CALIFORNIA HEALTHCARE FOUNDATION

Briefing Transcript:

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

October 21, 2010

California reached a pivotal milestone along the road to health reform implementation recently with Governor Arnold Schwarzenegger's historic signing of two bills creating the California Health Benefit Exchange.

This October 21 Sacramento briefing examined the central challenges facing the state as it works to establish an operational exchange by 2014. Participants provided a synthesis of the design and policy issues that informed California's approach to establishing an exchange.

Panelists were (in alphabetical order):

1. Scott Bain, principal consultant, California Senate Committee on Health
2. Kim Belshé, secretary, California Health and Human Service Agency
3. Rick Curtis, president, Institute for Health Policy Solutions
4. Patrick Holland, managing director, Wakely Consulting Group and former chief financial officer, Massachusetts Health Connector
5. Jennifer Kent, deputy secretary for legislation, Office of Governor Schwarzenegger
6. Jon Kingsdale, independent consultant and former executive director, Massachusetts Health Connector
7. Marian Mulkey, director, CHCF Health Reform and Public Programs Initiative
8. Ed Neuschler, senior program officer, Institute for Health Policy Solutions
9. Sumi Sousa, special assistant to California Assembly Speaker John Pérez

Slides from the presentations and a recording of the event are available at http://www.chcf.org/events/2010/briefing-california-health-benefit-exchange.

Marian Mulkey: Thank you very, very much for being here today. I am the director of Health Reform and Public Programs initiative at the California HealthCare Foundation, and under that initiative, CHCF works to support health reform implementation in California and to advance the effectiveness of public programs in the state. Over the past six months, we've provided information and analysis to support national experts, including several who are on our panel today, to help inform California's deliberations about health reform implementation. We are really pleased to have a stellar group of experts, policy staff, and all of you who are concerned about the way that this state moves forward under federal health reform here with us today. And of course, we're here to talk about a matter of central importance in how that unfolds the establishment of the California Health Benefit Exchange.

This session today is the first in a series of events that CHCF will be sponsoring on health reform implementation-related topics. We have one scheduled in mid-December on enrollment and eligibility issues with the National Academy for State Health Policy. There's more information about that on the back of your agenda. This session is being taped, as you can tell from the cameras, and materials and video are going to be available at the Sacramento Policy section of the CHCF Web site within just a few days. We also are planning to release a CHCF summary publication on exchange design that's going to be based primarily on today's event, so look for that in a few weeks. Not only do we have a full room here, we are also video streaming to another room in the Elk's building a block away, so we first of all really appreciate and acknowledge the forbearance of people who had to go to that other location, and we will be trying to incorporate their questions in the question-and-answer session as we go forward. I need, just briefly, to acknowledge the really terrific team who pulled together the logistics for this meeting, which turned out to be a little bit more of an undertaking than we thought, given your enthusiastic response to the event. So I want to extend thanks and kudos to the Center for Health Improvement — Peter Reid and, in particular, Michele Peterson, Sue Gutierrez, and Karen Shore, who worked long and hard to get this together; and also to CHCF's own Sacramento office — Danny Sandoval, and Terry Boughton, who also worked hard to make this all happen.

In your packets, there are a couple of informational handouts, and there's a meeting evaluation form. We actually do read what you tell us, so please share your feedback on a form before you leave. There are a lot of luminaries on our panel. There are some very knowledgeable and respected colleagues and friends in this crowd, as well. I can't acknowledge all of you, but I want to say I am aware of the very great contributions that many, many people have made to the thinking around the exchange and want to say that CHCF feels privileged to be in a convening role around that issue. There are also bios in this packet. I am not going to recite the long accomplishments of all the folks on our panel but rather move just to the real pleasure that it is to introduce California Secretary of Health and Human Services, Kim Belshé, who is well known to many, if not all of you, for her leadership and her long commitment and engagement to health issues.

Kim Belshé: Thank you, Marian, and thank you all for coming. And to those of you who are listening but we can't put our eyeballs on you. This convening absolutely is a gathering of the glitterati of the health care policy and political worlds. And you characterized them as well behaved. I don't think anyone's ever called most of the people in this room well behaved before, including myself. So, what an exciting time it is for this conversation to be coming together. We're talking about reform, and not just reform in terms of the big ideas, but reform in terms of

implementation. And the context for our state's efforts around implementation, we all just need to acknowledge, are extraordinarily difficult. And indeed, our context has been one that has led many people to say, "Well, slow down, California. Don't move so fast." We've got that big political transition in leadership looming large in our state. We've got that pesky little enduring double-digit structural budget deficit. There's still a lot of really important news for the federal government and guidance to provide. There's a lot of misunderstanding, if not misinformation, about what an exchange is and its role in overall exchange. It was striking to me that notwithstanding the fact that there were a lot of reasons not to move forward, our state did. And so we're having a conversation today that is not occurring in any other state. And that is implementing a health benefit exchange in the context of the new federal reforms.

And so notwithstanding the fact that there was a lot of disagreement and dissension around these bills, I frankly point to it with some pride. Our state, of late, has not been pointed to as a state that, shall we say, is a finely tuned machine that is working on its issues in a timely, responsive way, particularly big, complicated ones. And our legislature and our governor this time around stepped up and had the courage and capacity to put into law one of the really critical elements of federal reform in terms of the health benefit exchange, which we're going to be spending this afternoon talking about. But because of their action, in so doing, they have put in place a fundamental building block. And they did it in a way that I think offers great promise and potential for the exchange to deliver on its very significant aspirational goals around coverage, around affordability, around quality, and, most of all, about improving the health status of the people of our state. That's why we're doing what we do.

It's interesting to me, when we think about why California got to "yes," what those reasons were, and I want to touch upon them briefly. I think they augur well for California's ability to be successful. And those members who have been working with me in the administration on implementation planning know that I like alliteration. Everything has four *p*'s. You can boil anything down in life to four *p*'s. So these are my four *p*'s for why we got to yes and why I think it bodes well for California's efforts going forward.

Number 1 is our past program efforts, processes, and policy development. That actually counts as one *p*. The point here is we're not starting from scratch. You all know that better than most. California has been having a conversation about purchasing pools, exchanges, on their own and in the context of reform more broadly, for many, many years. The health insurance plan in California dating back to the Wilson administration, which became PacAdvantage, a lot of people point to those and say, "Ugh, failure." You know, we learned a lot. And it informed our thinking about purchasing pools and exchanges on their own and now in the context of comprehensive coverage. We tried to do much of what is now federal reform back in 2007, and working within the administration, with the legislature, with the broader stakeholder community, we thought about and worked through these issues: What is the overall theory of an exchange? What are the goals? What is the relationship between the exchange and the non-exchange market? How do we think the overarching purposes and objectives? The point is we weren't starting from scratch from a policy or a process perspective, and I think that gives us a great foundation for our 2010-2011 effort.

Number 2 is the people. We have some of the super-duper smarty-pants in our state, who have thought about and actually run purchasing pools — Sandra Shewry, John Grgurina, and John

Ramey. We have other smarty-pants like Brent Barnhart and Deborah Kelch. We had a team of individuals with state expertise that were complemented by super-smarty-pants like the fellows you're going to hear from this afternoon, who helped inform our thinking in 2010 about the exchange, on its own and, again, in the context of reform. So that really strengthened our ability to move forward, and to do so not only with the consultant people but also our legislative colleagues, who brought a very collaborative perspective and a commitment to giving the exchange the tools it needs to be successful.

The third *p* is political leadership. I don't think there's any Republican governor who has stood up and said, "I am committed to making reform work. It's not perfect, but the law is the law. Let's not let the perfect stand in the way of the possible." So the governor stood up in April and said, "These are my priorities. The exchange is one of them." And the legislative leadership stepped up and responded and worked very collaboratively and showed tremendous political courage in the face of some pretty significant opposition. So I want to acknowledge the political leadership that was critical to get us to where we are today and will be going forward.

And finally, our philanthropic colleagues, the fourth *p*. We really have a disconnect in state service between the work that's required, its complexity and import, and our internal capacity to get the work done. Our foundation partners stepped up and have been incredibly helpful, not only in terms of financial resources, to help secure some of the external expert capacity, to help us think through these issues, but also their sharing of their own intellectual and policy expertise. So I want to acknowledge our philanthropic partners to date and going forward.

Those are the four *p*'s that got us to where we are, that got us to yes, that I think really will be critical to advancing our work thoughtfully and successfully over the course of the next three years. A final note I would make before turning it over to the super-duper smarty-pants who are here this afternoon, and that is a word about Medi-Cal. We talk a lot about exchanges. We have convenings like this, where hundreds of people want to come and learn about it. It's the shiny new object that everyone's very excited about. But I want to encourage us all to not forget about Medi-Cal. Medi-Cal, come 2014, 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. It is no longer, come 2014, a welfare-based program, but it is really a full and foundational partner of the overarching objective around reform as it relates to coverage. So I would submit the success of the exchange is going to be very much related to the retrofitting and success of the Medi-Cal program. And how those two programs work together is going to be absolutely critical to our overall success with the exchange and health care reform in terms of coverage, in terms of affordability, and in terms of wellness.

I'll stop there and thank Marian and the Foundation for their amazing contribution and commitment to date. And we look forward to that ongoing partnership going forward. Thank you.

Marian Mulkey: I'm going to introduce the next three sets of speakers with one quick note here, which is that we've sort of organized the day today from the high, biggest picture down to the more specific and granular. And these first three presentations, starting with Jon Kingsdale, an Independent Consultant and formerly of the Massachusetts Connector, are going to start with

why we're talking about this exchange concept. Ed Neuschler of the Institute for Health Policy Solutions is going to take us through some of the key components that were written into the federal law. And then Sumi Sousa, Scott Bain, and Jennifer Kent in various legislative-related roles, are going to talk about the legislation that California did produce. So I'm going to allow you to hand off to one another, and I'll sit down and listen.

