DESIGN OPTIONS FOR AN ALABAMA INSURANCE EXCHANGE

ALABAMA DEPARTMENT OF INSURANCE

REPORT BMA10T3

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Chapter 1
Introduction

This report provides the Alabama Department of Insurance (DOI) with a detailed assessment of the functions and responsibilities of a health insurance Exchange, and it outlines options for state officials to consider as they seek to establish an Exchange that works best for Alabama residents and businesses. In this report, we review the major components of an Exchange—pursuant to the Patient Protection and Affordable Care Act (ACA) and federal guidance—and offer recommendations on setting one up in time to meet the October 2013 deadline. By that date, set in the Notice of Proposed Rulemaking issued in July 2011 by the Department of Health and Human Services (HHS),[1] state Exchanges must be operational, able to process eligibility, and capable of enrolling people in coverage that will take effect starting January 1, 2014.

On the basis of discussions with Alabama officials, stakeholders, and focus group participants, we propose leveraging existing resources, either public or private, whenever possible. The Alabama Exchange will have minimal, if any, regulatory responsibilities and will serve as a market facilitator and channel for distributing health insurance to individuals and small employers. DOI will continue to have responsibility for regulating the health insurance market in Alabama. The Alabama Medicaid Agency will continue to be responsible for determining eligibility for the Medicaid program, while potentially providing that critical function for the Exchange and the state's Children's Health Insurance Program (CHIP), ALL Kids.

In order to establish a fully functioning, ACA-compliant Exchange in time to meet the October 2013 deadline, Alabama will need to make a number of critical decisions in the coming months. This report outlines the issues that it will need to address and the functionality that it will need to develop to handle all the tasks required of an Exchange.

Our assessment consists of the following subsequent chapters: 2—Governance and Administration; 3—Eligibility; 4—Enrollment and Disenrollment; 5—Information and Outreach; 6—Exchange Financing; 7—Health Plan Certification; 8—Consumer Assistance; and 9—Regulatory Functions.

[1] Department of Health and Human Services 45 Code of Federal Regulations (CFR) Parts 155 and 156.

Chapter 2
Governance and Administration

GOVERNANCE STRUCTURE

Given that the broad range of tasks under the Exchange's purview does not lend itself to a common or typical organizational structure, either public or private, the ACA allows four governance and administrative options for the Exchange: an existing state agency, a new state agency, a quasi-public authority, or a non-profit organization. In this section, we analyze each of these options, highlighting particularly important operational or policy issues.

Existing State Agency

The state agency option is attractive because it supplies a preexisting management structure and staff, built-in accountability standards through the existing state laws that govern agency operations, and well-established paths for coordination with other agencies that may be affected by the Exchange.

The Utah Health Exchange, housed in the Governor's Office of Economic Development, is often cited as an agency model, but it performs significantly fewer duties than an Exchange set up pursuant to the ACA. It is primarily an online health insurance brokerage established to fill a niche in the Utah market by offering small employers a consumer-directed, defined contribution option for their employees. The Utah Exchange does not provide premium subsidies to individuals or small employers, and those wishing to purchase health insurance are directed to licensed producers[1] in the state. Many (if not all) of the other functions and responsibilities of the ACA version of an Exchange are not performed by the Utah Exchange.

Of the existing state agencies that could house the Alabama Exchange, the three most likely are: DOI, the state Medicaid Agency, or the State Employees' Insurance Board (SEIB). Each of these would bring both formidable strengths and shortcomings to the task, but key provisions affecting their operations as state agencies—civil service requirements, procurement rules, and ongoing state budgetary limitations—represent significant matters for consideration.

DOI regulates insurers and associated licensees, responds to consumer complaints, provides consumer-oriented websites and guides, reviews premium rate

[1] Per Section 27-7-1(5), Code of Alabama, 1975, the term 'insurance producer' is a person required to be licensed under the laws of the state to sell, solicit, or negotiate insurance. Throughout the report, this term refers to insurance agents and brokers.

increase requests, collects data from insurers, and licenses insurance producers. DOI monitors the activities of insurers in all lines of insurance, including life, workers' compensation, auto, homeowners, and health. Given the duties of an Exchange, DOI may face significant conflicts in regulating insurers while simultaneously promoting these entities as the administrator of the Exchange, or pursuing examinations or disciplinary actions against the same insurers for which it is acting as a distributor of their products.

The state Medicaid Agency operates Alabama's Medicaid program, which provides health coverage to more than 900,000 Alabamians. The agency is a major purchaser of healthcare services, determines eligibility for the program, enrolls beneficiaries in coverage, ensures network adequacy, reviews provider contracts, assists consumers, and collects encounter data and reports on quality and enrollment.

Its experience is with a fee-for-service model, and it has little if any involvement with insurers, insurance markets, and health plans. Given the agency's size and scope, and the activities that it will need to undertake with regard to the expansion of Medicaid eligibility in 2014, there's a risk that Exchange operations would be overshadowed by the Medicaid Agency's other significant duties.

The SEIB administers health and welfare benefits for state employees through the State Employees' Health Insurance Plan and local governmental units through the Local Government Health Insurance Plan. In addition, the SEIB administers the Alabama Health Insurance Plan (AHIP), which is an individual market product available to Health Insurance Portability and Accountability Act (HIPAA)-eligible individuals and offered by Blue Cross and Blue Shield of Alabama (BCBSAL) and United Healthcare.

In fiscal year 2010 the SEIB administered coverage for more than 60,000 active and retired state employees, and managed an accounting and eligibility system that paid out approximately $430 million in medical claims that year. Its management of these health insurance programs requires high-level negotiations with the state's major insurer, BCBSAL. The agency also has experience administering the AHIP in the individual market but may lack experience with lower income populations that would be served through an Exchange responsible for subsidy administration. In addition, the AHIP program is overseen by a smaller unit in a larger organization devoted principally to administering health benefits for state and local government workers and retirees.

Since the responsibilities of administering employee health benefits are materially different from those that the Exchange would have, SEIB is not currently positioned to carry out the necessary Exchange functions.

New Agency

Establishing an Exchange by creating a new agency would certainly provide a single-minded focus on Exchange activities and eliminate the potential conflicts of interest noted above, but it might run counter to the state's preference for smaller government and would encounter many of the same logistical and operational challenges that come with the existing agency model: staffing and hiring requirements, procurement rules, and state finance requirements and oversight.

Quasi-Public Authority

A third option for an Exchange is to create a new quasi-public authority. This option might offer more flexibility than an agency-based Exchange, and might be a better fit for its public-private roles and responsibilities. However, opposed to a state agency—either existing or new—which has built-in accountability standards, management structure, and operating guidelines, creating a quasi-public authority would require policymakers to determine how it is governed and how closely it would follow state hiring procedures, procurement rules, and finance requirements.

Non-Profit Organization

Lastly, the ACA authorizes states to establish a non-profit organization to fulfill the duties of an Exchange. A non-profit could operate under a similar structure as a quasi-public authority. Although a non-profit corporation has potential appeal due to ease of establishment and flexibility in its operations, such an approach might face a number of problems.

A non-profit Exchange might serve well as a market organizer, but it might be less appropriate for a non-governmental entity to determine eligibility for subsidized coverage, have the authority to grant exemptions from the individual mandate, or require penalty payments by individuals and businesses. On its face, a non-profit corporation would seem less well equipped to monitor developments in the non-Exchange market and work closely with other state agencies (such as the Department of Insurance and state Medicaid Agency), which will be required of the Exchange.

Internal by-laws and governance standards might assuage some concerns about accountability, but there would be a substantial risk that the entity would lack both buy-in from key stakeholders necessary for its success and credibility in the marketplace. A legislative effort to build in the accountability and governance standards that apply to state agencies or a quasi-public authority could result in an entity much like a state agency or quasi-public authority.

In addition, federal funding for establishing and initially operating the Exchange is limited to governmental entities through the Cooperative Agreement, and non-profits are not allowed to apply for funding directly. The application must be

made by a state or quasi-public authority, although a non-profit can then receive funding from a public entity.

GOVERNANCE BOARD

If the state chooses to establish a board or commission to oversee the operations of the Exchange, wherever it is housed, policymakers will need to determine the size of the board and how members are appointed. These decisions include whether

- the governor, legislature, or both are authorized to appoint members;
- key agency heads serve as ex-officio members;
- members are appointed based on their expertise in particular areas or as representatives of important interests, such as consumers, insurers, producers, or businesses; and
- the board should reflect a geographical balance.

Because board composition and qualifications will be of critical importance to the success of the Alabama Exchange, policymakers face a number of key decision points. A board that is too large may prove unwieldy and incapable of acting nimbly. A board structured under interest group membership may lose focus on the success of the enterprise as a whole. A board without individuals having specific expertise may lack the know-how to develop and execute a business plan.

In addition to creating the right balances between expertise and stakeholder representation, it will also be important to provide linkages to other state agencies. Unless it is envisioned as a "third regulator" with in-house capacity to regulate qualified health plans, for example, the new entity will need close coordination with DOI, since it will need to delegate or even contract with DOI to perform various functions. The Exchange will also need to closely coordinate with the Medicaid Agency and the ALL Kids program.

Chapter 3
Eligibility

One of the key responsibilities of the Exchange will be determining eligibility for medical coverage programs, including Medicaid, the ALL Kids program, and the advance premium assistance tax credits for qualified health plans available through the Exchange. Furthermore, the Exchange must

- certify exemptions from the individual mandate to obtain and maintain health coverage;
- determine an employer's eligibility to purchase coverage through the Exchange;
- verify eligibility of the employer's employees; and
- assist small businesses in applying for premium assistance tax credits.

Each of these requirements is discussed below, along with options for meeting them.

Determining Eligibility for All Publicly Subsidized Health Coverage Programs

The ACA calls for a streamlined, simplified, user-friendly approach to health coverage eligibility and enrollment, and for a comparable consumer experience regardless of the program for which a person is eligible (such as Medicaid, ALL Kids, or the Exchange). The intent of the healthcare reform law is to allow consumers to complete one standardized application to determine eligibility for Medicaid, ALL Kids, and the Exchange, instead of requiring individuals to submit separate applications for each program.

Verifying Eligibility

Consumers are to be offered multiple access points—web, phone, paper, and in person—to apply for coverage, with eligibility for all publicly subsidized medical assistance programs based primarily on the applicant's modified adjusted gross income, or MAGI (see box below for an overview of the MAGI standard).

In addition to MAGI, the eligibility determination process will need to verify the applicant's citizenship or legal residency status,[1] age, access to employer-sponsored insurance, and incarceration status, as well as whether the applicant is a Native American.

Determining Modified Adjusted Gross Income

The ACA establishes a new income standard for most Medicaid and CHIP recipients and for subsidy-eligible individuals and families seeking coverage through the exchange. For coverage effective January 1, 2014, Alabama will be required to use MAGI to determine eligibility for publicly subsidized health coverage programs for most non-elderly, non-disabled individuals. This income standard consists of adjusted gross income, as defined in the federal tax code, plus foreign income and tax-exempt interest. The new MAGI formula also eliminates asset tests and income disregard adjustments and therefore removes the need for applicants to report and provide paper verification of expenses as part of the eligibility determination process.

