Facilitated Session with Business Operations and Insurance Market Issues Workgroups

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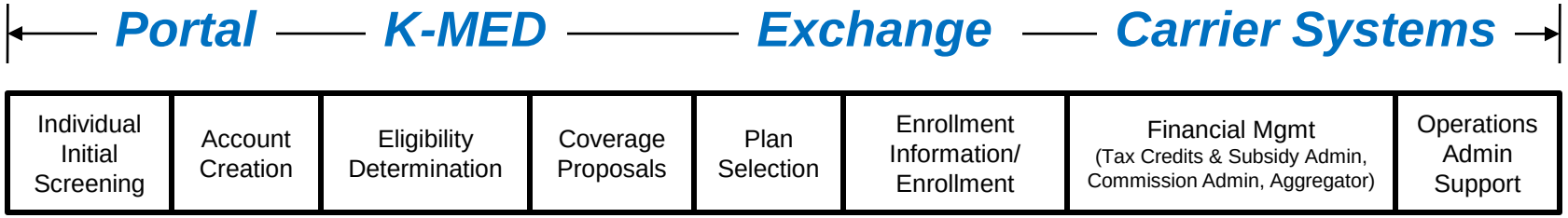
Agenda

- Objectives
- Background
- Framing the Question
- Decomposition of Exchange Functions
- Alternatives and Criteria
- Analysis of Alternatives vs. Criteria

Objectives

#1 What will be the business functions of the Exchange?



For solution design and construction this translates into:

Where are the boundaries between K-MED and the Exchange and the Exchange and carrier systems?

#2 Provide additional information to assist with other decisions

Background

Three key architectural decisions:

1. Where are the boundaries between K-MED and the Exchange and the Exchange and carrier systems?
2. Should there be a single door or multiple doors?
3. What is the state's best option for providing the Exchange functionality?

Architectural decisions are determined by trade-offs between:

- Impact on consumers
- Timeline
- Cost
- Technical feasibility
- Project risk
- Impact on operations
- Impact on stakeholders

Background

What will be the business functions of the Exchange?

The workgroup considered a wide array of issues, including the following:

- Whether to establish a “thin” exchange that performs the minimum requirements under PPACA or a “robust” exchange that performs additional functions.
- What kind of customer service the exchange’s toll-free hotline would perform.
- At what point (or points) in the consumer transaction to transfer responsibility between the exchange and insurance carriers.
- Whether the exchange should use a full, standard application or collect just the bare minimum information to perform its functions.
- Whether the exchange should collect health data during the application process.
- Whether the exchange should perform an “aggregator” function (combining payment streams from consumers and governmental sources) to simplify the billing process for small businesses.

Background

Guiding Principles:

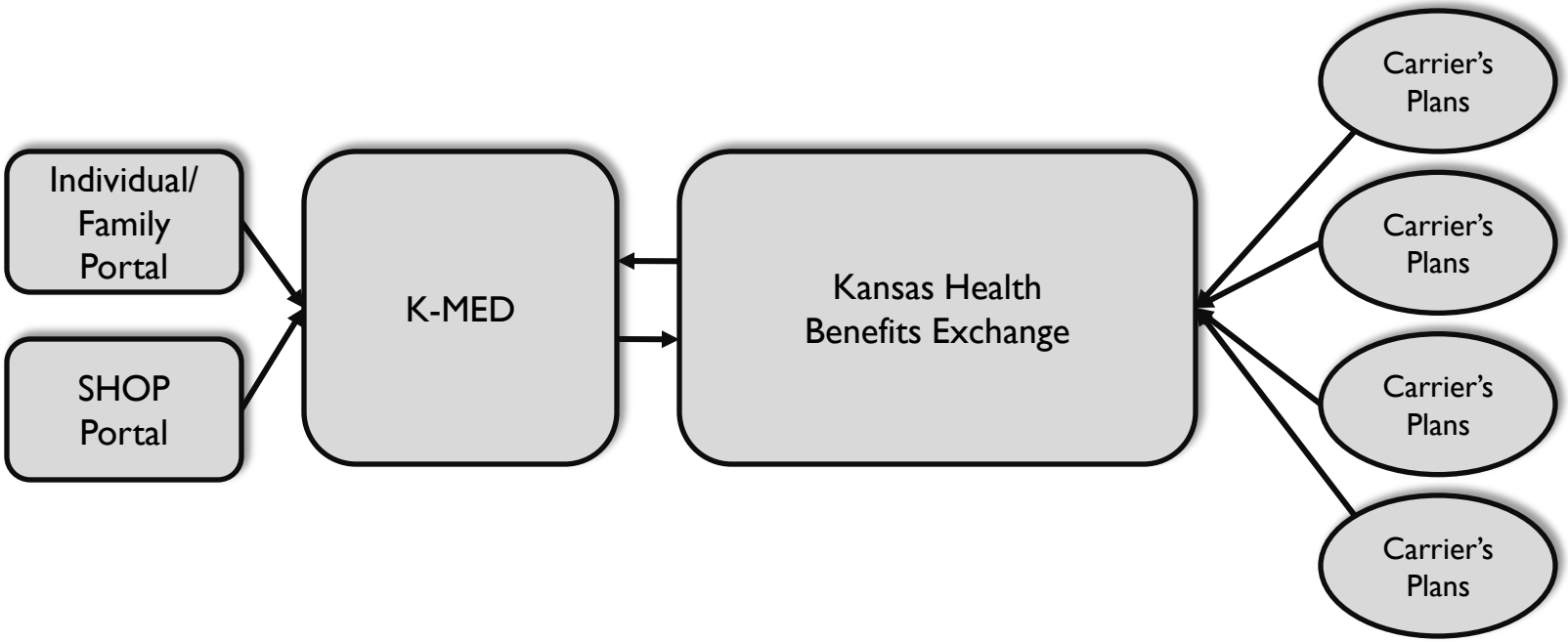
- Working for the best possible outcomes for Kansas consumers, Kansas agents and Kansas companies
- Balancing administrative simplicity, efficiency and effectiveness
- Continuity of care
- Providing user-friendly access to all eligible Kansans and Kansas-based businesses that desire access
- Leveraging and integrating with the K-MED system

