American Cancer Society/Cancer Action Network - Heidi Low

Cancer Action Network
American Cancer Society

**Threshold Questions for State Insurance Exchanges**

The Affordable Care Act (ACA) creates state health benefit exchanges that will be the central marketplace for many people to compare and buy insurance plans in the individual or small-group markets. As states consider how to create and implement an exchange, these are the most important questions for them to address.

**1. Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers, and small employers?**

*Rationale:* The governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management to successfully make the many critical administrative decisions that must be made by 2014. It is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, including patients and consumers, are best involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.

**2. Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate "adverse selection"?**

*Rationale:* It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

**3. Is the Medicaid program well integrated with the exchange?**

*Rationale:* Under the ACA, all individuals with incomes under 133 percent of the federal poverty level are eligible for coverage under Medicaid. The exchanges are responsible for screening and enrolling eligible people in the program. It will be critical that the exchange is well integrated with the state Medicaid program to ensure seamless enrollment. Further, because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.

**4. Is the exchange structured to emphasize administrative simplicity for consumers?**

*Rationale:* A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan's benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

**5. Does the exchange have a continuous and stable source of funding?**

*Rationale:* To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

**6. Does the exchange have the authority to be an active purchaser?**

*Rationale:* To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be "active purchasers" when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.

Heidi Low



## QUESTIONS FOR ACS CAN EVALUATIVE FRAMEWORK FOR ASSESSING SHOP AND HEALTH BENEFITS EXCHANGE PROPOSALS

The following is an "ACS CAN Evaluative Framework for Assessing SHOP and Health Benefits Exchange Proposals." These are important questions that may arise as exchange proposals are being developed and debated. They are organized by six criteria: availability, affordability, adequacy of coverage, administrative simplicity, governance and financing. ACS CAN's principles for meaningful coverage are attached as Appendix A. Governance and financing were added to this tool because they are important issues specific to the development of an effective exchange.

The questions in the Evaluative Framework are designed to illustrate the kinds of inquiries and analyses that should be considered in determining whether ACS CAN should take a position on health exchange proposals. Although the questions are far from exhaustive, they reasonably cover the spectrum of major issues that are likely to arise in health care exchange proposals.

This evaluative tool is intended to assist in analyzing legislative and regulatory proposals, and is not for use in comparing candidate position statements. The American Cancer Society Cancer Action Network does not comment on candidate platforms or proposals.

## ACS CAN Evaluative Framework for Assessing Insurance Reform Proposals

| Issue | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|
| ***Availability*** | | | |
| Outreach | Is outreach specifically targeted to those populations who are eligible for tax credits and cost-sharing reductions through the Exchange? | • Responsibility for targeting is clearly delegated to the exchange. | • |
| | What types of outreach are used? | • Outreach is publicly funded<br>• Uses community-based groups, school, churches and other trusted messengers (docs, etc.)<br>• Outreach campaigns at all employers, particularly those that do not offer insurance and/or have a large part-time workforce; medical facilities; and state human service agency offices<br>• Use of mobile units for outreach and enrollment<br>• Strategies for working with media (including ethnic media)<br>• Data used to tailor messages to segmented audiences<br>• Use of other public programs (unemployment, food stamps, school lunch program)<br>• State funding of outreach efforts, in addition to federal funds | • Outreach is only or primarily online |
| Application process | Is application process reasonable or cumbersome? | • Applications can be submitted by mail, phone, in-person, or online.<br>• Medicaid-eligible applicants are seamlessly transferred to the Medicaid program<br>• Existing information from other program records (income, citizenship, etc) is used for the application<br>• Application and materials are short, simple, and can be understood by a typical beneficiary<br>• Application materials available in languages other than English | • Extensive documentation (of income, assets, prior insurance status, etc.)<br>• Tight application deadlines (e.g., within 30 days of losing prior coverage)<br>• No toll free telephone access<br>• No in-person application venues<br>• Face to face interview required |

