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Establishing a Health Insurance Exchange

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Thank you, Chairwoman Alquist, Chairman Monning, and members of the committees for this opportunity to share with you some of our experience with reform in Massachusetts and exchanges in particular. I am Executive Director of the Health Connector—our exchange in Massachusetts.

First, congratulations on tackling these tough issues so expeditiously: the process from legislative drafting to full implementation took four years in Massachusetts, and we already had the insurance reforms set forth under the federal Accountable Care Act, such as community rating, in place in Massachusetts prior to our 2006 reform legislation. By getting a head start now, in 2010, you can anticipate and better oversee the many changes coming to California's health insurance markets.

As a preliminary matter, I would also underscore the importance to successful implementation of communication. Just as the Massachusetts Health Connector has done, the California Health Benefits Exchange can play a major role as a trusted information source in helping employers, consumers and everyone else understand, anticipate and adjust to health insurance reform here in California. For example, there are significant financial opportunities in 2010 for large employers to benefit from federal reinsurance for their high-cost early retirees—including state and local governments that cover early retirees. Equally, there are tremendous opportunities for small employers of low-wage workers to benefit from federal tax credits and extend that assistance to their newly covered employees. Especially because funding for the first program is limited and is available on a first-come-first-serve basis, it behooves the state, local government and the private employers located here to take maximum advantage of these new funding sources as soon as possible.

In Massachusetts, the Health Connector played a central role in promoting awareness and facilitating use of such federal programs, and I would think that California might do so as well.

Continuous, fulsome and accurate communications about reform will also help allay the substantial anxiety and confusion that may arise, as employers and all voters begin to hear about various programs from diverse sources. In the absence of a trusted central source of unbiased information, your citizens will pick up information and misinformation any where they can--talk radio, doctors, insurance agents, neighbors,

friends, even scam artists. ACA charges state-based exchanges with playing a central role in the massive outreach effort that will be needed to minimize confusion, and our experience in Massachusetts suggests the wisdom of that. Partly as a result, we have experienced tremendous popular support for Massachusetts' reform, ranging between 59 and 75 percent of adult, voting residents over the past three and a half years.

As one example of our communications efforts, the Health Connector partnered with community groups, employers, carriers, unions, local government officials and a variety of other groups to meet with audiences across the Commonwealth. We held 338 community outreach and education sessions across Massachusetts in the first two years of reform, and were fielding 2,500 general inquiries a week. Multiplied by your relative size, that translates into 1,700 educational sessions across California over the next two years and 12,500 inquiries a week.

Some Lessons Learned

Turning to the legislative framework for the California Health Benefits Exchange, I want to address four key questions that should help inform your legislative deliberations:

1. What is the core mission of an exchange?
2. How should an exchange be governed?
3. How "aggressive" can the exchange be as a purchaser?
4. What is single the biggest risk/challenge for the California Health Benefits Exchange that you can control and address early on?

1. Mission: The core mission of exchanges is to market insurance. Not only are exchanges designed to help individuals shop for and enroll in health plans, but their revenue model under the federal ACA is perfectly aligned with this mission. They are to be self-supporting as of January 1, 2015, based on surcharging the transaction of buying insurance. The exchange covers its administrative expense out of sales-generated administrative revenue.

Why set up a publicly-sponsored insurance store in the first place? One reason is to save on the expense of distributing insurance to the small end of the market. As an electronic insurance store, the exchange should realize significant economies of scale, so as its enrollment grows, costs per enrollee come down. With growth, the Health Connector has managed to lower its administrative expense from approximately 5% of premiums to 3% of premiums for our fourth full year, beginning July 2010. This compares with distribution costs across the country for non-group and small-group insurance of as much as 20% of premiums. I believe that California is at the higher end of this range.

Another reason is to offer buyers an easy-to-use choice of high-value, health plans. In Massachusetts, we award a "Seal of Approval" to the seven health plans offered on an unsubsidized basis. (Four of them are ranked among the top ten health plans in the country by the National Commission on Quality Assurance.) By making the differences

among the plans transparent and price shopping easy, we save buyers substantial time and money, and we encourage enhanced competition among the health plans. I would be happy to elaborate on this point with specific examples and numbers, if the Committee members are interested.

My larger point is that this is essentially a commercial enterprise with a set of public policy objectives—to improve consumer choice, to lower the very high distribution costs of insurance at the small end of the market, and to enhance competition among the health plans. This is a rather unusual role for state government.

The legislative framework for the California Health Benefits Exchange should reflect the unique nature of this public-sector enterprise. For example, the managers of the exchange will have to learn from experience "what sells" i.e. what its potential customers want to buy. I would suggest that this will differ between Fresno and Frisco, will differ between small employers and subsidize low-income households, and will change over time.