Jon Kingsdale: Thank you, Marian. I'm going to build on Kim's remarks by starting with her last *p* and thanking the California HealthCare Foundation and Marian for sponsoring this effort. It's a real pleasure to be here, and your past efforts — to pick up on that first *p* — are well known and well respected. And I come with a great deal of humility from the East Coast, where we're normally used to getting your weather and your reforms and everything else that California does as a late adopter on the East Coast. I expect to learn a lot, particularly from the questions today, and I look forward to that. And speaking of learning, certainly the personnel I've interacted with here — and Kim named most of them, but a lot of other folks in the audience that have come in and met with us — have been tremendously dedicated and knowledgeable and helpful. I'm going to try to lay out kind of a general theory, if you will, of exchanges. This is a work in progress. In other words, I'm making it up on the fly, so you'll notice that the slides actually have evolved a little bit since when they were printed until this morning, when I reviewed them again. I'm going to also then give you some idea of possible goals for exchanges and various exchange models, because if you've seen one exchange, you know that by comparing, say, PacAdvantage with CalPERS, which are both examples of exchanges, you've seen one.

Just to think a little bit about the theory of exchanges. This is very broad brushstrokes that I'm going to paint, so I'm going to overgeneralize and probably be misconstrued a little bit. I'm going to generalize about insurance. I actually come out of the HMO and insurance field, with 25 years working in the private sector for a couple of different health plans, so I feel entitled to be critical at times, as well as realistic and praising the industry when appropriate. The theory really begins with some issues. Eligibility determination processes for different programs should be streamlined and coordinated. This is frankly, more forcefully and explicitly put forward in the federal legislation — the Affordable Care Act — 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. But in states where sometimes it's county and sometimes it's the state and often it's in longhand rather than 21st-century-automated eligibility determination processes, and automation of shopping is considered by the telephone rather than the Web, there is a lot of opportunity for improvement in customer responsiveness in this element of determining eligibility and streamlining shopping.

Also, the insurance market itself is a bit flawed. Products are wildly variable. Even if you take something as complicated as a mortgage, you're basically talking about four or five variables that people can understand — points and percentage, and term to maturity, and is there a balloon payment? When you talk about health insurance, people very quickly glaze over with about 20 or 30 different variables, most of which they don't even understand, whether it's deductibles or co-insurance on out-of-pocket maximums or whatever. So that's one reason. They're anything but transparent typically. And frankly, a lot of competition among health plans is on risk selection rather than socially more useful ends, such as service and benefits and value. There's some room for improvement there. And again, I say that coming from the industry.

Those of us who believe in exchange — and I don't believe they can do miracles, but they can help — can drive what I call "healthy" competition among carriers. And so I'm thinking there about customer service and benefits. And this is a very, very — if you'll excuse the expression — American concept. It's not all that different from the SEC, in that we ought to have markets that actually work for customers.

And then finally, if you get really grandiose and this stuff all works well, there's the thought that since 80-90 percent of the dollars actually are about paying clinical providers for care, that the incentives, if we get them right and healthy competition happens, ought to drive constructive change in better integration and coordination of care delivery.

So that's kind of the theory, if you will, at least at this point. And that gives rise, naturally — I hope this follows fairly logically — to some potential goals for exchanges. One is to facilitate fast, easy, smooth eligibility determination and enrollment in health plans. And I'll just give you an illustration, something fairly mundane. If you were to come to Massachusetts pre-reform, in 2006 moved to Massachusetts, and went shopping on your own as a household for insurance, you would call up — we have a healthy, robust, competitive field — you'd call up Blue Cross/Blue Shield, and maybe you'd wait five or ten minutes to get through on the telephone, and then you'd get through to them, and you'd ask them what they've got, and they've got 13 different products. Well, what might be appropriate for me? And then, well, we don't know; what do you want? And back and forth. About a half hour later, you've got two pages of notes in response to 12 questions that you thought to ask. And then you'd call up Harvard Pilgrim and start all over with a different set of products that aren't comparable and a different set of questions. And by the end of the day, if you were really a diligent consumer, you'd have pages and pages of notes on noncomparable products with noncomparable answers and indecipherable handwriting. You'd walk across the street and you'd ask your neighbor, "What have you got?" And that's shopping for health insurance pre-exchanges, if you will, in America.

By contrast, you can get on the Web site at the Connector — and by 2014, hopefully, the California Health Benefit Exchange — put in a couple of pieces of information that are necessary for rating purposes and for narrowing and standardizing some comparison-shopping dynamics, like what's your age, because that's a rating factor; and how big is your household; and what's your ZIP code, because that will tell you which plans are available and what the rates are — and you want kind of those gold-level benefits that cost more in premium or down to silver or bronze, and then up pop, in Massachusetts, given that information, about three to five options. And they're apples-to-apples comparison, and you can look at the premium differences and who's in which networks and make an intelligent choice about a $10,000-$15,000 purchase decision in a matter of a half hour. So that's what I mean by facilitating shopping.

A second goal might be just to reduce the administrative costs. Administrative costs are pretty high in the non-group and small-group area. Estimates are anywhere from a low of 10 percent to a high of 40 percent of premium goes to just the administration of health insurance in that segment, and there's some real opportunities to reduce some of those costs, particularly in the distribution of insurance. And that might be a major goal.

Stimulating price competition would be a third, and that can be at both the wholesale level — so if you want, as a carrier, to get onto the shelf of this major new insurance store, the exchange

(and that's really what exchanges are; they're insurance stores), then you have to offer some value that would be attractive to potential customers — and then again at the retail level, there's the opportunity for competition; I just gave you that shopping example. An exchange could have very little competition at the wholesale level — say we only have two health plans in our state (and that describes a lot of states), so we're going to offer them both, of course; or ten is a good number, and we've got that, and we're going to offer all ten and let the retail competition proceed; or do it at both levels. And then finally — again, getting most ambitious — there is the opportunity through healthy competition to begin to reward the folks who really matter in the delivery of care — the physicians in the hospitals, etc. — for integrating care and coordinating it. And I don't need for Massachusetts to tell folks in California what that vision is all about.

But I do need to remind you that this is fundamentally and ultimately about people, so I'm going to tell you two stories. They are Massachusetts-specific, but they're just two of many, many examples, and they are applicable across the country, hopefully in 2014. And one is Jaclyn, who was a teacher in Norwood, Massachusetts — not that you would know that town. She had health insurance. She left it. She went to work for her family's restaurant — which, not atypically, didn't have health insurance — felt a lump in her breast, didn't have it followed up, because she couldn't afford the services. After our reforms went into effect in 2006, she got onto subsidized health insurance. She qualified from an income perspective. She did get it checked out. And she is alive and smiling and very happy today. And as she would tell you, one of two things would have happened to her had this program not been available: (a) she'd have been dead by now; or (b) her parents would have lost their house because of what they were paying for the $100,000 of bills to take care of her cancer.

Abby is a somewhat different story. Abby moved to western Massachusetts from another state, another progressive, liberal, East Coast blue state, where she was advised that when she went out of state, having several chronic conditions, she would not be able to get insurance again. She would lose her insurance in the state and not be able to get it. She moved to Massachusetts and was not only able, of course, to get it, because we have guaranteed issue and community rating, but able to go through that shopping experience I just described to you. Now, Abby is an upper-middle-class business consultant, very smart and savvy and well-to-do, relatively. And she was thrilled to be able to go through that shopping experience that I just described and get insurance in a matter of 20 or 30 minutes.

And then finally, I'm not going to go into detail here. I do just want to reinforce this idea that you all in California are going to figure out what the California Health Benefit Exchange — or exchanges — is/are going to look like. There are multiple models out there. Utah has got a model with relatively unstructured choice for each employee of a small employer or a mid-size employer to pick from any plan that's available in the state. Massachusetts and Connecticut have exchanges — ours is government sponsored; Connecticut's is private — where employees of small- and mid-size employers get to pick from a relatively structured set of options. New York and Massachusetts have exchanges for small employers where the employer picks from a relatively structured set of options, and the employee has a kind of traditional take-it-or-leave-it option. And then there are, of course, very aggressively bid, highly structured programs. Again, for some individuals in Massachusetts, it's through the Connector. You're probably familiar with CalPERS. Many large employers will offer two, three, four options. Still, the employees get to choose. And then, that ultimate vision the folks in Wisconsin talk a little bit about, which is

really driving all health plans toward fully rewarding, integrated, coordinated care. So you can see exchanges of various models, and you all will figure it out for yourselves. But if we can help at all, we'd be happy to do so. Thank you very much. And I guess it's on me to introduce the next smarty-pants — actually, the first real smarty-pants — Ed Neuschler.

Ed Neuschler: I was wondering if "pants" was one of Kim's *p*'s. I'd like to add my thanks to Marian and the Foundation for funding the technical assistance effort. Actually, in our case, it goes back to about 2004 we've been working on issues in California, and I've really been quite privileged to have a role in this process. And my role very often came down to, "And what exactly *does* the federal law say?" So that's my role on the panel today, too. I'm going to talk about key roles of the exchange, which Jon has pretty well covered, but we'll sort of say what the feds say about it. Who does the exchange serve — what kind of populations? And then do a very quick comparison to Massachusetts, because there are a couple of factors that are different between Massachusetts and the new federal construct. I will talk a little bit about benefit and coverage levels. And then I realized, after looking through the whole slide deck, that nobody is talking about premium rating rules, so I'm going to mention that very quickly.

