Service Center:

The California Health Benefit Exchange as a Consumer Destination

California HealthCare Foundation

ISSUE BRIEF

Overview

One of the goals of federal health reform legislation under the Affordable Care Act (ACA) is to organize the health insurance market so that health plans compete on delivering value to the consumer rather than on risk selection, and suppliers compete on factors such as meaningful customer service and effective health management. State-based health benefit exchanges are one of the primary mechanisms for implementing this alternative marketplace.

One approach to building a California Health Benefit Exchange (CHBE) that is likely to attract the broad-based public interest and involvement necessary to meet health reform goals is to focus on providing consumers robust options, clear and objective information, and a high level of customer support. A service-center Exchange focused on expanded options, information, and service for those seeking to purchase coverage would help build public support for reform and create the political leverage needed to transform the market. It would aim to become a major distribution channel for health insurance by emphasizing many plan options and appealing to a wide range of consumers.

For most California voters—including many who are skeptical about national reform—CHBE will be the "face" of reform: how well it serves them will strongly influence public judgment about the wisdom of a broader reform agenda. An Exchange built as a "consumer destination" would be well-positioned to earn broad-based public trust and a sufficient volume of customers, including difficult-to-reach, previously uninsured populations.

This paper describes the values and features of a service-center Exchange, and strategies such an Exchange should consider to maximize its chances of success.

Values and Benefits

A service-center Exchange would aim to become a trusted shopping destination for health care consumers by offering a wide range of products, as well as quality information and support. It would emphasize a robust and flexible array of health plan options, clear data, and transparency to help consumers compare plans and shop based on quality and price dimensions, as well as the use of sophisticated self-service tools for account management. A service-center CHBE would prioritize the importance of addressing the needs of diverse constituents in building a broad enrollee base. While many of the customer service features central to this model are required by either state or federal law regardless of the Exchange's strategy, a service-center Exchange would go beyond the legal requirements to execute its goal of premium customer experience.

Core to this model is the assumption that by focusing on consumer needs and experiences, the Exchange will attract a large and diverse pool of enrollees, which should both lower premiums and also allow for the cost of future enhancements to be spread across a larger population. Having a broad range of constituents served by CHBE would be a political "win" for health reform and

August 2011

state government, which would help build support for health reform efforts in general. The state would be providing a valuable service to its residents, and filling an important information gap that could help the market operate more efficiently.

In addition, attracting a broad customer base should help guard against adverse risk selection for the Exchange, compared to the outside market. Adverse selection is an important concern for exchanges, because exchanges could initially attract primarily those who would otherwise be in state high-risk pools or who are waiting for guaranteed coverage under community rating to make them insurable. By offering a range of service options and focusing on appealing to a broad range of consumers, CHBE is more likely to attract a larger portion of the non-subsidized population. Moreover, some carriers and brokers may decide that it is in their self-interest to work outside of an exchange while steering poorer health risks toward it. While both the ACA and California's legislation authorizing CHBE contain protections against adverse risk selection, having the broadest possible cross-section of enrollees serves as another form of protection.

Finally, delivering a positive customer experience would also position the Exchange to attract larger employer groups that may transition their employees to seek coverage through the Exchange as allowed by federal law in 2017.[1]

Key Features and Operational Considerations

A successful service-center CHBE would offer a broad array of choices to consumers, provide exceptional customer service, and respond to unmet needs in the current market for easy-to-use, easy-to-compare, objective information and advice about health plans. It would exceed the state and federal requirements for service by offering customers such features as additional points of customer support and more extensive customization options. By offering a convenient "insurance store" that provides culturally and linguistically appropriate services and outreach, beyond what is required by law, the Exchange would also expand coverage to hard-to-reach populations.

More specifically, a service-center Exchange would have at least three distinct features:

1. It would provide a broad choice of health plan designs, standardized across carriers so that shoppers could readily compare and select among them.
2. It would act and be perceived as a trusted information source for consumers, so that customers would feel secure in their selection of the right health plan.
3. It would be a convenient and appealing "place" for shopping that was easy to access, understand, and use, and that facilitated tasks such as choosing and enrolling in a plan, paying premiums, and learning about the health care system.

