THE MULTI-CARRIER MULTI EMPLOYER HIX IN CONTEXT

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Health care expenditures as a share of GDP have apparently levelled off at 17.4%. There isn't consensus on what caused this or whether this stability will continue. An analysis by Aon Hewitt found that after plan design changes and vendor negotiations, the average health insurance premium rate increase for mid-sized and large companies was 3.3% in 2013, 4.4% in 2014, and they project 5.5% in 2015. The health care inflation monster has been restrained, but it is not dead. And there is not much reason for confidence that it will not return.

For all their efforts, why have employers not been more effective at cost-containment? I think it is because they have let themselves be trapped in the traditional model of open-ended, uncoordinated fee-for-service, the most costly way of organizing and paying for medical care.

The Federal Government is innovating in payment for Medicare, the other last holdout of open-ended fee-for-service. In January of this year, Secretary Burwell announced "HHS has set a goal of tying 30 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016 and tying 50 percent of payments to these models by the end of 2018." …"HHS will intensify its work with states and private payers to

support adoption of alternative payment models through their own aligned work, sometimes exceeding the goals set for Medicare."

Private employers need to find a way to get on this path. My point today is that the model of large scale multi-employer multi-carrier private exchanges combined with defined contributions to employee health insurance is the most promising way of getting there. I say the most promising way because it relies on incentives and individual choice to motivate innovation, and not coercion. And it has proved effective and broadly acceptable where tried.

In 2014, among all private employers, 50% of covered workers were offered one plan type, usually a wide-access PPO. Only 31% were offered a choice set that included an HMO. If employees were offered a choice of plan, the alternatives were usually High-Deductible health plans which are little more than open-ended fee-for-service with some costs shifted to employees.

The original idea of the PPO was *selective* provider contracting, as opposed to "any willing provider" , that is, only economical providers would be preferred and covered by insurance. That has broken down because with only one plan, one size has to fit all, and employers tend to include every provider that some employees want. So called "must have" hospitals are included, even though they are likely to be the most expensive.

I recently learned about a case in which a self-insured employer wanted to drop some high-cost providers from its PPO network, and the carrier that administered its claims told the employer they could not drop the high-cost providers because the carrier needed them in their network for reasons of geographic coverage. And not infrequently one hears of

prominent hospitals with market power refusing to contract in other than the most favored tier.

So employers fought for and got legislative approval for selective provider contracting and threw away the potential economic advantage they could have from the threat to exclude providers from preferred status, and went to broad network PPOs because they wanted to include providers that employees wanted. That means not much bargaining power.

For similar reasons, employers over-insure: they offer broader coverage than employees would choose with their own money, perhaps because they want to satisfy their most demanding employees. Aon Hewitt, in their exchange, found that only about a third of employees chose Platinum or Gold plans. My esteemed Stanford colleague, the famous health economist Victor Fuchs, thinks it is because the senior executives or union leaders, who tend to be older than average, want the more generous coverage for themselves personally. And of course this is aided and abetted by the exclusion of employer contributions from the taxable incomes of employees which substantially lowers the after-tax cost of more costly health insurance. More than the money, people hate to leave a tax break unexploited. However Kaiser Permanente does well in some of those groups because of their quality and customer service.

In the case of the Silicon Valley employers who have young high paid employees, and therefore low health insurance costs as a percent of payroll, and are competing for highly talented employees, they want to be able to say to potential recruits “Don’t worry about health care; we pay for it all.” It’s hard to market quality cost effective care in that environment.

Also few employers offer employees a choice of plan and also a defined contribution. The Henry J Kaiser Foundation HRET survey of employers in 2014 reported that only 23% of large firms offering health benefits were even *considering* a defined contribution, which suggests that a much smaller fraction were actually doing a defined contribution which would make employees cost-conscious in choice of plan. At Stanford, we offer employees a fixed-dollar contribution set at the price of our most efficient plan. Our consultants tell us we are quite unusual in that respect.

The multiple choice of carrier and defined contribution approach—"Managed Competition"—has been around a long time and does cover millions of people, mainly in the public sector. The main examples are the FEHBP, CalPERS, the University of California, the State of Wisconsin employees' plan, and a few other states. All of these are large exchanges. In fact PERS is a multi-employer exchange because it brokers health insurance for the employees of more than 1500 local public agencies, and over 1500 school districts, not just employees of the State. And it works well for them. Many people make economizing choices. In all of these groups, HMOs achieve high market shares. The employers save a great deal of money which then can be used for pay or other benefits. Nobody is proposing that they roll back to a single fee-for-service plan. Managed competition is what we have done at Stanford for our employees since 1990 and nobody is proposing that we change to a typical employer model of single plan FFS.

Some employers offer a choice of carriers and pay 75 or 80% of the premium of the plan of the employee's choice. That sounds reasonable, almost fair, but in fact it is a very bad idea. It is inflationary. Consider the incentives for the competing health plans. A health plan innovating to reduce cost considers reducing its premium by one dollar.