The Insurance Market Issus Workgroup added four Guiding Principles:

- Encourage competition in the market whether it is inside or outside the Exchange
- Avoid adverse selection
- Avoid unintended consequences
- Maintain the Kansas Insurance Department as the single regulator

Background

Individual Initial Screening	Account Creation	Eligibility Determination	Coverage Proposals	Plan Selection	Enrollment Information/ Enrollment	Financial Mgmt (Tax Credits & Subsidy Admin, Commission Admin, Aggregator)	Operations Admin Support



For solution design and construction this translates into:

Where are the boundaries between K-MED and the Exchange and the Exchange and carrier systems?

Framing the Question

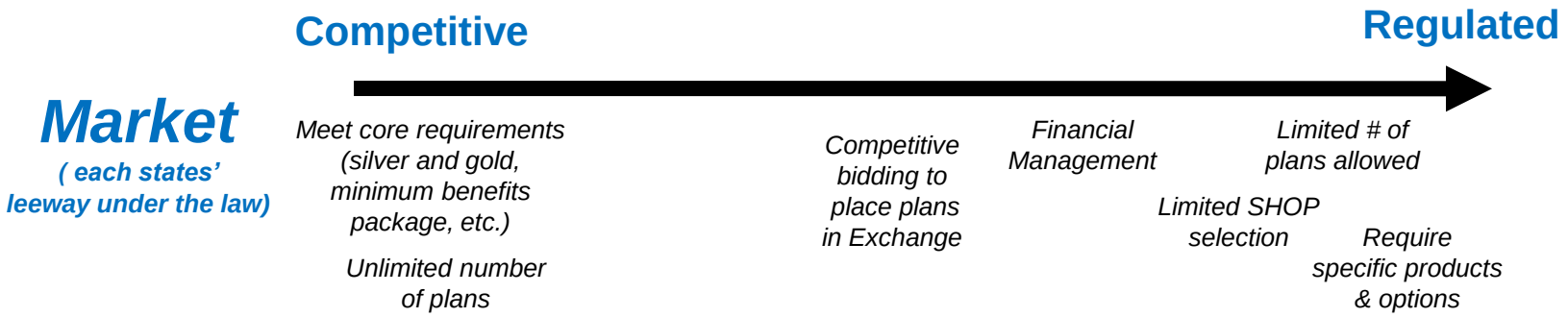
What will be the business functions of the Exchange?

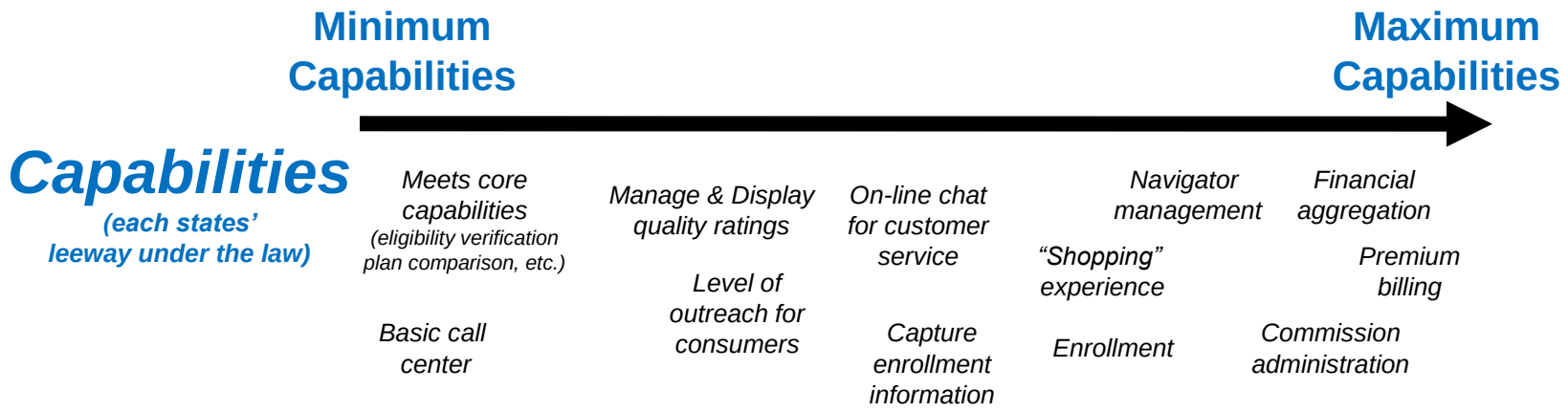
Three interrelated sub-issues will be addressed:

- ✓ **Whether to establish a "thin" exchange that performs the minimum requirements under PPACA or a "robust" exchange that performs additional functions.**
  - What kind of customer service the exchange's toll-free hotline would perform.
- ✓ **At what point (or points) in the consumer transaction to transfer responsibility between the exchange and insurance carriers.**
  - Whether the exchange should use a full, standard application or collect just the bare minimum information to perform its functions.
  - Whether the exchange should collect health data during the application process.
- ✓ **Whether the exchange should perform an "aggregator" function (combining payment streams from consumers and governmental sources) to simplify the billing process for small businesses.**

Framing the Question

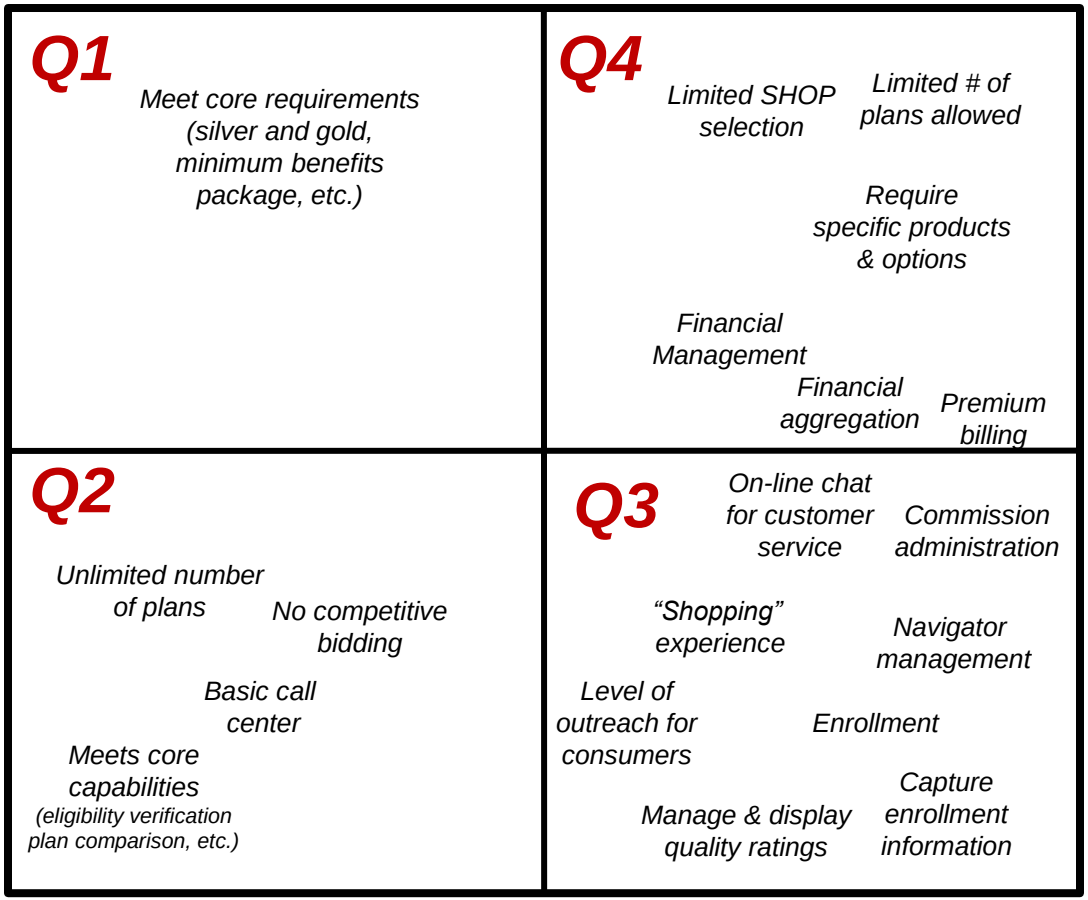
Consider two dimensions:





Framing the Question

Two dimensions create four "models" for the Kansas Exchange



Framing the Question

Four “models” characterized

Regulated

Q1
Purchaser- Oriented Exchange

- Limits carriers through competitive selection process
- Standardized products
- Minimal functions “owned” by Exchange

Q4
Market Curator Exchange

- Limits carriers through competitive selection process
- Selects products w/ customer in mind
- Robust-end-to-end consumer experience and management services including billing

Q2
Information Aggregator Exchange

- Bare minimum capabilities to meet the requirements of PPACA
- Impartial aggregator of carrier plans
- Provides structure to permit plan comparisons
- Accountability of the product or service is left to the agent/broker/ carrier

Q3
Retailer-Oriented Exchange

- Creates retail shopping experience with robust search/shopping capabilities, i.e. “shop-to-enroll”
- Offers broad range of products
- Provides education and outreach

Competitive

Minimum Capabilities — **Maximum Capabilities**

Decomposition of Exchange Functions

#1 What will be the business functions of the Exchange?