If successful in implementing these features, the Exchange could grow over time and reinforce its position as a service-center model. It could expand its products, for instance by adding related health services such as a personal health record, or it could add insurance lines such as dental, disability, and even life insurance. In developing and refining its features and offerings, CHBE should be carefully attuned to the needs of its customers, building in opportunities for customer input, market research, and continuous refinement of products and services based on understanding—even anticipating—customer preferences.

Consumer Choice

To become the preferred venue for buying health insurance, a service-center CHBE should offer consumers a broad selection of plan choices and benefit designs, and an easy way to compare options. While the core website features and selection choices may be common to all models of the Exchange, the service-center model would fulfill these features in the most robust way possible.

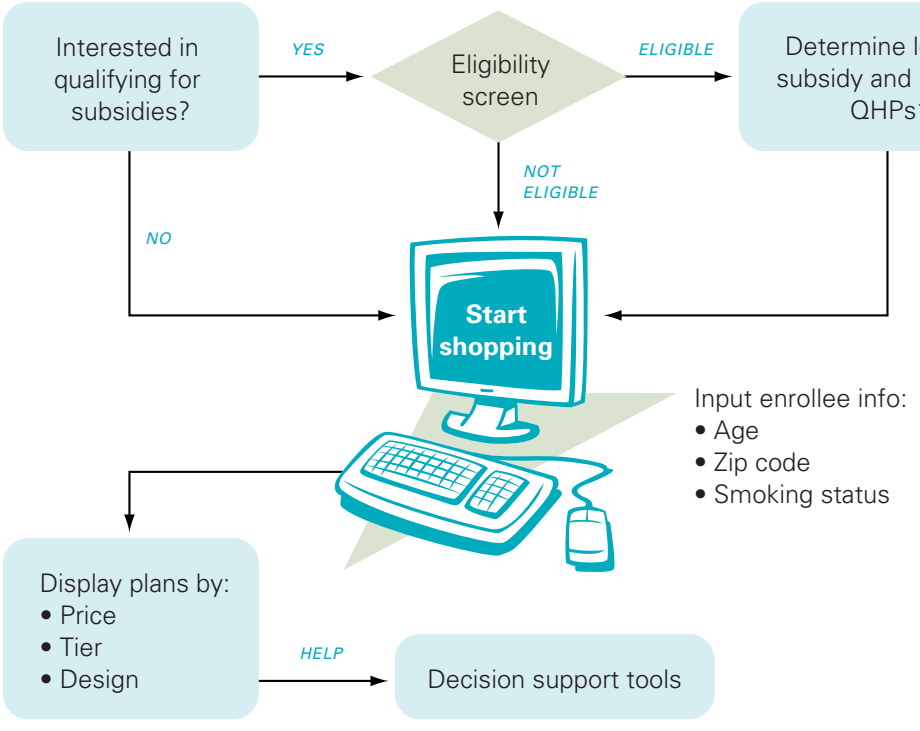
For example, to facilitate shopping, buyers should be able to start by self-selecting the non-subsidized shopping path, or opt for an easy-to-navigate, online eligibility assessment to help them determine whether or not they are likely to qualify for subsidies. (See Figure 1 for an illustration of the non-group shopping pathway.[2]) While many consumers may want to see what support they are eligible for, it is important for shoppers to have the option of bypassing an eligibility determination process before being "let into the shop."

Similarly, a service-center CHBE should accommodate other possible customer needs—for example, an exemption from the individual mandate, tax-credit information for filing purposes, or help with some other requirement of health reform—as efficiently as possible. The Exchange would need to have appropriate service and support options available for customers of all types, including those with a wide range of computer abilities, primary languages, understanding of health care issues, and complexity of individual circumstances.

A service-center Exchange should offer many different carriers, but should promote standardization of plan designs across carriers for each actuarial tier in order to simplify the shopping experience and reduce confusion for the consumer. In the experience of the Massachusetts Health Connector, Massachusetts' health reform program that was implemented in 2006, standardization across plan designs was essential for helping consumers make apples-to-apples comparisons and decisions based on value. Standardization around unpopular designs or offering too few choices will only drive consumers to other channels or directly to carriers.

