Testimony of
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Thank you for the invitation to be here today to discuss lessons from the California health reform effort and implications for national reform. I am Ruth Liu, Sr. Director of Health Policy in the Legal and Government Relations Department of Kaiser Foundation Health Plan ("Health Plan") and Kaiser Foundation Hospitals ("Hospitals"). Health Plan and Hospitals, together with the contracting Permanente Medical Groups, constitute the Kaiser Permanente Medical Care Program. Kaiser Permanente is the nation's largest private integrated health care delivery system, providing comprehensive health care services to more than 8.7 million members in nine states (California, Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington) and the District of Columbia. At the time of the California health reform effort, I was Associate Secretary at the California Health and Human Services Agency in the Schwarzenegger Administration. The views reflected in this testimony are my own, not that of Governor Schwarzenegger or his Administration.

Overview of Key Lessons

In the California reform effort, we focused on a broad definition of health reform, including prevention and wellness initiatives; a strategy for universal coverage and financing; and a focus on cost containment. I believe it is essential to focus on all three aspects simultaneously to ensure that any reform effort is financially sustainable in the long-term.

Second, we wrestled with issues of affordability, both affordability for purchasers of coverage and keeping the cost of the reform proposal affordable for the State. There are many lessons learned in terms of benefit design, subsidy design and shared responsibility that would translate well nationally.

Finally, we spent considerable effort in designing an approach that would allow us to transition as smoothly as possible from an underwritten, but robust, individual market to a guaranteed issue market without health status rating that preserved comprehensive offerings.

Broad Definition of Health Reform

The California reform effort was designed around three overarching principles:

- **A focus on prevention and wellness to ensure that the health reform effort had the objective of keeping people healthy at the center.** In this area we focused on strategies to foster individual responsibility for health through benefit product design; to promote more effective chronic care management; to engage communities in broad public health campaigns and initiatives; and to promote higher standards of patient safety in our hospitals.

- **Universal coverage to ensure that all Californians had access to high-quality, affordable health care.** To achieve universal coverage we felt it was imperative to have an individual mandate , as

a purely voluntary system will leave many individuals uninsured. The mandate also needed to be accompanied by subsidies for low-moderate income individuals and changes in market and rating rules in the individual market to ensure access and affordability for those with pre-existing health conditions. Effective enforcement of the mandate was also essential to spread risk broadly and keep premiums affordable.

- **Cost containment to move towards making health care more affordable for all purchasers of coverage and to promote strategies for more efficient health care delivery.** A key component in the area of cost containment for the currently insured was our focus on what we labeled the "hidden tax" or the cost shift that exists for commercial purchasers from both the uninsured and the underpayment of public programs. Medi-Cal, (California's Medicaid program) has one of the lowest provider reimbursement rates in the country and accounts for a significant shift of costs onto the private sector. A major financial component of our effort included increasing provider reimbursement rates for Medi-Cal by over $4 billion. This strategy was intended to both reduce the cost shift and improve access to providers for an expanded Medi-Cal program. Any significant expansion of the Medicaid program nationally under reform should take into account this issue. We also pursued a number of other initiatives to address the underlying costs of health care including promotion of health information technology and e-prescribing, pay for performance, fostering a greater reliance on evidence-based medicine and the prevention and wellness strategies noted above. Nationally, there are additional steps and policy levers at the government's disposal to drive more efficient care delivery and payment reforms.

Affordability for Individuals and the State: Benefit Design

A key consideration in designing a coverage proposal is the trade-off between the comprehensiveness and cost of a specified benefit design. For the subsidized benefit, this dilemma will affect both the overall cost of the program and the cost for the individual, in terms of any contribution towards the premium and associated cost sharing with the product. For the unsubsidized benefit, the question becomes what minimum level of comprehensiveness is appropriate in conjunction with an individual mandate. In the California proposal, we determined that it did not make sense to have one standard benefit for all income levels of the uninsured. Subsidized lower income individuals clearly needed a more comprehensive benefit with minimal cost sharing, but that same benefit design might be quite costly for individuals who were not subsidized, particularly for those with incomes just above the subsidy threshold level.

An addendum to this statement provides further detail, but in general the Administration proposed the following:

- Expanded public coverage for the lowest income individuals (Medic aid or CHIP for children up to 300% FPL; Medicaid up to 100% for all documented adults);
- Subsidized coverage with a sliding scale contribution towards premium for documented adults between 100-250% FPL. Subsidized coverage included a broad scope of benefits and moderate cost sharing;
- Mandated minimum coverage of a high deductible plan ($5,000), with preventive services, some office visits and some drug coverage outside the deductible for those above 250% FPL. The scope of benefits covered was similar to the subsidized benefit.

