

# **Demystifying Active Purchasing: Tools for State Health Insurance Exchanges**

*A White Paper Prepared for the Executive Board of the State of Maryland  
Health Benefit Exchange*

**Prepared by: Members of the Technical Advisory Committee to the Maryland  
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**Funded By: The Maryland Citizens' Health Initiative**

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***Please Note - this paper is represents a policy synthesis by the authors and it does not necessarily represent the position of the Maryland Citizen's Health Initiative or the Johns Hopkins University.***

## Executive Summary

In 2014, 9 million Americans are expected to receive their health insurance through state-based health insurance exchanges (HIEs). By 2021, the number of Americans purchasing health insurance through these state exchanges is expected to more than double to 24 million. As one of the main conduits for expanding insurance coverage, states should carefully consider how to structure these marketplaces for the near term as well as the future.

The main goal of this paper is to inform decision-makers about "active purchasing" in the context of state health insurance exchanges. It provides a brief overview of the federal authorizing law, the Patient Protection and Affordable Care Act of 2010 (ACA), and a subsequent Maryland law establishing the Maryland Health Benefit Exchange. The paper then goes on to provide an in-depth discussion of two of the most controversial tools used by active purchasers: selective contracting and price negotiation. To the extent feasible we review the existing health policy / health services research literature and discuss relevant experience to date in other US public and private health benefit / insurance contexts. It is our hope that this paper will help inform policymakers of the range of options available and the advantages and disadvantages of these different choices.

Under the ACA, states were given discretion in how to organize its health insurance exchange. For example, states can restrict entry of insurers into the exchange according to pre-established criteria based on premium, benefit design, or quality rankings; or allow all insurers who meet basic standards participate as they do now. In the former example, the state exchange can be described as taking an "active purchasing" approach, while in the latter example, the exchange would be categorized as an "open marketplace." The terms active purchasing and open marketplace, may be best understood as two ends of a continuum. States can adopt a range of tools and levels of intensity depending on their goals and the current market conditions. The goal of the HIEs, whether "active" or "open," is to create an economically efficient marketplace for the purchase of health insurance.

Active purchasing is an organizing principle for the exchange, which is implemented through a range of tools including regulation, contract negotiation, health plan quality ratings, pay for performance incentives, and consumer education. States who wish to employ these tools, should consider each tool carefully on its own as well as its interaction with other components. In this paper we also consider the potential impact of active purchasing on creating a competitive marketplace, stabilizing exchange enrollment, and administrative feasibility.

## Introduction and Goals of this White Paper

The Patient Protection and Affordable Care Act (ACA) requires that each state create an “American Health Benefit Exchange” where consumers, individuals, and small groups can purchase qualified health plans. The legislative language and ensuing regulatory guidance provide some specifics to states on how to design these marketplaces. However, each state maintains considerable discretion in the organization and management of these marketplaces. A fundamental issue facing states is whether it wants its exchange model to be an “active purchaser” or “open marketplace.” Box 1 provides working definitions of these two alternative HIE approaches.

### Box 1. Key Definitions

The **active purchaser** model seeks to leverage the HIE’s authority and market power to promote value for the consumer. Active purchasers can use a range of tools under its administrative authority from regulation, negotiation, and consumer education, to oversee the insurance market to minimize any gaming by insurers.

In the **open marketplace** model, the HIE is a clearinghouse where all qualified insurers meeting minimum standards may participate. The HIE serves as a one-stop shop where consumers find accessible and useful easy to understand information on a wide variety of health plans. In this model, insurers compete with each other based on price and quality and consumers have sufficient information to make an informed purchase decisions.

“Active purchasing” and “open marketplace,” may be best understood as two ends of a continuum. States can adopt a range of tools and levels of intensity depending on their goals and the current market conditions. The goal of the HIEs, whether “active” or “open,” is to create an economically efficient marketplace for the purchase of health insurance. HIEs are also tasked with administering federal subsidies, monitoring plan performance, and coordinating with other state and federal programs.

While components of the active vs. open organizational models are not mutually exclusive, it is likely that each HIE will want to adopt one approach as its dominant strategy. This choice is central and will frame many, if not most, decisions needed for implementation and roll-out of the HIEs. Policymakers will need to take into account factors such as their state’s unique political environment, health care delivery system, and current health insurance market conditions.

The main goal of this paper is to inform decision-makers about active purchasing in the context of state health insurance exchanges. Specifically, the key objectives of this white paper are to:

- Provide an overview of the federal statutory and regulatory framework;
- Offer relevant definitions, framework, and clarifying terminology;
- Briefly describe the history of active purchasing and open marketplace strategies;
- Describe the existing evidence of these strategies;
- Provide examples of these strategies in practice; and,
- Identify some key issues Maryland decision-makers should consider as they decide between these two models for their state's exchange.

## Federal Background

President Obama signed the Patient Protection and Affordable Care Act (ACA) (PL. 111-148) on March 23, 2010. The ACA is estimated to expand health insurance coverage to an additional 34 million Americans by 2021. State-based health insurance exchanges (HIEs) will likely provide coverage to the vast majority of the newly insured. In 2014, 9 million Americans are expected to receive their health insurance through state-based health insurance exchanges (HIEs). By 2021, the number of Americans purchasing health insurance through these state exchanges is expected to more than double to 24 million (Elmendorf 2011).

Even though the exchanges are a fundamental feature of the federal effort to expand affordable health insurance coverage, the organization, implementation, and management of HIEs was left to the states. While the ACA requires that exchanges perform certain oversight and management functions, such as certifying plans and providing consumers with a toll-free hotline, the law allows states considerable flexibility in how to achieve some of these functions. ("Patient protection and affordable care act; establishment of exchanges and qualified health plans" 2011) An overview of the required functions of the HIE are listed in Box 2.

While the federal law and regulation identifies requirements for states, it also identifies areas where states may design their own policies. For example, an exchange may operate as a regional or interstate exchange. In addition, exchanges are allowed to use market-based incentives to reward qualified health plans for improving quality of care (Section 1311(g) of PL 111-148). A politically contentious issue, and one left to state discretion, is whether states will operate their exchanges in the active purchaser model or as an open marketplace.

