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MANAGING HEALTH REFORM

CALIFORNIA: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

Rockefeller Institute of Government
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Field Research Associates



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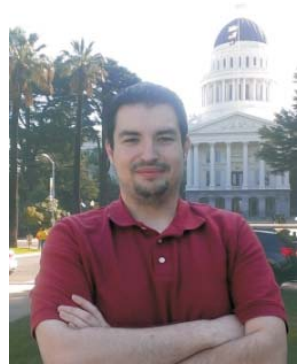
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Contents

- Part 1 – Setting the State Context 1
 - 1.1. Decisions to Date. 1
 - Navigating California’s Policy Process 2
 - Implementation in the Political and Fiscal Context of the Recession. 2
 - Key Decisions 3
 - 1.2. Goal Alignment 4
- Part 2 – Implementation Tasks. 5
 - 2.1. Exchange Priorities. 5
 - 2.2. Leadership – Who Governs? 6
 - The California Health Benefit Exchange Board. 6
 - The Executive Director 9
 - 2.3. Staffing. 10
 - Organizational Structure and Staff Breakdown 10
 - Information Technology Contracts 12
 - 2.4. Outreach and Consumer Education. 13
 - Outreach and Education Grant Program 14
 - Future Marketing and Outreach Efforts 14
 - 2.5. Navigational Assistance.. 15
 - Sources of Navigational Assistance 15
 - Capability of Assistance to Meet Anticipated Needs. 16
 - Types of Organizations 17
 - 2.6. Interagency and Intergovernmental Relations 18
 - 2.6(a) Interagency Relations 18
 - 2.7. QHP Availability and Program Articulation 19
 - 2.7(a) Qualified Health Plans (QHPs) 19
 - Plan Types and Network Availability 20
 - 2.7(b) Clearinghouse or Active Purchaser Exchange 20
 - 2.7(c) Program Articulation 21
 - 2.7(e) Government and Markets 21
 - 2.8. Data Systems and Reporting 23
- Part 3 – Supplement on Small Business Exchanges 23
 - 3.1. Organization of Small Business Exchanges 23
 - The Small Business Health Options Program (SHOP) 23
- Part 4 – Summary Analysis 25
 - 4.1 Policy Implications 25
 - 4.2. Possible Management Changes and Their Policy Consequences 27
- Endnotes 28

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Part 1 – Setting the State Context

1.1. Decisions to Date

In September 2010, six months after the passage of the Affordable Care Act, California became the first state in the nation to create its own insurance exchange, eventually named Covered California. In April 2011, the Board of Covered California held its first meeting. Although its fifth and final member had yet to be appointed, the Board hired an interim director and outlined an ambitious process to develop a comprehensive business plan and budget.¹

This accelerated timeline was consistent with California's desire to be, in the words of the state's Health and Human Services Secretary and Exchange Board Chair Diana Dooley, the "lead car" in implementation of federal health care reform.² Because of the speed with which it approached this task, as well as the sheer size of its coverage expansion, the decisions California has made have been influential both regionally and nationally. What has transpired in the state has had implications for other states as they addressed difficult issues, including minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs.^{3,4}

Navigating California's Policy Process

Soon after the passage of federal reform, the legislative leadership in California introduced its own bills and moved quickly to pass them. The legislation signed into law in California in September 2010 consisted of two bills. A state Senate bill established the basic governance and structure of the exchange, and a state Assembly bill outlined its activities and put in place insurance market regulations, some of which apply even to carriers that do not participate in the exchange.⁵

During the process of passing enabling legislation, leaders in Governor Arnold Schwarzenegger's administration and in the state legislature played important roles. The day-to-day activities, including drafting the Assembly and Senate bills and engaging with stakeholders, though, were led by an experienced team of legislative and administration staff, working closely with outside consultants with expertise in designing and running exchanges.⁶ This work received support from philanthropic foundations and involved the participation of a broad range of stakeholders, many of whom had been involved in insurance market reform for many years.

On one of the central issues for the exchange — whether it would serve as an active purchaser that negotiates on behalf of its enrollees — there was agreement among the political principals in the legislature and the administration. In initial conversations, Schwarzenegger made it clear that he wanted the exchange to negotiate. The political principals in the administration and legislature also agreed that they wanted to allow the Board as much flexibility as possible.

There was a great deal of accord among the principals and staff of the Democratic-controlled legislature and the Republican Schwarzenegger administration, and the legislative process moved very quickly. Nevertheless, a substantial amount of organized opposition was brought to bear at key points. The opposition to making the exchange an active purchaser was led, in particular, by Anthem Blue Cross and the California State Chamber of Commerce.

Implementation in the Political and Fiscal Context of the Recession

It was uncertain whether Schwarzenegger would sign the bill, despite the intense involvement of his team in drafting it. This was partly because the California Chamber of Commerce called the bill a "job-killer" and the governor had historically vetoed most measures so termed. There were also strong concerns expressed by members of the governor's inner circle about the impact of the program on state resources. While the federal government was paying for the development and planning of the exchange and the lion's share of the costs associated with the Medicaid expansion until 2019, the state's ongoing fiscal stress remained relevant. In early 2011, newly elected Governor Jerry

Brown proposed, and the Democratic-controlled state legislature passed, \$1.6 billion in cuts to the state Medicaid program based on the assumption that these cuts will be paired with tax increases that were by no means certain.⁷ Some observers found it difficult to square the state cutting back on its current set of commitments and activities to lower-income Californians while simultaneously planning to increase others.

With severe constraints on state resources, it was vital to develop exchange designs that offered the best chance for success. California's experience with a failed small-business purchasing pool demonstrated that there is no guarantee these entities will be successful. It is very important, in particular, to structure the markets inside and outside of the exchange to avoid adverse selection. It was also important to partner across parties and stakeholder groups, as it was in no one's interest to create a program that failed to fulfill its public purpose while simultaneously disrupting the private insurance market. Conversely, a well-designed and administered exchange had the potential to improve the entire insurance market and drive change in the medical delivery system.

Key Decisions

Establishing the Number of Insurance Markets and Exchanges

One of the first decisions states had to make is whether to have an individual insurance market outside the exchange. States that want to ensure the exchange is not affected by adverse selection can substantially reduce this concern by removing the outside market, but this decision may be politically infeasible.^{8,9} Even in California, where there was and is wide support for federal reform and a broad cross-section of stakeholders issued a report calling for a sole-source exchange, this option was not seriously considered.¹⁰ However, whether or not states eliminate the outside market, the exchange may over time swallow much of the individual market since the exchange is the only place consumers will receive subsidies.

States also had to consider the option of combining the individual and small-group exchanges. There are technical challenges to doing so, since many states have different regulations, products, and carriers for these markets. However, there are also strong policy reasons to combine the exchanges, particularly in states where exchanges will not develop a large enough risk pool. This was not a big issue in California because of the size of the state. California decided to leave its exchanges as separate pools, in part because of the distinct nature of these two markets. The California legislation specified, however, that a report be delivered to the legislature in 2018 making a recommendation about whether these markets should be merged.

Setting a Vision as an “Agent of Change”

The political principals and staff who designed the California exchange explicitly intended the Board to have significant leeway in setting and achieving goals. Jon Kingsdale, the former executive director of the Commonwealth Connector, the Massachusetts state exchange, laid out the parameters in broader terms: “The authorizing legislation embodies a vision of California’s exchange as an agent of change in the marketplace. The governance model suggests this vision, as do the provisions that empower the exchange to selectively contract with health plans and to specify benefits and cost-sharing for all qualified health plans. They suggest an active hand in shaping the market with certain policy goals in mind. The goals are not prescribed in legislation, but, instead, the board is encouraged to consider and act on such goals, rather than play a passive role.”

