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Exchange -- questions to consider for meeting on Friday, June 18th

These questions are organized to provide some insight and discussion on one of our initial, significant questions – a federal or state administered exchange. They consider operational and some policy issues pertaining to the Act. To date, we have not considered policy issues such as how an exchange should be developed to offer the best customer service at the lowest price, or what type of exchange will lead to offering the highest-quality coverage at the best price.

The supporting document attempts to provide what we know, what we think, or what we do not know. I expect this to be a working draft that changes often with what we as the workgroup come to know, think, and what still remains unknown. Please try to read or glance at it before the meeting.

Primary questions – what do we need to know to get started?

1. **Should the federal or state government administer an exchange in Washington?**
   a. We know that by January 1, 2013, states must have elected to make the required exchange operational and taken the actions necessary by this date to implement an exchange on January 1, 2014, as determined by HHS. § 1321(c)(1)
   b. We know that a state law or regulation can be used by HHS to determine that the Secretary's exchange standards will be implemented. § 1321(b)(2)
   c. We do not think that HHS will be required to approve that a state's exchange complies with the Secretary's standards (general reading of § 1321), but HHS may investigate an exchange and will conduct annual audits of an exchange (§ 1313).
   d. We do not know how HHS might choose to design an exchange for non-electing states or whether there will be flexibility in how HHS administers exchanges in different states. E.g.,
      i. HHS might establish a model framework of standard policies to be implemented in each of these states.
      ii. HHS might choose to set certain policies such as how the exchange will be governed, one exchange for the entire state, no regional exchanges with other states, separate exchanges for individuals and small groups, certify plans, and determine if a Basic Health Option could be administered by the same operational structure of the exchange; and provide options for other policies such as quality rating of plans, how quality

delivery of health care services can be rewarded, or collecting and combining of premium contributions from multiple sources.

e. We do not know how HHS might choose -- or whether there will be flexibility -- to administer an exchange for these states. E.g.,
    i. HHS might administer these exchanges from a central office.
    ii. We think it might be possible for HHS to direct the "State Medicaid agency under title XIX of the Social Security Act" to administer the exchange. § 1311(f)(3)(B)(ii)
    iii. HHS might select one or more contracted entities to administer these exchanges.
f. We do not know if a federal exchange opens Washington State up to additional federal direction on about how we should amend state laws to accommodate a federal exchange or direction on how Washington implements insurance reforms. § 1321(a) and (b) and (c)
g. We think it's possible that HHS will implement – or direct Washington State to implement – transitional reinsurance, risk corridors, and risk adjustment in a standard federal format for all states. § 1341, § 1342, and § 1343

2. Should the service area of the exchange be regional (multi-state or interstate) or subsidiary (geographically distinct area within a state) or statewide?

a. We know that each exchange must cover a geographically distinct area. § 1311(f)(1)(B)
b. We know HHS must approve a "regional or interstate" exchange. § 1311(f)(2)
c. We think an area of a state to join in another state's exchange. For example, southwest Washington, with the approval of Washington State, could make an exchange with Oregon. § 1311(f)(1) and § 1311(f)(2)

3. Will Washington State apply for a "health care choice compact" which allows qualified health plans to be offered in individual markets in more than one state?

a. We know that a health care choice compact cannot be effective until January 1, 2016. § 1333(a)(4)
b. We think this means that individual plans, under a compact, from another state must also be offered through all Washington exchanges. General reading of § 1333, § 1311(b), and § 1304(a)

4. Should the exchange be a market or a purchaser? If a market, then is the exchange prohibited from applying elements of a purchaser?

a. We know that, in general, exchanges are established to "facilitate the purchase of qualified health plans." § 1311(b)(1)(A)

b. We know that SHOP exchanges for small employers are established to assist small employers "facilitating" the enrollment of their employees in qualified health plans "offered in the small group market in the State." § 1311(b)(1)(B)
c. We know that the Basic Health Option directs states to "establish a competitive process for entering into contracts with standard health plans." § 1331(c)(1)
d. We know that in offering multi-state plans, the Office of Personnel Management is relieved of the responsibility to perform competitive bidding (OPM is not precluded from using competitive bidder, however). § 1334(a)(1)

5. Should there be separate exchanges for individuals and small groups?
   a. Should one administrative structure be used to operate separate exchanges for individuals and small groups?
   b. Should one exchange serve a merged risk pool offering the same qualified health plans to individuals and small groups?
   c. Should the small group exchange serve employers with 1-50 or 1-100 employees before January 1, 2016 when the national definition of 1-100 applies?
   d. How will reinsurance, risk corridors, and risk adjustment be developed and applied to the exchange and private markets?

