



Indiana Health Insurance Exchange Symposium Overview

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The Center for Health Policy

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This report was prepared as a public service for the State of Indiana to provide an overview of the Indiana Health Insurance Exchange Symposium sponsored by The Healthcare Implementation Work Group on October 11, 2011. The views expressed are those of the speakers and panelists and do not necessarily reflect the positions of Indiana University and the Center's partner organizations or funders.

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Introduction

The Indiana Health Insurance Exchange Symposium convened at the Indiana Government Center Auditorium on October 11, 2011. The Symposium was sponsored by The Healthcare Implementation Work Group, which consists of 40 Indiana consumer and provider organizations working to ensure Indiana makes educated decisions in implementing the Affordable Care Act (ACA).

On January 14, 2011, Indiana Governor Mitch Daniels signed Executive Order 11-01 conditionally establishing the Indiana Insurance Market, Inc. to serve as the health benefit exchange for the state under ACA. The Indiana Health Insurance Exchange Symposium discussions explored many avenues of health care reform and the possible steps Indiana legislators should take.

June Lyle, the State Director of Indiana AARP and the Chair of the Healthcare Implementation Workgroup, and the Honorable Charlie Brown, Ranking Minority Member of the Indiana House of Representatives Public Health Committee introduced the Keynote address “Health Care Reform State of Play – What’s at Stake for Indiana” presented by Tricia Brooks, Senior Fellow, Georgetown University Health Policy Institute’s Center for Children and Families.

Ms. Brooks opened by posing the question, “Why does America and Indiana need

health reform? It’s about getting better results from our health care expenditures.” The U.S. pays roughly 50% more per capita in health care expenditures than any other industrialized nation and Indiana’s expenditures on health care are on par with this rate. Despite this increased spending, the U.S. ranks 37th in life expectancy and high infant mortality. The Affordable Care Act (ACA) aims to transform the American health care system through: coverage expansions (both public and private); simplified, streamlined, and coordinated enrollment; quality and cost-containment measures; and workforce investment.

Brooks further stated the Act has already produced benefits: 1 million young adults gained coverage in the past year; 1.3 million seniors in the U.S. saved an average of \$517 on prescriptions; and 162,000 children have been aided by the elimination of pre-existing exclusions. The ACA includes other consumer protections, and allows for an investment in health care innovation to bring the American health care system into the 21st Century. By 2014, 544,000 Hoosiers will gain health insurance coverage, reducing the amount of uninsured from 15.9% to 6.0%. This is due largely to a significant federal investment into Indiana’s health care economy.

The estimates on the effect the ACA will have on the state



budget varies based on: take-up rates and crowd out estimates; unknown issues on federal guidance; the time period covered; and administrative costs. Though state cost estimates vary, health care reform will boost the state economy through: federal and state investment; increased purchase of insurance by individuals; and savings in uncompensated care to offset state costs and other direct service costs. The ACA will also have an indirect economic impact on: jobs and wages as well as spending and taxes leading to financially stable families.

Currently, states are moving forward with health care reform. All but four states have planning grants with some level of preparation and analysis of health care reform. Eight states will pursue a quasi-governmental agency route. Four will look to have state agencies run the exchange. Six states will pursue “active purchaser” model, in which plans would bid or enter into negotiations with high performing plans selected, and three would have a “clearinghouse” model, making information available to consumers to permit comparison. Currently Indiana

has established a health insurance exchange through Executive Order as a non-profit organization.

Ms. Brooks posed the question: “Can Indiana risk waiting for legal challenges to overturn the ACA?” She stated that 26 cases have been filed in district court, with only 8 of those making it to the appellate court level. Only one of those is expected to go to the United States Supreme Court in 2012. In that case, the District Court determined that not only was the individual mandate unconstitutional but it could not be severed from the law, therefore, the whole ACA law was unconstitutional.

Ms. Brooks cautioned that Indiana should bear in mind that there is less than nine months remaining for states to apply for federal grants for funding to run their exchanges through 2014. This funding covers all implementation and start-up costs for the first year of operation. States must include the following in planning: determine governance structure; evaluate basic health option; create a process for ongoing stakeholder engagement; coordinate with Medicaid/CHIP; and develop an IT infrastructure.



First Panel Discussion: To Exchange or Not to Exchange

The first panel discussion examined first and foremost whether Indiana should pursue the development of a health insurance exchange. This discussion, moderated by The Honorable Peggy Welch, a member of the Indiana House of Representatives Public Health Committee, comprised of four individuals: Anne Gauthier, Senior Program Director at the National Academy for State Health

Policy (NASHP); Seema Verma, President of SVC, Inc. and Health Care Reform Lead for the State of Indiana; Rachel Bevins Morgan, Health Committee Director of the National Conference of State Legislators (NCSL); and Benjamin Domenech, Managing Editor of Health Care News and Research Fellow at The Heartland Institute.

