The following is a discussion between Jon Hager, Executive Director of Nevada's Silver State Health Insurance Exchange, *Nevada Health Link*, and Peter Lee, Executive Director of *Covered California*, California's Health Benefit Exchange. Capital Public Radio's Health Care Reporter Pauline Bartolone asked the questions.

Bartolone: So both of you are leading state-based exchanges under the federal health law as opposed to being part of federally-run exchanges or partnership exchanges. How would you both describe your state's unique way of creating the new health insurance marketplaces in your states? Maybe we can start with Jon.

Hager: We've been implementing now since 2011. Our law was passed in 2011. We're moving forward with a leased solution so we can take advantage of the latest technology. We are outsourcing our call center. Our call center will be setup in Los Vegas, or sorry, in Henderson, Nevada. We are creating our own brand, Nevada Health Link, and you can go to NevadaHealthLink.com to find more information.

I think the most important thing for each state-based exchange is we can provide the proper messaging for our citizens. We know Nevadans; we understand Nevadans; we understand the challenges they face better than anybody else and each state can do that I think better for their citizens. Peter?

Lee: A couple of things. A couple of the big differences structurally is here in California, our legislation that formed us gave us the ability to be what's called an active purchaser which means we will be specifically selecting health plans and excluding some health plans from being in our marketplace. So we went through a process that ended up selecting across the state 13 health plans, and we have a pretty rigorous set of contract standards of those we selected in on what they need to deliver high-quality care for people with chronic illness, preventive care, etc. And that role of active purchaser is somewhat unique around the country.

The other thing I'd note, and again it's not so much a wrong way or a right way but there's ways we can learn from one another in California. Being an active purchaser, we're also standardizing benefits. So across the nation consumers will have new standards for what are called silver/bronze benefits, essential health benefits that everyone will get. California took that a step further and said within bronze, let's not have consumers be confused by having different co-pays, different co-insurance, but instead pick plans based on the difference between the networks. Who are the doctors in Plan A versus Plan B?

And that standardization of benefits is an area where California is not the norm. Three or four other states have done that, but we decided to take what we think is a step that will help consumers make better choices. And finally another difference is, as Jon notes, a lot of states need to decide what do they outsource and have a contractor provide versus what do they do themselves? I totally understand Jon and Nevada's choice to outsource the call center function. Who are the people that are going to answer the phones when people are confused? In California those are going to be our employed at Covered California. So we're in the process of not just building out the facilities, but developing the scripts, the training and hiring a lot of people to answer the phones.

Bartolone: I'm interested in other ways the health insurance marketplace in each state is going to be different. Peter, you had mentioned California has an active purchaser model. It's my understanding that Nevada has a free-market facilitator or clearing house model. I'm wondering if both of you can speak to which exchange do you think may do a better job at making healthcare more affordable and providing higher-quality healthcare and why? John, do you want to start with that?

Hager: You're correct, we did go with a free-market facilitator model. Our thought was that we want to let the insurance carriers figure out what plans they want to offer and let the consumers decide what plans are best for the consumer and let the market shake itself out. I don't know if either market is more or less correct; we simply wanted to let the consumers and the market decide how that works. We think that we've got a good model.

Now keep in mind that our market is completely different. We have a lot of rural areas. We have two major regions as opposed to several large regions. In fact, our major regions are much smaller than California's large regions so they have a different, like I said, set of complications and issues to deal with. So perhaps the active purchaser model in California is more appropriate. We just felt that in Nevada the free-market facilitator model would work best for us.

Lee: And I think that we're all going to see the Affordable Care Act is the biggest change in healthcare since Medicare. We need to learn from one another. We think that actually negotiating on behalf of consumers is the right thing to do, but we're going to learn in the first year. We have, as Jon noted, major metropolitan areas that are much larger than the metropolitan areas in Nevada. Throughout California we'll have anywhere from three to six health plans competing to get individuals enrolled. Those plans are all private plans that are putting their best foot forward, but it's not with differences in benefit design; it's difference in price and difference in networks.

And we think that's going to help consumers understand what their choices are and make better choices for them, but this is something that all of us are committed whether we're in Nevada, California, Oregon or Washington is we need to test to learn and we need to evaluate what works and measure consumers' experience. I think we'll have a much better picture a year from now than we do today.

Bartolone: Now California politically is a blue state; Nevada has a Republican governor. Nevada is one of the states that challenged the federal health law at the Supreme Court. I guess my question would be how politics have factored into the creation of the health insurance marketplaces in your individual states?

Hager: I think in Nevada, having that I don't know if it's schizophrenia if you will, but challenging the ACA and implementing it at the same time has actually benefitted us. It has allowed us to keep on task; it has allowed us to provide the messaging that's appropriate regardless of what political persuasion you feel you fall under. And so it has been challenging last year getting through the Supreme Court decision and getting through the election and making sure all the players are still on-board and moving in the same direction.

But on the other side of that, we have had bi-partisan support. We've had support from the governor; we've had support from the legislature on both sides of the aisle. That has really helped us be able to focus on implementation and not have to deal with potentially negative news articles that come out.