California made many of its major decisions prior to both the Supreme Court ruling and presidential election. However, its process signaled to other states that, even when there is broad agreement among political leadership about federal reform, it is still very difficult to pass the enabling legislation. The process of setting up an exchange is even more complex and challenging. In spite of the subsidies and provisions on elements like risk selection, exchanges are not guaranteed to succeed. Other purchasing pools in the past have failed. Federal health care reform, however, incorporates some lessons from experiences with exchanges and allows states broad leeway to develop exchanges that work for their own marketplaces.

1.2. Goal Alignment

It is very clear that California has taken an *affirming response* to the goals of federal reform in its implementation of Covered California as well as all of its other activities related to putting this sweeping legislation in place. Federal reform aims primarily to expand health care coverage to more Americans through subsidies to purchase insurance as well as an expansion of the Medicaid program for low-income people (called “Medi-Cal” in California). While the Affordable Care Act was being passed, California was already negotiating a waiver to expand its Medicaid population before 2014. The “Low Income Health Programs” provided Medicaid coverage to an additional 500,000 Californians who then joined the conventional program when the official expansion began on January 1, 2014.

California also quickly affirmed federal reform by creating its own state exchange, which exceeded significantly the threshold requirements for a state-based exchange. California chose to make this exchange an “active purchaser” and took significant steps (documented below) to create a “no wrong door” system for accessing insurance coverage. The Exchange Board also standardized the insurance products offered through this marketplace, which is permitted but not required by reform. The goal, aligned

with the high-level goals of reformers, was to create a simpler shopping experience for customers in order to unleash the power of informed choice and to give them greater clarity regarding the coverage offered by each insurance product.

Covered California has also sought to affirm and expand the commitment within federal health care reform to use purchasing power to improve the system of delivering health care, as well as to expand the number of people with coverage. Covered California has joined the Pacific Business Group on Health (PBGH) as an affiliate member. In addition to being a senior official at the Center for Medicare & Medicaid Innovation, Covered California Executive Director Peter Lee was the former executive director of PBGH. This coalition of large purchasers is committed to delivery system reform and, in particular, to increasing price transparency within the health care system. It has not always been possible for Covered California to implement transparency reforms as quickly as some of the members of the executive leadership and the Board have stated that they would prefer. Due to concerns about the differences in the networks of doctors and hospitals offered on Covered California, quality transparency information will not be immediately available to consumers. The exchange has a “Plan Management and Delivery System Reform” advisory group and is expected to take significant steps in coming years to attempt to use its purchasing power to drive down costs and improve quality.

Part 2 – Implementation Tasks

2.1. Exchange Priorities

California’s legislation established an exchange structure consistent with recommendations of Washington and Lee University law professor and leading health policy expert Timothy Jost that the entity “should be placed within an independent agency, which should be explicitly exempted, as necessary, from specific state administrative law or government operations requirements.”¹¹ Critically, the enabling legislation grants the exchange some exemptions to state personnel and contracting procedures and gives its Board the power to promulgate regulations on an emergency basis for two years. There was very little disagreement on this point among the main political actors in the state. They agreed a nonprofit structure would be unlikely to provide adequate transparency and accountability to the public. This, in turn, could undermine the exchange’s legitimacy.

There are important trade offs involved in this choice, however. The state’s government-run, small-business purchasing pool, the Health Plan of California, was transitioned after several years to the nonprofit Pacific Business Group on Health. Although this venture was ultimately unsuccessful, it was viewed as better run and more tightly managed when it was operated by a nonprofit. The decision-making process became shorter and faster, leading

to a substantial increase in responsiveness to market changes. Some stakeholders pointed out that one of the main reasons this purchasing pool had to be shut down was that its transition out of state control disconnected it from the policy process. This prevented state policymakers from having adequate notice to make legislative or regulatory changes that could have kept the pool viable, including, for example, the price parity requirements ultimately included in federal reform.

The experience with California's public programs, as well as within the Massachusetts and Utah exchanges, suggests that there will be instances in which the state will look to partner with other entities. One influential deciding factor was the tight timeline necessary to get up and running. Many of the California Health and Human Services Agency staff wore "2014 Is Tomorrow" buttons. Creating an exchange was a massive undertaking, even for a state like California that had a significant jump on the process.

2.2. Leadership – Who Governs?

The California Health Benefit Exchange Board

The California Health Benefit Exchange five-member Board of Directors is made up of appointees of the governor and the state legislature who serve four-year terms. Two Board members are appointed by the governor, one is appointed by the Senate Rules Committee, and one is appointed by the speaker of the Assembly. The secretary of the Health and Human Services Agency, or the secretary's designee, serves as an ex-officio voting member of the Board. The Board first met in April 2011 and has held more than thirty-eight meetings since then.¹²

The need for nimble participation in the market was also one of the main reasons for having a five-member Board – a much smaller Board than the marketplaces in Massachusetts, Oregon, and Washington.¹³ The California statute also has very strong conflict-of-interest provisions for the Board and does not allow anyone who currently draws money from an entity that could receive funding from the exchange (e.g., a provider or carrier) to serve as a member. However, the staff who designed this provision subsequently commented that they regretted making the conflict-of-interest provisions so stringent.

An analysis performed for the California Chamber of Commerce strongly critiqued the leeway given to the California Health Benefit Exchange Board. Specifically, it raised the concern that the Board's activities could create significant general fund liability for the state by increasing the scope of essential benefits and by unilaterally enrolling people in the state's Medicaid programs.¹⁴ Independent groups, including the nonpartisan Legislative Analyst's Office, pointed out that this conclusion appeared to be in direct contradiction to the plain language of the statute, which was written to protect the general fund; left authority to determine mandated benefits with the legislature; and required the exchange to

coordinate with existing public programs on issues of eligibility and enrollment.^{15,16}

Diana S. Dooley, Chair

The current chair of the board, Diana Dooley, was appointed as the Health and Human Services secretary by Brown in 2010. Dooley began her career as an analyst with the State Personnel Board and has worked as legislative director and special assistant to Brown. She has been an owner of public relations and advertising agency, a private practice lawyer, and general counsel and vice president at the Children's Hospital Center. She has also served on the Board of Directors for the UC Merced Foundation, Blood Source of Northern California, and the Maddy Institute at California State University, Fresno and as past president of Planned Parenthood, the Visalia Chamber of Commerce, and the Central California Futures Institute. Dooley is a native of Hanford, California, and holds a bachelor's degree in social science from California State University, Fresno, and a law degree from San Joaquin College of Law.¹⁷

Kimberly Belshé

Kim Belshé is executive director of First Five LA, an organization that has invested more than \$1 billion from tobacco tax revenues in the last twelve years to increase the number of Los Angeles County children ages 0 to 5 who are physically and emotionally healthy, ready to learn, and safe from harm. Previously, she was senior policy advisor with the Public Policy Institute of California and has held leadership positions in state government, where she has led efforts to improve the health and well-being of Californians in underserved communities. She served as the secretary of the Health and Human Services Agency under Schwarzenegger, as director of the Department of Health Services, and as deputy secretary of the Health and Welfare Agency under Governor Pete Wilson. She also serves on the Kaiser Commission on Medicaid and the Uninsured and has previously served on the Board of the Great Valley Center. Belshé was appointed to the Board by Schwarzenegger and will serve her term until January 2015. Belshé is a native of San Francisco, California, and holds a bachelor's degree in government from Harvard College and a master's degree in public policy from Princeton University.¹⁸

