**Health Insurance Exchanges—Key Choices for States**
**June 7, 2011**

The panel received too many questions during our June 7 "Health Insurance Exchanges" to answer during the Q&A session. Below, moderator Sara Collins and panelist Micah Weinberg address remaining questions.

***General Exchange Q&A***

**Q: How many states have submitted letters of intent regarding applying for a Level 1 Establishment Grants by the June 30 deadline?**

Sara Collins: According to HHS, 10 states have submitted letters of intent to apply for establishment grants.

**Q: Does HHS provide information on which states have received which exchange planning grants to date?**

Sara Collins: Yes, at this website: http://www.healthcare.gov/news/factsheets/grantawardslist.html#territory (This link shows planning grants).

This link shows the first round of early innovator grants
http://www.healthcare.gov/news/factsheets/exchanges02162011a.html

**Q: In reading PPACA and the related implementing regulations issued so far, it appears that the feds are looking for increasing participation in Medicaid beyond the expansion: getting the 20% or so of Medicaid eligible individuals that are not current enrolled into Medicaid. Do you agree that this is an important objective?**

Sara Collins: Yes. Enrolling everyone who is eligible for coverage, whether in Medicaid, the Children's Health Insurance Program, subsidized private health insurance through the exchanges, or the Basic Health Plan if states pursue this option, should be a primary goal. This will ensure that people get the timely health care that they need and will protect them from catastrophic medical costs. It will also help protect safety-net institutions and other providers from financial loss, and create broad and diverse risk pools that will help keep premium growth low.

**Q: Speak to the definition of Basic Health Plan.**

Sara Collins: Here is a definition of the Basic Health Plan from the Commonwealth Fund's Health Reform Resource Center: http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx

> The secretary of HHS is required to establish a Basic Health Program. The program gives states the option of pooling 95 percent of the federal premium and cost-sharing subsidies

for people earning between 133 percent and 200 percent of poverty who would otherwise be eligible for subsidized coverage through an exchange. The state can use the pooled subsidies to establish a non-Medicaid, state-based "standard health plan" offered by private insurers under contract with the state. Standard health plans would be required to meet the essential benefits package requirements. States and the secretary must ensure that eligible individuals do not pay higher premiums than they would pay in the exchange, and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with incomes below 150 percent of poverty or the gold plan for all other enrollees. The state will create a competitive process for entering into contracts with standard health plans, including negotiating premiums, cost-sharing, and benefit packages directly with private health plans. In negotiation with plans, states will consider additional factors such as incentives for care coordination and management, use of preventive care services, patient involvement in decision-making, managed care, and reporting on established performance measures in the areas of quality improvement and health outcomes. Individuals with incomes between 133 percent and 200 percent of poverty in states that create basic health programs would not be eligible for subsidies in the exchange. In addition, participating plans would be required to meet a minimum medical-loss ratio of 85 percent. State administrators would seek to provide a choice of more than one plan. States could band together to form regional compacts that would pool coverage of all eligible individuals in those states in contracts with standard health plans.

**Q: When is the most appropriate time (prior to 2014) to begin educating the public about the state exchanges?**

Sara Collins: Now is a great time to begin educating people about the exchanges and the coverage expansions (Medicaid and private subsidized health insurance through the exchanges) since open enrollment will begin in late 2013. The Commonwealth Fund has several papers on insurance exchanges and other resources such as webinars:

Two papers by Timothy Stoltzfus Jost:
http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx

http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx

Commonwealth Fund Webinar on exchanges featuring Timothy Jost, Michael McRaith, and Sandra Shrewry: http://www.commonwealthfund.org/Content/Resources/2010/Webinar-Health-Insurance-Exchanges.aspx

Weinberg-Haase paper on California Health Benefit Exchange:
http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/May/State-Based-Coverage-Solutions.aspx

**Q: Only plans offered through the exchange are eligible for subsidies. Yes/no?**

Sara Collins: Yes, only plans offered through the exchanges are eligible for premium and cost-sharing tax credits. This will be true in all states.

**Q: Does the individual market HAVE to be a separate pool from the group market?**

Sara Collins: No, states have the option to merge their individual and small group markets and their individual and small group exchanges.