During negotiations with the Legislature these parameters were modified, and the minimum benefit was never defined, but there was general agreement that a variable benefit design approach dependent on the income level of the individual was preferable for both individuals and the State.

Affordability for Individuals and the State: Subsidy Design

Closely associated to the issue of benefit design and affordability was the issue of subsidy design. As indicated above, the lowest income individuals received a full subsidy with a sliding scale subsidy for those with slightly higher incomes, and no subsidy for those above 250% FPL. Several factors were considered in designing the sliding scale subsidy level including affordability for individuals, minimizing employer crowd out and federal cost sharing rules.

During negotiations, it became clear that a subsidy design with the income cut off levels we had proposed would be particularly problematic for older individuals. We had taken steps to phase out health status rating, but we allowed a continuation of age rating (and rating based on family size and geography). This meant that older individuals over 250% FPL would face quite high premiums. We felt that some difference in premium between younger and older individuals was appropriate given that 1) older individuals have less constraints on their budget than young families (no child care or education expenses and lower housing expenses) and 2) health coverage is of greater value since average utilization increases with age. However, we concluded that some additional financial assistance would be needed for this population.

There was considerable discussion around what level of subsidy could be offered and what the subsidy should be benchmarked against. Several stakeholders argued that subsidies should be based on all possible out of pocket costs rather than on premium alone which would have been prohibitively expensive for the State. In the end, we decided that additional subsidies would be provided on a sliding scale basis for those between 250-400% FPL if the premium cost for a product with moderate cost sharing ($2,500 deductible) exceeded 5.5% of gross income. This allowed the subsidy costs to remain affordable, while ensuring that individual out of pocket expenses would be limited.

Affordability for Individuals and the State: Shared Responsibility

One of the underlying principles articulated by Governor Schwarzenegger was his desire to have all stakeholders in the health care system bear some responsibility for reforming the health care system. This proved to be a fairly popular approach because the proposal was designed such that all stakeholders both benefited in some way from the proposal and also bore some new responsibility, financial or otherwise. While some of the specific measures used in the California proposal would not translate well nationally, the general principle should. At the national level there are also additional opportunities for shared responsibility that states cannot pursue. For instance, an employer mandate at the state level generally has to be considered as a “pay or play” mandate due to ERISA concerns, but at the national level policymakers could mandate at least larger employers to simply “play” at some minimum level.

Market Reform

One of the most difficult policy challenges we faced in California was determining the most appropriate way to move from a highly underwritten, but quite robust, individual market to an individual market with guaranteed issue, no health status rating, but still preserving more comprehensive benefit offerings for those who preferred them.

Here we could not look to other states that had adopted broad health reforms such as Massachusetts since the market conditions and regulatory rules were completely opposite. In California, the individual market is quite robust with relatively low premiums and younger and healthier individuals that can pass medical underwriting in the market. In Massachusetts, guaranteed issue and rating rules were already in existence before broad reform, and the individual market was quite expensive and generally much higher risk than in California. An influx of new

individuals into the market in Massachusetts, some higher risk, but others lower risk, would generally lower premium costs. In California, an influx of individuals, particularly a large number of higher risk individuals, would likely increase premiums considerably.

In particular, this meant that if we were to have guaranteed issue, we needed to ensure that the mandate would be well enforced so that younger healthier individuals would be more likely to comply with the mandate and moderate the risk pool and overall premium increases. This was quite a controversial issue and the compromise bill left much to be determined by the state during implementation. However, the enforcement measures widely discussed included a concept called "seamless coverage" which would permit the state to adopt a number of education and enrollment steps to improve compliance with the mandate. It would also allow the state to default enroll individuals who did not comply with the mandate after a specified period of time in the mandated minimum coverage and pay their premium until the individual was in compliance.

