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Perspective

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After the False Start — What Can We Expect from the New Health Insurance Marketplaces?

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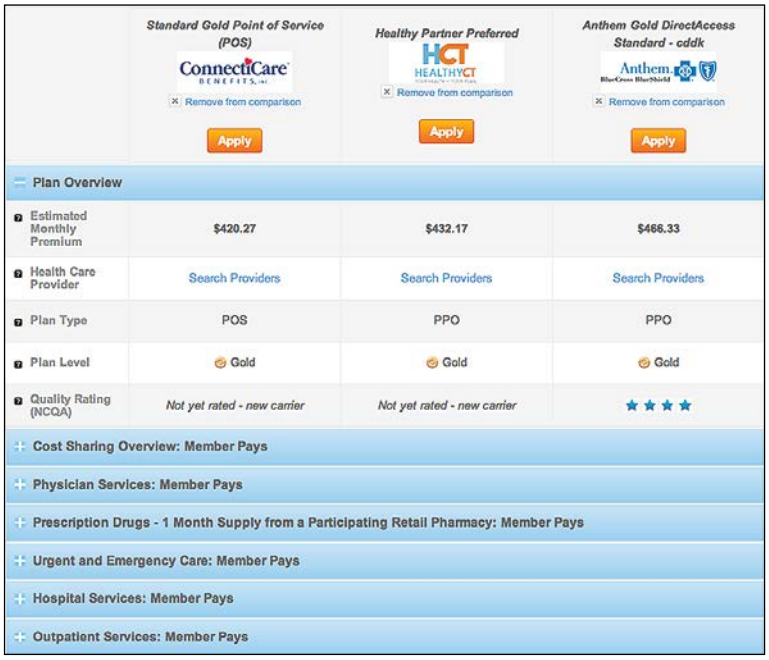
Health insurance reform was conceived as a way of improving consumer choice, and under the Affordable Care Act (ACA), the year 2014 should have provided a test of how best to do so. Instead, the flawed launch of the exchanges in most of the country will test the memory of voters and determine the electoral costs of having made it harder for Americans to buy (or keep) coverage. The first lesson from the rollout was thus entirely unintended: implementation counts.

Once the initial problems are corrected, the exchanges may still fulfill their promise, and it's worth remembering what that is. First, the exchanges must execute their core functions. An insurance exchange is a virtual insurance store. Like any retailer, it must decide which products (qualified health plans) to offer, which suppliers (insurance carriers) to work with, how to market its wares, and how to help customers compare options and select a product (see screen shot). With a core mission of selling private insurance, this novel form of public commercial enterprise is often organized as a hybrid of the public and private sectors — a quasi-independent government agency.

The ACA also charges exchanges with responsibilities that are more typically governmental, such as determining households' eligibility for tax subsidies and exemptions from the individual mandate to obtain insurance coverage. Ultimately, it's the Internal Revenue Service that determines the subsidy amount on the basis of tax filings for both lower-income individuals and very small, low-wage employers who purchase coverage through public exchanges. These functions need not be located in the exchange; for example, the Massachusetts Health Connector (for which I was the founding executive director and which is the model for the ACA exchanges) originally subcontracted them out to the state's Medicaid agency, and each state has had to work out its own division of turf.

The huge share of the gross domestic product that is financed through health insurance and the extreme difficulty that consumers have in discerning value in health plans[1,2] make last fall's disastrous rollout particularly unfortunate. Yet many ACA supporters seem



A Health Insurance Exchange Website.

The Connecticut insurance exchange, AccessHealthCT (www.accesshealthct.com), encourages shoppers to compare key features of selected plans. In this example, the shopper has selected a comparison of three plans with annual deductibles of $1,049 or less.

almost blind to the need for better public management. The federal and state-based marketplaces have encountered multiple obstacles: delays in contracting for technical assistance, inadequate pay scales and cumbersome hiring processes, political opposition and court challenges, delays in issuing controversial federal guidance, a shortage of relevant expertise, tension between new exchanges and existing state agencies, and the inescapable challenge of implementing such complex legislation.

Some of these problems were inevitable, but one failure in particular stands out: the public mismanagement of information technology (IT). Of course, IT is needed behind the scenes to operate any modern enterprise, but HealthCare.gov and the states' websites are the public face of health care reform and the linchpin of consumer choice.

