Legislative Commission on Health Care Access
Health Insurance Exchange Working Group

Responses to Homework Questions
September 23, 2010

1) Which governance model do you think Minnesota should select for the exchange and why? State governmental agency, non-profit, quasi non-profit with a public governing board, federal government on behalf of the state, or some other model?

1

Committee leaders asked each of us at the September 8 meeting, to comment on our preferences for a Minnesota Exchange. The following recommendations are based more on insuring the uninsured than concentrating on cost reduction. If the goal is to focus on cost reduction, the following recommendations may differ.

The largest category of uninsured individuals – 61.1 percent/290,800 – are those that qualify for government health plans, but do not enroll.[1] This is not a recent development. There are many different reasons for the high uninsurance rate among these individuals. The determination of eligibility and maintaining eligibility seems to be one of the leading reasons, as discussed at the September 8 meeting during Stephanie Radtke's presentation.

A. **Minnesota should have a Minnesota based <u>state</u> exchange**. We do not want to reduce the high quality of care to which Minnesotans have become accustomed. A regional or national exchange are undesirable because they would be complex, and federal regulators know very little about the concerns of Minnesotans or the unique system that has been developed here. In general, Minnesota's health care industry operates more efficiently than in most other areas of the country. Our medical providers are local and communicate locally, not nationally.

B. **Minnesota should have <u>one</u> exchange with <u>four departments</u>.** There are four distinct categories of coverage and they should not be mixed. However, they can be administered through one exchange with four distinct, separate departments: 1) individuals under age 65, 2) small group, 3) individuals age 65 and older, and 4) all government health plans.

[1] MSH Fact Sheet February 2010. Figure 8, P 4.

C. Whether the Exchange should be a state department or an independent board depends on its primary mission.

If the primary mission is to enroll individuals and small groups into non-government plans, then it should be managed by an independent board, not a state agency. An independent exchange board would operate more like MCHA. As a non-profit independent agency, the Exchange will be less prone to political concerns. It offers continuity of leadership, not subject to the political considerations of the appointment process. The board's membership would reflect various stakeholders. Its budget would be separate from the state budget, making both its finances and management more transparent and accountable.

If the <u>exclusive</u> mission is to enroll uninsured individuals into subsidized health plans and government health plans, then it should be managed by a state agency. The state already has experience enrolling those that qualify for government health plans. Policy for these plans is already driven by the political process and controlled by state budgets. If, however, the secondary mission is to enroll people into private plans, then the Exchange should be structured as a non-profit, independent organization as recommended above.

An Additional Note to Ponder:

The state has tried to overcome the challenge of qualifying people who are eligible for government health plans and to streamline the enrollment process. One of the methods it attempted was HealthMatch.

My understanding is that around 2004, Minnesota officials began a projected 18-month program to create HealthMatch as a means of creating efficiency in enrolling this population. After spending millions of dollars, the state discontinued HealthMatch in 2008 because it was not close to completion and suffered through difficulties with the vendor. HealthMatch had proved too complex, with more than 16,000 decision points required to enroll an individual in the appropriate program. Thinking that people can be enrolled into health insurance under the same model that Expedia uses to "enroll" people on airline flights did not work with HealthMatch.

Choosing the best plan for an individual or a small group, we know, can be very complicated. Government subsidies have made this more complex, not less. Experience with online insurance web portals demonstrates the difficulty faced by individuals trying to choose the right plan. It is common for insurance agents to receive calls asking for advice from individuals that attempted to purchase from an online source.

The Exchange, with four levels of plans from the Bronze to the Platinum, and an unknown number of plan choices within each level, along with calculation of potential subsidies (or answers about why none are offered) will create a programming nightmare. Each option adds to the decision points needed by web programmers. Exchange enrollees will rely heavily on personal help, and the Working Group should develop a strategy for this. The complexity of health plan products and the need to select the appropriate product are major reasons why the state requires that health insurance agents must be licensed and take continuing education classes. The license ensures a level of expertise to advise and protect the consumer's interests.

People who have a strong desire to fly somewhere go to Expedia to “buy” an airline ticket. Very few people “buy” health insurance, and the ones that do are usually those who are sick. The other 90 percent of the population must be *sold* health insurance on the basis that they “may need it” in the future. Individuals that enroll in health insurance or government health plans are sold on the idea by someone else, someone who is motivated to do so. While the new law includes a mandate to purchase coverage or enroll in an appropriate government plan, it is not clear that individuals will comply, and a website does not make this any more likely.

By its nature, the Exchange will likely limit consumer options as it has done in Massachusetts. While standardization will be necessity do this within the Exchange, we feel it is important to maintain a robust and flexible market outside the Exchange so that consumers will continue to have a full range of options available and a marketplace that provides plan innovation.

