Draft - Questions for Development of an Exchange

Initial Policy and Operational Questions

Questions	Background / Considerations
1. Should Washington State have a federal or state governed exchange?	a. 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. A state law or regulation can be used by HHS to determine that the Secretary's exchange standards will be implemented - leaving legislative sessions in 2011and 2012 available for legislative policy development on an exchange. § 1321(b)(2) c. It is unknown how HHS might choose to design an exchange for non-electing states. E.g., i. HHS might establish a model framework of standard policies to be implemented, with some latitude, state by state. 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, certification of plans, and determine if a Basic Health Option could be administered by the same operational structure as 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 premium contributions from multiple sources. d. It is unknown how HHS might choose to administer an exchange for non-electing 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. If implementation of an exchange is left to the federal government, we are unsure if the federal government can then delegate implementation tasks to the state such as directing the State Medicaid agency to administer all or key portions of an exchange. § 1311(f)(3)(B)(ii) iii. HHS might select one or more contracted entities to administer these exchanges. § 1311(f)(3) e. Does a federal exchange open Washington State up to additional federal direction about how state laws should be amended to accommodate a federal exchange or direction on how Washington implement insurance reforms? § 1321(a) and (b) and (c). f. Open enrollment periods will be established by HHS. It is unclear how much discretion states might receive to design open enrollment periods that address their potential concerns about adverse selection or other issues. § 1311(c)(6). g. It is possible that HHS will implement – or direct Washington State to implement –risk adjustment and transitional reinsurance in a standard federal format for all states. § 1343 and § 1341. The federal government will establish and administer a temporary risk corridors program. § 1342.
2. What should be the purpose of an exchange and what does it need to achieve?	What is the purpose for an exchange and what should it achieve, especially in terms of access to coverage and any potential impact on the efficient delivery of high-quality health care services. In general, exchanges are established to "facilitate the purchase of qualified health plans." § 1311(b)(1)(A)

	Exchanges must also implement market-based incentives that reward quality § 1311(g) and assign a rating based on relative quality and price to each qualified health benefits plan? § 1311(c)(3) SHOP exchanges for small employers are established to assist small employers by "facilitating" the enrollment of their employees in qualified health plans "offered in the small group market in the State." § 1311(b)(1)(B) The Basic Health Option if chosen directs states to "establish a competitive process for entering into contracts with standard health plans." § 1331(c)(1) In offering multi-state plans, the Office of Personnel Management is relieved of the responsibility to perform competitive bidding under the format prescribed for federal employees health coverage (OPM is not precluded from using competitive bidding, however). § 1334(a)(1) An exchange can set distinct rating areas within the area it serves. Who will set those rating areas, and if it's the exchange, might it need to coordinate with other agencies? § 1301(a)(4) and § 1311(f)(2)
3. How will Washington State choose to administer an exchange?	a. A state initiated exchange could be administered by the state Medicaid agency, other state agency, a public-private partnership, or some variation of these. § 1311(b)(1) b. States are provided with flexibility to determine which functions of the exchange should be handled in-house and which by contract with a non-carrier private entity or the state Medicaid agency. § 1311(f)(3).
4. What governance structure will be attached to the administration?	a. A governance board or alternative structure may balance concerns with the administrative model, e.g., if a public-private entity is developed a governing board membership can represent different perspectives and assure some public accountability
5. Should there be separate exchanges for individuals and small groups? Should there be separate risk pools?	a. Should one administrative structure be used to operate separate exchanges for individuals and small groups? Then, one exchange would administer two risk pools. b. Should one exchange serve a merged risk pool offering the same qualified health plans to individuals and small groups? Then, one exchange would administer one risk pool that merges individuals and small groups. i. Even in a merged risk pool, catastrophic plans can only be offered to individuals. § 1302(e) ii. Will the private market for grandfathered plans and plans offered outside the exchange also need to merge individual and small group risk pools if those risk pools are merged in the exchange? 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 current private markets? Transitional reinsurance program: each state will establish and administer, under the guidance of federal standards, a transitional reinsurance program from 2014-16 in the individual market for both qualified health

