California's Insurance Exchange:
Experts Tackle the Big Questions

California HealthCare Foundation

ISSUE BRIEF

In the immediate aftermath of Congress' passage of the Affordable Care Act, California became the first state to create an insurance exchange that would reflect the new opportunities and obligations established by the federal reforms. The California Health Benefit Exchange legislation is contained in AB 1602 and SB 900.

To help inform the development of exchange legislation and early thinking regarding exchange implementation, the California HealthCare Foundation has provided information, analysis, and other support. As part of these efforts, a briefing was held in Sacramento on October 21, 2010 to discuss policy considerations related to the establishment of the state's health exchange within the context of the federal law. Speakers included members of the Schwarzenegger Administration, legislative staff, and consultants with related experience nationally and in Massachusetts. Highlights of the briefing follow.

How California Got to Yes

"We're having a conversation today that is not occurring in any other state," Secretary of Health and Human Services **Kim Belshé** said in her opening remarks. "We're talking about [health care] reform, and not just reform in terms of the big ideas, but reform in terms of implementation." Noting the level of expertise represented in the briefing's panel as well as the audience, she said, "This absolutely is a gathering of the glitterati of the health care policy and political worlds."

The context for California's efforts around implementation has been an "extraordinarily difficult" one, she said, citing the political transition in Sacramento and a double-digit structural budget deficit in the state. Further, there is "a lot of misunderstanding, if not misinformation," about what an exchange is and its role in reform. In this context, said Belshé, "It was striking to me that, notwithstanding the fact that there were a lot of reasons not to move forward, our state did."

Belshé sees the specific content of the legislation as offering "great promise for the exchange to deliver on its very significant goals around coverage, affordability, quality, and, most of all, around improving the health status of the people of our state." She noted additional reasons for optimism.

First, she said, "We're not starting from scratch. California has been having a conversation about purchasing pools and exchanges for many, many years." She recalled the health insurance plan, PacAdvantage, that got its start during the Pete Wilson administration in the 1990s. It failed, she said, but "it informed our thinking about purchasing pools and exchanges." In 2007, California tried to enact many of the components that are now included in the federal law, working across the administration, the legislature, and the broader stakeholder community. At that time, California's leaders grappled with many of these same big issues. Said Belshé: "What is the overall theory of an exchange? What are the goals? What is the relationship between the exchange and the non-exchange market?"

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Other factors that bode well for the success of the state's exchange, added Belshé, include a high level of state expertise, augmented by consultants with direct exchange experience. She also commended the state's strong political leadership. Governor Schwarzenegger, she recalled, "stood up in April and said, 'These are my priorities. The exchange is one of them.'" Then, she said, the legislative leadership "worked very collaboratively and showed tremendous political courage in the face of some pretty significant opposition."

Belshé concluded her remarks with a strong plea not to forget Medi-Cal "in all the talk about exchanges—the shiny new object that everyone's very excited about." Come 2014, she said, "Medi-Cal is going to look dramatically different than it looks today. It is a totally new paradigm. It's one grounded in actually covering people and insuring that our eligibility and enrollment systems are streamlined and designed to bring people into coverage and to stay in coverage." By standardizing eligibility rules for the entire nation, from zero to 400 percent of the federal poverty level (FPL), Belshé said, "federal reform is saying we as a society have a value for near-universal coverage, and we are going to support a variety of policy changes to advance that objective, including providing financial assistance for those individuals for whom this requirement to purchase coverage is beyond their financial means." The Medicaid program, with eligibility up to 133 percent of the FPL, is the foundation for coverage, she noted, with the exchange extending eligibility from 133 to 400 percent of the FPL.

Rather than being a welfare-based program, she said, Medicaid will be "a full and foundational partner of the overarching objective around reform…. So the success of the exchange is going to be very much related to the retrofitting and success of the Medi-Cal program."

The Federal Framework for Exchange Goals and Models

Speaking from 25 years' experience in the health insurance field, most recently as executive director of the Massachusetts Health Connector, independent consultant **Jon Kingsdale** discussed possible goals and models for California's exchange.

