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Rethinking Healthcare.Gov:

As Covered California Goes, So Goes Nation?

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By David Johnson, CEO

The 17 state-run healthcare exchanges are real-life "laboratories" for the federally-run exchanges that operate in 34 states. No state exchange has flexed its market muscle more than California's. As an active purchaser of healthcare services, Covered California has achieved robust enrollment, moderate premium growth, high customer satisfaction and improving quality scores.

Administrators at the Centers for Medicare and Medicaid Services' (CMS) have taken notice. A February 11th National Public Radio (NPR)/Kaiser Health News (KHN) article reports that CMS has signaled through its proposed 2017 health exchange rules that it expects to be more active in standardizing health insurance plans offered for sale on the federal exchange.

Like most state-run exchanges, the federal exchanges have acted as passive clearinghouses for health plans that meet Affordable Care Act (ACA) specifications. Consumers pick and choose among multiple offerings that differ in price, deductible/co-pay levels, network participants and benefit coverage. An abundance of choice often confuses consumers and dampens enthusiasm for exchange products.

Well-functioning markets adapt to customer preferences. The refinement of the federal exchange based on successes and failures within state-run exchanges reflects a natural and elegant evolutionary process. To increase enrollment, health exchanges must work with health plans to create comprehensive, understandable insurance products that consumers want. Covered California has done just that.

Covering California Like a Blanket

With over 1.5 million members, Covered California is the nation's largest state-run exchange. It's also the most active in screening participating health plans and shaping benefit design. During its first two years of operation, Covered California rejected several health plans that met ACA participation requirements. Peter Lee, Covered California's Executive Director, describes their approach as follows:

> *"Not letting [health] plans define what's right for consumers, but defining it on behalf of consumers … is a better model for the market. We want to make sure every consumer has good choice but not infinite choice."*

Limiting choice seems counter-intuitive and perhaps un-American, but behavioral science has proven otherwise. People have a limited capacity to process choices and shut down when overwhelmed.

Too Much Jam

A famous grocery store experiment found that large-jam promotions attracted more customers than small-jam promotions, but generated substantially fewer purchases. 60% of customers tasted jams from 24-sample displays while only 40% tasted jams for 6-sample displays. On average customers sampled two jams from each display. Primed by a $1 coupon, however, 30% of small-display viewers bought jam while only 3% of large-display viewers did so.

In a corollary to health plan selection, vast investment menus embedded within company IRA programs diminish rather than stimulate employee participation. Participation increases when employers limit and shape investment choices. Behavioral finance predicts these results. Too much choice overwhelms prospective buyers and dilutes sales.

Back to California

Beyond limiting plan choices, Covered California actively manages health plan design and administration in the following ways:

- It negotiates premiums down and mandates adherence to defined quality goals
- It mandates participation in health-disparity workgroups, collection of health status data and monitoring of preventive health service use
- It standardizes co-pays and deductibles (e.g. for lab tests and doctors' visits)
- It caps monthly drug costs at $250 for gold, silver and platinum plans and $500 for bronze plans

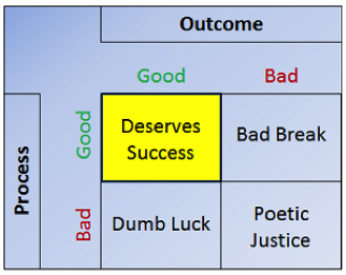
Health plans appreciate the clarity of Covered California's plan design. They understand the "ground rules." Standardization levels the playing field and facilitates the entry of new plans into the marketplace. Companies compete on price, network configuration and customer service.

Health plans also appreciate that Covered California provides access to new members. Unlike many state exchanges, Covered California aggressively markets its program to California citizens and small business. Seeing value, Californians are enrolling in record numbers. Increasing customer demand for their products increases heath plans' willingness to engage with Covered California on program design and pricing.

Another NPR/KHN article reports that Covered California is considering the adoption of quality and cost performance standards for hospitals and doctors. New provisions would require health plans to identify and expel under-performing providers. While these proposals are controversial, Peter Lee is crystal-clear on Covered California's outcomes-based goals,

> *"We are now shifting our attention to changing the underlying delivery system to make it more cost-effective and higher quality. We don't want to throw anyone out, but we don't want to pay for bad quality care either."*

Lee's statement reflects the power of market-based forces to propel American healthcare toward better care outcomes, lower costs and greater customer convenience. Winning health companies will differentiate on these performance criteria.



Process vs. Outcomes: Enlightened CMS Payment Policies

The fee-for-service payment mechanisms built into Medicare reimbursement policies are the root causes of American healthcare's fragmentation, inefficiency, waste, wide performance variation and high cost. Process-based payment formularies at best invite manipulation and at worst encourage fraud. Both providers and payors focus on revenue optimization at the expense of cost-effective provision of high-quality healthcare services. Revenue cycle programs flourish. Cost accounting investment withers.

Across all industries, government regulation works best when it establishes standards and measures participant performance against targeted outcomes-based measures. Covered California's active and outcomes-based approach works for all participants: consumers; payors and providers. It incentivizes better, higher-quality care at lower prices. It encourages prevention as well as appropriate treatment. It restrains price growth. It simplifies plan choice. It levels the competitive playing field.

As Covered California's experience demonstrates, a limited number of understandable health insurance choices increases consumer engagement and program enrollment. CMS has taken notice. It's proposed 2017 rules make the following observation,

> *"Many consumers … find the large variety of cost-sharing structures available on the Exchanges difficult to navigate. We believe that standardized options will provide these consumers the opportunity to make simpler comparisons."*

Moving to standardized plan designs is consistent with CMS's broader movement toward value-based payment for healthcare services. CMS expansion of the Medicare Advantage program, bundled payments for joint replacement surgery and value-based physician payment evidence its commitment. These initiatives are part of a national movement to employ market forces to improve American healthcare.

Unleashing American Innovation on Health-care

America's innovation engine works best when focused on delivering value to customers. "Smart" corporate, venture and private equity investment are flowing into healthcare services and provider-based services. Bottom-up, organic, market-driven competition is only force powerful enough to disrupt and replace healthcare's entrenched high-cost and inefficient business models.

Enlightened government regulation that supports market-driven reform will deliver better outcomes at lower prices. It's beyond time to give America the healthcare services the country wants and needs. It's good for the American people. It's good for American business. It's good for the American economy. Everyone wins.