Paul E. Fearer

Paul Fearer was appointed to the board in March 2011 by Speaker of the Assembly John A. Perez and was reappointed to serve until January 2017. Fearer has worked as senior executive vice president and director of human resources of the UnionBanCal Corporation and its primary subsidiary, Union Bank N.A., since 1996. He has also served on the bank's executive management committee, as the deputy director of human resources services with Stanford University, as chair of the board of

directors of the Pacific Business Group on Health, as chair of the executive committee of the Financial Services Group, on committees of the board of the Robert Rauschenberg Foundation in New York City, and as chair and a member of the PacAdvantage small business health benefit exchange. Fearer received a bachelor's degree from the Massachusetts Institute of Technology and did graduate studies at Stanford University.¹⁹

Susan Kennedy

Susan Kennedy was appointed to the Board by Schwarzenegger after working as his chief of staff and will serve her term until January 2015. Kennedy has also served as deputy chief of staff and a cabinet secretary for Governor Gray Davis, as communications director for Senator Dianne Feinstein, as executive director of the California Democratic Party, and as a commissioner on the California Public Utilities Commission. Kennedy was a leader in Schwarzenegger's health reform initiatives, which passed the state Assembly in 2007, but failed to pass in the state Senate. Schwarzenegger's plan was similar to the Affordable Care Act with the requirement for individuals to purchase health insurance coverage, a ban on denying coverage for pre-existing conditions, and the expansion of tax credits and programs for low-income families. Kennedy owns her own consulting firm in San Francisco and is currently a special advisor with the Berkeley Research Group, a senior policy advisor with the law firm of Alston & Bird, and an external advisor to McKinsey & Company. Kennedy graduated from Saint Mary's College with a degree in management.²⁰

Robert Ross, M.D.

Dr. Robert Ross was appointed to the Board by the Senate Rules Committee in June 2011 and will serve through January 2016. Dr. Ross also serves as president and chief executive officer of the California Endowment, a foundation established in 1996 to address Californians' health needs. Before working with the California Endowment, Dr. Ross was director of the Health and Human Services Agency for the County of San Diego and commissioner of public health for the City of Philadelphia. He has also served with the Rockefeller Philanthropy Advisors and as cochair of the Diversity in Philanthropy Coalition. Dr. Ross has been a Board member of the USC Center on Philanthropy and Public Policy, Grantmakers in Health, the National Vaccine Advisory Committee, the National Marrow Donor Program, the San Diego United Way, and the Jackie Robinson YMCA. He is a diplomat of the American Academy of Pediatrics, served on the President's Summit for America's Future, and was a chairman of the national Boost for Kids Initiative. Dr. Ross received his bachelor's and master's degrees in public administration and his medical degrees from the University of Pennsylvania in Philadelphia.²¹

The Executive Director

The Board hired its first executive director, Peter Lee, in August 2011. The executive director reports directly to the Board and is responsible for providing leadership and direction, formulating the exchange's strategic objectives, and maintaining effective relationships and communication with key stakeholders, and the executive and legislative branches of the federal and state government. In particular the executive director:

- Manages the planning, development, implementation, and ongoing administration and evaluation of exchange programs.
- Provides the overall direction and supervision to the executive staff of the exchange in carrying out program goals and objectives.
- Manages the entire staff of the exchange, including eligibility and enrollment staff, purchasing and negotiation staff, and administration and operations staff.
- Advises the Exchange Board on key policy and operational issues.
- Ensures the smooth operation of programs and operations under the Board's jurisdiction.
- Establishes liaison and ongoing communication with stakeholders and the executive and legislative branches of state government with responsibilities related to the duties of the Board and other health coverage issues.
- Advances the mission of the exchange through legislation, program administration, research, and other means, as appropriate.
- Maintains strong liaison and good communication with the executive and legislative branches of state government involved in health coverage issues.
- Assures compliance with applicable state and federal legal and regulatory requirements, including public meeting laws, federal expenditure requirements, and state personnel policies.
- Represents the exchange and its mission and programs at national, state, and local meetings and forums; in the media; and at legislative hearings.²²

Peter V. Lee

Lee was confirmed by a unanimous vote of the Board to his position as executive director on August 23, 2011. Prior to his appointment, Lee was the deputy director for Medicare & Medicaid Innovation at the Centers for Medicare & Medicaid Services in Washington, D.C., the director of delivery system reform for the Office of Health Reform in the U.S. Department of Health and Human Services, CEO and executive director of the Center for Health

Care Rights, and director of programs for the National AIDS Network. Before working in the public sector, he was an attorney in Los Angeles. Lee holds a bachelor's degree from the University of California, Berkeley, and a law degree from the University of Southern California.²³

2.3. Staffing

California's current law prohibits the use of the general fund to establish or operate the exchange. As a result, the Board has pursued federal grants as a primary funding source for its programs through 2014 and has received more than \$910 million for research, planning, information technology development, and implementation of the exchange. Since the exchange must be self-sustaining from charges assessed on qualified health plans and other supplemental products by 2015, the Board has budgeted for the first years of operation based primarily off these grants.

The exchange also currently utilizes accounting and administrative services from the California Department of Social Services to assist in meeting its federal financial reporting requirements. The exchange expects to create internal policies and procedures and to transition these functions as additional staff positions are available.²⁴

Overall, the exchange expects to directly employ nearly 1,000 staff, although hiring efforts throughout 2013 were relatively slow. Plans for three service centers located in Contra Costa, Fresno, and Sacramento counties were expected to require almost 800 staff — 350 of which should have been hired by May 2013. However, by June 2013, the exchange had made only forty-four hiring offers for these service center positions and was awaiting authorization from the legislature to perform background checks on subsequent hiring offers. When Senate Bill 509 became effective in June 2013, allowing the exchange to require fingerprinting and background checks as a condition of employment for both contracted and state employees, hiring efforts resumed at an increased rate.²⁵

Employees of the exchange are state employees subject to civil service requirements and are hired under job classifications specified by California law. In its federal grant requests, the exchange has requested funding for positions in a range of classifications, including accountants; program, budget, legal, and information systems analysts; systems software, research program, and personnel specialists; staff services and data processing managers; and a variety of career executive assignment positions for executive level division managers.

Organizational Structure and Staff Breakdown

The Health Benefit Exchange has seven main divisions: operations, finance, product development and sales, legal, program policy, communications and public relations, and government

relations. The operations division is the largest with more than 800 employees. This division includes the chief deputy executive director, with an expected staff of fifty-two; a deputy director of eligibility and enrollment, with thirty-four staff; a chief technology officer, with fifty-five staff; and the deputy director of the service centers, with an expected staff of 660.

The finance division, currently supported through borrowed staff from the California Department of Social Services, is expected to have at least fifty-five employees under a chief financial officer. The product development and sales division contains two branches, a director of the small business health options program with seven staff, and a director of health plan management, with twenty staff. The legal division is managed by the chief counsel and has twelve staff, while the program policy division has nine staff and is managed by a director of program policy. The communication and public relations division is overseen by a director of communications and public relations with a staff of forty-seven. The government relations division has only four staff under a director of government relations.²⁶

The service center branches in Contra Costa and Sacramento counties began operating in September 2013 and the third branch in Fresno became operational in November 2013. The exchange manages and operates the service centers in Fresno and Sacramento counties and partners with Contra Costa County's Department of Social Services to manage the Contra Costa service center. Although Contra Costa is responsible for hiring its own staff, the exchange will train their staff and provide oversight, policy, and procedures.