## **Box 2. Health Insurance Exchange Required Functions<sup>1</sup>**

- 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
- Administer exemption process for 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
- Generate sufficient revenue to be self-sustaining by 2015

Through the federal regulatory process, the Federal government has provided states with some additional guidance. The Secretary of Health and Human Services (HHS) in the proposed regulations governing exchanges from July 2011, identified a handful of issues states will need to consider in establishing its exchange. One of the most controversial issues is developing the exchange's organizational model. In the proposed rule outlines two archetypes: "active purchaser" and "open marketplace." (See Box 1 for definitions)

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<sup>1</sup> Modified from Silow-Carroll, S., D. Rodin, T. Dehner, and J. Bern. 2011. "Health insurance exchanges: State roles in selecting health plans and avoiding adverse selection." *States in Action*. The Commonwealth Fund.



Active purchasing can include a range of activities. Some of the components of active purchasing are selective contracting, negotiating on price and quality, requiring payment and delivery reforms as part of plan design, requiring additional certifications, providing consumer education materials, and further regulation of the market by standardizing health plan benefit packages. (Corlette et al. 2011; Corlette and Volk 2011; Weinberg and Haas 2011). These tools are described in greater detail below. While some of these activities are expected functions of an exchange as required by the ACA, the core difference between active purchasing and the open marketplace is the HIE's mission (Corlette and Volk 2011). While some states will want to take a more active role in monitoring the marketplace and selecting which plans can enter the marketplace; other states may prefer to defer to market forces.

### **Maryland Background**

Following the passage of the Affordable Care Act, Maryland was one of the first states to pass legislation to establish its own health insurance exchange. The Maryland Health Benefit Exchange Act of 2011 creates an independent public corporation to operate the exchange, and lays out the purpose and responsibilities of the Exchange (“Maryland health benefit exchange act of 2011” 2011).

The Maryland law describes five main purposes of the Exchange (§31-102(C)). They are:

1. Reduce the number of uninsured;
2. Create a transparent individual health marketplace for consumers and insurers;
3. Assist small businesses to enroll their employees in qualified health plans and access tax credits;
4. Help individuals access low income tax credits and cost sharing support; and,
5. Supplement the individual and small group insurance markets outside the exchange.

The Maryland law requires the exchange to provide the minimum functions required by the ACA (described in Box 2). The law goes beyond the ACA in some areas by encouraging the Exchange Board to use the procurement process to promote efficiency in the market place

that “achieves the maximum benefit from the purchasing power of the Exchange.” (§31-106(F)(2)(V)).

The law also requires the Exchange Board to study and make recommendations to the Governor and General Assembly on some of the more politically and practically contentious issues facing the state including selective contracting. Specifically, the law requires the Exchange to study and make recommendations on “the feasibility and desirability of the Exchange engaging in: 1. selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements....” (§31-110-5(1)(i)).

As discussed below, one of the most controversial tools of an active purchaser is the decision to only contract with some health plans and not others. In deciding to selectively contract, it is important for policy makers to also take into account some possible limits on the Exchange’s authority. In Section 109 of the Maryland law provides some protections to insurers, which closely mirrors the Affordable Care Act Section 1311 (e)(1)(B). The Maryland law says that a health benefit plan may not be denied certification for three reasons: 1) because it uses a fee for service reimbursement system; 2) “through the imposition of premium price controls by the Exchange;” and, 3) on the grounds that it provides treatments at the end of life (§31-109(E)(2)). For policymakers interested in active purchasing, the definition of premium price controls is not clear based on Maryland’s legislative language or the federal authorizing statute. Additional clarification may be necessary.

While state health insurance exchanges may represent a new entity with entirely new functions, the issues surrounding how governments should interact with private health plans are not new. Government entities such as state Medicaid programs, public employee health plans, and Medicare have struggled for decades with how to purchase health insurance, and design benefit packages. In addition, employers, business coalitions, Taft Hartley/Union plans have a long history trying to get the best value possible for their

“beneficiaries.” In the discussion below, we will describe some of the existing evidence from both public and private sector purchasers. While no example will be a perfect model for Maryland, past experience can guide future policymaking efforts.

Under this new system, many aspects of the current market and regulatory structure will continue to apply. State departments of insurance will continue to regulate the individual and small group health insurance markets. Departments of insurance will review annual rate increases and set the market rules for the exchange. In Maryland, the Health Services Cost Review Commission (HSCRC) will continue to set hospital rates for all payers, including those in the Exchange.

However, there are important differences in this new marketplace. State insurance exchanges will operate with a greater degree of transparency than other markets. In all states, exchanges must operate a website to provide health plan options. Health insurance exchanges must also provide information on the plan’s level of coverage and quality rating. In addition, qualified health plans must be determined to be in the interest of individuals and employers (§31-109(B)(7), ACA Sec 1311(e)(1)(B)).

Maryland is facing the same challenges and decision points as other states. For example, Maryland policymakers are continuing to discuss important issues regarding the merger of the individual and small group markets, as well as how to best serve individuals and families who may qualify for Medicaid part of the year and private insurance for part of the year. There are also challenges facing the Exchange such as the impact of allowing health insurers to offer qualified individual and small group health plans both within and outside of the Exchange.

### **Active Purchasing: Theory and Framework**

In theory, an efficient marketplace is one where the marginal cost of a good is equal to the marginal price. Under certain conditions, some markets may achieve this kind of perfect

competition, but this is the exception and not the rule. Achieving economic efficiency can be a tall order in the health insurance market where information asymmetries and bounded rationality complicate almost all transactions creating market failures.

### **Box 3. Market Failure Definitions**

**Information asymmetry** is when the consumer or the supplier has more information than the other person.

An example of an information asymmetry is when a sick person signs up for health insurance because he knows he will use it. This is an example of *adverse selection*.

**Bounded rationality** means that people are limited in the amount of information they can understand and process, as well as the time with which to make a decision.

