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Issue Brief

State-Based Coverage Solutions: The California Health Benefit Exchange

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ABSTRACT: California was the first state to create its own health insurance exchange after the passage of the Affordable Care Act. Because of its front-runner status and the sheer size of its coverage expansion, California's choices will have implications for other states as they address difficult issues, including minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs. California took advantage of the flexibility in the federal health reform law to create an exchange that will function as an active purchaser in the marketplace; take significant steps to combat adverse selection both against and within the exchange, including requiring all insurers to sell all tiers of products and making exchange participation a condition of selling catastrophic plans; and allow community-based health plans to develop commercial offerings for the exchange. This brief examines these decisions, which will provide a roadmap for other states as they set up their exchanges.

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OVERVIEW

On September 30, 2010, just six months after the passage of the Affordable Care Act, California became the first state in the nation to create its own insurance exchange in response to the provisions of federal health care reform. On April 20, 2011, the Board of the California Health Benefit Exchange held its first meeting. Although its fifth and final member had yet to be appointed, the board hired an interim director and outlined an ambitious process to develop a comprehensive business plan and budget for the exchange.

This accelerated timeline is consistent with California's desire to be, in the words of the state's Health and Human Services secretary and Exchange board chair Diana Dooley, the "lead car" in implementation of federal health care reform.[1] Because of the speed with which it has approached this task as well as the sheer size of its coverage expansion, the decisions California has made will be influential both regionally and nationally. What transpires in the state

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will have implications for other states as they address difficult issues, including minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs.[2,3] This brief reports on California's decisions, evaluates the likelihood that these choices will advance the goal of providing affordable access to high-quality care, and analyzes the extent to which these decisions can serve as a blueprint for other states.

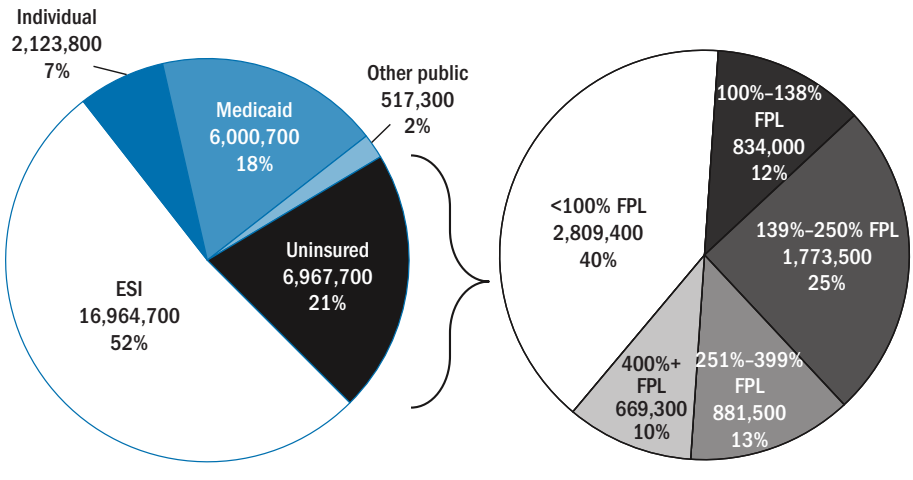
Federal legislation purposely gives states flexibility to craft their own insurance exchanges, entities that organize a marketplace of standardized insurance products for consumers. California took advantage of this leeway by:

- creating an exchange that will function as an active purchaser in the marketplace, rather than simply as a centralized portal for people to shop for subsidized health insurance;
- taking significant steps to combat adverse selection both against and within the exchange, including requiring all insurers to sell all tiers of products and making exchange participation a condition of selling catastrophic plans; and
- choosing not to preclude community-based health plans from developing commercial offerings for the exchange.

These decisions will help provide a roadmap for other states as they set up their own health insurance exchanges. Their influence will be tempered somewhat by the unique nature of California, including its size, demographic profile, and private health insurance market characteristics (Exhibit 1). In Los Angeles County alone, there are nearly 700,000 people who will be eligible for subsidized health insurance through the individual exchange, a larger group than the entire uninsured population in many states.[4] Overall, recent estimates project that by 2016 there will be 3.77 million people newly covered in California through the exchange and the Medicaid expansion. However, 3.1 million individuals will remain uninsured in part because of the state's high percentage of undocumented persons, another factor that differentiates California from other states.[5]

Exhibit 1. Seven Million Californians Are Currently Uninsured

California's nonelderly population by insurance status, 2008–2009



Note: FPL refers to Federal Poverty Level; ESI refers to Employer-Sponsored Insurance.
Source: Kaiser Family Foundation, Statehealthfacts.org,
http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=6&ind=125&sub=39.

California's Policy Process

Soon after the passage of federal reform, the legislative leadership in California introduced its own bills and moved very quickly to pass them. The legislation signed into law in California in September 2010 consisted of two bills. A state Senate bill established the basic governance and structure of the exchange, and a state Assembly bill outlined its activities and put in place insurance market regulations, some of which apply even to carriers who do not participate in the exchange.[6]

Building an exchange is an arduous and complex task. For the exchange to be successful, it must minimize adverse selection among the carriers who participate in the exchange and between the exchange and the outside market, create a system that helps facilitate access to private insurance and public programs, and operate effectively alongside many established interests, including insurance carriers, health insurance brokers, consumer advocates, and Medicaid managed care programs.

