



Washington State Health Benefit Exchange Program

Issue Brief #3: Health Benefit Exchange Functions and Responsibilities

As Submitted to the Federal Department of Health and Human Services

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Summary

A state is directed by the Patient Protection and Affordable Care Act (ACA) to establish American Health Benefit Exchanges or the federal Department of Health and Human Services (HHS) will work with states to establish a state-administered Exchange. While the ACA assigns numerous functions and responsibilities to an Exchange, a fair amount of flexibility is left to states to determine how to accomplish these tasks and answer key questions, such as:¹

- What eligibility, enrollment and benefit coordination responsibilities will an Exchange assume?
- What and how will benefit options be offered by an Exchange?
- Whether the Exchange will function as a premium “aggregator” for individuals purchasing through an Exchange?

Background

The ACA provides varying levels of detail for each of the following business functions of an Exchange discussed in this issue brief:

1. Determine and coordinate eligibility
2. Certify and select qualified health plans
3. Establish a website and call center for customer service and select how to aggregate premiums
4. Establish Navigator programs

1. Determine and coordinate eligibility and enrollment

Section 1311(d)(4)(F) of the ACA requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs. The federal government will provide the tools, including a “single, streamlined form,” and financial support for states to achieve this unified enrollment process. After eligibility is determined, an Exchange must also verify

¹ Patient Protection and Affordable Care Act sections 1301-1304, 1311-1313, 1321-1322, 1411-1413

eligibility for premium tax credits for individuals with household incomes between 133% and 400% of the federal poverty level.

Washington State is not new to coordinating eligibility for subsidized coverage among programs for low-income individuals. There are already numerous programs for which subsidized coverage must be coordinated, including Basic Health, CHIP, Medicaid, Washington State Health Insurance Pool (WSHIP), and the newly formed Health Insurance Partnership (HIP). However, the ACA’s vision for an Exchange will require significant enhancements to Washington State’s Information Technology systems in order to achieve the improvements in continuity of care across health programs. Coordination among state-administered health care programs is a necessary first step in maintaining continuous, affordable coverage and continuity of care.

Table 1 summarizes the new eligibility standards for individuals regarding Medicaid, premium credits and out-of-pocket subsidies.

Table 1: Eligibility Standards

Program	Eligibility for Premium and Out-of-pocket Subsidies
New individuals eligible for Medicaid	Minimal premium and out-of-pocket expenses for individuals in households with incomes starting at 0% up to 133% FPL.
Federal basic health option	Premium and out-of-pocket subsidies equal to 95% of the subsidies that would have been provided under the exchange for the same income group for: <ul style="list-style-type: none"> ▪ Families with incomes of more than 133% up to 200% FPL; ▪ Individuals not eligible for minimum essential coverage which includes Medicaid and an “affordable” employer-sponsored plan of “minimum value;”and ▪ Lawful aliens with family incomes from 0% -- 133% FPL and not eligible for Medicaid.
Exchange	Sliding-scale premium subsidies are provided through premium assistance tax credits designed to cap lower-income enrollee premium contributions from 2% --9% of income. Reduced cost-sharing subsidies are used to lower a plan’s out-of-pocket maximum for:

Program	Eligibility for Premium and Out-of-pocket Subsidies
	<ul style="list-style-type: none"> ▪ Families with incomes of more than 200% (or 133%FPL if basic health option not employed) up to 400% FPL. ▪ Individuals not eligible for minimum essential coverage which includes Medicaid and “affordable” employer-sponsored plans. ▪ Lawful aliens from 0% -- 133% FPL and not eligible for Medicaid. <p>Out-of-pocket subsidies provide graduated assistance for families with incomes between 100—400% FPL when enrolled in a silver level individual qualified health plan.</p>

Coordination with federal government

In addition to coordinating coverage among relevant state health programs, the Exchange will also need to coordinate with the federal government on numerous issues related to eligibility. For example, the Exchange is required to inform the Department of Treasury of each employee determined eligible for a premium tax credit subsidy, whose employer is not providing minimum essential, affordable coverage. (Generally, this is when an employee’s premium contribution exceeds 9.5% of household income or the employer-sponsored plan covers less than 60% of benefit costs.) The Exchange must also inform Treasury when an individual, whose employer is not providing minimum essential affordable coverage, has changed employers or the employee has ended coverage in a qualified health plan within the exchange.