We certainly could not find a perfect solution to solve the complexity of issues this transition engendered, but we agreed on several approaches that would: gradually transition to our stated end goal while minimizing disruption of the current market; moderate likely premium increases for those currently in the individual market; and keep premiums relatively affordable for those entering the market for the first time. We also wanted to ensure that a broad choice of benefits, from less comprehensive to more comprehensive would be available on a guaranteed issue basis with rating appropriate to the difference in benefits, not expected risk. A summary of reforms and proposed market changes submitted by a coalition of health plans in California are included as an addendum to this statement. Some of the key reforms in addition to guaranteed issue and an enforceable mandate included:

- A gradual phasing out of health status rate bands;
- Grandfathering of individuals with current insurance if they had that insurance 18 months prior to the mandate;
- Requiring risk adjustment among plans across the newly insured pool and the grandfathered pool to ensure all plans shared the new "risk" in the market equitably;
- A requirement to offer a wide variety of products and to price them in relation to the rest of an insurer's portfolio. These requirements would preserve broad choice for consumers with rating appropriate to the difference in benefits, not anticipated risk.
- Corresponding rules for the purchase of guaranteed issue products by individuals to ensure that the comprehensive plans were not adversely selected against and prices remained affordable.

Determining a single strategy for a smooth transition in a national reform effort may prove very difficult given the wide variation in market conditions and regulations across the country. It may be preferable to establish federal standards around benefit design and financial subsidies along with rules and regulations to ensure broad choice and fair rating for consumers and appropriate risk adjustment across plans. Implementation benchmarks could also be established through federal regulation. States could be allowed to design their own transitional strategies to meet these benchmarks with provision of federal subsidy dollars tied to meeting these standards and benchmarks.

The goal of national health reform is an ambitious, but much needed policy reform in this country. I look forward to discussing these lessons from California with you in greater depth and discussing additional opportunities not available at the State level as you move forward with the national health agenda.

Addendum:

1) Benefit Design Considerations in the California Reform Effort

2) CA Market Reforms Overview

3) Rules to Safeguard Market Viability Under Guaranteed Issue

Benefit Design Considerations in the California Reform Effort

One of the key issues policymakers face in determining an appropriate benefit design for the currently uninsured population is the trade-off between comprehensiveness of the product and the cost.

In the California reform effort, the Administration's health reform team considered comprehensiveness of the benefit from the standpoint of both the scope of covered benefits and the cost sharing associated with the product. Likewise cost was considered from the standpoint of the cost of the premium for the individual and the ability of an individual to afford associated cost sharing. In the case of the subsidized product, consideration was also given to the subsidy costs for the state, the impact on employer "crowd out", and federal cost sharing rules that would impact the ability to draw down federal funds.

In terms of the scope of benefits, all individuals were required to purchase a product that met the "Knox Keene" standard required for all HMO products in the state, plus prescription drug coverage. Knox Keene requires coverage of all "basic health care services" including physician services, hospital inpatient and ambulatory care services, diagnostic lab and radiological services, home health services, preventive health services, emergency health care services and hospice care. In addition to these general categories, state lawmakers have included specific mandates that are a subset of these categories.

Cost sharing for the products varied dependent on the income level of the individual. Since lower income individuals have less discretionary income, the subsidized population had a benefit with zero to moderate cost sharing. Individual contributions towards the cost of the subsidized product were established as part of the shared responsibility principle for all but those with the lowest incomes, to offset some of the subsidy costs for the state, and to mitigate employer crowd out. Cost sharing for the unsubsidized product was set with much higher parameters. The rationale for this approach was two-fold: higher income individuals generally have more discretionary income, and with no subsidy for the premium costs, might prefer a benefit design with higher cost sharing parameters. In a guaranteed issue world, an individual could purchase a more comprehensive benefit design if they preferred.

The Administration team originally modeled costs based on the following parameters:

- All children regardless of documentation status up to 300% FPL eligible for either Medicaid (up to 100%) or SCHIP (101-300%).
- Documented adults up to 100% FPL – Eligible for Medicaid
- Documented adults 101-250% - Eligible for subsidized coverage.
    - Subsidized coverage defined as Knox Keene benefits plus prescription drugs.
    - Individual cost towards premium- 100-150% FPL- 3% of gross income, 151-200% FPL – 4% of gross income, 201-250% FPL – 6% of gross income.
    - $500 deductible, $3,000 out of pocket maximum. Prevention, physician office visits and Rx outside the deductible with limited copays.
- Documented adults above 250% - mandated to purchase minimum coverage. Minimum coverage never defined in legislation, but modeled at:
    - Knox Keene benefits plus prescription drugs

- $5,000 deductible; $7,500 individual/$10,000 family out of pocket maximum. Prevention, some physician office visits and some drug coverage outside the deductible with low-moderate copays.

