Assume that the rule in the exchange is to allow each employer to choose whether to (a) place all of its employees with a single carrier, or (b) allow them to choose among all of the carriers within a tier. If this is the rule, should the exchange have an aggregator function? How exactly would the aggregator work? If the aggregator is costly, how should we pay for it?

I believe the Exchange should include an aggregator function. At this point, there are several key reasons for this assertion:

1. It is in consumers' best interest to have a variety of plans available to choose from. The best way for an employer to offer its employees a variety of plans through the Exchange is for the Exchange to serve as an aggregator. Practically speaking, employers will not see the variety of plans on the Exchange as a realistic offering for their employees if they must aggregate subsidy payments with employee payments in order to pay the premiums directly to a variety of insurance carriers. This would create a tremendous workload for small and large businesses' HR departments.
2. It is illogical for the Exchange to calculate the subsidy for each consumer, but not be involved in collecting the subsidies and processing premium payments. Keeping both functions within the Exchange creates a fully transparent process that consumers, employers, and insurance carriers can rely on.
3. One of the work group's on-going concerns is destabilizing the small group market. If small groups are required to serve as their own aggregators, that market is very likely to destabilize. It becomes more and more likely, then, that employers will stop providing employer-sponsored health insurance, which will have an adverse effect on the small group market.

The aggregator function of the Exchange should involve collecting the subsidies from the federal government, billing for and receiving premium payments from both consumers and employers, and then sending an aggregated payment to each carrier each month. The payment should be accompanied by a remittance advice detailing the amount being remitted for each consumer's policy with that carrier. If a consumer (or an employer) fails to make the required monthly payment, the Exchange should refer the case to the appropriate carrier for termination of coverage.

The question of the cost of the aggregator function needs to be included in the larger question of the cost of the Exchange. It makes the most sense to design the Exchange in the way that works the best for consumers and employers. Potential vendors should be asked to bid on the entire package. They can be asked to price each service/aspect of the Exchange separately in order to analyze the rates each vendor will charge for each service/aspect. It is premature to try to analyze the cost of an aggregator function prior to receiving vendor bids. It also is a good way to try to torpedo the concept of an aggregator without considering it in the context of the entire Exchange.

Kansas should consider offering services that are designed to ease the administrative burden of small business employers and carefully evaluate the potential effects of well-intentioned Exchange regulations that could ultimately result in increased prices and destabilization in the small business market. Requiring all employees of an employer within the SHOP Exchange to purchase from within one actuarial level helps to keep costs down by mitigating adverse selection.

There will be numerous funding streams, including federal subsidies, issuer cost-sharing reductions, employer contributions, individual contributions, and state payments for state-mandated benefits (if applicable). Consolidated billing would be especially valuable in the SHOP exchange; a small group's employees may be enrolled in several health plans, and multiple bills would create a significant administrative burden for the employer.

Based on Federal guidance available to date, we believe that an aggregator function should focus on billing consolidation and collection. The Exchange would receive separate billing files from the applicable carriers and pass them along in a consolidated bill to the small business employer. The employer can submit one payment to the Exchange, and the Exchange distributes the appropriate funds to the individual carriers. The Exchange will need to address billing issues, including if a bill is not paid in full due to a disputed amount.

Generally, with respect to the Exchange, we believe that broad-based funding mechanisms are preferred to minimize barriers to participation.

As the Exchange is already operating to offer multiple choices in a consolidated setting, it seems rational to add payment aggregation to its duties. So long as employers have an option to permit individual employee choice even if limited within a single metallic level, the Exchange should have an aggregator function. Consumers should have reasonable choice—at least within a tier of products--so that provider networks are fully available to different employees within a plan and even within a single family.

However, without an aggregator, an employer potentially will have multiple insurance companies with whom they interact for billing. With supplemental coverages such as dental being offered, the aggregator function will make even more sense. The absence of an aggregator would lead to unnecessary administrative costs and annoying accounting complexities for employers which might discourage group plan coverage. The potential for adverse selection which is often the main consideration will be controlled sufficiently by tier movement restrictions and other similar exchange rules and compensated for through the risk adjustment mechanisms.