Ideally, standardization should happen around the most popular plan designs, across most issuers on each tier—especially the silver, bronze, and catastrophic tiers,

Figure 1. Proposed Non-Group Shopping Pathway



*QHP stands for qualified health plan.

where different combinations of cost sharing can be used to achieve a target actuarial value.[3] Standardization should apply to features such as plan type (HMO, PPO, HSA), deductibles, copayments, and co-insurance. In competitive markets, such as California's major cities, this could result in as many as two to three popular benefit designs for each of the silver, bronze, and catastrophic tiers, multiplied by three different product types (pure HMO, pure PPO, and tiered-network HMO/PPO), multiplied by different cost sharing designs (high or low deductibles paired with low or high copayments and/or co-insurance), multiplied by about a dozen carriers. The total might exceed 100 options. While this may seem like a lot, the outside market will offer substantially more.

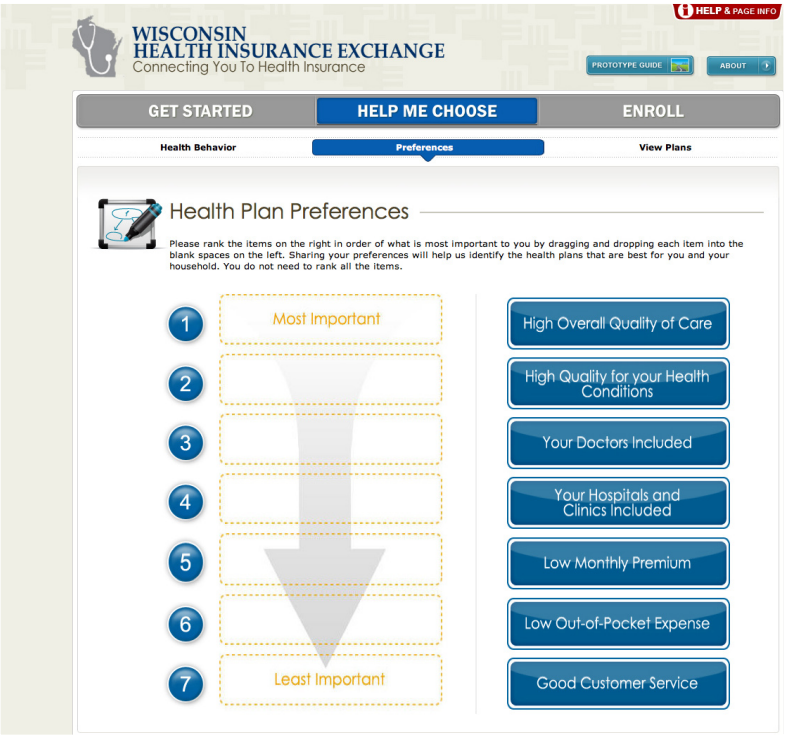
Standardization will require judgment in terms of which designs to select, and should be done on the basis of detailed consumer research, with caution and flexibility. On one hand, too much standardization and too few options stifle innovation; on the other hand, there is considerable research demonstrating that too many options confuse consumers which defeats meaningful choice.[4] Even with standardization, carriers can differentiate their products in the market on bases such as provider networks, customer service, care management programs, and other plan features. This differentiation will be important in driving innovation and pushing plans toward service excellence.

A service-center Exchange would need to exercise judgment and flexibility in its attempts to accommodate the full breadth of consumer preferences and to maintain or enhance important business relationships between CHBE (as a retailer of health plans) and health plans (CHBE's suppliers). For example, forcing a prepaid group practice that didn't offer a PPO or high-deductible plan to do so could actually confuse enrollees and undermine its particular value proposition, internal structure, operating systems, and other aspects of its business strategy. Conversely, forcing a broad-network PPO to offer platinum benefits could drive adverse selection for that plan. In the private sector, consultation between large, sophisticated manufacturers and retailers can be mutually beneficial. A similar consultative model between CHBE and supportive carriers is recommended here.

