Health Benefit Exchange Board Meeting - July 22, 2011

Summary of Public Feedback on Strategic Visioning

At the July 22, 2011 Health Benefit Exchange Board meeting members heard from various presenters on four potential Models for the California Health Benefit Exchange: (1) Price Leader; (2) Service Center; (3) Change Agent; and (4) Public Partner. Following Board discussion, members of the public were also offered opportunities to provide feedback to four specific questions:

1. Do any of these models resonate in particular, or raise cause for caution?
2. How will we know if we are successful? In the near term? In the long-term?
3. What words would you use to describe your vision for the Exchange?
4. What guiding principles do you suggest for the Exchange?

Stakeholders provided written feedback at the meeting itself, in additional to oral public comment. Stakeholders were also encouraged to submit comments on the questions via email - five agencies did so: the Bay Area Council, California Association of Health Underwriters (CAHU), California Primary Care Association (CPCA), Health Access, and United Way of California.

Summary of Written Responses at the Meeting

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

- Two people raised issues with the Change Agent Model, believing the role of the Exchange in it to be unclear, that it was redundant with other legislative programs and duplicative with other agencies.
- Three people saw benefits to this model:
  - It could help avoid financial hardship for providers
  - It ensures meaningful access to health coverage for low-income limited English-proficient Californians
  - It defines a potential role for the exchange
  - It uses navigators to increase outreach and education.
- Two people resonated with the Public Partner model:
  - It recognizes the necessity of working with high need populations, including low-income, limited English-speaking Californians.
- Three people discussed the Price Leader Model:
  - It could sacrifice exchange standards for advocacy, quality measurement and fraud detection
  - It might choke off the system by artificially holding down rates
  - It might not be able to work with the disability community concerning technology issues.
- Five people commented on the models as a group:

- Pieces should be taken from each model, and the change agent and service center models were seen as a means to focus on consumer needs, diversity and streamlining.
- The digital divide is important.
- Need to offer affordable products focused on improving care through a first-class user experience partnering with Medi-Cal.
- There is a missing focus on market mechanisms and having exchange just execute on its basic functions in near term, given all the tasks to accomplish.
- It is important to avoid duplication.

2. How will we know if we are successful? In the near term? In the long-term?

- Nine people offered near term suggestions.
  - Three identified enrollment.
  - One each identified:
    - Engaging people.
    - Accessibility.
    - Adequate networks for cultural and linguistic populations.
    - Consumer knowledge about the Exchange.
    - Stability of the pool.
    - Its reputation.

- Twelve people gave a long term suggestion:
  - two each identified:
    - Improved health.
    - Accessibility.
    - Affordability.
    - Ability to transform the system.
  - One each recommended:
    - Measuring whether the Exchange could achieve sustainability/
    - Cost control.
    - High volume of purchasers.
    - Ability for consumers to move between plans maintaining continuity of care.

- Six people offered recommended metrics that were not tied to time (near or long term), some of which overlapped with those related to time.
- Two people identified high enrollment (including the idea for a possible goal of two million enrolled on Day One).
- Two mentioned continued feedback.
- One each offered reaching hard-to-reach populations and transparency.

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

- The most frequently mentioned words, mentioned by four people each, were
  - Accessibility.
  - Cultural and linguistic competence.
- Three people each identified:
  - Quality and value.
  - Healthy competition for good prices for health coverage for many people.
- Two included:
  - Transparency.
  - The importance of focusing on the consumer.
- One person each raised:
  - It should be easy to use.
  - Informational
  - Trusted.
  - Effective
  - Efficient.
  - Modern.
  - Active.
  - Offer continuity.
  - Serve as the Human Resources Department for individuals, providing good information.
  - It should serve as the emblem of success of health reform.

4. What guiding principles do you suggest for the Exchange?

- Five people noted that the Exchange should be inclusive of all communities, leaving no one behind, driven by community needs for affordable coverage.
- One each mentioned that it should:
  - Be in full compliance with federal and state requirements.
  - Assist those eligible for the Exchange and other state programs.
  - Be transparent enough to allow consumers to compare health and dental plans based on separate offer and pricing.
  - Be user-friendly
  - Be creative and innovative and fundamentally unlike other state and federal programs.
  - Be modest.
  - Be competent.
  - Build and nurture strategic partnerships, with a long-term vision of high value insurance.

