Welcome and Introductions
10:00 AM

Gilbert Ojeda, Director, California Program on Access to Care (CPAC),
UC Berkeley School of Public Health

Peter Hansel, Chief Consultant, Senate Health Committee

Presentation
10:10 AM

Moderator: Stephen Shortell PhD, Dean, UC Berkeley School of Public Health;
Professor of Health Policy and Management

Health Care Reform: Moving Forward in California

Panel 1: Delivery System Reforms: Innovations in the Public and Private Sectors
10:20 AM

Ruth Liu, Senior Director, Health Policy, Kaiser Foundation Health Plan

The Kaiser Approach: Delivery System Changes in Health Reform

Leif Wellington Haase, Director, California Program, New America Foundation

We Have Seen the Future: Is It Us? California’s Delivery System after Federal Reform

Reaction Panel

Tom Williams, Executive Director, Integrated Health Care Association

Brenda Premo, Adjunct Associate Professor, Western University for the Health Professions;
Director, Center for Disability Rights and the Health Professions

David Meadows, Vice President, State Health Programs, Health Net, a California Health Plan

Co-hosted by the Senate Health Committee and the Assembly Health Committee
11:20 AM  Panel 2: Insurance Market Reforms: Risk Pools, Rate Regulation and Insurance Exchanges
Lucien Wulsin, Executive Director, Insure the Uninsured Project (ITUP)
The Exchange: Transformation of Individual Health Insurance
John Grgurina Jr., Chief Executive Officer, San Francisco Health Plan; Former President of Pac Advantage – a small employer exchange
Insurance Exchange and Market Reforms

Reaction Panel
Beth Capell, Policy Advocate, Health Access
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Schwarzenegger

12:15-30 PM  Questions and Answers

Co-hosted by the Senate Health Committee and the Assembly Health Committee
NATIONAL HEALTH CARE REFORM
FOR CALIFORNIA

Stephen M. Shortell, Ph.D.
Blue Cross of California Distinguished Professor of Health Policy and Management
Dean, School of Public Health
University of California-Berkeley
Good News

- California seniors will see the drug coverage gap (the “donut hole”) closed over time.
- Young adults can stay on their parents’ plan until age 26.
- State high-risk insurance pools for those uninsured for at least six months – but may not be enough. Only $5 billion for whole country. California’s estimated shared is $375 million.
- Increases Medi-Cal Payments to doctors
- 10 percent bonus to doctors who provide primary care to Medicare Enrollees
- Pays most of the cost for eligible Medi-Cal recipients through 2016. Up to 2 million low-income Californians newly enrolled
Good News (Cont’d)

• Medicare eliminates cost-sharing for preventive services.
• Tax credits for middle-class working families and Medicaid up to 4x poverty level ($88K for family of 4)
• Illegal Immigrants will not be covered. We have a high number.
• Little to show the rate of growth in costs or improve quality
  • Payment experiments
  • Accountable care organizations
  • Patient-Centered Medical Homes (PCMHs)
Not So Good News

- A lot will not take place until 2014, e.g. elimination of pre-existing conditions.
- Funding for Medicare advantage plans reduced. 34 percent of California Medicare beneficiaries vs. 22 percent nationwide. But bonuses for plans providing higher quality.
California Strengths

- High number of organized medical groups and IPAs, with experience in managing risk - the delegated model
  - About 200 such groups

- Leading health care systems
  - Kaiser-Permanente
  - Sutter
  - Catholic Health Care West
  - Sisters of St. Joseph of Orange

- Strong UC Medical centers and schools of Public Health
California Strengths (Cont’d)

- Innovative Foundations
  - California Healthcare Foundation
  - The California Endowment
  - The California Wellness Foundation
  - Henry J. Kaiser Family Foundation
  - Blue Shield California Foundation

- Strong Leadership Organizations
  - Public Health Institute
  - Prevention Institute
  - Public Health Advocacy Center
  - Integrated Healthcare Association (IHA)
  - California Association of Physicians Groups (CAPG)
  - Department of Managed Healthcare (DMPH)
  - California Quality Alliance
  - Many Others
California Weaknesses