The federal legislation, he said, provides a good foundation for streamlining and coordinating eligibility determination processes for different programs. In fact, he said, the Affordable Care Act puts these issues forward more forcefully and explicitly than in the legislation in Massachusetts that was enacted in 2006, "where we pretty much just piggy-backed on the existing Medicaid eligibility determination process." He noted that when counties and the state both play roles in determining eligibility, when most processes are paper-based, and when shopping for health insurance is still done on the phone rather than on the Web, "there is a lot of opportunity for improvement in customer responsiveness."

The insurance market itself is a bit flawed, he acknowledged. Products are wildly variable and lack transparency compared with other industries such as banking. Even shopping for something as complicated as a mortgage, he said, involves only about four or five variables that people can understand. In comparison, health insurance can involve "20 or 30 variables most of which are hard to understand. People very quickly glaze over."

Unfortunately, he added, "A lot of competition among health plans is on risk selection rather than socially more useful ends, such as service and benefits and value." But there are market incentives for consumer choice, he said. Exchanges can drive healthy competition among carriers in terms of customer service and benefits. This is a very "American concept," he added. "It's not all that different from [the idea behind] the Securities and Exchange

Commission — that we ought to have markets that actually work for customers."

Two Massachusetts Stories

Jon Kingsdale offered two stories of individuals affected by the Massachusetts reforms.

- Jaclyn Michalos worked for her family's restaurant, which did not offer health insurance. She didn't get a lump in her breast examined because she couldn't afford services. After the state reforms went into effect in 2006, she qualified for subsidized health insurance and went to the doctor. She was diagnosed with cancer and was successfully treated.
- Abbie von Schlegell moved to Massachusetts from another state, leaving her health insurance behind. Because of several chronic conditions, she was advised that she would not be able to get insurance again. But because of the state's guaranteed issue and community rating reforms, she was able to shop for and buy insurance "in a matter of 20 or 30 minutes."

A principal goal for exchanges, said Kingsdale, would be to facilitate fast, easy, and smooth eligibility determination and enrollment. He described the arduous, telephone-based research that health insurance shoppers go through, only to find that the variations from plan to plan make them difficult to compare. Finally, he said, "you'd walk across the street and you'd ask your neighbor, 'What have *you* got?'" Facilitating the process was a key goal of the Massachusetts Connector Web site, he said. Shoppers enter just three pieces of information that are necessary for rating: age, size of household, and zip code. Then, they pick a level of coverage — Gold, Silver, or Bronze — and three to five options pop up, in an apples-to-apples comparison.

Another goal, said Kingsdale, might be to reduce high administrative costs. In the non-group and small-group sector, he said, it is estimated that anywhere from 20 to 40 percent of premium goes to administration — and a lot of that is just the cost of selling and enrollment.

A third goal could be to stimulate price competition. Health plans will want to "get onto the shelf of this major new insurance store," and will compete on price in order to be selected. If they offer real value to potential customers, the exchange is going to want to offer these plans. In some states there might be only two or three plans with any presence in the local market. Massachusetts has currently selected nine major health plans to be in its exchange. First they had to compete to be in the exchange, and then they compete again to be selected by the individual consumer.

Finally, said Kingsdale, exchanges could drive quality improvement and cost containment by selecting and offering health plans that reward physicians and hospitals for integrating and coordinating care. Well-designed incentives, such as covering preventive care, paying for someone to coordinate specialized services, and not paying for medical errors ought to drive better integration and coordination of care delivery. California, he pointed out, already has considerable know-how and leads the nation in pay-for-performance, capitation, and development of integrated delivery systems. A major public policy question, he said, is how far the exchange should use its market leverage to drive further change in the delivery of medical care.

Kingsdale outlined the various models for exchanges that California can borrow from.

