Pennsylvania's Health Insurance Exchange: Problems and Solutions

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Executive Summary

The purpose of this report is not to recommend ways to improve the operation of the Affordable Care Act (ACA). In the opinion of Citizen Power, the ACA embeds a number of inefficiencies that, in the long-term, make it a poor way to administer the healthcare system of the United States. Instead, this paper is focused on maximizing the benefits provided to Pennsylvania through efficient utilization of the current ACA regulations. More specifically, this paper examines how Pennsylvania can manage the operation of the Exchanges in a way to achieve a number of policy objectives, some of which are not in the best interest of proponents of the ACA. As a precondition for all of the recommendations contained in this report, Pennsylvania must gain control over both the plan management and consumer outreach functions of the Exchanges.

The cornerstone of the Affordable Care Act (ACA) is the creation of the Exchanges, which are intended to provide a convenient marketplace for individuals and families who do not have insurance. The yearly process for each Exchange is that the insurers first submit plans to participate on the Exchange, the administrator of the Exchange then selects the plans to participate on the Exchange from those submitted, and after that consumers select which plans they want to purchase on the Exchange's website. A supplemental function of the Exchanges is consumer outreach which is focused on making consumers aware of the Exchanges and helping them navigate the enrollment process. The establishment of the Exchanges is an especially important component of the ACA because of the individual mandate, which requires that most individuals acquire insurance or be subject to a tax penalty. The Exchanges were intended to reduce the transaction cost of acquiring insurance by providing streamlined information to consumers, calculating any available subsidies, and encouraging competition between insurers by presenting the Exchange plans on equal footing. However, the Exchanges are not necessarily limited to only facilitating the process of signing up

consumers. Included within the ACA's provisions is the ability of the operator of each Exchange to modify the functioning of the Exchange in order to achieve other policy goals. Specifically, the ACA gives the entity operating an Exchange wide latitude in both plan management and consumer outreach. Creative use of these functions can allow for Pennsylvania to achieve goals beyond those contemplated by the ACA.

The operation of a particular state's Exchange is managed either by an entity designated by the state, or if the state does not elect to administer the Exchange, the Federal Government oversees the Exchange. Currently, Pennsylvania's Exchange is operating under federal supervision. As a precondition to the recommendations contained in this report, Pennsylvania would have to obtain control over both the plan management and consumer outreach functions of the Exchange. This could be achieved either by passing legislation to move Pennsylvania's Exchange to a state-run platform or to partner with the federal government and have the federal government delegate control of plan management and consumer outreach to Pennsylvania.

Citizen Power has identified seven distinct goals that could be impacted through modifying the operation of the Exchange: making healthcare affordable for all consumers, reducing the number of uninsured, improving the quality of the healthcare, lowering the overall costs of healthcare, reducing the cost of administering healthcare, maximizing the amount of subsidies received by the citizens of Pennsylvania, and influencing the structure of the market from which healthcare is provided in order to reduce market power. However, it should be noted that the amount of impact of our recommendations is relative to the overall functioning of the ACA. In areas that the ACA has been successful in obtaining improvements, such as making healthcare more affordable and reducing the number of unemployed, our recommendations build upon these improvements. However, where the ACA has fallen short, such as in reducing the overall cost of healthcare and

stripping down redundant administrative costs, our recommendations represent only a modest improvement upon the flawed model mandated by the ACA.

We believe that each of the nine Exchanges within Pennsylvania should be administered and regulated on an individualized basis since the healthcare and health insurance markets vary widely in their operation. As an example, the healthcare market in Venango County is markedly different than in Harrisburg. The regulation of the Exchange in each location should reflect those realities. Although, we believe that each rating area needs an individualized strategy, analyzing each healthcare market in the state is outside the scope of this report. However, as an example of the strategies that we propose, we included plan management recommendations for both the Pittsburgh and Philadelphia markets, as well as statewide consumer outreach proposals.

Our specific recommendations for Pittsburgh are for the Exchange to:

- **Require Bronze, Silver, and Gold plans to have wide networks[1].**
- **Allow Platinum plans to have narrow networks.**
- **Offer one narrow Bronze, Silver, and Gold plan on each Exchange.**
- **Require Exchange Plans to Structure Copays based upon the Value of the Service.**
- **Require Exchange Plans to Waive the First 20% of the Deductible.**
- **Require Exchange Plans to Incentivize Net-Benefit Procedures.**
- **Increase Utilization Rates through Increased Access.**

Our specific recommendations for Philadelphia are for the Exchange to:

- **Require Bronze, Silver, and Gold plans to have wide networks[2].**
- **Allow Platinum plans to have narrow networks.**

[1] Except for one "budget" bronze, silver, and gold plan.
[2] Except for one "budget" bronze, silver, and gold plan.

- **Offer one narrow Silver plan on each exchange.**
- **Set minimum medical loss ratios greater than those under the ACA.**
- **Require value based hospital care.**

Our specific recommendations for consumer outreach and information are for the Exchange to:

- **Increase the Budget for Advertising and Assistance.**
- **Provide State Notice of Rate Increases.**
- **Provide Information about Off-Exchange Policies.**
- **Coordinate with Other Assistance Agencies.**
- **Notify Insureds of Potential Coverage Lapses.**
- **Use Smart Default Options and Cost-Calculators.**
- **Reach out to the Uninsured with Health Issues**

It should be noted that, in Citizen Power's opinion, these recommendations concerning the operation of the ACA in Pennsylvania are imperfect measures when compared to the potential of a single-payer system which would have both lower costs and provide universal coverage.

Introduction

The establishment of the insurance Exchanges is a central component of the Affordable Care Act (ACA). The purpose of the Exchanges is to increase the numbers of insured and reduce the cost of insurance to lower-income Americans by providing them with a convenient web-based marketplace that both offers a wide array of plan choices, along with an instantaneous calculation of the subsidies that an individual can receive. As of the end of the 2015 open enrollment period, 11.7 million consumers had selected plans through a marketplace Exchange. Of these, 10.2 million had paid their premiums and had coverage on March 31, 2015. This number is up from the 6.3 million

people who were current with their premiums at the end of 2014.[3] Approximately 85% of participants in the marketplaces are obtaining subsidies to help pay for premiums while 57% of participants are receiving cost-sharing subsidies to reduce the cost of out-of-pocket expenses through the provisions of the ACA.[4] Specifically, anyone purchasing a marketplace plan that has a household income of below 400% of the federal poverty level is eligible for premium assistance. Similarly, anyone under 250% of the federal poverty level is eligible for help to pay out-of-pocket expenses if they purchase certain eligible plans.

427,454 individuals received coverage in Pennsylvania, of which 81.6% received tax credits to help pay for premiums and 57.3% qualified for subsidies to assist with out-of-pocket costs.[5] The average premium assistance in Pennsylvania for an individual was $2724 per year, which is less than the $3264 national average.[6] Pennsylvania's shortfall in premium subsidies as compared to the average subsidies nationally is over $188 million annually. There are four plan levels offered in the Exchanges: Bronze, Silver, Gold and Platinum. The majority of customers in Pennsylvania's marketplace purchased a Silver plan, which is understandable given that a Silver plan is a prerequisite for cost-sharing subsidies.[7]

The purpose of this paper is to look at the operation and results of the ACA generally, to investigate the functions of an Exchange, to propose a list of goals for Pennsylvania in its administration of the Exchanges, to examine the current healthcare environment, and to propose solutions to make the operation of the ACA work more effectively for the consumers of

[3] Centers for Medicare & Medicaid Services. March 31, 2015 Effectuated Enrollment Snapshot, *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.
[4] Centers for Medicare & Medicaid Services. March 31, 2015 Effectuated Enrollment Snapshot, *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.
[5] Centers for Medicare & Medicaid Services. March 31, 2015 Effectuated Enrollment Snapshot, Table 1, *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.
[6] Centers for Medicare & Medicaid Services. March 31, 2015 Effectuated Enrollment Snapshot, Table 2, *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.
[7] Centers for Medicare & Medicaid Services. March 31, 2015 Effectuated Enrollment Snapshot, Table 3, *available at*: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.

Pennsylvania. It should be noted that, in Citizen Power's opinion, these adjustments to the operation of the ACA in Pennsylvania are imperfect measures when compared to the potential of a single-payer system which would have both lower costs and universal coverage.

Though the focus of this paper is on the operation and regulation of the individual market Exchanges, it needs to be noted that there are two kinds of Exchanges under the ACA, one for individuals and another for small businesses. The Small Business Health Options Program ("SHOP") marketplace has been created by the ACA and is designed to function as an Exchange for employees of small businesses. Under the Affordable Care Act, there are three categories of businesses. Larger employers with 100 or more employees must provide quality coverage to 70% of their employees in 2015 and 95% of their employees in 2016. Employers with 50 or more employees do not have to provide coverage to their employees in 2015, but have to provide coverage to 95% of their employees in 2016. Employers with less than 50 employees, which are about 96% of all employers, do not have to provide any health insurance for their employees.[8] Although employers with less than 50 employees are not required to provide coverage for their employees, if they choose to do so they have the option of participating in the SHOP Exchange which, in some circumstances, provides the employer with a Small Business Health Care Tax Credit. As of September 2015, there are only approximately 200,000 participants in the SHOP Exchanges nationwide.[9] Although this paper does not directly address the operation of Pennsylvania's SHOP marketplace, it should be noted that the SHOP marketplace is subject to the same limited competition as found in the individual Exchanges. Though Pennsylvania should develop an individualized strategy for regulating the SHOP marketplace, many of the techniques would likely be similar to those recommended in this paper for the individual markets.

[8] U.S. Treasury Department. Fact Sheet: Final Regulations Implementing Employer Shared Responsibility Under the Affordable Care Act (ACA) for 2015, *available at*: http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf.
[9] www.acasignups.net.

I. ACA Overview

In March of 2010, the ACA was signed into law. The ACA is an extremely complex law which marked a significant change in the regulation of the healthcare and health insurance industries. The 906 page document included numerous provisions[10] including:

- Guaranteed issue which requires that policies do not deny coverage for persons with pre-existing conditions.
- Community rating which does not allow plans to base the premium amount upon anything other than age, location, and smoking status of the applicant and limits the degree to which premiums can vary from each other.
- An expanded list of essential health benefits that are required to be covered by all policies.
- An individual mandate requiring most citizens to have health insurance or face a tax penalty.
- The elimination of lifetime and annual policy benefit limits.
- Allowing dependent children to stay on their parent's insurance until they are 26.
- Rescissions (canceling a plan) for unintentional mistakes in applications have been banned.
- Allowing plan participants to designate a primary care physician as their provider.
- Expanding Medicaid to individuals and families up to 138% of the poverty level.[11]
- An employer mandate requiring larger employers (in 2015 those with 100 or more employees and in 2016 those with 50 or more employees) to provide coverage to their employees or pay a tax penalty.
- Minimum medical loss ratios which require policies to pay a certain percentage of the premium revenue towards health expenditures (80% for small group and individual plans).
- The creation of health insurance Exchanges through which some individuals and families could qualify for subsidies on premiums and out-of-pocket expenses.
- The elimination of higher copayments or coinsurance for emergency services that are out of network.
- The reduction of the Medicare Part D coverage gap until it is eliminated by January 1, 2020.

[10] Some of these provisions only apply to policies purchased after March 22, 2010.

[11] As a result of the Supreme Court decision in *National Federation of Independent Business v. Sebelius*, states are allowed to opt-out of the expansion of Medicaid. Pennsylvania is one of the states that did so, though they expanded Medicaid starting January 1, 2015.

The successful implementation of the ACA depends heavily on the establishment of Exchanges which allow consumers to compare and purchase qualified health plans (QHPs) on an apples-to-apples basis. Although some of the requirements of the ACA, such as guaranteed issue, could be made independent of the Exchanges, ultimately the success or failure of the ACA will be determined by the effectiveness of the Exchanges in achieving the goals of the ACA.

II. Goals of the ACA

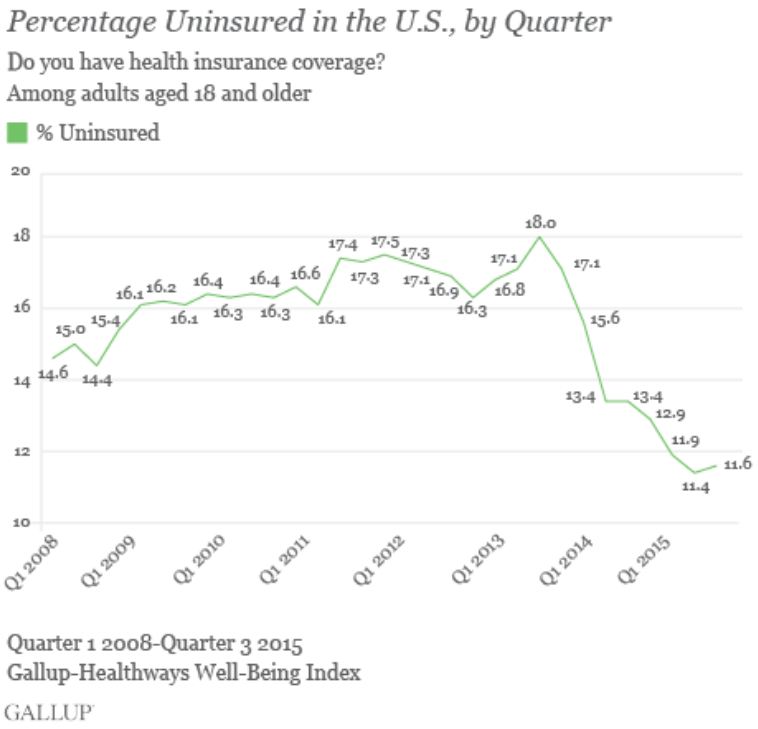
With President Barack Obama's signing of the Affordable Care Act into law in March of 2010, the provision of health care services as well as the health insurance industry in America has been significantly altered. So far, it can be said that the impact of the ACA have been mixed. The four main stated goals of the ACA were to reduce the number of the uninsured, to make healthcare more affordable, to lower the overall cost of healthcare, and to improve the quality of healthcare.[12]

a. Number of uninsured

The number of uninsured individuals has decreased significantly due to the subsidies available on the market, the potential tax penalties for not obtaining health insurance, the expansion of Medicaid, and the expansion of dependent age coverage through the 25th year. The percentage of uninsured individuals has decreased from 15.4% in 2012 to 13.3% in 2013 to 10.4% in 2014.[13,14] A

[12] Some commentators combine affordability and reducing the number of uninsured into one goal, *see*: The National Law Review. Vincent, G. Breaking Down the Affordable Care Act. *Available at*: http://www.natlawreview.com/article/breaking-down-affordable-care-act.
[13] United State Census Bureau. Smith, J.C. and Medalia, C. Health Insurance Coverage in the United States: 2014. September 2015. Pg 7, Table 2. *Available at*: http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.
[14] The New York Times, September 17, 2013. Pear, R. Percentage of Americans Lacking Health Coverage Falls Again. *Available at*: http://www.nytimes.com/2013/09/18/us/percentage-of-americans-lacking-health-coverage-falls-again.html?_r=0.

survey of individuals has similarly found that the number of uninsured has dropped since the beginning of the Exchanges.[15]



The number of people who did not have any insurance in 2014 was 33 million, of which 7 million were undocumented immigrants who are not eligible for coverage under the ACA, 3.8 million who fell in the Medicaid gap, and 7.7 million who were young adults.[16] Of the people participating in the Exchanges, more than half of them were uninsured prior to obtaining their new coverage.[17]

b. Affordability of coverage

[15] Note that different methodologies result in slightly different uninsured percentages. Gallup, for instance, uses a survey to determine the rate of uninsured. GALLUP. Marken, S. U.S. Uninsured Rate at 11.6% in Third Quarter. *Available at*: http://www.gallup.com/poll/186047/uninsured-rate-third-quarter.aspx?g_source=CATEGORY_WELLBEING&g_medium=topic&g_campaign=tiles.