Elderly, disabled, medically needy, and individuals eligible for Medicaid through other programs or waivers, such as long-term care, will continue to have their eligibility determined using "traditional" Medicaid rules and will continue to be subject to an asset test.

HHS has indicated that it will provide further guidance and regulations on the methods and definitions used to calculate family size and household income as these apply to eligibility based on MAGI.

Using information the applicant provides, the Exchange will verify eligibility by accessing multiple federal agency databases, as well electronic matching with Alabama-specific data sources. Because verification will require coordination with multiple federal agencies—including HHS, Social Security Administration, Internal Revenue Service (IRS), Immigration and Naturalization Service, and Department of Homeland Security—the federal government is establishing a data services hub that will coordinate verification of data across all federal agencies.

Alabama will be expected to use state data sources to verify information the applicant submits. This might include interacting with the state Departments of Human Resources (DHR), Revenue, Corrections, Industrial Relations, and Public Health (ADPH); as well as other data sources that may capture information that may be used to determine eligibility.

The state has established an "express lane eligibility" process for expedited enrollment of children in the Medicaid program if they have already been

[1] Under current law, most legal residents who have resided in the United States for less than 5 years are not eligible for Medicaid or CHIP. However, these legal residents will be eligible for subsidized coverage through the Exchange.

determined eligible for the Supplemental Nutrition Assistance Program (SNAP). Medicaid workers access information collected by DHR, which administers the SNAP program and other social service programs in Alabama. The DHR information is then used to verify the child's eligibility for Medicaid.

In 2010, approximately 168,000 children were determined eligible for Medicaid through this expedited process, and the state is currently working with Centers for Medicare & Medicaid Services (CMS) to expand it to adults. Extending it, in whole or in part, to the Exchange could expedite eligibility and help tens of thousands of Alabamians acquire health coverage and minimize administrative resources devoted to determining eligibility.

The Medicaid and ALL Kids programs allow for 12 months of continuous eligibility. This means that once an applicant has been determined eligible, their coverage is effective for 12 months, regardless of any change in circumstances (such as income, family status, or offer of employer-sponsored insurance).

Unlike under Medicaid and ALL Kids, eligibility for premium subsidies through the Exchange—and the amount of the subsidy for coverage—will not be set for a continuous 12-month period. Rather, as an individual's or family's circumstances change during the year, their subsidy eligibility and amount will need to be re-evaluated and adjusted to reflect the changed circumstances.

This difference in eligibility rules between Medicaid/ALL Kids and the Exchange has important ramifications, for both the state and for residents who will be receiving subsidized coverage through the Exchange. The Exchange will need to establish a process that allows for adjustments to eligibility during the year to account for mid-year changes in status. Given that an individual who is eligible for Medicaid is not eligible for premium subsidies through the Exchange, it will be necessary for the state to capture these mid-year changes in eligibility to ensure that the state is enrolling people in the appropriate health coverage program.

For people receiving premium subsidies through the Exchange, updating their eligibility status will have important financial ramifications. If the subsidy exceeds the amount for which they are eligible, enrollees will be responsible for repaying the federal government for the excess amount. The potential premium subsidy reimbursement is $600 for an individual and $3,500 for a family.

Options for Alabama

Alabama has established a single application form for determining eligibility for Medicaid, which is administered by the State Medicaid Agency, and ALL Kids, which is administered by ADPH. Applicants can complete the form manually and mail it to Medicaid or ALL Kids; fill it out and drop it off at district offices or county health departments across the state; or enter the information online and submit the application electronically. In addition, over the next 18 months, Alabama's Medicaid Agency plans to develop 17 customer service centers that will

allow residents to apply for Medicaid and ALL Kids at remote locations across the state; and the state is establishing 120 kiosks across the state that will allow more applicants to complete the eligibility process via the Web. These access points can be leveraged by the Alabama Exchange to provide residents with a one-stop shop for all medical coverage programs.

Although the state has established a single application that applies to both programs, each program has its own eligibility process and rules. That is, no single eligibility engine determines eligibility for both Medicaid and ALL Kids. An application may first be processed by the Medicaid Agency to determine eligibility under Medicaid, then sent to ADPH to determine eligibility for ALL Kids, or vice versa. CMS has informed the state that the current application process does not appropriately address the MAGI rules or the requirement that eligibility determinations be made in a single, streamlined manner.

In addition to separate eligibility systems and processes, in some instances families have one or more children covered by Medicaid while other children in the household are covered by ALL Kids. Medicaid eligibility differs based on the age of the child. Children up to, and including, age 5 are eligible if family income is no greater than 133 percent of the federal poverty level (FPL), while children ages 6 to 19 are eligible if family income is no greater than 100 percent of FPL. ALL Kids covers children who are not otherwise eligible for Medicaid with income up to 300 percent of FPL.

The Exchange will provide premium subsidies to individuals and families with income up to 400 percent of FPL. The amount of the premium for which they will be responsible depends on the applicant's FPL percentage and income. Tables 3-1 and 3-2 show the monthly premiums for various incomes and two household sizes—individual and family of four—based on the 2011 FPL standards.

Table 3-1. Exchange Premiums for Individual Coverage (household size = single)

Percentage of FPL	Annual income ($)	Premium as percentage of income	Member's share of monthly premium ($)
100	10,890	2.0	18
133	14,484	3.0	36
150	16,335	4.0	54
200	21,780	6.3	114
250	27,225	8.05	183
300	32,760	9.5	259
350	38,115	9.5	302
400	43,560	9.5	345

Table 3-2. Exchange Premiums For Family Coverage (household size = four)

Percentage of FPL	Annual income ($)	Premium as percentage of income	Member's share of monthly premium ($)
100	22,350	2.0	37
133	29,726	3.0	74
150	33,525	4.0	112
200	44,700	6.3	235
250	55,875	8.05	375
300	67,050	9.5	530
350	78,225	9.5	619
400	89,400	9.5	708

Expanding Medicaid to non-elderly residents with MAGI up to 138 percent FPL will essentially eliminate "split families" in which some children come under Medicaid and others under ALL Kids. However, with Exchange-based subsidies available to families with income up to 400 percent FPL, there will be families with income between 138 percent and 300 percent FPL in which the parents may be covered through the Exchange and the children through ALL Kids.

Because the state has already established a single application for Medicaid and ALL Kids, it only needs to modify a single application for the coverage expansions that will take effect in 2014, rather than consolidate multiple forms. The current strong working relationship and coordination between Medicaid and ADPH should enable the state to leverage these departments' resources in expanding Medicaid and establishing the Exchange.

The state is planning to review the current eligibility rules for Medicaid, ALL Kids, and the Exchange vis-à-vis the MAGI-based eligibility rules to determine how much they differ and how best to adjust them to ensure consistency across all programs. Federal guidance on eligibility determination for the Medicaid expansion and subsidized coverage through the Exchange, which is scheduled to be released shortly, will need to be incorporated as the state seeks to streamline the eligibility rules across all medical assistance programs.

The state will also need to address the potential financial liability for consumers who receive excess premium subsidies as it works on modifying its eligibility systems to support the Exchange. This could require the eligibility systems to permit robust income data matching, as well as a process for consumers to update information during the plan year regarding income or household composition that could affect their eligibility and the amount of premium subsidies through the Exchange.

With regard to the eligibility process itself, Alabama could choose to modify and consolidate all eligibility systems so that one system handles all applications for

coverage under Medicaid, ALL Kids, and the Exchange. The Exchange could then contract with the Medicaid Agency to handle eligibility on its behalf.

The state will need to evaluate whether the changes required to the Medicaid or ALL Kids eligibility system can be implemented in time to meet the mid-2013 date by which the updated eligibility system must be available, in order to process applications by October 1, 2013, for coverage that will take effect starting January 1, 2014.

An alternative approach to consolidating all programs under one eligibility system would be to modify either the Medicaid or ALL Kids process to incorporate the eligibility rules for Exchange coverage. This approach would require the state to maintain separate eligibility processes for Medicaid and ALL Kids. Because the Medicaid system will have to be modified anyway to handle its income expansion, the state will more likely modify the Medicaid system to also determine eligibility for the Exchange.

A third option is for the Exchange to set up its own eligibility system. Under this scenario, the Exchange would still need to work closely with Medicaid and ALL Kids, in light of the ACA objective to establish a "no wrong door" approach to applications for all medical assistance programs and in recognition of the requirement that the Exchange must screen for eligibility for Medicaid and ALL Kids.

The state should monitor the work of other states and the "Early Innovator" grantee states as they develop or modify eligibility systems for use by the Exchanges.[2] Early Innovator states received funding from the federal government for developing "cost-effective consumer-based technologies and models for insurance eligibility and enrollment for Exchanges."[3] The intent is for these states to develop information technology (IT) models that other states can adopt and tailor.

Adjudicating Appeals Pertaining to Eligibility Determination

The Exchange will need to establish a process to handle complaints and appeals by individuals and families found ineligible for premium subsidies or who disagree with the level of subsidy for which they were determined eligible. The method Alabama chooses to determine eligibility for the Exchange will likely influence the decision on how to handle eligibility complaints and appeals.

[2] Seven states individually or in consortia—Kansas, Maryland, Massachusetts, New York, Oklahoma, Oregon, and Wisconsin—were awarded approximately $241 million in total through the Early Innovator grant program. Since the award announcement in February 2011, Oklahoma and Kansas have opted out of the program and returned the grant.

[3] US Department of Health and Human Service, Office of Consumer Information and Insurance Oversight, *Cooperative Agreements to Support Innovative Exchange Information Technology Systems*, October 29, 2010.

Current Appeal Processes

Currently, the Medicaid and ALL Kids programs use separate in-house staff to handle eligibility appeals.

For the Medicaid program, information on appeal rights is included in the notice of determination sent to an applicant. If the applicant disagrees with the decision, the case is initially reviewed by a case worker, and if resolution is not achieved, the case is forwarded to a supervisor for review. The supervisor meets with the applicant, and if this meeting does not resolve the issue, the applicant can request a fair hearing before an administrative law judge. According to Alabama Medicaid officials, most appeals involve eligibility for long-term care (such as nursing homes), which will not be affected by the Exchange.

The ALL Kids program follows a similar procedure. Its staff reviews the case to verify that the determination was appropriate, and if that review does not resolve the appeal, the applicant can request an administrative review. ALL Kids staff also conduct the administrative review. Applicants can then request a final appeal with the state health officer or designee. ALL Kids officials indicate that only a handful of cases each year reach the administrative review stage.

