Models for the California Health Benefit Exchange (CHBE)

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Agenda

- Project context and overview
- Four models of the exchange:
  - Price Leader
  - Service Center
  - Change Agent
  - Public Partner
- Comparison
  - Metrics
- Questions and discussion

Visions for the CHBE

The project goal was to lay out well-conceived alternatives to surface and consider the impacts of embracing different models of CHBE goals and priorities.

These different models are intended to provoke discussion, not necessarily for a single model to prevail.

Papers include:

- Description and argument for this model
- Operational considerations
- Service considerations
- Risks and unintended consequences

Methodology

Each paper was considerably influenced by input and feedback from a diverse set of contributors.

- **Expert Input**: CHCF convened a meeting in January 2011, whereby more than 25 leaders, scholars, policy officials, advocates, and other stakeholders defined the scope of the project and narrowed down on the different models of the exchange for further exploration.
- **Distributed Authorship**: CHCF engaged a group of experts to prepare an initial draft of what each model of the exchange could look like according to a common outline.
- **Collaborative Reviews**: All initial contributors and an extended set of experts were invited to review and comment upon each paper during two rounds of review.
- **Editorial Integration**: The CHCF editorial and project teams prioritized and integrated feedback into a single product.

Project scope

Category	What it is	What it is not
Specificity	A high-level illustration of key decisions that differentiate this version of the exchange	A comprehensive plan for how the model would be developed under each model
Perspective	A presentation of visions for the CHBE from an *overly-differentiated* perspective	An actual representation of how an exchange would be developed – there could be a hybrid or layered approach
Market segment	General discussion of CHBE with a focus on the individual market, along with additional perspectives on the impact to SHOP as well.	A differentiated view of the individual and SHOP exchanges for each of the CHBE models.

Papers included in the CHCF project

Overview: This paper defines the goals of the paper, provides a market and policy context, and identifies the core assumptions underlying the papers.

Price Leader - CHBE drives down insurance premiums: The Exchange as a cost-focused store that seeks to drive down premium prices to expand access.

Service Center - CHBE provides stellar service: The Exchange provides a rich one-stop-shopping experience that entices customers.

Change Agent - CHBE catalyzes long-term finance and delivery reform: The Exchange drives change through prioritizing innovation.

Focus on Integration - CHBE partners with public programs*: The Exchange prioritizes integration public programs to improve access and ease transition between different types of coverage.

Foundational Operations: This paper defines and explores the foundational operational requirements that would be applicable with any focus CHBE adopts.

** This topic is covered in today's presentation but does not include a corresponding paper.*

Outline of the discussion for each model

- Description and primary motivation for adopting this model
- Implications for the following two functional areas:
  - Consumer education
  - Health plan management
- Potential risks associated with this model
- Closing thoughts

For the purposes of this exercise, presenters are taking on the role of advocating for a particular model of the exchange.

This is not to be interpreted as personal representation of or advocacy for any particular vision of the CHBE.

Price Leader:
Description and Rationale

Primary focus on premiums

- Selective contracting and efficient operations

Premiums affect coverage

- Increased coverage fundamental promise of health reform
- Realistic goal; can be achieved in short-term

Price Leader:
Consumer Assistance

- Meet all state and federal requirements for service
- Focus on opportunities for self-service and automation
- Prioritize resources and spending needs
- Examine role of brokers

Price Leader:
Health Plan Management

Focus on lower-priced plans and carriers

- Selective contracting
- Multi-year contracts
- Narrow networks
- Standardized benefit design and transparency

Price Leader: Risks & Potential Unintended Consequences

- Risk selection
- Public perception
- Long-term sustainability
- Cost-shifting
- Continuity of coverage

Service Center:
Description and Rationale

- Features first in class customer service; emphasizes understanding and meeting consumer needs
- Rationale
  - Drive consumers preferentially toward exchange
    - Achieve economies of scale
    - Increase market leverage
    - Protect against adverse selection
  - Help market work better
    - Simplify purchasing
    - Increase ease, transparency, accountability, knowledge
  - Help reform succeed
    - Exchange as public face of reform

