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The Role of the Exchange in California's Implementation of National Health Reform

Sacramento Briefing

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Vision & Goals for the California Health Benefit Exchange

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Agenda

1. Theory Behind State Insurance Exchanges
2. Possible Goals
3. Various Exchange Models

Theory Behind Exchanges under PPACA

- Eligibility determination processes for different programs should be streamlined and coordinated
- The insurance market is flawed, especially for individuals and small employers
- Market incentives and consumer choice can drive "healthy" competition among carriers
- Healthy competition among plans will reward medical providers for integrating and coordinating care

Possible Goals for Exchanges

- Facilitate eligibility determination, shopping, and enrollment in health plans
- Reduce the administrative costs of small-group and non-group insurance
- Stimulate price competition among health plans
- Encourage integration of care-delivery systems and improvements in health

Putting a Face to Reform

"If I didn't have health insurance, I would never have made an appointment with my doctor because of the cost. The cancer would have spread and I would not be alive today to tell you my story."

--Jaclyn Michalos, 27

Putting a Face to Reform (2)

Before moving to Mass in 2007, she was told by an insurance agent in her home state:

"You'll never get insurance, so don't waste your time."

After discovering Commonwealth Choice:

"I did the whole thing online and got a very good plan. I was just thrilled!"

-- Abbie von Schlegell , Commonwealth Choice member

Exchange Models: CA Will Have Its Own

- Relatively unstructured employee choice (Utah)
- Moderately structured employee choice (MA & CT)
- Moderately structured employer choice (NY & MA)
- Structured & aggressively bid individual choice(MA)
- Structured & aggressively bid employee choice (CalPERS, FEHBP, many large employers)
- Strategic purchaser (Wisconsin)
- Mix-and-match, plus everything in between

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The Federal Law: Role of the Exchange

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Agenda

1 Key Roles of the Exchange

2 Who Does the Exchange Serve?

3 Massachusetts Comparison

4 Benefits and Coverage Levels

The Federal Law:
Key Roles of the Exchange (1)

- Provide convenient access to consumer choice of competing qualified plans.
  - Including comparative information on quality, cost, etc.
  - Website; toll-free hotline.
  - Outreach through "Navigators."
- Certify "qualified health plans" (QHPs) to be offered through Exchange.
  - Using federal criteria, plus Exchange determination that offering is "in the interests of qualified individuals and employers."

The Federal Law:
Key Roles of the Exchange (2)

Arrange eligibility determinations:

- For individual tax credits.
- For "affordability" exemption from individual mandate (>8.0% of income).
- For access to Exchange coverage and tax credits despite being offered employer coverage (because employer's plan is inadequate or costs >9.5% of income).
- Inform individuals of eligibility requirements for public coverage programs; screen, and, if eligible, enroll them. ("One-door" eligibility)

The Federal Law:
Who Does the Exchange Serve?

Core Population:

- Must participate in Exchange to receive tax credits:
  - Modest income individuals; small, low-wage employers.
  - Individuals are not eligible for tax credits (subsidies) if they are eligible for affordable employer coverage, OR for Medicare or Medicaid.

Voluntary:

- Any lawful resident who is not incarcerated.
- Small employers with up to 100 employees.
  - State can limit size to 50 employees for 2014-15 only.
- Beginning in 2017, larger employers, at State option.

The Federal Law: *Key Differences from Massachusetts Connector Model*

- Mass. Connector has separate Exchanges—with different health plans—for modest-income subsidized participants <300% FPL and for non-subsidized individuals >300% FPL.
- American Health Benefit Exchanges make the same certified plans available to all individuals, both subsidized and non-subsidized, and . . .
- . . . All participants across "outside" commercial market and Exchange—including tax credit recipients—are in same risk pool.
- Like the Medicaid program, the Connector makes premium payments to plans on behalf of subsidy recipients.
- Under federal reform, the U.S. Treasury, not the Exchanges, pays subsidies (tax credits and cost-sharing subsidies) to plans.

