Commonwealth of Virginia
Office of the Governor

Robert F. McDonnell
Governor

November 25, 2011

The Honorable William J. Howell
Speaker of The House of Delegates
Virginia House of Delegate
Post Office Box 406
Richmond, Virginia 23218

The Honorable Charles Colgan
President pro tempore
Senate of Virginia
Post Office Box 306
Richmond, Virginia 23218

Dear Speaker Howell and Senator Colgan:

I have significant concerns regarding the impact the Patient Protection and Affordable Care Act (PPACA) will have on the Commonwealth of Virginia. Our health care system is in need of significant reform, including Virginians having access to affordable health care. The challenge is how to provide that access in an economically responsible and constitutional manner. That is why I strongly support the cases challenging the constitutionality of the federal health care law and the individual mandate. I have long argued that this is an issue that will have an enormous impact on states and their citizens, and one that demands finality as soon as possible. While uncertainty looms over its constitutionality, each day that that these cases remain unresolved means that states must spend more time and money to prepare for the expensive and burdensome requirements of the health care law.

As I have previously stated, I believe PPACA is not the answer to our health care challenges. I have shared my concerns with Secretary Sebelius and have unified my voice with other Governors calling for the repeal of PPACA. If PPACA is not repealed, significant amendments are necessary. This unfunded mandate will significantly and negatively impact the Commonwealth's budget and those of every state in the Union.

As Governor, I have considerable issues with the federal Department of Health and Human Services (HHS) lack of a coordinated, organized strategy in working with states. I have specific concerns about key facets of the law and the unfunded mandates that if implemented as written, may put serious additional strain on the Commonwealth's economy and overwhelm our health care system. With less than two years remaining for Health Benefit Exchanges to be operational, HHS leadership has not provided the necessary guidance and critical information needed for states to make informed decisions around exchange planning and development. Of significant concern is that if Virginia does not create an operational exchange, the federal government threatens to operate a federally facilitated exchange in the Commonwealth. HHS has neither released a model of the federal Health Benefit Exchange nor addressed the underlying policies that will govern such an exchange. Without the necessary guidance and rules that will

govern a Virginia exchange and a federal model to review, it is extremely difficult to evaluate whether ceding control of an exchange to the federal government or creating our own is in the Commonwealth's best interest.

As Governor, I will act in the best interest of Virginians to mitigate against unfounded federal intrusion. In August 2010, Virginia began forming its own strategies through the creation of the Virginia Health Reform Initiative Advisory Council. After naming the membership, I charged them with seeking innovative and affordable solutions to the challenges facing health care in Virginia. The experts and stakeholders of this group have spent the last nine months discussing and considering much of the information provided in the attached report.

Please find attached, the report they prepared pursuant to House Bill 2434 of the 2011 Session of the Virginia General Assembly. The bill directed the Secretary of Health and Human Resources along with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders to provide recommendations for consideration by the 2012 Virginia General Assembly regarding the structure and governance of a Health Benefit Exchange (HBE), if one is created in Virginia.

The report includes recommendations of the Virginia Health Reform Initiative and reflects the documents, discussions, stakeholder public comment, and recommendations made over the past several months by the Advisory Council and interested parties. The Advisory Council worked to address the five questions posed by the General Assembly as well as other questions deemed relevant by the Advisory Council members and stakeholders.

The decisions ahead are not easy and I will neither compromise the financial integrity of Virginia nor leave us vulnerable to the overreaching federal government. I will continue to evaluate these recommendations while working with Secretary Hazel and other trusted advisors in order to identify and pursue the best course of action for the Commonwealth. When it comes time to make a final decision regarding the best path for Virginia, I will appreciate your assistance and leadership in this effort to ensure the best outcome for our citizens.

Sincerely,

Robert F. McDonnell

CC: The Honorable G. Paul Nardo
Clerk, Virginia House of Delegates

The Honorable Susan Schaar
Clerk, Senate of Virginia

REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

Report Pursuant to House Bill 2434: Virginia Health Reform Initiative (VHRI) Advisory Council recommendations for a Health Benefit Exchange (HBE).

TO THE GOVERNOR AND
AND THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2011

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EXECUTIVE SUMMARY

The Health Benefit Exchange (HBE) is required under the Patient Protection and Affordable Care Act (PPACA). It is estimated that about 520,000 Virginians will gain insurance coverage; around 420,000 individuals through the expanded Medicaid program, another 100,000 through private insurance. The intent of the HBE is to: improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions. According to PPACA, a state run health benefit exchange must be determined to be on the way to being operational by January 2013 or the federal government will step in and implement the HBE regardless of Virginia's policy preferences.

This report is the result of House Bill 2434 of the 2011 Session of the General Assembly which states, "that the Commonwealth create and operate its own health benefits exchange to preserve and enhance competition in the health insurance market." This bill requests the Governor, through the Secretary of Health and Human Resources and with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders to provide recommendations for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange (HBE). According to HB 2434, the plan for the Virginia Health Benefit Exchange must meet the federal requirements under the Patient Protection and Affordable Care Act.

This report reflects the documents, discussions, stakeholder public comment, and recommendations made by the Virginia Health Reform Initiative (VHRI) Advisory Council over the past several months in order to address the five questions posed by the General Assembly and other questions deemed relevant by the Advisory Council. All meeting information and resources are available on the Secretary of Health and Human Resources website: http://www.hhr.virginia.gov/Initiatives/HealthReform/.

The VHRI Advisory Council made the following recommendations for the five legislative questions.

1. **Whether to create the HBE within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;**

There were four initial choices of where the governance structure could be located:

1. An existing state agency, such as the Department of Medical Assistance Services or the State Corporation Commission;

2. A new state agency that could report to the Governor, Secretary of Health and Human Services, or other Cabinet level Secretary;
3. Quasi governmental entity, similar to the Virginia Housing Development Authority (VHDA); or
4. A not for profit private entity, similar to the Virginia Health Quality Center (VHQC).

Following a lengthy discussion, the two main options discussed by the VHRI Advisory Council were to either create an exchange in a quasi governmental agency or an existing State agency, the State Corporation Commission. At the September 2011 meeting, the majority vote was 11-3 (with 2 abstentions) in favor of establishing a quasigovernmental agency with a governing board.

2. The make-up of the governing board for the HBE;

The VHRI Advisory Council recommended the following governance issues:

- The Governance structure should have the administrative flexibility in hiring, compensation, procurement, and transparency
- The Executive Director should be hired by the Governing Board/Advisory Committee
- Conflict of interest guidelines should follow existing state guidelines
- Members should be appointed to the Board/Committee by the Governor and the General Assembly
- The size of the membership should be from 11 to 15, with staggered terms of two years, not to exceed four consecutive years
- The Board/Committee should include the Secretary of Health and Human Resources as an ex-officio member.

The VHRI Advisory Council did not specify who should be on the Board. There was considerable discussion about who should be allowed and encouraged to serve on the governing Board, and the small employer survey reflected the view that consumers of insurance – small business owners and citizens – should have representation on the board and perhaps a majority of the seats. Opinions about insurance executives serving on the board were perhaps the most polarized, with inherent conflict of interest versus essential expertise the obvious points and counter-points; however, even among those who support insurance executives being allowed to serve, there seemed to be a consensus that representatives of the insurance industry should not determine the makeup of the Board. This guidance would be consistent with the proposed Board make-up regulation from HHS. It should be noted that PPACA does not require that a Board be appointed.

3. An analysis of resource needs and sustainability of such resources for the HBE;

The VHRI Advisory Council did not have the opportunity to receive and discuss information on the resource needs for a Health Benefit Exchange because the decision on the governance structure and location of the Exchange was not made until its final meeting in September. The VHRI staff will provide that information at a later date. One of the key policy options for minimizing adverse selection is to ensure broad funding of the HBE functions. The costs of these functions need to be covered by assessments or user fees to participating insurers in the Exchange, state funds, or some other source. If state agencies, such as the State Corporation Commission's Bureau of Insurance or Medicaid, absorb Exchange functions that are above and beyond their existing functions, some of these costs may also need to be allocated from the Exchange funding mechanism.

According to the federal Center of Consumer Information and Insurance Oversight (CCIIO), beginning in 2015, states electing to operate an Exchange must finance the administrative costs of operating an Exchange.

4. A delineation of specific functions to be conducted by the HBE; and

According to the PPACA, an Exchange must facilitate the purchase of qualified health plans, provide for the establishment of a Small Business Health Options Program, known as SHOP, and meet the minimum functions of an Exchange. CCIIO groups the minimum functions into five core functions: consumer assistance, plan management, eligibility, enrollment, and financial management.

In developing an effective and efficient Virginia HBE, it is important to clearly delineate the roles for various public and private partners involved in ensuring that it is compliant with state and federal requirements. While the governing structure will have overall responsibilities for the Exchange, many of the operational tasks can be performed through memorandums of understanding between agencies and/or through private contracts. In determining the exchange responsibilities, it is important to distinguish what is inherently better performed by the government and which activities are better performed by private contractors. In addition, most of the functions associated with the exchange can be centralized, standardized, and automated to ensure economies of scale and to improve the reliability and quality of the processes.

The VHRI Advisory Council discussed the potential role of existing exchanges, the Department of Medical Assistance Services (the Medicaid program) and the Bureau of Insurance. The VHRI Advisory Council discussed that Virginia:

- Should utilize existing Exchange entities to the extent possible to avoid duplication and costs of setting up an Exchange;
- Should conduct Medicaid eligibility determinations for the Exchange by the Department of Medical Assistance Services, acknowledging the work of the Secretary of Health and Human Resources and affiliated agencies through the development of a one stop system for Medicaid enrollment; and,
- Through the Bureau of Insurance, should potentially conduct HBE functions that are within their current mission and that the HBE or other state agencies should assume roles that are not.

5. An analysis of the potential effects of the interactions between the Virginia HBE and relevant insurance markets or health programs, including Medicaid.

The VHRI Advisory Council heard several presentations on the current individual and insurance market today and what it may look like under various options under the Exchange. A key concern was on how to mitigate adverse selection in the Exchange. The outcomes of those discussions were the following recommendations:

- Have one administrative structure for the HBE, but two separate risk pools, one for individuals and one for small groups;
- Have the same insurance market rules both inside and outside of the HBE;
- Have the same state mandates inside and outside of the HBE;
- Allow both agents and navigators to have a role in the HBE;
- Design the HBE to be a "passive purchaser" model by allowing all qualified health plans to participate, but in the event of extreme adverse selection, allow the Board, with approval of the Governor, to make temporary adjustments to stabilize the market; and,
- Set the parameters of what decisions should be determined by the legislature, the Board, and the Executive Director.

INTRODUCTION

The Health Benefit Exchange (HBE) is required under the Patient Protection and Affordable Care Act (PPACA). It is estimated that about 520,000 Virginians will gain insurance coverage; around 420,000 individuals through the expanded Medicaid program, another 100,000 through private insurance. The intent of the HBE is to: improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions. According to PPACA, a state run health benefit exchange must be determined to be on the way to being operational by January 2013 or the federal government will step in and implement the HBE regardless of Virginia's policy preferences.

This report is the result of House Bill 2434 (Appendix A) of the 2011 Session of the General Assembly which states, "that the Commonwealth create and operate its own health benefits exchange to preserve and enhance competition in the health insurance market." The purpose of the Exchange is, "to facilitate the purchase and sale of qualified health plans in the individual market and to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market."

This bill requests the Governor, through the Secretary of Health and Human Resources and with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders to provide recommendations for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange (HBE).

According to HB 2434, the plan for the Virginia Health Benefit Exchange must meet the federal requirements under the Patient Protection and Affordable Care Act. Based on the legislation, the recommendations should address at a minimum:

1. Whether to create the HBE within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;
2. The make-up of the governing board for the HBE;
3. An analysis of resource needs and sustainability of such resources for the HBE;
4. A delineation of specific functions to be conducted by the HBE; and
5. An analysis of the potential effects of the interactions between the Virginia HBE and relevant insurance markets or health programs, including Medicaid.

This report reflects the documents, discussions, stakeholder public comment, and recommendations made by the Virginia Health Reform Initiative Advisory Council over the past several months in order to address the five questions posed by the General Assembly and other questions deemed relevant by the Advisory Council. All meeting information and resources are available on the Secretary of Health and Human Resources website: http://www.hhr.virginia.gov/Initiatives/HealthReform/

BACKGROUND

In August of 2010, Governor Robert F. McDonnell appointed 24 government, health system, civic and business leaders to the Virginia Health Reform Initiative (VHRI) Advisory Council, with these words:

> *Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost.*

The VHRI Advisory Council is chaired and led by Secretary of Health and Human Resources, Dr. William Hazel. The Advisory Council was asked to develop recommendations about implementing health reform in Virginia, and to seek innovative solutions that meet the needs of Virginia's citizens and its government.