• State Economy
• Deteriorating Educational System
• Mediocre to Poor Health Statistics
• Lack of Adequate Primary care
• Acute Shortage of Trained Public Health Professionals
• Size and Diversity (Also Strengths)
• High Number of Uninsured – 6 Million
The Kaiser Permanente Approach: Delivery System Changes in Health Care Reform

Ruth Liu, Senior Director of Health Policy
Kaiser Permanente
KP Health Reform Vision

Kaiser Permanente believes that universal access to high-quality, affordable care is imperative. However, if we truly want to repair the broken US health care system, a broader focus than increasing access and how to finance it is needed. It is first and foremost necessary to reform how care is delivered and paid for. As a nation, we need to improve health care access, reduce costs and ensure quality care for all. In addition, health reform should address the root causes of poor health, by promoting public health programs, community health services and workplace efforts to support healthier lifestyles.
Quality in Today’s Healthcare System

Quality: Effective Care

Receipt of Recommended Screening and Preventive Care for Adults

Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2005</th>
</tr>
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<tbody>
<tr>
<td>U.S. Average</td>
<td>49</td>
<td>50</td>
</tr>
</tbody>
</table>
| U.S. Variation 2005
  - 400%+ of poverty | 58   |
  - 200%-399% of poverty | 47   |
  - <200% of poverty   | 39   |
  - Insured all year   | 53   |
  - Uninsured part year | 46   |
  - Uninsured all year | 32   |

*Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. See report appendix B for complete description.

Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

The infant mortality rate in the US is well above the median rate for high-income, industrialized countries.

Barely half of U.S. adults receive all recommended clinical screening tests and preventive care, according to national guidelines.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2009
Strong Opportunity for Savings through the Adoption of Best Practice Care Delivery Models

- Using Mayo Clinic as a benchmark for adopting the practices of organized practices, the nation could reduce health care spending by as much as 30% for acute and chronic illnesses.


- If the nation could move the delivery system half-way to this benchmark, it could reduce health care spending by as much as 15%.
Five percent reduction in chronic care conditions

- Reducing the costs of seven major chronic conditions by just 5% could realize a savings of $100 billion for the country in 2009.

### EXHIBIT 2
Chronic Disease: Current And Projected Burden, United States, 2003–2023

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Overall chronic illness</td>
<td>42%</td>
<td>$1.3 trillion</td>
<td>$4.2 trillion</td>
</tr>
<tr>
<td>Cancers</td>
<td>62%</td>
<td>$319 billion</td>
<td>$1,106 billion</td>
</tr>
<tr>
<td>Diabetes</td>
<td>53%</td>
<td>$132 billion</td>
<td>$430 billion</td>
</tr>
<tr>
<td>Hypertension</td>
<td>39%</td>
<td>$312 billion</td>
<td>$927 billion</td>
</tr>
<tr>
<td>Pulmonary conditions</td>
<td>31%</td>
<td>$139 billion</td>
<td>$384 billion</td>
</tr>
<tr>
<td>Heart disease</td>
<td>41%</td>
<td>$169 billion</td>
<td>$927 billion</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>54%</td>
<td>$217 billion</td>
<td>$704 billion</td>
</tr>
<tr>
<td>Stroke</td>
<td>29%</td>
<td>$36 billion</td>
<td>$98 billion</td>
</tr>
</tbody>
</table>

**Source:** R. DeVol and A. Bodrcussan, *An Unhealthy America: The Economic Burden of Chronic Disease* (Santa Monica, Calif.: Milken Institute, October 2007).

**Note:** Cost figures include medical costs plus reduced on-the-job productivity.

*Population is expected to grow 19 percent from 2003 to 2023.

*These figures do not include all chronic conditions but are based on data for the seven most common chronic diseases: cancers, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental disorders.

*Includes breast, colon, lung, prostate, and other cancers.
Federal reform offers opportunities to test different pilots and programs and provides the infrastructure to improve care and realize long-term cost savings. This is a first good step and can be successful if broadly applied.

- **Demonstration Projects**: (i.e. Medicare Medical Home Demonstration, Post-Acute Care Payment Reform Demonstration, Hospital Gainsharing Demonstration, etc.)

- **Patient Centered Outcomes Research Institute**: Established to improve health care decision making through research and evidence synthesis

- **Center for Quality Improvement and Patient Safety**: support multi-disciplinary research of best practices and ways to improve health outcomes and care delivery.

