

MEMORANDUM

From: Melissa Rodgers, Berkeley CHEFS
To: Scott Bain, Roger Dunstan, Richard Figueroa, Peter Hansel, Melanie Moreno, David Panush, Sumi Sousa, Marjorie Swartz
Re: Technical Assistance on California Proposed Legislation Creating the California Health Benefit Exchange (SB 900 and AB 1602)
Date: June 23, 2010

SB 900 (Alquist/Steinberg) and AB 1602 (Perez) would implement Section 1311 of the federal Patient Protection and Affordable Care Act (ACA) and establish a California Health Benefit Exchange (“Exchange”).

Two principles guide this memorandum:

- 1) Individuals who qualify for subsidized coverage in the Exchange need access to good, affordable coverage options, so incentives that shield the Exchange from adverse selection and encourage insurance issuers to offer the same coverage inside and outside the Exchange are essential.
- 2) Those who are ineligible to enroll in a health insurance plan through the Exchange need access to good, affordable coverage options outside the Exchange.

After proposing specific recommendations on legal and policy issues relating to insurance markets inside and outside the Exchange, this memorandum also offers three technical, but important amendments.

Part I: Good Reasons Exist for Maintaining Insurance Markets Inside and Outside the Exchange but SB 900 and AB 1602 Could Do More to Shield the Exchange from the Risk of Adverse Selection

1) Maintaining a market outside the Exchange

SB 900 explicitly maintains the individual market outside the Exchange. Whether or not the small group market would continue to exist outside the Exchange is



unspecified in the bill language. AB 1602 does not address the issue directly but it does not specifically prohibit the existence of an individual and small group insurance market outside the Exchange. As drafted, SB 900 and AB 1602 allow insurers to offer *different* coverage inside and outside the Exchange, which potentially puts the Exchange at risk.

There are good reasons for maintaining a market outside the Exchange. Under ACA § 1332, California could exercise its option to waive ACA § 1312(d)(1) (Continued Operation of Market Outside Exchanges) and make the Exchange the sole source for individual and small group health insurance. But the composition of California's uninsured population argues in favor of maintaining a market outside the Exchange for individuals who do not have the option of purchasing coverage through the Exchange.

Furthermore, ACA § 1515 amends section 125 of the Internal Revenue Code to preclude employees from using section 125 plans, also known as “cafeteria plans,” to purchase individual coverage through the Exchange on a pre-tax basis. (Employees of small employers who choose to make group coverage available through the Exchange may use section 125 plans to do so.¹) Individuals who benefit only marginally from subsidies—or who do not qualify for subsidies at all—may opt for individual plans outside the Exchange, paid for with pre-tax dollars, over plans in the Exchange.²

Recommendation

For these reasons, it makes sense to maintain a market outside the Exchange **but ensure the same rules apply inside and outside the Exchange.**

¹ Under ACA § 1312(f)(2)(B), California could expand the Exchange to the large group market beginning in 2017. The provisions of ACA § 1515 would then apply to some employees of large employers as well.

² For an excellent analysis of section 125 plans after the ACA (also flagging the issue of potential HIPAA violations stemming from the use of section 125 plans to purchase individual insurance in the presence of medical underwriting), see Amy B. Monahan, *Section 125 Plans in the Post-reform Environment: Issues for Individual Insurance* (June 2010), available at <http://www.rwjf.org/files/research/64728.pdf>.

SB 890 (Alquist), if enacted, will create increased parity between the Exchange and remaining markets (although ACA § 1311(c) imposes a series of requirements on plans within the Exchange that SB 890 does not similarly impose on plans that could be offered outside the Exchange and additional differences between SB 890 and the ACA remain to be addressed³).

2) Reducing incentives for insurance issuers to offer catastrophic plans and bronze plans outside the Exchange that could compete for low-risk enrollees with plans in the Exchange

Under SB 900 and AB 1602 as currently drafted, insurers could structure their offerings inside and outside the Exchange in such a way as to draw low-risk enrollees outside the Exchange. Over time, this would lead to price increases for those enrolled in Exchange plans.

ACA § 1301 specifies that insurers who offer coverage through the Exchange must offer at least one silver and one gold plan. Premium credits in the Exchange are benchmarked on the second lowest-cost silver plan offered in the Exchange. ACA § 1401.

SB 900 requires the Exchange to provide a choice between the five levels of coverage (bronze through platinum, plus catastrophic) described in the ACA but it does not specify that each insurer must offer the five levels. AB 1602 does not set forth any requirements for the levels of plans that must be offered through the Exchange (beyond what ACA provides in § 1301).