The Exchange is also responsible for coordinating with federal agencies in granting exemptions to the individual mandate. This task includes transferring a list of exempted people to the Department of Treasury. The Department of Treasury will, in turn, send an annual notice to each individual who filed a tax return and is not enrolled in minimum essential coverage. That notice will contain information on services and coverage available through that individual’s state Exchange. Each Exchange will need to coordinate with Treasury to produce this notice and prepare for the inquiries.

Each Exchange is also directed to assist the reconciliation process of advanced premium and reduced cost-sharing tax credits by providing information to the taxpayer and Treasury about any health plan provided through an Exchange. In fact, the Exchange will need the ability to provide the Treasury with information about a taxpayer’s Exchange plan, including the level of coverage, premium, all subsidy payments/tax

credits, and any change of circumstances that impact eligibility for subsidies.² The Exchange must inform Treasury when an employee, whose employer is not providing minimum essential affordable coverage, has ended coverage in a qualified health plan within the Exchange.³ The Exchange must also provide that information to the employer.⁴

Coordination with employers

Beginning in 2014, small businesses (25 or fewer full-time equivalent employees) applying for a Small Business Tax Credit will be required to purchase health insurance through the Exchange. An Exchange will likely need to provide information to small businesses to help them apply for the tax credit.⁵

Large employers not offering affordable minimum essential coverage, and who have at least one full-time employee receiving subsidized coverage in a qualified health plan through an Exchange, could be required to pay a “free-rider” penalty, assessed and collected by the Department of Treasury.⁶ The ACA does not direct the Exchange to assist Treasury’s assessment of these large employers. However, if the federal government needs Exchanges to help apply the free-rider assessment (such as determining exemptions), then coordination will be necessary.

Employers of any size, that offer minimum essential coverage, are required to offer free choice vouchers to employees whose premium contributions are between 8%--9.8% of their household income. The voucher represents the amount of the employer’s premium contribution and can be used by the employee to purchase a qualified health plan in an Exchange. The employer is allowed a tax deduction for the amount of the voucher.⁷ The Exchange will likely need to verify the amount of the voucher with Treasury, apply the voucher to the employee’s qualified health plan, and coordinate the receipt of the voucher with the employer.

Key Considerations

Coordination for the “no wrong door concept”

Implementation of eligibility and screening could be streamlined if based upon the same measure of income. Administrative simplification will be enhanced if modified adjusted gross income (MAGI) is used as a standard for income eligibility or screening across an exchange, Medicaid, CHIP, and the federal basic health option. Over the last two

² Section 1401(f)

³ Section 1311(d)(4)(I)

⁴ Section 1311(d)(4)(J)

⁵ Section 1421(b)(1)

⁶ Section 1513(a) and Section 1513(b).

⁷ Section 10108 following Section 1515 in PPACA and HCERA consolidated print.

decades, the Washington State Basic Health plan and Apple Health for Kids have often adjusted their definitions of income to accommodate the variety of ways people earn a living. While many of those adjustments have created equity for certain families, they have also added considerable complexity to the programs. Also, Washington State may be interested in exploring demonstration options, where MAGI could be used as the basis for determining the Federal Medical Assistance Percent (FMAP) claiming rates for both existing and new eligibility groups. Such an option could greatly simplify the coordination and administrative burden between the Exchange, federal basic health option, and Medicaid programs, reducing confusion for individual program enrollees.

Transitions between programs

Transitions between public programs are a necessity as families experience changes in their eligibility. However, to avoid undue movement between Medicaid and the Exchange due to frequent changes in income, Washington State may want to examine the trade-offs between the provision of accurate and equitable public subsidies and the burden of administering frequent changes in family accounts. Seamless transitions can also be enhanced by setting and consistently applying eligibility rules that clarify the populations to be covered by each program.

Continuity of care can be disrupted for families who experience relatively frequent changes in income. It may be worthwhile to examine methods of retaining or transferring enrollees between programs as their income changes, in a manner seamless to enrollees and with minimal disruption to care. For example, if a family's income decreases due to job loss and they transition to Medicaid, but their health plan is not participating in Medicaid, might we consider paying their current premium with Medicaid funds to enhance health outcomes through the continuity of care? Alternatively, Washington State could ensure that all plans participating in the Exchange, also participate in its Medicaid and CHIP programs. However, this could dissuade insurer participation in the Exchange altogether.