During the negotiations with the Legislature the benefit parameters were modified somewhat, to reflect the following changes:

- Documented adults from 101-150% would have no contribution towards the premium.
- Adults from 151-250% would be required to contribute up to 5% of their income based on a sliding scale.
- Subsidized coverage benefits would be based on a modified SCHIP product with similar cost sharing parameters.
- Minimum benefit standard for those over 250% would be determined at a later date by a state agency through a public hearing process.
- Additional subsidies would be provided on a sliding scale basis for those between 250-400% FPL if the premium cost for a product with moderate cost sharing ($2,500 deductible) exceeded 5.5% of gross income.

California Health Reform Market Reforms Overview

- Individual Mandate for the purchase of coverage.

Intent: Necessary to attain universal coverage. Can better meet affordability concerns if all individuals are required to purchase coverage.

Exemptions may be provided for the following reasons: new California residents, individuals who apply for and are granted an affordability or a hardship exemption by the Managed Risk Medical Insurance Board (MRMIB), and persons with incomes below 250 percent of the Federal Poverty Level (FPL) if the cost of premiums for minimum creditable coverage exceeds five percent of their income. (*The last exemption is basically for undocumented adults below 250% who would not be eligible for subsidized coverage. Documented adults below 250% would qualify for either Medi-Cal or new subsidized coverage and would not have to pay more than 5% of income for that coverage*.)

- Guaranteed Issue of all products from onset of the mandate, with carriers required to offer a diversity of products from high-deductible to comprehensive.

Intent: Broad choice of guaranteed issue products for consumers.

Guaranteed issue corresponds to the mandate. If you are exempt from the mandate, you do not qualify for GI coverage.

- Use the "seamless coverage" approach to ensure that people comply with the mandate.

Intent: Enforcement of the individual mandate is essential for guaranteed issue to work properly. The state will adopt a number of education and enrollment steps to improve compliance with the mandate and will default enroll individuals in coverage after a specified period of time and pay their premium until the individual is in compliance.

- Grandfather products that are below the minimum standard for those who have had those products for 18 months prior to the mandate.

Intent: Don't require people who have been purchasing insurance to change their coverage. By grandfathering these people their rates will also initially be protected from major rate increases as a consequence of the new market rules.

- Individuals are allowed to purchase and renew coverage below the mandated minimum up to enactment of the mandate, but individuals purchasing this type of coverage will not be grandfathered, unless they had this coverage 18 months prior to the mandate.

Intent: Ensure that a variety of low-cost products are available to consumers before the individual mandate goes into effect.

- Prohibit the introduction of new products below the minimum standard 18 months in advance of the mandate.

Intent: While people with long-standing existing coverage below the minimum should not be forced to change their coverage, insurers should be discouraged from selling coverage that doesn't meet the minimum standards to get around our new policy. Over time, individuals with coverage lower than the minimum will shift over voluntarily to products that meet the minimum standard.

- Establish coverage choice categories and require insurers to offer choice in a variety of levels using a similar rating portfolio.

Intent: Ensure that a broad range of products are offered on a guaranteed issue basis from less comprehensive to more comprehensive in the reformed market and that they are priced in

relationship to each other based on differences in benefit design, not based on possible risk selection.

- Gradually phase out increased charges for health status by limiting the amount insurers can "rate up" for those with health problems.
    - For the first 2 years insurers can rate 20% above or below based on a person's health status.
    - For the next 2 years insurers can rate 10% above or below based on a person's health status.
    - After four years insurers cannot vary their rates based on a person's health status. Insurers will only be allowed to vary rates based on age, family composition, and geography.

Intent: "Soften" the transition from a market that is not guaranteed issue and where rates differ dramatically according to health status, to a market that is guaranteed issue and rates vary only by age, family and geography. Individuals who are older and sicker will pay more, but the differential is limited and they are guaranteed issue coverage. By allowing health status rate bands initially, there will not be as big a premium increase for young, healthy individuals who had coverage or who will be buying coverage for the first time. Individuals who had coverage that exceeds the minimum will still see premium increases estimated at about 20% more than they pay today. To minimize that expected rate increase we would need to either broaden the health status risk bands or "re-insure" products for these individuals at a cost of approximately $300 million. In our language we give authority for this reinsurance mechanism if we choose to pursue this strategy.

- Apply an overall maximum ratio (for example; rates for a 60-64 year old cannot be more than XXX higher than rates for a 30-34 year old) for individuals between 30-34 and the 60-64 rate categories.