2

I prefer a quasi non-profit with a public governing board or something equivalent. A fixed method for funding this administrative body should be built into the health cost budget for enrollees. A state and federal government run model is less desirable due to the influence of politics in decision-making.

3

The Exchange should be a non-profit organization with the following key goals:

- Establish an easy to use, desirable market place for individuals, small businesses, and, ultimately
  Large businesses, to shop for and buy high value health insurance coverage.
- Create competition among plans to offer value, choice and ease of enrollment.

- Develop a coordinated system which coordinates and leverages State programs.

The Exchange should be a non-profit organization with key leaders that have expertise in the areas of healthcare, State programs, and insurance. The leadership also needs to hold themselvesto high standards of integrity with a key focus on delivering high quality healthcare to all Minnesota residents. In addition, the governance should reflect the range of skills to operation such a business including financial, medical, and operational skills.

4

The governance model should address:

- Adherence to mission – promote access to affordable coverage in a manner that supports efforts to promote improved health, quality care, and cost containment.
- Provide stability in a manner that somewhat insulates the operation from both the instability of changing political choices and the lack of new ideas and energy if too internally governed by "insiders".
- Public accountability – the state will retain responsibility for any MA audit errors (a huge financial risk) and accountability in the eyes of the voters who use it. It is possible that the majority of users will be public program enrollees.
- Promote public and provider confidence and trust through transparentcy and a governance model that invites external input and makes changes in a open process.

Based in this, I recommend it be a semi-state or state agency with a broad based board of directors and a board appointed executive officer. The board appointment of the executive and the staggered terms of the board members will provide long term stability and keep it from the being controlled by either the governor or the legislature. This model has been used successfully before to insulate policy from politics while retaining accountability. A cautionary tale from the past: A previously government formed non-profit established to provide affordable loans to MN higher education students drifted away from that mission and ultimately only loaned funds to those seeking high end professional degrees (law, medicine, dentistry, etc.) and wouldn't support MNSCU students.

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Although there are pros and cons for each of these models, the model that would provide the greatest overall benefit to the state and provide the most stable, effective structure would be a

quasi non-profit board. A quasi non-profit board, similar to the structure created for Minnesota's high risk pool, the Minnesota Comprehensive Health Association (MCHA), has proven that a combination of government and the private sector provides the necessary consumer and regulatory oversight and the benefits of the expertise and efficiencies which exist in the private market.

Unlike, MCHA, the Exchange will not contract with a health plan to provide the back office structure and operations, but will likely need to contract with an IT-based organization to establish the structure and operations of the multiple transactions that will run through the Exchange. Due to rigid procurement laws and other limitations that exist for government agencies, using a private entity that is closely aligned with and directed by a state regulator to identify contractors will likely result in a better outcome. At the most recent meeting of the exchange working group, there was some discussion regarding concerns with privacy laws and whether a non-profit or quasi non-profit would fall short of meeting these requirements. This issue would easily be resolved either through legislation, specifically giving certain powers and authorization to this entity, or through other legal contractual arrangements used currently in the private market to ensure compliance with HIPAA and state privacy laws.

It is also important to acknowledge that the expertise needed for this board will be much more technical in nature and diverse than the current MCHA board. Areas of skill representation should include IT, actuary, process management, market knowledge, eligibility requirements and general business operations. While it may be appropriate to have approval of some of the board members by the governor or government entity, the governance should, to the extent possible, independent from political influence.

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As a point of reference I am a healthcare system CFO with public accounting experience as well, so my perspective comes from that background and experience. I chair the Finance Committee of the Minnesota Hospital Association so I polled the members of the committee last week regarding these questions, so I will include the consensus vote of the approximately 20 healthcare finance executives along with my individual opinion.

My preference is a non-profit model with the appropriate operating parameters and guidelines. Those guidelines should encourage free market activity, while honoring the intent of the federal legislation to ensure insurance policies are accessible for everyone. The operating guidelines should also design a model for selecting the governing body that ensures that board

members are selected based on qualifications and experience, with a process that ensures that happens.

I think the state (and federal) government has so many issues to deal with; this one could be offloaded, knowing the exchange has to operate within the parameters of the federal legislation. The quasi-governmental model would be my second choice, but I think the limiting factor is that the governing body might be seated based on politics and cronyism, and subject to change frequently with the majority party.

The consensus of the healthcare finance executives is to favor a non-profit model.