[16] FiveThirtyEight. Barry-Jester, AM. And Casselman, B. 33 Million Americans Still Don't Have Health Insurance. September 28, 2015. *Available at*: http://fivethirtyeight.com/features/33-million-americans-still-dont-have-health-insurance/#fn-2.

[17] Alliance for Health Reform and The Commonwealth Fund. July 1, 2015 Briefing. Jost, T., Lee, P., Webb, B., and Lucia, K. The ACA: Experiences in Health Care Coverage and Access. Transcript, Pg. 2. *Available at*: http://allhealth.org/briefingmaterials/TRANSCRIPT7115_0Q.PDF.

Health insurance premiums have also become more affordable for a greater number of individuals. 86% of individuals participating in the health Exchanges have received a subsidy which is applied to premium payments, though these savings have been mitigated to some extent by the generally higher out-of-pocket expenses faced by those participating in the marketplaces, especially those found at the lower metal level policies.[18] On the other hand, premiums have increased under the ACA. For marketplace plans, the average second lowest-cost Silver plan premium has increased 4% from the 2014 coverage year to the 2015 coverage year.[19] A preliminary analysis of the anticipated rates for 2016 in eleven major cities finds an estimated 4.4% increase in the benchmark Silver plan.[20] However, a more comprehensive study found that the rate increases were between 12-14%, though this figure will be a bit high because it does not account for individuals switching from their current plan to a lower priced one in response to rate increases.[21] These rate increases are slightly higher than the rate increases before the ACA.

In addition, many people have had problems paying the higher out-of-pocket costs under the ACA. One study found that people are paying more out-of-pocket costs than any time in the last decade, independent of whether they are purchasing insurance on their own or it is provided by their employer. Two in five people with high deductibles (5% or more of their income) reported that they went without testing or treatment because of cost.[22]

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[18] The New York Times. Pear, R. 86 Percent of Health law Enrollees Receive Subsides, White House Says. March 10, 2015. *Available at*: http://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html?_r=0.

[19] The Henry J. Kaiser Family Foundation. Cox, C., Levitt, L., Claxton, G., and Duddy-Tenbrunsel, R. Analysis of 2015 Premium Change in the Affordable Care Act's Health Insurance Marketplaces. January 6, 2015. *Available at*: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/.

[20] The Henry J. Kaiser Family Foundation. Cox, C., Ma, R., Claxton, G., and Levitt, L. Analysis of 2016 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces. June 24, 2015. *Available at*: http://kff.org/health-reform/issue-brief/analysis-of-2016-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.

[21] Gaba, C. 2016 Rate Increases: Where Things Stand Nationally/State-by-State (12-14% overall). *Available at*: http://acasignups.net/15/08/28/2016-rate-increases-where-things-stand-nationallystate-state.

[22] The Commonwealth Fund. Collins, SR., Rasmussen, PW., Doty, MM., and Beutel, S. Too High a Price: Out-of-Pocket Health Care Costs in the United States – Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-

c. Cost of healthcare

The goal of reducing overall medical costs has not yet been successful and projections of future spending estimate that it will outpace increases in the gross domestic product. According to the Centers for Medicare and Medicaid Services (CMS), overall medical spending increased 5.5% in 2014 and is estimated to increase 5.8% per year between 2014 and 2024.[23] One of the main reasons for this is that the ACA's provisions intended to reduce medical costs are not nearly as extensive as the provisions intended to increase participation in insurance or those provisions to make healthcare affordable. The ACA does little to address the two main drivers of healthcare costs, the higher administrative costs in the United States due to the existence of a private insurance system and the use of inefficient mechanisms to reduce medical expenses.

The administrative costs related to health insurance are elevated partially because of the high salaries of the over 460,000 employees who work in the health insurance industry.[24] However, the administrative costs associated with the health provision system used in the United States are not limited to the costs of operating the enormous health insurance industry. There are also administrative costs imposed upon the health care providers themselves in having to interact with the health insurers. This drives up the total administrative costs far in excess of other countries that are based upon the government administration of insurance. For instance, one study found that in

October 2014. November 2014. *Available at*: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf.

[23] Centers for Medicare & Medicaid Services. 2014-2024 Projections of National Health Expenditures Data Release. July 28, 2015. *Available at*: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[24] Fortune. Pfeffer, J. Why Health Insurance Companies are Doomed. October 20, 2014. *Available at*: http://fortune.com/2014/10/20/health-insurance-future/.

1999 the total administrative costs accounted for 31% of health care expenditures in the United States, while the corresponding number in Canada was 16.7%.[25]

Additionally, medical expenses are higher than in other countries because of the excessive use of new medical technologies and the lack of administrative mechanisms to keep prices down. In Europe and Canada, the cost of using similar medical technologies is much less. Despite the lower per use cost, hospitals are less likely to use such technologies, which reduce the overall cost further. Even though they have lower utilization rates of advanced technologies, their clinical outcomes are the same or better than those found in the United States.[26]

d. Quality of healthcare

It is difficult to assess the quality of healthcare between countries. Although the United States has lower life-expectancies than many other developed countries, it is difficult to determine whether that is attributable to the healthcare system or lifestyle differences. On the other hand, looking at survival rates for particular conditions may give an idea of how well that condition is treated, but does not address how adequately a healthcare system has prevented the condition in the first place. Although our healthcare system is overpriced, the quality of care ranges widely, with the total quality similar to other developed nations in that it has its strengths and weaknesses.[27] However, the overall quality of our healthcare is impacted by the fact that the uninsured have poorer health outcomes than the insured in this country. The main way the ACA will improve the

[25] New England Journal of Medicine 2003; 349:768-75. Woolhandler, S., Campbell, T., and Himmelstein, D. Costs of Health Care Administration in the United States and Canada. *Available at*: http://www.nejm.org/doi/pdf/10.1056/NEJMsa022033.
[26] American College of Physicians. Ginsburg, J. Controlling Health Care Costs While Promoting the Best Possible Health Outcomes. 2009. *Available at*: https://www.acponline.org/acp_policy/policies/controlling_healthcare_costs_2009.pdf.
[27] The Robert Wood Johnson Foundation and the Urban Institute. Docteur, E. and Berenson, RA. How Does the Quality of U.S. Health Care Compare Internationally? August 2009. *Available at*: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411947-How-Does-the-Quality-of-U-S-Health-Care-Compare-Internationally-.PDF.

quality of healthcare is by increasing the amount of access to our healthcare system for currently underserved segments of the population.

Beyond more people getting care, the ACA does little to improve the care received by those with insurance. For example, the ACA does not mandate value-based healthcare provision models. In Pennsylvania, as well as most other states, the pay-for-service model is prevalent, which simply reimburses providers a fixed amount for services rendered. The main problem with this payment system is that it incentivizes medical providers to maximize their revenue by maximizing the services they provide, especially high-margin diagnostic services. Alternative service models, such as accountable care organizations which incentivize improved outcomes through increased payments to providers, have been shown to reduce overall medical costs while improving healthcare outcomes.[28]

III. Functions of the Exchange

Under the ACA, an Exchange, whether managed by the federal government or the state, has a number of required functions that must be performed. Specifically, an Exchange must:

- Certify plans are qualified health plans;
- Provide an individual and small group insurance Exchange portal (or combined portal);
- Present plan options in a standardized way (i.e., Platinum, Gold, Silver, and Bronze);
- Assign a quality rating to each qualified health plan;
- Provide electronic resources (e.g., cost calculators) and toll-free call center support to users of the Exchanges' Web portals;

[28] NueMD. Clarke, C., How the Affordable Care Act Will Affect Provider Reimbursement. *Available at*: http://www.nuemd.com/blog/affordable-care-act-will-affect-provider-reimbursement.

- Administer an exemption process for the individual mandate requirement;
- Determine eligibility for and enroll applicants in Medicaid and the Children's Health/Insurance Program;
- Determine eligibility for new tax credits and cost-sharing reductions;
- Facilitate advance payments of premium tax credits by the Department of Treasury to insurers;
- Determine whether employer-sponsored insurance is "affordable," i.e., less than 9.5% of household income;
- Establish a navigator program to facilitate enrollment in qualified health plans;
- Operate a consumer assistance program;
- Report user and employer data to Department of Treasury; and
- Generate sufficient revenue to be self-sustaining.[29]

These functions do not have to be performed solely on either the federal or state level. For example, a federally-facilitated Exchange could delegate the consumer assistance program to the state or a state Exchange could receive assistance from the federal government in determining eligibility for new tax credits. Some of these functions, such as reporting user and employer data to the Department of Treasury, do not provide wide latitude in the way they are performed. Although the process of reporting data can be made more efficient, the content of the data is determined by the Department of Treasury and is the same both under the standard federally-facilitated Exchanges and state-run Exchanges. Other functions, such as the certification of qualified health plans, can be performed in a variety of ways with significant impacts on the operation of Exchanges. It is these "flexible" functions that the rest of this paper is focused on.

[29] Members of the Technical Advisory Committee to the Maryland Citizens' Health Initiative. DuGoff, EH., and Weiner, J. Demystifying Active Purchasing: Tools for State Health Insurance Exchanges, pg. 8. November 14, 2011. *Available at*: http://healthcareforall.com/wp-content/uploads/2011/11/Active-Purchasing-and-HIEs-White-Paper-MCHI-TAC-Final-11-14-11.pdf. *citing*: The Commonwealth Fund. Silow-Carroll, S., Rodin, D., Dehner, T. and Bern J. Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection.

IV. State Options for Operating the Exchanges

For the 2015 coverage year, 16 states and the District of Columbia are operating state-run Exchanges while 34 states are operating some variation of a federally facilitated Exchange.[30] However, there are five main variations of these two basic types of Exchanges: 1) a standard federally facilitated Exchange; 2) a state-federal partnership Exchange; 3) a bifurcated Exchange; 4) a state-run Exchange with federal assistance; and 5) a standard state-run Exchange. Pennsylvania currently has a standard federally facilitated Exchange, which is the most popular model used with 26 states relying on the federal government to establish and operate their Exchange. Six states have decided to use a state-federal partnership Exchange. Under this approach the federal government has ultimate responsibility for the operation of the Exchange, but the state is responsible for the consumer assistance and/or the plan management aspects of the Exchange.[31] Utah and Mississippi both operate a bifurcated Exchange where they are responsible for the SHOP Exchange and the federal government runs the marketplace for individual coverage.[32] Four states utilize a state-run Exchange with federal assistance. In these states, the state is responsible for running the Exchange, but they use the federal healthcare.gov website in lieu of operating a state Exchange website. Finally, twelve states and Washington D.C. operate a standard state-run Exchange, where the state is in charge of all of the tasks that an Exchange is required to perform under the ACA.[33]

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[30] National Conference of State Legislatures. 2015 State Legislation on Health Exchanges/Marketplace Structure, *available at:* http://www.ncsl.org/Documents/Health/Changes_in_Health_Exchange_Structure-2015-_Final2.pdf.

[31] Michigan has received approval to move to a partnership exchanges, but has not done so for the 2016 plan year. National Conference of State Legislatures. State Actions to Address Health Insurance Exchanges, August 12, 2015, *available at*: http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

[32] Technically, Arkansas is also operating a state-run SHOP exchange with a federally facilitated individual exchange in 2016 as part of a move to a completely state-run exchange in 2017. National Conference of State Legislatures. State Actions to Address Health Insurance Exchanges, August 12, 2015, *available at*: http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

[33] National Conference of State Legislatures. State Actions to Address Health Insurance Exchanges, August 12, 2015, *available at*: http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

Although the Department of Health and Human Services (HHS) has indicated in its November 29, 2011 guidance that it intends to work with states that have Federally-facilitated marketplaces in order to preserve the traditional responsibilities of the state insurance departments, states that have a greater role in managing the marketplace have more flexibility in interpreting the regulations related to the operation of the Exchange. This may explain why states that have a role in managing their Exchange have greater reductions in the number of uninsured.

Although there are benefits inherent in a state operating its Exchange, the costs can also be high. California, for example, spends about $330 million annually on its Exchange, split almost equally between IT, customer service, and marketing.[34] Although the states operating Exchanges have in the past been supported by almost $5 billion dollars in federal grants; that funding ended at the beginning of 2015. As a result, *almost half of the state Exchanges are projected to be in financial trouble going forward*.[35] Part of the underestimated costs relating to the state Exchanges has been problems with developing and smoothly running their state run marketplace platforms. This has led Oregon, Nevada, and Hawaii to discard their state-based website while remaining a state-run Exchange in other respects in an effort to cut costs.[36]

V. Pennsylvania's Operation of the Exchanges

Pennsylvania operates under a standard federally facilitated Exchange model; however, this does not mean that it is completely removed from the operation of the Exchange. Forty six states,

[34] Alliance for Health Reform and The Commonwealth Fund. July 1, 2015 Briefing. Jost, T., Lee, P., Webb, B., and Lucia, K. The ACA: Experiences in Health Care Coverage and Access. Transcript, Pg. 15. *Available at*: http://allhealth.org/briefingmaterials/TRANSCRIPT7115_0Q.PDF

[35] The Washington Post. Sun, LH. and Chokshi, N. Almost Half of Obamacare Exchanges Face Financial Struggles in the Future. May 1, 2015. *Available at*: https://www.washingtonpost.com/national/health-science/almost-half-of-obamacare-exchanges-are-struggling-over-their-future/2015/05/01/f32eeea2-ea03-11e4-aae1-d642717d8afa_story.html.

