



Designing Success for California's Health Insurance Exchanges

By Adam Dougherty and Lucien Wulsin
Insure the Uninsured Project
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The passage of federal reform brings unprecedented opportunity to foster key improvements to the health insurance system. At the core of this prospect is the emergence of state-based health insurance exchanges, where individuals and small businesses will be able to receive tax subsidies in order to purchase affordable health insurance. The exchanges will contain new consumer protections that health plans must adhere to in order to take advantage of the new market. The exchange is slated to expand over time, and if implemented correctly has the possibility of becoming a transformative source of quality, affordable health care for individual, small, and even large group markets.

The federal law requires states to have fully functioning exchanges by 2014, and leaves a majority of the 'construction' to the states themselves. This fact essentially places the fate of real health reform at the state-level; as some have affirmed, the legislation's passage was not just one reform, but rather fifty distinct reforms. As such, California has the opportunity to build an exchange that is uniquely tailored to its own market needs. The state can and should be proactive in determining how the exchange should be built, using the best parts of the existing system. By properly aligning the regulatory process, market incentives, and our state's strong delivery models, California can take the lead as a national innovator.

The following analysis provides an overview of the law's provisions regarding the exchanges and offers recommendations for California's next steps.

Provisions Related to Health Insurance Exchanges¹

The law specifies that each state shall establish two state-based exchanges for individuals (American Health Benefit Exchange) and small businesses (Small Business Health Options Program, SHOP) by 2014 to be operated by a government agency or non-profit entity. Health plans must adhere to the exchange guidelines in order to offer coverage. Purchase of insurance through the exchanges will be available for U.S. citizens and legal permanent residents. States have the option of merging the individual and small business exchanges into a single pool, creating regional exchanges within a state, or forming multi-state pools.

American Health Benefit Exchange

The individual exchange will be open to individuals above 133% FPL, with sliding scale premium and cost-sharing subsidies for those between 133-400% FPL. These refundable tax credits will be tied to the second lowest cost silver plan (see Benefits Design below). Employees who are offered employer-sponsored coverage are not eligible for premium subsidies unless the employer plan covers less than 60% of the medical costs or the employee premium contribution exceeds 9.4% of income.

Small Business Health Options Program (SHOP)

The SHOP exchange is limited to small businesses up to 50 initially and then 100 employees, but allows states to expand availability to firms with greater than 100 employees in 2017. Small businesses with up to 25 employees that purchase insurance through the Exchange are eligible for a tax credit of up to 50% of the employer contribution (35% for non-profits), provided the employer contributes at least half of the total premium cost. This credit is 50% for firms starting with less than 10 employees and average wages under \$25,000 and is phased down and out for firms up to 25 employees and average wages of \$50,000.

Benefits Design

The law directs the Secretary of HHS to determine the essential health benefits package, which will comprise the minimum credible coverage that can be offered in the exchange². The package shall include at least the following general categories:

- Ambulatory patient services
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The package must adhere the maximum out-of-pocket spending to that of an HSA (\$5,950/\$11,900 for an individual family), and cannot be more generous than the average employer plan. The exchange(s) create 4 benefits categories in addition to a catastrophic plan:

Bronze	Covers 60% of plans' average medical costs for the essential health benefits	Note: represents minimum credible coverage
Silver	Covers 70% of plans' average medical costs for the essential health benefits	Note: Individual premium credits tied to second-lowest cost plan in this level
Gold	Covers 80% of costs	
Platinum	Covers 90% of costs	
Catastrophic	Coverage set at current HSA level, plus prevention benefits and three primary care visits	Note: available to those up to age 30 and individuals exempt from mandate due to financial hardship

Non-profit National Plan Option

In addition to private health plans, the law directs the Office of Personnel Management (OPM) to manage or contract with at least two multi-state plans to be offered through the exchange.³ At least one of the plans must be non-profit and at least one must not provide coverage for non-Hyde abortions.

Consumer Operated and Oriented Plans (CO-OPs)

The law fosters the creation of new member run health plans, appropriating \$6 billion by July 2013 for start up loans and grants. The plans must be non-profit and governed by an elected board, and the funds cannot go to existing organizations or state/local-sponsored plans.

Market Regulation

The law imposes new regulations on the individual and small group insurance markets, both inside and outside the exchange. These provisions include guaranteed issue and renewal, minimum medical loss ratios, barring of annual and lifetime caps, premium rating on only age (max. 3:1), geography, family size and tobacco use (max. 1.5:1), claims transparency and administrative simplification, and plan standardization for consumer comparison. Plans within the exchange are subject to additional marketing requirements, provider network minimums, and outreach and enrollment contracting.