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A nonprofit, quasi-public entity, similar to the governance of the Minnesota Comprehensive Health Association (MCHA) should be the model for the Exchange. MCHA's governing board consists of representatives with diverse expertise in individual and small group health coverage including administration and purchase of health coverage as well as consumers. This model would be similar to the Massachusetts Connector, as well as the model proposed in California.

The governance of the Exchange should be independent from state government to prevent undue political influence. It is important for the governing board to have the skills to oversee and lead this complex and important effort, yet have the flexibility to act responsively to emerging challenges.

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I believe that the preferred structure for governance must satisfy a number of core criteria. First, there should be no opportunity for political partisanship. Second, the governance model must be stable for the long term and not subject to change based on elections results. Third, and most importantly, there needs to be balanced representation for all the stakeholders including potential users and those who have confronted the challenges of providing timely access to quality health care. A well-designed non-profit model or the quasi-non-profit with a public governing board would serve this intent the best. A model that should be seriously explored is that of the governance structure of non-profit 501(c) 3 Federally Qualified Health Centers ("FQHCs"). The FQHC criteria for the selection of board members would be well suited

for identifying stakeholders with a strong interest in assuring the success of the future Minnesota Health Exchange.

The agency created must embody a culture of inclusion and participation. The role of the Minnesota Health Exchange and the approach for basic plans is to encourage the broadest participation possible. A recent story I heard regards the cultural change that has taken place since 1983 in the use of seat belts. Though the seat belt laws have existed for over 25 years, the initial resistance to their use was strong. Now, most people are now uncomfortable in their cars if they do not wear a seatbelt since they recognize the safety they provide. In the same way, the Exchange should be provided with a communication arm to provide positive and accurate information so that public perception will be based on the real benefits of the Exchange.

An idea shared by another member who serves on the commission is to have a broad based:"open enrollment period" for exchange members that would coincide with employee sponsored coverage enrollment periods. Longer eligibility periods and "normalizing" the process of signing up for your health care plan could support stability and reduce the erratic nature of monthly program eligibility checking and oversight.

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The Minnesota exchange should be governed as a non-profit corporation. While governance by a state agency may seem to offer the simplest path, putting a state agency in control will likely give future lawmakers and public employees too much flexibility to transform the exchange to suit their policy goals. A person that believes federal health care reform is damaging our health care system may wish to constrain or even scuttle an exchange. On the other hand, a person that believes federal health care reform fell short may wish to use an exchange to extend government's role in the market. Putting a non-profit in charge will encourage lawmakers to be clearer about the structure and operation of the exchange, because they will not have the flexibility to make changes once the exchange is established. The Minnesota Comprehensive Health Association offers a good example for how a non-profit can be structured to maintain a steady course despite changes in the state's leadership.

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We recommend a nonprofit model of governance similar to the structure that has successfully governed MCHA with representation from critical stakeholders, to the extent permitted by

federal law. This would be a quasi-public/private entity in which some of the members of the governing body could be subject to approval or appointment by a government official or entity, yet governance would be independent from state government. This is important to prevent undue political influence from being brought to bear on day to day operations. It will be imperative that the governing body has the skills and expertise to oversee and lead this complex and important effort, and has the flexibility to act responsively to effectively face emerging challenges. This model builds on the long, successful history of public/private partnerships and collaboration that has made Minnesota unique in approaching health care coverage and quality of care.

11

As a public creation aiming to serve public purposes – and moreover as one that could determine eligibility for state and federal subsidies, distributing public funds – the exchange should be a public entity. Whether it gets housed within an existing agency or we create a freestanding new agency or public authority for it, the exchange needs to be public so that it can be directly accountable to the citizens of Minnesota. A non-profit organization cannot be charged with the distribution of tens or hundreds of millions of dollars in public funds; either the exchange will have to redirect people to a separate (and public) eligibility-determination system or the exchange will itself be public. It is important to underscore that the people and firms using or operating within the exchange – individual-market health insurance consumers, insurers, small businesses and small-business employees – are not the only groups to which the exchange must be accountable; it must be accountable to all taxpayers. The other key characteristic – closely tied to *accountability* – the exchange's governance structure should ensure is *transparency*. Only with open meetings and other requirements incumbent upon a public agency can transparency be ensured. One of the most important changes an effective exchange can bring to the existing health insurance market is the requirement that insurers report a variety of kinds of data that are not now made available to policy-makers. Such data can improve both policy decision-making and consumer choice, partially correcting for one of the most important market failures characterizing health insurance markets: imperfect information. The function of maximizing transparency (through making and enforcing rules) while ensuring the protection of privacy rights is an eminently public one – not something a private non-profit organization can or should be charged with.