Intent: Health status rate bands will mean that older individuals in general will pay more than younger individuals both because of their age and their higher health risk. By requiring an overall rate ratio for middle age to the oldest category we protect the oldest individuals from very high rates. We exclude the youngest (19-29) because we need to keep prices affordable for the youngest who will be the least likely to comply with the mandate.

- Require plans to redistribute funds among themselves based on the number of high risk individuals each health plan has.

Intent: Make sure that all health plans share the new "risk" in the market equitably. This component is particularly important because we are grandfathering a large number of individuals who have coverage that does not meet the minimum standard. Without this structure some plans may not participate fully and fairly in the guaranteed issue market. All plans should bear an equitable cost for reforming the market.

- Authorize a shared reinsurance provision, should the age adjusted risk of individuals enrolled in the unsubsidized market, significantly exceed the incidence of risk of those enrolled in the subsidized program.

Intent: Split the cost of reinsurance by having the plans bear the first portion of risk if the risk is up to 10% higher. This methodology will incentivize plans to better manage risk as they will be on the hook for the first level of reinsurance. The state then bears the additional cost of reinsurance above 10% as a means to keep rates more affordable for the majority of individuals.

Proposed Rules to Safeguard Market Viability under Guaranteed Issue

March 14, 2007

Prepared by Blue Shield of California, HealthNet, Kaiser Permanente, United Healthcare

Proposals mandating guaranteed issue of health insurance are among the ideas for health care reform recently advanced. However, as the experiences of a number of other states attest, instituting guaranteed issue in the individual market can trigger severe unintended consequences, such as large, destabilizing premium increases and insurer flight from the market. It is therefore critical that in implementing guaranteed issue, careful attention be paid to minimizing these risks and assuring that a wide variety of benefit packages can continue to be offered at reasonable rates.

Mandating coverage for all individuals is an absolute requirement for successful implementation of guaranteed issue, but it alone is not sufficient for a good outcome. The two-phase proposal described below represents our initial thinking about how guaranteed issue could be established without harming the people currently served in the individual market and assumes that other elements of health care reform proposed do not undermine a viable market.

Phase One: Transitioning to Full Guaranteed Issue

Because of the major risks involved in moving to guaranteed issue, it is important that there be a transition period to assure that persons currently in the market do not experience a sudden increase in rates and that the individual market remains viable. We propose the following transition rules:

- The state will define a baseline HMO benefit plan and a baseline PPO benefit plan with the same actuarial value.
- At some reasonable time after the baseline plans have been defined, a carrier must offer at least one baseline plan on a guarantee issue basis. If a carrier chooses to offer more than one product in the individual market, it must offer the baseline benefit plan for each product. A product offered in the subsidized pool would be excluded from this requirement.
- In offering the guaranteed issue benefit plans, a carrier shall continue to have flexibility in establishing and maintaining provider networks as long as the carrier meets regulatory requirements for access to care and as long as guaranteed issue is available in at least one product using each network offered by the carrier.
- The baseline product for each network offered by the carrier shall be its lowest priced product and be subject to guaranteed issue.
- Carriers may also offer other benefit plans not subject to guaranteed issue. Carriers will be able to develop benefit plans and price as they do now.
- At the same time that plans begin offering the baseline benefit, the individual mandate shall commence and the state shall begin enforcement activities.
- The state will continue to operate a high-risk pool similar to MRMIP and shall continue to subsidize its cost by an appropriation of no less than the amount now provided for support of MRMIP, which is $40 million from the Tobacco Tax.

End of Transition Period

- The transition period will end when there is full compliance with the individual mandate. We will work together and with the Governor's Office and the legislature to define full compliance.
- When it is determined that there is full compliance with the individual mandate, the phase two framework will go into effect.

Phase Two: Implementation of Full Guaranteed Issue

Objective:

To establish a functional, sustainable market where Californians who are not eligible for subsidized coverage and are required to purchase coverage through the individual market have guaranteed access to affordable coverage, regardless of health status.

Assumptions:

- All Californians are mandated to obtain health coverage through direct purchase, employment or a public plan.
- The individual mandate is fully effective and the State actively monitors and enforces the enrollment requirement.
- The individual mandate requires minimum coverage of a plan with high cost-sharing, such as a $5,000 deductible plan, with a $7,500 out-of-pocket maximum. Californians could also satisfy the mandate by purchasing any plan which meets federal qualification for an HSA-compatible HDHP plan.
- These rules would apply to adults above 250% of poverty and children above 300% of poverty who are ineligible for other public programs.

