b] and 35 percent pay as little as $39/month. The ability to offer free health insurance has helped the overall risk profile of the CommCare population by attracting healthier people who might be less likely to enroll if they were charged a monthly premium.

**Individual Enrollee's Share of Monthly Premiums, Massachusetts Connector's CommCare Program and the ACA Exchange**

| Percent of Federal Poverty Level | Monthly Income | Monthly CommCare Premium | Monthly Exchange Premium |
|---|---|---|---|
| 150% | $1,361.25 | $0.00 | $54.45 |
| 200% | $1,815.00 | $39.00 | $114.35 |
| 250% | $2,268.75 | $78.00 | $182.63 |
| 300% | $2,722.50 | $116.00 | $258.64 |

Source: Author's analysis of CommCare premium data provided by the Commonwealth Health Connector, and analysis of modified adjusted gross income guidance for federal premium subsidies provided under Section 1301 of the Affordable Care Act.

Second, CommCare members are part of a separate risk pool and are not included in the carriers' individual market risk pool. The two Medicaid MCOs with the largest CommCare membership—Boston Medical Center's Health Net Plan and Cambridge Health Alliance's Network Health Plan—do not currently sell commercial health insurance plans.[c] Under the ACA, a carrier's exchange members will be combined with their non-exchange members, and the risk pool will include members that purchase coverage inside and outside the exchange.

Third, the health plans that participate in the CommCare program are essentially Medicaid MCOs, and the provider reimbursements paid by the MCOs are more closely aligned with Medicaid payments than with a commercial insurer's payment schedule. These differences in provider payment rates are another reason why the CommCare program has been able to hold year-over-year rate increases to roughly 5 percent while the commercial market's premiums have grown twice as fast.

Finally, people who are not eligible for premium subsidies through the CommCare program (i.e., adults with income above 300 percent FPL) are not allowed to purchase a CommCare plan, either through the Connector or directly from the carrier. Pursuant to the ACA, carriers that participate in the Exchange may not restrict coverage to subsidy-eligible individuals.

[a] Office of the Inspector General, Commonwealth of Massachusetts, Gregory W. Sullivan, Inspector General. December 13, 2007. *State Report on Issues Related to Health Care Reform Implementation Raised by the Joint Committee on Health Care Financing.*

[b] CommCare enrollees with income up to 150 percent FPL are not charged a monthly premium, while enrollees with income between 150 percent - 200 percent FPL are charged $39 per person per month. Children up to 300 percent FPL are covered by the state's Medicaid program, MassHealth, and are not charged a monthly premium.

[c] Boston Medical Center's Health Net Plan will begin offering commercial insurance in the individual and small group markets in January 2012.

also need to be evaluated on the impact it might have on purchasers and their choices in the market. In the Buffalo area, for example, a competitive procurement might exclude Independent Health Association, HealthNow BCBS, Univera (the Excellus BCBS plan that operates in the market on a "non-branded" basis), or United Healthcare, a for-profit plan that has established a small beachhead in the region. Since three of the plans also offer public programs, a decision to deny participation in the Exchange would prevent a member from maintaining coverage with the same plan, in the event that Medicaid eligibility is lost but subsidized Exchange coverage is gained. Similar scenarios—picking a winner from a small group of health plans serving both public and commercial enrollees—would play out in all upstate markets.

A price leader approach could also affect consumers and providers in other ways. A health plan that agrees to a discounted rate but seeks to maintain a certain level of profitability can accept a reduced profit margin on a per-member, per-month (PMPM) basis, in the hope that the increased volume of business it gains offsets the lower price; or it can reduce administrative expenses through improved technology, workforce reductions, or commission expenses. Typically, though, health plans also reduce costs by negotiating the same volume-based discounts with their participating providers. For consumers, particularly given the nonexclusive nature of the Exchange, this could mean the loss of providers from whom they customarily receive care, or entirely new products with a narrower provider network. For providers, a price leader procurement could depress reimbursement as well.

Of course, a price-focused procurement need not be structured as a winner-take-all proposition in which the Exchange enters into an exclusive agreement with one regional provider. As HHS notes in its proposed rules, the Exchange could negotiate premium reductions with all participating plans. This approach could minimize some of the market disruption, but it would still involve some or all of the logistical and practical issues mentioned above, and it would raise the question of whether New York regulators already have the tools they need on rates—i.e., the state's recently enacted prior approval law and the new ACA requirements. In either case, the winning bidders would return to the bargaining table with the Exchange knowing that awarding the succeeding year's contract to a different plan would create significant market disruption.