2. Certify and select qualified health plans

Exchanges are required to offer only qualified health plans (QHPs) that provide coverage for “essential health benefits.”⁸ QHPs must also be certified by the Exchange, be licensed and in good standing in the state, agree to offer one silver and one gold plan in an Exchange, agree to charge the same premium, both within and outside the Exchange, and comply with other regulations that apply to Exchanges.⁹ QHPs will be made

⁸ Section 1302(b) (1)

⁹ HHS will establish criteria for certifying QHPs including marketing requirements, sufficient provider choice, include essential community providers, be accredited, implement uniform quality improvement strategy, use an uniform enrollment form, use a standard format for presenting options, and provide information on quality standards used to measure plan performance.

available in four levels of coverage based on “actuarial value” (the average percent of medical costs covered by a health plan), with an additional catastrophic policy. The bronze-level plan has to provide benefits equivalent to 60 percent of the actuarial value, with the silver level at 70 percent, the gold level at 80 percent, and the platinum level at 90 percent. Catastrophic policies are only available for persons under age 30, or those who cannot otherwise find affordable coverage or would suffer a hardship in buying other coverage.¹⁰ These benefit levels differ primarily on the amounts of point-of-service cost sharing, with the platinum level requiring, on average, ten percent of the cost of care through co-payments, co-insurance, or other types of cost sharing.

The ACA creates new standards for health plan benefit designs for Medicaid, the federal basic health option, and the Exchange, which are summarized in Table 2.

Table 2: Health Plan Benefits by Program

Program	Health Plan Benefits
Medicaid	Medicaid benchmark benefits <ul style="list-style-type: none"> • The benchmark applies to existing and new Medicaid enrollees based on previous federal standards set for Medicaid programs. • The benchmark benefits must include the essential health benefits. (Medicaid coverage must meet “minimum essential coverage” which is based upon the essential health benefits.)
Federal basic health option	Standard Health Plans <ul style="list-style-type: none"> • Cover at least the essential health benefits. • States encouraged by ACA to offer multiple standard health plans. • Offering insurers must meet Insurance Commissioner’s regulatory requirements.
Exchange	Qualified Health Plans <ul style="list-style-type: none"> • Cover at least the essential health benefits. • Qualified Health Plans must meet Insurance Commissioner’s regulatory requirements.

¹⁰ Section 1302(e)

Key Considerations

Market organizer or active/selective purchaser

Washington State will need to address where its Exchange will reside on the spectrum between “market organizer,” offering all insurance products that meet some established threshold, and “active or selective purchaser.” By being more selective, an Exchange can set additional standards for qualified health plans to meet and/or an Exchange can choose plans based on the comparative “value” they offer to consumers.

It is possible for an Exchange to go even further, and be an “active purchaser”, where an Exchange would “negotiate” health plan premiums with insurers.^{11, 12} However, it is challenging to envision how an Exchange could initially function as an active purchaser with the number of rating and risk management issues that must be addressed before an Exchange can be implemented by January 1, 2014. This could also prove difficult to manage if products offered in an Exchange market are also offered outside the Exchange, since prices are required to be the same for insurers offering products both in and outside an Exchange.¹³ It might be more feasible for an Exchange to evolve into an active purchaser.

The Massachusetts and Utah models illustrate different approaches along this spectrum. In Massachusetts, the Connector uses a selective contracting process for its Commonwealth Choice product (plans offered to non-subsidized individuals and businesses) with insurers bidding for a spot on the Exchange. Prices are not “negotiated” under Commonwealth Choice, however, it uses an active purchaser model for its subsidized product “Commonwealth Care.” Importantly, subsidized products are not offered outside the Exchange, and two of the Commonwealth Care plans have no non-subsidized lives. The Utah Exchange uses the distribution channel approach, whereby criteria are set and all plans (who want to) can participate.

Benefit choice

A related question is how many health benefit choices will Washington State offer in its Exchange? Washington State will need to consider not only the number of insurers who will be participating, but also whether insurers should be restricted to offer a certain number of plans in the Exchange (including within a level), and also whether they should be required to offer plans in each benefit level. Choice among health plans is a value Exchanges are designed to encourage and provide to consumers, but some have

¹¹ Carey, Robert, Health Insurance Exchanges: Key issues for State Implementation, AcademyHealth, State Coverage Initiatives, September 2010.

¹² Jost, Timothy, Health Insurance Exchanges And the Affordable Care Act: Key Policy Issues, The Commonwealth Fund, July 2010.