Assuming Kansas is moving towards a Q3 Retailer Oriented Exchange model…

Then the business functions of the Exchange that need to be determined are:

- **Left Side** – Coverage proposals, plan selection and collecting enrollment information
- **Right Side** – Financial management

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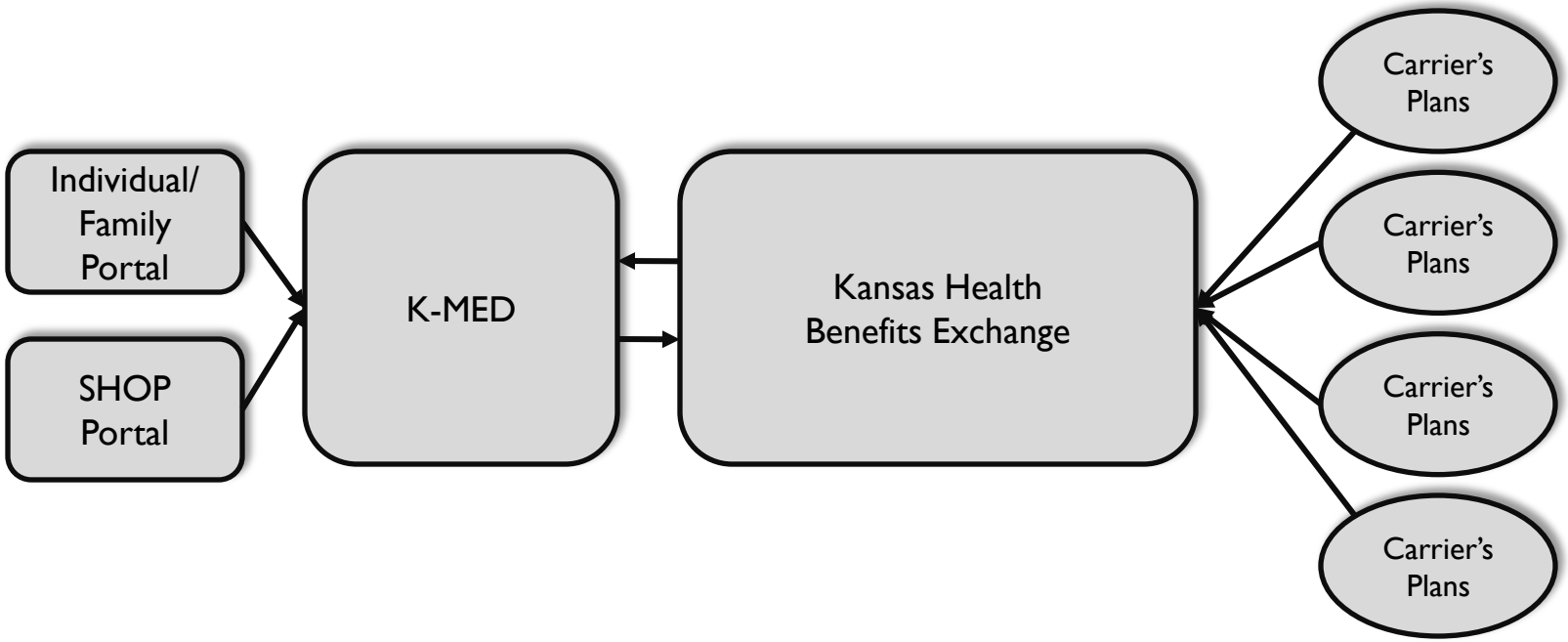


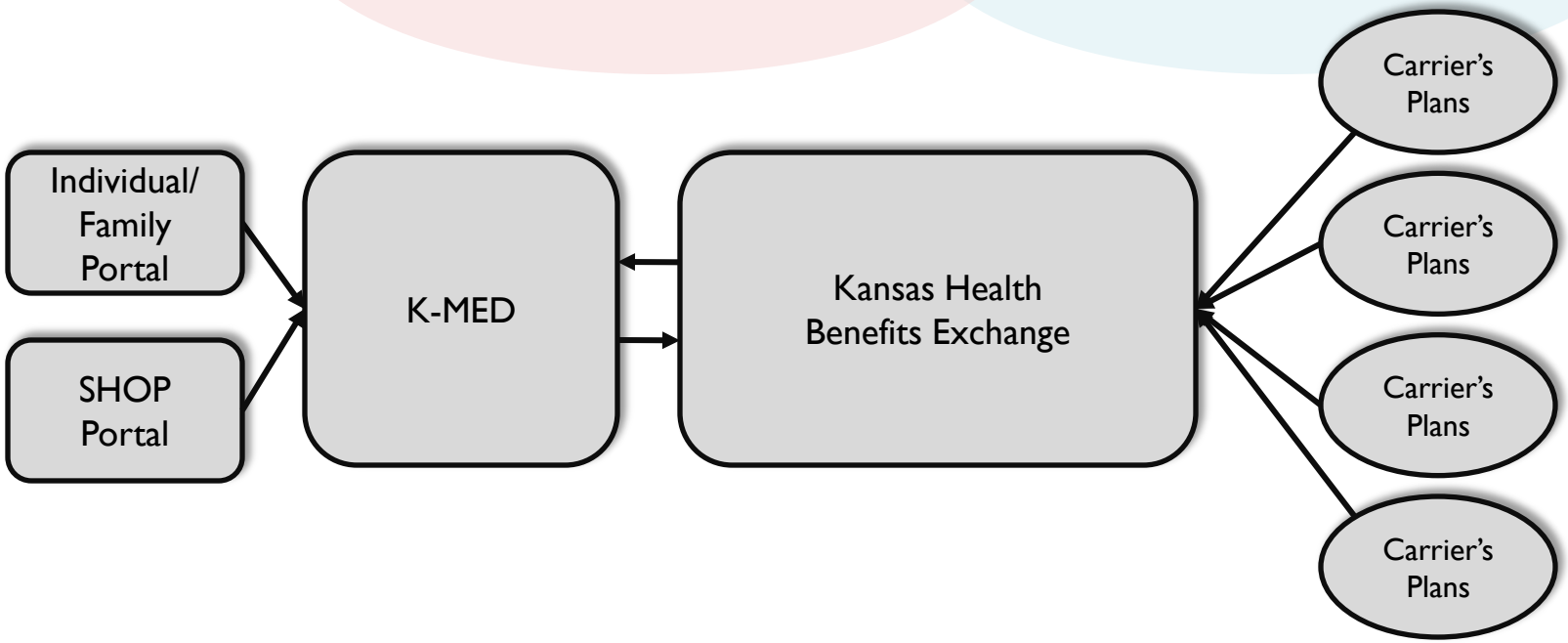
Plan Selection & Enrollment Info
K-MED or Exchange or Both?

