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Carrie Banahan, Executive Director  
Office of Health Policy  
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Dear Ms Banahan:

We write on behalf of the Kentucky Equal Justice Center, a civil legal services organization that works closely with legal aid organizations across Kentucky. Our advocates will assist consumers seeking coverage through the Exchange. We expect to hear many questions about enrollment, coverage, cost and continuity of care.

We greatly appreciate the chance to participate in this process of public input, as well the thoughtful and detailed questions you have provided. It is clear from these questions that you and your staff wish to create a robust Exchange to benefit the Commonwealth.

We have worked with Kentucky Voices for Health to develop the set of consumer-oriented managed care principles that was sent recently to Governor Beshear. Those principles have guided our responses here. In addition, during the process of considering your questions we identified four core elements of a good Exchange that we believe serve as touchstones for successful implementation. A strong Exchange should include the following:

- Robust consumer assistance and navigator programs
- Restrictions on adverse selection
- Active purchasing and negotiation by the Exchange
- Strict conflict of interest rules and transparency in both governance and operation

In the responses which follow, we have included the topics from your original document and the questions under each topic that we have chosen to answer.

While considering the questions and our answers, it became clear that implementation of the exchange will be a step-by-step process. After Kentucky makes the initial important decisions regarding its Exchange, more issues will arise. We hope that this opportunity for input will be the beginning of an ongoing process of engagement with stakeholders and the public.

## Functions

**Question 2:** *A “Navigator” program is required to be established under an Exchange to conduct outreach and assist individuals and employers with enrollment. What issues should be considered in establishing a “Navigator” Program?*

**Answer: The Exchange Needs a Strong and Diverse Navigator Program.**

The establishment of a robust and effective navigator program is necessary for a successful exchange because this will be the first time many consumers will choose a health plan.<sup>i</sup> Kentucky should create a program that can serve the wide variety of populations residing in our state. Specifically, it must ensure that there are a sufficient number of Navigators who possess the experience and capacity to serve disadvantaged, hard-to-reach, and culturally or linguistically isolated populations. In Kentucky, these populations include, but are not limited to, families in rural communities, individuals with limited English literacy, monolingual Spanish-speaking individuals and families, and refugees from around the world. Navigators must be specially trained to work with these groups and perform the duties listed in the PPACA. Further, effort should be made to recruit navigators from the communities they will serve. Because there inevitably will be some overlap between navigators and the existing system of agents and brokers, coordination between the two is imperative.

**Question 3:** *Agents play an important role in assisting individuals and employers with purchasing health insurance coverage. What role should agents play in assisting individuals with coverage in the Exchange?*

**Answer: Agents Can Be Useful but Must Be Regulated.**

Agents and brokers have the necessary expertise to assist consumers in the choice of plans and the enrollment process. This experience will make agents useful, especially in the first days of the Exchange, as navigators are trained. However, there must be safeguards to ensure that agents are not steering consumers away from the Exchange or encouraging adverse selection. To be a viable system, the Exchange needs a large, diverse pool of consumers. If healthier individuals choose plans outside of the Exchange, costs inside will rise.

If agents will be involved in Exchange enrollment, Kentucky should regulate them, with the threat of losing licensure for noncompliance, to ensure that the best interests of the Exchange and its consumers are met. Additionally, the State may wish to study the benefits of aligning incentives so that the rewards for placing a customer inside and outside the Exchange are equivalent. It is possible that converting from a commission, as agents and brokers use now, to a brokerage fee system, where they are paid per consumer, would be advantageous. Lastly, consumers should not be required to use an agent if that person does not meet their needs.

## Eligibility and Employers

**Question 6:** *What issues of other interest are important to employers with respect to their participation in an Exchange?*

**Answer: Aggregate Premiums Can Entice Employers.**

To encourage as many employers as possible to join the Exchange, ease of participation is paramount. Payment processes within the Exchange should be no more burdensome than those in the outside market. Allowing employers to pay aggregate premiums may make it more attractive for employers to join. The smaller administrative burden created by allowing employers to pay a single premium may promote higher participation.