In addition to the Advisory Council, six task forces were created to focus on six strategic areas: Medicaid Reform, Capacity, Service Delivery and Payment Reform, Technology, Insurance Reform, and Purchaser Perspectives. These task forces also increased the number of consumer stakeholders available to provide input to health reform initiatives. (The members of the Advisory Council and are listed in Appendix B.)

At the December, 2010 meeting of the Virginia Health Reform Initiative Advisory Council, there were two recommendations made regarding the planning for a Health Benefit Exchange. The first recommendation provided the intent to create a Virginia Exchange rather than default to the federal government:

> *Virginia should create and operate its own health benefits exchange to preserve and enhance competition. We suggest the Governor and legislature work together to create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law.*

The second recommendation provided some basic principles to be part of any Exchange design:

> *Whatever form the Virginia Health Benefit Exchange (HBE) ultimately takes, there is broad agreement about what the HBE should achieve in practice, about what would be considered a successful HBE, and therefore what the Secretary, Legislature and Governor should keep in mind., including:*
>
> 1. *Provide employers with an opportunity to be successful financially while providing affordable health insurance to their workers;*
> 2. *Provide a marketplace that works well for those currently without insurance ;*
> 3. *Provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency;*
> 4. *Transparency in all things should promote choice, stability and innovation*
> 5. *The HBE must address the cost of health care and the competitive; disadvantage that small firms and ultimately all United States firms labor under now. (We should not miss an opportunity to explore how the HBE can help on the cost fron).;*
> 6. *The HBE should help educate employees and employers through a user-friendly website;*
> 7. *Individuals and employees should be engaged in their own care as well as in regular wellness and prevention activities;*
> 8. *A goal of the exchange should be to maximize choice, innovation, the number of competing qualified health plans and effective competition with transparency regarding cost and quality in driving consumer decision making;*
> 9. *Long term care insurance should be included in the exchange; and,*
> 10. *Above all: remember to keep it simple, so that employers and average citizens can understand how to use and benefit from the HBE marketplace.*

The VHRI Advisory Council's recommendations on the Exchange then served as a basis for House Bill 2434, which passed during the 2011 Session of the General Assembly.

The Stakeholder Process

The Secretary of Health and Human Resources held three meetings in 2011 with the VHRI Advisory Council on key health benefit exchange issues to address the five questions posed by the General Assembly. The Commissioner of Insurance was present at all meetings to provide input as well. The VHRI Task Force members were invited to attend as a member of the audience and provide comment on the discussions.

Meeting Dates	Topics for Discussion
May 26, 2011	Basic Structure and Governance of an Exchange
July 15, 2011	Promoting Competition: Making Insurance Markets work Better for Small Employers and Individuals
September 9, 2011	Providing a Framework for Moving Forward with a Virginia Benefit Exchange

In order to receive the full spectrum of written public comments, prior to each of the three meetings, comprehensive memorandums on these topics were made available to the public simultaneously with being emailed to the Advisory Council and Task Force members.

All written public comments received by the designated time were compiled and sent to members of the Council and Task Forces and the public prior to the meetings of the VHRI Advisory Council. The memorandums and comments received formed the basis of the discussion at the public meetings. Oral public comments were also taken at each of the three meetings. All written materials are available at the VHRI website: http://www.hhr.virginia.gov/Initiatives/HealthReform/.

The number and the content of the written public comments demonstrated that this topic was extremely important to a variety of stakeholders. These groups included individual constituents, various consumer advocates, underwriters, independent agents, insurance companies and health plans, health care systems, various health care organizations, business groups, and general consulting groups.

Timeline for Exchange

The timeline for the development of an Exchange is ambitious for any state, as well as the federal government. Here are some very high level and critical milestones:

Date	Task
October 2010	Virginia receives a one year federal planning grant for strategic planning for development of an Exchange. Virginia has a no-cost extension until June 2012.
April 2011	HB 2434 sets the intent of the General Assembly to create and operate a health benefit Exchange
October 2011	Virginia Health Reform Initiative Advisory Council presents recommendations/options to the Governor and General Assembly for consideration during the 2012 Session of the General Assembly
June 2012	Last opportunity to obtain a federal Level II establishment grant for the start up costs of creating and operating an Exchange
Fall 2012	Federal Department of Health and Human Services starts accepting Exchange Approval Applications
January 2013	Federal Department of Health and Human Services determines that Virginia is willing and able to implement an Exchange by January 2014 (fallback is federal exchange or a federal/state partnership)
October 2013	State Exchange begins enrollment of individuals and small employers into the Exchange

January 2014	Exchange must be operational
2015	Exchange must be self-funded
2017	Virginia has an option to add large employers to the Exchange

It is important to be aware of where Virginia needs to be in order to apply for a Level Two Establishment grant to receive federal funding to create and initially operate a health benefit exchange. The last opportunity to apply for this funding is June 29, 2012. . In order to receive funding, Virginia must demonstrate completion (Tasks 1-7) or progress (Tasks 8-11) in the 11 exchange establishment core areas listed below. This level two funding and the requirements are likely an early proxy for demonstrating readiness for a Virginia Benefit Exchange in 2013, in order to avoid federal operation of the HBE.

1. Background Research completed on the individual, employer, and insurance markets;
2. Stakeholder Involvement;
3. The state has the necessary legal authority to establish and operate an Exchange that complies with federal requirements and provides for governance and exchange structure;
4. Governance structure determined and established;
5. Coordination has been established with the State Medicaid Agency and the state Department of Insurance, and other programs as appropriate;
6. Established business requirements for Exchange IT systems;
7. Plan for ensuring sufficient funding for ongoing operations after January 1, 2015;
8. Progress on Oversight and Program Integrity related to federal and state funds utilized to start-up and operate an Exchange;
9. Show progress implementing health insurance market reforms;
10. Progress on developing mechanisms to provide assistance to individuals and small businesses, coverage appeals and complaints; and,
11. Progress on the development and implementation of Business Operations/Exchange Functions.

What Other States Are Doing Regarding Health Benefit Exchanges

In early September 2011, more than 40 states and territories sent state officials to a meeting of the National Governor's Association (NGA) to share perspectives on the development of Exchanges. According to an NGA issue brief, several major themes emerged from the discussions at the meeting, including that the lack of federal regulatory guidance pursuant to the legislation that is clear, timely, and coordinated among programs. This lack of guidance is complicating states' abilities to move forward and meet the overall timeline of January 2014 for both Medicaid expansion and establishment of Exchanges. In addition, a major issue at the state level is how much can be done without enabling state legislation for an Exchange. It appears,

however, that states that have decided to create their own exchange, rather than default to the federal government, are moving forward as much as they can, given the uncertainty of enabling legislation in their states and the lack of timely federal Exchange requirements, such as what constitutes an essential benefit package and what defined premium contribution rules will govern the options for small employers and their workers. Both of these are highly relevant to cost, the ultimate metric by which HBE success will be judged.

At the NGA meeting, states discussed the variety of legislative calendars in order to deal with the enabling legislation for an Exchange. Some states debated whether they required legislative approval at all, moving forward instead with an Executive Order from the Governor. Most states agree that 2012 is a critical year for the legislative or executive authority to both create an Exchange and to apply for federal grant funding (the final application date is June 2012) to pay for the initial start up costs of establishing an Exchange.

Two weeks later, the federal Center for Consumer Information and Insurance Oversight (CCIIO) convened a meeting of states that have received exchange planning funding. The centerpiece of the meeting was a document unveiling a proposed Federal- State Partnership available to states interested in operating an exchange in conjunction with the federal government (as opposed to either operating the exchange themselves or deferring to the federal government to do so). Under the three varieties of partnerships, states would have the option of performing either consumer assistance functions, plan management functions or both of the above—while the federal government would operate all other elements of the exchange. CCIIO also provided a high-level outline of their efforts to develop the federal fallback exchange. State reaction to the description of the proposals was lukewarm at best. One concern was that the states were told that any partnership would still be deemed a federal exchange and the federal government would remain the single authority to ensure that all Exchange functions were carried out as they interpret the law. During the week of September 19, 2011, Governor Chafee of Rhode Island became the first to establish a full-blown exchange authority via executive order (Governor Daniels established the Indiana Insurance Market, Inc. through a similar order but it remains a provisional entity until a final decision on exchange development is made). Governor Chafee's creation of the Rhode Island Health Benefits Exchange came after legislation to establish an exchange failed earlier this year.

Below is an update of what states have decided regarding health benefit exchanges as of September 23, 2011[1]:

- Health Exchange Planning Grants
    - 49 states (all but Alaska) applied for and received a health benefits exchange planning grant.

- Early Innovator Grants for Health Benefit Exchange

[1] The key source for the legislative information is the McKenna Long and Aldridge LLP *State of the States* Report on Health Insurance Exchange Legislation, September 23, 2011.

- 7 states – Kansas, Massachusetts, Maryland, New York, Wisconsin, Oklahoma, and Oregon – have received "early innovator" grants to develop HBE-oriented technologies and eligibility determination systems that can serve as models for other states. The University of Massachusetts Medical School, as the grantee, is leading a multi-state New England consortia for Connecticut, Maine, Massachusetts, Rhode Island and Vermont. Both Oklahoma and Kansas have returned their Early Innovator grants. However, Kansas continues to develop information systems that will lay the technological groundwork for determining eligibility for Medicaid and the Exchange through a 90/10 funding formula from the federal government under a separate program.

- Legislation
  - Exchange Established by law:
    - Pre-PPACA (2): Massachusetts and Utah
    - Post-PPACA (10): California, Colorado, Connecticut, Hawaii, Maryland, Nevada, Oregon, Vermont, Washington, and West Virginia. As provided by the Henry J. Kaiser Family Foundation, the chart below describes the structure and type of exchange for the 10 states that have Exchange legislation.

State	Structure of Exchange	Type of Exchange
California	Quasi-governmental	Active Purchaser
Colorado	Quasi-governmental	Clearinghouse
Connecticut	Quasi-governmental	Active Purchaser
Hawaii	Non-profit	Clearinghouse
Maryland	Quasi-governmental	To be decided by the Board of Directors
Nevada	Quasi-governmental	Not addressed in legislation
Oregon	Quasi-governmental	Active Purchaser
Vermont	Operated by the state	Active Purchaser
Washington	Quasi-governmental	To be decided by the Board of Directors
West Virginia	Quasi-governmental	Not addressed in legislation

  - Passed by the legislature in both houses, vetoed by the Governor (1): New Mexico
  - In one of the houses within legislature (2): New Jersey and Pennsylvania
  - Implementation analysis/plan required (5): Illinois, Maine, North Dakota, Virginia, and Wyoming
  - Dead for 2011 because legislature has adjourned (27): Arkansas, Alaska, Arizona, Alabama, Delaware, Florida, Georgia, Iowa, Indiana, Idaho, Kansas, Kentucky, Louisiana, Minnesota, Missouri, Mississippi, Montana, North Carolina, Nebraska, New Hampshire, New York (expected to vote

in September), Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, and Texas
- No exchange legislation introduced (3): Michigan, Ohio, and Wisconsin

HIGHLIGHTS OF THE VIRGINIA SPECIFIC BACKGROUND WORK

In order to provide recommendations for the five questions posed by the 2011 legislation, VHRI staff and its consultants provided information through three memorandums, including the advantages and disadvantages on various options, for each of the following questions. These questions are outlined below.

Governance Questions Discussed at May 26, 2011 meeting
1. Where should the governance structure of the Exchange be located? 2. Should there be a Governing Board and/or Advisory Committee? 3. Who should have the authority to appoint members to the Board/Advisory Committee? 4. What should be the size of the Board/Advisory Committee? 5. What should be the composition of the Board/Advisory Committee? 6. Who should hire the Executive Director for the Exchange? 7. Should the Governing Body of the Exchange be given administrative flexibility?
Promoting Competition Questions Discussed at the July 15, 2011 meeting
1. How should Virginia seek to build capacity within the Virginia HBE so that it can maintain autonomy from the federal government while remaining compliant with federal performance requirements? 2. Should the Virginia HBE be statewide, multi-state, or a set of geographically contiguous sub-state exchanges? 3. Should Virginia combine the non-group and small group risk pools or keep them separate as they are today? 4. How small is a "small group?" 5. Should Virginia require more benefits than the "essential benefits package" (EBP)? 6. Should Virginia make all market rules that will be adopted inside the HBE also applicable to the parallel markets (individual and small group) outside the HBE? 7. Should Virginia encourage or require the HBE to be more of an active purchaser or an open market facilitator?
Providing a Framework for Moving Forward with a Virginia Benefit Exchange Questions Discussed at September 9, 2011 meeting
1. As a follow-up to the July 15th meeting discussion, what is the potential role of the Bureau of Insurance and the Health Benefits Exchange? 2. Through modeling of individual and insurance marketing data, what would the options for the July 15th meeting look like? 3. What are additional considerations to mitigate adverse selection in the Exchange? 4. What decisions should be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange?

