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"New Paradigm" Plans for Exchange Eligibles without Affordable Options

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With Support from the California HealthCare Foundation, based in Oakland, California

August 2011

Overview

To help inform the discussion about the California Health Benefit Exchange's early strategic and operational decisions, the California HealthCare Foundation (CHCF) contrasted varying visions for the Exchange. The intent: to formulate strong alternatives that could help crystallize the implications of pursuing one path over the others. This paper is a companion to that work, and offers an additional approach to meet the needs of Exchange eligible persons who would otherwise not have affordable access.

As discussed in the CHCF papers,[1] the California Health Benefit Exchange (CHBE) might pursue one of several different strategic approaches. One option, the "change agent/catalyst exchange" strategy, would primarily pursue more efficient provision and use of existing care modalities by aligning provider incentives toward better outcomes and lower costs.[2] While this approach has promise to curtail health cost escalation, bringing it more in line with overall economic growth, neither it nor any other primary Exchange purchasing strategy is likely to greatly reduce costs in the near term.

Both the change agent/catalyst exchange and other strategic alternatives focus primarily on populations accustomed to receiving care through usual arrangements, eligible for substantial premium assistance in 2014, or both. But there is a segment of the population that, despite health reform, runs a substantial risk of remaining uninsured. That population consists of people whose

[1] California HealthCare Foundation, [Issue Brief] "Setting the Stage: Visions for the California Health Benefit Exchange," August 2011. Links to all the papers in this series may be found at http://www.chcf.org/publications/2011/08/health-benefit-exchange-visions.

[2] California HealthCare Foundation, [Issue Brief] "Change Agent: The California Health Benefit Exchange as a Catalyst of Finance and Delivery Reform," August 2011.

incomes are somewhat above federal tax-credit eligibility thresholds and who, unless dramatically lower-cost arrangements can be developed, would have no coverage and care options that are affordable relative to their incomes. Under health reform provisions, these individuals would apply to CHBE for an "affordability waiver" to remain uninsured.

The plight of this population presents a unique challenge but also a potential opportunity for the CHBE. The Exchange could solicit development of breakthrough care modalities and plans designed to greatly reduce costs for the target population. We will call these innovative pilot arrangements "new paradigm plans."

Focusing new paradigm plans on this population is sensible for several reasons. One is simply that systemwide health care reforms could not be rapid and dramatic enough to address the target population's needs for affordable health coverage and care. With a focus on this population, small-scale pilot innovations could be undertaken that are much more feasible and that, as explained later, would not compromise the calculation of federal tax credits that should make individual coverage through the Exchange affordable for 2 million Californians. Further, the lower-risk people in the target population—those who are otherwise most likely to remain uninsured—are also more likely to be willing to accept nontraditional arrangements if the cost is enough lower. (Even though new paradigm plans would include a focus on lower-cost care modalities, their goal would be outcomes as good as or better than the "mainstream" system's. Still, alternative constructs that differ from established medical models would be less comfortable for people more accustomed to using mainstream care.)

In addition to meeting the affordable-care needs of the target population, the new paradigm plans would immediately benefit many others who purchase individual coverage. This is because, under health reform, people who are low risk are disproportionately likely to apply to CHBE for waivers to remain uninsured. Even though they would be eligible for traditional "catastrophic coverage" (intended to be somewhat lower cost than "bronze" plans), it is nevertheless estimated that three out of every eight individuals eligible for an affordability waiver will choose to remain uninsured.[3] While those with expensive health conditions would generally be among the five out of eight who do participate in coverage, those who are low risk would most often decline coverage. Similarly, many healthy young adults may decline coverage. The resulting higher risk profile would raise premiums in the individual market, both inside and outside the Exchange.[4]

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[3] From figures presented in Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs*, 30, no.1 (2011):63-70 <http://content.healthaffairs.org/content/30/1/63.full.html>, the present authors calculate that about 450,000 Californians with an affordability waiver will remain uninsured. Dr. Gruber estimates that a total of about 1.2 million Californians will qualify for an affordability waiver (personal communication). Most of those who qualify for a waiver would choose to purchase coverage anyway, but about 37.5% (450,000 / 1,200,000 = 3 / 8) would choose to remain uninsured.