Consequently, nothing prevents an insurer from offering a silver and gold plan through the Exchange, and offering bronze and catastrophic plans outside the Exchange. This has the potential to draw low-risk enrollees out of the Exchange. It could, for example, draw healthy, higher-income individuals (those with incomes above 300% of FPL) outside the Exchange if the monthly premium for a bronze plan outside the exchange were lower than the cost of a subsidized silver plan in the exchange.

³ For instance, SB 890 creates five standardized benefit plans (platinum to catastrophic) but the requirements for these five plans do not match those in the ACA.

The following example illustrates why a healthy adult at 350% of FPL may choose to enroll in an unsubsidized bronze plan rather than a subsidized silver plan.

Example:

Single 35 year old - 350% of FPL (\$37,905 per year in 2009)		
	Silver plan in the Exchange	Bronze Plan outside the Exchange
Actual annual plan premium	\$3436 (\$286/month) ⁴	\$3057 (\$255/month) ⁵
Maximum percentage of income spent on premium: 9.5%	\$3601 (\$300/month)	—
Premium credit	\$0	—
Annual premium payment (after credit)	\$3436 (\$286/month)	\$3057 (\$255/month)
Max out-of-pocket expenses	\$3867*	\$5800**

* ACA § 1402(c)(1)(A) specifies that reductions in out-of-pocket limits for plans sold within an Exchange will be based on limits for High Deductible Health Plans (HDHPs) as defined by 26 U.S.C. § 223(c)(2)(A)(ii) (\$5800 for single individuals in 2009). This limit is lowered by two thirds for individuals at or below 200% of FPL, by half for individuals at or below 300% of FPL, and by one third for individuals at or below 400% of FPL.

** ACA § 1201 creates § 2707 of the Public Health Service Act, which requires all individual and small group health plans (including those outside the Exchange) to cap out-of-pocket expenses in accordance with ACA § 1302(c) (which incorporates the limits for HDHPs set forth in the Internal Revenue Code, 26 U.S.C. § 223(c)(2)(A)(ii)).

⁴ Silver premium estimate is based on CBO estimates (11/30/09) of 2016 premiums for second lowest-cost “Silver” plan under HR 3590, deflated by 6.1 percent annually to estimate 2009 premiums. See UC Berkeley Labor Center Calculator at <http://laborcenter.berkeley.edu/healthpolicy/index.shtml#calculator>.

⁵ Bronze premium estimate is based on a CBO letter to Senator Olympia Snowe on January 11, 2010 estimating the average Bronze plans purchased individually in 2016 to be between \$4500 and \$5000. The midpoint of these figures, \$4750, was then deflated by 6.1 percent annually to arrive at an estimate for 2009.

The problem is exacerbated in the small group market, since the Exchange would not offer subsidies in that market. In the small group market, insurance issuers could draw low-risk groups outside the Exchange by offering different products, or possibly even charging different prices for the same products.

Note that as mentioned above, in the individual market SB 890 would reduce adverse selection against the Exchange by requiring insurers to sell only qualified health plans outside the Exchange.

Recommendation

Creating strong, market-wide risk adjustment mechanisms would reduce adverse selection⁶ but does not resolve the issue entirely. Protecting access to good, affordable coverage for Exchange plan enrollees could be achieved by (1) requiring insurance issuers who offer plans in the Exchange to offer all five plan levels (bronze through platinum, plus catastrophic) and (2) requiring issuers to charge the same amounts for the same plans inside and outside the Exchange.

3) Prohibiting insurers who sell coverage through the Exchange from circumventing single risk pool provisions and the recommendations outlined above by establishing subsidiaries or affiliates that would offer competing coverage outside the Exchange

Nothing in SB 900 or AB 1602 prohibits insurers from establishing subsidiaries or affiliates that could offer products outside the Exchange in direct competition with the plans offered through the Exchange.

ACA § 1312(c), establishing a single risk pool inside and outside the Exchange for plans offered on the individual market and plans offered on the small group market, provides some protection to the Exchange against adverse selection. However, the single risk pool provision only applies to “all health plans (other than grandfathered health plans) offered by [a health insurance] issuer.”⁷

⁶ See Katherine Baicker & William Dow, *Risk Selection and Risk Adjustment: Improving Insurance in the Individual and Small Group Markets*, 46 INQUIRY 215 (2009).

