St. Alphonsus Health System
Corey Surber

LEAD THE WAY

Transforming America's Health

We envision a nation with an affordable health care system that leaves no one behind. To achieve this vision, we must continue working together toward a health care system that delivers high value and clinical excellence across the continuum of care. Successful health insurance exchanges will expand access and facilitate consumer engagement with robust transparency around price, quality, and benefit designs.

What is a Health Insurance Exchange?

Health insurance exchanges will function as new marketplaces where individuals and small businesses can purchase health insurance. Through exchanges, consumers will determine eligibility for subsidies, access information about available plans, compare coverage options, access toll-free support, and enroll in the plan that best meets their needs. In addition, exchanges will coordinate with existing state programs, such as Medicaid and CHIP, to facilitate enrollment into relevant coverage options. An exchange must also certify and rate qualified health plans. Individuals with incomes between 133 percent and 400 percent of the federal poverty level (FPL) are eligible to receive federal premium and cost-sharing subsidies through exchanges. The Affordable Care Act requires states to establish health insurance exchanges by 2014 or defer responsibility to the federal government. The exchanges will serve more than 24 million individuals by 2019.

KEYS TO A SUCCESSFUL HEALTH INSURANCE EXCHANGE

- Engaged consumers
- Robust transparency
- High-performance (low-cost/high-quality) provider networks
- Broad range of evidence-based coverage options
- Managed risk environment
- Appropriate, affordable benefit packages
- Emphasis on quality, value, and care coordination
- Coordinated caregiver networks
- Active consumer outreach and enrollment

Saint Alphonsus Health System

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TRINITY HEALTH
Novi, Michigan

What are the Key Decisions for States Establishing Health Insurance Exchanges?

States must consider a number of operational factors for their exchanges. Key questions that policymakers must resolve include:

Governance

- Should the state set up its own exchange or defer to the federal government?
- Should an existing state agency, a quasi-public entity, or a new private nonprofit run the exchange?
- Who will be on the state board? How to ensure all stakeholders are properly represented?
- How will board members be selected?

Market Size

- Should the state pursue one or two exchanges for the individual and small markets?

Operations

- Is the role of the exchange to operate as a market organizer or active purchaser?
- What investments must the state make to upgrade IT platforms to facilitate Medicaid enrollment?
- How will the state ensure strong consumer education about the exchange and the plans offered?
- What are the initial start-up costs for implementation? What will be the ongoing maintenance and support cost?
- How will robust consumer outreach be achieved?
- What will be the role of insurance agents/agencies?

Benefit Design

- What are the appropriate protections to prevent adverse selection?
- How can the exchange encourage innovation and high-value care through evidence-based benefit design?

What Can Policymakers Do to Implement Effective Health Insurance Exchanges?

To ensure that insurance exchanges promote affordable high-quality coverage for all, policymakers should:

Governance

- Adopt the NAIC model legislation as framework for basic authorization for state-based exchange
- Create a quasi-public-private governance entity that is focused solely on the success of the exchange
- Select Board members from broad representations including newly insured consumers, hospitals, and physicians
- Ensure Board operates with full transparency

Market Size

- Seek administrative efficiency and avoid duplication of efforts when possible
- Promote more competition in the insurance marketplace

Operations

- Align the exchange application process so individuals eligible for other coverage options, such as Medicaid, are quickly identified and directed to the appropriate program
- Adopt adequate eligibility periods to minimize churning and ensure continuity of care
- Exchange should operate in the middle of the market organizer/active purchaser spectrum. Plan certification processes should be structured to promote broad participation and ensure competition, consumer choice, and transparency of provider performance.
- To update enrollment systems in advance of exchange implementation, the state should apply for enhanced federal funding
- Fund with premium assessments or health plan taxes, as they directly relate to policies sold on the exchange. Do not use provider taxes as a revenue source. This has the potential to drive up healthcare costs and could be burdensome to safety-net providers.