[4] Under PPACA, health insurance issuers/carriers are required to "consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market" [inside or outside the Exchange] "to be members of a single risk pool" and set their premium prices for all individual plans accordingly. PPACA §1312(c)(1). The same requirement applies to issuers/carriers serving the small-group market.

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Therefore, if lower-cost new paradigm plans bring a significant number of these lower-risk individuals into coverage, it would improve the risk profile and reduce premium costs for all individual coverage.

As explained later, to constructively fit within the overall health insurance reform framework, the new paradigm plans would combine insured coverage of catastrophic and preventive care with access to other services provided at a much lower cost than traditional delivery arrangements.

While it will be important to encourage innovation and not prescribe the design of these care arrangements, we offer some examples of potential paradigm shifts. The examples of alternative delivery approaches presented here are preliminary and general.

- Breaking the paradigm of face-to-face, "bricks and mortar" services for all types of health care, encourage the development of plans that rely on care provided through the least costly site or mode of care. Such a plan could be built around an array of low-cost care arrangements including low-cost convenient care settings, physicians' assistants and advanced-practice registered nurses, telehealth, self-service kiosks, teledoc-type telephone consultation, and web-based diagnostics. Such arrangements are feasible within current scope-of-practice laws.
  - *A particularly promising example of telemedicine is tele-ICU support, under which critical care doctors (intensivists) and nurses monitor and manage patients in multiple ICUs using audio, video, and electronic links. This approach could dramatically extend the utility and effectiveness of very expensive ICU physicians, and there is increasing evidence that it can decrease length of stay and mortality of ICU patients.*[5]

- Breaking the paradigm of unfettered choice of provider and treatment modality (regardless of efficacy or cost-effectiveness), constrain sites for care or impose limits on types of care. For example, for (specific) expensive procedures, such plans could require use of highly selective, cost-effective Centers of Excellence, which often might not be geographically convenient and would be outside the plan's core network of providers. For tests and procedures that can be performed more cost-effectively using more efficient technologies and equipment, such plans could limit service coverage to only the most efficient modalities.

- Breaking the paradigm of open-ended, cost-insensitive benefits, develop products that do not pay for ineffective or unnecessarily expensive treatments and service modalities. Enrollees might be asked to acknowledge at time of enrollment that the plan does not cover treatments or services that have not been shown to be efficacious for the patient's condition, with

[5] Craig M. Lilly, MD, et al., "Hospital Mortality, Length of Stay, and Preventable Complications Among Critically Ill Patients Before and After Tele-ICU Reengineering of Critical Care Processes," *JAMA*, 2011;305(21):2175-2183. Published online May 16, 2011. doi: 10.1001/jama.2011.697.

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characterizations of treatment efficacy subject to binding final determinations by expert panel(s).[6]

Such medical care and consumer measures of course are not without controversy. However, they should be less controversial if they are available through choice by middle-income persons who would otherwise have to pay highly disproportionate shares of their income for health coverage and care, and who will otherwise increase costs for others due to adverse selection and uncompensated care costs. Their participation would help lower the risk profile, and associated costs, of the insured population market-wide. However, to achieve the goals of the new paradigm construct, it would be important that new paradigm enrollees realize all of the cost savings associated with their more efficient care modalities, and not have additional costs for less efficient care shifted to them. If these savings are diluted, individuals' incentives to enroll in this coverage will be reduced, and new paradigm plans are less likely to succeed. While success would be uncertain, the potential pay-off is huge.