Key Points Raised by Panelists

Anne Gauthier

- States are more intimately familiar with specific consumer needs and should create state exchanges based on those needs

Rachel Bevins Morgan

- The purpose of the exchanges are to provide affordable and comprehensive care for Americans
- The exchange must be operational by 2014, with Federal grants available until 2015 to develop and operate an exchange, after which point the exchange must be self-sustaining
- There is potential the individual mandate could

- The Federal Government can operate an exchange for the state if a state has failed to establish one but there may be limited options from which consumers may choose if this occurs

be overturned, though there are other parts of the law with which states would have to comply

- A Federal exchange would basically be the same in each state, though there might be problems with how it would be run in conjunction with duties handed at the state level (e.g., licensure of health insurance companies, or determining Medicaid eligibility)



Seema Verma

- Indiana Governor Mitch Daniels has conditionally created a state exchange through Executive Order
- Planning and research for the exchange continues, however the State has not moved forward with implementation
- The information technology (IT) infrastructure with Indiana Medicaid is

outdated and needs to be updated to enable integration with the exchange

- Estimates for operating an exchange in Indiana is between 50 and 80 million dollars per year
- Even if the Federal Government were to operate an exchange, there are currently no models on how that exchange would look

Benjamin Domenech

- The legal status of the individual mandate within the Affordable Care Act (ACA) is under review and may be stuck down

- The creation of the Federal exchanges is a “hollow threat,” in that no funding is authorized within the law. The U.S. Department of Health and Human Services (HHS) would have to find money elsewhere

Key Discussion Questions

Question: What will happen if the individual mandate is ruled unconstitutional, but the rest of the law is deemed constitutional?

- Congress would need to reopen the law and make changes. There is current disagreement on whether there is a severability clause, allowing the law to stand if one part is deemed unconstitutional
- One problem with the individual mandate is the penalty for failing to obtain health insurance is relatively

weak. Many people may choose this rather than obtaining coverage

- Beyond the legal question, the actions of Congress could depend on the outcome of the 2012 election. The insurance industry supports an individual mandate. Currently, increased uncompensated care is driving up costs in the health care industry and the individual mandate would create a larger market



Key Discussion Questions

Question: Would there be legislation to rescind the essential benefits package within ACA?

- The essential benefits package is a huge issue, in that there are many unknown factors. It is up to the state to decide if this aspect will be rescinded
- Most employer-based plans already include essential benefits, so changes in this area

would not affect the majority of the population

- There are many unknowns in the system, including issues with IT. There is a defined open-enrollment period between October and December for the exchange that would allow an estimated 700,000 to 1.1 million Hoosiers to enroll in the exchange.

Question: What are other states doing?

- The vast majority of states are waiting to see what comes from the exchange studies

- Some states have passed legislation and are working on studies. These details should come out in the spring of 2012

Second Panel Discussion: Exchange Design – Options for Indiana

The second panel discussion examined design options available for Indiana in creating an exchange. This discussion was moderated by Tricia Brooks. The five panelists included: Paul Cotton, Director of Federal Affairs at the National Committee for Quality Assurance (NCQA); Preston Gee, Senior Vice

President of Strategic Planning and Marketing at Trinity Health; Brooke Bell, Director of State Affairs at the National Association of Health Underwriters (NAHU); Dr. Georgia Tuttle, Dermatologist with the American Medical Association (AMA); and Patrick Willard, State Health and Family Team at AARP.



Key Points Raised by Panelists

Paul Cotton

- Exchanges should be designed in such a way to promote higher quality health care at a lower cost through value-based competition
- Exchanges can promote value by: educating consumers on the importance of cost and quality over premiums; ensuring standardization of plans; rating plans to help consumers make a selection; and helping enroll people that do not choose into a high-value plan
- Companies will be required to use the Healthcare Effectiveness Data and Information Set (HEDIS) in the near future for accreditation. Data has shown that accredited health plans consistently perform better than non-accredited health plans

Preston Gee

- The fundamental reason for a health insurance exchanges is to increase access to care
- There are four components legislators should consider when creating successful health insurance exchange implementation:
 - Governance structure: the board should be diverse and have representation across multiple backgrounds with full transparency
 - Market size: should include a delivery system that rewards quality and value
 - Operations: should include detail of the plan offerings; transparency is very important here
 - Benefit design: there should be incentives from health plan providers for members utilizing low cost/high quality providers
- Transparency of the exchange is very important at both the consumer and education levels



