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Designing Exchange Framework as Building Begins

Before the Affordable Care Act was passed and signed, controversy swirled about whether a public plan should be included at the federal level. The public option did not survive in Washington, D.C., but it may take root in Sacramento.

At least one county-based public health plan **has announced plans** to participate in the California Health Benefit Exchange. Others may follow.

Details for how public and private plans might coexist or compete in California's exchange have not yet been determined.

The exchange board last month invited a **wide array of stakeholders** to discuss a variety of details:

- How many plans should be included in the exchange?
- What should the essential benefits look like?
- How can the exchange minimize language, cultural and geographic barriers to coverage?
- Should private and public plans compete in the exchange? If so, how?

We invited experts and stakeholders to share their thoughts on those issues, as well as one overall question: How should the exchange structure itself so California consumers are best served?

We got responses from:

- Thomas Williams, President/CEO, Integrated Healthcare Association
- Betsy Imholz, Special projects director, Consumers Union
- Margaret Murray, CEO, Association for Community Affiliated Plans
- John Grgurina Jr., CEO, San Francisco Health Plan

Structuring Plan Competition in the Exchange

Thomas Williams
President/CEO, Integrated Healthcare Association

When thinking about plan competition in the exchange, the appropriate question is not whether public plans should be allowed to compete or how many plans should be offered. Instead, it is how to structure competition between plans to ensure adequate consumer choice and increase the value of health care.

When the question is framed this way, the decision to include public plans alongside private plans should be decided by whether or not these plans meet the qualified health plan criteria that the exchange establishes. If they meet the same standards as their private counterparts, they should have the same chance for inclusion. Provider system-sponsored plans that meet these criteria should also be included.

Instead of placing the focus on the number of plans, the focus must be placed on the *nature of competition*that the exchange must engender. In order to truly impact the value of health care delivered in California (part of the exchange's mission), the exchange must offer multiple plan options that cover all providers in an area.

It must also work to encourage competition between both plans and providers. Currently, in most locales we have situations where multiple commercial plans compete with almost identical provider networks. Providers face little incentive to compete with one another on value; although perceived quality is important to patient choice of provider, lowering prices can actually penalize providers because this action is generally invisible to patients, whose premiums do not change if they choose lower-cost providers.

A way of breaking out of the current state is to encourage competition between qualified health plans at the regional level. In this scenario, there would be closer alignment between regional plan offerings and health systems, and the price of health plans could better reflect the value of care delivered by providers within those markets. This model, which is essentially the model of managed competition advocated by Alain Enthoven, will give providers a greater incentive to lower costs and increase quality.

This vision is likely a long way off for the California Health Benefit Exchange, which faces a number of immediate challenges -- building an enrollment system, minimizing barriers to access, ensuring seamlessness between public programs and maintaining a viable risk pool -- that must be dealt with before the exchange is operational.

However, in the long run, encouraging plan competition at the regional level will help the exchange to fulfill its vision of affordable, high quality health care.

Creating a First-Class Consumer Experience

Betsy Imholz
Special projects director, Consumers Union

Health benefit exchanges are the cornerstone of federal health reform -- one-stop shops for consumers and small businesses to find affordable policies. How our California Health Benefit Exchange (CHBEX) operates will affect whether consumers and small businesses sign up and believe in it.

Thus, the success of health reform itself is inextricably joined with the success of the CHBEX. How can it provide a first-class consumer experience?

- **Keep it simple.** Health insurance is anything but simple. Yet, the CHBEX needs to make things as simple as possible on its "storefront." Think of the Amazon.com model of a clear, intuitive website, even though the underpinnings are very complex. Make it easy for anyone seeking health insurance to find their way through the application process without having to figure out in advance what to apply for or being referred elsewhere, and to get their tax credits and subsidies.
- **Provide help for consumers when it's needed and geared to their needs**. Experience with other health programs has showed that consumers will need assistance with enrolling. An array of methods -- live chat, over the phone and in-person -- will be needed. Trusted, community-based organizations often are the most successful assisters. And more than one million of those eligible for subsidies provided through the exchange have limited English proficiency. As such, multiple language capability is important to get and keep these people enrolled.
- **Create meaningful choices.** Keep coverage affordable, standardize plan information and create a website that is not just a laundry list of choices, but that allows users to sort plan choices by the elements most important to them.

- **Drive health care quality.** More than just a "virtual marketplace," the CHBEX has the potential to improve health care quality, as well as individual and community health. It should use its contracting power to generate quality and cost information and encourage quality improvement.
- **Build in ongoing consumer testing for continuous improvement.** Figuring out the right number of plan offerings, the smoothest application process, what outreach is most effective and how best to display health plan descriptions requires hearing from the "end users" -- consumers themselves. The CHBEX needs to build in feedback from real people and flexibility to adjust in response over time.