¹³ Section 1301(a)(1)(C)(iii)

proposed that too much choice can be confusing for consumers¹⁴. If a lot of choice is provided, consumers may need more robust electronic tools to make the process easier for them to manage. Similar to popular airline travel search engines, where consumers are asked to specify certain criteria (non-stop flights, particular insurer, etc), consumers could be asked questions relating to health plan features important to them. In this way, Exchanges may be able to avoid limiting product choice - at least until they learn more about what consumers actually want and what insurers should compete over.

In the Massachusetts Connector, each participating Commonwealth Choice insurer is allowed to offer seven plans -- three bronze, three silver, and one gold plan. After some input from consumers (through focus groups), the Connector Board felt that this level of choice was sufficient for most consumers. Utah does not limit insurers to a particular number of plans.

Benefits exceeding the “minimum essential benefits”

An important issue to consider is whether Washington State will continue to require mandated benefits that exceed those determined by HHS to be “minimum essential benefits.” The ACA allows states to do this but the cost of those additional benefits (for subsidized individuals) must be covered with state-only dollars. In addition to the cost of these benefits, there is an additional challenge of the administrative complexity this would add to an Exchange. Washington State would need to enumerate the costs of these benefits and then pay insurers separately for these benefits. The federal government will be responsible for paying insurers directly for individuals eligible for premium tax credits.

Once HHS releases the list of benefits to be included in the definition of “minimum essential benefits,” Washington State will be able to conduct an analysis of adding all or some of the benefits not included. Washington State may want to analyze the costs of the state’s mandated benefits in 2011, in preparation for this analysis. The Health Care Authority has alerted HHS about the timeliness of these regulations, as budget deliberations by our Legislature will likely be necessary.

A related question is whether plans offered through an Exchange will be required to meet any additional criteria. HHS will further specify, through regulation, criteria for QHPs. Washington State will then need to carefully review these criteria and determine whether any additional requirements are desired of plans to align with the goals and objectives put forth for its Exchange.

¹⁴ Jost, Timothy; Health Insurance Exchanges and The Affordable Care Act: Key policy Issues. The Commonwealth Fund, July 2010.

Standardization

The question of how much standardization Exchanges should require of plans is a difficult question to consider. The ACA only requires that plans be organized into the categories of coverage based upon minimal variation in actuarial value.¹⁵ The challenge to greater standardization is that, to some extent, creativity and choice may be stifled. This could lead to a reduction in consumers' ability to trade off one type of cost-sharing for another. However, since variation is based upon actuarial value, it hopefully will not stifle the creative differences in cost-sharing found among different benefit designs with similar value. If HHS guidelines are too prescriptive, then an Exchange could also become out-of-synch with current trends in the market and could jeopardize the sustainability of an Exchange in the long run.

When Massachusetts first implemented its model, it began with only the actuarial level of standardization, similar to that found in the ACA, but with only three levels of benefit categories. In 2009, the Connector moved to greater standardization which they hoped would be less confusing to consumers and would help focus consumers on premium differences, network of health care providers, quality of plan, and reputation of the insurer. In addition to actuarial-value standards, the plans are standardized by tier for deductible amount, out-of-pocket maximums, co-payments and/or co-insurance for doctor visits, pharmaceuticals, emergency department visits and hospital stays.

Benefit coordination

Medicaid benchmark benefits, standard benefits and qualified health plans (see Table 2) could all be aligned around the definition of essential health benefits with sensible, specific policy goals accompanying any differences in benefit designs. Washington State might also benefit from coordinating the selection of Medicaid plans, the standard plans for the federal basic health option, and qualified health plans for an exchange by applying the same expectations and metrics, and possibly designating a single selection process across all programs.

3. Establish a website and call center for customer service and select how to aggregate premiums

Section 1311(d)(4) of the ACA requires that an Exchange establish and operate a toll-free hotline and maintain a website for providing information on plans to current and prospective enrollees. This website must include a display price and quality ratings of plans. The site will also present plan benefit options in a standardized format. In addition, the site must provide an electronic calculator to determine the actual cost of coverage, taking into account eligibility for premium tax credits and cost sharing reductions. Presentation of plan enrollee satisfaction survey results is also required

¹⁵ Section 1302(d)(3)

under Section 1311(c)(4). An exchange will also have a call center for the numerous questions that need personal assistance and expertise.