New Paradigm Plan Relationship to Health Reform Specifications

In order to be made available through the Exchange (or in the outside market), a new paradigm plan would have to comply with all the requirements of the new, reformed health insurance marketplace. In particular, it would have to be offered by a health insurance carrier that also offers the other four coverage levels prescribed under health reform, and its enrollees would be part of that issuer's/carrier's "single risk pool" in the individual market (and small-group market, if applicable). Thus, if a provider group or other organization wanted to develop a new paradigm plan, it would either have to become a fully licensed carrier in its own right or partner with a licensed carrier that was willing to "sponsor" the new paradigm arrangements.

In addition, the following design features would allow new paradigm plans to be viable and to be offered through the Exchange in a manner that is consistent with federal and state health reform provisions.

Limiting the Target (Eligible) Population

The population eligible for new paradigm plans would be limited to individuals who either qualify for an affordability waiver from coverage or are adults under age 30, for two reasons related to technical specifications of health reform provisions.

First, the "waiver-eligible" population will generally have incomes above the median household income in California, yet they by definition would have to pay more, often much more, than 8%

[6] Because new paradigm enrollees are not subject to the individual mandate, they are by definition choosing this plan entirely of their own volition. Thus, the plan does not constitute publicly imposed rationing. Rather, it gives people who otherwise have no affordable coverage a completely voluntary but substantially more affordable option that includes limits on wasteful spending they have agreed to in order to get coverage they can afford.

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of their income for a bronze plan that on average covers only 60% of their health care costs.[7] This target population bears the brunt of health care costs that have reached a breaking point, and its plight illustrates the need for the Exchange to do what it can to spur breakthrough innovations for more cost-effective health care delivery and financing.

Second, under the ACA, both the waiver-eligible population and adults under age 30 are eligible for catastrophic plans that are not available to tax-credit recipients and do not affect the calculation of the individual tax credits.[8] This means that innovative, dramatically lower-cost coverage and care alternatives, which likely would have limited capacity, could be made available to this population without compromising affordable access within the Exchange to the mainstream health care system and associated plans.

Target Population Size

Though targeted to only a subset of exchange participants, the eligible population should be large enough to motivate development of new paradigm plans, at least in California's population centers. While a formal estimate of the eligible population is beyond the scope of this paper, available estimates indicate that perhaps 1.2 million Californians would be eligible for the affordability waiver. In the absence of a much lower-cost new paradigm plan alternative, between 450,000 and 500,000 of them would likely remain uninsured.[9] The remaining 700,000 or so waiver-eligible individuals already projected to have coverage would also be eligible for this plan, although we would assume a relatively small percentage would choose a low-cost new paradigm plan instead of a traditional plan.

The number of adults under age 30 who do not now have employer coverage and are not eligible for Medi-Cal is an even larger group, but it seems reasonable to assume that only those in the

[7] "Affordability waivers" (exemptions from the individual mandate) are available to people whose only available health insurance options cost more than 8% of their income. But we conservatively estimate that, for example, a 60-year-old couple at 450% of poverty would have to pay over 23% of their income to enroll in a bronze plan. Most people who qualify for an affordability waiver will have incomes above the tax-credit threshold (400% of poverty). For comparison, the median household income for a family of three in California in 2009 was 369% of poverty. A few people with lower incomes might qualify despite having access to federal tax credits or employer coverage.

[8] The tax credit available to any individual or family is based on their income and on the premium for the second-lowest-cost "silver" plan. For a fuller discussion, see Rick Curtis and Ed Neuschler, "Continuity for (Former) Medi-Cal Enrollees in the California Health Benefit Exchange: Background and An Alternative Approach," Institute for Health Policy Solutions, with support from the California HealthCare Foundation, April 2011.