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Quasi non-profit with a public governing board

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My position would be to endorse a quasi non-profit with a public governing board at the state-level. I think that a non-profit may have stronger incentive to be managed efficiently as compared to a governmental agency. However, I also believe that given the broad role that an Exchange will have in terms of determining public program eligibility as well as premium assistance credits for private plans, it will be important that there be a strong connection to facilitate outreach to consumers who are eligible for coverage under either type of expansion.

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With the information I have to date, I believe the best governance option for the Exchange is a quasi non-profit with a public governing board. This approach provides a balance between ceding state governmental control (by handing governance over completely to the federal government or a non-profit) and the potential for the Exchange to become mired in the bureaucracy associated with running the Exchange entirely through a state agency. Two criteria I use to come to this conclusion is:

1) the Exchange should be designed to be transparent in how it is organized, how it functions, and how it spends its dollars.
2) the Exchange should drive a reorganization of the eligibility determination process that is presently split among state and counties, and is presently much too complicated to be supported electronically. An outside agency would provide more potential for innovative approaches to simplifying the enrollment process for all Minnesotans, which may encounter more resistance if run through a state agency.

The quasi non-profit approach would also provide more flexibility in hiring (by not running up against state salary caps), which would help ensure a strong talent pool to develop and run the Exchange.

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Legal Aid recommends a state governmental agency independent of our current Medicaid agency and separate from the agencies that regulate insurance. The operation of the exchange must be transparent and accountable to the public. A state agency model while not perfect is a

model that has the potential to be the most accountable to the public. We are not persuaded that transparency and accountability can be ensured in either the quasi-government or non-profit models. Also, the exchange will need to interact and negotiate with a host of government agencies and believe it will be in a stronger position if the exchange is an independent agency.

16

Quasi public-private. Needs to be outside of government and protected from political environment. Also, needs to be nimble and able to function in a changing environment.

2) Which structure would best serve Minnesota and why? It seemed a single state exchange was the predominant view, but please indicate your preference and the reasons why. Multiple subsidiary exchanges, single state exchange, or regional exchange?

1

My perception was that a single state exchange is preferable to subsidiary exchanges. There was little opportunity to explore the value of a state exchange versus a regional exchange, other than to say that it would likely be more complicated than setting up a MN only exchange. I cannot agree that a regional exchange may be more complicated, however, without at least getting basic information about what regional states are doing, we do not know this. Further, regional states are more similar to MN than dissimilar, i.e. not like MS, TX, or AL, so collaboration with them may lead to a better exchange, greater risk sharing, and greater portability of coverage.

I think that the work group should at least talk with "Exchange" leaders in surrounding states to hear what they are doing and if there is interest in collaboration and/or cross state acceptance of Exchange products. It will also open our eyes regarding interstate problems that might arise as Exchange coverage expands.

2

The Exchange should coordinate and leverage resources across State and applicable Federal programs.

- Develop capacity to coordinate coverage with public programs and make subsidies easy to understand and use for all consumers.
- Outline role and responsibilities for a Navigator role
- Facilitate public health activities, and leverage health education activities in schools and the workplace.
- The Exchange should work with existing resources, like ICSI and MNCM, and use provider peer grouping date, to develop a research plan that would help all consumers make better choices, and establish better and consistent coverage policies for all plans in Minnesota.
- Coordinate member eligibility to ensure appropriate program enrollment
- Manage and coordinate Federal and State subsidies

A regional (multi state) exchange has the advantage over single state exchange(s) or multiple subsidiary exchanges as follows:

- provides maximum patient choice, especially for complex care
- best leverage the infrastructure and support mechanisms already in place.

3

A single state exchange will streamline administration, marketing and accountability. Within that there may be multiple "doors" if there are good policy reasons supported by actuarial work to keep certain groups separate.

4

In our opinion, a single state exchange provides the most value and benefits to the people of Minnesota. Acknowledging that the exchange (or exchanges) must be self-sustaining by 2015, having multiple exchanges would make this directive even more challenging. It's also not clear the purpose of multiple exchanges. One 'pro' shared with the group was that multiple exchanges could provide geographic rates, implying that a single exchange could not. However, the federal legislation explicitly allows geography as one of the factors on which premiums can be based. This can be achieved through a single state exchange through a zip-code feature that would pull up specific products and rates for that geographic area.

It is also not clear that a regional exchange would add additional value over a state exchange. Because the requirements and responsibilities of each exchange are vast and the amount of work and planning needed to prove it is ready by 2013 is so overwhelming, it is hard to imagine how adding additional states to the process will ease the burden. Having said that, a Minnesota exchange will need to consider how it will interact and work with other state exchanges due to the inherent challenges created by border issues for employers, but this can be achieved without actually combining exchanges.

