Building a National Insurance Exchange:
Lessons from California

California HealthCare Foundation

ISSUE BRIEF

Introduction

Among the deliberations now taking place in the nation's capital regarding federal approaches to expanding health coverage, virtually all incorporate the idea of an insurance exchange—an entity to which people can go to select a health plan from a broad range of offerings. Over the past 15 years, California gained extensive experience in designing and operating just such an exchange, an effort that ultimately proved unsustainable.

This issue brief draws heavily on interviews with eight individuals who were either at the forefront of shaping the California exchange concept or played key roles in its design and operation, right through to its ultimate demise. The hope is that the lessons learned at the state level will prove useful to federal policymakers as they construct a viable plan for reform on a national scale.

Background

California's effort to create an effective insurance exchange began in 1993, when the Health Insurance Plan of California (HIPC) began offering small employers several standardized health insurance products being sold by several different health plans. Although initially a government entity under the auspice of the Managed Risk Medical Insurance Board (MRMIB), the authorizing legislation called for the exchange to be privatized. Accordingly, in 1999, operation was turned over to the Pacific Business Group on Health, where it became PacAdvantage. At its peak, the California exchange enrolled about 150,000 people. Nonetheless, it encountered major problems and ultimately closed in 2006.

In 2007 and 2008, California launched a major push to expand insurance coverage to all citizens of the state, an effort that was initiated by Governor Schwarzenegger and vigorously pursued by a number of legislators and stakeholders. An insurance exchange was a central element of all of the proposals. Ultimately, however, agreement on some key aspects of the reforms could not be reached, and the effort collapsed in 2008.

Exchange Models

The basic concept of an insurance exchange is not new, but there are several variations on the idea:

- **Active purchaser.** The model for this approach is large employers who negotiate and selectively contract with insurers that offer a high-value product in exchange for a large volume of enrollees. Where this exchange model has operated in the past, there has been a market both within and outside the exchange seeking to attract the same customers. The Health Insurance Plan of California (HIPC) and its successor PacAdvantage are examples of this model.
- **Passive clearinghouse.** An exchange built on this model is merely a "price taker" willing to accept all health plans, a place where employers and individuals can go to find a range of coverage offerings and compare price, quality, and service levels. Participating plans compete for exchange enrollees on the basis of cost and quality. The Federal Employees Health Benefit Program is an approximate example of this model.

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- **Hybrid market organizer.** An entity built on this model does not directly negotiate prices or selectively contract; however, it may define standard benefit packages, provide some degree of endorsement, and otherwise indirectly encourage health plans to offer high-value coverage. The Massachusetts Connector is an example.

The California Exchange

The Expectation

The founders of the California exchange designed it to be an active purchaser. They, like others across the country who were attracted to this exchange model, hoped to achieve a number of important objectives:

1. Provide an easy-to-navigate single point of entry where people could go to choose among several health plans. The exchange would contract with a number of health plans and then provide objective information about price, benefits, and plan performance to help people compare plan value and make wise choices.
2. Reduce the cost of coverage, using three primary mechanisms:
   - Reduce administrative costs by achieving economies of scale. The exchange would centralize some marketing functions, enroll individuals in their chosen plan, and collect and distribute premiums to health insurers. For people who choose not to use insurance agents, it would reduce the premium to reflect the savings from not having to pay a commission.
   - Command lower prices. Just as large employers do, the exchange would negotiate with health plans, offering contracts to only a selected few plans that offered favorable prices in exchange for a significant market share.
   - Foster market competition. Because insurers would be required to offer standardized health plans from which individual employees could choose every year (upon initial enrollment and again at annual renewal), they would be forced to compete on the basis of price, quality, and service—an approach known as "managed competition."
3. Enhance portability of coverage. Once individuals selected a health plan through the exchange, they could keep the same coverage if they changed jobs to work for another participating employer.

The Reality

The actual experience of the California exchange taught some hard lessons. It showed that none of these objectives is easily achieved.

