Change Agent:

The California Health Benefit Exchange as a Catalyst of Finance and Delivery Reform

California HealthCare Foundation

ISSUE BRIEF

Overview

Of the many possible priorities that could be emphasized by the California Health Benefit Exchange (CHBE), perhaps the farthest-reaching is system-wide reform of the health care delivery and finance systems. An exchange structured to prioritize long-term reform—called a "change-agent Exchange" in this paper—would establish incentives to encourage improvement in costs, quality, and efficiency in the delivery of health care. It would aim to help transform health care financing and delivery in the long term by offering health plans with a high degree of consumer choice among non-overlapping care delivery systems, and by promoting better-organized, more competitive, and more accountable providers. For consumers who are priced out of the market for conventional insurance products, a change-agent Exchange would be open to experimentation with dramatically lower-priced alternatives.

Compared to the models described in the companion papers (a price-leader Exchange and a service-center Exchange), a change-agent Exchange would have a longer planning horizon and would involve more collaboration with other purchasers. It would focus less on this year's premiums and more on system-wide performance of the health care industry years into the future.

Values and Benefits

In California and elsewhere, today's fragmented fee-for-service health care system increases costs by encouraging unnecessary services. Necessary services are often performed in needlessly expensive settings. Unlike other sectors of our economy, the demand for and development of new health-related technologies largely seeks to increase volume and revenues rather than to improve productivity and reduce costs.[1] When providers have joined together to develop larger systems, it has often been to gain a larger market share and command higher payment rates rather than to achieve efficiencies and reduce costs.[2] To date, employer and health plan efforts to manage costs have largely failed. Health care costs continue to escalate system-wide.

This inflationary environment drives prices throughout the health care market, resulting in unsustainable cost trends for employers, workers, individuals, and government. With a realignment of incentives, consumers could choose among provider organizations that do well financially by providing effective services that maintain or restore health in the most efficient way possible rather than by providing more services, regardless of their efficacy. A change-agent Exchange could serve as a catalyst for achieving this realignment of incentives.

Federal tax credits available under the Affordable Care Act (ACA) will partially offset premium costs and make health plans more affordable for modest-income individuals in the early years of reform. However, these credits will not extend to over half of the individuals and small-employer groups eligible for the Exchange. Even for tax credit recipients, the share of income spent on health insurance will grow over time—similar to the way in which employer-sponsored coverage has consumed a greater share of workers' total

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compensation over time — unless health care cost growth is brought into line with income trends.[3]

To make coverage affordable and sustainable over the long term will require fundamental changes in the way that care is delivered and financed. A change-agent Exchange would aim to transform California's health insurance market and its health care delivery system into a model characterized predominantly by individual choice among more affordable, accountable, and coordinated systems of care.

Key Features and Operational Considerations

A change-agent Exchange would feature incentives aimed at achieving long-term improvements in health care quality, costs, and efficiency, with lower-cost, higher-quality outcomes. It would use a variety of approaches and mechanisms to pursue its goals, including:

- Offering health plans with a high degree of consumer choice among non-overlapping care delivery systems.
- Promoting better-organized, more competitive, and more accountable providers.
- Promoting the development of financing and care systems that have aligned incentives to meet cost and quality criteria in the near term, and that can manage the utilization of care and be accountable for outcomes in the future.
- Collaborating with like-minded purchasers also committed to developing coordinated care systems and expanding enrollment in those systems.

On a pilot basis, the Exchange would also solicit development of significantly lower-cost alternative care modalities to serve target populations who otherwise would not have affordable access to care.

Even though CHBE will potentially be the largest single commercial plan purchaser in California, the goals described above are ambitious for an entity whose reliable core enrollment (i.e., tax credit recipients) is estimated to constitute about one-ninth of all private coverage in California.[4] But beyond its own purchasing role, CHBE could harness powerful forces at play in the current environment. It would solicit and reward substantially stronger alignments and stronger incentives for efficiency among providers already interested in becoming accountable care organizations (ACOs), so that they have both the ability and the incentive to manage costs. By pursuing more efficient and appropriate use of medical care, the Exchange would also help meet the widely understood need to stretch existing physician and hospital capacity to serve the large influx of newly insured Californians expected in 2014.