[9] We calculated the 450,000 figure from estimates presented in Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs*, 30, no.1 (2011):63-70 <http://content.healthaffairs.org/content/30/1/63.full.html>. Dr. Gruber estimates that about 1.2 million Californians will qualify for an affordability waiver. (Personal communication.) Not all of those who qualify for a waiver would choose to remain uninsured. Separately, we calculated the 500,000 figure from estimates presented in Matthew Buettgens and Mark Hall, "Who Will Be Uninsured After Health Insurance Reform?" The Urban Institute, March 2011. <http://www.urban.org/publications/1001520.html>

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income range somewhat above the tax-credit income threshold would generally be interested in the new paradigm plan.[10] This narrower group of 20-somethings totals around 600,000.[11]

Thus, between these two groups, we very roughly estimate that perhaps 1.8 million Californians could be the target eligible population, which seems to be an adequate number of persons to at least undertake new paradigm pilots in more populated areas of California. (Note that, for the most part, these individuals are *not* part of the Exchange's "core population" of individual tax-credit recipients.)

If successful applicants supply enough new paradigm capacity to serve additional populations (or if an additional population cohort seems advisable to reach a critical mass), new paradigm plans might also be made available to SHOP-Exchange-participating employer groups that have low average wages but are not small enough to qualify for a federal small-business tax credit.[12] This too is a population which would otherwise face disproportionate costs relative to earnings because they are above the size threshold for federal tax credits. Giving access to new paradigm plans to firms with 25-100 employees and average annualized wages up to $25,000 would increase the population eligible for such plans by perhaps 450,000 lives (workers and dependents).[13] New paradigm plans might also be of interest to larger low-wage employer groups, but would have to be offered to such groups directly, *not* through the exchange.[14]

[10] Because of the way the tax-credit amounts are calculated, reasonable assumptions regarding premiums would indicate that single adults under age 30 are unlikely to receive a tax credit if their income is above 275% or 300% of poverty. The exact threshold cannot be determined without knowing the actual premium levels in the Exchange. Since the age-rated premium for bronze-level coverage would likely fall below 5% of income around 500% FPL, it therefore seems reasonable to assume that the primarily young adult population most likely to be interested in a new paradigm plan would be those with incomes between about 275% and 500% FPL (and who do not have employer coverage).

[11] Authors' estimate using California data from the U.S. Census Bureau's Current Population Survey, 2010.

[12] Under PPACA, "catastrophic" plans can only be offered to individuals, not to small-employer groups. The cost sharing under a new paradigm plan could be adjusted to qualify at the bronze coverage level, but some way of limiting access to the desired subset of employers (i.e., to not be required to guarantee issue a new paradigm plan to any small employer) would have to be found. There is precedent for such "special project" limitations at the state level (e.g., the San Diego "FOCUS" program offered by Sharp Health Plan circa 1999-2002), but those precedents would have to be adapted to the new federal reform environment.

[13] Limiting access to firms with up to 50 employees would reduce the additional eligible population to perhaps 170,000 lives. Raising the average annual wage limit to $50,000 would increase the number of new eligibles by 140%. Authors' estimates based on special tabulations of the MEPS-IC employer survey for 2008 and 2009.

[14] Under current California law and related federal guidelines, small firms with between 51 and 100 employees will not be part of the small employer market reforms, and will not have access to the exchange until 2016. To reach these and larger low-wage employer groups (which federal law excludes from exchanges until 2017), new paradigm plans would thus need to be offered to them directly. If deemed desirable, the exchange could coordinate with such employer groups toward that end.

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Using the "Catastrophic Plan" Category

Under PPACA, both new paradigm target population groups are uniquely eligible for a lower-cost catastrophic plan.[15] But recent estimates[16] suggest that the actuarial value—and therefore the cost—of a traditional catastrophic plan meeting the statutory specifications may not differ very much from conventional high-deductible plans that could be made available at the bronze coverage level on which affordability waivers will be based (for those without access to employer coverage). New paradigm plans would involve arrangements for much lower-cost care.

