

For the past 20 years, the percentage of Americans receiving health insurance coverage through their employer has steadily dropped from near 65 percent to about 50 percent today. This has forced more Americans to purchase insurance in the individual market. In this market, patients often get coverage that is more expensive and less comprehensive than what they could receive through an employer-sponsored plan.

In order to address this inequity, federal health care reform creates Health Insurance Exchanges. These state-based exchanges will be marketplaces for individuals and small businesses to purchase standardized health insurance products. The idea behind the exchanges is to create a more competitive marketplace that produces more affordable coverage. The exchanges are a mechanism to move heavily regulate the insurance industry.

California must design and implement its exchange by January 1, 2014. Health reform legislation orders the federal government to define the requirements for the exchanges by March 2011.

### Summary of Provisions

#### Basic Structure of the Health Insurance Exchange

The exchange will mandate essential benefits and offer five tiers of plans – bronze, silver, gold, platinum and catastrophic – based on the amount of coverage and cost-sharing in the product.

By standardizing the products and requiring that they meet minimum benefit levels, the exchanges will allow individuals to compare products from different companies. This will also force health plans to compete only on price, quality and their provider networks, since much of the variation will be removed from the market.

Catastrophic-only plans will be allowed in the exchanges, but only for purchase by those under the age of 30, or those who cannot otherwise afford to purchase coverage.

#### Additional Responsibilities of the Health Insurance Exchange

Exchanges must:

- Certify whether plans are qualified to participate in the exchange based on federal requirements.
- Provide a variety of patient protections and consumer information, including hotlines, websites to compare plans, health plan ratings and uniform enrollment forms.
- Require plans to have an adequate provider network, spend a certain portion of revenue directly on patient care (a minimum medical loss ratio) and disclose information that allows consumers to compare plans' prices, rate changes, quality of care and other important factors. Plans also have to report on claims payment policies, claims denied, quality rankings and market share.

#### SHOP Exchanges

A "Shop Exchange" is a Small Business Health Options Program. It is similar in structure to the Health Insurance Exchange, except that it will be a marketplace for small employers – initially, employers with less than 50 employees - to purchase health insurance for their employees. States have the option of running their Health Insurance Exchanges and their SHOP exchanges as one combined program.

Small businesses with up to 25 employees may receive a tax credit of up to 50 percent of the employer contribution. The tax credit is 50 percent for employers with less than 10 employees and average wages under \$25,000 and phases

down for businesses with up to 25 employees and average wages of \$50,000.

### **Funding for the Exchange**

The federal government will provide states with grants to plan their exchanges, and with start-up funds to begin their operations. Beginning January 1, 2015, however, states must have identified their own funding sources. These funds could come from assessments on health plans

### **Employees with coverage through their employer**

Employees who have coverage through their employer and earn up to 400 percent of the Federal Poverty Level (FPL), which is \$88,200 for a family of four, will have the option to purchase an individual policy through the exchange or to stay with their current coverage.

### **State regulation through the Department of Managed Health Care or the Department of Insurance**

Plans offered through the state exchanges must be licensed and in good standing with their state regulatory bodies. In California, this means that they must be licensed by either the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI).

### **Coordination with Medi-Cal and Healthy Families**

When patients apply to purchase insurance through the exchange, the exchange will be required to determine their eligibility for Medi-Cal or Healthy Families. If a patient is found to qualify for one of these programs, the exchange will be required to enroll him or her in that program.

### **“CO-OP” Plans**

A “CO-OP” is a Consumer Operated and Oriented Plan. It is a small, non-profit health insurance alternative constructed

by the physicians and patients in a community. It is member owned, and any profits it earns must be either used to lower premiums or re-invested to improve services. The reform bill establishes a federal grant program to promote CO-OPs. It also allows them to be sold through the exchange.

### **Premium Rate Review**

Federal health reform gives state and federal regulators the authority to review the premiums and premium increases proposed by insurers. States may prohibit insurers from participating in the exchange if they find fault with their premium increases.

### **Concerns**

The exchange must safeguard against adverse patient selection and protect access to physicians by enforcing regulations requiring plans to have adequate physician networks. Also, the exchanges must make important information available to patients to help them choose among plans and physicians. It's crucial that this information, including any and all physician data, is accurate, relevant and helpful or it could do more harm than good.

### **Next Steps for Lawmakers**

1. Put in place the legal structure and funding plan for the California Health Insurance Exchange.
2. Form an advisory committee composed of physicians, providers, patients, small businesses, health plans and other experts to assist in the creation and implementation of the state's exchange.
3. Determine whether to establish two different exchanges, or even smaller regional exchanges. Rural areas that have low market penetration of health plans and

physician shortages will require special consideration to provide a choice of plans and physicians.

4. Determine how to protect against adverse patient selection in the exchange. If insurers cherry-pick healthy patients for enrollment outside the exchange, insurance will become unaffordable to all within the exchange.
5. Work with federal regulators to craft effective minimum risk adjustment factors for patients. Without such consideration, plans may avoid serving sicker, low-income, minority and ethnically diverse patients who traditionally have not had good access to care.
6. Create centralized help lines that will connect providers and consumers to DMHC, DOI, or the exchange, depending on the nature of the issue.
7. Work with local communities and providers to develop non-profit CO-OP plans as an alternative to private insurance.
8. Ensure physician quality data, and all other information provided by health plans to the exchange, is accurate and relevant.
9. Monitor exchanges to make sure regulators are enforcing all requirements.