# Setting the Stage:
## Visions for the California Health Benefit Exchange

California HealthCare Foundation

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### Introduction

The California Health Benefit Exchange (CHBE) will be a centerpiece in California's implementation of the health care reforms authorized by the federal Patient Protection and Affordable Care Act (ACA). Federal and state law define important aspects of an exchange's role and authority but leave considerable flexibility—and responsibility—to the exchange in establishing priorities and strategic direction. As it sets its course, CHBE will become a focus of hopes, expectations, and assumptions about how it can and should work to improve access to coverage and care, ensure a smooth and seamless consumer experience, and moderate insurance premiums and health care cost trends. An early challenge for CHBE will be to secure its identity in two distinct worlds: The exchange will operate simultaneously as a public entity entrusted with implementing the ACA's provisions, and as a marketer of insurance plans that must attract health insurance carriers and consumers alike.

To help inform discourse about CHBE's early strategic and operational decisions, the California HealthCare Foundation (CHCF) developed this set of papers intended to contrast four possible strategic models for the Exchange. These models reflect different visions regarding what the Exchange's primary—though not exclusive—goals might be. In developing these papers, the intent was to formulate strongly-drawn alternative paradigms that could crystallize, for CHBE Board members and concerned stakeholders, the implications and trade-offs associated with pursuing one focus more strongly than others.

It must be emphasized, however, that neither CHCF nor the contributors to these papers expect that a single set of goals and resulting strategic emphasis for CHBE will or should prevail. These models are not intended to be mutually exclusive, and the Exchange very well might want to incorporate elements of each model in its strategic planning. Instead, the purpose of the papers is to help bring to the surface assumptions and differences in viewpoint that might, unless debated and reconciled, impede CHBE's ability to establish a clear path forward.

From meetings convened by CHCF to identify a range of potential CHBE goals, four model approaches emerged that are developed in the following accompanying papers:

1. **Price Leader: CHBE as a driver of low premiums.** The Exchange would prioritize affordability and low premiums.
2. **Service Center: CHBE as a consumer destination.** The Exchange would position itself as a consumer-friendly one-stop shop with broad choices in plan design, detailed consumer information, and a high level of customer service.
3. **Change Agent: CHBE as a catalyst of finance and delivery reform.** The Exchange would focus on long-term system reform and on promoting innovation in the health care industry.
4. **Public Partner: CHBE as aligned with Medi-Cal.** The Exchange would adopt an array of policies and practices that align with Medi-Cal's goals.

Regardless of the primary policy goals it ultimately chooses, CHBE must demonstrate a range of core operational competencies. A separate fifth paper defines and explores the core operational competencies CHBE will need to develop, suggests key decision points and challenges associated with establishing them, and addresses associated risks and opportunities.

The four "model" papers are described more fully, and the implications of each compared, in the final section of this overview. But strategic options are best understood within the context of federal and state policy and the California health insurance marketplace. So, before presenting a fuller picture of these models, what follows immediately is a summary of both policy and market contexts.

## The Policy Context

The ACA will put into place significant changes to the nation's health care system, to be implemented over the next several years. Many provisions of the ACA focus on broadly expanding access to health insurance. In particular, the ACA requires states, by January 1, 2014, to establish health benefit exchanges that will provide a mechanism for individuals and small groups to shop for and purchase health insurance. The exchanges will also be responsible for determining eligibility for subsidies and for coordinating that process with Medicaid (Medi-Cal in California) and other government-sponsored coverage programs. The exchanges will be the sole means by which eligible individual purchasers and small businesses will be able to access federal subsidies to assist in paying for coverage.

The ACA and subsequent guidance from the federal Center for Consumer Insurance Information and Oversight have provided initial direction regarding the roles and responsibilities of state exchanges, and further federal guidance is forthcoming. Nevertheless, states will have considerable latitude in customizing their exchanges to fit their own priorities and market conditions. With the enactment of Assembly Bill 1602 and Senate Bill 900 authorizing CHBE in September 2010, California became the first state to pass post-ACA legislation to establish an exchange.[1] CHBE is governed by a five-person board that began meeting in April 2011.