The Fresno and Rancho Cordova (Sacramento County) service centers will each employ 500 staff members, who are primarily state employees, while the Contra Costa service center will have about 200 county staff. Staff members will provide information, answer questions, or refer clients to outside resources either by phone or through online real-time "chat" systems. Due to the diverse population in California, the exchange has hired staff members who speak English, Spanish, Mandarin, Vietnamese, and a variety of other languages, and has devices for the deaf and hearing impaired, to support clients who have questions about coverage options or need help with enrollment.²⁷

In its July 2013 report to the legislature, the California State Auditor initially expressed doubt that the Health Benefit Exchange would meet its hiring goals due to delays in the process; however, the service centers began handling statewide calls on November 18th with a relatively modest complement of 407 staff. However, the exchange has conducted several waves of hiring in order to meet its staffing goals and, as of the end of November 2013, 611 staff had been hired out of the total target of 810.²⁸

At its peak on the first day of operation, October 1, 2013, the service centers took 23,270 calls, although average daily workloads during October were between 7,000 and 8,000 calls.

Of the more than 200,000 calls received in October, 89 percent were English callers, 8 percent were Spanish clients, 2 percent were Asian language clients, and 1 percent spoke other languages. About half of the non-English speaking clients are handled by exchange staff and the remaining half are served by contracted language representatives. Although the service center maintains goals of 80 percent of calls answered within thirty seconds, 3 percent or less of calls abandoned, and 0 percent of calls receiving busy signals, the data from October demonstrated that staff were only able to answer between 21 and 58 percent of calls within thirty seconds and between 42 and 10 percent of all calls were abandoned.²⁹ The service centers are rapidly improving their capacity on a week-by-week basis and can be expected to meet their performance goals once the agency is fully staffed in 2014.

Information Technology Contracts

The exchange also relies on the implementation of a large information technology project, the California Health Eligibility and Enrollment and Retention System (CalHEERS), which is a shared system between the exchange, the Department of Health Care Services, the Managed Risk Medical Insurance Board, and other stakeholders. The system streamlines how individuals and businesses obtain health coverage by providing eligibility and enrollment services online and through the call center platform. The exchange obtained project management services from the California Health and Human Services Agency's Office of Systems Integration along with an independent consultant to review the work of its systems developer. The exchange's contract for development of the CalHEERS system was competitively bid throughout 2012, until the contract was awarded to Accenture in November 2012. This contract included the design, development, implementation, and support of the software and equipment necessary to operate the three service centers, including functions required for a call center platform, and a planned roll out using two releases at a cost of about \$183 million for initial development and \$176 for maintenance and support over the following three and a half years.

In July 2013, an initial release allowed clients to access a Web portal that provided a method to shop for and compare health plans. In October 2013, a second release allowed individuals to check eligibility for Medi-Cal, Healthy Families, or subsidized coverage on the exchange.³⁰ As a key interface with both internal systems and the public, the second release Web portal experienced more than one million unique visits in its first week of operation and a total of 2.2 million visits through October 2013.³¹

2.4. Outreach and Consumer Education

The exchange has conducted extensive marketing and outreach programs to reach targeted populations, meet federal and state requirements, and increase enrollment in the exchange. In connection with the California Department of Health Care Services, the exchange planned its marketing and outreach campaign around the following goals:

- Provide a one-stop marketplace for information and enroll uninsured Californians in affordable, high-quality plans.
- Provide Californians with educational materials to help them understand the benefits of health insurance coverage.
- Encourage currently insured Californians to continue their health insurance coverage.
- Ensure that affordable health care coverage is available for all Californians.³²

To support these goals, the exchange identified the core audience of approximately 5.3 million uninsured Californians, 2.6 million of which may qualify for federal subsidies, where the marketing and outreach campaigns could be focused for the greatest effect. Using available demographic information, the agency further refined its outreach strategies based around the idea that different groups will have different needs and motivations. This led the agency to take multiple approaches to market the exchange to groups based around age, gender, income level, and race or ethnicity. The agency worked to provide both statewide and targeted local outreach and marketing through partnerships with community-based organizations and paid media campaigns.³³

The outreach campaign was split into seven phases beginning in September 2012 through December 2015. Phase I, which involved research, media planning, creative development, partnerships, and social media, provided the build-up to Phase II and was completed by January 2013. Phase II, which encompassed the first phase of consumer outreach and education, ran until July 2013. It primarily involved the development of a comprehensive media plan and the establishment of connections with community-based organizations to educate consumers about the available health insurance options. As part of this second phase, the exchange's paid media campaign was launched in June 2013, with a wide variety of print, radio, social media, and television advertisements designed to educate consumers and small businesses about the exchange, the availability of federal subsidies, and the types of health plans on the marketplace. The exchange assessed the effectiveness of this first marketing blitz and planned for adjustments to its future marketing efforts, according to the available information.³⁴

Outreach and Education Grant Program

The outreach and education grant program, part of the Phase III marketing campaign beginning in July 2013, was the primary method to promote public awareness among consumers and small businesses. Out of about 200 applicants, the exchange awarded more than \$36.3 million in grants to forty-eight groups that included community-based organizations, health clinics, and government entities. The agency expects that between July 2013 and December 2014, the grantees will reach about nine million consumers and more than 200,000 small businesses to help address the barriers that prevent consumers and small businesses from purchasing health insurance coverage. Grantees are required to comply with the exchange's evaluation and monitoring plan, which includes completion of reports, monthly site visits, and thorough records of expenditures and activities. This plan also includes a mechanism to correct deficiencies when grantees fail to meet pre-existing targets and can result in the termination of the grant, if identified deficiencies are not corrected within a thirty day evaluation period.

In addition, four grantees – the California Academy of Family Physicians, the California Medical Association Foundation, the California Society of Health System Pharmacists, and the National Council of Asian Pacific Islander Physicians – were awarded grants to provide outreach and education to health care professional organizations and associations.³⁵

Future Marketing and Outreach Efforts

In order to continue its marketing efforts for Phase III and beyond, the Health Benefit Exchange contracted with Weber Shandwick, a global public relations firm, in May 2013 to provide a creative marketing and paid media campaign through April 2015. Beginning in September 2013, the firm was tasked with overseeing the use of \$86 million to advertise the exchange's programs with a \$12 million contract fee to cover the firm's development costs. The exchange has also retained the Ogilvy Public Relations group to support its media campaigns for Phase III through December 2014.³⁶

Overall, the exchange has allocated a large amount of the federal funds towards these marketing and outreach campaigns. In 2013, the marketing budget was about \$89 million, or 24 percent of the total budget, and in 2014 the agency expected expenditures to rise to \$106 million, or 28 percent of its overall budget. On the whole, the California State Auditor has found that the exchange's outreach plan is both deliberate and thorough and that it appears to meet state and federal standards.³⁷

2.5. Navigational Assistance

Sources of Navigational Assistance

In addition to the self-service functions available through on-line resources and the live chat and phone operators, the exchange also partners with a variety of entities to provide assistance and information on health plans, enrollment, and subsidies. Certified educators, who attended two and a half days of training from the exchange in July and August 2013, are expected to disseminate clear, accurate, and consistent information that will help to remove barriers that might prevent consumers and small businesses from applying for coverage through the exchange.

In addition, certified enrollment counselors were training during October 2013 to provide individual assistance to consumers who are attempting to enroll. California's assister program provides one-on-one, in-person assistance to help consumers learn about their health insurance options and to reduce any potential barriers to access. However, the assistance program also encompasses outreach and education, and there is no firm line demarcating these two program areas. The in-person assisters and navigators fulfill two very similar roles with differences only in the types of funding, compensation, and timelines involved.

In-person assisters began operating prior to the initial enrollment period in October 2013. They are funded through federal grants and receive a flat fee of \$58 for each successful application, or \$25 for a successful annual renewal. Navigators are paid from the exchange's operating funds, receive ongoing grants, and began operating only after the initial enrollment period started in October 2013.