6. Are direct premium tax credits and cost-sharing reductions only made available to publicly subsidize qualified low-income individuals only enrolled in individual ("nongroup") qualified health plans in the exchange?
   a. We know that the Act provides an exchange with the authority to request advance premium credits for individuals enrolled in qualified health plans in the individual market through the exchange for premium subsidies and cost-sharing reductions. § 1412(a)(1)
   b. In the procedures for determining eligibility for the exchange and premium assistance, discussion of subsidies is not linked with enrollment in the individual market. § 1411(a)(1)
   c. We know that the definition of a "qualified individual" is someone enrolling in a qualified health plan in the *individual market* through the exchange. At this time, we are not sure why there is a focus on enrollment in the individual market. § 1312(f)(1)(A)
   d. We know that the individual market is specifically referred to when the premium assistance amount are discussed under refundable tax credits. § 1401(b)(2)(A)
   e. We know that the individual market is referred to when the reference premium is discussed (second lowest cost silver plan). Of course, this could just be for reference purposes. § 1401(b)(3)(B)

f. We think the Act does not preclude premium assistance and cost-sharing reductions for eligible, low-income individuals enrolled in small group SHOP plans. If that's the case, then regulations on SHOP coverage will need to clarify considerable details on subsidies and the role of employers and employees to allow for administration of a three-share (employer, employee, and public premium contributions) program or employer defined contribution program. A defined contribution program that allows employees to choose any plan in the exchange has the potential to be more administratively complex than a three-share program. This is because premium assistance and cost-sharing reductions would likely be coordinated over more plans.

7. Can qualified low-income individuals receive tax credits when enrolled outside an exchange?

a. We do not know if the reconciliation process for premium tax credits implies that a qualified low-income individual can file to receive an annual tax credit when enrolled in a qualified health plan outside of the exchange? § 1411(f)
b. If so, we did not find where the exchange is directed to provide information to these people when they file for tax credits.

8. Should Washington State align its benefit mandates with the essential health services, or to say differently, will this state opt to require additional benefits in its qualified health plans?

a. We know that the state must bear the full cost of low-income subsidies for mandated benefits that exceed the essential service coverage requirements. § 1311(d)(3)(B)
b. We do not know if a federally administered exchange will inhibit or limit a state's ability to add benefits that exceed the essential health services. § 1321
c. How involved might the state want to become in providing input on the development of essential health benefits in § 1302?
d. Will the state want to align the development of qualified health plans with the Medicaid benchmark plan in § 2001?

9. Does Washington State want to determine the small group plans offered through the exchange?

a. We do not know if § 1311(b)(1)(B) means that all qualified health plans in the small group market must be offer through a SHOP exchange.
b. We know that HHS will establish in regulation the criteria for the certification of qualified health plans. § 1311(c)
c. We know that an exchange will implement the procedures for certifying a qualified health plan. § 1311(d)(4)

d. We know that the exchange will take information on the justification of premium increases before implementation of the increase, "excessive or unjustified premium increases," and "excess premium growth outside the exchange" into "consideration when determining whether to make such health plan available through the exchange." We think this implies that the exchange can exclude individual and small group plans in the certification procedure it establishes, i.e., will not be obligated to offer all individual and small group plans in their respective markets. § 1311(e)(2)

10. Will an exchange cover and serve distinct markets and programs?

a. We know that an exchange is directed to inform applicants of the eligibility requirements for Medicaid, CHIP, and applicable state and local programs (we presume this to include state and local programs that cover low-income individuals), and through the exchange screening the application, "enrolls" such individuals in any of those programs. This subsection does not state that individuals eligible for Medicaid/CHIP cannot enroll in a qualified health plan in an exchange. § 1311(d)(4)(F) and § 1413(a), § 1413(c).
    i. We did not find direction in the definitions of qualified health plan (§ 1301(a)), qualified individuals or qualified employer (§ 1312(f)) that excludes the enrollment of people eligible for Medicaid/CHIP.
b. We do know that multi-state plans and CO-OP plans will be qualified health plans offered through an exchange. § 1301(a)(2)
    i. We know the act allows issuers to offer CO-OP plans in the individual and small group markets. We think this means that CO-OP plans can be certified and selected to be offered in an exchange. (More information is needed about how much selection authority a governing body for an exchange will have.) Since they are qualified health plans, we think CO-OP plans will be rated in the same risk pool as other individual and small group plans. § 1322(a)(2)
    ii. Although we think CO-OP qualified health plans can be offered in the exchange, the subsection does not specify (as is done for multi-state qualified health plans) that tax credits can be used in CO-OP plan and we did not find any direction that these enrollees cannot be eligible for, or enrolled in, Medicaid/CHIP. § 1322
    iii. We know that each exchange will offer at least two multi-state qualified health plans for individual coverage, or in the case of small employers, group coverage. We know that multi-state qualified health plans will be deemed as certified for an exchange. § 1334(a)(1) and § 1334(d)
    iv. We know that multi-state qualified health plans "shall be treated as a separate risk pool" apart from FEHBP enrollees. We think this

means that issuers will offer and rate multi-state qualified health plans from its own risk pool and not the risk pools for individual or small group coverage. § 1334(e)(5)

v. Individuals enrolled in multi-state qualified health plans can be eligible for public credits. However, we did not find any direction that these enrollees cannot be eligible for, or enrolled in, Medicaid/CHIP. § 1334(c)(3)

c. We know that an eligible individual for the Basic Health Option has household income that exceeds 133% and does not exceed 200% of the poverty line and "is not eligible to enroll in the state's Medicaid program under title XIX of the Social Security Act." § 1331(e)(1)(A)

11. Does Washington State want to ensure that associations have an opportunity to facilitate the purchase of qualified health plans for individuals or small employers through the exchange?

a. We do not know: we have not found direction in the Act on how an exchange should treat health plans that cover associations or member-governed groups. Some help might be provided by the definitions of individual and group markets in § 1304.