Dr. Georgia Tuttle

- Exchanges can overhaul the insurance market and ensure millions of consumer, including those with pre-existing conditions, may obtain health insurance.
- The AMA has seven key recommendations for policy-makers to consider:
 - Governance structure
 - Choice
 - Type of model a person selects
 - Adequacy of networks
 - Quality improvement
 - Health plan transparency
 - Churn (i.e., when patients go through different health care plans based on their varying income levels) – patients should remain in one plan during this time period
- Physicians should be involved in exchange boards to provide an understanding of how the health care delivery system works by providing feedback before, during, and after the creation of the exchange
- An open-market model (such as the Utah model) with an array of health insurance plan choices should be used. Currently, patients and their families lose choice and bargaining power when there are not enough plans from which to choose
- Insurance plans must have an adequate network, however the state is allowed to decide what is considered “adequate,” which means patients may still find it difficult to obtain necessary medical care
- The health literacy (i.e., the ability to understand health information and make informed decisions) of patients is still a major concern



Patrick Willard

- States have two options – they can do nothing and wait to see what happens or they can take a proactive approach by looking at the various options. Indiana is one of those states that has taken the initiative and begun to do something
- There are numerous reasons for Indiana to operate an exchange:
 - Reduction of rural and urban care discrepancy
 - Increased market stability
 - Improved reimbursement for all services (reduce uncompensated care)
 - Economic development tool, creating more jobs and more tax revenue for the state
- A large number of uninsured will receive coverage under the exchange so it should be designed with consumers in mind
- There is the open-market model (such as the Utah model), the active-purchaser model (the Massachusetts model), or the Evaluator Model being considered by Indiana. This contains detailed information about each plan allowing consumers to select the best plan for their needs

Key Discussion Questions

Question: How important is data on quality to establish a baseline to the overall design of the exchanges?

- Exchange plans require data on both the clinical quality of care and customer experience of care. Indiana has the opportunity to take data and translate it into language the consumer can understand to select the plan best suited to their needs.
- Health plans should be transparent. Consumers may be responsible for a large burden of cost under the exchange, therefore they will need enough information to make informed decisions
- Exchange marketplace and outside marketplace should be healthy, with a mitigation of adverse selection between the two. The exchange should not be front loaded with high risk populations. The exchanges should use licensed agents and brokers to help patients make educated choices



Question: Should exchanges be created for the express purpose of including quality?

- If plans know that they are competing on quality of care, collecting and publically reporting data may be an incentive for them. Competition should be based on quality rather than premiums
- Transparency is very important here because consumers will be trying to make informed decisions. We want to incentivize based on

quality but need to also look at reducing costs. There should be narrow networks with high cost providers eliminated from exchanges

- Quality is very hard to define. We need to look at shared decision-making between physicians and consumers. Shared decision-making would likely result in consumers choosing a more conservative model when selecting plans

Question: If a State Agency runs the exchange, how will that governance structure work to have a role for the various groups (e.g., physicians, consumers)? This is easier to see with non-governmental and quasi-state agency boards that represent various stakeholders.

- A state agency does not have this, but there is more of a direct voter impact on a state agency than a non-governmental board. A Consumer Advisory Task Force should be created to have a role within that agency. A benefit of having the board vested in a state agency is that there is more transparency

through open meetings and open records that can create debate in the public pulpit

- The practice of medicine is complicated. It would be beneficial to have a physician on the board to help with the understand of what is or is not working and why
- Transparency is also important here. There should be consumer involvement in the board to provide perspective on exchange development. The exchange should be developed for the consumer, hence the board must consider how to get the necessary information to the consumer



Question: Open Market vs. Active Purchaser Model?

- An exchange should be as close to a Massachusetts-type model (active purchaser) as it can be, but align between that and a Utah-type plan (open-market). There should be active purchasing by the state on the contracts with insurance companies
- An open-market model provides more choices. In Indiana, there are two major insurers, so this model would allow smaller insurers to enter the market, consequently expanding consumer choice and opportunities
- In Utah the model is quite small, supporting

approximately 2,000 enrollees (employers and employees only, not individuals). In Massachusetts, there are seven or eight major players. The model Indiana selects should be substantive enough to encourage competition so consumers will have enough information to make decisions and drive the gears of the market

- If plans know they are competing on value and not low premiums it may drive choices for consumers
- An open-market model is the best approach and will force plans to be innovative, creating more choices for consumers

Question: How optimistic are you that the exchanges will improve health care five years from now?