Entities that are eligible to receive compensation as part of the navigational assistance program include American Indian tribes, attorneys, chambers of commerce, city governments, industry organizations, community clinics, community colleges, and universities. In addition, consumer assistance is also expected to be provided by outside public and private entities such as insurance agents, hospitals, commercial clinics, or county health departments that do not receive compensation from the exchange.³⁸

Individuals are able to apply for the federal subsidy in person or by contacting local agencies by phone and they may also obtain paper copies of the application to complete and submit at their convenience. The exchange has also worked with the California Department of Health Care Services to ensure that local county health agencies play a large part in enrolling eligible individuals. As a part of this effort, county workers were also trained to use the exchange Web site to determine eligibility for Medi-Cal benefits.³⁹

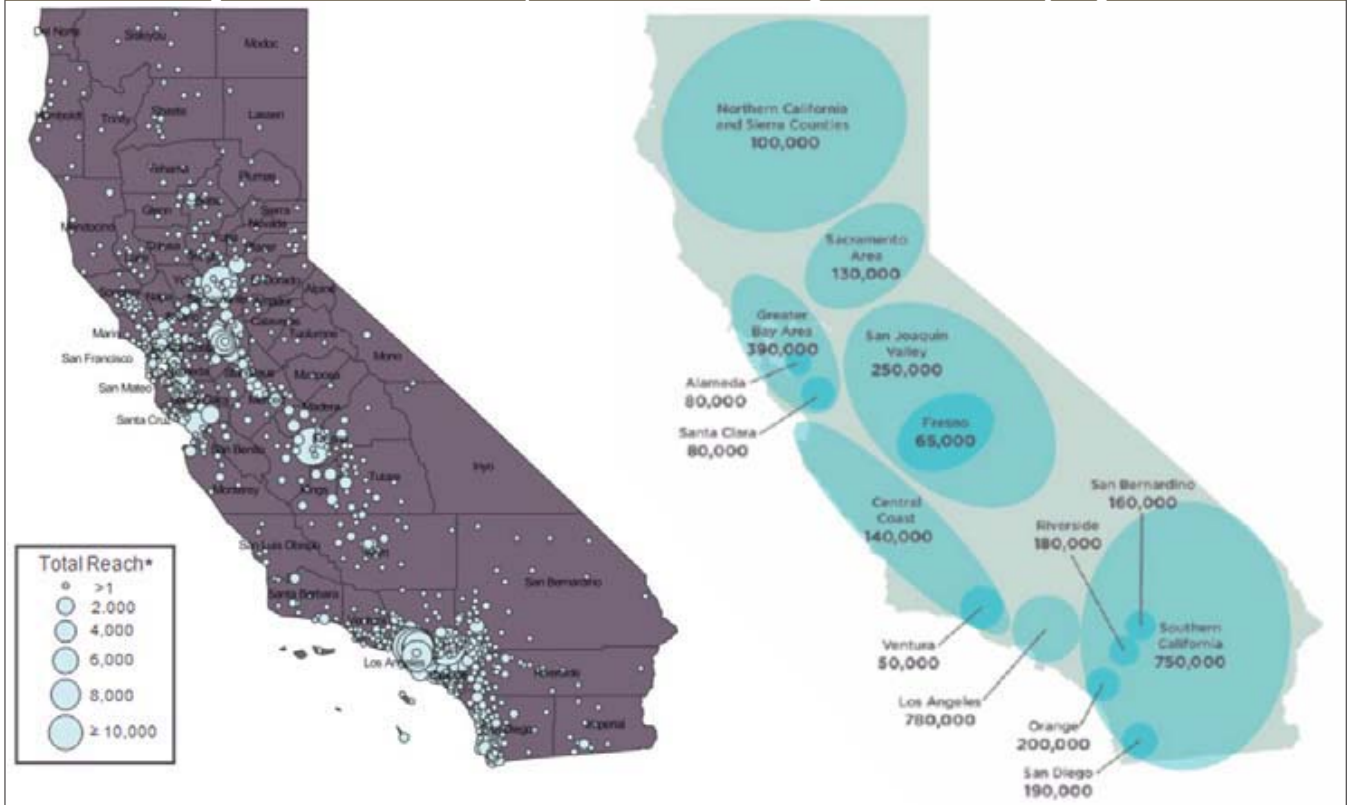
Certified licensed agents who represent the exchange were also trained to sell health insurance plans in both the individual and small-business markets. The certified insurance agents may enroll individuals through the exchange and receive market-rate commissions for such enrollments.⁴⁰

Capability of Assistance to Meet Anticipated Needs

The Health Benefit Exchange currently has more than 600 staff members in its service centers who are available by phone or through live online chats. In addition, more than 2,500 certified educators and more than 5,000 certified enrollment counselors were trained across the state to provide education and enrollment information to consumers. More than 19,000 certified licensed agents also registered with the exchange to help enroll Californians during the 2013 open enrollment period. Through a partnership with the California Department of Health Care Services, the exchange has also trained more than 10,000 county eligibility workers to assist consumers in enrolling for health insurance through the exchange marketplace. The exchange Web site also contains many self-service tools designed to allow individuals to choose an appropriate health plan, as well as a section with online community events where Californians can talk to certified educators about the benefits of the exchange’s products.⁴¹ As Figure 1 displays, grantees are expected to reach approximately nine million Californians and more than 200,000 small business owners throughout California.⁴²

After the first grant process is completed, the exchange plans to conduct an analysis of the grantee results to identify gaps in outreach or education in specific geographical areas or target populations and use this information to administer a second set of grants in 2014. Based on its research, the exchange expects that 50 percent

Figure 1. Grantee Reach Comparison to Individuals Eligible for Subsidies by Region⁴¹



of consumers will need assistance from its network of more than 21,000 individual assisters from more than 3,600 entities.⁴³

Types of Organizations

As mentioned above, the exchange has awarded forty-eight grants to promote outreach and assistance. Table 1 provides a

Table 1. Outreach and Education Grantees⁴³

2-1-1 San Diego	Community Health Councils
Access California Services	Council of Community Clinics
AHMC Health Foundation	East Bay Agency for Children
Asian Americans Advancing Justice - Los Angeles	Fresno Healthy Communities Access Partners
Bienestar Human Services, Inc.	John Wesley Community Health (JWCH) Institute, Inc.
Cal State LA University Auxiliary Services, Inc.	Loma Linda University Medical Center
California Black Health Network	Los Angeles County Federation of Labor, AFL-CIO
California Council of Churches	Los Angeles Unified School District (LAUSD)
California Family Resource Association(CFRA)	NAACP (California National Association for the Advancement of Colored People)
California Health Collaborative	Planned Parenthood Mar Monte, Inc
California Rural Indian Health Board, Inc.	Redwood Community Health Coalition
California School Health Centers Association	Sacramento Covered
Catholic Charities of California, Inc.	Sacramento Employment and Training Agency (SETA)
Central Valley Health Network	San Bernardino Employment and Training Agency (SBETA)
Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA)	Santa Cruz County Human Services Department
SEIU Local 521	The Regents of the University of California
SEIU United Long Term Care Workers	UC Davis, Center for Reducing Health Disparities
Social Advocates for Youth (SAY), San Diego, Inc.	United Ways of California
Solano Coalition for Better Health	University of Southern California
St. Francis Medical Center of Lynwood Foundation	Valley Community Clinic
The Actors Fund	Ventura County Public Health
The East Los Angeles Community Union	Vision y Compromiso
The Los Angeles Gay and Lesbian Community Services Center	Women’s Health Specialists

complete listing of all forty-eight groups that were awarded grants as of August 2013.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations

Exchanges are designed to facilitate access to private insurance and public programs. The Affordable Care Act directs exchanges to determine eligibility for public programs for people who interact with them. The state of California expanded on these responsibilities. Specifically, the Board is required to “coordinate ... eligibility, enrollment, and disenrollment ... with state and local government entities administering other health care coverage programs ... and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.”⁴⁵

This topic has inspired a great deal of conversation in California. It was identified by the California Department of Health and Human Services as one of the key opportunities in federal reform. According to a state planning document, “important policy and information technology systems issues will need to be carefully considered, including how the exchange’s eligibility and enrollment functions will interact with Medi-Cal (i.e., California’s Medicaid program), Healthy Families, and other public programs.”⁴⁶

Coordination among public programs was a complex issue in California even before the advent of the exchange. California is one of eight states with a stand-alone children’s health insurance program and, like many other states, it has a host of additional programs to assist specific populations such as women and infants, and children in need of specialty care. Because of the complexity of the market and the number of varying interests involved, California did not submit an application for a federal “Early Innovator” grant. These grants are for states that plan to use their exchanges to engage in technologically innovative methods to coordinate between public programs and private insurance coverage.