Government inability to procure IT seems to be more the rule than the exception. The Standish Group, an IT firm, rated as successful just 6.4% of government's major IT-development contracts executed in the past decade.[3] In Massachusetts, the model for national reform, the Connector's recent IT disaster was the state's third major one within a few months. Yet true to script, state and federal exchanges are blaming their vendors, as though they had nothing to do with selecting and managing them, and switching vendors after the damage is done.[4] For government to lead health care reform, it must modernize IT procurement. Perhaps the very public failure of HealthCare.gov will generate a much-needed systematic reform of government IT-procurement procedures.

Once exchanges are successfully launched, they should fulfill four key expectations (see box). First and foremost, they should promote enrollment and rational consumer choice. Commercial insurance is a "grudge buy" for many consumers, and with complex contracts and hard-to-decipher benefits designs, the shopping experience has been daunting and inefficient. Exchanges can make insurance plans transparent, easier to compare, and simple to buy. Automation and decision-support tools are already available from Web-based brokers and on private commercial insurance exchanges. The ACA adds a degree of product standardization by mandating coverage of a uniform set of essential health benefits at "actuarially equivalent" levels of consumer cost sharing (bronze, silver, gold, and platinum coverage levels) — which should facilitate meaningful choice. The Massachusetts Health Connector originally allowed each health plan to have its own set of deductibles, coinsurance, and copayments for reaching actuarial equivalence but found that so much variability confused consumers; it now requires a handful of standardized designs so that consumers can make apples-to-apples comparisons. Under the ACA, exchanges can impose such standardization, although so far only one third of state-based marketplaces are doing so. Facilitating shopping in this way saves consumers time, reduces confusion, and improves market efficiency.

Second, exchanges should reduce the cost of distributing in-

The Four Key Objectives of Health Insurance Exchanges.

Every exchange will set its own priorities, but these four objectives support the broader promise of health care reform and should be feasible for exchanges in many markets.

1. **Promote enrollment and rational consumer choice.** Insurance is often a "grudge buy" that even motivated consumers find hard to understand. Effective outreach, encouragement to buy, education, simplification of choice, and decision support are core functions of the exchange. Attracting the uninsured and helping consumers select the right coverage are both challenges and prerequisites of achieving additional objectives.
2. **Reduce the historically high cost of distributing insurance to small buyers.** In theory, the economies of scale and automation of distributing insurance through exchanges should reduce insurance overhead. The ACA caps at 20% of premiums the amount that insurers in the "small end" of the market can retain for administration and profit. Achieving this objective will require close cooperation, integration of systems, and some accommodation of new roles among exchanges, brokers, and insurers.
3. **Enhance "healthy" competition among insurers.** Rather than competing on risk selection, a practice that has been all too common in the individual and small-group segments, exchanges should catalyze value-based competition — that is, more insurers and more of them competing on the basis of price, benefits, provider access, and customer service. Such competition defines success in reforming the health insurance market.
4. **Encourage coordinated, high-value systems for delivering medical care.** Ultimately, the vision of health care reform goes beyond insurance to improving care delivery. Doctors, hospitals, and others must supply high-performing health systems, and exchanges can help nurture them by organizing a receptive market — a market in which each family can select the health care system it prefers, at a price that reflects the competitive value of that system, and can switch delivery systems (annually) if dissatisfied.

surance. For small employers and individual buyers, administrative costs account for as much as 40% of insurance premiums[5] — reflecting the high costs of selling to and enrolling many small purchasers. Exchanges should be able to handle distribution tasks in an automated, scalable way; the Massachusetts Health Connector distributed nongroup and small-group insurance, including billing and collections, for about 3% of premiums.

To ensure that the exchanges' economies of scale translate into savings, rather than another administrative layer, the exchanges must work closely with private insurance carriers. Because of the popular support for cutting administrative waste, this goal could be a high priority for exchanges, but it will require operational dexterity and systems integration with insurance carriers. For example, exchanges might reward (and eventually require) fully automated, paperless enrollment, fulfillment, and claims processing.