To simplify and facilitate consumer choice among hundreds of options, both web- and telephone-enabled assistance should make it easy for each consumer to find an individualized "express lane" to a limited set of products from which to choose. For example, if a consumer comes to the Exchange looking for a Kaiser plan, then a quick and easy way to present the Kaiser options should be available. This consumer may eventually decide to compare a particular Kaiser plan design to other issuers, and/or the Exchange may prompt the consumer to consider a lower-priced comparable design, or one that has more provider choices, but the consumer should be empowered by the Exchange to drive this process.

In addition to providing an "express lane" enabling shoppers to browse plans that meet their top priorities, a service-center Exchange should include sophisticated decision-support and data tools to accommodate more complex buying dynamics. It should also differentiate plans along an additional set of criteria, such as inclusion of primary care physician, specialists, hospitals, alternative medicine practitioners, disease management programs, and access to out-of-state centers of excellence. With these tools, consumers could prioritize the selection criteria most important to them and create customized rankings of health plans. Wisconsin's exchange prototype, for example, includes such a feature (Figure 2). The Exchange could also consider incorporating enrollee satisfaction measures, plan popularity, and consumer reviews into ranking algorithms, as other online shopping sites (such as Amazon.com or TripAdvisor.com) already do.

Figure 2: Wisconsin's Exchange Prototype Screenshot



Customer Service Issues

Besides offering robust consumer choice and selection, a service-center Exchange would need also to be convenient and trusted in order to fully develop its brand as a customer destination. Research by the Pacific Business Group on Health (PBGH) indicates that different types of consumers seek service through different channels.[5] As such, the Exchange would need to offer multiple points of contact, including a website and telephone line, and possibly walk-in locations throughout the state. To be truly consumer-friendly, these access points should provide extended service hours, including evenings and weekends.

To demonstrate its own trustworthiness and to reinforce its reputation as the destination site, the Exchange should also provide a list of carriers that are not offered through the Exchange, with contact information for and links to these carriers. (CHBE could offer non-Exchange carriers a direct link in return for a modest referral fee.) Telephone support should be staffed for service in the major languages spoken in California and be TDD-compatible. Similarly, the website should be accessible in multiple languages and compatible with screen-reader software. Beyond these venues required by law, the Exchange should work to make all of its communications and access points accessible by different languages and other special needs. The customer service line would need to maintain high service standards, such as short average response time, high first-call problem resolution rates, and low call abandonment rates.

Customer support does not stop with consumer selection of a plan. The Exchange should make enrollment and payment quick, easy, and secure. After a consumer selects a plan, the Exchange should confirm enrollment with the carrier, and provide rapid confirmation back to the enrollee, by e-mail, letter, telephone, or text. For consumers who would pay premiums through the Exchange, multiple forms of payment should be accepted, including auto-billing and payment.

After an enrollee selects a plan, the Exchange could act as a "customer advocate." For example, the Exchange might offer new enrollees three-way telephonic assistance with their health plan's customer service department, with a "navigator" and the client, or with a broker and their employer account.[6] The Exchange could offer a 30-day guarantee, allowing consumers to switch plans within 30 days if they experience one of a list of legitimate enrollment problems, such as unavailability of a primary care physician, unacceptable customer service wait times for the health plan, or delay in receiving a membership card.

A service-center Exchange should provide follow-up customer satisfaction surveys, allow customers to post reviews of health plans online and make this information available (with appropriate controls) to prospective shoppers. Monitoring and enforcing service guarantees in response to consumer complaints about health plans could generate a database of information that could

help to reduce future service issues and/or inform other shoppers. The annual re-enrollment period would provide another opportunity for the Exchange to advise and assist customers. The Exchange could profile options for enrollees and offer advice about new plans or cost-saving features. Again, a flexible, fair approach to working with health plans to resolve issues—and publicizing such cooperation—would be key to developing mutually advantageous relationships that would best serve Exchange customers in the long run.

Many such services could not and should not be initiated until the Exchange has built a substantial customer base and a track record for performing its own functions very well. As a distribution channel for participating health plans, the Exchange should develop any customer service guarantees in cooperation with its suppliers and should process consumer complaints in a fair and impartial manner. An adversarial relationship between the Exchange and its suppliers would undermine their joint business interests in serving consumers.