An Exchange will become the site for information about health plan choices, both benefits and costs, and subsidy levels that may be available. However, the ACA does not require an Exchange to handle the process of enrollment into a health plan. In fact, the federal government assumes the responsibility of paying insurers for the portion of the premium they will pay on behalf of individuals who are eligible for premium tax credits. Consequently, an Exchange is expected to refer consumers to insurers to complete the enrollment process, once they have selected a plan. Under this scenario, the insurer would be responsible for enrolling the individuals, handling premium billing and collection, and providing customer service. The insurer would bill the individual for the difference in premium that the individual owes, after the premium tax credit is factored in.

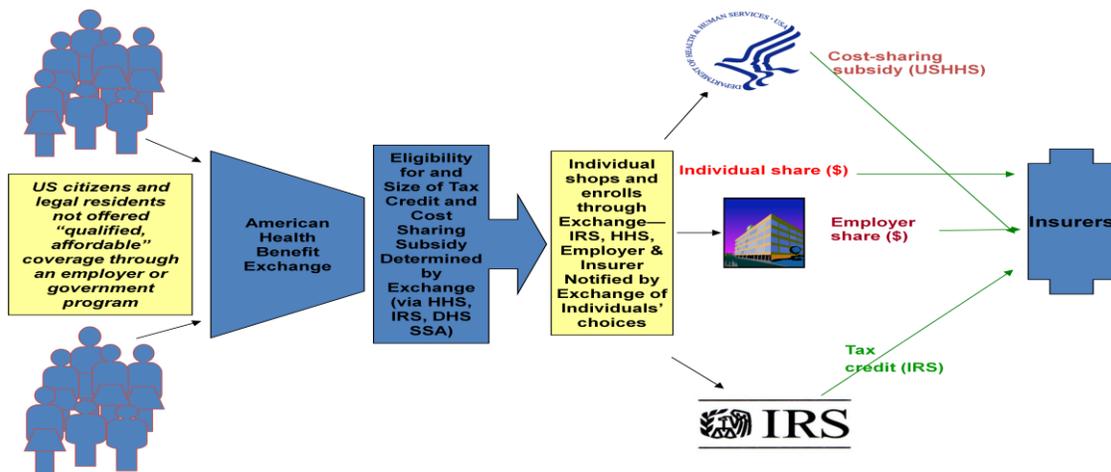
The ACA specifies that the Department of Treasury will make subsidy payments to insurers. These subsidy amounts are not combined with individual premium contributions before the total premium is paid to insurers. It is assumed that the insurer will combine the subsidies, and the individual premium contributions, into the correct accounts to form an accurate total premium for each enrollee.

Key Considerations

Complexity of insurers aggregating premiums

The following graphic developed by Group Health Cooperative demonstrates the complexities of an insurer, not an Exchange, aggregating the total premium for each account, in each qualified health plan.¹⁶ This process (described in the graphic) is uncommonly complex when we consider that it will need to be carried out by *every* insurer offering qualified health plans through an Exchange.

¹⁶ The Health Care Authority thanks Karen Merrikin for sharing this graphic with us.



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- The first three boxes are the process of verifying eligibility for individuals entering an exchange. Section 1411(c)(1) directs an Exchange to provide applicant information to the Department of Health and Human Services (HHS). Directed by section 1411(c)(2), HHS verifies the eligibility data with the Social Security Administration, Department of Homeland Security, and Department of Treasury. An Exchange also determines eligibility for subsidies in these three steps.
- Section 1412(c) specifies that the Department of Treasury (IRS), after receiving notice from an Exchange, pay advance premium tax credit subsidies to an insurer. Individuals, subsidized and non-subsidized, enrolled in qualified health plans through an Exchange, also pay premium contributions to the insurer. These individual premium contributions will likely include free choice vouchers, paid by employers, to an Exchange.¹⁷
- Employers that sponsor a qualified health plan, pay their premium contributions to an insurer. If an Exchange provides plans through merged Individual and Small Group risk pools, then an insurer will need to collect and match premium contributions from subsidized individual and small employer accounts for the same qualified health plan.¹⁸
- Section 1402(c)(3)(A) directs HHS to make cost-sharing reduction payments to insurers. Those payments enable the insurer to lower a qualified health plan's

¹⁷ Section 10108(d)(2).

