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Recommendations on Transforming Health Insurance
So Consumers and Families Get Coverage They Can Count On

California Working Families Policy Summit
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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA), signed into law on March 23, 2010, by President Obama, is historic in three ways, as:

1) the most important patient protection law passed by Congress, a “Patient’s Bill of Rights” that outlaws the worst practices of the insurance industry;
2) the largest expansion of health coverage since the creation of Medicare and Medicaid in the 1960s, providing both more security to those who have coverage *and* new, affordable options for everyone, including the uninsured and underinsured; and
3) the most comprehensive attempt in history to: encourage prevention and wellness, improve health care quality, control health care costs, and reduce the federal deficit.

While Health Access California and many health advocates are focused on defending ACA from efforts to repeal it, educating the public about ACA’s benefits, and working to implement and improve all facets of the new federal law, this paper focuses exclusively on the work of regulating and reforming the insurance market to be more transparent and consumer friendly.

The ACA provides new consumer protections, especially for those buying coverage as individuals (who currently have little leverage in purchasing coverage with large health insurers, and lack the bargaining power that comes with group purchasing). The ACA also prohibits abusive pricing practices by the insurance industry, such as discriminatorily denying coverage based on health status, age, or gender.

In addition, the ACA protects consumers from denials of coverage for necessary medical care and rescission of coverage retroactively. Of particular note, the law provides for the creation of a new transparent and consumer-friendly marketplace called an Exchange, a “one-stop shop” where consumers can purchase plans that cover all essential benefits. Through the Exchange, individuals with incomes between 138% and 400% of the federal poverty level can access affordability subsidies on a sliding scale for the purpose of purchasing health insurance.

California enacted several laws in 2010 that conformed state laws to the ACA, not just to implement but to improve upon the federal law. This legislation included the first-in-the-nation post-reform bill to set up an Exchange, which has the ability to negotiate for the best possible price and value. Other California consumer protections that took effect on January 1, 2011, include: requiring insurers to justify rate increases, ensuring that our premium dollars go to patient care rather than administration and profit, and phasing out denials for pre-existing conditions for children.

Much more is needed to prepare for full implementation of ACA, to provide consumer protections as soon as possible, and to foster a smooth transition from the "wild west" of our current market to the new transparent and consumer-friendly world of 2014. But the task is not simply to provide a set of new consumer protections, but to more fundamentally transform the core business model of insurers—from the current world where insurers compete based on how deftly they can avoid covering people who need care, to a new paradigm where they compete on cost, quality, customer service, prevention and wellness. The ACA begins that transformation, but the *specific* policies and regulations of implementation will determine if we actually achieve a health system that truly meets the needs of California families.

POLICY OBJECTIVE #1

Create a Transparent and Consumer-Friendly California Exchange.

Background

California has the largest individual market of any state (by size and proportion of total insured), including 2 to 2.5 million or about 6-7% of the under-65 population. Millions more remain uninsured, finding coverage unaffordable, or even unavailable. It's also complex, with a confusing myriad of plan choices with varying benefit levels that are typically more costly than employer-sponsored coverage. In the individual market, consumers can be denied for pre-existing conditions—they have no "guaranteed issue" (guarantee of coverage), no community rating (to prevent overcharging those who are sick), and there are few required standards for benefits. Individuals with pre-existing conditions are either denied coverage entirely or if they can get coverage at all, forced to pay much higher premiums.

Another 3 to 7 million Californians get coverage through the small group market, which covers small employers insuring 2 to 50 individuals per plan. Though this market has existing regulations governing how much participating small groups can be charged for covering their workforce, the Affordable Care Act offers additional reforms and assistance, such as the availability of small business tax credits.

Beginning January 1, 2014, individuals and small businesses will be able to buy coverage through a new California Exchange, authorized through AB1602/SB900, signed by then-Governor Schwarzenegger in 2010. California's Exchange will first and foremost provide subsidies to low- and moderate-income Californians so they can afford health care. This is a game-changer: people will pay premiums based on what they can afford—a sliding scale based on percentage of income—rather than how sick they are.

At its best, California's Exchange can provide individuals and small businesses with a purchasing pool that gives them the bargaining power that now only large employers and public programs have, to negotiate for the best price and value. The *effectiveness* of the Exchange will be determined by the decisions made in its first few years of implementation.

Recommended Actions

Legislation and regulations adopted to implement the California Exchange should incorporate the following principles and approaches:

A. Ensure that the Exchange is an "active purchaser," one that negotiates on behalf of its members for the best price and best value. Rather than the current "flea market" type system, where products offered vary in quality and value and the buyer must beware, the Exchange would use its power as a bulk purchaser to negotiate good bargains on cost, quality, and prevention.

B. Work to make sure that the new board and staff of the Exchange are independent of insurers or the health industry as a whole--so that the industry is not on both sides of the bargaining table, and the Exchange is clearly seen as a voice and a tool of purchasers, both consumers and small businesses.
C. Allow as quickly as possible individuals, employers, and the self-employed to participate in this publicly-operated health insurance purchasing pool. Work to broaden the pool as much as possible.
D. Ensure a consumer-oriented mission with fair governance for consumer and constituency concerns and the full diversity of California; empower consumer representatives and a consumer voice throughout the Exchange's processes; and ensure that the Exchange provides continuous, objective and fair information to consumers and is otherwise responsive to the "members" it serves.
E. Establish a streamlined process to provide consumers and small businesses the subsidies they need to make coverage affordable, including easy income verification and the ability to send one check to one place to get covered.
F. Build in the easiest, most consumer-friendly mechanisms for patients to navigate this new system of choosing health plans; create accessible and consumer-friendly mechanisms for grievance and appeal rights; and have the Exchange provide services as an HR department of a large employer.
G. Encourage the standardization of plans so consumers can make apples-to-apples comparisons; and truly make the insurers compete on cost, quality, prevention and wellness.
H. Make eligibility and enrollment easy if not automatic, and have the Exchange seamlessly integrate its eligibility and enrollment with that of Medi-Cal and private insurance, including COBRA so enrollees don't have to deal with a gap in coverage.
I. Get counties to expand local coverage initiatives through the Medicaid waiver, to draw down federal funds, get benefits to hundreds of thousands of Californians, and provide a "bridge to reform" where those enrolled get into Medicaid and the Exchange on January 1, 2014.
J. Create other mechanisms to identify Californians who would be eligible for Medicaid and financial assistance through the Exchange, and find ways to "pre-enroll" them, so that millions of Californians are signed up to get coverage on day one, in 2014.