Options for Alabama

The method for handling eligibility appeals for the Exchange may depend on the process and the entity that determines eligibility. If Alabama's Exchange leverages the Medicaid program's eligibility system and staff, it may be cost-effective and administratively efficient to have Medicaid staff handle appeals of eligibility. As the state looks to establish a "no wrong door" approach to eligibility for all medical assistance programs, instituting a centralized appeals process may also be worth pursuing. In addition, because some individuals will move between the Exchange and the Medicaid program over the course of a year as their circumstances change, the activities of these programs will need to be closely coordinated.

The Exchange could set up its own appeals process, with Exchange staff accessing the eligibility system to review information submitted by the applicant and the federal and state data sources used to determine eligibility. Regardless of the approach, the Exchange will need to adopt an appeals process, either independently or through an existing process.

Determining Eligibility for Exemptions from the Individual Mandate

An individual may be exempt from the individual mandate to obtain and maintain health coverage due to unaffordability of coverage, the individual's religious beliefs, or personal hardship. The Exchange will be responsible for certifying exemptions and verifying information submitted by an applicant and information

obtained from federal and state data sources. The Exchange will also need to report information to the IRS for individuals exempted from the mandate.

Qualifying for Exemption

If an individual's household income is less than the filing threshold for federal income taxes or if the required contribution for health coverage exceeds 8 percent of household income for the calendar year, coverage is considered unaffordable, and the individual will not be subject to a tax penalty.

Individuals may also file for an exemption based on religious beliefs or a hardship exemption if circumstances affect their ability to obtain or maintain coverage.

Determining eligibility for these exemptions will require coordination with, at a minimum, the IRS and HHS.

Options for Alabama

The Exchange will need to establish a process to certify exemptions from the individual mandate, in compliance with guidance to be issued by the federal government. Adjudicating these requests for exemption will likely require the development of both web- and paper-based applications for individuals to submit information necessary for making a determination.

Determining Eligibility of Businesses and Employees

For small businesses, the ACA establishes the Small Business Health Options Program (SHOP) Exchange. The SHOP Exchange is limited to firms with 50 or fewer full-time employees, but it also allows states to expand the small group market to firms of up to and including 100 employees in 2014. The federal healthcare reform law requires an expansion of the small group market to businesses with up to and including 100 employees by January 1, 2016, and allows the Exchange to offer coverage to larger groups (firms with more than 100 employees) in 2017 and beyond.

Defining Small Groups

Alabama will need to decide how it will define the small group market in 2014 and 2015, and whether it will expand the market from its current limit of 50 employees to 100 employees before it is required to do so in 2016.

In addition to the upper limits on the size of firms that may purchase coverage through the Exchange, the state may expand the definition of small groups to include sole proprietors or the self-employed. Currently, Alabama businesses with no employees beyond the owner of the firm and those in which a spouse is the

only employee are not allowed to purchase coverage in the small group market and must purchase coverage in the individual market. The definition of employer, under Section 1304 of the ACA, includes the following:

> (b) EMPLOYERS.—In this title:
>
> (1) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
>
> (2) SMALL EMPLOYER.—The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
>
> (3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a state may elect to apply this subsection by substituting "51 employees" for "101 employees" in paragraph (1) and by substituting "50 employees" for "100 employees" in paragraph (2).

The recently released proposed rule by CMS would allow the state to continue to define a small employer as a business with at least two employees (including the owner). Alabama—along with the vast majority of other states that define small employers in this fashion—can continue to prohibit the self-employed and sole proprietors from purchasing coverage in the small group market.[4]

Regardless of the size of firms allowed to purchase coverage, the Alabama Exchange will need to establish a process to verify, at a minimum, that

- the company is, in fact, a legitimate business;
- the employer meets Alabama's definition of a small group; and
- employees qualify for employer-sponsored insurance.

Information obtained from the employer will need to include, at a minimum, the employer's name and address, the employer's federal identification number, a roster of employees, and possibly payroll records or other documentation to verify that the employees meet the minimum requirements for participation in the employer's health insurance offering (such as that each eligible employee works, on average, at least 30 hours per week).

[4] The July 11, 2011 release of the proposed rule noted that states will be allowed to define their small group market to exclude "sole proprietors, certain owners of S corporations, and certain relatives of each of the above."

The Alabama Exchange may also need to verify that the employer meets the current participation requirements of 100 percent for groups with three or fewer employees and 75 percent for groups with more than three employees. That is, for the smallest groups (three or fewer employees), all of the employees must participate in the purchase of employer-sponsored insurance or have a valid waiver (covered through a spouse's policy, Medicare, or Medicaid); and for groups with more than three employees, at least 75 percent of eligible employees must take up the offer of employer-sponsored insurance or have a valid waiver.

Carriers may also have contribution requirements, which require an employer to contribute a minimum dollar amount or percentage toward employees' purchase of insurance. Minimum employer contributions of 50 percent of the monthly premium for individual coverage are currently required by some health insurers in the Alabama marketplace.

Options for Alabama

Employer and employee verifications are currently conducted in the market, either directly by health insurers—as is the case for BCBSAL, which employs captive agents and does not use independent agents—or by producers that handle this for other health insurers in the small group market. The Alabama Exchange will need to document the way health insurers verify that the employer qualifies to purchase coverage in the small group market, that the employees are eligible for coverage, and that the employer meets applicable participation and contribution requirements.

The Alabama Exchange will need to develop a standard eligibility process that applies to all health insurance carriers participating on the Exchange. This will allow an employer to complete one application and meet one set of eligibility standards. In developing this application process for small employers, the Exchange should consult with the carriers operating in the market to assess the similarities and differences in their processes.

If the Exchange were to allow each carrier to use its own application form and verification process for employers and employees purchasing through the SHOP Exchange, certain employers could be found eligible to purchase coverage through the Exchange from some carriers, but not all of them. Employers might also need to submit different types of information to satisfy the carriers' various verification processes. The recently released proposed rule indicates that CMS will require Exchanges to use a standard method for verifying employer and employee eligibility across all carriers participating in the Exchanges.

The Exchange will also need to determine how it will administer the eligibility verification process, whether Exchange staff will handle this in-house, the extent to which producers will be responsible for conducting these verifications, and the role of the health insurers.

With regard to participation and contribution requirements, Alabama will likely need to apply a consistent standard across all insurers. As with the employer and employee verification process, setting a uniform standard across all carriers in the Alabama Exchange will allow employers to meet one standard and complete one application.

These rules and procedures will need to be developed in close consultation with the carriers participating in the Exchange. In addition, consideration should be given to how these various standards apply to group coverage purchased outside the Exchange.

The following are a few key questions to consider:

- How is employer and employee verification currently conducted in Alabama's small group market?
- Do the major health insurance carriers collect similar information and use a common set of procedures to verify employers and employees?
- Can the Exchange adopt existing processes and develop a standard application form?
- Who will be responsible for carrying out these verifications?
- What role, if any, will producers play?
- Are there existing federal or state data sources that can be used to enable online verification of employers or employees?

ASSISTANCE TO SMALL EMPLOYERS FOR PREMIUM ASSISTANCE TAX CREDITS

To qualify for a small business tax credit in 2014, businesses with fewer than 25 employees that pay an average annual wage of less than $50,000 must contribute at least 50 percent of the premium for employee-only coverage purchased through the Exchange. The tax credits will be available to each eligible small business for up to 2 years.

Verifying Tax Credit Eligibility

Although the Exchange will not determine eligibility for the small business tax credit, it will need to coordinate with the IRS to verify employer eligibility for these tax credits and report enrollment information to the federal government.

Information on the availability of the employer premium assistance tax credits will need to be posted on the Exchange website and otherwise made available (for

example, via pamphlets and brochures) to employers and other interested parties. Call center staff, "navigators," and producers will need to be able to respond to inquiries regarding the tax credits or direct inquiries to people and entities that can respond.

Options for Alabama

At a minimum, the Exchange will need to make information available on the employer premium assistance tax credit program and support Alabama businesses in applying for those credits. This may include information, and possibly an electronic application, available to businesses via the Exchange website, as well as hard copy information and application materials. The Exchange will likely need to provide information to the IRS on the employers participating in the premium subsidy tax credit program.

Because these tax credits are limited to eligible employers that purchase coverage through the Exchange and are not available to employers that do not use the SHOP Exchange in 2014 and beyond, Alabama could use this exclusive arrangement to attract small employers to the Exchange. The Exchange could promote the availability of tax credits for small employers as part of a broader marketing campaign, and it could provide more focused outreach and assistance to employers who may be eligible.

Guidance from the federal government on the specific requirements of the Exchange with regard to the employer tax credit should be forthcoming. After reviewing this guidance, Alabama's Exchange will need to determine how it can best implement this program and support businesses that may be eligible for the tax credit.

Chapter 4
Enrollment and Disenrollment

The Exchange will need to facilitate health plan selection for an individual or family eligible to enroll in a qualified health plan, as well as for employees of employers who choose to purchase coverage through the SHOP Exchange. This facilitation will include

- providing a summary of benefits in a standardized manner about the qualified health plans available to allow for a comparison of health plans from the carriers participating in the Exchange;
- generating plan choice information that can be customized based on the individual's eligibility and personal preferences;
- calculating premiums and out-of-pocket limits for each qualified health plan;
- processing an individual's health plan choice and transferring enrollment data to the selected health carrier for the applicable qualified health plan;
- notifying CMS of the health plan selected by the enrollee to facilitate payments of the advance premium tax credit and the applicable cost-sharing reduction; and
- facilitating payment of premiums.

This facilitation will involve significant coordination and communication with the carriers offering qualified health plans through the Exchange and the federal government for individuals eligible to receive premium subsidies and reduced cost sharing. The section below reviews the functionality functions and processes that the Alabama Exchange will need to establish to facilitate enrollment in qualified health plans for the individual market and the small group market (SHOP Exchange).

INFORMATION ON QUALIFIED HEALTH PLANS

The Exchange will need to provide Web and hard copy information on the benefits under each of the qualified health plans so that potential enrollees can compare the plans' benefits and services.

Required Benefits

At a minimum, the information should include a basic overview of the major services covered (physician office visits, inpatient care, outpatient surgery, prescription drugs, etc.) and the point-of-service cost sharing for each service; a link or source to obtain more detailed information (evidence of coverage); and other information on the health carriers, as required by the ACA.[1]

All qualified health plans offered through the Exchange must cover the "essential health benefits" required by Section 1302 (b) of the ACA, and the health plans will be grouped into five coverage tiers or categories based on their actuarial value: platinum (90 percent), gold (80 percent), silver (70 percent), bronze (60 percent), and a catastrophic or high deductible health plan (HDHP). The HDHP plans will be available only to individuals under the age of 30 or individuals who have a certification of exemption from the individual mandate, based on affordability.

Structuring the market and grouping the health plans by their actuarial values—which is a summary measure of the percentage of allowed medical claims that are paid by the insurer—will allow consumers to evaluate comparable health plans offered by the carriers participating in the Exchange. However, because actuarial value will not be understood by most consumers and much health insurance vernacular is not well understood, the Exchange will need to develop tools and use terminology that is meaningful and understandable to its customers.