**Question 7:** *Individuals without access to employer coverage with incomes below 400% of the federal poverty level (\$88,000 for a family of four) will be eligible for premium subsidies for the purchase of coverage through an Exchange. A State may operate a “Basic Health Plan” for individuals between 133% and 200% of the federal poverty level and use 95% of the tax credits that would have been available to these individuals for Exchange coverage to operate the “Basic Health Plan.” Should Kentucky operate a “Basic Health Plan?” If so, what types of benefits should be included in the Basic Health Plan?*

**Answer: Kentucky Should Establish a Basic Health Plan if it Is Voluntary and Does Not Encourage Adverse Selection.**

The option of the “Basic Health Plan” could be tremendously helpful for some individuals. However, it must be structured to support consumer choice and convenience and reject adverse selection; otherwise, the Basic Health Plan is inadvisable. The Plan could be particularly useful to individuals whose incomes fluctuate between eligibility for Medicaid and premium tax credits. Because of intermittent or seasonal employment, there are many individuals who will sometimes be eligible for Medicaid and other times ineligible. If these individuals had the choice to use the Basic Health Plan while their incomes fluctuated between 133% and 200% of the federal poverty level, there would be fewer service gaps and more continuous service. Individuals with higher income levels who expect to remain ineligible for Medicaid could choose to opt out of the Basic Health Plan and use the Exchange normally. We do not recommend required enrollment in the Basic Health Plan. However, to assist consumers it may be best to enroll them in the Plan automatically and allow them to opt out if desired.

To be useful, the Basic Health Plan should provide the same services as Medicaid and be at least as comprehensive as the Exchange with regards to service and network coverage. This factor would reduce potential adverse selection because consumers would not be able to use the Plan to receive cheaper coverage. In addition, similarity between Medicaid and the Basic Health Plan would facilitate transfer between the programs. Ideally, the same providers also would be available in both programs, making the

transition simple. To determine the feasibility of using the Basic Plan as we describe it, the Cabinet should assess whether the 95% of tax credits will buy a plan that could work seamlessly with Medicaid.

**Question 8:** *One of the functions of an Exchange is to determine eligibility for Medicaid and premium subsidies. What issues need to be considered in establishing an Exchange that will determine eligibility for Medicaid and premium subsidies? How should the Exchange create a seamless system for individuals who fall back and forth between “Medicaid” eligibility and “premium subsidy” eligibility due to changes in income? How should continuity of plan coverage and provider networks be maintained for these individuals who fall back and forth between “Medicaid” eligibility and “premium subsidy” eligibility?*

**Answer: The Exchange Must Have a “No Wrong Door” Policy.**

Deciding which health plan is appropriate is always difficult and the process will be even more so for first-time health plan consumers. Therefore, one of the most important elements of a well-managed Exchange is to create a so-called “no wrong door” policy. This will allow consumers to be funneled correctly into Medicaid or the Exchange, regardless of where they initially attempt to gain coverage. Once an application is received, the Exchange should make interim medical assistance available for persons whose eligibility status for Medicaid or premium subsidies cannot immediately be determined. The Exchange, rather than the individual, must ensure that the individual is enrolled appropriately. Please see Appendix A (attached) for a flow chart and explanation detailing how the process might work, courtesy of the Tennessee Justice Center.

As stated above in #7, the Basic Health Plan, if executed properly, could help create a seamless system for individuals whose incomes fluctuate between Medicaid and premium subsidy-eligibility. At a minimum, the “No Wrong Door” policy must include (1) extensive coordination between the Exchange and the Department of Medicaid Services, as well as other states agencies, including the Department of Corrections, Department for Disability Determination, and the Department for Community Based Services; (2) a requirement that consumers will not lose coverage for either Medicaid or the exchange without determination of eligibility for the other program; (3) a safe harbor for individuals who improperly receive premium tax credits when ineligible; and (4) electronic applications and records to facilitate transfer between the programs. The Exchange should encourage providers to accept multiple forms of reimbursement to allow consumers to maintain the same health care team, regardless of the funding source.

#### Health Plan Participation

**Question 1:** *Health plans that wish to participate in an Exchange are required under PPACA to comply with a specified list of requirements. Beyond the PPACA requirements specified, should additional requirements be required of health plans to participate in an Exchange?*

**Answer: Kentucky Should Require that Exchange Plans Have Reasonable Rate Increases and Provide Quality Service and Care.**

The Exchange gives the Commonwealth power to protect the best interests of its residents when purchasing health care coverage. By providing additional requirements regarding price and quality, the Exchange can ensure better services are available. The justification for rate increases required by the PPACA brings new transparency to health insurance rates. The Exchange should exclude plans with a history of unreasonable rate hikes from participating, or at least require further assurances that premiums will remain reasonable. Additionally, the Exchange should evaluate the plans for quality and cost-value to shield Kentuckians from unscrupulous health care insurers.