Third, exchanges should enhance competition. According to the decades-old theory of managed competition, the escalation of medical costs and the slow pace of systematic quality improvement reflect deficiencies in the typical structure of health insurance markets. The theory is that if consumer choice among competing health plans is organized, if choices are subsidized equally so that the buyer bears the full difference in premiums, and if consumers are informed about the value of their options, then consumers will demand less-expensive plans offering higher-value providers. In turn, the private sector will supply more competitors, and the market will reward the development of plans offering higher value. This is exactly the point of new select-network plans (i.e., plans offering a limited provider network) — to capture the value of lower-priced networks in lower-premium health plans.

Preliminary evidence suggests that exchanges can enhance competition among health plans along these lines. Over time, the Massachusetts Health Connector recruited 3 new licensed carriers to the state's commercial insurance market and now offers products from a total of 10 carriers. Similarly, exchanges in California, New York, Rhode Island, and other states are attracting carriers that are new to commercial nongroup insurance. Individual buyers who use the Massachusetts exchange overwhelmingly favor low-priced plans with higher consumer cost sharing and a select provider network. In its subsidized program, the Connector offered only select-network plans and kept average annual premium increases below 2% from 2006 to 2013. Similarly, many of the qualified health plans nationally offer select provider networks and premiums that are considerably lower than expected.

However, both cost sharing and narrow provider networks threaten high-priced providers and impose trade-offs on consumers. The inevitable backlash will test these public–private partnerships.

Fourth, ultimately, health care reform should move beyond insurance to improving medical care. Physicians, hospitals, and

others must develop high-performing health systems, and some of the ACA's Medicare and Medicaid reforms directly stimulate the development of accountable care organizations and patient-centered medical homes. Exchanges can help nurture these systems by organizing a receptive market — one in which each family can select the health care system it prefers, at a price reflecting the competitive value of that system, and can switch systems annually if dissatisfied.

One important constraint on the influence of consumer choice, however, is the relatively small number of people who will be covered through public exchanges. Two movements may increase the effect of consumer choice on the demand for integrated delivery systems. First, employers are beginning to use private exchanges, and if this trend accelerates, millions of employees may also be shopping among competing delivery systems. Second, several states have begun envisioning coordinated state purchasing strategies for Medicaid, government employees, and public exchanges that would drive payment and delivery-system reform.

If such purchasing initiatives are implemented as part of a series of coordinated initiatives to nourish innovative delivery systems, they could eventually garner enough market power to help reshape medical care. To succeed, purchasing coalitions would have to work closely with private insurance carriers and physicians to drive long-term change. This vision assumes that the politics of health care reform can accommodate the sustained effort necessary for systemic, evolutionary change executed through public–private collaborations. That is a tall order.

To achieve these ambitious objectives, exchanges must perform a balancing act familiar to any retailer. As essentially commercial enterprises, exchanges can lead "disruptive" change only so long as they are willing to follow customer preferences. This requirement is both an advantage and a disadvantage for a fundamentally conservative, market-oriented vehicle for health care reform.

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Assessing the Clinical Benefits of Lipid-Disorder Drugs

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On October 16, 2013, the Endocrinologic and Metabolic Drugs Advisory Committee of the Food and Drug Administration (FDA) voted 9 to 2 against approval of Vascepa, a purified n–3 fatty acid formulation of ethyl eicosapentaenoic acid (EPA), for use as an adjunct to diet and in combination with a statin to reduce levels of triglycerides, non–high-density lipoprotein (non-HDL) cholesterol, apolipoprotein B, low-density lipoprotein (LDL) cholesterol, and very-low-density lipoprotein (VLDL) cholesterol in adult patients with mixed dyslipidemia and coronary heart disease or an equivalent risk of coronary heart disease. The sponsor and the FDA had previously agreed under a Special Protocol Assessment that triglyceride-lowering data from a 12-week study with lipid end points and 50% enrollment in a cardiovascular outcome trial would be sufficient for submission of a supplemental application seeking approval for the indication as an adjunct to a statin in patients with residually high triglyceride levels. After that agreement was reached, however, several clinical trials were published showing no cardiovascular benefit from drugs that lowered triglyceride levels or increased HDL cholesterol levels (see table).

This new information called into question the clinical benefit of the triglyceride target and the rationale for using triglyceride levels as a surrogate end point for regulatory approval. These issues affect clinical decisions, since several drugs are available for lowering triglyceride levels (e.g., fibrates, niacin, and n–3 fatty