

Comments on Exchange White Paper #3: Preparing for 2012 Exchange Legislation

To: **Virginia Health Reform Initiative**

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The implementation of a health benefit exchange in Virginia will require authorizing legislation that sets out the governance structure for the exchange and many of the rules that the Exchange will need to follow.

We have the following comments:

1. Section IV – Role of the Bureau of Insurance (BOI)

As noted in the paper, both the BOI and the Department of Health currently carry out certain reviews/certifications for health insurers in Virginia. As part of Virginia's implementation of the ACA, these various functions should be consolidated within one agency. It no longer makes sense for the Department of Health to have oversight of one kind of insurance plan (i.e. HMOs), but not others. Most of the ACA dictates apply to all types of health plans and this new reality should be reflected in Virginia law. We have previously indicated our support for the BOI to perform all ACA requirements for certifying qualified health plans.

While not included in the chart, it is important to point out that the BOI will also play a role in determining whether Virginia health plans meet the ACA Medical Loss Ratio requirements. We suggest that review of MLR

be included in later versions of the certification chart.

2. Section V – Distribution of Decisionmaking for the Exchange

“Major Decisions that Must Be Addressed By the General Assembly” – We agree that specifics regarding #1, 2 and 3b must be included in the legislation. In addition, we believe that #3e (funding), #3f (adherence to other state laws) and parts of #3i (competition, transparency and reporting) should be dealt with in the 2012 legislation. The remaining items can be delegated to the Governing Board.

It is absolutely essential for the legislation to give the Exchange Governing Board the discretion and authority to set strong requirements for plan participation, including quality of care, network adequacy and costs. Equally important are legislative standards to ensure competition and prevent adverse selection by requiring companies to offer the same plans inside and outside of the Exchange and prohibiting insurers outside the Exchange from only offering less comprehensive/less expensive coverage that attracts a younger and healthier risk pool. Without such provisions, the viability of the Exchange could be jeopardized.



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Specific comments follow :

- **#2 a, b and c. Governance**—As stated in the VHRI white paper, under the Affordable Care Act the General Assembly must set up the governance structure for the Exchange. We strongly agree with the Advisory Committee's preference that the Exchange be created as a “quasi-governmental” entity and the preliminary decisions to have a diverse Governance Board and/or advisory committee comprised of 11-15 members appointed to staggered terms.

As to specifics for the legislation: First, we believe the legislation should create both a Governing Board and an Advisory Committee; Second, we believe the legislation should include the specific types of experience and expertise required for members of the Governing Board who would be appointed by the Governor and General Assembly. In earlier comments we identified the range of expertise needed: certain ex-officio members representing state agencies; two consumer representatives with expertise in public health insurance programs and the needs of low income, disabled, and uninsured populations; one small business

representative; one member with expertise in health care financing and economics; one member with expertise as an insurance actuary; and two at-large members with expertise in any of the above-described areas. The Advisory Committee could have broader representation and would be selected by the Board and Executive Director.

- **#2 c. Conflict of Interest**—We wish to stress that the legislation should contain strong conflict-of-interest rules to prevent those with direct financial interests from making decisions regarding the Exchange. Members of the Governance Board will have a fiduciary duty to make decisions that are in the best interest of the overall exchange. This includes seeking to provide the most affordable and quality health plans possible for Virginia consumers and small businesses. As we stated in our earlier comments, to prevent conflicts, and even the appearance of a conflict, Virginia’s legislation concerning governance should specify that no employees or affiliates of insurers or insurance brokers can serve as voting members of the governing board for the Virginia Exchange.
- **#3bi. Exchange Executive Director should choose staff**—The white paper states the legislation would establish the Board’s authority to choose the “Executive Director and staff.” While the Board should undoubtedly choose the Director, staff decisions should be left to the Executive Director, who will lead the day-to-day operations of the Exchange.
- **#3bii. Discretion regarding plan participation**—The 2012 legislation should definitely give the Board discretion to strengthen

requirements for plan participation. The Board must have the authority to evaluate the quality of health plans in the Exchange, in terms of quality of care provided, networks and costs. The Board must have the ability to ensure the best value for Virginia consumers and purchasers. This must include the ability to negotiate prices to ensure the affordability of plans offered.