Therefore, the Exchange should be set up to experiment: for example, to offer more plans initially than fewer, and see "what sells." No matter how well organized, a store is only as good as the products it offers. So, it will be critical to the success of your exchange that it be positioned to the health plans of California as an attractive distribution channel. You will want the well-established health plans with large market share and brand name recognition competing to get on Exchange's shelf. You will also want the Exchange to offer new accountable care organizations, member-governed CO-OPs, county plans and other innovative, low-cost options ready access to large, new market segments. (The unfortunate demise of PacAdvantage is perhaps a lesson learned in this regard.) The estimate from UC Berkeley that the California Health Benefits Exchange could serve as many as 9 million residents represents a huge opportunity to improve health insurance, but only if the Exchange first succeeds in its primary function as an electronic insurance store.

By contrast, I would suggest that you avoid setting up the Exchange to function as yet a third insurance regulatory department in California. As we are experiencing in Massachusetts, regulatory disputes have a way of spilling over into "the aisles" of the store and interfering with the core mission of improving market competition. Indeed, being less prescriptive in legislation, especially about what the exchange <u>may not do</u>, is the prudent course, at least initially.

2. <u>Governance:</u> The governance model in SB 900 and AB 1602 seems to be a "semi-independent" agency, with its own board of directors, housed within Health and Human Services. It is not entirely clear to me what this means, but I would suggest the following considerations as you define this model further.

Relevant expertise in the make-up of the governing board should include insurance and retailing, perhaps consumer- and employer-representation, health policy, economics and health benefits specialists. On the other hand, as an agent of change affecting the distribution of health insurance, I would suggest that the board of the California

Exchange explicitly exclude representation from the insurance, brokerage, physician or other provider sectors. Moreover, the Exchange's staff will require experience from with insurance, actuarial sciences, sales, underwriting and entrepreneurship, which may not fit well within civil service pay scales. In sculpting the right mold for California's exchange, I recommend that you carefully consider these peculiar management challenges of running a successful commercial insurance store, and the advantages of political independence for the exchange.

3. Purchasing Stance: The Exchange must be able to select and offer high-value health plans, array them for ease of comparison shopping, and efficiently enroll subscribers, in order to function as something more than an automated yellow pages. The ACA contemplates state-based exchanges functioning in this capacity.

However, it also frames state health insurance reforms and state-based exchanges such that the plans offered within the exchange shall be available at the same prices outside the Exchange as well. This mirrors Massachusetts. In other words, the exchange is not really like a large self-insured employer simply driving down prices through negotiation on behalf of its beneficiaries. Were it to do so, it would function as a price regulator across the market—in and outside the exchange.

How can the Exchange put downward pressure on premiums without simply setting premium rates? There are three ways:

a. Selecting and offering higher-value plans—for which plans should compete;
b. Making it easy for buyers to shop on price, quality, etc. from the higher-value plans offered through the exchange; and
c. Reducing the distribution costs of health insurance.

Just how effective these means will become in pushing premiums down will depend on the California Health Benefits Exchange's success as a "market-maker." It must first succeed in selling a lot of insurance before the health plans will compete hard to meet its specifications. The point is that the legislation does not—perhaps cannot—define exactly what the Exchange's role in pressuring prices will be, because it will evolve. So long as the legislation guarantees the ability of the Exchange to be selective in its offerings, to be an aggregator of premiums, to offer its plans to all segments of the authorized market, with or without brokers -- as the exchange determines will best promote its core mission – and if the exchange is well governed and managed, I believe that it can make a significant impact.

Risks: Turning now to risks for the new California Health Benefits Exchange, there are many, only a few of which can be anticipated and addressed in this legislation. However, one in particular is the Herculean task of creating an automated, integrated eligibility determination process for California. ACA charges the exchanges to work with the IRS and the state (or county) Medicaid offices to determine eligibility for tax credits and other

subsidies. This is a huge challenge, on which the whole enterprise can easily flounder. It is critically important that California take advantage of the long lead time allowed under the ACA, prior to 2014, to develop automated, easy-to-use systems for determining eligibility, ideally the same system for MediCal as for federal tax subsidies through the California Health benefits Exchange.

Not having studied California's eligibility system(s) for MediCal, I cannot comment on the specific challenges you face. However, I do know that Massachusetts started with the huge advantage of a fully automated, statewide eligibility determination system that serves as a single point of entry for all health subsidy programs, plus food stamps, WIC, and other income-related programs. Even so, we will have to do substantial work to integrate with new federal-tax-generated means testing. I urge you to start early and devote considerable resources to this effort.

Thank you again for this opportunity. I will try to answer your questions, if I can.