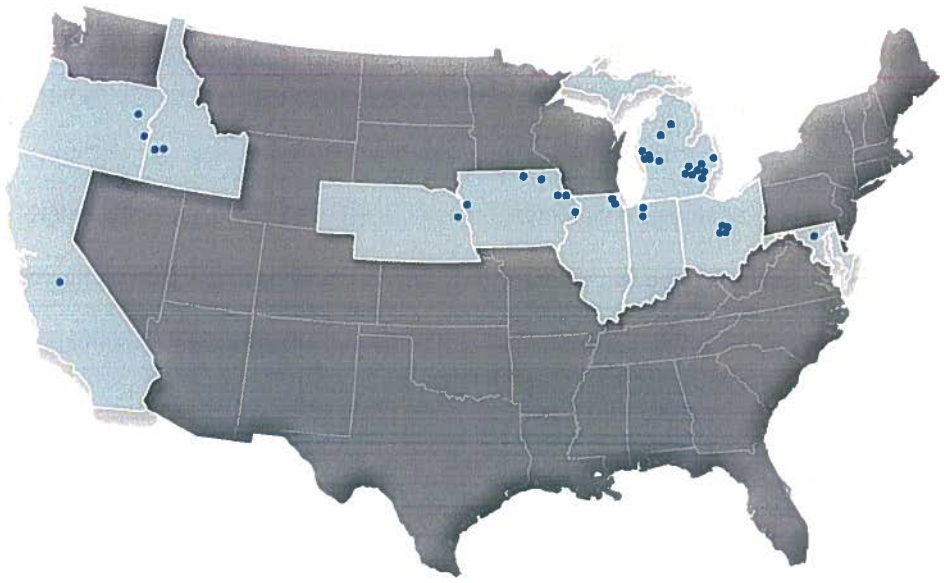
- Ensure that subsidy dollars are being spent on plans that are operating efficiently
- Detail specifics about plan offerings, provider networks, and performance on the exchange's website in a format that is easy for consumers to understand. Consider employing a rating system similar to the Medicare Advantage star ratings to help consumers compare plan performance.
- Promote health plans that fully utilize Health Navigators and partnerships with health care providers to reach all segments of eligible populations

Benefit Design

- Establish provider network adequacy requirements to ensure access to care, including safety-net providers
- Encourage health plan issuers to design a benefit structure that provides incentives to members who utilize low cost/high quality providers
- Include delivery system reforms that reward quality and value and promote care coordination; for example, encourage patient-centered medical homes

Less Regulated ← **Spectrum of Approaches to Exchange Operations** → **More Regulated**

Plan Participation		
Market organizer: Accepts all health plans; no additional rate review beyond state process	**Managed coordinator:** Requires plans to meet some additional certification criteria; negotiates with plans if rate increases are above desired levels	**Active purchaser:** Exchange aggressively negotiates with plans, limiting the number of participants; rejects plans with high rate increases
Benefit Design		
Market based: Imposes no benefit requirements in excess of ACA	**Moderately regulated:** Imposes some benefit requirement beyond ACA	**Regulated:** Imposes range of additional benefit requirements beyond ACA and standardizes the benefits within each tier
Governance		
Separate Non-Profit: Governed by separate non-profit entity	**Quasi-Government:** Governed by quasi-governmental entity	**Existing Office:** Governed within existing office
Financing		
Assessment on exchange: Assesses fee on exchange plans	**Assessment on all plans:** Assesses fee on all plans	**Alternative:** Uses other revenue sources (e.g., provider tax)
SHOP Exchange		
Separate: Completely separate governance and operations for individual and small group exchanges	**Joint governance:** Single governing entity runs two distinct programs	**Merged:** Governance and operations for both exchanges merged; individual and small group market risk pools merged
Consumer Outreach and Education		
Insurer-led: Insurers must only meet federal outreach and education activities; insurers may vary greatly in their approach	**Moderately regulated:** Requires some additional outreach and/or education activities beyond ACA	**State-led:** Additional outreach and education activities are required, such as broader language and point-of-access requirements



TRINITY HEALTH FAST FACTS

- One of the largest Catholic health systems in the United States (based on Operating Revenue)
- 53,400 full-time equivalent employees
- More than 9,000 active staff physicians
- 20 Ministry Organizations, encompassing 47 hospitals (35 owned, 12 managed)
- 401 outpatient clinics/facilities, 31 long-term care facilities, numerous home health and hospice programs in nine states
- Revenues of about $9 billion
- More than $450 million in community benefit ministry in fiscal 2011

Mission

We serve together in Trinity Health,
in the spirit of the Gospel,
to heal body, mind and spirit,
to improve the health of our communities,
and to steward the resources entrusted to us.

Core Values

Respect
Social Justice
Compassion
Care of the Poor and Underserved
Excellence

Vision

Inspired by our Catholic faith tradition, Trinity Health will be distinguished by an unrelenting focus on clinical and service outcomes as we seek to create excellence in the care experience. Trinity Health will become the most trusted health partner for life.

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