Utah's program, he said, offers relatively unstructured choices for employees of small or mid-size employers, allowing them to pick from any plan available in the state. Connecticut has a privately-sponsored exchange through which employees of small employers can pick from a relatively structured set of options. New York and Massachusetts have exchanges for small employers who pick from a relatively structured set of options while their employees have only the traditional take-it-or-leave-it option. For subsidized individuals, the Massachusetts Connector offers "very aggressively bid,

highly structured programs." Kingsdale compared this type of configuration with the health benefits programs for federal and California employees and many large employers that offer their workers three, four, or more options.

Finally, Wisconsin has been pursuing the "ultimate vision" of a new exchange as a strategic purchaser that will drive "all health plans toward fully rewarding integrated, coordinated care."

The Massachusetts program, he said was conceived as "a non-regulatory store for insurance with a substantial public subsidy involved and a mandate to serve the public." Therefore, he said, "it has a strong interest in long-term, value-based relationships with the health plans—meaning we wanted them to make a little money." He pointed out that it is important for individuals and small businesses to feel confident that their plan will not go out of business or leave the exchange. So, he said, if plans "do a good job and they deliver value and they play their role as tough buyers of services, they get financially rewarded in the marketplace."

The existence of the Massachusetts exchange, Kingsdale suggested, resulted in greater popularity for generic-brand health plans, which he referred to as the "salt-of-the-earth plans." These have more limited networks—some built around neighborhood health centers—than most large commercial plans, and low administrative expense ratios in the range of 6 to 8 percent of premium. They provide care for a substantial Medicaid population, and tend to emphasize primary care.

Key Components of the Federal Law

Ed Neuschler of the Institute for Health Policy Solutions enumerated the intended roles of the exchange as written into the federal law.

Since its key role is to provide convenient access to consumer choice of plans, he said, the exchange will need to have readily available comparative information on cost and quality through a Web site and a toll-free hotline. Exchanges will do outreach to various populations through "navigators" who have existing relationships with those populations. Grants to navigators from the exchange are intended to help people through the process. The precise roles and tasks of navigators have yet to be worked out.

Another role of the exchange, Neuschler said, is to certify the "qualified health plans" that are offered through the exchange. To become qualified, the plans first have to meet minimum federal criteria that will be specified by the HHS secretary. Then, the exchange will have to determine that a plan, in addition to meeting the federal criteria, is "in the interests of qualified individuals and employers." This is the basis on which the exchange will have selective contracting capability.

The exchange will also arrange eligibility determinations, Neuschler continued, noting that "the federal statute never actually says that the exchange makes an eligibility determination" except with respect to Medicaid. However, the exchange will be "in the middle of" the process of accepting applications from people who want to get federal premium tax credits or want to get an exemption from the individual mandate. Exemptions may be granted to individual purchasers if all available products cost more than 8 percent of income. This information, he said, will need to be put into some kind of system, which has not yet been determined.

In addition, noted Neuschler, the exchange is responsible for implementing the "No Wrong Door" eligibility concept. It should inform individuals of the eligibility requirements for the public coverage programs (in California, Medi-Cal and Healthy Families), screen people for eligibility for those programs, and, if they are eligible, enroll them.

The exchange can serve any lawful resident who is not incarcerated, said Neuschler. It can serve any small employer with up to 100 employees, although the state has the option of limiting the number to 50 for the first two years. In 2016, however, it has to go up to 100. Beginning in 2017, the state has the option of including larger employers as well.

Nobody is required to use the exchange, Neuschler said, but there is a core population that will have strong incentives to do so because that is the only way they will be able to get tax credits. This group includes modest-income people who buy individual coverage through the individual exchange, as well as small employers who can qualify for a federal tax credit toward their contributions. This core population will form the critical mass needed to make the exchange viable.

A tax credit for small businesses whose workers' average earnings qualify them as "low-wage" is in place already, added Neuschler. Once the exchanges are running, in 2014, the employers will have to purchase through the exchange in order to continue to qualify for those credits for an additional two years.

There are important differences between the federal construct and the Massachusetts Connector model, said Neuschler. First, the Massachusetts Connector, even on the individual side, effectively has separate exchanges with different carriers and products for the modest-income people—those below 300 percent of poverty— who are getting subsidized, and those nonsubsidized individuals above 300 percent of poverty. "It is really two different programs," he said.

