Operating and Administering
Health Insurance Exchanges

After 16 Years,
A Few Thoughts and Perspectives

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Biographical Profile

Terry McCorvie is President of Workable Solutions, an Orlando, Florida based third-party administrator. Terry has been involved in running and administering health insurance exchanges since 1994. In the 90's, these organizations were born out of the managed competition model as purchasing alliances or cooperatives. The market rules under which they had to operate were not as favorable as the support they'll receive under ACA, but many of the requirements (and potential pitfalls) are the same.

Beginning in 1993, Terry was Executive Director of the Community Health Purchasing Alliance (CHPA) in Orlando. The Orlando CHPA was one of 11 original districts created in Florida and subsequently merged with the Jacksonville district, making it the largest of the individual districts. While the CHPA achieved modest success, enrolling more than 100,000 participants at its peak, it eventually folded when market conditions and political support shifted.

In 1997, Terry founded Workable Solutions to take advantage of emerging web-based technologies to bring an efficient administrative model to individual and small business purchasing. Workable Solutions has administered employee-choice umbrella organizations in a number of states. It currently administers five choice-based organizations including HealthPass, the small employer Exchange in New York City and Brooklyn HealthWorks, which offers subsidized plans to employees of small businesses in conjunction with the Healthy New York program.

As an early pioneer in the employee-choice model, Terry has a unique perspective on what works and what doesn't, both from the viewpoint of a program executive and as the TPA administrator.

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Health Insurance Exchanges
And
The Affordable Care Act

Keeping Our Eye on the Goal

Over the coming months, the stakeholders in the health care reform process will expend an enormous amount of effort to transform the market into a new delivery model. But with all of the concentration on rule development, state statutory changes, vendor procurements, grants, operational processes, inter-program coordination, subsidies and legal agreements, we should be careful not to forget why Health Insurance Exchanges are being created in the first place. The goal is to create a better way for consumers to evaluate and buy health insurance.

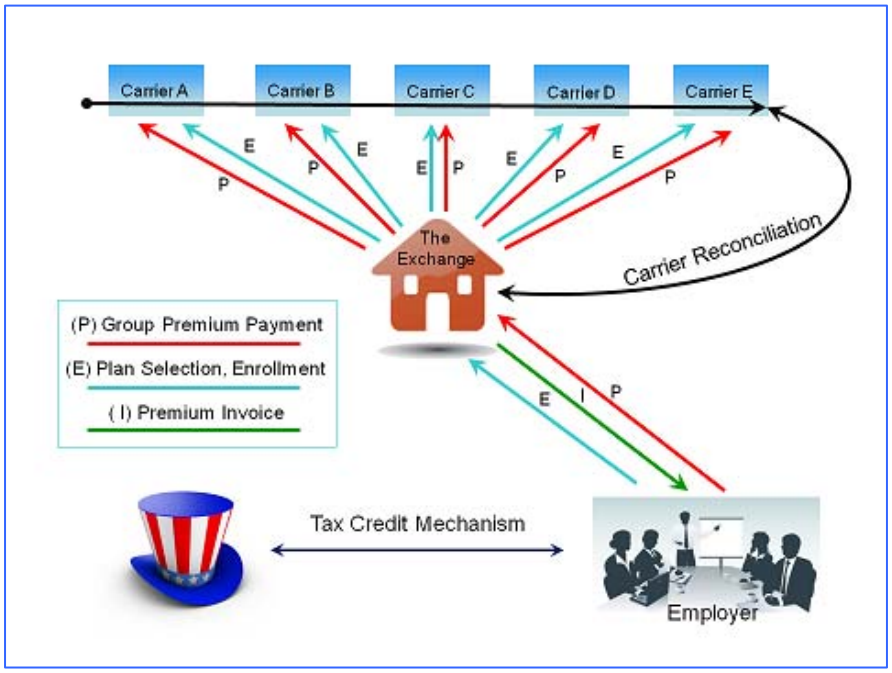
If Health Insurance Exchanges actually make it easier to understand and purchase insurance, employers and consumers will flock to them. If, on the other hand, they become bureaucratic, complex organizations that are not able to change with the market, they could merely end up as the place people go to get their subsidized coverage and little else. By their very design, exchanges are complex organizations, and the addition of subsidies makes them even more complex. It will take a great deal of thought, effort and coordination to make them SEEM friendly and simple to consumers.