Fortunately, as pointed out by Kim Belshé, the former state secretary of Health and Human Services and current California Health Benefit Exchange board member, the state was "not starting from scratch."[7] Many of the members of the core team that shepherded this bill through the legislative process had been involved in insurance market reforms for almost two decades. California's choices were informed by its own experiences designing and running other purchasing pools. These included the state children's health insurance program, administered by the Managed Risk Medical Insurance Board; the now-defunct small-business purchasing pool, initially run by the government as the Health Insurance Plan of California and eventually administered by the nonprofit Pacific Business Group on Health as PacAdvantage; and the public employee retirement system, CalPERS, which purchases health insurance on behalf of state employees.[8] During 2007 and 2008, California debated a comprehensive health reform proposal that ultimately failed to pass. The final version of the proposal included plans for an exchange to be called the California Cooperative Health Insurance Purchasing Program.

Key state actors

During California's process of passing the enabling legislation, leaders in Governor Arnold Schwarzenegger's administration and in the state legislature played important roles. The day-to-day activities, including drafting the bill and engaging with stakeholders, though, were led by a very experienced team of legislative and administration staff, working in close consultation with outside consultants with established expertise in designing and running exchanges.[9] This work received support from philanthropic foundations and involved the participation of a broad range of stakeholders, many of whom had been involved in insurance market reform for many years.[10]

On one of the central issues for the exchange—that is, whether it would serve as an active purchaser that negotiates the best price for enrollees—there was agreement among the political principals in the legislature and the administration. In initial conversations, Governor Schwarzenegger made it clear that he wanted the exchange to negotiate the best prices possible for enrollees. The political principals in the administration and legislature also agreed that they wanted to allow the board as much flexibility as possible.

There was a great deal of accord among the principals and staff of the Democratic-controlled legislature and the Republican Schwarzenegger administration, and the legislative process moved very quickly. Nevertheless, a substantial amount of organized opposition was brought to bear at key points. Success cannot be taken for granted—even in a state where there is broad agreement among political leaders.

Political and fiscal context

It was uncertain whether Governor Schwarzenegger would sign the bill, despite the intense involvement of his team in drafting it. This was partly because the California Chamber of Commerce called the bill a "job-killer" and the governor had historically vetoed most bills so termed. There were also strong concerns expressed by members of the governor's inner circle about the impact of the program on state resources. While the federal government will pay for the development and planning of the exchange and the lion's share

of the costs associated with the Medicaid expansion until 2019, the state's ongoing fiscal stress remains relevant. Recently, newly elected Governor Jerry Brown proposed and the Democratic-controlled state legislature passed $1.6 billion in cuts to the state Medicaid program based on the assumption that these cuts will be paired with tax increases that are by no means certain.[11] Some observers find it difficult to square the state cutting back on its current set of commitments and activities to lower-income Californians while simultaneously planning to increase others.

With severe constraints on state resources, it is vital to develop exchange designs that offer the best chance for success. California's experience with its failed small-business purchasing pool demonstrates that there is no guarantee these entities will be successful. It is very important, in particular, to structure the markets inside and outside of the exchange to avoid adverse selection. It is also important to partner across parties and stakeholder groups as it is in no one's interest to create a program that fails to fulfill its public purpose while simultaneously disrupting the private insurance market. Conversely, a well-designed and administered exchange may improve the entire insurance market and drive change in the medical delivery system.

California's Key Decisions

The following section describes some of the key decisions California made and examines whether and how they can serve as a roadmap for other states (Exhibit 2).

Structure and governance

California's legislation established an exchange structure consistent with Timothy Jost's recommendation that the entity "should be placed within an independent agency, which should be explicitly exempted, as necessary, from specific state administrative law or government operations requirements."[12] Critically, the enabling legislation grants the exchange some exemptions to state personnel and contracting procedures and gives its board the power to promulgate regulations on an emergency basis for two years. There was very little disagreement on this point among the main political actors in the state. They agreed a nonprofit structure would be unlikely to provide adequate transparency and accountability to the public. This, in turn, could undermine the exchange's legitimacy.

There are important trade-offs involved in this choice, however. The state's government-run, small-business purchasing pool, the Health Plan of California, was transitioned after several years to the nonprofit Pacific Business Group on Health. Although this venture was ultimately unsuccessful, it was viewed as better run and more tightly managed when it was operated by a nonprofit. The decision-making process became shorter and faster, leading to a substantial increase in responsiveness to market changes. Some stakeholders pointed out that one of the main reasons this purchasing pool had to be shut down was that its transition out of state control disconnected it from the policy process. This prevented state policymakers from having adequate notice to make legislative or regulatory changes that could have kept the pool viable, including, for example, the price parity requirements ultimately included in federal reform.

The need for nimble participation in the market was also one of the main reasons for having a five-member board—a much smaller board than the Massachusetts Health Connector as well as the exchange boards envisioned in other states.[13] The state program that administers California's purchasing pool for children has a five-member board, which has worked well. The California statute also has very strong conflict-of-interest provisions for the board and does not allow anyone who currently draws money from an entity that could receive funding from the exchange (e.g., a provider or carrier) to serve as a member. However, the staff who designed this provision subsequently commented that they regretted making the conflict-of-interest provisions so stringent.

