Kansas Insurance Department
Health Benefit Insurance Exchange
Focus/Business Operations Issues Workgroup

Requested By: Insurance Commissioner Sandy Praeger **Date: Revised April 6, 2011**

Team Purpose

Make recommendations to the Health Benefit Exchange Steering Committee related to the planning and development of a Kansas Health Benefits Insurance Exchange. Specifically this workgroup will be responsible for the focus/business operations issues.

Guiding Principles

Each workgroup will be guided by the following 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

Boundaries/Expectations

- Participants come to the table ready to share their knowledge and perspectives and be open to learning from others in order to achieve the best possible recommendations
- Work from shared data and information which may require effort between meetings
- Present recommendations to the Steering Committee using the format provided
- Strive to reach consensus if possible; when not possible, fairly present majority and minority perspectives

Policy Framework

- For now, small employer will be defined as those with 50 or fewer employees
- The four factors (geography, age, smoking and family status) to set premium rates have already been defined
- Regulation and approval of plans and rates remains with the Kansas Insurance Department
- The NAIC is working on a standard application form and the format for presentation of plans
- Subsidies are available only through the Exchange
- Plans must disclose:
  - Claims payment policies and practices
  - Period financial information
  - Data on enrollment/disenrollment
  - Number of claims denied
  - Rating practices
  - Cost-sharing and payments for out-of-network coverage
  - Enrollee rights under PPACA
  - Other information required by HHS Secretary
- Navigators may be
  Trade, industry, professional associations
  Ranching and farming organizations
  Community and consumer-focused non-profits
  Chambers of commerce

Unions
Licensed agents and brokers

Navigators cannot perform functions that would require a producer's license.

Tasks/Goals requiring Recommendations

Requirements with a 4/1/11 deadline:

IT Integration-related

1. How many Exchanges? (Small group and individual market, KC mini exchange, regional exchanges)

2. **In concert with the Insurance Markets workgroup,** what will be the business functions of the Exchange, i.e. what does state want it to do? For example, will the Exchange perform aggregator functions for small businesses? What exactly would that entail? (Need to define *eligibility* and *enrollment* and the functional line between K-MED, the Exchange and the Provider's system) Does this include enrollment? **Added: Can we say enrollment will be either within the Exchange or K-MED?**

Policy-related

1. Do we want the exchange to perform the aggregator function? Both MA and UT perform an aggregator function by making a single payment to insurers that includes payroll deductions and premium contributions.

Requirements with a 5/1/11 deadline:

The most critical task for this workgroup is to answer the 4/1 question around Functions of the Exchange in concert with Insurance Markets workgroup and present at the April 26, 2011 Steering Committee meeting.

5. In concert with the Insurance Market Workgroup: How will plans be "rated" and by whom? (***This question has been moved to HHS.)***

6. Premium increases will continue to be approved by the Insurance Department. How will premium increases be published, e.g. will notifications to consumers be required? ***(This question has been moved to KID)***

Requirements with a 6/1/11 deadline:

8. What type of demographic data (beyond geography, age, smoking and family status) should be collected in order to perform business analyses, complete enrollment and determine eligibility? ***(need direction from HHS)***

9. What type of health care initiatives (i.e. wellness and prevention) should the Exchange encourage and promote the companies to add as enhancements to their plans? ***(need direction from HHS)***

10. What are the business processes for administering premium credits and cost sharing assistance? (Research on this is currently being pulled together for the team which will be ready in late March.)

11. What is the best way to provide information to an employer re which employees are eligible for tax credit and how much? Who receives the tax credit? (Research on this is currently being pulled together in late March.)

14. How will subsidized consumers transition into Medicare when eligible?

June – July 2011

We suggest joint meetings with Insurance Markets, Agents Brokers/Navigators & Consumer Outreach workgroups during June and July to address:

- *Role of Navigators (include Consumer Outreach for this discussion)*
- *Compensation for agents/brokers*
- *# and type of plans offered*
- *Rating process*
- *Renewals, Enrollment, Disenrollment* ***????***

Requirements with an 8/1/11 deadline:

3. In concert with the Insurance Market Workgroup: How many types of plans (e.g. Bronze, Silver, Gold, Platinum, Basic and Catastrophic) should be offered and how will they be defined? What type of variations such as dental and vision enhancements (Silver and Gold are minimum requirements)?

4. In concert with the Insurance Market Workgroup: Will the State mandate additional benefits beyond the "Essential Benefits" package? Should there be restrictions on the number of plans? Should there be required price concessions or extra benefits and services for plans available in the Exchange?

7. In concert with the Insurance Market Workgroup: Should coverage renew automatically if participant fails to make a new election?

12. How will mandatory reinsurance work such that all group and individual insurers and third party administrators must contribute based upon total market share? What information is needed from the Exchange to support this requirement?

13. Should verification be conducted (use electronic data matching) to re-confirm eligibility and to verify coverage? If so how frequently? (This is also a question for the Medicaid and Interagency Communication workgroup. Guidance from the feds will be important here.)

15. How will the following be tracked: Plans whose claims exceed 103% of premiums (less admin expenses receive payments); plans whose claims are less than 97% of premiums (less admin expenses make payments). Guidance from the feds will be important here.

Other Policy-related Questions

1. Moved to the 4/1 deadline section

2. Process recommendations related to plan qualification, plan bidding, quality rating systems, rate justification and risk adjustment. Address those not addressed in the IT section.

3. In concert with the Insurance Market Issues workgroup, discussion of how agents' commissions are factored into the Exchange, how do we get a commission or fee to them if they sell a policy on the Exchange.

Target Timeline

Early March 2011	Initial Workgroup meeting, work on requirements with 4/1/11 due dates
March 15, 2011, 9am	Attend the Steering Committee meeting for overview information
March 31, 2011, 2pm	Attend and present recommendations to the Steering Committee
April 26, 2011, 2pm	Present recommendations to the Steering Committee
May 24, 2001, 2pm	Present recommendations to the Steering Committee
June 23, 2011, 2pm	Present recommendations to the Steering Committee
July 28, 2011, 2pm	Present recommendations to the Steering Committee

September – October 2011 Attend some of the public input meetings that will be scheduled

Resource Persons

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