Aligned Incentives for Cost-Effective Care

Using its authority to establish criteria for selecting qualified health plans (QHPs) to be offered through the Exchange, a change-agent Exchange would strongly encourage the development and use of health care delivery and payment structures that have substantial promise to reduce costs and improve outcomes.[5] The characteristics of these structures include:

- Provider incentives linked to lower total health care costs and improved health outcomes, aligned across the continuum of care.
- Consumer incentives that encourage appropriate use of services and self-care.
- Clear assignment of accountability with respect to cost and quality outcomes.

In practice, such a realignment of incentives requires the flexibility to implement (and pay for) new care arrangements. In today's market environment, this flexibility is uniquely feasible in the context of vertically integrated care systems that are paid on a capitation or global fee basis, rather than on a piecework basis. Where such systems are not feasible, reform objectives could be met through primary care physician groups that monitor

data related to utilization, costs, and outcomes, accept global fees for the services they provide directly, and share in the costs or savings associated with the cost of services they order and with the referrals they make.[6] As discussed below, the Exchange, in order to catalyze system improvements, could also provide information to consumers regarding access to primary care physicians.

The alignment of incentives can be approached in a few different ways which are described below: (1) by vertically integrating care systems, (2) by promoting primary physician group-managed plans, and (3) by providing consumer incentives and engagement. While the change-agent Exchange's goal would be to encourage finance and delivery system changes that go beyond existing structures and efforts, a few current efforts presage the kind of arrangements and performance improvements this Exchange would seek to achieve. Such efforts are described in the subsections below.

Vertically Integrated Care Systems

The Shared Savings Pilot in Sacramento is a recent effort to align incentives among a health plan, a medical group, and a hospital system to achieve improved care coordination and lower costs. The partnership between CalPERS, Blue Shield of California, Hill Physicians Medical Group, and Catholic Healthcare West serves 42,000 CalPERS Blue Shield members who use Hill Physicians. To achieve the goal of holding 2010 health care costs to 2009 levels, the parties are financially accountable to a global cap with each partner potentially realizing a share of cost savings, but also at financial risk for any variance from the targeted goal.

Initial results are promising: Through October 2010, hospital readmissions have been reduced by 17%, the average length of stay by a half-day, and total inpatient days by nearly 14%. The estimated savings are $15.5 million.[7] (A more comprehensive CHCF-funded evaluation of this pilot is underway with preliminary results due in Summer 2012.) This partnership, and others like it, can be packaged into QHPs offered by the Exchange alongside Kaiser-Permanente-style plans.[8]

To achieve lower costs and improved outcomes, vertically integrated care systems will need to adopt a wide range of innovative care arrangements, care management, and information system improvements. Though it need not, and probably should not, devise the precise tools and approaches that plans and providers should undertake, a change-agent Exchange would have a keen interest in establishing appropriate metrics for progress and in developing a comprehensive measurement dashboard. (Metrics are discussed further later in this paper.)

A choice of vertically integrated care systems should be achievable in most heavily populated areas of California. In these areas, at least one is usually available in the form of long-established Kaiser Permanente. Another example is Sharp Health Plan, an integrated regional health care delivery system with a substantial presence in San Diego. The early success of the CalPERS Shared Savings Pilot suggests that new or expanded vertically integrated options could also realistically be available by 2014.

Primary Physician Group-Managed Plans

In areas where vertically integrated plans are neither currently available nor likely to emerge, a change-agent Exchange might look instead to primary care physician (PCP) arrangements to serve as linchpins in organizing and delivering high-quality, cost-effective care. Whether through existing or new health plan arrangements, the hallmark of these efforts would be that PCPs would have the authority and financial incentives to manage care and referrals across primary, specialty, and inpatient care settings. Even without such incentives fully realized, existing efforts focusing on PCP arrangements have yielded risk-adjusted savings of 15% or more.[9]

An example of primary physician group care management is New West Physicians (NWP), which has served patients in the western and southern parts of the Denver metro

area since 1994. NWP is a primary care medical group with 68 primary care providers, including ten mid-level professionals and eight hospitalists. Almost since its inception, NWP has worked with contracts assigning NWP responsibility for the care of defined populations and tying payment to performance. In particular, NWP has been successful in controlling utilization and in demonstrating high quality for Medicare Advantage plans for Rocky Mountain Health Plan and United Healthcare. Leveraging the use of physician extenders and carefully selecting and managing specialty care have been important to NWP's success.