Almost every task that is expected of the exchange, including consumer protection, risk management, and coordination with public programs, will require the development of new health information technology solutions and careful work to guarantee that these technologies interface seamlessly with legacy systems. Fortunately, a great deal of work has already been done. In California, this includes work on the Health-E-App and One-E-App systems. To as great an extent as possible, given the tightly compressed timeline of implementation, states and the federal government should build on existing efforts.⁴⁷

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs)

Participation and Competitiveness

Thirty-two health insurance companies expressed interest in offering individual plans on California's Health Benefit Exchange in late 2012. Thirteen were tentatively approved to offer coverage in the first open enrollment beginning on October 1, 2013. Of the thirteen, four — Anthem Blue Cross, Kaiser Permanente, Blue Shield of California, and Health Net — covered more than 80 percent of individuals insured in California's individual market in 2013.⁴⁸ However, a number of small, regionally based insurers also chose to participate and were approved to offer coverage, including: Chinese Community Health Plan, L.A. Care Health Plan, and Valley Health Plan.

In the months leading up to open enrollment, one of the original thirteen plans approved to offer coverage through the exchange would not sign a final contract, and another would be dropped for regulatory reasons. Ventura County Health Care Plan (VCHCP) announced in August of 2013 that it would not be offered on the exchange for 2014, citing an "ongoing analysis of enrollment projections, start-up costs and certain factors whose outcome and impact are difficult to predict." The plan has indicated it hopes to offer plans in 2015. However, its departure highlights the difficulties and relative high cost smaller plans face.

In November 2013, it was announced a second of the original thirteen approved plans would not be sold on the state's exchange. Alameda Alliance for Health, a public nonprofit county health plan, was removed from the list of approved plans for failing to meet financial solvency requirements set by the Department of Managed Health Care. Alameda Alliance plans had been on the exchange site since open enrollment began October 1, so prospective enrollees had to be informed they would need to choose another plan. Like VCHCP's departure, the removal of Alameda Alliance four weeks after the start of open enrollment is indicative of the pace of reform implementation.

Notably absent from the list of companies expressing interest in offering plans on the exchange were prominent health insurers UnitedHealth, Aetna, and Cigna. With UnitedHealth — the nation's largest insurer — and other big names choosing to remain out of the state's exchange, stakeholders and the media questioned competitiveness in the marketplace. However, while UnitedHealth, Aetna, and Cigna are large national insurers, together they represented only 7 percent of California's individual market prereform.⁴⁹ Participation by both the "big four" in California, as well as a surprising number of midsize and small insurers, guaranteed that the exchange would have adequate competition.

Plan Types and Network Availability

Eleven insurers were offering plans on California's exchange as the deadline to obtain coverage by January 1 approached. Consumers in all of California's urban areas have a range of options for plan type, including HMOs, PPOs, and EPOs. A large number of California's rural counties also have robust choice, with only a select few lacking one of the three plan types available to urban consumers.

However, the nature of federal reform — including the elimination of medical underwriting — as well as California's decision to be an active purchaser in order to hold down premiums meant insurers were likely to significantly narrow networks for 2014. Prior to, and even during, the early months of open enrollment it was unclear to stakeholders and consumers how narrow the networks would be.

Covered California issued a press release in December 2013 saying more than 80 percent of the state's physicians were included within plans sold on the exchange, as well as more than 360 hospitals.⁵⁰ However the networks of individual plans are much smaller. Blue Shield of California, covering around 20 percent of California's individual market, said 2014 plans would include only 50 percent of the physicians it included in 2013. Consumer reactions are likely to play a large role in the development of plan networks in future years.

2.7(b) Clearinghouse or Active Purchaser Exchange

Because California has a tradition of active purchasing through its children's health insurance program, small-business purchasing pool, and state-employee purchasing pool, policymakers were building on an established history. The lesson for other states, however, is not necessarily that they should all make their exchanges active purchasers. Rather, they should let the decision in this critical area be driven — as California's was — by the experiences of their state, as well as by the nature and structure of their private insurance markets.

For an exchange to be successful it must have broad public support and be able to attract an adequate number of covered lives. California is distinct in important ways from other states both politically and demographically. In other states, an exchange may have to work hard to attract 100,000 people to the pool. This size is critical if the entities want to avoid getting "upside-down" on risk and to keep the administrative load per enrollee to a minimum. This is less of a problem in California where it is likely that the exchange will have at least one million to two million lives in private insurance coverage served by five or six major insurers, regardless of the choices it makes.

There are some cautionary lessons from California's experience in selective contracting. Chiefly, it is not primarily the size of a group that determines rates. Cost and utilization of health care services among enrollees is a major driver of rates. For example,

the state public employee retirement system, CalPERS, is one of the largest health care purchasers in the country, but the high prevalence of chronic disease among state workers, and their higher relative age, drives rates up for this group.

Having many different carriers participating in a marketplace increases competition. But having a smaller number of carriers presents the potential for partnerships through the development of strong relationships over time. In California, state employees in the Sacramento region have access to a virtually integrated delivery system, a partnership between Blue Shield of California, Catholic HealthCare West, and Hill Physicians group. This alliance has kept premiums stable for the employees who choose it and has been working to integrate the different systems and improve quality of care.⁵¹ According to the terms of the arrangement, the insurer, hospital system, and physicians' association were given autonomy to redesign their care delivery systems to promote better coordination and improve efficiency. For example, they worked to eliminate redundancies, such as having the same patient participate in multiple chronic disease management programs. At the end of the pilot period, CalPERS estimated it saved \$15.5 million through this "active purchasing" partnership and said it plans to expand the program.⁵²

2.7(c) Program Articulation

From the earliest phases of design, California pursued a "no wrong door" approach to exchange articulation with existing and future programs. One of eleven states working in cooperation with the federal government on Enroll UX 2014 — a set of design prototypes aimed at adopting best practices into the user experience — California ensures consumers are directed to any program for which they may be eligible.⁵³ Covered California's online portal allows consumers to directly enroll in individual and family coverage, Medi-Cal, and SHOP plans. The Web site can also direct individuals to California's online voter registration site. Consumers are not able to enroll in Medicare through the portal.