The idea of a regional exchange may be worth exploring once a state exchange is established and operational but the first efforts should be focused on creating an exchange that is providing value for the people of Minnesota.

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It should be one state-wide exchange. If that were broken down into smaller regional exchanges unnecessary waste and overhead would likely be created. The one consideration to make within that is to creating two tiers within the exchange for the Twin Cities area and Outstate areas. There are different market dynamics in the Cities compared to the rest of the state. I would caution against creating too many tiers or carve-outs which would likewise create unnecessary overhead with little gain for that.

The consensus of the healthcare finance executives is to favor one state-wide exchange.

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A Minnesota based Exchange would retain the unique contributions the state has already developed. These include innovative and nationally respected initiatives such as Community Measurements and ICSI Guidelines. These are unique to Minnesota and are very helpful as we strive for high-quality, low-cost coverage, preserving Minnesota's position as a national health care leader.

In addition, regulators in Minnesota have expertise in the state market and provide appropriate oversight of all aspects of the local insurance market. Continuing a state based exchange with local oversight would promote timelier implementation at lower costs. It would be more responsive to Minnesota consumers' needs due to the understanding of the local insurance market, other state health insurance programs and consumer preferences within the state.

7

I agree that a single state-wide exchange is preferred. In-state regionalization would increase costs with no real benefit and a clustering of states in one exchange presents many barriers to creating a seamless system. Different historical perspectives and uneven learning between states could easily slow the process of implementation. A state-wide exchange would need a variety of access points, accommodate for unique needs of rural and metropolitan subscribers and insure consistency so behavioral health and oral health needs are not neglected. Outreach programs to varying constituents should also be included.

8

The initial exchange should be structured as a single statewide exchange. There does not seem to be strong evidence that variations within the state warrant multiple exchanges. A regional, multistate exchange may be advantageous in the future, but, again, there does not seem to be a strong rationale supporting a regional approach. A regional exchange would likely be difficult to develop and administer because it would need to connect to each member states' unique Medicaid program. Creating a single statewide exchange tailored to Minnesota's Medicaid program is probably a far more efficient approach. Importantly, that does not mean that a state exchange could not offer a health plan from another state. Beginning in 2016, Sec. 1333 of the Affordable Care Act authorizes states to enter into "health care choice compacts" that enables the sale of health plans in the exchange that are subject to the laws and regulations of another state. Minnesota consumer protection standards would still apply under this sort of compact.

9

HealthPartners believes that Minnesota is best served by an Exchange that is a state based operation and provides a facilitating function in the marketplace. We have a highly functional market in Minnesota with strong small employer market regulation. An Exchange for Minnesota only, run by a Minnesota non-profit entity, would best be able to build upon the success of our marketplace, address the unique structures of our state public programs and coordinate with our ongoing reform activities.

That being said, we do believe that we should remain in conversation with surrounding states, both to understand the approaches that they are taking and to be able to identify opportunities which, down the road, may benefit Minnesotans through multi-state Exchange or through regional Exchange. We do have concerns that a regional Exchange would present "lowest common denominator" choices with other participating states which likely have fewer consumer and market protections in place than Minnesota. This would clearly not favor Minnesotans. However, as markets and other factors change, there may be need to revisit the idea of a regional option.

Minnesota should operate only one Exchange with two separate risk pools. By this, we mean that there would be one governance structure, one staff, one back-office and so forth administering a risk pool for the individual market and a separate risk pool for the small group market.

We don't see the need for multiple subsidiary exchanges as the rating rules that will exist in the exchange allow for geographic adjustments. This should adequately account for some of the variances in the cost and availability of health care that we experience across Minnesota.

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From a national perspective, a federal exchange would have been a much better policy choice than state exchanges; however, it does not follow from this that individual states – especially lower-cost, higher-quality coverage states like Minnesota – would be well served by defaulting to a federal exchange that includes some but not all states. As many working-group members agreed in our last meeting, *a single state-level exchange makes the most sense for Minnesota*. Given the size of our state's population, subsidiary exchanges would have a hard time exercising any leverage at all in seeking to deliver cost or quality improvements. A multi-state regional exchange, on the other hand, has a lot to recommend it – increased ability to drive cost and quality improvements, elimination of redundant administrative costs, perhaps reduced barriers to mobility within the region – but is impractical in the short term for reasons both of politics and existing state regulations. A multi-state exchange in the Upper Midwest might be an excellent option for Minnesota to pursue in a few years' time; but for now the focus should be on getting a robust and effective exchange established at the state level, building upon some of the strengths (relative to other states, anyway) of our existing market rules and outcomes.