5. Should Virginia consider a Basic Health Plan?

In addition to the three memorandums, the answers to these and related questions were informed by the written public comment, discussions at the meetings, and a series of background research projects completed by three contractors under the direction of VHRI senior staff and its George Mason University consultant:

- Alan Newman Research (ANR) of Richmond conducted eight focus groups and a representative survey (1,200 completed telephone surveys) of small and medium sized Virginia-based employers. The purpose of this work was to elicit small employer views about how the new insurance market might be re-organized and governed to better meet their needs.

- Price-Waterhouse-Coopers (PWC), the accounting firm that has done actuarial consulting for the Commonwealth's Medicaid program for over 12 years, was hired to analyze and describe the individual and small group insurance markets in the Commonwealth today, and then to identify Virginia's key policy choices and challenges in anticipation of insurers' and purchasers' expected reactions to implementation of the market rule changes required by the new federal law. The Bureau of Insurance was instrumental in this work by conducting a survey of Virginia insurers and in helping PWC access and analyze the responses to that survey in a timely and efficient manner. The insurers in the Virginia market are commended for responding to the survey quickly despite many competing priorities due to health care reform implementation.

- The Urban Institute, a non-profit policy research organization also provided background information. Their researchers have developed one of the nation's premier micro simulation models for changes in the health care system. This model has successfully predicted employer and individual behavior for the nation and for a variety of states now facing the same policy choices as Virginia. For Virginia, they were asked to predict who would gain coverage, how large the HBE might be, and how premiums might differ under various reform scenarios of interest to the VHRI Advisory Council.

This report focuses solely on results directly relevant to choices the VHRI Advisory Council had to make in September 2011. Each of the full presentations made by the three contractors at the July and September 2011 meetings are available from the VHRI web site (http://www.hhr.virginia.gov/Initiatives/HealthReform/).

Alan Newman Research (ANR). ANR reported that employers (and their employees) are most concerned about the cost of health insurance and health care, so that any "solution" must address cost and cost growth. In general, a majority of employers see value in most of the transparency-enhancing individual features of the HBE (such as a cost-calculator, toll-free hotline, financially neutral experts to advise about plan choice, enhanced employer and employee choice), for they understand the current market is not performing satisfactorily in many ways. At the same time, some Virginia employers (18%) are also deeply skeptical that government – even state government – can or will do much to improve insurance market performance. Employers expressed a strong preference for having small employer and "ordinary citizen" voices on any board that is chosen to govern the HBE, but they were not supportive of insurer executive or agent membership on the governing board. Focus group participants were generally supportive of the role agents play for them now and hope that their role of educating/advising role can continue in the future.

A clear majority of employers do not support allowing the HBE to impose restrictions on insurer participation beyond those required by federal law, i.e., they did NOT trust government to limit their choices arbitrarily and thus they did not support a so-called 'active' purchaser model for the HBE (53% to 35%). Employers also expressed a strong preference to have choice over what products their workers would have access to and over their own contribution amount within the HBE (as they have today in the marketplace). Given those two pre-conditions, however, they were also very supportive of maximum employee choice of plan, assuming that employees would pay the extra cost of a more expensive plan. Finally, a majority is or would be interested in low or no cost wellness programs for their workers, but the vast majority reported that today they simply cannot afford them.

Price-Waterhouse-Coopers (PWC). PWC drew upon their extensive experience in Virginia's and other insurance markets around the country to explain the importance of stable risk pools, both inside and outside the HBE, to facilitate future insurer competition and better market performance on price and quality from the point of view of purchasers, employers and citizens. The greatest threat to market stability, especially when regulations are changing in some but not all markets, is adverse selection, when high risk individuals or groups are not spread randomly among insurers and risk pools. If high risks are concentrated in specific plans or market segments, then those plans and markets will find premiums must rise to cover higher costs and the healthy will flee as quickly as possible, which would further worsen the balance in the risk pool. PWC's presentation described various elements of PPACA that are designed to minimize adverse selection, the most important of which are federal subsidies for the purchase of private insurance that are only available inside the HBE and the requirement that no one can be denied coverage or charged a differential premium because of health status either inside or outside the HBE. PWC also described some tools and rules that Virginia could consider adopting, either

through new law or permitted policy of the HBE governing authority, in order to further reduce the risk of adverse selection.

The clearest way for adverse selection to threaten the stability of *either* the HBE or the markets for small groups and individuals that remain outside the HBE would be if important market rules differ inside and outside the HBE in ways that advantaged one over the other. The simplest solution would be for the Virginia legislature to pass a law requiring the State Corporation Commission to issue regulations to ensure a level playing field, or effective equality of all market rules inside and outside the HBE. But that would require an extensive regulatory scheme and would represent a considerable departure from Virginia's historical and bi-partisan preferences for market freedoms and minimal regulation consistent with smooth market operations.

PPACA itself forces considerable but not complete congruence of market rules inside and outside the HBE, and PWC focused on the rules that are most likely to be highly relevant: benefit design and agent compensation. PPACA requires that the (as yet undefined) essential benefit package be offered by all commercial insurers in the HBE and in the small group and individual markets outside the HBE. PPACA also requires all insurance products to have at least the minimum actuarial value (level of generosity, or percent of expected health costs incurred by a group of average risks that will be paid by the health plan, 60 percent actuarial value), labeled "bronze" as a shorthand, and that no insurer may deny coverage or even charge a higher premium to anyone because of their health status per se (guaranteed issue). PPACA further requires that insurers competing in the HBE offer two particular actuarial value packages, silver (70 percent actuarial value) and gold (80 percent actuarial value), but does not require all insurers to compete and offer products inside the HBE. Thus, states could choose to adopt the maximum market freedom allowed by PPACA, and thereby allow insurers to offer bronze plans *only* outside the HBE. Given the intense concern about premium cost reported by the employer survey, and the overwhelming focus on cost within most practical reform conversations before, during and after PPACA passed, if the only bronze plans offered are outside the HBE, these plans will likely be very attractive to the healthiest (lowest risk) groups and individuals, compared to higher actuarial value plans in the HBE. Thus, PWC suggested that Virginia consider requiring any insurer that offers products in the HBE and wants to offer bronze outside the HBE also be required to offer a bronze package inside the HBE. This would lead to a more level competitive field between the HBE and the outside market; however, this would also be *more* regulatory encroachment than PPACA's minimum, and that is already more regulatory than many Virginians would instinctively like to have. At the same time, to do nothing is to implicitly accept the proposition that the U.S. Congress set the balance of insurance market competition rules exactly right, and as such this requirement is also an example of a relatively simple rule that might actually improve the law by protecting and stabilizing HBE risk pools and thereby make real insurance market competition stronger in the long run by giving the HBE a

chance to get off the ground. Judgment among these competing perspectives is precisely what the VHRI Advisory Council and the legislature eventually will be asked to make.

The other adverse selection issue PWC focused on was the importance of making sure that insurance agents, who today play a crucial educational and advocacy role for small employers and individuals alike, have no financial incentive to direct clients either inside or outside the HBE. It is PWC's judgment that the markets will function more as intended if agents are financially neutral about which specific choices their clients make. This too may require some state regulation to ensure, since today agents are paid by insurers, not by clients, and there are no regulations about the forms or levels that compensation can take.

The Urban Institute. The Urban Institute (Urban) was selected to do econometric modeling for the project because they have decades of relevant experience, and because their model is fairly unique among those organizations who predict the impact of reforms. Most entities that "predict" the impact of reform use existing survey data estimates as baseline estimates, build a model but never reveal it or subject it to testing and verification, and then make predictions about how many people will gain coverage based on factors they never fully reveal. Urban uses their model with details published and reviewable to "predict" the baseline, that is, they test their model against the reality we can observe in today's markets, they hone its accuracy by refining its ability to predict *which* firms offer today and which ones do not, which families accept employer offers, which buy non-group coverage, and which people who are eligible for Medicaid actually enroll. Therefore, when the model is "applied" to predict the future, we know it has been accurate in predicting today's choices based on today's prices and conditions. So, we can have more confidence in its predictions about future behavior based on future prices and policy conditions. This is why they are the modeler of choice for the Robert Wood Johnson Foundation's 10 State Initiative for Technical Assistance (of which Virginia is a participant along with Alabama, Michigan, New Mexico, Oregon, Colorado, Minnesota, New York, Maryland, and Rhode Island), and why they have been separately funded to model HBE issues for Missouri, Massachusetts, Washington, and New York, The Urban model is based on national and Virginia-specific survey data sets and decades of modeling experience as well as state of the art health economics and health services research.[2]

Urban was specifically asked to model four primary questions, (while cooperating with PWC to make sure they understood as much as possible about the Virginia health insurance market status quo):

(1) How many people will gain coverage, and of what type, when health reform is fully phased-in in 2014?

[2]See the methodology described as well as a list of recent research conducted by the Urban Institute's microsimulation team cited in http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf .

(2) How would the answers to #1 change if the HBE merged the small group and individual markets into one risk pool?
(3) How much would the answers to #1 change if the firms with up to 100 workers were allowed to purchase inside the HBE?
(4) What might happen in an adverse selection *nightmare*, what if bronze plans are only offered outside the HBE and the risk adjustment techniques called for in PPACA prove to be ineffective in shifting money from plans with a disproportionate share of high risks to plans with a disproportionate share of low risks? This last question was posed to let the VHRI Advisory Council determine if the possible results warranted taking some of the policy actions that PWC suggested would mitigate the risks.

Table 1 shows the estimated coverage changes between 2011 (today) and having all the reforms anticipated in PPACA fully implemented in 2014.

Table 1. Coverage changes from health reform for non-elderly Virginians (thousands)

	2011	2014	change
Uninsured	1,041	515	-526
Medicaid/FAMIS	1,245	1,665	+ 420
Private non-group	312	352	+ 40
Private group	4,331	4,397	+ 66

Source: Urban Institute, estimates for Virginia using their Health Policy Simulation Model, presented to the VHRI, September 9, 2011, and available at http://www.hhr.virginia.gov/Initiatives/HealthReform/

Urban estimates that roughly half of the uninsured in Virginia will gain coverage, a little more than 520,000 people, and that 420,000 of them will gain Medicaid coverage. A little over 100,000 Virginians would gain private coverage, and more than 60 percent of them will be in group as opposed to non-group markets. Urban also estimates that almost 400,000 of those who gain coverage are in households with incomes less than two times the federal poverty level, though 70,000 of the formerly uninsured earn more than three times poverty today.

Of the roughly 500,000 who are expected to remain uninsured, 35 percent are eligible for Medicaid but are expected to choose to not enroll (as do many who are eligible today). 23 percent are expected to qualify for an affordability exemption, (that is, they would have to pay more than 8 percent of their income for the single coverage for which they would be eligible), 16 percent are presumed to choose to pay the penalty[3] and remain uninsured,

[3] The penalty to avoid the individual mandate in the law is the *greater* of a flat dollar amount and a percentage of income. Both start out quite low in 2014 and increase over time. The dollar penalty goes from $95 to $325 (per person) from 2014 to 2015, and for calendar years beginning after 2016, $695 indexed for inflation. The percentage of income goes from 1% in 2014 to 2.5% in 2016 and thereafter. More uninsured don't just pay the penalty because paying the penalty is like a fine for which one gets nothing in return. Health insurance costs more, but you get coverage and financial protection out of that payment. Urban's model takes into account those for whom the net expected value of insurance is lowest, and predicts purchase/penalty behavior based on that calculation.

and 26 percent are believed to be undocumented persons and therefore ineligible to buy insurance through the HBE. So even though uncompensated care for the uninsured (and therefore implicit expense now borne by providers and public plus private payers) is expected to fall by over $800 million, the uninsured and demand for safety net care will not disappear from Virginia, though the scale of it should decline by roughly half.

This "most likely" scenario assumed the policy choices the VHRI Advisory Council eventually made: keep the non-group and small group risk pools separate, and keep the small firm size limit at 50. These comport with the status quo, and represent choices to minimize change and potential disruption in 2014. Table 2 shows the size of the HBE risk pools, and where the new HBE customers will come from.