In a “textbook” market, firms compete for customers based on price and the quality of the product or service. In many cases, this competition is thought to enhance efficiency and maximize utility. However, because of information asymmetries and bounded rationality in the health insurance marketplace, unmonitored competition has the very real possibility of reducing efficiency. If left unchecked, information asymmetries could lead to “opportunistic behavior” or gaming by both consumers and insurance providers that

have adverse consequences for efficiency. Insurance companies could offer benefit plans that will appeal to low risk individuals or worse, plans that are only appropriate for low risk individuals. In turn, consumers can try to game the system by waiting until they need coverage to buy a policy or use unnecessary health care services just because they are covered.

The ACA attempts to address many of these market failures. The ability of insurance companies to deny coverage based on medical underwriting will be eliminated and all individuals will be required to purchase coverage. Information on the health benefit plans offered in the exchange and a required set of essential health benefits will mitigate the bounded rationality of consumers and limit the benefit design strategies of insurers to deal with adverse selection. The HIE’s ability to address other market failures that put either the insurer or consumer at a disadvantage will depend on the state’s market rules.

Economists such as Alain Enthoven have suggested that market failures can be addressed by modifying an otherwise free marketplace into a “managed competition” marketplace. In managed competition a “sponsor” serves as a negotiator and regulator to ensure an efficient and fair marketplace (Enthoven 1993). This premise has influenced health policy debates since the late 1970s. It served as a central tenet of Clinton's health reform proposal and is the underlying premise of state health insurance exchanges. It is also the theoretical anchor of active purchasing (Corlette and Volk 2011).

An effective “sponsor” is viewed as relatively nimble entity that can react quickly to shifts in the market. A sponsor continuously monitors both insurers and purchasers to ensure a competitive market place. Enthoven writes: “Managed competition must involve intelligent, active collective purchasing agents contracting with health care plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition” (Enthoven 1993). Enthoven envisioned managed competition being carried out through what he termed privately managed health insurance purchasing cooperatives (HIPCs). Under the ACA, the state health insurance exchanges take on the role of sponsor.

There are two inter-related issues that Maryland’s HIE will have to grapple with in setting the Exchange marketplace. First, the Maryland HIE market is at risk of adverse selection. Less-healthy individuals may look to purchase insurance through the Exchange to take advantage of the transparency, quality ratings, guaranteed issue, and Federal low income subsidies. Healthy individuals who are more likely to be younger and wealthier, may look to purchase insurance outside the Exchange. Second, Maryland’s health insurance market is consolidated among very few insurers. It will be a challenge to attract insurance companies who can compete across the state to increase competition on price and quality.

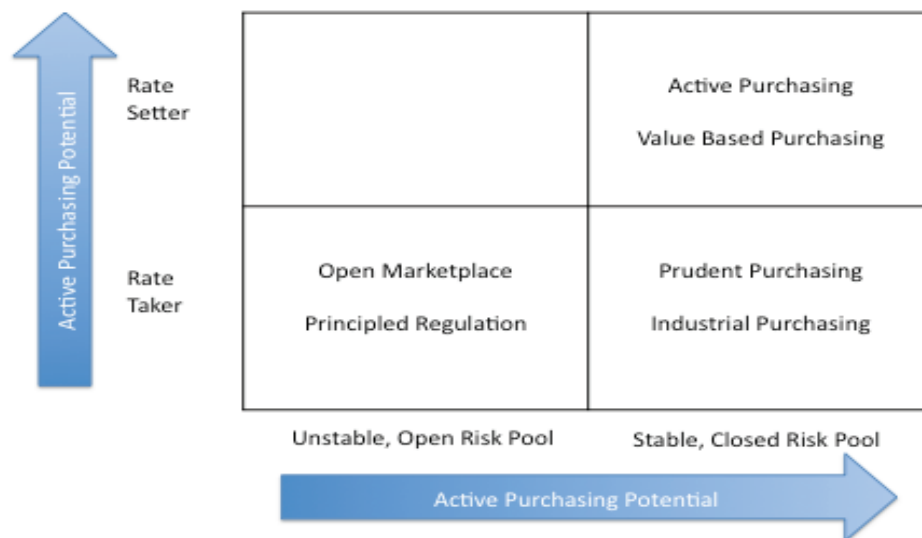
If mostly unhealthy people join the exchanges, the cost of insurance will escalate and the Exchange will look less and less attractive to potential consumers outside the Exchange. The smaller the pool of persons purchasing insurance inside the exchange and the more uncertainty there is regarding their health status, the less attractive the exchange will be to

insurance carriers as a place to sell insurance. Without a large and stable population purchasing insurance through the exchange, the HIE will not have the market power to influence competition on price and quality.<sup>2</sup>

### Range of Purchasing Strategies

In Figure 1<sup>3</sup>, we array several purchasing approaches illustrating a range of active purchasing models across two characteristics: negotiating power with insurance plans and the characteristics of the marketplace. The purchasing approaches and tools shift from the “open marketplace” model in the bottom left corner to the active purchasing model in the upper right corner.

**Figure 1. Continuum of Purchasing Strategies**



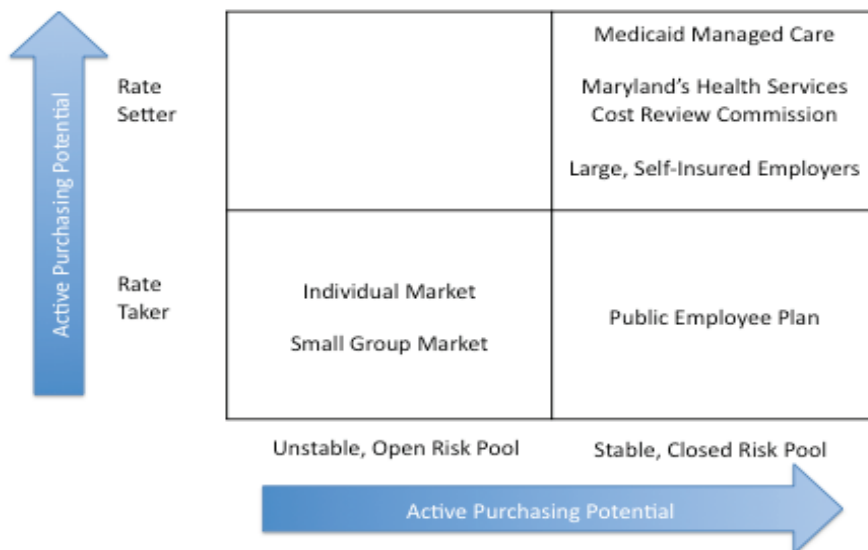
<sup>2</sup> Since the Exchange will be administering federal low-income subsidies for insurance there will be core population in the Exchange risk pool. States have options under the ACA to make this core population larger or smaller depending on how they treat the current Medicaid recipients and the persons who will be eligible for Medicaid in 2014. For more information about policy options see Benjamin Sommers and Sara Rosenbaum (2011).