The Federal Law:
Benefits and Coverage Levels (1)

- All* plans—inside and outside the Exchange—must offer the federally specified "essential health benefits package."
  - Service types are outlined in federal legislation. Covered services to be "equal to the scope of benefits provided under a typical employer plan." Details to be specified in regulations.
- All* plans must conform to one of four "coverage levels" defined based on "actuarial value" (AV)—the percentage of the cost of the essential benefits that the plan pays.
  - Bronze = 60% AV Silver = 70% AV
    Gold = 80% AV Platinum = 90% AV
  - Cost-sharing subsidies will increase the actuarial value for Exchange participants below 250% of poverty.

* Only "grandfathered" plans are exempt from these requirements.

The Federal Law:
Benefits and Coverage Levels (2)

- A lower-cost "catastrophic" plan may be sold only to people under age 30 or who qualify for an "affordability exemption" from the individual mandate.
- Plans may voluntarily offer benefits (i.e., services) in addition to the essential health benefits package.
- States may mandate benefits in addition to the federal list but, if so, the State must pay the additional cost of those benefits (with respect to qualified health plans).

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AB 1602 and SB 900
California Health Benefit Exchange

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Creating the CA Health Benefit Exchange

1 Goals/Concerns in Establishing the Exchange

2 How the Legislation Addresses These Issues

Key Goals in Establishing the CA Health Benefit Exchange

1. Define the Exchange's Role in Overall Market
2. Promote Value, Quality, Transparency
3. Reduce Potential for Adverse Selection
4. Establish Solid Governance and Financing Structure
5. Meet the 2014 Timeline

Considerations and Unknowns (1)

- Timeline: Despite many federal unknowns, meeting the 2014 deadline meant legislation should be passed this year.
- Unknown size – estimates range from 1.25M – 8M potential enrollees.
- Significant concerns with adverse selection and exchange viability relative to outside market.

Considerations and Unknowns (2)

- Significant difference in value of the federal subsidy between individual and small group, and concerns with merging the individual and small group markets.
- Need to provide choice, fair competition, transparency, and value.
- Need to coordinate systems with existing Medi-Cal, Healthy Families, county-based administrative structure, while at same time, make transitions between coverage easier.

Role of Exchange in Insurance Market

OPTIONS CONSIDERED:

- Exchange as the entire market
- Exchange as simple pass through for subsidy (Craigslist with tax credits)
- Exchange operates with outside market but drives value, quality, and choice *in part* through selective contracting

How Does Legislation Address These Concerns?

- "Third/Hybrid" Approach: Exchange operates in tandem with outside markets but meets goals through ability to standardize, selectively contract.
- Individual and small group market kept separate for now.
- Sets clear rules for participation in the Exchange to enable fair competition, drive value and quality, and promote transparency.
  - Exchange can standardize products
  - Exchange can selectively contract, based on choice, quality, value, and service
  - Rules for participation in the Exchange to reduce adverse selection
- Exchange must coordinate with Medi-Cal, HFP, and counties, but also try to reduce coverage and network disruption.
- Exchange is not a third regulator.

Governance & Financing (1)

- Federal Exchange, State Exchange, Exchange Operated by Non-Profit?
  - Scope and import of the changes pointed towards need for the openness and transparency of government vs. non-profit
  - Ability of a state exchange to meet CA needs was preferable to federal exchange

Governance & Financing (2)

- Significant Trade-Offs
  - If Exchange is to operate and be competitive with an outside market, needs to be agile, flexible, and responsive.
  - Need board and staff structure that supports this type of decision making.
  - State government provides transparency, but its ability to respond to outside market changes can be slower than outside private market.
  - Exchange funds need to be protected from state budget raids.
  - No state GF available and federal law requires Exchange to be self-supporting by 2015.
- Other Concerns with Exchange Authority
  - Limits on Plan Assessments
  - Limit ability to increase Medi-Cal or HFP costs
  - Responsiveness to legislative and executive branch

How Do the Bills Resolve These Trade-offs?

- Establish independent, 5 member Exchange governing board within state government; members must have significant demonstrated expertise in various Exchange-related health care areas, such as the individual and small group markets.
- Significant conflict of interest provisions that generally bar anyone working for insurers, agents or brokers, health care facilities, and health care providers.
- Staff will generally be civil service, but limited number of executive staff positions exempt from civil service.
- Board members are unpaid.
- One year revolving door provisions.
- Subject to state open meeting and public record act laws with an ability to meet in closed session regarding issues such as rate negotiations. Contracts are available 1 year after commencement.
- Must issue regulations but for first 2 years can issue emergency regulations.