Exchange Operations

Utilizing the above transparency authority, the exchanges will be able to gather and disseminate a wealth of information regarding plan pricing and financing, rate increases,

quality rankings of the plan and its provider networks, market share, minimum loss ratios, and provider networks, delivery, and reimbursement so that consumers have ample information to make informed choice about the plans and providers networks. The exchange will make decisions regarding a plan's inclusion/exclusion in the exchange and under what conditions. The exchange will also be responsible for creating a risk adjustment mechanism as well as a customer services center, and establish enrollment eligibilities and procedures. States will be required to review insurer premium rate increases during an interim period, and federal grants will be available to support state efforts to regulate rate increases.

Recommendations

The exchange needs to have a sufficient risk pool to have an impact in terms of both market attractiveness and spreading risk. Given the state's population, a multi-state compact may not be necessary. Experiences from the success of the Wisconsin State Health Plan suggest that the exchange should contain 20-25% of the non-Medicaid/non-Medicare population.⁴ As such, the individual and small group risk pools should be combined in the single exchange.

In California, we have had experience with the initially slow but steady, trial and error growth of our Healthy Families program and of the initial growth then plateau and decline of the HIPC/PacAdvantage. Under the exchange, we must prepare for and indeed lay the foundations for initial explosive growth of enrollment and a steady growth and durable expansion thereafter.

The exchange cannot ever again countenance nor afford the opportunity for becoming a high-cost dumping ground for the carriers. There are two choices for policy makers: the Exchange as the exclusive market for individuals and small employers or careful monitoring and tight regulation of plan's practices inside and outside the exchange. Though the refundable tax credit subsidies should be adequate to attract the majority of qualifying consumers, explicitly requiring the individual and small group market to operate exclusively through the exchange should be assessed as it guarantees a robust market with adequate controls over adverse selection. This would prevent the ability of certain carriers to 'cherry-pick' healthier individuals outside the exchange, which could easily lead to adverse selection to the exchange. The alternatives are very tight regulatory monitoring and oversight of plans' marketing, design and enrollment practices in and out of the exchange. A recent CHCF study also highlights this choice and goes on to suggest that the exchange must either require exclusivity or require plans to charge the same price inside and outside the exchange in order to avoid the adverse selection seen with HIPC/PacAdvantage.⁵

The exchange needs to make a choice between inclusivity and exclusivity of plans. Limiting the market to the best plans in terms of price, quality and benefit design incentivizes insurers to make the 'cut' in terms of quality and affordability to gain access to the market. On the other hand allowing unrestricted sale of insurance within the

exchange with excellent comparative information on price, quality and plan networks would provide maximum competition, flexibility, and the ability of many competitors to enter and compete in the market; subscriber choices would be expected to drive quality and affordability improvements.

Proper risk adjustment mechanisms will discourage plans from competing for just the healthiest enrollees. For example one plan may excel in alternative medicine and chiropractic care for those participating in yoga practices. While another plan may have the best networks and design for care and treatment of those with a cancer diagnosis. These plans will attract a very different risk pool. HIPC/PacAdvantage was unable to develop the right approach to risk adjust among its plans. Medicare Advantage plans have a mechanism in place that adjusts rates by diagnosis and warrants examination. Risk adjustment should tie incentives to proper case management, care continuity, and improved health outcomes, which could make improved care and outcomes for higher-cost enrollees desirable and financially rewarding.

Plans do neglect low-density markets⁶ where competition among providers is minimal to non-existent and the numbers of covered lives are small. These may be promising areas for the exchange and local communities to develop co-operative plans and networks that are funded in the reform legislation and flourish already in Utah, Minnesota, Washington and western Pennsylvania.

The federal legislation requires plans within the exchange to include safety net providers, such as community clinics and public hospitals. It does not mention California's safety net plans that already compete with the commercial plans in certain large metropolitan communities in Healthy Families. The emphasis on including the community clinic or public hospital is insufficient as they will lack the system of care to succeed in the new framework. In order to improve competition and build local networks, the exchange should put its emphasis on participation by systems of care that are the safety net plans.

A consumer focus is the most critical component of the exchange, in terms of enrollment, operations, health plan contracts, and clear presentation of health plans because it is consumers who will enroll and use the exchange. If they do not see and experience a marked value in the exchange, it will ultimately fail. We urge that small businesses and individuals with no connections to plans, providers or brokers be given a central role in the design, development and implementation of the exchange.