**Question 2:** *Should all health plans be required to participate in an Exchange and comply with the requirements or should health plans compete or bid to participate in an Exchange?*

**Answer: The State Should Be an Active Purchaser and Ensure that Only High-Quality Plans Can Participate in the Exchange.**

The Exchange is in an excellent position to evaluate potential health care plans and negotiate for the best possible health plans for Kentucky's residents. In the same way that Kentucky negotiates for Medicaid and state employee health coverage, the Exchange should work to provide a list of available plans that give the consumer and small business provider good value. Massachusetts' Connector program works in this way and has been able to achieve good results for its residents.<sup>ii</sup> Kentucky should use its clout as the provider of such a large consumer pool by requiring plans to compete to be part of the Exchange.

**Question 3:** *Should the number of benefit plans offered in an Exchange be limited or unlimited?*

**Answer: The Number of Plans Should Be Unlimited with the Option to Establish Limits if Necessary.**

To provide the maximum number of options to consumers, the number of plans in the Exchange initially should be unlimited. If a proffered health plan meets the heightened requirements of high quality and reasonable cost, as determined by the Exchange, it should be permitted to sell on the Exchange. There is a possibility that a high number of plans could confuse or overwhelm consumers. Therefore, the Cabinet should leave open the possibility of limiting the number of health plans on the Exchange in the future, if consumers have difficulty.

Market Rules

**Question 1:** *Health plans participating in an Exchange are required to comply with certain requirements in areas such as marketing and network adequacy, etc. Should the same rules exist for plans sold inside and outside an Exchange?*

**Answer: The Same Rules Should Exist Inside and Outside of the Exchange to Protect Against Adverse Selection.**

The Commonwealth should create the same rules for plans sold inside and outside the exchange to prevent adverse selection. The PPACA establishes requirements for Exchange plans, including accreditation and community networks, that are designed to ensure quality and access. Absent a parallel requirement, health insurers outside the Exchange would be able to create cheaper plans. Use of the same rules for all health plans would eliminate any disincentives to participate in the Exchange and prevent insurers operating outside it from designing benefit packages and marketing campaigns to attract healthier people away from the Exchange.<sup>iii</sup>

Establishing such a system is not difficult. States can simply apply the same standards that Health and Human Services sets for qualified health plans offered in an Exchange to plans offered in competing markets outside the Exchange. The Commonwealth must enforce the rules equally both inside and outside the Exchange for this protection to be useful.

**Question 2:** *Should health plans be required to offer the same product plans inside and outside an Exchange?*

**Answer: The Exchange Should Not Require All Health Plans To Offer the Same Plans Inside and Outside the Exchange But Should Require the Same Tiers To Be Offered.**

To the extent that the Commonwealth encourages competition within the Exchange and excludes plans that do not meet price and quality standards, some of the plans outside the Exchange will inevitably be lower quality. Requiring health insurers to offer the same plans inside and outside of the Exchange would provide a corresponding safeguard against adverse selection.

It may not be necessary, however, to require identical plans inside and outside the exchange. Instead, the Commonwealth can minimize adverse selection by requiring health plans to offer the same levels of plans both inside and outside the Exchange. For example, if a health insurance company in the Exchange provides the full array of coverage (i.e. platinum, gold, silver, bronze, and catastrophic coverage), it also would have to offer the same tiers in the outside market.<sup>iv</sup> California has used this approach and requires all carriers within its Exchange to offer all five levels of coverage in all regions of the state and offer the same levels outside of the Exchange.<sup>v</sup> Allowing insurers outside the Exchange to have only low-level plans would increase adverse selection as healthier people likely will choose to go outside the exchange where plans may be less expensive.

## Risk Sharing

**Question 2:** *A risk adjustment mechanism is required to be established for health plans sold inside and outside an Exchange to adjust for unequal distribution of actuarial risk. What issues should be considered in establishing a risk adjustment mechanism?*

**Answer: Conscientious Enforcement Is Necessary for the Risk Adjustment Mechanism.**

The PPACA requirements of risk adjustment and heightened technology have the potential to increase accessibility to health care and related services, but they must be enforced carefully to ensure that the mechanism works properly, and that insurers give accurate information. The risk of error in the mechanisms is high and the results costly to consumers and providers. For instance, under Medicare Advantage, some users were incorrectly given higher premiums because the mechanism made them appear sicker than they actually were.<sup>vi</sup>

**Question 4:** *States may merge their individual and small employer group markets for rating and risk sharing. What issues should be considered regarding this option?*

**Answer: The State Should Merge the Individual and Small Business Exchanges to Create a Larger Pool.**

Under the Affordable Care Act, states have the option to merge the exchanges for individuals and for small businesses. If Kentucky does not do this, it may find that the exchanges lack the necessary volume to attract a sufficient number of insurers, ensure a large enough pool of enrollees that is well-balanced between the healthy and the sick, and achieve the economies of scale that can keep the Exchange's administrative costs low.<sup>vii</sup> Merging the exchanges is advisable—unless and until data-driven analysis shows the same results can be achieved in separate exchanges.