Because catastrophic plans are uniquely available to the target population under PPACA, structuring new paradigm plans as catastrophic plans would automatically ensure that only the targeted population was eligible, which is necessary for the reasons presented earlier. Unless a federal waiver was obtained, this would require that the insured portion of the new paradigm plan be subject to the high-deductible out-of-pocket spending requirement.

But, to reduce the number of uninsured, new paradigm plans will have to be more attractive to the target population than a simple catastrophic plan. To accomplish this, a new paradigm plan would make available to its enrollees lower-cost delivery innovations that would reduce their out-of-pocket costs for routine care and other care received "within the deductible," that is, paid for before high-deductible insurance applies. Examples of such delivery innovations were given earlier. To make such services even more efficient and attractive to enrollees, new paradigm plans could be encouraged to investigate alternative payment arrangements such as global fees and to utilize them where they are cost-effective, consumer friendly, and permissible under applicable state rules.

Lowering the costs of more routine care used would reduce the percentage of new paradigm enrollees whose cost of care exceeds the deductible and, for enrollees who do reach the deductible, it would reduce the proportion of total costs remaining after the deductible. These factors, in addition to measures such as those outlined above to reduce costs for ineffective treatments and unnecessarily expensive service modalities, could substantially reduce premiums for the high-deductible insured plan.

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[15] While both groups are clearly eligible for a catastrophic plan under PPACA, it is uncertain whether a particular catastrophic plan could be made available to one of the groups but not the other. If not, and if a waiver cannot be obtained, inclusion of those under 30 would be a requirement rather than an option for new paradigm plans offered under the catastrophic category.

[16] In recent estimates commissioned by the Kaiser Family Foundation, one of three actuarial firms projected that the catastrophic plan design ($6,350 deductible in 2014, no coinsurance) would have an actuarial value higher than the bronze level in 2014. The other two estimates for bronze plans involved lower, though still substantial, deductibles plus coinsurance ($4,350 with 20% coinsurance or $2,750 with 30%)..The catastrophic plan design imposes *no* coinsurance once the deductible is met. See The Henry J. Kaiser Family Foundation, "What the Actuarial Values in the Affordable Care Act Mean" *Focus on Health Reform*, April 2011 (Publication #8177). <http://www.kff.org/healthreform/8177.cfm>

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Operational considerations

Pursuit of the new paradigm concept could involve a relatively small, or a more substantial, level of Exchange staff time and resources. The Exchange would not itself create or operate new paradigm plans, but could intensively advocate for and support development of such plans. Alternatively, it could limit its own activity to developing and issuing an RFP that outlines the concept, need, and opportunity, and reviewing any applications that are submitted. It might also coordinate with other purchasers potentially interested in such initiatives, such as modest-wage employers with more than 100 workers. Or it might seek technical assistance or resources from other interested entities, such as a foundation. Given its goal of promoting innovative alternative arrangements, the Exchange might want to encourage and approve different approaches in different areas of the state.

Additional demands on related core Exchange functions should be minimal. In this section, only items that differ from the discussion in the change agent/catalyst exchange paper[17] are included.

Managing eligibility and enrollment

Determining whether people qualify for an affordability waiver of the individual mandate is a task that the Exchange is already required to undertake, so no additional screening will be required to determine eligibility for new paradigm plans. If new paradigm plans were offered (only) to low-wage small employers through the SHOP Exchange, some additional screening functions would have to be performed.

Procurement issues

With respect to new paradigm plans, the Exchange would have to develop separate procurement policies that would generally encourage innovations designed to dramatically reduce costs of care, rather than prescribe specific measures. (It could well be that the characteristics of initiatives in different areas of the state would be substantially different.) But it also seems likely that the Exchange could more successfully solicit and procure dramatically different and lower-cost care arrangements if it solicits bids for only one or two new paradigm plans per area. Further, it seems realistic to anticipate that there would not be successful bidders outside of a few areas of the state, especially in the early years. If there are successful initiatives in the Exchange's early years, they could serve as models for new paradigm initiatives in other areas, and subsequently for broader application in other plans and care systems more generally as they seek ways to curtail future cost increases.

