



**Health Benefit Exchange Planning  
Preliminary Research Findings**  
September 30, 2011



As authorized by HB1126, the Insurance Department issued a Request for Proposal for a contractor to “research several issues regarding exchange planning in North Dakota, taking into consideration the unique characteristics of North Dakota’s insurance market.

*“All  
healthcare  
is local”*

- *Pittsburgh Regional Health Initiative*
- *Executive Director of the Kansas Regional Health Network – August 2011*
- *MCPD Consulting in a presentation on HCR in Colorado – December 2010*
- *Editor’s Corner – FierceHealth IT – April 2011*
- *Quad City Community Healthcare in Indiana and Illinois*
- *Transition Healthcare Company in Nashville Tennessee*
- *CMS Center for Medicare and Medicaid Innovation*
- *“All healthcare is local” conference in Indiana*
- *And so on....*

***HTMS’s goal is to provide data, analysis, and intelligence that assists North Dakota with developing an HBE solution that fits the state’s unique needs***

# Contents

- *Project Overview*
- *Data: The North Dakota marketplace in context*
  - *Population demographics*
  - *Marketplace demographics*
- *Perspectives: Feedback from stakeholders*
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- *What's next*

# HTMS services

*Healthcare  
Technology  
Management  
Services  
(HTMS) is a  
consulting firm  
that services  
private and  
public sector  
clients in the  
health industry*

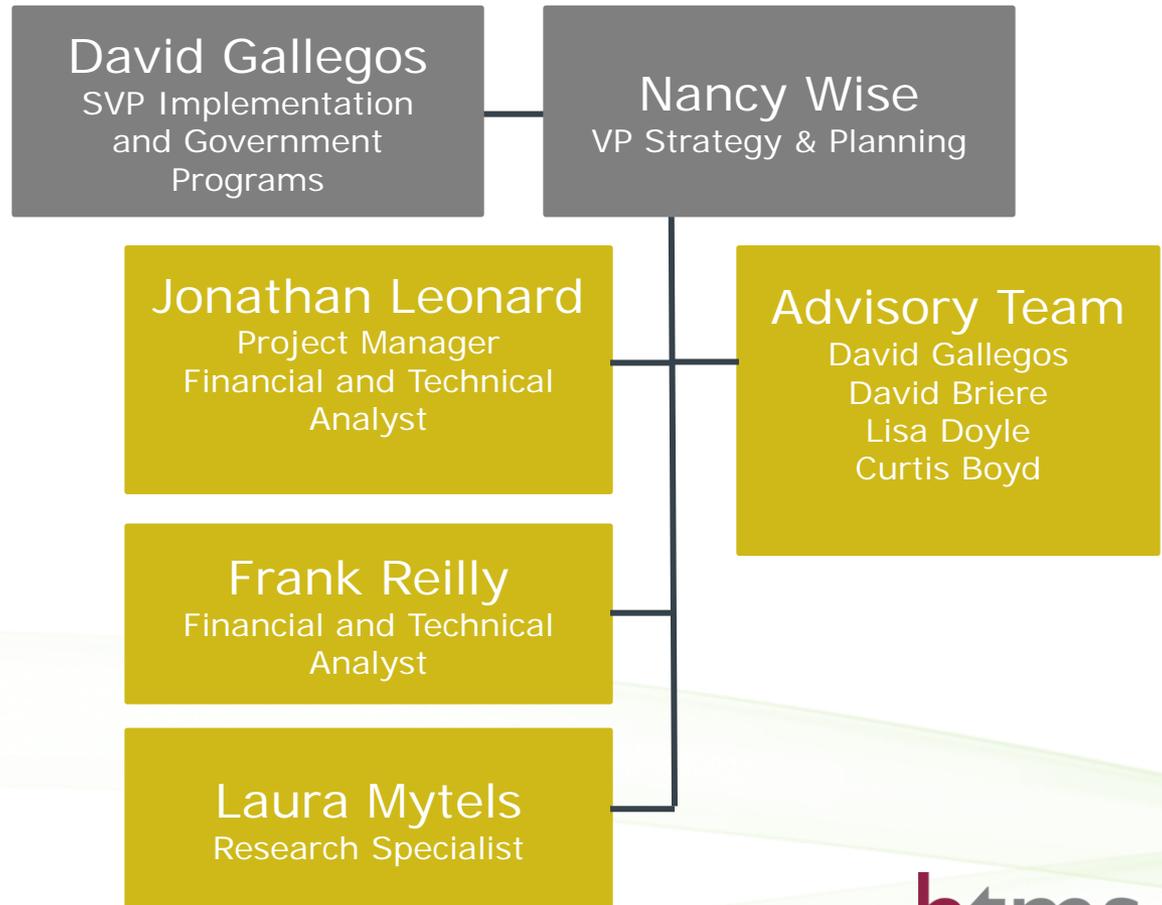


# Project Organization Chart

**Emdeon Government Affairs Department**  
Regulatory and governmental expertise

**Emdeon Payer Services Team**  
Expertise on transactions and data interchange

**HTMS Consulting Pool**  
Expertise on operations, technology, care management, & other aspects of healthcare administration



# The Research Plan (in progress) is intended to quickly survey perspectives of key stakeholders

*Findings in this report are based on research conducted through Sept 30, 2011. Additional findings will be summarized in future project deliverables.*

<b>Constituent</b>	<b>Summary of Research Method</b>	<b>Status</b>
<b>ND State Departments</b>	In-person interviews	<b>Complete – findings included in this document</b>
<b>ND Health Plans</b>	Online survey to a select group of health plans active in ND	Survey is currently in progress – no findings to date
<b>Agents / Brokers</b>	Utilize summaries from NDID stakeholder meetings	<b>Analysis complete – findings included in this document</b>
<b>ND Consumer Interests</b>	<ul style="list-style-type: none"> <li>Utilize summaries from NDID stakeholder meetings</li> <li>Online survey made available to consumer membership organizations that care about health insurance</li> </ul>	<ul style="list-style-type: none"> <li>Analysis of stakeholder notes complete – findings included in this document</li> <li>Survey launches early October – no findings to date</li> </ul>
<b>Providers</b>	Interviews with targeted provider group representatives	Scheduling underway – no findings to date
<b>Small Employers / Business</b>	Two group interviews (via conference call) with small businesses	Scheduling underway – no findings to date
<b>Other State Exchange Initiatives</b>	<ul style="list-style-type: none"> <li>Research published materials from other state reform efforts</li> <li>Interview target states</li> </ul>	To begin mid-October

# High level Financial Analysis (in progress) will estimate demographic, market, and business components of the HBE

## Demographics

- Uninsured
- “Take Up” and “Churn” rates for the exchange:
  - Medicaid
  - CHIP
  - Individual
  - SHOP

## Marketplace

- Explore the pros and cons of merging individual and small group markets into one rating pool
- Projected customer mix relative to health status
- Estimate number of enrollees and premium levels for private plans in exchange

## Business Modeling

- Infrastructure costs
- Revenue sources
- Design assumptions
- Personnel estimates and salary levels
- Exchange operation models

# Deliverables and project milestones

Milestone	Week Beginning	Driving Factors
Project Start	9/5/11	As agreed
Meetings in Bismarck	9/12/11	As agreed
Initial Research Findings	9/30/11	Materials supplied in advance of the HB1126 bill deadline to introduce legislation – Oct 15
Mid-Stage Research Findings	10/18/11	Interim research findings
Interim Deliverable	10/31/11	Draft materials provided before the special legislative session
Final Deliverable Due	Actual date - 12/2/11	Per the RFP

# Project goals – Outcomes

**Data Set** – Provides a concise compilation of the data needed to estimate impacts and requirements of the exchange

**Financial Models** – Estimates participation in the exchange and operational costs under a range of different scenarios