Under the federal framework, Neuschler said, an exchange is supposed to make the same certified qualified health plans available both to individuals who are getting subsidies through the premium tax credits and to nonsubsidized individuals. In addition, all people across the outside commercial market and the exchange market, including the tax-credit recipients, are in the same risk pool. Premium calculations for the individual market and the small-group market remain separate, but within each market—individual or small-group—an insurance carrier's premiums are established based on that carrier's combined risk for its enrollees both inside and outside of the exchange.

The second major difference, said Neuschler, concerns payment and billing. In Massachusetts, the Connector makes the premium payments to plans on behalf of the subsidy recipients. If there is a share of premium, the Connector collects those premium payments from the participants, bundles them together with the subsidies, and sends them to the health plans. Under the federal reform, he said, the U.S. Treasury is going to be making the advance payment of premium tax credits directly to the health plans, not through the exchange. That is a "pretty significant operational difference," he noted.

In terms of benefits and coverage levels, said Neuschler, the federal statute requires that all plans, both inside and outside the exchange in both the individual and small-group markets, offer the federally specified essential health benefits package. However, he said, grandfathered plans—those in existence at the time the federal law was enacted—are exempt from these requirements. The services that comprise essential health benefits are outlined in the federal statute but must still be fleshed out in regulations. The statute requires that the list of covered services be equal in scope to benefits currently provided under a typical employer plan.

The federal statute requires that all plans offer coverage at four different levels (Bronze, Silver, Gold, and Platinum) that are based on actuarial value, defined as the percentage of the cost of essential benefits that the plan pays for an average population. Neuschler noted that plans could have a variety of different cost-sharing structures: deductibles, co-payments, or co-insurance. But under the law plans will have to cover a specified

share of the expected full cost of the benefits (60 percent at the Bronze level, 70 percent at the Silver level, 80 percent at the Gold level, and 90 percent at the Platinum level). Every plan has to fall into one of those categories, he said. However, people below 250 percent of the FPL will get additional subsidies to help with their out-of-pocket costs, so the actuarial value for some of them will be higher—up to 94 percent for people below 150 percent of FPL, and ranging down after that.

An exception to the four-level configuration is the provision for a lower-cost catastrophic plan, Neuschler said. This type of plan will be sold only to people under age 30 or to those who would otherwise qualify for an affordability exemption. It would have a flat deductible equal to the out-of-pocket maximum established under federal law for health savings accounts (HSAs).For 2010, that amount is $5,950; it will be higher in 2014. After the deductible, coverage will be 100 percent, with a few doctor visits and certain other services outside the deductible.

The federal law allows plans to offer benefits in addition to the essential health benefits package if they choose to, said Neuschler. If the state wants to mandate service coverage in addition to the federal list, they can do so, but then the state is "on the hook for the additional cost with respect to qualified health benefit plans. In other words, the feds don't want their tax-credit money being used towards extra services that the state is requiring."

The federal premium rating rules will apply, both inside and outside the exchange, to the small-employer markets, Neuschler concluded. However, adjustments to premiums based on health status will be completely eliminated. "That is a big, big change in California for the individual market," Neuschler said. The only allowable rating factors will be single-versus-family coverage, geographic area, tobacco use (with a ratio of 1.5:1), and age (with a maximum variation for adults of 3:1).

Designing the California Law: The Big Choices

Three panelists at the briefing who helped craft AB 1602 and SB 900 discussed the reasoning behind various aspects of the legislation. **Sumi Sousa** is special assistant to Assembly Speaker John A. Perez. **Scott Bain** is principal consultant with the California State Senate Committee on Health. **Jennifer Kent** is deputy secretary for legislation in the office of Governor Schwarzenegger.

Sumi Sousa laid out the scope of the legislative team's work. "The first thing that we had to do," she said, was to figure out "what this exchange can and should be, given the federal law. How do we actually create an exchange that adds value….that's something more than just a place where you go get your tax credit?" Given the state's history of success and failure in terms of exchanges, she added, "we had a very clear job of trying to reduce the amount of adverse selection and increase the overall exchange viability."