- **Healthcare Acquired Conditions**: Nonpayment in Medicare and Medicaid, under DRA, for preventable medical errors in hospitals.

- **Hospital Readmissions Program**: to reduce preventable hospital readmission rates for certain selected conditions.
Delivery Reform Models Promoted in Federal Health Reform

**Medical Homes:**
- A health care setting where patients receive comprehensive primary care services, have an ongoing relationship with a primary care provider who directs and coordinates their care, and have enhanced access to non-emergency primary, secondary, and tertiary care.
- There are already demonstrations underway to experiment with this model through Medicare and Medicaid.

**Accountable Care Organizations (ACOs):**
- A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care.
- MedPAC has recommended ACOs as a way to control cost and improve quality.
Delivery and Payment Reform Models in Federal Health Reform

**Bundled Payments:**
- A mechanism of provider payment where various providers receive a single payment for all of the care provided for an episode of illness, rather than per service.

**Value-Based Purchasing:**
- A system that would tie a percentage of hospital payments under Medicare or another public program to performance on quality measures related to common and high-cost conditions.

**Health Information Technology:**
- Establishes the phased adoption and implementation of a single set of operating rules (i.e., guidelines and business rules) for each adopted HIPAA financial and administrative transaction standard. Also calls for the adoption of new standards and the additional of an electronic funds transfer requirement.
Healthy Bones is a multidisciplinary program piloted in our Southern CA region designed to identify members at-risk for osteoporosis and hip fractures, perform bone density screenings and clinical assessments for the group, and provide timely treatment to reduce the incidence of hip fractures.

The Healthy Bones program is made possible by regional teams of doctors, care managers, an inter-disciplinary Healthy Bones Committee and a database that identifies and stratifies members at risk for osteoporosis and/or hip fractures, and facilitates a robust outreach program and performance reporting and evaluation.

The Healthy Bones program was designed with an initial objective of reducing hip fractures by 25%. After 2 years of full implementation, the region has seen a 61% reduction of events, with an estimated savings of $36 million.

A 2004 US Surgeon General report on osteoporosis, estimated that in 2005 there were 2 million fractures at a cost of $17 billion in the US for both acute and long term care. It is projected that by 2025 the annual fracture rate will increases by 50% to approximately 3 million at an annual cost of $25 billion.

Reducing the fracture rate by 50% would translate into a savings for the country of $13.5 billion.
Setting Goals for Stage 2 of Health Reform

- The next step in health reform is to establish achievable, but significant, quality goals that will improve the health of all Americans.

- These can focus on prevention, chronic care management and patient safety.

- Through a team approach to care, with the right “tools” in the hands of providers, significant goals can be achieved.

- KP has been successful in a number of initiatives including improving cardiovascular care, and a reduction in deaths due to sepsis.
Why is Sepsis so important?

- Every year in the US over 750,000 people are hospitalized with sepsis
- 215,000 of these patients die: sepsis has a mortality rate of 30%
- Sepsis patients have long and expensive hospital stays
- The US health care systems spend over $25 billion annually on sepsis care
- In Kaiser Permanente in Northern California, sepsis accounts for 1 of every 40 admissions, about the same as heart attacks, but sepsis accounts for ¼ of all hospital mortalities, 5 times more than the heart attack
What is the right thing to do for sepsis?

- There is a substantial body of medical evidence* showing a highly effective, but difficult to implement, approach to better sepsis care that can reduce mortality by 30 to 50%, and can reduce hospital costs significantly.

- The approach, called Early Goal Directed Therapy (EDGT), requires several elements ideally achieved in the first 6 hours:
  - Early identification and stratification of all patients at risk, beginning at the moment of triage in the emergency department.
  - Aggressive treatment hydration and antibiotic treatment in the first hour.
  - Aggressive treatment to specific hemodynamic goals (resuscitation endpoints) in the first 6 hours, generally guided by placement of central venous catheter.

In June of 2008, KP Northern CA launched a pilot program to implement EGDT in four hospitals.

In the first 6 months of this program, mortality has dropped 43% in the four hospitals that have fully implemented EGDT.