First, as Jon said, the key role of the exchange is to provide convenient access to consumer choice of competing qualified plans, and so the exchange is going to have to have readily available comparative information on cost, quality, etc. through a Web site and a toll-free hotline. And they're supposed to do outreach to various populations through "Navigators," who are supposed to have existing relationships with key populations that need to be reached and are supposed to get grants from the exchange to sort of help people through the process. Another key role of the exchange is that they are going to certify the qualified health plans that are going to be offered through the exchange. Everything offered through the exchange is called a "qualified health plan." To become qualified, the plans have to meet minimum federal criteria that are going to be specified by the HHS secretary. Then the exchange has to determine that in addition to meeting the federal criteria, that offering a particular plan is — I'm quoting from the federal statute — "in the interests of qualified individuals and employers." That's the basis on which there is a foundation for the exchange having selective contracting capability, which is going to be talked about quite a bit in the second part of this presentation.

Another key thing the exchange does is arrange eligibility determinations. I say "arrange" because the federal statute never actually says that the exchange makes an eligibility determination except with respect to Med-Cal. But they are clearly 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 or whatever. And they're clearly going to have a key role in taking that information and putting it into some kind of system, and exactly what that system is going to look like is yet to be determined. But the particular areas here are for the individual premium tax credits; if people want to be exempt from the individual mandate because no product that's available to them costs them less than 8 percent of their income; if they have access to employer coverage but that's too expensive for them — in this case, more than 9.5 percent of income — and therefore they want to get into the exchange anyway; normally, they can't if they are offered employer coverage. And finally, the exchange is supposed to inform individuals of the eligibility requirements for the public coverage programs — Medi-Cal, Healthy Families — screen people for eligibility for those programs, and, if they are eligible, enroll them. So there's the whole one-door eligibility concept.

Now, who is the exchange intended to serve? First, I should say nobody is required to use the exchange, but there is a core population that will have strong incentives to use the exchange because that's the only way they'll be able to get tax credits, and that includes modest-income individuals who are buying individual coverage through the individual exchange. It includes small, low-wage employers who can qualify for a federal tax credit towards the employer's contributions. That tax credit is in place already. Once the exchanges come up, in 2014, the employers will have to be purchasing through the exchange in order to continue to qualify for those credits for another two years. And I should mention that individuals are not eligible for tax credits or cost-sharing subsidies if they are eligible for what's considered affordable employer coverage or for Medicare or Medi-Cal. So that core population that has to use the exchange if they want to get tax credits, that's where the critical mass is going to come from to make the exchange really viable. But on a voluntary basis, the exchange can serve any lawful resident who is not in jail. It can serve any small employer up to 100 employees, although the state has the option to limit that to up to 50 employees for the first two years. But once we get to 2016, it has to go up to 100. And beginning in 2017, the state has the option to let in larger employers if they want to. And of course, that raises a whole raft of issues.

I thought I would make a couple of remarks about key differences between the federal construct and the Massachusetts Connector model, because it does have operational implications. First, the Massachusetts Connector, even on the individual side, effectively has separate exchanges with different health plans for the modest-income people who are getting subsidized, which in Massachusetts is below 300 percent of poverty and for the nonsubsidized individuals above 300 percent of poverty. It's really different health plans. Under the federal construct, an American Health Benefit Exchange, as it's called there, or California Health Benefit Exchange here, is supposed to make the same certified qualified health plans available both to individuals who are getting subsidies through the premium tax credits and for nonsubsidized individuals. And in addition, all people across both the outside commercial market and the exchange market, including the tax-credit recipients, are in the same risk pool, so all the rates are supposed to be blended that way. That's separate for the individual market and the small-group market, but it's blended for the outside market and inside the exchange.

And then, the second major difference is a payment and billing one. In Massachusetts, like under the Medicaid program both in Massachusetts and here, the Connector is making the premium payments to plans on behalf of the subsidy recipients. And if there is a share of premium, which, under the Commonwealth Choice Program, there is, the Connector is collecting those premium payments from the participants, bundling them together with the subsidies, and sending them to the health plans. Under the federal reform, on the other hand, the U.S. Treasury is going to be making the advance payment of premium tax credits directly to the health plans, and that's not going to go through the exchange, and so that does become a pretty significant operational difference.

Moving on to benefits and coverage levels, the federal statute requires that all plans, both inside and outside the exchange in the individual and small-group markets, have to offer the federally specified essential health benefits package. And when I'm saying "all" here, there's always an exception for the grandfathered plans, which are exempt from these requirements. The essential health benefits is a list of services that has to be covered. There's an outlined list in the federal statute. It's going to be fleshed out in regulations, and the statute requires that the list of covered

services is supposed to be equal in scope to benefits provided under a typical employer plan at the moment. We aren't going to know what exactly that's going to be until the federal regulations come out.

And then, the second part of that is: Okay, you've got the list of services that are covered; now, how much does the plan have to pay? And here, the federal statute requires that all plans are going to have to offer their coverage at four different levels that are based on actuarial value. In this case that is defined as the percentage of the cost of essential benefits that the plan pays. So you could have a variety of different cost-sharing structures — deductibles, co-payments, co-insurance. But they're going to have to be set up so that they cover either 60 percent of the expected full cost of the benefits, which is the bronze level, ranging through 70, 80, up to 90 percent, which is the platinum level. And every plan that's offered is going to have to fall into one of those categories. Now, there is a caveat there, and that is that folks below 250 percent of poverty are going to get cost-sharing fill-in subsidies, and so the actuarial value for some of those lower-income folks getting premium tax credits are actually going to be higher — I think 94 percent for the folks below 150, and it ranges down after that.

The one exception to the four actuarial value levels is that there is a lower-cost catastrophic plan. That can be sold only to people under 30 or, if you're over 30 and you would otherwise qualify for an affordability exemption because there's not even a bronze plan around that will cost you less than 8 percent of income, then you would be permitted to buy a catastrophic plan. And that's basically a flat deductible. This year it would be $5,950 and 100 percent coverage after that, with a few doctor visits and such outside the deductible, but not a whole lot. Some of them require preventive services and a few doctor visits.

Two other things to say about the benefits and coverage levels in the federal statute are that plans can offer benefits that would be services in addition to the essential health benefits package. They can do that on their own hook, if they want to. If the state wants to mandate service coverage in addition to the federal list, they can do so, but then the state becomes 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.

That's the end of my slides. I decided I should say just a few quick words about the premium rating rules. They do apply, again both inside and outside the exchange, to the small-employer markets. The biggest change is that there will be no health rating whatsoever. That is a big, big change in California for the individual market. The only allowable rating factors will be the family tier — you know, single family versus family coverage — the geographic area you're in, the age of the applicant, with a maximum variation for adults of 3:1 and an allowable variation for tobacco use of 1.5:1. It will be interesting to see how they actually implement that. And with that, I will pass it on to our legislator panel.

Sumi Sousa: So we're going to go really quick, and we're going to line it up, because we're already running over, we know, and we figure most of the time will be better spent on the Q&A. So thanks again for having us here. I'm Sumi Sousa, from the Speakers' office. One very important thing that is in your packet, hopefully, is a summary of the bill. I was struck over the last month at how much — or how little, rather — people actually knew about the bill itself. So I would really recommend to you to either read it and also to look at the summary, because the

details really do matter, and so much of it was focused on the "Is he going to sign it? Is he not going to sign it? What's an exchange?" But the details of actually what the exchange will do in California and who actually will be running this thing are in those two bills, and they're very important to read. I really suggest that you kind of take a look at it when you've got some late-night sleeping that you need to do. So what we're going to talk about briefly are: What were the key goals, what were the key concerns that we had in establishing the exchange? And then, number 2, how does the legislation try to address these issues?

The first thing that we had to do, and the most obvious thing — and I think Jon and Kim and everybody set a good context for it — was really what can and should this exchange be, given the federal law? And so that's something that we spent a lot of time thinking about. Secondly, how do we actually create an exchange that adds value? How do we create an exchange that's something more than just a place where you go get your tax credit? So that was very much a key concern for us. Third, given the history that we've had of success and failure in terms of exchanges, we had a very clear job of trying to reduce the amount of adverse selection and increase the overall exchange viability. So we spent a lot of time on that. Rick's going to spend a fair amount of time on some of the market rules that we set up. But that was probably one of our key issues that we spent time on.

And then, given that overall tall order, how do you actually create a structure and a governance mechanism in order to make this thing work? How do you finance it, given what the federal requirements are and the federal law is — in terms of the exchange needing to be self-sufficient? And then lastly, how do you do this in a way that this thing is going to work by 2014? And the one thing that I really think is important to emphasize is that we approached this from a very practical standpoint. We have all worked long and hard together. We have a lot of familiarity. The one thing that we were very much focused on and that drove us was that this had to be able to work. And so the decisions that we made were very much grounded in that practical "will this work; is it possible?" And so Scott is going to talk a little bit more in detail about some of the considerations that we did.

Scott Bain: Good afternoon. My name is Scott Bain, and I work for the Senate Health Committee, and I staffed Senate Bill 900, which was one of two companion bills that establish the exchange. I'm going to discuss some of the context and some of the policy considerations that the members and all of us discussed and the thinking behind some of the policy choices. The first bullet is the timeline, and 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 2014?" The reason for that is the exchange has a number of big tasks to accomplish. Ed touched on a number of them. They have to certify and contract with health plans. They have to have an eligibility enrollment system. They have to establish a means to develop exemptions from the individual mandate and administer the federal tax credits. In addition, there's federal funding available up until 2015 for exchange start-up costs. The second bullet is an unknown. We really don't know how many people are going to enroll in the exchange. The estimates are pretty wide. The federal estimates at the time for national were somewhere in the range of 24-29 million people would be in the exchange. A third bullet is a concern we had with exchange viability. We have a history of a purchasing pool in California — the HIPC, as it was known, became PacAdvantage. And it's really a two-part concern. First is that it be viable and that it not go under, and a second concern

is that we get enough plans to participate in the exchange so that people have a choice of products.