An analysis performed for the California Chamber of Commerce strongly critiqued the leeway given to the California Health Benefit Exchange board. Specifically, it raised the concern that the board's activities could create significant general fund liability for the state by increasing the scope of essential benefits

Exhibit 2. California's Key Decisions

	Federal Law	California
Federal, regional, or state	Exchange can be set up by federal government, state, or regional consortium of states	Legislation signed on September 30, 2010, established the California Health Benefit Exchange
Structure	The exchange can be either a government agency or a nonprofit organization	Stand-alone government agency Exempt from some state personnel and procurement requirements Temporary emergency regulatory authority Subject to open meeting laws, except for discussions pertaining to certain legal, contracting issues
Governance	No specific guidance	Five-member board: secretary of Health and Human Services, two gubernatorial appointees, and two legislative appointees Strict conflict of interest requirements, unpaid
Number of exchanges	Individual and small-group exchanges can be pooled or separate	Separate individual and small-business exchanges (each with dedicated staff but administered by same board) Legislation requires study on topic of merging exchanges, to be presented in 2018
Size of small businesses	Small-group market can be limited to 50 employees before 2016	To be determined; pending legislation may reconcile regulation within two to 50 and 51 to 100 markets
Payment of premiums	Consumers may pay premiums to insurers or to the exchange	Exchange may choose to collect premiums directly from individuals Will collect premiums directly from businesses
Purchasing	Broad range of options from passive to active	Exchange can selectively contract with specific insurance carriers, excluding others as long as criteria for selection are consistent Exchange is an active purchaser seeking to promote "optimal combination of choice, value, quality, and service"
Reducing adverse selection	All plans participating in exchange must offer silver and gold plans	Insurers both inside and outside the exchange must offer all tiers of products Only carriers participating in exchange can offer catastrophic plans May require participating plans to offer additional products Board may standardize products
Coordination with public programs	Exchange must inform individuals of eligibility for public programs	Exchange must help coordinate enrollment in public programs Must assist in providing continuity of coverage for people who lose eligibility for subsidies or public programs Community-based health plans (Medicaid managed care plans) able to participate in commercial exchange
Exchange funding	After initial grants, must be self-sustaining by 2015; can be funded by surcharge on premiums, assessment on plans, businesses or individuals or state general fund dollars	Activities funded primarily by an assessment of fee on insurers who participate Exchange required to refund assessment if it exceeds annual budget (cannot amass surplus)

within the state and by unilaterally enrolling people in the state's Medicaid programs.[14] Independent groups, including the nonpartisan Legislative Analyst's Office, pointed out that this conclusion appeared to be in direct contradiction to the plain language of the statute, which was written to protect the general fund, left authority to determine mandated benefits with the legislature, and required the exchange to coordinate with existing public programs on issues of eligibility and enrollment.[15,16] Other states should carefully examine the decisions California made in this area to strike a balance between accountability and flexibility for the board.

The board will also have to carefully weigh the balance between hiring additional state personnel to build out and perform the functions of the exchange and developing relationships with vendors. The experience with California's public programs, as well as within the Massachusetts and Utah exchanges, suggests that there will be instances in which the state will look to partner with other entities. One influential deciding factor is the tight timeline necessary to get up and

running. Many of the California Health and Human Services Agency staff wear "2014 Is Tomorrow" buttons. Creating an exchange is a massive undertaking, even for a state like California that has gotten a significant jump on the process. A multitude of issues will require the time and attention of board and staff.

Number of insurance markets and exchanges

One of the first decisions states must make is whether to have an individual insurance market outside the exchange. States that want to ensure the exchange is not affected by adverse selection can substantially reduce this concern by removing the outside market, but this decision may be politically infeasible.[17,18] Even in California, where there is wide support for federal reform and a broad cross-section of stakeholders issued a report calling for a sole-source exchange, this option was not seriously considered.[19] However, whether or not states eliminate the outside market, the exchange may over time swallow much of the individual market as the exchange is the only place consumers will receive subsidies.

Separate small-business exchange. States will also have to consider the option of combining the individual and small-group exchanges. There are technical challenges to doing so since many states have different regulations, products, and carriers for these markets. However, there are also strong policy reasons to combine the exchanges, particularly in states in which exchanges will not develop a large enough risk pool. This was not a big issue in California because of the size of the state. California decided to leave its exchanges as separate pools in part because of the distinct nature of these two markets. The California legislation specified, however, that a report be delivered to the legislature in 2018 making a recommendation about whether these markets should be merged.

There is enthusiasm among small-business owners in California related to the promise of the small-group exchange in spite of the state's uneven experience with purchasing pools. According to John Arensmeyer, CEO of Small Business Majority, "When we tell small-business owners about the exchange provisions in the Affordable Care Act, there is tremendous interest, and one-third say that an exchange will make it more likely that they will offer coverage." On the other hand, there is no penalty in the law for groups with fewer than 50 employees that do not provide insurance. Some have discussed the possibility of ceasing to offer insurance in favor of increasing employees' salaries, many of whom would qualify for subsidies to purchase insurance on the individual exchange.

The primary value proposition of small-group exchanges has been a broader range of choices than in the outside market. In California and other states, the trade-off for this choice is that the plans offered through small-group exchanges have generally been more expensive than comparable plans in the outside market. These exchanges, therefore, have tended to cater to a niche clientele. Some businesses are willing to pay the relatively higher premiums to get this set of choices. One of the most popular products in PacAdvantage, California's defunct small-group purchasing pool, was PairedChoice. This option allowed employers to combine a Kaiser HMO plan, generally offered to their employees, with a PPO plan, generally taken up by the owners and their relatives.

Because the California statute requires insurers to offer the same products at the same price inside and outside the exchange, the exchange will not be at a price disadvantage relative to the outside market in the same way that exchanges like PacAdvantage have been. It is still unresolved, though, whether employers will have the option of making the plan-choice decision for their employees or whether "subscriber choice" will be required, meaning that all employees select their own plan, likely at a specified actuarial tier. Neither the federal nor the California legislation appears to require either arrangement for small businesses. The exchange will have to decide which is the most appealing to the market, most likely to fulfill the public purpose of the exchange, and most likely to be viable from a business perspective.