Another important feature of an easy-to-use "insurance store" is account self-service for enrollees. Enrollees who paid their premiums to the Exchange, whether with or without tax credits, should be able to look up a password-protected account profile and make changes to it. For example, enrollees should be able to change plan selections during the year as their circumstances change, add or delete dependents, establish and manage an HSA account through the Exchange, price different providers or procedures that they anticipate paying for out of pocket, and review quality data on providers.

The ACA sets up a complex set of payment options for individual exchanges, under which direct buyers may pay their premium contribution to either the carrier or the exchange. However, the U.S. Treasury will pay the premium subsidy directly to the carrier each month and the federal government will likely look to exchanges for authoritative information on enrollment, billing, tax credits, and enrollee payments.

To simplify this process, CHBE might require each participating issuer to designate CHBE as its billing and collection agency for all CHBE shoppers, as a condition for certification as a qualified health plan (QHP). Doing so would make it far easier for CHBE to serve customers and build loyalty—if the Exchange and its health plans work well together—than if the enrollee paid the health plan directly and the Exchange tried to track transactions between millions of enrollees, dozens of issuers, and the Treasury's trust fund without playing a clearinghouse role among such transactions. The Exchange should electronically connect to these carriers to facilitate quick and secure enrollment, payment processing, and coordination with the Treasury's trust fund for subsidy calculation and collections.

This process of real-time data exchange with multiple parties in the face of changing income and subsidy levels presents a major operational challenge for all state exchanges. Tracking out-of-pocket costs and calculating the resulting cost-sharing subsidies under the ACA is even more complicated. CHBE would need to ensure it had adequate resources for tasks such as developing expectations and performance standards jointly with QHP issuers, managing the relationships around this function closely, and de-certifying QHPs that weren't able to work hand-in-glove with CHBE to create a smooth, seamless system for enrollment, billing, collections, and enrollee card production.

For year-end tax filing, a service-center Exchange should provide forms needed by enrollees to apply for or to reconcile tax credits, as well as automated assistance with the tax filing process. Individuals who have purchased insurance through the Exchange should be able to request any forms needed for documentation of their coverage for purposes of the individual mandate.

SHOP Exchange Considerations

A service-center Exchange would need to recognize the distinct needs of the small group market that would participate in CHBE via the Small Business Health Options Program (SHOP). SHOP would need to offer the broadest range of purchasing options and structures as allowed by state and federal law. Failure to do so would weaken the consumer focus of SHOP and open the door for private distribution channels that offer more approaches to compete directly with the Exchange.

A service-center Exchange would also need to address the distinct customer service needs of the SHOP marketplace. A SHOP "store" would need its own web interface to allow employers to choose a plan or tier, identify employees, enter various amounts of employer contributions to see how these "play out" for their employees, work with their broker "live" on the website, address mid-year adds and terminations, deal with out-of-state employees, and handle COBRA coverage. The SHOP Exchange will need to demonstrate flexibility on timeliness and other processes in order to accommodate employers' individual needs.

In addition, employees' shopping experiences must be customized to reflect their employer's decisions: for example, showing which plan or tier their employer has chosen for them, or their monthly contribution rates after the employer's contribution. Small groups may also have different plan preferences than purchasers of individual insurance, making it more challenging to envision standardized benefit plans across the individual and SHOP Exchanges as well as a single procurement process for the two exchanges.

Because brokers play an especially important role in the small group market, the SHOP Exchange may want to work with brokers to maximize accessibility and visibility. Toward this end, it should make sure that many brokers are certified to help small groups select and purchase insurance via the Exchange, and that certified brokers fully appreciate and support CHBE's unique value proposition. CHBE should provide credentialed brokers with dedicated support services, as well as ongoing training. The broker support should include a set of web-based services for each broker's accounts, plus an overall summary and agency self-management features. The Exchange should also provide referrals to brokers for employers who wish to access broker services, as a service to both employers and credentialed brokers.

At the same time, the SHOP Exchange should be accessible to small businesses whether they use a broker or not. Because allowing employers to avoid brokers' fees could generate a backlash from brokers, the Exchange may not be able to provide any savings to employers who do not use a broker, and therefore the Exchange may decide to refer all employers who come in on their own to a de facto broker. Developing a long term, mutually beneficial relationship between CHBE and those brokers who appreciate its value and want to work with it would be a critical strategic and operational challenge in serving small employers in this model of CHBE.