- **#3biii. Active Recruiting**—As we said in previous comments, Virginia’s Exchange board should be active in recruiting and selecting plans for participation. In other words, the exchange should not be required to accept all plans if they do not meet reasonable standards of quality and value. The legislation should give the Board clear authority and discretion to set standards above the minimum and to deny plans that do not meet the needs of consumers.
- **#3e. Funding Mechanism**—This should be determined in the legislation in order to meet the June 29, 2012 deadline for a Level Two Establishment grant.
- **3f. Congruence with other state laws**—The 2012 Legislation should include specific provisions that require the Exchange and its Governing Board to adhere to open meeting, freedom of information (FOIA) and rulemaking laws.
- **#3h. Setting broad goals and accountability mechanisms can be left to Governance Board**—The Governance Board will be able to assess the realistic benchmarks for the Exchange and implement procedures to monitor the Exchange’s effectiveness in increasing coverage and providing affordable insurance options for the Virginia consumer.

- **#3i (ii & iii). Competition policies, transparency of information and comprehensive reporting requirements must be addressed by the General Assembly AND the Governance Board**—The issues of competition and transparency both inside and outside of the Exchange are very important for the Virginia consumer. Health plans must be affordable and comprehensive, and Virginians need to have complete and easily understood information to make informed choices on coverage. The 2012 Legislation should require transparency and comprehensive reporting by health plans both in and outside the Exchange.

The legislation also must include rules to ensure competition and prevent adverse selection. We made lengthy comments in response to White Paper #2 about ways to minimize adverse selection which could destabilize the exchange and hurt its viability. As a basic concept, the 2012 Legislation must require companies to offer the same plans inside and outside of the exchange and prohibit insurers outside the exchange from only offering less comprehensive/less expensive coverage that attracts a younger and healthier risk pool.

- **#3(i)(i). Brokers**—If the Legislation addresses the role of brokers, no certification requirements should be included that would prevent direct service providers, community based organizations and others working with low-income populations from operating as Navigators. In fact, if addressed in the legislation, statutory language should specifically authorize those entities to serve as Navigators.

- **#4. The General Assembly should delineate Exchange duties, but Governance Board should implement**—The VHRI white paper correctly lists the minimum Exchange requirements under the Affordable Care Act. Thus, the General Assembly must include these duties in the authorizing legislation. However, the Governance Board and Exchange staff should be responsible for details and implementation.

We are comfortable with the outlines of “Major Policy Decisions That Could Be Delegated Entirely to the Board” and the “Major Policy Decisions That Could Be Delegated to the Executive Director.”

3. Section VI – The Basic Health Plan

Virginia should fully evaluate a Basic Health Plan for individuals with income below 200 percent of the Federal Poverty Level (FPL).

As described in the VHRI white paper, the ACA grants states an option to create a Basic Health Plan (BHP) for adults with income above the new Medicaid eligibility level [133% of the federal poverty level (FPL)] but less than 200% FPL. Using 2011 figures (without consideration of applicable disregards), this population would have the following income:

Family Size	133% FPL Annual Income	200% FPL Annual Income
1	\$14,484	\$21,780
2	\$19,565	\$29,420
3	\$24,645	\$37,060
4	\$29,726	\$44,700

The Basic Health Plan will also cover legally residing immigrants with incomes below 200% FPL who are not eligible for Medicaid.

The Basic Health Plan is an alternative to health coverage through the Exchange. If a state adopts a BHP,

eligible individuals must get their health coverage from the BHP instead of the Exchange.

We believe a BHP could provide many significant advantages for low income consumers in Virginia, and it could also be in the state’s interest to have such a program because more individuals will secure coverage with a BHP in place. More research and analysis need to be completed to fully evaluate the cost and benefits of a BHP and to determine if the federal payment for a BHP will fully support such a program. We encourage the VHRI to recommend a complete analysis of this option.