The exchange is really two exchanges, one for small employers, and one for individuals. But there's a pretty big difference in the two exchanges in terms of the value of the tax credit. The federal tax credit for small businesses is limited, under current law, to the first two years of the exchange's existence, and it's limited to employers with generally lower-wage workers. The individual 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.

Sumi and Dr. Kingsdale have both discussed the goals of the exchange. We wanted it to be a place that would provide choice, competition, and value for consumers. And it also needed to coordinate with current public programs. One of the provisions of the federal law is an expansion of Medicaid eligibility, basically to single adults. And there's going to be a lot up to 133 percent of poverty. There's going to be a lot of people moving back and forth between the exchange and Medi-Cal and other public programs, so the exchange needs to do a good job of facilitating those transitions.

Some of the options we considered as part of the discussion and debate over the bill were you could have the exchange be the entire market. If you were an individual or a small employer buying coverage, you could say the exchange is the only place you can get it. If you're worried about adverse selection, this would be a good option for you. We didn't elect this option because we thought it would be potentially disruptive to current coverage arrangements, that the exchange may want to take products that are selling in the individual market that are innovative and that as the market evolves, you wouldn't want the exchange to be the only place to buy. There are also populations that are not eligible to buy coverage, so if the exchange were the only entity where you could buy coverage, certain people couldn't get insurance coverage at all. The second option is what Sumi calls the "Craig's List" option, and I believe Dr. Kingsdale calls it the Yellow Pages or phone book. What it would do is you would just take all of the products that are available in a market, and you would list them, regardless of their price, regardless of their quality. And the third is a hybrid. It would preserve the outside market, but the exchange would drive change in the market and in the exchange itself.

How would the exchange do that? Well, the bill sets forth that the exchange would pick products based on choice, quality, value, and service. We wanted the exchange to be a place where people were able to make an informed decision. They were able to compare the options they had available to themselves. Dr. Kingsdale refers to this as a store — I always like that as an analogy — that had retail space where people could go to make apples-to-apples comparisons among products. It would be done in a brief online transaction.

Another decision point we had in the bill was whether or not to merge the individual and small-group markets. That's an option 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. The bill calls for a study on that topic that will be provided in 2018. We also wanted the exchange to coordinate with public programs because of this issue of people moving back and forth between the exchange and Medi-Cal and Healthy Families as their

income changes. We envisioned a "no wrong door" approach, where if you went to the exchange and you ended up being eligible for Medi-Cal or Healthy Families, the exchange would enroll you and vice versa. Finally, we didn't view the exchange as a third regulator. California already has two regulators. Some would argue we really shouldn't have two regulators. We envisioned the exchange as an entity that was facilitating the purchase of insurance and would provide value, choice for people buying coverage. And I'd like to turn it over to Jennifer Kent, who is the administration's lead staff person on the bill and who really did a terrific job — putting in countless hours, and tons of work.

Jennifer Kent: Thanks. I have to say to the Foundation and to the rest of the people at this table, this was really an unparalleled opportunity for the administration, from the governor's perspective, working with the legislature and having the foundations provide all of the financial support. I know that when we first sat down and started having conversations about creating this exchange, we quickly realized that (a) it would be really scary if just the three of us maybe sat down and drafted something on our own. We needed expertise; we needed other people to come in and help, but it was also a drawing of both the talent from within the administration across the various departments. We do have a lot of people within in state government that have great experience, but it was really a melding. And the foundations — not only CHCF, but the others — all stepped up and helped provide a lot of talent and skill. So we sat in a room, and we said, "Well, okay, we have big choices about how we create a structure to not be a new market per se, but to be complementary to our existing market in California, where, for the people that are individuals or for 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?" And so the main decision point right off the bat was do we go with a governmental entity or a nonprofit? And the federal government allows for states to contemplate either one. I think fairly early on, we decided that we preferred a government option, and one of the main reasons was we're from government, so we like what we know; but second of all, I think the people that are sitting in this room can appreciate government is transparent in a lot of ways. And government has to conduct its business in the public. There is always opportunity for people to request documents, obviously, that are public documents and to participate in public meetings and hearings. And so that was kind of our fundamental threshold decision right off the bat: This is going to be a government entity because of those needs to ensure that there was a public transparency process.

The second thing that we wanted to ensure is that the board was nimble and could actually function. Obviously, I've spent some time in government, but I've also spent time in the private sector, and people in the private sector will tell you they're far more nimble in making decisions than government. And so the second tension point that we had to decide was, would the exchange be housed within the administration as a department? Or would it be better off as government, but maybe off the official administration branch of authority because of the need for them to be able to react to market forces, to be able to change products, to be able to perform some of their tasks without having to necessarily go through an administrative structure? And of course, Kim would never … I mean, her agency functions like [snap] that, and so if it was under Kim's agency, we know that it would be quite nimble, but other areas of the state government … I come from your agency [gesturing to Belshé].

So then, the second thing we talked about was who is this board going to be? The first decision that we made off the top was it's going to be small. Large boards, while they may make a lot of people feel really good to be able to sit on them, they're not necessarily nimble. And then we got to the criteria of who are these people going to be. And we looked at a lot of different models in state government. And we looked outside of our state, even, and said, "How do other boards and commissions handle themselves?" And the criteria that we established was very much grounded again in what Sumi talks about, is the practicality and the pragmatic need for decision making of this board. So we established criteria that said you need to have been a purchaser; you need to have been someone who has had experience in running a public program, who has designed benefits, who has purchased. So the criteria of that very small board was also grounded in the fact that these individuals, especially for the first few years, which are critical, they need to actually know what they're doing, and they need to have operated in this area before so that their experience will help California make the right decisions so that this is actually operational by 2014.

The other critical component when we talked about this exchange was going to do was the financing. The general fund is both good and bad in this situation. The general fund needed to be protected from a state perspective, and that was one of the governor's highest points that he reiterated several times to us, which is this shall not be something that puts the general fund at risk. So there are very specific provisions, and I'm not going to go into all of them, but the bills are chock full of general fund protections in this exchange. When these board members make decisions and if someone comes along later and decides to sue the board, the general fund is not at risk. But likewise, it cuts both ways. The exchange is going to have to function without the benefit of general funds, so the board is going to have to be making decisions about its operations and about what it's actually capable of doing and making sure that they have the budget to be able to operate within the funds that they have, which are going to be limited at this point to the federal grant awards that are available, to the assessments that will be on the premiums, and to any other generous, generous nonprofit foundational money that we may be taking advantage of.

And then some of the other governance issues that we talked about — and these bullets talk about the conflict-of-interest provisions — likewise, we want people with skill, experience, background, previous knowledge in setting up benefits and running markets and perhaps running health plans and other such things, but we are also very conscious of the fact that there can't be a conflict of interest in those decisions. It would be to all of our detriment if we had someone on the exchange that perhaps sat through the first contracting phase and then promptly went the next day and went to work for a health plan that was just awarded a contract. So we not only made it clear that you couldn't have people that were employed by the insurance industry — agents, brokers, providers, facilities — sit on the exchange and be employed at that time. But we also put a one-year ban on employment by those individuals after they left the exchange. And this is somewhat consistent with people leaving the administration. You know, I won't be able to lobby the administration once I leave. This is consistent across state government. When employees leave departments, they are subject to a one-year ban.

And then lastly, this is where we gave Scott a lot of grief, Sumi and I did, because he was the good government of the three of us. He loves regulations. He never met a notification that he didn't like. So there was quite a big debate in several of our nightly meetings, because he wanted

the full regulatory process. And we said, "Hey, how about we do some maybe abbreviated regulatory processes off the start?" So the emergency regulations were kind of the tweener that we chose, because, again, this board is going to have to work quickly to get up and operational by 2014, but that we also needed to respect the public's input and value that process. So there were lots of things that we tried to do that both keep people involved but yet allows the board to make some fairly quick decisions if they need to.

And then lastly — I don't want to go into all of these — these are the things that we did to ensure that the board is responsive to the legislature and to the administration. It is an independent governmental board. It does have appointments that are made by the governor and the legislature, but they're term appointments, and this was a very deliberate choice that we made, because this first exchange board, especially given the nature and the import of what they're going to be doing, has to be stable. These folks are going to have to get along, whether they like it or not, because they're going to be setting up this exchange. But a lot of these things were also to ensure that they didn't just go off on their merry way and start drafting up all these great, fantastic emergency regulations and not be working with both the legislature and the administration, because there's going to be so much cross-coordination. We have tax entities that need to be working with the exchange as well as the other departments that run public programs. And so hopefully we will live to find out whether we made the right choice in all of these various trade-offs. But I think that that really speaks well to the cooperation that we had on this.

Marian Mulkey: I really want to thank all our speakers so far, but especially Jennifer, Scott, and Sumi for that really helpful summary of what's in the legislation. We're going to turn to the second section of our agenda, and we are miraculously spot on timewise, so I have thank all our speakers and encourage the final two to meet the standards set by their predecessors. Patrick Holland, of Wakely Consultants, also formerly of the Massachusetts Connector, is going to talk a bit now about the more specifics of plan selection. And then Rick Curtis of the Institute for Health Policy Solutions is going to talk about some of those market and risk selection issues. And I think we're really on track for some good question and answer subsequent to those two segments.

Patrick Holland: Good afternoon, everyone. And I'd also like to thank the California HealthCare Foundation for inviting me to participate. I really appreciate the opportunity to work on this project. My role here is to actually give you a little bit of a taste of the certification and plan contracting process that we had in Massachusetts under the context of selective contracting. And again, this is a place where — you know, there's that whole process that I'll get into very quickly in terms of the plan certification process and then this concept of selective contracting and what we see as the benefits of selective contracting in Massachusetts. They kind of blend together and I'll try to tease it out for you as I speak.