The task of the legislative team, she said, was to design a structure, a governance mechanism, and a financing arrangement in view of the federal requirement that the exchange must be self-sufficient. Overall, Sousa said, the approach needed to work, and to work in perpetuity—across administrations and significant differences of political viewpoint. "So we tried to put in the most solid foundation that we possibly could, with the transparency and openness that one expects of government."

One section of the California legislation, she pointed out, is basically "a recitation of the key things in the federal law that the exchange is required to do." For example, the federal law requires that the exchange certify plans for participation and establish resources to assist potential enrollees in navigating their options, and the California statute also includes those requirements. But the California statute goes beyond federal law by authorizing the exchange to "selectively…contract with

carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."

The legislative team was in firm agreement that it did not want to put the exchange "in a situation where it becomes the de facto third regulator," Sousa said. "California is complicated enough with a dual regulatory system." However, she added, the question of rate regulation will not go away, and will likely be the subject of future legislation.

Because the program has to be in place by 2014, concluded Sousa, the team had to emphasize practicality. Therefore, she said, "the decisions that we made were very much grounded in that practical 'Will this work? Is it possible?'"

Still to Be Decided

Many policy and operational issues will need to be addressed by the exchange board, the Governor, and/or the legislature, including:

- What criteria will drive the exchange's selective contracting approach?
- How will coordination and transitions between the exchange, Medi-Cal, and other public coverage programs be supported?
- How will "No Wrong Door" for eligibility determination and enrollment be assured?
- To what extent will products, benefits, and cost-sharing be standardized?
- How will California-specific benefit mandates and products compare to the emerging federal definition of "essential benefits"?

Some Unknowns and Concerns

Scott Bain discussed the exchange timeline and some of the policy considerations. "One of the questions we were regularly asked is, "Why are you doing this now, when the exchange doesn't need to be enrolling people until

California's Exchange Legislation

Two pieces of 2010 legislation, signed into law by Governor Schwarzenegger, establish the California Health Benefits Exchange (CHBE) as of January 1, 2011. SB 900 establishes the exchange and its governing board. AB 1602 establishes the duties and operations of the exchange. Some key features of the legislation:

- The CHBE is an independent state entity governed by a five-member board. Two members are gubernatorial appointees, one is an appointee of the California Senate Rules Committee, one is an appointee of the Assembly Speaker, and one is the California Secretary of Health and Human Services. Board members are subject to strict conflict of interest provisions and receive no salary.
- The CHBE will comply with the federal requirements pertaining to state exchanges that were part of the federal Affordable Care Act of 2010.
- A Small Business Health Options Program (SHOP) will be established, separate from exchange plan options and administrative structures that serve individual purchasers.
- The CHBE will determine criteria and processes for eligibility, enrollment, and disenrollment that are consistent with federal law and coordinate with processes for other public coverage programs.
- The CHBE will establish and use a competitive process to select participating carriers in order to provide coverage options that offer "the optimal combination of choice, value, quality, and service."
- The CHBE board has authority to standardize products to be offered through the exchange.
- The CHBE board may require insurance carriers to regularly update, and make available to the exchange, electronic directories of the providers in their network.
- Requirements are imposed on insurance carriers in order to protect the exchange from adverse selection:
  - Carriers that participate in the exchange must sell coverage at all "precious metals" levels, both inside and outside the exchange.
  - Carriers that do not participate in the exchange may not sell catastrophic-only policies and, if the exchange chooses to standardize plans, must sell at least one standardized plan at each "precious metal" level.

2014?" The reason, he said, is that the exchange has a number of big tasks to accomplish before then. It has to certify and contract with health plans, devise an eligibility enrollment system, establish a means of developing exemptions from the individual mandate, and administer the federal tax credits. Federal funding is available until 2015 for the exchange start-up tasks, he noted.

