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Taxpayers watchdog since 1945
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California Health Benefits Exchange Backgrounder

January 2012

The implementation of the California Health Benefits Exchange, California's place for health care providers to compete for customers, is expected to transform health care in California. The California Health Benefit Exchange, as an "independent public entity," maintains the authority to make impactful implementation decisions. The San Diego County Taxpayers Association has produced this backgrounder to provide information to members and the public regarding the history and potential impacts of implementation decisions. As a backgrounder, this document presents related information as it exists as of the production of this report.

The State Health Benefits Exchange Legal Requirements:

The Patient Protection and Affordable Care Act of 2010 encourages the development of an American Health Benefits Exchange in each state intended to broker small group and individual plans offered by insurers.

Each exchange must be self-supporting by January 1, 2015, and is required to comply with detailed federal regulations including:

- Admitting only qualified health plans as defined by the new law,
- Meeting specific reporting, structural, and contracting requirements
- Producing required ratings, and
- Providing internet and telephone access.

Each state exchange is expected to perform the following functions:

- Determine eligibility for federal tax credits,
- Select health plans to be offered through the exchange,
- Provide comparative information regarding the cost, quality and value of offered plans,
- Serve as the only place where federal tax credits may be used.

If the exchange, on January 1, 2013, is not expected to be operational by January 1, 2014, the federal government will step in and operate its own exchange in that state or work with a non-profit to do so.

Existing State Health Benefit Exchanges:

Massachusetts

In 2006, Massachusetts became the first State in the Nation to pass legislation creating an agency to administer the health benefits exchange called the Massachusetts Connector Authority. However, this law did not come out of nowhere. As described by Alan G.

Raymond for the Blue Cross Foundation of Massachusetts in the report "Massachusetts Health Reform: A Five-Year Progress Report,"

> "Massachusetts health reform was more evolutionary than revolutionary. Enactment of the 2006 law was preceded by two decades of legislative and regulatory changes that reflected a commitment by lawmakers and other health care stakeholders to make coverage more accessible to uninsured residents."

The 2006 law employed the concept of shared responsibility among individuals, employers, and government that had come from the decades long debate and established four major changes that have withstood the modifications made to the reform since:

- Expansion of **subsidized public health insurance programs** for low-income residents without access to employer-sponsored health insurance,
- Established the **individual mandate** for adults to obtain health insurance if affordable coverage is available to them or else pay a penalty,
- Established **obligations for employers** with more than 10 employees to participate in health care coverage or pay a penalty, and
- Created the Commonwealth Health Insurance **Connector Authority** (Connector) to create the exchange.

The established Connector is a quasi-public organization, or independent state agency, with a board of directors of four ex-officio state government representatives and seven members representing private organizations.

The Connector is organized into two sections: Commonwealth Choice and Commonwealth Care. Commonwealth Care provides limited subsidized plan choices for adults who meet income eligibility requirements and do not have employer-sponsored insurance, while Commonwealth Choice is for the general public including small business employers. On their website, the Connector Authority boasts that the "online Commonwealth Choice marketplace is the only place where you can compare plans from the state's major insurers." For a plan to be offered in the Commonwealth Choice exchange, it must receive the Connector's "Seal of Approval," certifying quality, value, and the adequacy of the provider network (Raymond).

Initially financed with $25 million of the state's general fund, the Connector is now self-sustaining through administrative fees levied on participating health insurance firms. The Connector's current annual operating budget is approximately $32 million and it has a staff of 45 full-time employees (Raymond).