The small-group exchange will need to develop a value proposition that appeals to small businesses and insurers alike. Small-group exchanges have

historically struggled to attract and retain the participation of insurers. Some observers expressed concern that the main value proposition of the Affordable Care Act small-group exchange for insurance carriers—access to groups that utilize a modest tax credit that expires after two years—may not be adequate to attract their business. Insurers generally prefer not to split the business of a small group with another carrier. If the exchange offers subscriber choice, it would slice business that many insurers would prefer to have combined. Therefore, they may continue to prefer selling policies in the market outside the exchange.

Another critical issue is the relationship among the exchanges and the health insurance agents who serve this market. The small-group exchange is more likely to be successful if it enrolls a great number of people, and brokers have the broadest and most well-established set of relationships with the small-group market. In this area, California's made a choice consistent with the national recommendations from Tim Jost: "State enabling legislation should neither require nor bar the use of agents and brokers for the purchase of insurance from the exchange."[20] Figuring out the role of brokers in the exchange and how they operate with the "navigators" who will receive grants from the exchange to promote enrollment will be a key task for the exchange board and staff.

Size of the small-group market

An option available to states from 2014 to 2016 is to temporarily limit the size of employers who can participate in the small-group exchange to those with 50 or fewer employees. In 2016, it will expand to up to 100 employees in all states. California has yet to resolve this issue; the latest guidance suggests that the

Selective Contracting and Active Purchasing in California

Medi-Cal Managed Care. California engages in active negotiation with entities that manage the health services of the enrollees in the state's Medicaid program. There are several different models in the state, including county-organized health systems and "two-plan" counties with a public and private offering. The County Medical Services Program purchases services on behalf of enrollees in 34 rural counties.

Healthy Families. The state's stand-alone children's health insurance program, which covers children in families with incomes of up to 250 percent of the federal poverty level, has a history of selective contracting, active purchasing, and contracting for services that is similar to what is expected in the exchange. The five-member Managed Risk Medical Insurance Board oversees this program, as well as the state's pre- and post-reform high-risk pools.

PacAdvantage. In 1993, the state established the Health Plan of California, a small-group purchasing pool that was transitioned to a nonprofit and administered by the Pacific Business Group on Health. It was a selective contractor and active purchaser. It was the victim of adverse selection and ceased operations in 2006.

CalPERS. The state's public employee retirement system has a type of exchange similar to the California Health Benefits Exchange in that subsidies are provided for the purchase of insurance. Many observers are concerned about this parallel because this purchasing pool has narrowed the choice for public employees from eight or nine plans to two or three.

California Cooperative Health Insurance Purchasing Program (Cal-CHIPP). California's ultimately unsuccessful state-based comprehensive health care reform plan called for the creation of a purchasing pool that would have received bids from insurers, created a variety of benefit plan designs, and required an employer contribution in many cases.

California Health Benefit Exchange board may have the leeway to limit enrollment to smaller groups without further legislative action.

In California, as in many other states, this presents challenges for implementation. In California, the small-group market (i.e., two to 50 individuals) is age-rated, whereas the midsize market (i.e., 51 to 100 individuals) is community-rated. The practical implication is that the premiums for individuals, and hence for the group, can be different across these market segments. The technical requirements for producing the premiums for these two markets are distinct and combining them without standardizing the underlying law would be very challenging, if not prohibitively complicated. At its first board meeting, the exchange put this issue on the agenda for the near future.

The natural default for many states may be to restrict the size of the market for the first two years as these technical issues are worked out. However, an exchange set up to cater to the traditional small-group market exclusively, even for a limited time, may make different decisions than an exchange planning to serve groups of up to 100 individuals. These markets often have different structures, are served by distinct delivery channels, have varying compensation schedules for agents, and carry different customer service expectations. Further, for states that are smaller than California, it may not be feasible to limit the size of groups that can participate because of concerns about the total size of the market.

Exchange as purchaser

Perhaps the most critical decision states will make about structuring their exchanges is whether they will be "passive" or "active." A passive exchange is a centralized place where people can learn about coverage options. In the active model, the individual and small-group purchasing pools will negotiate separately or collectively with insurance plans and work with these carriers to design products that are appealing to their enrollees. This was one of the more contentious issues in California and is likely to be even more controversial in other states.

California made the choice to allow the exchange to be an active purchaser with the ability to selectively contract with certain insurers. Specifically, the California law directs that "in the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."

Because California has a tradition of active purchasing through its children's health insurance program, small-business purchasing pool, and state employee purchasing pool, policymakers were building on an established history. The lesson for other states, however, is not necessarily that they should all choose for their exchanges to be active purchasers. Rather, they should let the decision in this critical area be driven—as California's was—by the experiences of their state, as well as by the nature and structure of their private insurance markets.

For an exchange to be successful it must have broad public support and able to attract an adequate number of covered lives. California is distinct in important ways from other states both politically and demographically. In other states, an exchange may have to work hard to attract 100,000 people to the pool. This size is critical if the entities do not want to get "upside-down" on risk and keep the administrative load per enrollee to a minimum. This is less of a problem in California where it is likely that the exchange will have at least 1 million to 2 million lives in private insurance coverage served by five or six major insurers, regardless of the choices it makes.