Benefit Plans:	**Rationale:**

• The State will define five classes of benefit plans, each class having an increasing level of benefits.
  o Within each class, the state will define one baseline HMO and one PPO plan, and a baseline for any other type of product that meets the minimum mandated benefit.
  o The State will define reasonable benefit variation from the baseline that will allow for a diverse market within each class.
  o The benefits within each class could be standard and uniform across all carriers, or the benefits offered in each class could be defined based on actuarial equivalence.
  o Each carrier in the individual market will offer at least one plan in each class.
  o Carriers are not obligated to offer all product options, but if a carrier chooses to offer a product option in one class, it must offer that product option in all classes
  o All plans will be offered to individuals on a guaranteed issue basis once full application of the individual mandate has been achieved.
• Carriers participating in the individual market must offer all plans in all of their approved service areas.
• Any coverage that does not at least equal the minimum state mandated plan does not qualify as meeting the individual coverage requirement.
• Classes defined by the state must reflect a reasonable continuum between the class with the highest and lowest level of benefits.
	• This allows an individual to choose a benefit plan with the appropriate level of coverage for the individual's needs.
	• Carriers should compete on the basis of price, quality and service, not risk selection. The state would act as "referee" establishing the rules and preventing carriers from designing plans to avoid high risk enrollees.

Guaranteed Issue Requirements:	**Rationale:**
• Individuals would elect a plan within a benefit classification. An individual may change plans as follows: o Annually, in the month of the individual's birthday, within the same benefit classification. o Every three years, in the month of the consumer's birthday, the consumer may move up one level of benefits. o At any time, within the same carrier's portfolio, a consumer may move to a lower class. o At significant life events, the individual would have broader open-enrollment choices and can move up two or three bands (upon marriage, the death of a subscriber). • Individuals applying for coverage would be required to fill out a standardized health status questionnaire to assist plans in identifying (a) persons in need of disease management, and (b) high risk applicants.	• The time limitation on enrollment protects the more comprehensive plans from accruing a high level of risk that would result in making them unaffordable. It would encourage people to choose benefit plans that will meet their needs over the long term. • Prior identification of persons in need of disease management allows plans to reach out to these people to encourage them to get the care they need. • Prior identification of high risk applicants will facilitate the re-insurance mechanism discussed below. The identification of "high risk" applicants would be invisible to the enrollee, except to the extent they are candidates for disease management.

Rating Rules:	**Rationale:**
• Carriers may rate the entire portfolio in accord with expected costs or other market considerations, but the rate for each plan would be set in relation to the balance of its portfolio. • Each plan would be priced as determined by each carrier to reflect their expected costs with appropriate cost-subsidization across the entire individual risk pool. Additional rules would require the following: o If a carrier offers different provider networks on different plans, it may consider the effect on health care costs. o Rates may vary from applicant to applicant by: (1) Age – Legislation to define specified age bands. (2) Family – Legislation to define 5 family sizes (Single Sub, Sub/Sp, Sub/Ch, etc…). Carriers can chose to offer only member level rates (a family rate would be the sum of the individual rates for each family member) (3) Geographic rate regions, limited to 9 regions, of a carrier's choice. A region may not split a county more than once, and within a county, may not split any block of zip codes sharing the first three digits. (4) Health Improvement Discounts. A carrier *may* reduce co-payments or offer premium discounts for non-smokers, individuals demonstrating weight loss through a measurable health improvement program or individuals actively participating in a carrier's disease management program. Any discounts must be approved by the state. • A carrier must use the same rating factors for age, family size and geographic location for each plan. • No artificial constraints will be placed on differences in rates by age, family composition, or region.	• These are similar to the current rules in the small group market. • Allowing pricing flexibility between plans allows carriers to reflect the differences in their cost structure and anticipated experience under each plan. • This structure must be linked with an effective reinsurance pool to protect the richest plan category from the selection costs likely to occur.

Reinsurance Pool:	**Rationale:**
• Carriers would be allowed to cede high risk enrollees into a subsidized pool. • This process would be invisible to the enrollee as it would be a financial arrangement between the carrier and the state. • Financing for this pool would be broad-based and shall not rely only on the premiums from the individual market. • There are various approaches to re-insurance that have been used and that are being developed. We could discuss the details of what would be best in California as part of development of the final proposal.	• This would help to maintain affordability for individuals. • This also helps to ensure a level playing field so that carriers compete based on price, quality and service rather than risk selection