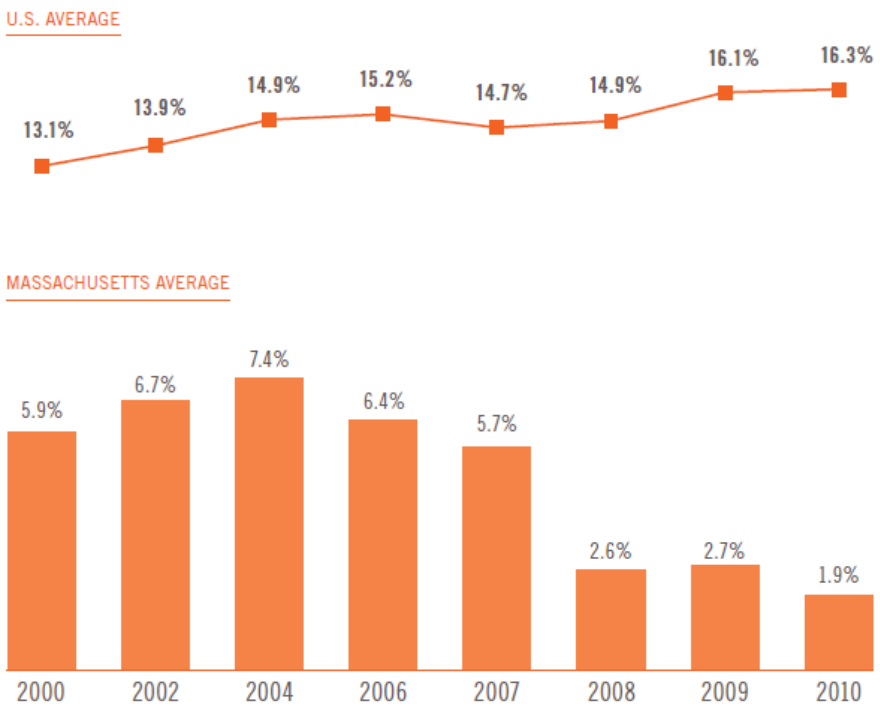
Initially, six plans, representing nearly all of the state's firms offering commercial health insurance, received the Seal of Approval. A seventh plan was added in 2010 and an eighth is expected in 2012.

The 2011 Health Connector Progress Report noted that "As of September 2010, individual, non-group coverage grew by 81,000 individuals since reform, with 32,000 purchasing

through the Health Connector's Commonwealth Choice program." Reflecting a figure for approximately a year later, the Blue Cross Foundation of Massachusetts identifies that "As of August 2011, there were 39,767 members enrolled."

In 2010, about 98 percent of Massachusetts residents had health coverage compared to 84 percent nationwide (Raymond). As seen in the following chart, much of the change occurred within two years of the bills' passage, and the trend differs from that of the increasing national average.

Percent of Residents Uninsured in Massachusetts and the U.S. Average



Source: Blue Cross Foundation of Massachusetts report "Massachusetts Health Reform: A Five-Year Progress Report."

Four general categories of implementation of a state exchange were outlined in the recently published "Health Reform Toolkit Series" by the Blue Cross Foundation of Massachusetts and the Massachusetts Health Insurance Connector Authority.

- Planning and implementing a successful risk mitigation strategy for the exchange
- Determining health benefit designs to be offered on the exchange
- Implementing a successful public education and marketing campaign to promote the exchanges
- Building an effective exchange website

Utah

In Utah, Health System Reform legislation was passed in 2008 that included directing the existing Office of Consumer Health Services to create an internet portal to facilitate the exchange. The resulting Utah Health Exchange was designed to connect consumers to information encouraging informed health care choices, and allow for a simple execution of that choice.

In 2009, legislation was passed that established a defined contribution market and the Utah Defined Contribution Risk Adjuster Board. Pending implementation, employers were required to contribute a defined level of funding rather than providing a pre-determined benefit for health care coverage.

Currently, Utah is modifying their system including an expansion of its internet portal to meet requirements put in place through federal health reform in order to best utilize subsidies, credits, Medicaid and the Children's Health Insurance Program (National Conference of State Legislatures).

In 2005, it was estimated that less than 40 percent of small businesses in Utah were offering health insurance (Thurston). A study of Utah businesses indicated that the primary reason was the unpredictability of costs. The newly-implemented small business portion of the exchange uses a defined contribution element designed to increase the number of small businesses that would offer insurance.

- It allows employers to offer a **pre-determined level of funding**, and
- Provides the employee with **more choices than a typical employer plan** would provide while maintaining the traditional tax-free nature.

The Utah Health Exchange is quickly growing. As of November 1, 2011, 196 small employer groups are participating, covering more than 4,500 individuals (Utah Health Exchange).