- Appropriate testing increased by 150%
- The number of sepsis cases identified by early screening increased 17%
- Despite a significant increase in the number of patients identified as having sepsis, the number of deaths caused by sepsis in these four hospitals decreased by 169 compared to the prior year.
The Impact of Cardiovascular Disease

- In 2008 Americans will suffer:
  - 1.2 million heart attacks
  - 800,000 strokes
  - 1.5 million new cases of diabetes
  - 6 million hospitalizations for CVD, 1.3 million angioplasties and 500,000 bypass surgeries
- An American dies from CVD every 35 seconds
- Heart disease and stroke are leading causes of disability
- The cost of heart disease and stroke in the United States is estimated at $450 billion in 2008. It includes direct medical costs and lost productivity from death and disability.
The ALL program was originally designed to decrease cardiovascular morbidity among at-risk Kaiser Permanente diabetic patients, by starting and maintaining at-risk patients on a 3 drug regimen—aspirin, lisinopril, and lipid lowering therapy.

Within our KP population this program was able to reduce the risk of stroke or heart attack by 30%.

The program was then translated across our 8 KP regions.
ALL Program Translation

- In 2005 the SCPMG began translation of this program with the San Diego Community Clinics Health Network.

- As of September 2009, 42 ambulatory clinic sites based at community health centers and public hospital systems in California’s safety net have initiated the ALL program with over 2,000 patients newly prescribed on the ALL medication regimen.

- Three key features led to its adoption in community settings:
  1. Impact on a sizeable group of at-risk patients
  2. Simplicity for implementation
  3. Cost savings

- The cost of starting the ALL program was about $300/new patient/year. One model suggests a cost savings of $600/person/year over 25 years.
We Have Seen the Future: Is It Us?
California’s Delivery System After Federal Reform

Leif Wellington Haase
Director, California Program
California in the Vanguard of Organized and Managed Care

- Advantages of Managed Care, Delegated Care for Care Coordination and Lowering Costs
- Importance of Kaiser Permanente, Multi-Specialty Groups, and Independent Practice Associations (IPAs): Early and Rapid Growth
- One Current Example: Integrated Healthcare Association (IHA): Expanding Existing P4P Projects to Improve Efficiency, Quality of Care
- Federal Reform Attempts to Expand Models of Coordinated Care Nationally
Going Against the Grain?

- Is Capitated, Delegated Model in CA Eroding as It Becomes Fashionable?
- Shift from HMO to PPO Products in Employer-Based Coverage: 70% to 63% from 2002 to 2008 in California; 45% to 32% Nationally
- Causes: Provider Consolidation in CA Regions, Consumer Pushback Against Managed Care, Management Outside California, Impact of Regulations (Berenson, Ginsburg, et. al., Center for Studying Health System Change)
- Consequences: Less Downward Pressure on Costs, Diminished Capacity to Adapt to New Federal Incentives?
HERE IT COMES!
JUST LIKE I WARNED YOU!

Rustle
Rustle

Can't wait to see the November attack ads —

Health Care

hop
Federal Reform: A Push, a Nudge, or a Ripple?

• Paying for Results, Not Procedures, the Endgame of Payment Reforms

• Dr. Atul Gawande: “One truly scary thing about health reform: far from being a government takeover, it counts on local communities and clinicians for success”

• New Center for Medicare Innovation established (2011); Physician Payment Reforms (2012); Hospital Value-Based Purchasing program (2012); Reducing Avoidable Readmissions (2012); Bundling Pilot (2013); Independent Payment Advisory Board (2015)

• Break for Tax-Exempt Insurers on Premium Tax
Bundling Payments: Makeover or Mirage?

• Fee Paid for an Entire Episode of Care, Rather than for Individual Procedures
• Bundled Payment Pilots in Medicare and Medicaid: Build on CABG and ACE (bypass surgery and lower back pain) demonstrations
• IHA: Plan for Bundled Knee and Hip Replacement with Cedars Sinai, Blue Shield, others
• Minnesota Model: Creating “baskets of care” for acute low-back pain, asthma, diabetes, total knee replacement
• Provider Consolidation and Market Power: Compromising the Effort to Use Greater Efficiencies to Lower Overall Health Costs? All-Payer Rates or Other Regulation in the Cards?
Accountable Care Organizations (ACOs)