[36] National Conference of State Legislatures. State Actions to Address Health Insurance Exchanges, August 12, 2015, *available at*: http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx.

including Pennsylvania, have received rate review authority from the federal government.[37] Though this authority gives the Pennsylvania Insurance Department (PID) the ability to review rates in Pennsylvania, this review is largely limited to determining whether the rates are reasonable based on an analysis of the projected costs of administering the plan versus the projected income from premiums.

States with a federally facilitated Exchange also have flexibility in adjusting the factors that insurers are allowed to consider when setting premium rates. Currently, under the ACA, premiums for a non-grandfathered plan can only vary to account for 1) whether the insured is an individual or a family, 2) tobacco use, 3) age of the insured, and 4) location of the insured. The federal government has set standards regarding how each of these factors impact premiums. For example, the premium rates for a smoker cannot be more than 1.5 times the rate for a non-smoker, the rates for those aged 64 and older cannot be more than 3 times the rate for someone who is 21. However, the ACA leaves states some flexibility to modify these rules under 45 CFR 147.103. Since a state does not have to operate a state-run Exchange in order to adjust the impact of these factors, a majority of the states have chosen to modify the federal default approach for at least one of the factors.[38]

Although a state with a federally-facilitated Exchange has some tools at its disposal to impact the operation of the Exchange, the number of tools expands exponentially with the operation of a state-run Exchange or a state-federal partnership Exchange. A state-run Exchange can determine how to implement the functions listed in Section III of this report. For example, a state-run Exchange can determine which plans are offered on the Exchange and choose how to spend marketing funds

[37] The Henry J. Kaiser Family Foundation. Rate Review Processes in the Individual and Small Group Markets, *available at*: http://kff.org/health-reform/state-indicator/rate-review-program-effectiveness/.

[38] The Commonwealth Fund. Giovannelli, J., Lucia, KW., Corlette, S. Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market. December 2014. *Available at*: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1795_giovannelli_implementing_aca_state_premium_rate_reforms_rb_v2.pdf?la=en.

in order to achieve the goals set by the state. However, legislation to replace Pennsylvania's federally facilitated Exchange with a state-run exchange has been unsuccessfully introduced in 2011, 2013, and 2015.[39] In addition, Pennsylvania asked for conditional approval to move to a state-run Exchange on May 1, 2015 as part of a contingency plan in case the Supreme Court overturned *King v. Burwell*, which would have required states to operate an Exchange in order to allow for individuals in those states to qualify for subsidies.[40] However, in a 6-3 decision, the Supreme Court upheld the ability of individuals purchasing insurance on federally facilitated Exchanges to continue to receive subsidies.[41] Although Pennsylvania had received permission to move to a state-run system,[42] Pennsylvania withdrew its plan in response to this ruling. Governor Tom Wolf has stated that using the federal Exchange was less expensive then setting up a state Exchange.[43]

Pennsylvania is currently investigating the possibility of moving to a state-federal partnership Exchange. Although the decisions in a state-federal partnership are ultimately the responsibility of the federal government, states are typically given the task of operating specific functions of the Exchange. Under a partnership Exchange, Pennsylvania envisions itself performing the plan management functions of the Exchange. A key advantage of a partnership Exchange is that it would

[39] National Conference of State Legislatures. 2015 State Legislation on Health Exchanges/Marketplace Structure, *available at:* http://www.ncsl.org/Documents/Health/Changes_in_Health_Exchange_Structure-2015-_Final2.pdf, 2014 State Legislation to Establish a State-Run Exchange, *available at*: http://www.ncsl.org/documents/health/states2014billsestablishstaterunexchange.pdf, and Health Reform: 2011-2013 State Legislative Tracking Database, *available at*: http://www.ncsl.org/research/health/health-reform-database-2011-2013-state-legislation.aspx.

[40] Tom Wolf to Sylvia Burwell, May 1, 2015, *available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/PA-Dec-Letter.pdf.

[41] *King v. Burwell*, 576 U.S.____(2015).

[42] Sylvia Burwell to Tom Wolf, June 15, 2015, *available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Signed-Letters-SBM-PA.pdf.

[43] Overland, Dina. Did King v. Burwell ruling just kill state-based exchanges?, FierceHealthPayer, June 25, 2015, *available at*: http://www.fiercehealthpayer.com/story/did-king-v-burwell-ruling-just-kill-state-based-exchanges/2015-06-25.

not require legislative approval, which may be difficult to obtain given the current composition of the legislature.[44]

VI. Proposed Pennsylvania Regulation Goals

In order to examine the regulatory options available to Pennsylvania, the goals of healthcare regulation need to be revisited. The stated goals of the ACA, making healthcare affordable, reducing the number of uninsured, improving the quality of the healthcare, and lowering the costs of healthcare, are clearly beneficial to Pennsylvanians. However, when looking at the regulatory options in the context of what can be done under the ACA, Pennsylvania can go beyond achieving the stated goals of the ACA and can adopt other policy goals. Specifically, Pennsylvania could also focus on reducing the cost of administering healthcare, maximizing the amount of subsidies received by the citizens of Pennsylvania, and influencing the structure of the market from which healthcare is provided.

Although some administrative costs are necessary in the functioning of a healthcare service system, the amount of administrative costs in the United States are unjustifiable. Reductions in administrative overhead should specifically be targeted by Pennsylvania in its regulation of the Exchanges. Similarly, federal subsidies benefit both the insureds and the healthcare system and need to be considered in Exchange design. There are three main subsidies that Pennsylvania should target: the premium subsidies that are available to most individuals purchasing insurance on the Exchanges, the cost-sharing subsidies available to those with Silver plans and who earn under 250% of the FPL, and the subsidies associated with the Medicaid expansion. All newly eligible individuals

[44] Comments of Pennsylvania Insurance Commissioner Theresa D. Miller at the Pennsylvania Health Action Network conference in Harrisburg, Pennsylvania on September 21, 2015.

who enroll into Medicaid are subsidized 100% by the federal government through 2016. After that, the federal government pays no less than 90% of the costs, with the Congressional Budget Office estimating that over the period from 2014-2022 the government will pay 93% of the total costs.[45]

Some of these goals are interrelated. For instance, a reduction in the number of the uninsured results in more individuals receiving subsidies from the Federal Government. In addition, if more people are insured there are less people without insurance being treated at Pennsylvania's medical facilities. Since medical facilities typically have to write off large portions of the expense resulting from uninsured patients, the cost of providing services to the uninsured is typically shifted onto other patients. Thus having fewer uninsured also lowers overall system costs. From Pennsylvania's perspective, the operation of the ACA has a different cost and benefit calculus than when looking at the impact of the ACA on the nation. Specifically, it is in the best interest of Pennsylvania to maximize the subsidies received both related to the number of people who receive subsidies and the amount of subsidies per person. In addition, health care costs should be limited to the extent possible while maintaining quality health care through requiring insurers to incentivize effective health care over less efficient solutions. It is our opinion that the operation of Pennsylvania's Exchange should be directed to improving the metrics in these seven areas:

a. Number of uninsured

A major goal of the ACA is to make health insurance affordable for everyone and therefore reduce the number of uninsured and underinsured. The cost of the failure to insure everyone has two major negative impacts. First of all, the uninsured receive less preventative and early diagnostic support while being less likely to seek medical attention when problems do arise. This often results in the uninsured having more severe medical issues when they ultimately are treated and/or greater

[45] Center on Budget and Policy Priorities. Angeles, J. How Health Reform's Medicaid Expansion Will Impact State Budgets. July 25, 2012. *Available at*: http://www.cbpp.org/research/how-health-reforms-medicaid-expansion-will-impact-state-budgets.

impacts on quality of life and life expectancy. One study estimated that between 2000 and 2006, 137,000 people died unnecessarily because they did not have health insurance.[46] Secondly, the costs of providing emergency medical treatment to the uninsured are usually not collectable, leading to negative credit implications for the uninsured individual while creating increases in uncompensated care expenses for hospitals. The total medical spending on the uninsured population in 2013 was $121 billion, of which $25.8 billion was recouped through out-of-pocket spending by the uninsured.[47] In 2013, the amount of uncompensated care for community hospitals was $46.4 billion dollars representing 5.9% of the total expenses.[48] It should be noted that some of these uncollectable expenses resulted from covered individuals not being able to afford out-of-pocket expenses. Before the implementation of the ACA, 41% of the population reported that they had medical debt or problems paying medical bills.[49] Of the bad debt incurred, in 2013 the average recovery rate for hospitals was only 15.3%.[50] In total, the average uncompensated care received per person was $1,702 for full-year uninsured individuals versus $232 for full-year insured individuals.[51]

From Pennsylvania's standpoint, reducing the number of uninsured persons needs to be a fundamental goal of the Exchanges. Since many of the uninsured are eligible for subsidies, much of the cost of insurance is passed along to the federal government while the benefits remain in

[46] Urban Institute. Dorn, S. Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality. Pg. 3, Table 2. January 2008, *available at*: http://www.urban.org/research/publication/uninsured-and-dying-because-it/view/full_report.

[47] The Henry J. Kaiser Family Foundation. Coughlin, TA., Holahan, J., Caswell, K., and McGrath, M. Uncompensated Care for Uninsured in 2013: A Detailed Examination. May 2014. Pg. 3. *Available at*: https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf.

[48] American Hospital Association. American Hospital Association Uncompensated Hospital Care Cost Fact Sheet, January 2015, *available at*: http://www.aha.org/content/15/uncompensatedcarefactsheet.pdf.

[49] The Commonwealth Fund. Collins, Sara R.; Robertson, Ruth; Garber, Tracy; and Doty, Michelle M., Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act – Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2012, Pg. 6, *available at*: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/apr/1681_collins_insuring_future_biennial_survey_2012_final.pdf.

[50] ACA International, the Association of Credit and Collection Professionals, Healthcare Collection Statistics, *available at*: http://www.acainternational.org/products-healthcare-collection-statistics-5434.aspx *citing*: ACA International's Top Collection Markets Survey, Jan. 1 – Dec 31, 2013.

[51] The Henry J. Kaiser Family Foundation. Coughlin, TA., Holahan, J., Caswell, K., and McGrath, M. Uncompensated Care for Uninsured in 2013: A Detailed Examination. May 2014. Pg. 2. *Available at*: https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf.

Pennsylvania. Targeted Exchange regulation, as described below, can reduce the costs of insurance and result in higher insurance enrollment rates. Increased and innovative marketing can also be used to further reduce the number of the uninsured.

b. Quality of care

The ACA does provide incentives to improve the quality of care provided to patients. However, the majority of these programs are targeted at the Medicare segment and do not impact the ACA Exchanges. An example of one of these programs is the Hospital Readmission Reduction Program which reduces Medicare reimbursement payments for hospitals that have higher rates of readmissions for certain types of hospitalizations.[52]

Similar quality metric programs can be required of insurance plans participating in the Exchanges, but only in cases where the state is involved in the plan management function. An example of a quality metric program would be if Exchange plans' reimbursement rates to hospitals for certain procedures were based upon an outcome, such as the number of patients re-admitted for the same procedure. Those hospitals with lower re-admissions would get a higher reimbursement rate and vice-versa. Although the ACA uses quality metric programs for Medicare coverage, Pennsylvania could benefit from a program to limit readmissions for Exchange plans. Current statistics indicate very mixed results for readmission rates in Pennsylvania between 2008 through August of 2014.[53]

c. Cost of healthcare

[52] JAMA October 26, 2011 – Vol. 306, No 16. Pg. 1795. Kocher, RP. And Adashi, EY. Hospital Readmissions and the Affordable Care Act: Paying for Coordinated Quality Care. *Available at*: https://monroecollege.edu/uploadedFiles/_Site_Assets/PDF/hospital%20readmissions%20and%20the%20affordable%20care%20act_JAMA.pdf.

[53] PA Health Care Cost Containment Council. Readmissions for the Same Condition: January – August 2014 Data, pg. 44-45. *Available at*: http://www.phc4.org/reports/readmissions/samecondition/14/docs/full-report.pdf.