### Required Benefits and Plans

The ACA requires that the federal Department of Health and Human Services (HHS) define an essential benefits package. The scope of the benefits in this essential package is to equal the scope of benefits provided under a "typical employer plan," which remains to be determined by HHS.

As required by the ACA, CHBE will offer coverage, including a choice of plans, at five levels of comprehensiveness, four of which will be based on actuarial value. Actuarial value is calculated as the average share of covered health expenses reimbursed by the health plan, for a typical population. The defined levels are:

- Platinum, with coverage at 90% of the full actuarial value of the essential benefits package.
- Gold, with coverage at 80% of actuarial value.
- Silver, with coverage at 70% of actuarial value.
- Bronze, with coverage at 60% of actuarial value.
- Catastrophic, a high-deductible plan available to people under age 30 and to people who qualify for an exemption (because other coverage is not affordable) from the ACA mandate to obtain coverage.

CHBE must provide a choice of plans at each of the five coverage levels.[2]

### Subsidies

The ACA provides tax credit subsidies that are linked to the premium prices for a particular cost-sharing level within an exchange, and to household income. Specifically, the subsidy is based on the premium for the second-lowest-cost silver-tier product available on the exchange within an individual's geographic area; this

is referred to as the "benchmark" product. An enrollee must pay any coverage costs above those provided by the subsidy. So, for example, an enrollee choosing a platinum-level product would pay the full cost difference between its premium and the benchmark silver-level premium.

Subsidies are also linked, on a sliding scale, to household income relative to the federal poverty level (FPL), so that lower-income people (down to 133% of FPL) pay a smaller share of annual income than higher-income people (up to 400% of FPL). These aspects of the law will be important in developing CHBE's purchasing strategy, because both consumer and carrier behavior will be influenced by the availability and structure of subsidies.

Carrier interest in CHBE will be substantially related to the size of the subsidized population and the degree to which coverage is subsidized. Carriers will view less-subsidized or non-subsidized coverage—for which consumers have to pay more out of pocket—as riskier business in the guaranteed issue environment beginning in 2014. Risk adjustment is intended to correct for carrier costs related to such higher-cost consumers, but carriers may not trust this mechanism to be fully effective, particularly in the beginning years of the new market rules.

CHBE will have to balance diverse considerations when selecting carriers and products, because its choices will influence the subsidy benchmark. If the benchmark price point is set low because of the particular features of the benchmark product such as a narrow network or low provider payments, products without these features may not be affordable for subsidized consumers. On the other hand, if the benchmark price is high, unsubsidized consumers may struggle to afford premiums for any type of coverage.

## Carriers and Plans

CHBE will be responsible for establishing the minimum requirements that a plan must meet for participation in the Exchange and for implementing procedures for the certification of qualified health plans (QHPs) to be offered through the Exchange. CHBE may engage in selective contracting, and in so doing "shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."[4] As discussed in the companion papers describing four possible "model" approaches, how CHBE executes its selective contracting role could differ substantially based on the vision embraced by the Exchange Board.

In addition to plans selected by CHBE, the ACA charges the federal government with contracting for two multi-

### Extending Standardization Outside the Exchange

The California Health Benefit Exchange (CHBE) may elect to define one or more standardized products at each actuarial value level. If it does so, it would trigger an important protection from risk associated with those carriers that are not participating in CHBE. State law provides that if CHBE elects to take advantage of its standardization authority, some standardization would extend to the outside market.[3] Specifically, this law requires a carrier that does not participate in the exchange to offer at least one of the exchange-designated standardized products in each of the first four levels of coverage offered through the Exchange.

