



Health Insurance Exchange: Stakeholder Forums

May 15, 2012

The Department of Health and Social Services (DHSS) in conjunction with Public Consulting Group (PCG) held three (3) stakeholder meetings April 18 – 20, 2012. The meetings were divided into representatives from insurance brokers, providers and tribal entities. Following is a summary of each meeting.

Insurance Brokers

The broker session was attended primarily by members of the Alaska Association of Health Underwriters. PCG representatives began the discussion with a high level presentation of health insurance exchange basics. Following the PCG presentation, they opened the floor to questions/discussion. The brokers were concerned about the Navigator function being an independent contractor who did not have the licensure/credentials or training of a certified broker. There was quite a bit of discussion about how the Navigator would be paid. PCG explained that the Navigator is paid as a grant to a qualified organization. A Navigator must have demonstrated connections to the community to enable them to conduct the outreach necessary to bring potential enrollees to the Exchange. The Navigator would work with the enrollee to enter the Exchange portal. PCG explained that they would not be in positions of explaining benefits or brokering the actual plan. Brokers expressed the need for Navigators to be trained and certified. Further, they felt that brokers could be Navigators.

PCG also provided possible ways in which an Exchange could be funded. Exchanges must be able to be self-sufficient following the development and implementation phases. Possible means include but are not limited to:

- 1) Administrative fee to insurance companies enrolled in the Exchange
- 2) Levy of a fee to all insurance carriers whether they're in the Exchange or not

- 3) Charge providers a fee or tax
- 4) Consumer fee

PCG asked the broker group to discuss possible governance structures. The options presented were non-profit, state agency or an independent state agency. The advantages of each were explored with the latter 2 options having more access to state resources and the former being able to execute procurement faster. There is a recognized time crunch for implementation of the Exchange which brought a recommendation to look at the existing ACHIA board with additions to broaden that boards make-up to meet the ACA requirements for an Exchange advisory board.

Final discussion point centered on potential purchasing models:

- 1) pure employee choice
- 2) employer can limit carriers
- 3) employer can define "metallic" level
- 4) employer defines the benefit package.

Brokers shared with PCG that small group averages in Alaska usually carried a \$2500 deductible with standard 80/20 co-pay. Miscellaneous discussion centered on what types of IT improvements would need to be made and whether the portal could be used for all eligibility programs including the Exchange, Medicaid, and CHIP.

Providers

The Provider session began with the same basic overview of the Exchange. Following the presentation, PCG opened the floor to discussion starting with essential health benefits. Providers indicated that transportation both emergent and non-emergent with escort was a large issue for Alaska. Providers brought up the need for telemedicine due to the rural and remote nature of our state. EHB also needed to include reproductive services and that all services needed to be confidential. PCG brought up the issue of the "churning" rate between Medicaid and the insurance subsidy. This has been estimated to be as high as 50%. Discussion then began about ensuring the continuity of care between Medicaid and the subsidy. There

was also discussion about the need for payment reform which allowed for a fee for service versus and episode of care.

PCG turned the discussion towards the role of the Navigator. There was discussion about patient navigators in hospitals and the role of the Community Health Centers in providing the outreach function of the Navigators. Providers agreed that the Navigator appears to be a “social work” function – established relationships, knowing the community, trusted member. There was discussion about the need to conduct additional outreach to stakeholders and consumer groups.

The discussion then turned towards actuarial analysis. There were questions about the feasibility of an Exchange given the small population in Alaska. Indian Health Services and the Military are not included in Exchange risk pool assessment. There was also discussion about the price point – what will our market support . It was discussed that while the Exchange will help identify those individuals who will qualify under the Medicaid expansion and will provide for a subsidy for those above the 133% level , it will not provide for deductibles or co-pay’s. This may be a hardship for many participants, especially those who “churn” between Medicaid and subsidies.

Final discussion points, as with the brokers, included governance options and timelines.

Tribal Entities

The Tribal session began with the same basic overview of the Exchange. Following the presentation, PCG opened the floor to discussion starting with options for communicating the Exchange to Tribal partners. The Tribal group felt that the existing Medicaid communication and outreach plan was very effective. The Tribal group described the tribal system in Alaska which includes 229 federally recognized tribes. They supported the idea that all tribal programs should be in the definition of essential community providers, that the process to determine 100% FMAP should be the same and that verification of tribal connection should be expanded to include tribal enrollment card or BIA as a back-up process. The Tribal group also felt that the Navigator role would need to be someone local in the community that speaks the

language and has the trusted connections. There was discussion about Express Lane agencies assuming the Navigator function. These are agencies where people typically go for other services that could expand their functions to include Navigator roles. This would require training for the potential Navigators.

The discussion turned to the PCG report. PCG reported that they would include an actuarial analysis which would address premium costs, risk profile and enrollment projections. They would also be addressing a program integration analysis with Medicaid and the development of an advisory board for implementation and ongoing review of Exchange outcomes. The Tribal group expressed that the Advisory board should include members of the disproportionate populations. They recommended that the PCG report be put out as a draft for public comment. There was also discussion about whether the Governor could establish an Exchange via Executive order or whether legislation would be required. The ACA allows for either but it was unclear as to whether the Alaska Constitution would allow the Governor to expend the level of funding required for the Exchange.

Final miscellaneous discussion centered on DHSS receiving capital funding to update the MMIS and EIS systems. There are also federal dollars for health information technology that can be leveraged for system integration. Again, the limited amount of time before the Exchange has to be ready was discussed.

PCG anticipates having their report done by the end of May/first of June. The Supreme Court is expected to have their ruling by the end of June at which time the Governor and Commissioner will make their decision on their next course of action. Should the Supreme Court uphold the ACA with the Exchange function, the State of Alaska will have to be in a position for the Exchange to be certified by the federal government by January, 2013, begin enrollment October, 2013 and be fully functional by January, 2014.