**Choice.** In addition to a focus on price—or in place of it—the Exchange could take a more active role in ensuring that price-sensitive individuals and small businesses could choose from a wide range of different premium options and different kinds of products.

A choice-oriented active purchaser Exchange could require health plans to offer products in all five of the ACA tiers, rather than just the gold and silver products required under the ACA. Within these benefit tiers, by carefully evaluating the range of products that are currently available in the market—HMO products, HMO products with a Point of Service (POS) or out-of-network benefit, High Deductible Health Plans (HDHPs) coupled with an HSA, EPO and PPO offerings—the Exchange could ensure that the widest possible menu of product platforms was available to its potential customers.

This approach would be useful in addressing the differing market dynamics in play for individual and small group purchasers today. As noted earlier, New York law requires that HMOs, alone among licensees, offer both an in-network only HMO and an HMO/POS option to individual purchasers. An Exchange with authority to extend this requirement to the Exchange market, in which health plans might tread cautiously given adverse selection issues, would provide some continuity and ease transitions among many current individual market purchasers. Similarly, there are also dynamics in the group market that need attention. With hundreds of thousands of out-of-state residents securing coverage through their New York-based employers, the Exchange would likely need to offer PPOs, HMO/POS products, or HMOs with provider networks that include out-of-state physicians

and hospitals, if it wants to be a destination for employer groups. The narrower range of products available to small employers is generally recognized as one of the shortcomings of the Massachusetts Connector's administration of its CommChoice program for unsubsidized coverage.

Another important component of consumer choice is the network of providers who deliver benefits covered under a contract to consumers. An active purchaser, following the same principles discussed earlier, could work to ensure a range of network offerings, including less costly options built on a narrow choice of providers, as well as broader networks that include noted specialty practice groups and centers of excellence for the treatment of certain conditions.

### Massachusetts's CommChoice as a Selective Contractor

The Massachusetts Connector Authority is also often cited as a selective contractor with regard to its Commonwealth Choice program (CommChoice),[a] which offers unsubsidized health insurance in the individual and small group markets. Massachusetts's health care reform law[b] required health insurers that covered at least 5,000 lives in the individual or small group markets to "file a plan with the Connector, for its consideration, which could attain the Connector seal of approval."[c] While much of the Connector's process involved the structure of benefits to be offered by participating plans, the Connector developed a number of standards on which procurement for participating plans would be based.

In addition to structuring the marketplace—similar to the way the ACA's exchanges will structure the market into five actuarial value tiers: platinum (90 percent), gold (80 percent), silver (70 percent), bronze (60 percent), and catastrophic (HDHP)—the Connector's request for responses (RFR) promoted several plan design features, including, but not limited to:

- Select/high performance networks in lieu of a broad network;
- Centers of excellence for complex conditions and procedures;
- Innovative pharmacy management programs;
- Enhanced consumer engagement; and
- High deductible health plans linked to a health savings account.

Although the Connector prescribed the benefits and services that needed to be covered, and established actuarial value standards in its initial RFR, carriers were provided significant latitude with regard to plan types and benefits structure (i.e., member cost-sharing). The RFR included the following clarification: "While the Connector, through this RFR, provides guidance and limitations with regard to the plan designs requested, our intent is to encourage health insurance carriers to develop and offer innovative plan designs that more effectively and efficiently deliver care to the residents of the Commonwealth."[d]

Ten carriers that met the 5,000-life membership threshold submitted responses to the RFR. The Connector's RFR included a broad range of criteria it used to evaluate each carrier's product offerings, including member cost-sharing, breadth of geographic coverage, provider network, and the commitment of the carrier to market the Connector, among others.

While all these criteria were used in the evaluation process, the cost of the policy (i.e., monthly premiums) was the most important factor used by the Connector staff in recommending which carriers and which health plans would receive the Connector's "seal of approval."