While carriers not participating in CHBE can offer other benefit designs and cost-sharing levels (so long as they meet the actuarial value specifications defined by the "metal" categories), the requirement that they offer at least one product at each level, and with the same benefit and cost-sharing details as plans offered in the Exchange, provides CHBE an important opportunity to control some of the adverse risk that an outside market may attempt to shift to the Exchange. (If the Exchange did not define standardized benefits, a carrier not participating in the Exchange would only be able to offer only "bronze" level plans designed to attract only healthy individuals.) Standardizing benefits would also provide consumers purchasing outside the Exchange at least one product at each level of coverage for which they could conduct "apple to apple" comparisons.

state carriers to make coverage available in every state and which must be offered by every exchange. Depending on the specific coverage and other terms offered by these federally-contracted carriers, they may offer an important fallback option in more sparsely populated regions for which there might otherwise be few local options. These contracts may also have implications for the benchmark subsidy price because they could affect which plans end up as the second lowest-cost silver option.

### The SHOP Exchange

CHBE will establish a Small Business Health Options Program (SHOP) separate from the individual market that will allow small employers the ability to purchase insurance and access subsidies (as eligible) through CHBE. The companion papers describing possible strategic models for the Exchange mainly focus on the individual market because CHBE will serve a greater share of total individual enrollment than will SHOP relative to the entire small group market.[5] Nevertheless, for many strategic and operational decisions it will be important for CHBE to assess impact on, and sometimes to develop distinct solutions for, both the individual exchange and the SHOP.

One important issue facing CHBE will be whether and how to link purchasing strategies between the SHOP and the individual exchange. The Health Insurance Plan of California/Pacific Health Advantage (a small-employer purchasing pool) found that some major carriers preferred to market directly to and enroll whole groups only, rather than participate in a pool or exchange that allowed individual workers to choose among plans. Linked purchasing strategies might help overcome carrier reluctance to participate in the SHOP, although CHBE would need to weigh other implications of shared strategies against these potential benefits.

### Financing

Federal grants are available to help states establish the exchanges, but the exchanges must be self-sustaining by January 1, 2015. Per state law, CHBE will assess a charge on qualified health plans in order to finance its operating expenses, and no state General Fund money may be used to support CHBE.

## The Market Context

CHBE has a very large constituent base to serve. There are 37.9 million people in California, approximately 15% (5.5 million) of whom currently obtain health insurance through the individual (2.1 million) and small group (3.4 million) markets. Estimates of the number of uninsured Californians range from 5.2 to 7.3 million. A substantial share of current individual purchasers, uninsured residents, and some small business workers and dependents are expected to obtain coverage through CHBE beginning in 2014.

### Exchange Enrollment

Forthcoming federal and state policy decisions, as well as CHBE strategic and operational steps and a range of other factors, will influence the size and composition of CHBE enrollment. For this reason, it is not possible at this time to precisely calculate enrollment. However, well-informed estimates suggest the following:

- By its third year of operation, California's individual Exchange will have a core enrollment of about 2 million tax-credit recipients.[6] This level of enrollment would represent approximately one-half of the total individual market. (If the State of California establishes a separate basic health program which would cover individuals up to 200% of FPL who are ineligible for other programs, enrollment in CHBE plans would be considerably lower.)[7] Based on the family income levels of California's current individual purchasers and uninsured residents, it appears that the core enrollment would be drawn in roughly comparable numbers from people who purchase individual coverage today and people who are currently uninsured.

- There could be considerable movement in and out of the Exchange during the year due to income volatility. According to a recent national estimate, half of adults with family incomes below 200% of FPL will experience a shift in eligibility from an insurance exchange to Medicaid, or the reverse, within a year.[8]
- Expected participants in the SHOP include employers that qualify for a substantial share of a sliding-scale tax credit, which is available only through the Exchange to businesses with fewer than 25 workers and average full-time equivalent wages of less than $50,000. Firms that already offer health insurance are expected to be most likely to seek coverage through the SHOP. In contrast, if employers don't already offer coverage, they and their employees may find coverage and tax credits available through the individual Exchange to be an attractive alternative. Based on these assumptions, CHBE's SHOP is expected to attract a core enrollment of about 500,000. This would represent about one-sixth of the current small-employer (up to 50 employees) market.[9]
- The size of CHBE enrollment is likely to attract significant interest from health insurance carriers, particularly those that have a major stake in the individual market today. Nevertheless, at least initially, plans sold through CHBE will comprise only about 10 to 15% of total enrollment in California's private health insurance market.[10]