California has many large physician group practices that currently participate in the "delegated model" whereby they are financially accountable for the delivery of outpatient services for HMO enrollees. Monarch HealthCare in Irvine, California, worked to improve continuity of care and patient outcomes by reviewing client data, identifying frequent Emergency Department (ED) users, and identifying barriers to care. Through ongoing physician reporting, promoting urgent care centers, and reaching out to frequent ED users directly, Monarch was able to reduce inappropriate ED use by 12.9% in the commercial population and by 15.5% in Medicare Advantage. In Los Angeles and Northern Orange Counties, HealthCare Partners has developed programs to tailor resources to patient needs, such as case management by a multidisciplinary team for complex patients and post-discharge clinics for high-risk patients. In these ways, each organization contributed to reduced inpatient utilization, readmissions, and ED use.[10]

Organizations that have focused on PCP arrangements are well-positioned to advance cost-effective care and to be accountable for outcomes. Lessons from California's rapid transition to risk-bearing physician organizations in the 1990s will and should inform the evolution of these relationships.[11] While that experience was grounded in capitated HMO arrangements with robust internal physician pay-for-performance programs, there are emerging efforts to leverage such integrated services in PPO plans. Along with Monarch and HealthCare Partners, Sharp Rees Stealy and Sharp Community Medical Group in San Diego have contracted with Anthem Blue Cross to deliver coordinated care to 70,000 insured PPO members through a care management fee structure.

Furthermore, the extent to which California-based physician organizations have submitted letters of intent to the Center for Medicare and Medicaid Innovation for the Pioneer ACO program may also indicate new product opportunities. Where inpatient costs would be difficult for physician groups to control due to local hospital monopsonies, the Exchange could develop standards to help leverage savings. (This is discussed further under "Procurement Issues.")

One significant barrier to developing PCP-oriented solutions to cost and delivery challenges is California's relatively short supply of PCPs and over-supply of other physicians.[12,13] The Exchange could catalyze constructive change by providing more robust consumer information regarding the actual availability and performance of PCPs for enrollees of respective health plans, while also encouraging use of nurse practictioners and other qualified professionals. One carrier (Aetna through its Aexcel product) has had demonstrated success with its full PCP network and narrow specialty network, which is designed to channel members toward specialists who have demonstrated clinical performance and efficiency standards.[14]

California law gives CHBE authority to develop a consumer directory of health care providers including information about the health plans in which they participate and whether they are currently accepting new patients.[15] If kept current in an online format, such information could constitute a powerful tool for informed choice, especially among relatively healthy consumers whose principal access concern is for a valued

PCP.[16] Making this information readily available could result in plans putting a higher priority on primary care capacity and access, and lead them to improve the terms and payment rates for PCPs and their affiliated licensed professionals. Both short term and long term PCP supply might be improved if specialists with applicable expertise extend their services or convert to a primary care practice, and if family practice and internal medicine become more attractive residency choices for medical school graduates than they are now.[17]

Consumer Incentives and Engagement

A change-agent Exchange's effort to drive lower costs and produce better outcomes fundamentally involves provider incentives, but it would also focus on the role that consumers play in driving the use of services and cost of care. It would encourage health plan benefit packages to offer incentives for consumers to use appropriate care, choose cost-effective providers, and engage in managing their own health care needs. For example, it would seek health plan partners that encourage enrollees to participate in health assessments and cost-effective health promotion activities.[18] It would seek health plan benefit designs aligned toward achieving value-based outcomes.[19]

The Exchange would actively encourage primary physician group-managed plans and vertically integrated care systems to focus on patients with chronic conditions, where effective care management promises a large payoff in both lowered costs and improved outcomes. In some cases, primary care physician groups may choose to delegate management of such patients to appropriate selected specialists.

An example of a successful initiative focusing on chronic illness is a Boeing program that provides intensified primary care to employees and dependents predicted to be in the highest-cost quintile.[20] Based on this successful experience, the Pacific Business Group on Health (PBGH) is working to implement a similar model for CalPERS and Pacific Gas and Electric Company with

"New Paradigm" Plans

While the main thrust of a change-agent Exchange strategy would be to encourage more efficient use of existing care delivery systems by aligning provider and consumer incentives toward better outcomes and lower costs, this model could also catalyze innovative care arrangements with significantly lower costs for populations that would otherwise be unable to afford coverage. In 2014, individuals who are slightly above federal tax-credit eligibility thresholds and have no affordable coverage and care options would be eligible for Exchange-granted waivers to allow them to remain uninsured. Low-risk individuals are disproportionately likely to use these waivers, despite their eligibility for relatively lower-cost catastrophic coverage.