<sup>3</sup> Modified from Wakely Consulting Group. “Maryland health benefit exchange operating model and insurance rules advisory committee.” 2011. *Operating Model and Insurance Rules Advisory Committee Meeting*. UMBC Technology Center Wakely Consulting Group.

The upper left corner of Figure 1 is empty because with an open unstable risk pool the HIE would not have the market power necessary to set rates. The bottom right corner includes middle of the road approaches strategies that engage in the marketplace through quality reporting and some negotiating on benefits. We outline some of their characteristics across key domains in the Appendix.

Figure 2 provides examples of our assessment of how the characteristics we lay out in the Figure above may play out for different health care payer/insurers' marketplaces.

**Figure 2. Examples of Active Purchasing Potential for Different Payers /Insurers**



In contrast to active purchasing type of strategies, Maxwell coined the term “industrial purchasing” to describe the “typical” purchasing strategy used by large private employers (Maxwell and Temin 2002). In a study of Fortune 500 companies, Maxwell found these employers often used traditional purchasing strategies, which they applied to obtain other goods and services, to the acquisition of health insurance for their workers, retirees and dependents. Industrial purchasing meant that the employer sought to find health plans for the best price at a particular level of "product quality."

A 2005 California HealthCare Foundation issue brief on employer purchasing pools described three types of purchasing pool arrangements: active purchasing, passive clearinghouses, and market organizers (Curtis and Neuschler 2005). "Active purchasers" negotiated the best value; "clearinghouses" served as information conduits; and "market organizers" are a hybrid of the two ends of the spectrum. For example, a market organizer may require certain benefit design features and quality reporting, but it would not negotiate premiums. In the context of Figure 1, a market organizer in the lower right hand corner that can negotiate with insurers on some plan features, but is still a rate taker.

### **Active Purchasing: Tools and Illustrations**

In their recent analysis of active purchasing in the HIE context, Corlette and Volk describe the gestalt motivating active purchasers: an entity that is “able and willing to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices” (Corlette and Volk 2011). If an exchange chooses to pursue the mission of achieving value for consumers, it can employ a number of tools such as selective contracting that requires payment and delivery reform, price negotiation, regulation, standardization, and public reporting. The focus of this section is on arguably the most controversial active purchasing tools: selective contracting and price negotiation. Other potential purchasing tools are briefly reviewed.



## Selective Contracting

With selective contracting, an exchange would choose to allow some plans and not others into the HIE's marketplace. Whether states adopt selective contracting may fundamentally affect the market both within and potentially outside of the exchange. If the HIE attracts a large number of individuals and small employers who are not receiving subsidies, then the size of the market outside of the HIE may be so small that health plans not contracting in the exchange may not be able to compete in the state. Conversely, if the HIE does not attract enough individuals and small groups then it may have trouble finding enough insurers to offer health plans inside the exchange.

Exchanges could use a wide range of criteria to select plans, including accreditation, premiums, plan enrollment, plan design, and quality rankings. Exchanges may choose to selectively contract for a number of reasons such as wanting to limit the number of options in the market or to reward plans who achieve high quality ratings. In addition, the ability to selectively contract with carriers may provide the exchange with the necessary leverage to negotiate plan premiums or other benefit design features.

A well-known active purchasing prototype is the California Public Employees' Retirement System (CalPERS), which purchases health insurance plans for 1.3 million California state and local public employees. CalPERS uses a range of criteria in ranking plans including consumer service, demographic risk, cost, and administration ("Real story in calpers talks lies beyond the headlines" 2011). Corlette and Volk report that the organization has used selective contracting since 2002 and it has actively applied financial performance and customer service metrics in its contracting process. CalPERS also requires an external audit of participating plans and may vary contract terms by plan. CalPERS partners with its plans to test payment and care management innovations (Corlette and Volk 2011). We were unable to find any evidence on the cost and quality impact of these interventions in the peer-reviewed literature.

Selecting criteria upon which to judge plans is a difficult task for policymakers. Jon Kingsdale, former executive director of Massachusetts' exchange, the Commonwealth

Connector, posits that all selective contracting criteria are discretionary judgments. He suggests that policymakers consider what kinds of plan designs will be attractive to the market. He also recommends that policymakers consider how to modify benefit designs as needs and delivery systems evolve, in order to maintain a degree of continuity among contracting plans to allow consumers to stay with the same plan for a number of years if they wish to. On a related note, a recent report from the Maryland Department of Hygiene and Mental Health (DHMH) explored the concept of selective contracting within Medicaid programs. The authors found that in the six state Medicaid agencies using selective contracting, five out of six programs require at least three-year contracts with the plans. Similarly, the Maryland public employee program requires five-year contracts with selected plans ("Maryland healthchoice program: Should maryland move to a selective contracting strategy?" 2011).

Other criteria that exchanges may want to consider for selection or continuation could include plan features that emphasize system-wide cost savings. Exchanges may want to emphasize quality of care performance and innovative approaches to improving quality such as value-based insurance design (see other MCHI sponsored white paper by Christine Buttorff and colleagues dedicated to this topic) or the patient-centered medical home (PCMH). Depending on their plans' market share, exchanges may also want to consider collaboration between other public plans and employers in order to more efficiently create delivery system reforms.