| Issue | Questions | Examples | |
|---|---|---|---|
| | | Helpful Language | (Potentially) Harmful Language |
| | | • Assistance in person or by telephone<br>• Can apply at point of service (community health center or hospital)<br>• Online application | |
| Enrollment | Is enrollment process reasonable or cumbersome? | • Automatic enrollment (coverage opt-out required)<br>• Ombudsman programs to assist consumers with enrollment issues<br>• Call center/in-person enrollment conducted by well trained employees with appropriate cultural competency and familiar with assisting low-income populations. | • Small businesses are required to meet participation rates higher than those required by the outside market<br>• Frequent re-certification requirements (less than 12 months) |
| | Is the enrollment process timely? | • Expedited enrollment<br>• Presumptive eligibility | |
| | Is coverage guaranteed for those who are eligible to enroll in the exchange? | | • Caps on enrollment in plans<br>• Waiting lists<br>• Specified number of "slots" for persons with subsidies<br>• Limited "service areas" –geographic area served by plan |
| | What is the duration of the open enrollment period? | • The open enrollment period is of reasonable duration<br>• Initial open enrollment period is longer to accommodate need for consumer education<br>• Open enrollment period waived for certain emergency situations<br>• Ability to address enrollment needs of populations who circumstances may change (income volatility, geographic moves, job loss, etc.) | • |
| | What are the criteria for special enrollment periods? | • Criteria are specified and easily accessible to consumers | • |
| Renewal process | Is the renewal process reasonable or cumbersome? | • Passive renewal<br>• Existing information from other program records (income, citizenship, program participation, etc) is used at the time of renewal | Frequent re-certification requirements (less than 12 months) |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | • Also online, phone, mail renewal | |
| | Marketing | | How are marketing materials reviewed? | • Joint authority between the Exchange/insurance department<br>• Standards inside and outside the exchange should be the same<br>• Can levy fines, issue cease/desist orders<br>• Consumer and small business input in design of marketing materials; focus groups<br>• Fund community-based organizations to do outreach to educate and enroll people in Exchange | • No meaningful enforcement power<br>• Lower standards for plans sold outside the exchange |
| | Choice of coverage | | Can new plans easily enter the market? | • Allow reasonable exceptions of criteria beyond ACA requirements for new plans to meet criteria for Exchanges as long as progress is demonstrated | • Only allow existing health plans to enter Exchange market |
| | | | Are Medicaid benchmark plans allowed to participate in the exchanges? | • Explicitly allow Medicaid benchmark plans into the exchange | |
| | | | To what extent does the Exchange negotiate with plans? | • Exchange can negotiate<br>• Negotiation abilities include premiums, benefits, and quality improvement programs<br>• Can provide extra "weighting" to plans that have experience with low income populations and include low income providers in their network<br>• Can provide extra "weighting" to plans that have scored well on quality measures, consumer satisfaction, and efficiency<br>• Authorize for selective contracting with plans[1] | • Exchange required to accept any eligible plan or otherwise barred from negotiating on premiums, benefits, quality, or other factors |
| | | | How is actuarial value of plans used in the Exchange? | • Exchange provides clear explanation | |

[1] Depends on competitiveness of market and political willingness to appropriately contract

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | of plan ratings<br>• Examples of estimated total cost using common chronic diseases as developed by HHS<br>• Grouping of plans beyond actuarial value, by standardized benefit plans | |
| | Choice of providers | | Is availability of physicians in the network easily determined? | • Consumer has easy access to information about provider network<br>• If provider network limited, consumer must receive clear notification<br>• Requirements for regular updates on physician network<br>• Ability to search within the Exchange portal by which carriers a provider contracts with and if they are accepting new patients | |
| | Quality | | Does the exchange provide information on quality of plans? | • There is a measure of quality of coverage—i.e., are all necessary services covered by the plan.<br>• There is a measure of consumer experience with the plan (i.e., benefit claims payment, appeals review, etc.).<br>• Consumer experience ratings are stratified by health status or frequency of plan use<br>• There is a measure of clinical quality provided by the plan.<br>• Quality measures are conveyed through intuitive and comprehensible measures, such as a star system<br>• In selecting plans for inclusion in the exchange, plans that perform well on quality measures get special consideration. | |
| | Role of Navigators | | What type of organizations can be used? | • Track record with the community, cultural competency<br>• Experience with low-income, Medicaid, ESL populations<br>• Knowledgeable of small business | • Insurance agents or brokers are the only navigators<br>• Licensing requirements for navigators |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | needs<br>• Credentialing process is acceptable (but not licensing of individual navigators) | |
| | | | When does the navigator program begin? | • Prior to Exchange operation | |
| | | | How should navigators be compensated? | • Flat fees (can be adjusted for number of encounters or time) | • Commissions based on signings or percentage of premium<br>• Commissions paid by insurers |
| ***Affordability*** | | | | | |
| | Ratings areas | | Do states allow multiple sub-state rating areas? | • Separate ratings areas are justified with data on significant geographic differences in health care spending and utilization but each area must have large population (only a few states have size for sub-areas)<br>• Same geographic ratings areas inside and outside of the Exchange | • Small ratings areas allowed<br>• Different rating areas than in exchanges |
| | | | What criteria are used to determine the adequacy of rating areas? | • Population size<br>• Significant medical cost differences within state due to geography | |
| | Size of the pools | | | • Merge the individual and small group markets<br>• Insurers not allowed to bypass pooling requirement through use of affiliates or subsidiaries | • Separate small group and individual market exchanges in small pop states, especially if there is insurance market outside the exchanges. |
| | Risk adjustment | | What are the data reporting requirements for plans inside and outside the exchange? | • Federal government given access to data insurers submit for risk adjustment purposes<br>• Insurance commissioner/exchange has authority to issue fines for submissions of fraudulent data or other reporting errors | |
| | Adverse Selection | | How is adverse selection minimized? | • Outside market rules are the same as exchange rules<br>• All insurers in the outside market must also offer plans in the exchange OR products outside the exchange are offered at exchange level (same actuarial value) | • Substantively different rules for products outside versus inside the exchange |