POLICY OBJECTIVE #2
Ensuring Access for those with Pre-Existing Conditions.

Background

Individuals with pre-existing conditions seeking health insurance often find that health coverage is unaffordable or completely unavailable at any price. People who lose coverage can find themselves uninsured and uninsurable due to a pre-existing condition.

Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) will require that insurers are no longer allowed to deny—or charge more—to individuals (both adults and children) with pre-existing conditions.

In the interim, there are two efforts to provide access. The federal health law prohibits denials for children with pre-existing conditions as of September 2010, but many California insurers responded by no longer selling child-specific coverage. California recently passed a law (AB 2244, sponsored by Health Access California) that required insurers to resume offering such coverage (or else they would have been barred from the market for five years). As of January 1, the state law also prevents insurers from charging for children with pre-existing conditions more than twice what they charge for any other child, if the child is enrolled during open enrollment periods.

Adults with pre-existing conditions who are denied coverage also have a new option: the Pre-existing Condition Insurance Program (PCIP), federally funded but run by the California's Managed Care Medical Insurance Board. This program was established by SB227/AB1887 in 2010 to create an equitable, adequate, and consumer-friendly "high-risk" pool.

Recommended Actions
Adopt legislation and regulations to increase access for individuals of all ages with pre-existing conditions, including:

A. Ensure that all Californians, including those with pre-existing conditions, have access to coverage, by conforming state laws to federal laws starting in 2014. Prevent unfair price discrimination based on age, gender, illness or other personal characteristics, starting in 2014.
B. Implement AB 2244 which prevents children with pre-existing conditions from being denied for coverage, or charged more than twice a premium of another child if they sign up in an open enrollment period. Monitor how rates are being impacted for child-only coverage to prevent children from being priced out of coverage.
C. Encourage more aggressive outreach for, and educate Californians about, their new option, the Pre-existing Condition Insurance Program (PCIP) for those denied for pre-existing conditions.
D. Work to set up effective risk-adjustment mechanisms, so insurers who take on patients with ailments are not punished but actually rewarded, as a way to encourage insurers to compete for and do well by these patients.

POLICY OBJECTIVE #3
Enhance Consumer Protections and Insurer Oversight.

Background
Health insurance premiums are skyrocketing, with Anthem Blue Cross of California announcing rate increases of up to 39% last year, and new increases this year. In the individual insurance market especially, insurers can raise rates without approval (though new legislation effective January 1, 2011 requires them to provide justification). Insurers can raise rates multiple times a year.

California's health insurance market is deemed "highly concentrated," with two insurers claiming more than 50% of every insurance market in the state. Californians who buy coverage as individuals have little market power, and are at the mercy of the big insurance companies. Buying insurance on the individual market is the least efficient, most expensive way to get coverage. A significant percentage of premium dollars goes to administration and profit, rather than patient care.

Enhanced consumer protections and insurer oversight are needed as soon as possible, and they should also establish the foundation (or "glide path") for a reformed health insurance market place.

Recommended Actions
Prior to the full implementation ACA in 2014, adopt legislation and regulations to protect consumers and increase oversight of insurers, including:

A. Fully implement and enforce the new consumer protections provided by the federal Affordable Care Act.
B. Conform other state laws to the federal ACA, including underwriting rules for the individual and small group markets, and other consumer protections.

C. Insist on strong, vigorous, and detailed review of all rate filings at both the Department of Managed Health Care and Department of Insurance. Require that regulators ask for the right information that will reveal specific rate hikes on specific populations, like children.
D. Pass legislation on full rate regulation, so state regulators will have explicit authority to approve, deny, or modify rate increase requests.
E. Ensure that a significant portion of premium dollars go to patient care, rather than overhead and profit, through a "medical loss ratio" that is well defined and strongly enforced
F. Pass legislation prior to 2014 that phases-in early key minimum benefit standards, like a requirement for maternity coverage.
G. Standardize benefits so that purchasers can better shop between comparable plans with similar benefit designs.
H. Weed out "junk" insurance that provides no value to consumers prior to 2014.
I. Limit health insurance brokers' fees that have been as much as 20% of the premium for individuals.
J. Encourage county-based public health plans to form joint ventures that can compete in the Exchange, thus serving as "public options."
K. Facilitate other public health insurance options to compete with private insurers and further keep them accountable.
L. Adopt and implement rules for insurers that apply to the individual and group markets.
M. Provide rules for Accountable Care Organizations, so any entity that takes risk must also act responsibly and abide by regulations and responsibility.

POLICY OBJECTIVE #4
Increase Coverage through Expansions of State and County Health Initiatives, Streamlined Systems of Seamless and Continuous Coverage, and Aggressive Pre-Enrollment.

See the Summit paper presented by Western Center on Law and Poverty.

POLICY OBJECTIVE #5
Reduce Costs and Improve Quality, Prevention and Wellness in Our Health System.

See the Summit paper presented California Pan-Ethnic Health Network.