Options for Alabama

The way health plan information is presented should take into account the health insurance literacy of the people who will be purchasing coverage through the Exchange. Most people in Alabama—as is true for most people across the country—have never actually shopped for health insurance as individual purchasers. Unlike other types of insurance such as auto, homeowners, or life, health insurance is not typically purchased by an individual.[2] It is provided either through state-federal programs, like the Alabama Medicaid and ALL Kids programs, or by employers to their employees.

[1] Section 1311 (e)(3)(A) of the ACA requires qualified health plans to submit to the Exchange, the federal Secretary of HHS, and the state insurance department the following information: claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment data, number of claims denied, rating practices, cost-sharing and payments for out-of-network coverage, enrollee and participant rights, and other information "as determined necessary by the Secretary."

[2] Based on 2009 data from the US Census Bureau's Current Population Survey, released in August 2010, direct purchase of health insurance by Alabamians represented roughly 6 percent of all people under age 65 covered by private health insurance. Across the United States, the direct purchase of health insurance comprised roughly 9 percent of all privately insured individuals under age 65.

In developing the website and hard copy information, the Alabama Exchange could leverage the expertise and experience of insurers, producers, and other entities and organizations that deal directly with consumers in the Alabama health insurance marketplace, particularly the individual and small group markets. There are also local and national consumer organizations with experience working with low- and moderate-income residents that might provide insight into effective ways to convey information to these people.

Health insurers typically prepare a summary of benefits giving an overview of the covered benefits and the cost sharing that applies to the major services. The Exchange will need to standardize this information across carriers to allow individuals and families to compare health plans uniformly. It will also need to give consumers access to more detailed information on the qualified health plans, as well as on the performance of the health carriers.

Additional information for potential enrollees might include a "provider look up" capability to enable an individual to enter a doctor's or hospital's name on the Exchange's website or to inquire through the Exchange's customer service unit and determine which of the health plans include the doctor or hospital in their respective provider network.

The Exchange will need to inform consumers about the health carriers offered through the Exchange. The specific types of information to be made public will be developed by HHS but will include claim payment policies and practices, financial disclosures, enrollment and disenrollment statistics, claims denied, rating practices, out-of-network coverage and cost sharing, and enrollee rights. The Alabama Exchange may choose to add to the federal disclosure requirements.

The ACA also requires the Exchange to rate qualified health plans offered in each benefit level (platinum, gold, silver, bronze, and catastrophic) on the basis of quality and price. This information will need to be given to potential enrollees and displayed on the Exchange website. Enrollee satisfaction survey results, for plans with more than 500 enrollees in the previous year, must also be posted on the Exchange's website and given to consumers.

A key decision for the Alabama Exchange will be the number of health plans offered and how they vary within each benefit level in terms of such factors as point-of-service cost sharing and the types of plans—health maintenance organization (HMO), preferred provider organization (PPO), indemnity. The ACA provides flexibility with regard to the plans offered and the cost sharing, within the parameters of actuarial value set by the ACA and the inclusion of the essential health benefits.

On the one hand, dictating the specifics regarding the amounts and types of cost sharing for each service within each benefit level might help focus consumer decisions on premiums, provider networks (hospitals and physicians), quality of service, and reputation of the carrier. On the other hand, an overly standardized

approach may stifle creativity in the market and reduce a consumer's ability to trade off one type of cost sharing (for example, an upfront deductible, with lower cost sharing after the deductible) for other types of cost sharing (such as no up-front deductible, with higher copayments) within the same benefit level.

While standardizing benefits may be desirable from the perspective of helping consumers navigate what can be a confusing process, being overly prescriptive and micromanaging the health plan designs within the Exchange may result in products that are out of sync with the market and may stifle innovation. The extent to which benefits are standardized will be an important decision for the Alabama Exchange.

GENERATING CUSTOMIZABLE PLAN CHOICE INFORMATION

As noted above, we project that the vast majority of Alabamians seeking coverage through the Exchange will be purchasing health insurance for the first time. To help people make informed decisions, the Exchange will need to give these consumers actionable information and decision support tools that enable them to customize their shopping experience and narrow their search to qualified health plans that best meet their needs. Identifying the criteria that are most important to individuals and families, and establishing a way for consumers to narrow their choices to qualified health plans that best meet their needs, much like consumers today narrow their choices for various products, will be key to the Exchange's success.

Information Needs

At a minimum, the Exchange will need to give consumers a way to sort qualified health plans by premiums and out-of-pocket costs (see the discussion below on calculating premiums). With qualified health plans available in five different levels or tiers (platinum, gold, silver, bronze and catastrophic), there will likely be a wide range of benefit designs. Consumers may want to sort their choices by deductible level, or cost sharing for physician office visits, or cost sharing for inpatient admissions, or the quality rating of the health plan, or any number of variables that consumers may find useful. As noted above, the Exchange might also provide a way for consumers to find out which qualified health plans include a particular physician or hospital in their provider network.

The recent proposed rule includes a requirement that insurers participating on the Exchanges provide, and regularly update, a database that includes providers in their network. Alabama's Exchange may want to use these files to help consumers customize their search for plans that include their preferred physician or hospital. The ability to narrow searches will be particularly important if there are multiple carriers offering numerous qualified plans on Exchange.

Options for Alabama

A number of private-sector vendors have developed health plan selection and consumer decision support tools that the state might review to determine whether they could provide the Alabama Exchange consumers with customizable plan information. The Exchange might consider issuing a request for information (RFI) or otherwise establishing a process that would allow it to evaluate the capabilities of the various vendors in the marketplace.

In addition, the federal government is soliciting private-sector vendors to assist the Center for Consumer Information and Insurance Oversight (CCIIO) in developing tools that help consumers purchase coverage through the federally facilitated Exchanges. The state should also monitor the activities of other states, including Early Innovator states that have received federal grants to develop prototypes and the IT infrastructure needed to operate Exchanges.

CALCULATING PREMIUMS AND OUT-OF-POCKET LIMITS

Each Exchange will need to provide consumers with a cost calculator that estimates the total cost of coverage, including premiums and point-of-service cost-sharing, taking into account both the advance premium tax credits as well as any cost-sharing reduction that may apply to the applicant.

Cost Calculator Features

At a basic level, the cost calculator would enable an individual to compare health plans based on annual premiums and maximum out-of-pocket expenses, which will vary based on the applicant's income and FPL.

A more advanced cost calculator might allow an applicant to enter member-specific information on expected healthcare utilization (office visits, prescription drugs, outpatient care, inpatient admissions, etc.), which would then generate potential member costs for the various health plans offered through the Exchange. This would require linking benefit designs (deductibles, copays, coinsurance) for the offered plans to a tool that can generate member-specific estimates.

Options for Alabama

As with consumer decision support tools (discussed in the preceding section), a number of private-sector vendors have developed cost calculators that the state might evaluate to determine whether they could enable the Alabama Exchange to give consumers customizable plan choice information. The exchange might consider issuing an RFI or otherwise establishing a process for evaluating the capabilities of these vendors.

The federal government is also soliciting private-sector vendors to provide CCIIO with a cost calculator that consumers could use to estimate their total cost of coverage. It will be important for Alabama to monitor the activities of other states, including Early Innovator states, to identify vendors that they and CCIIO might use for this capability.

PROCESSING AN INDIVIDUAL'S HEALTH PLAN CHOICE

Having provided the consumer with information on the qualified health plans available through the Exchange and the decision support tools to help them narrow their health plan choice, the Exchange will need to process an individual's health plan choice.

Facilitating Enrollment

Alabama's Exchange will need to notify the issuer of the qualified health plan selected by the individual, notify CMS to facilitate payments of advance premium tax credits and cost-sharing reductions, if applicable, and process the issuer's response to the Exchange enrollment transaction.

Options for Alabama

The state has a number of options with regard to how it processes enrollment. The private-sector enrollment systems already in place across the country offer Alabama a range of choices. Alabama's Exchange will want to establish a process to evaluate the capabilities of the various systems that are currently in the market, as well as enrollment systems being developed by CCIIO and other state Exchanges. Criteria for evaluating the systems will be greatly influenced by the extent to which the Alabama Exchange chooses to be involved in premium billing. Alabama could choose to use a third-party administrator to coordinate premium billing and aggregate premiums from multiple payers (individuals, employers, employees, and the federal government).

The Exchange might also consider making available a health risk assessment tool to allow an individual to share a limited amount of personal health information to enable the carrier to determine whether the enrollee might benefit from care management or disease management programs. Many of the people enrolling through the Alabama Exchange will be new to the insurers and probably newly insured, so a health risk assessment tool may be an added value that the exchange can bring to the market.

PAYING THE PREMIUM AND APPLYING THE ADVANCE PREMIUM TAX CREDIT

The ACA and the recently released proposed rule establish requirements relating to billing, collecting, and aggregating premiums, which could vary between the individual and small group markets.

Administering Payment

With regard to the individual market, the Exchange has three options for its role in administering premium payments:

- Play no active role.
- Facilitate the payment of premiums by creating an electronic pass-through without directly retaining any payments.
- Collect premiums from multiple sources and submit a reconciled aggregated sum to the qualified health plan issuers.

Regardless of the options elected, the Exchange will need to establish a process for consumers who wish to pay premiums directly to the health insurer.

The SHOP Exchange must be able to do the following:

- Accept payment of an aggregated premium by an employer.
- Facilitate electronic collection of premium payments, which could include the Exchange acting as a simple pass-through or the Exchange collecting and distributing premiums to the qualified health plan issuers.
- Develop a single monthly bill for all qualified health plans in which an employer's employees are enrolled and process a single monthly payment from the employer.

The employee choice model offered by Alabama's SHOP Exchange—and the extent to which an employer's employees are allowed to select from among the qualified health plans and health insurers offered through the Exchange (discussed further below)—will affect the capabilities of the premium payment process that the Exchange will need to establish. Because the proposed rule requires all SHOP Exchanges to permit employers to allow their employees to select from at least a subset of qualified health plans and health carriers, the Alabama Exchange will need to establish a way for an employer to receive a single bill that covers all health plans selected by its employees.

Options for Alabama

As noted above, a number of vendors in the market are touting solutions that the Alabama Exchange will want to evaluate to determine which offers the most robust and cost-effective way for the Exchange to facilitate health plan premium billing and collection. Alabama should be able to leverage work already completed or underway in other states for their Exchange IT solutions with regard to enrollment, premium billing, and collection, as well as systems being procured by the federal government.

PLAN CHOICE FOR EMPLOYERS AND EMPLOYEES IN THE SHOP EXCHANGE

How employers—and ultimately employees—can purchase coverage will be one of the more important policy decisions for the Alabama Exchange, and will likely determine the ultimate success of the SHOP Exchange. Key policy decisions include participation requirements, contribution requirements, and the number and types of health plans offered. Each is discussed briefly below.