| | Issue | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|
| | | | • Insurers may NOT offer only bronze, catastrophic or young adult plans outside the exchange | |
| | Negotiating power of the Exchange | Is the exchange an active or passive purchaser? (Ability may vary considerable depending on the size of state and the number of insurers in the market) But should have the authority to do so when the environment is more appropriate | • The exchange has authority to limit the number of plans in the exchange based on established criteria<br>• The exchange can negotiate rates or other components of plan offerings (e.g., provider networks)<br>• The exchange can remove a carrier for poor performance or unacceptable premium increases | • Exchange must accept all insurers ("Any willing insurer" provision)<br>• Exchange has little or no authority to remove poor performing insurer |
| | Premiums – Health Status | Do premiums vary based on health status? | • Gradually narrows rate bands for health, age, gender prior to 2014<br>• Narrows rating bands for age; eliminates tobacco use ratings | • Tobacco use premium rating adjustments<br>• Premiums adjusted for participation in wellness programs |
| | Premiums –consumer cash flow | Are premiums billed monthly or in other increments? | • Annual, Monthly or quarterly options available to consumer<br>• Multiple forms of payment are allowed | • Payment at enrollment must encompass first three months or more of coverage |
| | | Is there a grace period for late payments? | • 30-90 day grace period<br>• Premium invoices, late payment reminders<br>• Consumers can choose how to be reminded of payments (mail, email, text, etc). | • Coverage cancelled first day after payment due is missing<br>• No monthly premium invoice; enrollee must remember to submit payment |
| | Premium - stability | How are premium increases regulated? | • State has established a rate review process<br>• Exchange has authority to request a hearing on rate reviews | • Insurers do not have to explain rate increases |
| ***Adequacy*** | | | | |
| | Quality | What are the measures and standards used to assess plan quality? | • HEDIS/NCQA or other acceptable measures<br>• Authorizes use of heath outcomes measures<br>• Authorizes use of consumer satisfaction surveys and public disclosure of results | |

| Issue | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|
| | | • Authorizes use of measure regarding racial, ethnic, and socioeconomic disparities. | |
| | What measures/standards are used to assess provider quality? | • State reporting on provider performance (e.g., hospitals) is readily available to consumers<br>• Reporting on medical errors and hospital-acquired infections<br>• Reduction of racial and ethnic health disparities | |
| Covered Benefits | Are all services offered for all coverage groups? | • Essential benefits explained<br>• Limits on benefits are identified (e.g., number of doctor visits per year, etc.)<br>• Additional benefits are identified<br>• Exchange authorized to require greater standardization of benefits and cost-sharing within a coverage tier | • Tiered benefits based on health status with more benefits available for "less healthy" and less for "healthier" enrollees (this is permissible in Medicaid benchmark plans but should be discouraged)<br>• Tiered benefits based on health behavior with "enhanced" benefits available for enrollees who comply with requirements (this is permissible in Medicaid benchmark plans but should be discouraged)<br>• Restrictions on ease and speed of movement to another tier when health status changes<br>• Certain services not offered to certain tiers<br>• Beneficiaries excluded from coverage for certain behaviors (12-month waiting period to re-sign member agreement and re-enroll in an enhanced plan after failing to comply with plan requirements). Permissible in Medicaid benchmark plans but should be discouraged.<br>• Essential benefits not required in every plan |
| Transparency | Can beneficiaries readily discern what services are covered or how much they have to pay? | • Authorizes Exchange to promulgate regulations to require consumer-friendly plan disclosures<br>• Plan materials include examples to | • "Fine print" or vague contract language on limits of coverage<br>• Formularies, care authorization rules are unpublished or are hard to find |