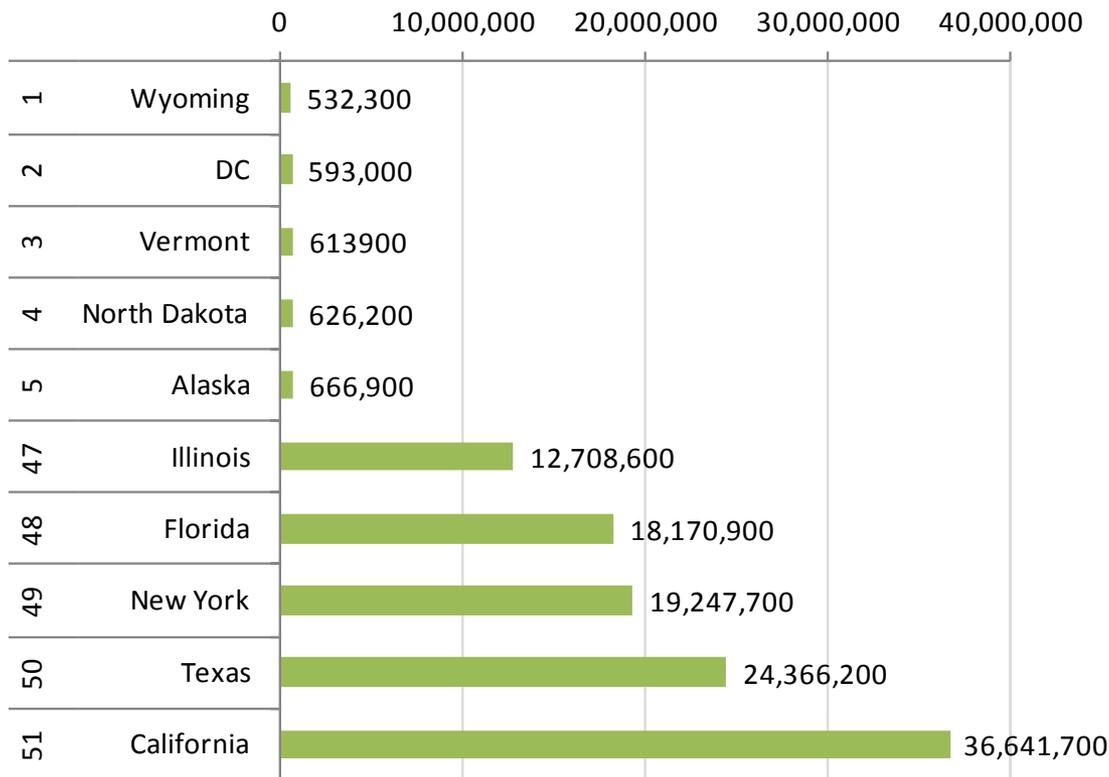
**Findings Report** – Includes high level findings from all portions of the project, including pros, cons, and consequences for a range of questions related to the exchange

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From a population size perspective, North Dakota is tracking the activities of some of the smaller states, such as South Dakota, Vermont, Delaware, and Rhode Island

### Big and Little States Population Comparison



*The extreme variation in population size between states illustrates why a there is no such thing as a one-size-fits all HBE solution.*

Note: Analysis includes 51 states because the District of Columbia is included in this source listing; state data represent two year averages

Source: "The Kaiser Family Foundation, statehealthfacts.org. Data source: Census Bureau's March 2009 and 2010 Current Population Surveys"

# In general, compared to the rest of the United States, North Dakotans are...

	North Dakotans	Americans
less likely to be poor	% living below 100% FPL	
	14	20
more likely to live outside of the city	% living in a non-metropolitan area	
	51	16
less likely to be uninsured	% of non-elderly without insurance	
	13	19
less likely to be on Medicaid	% growth in the non-elderly covered by Medicaid	
	9	17
less likely to have lost health insurance coverage	% growth in the non-elderly uninsured	
	-1.4	1.5
more likely to be very friendly	ND ranked as the friendliest state by Cambridge University in 2009	

*These elements are part of the unique factors that make North Dakota unique...*

*...and also those that define what needs to be included in an HBE*

Sources: "The Kaiser Family Foundation, statehealthfacts.org. Data source: ND Dept of Tourism

# North Dakota has the lowest Medicaid enrollment in the country

	# Enrolled, FY 2007
<b>U.S.</b>	<b>58,106,100</b>
1. North Dakota	69,400
2. Wyoming	78,100
3. Montana	110,800
4. Alaska	120,800
5. South Dakota	122,700
6. New Hampshire	143,500
7. Vermont	157,600
8. DC	164,900
9. Delaware	184,900
10. Rhode Island	195,400

*Medicaid enrollees will interact with exchange through eligibility and referral only.*

*The cost for the exchange to integrate eligibility with Medicaid could largely be a fixed sum and will be spread across a smaller number of individuals than it would be in other, larger states.*

*Note: Medicaid enrollment data here is based upon data from CMS and may differ from census data used to compare coverage for the population*

*Source: "The Kaiser Family Foundation, statehealthfacts.org. Data source: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2010.*

# North Dakota is also expected to experience one of the highest percent increases in enrollment among states due to Medicaid expansion under the ACA

	% change in Enrollment, 2019
U.S.	27.4%
1. Nevada	61.7%
2. Oregon	60.6%
3. Utah	56.1%
4. Montana	54.5%
5. Oklahoma	51.2%
6. Colorado	47.7%
7. Texas	45.5%
8. North Dakota	44.0%
9. Kansas	42.0%
10. Virginia	41.8%

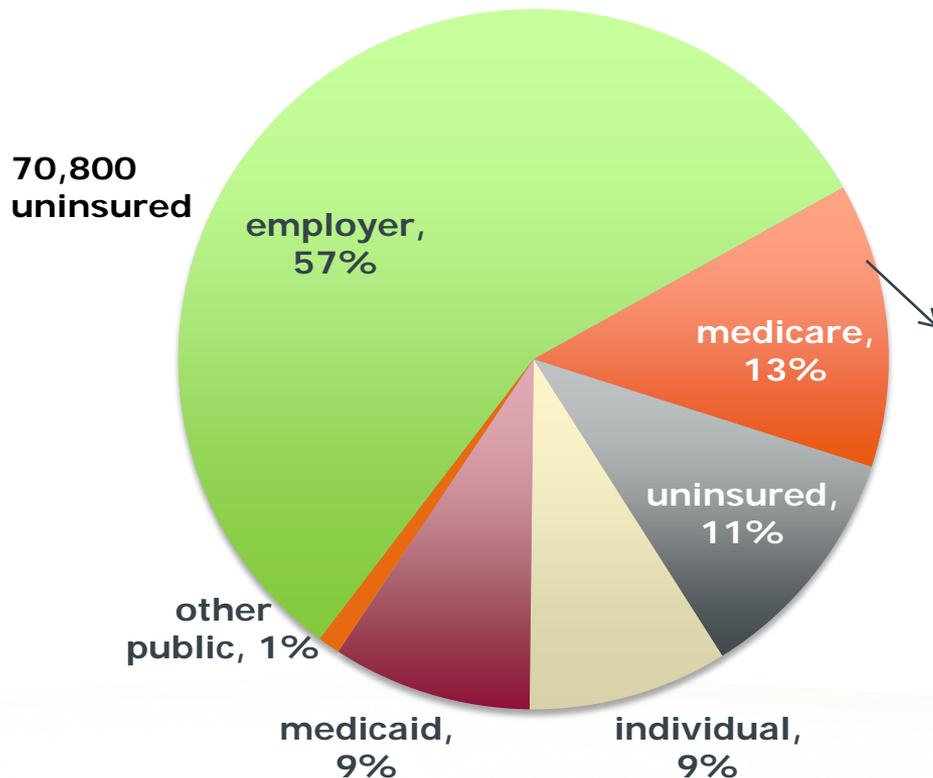
*Expanding the Medicaid population by 44% will result in additional program impacts that will require the department's attention.*

Source: "The Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org). Data source: Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL, the Urban Institute, May 2010. Available at: <http://www.kff.org/healthreform/8076.cfm>.

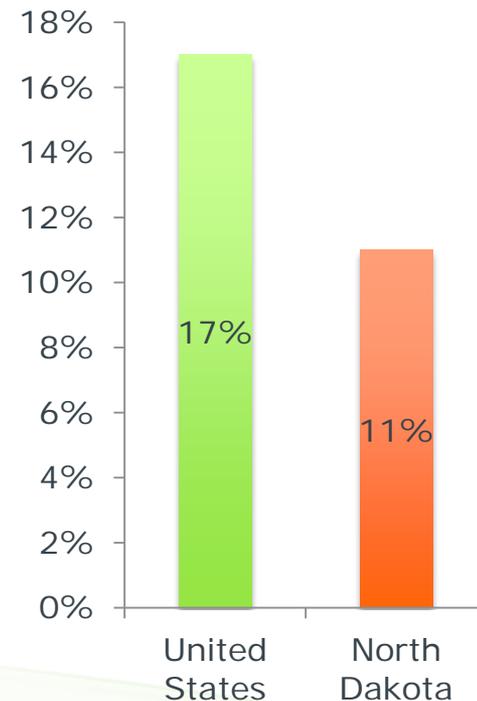
Note: For individuals whose income will be determined using the new income counting rules, the law also specifies that the first 5% of income be disregarded and deducted from an individual's income when determining Medicaid eligibility. This income counting rule effectively raises the upper income eligibility threshold for the new Medicaid eligibility group to 138% FPL.