An Active Purchaser

To achieve this goal, the Exchange has to be more than a choice portal. There are already dozens of private-market, web-based portals that present plans, networks and rates to employers and individuals. The private market is more than able to adapt to the new market rules and develop dynamic choice portals. If the private market can deliver choices, the Exchange has to deliver *more* than choices.

A major justification for the development of state Exchanges is that the Exchange becomes a proactive player in changing the market. It can be the "central nervous system" of a model that educates individuals and small business and efficiently delivers them to carrier partners. It must organize these two unorganized market segments by offering a better way for sellers to sell and buyers to buy. The Exchange needs to be the catalyst that reduces the confusion involved in qualifying and enrolling in insurance products. It must assist consumers with understanding and selection of appropriate plans, but also lead qualified individuals to existing government programs like Medicaid and CHIP.

Having the Exchange developed under the support of the state and federal governments provides a golden opportunity to create the synergies that will be needed for individuals to flow among and between government subsidies as their circumstances change AND to really deliver on the concept of "any open door" envisioned in the reform legislation. This is only possible if the Exchange does more than deliver options; it must also *manage* the model.

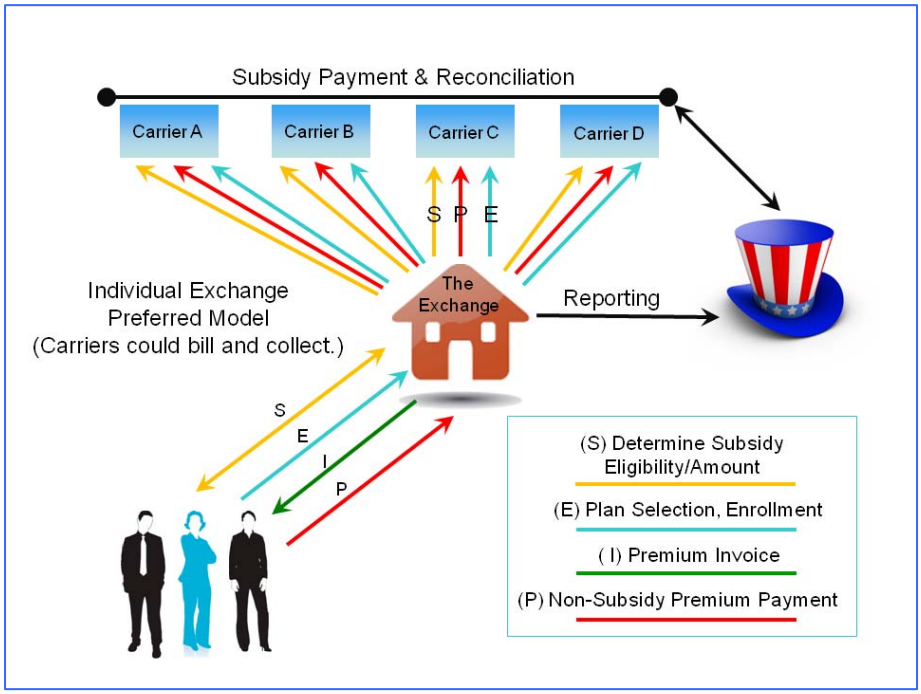


The two diagrams illustrate a centralized management model for the Exchange. The SHOP Exchange for businesses is shown to the left. The American Exchange for individuals is below.

Central Management

The Exchange needs to be the central manager of health benefits on behalf of its members, giving individuals and small businesses a seat at the table and a strong advocate for their interests. Unless the Exchange is an active purchaser, pushing for quality, value and efficient delivery of services, the potential it has to impact the market will be marginalized.

Finally, the Exchange must provide real value for its partners. That means it must make life easier, not more complicated for carriers, agents, employers, individuals and providers. It must remove some of the inefficiencies involved in serving these market segments by providing centralized education, quality ratings, online enrollment, participant eligibility maintenance, automated billing and collection, carrier EDI, electronic disbursements and reconciliation.