| | Issue | | Questions | Examples | |
|---|---|---|---|---|---|
| | | | | **Helpful Language** | **(Potentially) Harmful Language** |
| | | | | illustrate how coverage works<br>• Plan materials are written in simple language and include appropriate illustrations<br>• Translations are available, easy to obtain<br>• Plan and provider ratings are available on the web<br>• Sample cost and health benefit examples for common, high cost medical conditions | • Directory of network providers is unpublished or out of date<br>• Information on health plans only available after a person has enrolled |
| | | | | | |
| | Covered benefits | | *TBD based on Essential Benefits Package <u>proposal expected in latter half of 2011</u>* | | |
| | Covered providers | | Is coverage restricted to a network of providers that includes sufficient number, geographic distribution of cancer specialists? | • Specialists may be considered as primary care physicians while undergoing treatment<br>• Rules and costs for going out of network are clearly displayed<br>• List of providers updated quarterly to reflect any departures or additions to network | • No restrictions on balance billing for use of out of network providers |
| | | | Can patients reasonably seek out-of-network care if necessary? | | • Significantly higher amount of coinsurance for out-of-network coverage<br>• Vague or complicated rules for obtaining approval for out of network care |
| | | | Is care in comprehensive cancer treatment centers covered nationally—including in states other than place of residence? | | |
| | | | Are there protections against "balance billing?" | • Plan recognizes higher charge level for out-of-network care or negotiates fees with out of network providers | • Plan does not provide any limits on balance billing |
| | | | | | |
| | Authorization rules | | Is prior authorization required for hospitalization, surgery, other care? | • Exchange is authorized to set standard pre-authorization period<br>• Authorization process is timely, straightforward | • Plan not required to disclose clearly its prior authorization rules<br>• Protocols for approving care proprietary, not disclosed |
| | | | | | |
| | Transparency | | Can enrollees/prospective enrollees readily discern what is covered? | • Plan materials include examples to | • "Fine print" or vague contract language |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | Can enrollees/prospective enrollees readily discern how much they have to pay, billing procedures, and processes for filing claims and appeals? | illustrate how coverage works<br>• Plan materials include examples to illustrate how billing works and how appeals may be filed<br>• Plan materials are written in simple language (6th grade or below), and includes appropriate illustrations<br>• Translations are available, easy to attain, and free | limits coverage<br>• Formularies, care authorization rules, unpublished<br>• Directory of network providers unpublished, out of date<br>• Information on health plans only available after a person has enrolled |
| ***Administrative Simplicity*** | | | | | |
| | Enrollment | | How is eligibility coordinated between Medicaid/CHIP and the Exchanges? | • Enrollment is seamless—the patient does not have to submit different information or forms for each<br>• Modern IT system that will allow cross-agency coordination and data sharing within the state and with the federal government | • Different rules or forms for each |
| | | | Does the exchange use data linkages with other federal and state agencies to determine eligibility? | • Is the state pre-testing systems?<br>• Integrates multiple state and federal assistance programs over time<br>• Data linkages are consistent with federal and state privacy law | |
| | Collection and reporting of complaints/problems | | Is the exchange producing information that measures plan performance in a manner that helps consumers make informed choices? | • Exchange/state agency collects and publishes standardized data<br>• Includes information on resolution of complaints<br>• Trends can be examined<br>• Comprehensive privacy policy<br>• Explicit time frame for resolving complaints<br>• Sharing of complaint data with federal government<br>• Consumer or policyholder advisory board | • Prohibitions or restrictions on disclosing insurer performance or practices |
| | Premiums | | Does the Exchange handle the billing and collection of premiums? | • Rules seek to reduce administrative burdens on individuals and small businesses | • Prohibitions or restrictions on exchanges from performing these functions |
| | | | How are brokers paid? | • Paid by the Exchange on a flat fee basis<br>• Brokers and agents paid on a flat fee basis (i.e., they do not have an incentive to steer applicants to | • Paid by insurers on a commission basis<br>• Brokers are mandatory |