The history of the California experiment can be summed up in a single rule: Any exchange that seeks to be an active purchaser will have a very difficult time achieving its objectives if it is not the exclusive source of coverage for some populations, such as small employers or subsidized individual purchasers.

If there is competition for the same customers inside and outside the exchange, the exchange will be unable to offer lower prices on a sustained basis, for at least four reasons:

1. Some health plans may refuse to participate.
2. Economies of scale in administration are hard to achieve.
3. Participating health plans will not give the exchange a lower price.
4. The exchange is likely to attract higher-risk enrollees.

Moreover, without sufficient numbers of health plans, the exchange cannot offer meaningful choice or enhance portability.

The Participation Problem

An exchange can serve as a convenient place for people to choose among health plans only if a significant number of popular plans are willing to participate. However the attempt in California, as elsewhere, demonstrated that as long as the exchange is not the exclusive source of coverage for some populations, health plans may be reluctant to participate, including some of the largest plans.

Insurers do not particularly like the head-to-head competition that is a feature of the exchange concept, in part because they could lose any given enrollee to a competitor in any given year. Moreover, the people most likely to switch are the healthiest people, who are least costly to insure. If an insurer in the exchange has to raise premiums in any particular year, their healthy enrollees, who use the system infrequently and thus are less attached to particular providers or particular benefit structures, have fewer qualms about switching to another health plan to save a few dollars.

Insurers always prefer to insure whole groups directly rather than compete in the exchange. Not only do they get the whole group exclusively, but they can be reasonably assured of enrolling some healthy, lower-risk participants along with any higher-risk individuals that might be part of the group. Each insurer worries that if they participate in the exchange, their company may end up with a disproportionate share of the exchange's high-risk, high-use enrollees, a phenomenon known as "adverse selection."

If the exchange has a sizeable market share that health plans cannot afford to pass up, more will willingly participate. But without the inclusion of most large plans, the exchange will have trouble attracting enough enrollees to command a large market share. As one former director of the California exchange noted, "An exchange is often just one health plan loss away from failure."

The Elusiveness of Savings

Achieving lower prices over the long run also proved unworkable in California, for three reasons: the exchange was not able to produce administrative savings, it could not negotiate lower premiums, and it became a victim of adverse selection.

Few administrative efficiencies. Administrative economies of scale are not achievable without large enrollment. At its peak, the California exchange enrolled about 150,000 individuals—a tiny percentage of the small-group market. For each individual health plan, the business generated from the exchange was such a small proportion of the plan's total small-group enrollment that the plans did not realize any administrative savings, which meant they could not offer lower premiums to the exchange. Likewise, the exchange learned that it could not itself provide administrative services related to enrollment, premium collection, and the associated services at a cost significantly lower than that incurred by the health plans. Had the exchange dominated the small-group market, it might have produced some of the anticipated savings. But the cost of serving small employers and individuals will always be more expensive on a per capita basis than that for large employers.

A lack of pricing power. After some brief initial success, the California exchange also found it very difficult to negotiate lower prices. With only a small share of the total market, it had little bargaining power. Nor did it have a captive supply of customers that insurers could reach only by participating in the exchange. Health plans could always compete for those same customers outside the exchange. The key to bargaining is selective contracting—offering a few insurers access to a sizeable population in exchange for a good price, as large employers do. That was not a viable strategy for the exchange. In the end, the exchange needed the health plans much more than the health plans needed the exchange.

Not only was the exchange unable to negotiate lower prices; it was in constant danger of having to charge higher prices than those available in the regular market. One former executive director of the California exchange observed that health plans would never offer the exchange a price lower than what they charged outside the exchange, because they would enroll fewer people, losing some to other exchange insurers, and realize less money per enrollee. Rather than compete in the exchange, plans will always prefer to insure people directly.