Simple to Use

Simplicity is the key to adoption. Individuals who are getting a portion of their health insurance premiums paid for through a subsidy may put up with long forms and endless questions, but other consumers will not. Web-based enrollment technology has the ability to request information from consumers only if it is needed. The administrative platform must be able to ask a handful of initial qualifying questions and make a *preliminary* determination if an applicant may be eligible for Medicaid, CHIP, or a subsidy through the Exchange. Those that are not will be presented only with the standard online enrollment form, just like they would fill out in the outside market. Only those that are thought to be eligible will be asked additional questions (in the event of an Exchange subsidy) or they will be sent to the eligibility portals for Medicaid and/or CHIP. Government program complexity cannot become the common denominator through which everyone must pass.

Attractive for Carriers

Insurance carriers are not the enemy. In fact, without them, there is no Exchange. Properly structured, insurance exchanges can become a powerful ally to carriers by aggregating and efficiently delivering two inefficient market segments. Under healthcare reform, carriers must maintain non-clinical administrative costs within defined parameters. A well designed Exchange can actually help carriers lower their acquisition, eligibility maintenance and billing costs through efficient delivery of information about carrier products to potential buyers. Further, the Exchange can maintain participant eligibility, provide billing and collection services, transfer eligibility and net premiums to the carrier and pay fees to agents and navigators. In order to meet this goal, however, the Exchange must attract sufficient enrollment to allow the carriers to utilize the Exchange as their delivery model of choice for these segments.

With the Exchange assuming eligibility and billing functions, carriers in the Exchange will not even have to track enrollments group-by-group. Rather, they will be able to set up a handful of master groups delivered to them by the Exchange. The master groups would contain all the participants from multiple employers and individuals who enroll in coverage in a given plan in a given month. Under these monthly master groups, the premium rate would be guaranteed for 12 months. Each month, at the end of their 12 month plan year, the monthly subset of the overall Exchange population would renew.

This model eliminates the problem often seen in a trust, where the entire block renews in the same month. Not only does that model require enormous effort to get everyone renewed, it also, by design, requires a rate guarantee of less than 12 months during the first year of participation. Under a single master policy concept, the entire group might renew in January, for example. A new enrollee joining in September would only have September through October rates in place before he/she had to renew into the new plan year in January. (Normally at higher rates.)

With the Exchange providing most of the administrative functions associated with acquisition, maintenance, billing and reconciliation, carriers can properly focus on the quality of care the enrollee receives through its provider network and manage provider payments as care is given.

Inclusive of Brokers

Some say the Exchange should take its cue from the travel industry, which has gone from an agent model to an automated buying model almost entirely driven by the purchaser. For example, Kayak is often cited as an

example that efficiently drives consumers to the best airline fare or hotel rate by searching through multiple vendors. Purchasing health insurance is more complex, but many of the tools used by online travel services can be used as models to effectively filter plan choices based on provider choice, premium, out-of-network options, deductibles and out-of-pocket costs. Even with that, health insurance remains complex and industry experts, with properly designed incentives, can still be a valuable component in the new Exchange environment. Whether they are called consultants or navigators or agents, many employers and individuals will still want an expert on their side.

Health care reform will also create downward pressure on broker commissions and may even utilize flat fee arrangements paid per application. Like the Exchanges, agents and navigators under healthcare reform will need to be highly efficient and utilize automated tools to add value to the purchaser. Larger distributors could even be appointed by the Exchange as aggregators who would market Exchange products in a given geographic area and have "enhanced" access to feed enrollment files to the Exchange.

State regulators will also want to give careful consideration to market rules regarding agent compensation. For example, allowing carriers to offer higher commissions for products outside the Exchange would be a major deterrent to Exchange participation.

Under current law in most states, agents must be licensed by the state and appointed by the carrier. The Exchange could serve as the central clearinghouse for agent licensure verification and carrier appointment requirements.

Governance – State or Private?

In the case of insurance, the role of government is to create rules under which the marketplace operates. There may be natural conflicts which arise if government is also charged with operating a market-driven organization. Therefore, my strong recommendation is that the Exchanges be set up as a non-profit organization operating under the market rules established by ACA and the state. The governance of the non-profit should be made up of representatives of the market - employers, consumers, community organizations, providers and other stakeholders. It should be representative of the population. Balanced political views among board members are important. Board officers should be elected by the board members and rotate regularly.