Seven carriers were selected by the Connector – Blue Cross Blue Shield of Massachusetts, ConnectiCare, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan. At the time, these seven carriers insured over 95 percent of the individual and small group markets. The three carriers that were not selected—MEGA Life and Health Insurance Company, MidWest National Life Insurance Company, and United Healthcare—had limited market share in Massachusetts's individual and small group markets.[e]

The Connector eventually contracted with six carriers,[f] with ConnectiCare opting not to participate due in part to its relatively limited market share in Massachusetts and the perceived administrative and operational requirements of the Connector. These six carriers were allowed to offer one plan at the Premier level—based on the Connector's plan design included in the RFR—

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**Benefit Standardization.** To guard against "choice overload" and ease comparisons for consumers, an active purchaser could seek to standardize benefits offered by plans through the Exchange. A major standardization effort of New York's commercial market took place in the early 1970s, ushering in the "major medical, basic hospital, basic medical" organization of product offerings that stood for decades.[46] There are many more recent roadmaps for standardization, most of which start by paying attention to the current market. In its administration of the Part C Medicare Advantage and Part D prescription drug programs, the Centers for Medicare & Medicaid Services (CMS) has worked to reduce the number of products from which consumers

[46] New York Insurance Law, Section 3217 and 11 NYCRR Part 52.

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two plans at the Value tier, one plan at the Minimum Creditable Coverage level (available with and without prescription drug coverage), and one Young Adults Plan, with an optional prescription drug benefit.

The Connector's rollout of CommChoice provided significant latitude to health insurers with regard to the structure of their product offerings within broad actuarial value ranges. Since then, however, the Connector has chosen to standardize the plan designs and product offerings. The Connector's shift to greater benefits standardization is discussed further below.

Initially, the Connector sought to use CommChoice as a vehicle for change in the commercial market by pushing carriers to innovate and offer new plan designs that engaged consumers in their health care choices. In some respects the Connector was successful in spurring new plan design features, including health plans that utilized a select, high-performance network and health plans that offered more innovative prescription drug benefits.[g]

However, while the Connector helped promote change and innovation in the commercial insurance market, its share of the market has been quite modest. As of July 2011, approximately 38,200 residents purchased insurance through the Connector. The majority of these members were individual purchasers (i.e., non-group), with only 1,608 employers purchasing group insurance through the Connector. Furthermore, these employers are very small, with an average employer group size of less than two employees.

With approximately 800,000 people enrolled in Massachusetts's merged market,[h] roughly five percent of the market currently purchases insurance through the Connector. In pursuing a selective contractor approach with fewer plan choices, the Connector was reportedly responding to the preferences of the market (Corlette et al. 2011), as well as responding to the Connector board's desire to limit the number of health plan options available to enrollees. However, in doing so, the Connector may have adversely affected its ability to meet the diverse needs of individual consumers and small employers, who are voting with their feet in opting for the wider range of coverage options available outside of the CommChoice portfolio of products. This dynamic can be expected to change somewhat, with the introduction of subsidies and tax credits for eligible purchasers in the Connector.

[a] As noted earlier, under the CommCare program the Connector acts more like an active purchaser.

[b] Massachusetts Revised Statutes, Chapter 58 of the Acts of 2006.

[c] Massachusetts Revised Statutes, Chapter 58 of the Acts of 2006, Section 82.

[d] Connector's health plan RFR, December 2006.

[e] MEGA and MidWest have effectively pulled out of the Massachusetts market, and United stopped writing new policies in the Massachusetts individual and small group markets in 2011.

[f] In 2009, Celticare became the seventh carrier to participate in the CommChoice program. Celticare, a wholly owned subsidiary of Centene Corporation, also participates in the Connector's CommCare program.

[g] Prior to July 2007, only one health carrier in Massachusetts, Fallon Community Health Plan, offered a plan that utilized a select provider network. Currently, all of the major insurers in the state offer health plans that utilize a select network. Prior to the Exchange offering health plans that included an upfront prescription drug deductible that applied only to brand name drugs, this type of benefit design was not offered in the Commonwealth.

[h] Massachusetts combined the individual and small group markets effective July 1, 2007.

must choose by applying "low-enrollment" and "meaningful difference" tests.[47] In the first instance, plans are asked to "retire" products without significant enrollment. In the second instance, health plans are encouraged to withdraw products that are very similar to other products offered by the carrier.