Table 2: HBE enrollment, and source of coverage prior to reform (thousands)

Coverage source	**2011** Number enrolled in each source	**2014** Non-group HBE pool	**2011** Coverage source (2013 coverage source marked by /)	**2014** Small Group HBE pool (early years)	**2017** Small Group HBE pool (later years)
Total		283,000		232,000	473,000
Uninsured	113,000		12,000		
Non-group	136,000		9,000		
Group coverage	34,000		211,000/462,000		

Source: Urban Institute presentations and background research for VHRI, http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm

The chart shows that roughly 500,000 Virginians are likely to choose to purchase insurance in the HBE in 2014, almost equally in the non-group and SHOP pools initially. As the firm size limits increase (up to at least 100 by 2016 and larger if Virginia so chooses) and firms overcome natural inertia to move their workers, the SHOP HBE pools are projected to be twice as large as the non-group pool over time.

Two of the salient policy choices Urban was asked to model did not make much difference in terms of overall coverage or ultimate size of the HBE. Melding the risk pools, combining those in the small group and non-group markets both inside and outside the HBE would slightly lower non-group premiums and slightly raise group premiums (the non-group risk pool is not as healthy) but the net effect on coverage was a decline of 10,000. In a state of 7 million, that is not a very large effect, though it does argue for keeping the risk pools separate if the primary goal of the HBE is to maximize coverage in the Commonwealth. Of similar minimal effect, inertia will keep all but 16,000 more of those who would be eligible for the SHOP exchange pool outside of the HBE in 2014 even if the initial eligibility for firms is set at 'up to 100 workers.' Thus, this policy choice does not substantially add to overall coverage.

The final scenario Urban modeled was the "adverse selection nightmare" scenario, in which bronze plans are the only plans offered outside the HBE and only silver and gold plans are offered inside the HBE. Furthermore, we asked the Urban to assume that risk adjustment did not work among plans of different actuarial values, just to see the potential variance among premiums and coverage in a worst case scenario. Table 3 reports the main results.

Table 3: Effects of extreme adverse selection from benefit design and no risk adjustment

	Average (single) premium inside the HBE	**Average (single) premium outside the HBE**	**Net coverage in non-group market**	**Net coverage in group market**
Mostly likely, reform	5200	4800	352,000	4,331,000
Adverse Selection scenario	6900	1900	443,000	4,381,000

Source: Urban Institute Institute's presentations and background research for VHRI, http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm

Requiring bronze only plans outside the HBE and not having effective risk adjustment would lower average premiums outside the HBE by more than half, and raise them substantially inside the HBE. Interestingly, net coverage would *increase*, for two reasons. First, the premium declines outside the HBE would entice the purchase of insurance by some who would have paid the penalty and/or been exempt from the mandate due to income limits. This would be purchased either on their own or through their employer. Second, since the 100% federal subsidies inside the HBE are designed to limit the *percentage of income* paid by those who qualify and purchase there, in effect this puts the federal government at full risk for higher premium increases. The model predicts that many of the subsidized would still buy inside the HBE for even though the premium is higher, it is not higher to *them*, while adverse selection against the HBE lowers the price outside the HBE and thus induces more unsubsidized to buy there. Federal subsidy costs would rise under this scenario by $145 million, even though 115,000 fewer people are getting individual subsidies. Thus, the adverse selection scenario is worse for the federal government and taxpayers than it is for Virginians seeking coverage, though the premium differences are so stark it did give some VHRI Advisory Council members pause about permitting this bronze-only strategy to occur. The point of this scenario and the PWC presentation on policy options was to provoke serious analysis of a worst case scenario and consideration of the possible effects and remedies.

VHRI's RESPONSE TO HB 2434

Prior to the discussion of the recommendations for the five legislative questions in House Bill 2434, it is important to note the VHRI Advisory Council continues to unanimously support a Virginia specific Health Benefit Exchange rather than defaulting to a federal Exchange. This recommendation was made first at its December 2010 meeting and reaffirmed at its May 2011 meeting.

1. Whether to create the HBE within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;

This topic was discussed extensively at the May 2011 meeting of the VHRI Advisory Council. There were four initial choices of where the governance structure could be located:

I. An existing state agency, such as the Department of Medical Assistance Services or the State Corporation Commission;
II. A new state agency that could report to the Governor, Secretary of Health and Human Services, or other Cabinet level Secretary;
III. Quasi governmental entity, similar to the Virginia Housing Development Authority (VHDA); or
IV. A not for profit private entity, similar to the Virginia Health Quality Center (VHQC).

The Council members also heard a panel presentation on the option of creating the governance structure within an existing agency (specifically the State Corporation Commission), a quasi governmental agency like VHDA, and a non-profit agency like VHQC. The Council agreed that the second option, which was to create a new state agency, should not be considered. The preliminary majority vote at the May 2011 meeting was a creation of a quasi-governmental agency.

By the September 2011 meeting, the two options that were still being discussed by the VHRI Advisory Council were to either create an exchange in a quasi governmental agency or an existing State agency, the State Corporation Commission. At the September 9th meeting, the majority vote was 11-3 (with 2 abstentions) in favor of establishing a quasigovernmental agency with a governing board.

2. The make-up of the governing board for the HBE;

At the September 9th meeting, the VHRI Advisory Council voted to reaffirm their decisions from the May 26th meeting on the following governance issues:

- The Governance structure should have the administrative flexibility in hiring, compensation, procurement, and transparency;
- The Executive Director should be hired by the Governing Board/Advisory Committee;
- Conflict of interest guidelines should follow existing state guidelines;
- Members should be appointed to the Board/Committee by the Governor and the General Assembly;
- The size of the membership should be from 11 to 15, with staggered terms of two years, not to exceed four consecutive years; and,
- The Board/Committee should include the Secretary of Health and Human Resources as an ex-officio member.

The VHRI Advisory Council did not specify who should be on the Board but the proposed federal regulations on governance board structure (Section 155.110, Entities eligible to carry out the exchange) requires that a majority of the voting members 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. There was considerable discussion at the May meeting about who should be allowed and encouraged to serve on the governing Board, and the small employer survey reflected the view that consumers of insurance – small business owners and citizens – should have representation on the Board and perhaps a majority of the seats. Opinions about insurance executives serving on the board were perhaps the most polarized, with inherent conflict of interest versus essential expertise the obvious points and counter-points, but even among those who support insurance executives being allowed to serve there seemed to draw a consensus that representatives of the insurance industry should not dominate the makeup of the Board. This guidance would be consistent with the proposed Board make-up regulation from HHS. It should be noted that PPACA does not require that a Board be appointed.

3. An analysis of resource needs and sustainability of such resources for the HBE;

The VHRI Advisory Council did not have the opportunity to receive and discuss information on the resource needs for a Health Benefit Exchange because the decision on the governance structure and location of the Exchange was not made until its final meeting in September. The VHRI staff will provide that information based on a PWC report at a later date. One of the key policy options for minimizing adverse selection is to ensure broad funding of the HBE functions. The costs of these functions need to be covered by assessments or user fees to participating insurers in the Exchange, state funds, or some other source. If state agencies, such as the Bureau of Insurance or Medicaid, absorb Exchange functions that are above and beyond their existing

functions, some of these costs may also need to be allocated from the Exchange funding mechanism.

According to the federal Center of Consumer Information and Insurance Oversight (CCIIO), beginning in 2015, states electing to operate an Exchange must finance the administrative costs of operating an Exchange. The timeline for certification of financial management include these milestones:

- In 2012
    - Establish authorization for financial management of Exchanges and premium stabilization programs;
    - Develop an operational plan for the implementation of financial management requirements;
    - Finalize financial systems IT plan; and,
    - Develop guidance for premium processing requirements for employers, individuals, and issuers.
- In 2013
    - Ensure capability to soundly manage Exchange and state program finances; and,
    - Begin premium processing during the Exchange open enrollment period (which begins in October 2013).

4. A delineation of specific functions to be conducted by the HBE;

According to the PPACA, an Exchange must facilitate the purchase of qualified health plans, provide for the establishment of a Small Business Health Options Program, known as SHOP, and meet the minimum functions of an Exchange. CCIIO groups the minimum functions into five core functions:

Consumer Assistance	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Eligibility	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and

	conduct redeterminations and appeals.
Enrollment	Enrollment of consumers into qualified health plans; transactions with qualified health plans and transmission of information necessary to initiate advance payments of premium tax credit and cost-sharing reductions.
Financial Management	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs

In developing an effective and efficient Virginia HBE, it is important to clearly delineate the roles for various public and private partners involved in ensuring that it is compliant with state and federal requirements. While the governing structure will have overall responsibilities for the Exchange, many of the operational tasks can and should be performed through memorandum of understandings between agencies and/or through private contracts. In determining the HBE responsibilities, it is important to distinguish what is inherently better performed by the government and which activities are better performed by private contractors. In addition, most of the functions associated with the exchange can be centralized, standardized, and automated to ensure economies of scale and to improve the reliability and quality of the processes.

Existing Exchanges. Already in existence today are corporate and retirement insurance exchanges as well as some web-based insurance plan comparison tools. The VHRI Advisory Council discussed that Virginia should utilize these existing entities to the extent possible to avoid duplication and costs of setting up an Exchange.

Department of Medical Assistance Services (DMAS). DMAS currently is responsible for several activities that are needed in the Exchange for its current Medicaid and Children's Health Insurance Program (CHIP, FAMIS in Virginia) populations, including eligibility determination, call centers, outreach, health plan enrollment, and monitoring health care providers and health care plans. Through the work of the Secretary of Health and Human Resources and the development of a one stop system for Medicaid enrollment, the VHRI Advisory Council discussed that eligibility determination for Medicaid for the Exchange should be performed by DMAS.

Bureau of Insurance. According to their website, the Bureau of Insurance's (BOI) regulatory mission is: to ensure that citizens of the Commonwealth are provided with access to adequate and reliable insurance protection; that the insurance companies selling policies are financially sound to support payment of claims; that the agents selling company policies are qualified and conduct their business according to statutory and regulatory requirements, as well as acceptable standards of conduct; and that the insurance policies are of high quality, are understandable and are fairly priced. The VHRI Advisory Council discussed the additional roles/functions within

the Exchange should be performed by BOI. To inform the discussions, BOI provided the following information.

Requirements for Certification by the Health Benefit Exchange

NOTE: The following requirements are applicable to the Exchange itself. However, the enforcement or verification of many of these requirements, while not specifically addressed in insurance laws or regulations in Virginia, are generally within the scope of processes and procedures that the BOI undertakes in its review of carriers. Enforcement and/or compliance verification by the BOI of one or more of these functions may be more efficient and eliminate redundancy, but legislation or regulation would likely be needed, and some mechanism for compensating the BOI for staff and resources to perform these functions for the Exchange may also be necessary.

Qualified Health Plan and Issuer Requirements	**PPACA Citations**	**Proposed Federal Rule Citations**
Qualified Health Plan issuer must be licensed and in good standing	1301 (a)(1)(C)(i)	156.200 (b)(4) (note additional components)
Each QHP must provide the essential health benefits package in 1302(a).	1301 (a)(1)(B)	
Issuer agrees to offer at least one QHP in silver and gold.	1301 (a)(1)(C)(ii)	156.200 (c)(1)
Issuer agrees to charge the same premium rate for each QHP w/o regard to whether plan is offered inside or outside the Exchange.	1301 (a)(1)(C)(iii)	
Issuer must provide applications and notices		156.250 150.230(b)
Rating variations for issuers		156.255
Enrollment Periods		156.260
Enrollment Process		156.265
Termination General Requirements		156.270
Segregation of Funds for Abortion Services		156.280
SHOP Standards		156.285
Recertification/Decertification		156.290 155.1075 155.1080
Rx Drug Distribution Cost Reporting		156.295
Stand-alone Dental Plans		155.1065

Certification of Qualified Plans

The Patient Protection and Affordable Care Act requires an Exchange to make qualified health plans available to qualified individuals and qualified employers and to certify, recertify, and

decertify qualified health plans. In order to be certified, a qualified health plan must satisfy the requirements shown below. The requirements for which the Bureau of Insurance (BOI), has, does not have, or may have in the future, regulatory oversight are also identified below.