| | Issue | | Questions | Examples | |
|---|---|---|---|---|---|
| | | | | Helpful Language | (Potentially) Harmful Language |
| | | | | particular plans)<br>• Brokers and agents fees are visible | |
| | Coordination between small businesses and the Exchange | | Are administrative responsibilities designed to reduce the burden on small businesses? | • Consolidated billing (employers pay exchange for all workers with one payment ) | • Barriers or limits on exchanges handling administrative functions for small businesses |
| | Transparency for consumers | | How transparent is the availability, affordability, and adequacy of coverage (see above) for plan enrollees and prospective enrollees? | • Requirements that applications and plan descriptions be written in clear, concise language<br>• CLAS standards & other standards for non-English speaking or reading patients<br>• Access to a live operator/staff to help explain benefits<br>• Information about Navigators/consumer assistance presented in clear manner | |
| | | | How transparent and/or simple is the billing process? | • Information is easily available and accessible to enrollees | |
| | | | Are the processes for filing claims, grievances, and appeals easily understood and decisions are timely? | • Requires Insurance Commissioner or Ombudsman's office to create a model form that all plans must use<br>• Required forms are simple and may be easily completed | • Notice in legalese, fine print<br>• Decisions are lengthy and time-consuming |
| | | | How is information on the website accessible? | • Ability to narrow list of options<br>• Ability to search for specific providers<br>• Only requires minimum amount of personal data and supporting documentation to determine eligibility<br>• No need to re-enter data<br>• Ability to choose preferred form(s) of communication (email, txts, phone, mail)<br>• Health plans are standardized, to allow easy comparisons | |
| | Regulatory authority | | Is there clear and effective regulatory authority? | • Regulatory authority of exchange, if any, is clearly defined and consistent with other state agency(ies) authority<br>• Consumers can easily determine where/how to file a complaint – web | • Authority /responsibilities of state agencies vs. exchange is not clear |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | links to appropriate agencies<br>• Clear language requiring the Exchange to coordinate with the Department of Labor | |
| | Regulatory tools | | Are there sufficient rules and resources to allow for adequate monitoring and enforcement? | • Regulator has trained staff, audit authority, sanction and enforcement authority to effectively administer law | |
| | | | How is risk pooling monitored and enforced? | • Annual reports by the state on plan enrollment and enrollee profiles (e.g., age, risk factors, claims data, etc) | • No obligation on state insurance department to report publicly |
| | Multi-state exchanges | | Are the states ensuring coordination of their individual state laws and practices with those of the multi-state exchange? | • State insurance laws that are looser than ACA requirements are brought into conformance with exchange rules<br>• Determination of regulatory authority over plans that cross state lines | |
| | Federal exchanges | | | • Consumers in federal exchange have clear consumer rights and know where/how to seek recourse<br>• State laws are consistent with federal exchange rules and regs | • State insurance market operates under less rigorous rules than those for insurers inside the federal exchange |
| | Transparency issues | | Is there effective notice about the availability of coverage? | • Requires Exchange to develop a model notice of availability of coverage<br>• Written notice from the Exchange to the consumer is required; any application deadlines begin to toll following receipt of notice<br>• Notice in layman terms, available in other languages | • Lack of notice<br>• No requirement for "plain English" disclosure |
| | | | Is there effective outreach to make general public/ target population aware of coverage? | • Plan/program advertises widely<br>• Targeted outreach to eligible population (e.g., COBRA pamphlets distributed at unemployment office, high-risk pool info in hospitals)<br>• Funded outreach to trusted, community-based organizations | • No requirement for exchange to develop outreach strategy or fund outreach |
| | | | Is the cost of coverage obvious and knowable? | • Published premiums, copayments, co-insurance, and deductibles (e.g., on Internet) | • No or limited rate review authority for the state<br>• No ability for consumers to challenge |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | • Insurers have to explain rate changes and information is readily accessible to consumers<br>• Consumers have the ability to request public rate hearings<br>• Consumer know price before they purchased<br>• State has prior approval authority over rate increases; paid actuaries on staff to review<br>• State makes coverage facts label (as developed by HHS) available through the Exchange and the DoI | rate setting or request a hearing<br>• Renewal rating practices not published |
| **Governance** | | | | | |
| | Composition of the Board | | | • Strong consumer representation<br>• Insurance commissioner<br>• State Medicaid Director<br>• State public health officer<br>• Broad representation of stakeholders;<br>• Those with a financial interest in the Exchange are barred from serving on the Board, including insurers and providers and any first degree relatives | • Insurers and providers participating in the exchange outnumber consumer representatives |
| | Role/responsibility | | How long is each board member's term? | • Minimum two years; staggered terms | |
| | | | How does the Exchange interact with other state entities? | • Authority to communicate directly with state legislature<br>• Authority to communicate with other state entities<br>• Other state entities have authority to coordinate with the Exchange<br>• Exchange has clear authority to promulgate regulations where necessary | |
| | | | Does the exchange have the authority to conduct business? | • Authority to engage in contracts with other government entities and private sector | • Business or personnel responsibilities have to be executed through another state entity |