Another critical distinction is the number of insurers in the market. In states where there are one or two insurers that dominate, selective contracting in particular may not be feasible. In these states, policymakers may want to focus on developing nonprofit co-ops to increase competition through the development of new carriers.[21] On the other hand, in other large states where there is significant insurance market competition, setting up an exchange with the ability to

work actively with other payers to reduce costs may make good business sense. If policymakers in these states choose not to create an exchange with active purchasing powers, they may miss an opportunity to bring down costs on behalf of their enrollees.

There are some lessons of caution from California's experience in selective contracting. While the public employee retirement system that purchases health care on behalf of its workers previously had eight to 10 choices for employees, it now has two or three. It is not clear that the board continues to feel that it has good bargaining power with the remaining insurers, because it would be extremely difficult to exclude any of the remaining plans from the pool going forward. These insurers do have a large book of business with the state, which would seem to be a recipe for enhanced bargaining power for the state. However, it is not primarily the size of a group that determines its negotiating leverage. Utilization of health care services among enrollees is a major driver of rates, and the high prevalence of chronic disease among state workers, because of their higher relative age, drives rates up for this group.

The flip side of having a smaller number of carriers is that these strong relationships present the potential for partnership. In California, this led to the development of a unique offering to state employees in the Sacramento region: access to a virtually integrated delivery system, a partnership between Blue Shield of California, Catholic HealthCare West, and Hill Physicians group. This alliance has kept premium costs stable for the employees who choose it and has been working to integrate the different systems and improve quality of care.[22] According to the terms of the arrangement, the insurer, hospital system, and physicians' association were given autonomy to redesign their care delivery systems to promote better coordination and improve efficiency. For example, they worked to eliminate redundancies, such as having the same patient participate in multiple chronic disease management programs. At the end of the pilot period this past year, CalPERS estimated it saved $15.5 million through this "active purchasing" partnership and said it plans to expand the program.[23]

States that choose to allow the exchange to selectively contract must think carefully about the trade-offs. There is value to having a broad choice of plans. However, once a health plan is a part of a network, if it has a sizable enrollment, it is hard to drop without causing a disruption of care and communications that would allow people to fall through the cracks. However, a goal of active purchasing and of the exchanges is to raise the bar on quality and safety. There may be real promise to partnering with a relatively limited group of insurance carriers if these partnerships allow for innovative plans that enhance affordability and improve efficiency to be delivered to members. According to Sandra Shewry, a consultant to the Schwarzenegger administration, the boards of the state-based exchanges "will have to balance choice with the idea that as purchasers they are adding value to the equation by asking the providers to keep improving."

Adverse selection

In every state, the exchange boards will have to be very active in mitigating adverse selection among plans in the exchange, between the exchange and the outside market, and across market segments (e.g., individual, small-group, self-insured). Adverse selection occurs when actions by insurers or enrollees deliberately or inadvertently lead to a particular insurance risk pool of people who are substantially less healthy and more costly to insure. Once a poor risk profile has been developed for a particular product, it is difficult for the risk-bearing entity to remain financially viable. A review of the state's experience with its small-business exchange emphasizes the importance of avoiding adverse selection and warns that "very strong measures are needed to prevent exchanges from falling into a death spiral."[24]

The Affordable Care Act has several provisions that differentiate its exchanges from voluntary purchasing pools such as PacAdvantage. First, the exchange is the only place in which individuals and businesses can receive subsidies and tax credits, which will create

a "captive audience." This makes it less likely that the exchange will be selected against by the outside market because—particularly in states like California—the group is likely to be large enough to have an acceptable risk profile. Second, carriers within the exchange are required to offer products only at specified actuarial values (i.e., catastrophic, bronze, silver, gold, and platinum). This will help consumers make meaningful comparisons among products and may reduce somewhat the likelihood that plans will be adversely selected against within the exchange. Further, insurers are required to offer the same products at the same price both within and outside of the exchange. This also helps reduce selection against the exchange. The carriers who participated in PacAdvantage were unwilling to offer the same price for the same product. This requirement has the important implication, though, that there can be no price advantage because of negotiating clout or administrative efficiencies for participating in the exchange.

Some carriers expressed concern that the structure created by these regulations will mean that the price negotiated by the exchange will effectively set the prices for the rest of the products both within and outside this market. They believe that because the rating factors allowed are very specific, any price change in a market segment for any product may require price changes for all the other products in the portfolio. The rating factors that are allowed are now limited to a very small set, including age and tobacco use.

The full impact on market dynamics and prices is yet to be determined. It is clear, though, that elements of the reform law—in particular those related to exchanges—will have unforeseen implications for the private insurance market. There may also be significant consequences for providers who depend on payments from the private insurers that participate in the exchange. In the individual market, where an exchange will have a long-term captive audience because of the subsidies, these new purchasing pools may indeed set prices for the market. The exchange cannot negotiate a better price exclusively for its enrollees, but its activities may bring down the price for all participants in the individual market. In the small-group market, on the other hand, the exchange may not have as great an effect on the prices in the market since the tax credits are of limited duration and there is no requirement for employers with fewer than 50 employees to offer coverage. Overall, the requirement that prices be equal inside and outside the exchanges means the California exchanges are less likely to be subject to adverse selection, but it also takes away an important putative advantage—lower prices.

California built upon federal legislation to reduce the likelihood of adverse selection within and against the exchange. First, while the federal legislation requires plans to offer only the silver and gold levels of coverage within the exchange, California requires plans to offer all levels of coverage. Critically, this requirement relates to plans whether or not they participate in the exchange. Therefore, there will be a direct comparison across all carriers in the market at these actuarial values. The exception to this is related to the second important regulation that California put in place: the restriction that plans can only offer the catastrophic coverage plan—and access the relatively young and healthy enrollees to whom this product will appeal—if they participate in the exchange.

