April Todd-Malmlov, Exchange Executive Director, Minn. Dept of Commerce

An Interview with The Civic Caucus

8301 Creekside Circle #920, Bloomington, MN 55437

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Notes of the Discussion

Present : David Broden,Janis Clay,Pat Davies,Rick Dornfeld, Paul Gilje (coordinator), Verne Johnson (chair), Sallie Kemper, Dan Loritz (vice chair), Walt McClure, Tim McDonald, Dana Schroeder, April Todd-Malmlov.

Summary of Discussion : April Todd-Malmlov, exchange executive director at the Minnesota Department of Commerce, argues that getting better health care quality and value information to consumers through the state's developing health insurance exchange will drive competition in the health care marketplace, lowering costs, increasing innovation and improving quality. She describes the process Minnesota is using to design and develop its exchange and the significant challenge of the short time frame for doing that. She explores the impact the Affordable Care Act and the exchange will have on health care choices and coverage in the individual and small-group markets. She closes by saying that health reforms enacted in Minnesota in 2008 will allow the state to build a better health exchange than those developed in other states and the default exchange to be devised the Federal government.

A. Introduction of the speaker.

April Todd-Malmlov is the Exchange Executive Director at the Minnesota Department of Commerce. She is responsible for leading the design and development of Minnesota's health insurance exchange. Prior to this role, Todd-Malmlov served as Minnesota's State Health Economist and was responsible for monitoring the health care market and informing state health policy related to health care access, cost and quality.

Todd-Malmlov has also served as Director of Competitive Intelligence for United Healthcare and Vice President of Strategic Analysis and Communications for Government Affairs at UnitedHealth Group.

She holds a master's degree in public health from the University of Minnesota and a bachelor's degree from Beloit College. She was named one of the top business leaders to watch in 2012 by the Minneapolis-St. Paul Business Journal and the StarTribune.

B. Discussion.

The speaker outlined the problems the health insurance exchange is intended to address, including the lack of competition in the health care market. She addressed the goals of the exchange and strategies it will incorporate for improving innovation, competitiveness and quality in that market.

Background: What is a health insurance exchange?

Exchanges are new organizations that will be set up to create a more organized and competitive market for buying health insurance. They will offer a choice of different health plans, certify those plans that participate and provide information to help consumers better understand their options.

Beginning in 2014, exchanges will serve primarily individuals buying insurance on their own and small businesses with up to 100 employees. States can choose to include larger employers in the future. States are expected to establish exchanges, but the federal government will step in if a state does not set up an exchange on its own. An exchange can be a government agency or a nonprofit organization. States can create multiple exchanges, as long as only one serves each geographic area. States can work together to form regional exchanges. The federal government is offering technical assistance to help states set up exchanges.

(Source: The Henry J. Kaiser Family Foundation, http://healthreform.kff.org/Faq/What-is-a-health-insurance-exchange.aspx)

The problem.

Todd-Malmlov outlined the problem health insurance exchanges are intended to address. She said the problem has three parts:

(1) Health care is very complex and hard to understand.

(2) There is too little consumer engagement in making health care and health insurance decisions.

(3) The health care market does not operate like a true competitive market, due to the complexity of health care and the lack of information and incentive for consumers to make rational choices.

The goals.

Todd-Malmlov delineated the following goals for Minnesota's health exchange:

(1) Simplify and streamline access. Make it easy for people to get coverage.

(2) Provide information people can and want to use, something that's useful and helpful. Provide a process and incentive for people to meaningfully engage with the system.

(3) Drive health care and health care provider competition on innovation and value. Consumers must be engaged and making well-informed decisions on the information that drives value. A competitive market can drive down costs.

The strategies.

Todd-Malmlov identified the following strategies for meeting the goals outlined above:

(1) Streamlining access to public and private coverage. We can focus on the person's needs instead of on how each program or source of coverage operates. Everyone should be treated the same and have the same experience, regardless of the type of coverage for which they may be eligible. Streamlining the process will help more people obtain and maintain health care coverage and reduce the number of uninsured.