How Do the Bills Resolve These Trade-offs (2)?

- Exchange must determine sufficient financial resources exist prior to commencing operations and report to the Joint Legislative Budget Committee and Dept. of Finance.
- Annual report to the Legislature and Governor on expenses, performance, operations, and progress. This report is also posted on the Exchange website.
- Budget, including staff salaries, must be posted on Exchange website.
- No state GF and establishes a plan assessment to fund Exchange operations.
- CA Health Trust Fund is continuously appropriated but can only consist of non-GF (federal funds, assessments, CHFFA loan funds, etc.).
- Plan assessments limited to 1 year's approved operating budget – Exchange must reduce the charges in the following fiscal year if the assessments equal or exceed that amount.

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Plan Certification & Selective Contracting

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Agenda

1. Overview of Plan Certification Process
2. Selective Contracting
3. Benefits of Selective Contracting

Typical Process for Plan Certification

- State identifies specific criteria and standards of participation
- Publishes a Request for Proposal (RFP) or other type of solicitation document
- Develops scoring criteria by which to compare/ contrast respondents
- Score respondents based on established criteria
- Certify plans that meet or exceed pre-determined minimum thresholds

Selective Contracting

- California's recently passed law allows for selective contracting by Exchange
- Does not prohibit Exchange from accepting all plans
- Creates flexibility for Exchange in developing a plan certification process
- Enables Exchange to work with carriers that exhibit desire to work with Exchange to meet policy and business goals

Benefits of Selective Contracting

- Allows for greater level of partnership and collaboration between Exchange and carriers
- Provides for “healthy” competition between carriers
- Can be catalyst for market innovation
- Demands a transparent, objective procurement process

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Broader Insurance Market Rules and Related Exchange Design Issues

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Agenda

1. Overall Goal for Health Insurance Market Rules
2. Federal Market-Wide Measures
3. California's Exchange Law Further Curtails Opportunities for Adverse Selection
4. Treatment of Individual and Small Employer Markets
5. Exchange Functions Differ for Small Employers vs. Individuals

Overall Goal for Health Insurance Market Rules

Structure competitive rules so that:

- Market forces work for the best interests of individuals and small employers.
- Coverage is readily available at the same premium regardless of health status.
- Opportunities are minimized for "adverse selection" by insurers, i.e., to:
  - "Select" healthier/lower cost populations, and
  - "Refer" higher cost populations to the Exchange/other insurers. *(5% of population => 50% of costs)*
- Consumers' ability to make informed choice among plans is optimized.

Federal Market-Wide Measures

Reduce opportunity for and benefit of risk selection by:

- Guaranteed access to all plans *(except Grandfathered plans)*.
- Premiums cannot vary by health status.
- Each insurer's total individual enrollment is one risk pool *(ditto small employer enrollment).*
- Risk adjustment among insurers;
  reinsurance and risk corridors in initial years.
- Required benefits ("Essential");
  specified Actuarial Value levels (Silver, Gold, etc.)

California's Exchange Law Further Curtails Opportunities for Adverse Selection (1)

(Heightened concern due to CA experience—HIPC and current market.)

- Federal Rules regarding Actuarial Levels would leave opportunity for adverse selection.
  - In the Exchange, insurers must offer “Silver and Gold” level plans.
    - Cannot offer only Bronze or catastrophic plan attractive to low-risk persons.
  - But no such rule for the outside market.
    - Without further state rules, insurers could "skim risks" by offering only cheaper plans with high cost sharing.
- California law requires that all insurers in the market (inside and outside Exchange):
  - Must offer all “precious metal” level plans—Bronze, Silver, Gold, and Platinum.

California's Exchange Law Further Curtails Opportunities for Adverse Selection (2)

- Federal: Would allow sale of "catastrophic" plans by insurers not in the Exchange.
- California: Prohibits such insurers from offering catastrophic plans.
- Federal: Prohibits Exchange (Qualified) Health Plans from marketing practices that discourage enrollment by those with health needs; does not require them to be offered outside.
- California: Requires Exchange-participating insurers that sell any products in outside market to “fairly and affirmatively market” their Exchange Qualified Health Plans in outside market.