Rather than passively allowing such consumers to remain uninsured, a change-agent Exchange could encourage breakthrough care arrangements that dramatically reduce costs for this population. Such pilot arrangements, or "new paradigm plans," are discussed in greater detail elsewhere.[22] These plans might include, for example, substitution of telemedicine, phone consultations, self-service kiosks, or nurse visits for services typically provided face to face by doctors. The plans might also impose cost sharing, or limit coverage altogether, for treatments that have not been demonstrated to be cost-effective.

The support of new paradigm plans could enhance the change-agent Exchange's position as an agent of long term system change. Pilots accepted and appreciated by consumers have the potential to take root and offer a genuine, lower-cost alternative to the way that health care is currently delivered and financed. Because new paradigm plans would be targeted to persons who would otherwise be unlikely to participate in coverage and care, they are unlikely to be perceived as a threat to the interests of conventional providers.

Innovative, lower-cost care arrangements would benefit not only those individuals who would gain better access to care, but also all other individuals and small firms obtaining coverage by bringing a significant number of healthier persons into the risk pool. Because new paradigm plans would encourage market-wide risk pooling under reform, this approach should lower costs for all market participants.

the Humboldt Del Norte IPA, as well as with Boeing in Southern California. An earlier Boeing pilot in Seattle achieved a 20% savings in health care costs over two years.[21]

Consumer Choice

Providing individual choice among competing health plans helps create a conducive environment for vertically integrated care systems. When an employer offers only one or two plans to its employees (and the choice, if any, is often just between different benefit levels from the same carrier), there is strong pressure to select plans that offer a broad provider network so that all workers can access their own preferred providers. The systemwide effect is to encourage overlapping provider networks across health plans. In contrast, when individuals can choose among competing plans offering comparable benefits, non-overlapping competing provider systems become much more feasible.

In a change-agent Exchange, individuals (many of whom would be receiving a substantial subsidy toward their coverage for the first time) would all be able to choose among alternative provider group-based plans or a broad-network PPO. Furthermore, they would directly realize the full premium savings (or costs) associated with their choice. Under these circumstances, consumers would be much more likely to be satisfied than if a specified provider system were imposed on them with no affordable alternative choice.[23]

Consumer choice would need to be supported by a level of performance transparency that exceeds the information that is routinely available today. In addition to quality information about physicians and hospitals, price transparency would be a critical element of the consumer shopping experience — not only for the insurance plan option, but also for subsequent treatment choices and medical services.

Enrollment and Customer Service Issues

Because a change-agent Exchange would seek to offer non-overlapping care delivery systems wherever possible, it would need a particularly robust set of decision-support resources. Plan choice tools would be needed at the outset for a consumer to assess potential out-of-pocket costs and to identify features important to them, such as coverage for a specific service or access to a specific physician or hospital.

After enrollment, the focus in a change-agent Exchange on contracting with non-overlapping care delivery systems could lead to more patient complaints or inquiries to the Exchange about access to particular providers or services, and associated quality concerns, than under other Exchange strategies. To handle these anticipated customer issues, a change-agent Exchange could include additional post-enrollment service staff, whose primary role would be to help enrollees resolve complaints or concerns with their health plan, or to refer enrollees to their plan's internal appeal mechanism or to an external appeal mechanism, such as the appropriate regulatory agency. These important issues would need further investigation and refinement should the CHBE Board pursue the change-agent Exchange strategy.

The Exchange's "core enrollment," estimated to be approximately 2.5 million persons eligible for individual or small business tax credits, would constitute an attractive market opportunity for health plans and providers.

Carrier Procurement Issues

A change-agent Exchange would need to utilize its health plan procurement role creatively and aggressively in order to achieve its health care system reform objectives. It would develop standards and criteria for QHPs to be included in the Exchange that emphasize the reformed health care financing and delivery characteristics that it seeks. Specific performance standards and operational requirements would establish access and service

expectations, regardless of plan type, and should help to ensure quality and consistency of service across delivery system types without constraining innovation.

The Exchange's procurement criteria should reflect and encourage existing provider interest in reorganizations motivated by the trend toward ACOs. However, to achieve real change, the Exchange should establish even more specific and substantially more advanced criteria regarding responsibilities and incentives to manage total health care costs and outcomes for enrollees, as well as use of advanced payment models and performance-based incentives. The criteria could and should be framed so that a plan's provider arrangements would also qualify for participation as a Medicare ACO.