Other important criteria for plan selection could include provider network sufficiency, member exit surveys, member satisfaction surveys, and NCQA accreditation. According to a National Health Policy Forum background paper on state exchanges, in its first year, the Massachusetts Connector used a scoring system that factored in a variety of criteria such as premiums, cost-sharing and plan services such as wellness programs. The state also emphasized high-performance networks, plans' marketing strategies, and geographic coverage (Merlis 2009).

As in other government request for proposals, health plan bidders will expect that the selection criteria are explicitly described. Exchanges may want to consider creating a weighting system to evaluate health plan bids to promote transparency and trust in the selective contracting process.

### **Summary of the Evidence on Active Purchasing**

The employer group health insurance market typically serves as a rich source of information on innovative purchasing strategies. In the case of state HIEs, the experience of large employers should be considered with caution because large employers are insuring employees and their families who are a captive stable population. HIEs will not have a large stable population in the exchange in the first several years of operation. Second, large employers almost always are self-insured and not purchasing insured products from insurance carriers. They are usually purchasing only administrative services related to the health plan, processing claims, contracting with providers, and related services. However, the lessons learned from large employers can be instructive because they have been the most aggressive active purchasers. In addition, the employer population is similar in relative age to the HIE population, compared to children in Medicaid and seniors in Medicare.

While both public and private sponsors have experimented with active purchasing tools, the peer-reviewed literature has focused on the private market. In a survey of Fortune 500 companies, Maxwell found that 93 percent of surveyed employers had reduced the number of health plans it offered in the past five years. However, there is little evidence in the literature to guide policymakers in setting a target number of plans for a market. Maxwell and colleagues found that Fortune 100 and Fortune 500 companies using managed competition strategies did not achieve greater cost savings compared to companies that used a more typical industrial purchasing approach (Maxwell and Temin 2002). While Fortune 100 and 500 companies are may have significant leverage, it is unclear that one or

even a handful of companies together would be able to counter larger market forces at play.

The reason to selectively contract is to encourage greater plan competition. Reports from Arizona's Medicaid program and Massachusetts suggest that selective contracting can have powerful cost containment effects on the market. However, other studies on health insurance competition have reported mixed findings on the relationship between the level of insurance market competition and quality and cost. Scanlon and colleagues found that there was no relationship between measures of HMO market competition and quality metrics (Scanlon et al. 2005). Wholey and colleagues and Dafny have found a positive relationship between health plan market concentration (that is less competition) and health plan premiums (Dafny 2008). Glenn Melnick and colleagues approached affordability by looking at the relationship between health plan concentration and hospital prices. They found that greater health plan concentration in a metropolitan statistical area was associated with lower hospital prices (Melnick, Shen, and Wu 2011).

Lastly, a recent paper by McWilliams and colleagues found that 15 to 30 plan options in a market was associated with the highest rates of Medicare Managed Care plan enrollment (McWilliams et al. 2011). Markets with more than 30 plans were associated with lower rates of enrollment, suggesting that there is such a thing as too many choices. However, limiting choices too much may also have negative consequences on the market. Health economist Leemore Dafny finds that health plans continue to exhibit significant market power relative to employers when there are as many as 10 different health plans competing (Dafny 2008).

### **Price Negotiation**

In traditional government contracting, an agency publishes a request for proposals that describes the scope of a particular project, interested parties submit bids, and the agency then selects awardees based upon their submissions. Awardees are paid based on their submitted bid. In contrast to this process, active purchasers would be able to go back to

health insurance bidders to re-negotiate over premiums, benefit design and other components of the contract. Price negotiation is typically described as a corollary to selective contracting (Corlette and Volk 2011; Kingsdale and Bertko 2009; Wicks 2009). While an exchange can selectively contract without direct price negotiation, it may be difficult for an exchange to negotiate premiums without the ability to “walk away” (i.e., the ability to not contract with the insurer).

There is limited evidence in the literature on price negotiation strategies in the health insurance market. The bulk of the research on health insurance premiums has focused on the impact of competition, plan type, and quality on premiums. Previous surveys of large employers purchasing strategies have primarily focused on the use of financial incentives and quality metrics (Lo Sasso et al. 1999; Rosenthal et al. 2007).

### **Summary of the Evidence on Price Negotiation**

In 2000, Maxwell found that many Fortune 500 firms were using requests for proposals (RFP) as a price negotiation strategy. Of those using an RFP, 90 percent required detailed information from health insurers regarding their product, which may include level of coverage, benefits provided, provider network information and data on quality. After submitting bids, the employer compares the bids and then uses in-person negotiating to agree upon an acceptable price (Maxwell, Temin, and Watts 2001). While Maxwell refers to this process as competitive bidding, it is not as structured as the Medicare competitive bidding program.

In contrast, the Medicare competitive bidding program for certain durable medical equipment in selected markets is much more structured. Contractors submit bids to provide a product at a particular price. Medicare awards the contract to the lowest one or two bidders. In the Medicare competitive bidding process there is no opportunity for the government to then renegotiate a potential contractor’s bid price.

According to a DHMH white paper on selective contracting, some Medicaid programs employ premium negotiation (“Maryland healthchoice program: Should maryland move to

a selective contracting strategy?" 2011). Arizona Medicaid requires plans to bid within an actuarially defined range. The state is then allowed to go back to the plan to further negotiate the premium. The paper also reports that Iowa Medicaid once tried to limit its Medicaid MCO contract to a specific increase level because of budgetary pressures; but due to unrealistic expectations, the state did not receive any bids.

*Active Purchasing Case Study: Price Negotiation in Massachusetts*

In 2006, Massachusetts passed its landmark health reform law. In an effort to achieve near-universal health insurance coverage, the law created new insurance purchasing options for the uninsured and under-insured. These were known as "Commonwealth Care" and "Commonwealth Choice." The law also included an individual mandate requiring all adults to purchase insurance, if they can afford it. Since its implementation in 2007, the Connector reports that 411,000 Massachusetts residents are now insured. Based on state-wide surveys, Massachusetts now has a 2 percent uninsured rate.