# Eleven percent of North Dakota's population is uninsured and is a prime target for exchange enrollees

Sources of Insurance Coverage in North Dakota



*When compared to the rest of the US, there is a smaller portion of uninsured in North Dakota*



*Note: Further investigation into profile of uninsured is underway; Medicaid enrollment data based upon data from CMS and may differ from census data used to compare coverage for the population*

*Source: The Kaiser Family Foundation, statehealthfacts.org. Data source Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).*

# The uninsured will make up portion of those likely to seek coverage through exchange

FPL	Children	Adults	Coverage Eligibility
under 139%	5,000	24,100	Medicaid
139-250%	NSD*	18,100	Eligible for subsidies
251-399%	NSD	9,900	Eligible for subsidies
400%	NSD	NSD	Subject to mandate

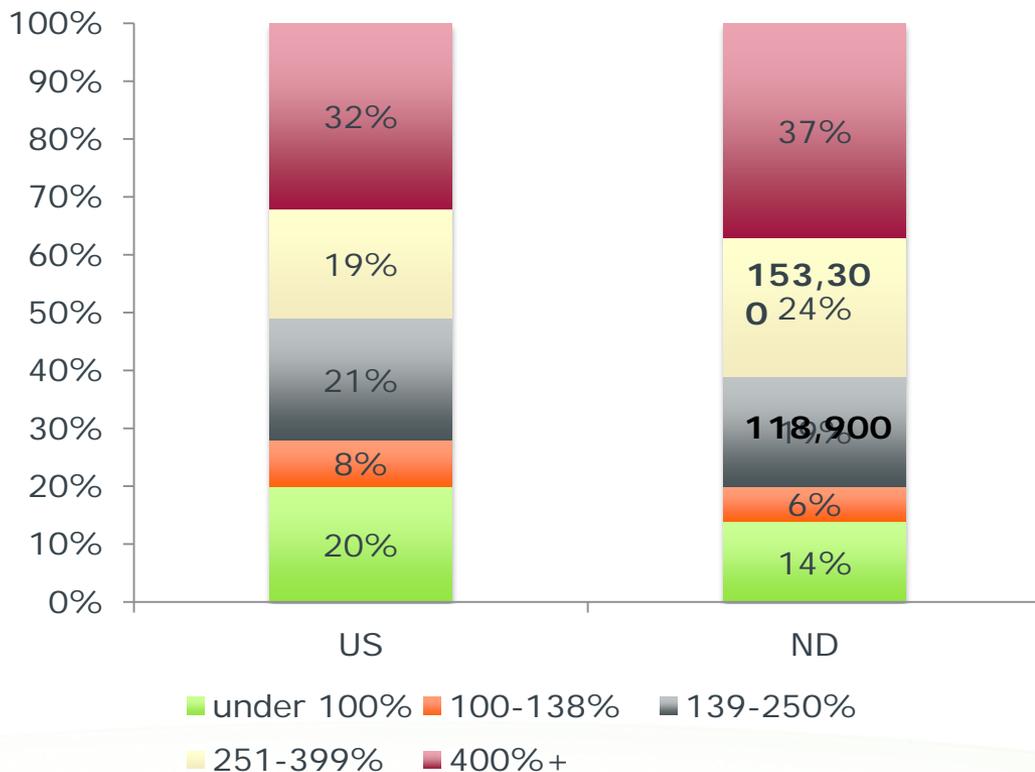
*Future modeling will estimate how many of those eligible to access the exchange will actually seek to purchase insurance through it*

*\*Not Sufficient Data*

*Source: The Kaiser Family Foundation, statehealthfacts.org. Data source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).*

# The percentage of North Dakotans eligible for subsidies mirrors that of the national population

Population by Federal Poverty Level



*Future modeling will help determine estimates for how many will access insurance through the exchange. Many of those eligible for the exchange may be obtaining insurance through their employer.*

***In 2014, subsidies will be available to individuals and families between 139-400% FPL through exchange***

Source: Source: "The Kaiser Family Foundation, statehealthfacts.org. Data source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

# Development of Navigator and language support services could be less onerous for North Dakota than many other states

	% Population over age 5 who speak English "very well"
<i>North Dakota</i>	98.7%
California	80.2%
Texas	85.6%
New York	86.5%
<b>United States</b>	<b>91.3%</b>

*North Dakota's exchange will have limited requirements for translation services when compared with other states*

*Although explicit language translation requirements have not been defined for exchanges, many are referring to CMS standards, which require translation for regions with at least 10% of the population primarily speak another language.*

Source: US census Bureau, 2010 American Community Survey 1-Year Estimates

# North Dakota is among several states that will need to pay particular attention to needs of Native American population when developing its exchange

	% American Indian/ Alaskan Native (one race only) *
<b>United States</b>	<b>0.9%</b>
1. Alaska	14.8%
2. New Mexico	9.4%
3. South Dakota	8.8%
4. Oklahoma	8.6%
5. Montana	6.3%
6. <i>North Dakota</i>	5.4%

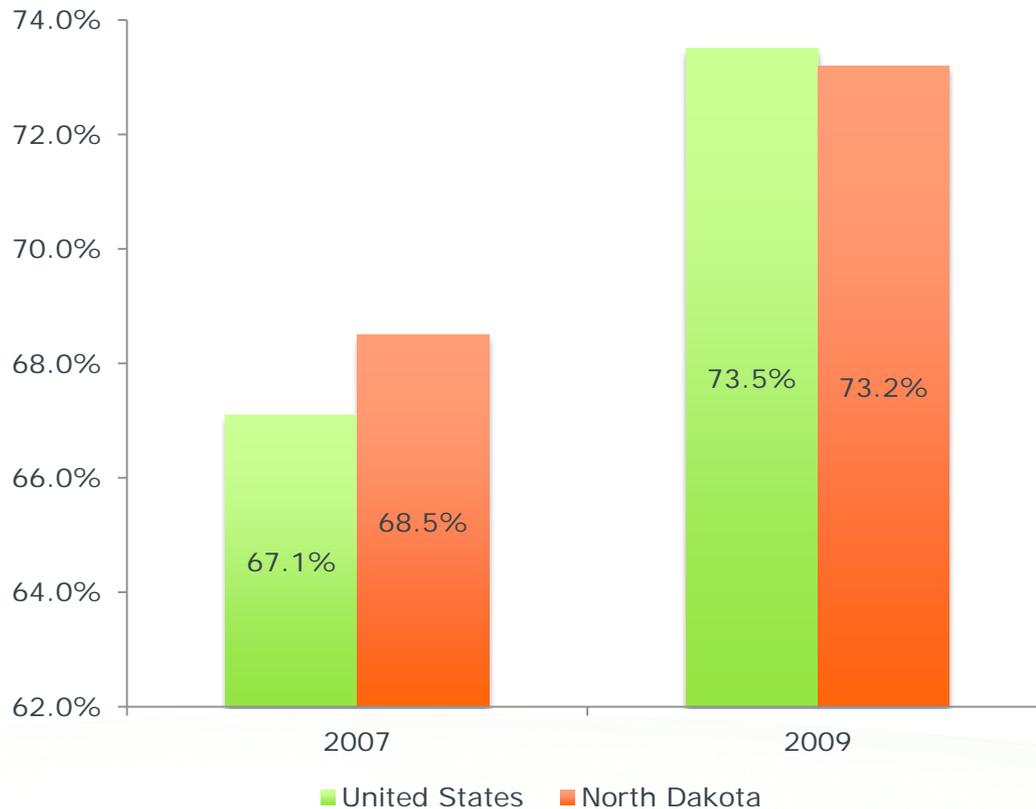
\* Includes only people who reported a single race alone  
Sources: US Census Bureau, 2010 Census and 2010 American Community Survey

*According to the US Census, although Native Americans represent only 5.4% of North Dakota's population, they represent 18% of the state's uninsured.*

*Further investigation could result in an adjustment of this figure for North Dakota; some experts suggest that the Native American population is be undercounted by the census.*

# The majority of North Dakotans have access to the internet

Reported Internet Access (Age 3 and Older) \*



*Similar to the rest of the country, internet access in North Dakota is on the rise.*

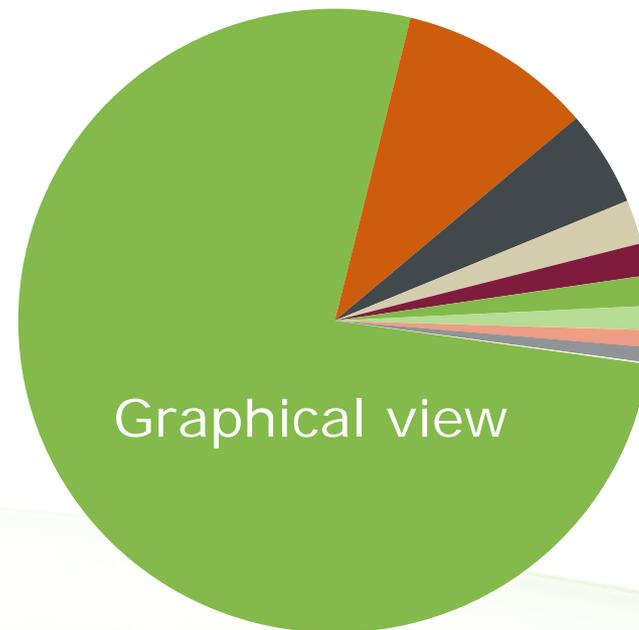
*This figure suggests that a large percent of North Dakota's population could have access to an online exchange, but that other access points will also be needed.*