To Be Certified Plans Must:	PPACA Citations	Proposed Federal Rule Citations	BOI Review, Approval, Enforcement Authority
Meet marketing requirements – no practices or plan designs that discourage enrollment	1311(c)(1)(A)	156.225	BOI currently enforces statutes and regulations addressing marketing of health insurance, but additional regulation may be needed to address all requirements addressed in the federal law or regulations
Provide adequate networks – ensure sufficient choice of providers and information on provider availability	1311(c)(1)(B)	156.230 155.1050	♣ BOI does not oversee or enforce, *(see footnote)*
Establish or evaluate the service areas of QHPs to determine if a minimum geographical area is covered; area established w/o regard to racial factors, etc.	1311(c)(1)(B)	155.1055	♣ BOI does not oversee or enforce *(see footnote)*
Include in networks essential community providers that serve low-income, underserved communities	1311(c)(1)(C)	156.230 156.235	♣ BOI does not oversee or enforce *(see footnote)*

To Be Certified Plans Must:	PPACA Citations	Proposed Federal Rule Citations	BOI Review, Approval, Enforcement Authority
Implement quality improvement strategies through market-based incentives	1311(c)(1)(E)	See 1311(g)(1) for details	♣ BOI does not oversee or enforce *(see footnote)*
Utilize a single streamlined application to determine eligibility for enrollment.	1311(c)(1)(F)	155.405	BOI currently reviews and approves application forms. A uniform form has been developed, and BOI will likely approve its use, but legislation or

♣ ***While BOI does not oversee or enforce the requirements for certification in this area, some or all of the requirements may be addressed in laws or regulations within the purview of the Virginia Department of Health. Follow-up with VDH found that these functions may be absorbed within existing resources.***

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To Be Certified Plans Must:	PPACA Citations	Proposed Federal Rule Citations	BOI Review, Approval, Enforcement Authority
			regulation may be necessary to effect this approval.
Utilize the standard format established for presenting health benefits plan options	1311(c)(1)(G)	155.205(b)(1)	BOI does not currently require or approve forms for presenting health benefit options, but a standard form has been developed, and BOI will likely approve is use. However, legislation or regulation may be necessary to effect this approval.
Provide information to the Exchange and enrollees on quality measures for health plan performance	1311(c)(1)(H)	See 1311 (h)(1) regarding quality improvement provisions	♣ BOI does not oversee or enforce *(see footnote)*
Transparency in Coverage			
Submit justifications of any premium increase prior to implementation and post it on the QHP's website. Submit benefit rate info annually.	1311(e)(2)	156.210 155.1020	Anticipated to be a BOI oversight function, but additional legislation or regulation may be necessary to effect and administer this requirement.
Use plain language	1311(e)(3)(B)	156.220(c)	Anticipated to be a BOI oversight function, but additional legislation or regulation may be necessary to effect and administer this requirement.
Requires Issuers to allow individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website	1311(e)(3)(C)	156.220 (d)	Not a BOI function, however BOI could review these measures through market conduct examinations and through the investigation of consumer complaints

Federal/state partnerships for the Exchange. The VHRI Advisory Council did not have the opportunity to address the potential federal/state partnerships for the Exchange. In recent proposed regulations for the Exchange, these partnerships have been provided to assist states who may not be able or do not want to assume all responsibilities for the Exchange. The three options recently proposed by CCIIO that States may choose to operate include the following exchange functions (ties to the five core functions of the Exchange described previously):

- Option 1: Plan management functions;
- Option 2: Selected consumer assistance functions; or

- Option 3: Both selected consumer assistance and plan management functions.

CCIIO further stated that the Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options. In addition, HHS will ensure that the Partnership meets all the Exchange standards.

5. An analysis of the potential effects of the interactions between the Virginia HBE and relevant insurance markets or health programs, including Medicaid.

The VHRI Advisory Council heard several presentations on the current individual and insurance market today and what it may look like under various options under the Exchange. A key concern was on how to mitigate adverse selection in the Exchange. Adverse selection occurs when some insurance pools attract a disproportionate share of those with high expected claims. This could be caused if the products offered or the rules of competition – who must sell to whom – are different inside and outside the HBE. It could also be caused if some insurance products are inherently more attractive to either the healthy or to the sick. Risk adjustment is one tool that is used to correct for selection differences among health plans and benefit plans.

In addition, the VHRI received presentations on what small employers want from an Exchange. Based on those presentations and discussions, the following policy decisions were recommended by the VHRI Advisory Council which sets the stage for moving forward with an Exchange in Virginia:

1. Have one administrative HBE structure or two?

The VHRI voted unanimously to have one HBE administrative structure, to achieve economies of scale and simplify applications, enrollment, and financial reconciliation with employers, insurers and other government agencies (DMAS, IRS, HHS, etc).

2. Have separate risk pools for individuals and for small groups (SHOP), or to meld the risk pools into one?

The VHRI voted 13-2 with two abstentions, to keep the risk pools separate within the HBE. This comports with current law and underwriting practice, and thus would require fewer ancillary changes to current market practice and norms and that in general is viewed as a good goal. This was the clear preference of those selling insurance at the moment Those who supported combining the pools worried about equity and argued that we may want to meld the markets eventually so why not now, but the vote was strongly supportive of minimizing unnecessary disruption to current market patterns. Urban's micro simulation work showing not much net

effect on coverage or premiums probably added to the sense that the potential gains from melding are not worth the possible disruption cost in year one.

3. Congruence of competitive rules inside and outside the HBE.

Prompted in part by the PWC and Urban presentations about the risks of not having a "level playing field" between the HBE and the outside market, a number of issues and specific votes for recommendations were taken in this area.

3a. Should the insurance market rules be made identical inside and outside the HBE?

In essence, this is a vote to erase the differences between the markets inside and outside the HBE, i.e., to make the entire small group and non-group markets identical with the HBE. PPACA has many rules that make the markets similar (essential benefits package, minimum actuarial value, guaranteed issue, restrictions on premium variance due to health status, etc)., but PPACA also gives states considerable flexibility about whether to force complete congruence or allow markets and competitors to experiment outside the specific rules of the HBE. The consensus of the Advisory Council is that the HBE should be tried but the "outside" or more traditional market should be allowed to function, develop, and evolve as well, as the customers of insurance are more likely to be well-served by competition within and across the HBE and the outside market.

3b: Should benefit mandates be the same inside and outside the HBE?

Virginia has more benefit mandates than most states. The Federal government is likely to require an "essential benefits package" (EBP) that is very rich, but it is not likely to be identical to Virginia's benefit mandates. This matters for three reasons. First, all that the *federal* law requires is for the EBP to be offered inside the HBE. If Virginia specific mandates are included in the HBE, i.e., if current mandates remain on the books, then whatever extra premium subsidy costs are necessitated by the Virginia-only mandates, they *must be borne by the Commonwealth of Virginia, not the federal government.* Second, if the legislature decides that the Virginia-specific mandates should only apply outside the HBE, then those plans would be disadvantaged vis-a-vis HBE plans in terms of cost. After much discussion, the Advisory Council voted to recommend that the legislature ensure the relevant state benefit mandates – whichever ones they decide to keep -- should be required both inside and outside the HBE, to make the playing field level.

3c: What should the role of agents and Navigators be in insurance markets inside and outside the HBE?

The federal law creates a new category of insurance advisor, Navigators, who must be paid (and certified) by the HBE on a salaried or per-person fee basis and NOT by insurers. This compensation structure is different from the traditional agent's compensation, which is typically a commission paid by the insurer. According to the employer survey, employers very much liked the idea of being able to get advice from experts who are financially neutral about the choice they make, which would be consistent with the navigator compensation structure, but not consistent with the current unregulated incentive arrangement, in which some plans pay agents higher commissions than others. The critical question for the Advisory Council was whether or not there is a way to preserve the important role agents play in the sale and support of health insurance coverage to their clients, while also keeping the playing field level between the HBE and the outside markets, while recognizing the differences in the roles and fee structures for navigators.

A number of recommendations emerged from discussions of these issues. There was unanimous support for the idea that agents play a vital role today and should tomorrow and therefore the HBE should allow licensed agents to be Navigators if they want to be. (There had been some fear that agents would be prohibited, as PPACA would seem to permit HBEs to do). There was also unanimous support for the idea that Navigators, who are not agents, must be trained and certified, for they are expected to not only explain complex insurance products but subsidies. There was also general support for observing and making sure that agents were not being incentivized to direct customers either inside or outside the HBE, and this will require that the HBE, in setting Navigator fees, be mindful of the competitive marketplace outside the HBE. There was no recommendation to regulate agent fees but instead the preference was to leave agent fees to be determined within the marketplace.

3d. Should the HBE be directed to be an "active" purchaser or a more "passive" one?

This issue has generated lots of commentary and controversy around the country and within Virginia. Essentially, should the HBE be given the discretion to add to the many new rules of competition created by PPACA for the HBE and outside markets? Advocates argue that so many rules are changing, why not give the minimally necessary rule changes a chance and then decide if more discretion or different rules are needed to improve market performance? However, as the "bronze only" nightmare scenario illustrated, the existing rules fail to foreclose serious risks of market imbalances. In the end, the Advisory Council voted 8-6 with two abstentions to hold the HBE to the "passive" course, with one exception. They voted (11 yes, 2 no, and 2 abstained votes) to empower the HBE Board, in the event of extreme adverse selection threatening the financial integrity or competitive potential of the HBE, and only if approved by the Governor, to temporarily suspend plan enrollments or make adjustments to the risk adjustment algorithm to stabilize the market until legislative remedies can be sought in the next session.

4. The Council also agreed to set the parameters of what should be determined by the legislature, the Board, and the Executive Director. This summary document also provides decisions on other items not discussed above. Refer to the September 9, 2011 meeting minutes (Appendix C) for the votes on these decisions.

VHRI Advisory Council's Recommendations for the Governor, Legislature, the Governing Board, and the Executive Director of the Exchange

Major Decisions That Should Be Addressed by the General Assembly
1. To create a Health Benefit Exchange, so that Virginia policy makers will have maximum freedom to shape health insurance markets and health reform in Virginia (HB 2434)
2. Governance Structure (required by HB 2434): a. Where to house the Health Benefits Exchange Whether Board is Governing or Advisory; whether to have both b. Composition of the Board and the selection process, terms, and conflict of interest rules (see VHRI recommendations) c. Reporting requirements of Board/HBE to Legislature, Committees of jurisdiction d. Level of administrative flexibility hiring, compensation, procurement, and transparency
3. Major Policy Directions to be set by Legislature a. To create i. Single administrative structure (ii. Within HBE, keep employer and individual risk pool set separate b. To set parameters of Board's Discretion i. To select executive director ii. To not have discretion to require more than the federal requirements for health plan participation. Thus this is a passive exchange. c. To define "small" as up to 50 until 2016 (2016, must go up to 100), starting in 2017, could be larger if legislature/HBE decides to. Need to determine lower bound of 1 or 2 i. Note: Virginia law now is 2-50. Defining small to include a firm size of 1 permits the self-employed to purchase in the group market. This is permitted under PPACA, but is not required. It would be advisable to conform the small group definition inside and outside the exchange, to prevent obvious selection risk if self-employed may enter the SHOP exchange (and be pooled with other small groups) but must buy in non-group market outside the HBE. ii. Set schedule for revisiting definition of small each year after 2015 iii. OR let Board decide each year after 2015 d. To give Board authority to determine a funding mechanism in order to self-finance the HBE after 2014. The Exchange shall have the authority to fund its operations through special fund revenues generated by assessment fees on health carriers which sell through the Exchange or the users who purchase through the Exchange or such funds as the General Assembly may appropriate. The Exchange is authorized to apply for and accept federal grants, other federal funds and grants from nongovernmental organizations for the purposes of developing, implementing and administering the Exchange (language provided by BOI). i. Financial reporting requirements separate from operational reporting requirements ii. Coordination with and auditing by state fiduciaries required e. To decide congruence (e.g., FOIA) or exemptions (procurement, personnel) from current state laws. T transparency should be consistent with FOIA; Personnel and procurement should be outside of current state personnel rules.

f. To define interactions with other state (and federal) agencies
    i. Responsibility for enrollment and eligibility determination
        1. Interface with BOI
        2. Interface with OSHHR, DMAS, and other state agencies
            a. Information system/portal construction
        3. Interface with HHS, IRS, DOL, etc.
g. To set broad goals and accountability mechanisms
    i. Reporting requirements
        1. Define Oversight committees
h. To define congruence of competition policy inside and outside HBE
    i. Roles of agents inside the HBE
        1. Agents can be Navigators, come 2014
    ii. Roles of Navigators
        1. Certification requirements for Navigators
    iii. Non-group market
        1. Benefit mandates, post-2014, congruent with Essential Benefits Package, inside and outside exchange, or not
        2. Allowed product offerings, post 2014, inside and outside Exchange
        3. Transparency/reporting requirements, post-2014, inside and outside Exchange
        4. Amend oversight and regulatory authority for BOI for inside and outside the exchange market, if necessary
    iv. Small group market
        1. Benefit mandates, post-2014, congruent with Essential Benefits Package, inside and outside exchange, or not
        2. Allowed or required product offerings, post 2014, inside and outside Exchange
        3. Transparency/reporting requirements, post-2014, inside and outside Exchange
        4. Amend oversight and regulatory authority for BOI for inside and outside the exchange market, if necessary