<u>Email Feedback from Five Organizations (a summary of each email):</u>

SUBMITTED BY BAY AREA COUNCIL

All present Board members articulated in one way or another that the Exchange should be an "efficient, transparent marketplace" for insurance. The focus of the Board, all of whom acknowledged that there were compelling aspects to each scenario, appeared to

be on sticking closely to the statutory charge and ensuring that the Exchange works for individuals and small businesses on 1/1/14. Many of the elements of the competing scenarios would complicate that goal or even run directly counter to it.

Particularly in the health care arena, clear and fair regulations are essential to creating functioning marketplaces. The California law that enabled the Exchange includes smart, useful provisions pertaining to standardizing the markets. A focus, particularly in the next two and a half years, on creating an efficient, transparent marketplace is the surest route through which to deliver on the promise of healthcare reform and to build a solid foundation for years to come.

SUBMITTED BY CALIFORNIA ASSOCIATION OF HEALTH UNDERWRITERS (CAHU)

The Board should not overlook partnering with licensed agents and brokers to drive the success of the Individual and SHOP Exchanges. Ensuring that there are no unreasonable barriers to licensed agents and brokers placing business within the Exchanges, and making sure there is the opportunity to negotiate with plans for reasonable compensation for doing so, will aid in finding that extra one million lives the presentations indicated were needed to make the Exchanges a success.

We support the staff recommendation that AB 52 (Feurer) is premature. AB 52 undermines the power of the Exchange just as it is getting underway. For example, the Board has the ability to selectively contract with health plans for products to offer within the Exchanges. However, AB 52 would give the Department of Insurance the power to veto HBEX Board decisions. Once an Exchange is up and running, AB 52 will continue to be a problem by making it impossible for the Exchange to offer the selected health care plans on a timely basis due to the open-ended approval and intervener process proposed in the bill. It would be best to get the Exchanges operating first and then re-evaluate to see if rate regulation is actually needed.

SUBMITTED BY CALIFORNIA PRIMARY CARE ASSOCIATION (CPCA)

We will know if we are successful in the near term if:

- Individuals eligible for insurance in 2014 will know about the Exchange and be able to easily locate its services.
- There would be a high take-up of individuals enrolling into care in the Exchange.
- Individuals would be able to access care/insurance options that are easily comparable and culturally and linguistically competent.
- Individuals would have resources available to them through Navigators/health educators to understand their options and receive assistance to access them.
- Safety-net providers, providers who historically see this population, would be adequate participants in the Exchange ensuring continuity of care for participating individuals.

- We will know that we are successful in the long-term if the Exchange would be able to utilize the numbers of individuals accessing the Exchange as leverage to drive down costs and require specific levels of quality.
- Words to describe the vision for the Exchange: consumer-focused; an entity that can require a high level of service and quality for participating health plans, affordable, access, trusted source of information.
- The same words for the vision should be used as guiding principles, along with culturally and linguistically competent, and ongoing consumer and stakeholder engagement.

SUBMITTED BY HEALTH ACCESS

The Broad Vision of the Exchange. The individual market for health insurance coverage is fundamentally broken. The Exchange is the heart of health reform. While the Exchange is not responsible for the whole of health reform, health reform cannot fulfill its promise if the Exchange is not successful. The Exchange is not just a place to buy and sell health insurance. Arguably the most important job of the Exchange is to seamlessly ensure that people get the subsidies they need and are entitled to, in order to better afford health coverage. It should be a trusted source of information. It should remove the barriers that currently exist to coverage, including access, affordability, adequacy, administrative simplicity. The Exchange should empower people to make decisions that are right for them. The Exchange should make the process seamless, easy, and hassle-free. It should be explicitly seen as on the side of consumers, to help them through this process. The Exchange should be a one-stop shop. The Exchange should be as a trusted, reliable source of objective information, uncompromised by the industry, with a distinct identity from the insurers. It needs a variety of mechanisms to take input from consumers and community organizations. The Exchange should be multicultural. The Exchange will need to be open to all comers, but mindful and responsive to the specific circumstances that bring them in.