### Enrollee Demographics

Like Californians generally, CHBE enrollees will be racially and ethnically diverse and some will have low or no English proficiency. State law emphasizes that information provided by CHBE must be culturally and linguistically appropriate for the population it serves, specifying that it be available in prevalent languages, plainly worded, and easily understandable.[11] The law also stipulates that the Exchange must provide oral interpretation services.[12]

## Four Visions for the Exchange

Following this overview paper are four companion papers, each of which articulates a different possible strategic model for CHBE. Each paper presents a potential primary focus for the Exchange, and describes its specific vision and the main reasons why the CHBE Board may want to pursue that particular direction. The papers also offer a view of some of the considerations and trade-offs associated with pursuing each focus and explore market impacts and other potential consequences that might be unique to that particular strategic model of the Exchange. In practice, CHBE may identify policy principles that may be cross-cutting or which combine attributes from each model.

The four models are summarized here, followed by a chart that compares their primary characteristics.

### Price Leader: CHBE as a Driver of Low Premiums

In prioritizing health plan affordability and access for consumers, this model would select and offer health plans that offer the lowest price. To better facilitate price comparison, this model would establish uniform benefit design standards. A price-leader Exchange's service functions would focus on minimizing operating costs through streamlined administration and by maximizing opportunities for automation and consumer self-service. To ensure sufficient volume for participating insurance companies, a price-leader CHBE would selectively contract with only a subset of potential carriers.

This model's success would be measured by to what degree lower-priced products would be offered both within and outside of the Exchange. However, it could face challenges in reaching this goal because the approaches of this model would do little to influence the underlying costs of care. The selective contracting at the heart of a price-leader model could also cause carriers, agents, brokers, or other stakeholders who feel excluded from the Exchange to actively work against its goals.

Significantly, a price-leader Exchange would emphasize immediate results and would not involve direct CHBE incentives to advance specific changes in the delivery of care.

### Service Center: CHBE as Consumer Destination

A service-center CHBE would provide a range of tools and services to make itself a consumer destination and a major distribution channel for health insurance to the population as a whole. This Exchange model would aim to attract consumers by offering a broad range of plan options, providing exceptional customer service, and responding to the unmet need for easy-to-use, easy-to-compare objective information and advice about health plans. A service-center CHBE would offer a larger range of carriers than a price-leader model, and a broader set of products, although with some standardization.

Risks associated with a service-center CHBE would include the possibility of confusing or overwhelming consumers with too many choices and complexity. Also, the level of options, information, and service envisioned for this model would result in high operational costs.

### Change Agent: CHBE as a Catalyst of Finance and Delivery Reform

A change-agent CHBE would seek to influence the transformation of health care finance and delivery. It would offer health plans that present consumer choice among non-overlapping care delivery systems, and would encourage better-organized, more competitive and accountable providers. Compared to other exchange models, a change-agent exchange would have a longer planning horizon and would work more collaboratively with other purchasers, such as purchasing collectives and large employers. Its focus would be not so much on the present year's premiums as on promoting system-wide improvements to health care delivery years into the future.

There are limits to how quickly this model could make significant differences in the market, and its impact on risk selection is uncertain. Among its risks are that the savings achieved would be too distant to establish immediate credibility for the Exchange. Also, because the change-agent CHBE would offer new models of care delivery, it could be confusing to consumers and require additional educational resources and communication.