⁷ The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization ...) which is

Recommendation

SB 900 and AB 1602 should expand the single risk pool requirement in ACA § 1312(c) to include health insurance issuers *and their subsidiaries or affiliates*.

Part II: Technical Amendments

The following suggested amendments would clarify statutory language to bring it in alignment with existing law and implementation mechanisms.

1) Clarify language regarding screening and eligibility determinations

In discussing the process that the Exchange will use to route eligible individuals to Medi-Cal or Healthy Families, SB 900 and AB 1602 borrow from the language of ACA § 1311(d)(4)(F): “if through *screening* of the application by the Exchange, the Exchange *determines* that ... individuals are eligible for [Medicaid, CHIP, or a State or local public program, the Exchange shall] *enroll* such individuals in such program.” (italics added.)

This language blurs an important distinction between screening and eligibility determinations. As California’s Single Point of Entry (SPE) process demonstrates, screening and eligibility determinations are two distinct processes. At the SPE, a screening is used to determine whether, based on a preliminary assessment, an individual appears eligible for Medi-Cal or Healthy Families. The SPE then routes the application to another entity to perform the eligibility determination—either to MAXIMUS, the private vendor under contract with MRMIB to perform Healthy Families eligibility determinations⁸ or to county offices to evaluate eligibility for Medi-Cal. There is no question that screening and eligibility determinations occur at separate points in time. In fact, the time lag between a screening and an eligibility determination can potentially translate into enrollment delays, particularly if a screening error causes the application to be routed incorrectly.

licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). 42 U.S.C. § 300gg-91(b)(2).

⁸ MAXIMUS also has responsibility for the SPE screening process. Nonetheless, the screening and the eligibility determination occur at distinct points in time.

Concerns about such delays prompted California to institute accelerated enrollment for Medi-Cal at the SPE.

Recommendation

The language of SB 900 and AB 1602 pertaining to the screening and eligibility determination functions in the Exchange should be amended to distinguish clearly between the screening function and the eligibility determination function and to allocate responsibility for each precisely and accurately. Although the details may be developed in regulations, accurate and specific statutory language will provide appropriate guidance to administrative agencies or Boards responsible for promulgating regulations.

2) Clarify language regarding dependent coverage for children of domestic partners

Health & Safety Code § 1373(c) currently requires “[e]very plan that provides coverage to the spouse or dependents of the subscriber or spouse [to provide] immediate accident and sickness coverage . . . to each newborn infant [and adopted child] of the subscriber or spouse.” This language does not clearly include the child of the subscriber’s domestic partner.

The California Insurance Equality Act (IEA) requires health care service plans and health insurance plans to provide coverage to the registered domestic partner of an employee, subscriber, insured, or policyholder that is equal to the coverage it would provide to that individual’s spouse. Cal. Health & Safety Code § 1374.58(a) (“A plan may not offer or provide coverage *for a registered domestic partner* that is not equal to the coverage provided to the spouse of an employee or subscriber.”) (italics added); Cal. Ins. Code § 381.5(a) (“Every policy issued, amended, delivered, or renewed in this state shall provide coverage *for the registered domestic partner* of an insured or policyholder that is equal to, and subject to the same terms and conditions as, the coverage provided to a spouse of an insured or policyholder.”) (italics added).

Recommendation

AB 1602 already amends Health & Safety Code § 1373 by inserting subparagraph (d)(5). Section 1373(c) should also be amended to cover domestic partners,

consistent with California law including the IEA by inserting “or domestic partner” after each instance of the word “spouse” in 1373(c) as amended by § 6 of AB 1602.

3) Clarify that the prohibition against preexisting condition exclusions applies to individuals 19 and older effective in 2014

AB 1602 brings California law into alignment with provisions of the ACA pertaining to insurance market reforms unrelated to the Exchange. The ACA prohibits preexisting condition exclusions beginning in September 23, 2010 for individuals under 19 years of age and for everyone beginning January 1, 2014. The language in §§ 5 and 7 of AB 1602 incorporate the ban on preexisting condition exclusions for those under 19 years of age only, but does not mention that the ban goes into effect for everyone in 2014.

Recommendation

In order to align California law with the ACA, AB 1602 should incorporate the ban on preexisting condition exclusions for individuals of all ages that takes effect in 2014.

The mission of the Berkeley Center on Health, Economic & Family Security at the UC Berkeley School of Law (Berkeley CHEFS) is to address the increasing insecurity faced by workers and families in the United States through the development of integrated and interdisciplinary policy solutions.

www.law.berkeley.edu/chefs.htm

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