Smaller boards tend to function well, with board members representing a variety of areas. In Florida, the CHPAs had 17 board members who lived throughout the region. Keeping board members engaged was difficult, and having a quorum at meetings was challenging.

Depending on the state, the non-profit corporation might also be able to operate outside of the strict requirements of government sunshine laws. The goal here would not be to allow them to operate under the radar, but rather to foster an environment where they can be market-responsive without having to notice every meeting and limit discussions between meetings. They could act more like a business.

More than One State Exchange?

There may not be a need for a state to operate more than one Exchange, since geographic distinctions can be accommodated within the Exchange web portal. We made that mistake with the CHPAs in Florida. There were 11 districts, with 11 independent boards all trying to act like one organization. We wasted more time and money traveling to central meetings than it was worth. Conflicts between districts also arose.

A dynamic administrative system will be able to subdivide available plans and rates based on geographic areas. Rather than create the additional overhead and complexity of more than one state exchange, the better option is to locate marketing managers in locations around the state so they can keep in touch with the needs of distinct geographic areas. If a given state has major cultural differences between regions, the web portal can be designed to accommodate these differences, with unique landing pages based on the location of the enrollee.

Multi-State Exchanges?

While there can be significant differences in state insurance laws, it may be beneficial for states to share resources, especially for Exchange development. Joint development does not preclude state autonomy. Again, your administration vendor's system should be able to present different plans, market rules, rates, etc. depending on the state of residence of their applicant. The same web-based platform could serve multiple Exchanges just by having a unique state-branded landing page. From there, the geographic location attached to the enrollee would determine the carriers, plans and rules presented. Partnering with other states on development and allowing your administrative vendor to leverage development costs over multiple states could save significant dollars and still give each state the ability to address its unique market requirements.

Combining the Small Group and Individual Markets?

The ideal Exchange platform must track coverage selection and eligibility at the individual level *even if the individual is a member of a group.* This is a necessity to assure customized plan choice and portability. With an appropriately configured Exchange platform, the individual and small group markets would not necessarily need to be combined. One Exchange could offer options to both groups and individuals. Their attachment or non-attachment to a group would filter their available coverage selections, rating and underwriting requirements within the portal. Under this model, an individual could flow back and forth from group to individual and back to group products within the Exchange as their employment circumstances changed.

Having one Exchange that serves both markets, without merging them, also preserves the ability to combine them at some future date if that makes market sense.

Market Rules Are Critical

Market rules inside and outside the Exchange should be mirrored as closely as possible. The Exchange will automatically attract individuals who are subsidy-eligible, but if the Exchange is to achieve the vision of being a vibrant marketplace that leads small businesses and individuals to individually tailored plans, then the plans offered inside the Exchange must deliver attractive benefits that consumers actually want to buy. While risk pools for individual and small group market, both inside and outside the Exchange will be combined, state regulators should not overlook market parity. If benefit designs inside the Exchange are already limited to the "precious metals" and one catastrophic plan, does that mean the direct market now has the incentive to get creative with plan designs and premiums?

In the SHOP Exchanges, for example, employee choice will require a consolidated list bill for the employer showing the premiums for each employee based on the plan and carrier they select. On its surface, this seems to preclude composite rating, which in many states is the norm for presenting small groups plans.

That creates a problem for the Exchange. As an employer, if I can get a composite rate for all my employees, it is simpler for me to present and explain benefits costs to my group AND simpler for me to set up payroll deductions. In the Exchange, because employees will not all pick the same carrier, composite rating is not realistic. That means employers will have to peg their contributions on a *percentage* of each employee's rates.

For example, if the composite rate for employee-only coverage is $500 and the employer contribution is $400, every employee with single coverage would payroll deduct $100 a month. Simple! Through the Exchange, premiums will vary based on carrier, plan selection, age, region and tobacco use. Based on age alone, the premium for single coverage may be three times more expensive for older workers. For example, if premium for a 25 year-old is $300, the premium for the same plan for a 59 year-old might be $900. If the employer contributes 75% toward each, the employee payroll deduction for the 25 year-old is just $75, while the deduction for the 59 year-old is $225.