Decomposition of Exchange Functions

Coverage proposals, plan selection and collecting enrollment information
K-MED or Exchange or both?

Financial management for subsidies and other transactions, aggregator functions

Individual Initial Screening	Account Creation	Eligibility Determination	Coverage Proposals	Plan Selection	Enrollment Information/ Enrollment	Financial Mgmt (Tax Credits & Subsidy Admin, Commission Admin, Aggregator)	Operations Admin Support

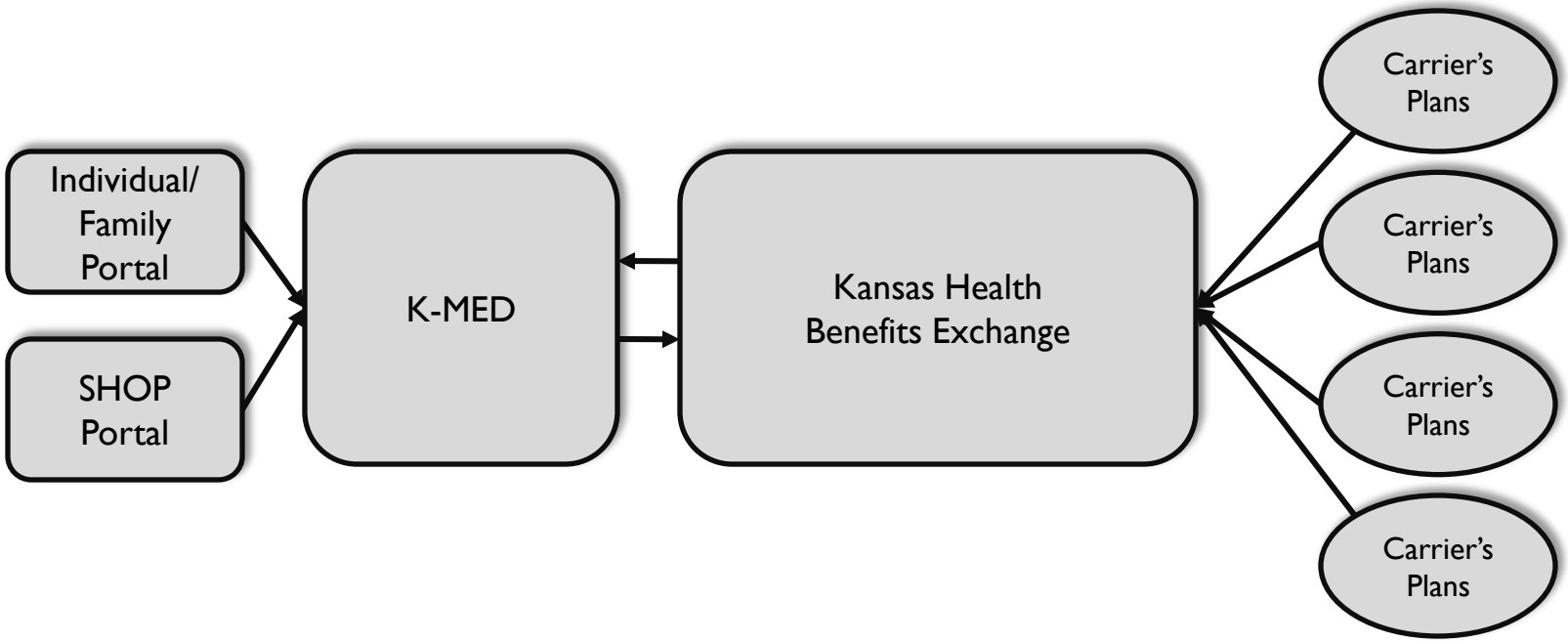


Plan Selection & Enrollment Info K-MED or Exchange or Both?

#1 What will be the business functions of the Exchange?

- By definition, anything requiring aggregation or a function that crosses carriers it belongs in either the Exchange or K-MED
- Anything that needs to be owned/controlled by the State (Medicaid/CHIP eligibility and enrollment) or the future Exchange governing body must be in either the Exchange or K-MED

Individual Initial Screening	Account Creation	Eligibility Determination	Coverage Proposals	Plan Selection	Enrollment Information/ Enrollment	Financial Mgmt (Tax Credits & Subsidy Admin, Commission Admin, Aggregator)	Operations Admin Support



Plan Selection & Enrollment Info K-MED or Exchange or Both?