Lee: California, which is a pretty blue state, I'll remind you that when we actually passed the law that established Covered California, that was with a Republican governor and a Democratic legislature. While there's a range of views across the state of California on the Affordable Care Act and some of its elements, one of the things I've been struck by – and this sounds similar to Nevada – is folks across the state who may not have supported the law originally have rolled up their sleeves to implement this and make it work.

Pauline: Now I wanted to hear a little bit more about what are some of the unique characteristics of each state that may pose different challenges in terms of building these new marketplaces? And I wanted to hear from each of you, who do you think has an easier job?

Hager: Who knows who has the easiest job? We each have challenges. In Nevada we have decided to do individual billing for consumers so that creates a whole bunch of challenges that we have to work through. Nothing that is overly taxing. We're going to be ready in October. But that certainly creates challenges.

On the other end, we have a centralized Medicaid system as I spoke about earlier which certainly makes things easier. We only have really two main regions that comprise the state at northern and southern Nevada, and the rural areas I guess is a third area with a very, very low population. So we can focus on various things. That said, with those rural areas come challenges. There are not a whole lot of providers in those rural areas and it's difficult to get plans and carriers willing to participate though we do think we'll have participation there. So that is a challenge. But I think certainly a smaller state makes it much easier to enroll. So I'd rather be in my position than Peter's, but maybe Peter has a different opinion.

Lee: Well I'm happy to be where I am, but I do think that John's right. Nevada's a big state but Nevada is, in terms of its population and number to cover, about the same size as a number of our counties. As Jon noted, we in California have 19 different pricing regions where there's prices different, different plans offered, I think from three to six plans. And the plans, the provider issues, the contracting issues in San Diego are very different than rural Northern California; are very different from Alameda County, Oakland, etc. So we certainly have more diversity, bigger size. With that comes some opportunities.

We have in California over 350,000 Asian and Pacific-Islanders who are eligible for subsidies. That's a lot of people. That's a challenge, but it means we have the opportunity of being able to translate our material into Mandarin, into Cantonese, into Hmong, into Farsi. Those are the sorts of things that size actually gives you some leverage to build capacity that's always going to be harder in a smaller state.

Bartolone: Covered California expects to enroll more than a million folks in the first year. In Nevada, are you guys projecting to enroll a little bit more than 100,000 folks in the first couple years?

Hager: Yeah, so our entire population is 2.7 million. Pretty much Covered California could enroll our entire population it sounds like. Our targeted enrollment is 115,000 so it makes sustainability a little more challenging than it would be in a larger state. We have fixed costs for our staff that have to be absorbed for staff payrolls, for rent, for contracts that have to be absorbed among a smaller group of people. On the other side of that, my staff is only going to be 13 people where I believe Peter's staff is going to be . . . what's your target Peter, 1,100?

Lee: We'll be close to 1,100. And again, some of this is the mix of deciding to have people on-staff to do work that Nevada is choosing to contract out. And so in many ways this is a big difference in model and this is true not just to what Jonis doing in Nevada but what other states are doing. In essence, is the job of the exchange to be a contract and vendor manager or a service provider? And that's one that, again, there's no right or wrong answers. We think hiring the people ourselves, training them, overseeing them is one route to accountability and good customer service but John's track of hire the right vendor and hold them to account is another. Again, the proof will be in the pudding. We're going to be able to test and learn not just within states but across states.

Bartolone: I actually asked this question of Peter about a year ago about what keeps you guys up at night? I imagine that has maybe changed over the past year.

Hager: Well there's a multitude of issues. There are things like making sure that we've got the proper navigators in place to help us enroll people, making sure they're properly trained, trying to look forward and figuring out what the next big newspaper article is going to be. There's a lot of positive press but there's also a lot of negative press. We want to try and make sure we're ahead of that if we can and deal with that appropriately.

Will we have enough enrollment? Will we meet our targets? I know we are not going to get exactly 115,000. I don't know if it will be high or low and I don't know how far off it will be. So over the fall we will be monitoring our enrollment on a daily basis to make sure we know where we're going. What else? There's the IT project itself. Everything we've seen points to us being ready in 99 days from today. There are a number of different issues that could derail and state-based exchange at any time and we all have our change management and risk mitigation procedures in place so we feel like we're pretty well prepared to make sure we hit that October deadline but any number of issues could come up. So the feds could create a regulation that changes something substantially that our workflows don't account for and it could make it difficult for us.

There could be something that comes up, let's say carriers. If the carriers were to get upset and walk away, that could be an issue. While I don't anticipate these things happening, I don't anticipate a major event like that occurring, you never know what could happen.

Bartolone: Anything you want to add Peter?

Lee: Yeah, a couple things. I don't so much look forward to my colleagues as shoulder to cry on as someone to celebrate with. I think we're going to be opening champagne in a few months, and I think the work we're doing here in California, what's happening in Nevada, Oregon, Washington, it's a huge undertaking which is historic. And the thing when I look at challenges is we're now, all of us, embarking on training programs. We're developing the curriculum, the scripts, so people are ready to answer the questions clearly in English or Hmong or Mandarin or Spanish. But answer them clearly in a way that people can understand. I think one of the biggest challenges we'll all have is how to make something which has always been complex, which is health insurance and healthcare coverage, understandable and actionable.