California's Efforts:

The Exchange's Planned Operations

In 2010, Governor Schwarzenegger signed two bills that created the California Health Benefit Exchange and its governing board, becoming the first state to enact such legislation under the new federal law. As is available to all states, California received the $1 million Exchange Planning and Establishment Grant to be used to develop a detailed business and implementation plan.

To be operational on January 1, 2014, the California Health Benefit Exchange will be designed to "enhance competition and provide the same advantages available to large employer groups by organizing the private insurance market, including a more stable risk pool, greater purchasing power, more competition among insurers and detailed information regarding about the price, quality and service of health coverage" according to the State's health reform website.

The California Health Benefit Exchange is planned to provide:

- Easy-to-understand, objective and comprehensive information for qualified plans,
- A web-based eligibility portal to help link individuals to appropriate coverage options, and
- A toll-free consumer assistance hotline.

Individuals and small employers (under 100 employees) are eligible to enroll in the exchange. The exchange will ensure that Californians eligible for federal subsidies (those incomes between 133 and 400 percent of the federal poverty level and meeting citizenship requirements) receive those benefits.

While the exchange will not alter the administration of Medi-Cal by the Department of Health Care Services, or the Healthy Families Program by the Managed Risk Medical Insurance Board, it will screen for and enroll eligible individuals in these programs to comply with federal law. The exchange will also coordinate the needed transitions between coverage programs for those whose eligibility changes.

The Exchange as an Organization

The California Health Benefit Exchange is an "independent public entity within state government" according to their website. The unpaid governing board is made of two appointees by the Governor, one by the Senate rules committee, and one by Speaker of Assembly. In addition, the Secretary of Health and Human Services for the State (or another designee) will serve as an ex-officio voting member. Each appointed member will serve a four year term. The current board is:

- Kim Belshe, Senior Policy Advisor - Public Policy Institute of California
- Secretary Diana S. Dooley - Health and Human Services Agency
- Paul E Fearer, Senior Executive VP and Director of HR - UnionBanCal Corporation
- Susan P. Kennedy, Former Chief of Staff to Governor Schwarzenegger
- Robert K Ross, M.D., President and CEO – The California Endowment

In August of 2011, Peter V. Lee was unanimously approved by the California Health Benefit Exchange Board to be, as of January 2012, the first Executive Director of the California Health Benefit Exchange.

The October 2011 adopted official Vision, Mission and Values of the California Health Benefit Exchange are attached to the document.

In November of 2011, the following three additional top management positions were announced:

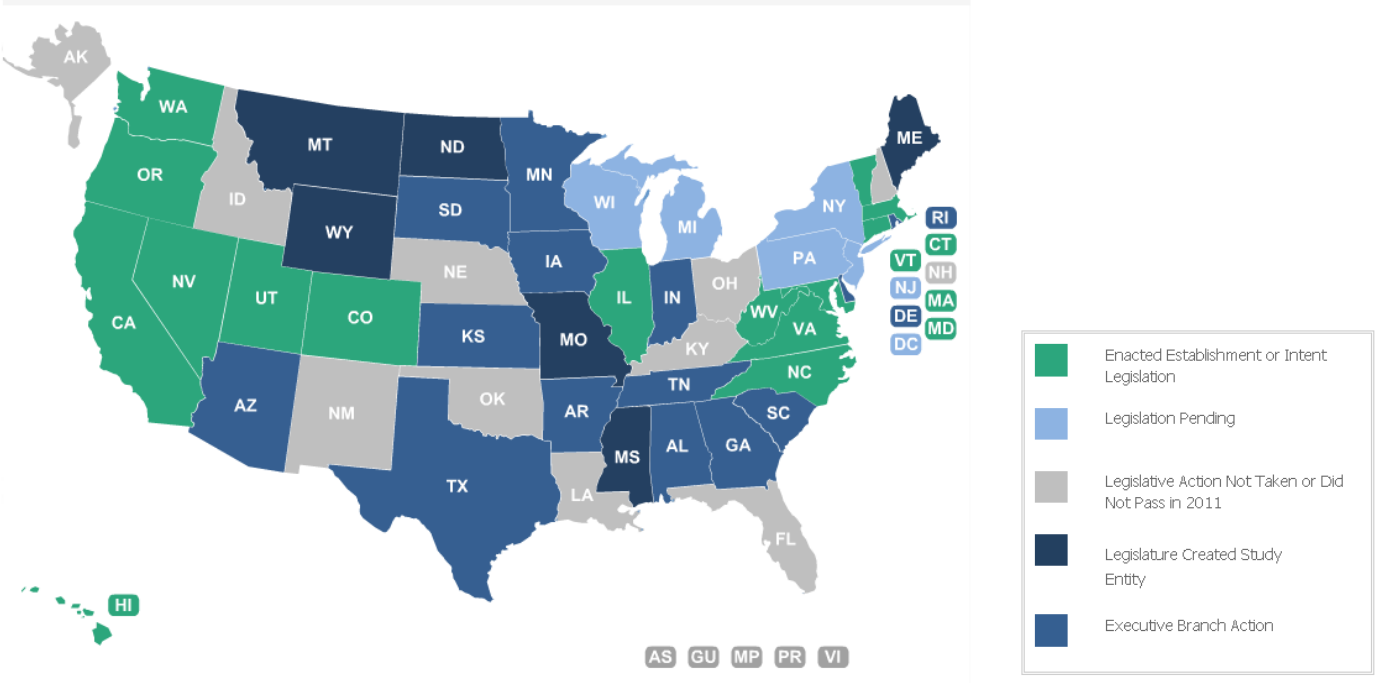
- David Maxwell-Jolly, PhD, appointed Chief Operations Officer – previously Undersecretary of California Health and Human Services Agency
- Sharon Stevenson, JD, appointed General Counsel – previously Chief Administrative Law Judge and Deputy Director of the California Department of Health Care Services
- David Panush appointed Director of Government Relations– previously Health Policy Advisor to California Senate President Pro Tempore Darrell Steinberg