The typical process for the certification of health plans is really to follow a structure in which — most people call it a procurement, and it's pretty common for Medicaid programs across the country — probably less so for commercial carriers. But the idea is to create kind of a standards and criteria and which you publish in a document. It's generally vetted by the board, and I think that will be the case, probably, here, where the exchange will develop the type of things that it's trying to achieve, both from a competitive perspective, but also from a policy perspective. And again, as people already pointed out on the panel, the exchange is going to be running a business,

so the idea is to try to structure the procurement in a way in which you are not only meeting your goals from a policy and business standpoint, but you also want to bring in the carriers so that they'll offer their products on your exchange. And that's kind of the sweet spot, trying to figure out what it is that you want to do in terms of structuring the procurement

Generally speaking, there's a request for proposals or some form of solicitation that then goes out to the marketplace, and carriers are allowed to respond to that. Most states, and the exchange including, will have a sort of formal scoring criteria that is developed internally. It's structured in a way in which you're going to weight those things that are important to you as an exchange in terms of working with carriers so that you are trying to get the right blend of product designs and carrier selection on your shelf. And that would be something that would be vetted again. More likely than not, at least in Massachusetts, it was with the board, so it was a pretty transparent process.

Finally, once the responders submit their RFP responses, the exchange will score the criteria, and they usually publish the results, again through a board meeting. And then the plans that are selected are awarded the certification. That's kind of broadly speaking how it plays out. There are lots of hybrids. You all in California will come up with your own formula, I'm sure, but generally speaking, that's sort of a broad outline of most procurements, whether it's in an exchange environment or even like a Medicare/Medicaid environment. They're very similar.

The next slide is about the whole selective contracting process. And again, already pointed out in the panel, the exchange is not a regulator, so in terms of working with the market, you're trying to bring in carriers, because that's how you're creating a shopping experience. If it's a market with two carriers, I suppose it's going to be limited by definition, but if you have a market with a large number of carriers, you want to create the kind of choice that people are used to having in that particular marketplace. So it's not about necessarily looking to not bring people in; it's actually really more about bringing people in. That's what we sort of did at the exchange in Massachusetts. In fact, for four years or so, we are running the procurements for both the subsidized and unsubsidized programs. Every carrier that wanted to participate with us did participate, just to give you an example of how it can play out. And again, the idea here is to create some flexibility for the exchange. You're running a business. You're trying to have people come to the exchange, to buy health care. You want to create a dynamic in which people willingly — both individuals and small employers — come to select carriers and select benefit designs. So you're going to try to create a model in which people want to come to the exchange to purchase. The overarching goal that we had in Massachusetts was to try to work with carriers, do it in a very transparent way. We had a lot of board meetings in which we vetted the criteria for the procurement. We articulated the goals of the procurement very clearly. We had a lot of communication with the carriers. So again, what I would offer in terms of the Massachusetts experience is oftentimes, as we were going through these procurement processes, there was a heavy amount of dialog back and forth in terms of how we were seeing the market. We'd get input from the carriers and other key stakeholders. In fact, oftentimes, it would inform our thinking, and we would alter the procurement slightly by issuing an amendment to the procurement. And so I think it's a very positive process for the marketplace in terms of getting people to communicate openly, have it be transparent. We like to think, at least in Massachusetts, we generally had a pretty good result.

The only other point I want to point out in terms of this last slide, of benefits … It's a little bit different in Massachusetts than you may have here in California. We actually had two different types of procurements. We had one for the subsidized program in which we were in fact negotiating a rate. It was called Commonwealth Care. That was more of a negotiation process. The markets are going to be more like the Commonwealth Choice side, in which we're not rate setters. Again, we weren't regulators. We didn't regulate the market. We simply tried to structure a procurement process in which carriers wanted to come in to the exchange and offer their benefit designs, offer their products, work with us in a collaborative fashion. We tried to be transparent. We tried to be consistent in how we approached the market, so year over year; they understood what we were looking for. Oftentimes, we would change the approach based on feedback from the carriers as well as the board and other key stakeholders, like the advocacy community in our state. So again, it was really more about trying to move the market in a positive way, create some innovation. Oftentimes, as part of the criteria, we would reward those carriers that were doing limited network designs or had certain types of care-delivery systems that we thought were attractive to the consumers looking to buy on the exchange. And again, I just want to point out, in Massachusetts, some carriers may differ, but I feel like it was a very open, robust process that most people felt was working pretty well, for better or for worse, but that's the way it worked out. With that, I'll turn it over to Rick Curtis.

Rick Curtis: Before I begin, I know that a number of you in the room have heard things that people are hearing nationally about Massachusetts dictating price from the Connector, and it's not the Connector that has been doing that. Patrick or Jon, do you want to just clarify that? Patrick?

Patrick Holland: Probably starting in late spring, the Division of Insurance started looking at the rate filings for carriers and basically put a cap on the increases that carriers were allowed to provide. And I think there has been some confusion in the marketplace as to whether that's actually happening at the DOI, which has the regulatory right to do that, or in the exchange. And it is, in fact, happening in the DOI and not the exchange. The exchange in Massachusetts is not a regulator. It doesn't set the premium price. The only place where we did that as part of the procurement process was in Commonwealth Care, but that was because we were the entire market for the subsidized program, and we were negotiating with Medicaid Managed Care plans for the most part. So I just want to make that point, and thank you, Rick, for allowing me to do that.

Rick Curtis: And similarly, a couple of points. One — you all know this, but I just want to emphasize — the people staffing this and doing the real work, who you've heard from, and there are others in the room, are extraordinary. They're extraordinary in their dedication; they're extraordinary in their knowledge; and their focus was always on, "Let's make it work." There were differences in perspective, occasionally, on some things, and I've never seen people working so hard to find a solution to problems. It's been a privilege for all of us to work for these folks. They and their bosses make the decisions. We just provide some technocratic advice.

I'm going to talk a little bit about the market rules. A lot of this is covered, and we want to leave lots of time to answer questions, so I'm going to cut through a lot of what's in your sheets there. But let me just mention in general that the purpose of the market rules, similar to the purpose of the approach to what's called selective contracting, is to make competition work for the

consumer, for the purchaser. It's structuring it so you don't have the current market where, by and large, for individuals, it's a trick-or-treat market. Let's trick people who are sick and cost a lot into going somewhere else. Let's treat people who are very healthy and give them a low price and attract them. There are a variety of market rules here that try 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 and that, more generally, the competition is over service and value and quality, not over who is best at attracting the best risks. There really is a pretty darn strong foundation that alluded to some of this in the federal laws. This is much better than what it was. One thing I don't think was mentioned that you all understand — in the reform market, there is guaranteed access to plans for everyone. That's a difference. It was mentioned. You're not rated more when you're sick. That's a big difference.

Then there are more technocratic things that are terribly important. Insurers are going to have to — and people like Cindy Ehnes are going to have to manage the regulation of this, but they've got to treat their enrollment as one risk pool. So they can't have their low-risk special that has lowest people in it, and they give them a very good price and then price way up the plan that's for higher-risk people and they really don't want any. They've got to spread the costs for the population across the various products. So that's helpful.

There's risk adjustment across the insurers in the market. This isn't just in the exchange; this is market-wide so that the plans that end up with a more costly population get compensation for that. Importantly, in the first several years, I'm sure a lot of you in this room have heard, "Well, gee, there's going to be a problem in the market the first several years, because there's a very weak individual requirement with very weak penalties if they don't come in. But with all these access and rating rules, the people with pent-up health needs are all going to come in, and prices are going to skyrocket. Well, in the first several years, there's reinsurance that's externally funded by a broad assessment. The state will be operating that. And then there are risk corridors that will compensate plans that have costs substantially outside of where they priced the premiums. Those measures should mean — should mean — that prices are very reasonable initially, and that, combined with the competition, the way the selective contracting that Patrick was describing in Massachusetts, and more specifically, what your law says, there will be competition to participate. So this is harnessing competitive market forces to get plans to compete to offer better value to participate in the plan. Very importantly, all this is enabled — as I mentioned before — by the fact that you have an individual requirement to participate in coverage so that you are going to, over time, have the healthy people as well as the sicker people participating. These kinds of market rules don't work in a voluntary individual market that is not subsidized. Massachusetts can tell you all about that, because they used to have that, and their premiums were sky high and came way down under reform. And secondly, very importantly, as has been mentioned, but I'm going to mention this in slightly different terms, the exchange is very, very different from the HIPC beyond these market rules, because, again, as has been mentioned, the people who are going to get the tax credits and the small employers who are going to get the tax credits have to participate in the exchange in order to get coverage. Ed's slide mentioned this as the core population. This is a very substantial core population. We think it's probably ballpark 70 percent of the individual market in 2014. It might be 50 percent. But it's big enough that it knows it's going to have this large population with a broad degree of risk.

I'm going to mention a couple of the other things, not go through all of this, but one big difference in the federal law about the outside-market rules and the inside-the-exchange rules is the federal specifications are that to participate in the exchange, a plan has to offer the silver and gold levels, those 70 and 80 percent actuarial value levels that Ed mentioned — at least. And that's to preclude a plan from just saying, "Oh, I'm just going to participate at bronze, where the healthy people are. I'm not going to offer any of the higher plans, and I'm going to be able to select good risk and make out like a bandit." They're not allowed to do that in federal law in the exchange. But they are allowed to do it in the outside market. So your law goes beyond that and says both inside and outside the exchange, any plan that participates in the market has to offer at all levels.