Participation and Contribution Requirements

Health carriers that offer coverage in the small group market require a minimum percentage of employees to enroll as a precondition for selling group coverage. An employer with three or fewer employees typically must enroll all of the employees in the group's health plan, unless an employee is covered under another plan (such as spousal coverage, coverage as a dependent under a parent's health plan, Medicaid, or Medicare). For groups of four or more employees, the participation requirement is generally 75 percent. If an employer cannot meet these enrollment thresholds, the health carrier will not sell the policy to the group.

Carriers also require employers to contribute a minimum amount of the monthly premium—generally 50 percent of the premium for single coverage—as a precondition for offering group coverage. Employers unable or unwilling to contribute at least 50 percent are not offered group insurance by the carrier.

The participation and contribution requirements protect against adverse selection and the risk of bad debt. The term "adverse selection" refers to the phenomenon where a person's demand for insurance, and level of coverage, is directly related to that person's perceived need for insurance. Older and sicker people may be more prone to participate in the insurance plan or enroll in the most comprehensive coverage, while those who are younger and healthier may choose to go without coverage or opt for a more limited policy.

Because carriers may not know the health status of group members, they cannot adjust prices to account for this selection bias. By requiring all or most employees

to be covered by the group policy, the carriers can minimize the potential for adverse selection. The contribution requirement helps reduce the risk of bad debt.

Key policy decisions for the Alabama Exchange will be whether the participation and contribution requirements that apply to employers purchasing coverage outside of the Exchange will apply to employers purchasing coverage through the Exchange. Besides establishing participation and contribution requirements, the Exchange will need to determine the method for calculating these requirements.

In today's marketplace, health insurers do not allow small employers to offer their employees a choice of insurers. This means that the participation and contribution requirements apply to a single carrier. Under an employee choice model that might be available through the Exchange, discussed further below, the employer could offer employees a number of health plans from a range of carriers.

The Exchange could require an employer to meet participation and/or contribution requirements, and a minimum percentage of employees would need to purchase coverage as part of the group through the Exchange. However, if these employees are allowed to choose coverage from multiple health insurers, the employer may not meet the participation requirements for each (or any) of the health insurers if employees opt for coverage from multiple health insurers.

Options for Alabama

How employers—and by extension their employees—purchase coverage through the SHOP Exchange will affect whether the Exchange can effectively serve the group market. While any number of purchasing models are possible, below we present four that Alabama could consider. These are not necessarily mutually exclusive, since the Exchange could allow employers to select from two or more options.

EMPLOYER PURCHASING MODELS

One Carrier, One Plan

The first model represents the traditional way that employers, particularly small employers, purchase insurance. The employer selects a carrier and a health plan, and the employees are allowed to enroll in the plan. The employer—aided, perhaps, by a producer—could use the exchange platform to compare health plans, assess premium contribution options, and select a carrier and plan for the employees. Table 4-1, and the others that follow in this section of the report, display hypothetical premiums for single coverage. The hypothetical premiums are not based on rates or plans available in the Alabama market, and are used purely to demonstrate how a SHOP Exchange might structure a purchasing model for an employer and his/her employees.

Table 4-1. Monthly Premiums for Single Coverage ($)

Health plan/carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	540	531	518	554
Gold	480	472	460	492
Silver	420	413	403	431
Bronze	360	354	345	369

A composite rate could be developed for the group (a monthly premium for single coverage, employee plus spouse/child, and family coverage), and the employer and employee shares of the premiums could be set for the entire group.

One Carrier, Multiple Plans

Under the second purchasing model, the employer would select a health carrier and allow employees to enroll in any of the health plans offered by that carrier through the Exchange. Table 4-2 illustrates how premiums for this model might be structured.

Table 4-2. Monthly Premiums for Single Coverage ($)

Health plan/carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	540	531	518	554
Gold	480	472	460	492
Silver	420	413	403	431
Bronze	360	354	345	369

Under this example, the employer selects carrier B and the employees may choose from any of the health plans it offers. The employer could set its share of the premium contribution as a percentage of the cost of a specific plan (for example, 70 percent of the cost of carrier B's silver plan), as a percentage of all plans' premiums, or as a flat dollar amount. In the example below, the employer's premium contribution is pegged at 70 percent of the cost of the silver plan.

The employee could opt for the silver plan or take the employer's contribution—in this case, 70 percent of $413, or $289—and purchase a gold or platinum plan, which would cost the employee more, or a bronze plan, which would reduce the employee's monthly premium. The employer's share of the cost is fixed, while the employee's amount varies depending on the plan. Table 4-3 shows how this defined contribution option might be structured for an individual employee.

Table 4-3. Employee Contributions under Single Carrier Model ($)

Carrier B	Total monthly premium	Employer's share of the premium	Employee's share of the premium
Platinum	531	289	242
Gold	472	289	183
Silver	413	289	124
Bronze	354	289	65

Because employees may select from a number of health plans offered by a single carrier, the group's premiums likely would need to switch from composite rating to list bill rating. Under composite rating, premiums are set on a group basis, and the same rates apply to all individuals and families who enroll in coverage. Under list bill rating, premiums are set for each individual and family who enrolls in coverage.

Take, for example, an employer with two employees, a 60-year-old and a 20-year-old. Under composite rating, the insurer quotes a premium for single coverage that applies to both employees—say, $400 per month per employee, or $800 in total. Using a list bill method, the premium might still total $800 for both employees, but the amount for the older employee would be higher than for the younger employee—perhaps $200 for the 20-year-old and $600 for the 60-year-old. If employees can select from a number of different plans through the Exchange, premiums will need to reflect the enrollment choices of individual employees.

All Carriers, One Plan Level

Under the third purchasing model, the employer would select a plan level (platinum, gold, silver, or bronze) and allow employees to select from any of the health carriers offering qualified health plans at that level. Table 4-4 illustrates how this model might be structured.

Table 4-4. Monthly Premiums for Single Coverage ($)

Health plan/carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	540	531	518	554
Gold	480	472	460	492
Silver	420	413	403	431
Bronze	360	354	345	369

The employer selects the silver level plan, and employees may choose from any of the carriers that offer a silver plan through the Exchange. The employer could set its premium contribution as a percentage of the cost of a specific plan, such as

70 percent of the cost of carrier B's silver plan. If the employee selects carrier B's silver plan, the employee would pay 30 percent of the cost.

The employee would then have the option of taking the employer's contribution—in this example, $289—and purchase a silver plan from any of the other carriers. The employer's share of the cost is fixed, while the employee's amount will depend on which carrier the employee selects. Table 4-5 shows how this approach might work for an individual employee.

Table 4-5. Employee Contributions under Plan Level Model ($)

Carriers' silver level plan	Total monthly premium	Employer's share of the premium	Employee's share of the premium
Carrier A	420	289	131
Carrier B	413	289	124
Carrier C	403	289	113
Carrier D	413	289	141

Because employees may select from a number of carriers within a plan level, premiums would likely need to switch from composite rating to list bill rating, as described above.

All Carriers, All Plans

Under the fourth purchasing model, employees would be allowed to select from any of the plans offered by the carriers participating in the Exchange. The employer's share of the premium could vary based on the percentage of the premium (for example, 70 percent of any plan's premium); or it could be set based on the premium of a particular plan offered by a specific carrier (for example, 70 percent of the silver plan offered by carrier B); or the employer could grant employees a flat dollar amount and allow them to use that contribution to purchase any health plan offered through the Exchange. Table 4-6 shows all of the possible premiums for covering an individual employee.

Table 4-6. Monthly Premiums for Single Coverage ($)

Health plan/carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	540	531	518	554
Gold	480	472	460	492
Silver	420	413	403	431
Bronze	360	354	345	369

As with the previous two models, because employees may select from any of the health carriers offered through the Exchange, premiums would need to be established on a list bill basis.

Each of these models brings with it implications for the Exchange's attractiveness and sustainability, operational and administrative challenges, the potential for adverse selection, and ramifications for the broader commercial insurance market. The Exchange will need to evaluate the advantages and disadvantages of each purchasing option and determine which model will work best for Alabama's employers, employees, residents, and insurers.

PREMIUM BILLING, COLLECTION, AND REMITTANCE

The need for the SHOP Exchange to administer premium billing, collection, and remittance will be particularly crucial. Depending on how the SHOP Exchange structures its purchasing model, employees may be able to choose coverage from a number of carriers. If the plans are responsible for premium billing and collection, an employer purchasing coverage through the Exchange would likely need to pay multiple health carriers for the different health plans selected by the employees.

From an employer's perspective, the prospect of paying multiple insurers would greatly diminish the attractiveness and value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for employee coverage, if premium billing and other administrative functions are not centralized within the Exchange, the employer would need to deal with various carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks now handled by the carrier or through a producer.

In light of those administrative challenges, the Exchange will likely be the most appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other mid-year administrative tasks, such as changes in enrollment, Consolidated Omnibus Budget Reconciliation Act (COBRA) notification, and so on. In addition, the Exchange could be responsible for administering the premium tax credits program for eligible small employers that employ low-wage workers. This responsibility might be better coordinated through a centralized process established by the Exchange.

DISENROLLMENT

The Exchange will need to establish policies and procedures to allow enrollees to terminate coverage, as well as a process that allows either the Exchange or the enrollee's QHP to terminate coverage. The recently released proposed rule includes a discussion of the circumstances under which enrollees may terminate coverage and the specific procedures that the Exchange and QHP must follow with regard to disenrollment.

For enrollees who choose to terminate coverage, the Exchange will need to set up a process that allows the subscriber to specify the effective date of coverage

termination. The proposed rule states that "the last day of coverage is the termination date specified by the enrollee, if the Exchange and QHP have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage;" or if the Exchange and QHP aren't provided a "reasonable amount of time," the last day of coverage is the "first day after such reasonable amount of time has passed."

Coverage for commercial insurance typically terminates at the end of the month, and enrollees are not allowed to specify the termination date. The Alabama Exchange will need to work with the QHP issuers to establish a process permitting enrollees to specify the termination date or otherwise accommodate mid-month terminations.

There will also be instances when the Exchange or the QHP terminate coverage. The proposed rules identify a number of circumstances that would allow either the Exchange or the QHP issuer to terminate coverage, such as the enrollee becoming ineligible, the enrollee selecting coverage by another plan in the Exchange or outside the Exchange, decertification of the QHP, relocation outside the QHP's service area, fraud and abuse, or failure to pay a premium.

With regard to failure to pay, the law requires the Exchange—and by extension the qualified health plan issuers—to grant enrollees receiving an advance premium tax credit a grace period of at least 3 consecutive months if the enrollee has previously paid at least 1 month's premium. This means that an enrollee must continue to receive coverage for at least 90 days after failing to pay a monthly premium. While the proposed rules state that QHP issuers are not required to grant a 3-month grace period to enrollees who are not receiving an advance premium tax credit, they also note that QHPs "must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium," and the policy "must be applied uniformly to enrollees in similar circumstances."

