

Health Insurance Exchange Forum - Notes  
Denver Central Library  
September 13, 2010

Joan Henneberry began the forum at 3:10 p.m. with introductions and thanks.

Gretchen reminded everyone of the ground rules and goals. This forum is centered on the transparency and disclosure elements of a health insurance exchange, and how they might be written in to law. Once the last forum is completed, Gretchen Hammer will compile a summary draft document for the public with the feedback from each forum.

Gretchen asked the audience: what needs to be done in order to ensure successful implementation of transparency and disclosure provisions?

- We need to have access to the information in an understandable way, probably through an internet portal where frequently asked questions are available, and the ability to ask clarifying questions.
- The exchange must be transparent in terms of how much everything truly costs so shared dollars can be spent wisely.
- It needs to be easy to compare coverage across plans, and the interaction between cost and coverage needs to be readily available.
- A plan comparison guide with basic information on complex concepts should be provided as an actual tool of transparency.
- Web-based digital tools allow for tremendous access to information, and a comparison shopping tool much like one that many brokers already offer can provide information on medical services in any given area. If purchased on a bulk basis, one of these comparison tools can be very useful through the exchange.
- Insurers need to do the research to present to the public in order to participate in the exchange.
- Transparency of outcomes and networks instead of costs, because people do not know what they may need in the future and discussions are rarely had over whether a patient truly needs a particular service.
- The governance structure has to facilitate trust and transparency, with decisions made in open session. The exchange should be able to exclude and negotiate with plans, and the governing body should be made up of those without a conflict of interest, including brokers and providers. The criteria for inclusion or exclusion should be different from Division of Insurance regulations, and the governing body needs to select the criteria in an open public session.
- Language needs to be kept as basic as possible, because it can be confusing all around, and the average consumer needs plain language.
- Elective surgery rules may be different, but for normal qualified events we all look to the insurance company for coverage.
- Must also be accessible somehow to people without internet access. Dollar charts, with cost per plan, might be a helpful tool for transparency.
- It is critical that the exchange operate with the same kind of transparency as government, regardless of governance structure running the exchange. The foremost function is to pair people with clear and appropriate plans at good value.
- Public options, non-profit options, and cooperatives are all possibilities from which to choose that can be included.

What will it take for the Division of Insurance to be appropriately resourced?

- Resources are always a problem, and it is very important that in addition to governance the rules and enforcement stay the same within and outside the exchange.

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- Do not duplicate regulatory functions already performed by the Division of Insurance. Limit the functions of the exchange to providing health insurance.
- Transparency of provider must be a part of the exchange, and nurse practitioners and physicians' assistants should be included as options of providers.
- There needs to be a mechanism for ensuring a good working relationship between DOI and the exchange, along with clear delineation and delegation of authority.
- The exchange should not be within the structure of the agency that regulates either plans or providers, or governed by a carrier's affiliate. It should be an independent entity capable of competing with and responding to market pressures; with the responsibility and resources to inform the public of the individual mandate, products, and value of maintaining continuous coverage.
- The average cost of the penalty as opposed to the average cost of premiums must be taken into consideration. Most people without insurance are without insurance because of the prohibitive cost.

What do we do with all of the information that is going to be disclosed and transparent? Do we have expectations about how that information will be used?

- Track the cost of health care and tie it to the cost of benefits. There will be a difference between what is available to consumers and what is being tracked for policy purposes. For consumers, the information needs to be kept as simple as possible. More information can be available for people who want it, but not every consumer should be made to go through all information.
- Simplicity is absolutely key, and most consumers need to weigh the option of paying more now or paying more later, but it should not be more complicated than that.
- There must be an emphasis on not turning this into another bureaucracy, because we do not want to wind up with an exchange that people will not want to use. Plans need to be categorized intelligibly for consumers that are not well-versed in this information.
- We have an opportunity to simplify what has become a complicated and amalgamated mess. Let's introduce an out-of-pocket maximum and plans that will all cover essential benefits.
- The governing body needs to have substantial consumer input for credibility and transparency's sake that will continue throughout its existence, not just this initiation.
- Price is the real driver, so keep it very simple. There are differences in things like ambulance coverage and physical therapy, while there are certain areas we expect to be benefit-rich. Let the customer decide whether they want a \$2,000 or \$5,000 deductible. Find good examples that already exist that can be used as platforms.
- There can be an educational component that allows consumers more information on chronic conditions, includes a registry to remind of appointments, etc.

Reflections on the legislation recently passed in California:

- This is something to consider as we move forward, in [SB 900](#) California establishes a governing board for the exchange. In [AB 1602](#) California specifies the powers and duties of the board.
- Initially, is California moving in the right direction?
- Hopefully we are different than California, and allow a non-profit option within our program. Federal legislation requires that one non-profit entity is included, but they are private entities.
- As a consumer, it would be helpful to be able to buy-in to a public option.

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- Does the exchange provide the mechanism to prove who is poor enough to access the subsidies? Yes, the exchange is tasked with assessing income to move people into appropriate groups and align with available public programs.
- Explaining coverage is a different skill set than determining eligibility, but the exchange does not necessarily have to do both. What the exchange does need is an intersection with an entity that does determine eligibility already, and in 2014 things will already be different: the floor of Medicaid eligibility will be raised nationwide, and determination of eligibility goes simply to modified adjusted gross income standards. Technology will likely adjust to these changes, but there will always be a need for human interaction and the law requires live customer service.
- How do people feel about California's legislation? Would Colorado prefer a public plan in ours? Massachusetts has a plan that competes very nicely with the private insurers, so it should be a consideration.
- We do not want to drive adverse risk, so the exchange must be inclusive in order to not run the risk of losing better carriers.
- California moves us in the right direction. Undoubtedly there will be changes but it is a great starting point, and risk adjustment and adverse selection are always considerations.
- Doctors are very concerned about reimbursement rates for Medicare.

Other comments:

- With respect to the principles of the exchange, consumers and employers must be the focus. The board should be consumer-represented and avoid conflicts of interest. There should be choice without complexity, and continuity of care. Be careful about the definition of consumers, as almost anyone can be considered a consumer of health care.
- The themes that will come out of this will reflect the will of the body, and we need to be careful about the language. Let's promote consumer health, and appropriately avoid segregating the market for those already in unfavorable positions (question of access is a critical issue).
- The definition of the consumer perhaps is a person who doesn't have substantial financial interest in the health care system. The Cover Colorado model did not always work very well, so take lessons learned.
- The web site should be more transparent and have more ability for the public to provide feedback.
- There needs to be a level of expertise on the board as well as people without conflicts of interest, and these may not be totally compatible with each other. Instead, opt for balance and meet somewhere in the middle.

Gretchen concluded the forum and announced the next forum on September 29, 2010 from 9:00 – 11:00 a.m. All materials and presentations will be posted to the [web site](#).