The CHBEX has the vision to operationalize these principles. It can make them a reality, continuing to work with stakeholders, and, in so doing, ensure California's role in the success of health reform.

Exchange Should Include Public Plans

Margaret Murray
CEO, Association for Community Affiliated Plans

In California, county-operated health systems (COHS) and local health plans should be allowed to participate in the new Health Benefit Exchange. California's COHS and local health plans fall under the broader definition of "safety-net health plans" -- not-for-profit health plans dedicated to serving low-income people enrolled in Medicaid and the Children's Health Insurance Program.

Because safety-net health plans currently provide coverage to people enrolled in Medi-Cal, Healthy Families and other public programs, they have a natural role in exchanges for other low-income consumers who qualify for premium tax credits. Medi-Cal is California's Medicaid program and Healthy Families is California's CHIP.

Safety-net health plans have developed support systems, physician networks and in-house expertise (such as care management services) expressly tailored to serving low-income customers. Efficient exchanges would include a health plan option that would offer the best value for low-income consumers, including those who may transition from Medi-Cal to the exchange. Safety-net health plans have unique expertise and insight into providing effective, efficient care for these populations.

Further, safety-net health plans can serve as a valuable tool for maintaining continuity of care for those who shuffle between Medi-Cal and the exchange. A 2009 study by George Washington University estimates that four in 10 Medi-Cal enrollees will experience at least one disruption in coverage within six months of enrollment, becoming eligible for subsidized coverage in the exchange.

Many will cycle right back to Medi-Cal. The same study estimates that three in 10 people in exchanges will experience disruptions in eligibility. Safety-net health plans are accustomed to this "churn" of members; if these plans serve both Medicaid and the exchange, enrollees will have a greater chance at continuity of coverage and care.

Finally, allowing safety-net health plans to serve the exchange will allow families whose eligibility is split among several programs -- Medi-Cal, Healthy Families, the exchange and the Basic Health Plan -- to maintain coverage under the same plan, simplifying a family's interaction with their health care and making it easier for family members to access and navigate their health benefits.

Most safety-net health plans are giving serious thought to serving exchanges. A recent survey by the Association for Community Affiliated Plans has found that 34 of 41 surveyed plans have said that serving exchanges is "very important" or "somewhat important." These are plans that are built to

serve the very populations that flow between Medi-Cal and subsidized exchange coverage. Including them in California's Health Benefit Exchange simply makes good sense.

Appealing Design, Active Marketing Are Key

John Grgurina Jr.

CEO, San Francisco Health Plan

California's Health Benefit Exchange will open for pre-enrollment in a little more than a year and a half. But this isn't "Field of Dreams." Even though California has built its exchange, it's not enough to just hope or expect folks to come and sign up for health insurance.

The exchange and its many public and private partners must make the compelling case for why people should purchase coverage.

In order to successfully attract and enroll millions of eligible Californians, the exchange will need to effectively execute three key implementation tasks in the next year:

1) **The sales and marketing message**. What will compel millions of individuals to enroll and actually pay premiums (even if subsidized) for a product they have previously gone without? A pitch will need to condense three simple but not always easy facts about the law:

a. You may be eligible for free insurance or deeply discounted insurance.

b. Health insurance will help keep you and your family physically healthy and avoid financial hardship.

c. You must have health insurance. It is the law and there are financial penalties for not complying.

This message will need to be delivered not just from a marketing campaign but from trusted sources of information, including community-based organizations, health plans, insurance agents, community clinics and providers working directly with individuals to help them enroll.

2) **The product.** What is being offered? A core feature of the exchange is the opportunity to choose among participating health plans whose prices, benefits, quality of service and provider networks are transparent and understandable. In order to attract customers, the exchange must offer affordable options that provide comprehensive benefits and a choice of health plans -- including statewide commercial plans, regional plans and safety-net plans that have experience and a high standard of quality -- to lower-income populations.

3) **Eligibility and enrollment.** How easy will it be for individuals to establish eligibility and how quickly can they enroll? The exchange, Medi-Cal and Healthy Families programs must have a transparent eligibility system and a consumer-focused enrollment process. There must be specific metrics and standards, such as call waiting times, after-hours enrollment, and turnaround times for application completion and processing. Whatever entity is performing these functions must publicly report their results and be held accountable for high customer service standards.

These are not easy tasks, but together we have the opportunity to cover millions of uninsured Californians and to begin the process of lowering the cost of health care. That would be a great ending to our movie.