I suppose you could make the argument that under those market rules, the Exchange would be a better choice for employers with younger workers. On the other hand, many decision makers within employer groups are older and may steer the group toward a path which is less costly for them outside the Exchange.

To the extent the rules are different outside the Exchange versus inside, there is room for market manipulation. States will need to consider how strongly to link rating rules inside and outside.

The schedule for rate filings and rate changes may also be coordinated so that employers and individuals are not directed one direction or another simply because of timing issues that may cause rate variations.

Portability of Coverage

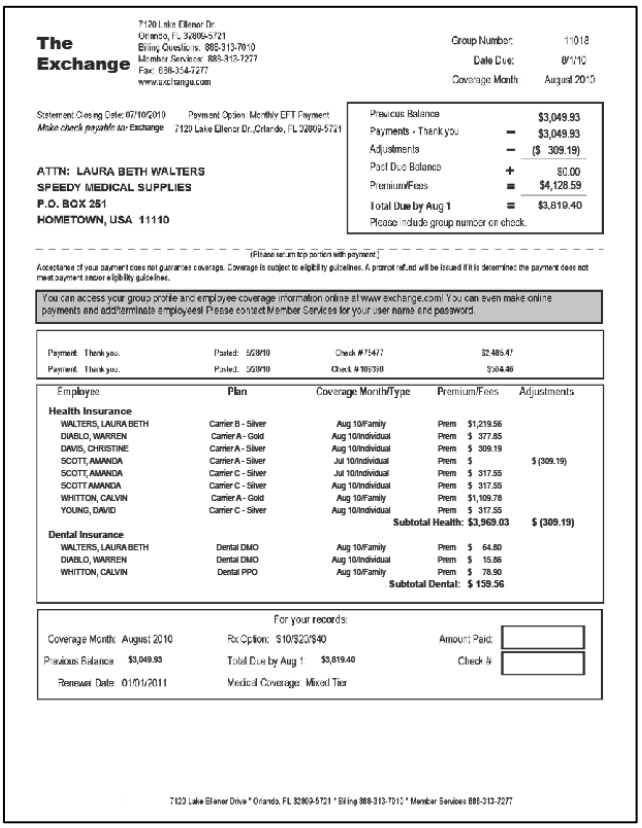
It will be vitally important for the Exchange platform to be able to track each employee at the participant level and not at the employer-level. For example, John Doe might be attached to an employer for a period of time, then become an unemployed individual who would be billed directly, then might be hired by another employer. None of these events should have an effect on the portability of coverage through the Exchange.

If the Exchange maintains centralized data for all participants, it will simplify billing, renewals and portability, particularly in the small employer segment.

Efficient Enrollment

One of the requirements of efficient market aggregation is the use of automation tools to reduce administrative costs. Because a centralized online enrollment portal can perform both enrollment and underwriting, showing only qualified options to enrollees, this is the enrollment method of choice. All enrollment and eligibility information is then maintained by the Exchange and sent electronically to the carriers. (The Exchange also manages all adds, changes and terminations.) Incentives to enroll online can be created by adding a fee for any employer, employee or individual who chooses not to use the online portal to complete his or her enrollment. Paper applications require manual review and underwriting of the information and then manual data input into the administrative platform. The additional cost associated with manual paper processing should be passed on. Enrollees who do not have online access can be funneled to navigators who can walk them through the process and conduct an assisted web enrollment.

A uniform process and timeline must be developed for enrollment requirements and cut-offs and all partners must agree to the process. Trying to manage individual carrier requirements leads to inefficiency and opens the door to mistakes.



The Exchange

7120 Lake Ellenor Dr
Orlando, FL 32809-5721
Billing Questions: 888-313-7010
Member Services: 888-313-7277
Fax: 888-354-7277
www.exchange.com

Group Number: 11018
Date Due: 8/1/10
Coverage Month: August 2010

Statement Closing Date: 07/10/2010 Payment Option: Monthly EFT Payment
Make check payable to: Exchange 7120 Lake Ellenor Dr.,Orlando, FL 32809-5721

Previous Balance		$3,049.93
Payments - Thank you	−	$3,049.93
Adjustments	−	($ 309.19)
Past Due Balance	+	$0.00
Premium/Fees	=	$4,128.59
Total Due by Aug 1	=	$3,819.40

Please include group number on check.