There are a number of other rules as well that you have lain out before you. In the interest of brevity, I'm blowing by those. Additionally, while the federal law allows and specifies that these actuarial value levels will be what are offered in the exchange, it doesn't specify that the cost-sharing configurations need to be standardized. When you get down to a bronze level or a silver level at 60 or 70 percent actuarial value, you can have wildly different configurations of deductibles and cost sharing that are very, very hard to compare. So the law does not specify what these would be or even that the board has to do it, but it authorizes the exchange board to move to standardization so people can make apples-to-apples comparisons. And if the board moves in that direction, adopts that, there's also a requirement that carriers in the outside market also offer among those offerings those standardized benefits. And that's to facilitate level-playing-field comparisons by consumers. And again, I had mentioned, this is a policy that evolved in Massachusetts, and they paid careful attention to what their members wanted. They surveyed them; they talked to them. And this is what their members wanted, and that's why they went there. I'm sure that there will be a similar process here. I don't know what the outcome will be, but the board will decide, based upon what the members of the exchange want.

The small-employer side — you know this in California, but I just want to remind you of this — that it's one exchange governance structure. There's provision for separate administration, even with a separate head, within the exchange to run the small-employer side. But if the small-employer side were to try to work like the individual side, where the employer, on behalf of each worker, is dealing with all these different health plans among which people are choosing from, it's an administrative nightmare for the employer. It would be an unfathomable administrative burden. Nobody would come. Nobody would participate. This is how it needs to work. The administrative functions are different. The employer, then, is dealing with one entity. People are enrolling in the plan of their choice. The employer is getting a billing from one place — the exchange — when a worker leaves, when a dependent is added, whatever. The employer is dealing with one place, and then the exchange is doing the heavy lifting administratively of dealing with all the different health plans.

So the upshot here is that you guys were very concerned here about risk selection, probably more than any other place in the country. The federal construct, puts these exchanges in a far better position to begin with than the Health Insurance Plan of California (HPIC) was with respect to selection. But beyond that, there are a number of additional measures that further assure that it should be in a better position. And most of you in this room have done a lot towards the enactment of this, and I know you support it, and I know you're going to be helping. I'm going to repeat this. I hope this doesn't give you heartburn, but I happened to be in a meeting a few

days ago, and the medical director from Anthem Wellpoint nationally took credit. So I'm going to point out to all of you in the room that no, they weren't exactly helpful to the enactment, that maybe we wouldn't have had national reform if they hadn't so aptly demonstrated how broken the individual market is.

Marian Mulkey: I guess that last comment was to demonstrate that we didn't script all of this. I want to thank, again, all of our speakers. And I especially want to thank you all for touching on what I think are a lot of really high and salient points but doing it in a pretty time-efficient manner so that we do have plenty of time for questions. Again, we do have folks in another location listening to this streaming, and because we so appreciate their patience and fortitude taking the extra walk over there, I'm going to start with just a couple of questions from them. And I'd urge all of you to be thinking of questions, too, and I think we'll have time for plenty from you all in this room, as well. So the first question here actually comes at the impulse of Consumers Union, who asks — and this is probably a question that maybe Ed and Rick may want to start with, but you all may have views on this. How do you envision — and actually, the legislative panel as well — how do you envision the interaction between federal HHS, our two state regulators, and the exchange working on rate regulation vis-à-vis certifying qualified plans? So what's that connection between the rates and the selection or certification process? Is it in the federal law or is it something to be worked out?

Rick Curtis: I'll leave the real answer to people like Sumi, but in terms of the construct, the federal government lays out basic rating rules. Those will get more detailed as those are implemented here. The federal law specifies that the exchange cannot dictate price. That's one of the reasons your law is framed the way it is. There's going to be competition to be accepted, and frankly, I think, given all the talent and dedication here in California, I don't envision any tension with the federal government. I can imagine some in some other states, where there may be concern that prices are too high in the exchange, and it's unnecessarily driving up federal tax-credit costs. So that could be a point of contention in other states. I don't expect it to be here.

Sumi Sousa: On this issue, the kind of interesting thing about the bill was that if you look at 1602, the first section in terms of what the board actually has to do; it basically is just a recitation of the key things in the federal law of what the exchange is required to do. And one of those is the exchange has to essentially look at premium rate increases and whether they have been unreasonable. And the exchange could effectively exclude a plan if it made that finding. But that's simply what the federal law is. The Secretary of HHS is going to have to make a determination of how that works. I have to say, I was fascinated by the amount of people who thought this was something brand new that the exchange was trying to regulate rates in California through the back door. Honestly, if you go back to 1312, whatever — Ed will remember, because he always remembers numbers — it really is just simply out of the federal law. So I don't really envision that there's much to be evolved with regard to that. But I think we were very clear. California is complicated enough with a dual regulatory system. And putting the exchange in a situation where it becomes the de facto third regulator — which, at times, for all of us, was very tempting, right? That's a great way to deal with adverse selection. So I really don't see that there will be a lot of tension. I do think, however, that overall, this question of rate regulation will not go away, and that will be the subject, as it was this year, of future legislation. But that's much more appropriately in DOI and the DMHC side as opposed to the exchange.

Marian Mulkey: Thanks. I'm going to take one more from the room, and then I'll look out here. So this question is two parts. What did Kim Belshé mean by "Don't forget about Medi-Cal"? And then, related but not precisely, the second question is, what impact will the exchanges have on the county organized health system models and perhaps some of our other Medi-Cal–managed care approaches?

Kim Belshé: My point was just to remind us all that notwithstanding the hope and promise of the exchange as a central element of reform, its relationship and clarity regarding roles and responsibilities between Medicaid and the exchange are going to be really important in terms of the success not only of the exchange, but to reform overall. In some respects, federal health reform has effectively nationalized health reform eligibility from 0-400 percent of poverty. Right? So 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, now 0-133 percent of poverty, is really that foundation for coverage, with the exchange extending from 133-400 percent of poverty. That construct raises all sorts of issues relative to the two programs. The exchange, for example, will have the responsibility to screen and enroll individuals for eligibility in public programs such as Medi-Cal. So that calls into question, so what are the enrollment processes and procedures and systems to facilitate that role? We have people we know who are at the 133 percent of poverty, 200, a lot of back and forth. How are those two programs going to work together in terms of facilitating those transitions and promoting continuity of coverage? The plans with whom Medi-Cal and the exchange contract: Are they going to be entirely different or are they going to be similar? So it means thinking through plan selection and performance standards that may be a part of those contracts. The sub-question regarding county-organized health systems, that will be a question for the exchange board as it contemplates what standards and criteria will we employ consistent with the authorities provided by AB 1602 to determine plans participating and offered as a choice in the exchange. Will they be only statewide plans that are available? Will they be, perhaps, regional? These will be some important questions that the exchange board is going to need to be thinking through. And no doubt, they'll be thinking through them in part with an eye towards the Medi-Cal program and seeing where there are opportunities, if not for overall integration, at least alignment and coordination.

Sumi Sousa: I think this is something that — as an add-on on that — that we thought a lot about on the bill. It's a smaller provision, but not only is there the required coordination within eligibility and enrollment, it's really trying to make the exchange work closely with the department in terms of trying to keep some type of consistency and seamlessness in terms of … What we know about this population is how much their income goes up and down, and that makes a very big difference for them in terms of what their coverage will be. So for example, I was in the exchange because my income was 150 percent, and I had Kaiser. The minute my income goes down to 132 percent, I'm not in Kaiser anymore. That's a real problem. So that was something that we spent a lot of time, and the exchange board is going to have to really kind of think about in terms of how do you reduce the amount of disruption in terms of people's providers? And there's another provision of the bill which essentially says one of the key things that we know people want, just generally, when they go into the exchange is who's my doctor? When I'm choosing my plan, right? So that was something that we really wanted to do was to say, "Hey, I'm able to input and find out whether or not my doctor accepts the plan." So that

trying to reduce the amount of disruption is a really key thing, and I think that for the county-organized health systems and the local initiatives, most of them are fairly interested in participating in the exchange because they have that population that is just going to be going in and off of the exchange and their own coverage.

Kim Belshé: Just a final note I would make is I would characterize the issues that the exchange board as well as the next administration and legislature to work on as it relates to the exchange/Medi-Cal relationship is both operational, in terms of how do you make these processes and procedures work? How do you think about continuity of coverage, plan selection, etc.? But it's also philosophical, in terms of what is the vision that the exchange brings to its role in the broader marketplace? Is it more of a Medi-Cal orientation or is it more of a commercial orientation? And how does the new administration think about the Medi-Cal program in the context of 2014? As I say, it's not your mother's Medi-Cal program anymore. It's dramatically different. And it's going to require a new way of thinking about Medi-Cal in this broader construct.

Marian Mulkey: Let's go way back. And if folks could identify themselves first.

Bernard Hayes: Sure. Bernard Hayes, independent clinical consultant. The question is, along with 47 CFR and the rewrite for meaningful use, there was a mandate to have something called the continuity-of-care document, which encourages the providing system to treat people more like a clinical trial; that is, longitudinally over time and target them to improve people's conditions over time. Given the health benefit exchange in a world where historically insurers regarded their actuarial base information as a very important part of their asset base, how will there be something similar to the CCD in a world where people will be purchasing and moving more freely than before in and out of the various exchanges? How will these insurers actuarially calculate and demonstrate adequate profits to their shareholders and adequate financial provisions to the legislatures? I shouldn't say the legislatures. I should say the actuarial gods, whoever they may be.

Kim Belshé: I would like an actuarial god to help understand your question. I have a very healthy regard for what I do and do not know, and there were a number of initials and concepts that I'm looking at my folks, and I've never seen so many furrowed brows. So I'm confident that one of these super-smarty-pants here … Come on guys, step up, this is your moment. Rick Curtis! Maybe we can have a seminar afterwards.

Jon Kingsdale: I'm going to take it. I'm going to take a shot at it.

Kim Belshé: Go, Jon.