Clarification of how the proposed rule will apply to those in the Exchange who are not receiving a subsidy will be needed before the Alabama Exchange can establish a uniform policy for terminating both subsidized and non-subsidized enrollees. In addition, the proposed rule requires carriers to continue to pay claims on behalf of the enrollee during the grace period. Standard insurance practice does not require insurers to pay claims outside the standard grace period, and carriers frequently suspend claims payments, particularly for non-emergency services and supplies during the grace period. Alabama Exchange staff will need to assess whether carriers providing coverage through the Exchange need to change their operating procedures.

Lastly, the Exchange and QHP issuers will need to notify enrollees that their coverage has been terminated, inform CMS each month about the number of terminations, and maintain comprehensive records of their disenrollment experience with Exchange enrollees.

Chapter 5
Information and Outreach

CUSTOMER SERVICE AND CALL CENTER

As part of its plan to provide assistance to individuals and small businesses, Alabama's Exchange must operate a toll-free number to respond to requests for assistance from consumers. The call center must be able to respond to the specific needs of the individual as well as employers and employees, such as inquiries related to eligibility, plan selection, premiums, tax credits, appeal status, and availability of providers in the different health plans offered through the Exchange, as well as enable callers to access the services of navigators and producers. In addition, the call center will need to be able to assist consumers with limited English proficiency (LEP), in much the same way that Medicaid and ALL Kids provide assistance to individuals with LEP. The call center will need to be operational no later than October 1, 2013, to support customers during the initial open enrollment.

In addition to the call center, the Alabama Exchange may also want to establish an online help center that would allow individuals, employers, and employees to ask questions and receive answers in real time through the Exchange website. The online help center could also provide guidance for navigators and producers when they have questions on behalf of the consumers they serve or if they need further clarification on product offerings or Exchange operations.

EXCHANGE WEBSITE

Alabama's Exchange will need to establish and maintain a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and complete enrollment. The website will need to post required transparency information. In addition, each Exchange website must provide an electronic calculator that allows people to view an estimated cost of their coverage once tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if applicable.

The website must be easily navigable and conform to Americans with Disabilities Act standards for accessibility, as well as provide access to information for residents with LEP. In addition to the general features described above, the website must also

- enable navigators and producers to assist individuals and employers in completing enrollment and renewals;

- enable identity verification;
- allow carriers to manage benefits, submit products for certification, and receive enrollment and network selection data and premium payments;
- allow employers to set up accounts; select plans by tiers, carriers, or products; apply contribution arrangements; and pay premiums; and
- track employer tax credits.

The Web portal will serve as a central point of access for individuals and employers to obtain information on commercial health insurance available through the Exchange, compare health plans, enroll in coverage, make premium payments, and update their account during the year. In addition, the website will need to enable individuals to apply for an exemption from the individual mandate. The site must, at a minimum, do the following:

- Allow a streamlined process for individuals and families to apply for subsidized health coverage, including Medicaid, ALL Kids, and premium subsidies available through the Exchange.
- Seamlessly link visitors to the eligibility engine, allow individuals and families to enter information online, and determine their eligibility for all health coverage programs.
- Direct people eligible for Medicaid or ALL Kids to those programs to complete the enrollment process.
- Have individuals found eligible for coverage through the Exchange—whether or not they are eligible for premium subsidies and reduced cost sharing—continue on Alabama's Exchange website to evaluate their health plan options and continue with the enrollment process.

The eligibility engine will determine whether an individual or family is eligible for coverage through the Exchange, and whether the applicant qualifies for premium subsidies and reduced cost sharing. The engine will do this by processing the following information:

- Name, address, and date of birth of each person to be covered (if the person is applying for family coverage, data on each member to be covered by the plan must be entered into the system)
- Social Security number and information on the enrollee's immigration status
- MAGI
- Family size

- Availability of employer-sponsored insurance, including
  - the employer's name, address, and employer identification number (if available) and
  - whether the applicant is a full-time employee and is offered minimum essential coverage.

If the employer offers minimum essential coverage, then the engine will need to identify the lowest cost health plan offered by the employer and the enrollee's share of the premium for the single coverage to determine whether the employee's share of the premium is "affordable."[1]

For legal residents who are not offered employer-sponsored insurance, with income between 138 percent and 400 percent of FPL, the Exchange website—or rather the business process that runs behind it—will need to be able to receive data from the eligibility engine to calculate the premium subsidies and reduced cost sharing for which an individual or family may be eligible. The Exchange will need to be able to generate rates (or otherwise obtain rates from the carriers in real time) for all health plans, apply the appropriate premium subsidy and cost-sharing reduction, and display that information for the eligible individual or family.

In addition to generating premiums and cost-sharing reductions, the Exchange website will need to display benefit summaries to allow a consumer to compare plans. This will likely include both a summary plan description that captures the major benefits and applicable cost sharing, as well as a link to more detailed information for each plan offered through the Exchange.

The website will need to provide a cost calculator that provides an estimate of the total cost of coverage, including premiums and point-of-service cost sharing (discussed above). Additional website functionality might include the provider look-up tool, as well as a health risk assessment tool to allow an individual to share a limited amount of personal health information to enable the selected carrier to determine whether the new enrollee might benefit from care management programs.

The website will need to display comparative information on the carriers and plans offered through the Exchange. The specific types of information to be made public will be developed by HHS but will include claims payment policies and practices, financial disclosures, enrollment and disenrollment statistics, claims denied, rating practices, out-of-network coverage and cost sharing, and enrollee rights. The Alabama Exchange may add to the federal disclosure requirements.

The ACA requires the Exchange to rate qualified health plans offered at each benefit level (platinum, gold, silver, bronze, and catastrophic) on the basis of

[1] Employer-sponsored insurance is considered affordable if the employee's share of the premium is not more than 9.5 percent of the applicant's MAGI, and the health plan has an actuarial value of at least 60 percent.

quality and price. This information will need to be provided to potential enrollees and displayed on the Exchange website. The website must also post enrollee satisfaction survey results, for plans with more than 500 enrollees in the previous year.

The website must also contain information, and most likely an online application, for people to apply for an exemption from the requirement to obtain and maintain health coverage (the individual mandate). People may be eligible for an exemption from the mandate based on affordability (if the cost of coverage is more than 8.0 percent of their MAGI), religion, membership in an Indian tribe, or personal hardship, based on criteria to be determined by the secretary of HHS. A process to handle these applications, as well as an appeals process, must also be established by the Exchange (see the previous discussion for additional details on these responsibilities).

Chapter 6
Exchange Financing

The Exchange will act as a conduit for premium payment transactions, including processing and tracking payments, applying premium tax credits, and managing premium aggregation from multiple sources (including employers, individuals, and spouses' employers). In addition, the Exchange will be responsible for tracking delinquent payments, administering the determined tax credits and cost-sharing reductions, and facilitating data exchange among various state and federal systems. Many of the required financial functions will directly depend on financial determinations calculated as part of the eligibility process.

The ACA requires a number of financial and risk management capabilities and functions, including

- risk management,
- premium payment administration, and
- financial sustainability.

FINANCIAL MANAGEMENT AND RISK MANAGEMENT

The risk management requirements mandate solutions to smooth out or spread risk. The primary processes may include administering a reinsurance program; receiving, processing, and paying high-risk claims that reach the assigned attachment point; and measuring, reporting, and analyzing financial performance across the commercial markets, for health plans sold inside and outside the Exchange.

Alabama insurers are currently allowed to set premiums in the individual and small group markets based, in part, on the health status of applicants or small employer groups; they are allowed to raise premiums if individuals or small group members become ill; and they are not required to accept all applicants for coverage in the individual market (there is no guaranteed-issue requirement).

Under the federal healthcare reform law, medical underwriting will no longer be allowed in the individual and small group markets. In 2014, health insurance policies in these markets will be guaranteed-issue using a modified community rating system to set premiums. Premiums will still vary, primarily based on the age of the applicant, but also may vary based on tobacco use, geographic rating area, and rate basis type (e.g., single, parent and child, family). However, the health status of individuals or groups will not be a factor in setting premiums.

These changes in the rating rules will mean that individuals and small employers who are currently unable to purchase insurance or who are effectively priced out of the market due to health status or preexisting conditions may be able to purchase coverage. They will also mean that individuals and small employers who have coverage today may see their premiums increase, because people who had previously been denied coverage due to their medical conditions will now be included in the individual and small group market risk pools. For example, people covered in Alabama's federally administered high-risk pool (the Preexisting Condition Insurance Plan) will be able to purchase coverage through the Exchange and will become part of the individual market risk pool.

The law recognizes that these changes to the individual and small group market rules may cause risk selection problems for some insurers. To mitigate the impact of these changes, section 1341 of the healthcare reform law includes three mechanisms for addressing risk selection and giving insurers some financial protection:

1. A transitional reinsurance program for the individual market in each state

2. Risk corridors in the individual and small group markets

3. Risk adjustment to transfer funds among plans that offer coverage in the individual and small group markets based on the relative health status of their enrollees.

These provisions are designed to mitigate the adverse risk selection problems that could result from the switch to a guaranteed-issue, modified community rating system. Each mechanism is briefly described below. These provisions will not apply to grandfathered plans.[1]

[1] Many provisions of the ACA apply to all health plans, both those in existence on March 23, 2010, when the ACA was signed into law—grandfathered plans—and new health plans. However, some provisions apply only to new health plans, exempting existing plans from making changes. Grandfathered plans that people purchase on the individual market are exempt from provisions such as a ban on preexisting condition exclusions and bans against annual limits on coverage.

All grandfathered plans are exempt from certain requirements so long as employers do not significantly lower their premium contributions to employee plans and plans do not increase people's cost-sharing requirements beyond certain limits. Grandfathered plans do not have to comply with the following provisions:

- Offer an essential benefit package in the individual and small group markets in 2014
- Eliminate cost-sharing for preventive services
- Report on quality improvement activities
- Guarantee access to emergency, pediatric, and OB-GYN services.

In general, health plans can retain grandfathered status if the changes they make do not reduce the comprehensiveness of the plan.

Reinsurance

For the first 3 years of the Exchange (January 1, 2014–December 31, 2016), states that choose to operate an Exchange must establish a reinsurance program for the individual market. A reinsurance entity will collect payments from insurers in all markets (the individual and group markets, as well as from third-party administrators) and make reinsurance payments to the insurers in the individual market to cover the costs of high-risk individuals. The Secretary of HHS, in consultation with the National Association of Insurance Commissioners and the states, will develop guidelines and procedures for the transitional reinsurance program. The Secretary of HHS will also develop the method for determining how much insurers contribute to the reinsurance program.

Risk Corridors

The Secretary of HHS must establish a national risk corridors program for qualified health plans in the individual and small group markets that will be effective 2014 through 2016. If a health plan's "allowable" (non-administrative) costs in the individual and small group markets exceed 103 percent of total premiums (excluding administrative costs), HHS will make payments to the health plan to defray the excess costs. Conversely, if a plan's non-administrative costs are less than 97 percent of total premiums (excluding administrative costs), the health plan will need to pay HHS a portion of the excess premiums. Recently released proposed rules for the risk corridors program suggest that this provision will apply only to qualified health plans sold through the Exchange.