ATTN: LAURA BETH WALTERS
SPEEDY MEDICAL SUPPLIES
P.O. BOX 251
HOMETOWN, USA 11110

(Please return top portion with payment.)

Acceptance of your payment does not guarantee coverage. Coverage is subject to eligibility guidelines. A prorated refund will be issued if it is determined the payment does not meet payment and/or eligibility guidelines.

You can access your group profile and employee coverage information online at www.exchange.com! You can even make online payments and add/terminate employees! Please contact Member Services for your user name and password.

Payment Thank you.	Posted: 6/28/10	Check #75477	$2,485.47
Payment Thank you.	Posted: 6/28/10	Check #189398	$564.46

Employee	Plan	Coverage Month/Type	Premium/Fees	Adjustments
Health Insurance				
WALTERS, LAURA BETH	Carrier B - Silver	Aug 10/Family	Prem $1,219.56	
DIABLO, WARREN	Carrier A - Gold	Aug 10/Individual	Prem $ 377.85	
DAVIS, CHRISTINE	Carrier A - Silver	Aug 10/Individual	Prem $ 309.19	
SCOTT, AMANDA	Carrier A - Silver	Jul 10/Individual	Prem $	$ (309.19)
SCOTT, AMANDA	Carrier C - Silver	Jul 10/Individual	Prem $ 317.55	
SCOTT AMANDA	Carrier C - Silver	Aug 10/Individual	Prem $ 317.55	
WHITTON, CALVIN	Carrier A - Gold	Aug 10/Family	Prem $1,109.78	
YOUNG, DAVID	Carrier C - Silver	Aug 10/Individual	Prem $ 317.55	
		Subtotal Health:	**$3,969.03**	**$ (309.19)**
Dental Insurance				
WALTERS, LAURA BETH	Dental DMO	Aug 10/Family	Prem $ 64.80	
DIABLO, WARREN	Dental DMO	Aug 10/Individual	Prem $ 15.86	
WHITTON, CALVIN	Dental PPO	Aug 10/Family	Prem $ 78.90	
		Subtotal Dental:	**$ 159.56**	

For your records:

Coverage Month: August 2010	Rx Option: $10/$20/$40	Amount Paid:
Previous Balance $3,049.93	Total Due by Aug 1 $3,819.40	Check #:
Renewal Date: 01/01/2011	Medical Coverage: Mixed Tier	

7120 Lake Ellenor Drive * Orlando, FL 32809-5721 * Billing 888-313-7010 * Member Services 888-313-7277

Automated Billing

One area that will require some careful thought and attention is the billing methodology. In the SHOP Exchanges, the law seems to provide the ability for the Exchange to provide a consolidated monthly bill to the employer. For individuals, the law says payments "may" be made directly to the carrier. The better option is for the Exchange to be the central repository for all eligibility, billing and payment information for all non-subsidy premiums. The Exchange would pay carriers all premiums not paid through subsidy and carriers would consider it payment in full. (Subsidies would be applied as they were paid out by the government.)

The billing, disbursement and accounting function is a vital and often overlooked component of Exchange administration. Premium billing and collection is not as simple as sending a bill and getting payment. It would be great if all employers and individual made timely payment of exactly what is due, but that's not real world. The Exchange platform will need to track payments versus billing to make monthly determinations of who has paid enough premium to make disbursement to the carrier and who is late. As the billing cycle continues, the Exchange platform will need to determine which groups and individuals need notice of late payment and who is outside of their grace period and must be termed. The platform will need to track creation of appropriate termination notices and provide refunds back to employers and individuals for partial payments.

A uniform timeline needs to be developed for the billing cycle. When are bills generated? When is payment due? When are late notices produced? What is the grace period for payments? When are groups and individuals termed for non-payment? How far back are retro terminations allowed? The Exchange and its carrier partners must jointly develop this process and everyone agree to abide by it. Again, different rules for multiple carriers beg for problems.