| | Issue | | Questions | Examples: Helpful Language | Examples: (Potentially) Harmful Language |
|---|---|---|---|---|---|
| | | | | • Requirement to issue annual reports on the individual and small group exchanges<br>• Requires Insurance Commissioner to monitor and report on any adverse selection against the Exchange<br>• Authority to hire and remove staff<br>• Administrative rules are defined (e.g. compliance with state personnel rules, use of contractors, etc.); exemption from state procurement rules may be necessary | • Allows private contractor to run Exchange without adequate state oversight |
| | | | What is the basis for removal from the board? | • Conflicts of interest or failure to disclose conflicts of interest, including financial<br>• Conduct detrimental to the exchange<br>• Clear process and responsibility for removing member | • No process and criteria for removal are defined in law |
| | | | How are the board members compensated? | • No compensation other than travel and administrative costs for participating | |
| | Transparency | | How are stakeholders involved? | • Standing advisory board with consumer representation<br>• Public hearings and "sunshine" provisions<br>• Opportunity for notice and comment | • No public reporting or open meeting provisions |
| | | | How does the Board communicate with the public? | • Exchange Board complies with open meeting laws<br>• Agendas, minutes, and informational documents are available to the public and on their website | • No public reporting or open meeting provisions |
| ***Financing*** | | | | | |
| | Source of funding | | | • Paid by all insurers in market (not just those in Exchange) | • Paid by enrollees in the exchange |
| | | | How stable and secure is the funding? | • Not subject to annual appropriations or approval by legislature | |
| | | | Is funding sufficient to conduct exchange duties? | | |

# Appendix A:
# Principles on What Constitutes Meaningful Health Insurance

Appendix A

Statement of Principles

It is a fundamental principle of the American Cancer Society that everyone should have meaningful public or private health insurance.

Meaningful health insurance is adequate, affordable, available and administratively simple.

Adequate health insurance means:

- ✓ *timely access and coverage of the complete continuum of quality, evidence-based healthcare services (i.e., rational, science-based, patient-centered), including prevention and early detection, diagnosis, and treatment*
- ✓ *supportive services should be available as appropriate, including access to clinical trials, chronic disease management, and palliative care*
- ✓ *coverage with sufficient annual and lifetime benefits to cover catastrophic expenditures*

Available health insurance means:

- ✓ *coverage will be available regardless of health status, or claims history*
- ✓ *policies are renewable*
- ✓ *coverage is continuous*
- ✓ *choice in plans*

Affordable health insurance means:

- ✓ *costs, including premiums, deductibles, co-pays, and total out-of-pocket expenditure limits, are not excessive and are based on the family's or individual's ability to pay*
- ✓ *premium pricing is not based on health status or claims experience*

Administratively simple health insurance means:

- ✓ *clear, up-front explanations of covered benefits, financial liability, billing procedures, and processes for filing claims, grievances, and appeals are easily understood and timely, and required forms are readily comprehensible by consumers, providers and regulators*
- ✓ *consumers can reasonably compare and contrast the different health insurance plans available and can navigate health insurance transactions and transitions*

- **Active/Passive renewal**: Active renewal means that the enrollee must affirmatively do something to remain enrolled in a plan for the next year. Passive renewal means that enrollment will continue automatically and indefinitely until the enrollee affirmatively states that he/she wants to discontinue coverage in a plan.