Commonwealth Care is a subsidized program providing insurance options for people below 300% of the federally poverty level (FPL). Commonwealth Choice is a program offering unsubsidized access to insurance options. In both programs, there are four health plan benefit levels: gold, silver, bronze, and young adults plans. In 2011, six health insurers offer plans through its exchange, known as the "Commonwealth Connector" ("Health reform facts and figures" 2011). The Massachusetts' Commonwealth Health Insurance Connector Authority is an independent state agency responsible for administering the Commonwealth Connector.<sup>4</sup>

As one of the key models for active purchasing and the American Health Benefit Exchange provision of the Affordable Care Act, the attributes of the Commonwealth Connector have been well documented by others (Corlette et al. 2011; Kingsdale 2009). Among its many accomplishments, the Connector reports that it successfully managed to slow the rate of

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<sup>4</sup> The Commonwealth Connector also manages two additional programs. The Commonwealth Bridge program is for certain legal immigrants. The Commonwealth Business Express program is targeted for small employers.

growth of health plan premiums. The average annual premium increase among the plans participating in the Connector was 3.5%, over the period of 2007 to 2010, compared to Kaiser/HRET Survey of Employer-Sponsored Health Benefits from the same period, the average annual increase premiums for an individual plan was 4.46 percent.

While not meeting the definition of a “competitive” marketplace, Massachusetts’ individual and small group markets are relatively more competitive compared to other states like Maryland.<sup>5</sup> A 2011 study by Kaiser Family Foundation found that in 2010, in Massachusetts the largest insurer accounted for 57 percent of the individual market and 46 percent of the small group market. Four other insurers accounted for more than 5 percent of the individual and small group markets (“How competitive are state insurance markets” 2011). This high degree of concentration among health insurers puts the HIE at a disadvantage with respect to imposing requirements on plans or efforts to negotiate prices. Despite these challenges, Massachusetts has been successful at slowing premium increases in Commonwealth Care.

In 2009, the five bidders for the Commonwealth Care program submitted bids on average 2.5% below the target. While there may be multiple contributing factors to Massachusetts’ success at holding down premium increases, at least one key factor attributed to their success is the ability of the Connector to negotiate premiums with plans. Jon Kingsdale and John Bertko describe Massachusetts’ approach to premium negotiation as follows:

*For example, in its latest round of contracting (2009), Commonwealth Care used historical claims for a relatively stable population of enrollees to project cost trend and set a maximum premium. The bidders had to decide whether to reject this price (and forego participation), accept it, or bid below the administered price. The incentive to bid lower is that an enrollee earning above 101 percent of FPL pays the entire difference in premium between the plan he/she selects and the lowest priced*

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<sup>5</sup> A competitive marketplace is defined as having Herfindahl–Hirschman Index of less than 1800. According to Kaiser Family Foundation’s 2011 report on the individual market competition, Massachusetts scored a 3872, while Maryland scored a 5366.

*plan available, and an enrollee earning less than 101 percent of FPL who does not select a plan is auto-assigned to one of the lowest priced plans. Five plans bid, and most bid below the administered price. (Kingsdale and Bertko 2009)*

Over all, the Massachusetts Connector reports that the capitated rate per person for Commonwealth Care, the subsidized program, has grown on average 3.5% annually from 2007 to 2010 (“Health reform facts and figures” 2011). In comparison the average annual increase premiums for an individual plan was 4.08% and 4.4% for family plans, according to a Kaiser/HRET Survey of Employer-Sponsored Health Benefits from the same period.

### **Other Active Purchasing Tools**

Along the spectrum of active purchasing tools, sponsors have employed a number of tools on their own or in combination to promote value.

Quality improvement is widely used by public programs. Quality improvement can take a number of forms ranging from requiring health plans to report selected quality metrics to promoting quality through use of financial incentives and disincentives (like Maryland’s HealthChoice program). The use of financial incentives is often called value based purchasing or pay for performance (Epstein 2006; Rosenthal et al. 2007). These types of programs have been implemented at to influence provider behavior. These programs can provide rewards directly to providers for meeting clinical quality metrics or these programs can provide rewards to plans that meet clinical quality metrics for their enrolled population, as well as at the plan-level. For example, in Maryland, Medicaid MCOs report their plan-level performance on quality measures such as lead screenings cancer screenings. As in Maryland, one way to structure these incentives is for the state to withhold a certain proportion of the total program payment and then redistribute these monies to high performing plans. An alternative approach is to provide bonus payments on top of the current payment system for high performing participants.

Quality improvement strategies cannot function without proper measurement and reporting. While some states and programs develop their own quality metrics, independent



organizations such as NCQA have developed quality measures that are used by a wide variety of stakeholders. The National Quality Forum (NQF) also approves quality measures for providers and health plans. An advantage of using validated quality measures is that it allows for comparison to other states and other programs within a state. A downside is that the measure may not exactly capture the dimension of care or target population of interest.

Consumer education and engagement is also a common component to many purchasing strategies. Consumer education can range from one-on-one discussions with an independent agent, to offering consumer's health plan report cards describing plan performance, and use of web-based enrollment decision support tools. In a review of the literature, Hibbard and colleagues find that studies evaluating health plan report cards have found that consumers often do not use report cards to switch health plans. However, one study found that people who have to make a decision about enrolling in a new plan are more likely than others to actually study and use report cards. Hibbard and colleagues found that among individuals who said they saw a health plan report knew more about their health plan than those saying they never had seen such a report card (Hibbard et al. 2002). Overall, the evidence suggests these efforts may have a small effect on health plan decisions on average.

Requiring or encouraging plans to adopt care delivery innovations would be another tool in the active purchasing toolbox. Exchanges may be able to negotiate individually with plans to implement innovative programs, like CalPERS. Or it may require these kinds of programs as part of defining qualified health plans. It is important to note that the feasibility and effect of interventions may vary by the plan's enrollment and past experience. For example, while a telephonic case management for the chronically ill may be more straightforward for a small plan to adopt, creating its own pay for performance program may be too difficult for plans with limited influence over providers.