- Not talking about all the folks who have health coverage from their employer, i.e. 2/3 s of population of Kansas
- Talking mostly about people who are already in Medicaid/CHIP and others who do not currently have health insurance
- For this population the objective is to make eligibility/enrollment quick and easy; large percentage of the population expected to get coverage from more than one source, e.g. CHIP for their children and subsidized coverage for one or more parents

Up to 133% of FPL

460,000 eligible
300,000 enrolled

CHIP
205,000 eligible
40,000 enrolled

133% - 400%of FPL

400 – 700K eligible for subsidies

Alternatives

Medicaid/CHIP (K-MED)

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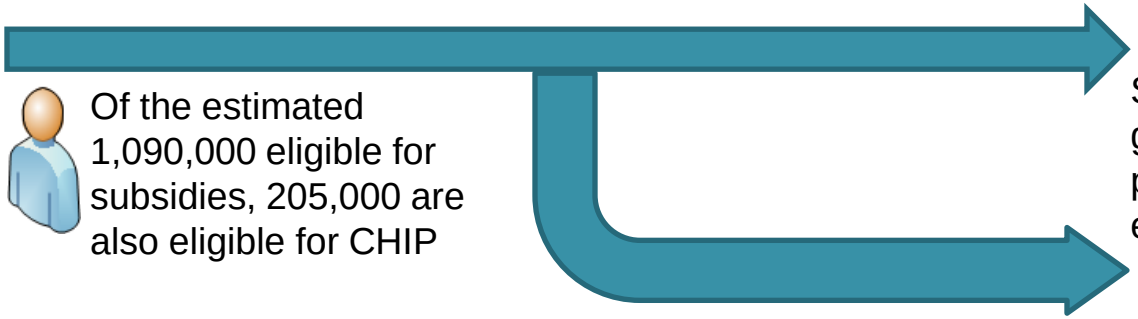

Of the estimated 1,090,000 eligible for subsidies, 205,000 are also eligible for CHIP

Should individual/family go to one or two different places to get family enrolled?

Individual Initial Screening	Account Creation	Eligibility Determination	Coverage Proposals	Plan Selection	Enrollment Information/ Enrollment	Financial Mgmt (Tax Credits & Subsidy Admin, Commission Admin, Aggregator)	Operations Admin Support

Subsidized Private Insurance (Exchange)

Similar functions are required for presenting coverage options, plan selection and collecting enrollment information in K-MED and the Exchange; transparent to the user

Criteria – Trade-offs Used to Evaluate Alternatives

Criteria:

- Impact on consumers
- Timeline
- Cost
- Technical feasibility
- Project risk
- Impact on operations
- Impact on stakeholders

Guiding Principles:

- Working for the best possible outcomes for Kansas consumers, Kansas agents and Kansas companies
- Balancing administrative simplicity, efficiency and effectiveness
- Continuity of care
- Providing user-friendly access to all eligible Kansans and Kansas-based businesses that desire access
- Leveraging and integrating with the K-MED system

The Insurance Market Issus Workgroup added four Guiding Principles:

- Encourage competition in the market whether it is inside or outside the Exchange
- Avoid adverse selection
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Plan Selection & Enrollment Info K-MED or Exchange or Both?

Criteria	Alternatives	
	Combined Eligibility/Plan Shopping in K-MED	Separate Eligibility/Plan Shopping in K-MED and Exchange
Impact on consumers	X	
Timeline	X	
Cost	X	
Technical feasibility	X	
Project risk	X	
Impact on operations	X	
Impact on carriers	?	?
Impact on agents/brokers	?	?
Impact on providers	?	?

X = good

? = uncertain of impact

Plan Selection & Enrollment Info K-MED or Exchange or Both?

If you do not want to split enrollment recommend doing all plan presentation/selection/ enrollment in K-MED for the following reasons:

- All means to ensure continuity of care is in a state-controlled system
- The flow, the “look and feel”, navigation, i.e. user experience can be precisely designed
- Putting as much user facing functionality into one system (K-MED) provides a consistent user experience
- Control provides more flexibility and autonomy should the state elect to forgo a third-party exchange provider in the near-term or in the future
- Putting enrollment for Medicaid in the Exchange may subject the state to an enrollment cost of several dollars per family member per month
- Unsure of reasons not to do this…

Answered the 1st Part of the Question

What will be the business functions of the Exchange?

Three interrelated sub-issues will be addressed:

- ✓ **Whether to establish a "thin" exchange that performs the minimum requirements under PPACA or a "robust" exchange that performs additional functions.**
  - What kind of customer service the exchange's toll-free hotline would perform.
- ✓ **At what point (or points) in the consumer transaction to transfer responsibility between the exchange and insurance carriers.**
  - Whether the exchange should use a full, standard application or collect just the bare minimum information to perform its functions.
  - Whether the exchange should collect health data during the application process.

Whether the exchange should perform an "aggregator" function (combining payment streams from consumers and governmental sources) to simplify the billing process for small businesses.

Should there be an Aggregator Function in the Exchange?