### Public Partner: CHBE Aligned with MediCal

The Exchange as Medi-Cal Partner would adopt an array of policies and practices that would align with Medi-Cal's efforts to improve the health status and health care outcomes of low-income, high-need individuals. While the influence of Medi-Cal on California's health care delivery system is already substantial, both the likelihood and magnitude of meaningful improvements in quality, efficiency, and outcomes across the state's entire health care system would be even greater if, instead of pursuing different goals or competing strategies, CHBE and Medi-Cal worked closely together as purchasers, providing the marketplace with a coherent and consistent set of signals and incentives. Alignment would also improve continuity of coverage and care among individuals who experience shifts in program eligibility due to changes in income.

While closely aligning CHBE with Medi-Cal could amplify the impact of the Exchange, a partnership between CHBE and Medi-Cal would not be without risks. One potential issue is that collaborating with Medi-Cal could slow decision-making and impede innovation. In addition, if relatively healthy, higher-income people are put off by the Exchange's link to public programs, the Exchange's enrollment and risk profile could suffer.

Table 1 on page 7 provides a quick side-by-side view of some of the differentiating features of each Exchange model.

**Table 1. Four Strategic Models for CHBE: A Comparison of Features**

| | PRICE LEADER | SERVICE CENTER | CHANGE AGENT | PUBLIC PARTNER |
|---|---|---|---|---|
| **Defining characteristics** | While maintaining quality thresholds, would pursue the lowest-priced health plans. | Would choose products and offer services to make CHBE the "go to" location for buying health insurance for the population as a whole. | Would advance reforms to reduce system costs and improve quality through innovative, long-term delivery system changes. | Would adopt an array of policies and practices that align with Medi-Cal's goals. |
| **Descriptors** | Affordable, pragmatic, aggressive. | Accessible, convenient, supportive. | Innovative, forward-looking, collaborative, ambitious, long-term. | Collaborative; emphasizes the interests of the low-income population. |
| **Core values** | Premium price is the greatest barrier to access. Price must be addressed immediately to get as many people covered as possible. Given policy pressures and CHBE's scale, to do more would be an overreach. | One of the promises of reform is the reorganization of the health insurance marketplace to compete on customer value. To achieve this goal, CHBE must make the comparative shopping experience informative and accessible enough to attract all customer segments. | Health care delivery and financing drive long-term cost trends. Incentives are needed so that providers can profit by improving efficiency and producing better outcomes. CHBE can leverage unique policy levers to catalyze this process. | It is essential to support and improve Medi-Cal in order to achieve the promise of health reform. By collaborating with Medi-Cal, CHBE can contribute to Medi-Cal's long-term success and have a greater impact on California's health system. |
| **Elements** (includes procurement, service, and choice) | • Highly standardized benefit design to facilitate price comparison.<br>• Self-service and automation where possible.<br>• Limited number of QHPs per geographic region. | • Benefits sufficiently standardized to allow meaningful comparison, but variation would allow for some consumer choice.<br>• Service highly developed to support broad range of customer needs through multiple venues.<br>• More carriers in response to consumer needs (though still limited). | • Common benefits but choice of non-overlapping provider systems.<br>• Tools and support services to educate consumers on alternative care arrangements, network limitations, and other unique features.<br>• Contracting strategy would prioritize integrated delivery, accountable payment mechanisms, and lower-cost care delivery innovations. | • Service would emphasize interests of low-income population.<br>• Plan selection intended to foster greater uniformity of plans and provider networks across CHBE and Medi-Cal.<br>• Contracting would leverage combined purchasing strength of Medi-Cal and CHBE by aligning standards, quality improvement goals, and payment policies. |