Managing Eligibility and Enrollment

A service-center Exchange would allow consumers easy and seamless eligibility determinations and enrollment. The Exchange should serve as a trusted advisor, providing honest and unbiased information about plans. The Exchange should offer features to help consumers understand insurance terms and options. For example, it could provide tools for consumers to understand how much they might end up paying under each plan design, under different scenarios. This could be a calculator (online or via a mobile application) that showed the costs to the consumer resulting from different co-insurance, deductibles, co-payments, and out-of-pocket maximums, under different patterns of utilization. The Exchange could also provide analyses tailored to special segments of shoppers, such as former employees eligible for COBRA, part-time or seasonal workers, early retirees, and group enrollees without dependent coverage.

While online tools can be very helpful, many consumers want to talk to a real person before making an enrollment decision. A service-center Exchange would also provide options for in-person and phone support to walk customers through options and provice guidance on plan selection.

Service solutions through all channels would need to address a general lack of health care-related literacy among much of the population. Commonly used terms such as HMO, deductible, copayment, and out-of-pocket maximum would need to be explained. To take on the purchasing role for a product they may never have purchased (or even used) before, enrollees would need to learn basics about how health coverage works, what purchasing health insurance means, and how to obtain care.

Carrier Procurement Issues

A service-center Exchange would favor a breadth of plan choice, as opposed to the more selective contracting approach envisioned for the price-leader and change-agent models. A service-center CHBE would need to balance breadth of plan choice with simplicity for consumers.

A service-center Exchange would be likely also to have a greater focus on procurement of additional vendors for customer decision support, quality and cost information, and other service tools. For this reason, the procurement function would need to be backed by technical and business expertise beyond the realm of health plan contracting.

Finally, this model for CHBE would have higher customer service and administrative costs. To the extent that these costs would be "passed on" in the form of higher premiums, the amount of downward pressure that the Exchange could put on health insurance premiums through the procurement process would be limited.

Revenue Channels

A service-center Exchange reflects a high-cost service model, which would generate a sizeable budget. After initial federal funds for start-up, the Exchange is expected to be self-sustaining by January 1, 2015, supported in part by charging assessments to participating carriers. Unless the Exchange realizes significant economies of scale and/or generates additional sources of revenue, this model would likely require somewhat higher carrier assessments than other models. Whether higher overall costs could be partially or fully offset by higher customer volume is an important analytic question which requires financial modeling.

To generate additional revenue to offset administrative costs or even defray core operating costs, the Exchange could diversify into other lines of service or add optional features. For example, the Exchange could add other insurance lines such as dental, vision, life, or long-term care insurance. The Exchange could also offer other health-related services such as provider profiling data available in state Health Information Exchanges, a personal health record, health risk assessments, disease management, health management and health tracking tools, coupons for services that support a healthy lifestyle, or health coaching services. While some of these features could be offered under any of the Exchange models, the service-center Exchange might be uniquely motivated and positioned to do so.

There are several models for pursuing this strategy, including: (1) a transaction surcharge on other insurance purchases through the Exchange (e.g., dental, life); (2) an enrollee transaction fee for additional services, such as a provider profile; (3) an annual membership fee that provides access to a suite of services; (4) paid advertising targeted at supplementary service users such as wellness and fitness vendors; and/or (5) allowing private vendors to offer supplementary services and products to enrollees (at no cost to the Exchange) under an agreed-upon revenue model developed by the vendor.

Role of the Board and Staffing Requirements

There are major implications for the board's role and public stance stemming from the added level of managerial expertise and expense associated with a high-performing shopping experience—including the challenges of maintaining a robust, high-traffic website with extensive self-service features. The Exchange would need to be staffed adequately to provide the level of customer service required; to manage the technical aspects of the Exchange website to ensure it functions reliably and smoothly; to manage and integrate relationships with brokers, carriers, and other partners in the public and private sectors; and to manage diversified services as they may emerge. While some elements of customer service and program evaluation functions could potentially be outsourced, the Exchange would need sophisticated management to oversee operations and vendors.