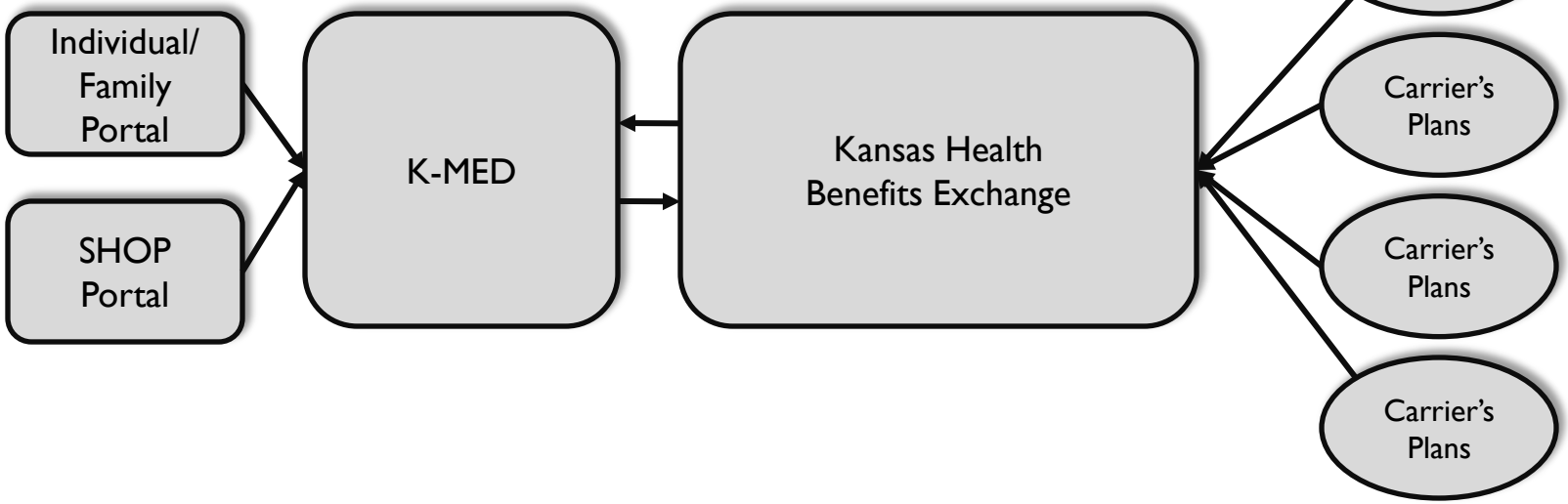
Decomposition of Exchange Functions

By definition, anything requiring aggregation or a function that crosses carriers it belongs in either the Exchange or K-MED

Coverage proposals, plan selection and collecting enrollment information K-MED or Exchange or both?

Financial management for subsidies and other transactions, aggregator functions

Individual Initial Screening	Account Creation	Eligibility Determination	Coverage Proposals	Plan Selection	Enrollment Information/ Enrollment	Financial Mgmt (Tax Credits & Subsidy Admin, Commission Admin, Aggregator)	Operations Admin Support



Should there be an Aggregator Function in the Exchange?

- Benefits: what are they and who benefits?
- Costs: what are they and who pays?
- Exchange vendors who operate exchanges for large and mid-size employers have indicated that:
  - Exchanges decrease acquisition costs for carriers
  - Exchanges decrease administrative costs for carriers

Should there be an Aggregator Function in the Exchange?

Alternatives:

- Include an aggregator function or not?
- Are there other financial management functions that should be discussed?

Criteria – Trade-offs Used to Evaluate Alternatives

Criteria:

- Impact on consumers
- Timeline
- Cost
- Technical feasibility
- Project risk
- Impact on operations
- Impact on stakeholders

Guiding Principles:

- Working for the best possible outcomes for Kansas consumers, Kansas agents and Kansas companies
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Should there be an Aggregator Function in the Exchange?

Benefits and Beneficiaries:

- **Consumers** – could allow employees to apply premiums from different sources to the purchase of a product of their choice; an employee with contributions from multiple employers or a couple with contributions from each spouses' employers can use funds from all available sources to cover a portion of their plan's premium

- **Employers** – would provide SHOP employers one invoice regardless of how many different carriers their employees purchased plans from

- **Carriers** – would provide most of admin functions associated with acquisition, maintenance, billing and reconciliation; would eliminate need to track enrollments by group (only a couple of master groups required; would eliminate the problems inherent in reconciling individual premiums with three partial payments (e.g. employer, employee, subsidy)

Costs:

- Contracting with an Exchange Service provider (eHealth, Choice Administrators, GetInsured.com) may be expensive; plans will be more expensive if aggregation services are required (perhaps $2 - $3 more per person per month)

- Would require uniform and agreed-upon processing timelines, e.g. billing/payment cycles

Should there be an Aggregator Function in the Exchange?

Criteria	Alternatives	
	Aggregator Function in Exchange	No Aggregator Function in Exchange
Impact on consumers	X	
Timeline		X
Cost		X
Technical feasibility		X
Project risk		X
Impact on operations		X
Impact on carriers	?	?
Impact on agents/brokers	?	?
Impact on providers	?	?

X = good

? = uncertain of impact

Answered the 2nd Part of the Question

What will be the business functions of the Exchange?