Service Center:
Consumer Assistance

- Guiding vision
  - One-stop-shop for trusted, reliable information and services related to health insurance and reform
- Specific features
    - Exceeds federal requirements for service at all levels, including with modes of access; culturally and linguistically appropriate services; accessibility to those with disabilities, etc.
    - Highly trained staff with robust IT support
    - Thoughtful decision support and education tools
    - Responsiveness to consumer preferences/needs

Service Center:
Health Plan Management

- Guiding vision
    - Create “meaningful choice” for consumers
- Specific features
    - Facilitate choice among broad array of options
    - Provide wide choice of carriers
    - Understand and respond to consumer preferences
    - Incorporate mechanisms for evaluation/feedback on consumer experience
    - Develop expectations/standards for customer service with plans, provide seamless service between exchange and plans

Service Center: Risks & Potential Unintended Consequences

- Higher build and operating costs
  - Potentially mitigated by higher exchange volume
- Need for careful balance on degree of choice
  - Too much choice could create consumer confusion
  - Choice among plan designs increases potential for adverse selection
  - Too little choice makes it hard to entice consumers
- Requires careful cultivation of relationships with carriers, brokers, navigators

Service Center: Summary

- Use government to organize the market, but with an entrepreneurial focus
  - More of a “dot com” than a “dot gov” experience
- Provide premier consumer experience to all while expanding access to hard-to-reach populations
- Success measured by uptake, particularly among non-subsidized populations

Change Agent:
Description and Rationale

- Care delivery redesign and payment reform must be accelerated to improve health system performance and expand existing provider capacity
- Promote market and price competition through vertically integrated delivery systems and regionally organized accountable care organizations
- Promote use of high performing physicians and hospitals that meet cost and quality criteria
- Reward improved health outcomes and care coordination

Change Agent:
Consumer Assistance

- Focus on consumer impact on choice of services and cost of care
- Inform consumers about choice of care delivery system within a traditional health plan and implications for self-referral and access
- Disclose coverage rules for out-of-network services and out-of-pocket costs
- Educate health care navigators about the role of incentives to use appropriate care, choose cost-effective providers and engage in self-care and personal health risk reduction
- Coordinate appeals and grievances in an integrated delivery system with health plan review processes

Change Agent:
Health Plan Management

- Develop standards and criteria to ensure consistent quality of service and operations across integrated delivery systems
- Balance standards with flexibility that encourages delivery system redesign and innovation
- Set objective goals for managing total health care costs and health outcomes
- Require use of advanced payment models and performance-based incentives with an eye towards public sector alignment with Medicare Shared Shavings Program and CMS Hospital Value-Based Purchasing Program
- Reward efficiency and care coordination
- Assure availability of comprehensive provider network, including specialty coverage and tertiary services

Change Agent: Risks and Potential Unintended Consequences

- Supporting rural access to high-performing provider systems as vertically integrated systems may be more limited to major metropolitan areas
- Assuring consistency of member experience
- Operational and service requirements need not be a barrier to entry for emerging accountable care organizations
- Assuring financial solvency of newly formed integrated groups
- Balancing narrow network options with consumer choice of plans
- Expanded role for Health Benefits Exchange Board for oversight
- Maintaining continuity of care for members who may have intermittent Medi-Cal eligibility or those who change plans due to income subsidy availability

Public Partner:
Rationale and Vision

Rationale

- Public programs will serve 1-in-4 Californians
- Public programs cover lowest-income, highest-need Californians, and are safety net for all
- Half of expected coverage growth under ACA through Medi-Cal
- Half of low-income adults estimated to move between eligibility for Medi-Cal and Exchange within a year

Vision

- The Exchange will position itself as an ally of California's public programs, working in concert with one another to:
  - Improve the health status and outcomes of low-income Californians
  - Minimize pressure on state spending
- Requires commitment from Public Programs to collaborate