Existing state agencies have a vital role to play. An agency like MRMIB could be the base of the exchange operations. If so, its status as a quasi-governmental agency should be enhanced. It needs the requisite distance from the state's budget woes when it is running a program, overwhelmingly financed by the federal government, individual and small business subscribers, rather than by the state General Fund. It needs the ability to hire, fire and retain staff, purchase and secure equipment and hire the requisite consultants free from the state rules. Its deliberations and discussions should be inclusive and transparent to build trust and support. Other state bodies have important roles to play in support of the exchange, including but the Departments of Insurance and the

Department of Managed Health Care, the Office of the Patient Advocate and the Departments of Public Health and Health Care Services. Assembling an inclusive advisory board made up of entities from all sectors could be the basis of an effective public private partnership, much like the Massachusetts Connector. The exchange should utilize existing eligibility determination and enrollment tools such as brokers, CAAs and One-E-App, in addition to Medicaid providers as allowed by the new law. New outreach and enrollment approaches should maximize awareness, initiating campaigns through professional sports, universities, interest groups, and well-known businesses/individuals. An ‘amazon.com/yelp.com/travel website’ approach should be taken to be able to compare plans on price, benefits, provider networks, customer satisfaction, and other variables, while addressing groups with limited internet access through local information centers and point of service assistance.

The roles of county systems and state programs like Medi-Cal, Family PACT, Healthy Families and AIM need to be reassessed to determine what can be rolled into the exchange and what needs to be preserved for individuals who may still fall through the cracks. The extent of outside safety net services also depends on what is ultimately included into the reference benefits packages, as any cost sharing in the exchange will effect utilization (particularly for low-income individuals). The creation of a Basic Health Plan for individuals between 133%-200% FPL, as the federal law allows, should be seriously considered in this regard as well. The Basic Health Plan could ease affordability concerns for this population, though carving them out of the exchange may limit effective risk pooling.

It is important for larger employers to be able to purchase through the exchange as soon as it has proven its worth for individuals and small employers. The exchange could also seed other creative efforts from results yielded by new Medicare pilots, such as plans that utilize effective pay for performance models and that best incentivize the adoption of health information technology in provider networks. Some will want to renew the push for a public option, but we already have public plans in California, some of which are of very long-standing, so that seems to us to be superfluous, and we would urge attention to making the existing plans successful competitors within the exchange because they can offer better quality, service and price; that would be the true test of their merit. Some will argue for long-term rate regulation of plans as opposed to the competitive model that seems to be California’s wont; the need for rate regulation will emerge or not if plans and providers fail to avail themselves of the opportunities to improve coverage, price and quality offered under the federal reform law.

The significance of effective exchange establishment cannot be understated; it is truly the bridge from the system that we have to the system that we desire. It is important to learn from past successes and failures, incorporating ideas from experiences found in PacAdvantage, the Massachusetts exchange, and even health systems that we are now evolving closely toward like the Netherlands and Switzerland. California will be freed from many of the untenable restrictions it has experienced in trying to develop its own health reforms by utilizing the sizeable funding streams and important flexibility granted in the federal law. Many interest groups have a part to play and it is important to not lose

focus on the goal of enacting real health reform that works for every Californian. The timing is now, and decisions are already beginning to be made⁷; groups must make their cases at the legislative table quickly or risk losing their voice in the process altogether to those who have already shifted their attentions to the California legislature. Efforts and attention must shift immediately to the state and local levels in order to facilitate new implementing legislation, with sustained input and collaboration from local, regional, public and private entities. To assure success when the clock strikes 2014, we must begin now.

¹ Title I, Subtitle D, Patient Protection and Affordable Care Act, Public Law 111-148

² This requirement also applies to plans outside the exchange, with exceptions for grandfathered (existing) plans

³ The OPM currently manages the Federal Employee Health Benefits Program (FEHBP), though the new plans will be a separate risk pool

⁴ Enthoven A., et al, *Making Exchanges Work in Health Care Reform*, Committee for Economic Development, December 14, 2009

⁵ Wicks, E., *Building a National Exchange: Lessons from California*, California Health Care Foundation, July 2009 at:

<http://www.chcf.org/topics/download.cfm?pg=insurance&fn=BuildingANationalInsuranceExchange%2Epdf&pid=512475&itemid=134010>

⁶ E.g. the Rural North, portions of the Central Coast, Central Valley and all of eastern California.

⁷ For more information see the California bills to establish an Exchange, AB 1602:

http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100105_introduced.html and SB 900: http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_0851-0900/sb_900_bill_20100126_introduced.html,

the implementation intent bill, SB890:

http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_890_bill_20100121_introduced.html, and the ITUP Conference materials from the sessions on Federal Insurance Market Reforms and the Impact of Federal Reform in California: <http://itup.org/this-years-conference.html>