4. Delineate the Duties of the Exchange (the following list are the minimum to meet compliance with ACA)
    a. Certification, recertification, and decertification of qualified health plans
    b. Call Center
    c. Exchange Website
    d. Premium Tax credit and cost sharing reduction calculator
    e. Quality rating system
    f. Navigator program
    g. Eligibility determinations for exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
    h. Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs
    i. Enrollment process
    j. Applications and notices
    k. Individual responsibility determinations
    l. Administration of premium tax credits and cost-sharing reductions
    m. Adjudication of appeals of eligibility determinations
    n. Notification and appeals of employer liability
    o. Information and reports to IRS and enrollees

p. Outreach and Education
q. Free Choice Vouchers
r. Risk adjustment and transitional reinsurance
s. SHOP exchange-specific functions

Major Policy Decisions That Should Be Delegated Entirely to the Board

1. Determine Board's meeting schedule
2. Hire Executive Director (ED), determine compensation, and whether it serves at the pleasure of the Board
    i. Delineate authority of ED and what requires Board's Approval
3. Rent space using Commonwealth of Virginia General Services entity
4. Set fees for financial self-sustainability, pursuant to authority granted by legislature
5. All functions required to be compliant with PPACA, not elsewhere specified
    i. One-stop Enrollment and eligibility determination system, including eligibility for Medicaid/FAMIS, premium tax credits, cost-sharing tax-credits, and lower wage-small employer tax credits
    ii. Determine if individual is entitled to an exemption from the purchase mandate due to affordability or religious reasons
    iii. Premium aggregation service for small employers (so they may write one check per month)
    iv. Website with comparative plan information, ombudsman, toll free hotline, Navigator program, cost calculator, value ranking, etc.
    v. Review premium growth inside and outside the HBE, and use that knowledge to make judgments about how small is small and whether market performance in either or both sectors could be improved with new or relaxed rules
    vi. Communicate relevant information with the IRS and HHS
6. Choose which mechanism and how to implement reinsurance, and risk adjustment, inside and outside the HBE and therefore in conjunction with the BOI
7. Discretion to temporarily adjust market rules inside or outside the HBE, if, in the combined judgment of the HBE Board and the Governor, extreme adverse selection threatens the financial integrity and competitive potential of the HBE *OR* of the outside market. These adjustments could be over-ridden by the legislature when next in session, after relevant reports and testimony by the BOI, the Executive Director of the HBE, and relevant stakeholders. These adjustments could include:
    i. Temporary freeze in enrollment in certain products
    ii. Temporary adjustments to the risk adjustment algorithm
8. Create an Annual Report to the General Assembly on how meeting goals and recommendations on appropriate policy changes.

Major Policy Decisions That Could Be Delegated to the Executive Director

1. Under the direction of the Board, the Executive Director shall be:
    a. The Chief Administrative Officer of the Exchange;
    b. Direct, administer, and manage the operations of the Exchange;
    c. Perform all duties necessary to comply with the Exchange legislation, other state law and regulations, and the Affordable Care Act
2. Hire staff

i. Need to determine whether hiring practices are within state personnel rules or whether there is flexibility (VHRI voted for flexibility)
3. May retain independent contractors as necessary to carry out the planning, development, and operations of the exchange i. Need to determine procurement rules (VHRI voted for flexibility)
4. Enter into interagency agreements or memorandum of understanding with the Department of Medical Assistance Services, the Bureau of Insurance, and other appropriate state agencies to coordinate, subcontract, share data, or delineate the roles of the agencies with the Exchange
5. Promoting competition

Appendix A

VIRGINIA ACTS OF ASSEMBLY -- 2011 RECONVENED SESSION

CHAPTER 823

An Act to state the intent of the General Assembly to create and operate a health benefits exchange.

[H 2434]

Approved April 6, 2011

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That it is the intent of the General Assembly that the Commonwealth create and operate its own health benefits exchange or exchanges, hereafter referred to collectively as the "Virginia Exchange," to preserve and enhance competition in the health insurance market. The purpose of the Virginia Exchange shall be to facilitate the purchase and sale of qualified health plans in the individual market and to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. To accomplish this purpose, the Virginia Exchange shall, at a minimum: (i) meet the relevant requirements of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively referred to as the Affordable Care Act), regarding the establishment of an American Health Benefit Exchange or Small Business Health Options Program by the prescribed deadline imposed by the Affordable Care Act in order to avoid development and implementation of a federal exchange in the Commonwealth; (ii) ensure that no qualified health insurance plan that is sold or offered for sale through an exchange established or operating in the Commonwealth shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto; and (iii) the limitation set forth in (ii) shall not apply to an abortion performed (a) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (b) when the pregnancy is the result of an alleged act of rape or incest.*

§ 2. The General Assembly requests the Governor, through the Secretary of Health and Human Resources and with the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and stakeholders generally to provide recommendations for consideration by the 2012 Session of the General Assembly regarding the structure and governance of the Virginia Exchange. The Governor's recommendations shall address, at a minimum, the following: (i) whether to create the Virginia Exchange within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity; (ii) the make-up of a governing board for the Virginia Exchange; (iii) an analysis of resource needs and sustainability of such resources for the Virginia Exchange; (iv) a delineation of specific functions to be conducted by the Virginia Exchange; and (v) an analysis of the potential effects of the interactions between the Virginia Exchange and relevant insurance markets or health programs, including Medicaid. These recommendations shall be presented to the General Assembly by October 1, 2011, in order that any necessary amendments to the Code of Virginia and any appropriation necessary for establishment of the Virginia Exchange may be considered during the 2012 Session of the General Assembly.

2. That the provisions of this act shall expire on July 1, 2014.

3. That nothing in this act shall be construed or implied to recognize the constitutionality of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

4. That the provisions of this act constitute the election of the Commonwealth to prohibit abortion coverage in qualified health plans offered through an exchange in the Commonwealth as amended by § 1303(a)(1) of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Appendix B

Commonwealth of Virginia

Office of Governor Bob McDonnell

FOR IMMEDIATE RELEASE
August 16, 2010

Contact: Stacey Johnson
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E-mail: Stacey.Johnson@Governor.Virginia.Gov

Governor Bob McDonnell Announces Members of the Virginia Health Reform Initiative Advisory Council

RICHMOND-Governor Bob McDonnell today announced the members of his Virginia Health Reform Initiative Advisory Council. This Council will provide recommendations to the Governor towards a comprehensive strategy for implementing health reform in Virginia. The Advisory Council will go beyond federal health reform and recommend other innovative healthcare solutions that meet the needs of Virginia's citizens and government. The Advisory Council's recommendations for addressing health care access, cost and delivery in Virginia may serve as a model for other states. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost.

Speaking about the Council's composition, Governor McDonnell remarked, "Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. This group of leaders will help us plan for the future of healthcare in Virginia, and the growing costs that will have a significant impact on our budget and our taxpayers unless we act proactively and wisely today. The tremendous rate of growth in Medicaid spending in Virginia, which is only going to increase due to federal health care reform, is unsustainable. I look forward to their recommendations and work in the months ahead."

Secretary of Health and Human Resources Dr. Bill Hazel remarked, "We have assembled a dynamic group of leaders from the legislature, health care delivery, health care policy, health insurance, and the business community that will help shape the future of healthcare in Virginia. I am grateful for their time, expertise, and commitment to the task of ensuring a safe, effective, and quality healthcare delivery system while reducing costs."

The Advisory Council will establish task forces in six key areas: Medicaid Reform, Insurance Market Reform, Delivery and Payment Reform, Capacity, Technology, and Purchasers Perspective. In June, Governor McDonnell appointed Cindi Jones as the Director of the Virginia Health Reform Initiative; Jones is one of the nation's first state officials dedicated to health care reform. Additional healthcare stakeholders and business representatives will be asked to serve on these critical task forces. The Advisory Council will hold its initial meeting on August 20 and August 21, 2010 in Roanoke, Virginia.

Members of the Virginia Health Reform Initiative Council

Chair

- **Dr. Bill Hazel**, Secretary of Health and Human Resources

Council Members:

- **Cindi B. Jones**, Director, Virginia Health Reform Initiative (ex-officio)
- **W. Scott Burnette**, President, and Chief Executive Officer, Community Memorial Health Center
- **Geoff Brown**, Senior Vice President and Chief Information Officer, INOVA Health System
- **Jim Carlson**, Chairman and Chief Executive Officer, Amerigroup
- **Honorable Ben L. Cline**, Member, Virginia House of Delegates
- **Monty Dise**, President, Asset Protection Group, Inc.
- **William H. Fralin, Jr**., Chief Executive Officer and President, Medical Facilities of America
- **Shirley Gibson**, RN, Interim Vice President of Nursing Operations, VCU Health System
- **Chuck Hall**, Executive Director, Hampton/Newport News Community Services Board
- **Richard M. Hamrick, III**, MD, Physician and Partner, Pulmonary Associates of Richmond
- **Honorable Patrick A. Hope**, Member, Virginia House of Delegates
- **Steve Horan**, President, Community Health Solutions
- **Honorable R. Edward Houck**, Member, Virginia State Senate
- **Clarion E. Johnson**, M.D., Global Medical Director, Medicine and Occupational Health Department, Exxon Mobil Corporation
- **W. Scott Johnson**, Hancock, Daniel, Johnson & Nagle, P.C
- **Honorable S. Chris Jones**, Member, Virginia House of Delegates
- **C. Burke King**, President, Virginia Market, Anthem Blue Cross and Blue Shield
- **Jane Kusiak**, Executive Director, Council on Virginia's Future
- **John A. Luke, Jr**., Chairman and Chief Executive Officer, MWV MeadWestvaco
- **Elizabeth Teisberg**, Ph.D., Darden Graduate School of Business, University of Virginia
- **Dixie Tooke-Rawlins**, D.O., Dean and Executive Vice President, Edward Via College of Osteopathic Medicine (VCOM)
- **Honorable William C. Wampler, Jr**., Member, Virginia State Senate
- **Joe R. Wilson**, Chief Operating Officer, PermaTreat Pest Control

Appendix C

Virginia Health Reform Initiative
Advisory Council Meeting
September 9, 2011: 9 a.m. to 5 p.m.

Virginia Department of Health Professions (located at the Perimeter Center)
2nd floor Board Room in the Commonwealth Conference Center
9960 Mayland Drive, Henrico, Virginia 23233

MINUTES

Welcome/Introductory Remarks
Dr. Bill Hazel, Secretary of Health and Human Resources
The Governor asked: would you have a Health Benefits Exchange (HBE) if you didn't have to? Council has determined to do so rather than have the federal government doing it. Almost every state is doing so but not talking about it. Gov. Barber of MS said he has been trying to do so since 2007. Council is to offer recommendations to go forward with HBE.

Employer Input into Health Reform: Results of the Survey
Lee Ann Holdren, Alan Newman Research
This was Phase 2 of our research: what do people know about HBE, what do they think about it, how should board be constituted?
1200 surveys across state; companies had to offer insurance or be considering it. We used health dept. regions. Not a lot of difference in response by region, but by size of company: "skeptical optimism"
Negative comments related to government control or ability of VA to implement.

Responses:
About half of companies who offer health insurance indicated that 75% or more of employees participated in the company plan.
Most likely reason for employees declining company sponsored insurance is availability of insurance coverage from a family member.
Among companies that do not currently offer employee health insurance, high premium and out of pocked costs are most frequently cited as reasons.
Alternative coverage does not emerge as primary reason for opting against company coverage.
Least likely to be identified as a reason for not offering company sponsored insurance: lack of employee interest.
Larger organizations are more likely to have heard of HBE than smaller companies.
Toll-free hotline and freedom to purchase inside or outside the HBE were most appealing; also Tools to compare plans in HBE and help calculate out of pocket costs.
Nearly half were positive about availability of unbiased experts and cost parity in and out of HBE.
Assistance in determining eligibility for public programs or tax credits was less positively received.

Of key HBE features, nearly half thought they were "somewhat favorable," 26% very favorable.
Nearly two thirds strongly agreed that small business representatives be on HBE board.
Opinions mixed on including various other types of people should be on HBE board
Most likely to react negatively to board were elected officials, insurance executives and drug company representatives.