\*Individual lives in household with internet access

Source: US Census Bureau, Current Population Survey, October 2007 and October 2009

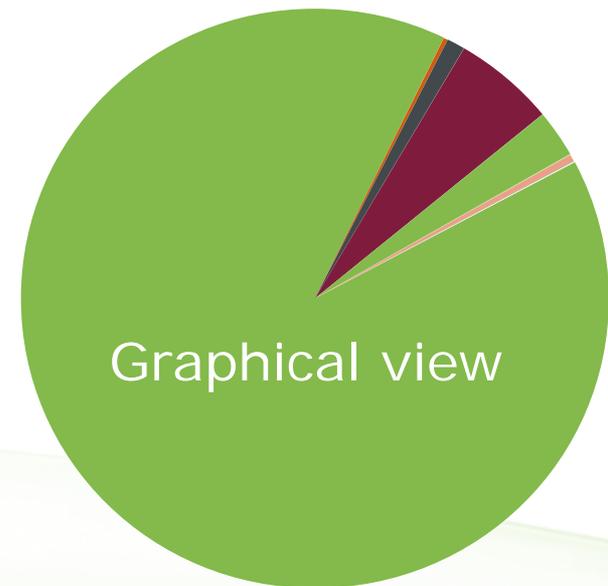
# Individual: Health insurance carrier market share

Carrier	Market Share
Blue Cross/Blue Shield (Noridian)	76.67%
Time Insurance Company	9.96%
American Family Mutual Insurance Co.	4.94%
Not marketing in ND or Association Group	2.27%
American Republic	1.68%
World Insurance Company	1.58%
John Alden Life Insurance Company	1.24%
Heart of America (HMO)	0.87%
Medica Insurance Company (MIC)	0.79%
American Medical Security Life Insurance Co.	0.07%
<b>Total</b>	<b>100%</b>



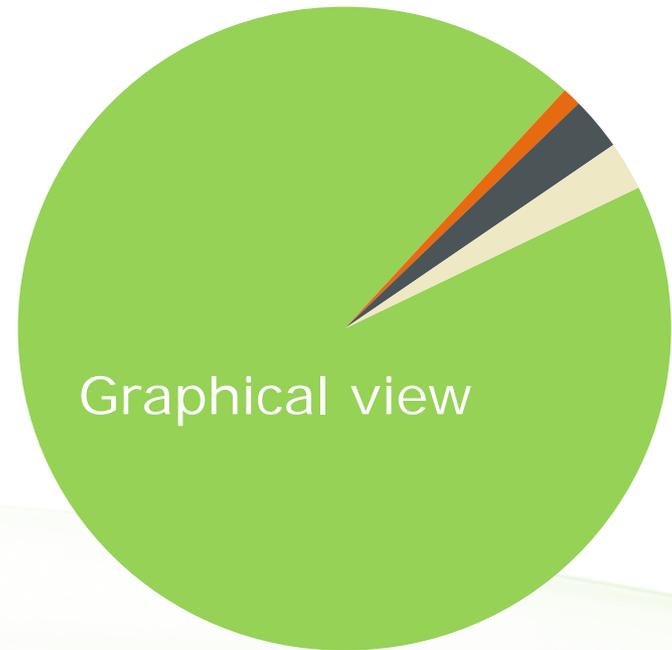
# Small Group: Health insurance carrier market share

Carrier	Market Share
Blue Cross/Blue Shield (Noridian)	90.00%
Heart of America (HMO)	0.23%
John Alden Life Ins. Co.	1.00%
Madison National Life Insurance Company	0.02%
Medica (HMO)	5.59%
Medica Insurance Company (MIC)	2.63%
Sanford Health Plan	0.06%
Time Insurance Company	0.36%
United Health Care	0.04%
Not marketing in North Dakota	0.07%
Total	100.00%



# Large Group: Health insurance carrier market share

Carrier	Market Share
Blue Cross Blue Shield (Noridian)	93.97%
Heart of America (HMO)	0.95%
Medica Health Plans (HMO)	2.66%
Medica Insurance Company (MIC)	2.42%
Totals	100.00%



# Despite the concentrated marketplace, there are still many insurance carriers doing business in the state

	Individuals		Small Employers (2-50)		Large Employers (50+)	
	Plans	High-deductible	Plans	High-deductible	Plans	High-deductible
Aetna Life Insurance Company					X	
American Republic Insurance Company	X	X				
Blue Cross/Blue Shield of North Dakota	X	X	X	X	X	X
Companion Life (Association Group)	X	X				
Heart of America Health Plan (HMO)	X		X		X	
John Alden Life Insurance Company	X	X	X	X	X	X
Madison National Life Insurance Company			X	X		
Medica Insurance Company	X	X	X	X	X	X
Time Insurance Company	X	X	X	X		
Sanford Health Plan	X	X	X	X	X	X
Unicare Life & Health Insurance Company					X	X
World Insurance Co.	X	X				

Note: High-deductible health plans are sold in conjunction with health savings accounts (HSAs).

Source: North Dakota Department of Insurance, 2011

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# Initial analysis includes input from two sets of research

## *HTMS Interviews with Employees in the Following State Departments*

- North Dakota Insurance Department
- Department of Human Services
- Department of Health
- Information Technology Department
- North Dakota Indian Affairs Commission

## *NDID Stakeholder Meetings*

- Bismarck – Consumers / Employers / Government (Aug. 30, 2011)
- Bismarck – Producers / Agents (Aug. 31, 2011)
- Fargo – Consumers / Employers / Government (Sept/ 6, 2011)
- Fargo – Producers / Agents (Sept. 6, 2011)
- Grand Forks – Consumers (Sept 7, 2011)
- Minot – Consumers / Employers / Government (Sept. 8, 2011)

# Governance: Stakeholders saw the primary purpose for developing as complying with federal law

While some stakeholders did see the exchange potentially helping some consumers (possibly those who are currently uninsured, or perhaps small business) ....

*"The exchange will help the working uninsured."*

*"The exchange could help small businesses. They are the ones who have the hardest time getting coverage. They are the biggest part of the uninsured."*

... the most common view is that the primary purpose of the exchange is to comply with Federal law.

*"The exchange would be successful if it were a fiscally responsible entity."*

*"Success will be meeting the requirements of the Affordable Care Act."*

# Governance: There were a variety of perspectives about whether the exchange should be developed at the state or federal level

## ***Benefits of Running Exchange at State Level***

- Decisions made by those who know North Dakota and what is needed specifically for this state
- Viewed as being more efficient and more responsive than a Federal entity
- Can tailor the exchange to meet the particular needs of North Dakota
- Specifics of Federal exchange are unclear or unavailable

## ***Benefits of Running Exchange at Federal Level***

- Potentially more details up front about financial requirements
- Can start at the Federal level and then move to State once more details have been decided and exchanges are more accepted in the marketplace
- Don't need human resources to run the exchange in North Dakota

*"We should do it ourselves. We know ourselves better."*

*"As a purist, I don't like the idea of 50 states creating the same thing."*

*"The federal option buys time for Congress and the Supreme Court. It gives everyone a chance to see what is going to happen in a few years so that we do not go through the time and expense for nothing."*

*"We don't have enough information from the Feds to know whether that is a good option. Want to ensure what they build is relevant for North Dakota."*

# Governance: Practical considerations such as costs and timelines were big factors in decision-making for many

*"What is the cheapest way to do it?"*

*"I don't think we have time to build to meet a deadline."*

*"The driving factor for the decision [about a federal vs. state run exchange] is the 2014 deadline."*

*"The state will have a big job in itself upgrading its Medicaid system. Six months ago, upgrading the Medicaid system was estimated to be a forty-four month project."*

*"The driving factor for our decision is the 2014 deadline. We need to outsource."*

*"The Feds could build something that we can't afford to maintain when it comes back us."*

*"There are still a lot of unanswered questions regarding money, time, and human resources. Why not allow the Feds to take the risk – including with integrating technology.."*

# Many stakeholders indicated that they have significant concerns about risk selection between the markets inside and outside of the exchange

*"I have huge concerns, especially for some carriers who choose not to offer their plans through the exchange. The risk-adjustment piece of it has to work. The market needs to stay healthy – from a solvency perspective."*

*"I have grave concerns regarding the risk pool, risk adjustments, and risk corridors."*

*"It is critical to have a meaningful individual mandate. ... A mandate that requires coverage but without much penalty isn't effective either. It's a huge issue for the risk profile."*

## Examples of Risk Mitigation Strategies (Note: Not all strategies may be relevant for any particular state or exchange)

- Establish Essential Health Benefits inside and outside of the exchange
- Create a menu of cost-sharing options for each coverage level
- Require insurers that want to operate in an exchange to offer products in all exchange coverage levels
- Conduct strong and ongoing enforcement and oversight
- Restrict the ability for carriers not participating in the exchange to sell catastrophic coverage outside of the exchange
- Require that insurers market plans evenly inside and outside of the exchange
- Require common pricing inside and outside of the exchange for the same product
- Establish open enrollment periods

Sources: Sara Lueck, "States should take additional steps to limit adverse selection among health plans in an exchange," Center on Budget and Policy Priorities, June 28, 2011.