By doing so, it would reduce its revenue by one dollar times their total membership. They would only do this if they thought a lower premium would attract enough more members to offset the revenue loss. But with this employer policy, it will get only 20 or 25 cents worth of new members. That is, the prospective member sees only a 20-25 cents price reduction. That makes the demand curve it faces inelastic, which means no incentive to cut its premium, and in fact a reward for raising its premium. With employer policies like that, no wonder health insurance premiums have been soaring! The State of Massachusetts sponsors employee insurance this way.

A much better policy is the one built into the Affordable Care Act (ACA) exchanges. The government makes a defined contribution keyed to local area costs that does not increase if the beneficiary chooses a more costly plan. That has created a competitive force that helps hold down premiums.

There are at least three broad alternative ways of reducing the cost of health insurance below that of the wide-access PPO. They are:

- Narrow networks;
- Integrated Delivery Systems; and
- High consumer cost sharing such as high deductible health plans.

Let me comment on each.

Narrow networks are being used by some carriers in the public ACA exchanges. The idea is to limit coverage to a list of economical providers. Narrow networks are having problems. Apparently some people choosing them didn't understand what they were getting into and then were disappointed that they couldn't access their accustomed providers. State regulators are getting involved. Narrow networks need to be regulated to assure people access to the care they need when they

need it. Also narrow networks could be an effective way of excluding people with costly chronic conditions by excluding the specialists they need to care for their conditions.

Medicine is a team sport. There must be coordination and teamwork among the different specialists caring for a patient including sharing information about the patient's condition. Narrow networks do not necessarily foster teamwork, and the economies they offer may not be realized. On the other hand, narrow networks are a way of creating badly needed competition among providers and that is important and valuable.

The health benefits branch of the California Public Employees' Retirement system (CalPERS) offers State employees a Managed Competition model with several HMOS and 3 PPOs. Most of their members choose HMOs, but CalPERS must continue to offer fee for service plans because some of their beneficiaries do not live in HMO service areas, some have strong attachments to traditional FFS providers and are willing to pay extra to keep them. PERS started with PERS Care, a wide access PPO. Then they found it going into a premium "death spiral." So, keeping the same insurance contract, they offered a more selective plan, and then a third with a narrower network with modest success. The narrowest network premium is 14% below that of the broadest network.

Cal PERS illustrates the important benefit of a large exchange. An insurance product offered to a single employer, such as a narrow network, might offer too few takers to make developing it worthwhile for an insurance carrier or a provider. But in CalPERS, covering more than 1.4 million employees, retirees and dependents, if the narrow network can attract, for example, a 10% market share, that is 140,000 lives, worth developing the product for.

For the most part, the narrow network model remains uncoordinated open-ended FFS. I doubt its strength or viability in the long term unless it evolves to become a fairly wide network with only comparatively few high cost providers excluded.

The next alternative is the *Integrated Delivery System (IDS)*. The IDS is organized and publicly accountable for cost and quality. The hallmarks or key characteristics of the IDS include:

- Provider incentives aligned with the needs and wants of consumers/patients for better health, better care and lower cost (the 'triple' aim).
- Full sharing of patient information among providers caring for a patient.
- A culture of teamwork and shared responsibility; clinical integration.

The main examples of *IDS* are Kaiser Permanente, Intermountain Healthcare, the Geisinger Health System, but there are many more. The Prepaid Group Practices have been studied intensively for many years, most notably in the RAND Health Insurance Experiment, the Group Health Cooperative of Puget Sound provided high quality care for 28% less cost than FFS in Seattle.

The main problem with the IDS as a national solution is that there aren't enough of them and they appear to be hard to start, especially on the East Coast. To succeed, they need markets in which employers will offer them as a choice with a defined contribution so that those choosing the less costly system get to keep the full savings for themselves. Another problem is that some people consider them to be bureaucratic or inconvenient or they are attached to a local traditional practitioner. And of course, those people should have a choice.

Since its early days, Kaiser Permanente has advocated for patient choice because their doctors found that it is hard to establish a good doctor-patient relationship with people who don't want to be there. To accomplish this in a small group can be difficult because a traditional insurer is likely to find the number of patients preferring FFS to be too small to be worth the administrative cost. That is all the more reason small employers need to join a HIX.

Of course, not all IDS are based on group practice with a "clinic style." Some prepaid group practices have innovated in ways to make the care feel to the patient like the care in a small group. Also, some IPAs in California and elsewhere are proving to be effective competitors. And their startup costs may be much lower than that of the Prepaid Group Practices.

The third major category of cost reduction is high patient cost-sharing, such as high coinsurance rates, copayments and deductibles. High deductibles are gaining popularity with employers because of their simplicity and the absence of alternatives. The RAND Health Insurance Experiment showed that they too can reduce cost relative to first-dollar open-ended FFS, and can do so without harming the health of the patients. High cost-sharing aims to have people think twice before going to the doctor, to question the need for that MRI scan, to shop around for the best price for a colonoscopy or CT scan, or at least to be personally aware of what things cost.

One reservation I have about this approach is that the most costly 5% of the population account for half the spending. So these people are very likely to exceed their annual deductibles and out of pocket limits, in which case the model provides no incentive for the patient to want to contain costs.