Health plan inclusion scenarios:
HBE open to every qualified health plan that meets federal requirements.
Most employers preferred a flexible approach featuring defined contribution, all available HBE plans and an option for employee to pay difference.
Less likely to believe that HBE will make health insurance more affordable for small business.
Nearly ¾ of small businesses believe that HBE will make health insurance less complex.
Small battery of questions re wellness programs: By a wide margin, larger employers are most likely to offer; 52% of employers with 50-499 do offer

Q – Dise – surprised by difference in telephone v. focus group responses
Q – Hazel – how do we use this? Note that many of Advisory Council not recommended for HBE board.
Recommended allowing all qualified plans in the HBE; Tax credits and how to lower overall costs; governance means something to small businesses.
Q – Massie – sees that small businesses need the help so we should discuss this afternoon.
Q – Task Force member – HBE should provide assistance to employers with employee eligibility for Medicaid and other public assistance.
Q – Fralin – Presentation was a good overview of business perspective. The positive response to tax credit may be due to their being unaware that they will then be penalized as a result of employee qualifying.
Q – Task Force member – There seemed to be a much broader sense of the costs associated with HBE.
Q – Wilson – noted that responses were based on lack of details, but we will put more meat on bones
Q – Audience member – any research done on contents of plan or certain minimum list of benefits that will be available? Something like, a single male employee would not be interested in maternity coverage?
Response – did not get specific about plan coverage

Hazel – we are likely to meet again especially when essential benefits package is released.
Change in order of presentations to go next with PWC.

<u>Making the Market Work Better, PricewaterhouseCoopers LLP – Sandra Hunt</u>
Issues that I will be addressing: importance of stable insurance market and the HBE; elements of ACA that intended to minimize adverse selection risk; structural options to reduce risk; compensating navigators; and measuring success of HBE.
Design elements and regulatory measures that could be used to protect HBE from risks, e.g., adverse selection:

Influx of high risk due to guaranteed issue
Offering only bronze plans
Benefit design differences
Variation in navigator compensation.
Covering the costs of other HBE functions, i.e., Medicaid other public assistance.
Overall size of HBE to help cover costs
Adequacy of risk adjustment

Key structural decisions:
Will market rules be identical in and out of HBE?
Will insurance products be allowed to vary in and out of HBE?
Will the state create separate or combined individual and small business exchanges?
Will the state create separate or combined risk pools?
How will navigators/brokers be compensated?
How will additional HBE functions be funded?
How robust will the risk adjustment process be?

Policy options:
Align insurance company licensure requirements with requirements for QHP under ACA.
Consider range of benefit design differences allowed between HBE and external market: within tiers and across tiers; within HBE, insurance carriers must offer silver and gold plans, but do you require for external as well; if offer bronze in external, do you require that they also must sell in HBE.
Standardize the treatment of the individual and small group markets: Will state offer separate SHOP and individual exchanges?
Standardize impact on premium of navigators and brokers in HBE and the external market.
Ensure broad funding of additional HBE functions, e.g., assessing eligibility for Medicaid and subsidies, tracking employer participation, reporting on quality, access, cost and other market characteristics.
Ensure the risk assessment/adjustment process is robust.
Measuring success: measuring value usually thought of as value = quality/cost.
Measuring stability is reduction in number of uninsured, number of enrollees meets or exceeds targets, continuity of insurance coverage for newly insured, financial performance of HBE insurers meets targets.
Measuring choice: number of qualified MCOs meets or exceeds target; number and range of QHPs meets or exceeds target; and provider networks of QHPs are comparable to those in external market.

Q – Johnson – plans must be copycats, how does this enhance competition and lower cost to small business?
Pooling of small employers will help; standard plan design will give greater choice and comparing various tiers will enable greater and better choices, including costs.
Q – Kusiak – with your knowledge of VA insurance, how much regulation is needed?
Difficult to answer; VA has a well regulated market.
Q – Kusiak – what are most important issues?
Bringing more people into the market

Q – Fralin – what if we set criteria and large insurers don't show up? If we want a robust market, do we let the external market be different and permit adverse selection into HBE? If adverse selection is permitted, it will eventually go out of business.
Q – Fralin – even with all federal subsidies, employer penalties, etc?
Subsidy is one form of risk adjustment and then broader adjustment in market; transfer of funding from low risk individual to high risk individual. Could design HBE to account but premium rates would rise.
Q – Tax nonparticipating insurance companies to help cover cost of HBE for additional services?
Certain functions of HBE must be included, i.e., screening for Medicaid. Cost for those should be broadly shared.
Q – Hazel – is there any flexibility to paying for the HBE?
Q – Fralin – do rules have to be so strict in and out of HBE?
King – if HBE rules are too strict, yes, insurers will not participate. Adverse selection is overblown; plenty of rules exist to protect HBE.
Dise – underwriting is pretty much gone; will minimize adverse selection.
Q – Hazel – how do we do this, to setup the HBE; go back to General Assembly? Does General Assembly tell BOI to make in and out of market equal?
Cunningham – yes, General Assembly would have to tell us to do so. General Assembly could authorize BOI to equalize and then through a public process BOI would develop regulations.
Q – Hazel – how long does process take?
3-6 months possibly; it's incredibly complicated so perhaps 6 -9 months with public input
Q – Fralin – we have not decided where it will be located. General Assembly will determine. Insurance rules will have to be established regardless of where it's established.
Q – Kusiak – Have states made the decision of whether plans can choose not to participate in the HBE?
Nichols – varies widely; CA has decided to limit the number of plans within HBE. As Burke mentioned, there are a lot of rules in the law to deter adverse selection.
Q – Nichols – once rules are set by BOI, how long to price a plan?
King - By January 2013
Q – Hall – Dr. Hazel, have you decided that members of the advisory council will not be on the HBE board?
There is no decision at this point. We have to give guidance to the governing board.
Q – Wilson – if larger insurance companies do not participate, it will greatly reduce small business choice and network access.
Q – Hamrick – Slide refers to transfer of funds; who's transferring funds?
Risk adjustment moves money from one carrier to another and has potential to require that risk adjustment be done at the tier level. Similar to how done in Medicaid today.

<u>Predictions About Exchange Enrollment, Urban Institute</u>
Scenarios modeled: coverage separate for small business (up to 50) and individual markets; policy choice re merging small group and individual markets; policy choice re defining small firms as up to 100 workers v. 50; the risk of adverse selection in the HBE.

Major Findings re coverage: half of current 1 million VA uninsured would be covered.
Leads to $860 million less spent on uncompensated care.
67,000 gain group coverage, 39,000 gain individual coverage; Medicaid increase by 420,000.

Non-group exchange pool would cover 283,000.
Small employer pool would cover 232,000 in early years, rising to 473,000 in later years with expansion of small group market to 100 workers.
Major findings re merging risk pools: raise small group premiums about $220 on average resulting in 25,000 fewer covered by group plans; non-group premiums would decrease by $500 on average resulting in 31,000 more covered in non-group market and 52,000 in HBE; 10,000 fewer uninsured with the merger.
Major findings re small firms up to 100: relatively small increase in size of HBE population.
Major findings re risk of adverse selection: average non-group premium outside HBE falls from $4800 to $1900; inside the premium rises from $5200 to $6900; resulting in federal cost of subsidies rising by $146 million.

Health insurance policy simulation model:
Data – based on a representative population of Virginians and their health care costs
Model - A set of math equations derived from decades of economic and health research on employer and individual behavior
Results – premiums are determined by health care costs of covered persons; premium computation and choices of employer and individual are repeated until decisions settle.
More than half of the population who are below 200% of poverty become insured under health reform, largely with Medicaid. A series of graphic displays illustrated the data re the impact on health insurance coverage with and without health reform as discussed under major findings above.

Q – Hazel – have you modeled what happens without mandate to purchase coverage?
Yes, most impact on higher income population of 300-400% of poverty.
Q – King – state of NY has mandatory issue and premiums are about 4 times those of VA. People wait until they need coverage before buying it.

Federal subsidies: about 150,000 would receive.
Small employer enrollment: 40% of non-group market would be in HBE, assuming broker neutrality.
In later years, small group market goes up to 100 employees so many more enroll (60%).
Policy choice: do you pool small companies with individual market? When merged, model shows slight increase in cost to small company premium and about 10% reduction in individual premium.
Policy choice: expanding small group to 100 employees? Doesn't change much if done at outset.
Q – King – did you model if companies opt to stay out of HBE and self insure? No.

The risk of adverse selection in HBE scenario: bronze is only benefit level offered outside HBE; only higher tiers offered in HBE; no effective risk adjustment between the two; small company's definition is up to 50 and markets are separate.
Outside HBE premiums are reduced v. inside they are higher, driving higher subsidies.

Conclusions:
Health reform would cut the number of uninsured Virginians by half.

The exchange would cover half a million, rising to nearly 800,000 after several years.
Merging markets would raise small group premiums and lower individual premiums.
Defining small group as up to 100 during 2014-2015 would increase the size of the exchange only modestly.
Adverse selection in the exchange could be substantial if plans outside are allowed to differentiate themselves at the bronze level and risk adjustment is limited in effectiveness.

Q – Kusiak – on slide 14, what's the cause for the increase in insured, what's driving it?
Subsidies, benefit coverage expansion
Q – Kusiak - Assumes benefit structure is no different in the HBE?
Must be same in and out
Q – Task Force member– what was size of model for small group?
1-50 employees
Q – Audience member – people with income above 133 and 200 % are just getting by as it is. How did you model based on affordability?
$1,000 out of pocket deductible and $300-400 premiums annually, so is much more affordable. Followed prevailing assumption, that the individual mandate will cause many to purchase as many are price responsive. Take-up rates are nowhere near 100%.
Nichols – many are buying today though they are low income. Lower prices and subsidies will definitely impact increase enrollment.
Q - Burnette – what does the 4800 meant on slide 27?
Non-group premiums, not group.
How is this not a good thing that we want to drive?
Q – Audience member – did you assume affordability based on individual or family?
Individual.

Public Comment (first 10 people who sign up, 2 minutes each)
- Speaker said he would pass, as his question was addressed in presentation.
- Jim Lindsey, reading from a letter by Prof. Jost, Washington and Lee University School of Law, re risk selection: Require level playing field; require insurers to offer same plans in and out of market; either ban stop/loss coverage or modify it.
- Ray Scher – volunteer for Virginia Organizing – concerns: HBE board open meeting and transparency, consumer members, negotiate with plans.
- Maximus representative – comments: definition of eligible entity should include those with Medicaid experience; have no direct or indirect relationship with providers or insurers.

Lunch Break (Provided for Advisory Council members, Task Force Members, staff)

Panel Discussion How Exchanges Should Be Organized
Mark C. Pratt, Senior V.P., State Affairs, America's Health Insurance Plans
AHIP focused on implementation of ACA; working with the administration and Congress. Position on HBE is positive to help promote availability, transparency and competition. HBE development has to be done within the individual state's culture. The right HBE model that is market based competition v. government based. It needs to be state based and market oriented. VHRI is making the right choices. The HBE as a market facilitator is the best choice, rather than as an active purchaser. All QHPs should be allowed to participate, without the HBE negotiating

rates. The market will be dramatically changed in 2014 regardless. It's a fallacy to believe HBE will reduce costs. The MA Connector is a good example, while greatly improving coverage (98% covered), costs have continued to rise significantly. AHIP supports the development of HBE by the states.

Barbara Wallace, President and CEO, Virginia Business Coalition on Health (VBCH)
The coalition represents 50 companies and 350,000covered lives. Mission is to educate employers on health care coverage purchasing; promote value based purchasing. The organization evaluates health plan performance through conducting a statewide hospital survey re quality and safety. Our members want something that works: costs are addressed, quality is addressed, and that employers make up a majority of the HBE board. As 501c3, we are a neutral organization. VA Chamber has established a health reform task force to be chaired by member of VBCH.

Q – Houck – Mark, can you expand on "market-oriented"?
Let all QHPs participate v. government entity picking winners and losers, i.e., who gets to participate. Decision making should be made by the businesses that will purchase.
Q – Massee – how would you define "user-friendly"?
Simple and less complex, than the hybrids we tend to have. The information is complicated.
Q – Massee - HBE needs to have an education component?
Definitely.
Q – Hazel – Mark, how do you do a robust market outside? Is it same as inside the HBE?
Some things need to be same to keep both markets healthy. All carriers will not necessarily participate. It all depends on how it's built. MLR can impact that. You want the small, large and national carriers excited about participating. Should have high deductible health plans outside.
Q – Hazel – whatever gets set up by General Assembly, like many new businesses, may fail. How do you adjust the business model to succeed?
Q – Hamrick – Based on 90% price, 10% customer service when companies select plan. How will plans differentiate?
Wallace -Center for healthy small business through VDH could help.
King – It's not 90% price. Network and service design are factors as well as price.
Mark – transparency will be an important part of HBE.
Q – Nichols – Mark, what do you think should have been part of the ACA?
Law provides a lot of flexibility. We just have to make sure we don't create problems by doing too much too fast, making less choice and competition.
Q – Hazel – Mark, how much lead time for "go" or "no go"? What do you see around the country?
2012 is important. 2013 beta testing begins with federal government. It's an aggressive time line and VA seems to be making positive headway.
Q – Kusiak - Where does cost figure into this? What can we do today that will address cost?
Mark – HBE will facilitate subsidies and tax credits, but does not fundamentally address the cost problem. In MA, the Governor told insurance commissioner to not allow health insurance premiums to increase this year.
Q – Hazel – without any controlling entity, how do we create a balance?