Most New York health plans market a range of products, but enrollment is typically clustered in just a few offerings. Enrollment in Oxford Health Insurance Company, the Article 42 licensee, exceeded 270,000 in the first quarter of 2011, but three "policy forms," or products, accounted for over 196,000 in enrollment.[48] EmblemHealth's GHI licensee reported over 173,575 in small group enrollment for the same period, but three products accounted for over 133,000 of that enrollment. Most health plans show similar patterns. Within these high-enrollment products, there is significant variation in cost-sharing, but there are clusters of enrollment as well. Past research by the Fund, for example, based on a survey conducted by the state Insurance Department to determine products with significant small group enrollment, identified typical small group HMO/POS and PPO coverage, in terms of cost-sharing and benefits (Tables 2 and 3 in Gorman 2008). As noted above, the Massachusetts Connector engaged in an exercise to standardize products based on those types with significant enrollment and by soliciting consumers' views on desirable choices. The Cuomo Administration recently undertook a study to identify products with significant small group enrollment as well.

Two other advantages might accrue to the market as the results of a standardization effort. First, a reasonable but narrower range of products would increase efficiency for both the health plans that market them and the regulators who review them, which could free up resources for other purposes. Second, standardization could be a useful tool to combat adverse selection. In some ways, market reforms and underwriting restrictions have created greater incentives for health plans to market benefits designs that are sensitive to the risk profile of potential enrollees. Given the choice of a range of benefit options, consumers will "self-select" (Stone 1993). Standardization coupled with broad choice may help the Exchange rein in some of the outliers, and spread risk among participating plans.

**Quality.** Quality improvement is a focal point of the ACA. The minimum standards that the Exchange will monitor and enforce, as noted earlier, include new quality rankings that HHS will develop, based on the star rating system for health plans offering Medicare Advantage products, and strategies for market-based quality improvement incentives. There are a number of options for a quality-focused active purchaser Exchange to advance these goals further. Most apparent, the Exchange could set a minimum rating threshold for eligible health plans.[49] Short of a "you're in or you're out" approach based on an overall quality ranking, the Exchange could target specific areas of health plan performance for improvement. In addition, New York's Exchange could utilize a wealth of underutilized data on health plan quality and consumer responsiveness maintained by the State Departments of Financial Services and Health to set

[47] Centers for Medicare & 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. Letter to All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties. Available at https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf (accessed November 21, 2011).

[48] New York State Department of Financial Services response to United Hospital Fund FOIL request. September 2011. Health Insurance Data Exhibit, Small Group market, first quarter 2011.

[49] Affordable Care Act, Section 1311(c)(3).

goals for health plan improvement, or provide additional information to consumers.[50] A health plan with above-average scores on managing diabetes, for example, could be listed as a "preferred" plan for consumers who might be interested in that particular measure.[51]

**Alignment.** Even an exchange with limited market share could pursue related goals and amplify its volume by aligning with larger purchasers—the state Medicaid program or the New York State Employee Health Insurance Program, for example, or coalitions of large commercial group purchasers such as the LeapFrog Group or the Northeast Business Group on Health—to send a consistent signal on quality improvement goals, such as reducing hospital readmissions or avoiding "never events." With regard to the important role the Exchange plays in enrolling eligible applicants in public programs—and the reality that many individuals will transfer between public programs and subsidized coverage in the Exchange—the Exchange could align itself closely with Medicaid standards and practices, and incorporate provisions to ease transitions by establishing a preference for plans that incorporate important public program providers in their networks or serve both public and commercial markets (Holahan 2011; California HealthCare Foundation 2011c; Bachrach et al. 2011).

**System Change.** Along similar lines, and echoing the "change agent" approach evaluated for the California Health Benefit Exchange (California HealthCare Foundation 2011a), an active purchaser Exchange could bypass the immediate gains to be had from a price leader approach to premium growth, and instead focus on bringing about longer-term changes that experts agree are a necessary component of genuine health care reform. Each of the major reforms emphasized in the ACA—Accountable Care Organizations, Patient-Centered Medical Homes (PCMHs), bundled payments, and other payment reforms—could be advanced in this manner (Commonwealth Fund 2011). For example, while New York is a national leader in the formation of PCMHs (Burke 2011), an Exchange that built the principles of the Patient-Centered Care Coalition into its minimum standards could help bring about a "critical mass" among payers, level the playing field among health plans, and drive the development of consistent standards.