HTMS also consulted models from other state legislation.

# The role of brokers in the exchange needs to be defined, but generally, stakeholders overall indicated that brokers will continue to play an important role in the distribution of health insurance

*"We will work with it. It's currently difficult to work with individuals with limited means. The exchange might improve this, assuming agents will work as navigators."*

*"Navigators may not be sufficient."*

*"I think it's critical to have brokers involved. People have questions – they are going to want to call the agents who are trained in health insurance.."*

*"If the exchange is where people have to go to buy health insurance, this is where we need to be."*

*"They took all the duties an agent already does and came up with a stupid name: Navigators."*

*"Navigators should be compensated. Agents are already in the best position to provide that service."*

*"First thing I'm concerned about is that agents not be eliminated from the exchange."*

***There are important decisions to be made about the role of brokers. Additional research will be required to determine how these resources should connect to or participate in the exchange.***

# Stakeholders generally indicated the preference for broad choice in the exchanges, but research indicates that there are limits to how much choice benefits consumers

*"It sounds better to have more choices."*

*"The more choices, the better."*

*"I'd like to see all my options."*

## Examples from Other Industries

- **RESEARCH:** *"There is now ample evidence that when you increase choice by offering more and more options, a point is reached at which paralysis rather than 'freedom' is the result."*<sup>1</sup>
- **FINANCIAL SERVICES:** *"Columbia University social scientists...found that as companies did their employees a 'favor' by offering more and more mutual-fund options for their 401(k) contributions, fewer and fewer people elected to participate."*<sup>1</sup>

## Examples from Other Exchanges

- **MASSACHUSETTS EXCHANGE:** *In consumer focus groups, respondents indicated that the degree of choice originally offered through the Connector was overwhelming. As a result, the Connector now requires participating carriers to offer a standardized set of benefit packages.*
- **UTAH EXCHANGE:** *"[T]he large number of choices [on the Utah Exchange] appears to be overwhelming and confusing to potential enrollees. According to a Utah agent who has worked with many small businesses exploring the exchange, many employees enroll in the 'default' product because they prefer to have their product chosen for them."*<sup>2</sup>

<sup>1</sup> "Too Many Choices," *Slate Magazine*, Nov. 2005  
<sup>2</sup> "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned," *Georgetown University Health Policy Institute*, March 2011.

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# There are some decisions outside of local control, and some decisions that can still be made

## ***Federal Decisions***

### **Authority**

*The requirement to develop or facilitate a HBE in ND, and approval that sufficient progress has been made*

### **Deadlines**

*Define timelines for funding, development, approval, enrollment periods, etc.*

### **“Federal Floor” that guides state flexibility**

- *Governance*
- *Consumer support functions, including the role of the navigator*
- *Eligibility processes*
- *Health plan and network requirements*

## ***State Decisions***

### **Governance**

*Leadership, ownership, accountability, funding, management, etc.*

### **Strategy and goals**

*Primary purpose, secondary goals, strategic orientation, guides decisions*

### **Model**

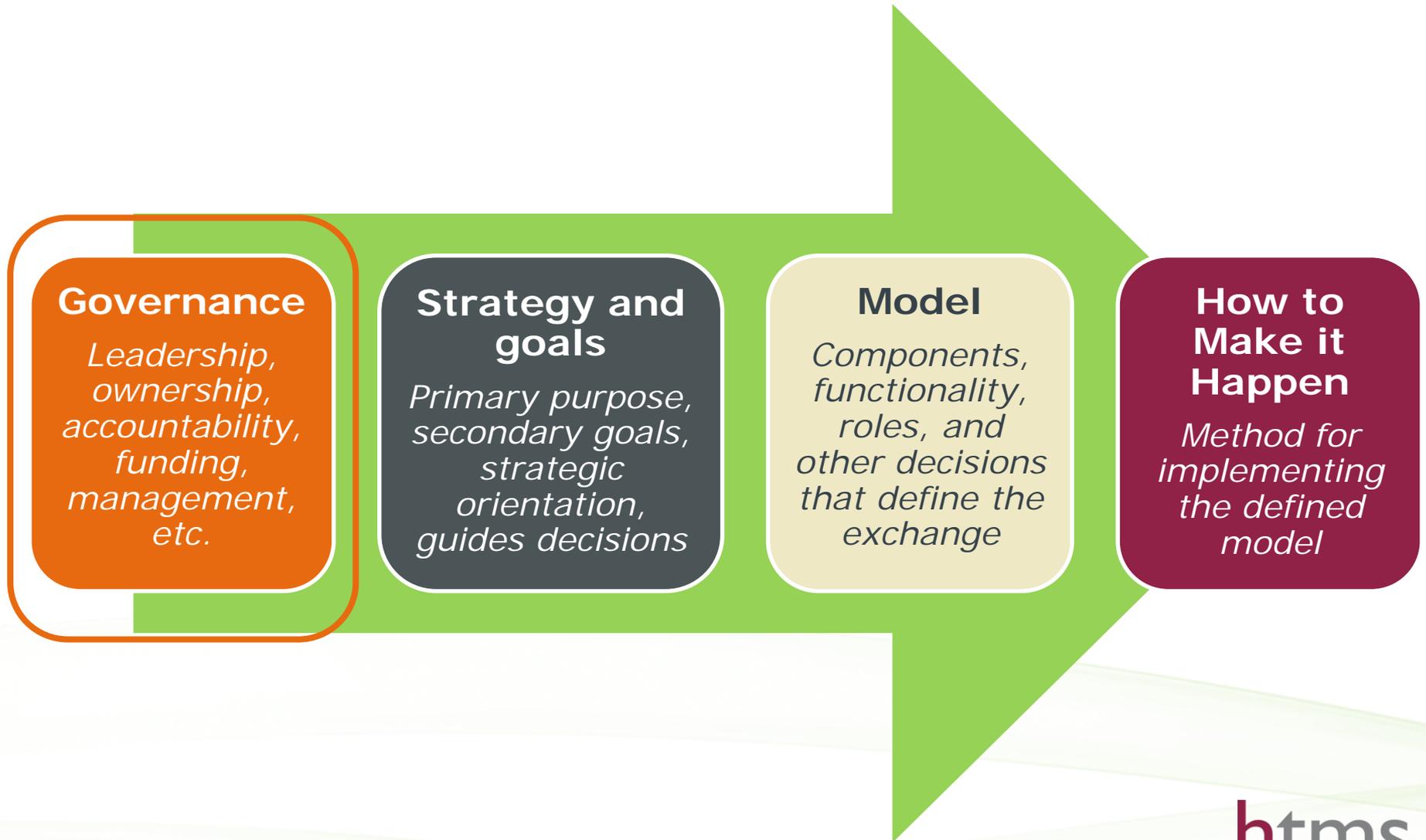
*Components, functionality, roles, and other decisions that define the exchange*

### **How to Make it Happen**

*Method for implementing the defined model*

*Referenced from: Bonnie Washington, Avalere Health, LLC, Insurance Exchanges / Federal Regulations & State Flexibility, August 3, 2011, <http://www.avalerehealth.net>.*

# There is a spectrum of decisions for the state level



# Governance decisions related to Health Benefit Exchange (HBE)

<i>Governance Decision</i>	<i>Sample Variables</i>
Jurisdiction	State, federal, partner
Geography	Single state, multi-state, which state/s
Structure	Government agency, quasi-government agency, independent organization
Regulatory Oversight	Insurance Department, Human Services, Office of Management and Budget, etc.
Board Oversight	The size, background, role and degree of authority granted to a governing board
Public Inclusion & Oversight	Role of stakeholders, communications, and transparency
Market	Degree of separation for Individual and SHOP exchanges

# Governance decisions could be arrived at by a range of different perspectives

People could arrive at the same conclusion for a variety of reasons

Federal Exchange

Partner

State-Run Exchange

- Reticence to move forward driven by the potential that all or components of HCR will be repealed

OR

- Intentional decision to allow the government to proof-test the concept before the state takes on accountability

OR

- A practical decision given the range of operational and technical challenges the state will need face to become ready to interact with any exchange – state or federal

- Take advantage of federal modules where they provide value, reduce costs, or assist with time pressure.