2.7(e) Government and Markets

In every state, exchange boards will have to be very active in mitigating adverse selection among plans in the exchange, between the exchange and the outside market, and across market segments (e.g., individual, small-group, self-insured). Adverse selection occurs when actions by insurers or enrollees deliberately or inadvertently lead to an insurance risk pool of people who are substantially less healthy and more costly to insure. Once a poor risk profile has been developed for a particular product, it is difficult for the risk-bearing entity to remain financially viable. A review of the state's experience with its small-business exchange emphasizes the importance of avoiding adverse selection and warns that "very strong measures are needed to prevent exchanges from falling into a death spiral."⁵⁴

The Affordable Care Act has several provisions that differentiate its exchanges from voluntary purchasing pools such as PacAdvantage. First, an exchange is the only place in which individuals and businesses can receive subsidies and tax credits, which will create a “captive audience.” This makes it less likely that the exchange will be selected against by the outside market because — particularly in states like California — the group is likely to be large enough to have an acceptable risk profile. Second, carriers within an exchange are required to offer products only at specified actuarial values (i.e., catastrophic, bronze, silver, gold, and platinum). This will help consumers make meaningful comparisons among products and may somewhat reduce the likelihood that plans will be adversely selected against within the exchange. Further, insurers are required to offer the same products at the same price both within and outside of the exchange. This also helps reduce selection against the exchange. The carriers who participated in PacAdvantage were unwilling to offer the same price for the same product. This requirement has the important implication, though, that there can be no price advantage because of negotiating clout or administrative efficiencies for participating in the exchange.

Some carriers expressed concern that the structure created by these regulations will mean that price negotiated by an exchange will effectively set prices for the rest of the products within and outside this market. They believe that because the rating factors allowed are very specific, any price change in a market segment for any product may require price changes for all the other products in the portfolio. The rating factors that are allowed are now limited to a very small set, including age and tobacco use.

The full impact on market dynamics and prices is yet to be determined. It is clear, though, that elements of the reform law — in particular those related to exchanges — will have unforeseen implications for the private insurance market. There may also be significant consequences for providers who depend on payments from private insurers that participate in the exchange. In the individual market, where an exchange will have a long-term captive audience because of the subsidies, these new purchasing pools may indeed set prices for the market. The exchange cannot negotiate a better price exclusively for its enrollees, but its activities may bring down the price for all participants in the individual market. In the small-group market, on the other hand, the exchange may not have as great an effect on the prices in the market since the tax credits are of limited duration and there is no requirement for employers with fewer than fifty employees to offer coverage. Overall, the requirement that prices be equal inside and outside the exchanges means the California exchanges are less likely to be subject to adverse selection, but it also takes away an important putative advantage — lower prices.

California built upon federal legislation to reduce the likelihood of adverse selection within and against the exchange. First,

while the federal legislation requires plans to offer only the silver and gold levels of coverage within the exchange, California requires plans to offer all levels of coverage. Critically, this requirement relates to plans whether or not they participate in the exchange. Therefore, there will be a direct comparison across all carriers in the market at these actuarial values. The exception to this is related to the second important regulation that California put in place: the restriction that plans can only offer the catastrophic coverage product – and access the relatively young and healthy enrollees to whom this product will appeal – if they participate in the exchange.

The federal law also includes a provision on statewide risk adjustment that applies to plans both in and outside an exchange. In theory, this should eliminate most concerns about adverse selection because plans that have unhealthier pools will receive money from those with healthier ones. However, there are important caveats because risk adjustment, even under ideal circumstances, is imprecise. There is some disagreement as to whether it was done effectively in the past, for example, within California's small-business purchasing pool.⁵⁵ But even assuming risk adjustment is done perfectly, it is designed to smooth differences within relatively narrow bands. If carriers' payments to each other become very large proportions of total revenues, this may undermine the entire model. The subsidies paired with risk adjustment, therefore, will not guarantee success for an exchange either in terms of fulfilling its public purposes or succeeding as an entity operating within the private market. Therefore, states should give serious consideration to adopting the further steps that California took to reduce adverse selection.

2.8. Data Systems and Reporting

Data systems and reporting are still in development.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

The Small Business Health Options Program (SHOP)

There is enthusiasm among small business owners in California about the promise of the small-group exchange in spite of the state's uneven experience with purchasing pools. According to John Arensmeyer, CEO of Small Business Majority, "When we tell small business owners about the exchange provisions in the Affordable Care Act, there is tremendous interest, and one-third say that an exchange will make it more likely that they will offer coverage." On the other hand, there is no penalty in the law for groups with fewer than fifty employees that do not provide insurance. Some have discussed the possibility of ceasing to offer insurance in favor of increasing employees' salaries, many of whom

would qualify for subsidies to purchase insurance on the individual exchange.

The primary value proposition of small group exchanges has been a broader range of choice for employees than is traditionally offered within the outside market where insurers place strict participation requirements on small groups. In California and other states, the trade off for this choice is that the plans offered through small group exchanges have generally been more expensive than comparable plans in the outside market. These exchanges, therefore, have tended to cater to a niche clientele. Some businesses are willing to pay the relatively higher premiums to get this set of choices for their employees. One of the most popular products in PacAdvantage, California's defunct small group purchasing pool, was PairedChoice. This option allowed employers to combine a Kaiser HMO plan, generally offered to their employees, with a PPO plan, generally taken up by the owners and their relatives.

The small group exchange will need to develop a value proposition that appeals to small businesses and insurers alike. Small group exchanges have historically struggled to attract and retain insurers. Indeed, Anthem Blue Cross, the insurer with the largest share of the state's small group business, chose to drop out of the SHOP exchange and continue to participate in a private exchange, CalChoice, which competes with the SHOP. Some observers expressed concern that the main value proposition of the Affordable Care Act's small group exchange for insurance carriers — access to groups that utilize a modest tax credit that expires after two years — may not be adequate to attract their business. Insurers generally prefer not to split the business of a small group with another carrier. With California choosing to offer "employee choice," business that many insurers would prefer to have combined may be sliced. Therefore, they may continue to prefer selling policies in the market outside the exchange.

Another critical issue is the relationship among the exchanges and the health insurance agents who serve this market. The small-group exchange is more likely to be successful if it enrolls a great number of people, and brokers have the broadest and most well-established set of relationships with the small group market. California chose to allow only certified insurance agents to sell SHOP products. Certified enrollment counselors will serve solely the individual market.

Size of the Small Group Market

An option available to states from 2014 to 2016 is to temporarily limit the size of employers who can participate in the small group exchange to those with fifty or fewer employees. In 2016, it will expand to up to 100 employees in all states. California has chosen to limit enrollment to smaller groups until 2016.

In California, as in many other states, this presents challenges for implementation. In California, the small-group market (i.e., two to fifty individuals) is age-rated, whereas the midsize market

(i.e., fifty-one to 100 individuals) is community-rated. The practical implication is that premiums for individuals, and hence for the group, can be different across these market segments. The technical requirements for producing the premiums for these two markets are distinct and combining them without standardizing the underlying law would be very challenging, if not prohibitively complicated.

The natural default for many states has been to restrict the size of the market for the first two years as these technical issues are worked out. However, an exchange set up to cater to the traditional small group market exclusively, even for a limited time, may make different decisions than an exchange planning to serve groups of up to 100 individuals. These markets often have different structures, are served by distinct delivery channels, have varying compensation schedules for agents, and carry different customer service expectations. Further, for states that are smaller than California, limiting the size of groups that can participate raises concerns about the total size of the market.

Part 4 – Summary Analysis

4.1 Policy Implications

What groups and institutions appear to be winning or are likely to win (i.e., gain benefits, resources, and influence) as health reform is implemented? What groups and institutions are losing or are likely to lose? How has the implementation of health reform affected the power and alignment of groups, interests, and institutions in health policymaking?

In many ways, the implementation of health care reform has not – or at least not yet – dramatically changed the status quo in California in terms of health care coverage. One somewhat surprising trend is that more than 96 percent of enrollees in the state exchange in the first two months enrolled in one of the four plans that had the largest share of the market for individual insurance before reform – Anthem Blue Cross, Kaiser Permanente, Blue Shield of California, and HealthNet. Some analysts had predicted that new entrants to the marketplace for commercial insurance, such as traditional Medicaid Managed Care plans, LA Care, and Molina, would do extremely well given their familiarity with marketing to subsidized populations. This dynamic may change, however, after California implements legislation passed in 2013 (SB X 1-2, Hernandez), that will give consumers the ability to remain with their Medicaid Managed Care plans as their income increases. Traditional safety net health care providers also expected to be well positioned to expand under reform, but are beginning to feel as if the provisions designed to assist them, such as the requirement that plans include “Essential Community Providers” in their networks, will have no substantial influence on the status quo.