[17] California HealthCare Foundation [Issue Brief], "Change Agent: The California Health Benefit Exchange as a Catalyst of Finance and Delivery Reform," August 2011. <http://www.chcf.org/publications/2011/08/health-benefit-exchange-visions>

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Metrics for success

The success measures used by the catalyst exchange for its other plans should be tracked for new paradigm plans as well. Overall availability of and enrollment in new paradigm plans should also be tracked. In addition, given the catastrophic-only benefit design, it would be important to develop metrics to measure whether enrollees access care at an appropriately early stage of illness.

Role of the board and staffing requirements

The level of resources committed to a new paradigm initiative could vary, as has been discussed.[18] In addition, because new paradigm plans would have to be licensed in order to offer coverage through the exchange, the exchange board and its staff would also have to work with California's two regulators to develop and implement a common vision for these plans. While there are well-established performance measures and medical loss-ratio management and risk-bearing guidelines in use for qualified health plans, those elements may need to be modified or adapted to encourage development of the new arrangements envisioned here.

Integration with public programs

Federal Medicaid and California rules would not permit Medi-Cal to offer new paradigm plans, given their participant cost-sharing levels.

Risks and Unintended Consequences

Managing potential risk selection problems could be a challenge with new paradigm plans. These plans are likely to attract healthier individuals who do not have established relationships with traditional medical care delivery constructs. Other plans will therefore be particularly reliant on the risk adjustment instruments used in California after the initial years' reinsurance and risk corridors have expired. On the other hand, risk adjustment assessments should not be disproportionate relative to a new paradigm plan's more efficient, lower-cost structure for any given population. If risk adjustment cannot be adequately refined to be sufficient to this task, it could compromise new paradigm plans' realization of lower costs.

Conclusion

As a complement to its primary strategy (discussed in the CHCF paper), the change agent/catalyst exchange could also incent development of alternative care arrangements that substantially reduce costs for individuals who otherwise would be unlikely to participate in coverage, and do so without compromising affordable access for others. The new populations

[18] See the beginning of this section on operational considerations on p. 8.

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that would be covered through new paradigm plans potentially afford a unique opportunity for the development of much more efficient and higher quality health care delivery and financing systems. If new paradigm plans are accepted and appreciated by consumers, they have the potential to take root and begin to offer a genuine, lower-cost alternative to the way that care is currently delivered and financed. Because the most likely alternative to accessing care through such lower-cost approaches is going without coverage altogether, the new paradigm plan strategy can be seen as a disruptive innovation that "competes against non-consumption" for the target population.[19]

Such new types of providers and sites of care could expand capacity and improve access that would otherwise be stretched very thin with 2014's major expansion of coverage. This should help contain near-term costs for all exchange participants through an improved risk pool, as well as pioneer cost-effective innovations that could be adopted more broadly in the longer term.

The new paradigm strategy should also immediately benefit all other individuals and firms obtaining coverage. Unless dramatically lower-cost options are available to the target population, those who are healthy would be less likely to pay the "unaffordable" costs for coverage they would otherwise face. In contrast, most of those who have high-cost conditions, or who are at high risk of needing costly care, will be likely to obtain coverage despite its costs (in part because, under reform rules that prohibit health rating, premiums will still be low relative to expected medical costs for such high-risk populations). This in turn would adversely affect the risk profile and costs for all Exchange enrollees. A much lower-cost new paradigm plan should bring a significant number of healthier persons into the risk pool, lowering costs for all individual exchange enrollees.

[19] Business Innovation Factory, "Competing Against Non-Consumption: A Conversation with. Clay Christensen," <http://businessinnovationfactory.com/files/pdf/christiansenconversation1.30.06.pdf.> One example of 'competing against non-consumption' was the development, in the late 1970's, of personal computers for home customers who otherwise would have had no access to computing technology.

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