The federal law also includes a provision on statewide risk adjustment that applies to plans both in and outside the exchange. In theory, this should eliminate most concerns about adverse selection because plans that have unhealthier pools will receive money from those with healthier ones. However, there are important caveats because risk adjustment, even under ideal circumstances, is imprecise. There is some disagreement as to whether it was done effectively in the past, for example, within California's small-business purchasing pool.[25] But even assuming risk adjustment is done perfectly, it is designed to smooth differences within relatively narrow bands. If carriers' payments to each other become very large proportions of total revenues, this may undermine the entire model. The subsidies paired with risk adjustment, therefore, will not guarantee success for the exchange either in terms of fulfilling its public purposes or succeeding as an

entity operating within the private market. Therefore, states should give serious consideration to adopting the further steps that California took to reduce adverse selection.

Coordination with public programs

The exchanges are designed to facilitate access to private insurance and public programs. The Affordable Care Act directs the exchanges to determine eligibility for public programs for people who interact with the exchange. The state of California expanded on these responsibilities. Specifically, the board is required to "coordinate . . . eligibility, enrollment, and disenrollment . . . with state and local government entities administering other health care coverage programs . . . and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage."[26]

This topic has inspired a great deal of conversation in California. It was identified by the California Department of Health and Human Services as one of the key opportunities in federal reform. According to a state planning document, "important policy and information technology systems issues will need to be carefully considered, including how the exchange's eligibility and enrollment functions will interact with Medi-Cal (i.e., California's Medicaid program), Healthy Families, and other public programs."[27]

Coordination among public programs was a complex issue in California even before the advent of the exchange. California is one of eight states with a stand-alone children's health insurance program and, like many other states, it has a host of additional programs designed to assist specific populations such as women and infants, and children in need of specialty care. Because of the complexity of the market and the number of varying interests involved, California did not submit an application for a federal "Early Innovator" grant. These grants are for states that plan to use their exchanges to engage in technologically innovative methods to coordinate between public programs and private insurance coverage.

Almost every task that is expected of the exchange, including consumer protection, risk management, and coordination with public programs, will require the development of new health information technology solutions and careful work to guarantee that these technologies interface seamlessly with legacy systems. Fortunately, a great deal of work has already been done. In California, this includes work on the Health-E-App and One-E-App systems. To as great an extent as possible, given the tightly compressed timeline of implementation, states and the federal government should build on existing efforts.[28]

Participation of Community-Based Health Plans and Co-ops

One associated policy question is whether community-based health plans (e.g., county-based Medicaid managed care plans) will be allowed to develop commercial offerings to compete with traditional private insurance products within the exchange. California's legislation does not preclude Medicaid managed care plans from doing so. A separate piece of legislation that would have explicitly permitted their participation was not passed by the legislature.

Once again, there are important trade-offs. Because community-based plans generally contract with lower-cost provider networks, they may be able to offer more affordable health insurance options to the newly subsidized populations. However, these providers are unlikely to accept rates from private insurance—even private insurance products created by Medicaid plans—that are as low as those they receive from the state's Medicaid program. However, the plans may remain more affordable, and therefore appealing for the exchange, through the partnership with these lower-cost providers.

There are substantial concerns, however, about capacity within the provider networks that contract with managed care plans and the impact on the price of services this restriction on supply may create. By increasing the demand for a resource without increasing the supply, the price is likely to increase. In addition, the workforce that serves this population is

unlikely to expand as quickly as demand and may be shrinking as physicians seek greater remuneration outside these programs.[29] It is possible that instead of significantly bringing down the cost of private insurance, this may instead raise the cost of services purchased on behalf of public entities. There are also significant administrative challenges for the community-based plans, which will have to increase their capacities and likely bring on additional staff to develop, modify, and service these products. One technical issue will be ascertaining which administrative costs should be charged to the public programs and which should be covered by the assessment on health plans levied by the exchange.

In California, the extent of commercial market participation by community-based health plans is likely to vary by county and by the capacities of these plans.[30] Some have larger staffs, more resources, and greater technical capabilities. A recent paper by Walter Zelman, current chair of the board of a community-based health plan, reviews all the key issues related to exchange participation by community-based health plans in state exchanges.[31] He observed that the statute empowers the exchange to provide individuals with "the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits. In all likelihood, one of the easiest means of achieving these goals is to facilitate the participation of Medi-Cal plans in the exchange." This may be in practice similar to the COBRA program in which people losing employer coverage have the option of remaining enrolled in their employer plan if they pay the full unsubsidized amount for coverage.

Another complicating factor for California, as with other states, is whether it chooses to create a "Basic Health Plan." The Basic Health Plan is an option under the Affordable Care Act to establish a new government program to cover individuals with incomes from 133 percent to 199 percent of the federal poverty level.[32] Instead of receiving subsidies through the exchange, qualifying individuals would instead be eligible for a state-run program that uses 95 percent of the amount they would have received in federal subsidies to create a benefit package through a network of plans that contract with the state. The community-based health plans would be among the natural recipients of these contracts as they are accustomed to serving these populations and often already serve the children of the people eligible for the program. States that select the Basic Health Plan option, and hence reduce the number of people eligible for subsidies, may choose to limit the participation of community-based health plans in this new market. This issue has tremendous implications for state exchanges in terms of coordination across programs and also because it reduces the population eligible for subsidies to purchase private insurance through the exchanges. A recent study by Mercer estimated that of the approximately 2.6 million people expected to enroll in the California Health Benefit Exchange, roughly 725,000, or 30 percent, would be eligible only for the Basic Health Plan were the state to pursue this option.[33]

CONCLUSION: A VISION FOR STATE-BASED EXCHANGES

While this brief has documented and analyzed the state-based coverage solutions chosen by California, each state will have to design solutions tailored to its own political, demographic, and market characteristics. There are technical decisions each state will have to make. Should the exchange be run by a nonprofit or a government agency? Which additional steps should it take to reduce adverse selection?