The enrollment infrastructure has been changed somewhat through the creation of certified enrollment counselors, a new

class of people able to assist consumers in selecting a coverage option. Covered California has also created large call centers with staffs that are empowered to enroll people in private or public coverage. However, for the time being, the incumbent enrollment infrastructure has been largely kept in place. There have been many concerns expressed by insurance agents about difficulties becoming certified insurance agents able to place business within the exchange, but these difficulties have also extended to certified enrollment counselors. There have also been few major changes or immediate-term threats to the roles of the substantial county-based enrollment infrastructure of public employees. In fact, one of the three call centers created by Covered California is administered by Contra Costa County.

The biggest changes in terms of long-term implications for health care markets, as well as policy, has little to do with the choices that California has made and more to do with the financial implications of reform. In the past, the individual market in the state was dominated — with the substantial and significant exception of Kaiser Permanente — by broad network PPOs. Insurers kept premiums down for consumers primarily through risk selection, as well as through often nontransparent changes to consumer cost-sharing.

However, in a policy framework in which consumer cost-sharing is standardized and risk selection is not possible, the only effective, immediate-term way to generate a lower price point is to purchase health insurance from lower-cost providers. Hence the networks that were put together by insurers for Covered California, as well as those for networks across the nation, whether or not the exchanges chose to be selective purchasers, are quite narrow. There are many hospitals, including prominent facilities such as Cedars-Sinai Medical Center in Los Angeles, that are in very few or no exchange networks. It is an open question as to what extent this dynamic will accelerate or moderate in the future as plans — and through them providers — compete for the business of newly subsidized customers. However, there has already been something of a backlash within the state — in particular directed at “Exclusive Provider Networks” (EPOs) that provide no access to out-of-region providers. It is possible that there will be legislative move to address these issues.

Also, in California, as elsewhere, the broader changes in health reform have led to hundreds of thousands of consumers who were currently purchasing health coverage in the individual market having to pay more for similar or less comprehensive coverage since they are no longer benefitting from risk selection. Conversely, of course, there are millions of consumers who are now eligible for generous subsidies. These subsidies, however, end at 400 percent of poverty, causing dramatic effective marginal tax consequences for crossing this income threshold for consumers in areas with higher health care costs.

Another interesting question, as yet unresolved, is the extent to which the changes in federal reform will catalyze the balance of power among the different agencies of state government. Since the passage of reform, the Department of Managed Health Care was reorganized to report directly to the secretary of Health and Human Services. There is some question as to whether it is appropriate for the regulator of health insurance to report to the same person who is the chair of the Board of Covered California, a participant in the health insurance marketplace. And the role of the Department of Managed Health Care is growing. Over the past ten years, as there has been an increasing imperative for insurance companies to reach a lower premium through increased consumer cost-sharing, many carriers have developed products that were subject to the lower regulatory threshold of the Department of Insurance.

This department is run by the insurance commissioner, currently Dave Jones, a Democrat, who is an elected constitutional officer in the state. In the past, the majority of the individual market fell under the Department of Insurance, but under the exchange only some of the products offered by one carrier, HealthNet, are regulated by the Department of Insurance. The rest are regulated by the Department of Managed Health Care. However, a ballot initiative that voters will consider in 2014 would give the insurance commissioner the authority to reject rate increases proposed by any insurer participating in the individual or small group marketplace, effectively leading to multiple layers of regulation and complicating the picture in terms of the balance of power going forward in the state.

The balance of power between Covered California itself and the rest of the state infrastructure remains something of an open question. To date, the exchange has coordinated very closely with the Department of Health Care Services, which administers the state Medicaid program, and has generally deferred to the Department on issues related to Medicaid. However, in a structure in which certified insurance agents and certified enrollment counselors, both managed by the exchange, are able to enroll people in Medicaid, this may have a significant impact on the balance of power within the state. Finally, the state legislature has given Covered California a substantial amount of leeway in its first three years of operations. However, it may take a more active oversight role and issue legislation directly affecting Covered California, in particular once the initial phase of setting up this marketplace is perceived to have been successfully accomplished.

4.2. Possible Management Changes and Their Policy Consequences

Although we have seen many states with significant management changes, including the resignation of many executive directors, California's leadership has been consistent at the senior level. There is not expected to be any short-term changes in the

composition of the five-member Board, and Peter Lee, the executive director, has enjoyed the consistent support of the Board. Since the secretary of Health and Human Services is automatically a member of the Board, it is possible this position will change if Dooley retires or if Brown does not win re-election as governor. However, Brown does not currently have any significant opposition within his own party or from the California Republican Party. There have been some changes at the management level, including the retirement of David Maxwell-Jolly, who had served in several positions, including as the first chief operating officer of the exchange. In spite of some turnover, the policy orientation and direction of the exchange has not changed to any great degree since the passage of the enabling legislation. Since California has led the nation – both to the extent that its IT systems have worked relatively well and the fact that it was relatively successful in enrolling people in coverage – there is not likely to be much demand for changes in exchange leadership in the immediate term unless there are massive problems in converting plan selections into enrollments and, ultimately, health care access. California has had significant challenges, and its first year enrollment will fall at the very low end of initial projections, but within the broader context of the implementation of federal health care reform, it has been seen as a model of how to set up and run such a marketplace.

Endnotes

- 1 Sections of this report rely on an earlier piece by Dr. Weinberg and Leif Wellington Haase for The Commonwealth Fund entitled *State-Based Coverage Solutions: The California Health Benefit Exchange* (New York, NY: The Commonwealth Fund, May 2011), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/May/1507_Weinberg_california_hlt_benefit_exchange_ib.pdf.
- 2 Sarah Kliff, “California wants to lead the way on health care,” *Politico*, January 18, 2011, <http://www.politico.com/news/stories/0111/47706.html>.
- 3 Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, September 2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.
- 4 Alain Enthoven and Richard Kronick, “A Consumer-Choice Health Plan for the 1990s. Universal Health Insurance in a System Designed to Promote Quality and Economy,” *New England Journal of Medicine* 320, 1 (January 12, 1989):29-37
- 5 California State Assembly Bill 1602, http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html; and California State Senate Bill 900, http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB900.
- 6 Jon Kingsdale, “Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned,” *Health Affairs* 28, 4 (2009): 588-94, <http://content.healthaffairs.org/content/28/4/w588.full.pdf+html>; Rick Curtis and Ed Neuschler, “Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California,” *Health Affairs* 28, 3 (2009): 431-45, <http://content.healthaffairs.org/content/28/3/w431.full.pdf+html?sid=6a291fad-a172-4d8e-8a3c-5969ce074ebd>.

- 7 Since California requires the votes of two-thirds of each house of the legislature to increase tax rates or fees, Republican votes were required to raise the revenue necessary to stave off these cuts.
- 8 Though the Affordable Care Act stipulates that there will be marketwide risk adjustment by segment (e.g., individual, small-group), this process is not a panacea for all risk-related issues. There is substantial disagreement on the extent to which existing risk-adjustment processes weight the appropriate factors correctly.
- 9 As it is still possible for adverse selection to occur among markets (e.g., federally regulated self-insured plans gaming risk in ways that impact the state-regulated market), eliminating the outside market for individual insurance does not entirely remove issues related to adverse selection.
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