How shall plans be rated and by whom?
Assuming that HHS allows states to determine how to develop its own quality rating standards, the Kansas Insurance Department should get input from major underwriters of health insurance policies, and leaders of private business in the state, to assist in the development of these quality rating standards. Subjective information should not be considered in the quality rating matrix. The Kansas Insurance Department, with input from stakeholders, should develop the quality rating standards.

Premium increases will continue to be approved by the Insurance Department. How will premium increases be published – will notifications to consumers be required?
The Kansas Insurance Department and the underwriting carriers should manage notifications and publication of premium increases. As well, the insurance department should provide some contextual data with regard to trends – the cost of health care services in the state. People need to understand the underlying reasoning behind the cost of their insurance coverage and any increases in the premiums. The KID should publish premium increase information on its website (available in written form). Carriers should continue to provide notices of policy changes directly to its policyholders.

Should coverage renew automatically if participant fails to make a new election?
Yes, coverage should automatically renew if a participant fails to make a new election. There should be an "automatic" renewal process, where the issuer provides renewal information to the participant in a timely manner, constant with the Exchange's open enrollment procedures. As long as the participant continues to make premium payments, and does not elect to make a change, the coverage should renew without the participant having to go through another enrollment/application process. If a specific plan option is eliminated, the participant should be offered a similar plan into which the participant will be automatically enrolled, unless the participant makes another election.

What type of demographic data should be collected in order to perform business analyses, complete enrollment and determine eligibility?
The Exchange should only collect the information necessary to determine the eligibility of the proper public, subsidized or private coverage option. Once the proper coverage option (public, subsidized or private) is determined, the additional enrollment information should be collected by the issuer specific to that determination.

The primary question in determining eligibility for public, subsidized, or private coverage is an individual's income. A gatekeeper question can be asked to get the individual's estimated income. If an individual is eligible for public coverage, then the individual should be directed to the proper public coverage option, through K-Med, to complete their enrollment.

If an individual is only eligible for private coverage, then the individual should be provided private plan comparisons, and allowed to choose a qualified plan from those

choices. The individual can then be directed to that selected carrier/plan to complete their enrollment.

If an individual is eligible for subsidized private coverage, then the individual will need to complete additional questions, and an attestation, to verify their income and legal citizenship. With the confirmation of income and citizenship, the individual should be provided with a calculation of their subsidy and plan comparisons. The individual can make a selection and be directed to the selected carrier/plan to complete their enrollment.

For Small Groups, the group contact should be directed to the SHOP webpage. They should be provided with tools to understand available tax credits, a listing of the carriers certified to operate inside the Exchange, a coverage comparison of the available plans, and a tool to estimate premium based on a plan selection. Based on their selection, the Small Group contact should then be directed to the selected plan/carrier to complete the small group application process.

QUESTION: How will plans be rated?
RESPONSE: Certified plans (QHPs) should be rated on the basis of quality, price and consumer satisfaction only.

QUESTION: How will premium increases be published?
Response: Plan enrollees should be notified by the carrier of any premium increase and such increases will be also published by the KID. In addition, the KHBE will note the premium increase on its website in at least two locations: the plan pricing page and in the consumer information "important notices" section.

QUESTION: Should coverage renew automatically if consumer fails to make a new election?
RESPONSE: Coverage should renew automatically if an enrollee fails to make a new selection at the designated time. The renewal should apply to the same plan even if the cost has increased based on a "premium increase notice" being sent to the consumer. If the plan benefits change, renewal should be automatic with the enrollee placed in a plan comparable (benefits and price) to the one being eliminated.

QUESTION: What type of demographic data should be collected in order to perform business analyses, complete enrollment and determine eligibility?
RESPONSE: Demographic data needed to screen applicants or determine eligibility for Medicaid, CHIP or a premium subsidy should include the following:

- Name
- Date of Birth (age)
- Driver's License
- Zip
- Social Security Number
- Confirmation of

Number	Identity
• Income	• Household Status

Once the screening process is completed, consumers would be directed to a portal showing all of the plans available to them based on the information obtained in the screening/application process. When a consumer selects a plan, the enrollment form should be very simple since most of the pertinent information has already been collected during application. Following completion of an enrollment form, the carrier can then request additional information from the enrollee providing submission of such information is strictly voluntary on the part of the consumer.

Carriers should be free to collect data from enrollees not prohibited by the ACA. Enrollees should not be penalized for failure to provide the information requested by carriers. However, the KHBE should post pertinent consumer information provided by carriers including:

- Policies and practices related to paying claims
- Claim history including those paid and denied
- Periodic financial information
- Enrollment and disenrollment numbers
- Rating practices by carriers
- Cost-sharing and payments for out-of-network coverage
- Enrollee rights under the ACA
- Other information as required by HHS (TBD)