## Structure and Governance

**Question 1:** *An Exchange may be operated by a government agency, a non-profit entity established by the state, or the federal government on behalf of a state if a state does not wish to establish an Exchange. Should Kentucky operate its own Exchange or allow the federal government to operate the Exchange? If Kentucky operates its own Exchange, what issues should be considered in deciding which option to choose for Kentucky?*

**Answer: The Exchange Should Be Transparent and Independent.**

Additional research on potential governance structures is needed before an informed answer can be given to this question. However, Kentucky should create and operate its own Exchange, rather than allow the federal government to do so. Regardless of where the Commonwealth chooses to place it, it must ensure that the Exchange abides by state and federal rules and regulations regarding transparency. Of particular import, the

Exchange must follow Open Records and Open Meetings laws, as a government entity would be required to do. Additionally, the Exchange should not be placed within another state agency with which it might have a conflict, such as the Departments of Insurance or Medicaid. It is possible that the quasi-governmental model, which has been chosen by several other states, would meet both conditions.

**Question 2:** *Various options for the structure of the Exchange are permitted: 1) joint Exchange for individuals and groups, 2) separate Exchanges for individuals and groups, 3) multiple subsidiary Exchanges each serving a distinct geographic area, or 4) regional Exchange including multiple states. Which option(s) should Kentucky choose to structure its Exchange? What issues should be considered in deciding which option to choose for Kentucky?*

**Answer: The State Should Create a Large Enrollee Pool and Consider a Multi-State Regional Exchange with Governance in Kentucky.**

Given the wide array of options to structure the Exchange, the State should investigate all possibilities to produce a plan that benefits consumers. The decision should be influenced by the fact that larger Exchanges are more likely to succeed. With a larger pool of enrollees, the risks of a high-cost concentration of consumers would be lower, encouraging more health plans to vie for a spot in the Exchange. The same reasoning suggests that there should be a joint Exchange for individuals and groups. Having multiple subsidiary Exchanges serving different geographic areas would risk cost effectiveness and quality of care. On the other hand, a larger Exchange involving multiple states could be advantageous. However, the Exchange should establish governance and oversight within the Commonwealth to maintain accountability, perhaps under a consortium approach

#### Consumer Outreach and Education

**Question 1:** *What kinds of outreach strategies are likely to be most successful for an Exchange in enrolling individuals who are eligible for premium subsidies and cost-sharing reductions, and retaining these individuals in the Exchange? How can these outreach efforts be coordinated with efforts for other public programs?*

**Answer: The Exchange Should Use a Broad-Based Outreach Strategy.**

Because of the importance of the health coverage to Kentucky residents, the Exchange should implement a broad-based consumer outreach program to reach as many individuals as possible. Different outreach materials and venues could be developed and geared towards those who might qualify for premium subsidies, as well as those who might qualify for Medicaid or KCHIP. Kentucky has been successful in its outreach efforts to increase KCHIP enrollment. During that campaign, residents received information through radio and television advertisements, at their and their children's schools, and through local health departments. The state workers, advocates and community-based groups who worked to increase KCHIP enrollment would be a good

resource for planning the Exchange's outreach strategy. Additionally, the Social Security Administration, which uses fliers, mailers, and the internet, also has had success. Lastly, the state should consider creating a website on which individuals can apply for both health coverage and an array of public benefits programs, and incorporate that within the Exchange.

**Question 3:** *What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside the Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparison, and eligibility for premium subsidies, or eligibility for Medicaid? What types of effort could be taken to reach individuals from diverse cultural origins and those with a disability or low literacy?*

**Answer: The Exchange Should Maintain a Comprehensive Website, Which Includes Cost and Coverage, and a Toll-Free Hotline.**

To help consumers find the best coverage, the Exchange should maintain a comprehensive website and a toll-free hotline. The website should be available in English and Spanish and should include detailed information on all plans offered in the Exchange, including the network of providers, breadth of coverage (i.e. which types of services, prescriptions, equipment and supplies will be covered), applicable deductibles and co-insurance, language spoken and geographic coverage. On the website, consumers of qualified health plans should be able to obtain comparative information on all available plans. It also would be helpful if the Exchange provided a rating system for plans that included a numeric value to assess value of care. It is important for the information to be standardized to enable consumers to compare differing plans. Additionally, the Exchange should operate a toll-free telephone hotline to respond to requests for assistance, utilizing staff that is trained to provide assistance in a culturally and linguistically appropriate manner. Specially-trained navigators should also be assigned to work with distinct populations.