OR

- Begin with a federal exchange with the intent to move the exchange to state-level oversight at some time in the future

- Enthusiastically embrace exchanges as an opportunity to refine the insurance marketplace

OR

- Reluctantly embrace so that the state retains control over its own institutions

OR

- Practically embrace because the institution is sure to be developed with the unique needs of ND in mind

*The Multi-State exchange is also a possibility to explore. There are limited multi-state exchanges identified at this time; the primary example is the New England consortium*

# Thirteen states have enacted legislation or issued an executive order to establish or intent to establish an **HIX** (highlighted in maroon below) and five states are performing feasibility studies

Enacted legislation			Executive order		Legislation		
To establish HIX	Intent to establish HIX	Study feasibility of establishing an exchange	Study feasibility of establishing an exchange	Intent to establish an exchange	Pending (through 2011 session)	None proposed	Failed
10	2	3	2	1	4	11	16
CA, CO, CT, HI, MD, NV, OR, VT, WA, WV	IL, VA	MS, ND <sup>3</sup> , WY	AL, GA	IN	DC, NJ, NC, PA	DE, FL, ID, KS, KY, LA <sup>1</sup> , MI, OH, SD, TN, WI	AK, AZ, AR, IA, ME, MN, MO, MT, NE, NH, NM <sup>2</sup> , NY, OK, RI, SC, TX

<sup>1</sup>LA: Governor announced that there will be no exchange in the state

<sup>2</sup>NM: Governor vetoed legislation

<sup>3</sup>ND: State legislation specific for feasibility study only

Source: <http://www.kff.org/healthreform/upload/8213.pdf> accessed on 09/26/2011

# Characteristics of state exchanges furthest along in establishing *single state only* exchanges

State	Exchange structure	Exchange type	Board members	Stakeholder representation; subject matter expertise
California	Quasi-governmental	Active purchaser	5	Various subject matter areas
Colorado	Quasi-governmental	Clearinghouse	12	Various subject matter areas
Connecticut	Quasi-governmental	Active purchaser	14	Health insurance coverage of individuals and small employers; health care finance; health benefit administration; health care delivery; health economist; health care access for the self-employed; barriers to individual health coverage
Hawaii	Non-profit agency	Clearinghouse	15	Insurance plans; provider group, hospital trade association; health care consumer labor management; native Hawaiian health care organization; federally qualified health center; business; health information exchange
Maryland	Quasi-governmental	TBD by Board of Directors	9	Employers and individuals using exchange; various subject matter areas

Source: <http://www.kff.org/healthreform/upload/8213.pdf> accessed on 09/26/2011

## ...continued: Characteristics of *single state only* exchanges

State	Exchange structure	Exchange type	Board members	Stakeholder representation; subject matter expertise
Massachusetts	Quasi-governmental	Active purchaser	11	Actuary; health economist; small business; employee health benefits plan specialist; health consumer organization; organized labor
Nevada	Quasi-governmental	Not addressed in legislation	10	Various subject matter areas
Oregon	Quasi-governmental	Active purchaser	9	Various subject matter areas; at least 2 small employer consumers of the exchange
Utah	Operated by State	Clearinghouse	Up to 9	Insurance carriers; employee or employer; Office of Consumer Health Services; Public Employee's Health Benefits Program
Vermont	Operated by State	Active purchaser	5	Various subject matter areas

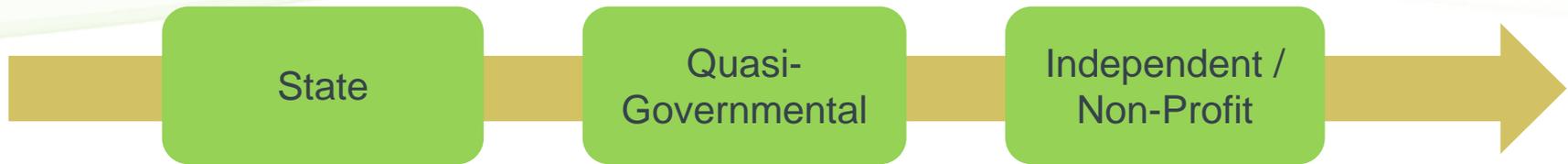
Source: <http://www.kff.org/healthreform/upload/8213.pdf> accessed on 09/26/2011

## ...continued: Characteristics of *single state only* exchanges

State	Exchange structure	Exchange type	Board members	Stakeholder representation; subject matter expertise
Washington	Quasi-governmental	TBD by Board of Directors	11	Employee benefit specialist; health economist or actuary; consumer advocate; small business; various subject matter areas*
West Virginia	Quasi-governmental	Not addressed in legislation	10	Health care consumers; small employers; organized labor; insurance producers; payers; health care providers

Source: <http://www.kff.org/healthreform/upload/8213.pdf> accessed on 09/26/2011

# Health Benefit Exchange governance models



Model	Description
State agency	<ul style="list-style-type: none"> <li>• <b>Oversight and regulatory control by the state</b></li> <li>• Exists either in an existing agency, such as, Medicaid agency or insurance department <b>or</b> a new state agency is created</li> </ul>
Quasi-governmental entity	<ul style="list-style-type: none"> <li>• <sup>1</sup>Per HHS, a quasi governmental entity is <b>created or established by the State</b> (through legislation or other law), and <b>has State oversight</b> (i.e. the governing body is established, appointed, and overseen by the State) <b>and the entity is subject to specific limitations on its authority to act established by the State</b></li> <li>• Partially or majorly funded by the state</li> <li>• May receive some revenue from charging customers for its services</li> </ul>
Independent/non-profit	<b>Separate from state government</b>

**Ultimately, a state's unique set of statutes, regulations, and strategic objectives will drive its HIX governance structure. Approaches defined by certain states may not fit exactly into one of these models. .**

<sup>1</sup>U.S. Department of Health and Human Services, Exchange Establishment Cooperative Agreement Funding FAQ (Washington: The Center for Consumer Information and Insurance Oversight, 2011).

# Comparative aspects of HBE governance model

## Model: State Agency

*Place exchange in an existing agency*

### Pros

- Leverage existing administrative systems, resources and procedures, including access to information databases for streamlining enrollment
- Existing authority to procure plans and negotiate with third parties
- Easy access and greater accountability to elected officials
- Better interagency coordination
- Existing knowledge in at least one of exchange functions

### Cons

- Competing priorities between existing functions and roles vs. exchange requirements
- May try to fit new exchange functions into traditional environment rather than spur innovation
- May hinder the ability of the exchange to directly communicate with other state agencies to make sure the exchange's multiple functions operate cohesively
- Conflict of interest in roles and responsibilities

*Example: If exchange is placed within the insurance dept, potential conflict between monitoring financial solvency of insurance plans and adherence to regulations vs. exchange role of negotiation for best plan pricing*

### References

1. National Academy of Health Insurance. *Governance Issues for Health Insurance Exchanges. Health Policy Brief No. 1, Jan 2011*
2. Families USA. *Options for Governance and Oversight. April 2011*

# Comparative aspects of HBE governance model

## Model: State Agency *Develop a new agency*

### Pros

- Clear focus on exchange development; no competing roles and responsibilities
- Direct communication with Governor rather than through other state agency leadership
- Ability to secure cooperation from other agencies based on equal status with other state agencies and relationship with governor

### Cons

- Exchange leadership could be subject to changes in governorship and could cause progress derailment/slowdown
- Would need to start from scratch to build new relationships with agencies
- Being a start up adds additional activities, such as hiring for a broad set of positions, space, development of agency processes and procedures, etc.
- State laws and procedures that can be barriers to exchange development may still apply
- There could be political challenges with establishing another government agency

### References

1. National Academy of Health Insurance. *Governance Issues for Health Insurance Exchanges*. Health Policy Brief No. 1, Jan 2011
2. Families USA. *Options for Governance and Oversight*. April 2011

# Comparative aspects of HBE governance model

## Model: Quasi-Governmental

### Pros

- Focused efforts on developing the exchange rather than competing priorities
- Potential freedom from existing procedural constraints (personnel hiring, procurement) and flexibility to design processes
- Greater insulation from political influence and special interest groups
- Depending on board structure, close ties to political process exist or can be easily forged
- May have access to the information systems facilitating enrollment
- May be able to more easily secure the authority to procure health plans and information technology and negotiate with third parties

### Cons

- Limited resources may require outsourcing of many functions
- Building/start up from scratch is always difficult including hiring, space, development of agency processes and procedures, etc.
- Would need to start from scratch identifying and building new relationships with state agencies
- Need to ensure transparency and public accountability, such as the requirement to adhere to open meeting and open record laws

### References

1. *National Academy of Health Insurance. Governance Issues for Health Insurance Exchanges. Health Policy Brief No. 1, Jan 2011*
2. *Families USA. Options for Governance and Oversight. April 2011*

# Comparative aspects of HBE governance model

## Model: Independent / Non-profit Entity

Pros	Cons
<ul style="list-style-type: none"><li>• Focused efforts on developing the exchange</li><li>• Potential freedom from existing procedural constraints (personnel hiring, procurement)</li><li>• Greater independence from political process; less affected by political leadership changes</li><li>• Enhanced flexibility in designing operations and managing issues</li></ul>	<ul style="list-style-type: none"><li>• Political isolation may cause difficulty in communication and coordination with state agencies critical to implementation. Will need to build strong relationships with state agencies usually from scratch</li><li>• State hesitancy to assign operations and resources to an entity which it has limited control</li><li>• Certain functions, by state constitution, can only be performed by the state such as regulating economic activity and levying taxes</li><li>• May be required to meet statutory requirements applicable to government agencies, particularly those that ensure transparency and public accountability</li><li>• Conflict of interest if providers, insurers, brokers, etc. are on the board; may invite scrutiny under antitrust laws</li><li>• May not have easy access to state databases that allow for enrollment into state programs</li><li>• Federal and state laws, yet to be identified and analyzed, may have many negative implications for non-profit entities managing exchanges</li></ul>