## **Key Considerations for Maryland's Health Insurance Exchange**

As Alain Enthoven identified almost two decades ago, policy makers are likely to encounter a number of difficult design issues in building the exchange marketplace. As we have noted, a particularly pressing political issue is whether a market sponsor—be it a state government agency or non-profit semi-autonomous organization—should become an “active purchaser” or “open marketplace.” But the use of these terms creates a false dichotomy suggesting that there is little room in between. In our view, decision-makers may want to consider components of these two purchasing strategies depending on their particular market conditions. The July 2011 proposed rule establishing HIEs suggests that Exchanges consider its size, risk profile, market concentration, and interaction with existing state rules governing insurance.

If a state wants to take an active purchasing approach, then policymakers should consider each component carefully on its own, as well as its interaction with other components. The Board may also want to consider adopting an active purchaser mission, but implement components of this strategy over time or with differing levels of "activism intensity" over time. As these new marketplaces mature and stabilize, state regulators may be more comfortable intervening in the marketplace with additional program participation requirements, financial disincentives, and selective contracting. In Table 1, we summarize some of the key advantages and disadvantages of the purchasing tools.

In Maryland, there are several market factors to be considered in the design and organization of the state insurance exchange. Below we consider some of the key issues to consider and potential implications in Maryland's Exchange.

**Table 1. Potential Advantages and Disadvantages of Key Active Purchasing Components**

	<b>Selective Contracting</b>	<b>Price Negotiation</b>	<b>Require Innovative Programs</b>	<b>Public Reporting</b>
<b>Advantages</b>	<ul style="list-style-type: none"> <li>- Creates price competition</li> <li>- Multi-year stability depending on contracting</li> </ul>	<ul style="list-style-type: none"> <li>- May ensure affordable premiums</li> <li>- May increase enrollment</li> </ul>	<ul style="list-style-type: none"> <li>- Drives quality improvement</li> <li>- Can be required in RFP or contract</li> </ul>	<ul style="list-style-type: none"> <li>- Administrative straight forward to collect existing measures</li> <li>- Allows for comparisons to other plans and states</li> <li>- Can be implemented on its own</li> </ul>
<b>Disadvantages</b>	<ul style="list-style-type: none"> <li>- Limits plan options</li> <li>- May lead to market consolidation</li> <li>- Only effective if there are many plans bidding</li> </ul>	<ul style="list-style-type: none"> <li>- Most effective with selective contracting</li> <li>- May require benefit trade-offs</li> </ul>	<ul style="list-style-type: none"> <li>- May create additional administrative burden on plans</li> <li>- Program may not be effective</li> <li>- May be most effective with public reporting</li> <li>- May be most effective when coordinated with other payers and programs</li> </ul>	<ul style="list-style-type: none"> <li>- Uncertain if consumers use publicly available information</li> <li>- May require using existing quality measures</li> </ul>

**Creating a competitive marketplace:** Maryland’s insurance market is more concentrated than Massachusetts. Maryland’s dominant insurer has a larger market share than the dominant insurer in Massachusetts. Maryland has fewer health plans with more than 5 percent market share. Specifically, in an August 2010 presentation, Chuck Milligan, Deputy Secretary of DHMH, reported that over 96 percent of Maryland’s regulated health insurance market was controlled by six health insurers. In 2010, the dominant insurer controlled 72 percent of the market and only two other health plans accounted for more than 5 percent of the individual market. In the small group market, the dominant insurer controlled 46

percent of the market and only three other health insurers accounted for more than 5% of the market (“How competitive are state insurance markets” 2011). However, Maryland does have a number of small, local health plans, who could potentially grow with the HIE marketplace.<sup>6</sup>

Given Maryland’s level of market concentration, the largest insurers will have significant leverage compared to the Maryland Exchange in a negotiation. In Figure 1, the state would most likely be a rate taker when working with large insurers, but could be a rate setter when working with smaller plans. In the early years of the program, policymakers may want to consider focusing on growing the marketplace. Like Massachusetts, encouraging new entrants to the market that can keep premium bids competitive may be a strategy to consider.

**Stabilizing HIE enrollment:** In 2014, it is expected that 180,000 people will purchase health insurance through Maryland’s Exchange (Milligan 2010). Maryland policymakers plan to transition the Maryland High Risk Pool program (MHIP), a state managed health insurance program for residents who are otherwise unable to obtain insurance. MHIP enrolls about 20,000 residents.

State decisions regarding whether Maryland will allow individuals to purchase plans both inside and outside the exchange will influence the stability of the market as well as the number of people who buy insurance. Wicks and Kingsdale suggest that active purchasing strategies are most effective when the exchange has a “captive” market (Kingsdale and Bertko 2009; Wicks 2009). If many consumers can easily move inside and outside of the exchange, then an active purchasing strategy may backfire as consumers look outside the exchange for lower cost plans. These problems can be at least partially addressed with "risk adjustment" approaches to control for risk selection within and outside of the HIE

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<sup>6</sup> We were unable to find data on the concentration of Massachusetts’ individual and small group markets prior to the implementation of its 2006 health reform law. These data on the market’s competitiveness prior to reform would be a helpful guide to state policymakers trying to better understand how to replicate Massachusetts’ success.

marketplace (Weiner et al. 2011). Other options may be limiting movement inside and outside the Exchange, maximizing the number of people who will most benefit from purchasing inside the Exchange, and limiting the marketplace outside the Exchange.

Lastly, it is estimated nationally that due to changes in income, more than 35 percent of low income adults and families may oscillate in their eligibility between Medicaid (133 percent of the federal poverty level) and HIE subsidies every six months (Sommers and Rosenbaum 2011). This churning of individuals from HIE plans to Medicaid and back again may create an administrative burden for plans and the Exchange, but also increases the risk of discontinuities in care for vulnerable adults and families. In order to stabilize the market for health plans and ensure consistency for enrollees, policy options for states include guaranteeing a minimum enrollment period and requiring some plans to serve both the Medicaid program and the HIE program.

In the early years of the program, Maryland's Exchange will not have historical claims data from which to estimate cost trends. Maryland's Exchange risk pool is also likely to be unstable in the early years as consumers become acquainted with the Exchange. Like Massachusetts, consumers in Maryland will be able to purchase qualified insurance plans both inside and outside the Exchange. In order to avoid adverse risk selection against health plans participating in the Exchange, it will be important for the Exchange Board to carefully build a marketplace that will encourage broad participation among insurers and consumers.