In addition, each state must establish a vision of what it wishes to accomplish. For some states, it will simply be a more streamlined marketplace for consumers, which allows meaningful comparisons among products. States that choose to pursue a more active role for their exchange, on the other hand, may choose to have it focus on specific goals. Will the main focus be driving lower prices? Will it focus on shifting the delivery system toward greater integration? Will it hone in on patient safety? The board will need to be clear with the staff about priorities and states should be somewhat modest about what is possible to accomplish.

Sandra Shewry points out that the exchange will not operate independently. There is, she remarks, "an opportunity to get in coalition with other purchasers, such as large employers and other state-funded programs, and pick a few key goals. It might be asthma outcomes or it could be heart disease. But I think that using purchasing as a tool for the ultimate goal is appropriate." Shewry also emphasized the compressed timeline: "2014 is tomorrow and there are some very complex tasks given to the exchange. You need to simplify eligibility and make a world-class, state-of-the-art experience for the people who are enrolling. That is going to mean partnering with Medicaid programs, with CHIP programs, and with other health and social programs."

The political principals and staff who designed the California exchange explicitly intended the board to have significant leeway in setting and achieving goals. Jon Kingsdale, the former executive director of the Commonwealth Connector, the Massachusetts state exchange, lays out the parameters in broader terms: "The authorizing legislation embodies a vision of California's exchange as an agent of change in the marketplace. The governance model suggests this vision, as do the provisions that empower the exchange to selectively contract with health plans and to specify benefits and cost-sharing for all qualified health plans. They suggest an active hand in shaping the market with certain policy goals in mind. The goals are not prescribed in legislation, but, instead, the board is encouraged to consider and act on such goals, rather than play a passive role."

Another important decision California made was to take steps to minimize adverse selection against the exchange and among plans within the exchange. Though it is impossible to predict the outcomes that these new structures will create, California was relying on wise policy guidance as well as on the hard lessons learned from its own uneven experience in these areas. Even plans that do not participate in the exchange must offer products at the bronze, silver, gold, and platinum levels. This should facilitate comparison among products market-wide. The board of the exchange may require plans that do participate to standardize their products and even to offer additional products. There is a significant enticement for plans to participate in the exchange beyond the subsidies created through federal reform. In California, insurance carriers are only allowed to offer catastrophic plans in the individual and small-group markets if they participate in the exchange. Though marketwide risk adjustment should reduce concerns about adverse selection, it will take time to refine the risk adjustment tools for this market. Insurance carriers will want to be able to pursue the under-30 population, for whom the more-affordable catastrophic plans may be an appealing option.

California's process should also serve as a reminder to other states that, even when there is broad agreement among political leadership about federal reform, it is still very difficult to pass the enabling legislation. The process of setting up the exchange is even more complex and challenging, so states should proceed as quickly as is feasible. In designing the exchange, states should be collaborative but not make compromises that undercut the value proposition of these new marketplaces. In spite of the subsidies and provisions on elements like risk selection, exchanges are not guaranteed to succeed. Other purchasing pools in the past have failed. Fortunately, federal health care reform incorporates lessons from experiences with exchanges and allows states broad leeway to develop exchanges that work for their own marketplaces. States should make the most of that latitude.

NOTES

1 S. Kliff, "California Wants to Lead the Way on Health Care," *Politico,* Jan. 18, 2011, http://www.politico.com/news/stories/0111/47706.html.

2 T. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, Sept. 2010).

3 A. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s. Universal Health Insurance in a System Designed to Promote Quality and Economy," *New England Journal of Medicine,* Jan. 5, 1989 320(1):29–37.

4 S. A. Lavarreda Y. J. Chia, L. Cabezas et al., *Health Policy Fact Sheet: California's Uninsured by County* (Los Angeles: UCLA Center for Health Policy Research, Aug. 2010).

5 P. Long and J. Gruber, "Projecting the Impact of the Affordable Care Act on California," *Health Affairs,* Jan. 2011 30(1):63–70.

6 California State Assembly Bill 1602, http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.pdf; and California State Senate Bill 900, http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.pdf.

7 California HealthCare Foundation, Briefing Transcript: The Role of the Exchange in California's Implementation of National Health Reform (Oakland, Calif.: CHCF, Oct. 2010), http://www.chcf.org/~/media/Files/PDF/S/PDF%20Sacto10212010HealthBenefitExchangeTranscript.pdf.

8 Another small-business purchasing pool, CalChoice, which is run by the general agency Word and Brown, is still active in the state.

9 J. Kingsdale, "Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned," *Health Affairs* Web Exclusive, May 2009 28(4):w588–w594; R. Curtis and E. Neuschler, "Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California," *Health Affairs* Web Exclusive, May 2009 28(3):w431–w445.