- Payments to Provider Groups (e.g. primary care practices, specialists, one or more hospitals) to Care for Defined Population, Retain Additional Funds, Receive Quality Bonuses
- Models: Medicare Physician Group Practice Demonstration/Community Care of North Carolina
- The “Virtual Integrated Delivery System?” State Employee Health Exchange Partners with CalPERS, Blue Shield, Catholic Healthcare West to Coordinate Care, Control Costs
- Challenges: Limited Real World Experience, Defining Leadership, Technical Challenges
Medi-Cal Delivery Reform

• Major boost to Medi-Cal Rolls and Higher Primary Care Physician Payments (to Medicare level) Will Make the Most Immediate Impact

• Reductions In Uncompensated Care/ Phase-out of DSH payments? Who Will Be Helped, Who Will be Hurt?

• How Can California’s Hospital Waiver Renewal Boost Coordinated Care?
Strengthening the CA Safety Net?

- New Payments to Federally-Funded Clinics: $12.5 billion (up from ~ 2 billion) in Legislation
- Rural Safety Net Hospitals: Helped with New Federal Payments
- “Medical Home”: Federal Government to Cover 90% of cost for Medicaid Beneficiaries with Chronic Illnesses who are in a Medical Home
Thank you

Leif Wellington Haase
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(916) 448-5287
The Exchange – Transformation of Individual Health Insurance

Lucien Wulsin
March 31, 2010
Health Insurance Exchange

- State exchanges with federal oversight
  - Incomes between 133-400% FPL eligible for subsidies
  - Individuals pay sliding scale premiums capped at 2%-9.5% of income
  - Would cover 2.3 million uninsured in CA (UCLA)
  - Would subsidize 45% of individually purchased private insurance in CA (CHIS calculation)
  - Would subsidize small lower wage businesses

- Initial focus – individual and small group (50, then 100) markets – separate risk pools
  - CBO projects 25 million (nationally) would purchase through Exchanges -- over 3 million Californians
## Sliding Scale Premiums and Out of Pocket – tied to Price Level (FPL)

<table>
<thead>
<tr>
<th>Income Level (FPL)</th>
<th>Max premium contribution, % of income</th>
<th>Actuarial value floors</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;133%</td>
<td>2.0%</td>
<td>94%</td>
</tr>
<tr>
<td>133-150%</td>
<td>3.0-4.0%</td>
<td>94%</td>
</tr>
<tr>
<td>150-200%</td>
<td>4.0-6.3%</td>
<td>85%</td>
</tr>
<tr>
<td>200-250%</td>
<td>6.3-8.05%</td>
<td>73%</td>
</tr>
<tr>
<td>250-300%</td>
<td>8.05-9.5%</td>
<td>70%</td>
</tr>
<tr>
<td>300-400%</td>
<td>9.5%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Source: HR 4872, The Reconciliation Act
## Exchange for Individuals in CA

<table>
<thead>
<tr>
<th>Poverty Level</th>
<th>Uninsured</th>
<th>Private individual</th>
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<tbody>
<tr>
<td></td>
<td>Est. N</td>
<td>%</td>
</tr>
<tr>
<td>0-99% FPL</td>
<td>1,491,000</td>
<td>31</td>
</tr>
<tr>
<td>100-199% FPL</td>
<td>1,494,000</td>
<td>31</td>
</tr>
<tr>
<td>200-299% FPL</td>
<td>733,000</td>
<td>15</td>
</tr>
<tr>
<td>300% - 399% FPL</td>
<td>397,000</td>
<td>8</td>
</tr>
<tr>
<td>400% FPL and Above</td>
<td>701,000</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>4,817,000</td>
<td>100</td>
</tr>
</tbody>
</table>

CHIS, 2007
Insurance Market transformation

New protections across entire market

- Minimum benefits package (grandfathering exceptions)
- Guaranteed issue and renewal (kids in 2010, adults in 2014)
- Minimum medical loss ratio (2011)
- Transparency in claims, costs, enrollment, etc. (begins 2010)
- Standardizing administrative processes (begins in 2011)
- No copays for effective preventive services (2010)
- No annual or lifetime caps (2014, limited in 2010)
- No more plan or job lock (2014)
Individual Market transformation