**Administrative Feasibility:** Another consideration is the administrative resources necessary to implement an active purchasing strategy. The contracting process is highly staff intensive. Many Medicaid programs using selective contracting require plans to commit to at least a three-year contract. In addition, staff will need to develop expertise in managing the RFP process. While the Health Choice program and the MHCC have some related experience, in general government agencies in Maryland have had limited experience with a selective contracting process.

Active purchasing is not a strategy without precedent in Maryland. As a recent paper from the Hilltop Institute reports, the state has used selective contracting in the context of the state employee health benefit program, which insures 230,000 workers and families (Somerville, John, and Skopac 2011). The Maryland Department of Management and Budget requests sealed proposals from interested health plans that include a technical proposal describing plan services and network adequacy, and a financial proposal describing its reimbursement rates. In 2008, Maryland awarded three five-year contracts to CareFirst, United Healthcare and Aetna.

## **Conclusions**

As state policymakers take on the challenge of creating and implementing HIEs, there are a number of considerations and issues to consider. Each state's market conditions may dictate a somewhat different approach. As policymakers look to maximize coverage and the new benefits available through HIEs, it will also be important to constantly evaluate how to ensure the affordability of these plans to individuals and families and to the state.

As a mechanism to expand coverage to some of the hardest to reach residents, HIEs may be a powerful partner in the effort to control health care costs and drive quality improvements across states. Active purchasing may serve as the foundation for state exchanges to closely monitor and ensure fair competition in their states.

Within its own market, exchanges can have significant influence on how to promote value for enrollees if empowered by the state. Exchanges can engage in a wide range of activities to maximize its benefit to the state. How the exchange will likely want to oversee and involve itself in the market will differ on existing market conditions, but also how the market is expected to evolve over time. As Enthoven cautioned, market sponsors must be vigilant and judicious to ensure a fair and transparent marketplace. In this paper, we have identified some of the key tools available to exchanges to ensure a fair and successful marketplace.

**Appendix. Characteristics of Alternative Purchasing Strategies Used in the Past by Health Benefit Sponsors/Conveners**

<b>Domains</b>	<b>Open Marketplace</b>	<b>Principled Regulation</b>	<b>Industrial Purchasing</b>	<b>Prudent Purchasing<sup>7</sup></b>	<b>Value Based Purchasing<sup>8</sup></b>	<b>Active Purchasing</b>
<b>Information Gathering and Sharing</b>	None	None	Collects data on quality	Collects data on quality	Collects data on quality	Collects data on quality
<b>Contracting</b>	Passive Price Taker	Passive Price Taker	May selectively contract	May selectively contract	May selectively contract Aggressive price taker (i.e., competitive bidding)	Negotiate price/quality Selective contracting Additional certification criteria Setting standards for cost-sharing

<sup>7</sup> Bruce Bullen described the goals and tools of the prudent purchaser in 1998: “[T]o obtain health care value, the prudent purchaser must define quality, measure it, seek to improve it, and exert market leadership...The prudent purchaser must put into place the elements of a good quality management system—negotiated performance goals, member satisfaction surveys and focus groups, independent external reviews, continuous quality improvement systems, data reporting, and consequences for underachievers.” Fossett, J. W., M. Goggin, J. S. Hall, J. Johnston, L. C. Plein, R. Roper, and C. Weissert. 2000. “Managing medicaid managed care: Are states becoming prudent purchasers?” *Health Aff (Millwood)* 19(4): 36-49. Bullen added that prudent purchasers should remember that: “the system should not be micro-managed, or made to respond to unrealistic expectations.”

<sup>8</sup> Today, the term "value based purchasing" is now largely synonymous with sponsors who have implemented significant pay-for-performance programs. These are not to be confused with the term value based benefit design (VBID), which relates to covering services deemed effective by the scientific evidence. However, in the late 1990s and early 2000s, it was a term that also was more closely tied to managed competition. Meredith Rosenthal and colleagues describe value based purchasing as: an approach where employers and other large purchasers of health care are expected to contract with health plans according to quality and cost.” Rosenthal, M. B., B. E. Landon, S. L. Normand, R. G. Frank, T. S. Ahmad, and A. M. Epstein. 2007. “Employers' use of value-based purchasing strategies.” *Jama* 298(19): 2281-8. The key element of value based purchasing is tying financial incentives to certain performance standards or quality metrics.

<b>Consumer Education</b>	None	Limited. Products sold through independent agents	Sponsor may educate consumers on quality	Sponsor may educate consumers on quality	Sponsor may educate consumers on quality	Use of web-based decision tools to drive value oriented decisions by consumers.
<b>Quality Management</b>	None	None	Partnering with plans to improve quality	Require quality improvement programs	Promoting quality through financial incentives	Piloting new delivery system and reimbursement strategies
<b>Incentives</b>	None	None	None	Uses financial incentives/disincentives	Uses financial incentives/disincentives	May use financial incentives/disincentives
<b>Market Involvement</b>	Accepts all qualified plans	Accepts all qualified plans	Limited market involvement	May restructure market areas	Aligning with other purchasers	Recruiting and assisting new market entrants Aligning with other state purchasers
<b>Evidence of Impact</b>	TBD	Minimal impact on the uninsured	Minimal impact on premiums	Successfully sustained a number of competing plans.	An estimated \$160 million in pharmacy savings over three years in Wisconsin	Some evidence of lower annual premium increases
<b>Examples of this model</b>	Utah Health Exchange	Florida's Community Health Purchasing Alliance	Most large employers	Arizona Medicaid	Wisconsin's Department of Employee Trust Funds	Massachusetts Connector, Health Insurance Pool of California (Enthoven and Singer 1996)

Table developed by authors using data from a variety of sources. Domains on table adapted from Meyer et al, Theory and reality of value-based purchasing: lessons from the pioneers. Agency for Health Care Policy and Research. Pub. No. 98-0004, 1997. Available at: <http://www.ahrq.gov/qual/meyerrpt.htm>.



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