Exposure to adverse selection. But the greatest threat to the exchange is adverse selection. People involved in operations of the California exchange agreed that when there is competition for the same customers within and outside the exchange, the exchange is in "extreme peril" of becoming a victim of adverse selection. If an exchange attracts a disproportionate share of higher-risk individuals and groups, as the California exchange did at various times, it cannot succeed. The average medical claims cost of people enrolled in the exchange will be higher than in the outside market, which means that premiums must be higher, making it impossible for the exchange to attract customers. People will not buy health insurance through the exchange or stay within it if they can get the same coverage less expensively elsewhere. Eventually, the exchange will fail.

To protect itself against adverse selection, an exchange must not be more lenient than outside insurers in accepting higher-risk enrollees. It must employ whatever medical underwriting and risk-rating practices are allowed in the regular market to avoid becoming a magnet for the unhealthy. California law permits insurers to adjust premiums up or down by 10 percent based on health status. The California exchange made the initial mistake of not varying rates based on enrollees' health status, while outside insurers did. The result was adverse selection against the exchange.

Even if an exchange avoids such mistakes, it can fall prey to adverse selection because health plans have strong incentives to channel high-risk people to the exchange (as well as to other insurers). For insurers, avoiding high-risk people is not just a matter of making profits; it is a matter of survival. An insurer that enrolls a disproportionate share of unhealthy people with costly medical conditions will be at a permanent competitive disadvantage and will lose market share. The danger is especially acute if insurance market rules significantly limit insurers' ability to vary premiums based on risk—as most reformers agree is necessary.

It is thus not surprising that insurers operating outside the exchange, as well as their agents, may encourage high-risk individuals and groups to go to the exchange rather than buy from them. Even insurers participating in the exchange may do this, because many of the costly people will choose other exchange insurers (assuming that the exchange rules permit individual employee choice).

Contrary to common thinking, even being big—as a national exchange would be—will not by itself ensure a representative, viable risk pool. An exchange can become a big pool of high-risk people.

The Portability Mirage

The last objective sought by proponents of exchanges—greater portability of coverage—cannot be achieved in a meaningful way if few people are insured through the exchange. Real portability for the employees of small firms is achieved only if many small firms offer coverage through the exchange, so that when employees change jobs they are likely to move to another participating employer, which makes it possible for them to stay enrolled in the same health plan.

Implications

The key lesson of the California experience is that if the exchange is to operate as an active purchaser and achieve desired objectives, it needs to be the exclusive source of coverage for certain defined population groups. Structuring the exchange in this way changes the equation in such a way that the pitfalls of the California experiment can be avoided.

Desirable Incentives for Insurers

If the exchange is the sole source of coverage for some market segments, it will be able to attract insurers, selectively contract with health plans, and bargain for better prices in the same way that large employers do, because it will be the only point of access to this business. Since the exchange is the whole market for these defined populations, it cannot suffer from adverse selection. (This assumes that everyone will be required to buy coverage in a reformed market. If there is no such mandate, the individual market as a whole—and thus the exchange—will almost surely experience adverse selection.)

The exchange is likely to achieve some price reductions, both through bargaining and because managed competition is likely to work as envisioned. When individual enrollees can change health plans every year and the insurers cannot get access to them except through the exchange, the insurers will have strong incentives to offer attractive prices, good quality, and superior service to maintain or expand market share. Portability will also become a reality for the populations buying through the exchange because they can readily keep their health plan when they switch employers.

Effective Risk Adjustment

Making the exchange the sole source of coverage for some market segments does not solve all problems. Although the exchange will not suffer from adverse selection, individual insurers operating within the exchange may do so. The California experts interviewed for this analysis agreed that an exchange should establish a risk-adjustment mechanism to offset any financial advantages or disadvantages health plans experience as a result of not enrolling a representative risk sample. A risk-adjustment mechanism creates fair competition by requiring health plans with a disproportionate share of low-risk people to transfer funds to plans with a disproportionate share of high-risk people.