The ACA has a stated primary goal of lowering the cost of healthcare, though many health policy experts disagree about whether the programs under the ACA will have any significant impact on costs. One of the main ways the ACA intends to reduce costs is by increased competition through the healthcare Exchanges. Other programs under the ACA include taxes on high-priced plans, limits on Medicare increases, prevention and wellness programs, and increased monitoring of Medicare and Medicaid for fraud.[54] In totality, the proposed programs have been described as having slowed down the growth of healthcare costs as opposed to actually lowering costs.[55]

However, one of the potential drivers keeping healthcare costs down is the high out-of-pocket expenses encountered by those shopping on the Exchanges. Although the intent of higher deductibles, co-insurance, and co-pays is to incentivize the insured to only ask for necessary services and use lower priced providers, insureds may also forgo necessary procedures because they are unaffordable. A number of studies have found that higher out of pocket costs result in lower levels of spending on healthcare and the only study investigating why spending decreased indicated that the primary reason is insureds forgoing medical services. There was no evidence of insureds shopping for better prices and only a minor impact from patients substituting cheaper procedures for more expensive ones. Furthermore, the evidence indicates that consumers reduce all types of care across the board, including both valuable and wasteful care.[56]

Assuming plan management control, Pennsylvania can at least partially impact the cost of healthcare through the Exchanges by careful plan and benefit selection. Specifically, Pennsylvania

[54] Robert Wood Johnson Foundation. Health Policy Snapshot Health Care Costs. Issue Brief July 2011. *Available at*: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71451.
[55] Urban Institute. Zuckerman, S. and Holahan, J. Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs. October 2012. *Available at*: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Costs.PDF.
[56] National Bureau of Economic Research. Brot-Goldberg, ZC., Chandra, A., Handel, BR., and Kolstad, JT. What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. Working Paper 21632. Pg. 8. October 2015. *Available at*: http://www.nber.org/papers/w21632.pdf.

could require plans that participate in the Exchanges to provide out-of-pocket options that minimize the potential of consumers forgoing necessary services. This will be discussed later in this report.

d. Affordability of care

Although the ACA was designed to make health insurance premiums affordable, it does not guarantee that an individual can afford the out-of-pocket expenses. The ACA does address some of the affordability issues by mandating that certain services, such as preventative health services, do not have a co-pay.[57] In fact, there are 63 new preventative services that have no co-pay if performed in network.[58] In addition, there are subsidies available for those under 250% of the FPL to moderate the cost of out-of-pocket expenses. However, there are no standards regarding the total out-of-pocket costs that any particular insured may incur beyond the out-of-pocket maximum (set at $6,850 for self-only coverage in 2016). One study found that more than half of those who were previously uninsured will face a higher financial burden by participating in the Exchanges while experiencing lower estimated benefits, and that study was using optimistic assumptions.[59] Pennsylvania should address this problem through selectively including plans on the Exchange in order to minimize the out-of-pocket expenses for insureds.

e. Cost of healthcare administration

The main provision in the ACA that attempts to reduce the cost of healthcare administration is the adoption of minimum medical loss ratios which require that a certain percentage of premium payments go towards actual healthcare costs, (80% for non-grandfathered individual and small

[57] U.S. Centers for Medicaid and Medicare Services. Preventive health services for adults. *Available at*: https://www.healthcare.gov/preventive-care-benefits/adults/.
[58] NueMD. Clarke, C. How the Affordable Care Act Will Affect Provider Reimbursement. *Available at*: http://www.nuemd.com/blog/affordable-care-act-will-affect-provider-reimbursement.
[59] National Bureau of Economic Research. Pauly, M., Leive, A., and Harrington, S. The Price of Responsibility: The Impact of Health Reform on Non-Poor Uninsureds. Working Paper 21565, Pg. 1. *Available at*: http://www.nber.org/papers/w21565.pdf.

group plans).[60] Though this provision does put a cap on administrative costs, the cap is similar to the current average loss-ratios found nationally.[61] Even with caps, insurance through the Exchanges will be more expensive than a single-payer model due to the layer of administrative costs that comes with including private insurers in the program design. Medicare, for instance, has administrative costs of around 2%, which corresponds to a medical loss ratio between 97% and 98%.[62]

Although the Pennsylvania Exchange will never approach Medicare as far as efficiency, using an active purchasing methodology to determine which plans are included in the Exchanges could reduce administrative costs in two ways. First, by bargaining directly with the insurers, Pennsylvania could negotiate more favorable medical loss ratios than those required under the ACA. Second, by standardizing insurance provisions, such as requiring all insurers to use the same health claim form, Pennsylvania can reduce the amount of administrative work performed by the insurers. Just as the elimination of pre-existing condition exclusions have reduced the amount of administrative work necessary to process applications (insurers no longer have to inquire about an applicant's past medical history or perform an analysis of their chances of becoming sick), Pennsylvania can dictate additional requirements for participation on the Exchange that reduce the amount of remaining administrative work necessary.

f. Subsidies from the federal government

The federal government pays a significant percentage of the healthcare costs of those insured in the Exchanges and through expanded Medicaid. From a purely state-oriented view, increases in the

[60] Citizen Power. North, T. and Robinson, T. Ed: Hughes, D. Pennsylvania's New Health Insurance Landscape: PPACA and its Impact on Regulation, pg. 120. August, 2013. *Available at*: http://citizenpower.com/wp-content/uploads/2014/08/HealthInsuranceReport.pdf.

[61] The Henry J. Kaiser Family Foundation. Cox, C., Claxton, G., and Levitt, L. Beyond Rebates: How Much are Consumers Saving from the ACA's Medical Loss Ratio Provision? June 6, 2013. *Available at*: http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/.

[62] Mainstreet Alliance. National Minimum Medical Loss Ratio Would Save Tens of Billions of Dollars For Businesses, Individuals, pg. 3. December 2009. *Available at*: http://mainstreetalliance.org/wordpress/wp-content/uploads/Ensuring-Value-for-Premiums.pdf.

insured population and increased utilitization of hospital services will be an economic positive. In addition, the Silver Exchange market can be subtly manipulated in order to maximize the amount of subsidies received in the Commonwealth. Although a tragedy of the commons type problem[63] could occur if multiple states managed their Exchanges in a way to maximize subsidies, it may be possible for Pennsylvania to utilize the current rules to its advantage if it is able to move to either a state-federal Exchange or a purely state-run Exchange.

g. Regulation of market structure

The structure of the healthcare and associated health insurance markets prevents them from operating as an ideal market should. The most efficient markets are found under what is termed perfect competition. Although no market is "perfect", most markets operate close enough to the perfect ideal to determine the correct price and quantity for a product. However, there are many preconditions that are necessary for perfect competition to develop: there has to be many buyers and sellers, and each one has to be small enough that they cannot influence the price; the products must be homogenous; there cannot be any barriers to entry for firms trying to enter the market; the market participants must have perfect information about products and prices; and there cannot be any externalities in either production or consumption.[64] Under perfect competition, prices are driven down to the marginal cost for producing a good. Markets that operate in an environment that approximates perfect competition will also see prices driven down close to the marginal cost. Even markets that do not operate in an environment that approximates perfect competition may see prices driven down near costs if there are enough "good" substitutes for the product. For example, if pears are out of season and the one remaining producer raises prices significantly,

[63] Tragedy of the Commons refers to a situation where individuals, each acting in their own best interest, produce a result that is not in the best interest of society. The common example is a town pasture where townspeople are all allowed to graze their sheep. With a free grazing area it is in each townsperson's interest to get more sheep. However if everyone gets more sheep there won't be enough pasture to provider for all the sheep and they will go hungry.

[64] SQU Med J, August 2011., Vol. 11, Iss. 3, Pg, 330. Mwachofi, A. and Al-Assaf, A.F. Health Care Market Deviations from the Idea Market. *Available at*: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3210041/pdf/squmj-11-328.pdf.

consumers can switch to apples to avoid having to pay much more than the marginal cost of harvesting pears.

Although few markets exist under perfect competition, there are many markets that have enough of the required characteristics to operate without much inefficiency. Unfortunately, healthcare and health insurance are naturally inefficient as markets because they lack the characteristics of markets operating under perfect competition. First, the number of entities selling medical services, especially hospital services, is typically limited within a geographic region. This lack of diversity of supply is further limited by the increasing trend of consolidation among medical providers. On the other hand, because consumers primarily purchase medical services through their insurer, the number of buyers is similarly limited. A number of studies, as described below, have shown that both medical service providers and insurers can artificially influence prices on a local level. Furthermore, medical services are not homogenous. Some medical providers are perceived to be better than others and this differentiation can create market inefficiencies. In addition, there are high barriers to entry and exit in both the medical services and health insurance fields. If a medical provider is earning above market rents in a location, it is not easy for a competitor to enter the market because of a number of start-up costs. Also, there is very poor information available to patients regarding the costs of medical services since they do not directly pay for those services. Finally, there is not any good alternative to many medical procedures. Although an apple may work to replace a pear, there may be no effective alternative to chemotherapy or surgery if you have cancer.

Efficient markets for medical services and health insurance do not naturally develop. Usually an area ends up with a limited number of health providers and insurance companies available to them. This results in a lack of competition, allowing for market power and keeping prices higher and

quality lower than they should be. Regulation of these markets is necessary to keep the most glaring excesses in check. However, this regulation of imperfect markets is in itself very inefficient because of the complexity of the markets that develop in different locations making uniform regulation ineffective. For example, in one area a dominant medical provider may have market power, in another two health insurers may have informally segmented the consumer base, and in a third there may be one main medical system and one main insurer fighting for market power. All three of these outcomes are possible, and they result in completely different price and quantity distortions. Pennsylvania can, through regulatory action, attempt to minimize the impact of market inefficiencies inherent in these market structures through regulation targeted to address the specific market conditions of a location.

The provision of healthcare in Pennsylvania occurs within a wide variety of market structures, ranging from competition between two vertically integrated healthcare giants in the western part of the state, to the Philadelphia market which features a dominant health insurance company contracting with a number of healthcare providers that lack significant market power. The insurance department has had a significant impact on the structure of these markets through its regulatory powers, most notably in its decisions to condition the proposed merger of Highmark and Independence Blue Cross on terms that were restrictive and resulted in the merger falling through, the approval of the merger between Highmark and West Penn Allegheny Health System, and the approval of the merger between Highmark and Blue Cross of Northeastern Pennsylvania. Pennsylvania has the ability to further regulate the healthcare markets through the use of additional regulatory powers provided by the ACA such as moving to an active purchasing model for all plans sold in the Exchange. Under an active purchasing model Pennsylvania would directly negotiate with insurers to determine which plans are allowed to participate on the Exchange as well as the terms of

each policy participating on the Exchange. Pennsylvania should selectively use these powers in response to the market conditions found in each part of the state.

VII. Pennsylvania's Regulatory Options under the ACA

The amount of regulatory control and the types of tools available to Pennsylvania in regulating the health insurance industry are significantly impacted by the ACA. Under the ACA, Pennsylvania retains control over some of the traditional aspects of the health insurance industry including monitoring insurance company finances, investigating complaints, licensing companies and agents, and reviewing rates. However, the ACA contains an extensive list of mandates and largely preempts state regulation in these areas. For example, the ACA has a list of essential health benefits (EHB) that all plans must cover; a state does not have the power to eliminate any of the EHBs. Although the authority of the Pennsylvania Insurance Department to regulate the insurance industry based upon state laws is limited by the ACA, the ACA has provisions that allow for an expanded role of the state in the administration of the ACA itself.

As described above, there are five types of Exchanges potentially available to Pennsylvania. Within these Exchange types, there are four potential ways to operate the Exchange for the individual market: a federally facilitated Exchange, a state-federal partnership Exchange, a state-run Exchange with federal assistance, and a state-run Exchange. Pennsylvania currently operates under a federally-facilitated Exchange, which limits the state's ability to regulate the Exchanges.

In the first main alternative, a state-run Exchange, the state is responsible for all core functions of the Exchange and gives the state significant control over the operation of the Exchanges. However, the state is also responsible for all of the administrative tasks relating to the operation of

the Exchange. The second option, a state-based Exchange with federal assistance, also gives the state considerable control over the Exchanges. In addition, under a state-based Exchange with federal assistance, the state maintains flexibility in the operation of the Exchange while having the option to shift onto CMS the responsibility to determine premium tax credit and cost sharing eligibility for potential insureds (through the healthcare.gov website), determining exemptions from the individual mandate, operating the risk adjustment program which compensates plans with unusually high-risk individuals while receiving funding from plans with low-risk individuals, and the reinsurance program which is a temporary program that offsets some of the costs incurred from high-risk individuals.[65]

The third main option, a state-federal partnership Exchange is a bit more complicated. Under this organizational structure, the ultimate responsibility for all of the core functions rests with the federal government. However, the federal government assigns the responsibility of performing many of the Exchange activities to the state. The two general categories of Exchange functions that the state can take over are plan management and consumer assistance. Plan management functions involve determining which plans are certified to participate on the Exchanges, a system to collect data from qualified health plans, ensuring plan compliance with the ACA, providing technical assistance to plans on the Exchange, recertifying or decertifying plans, hearing appeals regarding plan certification, and providing the public with reports regarding the quality of plans on the Exchange. On the other hand, consumer assistance functions include the establishment of an in-person assistance program and the provision of support to the federal Navigator program. State-federal partnership Exchanges are different than state-based Exchanges in two main ways. First, there are certain Exchange activities (such as the eligibility determination and enrollment of

[65] CMS. Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges. November 2012. *Available at*: https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf.

individuals) that cannot be performed by the state under a state-federal partnership. Second, though the federal government transfers many functions of the Exchange to the state under a state-federal partnership, they do not transfer the ultimate responsibility for the performance of the functions. If the federal government strongly disagreed with a state decision under a state-federal partnership, the federal government is not required to follow the state's approach. This may limit the use of unorthodox approaches to plan management in state-federal partnerships.

VIII. Central Exchange Functions

Although there are a number of Exchange functions that a state can have control over, only a few of them are potentially impactful regarding achieving state goals. Specifically, the functions that a state should focus upon in regulating the Exchange are the qualified health plan ("QHP") certification process and the operation of a consumer assistance program.

The most important Exchange function potentially under state control is the certification of QHPs. There are two distinct schools regarding the operation of an Exchange, either to allow any plan that meets the minimum requirements to participate in the Exchange or to use an active purchasing approach. Active purchasing refers to a wide range of strategies that the Exchange can effectuate in choosing plans for the Exchange in order to benefit consumers including: additional selection criteria, selective contracting, limiting the amount of products, setting cost-sharing standards, and instituting new reimbursement strategies.[66]

[66] Georgetown University Health Policy Institute and National Academy of Social Insurance. Corlette, S. and Volk, J. Active Purchasing for Health Insurance Exchanges: An Analysis of Options. Pg. 6. *Available at*: https://www.mnsure.org/images/Bd-2013-11-06-Active-Purchasing.pdf.

There are only a half dozen states that use active purchasing in their operation of their Exchanges. Of these, perhaps no state is more active than California. Peter Lee, the Executive Director of California's state based Exchange has identified four key elements to active purchasing: 1) selecting plans, 2) negotiating price, 3) standardizing benefit designs, and 4) adding contractual provisions to modify the health service delivery system.[67] California has used standard benefit designs to regulate the marketplace in ways that are beneficial to consumers. For example, all of the Silver, Gold, and Platinum plans do not allow any costs to count towards the deductable except for hospital care and a limited number of specialty drugs.[68]

Pennsylvania, as a federally-facilitated Exchange, currently allows all plans that meet the minimum requirements for a qualified plan to participate in the Exchange. Some of the requirements include the following: plans must have an adequate network, meet marketing requirements designed to prevent discrimination, include essential low-income community providers in network, be accredited based upon quality measures, have "market-based" strategies in place to foster quality improvement, provide information back to the Exchange regarding quality performance, provide public information regarding performance on certain metrics, and only contract with health care providers that are implementing quality improvement mechanisms.[69] Plans that meet these minimum requirements are allowed to participate in Pennsylvania's Exchange.

Under an active purchasing methodology, the Exchange is more selective about which plans participate on the Exchanges. One common way this is done is to add additional requirements for

[67] Alliance for Health Reform and The Commonwealth Fund. July 1, 2015 Briefing. Jost, T., Lee, P., Webb, B., and Lucia, K. The ACA: Experiences in Health Care Coverage and Access. Transcript, Pg. 14. *Available at*: http://allhealth.org/briefingmaterials/TRANSCRIPT7115_0Q.PDF.