12. How will the Washington State exchange interface and coordinate programs and markets?

a. Basic Health Option is "in lieu" of coverage through an exchange, but can Basic Health be administered by the same operational structure, and if not, how will Basic Health and the Exchange coordinate? § 1331

b. We know that eligibility of low-income subsidies can be performed by the state's Medicaid agency. § 1413(d)(2)(A) Along with the coordination suggested in § 1311(d)(4)(F), we think this could be interpreted that a state could form a single agency for eligibility or eligibility and enrollment for low-income coverage programs.

c. How will exchange operationally provide information to individuals and Dept of Treasury on the amount of premium credits for tax returns? § 1311(d)(4)(G)

d. The exchange grants certification to individuals that the individual mandate does not apply to them, i.e., they are exempt from the penalty imposed on those who are determined to be able to purchase coverage. § 1311(d)(4)(H)

e. The exchange must report to the Treasury the name and taxpayer identification of those individuals exempt from the individual mandate and communicate whether an employer did not provide minimum essential coverage or coverage of minimum actuarial value. § 1311(d)(4)(I)

f. Will the exchange need to pay the subsidies for any additional benefits that might be added to the essential health benefits?
g. How will the exchange coordinate with the private individual and small group markets?
h. Free choice vouchers: the exchange will need to receive payments from applicable employers and credit those amounts against the employee's premium in the exchange. § 10108 following § 1515
i. Although not specified in the Act, exchanges will likely need to coordinate with other exchanges.

I don't think we'll have to time to discuss the questions and topics below on June 18th. They are listed here so we won't lose them. – MA

Next – what questions will soon arise

1. How will the exchange verify legal presence in the state and can this task be part of income calculation/documentation?

2. How will the operations be self-sustaining beginning January 1, 2015?

3. Who will establish and operate the "navigator" that carries out many of the education, information, and enrollment processes?
4. How will the navigator coordinate with private producers?

5. How will the exchange verify that qualified health plans have only contracted with hospitals (with for more than 50 beds) that meet safety and effectiveness standards as of January 1, 2015?

6. When and how will the exchange implement market-based incentives that reward quality?
7. How will the exchange assign a rating based on relative quality and price to each qualified health benefits plan?

8. How will the exchange operationally provide toll-free consumer assistance services and a website to provide standardized comparative information on qualified health plans?
9. How will the exchange provide information to employers on employees who cease coverage in a qualified health plan?
10. Will there be annual open enrollment provisions for exchange plans?

11. How will the exchange and/or health plans ensure that low-income member's point-of-service cost-sharing does not exceed federal limits? (Confirm if this is a requirement….)

12. Will the exchange have the latitude to direct health insurance issuers to offer qualified health plans in more levels than silver and gold (as required by the Act), and if so, should Washington's exchange have any need to require health insurance issuers to offer plans in more than those levels?
13. Will the Governor or Legislature elect to prohibit coverage of abortion services in qualified health plans consistent with state laws?
14. How will HHS, health insurance issuers, and the exchange operationally reduce the cost-sharing of silver plan individuals with household income that exceeds 100% but does not exceed 400% FPL? HHS can make "capitated payments" to carry out cost-sharing reductions and will those be made through the exchange, directly to the issuers?
15. What would be the impact on the exchanges ability to pool risk if Washington adopts the BH option to cover low-income persons between 133% and 200% of FPL?

Insurance Market Analysis: What do we need to know in order to answer the policy questions related to the insurance market and establishment of the exchange(s)?

1. What is the current status of our insurance market?
   Individual, small group, large group, Association Health Plan, uninsured
   Analyze: Market concentration, enrollees in each, average premiums, range of benefit plans, market share by carrier in each.
2. What trends are we seeing over the past 5 years, 3 years, 2 years?
3. What are the potential causes of any significant changes in status or standing? For example, what incentives might cause employers to self-fund?
4. What are the potential impacts of our small group definition changing in advance of the 2014 date?
   - Who decides to go to the small group market instead of the individual market?
   - What market impact will that have?
5. What kinds of policies do we anticipate seeing in each of these markets between now and 2014? How will PPACA immediate insurance reforms impact that scenario? What will be the cost impact of offering qualified health plans?
6. It is believed the growth of the AHP market has destabilized the small group market. What is the trend for AHP between now and 2014, and what will the definition of "grandfathered plan" mean to AHPs and subsequently the small group market?
7. What impact on the individual market will the Washington Health Plan make? Will it draw out a considerable number of lower risk enrollees, leaving the individual market with more expensive folks?
8. What does the risk pool currently look like in the individual, small group and large group markets, and among the uninsured in our state? What benefit could

be gleaned if the individual and small groups were combined pools? What would the impact be in the near future, what would it be as time goes on?

Do we need to understand the status of our self insured market to make these decisions?