First and foremost, the board would need to understand and fully support the strategic and operating requirements of a customer service-focused model. The priorities of this model entail trade-offs and tension with other health reform goals, so the service-center model must be fully understood, endorsed, and consistently promoted at the board level. A commitment to this vision and an understanding of the importance of consistency of message would be essential for the Exchange in building long-term, mutually-supportive relationships with a variety of private-sector suppliers and partners. As such, it would be important for Exchange Board and staff to have expertise in managing consumer satisfaction, engagement, and loyalty, with this expertise possibly coming from fields outside of the health care industry.

Second, the success of this model would depend on its execution, therefore the board would need to hire and empower highly skilled managers with the requisite experience and skills to achieve this vision. In particular, it would be important to recruit leaders and staff members with robust experience in customer service and insurance. It would also need to be thoughtful and strategic in developing appropriate relationships with the private sector in all of its very public decision-making and communications. Because the board is charged with conducting public business in a transparent manner, and its activities would be sure to attract some degree of media coverage, it would need to understand the importance of consistency and unity of message.

Third, the board would need to maintain its own discipline in planning, implementation. and evaluation. This would include developing realistic schedules for rolling out "core" versus "nice-to-have" features; clearly setting forth achievable-but-challenging one-year and multi-year plans; and evaluating and regularly re-visiting its own decisions and management's progress against measurable objectives. Clear metrics, data collection, program evaluation, and market research would be important functions for a service-center model.

Integration with Public Programs

A focus on consumer appeal may present challenges to coordinating the Exchange with Medi-Cal and other public programs. For example, Medicaid Managed Care Organizations often rely on community clinics and other public providers in their networks, and therefore may not be as appealing among commercial buyers. Therefore, CHBE could find it difficult to achieve continuity in coverage among low-income enrollees as they migrate back and forth between the Exchange and Medi-Cal. Additionally, plans defined for the Exchange population may not match the plans offered through other public programs. And a service-center model that offers a broad range of plans may make it more difficult to do a joint procurement with Healthy Families and Medi-Cal.

Nevertheless, a service-center Exchange would pursue coordination with public programs in order to support enrollees' ability to move between programs if their income or eligibility changed. It would also provide outreach at points of contact with other programs of value to low- and modest-income consumers, such as

California's Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families programs.

Metrics for Success

In addition to the standard set of metrics that should be used to measure the performance of the Exchange regardless of the model chosen, a service-center Exchange should pay particular attention to metrics that reflect its performance toward its consumer-oriented strategic goals.[7] A successful service-center Exchange should attract significant market share from diverse sub-populations ("target segments"), rate highly in customer satisfaction measures, and meet or exceed benchmark standards for services such as call center operations (measured by such factors as call wait times, call abandonment rates, turnaround time for issue resolution, and percentage of problems resolved on the first call).

Two sets of metrics specific to a service-center model are recommended: (1) enrollment volume and growth rates, including penetration of both tax credit-eligible and unsubsidized direct purchasers and small employers; and (2) customer satisfaction, persistency, and disenrollment rates referenced against "outside" market performance. In order to improve and optimize its customers' experiences, it would also be important for the Exchange to understand the reasons behind performance along these dimensions. The Exchange should frequently be in touch with its customers and potential customers, evaluate their needs, and refine its program operations and offerings on an ongoing basis to meet those needs. A sophisticated market/customer research capability (using surveys, focus groups, and other analytic tools) and understanding of insurance sales dynamics would be required.

Risks and Unintended Consequences

Along with the many benefits to adopting a service-center model for the California Exchange that have already been described, there are also a number of risks and trade-offs. An over-arching challenge of this approach is that even outstanding service may not deliver volume in the face of high and rising premiums. Consumer buy-in may depend in part on the extent to which Californians embrace a new "culture of coverage" in 2014 and take seriously their new opportunities and obligations under the ACA. Many of the conditions that would encourage such a shift are outside the control of the Exchange.