- This is dependent on how the state will structure the exchange. Data should be translated into a language and information consumers can understand
- The exchange empowers patient by placing them in charge of the decision-making. Plans will be transparent and accountable

- The Federal Health Employee Benefit Plan, the plan members of Congress and federal workers receive, is an exchange-like model that has worked for years. It is an open-model with a variety of choices and plans that compete with one another.
- There should be an increase in consumer buy-in and a greater role for consumers to play in the exchange



Third Panel Discussion: Meeting the Unique Needs of Special Populations

Key Points Raised by Panelists

The third panel discussion examined what actions Indiana should take to create an exchange that will meet the unique needs of special populations. This discussion was moderated by The Honorable Jean Breaux from the Indiana Senate Democratic

Caucus, and was comprised of three panelists: Tricia Brooks; Enzo Pastore, Director of Health Policy at the State Associations of Addiction Services; and David Woodmansee, American Cancer Society Cancer Action Network (ACS CAN).

Tricia Brooks

- Unique populations served by the exchange may include those who: lack education, face poverty, language barriers, disability, and illness. The exchange should be designed for a consumer friendly environment to ensure accommodations for every population
- Children should be taken into account in the exchange design. Children are not little adults. An essential benefits package must address the needs of children. This package should include health and non-health related services
- It is important to have coordination among CHIP, Medicaid, and the insurance exchange to ensure eligible individuals

are appropriately covered by insurance through one of the programs. CHIP should continue because the exchange and Medicaid may not individually have enough support to cover the unique needs of children

- There is a need for robust navigators within the community to overcome specified barriers within the community. There should be one enrollment center for all programs, staffed by these navigators so consumers are aware of all options and can easily enroll in the most appropriate plan. This is especially important for the 20% of the population who may not be able to use a web based portal to compare and enroll in health plans



David Woodmansee

- ACA does not exclude pre-existing conditions within health plans, which allows high-risk individuals get health insurance. This is very important for those who have had cancer. Normally, these individuals would not qualify for health insurance
- There are additional conditions and circumstances not currently accounted for by the United States Preventive Services Task Force, such as the screening of high risk

diseases, that must be included in the exchange program. Exchanges should be designed so plans cover underlying treatment.

- The American Cancer Society supports five features that should be included in the exchanges: governance structure; coordination between CHIP and the exchange; funding; existence of a prevention fund; and support the more structured format of the Massachusetts model over the more flexible Utah model

Enzo Pastore

- There are seven recommendations made by the State Associations of Addiction Services to CMS:
 - Mental health agencies need to be identified as community providers for exchanges due to the high risk populations served
 - A robust benefits package for mental health care is necessary and should be available to a variety of individuals
 - Network standards must be developed for essential benefits and there must be adequate choices of providers

- Medical management tools should be utilized within the exchange to ensure confidentiality while providing required care
- There must be easily accessible coverage to ensure individuals with mental health and other disorders get care; navigators in the community should be trained to help individuals obtain care
- The exchange must include educational outreach to vulnerable populations
- Governing board and administration must utilize mental health administration in decisions



Key Discussion Questions

Question: Is there one type of exchange design that would be better for the consumer?

- Governance structure, detailed information to select the right type of plans, and building upon infrastructure should be included in the exchanges
- A single, combined eligibility system that directs consumers where to go should be supported. Some states

Question: The federal government will provide 100% of the costs of the IT package up front and then 75% after that. What type of information should be provided in the IT infrastructure to ensure seamless coverage?

- CMS has provided strong technical assistance to the states. The processes and systems must be efficient and effective for the

Question: For essential health benefits and network adequacy, what should Indiana do to ensure that the state exchange has coverage benefits for children, special populations, and others?

- HHS has indicated an essential benefits plan will not be released until 2012. An exchange including that coverage cannot be created without that plan
- The recommendations of

are best served with this handled by their Medicaid department, but it differs by state as to whether eligibility should be run by an existing state agency

- Currently, ACA creates two types of exchanges: one for individuals and one for employers. The American Cancer Society believes that the government should have one system

exchanges to work. These systems should be data driven and allow coordination between programs such as CHIP and Medicaid. Indiana does not have to start from scratch; The Centers for Medicare and Medicaid Services has a repository of systems currently in use by other states which Indiana could adopt

- the State Associations of Addiction Services to CMS at the federal level can also be made to Indiana when designing exchanges
- The federal government is allowing a great deal of flexibility for the states to create their own program, meaning states should not expect the federal government to make these decisions on their behalf