[68] Alliance for Health Reform and The Commonwealth Fund. July 1, 2015 Briefing. Jost, T., Lee, P., Webb, B., and Lucia, K. The ACA: Experiences in Health Care Coverage and Access. Transcript, Pg. 17. *Available at*: http://allhealth.org/briefingmaterials/TRANSCRIPT7115_0Q.PDF.

[69] National Association of Insurance Commissioners. Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges. April 20, 2010. *Available at*: http://www.naic.org/documents/committees_b_Exchanges.pdf.

any plan that wants to participate in the Exchange. Examples would be to require networks larger than the federal adequate network standard or to mandate benefits beyond the Essential Health Benefits required by the federal government.[70] Of course, additional requirements typically lead to higher premiums and the more restrictive the requirements the higher the premiums will be. Another active purchasing strategy is to directly contract with the health insurance carriers and only allow those plans that provide desired rates and terms to participate in the Exchange. The drawback to this strategy is that if the Exchange bargains too aggressively, there may not be enough options available to consumers in the Exchange. A third active purchasing avenue is to allow all insurance providers to participate in the Exchange, but to limit the number of products that each provider can offer. Studies have shown that too many choices regarding health insurance products can lead to consumers not picking the best product.[71] Limiting the amount of options can be beneficial to consumers. A fourth active purchasing option is to manage cost-sharing among plans in the Exchange in order to minimize the impact upon consumers, especially lower-income consumers.[72] Value based cost-sharing is one option that can improve the availability of necessary services at a lower cost to consumers on the Exchange. A fifth active purchasing option is to require insurance companies to incentivize quality healthcare through basing payments on patient outcomes. For example, insurers would pay a hospital a greater amount if it reduced the rate of readmissions.

The other meaningful group of Exchange functions that the state can take active control of involves public information. Under the ACA, a state-based Exchange can oversee the Exchange website, outreach and education, the Exchange call center, the navigator program, and a consumer

[70] Additional premium costs attributable to required benefits beyond the section 1302(b) essential health benefits must be assumed by the state. ACA § 1311(d)(3)(B).
[71] Georgetown University Health Policy Institute and National Academy of Social Insurance. Corlette, S. and Volk, J. Active Purchasing for Health Insurance Exchanges: An Analysis of Options. Pg. 8. *Available at*: https://www.mnsure.org/images/Bd-2013-11-06-Active-Purchasing.pdf.
[72] One group that might need targeting is those making over 250% of the FPL since they are not eligible for reductions in out-of-pocket expenses.

assistance program including in-person assistance. A state-federal partnership Exchange is more limited, but still allows the state to participate significantly in education and consumer assistance. The design of the consumer outreach approach is important because an effective program can increase the number of participants in the marketplace.

IX. Market Competition Regarding the Provision of Healthcare Services

So far in this report we have looked at the current status of the ACA generally in the United State and specifically in Pennsylvania, the functions of the ACA, the possible goals of Pennsylvania in the context of the ACA, and the mechanisms available within the ACA to achieve those goals. However, regulation of health insurance and healthcare markets is very tricky because the regulation exists in the context of each particular market. Although all health insurance/healthcare markets can be characterized by problems with market power and inefficient economic signals, the markets are inefficient in unique ways depending upon the location and therefore need regulation to address the specific problems of each individual market. Without a universal healthcare model in place, the nature of healthcare will inevitably lead to market concentration. It is in the best interest of medical service providers to consolidate in order to improve their negotiating power with insurers. Similarly, insurers obtain more market power and leverage the bigger they become.

The provision of modern healthcare is unusual because healthcare services are typically not purchased directly but rather through an intermediary. The reason for this is that the costs associated with healthcare in some cases can be large enough that direct payment is not a realistic option for most Americans. For those not covered by a federal program such as Medicare or Medicaid, the typical way one covers healthcare costs is through healthcare insurance. However, the existence of insurers complicates the market for the provision of healthcare services. If

insurance companies did not exist and individuals purchased healthcare services directly, the amount of competition could be determined by looking at the number of healthcare providers supplying a certain service in a given area. Governmental regulation to regulate prices may be warranted if the number of providers is not enough to provide competition.

The inclusion of insurance companies makes an analysis of the market for healthcare services much more complex. There are three main determinants needed to characterize the market for healthcare services for any given location: 1) the amount of competition in the health insurance arena, 2) the amount of competition between medical providers, and 3) the amount of integration between the health insurers and the healthcare providers. The number of potential combinations results in vastly different markets in different locations.

Another issue regarding the operation of the healthcare markets is the highly inelastic demand for many healthcare services. In theory, a properly operating market will drive prices down to the cost of providing a service. However, in the case of medical services which impact people's health, people will tend to pay above the actual cost of providing a service. This inelastic demand, combined with the non-direct nature of payment, has led to an expansion in the cost of diagnostic and other healthcare services that is divorced from any true cost/benefit analysis.

The degree of competition between health insurance providers is significantly limited by the number of insurers providing coverage for individuals in a specific area. The amount of market concentration in an industry can be measured by the Herfindahl-Hirschman Index ("HHI"), which is represented by the formula:

HHI = s1^2 + s2^2 + s3^2 + ... + sn^2 (where sn is the market share of the th firm)

In this formula, s1 is the percentage market share of the largest firm expressed as a number between 1 and 100, s2 is the percentage market share of the second largest firm, s3 is the percentage market share of the third largest firm, and so on until you reach the smallest firm, the th firm. The highest that a HHI number can be is 10,000 representing one firm with a market share of 100% (100^2=10,000). On the other hand, and industry with thousands of competitors with marginal market share would have an HHI near 0. In their analysis of potential mergers, the United States Department of Justice considers a post-merger HHI of over 1800 to be a highly concentrated market.[73] Competition in the individual insurance market is generally highly concentrated, with only 3 states having an HHI of less than 1,800.[74] However, even these high HHI numbers underestimate the degree of market concentration since they represent the statewide market share of insurers, and many insurers do not offer their policies statewide. For example, imagine a state that has 5 insurers, each holding a 100% monopoly over 20% over the state. An analysis of the competitiveness of the industry from a statewide perspective would find that there exists a highly concentrated market at an HHI of 2000. However, if you looked at the market from the perspective of an individual consumer in a specific area, the HHI would actually be 10,000 since there would only be one monopolistic insurance company. Keeping that in mind, Pennsylvania's HHI of 2,116 is an underestimate of the amount of concentration for any individual area since many of the major insurers operate in limited regions of the state.

This competition problem is further complicated by fact that each insurer needs to contract with medical providers in order to build a network that is sufficient to serve the complete healthcare needs of an individual. In fact, one of the factors that is looked at in determining which plans are allowed to participate on the ACA Exchanges is the adequacy of their network. Since insurers have

[73] U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, Section 1.5 Concentration and Market Shares, *available at*: http://www.justice.gov/atr/15-concentration-and-market-shares.
[74] The Henry J. Kaiser Family Foundation. Individual Insurance Market Competition 2013, *available at*: http://kff.org/other/state-indicator/individual-insurance-market-competition/.

to contract with enough medical providers to put together an adequate network, those providers in turn can have significant market power if there is a small enough number of them delivering a particular service. In fact, a meta-study found both a positive relationship between hospital concentration and price as well as large price increases result from the merger of hospitals.[75] This market power can be increased by medical providers collectively bargaining together to set the rates which they charge insurance companies for medical procedures. In many areas, there is only one medical system providing key services, and any insurance provider has to contract with them if they want to provide insurance to individuals in that location. Of course, the reverse can also be true, if an area has a dominant insurance provider, a medical provider may have to contract with that insurance provider to have adequate utilization rates, giving the medical provider a substantial negotiation advantage. It is this power struggle between insurers and providers that determines how the market for healthcare services operates.

Further confusing matters, there is another type of delivery system that is gaining popularity: an integrated delivery network ("IDN") where the insurance company and the healthcare services network combine to form one entity. Under this arrangement, there is no risk of the insurer using their market power against the associated medical provider or vice-versa. However, the combined entity can have substantial market advantages over other insurers and medical providers in the region. Furthermore, it is unclear whether these integrated organizations actually are more efficient or benefit consumers. One study of IDNs found that integration of health insurance operations with health service providers did not result in either lower charges or better medical efficiency.[76] Another

[75] National Bureau of Economic Research. Gaynor, M. & Town, R.J. Competition in Health Care Networks. Pg. 32, 34. July 2011. *Available at*: http://www.nber.org/papers/w17208.pdf.

[76] National Academy of Social Insurance. Goldsmith, J., Burns, LR., Sen, A., and Goldsmith, T. Integrated Delivery Networks: In Search of Benefits and Market Effects, Pg. 2. February, 2015. *Available at*: https://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf.

study looking specifically at healthcare provider-owned insurance plans found that they were on average 12% more expensive than plans offered by insurers not owned by healthcare providers.[77]

The market dynamics regarding health insurers and healthcare providers in Pennsylvania are as varied and dynamic as anywhere in the country. The Philadelphia region is characterized by numerous healthcare provider organizations competing for business in an environment that contains the two largest insurers in the state, though Independence Blue Cross currently has a dominant market position over Aetna.[78] On the other hand, western Pennsylvania, including Pittsburgh, is distinguished by two vertically integrated healthcare delivery networks that combined have a dominant market share. This market structure is unusual among the market structures found in the United States.[79] The rest of the state is characterized by competition between regional not-for-profit insurers with varying degrees of market power. Due to the varying types of market structures found around the state, Pennsylvania needs to customize its regulation of the Exchanges to best meet the localized needs of each market. Specifically, the rules applied to each Exchange should account, and attempt to correct, for the market inefficiencies for that area. For example, if the insurance company has market power in their negotiations with medical providers in a certain location, the rules of the Exchange can be developed in order to increase the bargaining power of the medical providers.

X. Competition within the Exchanges

[77] HealthPocket. Coleman, K. and Geneson, J. Cheapest Healthcare Provider-Owned Insurance Plans Still 12% More Expensive than Cheapest Insurance Plans Not Owned by Providers. August 8, 2015. *Available at*: https://www.healthpocket.com/healthcare-research/infostat/fee-for-service-and-provider-health-plans#.VghIhdJViko.
[78] HealthLeaders InterStudy. Cherry, M. Philadelphia Pennsylvania 2014 Market Overview. *Available at*: http://hl-isy.com/Products-and-Services/Market-Overviews/Northeast/2014/Philadelphia-PA-9-25-14.
[79] Healthcare Payer News. Brino, A. Tipping Points? Competition and barriers in a region with two IDNs. June 5, 2015. *Available at*: http://www.healthcarepayernews.com/content/tipping-points-competition-and-barriers-region-two-idns#.VgGwWtJVikp.

The health care Exchanges were created, in part, to increase competition between insurers by providing a more transparent shopping experience where consumers could compare different plans in one location. However, the evidence does not support the hypothesis that Exchanges are more competitive. In both Philadelphia and Pittsburgh, the lion's share of Exchange market share is split between two insurers. One early study of seven state Exchanges found mixed results regarding the market share concentration of insurers found on the Exchanges versus what existed in the 2012 individual market.[80] Another study found the largest insurance company in the 34 federally facilitated and state-partnership Exchanges on average increased their rates 75% more than other insurers between 2014 and 2015, suggesting the existence of anti-competitive pricing.[81] The Exchanges are similar to the broader health insurance market in that they are characterized by the existence of market power and inefficient price signals; and that an Exchange in one region might be completely different from an Exchange in another, necessitating different regulatory approaches. It is the opinion of Citizen Power that an individualized regulatory approach needs to be developed for each region. For the purposes of this report, we will examine potential regulatory options in response to the market conditions in both Pittsburgh and Philadelphia.

XI. Market Competition in Pittsburgh

The Pittsburgh market has become a highly integrated duopolistic healthcare market. On one side is Highmark, the largest regional insurer who, in 2013, acquired the second largest health system in Pittsburgh, Allegheny Health Network (AHN). On the other side is UPMC, the largest health system in Pennsylvania, which has steadily been growing its affiliated UPMC Health

[80] The Henry J. Kaiser Family Foundation. Cox, C., Ma, R. Claxton, G., Levitt, L. Sizing Up Exchange Market Competition. March 2014. *Available at*: http://files.kff.org/attachment/issue-brief-sizing-up-exchange-market-competition.
[81] Journal of Technology Science. Wang, E. and Gee, G. Larger Issuers, Larger Premium Increases: Health Insurance Issuer Competition Post-ACA. August 11, 2015. *Available at*: http://techscience.org/a/2015081104/.

[insurance] Plan and is now the second largest regional insurer. Combined, Highmark/AHN and UPMC dominate both the health insurance and healthcare markets.

On the insurance side, Highmark had a 60% share of the health insurance market in Western Pennsylvania as of January, 2015.[82] On the other hand, UPMC's share of the commercial insurance market was 24%, their share of the Medicaid Advantage market was 31%, and their share of the Medicaid market was 53%.

UPMC is the dominant healthcare provider market leader with 43% of admissions in 2013 while the Allegheny Health Network was in second place with 17%.[83] UPMC had an operating margin of 3% in the first six months of fiscal 2015. West Penn Allegheny Health System reported a $2.2 million dollar profit in the fourth quarter of 2014, though they lost $13.3 million in all of 2014.[84] The operating margin for this period was around -.78%. On March 9, 2015, Highmark filed a request with the Pennsylvania Insurance Department to approve a $175 million transfer of funds from Highmark to Allegheny Health Network in the form of a grant in order to modernize operations. The PID approved the financial transaction, with conditions.[85]

The seven-county Pittsburgh region has excessive supply as there are 3.8 beds available per 1,000 individuals versus the national average of 2.6.[86] In 2003, the UPMC Health System was composed of 11 hospitals with 3,664 available beds while the Allegheny Health Network had 6

[82] TribLive Business. Nixon, A. and Smeltz, A. Highmark loses subscribers in possible fallout from UPMC fight. February 4, 2015. *Available at*: http://triblive.com/business/headlines/7707881-74/highmark-company-percent#axzz3lJ2RfC00.
[83] HealthLeaders Interstudy. Cherry, M. 2013 Market Overview: Philadelphia, Pg. 10. August 2013. *Available at*: http://astellashealthcarereformonestopshop.com/documents/Pittsburgh%20PA%202013%20Market%20Overview%20(Event%20Driven).pdf.
[84] Modern Healthcare. Kutscher, B. Rivals UPMC, West Penn Allegheny see gains. February 2015. *Available at*: http://www.modernhealthcare.com/article/20150205/NEWS/302059952.
[85] Correspondence from Teresa D. Miller to Jack M. Stover. June 19, 2015. *Available at*: http://www.portal.state.pa.us/portal/server.pt?open=space&name=Dir&id=cached&psname=Dir&psid=0&in_hi_userid=2&cached=true&control=DirRepost&rangeFrom=21&rangeTo=34&subfolderID=190327&DirMode=1#.
[86] HealthLeaders Interstudy. Cherry, M. 2013 Market Overview: Philadelphia, Pg. 11. August 2013. *Available at*: http://astellashealthcarereformonestopshop.com/documents/Pittsburgh%20PA%202013%20Market%20Overview%20(Event%20Driven).pdf.

hospitals with 2,328 available beds. Excela Health was in third place with 3 hospitals and 589 available beds.