- **Actuarial Equivalence**: A measure of the level of coverage a plan offers. It is expressed as a percentage of the cost of covered benefits the plan would be expected to pay for a general population (not necessarily the population actually enrolled in the plan). The percentage of coverage for each individual will vary based on their use of medical care [See Plan Ratings, below]

- **Any Willing Insurer**: This means that an exchange would have to allow any insurer that meets the state licensing requirements to sell its products in the exchange. The exchange could not set higher standards for its plans.

- **Balance Billing**: In Medicare and private fee-for-service health insurance, the practice of billing patients for charges that exceed the amount that the health plan will pay. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge.

- **CLAS Standards**: Culturally and Linguistically Appropriate Services for health care are standards developed by the Office of Minority Health in the Department of Health and Human Services. They are not regulations, and therefore, do not have the force of law, but they can help health organizations respond to their patients cultural and linguistic needs.

- **Cost Sharing:** Any out-of-pocket payment the patient makes for a portion of the costs of covered services. Several forms of cost sharing are in use, including, deductibles, co-insurance, and co-payments.

- **Formulary**: List of preferred pharmaceutical products – generic and brand name – to be used by a managed care plan's network physicians. Formularies are based on evaluations of the efficacy, safety, and cost effectiveness.

- **FPL**: *Federal Poverty Level*; The amount of income determined by the federal Department of Health & Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size.

- **Guaranteed Issue**: Requirement that insurance carriers offer coverage to groups and/or individuals during some period of the year – regardless of their health status.

- **HEDIS and NCQA**: HEDIS stands for the Healthcare Effectiveness and Information Set which is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

- **Limited Service Area**: When an insurance plan does not cover an entire geographic area that other plans cover. A limited service area may be justifiable for certain kinds of plans, such as HMOs that rely heavily on their own facilities (e.g., Kaiser Permanente Health). But it is also can be a way for insurers to "redline" areas where there are higher risks—i.e., insurers try to avoid communities or zip codes where there is higher disease incidence.

- **Medicaid Benchmark Plan**: A Medicaid Benchmark plan is coverage that is actuarially equal to either the state employee health care coverage, the largest HMO coverage in the state, the Blue Cross/Blue Shield offered to federal employees, or some other coverage approved by the Secretary of HHS. The states have flexibility in deciding the scope of coverage but must include the essential benefits in all benchmark plans.

- **Navigators**: The ACA establishes a navigator program within the exchanges to assist people with the array of insurance problems that might arise. (This program is distinct from the "patient navigator" programs that ACS and HHS run, which are more specifically directed at assisting patients navigate medical and provider issues.)

- **Ombudsman**: An individual who assists enrollees in resolving problems they may have with their managed care organization/prepaid health plan. An ombudsman is a neutral party who works with an enrollee, the managed care organization/prepaid health plan, and the provider to resolve individual enrollee problems.

- **Open Enrollment Period**: The period of time in which anyone eligible may enroll in all the plans being offered.

- **Plan ratings**: Under ACA, all plans in the exchanges must offer the essential benefits package (which HHS will define through regulations before 2014). Plan premiums will vary based on the deductible and cost-sharing under the plan. Plans will have ratings based on their actuarial value (see above) of "bronze" (60% actuarial value), "silver" (70%), "gold" (80%) and "platinum" (90%). These ratings must be disclosed in marketing and other plan materials sold through the exchanges.

- **Presumptive eligibility**: Presumptive eligibility provides children immediate access to health services by giving them temporary health insurance through Medicaid or SCHIP if they appear to be eligible. The eligibility generally lasts 60 days while an application is reviewed.

- **Rating Areas**: The geographical area in which premium rates apply. It is strongly preferable for the rating area to include a large number of people. In lesser populated states, the entire state should be a single rating area.

- **Rating Bands:** Amounts by which insurance rates for a specific class of those insured may vary. Under ACA, all plans (inside and outside the exchanges) can only use age (3:1), geography and family size. The state defines permissible geographical regions and family size units—i.e., parent/single child, two parents with one or two children, etc.

- **Risk Adjustments:** Methodologies have been developed to measure the relative of risk profiles of different insurance pools. Insurance pools that have a disproportionately high share of high risks receive more premium dollars than plans with relatively low risks. If implemented properly, the risk adjustments make covering high risk patients more attractive to insurers and act as an incentive for them to develop efficient, high quality provider networks to treat patients with serious medical conditions.