This situation could inspire a complementary innovation. Dr. Arnold Milstein of Stanford has led in the development of the "Ambulatory Intensive Care Unit" in which people with high cost conditions are invited to get their care from a special unit set up to manage them and to prevent costly exacerbations that lead them to the emergency room. The incentives to join can be relief from cost sharing obligations and avoidance of the unpleasantness of the emergency room.

There are pros and cons associated with each approach. The best answers might be combinations of these ideas. The best outcome for employers and consumers would be a market test on a level playing field, to attract the custom of the informed cost-conscious consumer. An exchange can organize and manage that.

And there are other ideas such as reference pricing. CalPERS announced that the maximum they would pay for a complete joint-replacement procedure was $30,000. It was remarkable how many hospitals found they could do the job for $30,000!

And there are bundled payments for costly procedures such as joint replacements or open heart surgery. In 2006, Geisinger Health System, already a famous IDS, announced Proven Care, a 90-day warranty for bypass graft surgery. They reported a 67% reduction in operative mortality and a 15% reduction in cost. The key was standardization.

The bundled payments idea leaves open the large issues of prevention and appropriateness: could the need for the operation be avoided by better outpatient medical management or lifestyle changes, and was it appropriate? Prospective global payment addresses those issues by rewarding efforts to improve health by diet and exercise, and choosing more judiciously who is a candidate for surgery.

Most of these ideas could be tried in a variety of combinations. There is a need and room for a great deal of innovation beyond the wide access PPO and the High-Deductible Health Plan. Single employers might not be large enough to attract this innovation. But a Private Health Insurance Exchange enrolling hundreds of thousands of lives or more would be in a position to offer large enough markets to attract such innovation. And employers are naturally very conservative about innovations that are to be imposed uniformly on their whole group. But they could try these innovations by offering them to their employees as a voluntary choice. If employers want to see a market made up of competing health plans and delivery systems, each striving for the triple aim, the large multi-carrier health insurance exchange, combined with defined contributions and good information on quality and customer satisfaction must be the answer.

For decades, I have been hearing arguments as to why consumer choice of health plan cannot be done. One is that health insurance is extremely complex, which is true. Very few people even bother to read their contracts beyond the headlines about coinsurance, deductibles and out of pocket maxima, and even fewer understand the contracts. They need experts to read them for them and protect them from harmful contracts, a role often played by employee benefits managers and consultants. Also, if free to do so, insurance companies may add features designed to select risks, segment markets, and make it harder for people to make comparisons so they will be less likely to switch plans. There is an answer to these problems in a market managed by an exchange: i.e. standardization. I particularly liked it when an Aon Hewitt executive told me that in their exchange, all Silver plan contracts were exactly the same so that people would be guided, as they should be, to focus on price and quality. Competition could work better on the ACA Public exchanges if they did that.

The other argument against consumer choice and competition is concern over biased selection: "we always get all the bad risks; the other guys get the good risks." This is a very important issue because of the incentive it gives health plans. It would be bad if the model rewarded those who did not get the bad risks, so the incentive would be to not develop capabilities to provide excellent care to very sick people, or as I just mentioned, to charge excessive cost-sharing for some drugs. One answer to that is that "risk adjustment" which is doing a good job of using patient characteristics, including prescription drugs that map into presence of chronic conditions, to predict expected costs. Then the exchange can adjust payments to compensate for adverse selection. This was developed for Medicare to be sure HMOs were not prospering at Medicare's expense by enrolling better-than-average risks. It appears to have satisfied the skeptics, and we use it at Stanford. The large benefits consulting firms now can deploy this technology.

I recently read about another serious risk selection problem with competition: some carriers are setting prohibitive levels of cost-sharing for prescription drugs associated with costly chronic conditions in order to drive these patients away. Of course, this will be noticed by the affected patients and also by the responsible health plans that do not do this. This is now being met by a regulatory response, standardized contracts, and I think it has to be. The exchanges can do this. A completely "free market" cannot work in health insurance. There must be rules.

Another argument against consumer choice of plan is administrative costs. It is more work to deal with several carriers than one. Exchanges are meant to be an answer to that problem. They enable the employer to outsource the administrative cost of dealing with multiple health plans, and the exchange can achieve economies of scale

by making one contract with a health plan to serve many employers. Exchange companies are competing with each other, which should help to keep their costs down.

What about Stanford University where I chair the Committee on Faculty/Staff Human Resources that advises the VP for Human Resources on health benefits.

We adopted Managed Competition among health plans in 1990.We offer employees a choice among several plans and the University pays the premium of the low-priced plan which is usually Kaiser Permanente. Our active employees naturally live near the campus, so we can cover them with plans that cover the San Francisco area. In effect, we run our own exchange. But we are in the early stages of considering a private Health Insurance Exchange for Medicare retirees who are subsidized with a defined contribution. Many move to faraway places, and we would like them to be able to get the best value for their money wherever they go. There are complex choices among Medicare Advantage, Part D for drugs, and Medicare Supplemental. An exchange can provide trained and certified health insurance advisors who can have expertise in local market conditions all over the country. One employer couldn't afford that.