While the ACA limits cost-sharing for primary care and preventive care, the Exchange could set standards to encourage value-based insurance designs that incentivize or reward policyholders who adhere to treatment plans by providing lower-cost-sharing for high-value medical services. In the same vein, a system change approach could prioritize broader delivery system reform by promoting value-based networks, in which lower cost-sharing is used to steer patients to high-quality, lower-cost providers, or by encouraging health plans and providers to experiment with innovative, vertical delivery systems, a key goal of the "change agent" approach discussed in California.

Like the passive market organizer approach, an active purchaser model must be measured on its potential consequences, given an environment of mostly voluntary health plan participation, and an uncertain market share for New York's Exchange. On its face, the end result of a price leader approach would be fewer participating health plans, and thus fewer choices for consumers. Similarly, setting standards for product choice, quality, alignment, and system change

[50] For example, the New York State Department of Health issues several reports that were developed to enable consumers to evaluate the quality of health care services provided by New York health plans. Reports include: an annual Report on Managed Care Performance; an annual Managed Care Utilization and Access Report; and the Consumer's Guide to Managed Care, all available at http://www.health.ny.gov/health_care/managed_care/reports/. The Department of Financial Services issues a Consumer Guide to Health Insurers, which evaluates the quality of plans, available at http://www.dfs.ny.gov/insurance/consumer/health/cg_health_2011.pdf.

[51] New York State Department of Health. eQUARR – 2011. An online report on managed care plan performance in New York state, available at http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/index.htm (accessed December 14, 2011).

might result in some health plans opting to stay on the sidelines. If the standards are set at a level that most health plans can reach, however, another possible result would be higher-quality, more accountable health care, and perhaps improvements in population health. This approach also could broaden investments in improved quality and innovation among all health plans, including the slower members of the convoy. In a sense, a decision to innovate can be anticompetitive for a health plan, since its investment might increase its cost compared to a more laggardly competitor.

Another concern commonly expressed by health plans is that a heavy-handed active purchaser Exchange will strangle innovation. This concern is certainly worthy of a broader discussion, which would involve health plans citing their innovative products, regulatory barriers they encounter under the current system, and why an annual certification process could not accommodate innovative product designs. The Exchange might even establish a streamlined process for consideration of innovative products, or establish a separate allowable category for products considered innovative. Above all, it is worth considering the possibility that an active purchaser might draw minimum standards from the bottom up, instead of dictating them from the top down.

Empire BlueCross BlueShield and NYU Langone Medical Center, for example, recently announced an agreement to link significant portions of payment to health outcomes, patient-safety measures, and patient satisfaction benchmarks.[52] In 2015, following on the heels of a promising study it supported this year (Choudhry et al. 2011), Aetna will launch a value-based program for its large group customers aimed at preventing recurring heart attacks by reducing cost barriers for targeted prescription drugs, and increasing patient support. In 2010, Excellus BCBS began making available a value-based insurance design which reduces cost-sharing for drugs and other services used to treat a range of chronic diseases.[53] Most health plans have programs designed to engage enrollees more actively in their health and promote the use of electronic medical records; many health plans were early and active participants in Patient-Centered Medical Home demonstration projects (Burke 2011). The main leverage an active purchaser might exercise for "the little guy" is to enhance the availability of value-based, innovative products, which are typically marketed to large group, fully insured, and self-funded contracts long before they turn up in the individual and small group markets.

Cost increases that might result from these active purchaser activities must also be evaluated carefully. For the Exchange, which must find a sustainable way to support its infrastructure and services and remain competitive with the non-Exchange market, increased costs might be incurred in developing, reviewing, and monitoring additional standards. And as a national trade group pointed out recently, any added costs will come on top of ACA assessments that health plans will pass on to their customers beginning in 2015 (Carlson 2011). Still, an active purchaser Exchange could piggyback on some of the activities regulatory agencies already undertake, the mechanisms they use to guide health plans on filings and facilitate electronic filings.[54]

In addition to the cost issues, decisions on

[52] Empire BlueCross BlueShield. Press release, October 21, 2011. "Empire BlueCross BlueShield Announces Ground-Breaking Contract Agreement with NYU Langone Medical Center Based on Payment for Value." Available at http://www.prnewswire.com/news-releases/empire-bluecross-blueshield-announces-ground-breaking-contract-agreement-with-nyu-langone-medical-center-based-on-payment-for-value-132683938.html (accessed December 8, 2011).