In order to drive a payment reform that addresses underlying cost drivers and misaligned incentives from fee-for-service payment structures, the procurement criteria could also set explicit requirements for a high level of payments to be linked to performance-based contracting or health outcomes, as well as use of shared savings models.

The Exchange would be more likely to achieve its system reform goals if it limits the number of issuers it offers in each service area. The number might vary somewhat with the population base in a given area. But, in general, plans and providers seem much less likely to make the considerable effort needed to achieve a change-agent Exchange's objectives if they do not have a strong prospect of being rewarded with enrollment. The Exchange could choose those integrated system and primary care group-driven applicants who best meet the criteria it establishes. Further, the Exchange could work with like-minded employers such as CalPERS or other large-employer members of PBGH toward getting these employers to offer one or more such plans selected by the Exchange.

Because the Exchange would be the only coverage option for modest-income individuals and families receiving tax credit assistance, and because some of those families may strongly prefer a broader network PPO plan (for example, because of a variety of conditions and physician allegiances within the same family), the Exchange would seek to offer at least one PPO in all areas. This need may be met by the national plans that are to be offered in all exchanges under federal law.[24] If however those plans do not offer good value, CHBE may need to solicit and select a better value PPO option. A PPO-type plan would also be an important option to maintain in geographic areas where there are no, or only one, integrated care systems or primary physician group-based plans.

In general, the Exchange's procurement strategies would seek to strengthen incentives and create a supportive environment for improved efficiency and care coordination, without micro-managing health plan or medical provider operations. However, creating a competitive marketplace alone might not suffice in geographic areas where hospitals wield a great deal of market power.[25] For such areas, the Exchange could pursue a fallback option to facilitate reductions in unnecessary costs.

For example, the Exchange might establish criteria requiring qualifying plans and health care systems to not include in their core network (i.e., the providers to whom the lowest consumer cost sharing applies) a hospital whose rates are above a given percentile of its peers statewide, or alternatively, whose costs exceed the mean by more than a specified percentage. Note that this concept could be selectively applied to categories of services so that, for example, a hospital could be contracted for tertiary or quaternary care in which it excelled, but might be excluded from the core network for more routine services for which its rates are excessive relative to other hospitals that yield excellent outcomes.

Role of the Board and Staffing Requirements

Using the Exchange to promote lower-cost, higher-quality health care system reform would require clear vision and significant perseverance on the part of CHBE Board and executive staff to overcome the inertia inherent in systems as complex as those in health care. As such, it would require leadership with long-term focus and vision. It would also require more resources and more sophisticated staff skill sets than it would if contracting with traditional established health plans offering a set of standardized benefit designs.

Because by itself the Exchange would probably not be large enough to effect the kinds of changes discussed in this report, the board and the staff would also have to work with other purchasers, including public programs and large employers, to develop and implement a common vision over an extended time frame. That requirement would also have implications for the kind of communication and consensus-building skills the Exchange's leadership would need to have.

Because the QHPs would have to be licensed in order to offer coverage through the Exchange, the CHBE Board and staff would also have to work with California's two regulators, the Department of Managed Health Care and the California Department of Insurance. While there are well-established performance measures already in use by these regulators, including medical loss ratio standards and risk-bearing guidelines for QHPs, those measures may need to be modified to encourage development of the new arrangements envisioned here.

Integration with Public Programs

State budget constraints make it unlikely that the Medi-Cal or Healthy Families programs could pay enough to cover the costs of the integrated care systems offered by a change-agent Exchange in the foreseeable future. Therefore, a change-agent Exchange could face additional challenges when attempting to integrate closely with public programs.