The problem with the market structure in Pittsburgh, from a consumer standpoint, may ironically be too vigorous competition between Highmark and UPMC. The genesis of the current competitive market was when UPMC began its Insurance Services Division in 1997. Although UPMC's share of the insurance market started modestly, it effectively served as bargaining leverage for the UPMC healthcare network in their negotiations with Highmark. In 2000, Highmark financed a merger between a number of financially distressed hospitals to form West Penn Allegheny Health System in order to provide itself with an alternative to UPMC and therefore increase its bargaining leverage in negotiations with UPMC. It was alleged by West Penn Allegheny that UPMC and Highmark called a truce in 2002, and then colluded to maximize their profits and market share at the expense of West Penn. Highmark then refused to refinance the loan that was used to fund the 2000 merger establishing the West Penn Allegheny Health System.[87] Between 2002 and 2011, both UPMC and Highmark earned significant profits while steering business away from West Penn Allegheny. However, the truce between UPMC and Highmark eventually came to an end and Highmark started negotiations with West Penn Allegheny in 2011 to purchase the financially troubled medical system, leaving the region with a duopoly of vertically integrated health insurance and healthcare providers.

When there is a duopoly present, one of two things typically happens: one possibility is that both companies informally agree not to compete for the same customers. The two companies structure their services in a way that both of them are allocated certain market segments and they then are able to raise prices for their customers because they do not have to worry about significant competition. The other possibility is that one or both of the companies believe that they can gain

[87] West Penn Allegheny Health System, Inc. v. UPMC; Highmark, Inc., 3d Cir., No. 09-4468 (Nov. 29, 2010).

significant market share based upon their competitive advantages. In this case, short-term loss caused by lowering prices may be acceptable to a market participant if it potentially leads to long term market power. Currently, UPMC and Highmark are waging a war for market share which has led to lower Exchange prices but much lower subsidies.

The question is whether this war is good for the region's consumers. Both Highmark and UPMC have between $4 and $4.5 billion in reserves.[88] However, these reserves were accumulated through premium and healthcare payments from the citizens of Western Pennsylvania. As non-profit organizations, the money raised by UPMC and Highmark should be used to further the mission of each of these companies. It is clear that the PID approved Highmark's purchase of the Allegheny Health System because it thought that the competition it would provide would be in the consumer's interest. However, the continued existence of Allegheny Health System also ensured that the region would have a general oversupply of medical services. The cost of maintaining two separate integrated medical networks, much of which represents a redundant oversupply of services, will continue to be borne by the public. If competition drives prices down, the cost of maintaining the healthcare systems will result in losses, cutting into the reserves built up through funding from the public. One study found that hospitals with the lowest operating profit margins have higher incidences of adverse safety events.[89] Eventually if one entity experiences enough losses, they may end up going bankrupt or being forced to sell their assets, leading to the monopoly situation that the PID was trying to avoid in the first place. If UMPC and Highmark reach a détente, prices will rise and the additional costs will be placed upon the non-subsidized premium payers. Ideally, UPMC and AHN would voluntarily reduce their services to a more efficient level without impacting underserved

[88] UPMC Fiscal Year 2014 Financial Results Media Slides. August 20, 2014. *Available at*: http://www.upmc.com/about/finances/Documents/fy2014-q4-financial-results-media-slides.pdf and TribLive News. Smeltz, A. Highmark Waits While State Weighs its Cash Infusion Proposal. March 13, 2015. *Available at*: http://triblive.com/news/editorspicks/7965598-74/highmark-health-allegheny#axzz3o0tcWjQN.

[89] Inquiry: The Journal of Health Care Organization, Provision, and Financing. Spring, 2005. 42(1):60-72. Encinosa, W.E. & Bernard, D.M. Hospital Finances and Patient Safety Outcomes.

populations. Unfortunately, because of the competition between them, they are increasing investments in potential profitable locations, such as Monroeville, resulting in additional problems with oversupply while simultaneously under-serving less profitable areas such as Braddock.

XII. Strategies for the Pittsburgh Exchange[90]

A. **Require Bronze, Silver, and Gold plans to have wide networks[91].** Pittsburgh currently has some of the lowest Exchange premium rates in the nation as a result of the intense competition between UPMC's Insurance Services Division and Highmark. While low prices are typically a desirable consumer outcome, in the case of the Exchange it is less desirable since the majority of Exchange participants receive subsidies and those subsidies are tied to the premium rates. One of the ways that both insurers have been able to cut their premiums so much is that they offer narrow networks that tend to be limited to their affiliated healthcare provider. In fact, the use of narrower networks was predicted to be a response to the ACA.[92] However, because of subsidies, this results in most Exchange participants paying the same for a narrow network as they would if the network was expanded, since any price savings from the lower premiums is offset by lower subsidies.

The Exchange should set a network adequacy requirement for Western Pennsylvania that mandates that any Bronze, Silver, or Gold plan participating in the Exchange must include both the UPMC and the Allegheny Health Network in their plan.[93] This requirement

[90] Please note that these strategies and the strategies described in the section on Philadelphia are dependent on Pennsylvania having control over the operation of the plan management functions of exchange.
[91] Except for one "budget" bronze, silver, and gold plan as described later.
[92] HealthLeaders InterStudy. Cherry, M. The Reverse Bait and Switch. June 11, 2015. *Available at*: http://hl-isy.com/Healthcare-Reform-Blog/June-2015/The-Reverse-Bait-and-Switch.
[93] The language would not specifically mention UPMC or AHN, but would require a certain percentage of providers to be in an Exchange plan which would de facto require both UPMC and AHN, except in Westmoreland Country where Excela Health may serve as a substitute.

would not apply to plans outside of the Exchanges. This would result in one of two scenarios. The more unlikely scenario is that UPMC and Highmark would begrudgingly allow the other to use their network, resulting in UPMC and Highmark offering wider plans on the Exchange. The second outcome is that other insurers would come in and negotiate with both UMPC and the AHN to offer wide network plans. Since these other insurers would have limited market power, which would be compounded by the wide network requirement, they probably would not be able to negotiate inexpensive reimbursement rates and the Silver plans would be more expensive than they currently are. However, the increased cost will primarily be picked up by the federal government through increased subsidy payments.

B. **Allow Platinum plans to have narrow networks.** One of the main issues for participants in the Exchange is the affordability of out-of-pocket costs. Although the federal government partially subsidizes these costs for individuals on the Exchange that have a Silver plan and earn up to 250% of the FPL, those over 250% of the FPL can have trouble paying their deductibles and co-pays. Platinum plans in the Exchange are designed to pay for 90% of out-of-pocket expenses instead of the 70% for Silver plans. However, Platinum plans are usually much more expensive than Silver plans and therefore are not affordable to those of modest income.

The Exchange should allow UPMC and Highmark (as well as any other insurer who wants to participate) to offer narrow network plans in the Exchange at the Platinum level. Assuming that the benchmark Silver plan has a relatively high premium because of the requirement of a wide network, the narrower network of these Platinum plans, combined with the competition between UPMC and Highmark, should reduce the price of these plans enough to be affordable for many insureds receiving premium subsidies.

C. **Offer one narrow Bronze, Silver, and Gold plan on the Exchange.** The inclusion of one budget Bronze, Silver, and Gold plan on each Exchange would not significantly impact the benchmark premium, since that plan would still have to offer a wide network. However, one narrow Bronze, Silver, and Gold plan would provide one budget offering for each metal level. In addition, a budget Silver plan would provide an option for those who earn between 133% and 250% of the FPL and need to choose a silver plan to qualify for cost-sharing subsidies. This population may not be able to afford a Platinum plan, even at a discounted price, or even want to because they cannot receive cost-sharing subsidies with a Platinum plan.

The Exchange should offer one narrow network Bronze, Silver, and Gold plan and negotiate with both UPMC and Highmark using a competitive bidding approach to determine which insurer will be allowed to offer their plan on the Exchange. Competition should ensure that the premiums for these policies are well below the benchmark, allowing for an extremely affordable plan options.

D. **Require Exchange Plans to Structure Copays based upon the Value of the Service.** The existence of copays generally impacts the utilization of a service. Generally, the higher the out-of-pocket costs that a consumer faces, the more likely they are to forgo a certain service. When different treatments with different costs result in similar outcomes, consumers can be encouraged to choose the lower cost option by the strategic implementation of higher copays for the higher priced service. This leads to lower overall costs and a more efficient utilization of healthcare services.[94]

[94] The American Journal of Managed Care.Tunis, SR. and Weiner, JP. Encouraging Value-Based Insurance Designs n State Health Insurance Exchanges. July 22, 2013. *Available at*: http://www.ajmc.com/journals/issue/2013/2013-1-vol19-n7/encouraging-value-based-insurance-designs-in-state-health-insurance-exchanges.

The Pennsylvania Exchange should establish a commission, similar to Oregon's Health Services Commission, in order to determine a ranking for services based on the amount of benefit of that service along with other metrics. This ranking can then be used to appropriately assign the amount of copayments that should be required for differing services. The benefit of having higher out-of-pocket costs for expensive services that have minimal advantages compared to other treatments is that the savings can be used to reduce out-of-pocket costs for vital services while still keeping the out-of-pocket percentage in the range that corresponds to the metal level of the plan (e.g., 30% for Silver plans).

E. **Require Exchange Plans to Waive the First 20% of the Deductible.** Not only do insureds tend to forgo medical treatment in response to out-of-pocket costs, but this tendency is based upon the spot price (to the consumer) of the medical service. The true cost of medical service to the consumer is the price they are paying at the end of the year. For example, if a procedure costs a consumer $100 out-of-pocket, but by the end of the year the insured has paid the out-of-pocket maximum, the total amount the insured paid is the same whether they chose to undergo the $100 procedure or not. By creating a deductible structure that does not apply to the first few dollars spent, healthy insureds will not be discouraged from obtaining inexpensive and routine medical services which may prevent them from having to undergo more expensive procedures in the future. In addition, the healthy individuals that the Exchange is trying to attract may see more value in purchasing insurance if at least some of their projected medical expenses will be covered. Of course, reducing the out-of-pocket costs for some members will increase the out-of-pocket costs for others, since the actuary value of the plan depends on its metal level and must remain consistent. Therefore, the impact of this type of deductible structure on the out-of-pocket costs of less-healthy insureds must be monitored.

F. **Require Exchange Plans to Incentivize Net-Benefit Procedures.** Based on a review of the medical literature, some procedures universally provide a net benefit, on average, to society. For example, it has been estimated that the flu vaccine has a net benefit of $39.48 per vaccination of an employee.[95] Many of these types of procedures are provided for free under the ACA's list of preventative services. However, the opportunity cost of obtaining such medical services for an insured can be high, especially in today's busy environment. Exchange plans should be required to incentivize identified "net societal benefit procedures" by sharing the savings with the insured. The state would review the current medical literature to determine which procedures would be labeled as "net societal benefit procedures." The insured would receive a credit for undergoing a "net societal benefit procedure" which can be applied toward future out-of-pocket expenses using a formula that allocates half of the forgone benefits to insureds where the amount of forgone benefits is measured by the number of people who do not undergo the procedure times the net benefit of the procedure. In short, any insured undergoing a "net societal benefit procedure" would receive a credit in the amount of:

50% * NB * (100% - % who undergo the procedure)

where NB is the net benefit of the procedure. As an example, suppose that a colonoscopy has a net benefit of $500 for individuals over 50 years of age and 67% of eligible individuals undergo the procedure. Under the sharing provision, the insured would receive a credit of $82.50 for the colonoscopy which is 50% of the $500 net benefit of the procedure times 33% (which is percentage of eligible individuals *not* undergoing the procedure). This would increase the utilization rates for procedures that benefit society.

[95] In 1991 Canadian dollars. The Canadian Journal of Infectious Diseases. Yassi, A., Kettner, J., Hammond, G., Cheang, M., and McGill, M. Effectiveness and Cost-benefit of an Influenza Vaccination Program for Health Care Workers. Autumn 1991. *Available at*: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3328002/.

G. **Increase Utilization Rates.** It is in the best interest of Pittsburgh not only to increase the number of insureds, but also to increase the utilization of health care facilities. Pittsburgh currently has an oversupply of services, and one of the ways to shrink that gap is to improve the utilitization of services. The benefits of increased healthcare utilitization accrue not only to the citizens of Pittsburgh through better quality of life, but also to the economy of Pennsylvania though increased worker productivity and the fact that higher utilization numbers spread fixed healthcare costs across a larger number of people. The costs, however, are partially paid for by the Federal government, resulting in a positive cost/benefit ratio for the Pittsburgh region. Increased numbers of insured correlate with higher utilitization rates. The increase of insureds through the Exchange and expanded Medicaid should increase the demand for services. There are other ways to increase utilization. Increases in the types of procedures covered can positively impact utilization of healthcare facilities.[96] However, under the ACA, the state is responsible for any increased federal costs stemming from additional services required by the state. Access to healthcare facilities is also an important determinant in utilization rates. In general, the broader a network, the greater the access is for insureds. For example, if one potential health care provider is fully booked for a certain procedure for two months, the availability of other providers in the network increases the amount of access to healthcare. In addition, the location of healthcare providers that are in network can be important, especially to those without adequate transportation options. One study in North Carolina found that individuals with a driver's license have more frequent visits to healthcare facilities and better health

[96] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Center for Health Statistics. Health Care in America: Trends in Utilization. Berstein, AB., Hing, E., Moss, AJ., Allen, KF., Siller, AB., and Tiggle, RB. Pg. 6. 2003. *Available at*: http://www.cdc.gov/nchs/data/misc/healthcare.pdf.

outcomes.[97] For these reasons, use of the above requirement for broader networks should have regional benefits. However, these broader networks can be supplemented through a state fund to pay for transportation options for anyone visiting a medical professional.