A major barometer for the Exchange is enrollment. The Exchange should have a goal of mass enrollment on day one, January 1, 2014. A broader goal is for the Exchange to be the transformed marketplace of what the current individual insurance market is not: an open, organized, transparent, seamless, affordable, accessible, consumer-friendly purchasing pool, where insurers are actually competing on cost and quality, rather than on avoiding risk.

Comments on Specific Exchange Models. Health Access requested that the California Health Care Foundation make public the group of “leaders” with which it consulted, and in particular the consumer groups that were consulted in the process of developing these papers.

Price Leader Concept. Health Access California strongly supported the concept of the Exchange as an active purchaser that could negotiate based on cost, quality and value. Negotiating on price is an intrinsic part of active purchasing. Some will see the success

or failure of health reform as entirely a matter of its impact on health insurance rates, and support using the Exchange's selecting contracting ability as one tool, among others, for dealing with health costs. The organization is concerned that focusing on price will force skimping on basic service. If the Exchange skimps on service, it will undermine the Exchange's ability to reach non-subsidized populations. Many of the features for this model are consistent with good service and negotiating to drive change in the delivery system: standardized design facilitates consumer choice and is helpful to good service; narrow networks are not antithetical to changing the delivery system to focus on prevention and better integrated care.

The "price leader" paper focused on the goal of low premiums, with less emphasis about the affordability of out-of-pocket costs. While affordability is essential, but lower premiums should not come with high deductibles and cost-sharing. Focusing on premium is not enough to drive down health care costs over time. Market power through significant market share should be the objective to minimize price while maximizing cost and quality.

Service Leader Concept. The service leader concept paper nicely describes the basic level of service we expect from the Exchange. This should be the minimum, rather than the maximum. The Exchange needs to fulfill the functions of the human resources department of a large employer as well as the role of Social Security and Medicare for the middle class, providing substantial and detailed information about what individuals are eligible for. Providing information about cost sharing, premiums, and reconciliation exposure should be basic to the Exchange. Health Access strongly supports much in the service leader concept paper, particularly the notion of requiring each participating issuer to designate the Exchange as its billing and collection agency so that the Exchange builds customer loyalty, as well as continuing research on consumer preferences and standardization of products to facilitate consumer choice.

On the other hand, Health Access was troubled by some aspects and ideas in the "revenue channels" discussion. The notion of paid advertising on a government website raises many red flags. Having the Exchange require additional "membership fees" for certain services or offer supplemental services beyond basics like vision and dental raises many similar and additional issues.

Change Agent Concept. This paper, along with the service leader concept, best described Health Access's vision for the Exchange. The Exchange should help to drive health care system change. However, the paper fails to consider the challenge of churning of enrollment. In Massachusetts, a quarter of the Connector population turns over each year. Management of care, while important, is difficult to do for short-term enrollees. Prevention in the broad sense should be part of a change agent strategy, but must be realistic concerning the consumers' reality.

Some so-called consumer incentives may allow for backdoor underwriting, and there is not evidence that they actually work. These are sometimes a guise for shifting costs to

consumers while reducing benefits. Cost-effective health promotion activities need to take into account the income level of the enrollees.

Public Partner Concept. The Exchange needs to be a bridge to public programs, especially Medi-Cal. However, anchoring the Exchange exclusively with Medi-Cal may ignore other functions that the Exchange fills, such as serving the middle class. An appropriate public partner would be CalPERS or perhaps UC or CSU, as the Exchange will also be negotiating health coverage on behalf of several million middle class consumers. Health Access expressed deep concern about the suggestion that the objective of this model is to reduce General Fund exposure by reducing outreach and enrollments efforts during bad budget times.

SUBMITTED BY UNITED WAY

United Way recommended a vision and guiding principles that include:

- An Exchange with eligibility and enrollment systems that provide effective outreach, ease of enrollment, interconnectedness, easy transfer of information across counties and states, easy renewal, and seamless integration with state and federal systems to confirm eligibility.
- A user-friendly Exchange that works for a wide variety of health care consumers.
- Affordable products of high quality, with easy access to care.
- An integrated and proactive outreach system ready to inform and invite consumers who are considering their health coverage options.
- A “single point of entry” that provides individuals access to all public benefits for which they are eligible.
- Transparency to the public and stakeholders at all levels, with the ability to generate timely and accurate data.
- Serving as an innovative model of how to provide the most appropriate coverage and meet the needs of individuals, families and small businesses.