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Single state exchange

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I would endorse a single state exchange. There will be large fixed costs to running an exchange and scale will be important for the purpose of spreading those costs. There should be a way to separate the individual and small employer pools for the purpose of premium-setting.

If this is not the case, then it will be critical to do a study to understand differences in predicted expenditures/premiums between these populations. This modeling exercise is not as simple as just looking at the historical profiles of these two groups.

Among small employers, there are two types: (1) those that sponsor coverage and (2) those that do not. We could use historical information about the expected expenditures and premiums associated with group (1). We would need to know much more about the differences between (1) and (2) for thinking about pooling within the Exchange. Moreover, another wrinkle is that small employers with healthier employees will likely utilize the "grandfathering" clauses as long as they can.

For individuals, there are really three groups: (1) uninsured; (2) individuals who already purchase insurance in the regular market; and (3) enrollees in MN's high risk pool. Understanding the variation in costs/risk across these three segments may also help to inform the potential impact of combining individuals and small groups.

I'm less in favor of a regional exchange given the differing regulatory environments across states. I'm opposed to sub-state Exchanges since I don't think there is sufficient scale. I wouldn't be opposed to a federal exchange, except that I think the state has much better capacity to develop and run an Exchange.

13

Minnesota has the expertise and experience to run its own Exchange versus joining a regional effort which would significantly complicate decision-making on design and implementation issues. The single state option should provide a sufficiently large risk pool while still allowing for some level of local control and ensuring consistency with the state's regulatory framework. Exchange navigators could provide more customized local consumer assistance as needed.

14

A single state exchange because it seems to be the most feasible approach. Multiple exchanges would probably add complexity to the system for consumers. Also, it would be easier to integrate one exchange with other public program eligibility and enrollment.

15

Single state exchange. There appears to be no advantage in doing a multi-state exchange. MN has a fairly health population and the risk profile of a MN-state pool would be better than combining with another state. Also, the complexities of state insurance regulations make a multi-state pool almost impossible. I would want one state exchange - not multiple exchanges. Not sure about combining the small and individual market without more data on the risk profiles of each group.

3) Next meeting we'll be discussing the pros and cons regarding the adoption of a basic health plan option for individuals between 133 and 200% FPG. What do you believe are some of the pros and cons of establishing a basic health option for this population versus having these individuals purchase insurance through the exchange? What questions do we need answered before making this decision?

1

Having been a voting member of the Minnesota state Essential Benefit Set (EBS) Work Group in 2009, it is my feeling that MN should define a "basic health plan (benefit) option" with purchasable upgrades that would be enforceable for all insurance products offered in MN, not just those below or near the FPG or for that matter those purchasing from the MN Exchange. Only by doing so will it be possible to capture the greatest opportunity for improving health and lowering cost for Minnesotans, i.e. by creating a healthier population through affordable access to basic health care.

The MN mandated EBS Work Group was tasked by the state with creating an EBS that: 1) was not essential, i.e. not all state health plan insurance products would be required to offer essential benefits, and 2) retained segmented risk pools that would make it impossible to provide a health enhancing essential benefit product at an affordable price. As a result, the MN EBS Work Group mandated charge prevented it from being able to arrive at essential benefit set options that could even be actuarially "priced."

All Minnesotans should be exposed to an essential benefit set (basic health plan option) that exposes them to affordable services that maximize health. If this is offered than the 5% of patients that use 70% of health services will have greater likelihood of improved or stabilized health and associated substantially lower health service use and cost. This is where the real opportunity for cost savings is. Those with no health benefits (uninsured) or unnecessarily limited benefits (poorly insured), of whom many are at or near the poverty level and also will become a part of those accessing the Exchange, will continue to have illness that requires excessive use of health services and high cost.

2

Pros:
- ensures fair treatment to this population,
- ensures best use of federal support (subsidies),

- better supports universal coverage
- transparent benefit determination for provider billing
- administrative ease

Cons:
- could limit choice for this population,
- could drive the plan design down to the lowest common denominator.

3

Getting any information we have available about health status, typical length of time without coverage, etc. would help us identify if this population has unique needs that merit a basic health plan option tailored to their needs. At this level of earning it would not be unusual to identify a population with unique needs.

4

Any consideration of a basic health plan option for Minnesota needs to carefully review what we want MinnesotaCare to look like in a post-reform era (including whether MinnesotaCare is a viable option). At this point, we do not have a recommendation but have identified a number of questions that should be considered.