Jon Kingsdale: Lack of understanding has never held me back. Like Kim, I must confess I didn't fully understand the question, but I did get this concept at the end about how about making money versus providing value to the public. So I'm going to pick up on that and assume that's one essence of one part of your question. And maybe Patrick wants to elaborate on it. As a nonregulatory retailer, or wholesaler — store — for insurance with a substantial public subsidy involved and a mandate to serve the public, in Massachusetts, at least, the exchange — and I think the legislative authorization set up here is similarly directed — had a strong interest in

long-term, value-based relationships with the health plans — meaning we wanted them to make a little money. And if you are skeptical because you have an image of health plans that's fairly negative and has a lot of green eyeshades and dollars around it and other negative … think about struggling Medicaid MCOs or think about SafeNet provider-sponsored health plans. Or think about your favorite health plan if you can conceive of a favorite health plan. You don't want them, any more than the wealthiest, largest ones in the country, going out of business or going out of your exchange and your market because they can't make a decent return. Rather, you want them to have confidence that over time, you're going to keep their nose to the grindstone, and you're going to make them drive value in order to be able to make money. So enough pressure that they don't — and I won't name any markets, but I happen to come from one where they have tended to say, "Oh, you all want a 10 percent increase to providers next year? As long as you give my competition a 10 percent increase, you could have a 10 percent from me." That's the cycle you're going to want to break. But the only way to do that is to allow them, actually, if they 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.

Gil Ojeda: Gil Ojeda. I run a program called CPAC for the University of California. And as is my wont, I'd like to ask a political question that Kim alluded to. We're going to have a new governor come January. I suspect that virtually every agency that is going to be linked to this venture one way or another is going to have a new leader. Whether that person happens to be a Democrat or a Republican, they will be new, so there will be an opportunity for the state to reexamine some of the things that might have gone into the exchange bill, that maybe should have, but weren't because of elements of that dichotomy between Republican and Democratic political thinking. So the question, I guess, is for the Massachusetts people. If there were adjustments, if you will, to the exchange bill that would be more in keeping with some successful experiences in Massachusetts, what might those be, in a blue-sky world?

Jon Kingsdale: Okay, I think California did legislation that's got all the good elements of Massachusetts and added some more to it, so I'm not sure what I'd add. Patrick, do you?

Patrick Holland: Yeah, I would just add that we were constantly refining and tweaking, not so much the law, but the way we ran the exchange. Every year, we've learned more about the market; we've learned more about our stakeholders; we've learned more about ourselves. And we would constantly be refining and redoing how we did things in the past. So I think it would be an ongoing learning evolution.

And I wonder if either the legislative staff or Kim, you'd like to talk at all about the plans for the Foundation? I know it's been on your mind that there is a change coming.

Kim Belshé: Ever present. Two points — one, in terms of the processes I and others alluded to in our comments, there was a purposeful effort by the state on the administrative and legislative side to learn from the experience of Massachusetts and others. We appreciate, we're pretty bright in California, and we have some learning and experience that other states haven't, but with the support of the foundations, we were able to bring in some of the smartest people in the country and ask just that question, Gil. We had that discussion with Jon and Patrick in terms of, "So what did you learn? What would you do differently? How can we benefit as we develop this legislation?" So I think we did it very thoughtfully and very appropriately with the assistance of

the Foundation and our smart colleagues. In terms of transition, yeah, change is in the wind. And the governor made a commitment to move forward with implementation, notwithstanding the fact that a new set of leaders are going to pick up, come January. In our planning efforts, we have endeavored to account for that reality by ensuring that it's not only exempt appointees who are involved with implementation planning, but our civil service colleagues as well, so that we are building capacity, we're building processes across departments and agencies and building some sustainability into the new administration. Will the new administration bring a different perspective? Possibly. But the governor felt so strongly about the need to get on with it, the recognition that this exchange is big and difficult and complicated and will require time — and he had a point of view about its role in the context of broader reform and the contribution it can make — that he wanted to make sure he put his stamp and his imprimatur on it. And that is the framework that we will be, as a state, moving forward with until the next leadership and the next legislative session has a different perspective. Sumi can talk, and Scott, to whether or not … Every bill can change.

Sumi Sousa: The bill was drafted cognizant of the fact that we will have change, so that's why it's drafted the way it is. It's different from Massachusetts's governing board. It's smaller. And we thought of that as a positive. I think Jennifer did a good job of outlining all of those key decisions of you want this thing to be viable; you need it to work. And it needs to work in perpetuity, for all we know, across administrations and very large differences of political, practical funding decisions. So we tried to put in the most solid foundation that we possibly could, with the transparency and openness that one expects of government, particularly given the importance of the decisions that the exchange is making, but at the same time, providing for flexibility in order to actually compete and operate within a much broader market context. So I think that we were very cognizant of that, and that's why you see the board structure that you do.

Marge Ginsburg: Marge Ginsburg with Center for Health Care Decisions. I'm always concerned about the affordability of it to the individuals who are signing up for the exchange. I know in the ACA, it talked about gold, bronze, silver, and platinum. So if you're saying that the individual has to have — will have — 20 percent of the actuarial value under a bronze plan, does that mean, for example … Let's say it's a $5,000 annual premium for a particular plan. Does that mean the individual is going to eat up, through some various cost sharing, about $1,000 of that $5,000? Or does it mean if they have a horrible catastrophic event and they eat up $200,000 of medical bills in a year, they're going to be faced with $40,000 of cost sharing?

Rick Curtis: Those actuarial values are for an average person only, so that a plan that would be 80 percent — and actually, that's gold — that's for an average person. Somebody who's very sick, that plan is going to cover 99 percent of their costs. There are out-of-pocket limits. There are very substantial protections for people who get very sick and very expensive. It's just on average. Let me just use a simple example. If you have a $1,000-deductible plan, somebody who is healthy, who goes to the doctor a few times outside of the primary care visits, would never reach the $1,000 threshold and would receive no additional benefits from the plan; whereas somebody who goes to the hospital and has a $100,000 bill is going to have working towards — except for some of the cost sharing — $98,000-$99,000 of that covered. So it's not 90 percent or 80 percent no matter who you are. It's for an average person, and it's much higher than that for costly people.

Jon Kingsdale: And there's also protection for low-income people. There's actually less cost sharing for a low-income person than for a median-income person, so there's some protection there. So that threshold, if you don't really spend a lot of your money if you've got big bills; you actually spend even less of your money if you're low income.

Ed Neuschler: And we didn't talk about it, but along with the actuarial value percentages, there are also maximum out-of-pocket limits for each of the levels that don't go beyond the maximum out-of-pocket limits under health savings account compatible plans, I think.

Micah Weinberg: Hi, I'm Micah Weinberg from the New America Foundation. First, this is an absolutely tremendous event, and it really just went over all the issues in a comprehensible and really useful way. So thanks to everybody. Also, I'm a policy wonk, although I prefer the term policy aficionado. And watching this process, the extent to which it built on California's experience and brought in the expertise of such a broad range of people is just so great to see, because it's how government is supposed to work, and it almost never works that way. So thank you to everybody who was involved in this process. Also, I really loved, Jennifer, your behind-the-music account of how the process went on and some of the conversations, so that was really great. My question, though, is about three words. And those three words are: "if eligible enroll." Because in some of these conversations, we talk about protection for the general fund through the exchange board's activities. But if the exchange makes it dramatically easier — as, hopefully, it will — for people to enroll in Medi-Cal, and if the people who are currently eligible but not enrolled in Medi-Cal are not matched at the higher federal rate, but at the regular federal 50 percent rate, that's going to have huge implications for the state's general fund, to the tune of some amount of billions of dollars. So I would be interested in folks digging a little bit further into this issue of "if eligible enroll," and talk about what that might mean for the state, what some of the state's options would be in that regard, and what you see coming out of this provision and function of the exchange.

Jon Kingsdale: I can talk a little bit to this, because we spent a lot of time on this, and we had shared with the legislature modeling that Medi-Cal had done. We did some very sophisticated analyses once the federal reform bill finally set itself to say how many people are going to come into Medi-Cal, who are they, where are they going to come from, or they show up in a hospital on the grid for the first time and they get enrolled. And so, the exchange is one place where someone who is eligible for Medi-Cal is going to come. But the way that we tried to protect inappropriate placement and eligibility in Medi-Cal was to make sure that the exchange — and I can almost quote it verbatim — there's a provision in the bill that says the exchange has to work with both the Healthy Families program and the State Department of Health Care Services to make sure that they coordinate their eligibility and enrollment processes. And that was to address the concern that the exchange would be, like, "Hey, you have jeans on. You look kind of poor. We think we'll put you in Medi-Cal because that would be a nice place to put you." I mean, that's not the way it's going to be. The exchange can't have a different eligibility standard for Medi-Cal than what Medi-Cal has for itself. And so I think what we're looking at is you're going to have a lot of transferring of people as they come in and off of the program, depending on what their income level is. But there will be a general fund impact, no matter what, and that was the standard fact of federal reform.

Sumi Sousa: It's the general fund impact that happens … I mean, the key, too, it's general fund impact that happens, regardless of whether you have a state exchange or not, because if there's a federal exchange, the same thing happens. These people are eligible as an entitlement. That's the change. So I think the bigger issue, in some ways, in terms of general fund, is in the Medi-Cal program. How do you, with the large, large numbers of people that are coming in, how do you sustain the rates that you have right now? And that's the biggest general fund worry that I think all of us have. So it was less about what the state exchange would be, now that you have this culture of coverage and you have an entitlement and childless adults and all of those sorts of things, really, it is a fundamental kind of a Medi-Cal issue, and Kim is right. Medi-Cal is changing dramatically. It's less about the exchange.