### References

1. National Academy of Health Insurance. *Governance Issues for Health Insurance Exchanges*. Health Policy Brief No. 1, Jan 2011
2. Families USA. *Options for Governance and Oversight*. April 2011

# Comparative aspects of HBE governance model

## Model: Multi-state

Pros	Cons
<ul style="list-style-type: none"><li>• Economies of scale can be obtained for administrative functions</li><li>• Greater number of competing health plans leading to lower premiums</li></ul>	<ul style="list-style-type: none"><li>• Greater complexity in identifying, managing and integrating multiple state laws, requirements, and agencies into operations given the short timeframe</li><li>• May require adoption of identical statutes which may potentially require Congressional approval</li><li>• Risk segmentation may be difficult to avoid if rules governing plans in the multi-state exchange differed from those governing plans operating outside the exchange in even one state</li></ul>

*There is only one multi-state effort known at this time. A consortium is being led the University of Massachusetts Medical School to create and build a flexible exchange information technology framework in Massachusetts and to share the platform with other New England states including CT, MN, MA, RI, and VT. This consortium has received \$35.6M in Exchange Innovator funds.*

Reference: National Academy of Health Insurance. Governance Issues for Health Insurance Exchanges. Health Policy Brief No. 1, Jan 2011

# There are several reasons why a state would consider partnering with another

## *Reasons for developing a multi-state exchange*

1. Potential administrative economies of scale
2. Regional exchanges could make sense in large metropolitan areas that cross state boundaries.
3. Risk pooling across state lines
4. Establishing greater critical mass in small population states

*Most states are expected to pursue multi-state exchanges for a single reason: Administrative economies of scale*

Cross-state risk-sharing would inevitably lead to one state population effectively subsidizing another and create a complex environment for policy decision-making.

Source: Linda J. Blumber, "Multi-state Health Insurance Exchanges<sup>1</sup>: Timely Analysis of Immediate Health Policy Issues," RWJF, April 2011

# There has been considerable focus on the potential conflicts of interest of the board in other states

May 2, 2011

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HEALTH INSURANCE EXCHANGE

## Some question makeup of Colorado's new health-insurance exchange board

By Michael Booth  
The Denver Post

POSTED: 07/12/2011 01:00:00 AM MDT

*"I have a strong opinion about insurer participation. We need to be careful with a conflict of interest – it could be a public perception issue.... We should have a separate carrier advisory board, also one for agents and providers, one for consumer reps and other agencies."*

*"The board needs to include all the stakeholders. Consumers need to be on the exchange to provide public input. Insurance companies. Insurance agents. The health department. Both the public and private sector..."*

July 7, 2011

# There has been considerable focus on the potential conflicts of interest of the board in other states

Other states are addressing potential conflicts of interest in a variety of ways:

<i>State (select examples)</i>	<i>Details of their Approach to Conflict of Interest</i>
<b>California</b>	Members of the board of the independent state agency running the exchange cannot be affiliated with any entity involved in the exchange (carriers, brokers, providers, etc.) or benefit financially from the exchange while serving on the board.
<b>Colorado</b>	Members of the board of the non-profit running the exchange may not make decisions that benefit them financially
<b>Connecticut</b>	Does not allow any representative of the insurance industry or providers as board members of the quasi-public agency running the exchange.
<b>Maryland</b>	Members of the board of the independent state agency running the exchange cannot be affiliated with any entity involved in the exchange (carriers, brokers, providers, etc) or benefit financially from the exchange while serving on the board.
<b>Nevada</b>	Board member of the independent state agency running the exchange cannot be affiliated with insurance carriers or be a legislator.
<b>Oregon</b>	The board of the independent public corporation of the state that is running the exchange is required to maintain a balance of consumer representation and health insurance experts. No more than two members can be affiliated with an insurer or provider.
<b>West Virginia</b>	Board members of the new entity within that Office of the Insurance Commissioner that is running the exchange are not allowed to receive compensation and must represent various stakeholders as defined in the law.

Source: National Conference of State Legislators, "Exchange Establishment Laws," available at <http://www.ncsl.org/default.aspx?tabid=21388>, accessed 9/28/11

# Core exchange functions and HHS support activities

Exchange Functions	Description
<b>Consumer Assistance</b>	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment
<b>Plan Management</b>	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality
<b>Eligibility</b>	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals
<b>Enrollment</b>	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions
<b>Financial Management</b>	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs

Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. State Exchange Grantee Meeting September 19-20, 2011.

# Core exchange functions and HHS support activities

## HHS support for state-level exchanges

- Support grants
- Data Services Hub or support system to connect to IRS, SSA, and DHS
- Financial management support related to payment processing of financial assistance
- If the state chooses, HHS will provide the Federal risk adjustment model or allow HHS to run risk adjustment on the state's behalf
- HHS will run the risk corridors program

*Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. State Exchange Grantee Meeting September 19-20, 2011.*

# The federally administered exchange puts a great deal of decision-making at the federal level

## Core exchange functions

Consumer Assistance	Plan Management	Eligibility	Enrollment	Financial Management
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***HHS will use the following principles in building and running federally facilitated exchanges:***

- Consult and work with key state and local stakeholders to perform outreach and education to consumers and small businesses about health plan options*
- Make decisions where there is flexibility to make them ex. Network adequacy, marketing*
- Utilize state standards to synchronize rules in and outside the exchange*
- Determine eligibility for QHPs, tax credits, cost sharing, Medicaid and CHIP*
- Provide eligibility information to applicable State agencies for health coverage enrollment*
- Potentially charge user fees to insurance companies selling plans on the exchange*
- Solicit input when running the exchange*

*Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. State Exchange Grantee Meeting September 19-20, 2011.*

# New options: State and federal partnership model

	State	Federal
Option 1 Plan management	<ul style="list-style-type: none"> <li>• Tailor health plan choices</li> <li>• Collection and analysis of plan information, such as rates, benefit packages, etc.</li> <li>• Monitoring and oversight of health plans and products, data collection, and analysis for quality</li> </ul>	<ul style="list-style-type: none"> <li>• Coordination with state on health plans and data to enter into federally facilitated exchange eligibility and enrollment functions</li> <li>• Coordination with state on plan oversight, including consumer complaints and issues with enrollment reconciliation</li> </ul>
Option 2: Consumer access & assistance	<ul style="list-style-type: none"> <li>• Management of Navigator program, including providing direct assistance to help people sign up for insurance</li> <li>• Outreach and education to consumers and small employers</li> </ul>	Management of call center operation, consumer website, and written correspondence with consumers
Option 3:	States manage all plan management and consumer access & assistance functions	

# State and federal partnership model

## Pros

- States will be able to get federal help in setting up their health insurance exchanges without having the federal government run the whole exchange
- Allows states to tailor their exchange to local needs and market conditions while offering a way to transition to fully operating their own exchanges
- Takes advantage of the State's expertise and knowledge of their insurance markets to support a seamless consumer experience

## Cons

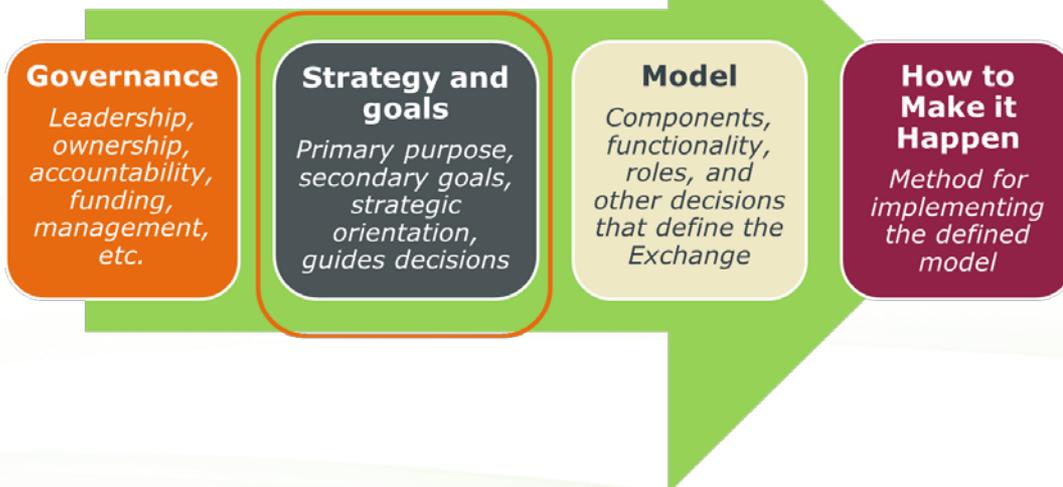
- Design and specifications on partnership are still evolving. Public comment being sought.
- Delays ultimate ownership of the exchange
- Increased coordination requirements between federal and state agencies
- There is not currently funding available to assist states with taking over remaining federal functions at some future date