**Q: Where does Maryland stand? Seems they are doing something but in name only?**

Sara Collins: Maryland has signed legislation to establish its exchange and has appointed a board. It held its first meeting on June 3.You can find out more about where Maryland is in implementation at this link: http://dhmh.maryland.gov/healthreform/exchange/index.html

**Q: How are exchanges getting income information for tax credits and determination of what level they fall into?**

Sara Collins: Eligibility for tax credits will be based on someone's most recent federal income tax returns provided by the U.S. Department of the Treasury to the exchange. You can learn more about this in a recent issue brief by Pamela Short and colleagues at: http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/May/Maintaining-Coverage.aspx

***California Exchange Q&A***

**Q: How will the Medicaid program interact with the exchange?**

Micah Weinberg: In a general sense, there will be a process for screening applications first for eligibility for Medicaid and other public programs, as the exchange must be a portal to all different types of coverage. So programs have to have interoperable systems. If you move from Medicaid to the exchange, you are supposed to be able to keep your provider. The exchange will also, in states where this is permitted, work in coalition with other payers, such as Medicaid, to promote better value for medical spending.

**Q: What evidence-based research from the Utah and Massachusetts exchanges did California apply to expanding access, controlling cost, and quality outcomes?**

Micah Weinberg: Jon Kingsdale, who ran the Massachusetts Connector was a key consultant who helped design the California exchange, as were researchers that had published studies on Massachusetts and Utah and elsewhere (Institute for Health Policy Solutions). The Massachusetts exchange was more of a model for California than the Utah exchange, in part because of philosophical distinctions, in part because the Utah exchange isn't large enough, nor has it been in place long enough, to provide any meaningful data for evaluation.

**Q: Were the decisions about the exchange made with any public/consumer input? How was this input obtained? Are there any surveys or focus group guides that California developed that you are willing to share with other states?**

Micah Weinberg: I don't believe that there were any formal surveys or focus group guides. The team that wrote the bill brought in a broad cross-section of stakeholders (including consumer organizations) and there was intensive lobbying during the legislative process, but there was not a formal stakeholder engagement process.

**Q: Will the details of the Basic Health Plan option be determined by the board or through separate state legislation?**

Micah Weinberg: Whether California elects to pursue a Basic Health Plan will be determined by its legislature. The bill has already passed our State Senate and is making its way through the State Assembly.

**Q: How will the California exchange communicate with employers to verify employment and current eligibility for ESI for purposes of determining individual's eligibility for premium subsidies? Will the exchange contact employers at some point in the process prior to the notice of potential liability for Code 4980H penalties?**

Micah Weinberg: I'm certain that they will contact employers, but I don't think that the process has been officially established yet. It will also be shaped by the exchange regulations that have yet to be issued.

**Q: What are the projections on primary care provider supply as well as the impact of such legislation as AB97?**

Micah Weinberg: A very big question, not particularly unique to thinking about the exchange (and touched by many issues including the increased copayments of AB97). California is projected to need many more primary care providers.

**Q: How is a small group defined in California?**

Micah Weinberg: Currently 2 to 50 employees, though legislation has been proposed that would standardize the market from 2 to 100, which is needed by 2016 when the state will be required to expand the small group exchange to 100 or fewer employees.

**Q: Question concerning plans inside and outside the exchange in CA. It seems that a plan could design a very plan with a very slight difference and could get away.**

Micah Weinberg: In California, you will only be able to sell insurance at specified four actuarial tiers (plus catastrophic through the exchange). This requirement, in addition to risk pooling and risk adjustment, means that it's going to be more difficult, though not at all impossible, for insurers to game the system simply by making small adjustments to their benefit designs.

**Q: Will the two exchanges have separate boards?**

Micah Weinberg: No. Though they may have separate advisory boards.

**Q: Any indications from large health care insurance providers that may opt out of these mandatory issue state exchanges?**

Micah Weinberg: Well, the market is going to be guaranteed issue inside and outside of the exchanges. At this point, I believe that all of the major insurers (at least those I have talked to) are waiting to see how things proceed both in California and nationally before making a commitment one way or the other in terms of exchange participation.