A change-agent Exchange could explore additional ways of assuring continuity of coverage and care for people who transition from Medi-Cal to Exchange coverage.[26] One approach would be to allow Medi-Cal plans to participate in the Exchange to serve only people who had been enrolled in that plan under Medi-Cal, but who lost eligibility for Medi-Cal due to increased income. In addition, the Exchange could offer one low-cost "essential community provider network plan" (presumably a Medi-Cal plan) to provide a lower cost option for all low-income Exchange participants. This limited-participation approach would address the continuity-of-provider-relationship issue for the directly affected population, without undercutting the Exchange's broader contracting strategy of relying on being able to deliver enrollment volume to new integrated care systems. (This approach is analyzed in greater detail, and compared to other approaches aimed at addressing continuity concerns, in an Institute for Health Policy Solutions report.[27])

Degree of Integration or Separation for Individual and SHOP Exchanges

Under the ACA, small businesses with 25 or fewer employees and average full-time-equivalent wages below $50,000 can qualify for federal tax credits if they purchase coverage through the Small Business Health Options Program (SHOP) of the Exchange. A change-agent Exchange would be more likely to achieve its objectives if it offered the same integrated delivery systems and primary care group-based plans to both individuals and small-firm workers. Offering the same QHPs in the individual Exchange to the SHOP Exchange would broaden the potential enrollees for the plans.

Simply put, the bigger the population the Exchange can bring to the participating health plans, the more likely it will be that providers and plans will make the substantial investments in time and resources needed to develop these new systems of care. Because the SHOP Exchange is to offer workers a choice of plans, both the SHOP

Exchange and the individual Exchange are ideally situated to nurture the development of a health care coverage and delivery system in which individuals choose from among non-overlapping provider systems that compete to best and most cost-effectively meet their needs.

Offering the same QHPs across the SHOP and individual Exchange programs would also ensure that workers and their dependents could keep the same plans and associated providers if they switched between individual and SHOP employer-based Exchange coverage.

The Exchange should realize substantial operational efficiencies if it does not need to duplicate professional staff functions dedicated to health plan and provider-system performance measurement and contracting activities, developing consumer information on plan attributes, and providing consumer assistance regarding health plan service and access issues. Nevertheless, the Exchange would still need to maintain separate systems for purposes of health insurance market functions that differ between group and individual coverage, such as marketing, enrollment, premium collection, and plan payment. These functions are discussed in detail in a separate report published by the Institute for Health Policy Solutions.[28]

Metrics for Success

In evaluating the success of a change-agent Exchange, it would be important to employ metrics to capture major drivers for health care value, distinguishing organizations on clinical outcomes and cost management. Besides the standard set of metrics that should be used to evaluate Exchange performance regardless of the model chosen, some metrics would be particularly important for a change-agent Exchange to track.[29] These would include:

- Appropriate utilization (e.g., less unnecessary care, more appropriate settings, fewer preventable hospitalizations).
- Premium growth measured on a multi-year horizon.
- System-wide health spending and spread of alternative methods of delivering and financing care.

Risks and Unintended Consequences

As with any ambitious and complex undertaking, a change-agent Exchange would face a number of risks and challenges.

An overarching challenge is that the long-term, system-wide focus of this approach may make it difficult to gain traction — particularly early in the Exchange's existence — toward lower-cost or better-value outcomes. Having an impact will require sustained focus and constancy of purpose, which may prove challenging in a turbulent policy and market environment. Additional challenges are discussed below.

Cultivating cost-sensitive, provider-based entities. Threshold operational requirements for provider-based entities may bias participation toward plans involving large, established medical groups or hospital-led vertically integrated systems. Some regions may have little potential for competing provider systems due to significant provider consolidation. In such cases, the Exchange could evaluate whether that consolidation is likely to constructively manage total health care costs and outcomes, or whether its purpose is to undermine efforts to promote price and quality accountability. Such strategic judgments would be a particular challenge for the Exchange.

In rural areas, the development of competing integrated systems would most likely neither be sensible nor feasible, so other approaches to improving quality and reducing costs should be explored. Seeking one alternative-to-PPO plan per area that incorporates vertically coordinated care arrangements with aligned incentives among participating local (primary, secondary) and regional (secondary, tertiary) providers may well be the most sensible way to achieve cost and outcome accountability. This approach may be feasible, given that the Exchange's individual and small-group clients will typically represent a larger share

of the private market in rural areas, and that Medicare also typically accounts for a higher share of the total market there.

In any case, making progress toward developing integrated approaches in rural areas would require a sustained effort and would have only modest potential impact. It may not warrant a great deal of Exchange Board attention in the first few years of operation.

Managing potential risk selection problems. It seems probable that individuals would be more likely to select from among the integrated delivery system-based plan choices (than from among broad network plans) based upon their particular health status and service needs. But any plan that specializes in managing complex chronic conditions would be at risk for adverse selection. Plans would therefore be particularly reliant on the risk adjustment instruments used in California after the initial years' reinsurance and risk corridors have expired. If risk adjustment efforts are inadequate, the financial viability of some health plans may be threatened. They may spend more energy trying to avoid people with expensive conditions than on providing cost-effective treatment and efforts to improve outcomes for those conditions.