There have been concerns about exchange viability, said Bain, partly rooted in California's experience with the Health Insurance Plan of California (HIPC), which became PacAdvantage. "It's really a two-part concern," he said—first, the exchange's overall viability, and secondly, "that we get enough plans to participate in the exchange so that people have a choice of products."

The exchange is really two exchanges, Bain noted, "one for small employers, one for individuals." There is a big difference between them in terms of the value of the tax credit, he said. The federal tax credit for small businesses is limited under current law to the first two years of the exchange's existence. It is also limited to employers with generally lower-wage workers. The tax credit for people buying individual coverage is not time-limited. "It goes up to a higher income level and is permanent…and so we think there's going to be a lot more people taking advantage of the individual tax credits, and enrollment in the exchange may reflect that." Bain noted that planning is complicated by the fact that "We really don't know how many people are going to enroll in the exchange." The federal estimates were in the range of 24 to 29 million people, while California estimates from different sources range widely, from 1.25 to 8 million, he said.

Bain reviewed some frameworks that were considered in devising the legislation. One possibility was making the exchange the entire market so that individuals and small employers would only be able to buy coverage through the exchange. However, this option was rejected because the team thought it might be disruptive to current coverage arrangements. Over time, he explained, the exchange may want to include innovative products that are emerging in the individual market. "As the market evolves, you wouldn't want the exchange to be the only place to buy." Further, he noted, under the federal law some populations, such as undocumented immigrants, are not eligible to buy coverage on the exchange. If the exchange were the only option, these people could not get insurance coverage at all. A second option was to make the exchange a simple "pass through" for subsidy. This approach was likened by Jon Kingsdale to a "phone book option" in which all of the products available in a market would be listed in the exchange, "regardless of their price, regardless of their quality."

As part of these decisions, said Bain, the team had to decide whether to merge the individual and small-group markets, which is allowed under federal law. "We elected not to take that option, in part because we didn't know the impact of premiums on small employers and individuals if we did merge those markets." However, he said, the California legislation calls for a study on that topic to be provided in 2018.

In the end, the team decided on a third hybrid model that "would preserve the outside market, but the exchange would drive change in the market and in the exchange itself." He likened the exchange to an "insurance store" that would enable people to make apples-to-apples comparisons among products, then make their purchase in a brief online transaction. The team set clear rules for participation in the exchange in order to enable fair competition and drive value, Bain said. Through these rules the exchange can standardize products, and can selectively contract based on choice, quality, value, and service. The rules, he said, are devised to reduce adverse selection. Adverse selection occurs when a disproportionate share of high-risk and high-utilizing individuals purchase coverage within an overall pool. If the exchange experienced adverse selection, its costs would rise at an unsustainable pace and it would be unable to offer affordable insurance products.

Governance and Financing

Jennifer Kent discussed the team's charge to create a structure that would be complementary to the existing market in California. "For individuals and small businesses that have no purchasing power, if they come to the exchange, how are we going to do a better job for them and how are they going to have choices that are readily available, accessible, and easy to compare?"

The first decision point, she said, was whether to make the exchange a governmental entity or a nonprofit, since the federal law allows for states to choose either. She said they decided on a government option principally because government "has to conduct its business in the public." People have the opportunity to request documents and to participate in public meetings and hearings. That was a fundamental threshold decision, Kent said. "This is going to be a government entity because of those needs to ensure that there is a public transparency process." Further, in order to better meet California's needs, it was decided to make the exchange a state entity, rather than to participate in the fallback federal option established under the Affordable Care Act.

A second major decision was where to house the exchange—within the administration as a department, or off the administration branch of authority so that it could perform some tasks "without having to necessarily go through an administrative structure." The legislative staff decided on an independent, five-member exchange governing board within the state government. Board members would be appointed by the Governor and legislative leadership, and the exchange staff would report to the exchange board. The board members would be unpaid, and significant conflict of interest provisions were created to bar individuals who work for insurers, agents/brokers, health care facilities, or health care providers. In addition, there is a one-year ban on such employment after board members leave the exchange. The staff would be civil service, except for a limited number of executive staff positions.