- Exchange plans in 2014
  - Guaranteed issue and renewal, no pre-existing condition exclusions
  - Compete on price and quality, not medical underwriting
  - Rating variation: age, geography, family size, and tobacco use
  - Risk-adjustment mechanisms
  - ‘Essential community providers’ must be included in plan networks
  - Statewide cooperatives and national plans
  - Interim rate increase justification and regulation
  - Informed comparison shopping
Minimum Benefits

- Covered Benefits
  - 4 benefits categories ranging from 60 to 90% of the actuarial value of the covered benefit packages (Bronze 60%, Silver 70%, Gold 80%, Platinum 90%), mandate tied to bronze
  - Grandfathers existing benefits (you like it, you keep it)
  - Prohibits annual/lifetime limits
  - Prohibits cost sharing for preventive services
  - Young invincible coverage:
    - Prevention and catastrophic coverage for those up to age 30 or individuals exempt from mandate due to financial hardship
    - Allows children to stay on parents plan until 26th birthday
  - Exchange subsidies vary by income, at least linked to 2\textsuperscript{nd} lowest cost silver plan for those at a higher income level; individuals pay the incremental cost difference (Enthoven on steroids)
  - States pay incremental cost of state mandates above federal floor
Short Term Implementation

- June, 2010: $5 billion for temporary high risk pools until 2014 for uninsured individuals with pre-existing conditions
  - Could be $700+ million for California pool
    - Federal guidelines: Standard premium rating, 65% AV, age rating max 4:1, annual out of pocket max $5K/$10K for individual/family
  - MRMIP is CA’s high risk pool w/ wait list
    - $37 million program with 4 plans (Kaiser North, Kaiser South, Anthem Blue Cross, Contra Costa Health Plan)
    - More plans needed? (COHS, LIs, commercial plans)
  - Affordability issues
    - Sliding scale contributions using realigned tobacco tax funding
    - Benefit designs
Long Term Choices

- State, Interstate, or Intrastate regional Exchanges, Interstate plans and compacts, Co-ops
- Regulation of conduct in and out of Exchange
- Exchange as a price clearinghouse or active negotiator
- Risk adjustments
- Expansion to larger small employers
- Interface with large employers – flex workforce
- Bending the cost curve – CA style
- Safety net plan and provider participation
- Enhancing competition (rural and other markets)
- Independence, innovation and governance
- Customer satisfaction and value are the keys
Additional Resources from ITUP

For more information on insurance market reform, see the Reports and Conference sections at www.itup.org

- “Implementing Health Reform: High-Risk Pool” March 2010
- “Implementation Timeline for Health Reform, 2010-2011” March 2010
- “Improving Affordability Under Federal Reform” Nov 2009
- ITUP Conference presentations and discussion
Insurance Exchanges and Market Reforms
John F. Grgurina, Jr.
March 31, 2010
Goals for the Small Group Pool/Exchange in CA in 1993

- Increase Access
- Pool Lowers Rates
- Pool Lowers # of Uninsured
- Choice of Plan for Employees
Small Group Exchange Design

• Voluntary
  • Insurance carriers could participate or not
  • Employers could purchase or not
  • Distribution arm (agents/brokers) could sell or not
• Government run (MRMIB) then transitioned to not for profit (PBGH)
• Key policy decisions “different than the market”
  • Agent/broker commission
  • No underwriting for groups
  • Not using +/- 20% then 10% rating factor
• Starts with no membership and must take membership away from commercial market to build business
Key Lesson Learned: Voluntary Pool/Exchange won’t lower rates

Why?

1. Carriers do not like “sliced” business
2. Carriers won’t offer lower rates for fear of cannibalizing their current block of business
3. Carriers are the Bigger Bully – they have more membership in small group than they will have in exchange

This leads to higher exchange rates which leads to:

Adverse Selection which leads to “death spiral”
Duh – I knew that!
Must have all 3 legs of the stool for well functioning market
What next?

"I'll be happy to give you innovative thinking. What are the guidelines?"
Key policy questions for design of exchange:

1. Is exchange sole market or competing market?

2. Can individual market be combined with small group market?

3. Can 51-100 mid sized market be combined with small group market?
Other important exchange design questions:

• Exchange - Price Taker or Negotiator?

• Must Plans Participate in Exchange?

• Risk Assessment/Adjustment between markets (if exchange is competing with commercial market)?

• Will market be allowed to have different benefit packages than exchange?
Where are we headed?