Advantages

a) Affordability

The BHP option allows states to create a program with lower out-of-pocket costs than Exchange plans. This would be an obvious benefit for low-income consumers, especially if Congress reduces the federal cost-sharing subsidies.

b) More Uninsured Virginians will Obtain Health Insurance

Without a BHP, people with income above Medicaid levels will have to seek coverage from the Exchange, and those plans may still prove too costly. If low income people are unable to afford Exchange plans (and they meet exceptions to the mandate) they may simply remain uninsured – continuing to forego needed health care and/or shift costs to the rest of the market through charity care and other mechanisms. The BHP would be more affordable – enabling more low income individuals and families to actually get insurance.

c) Family Unity

A BHP can facilitate coverage of adults and their children under one umbrella rather than splitting families

between the Exchange and other state-administered programs. For example, Virginia’s FAMIS program covers children with family income up to 200% FPL. With a BHP, the parents of FAMIS eligible children ideally could receive coverage from the same health plan. Aligning coverage and renewal dates for the entire family supports the concept of a “medical home.”

d) Continuity of Care

People and families with income below 200% FPL are likely to experience more fluctuations in income that would technically move them in and out of Medicaid eligibility. A BHP would provide much easier transitions between programs, especially if the same health plans were available. Avoiding gaps in coverage enhances continuity of care and, again, promotes the “medical home” concept.

The more a state’s Basic Health program resembles its Medicaid and/or CHIP programs in terms of having the same provider network, covered benefits, and cost-sharing requirements, the easier it will be for families whose incomes fluctuate during the year. We envision the BHP being administered by DMAS as an extension of Medicaid and FAMIS – programs DMAS already operates.

e) Coverage for Immigrants

The BHP provides federal financing to cover lawfully present immigrants who are not currently covered under Medicaid or FAMIS. Virginia currently has many gaps in Medicaid/FAMIS coverage for legal immigrants. While the state could exercise existing options to cover several groups of legal immigrants (e.g. pregnant women during their first five years in the US, FAMIS-eligible children during their first five years in the US, and all legal immigrants following the five-year bar) Virginia has not adopted these options. The BHP would offer coverage to these

groups and other legal immigrants – some of whom would have very low income and not be able to afford Exchange products.

Concerns and Analysis Needed

a) Will the federal dollars that are available to support the Basic Health program be adequate to create such a program?

To fund a BHP, the federal government will transfer to the state 95% of the premium credits and cost sharing reductions that individuals would otherwise have received if enrolled in the Exchange. In theory, States will receive substantially more per capita than they currently spend on Medicaid, making it possible for them to operate a BHP with lower out-of-pocket costs and possibly better benefits for enrollees and higher payments to providers (than current Medicaid payments). Such analysis would require an estimate of the number of people who would be in the Basic Health pool, the expected per capita costs, and a projection of the available federal revenue.

b) Will funding be sufficient to offer lower premiums and cost sharing than in Exchange plans?

Since the greatest advantage of a BHP for low income consumers is the potential for lower out of pocket costs, this aspect of the financial analysis is critical. Estimated “savings” can be used to reduce cost-sharing and increase benefits for Basic Health enrollees to, for example, align benefits with those provided in Medicaid/FAMIS. Competitive purchasing would be integral to achieving this goal.

c) How will the state ensure adequate provider networks and participation?

Provider payment rates in a BHP will be likely be lower than those paid in commercial plans offered by the Exchange, but they could be higher than Medicaid/FAMIS. Virginia could consider incentives to encourage plan and provider participation by combining the purchase of Medicaid/FAMIS and BHP plans and coordinating provider payments.

The impact of payment rates on the adequacy of provider networks and provider participation must be thoroughly examined. If a BHP is adopted, it must incorporate strong safeguards regarding network adequacy in its contracts, and the ability and commitment to enforce the contract if problems arise.

d) Are Virginia Health Plans and providers interested in providing coverage through the BHP?

The law contains many requirements for services, quality, case management, care coordination and a Medicaid Loss Ratio of 85%. We would expect that plans and primary care physicians currently serving Medicaid and FAMIS enrollees would also have an interest in BHP. To the extent possible, the state would want to contract with health plans and providers that provide coverage in Medicaid, FAMIS and Basic Health to ensure that the provider network across all three programs includes an array of providers that meets the needs of this population. That way, families would not have to switch plans and providers when they move between programs.

e) Will a BHP jeopardize the viability of the Exchange?

There must be additional analysis to consider the impact that a BHP would have on insurance market dynamics. If the Basic Health pool is removed from the Exchange, the Exchange risk pool for individuals becomes smaller. Will that affect the viability of the Exchange and/or the willingness of plans to participate in the Exchange?



In summary, the Basic Health Plan deserves serious consideration. It is a very attractive option because it can offer more affordable coverage and better continuity of care for low-income Virginians with income below 200% FPL. However, additional work is needed to fully evaluate the merits of a BHP – for both Virginia and the target population. VHRI should recommend comprehensive analysis of the option.