Delivering quality and access as well as cost. Any initiative that holds providers financially accountable for medical costs runs the risk of creating incentives for underservice. For this reason it will be important for provider payment schemes to incorporate measures of quality and outcomes in addition to cost.

Flexibility and feasibility. The innovations favored by the change-agent Exchange model described here are not new to the industry. However, they are beginning to gain more of a foothold as the cost of health care continues to rise, technology facilitates more data collection, and the ACA encourages re-examination. Still, the technical and operational infrastructure required to implement these changes may not be commercially available. Further, these changes would require significant shifts in culture, processes, contracts, and relationships among providers who may already be short on resources, time, and capital.

Conclusion

The principal goal for CHBE is to provide a choice of affordable health plans to individuals and small firms and their workers. But this goal will be out of reach unless California's unaffordable health care and coverage cost trends are addressed.

A change-agent Exchange would serve as a catalyst for developing much more efficient, affordable, and high-quality health care delivery and financing systems that would address Californians' health care needs. The Exchange's core roles as established in the ACA are to provide consumers with informed choices on health plans, and to be the exclusive coverage source for millions of federal tax-credit recipients. These designated roles constitute a critical impetus for creating vertically integrated care systems and primary physician group-based plans that have the capacity for and properly aligned incentives to manage costs and improve care.

Importantly, if CHBE chooses to embrace this reform-oriented strategy and vision in a timely manner, it could leverage the current high level of provider interest in developing alternative models to care, and could work with other major purchasers to develop criteria for providing manageable and consistent incentives to providers and plans that reward quality and value, rather than unnecessary and over-priced care.

A change-agent Exchange could also reward the development of alternative care arrangements that substantially reduce costs for individuals who otherwise would be unlikely to participate in coverage—and do so without compromising affordable access for others. Such "new paradigm plans" could expand capacity and improve access that would otherwise be stretched very thin with 2014's major expansion of coverage. This should help

contain near-term costs for all Exchange participants through an improved risk pool, and pioneer cost-effective innovations that could be adopted more broadly in the longer term.

To achieve its potential, a change-agent Exchange would need to undertake a challenging range of critical administrative functions. It would have to sustain a focus on long-term impact rather than short-term solutions, and it would need to develop and maintain collaborative working relationships with other purchasers. These requirements would be highly demanding with uncertain short-term outcomes. Yet the long-term payoff, in terms of affordable health care coverage and plan choices, would be great.

Project Contributors

CHCF Project Lead

Marian Mulkey

Primary Contributors

Lori Chelius
Lesley Cummings
Rick Curtis
Patrick Holland
Emma Hoo
Ann Hwang, MD
Jon Kingsdale
Ed Neuschler
Chris Perrone
Sandra Shewry
Nancy Wise
Lucien Wulsin

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Endnotes

1. Ezekiel J. Emanuel and Victor R. Fuchs, "The Perfect Storm of Overutilization," *JAMA* 299(23) (June 18, 2008): 2789–91.

2. Paul Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," HSC Research Brief No. 16, November 2010, www.hschange.org.

3. Internal Revenue Code §36B(b)(3)(A)(ii), as added by PPACA §1401.

4. Total private coverage in California in 2016 is projected to be 22.9 million. Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs* 30(1) (2011): 63–70, www.healthaffairs.org. Of this number, about 500,000 will be workers and dependents in small-employer groups that are likely to qualify for a substantial small-business tax credit if they purchase through the small-employer ("SHOP") Exchange. (Authors' estimate.) And about 2.1 million (or about 9%) will be tax-credit recipients obtaining coverage through the individual Exchange. (Personal communication with Dr. Gruber's research assistant. The 4 million Exchange-enrollment figure cited in the *Health Affairs* paper includes non-subsidized people with individual coverage who could choose to purchase directly from carriers rather than through the Exchange.)

5. California law directs the CHBE Board to "[d]etermine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall … seek to contract with carriers so as to provide health care coverage choices that *offer the optimal combination of choice, value, quality, and service."* Government Code §100503(c), emphasis supplied.