Three interrelated sub-issues will be addressed:

- ✓ **Whether to establish a "thin" exchange that performs the minimum requirements under PPACA or a "robust" exchange that performs additional functions.**
  - What kind of customer service the exchange's toll-free hotline would perform.
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- ✓ **Whether the exchange should perform an "aggregator" function (combining payment streams from consumers and governmental sources) to simplify the billing process for small businesses.**

High-Level "Parent" Requirements

High-Level Requirements					
Rqmt #	**Requirement**	**Requirement Description**	**M M/F O**	**Source**	**Actual Source**
CUE	**Exchanges must be able to enroll individuals and small businesses (with up to 100 workers) into coverage in a user-friendly way.**			**HHS**	
CUE1	Web Portal	Implement a web portal where consumers and businesses can view coverage options, with benefits and costs presented in a standardized format.	M	HHS	1
CUE2	Hotline	Operate a toll-free hotline for consumer assistance.	M	HHS	1
CUE3	Calculator	Make an online calculator available so that people can see the actual costs of their coverage after accounting for the premium tax credits they may receive;	M	HHS	1
CUE4	Medicaid/CHIP Eligibility Screening	Be able to screen eligibility for, and enroll people in, Medicaid, the Children's Health Insurance Program (CHIP), and other public programs.	M	HHS	1
CUE5	Standardized Enrollment	Use a standardized enrollment form for coverage.	M	HHS	1
CUE6	Enrollment Periods	Provide for an initial enrollment period as well as annual and special enrollment periods.	M	HHS	1
CUE7	Navigators	Establish "navigators"—individuals or entities that help consumers and employers learn about, and enroll in, coverage options.	M	HHS	1
CUE8	Consumer Information	Inform consumers of plan quality and enrollee satisfaction ratings.	M	HHS	1
CUE9	Exemptions	Have the capability to identify, and inform the U.S. Treasury, about consumers who are exempt from the law's individual responsibility requirements.	M	HHS	1
PC	**An exchange must be able to certify that plans sold in the exchange meet a number of standards outlined in the Affordable Care Act.**			**HHS**	
PC1	Essential Benefits	Coverage for a federally determined essential benefits package (as well as any other benefits the state requires) in a plan that has the required out-of-pocket caps;	M	HHS	1
PC2	Plan Offerings	The offering of only specified tiers of coverage: bronze, silver, gold, and platinum. A bronze plan covers 60 percent of medical costs for covered services (excluding premiums) for an average enrollee population; silver covers 70 percent; gold covers 80 percent; and platinum covers 90 percent.2 Any insurer participating in the exchange must offer at least one plan at the silver level and one plan at the gold level. Insurers may also offer "catastrophic" plans for people under 30 and people who are exempt from the individual responsibility requirements (see Section 1302 of the Affordable Care Act).	M	HHS	1
PC3	Number of Network Providers	Availability of an adequate number of providers in the plan's network, including providers that serve predominantly low-income, medically underserved individuals (where applicable).	M	HHS	1
PC4	Marketing Standards	Marketing standards.	M	HHS	1
PC5	Quality and Accreditation	Specified quality, quality improvement, and accreditation standards.	M	HHS	1
PC6	Transparency	Transparency standards, such as disclosure of information on claims denials, plan finances, cost-sharing information, and enrollee rights in plain language.	M	HHS	1
PC7	Preimum Increases	Prior justification of any premium increases (which will be made public, and which exchanges are asked to consider when determining whether to allow an insurer to participate).	M	HHS	1
OR	**Additionally, Exchanes must meet these additonal requirements.**			**HHS**	
OR1	Stakeholder Participation	Consumer and public input: Exchanges must consult with stakeholders, including educated health care consumers, enrollment experts, small business representatives and self-employed individuals, and advocates with experience enrolling hard-to-reach populations.	M	HHS	1
OR2	Transparency	Exchanges must publish specified financial information for public inspection and must undergo annual audits by the Secretary of Health and Human Services.	M	HHS	1
OR3	Financial Stability	Exchange administration must be self-financing by January 1, 2015 (through premiums or other sources). Until 2015, federal grants will be avaialable to help states implement exchanges.	M	HHS	1

Actual Source

1 Implementing Health Insurance Exchanges, A Guide to State Activities and Choices, Familes USA October 2010

Legend	
CUE	Consumer Usability and Enrollment
PC	Plan Certification
OR	Other Requirements

Definitions

Eligibility – the determination if and to what extent an individual meets the criteria for a given category or categories of medical coverage.

In K-MED this is performed by applying business logic to a set of data required data; eligibility will be different depending on the type of coverage, it may include: age, family status, healthcare need, smoking, geographic location.

Enrollment – the assignment of eligible individuals to health care plans that are available to that eligibility category after individual has made a selection (if applicable). Plans may be restricted to eligible beneficiaries based on geography or other criteria.

Enrollment generally includes options to choose a plan, but may also default assignments based geography, 'previous care providers, risk pools, etc.

Functional Overview – TBD

- Portal
  - Preliminary screening (additional rules and subsidy calculator)
  - Account Creation (needed for Exchange consumers, i.e. individual/families and SHOP employees)
  - Master Data Management
- K-MED
  - Eligibility Determination (additional business rules and subsidy calculator) for
  - Coverage proposals (QHP based on eligibility, search and sort capabilities, comparison capabilities)
  - Shopping and Plan selection
  - Collect enrollment information for subsidized coverage
- Exchange
  - Aggregate plan information and transmit to K-MED
  - Transmit enrollment information to Carriers and to K-MED
  - Track financial transactions (TBD)