The high administrative costs of this service model present another challenge. In building appeal for consumers, a service-center CHBE would feature sophisticated interactive online capabilities that would require significant resources to build and maintain. The model also depends on having high-quality, well-trained, and accessible customer service representatives who can be accessed online, by telephone, and in person. Providing culturally and linguistically appropriate services would likewise be costly, as would the ongoing research necessary to remain responsive to shifting consumer needs.

This model's emphasis on consumer choice presents additional risks. Broad choice can confuse consumers, so the Exchange website and decision-support tools would have to be effective at reducing complexity and confusion. Because a broad range of plans would be offered under this model, some consumers could select options that others would not perceive to be in their best interest.

Consumer choice among many different plan designs could also increase the risk of adverse selection, which may not be fully mitigated by retrospective risk adjustment and deep market penetration. While broad choice and mass appeal may reduce adverse selection for the Exchange vis-a-vis the outside market, it can increase risk selection among QHPs within the Exchange. For example, making a broad-network PPO offer the same rich (platinum) benefits as a select-network HMO in the name of consumer choice could drive a disproportionate share of very sick enrollees into the PPO. This is one of the many dynamics that would need to be monitored and managed carefully.

Relationships with brokers and carriers would be key to the success of a service-center Exchange, and these relationships would need to be carefully tended. If CHBE does not work with a reasonably broad subset of eligible brokers, and is not assiduous in cultivating support from them, the brokerage industry as a whole could feel threatened by the Exchange and work against it. This notion is particularly important with the SHOP Exchange.

The Exchange would also need to carefully steer a middle ground in relationships with carriers, making sure these relationships are neither too cozy nor too adversarial. It would need to take time to devote the resources necessary for integrating operationally with carriers so that they are able to handle large numbers of enrollment, billing, customer service, and collections transactions smoothly and efficiently. Ideally, most carriers would be wired right into CHBE, so that once a shopper selected a plan, the Exchange would function as the portal directly into that carrier for purposes of enrollment, billing, and premium payment.

Preserving its independence and objectivity would be critical if the Exchange were to carry out its role of trusted advisor to the consumer. For example, the Exchange might incorporate both "objective" performance data and consumer opinions in its ratings of health plans—but this process should be reasonable, transparent, and credible to carriers. The more the Exchange were to embrace the role of enrollee advocate, the more potentially complicated it would be for it to navigate relationships with carriers.

In pursuing these crucial business relationships, a service-center Exchange would need to hew consistently to the principle that it will make decisions in the best interests of marketing fairly and efficiently to a broad swath of customers. The Exchange could not expect the cooperation of participating brokers and carriers in selling health insurance if it simultaneously tried to restrict their activities or impose significant regulatory burdens beyond California's existing processes for licensing and regulating plans and products.

Conclusion

By shaping itself as a service-center Exchange, CHBE has the opportunity to become a well-known consumer destination and attract a broad customer base that would help the Exchange achieve economies of scale and market power, mitigate adverse selection, and generate public support and confidence. An Exchange based on this model would offer best-in-class customer service, a broad range of health plans, easy comparison shopping, and objective and trustworthy advice on plan selection.

At the same time, this model presents important trade-offs, given its anticipated start-up and operational costs and the risks associated with an emphasis on consumer choice. Building and maintaining a successful service-center Exchange would require careful attention to what consumers want, both in their shopping experience and in the products they demand, and to the nurturing of long-term relationships with health plans and brokers.

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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. ACA §1312 (f)(2)(B).
2. Authors' analysis.
3. See definitions in the companion overview paper, "Setting the Stage: Visions for the California Health Benefit Exchange."
4. See, for example, research reviewed by Hanoch and Rice: Yaniv Hanoch and Thomas Rice, "Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance," *Milbank Quarterly* 84:1 (2006), www.milbank.org, and Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," (Cambridge, MA: National Bureau of Economics, February 2009), econ-www.mit.edu.
5. "Helping Employees Choose Health Plans," PBGH Issue Brief (2011), www.pbgh.org.
6. ACA provides grants to entities called "navigators" to conduct public education activities, distribute information about enrollment in plans and subsidy availability, facilitate enrollment in plans, and provide referrals to health insurance consumer assistance offices or ombudsmen to enrollees with grievances, complaints, or questions.
7. 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.