6. Such systems could, but need not, be single organizations such as Kaiser Permanente. As illustrated by the Sacramento-area example that follows, they could also be negotiated arrangements among several provider organizations. The key element is the alignment of financial incentives to achieve responsibility and incentive for lower total patient care costs and improved outcomes.

7. "Integrated Health Care Pilot Exceeds Expectations," CalPERS Press Release, April 12, 2011, www.calpers.ca.gov.

8. An example is the ACO initiative being undertaken by Hoag Hospital and Greater Newport Physicians IPA in Orange County, www.ehcca.com.

9. Arnold Milstein and Elizabeth Gilbertson, "American Medical Home Runs," *Health Affairs* 28(5) (2009): 1317–26.

10. Ibid.

11. California HealthCare Foundation, "Accountable Care Organizations: Avoiding the Pitfalls of the Past," 2010.

12. California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009, www.chcf.org.

13. California HealthCare Foundation, "California Physician Facts and Figures," July 2010, 6, www.chcf.org.

14. Aexcel®: Specialist Designation in Aetna Performance Network Methodology Guide, 2010, www.aetna.com.

15. Government Code §100504(a)(9).

16. The Exchange has the authority to either require participating carriers to submit such information electronically, or to establish methods that would allow providers to transmit information directly to the Exchange. The former approach could mean considerably less work for the Exchange itself, and could provide more comprehensive information. But it could be more problematic for PCPs, who would have to update their status regarding new patients respectively to each plan in which they are a contracting physician. Such a directory seems much more likely to work if it is seen as a helpful service by PCPs as well as by consumers, so it would be sensible to make this decision based on consultation with PCPs — for example, based on a survey.

17. "California Physician Facts and Figures," 20.

18. Rachel M. Henke, Ron Z. Goetzel, Janice McHugh, and Fik Isaac, "Recent Experience in Health Promotion at Johnson & Johnson: Lower Health Spending, Strong Return on Investment," *Health Affairs* 30(3) (2011):490–499; J.F. Fries, C.E. Koop, J. Sokolov, C.E. Beadle, and D. Wright, "Beyond Health Promotion: Reducing Need and Demand for Medical Care," *Health Affairs* 17(2) (1998):70–84.

19. Examples include: Offering no or low copayments for maintenance medications that reduce the likelihood of hospitalization; having higher copayments for emergency room utilization to ensure that this channel is not used for routine care; ensuring that plans have arrangements for cost-effective ambulatory urgent care that is available 24/7.

20. Arnold Milstein, MD, and Pranav Kothari, "Are Higher-Value Care Models Replicable?" Health Affairs Blog, October 20, 2009, www.healthaffairs.org/blog.

21. Ibid.

22. See Rick Curtis and Ed Neuschler, "'New Paradigm' Plans for Exchange Eligibles without Affordable Options," July 14, 2011 [pre-publication draft], www.ihps.org.

23. Research in the mid-1990s found that people who had a choice between managed care (i.e., a network-based health plan) and a fee-for-service plan had similar overall levels of satisfaction, regardless of the option chosen. But people who had no choice and enrolled in a single managed care plan reported consistently lower satisfaction. See R. Ullman, et al., "Satisfaction and Choice: A View from the Plans," *Health Affairs* (May/June 1997): 209–217; K. Davis, et al., "Choice Matters: Enrollees' Views of Their Health Plans," *Health Affairs* (Summer 1995): 99–112; and M.A. Sachs and G.T. Pickens, "What Members Want," *HMO Magazine* (March/April 1995): 21–24.

24. PPACA §1334, which refers to these plans as "multi-State plans."

25. See, Paul B. Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Research Brief 16, Center for Studying Health System Change, November 2010, www.hschange.org.

26. California law authorizes the Exchange Board to collaborate with DHCS and MRMIB to address the continuity-of-care issue for people whose eligibility status changes.

27. Rick Curtis and Ed Neuschler, "Continuity for (Former) Medi-Cal Enrollees and Affordabilty for the Low-Income Exchange Population: Background and an Alternative Approach," Institute for Health Policy Solutions, with support from the California HealthCare Foundation, June 2011, www.ihps.org.

28. Rick Curtis and Ed Neuschler, "Small-Employer ("SHOP") Exchange Issues," Institute for Health Policy Solutions, with support from the California HealthCare Foundation, March 2011, www.ihps.org.

29. See companion paper on operations, "Competing Demands: Operational Imperatives for the California Health Benefit Exchange" for a description of the suggested standard set of metrics.