

Exchange Advisory Task Force Recommendations

DRAFT – 1/17/2012

NOTE: See options and new language submitted by Task Force Members in Red

Adverse Selection

Initial Issues Considered:

- Should the market rules for health plan certification be consistent inside and outside the Exchange?

1a. Recommendations: Market rules, certification requirements, and regulatory provisions inside and outside the Exchange should be the same to encourage fair competition, promote regulatory simplification, and mitigate adverse selection. Rules should be structured to encourage innovation, competition, and market participation.

1a -1. Option: Market rules, certification requirements, and regulatory provisions inside and outside the Exchange should be the same to encourage fair competition, promote regulatory simplification, and mitigate adverse selection. Market rules should continue to be made through the legislative and regulatory process, and be structured to encourage innovation, competition, and market participation.

- What should the participation rules be for insurers and health benefit plans inside and outside the Exchange? Should insurers be allowed to offer different products inside and outside the Exchange?

1b. Recommendations: The Exchange should encourage innovation and competition on value, market participation, affordability, meaningful choices, portability, health improvement and long term care management for individuals and employees of small employers. Participation provisions should be structured to encourage insurer and health benefit plan competition and discourage adverse selection and competition between the Exchange and outside market.

- Should the definition of small group be increased from a maximum of 50 to a maximum of 100 in 2014 before this change is required in 2016?

1c. Recommendations: Market rules should stimulate participation by small employers with various characteristics. The definition of the small group market should be considered in combination with provisions to protect the small group market from adverse selection resulting from self-funding.

- Should Minnesota defer to a federal risk adjustment model or propose a state risk adjustment model?

1d. Recommendations: Minnesota should pursue a state-level risk adjustment model to take account of state-specific market characteristics and take advantage of state-specific

opportunities. Minnesota's all payer claims database should be authorized and modified as necessary for use in a state-level risk adjustment model.

- Should the individual and small group market risk pools be merged?

1e. Recommendations: Adverse selection, the stability of risk pools and risk sharing, and premium variability should be closely and regularly monitored regardless of whether Minnesota merges its individual and small group markets. Regulatory entities should have the ability to respond quickly to protect the market.

Financing

Initial Issues Considered:

- What ongoing financing options should be considered?

Recommendations:

- 2a. Funding mechanisms should be considered against the recommended principles of equity, transparency, sustainability and simplicity, as well as avoid negative impacts. Equity being the top principle.
- 2b. Funding mechanisms should not disproportionately burden one group over another, and as much as possible be proportionate to the benefit received by the paying group.
- 2c. Funding of the Exchange should include a combination of funding sources to ensure that those benefiting from an Exchange also support it, at a minimum include Medicaid or a percent of premium mechanism (to the extent it does not discourage participation or create adverse selection). Consideration of other resources should reflect overall budget needs, overall benefits of the Exchange and other decisions yet to be made.
- 2d. Funding mechanisms should be implemented in time to meet needs of Navigator program as well as cash flow and reserve needs of the Exchange to be self-sustaining beginning in 2015.

2d-1. Option: Funding mechanisms should be implemented in time to meet needs of Navigator program no later than July 1, 2013, as well as cash flow and reserve needs of the Exchange to be self-sustaining beginning in 2015.

Governance

Initial Issues Considered:

- What governance structure is recommended for Minnesota's Exchange?

- Should the Exchange have a governing body?
- What Minnesota statutes should apply to the governance structure?

Recommendations:

- 3a. The governance structure should assure compliance with Federal Medicaid laws given that the Exchange is responsible for Medicaid eligibility and enrollment.
- The Exchange should have a Board of Directors with the following characteristics:
 - 3b. 11-15 members, **New: and utilize advisory committees to consult with stakeholders on an ongoing basis (as supported by HHS proposed rules)**

3b -1. Option: 15-20 members

- 3c. Staggered terms
- 3d. New: Term limited
- 3e. A mixture of appointed and elected (self-perpetuating) members, **New: with the elected members being nominated and elected by the Board of Directors. For both appointed and elected members, the Minnesota Secretary of State's open appointments process should be followed.**
- 3f. Statutorily designated guidance as to attributes of members

3f -1. Option: (Language from HHS proposed rules) Majority of members should represent the interests of consumers and small businesses. Majority of members should have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. (In addition to HHS proposed rules, care should be taken to ensure diversity of thought and experience on the Board).

3f -2. Option: Membership should reflect the diversity of the state's population.

3f -3. Option: At least one member must have demonstrated expertise in public health and health disparities.

3f -4. Option: Membership should include health care practitioners.

- 3g. Per diem and expense reimbursement for members; **New: stipends should be paid to members who represent the interests of consumers, including small businesses, who would not be paid by an employer for their time spent serving on the Board.**

- The governance structure should include the following provisions for accountability:
 - 3h. Subject to the Legislative Auditor’s jurisdiction
 - 3i. Have a rigorous conflicts of interest policy with the goal of a fair and open marketplace; including Minnesota’s Gift Ban and state employee conflicts policy (Minnesota Statutes Chapter 10A) or Minnesota’s nonprofit law conflicts policy (Minnesota Statutes Chapter 317A)

3i -1. Option: Stipulate that individuals who are employed by or affiliated with insurers or insurance brokers are prohibited from serving on the Board.