[53] Rate Manual for Excellus Health Plans, Inc. Accessed through a Freedom of Information Law request filed with the Department of Financial Services. October 2011.

[54] See, for example, DFS guidelines and templates for health plan filings, available at http://www.dfs.ny.gov/insurance/ihealth.htm#fileres, and DFS electronic filings, available at http://www.dfs.ny.gov/insurance/health/hsGenIns.pdf, through the System for Rate and Form Filings (SERFF), a national program for electronic filings administered by the National Association of Insurance Commissioners (both accessed December 8, 2011).

the role for New York's Exchange must also be viewed in the context of the broader commercial market. With one voice, health plans have warned of the risks of "two sets of rules" that health plans must follow in the Exchange and non-Exchange markets. For reasons of increased costs and intramarket adverse selection issues, this is a legitimate concern, particularly for those national health plans that operate in multiple states and will operate in multiple state exchanges. Health plans and regulators are already saddled with monitoring different blocks of "grandfathered" and "non-grandfathered" plans. The New York Exchange legislation calls for a study of this problem. It could potentially be addressed through voluntary actions by health plans, regulatory actions by existing agencies to close some of the gaps, or state legislation conforming market requirements in and out of the Exchange.

Another risk of an active purchaser approach is the range of offstage players that might participate in the Exchange, such as the Multi-State Plans[55] to be selected by the federal Office of Personnel Management, and the new Consumer-Operated and Oriented Plans (CO-OP) authorized and funded by the ACA.[56] In the case of the multistate plans, early guidance from HHS suggests that there may be limits to state exchanges' ability to set additional standards for them.[57] Similarly, new standards adopted by an active purchaser Exchange would add to the competitive pressures fully funded plans face when competing against self-funded arrangements exempt from state Insurance Law provisions.

[55] Affordable Care Act, Section 1334.

[56] Affordable Care Act, Section 1332.

[57] Comments of the National Association of Insurance Commissioners in response to Request for Information from the U.S. Office of Personnel Management, Cheryl D. Allen. August 10, 2011. Available at http://www.naic.org/documents/committees_b_110810_naic_comments_msp_to_opm.pdf (accessed December 14, 2011).

## Conclusion

Creating a new Exchange market from scratch would be vastly simpler than superimposing a new structure on an insurance market that has grown and evolved since the first nonprofit health plans created a health insurance market in the late 1930s, and in which more than two million enrollees are covered in regional markets with different characteristics and histories. The passive market organizer versus active purchaser framework is a useful tool, but has its limitations. We have tried to raise the level of the discussion by illustrating how these models have played out in practice, focusing on different options within these models, and describing unique features of New York's market and regulatory scheme that color the choices policymakers face.

Given New York's long history of regulatory intervention in health insurance markets, the public investment provided through the ACA, and the well-documented shortcomings of New York's health system overall, a purely passive market organizer approach does not seem a likely direction for New York's Exchange. At the same time, while an Exchange with broad discretion to undertake active purchaser activities is attractive from an operational perspective, it requires politically difficult accommodations involving the respective roles of the executive and legislative branches of government, and regulated entities' natural wariness of regulator discretion, even if exercised by existing state agencies.

The challenge for New York policymakers, then, may be to chart a course somewhere in between the passive market organizer and active purchaser approaches, using two polestars: the clear intent of the ACA to promote informed, value-driven, and easily comparable consumer choices that improve quality and reduce costs; and a realistic understanding of New York's market characteristics and regulatory scheme. In many ways, this framework resembles the option HHS suggests of "implementation of selection criteria beyond minimum certification standards."

Whether the operating sphere for this type of exchange is established in the corporate bylaws of an administratively established exchange, or in state legislation, its charter could rule out discretion in certain areas, establish parameters and goals for exchange decisions in others, delineate the role of existing state regulators, and explicitly map out the collaborative processes it will use in its determinations.

With the first open enrollment period less than two years away and federal preemption looming, launching an exchange with an urgent mandate and the tools needed to create a broad but coherent set of product choices for consumers with diverse needs—informed by a bottom-up review of current offerings—would put New York in a position to meet immediate deadlines, and would set the stage for the achievement of longer-term goals at the heart of the ACA.

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