Public partner: Description

- Align outreach, screening and enrollment strategies
- Adopt policies and practices that promote continuity of coverage
- Align consumer protections and access standards
- Align public reporting and quality improvement activities
- Protect viability of the safety net
- Align health plan payment strategies
- Minimize duplication
- Pursue federal matching funds

Public Partner:
Consumer Assistance

- Adopt consumer education and assistance practices that reflect the needs of low-income, high-need populations
  - Provide information that allows low-income consumers to easily determine whether they would have to switch their health plan or provider if their income changes
  - Provide materials available in multiple *languages*, in multiple *formats*, and through multiple *channels*
  - Offer one-on-one, culturally competent assistance at multiple points of engagement
  - Build capacity to handle coverage appeals and grievances and provide complaint resolution support
- Calibrate outreach based on enrollment objectives for Medi-Cal and Healthy Families, potentially scaling up or down

Public Partner:
Health Plan Management

- Evaluate an array of contracting options to maximize continuity of coverage and care
- Align consumer protections and health plan contract standards
- Align data reporting requirements, performance measures, and quality improvement goals
- Align health plan and provider incentives
- Collaborate, consolidate activities, share resources, jointly purchase services

Public Partner: Risks and Potential Unintended Consequences

- Exchange is slower to innovate because:
  - Collaboration takes time
  - Legacy systems can be difficult to change
  - Many decisions made through legislative process
  - Competing policy goals for public programs
- Lose potential customers if:
  - Alignment has negative impact on consumers' perceptions or experiences
  - Consumer protections or adverse selection lead to higher premiums

Comparative metrics dashboard

	Price Leader	Service Center	Change Agent	Public Partner
Cost	Annual premium growth under key state, and federal, and historic benchmarks	Annual premium growth under key state, and federal, and historic benchmarks	Annual premium growth under key state, and federal, and historic benchmarks , **particularly measured on a multi-year horizon**	
Customer satisfaction measures	Broad set of customer satisfaction measures, e.g., loyalty, wait times, problem resolution	• Broad set of customer satisfaction measures • Continuously improving customer service, tracked against benchmarks both outside the exchange	Broad set of customer satisfaction measures, e.g., loyalty, wait times, problem resolution	Customer satisfaction compared by income levels and program participation

Primary

Supporting

Comparative metrics dashboard, p2

	Price Leader	Service Center	Change Agent	Public Partner
Access / Consumer demo-graphics		Balanced participation across income-levels (including subsidy vs. non-subsidy), demographics, and geography	Balanced participation across income-levels (including subsidy vs. non-subsidy), demographics, and geography	Continuity of coverage among low income enrollees
Efficiency of care utilization		• More efficient use of care (less unnecessary care, more appropriate setting, fewer preventable hospitalizations, etc.) • Better population and chronic care management	• More efficient use of care (less unnecessary care, more appropriate setting, fewer preventable hospitalizations, etc.) • Better population and chronic care management	

Primary

Supporting

Comparative metrics dashboard, p. 3

	Price Leader	Service Center	Change Agent	Public Partner
System-wide health spending			System-wide health spending and spread of innovation in delivery system and finance throughout state	• Percent of those eligible for public programs or subsidies enrolled through the exchange. • Metrics are aligned with those tracked by Medi-Cal

Primary

Supporting

Core operational metrics will be monitored regardless of the strategic vision embraced

Category	Sample metrics
Price	• Premium • Premium trends
Cost	• Administrative cost per enrollee • Administrative cost as a percent of premium
Enrollment	• Initial volume and persistency / retention – both for the subsidized and non-subsidized populations • Demographics
Customer service and quality of care	• Service quality targets • Care quality metrics as monitored and reported by health plans

Discussion questions for the Board

Do any of these models resonate in particular, or raise cause for caution?

How will we know if we are successful?

- In the near-term?
- In the long-term?

What words would you use to describe your vision for the Exchange?

What guiding principles do you suggest for the Exchange?

Primary contributors

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