Kent described the thinking on governance of the exchange. The team quickly decided that the board would be small. "Large boards," she said, "while they may make a lot of people feel really good about being able to sit on them, are not necessarily nimble." In devising criteria for the make-up of the board, the team looked at numerous models in state government and outside it. The final criteria, she said, were grounded in the pragmatic need for decisionmaking by this board. There must be purchaser experience as well as expertise in running a public program and designing benefits. "These individuals, especially for the first few years, which are critical… need to actually know what they're doing… so that this is actually operational by 2014."

Although the board will be subject to state open-meeting and public-record laws, it will have the ability to meet in closed session on issues such as rate negotiations. For the first two years, the board can issue emergency regulations.

"This first exchange board, especially given the nature and the import of what they're going to be doing," said Kent, "has to be stable. These folks are going to have to get along." Provisions were devised to ensure that the board worked with both the legislature and the administration because a great deal of coordination will be needed. For example, Kent said, tax entities will need to work with the exchange as will the departments that run public coverage programs. The bill takes effect January 1, 2011, and it is expected that board appointments will be made very shortly thereafter.

Kent described the design of the financing component of the legislation. From the state's perspective, and as emphasized by the Governor, the General Fund cannot be at risk. Therefore the bills are "chock full of General Fund protections," she said, so that if someone decides to sue the board because of one of its decisions, the General Fund will not be affected.

Because the exchange will have to function without General Fund dollars, Kent added, the board will have to decide what it is capable of doing within the resources that they have. These funds will be limited to federal grant awards, assessments on premiums when the exchange is operational, and to any nonprofit or foundation money that may be available. The exchange must report annually to the legislature and the Governor on expenses, performance, operations, and progress. This report must also be posted on the exchange Web site, Kent said.

Finding the Sweet Spot: Trade-Offs in Selective Contracting Design

The specifics of plan procurement—selection, certification, and contracting—were outlined by **Patrick Holland,** of Wakely Consulting Group, formerly with the Massachusetts Connector.

"The exchange is going to be like running a business," he said, "so the idea is to structure the procurement in a way in which you are not only meeting your goals from a policy and business standpoint, but you…bring in the carriers so that they'll offer their products on your exchange. That's the sweet spot."

The procurement procedures that Medicaid programs across the country have established over time can help inform the way the exchange selects plans, said Holland. Standards and criteria are created, published, and then vetted by the governing authority. First, a request for proposal or other form of solicitation goes out to the marketplace. Most states have formal scoring criteria that are developed internally. The criteria, he said, are structured to reflect the priorities of the governing authority.

A similar process could help the California exchange get "the right blend of product designs and carrier selection," said Holland. The criteria would be vetted by the board so that the process is transparent. When the responses came in, the exchange would score them against the criteria, and publish the results through a board meeting. The plans that are selected would be awarded certification.

Holland said such a process should enable the exchange to be viable in the market. "You're trying to bring in carriers, because that's how you create a shopping experience." The idea, he said, is that "You really want to create a dynamic in which people willingly—both individuals and small employers—come to the exchange to select carriers and select benefit designs." Holland stressed the importance of transparency. "In Massachusetts, we articulated the goals of the procurement very clearly. We had a lot of communication with the carriers….Oftentimes, carrier input would inform our thinking, and we would alter the procurement slightly by issuing an amendment to the procurement."

Insurance Market and Exchange Rules

Rick Curtis of the Institute for Health Policy Solutions talked about the market rules, which, he said, are intended to make competition work for the individual consumer and small employer. The aim is to achieve a market "in which it's safe for an exchange to do the right thing and not be basically killed by adverse selection…. More generally, the competition is over service and value and quality, not over who's best at attracting the best risks."

The federal law establishes a strong foundation for the avoidance of adverse selection, he said. "In the reform market, there is guaranteed access to plans for everyone. You're not charged more if you're sick or likely to get sick. That's a big difference."

Importantly, said Curtis, insurers must treat their enrollment as one risk pool. They can't, he said, have their "low-risk special" with a very good price for the healthiest population, and then price the plan way up for higher-risk people. Insurers have to "spread the costs for

the population across the various products." There is risk adjustment across the insurers in the market, said Curtis. "This is market-wide so that the plans that end up with a more costly population get compensation for that."