(2) Developing new information sources and using existing ones to drive decision making and encourage competition on value. We can use existing sources of information, such as Minnesota Community Measurement and develop new information as required under the Affordable Care Act to provide consumers with information on health plan quality and customer satisfaction. We're using some research about how to use decision-support tools to help people make decisions.

She said Minnesota is working with 11 other states on a project called User Experience 2014. The project focuses on how people understand health insurance, how we can make things simple for them and how we can help them make good decisions. The state is also looking at market research it has done recently on what information people trust and want.

Todd-Malmlov said that a small percentage of the public now uses information on health care quality. She hopes the exchange will alter that. "Hopefully, making good decisions on value and quality will drive competition," she said.

She offered an example of how a diabetic might use the new health exchange. The person could enter the system saying, "I want to find the best clinic that treats diabetes within 10 miles of my home." The person will be able to find the clinics within 10 miles and see what health plans the clinics are associated with, who's in the network and what their cost-sharing and deductibles would be for that tier of provider. The person can find out what programs the clinics and health plans use for management of diabetes and how they help someone with that condition. The diabetic person can use all that information to pick the best plan for him or her.

Having a health care market based on that type of information, Todd-Malmlov said, encourages providers and health plans to improve the quality and value of services they provide.

The Affordable Care Act is intended to create a more competitive health care marketplace, along with more valuable insurance coverage for more people.

Todd-Malmlov said the broad, high-level goals of the Affordable Care Act include:

- Making coverage more affordable and valuable through competition, tax credits and a minimum benefit set;

- Incenting higher quality and value of care, through transparency of understandable information and competition;
- Getting more people covered; and
- Making it easier for people to access care.

Sixty percent of uninsured people in Minnesota are eligible for public programs, she noted, "but for some reason, they are not making use of them." Less than 25 percent of the uninsured are children. However, when she was the state health economist, she saw that more and more children have become uninsured because of the recession, because a lot of people laid off have been young workers who have young children.

Minnesota's Department of Commerce had been leading the effort to design and develop the health exchange.

(Note to readers: On Tuesday, September 18, just as the Civic Caucus was completing work on notes of the meeting with Todd Malmlov, Governor Mark Dayton reassigned responsibility for developing the health exchange from the Department of Commerce to the Department of Management and Budget.)

In the absence of state legislation creating a health exchange (a bill to establish the Minnesota Insurance Marketplace as a state-based health insurance exchange failed to pass during the 2012 legislative session), the Department of Commerce had led the state's exchange planning initiative. In October 2011, Governor Mark Dayton issued an executive order directing the Commerce Department to work with the Departments of Health and of Human Services to design and develop the exchange.

On Oct. 31, 2011, the Department of Commerce introduced the Minnesota Health Insurance Exchange Advisory Task Force to guide the design and development of a health insurance exchange. The 15-member task force, appointed by the Commissioner of Commerce, includes representatives of employers, consumers, organized labor, health plans, health care providers, brokers, counties, tribes and four legislators. In addition, the commissioners of Commerce, Human Services and Health serve as ex-officio members.

The task force began meeting regularly in November 2011 and established 10 technical working groups, with roughly 20 members serving on each group. Members include stakeholders, such as small employers, individual consumers, community organizations, health plans, providers, brokers, people serving Medicaid patients, counties, tribes, state agency and legislative staff and content experts. The working groups will continue to make recommendations to the task force this fall.

The health-exchange task force released early recommendations in January 2012.

In January 2012, the task force released a set of recommendations related to governance, financing, adverse selection, and navigators/brokers that included the following recommendations to the governor and the legislature on design of the exchange:

- A board of directors with 15 to 20 members, some appointed and some elected, should govern the exchange. A majority should represent the interests of small businesses and consumers and have expertise in the health care market.

- Health plans both inside and outside the exchange should have the same market rules, certification requirements and regulatory provisions.
- Funding mechanisms should be in place by July 1, 2013. A variety of sources should fund the exchange and the funding should not disproportionately burden one group. The sources should be proportionate to the benefits received by the paying group.
- The Navigator/agent/broker program should support multiple roles. The program should meet the needs of all consumers who need and want assistance, especially those most likely to face enrollment barriers. The program should consider performance-based compensation models.