- Benefits: How will the essential benefit set compared to the MinnesotaCare benefit package? Are there benefits that have proven valuable in MinnesotaCare that will not be included in this product and what are the implications of these differences? Would a difference in the benefits create risk selection issues within the Exchange?
- Choice: Today, individuals who enroll in MinnesotaCare have a choice as to which health plan they prefer. This choice should be maintained moving forward.
- Funding: The state should seek to leverage the largest amount of federal funding as possible. How do the subsidies for a basic health plan compare to current federal funding levels for the MinnesotaCare program? Will the federal matching dollars remain a viable option in a post reform era?
- Eligibility: Will the eligibility requirements for the basic health plan be similar to or vary greatly from the current CHIP supported populations in MinnesotaCare? How will maintenance of effort requirements interact with this new program?
- Interaction with the Private Market and the Exchange: The state should analyze and address the various risks for adverse selection in the private market, the exchange

and any state public program or basic health plan program when developing policy for individuals and families currently served by MinnesotaCare.

These issues are just a partial list of the many issues to consider and likely further clarification will be required from the federal government before many of these issues can be answered.

5

Not having the benefit of discussion on this topic, I'm not sure what the context is for creating a basic health plan for individuals in a certain income bracket. If the thought is that they are unable to select their own health plan, this stratification becomes potentially arbitrary because I'm sure there are people in this income bracket who would make good choices and others in other income brackets that would not.

The advantage is that the choice is made; it's easy and doesn't require any thought or energy. In a complicated world maybe that's what people want. The disadvantage would be that because the individuals are not going through a selection process they may not take ownership for the policy being their own. Engagement happens when you are involved and provide input, and generally have a stake in it. If we go through this exercise of requiring everyone to have insurance and don't get engagement, then we will further accelerate healthcare spending.

One step to take is poll individuals in this demographic or any demographic for that matter, and ask them if they want some options or if they want it pre-designed. That would be one of the best ways to know, particularly if the vote was heavy one direction or another.

The consensus of the healthcare finance executives is to favor choice, rather than a basic health plan.

6

If the Basic Health Plan were to be established, it should function in a manner that complements, or possibly replaces, the MinnesotaCare plan that exists today. The eligibility concerns will vary depending upon the underlying basis for eligibility. For example, would CHIP-supported populations have different eligibility requirements than populations financed solely with subsidy dollars?

The Essential Benefit Set is not yet fully defined by the federal government; therefore, it is difficult to know how it will compare to the current benefit set in MinnesotaCare. Would a different benefit set create additional risk selection issues within the Exchange?

How can MN leverage the programs to get the most federal funding under existing public programs, like CHIP? Is there additional state funding that would be redirected towards this program?

Would all current health plans that administer MinnesotaCare choose to administer a Basic Health Plan, and what is the burden on them to administer another plan beyond the bronze, silver, gold and platinum plans? The value of reasonable choice of health plan organizations should be retained in programs developed.

The state needs to analyze the potential risks for adverse selection to the private market, the Exchange or other State Public Programs.

7

A basic plan option would support broad access. If a MN Care type plan is considered, a different standard of hospital coverage would be needed and preventative care, medication plan, and behavioral health and oral health option should be considered. The basic plan would be priced accordingly and integrate the levels of service described in the bronze, silver and gold levels. Questions that need to be asked are:

(a) Will the overall costs, including administrative costs be prohibitive and duplicative?
(b) Will there be a disparity between the basic health plan and those plans available on the exchange?
(c) Will both options include potential incentives for patients to seek primary care at a medical home and the right to seek care for the other services described above?
(d) Which approach would support an “all in” world-view as compared to that of excluding?
(e) Which is less cumbersome?
(f) Without a basic health plan, will the number of uninsured remain higher than one had hoped?

8

Under the basic health program, a state may contract with one or more health plans to provide health coverage for certain low-income people. A possible advantage to this approach is that the state would be able to negotiate a health plan contract that is better targeted to the unique needs of low-income families and individuals. Whether this population has unique needs that can benefit from a state-negotiated health plan is certainly debatable. MinnesotaCare is the current state program that serves this population and I am not aware of any evidence that MinnesotaCare serves this population better than a standard private health plan. Thus, an important question to ask is whether a state negotiated contract would be remarkably different (and better) from a standard contract. There are at least three serious disadvantages. First, the basic health plan would not be portable and would, therefore, force enrollees to move to a new plan when they lose eligibility. Second, just as with MinnesotaCare, the state may shift a portion of the cost of the health plan to the private health plans by negotiating premiums that are lower than the basic health plan's costs. Third, forcing low-income families and individuals to use the basic health plan restricts their ability to benefit from any positive developments that occur in the private market through increased competition.

9

In looking at the Basic Health Option, there are a variety of issues to address. While there is the promise of federal dollars for this population, it comes at a price – further dividing up the market and increasing the complexity of the insurance options for the State.