10 The political leadership of California in 2010 included Governor Arnold Schwarzenegger, Secretary of Health and Human Services Kim Belshé, Speaker of the Assembly John Perez, Senate President Pro Tem Darrell Steinberg, Chair of the Senate Health Committee Elaine Alquist, Chair of the Assembly Health Committee Bill Monning, as well as past Assembly Health Committee Chair Dave Jones, who was elected Insurance Commissioner in November. The staff team included Sumi Sousa in the office of the Speaker of the Assembly; Scott Bain, a consultant to the Senate Health Committee; and Jennifer Kent, Deputy Legislative Secretary, who along with Sandra Shewry, represented the administration at most meetings. Shewry had been the head of the Department of Health Care Services earlier in the Schwarzenegger administration as well as an executive director of Managed Risk Medical Insurance Board (MRMIB). In this process, they worked closely with longtime state health care leaders John Ramey, currently the executive director of Local Health Plans of California, the trade association for the state's Medicaid managed care plans, who was also the first executive director of MRMIB; and John Grgurina, CEO of the San Francisco Health Plan and the last executive director of the state's small-business purchasing pool, PacAdvantage. They were joined by two outside consultants, Rick Curtis and Ed Neuschler of the Institute for Health Policy Solutions, who worked extensively on California's own state-based comprehensive health care reform process, as well as by Jon Kingsdale, who was the executive director of the Massachusetts Health Insurance Connector. It remains important to understand the personalities and preferences of the Schwarzenegger-era team as the governor was empowered to and did choose to appoint two of his senior staff members to positions on the board of the exchange: Secretary Belshé and Susan Kennedy, his Chief of Staff who was also involved in the process at key decision points.

11 Since California requires the votes of two-thirds of each house of the legislature to increase tax rates or fees, Republican votes would have been required to raise the revenue necessary to stave off these cuts.

12 T. Jost, *Health Insurance Exchanges,* 2010.

13 Health Insurance Exchange Draft Policy Recommendations Submitted to the Oregon Health Policy Board, Aug. 13, 2010.

[14] Michael Genest, Letter to California Chamber of Commerce, Genest Consulting, Sept. 2010.

[15] S. T. Mohajer, "LAO: California Health Care Bills Won't Add to Deficit," *Bloomberg Business Week*, Sept. 24, 2010.

[16] No state general fund money shall be used for any purpose (related to operation of the exchange) without a subsequent appropriation. No liability incurred by the exchange or any of its officers or employees may be satisfied using moneys from the general fund.

[17] Though the Affordable Care Act stipulates that there will be marketwide risk adjustment by segment (e.g., individual, small-group), this process is not a panacea for all risk-related issues. There is substantial disagreement on the extent to which existing risk-adjustment processes weight the appropriate factors correctly.

[18] As it is still possible for adverse selection to occur among markets (e.g., federally regulated self-insured plans gaming risk in ways that impact the state-regulated market), eliminating the outside market for individual insurance does not entirely remove issues related to adverse selection.

[19] M. Weinberg and L. W. Haase, *The California Task Force on Affordable Care* (Washington, D.C.: The New America Foundation, May 2010).

[20] T. Jost, *Health Insurance Exchanges,* 2010.

[21] The idea of co-ops originated in the Senate legislation. They are insurance-offering entities that will receive grants from the federal government for their development. Critically, these have to be new entities, not existing carriers that attempt to rebrand themselves under the co-op moniker. California did not include any provisions in its law specific to co-ops. The amount of funding to develop co-ops was also reduced under the continuing resolution adopted by Congress in April 2011.

[22] M. Weinberg, "Using Medical Efficiency to Drive Down California's Health Care Costs," *Healthycal.org,* March 5, 2010, http://www.healthycal.org/using-medical-efficiency-to-drive-down-health-care-costs.html.

[23] C. Rauber, "CalPERS Says It Saved $15M with ACO Pilot Program, Will Likely Expand It," *San Francisco Business Times*, April 12, 2011, http://www.bizjournals.com/sanfrancisco/news/2011/04/12/calpers-says-its-saved-5m-on-aco.html. It is not entirely clear, however, that the federal legislation would permit exchanges to offer this exact type of network product because of the requirement that each Qualified Health Plan contract with "essential community providers" and not discriminate against certain types of providers.

[24] P. Lee and J. Grgurina, "What People Don't Know About Health Insurance Exchanges," *Health Affairs* Blog, Aug. 12, 2009, http://healthaffairs.org/blog/2009/08/12/what-people-don%E2%80%99t-know-about-health-insurance-exchanges/.

[25] M. Weinberg and L. W. Haase, *California Task Force,* 2010.

[26] California General Code § 100503(a) per Assembly Bill 1602 § 7.

[27] California Department of Health and Human Services, "Implementation of the Affordable Care Act in California: Window of Opportunity for State Policy Makers," Dec. 2010.

[28] E. Ange, L. Chimento, C. Park et al., *Assessment of One-e-App: A Web-Based Application and Enrollment Application for Public Health Insurance Programs* (Falls Church, Va.: Lewin Group, Oct. 2008).

[29] A. Bindman, P. Chu, and K. Grumbach, *Physician Participation in Medi-Cal, 2008* (Oakland, Calif.: CHCF, July 2010).

[30] In California, such plans exist in two types of counties, those that have a single, county-organized health system and those that have a local option or local initiative alongside a private offering, the so-called two-plan counties.

[31] W. Zelman, *Community-Based Nonprofit Medicaid Plans and the New Health Insurance Exchanges: Opportunities and Challenges* (Washington, D.C.: AcademyHealth, Oct. 2010).

[32] S. Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (Princeton, N.J.: Robert Wood Johnson Foundation, March 2011).

[33] Mercer, Exploring the Financial Feasibility of a Basic Health Program in California, May 12, 2011, http://www.chcf.org/~/media/Files/PDF/S/PDF%20Sacto05122011BasicHealthProgramCA.pdf.

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