Risk Adjustment

Third, Alabama, in consultation with the Secretary of HHS, will be required to establish a risk adjustment program for the individual and small group markets, or the state can choose to defer to the federal government to operate a risk adjustment program in Alabama. The program will assess charges against health plans with enrollees of lower than average risk and make payments to health plans with enrollees of higher than average risk.

The premium payment administration requirements, discussed above, include processes relating to billing, collecting, aggregating, transmitting, reporting, and reconciling insurance premium payments from multiple sources, including individuals, employees, employers, and the federal government.

FINANCIAL SUSTAINABILITY REQUIREMENTS

The financial sustainability requirements relate to the need for the Exchange to be financially self-sustaining by 2015. This will require Alabama to establish a means to support Exchange operations once federal funds are no longer available (the end of the first year of operations).

Establishing the Exchange will require the state to prepare a comprehensive financial management plan to ensure successful implementation. The Exchange will be responsible for not only managing federal grant funds but also establishing a financial sustainability plan for 2015 and beyond. It is critical that the Exchange develop a financial management system that offers integrity and a thoughtful and detailed approach to maintain credible spending, revenue, and accounting streams.

As required by federal regulations, the Exchange must have adequate financial management systems and provide efficient and effective accountability and control of all property, funds, assets, and related grants and cooperative agreements. The budget for the Exchange will need to include the following:

- Staff salaries and benefits
- General administrative services
- Consultants and professional support
- Facility costs
- Maintenance
- IT and communication
- Marketing and outreach
- Eligibility, enrollment, and premium billing services
- An evaluation plan
- Enforcement of the individual mandate and appeals.

Some of these functions will be outsourced and others performed in-house. Federal guidance indicates that Medicaid eligibility determination systems will be eligible for an enhanced federal matching rate of 90 percent for system design and development and 75 percent for ongoing maintenance. A cost allocation methodology will need to be developed to determine the federal portion of the design and build costs and the state obligation for them. Lastly, the Exchange will need to establish and execute financial controls and audit protocols to ensure the validity and appropriateness of all financial transactions occurring within the Exchange. This information will need to be made publicly available, as well as a number of reports that the Exchange will need to produce that summarize its finances and operations.

Chapter 7
Health Plan Certification

CERTIFICATION, RECERTIFICATION, AND DECERTIFICATION

The Exchange will offer health plans at five benefit levels: platinum, gold, silver, bronze, and catastrophic. The levels will vary by actuarial value, which is a summary measure of the amount of medical claims paid by the health plan (not including member cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Platinum plans will cover 90 percent of the cost of care, which means a person enrolled in a platinum plan, on average, would pay 10 percent of the cost of healthcare through copayments, coinsurance, and other types of cost sharing. The premiums would cover the rest of the cost of care.

Gold plans will cover 80 percent, silver plans 70 percent, and bronze plans 60 percent. Catastrophic plans, which are HDHPs, will also be available to individuals under 30 years of age and to people who are exempt from the insurance mandate due to affordability.[1]

The law requires participating insurers to offer at least one plan at the gold and silver levels. An important policy decision for Alabama will be whether the Exchange will require participating insurers to offer plans in all of the other coverage tiers (platinum, bronze, and catastrophic).

Another key decision will be how much to standardize benefits within each level, such as the amount of cost sharing for different services, and the types of plans offered, such as HMO, PPO, or indemnity. The federal law and proposed rule provide some flexibility on the plans offered and the cost sharing, within the actuarial value parameters set by the law and the essential health benefits requirements.

Essential Health Benefits

The federal law requires the Exchange to offer qualified plans in the coverage tiers described above, which must cover essential health benefits. The terms

[1] A high-deductible health plan (HDHP) offered through the Exchange must cover all of the essential health benefits, as determined by the secretary of HHS, but may have larger up-front deductibles and a lower actuarial value than bronze plans. In 2010, HDHPs could have deductibles of $5,950 (individual) and $11,900 (family).

"qualified" and "essential health benefits" will be further defined by the secretary of HHS. The law does, however, enumerate services that must be covered, including the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.[2]

In addition to these federal requirements, Alabama may require health plans to cover additional benefits or services. The state currently has very few mandates. For coverage sold through the Exchange, the federal law requires the state to pay for any mandated benefits that exceed the federally defined essential health benefits.

Alabama will need to review the federal essential health benefits, once they are fully defined, and compare them with the state's mandated benefits. It will then need to make a policy decision regarding whether it will continue to require health plans to cover benefits and services above and beyond the essential health benefits and, if so, how it will pay for those benefits for the policies purchased through the Exchange.

While the law imposes new regulatory requirements on all health insurers, health plans offered through the Exchange must also meet additional requirements, including those governing marketing standards, network adequacy, accreditation, and quality improvement programs. The Exchange may certify a plan for participation only if it "determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates."[3]

[2] Section 1302.

[3] Section 1311 (e) (1).

The law also requires health insurers that are seeking certification as a qualified health plan to submit to the Exchange a justification for any premium increase before implementing the increase, and health insurers must "prominently post such information on their websites."[4] The Exchange must take this information—along with information and recommendations provided by the state Department of Insurance relating to patterns or practices of excessive or unjustified premium increases—into consideration when determining whether to make a health plan available through the Exchange.[5]

Insurers will also be required to submit certain information to the Exchange, the Department of Insurance, and the secretary of HHS and to disclose that information publicly, including

- claims payment policies and practices,
- periodic financial disclosures,
- data on enrollment and disenrollment,
- data on the number of claims that are denied,
- data on rating practices,
- information on cost sharing and payments with respect to any out-of-network coverage,
- information on enrollee and participant rights, and
- other information as determined appropriate by the secretary of HHS.

Given the Exchange's ability to offer premium subsidies to low- and moderate-income individuals and families, insurers offered through the Exchange will likely have access to a large group of new consumers. This heightens the responsibility of the Exchange to establish a fair and open certification process for all qualified plans.

Options for Alabama

Because the ACA requires the Exchange to offer qualified health plans, Alabama will need to establish a process and selection criteria for soliciting plans from insurers. Three basic options or selection processes are available: any qualified plan, selective contracting agent, or active purchaser.

[4] Section 1311 (e) (2).

[5] T.S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, The Commonwealth Fund, September 2010.

Any Qualified Plan

Under the first option, Alabama's Exchange would establish threshold criteria, perhaps no greater than the minimum standards outlined in the ACA and the federal regulations, and offer all qualified health plans that meet the threshold criteria. Under this option, the Exchange acts as an impartial source of information; provides structure to the market to enable consumers to compare health plans based on relative value; administers premium subsidies; and serves, essentially, as a broker of health insurance.

Selective Contracting Agent

The second approach would require the Exchange to play a somewhat more active role in the marketplace. It would exert some influence in the market by contracting with a limited number of carriers offering a select group of health plans, or by requiring that health carriers and health plans meet certain cost and/or quality metrics above and beyond the federal minimums. The Exchange might solicit plans based on plan design parameters or preferred plan types.

Active Purchaser

A third approach would require the Alabama Exchange to act more like a purchaser of health insurance, much as an employer establishes and purchases health benefits on behalf of its employees. This model assumes the Exchange will cover a large and broad risk pool that enables carriers to offer competitively priced plans. Initially, it will be difficult for the Alabama Exchange to act as an active purchaser, due to the fact that the carriers will be required to establish premiums based on numerous unknown factors (the number of people purchasing coverage through the Exchange, health status of enrollees, demographic characteristics, etc.).

Because the Exchange will provide access to affordable coverage for tens of thousands of newly insured Alabamians, carriers offered through the Alabama Exchange will likely have exclusive access to a sizeable population. This heightens the responsibility of the Exchange to establish a fair and open process for selecting carriers and plans, regardless of whether the state decides to offer any qualified plan, to act as a selective contracting agent, or to be an active purchaser.

Network Adequacy Standards

Adequacy Requirement

Section 1311 of the ACA directs the secretary of HHS to establish network adequacy standards for insurers seeking certification of their qualified plans that may be offered by state Exchanges. However, the recently released proposed rule largely defers this responsibility to each state Exchange to "ensure that enrollees

of [qualified health plans] have a sufficient choice of providers."[6] The proposed rule both enables and requires Alabama to establish network adequacy standards that fit the geography, demographics, local patterns of care, and market conditions.

Options for Alabama

Currently, there are no network adequacy standards in effect in Alabama, and no standards or requirements that DOI enforces or monitors as part of its licensing and review process. Assuming no significant changes occur when the proposed rule is finalized, Alabama will have significant latitude in establishing these standards. It could adopt network adequacy standards that apply only to qualified health plans sold through the Exchange, or adopt standards for all health plans licensed for sale in the state. The state might also consider adopting different standards for managed care plans than for preferred provider or indemnity plans.

A first-line decision for Alabama is which entity or agency will be responsible for developing the standards. With DOI responsible for regulating the health insurance market in Alabama—and the likelihood that an Alabama Exchange will have little, if any, regulatory authority—directing the DOI to develop these standards may be the preferred approach. The National Association of Insurance Commissioners has developed a Managed Care Plan Network Adequacy Model Act that the state could consider as it begins developing these standards.

RATE REVIEW AND APPROVAL

Section 1311 (e)(2) of the ACA requires an Exchange to consider rate increases in determining whether to make a health plan available:

> (2) Premium Considerations.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the state under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

[6] Department of Health and Human Services, 45 CFR Parts 155 and 156, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, "Establishment of Exchange network adequacy standards (§155.1050)," pages 106–108.

Required Process

In July 2011 the federal government notified Alabama that it did not have an "effective rate review" process for either the individual or the small group market. This means that the federal government (in particular, CMS) will review the proposed rates for insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets, and carriers will be required to publicly disclose the proposed increases and the justification for them. Federal officials will review such increases to determine whether they are unreasonable. In future years, the threshold for review will be set on a state-by-state basis using data that reflect insurance and health cost trends in each state.

According to CMS, an effective rate review system does the following:

- Receives sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- Considers the factors below as they apply to the review:
  - Medical cost trend changes by major service categories
  - Changes in utilization of services (hospital care, pharmaceuticals, doctors' office visits) by major service categories
  - Cost-sharing changes by major service categories
  - Changes in benefits
  - Changes in enrollee risk profile
  - Impact of over- or underestimating medical trends in previous years on the current rate
  - Reserve needs
  - Administrative costs related to programs that improve healthcare quality
  - Other administrative costs
  - Applicable taxes and licensing or regulatory fees
  - Medical loss ratio
  - The issuer's capital and surplus.
- Determines the reasonableness of the rate increase under a standard set forth in state statute or regulation.

- Posts either rate filings under review or preliminary justifications on their websites or posts a link to the preliminary justifications that appear on the CMS website.
- Provides a mechanism for receiving public comments on proposed rate increases.
- Reports results of rate reviews to CMS for rate increases subject to review.

Options for Alabama

The state will need to determine the role, if any, of the Exchange in reviewing proposed rates, vis-à-vis the role of the state Department of Insurance. Currently, the federal government is responsible for conducting rate reviews in Alabama's individual and small group markets.