If all works well, the result would be to greatly reduce or eliminate the cost advantage or disadvantage of not enrolling a population of representative risk, thereby reducing the incentive for plans to "cherry pick." Such a mechanism will have the added benefit that a health plan particularly skilled at serving people with expensive acute or chronic conditions will not be financially disadvantaged by attracting a large number of such individuals. Everyone benefits when people with difficult health problems enroll in health plans that are especially skilled at treating their maladies. Without risk adjustment, no health plan can enroll a disproportionate share of such people and survive.

A Single Source of Coverage

If the exchange is to become the only source of coverage for some population groups, who are likely candidates? Analysts generally agree that the people least well served by the existing insurance market are those who buy as individuals and small groups. They have virtually no bargaining power and no influence on insurer practices. They pay substantially higher prices. They cannot easily and effectively negotiate the market because they lack time, resources, and inexpensive access to reliable sources of information. Buying insurance through an exchange could alleviate some of these problems. It thus seems logical to have the exchange be the place where individuals and very small employer groups, perhaps all those with fewer than 10 or 15 employees, go to get coverage.

The California experts suggested that it would also be logical for the exchange to be the sole source of coverage for people who are being subsidized to buy private coverage, as the leading federal proposals envision. The exchange can efficiently administer the process and can effectively negotiate on their behalf. If tax dollars are to be used to make coverage affordable, policymakers have an obligation to ensure that the money is well spent, to see that subsidized people are buying high-value, cost-effective plans. The exchange provides an effective and efficient mechanism for determining who is eligible for subsidies and for ensuring that subsidized people are buying coverage appropriate to their needs.

Choosing the Right Model

Another implication of the California experience is that if the exchange is to compete with insurers selling coverage to the same customers in the regular market, it should be structured on either the "clearinghouse" model or the "hybrid" model. That is, it should not attempt to negotiate or bargain with health plans but instead should accept all willing insurers and let them establish prices based on their own assessment of the competitive conditions. The primary role of the exchange should be to serve as a convenient place for people to choose among competing health plans, giving them reliable, objective information that allows them to compare coverage based on price and value.

If the exchange is to serve this purpose effectively, insurers should be required to offer a limited number of standardized benefit packages. Without standardization, it is very difficult for people to compare plans in a meaningful way. When the number of benefit structures is very large and each is offered at a different price, the number of variables is too large for people to deal with rationally. They cannot make wise choices.

The clearinghouse or hybrid models may still be compatible with the goal of allowing individual employees to choose a health plan that best suits their needs and preferences rather than having the employer make that choice—a feature that is necessary if the existence of the exchange is to increase coverage portability and keep prices in check through managed competition. But once individual choice is part of the exchange design, insurers will prefer to generate business outside the exchange, as occurred in the California experience. Thus it will probably be necessary to require both that insurers participate and that they charge a price no higher than the one they offer outside the exchange. The insurers will still have an incentive to direct higher-risk people to the exchange rather than insuring them directly, in hopes that they might pass off some of the "bad" risks to other insurers. However, establishing an effective risk-adjustment mechanism that operates both inside and outside the exchange would nullify the benefits gained from such tactics.

Summary

The history of the California exchange yields a number of important lessons that have implications for the design of a health exchange at the national level:

- An exchange that seeks to be an active purchaser will have a difficult time achieving its objectives if insurers are able to compete for the same customers outside the exchange market. It will have trouble getting and keeping health plan participation and bargaining for lower prices, and it will face a constant threat of adverse selection.
- If the exchange is to operate as an active purchaser and achieve desired objectives, it needs to be the exclusive source of coverage for certain defined population groups. Logical candidates include people who receive subsidies to buy private health insurance, people seeking coverage as individuals, and small employers.
- If the exchange is to compete with insurers selling coverage to the same customers in the regular market, it should be structured on the "clearinghouse" model

or the "hybrid" model. To make even these models work, especially if there is individual employee choice, it may be necessary to require health plans to participate and to require them to charge the same price both inside and outside the exchange.

- Regardless of model, the exchange will be more likely to achieve desired objectives if it requires insurers to offer a limited number of standardized benefit packages and includes a risk-adjustment mechanism.

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