	plans and new plans (excludes grandfather plans) offered in the exchange and the current private market. § 1341 Transitional risk corridors for the individual and small group markets: HHS, not the state, will establish and administer a "payment adjustment system" based on "risk corridors" for the individual and small group markets. Qualified health plans in the individual and small group markets offered through the exchange or the current private insurance market are required to participate in 2014-16. The subsection does not specify that the payment adjustment system must apply to a merged market or separately to each market. § 1342 Risk adjustment for individual and small group markets: Each state will establish and administer, under the guidance of federal standards, a mandatory risk adjustment program for qualified and new health plans (excludes grandfather plans) offered in the individual and small group markets, which includes plans offered in the private insurance markets and through the exchange. Self-funded plans are specifically excluded. This program is not transitional and the subsection does not specify whether the risk adjustment program must apply to a merged market or separately to each market. § 1343
6. Should an exchange be regional, multi-state or interstate? **7. Should service areas have a geographically distinct area within a state or be statewide?**	b. Each exchange must cover a geographically distinct area. § 1311(f)(1)(B) c. HHS must approve a "regional or interstate" exchange. § 1311(f)(2) d. An area of a state could potentially 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) e. A regional exchange might be a feasible option to transition to sometime in the future. f. A multi-state exchange is sufficiently complex, with layers of responsibility and decision making, that it likely cannot be developed by 2014.
6. How will an exchange certify qualified health plans?	An exchange will implement the procedures for certifying a qualified health plan. § 1311(d)(4) HHS will establish in regulation the criteria for the certification of qualified health plans. § 1311(c) It is unclear if § 1311(b)(1)(B) means that all qualified health plans in the small group market must be offered through a SHOP exchange. In certifying qualified health plans in an exchange, an exchange is directed to make plans available that are in the "interest" of qualified individuals and employers. We believe regulations or the eventual governing entity of the exchange could clarify how an exchange should interpret that "interest." § 1311(e)(1)(B). 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." This implies that the exchange can establish certification procedures that allow for excluding individual and small group plans, i.e., will not be obligated to offer all individual and small group plans in their respective markets. So, is it possible exchanges can selectively certify plans but cannot negotiate or set premiums. § 1311(e)(1) and § 1311(e)(2)

	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? § 1301(a)(1)(C)(ii) 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? § 1402 What would be the impact on an exchange's ability to pool risk if Washington adopts the Basic Health Option to cover low-income persons between 133% and 200% of FPL? § 1331
7. Are direct premium tax credits and cost-sharing reductions only made available to publicly subsidized qualified low-income individuals enrolled only in individual ("nongroup") qualified health plans in the exchange?	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) In the procedures for determining eligibility for the exchange and premium assistance, the discussion of subsidies is not linked with enrollment in the individual market. § 1411(a)(1) The definition of a "qualified individual" is someone enrolling in a qualified health plan in the *individual market* through the exchange. Some clarity will be needed. § 1312(f)(1)(A) The individual market is specifically referred to when the premium assistance amounts are discussed under refundable tax credits. § 1401(b)(2)(A) The individual market is referred to when the reference premium is discussed (second lowest cost silver plan). § 1401(b)(3)(B) An employer *may* specify the level of a plan and then the employees may choose a plan within that level. § 1312(a)(2) Regulations need to clarify how premium assistance and cost-sharing reductions for eligible, low-income individuals enrolled in small group SHOP plans can be implemented under the Act. Regulations on SHOP coverage will need to clarify considerable details about subsidies and the role of employers and employees if the Act is to allow for the administration of a three-share (employer, employee, and public premium contributions) program or employer defined contribution program for small employers. 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 for each employer.

8. Will an exchange cover and serve distinct markets and programs?	An exchange is directed to inform applicants of the eligibility requirements for Medicaid, CHIP, and applicable state and local programs, and by screening an application, the exchange "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). The definitions of qualified health plan (§ 1301(a)), qualified individuals or qualified employer (§ 1312(f)) do not appear to exclude the enrollment of people eligible for Medicaid/CHIP. Multi-state plans and CO-OP plans will be qualified health plans offered through an exchange. § 1301(a)(2) 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. 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) 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) Multi-state qualified health plans "shall be treated as a separate risk pool" apart from FEHBP enrollees. Until regulations provide further clarification, we do not know if multi-state qualified health plans will be pooled in an exchange risk pool or some other risk pool representing the nation, a state, or multi-state risk pool. § 1334(e)(5) 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) 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) What is the impact on the Exchange if the Basic Health Option is chosen
9. How will the Washington State exchange interface and coordinate programs and markets?	Eligibility for 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), this could be interpreted that a state could form a single agency for eligibility or eligibility and enrollment for low-income coverage programs. The Basic Health Option provided in the Act is "in lieu" of coverage through an exchange, but if chosen can Basic Health be administered by the same operational structure, and if not, how will Basic Health and the Exchange coordinate? § 1331 How will an exchange operationally provide information to individuals and Dept of Treasury on the amount of premium credits for tax returns? § 1311(d)(4)(G)