The proposed rule indicates that an Exchange "may receive this information (rate review data) from the state DOI (or HHS, if applicable), to satisfy its obligation to receive such a justification."[7] With the Alabama Exchange likely serving as a facilitator of qualified health plans, and not as a regulator or selective contracting agent, the Exchange will probably defer responsibility for rate reviews and approvals to whichever entity (HHS or DOI) handles this responsibility for Alabama's broader individual and small group markets.

[7] Department of Health and Human Services, 45 CFR Parts 155 and 156, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, "Subpart K—Exchange Functions: Certification of Qualified Health Plan," pages 96–104.

Chapter 8
Consumer Assistance

ROLE OF NAVIGATORS AND PRODUCERS

The Exchange must provide assistance to individuals and small businesses that will include

- assisting people with determining eligibility for health coverage;
- helping people enroll in the appropriate health coverage;
- helping individuals and businesses file insurance grievances and appeals;
- providing information on consumer protections; and
- collecting data on inquiries and problems, as well as their resolution.

If the Alabama Exchange is to attract a sufficient volume of individuals, families, and small businesses, it will need to develop a multi-pronged outreach, education, enrollment, and consumer assistance program. Such an effort might include a wide array of organizations and individuals, including Exchange staff, social service agencies, schools, community-based advocacy organizations, faith-based organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, paid media, and public service announcements.

In addition to establishing a website, a customer service unit, a call center, and facilities to provide consumer assistance, the Exchange will need to work with outside entities that can provide assistance to individuals and employers. The ACA requires the Exchange to establish a grant program for navigators who will be responsible for

- conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange;
- distributing "fair and impartial" information concerning enrollment and the availability of premium subsidies and cost-sharing reductions;
- facilitating enrollment in qualified health plans;

- referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and
- providing information in a culturally and linguistically appropriate manner.

Navigators are entities such as trade, industry, and professional associations; chambers of commerce; faith-based and community based organizations; producers; and other groups that have established or can readily establish relationships with employers, employees, consumers, or self-employed individuals. Federal law prohibits health insurers from serving as navigators and prohibits navigators from receiving "direct or indirect payments" in connection with the enrollment of an individual or an employee in a qualified health plan. This prohibition may preclude producers from serving as navigators.

The Exchange will need to establish a selection process for awarding grants to navigators. Community-based groups that currently help with outreach and enrollment for Medicaid, ALL Kids, and other public assistance programs may be prime candidates. Medicaid also trains and certifies "Application Assisters" who help with the initial processing of applications. In addition to these groups of individuals, the Exchange will need to expand outreach efforts to reach people who normally are not eligible for public assistance programs (individuals and families with income up to 400 percent FPL).

In addition to navigators, the Alabama Exchange will need to determine the role for producers and how they might be used to help consumers. Although producers often play an important and influential role in distributing health insurance, the exchange will need to address the exclusion of independent producers from selling health plans offered by BCBSAL.

In determining the appropriate role of producers and navigators, a number of key issues are worth considering:

- What type of assistance is currently provided by various organizations, and how might the Exchange involve these groups in its outreach, education, and enrollment efforts?
- What should be the role of navigators, and should they be credentialed or licensed? If so, which entity should handle credentialing?
- What is the current role of producers in the individual and small group markets, and how can the Exchange best leverage their expertise?
- How are producers compensated today, and what type of producer compensation model might the Exchange establish?
- What should be the role of insurers in outreach, education, and enrollment?

- How can providers, hospitals, community health centers, and other front-line entities support outreach and enrollment?
- What types of information will people need to help them make informed decisions?
- How should the Exchange structure the health benefits that will be available to individuals and small businesses?
- Will the outreach, education, and enrollment needs of individuals differ from those of small employers and their employees?

Establishing an effective, efficient, and sustainable outreach, education, and enrollment effort will be one of the more important initiatives undertaken by the Exchange. Determining how best to leverage the expertise of health insurance producers, community-based organizations, health centers, and other key groups, and proactively including these individuals in the outreach and enrollment program, will be critical to success.

CORRESPONDENCE AND NOTIFICATIONS

The Exchange will be responsible for notifying a number of different entities when decisions are reached on pending issues. On the individual level, the Exchange must communicate verification of eligibility for Medicaid, ALL Kids, premium tax credits, and cost-sharing reductions, in addition to relaying final decisions on individual appeals. On the employer level, the Exchange must notify employers of employee eligibility for advance premium tax credits where the employer does not provide minimum essential coverage or coverage is deemed unaffordable. The Exchange must also notify carriers of premiums and tax credits to be applied to individual and group coverage, ratings of plans submitted to the Exchange, and certification status of submitted plans.

As noted under the eligibility section, in a number of instances the Exchange will need to communicate with or notify various federal and state agencies, including HHS, the IRS, Homeland Security, the Alabama Department of Revenue, ADPH, the Medicaid Agency, and the state DOI.

The communication responsibilities of a fully functioning Exchange are significant, even if HHS has not yet fully articulated them. The Exchange must facilitate communication and notification for a number of different entities, including individuals, employers, health plans, and state and federal agency partners.

Chapter 9
Regulatory Functions

MONITORING AND EVALUATING THE EXCHANGE

Ensuring the quality of both the products offered through the Exchange and the overall user experience will be critical to its success. The Exchange therefore must regularly monitor plan transactions and its own operations.

Additionally, the Exchange will be required to administer a number of functions as needed. For example, when an individual or employer submits a complaint, appeal request, or formal grievance, the Exchange must track the submission through to a resolution.

OVERSIGHT AND PROGRAM INTEGRITY

Oversight and program integrity mechanisms are designed to protect the Alabama Exchange planning and establishment expenditures, as well as provide for ongoing program monitoring and oversight.

Focus Areas

The Exchange will need to address five main areas in its oversight and program integrity efforts:

1. *Fraud, waste, and abuse*. The Exchange will need to seek to prevent fraud, waste, and abuse through a variety of methods, including streamlining enrollment and minimizing acquisition expenses. It will need to implement policies to prevent and detect fraud, waste, and abuse and promote financial integrity.

2. *Eligibility determination and post-enrollment audits*. The Exchange will need to implement a robust audit strategy by creating criteria and protocols using data sources from its partners and stakeholders.

3. *Availability of commercial insurance*. The Exchange will need to work with insurers and other key stakeholders (navigators, producers, employers) to develop processes and procedures for determining whether an applicant or enrollee has available employer-sponsored insurance.

4. *Coordination with insurers*. The Exchange will need to coordinate and share information with insurers to ensure appropriate coordination of

benefits, if applicable, and to ensure that individuals, families, and employees are enrolled in the appropriate health program.

5. *Opportunities for disruption in the commercial markets*. The Exchange will need to work with health insurers, DOI, and other key stakeholders to develop processes and protocols for minimizing unintended disruption to the commercial health insurance markets. This includes, but is not limited to, enforcement and monitoring of off-cycle enrollment, underwriting requirements, and verification of "groups," as that term applies to the small group health insurance market.

Options for Alabama

The Exchange will need to coordinate its program integrity protocols and procedures with participating insurers as well as DOI and key stakeholders, including navigators, producers, and employers.

It will need to combat fraud, waste, and abuse within its financial management system, as well as in the processing of data, information, and funds that flow through the Exchange. The strategy developed for program integrity will need to incorporate the different methods necessary for auditing of the Exchange's financial management system as well as overseeing and monitoring participants, including insurers, navigators, producers, employers, and consumers. To ensure that the Exchange can share relevant data for program integrity, monitoring, and oversight, one of its first activities will be to complete data sharing agreements and establish ongoing coordination activities with its partners and key stakeholders.

An additional priority is to develop program integrity provisions to ensure that individuals, families, employers, and employees are appropriately enrolled in coverage for which they are eligible. Because the Exchange will determine eligibility for people purchasing coverage in the health insurance markets (individual and small group markets, initially), it will be incumbent upon the Exchange to protect the program and participating insurers, and minimize the opportunity for individuals to "game" the system or otherwise engage in improper activities. The Exchange will need to develop these program integrity provisions by evaluating enrollee and provider audit strategies currently in place for the Medicaid and ALL Kids programs, as well as audit procedures used by insurers in the Alabama market.

Although many of the Medicaid and ALL Kids audit strategies are designed to oversee the provider community, there are protocols and criteria for reviewing their enrollees that could be adapted and tailored for the Exchange. In addition, program integrity policies and procedures are likely to be available in the commercial health insurance market that will prove useful and appropriate.

SECURITY

Given the sensitive nature of the information shared through the Exchange, a number of security measures must be in place to protect all users. These will include identity management for individuals and entities and various levels of access control, including authentication procedures and any necessary firewalls to protect electronic transactions. Specifically, the Exchange must comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), and it must employ mechanisms and redundancies to protect both personal identification information and protected health information.

Although the federal healthcare reform law does not explicitly discuss identity access management, CMS does describe the need for consumers who purchase coverage through the Exchange to be able to establish accounts, along with user IDs and passwords. These privacy and security requirements implicitly necessitate that the exchange have built-in identity access management. It must be able to trust the identities of users requiring access and easily administer user identities efficiently and effectively. Such capabilities depend on an integrated, efficient, and centralized infrastructure. They rely on business processes, policies, and technologies that enable organizations to

- provide secure access to any resource,
- efficiently control this access,
- respond to changing relationships, and
- protect confidential information from unauthorized users.

When implementing any technology that allows access to protected information, the following questions should be considered:

- Have the different user roles been considered, and are they included in the identity management process?
- How will the system verify identities, ensure that users are who they claim to be, and evaluate them for risk and access purposes?
- What level of authentication strength is required?
- Are there national or state regulatory requirements or technical standards with which the Exchange needs to comply?
- After authentication, what is the process for credentialing these individuals?
- How often will credentialed individuals need to be re-authenticated?

Exchanges are subject to privacy and security requirements and to civil monetary penalties for infractions, as under HIPAA. HIPAA security standards and electronic transaction rules also apply, although the proposed rule allows states flexibility to create a more "appropriate and tailored" standard with regard to privacy. The proposed rule may require each Exchange to adopt privacy policies that conform to the Fair Information Practice Principles.

Appendix
Abbreviations

ACA	Affordable Care Act
ADPH	Alabama Department of Public Health
AHIP	Alabama Health Insurance Plan
BCBSAL	Blue Cross Blue Shield of Alabama
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
HHS	Health and Human Services (federal)
DHR	Alabama Department of Human Resources
DOI	Alabama Department of Insurance
FPL	federal poverty level
HDHP	High Deductible Health Plan
HHS	US Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
IRS	Internal Revenue Service
IT	information technology
LEP	limited English proficiency
MAGI	Modified Adjusted Gross Income
PPO	preferred provider organization
RFI	request for information
SEIB	State Employees Health Insurance Board
SHOP	Small Business Health Options Program
SNAP	Supplemental Nutrition Assistance Program