We must not lose sight, however, that employers purchasing coverage through a SHOP exchange are only <u>one</u> group utilizing the Exchange. Large and or blended families, who might find an economic advantage purchasing plans through multiple carriers, will greatly benefit as a result of the aggregator if their total family premiums could be billed

to them as a unit. Fewer parties to pay will lead to fewer possible errors in payment which could lower administrative costs for all parties.

Aggregator Function and How It Will Be Paid For.
Payment aggregation should have at worst a net-neutral and at best a net-positive effect on the costs of administering employee insurance plans, when the entire health care financing mechanism is considered. The aggregator function of the Exchange will reduce the organizational complexity of a business purchasing multiple plans from multiple carriers including medical and dental carriers. With proper "back of house" organization, this process should be streamlined and straightforward for the operating entity of the Exchange. As administrative costs are being reduced for both the purchasing party and the insurance company, the costs associated with the aggregator function of the Exchange should be split. A formula should be developed calculating the aggregation cost to the purchaser based on the number of different carriers and the number of different plans within the carrier per transaction. This per employee per plan charge should be less than the real costs of processing multiple payments for most small employers with limited technology or accounting capacity.

We do not support the Exchange having an aggregator function.

The individual mandate, guarantee issue coverage, and the significant premium subsidies as provided for under the Affordable Care Act, are all central to attracting consumers to the Exchange. Without these provisions, the viability of the Exchange can become an issue.
The long term viability of the Exchange will depend, in large part, on its ability to deliver affordable health insurance coverage. However, given the current political climate and ongoing litigation (where two of the rulings have found the individual mandate unconstitutional) an element of uncertainty has been introduced which must be taken into consideration.

• **The principal focus of the Exchange should be in providing coverage to individuals – to the underserved and uninsured.**
It will be challenge enough – integrating the delivery of individual coverage through the various public and private issuers – and then to keep the operation financially viable over the long term, given the potential evolution of available funding sources.
As well, polling shows there is broad support to providing affordable coverage to individuals who find themselves uninsurable because of pre-existing medical conditions. There is also broad support with the idea of getting more of the uninsured covered.

• **The Exchange should build on the K-Med platform**
Kansans have been leaders in establishing programs to meet the needs of low income and uninsured individuals. The development of a Health Insurance Exchange, with a focus on delivering individual coverage, will be well positioned to build on, and integrate with, these programs.

• The SHOP / Small Group Exchange should be developed to be minimally invasive to the current structure of the small group health insurance marketplace in the state – increased competition and population risk management should be the drivers.

There are significant changes contemplated under the Affordable Care Act which affect the small group health insurance market – the changes include: medical loss ratio requirements, premium rate regulation, guaranteed issue coverage requirement, and special reinsurance and risk pooling provisions. These changes are massive regulatory intrusions into an already complex marketplace.

Given the complexity of these changes affecting the small group market – their ongoing development and evolution – it does not seem prudent to begin the development of a Small Group Health Insurance Exchange before they are better understood. However, since waiting is not an option – the SHOP / Small Group aspects of the Exchange should be developed within the minimum requirements, as dictated by the ACA.

Relating to the assumption:

> We are in strong support that the State allow "employer choice" (a) above to minimize the need for an extensive aggregator function and the related cost (estimated at $2-$3 PMPM). Without selecting a carrier, small groups are jeopardizing their ability to offer customized benefit plans, such as those including tailored wellness programs, and to effectively monitor outcomes.
>
> The State could require that individuals with access to affordable employer-provided coverage cannot purchase individual coverage either inside the exchange or outside the exchange. In order to proactively monitor the exchange for employer dumping, enrollees should be asked whether they have the option of employer-sponsored coverage, even if they are not seeking subsidies.

Relating to the aggregator function:

> We recommend an "aggregator-lite" model where the aggregator function is limited to a reporting-only model where the minimum necessary data is provided by the Qualified Health Plans to produce a monthly composite statement / summary by household or employer.
>
> Low-cost, paperless solutions should be deployed for distribution / on-line viewing of statements / summaries, notifications, and other communications, whenever possible. Such communications will need to be coordinated with the Qualified Health Plans to avoid duplications, errors, and omissions.

The aggregator should not have any fiscal responsibilities—such as billing, payment processing / allocation, subsidy handling, reconciliation, and collections—in order to keep costs to a minimum.