	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) 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) How will the exchange coordinate with the private individual and small group markets? If premiums must be the same inside and outside of the exchange and if rating and pooling regulations are also identical, will consumers see any benefit from being able to purchase health plans outside of the exchange? Does the exchange become the new market for small group and individual policies? § 1301(a)(1)(C)(iii) 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 Although not specified in the Act, exchanges will likely need to coordinate with other exchanges. § 1311
10. Can qualified low-income individuals receive tax credits when enrolled outside an exchange?	A qualified health plan cannot be offered outside of an exchange. § 1311. Directions on premiums for qualified health plans are in § 1401 and people can only receive premium tax credits when enrolled in a qualified health plan, i.e., enrolled in an exchange. Also, see definition of "qualified individual" and "qualified employer" in § 1312(f)(1). The Act states that qualified individuals and qualified employers can purchase "health plans" (the term qualified health plan is not used) outside of an exchange. § 1312(d) but it appears they could not qualify for the tax credit.
11. Should Washington State align its benefit requirements with the essential health services, or opt to require additional benefits in its qualified health plans?	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) It is unknown whether a federally administered exchange will inhibit or limit a state's ability to add benefits that exceed the essential health services. § 1321 Will the state want to align the development of qualified health plans with the Medicaid benchmark plan in § 2001? How will the Governor or Legislature address coverage of abortion services in qualified health plans, consistent with state laws? "Nothing in this act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions…" § 1303(c)(1) Chapter 9.02 RCW contains the state's current public policy on abortion but does not resolve the public policy issue about funding the coverage of abortion services in qualified health plans.

12. 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 an exchange?	It is unclear in the Act 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 or by regulations. This could depend heavily on how long association health plans retain their grandfathered status. E.g., if associations lose their grandfather status relatively quickly, then they might have more interest in purchasing through an exchange. § 1251. Associations are cited in § 1311(i)(2)(B) as an entity that could perform navigator services under a grant from an exchange.
13. 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?	The Acts says a health care choice compact cannot be effective until January 1, 2016. Consequently, any consideration of a choice compact will not likely impact how to implement an exchange in 2014. § 1333(a)(4) Under a compact, it is possible this means that individual plans from another state would have to be offered in all Washington State exchanges. General reading of § 1333, § 1311(b), and § 1304(a)
14. What are some of the key operational issues that remain?	Undocumented individuals cannot be enrolled in an exchange and how will the exchange verify legal presence in the state and can this task be part of the income calculation/documentation process? § 1413 How will the operations be self-sustaining beginning January 1, 2015? § 1311(d)(5) Who will establish and operate the "navigator" that carries out many of the education and information processes for enrollment? § 1311(i) How will the navigator coordinate with private producers? § 1311(i) How will the exchange verify that qualified health plans have only contracted with hospitals (with more than 50 beds) that meet safety and effectiveness standards as of January 1, 2015? How will the exchange operationally provide toll-free consumer assistance services and a website to provide standardized comparative information on qualified health plans? § 1311(d)(4)(B) How will the exchange provide information to employers on employees who cease coverage in a qualified health plan? § 1311(d)(4)(I)(ii) American Indian/Native Americans cannot pay cost-sharing when enrolled in a qualified health plan in an exchange. It's possible that an exchange will need to assure that no cost-sharing is paid by American Indian/Native Americans.

Relevant Dates in the Bill

By January 1, 2014: Established exchange(s) in the state serving individuals and small groups.

- By March 23, 2011: Grants will be available to assist states with establishing exchanges. This grant program will end January 1, 2015.
- By July 1, 2012: HHS will determine the scope and guidelines of an initial open enrollment period for the exchange.
- By January 1, 2013: HHS will determine whether the State can/may implement the exchange.
- By July 1, 2013: HHS will issue regulations for the creation of health care choice compacts (limited purchase across state lines).
- By January 1, 2014: States must have in effect State law(s) that enable the operation of exchanges as described by HHS.
- By January 1, 2014: States must have in effect, according to Federal regulations, a reinsurance program for the individual market.
- By January 1, 2015, the exchange(s) must be self-sustaining.
- After January 1, 2016: A state may choose to enter into a health care choice compact if the state enacts a law authorizing such action.
- Beginning in 2017, states may allow large groups the ability to purchase qualified health plans through the exchange