3i -2. Option: (Language from HHS proposed rules) Ensure that majority of membership on the Board is not made up of representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers or any other individual licensed to sell health insurance.

3i -3. Option: Members with potential conflicts of interest should at most represent a small minority of the Board of Directors. Advisory committees to the Board could also be considered to consult with industry stakeholders.

- The governance structure should include the following provisions for operational flexibility:
 - 3j. Apply requirements of Open Meeting Law but with carefully crafted exceptions (Minnesota Statutes Chapter 13D)
 - 3k. Requirements of the Data Practices Act but with carefully crafted exceptions- importantly related to strategic/competitive and commercially sensitive information (Minnesota Statutes Chapter 13)
 - 3l. No statutory mandate for compliance with state procurement laws (Minnesota Statutes Chapter 16), but requirements for responsible procurement
 - 3m. Specify the Exchange is a nontaxable entity
 - 3n. Allow for intergovernmental transferability
 - 3o. Not subject to statutory rulemaking (Minnesota Statutes Chapter 14), but provide a mechanism for consumer and industry input into policy decisions

Navigators/Brokers

Initial Issues Considered:

- What should Navigators do? Should there be different levels of responsibility?
- What certification/licensure should be required of Navigators? Should there be different levels?
- How should Navigators be compensated? Should there be different levels and types of compensation?

Recommendations:

- 4a. The Navigator program should support the creation of different Navigator roles, with appropriate responsibilities, designed to address the specific needs of the particular populations served by the Exchange.

4a -1. Option: The Navigator program should be structured to support different Navigator roles designed to address the specific needs of diverse populations, in particular those experiencing the highest levels of uninsurance and the worst health disparities. This set of roles includes – in the small-group market – the role played by agents/brokers in helping both employers and employees understand their options.

- 4b. The Navigator program should develop certification/training/licensure requirements that align with the defined Navigator roles and level of service provided. This process should support sufficient Navigator capacity and allow for different entities to serve in any of the Navigator roles, based on ability to meet the established requirements.

4b -1. Option: The Navigator program should develop certification/training requirements that align with the defined Navigator roles and level of service provided. This process should support sufficient Navigator capacity and allow for different entities to serve in any of the Navigator roles, based on ability to meet the established requirements.

- 4c. New: The Navigator program should leverage existing infrastructure and current relationships while also seeking to fill significant “gaps” in the current system.
- 4d. New: Because of their existing relationships with populations that experience health disparities, Navigator services should be located in community-based organizations such as neighborhood and ethnic organizations, faith-based organizations, community health clinics, community mental health care centers, Indian health care centers, consumer advocacy groups, and culturally-specific human service providers.
- 4e. New: Existing programs that require certification, such as community health workers and certified peer specialists, should be “grandparented” in and recognized as Navigators. County workers, such as case aides and social workers, should also be considered to be Navigators.
- 4f. The Navigator program should ensure that consumers are seamlessly transitioned between different Navigator roles, if needed, to prevent gaps in service delivery.

4f -1. Option: The Exchange will serve a diverse group of consumers in different eligibility groups and insurance markets such as Medicaid, the individual market (with and without premium tax credits), and the small group market. Some individuals may shift eligibility between Medicaid, the individual market (with or without premium tax credits), and the small group market. Navigators should provide services that support individuals whose circumstances and eligibility may change over time. Due to the unique needs of consumers, employers, and communities using the Exchange, the

Navigator program should utilize Navigators with the expertise to meet the needs of each group and ensure a seamless experience to ensure no one falls through the cracks.

4f -2. Option: The Navigator program should minimize transitions or hand-offs for consumers to prevent gaps in service delivery. In the event a transition is needed, the transition should be seamless.

4f -3. Option: The Navigator program should support the creation of different Navigator roles designed to address the specific needs of the diverse populations served by the Exchange and must ensure that consumers are seamlessly transitioned between Navigators if needed.

- 4g. Compensation levels for Navigators should align with the different types of services being offered within each Navigator role and provide flexibility to allow for creation of performance based incentives.

4g -1. Option: Compensation levels for Navigators should align with the different types of services being offered within each Navigator role and provide flexibility for pay for performance models.

- 4h. Funding decisions for the Navigator program should be made in a timely manner to allow for an evaluation of the amount of resources available and the appropriate allocation of those funds to meet program priorities.

4h -1. Option: Funding decisions for the Navigator program should be made in a timely manner to allow for an evaluation of the amount of resources available and the appropriate allocation of those funds to meet program priorities by July 1, 2013.

4h -2. Option: Funding for the Navigator program, where Medical Assistance does not already reimburse, should be available no later than July 1, 2013.

- 4i. The Navigator program should be consumer focused and determine program priorities based on the needs of consumers.

4i -1. Option: The Navigator program should be consumer focused and determine program priorities based on the needs of consumers who are most likely to face barriers to successful enrollment.

4i -2. Option: The primary goal of the Navigator program must be to help individuals and communities overcome obstacles to obtaining and maintaining appropriate health insurance. Decisions about funding and contracts should reflect this priority.

- 4j. The Navigator program must be developed to ensure that Navigators do not directly or indirectly benefit from enrolling individuals or small employers in one insurer over another.

- 4k. New: Outreach is a critical function of Navigators, and development of the Navigator program should be undertaken in close concert with planning for outreach and marketing.