Kim Belshé: Just a final point on that. I think it's one of many reasons why the state made the responsible policy decision, which was that the state of California should administer the exchange and not the federal government. Because the exchange, whether it's a state-administered exchange or a federal-administered exchange, has a responsibility screen and enroll. And I think far better than California leadership and policymakers are screening and enrolling and making those determinations in concert with the state Medicaid program, as opposed to Washington, D.C. But most fundamentally, it's all about the paradigm shift. Medi-Cal is now about coverage. And that is embodied in two significant areas. One is the very different rules around eligibility, which makes it much easier. It's an income-based eligibility standard. Very, very different in terms of versus what we have today. And secondly, the streamlined enrollment standards. Single application. Online enrollment. No wrong-door philosophy. That is all about getting people enrolled. And the federal government financially is picking up the tab for the overwhelming majority of those costs. So it's a reflection of the policy.

Marian Mulkey: I'm going to take one card; then I'm going to go back there and I'm going to go up to Sandra Shewry here in the front row. So this is a quick one, I think, from Soap Dowell in the remote location. When will the exchange board members be appointed, and when will it commence operation of the exchange?

Kim Belshé: Hello, Soap. Soap was one of our models as we thought about boards and board members. So, in seriousness, obviously, the bill takes effect January 1, and appointments will be made very, very shortly thereafter. On the governor's side — I won't speak for our legislative colleagues, but — again, one of the major reasons why the governor moved was to get a bill, get this in place and get moving on it.

Sumi Sousa: If you think about it, one of the things that Scott kind of touched on was in terms of the timeline. We had so many people just sort of saying, "Are you insane? Why are you doing this now?" Walk back in terms of the timeline. The exchange has to be up and running by 2014, meaning we really have to be ready six months ahead of that — with a system in place. Well, we didn't have two-thirds vote for an urgency bill. That means the bill becomes effective January 1, 2011. They have to essentially start as a start-up. So really, two and a half years to do this entire thing with many millions of eligible people — that just doesn't happen on a dime. And so again, that's really what was driving the timing and the decision making.

Alison Lobb: Hi, I'm Alison Lobb with the California Children's Health Initiative. And to make things work really well for the public, it helps to have public members or consumer

advocates in some sort of governance or oversight position, and I was wondering if you already have thoughts about what sort of mechanisms or bodies you might be creating down the line to make sure that the exchange works really well for California's consumers.

Sumi Sousa: Actually, the board statute in some ways is very different from most statutes. You see a 15-member board where there's a doc and an insurer and a … And it's very clear in the statute. The board is essentially there to enact the federal law and to meet the needs of its enrollees. So it's very clear from the beginning. And the enrollees are who? They're consumers. You know, they're individuals and small businesses. And I think that needs to be really underlined. That's why we took so much care with who could be appointed, too. That's why there's no board salary. You know all the things that happen with these boards. Everybody has the same intentions of wanting a really good board structure. And somehow, over time, things kind of don't work out so well. So I think it's too early to talk about whether or not there's going to be … I mean, the federal law essentially says you have to consult with consumers and … there's state Medicaid … in the back of the bill, you'll see who you have to consult, and that's basically what's in the federal statute. Of course, without saying, that's basically what … This thing has to have consumers who want to enroll, so this whole argument of selective contracting is really there to exclude people, whatever. We have to have products that people want to buy. The exchange is going to be competing. Particularly at the upper-income levels, at 300 percent, where that subsidy isn't so valuable, it's going to be competing for members, so it's got to be very, very responsive to the people who are going to be enrolled. Otherwise, it's not going to last very long. I think overall, if you look through that, everything about that structure was really trying to say, "We're open for business, but we're open for business for people."

Kim Belshé: And the administration is planning a grant to the federal government for the one million dollars. We articulated a number of steps that needed to occur around stakeholder engagement, which this administration will begin and hand off to the next administration. One-on-one meetings, group meetings, broad community meetings. This will be an area where we're eager to hear from people in terms of what types of mechanisms or processes are helpful from an advisory group perspective. All of our boards ultimately evolve into having some kind of structure such as those. Those will be decisions for the next exchange board to make, but those are issues we're interested in hearing initial thoughts on.

Jon Kingsdale: Just one additional perspective from our experience in Massachusetts is that there are buyers, who are people who spend money to purchase a service, and I think you've heard that those folks, whether employers or employees or individual consumers, need to and are being represented. There also are a host of organizations in California and in Massachusetts and around the country who are trying to help folks who need services and who need access. And I would guess — and it certainly has been the history in Massachusetts — that that very robust, active community of "consumer advocates" — that's the term that they usually adopt for themselves — these can be churches; these can be nonprofit organizations; they're often very community rooted; they're in one locality and not another — very robust role for them. Not only does the California statute echo the federal one that you should consult with those folks. This is a golden opportunity for you all in the community to get active, to help find constituents who need services and to help those constituents get the services they need. And those advocacy organizations were extremely active and plugged in. And the same kind of dialog that Patrick

mentioned we have with carriers, we have with those advocacy groups at the Connector in Massachusetts, and I'm sure in California you will as well.

Sandra Shewry: Thank you for the great panel.

Marian Mulkey: This is Sandry Shewry, who played a big role …

Sandra Shewry: I'm Sandra Shewry, and I know most of you. You previewed several of the public policy issues that will either need to be reckoned with by the exchange board or the legislature and governor between now and 2014. The ones I heard you mention were selective contracting criteria — how would that work; the relationship to Medi-Cal — what's the alignment and what are the transitions; I think I heard you say something about how many regulators might the state need; how will "no wrong door" be implemented. I was wondering if you could give us a sense of some of the other public policy issues that the statute and the fact that the exchange will need to make real all the provisions that are in there that will either come before the legislature or will come before the exchange board … if you might highlight a couple more of those for us.

Marian Mulkey: It was a pretty good list that she started with. Does anybody have others to add?

Jon Kingsdale: I'll venture one more, which is to what extent does the exchange want to use the market competition and the incentives to drive change in the delivery of medical care, which is really, in some ways, what we all care about. I mean, even if you have an insurance card, if there aren't any doctors or if they're not set up in the optimal way for you to manage a variety of your chronic illnesses, whatever — the insurance card if worth something, but not nearly what it could be. So that's not a direct line. That's a pretty nuanced and long-term challenge, but it's a real public policy challenge, how do we use market competition to the exchange and its impact beyond the exchange for the rest of the market to drive rewards for physicians and nurses and hospitals and physical therapists and laboratories, etc., etc. to coordinate, integrate, and provide better quality, more cost-effective care?

Scott Bain: Sumi wants me to talk. So far.

Marian Mulkey: Scott, do you have a pet issue we need to hear about?

Scott Bain: No. One of the issues we discussed is product standardization, individual market in the context of the exchange and in the context of a separate bill. And we had a disagreement over whether or not products should be standardized in the market. Should we have Medicare supplement policies RA through J — or whatever the letters are — where the benefits in the cost sharing are the same across all products and you're making apples-to-apples comparisons on provider network choice, quality of competing networks? The bill does not do that. It allows the exchange … And it reflects the Massachusetts experience, which is, the exchange went into the market and then used its experience on what was popular and what sold and then standardized those products. And so that may be something that is addressed further or is discussed as part of the debate over the bill.

Kim Belshé: One more I'd call out is the definition of essential benefits, and it's an important issue to call out, because it seemed to be an issue where there was a lot of misunderstanding about where authority rests in determining essential benefits. That will result in a very active and robust dialog, no doubt, here in California in terms of what that looks like relative to Knox-Keene, relative to what other standards our state legislature and governor determine. But that will be a decision for the legislature and the governor to make, come 2011-2012, not the exchange board.

Marian Mulkey: I'll take one more question back from the room and then I'm going to take a break and let those who have to leave.

David Rankey: Hi, my name is David Rankey. I'm a local emergency physician. Thanks again for putting this on. It's been great. My question is for the people from Massachusetts. I was interested in some of the trends in regards to innovation that you've seen in new products with the transparency. And also, have the insurers now become more cost conscious? And are you seeing a shifting in terms of going more into the bronze products as compared to gold and silver?

Jon Kingsdale: Well, a couple of things to note. I actually love new products, and I can't say that Massachusetts is now inundated with new products as a result of the exchange. But there have been some trends, I think, worth noting that the exchange had something to do with. One is greater demand popularity enrollment in what I call the generic-brand health plans. So we've got some health plans in Massachusetts that I kind of think of as salt-of-the-earth plans. They're a limited network. Some are, frankly, built around neighborhood health centers. They have very low administrative expense ratios, like 6 and 7 percent of premium, not 15 and 20 percent. They care for a substantial Medicaid population. And they are very primary-care driven in their experience, even in our unsubsidized exchange, far disproportionate share of the enrollment relative to their size in the rest of the market through the exchange. So we're driving, if you will, the exchange is driving some demand for what I'd call these generic brand integrated delivery systems. There have been some specific elements, like two-tier networks that, again, this choice dimension encourages. We've had a couple of plans come out with tiered networks, where the consumer can pick a broader or more narrow network, and the consumer will keep or spend more money accordingly. One specific innovation that we promoted that a couple of plans adopted and some didn't was the idea if you're going to have to share costs and you're going to share costs around drugs, to do it through a deductible on non-preferred brand drugs, because much of the game around marketing non-preferred brand drugs is to quote-unquote "hook" somebody on those drugs. A significant disincentive would be if you're going to have some deductible, don't have it on generics, don't have it on preferred, but have it on only non-preferred. And a couple of plans adopted that. They thought that made sense. And a couple said, "We don't have the systems" or "We don't like it" or whatever, and you know what? That's great. I love that kind of diversity in choice.

Marian Mulkey: We're going to stop there. I want to thank our panelists, who did a wonderful job. I want to thank all of you. I'd ask that you fill out an evaluation form, if you haven't already, on your way out. And again, thank you very much. Look for more materials on our Web site summarizing this in days to come.