¹⁸ Small employer accounts can also be subsidized through the Small Business Tax Credit in Section 1421. However, since the tax credit is paid to the small employer, the subsidy is part of the **Employer share (\$)** in this graphic.

out-of-pocket maximums for low-income enrollees. An Exchange may establish a system of capitated payments to carry out the cost-sharing reductions.¹⁹

Because this process is quite complex, a Washington State Exchange should consider assuming the role of premium aggregator. Washington State has experience in this role. For example, under the Washington Basic Health plan, the state collects individual premium contributions, draws funds from a trust account, and pays a total premium to an insurer. The Washington State Health Insurance Partnership (HIP), which operates a “three-share program” covering low-income employees, established accounts to aggregate the premium contributions from 1) employers, 2) employees, and 3) federal subsidies, and then sends that total (aggregated) premium to insurers.

Washington State policymakers may want to consider discussing with the federal government our state’s experience as an aggregator to determine whether any flexibility in this area of responsibility is possible. There are a number of reasons why it may make sense for our state Exchange to function as a premium aggregator. Section 1401(f)(3)(E) and section 1412(b)(2) direct an Exchange to manage an account when household circumstances change. For example, income changes can lead to adjusting a household’s premium subsidy. If an Exchange is not aggregating the multiple contributions to the total premium, then it loses an opportunity to verify that the subsidy dollars align with the circumstances of the account.

In addition, Section 1341(a) allows states to establish the entity to conduct transitional reinsurance, and section 1343(a)(1) directs each state to assess a risk adjustment charge on health plans. If an Exchange serves as the aggregator of total premiums, then it could be in a better position to either support or conduct transitional reinsurance or risk adjustment.

There are significant costs and benefits that must be considered when analyzing whether an Exchange should be a premium aggregator. It would likely be easier for consumers to navigate a process that occurs completely within an Exchange, as opposed to linking to the processes of each insurer. An Exchange may be able to better facilitate premium billing, collection, and remittance to insurers, as well as changes in enrollment status, especially if these processes are performed for an entire population on a monthly basis. If an Exchange innovates, then simplified transactions can be experienced by consumers, employers, and insurers. However, including this enrollment and billing capacity within the Exchange is resource intensive and will add significant administrative costs to an Exchange. It creates some redundancy in the market, as insurers already have individual and group enrollment processes, but not means-tested eligibility processes in place. Administrative costs would be reduced only if it is more efficient for the exchange to aggregate premiums in a single location, instead of each insurer performing that task.

¹⁹ Section 1402(c)(3)(B).

4. Establish Navigator programs

The ACA creates many new options for covering consumers. In all cases, streamlined eligibility and enrollment is envisioned. It is hoped that these options support consumers as they navigate within and through these new options for coverage. Undoubtedly, these new forms of coverage will create some initial confusion in the marketplace, challenging an exchange and other programs to live up to the expectations of administrative ease.

Section 1311(i) of the ACA requires an Exchange to establish a Navigator program that provides grants to entities that assist consumers as they seek services from an Exchange. To be eligible as a Navigator, an entity must demonstrate that it has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to enroll in a qualified health plan. Further, the law defines the duties of navigators to:

- Conduct public education activities that raise awareness of the availability of qualified health plans;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the law, or any other appropriate state agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by an Exchange.

Key Considerations

Navigator role

Navigators will be central to addressing special needs and gaps in the general education efforts of states. The ACA envisions the consumer as the client for a Navigator. The ACA stipulates that payment will be in the form of grants. That is, payment should not create incentives to encourage or discourage certain consumer behavior or preferences. Information should be provided to consumers in a way that can be understood by the consumer, including presentation of information in a culturally sensitive manner, or for those with low-proficiency English and people with disabilities who have special communication needs.

Navigators can help applicants and enrollees compare benefit designs and plan features, as well as present information about the relative price and quality of the health plans offered through an Exchange.

Navigator entities

The population needs may be very different than those we see in the market today. For example, there will be more lower-income families, people with different racial and ethnic backgrounds, and special needs populations (such as disabled and speech-impaired individuals) than are served by today's health insurance market. Different Navigator entities will likely be needed to meet the diverse needs of the new consumers who will be accessing an Exchange for insurance coverage. Identifying how and where various populations seek information and assistance around health insurance issues will be critical in this process. For example, Washington State will need to meet with stakeholders, community organizations, and other state and federal partners, including tribes and Indian Health Services, to determine the needs of the various populations who will be served by an Exchange.

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