All billing invoices, both current and historical, should be available to employers and individuals on demand through the web portal. If members opt for a paper bill via U.S. Mail, the Exchange may want to consider a "paper billing fee" to cover the cost of printing and postage.

Normal methods of payment in the small group environment are: pay by paper check, manual payment by telephone, manual online payment and recurring ACH (electronic) payments. The Exchange will need to consider the viability of accepting credit card payments. Such payment methods may be a great

convenience for consumers, but they carry a transaction fee that is normally between 1.5 and 3%. Someone has to pay that fee. Most credit card agreements do not allow an additional "convenience" fee to be added to credit card payments, unless the same fee is applied to other types of payments made in the same manner. (New banking regulations may provide some flexibility here.)

There will need to be monthly reconciliation algorithms which compare billed items, payments, disbursed and undisbursed funds and provides a report that ties all platform information back to trust account balances.

The Exchange also will need to give careful consideration to accounting issues. Will the Exchange operate under normal accrual accounting standards? If so, will the Exchange platform provide the accounting component, or will accounting data be exported to a stand-alone accounting system for accrual tracking? If separate systems are used, what methods will be utilized to provide for true-ups and audits?

Role of Employers

The Exchange will likely shift the role of the small employer from a "selector and provider" of benefit packages to becoming a partial "funder" of employee benefits. Employees would then use the Exchange to make personal, customized selections, using the online calculator to display the actual remaining employee responsibility by plan.

The Exchange platform would have the ability to attach participants to a given small group within the Exchange platform. This is typically accomplished by first setting up an employer profile within the platform. The employer profile captures billing and contribution information and assigns a unique group ID to the employer. Employees are then provided with the group ID and an initial password to use for their enrollment. As employees enroll, the employer verifies they are attached to the group.

Based on selections made by employees, the Exchange platform would also provide the employer with information for employee payroll deductions. There is no reason to complicate things by tracking employee payroll deductions inside the Exchange. The Exchange can provide the employer with a report to use to set-up employee contributions within their payroll software.

The Exchange platform then bills the employer for the monthly premium for the group's employees. The monthly premium payment is a combination of the employer contribution and employee pre-tax payroll deductions for the employee responsibility. The employer writes one check to the Exchange (or pays electronically) and the Exchange platform disburses the appropriate premiums to each participant-selected carrier. Employer subsidies, if applicable, would be handled outside of the Exchange.

The availability of tax credits to small employers will create initial demand, but if the Exchange does not deliver a better solution, those same employers may depart in droves when the credits end after two years.

Limiting Plans to Employer-Selected Tier

Since the SHOPs will require employers to adopt a defined contribution model of funding their employer contributions, what is the benefit of limiting employee-choice only to one tier selected by the employer? The law says that employers "may" select one tier of "precious metal" plans to offer to its employees and employees then "may" select plans only from within that tier. If the same plans are available outside the

Exchange, presumably at the same price, one of the real advantages of opting toward the Exchange for a small business is that it takes the employer out of the plan selection business.

As a small employer myself, I dread having to review the benefit schedules of multiple carriers and picking *one* benefit design for my group, knowing it may not be an ideal fit for all of my employees. I would be much more inclined to use the Exchange if I could determine my defined contribution toward benefits and send my employees to the exchange to use that money to purchase whatever they want. I would likely peg my contribution to a middle tier plan (silver or gold.) If an employee selected a richer plan, their payroll deduction contribution would be higher. Likewise, if an employee selected a lower tier product, my employer contribution would cover more of the cost.

I assume the reason why ACA contemplates some level of plan filtering by the employer is to reduce adverse selection among the richer plans. So long as HHS comes up with standardized risk adjustment formulas, taking into account all tiers, expanding employee choice might be a more attractive model for the SHOP Exchange. (Individuals will already be able to pick from any available plan.)

As for the fear that too much choice is overwhelming, that can be easily handled as part of the plan selection process. The employee would be asked to name important providers, desired out-of-pocket costs, desired monthly employee cost, etc. Based on these "filters", only plans that met criteria would be presented. If the enrollee was not happy with the selection, he or she would change the criteria and come up with a new subset of plans. Think of all the hotels or flights available through an online travel portal. If you had to thumb through all of them to find the best one for you, it would be overwhelming. That never happens because the system filters thousands of options down to just the handful that meet your travel needs. The same concept would apply in the Exchange.