Other State's Statuses:

As presented in the following map,

- 15 States have enacted establishment or intent legislation including California
- Six have such legislation pending
- In seven States the legislature created a study entity
- 12 States' executive branches have taken action, and
- The remaining 10 states have yet to take action.

Status of State Exchange Implementation Efforts



Source: National Conference of State Legislatures

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Implementation Direction:

The California Health Benefits Exchange does have the authority, flexibility and responsibility to make significant implementation decisions. The California Healthcare Foundation has produced a series of reports identifying and contrasting four "varying visions for the exchange" and the "Key Features and Operational Considerations" that, they feel, go along with each. The following are the general descriptions of each as described in the California Healthcare Foundation report.

- **Price Leader: (The Exchange) as a Driver of Low Premiums.** The promise of health reform is to make health insurance more affordable and accessible for individuals and small businesses. This approach focuses on the exchange as primarily a cost-focused store that offers the most competitively priced health plans.

- **Service Center: (The Exchange) as a Consumer Destination.** An exchange centered on service and expanded consumer options would help to build public support for reform and create political leverage to transform the market. This approach positions the exchange as a consumer-friendly, one-stop shop with broad choices on plan design, accessible information, and strong customer service.

- **Change Agent: (The Exchange) as a Catalyst of Finance and Delivery Reform.** One of the many possible priorities that could be emphasized by the exchange — and perhaps the farthest reaching — is long-term reform of the health care system. Such an exchange would establish incentives to encourage innovation and improvement in the cost, quality, and efficiency in health care delivery.

- **Public Partner: (The Exchange) Aligned with Medi-Cal.** The exchange as Medi-Cal partner would adopt an array of policies and practices that align with Medi-Cal's efforts to improve the health status and health care outcomes of low-income, high-need individuals. It would focus on enrolling and retaining these groups and maximizing continuity of coverage and care for people who experience changes in income and program eligibility. It would carefully consider the impact of decisions on Medi-Cal spending and the state budget, and seek to minimize budgetary pressures to reduce Medi-Cal benefits, provider payments, or eligibility.

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Sources:

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Attachment 1: California Health Benefit Exchange Vision, Mission, and Values

EDMUND G. BROWN JR.
GOVERNOR

State of California
Health Benefit Exchange
Vision, Mission and Values

Adopted October 21, 2011

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality care.

The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

- **Consumer-focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.
- **Affordability:** The Exchange will provide affordable health insurance while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.