Todd-Malmlov said recommendations on design and development are coming to the Task Force on a rolling basis. Some recommendations have already been voted on by the Task Force and more will be considered by the Task Force this fall.

Higher minimum-benefit set requirements will raise premiums for individual insurance that will be offset by tax credits for those with incomes below 400% of the federal poverty level.

Under the Affordable Care Act (ACA), most people will be required to have health insurance at least at the "bronze level", which provides payment of 60 percent of total covered expenses. So the "bronze level" insured, on average, would pay 40 percent of the cost of health-care services through things like deductibles and copays. This "bronze level" requirement could be a higher benefit set for some people, which will lead to higher premiums for them, Todd-Malmlov said.

Currently, people who are denied coverage because of preexisting conditions can get coverage through Minnesota's high-risk pool, MCHA (Minnesota Comprehensive Health Association). Their premiums are about 20 to 25 percent higher than average premiums in the individual market.

Todd-Malmlov said that guaranteed issue under the ACA for people with preexisting conditions will also raise average premiums. To offset that, she said, many people will be getting insurance premium tax credits. Because of the credits, on average, people will see a 20 percent reduction in their premiums on the individual side.

The small-group market will not be impacted as much by new minimum benefit levels.

Currently, she said, actuarial value levels for the small-group market are higher than those in the individual market. So the ACA's minimum benefit levels will not impact the small-group market as much as on the individual market side.

Changing market rules under the ACA starting in 2014 will encourage defined contribution in the small group market. That means an employer, instead of providing one benefit plan for their employees, can establish a dollar amount they will give to their employees, who can then pick whatever plan they want. Defined contribution is assumed to reduce costs for the employer and the employees.

Some small employers with 25 employees or less and $50,000 or less average wage can receive federal tax credits through the exchange, so their premiums will go down through the exchange, as well.

Insurance agents and brokers are concerned about coming changes .

In response to a question about the Minnesota Chamber of Commerce's concerns about the exchanges, Todd-Malmlov said she thinks agents and brokers associated with the chamber are nervous "because the market will be changing in a short period of time. It's very expected that people would be nervous about what is coming down the pike," she said. "But even though we're trying to simplify the system, we're going to need agents and brokers and community organizations to help people make decisions. We're working with them to figure out the best way to do that."

She said the nature of the agents' and brokers' concern is what their role will be going into the future, whether their income will change and whether they will lose business. Agents and brokers will still be needed, she said, especially for small-group employers, who "really don't want anything to do with health insurance. They want to run their businesses. They want to help their employees and they want to make sure they're well take care of, but they really don't want to deal with the administrative hassle of health insurance."

The exchange will help employers, but they're going to need people to help them understand how to make that transition. "Brokers, agents, exchange 'navigators' trained to help people use the exchange and community organizations are really going to essentially be our effective sales force to get the word out about the exchange, to bring people there to get them engaged and enrolled," she said.

Minnesota's earlier health exchange went out of business.

Walt McClure pointed out there was an exchange in Minnesota and asked why it went out of business. Todd-Malmlov said in the early 1990s, Minnesota and a lot of states had purchasing pools for small groups. "Most of them died a very sad death," she said.

Small employers participated in the purchasing pool as a group, but participation was voluntary over time, so the healthy groups dropped out. "Each consecutive year, the premiums would go up and up and up," she said. "It's the death spiral issue." The sickest groups stayed and the healthy groups broke off and got better rates.

Some things were put into the ACA specifically to prevent this problem. One is the requirement that risk pools span both inside and outside the exchange for individuals and small groups, so risk is pooled for the entire market. Another is risk adjustment, where money will transfer among the plans based on the risk they actually attract.

"Those two things should be very helpful," she said.

Also helpful is the requirement in the ACA that 80 to 85 percent of the money collected by insurance companies is spent on health care services and health care quality improvement. In other words, medical loss ratios, the amount spent on administrative and overhead costs, cannot exceed 15 to 20 percent.