Affordability

It is important that the Exchange provide a one-stop shop for its target markets of small businesses and individuals. To maximize affordability, it is likely that insurance plans provided through the Exchange will include plans with higher deductible amounts. For added value, the Exchange should also provide a seamless source of consumer-driven, tax-advantaged plans to couple with its insurance offerings. These would include simple Premium-Only-Plans to allow employees to make their premium contribution pre-tax. (These are allowed under ACA if the employer contributes toward employee insurance.) Flexible spending accounts, health reimbursement arrangements and health savings accounts would also provide savings. The ideal Exchange platform would allow participants to include these tax-advantaged plans as part of their benefit mix.

ACA also provides for "wellness rewards" to employees of small business, which could reduce premium by up to 30%. There are a number of excellent online wellness portals that include health risk assessment, lifestyle coaching, personal health records and medical information. Access to online wellness tools through the Exchange portal will provide a wonderful value-added option for member groups and individuals.

Administrative Vendor

With the advent of health insurance exchanges, there is a lot of interest among administrators and software vendors looking to get into this space. Exchange administration may not seem that different from single employer administration, but it is. If you have not done it, you don't know. It is a lot more than just filtering

and presenting choices. The platform must track multiple carriers, multiple plans, multiple tiers, multiple subsidies, multiple master groups and master groups of individuals. I hope some of the discussion points in this document help readers begin to understand the complexities.

One other thing is certain about an Exchange: It will always be changing. This is a bold experiment and it is impossible to envision all of the practical day-to-day requirements and tools until operations begin. Therefore, the administrative platform that powers the Exchange cannot be an "off-the-shelf" solution. The administrative vendor will need to have a proprietary platform that can accommodate changes. Flexibility, agility and adaptability will be key components for success.

Summary and Recommendations

- As we weave our way through the complexity of rulemaking, development and launch, we must remember the goal of the Exchange is to give consumers a better way to evaluate and purchase health insurance.
- Exchanges must be more than a point of entry; they must actively manage the acquisition, maintenance, billing and disbursement of its products – passing eligibility to carriers and the government, billing and collecting from individuals and groups, paying net premium to carriers, fees to navigators and giving members a seat at the table in the insurance market.
- Exchange web platforms must be designed to do a quick enrollee evaluation of eligibility for a subsidy or other government program, but the selection and enrollment process cannot be more burdensome for non-subsidy enrollments than it would be in the outside market.
- An Exchange can help carriers reduce their non-clinical costs by efficiently organizing two unorganized markets – small business and individuals. It can provide a central point of acquisition and eligibility management on behalf of carrier partners.
- The Exchanges can take advantage of existing distribution channels, including brokers, but the broker community will need to become more efficient and add real value to consumers.
- The non-profit model has worked well for existing Exchanges. It allows the Exchange to be market-focused and adaptable.
- One state Exchange is more efficient and can accommodate regional differences through its web portal design. However, states may find sharing development processes and expenses with other states to be an effective way to leverage resources, while maintaining state autonomy.
- The Exchange administrative system should be able to manage both the small group and individual markets by filtering plan options, based on whether an individual is attached to an employer. A single Exchange handling both markets allows for merging of the markets down the road, if needed.
- Market rules inside and outside the Exchange should be the same. The difficulty of composite rating inside the Exchange could pose a disadvantage.
- To maximize flexibility and portability, the Exchange should administer coverage at the individual level. Individuals may or may not be attached to a group.
- It is vital that the Exchange operates under one set of rules that are adopted by all carriers.
- Billing, collection and disbursement are vital functions of the Exchange.
- The role of the employer within the Exchange is shifting from “selector and provider” of coverage to “partial funder” of coverage. States may want to consider more open plan selection in the SHOP Exchange, rather than have the coverage level limited by the employer.
- Exchanges are complex. The Exchange and its administrator must be able to maintain flexibility and adaptability as the Exchanges are launched and mature.