#### Other Comments

**A Non-Conflicted, Diverse Board of Directors Is Essential for the Exchange.**

Creating an inclusive and diverse Board will not only provide important guidance and management, but also will demonstrate to the public that the new entity has the best interests of all consumers in mind. The Exchange statute must include explicit conflict of interest language to ensure that only individuals without conflicts can serve. For an illustration, see the Rhode Island Health Benefit Exchange Act (2011 S 0087), which prohibits compensation for service on the Board (other than a per diem and travel reimbursement) and bars anyone employed by, a consultant to, or affiliated with a health insurer, broker, or provider from membership of the Board.<sup>viii</sup> Kentucky also may wish to consider appointing a special master to review potential appointees and check for conflicts.

Second, the composition of the Board of Directors must represent the interests of the consumers who will utilize the exchange. Representation of both individual consumers and small business owners should be required, since both groups are meant to benefit from the exchange. (The Rhode Island Health Benefit Exchange requires two consumer advocates and two small business advocates to be present on the eleven-member Board.<sup>ix</sup>) Additionally, the Exchange should ensure that the Board members reflect the diversity of Kentucky culturally, racially and geographically so that the Exchange acts in the best interests of the whole state.

Again, we appreciate this opportunity to comment on Kentucky's proposed Exchange. Please feel free to contact the Kentucky Equal Justice Center at (859) 233-0323 at any time. We would be very happy to provide additional information.

Sincerely,

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Rich Seckel, Director  
Anne Marie Regan, Senior Staff Attorney

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<sup>i</sup> A report published by the Kaiser Foundation found that 65% of Exchange users will transition from being uninsured. *Focus on Health Reform: A Profile of Exchange Enrollees*, March 2011, available online at <http://www.kff.org/healthreform/upload/8147.pdf>.

<sup>ii</sup> Please see <http://www.mahealthconnector.org> for information on the Massachusetts Health Connector program.

<sup>iii</sup> For more information see *States Should Structure Insurance Exchanges to Minimize Adverse Selection*, available online at <http://www.cbpp.org/cms/indez.cfm?fa=view&id=3267>.

<sup>iv</sup> For an example of this type of legislation, please see the California Health Benefit Exchange, or [http://www.californiahealthbenefitexchange.com/active\\_purchaser.htm](http://www.californiahealthbenefitexchange.com/active_purchaser.htm).

<sup>v</sup> The pertinent text reads: (c) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(d) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act.

(e) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal act. The board may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504.

(f)(1) Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

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(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange. Title 22, California Government Code, Section 100503 (c)-(f).

<sup>vi</sup> *States Should Structure Insurance Exchanges to Minimize Adverse Selection.*

<sup>vii</sup> See *id.*

<sup>viii</sup> The pertinent text reads: (d) A member of the board or of the staff of the exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, an insurer, a health insurance agent or broker, a health care provider, or a health care facility or health clinic while serving on the board or on the staff of the exchange. A member of the board or of the staff of the exchange shall not be a member, a board member, or an employee of a trade association of insurers, health facilities, health clinics, or health care providers while serving on the board or on the staff of the exchange. A member of the board or of the staff of the exchange shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(e) A board member shall not receive compensation for his or her service on the board but may receive a per diem and reimbursement for travel and other necessary expenses, while engaged in the performance of official duties of the board.

<sup>ix</sup> The full text of Section 42-154-6(a) and (b) reads: (a) The exchange shall be governed by an executive board which shall consist of eleven (11) members as follows:

(1) The director of the department of administration or his or her designee;

(2) The commissioner of the office of the health insurance commissioner or his or her designee;

(3) The secretary of the executive office of health and human services or his or her designee; and,

(4) Eight (8) shall be appointed by the governor from the general public, with the advice and consent of the senate, two (2) of whom shall represent a consumer organization and two (2) of whom shall represent small businesses. The balance of the appointments to the board shall be made to provide demonstrated and acknowledged expertise in a diverse range of health care areas including, but not limited to, the following:

(i) Individual health care coverage;

(ii) Small employer health care coverage;

(iii) Health benefits plan administration;

(iv) Health care finance;

(v) Administering a public or private health care delivery system;

(vi) Purchasing health plan coverage; and

(vii) State employee health purchasing.

(b) The governor shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a range and diversity of skills, backgrounds, and geographic and stakeholder perspectives.