XIII. Market Competition in Philadelphia

Philadelphia's market is characterized by a highly concentrated health insurer segment, a moderately concentrated physician segment, and a fragmented hospital segment. Although Independence Blue Cross and its affiliated subsidiaries control 50% of the insurance market and Aetna serves another 24%, no hospital has more than 18% of the market.[98] This concentration of market power within an insurer can create a monopsony situation. A monopsony occurs where the purchasers of a service, in this case the insurance companies with a dominant market position in the purchase of healthcare services from medical providers, have the ability to use their purchasing market power to obtain price reductions beyond those that would occur in a properly functioning market. Although lower healthcare costs seem like a benefit to consumers, a monopsony has two distinct potential drawbacks. First, there is the potential that lower reimbursements to the medical providers may hamper investment and result in less supply of services over time. Second, any cost savings are not necessarily passed on to consumers. There is evidence that for-profit insurers and some non-profit insurers can use their market power in both buying medical services and in pricing those services to consumers in order to maximize profit or in the case of non-profits, a surplus.[99] On the other hand, there appears to be countervailing evidence that a greater concentration of buyers

[97] Anthamattan, P. & Hazen, H. An Introduction to the Geography of Health, Pg. 158. New York: Routledge. 2011. Print.
[98] HealthLeaders Interstudy. Cherry, M. 2013 Market Overview: Philadelphia. October 2013. *Available at*: http://astellashealthcarereformonestopshop.com/documents/Philadelphia%20PA%202013%20Market%20Overview%20(Event%20Driven).pdf.
[99] Health Services Research 33:5, pg. 1451. Pauly, MV. Managed Care, Market Power, and Monopsony. December 1998. *Available at*: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070328/pdf/hsresearch00031-0048.pdf.

(insurance companies) does not create a monopsony behavior but instead counters the market power of medical providers and results in pressure upon the medical providers to produce services more efficiently.[100] The end result in Philadelphia is that Independence Blue Cross has been successful in using its market power to move most of the region's health systems to an accountable care payment model, which reimburses medical providers not based upon the number of procedures performed but on a formula that combines medical expenses with overall savings below a benchmark of what "typical" services should cost. The shared savings portion of reimbursement can range from 30 to 50 percent of the total.[101]

In response to the market conditions, there has been increasing health system consolidation, though in some areas there remains a localized over-supply of services. Similar to the Pittsburgh market, this has not stopped health systems from attempting to expand into the more affluent suburban markets.

XIV. Potential strategies for the Philadelphia Exchange

A. **Require Bronze, Silver, and Gold plans to have wide networks[102].** This recommendation is the same as for the Pittsburgh area, but for a completely different reason. Unlike the Pittsburgh region, competition by itself will not potentially push prices below the cost of providing a service. However, the monopsony environment in Philadelphia may result in a similar effect of too low reimbursement rates. Since the majority of people on the Exchanges receive subsidies

[100] International Journal of Health Care Finance Economics. Bates, LJ. And Rexford, ES. Do health insurers possess monopsony power in the hospital services industry?, Pg. 10. July 19, 2007. *Available at*: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2780653/.
[101] HealthLeaders Interstudy. Cherry, M. 2013 Market Overview: Philadelphia. Pg. 12. October 2013. *Available at*: http://astellashealthcarereformonestopshop.com/documents/Philadelphia%20PA%202013%20Market%20Overview%20(Event%20Driven).pdf.
[102] Except for one "budget" bronze, silver, and gold plan as described later.

that are tied to what they can afford and not to the general premium costs of the plans, it is not in the regional best interest to keep Exchange premiums that are too low to properly reimburse medical providers. Requiring wider networks for some plans has three benefits: first, the quality of the plans that Philadelphians are able to purchase increases significantly; second, the wider networks should increase area utilization rates; third, by requiring the insurance companies to contract with a number of medical systems, the insurance companies should have less market power in their negotiations.[103]

B. **Allow Platinum plans to have narrow networks.** Similar to the recommendation for Pittsburgh, allowing Platinum plans to limit coverage to a narrow network will allow for consumers to purchase a plan with a lower out-of-pocket cost for a reasonable premium.

C. **Offer one narrow Bronze, Silver, and Gold plan on the Exchange.** Also similar to the recommendation for Pittsburgh, the inclusion of one narrow Bronze, Silver, and Gold plan on the Exchange would provide consumers with highly subsidized "budget" plans that have lower out-of-pocket costs than a catastrophic plan. In addition, by limiting the number of narrow Silver plans to one, the impact on the premium of the benchmark plan is limited.

D. **Set minimum medical loss ratios greater than those under the ACA.** Under the ACA, insurance policies must spend a minimum of 80% of their premium income on healthcare services. However, since many of the requirements of the ACA have reduced the amount of administrative work for the insurance companies, there may be the potential for setting minimum loss ratios above 80% for those plans in the Exchange.[104] In the alternative, the

[103] National Bureau of Economic Research. Gaynor, M. & Town, R.J. Competition in Health Care Networks. Pg. 21. July 2011. *Available at*: http://www.nber.org/papers/w17208.pdf.

[104] The ACA did impose some significant new regulatory requirements on insurers. However, many of the provisions of the ACA reduced the amount of work necessary to administer insurance plans and these provisions should hypothetically outweigh the new requirements. For example, the removal of pre-existing conditions as a basis for setting premiums should, by itself, substantially reduce the workload of insurers since they do not have to evaluate and verify the health histories of each applicant.

Exchange could use minimum loss ratio as one of several factors in deciding which plans should be allowed to participate in the Exchange.

E. **Require value based hospital care.** In Pittsburgh, since the main healthcare model is the insurance company being vertically integrated with the healthcare provider system, it does not make much sense to base the reimbursement rate for a procedure on its outcome since the overall reimbursement is more based on an overall corporate strategy. Simply put, market forces between the insurer and the healthcare provider do not exist and incentives are relatively ineffective.

However, in the Philadelphia market, there are a number of healthcare systems competing for reimbursements from insurers. By using quality metrics, such as readmission rates for certain procedures, to determine the reimbursement rate, there is an incentive for healthcare providers to provide better healthcare which reduces the overall regional medical cost. The Philadelphia Exchange should require that plans base reimbursement for certain procedures on the value based hospital care model.

XV. Impact of Strategies for the Pittsburgh & Philadelphia Markets

Implementing the recommended strategies should result in improvements in some of the seven identified goals for the Pennsylvania Exchanges. As identified above, the seven goals that we are attempting to achieve through the regulation of our Exchanges are: increasing the number of uninsured, increasing the quality of care, reducing the cost of healthcare, making health insurance more affordable, reducing the cost of healthcare administration, increasing the subsidies from the federal government, and regulating the structure of the market. In general, the above strategies will mainly make health insurance more affordable for the majority of

those participating on the Exchanges and will considerably increase the subsidies received from the federal government. In addition, from a market standpoint, it will force UPMC and Highmark to either cooperate or face giving another insurer a greater share of the health insurance market in Western Pennsylvania.

As noted earlier in this report, our recommendations mainly increase the amount of people with insurance, reduce the cost of insurance, and increase the amount of subsidies received by Pennsylvanians. Both Pittsburgh and Philadelphia have three recommendations in common that focus on these goals: requiring Bronze, Silver, and Gold plans to have wide networks; allowing platinum plans to have narrow networks; and using a competitive bidding process to offer one narrow network Silver plan on each Exchange. In order to illustrate the potential impacts from these strategies, let's look at the impact of these strategies on a hypothetical market.

To begin with, let us look at the policies currently available to a 40 year old, non-smoker in Allegheny County making $25,000 per year. Under the ACA, this individual's "fair share" (the premium they can afford based on income) is $144 per month. The second least expensive Silver plan on the Exchange (the benchmark plan) has a premium of $190 per month. Therefore, this individual would receive a $46 dollar subsidy per month regardless of which plan they chose on the Exchange. They would have a number of choices regarding which plan they purchase, including 10 Bronze plans (between $120 and $231 after subsidies), 20 Silver plans (between $141 and $294 after subsidies), 9 Gold plans (between $189 and $369 after subsidies), and 4 Platinum plans (between $355 and $464 after subsidies).

If the Bronze, Silver, and Gold plans on the Exchange were required to have wider networks, the cost of the plans would increase. However, the benchmark would also increase which would correspondingly increase the subsidies. As an example of what a wide network plan may cost,

there is only one Silver plan that includes both Allegheny General and UPMC Presbyterian in its network; an Aetna plan with a monthly premium of $266.[105] Conservatively estimating that a second wide network plan would have a similar premium, the monthly subsidy would increase from $46 to $122 (based upon the "fair share" of $144 per month). However, the premiums for the plans would also be higher to account for the requirement of the wider network. Based upon the current premiums for wide networks plans in Allegheny County, one would expect that the cost of a bronze plan would be approximately $212 (or $90 after the subsidy), the cost of a silver plan would be $266 (or $144 after the subsidy), and the cost of a gold plan would be $316 (or $194 after the subsidy).

This higher subsidy number would also have an impact upon the cost of the Platinum plans available to the hypothetical individual. With the current $46 subsidy, the premium for the available Platinum plans would range between $355 and $464 per month. However, with a higher subsidy due to a more expensive benchmark plan, the monthly premium would be reduced to between $279 and $388 per month. Although these premiums are not as affordable as the plans that have higher deductibles, they may be a more attractive option for those trying to keep their out-of-pocket costs down.

Finally, allowing one narrow network plan at each of the Bronze, Silver, and Gold metal levels would provide reasonably inexpensive policies for those who value lower premiums more than an expanded network. Assuming an increase in the subsidy from $46 to $122, the cost of the cheapest plan's monthly premium in each level is greatly reduced; from $120 to $44 at the bronze level, from $141 to $65 at the silver level, and from $189 to $113 at the gold level. The impact on a hypothetical Exchange can be seen in the following graphics:

[105] UPMC Presbyterian is broken up into different departments. For this example the UPMC Presbyterian Oncology Department was chosen as a proxy.

Current Premiums for a non-smoking 40 yr. old in Allegheny County making $25,000 ($46 subsidy)

Bronze **Premium Amt.** 10 plans	**Network** (Narrow/ Wide)	Silver **Premium Amt.** 20 plans	**Network** (Narrow/ Wide)	Gold **Premium Amt.** 9 plans	**Network** (Narrow/ Wide)	Platinum **Premium Amt.** 4 plans	**Network** (Narrow/ Wide)
$120.00	Narrow	$141.00	Narrow	$189.00	Narrow	$355.00	Narrow
$122.00	Narrow	$144.00	Narrow	$190.00	Narrow	$376.00	Narrow
$127.00	Narrow	$144.00	Narrow	$193.00	Narrow	$439.00	Narrow
$129.00	Narrow	$145.00	Narrow	$202.00	Narrow	$464.00	Narrow
$136.00	Narrow	$151.00	Narrow	$206.00	Narrow		
$156.00	Narrow	$154.00	Narrow	$240.00	Narrow		
$160.00	Wide	$154.00	Narrow	$270.00	Wide		
$173.00	Wide	$155.00	Narrow	$356.00	Narrow		
$217.00	Narrow	$159.00	Narrow	$369.00	Narrow		
$231.00	Narrow	$164.00	Narrow				
		$165.00	Narrow				
		$169.00	Narrow				
		$180.00	Narrow				
		$184.00	Narrow				
		$185.00	Narrow				
		$185.00	Narrow				
		$220.00	Wide				
		$287.00	Narrow				
		$292.00	Narrow				
		$294.00	Narrow				

Benchmark Plan

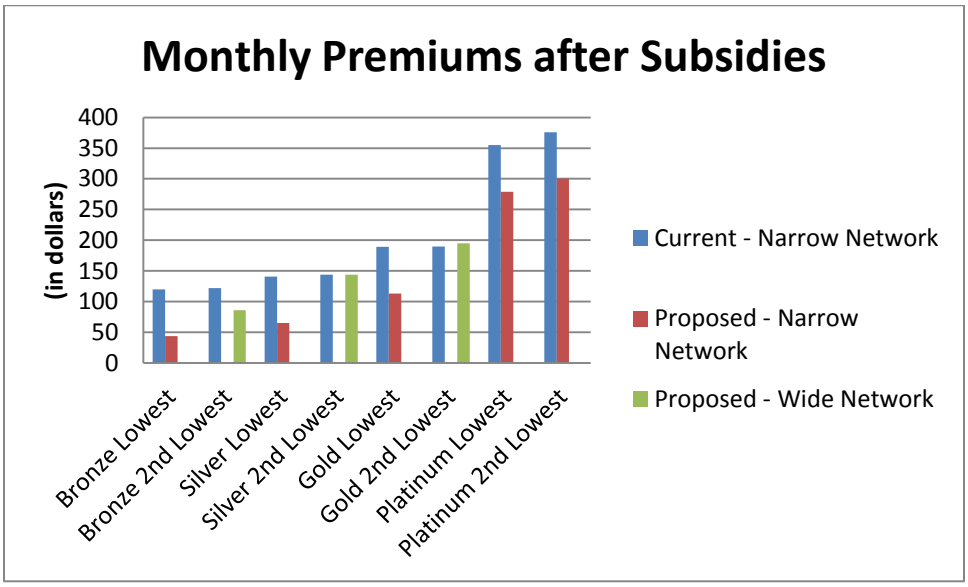
Premiums for a non-smoking 40 yr. old in Allegheny County making $25,000 ($122 subsidy) after market regulation

Bronze **Premium Amt.** 10 plans	**Network** (Narrow/ Wide)	Silver **Premium Amt.** 20 plans	**Network** (Narrow/ Wide)	Gold **Premium Amt.** 9 plans	**Network** (Narrow/ Wide)	Platinum **Premium Amt.** 4 plans	**Network** (Narrow/ Wide)
$44.00	Narrow	$65.00	Narrow	$113.00	Narrow	$279.00	Narrow
$86.00	Wide	$144.00	Wide	$195.00	Wide	$300.00	Narrow
$91.00	Wide	$144.00	Wide	$198.00	Wide	$363.00	Narrow
$93.00	Wide	$145.00	Wide	$207.00	Wide	$388.00	Narrow
$100.00	Wide	$151.00	Wide	$211.00	Wide		
$120.00	Wide	$154.00	Wide	$245.00	Wide		
$124.00	Wide	$154.00	Wide	$275.00	Wide		
$137.00	Wide	$155.00	Wide	$361.00	Wide		
$181.00	Wide	$159.00	Wide	$374.00	Wide		
$195.00	Wide	$164.00	Wide				
		$165.00	Wide				
		$169.00	Wide				
		$180.00	Wide				
		$184.00	Wide				
		$185.00	Wide				
		$185.00	Wide				
		$220.00	Wide				
		$287.00	Wide				
		$292.00	Wide				
		$294.00	Wide				

Benchmark Plan

Note: It is impossible to predict what the impact of these recommendations would be on the number of plans offered into the Exchange, though intuition points towards a reduction in the number. However, since the number of plans cannot be predicted, the hypothetical uses the same number of plans as

currently exists and adjusts the prices to reflect the increase in subsidy as well as the increased cost of a wider network.