Todd-Malmlov said that recently, plans around the country with administrative costs above that level had to give rebates, so millions of dollars across the country went back to premium payers. In response to a question, Todd-Malmlov said the administrative costs for insurance in Minnesota are, on average, below 10 percent of the total cost of insurance.

Minnesota enacted important health reform measures in 2008.

In response to a question about cost control, she said that in 2008, Minnesota enacted a variety of different reforms intended to lead to payment reform. The goal of those reforms was to make information available on health care provider outcomes and quality so that payment could be based on the value, not volume, of services provided. This information was also intended to help consumers make good decisions, which would encourage innovation and cost-effective care delivery by health care providers. Minnesota is the only state that started doing that then and so it will be able to fold those reforms into its health exchange.

A questioner asked how cost management is going to account for advancement in medicine and whether it will constrain medical advances. Todd-Malmlov said that in the past Minnesota had a certificate-of-need process to do things like build a new hospital. But in the years of the certificate-of-need process, only a few projects were denied. "The process didn't really work," she said.

A hospital moratorium was then put in place. No new hospitals could be built unless a study was done and the Legislature agreed the hospital should be built. The new Maple Grove hospital, after a long process, was one of the few hospitals built since the moratorium started. The moratorium did not apply to the new children's hospital at the University of Minnesota, because the University had an exception in the moratorium law.

Todd-Malmlov said that in recent years, Minnesota has been trying to take a more market-based tack and develop information to help improve care delivery and help purchasers make more informed health care decisions. With this information, health plans may say, for example, "We're not going to pay for that if it doesn't improve efficiency and value." She also said that the ACA puts more money into cost-effectiveness research on things like drugs and procedures in order to encourage care that is more effective.

Walt McClure commented, "If we begin to pay for outcomes versus costs for providers, then nobody will care what services are provided as long as outcomes keep improving. The biggest improvement in outcomes has nothing to do with technology. Get people to act healthier...and costs will come down for providers. Costs will come down if we pay providers for outcomes, not services. Government won't have to worry about effectiveness research, because health plans will do it themselves."

The time frame for exchanges is very short.

Todd-Malmlov said the timeline is the biggest challenge facing exchanges now, since open enrollment is only a year away. "Many of us are working 80-hour weeks," she said. "There's a lot to do in a short amount of time."

In response to a question about whether any legislation will be required, she said Governor Dayton has stressed that he wants:

- To have a bipartisan solution, whether now or later; and
- To ensure that Minnesota has its own exchange and doesn't give that up to the federal government.

A questioner asked what would happen if the ACA gets repealed or changed. Todd-Malmlov said, "The idea has been there for some time. The need is there. There may be different terminology and changes in the law, but hopefully the principles will go forward."

Even if the law gets off the track for a few years, she said, Minnesota will likely continue to push forward as it always has in an innovative way.

McClure commented, "If we move expeditiously, we will lead. If we don't, other people will make decisions elsewhere, which will get marvelously in our way." He said if people can buy diabetes care from providers based on outcomes, it will cut down the number of diabetics who go comatose or lose legs or go blind. It costs $1,500 a year to keep a diabetic under control, but $20,000 to $30,000 if the disease is not under control.

"If you measure by outcomes versus costs, how are you going to mix the technology?" he said. "It's very different. If I'm paid fee-for-service, I don't care if patients are under control. I make more money when they're out of control."

"The Federal exchange will not be good for us."

In response to a question, Todd-Malmlov said the Federal government is far along in the process of developing their health exchange and it will be ready on time. "The system is very bare bones," she said. "It's one-size-fits-all-the lowest common denominator for all the states-since it must work for all of them."

She cautioned that Minnesota would be worse off if somehow the state isn't ready with its own exchange and has to take part in the Federal exchange. "The Federal exchange will not be good for us," she said. "That is an understatement."

McClure commented that Minnesota is the only state putting a market reform cost-control strategy in place with broadened coverage. Todd-Malmlov agreed and said, "We're trying to merge things that Minnesota has in place in terms of reform with increasing coverage. When the exchanges come online, Minnesota's will look very different. We can put lots of things in that other states don't have."