In our response to the State's Request for Comments on a Health Insurance Exchange, we expressed the opinion that Minnesota should not establish a "Basic Health Plan". The concept of the basic health plan is that the State can concentrate its buying power at one or more health plans, thus allowing State support dollars to go further. However, dividing the group of Minnesotans eligible for a federal subsidy into two groups - those eligible for the Basic Health Plan and those eligible for commercial coverage in the Exchange - increases complexity in education, eligibility and administration.

In Minnesota, the potential "Basic Health Plan" population is a sub-segment of those currently eligible for MinnesotaCare. We believe that all MinnesotaCare members should be allowed to remain dispersed among the plans, given that those plans will all participate in the Exchange, or choose new options that may be available through the Exchange. The State's premium supports could be re-purposed as subsidies over and above the Federal tax credits or to some other purpose.

This issue needs to be addressed in a way that minimizes risk selection challenges and administrative complexity while retaining choices for Minnesotans.

10

The Basic Health Plan is definitely something we should consider. It could provide coverage to low-income Minnesotans that is both more comprehensive and more affordable than their existing options. However, there are several critical questions we need to consider before we will know whether a Basic Health Plan is the right path to pursue:

- What federal rules and standards will HHS establish for these Basic Health Plans? What minimum characteristics must a state plan have to qualify as a Basic Health Plan?
- If we choose to exceed federal standards/requirements for a Basic Health Plan, how will it be paid for? More broadly/generally: what are the expected fiscal implications of establising a Basic Health Plan in Minnesota?
- Can the Basic Health Plan be offered through the exchange, or must it be a separate program? If the latter, is there some way to coordinate health-plan purchasing between the two (Basic Health Plan and exchange) to increase leverage on cost and quality improvements?
- What will happen to the state's existing high-risk pool, as we move forward with PPACA implementation?
- Would a Basic Health Plan allow more low-income families to have all family members receive care through the same program? (Would it reduce the number of families where the children are on one subsidized program while the parents are on another, or where spouses are on different programs?)

11

While I would need to further familiarize myself with the specifics of a potential basic health plan option, I would think one of the key questions is whether the closest benefit package in the exchange is similar to one that would be designed as the basic plan for these individuals. All else being equal, it seems that it would be preferable to have them purchase through the exchange.

12

The key issue is whether this would substitute for existing state-based public programs (e.g., Minnesota Care?). It might add additional complexity because now there would be 3 types of plans -- Medicaid for < 133% FPL; a basic health plan for 133-200%; and subsidized private plans for those 200-400%FPL.

What would be the funding mechanism for the basic health plan? Does this put the state at any greater risk financially?

13

Pros of a Basic Health Plan: For lower income individuals, enrolling in one state program with standardized benefits may be easier than selecting a private plan through the Exchange. It may also be an easier transition for people who were previously enrolled in MinnesotaCare. The state may also be able to realize greater efficiencies by enrolling all of these individuals into one plan. I believe the pros of establishing a Basic Health Plan for this group of low-income Minnesotans outweigh the cons.

Cons of a Basic Health Plan: would limit consumer choice for people in this income range, who may prefer to have a wider range of coverage options available to them. Depending on reimbursements, consumers may also face more limited provider choices through the Basic Health Plan

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While the federal law provides some details about the basic health plan option, experts at the national level agree that there are many questions about the basic health plan option that need to be answered through federal rulemaking and CMS guidance. Thus, until there is more federal guidance following is a list of questions:

- What federal rules and standards will HHS establish for these Basic Health Plans?
- How will Minnesota provide comprehensive and affordable health coverage for low-income Minnesotans between 133%-275% FPG.

- What Maintenance of Effort requirements must Minnesota take into account as we develop the exchange?
- What system will best ensure seamless transitions for low-income families/individuals as they transition from Medicaid?
- Could MinnesotaCare transition to the Basic Health Plan?
- What consumer protections will be established for the Basic Health Plan?
- What minimum characteristics must a state plan have to qualify as a Basic Health Plan?
- Can the Basic Health Plan be offered through the exchange, or must it be a separate program? If the latter, is there some way to coordinate health-plan purchasing between the two (Basic Health Plan and exchange) to increase leverage on cost and quality improvements?
- Would a Basic Health Plan allow more low-income families to have all family members receive care through the same program? (Would it reduce the number of families where the children are on one subsidized program while the parents are on another, or where spouses are on different programs?)

15

I am supportive of developing a basic health plan option but that it be integrated into the enrollment and eligibility through the exchange. The financing will be different but the process should be seamless. The advantage of course is the federal funding for this population. I would suggest a wraparound of the premium with HCAF dollars to make this option affordable with very low premiums if any and limited cost-sharing.