# Contents

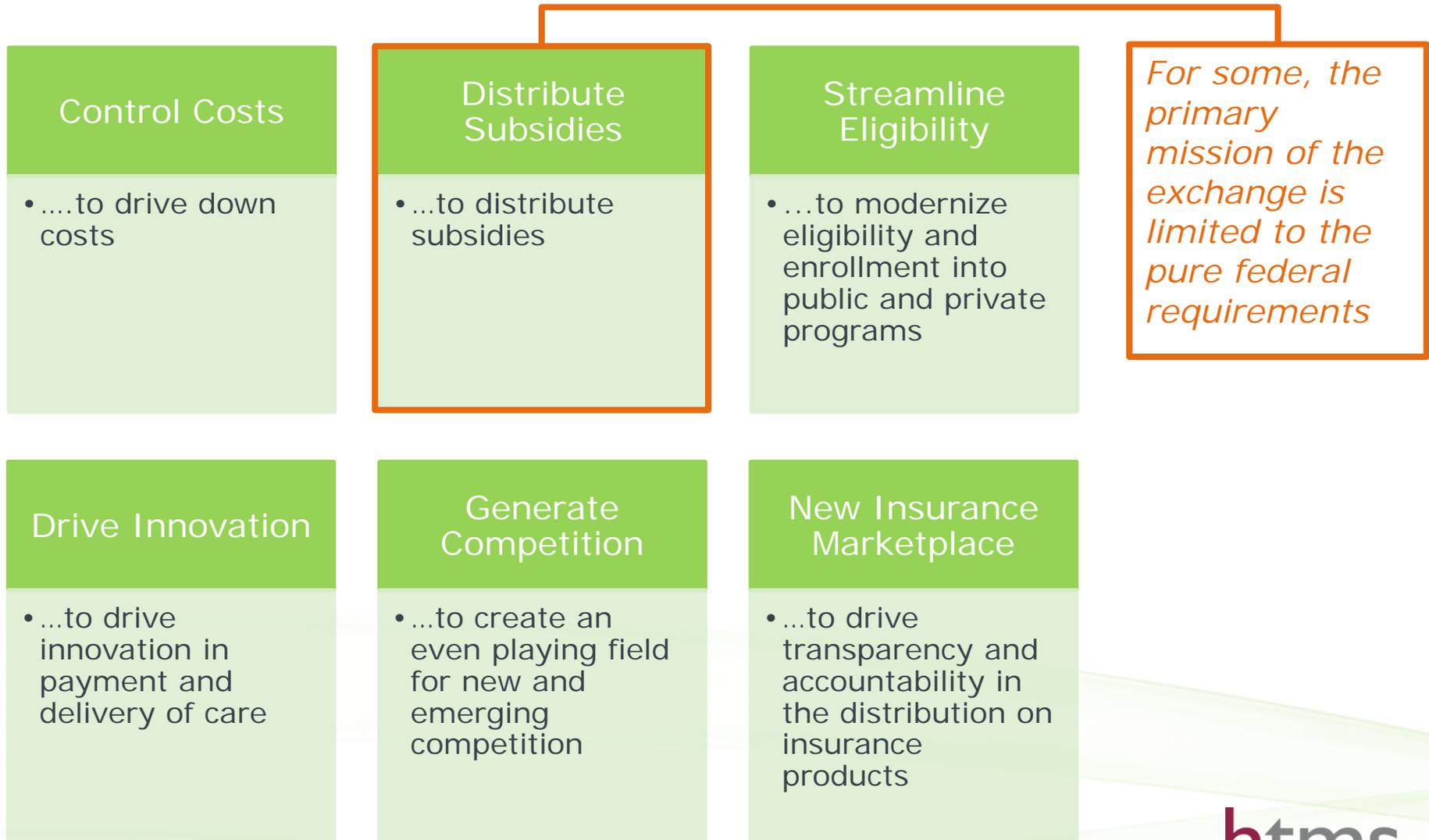
- *Project Overview*
- *Data: The North Dakota marketplace in context*
  - *Population demographics*
  - *Marketplace demographics*
- *Perspectives: Feedback from stakeholders*
- *Decisions*
- *What's next*

# Defining a strategy for the exchange guides the decision-making for the model and the execution of the exchange

1. *What is the primary purpose of the exchange?*
2. *How will success be measured?*
3. *Who is the target audience of the exchange?*
4. *What is the timeline for success?*



# Defining the strategy for the exchange drives implementation decisions



# Examples of how execution would vary by orientation

	Distribute Subsidies	New Health Insurance Marketplace
Market regulations	Little change to the market; no expectation for significant use of the exchange beyond accessing subsidies	Consider regulation designed to minimize adverse selection inside / outside of the exchange
Service / Customer support	Maximize support options through channels that already are targeted at low-income populations (eligibility workers, agents, etc.)	<ul style="list-style-type: none"> <li>• Communicate with the public smoothly and regularly that the exchange is a viable option for purchasing insurance</li> <li>• Ensure that support options are sufficiently valuable so as to draw non-subsidized consumers.</li> </ul>
Website focus	Focus on mechanisms to identify consumers eligible for subsidies and getting them quickly and easily enrolled in coverage	Provide transparency into plan costs and performance in ways that are easily accessible to consumers

# Financial and business modeling will provide insight into cost and impact for different approaches

***The most economically viable exchange could be achieved in a range of ways.***

***At times, optimizing the cost may not always follow intuitive logic.***

## ***Example of additional considerations***

- 1. Minimizing the impact of the exchange could make it more expensive because the costs of running the exchange are distributed across a smaller set of enrollees*
- 2. Carriers could see more value in investing in an exchange if they see the potential for higher volume through it*
- 3. Maximizing alignment with Medicaid could have additional implications for the Medicaid program*
- 4. Decisions for establishing the market inside the exchange will have large implications for the market outside of the exchange*
- 5. Each strategic approach will have implications for consumers, small business, insurance carriers, agents, providers, government, and other stakeholders*

# Defining the model enables more specific estimates of time, resource, and financial requirements

## **Examples of decisions to be made:**

1. *How tightly regulated will the market be?*
2. *How rich or light will exchange operational and support functions be?*
3. *What will the roles of agents, Navigators, and customer support be defined?*
4. *What will be the rules for carrier participation?*
5. *What kind of options will small businesses have with the exchange?*



# Making it happen – a model for implementation

1. *Build: Make it yourself*
2. *Buy: License or outsource the capability from a vendor*
3. *Borrow: Make use of solutions developed by Innovator state*
4. *Blend: Deliver the exchange through several approaches*

## **Governance**

*Leadership, ownership, accountability, funding, management, etc.*

## **Strategy and goals**

*Primary purpose, secondary goals, strategic orientation, guides decisions*

## **Model**

*Components, functionality, roles, and other decisions that define the Exchange*

## **How to Make it Happen**

*Method for implementing the defined model*

# A note on flow – and how there are many paths



*These steps can be reorganized based upon the unique needs of the state.*

*For instance, if North Dakota decides to build its own exchange in house (A decision in the How to Make it Happen box), that becomes a set of boundaries within which the remaining decisions need to be made.*

# Contents

- *Project Overview*
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# October activities for HTMS

*HTMS was hired for a rapid-fire survey process to bring a broad spectrum of information to the fore in a short period of time.*

*North Dakota may want to consider performing deeper analysis on a range of factors that may contribute to exchange planning*

Deliverable	Key Activities
Research	<ul style="list-style-type: none"><li>• Continue interviews and surveys</li><li>• Summarize findings</li></ul>
Analysis	<ul style="list-style-type: none"><li>• Perform high level analysis for demographic, market, and business considerations for the exchange</li><li>• Vet assumptions with stakeholders</li><li>• Perform limited sensitivity analysis on models</li><li>• Summarize findings</li></ul>
Prepare deliverables	<ul style="list-style-type: none"><li>• Prepare final data source spreadsheet</li><li>• Prepare overview of findings</li></ul>

# Key Funding Dates

<i>Date</i>	<i>Milestone</i>
06.29.2012	Level two exchange establishment grant due. Level two grants provide increased funding for states that have already made significant preliminary progress in establishing the exchange.
01.01.2013	HHS will assessment to determine if State is ready for exchange implementation by 2014.
01.01.2014	Exchange must be operational
01.01.2015	Exchange must be fully self funded
2011-2014	Mandatory consultation with all federally recognized Indian tribal governments (each year)
2011-2015	Federal match for development (90%) and maintenance (75%) of Medicaid IT systems ends
01.01.2017	Large employer groups may begin participating in the exchange

<sup>1</sup> If the Level 1 planning grant is not submitted until 12.30.11, the mandatory 2011 milestones must be complete prior to submission of the grant..