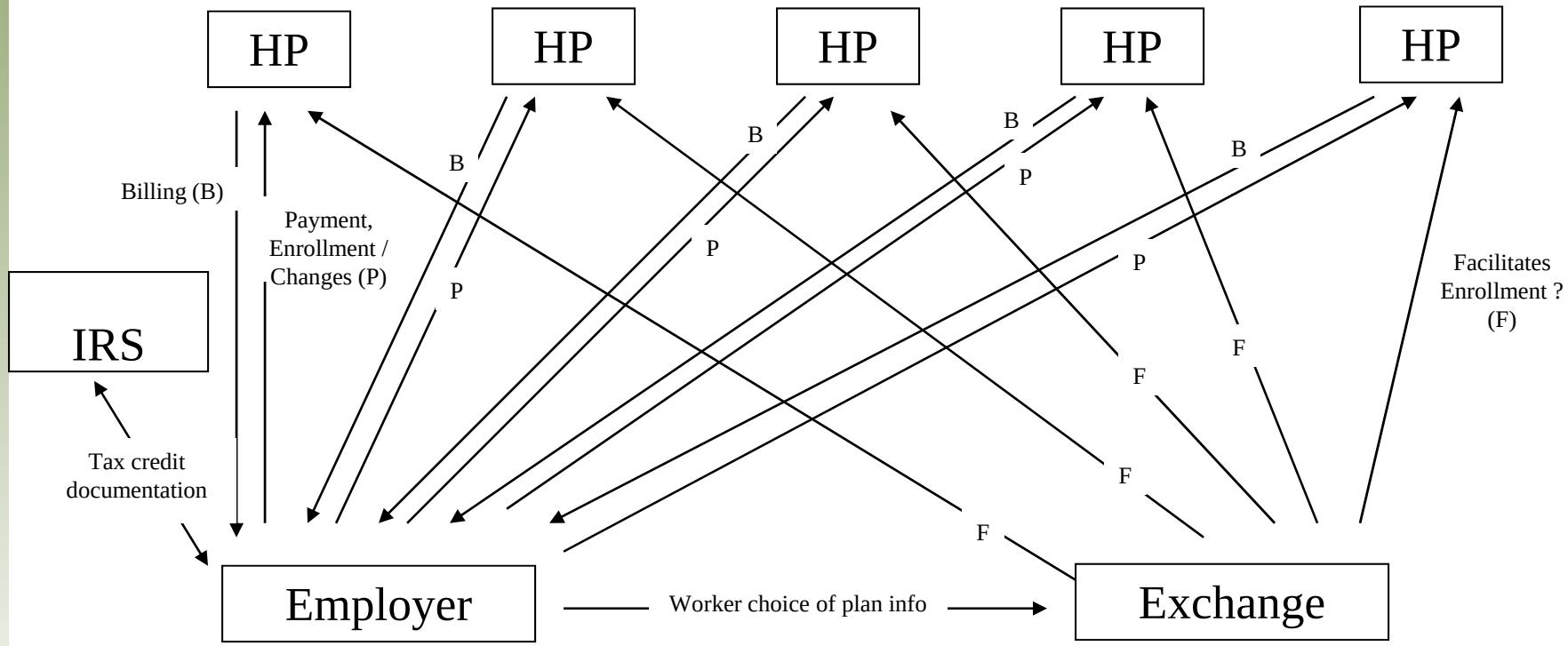
California's Exchange Law Further Curtails Opportunities for Adverse Selection (3)

- Federal: Allows myriad and inconsistent cost-sharing configurations among competing Exchange Qualified Health Plans.
- California:
  - Allows the Exchange to standardize Qualified Health Plan benefit/cost-sharing packages across competing insurers (as Mass. Connector did).
  - If Exchange does so, insurers in the outside market must offer at least 1 standardized product at each of the 4 "precious metal" levels.