Q – King – number of health care procedures consumed times the cost per procedure is what drives total health care costs. Is the HBE going to go in and set price caps on what hospitals and doctors are paid? No. Is the HBE going to say who can and cannot get procedures? No.
Q – Dise – is MLR a good cost containment solution? Would a provider loss ratio (PLR) cut costs?
Q – Horan – VHRI principle: can a HBE do those things?
Perhaps.
Q – Are there examples out there of market v. government?
CO law specifies that HBE shall encourage market and not negotiate price; not a lot of operating models.
Q – Hope – are there any similarities to federal employee benefits program?
Nichols – OPM sets some broad parameters but does not dictate pricing.

Advisory Council Decision Making
Dr. Bill Hazel, Secretary of Health and Human Resources
(Secretary Hazel did not vote on any of the policy issues.)

Major policy directions to be set by legislature:

Single admin structure or separate? Vote: Single, no nays.

Within HBE, SHOP vs. non-group pool? Motion and second: Fralin/King – separate

Q – Hall – Object to separating, driving costs up in one and down in the other

Q – Horan – Will separate pools effect the outside?

Have to have same inside if same plans are outside because it will create adverse selection.

Vote: motion carries 13 yes (Clarion Johnson, Dise, Little, Tooke-Rawlins, Fralin, Burnette, Wilson, Kusiak, Scott Johnson, Massee, King, Horan and Hamrick), 2 no (Patrick Hope and Chuck Hall), 1 abstain (Houck).

To set parameters of board's discretion:

Select Executive Director? Motion and second: Fralin/Horan – Yes

Vote: Yes - unanimous except 1 abstain (Houck).

To have discretion to require more than the federal requirements for health plan participation? Motion: Yes – Hall/ no second.

- Rawlins – offer additional language "the board will review objective data on" quality of health plans, etc.
- King – board should not have authority to make these decisions; should remain with legislature; MCHP rules cover
- Fralin – should not go into this level of detail; leave to legislature and/or the board.
- Cunningham – some of the standards have ambiguity; should have far more specificity; MCHP covers
- Wilson – too much time spent on this issue. I go back to voting NO.
- Kusiak – if we intend to provide transparency and improve quality, then we need a system
- Hall – agree

- Burnette – if board has discretion to create new requirements, standards, then I have concerns.
- Littel – General Assembly may do so, create requirements, but we don't want board to do it on own.
- S. Johnson – if we reference existing regulations, then it doesn't allow board creation.
- Hamrick – how do we find middle ground philosophically, where "no harm" unintentionally.
- Fralin – motion to adopt 3b.ii.1: No
- Kusiak – if strike #2, the baseline is state and federal law.
- Houck – I'm purposely staying out of this, as I came to get a flavor of the thoughts of this group; thus, abstaining on all votes. Neither the Governor nor legislature will pass off on authority to this board; will not let it elect to exceed federal standards.
- Wilson – 2nd on motion? Yes, King. Add "subject to approval by General Assembly"
- Vote: NO - 8 in favor (Dise, Littel, Tooke-Rawlins, Fralin, Burnette, Scott Johnson, Massee, King), 6 opposed (Hall, Clarion Johnson, Hope, Wilson, Horan, Hamrick), 2 abstain (Houck and Kusiak).
- Hazel - To the extent standards are required, the board will use nationally recommended standards, not creating its own. Also abstaining on votes unless there is a tie.

To be an Active Recruiter of plans to compete inside the HBE?

- Horan – who is responsible to improve access?
- Motion and second: Horan/Hall : Yes
- S. Johnson – add "to participate in and compete."
- Little – are you proposing mandating plans participate?
- Horan – no.
- King amendment/second by Wilson: no additional compensation
- Cunningham – no standard to be met?
- Horan – have to play by the same rules.
- Fralin – don't need to actively recruit if free market; will note No.
- Burnette – are we not requiring a statewide network?
- Horan – not suggesting anything more than doing what is needed in order to provide access as stated in VHRI principles.
- Hazel – add language re the board is to "report to the General Assembly and Governor to recommend policies and changes…"

To require risk pools of SHOP and non-group markets be kept separate

To define 'small" as 1-50 until 2016?

- Motion by King to use 2-50; self employed should stay in individual market.
- Wilson – what about groups of 2?

- King – they can come into group coverage within 60 days of application.
- Task Force member – self employed have more to do than worry about enrollment in a health plan.
- Substitute motion by Johnson to hold off on vote/second by Littel.
- Vote: by voice, only 1 no (Fralin), 1 abstain (Houck).
- Hazel – raise limit from 50 to 100?
- Wilson – favor increasing to 100
- King – those employers 50-100 tend to self fund. If small group increased to 100, it will pull some out of pool.
- Hunt/PWC – Agree.
- Vote: limit of 50 – Yes 12 (Hall, Clarion Johnson, Dise, Little, Fralin, Burnette Hope, Kusiak, Massee, King, Horan, Hamrick, 3 no (Dixie Tooke-Rawlins, Joe Wilson and Scott Johnson) and 1 abstain (Houck).
- Hazel – can we get clarification on whether to use 1 or 2 if law permits?
- Dise – is question for 1 person proprietor or all individuals? Proprietor.
- Hall – should help all businesses. Let sole proprietor be in small group.
- Dise – need to be requirements to be determined as sole proprietor.
- Horan – what does this do to the various markets? Don't underestimate the ripple effect.
- Wilson – need safeguards as Monty mentioned, perhaps require tax reporting as a business before allowing to enter group market. Should have open enrollment period each year.

To give board authority to determine a funding mechanism in order to self finance the HBE after 2014

- Hazel – board needs to have authority to charge fees to be self sufficient.
- Massee – what do you mean, fees? Charges for QHP participation, enrollee fees, etc.
- Cunningham –gives exchange authority to fund its operations through revenues generated by assessment fees on carriers or users that purchase through the Exchange, or other fees as General Assembly may appropriate)
- Hazel: motion to adopt
- Vote: Yea by all but 2 (Fralin and King), 1 abstain (Houck).

To decide congruence or exemptions from current state laws

- Cunningham – SCC is not subject to FOIA but does take public input at open hearings. If assigned to SCC, the HBE director appointed by SCC could hold public hearings.
- Houck – if VHRI wants non-FOIA, then create an exemption in FOIA.
- Hall – HBE should be subject to FOIA; transparency in governance and administration.
- Hazel – we want above transparency.
- Vote: Yes – unanimous except 1 abstain (Houck)

- Personnel administration outside of state requirements
- Vote: Yes - unanimous except 1 abstain (Houck)
- Board function
- Vote: Yea – unanimous except 1 abstain (Houck)

To set broad goals and accountability mechanisms

- Report to General Assembly
- Vote: Yea – unanimous except 1 abstain (Houck)

To define congruence of competition policy inside and outside

- Cindi – at NGA, brokers and navigators are seen as different. There is a distinction between navigators helping low income v. brokers who largely work directly with employers.
- Hazel – drop "outside" from role of agents.
- Dise – board should not set broker fees
- Fralin – allowing payment for inside and outside the HBE to vary will drive enrollment.
- Burnette – board should not control anything outside; needs to be parity though.
- Hazel – broker rates in and out of the HBE should be the same
- S. Johnson – transparency in the amount of rates is needed
- Dise – motion that the board does not have authority; strike #3
- Fralin – agree with motion, should not be doing
- Dise – its talking about agents not navigators. We're already engaged in some of these things and will have to direct people to HBE. Brokers probably won't be both agent and navigator.
- Task Force member – please clarify #1 and 2; and what is meant by navigator? Will they work with Medicaid and other low income groups?
- Nichols – agents can be navigators. It is permitted not required. There have to be certification requirements for navigators to work in the HBE. #3 is intended to provide for a level playing field.
- Hamrick – if agent takes client to HBE, will agent disclose fee paid by insurer?
- Hall – agree with Monty. We use a "navigator" through our office to help negotiate price and think it's necessary and valuable resource.
- Dise – motion to strike #3
- Vote – unanimous with 1 abstention
- Hamrick – motion that agent coming through HBE must disclose fee paid.
- Rawlins – shouldn't the board define roles?
- Burnette – if not asking board to ensure parity in and out, then someone has to do it, whether BOI or elsewhere.
- Dise – need a broader brush re transparency.

Dr. Hazel called for a brief break.

Reconvene:

- Dise – if looking at fees in HBE, then should look at all fees.
- Burnette – needs to be some required transparency in and out of the HBE, whether at BOI. Motion for transparency and parity/no second.
- Nichols – essential benefits package will not configure exactly with VA mandates. The state will have to pay for those benefits required outside that package. One way to deal with it is to say no required benefits beyond the federal package.
- Fralin – hot button benefit recently on autism. If not included in the essential package, then we'd be taking away benefits. Could have the federal package only in the HBE and require the state mandated benefits in the outside market.
- King – Motion: if Virginia does pass another mandate, then it should apply both in and out of HBE.
- Hazel – what about current mandates?
- King – current and future General Assembly mandates should be required both in and out of HBE.
- Dise –Second the motion.
- Hall – do you leave it in perpetuity?
- Wilson – adverse selection impact if only required outside HBE; need to be same in and out of HBE.
- Horan – do we want to tell the General Assembly what to do on this?
- Vote: Yes 9 (Hall, Clarion Johnson, Dise, Littel, Tooke-Rawlins, Burnett, Hope, King, Horan), 5 no (Fralin, Wilson, Kusiak, Scott Johnson and Hamrick), 1 abstain (Houck).

Delineate the duties of the HBE

- Hazel – as we have previously made these decisions: without objection, consider these duties of the HBE

Major policy decisions that could be delegated to the board

- King – object only to 4, 5vi, and 7
- Hazel – 1, 2, 3, 5 and 6 have been previously agreed upon.
- Fralin – do we not need a safety outlet if things go haywire; ejector seat parameters?
- Hall – without #7, it would be like a sail boat without the rudder.
- Nichols – with 2 separate viewpoints it seems reasonable.
- Fralin – propose amending #7 to add Governor to the decision-making authority.
- Horan – what happens if one of the 3 doesn't agree?

- Fralin – if the board is appointed by the Governor, then I would not have a problem.
- Horan – my problem is with the board.
- Fralin – propose amending to add "As certified by the board and BOI"
- Cunningham – I have difficulty with giving this charge to BOI. It has responsibility to insure that the health plans are financially secure but not so with the HBE.
- Hazel – change language to have only the Governor and board
- Motion: upon certification by the exchange board and the Governor, the board may take these extreme actions
- Vote: 11 yes (Hall, Littel, Tooke-Rawlins, Fralin, Burnette, Hope, Wilson, Kusiak, Scott Johnson, Horan, Hamrick), 2 no (Dise and King), 1 abstain (Houck) and 2 absent (Clarion Johnson and Ned Massee).

Major policy decisions that could be delegated to Executive Director

- Hazel - without objection, these have already been agreed upon.

Return to address #2. Governance (required by HB 2434) on page one the decision tree document:

- Fralin – motion to adopt as new public entity
- Hall - second
- King – should be located at SCC for stability to businesses and the market. Ask Commissioner Cunningham to address how this might be housed there.
- Cindi – please see SCC overview, mission, organization chart, etc. included in today's handouts.
- Cunningham – HBE could be a division of the SCC. Commissioners could serve as a board. HBE would take stakeholder input through public meetings. While not opposed to an advisory board, the Commissioners would prefer to get input through public meetings. SCC would hold hearings on proposed rules.
- Hall – BOI does excellent work given the complex nature of its work. However, I see mission creep with taking on the HBE and a very different role than its current role. Find access to the Commissioners difficult.
- Cunningham – it would be a very different role for SCC, but could be done.
- Fralin – SCC is not the right place. This is setting up a market and these are judges. HBE has to have some political oversight.
- Cunningham – It's true that SCC's role is traditionally more regulatory, but is also very much focused on consumer protection.
- Vote: 11 yes (Hall, Clarion Johnson, Tooke-Rawlins, Fralin, Burnette, Hope, Wilson, Kusiak, Scott Johnson, Horan, Hamrick), 3 no (Dise, Littel, King), 1 abstain (Houck) and 1 absent (Massee).

Dr. Hazel – meeting adjourned