*continued*

**Table 1. Four Strategic Models for CHBE: A Comparison of Features,** *continued*

| | PRICE LEADER | SERVICE CENTER | CHANGE AGENT | PUBLIC PARTNER |
|---|---|---|---|---|
| **Metrics** | Annual premium growth under key state and federal benchmarks. | • Broad set of customer satisfaction measures (e.g., loyalty, wait times, problem resolution).<br>• Continuous improvements in customer service, tracked against benchmarks both inside and outside the exchange.<br>• Balanced participation across income levels (including subsidy vs. non-subsidy), demographics, and geography. | • More efficient use of care (e.g., less unnecessary care, more appropriate settings, fewer preventable hospitalizations).<br>• Better population and chronic care management.<br>• Premium growth measured on a multi-year horizon.<br>• System-wide health spending and spread of innovation in delivery system and finance throughout state. | • Continuity of coverage for individuals moving between Medi-Cal and subsidized plans.<br>• Continuity of providers between plans covering Medi-Cal and the subsidized population.<br>• Consumer satisfaction, access, and quality of care measures, stratified by income, race/ethnicity, language spoken, disability, and type of coverage. |
| **Risks** | • Carrier discounts may not sustain over time.<br>• If discounts arise from cost-shifting, other market participants would pay more.<br>• Any perceived imbalances between the Exchange and the external market could cause the external market to undermine the Exchange. | • Extensive support could significantly increase costs.<br>• Focusing on the market as a whole could spread the focus beyond the particular needs of the subsidized population. | • Feasibility, long ramp-up.<br>• Many external dependencies (i.e., highly contingent upon actions of partners, providers, consumers, and other constituents). | • Collaboration could slow innovation and limit the Exchange agenda.<br>• Premiums could become too expensive due to added consumer protections and reporting burdens.<br>• The Exchange could be less desirable for the commercial population if it is perceived as too similar to Medi-Cal in terms of customer service and access to providers. |

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## About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

## Endnotes

1. Additional details from, and a side-by-side comparison of, the federal and California legislation can be found in the CHCF-published report "Health Benefit Exchange: California vs. Federal Provisions," www.chcf.org.

2. State law requires insurance carriers participating in CHBE to sell at least one product within each of the five levels and authorizes CHBE to require that carriers provide standardized products within each category.

3. California Health and Safety Code §1366.6(e) and California Insurance Code §10112.3(e), per Assembly Bill 1602 §§7,15,16 (2010).

4. California Government Code §100503(c), per Assembly Bill 1602 §7 (2010); see "Health Benefit Exchange: California vs. Federal Provisions," California HealthCare Foundation, February 2011.

5. Under the ACA, "small employers" are defined as those with up to 100 employees. But California apparently will elect to keep the upper limit at 50 employees for plan years beginning before January 1, 2016, as allowed by the ACA.

6. Two estimates converge on this figure. First, Peter Long and Jonathan Gruber, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs,* 30, no.1 (2011), 63–70, estimate the exchange size in California as 4 million in 2016 but, per personal communication with Dr. Gruber, this estimate includes all non-grandfathered individual coverage. (With grandfathered plans included, the individual market also totals 4.9 million.) Dr. Gruber reports that individual tax-credit recipients will total about 2 million. Second, the UC Berkeley Labor Center and the UCLA Center for Health Policy Research also project 2 million individual exchange enrollees with subsidies in 2016, and 1.8 million individual policyholders without subsidies. (Presentation to CHBE May 11, 2011 meeting by Jerry Kominski, "The Potential Impact of the Affordable Care Act on California.")

7. "State of California Financial Feasibility of a Basic Health Program," CHCF-funded Mercer report, June 28, 2011, www.mercer-government.mercer.com.

8. B. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs* (February 2011).

9. The estimated range is 450,000 to 650,000. See Rick Curtis and Ed Neuschler, "Small-Employer ('SHOP') Exchange Issues," Institute for Health Policy Solutions, with support from the California HealthCare Foundation, June 2011, www.ihps.org.

10. Total private coverage in California in 2016 is projected to be 22.9 million. Long and Gruber, "Projecting the Impact," 63 – 70.

11. California Government Code §100503(y), per Assembly Bill 1602 §7 (2010).

12. Ibid.