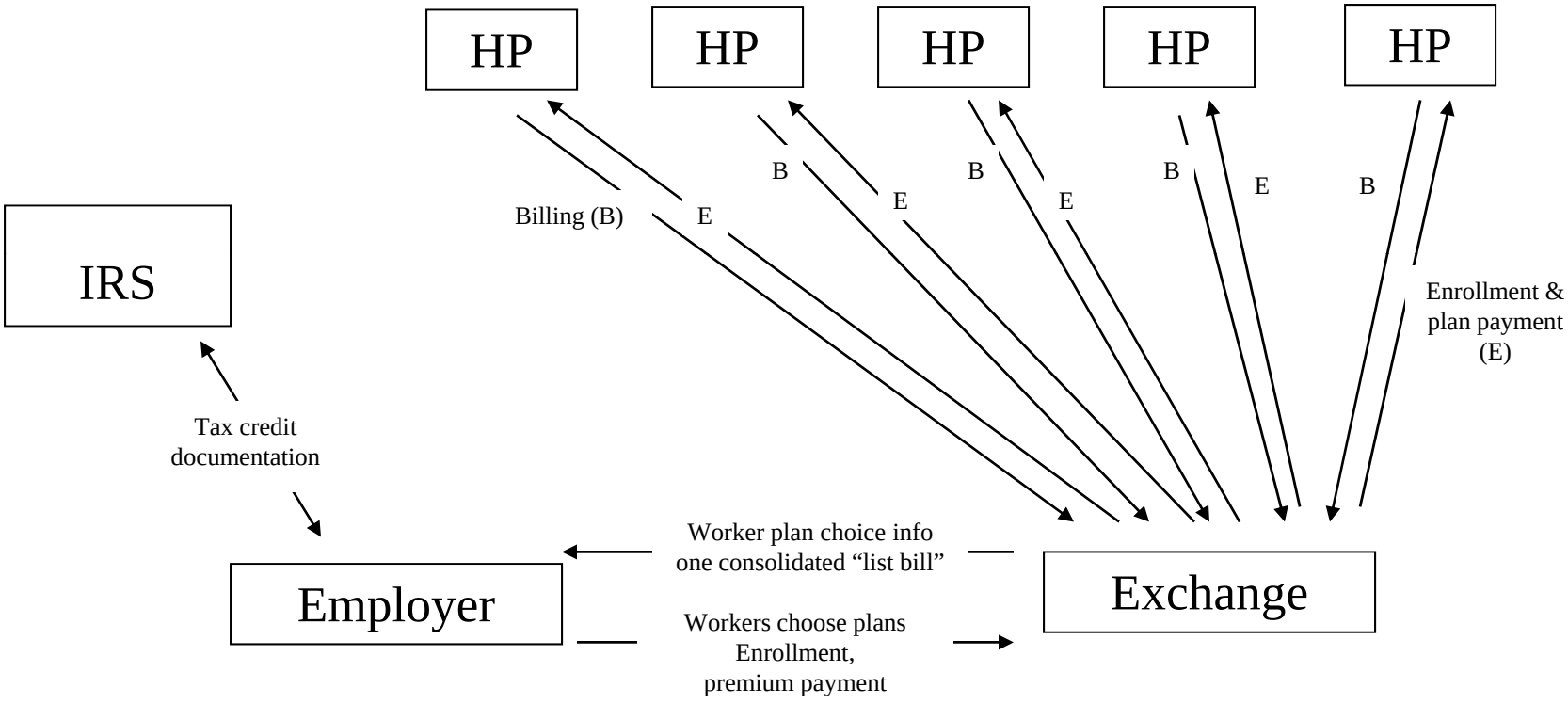
Treatment of Individual and Small Employer Markets

- Federal: Allows State to keep separate or combine the small employer and individual markets.
- California:
  - Maintains as separate markets.
  - Calls for report by Dec 2018 assessing costs in both markets and projected effects of combining into one.
- Federal: Defines small employer market subject to rules and eligible for Exchange as <=100, gives state option to keep at <= 50 until 2016.
- California: Does not amend small employer market size (50 workers).
- Federal: Allows state to have one Exchange serving both individuals and small employers, or have separate small employer (SHOP) Exchange.
- California Health Benefits Exchange to serve both individuals and small employers, with separate administrative structure to serve small employer needs.

Employer "SHOP-YOU-WOULD-DROP" Exchange



Employer One-Stop SHOP Exchange
(To make employee choice work for the employer)



The California Health Benefits Exchange Is Empowered to Avoid . . .

Death by Risk Selection

(The HIPC—PacAdvantage experience)

- Much stronger market-wide rules.
- Sizable "core populations" with healthy risk mixes—
  Tax credit recipients who can enroll only via the Exchange.
- The World Is Watching (and most of you are helping).