Although it is difficult to say what the ultimate impact of these three recommendations would be, if the above example is typical for an individual receiving subsidies, the average Pennsylvanian could receive over $900 per year in increased subsidies. If you multiply this by the approximately 348,800 Pennsylvanians in the Exchange receiving subsidies, the increase in subsidies for Pennsylvanians would be over $318 million per year. This number may even be a conservative estimate since the number of people on the Exchange may increase with an increase in subsidies, especially among the younger population that currently does not have a high participation rate.

XVI. Exchange Public Education Functions

The primary goal for consumer education through the ACA is to inform consumers about the Exchange and the availability of subsidies in order to increase the number of eligible individuals participating in the Exchange. This has the additional benefit of lowering healthcare costs because of higher utilitization rates spreading fixed costs to a greater number of insured patients, as well as increasing federal subsidies received by the region. In Pennsylvania, the percentage of uninsured

decreased from 9.7% in 2013 to 8.5% in 2014.[106] Nationwide, many of the remaining uninsured are unaware of the marketplaces or of Medicaid expansion.[107] From the standpoint of reducing the number of uninsured, in one sense Pennsylvania is at an advantage. Undocumented workers are not eligible for marketplace subsidies or government insurance programs. The estimated percentage of undocumented immigrants in Pennsylvania is at 1.3%, well below the national average of 3.5%.[108]

It is necessary for Pennsylvania to move to either a state-run or state-federal partnership Exchange in order to allow for the types of innovations necessary to improve the public education functions of the Exchange for the citizens of Pennsylvania.

Recommended Public Information Strategies:

A. **Increase the Budget for Advertising and Assistance.** The most important part of any strategy to increase the number of insureds through the Exchanges is through extensive advertising and in-person assistance. State-run marketplaces have received far more funding for consumer assistance.[109] Under a state Exchange, Pennsylvania should substantially increase the budget for public information and ACA signup help and assign any additional costs to the plans participating on the Exchange. Although this strategy would increase the premiums for the plans on the Exchange, this would not impact what a typical insured pays because of federal premium subsidies. The additional funding could be used to

[106] United State Census Bureau. Smith, J.C. and Medalia, C. Health Insurance Coverage in the United States: 2014. September 2015. Pg 26, Table A-1. *Available at*: http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf.

[107] Alliance for Health Reform and The Commonwealth Fund. July 1, 2015 Briefing. Jost, T., Lee, P., Webb, B., and Lucia, K. The ACA: Experiences in Health Care Coverage and Access. Transcript, Pg. 3. *Available at*: http://allhealth.org/briefingmaterials/TRANSCRIPT7115_0Q.PDF.

[108] Washington Post. Chokshi, N. The undocumented immigrant population explained, in 7 maps. November 21, 2014. *Available at*: http://www.washingtonpost.com/blogs/govbeat/wp/2014/11/21/the-undocumented-immigrant-population-explained-in-7-maps/.

[109] The Commonwealth Fund. Dash, SJ. And Thomas, A. New State-Based Marketplaces Unlikely in 2015, but Technology Challenges Create More Shades of Gray. May, 1, 2014. *Available at*: http://www.commonwealthfund.org/publications/blog/2014/may/new-state-based-marketplaces-unlikely-in-2015.

specifically target hard-to-reach groups as well as increase the ability of navigators to spend more time with clients.

B. **Provide State Notice of Rate Increases.** Pennsylvania should send notices from the State informing people when their rate is projected to increase by 10% or more and advising them that more affordable options may be available on or off the Exchanges. It is important that this information come from the PID directly as people are more likely to open mail from governmental agencies.

C. **Provide Information about Off-Exchange Policies.** A general strategy advocated throughout this report is to increase the cost of certain plans on the Exchanges in order to maximize subsidies. However, this does not help individuals who are not eligible for subsidies. Pennsylvania needs to provide information concerning off-Exchange policies available for those who do not qualify for subsidies on the State's **pahealthoptions.com** website.

D. **Coordinate with Other Assistance Agencies.** Many of the remaining uninsured are from "difficult to reach" populations. However, many of these individuals do receive other types of assistance, such as energy cost assistance through non-profit agencies. Pennsylvania can increase the number of insured if it provides funding specifically to these agencies to sign up individuals and gives cash bonuses to anyone signing up.

E. **Notify Insureds of Potential Coverage Lapses.** The number of people with active policies through the marketplaces dropped 15% between the end of the enrollment period in February and the end of June.[110] Some of those who lost coverage could have avoided a lapse, but they did not respond to important communications from either the insurer or the Exchange. The average household receives 848 pieces of junk mail a year, along with

[110] The New York Times. Goodnough, A. Insurance Dropouts Present a Challenge for Health Law. October 11, 2015. *Available at*: http://www.nytimes.com/2015/10/12/us/insurance-dropouts-present-a-challenge-for-health-law.html.

hundreds of other letters.[111] Some of these letters come from the insurance companies themselves and contain material that while informative, is not vital for the insured to review. Pennsylvania should design an envelope that would indicate that the material inside the envelope is important and/or time-sensitive. The use of this envelope would be limited to events as designated by the legislature as important events and would include notifications of the potential cancellation of an active insurance policy. Alternatively, Pennsylvania should require that all final notices before the cancellation of a policy need to be sent registered mail.

F. **Use Smart Default Options and Cost-Calculators.** Studies have shown that insurance purchasers do not always purchase the right plan based upon their prior health conditions and the pricing structure of the available plans. There are many reasons for this, including the fact that consumers focus on specific costs, such as premiums, in their insurance decision making. This can lead to them choosing a plan that has higher costs. A variety of studies on the marketplace behavior of purchasers of Medicare Part D plans found that poor plan choice increased costs to the consumer of more than 30%. The use of cost-calculators and smart default options in the choice architecture of the Exchange website can increase the rate of optimal insurance decisions from a consumer perspective.[112] Pennsylvania should investigate the potential for modifying the default healthcare.gov website for those searching the Pennsylvania marketplaces in order to minimize the cost of Exchange plans to consumers.

G. **Reach out to the Uninsured with Health Issues.** Even with the existence of the Exchanges, some consumers do not have health insurance and subsequently experience a medical

[111] New York University Law. Junk Mail. *Available at*: http://www.law.nyu.edu/about/sustainability/whatyoucando/junkmail.
[112] Cloney, M. Health Care Workshop, Project no. P131207: Structuring the Choice Architecture of Insurance Exchanges Created Under the Affordable Care Act. *Available at*: http://www.justice.gov/atr/public/workshops/healthcare/2015/02/comments/00045-93725.pdf.

condition that requires treatment. Some of these medical conditions are non-emergencies; they may be slowly progressing conditions that will need to be treated in the future. Pennsylvania should provide outreach to medical professionals to identify uninsured individuals that have conditions that would benefit from them enrolling in the Exchanges during the next open enrollment period. These individuals should then be referred to specialized Certified Application Counselors that would work with them to make sure they enroll during the next window. This would help prevent uninsured individuals from developing expensive emergency conditions in the future, much of the cost of which would eventually be paid by the local medical systems as charity care.

XVII. Other State Strategies

As discussed previously, states have flexibility in adjusting the factors that insurers are allowed to consider when setting premium rates. One of the factors that premiums can be based upon is smoking status, which allows a policy to be priced up to 50% more for a smoker versus a non-smoker. In fact, smoking is different than the other factors because the default federal rules base the smoking surcharge on the unsubsidized cost of the insurance, which can make a huge difference in the amount paid by the insured.[113] For example, if an individual purchases a policy that would be $400 a month for a non-smoker and $600 a month for a smoker, but has a subsidy based upon her affordable payment of $100 a month, if the individual was a non-smoker they would get a $300 subsidy and pay $100 a month. However, if she smoked, she would be responsible for the entire

[113] The Commonwealth Fund. Giovannelli, J., Lucia, KW., Corlette, S. Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market. Pg. 3. December 2014. *Available at*: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1795_giovannelli_implementing_aca_state_premium_rate_reforms_rb_v2.pdf?la=en.

$200 surcharge, making her premium $300 a month. In this way a 50% increase in the premium can result in a 200% increase in the premium paid by the insured.

The problem with a 50% surcharge that is not covered by federal subsidies is two-fold. First of all, since smoking is an addictive activity, many insureds may not be able to quit and the impact of the surcharge may make premiums unaffordable. This will result in lower insured rates and corresponding higher uncompensated care costs which ultimately are spread to all individuals in the region through higher prices for healthcare. Second, since the surcharge is not subsidized by the federal government, the total subsidy received by Pennsylvania is reduced if there is a surcharge. On the other hand, if insurers were not allowed to charge higher premiums for smokers on the Exchanges, then the premiums for non-smokers would have to be increased to compensate for the shortfall. However, since the amount paid by insureds is not based on the cost of the coverage but on what is affordable to the insured, this increase would mainly be covered by increased subsidies.[114] For these reasons, Pennsylvania should eliminate smoking as a rating factor.

XVIII. State Innovation Waivers

Although beyond the scope of this report, it needs to be mentioned that there is a provision in the ACA which allows a state to significantly modify the entire healthcare provision system. Under Section 1332 of the ACA is the State Innovation Waivers program, which gives states extremely wide discretion in how they operate their health insurance and healthcare systems beginning in 2017, as

[114] There may be a slight difference in what an insured pays toward the monthly premium if the policy that they have coverage under has to increase their premiums in response to the prohibition against discrimination smokers more or less than the second cheapest silver plan.

long as they accomplish the goals of the ACA.[115] Specifically, a 1332 waiver must provide benefits as comprehensive as those under the ACA, provide cost-sharing protections and have coverage be at least as affordable as the marketplaces would have been and cover at least as many people as would have been covered under the ACA, and not cost the federal government any more than what it would have paid under the ACA.[116] Once a plan is approved, the state can use the funding that the federal government would have spent on subsidies to fund their alternative plan.

XIX. A Special Note Regarding Medicaid

Although it is not the main focus of this paper, it should be noted that state policy can impact the effectiveness of non-Exchange portions of the ACA. For example, under existing Medicaid laws, states must recoup Medicaid expenses from the estates of Medicaid participants. However, it is up to the states to run their recovery programs and the effectiveness and scope of the programs vary widely.[117] Since evidence shows that the threat of the depletion of one's estate serves as a barrier to participation in Medicaid and since the ACA has significantly increased the potential number of people covered under Medicaid, it may be in the best interest of Pennsylvania to limit its recovery as much as possible in order to have as many people as possible participate in Medicaid.[118] The benefits from having more participants in Medicaid, which for newly eligible enrollees the state is paid 100% by the federal government through 2016 and no less that 90% afterwards, is surely more

[115] HealthAffairs. Howard, H. and Benshoof, G. Section 1332 Waivers and the Future of State Health Reform. December 5, 2014. *Available at*: http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/.
[116] Center of Budget and Policy Priorities. Schubel, J. and Lueck, S. Understanding the Affordable Care Act's State ("1332") Waivers. February 5, 2015. *Available at*: http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers. ACA §1332(b)(1).
[117] Daily Kos. Woods, B. Estate Recovery – It's Worse Than You Thought. October 21, 2013. *Available at*: http://www.dailykos.com/story/2013/10/22/1249471/-Estate-Recovery-It-s-Worse-Than-You-Thought.
[118] ABA Commission on Law and Aging. Karp, N., Sabatino, CP., and Wood, EF. Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices. June 2005. Pg. 17. *Available at*: http://assets.aarp.org/rgcenter/il/2005_06_recovery.pdf.

than the opportunity cost of forgoing income by raiding the often meager estates of Medicaid recipients.

XX. Conclusion

The positive impacts of the ACA have mainly been in the reduction of the number of uninsured and an increase in the affordability of health insurance for many Americans. However, the ACA has not significantly impacted the trend of increased healthcare and healthcare administration spending or improved the quality of care. Although the ACA does not adequately affect the cost issue, it does provide some flexibility for states in the management of some of its provisions; as long as the state chooses to take over those parts of the ACA.

Although Pennsylvania has not yet moved to a greater role in the administration of the ACA, it has indicated that it may investigate moving to a state-partnership Exchange beginning in 2017. This move would allow Pennsylvania, through the Pennsylvania Insurance Department, to modify the existing operation of the Exchange in a way that would improve the healthcare of its citizens. Specifically, Pennsylvania could change the way that the Exchange operates both its plan management and consumer outreach functions. These modifications should be tailored to each specific healthcare market within the state (and the corresponding Exchange).

To review, our recommendations for the Pittsburgh Exchange include the following: require Bronze, Silver, and Gold plans to have wide networks, allow Platinum plans to have narrow networks, offer one narrow Silver plan on each Exchange, require Exchange plans to structure co-pays based upon the value of the service, require Exchange plans to waive the first 20% of the

deductible, require Exchange plans to incentivize net-benefit procedures, and to increase utilization rates through increased access.

Our recommendations for the Philadelphia Exchange is for it to: require Bronze, Silver, and Gold plans to have wide networks, allow Platinum plans to have narrow networks, offer one narrow Silver plan on each Exchange, set minimum medical loss ratios greater than those under the ACA, and require value based hospital care.

Furthermore, our statewide recommendations for consumer outreach and information are for the Exchange to: increase the budget for advertising and assistance, provide State notice of rate increases, provide information about off-Exchange policies, coordinate with other assistance agencies, notify insureds of potential coverage lapses, use smart default options and cost-calculators, and to reach out to the uninsured with health issues.

To conclude, by creatively using the existing authority under the ACA to manage the Exchange, Pennsylvania can accomplish a number of healthcare goals such as lowering the uninsured rate and making coverage more affordable for significant segments of the population. However, in order to use this authority, Pennsylvania first must gain control over the plan management and consumer outreach functions of the Exchange.