Curtis addressed a common worry that because of weak initial year penalties on individuals who do not obtain health insurance, high shares of people with pent-up medical needs will obtain coverage, causing costs and premium prices to skyrocket. However he pointed to federal provisions protecting against such premium price hikes in the first several years. In particular, there will be reinsurance that is externally funded by assessments on a broad base of health plans (including administrators of large employer self-insured plans), operated by the state. Further, he said, there are risk corridors that will compensate plans that have costs substantially outside of where they priced the premiums.

All of these measures, said Curtis, "should mean that prices are very reasonable initially, and that "plans will be eager to participate." He added that "This is harnessing competitive market forces to get plans to compete to offer better value."

The competitive market with guaranteed access for individuals is enabled by the individual requirement to participate in coverage, he emphasized, so that over time the healthy people as well as the sicker people will participate. "These kinds of market rules don't work in a voluntary individual market that is not subsidized," said Curtis. Massachusetts tried it that way, he recounted. "Their individual market premiums were sky high and came way down under state reform." He said that the exchange in California will be "very, very different from the HIPC" because the individuals and small employers who are eligible for tax credits have to participate in the exchange in order to take advantage of them. "This is a very substantial core population," he said. "It will be a large population with risk spread broadly."

There is an important difference between the federal and California legislation concerning the exchange rules and the outside-market rules, Curtis said. The federal law specifies that to participate in the exchange, a plan has to offer at least the Silver and Gold levels. This precludes a plan from participating only at the Bronze level, "where the unsubsidized healthy people will be," but this federal restriction pertains only within the exchange, not in the outside market. The California law, said Curtis, goes beyond that and requires any carrier participating in the exchange to offer at least one plan at all five levels — Catastrophic, Bronze, Silver, Gold, and Platinum — inside and outside of the exchange for the individual or small group market, or both, if the carrier participates in both.

The California law gives the exchange board authority to standardize the products offered in the exchange. Should it exercise that authority, all issuers in the outside market not participating in the exchange will also be required to offer at least one standardized product in each of the precious metal categories. If the board does not choose to standardize plans, there is no requirement on outside market carriers — who do not participate in the exchange — to offer the plans at each metal level. However, the exchange is likely to standardize, Curtis said, because if it does not, issuers in the outside market will only be able to offer Bronze-level plans and thus will disproportionately attract low-risk persons and lure them away from exchange-participating plans.

While the federal law allows a variety of cost-sharing configurations that can be hard to compare, Curtis said, the California legislation authorizes the exchange board to move to standardization in order to enable apples-to-apples comparisons. The exchange's ability to specify standardized products at each of the four levels that carriers in the outside market must offer is designed to facilitate comparisons by consumers, said Curtis. Massachusetts evolved to standardizing all offerings in their exchange, he said, after the exchange

surveyed members and found out this is what they wanted. "Similarly, an evolution responding to consumer preferences is likely in California," he said.

Curtis compared the federal and California provisions in terms of the small-employer exchange. The federal law allows states to either combine the small employer and individual exchange under one umbrella or keep them separate. While California chose to have one umbrella organization, the exchange is to have separate administrative capacity to provide consolidated billing and enrollment services for small employers. Otherwise, he said, worker choice of plans through the exchange would be "an administrative nightmare for the employer," because every employer would have to conduct separate transactions with all the different health plans in which their workers enroll. Instead, employers will deal with only one entity while the exchange does the "heavy lifting" of dealing with all the different health plans.

Due to its previous experience, he said, California is very concerned about risk selection, "probably more than any other place in the country." Fortunately, the federal construct "puts these exchanges in a far better position to begin with than the HIPC was with respect to selection," he said. Beyond that, he added, a number of additional measures that the legislative team placed in the California law should further circumvent problems. "I've never seen people working so hard to find a solution to problems," said Curtis. "Their focus was always on 'Let's make it work.'"